Sun, sea, and sex: understanding the adoption of HIV prevention and control practices in the Trinidad and Tobago tourism sector

Thesis submitted to the University of London for the Degree
Doctorate of Public Health (DrPH)

by

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DECLARATION

I , Renée M West declare that I have read the London School of Hygiene and Tropical Medicine's definition of plagiarism and cheating given in the Research Degrees Handbook. I confirm that the work presented in this thesis is my own work. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Date: 21st January 2013

INTEGRATING STATEMENT OF DRPH

The Doctor of Public Health (DrPH) offered at the London School of Hygiene and Tropical Medicine (LSHTM) aims to enhance public health professionals with the leadership, management and research skills necessary to effectively lead public health agencies at either the national or international level. The DrPH programme is designed for those whose career path is destined to follow a professional rather than a strictly academic one. The DrPH programme at LSHTM has three separate components: a taught component, a professional attachment and, a research project.

After over ten years of working in and with public health Non-Governmental Agencies (NGOs) at the national, the (Caribbean) regional and international levels, I wanted to improve my skills in planning and policy development. The DrPH appealed to me since it was not solely focused on research but would allow me to increase my knowledge of leadership and management theories which could then be used in conjunction with my practical working experience.

Taught component

The taught component consists of two compulsory modules: *Evidence-Based Public Health Practice (EBPHP),* and *Leadership Development and Management (LDM).* The first module, EBPHP, sought to enhance students' understanding and use of research-based information in planning and implementing public health policy. The first assignment for EBPHP involved the design of a knowledge transfer strategy. In this exercise, using health policy theories and frameworks, I outlined the necessary strategies that would place the issue of condom distribution in the tourism sector on the Ministry of Health's public policy agenda. This assignment was a useful exercise in developing a theoretically-based strategy as a solution to gain support for a public health intervention in a sector which was mainly private-sector focussed. The second assignment involved a systematic review of the effectiveness of lay health worker interventions in primary and community health care to reduce morbidity and mortality in children under five years. This assignment allowed me to focus on critically analysing papers while increasing my skill in evaluating how research studies could be

relevant, or not, to a particular future study or intervention; this exercise also added to my understanding of the process often described as 'from research to policy'.

The second module, LMD, sought to give me a greater understanding of leadership and management theories and how to apply them in my role as a future public health leader. This module also included a weekend seminar away from the LSHTM's usual classroom environment and allowed me to evaluate my personal leadership and management skills and what areas I would need to develop in order to reach my full potential. For this module's assignment, I used leadership and motivational theories, in particular, transformation theory, Maslow's hierarchy of needs and Herzberg's hygiene and motivational factors to analyse and provide recommendations to resolve the issue of high staff turnover in the secretariat of a Caribbean non-profit HIV organisation. This module also provided the foundation for the second component of the DrPH – the Professional Attachment.

In addition to these compulsory modules, I completed modules in Qualitative Methodologies, Research Design and Analysis, and Sexual Health. I also audited a fourth module, Gender and Health to acquire the relevant knowledge for my future career. The Research Design and Analysis module was particularly interesting as this enabled me to really 'sink my teeth' into the 'research design and analysis' of a quantitative research project as I have been more familiar with qualitative research projects.

Professional attachment

The aim of the Professional Attachment (PA) was to give the student the relevant experience to observe and analyse a specific mandate of an agency that works in public health, using organisational theory and research methodology. It would have been easy to return to a former place of employment in my home country, and request permission to conduct my PA. However having worked in several public health agencies in a developing region, I wished to get additional experience in another region or country, preferably in a developed country. Finding a public health organisation which would accept me and basically allow me to 'dig into and criticise their internal organisational workings' proved to be a challenging task. However, I used all contacts

and was able to conduct my PA within the Health Portfolio (HP) of a non-profit consultancy agency in the UK – Oxford Policy Management (OPM). Over a period of four months I collected data using semi-structured interviews, participant observation and document review. This allowed me to identify key factors of OPM's internal organisational and management structures and external environment which enabled the HP to successfully interact with its clients. Using frameworks and theories learned in the LMD module, Mintzberg's Design School model, PEST (Political, Economic, Sociocultural and Technological), 7-S and International Development Research Centre (IRDC) frameworks, I used an adapted model to analyse the HP and achieve my aim. Using organisational theory enabled me to design and analyse a more appropriate research study than I would have originally done. Further to this, being able to use the research findings to recommend strategies to achieve OPM's goal of successful client interaction furthered my understanding and capacity to apply evidence-based research to inform policy. Together with my final report to LSHTM, I also provided an adapted version of the report to OPM, with a presentation to the HP and OPM's management committee. I would like to suggest that LSHTM assist and encourage students to use their PA experience to challenge themselves and conduct research in an unfamiliar working environment. Even though this did not transpire in my case, LSHTM has many international contacts from which they can draw upon and find suitable placements for the students.

Research project

My research project, *'Sun, sea, and sex: understanding the adoption of HIV prevention and control practices in the Trinidad and Tobago tourism sector'* arose from my concern regarding the relatively high HIV prevalence in Trinidad and Tobago (TT), the growing importance of the tourism industry to TT, in particular the more leisure-based island of Tobago and, the linkages between the tourism industry and HIV transmission identified in the research literature. The aim of this study was to analyse the factors that influence or hinder the adoption of HIV policies and practices within Trinidad and Tobago hotels. Using a qualitative approach and collecting data using semi-structured interviews with hotel owners/managers and participants of national organisations including government tourism and health/HIV ministries, and document review, I was able to achieve this aim. The knowledge that I gained from the EBPHP, LMD and other modules, in particular Qualitative Methodologies, together with the experience from

the PA, enabled me to successfully design, conduct and analyse my research project. Conducting empirical research at this level gave me the confidence to undertake future research in my professional career.

Conclusion

Overall this degree is not just more 'letters behind my name' but also a learning experience which has enhanced my skills and knowledge to develop health policies and programmes, and to implement and evaluate them. The practice of designing and conducting two rigorous research projects, analysing them and then providing policy recommendations has been invaluable. My greatest challenge has been in writing for an academic audience rather than writing reports for national, regional or multilateral developmental agencies; I hope that this thesis can provide testimony to my increased ability. This programme has taught me not only how to critically analyse research papers but also how to analyse myself, especially in terms of my personal management and leadership skills – where I was when I started this degree, where I am now and where I would like to be in the future.

Finally because of the three distinct elements of the DrPH programme – theory, organisational research and a practical thesis study – I believe that the DrPH tests a person's intellect and creates an inner determination to excel even further than the conventional PhD – it can be described as a PhD with 'something extra'!

ABSTRACT

Background: UNAIDS estimated the adult HIV prevalence rate in Trinidad and Tobago was 1.5% in 2010 – the fourth highest in the Caribbean. Global and Caribbean evidence demonstrates that areas of high tourism activity can be sites of high-risk sexual interaction between tourists and locals, and this may contribute to the growing HIV transmission. The aim of this study is to explore and understand the factors that influence the adoption of HIV practices within hotels in Trinidad and Tobago. By examining hotels' (lack of) response to national policies, recommendations are made to inform future policies of a major public health concern within the private sector.

Methodology: The study uses policy analysis approaches to understand why hotels adopt HIV prevention and control practices, and an ecological lens to categorise these factors. Qualitative data were collected using semi-structured interviews with representatives from 54 hotels, government agencies and hotel and tourism associations, together with a review of relevant policy documents.

Results: Commonly reported practices in the tourism sector include non-discrimination towards HIV-positive staff and guests; use of gloves to clean rooms; preventing staff-guest interactions; and HIV training and sensitisation. Commonly reported barriers included HIV not being considered a priority; limited hotel resources; and staff attitudes and resistance, while important facilitators included existing hotel systems and procedures; and management being directly affected by HIV.

Conclusion: Recommendations include increased HIV awareness for both hotel management and staff using hotels' already existing systems; increased leadership among hotel and tourism associations in the adoption of HIV policies and programmes through sharing of information and peer collaboration; and further operational research on HIV in the tourism industry to help inform the decisions of hotel owners/managers and policy makers.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

LIST OF APPENDICES

ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Anti-retroviral Therapy
ARV:	Anti-Retroviral
AWiSA:	AIDS Workplace Programmes of Southern Africa
B&B:	Bed and Breakfast
BHTA:	Barbados Hotel and Tourism Association
CAREC:	Caribbean Epidemiology Centre
CAST:	Caribbean Alliance for Sustainable Tourism
CARIFOURM:	Caribbean Forum of African, Caribbean and Pacific States
CBO:	Community-based organisation
CF:	Conceptual Framework
CHRC:	Caribbean Health Research Council
CHAA:	Caribbean HIV/AIDS Alliance
CHTA:	Caribbean Hotel and Tourism Association
CRN+:	Caribbean Regional Network of Persons Living with HIV/AIDS
CRSF:	Caribbean Regional Strategic Framework
CTO:	Caribbean Tourism Organization
DFID:	(UK) Department For International Development
DHSS/THA:	Division of Health and Social Services, Tobago House of Assembly
DR:	Dominican Republic
DrPH:	Doctor of Public Health
DTT/THA:	Division of Tourism and Transportation, Tobago House of Assembly

EAP:	Employee Assistance Programme
EBPHP:	Evidence-Based Public Health Practice
EDF:	European Development Fund
FSW:	Female sex workers
GBC:	Global Business Coalition
GDP:	Gross Domestic Product
GHESKIO:	Le Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (Haitian Study Group on Opportunistic Infections and Kaposi's Sarcoma)
GFATM:	Global Fund to fight AIDS, Tuberculosis and Malaria
GHI:	Global Health Initiatives
GORTT:	Government of the Republic of Trinidad and Tobago
HASC:	HIV and AIDS Advocacy Sustainability Centre
HEU:	Health Economics Unit
HIV:	Human Immunodeficiency Virus
HP:	Health Portfolio
HR:	Human Resource
HTA:	Hotel and Tourism Association
IADB:	Inter-American Development Bank
IF:	Internationally Franchised (hotel)
IHRA:	International Hotels and Restaurants Association
IDU:	Injection Drug Use(r)
ILO:	International Labour Organisation
IRDC:	International Development Research Centre
LDM:	Leadership, Development and Management

LSHTM:	London School of Hygiene and Tropical Medicine
M&E:	Monitoring and Evaluation
MARP:	Most-At-Risk Population
MDG:	Millennium Development Goals
MLSMED:	Ministry of Labour, Small and Micro Enterprise Development
MSM:	Men who have Sex with Men
NACC:	(TT) National AIDS Coordinating Committee
NAP:	National AIDS Programme
NSP:	National Strategic Plan
NGO:	Non-Governmental Organisation
OP:	Operational Plan
OPM:	Oxford Policy Management
OSHA:	Occupational, Safety and Health Act
PA:	Professional Attachment
PAHO:	Pan American Health Organization
PANCAP:	Pan Caribbean Partnership Against HIV/AIDS
PCBC:	Pan Caribbean Business Coalition to Fight HIV/AIDS in the Caribbean
PEST:	Political, Economical, Sociocultural and Technological
PLHIV:	People Living with HIV
PMTCT:	Prevention Mother-To-Child Transmission
QTC:	Quality Tourism for the Caribbean
S&D:	Stigma and Discrimination
SME:	Small and Medium Enterprise
SATSA:	Southern Africa Tourism Service Association

SSI:	Semi-Structured Interview
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection
SW:	Sex Workers
TDC:	Tourism Development Company
THA:	Tobago House of Assembly
THACCS:	Tobago HIV/AIDS Coordinating Committee Secretariat
THETA:	Tourism Hospitality and Sport Sector Education and Training Authority
THRTA:	Trinidad Hotels, Restaurants and Tourism Association
THTA:	Tobago Hotel and Tourism Association
TIDCO:	Tourism and Industrial Development Company
TPDCo:	(Jamaican) Tourism Product Development Company
TSHASP:	Tourism Sector HIV/AIDS Support Programme
TT:	Trinidad and Tobago
TTBS:	Trinidad and Tobago Bureau of Standards
TTHTA:	Trinidad and Tobago Hotel and Tourism Association
TTHTI:	Trinidad and Tobago Hospitality and Tourism Institute
TTTAS:	Trinidad and Tobago Tourism Accommodation Sector
UK:	United Kingdom
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNGASS:	United Nations General Assembly Special Session
UNWTO:	United Nations World Tourism Organization
US:	United States
USAID:	United States Agency for International Development

USDOL:	United States Department of Labor
UWI:	University of the West Indies
VCT:	Voluntary Counselling and Testing
WEF:	World Economic Forum
WTTC:	World Travel and Tourism Council

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This thesis is dedicated to wonderful parents

Samuel Doveton and Dalma Doreen West

Always, Favourite Daughter

CHAPTER 1 INTRODUCTION

The United Nations World Tourism Organization (UNWTO) defines tourism *as 'the activities of persons travelling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business and other purposes,'* [2, pg1]. Tourists are persons who partake in such movement. The tourist industry consists of directly-related services and systems including airlines, hotels, and car rental companies and indirectly-related systems and services such as manufacturing, construction, government, fuel and catering companies, and laundry services.

The Caribbean is one of the most economically tourism dependant regions in the world[3-5]. According to the World Travel and Tourism Council (WTTC), in 2004 travel and tourism in the Caribbean was estimated to contribute, directly and indirectly 14.7% of total Gross Domestic Product (GDP), with 814,550 direct industry jobs and 2.4million jobs overall[6]. WTTC estimates that, in 2010, Trinidad and Tobago's (TT) travel and tourism industry, will directly and indirectly account for 10.9% total GDP and 95,000 jobs overall[7] .

At the end of 2009, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated TT's adult HIV prevalence to be 1.5%[8], compared to the overall Caribbean rate of 1.0%, which as a region has the second highest adult prevalence rate after sub-Saharan Africa[9]. It is not surprising, that TT and other Caribbean states which rely on tourism are reluctant to draw attention to the crisis of HIV and AIDS for fear that this might deter tourists and subsequently, have serious consequences on the region's economy[10-12].

Globally, well documented evidence exists linking the tourism sector to risky sex. For example, Bisika (2009) noted that one of the main tourism areas in Malawi has an HIV prevalence rate higher than the national average[13], and in South Africa, Tajudeen et al's (2011) study of tourism workers, including those employed in hotels revealed that 46.2% of the workers had sexual experiences with hotel guests and 39.6% had not used a condom during their last sexual experience[14]. According to Campbell et al (1999) Jamaica, and the wider Caribbean, is generally marketed to tourists as 'sun, sea, sand and sex'[15]. Forsythe (1999) describes the

tourism sector as being *'associated with casual sex, frequently unprotected, and drug and alcohol use – factors linked to an increased risk of HIV'*[16, pg2]. When tourists have high risk sexual interactions with the local community, HIV may be transmitted from the tourists' home countries to the visiting destination, and vice versa[16]. Hotels are sites where sexual interaction occurs between tourists and locals. The local population may include hotel staff, members of the community or Sex Workers (SWs) including Men who have Sex with Men (MSM). Forsythe et al's(1998) study in the Dominican Republic (DR) revealed that 17% of hotel staff engaged in *'sexual relations with tourists'*[10, pg283]. Brebnor(2007) in her review of the HIV epidemic in TT, suggested that *'sex tourism [was being] facilitated by 'travel agents', hotels and guesthouses'*[17, pg13]. Studies point to a clear relationship between HIV and tourism in the Caribbean. For example, Garris et al(1991)[18] and Figueroa et al(1995)[19] made this link by demonstrating that areas of high tourism activity in the DR and Jamaica, have a higher adult HIV prevalence rate than areas not so economically dependent on tourism. In 2003, the Caribbean Epidemiology Centre(CAREC) reported that, *'tourism dependant economies [in the Caribbean, including Tobago] are among the most affected in terms of HIV seroprevalence and reported AIDS incidence'[20, slide9].* Gittens et al's(2001) study of HIV-1 sequences in Trinidad and Barbados and blood samples from Europe suggested that the transmission of these HIV-1 sequences from Europe to the Caribbean or even the other way around, may have been as a consequence of tourism[21].

The Government of the Republic of Trinidad and Tobago (GORTT) has developed a number of policies and strategies aimed at preventing and controlling the spread of HIV including the creation of a coordinating unit – the National HIV/AIDS Coordinating Committee (NACC) – which developed a Five-year National HIV/AIDS Strategic Plan (2003-2008/10) (NSP)[22]. Developing from the NSP, in 2006, several sectoral programmes were formed including the Tourism Sector HIV/AIDS Support Programme(TSHASP) within the Ministry of Tourism[23]. Despite these national efforts, as this study will show, there is little evidence to suggest that hotels have widely adopted policies and strategies to deal with the growing HIV problem, although many have adopted informal, ad hoc HIV practices with limited regard for government HIV policies and programmes.

Policies and programmes can be made and implemented by either the public or private sector. In this study, the researcher refers to the implementation of government HIV prevention and control policies and programmes, for example the NSP, and the adoption of hotel practices. See

Box 1.1. The practices adopted by a hotel may be categorised as formal (documented or regularly put into action) or informal (adopted but not written down, and/or performed in an ad-hoc manner). The researcher also categorised direct practices as those whose main goal was to prevent and control HIV transmission whereas indirect practices were those whose original goal did not specifically target HIV prevention and control.

Box 1.1: Glossary of government policies and programmes and hotel practices

Government HIV prevention and control policies and programmes: a policy is any statement of intended activities. A policy may also be described as a programme or framework of on-going, systematic activities. Policies and programmes can be formally documented or maybe informal and unwritten[1]. In this study these may also be referred to as **national HIV policies and programmes.**

Hotel HIV prevention and control practices: any activity adopted within the operational procedures of the hotel. These practices may be as a result of a specific government policy being implemented or may have been initiated from within the hotel, through actions of its management and/or staff. In this study these may also be referred to as **HIV practices.**

Padilla et al (2010) described *'...Caribbean tourism areas [as] geographically, socially and environmentally distinct spaces that function as ecologies of heightened vulnerability contributing to the transmission of HIV and other STIs among mobile populations both within and across national borders'*[24, pg70]. This study adopts a health policy analysis approach with an ecological perspective to realise its objectives. The researcher draws on and adapts policy implementation theory as the basis for her conceptual framework to describe and explain policy content and how the policy process has evolved over time. Specifically described and analysed are the range of HIV practices being adopted by the hotels and the factors that supported and hindered this adoption. These were analysed in relation to the ecological framework.

1.1. STUDY AIM, OBJECTIVES AND VALUE OF STUDY

The aim of this thesis is to analyse the factors that influence or hinder the adoption of HIV practices within TT hotels. The study also offers policy lessons and recommendations which it is hoped will be valuable to the government and tourism sector in TT and the wider Caribbean.

The objectives of this study are:

1. To document the range of HIV practices adopted by hotels in the TT tourism sector.
2. To identify the most important factors influencing whether and to what extent HIV practices are adopted by hotels in TT.
3. To document TT national HIV policies and programmes and examine how the hotel and tourism sector has responded.
4. To recommend strategies in which the present TT HIV policies and programmes can be further supported and enhanced.

The public health value of this study is that it will:

1. Document existing HIV practices within the TT hotels.
2. Add to the body of research, and introduce a framework, that seeks to understand the factors that facilitate and hinder the adoption of HIV practices within the tourism accommodation sector and more specifically, within TT.
3. Add to the broader literature on how public health concerns are addressed by stakeholders outside the government health sector – namely the private sector actors of the TT hotels. This will be valuable since most studies thus far have focussed on how public sector implementers deal with public health concerns.

CHAPTER 2 CONTEXTUAL BACKGROUND AND REVIEW OF LITERATURE

INTRODUCTION

This chapter discussed the literature on international, Caribbean and national perspectives of the tourism industry, HIV and the relationship between these two elements. It also gives some background information on socio-cultural, economic and political factors of Trinidad and Tobago (TT) relevant to the study. Where there were gaps in the literature, some of the data collected from the interviews were used. Finally the chapter explores the concepts of health policy analysis and an ecological framework which form the basis of the study's conceptual framework (CF).

2.1. INTERNATIONAL PERSPECTIVE

2.1.1. TOURISM INDUSTRY

International tourism plays an important economic role to developing and developed countries alike and despite global economic fluctuations tourist arrivals have continued to grow. The United Nations World Tourism Organization (UNWTO) reported that international tourist arrivals increased to 940 million in 2010. Between January-June 2011 total arrivals increased by 5.5% (19 million more) to 440 million, over the same time period for 2010. Tourism plays a vital role in providing jobs especially in developing countries and those with emerging economies; tourism provides approximately 6-7% global jobs. Tourism may also account for 2-10% of national Gross Domestic Product (GDP) depending on the importance it plays in the country's economy, and for an overall estimated 5% of worldwide GDP[25].

2.1.2. HIV EPIDEMIC

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010 Report on the Global AIDS Epidemic, at the end of 2009 there were approximately 33.3 million People Living with HIV (PLHIV) with 1.8 million people having died from HIV-related illnesses that same year.

Even though total global percentages of PLHIV have stabilised since 2000 with the number of new infections decreasing since the late 1990s, the number of PLHIV has steadily increased as HIV treatments extend life and as new HIV infections outnumber AIDS deaths; in 2009 there was an estimated global HIV adult prevalence of 0.8% and a total of 2.6 million new infections in adults and children. Regionally sub-Saharan Africa remains the epicentre of the global epidemic with 22.5 million PLHIV and 1.3 million deaths from HIV-related illnesses reported in 2009[9].

2.1.3. RELATIONSHIP BETWEEN HIV AND TOURISM

Globally there exists well documented evidence that links tourism to risky sex characterised by a thriving sex industry within the tourism sector. For example, Wright's 2003 study of HIV risk suggested linkages between HIV transmission and the tourism industry with older people engaging in sex tourism while away from their normal place of residence[26]. Townsend citing Mulhall suggested that of the foreign Japanese men visiting Thai female Sex Workers (SWs), only 28% always used condoms[12]. Bisika (2009) found that a major tourism area in Malawi has an HIV prevalence rate higher than the national rate of 17.5% and that about 25% of the tourism workers admitted to having sex with a non-regular partner and 26.2% reported irregular condom use during these sexual relations[13]. In the Gauteng Province in South Africa, a study of tourism workers, including hotel employees, indicated that 46.2% of the study participants had at least one sexual experience with one hotel guest/tourist. The study also revealed that 39.6% of tourism workers did not use a condom during their last casual sexual encounter but it was unclear from the literature whether or not this high-risk casual sexual encounter by the tourism worker was with the hotel guest or another local [14]. The results taken from a survey of attendees at a London genitourinary medicine clinic who had recently travelled abroad revealed that 25% had sex with a new person and of these two-thirds *'never or inconsistently used condoms'*[27, pg351].

Anthropological studies have identified a certain degree of *'liminality [with tourists, who] lose inhibitions and behave as they would not at home...[thus] increase[ing] people's risk-taking behaviour'* [12, pg5]; this is particularly evident when tourists indulge in heavy alcohol and drug use which can lead to risky sexual behaviours[28, 29]. In Southern Africa, particularly Namibia, South Africa, Zambia and Botswana, HIV is linked to the high mobility of hotel employees due to the seasonal nature of tourism employment and the relatively young age of the workers[30]. The issue of migration and mobility, and being away from regular sexual partners, has raised

concerns for HIV transmission in hotel workers, when they have sex with local SWs as in the case of India[31].

Finally, because of the nature of the tourism industry, many workers themselves felt that they were at risk of Sexually Transmitted Infections (STIs), including HIV[13, 14] and therefore, for the purposes of this study, the researcher has classified tourism workers as a Most-At-Risk-Population (MARPs) for contracting HIV. In fact HIV prevalence studies in two tourist cities of Tirupati and Pune in India have shown prevalence rates among hotel workers to be 0.9% (1991) and 3.4% (2006)[31] respectively and also HIV prevalence rates among female bar/hotel workers in Moshi, Tanzania to be 19%(2006)[32]. Many of these trends are also mirrored in the Caribbean tourism industry. See section 2.2.3.

2.1.4. HIV PREVENTION AND CONTROL INTERVENTIONS WITHIN THE TOURISM INDUSTRY

Private sector organisations in several countries have realised the importance that HIV and AIDS have had, or will have, on their businesses and the country's economy as a whole. As a result there have been several interventions to reduce HIV transmission and mitigate the social and economic impact of the epidemic. However within the tourism sector, there have been relatively few such interventions, especially within hotels. These have been chiefly among large hotel chains (over 2000 employees) which have introduced HIV workplace guidelines and programmes for their staff and surrounding communities, such as Serena Hotels Group which has over 19 hotels in Kenya, Rawanda, Uganda and United Republic of Tanzania and Zanzibar[33], and Grupo Visaberio which also has hotels in Angola and Mozambique[34]. As part of their HIV prevention programme some hotels such as Kimball Plaza in the Philippines[35, 36] and Regent Hotel in Bangkok have provided HIV awareness training for all new staff[35].

In 2005, the World Economic Forum (WEF): A Global Review of the Business Response to HIV/AIDS 2004-2005[1] reported that worldwide 71% of companies did not have HIV policies

[1] This Review used information collected during the 2004-2005 Executive Opinion Survey that forms part of the World Economic Forum's annual Global Competiveness Report. Businesses in the survey can be divided by sector: 25% manufacturing; 10% wholesale and retail trade; 10% financial; 9% transport,

and it was only in countries with a prevalence rate above 20% did most firms have them. This Review also indicated that 12% of companies had informal HIV policies[2] compared to 7% which had written ones. Of the companies who partook in this Review, hotels and restaurants formed part of the category 'other' which constituted 42% of the total number of companies in this report[37]. This lack of HIV policies concurred with research undertaken in 2002/3 for the Tourism, Hospitality and Sport Sector Education and Training Authority (THETA), *'...93% of businesses[in the tourism sector] ...do not have a company HIV/AIDS policy and 92% of employers...have not provided any HIV/AIDS-related training for their employees...'[38, pg3].* Ketshabile's (2010) research study on tourism accommodation companies in Botswana (including hotels, lodges/camps and guesthouses) found similar results to the THETA study in that a large proportion of companies did not have HIV workplace policies. Ketshabile concluded that it was only when tourism companies experienced the impact of HIV and AIDS, eg through loss in profitability, were they more likely to have an HIV workplace policy than those who did not experience the impact[39]. HIV workplace guidelines have been developed through private-public partnerships with international business organisations, such as The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) and the International Hotel and Restaurant Association (IHRA), and local Non-Governmental Organisations (NGOs) for use in the tourism and hospitality industry[33, 35, 36, 40]. See Appendix 1 for further detail and more examples of international interventions.

Linkages between HIV transmission and the tourism sector have been recognised at the international level, through studies and interventions mentioned above. What these examples suggest is there are certain common factors fostering uptake, eg resources, in particular financial and technical, being available to develop and adopt such HIV practices. This study examines this question in the TT context. It explores why hotels in TT adopt (or not) HIV practices. In addition to interviewing hotel owners/managers the researcher also interviewed representatives of hotel and tourism associations (HTAs) in order to understand their views and concerns about the effect HIV has on the tourism sector.

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storage and communications; 5% construction and 42% other; hotels and restaurants are included in the 'other' 42% of total businesses. The researcher was unable to ascertain the exact percentage of businesses that constituted hotels and restaurants. (Bloom et al (2005))

[2] The World Economic Forum (2005) Report: A Global Review of the Business Response to HIV/AIDS 2004-2005 describes, 'informal policies [as being] less comprehensive than formal policies' (Bloom, D et al (2005))

2.2. CARIBBEAN REVIEW

The Caribbean region is made up of 34 nations[3] and territories[4] [41, 42] (See Figure 2.1). They can be divided according to independent island states, mainland countries in Central America and South America, Spanish speaking, Netherlands Antilles and Aruba, United Kingdom (UK) territories, United States (US) territories and the French departments.

Figure 2.1: Map of the Caribbean

Source: Trans Caribbean HIV/AIDS Research Institute http://www.tchari.org/default.asp

Countries in the Caribbean region differ substantially according to economic indicators. Table 2.1 gives a comparison of some of the region's nations in 2010[43]. As an independent state TT ranks the second highest with respect to regional GDP. Haiti is the poorest country in the Western Hemisphere having a GDP per capita of US$1,200 while the Bahamas, whose economy is based on tourism and offshore banking, has a GDP of US$28,700 per capita[43]. The region's nations are economically dependent on one or more of the following: agriculture, finance, and tourism[42]. Exceptionally, TT benefits from an energy-based economy where liquefied natural gas and oil are its chief exports. However tourism in TT is a growing industry accounting for

[3] The terms nation, state and country are used interchangeably to denote countries that were formerly territories and have now achieved independence.
[4] The term territory is a legally administrated, non-sovereign geographic area, which comes under the authority of another government. http://en.wikipedia.org/wiki/Territory

12.8% GDP in 2009[44]. The National Tourism Policy of TT (2010) stated that tourism, directly and indirectly, accounted for 36.9% of the economic activity in Tobago[45].

Table 2.1: Comparison of Gross Domestic Product within Caribbean nations[43]

	Country	GDP per capita 2010 (US$)
INDEPENDENT STATES	Bahamas	28,700
	Trinidad and Tobago	21,200
	Barbados	19,100
	Antigua and Barbuda	16,400
	St Kitts and Nevis	13,700
	St Lucia	11,200
	Dominica	10,400
	St Vincent and the Grenadines	10,300
	Grenada	10,200
	Suriname	9,700
	Dominican Republic	8,900
	Belize	8,400
	Jamaica	8,300
	Guyana	7,200
	Haiti	1,200
DEPENDENT STATES	Bermuda	69,900 (2004 est.)
	Cayman Islands	43,800 (2004 est.)
	British Virgin Islands	38,500 (2004 est.)
	Anguilla	12,200 (2008 est.)
	Turks and Caicos Islands	11,500 (2002 est.)
	Montserrat	3,400 (2002 est.)

2.2.1. CARIBBEAN TOURISM INDUSTRY

Travel and tourism is not confined to the tourism sector; it impacts economically on all sectors including construction, agriculture, education and even health. According to the World Travel and Tourism Council (WTTC), in 2004 the Caribbean travel and tourism industry was predicited to contribute 14.75% of total GDP (US$8.7billion to the industry directly and US$28.4billion for the travel and tourism economy overall) with 15.5% of total employment (814,550 direct industry jobs and 2.4million jobs overall). By 2014 travel and tourism's overall share of GDP and employment is expected to rise to 16.5% and 17.1% respectively[6]. This information is summarised in Table 2.2.

Table 2.2: Caribbean travel and tourism national accounts for 2004 and 2014[6]

	2004 (Estimated)	2014 (Predicted)
Direct and indirect contribution to regional economy GDP (US$million)	28,428.00	58,495.00
% direct and indirect contribution to regional economy of total GDP	14.75%	16.55
Contribution (direct) to industry GDP (US$million)	8,671.10	18,407.00
% contribution (direct) of industry to GDP	4.5%	5.21%
Jobs (direct and indirect) contributing to total regional employment	2,416,500	3,170,600
% jobs (direct and indirect) contributing to regional employment	15.48%	17.06%
Jobs (direct) within industry employment	814,550	1,092,100
% industry jobs of regional employment	5.2%	5.88%

According to several researchers including Grenade (2007), Marsh (2007), Orisatoki et al (2009), Government of the Republic of Trinidad and Tobago(GORTT) (2010), Angulo-Arreola et al (2011), there are major regional concerns by national policy officials relating to the tourism sector including issues of security, crime, use and sale of illegal drugs, sex work and HIV [11, 45-48].

2.2.2. CARIBBEAN'S MOSAIC HIV EPIDEMIC

Variations in the Caribbean's cultural traditions, languages, and economic development are reflected in the differing HIV national epidemics[42, 49]. In 2009, UNAIDS estimated the Caribbean adult HIV prevalence to be 1.0%, second only to sub-Saharan Africa[9]; there were approximately 240,000 PLHIV (with three-quarters living in the Dominican Republic (DR) and Haiti), 17,000 new cases and 12,000 deaths from AIDS[9]. The main mode of transmission was unprotected heterosexual intercourse, predominately paid sex[41]. Other modes of transmission included risky sex among Men who have Sex with Men (MSM) and unsafe Injection Drug Use (IDU). (IDU is primarily a concern in Puerto Rico and Bermuda)[42, 49]. The Caribbean epidemic is largely fuelled by factors of stigma and discrimination, multiple partners, high mobility, high levels of poverty and unemployment, homophobia, early initiation of sexual activity, sex tourism, gender and other inequalities[20, 41, 50, 51]. The accompanying MARPs include SWs, mobile and migrant populations, youth, prisoners, MSM, and women [41, 49, 52-56]. Additionally there are more female PLHIV than male; in 2009 53% PLHIV were female[9].

In 2000 Marquez quoted the World Bank in describing the Caribbean as having *'not a single HIV/AIDS epidemic, but a mosaic of epidemics.'*[4, pg8]. Generalised epidemics exist in Haiti, Bahamas, Barbados, the DR and Guyana; concentrated epidemics in Jamaica and TT, and in other countries the epidemics were either nascent or there was inadequate national surveillance data[4]. Table 2.3 illustrates how the estimated adult prevalence and the MARP rates vary throughout the region. Note that this table does not demonstrate high prevalence rates specifically within the tourism sector but gives data of MARPs known to practice high-risk sexual behaviours within it, ie MSM and SWs. Allen et al (2004) pointed out that in the Caribbean there was no *'obvious correlation between rates of HIV and social and economic indicators'* [57, pg7]. For example Haiti, the poorest independent Caribbean state has a relatively high HIV prevalence rate yet more wealthy countries such as the Bahamas and TT also have relatively high rates (see Tables 2.1 and 2.3).

Table 2.3: National adult (15-49) HIV and MARP prevalence rates in select Caribbean countries

Caribbean Country	Estimated adult HIV prevalence rate (%) (2009)[9]	MARP prevalence rate (%) (2005)[53]
Bahamas	3.1	Data not available
Belize	2.3	Prisoners: 5% (2005)
Haiti	1.9	Data not available
Jamaica	1.7	MSM: 25-30% (2006) SW: 9% (2005)[58] Prison inmates: 3.3% Crack/cocaine users: 8.3% (2005)[41] STI clinic attendees: 3.6% (2007)
Trinidad and Tobago	1.5	Females illicit substance users: 19.7% (2004)[41] MSM: 20% (2003) [49]
Turks and Caicos	1.4[59]	Data not available
Barbados	1.4	Data not available
Guyana	1.2	MSM: 21% (2007)[49] FSW: 27% (2007)[49]
Suriname	1.0	MSM: 18% (2005) SW: 21% (2003)[41]
Dominican Republic	0.9	MSM: 10-13% (2005) Drug users: 5% (2000) FSW: 4.5%-12.4% (2000)[41]
Cuba	0.1	MSM: 5.2% (1988)

HIV illnesses and AIDS-related deaths pose significant challenges to Caribbean public health systems and have the potential to deplete the labour force. According to the Caribbean

Epidemiology Centre (CAREC) (2007) AIDS-related mortality is, *'the leading cause of death among men and women in the Caribbean aged 20-59, accounting for 15.7% and 14.5% of deaths respectively; ... overall AIDS-related illnesses is the fourth leading cause of death among women and the fifth among men'*[51, pg2]. This age group accounts for most of the labour force, including those in the tourism industry. Fortunately, according to Boxill et al's(2004) study in the Bahamas and Jamaica, HIV illnesses and AIDS-related deaths have, '... *not had the impact of reducing the pool of trained employees available for work in [the Caribbean] tourism [sector], as in the case of Southern Africa...'[3, pg57]*.

2.2.3. SUN, SEA, SAND AND SEX – THE CARIBBEAN'S RELATIONSHIP BETWEEN HIV AND TOURISM

The Caribbean is often viewed by visitors as a source of *'sun, sea, sand and sex'* [15, pg126]with the tourism sector being associated with casual sex, frequently unprotected, and drug and alcohol use – factors linked to an increased risk of HIV infection[60]. By extension, when tourists engage in unprotected sex with SWs, hotel workers and other persons in the local population, a bridge may be created for HIV to cross back and forth between the tourists' home country and their destination. There is little literature examining the linkages between HIV and tourism in the Caribbean, or in TT; most existing studies focus on the DR, Jamaica, the Bahamas and Barbados.

HIV was first reported in the Caribbean among gay men who had had sex with North American men, either in the Caribbean or while on travels to North America[57]. Linkages between the tourism industry and HIV transmission in the Caribbean were noted in research studies and reviews by Forsythe et al(1998)[10]; Townsend (2003)[12]; Boxill et al(2004)[3]; Bombereau and Allen (2008)[61]; the HEU/UWI (2009); and Padilla at al (2010)[24]. The Jamaican Tourism Sector HIV Workplace Policy identified factors which point to the tourism industry's vulnerability to HIV[62, 63]. However Boxill et al (2004) quoted Boxill (2003) where the author advised caution when attempting to make this linkage between HIV and tourism, *'...the question we have to ask ourselves is whether or not HIV/AIDS infection rates are more prevalent in these areas because they are tourism areas, because tourism promotes a certain type of behaviour, or is it that people with HIV or AIDS are coming to tourist areas?'[3, pg10]*

Sexual services within the tourism industry do not only entail sex between a tourist and a SW for monetary exchange but also includes transactional relations, where romance may occur. Even though sexual exchanges are predominately with young local females, there is also that share of Caribbean men as sex providers to women tourists[64], as with the 'beach boys'of Barbados, the 'rent-a-dread' of Jamaica and the 'trabajadores sexuales'[5] in the DR[24, 60]. Here transactions (may) involve more than physical exchanges, and SWs often play multiple roles including holiday companions and tour guides[60].

Bombereau and Allen's (2008) review of the social and cultural factors driving the HIV epidemic in the Caribbean, illustrates that SWs are vulnerable due to the financial power of the tourists. Sex workers are usually of lower economic status than the tourists and are willing to have sex (including sex without a condom, anal or group sex) for either money or material goods[61, 65]. Padilla (2010) also discusses that sex work between locals and tourists is preferred to that between locals and other locals because of the perception that tourists have a greater economic value[24].

In Jamaica Boxill et al (2004) reported that 17% of tourists had sex while on vacation with Jamaican nationals or SWs during their visit to the island and fewer than 50% of the aforementioned tourists used a condom. Similar results were found in the Bahamas where 23% of tourists had sex with Bahamian nationals or SWs and 70% of these tourists did not use a condom[3]. Figueroa (1995) reported that the highest prevalence rates in Jamaica were in the tourist area of Montego Bay (parish of St James), and in the capital Kingston (parish of Kingston and St Andrew). Additionally, MARPs include SWs whose customers were mainly local men as well as tourists to Jamaica[19]. In 2003, UNDP reported that the highest prevalence rates in Jamaica were still in '*the parish of St. James and the parish of Kingston and St. Andrew, where the prevalence rates were 2.47% and 2.09% respectively. Other parishes ranged between 0.85% and 1.67%'*[66].

Lacharme et al (2002) administered a behavioural survey to 240 tourism workers including those working in hotels, bars and on the beaches on Saint Andrew, the Colombian island in the

[5] Rent-a-dread and trabajadores sexuales are men who engage in transactional sex usually with foreign women. Rent-a-dread: term usually used for young men, in Jamaica, who wear a distinctive hairstyle of long uncombed and matted 'locks'. Trabajadores sexuales is a Spanish term for sex worker. Beach boys defined in footnote #27.

Caribbean. The results revealed *'frequent sex with tourists, predominance of unsafe sex practices, and frequent combination of unprotected sex and substance abuse'*[67].

Tourism as a focal sector, through mobile and migratory populations (a recognised vulnerable group in the Caribbean) has been included in the second Caribbean Regional Strategic Framework (CRSF) 2008-2012. The strategic objective is, *'to scale up the HIV/AIDS response throughout the tourism sector'*, with expected national results being that '*(a)Caribbean countries have adopted and implemented HIV workplace policies and programmes in the tourism and/other sectors and (b)programmes to raise awareness and improve prevention throughout the tourism and/or other sectors have been developed and implemented'*[53, pg29]. Padilla (2009) also indicated internal migration to areas of high tourism for reasons of employment, in the DR [24].

Additionally, CAREC (2003) reported that the countries/islands with *'tourism dependant economies are among the most affected in terms of HIV seroprevalence and reported AIDS incidence'*[20, slide9]. These included the Bahamas, Barbados, Bermuda, the DR, Turks and Caicos, Jamaica, St Maarten/St Martin and Tobago. Finally microbiological evidence linking HIV and tourism through global migration is noted by Gittens et al (2001) who found an association between HIV-1 types in Barbados and Trinidad and countries in Europe[21]. Camara (2003) also noticed the *'same HIV Clade B strain [was found] in both North America and the Caribbean'*[20, slide4] as compared to different strains in other global regions.

2.2.4. CARIBBEAN POLICY – RESPONSES TO HIV AND TOURISM

Globally, the Caribbean is economically one of the most tourism dependant regions[3-5]. Since many of these small island states with their fragile economies are dependent on tourism they are reluctant to draw attention to the crisis of AIDS for fear this might deter tourists [10, 11]. This is exactly what happened in the early 1980s, when it was established that a number of the early HIV cases in the US occurred among Haitian immigrants or those travellers recently returning from Haiti; people were quick to associate this new problem with Haiti[12]. Dr Jean Pape of the Haitian Study Group on Opportunistic Infection and Kaposi's Sarcoma (GHESKIO), is quoted as saying, *'The tourism industry died. Nobody wanted to come here.'*[68, pg470].

Prior to 2007, there were few direct interventions to prevent and control HIV within the Caribbean tourism sector and limited evaluation systems existed for these interventions[65]. Following are some interventions of exceptional note. Kerzner Holdings which owns the Atlantis Resort in the Bahamas, partners with the Bahamian government, the Bahamian AIDS Secretariat and the Bahamian AIDS Foundation to raise money and increase awareness of the HIV epidemic. In November the Atlantis Resort prepares and reminds hotel employees of World AIDS Day and, working with the Bahamian AIDS Secretariat and the Bahamas AIDS Foundation, hosts HIV awareness programmes for all hotel workers[34, 65]. The Atlantis Resort continues to be actively involved in community HIV-related activities and hosted the 2011 Caribbean HIV/AIDS Conference.

In 1994 Sandals Resort Montego Bay, part of the larger Sandals groups of hotels, developed an HIV workplace programme after one of its workers died from an AIDS-related illness. This workplace programme has been adopted by Sandals Hotels across the Caribbean[65, 69, 70]. Sandals Montego Bay conducted HIV and AIDS awareness for its new staff, on-going sessions for existing staff and sessions in the neighbouring communities from which most of its staff are recruited. Sandals Negril and the Negril Chamber of Commerce received HIV sensitisation training and then worked to improve HIV awareness among out of school youth in the neighbouring areas through a multi-sectoral response. This project included the National AIDS Programme (NAP), Jamaica AIDS Support for Life, HEART Vocational Training Programme and the media[71].

Boxill et al's (2004) research in Jamaica and the Bahamas interviewed 15 hotel Human Resource (HR) managers in each country. In this study HIV practices within the hotels included HIV awareness seminars using national AIDS coordinating agencies and other HIV NGOs together with HTAs and tourism government agencies at both health fairs and regular staff meetings[3]. In the DR, there was a United States Agency for International Development (USAID) project involving HIV awareness sessions and condom distribution to tourism employees; this project ended in 1998 as funding became unavailable[72]. A 2009 review by the Health Economics Unit of the University of the West Indies (HEU/UWI) in 2009 reported that HIV awareness programmes targeted towards the tourism sector by national AIDS programmes and local NGOs in collaboration with the Ministry of Tourism also exist in St Lucia (geared towards tourism staff workers) and Barbados (geared towards high-risk groups such as MSM and SWs)[70]. The WEF

2004-2005[6] Review indicated that 6% of the Caribbean workplace policies included provision of condoms; the researcher was unable to ascertain if this included tourism sector workplace policies[37].

The Quality Tourism for the Caribbean (QTC) project (1999-2003) implemented by CAREC, was originally created *to 'establish and promote quality standards and systems designed to ensure healthy, safe and environmentally conscious products and services',* [65, pg38] to the Caribbean tourism sector but then expanded to include the development of HIV workplace policies and programmes[65, 73]. This project produced three items specifically for the Caribbean tourism industry: HIV/AIDS Policy Guidelines; an HIV/AIDS Education Train-the-Trainer Manual; and an HIV/AIDS Education Video. Due to a lack of funding this project ended in 2003, however the manual and video are still being used by the region's tourism industry, eg TT Tourism Development Corporation and Coco Reef Resort, Tobago.

The International Labour Organisation (ILO) in partnership with the US Department of Labor(USDOL) launched the International HIV/AIDS Workplace Education Programmes in several Caribbean countries including Barbados (2003-2008) and TT (2005-2008). Out of the TT programme, two hotels developed HIV workplace policies[7]. In Barbados workplace policies were developed at the Amaryllis Beach Hotel, Blue Horizon, Time Out at the Gap and the Savannah Hotel[74].

Pan Caribbean Business Coalition to Fight HIV/AIDS in the Caribbean (PCBC) was launched in 2005 and aimed to disseminate HIV information and prevention and control guidelines and model policies that can be adapted by the business community. Five Coalitions were created in Barbados, Belize, Guyana, Jamaica and Suriname[40, 65].

The UK Department for International Development (DFID) supported a project (2007-2009) with the Caribbean HIV/AIDS Alliance (CHAA), in Barbados and Jamaica, which targeted actors in the tourism sector and health governmental agencies[65]. Out of this project the Barbados HTA developed *'A Toolkit for Workplace HIV Health & Wellness Programming in the Tourism*

[6] See note 1
[7] At the time of this study one hotel was awaiting management approval.

Sector' [75] and the CHAA a *'Toolkit of HIV& AIDS and Responsible Tourism Models in the Caribbean'*[71] and *'A Compendium of Best Practice Case Studies'*[76].

The Jamaican Tourism Product Development Company (TPDCo) led the development of the Jamaican Tourism Sector HIV/AIDS Workplace Policy (2007) – the only policy of its kind in the Caribbean – and a Workplace Programme on HIV/AIDS [63, 70, 76]. TPDCo, working with the Jamaican NAP distributed condom vending machines to tourism establishments, held HIV awareness workshops in hotels, developed a peer educator training manual, and encouraged and provided Voluntary Counselling and Testing (VCT) training to health and human resource officers in the tourism sector[69]. TPDCo, the Jamaica Business Council on HIV and AIDS and the Jamaican HTA worked together with senior hotel managers as part of a private-public partnership to raise awareness about HIV and AIDS and the development and adoption of HIV policies and programmes in the tourism sector [76].

In 2009 the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) (See Appendix 2) developed an HIV Anti-Stigma Toolkit for the Tourism Sector. The aim of this toolkit was to help employers and employees in the tourism sector to understand how stigma and discrimination (S&D) act as barriers to effective HIV programming and policy-making and to explore strategies to overcome these challenges[77]. Boxill et al's (2004) research in Jamaica and the Bahamas pointed out that most HR interviewees had a policy of non-discrimination towards HIV-positive staff at their hotel, and would still hire them once they were able to carry out their work. However one interviewee in the Bahamas stated that they would not hire a prospective employee that was HIV-positive, *'...it was too much headache...'*[3, pg55]. The WEF 2004-2005 Review indicated that, *'...20% of Caribbean firms [in this survey] prohibit disclosure of HIV status'*[37]. Some Caribbean hotels in the DR [10, 72] and Jamaica [70] reported testing of employees, despite legislature indicating that HIV- testing was illegal.

Another important HIV practice in hotels, though indirect, is that of non-fraternisation between guests and staff. Such interaction was reported to lead to immediate dismissal of the employee in Boxill et al's research (2004) in Jamaica and the Bahamas. Even though this practice was enforced while the employee was on the hotel property, it was recognised that hotel management had no control over this practice once both guest and employee were off-property[3].

Interventions which target tourists directly have been few in the Caribbean. One example occurred in 2002 when Barbados adopted a *'warning welcome'*[11, pg8]. This took the form of a leaflet given to tourists at the airport, from the then Prime Minister, advising them about the country's HIV epidemic. This has since been discontinued due to negative response from the tourists[11]. A regional intervention which indirectly targeted tourists was suggested for adoption during the 2007 Cricket World Cup held in the Caribbean. The legalisation of sex work, in order to *'regulate the women and men [and therefore, to curtail the possible] spread of HIV...'* was suggested by the Health Minister from Antigua but opposed by his colleagues from Barbados and St Kitts and Nevis[11, pg19]. The thesis researcher concludes that regional governments opposing this recommendation, apart from not wanting to be seen as condoning sex work and homosexuality on moral grounds, were fearful of HIV deterring future visitors. This double-edged sword of wanting to increase visitor arrivals while simultaneously protecting tourists and the local population from a global disease which can cross international borders has been a dilemma for government agencies and private-sector companies alike. In Jamaica, there is a perception within the industry that adoption of the HIV/AIDS practices will result in deterring tourists from visiting the island[70] and in the DR policymakers have held a long standing, *'...fear of contaminating the industry with unappetizing references to HIV/AIDS...'*[24, pg75].

2.3. TRINIDAD AND TOBAGO CONTEXT

2.3.1. OVERVIEW

Trinidad and Tobago is the southernmost country in the Caribbean: one country – two islands (see Figure 2.2). Each island has separate and distinct tourism products. Trinidad, the larger of the two islands and whose economy is dominated by its natural gas and oil reserves is the more *business*-visitor orientated island whereas Tobago, with its whiter sands and abundance of flora and fauna is the more *leisure*-visitor oriented island. Trinidad and Tobago gained independence from Britain in 1962, and in 1976 became a republic within the British Commonwealth[78]. Figure 2.3 gives a pictorial representation of the differing tourism products offered by each island.

Figure 2.2: Map of Trinidad and Tobago

www.vidiani.com

Figure 2.3: Trinidad and Tobago: one country – two islands

The twin-island republic is governed by a democratically elected government through the Office of the Prime Minister. However Tobago has some powers of self-governance under the Office of the Chief Secretary through its Tobago House of Assembly (THA). Although the country has an appointed President, overall executive power is held by the Prime Minister and his/her parliamentary representatives[78]; in Tobago executive power of the THA is held by the Chief Secretary who is collectively responsible for the effective functions of the Divisions[8]. In the context of this study the most important Ministries and Divisions are listed in Table 2.4.

Table 2.4: Ministries and Divisions in Trinidad and Tobago most relevant to this study

Sector	Ministry (Trinidad and Tobago)	Division (Tobago)
HIV	Office of the Prime Minister	Office of the Chief Secretary
Health	Ministry of Health	Division of Health and Social Services
Tourism	Ministry of Tourism	Division of Tourism and Transportation
Labour	Ministry of Labour and Small and Micro Enterprise Development	Not applicable for this study

Trinidad and Tobago has a total area of 5,128km^2 and a population of approximately 1.3 million[79]; Tobago, the smaller (300 km^2) of the two islands has a population of approximately 52,000[50]. A diverse cultural background is the result of many ethnic groupings, mainly Indian and African, with predominant religions being Catholic and Hindu[43]. Besides petroleum and liquefied natural gas exports, TT is a leading supplier of manufactured goods such as food, beverages and cement to its Caribbean neighbours as well as a financial centre and a growing tourism sector.

2.3.2. CARNIVAL IN TRINIDAD AND TOBAGO

The greatest number of visitor arrivals occur during TT's annual Carnival; between 2000-2008 the Ministry of Tourism recorded an annual average of approximately 39,000 visitor arrivals[9] during the two weeks preceding Carnival celebrations[80]. It is important to note that non-nationals and returning nationals living abroad partake in the celebrations including that of

[8] Divisions in Tobago are similar to Ministries in Trinidad; however Ministries provide overall policy direction for the entire country.

[9] Even though visitor arrivals include both non-nationals and returning nationals living abroad both are considered foreign tourists as their usual place of residence is outside of TT. The researcher was unable to locate reliable statistics of what percentages, of each group, were actually non-nationals and what percentage stayed in hotels during their visit.

heavy alcohol use, and anecdotally, risky sexual behaviour[50]. Carnival is the largest national festival in the country with the season beginning on Boxing Day and ending with a street festival the Monday and Tuesday before Ash Wednesday. Celebrations have been described as, *'...two months of cultural events, highlighting rhythmic music, drinking and festivities [which] culminate in a 2-day street parade of spectacular costumes, revelry and euphoria. This 2-day period is almost universally regarded as a time during which the liberation of [sexual] inhibitions and violation of social norms are acceptable...'*[50, pg2]. The festival is celebrated in most towns and villages across the two islands where hundreds of thousands of people flock to the streets, either in costume or as spectators. Because of the close link between increased visitor arrivals, abandonment of sexual inhibitions and HIV, Carnival is a time when both hotel, and other tourism, workers are targeted with increased HIV prevention activities by government and NGOs, eg, increased distribution of condoms and information pertaining to safe sexual practices. Figure 2.4 gives a pictorial representation of some aspects of TT Carnival.

Figure 2.4: Carnival in Trinidad and Tobago

2.3.3. HIV AND AIDS IN TRINIDAD AND TOBAGO

The first known case of HIV in TT was in 1983 among the MSM population[50, 81] however the main mode of transmission is now unprotected heterosexual intercourse[8, 50, 78, 82]. The HIV prevalence rate has increased slightly from 1.2% in 2006 to 1.5% in 2009 with a cumulative (1983 to 2009) total of 6,208 AIDS cases and 3,845 AIDS-related deaths. Even though the actual number of new infections is decreasing (see Table 2.5) the increase in prevalence rate is due to PLHIV living longer as a result of the free treatment programme instituted throughout the twin-island republic.

Table 2.5: Cumulative HIV, AIDS cases and deaths 1983- September 2009 in Trinidad and Tobago[8]

	2007	2008	2009[10]	Cumulative total 1983-2009
New HIV infections	1,404	1,448	859	20,255
AIDS cases	161	93	85	6,208
AIDS-related deaths	114	81	37	3,845

The exact adult HIV prevalence rate for Tobago varies even though it is believed to be significantly higher than the national figure. In 2010, the Tobago rate was reported as 2.6% and 3.5% by two separate researchers[50, 83]. Anecdotal evidence has attributed the *'dramatic increase in HIV infection [in Tobago] to the advent of sex tourism...prostitution... pornography...Tobago culture [of multiple sex partners]'*[84, pg1]. In 2009, based on HIV testing at the Health Promotion Clinic, the main treatment centre in Tobago, the estimated adult prevalence rate was 2-3%; antenatal clinic attendees gave a rate of 2.5% and community outreach testing (which offered an incentive prize to be tested) found 6 out of 290 (2.1%) persons to be HIV-positive[85].

In 2000, the World Bank reported that TT had a concentrated epidemic (see section 2.2.2) but currently this has changed to a generalised epidemic. The TT National AIDS Strategic Plan (NSP) 2004-2008/10[11] described the MARPs as being SWs, MSM, women, youth, children, migrants and low-income workers. However in 2009, as a result of the limited research or surveillance data on MARPs, and some of them having high prevalence rates (see Table 2.3), the National

[10] These figures cover January 1 to September 30 2009 only.
[11] After 2008, the TT NSP was extended to 2010. See section 2.3.5

AIDS Coordinating Committee (NACC) indicated the possibility of the country having both a generalised and a concentrated epidemic[8, 22]. Research reported in the 2010 TT United National General Assembly Special Session (UNGASS) Report gives the results of four studies on the MARPs throughout both islands[8]. (see Appendix 3 for further information). The following key patterns from the different studies emerged:

- Most of the MARPs interviewed were not having safe sex;
- Substance users and homeless persons participate in sex work;
- Research specific to Tobago showed that male condoms are easily accessible;
- Research specific to Tobago also indicated that among MSM and SWs, knowledge of how HIV was transmitted was low and even though use of condoms as a preventative measure was widely known, condoms were used inconsistently.

Most At Risk Populations in these studies included SWs, MSM, youth and substance users. While the category ' tourism workers' was not included, those employed in the tourism industry may or may not be part of one or more of these MARP groups, eg a tourism worker may also partake of sexual relationships with foreign tourists for additional income. Even though these conclusions are drawn from different studies there is the possibility that foreign tourists may be practicing risky sex with the MARPs. Additionally, in 2008, it was estimated that two-thirds of the tourism employees in Tobago were women[45]; this may also have some bearing on the relationship between financial constraints and sex work.

2.3.4. DETERMINANTS OF THE HIV EPIDEMIC

Barnett and Whiteside (2002) categorised the proximal and distal determinants of an HIV epidemic in terms of: '*macro-environment (wealth, income distribution, culture, religion and governance), micro-environment (mobility, urbanisation, access to healthcare, levels of violence, women's rights and status), behaviour (rate of partner exchange, prevalence of concurrent partners, sexual mixing patterns, sexual practices and condom use, breast feeding), and biology(virus sub-types, stage of infection, presence of other STDs, gender, circumcision)'* factors [86, pg78].

The TT NSP 2004-2008/10 has broadly listed the determinants of the HIV epidemic in each island, and the researcher has analysed these using the Barnett and Whiteside classification in Table 2.6[22, pg6]. The TT NSP did not define any of the most proximal determinants in the

category of biological and behavioural determinants that were seen to be fairly consistent in both islands. Given that the main mode of transmission in the country is unprotected sexual intercourse[8], the determinants listed under this category, in particular sexual networking, are not surprising. What is interesting to the thesis researcher is that inconsistent condom use only appears as a behavioural determinant in Trinidad and not in both islands, especially as the estimated HIV prevalence rate in Tobago is much higher than the national average. The more distal determinants of HIV transmission are reflected in the wider context of the social, economical and cultural environment of the individual and are often inter-related [87] . For example, legal prohibitions of homosexual acts can often result in gay men entering heterosexual relations to disguise their sexuality. Self-stigma by gay men may exacerbate violence between males and females. In examining the marco- and micro-environmental determinants, given that TT has exhibited a rising number of female HIV incident cases, it is not unexpected that issues of gender, on both islands, have been identified as determinants of HIV transmission. The thesis researcher notes that this rise in female PLHIV may also be the result of the greater biological susceptibility of women to HIV transmission.

Table 2.6: Analysis of the distal and proximal determinants of the HIV epidemic in Trinidad and Tobago using Barnett and Whiteside's classification

	Distal determinants → **Proximal determinants**			
ISLAND	**MACRO-ENVIRONMENTAL**	**MICRO-ENVIRONMENTAL**	**BEHAVIOURAL**	**BIOLOGY**
TRINIDAD	• Legal prohibitions, in particular homosexual acts	• Increased levels of violence among males and between men and women • Gender inequality especially among those of lower economic status • Regional and extra regional mobility especially around holiday and festivals • Stigma and discrimination	• Substance and alcohol use • Commercial sex work • Sexual networking • Inconsistent condom use	NONE WERE SPECIFIED IN THE NSP
TOBAGO	• Lack of coordinated HIV response targeted to Tobago's particular situation	• Unemployment especially among youth • Inability of women to change cultural norms regarding child rearing and multiple partnering • Increasing expatriate population • Stigma and discrimination	• Substance and alcohol use • Commercial sex work	NONE WERE SPECIFIED IN THE NSP

Source: Trinidad-University of the West Indies (2001). Tobago-University of the West Indies (2002)

2.3.5. TOURISM IN TRINIDAD AND TOBAGO

According to the WTTC, in 2010 total travel and tourism in TT accounted for US$2.5billion (10.9% of the country's GDP), with a forecasted rise to 12.7% in 2020. Total travel and tourism employment is also expected to rise from 95,000 jobs (15.1% of total employment), as reported in 2010, to 129,000 (17.6%) in 2020[7]. Ministry of Tourism 2009 figures suggest that Tobago has a particularly tourism dependent economy accounting, directly and indirectly, for 36.9% of its economic activity and approximately 14,000 jobs(47.6% of all those employed) on the island[45]. Table 2.7 gives a comparison of the regional tourism indicators. Even though TT's percentage GDP of tourism and related employment figures are lower than Jamaica, St Lucia, or Barbados, among these countries TT is predicted to have the largest tourism growth.

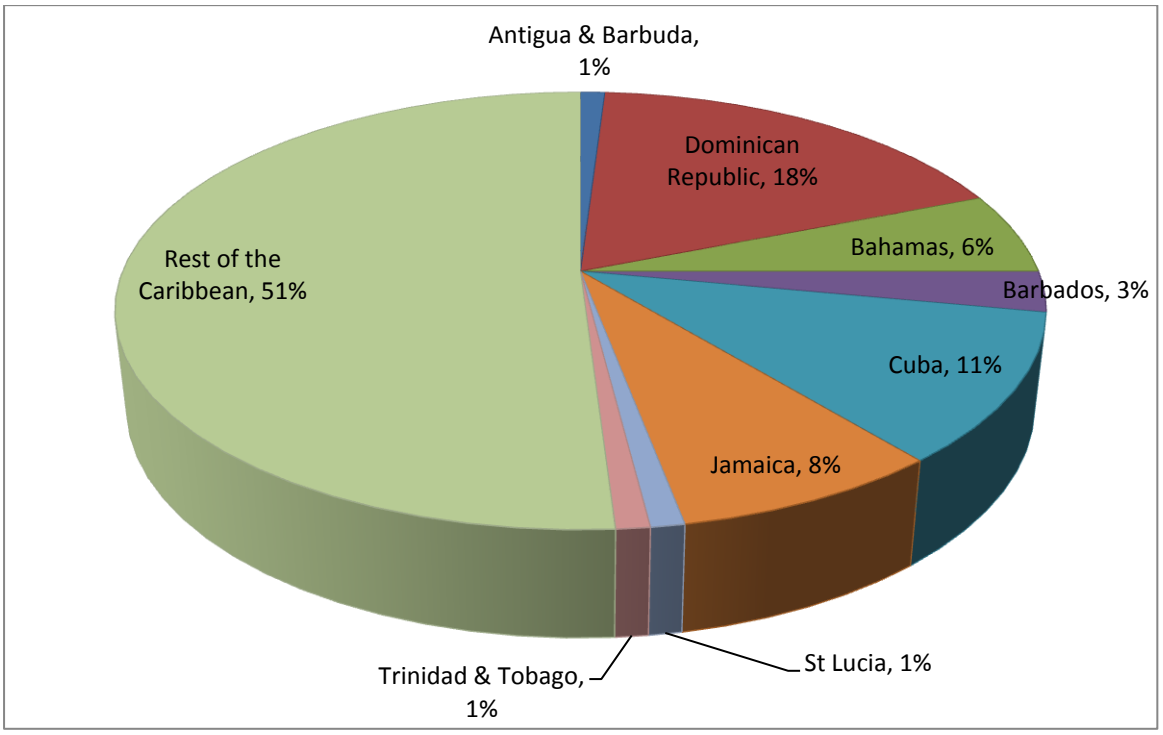
Table 2.7: Regional comparison of tourism indicators

	Total travel and tourism as % GDP[12] (2009)	**Total travel and tourism as % GDP (Predicted 2019)**	**Average % GDP growth per annum over next 10 years[13] (2009)**	**Total travel and tourism employment as % total employment[14] (2009)**	**Total travel and tourism employment as % total employment (2019)**
Trinidad and Tobago[15]	12.8	13.9	4.1	16.2 (98,000 jobs)	17.5 (123,000 jobs)
Jamaica[16]	27.0	30.4	3.4	23.7 (276,000 jobs)	26.9 (351,000 jobs)
St Lucia[17]	37.4	42.1	3.9	37.1 (26,000 jobs)	42.2 (35,000 jobs)
Barbados[18]	39.0	40.6	3.2	43.7 (61,000 jobs)	46.2 (71,000 jobs)

[12] GDP contribution from all sectors contributing to travel and tourism.
[13] Predicted annualized real GDP growth, from all sectors, over the next ten years (from 2009).
[14] Employment contribution from all sectors contributing to travel and tourism.
[15] World Travel and Tourism Council, *Travel and Tourism Economic Impact Trinidad and Tobago 2009*. 2009, World Travel and Tourism Council
[16] World Travel and Tourism Council, *Travel and Tourism Economic Impact Jamaica 2009*. 2009, World Travel and Tourism Council
[17] World Travel and Tourism Council, *Travel and Tourism Economic Impact St Lucia 2009*. 2009, World Travel and Tourism Council
[18] World Travel and Tourism Council, *Travel and Tourism Economic Impact Barbados 2009*. 2009, World Travel and Tourism Council

Trinidad and Tobago accounts for only 1% of the visitor arrivals to the Caribbean and attracts visitors who spend proportionately less (see Figure 2.5). In 2007 the average expenditure per visitor to TT was only US$1,031 as compared to Barbados which was US$1,717[45].

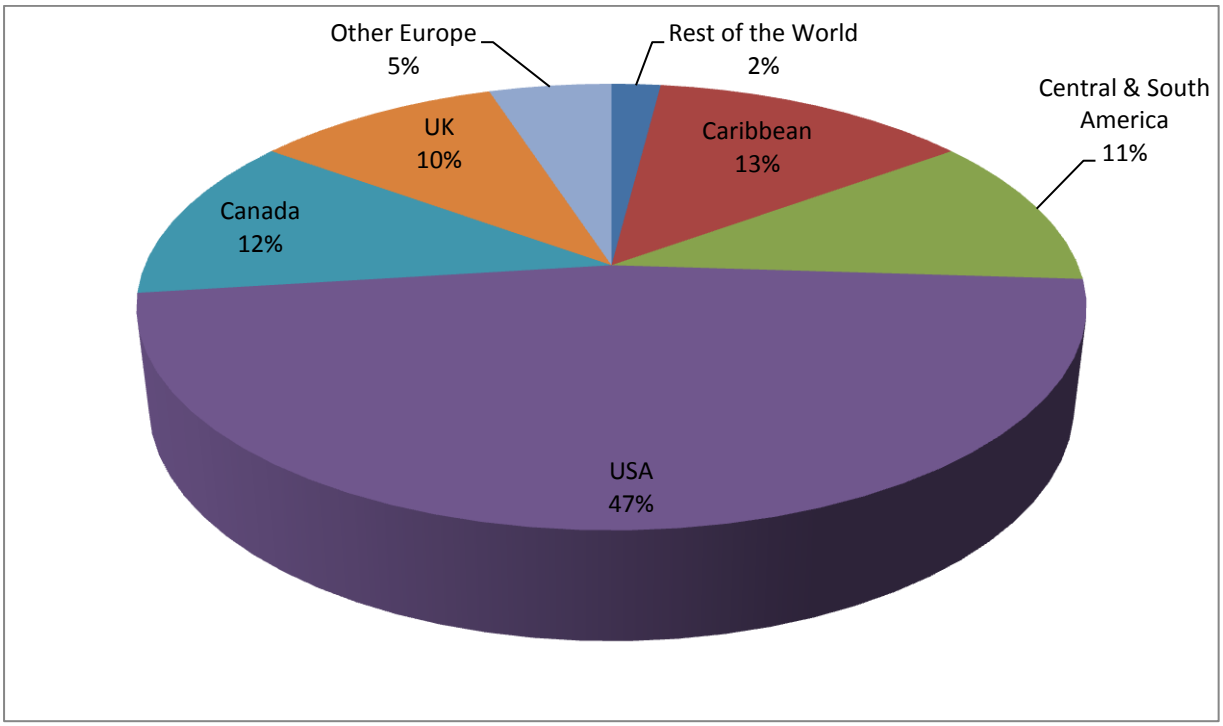
Figure 2.5: Share of tourism arrivals to select Caribbean countries in 2009



Source: Caribbean Tourism Organization, 2009[45, pg9]

The visitor market to the two islands differ; those to Trinidad being the business visitor and nationals living abroad, their friends and relatives mainly from North America and the Caribbean. Foreign visitors to Tobago are mainly from UK (73% of international arrivals) and Europe. Tobago is also visited as holiday getaway for local Trinidadians, especially during the school holiday months. Figure 2.6 shows that across both islands, the largest share of visitor arrivals is from the US, followed by the Caribbean[45].

Figure 2.6: Tourism arrivals to Trinidad and Tobago by country in 2009



Source: Caribbean Tourism Organization, 2009[45, pg13]

The Trinidad and Tobago Hotel and Tourism Association (TTHTA) has two branches – the Trinidad Hotels, Restaurants and Tourism Association (THRTA) and the Tobago Hotel and Tourism Association (THTA). The TTHTA was formed as the main link between the government policy makers in the Ministry of Tourism and its implementers, the Tourism Development Company (TDC). It is important to note here that not all hotels are mandated to be members of the either the THRTA or the THTA.

Most hotels and other accommodation properties in TT are locally and privately-owned[45]. In Trinidad, while most properties are small to medium sized, there were four large *'internationally-branded and managed'* [54, pg27] hotels. In Tobago, 68% of the rooms can be found in smaller hotels[45]; on this island no internationally-branded or government-owned hotels presently exist. Further detail can be found in the methods chapter.

2.3.6. POLICIES AND PROGRAMMES IN RESPONSE TO HIV AND AIDS IN TRINIDAD AND TOBAGO

Policies and programmes responding to the HIV and AIDS epidemic in TT cut across ministries: Ministry of Health, Office of the Prime Minister, Ministry of Legal Affairs, and Ministry of Labour, Small and Micro Enterprise Development (MLSMED). Those policies and programmes within the Ministry of Tourism and their relevance to HIV will be discussed in section 2.3.7. Additionally, in 2006, the GORTT has developed a Vision 2020 NSP[88] for all sectors of the country. Recognising that AIDS was a threat to the nations' workforce, the Vision 2020 Operational Plan 2007-2010, under Goal No. 5 states, *'The HIV/AIDS epidemic will be contained and care will be provided for those infected and affected'*[89, pg64].

Ministry of Health: The initial government response to the TT HIV epidemic was the formation, in 1986, of the NAP within the Ministry of Health. In 2009 an HIV and AIDS Counselling and Testing Policy was developed[8]. Under this policy rapid testing and VCT is available at 28 sites throughout the country, some which include same day results. Since 2002 free Anti-Retroviral (ARV) treatment has been available at seven locations including two centres in Tobago [8, 50, 78]where treatment began in 2003[83]. In 2010 2,434 patients were registered for care and treatment in Trinidad but only 340 in Tobago[83]. In Tobago, the Health Promotion Clinic, initially treated only HIV and AIDS patients but now has an integrated clinic for most illnesses. This clinic which was originally known to the general public as the 'AIDS clinic', has also treated tourists. One aspect of HIV preventative treatment, for the tourism sector is the treatment of tourists with post-exposure prophylaxis medication for those who may have had an indiscriminate, sexual encounter, often without a condom. The clinic would be referred to the tourist through the community of local beach boys. Because doctors still remain fearful of treating HIV-positive patients and the high level of S&D, patients only go to the clinics when they have progressed to AIDS[8]. A National Prevention of Mother-to-Child Transmission (PMTCT) programme exists with HIV testing of pregnant mothers at all public antenatal clinics[78].

Office of the Prime Minister[19]*:* In 2003 the national HIV and AIDS response further developed with the programme being managed by the NACC under the Office of the Prime Minister[8, 22].

[19] Office of the Prime Minister is named as a separate department of government within the Constitution of the Republic of TT.

The NACC also had the responsibility for finalising the 2002 National HIV Policy[90] which at the time of this study was still in draft form. The NACC's activities are guided by a NSP 2004-2008/10 whose priority areas are *'prevention; treatment, care and support; advocacy and human rights; surveillance and research; and programme management, coordination and evaluation'*[22, pg19]. See Appendix 4. In 2006, eight HIV/AIDS coordinators were appointed by the NACC, for assignment to line Ministries of Health; Sport and Youth Affairs; Community Development, Culture and Gender Affairs; Labour and Small and Micro Enterprise Development; Social Development; Local Government; Personnel Department and Tourism (see section 2.3.7) in Trinidad[91]. By 2010 there were only six coordinators including those in Ministries of Health; and Labour and Small and Micro Enterprise Development but not Tourism[8]. The HIV response in Tobago is executed by the Tobago HIV/AIDS Coordinating Committee Secretariat (THACCS) – the Tobago arm of the NACC. The THACCS falls under the Office of the Chief Secretary (equivalent to the Prime Minister) in the THA[85]. The THACCS believed that Tobago had island-specific issues in relation to its AIDS response and therefore developed its own plan of action. During January 2008-December 2009, the NACC and the THACCS experienced extreme staff shortages including the absence of a NACC Director[8].

Ministry of Legal Affairs: There is no specific law that addresses S&D directed towards PLHIV and those suspected of being HIV-positive. The Equal Opportunities Act (2000) of TT broadly addresses issues of anti-discrimination, in particular, those of *'employment, accommodation and the provision of goods and services'*[92, pg948]; but does not directly address HIV. However the 1976 Constitution of the Republic of Trinidad and Tobago, even though it does not include HIV, does not exclude it and can therefore be used as a legal defence by anyone who believes themselves to be discriminated against on the grounds of their HIV status. In an effort to develop HIV legislation there has been a review of the legislation regarding HIV and AIDS discrimination and other human rights infringements. This review was expected to have been completed and presented to the Office of the Attorney General but the thesis researcher was unable to find any evidence as to whether this actually happened[8, 90]. Acts of homosexuality, sex work and drug use are criminal offences in TT and this can hamper effective implementation of prevention interventions among these MARPs[8].

Ministry of Labour and Small and Micro Enterprise Development (MLSMED): The GORTT through its MLSMED implemented a joint GORTT/International Labour Organisation/United States Department of Labor (GORTT/ILO/USDOL) International HIV/AIDS Workplace Education

Programme (2005-2008). One of the major outputs from this project was the development of a National Workplace Policy on HIV and AIDS[54]. This Policy was created to '*set minimum standards for managing HIV in the workplace; promote structures and programmes to reduce discrimination in the workplace against PLHIV or persons affected by HIV; contribute to ongoing national efforts to reduce the spread of HIV infection and mitigate the epidemic's impact; guide employers, managers and employees on their rights and obligations regarding HIV and AIDS; and guide workplace polices and programme development'*[54, pg12]. This Policy is being used by the HIV/AIDS coordinators within line Ministries to develop their sector HIV workplace programmes, educate Ministry staff and also assist in reducing S&D. For example, the Ministry of Education and Ministry of Health have each developed workplace policies; however there is no country-wide approved HIV policy in the tourism sector (either by the industry actors or by the GORTT). A sustainability plan for this Policy has been developed to implement HIV and AIDS workplace policies and programmes in all organisations throughout the informal economy and the formal public and private sectors, including hotels. The government has supported this plan and approved a five-year budget. Even though the Policy was approved by government it is not legally mandatory for companies to have an HIV workplace policy, rather it acts as guidelines to those wishing to develop and implement their own workplace policy[90].

As can be seen by the variety of national policies and programmes there has been international collaboration, through the UN's 'Three Ones' initiative for the development of the NACC and the GORTT/ILO/USDOL International HIV/AIDS Workplace Education Programme. The GORTT has also made substantial progress through their achievements in VCT, ARV and PMTCT programmes. However there still is no final National HIV Policy and the NSP has now ended, after being extended to 2010. In the context of this study the two most important actions have been the appointment of an HIV/AIDS coordinator in the Ministry of Tourism and the development of the National Workplace Policy on HIV and AIDS (these will be further discussed in section 2.3.7). Stigma and discrimination with respect to HIV still need to be addressed at the governmental level, especially concerning the criminalisation of homosexuality and sex work. These last three events and issues have and will directly impact the ability of hotels in TT to adopt HIV practices.

2.3.7. POLICIES AND PROGRAMMES IN RESPONSE TO HIV AND TOURISM IN TRINIDAD AND TOBAGO

There are a myriad of national responses pertaining to HIV and to the tourism sector (see Box 2.1); the extent to which those specifically addressing HIV also address tourism, and vice versa, vary greatly, and in some cases, not at all. As seen in the previous section, 2.3.6, since the first case of HIV was reported in TT there have been many policies and programmes formulated and implemented by different Ministries and non-state actors (eg hotels and NGOs). In this section the researcher will discuss those policies and programmes that pertain to HIV prevention and control in the tourism sector.

Box 2.1: National HIV and tourism policies and programmes with relevance to HIV prevention and control in the tourism sector

- 2000: Tourism Development Act – replaced 1963 Hotel Development Act
- 2002: Tourism Rolling Plan
- 2002: Draft National HIV Policy
- 2003: Revised Tourism Development (Amendment Bill)
- 2004: Trinidad and Tobago National AIDS Strategic Plan 2004-2008/10
- 2004: Occupational Safety and Health (Amendment) Act
- 2006: Draft Vision 2020 National Strategic Plan
- 2006: Tourism Sector HIV/AIDS Support Programme
- 2007: Vision 2020 Operational Plan 2007-2010
- 2008: National Workplace Policy on HIV and AIDS
- 2010: National Tourism Policy

There have been several policies developed for the tourism sector including the Tourism Development Act (2000)[93]; the Tourism Development (Amendment Bill) (2003); and the Tourism Rolling Plan(2002)[94]. The 2000 Act sought to attract investments in the tourism industry but was seen as failing to address health concerns, in particular HIV; it was subsequently amended in 2003. In 2002 the Rolling Plan identified and addressed areas that were previously omitted in the 2000 Act and needed to be dealt with. However the researcher was unable to review a copy of this Rolling Plan and does not know whether it addresses HIV or any other health issues. To date this plan has not been implemented.

Other key GORTT policies pertaining to HIV and tourism are the draft National HIV Policy (2002), NACC NSP (2004-2008/10)[22], Occupational Safety and Health Amendment Act (OSHA) (2004)[95], draft Vision 2020 NSP (2006)[88], Vision 2020 Operational Plan 2007-2010[89], and the National Workplace Policy on HIV and AIDS(2008)[54]. The TT National Tourism Policy (2010) has acknowledged HIV as an important issue and has as one of its socio-

cultural goals, *'...to address issues of drug trafficking, crime and harassment of individuals and the incidence of HIV/AIDS that are critical to both the health of citizens and tourists alike...'*[45, pg22].

The most important national programme in support of HIV and tourism is the 2006 Tourism Sector HIV/AIDS Support Programme (TSHASP)[96]. Using the NACC NSP 2004-2008/10 as the country's overarching response to HIV and AIDS and taking into account the draft Vision 2020 NSP, the Ministry of Tourism created the TSHASP. The overall goal of the TSHASP is *'to increase the number of persons in the tourism sector with "full, correct knowledge of HIV and AIDS" in order to guide them in effective decision making with regard to HIV prevention and control. Other goals include the reduction of stigma and discrimination in the workplace of persons living with HIV and the increase in the number of persons who engage in positive risk reduction and the promotion of safe and healthy behaviour among the targeted population'*[23, pg3]. To date the Ministry of Tourism has worked with the NACC, ILO Subregional Office for the Caribbean, regional and national NGOs, stakeholders in the tourism sector, and the Vision 2020 Operational Plan 2007-2010 to achieve its goal. This programme conducted HIV awareness activities for Ministry of Tourism staff and stakeholders, including the hotel employees[20], from 2006-2008. Due to budgetary challenges during 2008-2009, programme activities were minimal. However renewed funding in late 2009 allowed the programme to continue. There were other HIV and AIDS activities within this programme that did not directly affect the hotels. These included similar sensitisation workshops for Ministry of Tourism staff, tour operators, taxi drivers and other industry members[96]. These activities were conducted with the Trinidad hotels and tourism agencies only; any HIV activities in Tobago would be coordinated by the Tobago arm of the NACC, through the THACCS and the THTA.

In Trinidad, the TDC maintained collaborative efforts with the THRTA and the NACC to conduct HIV and AIDS awareness seminars that allowed hoteliers to better understand how HIV impacted on the tourism sector and how they could protect themselves and their guests against HIV transmission. For example, during Carnival 2006, HIV information call cards and posters were produced by the TSHASP and given to the THRTA to be distributed to the hotels. These call cards were placed in Carnival packages to be distributed to the hotels' guests. In Tobago the THACCS reported that there were informal ad-hoc HIV sensitisation and behaviour change

[20] Cascadia Hotel and Conference Centre, Courtyard by Marriott, Kapok Hotel, Crowne Plaza, Paria Suites, Cara Suites, Trinidad Hilton and Conference Centre, Holiday Inn Express, Bel Air International Hotel, Piarco International Hotel, and Chancellor Hotel.

communication activities with the 'beach boys'[21] (which took place on Store Bay and Pigeon Point beaches) 8-10 years ago, however presently there were no HIV policies in Tobago hotels or elsewhere in the tourism sector. The reason for this, as stated by the then President of the THTA, was because, *'...HIV/AIDS is not seen as impacting the tourism sector significantly ....[HIV is] not seen as a real concern [and priority] for the Association'*[70, pg80].

There have been two major regional activities that affected the TT tourism industry. The QTC project (described earlier in section 2.2.4) held several training sessions with some of the larger hotels (2006 and 2010) in TT in an attempt to develop HIV workplace policies and programmes. Another non-national programme of importance to the tourism industry was the GORTT/ILO/USDOL International HIV/AIDS Workplace Education Programme (2005-2008) which not only produced the TT National Workplace Policy on HIV and AIDS (see section 2.3.6) but also resulted in HIV workplace policies for two hotels (Kapok and Marriott).

Finally the thesis researcher notes that it is the TSHASP, in conjunction with the agency charged with the implementation of the National Workplace Policy on HIV and AIDS through its sustainability plan (see section 2.3.6.), that has the greatest potential to collaborate with the hotels and develop HIV workplace practices targeting staff, guests, and even the surrounding communities from which tourism workers are usually drawn. This will be discussed as part of Objective 4: To recommend strategies in which the present TT HIV policies and programmes can be further supported and enhanced.

2.4. HEALTH POLICY ANALYSIS

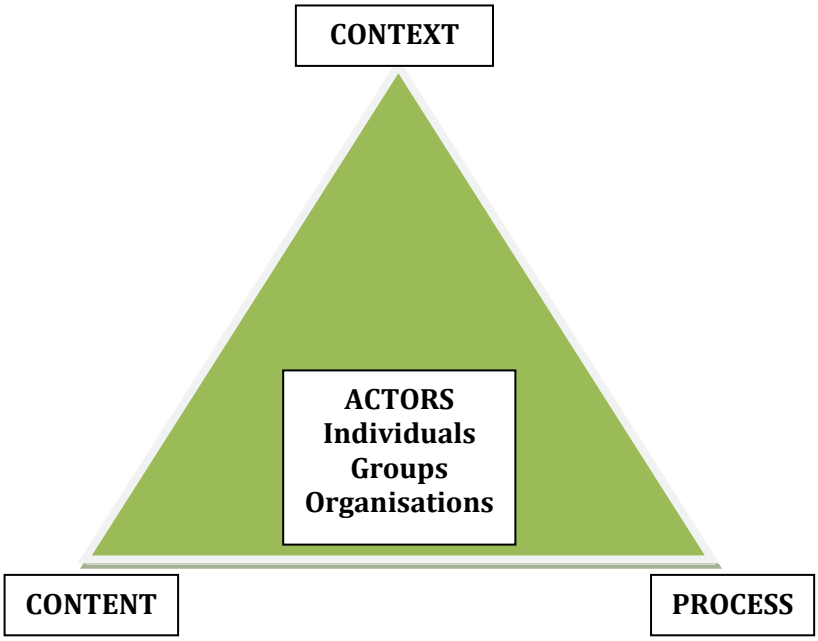
2.4.1. OVERVIEW OF POLICY ANALYSIS

This study adopts a policy analysis approach to its design and analysis. Policy draws on theories of sociology, administration and management, science, economics, anthropology, organisational management and politics[97, 98]. Walt and Gilson's (1994) policy analysis 'triangle' framework (see Figure 2.7) is one of the more commonly used overarching health policy analysis frameworks. This framework examines the four factors of policy *content*, *process, context* and

[21] Beach boys: term usually used for young men who 'work' on the beaches soliciting women for transactional sex.

actors which are intertwined and dependant on one another[1, 97, 98]. Policies can be made by both the public, and private, sector. This thesis research examines aspects of hotels' HIV practices which may be in response to specific government policies and programmes or may have originated from within the hotel, through actions of its management and/or staff independently of government policy.

Figure 2.7: Walt and Gilson's policy triangle[1, pg8]



Actors include groups, individuals and organisations which have an effect on the policy process and may not always have the same views. Actors can be classified as governmental, private sector and civil society organisations. In this thesis research actors included officials at the Ministries of Tourism and Health, hotel owners/managers, HTAs and NGOs working in HIV programmes. Actors may be instrumental in the policy process at national, regional and international levels. Actors such as the HTAs, with the majority of industry members[22] as part of its membership play a pivotal role between government policy-makers and the industry actors. The role of actors within the policy process is not divorced from the notion of power, however due to the limitations of this study, power will not be addressed in this analysis.

[22] Industry members include organisations directly and indirectly involved in the tourism industry, such as hotels, restaurants, tour operators, airlines, taxi operators etc

Expanding on the Walt and Gilson policy triangle, when describing context Leichter's (1979) typology is often used[1, 99]. Here context is described as follows:

- Situational factors: temporary or specific events. Such incidents are referred to as 'focussing events' which may occur once or may take time to be recognised as a priority.
- Structural factors: constant aspects of the environment, eg political, cultural and economic base of the country.
- Cultural factors: values, beliefs and attitudes of the society, eg gender, S&D, and religious beliefs.
- International or exogenous factors: cooperation between regional and international states and organisations.

Policy content is described as the *'substance of a particular policy which details its constituent parts'*[1, pg193]. It is the words and/or diagrams that describe what the policy is intended to achieve and how it will achieve this. The thesis researcher describes the HIV practices adopted by the hotels as policy content, eg HIV sensitisation seminars. Policy content is also used to describe national HIV polices, eg NSP.

The 'stages heuristic', used to describe the policy process, is one of the most common policy frameworks. It separates the process into four stages: '*problem identification and issue recognition; policy formulation; policy implementation; and policy evaluation'*[1, pg13]. This thesis study focuses on the policy implementation stage, and draws on related key literature (see sections 2.4.2-2.4.3). The major limitation with this conceptualisation is that it breaks the process into distinct occurrences that appear to flow one after the next, yet in reality this does not happen. These stages often overlap with their individual importance contingent on the other elements of the policy triangle. The advantage here is that the segmentation is useful for understanding the entire policy process [1, 100].

2.4.2. TOP-DOWN APPROACHES

The top-down model of studying policy implementation is defined by John (1998) as *'an approach ... that stresses the perspective of higher-level bureaucrats and executive decision-making. Policy is decided by the centre. Then lower-level organizations carry it out, or not as the case may be'*[101, pg206]. The top-down approach assumes a rational approach to policy-

making and can be seen quite clearly in the stages heuristic[1, 102]. Various theorists of the top-down approach include Pressman and Wildavsky(1973), Van Meter and Van Horn(1975), Bardach(1977), Gunn(1978), Sabatier and Mazmanian(1979) and Hogwood and Gunn(1984) [102]. Pressman and Wildavsky (1984)[23], postulated that the *'key to effective implementation lay in the ability to devise a system in which the causal links between setting goals and the successive action designed to achieve them were clear and robust'*[1, pg123]. Sabatier and Mazmanian (1979) drew up the following list of conditions to ensure that policy is effectively implemented [1, pg123]:

- *Clear and logically consistent objectives.*
- *Adequate causal theory (ie a valid theory as to how particular actions would lead to the desired outcomes).*
- *An implementation process structured to enhance compliance by implementers (eg appropriate incentives and sanctions to influence subordinates in the required way).*
- *Committed, skilful, implementing officials.*
- *Support from interest groups and legislature.*
- *No changes in socio-economic conditions that undermine political support or the causal theory underlying the policy.*

Hogwood and Gunn's (1984) list was even more rigorous than Sabatier and Mazmanian's, and their intent was to show that *'perfect implementation'* was, realistically, not possible. Their list is as follows[1, pg124]:

- *Circumstances external to the agency do not impose crippling constraints.*
- *Adequate time and sufficient resources are available.*
- *Required combination of resources is available.*
- *Policy is based on a valid theory of cause and effect.*
- *Relationship between cause and effect is direct.*
- *Dependency relationships are minimal – in other words, the policy makers are not reliant on groups or organisations which are themselves inter-dependent.*
- *There is an understanding of, and agreement on, objectives.*
- *Tasks are fully specified in correct sequence.*
- *Communication and coordination are perfect.*
- *Those in authority can demand and obtain perfect compliance.*

[23] Pressman and Wildavsky (1984) was the third edition of the original 1973 book, also entitled *Implementation.* The second edition was published in 1983.

Critics conclude that this approach is merely theoretical as all conditions are highly unlikely to be present at any one given time and in reality implementation is multifaceted and not straightforward. Another criticism of this approach is that it focuses on the central decision-makers with limited attention on front-line implementers. Also it does not take into account situations where there is more than one policy being simultaneously implemented by several agencies, or multiple levels of organisations, actually implementing the policy or multiple policies[1, 103]. Policy implementation theorists such as Lipsky(1980), Elmore(1980), Hjern and Porter(1981), Barrett and Fudge(1981) and Hjern and Hull(1982)[102] have thus put forth a bottom-up approach. This model *'...stresses the involvement of lower-level bureaucrats and others who carry out public decisions. The ideas and influence of these actors feed back to the peak decisions-makers to influence policy choices'*[101, pg203]. This thesis study draws on and adapts the top-down approach as it seeks to analyse the factors that hinder or facilitate the adoption of HIV practices in hotels in TT and the hotels' response to national HIV policies and programmes.

2.4.3. EXAMPLES OF HIV POLICY RESEARCH

There have been relatively limited analyses of HIV policy implementation in research taking a health policy analysis approach in low and middle income countries[98]. Following are some of the more interesting and relevant HIV policy implementation and adoption research studies.

International: The following studies analyse the role of the actors, context and to a limited extent, content of the policy implementation triangle. Schneider and Stein (2001) examined the development and implementation of AIDS policy in post-Apartheid South Africa. They stress the importance of policy analysis to take into account the role of non-state actors; leadership of both state and non-state actors and other contextual factors such as the wholesale adoption of universal models of HIV prevention and control[104]. Parkhurst (2001) analysed the Ugandan response to HIV through government's written (formal) policies and unwritten (informal) policies stating that the Ugandan AIDS response was unique to the country's context [105]. Asthana and Oostvogels's (2001) ethnographic study examined the important differences between India and the West regarding MSM's sexual identities, circuits, partnerships and practices[24]. Their paper suggested that it is important to take into account the socio-cultural context (eg lack of 'collective solidarity' and diversity among MSM) when designing and

[24] Sexual identity: self-classification of one's sexuality; circuits: networks of MSM; partnerships: sexual relationships with other MSM; and practices: sexual activities.

implementing effective HIV interventions[106]. Schnieder (2002) examined the importance of leadership and power, of both the state and the non-state, in addressing the AIDS crises in South Africa. She also examined non-state actors role in forming 'bridging networks'[25] [pg162], and offering 'focussing events'[26] to move policy forward[107]. Phaladze (2003) examined the role of nurses in the implementation of HIV/AIDS policy in Botswana. The study showed, in the policy process, participation by the nurses was neglible and that inclusion of their views would have greatly assisted the process. Barriers to lack of involvement of nurses included issues of their gender and the fact that nurses were, '*....not perceived as powerful and autonomous as they are sometimes alleged or inferred to be'*[108, pg 27].

Allen and Heald (2004) discussed the contextual factors influencing/hindering the implementation of HIV policies in Uganda and Botswana. These factors included the maturity of the epidemic, the acceptance of condom promotion sexual behaviour change communication, economic incentives through international aid, state and local leadership, and the somewhat contentious measures of local councils to enforce changes in sexual behaviour[109]. Parkhurst and Lush (2004) compared how elements of the policy environment, eg political leadership, bureaucratic structures, health care systems and the role of non-state actors, can facilitate and/or hinder effective HIV implementation in Uganda and South Africa[110]. Ramiah and Reich (2006) identified lessons for managing relationships in a private-public relationship in Botswana, primarily during the implementation of the government's ARV programme. The lessons learned focussed on the importance of the relationship between the partners in an effort to foster trust and collaboration[111]. Hanefeld and Musheke (2009) examined the effect that Global Health Initiatives (GHI), such as the Global Fund to Fight HIV, Tuberculosis and Malaria (GFATM), have on human resources during ART roll-out in Zambia. This qualitative policy analysis found that local programmes supported by GHI removed skilled human resources from the public sector to the highly competitive GHIs[112].

There has been international research which though not directly focussed on the policy process has indicated several factors which hinder and facilitate the adoption of HIV practices. Bakuwa's

[25] Bridging networks: linkages between networks of actors from different social dimensions who have common issues. Eg. marginalized gay men and township youth who have HIV issues and concerns.
[26] Focussing events: events that have the potential to cause policy change. These events may be brought to light and further highlighted through the media and other communication networks such as the internet. Eg International AIDS Conference in Durban (2000) illustrates such an event as it was the first time this Conference was held in the Southern Hemisphere, 'focussing' the AIDS crisis on Southern Africa and the global disparties of AIDS medications.

(2010) research in Malawi found that service companies, which included those in tourism, were at the forefront of adopting HIV workplace policies. Her review of the literature identified factors such as *'top management support; pressure to demonstrate corporate social responsibility; perceived impact of HIV and AIDS ; industry/sector; availability of information; presence of individual champions; and practices of parent corporations and size of the company',* as factors that might enable adoption of HIV practices [113, pg3]. In 2011 Bakuwa concluded that the most important factor hindering the adoption of HIV workplace policies by private sector companies in Malawi (31% of companies were from the service sector including the tourism sector) was that HIV was not considered a priority issue by company management. Some of the reasons given as to why HIV was not ranked as a priority include resources being needed for other day-to-day company operations; the relatively long latency period before any illnesses appeared within the staff which often leads to an under-estimation of potential workplace problems; difficulty in demonstrating financial benefits for the company in adopting HIV practices now rather than having to pay for future HIV treatment; lack of worker prioritisation of HIV; and issues of stigma and discussing sex and sexuality[114]. Bakuwa also identified other factors in the adoption of HIV practices in her study, some of which concurred with the literature from her 2010 review. The second most important factor included management's lack of recognition of the potential impact of HIV on the company. In order for owners/managers to begin adopting HIV practices it is necessary that they understand this impact through issues of absenteeism, high staff turnover, loss of productivity and morale. Stigma may also result in an under-calculation of HIV impact as this social factor often leads employees to hide their HIV-positive status from their employers, and families of deceased employees do not always record cause of death as AIDS[114]. Stigma, also identified in Small and Medium Enterprises (SMEs) in South Africa by Connelly and Rosen (2005), was a cause for staff leaving their jobs without claiming benefits and again miscalculating the true impact of HIV on the company[30]. Staff involvement in other HIV institutions thus facilitating an increased knowledge about HIV was recorded as the third most important factor facilitating adoption of HIV policies by Bakuwa. This issue of staff participation was also linked to another factor, also mentioned by Bakuwa – awareness of HIV actions by other companies, and a further factor of networking through member associations (described later in this section). Thus collaborations with other organisations can also act as a facilitator to the adoption of HIV practices through the sharing of resources including financial and technical[114].

Connelly and Rosen (2005) identified a lack of HIV knowledge by managers as a barrier to adopting HIV practices and very often financial resources had to be used to hire technical

expertise to do the job[30]. Parsadh et al (2005) indicated not only knowledge but managerial leadership as a factor to ensure effective policy and programme implementation in SMEs in South Africa[115].

Datye et al (2006) looked at communication skills of private practitioners, with their patients around HIV pre- and post- testing in India as a factor of policy implementation. Through in-depth interviewing this study examined the gap between policy and practice in HIV testing. Factors that need to be taken into account to ensure successful communication around HIV testing focussed on the cultural and legal policy context. These included a coordinated approach of policy directives, regulating role of the medical councils/associations, and training doctors in VCT and the use of communication methods suitable in the local context[116].

Studies have shown that owner/management participation in membership associations has a collective, facilitating effect when adopting HIV practices. In the Philippines (2002) a significant relationship was demonstrated between managers, who belonged to membership associations, of non-brothel establishments (eg karaoke bars, massage parlours, hotels and bars) where employees may also be involved in sex work and the adoption of workplace sexual health policies that supported condom use[117]. In Malawi, it was demonstrated that businesses in the service industry (including tourism) were more likely to adopt HIV workplace polices than those of the transport and communication sectors because most of those service companies belonged to HIV and AIDS networks such as the Malawi Business Coalition against HIV and AIDS, and the AIDS Workplace Programmes in Southern Africa which actively disseminated HIV information and provided technical assistance to their members on the HIV expenses they may incur, risks they may encounter and the benefit of HIV practices[113]. Lyttleton et al (2007) also examined the dynamic, yet critical, role of networks such as the Thai Network for People Living with HIV/AIDS, in the government's programme for expanded ARV provision. PLHIV support groups work with health officers in the dissemination of information and through personal contact with other PLHIV to ensure adherence[118]. Tantivess and Walt (2008) examined the influential role of policy networks in the policy process during the scale-up of ART in Thailand. The study also addressed the critical role of non-state actors, eg treatment advocacy coalitions with government actors and international actors who provided HIV treatment technical knowledge[119]. Vass' (2008) study of workplace committees in Southern Africa demonstrated that networks within workplace committees, despite limited decision-

making powers, were effective in ensuring employees' social protective rights[27] and facilitating implementation of HIV programmes[120].

Research studies, though not specifically in the tourism sector, have identified company size as a factor which either facilitates or hinders the adoption of HIV practices. A study on HIV workplace practices among SWs in non-brothel establishments in the Philippines (2007) indicated that the larger non-brothel establishments with more workers were inclined to have workplace sexual health policies. The reasons suggested was that either the larger companies wished to, *'protect their assets'* [117, pg5](ie the SWs)or they had access to resources that smaller establishments did not have to adopt such policies[117]. The WEF 2004-2005 Review concurred that, *'larger firms (with more than 50 employees) are more concerned than smaller firms about the current and future effects of HIV/AIDS on their businesses'[37, pg24]* and Siiskonen's (2009) review cited Rosen et al's (2006) study indicating that *'HIV/AIDS was not considered a serious concern among small and medium-sized tourism companies'* [30, pg134]. Bakuwa's 2010 research which examined company size against the different sectors adopting HIV workplace polices found that size did not play a role in the adoption of company HIV workplace policies [113]. However, even if these larger firms, again not tourism specific, exhibit concern about HIV it does not necessarily translate into action; this is particularly true for sub-Saharan Africa, Eastern Europe, Central Asia and the Caribbean. Research studies in sub-Saharan SMEs report that the lack of resources by SMEs has led to a lack of HIV practices being adopted[115, 121].

Another factor, of which again there is little previous research, was the relationship between ownership of tourism companies and whether or not the company had an HIV workplace policy. Ketshabile (2010) found there was, *'insignificant relationships between tourism [accommodation] companies owned by Botswana citizens, non-Botswana citizens and a partnership between non-citizens and citizens of Botswana'*[122, pg256]. Siiskonen's (2003) review described a further barrier to the adoption of HIV practices among tourism organisations in Southern Africa – whose responsibility it was to engage in HIV prevention and control activities in the tourism sector – should it be the responsibility of the tourism organisations, the health care professionals or the HIV national coordinating committees?[30] Bakuwa (2011) also found that among the private sector companies in Malawi, other factors

[27] Social protective rights: mandatory human rights, the ability to advocate and communicate such rights and any other rights and benefits related to HIV/AIDS prevention, treatment and care.

affecting the adoption of HIV practices included legislation mandating HIV practices; management support; human resources; employee union support; and financial resources. Interestingly financial resources, though an important factor because without it HIV practices would be limited or inadequately adopted, was ranked in Bakuwa's (2011) study as the least likely factor to hinder the adoption of HIV policies. This factor – a lack of resources – has been linked to the fact that there is no management support for the adoption of HIV practices because management probably does not understand the impact of HIV on the company and therefore has not prioritised the development of HIV practices and the allocation of the necessary financial resources to do so[114].

In summarising the limited studies which identified facilitators and barriers to the implementation of HIV practices at the international level, the most important factor as statistically measured by Bakuwa (2011) in her study in Malawi was that HIV was not considered a priority by the adopting company; this included those in the tourism sector[114]. Other factors included understanding the impact that HIV may have on its profitability and resources[30, 113, 114]; staff involvement in other HIV institutions[114]; networking through management associations and PLHIV coalitions; and the use of committees[113, 114, 117, 123]. Other factors, though apparently not as significant on the extent of adoption of HIV practices was communication skills of those implementing the policy[116], company size[30, 37, 115, 117, 121], local ownership of company[122], legislation mandating HIV practices[114], management support, knowledge and leadership[30, 113-115], financial resources[114], and lack of agreement in the tourism sector on whose responsibility it is to develop and lead on HIV activities[30]. Note that these factors are inter-related, eg the hindering factor of there being a management lack of knowledge within the company is related to understanding the impact that HIV may have on the company and the subsequent non-adoption of HIV practices. Additionally these studies were not specific to the tourism sector but did incorporate it as part of the SMEs, service companies and non-brothel establishments.

Caribbean: The limited literature of HIV studies identified by the thesis researcher with elements of health policy analysis were as follows: Kerrigan et al(2001)[124], Lacharme et al(2002)[67], Kumar et al(2004)[125], Baez-Feliciano et al (2005)[126], Kerrigan et al(2006) [127], HEU/UWI (2009) [70]and Padilla et al (2011)[72]. Only Kerrigan et al(2001)[124], HEU/UWI (2009) [70] and Padilla et al(2011)[72] studies may be of interest to researchers involved in HIV policy analysis in the tourism sector, even though they are not strictly policy

implementation studies themselves. Kerrigan et al (2001) investigated the possibility of adopting the Thai 100% condom policy in the DR among SWs. The study found that barriers to effective implementation of this policy included: government's available resources to implement the programme including their ability to screen and treat SWs for sexually transmitted infections (STIs); and financial incentives offered to SWs not to use a condom with clients[124]. The HEU/UWI (2009) examined the economic impact of HIV and AIDS in the tourism industry in five Caribbean territories (DR, Jamaica, Barbados, St Lucia and Tobago). Facilitators to HIV practice adoption included private and public sectors working together; and hotel corporate social responsibility. Barriers included there being no coordinated effort between private (HTAs) and public tourism sectors; lack of resources; the belief by tourism industry officials that HIV workplace practices would deter tourists from visiting the country; general cultural viewpoints that deny the existence of sex tourism, eg sex tourism by locals only exists among the 'poor and working class'[70, pg75]; lack of support from hotels to attend HIV sensitisation seminars; the belief that HIV will not have an impact on the tourism sector, and the absence of data to suggest any negative economic impact within the industry[70]. These barriers suggest that adoption of HIV was not a priority in these tourism areas. Padilla et al (2011) investigated the barriers and resources for HIV prevention policies and programmes in the DR tourism sector. Barriers included HIV prevention not being viewed as a priority among the hotel industry; mobility of workers; lack of funding; fear of discouraging tourists; lack of national policies for HIV prevention services for the tourism sector; and lack of collaboration between sectors. Facilitators included initial sensitisation of hotel owners/managers; and use of HTAs, hotel employees and leaders in the industry as change agents to mobilise resources and encourage participation in the sensitisation seminars[72].

Summarising the research conducted in the Caribbean, the studies presented above examine the policy process and identify policy implementation barriers and facilitators particularly with respect to policy actors. Several of these factors that enable successful implementation were identified by Sabatier and Mazmanian (1979) and Hogwood and Gunn (1984) – see section 2.4.2. For example, Kerrigan et al (2001) refer to government's abilities to implement and enforce elements of the 100% programme; this relates to Sabatier and Mazmanian's (1979), *'committed and skilful implementation officials'* [1, pg123]. Additionally lack of funding and other resources mentioned by HEU/UWI (2009) and Padilla et al (2011) can be linked to Hogwood and Gunn's (1984) referral to *'adequate time and sufficient resources'* [1, pg124]as a factor for successful policy implementation. From the limited research in the Caribbean, the most common barriers cited were HIV not being a priority within the tourism industry; fear of

discouraging tourists; lack of resources; lack of inter-sectoral and private-public collaboration. The most common facilitators were available resources and private-public collaboration. This research attempts to fill some of the gaps found in the above literature by conducting a qualitative study based on both health policy analysis and ecological frameworks (described next). It focuses on how hotels have responded to government policies and programmes related to HIV and tourism, which is a particularly under-researched field of study.

2.5. ECOLOGICAL APPROACHES TO HIV PREVENTION AND CONTROL

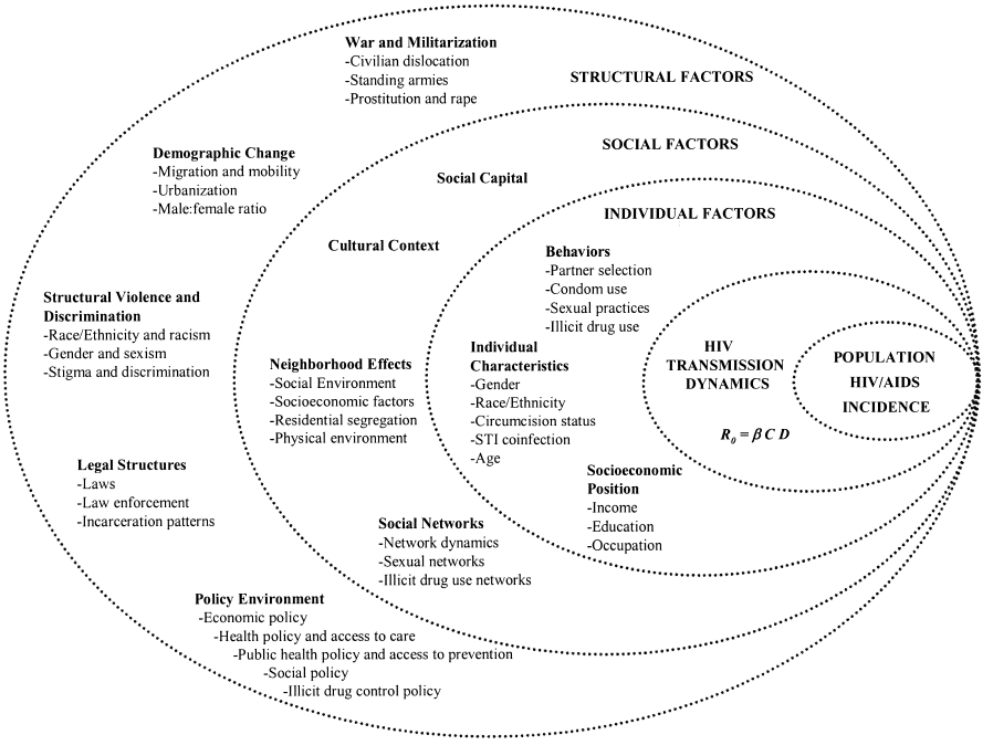
2.5.1. OVERVIEW OF ECOLOGICAL THEORY

HIV transmission and the effectiveness of HIV prevention and control are determined not only by an individual's behaviour (eg hotel staff or management) and circumstances but also the wider social, economic and political context in which the individual is situated. Many researchers such as Sumartojo (2000) [128], Napp et al (2002), Chillag et al (2002), Collins et al (2007) and Gupta et al (2008) [129] have used different models for classifying the environmental factors influencing the adoption and effectiveness of HIV practices. For example Chillag et al (2002)used the classification of '*structural, socio-cultural, organizational and individual client factors'* to describe barriers and facilitators to the implementation of HIV services by managerial and frontline staff in community-based organisations (CBOs) [130, pg27] and Napp et al (2002) investigated facilitators and barriers to undertaking evaluations within CBOs implementing HIV prevention programmes. Note that factors concerning staff skill and funding issues were identified as being important individual and organisational barriers and/or facilitators in Napp et al, Chillag et al and Collins et al's studies. Napp also noted that many of these factors were *'interrelated and, at times, mirror images of each other'*[131, pg41].

McLeroy et al (1988) adopted Bronfenbrenner's (1977) ecological model of human development and described factors that would ultimately influence behaviour in terms of '*intrapersonal (characteristics of the individual), interpersonal processes and primary groups (social networks and support systems), institutional (social institutions with organizational characteristics and rules and regulations for operation), community (relationships among organizations, institutions and informal networks)and public policy (national laws and*

policies)'[132, pg355]. Poundstone et al (2004) used a social epidemiology[28] model to describe the factors influencing HIV vulnerability at the individual, social and structural level. This model also contains sub-levels of 'HIV transmission dynamics and 'population HIV incidence' to describe HIV transmission; these sub-levels have less significance to this thesis study as this research focuses more on the individual, social and structural factors as described in Figure 2.8[133].

Figure 2.8: Social epidemiology model of HIV transmission



Source: Poundstone et al (2004)[133]

This ecological model portrays the different levels interacting with one another as illustrated by dotted lines in Figure 2.8. This model of interaction corroborates findings by Napp et al (2002) that factors are interrelated [131].

Padilla (2010) has suggested that *'Caribbean tourism areas are geographically, socially and behaviourally distinct spaces that function as ecologies of heightened vulnerability, contributing to the transmission of HIV and other STIs among mobile populations both within and across national borders '*[24, pg70]. In order to provide effective interventions at various levels that prevent and

[28] Social epidemiology focuses on the social aspects of how disease is transmitted.

control HIV transmission, Padilla has suggested ecological research that investigated tourism areas as whole systems. McLeroy et al (2009) stated that *'if individual's behaviours are a result of social influences...then changing behaviour [in order to achieve successful interventions] may require using social influences'*[134, pg531].

Only three Caribbean HIV studies stand out as having an ecological approach: Boxill et al (2004)[3]; Kerrigan et al (2006)[127]; and Padilla et al (2010)[24]. Kerrigan et al's (2006) study evaluated two environmental-structural interventions aimed at reducing HIV/STI transmission among female sex workers (FSWs) in the DR. The two interventions consisted of the solidarity[29] approach implemented in Santo Domingo, the country's capital, and the solidarity approach plus governmental regulation[30] implemented in Puerto Plata – an area of high tourism activity the DR. The study found that the combined approach produced a reduction in HIV risk among the FSWs[127]. Padilla completed an ethnographic three-year study of male tourism workers and HIV in two cities, (Santo Domingo the capital and Boca Chica, a tourism area) in the DR (1999-2001). Study participants were men who worked in the tourism industry (including hotels) and supplemented their incomes through sexual engagements with foreign men and/or women visiting the country. Additionally the study demonstrated that due to political and economic realities of the country, many of the men had migrated, from other regions, to these areas of high tourism activity [24, 135]. Boxill et al's (2004) study in Jamaica and the Bahamas examined the nature of relationship between tourism and HIV in the Caribbean by analysing the types of high-risk behaviours exhibited by tourists and their concerns; the experiences of persons working directly and indirectly in the tourism industry; the impact of HIV on the tourism industry; and finally identifying interventions to mitigate this impact[3].

In this thesis study the researcher uses an ecological framework in two ways. Firstly to classify the determinants of the tourism industry which under the correct circumstances, promote an increased risk of HIV transmission between tourists and nationals or vice versa. These determinants have been identified in international literature by Hawkes et al (1995)[27], Bloor et al (1998)[29], Apostolopoulos et al (2002)[28], Ao et al (2006)[32], Pawar et al (2006)[31], Bisika (2009)[13], Siisskonen (2009)[30] and Tajudeen at al (2011)[14], and in Caribbean literature by Forsythe et al(1998)[10], Mulhall (cited by Townsend 2003)[12], Boxill et

[29] The solidarity approach involved mainly an educational and awareness campaign among SWs and brothel owners.
[30] Government regulation involved the enactment of a government policy mandating 100% condom use in brothels and sanctions against owners for non-compliance.

al(2004)[3], Bombereau and Allen(2008)[61] and Padilla et al(2008)[136]. As can be seen in Table 2.8 these determinants can act at various levels – in this study the levels are categorised with the hotel as the focal point, as external to the hotel, internal to the hotel and again internal to the hotel but at the level of one's individual behaviour. The researcher's classification of these determinants also uses the Barnett and Whiteside categorisation of proximal and distal determinants (see section 2.3.4) [86] to illustrate that the determinants have different degrees of effect on HIV transmission. Some determinants may be inter-related at more than one level, eg, heavy use of alcohol and drugs is categorised as an individual behaviour determinant. However access to alcohol and drugs is related to determinants external to the hotel in the form of the national laws pertaining to the sale of alcohol and drugs.

Table 2.8: Determinants of tourism industry that can lead to an increased risk of HIV transmission

DISTAL DETERMINANTS → **PROXIMAL DETERMINANTS**		
EXTERNAL HOTEL ENVIRONMENT	**INTERNAL HOTEL ENVIRONMENT**	**INDIVIDUAL STAFF/MANAGEMENT/TOURIST BEHAVIOUR**
Lack of AIDS workplace policies/guidelines for the tourism sector and within the hotels themselves. Travel requires financial resources which are more common in an older population. This economic differential between the traveller and the hotel and tourism employee may encourage risky behaviour. Legal prohibitions including the criminalisation of sex work.	Hotel and tourism employees are frequently mobile and away from their families and regular partners for prolonged periods of time as they travel to work.	Many opportunities for (sexual) interactions between hotel and tourism employees and tourists, especially the younger holiday-makers. Heavy use of alcohol or drugs by tourists and/or hotel and tourism employees. Increased risky behaviour, including sexual networking and inconsistent use of condoms. Stigma and discrimination.

The second use of the ecological framework, with the hotel as the focal point is to describe the *different levels of factors* within the tourism context that facilitate and hinder the adoption of HIV practices in the hotel sector, and the hotels' response to national policies and programmes. See Table 3.1.

SUMMARY

International and regional research suggests linkages between HIV and tourism. There are multiple determinants of the HIV epidemic, in the Caribbean and TT that are manifested through aspects of the tourism industry. For example multiple partnering being exacerbated with the many opportunities for sexual interactions between tourists and the local population coupled with significant use of alcohol and other drugs leading to increased risky sexual behaviours. Other drivers include legal prohibitions, including the criminalisation of sex work, migration and mobility of workers, who are away from their regular partners for extended periods of time and economic inequalities which may lead to risky sex for financial or material gain.

Trinidad and Tobago –has different policies and programmes relating to HIV prevention and control in the tourism industry. These policies and programmes span the health, tourism and labour sectors. The overarching policies and programmes are the national HIV prevention and control programme implemented by the NACC and more specifically in Tobago, the THACCS. From the TT NSP, the TSHASP within the Ministry of Tourism was created. Joint national, regional and international programmes have resulted in the QTC project (1999-2003) and the GORTT/ILO/USDOL International HIV/AIDS Workplace Education Programme (2005-2008). However there are no unified or coordinated national HIV policies or programmes for the hotels and other tourism-related actors.

This research adopts a health policy analysis approach, and specifically draws on and adapts the theory of top-down policy implementation as the basis of its conceptual framework (see section 3.1). Top-down policy implementation theory is predominately used to analyse policies having been implemented by government workers. In this thesis study, these theories are adapted to examine the adoption of HIV practices by hotels and how these (mostly private sector) hotels have responded to government policies. The thesis researcher also presents an ecological perspective to the study to classify the different types of factors facilitating and hindering the adoption of HIV practices by hotels ranging from those related to individual behaviour to more external environmental factors including those affecting public policy. With regard to HIV policy analysis studies in the Caribbean, there are a few that may be of interest to HIV policy analysis in the tourism sector despite them not being strictly implementation studies. This thesis study attempts to fill some of the gaps found in this literature. It will help to shed light on a global

public health concern (HIV) in a generally private sector environment (hotels) in the Caribbean, where there is very limited research on this topic.

Research at both international and regional levels has shown that there are various factors which facilitate and hinder the adoption of HIV practices. Facilitators included were the prioritisation of the development and adoption of HIV practices through the allocation of resources, in particular financial and technical; management support through a complete understanding of the impact of HIV on the company; knowledge sharing through staff involvement with HIV institutions and owner/manager networking via membership organisations, eg HTAs. Barriers found in the literature include the lack of prioritisation of HIV within the organisation; lack of understanding of the impact of HIV and AIDS on the organisation's effectiveness and profitability; lack of institutional HIV knowledge; and weak guidelines or absent legislation mandating the adoption of HIV practices. Some barriers were found to be the converse of the facilitators such as absence or presence of resources.

Finally, the linkage between HIV and tourism industry is not a direct one; because you are a tourist or work in the tourism industry does not directly predispose you to being more at risk of becoming HIV-positive. Previous research described determinants of the tourism industry which, when acting separately or in tandem with one or more other determinants, promote risky sexual behaviour between the MARPs in the tourism industry and consequently result in the transmission of HIV. This becomes an important issue when tourism industry actors (eg hotel owners/managers) attempt to adopt HIV practices while at the same time government sector actors (eg officials in the Ministry of Tourism) attempt to implement HIV policies and programmes.

CHAPTER 3 CONCEPTUAL FRAMEWORK AND RESEARCH STUDY DESIGN

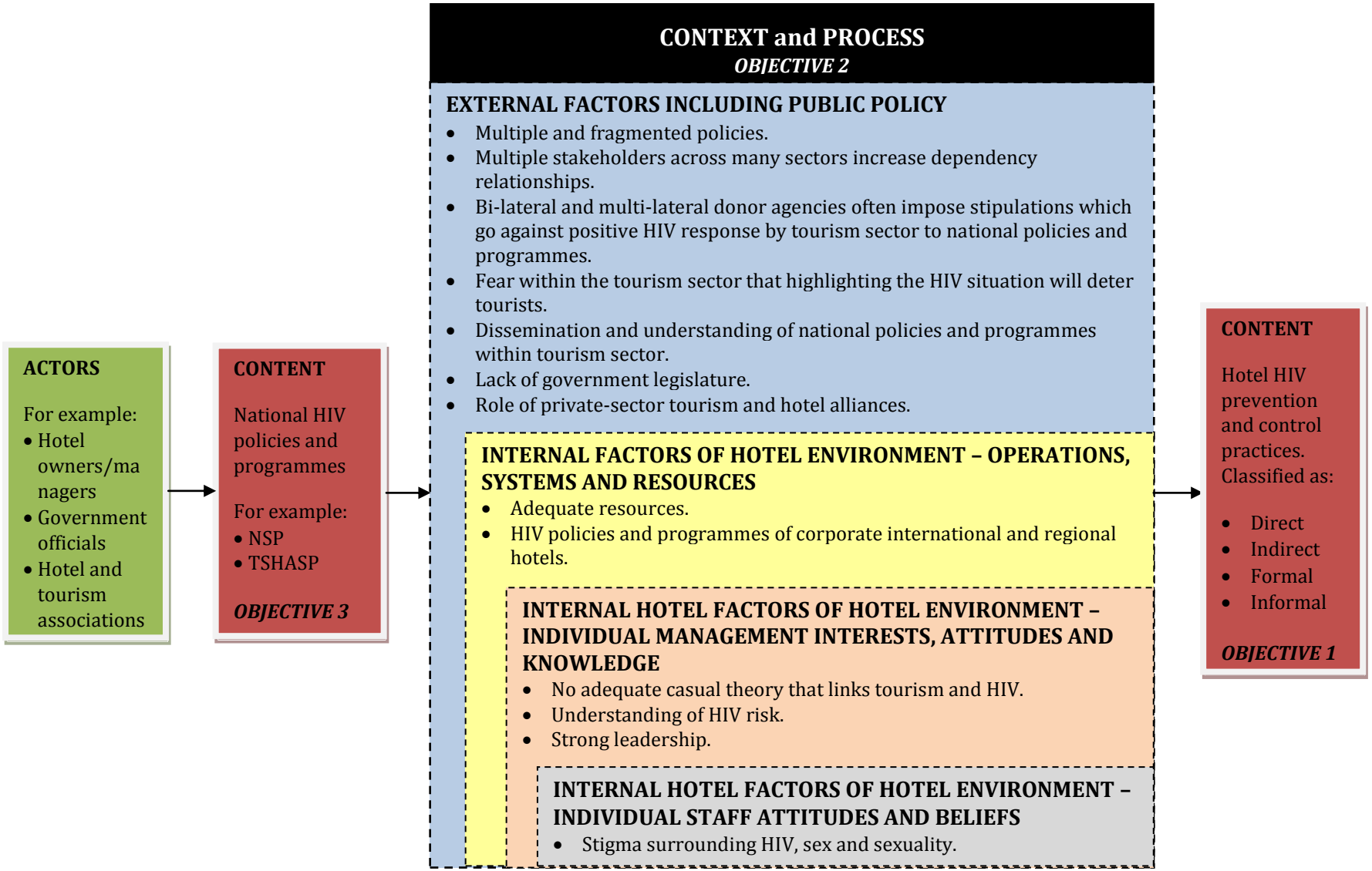
INTRODUCTION

This chapter describes the conceptual framework (CF) and describes and justifies the data collection and analysis methods used in this thesis study, including how the sampling framework was chosen and details on research ethics and validity and reliability of the study are also discussed.

3.1. CONCEPTUAL FRAMEWORK

Miles and Huberman (1984) defined CFs as *'current versions of the researcher's map of the territory being investigated.'* [137, pg33]. In this study the 'territory' being investigated was the HIV policy and programmatic arena at both the hotel tourism level and the national, governmental level. Lesham and Trafford (2007), further described a CF as *'a map of theories and issues relating to the research topic'*,[138, pg 99]. This thesis study uses the Walt and Gilson's policy analysis triangle (see Figure 2.7) as the basis for its CF – the main elements of this triangle being process, content, context and actors; it also builds on an ecological framework and top-down implementation policy theory informed by the literature reviewed in Chapter 2. This researcher acknowledges that this study is not strictly an analysis of the implementation of government policy, but adapts the policy analysis triangle and implementing theory as the overarching framework to understand the factors influencing the adoption process of HIV practices by hotels in the Trinidad and Tobago (TT) tourism sector. Figure 3.1 demonstrates the CF developed by the researcher in this thesis study. The dotted lines indicate that these factors are fluid and may occur at different levels; they may also interact with one another.

Figure: 3.1. Conceptual framework



Actors within the policy analysis triangle are defined as individuals, groups or organisations which have an effect on the implementation, or in this thesis study, the adoption process of HIV practices by hotels. These actors may influence facilitators and barriers at levels both external and internal to the hotel environment. Actors in this study may include officials at the Ministries of Tourism and Health, hotel owners/managers, hotel and tourism associations (HTAs) and Non-Governmental Organisations (NGOs) working on HIV programmes.

Policy content usually refers to documented details of the aims, objectives and outcomes of a governmental policy or programme. However in this study, the researcher uses content to refer to HIV practices adopted, or not, by the hotel as well as national HIV policies and programmes (Objective 1 and 3). In the hotels, this content could take the form of HIV sensitisation seminars, HIV testing etc. At the national level HIV policies and programmes which have directly impacted on the tourism sector include the National Strategic Plan (NSP) and the Tourism Sector HIV/AIDS Support Programme (TSHASP) for example. Regional and international collaborative programmes included the Quality Tourism for the Caribbean (QTC) project (1999-2003)and the Government of the Republic of Trinidad and Tobago/International Labour Organisation/United States Department of Labor (GORTT/ILO/USDOL) International HIV/AIDS Workplace Education Programme (2005-2008).

Context factors as they pertain to HIV prevention and control have been categorised and discussed by many authors such as Leichter (1979)[1]. These include the situational, structural, cultural and exogenous factors of the country. In this study these may refer to the high levels of stigma and discrimination (S&D) in TT society leading to negative beliefs about sex and sexuality thus creating barriers to the adoption of HIV practices.

The policy process is defined by the researcher as the adoption of HIV practices within the TT tourism sector and specifically in hotels. Sabatier and Mazmanian's (1979)[1] and Hogwood and Gunn's (1984) [1] top-down policy implementation theories were adapted for this study to understand the factors that facilitate and hinder the adoption process and how the hotels have responded to national HIV policies and programmes (Objectives 2 and 3). These factors have been categorised using an ecological framework of factors

internal and external to the hotel environment as adapted from McLeroy et al's (1998)[132] and Poundstone et al's (2004)[133] models. These implementation theories and ecological models, together with the researcher's knowledge and personal experience of the hotel sector in TT were a useful starting point for creating a list of facilitators and barriers that were expected to influence the adoption of HIV practices by hotels and the hotels' response to national policies and programmes. In the first column in Table 3.1 – *Ecological framework theme* – the researcher categorised the factors according to an ecological framework of factors that are both external and internal to the hotel environment. Those factors that are internal to the hotel environment are further subdivided to address hotel operational factors; individual behavioural factors of management; and individual behavioural factors of staff. The researcher has also incorporated those conditions necessary for effective policy implementation with potential facilitators and barriers for the adoption of HIV practices as identified in the literature – this is represented by the second column in Table 3.1 – *Potential factors for the adoption of HIV practices.*

Table 3.1: Factors that are expected to facilitate or hinder HIV practices in hotels in Trinidad and Tobago

Ecological framework theme	Potential factors for the adoption of HIV practices[1]
EXTERNAL FACTORS INCLUDING PUBLIC POLICY	Multiple policies often lead to the lack of a coordinated approach and agreement of objectives between executing agencies. Policies and programmes can also become fragmented due to a lack of resources resulting in programme inconsistency.
	Multiple stakeholders potentially decrease communication and coordination and increase dependency between policy-makers and those responding to the policies and programmes.
	Bi-lateral and multi-lateral donor agencies often impose financial stipulations which go against HIV policy implementation within the tourism sector.
	Fear within the tourism sector that highlighting the HIV situation will deter tourists from visiting the country and this may lead to high-level officials not supporting HIV policies and programmes in the tourism sector.
	Dissemination and understanding of national HIV policies and programmes within the tourism sector; hotel owners/managers need to have an understanding of HIV risk issues within their environment and also be aware that such national policies and programmes actually exist.
	HIV practices are not legally mandatory within TT workplace.
	Role of the private-sector tourism and hotel alliances which can provide fora for knowledge sharing and policy dissemination.
INTERNAL HOTEL FACTORS – HOTEL	Adequate resources (eg financial, human) to develop and adopt HIV prevention and control practices including strong leadership.

Ecological framework theme	Potential factors for the adoption of HIV practices[1]
OPERATIONS, SYSTEMS AND RESOURCES	Corporate international and regional hotel sector HIV policies and programmes may be geared towards protecting the image of the hotel rather than the health and safety of the employees and guests.
INTERNAL HOTEL FACTORS – INDIVIDUAL MANAGEMENT INTERESTS, ATTITUDES AND KNOWLEDGE	Adequate causal theory. Tourists by themselves do not cause HIV but rather, among others issues, the socio-cultural factors and economic disparities surrounding the tourism industry creates an environment for the increased the risk of HIV from visitors to nationals and vice versa.
	Adequate understanding of HIV issues by hotel owners/managers which will result in their agreement of objectives to be achieved by HIV practices.
	Adequate resources in place (eg human, financial, time) to develop and adopt HIV practices.
	Strong leadership within the hotel sector to ensure HIV practices adopted.
INTERNAL HOTEL FACTORS – INDIVIDUAL STAFF ATTITUDES AND BELIEFS	Stigma surrounding HIV, sex and sexuality.

[1]Incorporates list of conditions necessary for effective implementation as described by Sabatier and Mazmanian (1979)[1] and Hogwood and Gunn (1984)[1]; international and Caribbean research and reviews; HIV prevention and control interventions in the tourism industry; existing literature from TT HIV policies and programmes and the researcher's knowledge of the TT tourism industry from personal experience.

This list though not exhaustive was used by the researcher to guide the structure of the study research questions and to explore if these factors did hold true for the TT tourism sector. The researcher also worked inductively to identify, and further explore, any other facilitators or barriers that arose during data collection.

3.2. STUDY APPROACH

This study uses qualitative research methods to address its aim and objectives. Green and Thorogood (2004) indicated that the simplest rationale for the use of qualitative research as opposed to quantitative, was studies whose *'aims are generally to seek answers about the 'what', 'how', or 'why' of a phenomenon, rather than questions about 'how many' or 'how much'*[139, pg5]. The aim of this research is to analyse the factors that influence or hinder the adoption of HIV practices within TT hotels. To do this, it was necessary to understand 'what' were these barriers and facilitators and 'how' they hindered or supported the adoption of HIV practices in hotels, hence qualitative methods rather than quantitative, were used. Qualitative research does not strive to *'generalise*

about the distribution of experiences but to generalise about the nature and interpretive processes involved in the experiences'[140, pg45]. Another reason why qualitative research was used was because the researcher wished to understand 'why' and 'why not' these practices were adopted rather than 'how many' practices of a certain type were adapted.

The study also embraces a case study approach. Yin (2003) defines a case study as *'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident'*[141, pg13]. Yin (2003) also goes on to explain that the case study methodology is the most appropriate strategy to use when answering the 'how' and 'why' research questions. Because case studies are used to gather unique, in-depth data about a community, organisation or setting, qualitative methods in-depth SSIs, unstructured interviews or participant observation are usually employed[142]. This research qualitatively examined the 'unique community' of TT hotels; gathering 'in-depth' data on 'how' and 'why' certain HIV practices were adopted.

The researcher decided that for this study one-on-one, semi-structured interviews (SSI) (see section 3.2.1.) should be the main method of data collection to explore the reasons for adoption, or not, of HIV practices; with document review as the supplemental method (see section 3.2.2.). Observational methods are often considered important in qualitative work as they can capture what the interviewee 'does' rather than only what s/he 'says'[139]. However this method was considered not to be feasible for achieving this study's objectives as observing how the hotel owners/managers adopted or did not adopt HIV practices, eg by direct participant observation of the decision-making processes, actual HIV training sessions or how staff interacted with tourists, would have been too time-consuming and in some cases personally intrusive for the purposes of this study. Focus groups can be used to gather data generated about interactions between the participants, of the groups[142]. However focus groups were not used in this study because the researcher believed they would be difficult to organise both in terms of agreeing upon a suitable time for all participants and then for them to all actually attend.

3.2. DATA COLLECTION METHODS

3.2.1. SEMI-STRUCTURED INTERVIEWS

Semi-structured interviews enabled the researcher to explore this study's questions in-depth by interviewing and eliciting detailed responses from a relatively small number of participants. The use of SSIs also allowed the researcher to discuss sensitive issues, eg sexual liaisons between guests and staff, and HIV. Conducting the interviews face-to-face and being able to make eye contact was one way of building rapport between the researcher and the research participant. This enabled an approach that allowed participants to focus on issues that were important to them. Unanticipated ideas and emerging themes that arose in the course of data collection, eg hotel systems such as monthly staff meetings, that already existed as part of routine hotel operations where an HIV awareness session would be easily incorporated, were discussed; often uncertainties on the part of both the interviewer and the participant were clarified[139, 141, 142].

A chief disadvantage of SSIs is that they rely on what people 'say' rather than what they 'do' (recall bias) [139]. To overcome this data needed to be interpreted by the researcher, in terms of the context in which it is collected. Often this could be done by verification through a separate interview with a different interviewee in the same organisation or through other data collection methods such as document review (data triangulation). Another disadvantage of SSIs is social acceptability bias meaning an interviewee typically responds to the researcher in a manner that the interviewee feels is acceptable, morally and culturally, with the researcher's viewpoint. This can be the case when discussing sensitive issues such as those associated with this study, eg HIV, sexuality, and stigma and discrimination (S&D) in the workplace. These disadvantages, in the context of this study, are further discussed in section 8.1 – Study limitations.

Two topic guides were created to explore the study's objectives; one for interviewees at hotels (Appendix 5) and another for national organisations (including government departments and HTAs) and other key informants (Appendix 6). These topic guides were pilot tested with the first 5-7 interviews in each category and small adjustments were made accordingly to ensure that interviewees understood the questions and what was

being asked of them. Further adjustments were made to the topic guide during data collection as new themes were introduced[139, 142].

3.2.2. DOCUMENT REVIEW

Policy and programmatic documents collected for this study were for two purposes: (1)to document national policy and programmes and (2)verification of data collected during the SSIs. Table 3.2 lists documents collected and reviewed for (1) and (2).

Table 3.2: Documents reviewed to determine the Trinidad and Tobago policy and programmatic aspects of the study and for verification of data collected

Health/HIV and AIDS	Tourism	Other
• Trinidad and Tobago Public Health Ordinance Ch12, No4, 1917 • Trinidad and Tobago Five-year National HIV/AIDS Strategic Plan 2003-2008 • Draft Tobago National Strategic Plan 2004-2008 • Occupational Safety and Health Act 2004 • TT National Workplace Policy on HIV and AIDS, 2009 • Occupational Safety and Health (Amendment) Act 2006 • Vision 2020 HIV/AIDS Sub-committee Report, circa 2005 • UNAIDS UNGASS 2010 Country Progress Report, Trinidad and Tobago.	• Vision 2020 Tourism Sub-committee Report, circa 2005 • Trinidad and Tobago Bureau of Standards, Requirements for Tourism Accommodation Part 1: Hotels and Guesthouses, 2006 • Trinidad and Tobago Bureau of Standards, Requirements for Tourism Accommodation Part 2: Bed & Breakfast and Self-Catering Facilities, 2008 • Tourism Development Company: Visitor Safety Tips • Ministry of Tourism Sector HIV/AIDS Support Programme and Progress Report 2007-2008 • Draft National Tourism Policy of Trinidad and Tobago, 2009	• Equal Opportunities Act 2000 • Draft Vision 2020 National Strategic Plan • Vision 2020 Operational Plan 2007-2010, 2007

Many of the policy and programmatic documents were found though electronic database searches or the researcher was given the pertinent documents (especially unpublished documents) by interviewees. Electronic searches were conducted on datasets of PubMed and Google Scholar using Boolean combinations of the search terms 'policy', 'implementation', 'analysis', 'facilitator', 'barrier', 'HIV', 'AIDS', 'Caribbean', 'Trinidad',

'Tobago', 'tourism', 'tourist', 'adoption', 'private', and 'workplace'. Dates used in these searches were until 2009. After the initial searches were performed the search terms were refined to capture relevant papers published or posted online until December 2011:

- [touris*, HIV Caribbean, OR Trinidad, OR Tobago]
- [touris*, Caribbean HIV, OR AIDS economic impact]
- [touris*, HIV, workplace barrier OR facilitator]
- [barriers, facilitators, HIV, prevention, implementation, hotel]

Additionally 2010 statistical updates and reports from key public health and tourism organisations such as the United Nations Joint Programme on HIV/AIDS (UNAIDS), World Travel and Tourism Council (WTTC) and United Nations World Tourism Organization (UNWTO) were used. Such documents included the TT United Nations General Assembly Special Session (UNGASS) Country Report(2010)[8], World Travel and Tourism Council's (WTTC) Travel and Tourism Economic Impact report for TT(2010)[7], UNAIDS Report on the Global AIDS Epidemic(2010)[9], and UNWTO Tourism Highlights(2011)[143]. In addition through previous experience working in this field of HIV policy and programming in the Caribbean tourism sector, the researcher had collected documents including unpublished reports, policy documents and other literature reviews for over ten years. Documents particularly grey literature in the form of unpublished research and reports by key public health officials and newspapers clippings were gathered in the field through suggestions to the researcher by the key informants during the interviews.

Scott (1990) [142]suggested four criteria to assess documentation. These were used by the researcher to help select the documentation that was analysed for this research. '*Authenticity: Is the evidence genuine and of unquestionable origin?*'[142, pg122] Official documents from national governments and state enterprises (eg TT Ministries of Health and Tourism, Tourism Boards etc), multi-lateral and international agencies (eg UN agencies, WTTC etc), NGOs, and private sector and quasi-private agencies (eg UWI, Tourism Alliances etc) usually bore the organisations' logo or stamp and were considered by the researcher as authentic. Or, such documents were given directly to the researcher from the author or publishing organisation. Published journal articles

have been peer reviewed and deemed authentic by the journal peer review committee. *'Credibility: Is the evidence free from error and distortion?'*[142, pg123] Where documents appeared to have differing content, eg reports from the National AIDS Coordinating Committee (NACC) and the Ministry of Tourism, the researcher attempted to clarify the content by contacting the author directly or by reviewing other documents. Such ambiguity demonstrates possible biases and/or inaccuracies in the documents in the interest of whoever wrote and/or published the document. Because of their very nature, peer reviewed journals were believed to be credible by the researcher. *'Representativeness: Is the evidence typical of its kind, and if not, is the extent of its uniqueness known?'*[142, pg123] Documents reviewed by the researcher from governmental, multi-lateral and international organisations, and non-governmental and private sector agencies were believed unique in their subject matter; ie there were no other such documents on the subject matter in the environmental context in which it was written. The researcher assumed that *'the extent of [the documents'] uniqueness'*[142, pg123] is relatively high since the area of HIV policy and programming within the tourism industry, especially in the Caribbean, is comparatively new. Even though this individuality is presumed for this case study it cannot be known for certain. *'Meaning: Is the evidence clear and comprehensible?'*[142, pg123] Documentation selected for this study was written in a precise and logical fashion. If there were any specific ambiguities within particular documentation or entire documents the researcher made every attempt of clarification with the document author, via email or conversation, or did not analyse the data as part of this study.

Some advantages of documents are that they can be reviewed many times over; they are unobtrusive and do not disrupt the participant's lifestyle; they are not created for the sole purpose of the study and some may argue they may be a more truthful representation of reality; if written precisely their content is deemed accurate and they may include a wide range of topics and events, over many years under varied situations; data examination of documents is typically easier to conduct, and cheaper to gather, than other methods such as interviews. However sometimes permission was needed to access documents [139-141]. When chronically documenting national HIV policies and programmes, having the document in hand made it easier to refer to any precise tourism references. Most policy documents, eg the TT NSP 2003-2008/10[144] made reference to the epidemiology and determinants of HIV in TT context. This assisted the researcher in understanding the context of HIV in relation to the tourism industry.

Disadvantages of using document review as a method for data collection include that some documentation may be difficult to find, not easily accessible or have deliberate restrictions placed on access and therefore may be more time-consuming to retrieve than primary data. For example, the researcher was unable to review the draft National HIV/AIDS Policy because it was still in draft form. Other disadvantages included selectivity bias in that the documentation may be incomplete; reporting biases as they represent the author's views and rely on the researcher's skill to retrieve and interpret content[139-142]. Disadvantages that occured up in the field were especially linked to accessibility of hotels' HIV policies or posters and/or flyers distributed to staff and/or guests.

3.2.3. FIELD STUDY NOTES

In addition to SSIs and document review, the researcher kept a field diary during data collection. These memos included operational notes regarding issues and challenges faced during this period, eg difficulties in getting an interview with a particular hotel owner/manager and names and contact information of prospective interviewees recommended by other participants. Also included were theoretical memos including emerging themes and relationships between themes[139]. Field study notes were also used to write interview notes for those participants who did not wish to be digitally-recorded of which there were 11 (three interviews with hotel owners/managers and eight with national organisations or key informants).

3.3. SAMPLING

Sampling methods in qualitative research include purposive, extreme or deviant, critical case, snowball, opportunistic, convenience, typical case and triangulated sampling, to name a few [139, 140, 142]. Purposive sampling, defined as *'selecting interviewees who will generate the appropriate data'* [139, pg102]was used in this research because it allowed for the selection of interviewees (from both groups – (1) hotels and (2) national organisations and key informants, as defined below) who could give *'information-rich… [data from which the researcher can then]… examine meanings, interpretations, processes and theory.'*[140, pg46] Purposive sampling allowed for the selection of respondents

who were able to answer the research questions and permitted the thesis researcher to achieve the study aim.

Data were collected from two groups of interviewees:

Hotels. In this study the term 'hotel' refers to an accommodation property in either Trinidad or Tobago that is NOT self-catering. This includes hotels, guesthouses, eco-resorts, and Bed and Breakfast (B&B) establishments. These types of accommodation properties were focussed on as they provided large amounts of interaction between guests and staff on a daily basis and examining these types of interactions, in the context of HIV policies and programmes that were adopted by the hotel industry, was necessary to achieve study objectives.

National organisations and other key informants. This group of interviewees was chosen to include perspectives of the private and public (government) organisations involved in policy formulation and programme design and implementation within the tourism or health sectors. This included public sector ministries and their implementing agencies, eg Ministry of Health, NACC, Ministry of Tourism, (in Trinidad) and Division of Health and Social Services (DHSS), Tobago HIV/AIDS Coordinating Committee Secretariat (THACCS), Division of Tourism and Transportation (in Tobago). Also included were private sector associations, eg HTAs. Key informants who have an intimate knowledge of the tourism and/or HIV sector were also included in this group, eg researchers in these sectors, persons who had expert contextual knowledge about the subject matter and/or information pertaining to the socio-cultural context of the country. See Appendix7 for the coded list of interviewees and organisations and Table 3.3 for numbers of interviews conducted per island.

3.3.1. HOTEL INTERVIEWS

Each island has its own HTA; the Trinidad Hotels, Restaurants and Tourism Association (THRTA) and the Tobago Hotel and Tourism Association (THTA). Each HTA had a registered list of hotels for the period 2009-2010, although not all hotels operating in TT are registered with either of these HTAs as it is not mandatory to do so. These registered

hotels – 32 in the THRTA and 38 in the THTA – were used as the sampling pool from which the researcher selected her participant properties. The researcher believed that it was necessary to have a sampling framework that included hotels from both islands as each island has a distinct tourism product and attracts tourists with differing expectations – Trinidad for the more business-oriented and Tobago for the more leisure-oriented visitor. Additionally the literature made reference to the possibility of different results between hotels with differing characteristics such as size and ownership. For example, Bakuwa's research (2010)[113] and WEF/Bloom et al's review (2005)[37] discussed the size of a company or hotel as being a factor in determining whether or not HIV practices were adopted, and Ketshabile (2010)'s[39] research in Botswana made inferences about companies that were locally-owned or joint locally and foreign-owned to the adoption of HIV workplace policies. In order to make comparisons between hotels in this thesis study, the following sampling frame was used:

a. Hotels from Trinidad and hotels from Tobago.
b. Hotels that were privately-owned and/or internationally franchised[31] or those that are government-owned and internationally franchised[32]
c. Hotels that was small, medium or large.

The sample of hotels is represented in Table 3.3. Based on (a-c above) and willing to participate in the study a total of 41 interviews were conducted on both islands (19 in Trinidad; 22 in Tobago). This included 43 different properties (19 in Trinidad; 24 in Tobago). In selecting potential interviewees within the hotels the researcher attempted to interview those persons who would have information necessary to achieve the study's objectives, eg the owner or staff member who is responsible for designing and implementing safety and health policies and practices for the hotel. Interviewees included owners, General Managers, and Human Resource (HR) Managers. The time span in this position varied considerably, from two weeks to 17 years. Collectively the researcher referred to this group of interviewees as hotel owners/managers. Both island-based HTAs classified their hotels' size according to number of rooms, each using a different classification scheme. In order to compare hotels by room size on each island, the researcher used an adapted classification scheme – small-sized: less than 20 rooms; medium-sized: 21-100 rooms; large-sized: 101 rooms and over. All hotels were

[31] These include solely privately-owned properties and internationally franchised properties that are privately-owned. Private ownership maybe with an individual, family or large local company.
[32] These include government-owned hotels that are internationally franchised properties. There are no solely government-owned hotels on either island.

privately-owned (by local family businesses/large corporate companies) or government-owned. Within both of these categories, hotels may be internationally franchised (IF), ie managed by operational guidelines of an international parent hotel chain. There were four IF hotels in Trinidad – two were government-owned and two were privately-owned; there were no IF hotels in Tobago. All IF hotels were classified as large hotels.

Table 3.3: Hotel sample represented in study

SIZE OF HOTEL		
	Trinidad	**Tobago**
Number of hotels	Small: 6 Medium: 7 Large: 6	Small: 12 Medium: 8 Large: 4
OWNERSHIP OF HOTEL		
	Trinidad	**Tobago**
Number of hotels privately owned and/or internationally franchised	17[33]	24
Number of hotels government-owned and internationally franchised	2[34]	0
SUMMARY NUMBER OF INTERVIEWS/HOTELS		
	Trinidad	**Tobago**
Number of interviews[35]	19	22
Number of hotels[36]	19 (59% of sampling pool)[37]	24 (63% of sampling pool)[38]

3.3.2. NATIONAL ORGANISATIONS AND OTHER KEY INFORMANTS

Representatives from national organisations (including the separate governmental administrations on each island) were purposively sampled based on their ability to provide detailed accounts relevant to the study. Some snowball sampling also occurred based on interviewees who were referred to the researcher by other interviewees because of their specific knowledge relevant to the study. Table 3.4 shows the interviews conducted with public and private sector organisations which operate at the national or island level.

[33] These 17 privately-owned hotels include two that were IF.
[34] Both government hotels are IF.
[35] One property was interviewed on two separate occasions with different interviewees.
[36] Three interviewees owned/managed two different properties.
[37] Sampling pool includes total of 32 hotels in Trinidad.
[38] Sampling pool includes total of 38 hotels in Tobago.

Table 3.4: Sampling framework of interviews at national and island levels

Organisation	Scope of Organisation	Sector	No of Interviews	Island
TT NACC[39]	National/Public	Health	1	Trinidad
Tourism Development Company	National/Public	Tourism	1	Trinidad
Ministry of Tourism	National/Public	Tourism	2	Trinidad
Trinidad Hotels, Restaurants and Tourism Association	Island/Private	Tourism	2	Trinidad
Ministry of Labour and Small and Micro-Enterprises Development	National/Public	Labour	1	Trinidad
University of the West Indies	Regional/Public	Health/ Tourism	1	Trinidad
Tobago AIDS Coordinating Committee	Island/Public	Health	3	Tobago
Division of Tourism and Transportation	Island/Public	Tourism	3	Tobago
Division of Health and Social Services	Island/Public	Health	2	Tobago
Tobago Hotels and Tourism Association	Island/Private	Tourism	2	Tobago
Tour operator	Island/Private	Tourism	1	Tobago

3.4. VALIDITY AND RELIABILITY

Lincoln and Guba (1985) [142, 145]argued qualitative research should be assessed on issues of *trustworthiness* rather than those of reliability and validity which are more suited to quantitative research. Such an evaluation would include issues of:

- Credibility (related to internal validity): are the results a true representation of reality? Was the researcher subjective when collecting and analysing the data? The researcher sought to ensure credibility through reflexivity and triangulation of data.

[39] The TT NACC is responsible, in theory for both islands (hence National) however, in practice it is only responsible for Trinidad.

- Transferability (related to generalisability): can the results be used in other situations and contexts? By reporting rich, detailed, in-depth accounts of results, by describing the how, when, where of every event including the researcher's emotions and thoughts at the time of data collection, the results may be used for future research comparisons[146].
- Dependability (related to reliability): will the results of the study be the same if repeated? Dependability was enhanced by keeping thorough records throughout the research process, eg for sampling, fieldwork etc.
- Confirmability (related to objectivity): if the data is sampled and collected in a comparable manner by another researcher, will s/he conclude similar findings? It is necessary that the researcher does not allow personal biases or theoretical perspectives to be overly introduced when collecting and analysing data. This was done through the researcher being reflexive during the study processes.

Critics of case study design have particular concerns with transferability. It is important to note that case study researchers may not aim to apply findings to other settings but rather are interested in gaining in-depth knowledge about a particular occurrence in a specific situation[141, 142, 147]. Several methods for ensuring trustworthiness in qualitative research exist[141, 142, 148, 149]. These include respondent validation; attention to deviant cases; fair dealing; triangulation; reflexivity and giving a clear account of the process of data collection. For the purposes of this study the researcher used the latter three.

Triangulation can be defined as the *'use of more than one method or source of data in a study of social phenomenon so that the findings may be cross-checked'*[142, pg387]. Triangulation was used by the researcher to corroborate data collected from interviews with document review. For example, data collected during interviews with the HIV Coordinator in the Ministry of Tourism with respect to HIV sensitisation events were corroborated through progress reports. Because data may be provided in different forms, eg through SSIs and documents, it can be difficult to compare information. Similar information from different data sets only allow for agreement of findings; when similar information cannot be found this does not prove that the findings are untrue. This is because each data set only provides a *'partial view of the whole picture'*[150, pg1117]. By examining another data set triangulation gave the researcher a more holistic view of the

process under examination. Document review was also used as a source of triangulation (see section 3.2.2.) to enhance the rigour of this study[140]. This was particularly useful when separate interviewees' accounts differed from each other or they could not remember details. For example, some interviewees were unsure about the exact dates of HIV sensitisation meetings and which hotels participated; this information was confirmed using meeting and annual organisational reports.

Reflexivity acknowledges the researcher's role in collecting and analysing the data. The reflective researcher takes into account her/his personal context, biases, prior assumptions and experience and clearly documents these when writing-up the study report. The researcher is a citizen of TT and lived most of her adult life in that country. She worked in both TT and other Caribbean islands with over ten years experience in the public health, and the private and public tourism sector. Her close working relationship with members of both sectors including private-public partnerships and regional involvement, allowed her an in-depth knowledge of the relevant stakeholders. She also worked with the QTC project which involved training tourism sector personnel to develop their own HIV practices. This former relationship with the majority of interviewees, knowledge of HIV practices and the processes involved in their adoption within a hotel, and an awareness of the socio-cultural climate of the country was acknowledged by the researcher. It was very important for the researcher during the study design process, data collection and analysis, forming conclusions; and giving recommendations not to express her personal views on why or why not a particular practice was or was not adopted and in particular, not to cloud the analysis with her former experience.

A clear account of the data collection process and all case study raw materials (documents, recorded interviews, transcribed interviews and field study notes – hard copy and electronically, where possible) have been kept. By *'maintain[ing] a [direct] chain of evidence'* [141, pg105], the material is available for independent investigation and the process of data collection can be re-traced if necessary. This will allow any independent observer to trace the researcher's steps from research question to the study design to the data collection to the analysis and conclusion, and back again.

3.5. RESEARCH ETHICS

The study was approved by the Ethics Committees at the London School of Hygiene and Tropical Medicine (LSHTM) (February 17th 2010) and the Ministry of Health, Port of Spain, Trinidad and Tobago (April 29th 2010). See Appendix 8a and 8b.

All interviewees were informed about the aims and nature of the project verbally by the researcher and through an information sheet (see Appendix 9) at the start of the interview. They were then invited to ask any questions about the research process and asked to sign a consent form (see Appendix 10) prior to the interview. Interviewees' consent was sought for the digital sound recording of interviews and the use of data provided. Because the study involves a small number of participants in specific organisations, particular attention was given to preserving confidentiality. In order to maintain confidentiality each participant was assigned a unique study identification number and on completion of the thesis, the identification numbers will be de-linked from personal identifiers. This procedure ensures that no data can be linked back to an individual. All data were stored in password protected files; this password is known only to the researcher. On completion of the study all research files pertaining will be deleted and removed from the researcher's hard drive. To avoid possible identification of interviewees in the final thesis, individual names and positions/roles were not linked to quotes; care was taken to ensure that quotes do not identify individuals; and data was presented in aggregate form. Interviewees were given the option of not being quoted at all, if they preferred.

3.7. DATA ANALYSIS

A framework approach to analyse the data was used. This involved the steps of transcription, familiarisation, thematic analysis, indexing, charting, mapping and interpretation [139, 151, 152].

- Transcription: recorded interviews were transcribed verbatim by two professional transcribers shortly after the interviews. Where the transcribers could not understand what was being said from the sound recordings, the researcher reviewed the sound file herself and clarified the written data. To

ensure quality of these transcriptions a random sample of eight transcripts was checked by the researcher against the original recordings. These proved to be accurately transcribed and no further transcripts were checked by the researcher. Some interviews were not sound recorded since interviewees refused. Instead these were captured as study notes by the researcher and written up in full shortly after each interview.

- Familiarisation: Transcribed interviews were then read by the researcher for her to familiarise herself with the content.
- Thematic analysis: To develop a draft list of themes two transcriptions were first reviewed in detail. While ensuring that all the research questions were addressed, key themes were identified and new and emerging themes noted from these two transcripts. These themes allowed the researcher to develop a coding frame based both on *a priori* and emerging themes.
- Indexing: Transcriptions and interview notes of the entire data set were then systematically coded according to the coding frame.
- Charting: The data fragments were then arranged according to themes.
- Mapping and interpretation: Themes were then grouped into concepts (eg management interests, attitudes and knowledge); extent and nature of the phenomena mapped (eg formal and informal HIV practices); relationships between themes and the meaning of these relationships explored (eg is the lack of hotel HIV workplace policies because of the fragmentation of national HIV policies?).

SUMMARY

The CF drew on a policy analysis framework and top-down policy implementation theory with an ecological perspective. It was also informed by empirical and contextual literature relevant to the subject and the thesis researcher's knowledge of the hotel sector in TT. From the review of the literature a list of expected facilitators and barriers to hotels developing HIV practices was drawn up and used to guide the data collection. The research study design used a qualitative approach with SSIs and document review as the main data collection methods. The two main groups of interviewees were representatives of TT hotels, and national organisations and key informants. Purposive sampling, with some snowballing was used to select interviewees as this allowed for the greatest variety of respondents to supply data that would enable the researcher to

answer the study's objectives. Table 3.5 shows how these methods relate to the study objectives.

Table 3.5: Study objectives and related data collection methods to achieve objectives

Study objective	Data collection method	
	Semi-structured interviews	Document review
1. To document the range of HIV prevention and control practices adopted by hotels in the TT tourism sector.	Principal	Supplementary
2. To identify the most important factors influencing whether and to what extent HIV prevention and control practices are adopted by hotels in TT.	Principal	Did not use this method.
3. To document TT national HIV policies and programmes and examine how the hotel and tourism sector has responded.	Supplementary	Principal
4. To recommend strategies in which the present TT HIV policies and programmes can be further supported and enhanced.	This objective was achieved through analysis and conclusions drawn from Objectives 1-3.	

The sampling pool for the hotels was taken from the registered hotel members' listing of each of the island-based HTAs. In Trinidad owners/managers of 19 hotels (59% of the THRTA-listed hotels) and in Tobago, owners/managers of 24 hotels (63% of the THTA-listed hotels) were interviewed. Interviewees from the second group, national organisations and key informants were drawn from government ministries responsible for national health, tourism and labour, based in Trinidad; government divisions responsible for health and tourism in Tobago; ministerial implementing agency for tourism; island-based coordinating agencies responsible for HIV; and key informants at UWI involved in national research on both HIV and tourism and a tourism operator in Tobago. There were a total of 19 interviews from 11 national organisations and key informants.

The thesis study was approved by ethics committees at LSHTM and the TT Ministry of Health. Before each interview, participants were required to read a study information sheet and sign a consent form. The interviews were either digitally recorded or detailed field notes were made; all data was reported in the thesis anonymously and in aggregate form. Data analysis was conducted using a framework approach. Lincoln and Guba's framework for trustworthiness of qualitative research was adopted: this involved the researcher incorporating concepts of triangulation, reflexivity and documentation of a clear and logical account of data collection into the study design.

CHAPTER 4 RESULTS: HIV PREVENTION AND CONTROL PRACTICES ADOPTED BY THE TOURISM SECTOR IN TRINIDAD AND TOBAGO

INTRODUCTION

The results presented in this chapter examine the HIV practices adopted by hotels in Trinidad and Tobago (TT) during the study period. They are based on data collected during semi-structured interviews (SSIs) with hotel owners/managers and where appropriate triangulated with data from documents and interviews with national organisations and key informants.

The thesis researcher describes policy content, or in this study, HIV practices reported by interviewees as adopted by the hotels. Hotel HIV practices were classified by the researcher as formal and informal, direct and indirect (see Box 4.1.).

Box 4.1: Classification of hotel HIV prevention and control practices

- Formal: practices that were documented and/or regularly put into action.
- Informal: practices that were not written down or were adopted in an ad-hoc manner.
- Direct: practices that were adopted specifically to prevent and control transmission of HIV and mitigate the associated impact.
- Indirect: practices that, when originally put in place, were not done so to address HIV prevention and control.

The following sections explore the content of direct and indirect, formal and informal practices in detail. They also analyse the different HIV practices according to the hotel which adopted the practices –on which island the hotel was located; whether or not the hotel was Internationally Franchised (IF) (there were only four IF hotels in this study and all of them were in Trinidad), whether or not the hotel was privately or government-owned (there were only two government-owned hotels in this study, both of which were large, IF and located in Trinidad); and the size of the hotel (small, medium and large). The practices discussed in sections (4.1-4.2) are presented and analysed according to of the number of different hotels that discussed the factors; the most commonly reported being presented first.

4.1. DIRECT HIV PREVENTION AND CONTROL PRACTICES

Non-discrimination towards staff and guests: Many owners/managers indicated that they adopted HIV practices whose content included non-discriminatory practices towards existing staff, or potential new staff, who are known to be HIV-positive. Such practices included staff not being fired, nor a potential candidate being refused employment once they had the relevant qualifications and experience and they were decidedly the best candidate. Hotel owners/managers also discussed stigma and discrimination (S&D) of known HIV-positive guests and all indicated that such guests would not be refused accommodation. In this case the room would be cleaned by only one staff member who would be duly informed of the occupant's HIV status and be trained on how to reduce risk of HIV transmission. Guest status would be kept confidential, known to only management and front desk and the relevant housekeeping staff. Even if these practices were not written down they were regularly practiced and thus classified as formal. A total of 27 hotels (out of the 43 partaking in this study) adopted this practice of non-discrimination. Of these 27 hotels 10 were in Trinidad and 17 were in Tobago. In Trinidad eight were privately-owned and two were government-owned. Three of these hotels were classified as small, three as medium-sized and four as large; two hotels were IF. In Tobago eleven were classified as small, four as medium-sized and two as large. Even though 27 out of the 43 hotel owners/managers reported having non-discrimination practices this is not to say that the remaining 16 hotels had not adopted any similar practice as discrimination of any form is illegal in TT.

HIV training and sensitisation seminars: HIV practices whose content included both formal and informal in-house staff training and HIV sensitisation seminars were reported at several hotels. These sensitisation seminars were held 1-4 times per year with staff and included such topics as HIV risk reduction, proper condom use, non-discrimination towards guests and staff, and how to treat known HIV-positive staff. One hotel owner/manager indicated that s/he had hired a Non-Governmental Organisation (NGO) to assist with the training and another described the hotel's Family Day for their staff. Family Day would have a booth, hosted by a local HIV NGO and dedicated to HIV prevention sensitisation, *'...there would be a whole session, [NGO] would give out free condoms and leaflets with demonstrations on the correct way to use condoms...'* This hotel owner/manager noted that at the Family Day fair, because, *'...[HIV] is so tabooed...'* the staff would not initially visit the booth but after the first few staff went then everyone started to go to the booth. A total of 11 hotels in Trinidad and seven hotels in Tobago

reported HIV training and sensitisation seminars. In Trinidad ten hotels were privately-owned and one was government-owned; three were classified as small hotels, five as medium-sized and three as large; one was IF. In Tobago two were classified as small hotels, three as medium-sized and two as large. The formal HIV sensitisation seminars were reported at six hotels. Four of these hotels were in Trinidad and two in Tobago. Five of these hotels were privately-owned and the remaining one was government-owned. One was classified as a small hotel, two as medium-sized and three as large; two hotels were IF.

Informal, ad-hoc or seasonal staff trainings were usually conducted, as one hotel interviewee reported, *'...in order to pacify...'* staff concerns such as finding used condoms in a room. These were hosted by policy actors such as the National AIDS Coordinating Committee (NACC), albeit at irregular intervals, in conjunction with the island-based hotel and tourism association (HTA) during periods of heightened HIV awareness, eg at Carnival time. Or, as indicated by two hotel owners/managers, on a one-on-one basis to staff who were in need of sexual health advice or a reminder about HIV risk-reduction procedures. Interviewees mentioned that posters or flyers were occasionally given to staff attending government training seminars or distributed seasonally by government and then placed in the staff area. However these posters were not replaced on a regular basis. One manager from a hotel in Tobago remarked that he did not distribute such flyers because, '*...none were given to them...'*

Reasonable accommodation: Several hotel interviewees indicated they provided flexible working conditions for staff not able to work in their usual position or area of the hotel due to the stage of their HIV infection. This practice of flexibility, defined by Joint United Nations Programme on HIV/AIDS (UNAIDS) as 'reasonable accommodation'[153], had content that included offering a desk job rather than one with a more strenuous role such as in housekeeping or working outdoors on the hotel grounds. However, as reported by a hotel owner/manager, even if an alternative position was offered, staff often did not wish to remain employed, *'...for fear of mauvaise langue [by other staff] ...for people to say, "boy look at he"...'* This practice was classified as informal by the researcher as it was not a common occurrence and only offered as the need arose. Of the hotels adopting this practice, six hotels were in Trinidad and seven were in Tobago. In Trinidad, five were privately-owned and one was government-owned. One hotel was classified as

small, two as medium-sized and three as large; two were IF. In Tobago three were classified as small, three as medium-sized and one as large.

Care and support of staff: Several hotel owners/managers discussed how they adopted care and support practices for staff. Practices included content that ensured HIV-positive staff had adequate information through trained peer counsellors; time-off to attend clinic sessions; and home visits by other staff and friends to offer support and assistance such as food delivery and transportation. This practice was neither documented nor widely publicised to staff because hotel management believed that they would not respond to the assistance offered, therefore this practice was classified as informal. Of the hotels adopting this practice, three were in Trinidad and three were in Tobago; all were privately-owned. In Trinidad all were classified as medium-sized. In Tobago one was classified as small and two as medium-sized; none were IF.

Condom distribution to staff and guests: Some hotels indicated availability of condoms to guests or staff on both a regular and an ad-hoc basis – this practice was classified as both formal and informal. One hotel owner/manager reported, '*initially we put them in the bathroom; in the staff room...they disappeared in no time.'* During peak visitor times, condoms were distributed by government (eg NACC, Ministry of Tourism) to hotels to be given to guests, *'... [at] carnival time somebody may hand out condoms [which] we give out loosely.'* In some hotels, guests were directed to the hotel pharmacy/gift shop or nearby 'corner shop' to purchase condoms. Interviewees from several additional hotels indicated that they did not make condoms available to staff or guests. Reasons given by these interviewees included either that there were pharmacies close by, there was no space on the hotel premises or because of moral grounds *'...I don't feel I should be party to encouraging it [sex]...'* Of the hotels that made condoms available to staff and guests, three were in Trinidad and two were in Tobago; none were IF. All five hotels were privately-owned. In Trinidad, all were classified as medium-sized. In Tobago one was classified as medium-sized and one as large. Of the seven hotels that did not make condoms available to staff and guests, five were in Trinidad and two were in Tobago. On both islands all the hotels were privately-owned; none were IF. In Trinidad, three were classified as small and two as large. In Tobago both hotels were classified as small.

Documentation for staff and guests: Several hotel owners/managers discussed a regular formal HIV practice whose content consisted of a list of emergency number lists including AIDS Hotline telephone contacts. The Tourism Development Company (TDC) – the government implementing agency – developed a brochure (see Appendix 11) which contains the National AIDS Hotline and is available to hotels. In this instance, actors in the adoption of this practice also included the TDC. One hotel from Tobago also reported placing information on condom use in the guest rooms. Interviewees from the hotels in Trinidad who reported this practice stated that this information was also available to staff through the hotel's Human Resource (HR)department, on staff notice board or in brochures distributed to staff. A Trinidadian hotel manager, who was particularly concerned about the sexual health of his staff, questioned *'...why can't the Ministry help us with these things?'* and retrieved information from the internet and made his own HIV pamphlets for distribution to staff. Of the six hotels reporting this practice, three hotels were in Tobago and three in Trinidad. On both islands all the hotels were privately-owned; none were IF. In Trinidad, two were classified as medium-sized and one as large. In Tobago all three hotels were classified as small.

HIV testing: Some hotels indicated HIV testing of staff prior to or during employment as part of the hotel's formal operational procedures. The reason given for testing was not to discriminate against hiring/firing someone who was HIV-positive, but to enable the employer to take precautions to mitigate HIV transmission in the workplace and/or as a requirement for the hotel insurance and pension schemes. In this instance, the actors were not only the hotel owners/managers but also the insurance and pension scheme companies. All of the nine hotels which specifically stated HIV testing, or not, of (potential) employees also indicated they had either an informal or formal policy of non-discrimination towards HIV-positive staff. Of these five hotels which requested HIV testing, three were in Trinidad and two were in Tobago. In Trinidad two of the hotels were privately-owned and one was government-owned. Two hotels were classified as medium-sized and one as large; one was IF. In Tobago, one were classified as medium-sized and the other as large. Four additional hotels said that they did not test staff or require that staff be tested. Of these four hotels one was in Trinidad and three were in Tobago. All hotels were privately-owned. In Trinidad the hotel was classified as medium-sized. In Tobago, two were classified as small and the other as medium-sized.

Overarching HIV workplace policies: When the interviewees were asked if their hotel currently had formal written HIV workplace policies or practices for staff or guests, very few had documented overarching HIV workplace policies and one was waiting for approval from management. The content of these workplace policies, as reported by hotel owners/managers laid out the hotels' strategies on HIV prevention and control in the workplace, including an awareness programme for both staff and guests and the rights and responsibilities of any Person Living with HIV (PLHIV) – staff or guest – at the establishment. Only three hotels in this study had a documented HIV workplace policy; a fourth was awaiting management approval. All of these four hotels were located in Trinidad. Three were privately-owned and one was government-owned. Two were classified as medium-sized hotels and two as large; two were IF. Additionally six hotels in Trinidad and 13 hotels in Tobago explicitly stated that they had no HIV-specific policies or programmes; none were IF. In Trinidad, all hotels were privately-owned and three were classified as small and three as medium-sized. In Tobago seven were classified as small hotels, four were medium-sized and two were large.

4.2. INDIRECT HIV PREVENTION AND CONTROL PRACTICES

Interviews with hotel owners/managers revealed that most hotels had policies and practices that when initially adopted did not seek to address HIV prevention and control but yet did so indirectly. These indirect practices were usually adapted from accommodation guidelines issued by the Trinidad and Tobago Bureau of Standards (TTBS)[154]. This extrapolation of safety to HIV practices was made by the researcher and then followed up with further probing of the interviewee. The exception to this was made by a few owners/managers, who believed that the use of gloves when cleaning rooms was a direct HIV prevention practice.

Use of gloves: The use of gloves when cleaning was reported by many hotel owners/managers as a regularly enforced and formal practice. Content of this HIV practice included use of gloves when cleaning guestrooms to prevent harm from corrosive chemicals, changing linens that were visibly soiled with blood or other bodily fluids and removing used condoms and needles/syringes. Housekeeping staff in the hotels were reported *'...to have all done training on wearing gloves and handling bed linens regardless of any disease'.* The majority of interviewees reported that cleaning staff

did not like to wear gloves. As reported by a hotel owner/manager when paraphrasing a staff member, *'...dem gloves does make mih hands too sweaty...'* and only two of these hotels (both in Tobago) indicated that use of gloves was mandatory. Some of the owners/managers negotiated with cleaning staff to ensure that they used gloves when changing soiled bed linen or emptying bins but did not enforce the use of gloves when handling clean linen. Of the 25 hotels who adopted this practice, 12 were in Trinidad and 13 in Tobago. On both islands all the hotels were privately-owned; none were IF. In Trinidad four were classified as small, six as medium-sized and two as large. In Tobago, eight were classified as small and five as medium-sized.

Staff-guest interaction: The practice of reducing staff-guest interaction was reported by many hotel owners/managers, *'...it is not the best thing [for staff] to be fraternising with the guests ... not because of HIV alone, we are talking about guest security, ... if your workers get too familiar accusations left, right and centre can occur...'* Content of such practices included: staff not permitted to have relationships (sexual or otherwise) with guests while on the property; unregistered guests staying in the room overnight incurred an additional charge; and guests encouraged to meet their visitors outside the guest room. It was reported by interviewees that these indirect practices were originally adopted in order to avoid or mitigate (bodily) harm to guests and consequent legal action against the hotel. Hotel owners/managers who reported that staff were not permitted to have relationships with guests on the property also discouraged such relationships off the hotel premises. Hotel owners/managers also reported that the names of unregistered visitors to guest rooms, in particular those who stayed overnight, must be noted at reception. A hotel owner in Trinidad intentionally charged a double room rate for all rooms to avoid having to charge the guest extra if they had a visitor overnight. In Tobago interviewees indicated that they had hotel security guards monitor the movement of people in and out of the rooms, especially at night. These security officers were important in the adoption of this practice as at least one hotel owner/manager reported that guests would bribe the security guards to look the other way. These HIV practices were all classified as formal practices, as they were practiced regularly at hotels, even though not always documented in the hotel's operating manual. Of the 24 hotels adopting this practice, nine were in Trinidad and 15 in Tobago. In Trinidad eight were privately-owned and one was government-owned. Four were classified as small, three as medium-sized and two as large; one was IF. In Tobago seven were classified as small, six as medium-sized and two as large.

First aid kits and trained staff member on premises: Several hotels indicated that they had first aid kits on hotel premises as part of the formal operating procedures. Having such kits and a member of staff trained in first aid techniques, is a regulation stipulated by the TTBS[154, 155]. At one hotel, content of this practice included a specifically trained staff group called 'first responders' who attended any accident, *'...where there is the risk of blood-borne pathogens including HIV [being present].'* Of the five hotels adopting this practice, two were in Trinidad and three in Tobago. In Trinidad one was privately-owned and the other was government-owned. One was classified as small and the other as large; one was IF. In Tobago one was classified as small, one as medium-sized and one as large; none were IF.

SUMMARY

Table 4.1 summarise the 11 different HIV practices adopted by hotels in TT. All hotels had some form of HIV practice even if it was not set in a regular, documented HIV programme or organisational policy; most hotels were reported to have a combination of different HIV practices, eg some hotels had informal direct practices pertaining to HIV testing and sensitisation seminars and at the same time formal indirect practices about the use of gloves to clean rooms.

Table 4.1: Direct and indirect HIV practices that were adopted by the hotels

	Number of hotels			
Direct HIV practices	**Formal**	**Informal**	**Trinidad**	**Tobago**
Non-discrimination towards HIV positive staff and guests	27	0	10	17
HIV training and sensitisation seminars (regular and ad-hoc) for staff including poster and fliers in staff area	6	12	11	7
Reasonable accommodation for staff and flexibility of working conditions	0	13	6	7
Care and support for HIV positive staff and their families	0	6	3	3
Condom availability for staff and guests[40]	5		3	2
Documentation for staff and guests	6	0	3	3
HIV testing prior to, or during employment	5	0	3	2
HIV prevention and control overarching workplace policy in place for hotel[41]	4	0	4	0

[40] Researcher unable to ascertain exact number of hotels that had this practice as formal or informal.
[41] Three hotels had written HIV workplace policies and a fourth was waiting approval.

	Number of hotels			
Indirect HIV practices	**Formal**	**Informal**	**Trinidad**	**Tobago**
Use of gloves to clean rooms	25	0	12	13
Staff-guest interaction[42]	24	0	9	15
First aid kits and staff member trained in First Aid techniques on premises	5	0	2	3

SUMMARY TOTAL NUMBER OF HOTELS	**TRINIDAD**	**TOBAGO**
ADOPTING DIRECT PRACTICES	**18**	**18**
ADOPTING INDIRECT PRACTICES	**18**	**21**
ADOPTING EITHER DIRECT AND INDIRECT PRACTICES	**19**	**24**

Note

1. The same hotel may have adopted more than one practice.
2. Not all hotels responded to having/not having a particular practice, for example according to the Table 4.1, at the time of the study 13 hotels in Tobago had reported the use of gloves to clean rooms. Bearing in mind that owners/managers from 22 hotels in Tobago were interviewed in this study this does not necessarily mean that 9 (22-13) hotels in Tobago did not stipulate that staff use gloves to clean rooms; what this means is that 12 hotels did not discuss this issue with the researcher.

By method of simple counts, the most common type of direct HIV practice at hotels was that of non-discrimination towards either guests or staff or both; this was followed by HIV training and sensitisation seminars for staff and then by the practice of reasonable accommodation for HIV-positive staff. Other practices included care and support for HIV-positive staff and their families, condom availability for staff and guests, emergency numbers and other HIV prevention literature, HIV testing of staff and HIV specific workplace policies. The most common type of indirect practice reported by hotel owners/managers was the use of gloves to clean rooms followed by those practices aimed at reducing staff-guest interaction and the presence of first aid kits and staff trained in first aid procedures. Generally, it was reported by most of the hotel interviewees that the tourism and hospitality industry in TT had strict practices, whether formal or informal, of non-discrimination towards guests and staff and non-fraternisation between guests and staff. The thesis researcher noted an interesting fact – HIV testing prior to, and during employment, existed within the TT labour market, even though TT was a signatory to the International Labour Organisation Code of Practice on HIV/AIDS and the World of Work. This Code of Practice strictly prohibits HIV testing as a *'...condition at the time of recruitment or as a condition of continued employment.'* [156, pg44]. While there was a mixture of formal and informal practices for those that were direct practices, all the indirect practices were formal or reported to occur on a regular basis. The thesis researcher suggests that these indirect practices were adopted as a

[42] This category included staff not being permitted to have relationships (sexual or otherwise)with guests on property; unregistered visitors of guests who stay overnight, will incur additional room charges; and any visitors of guests must meet guests outside of the room.

result of mandatory regulations or guidelines set out by the TT tourism and accommodation industry. They were generally preventative measures against possible legal action being taken against the hotel, eg the practice of non-fraternisation between guests and staff which could result in injury to guests and possible legal action.

The TT hotels in which HIV practices were adopted can also be classified in terms of being privately-owned or government-owned and in terms of size – small, medium or large (see section 3.3.1). This data has been summarised in Table 4.2. The researcher has also indicated practices adopted by IF hotels. In this study only four hotels were IF; all in Trinidad and all classified as large. The IF hotels adopted HIV practices whose content, if not followed, could lead to legal action such as practices to prevent non-discrimination towards HIV-positive guests and staff, and practices that reduce staff-guest interaction; yet one IF hotel also adopted the HIV testing of employees which goes against the ILO Code of Practice. In Tobago there were no government, or IF, hotels and therefore comparison across both islands by ownership, size and whether or not the hotel was IF proved difficult. By method of simple counts it can be seen that in Trinidad, government hotels adopted seven different types of HIV practices whereas the privately-owned hotels have adopted the full range of 11 different types of HIV practices found in this study. In Tobago, where there are only privately-owned hotels, ten out of the 11 different types of practices were adopted. With regard to hotel size, and again using a simple count, on both islands there does not appear to be any great differences regarding the number of HIV practices adopted –in Trinidad, the small, medium-sized and large hotels have adopted six, ten and nine different types of HIV practices respectively and in Tobago, the small, medium and large hotels have adopted eight, nine and seven types of practices respectively.

Finally, in this thesis study policy actors can be defined as persons or organisations that influence the adoption process of HIV practices. Such actors as discussed in this chapter were noted to be not only the hotel owners/managers but also hotel security guards who assisted in ensuring that the practices were effectively adopted; state implementing HIV and tourism agencies; national regulatory boards who produced safety and health guidelines for the tourism industry; and non-state actors such as NGOs who assisted with HIV awareness sessions and private-sector insurance and pension scheme companies.

Table 4.2: HIV practices classified according to hotel ownership, size and international franchise

Direct HIV practices	Number of hotels									
	Trinidad						Tobago			
	Ownership		Hotel size			IF	Ownership	Hotel size		
	Government	Private	S	M	L	IF	Private	S	M	L
Non-discrimination towards HIV positive staff and guests	2	8	3	3	4	2	17	11	4	2
HIV training and sensitisation seminars (regular and ad-hoc) for staff including poster and fliers in staff area	1	10	3	5	3	1	7	2	3	2
Reasonable accommodation for staff and flexibility of working conditions	1	5	1	2	3	2	7	3	3	1
Care and support for HIV positive staff and their families	0	3	0	3	0	0	3	1	2	0
Condom availability for staff and guests	0	3	0	3	0	0	2	0	1	1
Documentation for staff and guests	0	3	0	2	1	0	3	3	0	0
HIV testing prior to, or during employment	1	2	0	2	1	1	2	0	1	1
HIV prevention and control overarching workplace policy in place for hotel	1	3	0	2	2	2	0	0	0	0
Indirect HIV practices										
	Trinidad						Tobago			
	Ownership		Hotel size			IF	Ownership	Hotel size		
	Government	Private	S	M	L	IF	Private	S	M	L
Use of gloves to clean rooms	0	12	4	6	2	0	13	8	5	0
Staff-guest interaction	1	8	4	3	2	1	15	7	6	2
First aid kits and staff member trained in First Aid techniques on premises	1	1	1	0	1	1	3	1	1	1

SUMMARY: TOTAL NUMBER OF PRACTICES (DIRECT and INDIRECT) ADOPTED BY DIFFERING HOTEL TYPES	TRINIDAD	TOBAGO
ADOPTED BY GOVERNMENT HOTELS	**7**	**No government-owned**
ADOPTED BY PRIVATE HOTELS	**11**	**10**
ADOPTED BY SMALL HOTELS	**6**	**8**
ADOPTED BY MEDIUM-SIZED HOTELS	**10**	**9**
ADOPTED BY LARGE HOTELS	**9**	**7**
ADOPTED INTERNATIONALLY FRANCHISED HOTELS	**7**	**No IF**

Note: Ownership: Private or Government ownership. Size of hotel: small (S), medium (M) or large (L). Internationally Franchised (IF): whether or not hotel was managed by operational guidelines from an international parent hotel chain. There are no government or Internationally Franchised hotels in Tobago.

CHAPTER 5 RESULTS: FACTORS INFLUENCING HOTELS' ADOPTION OF HIV PREVENTION AND CONTROL PRACTICES

INTRODUCTION

This chapter explores factors influencing the development and adoption of HIV practices in Trinidad and Tobago (TT) hotels. As in Chapter 4, the results presented in this chapter are based on data collected during semi-structured interviews (SSIs) with hotel owners/managers and where appropriate triangulated with data collected from documents and interviews with national organisations and key informants. The study's conceptual framework (CF) (Figure 3.1) uses the elements of policy analysis – context, content, actors and process. This chapter analyses those factors that support (ie facilitators) and hinder (ie barriers) the adoption process of policy content, or in the case of this study, hotel HIV practices. In analysing the factors to the process of adopting HIV practices, the researcher also examines the actors involved, for example hotel owners/managers.

The researcher categorised the facilitators and barriers according to an ecological framework of factors that are both external and internal to the hotel environment. Factors that are internal to the hotel environment are further subdivided into three themes that address hotel operational factors, individual behaviour factors of management and individual behaviour factors of staff (see Figure 3.1). Also demonstrated in the CF by the dotted line, is that these themes are often interconnected. The facilitators and barriers in each of the following sections (5.1-5.2) are presented and analysed according to the number of different hotel interviewees that discussed the factors; the most commonly reported factors being presented first. Factors reported by national interviewees, did not refer to any particular hotel(s) in either Trinidad or Tobago but were rather a general comment about hotel owners/managers. Factors external to the hotel environment including public policy are presented and discussed in Chapter 6.

5.1. FACILITATORS AND BARRIERS: HOTEL STAFF ATTITUDES AND BELIEFS

Knowledge of and attitudes to HIV and AIDS: Hotel owners/managers suggested that amongst the general TT population, including most of the local tourism employees, there was a relatively high level of knowledge about HIV due to government health promotion programmes which targeted them. Additionally, hotel interviewees reported that nearly everyone on both islands was either acquainted with someone who was HIV-positive or who had died from AIDS. Actors such as hotel owners/managers reported that staff awareness of HIV acted as a facilitator in the adoption process of HIV practices. As such, staff were now more receptive to receiving HIV information than in the past, and more willing to attend HIV sensitisation seminars on, for example, modes of HIV transmission and how to reduce it. Some hotel owners/managers reported their hotels had been used as venues for HIV seminars/conferences. It was the staff's negative reaction to these events that triggered management to adopt HIV practices, eg in-house seminars, to increase staff HIV awareness. Interviewees reported that, '*...staff will start to get sceptical, "you know, these people coming here and they have AIDS," and I think that was an incentive then and there to get the staff trained as to how to deal with situations and with people who are supposed to be HIV-positive'.* Knowledge of and attitudes to HIV and AIDS was reported as a facilitator by 14 hotels. In Trinidad seven hotels were privately-owned and one was government-owned; two were classified as small, four as medium-sized and two as large; one was Internationally Franchised (IF). In Tobago two were small, three were medium-sized and one was large.

Contradictory to this reported increase in HIV awareness from the hotel owners/managers, statements from national tourism and health sector interviewees indicated, *'...a high level of ignorance surrounding HIV...',* among the general public and hence the pool of tourism employees. This reported low level of knowledge acted as a barrier in the adoption process of HIV practices. It should be noted that it was hotel interviewees that reported an increased level of HIV knowledge among staff whereas national interviewees reported a low level of HIV knowledge among hotel owners/managers. These statements, reported by national interviewees, did not refer to any particular hotel but were general comments about hotel owners/managers. The thesis researcher suggests these contradictory views were as a result of hotel

interviewees stating this facilitator from an anecdotal point of view whereas the national interviewees basing their statements that this factor was a barrier on research data[8].

Staff resistance to the adoption of hotel practices: Hotel owners/managers reported that expressions of staff's resistance to increasing one's HIV knowledge, eg denying that HIV is a problem, HIV is a health issue that may not even affect them, '*...I'm not one of them who is going to get it, (steups[43]) I don't need to know anything'*, or just burn-out from hearing about HIV, '*...Oh God! Ah nex' meeting again, on the same thing!'* were factors that acted as barriers in the adoption process of HIV practices. Further incidents of hotel staff resistance to the adoption process occurred when the staff objected to wearing gloves when cleaning rooms, particularly in Tobago. The preferred habit when cleaning rooms is to use one's bare hands, '*...housekeeping say that it is uncomfortable...'* and this cultural context acted as a barrier towards the adoption of HIV practices. Another example of resistance to the adoption process was that staff often became forgetful and management would have to frequently remind them to adopt the practices even though both parties had previously agreed, '*...even if you tell them something now, ten days down the road, fifteen days, a month after, they'll want a refresher'.* This factor was reported as a barrier by hotel interviewees at 16 hotels; eight in Trinidad and eight in Tobago. In Trinidad seven hotels were privately-owned and one was government-owned; three were classified as small, four as medium-sized and one as large; one was IF. In Tobago four were small, three were medium-sized and one was large.

Stigma: HIV, sex and sexuality: Another barrier to the adoption process of HIV practices as reported by hotel interviewees was hotel staff's beliefs relating to stigma surrounding HIV, sex and sexuality. This barrier hindered hotel owners/managers wishing to adopt HIV practices whose content included attendance at HIV sensitisation sessions; provision of care and support; and retention of HIV-positive staff members. Part of the stigma associated with HIV is linked to homosexuality. Homosexual acts are illegal in TT and also considered morally wrong by large sectors of society particularly the church. It was reported by hotel interviewees that homosexuality was not spoken about openly, in any forum either at school or the workplace, '*... if a high school student went to a teacher now and wanted to discuss something related to sexual education, he would probably get "skins and grins"[smiling broadly usually because of an embarrassing situation, ie*

[43] Noise of disgust or disapproval made by sucking tongue against the teeth.

homosexuality…]'. In the Caribbean context sex and sexuality are considered culturally taboo and should not be discussed in the workplace, '*...the general circuitry in the West Indian mind is that sex and sex education is not something that is openly discussed. It's like talking about politics and religion; in our culture you are told from very small not to talk about that'.* It was reported that some hotel employees did not want to attend the training sessions which discussed homosexuality because if they did, their colleagues would believe that they themselves were gay. The TT cultural context is one of 'machoism' and being gay is considered to be feminine.

Another example was given when one Tobagonian hotel owner/manager reported that it was difficult to encourage staff to attend the Tobago Health Promotion Clinic as it was originally an AIDS-specific treatment centre,'... *once people see you going there they say, "that is the AIDS place", you know that kind of thing, they had that sort of stigma'* . This stigma towards HIV and sexuality has led some hotel owners/managers to not adopt flexible working conditions for HIV-positive or gay staff as they believed that the employees would treat such staff members in a discriminatory and hurtful manner. This cultural taboo about sex and sexuality may be somewhat conflicting to ideas and beliefs of other hotel interviewees when they stated that, '... *[being HIV-positive] is not considered like a big thing anymore...'* . The thesis researcher believes that this speaks to the context of Tobago's culture and its people's attitudes towards sex and sexuality. In Tobago as reported by Allen (2002)[157] and Brebnor (2007)[17] sex is not discussed publicly and people keep their sexuality a private matter, therefore adopting HIV practices, whose content involves public discussions of sex and sexuality are not encouraged.

Related to stigma is the concern about confidentiality of one's HIV status among the general population, particularly in Tobago, and hence within the tourism workforce. This was mentioned as a barrier by national interviewees in the tourism sector, *'... you go to the hospital and before you could leave somebody down the road could tell you your status...'* Confidentiality, or lack thereof, was also corroborated by hotel owners/managers in Tobago, as a factor of the cultural context that hindered the adoption process, '*…in a small clannish society like ours where everybody knows everything and there is nothing confidential, let's put it like that…'.* This barrier was reported by hotel interviewees at eight hotels; four in Trinidad and four in Tobago. In

Trinidad all four hotels were privately-owned; one was classified as small, two as medium-sized and one as large; none were IF. In Tobago three were medium-sized and one was large.

Hotel staff educational level: Educational level of staff was also cited as a barrier towards the adoption process of HIV practices by hotel interviewees, '*...cleaning staff are cleaning staff, they are pretty much at the bottom of the food and intellectual chain and too much information might just be overkill for them...'* Actors, such as hotel owners/managers believed that if employees did not have a basic education then it was very difficult for them to understand the content of an HIV sensitisation seminar where issues of HIV transmission and condom use were discussed. Additionally it was reported by hotel owners/managers that if an employee was sent on an HIV training exercise, because of their low educational level, they would not be competent or have the confidence, to share the knowledge they gained with other staff members on their return and therefore dissemination of such information would be limited, '*...you will always get the defensive role in "Do I have to do that?" "How would I know?" and some of them you start to see a fear come over them...it took a while for people to comprehend...that is because of the level of education'.* Actors involved in the adoption process included either the hotel staff itself (internal actors) or government agencies or AIDS Non-Governmental Organisations (NGOs) (external actors) involved in organising of HIV awareness sessions for staff. This barrier was reported more substantially in Trinidad than in Tobago, by hotel interviewees at five hotels; four in Trinidad and one in Tobago. In Trinidad all hotels were privately-owned; one was classified as small, two as medium-sized and one as large; none were IF. In Tobago, the single hotel was classified as small.

5.2. FACILITATORS AND BARRIERS: HOTEL MANAGEMENT INTERESTS, ATTITUDES AND KNOWLEDGE

HIV as a priority within the tourism sector: Lack of recognition that HIV was an important issue within the tourism sector was reported by many hotel owners/managers as a barrier to the adoption process of HIV practices. Reasons given by interviewees why HIV was not considered an important issue, reflected by the limited adoption of HIV-related practices in hotels, included the following beliefs by hotel owners/managers: the visitor focus in Trinidad was more on the business rather than

the leisure market hence there would be minimal, if any, high-risk sex tourism; HIV prevalence rates within Tobago were decreasing despite sex tourism being common; high HIV rates in TT did not have, and will not have, an impact on visitor arrivals; HIV does not affect the tourism workforce (in terms of productivity and absenteeism); and hotel management's belief that they have had or will have either a staff member or a guest who is HIV-positive. An interviewee (in Tobago) voiced his concern that introducing HIV practices *'would not help to bring more tourists here. That's my priority'.* Linked to the issue of HIV being a low priority within the tourism industry and the limited adoption of HIV practices within hotels is the issue of resource allocation. Some hotel owners/managers indicated that*, '...anytime it's a consideration of how much [a specific activity] is costing and there are other things that have to be paid for right now, [that specific activity] would always get done tomorrow...And you know what, tomorrow never comes, next week never comes'.* Reasons given why HIV practices whose content included HIV sensitisation or flexibility of responsibilities for HIV-positive employees were not adopted included a shortage of hotel resources such as time, money and staff. Resources as a barrier to the adoption process will be discussed further in section 5.3. This factor was reported as a barrier by hotel interviewees at 23hotels; 11 in Trinidad and 12 in Tobago. In Trinidad ten hotels were privately-owned and one was government-owned; five were classified as small, three as medium-sized and three as large; two were IF. In Tobago six were small, five were medium-sized and one was large.

Conversely there was recognition by some hotel owners/managers that HIV was a priority in the tourism industry and that their managerial involvement, as actors in the adoption process, acted as a facilitator. A hotel owner/manager in Trinidad reported, *'...it is extremely important especially now that you hear all the talk, you hear the communication being passed about HIV and the epidemic that we are in...that you take prevention [practices]'.* This supporting factor in the adoption process was reported by hotel interviewees at 15hotels; ten in Trinidad and five in Tobago. In Trinidad nine hotels were privately-owned and one was government-owned; four were classified as small, four as medium-sized and two as large; one was IF. In Tobago three were small, one was medium-sized and one was large.

<u>Management attitudes and knowledge of HIV:</u> Positive management attitudes towards, and increased knowledge of, HIV facilitated the adoption process of HIV practices.

Incidents shared by hotel interviewees revealed management's wish to increase staff's knowledge by developing a learning culture within the hotel. Owners/managers of some of the smaller, family-run hotels reported, '*...you have to prepare your staff for all the eventualities of life. There is a paternalistic approach to the staff here because you try to look out for their welfare because they feel kind of family-like'.* The thesis researcher believes that increased HIV knowledge by hotel owners/managers can be related to a personal incident, such as an employee being HIV-positive. In some cases, in order to protect their staff, actors such as hotel owners/managers took it upon themselves to develop HIV material, whose content included information on modes of HIV transmission, and distributed them among the staff. Another hotel manager indicated that if he found any unused condoms still in their intact packaging that had been left in the rooms by guests, he would make them available to staff. National interviewees agreed that when hotel owners/managers became aware of issues pertaining to HIV transmission and risk, they acted to protect their staff. This heightened awareness acted as a facilitator to owners/managers in the adoption process, *'... (name of hotelier) was sensitised to HIV because of the QTC (Quality Tourism for the Caribbean) project...and his wife worked with the Ministry of Health...that is why (name of hotelier) would sensitise his staff'.* A national interviewee commended Trinidad hotel management actors who re-arranged staff schedules and facilitated attendance at sensitisation meetings. However in Tobago such re-arrangements, as reported by the national interviewee, were more difficult to accomplish, *'...[hotel owners/managers] have a problem with sending staff to get trained...they want to get all they can from staff'.* . This facilitating factor was reported by hotel interviewees at 11 hotels; six in Trinidad and five in Tobago. In Trinidad five hotels were privately-owned and one was government-owned; three were classified as medium-sized and three as large; two were IF. In Tobago two were small, two were medium-sized and one was large.

National interviewees indicated that developing an HIV policy and programme is believed to be daunting, especially among the smaller properties. This management attitude acted as a barrier to the adoption process and was met with automatic resistance, *'...developing a policy sounds like a big thing for a small organisation...'.* National interviewees believed that hotel management, *'...needed to understand that policies were not fixed in stone...policies can change and adapt and flex according to the needs of society...'* . A national interviewee also stated that it was her belief that hotel owners/managers were afraid of *'taking ownership [of an HIV policy and programme]*

just on the odd chance it did not work' and it was this fear that acted as a barrier towards the adoption process of an HIV strategy.

Management's response to guest's behaviour and perception of their needs:

Management interests and attitudes that facilitated the adoption process of HIV practices in hotels have also been shaped as a result of management's role in responding to the perceived needs of the hotel's guests. At the staff level, a hotel owner/manager indicated that by conducting HIV sensitisation seminars, highlighting modes of HIV transmission, gave staff the confidence to remove linen soiled by blood or other bodily fluids or even remove used intra-venous needles from guest rooms without fear of contracting the virus. Such situations, as described by the hotel interviewees, manifested themselves when staff had personal[44] contact with, or when cleaning the room of, a person known to be HIV-positive or gay; staff and/or guest requested condoms; and guests brought additional, unpaid guests into the room overnight. This facilitating factor was reported by hotel interviewees at four hotels; three in Trinidad and one in Tobago. In Trinidad all three hotels were privately-owned; one was classified as small and two as medium-sized; none were IF. In Tobago, the single hotel was classified small.

Hotel management's response to the perceived wishes of guests was indicated as a barrier to the adoption process, and reported, '*...guests want to escape their 9-to-5 jobs, their routine lives, traffic, the news, foods, everything bad that is happening in the world and while people should still be protective of themselves and make their own decisions, I think it is also our jobs to allow people to escape from that...'.* This hindering factor took several forms: management stating that guests were on holiday and wanted to be removed from reality, not wishing to be restricted even by literature on HIV/health issues; interactions between guests and staff did not harm either party, some hoteliers believed that if the guests and staff were discreet in their liaisons then, '*...does it really matter?'*; and guests would be offended by HIV practices adopted by the hotel, eg some hoteliers indicated that an HIV practice, whose content including wearing gloves to clean rooms would offend guests who may worry that there was a contagious illness at the hotel. The preceding three beliefs were reported by interviewees from hotels in Tobago. In Trinidad several hotel interviewees reported that it was not the hotel's responsibility

[44] Personal contact: speaking to an HIV-positive person or a group of HIV-positive people; possible light touching of the body but no sexual interactions.

to give advice on sexual health practices to its guests because most of the guests were adults or that '*the hotelier is certainly not an expert on the disease'.* This factor was reported as a barrier by hotel interviewees at 12 hotels; five in Trinidad and seven in Tobago. In Trinidad four hotels were privately-owned and one was government-owned; three were classified as small, one as medium-sized and one as large; one was IF. In Tobago five were small and two were medium-sized.

Personal incident: Hotel owners/managers reported that having been directly affected by HIV acted as a catalyst, and thus a facilitator, to the adoption process of HIV practices within their hotels, '*...a few years ago when one of our staff was stricken with [AIDS]... our staff got together to help him...so that is how the whole thing evolved...in a way it was kind of a turning point'.* National interviewees have also acknowledged that when hotel owners/managers are directly affected by HIV this facilitated the adoption process. Personal incidents reported by both hotel owners/managers and national interviewees took the form of having an employee, family or friend who was HIV-positive or died from AIDS; family, spouse or close friend who worked in the health system; HIV being an important public health issue and discussed in the media; or a staff member who was gay or bi-sexual and hotel management felt responsible to educate staff on HIV risk reduction. Such incidents facilitated management's decision to contact HIV government agencies or ask a personal contact working in the health sector to speak with staff about HIV and AIDS. One hotel manager in Tobago reported that she had looked after her friend who was dying from an AIDS-related illness. Another manager took it upon herself to speak with her gay employee about HIV transmission when it came to her attention that this particular employee was spending a lot of time with a male guest. All such personal catalysts made the particular owners/managers aware of the importance of, not only educating staff but, being actors in the adoption process that would assist HIV-positive employees to continue working and remain healthy. This facilitating factor was reported by hotel interviewees at nine hotels; five in Trinidad and four in Tobago. In Trinidad four hotels were privately-owned and one was government-owned; one was classified as small, three as medium-sized and one as large; none were IF. In Tobago three were small and one was medium-sized.

Concerns about hotel's reputation: Interviewees from hotels on both islands, but mainly in Trinidad, had concerns about the hotel's reputation if the content of HIV practices

included distribution of HIV literature or the placement of condoms in guest rooms, '*...the first thing that comes to mind is that if I put condoms or [condom] vending machines [for guests], it's almost as if you are telling the guest that there is a potential problem here and not necessarily that I'm equipping you to prevent you from a potential problem'.*Hotel interviewees reported that they believed if guests or staff knew there was an HIV-positive employee at the hotel or that HIV-positive guests were staying or had stayed at the hotel, the hotel's reputation would become tarnished. '*...you know in this business you don't want a scandal, you can get blacklisted very, very quickly and it does not take much for word to get out [that you have an HIV-positive staff member] ...it is very, very difficult to keep a secret...any minute that information could go public and I would be really, really worried about that'.* These concerns were linked to a fear of loss of potential revenue by hotel interviewees who reported, '*...It is a bit tricky; it is a potential double-edged sword. You don't want to announce that there are things that could potentially turn-off business but still you want to warn visitors that [they] need to be cautious'.* Thus these concerns manifested themselves as barriers in the adoption process. This factor was reported as a barrier by hotel interviewees at eight hotels; five in Trinidad and three in Tobago. In Trinidad four hotels were privately-owned and one was government-owned; two were classified as small, one as medium-sized and two as large; one was IF. In Tobago, all hotels were small.

<u>Buy-in from hotel head office:</u> Another facilitating factor to the adoption process of HIV practices, as reported by national interviewees was buy-in and support from the particular hotel's head office. For example one particular IF hotel was receptive to the development of an HIV workplace policy, through the Government of the Republic of Trinidad and Tobago/International Labour Organisation/United States Department of Labor (GORTT/ILO/USDOL) International HIV/AIDS Workplace Education Programme. This IF hotel was amenable to developing an HIV workplace policy because it had received encouragement from high-level management actors within the hotel chain; it was *'...an international directive [from the hotel chain's head office] to address HIV'.* This point was confirmed by a national interviewee from a tourism agency that *'...you might stand a greater chance of getting it [policy and programme development] done with an international chain as opposed to a locally owned hotel...because the local decision-makers don't see it as being important'.* In a related example, another national interviewee reported that even though management appeared to be interested in developing a policy, one of the major reasons no workplace policy or programme of activities was eventually

formulated was because it was the staff nurse who attended the workshops for the development of a workplace policy. This particular national interviewee suggested that though the nurse may have had the requisite technical skill in understanding what was necessary for an HIV policy to be successfully implemented, s/he did not have any authority to allocate resources to such policy development. Perhaps if management or another staff member with the necessary authority had attended the workshops, such a policy or programme would have been adopted. The researcher suggests that this lack of management buy-in and support, through not allocating the necessary resources (human/technical and financial) acted as a barrier to the adoption process. This example illustrates how different levels of actors, eg head office, and the importance of actors, (ie high-level management issuing an international directive) can have an impact on the development and adoption process. In these statements concerning buy-in from a hotel's head office as a supporting factor, the national interviewees did not name any particular hotel(s) in either Trinidad or Tobago.

5.3. FACILITATORS AND BARRIERS: HOTEL OPERATIONS, SYSTEMS AND RESOURCES

Existing hotel systems and operations: Hotel owners/managers indicated existing hotel systems and operations facilitated the adoption process of HIV practices. These systems, as reported by hotel interviewees, included staff events, such as Family Day, where staff came together enjoyed themselves as a family, '*... normally we have a booth run by PSI (Population Services International[45]) who would have a whole session, they give out free condoms, they have HIV leaflets...*'; Human Resource (HR) departments which have staff development and assistance programmes where, for example HIV-positive employees, their family and friends could receive counselling and support, or even financial assistance; health and safety committees which included HIV awareness sessions on their programme; regular and ad-hoc/informal staff meetings where employees who participated in HIV awareness programmes had a forum to relay their new knowledge onto the rest of the staff or alternatively, it was used to reinforce certain preventative practices; staff notice boards for HIV pamphlets or flyers; constant, on-the-job, verbal, one-on-one reminders by management or supervisors of HIV practices to staff; and staff involvement in decision-making processes for the adoption of new operational

[45] International NGO with offices in Trinidad and Tobago

procedures. National interviewees within the tourism sector reiterated the point that hotel systems that were in place to train staff facilitated the adoption process, *'...the [name of hotel] is good in that they seem to have a system where there is continuing education...they had these education sessions...they would put stuff on their notice board...they communicated with staff regularly by electronic media and such things...'.* In this example HR departments also play a role in the adoption process and so are considered actors along with the hotel owners/managers. It can be noted that it was the larger hotels in Trinidad that had the more formal systems such as HR departments or formal monthly meetings as compared to the smaller hotels in either Trinidad or Tobago which relied more on ad-hoc meetings and constant reminders from management about correct HIV practices. This facilitating factor was reported by 12 hotels in Trinidad and 10 in Tobago. In Trinidad ten hotels were privately-owned and two were government-owned; four were classified as small, three as medium-sized and five as large; four were IF. In Tobago seven were small and three were medium-sized.

Available resources: Resources – staff, technical expertise, product supply, time, and financial – were reported as both a facilitator and a barrier to the adoption process of HIV practices by hotels owners/managers and national interviewees.

Staff: Having either a small- or large-sized hotel was reported to act as a facilitator to the adoption process of HIV practices, while for hotels with a medium-sized staff this was reported as a barrier. A hotel owner/manager reported that a small staff facilitated easy informal meetings to transfer information, '...*we are so small and everybody interacts with everybody on a daily basis, usually the things you want to get out is easy to get out without a meeting, just tell one, tell two, tell three and that is it'.* A large-sized staff, as reported by hotel owners/managers, allowed for increased coverage of duty stations thus allowing employees to attend training sessions, either on or off the hotel premises.

Expertise in the field of HIV: An HIV focal point or committee is an actor who has been trained to develop and ensure a successful adoption process within the hotel. Lack of such an actor can act as a barrier as it is this person who is the driving force for the programme and not necessarily the hotel's owner/manager who may not have the technical skill and may be too busy with other responsibilities. Such resources were

often reported to be lacking in smaller hotels, '*...you don't just have a policy and lay it out there, there are certain things that are instrumental in making sure that policy works...the focal point committee and the peer counsellors were very instrumental in helping us with the processes involved.'* Availability and accessibility of in-house technical capacity being present was also related to hotel staff size, therefore the smaller the hotel and its staff size, the less chance of internal technical capacity being present. This lack of internal technical knowledge, reported even among the hotel owners/managers, *'...they do not understand the responsibility to have an active, dynamic, eclectic HIV policy...',* was also acknowledged by national interviewees and may be attributed to the overall population educational level. Some of the hotel interviewees also indicated that they did not know where to source such expertise and information for assistance with developing their own HIV practices, '*...I don't even know where to begin to do it [staff awareness]!'* and this could act as a barrier; national interviewees reported that there is the need to *'hold [hotel owners/managers'] hands',* and assist closely with the development and adoption process of HIV practices.

Product supply: Some hotel owners/managers reported that it would be too great an effort for them to adopt new practices, such as making condoms available to the guests and staff, especially if they perceived that there was no immediate (and legal) requirement to do so. One hotelier even indicated that if actors such as Ministry of Health delivered condoms directly to the hotel then he would make them available to staff and guests. However, on his own he would not collect and distribute the condoms and hence lack of product acted as a barrier to the adoption process of an HIV practice.

Time: A lack of time to send staff to training sessions being hosted in the hotel itself or off-site, was reported by hotel owners/managers as a barrier to the adoption process of HIV practices. This factor was linked to staff size and shortages, and is also related to the time of year when the training was held. For example, the busiest time for a hotel in the Caribbean, is during the North American winter months when the hotels are full with foreign guests and therefore hotel owners/managers are unlikely to send staff to training sessions during these periods. A hotel owner/manager cited the logistics of getting staff together for an in-house training session as a barrier, '*...in this industry, people have different shifts and it is difficult to get a quorum of people together'.* Lack of time was indicated as a barrier in relation to the length of time it would take to develop

and monitor the HIV practices within the hotel. As stated by national tourism and HIV agency interviewees, *'...it is tedious, it is a time consuming effort...it is important to follow-up to ensure that the process is complete...'*.

Financial: The high rate of staff turnover was reported as a barrier to the adoption process of HIV practices by hotel owners/managers,

> *' ...if I pay to train five/six persons [who] are going to leave a few months later and then I replace those five/six persons that means that I have to go over that process again and my boss is gonna come and say, "You know what, we are spending money behind this thing and while it is well-intended it is a cost that I'm using to educate the next hotel that he or she works for and it doesn't benefit me"' .*

Hotel interviewees indicated that if they could have access to a trainer, a condom vending machine or leaflets, for example, at no cost they would be willing to adopt these practices, '...*I can't be spending money aimlessly... I am looking for some sort of service provided from the Ministry to the hotels, a free service'.* A Trinidadian hotel manager indicated that adopting HIV practices for staff or guests was going to be treated like any other business project whose content was going to be assessed according to its financial benefits, '...*what is my return on investment on such an [HIV] activity?*'

Financial resources were also cited as a barrier to adoption process by interviewees from national AIDS and tourism agencies with the recent downturn in the economy being reported as a factor, *'...the hoteliers would only do what does not cost them money...'.* In Tobago, it was reported by national interviewees that the government prevention programme was sufficient and there was no point in duplicating efforts, thereby saving their limited resources to tackling other issues, such as crime, that were thought to be of greater priority to the tourism sector. One key informant in the health sector indicated that a barrier to hotels adopting an HIV programme was that, *'...it is an employer's market rather than an employee's market...'* If an HIV-positive employee became too ill to work or died from AIDS there were many other replacement candidates. Also, if a potential employee was HIV-positive, the hotel would simply not hire them. The thesis researcher

was unable to ascertain whether this was due to the costs associated with hiring and training new employees in the hotel's operations or because of the HIV-related stigma and the hotel owners/managers belief that this may cause a reduction in visitors if it were known that the hotel employed HIV-positive workers. Linked with the concept of limited financial resources was the concern that the practices being suggested for hotels were actually effective, eg training programmes for staff and placing condoms and HIV prevention literature in the guest rooms – would such practices have an effect in reducing HIV transmission? As reported by one hotel owner/manager, '*...we [the hotel] are not certainly opposed to it, it's just how do you make it that it would really work?'* The thesis researcher suggests that even if hotel owners/managers believed that adopting HIV policies and practices would protect their staff's health but would negatively affect the hotel's financial bottom line, then the practices would not be put into place.

As a facilitator, available resources were indicated by hotel interviewees at nine hotels; five in Trinidad and four in Tobago. In Trinidad four hotels were privately-owned and one was government-owned; one were classified as small, two as medium-sized and two as large; one was IF. In Tobago three were small and one was medium-sized. As a barrier, lack of resources was reported by hotel interviewees at 21hotels; 11 in Trinidad and 10 in Tobago. In Trinidad ten hotels were privately-owned and one was government-owned; four were classified as small, four as medium-sized and three as large; two were IF. In Tobago three were small, four were medium-sized and three were large.

SUMMARY

Barriers and facilitators to the adoption process of HIV practices were categorised using an ecological framework into themes – hotel staff attitudes and beliefs; hotel management interests, attitudes and knowledge; and hotel operations, systems and resources. Table 5.1 summarises the major barriers and facilitators in the adoption process of HIV practices. The most commonly reported facilitators as determined by method of simple counts, were the existence of hotel systems and operations and the recognition that HIV considered a priority in the tourism sector. Conversely the barriers most reported, again determined by simple counts, were that HIV was not considered a

priority issue in the tourism sector and a lack of resources – time, staff, technical, product and financial.

Table 5.1: Facilitators and barriers to developing and adopting HIV prevention and control practices in hotels in Trinidad and Tobago

Themes emerging from study		Number of hotels			Number of hotels	
	Facilitator	**Trinidad**	**Tobago**	**Barrier**	**Trinidad**	**Tobago**
Staff attitudes and beliefs	High knowledge of HIV and AIDS	8	6	Lack of knowledge of HIV and AIDS	See note 2 directly below table	
				Staff resistance to the adoption of hotel practices	8	8
				Negative beliefs relating to stigma HIV, sex and sexuality	4	4
				Low staff educational level	4	1
	TOTAL NUMBER OF DIFFERENT HOTELS REPORTING ON THIS THEME AS A FACILITATOR	**8**	**6**	**TOTAL NUMBER OF DIFFERENT HOTELS REPORTING ON THIS THEME AS A BARRIER**	**10**	**11**
Management interests, attitudes and knowledge	HIV considered a priority in the tourism sector	10	5	HIV not considered a priority issue in the tourism sector	11	12
	Positive attitude towards, and increased knowledge of, HIV	6	5	Negative attitudes towards issues pertaining to HIV	See note 2 directly below table	
	Response to guests' behaviour and perceptions of their needs	3	1	Lack of adoption due to perceived guests' behaviour and their response	5	7
	Personal incident relating to HIV that has affected management	5	4	Concerns about hotel's reputation	5	3
	Buy-in from hotel head office	See note 2 directly below table		Lack of buy-in from hotel head office	See note 2 directly below table	
	TOTAL NUMBER OF DIFFERENT HOTELS REPORTING ON THIS THEME AS A FACILITATOR	**13**	**10**	**TOTAL NUMBER OF DIFFERENT HOTELS REPORTING ON THIS THEME AS A BARRIER**	**12**	**17**
Hotel operations, systems and resources	Existing hotel systems and operations	12	10	Lack of resources	11	10
	Available resources	5	4			
	TOTAL NUMBER OF DIFFERENT HOTELS REPORTING ON THIS THEME AS A FACILITATOR	**13**	**10**	**TOTAL NUMBER OF DIFFERENT HOTELS REPORTING ON THIS THEME AS A BARRIER**	**11**	**10**

Note:

1. There were a total of 43 hotels in this study; 19 in Trinidad and 24 in Tobago. It is important to realise that (1)not all hotel owners/managers responded to every factor as either a barrier or a facilitator; (2)the majority of owners/managers responded to more than one facilitator or barrier within the same theme; and (3)some owners/managers did not respond to any of the facilitators or barriers above.
2. These factors were reported by national interviewees of what they believed of hotel staff and/or management. No specific number of hotels which may have had this factor was given by national interviewees to the researcher.

Table 5.1 also gives the total number of different hotels that identified facilitators and barriers within a particular theme, in both Trinidad and Tobago. In summary the hindering and supporting factors to the adoption process were reported fairly equally between the different themes, except for the supporting factors under the theme of staff attitudes and beliefs, which was reported in fewer hotels than the other two themes. The most commonly reported barriers fell under the theme of management interests, attitudes and knowledge, and the most commonly reported facilitators fell under the themes of management interests, attitudes and knowledge; and hotel operations, systems and resources. Table 5.1 includes facilitators and barriers solely commented upon by national interviews – lack of knowledge of HIV and AIDS; negative attitudes towards issues pertaining to HIV development of practices and PLHIVs; and the buy-in or lack thereof, by hotel's head office were perceived views of hotel staff or management by national interviewees.

Table 5.2 illustrates the total number of hotels, collectively on both islands, of facilitators and barriers for the adoption process of HIV practices according to the hotel ownership, size and whether the hotel was IF. For some factors there were differences between the islands of Trinidad and Tobago. For example, stigma relating to HIV, sex and sexuality as a barrier, appeared to be more a common occurrence in Tobago. Additionally concerns about guests' perceived needs, for example, guests not wanting to be reminded about HIV and health concerns while on holiday appeared to be more of a barrier in adopting HIV practices in Tobago than in Trinidad. Conversely concerns about the reputation of the hotel, or even the destination as a whole, appeared to be more predominant in Trinidad than in Tobago. However one hotelier indicated that having HIV practices could have both a positive effect on the country, in that it allowed the tourist to see that the country was putting measures in place to address the HIV epidemic, and a negative effect as the country may be viewed as the *'AIDS capital of the Caribbean'*.

Table 5.2: Facilitators and barriers to adoption of HIV practices classified according to hotel ownership, size and international franchise

FACILITATORS	No of hotels by theme	Number of hotels (Trinidad and Tobago)					
		Ownership		Hotel size			IF
		Government	Private	S	M	L	IF
THEME: STAFF ATTITUDES AND BELIEFS							
High knowledge of HIV and AIDS SUB-TOTAL: THEME: STAFF ATTITUDES AND BELIEFS	14	1	13	4	7	3	2
THEME: MANAGEMENT INTERESTS, ATTITUDES AND KNOWLEDGE							
HIV considered a priority in the tourism sector		1	14	7	5	3	1
Positive attitude towards, and increased knowledge of, HIV		1	10	2	5	4	2
Response to guests' behaviour		0	4	2	2	0	0
Personal incident relating to HIV that has affected management		1	8	4	4	1	0
Buy-in from hotel head office		Reported generally by national interviewees. No specific number of hotels stated.					
SUB-TOTAL: THEME: MANAGEMENT INTERESTS, ATTITUDES AND KNOWLEDGE	23	2	21	10	9	4	2
THEME: HOTEL OPERATIONS, SYSTEMS AND RESOURCES							
Existing hotel systems and operations		2	20	11	6	5	4
Available resources		1	8	4	3	2	1
SUB-TOTAL: THEME: HOTEL OPERATIONS, SYSTEMS AND RESOURCES	23	2	21	11	6	6	4
BARRIERS		**Ownership**		**Hotel size**			**IF**
		Government	**Private**	**S**	**M**	**L**	**IF**
THEME: STAFF ATTITUDES AND BELIEFS							
Lack of knowledge of HIV and AIDS		Reported generally by national interviewees. No specific number of hotels stated.					
Staff resistance to the adoption of hotel practices		1	15	7	7	2	1
Negative beliefs relating to stigma: HIV, sex and sexuality		0	8	1	5	2	0
Low staff educational level		0	5	2	2	1	0
SUB-TOTAL: THEME: STAFF ATTITUDES AND BELIEFS	21	1	20	9	8	4	1
THEME: MANAGEMENT INTERESTS, ATTITUDES AND KNOWLEDGE							
HIV not considered a priority issue in the tourism sector		1	22	11	8	4	2
Negative attitudes towards issues pertaining to HIV		Reported generally by national interviewees. No specific number of hotels stated.					
Lack of adoption due to perceived guests' behaviour and their response		1	11	8	3	1	1
Concerns about hotel's reputation		1	7	5	1	2	1
Lack of buy-in from hotel head office		Reported generally by national interviewees. No specific number of hotels stated.					
SUB-TOTAL: THEME: MANAGEMENT INTERESTS, ATTITUDES AND KNOWLEDGE	29	1	28	16	9	4	2
THEME: HOTEL OPERATIONS, SYSTEMS AND RESOURCES							
Lack of resources SUB-TOTAL: THEME: HOTEL OPERATIONS, SYSTEMS AND RESOURCES	21	1	20	7	8	6	2

Note: Size of hotel: small (S), medium (M) or large (L). Internationally Franchised (IF):Hotel was managed by operational guidelines from an international parent hotel chain. There are no government or IF hotels in Tobago.

For example, in Trinidad, the issue of the educational level of the staff was cited as a greater hindrance than in Tobago. Comparison between islands related to whether or not the hotels were government-owned or IF was difficult since there were no government or IF hotels in Tobago. All hotel owners/managers, regardless of hotel size gave reasons for supporting or hindering the adoption process of HIV practices.

Often these factors were linked to one another; eg lack of recognition that HIV was an important issue in the tourism sector led to a lack of resources being allocated towards the adoption of an HIV practice. Some facilitators were also found to be the converse of the barriers; eg availability of hotel resources was found to be a facilitator whereas a lack of resources was deemed a barrier. There were some contradictions in the interviewees' statements. For example, some interviewees described how sex and sexuality acted as a barrier since it was considered a taboo subject, and not to be addressed in public forums, while others indicated these topics were spoken about freely and did not constitute barriers. Finally, the study revealed that actors who both supported and hindered the process of adopting HIV practices were not only hotel owners/managers but also hotel staff. These included actors such as HR managers who oversaw staff assistance programmes (facilitator); lack of HIV focal points (barrier); and government and NGOs such as NACC and PSI (barrier or facilitator).

CHAPTER 6 RESULTS: FACTORS INFLUENCING HOTELS' RESPONSE TO NATIONAL POLICIES AND PROGRAMMES

INTRODUCTION

Chapter 2 reviewed national policies and programmes[46] relating to HIV and AIDS in Trinidad and Tobago (TT) (section 2.3.3.) and then those specifically pertaining to HIV and the TT tourism industry (section 2.3.7.). The overarching HIV policy was the TT National AIDS Strategic Plan, 2004-2008/10 (NSP)[144]. The National AIDS Coordinating Committee (NACC) was created along with a secretariat based in Trinidad to implement the NSP. The Tobago House of Assembly (THA) subsequently created the Tobago HIV/AIDS Coordinating Committee Secretariat (THACCS). Out of the NSP, the Ministry of Tourism established the Tourism Sector HIV/AIDS Support Programme (TSHASP) whose activities included HIV sensitisation seminars for the Ministry of Tourism staff and stakeholders including hotels. Despite the above policies and programmes any HIV prevention activities in the tourism sector specifically relating to hotels, on either island, were implemented on an ad-hoc and unstructured basis.

This chapter examines the facilitators and barriers in the environment external to the hotel, particularly national policies and programmes for the adoption process of HIV practices by hotels. The results in this chapter are based mainly on semi-structured (SSI) interviews with national actors from health and tourism ministries and their implementing agencies, and private-sector actors from the island-based national hotel and tourism associations (HTAs), one in Trinidad and another in Tobago. Views of other actors, such as the hotel owners/managers are used to triangulate data.

A wide variety of facilitators and barriers were identified from data collection. Because the majority of factors were indicated in a general sense, ie no specific hotels were identified, the results were not analysed in terms of hotel size, ownership or whether or

[46] Regional and international policies and programmes described here are part of a joint collaborative effort with the Government of the Republic of Trinidad and Tobago and are therefore included under the ambit of national policies and programmes.

not the hotel was Internationally Franchised (IF). The policy process in this study can be described in terms of the stages heuristic model: *'problem identification and issue recognition; policy formulation; policy implementation and policy evaluation'*[1, pg13] see section 2.4.1.). The researcher uses this model to group the facilitators and barriers associated with national policies and programmes in the adoption process of HIV practices. Factors of policy evaluation were not described by interviewees in this study and are therefore not discussed in this analysis.

6.1. FACILITATORS AND BARRIERS: PROBLEM IDENTIFICATION AND ISSUE RECOGNITION

National interviewees indicated that HIV was not a priority for the tourism industry, including hotels. Actors such as the national HTAs do not proactively participate in either their own, or national HIV programmes through the NACC Secretariat or the TSHASP in Trinidad and the THACCS in Tobago. The thesis researcher surmised that a lack of prioritisation prevents problem identification and issue recognition of HIV in the tourism sector, stopped it from getting onto the government's agenda as a matter of national importance, and therefore acted as a barrier to the adoption process by some hotel owners/managers. In Trinidad, one national interviewee stated, *'right now HIV is not an issue...it isn't on the front burner for hotel accommodation centres.'* Rather the HTAs '*focus mainly on business things or issues of today. This [HIV] has not become a big issue for them.'* Tourism is still a growing industry especially in Tobago therefore government and private-sector projects, eg safety (including food safety) and security of the visitors, take priority over HIV practices, *'[HIV] would fall under secondary investment for tourism.'* Lack of prioritisation was also demonstrated through the removal of an HIV/AIDS coordinator from the Tobago Division of Tourism and Transportation (DTT). Another national interviewee stated that *'...the Division did not have any set [HIV] programmes...'* and from further probing of this interviewee by the researcher, there did not appear to be any future plans, by the Division, to address HIV and AIDS in the near future, and specifically within the hotel sector.

The researcher interprets this lack of prioritisation is a result of several factors. Firstly, despite national policies and programmes such as the TSHASP, several national interviewees reported a disagreement as to the extent of the HIV epidemic and the

existence of sex tourism in the country, particularly in Tobago, the more tourism-oriented island. This controversy at the national level creates barriers to the adoption process of HIV practices by hotel owners/managers. As a national interviewee reported, *'...how could we, why should we function as if HIV is an invisible person; an invisible disease when it is not...HIV is a 29 year old disease so how could you deny a 29 year old human being? Everybody knows by the time you are 29 years old everybody in the village knows you. So you are alive and well.'* It was also reported that in Tobago, *'...government will deny that there is sex tourism and that there is a big HIV problem...and all their policies will be based on the factor of denial...if you don't have a problem there is no need to solve it'.* Secondly in Trinidad, a national interviewee stated that because the visitors to this island were more business-oriented compared to Tobago and the rest of the Caribbean there was less sex tourism, and therefore believed there to be fewer high-risk sexual interactions between guests and hotel staff, *'... [employee] interactions with guests [were] at a different level [as] guests mainly left before the weekends as they [were] there for business...'*, hence there was no reason for hotels to adopt policies whose content focussed on HIV practices.

6.2. FACILITATORS AND BARRIERS: POLICY FORMULATION

Collaboration between government agencies acted as a facilitator in the formulation of national HIV policies and programmes. For example, the joint efforts of the NACC and the Ministry of Tourism in the formulation of the TSHASP (2006) which resulted in HIV sensitisation and awareness practices within the tourism sector including hotel staff. An international partnership between the Government of the Republic of Trinidad and Tobago (GORTT) (through the Ministry of Labour and Small and Micro-Enterprises Development (MLSMED)), International Labour Organisation (ILO) and United States Department of Labor (USDOL) resulted in the International HIV/AIDS Workplace Education Programme. One of the outputs of this Programme was the formulation of the National Workplace Policy on HIV and AIDS (2008) whose sustainability plan includes the adoption of HIV practices whose content would include workplace policies throughout all sectors including tourism and hotels. The GORTT/ILO/USDOL International HIV/AIDS Workplace Education Programme also enabled the development of an alliance between the MLSMED, NACC and the hotels (in Trinidad) which facilitated the formulation of HIV workplace policies in two hotels.

A national interviewee made the point that also substantiated the low level of prioritisation of HIV in the tourism sector; the main HIV programmes incorporating the tourism sector have been as a result of non-national actors, *'...tourism has not played a central role in our [national] response, because the two main initiatives...Quality Tourism for the Caribbean (QTC) which was a regional project developed and implemented by CAREC (Caribbean Epidemiology Centre) and the collaboration between the GORTT, ILO and USDOL, were outside of the government...there has only been one real government-led project, TSHASP, which was actually a part of the NACC...'* Additionally the NACC, which is a committee of key stakeholders in the national HIV response, does not view the Ministry of Tourism as an important actor since it has no tourism representative. Actors in the adoption process include not only hotel owners/managers and governmental agencies but also regional and international organisations such as CAREC, ILO and USDOL.

6.3. FACILITATORS AND BARRIERS: POLICY IMPLEMENTATION

Resources: Lack of resources acted as a barrier to the implementation of national HIV policies and programmes in the tourism sector and the adoption process of HIV practices within hotels. In some cases *financial resources* were reported as both facilitators and barriers. For example financial support from government actors such as the NACC facilitated the development and initial implementation of the TSHASP. This funding ended in 2008 and a lack of financial resources acted as a barrier resulting in the temporary suspension of activities; funding was resumed directly, in 2009, from another government actor, the Ministry of Tourism. Financial resources facilitated the development of the sustainability plan for the National Workplace Policy on HIV and AIDS and a five-year GORTT-approved budget of TT$30M. External actors, eg ILO, USDOL, also played a facilitating role in the implementation of national HIV policies and programmes.

Technical resources: The implementation of the TSHASP was facilitated by technical resources from regional and international programmes, eg the ILO's Code of Practice and CAREC's QTC HIV/AIDS Education Train-the-Trainer manual and video for the Caribbean tourism industry. Other expertise was supplied by actors such as Non-Governmental Organisations (NGOs) or government officials who participated in HIV programmes which included condom demonstrations and/or HIV sensitisation sessions.

Regional documents were used by actors such as the national coordinator of the GORTT/ILO/USDOL International HIV/AIDS Workplace Education Programme to facilitate the development of HIV workplace policies within Trinidad (not Tobago) hotels. These documents included the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) Caribbean Workplace Policy[158]; the Barbados Hotel and Tourism Association Toolkit for Workplace Health and Wellness Programming in the Tourism Sector[75]; and the HIV workplace programme developed by the Sandals Luxury Resorts, Jamaica[69]. A hotel owner/manager indicated that she used the draft TT National Workplace Policy on HIV and AIDS to develop her hotel's HIV workplace policy. A national interviewee indicated that a shortage of technical statistical information through the lack of HIV socio-economic impact data, and specifically within the national tourism sector acted as a barrier to the adoption process within hotels. This data is necessary to firstly convince the hotel owners/managers of the HIV impact on the tourism sector and secondly to assist the owners/managers in developing and adopting their own workplace policies and programmes, *'...one of the other barriers is that of existing sufficient research that would allow you to make well informed decisions.'* Lack of technical data leads to a lack of prioritisation of HIV within the tourism sector and can be linked as a barrier under problem identification (see section 6.1.).

Product supply: Lack of documentation or information given to participants at HIV awareness workshops acted as a barrier to the implementation of national HIV policies and programmes as this information could be further disseminated to hotel co-workers or managers, '...*again I refer to the leaflet or information guide when they leave [a seminar], there was nothing given to them. When I am sending people out, what am I getting back from my staff? Are they going to have information? A guide on what to do?*' In this example actors included governmental agencies or NGOs hosting the workshops.

Lack of human resources and a high turnover of staff were experienced by government actors such as the NACC secretariat and the THACCS, and this acted as a barrier to the implementation of HIV national programmes on both islands; particularly in Tobago. The MLSMED which was responsible for the implementation of the National Workplace Policy on HIV and AIDS also experienced a shortfall in technical capacity. The ability of the sector HIV/AIDS Coordinators (in the Ministries responsible for health, tourism and labour as created by the NACC in 2006 – see section 2.3.6) to organise and execute the

HIV programme also facilitated the national programme being successfully implemented, eg when an HIV awareness seminar for the hotels was organised, it was important that the HIV/AIDS Coordinators had the correct skills to achieve the seminar goals; this included making certain that all participants not only gained knowledge during the seminar but enjoyed the learning process and would not be hesitant to return for another workshop or to encourage their co-workers to attend a similar one in the future.

Partnerships: Hotels forming partnerships with HIV governmental agencies facilitated the implementation of national HIV policies and programmes and subsequent adoption processes of HIV practices. This was demonstrated when an unofficial partnership was formed between a hotel and the medical director at the Tobago Health Promotion Clinic. Here the medical director was invited, as a personal favour to the hotel owner, to participate in the hotel's HIV sensitisation meetings to encourage Voluntary Counselling and Testing (VCT).

Lack of coordination across government sectors: One of the main reasons for this was the fear of duplicating HIV programmes across sectors as reported by government tourism agencies and HTAs on both islands. Fear of duplicating the NACC's activities and the Ministry of Tourism's TSHASP acted as a barrier to the tourism sector not having a sustained HIV programme specifically targeted at hotels. A national tourism interviewee was quite adamant that the THACCS had *'...a great programme ... no need for a specific interface with the accommodation sector.'* Other interviewees from Tobagonian government tourism agencies suggested that it was not their role to develop and implement HIV programmes, *'...it should be the Division of Health or perhaps the National AIDS Awareness Committee that needs to be at the forefront...'* It was reported that a lack of consistency in the implementation of government HIV programmes had a negative effect, and acted as a barrier, to the adoption process. At the time of this research study there was, in Tobago, *'...no structured on-going work with HIV in the tourism sector...'* , however the researcher was informed of previous outreach programmes implemented by government actors such as the Division of Health and Human Services in Tobago, which targeted beach boys working on the major beaches frequented by tourists.

Communication of existing national policies and programmes: Lack of effective communication to the hotels by actors of government agencies was reported as a barrier to the implementation of national HIV policies and programmes and subsequent adoption process of HIV practices. In Trinidad, a national interviewee indicated, *'...he knew very little about the [national] policies on HIV...[despite] working very closely with the Ministry of Tourism and the Tourism Development Company...I have heard more from the Ministry of Health on smoking than on HIV...'* Of the hotel owners/managers interviewed, approximately half (equally divided between the two islands) were unaware of either a structured, on-going national or island-based HIV programme being implemented by the government. Yet they were aware of individual HIV prevention, treatment and support activities that constituted the national HIV programme, eg general public AIDS awareness education through flyers, television and radio public service announcements and availability of HIV treatment at the health centres and hospitals; the Tobago Health Promotion Clinic was repeatedly mentioned.

Fear of deterring tourists: This fear – resulting in a lack of prioritisation – acted as a barrier to the implementation of HIV policies and programmes in the tourism industry, and consequently, HIV practices not being adopted in hotels. This fear emanated from tourism officials' belief that an HIV programme that openly discussed the country's HIV prevalence rates and modes of transmission would negatively affect visitor arrival. As described by one national interviewee, *'... there are places in the Caribbean where you walk through the airport and see "if you're having sex, use a condom", ever see that in Trinidad and Tobago? No way! Never!'* Interviewees from the tourism government agencies and HTAs were also cautious in their statements that encouraged the belief that tourism industry employees were more vulnerable to contracting/transmitting HIV, *'...just because you are in the tourism business does not mean that you are at higher risk...'* The researcher suggests that these aforementioned interviewees believed that tourists, whose main activity was to partake in sex tourism would refrain from visiting that country if they thought the general population, including those working in the tourism sector[47], were at risk of transmitting HIV.

[47] In Tobago 47.6% of the island's employed population, work in the tourism industry. (National Tourism Policy of Trinidad and Tobago, 2010)

Adoption of public policies and guidelines are not legally mandatory: In the legal context, adoption of HIV practices by any sector or business is not mandatory in TT. One tourism national interviewee stated, *'...there is no law that requires [hoteliers to adopt an HIV policy or programme] and they see no natural benefit...'* A Tobago hotel interviewee indicated, '*...there's no penalty, no punishment, for not having [HIV] policies...and this is not going to help me build my business, why worry?'* Only in 2008 was the National Workplace Policy on HIV and AIDS approved by the GORTT and even this Policy is not mandatory; it only serves as guidelines.

Nevertheless legal requirements stipulated by various national bodies can also serve as facilitators to the adoption process, eg the practice of non-discrimination is legally mandated by the Constitution of the Republic of Trinidad and Tobago[8, 159]. It infers that employers must be non-discriminatory towards employees or potential employees of (perceived) HIV-positive status, neither dismissing them nor refusing employment. As with the hotel interviewees, the most frequently mentioned government policies by national interviewees were those pertaining to anti-stigma and discrimination law relating to dismissing or not hiring, a potential HIV-positive employee; the researcher surmised that this was because discrimination, of any kind was illegal under the TT Constitution.

Enthusiasm and level of HIV awareness: On an individual basis the enthusiasm exhibited by the government HIV/AIDS Coordinators working in the various sectors of health, labour and tourism, facilitated the implementation of the national HIV programmes. A national tourism interviewee reported, *'the persons in the field ... who got the work accomplished...they are passionate about what they do...'* Another facilitating factor was the extent of HIV awareness or *'...level of consciousness...'* of those working in the national HIV programmes, either generally or on specific tourism activities, eg if the tourism worker was aware of existing HIV literature, they were proactive and included it in the tourist packages.

SUMMARY

This chapter analysed aspects of national policies and programmes that supported and hindered the adoption process of HIV practices by hotels. Table 6.1 summarises these factors, external to the hotel environment, according to the stages heuristic model of the policy process. Facilitators and barriers were identified at all stages except policy evaluation. Actors in this analysis of factors were indicated not only as the national HIV implementing agencies but also as regional and international agencies working in TT such as CAREC, ILO and USDOL. The main actors were the various GORTT ministries and their implementing agencies as well as the island-specific HTAs.

Table 6.1: Facilitators and barriers influencing Trinidad and Tobago hotels' response to national HIV policies and programmes

Stages heuristic model	Facilitators	Barriers
Problem identification and issue recognition		• Government HIV and tourism agencies and hotel and tourism associations do not view HIV as a priority
Policy formulation	• Partnerships	
Policy implementation	• Provision of resources • Partnerships • Some HIV practices are legally mandated • Enthusiasm generated by hotel staff and passion and level of awareness of government sector HIV/AIDS programme Coordinators	• Lack of resources • Lack of coordination across government sectors resulting in lack of programme consistency and fear of duplicating efforts • Ineffective communication of national policies and programmes • Fear of deterring tourists • Most HIV practices are not legally mandated

There was a wide variety of facilitators and barriers to the implementation of the national HIV policies and programmes that were targeted towards the tourism industry, and more specifically, the hotel sector. The underlying barrier as to why there was minimal if any at all, implementation of national HIV policies and programmes occurred at the initial stage of policy problem identification and issue recognition. HIV was perceived as not being a priority for the government and hence not for hotels and HTAs. National interviewees indicated that the GORTT did not believe that there was a *'big problem'* with sex tourism. This concern was re-affirmed by hotel owners/managers; if sex tourism was first acknowledged then the next step would be to target the tourism

industry including hotel management and staff for *'special educational programmes'* through the national HIV programmes At the policy formulation stage, partnerships provided resources for the development of national HIV policies and programmes such as the National Workplace Policy on HIV and AIDS and the TSHASP. Partnerships between the GORTT and hotels also provided resources for the implementation of national HIV policies and programmes.

A factor, that was stated by interviewees as both a facilitator and a barrier, at the policy implementation stage of national HIV programmes, and hence the adoption process of HIV practices by the hotels was the provision, or lack, of resources by the GORTT to the national agencies. The researcher concludes that if the GORTT made its national HIV policies a priority then resources for a coordinated programme implementation within and between sectors, and the effective communication of its HIV policies and programmes would become available thereby removing these barriers. Fear of sectors duplicating HIV prevention and control efforts was a barrier relating to lack of coordination and a shortage of resources; if sufficient resources were available this barrier would be non-existent. Another barrier was the fear of deterring tourists from visiting TT if an HIV programme was implemented that openly discussed the country's HIV prevalence rates and modes of transmission. This fear resulted in a lack of prioritisation of HIV within the tourism sector. Other facilitators to policy implementation of national HIV programmes included unofficial partnerships formed between government implementing agencies, eg the Tobago Health Promotion Clinic and hotel owners. Official partnerships such as that between GORTT and international organisations facilitated policy implementation and adoption of HIV practices by hotels in the form of hotel HIV workplace policies. A final facilitator was the passion exuded by the technical staff of the implementing agencies as they ensured that HIV training sessions had a positive impact on the recipients. Whether or not the adoption of HIV practices by the hotels was legally mandated was indicated as both a facilitator and a barrier. HIV practices that were adopted by the hotels were facilitated by policies such as the TT Constitution which mandates non-discrimination. However most national HIV policies are not legally mandated and this acted as a barrier to the adoption of HIV practices by hotels.

CHAPTER 7 DISCUSSION

INTRODUCTION

This chapter discusses the study results from Chapters 4, 5, and 6 and relates these to the existing literature. It examines the most commonly reported HIV prevention and control practices among sampled hotels in Trinidad and Tobago (TT); facilitators and barriers to the adoption of HIV practices; and factors influencing hotels' response to the national HIV policies and programmes. It then recommends possible actions to increase the adoption of HIV practices within the tourism sector.

7.1. HIV PREVENTION AND CONTROL PRACTICES ADOPTED BY HOTELS

All hotels in this study had some form of policy content, or in the case of this study, HIV practice, whether direct or indirect, formal or informal. This section will discuss the most commonly reported HIV practices of hotels in this study, hotel ownership and size and whether or not the hotel was Internationally Franchised (IF).

7.1.1. MOST COMMONLY REPORTED HIV PREVENTION AND CONTROL PRACTICES

Non-discrimination: There is no specific law in the TT judicial system which must be upheld for fear of punitive actions that directly pertains to anti-discrimination of People Living with HIV (PLHIV) for hotel staff and visitors [92, 159]. Yet 27 hotel owners/managers of the 43 hotels interviewed believed that TT laws which govern discrimination in the Constitution of the Republic of Trinidad and Tobago(1976)[159] and the Equal Opportunities Act (2000)[92] did in fact prohibit acts of stigma and discrimination (S&D) towards PLHIV. The researcher concludes that this direct practice, which in some cases was part of hotels' operational procedures, was adopted due to media attention given to cases of workplace HIV discrimination. The researcher also believes that particularly in Tobago hotel owners/managers are very careful not to draw

issues of human rights violations into the international public forum for fear of damaging the island's reputation and reducing the number of external visitors.

HIV testing prior to, or during employment, was identified as a separate direct HIV practice by five hotels yet can be linked to the practice of (non-)discrimination. Rather than acknowledge that such testing was an act of discrimination hotel owners/managers put the blame on insurance companies/pension providers who demanded this test be conducted or stated that in order to mitigate HIV transmission within the workplace they needed to know employees' HIV status. In light of the country's widely acknowledged anti-discrimination policies this practice of HIV testing shows some contradictions, and possibly misunderstanding, by the owners/managers and the insurance companies/pension providers about the types of insurance/pension schemes under offer as well as the country's labour laws. Even if hotel owners/managers were aware of anti-discrimination laws, it was unlikely that they would admit to having discriminatory practices at their hotel and would seek to rationalise HIV testing on another party. Literature demonstrates that HIV testing was adopted in most hotels in the Bahamas and Jamaica. Contrary to this thesis study a hotel manager of a small property in the Bahamas and that of a large property in Jamaica stated that they would not hire an HIV-positive person because they believed that *'tourists are concerned for their safety [and therefore the staff need] to be extremely clean, extremely presentable and healthy'*[3, pg86]. Forsythe et al's study in the Dominican Republic (DR) (1998) reported HIV testing of employees was also reported; two out of the eight hotel managers indicated they would dismiss any employee found to HIV-positive, despite being fired on the grounds of one's HIV status being illegal in the DR[10]. Interestingly, all five hotels in this thesis research study, whose practice it was to test prospective employees for HIV also indicated they adopted non-discrimination practices towards their staff and guests; that they would still hire someone who tested HIV-positive explains why they consider themselves to be a non-discriminatory establishment. The researcher believes that some of the hotel owners/managers reported what they believed she wanted to hear and what they wanted other members of the tourism sector to believe of their operational practices (social acceptability bias).

<u>Use of gloves to clean rooms:</u> This practice was originally adopted to avoid harm to the workers using cleaning chemicals and now to prevent HIV transmission. Even though

use of gloves as a means of preventing HIV transmission has been generally acknowledged by the scientific community as a misconception this study shows that hotel owners/managers still believe this to be so and thus the practice, even though not always enforced, is generally part of hotel operating procedures. This concurs with studies in South Africa where hotel staff believed themselves to be at risk of contracting HIV from bed linens that were soiled with bodily fluids[14].

Staff-guest interaction: Research in hotels in Jamaica[3], the Bahamas[3], and the DR[10] have also noted this practice of attempting to reduce staff-guest interaction. This practice was originally adopted to prevent a reduction in hotel service standards and also to reduce any security risks towards guests. As reported by hotel interviewees, when staff and guests fraternise there is always the possibility that staff will break hotel operational rules and conduct favours for that particular guest(s). There is also the possibility that a guest may find themselves in a vulnerable position while consorting with the staff member and staff taking advantage of this, possibly either stealing from, and/or physically harming, the guest; this is particularly relevant as crimes against tourists have increased in Tobago[160]. The researcher believes that this practice was also introduced to reduce sex tourism, and by extension, HIV transmission, thereby protecting the hotels', and country's, reputation as being a sexual and morally loose haven for tourists. High-risk sexual behaviours between tourists and hotel workers have been cited internationally[13, 14], regionally[3, 10, 19-21, 67] and in TT where health officials have linked the rise in HIV infections to sex tourism[84]. Though identified by only 24 hotels owners/managers, *'...sexual relations between staff and guests is a 'no no' within the industry...'* , therefore this practice was believed, by the thesis researcher, to be more widespread whether formal or informal than actually indicated in this study.

HIV training and sensitisation: This direct practice of HIV training and sensitisation seminars for staff was reported as both informal, occurring at ad-hoc times of the year, particularly during the tourist season and the annual Carnival period, and formal whereby some hotels have regular training sessions. Caribbean studies have demonstrated the existence of HIV awareness programmes and policies are varied – in Jamaica and the Bahamas some hotels had no HIV training and programmes whereas others had awareness seminars that used existing hotel systems such as health fairs and local Non-Governmental Organisations (NGOs)[3]. In 2009, the Health Economics Unit

of the University of the West Indies (HEU/UWI) noted the existence of HIV awareness programmes targeting the tourism industry in St Lucia (tourism staff workers) and Barbados (high-risk groups associated with the tourism sector – Men who have Sex with Men (MSM) and sex workers (SWs))[70]. The DR also had a US Agency for International Development (USAID) project involving HIV awareness sessions for tourism employees but this was discontinued in 1998[70, 72]. Internationally hotel chains in Africa such as the Serena Hotels Group and Grupo Visaberio adopted HIV awareness sessions for their employees[33, 34] as well as individual hotels such as the Kimball Plaza in the Philippines[35, 36] and the Regent Hotel in Bangkok[35]. Research conducted for the Tourism, Hospitality and Sport Sector, Education and Training Authority (THETA) in Southern Africa found that most of the organisations in the hospitality sector did not have any HIV training and awareness for their employees [38, 122].

The thesis researcher found the majority of these training sessions were informal and ad-hoc and occurred as a result of staff needing to know more about HIV transmission or from Ministry of Tourism or National AIDS Coordinating Committee (NACC) initiatives; hotel management had very little to do with initiating the adoption of this practice. This clearly lends to the argument that hotel owners/managers do not see HIV prevention and control as a priority. It was encouraging to learn that out of those four hotels[48] that reported having written HIV workplace policies three also adopted formal HIV training and sensitisation for their staff. This indicated to the researcher that having a specific written workplace policy or programme did increase the chances of adopting HIV practices, as least as far as ensuring that regular training and sensitisation are available to the staff. This scenario has also been demonstrated with the workplace programme at the Sandals Hotels in the Caribbean where formal HIV sessions with new staff and regular sessions with all employed staff including senior management, are conducted[71].

Of special note are HIV workplace policies as these outline a hotel's actions relating to HIV prevention and control for staff and guests. In this study, only four hotels reported having adopted HIV workplace policies of which two were developed as a result of the collaborative Government of the Republic of Trinidad and Tobago/International Labour Organisation/United States Department of Labor (GORTT/ILO/USDOL) International

[48] One hotel was still awaiting management approval

HIV/AIDS Workplace Education Programme Of these four, all were located in Trinidad and two were Internationally Franchised (IF). This lack of HIV policies concurs with previous research conducted by Bakuwa (2011) of private sector companies in Malawi[114], Ketshabile (2010) of tourism establishments in Botswana [122], Withers et al (2007) of sex work establishments in the Philippines[117], and Bloom et al's international review for the World Economic Forum (WEF) (2005)[49][37]. Research conducted for THETA (2003) stated that, *'...93% of businesses [in the tourism sector]...do not have HIV/AIDS policies*'[38]. In the Caribbean HIV workplace policies have also been developed in the tourism sector in Barbados as a result of the ILO/USDOL International HIV/AIDS Workplace Education Programme at Amaryllis Beach Hotel and GEMS of Barbados. Independent of the ILO/USDOL Programme, hotels in the regional Sandals Hotel chain have also adopted HIV workplace policies[74].

Other direct and indirect practices reported in this study included reasonable accommodation for staff and flexibility of working conditions, care and support for HIV positive staff and their families, condom availability for staff and guests, HIV documentation for staff and guests, and first aid kits with staff members trained in first aid techniques on hotel premises. Condom availability for staff was also noted by Bloom et al in his review for the WEF (2005) which indicated that only 6% of Caribbean workplace policies included provision of condoms[37]. Regionally, the Jamaican Tourism Product Development Company (TPDCo) worked with Jamaican National AIDS Programme (NAP) to distribute condom vending machines to tourism establishments within the country[69]. Also in the DR there was a programme that included the distribution of condoms to tourism employees[70, 72]. The other HIV practices mentioned in this paragraph were not specifically mentioned in any previous international and regional literature yet may fall under the umbrella of HIV workplace policies in the case of care and support for staff and guests, or under health and safety policies which may include first aid kits on site.

[49] This review used information collected during the 2004-2005 Executive Opinion Survey that forms part of the World Economic Forum's annual Global Competiveness Report. Businesses in the survey can be divided by sector: 25% manufacturing; 10% wholesale and retail trade; 10% financial; 9% transport, storage and communications; 5% construction and 42% other; hotels and restaurants are included in the 'other' 42% of total businesses. The researcher was unable to ascertain the exact percentage of businesses that constituted hotels and restaurants. (Bloom et al (2005))

7.1.2. COMPARISON OF HIV PREVENTION AND CONTROL PRACTICES BETWEEN THE TWO ISLANDS

Tobago is the more tourist-orientated island as compared to Trinidad. The exact adult HIV prevalence rate for Tobago varies between 2.6-3.5% [50, 83] and is significantly higher than the national figure of 1.5%[8]. Taking these two facts into account it may be thought that the hotels in Tobago would have adopted considerably more HIV practices than those in Trinidad (Table 4.1) however all 11 different types of practices identified in this study were found in Trinidad hotels as compared to ten different types identified in Tobagonian hotels. Trinidad was the only island that reported formal HIV workplace policies; no hotels in Tobago had reported such an intervention. That the hotels in Tobago did not have all the identified HIV practices and particularly HIV workplace policies was a notable result for the thesis researcher considering that Tobago is the more service-orientated island. The researcher explained this as a result of the following facts. Firstly of the four[50] hotels with workplace policies, all of which were situated in Trinidad, two were large and IF hotels with the necessary resources to adopt such a workplace policy; Tobago did not have any IF hotels. Trinidad hosts the capital of this study's twin-island republic and many of the national HIV and tourism agencies are located on this island. Even though not deliberately, those hotels in Trinidad are more exposed to HIV-related events and seminars, therefore hotel owners/managers and staff are more familiar with the benefits of workplace policies. This fact was evident in the development of the third HIV hotel workplace policy which was as a result of the GORTT/ILO/USDOL International HIV/AIDS Workplace Education Programme. Even though companies including hotels from both islands were invited to partake in the Programme it was only hotels from Trinidad that actually did so. It was reported to the thesis researcher that the fourth and final hotel created their HIV workplace policy as a result of management's desire to develop its human resources policies. The rationale for the development of the last two HIV workplace policies indicates to the researcher, that those hotel owners/mangers in Tobago did not see HIV as a concern for the island's tourism sector. HIV training and sensitisation was the only other practice reported in more hotels in Trinidad than Tobago. Again the researcher explains this by the fact that most of the governmental and non-governmental international, regional and national HIV programmes, except for the governmental island-based Tobago HIV/AIDS Coordinating Committee Secretariat (THACCS), are located in Trinidad and therefore

[50] At the time of this research, three hotels had completed HIV prevention and control policies and one hotel was awaiting management approval.

there is easier access for hotel owners/managers to receive technical HIV training support and materials. Another possible explanation, by the thesis researcher for more hotels in Trinidad adopting this practice on an ad-hoc basis is that the most important national festival, Carnival, which brings on average 39,000[51] foreign tourists to TT[80], is more widely celebrated in Trinidad than Tobago. The second practice of note where there was a relatively large reported difference between the islands (10 in Trinidad; 17 in Tobago) was the practice of non-discrimination towards HIV-positive staff and guests. Again, the researcher attributes this result to Tobago being the more tourism- and service-oriented of the two islands and hotel owners/managers not wishing to raise issues of discrimination which may lead to lower hotel occupancy rates. This result also concurs with the HEU/UWI (2009) research findings in Tobago, which state that there is *'a policy of no discrimination towards PLHIV in the industry'*[70, pg80].

There does not appear to be any distinctive pattern regarding the number of different HIV practices adopted by small, medium-sized or large hotels on either island. Table 4.2 shows that small hotels adopted six different practices in Trinidad and eight in Tobago, medium-sized hotels adopted ten different practices in Trinidad and nine in Tobago and large hotels adopted nine different practices in Trinidad and seven in Tobago. Several international studies and reviews (Bakuwa (2010)[113], Siiskonen (2009) citing Rosen et al's (2006)[30], Withers et al (2007)[117] and WEF/Bloom et al (2005)[37]) though not specifically tourism-oriented have identified company size as a factor for adopting HIV practices. Data collected in this thesis study also demonstrated that if a hotel was, or was not IF did not play a role in whether HIV practices were adopted, eg two out of the four IF hotels adopted HIV workplace policies. Additionally IF hotels, which have greater access to resources, and were in a better position to adopt more practices, had not adopted all the different types of practices reported in this study. Bakuwa (2010) review of the literature also indicated, *'...practices of parent corporations ...'*[113, pg 3], or in the case of this study, policies of the international franchise, acted as enablers to the adoption of HIV workplace policies. The only noticeable pattern observed between hotel type and adoption of HIV practice in this thesis study, was that private hotels in Trinidad adopted all 11 different types HIV practices reported in this study whereas government hotels adopted only seven practices. In Tobago, private hotels adopted ten types of HIV practices; there were no government hotels in Tobago to compare. Ketshabile's (2010) research found, *'insignificant relationships between tourism [accommodation] companies*

[51] Between 2000-2008

owned by Botswana citizens, non-Botswana citizens and a partnership between non-citizens and citizens of Botswana'[122, pg256] and the adoption of HIV workplace policies. Company size, IF and ownership as factors determining adoption of HIV practices will be further discussed in section 7.2.

7.2. FACILITATORS AND BARRIERS TO THE ADOPTION OF HIV PREVENTION AND CONTROL PRACTICES

Facilitators and barriers to the adoption process of policy content, or in case of this study HIV practices, are both external and internal to the hotel environment. The section discusses factors internal to the hotel environment which are subdivided according to three different themes: hotel operational factors, individual behaviour factors of management and individual behaviour factors of staff. Factors external to the hotel environment are further discussed in section 7.3.

Table 7.1: Most commonly reported facilitators and barriers to the adoption of HIV practices in hotels in Trinidad and Tobago

		No of hotels				No of hotels	
Ranking [1]	**Facilitator**	**Trinidad**	**Tobago**	**Ranking [1]**	**Barrier**	**Trinidad**	**Tobago**
1st	Existing hotels systems and operations	12	10	1st	Management not considering HIV a priority issue in the tourism sector	11	12
2nd	Management's consideration of HIV as a priority in the tourism sector	10	5	2nd	Hotels lack of resources	11	10
3rd	Staff having a high knowledge of HIV and AIDS	8	6	3rd	Staff's resistance to the adoption of hotel practices	8	8
4th	Management's positive attitude towards own increased knowledge of HIV	6	5	4th	Lack of adoption due to management's perceived guest behaviour and guest response	5	7
5th	Personal incident relating to HIV that has affected management	5	4	5th	Management's concern about hotel's reputation	5	3
5th	Hotel's available resources	5	4	5th	Staffs negative beliefs relating to stigma HIV	4	4

		No of hotels				No of hotels	
Ranking[1]	**Facilitator**	**Trinidad**	**Tobago**	**Ranking[1]**	**Barrier**	**Trinidad**	**Tobago**
					sex and sexuality		
7th[3]	Management's response to guest behaviours	3	1	7th[3]	Low staff educational level	4	1
No ranking possible	Buy-in from hotel head office	See note 2 directly below table		No ranking possible	Lack of staff knowledge of HIV and AIDS	See note 2 directly below table	
					Lack of buy-in from hotel head office	See note 2 directly below table	

[1]Ranking by simple counts
[2]Reported by national interviewees, in the general sense with no actual hotel numbers given
[3]No '6th' place as there were two facilitators/barriers ('5th') reported by the same number of hotels

7.2.1. MOST COMMONLY REPORTED BARRIERS

The most commonly reported barrier to the adoption process of HIV practices was management's lack of prioritisation of HIV in the tourism sector. This was also discussed as the most significant barrier to the adoption of HIV practices by Bakuwa in Malawi (2011) [114] and by HEU/UWI in Tobago (2009), *'...[the HTA did not view] HIV/AIDS as impacting the tourism sector significantly and as such it [was] not seen as a real concern for the Association'*[70, pg80]. The thesis researcher explains that this barrier is linked to other barriers mentioned in this research study such as management's concern about the hotel's reputation and what management believes of guest behaviour and what their response to HIV practices within the hotel would be; if hotel owners/managers were less concerned that guests would think negatively about their hotel they would be more inclined to introduce HIV practices. This concern about the hotel's reputation was also expressed as a barrier by HEU/UWI (2009)[70] and Padilla et al (2011)[72]. Forsythe et al (1998) stated that in the Dominican Republic (DR), where hotel managers were concerned that public AIDS awareness campaigns may discourage tourists from visiting the country, *'...more than 80% of tourists indicated that their perceived prevalence of HIV in a tourist destination made absolutely no difference to their travel plans.'* [10, pg284].

Also Pape (2006), reiterated the death of the tourism industry in Haiti at the start of the epidemic, when the link was made between HIV incidence and Haitians[68]. The thesis researcher notes that even though this concern was discussed by eight hotels in this

study it should not be assumed that this was not a fear held by a greater number of the hotels. Bakuwa's (2011) study in Malawi suggests other reasons for lack of prioritisation of HIV including the company's lack of resources; lag time between HIV transmission and development of AIDS thereby questioning the effectiveness of an HIV workplace programme; stigmatisation of HIV and the disease; and also the fact that employees themselves do not prioritise HIV within the workplace[114].

Another important barrier, and example where the converse of a barrier was reported as a facilitator, was the lack of hotel resources (financial, human, time and product).This thesis study concurs with Rosen et al (2007)[161] where an abundance of these resources enabled the development and adoption of HIV practices. Lack of financial resources was also mentioned as a barrier to the adoption of HIV practices by HEU/UWI (2009)[70] and Padilla et al (2011)[72]. This thesis study indicated that a lack of buy-in from hotel head office is a barrier to the adoption process of HIV practices. This concurs with Kamazora (2009)[162] and Bakuwa's (2011)[114] studies which link top-management support with the provision of financial resources.

Staff resistance to the adoption of HIV practices was also indicated as a barrier to the adoption process by hotel owners/managers. This was particularly common for the use of gloves by staff when cleaning rooms and for the attendance at HIV awareness seminars. The thesis researcher posits that this barrier is also related to others, such as the lack of HIV and AIDS knowledge by both management and staff as also noted by Siiskonen (2001)[30], Bakuwa (2010, 2011) [113, 114]and Parsadh et al (2005)[115]. The thesis researcher also proposes that resistance of staff to attend HIV awareness seminars is related to barriers such as HIV stigma pertaining to sex and sexuality and their low educational level. The thesis researcher concludes that staff resistance is an excuse for hotel owners/managers not to offer HIV awareness seminars.

7.2.2. MOST COMMONLY REPORTED FACILITATORS

The most common facilitator to the adoption process of HIV practices was the existence of hotel systems and operations. This factor was not widely cited in the literature. Rather it was limited to hotels in Jamaica and the Bahamas (2004) where, similar to TT, local

NGOs would be used to discuss HIV at previously planned health fairs and education seminars. One hotel in Jamaica used weekly meetings to '*.... sensitise employees to the disease [HIV]'* [3, pg53]. Having existing systems in place, eg regular staff meetings, allowed the financial cost and time away from work duties to be minimised. Another reported facilitator in this study was that of HIV being considered a priority issue in the tourism sector by hotel management. HEU/UWI's (2009) study concurs with this factor as a facilitator, '*in Tobago...in the early days of the epidemic, HIV/AIDS was recognised and acknowledged as an issue of importance to the sector...'*[70, pg80].This has been extensively discussed previously (see section 7.2.1.) as it was the most cited barrier to adopting HIV practices being adopted.

Staff having an increased knowledge about HIV and AIDS was also reported by hotel owners/managers as a facilitator. Bakuwa(2011), referring to Swan and Newell (1995), believed that before practices were adopted staff needed to know and understand the benefits of the said practices[114]. The thesis researcher believes that with an increased knowledge of HIV and its modes of transmission, together with the potential health issues to the individual and the community, staff would be more willing to attend HIV seminars. Another facilitator noted in this study, was management's positive attitude towards, and increased knowledge of, HIV. The thesis researcher suggests that when management understood the impact of HIV on their staff, this acted as a facilitator whereby hotel owners/management sought to protect their staff by increasing their knowledge and awareness through adopting HIV practices. Management's understanding of the impact of HIV on the company's operations, and their support, knowledge and leadership in developing and adopting HIV practices were also discussed as a factor in international studies[30, 113-115].

7.2.3. RELATIONSHIP BETWEEN FACILITATORS AND BARRIERS

The thesis researcher observed that some facilitators and barriers reported by hotel owners/managers and national interviewees could be categorised within more than one theme of the conceptual framework (CF). Knowledge of HIV and AIDS was considered a facilitator within both themes of staff attitudes and beliefs and management interests, attitudes and knowledge. Other factors are also intertwined within the same theme, eg if the staff is sufficiently large, employees can substitute for one another and attend

training sessions; thus a large staff acts as a facilitator. Several researchers and international organisations including Parsadh et al (2005)[115], WEF/Bloom et al(2005)[37], Withers et al (2007)[117], and Siiskonen's (2009)[30] found that larger firms, as compared to the small and medium-sized enterprises (SMEs), had a greater tendency to adopt HIV practices. In this thesis study adoption of practices through knowledge transfer was reported by hotel interviewees to be relatively easy to accomplish in smaller hotels and not necessarily easier than in medium-sized ones; this means that having a medium-sized staff may act as a barrier to the adoption process of HIV practices. Bakuwa's 2010 analysis within differing industries found that company size acted as neither a facilitator nor a barrier[113]. In some instances barriers and facilitators were found to be the opposite of one another. For example, HIV being, or not being, considered a priority issue in the tourism sector by hotel management was reported as both a facilitator and a barrier. This was also true for the factor pertaining to the availability, or lack, of resources. A lack of funding was also reported as a barrier and affects the hotel's ability to acquire or employ in-house technical capacity. The thesis researcher posits that when a hotel has more money available as noted in the larger hotels and/or those with that are IF, the staff size is usually bigger and thus the ability to have more highly qualified employees who have a greater skills base is greater. Interestingly Ketshabile's (2010) Botswana study found that there was little difference in the adoption of HIV policies among tourism companies if it was locally-owned, owned by non-nationals or a mixture of both these groups[39].

Stigma and discrimination has been acknowledged as one of the contextual determinants of the TT HIV epidemic[22] and barriers to the adoption process of HIV practices, such as negative beliefs relating to HIV, sex and sexuality are perpetuated by issues of S&D. Another element of this thesis study's context is that life in the Caribbean is often perceived by visitors to revolve around 'sun, sea, sand and sex'[163]; sex tourism and its linkages to HIV have been widely acknowledged in the Caribbean including TT[3, 10, 17-21, 24, 48, 61, 64, 65, 70, 72, 84]. Barriers to the adoption process were created by management's concerns about the hotel's reputation, eg management's belief that condom distribution would encourage the idea that the hotel condones sex tourism. Situational factors such as the annual Carnival celebrations created facilitators for the adoption of HIV practices such as HIV training and sensitisation seminars for staff. It was acknowledged by several of the national interviewees that everyone, including hotel owners/managers, had their own *'personal policy'* that reflected their attitudes towards

HIV and AIDS; this included S&D towards PLHIV and those affected by HIV and issues about sex and sexuality. These national interviewees indicated that negative attitudes towards PLHIV acted as a barrier to acknowledging one's own personal policy and the ability to differentiate it from one's professional policy[52], thus subsequently hindering the development and adoption process within the hotel.

7.3. RESPONSE OF THE HOTEL AND TOURISM SECTOR TO NATIONAL HIV POLICIES AND PROGRAMMES

This section discusses the facilitators and barriers to the adoption process of HIV practices in the TT hotels' external environment; specifically it examines implementation of national HIV policies and programmes. These factors were categorised according to the stages heuristic model [1, pg13].

At the initial policy stage of problem identification and issue recognition, lack of prioritisation of HIV within the tourism industry was noted as a major barrier to the adoption of HIV practices. This factor (see section 7.2.1.) was also noted by Siiskonen in Southern Africa (2009)[30], HEU/UWI in Tobago (2009)[70] and Bakuwa in Malawi (2011) [114]. In the Tobagonian context, tourism is a major structural factor in the country's economy. However issues of national concern such as visitor security, illegal drugs and sex work[11, 45-48], together with the disagreement as to the extent of the national HIV epidemic and the existence of sex tourism, has led these other issues to take precedence over HIV as a priority in the tourism sector.

Formation of partnerships is a very important factor in policy formulation. This can be influenced by both state and non-state actors – governing political party's ideology and civil society interests[1]. In this study state actors formed partnerships among themselves (NACC and Ministry of Tourism) and with international agencies (GORTT/ILO/USDOL) which resulted in the formulation of TSHASP and the National Workplace Policy on HIV and AIDS, respectively. Within the context of this study, international factors such as partnerships between foreign governments are very

[52] Professional policy: attitudes and interests that one must adopt at a professional level or within one's workplace

important to the GORTT not only because of the potential revenue from exporting local energy resources to the US and visiting tourists (US visitors accounted for 40% of TT's tourism arrivals in 2007[45]) but also from the standpoint of good foreign relations. Additionally because the GORTT adheres to the ILO Code of Practice on HIV/AIDS and the World of Work it welcomed the ILO/USDOL International HIV/AIDS Workplace Education Programme in TT(2005-2008)[74].

Several facilitators and barriers were identified by national interviewees during the implementation stage of national HIV policies and programmes. Provision of resources (financial, technical, product and human) acted as both a barrier and facilitator. This concurs with Caribbean research by HEU/UWI (2009)[70] and Padilla et al (2011)[72] and international research by Rosen et al (2007)[161] and Bakuwa (2011)[114] (see also 7.2.1). Kamuzora (2006) in his study of the lack of occupational health policies in developing countries suggested, *'...the main reason for under-funding is lack of political will rather than lack of funds...'*[162, pg66]. Kerrigan et al (2006)'s research in the DR did not specifically state lack of human resources as a barrier to the implementation of an adapted version of the Thai 100% condom policy but indicates, *'...structural level barriers as... the lack of systemization and supervision by the Ministry of Health regarding STI screening and treatment of sex workers and the role of government health inspectors...'* [127, pg237] Financial resources from external actors, such as the USDOL also facilitated implementation of national HIV programmes. This was also demonstrated when external funding was given to Uganda[109] and Zambia (2009)[112]. Another factor which acted as both facilitator and barrier to policy implementation was when some national policies and programmes were legally mandated (eg anti-stigma and discrimination section of the Constitution of the Republic of TT) while others were simply guidelines (eg National Workplace Policy on HIV and AIDS). Bakuwa's (2011) study in Malawi ranked *'absence of HIV/AIDS legislation'*, [114, pg1077]as a barrier to adopting HIV workplace policies.

Other facilitators to the adoption process, as reported by national interviewees, included partnerships between state actors and hotels (which was also a facilitator at the policy formulation stage) and enthusiasm and level of HIV awareness by the implementing actors. The HEU/UWI study (2009)[70] also identified such partnerships as facilitators, eg between Ministries of Health, tourism agencies and hotels. Private-public partnerships were also used in Botswana to deliver the country's anti-retroviral

programme[111]. Enthusiasm by national actors as a facilitator was not previously indentified in the literature yet it relates to the importance of actors in the implementation of programmes. The thesis researcher suggests that such enthusiasm and HIV awareness by the tourism workers, translated into the workers being proactive and taking a leadership role in ensuring the implementation of the programme. This concurs with Parsadh et al (2005)[115] who discussed leadership (and awareness) as a facilitator in small and medium enterprises (SMEs) in South Africa, to ensuring effective implementation. Barriers to the adoption process also included lack of coordination across sectors, ineffective communication of national policies and programmes and fear of deterring tourists from visiting TT resulting in a loss of revenue. Research from the Caribbean demonstrates that the most common barriers to policy implementation included a fear of discouraging tourists and a lack of inter-sectoral and private-public collaboration[70, 72]. Ineffective communication of national policies, as a barrier to policy implementation, was discussed by Datye et al (2006) in his account of communication practices among doctors in India and that doctor-patient communications were hindered due to multiple policies and *'a lack of effective mechanisms to ensure that these guidelines [were] relayed to the private [medical] sector'*[116, pg349] Datye et al's factors of multiple policies and lack of effective delivery mechanisms could be compared to this thesis study in that TT has a myriad of national HIV policies and programmes which lead to uncertainty as to which organisation (HIV/health or tourism) is responsible for implementing government HIV policies in the tourism sector or where the hotel owners/managers are able to access technical information or product supply such as condoms. A final barrier reported in this thesis study was that adoption of HIV practices was not legally mandatory and many hoteliers see the adoption of such practices as an inefficient use of already limited financial and human resources. Bakuwa's (2011) study in Malawi[114] also indicated that legislation mandating HIV practices was a factor to their adoption. This barrier is determined by the legislative context of the country and political interests of the government.

7.4. RECOMMENDATIONS TO STRENGTHEN HIV POLICIES, PROGRAMMES AND PRACTICES IN THE HOTEL AND TOURISM SECTOR.

The thesis researcher used an adapted ecological McLeroy's framework to demonstrate that the facilitators and barriers identified in this study were both internal and external to the hotel. Therefore recommendations for continued adoption and implementation of

these practices and policies or changes that allow for development and subsequent adoption must be made at levels internal and external to the hotel. In this section the thesis researcher provides recommendations to support the hotel and tourism sector with regard to the adoption of HIV practices. These recommendations, directed towards four different groups – hotels, HTAs, national government agencies, and regional and international agencies – are based on barriers and facilitators to the adoption of HIV practices reported in this thesis research study.

7.4.1. RECOMMENDATIONS FOR HOTELS

HIV awareness by hotel management and staff: The researcher recommends that all management and staff be sensitised about HIV prevention and control through a programme of training modules. The training should be targeted at different groups within the hotel, for example, management staff sessions would focus on HIV and its impact on the tourism industry, confidentiality and the legal ramifications of not hiring, or firing, a highly competent yet HIV-positive employee whereas housekeeping staff sessions would have demonstrations of how to handle blood soiled linens and remove used injection needles from the waste bin. Existing hotel systems and operations should be used to deliver HIV sensitisation messages. For example, monthly meetings could be used to conduct an HIV awareness session, or information leaflets could be posted on staff notice boards; a session could be conducted at the end of a shift so that both those leaving and those starting their shift could benefit. Each training session could be more advanced than the previous one, eg starting with basic facts and myths about HIV, and continuing onto modes of transmission, sex and sexuality, access to Voluntary Counselling and Treatment (VCT) and other care services. Different methods of delivering the information such as focus groups or role play could be incorporated so participants would learn new information while avoiding 'burn-out'. Other training modes could be community work with PLHIV to create a level of empathy amongst the tourism workers that would assist in decreasing S&D towards PLHIV. The entire programme of sessions should be adopted on a continual basis, beginning with the induction sessions for new staff and then continued throughout the year. For smaller hotels, the thesis researcher recommends training be held with a group of the hotels rather than on an individual basis. This increased HIV awareness would assist in overcoming most of the barriers reported in this study especially those of management not considering HIV a priority, lack of staff knowledge of HIV and AIDS, staff resistance

to hotel adoption of HIV practices, and staff's negative beliefs relating to stigma, HIV, sex and sexuality while making use of reported facilitators such as existing hotel systems and operations. HIV awareness training sessions can be developed and implemented by the HIV focal point, in collaboration with the TSHASP, the NACC and local NGOs.

Resources for the adoption of HIV practices: It is strongly recommended, by the thesis researcher, that each hotel appoint an HIV focal point to ensure that the HIV practices are developed, implemented and evaluated on an on-going basis. Using existing hotel human resources the focal point needs to have basic HIV knowledge, a keen sense of interest in developing a workplace programme and the respect of his/her fellow staff members. The hotel owner/manager or Human Resource (HR) manager should only be used for this position if there are no other suitable candidates as they already had many duties and responsibilities. One of the key tasks of the focal point would be to source further technical, financial and product resources. Initial technical and product resources may be obtained through government agencies (NACC, TSHASP, MLSMED) and NGOs. A specific budget for continuing development and adoption of HIV practices must be allocated and the education of hotel owners/managers as to the benefits of such practices is part of the process.

HIV workplace guidelines: The researcher advises using the term 'guidelines' as being more palatable and less threatening to the hotel owner/manager as many non-legislative persons believe that policies are 'cast in stone' and, with changing circumstances, cannot be adapted over time. Each hotel should have written HIV workplace guidelines; either as a stand alone document or incorporated into the hotel's health and safety operational procedures. Having such guidelines is facilitated by management's consideration of HIV as a priority and their positive attitude towards increasing their HIV knowledge. The HIV workplace guidelines may be individually adapted from the ILO Code of Practice on HIV/AIDS[164] to a particular hotel (as is more likely in the case of the larger hotels) or maybe a standard template of HIV workplace guidelines designed for use in the small or medium-sized hotels.

7.4.2. RECOMMENDATIONS FOR HOTEL AND TOURISM ASSOCIATIONS

Enable HIV policies and programmes: Literature has shown that professional associations play an important role in adopting HIV practices through information dissemination and peer collaboration[14, 113, 117, 118, 123]. The two island-based HTAs could play a greater role as enablers for its membership to adopt HIV practices. For example, the researcher suggests that a monthly meeting could be used to discuss the implementation of HIV-related policies, such as the National Workplace Policy on HIV and AIDS, and how to overcome any possible challenges that may be encountered; this could be facilitated through a presentation followed by a discussion led by the MLSMED. Research results on the importance of HIV to the tourism industry, and its effect on guests to the hotels, can be also presented to the hotel owners/managers through the HTAs. Using HTAs would assist hotels owners/managers in overcoming barriers to the adoption of HIV practices, eg management's concern about hotel's reputation and their perceived ideas about guest behaviour and guest response to HIV practices. At these forums, management could discuss such concerns with other hotel owners/managers already adopting HIV practices and with technical experts such as the MLSMED. The HTAs can act as an information repository for the development and adoption of HIV practices for the hotels by storing contact information for government, civil society and private-sector organisations that may assist the hotels.

7.4.3. RECOMMENDATIONS FOR NATIONAL GOVERNMENT AGENCIES AND MINISTRIES

Research: There are a number of recommendations for further research in TT, the Caribbean and indeed internationally. The researcher recommends studies be undertaken to determine the economic impact of HIV on the tourism industry, nationally and regionally. This would include direct costs incurred by the hotel eg increased insurance cover and medical costs, and indirect costs, eg absenteeism and time to re-train staff[165]. Research is also necessary to understand which of, and to what extent, the determinants (see Table 2.8) of the tourism industry have a direct impact on HIV transmission. Additional research into S&D at the workplace in the context of the national tourism industry also needs to be examined, in particular issues around sex and sexuality. Research studies to determine the visitor perspective on HIV practices within the hotel industry, eg, should there be any such practices at all? Would such practices deter guests from visiting that country or island? For example, would a guest be

offended by having HIV practices in the hotel? What form of practices would be acceptable to guests? Such research will assist in overcoming barriers related to management's consideration of HIV as a priority issue in the tourism sector, management's perceived ideas of guest behaviour and guest response to HIV practices and management's concern about hotel's reputation. The researcher also recommends that further research be conducted to quantitatively demonstrate whether or not the most common facilitators and barriers, found in this study are statistically significant, in the adoption of HIV practices by the hotels.

National HIV Guidelines for the Tourism Industry: The researcher recommends that National HIV Guidelines for the Tourism Industry be developed as was done in Jamaica[166]. Working through the HTAs, a standard template of workplace guidelines could be created and then the hotel owners/managers be taught how to adapt these guidelines to suit their own hotel staff's circumstances.

Mentoring system: Often, after a training session on the development and adoption of HIV practices, the participant will have questions or need further assistance. However there is no assigned agency from which they could seek such assistance. The researcher recommends a system of 'hand-holding' or mentoring should be made available at the TSHASP. This recommendation can assist in overcoming the barrier related to limited hotel resources as all hotels may not have in-house technical expertise.

Address HIV education in all sectors especially education: Another important recommendation by the researcher would be to ensure that HIV awareness, together with sex and sexuality is part of the national curriculum for all youth in secondary school including those as young as11 years old. HIV awareness should also be continued into tertiary education including the national Hotel and Hospitality Institutes but at the Institutes the focus would be on HIV in the tourism industry. Such a change at the national level would involve the Ministry of Education. This recommendation would use existing educational systems to overcome most of the barriers reported in this study, in particular staff's low educational level, lack of HIV and AIDS knowledge, and negative beliefs relating to stigma, sex and sexuality.

Improved coordination: Government agencies, such as those working in HIV/health (NACC, THACCS), labour (MSLMED) and tourism (TSHASP, Tourism Development Company (TDC)), need to work together with the HTAs and the hotels in a more coordinated approach to provide continuing HIV policies, programmes and support for hotels. Hotel and tourism associations are channels to the hotel owners/managers, the researcher recommends that government agencies work through the HTAs, taking their views and resources into consideration; not seeing the hotels as a conduit just to meet their targets but as a full partner in the coordination and implementation of such programmes.

7.4.4. RECOMMENDATIONS FOR REGIONAL AND INTERNATIONAL AGENCIES

Increased cooperation and sharing of technical information: The researcher recommends increased regional cooperation to share technical information between countries that already have national HIV policies in the tourism sector and HIV practices in the hotels and those countries wishing to develop such national HIV policies and programmes. For example, the Jamaican Tourism Product Development Company which has led the development of the Jamaican Tourist Sector HIV/AIDS Workplace Policy, and hotel resorts with HIV programmes, eg Amaryllis Beach Hotel and Blue Horizon hotel in Barbados, and Sandals Resorts in Jamaica (and throughout the Caribbean). This can be facilitated by the regional Pan Caribbean Business Coalitions to Fight HIV/AIDS in the Caribbean (PCBC), the national business coalitions, and the national HTAs. International organisations such as the ILO should be encouraged by national governments through their labour ministries, and the regional HIV agency – Pan Caribbean Partnership Against HIV/AIDS (PANCAP) – to resurrect their former International HIV/AIDS Workplace Education Programme which resulted in HIV policies in hotels in Trinidad and Barbados. This would provide technical as well as financial resources for the development of further HIV policies and programmes in hotels.

The researcher also recommends that areas of high tourism activity and HIV rates (eg the Caribbean, southern Africa) share information at the regional level. For example, resources developed by, and technical expertise of, the Tourism, Hospitality and Sport Sector Education and Training Authority (THETA) for South African tourism companies, the Southern Africa Tourism Service Association (SATSA) and the AIDS Workplace

Programmes of Southern Africa (AWiSA) can be shared with the Caribbean Tourism Organization (CTO), the Caribbean Hotel and Tourism Association (CHTA) and the Pan-Caribbean Business Coalition on HIV and AIDS (PCBC).

Increased resources: Development and adoption of HIV practices involves use of already limited resources. The researcher recommends that PANCAP uses its financial and technical resources to achieve one of the specific strategic objectives of its second Caribbean Regional Strategic Framework on HIV/AIDS (2008-2012) to ensure that *'Caribbean countries have adopted and implemented HIV workplace policies and programmes in the tourism sector.'*[53, pg34-35]. The researcher also recommends that regional development agencies such as the Caribbean HIV/AIDS Alliance (CHAA) and its parent organisation the International HIV/AIDS Alliance in the United Kingdom, and the Caribbean Epidemiology Centre (CAREC) who have conducted a great deal of HIV research, and offered technical assistance to the adoption of HIV practices in the Caribbean tourism sector, continue to do so. Additionally, several technical resources developed by these organisations such as manuals and toolkits for HIV prevention and control programmes in the tourism sector [71, 73, 76, 167], can be used by the hotels in developing their HIV practices. This assistance and dissemination of resources can be offered through regional HIV and public health agencies such as PANCAP and CAREC, regional tourism agencies such as the CTO and the CHTA, and national HTAs.

SUMMARY

In discussing the results of this study, the researcher considered the content of HIV practices most commonly adopted by hotels in TT. The most common direct practice was identified as that relating to S&D towards PLHIV by hotel owners/managers and other members of staff who believed that there was a specific legal mandate against this; ironically the laws of TT do not specifically mention HIV S&D. Additionally a small selection of hotels, who indicated that they did not discriminate against HIV-positive staff or guests, adopted the practice of HIV testing before hiring new employees. The indirect practice of staff-guest interaction was considered a 'no-no' throughout the industry to prevent sex tourism, protect the hotel and country's moral reputation, and prevent any possible libel action against the hotel. HIV training and sensitisation seminars were adopted as a result of initiatives by the national HIV and tourism agencies

(not hotel management) thus supporting the notion that hotel owners/managers did not view HIV prevention and control as a priority issue in the tourism industry. There was no pattern regarding the number of different patterns of HIV practices adopted by small, medium-sized and large hotels on either island but a comparison of this data was limited as there were no IF or government-owned hotels in Tobago.

Within the internal hotel environment, the most commonly reported barrier was the lack of prioritisation of HIV in the tourism sector by hotel management. This factor can be related to other barriers such as management's concern about the hotel's reputation, what management believes of guest behaviour and guest response to HIV practices being adopted by the hotel, and lack of hotel resources which are largely under the control of management. The most common facilitator was the existence of hotel operating systems which could be linked to resource allocation. The majority of both facilitators and barriers were categorised under the theme of management interests, attitudes and knowledge, leading the researcher to conclude that hotel management has the most significant influence on whether or not HIV practices are adopted. Many of these barriers can be related to the socio-cultural context of the country. Stigma and discrimination (S&D) which has been acknowledged as one of the major drivers of the country's epidemic can be used to explain barriers such as staff negative beliefs relating to stigma, sex and sexuality. Situational factors such as the annual Carnival celebrations act as facilitators for adopting HIV training and awareness sessions.

In the external hotel environment, facilitators and barriers influencing hotel adoption of HIV practices can be examined through the hotels' response to national policies and programmes. These were classified according to policy processes of problem identification and issue recognition (lack of prioritisation), formulation (formation of partnerships) and implementation (government resources, partnerships, legally mandated practices, enthusiasm and levels of awareness by government implementers, lack of coordination across sectors, ineffective communication of national policies, and fear of deterring tourists). The importance of context in this study was demonstrated through structural (tourism as an economic asset) and international factors (political partnerships with the US).

Actors in this study's adoption process were not only hotel owners/managers, government ministries, and national HTAs. Also included were regional and international agencies; NGOs; hotel security guards who ensured the effective adoption of HIV practices aimed at controlling staff-guest interaction; and insurance companies stipulating that hotel staff must undergo HIV testing.

Finally recommendations to strengthen HIV policies, programmes and practices in the hotel and tourism sector were targeted at the hotels, HTAs, national government agencies and ministries, and regional and international agencies. Recommendations by the researcher for hotels included increased HIV awareness by hotel management and staff; increased or re-allocation of resources for the adoption of HIV practices and development of HIV workplace guidelines. The HTAs may not have the resources, but they are in a unique position to act more quickly in all matters such as developing, and having their members adopt, HIV practices. The major recommendation for HTAs was to become an enabler for HIV policies and programmes by using the existing HTA forum for discussing national policies and challenges concerning their implementation. Recommendations for government agencies and ministries included further research, development of National HIV Guidelines for the Tourism Industry, system of mentoring, HIV awareness in all sectors and improved coordination between national agencies and hotels. Recommendations for the regional and international agencies included the provision and facilitation for increased cooperation and sharing of technical information, and increased resources.

CHAPTER 8 CONCLUSION

This chapter offers some study limitations and finally explores the researcher's contribution to knowledge.

8.1. STUDY LIMITATIONS

The study design only allowed for collection of data based on interviews with the hotel owners/managers and national interviewees. Due to the limited time frame of the study it was not possible for the researcher to corroborate these statements through further interviews with the staff (that were not part of management); this would have verified some of the practices that owners/managers indicated were in place and any of the facilitators and barriers to their adoption. Even though owners/managers in over half of hotels within the sampling framework were interviewed, there were some hotels that may have provided additional data but were unwilling to be included in the study. Additionally, the data collected through interviews was based on what the respondents said they did and not necessarily on what they actually did.

The researcher believed that there were some instances of recall bias, eg not remembering if hotel staff attended HIV sensitisation meetings, and social acceptability bias, eg hotel owners/managers telling the researcher that given the choice they would adopt HIV practices in the future. Not being able to access any actual hotel policy documents was also a limitation, as neither the exact contents of the documents could be analysed nor their actual existence confirmed by the researcher. In some instances when the researcher requested copies of these documented policies or programmes from the hotel owners/managers, they claimed that they were confidential documents, or that they *'...presently [did] not have any pamphlets available...'* except the Tourism Development Company brochure (see Appendix 11). However, in some cases, it was possible for the researcher to confirm these practices, for example by checking the hotel shop for condom availability.

HIV practices, and barriers and facilitators to the adoption of these practices were expressed by the researcher as 'most common' and derived by method of simple count. The researcher acknowledges that this data has not been statistically proven and the reporting of results, in order 'most common', was analysed considering the total number of hotels responding to a particular question. The researcher would like to reiterate that even though the greatest of care was given to ensure that all relevant questions were answered by all interviewees, if all hotels responded to having a particular practice, eg only 27, out of the 43, hotels reported non-discrimination practices, it cannot be extrapolated that the remaining hotels did not have such practices. This thesis study represents events, beliefs and knowledge occurring during a particular period of time. Subsequent to the investigative period which ended in June 2010, other events have occurred that were not captured as part of the document analysis, eg the disbandment of the NACC in March 2011, which may have had an impact on the adoption of HIV practices, eg the reduction of NACC activities.

Another important limitation for the researcher was the ability to be reflexive throughout her collection and analysis of the data. Because of her extensive international, regional and national knowledge and experience of the topic, this was very challenging for the researcher. However, as much as possible she was able to keep her own views out of the data collection and analyse the data in an unbiased manner.

8.2. CONTRIBUTION TO KNOWLEDGE

The research produced several contributions to knowledge. Firstly, it produced a comprehensive review of the literature linking HIV and tourism in the Caribbean and a listing of policies and programmes pertaining to the TT AIDS response in the tourism sector. Linkages between HIV and tourism, internationally and in the Caribbean, have been studied in the past but this study brings all such studies together and updates any former reviews. Again, TT policies and programmes relating to the AIDS response in the tourism and hotel industry cover a broad spectrum of sectors; by detailing these policies and programmes, this research demonstrates the non-specificity and ad-hoc manner in which the AIDS response attempts to target the tourism and hotel industry.

This research produced a detailed list of HIV practices within the TT hotel sector that were adopted. Even though, the research did not evaluate the effectiveness of these practices, this list can now be used by other hotels wishing to start the process of adopting such practices, especially since some hotels claimed they did not know where to start the process. Hotel owners/managers can begin developing their own in-house programme with a self-assessment and categorisation of their health and safety practices by using the researcher's definition of formal/informal and direct/indirect practices. By specifically identifying the facilitators and the barriers to the adoption of HIV practices within the hotels in TT, the researcher has given policy makers, at both the national level (eg government ministries) and the industry level (hotels), causes as to why HIV practices were easy or hard to adopt.

This study sought to qualitatively analyse a major public health issue in the context of a predominately private sector industry. Such studies in the Caribbean, and more specifically TT, are very limited; this study adds to the broader research literature on HIV and tourism. Additionally through the qualitative approach taken by the researcher this study created an awareness among the hotel owners/managers and the national agencies of the importance of HIV within the tourism industry and its potential economic implications.

Finally this study seeks not to generalise the facilitators and barriers to the adoption of HIV practices within in TT hotels to other countries, either within the Caribbean or internationally, but rather to add to national knowledge in order to overcome obstacles for future development and implementation of HIV policies and programmes in the hotel and by extension, tourism sector.

8.3. RESEARCHER'S FINAL REFLECTIONS

The researcher is a citizen of TT with over ten years working experience in public health. For many years she worked in the Carnival camps distributing costumes for those about to spend two days, dancing and gyrating to the rhythmic sounds of steel bands and calypso music, more often than not intoxicated with alcohol which is so frequently associated with this festival. Many visitors arrive in the country during this time to join

in the festive parades; sex tourism via liaisons between foreign visitors and locals, often initiated at the hotels, is not uncommon. It was against this backdrop that the researcher became interested in the protection of the local community from a public health perspective.

Grenade (2009) speaks to the globalisation of infectious diseases in terms of global travel and tourism[11, 168] and *'the securitization of global public health...at the risk of tourists activities undermining global public health and human security'*[168, pg2]. Grenade discusses the balance between implementing HIV policies and practices to protect the citizens of the Caribbean and the fear of reducing economic revenue from a sector upon which such countries are highly financially dependent. The thesis researcher believes that it is necessary for policy makers at both national and industry level to understand the linkages between HIV and tourism in order to appreciate the potentially devastating economic impact on both the hotel and country. The balance that Grenade refers to can be achieved by creating HIV policies and programmes that are effective in reducing transmission and mitigating the effect of HIV and AIDS while at the same time being palatable to the tourist. From this research study it has become apparent that prioritisation of HIV within the tourism sector must be addressed to reduce new HIV infections throughout TT. This prioritisation must come first through the government, then the HTAs and finally the hotel owners/managers. By recognising that tourism, through tourism workers such as hotel employees, is a route to increased HIV transmissions national policies and programmes can be developed and implemented.

Appendix 1: Case studies of international HIV interventions in the tourism sector

- ACCOR is an international company within the travel and tourism market with over 4000 hotels in 90 countries. In collaboration with Air France, ACCOR produced two films in 2007 which seek to inform travellers about HIV and AIDS in order for them to make choices that reduce their probability of undertaking risky sexual behaviours while on holiday. The films are shown throughout ACCOR's hotel chains and Air France's international vaccination centres and airport lounges[34].

- Serena Hotels Group consists of 19 hotels and lodges in Kenya, Rwanda, Uganda and United Republic of Tanzania and Zanzibar. In partnership with the International Finance Cooperation, the Hotels Group created and put into practice an HIV and AIDS workplace programme, which in 2007 was expanded into a broad wellness programme. The programme also addresses issues of violence, sexual harassment, and drug abuse (including alcohol). Of note is that the number of new HIV infections and AIDS-related deaths among staff fell and absenteeism dropped [33].

- Visabeiro Turismo is part of Grupo Visabeiro, an international company whose portfolio includes hotels in both Mozambique and Angola. Beginning in 2006/2007 and in collaboration with the Mozambique Business Coalition against AIDS and the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria, Visabeiro Turismo has developed a workplace programme targeting over 2000 of its employees. This included HIV prevention brochures and posters that were adapted to the local Mozambican culture. Grupo Visabeiro also bought and distributed condoms to its employees[34].

- Virgin Group, has several businesses including those within the area of travel, transport and tourism; the Group employs approximately 50,000 people in 29 countries. In 2006, Virgin Group developed its Global HIV/AIDS Policy and Management Guidelines for the company's hotels and has implemented its "0% Challenge – 0% deaths from HIV/AIDS; 0% new infections; 0% transference of infection from mother to baby; and 0% tolerance of discrimination against those infected"[34].

- The Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria has also produced several working documents aimed at assisting companies to develop and implement their own workplace policies and programmes including a document entitled *'What Can Travel and Tourism Companies do to Fight Against HIV/AIDS, Tuberculosis and Malaria – a Best Practice Guidebook'* (2008) [34].There has also been the formation of several national and regional Business Councils on AIDS including the South African Business Council on HIV/AIDS, Thai Business Coalition on AIDS, The European AIDS and Enterprise Network, The Pan Caribbean Business Coalition on HIV/AIDS (2005), The Pan African Business Coalition on HIV/AIDS (2005), and Asia Pacific Business Coalition on AIDS (2006)[33, 35, 40].

- International Hotel and Restaurant Association, whose headquarters are in Paris, undertook research to highlight HIV issues concerning impact of health issues

on hotels, restaurants and their customers (1995-1998)[35]. Together with UNAIDS, Non-Governmental Organizations (NGOs) and the Thai Business Coalition a publication entitled, *'The Challenge of HIV/AIDS in the Workplace: A Guide for the Hospitality Industry*' (1999) was developed. This document provides guidelines for hotels and restaurants to develop their own policies and programmes as well as to help users understand HIV-risk and modes of transmission; it also emphasizes the importance of high level management support[36].

- Regent Hotel in Bangkok, Thailand has a workplace HIV and AIDS prevention programme in which all new staff undergo HIV sensitization and awareness training. The human resources division has made available audio and visual information to provide continuous education for staff. The hotel has also participated in some community projects and assisted other businesses in developing their own programmes[35, 36].

- Kimball Plaza in the Philippines provided STI/HIV/AIDS awareness training to all employees as part of its pre-service training. It also disseminated further information disseminated during mealtime breaks to staff[35].

Appendix 2: Background to some of the Caribbean's agencies involved in tourism and HIV and AIDS prevention, treatment, care and support programmes

'Caribbean Tourism Organization (CTO): *The Caribbean Tourism Organization was established in January 1989 out of a merger of the Caribbean Tourism Association (founded 1951) and the Caribbean Tourism Research and Development Centre (founded 1974). It is an international development agency functioning under a Headquarters Agreement with the Government of Barbados where its headquarters are located. It also has marketing operations in the tourism generating markets in New York and London. The purpose of CTO is to establish a forum where individuals, particularly travel agents, connected with selling travel and providing services for the Caribbean, can meet for the primary purpose of developing a greater awareness of the destination and product knowledge and therefore expanding travel and profit opportunities. Its main aims are: i) to continually educate the travel agents on product and knowledge; ii) to bring Representatives and CTO Members together regularly; and iii) to develop a closer working relationship, better understanding of travel.'[169]*

'Caribbean Hotel [and Tourism] Association (CH[T]A): *The members of CH[T]A represent the entire spectrum of the hospitality industry's private sector. Some 849 member hotels in 36 national hotel associations represent approximately 125.476 rooms in the Caribbean, from the small guest houses to the mega resorts. The allied members: airlines, tour wholesalers and travel agents, trade and consumer press, advertising and public relations agencies, and hotel and restaurant suppliers, among many, account for more than 536 members. Altogether, they are the hospitality industry of the Caribbean, and CHA is their voice. By the early 1990's CHA developed a host of programmes: the Caribbean Culinary Federation (CCF) for culinary development, the Caribbean Hospitality Training Institute (CHTI), for training and education; the Caribbean Tourism Credentialing Programme (CTCP), for certification and credentialing; the Caribbean Hotel Foundation, for scholarships and grants; and the Caribbean Alliance for Sustainable Tourism (CAST), for environmental management, among many others – all geared to help Caribbean hoteliers increase the quality of their product/service and their competitiveness. As a result of the complete range of initiatives, CHA has become over time the recognised representative of the Caribbean hospitality industry, as well as the private sector developmental partner, by international agencies active in the region, such as the European Union, the InterAmerican Development Bank, the Organization of American States, and the United States Agency for International Development.'[169]*

'Caribbean Alliance for Sustainable Tourism (CAST): *CAST is a non-profit organization established in 1997 by an agreement among the International Hotels Environment Initiative, The Caribbean Hotels Association and Green Globe 21 to promote the tourism industry's adoption of Agenda 21 for the travel and tourism industry. CAST undertakes collaborative environmental activities within the hotel and tourism sector, promotes effective management of natural resources and provides access to expertise in operational efficiencies and sustainable tourism. At present it has 225 members throughout the wider Caribbean.'[169]*

The Pan Caribbean Partnership Against HIV/AIDS (PANCAP): In 2001, with the Declaration of Commitment to PANCAP, the Caribbean Heads of State and Government endorsed this budding agency. Today PANCAP has become the umbrella regional

organization that brings together national HIV programmes with international and regional organizations involved in the fight against AIDS in the Caribbean[53]. There have been two Caribbean Regional Strategic Frameworks (CRSF) – 2002-2006 and 2008-2012 which provide the basis for the implementation of PANCAP's work. With the latest CRSF, the Project Coordinating Unit of PANCAP has been re-organized into four divisions to ensure effective implementation of the CRSF 2008-2012 – Strategy and Resource; Strategic Information; Policy Analysis and Corporate Services[170]. The objectives of PANCAP are to: '*1. provide a unified vision and direction among all partners in reducing the spread and mitigating the impact of HIV in the Caribbean; 2. coordinate the programmes and activities of partners at the regional level, particularly with respect to the CRSF; 3. increase the flow of resources to the region; 4. act as a clearing-house of information for decision-making; 5. build capacity among partners; and 6. Monitor the impact of programmes in Member States and organizations'*[53].

***'The Organisation of Eastern Caribbean States** (**OECS**), created in 1981, is an inter-governmental organisation dedicated to economic harmonisation and integration, protection of human and legal rights, and the encouragement of* good governance *between countries and dependencies in the Eastern* Caribbean*. It also performs the role of spreading responsibility and liability in the event of natural disaster, such as a hurricane'[171].* The Organization's *'mission is to be a major regional institution contributing to the sustainable development of the OECS Member States by assisting them to maximise the benefits from their collective space, by facilitating their intelligent integration with the global economy; by contributing to policy and program formulation and execution in respect of regional and international issues, and by facilitation of bilateral and multilateral co-operation'[172].*

***'The Caribbean Epidemiology Centre (CAREC)** is a specialized public health monitoring and disease prevention agency with 21 member countries, administered by PAHO/WHO. Since 1983, CAREC has responded to AIDS in the Caribbean, initially through tracking the epidemic and providing laboratory support, and then by establishing a formal AIDS Program in 1987. CAREC has encouraged the involvement of Caribbean governments and multiple other sectors in the fight against AIDS in the English and Dutch speaking countries of the Caribbean which comprise its membership. CAREC was also a key member of the Task Force on HIV/AIDS, providing technical support for development of the Regional Strategic Plan on HIV/AIDS, and sharing its experience in coordinating regional AIDS initiatives. Regional epidemiological information about the epidemic provided by CAREC helped convince leaders that individual countries could not deal with the issue on their own'[42].*

***'The Caribbean Forum (CARIFORUM)** is the Caribbean arm of the African, Caribbean and Pacific (ACP) States. This group of countries (currently 79: 48 African, 16 Caribbean and 15 Pacific) was created by the Georgetown Agreement in 1975. The group's main objectives are sustainable development and poverty reduction within its member states, as well as their greater integration into the world's economy'[173].*

***'The Pan American Health Organization (PAHO)** is an international public health agency which works to improve health and living standards in the countries of the*

Americas, including the Caribbean. It serves as the Regional Office for the Americas of the World Health Organization. PAHO has been a strong regional participant in action to fight AIDS since the beginning of the epidemic in the Caribbean. It was a key player in stimulating and supporting the initiatives which set the stage for the establishment of PANCAP, a core member of the Task Force on HIV/AIDS, and one of the six original signatories to the Caribbean Partnership Commitment. PAHO was instrumental in providing technical support to assist the smaller member countries of the Organization of Eastern Caribbean States to develop and implement AIDS strategies and programmes'[42].

*'**The University of the West Indies (UWI)**, in particular the Health Economics Unit (HEU), was instrumental in gathering and analysing data that made the economic case for action on AIDS-related issues which was so crucial in gaining the attention of Finance and Development Ministers, and then building the commitment of Heads of Government. The existence of a regional institution such as the HEU, with researchers who can provide technical expertise and support to regional initiatives, and who understand the economic and cultural context of the region, was an important building block for the regional response. The HEU was part of the Task Force, and then became a key partner in PANCAP's ongoing work. In addition, the Caribbean HIV/AIDS Research and Training Initiative is coordinated by UWI which has also initiated advocacy efforts across the three campuses of the University aimed at increasing the awareness and involvement of the University community in the fight against HIV and AIDS'[42].*

*'**The Caribbean Regional Network of Persons Living with HIV/AIDS (CRN+)** was established in 1996 to share information, build capacity among persons living with HIV and support AIDS advocacy in the countries of the Caribbean. It has affiliates in 17 Caribbean countries. CRN+ became involved early in advocacy for regional action, and was instrumental in helping to put a personal face on the epidemic and in creating a sense of urgency into the need for regional cooperation. As a member of the Task Force, and then of PANCAP, CRN+ has been a very strong force to ensure that the needs and priorities of persons infected and affected by HIV are at the centre of the regional response. CRN+ was one of the original signatories of the Caribbean Partnership Commitment which served to formally launch PANCAP. Its annual meetings serve to bring together its membership to review and to plan an agenda and strengthen the bonds and commitment to stated goals for people living with HIV and AIDS'[42].*

*'**The Caribbean Health Research Council (CHRC)** is the regional organization with responsibility for promotion and coordination of health research in the Caribbean. It serves the member states of CARICOM, providing advice to their Ministries of Health and supporting health research efforts. CHRC has led AIDS research and evaluation in the region since the beginning of the epidemic, and was a key contributor to the Regional Strategic Plan on HIV/AIDS. CHRC now has the regional lead on monitoring and evaluation activities for the Caribbean regional response to AIDS, within the overall global lead of UNAIDS for monitoring and evaluation'[42].*

*'**The Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC)** is a forum whereby national AIDS coordinators can work together, share their resources and skills, and assist one another in building national capacity. It is the primary link within*

PANCAP between regional level action and action at the country level. It had representation on the Task Force on HIV/AIDS (Task Force meetings were held in conjunction with CCNAPC meetings), and has been instrumental in helping to identify needs, facilitate horizontal cooperation and build the capacity of countries to respond to the AIDS epidemic'[42].

Appendix 3: Trinidad and Tobago National AIDS Coordinating Committee and the Tobago HIV/AIDS Coordinating Committee supported studies on the Most-At-Risk Populations[8]

Name of study	Focus	Objectives	Key findings
Research on Risk Factors of Key Populations for Contracting HIV and other STIs	MSM; Sex Workers; Homeless or socially Displaced populations; Substance Users; Youth	To investigate the sexual behaviour, belief and practices of the identified populations	• The groups investigated were familiar with the prevention messages featuring local celebrities which form part of the NACC's HIV prevention campaign • While the groups had general knowledge about how HIV is transmitted, some still had their own ideas and prevention practices; • The majority of persons interviewed were not practicing safe sex and were indulging in risky behaviour; • Substance users and homeless populations engage in sex work to finance their addiction or in the case of the homeless to earn income • A strong correlation was observed between substance use, economic needs and the consequential adoption of risky sexual behaviours and lifestyles. • Prevention and care programmes will have to address the psychosocial • needs of these groups many of whom also fall prey to violence, stigma and discrimination and other abuse. • In addition, policies and programmes need to tackle some of the structural and cultural issues
HIV and AIDS Social and Behaviour Mapping in East and Wes Tobago	Cross section of Community Members	To investigate the perceptions and attitudes relating to sex, sexuality and HIV and AIDS	• Main agents of socialization and education about sex and sexuality for men are their peer groups particularly the men who "Lime" on the block; • Young women obtain their information about sex and sexuality from young men, schools and community resources; • Respondents reported widespread sexual activity among the young and early sexual debut; • Religion and established churches were identified as powerful agents within communities and dictators of norms and values. • Many respondents were knowledgeable about transmission and prevention but many also harboured misconceptions • Economic realities and gender vulnerability were strong determinants of risks to HIV. • Male condoms were more widely

Name of study	Focus	Objectives	Key findings
			available as well as cheaper; • General feeling that public testing sites did not afford confidentiality and there was greater confidence in private testing sites.
HIV and AIDS Baseline Risk and Needs Assessment of MSM, MSM, Sex Workers and MSM Subpopulations in Tobago	MSM	To develop a profile of MSM and conduct a risk and needs assessment relating to HIV transmission and prevention, drug use and sexual behaviour.	• Respondents were weary of and reluctant to be labelled; • Sexual identity and status of those • surveyed were varied – straight homosexual, MSM who are dating married or living with female partners, single and willing to connect with whoever; • Knowledge of HIV transmission was relatively poor and though there was awareness about the use of condoms to prevent transmission, condoms were not consistently used
Assessment of Tobago's Culture as a Critical Component in HIV Prevention	General influence of culture	To assess the cultural diversity of Tobago, its general characteristics, unique and distinct features with emphasis on the socioeconomic environment, gender relations, childrearing, religious practices and geographic influences, its potential and practical impact on HIV prevention	• Local culture influences responses to health seeking behaviours and health care and thus must be considered in designing appropriate prevention and education programmes.

Appendix 4: Trinidad and Tobago HIV National Strategic Plan 2004-2008/10 priorities

Priority Areas	Strategies
Prevention	• Heighten HIV/AIDS education and awareness. • Improve the availability and accessibility of condoms. • Extend the responsibility for the prevention of HIV to all sectors of government and civil society. • Introduce behaviour change intervention programmes targeted to young females. • Introduce behaviour change interventions targeted to youths in and out of school. • Support behaviour change programmes targeted to MSM. • Implement a nationwide MTCT programme. • Develop a comprehensive national VCT programme. • Promotion of VCT services. • Ensure the availability of adequate post exposure services. • Increase knowledge and awareness of the symptoms of STIs • Ensure effective syndromic management of STIs. • Provide "youth friendly" sexual and reproductive health services.
Treatment, care and support	• Implement a national system for the clinical management and treatment of HIV/AIDS. • Improve access to medication, treatment and care for persons with opportunistic infections. • Provide appropriate economic and social support to the PLHIV and to the affected.
Advocacy and human rights	• Promote openness and acceptance of PLHIV in the workplace and in the wider community. • Creation of a legal framework that protects the rights of the PLHIV and other groups affected by HIV/AIDS. • Monitor human rights abuses and implement avenues for redress. • Mobilize opinion leaders on HIV/AIDS and related human rights issues.
Surveillance and research	• Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS. • Conduct effective epidemiological research and clinical trials.
Programme management, coordination and evaluation	• Develop an appropriate management structure for the national expanded response. • Gain wide support for the NSP. • Mobilize adequate and sustained resources to support implementation of the NSP. • Monitor the implementation of policies and programmes as outlined in the NSP. • Strengthen the key constituents of NACC. • Strengthen support groups for PLHIV to better respond to the epidemic and increase the number of these support groups.

UNGASS Country Progress Report: Trinidad and Tobago 2010[8, pg22]

Appendix 5: Topic guide used during semi-structured interviews with hotels

Topic guide – Hotels

Interviews with:

- Hotel managers/HR managers/Health and Safety managers
- Staff/Union representatives
- Medical hotel staff
- HIV focal points

Opening questions:

- How large is your hotel?
    a. number of staff
    b. number of rooms
    c. number of guests
- Where do most of your guests come from?
- POSSIBLE INTERNATIONAL HOTEL What is the ownership status of this hotel? Is it internationally owned? A franchise?
- FOREIGN HOTELIER How did you manage to land up working in Tobago?
- GENERAL MANAGER Do you have a HR/Health and Safety Manager /medical officer?

Objective 1 HIV practices in this hotel

1.1 Current HIV prevention practices

- Does this hotel have HIV prevention practices? If so what practices – please describe them.

Probes –

- ✓ Staff training/awareness
- ✓ Guest awareness
- ✓ Condom access
- ✓ Support to staff for access to services for counselling, testing and treatment
- Probe – does this hotel have sexually transmitted infections prevention practices – please describe
- Does this hotel have any practices for preventing sexual relations between guests and staff or between guests and visitors, in the hotel? Please describe
- Are these practices formal/written, or informal/unwritten? Why are they formal or informal?
- When were these practices adopted?
- Who decided that these practices should be adopted?

1.2 Implementing this hotel's HIV prevention practices

- Was it easy to put the practices into action within the hotel? Why?

- Have there been any problems putting these practices into action within the hotel? If so what were the problems? (Probe – e.g. staff accepting the practices, clients resisting the practices?)
- Have these HIV prevention practices been effective or ineffective? In what ways? What makes them effective/ineffective?

1.3 Past and future HIV prevention practices

- Are current HIV prevention practices sufficient in this hotel? Does more need to be done?
- Are additional HIV prevention practices planned in this hotel? Why? What additional practices? – Please describe. When will these be introduced?
- Did this hotel adopt HIV prevention practices in the past but has since dropped them? Why?

Objective 2 Factors facilitating/inhibiting HIV prevention practices in this hotel

2.1 Reasons for adopting HIV prevention practices

- *Why* did this hotel to adopt HIV prevention practices? What were the *main reasons* they were adopted? THIS QUESTION SHOULD BE AS OPEN-ENDED AS POSSIBLE

Probes -

- ✓ The hotel was influenced by government policies/guidelines TT POLICIES/TRINIDAD POLICIES/TOBAGO POLICIES
- ✓ The hotel was influenced by International/Caribbean policies/programmes/guidelines
- ✓ The TTHA encouraged this hotel to adopt these HIV prevention practices
- ✓ HIV is seen as a problem/potential problem in this hotel – it is therefore important to do something about it
- ✓ The hotel manager took the initiative in adopting these HIV prevention practices
- ✓ Other hotels in the area adopted HIV prevention practices – this encouraged this hotel to adopt them
- ✓ What we have done in this hotel was decided by head office
- ✓ External donors have introduced HIV prevention practices in this hotel. Who are these external donors and what are their programmes?

- What were the *most influential* reasons for adopting HIV prevention practices in this hotel?

2.2 Reasons for not adopting HIV prevention practices

- IF NO PRACTICES EXIST. Are there any specific reasons for *not* adopting HIV prevention practices in this hotel/ have made it difficult to adopt HIV prevention practices ?
- IF FUTURE PRACTICES ARE PLANNED What do you see as the main problems to introducing further practices in this hotel?

- IF THERE ARE EXISTING PRACTICES BUT DON'T PLAN MORE. Where there barriers to introducing the HIV prevention practices in this hotel?

Probes –

- ✓ Government (TT/TRINIDAD ALONE/TOBAGO ALONE) policies and programmes are not clear on what should be done
- ✓ The government has not provided sufficient support/guidance
- ✓ International/Caribbean policies/programmes/guidelines are not clear on what should be done
- ✓ The TTHA is not clear on what should be done/is not supportive
- ✓ HIV is not a problem in this hotel
- ✓ Concerns about this hotel's reputation/ concern that adopting HIV prevention practices will put off tourists/clients (TRY TO GET VALID ANSWER)
- ✓ Very little can be done to prevent HIV
- ✓ What we do or do not do in this hotel is decided by head office
- ✓ It is difficult to find the resources to adopt HIV prevention practices

Objective 3 Adoption of government, international and Caribbean policies on HIV

3.1 TT Government HIV policies

- What government HIV policies do you know about?

- Probe – TT vs. Tobago level policies

- Have the government's HIV policies influenced HIV prevention practices in this hotel? How? Which specific policies have been influential? How/why?
- Has the government done enough to support the TTAS in the area of HIV prevention? What more needs to be done?

3.2 International/Caribbean HIV policies

- Have International or Caribbean regional HIV policies, programmes or guidelines influenced HIV prevention practices in this hotel? Which specific policies have been influential? How/why?
- Are International/Caribbean HIV policies relevant to the situation here in Trinidad/Tobago? Are they relevant to this hotel? How?

3.3 Corporate vs. government policies (INTERNATIONAL HOTELS)

- To what extent does HYATT INTERNATIONAL decide what is done/not done in this hotel (probe – relating to HIV prevention)? How much freedom do you have to decide what is done/not done?
- Which is most important in determining what HIV prevention practices are adopted in this hotel – government policies or instructions from your Head Office? Why?

DOCUMENTATION

- Do you have any documentation detailing your formal/informal practices that I might get a copy? (Probe – e.g. health and safety policies and programmes, newsletters, websites)
- Do you have any documentation on the government (TT/TRINIDAD ALONE/TOBAGO ALONE) HIV policies? Detailing whether or not, and to what extent they have been? (Probe – e.g. health and safety policies and programmes, newsletters, websites)

Appendix 6: Topic guide use during semi-structured interviews with national organizations and key informants

Topic guide – National organizations and key informants

Interviews with:

- NACC
- Tobago HIV/AIDS Coordinating Committee Secretariat
- Tourism Development Company
- Ministry of Health
- Ministry of Tourism
- Division of Health and Social Services, Tobago
- Division of Tourism and Transportation, Tobago
- Trinidad Hotels, Restaurants and Tourism Association
- Tobago Hotel and Tourism Association
- University of the West Indies
- Key informants

Opening questions

- Could you tell me about the work of this organisation?
- Is tourism an important focus of the government's HIV programmes in TT?
- Is tourism going to be an important part of the new government strategic plan?
- Does the tourism section see HIV as a major concern? What are the effects of HIV on tourism in TT?
- What is the main focus of this organisation's work in this area?
- Is this a major concern of the government/what is the government doing in this area?

Objective 2 Factors facilitating/inhibiting HIV prevention practices in hotels

<u>2.1 Reasons for adopting HIV prevention practices</u>

- Are hotels adopting HIV prevention practices? Which ones?
- Do you think it is important for hotels to adopt HIV prevention practices?
- Why do you believe that some hotels *have actually adopted* such practices? Of the hotels that have adopted HIV prevention practices, what do you believe was their reason for doing so?

THIS QUESTION SHOULD BE AS OPEN-ENDED AS POSSIBLE

Probes -

- ✓ The hotel was influenced by government policies/guidelines TT POLICIES/TRINIDAD POLICIES/TOBAGO POLICIES
- ✓ The hotel was influenced by International/Caribbean policies/programmes/guidelines
- ✓ The TTHA encouraged this hotel to adopt these HIV prevention practices
- ✓ HIV is seen as a problem/potential problem in this hotel – it is therefore important to do something about it
- ✓ The hotel manager took the initiative in adopting these HIV prevention practices

- ✓ Other hotels in the area adopted HIV prevention practices – this encouraged this hotel to adopt them
- ✓ What we have done in this hotel was decided by head office
- ✓ External donors have introduced HIV prevention practices in this hotel. Who are these external donors and what are their programmes?

- What were the *most influential* reasons for hotels adopting HIV prevention practices?

2.2 Reasons for not adopting HIV prevention practices

- Why have some hotels *not* adopted HIV prevention practices and/or only done a limited amount?
- Is NACC doing anything to encourage hotels to adopt HIV prevention practices in the future? [NSP?]

TRY TO ENSURE THAT THE REASON IS VALID (TRUTHFUL)

Probes –

- ✓ Government (TT/TRINIDAD ALONE/TOBAGO ALONE) policies and programmes are not clear on what should be done
- ✓ The government has not provided sufficient support/guidance
- ✓ International/Caribbean policies/programmes/guidelines are not clear on what should be done
- ✓ The TTHA is not clear on what should be done/is not supportive
- ✓ HIV is not a problem in this hotel
- ✓ Concerns about this hotel's reputation/ concern that adopting HIV prevention practices will put off tourists/clients (TRY TO GET VALID ANSWER)
- ✓ Very little can be done to prevent HIV
- ✓ What we do or do not do in this hotel is decided by head office
- ✓ It is difficult to find the resources to adopt HIV prevention practices

Objective 3 National HIV policies and programmes

3.1 TT Government HIV policies

- OMIT FOR HOTEL ASSOCIATIONS What are the most important HIV-related TT government HIV policies and programmes (TT/TRINIDAD ALONE/TOBAGO ALONE)? Can you give me a history of their development? Which are the most important?
- Which of these policies/programmes or elements of a policy/programme relate to tourism? To the hotel industry?
- Why were these policies/programmes developed? What facilitated their development?
- Were there any barriers to the development of these policies/programmes? What were they?

Probes –

- ✓ Stigmatization of HIV

- ✓ Donor funding
- ✓ International/regional initiatives

- Are there any other policies/programmes outside the direct mandate of HIV that may relate to HIV prevention and control within hotels? (Probe – OSHA, Employment Act)

3.2 Adoption of government, international and Caribbean policies on HIV

TT Government HIV policies

- To what extent are hotels expected to follow government policies/laws/rules concerning HIV prevention? Must they be followed? What happens if they are not followed?
- Have the government's HIV policies influenced HIV prevention practices in the hotel sector? How? Which specific policies have been influential? How/why?
- Are the government's HIV policies relevant to what is done the hotel sector? How?
- Are government HIV policies appropriate? Are they useful?
- Has the government done enough to support the TTAS in the area of HIV prevention? What more needs to be done?

International/Caribbean HIV policies

- Have International or Caribbean regional HIV policies/programmes/guidelines influenced TT government HIV prevention policy? If so, which ones?
- Have International or Caribbean regional HIV policies, programmes or guidelines influenced HIV prevention practices in the hotel sector? How? Which specific policies have been influential? How/why?
- Are International/Caribbean HIV policies relevant to the situation here in Trinidad/Tobago? Are they relevant to the hotel sector? How?

Corporate vs. government policies

- To what extent do internationally owned hotels have to follow government policy (probe – relating to HIV prevention)? How much freedom do they have to decide what is done/not done?
- Which is most important in determining what HIV prevention practices are adopted by an internationally owned hotel – government policies or instructions from their Head Office? Why?
- Are there any examples of where internationally owned hotels have not followed government policies?

DOCUMENTATION

- Do you have any documentation on the government (TT/TRINIDAD ALONE/TOBAGO ALONE) HIV policies and programmes?

Probes –

- ✓ TT HIV/AIDS National Strategic Plan 2004-2008
- ✓ Draft Tobago National Strategic Plan 2004-2008
- ✓ TT Draft National HIV/AIDS Policy
- ✓ TT National Workplace Policy on HIV and AIDS
- ✓ Vision 2020 HIV/AIDS Sub-committee Report
- ✓ Vision 2020 Tourism Sub-committee Report
- ✓ Draft Vision 2020 National Strategic Plan
- ✓ Vision 2020 Operational Plan 2007-2010
- ✓ Ministry of Tourism Sector HIV/AIDS Support Programme
- ✓ Draft National Tourism Policy
- ✓ Tourism Development (Amendment Bill) 2003
- ✓ Tourism Rolling Plan
- ✓ Any legislation governing health and safety within the accommodation sector (eg OSHA)
- ✓ And legislation governing employment within the accommodation sector

- Do you have any documentation detailing whether or not, and to what extent government HIV policies/programmes have been adopted/implemented (TT/TRINIDAD ALONE/TOBAGO ALONE)??

Probes –

- ✓ Progress and evaluation reports of NACC and Tobago HIV/AIDS Coordinating Committee
- ✓ Progress reports on Vision 2020 Operational Plan 2007-2010

- Do you have any documentation that may support your recommendations for supporting and enhancing the adoption of HIV prevention practices

- ✓ HIV prevention and control strategies within the tourism/hotel sector throughout the Caribbean and international

Appendix 7: Interviewee key

Island	SID Reference	Category	Recording Number
Trinidad	Tr1/O	Key Informant	NOT RECORDED
Trinidad	Tr2/O	Association/Tourism	NOT RECORDED
Tobago	Tb1/G	Govt/HIV	NOT RECORDED
Tobago	Tb2/O	Association/Tourism	NOT RECORDED
Tobago	Tb3/G	Govt/Tourism	NOT RECORDED
Tobago	Tb4/G	Govt/HIV	NOT RECORDED
Tobago	Tb5/G	Govt/Health	NOT RECORDED
Trinidad	Tr3/G	Govt/Tourism	011
Trinidad	Tr4/A	Accommodation	012
Trinidad	Tr5/G	Govt/HIV	013
Trinidad	Tr6/A	Accommodation	014
Trinidad	Tr7/A	Accommodation	015/016/017/018/019
Trinidad	Tr8/A	Accommodation	020
Trinidad	Tr9/A	Accommodation	021
Trinidad	Tr10/A	Accommodation	022/023
Tobago	Tb6/O	Association/Tourism	024
Tobago	Tb7/A	Accommodation	024
Tobago	Tb8/A	Accommodation	025/026/027/028/029
Tobago	Tb9/A	Accommodation	030
Tobago	Tb10/G	Govt/HIV	031/032/033/034
Tobago	Tb11/O	Key Informant	NOT RECORDED
Tobago	Tb12/A	Accommodation	035
Tobago	Tb13/A	Accommodation	036/037/038
Trinidad	Tr11/A	Accommodation	039/040
Trinidad	Tr12/A	Accommodation	NOT RECORDED
Trinidad	Tr13/A	Accommodation	046/047
Trinidad	Tr14/A	Accommodation	048
Trinidad	Tr15/A	Accommodation	049
Trinidad	Tr16/A	Accommodation	050
Trinidad	Tr17/A	Accommodation	051/052
Trinidad	Tr18/A	Accommodation	053/054/055
Trinidad	Tr19/A	Accommodation	NOT RECORDED
Trinidad	Tr20/O	Association/Tourism	056/057/058
Trinidad	Tr21/A	Accommodation	059/060
Trinidad	Tr22/G	Govt/Tourism	061/062/063
Trinidad	Tr23/A	Accommodation	065
Trinidad	Tr24/A	Accommodation	066/067/068
Tobago	Tb14/A	Accommodation	069/070/071/072/073/074/075/076/077
Tobago	Tb15/A	Accommodation	078/079/080/081
Tobago	Tb16/A	Accommodation	082
Tobago	Tb17/A	Accommodation	083
Tobago	Tb18/A	Accommodation	084
Tobago	Tb19/A	Accommodation	085/086
Tobago	Tb20/G	Govt/Tourism	089/090/091
Tobago	Tb21/A	Accommodation	092
Tobago	Tb22/A	Accommodation	093/094/095/096
Tobago	Tb23/A	Accommodation	097/098/099/100

Island	SID Reference	Category	Recording Number
Tobago	Tb24/A	Accommodation	101/102
Tobago	Tb25/A	Accommodation	NOT RECORDED
Tobago	Tb26/A	Accommodation	103
Tobago	Tb27/A	Accommodation	104
Tobago	Tb28/A	Accommodation	105/106/107
Tobago	Tb29/A	Accommodation	108/109
Tobago	Tb30/G	Govt/Tourism	110
Tobago	Tb31/A	Accommodation	111/112
Tobago	Tb32/A	Accommodation	113/114/115/116/117/118
Tobago	Tb33/G	Govt/Health	119
Trinidad	Tr25/A	Accommodation	120/121/122
Trinidad	Tr26/G	Govt/Labour	123/124/125/126/127/128/129/130/131
Trinidad	Tr27G	Govt/Tourism	NOT RECORDED

SUMMARY INTERVIEWS

	Trinidad	Tobago	TOTAL INTERVIEWS
Accommodation	**19 (19 properties)**[53]	**22 (24 properties)**[54]	**41**
Government	**5(3 Tourism**[55] **+ 1 Health/HIV + 1 Labour)**	**8 (3 Tourism + 5 Health/HIV)**	**13**
Association/Key Informant	**3 (2 Tourism + 1 NGO)**	**3 (3 Tourism)**[56]	**6**
TOTAL INTERVIEWS	**27**	**33**	**60**

[53] One owner had two different properties and one property was interviewed on two separate occasions
[54] Two owners had two different properties
[55] One person was interviewed on two separate occasions
[56] One person was interviewed on two separate occasions

Appendix 8a: Ethics approval from the London School of Hygiene and Tropical Medicine

LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM
Application number: 5643

Name of Principal Investigator	**Renee West**
Department	**Public Health and Policy**
Head of Department	**Professor Anne Mills**

Title: Sun, sea, sand and sex: an analysis of the factors which influence or hinder the adoption of HIV policies and programmes by the Trinidad and Tobago tourism industry.

This application is approved by the Committee.

Chair of the Ethics Committee ..... [redacted] .....

Date ..17/02/2010

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.

Appendix 8b: Ethics approval from the Ministry of Health, Trinidad and Tobago

MINISTRY OF HEALTH Government of the Republic of Trinidad and Tol

OFFICE OF THE CHIEF MEDICAL OFFICER
627-0014 ext. 616/600 D: (868)-625-0066 F: (868)-623-3755
e-mail: anton.cumberbatch@health.gov.tt

April 29, 2010

Ms. Renee West
7A Bel Air Drive
Bel Air
La Romain

Dear Ms. West

Re: Sun, Sea, Sand and Sex: an analysis of the factors which influence of hinder the adoption of HIV policies and programmes by the Trinidad and Tobago tourism industry

The Ethics Committee of the Ministry of Health has reviewed your proposal entitled **"Sun, Sea, Sand and Sex: an analysis of the factors which influence of hinder the adoption of HIV policies and programmes by the Trinidad and Tobago tourism industry".**

We are please to inform you that approval has been granted for the conduct of the study for the period **April 29, 2010 to April 28, 2011** at which time you are to submit a report and reapply for approval to conduct study for an extended time.

Sincerely

[redacted]

Dr. Anton Cumberbatch
Chief Medical Officer [redacted]

www.health.gov.tt
63, Park Street, Port of Spain, Trinidad. T: (868) 627-0010/12/14

Appendix 9: Interview information sheet

London School of Hygiene & Tropical Medicine
Keppel Street, London, WC1E 7HT, United Kingdom

INFORMATION SHEET

Study title: An analysis of the factors which influence or hinder the adoption of HIV policies and programmes by the Trinidad and Tobago tourism industry.

Investigator Name and Contact No: Renée M. West (+18686525059/+4407903353171)

Background
This study forms the thesis research component of a Doctorate in Public Health programme that is being undertaken by the investigator at the London School of Hygiene and Tropical Medicine. The Doctorate of Public Health degree programme seeks to provide doctoral level training for future leaders in public health.

Study aim and conduct
To analyze the factors that influence or hinder the adoption of HIV policies and practices in the Trinidad and Tobago tourism accommodation sector (TTTAS).

The data collected during the study will be analysed and collated into a final thesis report in fulfilment of the Principal Investigator's doctorate in public health degree. The study will involve limited interviews with key informants and the analysis of documentation from the Ministries of Health and Tourism, their implementing agencies and hotel and tourism alliances and the hotels themselves. Additionally programmes and action plans from within the TTTAS will be reviewed.

Your participation in this study is important to provide input on how, and to what extent the accommodation sector in the tourism industry in Trinidad and Tobago has implemented national HIV policies of prevention and control and what challenges the hotels face in implementing the HIV practices that presently exist in the TTTAS.

Your participation
Participation in this research is confidential and entirely voluntary. Withdrawal with no adverse consequences is possible at any time without having to give a reason. If you agree to take part, you will be invited to participate in an interview to explore your views in more detail. If consent is given, the interview may be tape-recorded.

How confidentiality will be ensured
The transcripts of meetings and interviews are available to the investigator only. Information obtained through interviews will be used in aggregate form. Where transcripts are quoted no reference will be made to your name, age, gender or job title, even anonymously and any quotes will only be included in the final thesis report with your expressed approval. All transcripts will be kept by the investigator in a secured file and for the duration of the doctorate candidature after which they will be destroyed. There is no financial reimbursement for taking part in the study.

Ethical approval
This study has been approved by (1) the London School of Hygiene and Tropical Medicine and (2) the Government of Trinidad and Tobago Ministry of Health Ethics Committees.

If you have any further questions or queries about the study please do not hesitate to contact me at renee.west@lshtm.ac.uk or rmdwest@gmail.com

Appendix 10: Interview consent form

London School of Hygiene & Tropical Medicine

Keppel Street, London, WC1E 7HT, United Kingdom

CONSENT FORM

Title:	An analysis of the factors which influence or hinder the adoption of HIV policies and programmes by the Trinidad and Tobago tourism industry.
Principal Investigator:	Renée M. West
Email Address:	*Renee.West@lshtm.ac.uk* rmdwest@gmail.com
Telephone	**+**447903353171/+18686525059

Introduction

You are being asked to take part in the above-mentioned research study. To join the study is voluntary. It is important that you understand this information so that you can make an informed choice about being in this research study. You have the right to ask, and have answered, any questions you may have about this research.

What is the aim of this study?

To analyze the factors that influence or hinder the adoption of HIV policies and practices in the Trinidad and Tobago tourism accommodation sector (TTTAS). The data collected during the study will be analysed and collated a final thesis report in fulfilment of the Principal Investigator's doctorate in public health degree.

Procedures

If you decide to be in this study, you will be one of the approximately 50 individuals (sampled from the private and public tourism and health sectors in Trinidad and Tobago) who will be asked to participate in the interviews. Interviews will be recorded on a tape and transcribed. There are no follow-ups this study.

How will your privacy be protected?

Once you have consented to participate in the study, you will be assigned a code which will be used for confidentiality and data storage purposes. The transcripts of meetings and interviews are available to the investigator only. Information obtained through interviews and observation will be used in aggregate form. Where transcripts are quoted no reference will be made to your name, age, gender or job title and only following your approval. All transcripts will be kept by the investigator in a secured file and for the duration of the doctorate candidature after which they will be destroyed.

Participant's Agreement

- I have read the information provided about this study and I understand what will be required of me.
- My questions concerning this study have been answered by the Principal Investigator.
- I understand that at any time I may withdraw from this study without giving a reason.
- I voluntarily agree to participate in this study.

☐ I agree to have this interview taped.
☐ I agree to quotes or other results arising from my participation in the study being included, even anonymously in any reports about the study.

☐ I do not agree to have this interview taped.
☐ I do not agree to quotes or other results arising from my participation in the study being included, even anonymously in any reports about the study.

Signature of Research Participant **Date**

Signature of Principal Investigator **Date**

Appendix 11: Tourism Development Company Brochure (which includes AIDS Hotline)

Important Numbers

Police	999, 555
Fire	990
Ambulance	990
Coast Guard	634-4440
Port of Spain General Hospital	623-2951
San Fernando General Hospital	652-3581
Tobago Hospital	639-2551
Local & Overseas Assistance	0
Directory Assistance	6411
AIDS Hotline	800-4HIV
Tourism Development Company Limited (TDC)	675-7034-7/669-5196 669-6044
Tobago House of Assembly	639-2125/4636

Diplomatic Missions - Trinidad

British High Commission 19 St. Clair Ave., St. Clair	622-2748
High Commission for Canada Maple House, 3-3A Sweet Briar Rd, St.Clair	622-6232
Embassy of the French Republic 6th Floor,Tatil Building 11 Maraval Road,Port of Spain	622-7446
Embassy of the Federal Republic of Germany 7-9 Marli Street, Newtown	628-1630-2
Embassy of the United States of America 15 Queen's Park West, Port of Spain	622-6371-6
Embassy of the Republic of Venezuela 16 Victoria Ave, Port of Spain	627-9821-4

Fast Facts

- Official Name: Republic of Trinidad and Tobago
- Capital: Port-of-Spain
- Population: 1.3 million
- Official Language: English
- Currency: Trinidad and Tobago Dollar (TT$)
- Exchange Rate: 1$ US = $6.16TT (approximately)
  Hotel Room Tax: 10%
  Service Charge: 10%
  Value Added Tax on some goods and services: 15%
- Electricity: 115 volts/230 volts (+/-6%); 60 Hz
- Climate: Tropical; rainy season (June through December); dry season (January through May)

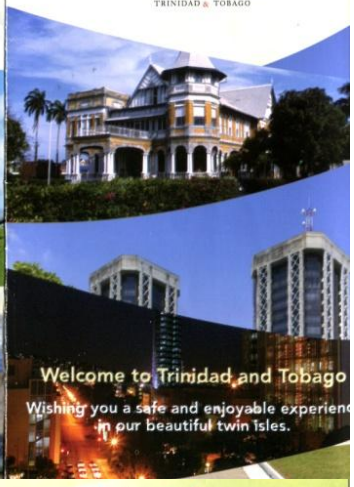
For more information visit www.gotrinidadandtobago.com

1. Port-of-Spain, Trinidad

2. Scarborough, Tobago

VISITOR SAFETY TIPS

TDC
Tourism Development Company Limited
TRINIDAD & TOBAGO



Safety Suggestions

General Safety

- Obey all local laws and respect local customs.
- Where possible, use credit cards and travelers cheques instead of cash. If you must use cash, carry small amounts.
- Should your passport, credit card or travelers cheques be lost or stolen, report it immediately to the police. Call 999 for the nearest police station.
- Keep all purses, wallets and cell phones safely tucked away.
- Be discreet at cambios, ATMs and public telephones.
- Remain alert, trust your instincts and pay attention to your surroundings. Report any suspicious activities to the police, security or staff personnel.
- Avoid over consumption of alcohol.
- Do not wear expensive or flashy jewellery. Do not carry expensive cameras round your neck.
- Never leave bags and valuables unattended.

It is illegal to use, sell or have in your possession, drugs such as marijuana, cocaine or any controlled substance.

Trinidad & Tobago Police Service

You can identify our male police officers by their uniform of dark blue trousers and grey short sleeved shirts while our female officers can be identified by their uniform of dark blue jackets and skirts with inverted pleat to the front.

Beach & Water Safety

- Lifeguards can be identified at our beaches by their uniform of red pants and a bright yellow vest with the word "LIFEGUARD" clearly emblazoned in black block letters on its front.
- Follow the advice of the lifeguards. They are trained in beach and water safety.
- Before bathing check to see if a red flag is up or check with a lifeguard for water conditions, beach conditions or any other potential hazard.
- Beware of rip currents. If you get caught in one, do not panic. Swim parallel to the shore until you are clear of the current, then swim into shore. Never swim against the current.
- Do not dive into waters you do not know or into shallow breaking waves - feet first, first time.
- When in trouble, signal a lifeguard by shouting "HELP" or waving your hands.
- Use sunscreen to avoid sunburn or damage to your skin
- Scuba dive only if you are trained and certified and within the limits of your training.

Food Safety

- Purchase food and beverage from vendors with valid food badges (see below).
- If you have allergies, enquire about the ingredients used to prepare the meal before purchase.

Accommodation Safety

- Listings of approved and registered accommodation and transportation providers are available from the Tourism Development Company Limited and the Department of Tourism.
- Keep your room door locked at all times. Check sliding glass doors, windows and connecting room doors to ensure all locks are operational.
- Do not invite strangers into your room. If someone claims they are from maintenance, security or a hotel employee, phone the front desk to make sure the visit is legitimate.
- Keep all valuables in your hotel room safe or at the front desk safety deposit box and check them regularly.
- Familiarize yourself with the hotel's emergency plan. Locate the fire exits, elevators and nearest phone.

Travel Safety

- Keep close watch over your luggage at all times and never leave bags unattended.
- Plan your route carefully. Make sure you have a detailed map where you can identify your destination, hotel, tourism offices, embassy, police and hospital. Be discreet when reading.
- Do not hitchhike and do not pick up hitchhikers
- Avoid traveling late at night and park in well-lit, populated areas.
- Drive on the left hand side of the road and heed traffic signs.
- If you are lost or think you are being followed, go to an open well lit business area or police station and ask for help.
- If you are using a vehicle, never leave valuables in view, and never leave the vehicle unsecured.

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