

**EVALUATING THE IMPLEMENTATION OF HIV AND AIDS POLICIES AT A MAJOR
SOUTH AFRICAN HOTEL GROUP**

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DECLARATION OF INDEPENDENT WORK

I, Christine M van der Berg, ID number 851204 0019 081 and student number 205002366, do hereby declare that this research project submitted to the Central University of Technology, Free State for the degree **MAGISTER TECHNOLOGIAE: TOURISM AND HOSPITALITY MANAGEMENT**, is my own independent work; and complies with the Code of Academic Integrity, as well as other relevant policies, procedures, rules and regulations of the Central University of Technology, Free State; and has not been submitted before to any institution by myself or any other person in fulfilment (or partial fulfilment) of the requirements for the attainment of any qualification.

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DATE

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SUMMARY

South Africa is the country with the largest population of HIV and AIDS sufferers in Sub-Saharan Africa. Since AIDS is an incurable disease that mostly affects individuals in their productive years, it could have a disruptive impact on the productivity and financial sustainability of organisations, which is especially true in the hospitality industry where long and strenuous working hours are often expected from staff. With this in mind, the study aimed to evaluate the level of implementation of HIV and AIDS policies in the hospitality industry, by focusing on a major South African hotel group.

This particular hotel group operates a number of individual hotels throughout South Africa. To ensure that all geographical areas were covered, major cities in three different provinces were identified as suitable locations for individual hotels to be identified for the study. The city of Durban, representing the Kwazulu-Natal Province, was selected on the basis of being the worst-affected area, with Bloemfontein (Free State Province) and Cape Town (Western Cape Province) as the medium-affected and least-affected area respectively. The data, which was gathered by means of a questionnaire, was interpreted both qualitatively and quantitatively. The findings show that the respondents were not always aware of the existence of HIV and AIDS policies and that these were not being adequately communicated to staff. The findings also indicate that the respondents do not fully comprehend the disruptive nature of the disease or the fact that it could negatively affect productivity and profit.

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CHAPTER 1: INTRODUCTION

1.1 BACKGROUND TO THE STUDY

The hospitality industry takes pride in being hands-on and service-oriented enterprise, built on dedication, quality of service and customer satisfaction. It is also a labour-intensive industry, with employees often having to work long and strenuous hours. Sub-Saharan Africa has the largest number of people living with HIV and AIDS in the world, with South Africa as the country with the largest population of HIV and AIDS sufferers (DPSA, 2002:75). Both HIV (earlier stages of disease) and AIDS (advanced stages of disease) have an enormous impact on organisations in the hospitality industry.

HIV is the abbreviation of the term “Human Immunodeficiency Virus”, which represents the initial stage of infection, while AIDS (“Acquired Immune Deficiency Syndrome”) is used to describe the advanced stage of infection (Barrett-Grant, Fine, Heywood & Strode, 2003:110; Cathsseta, 2003:4; DoH, 2000b:1; Hardy & Kleinsmidt, 2004:2; ILO/ECP, 2008:1; Simelela, Crowley & Schaay, 2002:7; Stevens, Lynn & Glass, 2008: 614); Teklemariam, 2006:7; UNAIDS/IHRA, 1999:9; Van der Walt, 2007:25.1).

HIV and AIDS sufferers are likely to suffer most in an industry where intensive working schedules are expected. It is thus imperative that organisations in the hospitality industry not only have sound HIV and AIDS policies in place, but that they also implement such policies to the benefit of employees suffering from HIV and AIDS in particular (Douglas & Sutherland, 2009:56; Lloyd & Abramson, 1999:10). The effective implementation of HIV and AIDS policies may contribute to the effort of meeting

employee and business needs. Through awareness, counselling and treatment programmes, infected employees may once again become productive members of the workforce (IFC, 2002:7).

HIV and AIDS was diagnosed as a disease for the first time in the 1980s (Barrett-Grant *et al.*, 2003:11; DoH, 2006:2). HIV and AIDS cannot be seen as a single disease, but rather a combination of different illnesses caused by the total breakdown of the immune system, leaving it unable to protect the body against infection. In the advanced stage of HIV and AIDS, the body has little or no defence against any infection or illness, which usually results in death (Lloyd & Abramson, 1999:129; Stevens *et al.*, 2008:614). Within the first six weeks to three months of becoming infected, the person develops antibodies against the disease (DoL, 2000b:66; Simelela *et al.*, 2002:7) and could experience “flu-like” symptoms (Stevens *et al.*, 2008:614).

An HIV test could show a negative result if taken within the initial six weeks to three months of infection, which is known as the “window” period, but the person is still able to transmit the virus to others. This is followed by a “silent” period of between two to 15 years, during which HIV progresses into AIDS (DPSA, 2002:15). Those most affected by AIDS are young and middle-aged adults during their peak production and reproduction years, impacting negatively on business and on employees’ lives (DoH, 2006; DPSA, 2002:13; Douglas & Sutherland, 2009:54). The direct economic impact involves increased financial challenges that may reduce workforce capacity and productivity (Vass & Phakathi, 2006:8).

The Actuarial Society of South Africa (ASSA, 2005) estimates that close to one in every five South Africans between the ages of 20 and 64 years is infected with HIV. The disease can be transmitted in a variety of ways, most notably through unprotected sex, contact with infected blood and other bodily fluids, shared hypodermic needles, and mother-to-child transmission at birth or through breastfeeding (Barrett-Grant *et al.*, 2003:11; Cathsseta, 2003:5; ILO/ECP, 2008:2; Lloyd & Abramson, 1999:14; Stevens, *et al.*, 2008:614). Although HIV and AIDS is an incurable disease, antiretroviral (ARV) treatment can prolong productive life (Charalambous *et al.*, 2007:35; Dreger, 2009:243).

Employing individuals with HIV and AIDS might prove a challenge to business (Fulford, Rothman & Lynch, 2007:91; Nyblade, 2004:5). With a growing HIV and AIDS population in South Africa, an HIV-infected individual is certain to become an employee of some sort eventually, reiterating the importance of sound policies in this regard (HSRC, 2005:xix). According to Ramsingh and Van Aardt (2006:192) and Schoeman (1992), confidentiality (not revealing an employee's HIV and AIDS status to others in the workplace) could provide some protection from discrimination (Breuer, 2004:166; CoGTA, 2007:5; DoE, 1999:6; DoL, 2000b:16; Government of Nova Scotia, 2001:6-26; Government of South Africa, 1996; Government of South Africa, 1998; Ngwena, 2000:100). This enables the affected employee to act with authority and autonomy, without bias from others in the workplace.

Keeping employee medical information confidential is a right and sanctioned by

legislation – notably the Labour Relations Act, 66 of 1995 (Government of South Africa, 1995) and the Employee Equity Act, 55 of 1998 (Government of South Africa, 1998). In terms of these acts, five main aspects apply to HIV and AIDS in the workplace:

- 1) Non-discrimination against employees infected with HIV and AIDS;
- 2) Confidentiality;
- 3) Equitable employee benefits;
- 4) Dealing with dismissal related to HIV and AIDS; and
- 5) Managing grievances (unfair dismissal or unfair treatment).

According to Grant (2003), policies should be implemented to assist employers in managing the effects of HIV and AIDS. Businesses are uniquely positioned to use their influence to challenge the stigma associated with the disease, to promote prevention and to initiate treatment and support for employees (Douglas & Sutherland, 2009:55). In alerting and preparing the workforce to deal with the issue of HIV and AIDS, strategies include providing training and education on HIV and AIDS; launching awareness campaigns, providing counselling, and promoting the use of condoms (Douglas & Sutherland, 2009:56; DPSA, 2002:75; Yap & Ineson, 2009:5). Businesses must ensure that their infected employees are treated equally and given the same opportunities for promotion as other employees (Allen, Gould, Koteff & Martin, 2005:20; Ellis, 2007:49; Government of South Africa, 1995).

Past research conducted by Cohen, (2000), Hartline & De Witt, (2004) and Rhoades & Eisenberger, (2002) has shown that the level of commitment from organisations is

positively related to employee retention, benefiting not just employees but companies as well. Due to its prolific impact, HIV and AIDS affects economic markets, savings rates, investment and consumer spending which in turn could impact negatively on companies (Lloyd & Abramson, 1999:16; Rau, 2002:23). The emphasis once again the importance of effectively implementing HIV and AIDS policies in the workplace.

1.2 PROBLEM STATEMENT

HIV and AIDS impacts negatively on business performance by increasing cost and decreasing productivity (Agbola, Damoense & Saini, 2004; Aggleton, Wood, Malcom & Parker, 2005; Cathsseta, 2003:6). Given the potentially disruptive nature of HIV and AIDS in the workplace, it is crucial that organisations in the hospitality industry not only have sound HIV and AIDS policies in place, but that they also take steps to adequately implement such policies (Douglas & Sutherland, 2009:56; Lloyd & Abramson, 1999:10). The major hotel group that formed the focus of this study could find the results most valuable in their effort to effectively implement HIV and AIDS policies within the organisation.

1.3 EXPECTED OUTCOMES

Primary objective:

To evaluate the implementation of HIV and AIDS policies at a major South African hotel group.

Secondary objectives:

To reflect on the HIV and AIDS issues faced by organisations, by focusing on relevant

literature.

To evaluate the existing HIV and AIDS policy implementation strategies at a major South African hotel group.

To make specific recommendations to the hotel group regarding HIV and AIDS policy implementation.

1.4 RESEARCH METHOD

The main aim of this investigation was to ascertain how well HIV and AIDS policies are implemented in a major South African hotel group. Data was captured by means of a structured questionnaire. The questionnaire was based on the constructs identified by literature and were divided into five sections. The first section captured the demographic composition of the respondents that included age, gender, race, educational level and current position. The second section captured the HIV and AIDS policy information and its communication, the third section captured employees perceptions on the influence of HIV and AIDS on job performance and the fourth section the hotels attitude to HIV and AIDS, the fifth section captured employee perception on programmes offered by the hotel group. The hotel group under investigation has individual hotels throughout South Africa – from the worst- to the least-infected areas. One city in each of the infected areas was selected for data collection - Durban (representing Kwazulu-Natal) is the worst-infected area, while Bloemfontein (Free State) is a medium-infected area and Cape Town (Western Cape) is the least-infected area.

1.5 LIMITATIONS OF THE STUDY

Obtaining consent from the hotel groups head office was a time-consuming process, and

some of the hotels in the group refused to participate in the study. Employee participation was voluntary, with the result that the views of those employees who refused to participate are not reflected. As this study evaluated the implementation of HIV and AIDS policies at one particular hotel group, the findings cannot not be generalised to other hotel groups.

1.6 CHAPTER LAYOUT

1.6.1 Chapter 2: HIV and AIDS – Setting the Scene

Chapter 2 sets the scene for a thorough comprehension of the nature and extent of HIV and AIDS, detailing the lifecycle of the virus and the regulations applicable to HIV and AIDS in the workplace.

1.6.2 Chapter 3: Organisational Challenges in Dealing with HIV and AIDS

Chapter 3 reflects the organisational challenges in dealing with HIV and AIDS and proposes some prevention programmes that could be considered.

1.6.3 Chapter 4: HIV and AIDS Policy Considerations

Chapter 4 highlights the importance of policies, as well as the policymaking process and policy lifecycle. It also reflects on lessons learned from previous policy implementation endeavours.

1.6.4 Chapter 5: Methodological Overview and Analysis of Results

Chapter 5 presents the methodological overview and data analysis, including the study

design, measuring instruments, pilot study and main study. It also details the descriptive analysis of the data and presents inferential statistics.

1.6.5 Chapter 6: Conclusions and Recommendations

Chapter 6 details the conclusions and subsequent recommendations of the study.

CHAPTER 2: HIV AND AIDS – SETTING THE SCENE

2.1 INTRODUCTION

The hospitality sector is characterised by physical labour and long, strenuous hours (Herholdt-Smith, 2006; Rosen *et al.*, 2004:317). HIV and AIDS are South Africa`s fastest growing epidemic and has a massive impact on human and organisational life (Barrett-Grant *et al.*, 2003:12; Brand, 2010b:28; O`Grady, 2004:205). The impact of HIV and AIDS, especially on business, is worse in South Africa than anywhere else in the world (DoH, 2006; Douglas & Sutherland, 2009:54; Ngwena, 2000:96; Poggenpoel, 2006:1). The pandemic has grown exponentially, and the AIDS Foundation of South Africa (AFSA, 2008) estimates that the lack of co-ordination in response to the pandemic could be the primary cause of the dire situation in the country.

It is essential to respond to human loss, but also to ensure that a sustained support and treatment system is in place with reasonable accommodation for infected employees (Dreger, 2009:243; ILO, 2003b:10; UNICEF, 2008:10). This will inevitably influence organisations, reiterating the importance of implementing HIV and AIDS policies in a consistent manner. Lower productivity is inevitable when skilled workers are lost (Setswe, 2009:82), and the impact of the disease forces management to consider appropriate policies to fight the pandemic in the world of work. This is not enough, however, and policies also need to be adequately implemented in order to be of value to organisations. The implementation of HIV and AIDS policies is regulated by the Code of Good Practice, as part of the Labour Relations Act, 66 of 1995 (Labour Protect, 2006:1).

By 1999, 32 million people were infected and living with HIV and AIDS worldwide – most of whom were at the peak of their productive years (Colgate-Palmolive Company, 2008:2; Dreger, 2009:243; Mamotte, Wassenaar, Koen & Essack, 2010:1; UNAIDS 2008:202; UNAIDS/IHRA, 1999:9). In 2010, the South African population stood at around 50 million, with an estimated 10.5% (or 5.3 million) infected with HIV (Brits, 2011:7; Stats SA, 2011:6). It is further estimated that globally, there are 6 800 new infections and 5 700 AIDS-related deaths daily, with 76% of those deaths occurring in Sub-Saharan Africa (USAID, 2005:8). It is further postulated that 68% of infected individuals worldwide are living in South Africa (KFF, 2007:1; NTC/GAC, 2004:3; Pienaar, 2011:11).

HIV and AIDS affects six out of 10 men, eight out of 10 women, and nine out of 10 children. It is estimated that one fifth of South African women were infected with HIV and AIDS in 2010, with the percentage of infected pregnant women rising from 1% in 1990 to 24% in 2003 (Barrett-Grant *et al.*, 2003:36). Women are also at greater risk of infection than men, mainly due to their anatomy (Jantjie, 2009:7; Ndobu, 2006:1; NPA, 2005:1; Strand, Matlosa, Strode & Chirambo, 2004:44; UNICEF, 2008:16). Moreover, since women are generally the caregivers in society, the increased rate of infection amongst women could have an adverse affect on society in general.

Possible ways of containing new infections are by delaying youthful sexual activity, dating individuals of the same age group, being faithful to one's partner, and not feeling pressured to have sex in a relationship (USAID, 2005:17). This is crucial, as the youth (aged between 15 and 24 years) account for 45% of new HIV infections worldwide (Avert,

2009b; Grant, Strode & Smart, 2002:16; UNAIDS, 2005:1; Yap & Ineson, 2009:504). Educating the youth is a key strategy in mitigating the spread of the disease. Quite encouraging is a report indicating that the infection rate amongst youth aged 15 to 24 years dropped from 9.2 million in 2005 to 7.7 million in 2010 (ASSA, 2011:1), emphasising the importance of focusing on the youth.

One possible aspect aggravating the spread of the disease is economic inequality since the disease spreads faster among the poor than those who can afford education. Educated individuals are generally better informed about the disease and in a better position to avoid infection (AGOA Forum, 2001:2; UNAIDS/WHO, 2009:24). People living in informal urban areas are also more likely to become infected than those living in urban areas, mostly due to poverty and lack of awareness of the detrimental effects of the disease (Barrett-Grant *et al.*, 2003:33; Bodiang, 2001:4; DoH, 2000a:6; DoH, 2007b:30).

Intervention strategies should support and empower individuals to make changes in their lifestyle and to ensure that they know how to treat the illness and thus ensure a longer, more productive life. This can be achieved through the use of ARV, and by following a balanced diet that consists of regular meals and includes plenty of fresh fruit and vegetables. Good nutrition and a healthy lifestyle help support the body's natural immunity, while alcohol, caffeine and sugar suppress the immune system and should ideally be avoided by infected individuals (Brand, 2010b). Emotional support of the sufferer is also extremely important in improving quality of life (Avert, 2009a).

2.2 NATURE AND EXTENT OF HIV

HIV and AIDS attacks and weakens the immune system, leaving the physical body defenceless and unable to fight off illnesses or infections (MFLOHC, 1999:1). Notable symptoms in the HIV stage could include weight loss, fever, diarrhoea, lymph-gland enlargement and skin conditions caused by the immune system's inability to fight off the virus (ILO/WHO, 2005:33). There is a time gap between initial infection and the onset of symptoms (Fasset, 2005:10), making HIV and AIDS a lentivirus or slow virus (Baloyi, 2004:1).

The virus incorporates itself into the generic material of the CD4 cell or T-cells, rendering the immune system totally defenceless against infection (Fasset, 2005:10). The virus is nothing more than replicating particles of biological material, which interacts with specific cells of the immune system which needs T-cells to fight off infection (Van Wyk, 2003). The immune system is a collection of tissue and cells patrolling the body for invaders, while T-cells are a combination of CD4 cells (secreted by white blood cells) and CD8 cells (killer cells) that directly kill viral infections and parasite cells (Cichocki, 2007b). The HIV and AIDS virus destroys the immune cells quicker than they can reproduce to protect the body.

HIV needs 'host' cells to be able to replicate itself and CD4 cells could act as host cells (Cichocki, 2007a). The fewer the number of functioning CD4 cells, the weaker and more vulnerable the immune system could become (Cichocki, 2007b; Grant *et al.*, 2002:14), leading to other viral infections and eventually death. CD4 cells are the 'helper' cells that

lead attacks against infection (AIDS InfoNet, 2010; WebMD, 2009). HIV belongs to the retrovirus family, i.e. a virus that affects the DNA/RNA compilation (Baloyi, 2004:1; Daar, 2010) and infects and kills the T-cells that should defend the body against infection (ILO/ECP, 2008:29; Yap & Ineson, 2009:507).

The CD4 cells could deteriorate in time, indicating a weakened immune system. A normal CD4 count is 1200 per 600 cubic millimetres of blood (cubic millimetre being the measure taken by a medical machine to determine the number of CD4 cells in a person's blood) and a count below 200 is an indication of full-blown AIDS (AIDS InfoNet, 2010; Cichocki, 2007b; Johansson, Robberstad & Norheim, 2010:1).

With the above as background, the importance of ARV treatment is highlighted as a means of supporting the immune system and prolonging life (Daar, 2010; Dorrington, Johnson, Bradshaw & Daniel, 2006:1; Poggenpoel, 2006:12). ARV treatment slows the progression of the virus and makes it less effective, thus delaying the damage to the immune system (Dickinson, 2006a:705; DoH, 2005).

The downside of ARV treatment is that it increases the risk of heart disease, diabetes and other complications and the monitoring of kidney and liver functioning should be monitored closely in infected individuals (Brand, 2010b:28). ARV treatment could also cause some initial side-effects as the body adjusts to the medication, which could last about two weeks to three months (Baloyi, 2004:5).

Six months after starting treatment, a blood test must be done to ensure that the correct dosage is being administered, with adjustments to be made if necessary. Thereafter, intermittent blood tests should be done to ensure that treatment remains optimal (Daar, 2010).

Although Sub-Saharan Africa has the largest ARV treatment programme in the world (DoH, 2007a: 49), more than half of infected individuals are still not receiving treatment in the region (Dorrington *et al.*, 2006:5; UNAIDS/WHO, 2009:25). Global ARV coverage rose from 7% in 2003 to 42% in 2008 – an indication of more people seeking treatment for the illness (UNAIDS/WHO, 2009:9). But by the end of 2007 only an estimated 28% of infected individuals in South Africa were receiving treatment, indicating that access to treatment is a serious problem in this country (WHO, 2008). On the African continent, only 30 000 infected individuals received ARV treatment in 2003 (Barbra, 2003:1). According to Brits (2011:7), 795 000 of infected South Africans received treatment in 2011.

Organisations could consider contracting a mobile clinic to make healthcare more accessible to employees. ARV treatment is for life, and ensuring that infected employees are continuously treated is crucial (UNAIDS, 2008:194; UNAIDS/IHRA, 1999:22). There are cases of individuals, such as Howard Armistead, who have been living with AIDS for years and who are able to lead normal lives with the right treatment (Chinga, 2006; DoH, 2006:5).

2.2.1 HIV Lifecycle

Mak, Mo, Cheung, Woo, Cheung and Lee (2006:1913) compared public attitudes towards HIV and AIDS and tuberculosis (TB) and found that people with HIV were viewed as being responsible for contracting the disease, whereas those with TB were not. TB, which is caused by the *Mycobacterium tuberculosis* bacterium, destroys the soft tissue of the lungs, causing cavities (DoH, 2001). People are more likely to stay away from those with HIV and AIDS than those with TB, despite the fact that TB is an airborne disease that is much easier to contract than HIV and AIDS, which can only be spread through unprotected sex and exposure to infected blood and bodily fluids.

The fact that HIV and AIDS impairs the immune system leaves the body vulnerable to opportunistic infections such as skin diseases, cancer, diarrhoea, shingles, rashes, and genital sores (Giliomee, 2006:1; UNAIDS/IHRA, 1999:14). Someone suffering from TB or a sexually transmitted disease (STD) is at an increased risk of contracting HIV and AIDS (Simelela *et al.*, 2002:8). Co-infection with TB, STDs, and HIV and AIDS occurs in 50% of cases, indicating that the treatment of TB and STDs is just as important as HIV and AIDS treatment (Simelela *et al.*, 2002:8).

The stigma associated with HIV and AIDS is more severe than in the case of other physical or mental illnesses (Herek, Capitanio & Widaman, 2002:373). Lee, Wu, Rothram-Borus, Detels, Guan & Li (2005:436), in a study in China, found that people with HIV and AIDS were shunned and in many instances not allowed to take care of others or work with those not infected. This type of isolation and rejection of infected individuals

indicates the enormous stigma and discrimination that is still attached to the illness in the 21st century.

Table 1 indicates the HIV and AIDS lifecycle. The period following the initial infection is called the window period. Sero-conversion is the development of antibodies in the blood directed against an infectious agent. Antibodies seroconvert from antibody-negative to antibody-positive, trying to protect the body against the virus. HIV-well refers to the stage after sero-conversion, when individuals usually experience a symptom-free or asymptomatic period, which could occur after the sero-conversion period and could last for years. Although an HIV-infected person has no symptoms in the initial phase, the virus continues to replicate. HIV-ill refers to the slow weakening of the immune system, characterised by symptoms such as weight loss, swelling in the neck, sores, rash, TB, fever and diarrhoea. AIDS creates severe immune cell loss, leading to the symptomatic period, which is also referred to as AIDS sickness. Once this stage is reached, death is likely to occur within one to two years (Barrett-Grant *et al.*, 2003:22; Fasset, 2005:11)

Table 1: HIV and AIDS lifecycle

Infected	HIV-well	HIV-ill	AIDS
↓	↓	↓	↓
Window period (sero- conversion)	Look & feel well	Weight loss, swelling in neck, sores, rash, fever, diarrhoea (CD4 350 to 200)	Susceptible to opportunistic infection (CD4 200 and less)
↓	↓	↓	↓
HIV-well	Destroying of immune system (CD4 600 to 350)	TB, fever, diarrhoea	TB, cancer, shingles, STDs
	↓	↓	↓
	HIV-ill	AIDS	Death within 1–2 years

Adapted from: Barrett-Grant *et al.* (2003:22), Dorrington *et al.* (2006:29), Fasset (2005:11) and Orr and Patient (2006:5).

2.3 REGULATING HIV AND AIDS IN THE WORKPLACE

As already mentioned, the Code of Good Practice regulates HIV and AIDS in the workplace and encourages the development and implementation of policies that will lead to a workplace where employees and employers respect one another's HIV and AIDS status and support one another (ILO, 2001:12). It stipulates that no individual is obliged to disclose his/her HIV and AIDS status or undergo HIV and AIDS testing in order to be employed. Moreover, no employee may be unfairly discriminated against and may not be dismissed solely on the grounds of HIV and AIDS status. As such, HIV and AIDS policies

must be established to protect the human rights of infected individuals (ILO, 2005:2; Mpundu, 2002:1; Muthaura & Njau, 2005:xvi; NTC/GAC, 2004:4; Vass, 2008:3).

Policies must be designed to be sensitive to the characteristics of business, while at the same time providing clear and appropriate guidance (UNAIDS/IHRA, 1999:10). By having clear policies and procedures, an organisation is better equipped to provide assistance in terms of training, education and support (Yap & Ineson, 2009:507). This is especially applicable to the hospitality industry where, as indicated before, long and strenuous hours are expected from employees (Rau, 2002:14).

One of the goals of HIV and AIDS policies and procedures is to alleviate and reduce the rate of infection (ILO, 2009:2; Labour Protect, 2006:1; UNAIDS, 2005:4). While the existence of a policy does not necessarily reflect effective governance, it does indicate a written commitment to a set of principles, which is an essential step in managing HIV and AIDS in the workplace (Vass, 2008:3). Yap and Ineson (2009:515) reported a lack of policy awareness, and even an unwillingness to implement policy on the part of many hospitality industry managers in several Asian countries.

Workplace policies and procedures could assist in limiting the stigma and discrimination associated with the disease (Smart & McKenna, 2006:6; Zaccagnini, 2009:3). In this regard, organised labour (unions) could also assist by emphasising the importance of a unified effort from management and employees (Mapolisa, Schneider & Stevens, 2004:165; Rau, 2002:9; Stevens, Weiner, Mapolisa & Dickinson, 2005:296). Policies and

procedures should constantly be updated to remain relevant.

The extent and nature of a policy should be guided by the needs of the business and the employees, in relation to being affected by the HIV and AIDS pandemic. The reality of HIV and AIDS is enormously complex, and responding to the challenge requires action (such as prevention, support, treatment, care, training and education) on the part of the organisation (Bateesa, 2009:9; Forsythe, 2002:2; ILO, 2003a:21; Van der Walt, 2007:25.2). HIV and AIDS policies and procedures could contribute towards managing the negative impact of HIV and AIDS (Connelly & Rosen, 2005:615). The implementation of HIV and AIDS policies and procedure addresses business vulnerability with regard to the pandemic and should provide ways of mitigating the effects of the pandemic (ILO/WHO, 2005:3; UNAIDS, 2008:196). Management and employees at all levels should comprehend and be aware of the HIV and AIDS policies and procedures (Ramsingh & Van Aardt, 2006:191; Rau, 2002:14; UNAIDS/IHRA, 1999:19).

According to the Botswana Training Authority (BOTA, 2005:1), a cross-sectional approach is needed to implement HIV and AIDS policies and procedures by using individuals from one department to inform employees of another department about HIV and AIDS. Policies and procedures should balance employee and employer needs (BOTA, 2005:3), as well as productivity and profitability, while keeping employees' health in mind (DoH, 2006:16). Shared responsibility should exist between human resources, management and employers in the workplace, and formal and informal communication channels should be used to continuously inform employees (Stevens *et al.*, 2005:287). Working to prevent the

spread of HIV is not only a humanitarian imperative but rather a long-term response to the epidemic (Douglas & Sutherland, 2009:56). Due to a lack of knowledge and understanding about HIV and AIDS, some employees might find it difficult to accept infected co-workers and may have a negative attitude towards them (UNAIDS/IHRA, 1999:20). As such, the adequate implementation of policies could lead to a better understanding of HIV and AIDS (Pulerwitz, Greene, Esu-Williams & Stewart, 2004:9).

Mundy and Dickinson (2004:177) indicated that businesses in South Africa have been slow to respond to HIV and AIDS because the provision of education and treatment could be expensive (Guilwe, 2007; Reed, 2004:235; Stevens *et al.*, 2005:296). It is encouraging, however, that the hospitality industry appears to have been proactive in addressing the HIV and AIDS issue (AGOA Forum, 2001:16).

2.4 SUMMARY

This chapter detailed the nature and extent of HIV, emphasising the potentially unsettling impact it can have on organisations. It also detailed the prevalence of the disease worldwide and in the South African context, as well as the lifecycle of the pandemic. In reiterating that policies and procedures should assist organisations in mitigating the potentially disruptive impact of HIV and AIDS, this chapter stressed the importance of employees having knowledge of the relevant policies and procedures, so that they may join together in fighting the epidemic. Everyone must know as much as possible about HIV and AIDS, the treatments available and the effects of the disease, so as to increase their chances of living a healthy life. Reality requires more than the implementation of a

policy, but rather a holistic approach to the pandemic by considering its impact on the work environment, as well as the community at large.

CHAPTER 3: ORGANISATIONAL CHALLENGES IN DEALING WITH HIV AND AIDS

3.1 INTRODUCTION

Not since the outbreak of the co-called “Spanish flu” in 1918, which claimed millions of lives, has the world experienced such a devastating pandemic as HIV and AIDS. The profound impact of the disease on business is forcing all industries, including the hospitality industry, to focus on the importance of awareness and appropriate action. HIV and AIDS has a profound social, economic and emotional impact on the sufferer, who may be left feeling socially unwelcome, emotionally isolated due to lack of support from friends and family, and economically pressured due to the high cost of treatment, nutritious food and transport (Pharaoh & Schonteich, 2003:138; Vass & Phakathi, 2006:15).

The hospitality industry is extremely labour intensive, and infected individuals could find it difficult to keep up with the strenuous working hours and arduous mental and physical effort expected from staff. This calls for an approach that considers the physical, social and psychological needs of employees and their families, as well as organisations (CETU, 2001:21).

It is predicted that South Africa’s economy could show a 5.7% decline by 2015 as a result of the HIV and AIDS pandemic (Jugdeo, 2009:13), with a prediction of a 5% to 35% reduction in the labour force by 2020 (Bollinger & Stover, 1999:3; Falkier, 2004:89). HIV and AIDS diminishes the value of human capital due to absenteeism, increased workload, discrimination, general uncertainty and the fear of infection, all of which

undermine staff morale (Jugdeo, 2009:15). The annual loss due to absenteeism in 2009 was estimated at R12 billion (Pillay, 2009:2). Phaswana-Mafuya and Pelzer (2005:278) indicated that approximately 250 productive days are lost over the course of a single person's illness.

The challenges posed by HIV and AIDS could intensify in the coming years due to ARV shortages and the lack of funding for treatment (Aspen CBE, 2008:1; Du Toit & Burger, 2004:2). As this is a public health issue, it can have serious implications for employment relationships (CETU, 2001:13; Van der Walt, 2007:25.1). Health workers and management needs to work with employees to make sure that the correct information about HIV and AIDS is available and communicated, and organisations must be prepared to deal effectively with the challenges posed by HIV and AIDS if they are to maintain productivity and service delivery (Grant *et al.*, 2002:1).

Apart from the stigma and discrimination associated with HIV and AIDS, there is often a lack of accurate information amongst employees (Bos, Schaalma & Mbwambo, 2004:3; DoH, 2007a:35; Hikuam, 2004:8; HSRC, 2005:91; HSRC, 2009; ILO, 2001:3; Kerkhoven & Lowik, 2004:20; Mahendra & Gilborn, 2004:13; Morrison & Cuadra, 2004:12; Nyblade, 2004:5; Seale, 2004:3). Coombe (2002:vii) proposed a move from a narrow to a broader education campaign, with information as the only social vaccine available against HIV and AIDS. An investigation by the South African Department of Health (DoH, 2003) on the impact of HIV and AIDS on the hospitality sector indicated that there is a critical need for practical tools and guidance in developing and taking action against the pandemic.

The severe impact of HIV and AIDS on business could be managed by means of training, education and awareness (Baker *et al*, 2004:5; Njjang'iru, 2008). Four aspects have been found to be particularly important with regards to infected individuals (ILO, 2001): prevention, management and/or interaction, care and support, and the elimination of stigma. According to Brand (2010a) awareness in the hospitality industry has increased due to the availability of treatment, greater awareness and better understanding. Awareness is the first step to ensure training and education could occur.

3.2 HIV AND AIDS CHALLENGES

HIV and AIDS poses certain challenges for the organisation, firstly is the stigma associated with the illness and discrimination on the part of the organisation, colleagues or superiors. Secondly the illness could also lead to higher levels of absenteeism and reduced job performance, which is discussed in more detail below.

3.2.1 Stigma and Discrimination

Stigma and discrimination is a major obstacle for infected employees (AGOA Forum, 2001:2; CHAA, 2010:49; FDA, 2004:1; ILO, 2003b:26; Seale, 2004:1; USAID, 2008:9). Stigma could be described as an extreme social label that affects one's attitude towards others and could be directed at persons or objects that bear certain qualities, marks of disgrace or defects (USAID, 2008:9). Discrimination means that individuals are not treated equally because they belong to a particular group or have certain characteristics, and both stigma and discrimination lead to prejudice (unfair treatment of persons or

objects) (Seale, 2004:1). Stigma and the ensuing discrimination could also lead to the abuse of human rights (Seale, 2004:2).

It has also emerged that employees are often reluctant to be tested for HIV and AIDS due to the associated stigma and discrimination by their community or culture (Dickinson, 2006b:322; Dickinson & Stevens, 2004:78; DoL, 2000a:2; Guilwe, 2007; ILO/ECP, 2008:3; Mapolisa *et al.*, 2004:166; O'Grady, 2004:210; Pulerwitz *et. al.*, 2004:8; Stevens, 2004:282). In some cultures, being infected could mean being disowned and rejected by family members, and in developing countries in general, stigma and discrimination are related to the values and beliefs of specific cultures, making this a highly complex problem (Atkins-van Kogelenberg & Nyirenda, 2004:15; Bos *et al.*, 2004:4; Masindi, 2004:7; Yap & Ineson, 2010:70).

Stigma and discrimination is a reflection of societal attitude or behaviour in terms of power differences in social status (Markowitz, 2005). Stigma and discrimination function at the intersection of culture, power and differences, leading to behaviour changes against those infected by HIV and AIDS (Parker & Aggleton, 2003:13; Poggenpoel, 2006:13). Inaccurate or incorrect information could increase the stigma and discrimination associated with HIV and AIDS (IOE, 2002:16). As already mentioned, the stigma attached to HIV and AIDS is heightened by the fact that HIV is a sexually transmitted disease – making it a moral issue (CoGTA, 2007:2; Dickinson, 2003:21).

The fear of not being promoted could also arise from a positive HIV status. As already

indicated, both the Labour Relations Act and the Employee Equity Act stipulate that someone suffering from HIV and AIDS may not be dismissed solely on the basis of his or her HIV and AIDS status, except when that employee becomes too ill to perform essential tasks (Guilwe, 2007; Pauw, 2006). Patient and Orr (2004:3) found that individuals would rather attend wellness training and other intervention programmes in groups than alone, which shows that a collective effort is more successful in this regard.

Although pre-employment and employment testing is prohibited by law, infected individuals could isolate themselves from others due to a fear of rejection, judgment and discrimination (Gertholtz, 2004:40; Jugdeo, 2009:28). Reasonable steps could be taken to accommodate and redeploy infected employees, for instance by moving an employee from a manual-labour position to an office-based job that is less physically demanding (ILO/UNESCO, 2006:14; ILO/WHO, 2005:5).

This implies organisational flexibility in accommodating employees (Dreger, 2009:244). A non-discrimination policy in a business could promote non-judgemental behaviour on the part of colleagues and superiors, leading to a supportive working environment (CETU, 2001:13; DoH, 2000b:2; Dreger, 2009:243; GBC, 2007:2; Government of Nova Scotia, 2001:6-25; Government of Uganda, 2007:4; ILO, 2005:2; ILO/UNESCO, 2006:6; NMBM, 1998:2; NTC/GAC, 2004:5; Rampersad, 2006:80; Setswe, 2009:84).

Poor attitudes, denial, stigma and discrimination associated with HIV and AIDS can only be addressed through correct information provided by means of prevention programmes

and treatment campaigns (Pharaoh, 2005:25; Zaccagnini, 2009:2). Promoting tolerance and compassion for those infected could improve the workplace situation (Douglas & Sutherland, 2009:55; ILO/WHO, 2005:11; UNAIDS, 2008:194), and as such it is advisable for HIV and AIDS training to be integrated into routine and entry-level training (ILO, 2003:27; Versteeg, 2004:343). The workplace offers a unique setting to confront stigma and discrimination and to adequately inform employees and management about the disease (AGOA Forum, 2001:4; Barrett-Grant *et al.*, 2003:38; Bodiang, 2001:4; DoH, 2000b:3; IFES, 1997:7; ILO/ECP, 2008:36; Ndobu, 2006:4; Pulerwitz *et al.*, 2004:10). Addressing stigma and discrimination should be instigated by the senior leadership of a organisation, because a strategic focus is required to manage the adverse effects of their disease (Morrison & Cuadra, 2004:12; Rao, Angell, Lam & Corrigan., 2008:1547; Yap & Ineson, 2009:504).

Policies and procedures should fight stigma and discrimination and protect individuals from victimisation and discrimination (Hikuam, 2004:8). It is important to note that stigma and discrimination will never be totally eradicated in any organisational context (Atkins-van Kogelenberg & Nyirenda, 2004:15). Reidpath, Brijnath and Chan (2005:5120) examined employer policies and practices in respect of HIV and AIDS and observed the following employment-related discrimination: mandatory testing as part of recruitment, lack of confidentiality, and dismissals and restrictions of job duties for those with HIV and AIDS. Saich (2006) found similar discrepancies between public policies and local practices in terms of the employment of people living with HIV and AIDS.

The existence of these types of practices is cause for concern and reiterates the importance of tackling these challenges at managerial level. The effect of stigma and discrimination could be mitigated in the hospitality industry by managerial openness, clear information on HIV and AIDS, compliance with the law, peer education, condom provision, voluntary counselling and testing (VCT), and the diagnosis and treatment of infections (GBC, 2007:34). The hospitality industry would benefit from looking after the health and wellbeing of its employees, especially by means of VCT campaigns (Brand, 2010a).

3.2.2 Absenteeism and Job Performance

HIV and AIDS increases absenteeism and negatively affects productivity, as already mentioned (ASSA, 2006; Jantjie, 2009:4; Muthaura & Njau, 2005:x). Absenteeism is reflected by the number of days recorded as sick leave taken by employees (Orr & Patient, 2006:1). Absenteeism due to HIV and AIDS has increased exponentially as predicted by Haldenwang, (2008). Absenteeism (due to ill health) has an immense impact on other employees, the workload, productivity, service delivery and profit (Bateesa, 2009:1; DoL, 2000a:3; Douglas & Sutherland, 2009:56; ILO, 2001:3; ILO, 2003b:8; Jantjie, 2009:72; KFF, 2007:4; Ngwena, 2000:99; NPA, 2005:1; Pauw, 2006; Setswe, 2009:82; Teklamariam, 2006:3).

Absenteeism puts enormous pressure on other employees, as fewer hands are available to complete the tasks at hand. The effect of HIV and AIDS is not only a calculus of lost labour, but has the deeper effect of having to sustain productivity capacity due to the loss

of human capital (Fasset, 2005:16; ILO, 2003a:7). Needless to say, high rates of absenteeism along with an estimated 950 AIDS-related deaths occurring daily have an enormous effect on the South African economy (ASSA, 2006; Health24, 2006; Yap & Ineson, 2010:71). According to Reed (2004:235), those infected with HIV and AIDS are likely to take more days sick leave per year than other employees, with each death equivalent to four days of management productive time lost. This affects profitability and decreases productivity, placing more strain on organisational resources (Bodiang, 2001:3; DoL, 2000b:1; Labour Protect, 2006:1; Versteeg, 2004:331).

Lower productivity and increased absenteeism could affect a company's employment decisions in diverse ways, for example the decision to rather employ older individuals (Ellis, 2007:45). Labour-intensive industries such as hospitality, mining and farming are hardest hit, as they require significant manual labour (ILO, 2003a:7; UNAIDS, 2002:3), which could also lead to early retirement due to ill health (CETU, 2001:7; ILO, 2002:1).

Research into employee productivity in terms of HIV and AIDS (Dickinson, 2004:59; Falkier, 2004:89; O'Grady, 2004:207; Strand *et al.*, 2004:13) confirms that the disease is reducing society's capacity to be productive and economically prosperous (Bowler, 2004:16; Majors, 2004:125; Mapolisa *et al.*, 2004:161). Haldenwang (2008) projected some years ago that AIDS-related illnesses would soon exceed all other causes of death in the South African workforce, and the associated probability of key personnel being lost is unavoidably disruptive to productivity, service provision and employee morale (ILO, 2003b:8; O'Grady, 2004:199; Reed, 2004:235). By ensuring early treatment of the

disease, companies would reap the benefits of lower absenteeism rates, a more positive working environment, and increased productivity (Douglas & Sutherland, 2009:56; ILO/WHO, 2005:21). Absenteeism is usually reduced after six months of ARV treatment, making it a viable avenue to pursue (Habyarimana, Mbakile & Pop-Eleches, 2007:14-15).

As indicated by Rau (2002:22), employee productivity is influenced by attitude, as well as the external environment. As the illness progresses in an affected employee such an employee is more likely to be absent from work, which could affect the organisation in a number of ways – for example, equipment loss due to maintenance being left to inexperienced employees, employees could become de-motivated as the work load increases due to absent employees, ect. (Rau, 2002:24). In a study by Bateesa (2009:9), 70% of respondents indicated that HIV and AIDS have a negative effect on productivity, the workplace and employee income. According to Van Zyl and Lubisi (2009:214) a negative relationship exists between HIV and AIDS prevalence rates and a firm's efficiency. The vulnerability of businesses could vary depending on the type of business, the product and the production processes involved, but the hospitality industry is particularly at risk (Du Toit & Burger, 2004:3). The nature of the epidemic, which is marked by recurring opportunistic infections, presents a particular challenge to both employers and employees when it comes to retaining productivity levels (Dreger, 2009:243).

3.3 HIV AND AIDS PREVENTION PROGRAMMES

Due to the challenges posed by the HIV and AIDS pandemic, organisations should

institute certain prevention programmes to assist not only the organisation in coping with these challenges, but also the infected individuals and their families. For this to happen, awareness of the pandemic needs to be created through effective treatment, care and support programmes, while training, education and counselling should also be made available to employees. Awareness is defined as knowledge gained by means of information on a specific topic, and prevention programmes are aimed at raising awareness through multiple preventive strategies to curb the detrimental effect of the disease (DoH, 2000b:1; Government of Uganda, 2007:6), while simultaneously fostering greater tolerance for those already infected (ILO, 2001:9).

As part of a co-ordinated HIV and AIDS effort within the organisation, an on-site clinic could also be made available to employees (Reed, 2004:233), and should be positioned in a high-traffic area so as to remind employees of the importance of good health (Reed, 2004:244). Workplace interventions like VCT and awareness programmes should seek to mitigate the spread of HIV (ILO/ECP, 2008:23) and one way of doing this is to take employees to visit infected patients in a hospital (Reed, 2004:241).

3.3.1 Treatment, Care and Support Programmes

According to ILO (2003b), two out of three infected workers remain in their jobs, showing that the workplace could be a vital entry point for HIV and AIDS treatment, support and care. Treatment is defined as the administration of remedies to a patient, care implies taking responsibility for the patient's treatment, and support involves promoting the interests of the patient. There is an enormous need for care, support and counselling in

Africa (ECA, 2004:16), with the focus of such programmes to be on preventing new infections while also providing support and assistance to those already infected. By instituting outreach programmes within communities, organisations can also enhance their social responsibility profile (Bowler, 2004:18; Poggenpoel, 2006:1). For any such programme to be successful, it must be adequately communicated to all employees (Dickinson & Stevens, 2004:69).

Prevention programmes, as the central strategy to mitigate the spread of HIV and AIDS (ILO/ECP, 2008:26), consist of three stages: 1) information and awareness, 2) education, and 3) behaviour change. The first stage is where individuals are made aware of HIV and AIDS, the implications of the disease, and its potential effect. The second stage focuses on behaviour that would alleviate the spread of the disease, while the third and final stage involves changing people's behaviour towards those infected, in view of providing support and care (UNICEF, 2008:8). Employees should be aware of the prevention programmes offered by the organisation, as well as their own HIV status (Dickinson, 2003:13). The objective of treatment, care and support programmes is to ensure that employees remain healthy and fit to perform their work (Dreger, 2009:248; Kerkhoven & Lowik, 2004:22; UNAIDS, 2003:20).

Care, treatment and support are important elements of an effective response towards HIV and AIDS (Muthuswamy, 2005:602; Yap & Ineson, 2009:516). It is of the utmost importance that employees are informed about the programmes offered by the organisation and that they have a forum for discussing HIV and AIDS issues for example

monthly information sessions (IOE, 2002:8). Workplace programmes are only successful if they are driven and supported by management (Cathsseta, 2003:9), which should include support from the CEO and senior management. It is estimated that worldwide, new infections are equivalent to AIDS-related deaths annually, meaning that lowering the infection rate remains vitally important (Dorrington *et al.*, 2006:3).

Long-term treatment, care and support programmes are necessary to effectively address the pandemic at organisational level (ILO/WHO, 2005:21) and the workplace environment should reflect the importance with which the organisation views its employees' health and wellbeing (Grant *et al.*, 2002:17; UNAIDS, 2008:208). Such programmes could even reduce the amount of sick leave taken by employees, and a long-term approach to treatment, care and support would go a long way towards diminishing the spread of the disease and limiting its social and economic impact (ABCA, 2002:8; Johansson *et al.*, 2010:7).

Rosen and Simon (2003) outlined four reasons why companies should take advantage of treatment, care and support programmes, namely: 1) to prevent the spread of HIV and AIDS, 2) to provide treatment in view of prolonging the productivity of infected individuals, 3) to provide training and education to new employees in an effort to broaden the prevention effort, and 4) to alter benefits to suit individual and business needs.

Employee assistance programmes (EAPs) are highly effective when it comes to helping employees deal with the disease and its effects (Ndobo, 2006:11) and this allows for a

wide spectrum of employees to be reached. Such a programme involves an arrangement between the organisation and the employee, in terms of which the employee is provided with assistance and support in coping with personal and work-related problems. By drawing on the skills of qualified social workers, psychologists, nurses and medical practitioners, EAPs also provide the necessary support and assistance to the families of affected employees (Jantjie, 2009:1).

Besides benefiting employees, EAPs also benefit the organisation by minimising HIV and AIDS related problems and maximising profit. By providing employees with timely and professional help (that employees pay for themselves) on the actual business premises, the organisation can limit the degree of interference with job performance. Peer educators, who have equal standing to the individuals being educated, are also effective in assisting with HIV and AIDS matters within an organisation (Mapolisa *et al.*, 2004:167; Stevens, Blaauw & Mapolisa, 2004:297). In fact, peer education and training has been found to be more successful than a formal approach to the situation (ILO, 2003a:27). By instituting HIV and AIDS treatment, care and support programmes for their employees, organisations can align themselves with government's efforts in this respect – as per the following statement made in 2009 by Barbra Hogan, then Minister of Public Enterprises: "...that the National Strategic Plan calls for treatment, support and care for 80% of HIV and AIDS positive people by 2011 and that they are committed to reach the target" (Hogan, 2009).

3.3.2 Training, Education and Counselling Programmes

High-level awareness of HIV and AIDS is only the first step towards prevention (Colgate-Palmolive Company, 2008:6; Grant *et al.*, 2002:37), and training, education and counselling programmes should also form part of a holistic approach towards the pandemic (BOTA, 2005:4; DoE, 1999:6; DoH, 2000b:3; ILO, 2005:3; NTC/GAC, 2004:13;). Training is an organised activity aimed at imparting information and knowledge to individuals, while education is an essential building-block in the development of accurate knowledge on the topic (Bodiang, 2001:10). Counselling, in turn, can be explained as a one-on-one process that enables a person to reorganise the issues affecting his or her life. Together, training, education and counselling have the potential to combat stigma, discrimination and irrational responses towards HIV and AIDS in the workplace (Genesis Group, 2007:1) and the potential to influence individual attitudes and behaviour makes such efforts a valuable tool for organisations to utilise (Jugdeo, 2009:18).

Trained and educated employers and employees are better equipped with the necessary facts and skills to address the issues surrounding the disease (Ellis, 2007:49; Fasset, 2005:32; ILO/UNESCO, 2006:6). Information received at the workplace could be spread to the community by employees (Rau, 2002:11), thus broadening the scope of the information and enhancing the effect of awareness programmes (Rau, 2002:47). According to Barbra (2003:3), better results are achieved with a combination of counselling, appropriate drug treatment and education, by an qualified nurse for example.

Besides employees and health workers, training and education programmes should be targeted at the youth in the community by schools or universities (Coombe, 2002:vii; Oshi, Nakalema & Oshi, 2005:177; Morrison & Cuadra, 2004:13) since targeting learners at the earliest possible age before the onset of sexual activity can assist in curbing the spread of the disease. Another training and education method that was introduced some years ago is school-based sex education and it aimed at improving learners' knowledge, changing their attitude towards sex, and discouraging them from engaging in risky behaviour, such as unprotected sex (UNICEF, 2008:19). Machekanyanga *et al.*, (2002:124) suggested that children should be exposed to sex education at primary and secondary school level.

HIV and AIDS training and education should constantly be updated (Yap & Ineson, 2010:79) to ensure that the correct information is conveyed. It is not just about training and educating employees but also changing the attitudes of employees and management (UNAIDS, 2002:5). Patient education and counselling is just as important as ARV treatment and should form part of an integrated approach to the pandemic (Charalambous *et al.*, 2007:35; Dickinson, 2006b:324) as this will contribute towards alleviating effects of HIV and AIDS on South African businesses (Aspen CBE, 2008:1; CoGTA, 2007:1).

Essential time within work hours should be dedicated to employee programmes (to curb the spread of HIV and AIDS and reduce employee infection rate) (ILO.UNESCO, 2006:9) which may involve integrated on-the-job training on the prevention and treatment of the

disease (ILO, 2003b; UNAIDS/IHRA, 1999:20). Coalitions between organisations could also be formed to consolidate resources and provide better treatment, care and counselling (UNAIDS/IHRA, 1999:9). Overall, organisations must invest their effort, time and resources in education and training if they wish to protect their business from the devastating effects of the HIV and AIDS pandemic (Fasset, 2005:31).

Confidential counselling, care, support and treatment programmes are essential in helping infected individuals to cope emotionally, psychologically and physically with the demands of the illness (Masindi, 2004:7; Ndobu, 2006:12). Employees must understand the social and psychological concerns related to HIV and AIDS (NTC/GAC, 2004:7) since the disease often first presents itself in the form of emotional symptoms – thus the need for counselling. HIV and AIDS counselling faces a number of challenges, however, including cultural beliefs, inherent fear and anxiety, prevailing attitudes, and mental health, which must be explored before the counsellor can address the issues of meaning, purpose and mortality (Jantjie, 2009:121).

Training, education and counselling programmes should be seen as a sound investment in health for both the employee and the employer (KFF, 2007:6) and should be targeted and adapted to suit the intellectual abilities of all participants (ILO, 2001:12).

3.3.3 Organisational Communication

Communication is a two-way process of exchanging information and interchanging thoughts. Managers should utilise the available means of communication to allow a free

flow of information on HIV and AIDS (Teklemariam, 2006:55), which could include mass media communication like radio, newspapers or magazines, as well as communication via organisational structures such as notice-boards and information sessions. Media campaigns have been shown to have a positive impact on awareness, this includes TV or radio advertisements for example (Jantjie, 2009:84). Communication could also occur via team leaders, supervisors and colleagues, while managers at a tactical level (such as marketing and human resources managers) can also play a part in this regard (CoGTA, 2007:6). The use of electronic communication should also be considered, including e-mails, social networks and blogs (HSRC, 2005:108).

A top-down approach to communication is most effective (Pharaoh, 2005:31) and all information must be clearly understood by everyone involved. A lack of communication, along with misinformation, is the primary cause of the fear people have of the disease and those suffering from it (Nyblade, 2004:5). There should be mutual trust amongst employees and a feeling of openness and freedom to communicate with others (USAID, 2005:21). Management should remain involved at all times so as to ensure that the organisation's awareness programmes reach all levels of employees (Ramsingh & Van Aardt, 2006:191).

3.4 SUMMARY

The prevalence of HIV and AIDS has highlighted many organisational challenges such as stigma, discrimination, absenteeism and job performance. The stigma and discrimination associated with the illness make it crucial that organisational support is available to

employees in the form of awareness programmes, treatment, care, support, training, education and counselling initiatives. Effective organisational communication, along with the regular updating and attendance of employee programmes, has been highlighted as important in the effort to reach employees and the wider community.

CHAPTER 4: HIV AND AIDS POLICY CONSIDERATIONS

4.1 INTRODUCTION

The hospitality industry is the world's largest industry, and in South Africa it supplies numerous job opportunities and contributes substantially to the national economy (Vass & Phakathi, 2006:15). As such, industry employees are required to work long and strenuous hours that are particularly taxing on someone in the grips of HIV and AIDS. As explained in the previous chapter, it is imperative that the effects of the pandemic are considered from a socio-economic and organisational perspective (DoH, 2000a:7; HSRC, 2005:1).

This chapter reflects on the important guiding role of policies and the associated procedures, including the policymaking process and the lessons learned from policy implementation endeavours in the hospitality industry and elsewhere.

4.2 IMPORTANCE OF POLICY DEVELOPMENT

For an organisation, the purpose of a policy is to outline authority, provide instructions, and assign responsibility. Bernier and Clavier (2011:112) described a policy as a purposive course of action followed by an actor or a set of actors in dealing with a problem or matter of concern. A policy thus represents the organisation's position on a particular issue (CoGTA, 2007:2; DoE, 1999:1; DoH, 2006:15; DoL, 2000b:45; Grant *et al.*, 2002:49; Nobongoza, 2006:41; Parker, 2005:5; Smart & McKenna, 2006:12; Vass, 2004:318; Vass & Phakathi, 2006:77).

There should be structured efforts in relation to HIV and AIDS prevention programmes (Barrett-Grant *et al.*, 2003:172; Bateesa, 2009:9; Rau, 2002:35; Roberts, 2004; WEF, 2005-2006:17) and these should be closely aligned with policies and constantly updated to mitigate the impact of HIV and AIDS in the workplace (Dickinson, 2003:26; Jones, 2005:421). A policy must be clearly understood by both managements and staff, and must be sensitive to the nature of the business while simultaneously providing appropriate guidance (Hamilton, 1999:7; Laas, 2009:8; UNAIDS/IHRA, 1999:10). A policy usually includes stated and unstated goals, intentions, and redefined aspects to be addressed by the policy (Hamilton, 1999:1; Roux, 2002:425). A policy also encapsulates plans and guidelines that influence decision-making and provide a framework for the co-ordination of all actions and activities (Laas, 2009:2).

It is imperative that policies comply with legislation (Bakuwa, 2010:3; DWAF, 2000:1; MacDonald & George, 2002; Manitoba, 2003:2). Booyesen, (2011:1) and Mohammed (2006:30) notably suggested HIV and AIDS policies should be made compulsory by government and for every organisation, no matter the size. Both Korea and Japan, whose governments tightly control and enforce health-related policies and the implementation thereof (Yungoh & Mikyung, 1998:47) are experiencing a decrease in the HIV infection rate.

Procedures detailing an organisation's plan of action in connection with HIV and AIDS, should also be in place, in the form of a step-by-step sequence of activities with a definite starting point and end point, which must be followed in the given order (WebFinance Inc.,

2010). Procedures are specific, factual and to the point (Swinburne University of Technology, 2009). Procedures detail the actions that will take place in a systematic manner and identify the individuals that are responsible for implementing the various actions (WebFinance Inc., 2010). By having clear policies and procedures, an organisation is better able to provide assistance in terms of training, education and support regarding HIV and AIDS (Yap & Ineson, 2009:507).

4.3 POLICYMAKING PROCESS

Before embarking on policy development, careful consideration should be given to how a policy will be managed and what resources will be used. Policy implementation should be contemplated during the policy planning process and should be based on factual evidence and the needs of both the employees and the organisation (Hamilton, 1999:12). Programme and project management (PPM) is a technique that can be used during the policy planning process to set goals to be achieved within a particular timeframe and in a cost-effective manner (Hamilton, 1999:13).

According to Hamilton (1999:13), the advantage of PPM is that it provides clarity on the plans and achievements related to policy development, starting with the following steps (Hamilton, 1999:30; Jones, 2005:433): 1) Establishing the policy needs, 2) defining the policy objectives, 3) identifying and describing policy options, 4) detailing the potential impact of the policy, 5) summarising findings, 6) making recommendations, and 7) monitoring and evaluating progress.

An organisational response to HIV and AIDS involves policy implementation, education, prevention, care and support for employees. Once organisations are aware of the importance of having sound policies in place, the implementation process becomes easier. Once the need for a policy has been established, management must decide on the type of intervention required and then plan the process accordingly, select and initiate relevant role players, and decide on the control mechanisms to be used. The next step, i.e. considering the resources available, is crucial as it will affect the type of programmes to be offered by the organisation. The final stage is future oriented and focuses on the contribution the policy is likely to make to the organisation. It is advisable to reflect on the implementation process to enable role players to make adjustments where necessary (ABCA, 2002:3-7; Bakuwa, 2010:3; Rauner, 2002:122).

4.3.1 Policy Planning Process and Policymaking Cycle

Policies usually evolve through different cycles which are: initiation, problem identification and evaluation, alteration, implementation and communication (Jones, 2005:427). The process commences with initiation, involving the commitment of resources and the support of management (IPDRU, 2007:2; Roux, 2002:422:2). Problem identification and evaluation is the process of exploring and clarifying the dimensions of the problem, implying that the problem should be identified and a suitable solution found (IPDRU, 2007:2). Policy alteration involves some divergent thinking to generate creative ideas by exploring all possible solutions (Kemp & Weehuizen, 2005:3). This helps to clarify the choices in terms of policy options, and it is important to contemplate the implementation and consequences of the policy at this stage (IPDRU, 2007:3; Roux, 2002:423). Policy

alteration, evaluation and decision-making require an understanding of the advantages and disadvantages of each option available. The implementation of the policy should occur, this is where the policy planning process is executed and communicated.

The final decision should be based on valid theories of cause and effect in relation to employees and the employer (Roux, 2002:424). The implementing parties should be clear on their respective roles (IPDRU, 2007:3) communication plays a vital part in the process. In South Africa, policies relating to HIV and AIDS must respond to five priority areas (DoH, 2000a): 1) prevention, 2) treatment, care and support, 3) human rights, 4) research, monitoring and evaluation, and 5) information and education aimed at maximising efficiency and effectiveness. Even former South African President Nelson Mandela reiterated that should businesses fail to implement HIV and AIDS policies, they would suffer due to a loss of skills, productivity and profit, thus impeding economic growth (Schreiner, 2003:16).

4.4 LESSONS LEARNED FROM POLICY IMPLEMENTATION

This section provides some examples of the successful implementation of HIV and AIDS policies. One success story is that of Levi Strauss & Co. which began implementing HIV and AIDS policies as far back as 1982 (UNAIDS, 2000:19), leading to tremendous HIV and AIDS prevention and awareness amongst employees.

The ACCOR hotel group (with about 4 000 hotels worldwide) is one of the foremost leaders in the fight against HIV and AIDS, with the interests of the 145 000 employees

taking precedence over the interests of the organisation (GBC, 2007:16). The ACCOR group's first initiative in 2006 was to produce two educational films on HIV and AIDS for employees, travellers and guests of all cultures and educational levels. These films are estimated to have been viewed by 121 million individuals worldwide (GBC, 2007:18) and by all indications have helped to spread awareness of the disease.

Kerzner International Holdings Limited operates numerous resorts, casinos and luxury hotels worldwide implemented an HIV and AIDS policy in 1991 with the emphasis on education, awareness and prevention campaigns (GBC, 2007:24). Recognising the limited funding available for ARV treatment, the company, which is based in the Caribbean, partnered with the local business community to raise \$1 million to assist local organisations to improve the lives of those infected and reduce the transmission of the disease, and develop a national/regional HIV and AIDS resource centre in the region. It is thus clear that commitment from an organisation, along with private and public partnerships, can go a long way towards addressing the challenges associated with HIV and AIDS – especially in the case of the service-intensive hospitality industry (GBC, 2007:31).

Serena Hotels in Kenya is engaged in efforts to reduce absenteeism, increase productivity and the prevention of AIDS mortality. Between 1998 and 2002, Serena Hotels lost an estimated 35 employees to AIDS (Lutalo, 2007:1), which prompted them to set clear objectives in managing the effects of the disease, including: 1) reducing infection, 2) diminishing the impact on infected individuals, 3) empowering individuals to

respond to HIV and AIDS by speaking to others about the disease, and 4) eliminating stigma and discrimination. Regular awareness, education, prevention, care, treatment and VCT campaigns help to maintain the good health of all employees (Cloete, 2004:56; Lutalo, 2007:3).

The South African Business Coalition on HIV and AIDS (SABCOHA), which was established in 2000, has set up the AIDSOnline Knowledge Centre to provide information and resources to the South African people (UNAIDS, 2000:69). The International HIV/AIDS Alliance and GlaxoWellcome`s Positive Action programme launched a three-year partnership programme called “Community Lessons, Global Learning” in 1997, aimed at sharing information and best practice, and moving beyond awareness, care and community support through the constant improvement of policies and programmes (UNAIDS, 2000:70-71). The International HIV and AIDS Alliance (IHAA, 2010) conducted interviews with industry leaders regarding the needs applicable to the hospitality and tourism sector in the Caribbean, aimed at establishing participation and facilitating interventions like formulating policies and procedures, improving communication, and reducing stigma and discrimination – with the ultimate goal of accelerating the response to HIV and AIDS.

Warsaw Marriot Hotel identified HIV and AIDS as an issue not openly discussed in Poland and instituted successful staff education and training programmes to increase awareness and knowledge (UNAIDS, 2000:47). The hospitality industry is particularly affected by the pandemic due to its prolific nature and demanding work environment

(UNAIDS, 2000:57). In response to this, the International Hotel and Restaurant Association (IHRA) developed policies to provide information, raise awareness and solve practical problems related to HIV and AIDS in the industry (UNAIDS/IHRA, 1999), which led directly to vast numbers of hospitality and tourism businesses implementing their own policies.

The City Lodge Hotels group recognises that employees suffering from HIV and AIDS are entitled to the same rights as any other employee and has therefore taken action to create a supportive working environment free from bias and discrimination. In compliance with legislation, their policy applies to all employees (City Lodge Hotels, 2004:1405) and includes voluntary testing, the right to privacy, openness about HIV and AIDS in the workplace, acceptance of others, and support to infected individuals.

Although not in the hospitality industry, a number of companies that deserve mention for their successful implementation of HIV and AIDS policies are:

- Pfizer Incorporated (a pharmaceutical company). Pfizer's HIV and AIDS policy is implemented by its global constituents and is adapted locally to meet local needs, focusing on non-discrimination, confidentiality, VCT, education, awareness, a safe working environment, and access to treatment (Pfizer Incorporated, 2011).
- ETC Crystal has identified awareness, prevention, non-discrimination, confidentiality and education as crucial considerations, with leadership being indispensable in managing the effects of HIV and AIDS (ETC Crystal, 2011).
- Total South Africa also seeks to minimise the social, economic and developmental

effects of HIV and AIDS on its businesses and employees by protecting employees, creating awareness, encouraging behavioural change, and enhancing fair and equal treatment. As such, the company provides education, training, and pre- and post-testing counselling for employees (Total South Africa, 2002). The

- Pick 'n Pay group of stores in South Africa has also successfully implemented a comprehensive HIV and AIDS strategy (Ndobu, 2006:3).

To summarise, it is clear that adequate policy implementation has a positive effect on the awareness of the disease and the organisational response to the pandemic. Policies can also be seen as maps that need to respond to new and challenging situations (DoH, 2006:10; Grant *et al.*; 2002:34; Smart & McKenna, 2006:1), and should provide the framework that governs the rights and responsibilities of stakeholders and employees. Working in partnership with business and industry, government is more likely to supply ARV and other treatment free of charge to infected individuals. Initiating preventative action is more cost effective in the long run than treating infected employees. With policies in place, employees have access to treatment that may reduce mortality, as well as accurate information that will help to create an environment of non-discrimination, equality, reduced absenteeism and increased productivity.

The cases presented above illustrate that a clear, well-communicated HIV and AIDS policy has many advantages, including increased employee retention and productivity, reduced absenteeism, and ultimately improved business profit). Employees' attitudes are also likely to change as they become more knowledgeable about HIV and AIDS, which

could assist in curbing the spread of the disease and supporting those already infected. CEOs and senior management are the driving forces when it comes to policy implementation and their strategic buy-in is of the utmost importance.

4.6 SUMMARY

This chapter elaborated on the policymaking process, highlighting the importance of adequately implemented HIV and AIDS policies. Some companies in the hospitality industry and other sectors were cited as examples of organisations that have successfully implemented HIV and AIDS policies. This supports the importance and necessity of this study and sets the scene for the empirical part of the investigation.

CHAPTER 5: METHODOLOGICAL OVERVIEW AND ANALYSIS OF RESULTS

5.1 INTRODUCTION

This chapter explains the population and sampling method used, as well as the pilot study conducted prior to the main study, with the findings documented and analysed. The main aim of this investigation was to ascertain how well HIV and AIDS policies are implemented in a major South African hotel group. Data was captured by means of a structured questionnaire. The questionnaire consisted mostly of closed-ended questions, based on a five-point Likert scale (Leedy & Ormrod, 2005:185), along with three open-ended questions. The questionnaire was based on the constructs identified by literature and were divided into five sections. The first section captured the demographic composition of the respondents that included age, gender, race, educational level and current position. The second section captured the HIV and AIDS policy information and its communication, the third section captured employees perceptions on the influence of HIV and AIDS on job performance and the fourth section the hotels attitude to HIV and AIDS, the fifth section captured employee perception on programmes offered by the hotel group. The hotel group under investigation has individual hotels throughout South Africa – from the worst- to the least-infected areas.

5.2 ETHICAL ASPECTS

The study complied to certain ethical aspects, namely respect for individual rights, dignity and welfare; avoiding harm to participants; obtaining informed consent; not deceiving respondents; and maintaining anonymity and confidentiality (De Vos, Strydom, Fouche & Delport, 2005:58; Jugdeo, 2009:42; Muthuswamy, 2005:603; Wolf & Lo, 2001). The

researcher briefed the respondents prior to the completion of the questionnaire to ensure that they understood what was expected of them.

5.3 STUDY DESIGN

5.3.1 Population and Sample

A literature study and an empirical study were conducted and a combination of qualitative and quantitative research methods was used. This section details the empirical part of the investigation, focusing on the data-collection methods. Table 2 below reflects the HIV and AIDS infection rates of the nine provinces of South Africa.

Table 2.1: Geographical HIV and AIDS infection rates in the nine South African provinces

Province	HIV Prevalence %	
Kwazulu-Natal	16%	Worst-infected HIV and AIDS areas
Gauteng	15%	
Mpumalanga	14%	
Free State	13%	Medium-infected HIV and AIDS areas
North West	13%	
Eastern Cape	10%	
Northern Cape	7%	Least-infected HIV and AIDS areas
Limpopo	7%	
Western Cape	5%	

Sources: DoH (2006); Ndobu (2006:3)

**Table 2.2: Geographical HIV and AIDS infection rates in the nine
South African provinces**

Province	HIV Prevalence %	
Kwazulu-Natal	39,5%	Worst-infected HIV and AIDS areas
Mpumalanga	35,1%	
Free State	30,6%	Medium-infected HIV and AIDS areas
Gauteng	30,4%	
Eastern Cape	29,9%	
North West	29,6%	
Limpopo	21,9%	Least-infected HIV and AIDS areas
Western Cape	18,5%	
Northern Cape	18,4%	
National Total	30,2%	

Source: South Africa HIV and AIDS Statistics, 2011

The population for this study consisted of the employees of a major hotel group in South Africa. The sample was selected to include hotels from all three levels of infection from the worst- to the least-affected areas of South Africa as indicated in Table 2. Durban (representing Kwazulu-Natal) is the area worst affected by HIV and AIDS, while

Bloemfontein (Free State) is a medium-affected area and Cape Town (Western Cape) is least affected (DoH, 2006; DoH, 2007a; HSRC, 2005:37; Ndobu, 2006:3; Noble, 2008). Five hotels, operated by the hotel group, in the cities of Bloemfontein, Durban and Cape Town formed the sample for the study, as shown in Table 3 below.

Table 3: Sample for the study

	Bloemfontein	Cape Town Grand West	Cape Town V&A	Durban Umhlanga	Durban
Population size	35	60	50	30	31
Sample per hotel	20	20	22	22	23
Sample Size	107				

Twenty questionnaires were administered at the Bloemfontein and Grand West Cape Town hotels, 22 questionnaires at the Umhlanga and Cape Town V&A hotels and 23 questionnaires at the Durban hotel. From a total of 206 questionnaires distributed, 107 were returned, representing a response rate of 53%. Respondents were selected by means of stratified random sampling to include members from all organisational levels – namely managerial, tactical (or front-of-house staff such as reception, reservation and restaurant staff, as well as porters and concierges) and operational (or back-of-house staff such as housekeeping, cleaning, kitchen, maintenance and security staff)

(Blumberg, Cooper & Schindler, 2005:215; Blumberg, Cooper & Schindler, 2008:244; Salkind, 2006:91; Saunders, Lewis & Thornhill, 2007:213). The group's head office granted prior permission for this study to be conducted (Annexure A).

5.3.2 Pilot Study

Prior to the commencement of the main study, a pilot study was conducted at the Kimberly branch of the hotel group. Questionnaires were handed out to 10 employees at different levels of employment, to determine whether they understood the questions. The respondents indicated that they understood the questions and were able to complete the questionnaire easily and no alterations therefore had to be made.

5.3.3 Main Study

Individual arrangements were made with the different hotels and the data was collected during September and October 2011. Respondents at the various hotels in Bloemfontein, Durban and Cape Town were targeted to complete the questionnaires at a scheduled date, time and venue. After completion, the questionnaires were returned to the researcher and the responses were captured in an Excel workbook. The next section presents the analysis of the data, based on the layout of the questionnaire (Annexure B).

5.4 STATISTICAL ANALYSIS OF RESULTS

5.4.1 Descriptive Statistics

Table 4 reflects the number of questionnaires collected from each hotel.

Table 4: Questionnaires collected from each hotel

Hotel	Count	Percentage
Bloemfontein	20	18.6
Umhlanga	22	20.6
Durban	23	21.5
Cape Town V&A Waterfront	22	20.6
Cape Town Grand West	20	18.7

As shown in Table 4, 18.7% of the completed questionnaires came from Bloemfontein, 20.6% from Umhlanga, 21.5% from Durban, 20.6% from Cape Town V&A Waterfront, and 18.7% from Cape Town Grand West.

Question 1: To determine the age composition of respondents

Table 5: Age composition of respondents

1. Age	Count	Percentage
<24	8	7.5
25-34	52	48.6
35-44	28	26.2
45-54	12	11.2
>55	7	6.5

As shown in Table 5, the majority (48.6%) of respondents were between 25 and 34 years of age.

Question 2: To determine the gender composition of respondents

Table 6: Gender composition of respondents

2. Gender	Count	Percentage
Female	83	77.6
Male	24	22.4

The sample population consisted of three times as many women as men.

Question 3: To determine the racial composition of respondents

Table 7: Racial composition of respondents

3. Race	Count	Percentage
Coloured	25	23.4
African	60	56.1
White	16	14.9
Indian	5	4.7
Asian	1	0.9

According to the data gathered, 23.4% of respondents were Coloured, 56.1% African, and 14.9% White, with the remainder composed of Indian and Asian individuals.

The histogram below reflects the racial profile.

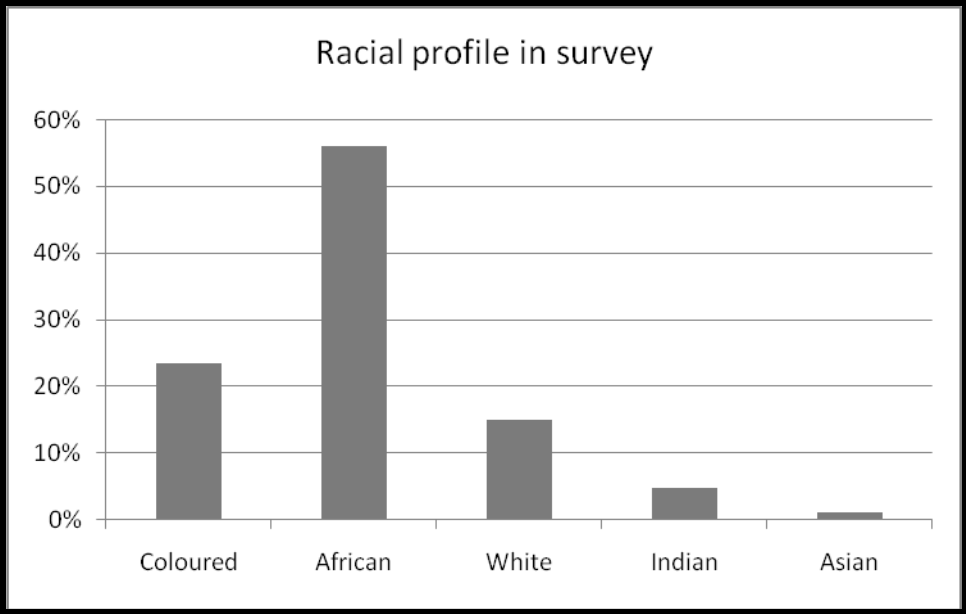


Figure 1: Racial composition of respondents

Question 4: To determine the educational level of respondents

Table 8: Educational level of respondents

4. Educational Level	Count	Percentage
Tertiary	26	24.3
Secondary	81	75.7

With regard to the educational level of respondents, 24.3% were in possession of a tertiary qualification and the remainder a secondary education.

Question 5: To determine the current position of respondents

Table 9: Current position of respondents

5. Current Position	Count	Percentage
Management	17	15.9
Back-of-house	58	54.2
Front-of-house	32	29.9

A total of 54.2% of questionnaires were completed by back-of-house employees, 15.9% by management, and 29.9% by front-of-house employees.

Question 6: Policy information

Table 10: Policy information

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.1 Your hotel has an official HIV and AIDS policy.	Count	8	13	51	24	11
	Percentage	7.5	12.1	47.7	22.4	10.3

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.2 The HIV and AIDS policy stipulations are communicated to all staff.	Count	11	18	43	20	15
	Percentage	10.3	16.8	40.2	18.7	14.0
6.3 All employees understand the HIV and AIDS policy clearly.	Count	3	17	43	25	19
	Percentage	2.8	15.9	40.2	23.4	17.8
6.4 Employees are important to the hotel.	Count	2	6	10	40	49
	Percentage	1.9	5.6	9.3	37.4	45.8
6.5 The hotel uses awareness programmes to inform you about HIV and AIDS challenges.	Count	6	25	25	33	18
	Percentage	5.6	23.4	23.4	30.8	16.8

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.6 The hotel finds HIV and AIDS preventative programmes important for its employees' wellbeing.	Count	5	16	36	35	15
	Percentage	4.7	15.0	33.6	32.7	14.0
6.7 Treatment, care and support programmes are made available to all employees.	Count	14	26	36	21	10
	Percentage	13.1	24.3	33.6	19.6	9.3
6.8 The hotel's HIV and AIDS policy includes training, education and counselling programmes.	Count	14	27	29	28	9
	Percentage	13.1	25.2	27.1	26.2	8.4

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.9 Counselling is available to all employees.	Count	14	25	31	23	14
	Percentage	13.1	23.4	29.0	21.5	13.1
6.10 Personal HIV and AIDS information remains confidential.	Count	4	9	27	35	32
	Percentage	3.7	8.4	25.2	32.7	29.9
6.11 The hotel has arranged awareness/ educational programmes on HIV and AIDS for all employees.	Count	10	19	32	36	10
	Percentage	9.3	17.8	29.9	33.6	9.3

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.12 I have attended awareness/ educational programmes on HIV and AIDS presented by the hotel.	Count	16	26	14	39	12
	Percentage	15.0	24.3	13.1	36.4	11.2
6.13 I have attended three or more awareness/ educational programmes in the past year at the hotel.	Count	23	46	16	17	5
	Percentage	21.5	43.0	15.0	15.9	4.7

Table 10 indicates that one third of respondents were aware of the hotel group`s official HIV and AIDS policy (number 6.1) and the same applies to ineffective policy communication. The number of respondents who indicated that they understood the HIV and AIDS policy (number 6.3) exceeded the number of respondents who indicated they were aware of prevention programmes (number 6.5). A total of 47% of respondents knew of the awareness programmes offered by the hotel, with 83.2% agreeing that the

hotel considers such programmes to be important. While 47.6% of respondents were aware of the prevention programmes in place, very few knew whether treatment, care and support programmes were available.

A total of 27.1% of respondents did not know whether training, education and counselling were offered by the hotel group (number 6.8), while more than 30% were not aware of the existence of training, education and counselling programmes. More than half the respondents agreed on the importance of confidentiality (number 6.10), while 42.9% identified awareness and education as important in the fight against the epidemic. More than three quarters of the respondents indicated that they had not attended awareness, educational or counselling programmes at the hotel (number 6.9 and number 6.12).

To recap, 47.7% of respondents did not know whether or not their hotel had an official HIV and AIDS policy in place, while 71% were not aware of any treatment, care and support programmes offered by the hotel group. Moreover, 43% of respondents had not attended three or more awareness/educational programmes at the hotel within the past year.

Question 7: HIV and AIDS knowledge

Table 11: HIV and AIDS knowledge

		Disagree	Don't Know	Agree
7.1 HIV and AIDS differ from each another.	Count	25	15	67
	Percentage	23.4	14.0	62.6
7.2 HIV and AIDS can be cured.	Count	71	16	20
	Percentage	66.4	15.0	18.7
7.3 Using a condom protects you against HIV and AIDS.	Count	12	7	88
	Percentage	11.2	6.5	82.2
7.4 Homosexuals are more at risk of getting HIV and AIDS.	Count	31	25	51
	Percentage	29.0	23.4	47.7
7.5 HIV and AIDS leads to death.	Count	14	5	88
	Percentage	13.1	4.7	82.2
7.6 HIV and AIDS testing should be done regularly at the hotel.	Count	32	20	55
	Percentage	29.9	18.7	51.4

		Disagree	Don't Know	Agree
7.7 HIV and AIDS can be transmitted to an unborn baby by its mother.	Count	17	7	83
	Percentage	15.9	6.5	77.6
7.8 HIV causes AIDS.	Count	4	5	98
	Percentage	3.7	4.7	91.6
7.9 Regular ARV treatment can prevent HIV and AIDS.	Count	33	23	51
	Percentage	30.8	21.5	47.7
7.10 ARV treatment can prevent the spread of HIV and AIDS.	Count	45	21	41
	Percentage	42.1	19.6	38.3
7.11 ARV treatment can prevent mother-to-child transmission of HIV and AIDS.	Count	18	23	66
	Percentage	16.8	21.5	61.7

A total of 62.6% of the respondents indicated that there is a difference between HIV and AIDS (number 7.1), while 66.4% indicated that HIV and AIDS cannot be cured (number

7.2). More than three quarters of the respondents indicated that condoms protect against contracting HIV and AIDS (number 7.3), and that HIV and AIDS leads to death (number 7.5). A total of 91.6% of respondents indicated that HIV causes AIDS (number 7.8), while 77.6% indicated that infected mothers can transmit the disease to their unborn babies (number 7.7).

More than 50% of respondents indicated that ARV treatment could help prevent the spread of HIV and AIDS from mother to child (number 7.11), and approximately the same number either did not know whether or not ARV treatment can prevent the spread of the disease, or disagreed that this is the case (number 7.10).

To summarise, 91.6% of respondents indicated that HIV leads to AIDS, 66.4% indicated that HIV and AIDS can be cured, and 47.7% agreed that regular ARV treatment can prevent HIV and AIDS.

Question 8: HIV and AIDS knowledge

Table 12: HIV and AIDS knowledge

		Disagree	Don't Know	Agree
8.1 You can contract HIV and AIDS from insect bites.	Count	69	25	13
	Percentage	64.5	23.4	12.1

		Disagree	Don't Know	Agree
8.2 You can contract HIV and AIDS from donating blood.	Count	42	22	43
	Percentage	39.3	20.6	40.2
8.3 You can contract HIV and AIDS by shaking hands.	Count	97	8	2
	Percentage	90.7	7.5	1.9
8.4 You can contract HIV and AIDS by kissing.	Count	87	10	10
	Percentage	81.3	9.3	9.3
8.5 You can contract HIV and AIDS by being coughed on.	Count	80	21	6
	Percentage	74.8	19.6	5.6
8.6 You can contract HIV and AIDS by being sneezed on.	Count	86	15	6
	Percentage	80.4	14.0	5.6
8.7 You can contract HIV and AIDS by sharing a cigarette.	Count	90	14	3
	Percentage	84.1	13.1	2.8

		Disagree	Don't Know	Agree
8.8 You can contract HIV and AIDS by eating food made by an HIV-positive individual.	Count	94	8	5
	Percentage	87.9	7.5	4.7
8.9 You can contract HIV and AIDS by sharing a toilet.	Count	87	13	7
	Percentage	81.3	12.1	6.5
8.10 You can contract HIV and AIDS by sharing a needle/syringe.	Count	15	5	87
	Percentage	14.0	4.7	81.3
8.11 You can contract HIV and AIDS by having unprotected sex.	Count	6	0	101
	Percentage	5.6	0	94.4
8.12 You can contract HIV and AIDS by coming into contact with sweat or tears.	Count	86	17	4
	Percentage	80.4	15.9	3.7

		Disagree	Don't Know	Agree
8.13 You can contract HIV and AIDS from open wounds.	Count	12	11	84
	Percentage	11.2	10.3	78.5
8.14 You can contract HIV and AIDS by coming into contact with semen/ vaginal excretions.	Count	8	14	85
	Percentage	7.5	13.1	79.4
8.15 You can contract HIV and AIDS by coming into contact with saliva or by sharing a cup.	Count	76	22	9
	Percentage	71.0	20.6	8.4
8.16 You can contract HIV and AIDS by coming into contact with urine.	Count	65	28	14
	Percentage	60.7	26.2	13.1
8.17 You can contract HIV and AIDS by coming into contact with blood.	Count	4	5	98
	Percentage	3.7	4.7	91.6

This set of questions was aimed at establishing whether the respondents had knowledge about HIV and AIDS. The findings revealed that the respondents were ill-informed about the process of donating blood (number 8.2), with more than half not knowing whether HIV and AIDS can be contracted by donating blood. Two quarters of respondents indicated that HIV and AIDS can be contracted by being sneezed upon by an infected individual (number 8.6).

The majority (81.3%) of respondents were aware that HIV and AIDS can be contracted by sharing a needle or syringe (number 8.10), while 5.6% indicated that HIV and AIDS cannot be contracted by having unprotected sex (number 8.11). Approximately 79.4% of respondents indicated that HIV and AIDS can be contracted through semen or vaginal fluids (number 8.14).

A total of 23.4% of respondents did not know whether or not HIV and AIDS can be contracted from insect bites (number 8.1), while 20.6% did not know whether it can be contracted by sharing a cup (number 8.15), and one third did not know that HIV and AIDS can be contracted through urine (number 8.16).

Question 9: Influence on job performance

Table 13: Influence on job performance

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
9.1 HIV and AIDS impact negatively on job performance.	Count	16	21	31	27	12
	Percentage	15.0	19.6	29.0	25.2	11.2
9.2 HIV and AIDS impact negatively on service delivery.	Count	18	30	24	29	6
	Percentage	16.8	28.0	22.4	27.1	5.6
9.3 AIDS sufferers take more sick leave.	Count	13	19	22	38	15
	Percentage	12.1	17.8	20.6	35.5	14.0
9.4 Employees feel resentful towards co-workers with HIV and AIDS.	Count	12	23	42	24	6
	Percentage	11.2	21.5	39.3	22.4	5.6
9.5 Workload increases for employees when other employees are on sick leave (possibly AIDS-related).	Count	8	20	32	30	17
	Percentage	7.5	18.7	29.9	28.0	15.9

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
9.6 HIV and AIDS impact negatively on sales.	Count	14	35	39	14	5
	Percentage	13.1	32.7	36.4	13.1	4.7
9.7 HIV and AIDS impact negatively on hotel profit.	Count	19	36	34	12	6
	Percentage	17.8	33.6	31.8	11.2	5.6
9.8 HIV and AIDS impact negatively on service quality (cleaning, service, time management, etc.).	Count	17	32	33	19	6
	Percentage	15.9	29.9	30.8	17.8	5.6
9.9 HIV and AIDS have an impact on the level of expected performance of employees.	Count	15	25	33	23	11
	Percentage	14.0	23.4	30.8	21.5	10.3

This set of questions aimed to determine whether respondents comprehended the influence of HIV and AIDS on job performance. A total of 36.4% of respondents agreed

that HIV and AIDS impacts negatively on job performance (number 9.1), while 34.6% disagreed and 29% did not know whether or not it has any impact. More than half the respondents indicated that they did not know or disagreed that HIV and AIDS impacts on service delivery (number 9.2). A total of 49.5% of respondents indicated that AIDS sufferers take more sick leave (number 9.3), while one third indicated that absenteeism causes an increase in workload (number 9.5).

To recap, 56.1% of respondents did not know or disagreed that by taking sick leave, infected employees increase their colleagues' workload, while 51.4% disagreed that HIV and AIDS has a negative impact on the profit of the hotel group. A total of 34.6% of respondents indicated that HIV and AIDS does not impact negatively on job performance.

Question 10: Policy impact

Table 14: Policy impact

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
10.1 The HIV and AIDS policy provides additional sick leave for infected employees.	Count	8	25	55	12	7
	Percentage	7.5	23.4	51.4	11.2	6.5

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
10.2 The HIV and AIDS policy protects infected employees in the work environment.	Count	6	11	43	40	7
	Percentage	5.6	10.3	40.2	37.4	6.5
10.3 Employees benefit directly from the HIV and AIDS policy.	Count	5	15	58	25	4
	Percentage	4.7	14.0	54.2	23.4	3.7
10.4 The hotel can dismiss an employee because of his/her HIV and AIDS status.	Count	42	32	27	5	1
	Percentage	39.3	29.9	25.2	4.7	0.9
10.5 The HIV and AIDS policy takes care of the employee first, and then the hotel.	Count	11	16	49	28	3
	Percentage	10.3	15.0	45.8	26.2	2.8

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
10.6 The HIV and AIDS policy takes care of the hotel first, and then the employee.	Count	9	23	60	10	5
	Percentage	8.4	21.5	56.1	9.3	4.7
10.7 The HIV and AIDS policy is displayed visibly in the hotel.	Count	15	29	47	14	2
	Percentage	14.0	27.1	43.9	13.1	1.9
10.8 HIV and AIDS information sessions are held regularly to inform employees about the policy.	Count	20	26	45	13	3
	Percentage	18.7	24.3	42.1	12.1	2.8
10.9 The HIV and AIDS policy informs employees about assistance/training/educational programmes, etc.	Count	12	21	41	30	3
	Percentage	11.2	19.6	38.3	28.0	2.8

The first question of this set aimed to establish whether the HIV and AIDS policy provides additional sick leave for infected employees, and 17.7% of respondents indicated that this is indeed the case (number 10.1). Approximately 25.2% did not know whether an

infected employee could be dismissed because of his or her HIV and AIDS status (number 10.4).

The majority (85%) of respondents were not aware of any visible display of the policy (number 10.7), e.g. on hotel notice-boards. More than two thirds of respondents did not know or disagreed that the policy informs employees about assistance, training, education programmes (number 10.9), etc., while 40.2% indicated that they did not know whether the HIV and AIDS policy protects infected employees (number 10.2).

The questionnaire contained three open-ended questions and the responses in this regard are reflected below.

Question 11: Any comments, suggestions or recommendations on how to improve HIV and AIDS policies in your establishment?

Twenty-nine respondents responded to this question and 20 indicating that they would like to see more educational workshops and awareness training, as well as some educational posters displayed in the canteen. Five respondents indicated a need for VCT and condom distribution while four identified policy information as a requirement.

Question 12: Does your hotel policy really help staff in general? Please motivate your answer.

In general, the responses obtained suggested that the respondents were not aware of the existence of an HIV and AIDS policy and that hotel management was not providing

adequate information to staff. Some respondents indicated that the HIV and AIDS issue was not being discussed in the workplace, that training was a rare occurrence, and that the hotel was not creating awareness of health-related issues.

Question 13: Have you learned anything new about HIV and AIDS from your hotel that you did not know before? If so, what?

The majority of respondents indicated that they had learned nothing new about the pandemic from programmes presented by the hotel. Although 47% of respondents indicated that the hotel do use awareness programmes to inform them of HIV and AIDS as indicated in Table 10.

5.4.2 Inferential Statistics

This section reflects the analysis of the data with cross-tables, as well as Pearson chi-square and maximum likelihood chi-square tests, representing the relationship between two variables. A significance level of 0.05 was used throughout. All the questions cannot be documented in a cross table or with a chi-square test and some questions will be left for further studies. The questions will run concurrently from question 6 to question 10.

Table 15: Cross-table of gender versus current position (Question 2 and Question 5)

	Management	Back-of-House	Front-of-House	Row
Female	11	46	26	83
Male	6	12	6	24
Total	17	58	32	107

Table 15 indicates the contingency between gender and current position. Of the 24 male respondents, six were in management positions, 12 in back-of-house and six in front-of-house positions. Women represented 83 of the 107 respondents, with 11 in management, 46 in back-of-house and 26 in front-of-house positions. This is reflected in Figure 2 below.

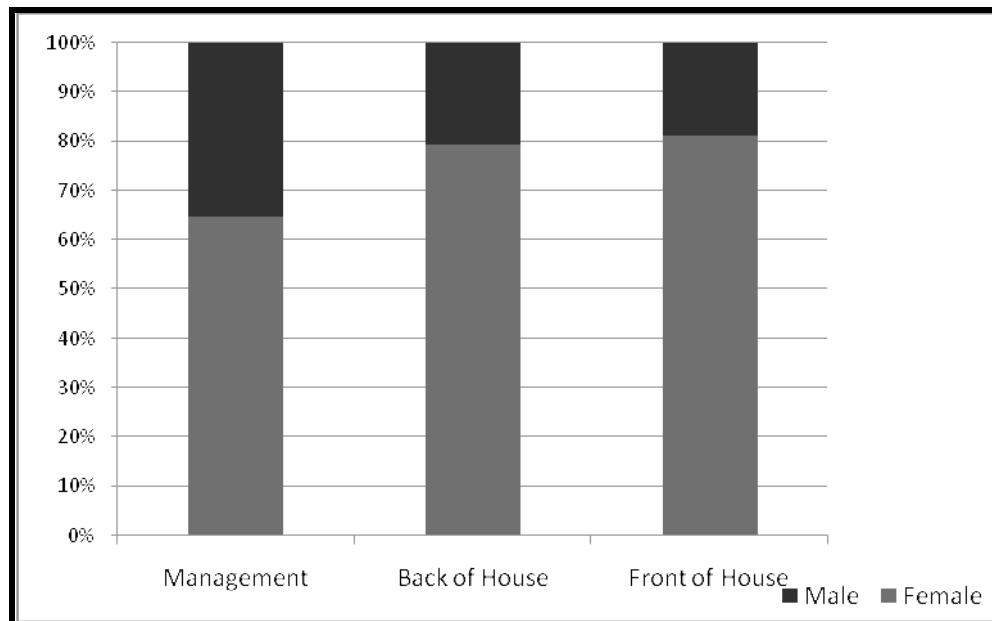


Figure 2: Current position versus gender of respondents

Table 16: Chi-square tests of gender versus current position (Question 2 and Question 5)

	Chi-square	Degree of freedom (df)	P
Pearson Chi-square	1.9	df=2	p=.4
Maximum likelihood chi-square	1.8	df=2	p=.4

The chi-square tests yielded a p-value of 0.4, and therefore no significant relationship exists between the gender of a respondent and his or her current position at the hotel.

Table 17: Cross-table of educational level versus current position (Question 4 and Question 5)

	Tertiary Education	Secondary Education	Row
Management	12	5	17
Back-of-House	5	53	58
Front-of-House	9	23	32
Total	26	81	107

Table 17 displays the respondents' current position in relation to educational level. Out of a total of 17 respondents in management positions, 12 had a tertiary-level education and

five a secondary-level education. Of the 58 back-of-house employees, five had a tertiary-level education and 53 a secondary-level education. Of the 32 front-of-house employees, nine had a tertiary-level education and 23 a secondary-level education.

**Table 18: Chi-square tests of current position versus educational level
(Question 4 and Question 5)**

	Chi-square	df	P
Pearson chi-square	27.8	df=2	p=.0
Maximum likelihood chi-square	25.9	df=2	p=.0

The relationship between the current position and educational level of respondents was tested by means of chi-square to determine whether there is any significance. The test yielded a p-value of 0.0, pointing to a significant relationship between the current position and educational level of employees.

Table 19: Knowledge of policy existence versus level of policy communication, expressed in average terms (repeat of Table 10 – Question 6.1 and Question 6.2)

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.1 Your hotel has an official HIV and AIDS policy.					
Count	8	13	51	24	11
Percentage	7.5	12.1	47.7	22.4	10.3

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.2 The HIV and AIDS policy stipulations are communicated to all staff.					
Count	11	18	43	20	15
Percentage	10.3	16.8	40.2	18.7	14.0

The average was calculated for Question 6.1 (official HIV and AIDS policy) and Question 6.2 (stipulations are communicated). Responses indicated a significant relationship between the existence of an official policy and whether or not it is adequately communicated, indicating that the policy existence was not communicated.

**Table 20: Cross-table of policy existence versus policy communication
(Question 6.1 and Question 6.2)**

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	16	4	1	21
Don't Know	13	31	7	51
Strongly Agree/ Agree	0	8	27	35
Total	29	43	35	107

Fifty-one respondents indicated that they did not know whether the hotel has an official

HIV and AIDS policy, while 43 indicated that they did not know whether the stipulations are communicated.

Table 21: Chi-square tests of policy existence versus policy communication

	Chi-square	df	p
Pearson chi-square	70.29	df=4	p=.00
Maximum likelihood chi-square	72.45	df=4	p=.00

Table 21 reflects a significant relationship between the existence of a policy and how it is communicated.

Table 22: Cross-table of policy existence versus the offering of awareness programmes (Question 6.1 and Question 6.5)

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	13	2	6	21
Don't Know	16	17	18	51
Strongly Agree/ Agree	2	6	27	35
Total	31	25	51	107

As shown in Table 22 above, 51 respondents did not know whether the hotel has an

official HIV and AIDS policy and 56 indicated that they did not know or disagreed that the hotel offers awareness programmes.

Table 23: Chi-square tests of policy existence versus the offering of awareness programmes

	Chi-square	df	P
Pearson chi-square	28.59	df=4	p=.00
Maximum likelihood chi-square	29.61	df=4	p=.00

With a p-value of 0.00, a significant relationship can be observed between policy existence and the offering of awareness programmes.

Table 24: Cross-table of policy existence versus the offering of treatment, care and support programmes (Question 6.1 and Question 6.7)

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	16	3	2	21
Don't Know	15	25	11	51
Strongly Agree/ Agree	9	8	18	35
Total	40	36	31	107

Table 24 shows that 87 respondents did not know of any treatment, care and support programmes offered to all employees, while 51 respondents did not know whether the hotel has an official HIV and AIDS policy in place.

Table 25: Chi-square tests of policy existence versus the offering of treatment, care and support programmes

	Chi-square	df	P
Pearson chi-square	27.53	df=4	p=.00
Maximum likelihood chi-square	26.06	df=4	p=.00

A significant relationship can be observed between the existence of policy and the offering of treatment, care and support programmes.

Table 26: Cross-table of policy existence versus the offering of training, education and counselling programmes (Question 6.1 and Question 6.8)

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	16	3	2	21
Don't Know	21	21	9	51
Strongly Agree/ Agree	4	5	26	35
Total	41	29	37	107

Table 26 reflects the responses related to the existence of an HIV and AIDS policy and the offering of training, education and counselling programmes. More than two thirds of the respondents indicated that they did not know whether or not the hotel offers training, education and counselling programmes.

Table 27: Chi-square tests of policy existence versus the offering of training, education and counselling programmes

	Chi-square	df	P
Pearson chi-square	45.69	df=4	p=.00
Maximum likelihood chi-square	45.15	df=4	p=.00

With a p-value of 0.00, a significant relationship can be observed between policy

existence and the offering of training, education and counselling programmes.

Table 28: Cross-table of policy existence versus the attendance of awareness/ educational programmes (Question 6.1 and Question 6.12)

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	13	2	6	21
Don't Know	24	11	16	51
Strongly Agree/ Agree	5	1	29	35
Total	42	14	51	107

Forty-two respondents indicated that they had not attended any HIV and AIDS awareness or educational programmes offered by the hotel.

Table 29: Chi-square tests of policy existence versus the attendance of awareness/educational programmes

	Chi- square	df	P
Pearson Chi-square	28.44	df=4	p=.00
Maximum likelihood chi-square	29.67	df=4	p=.00

The chi-square tests yielded a p-value of 0.00, indicating a significant relationship

between policy existence and the attendance of awareness or educational programmes.

Table 30: Cross-table of condom usage versus the practising of unprotected sex (Question 7.3 and Question 8.11)

	Disagree	Don't Know	Agree	Row
Disagree	1	0	11	12
Don't Know	1	0	6	7
Agree	4	0	84	88
Total	6	0	101	107

Table 30 indicates the association between condom usage and the risk of contracting HIV and AIDS through unprotected sex. Eighty-four respondents agreed that condom usage can prevent the transmission of HIV and AIDS, and that the disease can be contracted through unprotected sex.

Table 31: Chi-square tests of condom usage versus the practising of unprotected sex

	Chi-square	df	P
Pearson chi-square	1.4	df=2	p=.5
Maximum likelihood chi-square	1.1	df=2	p=.5

The chi-square tests yielded a p-value of 0.5, therefore no significant relationship can be observed between the respondents' perception of condom usage and the practising of unprotected sex.

Table 32: Cross-table of transmission of HIV and AIDS to unborn babies versus whether ARV treatment can prevent this (Question 7.7 and Question 7.11)

	Disagree	Don't Know	Agree	Row
Disagree	4	5	8	17
Don't Know	1	3	3	7
Agree	13	15	55	83
Total	18	23	66	107

Fifty-five respondents agreed that HIV and AIDS can be transmitted from an infected mother to her unborn baby.

Table 33: Chi-square test of transmission of HIV and AIDS to unborn babies versus whether ARV treatment can prevent this

	Chi-square	df	P
Pearson chi-square	4.3	df=4	p=.4
Maximum likelihood chi-square	3.9	df=4	p=.4

With a p-value of 0.4, no significant relationship can be observed between the transmission of HIV and AIDS from a mother to her unborn baby, and whether ARV treatment could prevent this from happening.

Table 34: Cross-table of the negative impact of HIV and AIDS on job performance versus more sick leave taken by infected individuals (Question 9.1 and Question 9.3)

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	19	6	12	37
Don't Know	8	10	13	31
Strongly Agree/ Agree	5	6	28	39
Total	32	22	53	107

Fifty-four respondents indicated that they did not know or disagreed that infected individuals take more sick leave than others. More than two thirds of respondents indicated that they did not know whether HIV and AIDS impacts negatively on job performance.

Table 35: Chi-square tests of the negative impact of HIV and AIDS on job performance versus more sick leave taken by infected individuals

	Chi-square	df	P
Pearson chi-square	19.03	df=4	p=.00
Maximum likelihood chi-square	18.69	df=4	p=.00

A significant relationship can be observed between the negative impact of HIV and AIDS on job performance and the amount of sick leave taken.

Table 36: Cross-table of the provision of additional sick leave versus whether the hotel puts the employee’s needs first (Question 10.1 and Question 10.6)

	Strongly Disagree/ Disagree	Don’t Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	15	11	7	33
Don’t Know	11	41	3	55
Strongly Agree/ Agree	6	8	5	19
Total	32	60	15	107

Table 36 shows that 55 respondents did not know about the granting of additional sick leave to infected employees, while 60 respondents indicated that they did not know whether the hotel puts employee’s needs first.

Table 37: Chi-square tests of the provision of additional sick leave versus whether the hotel puts the hotel’s needs first

	Chi- square	df	P
Pearson chi-square	17.69	df=4	p=.001
Maximum likelihood chi-square	18.11	df=4	p=.001

With a p-value of 0.001, a significant relationship can be observed between the granting

of additional sick leave and whether the hotel puts the hotel's needs first.

Table 38: Cross-table of policy existence versus the visual display of policy (Question 6.1 and Question 10.7)

	Strongly disagree/Disagree	Don't Know	Strongly agree/Agree	Row
Strongly disagree/Disagree	11	7	3	21
Don't know	18	30	3	51
Strongly agree/Agree	15	10	10	35
Totals	44	47	16	107

Only sixteen respondents indicated that the HIV and AIDS policy is visibly displayed, whilst most respondents did not know.

Table 39: Chi-square tests of policy existence versus the visual display of policy

	Chi-square	df	P
Pearson chi-square	13.24	df=4	p=.01
Maximum likelihood chi-square	13.19	df=4	p=.01

The chi-square tests yielded a p-value of 0.01, therefore a significant relationship can be observed between the existence of an official HIV and AIDS policy and whether it is visibly displayed.

Table 40: Cross-table of policy existence versus the holding of regular information sessions (Question 6.1 and Question 10.8)

	Strongly Disagree/ Disagree	Don't Know	Strongly Agree/ Agree	Row
Strongly Disagree/ Disagree	12	5	4	21
Don't Know	17	30	4	51
Strongly Agree/ Agree	17	10	8	35
Total	46	45	16	107

Table 40 displays the responses to the existence of an HIV and AIDS policy and whether regular information sessions take place, showing that 91 respondents were not aware of regular information sessions taking place.

Table 41: Chi-square tests of policy existence versus the holding of regular information sessions

	Chi- square	df	P
Pearson chi-square	12.35	df=4	p=.01
Maximum likelihood chi-square	12.60	df=4	p=.01

A significant relationship can be observed between the existence of an official HIV and AIDS policy and the holding of regular information sessions.

For the sections questions 6 to 10, respective averages across all respondents were calculated. Firstly, the five group means were compared using Wilks' lambda test for the question averages of questions 6 to 10 as a whole, with regard to distinct groups in age, gender, race, educational level and current position respectively. Where there was a significant indication of differing means from the multivariate Wilks' lambda test, the individual groups (questions 6, 7, 8, 9 and 10) were tested separately for means across the five different sections of age, gender, race, position and educational level, per section. Where no significant relationships were found, the results have not been reported.

Table 42: Wilks' test of Question 7 (HIV and AIDS knowledge) and educational level

	Test	Value	F	Effect	Error	P
Educational Level	Wilks'	0.95	0.97	5	101	0.44

Educational level did not cause a variance in the means of questions 6 to 10 as a whole, although Question 7, which related to HIV and AIDS knowledge, differed significantly on its own.

Table 43: Wilks' test of Question 8 (HIV and AIDS knowledge) and current position

	Test	Value	F	Effect	Error	P
Current Position	Wilks'	0.84	1.82	10	200	0.06

A borderline significance was observed between the current position of respondents and their knowledge regarding HIV and AIDS.

Table 44: Wilks' lambda test of Question 9 (job performance) and age

	Test	Value	F	Effect	Error	P
Age	Wilks'	0.72	1.62	20	325.97	0.04

The means of the totals for Question 9 show that job performance is significantly impacted by age.

Table 45: Wilks' test of Question 10 (policy impact) and race

	Test	Value	F	Effect	Error	P
Race	Wilks'	0.72	1.66	20	325.97	0.03

The means of the totals from policy impact differed significantly with regard to the various racial groups.

5.5 SUMMARY

The literature review (Chapters 1 to 4) formed the basis of the empirical study. The

questionnaire was piloted and administered to the employees of the selected major South African hotel group, and the sample was selected to include responses from all the levels of infection from the most-affected to the least-affected areas in the country in respect of HIV and AIDS. Stratified random sampling was applied to include individuals from all organisational levels. The data was analysed according to the layout of the questionnaire, and descriptive and inferential statistics were applied to the data.

In this chapter it is clear that the policy existence has not been communicated in a satisfactory manner to employees as they are unaware of the policy existence. However more employees indicated that they understood the policy that indicated its existence. A fast number of employees indicated that awareness and educational programmes has been attended regarding HIV and AIDS. This leads to that the existing policy should be discussed and adjusted to maximize awareness and knowledge of the policy as well as HIV and AIDS.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter concludes on the findings documented in Chapter 5 and provides some useful recommendations to the hotel group under investigation.

6.2 CONCLUSIONS

Through the evaluation of the implementation of the HIV and AIDS policy which occurred with a questionnaire the issues faced by the organisation could be looked at and is addressed below. The aim of this investigation was to reflect on how well a major hotel group implements its HIV and AIDS policy. The statistical analysis did not produce any unexpected results that were not confirmed by literature. The chi-square test performed on the data indicated that there is a significant relationships between the existence of a HIV and AIDS policy and its communication, as well as with relation to treatment, care and support programmes, training, education and counselling programmes and attendance of these programmes (Barrett-Grant *et al.*, 2003: 172; Bateesa, 2009: 9; Roberts, 2004). This also applies to the existence of an official HIV and AIDS policy and the having regular information sessions (Nyblade, 2004: 5).

It also emanated from the findings that employees were not sufficiently informed about the existence of the various awareness, education and counselling programmes. It could thus be concluded that although a policy exists employees are often not well informed of its stipulations – this could either be due to a lack of interest on the part of employees of ineffective communication on the part of management. Most of the employees were not aware of the existence of an HIV and AIDS policy at the hotel, pointing to poor

communication in this regard. A significant relationship was found to exist between the existence of an HIV and AIDS policy and its communication. This conclusion supports the importance of organisational communication and the level of interaction with staff. The vast majority of respondents indicated that they were not aware of the HIV and AIDS policy being visually displayed, which shows that communication within the organisation could be better co-ordinated. It also became clear that not all employees were informed about the availability of staff training and educational programmes in respect of HIV and AIDS.

Respondents also lack an understanding of the potentially disruptive consequences of the disease, especially relating to job performance, service delivery, profit margins and service quality. Moreover, few employees were aware of the fact that HIV and AIDS impacts negatively on job performance and profit, and that sick leave results in increased costs. This points to a lack of communication, and shows that employees do not comprehend the disruptive impact that the disease is likely to have on the organisation.

According to the biographical details provided, more than half of the respondents fell into the age group of 24 to 34 years. The organisation thus has an opportunity to influence the youth's behaviour and attitude towards HIV and AIDS. The majority of respondents were female, and since women are at greater risk of contracting the disease than men, the effective implementation of an HIV and AIDS policy would be particularly beneficial to this group. It also emerged that the African population group comprises the majority of the hotel's employees, followed by the Coloured group.

The majority of respondents had a secondary-level education, with 24.3% having a tertiary-level education. A significant statistical relationship was observed between current position and educational level. Not all respondents were aware of the ways in which the disease can be transmitted – for instance, there was no significant relationship between condom usage and the transmission of HIV and AIDS through unprotected sex. In some instances, a large majority of respondents had sufficient knowledge on matters like the transmission of HIV to unborn babies, the fact that ARV treatment can prevent mother-to-child transmission, and that HIV leads to AIDS. It is interesting to note that more than half of the respondents knew of the existence of awareness programmes offered by the hotel, and a significant relationship was observed between the existence of an HIV and AIDS policy and the offering of awareness programmes.

A significant relationship was also observed between the existence of an HIV and AIDS policy and the offering of treatment, care and support programmes, as well as training, education and counselling programmes. The same tendency also applies to the attendance of awareness programmes and the offering of regular information sessions. These findings reveal the importance of having HIV and AIDS policies in place to serve as a guideline for the various awareness and training programmes offered by the organisation. An important conclusion is that the majority of the respondents were not aware of HIV and AIDS being contracted through the donating of blood.

More than half of the respondents were not aware of additional sick leave being granted

to infected employees, while many were unaware of the fact that an HIV and AIDS policy must protect employees with the disease. The majority of respondents indicated that although the employees seem to be important to the hotel, their needs are not always put first.

As seen from the data gathered very few were aware of the hotel groups HIV and AIDS policy and this indicates that the existing policy implementation strategies would need to be looked at and drastic adjustments has to be made.

6.3 RECOMMENDATIONS

Based on the objectives the following recommendations are made. Policy implementation has been indicated as poor and could be rectified by reflecting on the issues faced by the organisation:

- Regular treatment, care and support programmes, as well as effective counselling for staff, should be offered by the hotel – either through internal administration processes, or the contracting of outside professionals.
- The treatment, support and educational programmes offered by the hotel must be adequately communicated to all staff, by means of regular information sessions and the use of notice-boards and electronic media.
- Policy revision must take place annually to ensure that employees always have access to the most accurate information available.
- A mobile clinic could travel to the various hotels on a monthly basis in order to provide employees with the most up-to-date and accurate information on health

issues and their HIV status, this could be done in collaboration with government.

A mobile clinic could help make staff feel that the hotel supports them in their struggle against the disease and cares about their wellbeing.

With the above said it is clear that the policy implementation strategy is inactive and would need to be revised and adjusted to suit the specific needs of each hotel in the group.

REFERENCES

ABCA (Asian Business Coalition on AIDS). 2002. *Business taking action to manage HIV/AIDS: A selection of business practices responding to HIV/AIDS in- and outside the Asian workplace*. Available online at: <http://www.hivpolicy.org/Library/HPP000308.pdf>. [Accessed: 10 February 2010].

AFSA (AIDS Foundation of South Africa). 2008. *HIV/AIDS*. Available online at: <http://www.aids.org.za/hiv.htm> [Accessed: 10 February 2010].

Agbola, F.W.; Damoense, M.Y. & Saini, Y.K. 2004. South Africa: Impact of HIV/AIDS on food demand. *International Journal of Social Economics*, 31(7): 721-731.

Aggleton, P.; Wood, K.; Malcom, A. & Parker, R. 2005. HIV-related stigma, discrimination and human rights violation. *Case Studies of Successful Programmers*. Geneva: UNAIDS.

AGOA Forum (African Growth and Opportunities Act Forum). 2001. *The HIV/AIDS crisis: The implications for achieving AGOA objectives*. Paper presented at the Plenary Session on HIV/AIDS, AGOA Forum, Washington DC, 30 October 2001, pp. 2-28. Available online at: http://www.policyproject.com/pubs/AGOA_1.PDF. [Accessed: 20 March 2010].

AIDS InfoNet. 2010. *CD4 cells*. Available online at: <http://thebody.com/content/art6110.html> [Accessed: 2 July 2010].

Allen, R.L.; Gould, A.; Koteff, E. & Martin, R. 2005. Industry comes out of closet, debuts hiring, promotion programs for gays and lesbians. *Nation's Restaurant News*, 39(16): 20.

Aspen CBE (Aspen Institute Center for Business Education). 2008. *A closer look at business education: HIV/AIDS*. Available online at: <http://www.aspenbe.org/documents/HIV%20AIDS%20Closer%20Look.pdf>. [Accessed: 20 March 2010].

ASSA (Actuarial Society of South Africa). 2005. *AIDS demographic model 2002*. Available online at: <http://www.assa.org.za> [Accessed: 26 January 2010].

ASSA (Actuarial Society of South Africa). 2006. *Initial observation on the comparison of the 2005 HSRC household HIV prevalence and behaviour survey estimates from the ASSA 2003 AIDS and demographic model*. Available online at: <http://www.assa.org.za/aids> [Accessed: 10 January 2010].

ASSA (Actuarial Society of South Africa). 2011. Expansion of ARV programme in South Africa slows AIDS mortality rate. *HIV/AIDS Newsletter*, 10: 1-4. Available online at: <http://aids.actuarialsociety.org.za>. [Accessed: 5 October 2011].

Atkins-van Kogelenberg, N. & Nyirenda, W. 2004. Consulting the community on stigma and discrimination in Zambia. *Sexual Health Exchange*, 2004(2): 15-16.

Avert. 2009a. *AIDS*. Available online at: <http://www.avert.org/aids.htm> [Accessed: 8 June 2010].

Avert. 2009b. *HIV & AIDS in South Africa*. Available online at: <http://www.avert.org/aidssouthafrica.htm> [Accessed: 4 February 2010].

Baker, S.; Sartsara, S.; Rumakom, P.; Guest, P.; Schenk, K.; Pramualratana, A.; Suksakulwat, S.; Panakitsuwan, S. & Moonmeung, S. 2004. *Using incentives to encourage AIDS programmes and policies in the workplace: A study of feasibility and impact in Thailand*. Washington DC: Population Council, pp. 1-52.

Bakuwa, R. 2010. Adoption of formal HIV and AIDS workplace policies: An analysis of industry/sector variation. *Journal of Social Aspects of HIV/AIDS*, 7(4): 2-9.

Baloyi, M. 2004. Frequently asked questions. *Positive Living*, August 2004, pp. 1-8. Available online at: www.fasset.org.za/downloads/sdf7_scg_faq.DOC. [Accessed: 5 October 2011].

Barbra, N.A. 2003. AIDS and antiretroviral drugs in South Africa: Public health, politics and individual suffering – A review of Brian Tilley's 'It's My Life'. *Journal of Law, Medicine and Ethics*, (31)1: 144 -148.

Barrett-Grant, K.; Fine, D.; Heywood, M. & Stode, A. 2003. *HIV/AIDS and the law: A resource manual*. 3rd Edition. Johannesburg: University of the Witwatersrand.

Bateesa, C.S. 2009. *Workplace response to HIV/AIDS and the effect of HIV/AIDS on the careers and occupations of the infected urban population*. Master's Degree Dissertation. Stellenbosch: Stellenbosch University, pp.1-15.

Bernier, N.F. & Clavier, C. 2011. Public health policy research: Making the case for a political science approach. *Health Promotion International*, (26)2: 109-116.

Blumberg, B.; Cooper, D.R. & Schindler, P.S. 2005. *Business research methods*. Maidenhead: McGraw-Hill Education.

Blumberg, B.; Cooper, D.R. & Schindler, P.S. 2008. *Business research methods*. 2nd European Edition. Maidenhead: McGraw-Hill Education.

Bodiang, C.K. 2001. *HIV/AIDS: The multisectoral approach – A focus on Africa*. Basel: Swiss Agency for Development and Co-operation, pp. 1-12.

Bollinger, L. & Stover, J. 1999. *The economic impact of AIDS in South Africa*. Available online at: <http://www.policyproject.com/pubs/SEImpact/southafr.pdf>. [Accessed: 8 June 2010].

Booyesen, V. 2011. Sakesektor moet pas aangee. *Rapport*, 4 December 2011, p. 1.

Bos, A.; Schaalma, H. & Mbwambo, J. 2004. Reducing AIDS-related stigma in developing countries: The importance of theory and evidence-based interventions. *Sexual Health Exchange*, 2004(2): 3-4.

BOTA (Botswana Training Authority). 2005. *Develop and implement HIV/AIDS policies for a workplace*. Gaborone: BOTA, pp 1-6.

Bowler, J. 2004. A pilot study into the impact of and response to HIV/AIDS by workplaces in the Nelson Mandela Metropolitan Municipal Area – 2002. *Proceedings of the HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 12-32.

Brand, A. 2010a. *Managing HIV/AIDS in the hospitality industry*. Available online at:http://www.hotelandrestaurant.co.za/new_site/content/training/singlepage.asp?id=1438 [Accessed: 20 January 2011].

Brand, A. 2010b. *Tsebo takes wellness to heart*. Available online at:
http://www.fedics.co.za/news/wellness_to_heart.asp.

Breuer, N.L. 2004. Teaching the HIV-positive client how to manage the workplace. *Journal of Vocational Rehabilitation*, 22: 163-169.

Brits, E. 2011. Jel teen MIV onttrek na studie se bevindings oor oordrag. *Volksblad*, 29 November 2011, p. 7.

Cathsseta (Culture, Art, Tourism, Hospitality & Sport Sector Education and Training Authority). 2000. *HIV/AIDS handbook for South African tourism and hospitality companies*. Available online at:

http://www.cathsseta.org.za/downloads/HIV_AIDS_HANDBOOK.pdf

CETU (Confederation of Ethiopian Trade Unions). 2001. *Workplace HIV/AIDS policy: Guidelines*. Addis Ababa: CETU, pp. 1-26.

CHAA (Caribbean HIV & AIDS Alliance). 2010. *Toolkit of HIV & AIDS and responsible tourism models in the Caribbean*. Trinidad & Tobago: CHAA, pp. 1-62.

Charalambous, S.; Grant, A.D.; Day, J.H.; Pemba, L.; Chaisson, R.E.; Kruger, P.; Martin, D.; Wood, R.; Brink, B. & Churchyard, G.J. 2007. Establishing a workplace antiretroviral therapy program in South Africa. *AIDS Care*, 19(1): 34-41.

Chinga, A. 2006. Howard Armistead: Living with HIV for 23 years. *Zambia Daily Mail*, 19 September 2006.

Cichocki, M.R.N. 2007a. *HIV viral load*. Available online at: <http://aids.about.com/od/newlydiagnosed/qt/viralload.htm> [Accessed: 20 July 2010].

Cichocki, M.R.N. 2007b. *What are CD4 cells?* Available online at: <http://aids.about.com/od/newlydiagnosed/qt/cd4.htm> [Accessed: 20 July 2010].

City Lodge Hotels. 2004. HIV/AIDS policy. *Human Resources Manual*, 2: 1405-1407.

Cloete, M.S. 2004. *The influence of workplace support programmes on the job performance of HIV/AIDS infected employees*. Pretoria: University of South Africa, pp. 1-180.

CoGTA (Department of Co-operative Governance and Traditional Affairs). 2007. *HIV and AIDS policy*. Pretoria: Government Printer.

Cohen, A. 2000. The relationship between commitment forms and work outcomes: A comparison of three models. *Human Relations*, 53(3): 387-417.

Colgate-Palmolive Company. 2008. *HIV/AIDS policy statement*. New York: Colgate-Palmolive Company, pp.1-12.

Connelly, P. & Rosen, S. 2005. Will small and medium enterprises provide HIV/AIDS services to employees? An analysis of market demand. *South African Journal of Economics*, 73: 613-625.

Coombe, C. 2002. HIV/AIDS and education. *Perspectives in Education*, 20(2): vii-x.

Daar, E.S. 2010. *HIV and AIDS causes, symptoms, treatment, prevention facts and testing*. Available online at:

http://www.medicinenet.com/human_immundeficiency_virus_hiv_aids/article.htm

[Accessed: 8 June 2010].

De Vos, A.S.; Strydom, H.; Fouche, C.B. & Delport, C.S.L. 2005. *Research at grass roots: For the social sciences and human service professions*. 3rd Edition. Pretoria: J.L. van Schaik Publishers.

Dickinson, D. 2003. Managing HIV/AIDS in the South African workplace: Just another duty? *South African Journal of Economic and Management Sciences*, 6(1): 1-31.

Dickinson, D. 2004. Medium-sized companies, many stakeholders: The sociology, psychology and political economy of HIV/AIDS responses in three manufacturing companies. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 36-64.

Dickinson, D. 2006a. Fighting for life: South African HIV/AIDS peer educators as a new industrial relations actor? *British Journal of Industrial Relations*, 44(4): 697-717.

Dickinson, D. 2006b. Smokescreen or opening a can of worms? Workplace HIV/AIDS peer education and social protection in South Africa. *African Studies*, 65: 321-342.

Dickinson, D. & Stevens, M. 2004. Understanding the response of large South African companies to HIV/AIDS. *Proceedings of the HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 67-84.

DoE (Department of Education). 1999. *National policy on HIV and AIDS for learners and educators in public schools and students and educators in further education and training institutions*. Pretoria: Government Printer, pp. 1-18.

DoH (Department of Health). 2000a. *HIV/AIDS/STD strategic plan for South Africa: 2000-2005*. Pretoria: Government Printer.

DoH (Department of Health). 2000b. *HIV/AIDS and STDs in the workplace*. Pretoria: Government Printer.

DoH (Department of Health). 2001. *Tuberculosis (TB)*. Pretoria: Government Printer.

DoH (Department of Health). 2003. *Investigating the impact of HIV/AIDS on the hospitality sector, 2002-2003*. Pretoria: Government Printer.

DoH (Department of Health). 2005. *What is antiretroviral therapy?* Pretoria: Government Printer.

DoH (Department of Health). 2006. *Summary report on the state of the South African HIV/AIDS epidemic*. Pretoria: Government Printer.

DoH (Department of Health). 2007a. *HIV/AIDS and STI strategic plan for South Africa: 2007-2011*. Pretoria: Government Printer, pp. 1-130.

DoH (Department of Health). 2007b. *National HIV and syphilis prevalence survey*. Pretoria: Government Printer.

DoL (Department of Labour). 2000a. *Code of good practice: Key aspects of HIV/AIDS and employment*. Pretoria: Government Printer, pp. 1-12.

DoL (Department of Labour). 2000b. *HIV/AIDS technical assistance guidelines*. Pretoria: Government Printer.

DPSA (Department of Public Service and Administration). 2002. *Managing HIV/AIDS in the workplace*. Pretoria: Government Printer, pp. 1-119.

Dorrington, R.; Johnson, L.; Bradshaw, D. & Daniel, T.J. 2006. *The demographic impact of HIV/AIDS in South Africa*. Cape Town: Centre for Actuarial Research, pp. 1 – 105.

Douglas, R. & Sutherland, M. 2009. An organizational change model for successful HIV/AIDS workplace interventions. *South African Journal of Labour Relations*, 33(2): 54-74.

Dreger, M. 2009. HIV and AIDS in the workplace. *Journal of Occupational and Environmental Medicine*, 51(2): 243-250.

Du Toit, J. & Burger, A. 2004. Tackling HIV/AIDS in the workplace. *EBF*, 17: 2-3.

DWAF (Department of Water Affairs and Forestry). 2000. *The process of incremental decision making*. Pretoria: Government Printer.

ECA (Economic Commission for Africa). 2004. *A report on the CHGA interaction sessions on HIV/AIDS and the world of work*. Addis Ababa: ECA, pp. 1-21.

Ellis, L.L. 2007. The impact of HIV/AIDS on selected business sectors in South Africa. *Studies in Economics and Econometrics*, 31(1): 29-52.

ETC Crystal. 2011. *Evaluations of HIV/AIDS workplace policies*. Available online at: <http://etc-crystal.org/index.php?id=721> [Accessed: 27 March 2011].

Falkier, A. 2004. The Global Reporting Initiative's HIV/AIDS reporting guidelines in South Africa: Perceptions, uses and possible outcomes. *Proceedings of the*

HIV/AIDS in the Workplace Symposium, University of the Witwatersrand, 29-30 June 2004, pp. 87-105.

Fasset (Sector Education and Training Authority for Finance, Accounting, Management Consulting and other Financial Services). 2005. *A guide to HIV/AIDS in the workplace*, p. 1-65. Available online at: http://www.fasset.org.za/downloads/hiv_booklet.pdf.

FDA (Foundation for the Development of Africa). 2004. *HIV/AIDS issues for employers*. Johannesburg: FDA, pp. 1-6.

Forsythe, S. 2002. *The economics of addressing HIV/AIDS in the workplace: Is enlightened self-interest the "right" argument?* Alexandria, VA: International AIDS Economics Network, pp. 1-2.

Fulford, M.D.; Rothman, R. & Lynch, M. 2007. Effective HR strategies of HIV-positive employees. *Journal of Organizational Culture, Communications and Conflict*, 11(1): 91-103.

GBC (Global Business Coalition on HIV/AIDS, TB and Malaria). 2007. *What can travel and tourism companies do to fight against HIV/AIDS, tuberculosis and malaria?* Available online at: http://www.gbcimpact.org/itcs_node/0/0/report/952. [Accessed 10 June 2010].

Genesis Group. 2007. *AIDS awareness in the workplace*. Tampa, FL: Genesis Group, pp. 1-3.

Gerntholtz, L. 2004. An overview of some of the key legal developments in HIV/AIDS and the law – 2003. *Southern African Journal of HIV Medicine*, 5(1): 40-43.

Giliomee, T. 2006. *Dealing with AIDS in the workplace: AIDS does affect every employer*. Available online at:

<http://www.saels.co.za/forms/AIDS/EMPLOYER.doc> [Accessed 10 June 2010].

Government of Nova Scotia. 2001. HIV/AIDS in the workplace. *Human Resources Management Manual*. Halifax: Government of Nova Scotia, Ch. 6, pp. 25-30.

Government of South Africa. 1995. *Labour Relations Act, Act 66 of 1995*. Pretoria: Government Printer.

Government of South Africa. 1996. *Constitution of the Republic of South Africa, Act 108 of 1996*. Pretoria: Government Printer.

Government of South Africa. 1998. *Employee Equity Act, Act 55 of 1998*. Pretoria: Government Printer.

Government of Uganda. 2007. *Kasese Town Council HIV/AIDS workplace policy*. Kampala: Government of Uganda, pp. 1-14.

Grant, K.B. 2003. *HIV/AIDS and the law*. Johannesburg: University of the Witwatersrand, Ch. 1, pp. 1-28; Ch. 2, pp. 29-44; Ch. 7, pp. 156-180.

Grant, K.B.; Strode, A. & Smart, R. 2002. *Managing HIV/AIDS in the workplace: A guide for government departments*. Pretoria: Department of Public Service and Administration, pp.1-154.

Guilwe, T. 2007. *HIV/AIDS in the workplace: Exploring the role of labour in tackling the pandemic*. Available online at: <http://www.sarpn.org.za/documents/d0002766/index.php> [Accessed: 2 July 2010].

Habyarimana, J.; Mbakile, B. & Pop-Eleches, C. 2007. *The impact of HIV/AIDS and ARV treatment on workers' absenteeism: Implications for African firms*. Available online at: <http://www.columbia.edu/~cp2124/papers/arv.pdf>. [Accessed: 2 July 2010].

Haldenwang, B. 2008. A bi-monthly electronic briefing for the business community on developments in the field of HIV and AIDS. *AIDS Watch*, 25(April): 1-2.

Hamilton, N. 1999. *A practical guide to policy making in Northern Ireland*. Belfast, NICS, pp. 1-79.

Hardy, C. & Kleinsmidt, A. 2004. *HIV/AIDS and the workplace: Your rights as a domestic worker*. Johannesburg: University of the Witwatersrand, pp.1-20.

Hartline, M.D. & De Witt, T. 2004. Individual differences among service employees: The conundrum of employers' recruitment, selection and retention. *Journal of Relationship Marketing*, 3(2): 25-42.

Health24. 2006. *Shocking SA AIDS stats released*. Available online at: <http://www.health24.com/prinarticle.htm> [Accessed: 3 June 2010].

Herek, G.M.; Capitano, J.P. & Widaman, K.F. 2002. HIV-related stigma and knowledge in the United States: Prevalence and trends. *American Journal of Public Health*, 92(3): 371-377.

Herholdt-Smith, J. 2006. *The economic impact of HIV/AIDS in Africa*. Available online at: http://www.africacncl.org/HIV_AIDS/about_aai/sector/hospitality.asp [Accessed: 17 January 2011].

Hikuam, F. 2004. Global action against HIV/AIDS: Related stigma and discrimination. *Sexual Health Exchange*, 2004(2): 8-9.

Hogan, B. 2009. *Closing speech to 4th South African AIDS conference*. Available online at: http://www.saaid.co.za/index.php?option=com_content&task=view&id=94&Itemid=129 [Accessed: 4 February 2010].

HSRC (Human Sciences Research Council). 2005. *South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005*. Cape Town: HSRC Press.

HSRC (Human Sciences Research Council). 2009. *South African national HIV prevalence, incidence, behaviour and communication survey, 2008: A turning tide among teenagers?* Available online at: <http://www.hsrc.ac.za/SAHA.phtml> [Accessed: 4 February 2010].

IFC (International Finance Corporation). 2002. *Good practice note: HIV/AIDS in the workplace*. Washington DC: IFC, pp. 1-24.

IFES (International Foundation for Electoral Systems). 1997. HIV/AIDS as a human rights and legal issue. *Transition and the Constitution Training Manual*. Washington DC: IFES, p. 1-12.

IHAA (International HIV/AIDS Alliance). 2010. *Responsible tourism model in Caribbean*. Available online at: <http://www.aidsalliance.org/NewsDetails.aspx?Id=567> [Accessed: 11 February 2011].

ILO (International Labour Organization). 2001. *An ILO code of practice on HIV/AIDS and the world of work*. Geneva: ILO, pp. 1-32.

ILO (International Labour Organization). 2002. *Action against AIDS in the workplace: Asia-Pacific region*. Geneva: ILO, pp. 1-4.

ILO (International Labour Organization). 2003a. *Global compact policy dialogue on HIV/AIDS*. Geneva: ILO.

ILO (International Labour Organization). 2003b. *Workplace action on HIV/AIDS: Identifying and sharing best practice*. Geneva: ILO, pp. 1-62.

ILO (International Labour Organization). 2005. *A workplace policy on HIV/AIDS: What it should cover*. Geneva: ILO, pp. 1-5.

ILO (International Labour Organization). 2009. *HIV/AIDS and workplace programs and policies in industrial mining companies*. Geneva: ILO, pp. 1-5.

ILO/ECP (International Labour Organization & Employers' Confederation of the Philippines). 2008. *Managing HIV/AIDS in the workplace*. Geneva: ILO, pp. 1-96.

ILO/UNESCO (International Labour Organization & United Nations Education, Scientific and Cultural Organization). 2006. *An HIV/AIDS workplace policy for the education sector in the Caribbean*. Geneva: ILO, pp. 1-26.

ILO/WHO (International Labour Organization & World Health Organization). 2005. *Joint ILO/WHO guidelines on health services and HIV/AIDS*. Geneva: ILO, pp. 1-57.

IOE (International Organisation of Employers). 2002. *Employers' handbook on HIV/AIDS: A guide for action*. Geneva: UNAIDS, pp. 1-39.

IPDRU (Institute of Policy Development, Research Unit). 2007. *Policy development in practice: An overview of the policy process*. Available online at: <http://www.ccollege.gov.sg/cgl/pdf/PDP%20-%20Policy%20Cycle.pdf>.

Jantjie, K.G. 2009. *Challenges of HIV and AIDS experienced by working women: The role and response of employee assistance programmes*. PhD Thesis. Pretoria: University of Pretoria.

Johansson, K.A.; Robberstad, B. & Norheim, O.F. 2010. Further benefits by early start of HIV treatment in low-income countries: Survival estimates of early versus deferred antiretroviral therapy. *Journal of AIDS Research and Therapy*, 7(3): 1-9.

Jones, P.S. 2005. A test of governance: Rights-based struggles and the politics of HIV/AIDS policy in South Africa. *Political Geography*, (24): 419-447.

Jugdeo, N. 2009. *Exploring HIV/AIDS stigma in the workplace: Voice of the stigmatized*. Pretoria: University of South Africa, pp. 1-77.

Kemp, R. & Weehuizen, R. 2005. *Policy learning: What does it mean and how can we study it?* Maastricht: Maastricht University, pp. 1-23.

Kerkhoven, R. & Lowik, M. 2004. *Human resource management and HIV/AIDS: A study among Share-Net members*. Amsterdam: Netherlands Network on Sexual and Reproductive Health and AIDS, pp .5-57.

KFF (Kaiser Family Foundation). 2007. *The multisectoral impact of the HIV/AIDS epidemic: A primer*. Menlo Park, CA: KFF, p. 1-10.

Laas, A. 2009. *HIV/AIDS workplace policy development and implementation in a selected sample of South African organizations*. Master's Dissertation. Stellenbosch: University of Stellenbosch, pp. 1-27.

Labour Protect. 2006. *HIV/AIDS: South African law and code of employment*. Roggebaai: Labour Protect.

Lee, M.; Wu, Z.; Rotheram-Borus, M.J.; Detels, R.; Guan, J. & Li, L. 2005. HIV-related stigma among market workers in China. *Journal of Health Psychology*, 24(4): 435-438.

Leedy, P.D. & Ormrod, J.E. 2005. *Practical research: Planning and design*. 8th Edition. Upper Saddle River, NJ: Pearson Educational.

Lloyd, J. & Abramson, B. 1999. *The challenge of HIV/AIDS in the workplace: A guide for the hospitality industry*. Geneva: UNAIDS, p. 1-44.

Lutalo, M. 2007. *The wellness program of Serena Hotels, Kenya – A case study*. Washington DC: IFC, pp. 1-10.

MacDonald, J. & George, G. 2002. *AIDS brief for professionals: Human resource managers*. Pietermaritzburg: University of Natal.

Machekanyanga, Z.; Mpofu, F.; Masvikeni, M.; Nyazema, N.Z. & Sithole, J. 2002. HIV prevention and control beyond the workplace: The role of the private sector in Zimbabwe. *Proceedings of the XIV International AIDS Conference*, Barcelona, Spain, 7-12 July 2002, pp. 123-127.

Mahendra, V.S. & Gilborn, L. 2004. PLWHA-friendly hospitals in India: Reducing AIDS-related stigma and discrimination. *Sexual Health Exchange*, 2004(2): 13-15.

Majors, S. 2004. The public service is not immune to HIV/AIDS: Is government prepared? *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 124-156.

Mak, W.; Mo, P.; Cheung, R.; Woo, J.; Cheung, F. & Lee, D. 2006. Comparative stigma of HIV/AIDS, SARS and TB. *Journal of Social Science and Medicine*, 63: 1912-1922.

Mamotte, N.; Wassenaar, D.; Koen, J. & Essack, Z. 2010. Convergent ethical issues in HIV/AIDS, tuberculosis and malaria vaccine trials in Africa. Report from the WHO/UNAIDS African AIDS Vaccine Programme's Ethics, Law and Human

Rights Collaborating Centre Consultation, 10-11 February 2009, Durban, South Africa. *BMC Medical Ethics*, 11(3): 1-5.

Manitoba, M. 2003. *A guide to policy development*. Pretoria: Government Printer.

Mapolisa, S.; Schneider, H. & Stevens, M. 2004. Labour response to HIV/AIDS in the workplace: Can HIV/AIDS compete with bread and butter issues? *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 160-172.

Markowitz, F.E. 2005. Sociological models of mental illness stigma: Progress and prospects. In: P. Corrigan (Ed.). *On the stigma of mental illness*. Washington DC: American Psychological Association.

Masindi, N. 2004. Siyam'kela: Linking research and action for stigma reduction in South Africa. *Sexual Health Exchange*, 2004(2): 7-8.

MFLOHC (Manitoba Federation of Labour Occupational Health Centre). *AIDS and the workplace*. Winnipeg: MFLOHC.

Mohammed, A. 2006. *Knowledge, attitude and practices regarding HIV/AIDS of hotel staff from selected hotel groups in Cape Town*. Master's Dissertation. Cape Town: Cape Peninsula University of Technology.

Morrison, K. & Cuadra, S.M. 2004. HIV-related stigma and discrimination in Mexican health-care services. *Sexual Health Exchange*, 2004(2): 12-13.

Mpundu, M. 2002. *Naspsa launches HIV/AIDS workplace policy*. Available online at: http://www.accessmylibrary.com/coms2/summary_0286-26914187_ITM
[Accessed: 26 January 2010].

Mundy, J. & Dickinson, D. 2004. Factors affecting the uptake of voluntary HIV/AIDS counselling and testing (VCT) services in the workplace. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June, pp. 176-194.

Muthaura, K.F. & Njau, P.S. 2005. *Public sector workplace policy on HIV and AIDS*. Kenya: Government Publishers.

Muthuswamy, V. 2005. *Ethical issues in HIV/AIDS research*. New Delhi: Indian Council of Medical Research, pp. 601-610.

Ndobo, N.G. 2006. *What impact does HIV/AIDS workplace policy have on HIV/AIDS management in Mdantsane High School, in East London?* Stellenbosch: Stellenbosch University, pp. 1-71.

Ngwena, C. 2000. *HIV/AIDS and equal opportunities in the workplace: The implications of the Employee Equity Act*. Pretoria: Vista University, pp. 96-109.

Njngang'iru, F.K. 2008. *The Pan African Health Congress: The impact of HIV/AIDS on business*. Available online at: <http://medical.bizcommunity.com/article/196/309/18373.html> [Accessed: 25 May 2010].

NMBM (Nelson Mandela Bay Municipality). 1998. *Workplace policy on HIV/AIDS for the Nelson Mandela Metropolitan Municipality*. Available online at: <http://www.nelsonmandelabay.gov.za/Documents.aspx?objID=85&cmd=download&docID=55>. [Accessed: 25 May 2010].

Noble, R. 2008. *HIV/AIDS statistics for South Africa*. Available online at: <http://www.avert.org/safricastats.htm> [Accessed: 28 April 2010].

Nobongoza, F.F. 2006. *The strategic management of HIV/AIDS in the workplace*. Port Elizabeth: Nelson Mandela Metropolitan University, pp. 1-103.

NPA (Norwegian People's Aid). 2005. *HIV/AIDS workplace policy*. Oslo: NPA, p. 1-4.

NTC/GAC (National Tripartite Committee & Ghana AIDS Commission). 2004. *National workplace HIV/AIDS policy*. Accra: GAC, pp. 1-15.

Nyblade, L. 2004. Disentangling stigma to find entry points for intervention. *Sexual Health Exchange*, 2004(2): 5-6.

O'Grady, M. 2004. Managing HIV/AIDS in the workplace: NGOs in South Africa, Zambia and Zimbabwe. *Proceedings of the Symposium on HIV/AIDS in the Workplace*, University of the Witwatersrand, 29-30 June 2004, p. 198-228.

Orr, N.M. & Patient, D.R. 2006. Absenteeism and HIV/AIDS: A hospitality industry case study. *Empowerment Concepts*, March 2006. Available online at: <http://www.empow.co.za/absenteeism-study.htm> [Accessed: 25 May 2010].

Oshi, D.C.; Nakalema, S. & Oshi, L.L. 2005. Cultural and social aspects of HIV/AIDS sex education in secondary schools in Nigeria. *Journal of Biosocial Science*, 37(2): 175-183.

Parker, R. & Aggleton, P. 2003. HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Journal of Social Science and Medicine*, 57(1): 13-24.

Parker, W. 2005. *HIV/AIDS, claims making and public sphere: Are we being critical enough about the epidemic?* Johannesburg: CADRE, pp. 1-6.

Patient, D. & Orr, N.M. 2004. Stigma and HIV/AIDS intervention structures. *Empowerment Concepts*, June 2004. Available online at: <http://www.empow.co.za/stigma-intervention-structures.htm>. [Accessed: 14 June 2010].

Pauw, I. 2006. *AIDS in the workplace*. Available online at: <http://www.career24.com/recruiter/print.htm> [Accessed: 3 June 2010].

Pfizer Incorporated. 2011. *HIV/AIDS workplace policy*. Available online at: http://www.pfizer.com/responsibility/workplace_responsibility/hiv_aids_workplace_policy [Accessed: 7 March 2011].

Pharaoh, R. 2005. *Not business as usual: Public sector responses to HIV/AIDS in Southern Africa*. Pretoria: Institute for Security Studies, pp. 19-32.

Pharaoh, R. & Schonteich, M. 2003. AIDS, security and governance in Southern Africa: Exploring the impact. *Institute for Security Studies Occasional Paper*, 65(1): 134-154.

Phaswana-Mafuya, N. & Pelzer, K. 2005. Perceived HIV/AIDS impact among staff in tertiary institutions in the Eastern Cape, South Africa. *Journal des Aspects Sociaux du VIH/SIDA*, 2(2): 277-285.

Pienaar, A. 2011. MIV in SA neem af. *Volksblad*, 23 November 2011, p. 11.

Pillay, M. 2009. *Absenteeism in the workplace*. La Lucia Ridge: Sikhaya Consulting, pp. 1-10.

Poggenpoel, J.M. 2006. *HIV in the workplace: A critical investigation into the present legislative protection afforded to the HIV-positive employee*. Cape Town: University of the Western Cape, pp. 1-82.

Pulerwitz, J.; Greene, J.; Esu-Williams, E. & Stewart, R. 2004. Addressing stigma and discrimination in the workplace: The example of ESKOM, South Africa. *Sexual Health Exchange*, 2004(2): 9-10.

Rampersad, R. 2006. HIV/AIDS and corporate social investment in South Africa. *China Media Research*, 2(3): 77-82.

Ramsingh, R.O. & Van Aardt, J.C. 2006. An evaluation of the policy framework on HIV and AIDS in South African public service: The effectiveness of the current

guidelines and the ability of the policy framework to absorb the impact of HIV and AIDS within the public service. *Public Personnel Management*, 35(3): 181-197.

Rao, D.; Angell, B.; Lam, C. & Corrigan, P. 2008. Stigma in the workplace: Employer attitude about people with HIV in Beijing, Hong Kong and Chicago. *Journal of Social Science and Medicine*, 67: 1541-1549.

Rau, B. 2002. *Workplace HIV/AIDS programs: An action guide for managers*. Arlington, VA: Family Health International, pp. 1-101.

Rauner, M.S. 2002. Using simulation for AIDS policy modeling: Benefits for HIV/AIDS prevention policy makers in Vienna, Austria. *Health Care Management Science*, 5: 121-134.

Reed, C. 2004. Workplace interventions in multinational companies: A case study approach. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 232-258.

Reidpath, D.; Brijnath, B. & Chan, K. 2005. An Asian Pacific six-country study on HIV-related discrimination: Introduction. *AIDS Care*, 17(2): 5117-5127.

Rhoades, L. & Eisenberger, R. 2002. Perceived organizational support: A review of the literature. *Journal of Applied Psychology*, 4: 698-714.

Roberts, M. 2004. *Healthy workforce: A toolkit for HIV/AIDS advocacy and behaviour change communication in the workplace*. Available online at: <http://www.unaids.org> [Accessed: 14 June 2010].

Rosen, S. & Simon, J. 2003. Shifting the burden: The private sector's response to the AIDS epidemic in Africa. *Bulletin of the World Health Organization*, 81(2): 131-137.

Rosen, S.; Vincent, J.R.; MacLeod, W.; Fox, M.; Thea, D.M. & Simon, J. 2004. The cost of HIV/AIDS to business in Southern Africa. *AIDS*, 18: 317-324.

Roux, N.L. 2002. Public policy-making and policy analysis in South Africa amidst transformation, change and globalisation: Views on participants and role players in the policy analytic procedure. *Journal of Public Administration*, 37(4): 418-437.

Saich, T. 2006. Social policy development in the era of economic reform. In: J. Kaufman, A. Kleinman & T. Saich (Eds.). *AIDS and social policy in China*. Cambridge, MA: Harvard University Asia Center.

Salkind, J.N. 2006. *Exploring research*. 6th Edition. Upper Saddle River, NJ: Pearson Educational.

Saunders, M.; Lewis, P. & Thornhill, A. 2007. *Research methods for business students*. 4th Edition. London: Pearson Education.

Schoeman, F.D. 1992. *Privacy and social freedom*. New York, NY: Cambridge University Press.

Schreiner, W. 2003. Business avoiding questions over HIV/AIDS policies. *Media Tenor SA Research Journal*, 12: 16.

Seale, A. 2004. Breaking the cycle of HIV/AIDS-related stigma and discrimination. *Sexual Health Exchange*, 2004(2): 1-3.

Setswe, G.K.G. 2009. Best practice workplace HIV/AIDS programmes in South Africa: A review of case studies and lessons learned. *African Journal of Primary Health Care & Family Medicine*, 1(1): 82-87.

Simelela, N.; Crowley, J. & Schaay, N. 2002. *Learning through practice: Integrating HIV/AIDS into NGO programmes – A guide*. Cape Town: Futures Group International, pp. 1-54.

Smart, R. & McKenna, S. 2006. *Workplace HIV and AIDS policy manual*. Lusaka: Afya Mzuri.

Stats SA (Statistics South Africa). 2011. *Mid-year population estimates*. Pretoria: Stats SA.

Stats SA (Statistics South Africa). 2011. *South African HIV and AIDS stats*. Pretoria: Stats SA.

Stevens, M. 2004. Stigma: A certain barrier to managing HIV/AIDS in the workplace. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 278-287.

Stevens, M.; Blaauw, D. & Mapolisa, S. 2004. Comparisons over time: Managing HIV/AIDS in the workplace. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 292-304.

Stevens, M.; Lynn, C. & Glass, R.M. 2008. HIV infection: The basics. *Journal of the American Medical Association*, 300(5): 614.

Stevens, M.; Weiner, R.; Mapolisa, S. & Dickinson, D. 2005. Management responses to HIV/AIDS in South African workplaces. *South African Journal of Economic and Management Sciences*, 8(3): 287-299.

Strand, P.; Matlosa, K.; Strode, A. & Chirambo, K. 2004. *HIV/AIDS and democratic governance in South Africa: Illustrating the impact on electoral processes*. Pretoria: Institute for Democracy in South Africa.

Swinburne University of Technology. 2009. *Policies and procedures*. Available online at: <http://www.swinburne.edu.au/corporate/registrar/ppd/fag> [Accessed: 11 January 2011].

Teklemariam, L.M. 2006. *The impact of reasonable accommodation on HIV/AIDS in the workplace*. Mafikeng: North West University, p. 1-64.

Total South Africa. 2002. *Workplace policy on HIV/AIDS*. Available online at: http://www.total.co.za/os/ossouthafrica.nsf/VS_OPM/77900975F2B58084C1256F330 [Accessed: 17 March 2011].

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2000. *The business response to HIV/AIDS: Impact and lessons learned*. Geneva: UNAIDS, pp. 1-73.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2002. *Employers' handbook on HIV/AIDS: A guide for action*. Geneva: UNAIDS, pp. 1-39.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2003. *HIV/AIDS: It's your business*. Geneva: UNAIDS, pp. 1-27.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2005. *Action against AIDS in the workplace*. Geneva: UNAIDS, pp. 1-4.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2008. *Report on the global AIDS epidemic*. Geneva: UNAIDS, pp. 188-210.

UNAIDS/IHRA (Joint United Nations Programme on HIV/AIDS & International Hotel and Restaurant Association). 1999. *The challenge of HIV/AIDS in the workplace: A Guide for the hospitality industry*. Geneva: UNAIDS, pp. 1-42.

UNAIDS/WHO (Joint United Nations Programme on HIV/AIDS & World Health Organization). 2009. *AIDS epidemic update*. Geneva: UNAIDS, pp. 7-99.

UNICEF (United Nations Children's Fund). 2008. *Children and AIDS: Third stocktaking report*. Geneva: UNICEF, pp. 1-44.

USAID (United States Agency for International Development). 2005. *Capacity-building program on HIV and AIDS prevention*. Washington DC: USAID, pp. 1-41.

USAID (United States Agency for International Development). 2008. *HIV/AIDS services through the workplace: A survey in four Sub-Saharan African countries*. Washington DC: USAID, pp. 1-42.

Van der Walt, H. 2007. *Code of fair labour practice and productivity*. Weltevredenpark: Cofesa, Ch. 25, pp 1-8.

Van Wyk, B. 2003. *What is HIV/AIDS?* Available online at: <http://www.csa.za.org/articleview/224/1/8/> [Accessed: 20 July 2010].

Van Zyl, G. & Lubisi, C. 2009. HIV/AIDS in the workplace and the impact on firm efficiency and firm competitiveness: The South African manufacturing industry as a case study. *South African Journal of Human Resource Management*, 1(7): 207-220.

Vass, J.R. 2004. Policy versus reality: A preliminary assessment of the South African code of good practice on HIV/AIDS and key aspects of employment. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 307-326.

Vass, J.R. 2008. The role of HIV/AIDS committees in effective workplace governance of HIV/AIDS in South African small and medium-sized enterprises. *Journal of Social Aspects of HIV/AIDS*, 5(1): 2-10.

Vass, J.R. & Phakathi, S. 2006. *Managing HIV in the workplace: Learning from SMEs*. Cape Town: HSRC Press, pp. 1-97.

Versteeg, M. 2004. A licence to choose? HIV/AIDS workplace responses from South African profit-making companies in context. *Proceedings of HIV/AIDS in the Workplace Symposium*, University of the Witwatersrand, 29-30 June 2004, pp. 330-349.

WebFinance Inc. 2010. Procedure. *BusinessDictionary*. Available online at: <http://www.businessdictionary.com/definitions/procedure.html> [Accessed: 11 January 2011].

WebMD. 2009. CD4 count: What does it mean? *HIV & AIDS Guide*. Available online at: <http://www.webmd.com/hiv-aids/cd4-count-what-does-it-mean> [Accessed: 2 July 2010].

WEF (World Economic Forum). 2006. *Business and HIV: A healthier partnership? A global review of the business response to HIV/AIDS 2005-2006*. Geneva: WEF, pp. 1-40.

WHO (World Health Organization). 2008. *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector – Progress report 2008*.

Available online at: <http://www.who.int/hiv/pub/2008progressreport/en/index.html>
[Assessed: 4 February 2010].

Wolf, L.E. & Lo, B. 2001. *Ethical dimensions of HIV/AIDS*. Available online at:
<http://hivinsite.ucsf.edu/Insite?page=kb-08-01-05#S2X> [Accessed: 29 July 2010].

Yap, M.H.T. & Ineson, E.M. 2009. HIV-infected employees in the Asian hospitality industry. *Journal of Service Management*, 20(5): 503-520.

Yap, M.H.T. & Ineson, E.M. 2010. Hospitality managers' knowledge of HIV and HIV education: An explanatory study. *Journal of Contemporary Hospitality Management*, 22(1): 69-81.

Yungoh, S. & Mikyung, K. 1998. Health care systems in transition II: Korea part II – The current status of HIV/AIDS in Korea. *Journal of Public Health Medicine*, 20(1): 47-51.

Zaccagnini, M. 2009. *Stigma, discrimination and attitudes to HIV and AIDS*. Available online at: <http://www.avert.org/aidsstigma.htm>. [Accessed: 11 January 2011].

ANNEXURE A: PERMISSION LETTER

From: Heather Prinsloo [mailto:HPrinsloo@citylodge.co.za]
Sent: 14 June 2010 10:10 AM
To: Moolman Manie
Cc: Tony Balabanoff
Subject: Data Gathering for M Tech Project

Dear Adv Moolman

I am in receipt of your letter of request to our Mr Balabanoff regarding data gathering for Christine van der Berg's study "Evaluating the implementation of HIV/AIDS policies at selected South African hotels"

City Lodge would happy to assist Christine with her study, as we believe that by addressing the social and health issues that affects our employees will impact positively on our society.

We have informed our General Managers at the selected hotels of your request and have also advised them that Christine will be contacting them directly.

Below please find the contact details for the hotels concerned.

City Lodge Bloemfontein: General Manager – Stephan Pietersen, email – clbloem.gm@citylodge.co.za, telephone - 051 4442974

City Lodge Durban: General Manager – Ockert Brits, email cldbndb.gm@citylodge.co.za, telephone – 031 3321447

City Lodge GrandWest: General Manager – Stefan Janse van Rensburg, email clgw.gm@citylodge.co.za, telephone - 021 5353611

Please do not hesitate to contact me should you require any further information or assistance.

We look forward to hearing of the outcome of Christine's research.

Kind Regards

Heather Prinsloo
Divisional Director: Transformation
City Lodge Hotels Limited
"The Lodge" Bryanston Gate Office Park
Cnr Homestead Ave & Main Road
Bryanston, 2191
P.O. Box 97, Cramerview, 2060
Tel: +27 11 5572600
Fax: +27 11 5572603
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ANNEXURE B: QUESTIONNAIRE



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Please complete the questionnaire by drawing an X alongside the applicable answer.

Section A: Biographical Details

1. Please indicate your age:

1.	15 – 24	
2.	25 – 34	
3.	35 – 44	
4.	45 – 54	
5.	55 – 64	
6.	65 and older	

2. Indicate your gender:

1.	Male	
2.	Female	

5. Indicate your current position:

1.	Management	
2.	Front-of-House (Reception/ Reservations/ Restaurant/ Porter/ Concierge)	
3.	Back-of-House (Housekeeping/ Cleaning/Kitchen/ Maintenance)	

3. Indicate your racial group:

1.	White	
2.	African	
3.	Coloured	
4.	Indian	
5.	Asian	
6.	Other	

4. Indicate your highest level of education:

1.	Primary Education	
2.	Secondary Education	
3.	Tertiary Education	

Section B: Implementation of HIV and AIDS policies at your hotel

Please indicate your level of agreement with the following statements:

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
6.1	Your hotel has an official HIV and AIDS policy.	1	2	3	4	5
6.2	The HIV and AIDS policy stipulations are communicated to all staff.	1	2	3	4	5
6.3	All employees understand the HIV and AIDS policy clearly.	1	2	3	4	5
6.4	Employees are important to the hotel.	1	2	3	4	5
6.5	The hotel uses awareness programmes to inform you about HIV and AIDS challenges.	1	2	3	4	5
6.6	The hotel finds HIV and AIDS preventative programmes important for its employees' wellbeing.	1	2	3	4	5
6.7	Treatment, care and support programmes are made available to all employees.	1	2	3	4	5
6.8	The hotel's HIV and AIDS policy includes training, education and counselling programmes.	1	2	3	4	5
6.9	Counselling is available to all employees.	1	2	3	4	5
6.10	Personal HIV and AIDS information remains confidential.	1	2	3	4	5
6.11	The hotel has arranged awareness/ educational programmes on HIV and AIDS for all employees.	1	2	3	4	5
6.12	I have attended awareness/educational programmes on HIV and AIDS presented by the hotel.	1	2	3	4	5
6.13	I have attended three or more awareness/ educational programmes in the past year at the hotel.	1	2	3	4	5

Indicate whether you agree with the following statements:

		Disagree	Don't Know	Agree
7.1	HIV and AIDS differ from one another.	1	2	3
7.2	HIV and AIDS can be cured.	1	2	3
7.3	Using a condom protects you against HIV and AIDS.	1	2	3
7.4	Homosexuals are more at risk of contracting HIV and AIDS.	1	2	3
7.5	HIV and AIDS leads to death.	1	2	3
7.6	HIV and AIDS testing should be done regularly at the hotel.	1	2	3
7.7	HIV and AIDS can be transmitted by a mother to her unborn baby.	1	2	3
7.8	HIV leads to AIDS.	1	2	3
7.9	Regular ARV treatment can prevent HIV and AIDS.	1	2	3
7.10	ARV treatment can prevent the spread of HIV and AIDS.	1	2	3
7.11	ARV treatment can prevent mother-to-child transmission of HIV and AIDS.	1	2	3
8.1	You can contract HIV and AIDS from insect bites.	1	2	3
8.2	You can contract HIV and AIDS from donating blood.	1	2	3
8.3	You can contract HIV and AIDS by shaking hands.	1	2	3
8.4	You can contract HIV and AIDS by kissing.	1	2	3
8.5	You can contract HIV and AIDS by being coughed on.	1	2	3
8.6	You can contract HIV and AIDS by being sneezed on.	1	2	3
8.7	You can contract HIV and AIDS by sharing a cigarette.	1	2	3
8.8	You can contract HIV and AIDS by eating food made by an HIV-positive individual.	1	2	3
8.9	You can contract HIV and AIDS by sharing a toilet.	1	2	3
8.10	You can contract HIV and AIDS by sharing a needle/syringe.	1	2	3
8.11	You can contract HIV and AIDS by having unprotected sex.	1	2	3

		Disagree	Don't Know	Agree
8.12	You can contract HIV and AIDS by coming into contact with sweat or tears.	1	2	3
8.13	You can contract HIV and AIDS from open wounds.	1	2	3
8.14	You can contract HIV and AIDS by coming into contact with semen/ vaginal excretions.	1	2	3
8.15	You can contract HIV and AIDS by coming into contact with saliva or by sharing a cup.	1	2	3
8.16	You can contract HIV and AIDS by coming into contact with urine.	1	2	3
8.17	You can contract HIV and AIDS by coming into contact with blood.	1	2	3

Do HIV and AIDS influence job performance?

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
9.1	HIV and AIDS impact negatively on job performance.	1	2	3	4	5
9.2	HIV and AIDS impact negatively on service delivery.	1	2	3	4	5
9.3	AIDS sufferers take more sick leave than other employees.	1	2	3	4	5
9.4	Employees feel resentful towards co-workers with HIV and AIDS.	1	2	3	4	5
9.5	Workload increases for employees when others are on sick leave (possibly AIDS-related).	1	2	3	4	5
9.6	HIV and AIDS impact negatively on sales.	1	2	3	4	5
9.7	HIV and AIDS impact negatively on hotel profit.	1	2	3	4	5
9.8	HIV and AIDS impact negatively on service quality (cleaning, service, time management, etc.).	1	2	3	4	5
9.9	HIV and AIDS have an impact on the level of expected performance of employees.	1	2	3	4	5

Indicate your level of agreement with the following in terms of policy impact:

		Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
10.1	The HIV and AIDS policy provides additional sick leave for infected employees.	1	2	3	4	5
10.2	The HIV and AIDS policy protects infected employees in the work environment.	1	2	3	4	5
10.3	Employees benefit directly from the HIV and AIDS policy.	1	2	3	4	5
10.4	The hotel can dismiss an employee due to his or her HIV and AIDS status.	1	2	3	4	5
10.5	The HIV and AIDS policy takes care of the employee first, and then the hotel.	1	2	3	4	5
10.6	The HIV and AIDS policy takes care of the hotel first, and then the employee.	1	2	3	4	5
10.7	The HIV and AIDS policy is displayed visibly in the hotel.	1	2	3	4	5
10.8	HIV and AIDS information sessions are held regularly to inform employees about the policy.	1	2	3	4	5
10.9	The HIV and AIDS policy informs employees about assistance/training/educational programmes, etc.	1	2	3	4	5

Please answer the following questions (print clearly).

11. Any comments, suggestions or recommendations on how to improve HIV and AIDS policies in your establishment?

.....

.....

12. Does your hotel policy really help the staff in general? Please motivate your answer.

.....

.....

13. Have you learned anything new about HIV and AIDS from your hotel that you did not know before? If so, what?

.....

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Thank you for participating in this study.