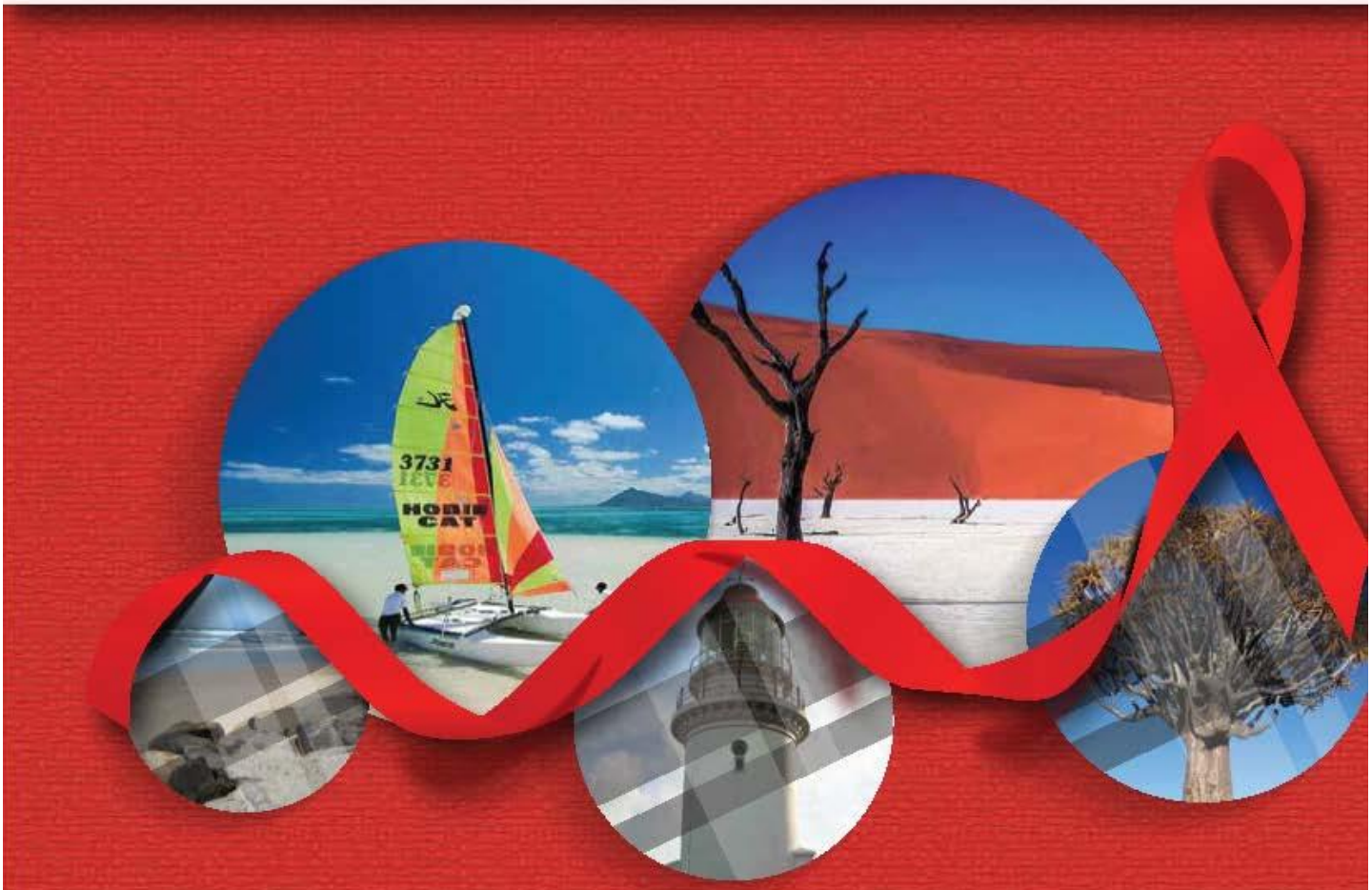
What works in HIV and AIDS and the World of Work in the South African and Namibian tourism industry at selected country sites

Country Report: South Africa



Adlai Davids, Martin Weihs, Azola Tunzi & Dimitri Tassiopoulos

HSRC Human Sciences Research Council
NAMIBIA UNIVERSITY OF SCIENCE AND TECHNOLOGY
NRF National Research Foundation
NCRST

Report on

WHAT WORKS IN HIV AND AIDS AND THE WORLD OF WORK IN THE SOUTH AFRICAN AND NAMIBIAN TOURISM INDUSTRY AT SELECTED COUNTRY SITES

Country Report: South Africa

Adlai Davids, Martin Weihs, Azola Tunzi &Dimitri Tassiopoulos[†]

30 December 2017

[†] Dr Dimitri Tassiopoulos (1966-2017) sadly passed away during the course of this project. He conceptualized and lead the study since its inception as principal investigator. Sections of this report were based on his written inputs made to the study prior to his untimely passing.

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List of Acronyms

TERM	DEFINITION
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral therapy
HCT	HIV Counselling and Testing
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
IDI	In-depth Interview
ILO	International Labour Organization
M&E	Monitoring and Evaluation
NGO(s)	Non-Governmental Organization(s)
NCRST	Namibia Commission for Research, Science and Technology
NRF	National Research Foundation (South Africa)
NUST	Namibia University of Science and Technology
PLHIV	People Living with HIV
TB	Tuberculosis
UN	United Nations
VMMC	Voluntary Medical Male Circumcision
WAD	World AIDS Day
WHO	World Health Organization
WP	Wellness Programmes

Executive summary

The International Labour Organization (ILO) has over the years implemented innovative HIV workplace initiatives in collaboration with partners, in high burden countries guided by the ILO Code of Practice on HIV/AIDS and the world of work (2001) and the ILO HIV and AIDS Recommendation, 2010 (No. 200). The threat of the HIV and AIDS pandemic presents a formidable challenge to South African and international tourism. Added to the human tragedy is the economic threat to sub-Sahara African nations most of which rely on tourism. Tourism industry workplace HIV and AIDS programmes and policies in South Africa are seemingly rarely evaluated. HIV and AIDS has become one of the most devastating epidemics in history.

The overall aim of this study was to investigate, in terms of the ILO Code of Practice on HIV/AIDS and the world of work (2001), ILO HIV and AIDS Recommendation, 2010 (No. 200) and ILO HIV and AIDS: Guide for the tourism sector (2012) "what works" in the South African tourism industry workplace in terms of HIV and AIDS, and to find out which 'conducive environmental' factors (if any) contributed to the good outcomes.

A key data set of potential participants in the study proved to be out-dated as it contained a large number of tourism businesses that no longer existed. Of those that did exist, only 55 agreed to participate in the study and then only to focus on basic characteristics and reasons for not having taken up a tourism workplace HIV and AIDS programme. This quantitative survey did however yield valuable views as to why workplace HIV and AIDS programmes are not be implemented.

Themes generated during the search for conducive factors through in-depth interviews with external stakeholder with an interest in tourism as a sustainable economic activity, yielded much

context for the results of the quantitative survey, even if that was not the primary intention. Those themes could serve as useful foci in continuing a research focus on tourism workplace HIV and AIDS programmes in South Africa.

Despite the low numbers of participants that qualified and consented to be part of the study, in-depth interviews showed three useful leads toward obtaining good outcomes from tourism workplace HIV and AIDS programmes. These were management support, and integrated wellness programme and a conflation of the two, showed that a focus on employee wellness in the context of HIV and AIDS can be beneficial to workplaces.

In general, the findings from this study suggest that effective workplace approaches remain widely lacking in the tourism sector in the study sites. Whereas the limited study sites may have contributed, a lack of awareness of HIV and AIDS, as well as resources and capacity to deal with the disease as a workplace issue is key reason for not implementing a workplace HIV and AIDS programme. In many small and medium tourism businesses, a tourism workplace HIV and AIDS programme may prove too expensive and too complicated to implement.

A limitation of the study was to focus only on the two metropolitan municipalities in the Eastern Cape. The reasons for this are stated in the report, but it means that a large portion of the tourism workplace HIV and AIDS programme picture in South Africa has not been illuminated. . Since tourism remains one of South Africa's flagship economic sectors and a major contributor to its gross domestic product (GDP), more research support towards the mitigation of any negative consequences of the disease for the industry will be vital.

SECTION 1

1.1 The impact of HIV and AIDS on the world of work

Management of HIV in the workplace is increasingly a priority in countries suffering an HIV epidemic such as South Africa (Arimoto, Seiro, Kudo, & Kazunari, 2013; George, Surgey, & Gow, 2014) as HIV and AIDS are jeopardising companies' investments, with trained staff affected by HIV (Arimoto et al., 2013; George et al., 2014). In companies that experience increased illness and death among their employees, the resulting rising costs and falling productivity may be likened to a payroll tax. Where organisations are confronted with high rates of absenteeism, frequent disability retirements, or legal disputes due to HIV and AIDS, HIV management is increasingly becoming a dominant issue on corporate strategic agendas. As HIV and AIDS is impacting the working population, the ensuing challenges are increasingly being understood as risks to businesses, with the epidemic affecting companies' competitiveness and efficiency. However, organisations might be impacted differently, subject for example to geographic location, nature of the business, size, structure and socio-demographics of the workforce.

HIV and AIDS is causing increased mortality and morbidity within the workforce resulting in a decline in labour and total factor productivity which, according to macroeconomic models, impacts negatively on the economy (Booysen, Geldenhuys, & Marinkov, 2003). The consequences of morbidity translate into absenteeism, "presenteeism" (i.e. being present at work - but with restricted job performance), increasing employee turnover, a reduction in productivity, and increasing production costs. The consequence is companies losing income. Although in

regions with high numbers of unskilled labour the cost of replacing unskilled employees who are sick or have died can be small (Bloom et al., 2007), it may take between one to four years to bring newly recruited workers up to full competency (Dickinson, 2004; UNAIDS, 2014): consequently, replacement and training costs could be considerable.

1.2 HIV management in the workplace in South Africa

South Africa is suffering from the largest HIV and AIDS epidemic in the world (UNAIDS, 2014). The epidemic influences various aspects of society such as businesses, communities and families. In 2014, an estimated 19 million of the estimated 35 million HIV positive people in the world did not know they were infected (UNAIDS, 2014). The responses of South African organisations in seeking to address the impact of HIV and AIDS are influenced by international guidelines, national legislative frameworks, and social and economic factors. The former South African National Strategic Plan on HIV, STIs and TB (NSP) 2012-2016 (SANAC, 2012) as well as the new NSP 2017-2022 (SANAC, 2017) are multi-sectoral in their focus and with multiple references to workplace interventions for achieving the set targets (SANAC, 2012, 2017). The reasoning behind seeking private sector involvement is mainly to limit the potential negative macroeconomic impact of HIV and AIDS on the national economy and, to reduce the direct costs to organisations by reducing the negative impacts on productivity (Coates et al., 2007). In addition, there is a perceived need to fulfil the principles of corporate social responsibility (Coates et al., 2007; Dickinson & Stevens, 2005), and also to comply with legislative requirements (Mahajan, Colvin, Rudatsikira, & Ettl, 2007). Consequently, a number of companies in South Africa have introduced HIV and AIDS Workplace policies and programmes (Arimoto et al., 2013; Ellis & Terwin, 2005).

The workplace is a good place to address women and men for HIV prevention, HIV counselling and testing (HCT), treatment and care activities (Bhagwanjee, Petersen, Akintola, & George, 2008; Mundy & Dickinson, 2004; SABCOHA, 2012; van Dyk, 2008). Although staff members come from varying social backgrounds and cultures, speak different languages and follow different traditions, employers and employees all share the same organisational culture in which they have the same visions, follow the same guidelines and adhere to the same rules.

The South African government has developed a code of good practice on HIV, AIDS and the world of work, gazetted on the advice of the Commission for Employment Equity in terms of section 54(1)(a) of Employment Equity Act 55 of 1998 (Department of Labour, 2012a). In the introduction to this code, it is stated that the implementation of HIV and AIDS policies and programmes is a very effective way to reduce and manage HIV and AIDS in the workplace. These programmes should result in the elimination of unfair discrimination and stigmatisation in the workplace. Furthermore, they should amongst others cover HCT, confidentiality, HIV awareness and employee benefits. The code is applicable to all economic sectors, all workplace and all forms of employment, including people in training, e.g. interns and volunteers. The South African Department of Labour has developed Technical Assistance Guidelines to complement the revised 2012 Code of Good Practice on HIV and AIDS and the world of work (Department of Labour, 2012b). Technical Assistance Guidelines have been developed to equip employers, workers and their organisations in the private and public sectors with practical tools to take appropriate action in their responses to HIV and AIDS. The guidelines provide detailed plans on how to eliminate unfair discrimination in the workplace, promote a safe working environment, manage HIV and AIDS in the world of work: they also include recommended courses of action

on implementation, monitoring and evaluation of workplace interventions that aim to address HIV and AIDS in the workplace.

The former South African National Strategic Plan on HIV, STIs and TB, 2012 – 2016, stated that all workplaces should address HIV, STIs and TB aligned with national standards, and in accordance with the South African HIV National Standard for Workplace Programmes, SANS 16001 (SANAC, 2012). In the new NSP 2017-2022 (SANAC, 2017), the South African government increases its effort to address the HIV epidemic. The South African government particularly aims to promote efforts to encourage all sectors, including the private sector, to increase their engagement. It is hoped that through diversifying testing approaches and services the private sector will play its part in achieving government's ambitious goals of expanding HIV testing. Furthermore, The Department of Health in 2014 published The National Health Promotion policy and Strategy of 2015 - 2019 in which workplaces are highlighted as key stakeholders for health and the combating of HIV, AIDS and TB which are seen as priority areas for health promotion (Department of Health, 2014).

South Africa bears an inordinate share of the global HIV burden with literature suggesting that touristic zones are high-risk environments as internal migrants and mobile foreign travellers are often involved in transactional and high HIV risk behaviour (Padilla, Guilamo-Ramos, Bouris, & Reyes, 2010). Despite these risks, only limited research exists regarding HIV and AIDS workplace programmes in the tourism sector in South Africa. It is important to conduct research on HIV and AIDS workplace initiatives, strategies, and practices that are feasible, sustainable, acceptable, efficient and effective in the prevention, treatment and care of HIV and AIDS in

tourism workplace settings that will allow finding out which 'conducive environmental' factors (if any) contributed to the good outcomes.

1.3 Aim and objectives of the study

The overall research aim of this study is to investigate, in terms of the ILO Code of Practice on HIV/AIDS and the world of work (2001), ILO HIV and AIDS Recommendation, 2010 (No. 200) and ILO HIV and AIDS: Guide for the tourism sector (2012) "what works" in the South African tourism industry workplace in terms of HIV and AIDS.

The objectives were to:

- determine the good outcomes from tourism workplace HIV and AIDS programmes
- find out which conducive factors contributed to the good outcomes;
- assess how good outcomes from tourism workplace HIV and AIDS programmes were achieved

1.4 Summary

This section presented the background, the impact of HIV and AIDS in the world of work, factors that influence HIV and AIDS management in the workplace in South Africa and the aim and objectives of the study.

SECTION 2

2.1 Impact of HIV and AIDS on Tourism

The tourism economy makes up for more than seven percent of the total global economy (Statista, 2017) (Statista, 2017). Globally, as an export category, the World Travel and Tourism Council (WTTC, 2017) indicates that the "global tourism (direct) industry GDP is larger than the automotive and chemicals manufacturing sectors", generating more than twice the automotive manufacturing sector's contribution to the global GDP. It is thirty percent larger than the global chemicals industry. The total contribution of Travel and Tourism to the South African GDP was estimated at 9.3%, and is forecast to rise by 2.5% in 2017 (WTTC, 2017). Over the past years, tourism played an increasing part of global economic activities. It helped to create important economic development and employment. This needs to be seen in relation to the continued spread of the HIV pandemic in a lot of poor "exotic" and "paradise" travel destinations. In these countries, chances are high that tourism is linked to the further spread of HIV.

The tourism industry has a reputation of poor working conditions because the sector is very fragmented with small and medium sized enterprises and low union density, low wages, low levels of skill requirements and its seasonal character (ILO, 2017). By nature, touristic areas are high-risk environments as internal migrants and mobile foreign travellers are often involved in transactional and high HIV risk behaviour combined with alcohol and drug use (Padilla et al., 2010). However, no formative HIV-prevention studies have examined the specific tourism environments and how they contribute to the spread of HIV (Padilla et al., 2010). Governments in developing countries are often reluctant to conduct studies in this regards for fear to scare

away tourists as they are reliant on the tourism industry to increase their economies (Falola & Achberger, 2013). It is estimated that 5%–50% of international travellers have sex with a new partner while abroad (Centers for Disease Control and Prevention, 2017). The tourism industry can therefore play a significant role in the response to HIV and AIDS given its specific characteristics. The threat of the HIV and AIDS pandemic presents a formidable challenge to local and international tourism. HIV and AIDS has become one of the most devastating epidemic in history. Added to the human tragedy is the economic threat to sub-Sahara African nations most of which rely on tourism. Tourism industry workplace HIV and AIDS programmes and policies in sub-Sahara African nations are seemingly rarely evaluated.

2.2 Size of the SA tourism industry

The direct contribution of South Africa's tourism sector to the GDP is twice as large as the impact of the automotive manufacturing industry (WTTC, 2013). As indicted in the Figure 2 below in South Africa "tourism directly employs more people than the mining, communication services, automotive manufacturing, and chemicals manufacturing sectors" (WTTC, 2013).

South Africa's travel and tourism industry supports more than 1.4 million jobs across the entire value chain (WTTC, 2013). Figures published in the latest Tourism Satellite Account (TSA), which was released by Statistics South Africa in February 2016, show that the tourism industry directly employed more than 700 000 people (Statistics SA, 2016b, 2016a). The internal

expenditure on travel agencies and similar services in 2014 amounted to just over R9.24bn, with domestic and inbound foreign expenditure in the sector accounting for R6.51bn and R2.73bn,

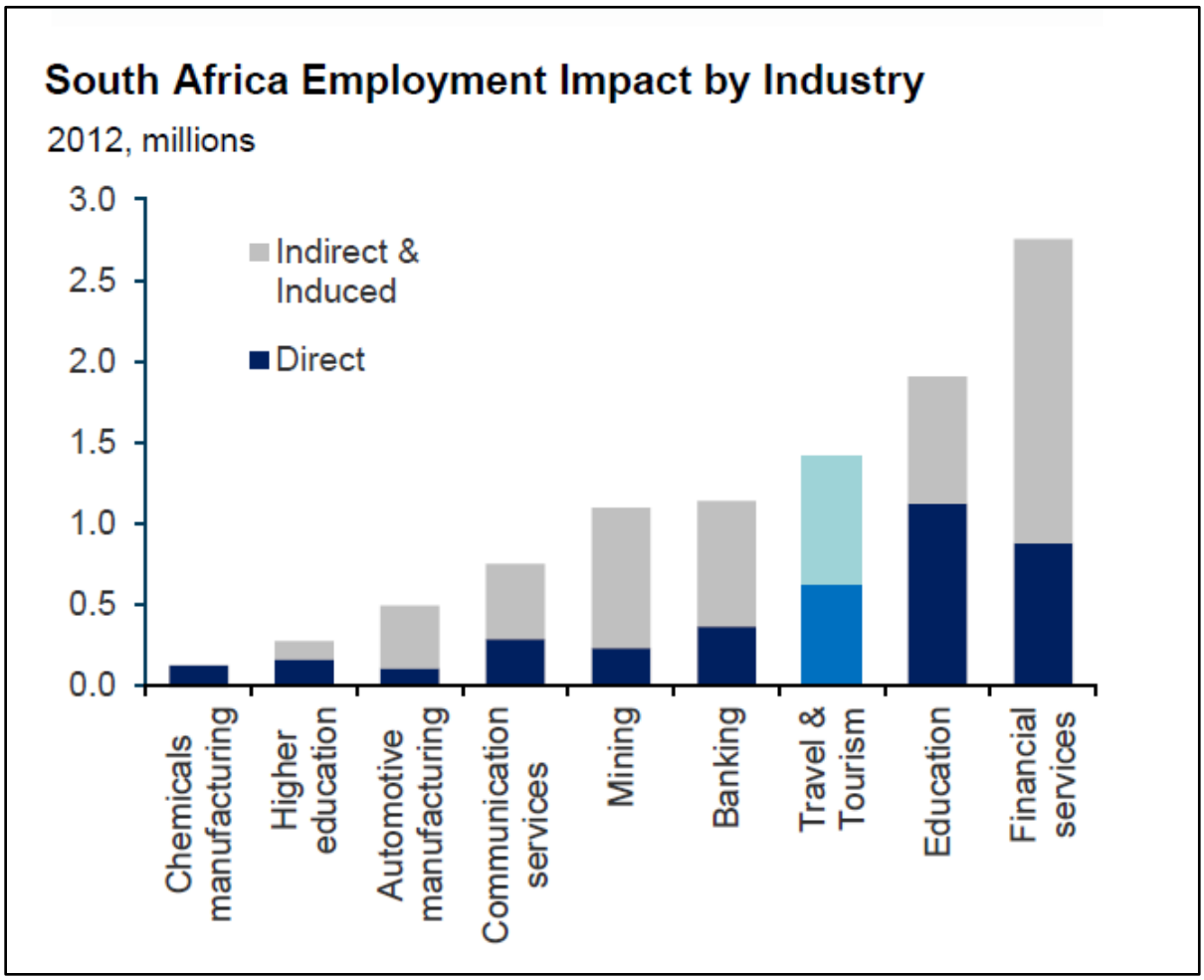

Figure 2: South Africa Employment Impact by Industry (WTTC, 2013)

respectively. Preliminary, figures for the tourism value chain in 2014 are that expenditure on inbound tourism was R106.7bn, expenditure on outbound tourism was R68.4bn and Expenditure on domestic tourism (including the domestic element of outbound tourism) was R132.01bn; and South Africa recorded a positive tourism trade balance of R38.3bn (Statistics SA, 2016b).

2.3 Impact of HIV on the SA tourism industry

It is noted by UNAIDS that the 2013 HIV prevalence for South Africa is 18.9% (for 15-49 years old) (UNAIDS, 2017), which suggests that of the estimated 712 000 people (Statistics SA, 2016a) employed directly in the South African tourism industry, more than 100 000 employees are likely to be HIV positive. HIV and AIDS is a risk to the South African tourism industry's growth and resilience for many reasons:

- Travel by definition creates contact between tourism workers, host communities and tourists; international studies show that such proximity results in high levels of sexual activity, particularly in hospitality environments, putting not only workers but also their families and communities at risk;
- International and domestic holiday-makers as well as business travellers often engage in risky behaviour when travelling, including sexual promiscuity and drug and alcohol use;
- Sex tourism often is discussed as an important factor contributing to the spreading of the HIV virus; furthermore, sex tourism is not limited to traditional "sun, sea and sand" resorts but also occurs within business, urban and rural travel contexts;
- Certain forms of tourism, for example safaris in nature protected areas require workers to be away from home for long periods of time, which may result in sex with multiple partners (migrant labour effect); and
- Certain categories of labour in the tourism industry may be at risk for accidental exposure to HIV (for example when working with sharp equipment in kitchens).

HIV and AIDS thus also affect the profitability and, thus, viability of tourism businesses in a range of ways. Primarily, HIV and AIDS reduce worker productivity, increases costs "and

diminish the capacity of national economies to deliver goods and services on a sustainable basis" (ILO, 2003). Although there is no lack of information on what types of measures/interventions businesses can take and suggestions of good practices little is known about how tourism businesses respond to and cope with the pandemic within their workforce.

As HIV and AIDS is one of the key challenges to social development of developing countries, the topic is of importance to corporate social investment (CSI) and the development of wellness workplace programmes. CSI is essential for the long-term sustainability of a firm, is a responsible tourism business decision that can lead to sustainability when HIV and AIDS is considered into decision-making as part of business management regarding the wellness of its employees as this will ensure staff retention and improve profitability.

2.4 Public and private tourism industry responses to HIV and AIDS in South Africa

At the June 2001 United Nations General Assembly Special Session (UNGASS) on HIV and AIDS (United Nations, 2001), governments from 189 countries signed a Declaration of Commitment to fight HIV and AIDS. Member states committed to, inter alia:

- Developing multi-sectoral strategies to combat HIV and AIDS through the promotion of multi-stakeholder interaction;
- Developing and implementing HIV and AIDS prevention and care programmes in private, public and informal economic sectors;
- Creating supportive workplace environments for HIV positive people.

UNGASS indicated that the challenges with regard to the spread of the HIV epidemic undermine sustainable socio-economic development and that all levels of society are affected (United Nations, 2001).

Tourism is no exception and South Africa, like most developing countries, has identified tourism as a priority sector for job and wealth creation and a vehicle for rural development, poverty reduction and community beneficiation. Although tourism is widely hailed as a vehicle for job creation, labour standards in tourism are notoriously low. The industry has been slow to embrace the global business and human rights agenda. Nonetheless growing numbers of tourism businesses, including SMEs, are embracing more inclusive and responsible workplace practices that improve employee benefits and wellness and contribute to sustainable livelihoods. In many cases particularly in economically poor communities, corporate social responsibility (CSR) and community outreach programmes provide services and infrastructure where the state's capacity to deliver is lacking. In South Africa, businesses are under increasing pressure to meet transformation imperatives, for example training and development of black staff to increase job mobility. The HIV and AIDS epidemic threatens to erode transformation and livelihoods gains achieved by the industry over the past two decades: a correlation of HIV prevalence statistics, tourism employment rates and age/gender demographics.

In 2003, the Department of Health and THETA published a first "HIV/AIDS Handbook for South African Tourism and Hospitality Companies", based on a survey of 4,500 employees and an assessment of 450 businesses (THETA, 2003). The Handbook is an easy-to-use guide containing practical information and tools targeting the hospitality industry big and small. The

Handbook was widely distributed via industry associations (e.g. the Federated Hospitality Association, FEDHASA); however an impact assessment was never conducted. According to the handbook, three quarters of hospitality sector's employees did not have access to a person managing HIV and AIDS at the workplace and more than 90% of sector's organisations did not have an HIV and AIDS policy, offered HIV and AIDS awareness sessions or distributed condoms in the workplace. 99% of the businesses did not offer any form of care services for employees living with HIV. The majority (64%) of the employers however believed that HIV and AIDS will negatively influence business operations in the future (THETA, 2003).

The Cape Town Declaration, which was formulated in 2002, outlines a strategy of responsible tourism development. South Africa was the first country to apply fair trade criteria to tourism products through Fair Trade in Tourism South Africa (FTTSA). While Fair Trade is not strictly environmental, it makes an important contribution to climate change mitigation by promoting sustainability. Before receiving FTTSA accreditation, tourism products and travel packages are required to meet specific sustainability criteria, which are based on global Fair Trade standards, as well as locally relevant issues such as skills development, transformation and HIV and AIDS management (FTTSA, 2012).

In addition, changing patterns of demand create new challenges for destinations, particularly those located in the Global South. For example, the rise of independent travel over the past 15 years has broadened the range of destinations available to tourists. Independent travellers are more inclined to travel 'off the beaten track' for ecotourism and cultural experiences, in contrast to all-inclusive and other forms of packaged tourism. Similarly, the popular trend of combining

volunteer work and travel ('voluntourism') puts travellers, mainly youth, in direct contact with communities, including children and youth. While such trends away from "mass tourism" support national strategies to diversify tourism product offerings and increase the geographic spread of tourism revenue, the evolution of tourist preferences creates new risks and threats that must be managed proactively.

2.5 Summary

This chapter presented the background, the impact of HIV and AIDS, and factors that influence HIV and AIDS management in the workplace in the South Africa tourism industry.

SECTION 3

3.1 Study Setting

The South African component of the study focused on tourism workplaces in of the Nelson Mandela Bay and Buffalo City metropolitan municipalities in the Eastern Cape province (Figure 3).

The choice of Nelson Mandela Bay and Buffalo City municipalities hinged on their relatively smaller tourism market of their major cities when compared to other coastal cities such as Cape Town and Durban. The Eastern Cape had an HIV prevalence of 11.6% in 2012 (Shisana, et al 2013) and the province is known for its advancement of workers' rights in many sectors,

Figure 3: Location of study sites

especially in the automotive industry. Given the inherent risks that HIV poses to the health and productivity of tourism employees, it would have been expected that tourism workplaces in the Eastern Cape would implement and sustain HIV and AIDS workplace programmes to mitigate potential losses of income.

3.2 Research design

The research design was a multi-method descriptive study that included a situational analysis, quantitative survey and in-depth interviews (IDIs). The situational analysis and quantitative survey components were the primary foci given the dearth of detailed information on workplace HIV and AIDS programmes in South Africa. The IDIs, the qualitative component, served as secondary focus of the research which sought to find out which factors contributed or hindered any good outcomes, by interviewing external stakeholders not aligned to individual workplaces. Where good outcomes were identified through engagement with tourism workplaces, internal key informants were also interviewed through IDIs. The research team was sensitive toward getting a suitably nuanced understanding of the differentiated impacts that workplace HIV and AIDS programmes may have on women and men employees in the tourism sector.

3.3 Data Collection

As part of the situational analysis and quantitative survey components of the study, the research team approached the Eastern Cape Parks and Tourism Agency (ECPTA) for its database of

registered tourism businesses. The database was shared and contained in excess of 600 records. Many of these were small businesses, especially providers of accommodation that were likely registered in anticipation of a great boom associated with the FIFA World Cup 2010 in South Africa. The data collection team made phone calls and several follow-ups to these businesses to ascertain whether these had any HIV and AIDS workplace programmes in place and to set up face-to-face or telephonic interviews where these existed.

For the qualitative component of the study, IDIs were conducted with key external stakeholders who were identified by the South African government's Department of Tourism. Other external participants who participated were representatives of national and international bodies with an interest in the advancement of tourism as a sustainable economic activity in South Africa. Where workplaces reported a tourism HIV and AIDS workplace programme with good outcomes, key informants were then identified on these good outcomes.

3.4 Summary

This section outlined the study setting, research design and data collection components of the study.

SECTION 4: RESULTS AND DISCUSSION

4.1 Results from the quantitative component

Telephonic contact as made with the businesses listed in the ECPTA database, but after numerous and exhaustive phone calls and follow-ups, the research team concluded that an overwhelming majority of these businesses no longer operated. Where businesses did exist, only a few had some HIV and AIDS activities in place. Where those existed, these were never part of a structured workplace HIV and AIDS programme. Some larger workplaces with formal structured workplace HIV and AIDS programmes in place also could not be persuaded to consent to participation in the study.

Whilst this was disappointing, given the dearth of HIV and AIDS workplace programmes identified in an earlier study that included South Africa (ILO, 2015), this was not entirely unexpected. A section was included in the quantitative questionnaire to determine reasons for non-uptake of HIV and AIDS workplace programmes in tourism businesses. Whilst this section was initially reserved for a minority of respondent workplaces, reasons for non-uptake of HIV and AIDS workplace programmes contributed to the vast majority of the data obtained from the quantitative survey.

Across the two study sites, the Nelson Mandela Bay and Buffalo City municipalities, 55 workplaces formed a convenience sample on reasons for the non-uptake of workplace HIV and AIDS programmes. Only a further three workplaces that operate in the study sites were identified as having a HIV and AIDS workplace programme that reported good outcomes. Key informants of these workplaces where then identified and interviewed through IDIs and these interviews were transcribed and analysed.

Table 1: Participants in the quantitative survey

Tourism Sector	Number	Percentage
Transportation	2	3.6
Private sector support services	2	3.6
Recreation and leisure	3	5.5
Travel, wholesale and retail	3	5.5
Events and attractions	7	12.7
Accommodation and catering	36	65.5
Public sector	1	1.8
Not specified	1	1.8
Total	**55**	**~100**

Nearly two-thirds of the respondents operated in the Accommodation and catering sector of the tourism sector (65.5%), followed by the Events and attractions sector (12.7%). This data set allowed the research team to explore which factors respondents deemed to impede their implementation of any HIV and AIDS workplace programmes.

Somewhat serendipitously, the research team actually unearthed some valuable insights about the dearth of tourism workplace HIV and AIS programmes in the study sites. Statements were posed to the participating workplaces as to what may have negatively impacted on their uptake of a workplace HIV and AIDS programme using a five-point Likert scale between Strongly Disagree

(1) to Strongly Agree (5). Responses to the combined statements of Agree (4) and Strongly Agree (5) were combined and are collated in Table 2 below.

About two-thirds of respondents indicated that their own lack of knowledge of HIV and AIDS contributed to their non-uptake of a workplace HIV and AIDS programme. The assumption here is that one cannot apply that which one does not understand, so any possible negative impacts of HIV and AIDS to the business cannot be fully grasped. The reasons for any intervention to mitigated any negatives for the business is likely thus also not appreciated.

Table 2: Responses to statements on non-uptake of workplace HIV and AIDS programmes

Impediment to Implementation of Workplace HIV and AIDS programmes	**Number** ***(Agree & Strongly Disagree responses)***	**Perc (%)**
Lack of knowledge about HIV and AIDS	37	67
Government and civil society should implement	34	61
Legislation regarding HIV and AIDS in the workplace not in place	31	57
Limited capacity / resources available to manage a workplace HIV and AIDS programme	30	55
Employees seek help elsewhere once infected or affected by HIV and AIDS	28	51
Costs should be carried by government and civil society	28	51
The private sector *does not* have a role to play in financing workplace HIV and AIDS programme	9	16

More than 60% of the respondents agreed that any intervention towards mitigating HIV belongs in the mandate of government and civil society. One can assume that these responses are informed by the fact that HIV and AIDS is generalised in society, its impact is broader than a single industry and should be dealt with accordingly.

More than 50% of respondents indicated that the absence of a workplace HIV and AIDS programme was that there is no specific legislation in place related to HIV and AIDS. The assumption here is that whereas legislation may exist regarding basic conditions of employment, health and safety and others, these did not apply to HIV and AIDS or any other disease specifically. Thus the workplace is not compelled to have a programme in place.

Costs of operating a small or medium tourism business and the need to keep the business going in a competitive environment, may have driven a small majority of respondents' (55%) views that limited capacity and resources precluded a workplace HIV and AIDS programme. The view may be that it funds are too scarce to apply to a disease that is the domain or preserve of the public and private health sector.

Just more than 50% of respondents indicated that employees who feel that they are at risk of HIV or are HIV-infected, will seek help elsewhere, mainly from the public health sector. The source of relief and support in this regard will then not be the employer, but rather the health sector whose mandate it is to service the needs of person who are ill.

Possibly related to this view, is that costs for HIV and AIDS treatment and care, should thus be carried by the public sector as well, a statement to which more than half of respondents (51%) agreed on. This adds to the previously discussed responses to statements that dealing with HIV and AIDS is a preserve located outside of the tourism workplace. Very paradoxically, only a minority of respondents (16%) agreed that the private sector, the sector in which they operate, does not have a role to play in financing a workplace HIV and AIDS programme.

4.2 Qualitative results: Interviews with external stakeholders

The initial aim of the In-depth Interviews (IDIs) with external stakeholders, who had an interest in the advancement of tourism, was to determine which conducive factors in South Africa lead to good outcomes in tourism workplace HIV and AIDS programmes. Analyses of the transcripts of these IDIs yielded seven broad themes that shed much light onto the results of the quantitative survey. These themes are listed below and will be discussed separately.

- HIV and AIDS is not a priority for the tourism industry
- Government is treating HIV and AIDS as a priority
- Some HIV and AIDS activities are in place in the tourism industry
- HIV and AIDS should be a priority issue for the tourism industry
- A tourism sector HIV and AIDS strategic plan will be needed

- Multi-sectoral approaches will be required

- Monitoring and Evaluation will be key

4.2.1 HIV and AIDS is not a priority for the tourism industry

The theme talks to a perception that the nature of the epidemic is somehow not really an issue that requires the attention of the tourism industry. This is not only from their point of view as providers of tourist services, but also its consumers' attitudes towards HIV and AIDS. The selection of quotations below highlights these views.

"I think that the tourism industry is one of those industries that are left behind. Unlike the mining industry…." – International Stakeholder A

"(The) international tourist can travel to South Africa actually knowing that they are at the centre of HIV epidemic, and I find it also striking that, they never ask these questions anywhere."- – International Stakeholder B

"(HIV and AIDS) has never ever come up as topical issue, maybe its regarded as an operational issue, I don't know, I have no clue." – Local Stakeholder B

"I think the industry has just gone into a, you know, HIV is just something that we do when we can or we just do not do it." – National Stakeholder B

4.2.2 Government is treating HIV and AIDS as a priority

The seemingly distant attitudes towards HIV and AIDS in the tourism industry according to the external stakeholders, is that the South African government has taken such a leading role in addressing HIV and AIDS. To this extent, it may be that this political leadership drives responses to the diseases from outside any given economic sector, in this case the tourism industry. The large-scale roll-out of anti-retroviral therapy (ART) is often also specifically mentioned. The quotations below represent some of these views.

"Look, it depends, I think that if you look at the two, you are talking about tourism industry, but you are also talking about something else. It is considered a priority in the country's perspective and also from the department of health's perspective." – Local Stakeholder C

"...if you look at the political environment that we are operating in now, where HIV is very much a national issue, if we look at the South African National AIDS Council" – National Stakeholder B

"…there are many programmes that the government has implemented. One of them is to roll out the anti-retroviral tablets" – Local Stakeholder A

"I think the decisions that has been taken by the government of the country to say let us allocate resources to tackle the issue of HIV and AIDS or assist people who are living with HIV and AIDS."

– Local Stakeholder A

4.2.3 Some HIV and AIDS activities are in place in the tourism industry

Stakeholders did however, point out specific instances where the industry has made some effort to address the spread of HIV. Two key aspects are awareness creation and HIV prevention, as can be seen in the quotations below.

"…for an example, if you look at the prevention and side of it you'd pick up if you go to hotels in certain areas there's, some of them now provide condoms and all of that" – Local Stakeholder C

"..we'd been outlined to come and guide those lodges on how to deal with HIV and AIDS. So that's how far we have gone, but there's a great need now to engage the tourism industry more."

- International Stakeholder A

"Furthermore I think that these ae various NGOs who are dealing with the matter and are given the opportunity to come and present whatever plans they have." – Local Stakeholder A

"…and I think there's enough awareness being created about it, and the fact that there's first of December, and the month of December for that matter, is being recognised as (World) AIDS Day." – Local Stakeholder A

4.2.4 HIV and AIDS should be a priority issue for the tourism industry

Despite the seemingly non-involved or at best, limited stance of the industry and the prominent role that government is playing in mitigating the impact of HIV and AIDS, the external stakeholders felt that HIV and AIDS should be actually be a priority for the tourism industry. Their views are premised on the nature of the industry and the impact it has on income generation for the South African economy. The quotes below typify these views.

"The sector often in characterised by a young workforce, or whom many are very mobile, and (tourism) is fun and pleasure (and) the availability of drugs and alcohol, and if you may recall these are some of the drivers…." – International Stakeholder A

"Because we all understand that HIV and AIDS somehow affects one's performance in a workplace, and our industry is service orientated and it needs a body to be there." – Local Stakeholder B

"…HIV and AIDS for example, it's got an impact or it's definitely gonna have an impact on tourism generally". – Local Stakeholder C

"…there is so much cost implications in losing an employee, people need to understand". – Local Stakeholder C

4.2.5 A tourism industry HIV and AIDS strategic plan is needed

The tourism sector does not have a coherent trade bargaining council, although sectors such as catering and transport do have collective bargaining systems in place. Given that international standards do exist, such as those set by the ILO and Free Trade Tourism (FTT), it would be important for the South African tourism industry to strategize on the types of sector-specific action they will embark on. The selection of quotations below speaks to external stakeholders' views on the matter.

"…but I can tell you, when it comes to other sectors, what has worked is in fact to understand that particular sector, and once you understand the sector then you are able to design interventions that are customized for the particular sector". – International Stakeholder A

"…once we have a good legal framework to protect and encourage the implementation of it and that is what we are lacking". – National Stakeholder A

"I think even in the tourism industry, the tourism stakeholders are encouraged to develop policies to govern or to guide their operation in their individual businesses when it comes to dealing with issues of HIV and AIDS". – Local Stakeholder A

4.2.6 Multi-sectoral approaches will be required

Even with a sector specific-strategic plan, the gains made in other sectors will require attention. This includes the role of government and its own national Strathy to mitigate the spread of HIV and its impacts on the country as a whole. The principle of collaboration is key and this was proposed by external stakeholders.

"I think the overall is the partnership, the importance of partnership, the issues of HIV and AIDS is not a family issue, well it's not an individual issue, it's not a family issue, it's not a government issue, but it's all of us combined because it affects many aspects of our society." – Local Stakeholder A

"I think the lesson that we can learn is that how do we put tourism back into the (South African) strategic plan (on HIV, TB and STIs)" – National Stakeholder B

"I think more of the private sector need to come on board as well in terms of coming up with programmes and resources, as well as make sure that we tackle the issue of HIV and AIDS." – Local Stakeholder A

"I think it should be a collaborative exercise between government, between civil society, between the private sector, so it's like who is able to provide what." – National Stakeholder C

4.2.7 Monitoring and Evaluation would be key

A key component of any strategy will be monitoring and evaluation (M&E) of any strategic programmes implemented. This will assist the tourism industry in maintain the positive impacts of good practices, whilst altering or terminating those initiatives that do not yield any positive changes in dealing with HIV and AIDS in tourism workplaces. External stakeholders' views on this theme are captured in the quotations below.

"…one lesson could be we need to document some of the poor documented practices in HIV and AIDS, because I want people to review the code of practice of HIV and AIDS in the world of work." – International Stakeholder A

"You know basically finding ways to assist the tourism industry and finding people to deal with such issues such as monitoring and evaluation." – National Stakeholder B

"At this point in time, I would not be sure because we have not yet done an impact study…more on how much our training has impacted on the prevalence of HIV." – National Stakeholder A

"I think if we do not put HIV on that as a reporting issue, if we do not it will never be dealt with or brought to the attention of the CEOs" – National Stakeholder B

These themes generated through interactions with external stakeholders presented valuable insights as to how tourism workplaces can approach the implementation of workplace HIV and AIDS workplace programmes. As part of the research design, multiple invitations were sent to

tourism workplaces across the various sectors in the two study sites. The aim was to recruit these workplaces to the study, to determine whether they had any HIV and AIDS workplace programme and whether these resulted in any good outcomes as set out in the situation analysis tool. Where good outcomes were identified through engagement with tourism workplaces and supported by evidence, internal key informants asked to be interviewed through IDIs.

4.3 Qualitative results: Workplace interviews

This study could only recruit three tourism-related workplaces, in the study sites who could present some evidence as to implementation of workplace programmes. As with the recruitment for the quantitative component of the study, the dearth of HIV and AIDS workplace programmes identified by the study by the International Labour Organization (ILO, 2015) for the IDIs, was also not entirely unexpected.

The three workplaces that participated operate in the public sector in support of tourism (Workplace 1), accommodation and catering (Workplace 2) and transportation (Workplace 3) sectors of the tourism industry. Key internal stakeholders were identified and their views on how good outcomes were achieved at their workplaces are presented below.

The study utilised a situation analysis tool that was presented to all potential participating workplaces. The tool consisted of 12 indicators derived from the ILO Recommendation 200 and those identified for the three workplaces were:

- Increased HIV and AIDS knowledge

- Increased uptake HIV testing
- Reduced Risky Sexual Behaviour
- Occupational Risk
- Increased uptake of Anti-retroviral Treatment (ART)
- Reduced Stigma
- Community support
- Reduced Absenteeism

4.3.1 Increased HIV and AIDS knowledge

This indicator focused on activities that had lead, or potentially lead, to an increase in knowledge of HIV and AIDS. This included actual knowledge and perceptions studies, or simply the attendance of information sessions in HIV and AIDS by staff.

In Workplace 1, a major contributor to achieving the good outcome of increased HIV and AIDS knowledge, was the support of the workplace senior management who encouraged and supported the launch of a HIV and AIDS workplace programme. *" The employer launched the HIV and AIDS programmes which we call peer education…* - Senior Manager, Workplace 1

In the absence of in-house skills, the workplace outsourced the provision of training of peer educators until the programmes could be self-supporting from within the workplace.

"Our first service provider was a Johannesburg based service provider and we stayed with that service provider for five years. The service provider's responsibilities were coaching….and training." - Senior Manager, Workplace 1

Workplace 3 also conducted their workplace HIV and AIDS programme through an external service provider. Their innovation was also to include member of staff's households in their HIV and AIDS awareness programmes.

"Before we know about specific incidents about HIV with our staff, (name of external service provider) runs awareness programmes in that regard, which all members have access to as well as anybody living under their roof." – Senior Manager, Workplace 3

One of the key features of the workplace HIV and AIDS programme in Workplace 1 was the investment in peer educators. These were individuals identified for training from within the various business units of the workplace. This meant that peer became increasingly responsible for imparting knowledge, as well as to imparting of HIV and AIDS knowledge from within the workplace ranks.

"… the service provider issued all peer educators with certificates of competence. Peer educator training takes five days, on the last day the training instructor asses all peer educator. The service provider would bring posters and flyers to the workplace…(and)… they would also issue tool kits" - Senior Manager, Workplace 1

"(The workplace) has trained more than 70 peer educators, the peer education programme is voluntary;, to the peer educators and the employees who attend the peer education sessions. - Senior Manager, Workplace 1

Workplace 3 opted to contract trained counsellors to be available for staff with any kind of personal concern as part of their employment wellness programme. Whilst this is not a HIV-specific programme, the counsellors are trained in giving HIV counselling and HIV-related information to create awareness of the disease.

"We have onsite counsellors every week or every second week in all the workplace branches around the country, these counselling sessions are not specifically focused on HIV, they are for all employee issues.), but the counsellors are HIV trained counsellors that can be reached in a call centre or outside the workplace" - Senior Manager, Workplace 3

In all, knowledge of HIV and AIDS improved to such an extent that the increased knowledge was indeed a good outcome of its workplace HIV and AIDS programme.

"The company benefited from the programme because there was increased knowledge, adherence to treatment, absenteeism also improved and there is now less people die because of HIV and AIDS." Senior Manager, Workplace 1

Other indicators such as a decrease in absenteeism and greater adherence to ART, was also evident, but since absenteeism was not specified in terms of the cause, this could only be regarded as anecdotal.

Workplace 2 also offered evidence of Increased HIV and AIDS knowledge as a good outcome of their workplace HIV and AIDS programme. As a national provider of accommodation and catering, the workplace noticed that HIV and AIDS started having a negative impact on their workforce. Creating awareness was the main part of their workplace HIV and AIDS programme through.

"…we went around the country with a medical doctor, awareness was done, there was also other awareness activities (such as) Soul City magazines were distributed. This was done on a monthly and quarterly bases in all branches/offices of the workplace. – Senior Manager, Workplace 2

These awareness programmes were supported by the establishment of awareness centres nationwide, including in study areas of this study.

"Each branch of the workplace put up an awareness centre where they made information available …." – Senior Manager, Workplace 2

Further to this, the workplace expanded information on available medical aid schemes, as membership were not compulsory. Whist membership was not compulsory, attending information sessions were.

"...with the added awareness (of HIV and AIDS) gained, it made people look at joining the medical aid, because it's only compulsory from a particular level upward, and fitting the correct programme on that medical aid for the condition. – Senior Manager, Workplace 2

"..*all our staff, every staff member was required to attend the sessions, and they have to sign a register."* – Senior Manager, Workplace 2

Workplace 3 also introduced HIV awareness periods and events in addition to the wellness programme, to cast specific attention of HIV at all their worksites, including those in the study areas of this study. These HIV awareness days and months are operated in conjunction with their external service provider.

"The service provider will provide material and will distribute it, so there's a…. like an HIV awareness month, (name of service provider) will provide us with material in that regard that will be distributed to staff so that's just all our proactive awareness that we do" – Senior Manager, Workplace 3

"So that is the first thing, the first thing is the employee wellness programme, there's the normal HIV days that go around the country that we partake in" – Senior Manager, Workplace 3

4.3.2 Increased uptake of HIV testing

HIV Counselling and testing (HCT) and Voluntary Counselling and Testing (VCT) were the frontrunners of HTS. In the context of this study, internal stakeholders were prompted as to how an increase in staff testing for HIV was achieved at their respective workplaces. This was supported by reports on HIV tests done by external or later internal service providers who kept records on the increase of HIV testing in the workplace.

Given the stigma that is associated with testing for HIV, Workplace 1 opted to incentivize HIV testing at first, which lead to HIV testing becoming fully voluntary and non-incentivized.

"*In the beginning we started issuing out t-shirts, caps and HIV brochures to employees who got tested, but now HCT is voluntary"* – Senior Manager, Workplace 1

One of the key drivers of increased HIV testing, was the inclusion of HIV as part of a comprehensive wellness programme at this public sector tourism support entity.

"HIV and AIDS is also included in (the) comprehensive wellness (programme), this integrated approach works well as it also encourage the employees to live healthy, change in diets (and) exercising. – Senior Manager, Workplace 1

In Workplace 3, their increase in HIV testing was as a result of specified wellness days, where the need for HIV testing is accentuated in a jovial and collective atmosphere.

"We also have our Wellness Days every year at which HIV voluntary testing is available for staff to get themselves tested to be aware of their statuses, with counselling as well, that the proactive side of things." – Senior Manager, Workplace 3

In addition, the offering of HIV testing was not limited to one site in the workplace only, but was available at decentralized sites as well.

"HCT testing is always available at the (name of) clinic, there is an employee wellness clinic and some branches have satellite clinics with service providers." – Senior Manager, Workplace 1

As with Workplace 2, the HIV testing sessions was also an opportunity for those involved in the workplace programme to advocate membership to medical aid schemes to benefit from chronic medication provisions of such schemes.

"Medical aid is taken up on voluntary basis in the workplace, but the nurses do advise employees with chronic illnesses to have medical aid because not all medication required for chronic illnesses is available at the WP's clinic." – Senior Manager, Workplace 1

Conditions of employment at Workplace 3 requires that all staff must belong to a medical aid, thus staff can join a dedicated HIV programme offered by that majority medical aid scheme.

"All staff are required to be on discovery medical aid, not unless they are covered by their spouses medical aid. About 95% of the staff is on the company's medical aid" – Senior Manager, Workplace 3

"…and part of the (medical scheme name) offering is that they will get enrolled on the (medical scheme name) HIV programme with chronic medication." – Senior Manager, Workplace 3

A further benefit derived from membership to this specific medical scheme at Workplace 3, is that loyalty points can be accrued, that has other financial benefits for the scheme member. Although this incentive was not introduced by the workplace, but is rather a spin-off from its

choice of medical scheme, loyalty points can be accrued during the workplace-sponsored wellness days.

"…it's the wellbeing days, we have an annual wellness day for all branches around the country and that's obviously paid for by the company, it's not only about HIV that's that one part of the wellness day, basically all the staff go and get their health tested and there's the points …" – Senior Manager, Workplace 3

In Workplace 3, testing for HIV can also be attributed to the direct involvement of managers during wellness days, who takes the lead for testing for HIV and other conditions through the employee wellness programme at the workplace.

"Managers are encouraged to come out on wellness days. Wellness days are done regionally and everyone in management would have their days for wellness and testing in their regions, together with the senior staff they would partake on wellness days…" – Senior Manager, Workplace 3

4.3.3 Reduced Risky Behaviour

Internal stakeholders were also asked about their workplace efforts to reduce risky sexual behaviour that can lead to the spread of HIV amongst their workforce. Most of these activities centred upon the distribution of both male and female condoms, but also included on-going information sessions. Workplaces also had some arrangement with the National Department of

Health, whereby they opted to distribute flavoured condoms in the workplace once these were launched by the department.

"There's also sexual awareness sessions almost every month, there are no targeted survey from service providers, the reduced risky behaviour is pretty much continuous education about sex and providing tools, both male and female condoms, access and support through the Employee Wellness Programme." - Senior Manager, Workplace 3

"*The managers support distribution of condoms, the (public sector) clinic gives the co-ordinator boxes of condoms. Condoms are filled into the condom dispensers, condoms are also distributed in peer education sessions. We distribute about 2000 condoms in a month, (but) there is no assessment for condom use. "*- Senior Manager, Workplace 1

"The company gets large condom boxes and we distribute them all over the country, there are condoms dispensers in bathrooms that are filled in both male and female bathrooms." - Senior Manager, Workplace 3

"We also noticed that people are moving away from the blue condoms to the flavoured, that is something that we are also experiencing." - Senior Manager, Workplace 3

4.3.4 Increased uptake of Anti-retroviral Treatment (ART)

One of crucial elements of HIV and AIDS awareness and HTS is that once a person is diagnosed with HIV, that person is linked to suitable treatment, care and support. Since workplaces indicated on the situation analysis tool that an increased uptake of anti-retroviral treatment (ART) has been a good outcome of their workplace HIV and AIDS programme, the internal stakeholders were probed as to how this was achieved. One such mechanism was that the peer education programme not only created awareness of HIV and the need for HIV testing, the programme also educated staff on the need for ART.

At (workplace name) ART is free and is always available (and) knowledge, education from peer educators as well as testimonies from PLHIV helped in increasing ART uptake …" – Senior Manager Workplace 1

The workplace programme also assists in making sure the ART is available at the workplace, although some workers on ART needs still to collect theirs directly from public sector clinics. This is subject to the nature of the work done in the depot and is done at the diccretion of the managers of the depots in this public sector workplace.

"Some depots get their ART delivered to them and in some other depots employees have to go to the clinic to collect their ART…" – Senior Manager Workplace 1

The counselling role played by the external service provider at Workplace 3 after the diagnosis of an HIV-positive worker is also important. It is likely that the continuous support in preparation for life-long ART contributes to a greater uptake of ART in the workplace.

"All staff members can be involved on the HIV programme with the service provider which provides them three counselling sessions to equip them with the knowledge of how to deal with what it means to be on ARVs, what's going to happen when you on ARVs" – Senior Manager Workplace 1

The internal stakeholder at Workplace 1, also referred to a practice whereby informal, but voluntary support are coming from fellow staff members who actively support those having to take daily doses of ART at work.

"*In some depots the cooking ladies help the employees take their ART's as they are the ones giving the employees their ART after breakfast (quick mix porridge, employees buy this porridge for themselves* – Senior Manager Workplace 1

In Workplace 3, a more formal approach to workplace support was adopted whereby line managers also become involved once a worker has been diagnosed with HIV and linked to care.

Some flexibility also exists whereby the specific work environment of the HIV-positive worker is taken into account, especially at the early stages of starting ART.

"…we try and provide a supporting environment, reactively when staff come to (know) they are HIV positive, we take a very flexible and supportive approach adapting work conditions and

making all these programmes available, counselling for the managers, counselling for the staff members in terms of how to deal with going forward…"-– Senior Manager Workplace 3

Whilst the role of the external service provider is crucial, the key stakeholder was adamant that management has to play an active role once the clinical diagnosis has been made. This includes the emotional support that a newly diagnosed staff member with HIV. Such support should count as one of the key reasons why this good outcome of the workplace HIV and AIDS programme has been achieved.

"…the service provider just does the clinical stuff, the management, the relationship management, that's why we like to do manager referral, the manager is equipped with how to deal, what to expect, what is reasonable and what is not with employees who have disclosed." - Senior Manager Workplace 3

"Service providers deal with the clinical side and then the management deals with support. So we don't hand it over to the service provider, we hand the medical part and emotional wellbeing but the support is from management and HR" - Senior Manager Workplace 3

"The second part is if you are HIV positive and you on the meds or you getting the support that you need from the psychological point of view and there is impact at the moment we don't treat you differently, it's not like the minute you declare yourself HIV something happens, we just

make sure you get the emotional support and the emotional management" - Senior Manager Workplace 3

4.3.5 Reduced Stigma

A reduction in stigma is an obvious outcome of a well-functioning workplace HIV and AIDS programme. Internal stakeholders shared their views on how this was achieved in their workplaces.

"Stigma is reduced through knowledge, telling the employees that PLHIV are no different from the employees who are (HIV) negative. We tell our employees that there is no difference between people living with diabetes and PLHIV…" - Senior Manager Workplace 1

"Because the wellness programme has been in place for many years, this also helped with stigma and discrimination in the company. HIV is treated like all other life treating diseases like cancer and TB". - Senior Manager Workplace 3

"Peer education is to advocate de-stigmatisation and the adherence to treatment and also to make sure that PLHIV are not alienated from other people." - Senior Manager Workplace 1

"So the goal is to obviously have staff treated as normal just with their educational support and psychological support and medical support in the background."- Senior Manager Workplace 3

4.3.6 Impact of family and community

Whilst a workplace HIV and AIDS programme targets by definition the employees at the workplace, internal stakeholders indicated that their efforts cannot operate in isolation. Although no evidence could be submitted, workplace stakeholders shared views that include those affected and infected by HIV outside the workplace.

"What you've got look at is the having an impact on, if you are a (name of workplace) employee your wife and your children are through this kind or any kind of trauma or illness it is going to affect you and your work and the idea is to try and have you know the support for you directly and the support for you by sending it to your family so that there is work life balance and your ability to do your job is not affected by things we can help with." - Senior Manager Workplace 3

Peer education is not limited to the WP, peer educator can continue with their peer education even outside of the WP in their communities. There are no monitoring of these sessions. - Senior Manager Workplace 1

4.3.7 Reduced Absenteeism

A major business case for implementing workplace HIV and AIDS programme is that absenteeism related to health and disease should be reduced in order to maintain levels of productivity. Some internal stakeholders interviewed also pointed to the impact of their

programmes in this regard. Given efforts towards non-stigmatisation of HIV and other diseases, reasons for absenteeism are not usually recorded, so no evidence could be sourced.

"The thing is what we've noticed is that when the staff doesn't get support from management the absenteeism rates go through the roof." - Senior Manager, Workplace 3

"This is due to increased uptake on ART. The WP has its own clinic and the employees don't have to queue for long hours at public clinics, which mean there's no taking of sick leave or leave to be taken for treatment collection." – Senior Manager, Workplace 1

This study showed that there are currently no real strategically aligned HIV and AIDS workplace programmes being implemented by South African tourism workplaces in the Eastern Cape Province. Thus, the focus on HIV prevention, treatment and care for workers in the tourism industry in the selected study areas remains largely in the domain of the generic programmes offered by the Department of Health at provincial and local government levels. For the few cases where this study unearthed evidence, is shows that HIV and AIDS workplace programmes can contribute towards the visibility and acknowledgement of the centrality of workplaces in the tourism industry in addressing the HIV and AIDS epidemic in South Africa.

4.4 Summary

This section outlined the results of the quantitative and qualitative components of the study. The results from the quantitative interviews with workplaces hinged primarily on reasons for the non-uptake of workplace HIV and AIDS programmes in the tourism industry. Qualitative interviews with external stakeholders revealed useful themes on which the future development of workplace HIV and AIDS programmes in tourism industry can be based. The limited number of qualitative interviews with workplaces that had workplace HIV and AIDS programmes, pointed to distinct possibilities for the tourism industry in this regard.

5. CONCLUSION

Given that the overall aim of this study was to investigate, in terms of the ILO Code of Practice on HIV/AIDS and the world of work (2001), ILO HIV and AIDS Recommendation, 2010 (No. 200) and ILO HIV and AIDS: Guide for the tourism sector (2012) "what works" in the South African tourism industry workplace in terms of HIV and AIDS, the success of this study was limited.

The reason for this statement is that in terms of the set objectives towards this aim, selecting a representative sample of tourism workplace HIV and AIDS programmes proved to be a futile exercise. Despite an assertion that there will be a dearth of qualifying workplaces as proven by another study (ILO, 2013), workplace HIV and AIDS programmes in the tourism industry was rare in the study sites. As indicated, only 55 tourism workplaces could be identified to primarily determine why they did not implement a tourism workplace HIV and AIDS programme.

Of these 55, only three tourism workplaces reported good outcomes from their workplace HIV and AIDS programmes which could be substantiated with good evidence. This meant very limited opportunities to determine what contributed to good outcomes, as was initially set out as an objective of the study. Although some assessment as to how good outcomes from tourism workplace HIV and AIDS programmes were achieved was made, such could only be gauged from the three qualifying workplaces, albeit from different sub-sectors of the tourism industry.

Despite this limited engagement with the implementers of tourism workplace HIV and AIDS programmes, the study did benefit from the exogenous insights gleaned from in-depth interviews (IDIs), representing the views of internal, national and local tourism stakeholders. These IDIs uncovered very rich information as to why tourism workplace HIV and AIDS programmes are scarce, not only in the study sites, but in South Africa as a whole.

Their views were wide-ranging, based on themes that HIV and AIDS is not a priority for the tourism industry and that the South African government is treating HIV and AIDS as a priority for the country as a whole. Some views were put forward that some HIV and AIDS activities are in place in the tourism industry and that the disease should actually be a priority issue for the tourism industry. However, any wide ranging implementation of tourism workplace HIV and AIDS programmes, should be based on a tourism sector HIV and AIDS strategic plan that take into account multi-sectoral approaches and of which monitoring and evaluation will be an important component.

Although only three tourism workplaces were identified that had workplace HIV and AIDS programme, some good outcomes were identified based on the ILO Code of Practice on HIV/AIDS and the world of work (2001), ILO HIV and AIDS Recommendation, 2010 (No. 200) and ILO HIV and AIDS: Guide for the tourism sector (2012). These workplaces could share with the research team evidence and views of the good outcomes of increased knowledge of HIV and AIDS, increased HIV testing, reduced risky behaviour, increased ART uptake, reduced stigma, reduced absenteeism and impact of family and community.

What could be gleaned from the qualitative IDIs with internal stakeholders, were factors that proved to be conducive for achieving the good outcomes from the workplace HIV and AIDS programme. These were management support, the implementation of an integrated employee wellness programme and a conflation of the two categories and will be discussed seperately.

5.1 Management support of the workplace HIV and AIDS workplace programme

The tacit support offered by senior management for the workplace HIV and AIDS programme was clear. Whether this was in the shape of launching and funding a peer education programme, or the appointment of an external HIV and AIDS training service provider, management support proved vital. Management support also meant the sustainability of the programme through continuous training of peer educators, availability of trained counsellors, constant supply of male and female condoms and the creation of decentralised HIV awareness centres where information, education and communication (IEC) could be made available to all staff. The participation of

senior managers in HIV and AIDS related events also proved to be a valuable asset for a workplace HIV and AIDS programme to deliver good outcomes.

5.2 An integrated wellness programme

The acceptability of a workplace HIV and AIDS programme drew impetus from senior management support for an integrated wellness programme, one where the HIV and AIDS component of the programme is immersed with treatment and care of non-communicable diseases, financial planning and other personal services. Such helped with the good outcomes of increased testing for HIV in the workplace, as well as reducing stigma amongst workers. The increased uptake of ART as a good outcome also resulted because of HIV and AIDS no longer being 'exceptionalized' and treated as any other chronic illness. Organising regular wellness days and observing United Nations commemoration days such as World AIDS Day and World Diabetes Day then results, combining serious concerns for health and well-being with fun and camaraderie at the workplace.

5.3 The conflation of management support and integrated wellness

Increased uptake of ART as a good outcome of the workplace HIV and AIDS programme has been a result of the conflation of management support and the implementation of an integrated wellness programme. Whilst in some cases, external services providers took responsibility for the clinical management of staff on ART, management ensured that internal social support was

provided for such staff. The latter was provided through formal engagements between staff on treatment and their line managers, or through the encouragement of informal support networks. This approach was also evident in that resources made available for staff, especially awareness and support, was made available to the households infected and affected by HIV.

Despite these conducive factors, the findings from this study suggest that broad and effective workplace HIV and AIDS programmes still lacks in the tourism sector. The quantitative component especially, points to a lack of awareness and capacity, as well as to apathy and perhaps outright denial that HIV infection amongst workers in the tourism industry cannot have a marked effect, when viewed against health-related threats such as Ebola and Sever Acute Respiratory Syndrome (SARS), amongst others.

Many small and medium tourism businesses may also deem the management of HIV and AIDS in the workplace as too expensive or even too complicated, or something that should be firmly entrenched as a health-related mandate of the public sector. Hence, there is a clear need for an attempt to change behaviour and attitudes amongst all industry stakeholders by starting to make a business case for an HIV and AIDS programme as an industry workplace innovation. Voluntary compliance to Free Trade Tourism (FTT) principles and directives related to HIV and AIDS, can also serve to give the South African tourism even more visibility in terms of sustainability and corporate social responsibility.

One of the salient features of good outcomes in the few workplaces that did implement workplace HIV and AIDS programmes was the normalisation of HIV and AIDS as a chronic

disease through the implantation and support of an integrated wellness programme. Creating awareness about HIV and AIDS on the same platforms as awareness of diabetes, TB and cancer, and then making relevant support services available for care, treatment and support could prove a valuable approach to assess a return on financial investment. A good wellness programme means that a tourism workplace invests in its employees and as a result employees stay healthier for longer and contribute to the core business of the company for longer as well.

Future research in this field will be a necessity. Not only should the reach of the study be expanded so as to have a national focus, but larger tourism workplaces in terms of employee numbers should especially be included. Given the anecdotal evidence of extensive successes with their workplace programmes in some of these workplaces, but who could not be persuaded to participate, means that a large portion of the tourism workplace HIV and AIDS programme picture remains unseen. Thus, an expanded research focus is needed as tourism remains one of South Africa's flagship economic sectors and a major contributor to the gross domestic product (GDP). In South Africa, a country with a generalized HIV epidemic, any research support towards the mitigation of any negative consequences of the disease on the future sustainability of this flagship industry will be vital.

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