HIV POLICIES & PROCEDURES IN THE ASIAN HOSPITALITY WORKPLACE: AN EXPLORATORY STUDY

Matthew Hong Tai Yap, MSc.
Director, Postgraduate Programme
University Centre César Ritz, Switzerland
Matthew.yap@ritz.edu
Elizabeth Ineson, Ph.D.
Senior Lecturer
Manchester Metropolitan University, UK
E.Ineson@mmu.ac.uk

ABSTRACT
This study aims to identify, explore and discuss Asian hospitality managers’ perceptions of policies and procedures that may address HIV and HIV-related issues in their workplaces. Thirty-two English speaking Asian hospitality managers responded to the postal questionnaire and 12 of them agreed to participate in follow-up telephone interviews. The findings determined that they were in favour of employing mandatory HIV blood testing and they stressed the need for their companies to address their customers’ doubts of HIV transmitting via handling of food from infected employees. They also perceived that education, training and counselling should be employed to tackle HIV issues in their workplaces as a matter of urgency. However, they determined that employees should be responsible for organising informal HIV events. In conclusion, the hospitality companies in Asia did not implement mandatory HIV blood testing for potential and existing employees. In addition, HIV-related formal and informal policies and procedures were not implemented in most hospitality workplaces. They were in favour of using education, training and counselling to address HIV-related issues in the workplace. General and specific recommendations were provided for Asian hospitality managers, and education and training in formulating HIV policies and procedures.

1. INTRODUCTION

The AIDS Epidemic Update (UNAIDS/WHO, 2005) revealed a total of 40.3 million people living with Human Immunodeficiency Virus (HIV) in year 2005. The majority of new infections occurred in people in a constructive workforce aged 15-49 years old (Firmansyah and Kleiner, 1999; UNAIDS/WHO, 2005). Worst of all, the HIV/AIDS epidemic is shifting from Africa to Asia (Jagan, 2001). Relatively, UNAIDS (2000c) identified that the most populous developing countries in Asia (Cambodia, China, India, Indonesia, Myanmar, Thailand and Vietnam) have the highest HIV infections in Asia.

Commonly, HIV-infected patients can take from 2 to 15 years (incubation period) to develop the AIDS phase (Lloyd and Abramson, 1999). During this period, these patients show no symptoms of contraction and can perform common tasks like healthy human beings (Lim and Loo, 2000). This identification modified the demographics of employees working in the labour intensive hospitality industry. This implied that there could be more HIV-infected people joining the workforce in the hospitality industry, which is experiencing a great shortage of labour at the moment (Olsen et al., 2001). Therefore, Asian hospitality managers will face challenges in managing HIV-infected employees in the workplace, in the near future.

Two decades since the discovery of the HIV virus, there is no cure or preventative vaccine imminent (Adler, 2001). Hedgepeth and Helmich (1996) suggested that the only prescription available
at the moment is continuous education and training. Despite substantial effort in curbing the HIV infections spreading worldwide, the number of infections is increasing rapidly each day (UNAIDS/WHO, 2005).

In recent years, the impact of HIV has become a costly problem for all businesses (Daly, 2000). UNAIDS (UNAIDS Point of View, 1998) recognised that anti-HIV measures require a multi-sectoral approach. It is crucial that the business sector and its workplaces play a key role in caring for and supporting those affected (UNAIDS Technical Update, 1998a). As the Asian hospitality industry is considered to be one of the largest business sectors in the world (WTO, 1998), an exploration of HIV policies and procedures to address HIV-related issues in Asian hospitality workplace is needed.

Furthermore, UNAIDS (UNAIDS Technical Update, 1998b) and other researchers (Bharat et al., 2001) discovered that HIV-related stigmatisation and discrimination were immense barriers to effective responses to the epidemic. According to Lim and Loo (p. 129, 2000), “many employers choose to take the expedient measure of dismissing them once their HIV status is known”. The researchers implied that workplace discrimination against HIV positive workers is evident in Asia.

Scientific and social research on HIV and AIDS (e.g. Daly, 2000; Lim and Loo, 2000; Bharat et al, 2001; Lau and Thomas, 2001; Monico, Tanga, Nuwagaba, Aggleton and Tyrer, 2001) is extensive. However, most of them concentrate on medical research and the development of the virus, epidemic updates, the social and cultural impact, humanitarian issues and various workplace issues not including the Asian hospitality industry. Moreover, little attention has been devoted to studying the impact of HIV on the hospitality industry and “few articles have been published in academic journals” (Firmansyah and Kleiner, p.56, 1999). The only well acclaimed publication dealing with this sector is “The Challenge of HIV/AIDS in the Workplace: A Guide for the Hospitality Industry” jointly produced by the International Hotel and Restaurant Association and UNAIDS (Lloyd and Abramson, 1999). However, there were several gaps identified in previous researches.

Firstly, they did not focus extensively on Asian hospitality industry and Asian hospitality managers. Secondly, the Asian managers’ perceptions of HIV policies and procedures in managing HIV and HIV-related issues in the Asian hospitality workplace were not explored. Thirdly, HIV policies and procedures suitable for the Asian hospitality workplace were not determined. Therefore, this paper aims to identify, explore and discuss Asian hospitality managers’ perceptions of HIV policies and procedures in managing HIV and HIV related issues in their Asian hospitality workplace. The objectives to address the stated aim of this paper are as follows:

1. To review literature pertaining to HIV and HIV-related issues in the hospitality industry.
2. To explore and analyse Asian hospitality managers’ perceptions on HIV policies and procedures in their workplaces.
3. To provide general and specific recommendations to Asian hospitality managers in formulating HIV policies and procedures.

1.3 Structure of the Paper

The introduction will provide an overview of this study by justifying to readers the need to conduct this study, and the aim and objectives. Section two aims to thoroughly review both methodological and topic literature related to HIV and HIV-related issues in the hospitality industry. Thereafter, the issues requiring further considerations will be formulated. Section three discusses and justifies the employment of research philosophy, approach, strategy, data collection instruments and data analytical methods. Additionally, the research population, sample, sampling frame, sampling techniques and respondents will be identified. By discussing and analysing the quantitative and qualitative findings from the respondents, section four attempts to address the four research questions posed earlier. The final section five will conclude the objectives of this study and provide general and specific recommendations to the Asian hospitality managers in formulating HIV policies and procedures in their workplaces. The limitations, reflections and recommendations for future research will also be included.

2. LITERATURE REVIEW
This section aims to thoroughly discuss the discovery and characteristics of HIV, the modes of transmissions, and the effects of HIV epidemics. Additionally, HIV-related issues in the hospitality industry and Asian hospitality industry are explored. Thereafter, issues requiring further considerations with reference to the gaps identified after thoroughly reviewing literature will be stated.

2.1 Human Immunodeficiency Virus

The U.S. CDC discovered the first case of AIDS in 1981 (U.S. Center for Disease Control, 1989). Two of the scientists, Robert Gallo and Luc Montagnier, gained fame by discovering HIV, the virus that caused AIDS (Powell, 1996). 20 years later, the spread of HIV is like wild fire devastating and threatening the existence of mankind (UNAIDS/WHO, 2005). Presently, HIV infection rates are in excess of 40 million in 200 countries, and these numbers are still growing (UNAIDS/WHO, 2005), making it the fourth-biggest killer (Vass, 2001). Out of the 40 million, Asia has more than 8 million cases, being the second largest area of HIV infections (UNAIDS/WHO, 2005).

HIV belongs to the family of retroviruses that infects and kills the white blood cells that defend human bodies against disease (Tonks, 1995). Specifically, it is not air-borne and cannot survive when exposed to air (Powell, 1996). HIV infections on patients can be divided into stages (Tonks, 1995):

- first stage: no symptoms of infections.
- second stage: symptoms like fever, chills, symptoms that resemble flu, rashes and swollen lymph glands.
- final stage: HIV sufferers can be considered as AIDS patients whereby their weak immunity to opportunistic infections is life threatening.

The stages of HIV infection can last for 2 to 15 years before developing into AIDS (Lloyd and Abramson, 1999). The former scholars also concurred that HIV positive patients are different from those patients having AIDS.

With reference to many studies (e.g. Barrows et al., 1996; Powell, 1996; Lloyd and Abramson, 1999; Adler, 2001; Lau and Thomas, 2001) HIV can be transmitted via unsafe sexual activities, sharing of contaminated needles, mother to child through birth and breast-feeding, workplace exposure, transfusion of blood products, and donation or transplantation of organs. However, HIV cannot be transmitted through ordinary social, casual, nonsexual contact or items used by an infected person (except needles) (Nowak and McMichael, 1995; Powell, 1996; Umeh, 1997; Lloyd and Abramson, 1999; Adler, 2001). The main reason for this is because HIV cannot survive outside the human body.

Several studies (“Epidemiology: China Confronts,” 2001, December 3; Henderson, 2001) commented that many cases were unreported in populous countries in Asia like China and India. Additionally, they predicted that Asia’s infection rates could outpace those of Africa and spread faster than any country in the near future due to the larger population and many developing countries (Williams, 2001, May 3). The implications for this scenario are seriously negative. To date there is no cure for HIV, the only effective antidote available is continuous education and training (Bor and Elford (editors), 1994; Barrows et al., 1996; Daly, 2000; UNAIDS/WHO, 2005). Overall the spread of HIV has affected households, individuals, society, governments, workforces, businesses and macroeconomics of countries. These effects can be categorised into tangible and intangible (McLean and Moore, 1997; ILO, 2002, June8; Daly, 2000; Dixon, McDonald and Roberts, 2002).

HIV and AIDS infected employees in the United States of America and the United Kingdom are directly and indirectly protected against discrimination in employment (Franklin et al., 1992; Goldsmith et al., 1997; Deakin and Morris, 2001). However, there is no formal written legislation from governments in Asian countries to protect HIV-infected workers against unfair practices in employment. Mandatory HIV blood testing for employment varies in different professions across different states in America (Brown and Turner, 1989). HIV blood tests are applicable for some federal agencies’ employees as job-specific criteria (Rutsohn and Law, 1991). UK employers, on the other
hand, have no contractual rights to force employees to take mandatory HIV blood tests. Companies can include HIV blood testing or submission of HIV status as part of employment contracts but are not allowed to use them for the purposes of discrimination (Goldsmith et al. 1997). The former scholars also revealed that the UK government strongly advises against mandatory HIV blood tests for all professions. There is no regulated mandatory HIV blood testing in most of the Asian countries.

2.2 Human Immunodeficiency Virus in the Hospitality Industry

As mentioned by several scholars (Ball et al., 2000; Dittmer, 2001), the hospitality industry is different to other industries because the hospitality industry is people-intensive, provides generous, friendly and caring services, and produces and sells its products simultaneously. It is dynamic, constantly growing, involves endless changes, generates more than US$200 billion revenue and employs 11 million employees (Ball et al., 2000; Olsen et al., 2001). With reference to Hing et al. (1998), the hospitality industry in the Asia-Pacific region make up of five major sectors, namely, the meetings, incentives, conventions and exhibitions (MICE) sector, the casino sector, the licensed clubs sector, the accommodation sector and the restaurant sector. Pine et al. (1998) determined that the hospitality industry in Asia is extremely profitable and can generate tremendous growth potential. The continuous expansion of the hospitality industry in Asia requires hospitality companies to attract and hire more workers, including HIV-infected workers. However, HIV-infected employees working in the global hospitality industry feel that they are being discriminated, stigmatised and treated unfairly in the context of promotions, employment and rewards (Lloyd and Abramson, 1999). Specifically, Asian hospitality companies can draw on international labour markets and the migration of labour forces to supplement qualified labour shortages. This means that managers and employees working in the hospitality industry in Asia can be in contact with customers from all over the world, including HIV-infected customers.

According to WHO and UNAIDS (2005), most of the daily new HIV infections occur in persons aged 15-49 years old from developing countries. The majority of the Asian countries are classified as developing and their working population is young (WHO/UNAIDS, 2005). In general, HIV epidemics have impacted the global hospitality industry (Adam-Smith and Goss, 1993; Tarpey, 1993; Barrows et al., 1996; Lloyd and Abramson, 1999) in the context of customers, employers, employees, businesses, image and reputation, revenue and profits, formulation of policies and procedures, management, new products development, increment of costs, strengthening training and education, and legislations. The impacts determined that hospitality managers, employers, employees and customers will face these challenges and need to address them immediately.

With reference to Adam-Smith and Goss (1993) and Tarpey (1993), the emergence of HIV in the hospitality industry could have effects on commerce and mankind because hospitality customers displayed fear of contracting HIV via food handling from the HIV-infected chef. Additionally, the ignorance of the methods of transmitting HIV and damaging rumours could tarnish the reputations of hospitality businesses. Hence, hoteliers, restaurateurs, chefs and contract catering managers should focus on questions surrounding the legal rights of both employer and infected staff member.

Adam-Smith and Goss (1993) and SmithKline Beecham (1995) identified some areas of work in the hotel and catering industries that are perceived to have very low risk exposure to HIV. For instance, housekeepers were pricked by contaminated needles and syringes in rubbish while cleaning body fluids in guest rooms and getting. Another example showed that security guards in bars or pubs engaging in fights involving blood-to-blood contact with customers or other employees. Hence, training on handling blood-borne pathogens should be provided to hotel and catering employees. Furthermore, HCIMA as cited by Goldsmith et al. (1997) suggested hospitality employers trained and retrained employees in hygiene, cleaning procedures, food handling, first aid and handling blood-borne products like used razors, razor blades and hypodermic needles, soiled linens and used hygiene products.

Barrows et al. (1996) and Goldsmith et al. (1997) specified that HIV epidemics could create legal implications for hospitality operators when hospitality managers and employers practise discrimination on HIV-infected employees in the workplace to win back customers. Such removal of
HIV-infected employees was done unfairly with prejudice, stigmatisation and discrimination, might involve hospitality companies in unfair dismissal lawsuits. Hence, Lloyd and Abramson (1999) advised to hospitality employers and managers to first set up HIV policies and procedures which will enable their companies to maintain consistency and compliance to their local and national laws, guide their employees to acceptable behaviour and direct all employees on how and where to seek help on HIV topics and questions.

Additionally, managers and employers could and should implement HIV policies and procedures like the “deliberate no-policy” policy, the “life-threatening illness” policy and the “AIDS-specific” policy to manage existing and potential HIV-infected employees (Barrows et al., 1996). Specifically, hospitality managers and employers should consider the following suggestions in managing potential and existing hospitality HIV-infected employees (NACO, n.d.; Adam-Smith and Goss, 1993; Hays, McKusick, Pollack, Hilliard, Hoff and Coates, 1994; Barrows et al., 1996; Goldsmith et al., 1997; Lloyd and Abramson, 1999) as displayed in Table 1.

Table 1 – Suggestions to Manage HIV-infected employees

- Understand the similarities and differences between HIV-infected and AIDS employees.
- Select the appropriate policy that best suits the company
- Counsel employees to cope with HIV
- Assign a taskforce to develop, advise and monitor policy and education development and implementation.
- Educate and gain the support of all management
- Must include education and training in the policy.
- Evaluate the impacts on employers, employees, customers and the community.
- Company policy should address HIV and AIDS separately
- Integrate HIV policy into fair staffing-decisions and employees’ benefits.
- Allow all employees to access information pertaining to HIV policy.
- HIV policy must promote anti-discrimination and penalties on discriminative actions
- Confidentiality statement must be incorporated into HIV policy
- HIV should be treated as a life-threatening illness and as a form of disability.
- Companies must set up discipline and grievance procedures
- Reasonable ways should be provided for HIV-infected employees and their carers
- HIV policy should include employee training and retraining in hygiene, cleaning procedures, food handling, first aid and handling blood-borne products.
- HIV policy should be written in several commonly used
- Managers and employers must be aware of sensitivity and care.
- Provision of interactive training sessions
- Policy must be consistent and comply with local and national laws
- Should address the issue of mandatory HIV blood tests
- HIV-infected employees’ fitness to work must be discussed on an individual basis.

2.3 Issues Requiring Further Considerations

After reviewing methodological and topic literature pertaining to HIV, hospitality industry, Asian hospitality industry and HIV-related issues in the hospitality industry, some gaps were identified and they were being transformed into four research questions as follows:
1. What are the perceptions of Asian hospitality managers towards general and specific HIV policies and procedures?
2. What are the perceptions of Asian hospitality managers towards mandatory HIV blood testing for all existing and potential employees?
3. How do Asian hospitality managers view the disclosure of HIV positive status of infected employees to fellow employees and employers?
4. What are the perceptions of Asian hospitality managers towards HIV education?
In order to address all the above research questions, the author subsequently developed instruments to collect first hand data, thereafter analysing the data using statistical analysis techniques. Following is the elaboration and justifications of the methodology employed.

3. METHODOLOGY

In order to address the five research questions posed at the end of section two, this section three will discuss and justify the research designs and methods employed in identifying and determining the respondents in collecting primary data and analysing them.

3.1 Research Design

The concept of triangulation (Creswell, 1994; Saunders et al., 2003) was employed to design the research methods for this study to address the research questions posed earlier. The design of this research employed both interpretive and humanism philosophies. The humanistic aspect could be justified because the subjects involved in this study were Asian hospitality managers and their perceptions and knowledge of HIV were being studied (Saunders et al., 2003), while the interpretive research was preferred due to time and financial constraints in not being able to observe the respondents in real life situations in different Asian countries (Saunders et al., 2003). The research philosophies addressed by both inductive and deductive approaches aimed to develop new HIV policies and procedures for Asian hospitality managers to employ to manage HIV-related issues in their workplaces, and build on the existing HIV policies and procedures employed in other countries and industries (Saunders et al., 2003). The mixed-methodology design (Creswell, 1994) of incorporating both quantitative and qualitative data and analytical techniques aimed to bring the benefit of justifying findings empirically, while qualitative research methods could supplement the shortfalls of quantitative methods by exploring the study further with breadth and depth (Creswell, 1994; Saunders et al. 2003).

3.2 Determination of Population, Sample and Respondents

Since this study involves Asian hospitality managers working in hospitality organisations located in Asia, the population determined for this research was classified into two groups:

- all hospitality organisations located in Asia
- all Asian hospitality managers working for all hospitality organisations located in Asia.

The exact number of elements in each group was difficult to identify. They might be in excess of millions. Hence, sampling was employed to narrow down the cases to be studied (Frey and Oishi, 1995; Zikmund, 2000). Relatively, the sample identified for this study was also divided into two groups:

- all domestic and international airline companies, all 4 and 5 star hotels and all full-service restaurants located in Cambodia, China, India, Indonesia, Myanmar, Thailand and Vietnam, and all cruise companies that have destinations to Asia.
- all Asian hospitality human resources managers (HRMs) who can comprehend English and have heard of HIV and AIDS working for the above airline companies, hotels, restaurants and cruise companies.

The sampling frame that helped to identify the above two groups of sample was compiled using publications from various sources. In total, 608 hospitality organisations were identified in the sampling frame. Assuming that each company in the sampling frame had one HRM, 608 letters of invitations were sent to the companies to invite their HRMs to participate in the postal questionnaire. As a result, the probability and non-probability sampling techniques raised 60 participants. The determination of participants was time-consuming due to the sensitive nature of this study.10 of them were used for the pilot testing and 50 of them for the actual field work.
3.3 Instruments Design and Data Collection

This study employed two data collection instruments, postal questionnaire and telephone interview schedule, to collect primary data from the identified participants. The main justification for employing two instruments is that each instrument has its strengths and weaknesses and they can complement each other to enhance the validity and reliability of the study (Mangione, 1995, Gillham 2000a). The items in the postal questionnaire and the telephone interview schedule were adapted and developed based on the literature reviewed (Saunders et al., 2003). They comprised of open-ended, partially open-ended and close-ended questions to complement the shortfalls of each type of questions (Frey and Oishi, 1995; Gillham, 2000b; Saunders et al., 2003).

There were two sections in the postal questionnaire. Section A included six items to determine the Asian hospitality managers’ perceptions on HIV-related policies and procedures in their workplaces. Five point Likert scale was employed as the structured options for the respondents to select their responses to enhance the reliability and validity of the primary data (Burns, 2000). Section B included six items to collect the respondents’ demographic profiles, workplace attributes and their willingness to participate in the telephone interviews. On the other hand, five questions were developed for the telephone interview schedule. These open-ended questions aim to collect the respondents’ perceptions on formal and informal HIV policies, the operation of formal and informal HIV policies, mandatory HIV blood testing and HIV education in their workplaces. Pre-tests and pilot tests were conducted on the developed questionnaires to ensure clarity, reliability and validity (Zikmund, 2000; Saunders et al., 2003). The final postal questionnaire and telephone interview schedule were attached in the appendices A and B.

Informed consents were obtained from the participants to observe positive research ethics (Saunders et al., 2003). The postal questionnaire was sent to 50 participants and 32 completed questionnaires were returned and all were deemed usable, while the number of participants for the telephone interview was determined by the responses from the postal questionnaire. In total, 12 participants agreed to participate in the telephone interviews with no drop-out. The interviews were tape-recorded to assist the interviewer in multi-tasking. Once again, informed consents were obtained from the interviewees to tape-record the interviews. The data collection process went quite smoothly.

3.4 Data Analytical Techniques

The collected raw data from postal questionnaire were coded numerically and entered into Statistical Package for the Social Science version 12.0 (SPSS). The responses from section A of the postal questionnaire was treated as categorical ranked or ordinal data (Zikmund, 2000; Saunders et al., 2003). While the demographic profiles and workplace attributes were treated as categorical descriptive or nominal data (Zikmund, 2000; Saunders et al., 2003). Then, they were transformed, handled, summarised and manipulated using SPSS to perform reliability tests, descriptive and detailed analyses (Brace et al., 2000). The preferred detailed analyses were selected nonparametric tests to test for level of significance between dependent and independent variables because the collected quantitative data cannot assume normal distribution in the sample and target population due to the employment of snowball sampling technique (Saunders et al., 2003).

The tape-recorded telephone interviews were transcribed, coded, categorised, interpreted and analysed using template analysis (Mills and Huberman, 1994; Strauss and Corbin, 1998; Saunders et al., 2003). This qualitative data analytical technique was employed over grounded theory due to flexibility to modify codes, categories and themes as the analyses of qualitative data progress (King, 1998; Crabtree and Miller, 1999; Miller and Crabtree, 1999). The template was set up with first level codes before the interviews. Thereafter, the responses from the respondents were inserted into the template as second level codes. At the same time, additional codes, categories and themes were added according to the qualitative data collected from the interviewees. When the analyses were completed, the results can be discussed and reported in next section four.

4. RESULTS
The purpose of analysing the collected data is to reveal the essence of the respondents’ perceptions thereby addressing the research questions posed. Firstly, the reliability of the collected data from both the postal questionnaire and the telephone interviews will be assessed. Next, an overview of the respondents’ demographic profiles and workplace attributes will be presented and discussed. Thereafter, their responses on the postal questionnaire and their interviews will be analysed and discussed. Finally, Kolmogorov-Smirnov test of difference and Spearman’s correlations will be performed on the data collected from the postal questionnaire and the findings from the telephone interviews will supplement the collected quantitative data.

4.1 Assessment and Discussion of Instruments’ Reliability

Cronbach’s alpha was performed on the postal questionnaire to measure the internal consistency of the instrument (Brace et al., 1999; Saunders et al. 2003). The Cronbach’s alpha obtained for the postal questionnaire was 0.74 (Appendix C). The alpha score implied that the postal questionnaire had collected data that was 74% confident in reliability. Hence, the postal questionnaire as a whole was determined to be reliable. The achievement of this score could be due to the rigorous processes of designing and pilot testing the postal questionnaire. On the other hand, Goldsmith et al. (1997) stated that discussions of HIV issues are sensitive for employers and employees. The alpha score of 74% determined that some of the respondents were reluctant to discuss HIV-related issues openly.

An assessment of reliability was carried out on the telephone interview schedule to ensure this study is stable and consistent over time, generating quality qualitative data with care (Miles and Huberman, 1994). In general, the reliability of the telephone interview schedule was checked and assessed using the following checklist (Appendix D) adopted from Miles and Huberman (1994). The seven questions on the checklist, enquiring about content validity, external validity, internal validity, construct validity and reliability of the questions and answers from the telephone interviews were addressed. Hence, the data collected from the telephone interviews were also deemed valid and reliable.

4.2 Overview of Respondents’ Demographic Profiles and Workplace Attributes

A total of 32 respondents replied to the postal questionnaire (Appendix E). This small number of respondents reflected a high level of difficulty in persuading the respondents to participate in a sensitive study. Nevertheless, the quantitative data collected from 32 respondents were minimally sufficient to conduct non-parametric analytical tests (Saunders et al., 2003). The majority of the respondents were male (n=22). This may be due to the fact that there are more male managers than female managers working in the hospitality industry in Asia, in general. More than half of the respondents were aged less than 40 years old. This may be due to the high number of younger workers employed in the hospitality industry in Asia or may be the general population in Asia is younger since Second World War. More than half of them (n=19) were degree holders. This may be due to the fact that Asian hospitality companies prefer to employ managers with degrees. The majority of them were from Asian countries most infected with HIV. All the respondents held management positions in human resources department and half of them were HRMs. Almost all of them (n=31) worked for the hotel industry and only one respondent was from the airlines industry. These numbers reflected the reality that there is more hotel companies than airlines companies identified in the sample and target population. Additionally, the number of respondents determined a higher level of willingness from hotel companies to participate than airline companies. Out of the 32 respondents, 12 agreed to participate in the telephone interviews (Appendix F). Therefore their demographic profiles and attributes are amongst those discussed above. Similarly, there were more male (n=9) interviewees than female (n=3). The majority of them (n=11) were from Asian countries most infected with HIV (Cambodia, China, India, Indonesia and Thailand), except one from the Philippines who is female.
4.3 What are the perceptions of Asian hospitality managers towards general and specific HIV policies and procedures?

The majority of the respondents (n=31) agreed to counsel all employees to cope with HIV (Appendix G). This finding concurred with Hays et al. (1994) and NACO (n.d.) that HIV positive employees should be counselled to deal with their illnesses and to help them take precautions in order not to spread their infections. Further, counselling the healthy employees can help to eliminate panic situations on workplace health and safety hazards. Additionally, the majority of them (n=26) agreed to bring in experts to answer employees’ questions on HIV. This finding determined that the respondents have positive perceptions towards employing HIV policies and procedures in addressing HIV and HIV-related issues at their workplaces.

Furthermore, 25 of the respondents agreed that a formal policy should be drawn to address HIV in the workplace. For instance, 1A and 1F confirmed in the telephone interview that their hotel companies had formal policies in place to address HIV issues. Additionally, 1D and 1F stated that their employees had set up informal policies on a voluntarily basis to help HIV-infected colleagues. Out of the above respondents, only 1F stated that her company had both formal and informal policies in place to address HIV issues. These findings concurred with Lloyd and Abramson (1999). On the other hand, some of them stated that their companies had no general formal (1A, 1B, 1C, 5D, 1E) or informal (2A, 1B, 1C, 4D, 1E) policies in their workplaces to address HIV issues. For instance, 1D (Appendix H) said that:

“Thus far, my company has no formal or informal policies to address HIV-related issues in the workplace because the company has no way to detect the HIV status of employees. [pause] Hence it is not necessary to have any policies.”

Another 1D felt that the operation of general formal and informal policies to address HIV-related issues in his workplace was not currently of importance because HIV was not a popular topic of discussion amongst the locals. On the other hand, less than half of them (n=15) agreed to allow HIV-infected employees to have physical contact with customers and only half of them allow HIV-infected employees to have physical contact with fellow healthy employees. These findings revealed that some Asian hospitality managers have the tendency to discriminate HIV-infected employees in their workplaces.

Three interviewees (1B, 1D, 1E) stated that there should be some HIV cases visible in their workplaces in order to properly operate HIV policies. Their perceptions did not reflect willingness to proactively develop and implement HIV policies to address upcoming challenges in the Asian hospitality industry. Further, 1C stated that legislation should intervene in the operation of HIV formal policies, not only in Asian countries, but on an international level. 1F stated that the operation of formal and informal policies in her workplace was successful with no big problems having been encountered so far. Her company also receives subsidies from the government for implementing such policies. An Indonesian revealed that his hotel had informal policies by working with three local hospitals to look after employees and their families’ health issues. 1E also added that the operation of HIV policy in the workplace was inexpensive.

The results showed no statistical significant difference in the respondents’ perceptions towards addressing HIV policies in their workplaces regardless of their gender (n=32), nationalities (N=20), age (n=30), education qualification (n=30) and their positions (n=30). These findings implied that the respondents’ perceptions towards HIV policies were not dependent on their demographic profiles or their workplace attributes.

4.4 What are the perceptions of Asian hospitality managers towards mandatory HIV blood testing for all existing and potential employees?

The respondents had mixed positive and negative perceptions of HIV blood testing for applicants and employees. Their perceptions were based on cultural, financial and legal reasons. For instance, 1D said:
“I am in favour for HIV blood testing for potential and existing employees. I will arrange for the company doctors to do the HIV blood testing and the test results will be sent to the company confidentially. [pause] But the cost of such tests is costly for my company and my company cannot pay for them. Additionally, Balinese are very traditional people. [pause] They don’t like to talk about HIV issues and they are not open towards HIV issues. I think that HIV blood testing might not be suitable for Balinese.”

The above reasoning was supported by other respondents (1B, 1C and 2D). They concurred that HIV blood testing was expensive in their countries and that both applicants and employees could not afford to pay for them. On the other hand, 1A believed that HIV blood testing was necessary because it can detect those who are infected with the virus and therefore they could get treatment earlier to prolong their lives. He added

“My hotel company only encourages blood testing sometimes because some staff goes very often to night clubs. My hotel has a form for volunteers to fill in front of a witness, if they would like to be tested for HIV using a blood test. [pause] But this is not done often. My hotel will pay for all blood tests including HIV, also all medical check-ups.”

1F also supported HIV blood testing. However, such practice is prohibited by national legislation as described below. Therefore, HIV screening has to be done alternatively.

“I encourage HIV blood testing for potential and existing employees. However, my hotel cannot do it because of Thailand’s labour law to eliminate discrimination of applicants. [pause] But hotels are allowed to conduct other blood tests, for instance Hepatitis B because this illness is popular in foreign countries and there are a lot of foreigners working in Thailand. [pause] My hotel screen employees indirectly for HIV by asking Red Cross to come to the hotel for blood donations. Those employees who participated in blood donations must go through cost free HIV blood screenings. Those employees who cannot donate blood due to HIV infections will be notified by the Red Cross confidentially. At least, my infected colleagues will know that they have been infected and can seek treatment immediately.”

With reference to the above findings, all the respondents had positive perceptions of HIV blood testing policies implemented in their workplaces. This finding concurred with Ruston and Law (1991). However, there are financial constraints, legal and cultural obstacles to overcome. With reference to the financial constraints and legal obstacles, the method proposed by 1F is of great importance. Moreover, 1A’s company’s willingness to take care of the HIV blood testing expenses is encouraging. However, cultural obstacles as highlighted by 1D are difficult to overcome. One of the long-term solutions may be continuous education and getting all employees to participate in such policies.

4.5 What are the perceptions of Asian hospitality managers towards HIV education?

The majority of the respondents (n=30) agreed that HIV education was one of the best methods for slowing down the spread of HIV (Appendix G). This finding also concurred with the information identified by previous research. Additionally, six interviewees gave strong support and encouragement for HIV education in their workplaces. However, UNAIDS (UNAIDS Point of View, 1998) stated that HIV prevention programmes were not successfully implemented in workplaces in conservative and underdeveloped countries. 1B supported this by stating that “My hotel has not implemented any HIV education in the workplace because [pause] my company believes that the government is responsible for such programmes.” She continued that employees would find it strange if such education were implemented in the workplace. On the other hand, 1A, 1C and 1D said that HIV education was not the responsibility of their companies or their governments. It should also be done at home or school. Nevertheless, all the respondents (n=12) unanimously agreed that HIV education could reduce HIV infections when implemented properly in the workplace. In addition, two of them believed that HIV education could enhance HIV knowledge and understanding, eliminating misconceptions and negative attitudes.
All the interviewees provided some suggestions on how HIV education could be conducted in their workplaces. The most popular method was to invite guest speakers to present HIV materials via seminars and forums, while some believed that the mass media, lectures, group discussions, religious gatherings and visual aids could be used to deliver HIV education. Additionally, two interviewees recommended that all employees should participate in HIV education in order to enhance the effectiveness of such sessions. Overall, the findings reflected that they understood how HIV education should be implemented in their workplaces in order to generate benefits for their organisations and all employees. Finally, the results found no statistical significant difference at a 95% level of confidence in the respondents’ (N=20) perceptions of HIV education is one of the methods for slowing down the spreading of HIV regardless of their nationalities. This finding may imply that respondents from Asian countries most infected with HIV epidemics are not putting urgency into implementing HIV education in their workplaces.

4.6 How do Asian hospitality managers view the disclosure of HIV positive status of infected employees to fellow employees and employers?

With reference to Hays et al. (1994), disclosure of positive HIV status can affect relationships. Additionally, there are instances documented whereby employees with positive HIV status were discriminated against by healthy employees in their workplaces (Barrows et al., 1996; Bharat et al., 2001). The majority of the respondents (n=23) agreed with not disclosing the positive HIV status of infected employees to fellow colleagues. The respondents’ justifications against disclosure of positive HIV status of infected employees to colleagues are

- can affect morale of workers and directly affect productivity (1D, 1E)
- line employees with a low level of education cannot understand the complexities of HIV and hence cannot accept HIV-infected colleagues. (1D)
- can generate gossips amongst employees in the workplace and these informal grapevines can be damaging and misleading. (1D)
- relationships amongst workers can be negatively affected. (1C, 1E)
- such status should be treated confidentially and is not the concern of other employees. (1D)
- Balinese workers do not want to be associated with people who are infected with HIV and do not want to go near them. (1D)

The above findings concurred with Hays et al. (1994), Barrows et al. (1996) and Bharat et al. (2001). The majority of the respondents made their justifications in favour of their fellow employees and their hotel companies. However, they did not take into consideration the infected employees’ feelings and psychological context and few comments were made about the welfare of HIV-infected employees. Lim and Loo (pp. 129, 2000), stated that “many employers choose to take the expedient measure of dismissing them (HIV positive employees) once their HIV status is known”. Bharat et al. (2001) disclosed that employment-related discrimination and stigmatisation have begun to appear in Asian societies because individual cases of job loss and denials of employment are based on positive HIV status. The following paragraphs explore the respondents’ perceptions of disclosing the positive HIV status of infected employees to employers. The minority of the respondents (n=9) agreed with not disclosing the positive HIV status of infected employees to employers. These perceptions may be the causes of the above mentioned discrimination. Alarmingly, the majority of the respondents disagreed with not disclosing employees’ HIV status to employers. Some of their justifications are

- infected employees can be counselled to seek treatment immediately. (1B)
- allow employers to ask sick employees to leave. (1B, 2D)
- allow employers not to extend work contracts before and after probation period. (1A, 1D, 1F)
- allows employers not to extend work contracts in order to uphold a healthy and safe work environment for other employees. (1D)

The majority of the justifications were made in favour of their companies by asking HIV-infected employees to leave the organisation or by not extending their contracts. Not much consideration was given to the HIV-infected employees. Finally, there was no statistical significant correlation detected
between 25 respondents’ perceptions not to disclose employees’ HIV positive status to co-workers and to employers at a 95% level of confidence with a low correlation coefficient of .343. The finding implied that the respondents’ perceptions towards not disclosing the positive HIV status of infected employees to fellow colleagues were not related to their perceptions towards not disclosing positive HIV status of infected employees to employers.

5. CONCLUSION

In this section, the objectives of this paper will be concluded based on the earlier findings. Additionally, general and specific recommendations will be provided to Asian hospitality managers in formulating HIV policies and procedures in their workplaces. Finally, the limitations and reflections of this study will be discussed.

5.1 Conclusions and Recommendations

With reference to the literature reviewed in earlier sections, the number of HIV infections is increasing rapidly each day. HIV epidemics have spread to Asia and devastated the Asian hospitality industry in the context of businesses, employers, employees, customers, health and safety provision, costs, education and training, macroeconomics, households, individuals, societies, governments and new products. To date there is no cure or preventative vaccine imminent. There are tangible and intangible differences between patients having AIDS and being HIV positive. However, discrimination and stigmatisation against HIV positive workers are evident in the Asian hospitality workplace. Therefore, this study recommended Asian hospitality managers to explore HIV policies and procedures to address the challenges posed by HIV and HIV-related issues in their workplaces.

The majority of the Asian hospitality managers stated that their companies have no formal or informal policies and procedures to address HIV and HIV-related issues in their workplaces. Their perceptions did not reflect a willingness to proactively develop and implement HIV policies to address upcoming challenges in the Asian hospitality industry. However, they are positive about various HIV policies and procedures. Therefore, this study recommended Asian hospitality managers to proactively implement formal and informal HIV policies and procedures in their hospitality workplaces. These policies and procedures should include counselling sessions, education and training, information sessions by experts, mandatory HIV blood testing, not disclosing HIV status to co-workers, and allow physical contact with employees and customers. On the other hand, some of them reacted negatively on not disclosing employees’ HIV positive status to employers. The findings also identified that some Asian hospitality managers have the tendencies to discriminate HIV-infected employees. Some of their justifications behind the implementation of specific HIV policies and procedures were made in favour of their healthy employees and their companies. The feelings and psychological context of those HIV-infected employees were not taken into considerations. Therefore, this study recommended Asian hospitality managers to adopt the suggestions specified by NACO (n.d.), Adam-Smith and Goss (1993), Hays et al. (1994), Barrows et al. (1996), Goldsmith et al. (1997), and Lloyd and Abramson (1999) in managing potential and existing hospitality HIV-infected employees. These suggestions address workplace equality, education and training, compliance to legislations, impacts of HIV, confidentiality, discipline and grievance procedures, and discipline and penalties.

With reference to mandatory HIV blood testing, the respondents have mixed perceptions due to cultural, financial and legal reasons. They stated that some of the Asian cultures and legislations do not allow employers to screen employees using mandatory HIV blood testing. Additionally, HIV blood testing is expensive in Asia. In order to overcome the above obstacles in mandatory HIV blood testing, this paper recommended hospitality companies in Asia to pay for the costs of HIV blood testing. Asian hospitality managers must not use mandatory HIV blood testing as a tool to discriminate HIV-infected potential and existing employees. They should also educate their employees that mandatory HIV blood testing is helpful in allowing HIV positive employees to seek treatment immediately and not to further infect other people. Furthermore, Asian hospitality managers may adopt the method suggested by IF in implementing HIV blood testing in her workplace.
Almost all the Asian hospitality managers agreed that HIV education was one of the best methods for slowing down the spread of HIV. They agreed that HIV education, when implemented correctly, can bring many benefits like enhancing knowledge, eliminating misconceptions and negative attitudes. Therefore, this study strongly recommended Asian hospitality managers to incorporate HIV education into HIV policies and procedures. HIV education can be conducted via seminars and forums, mass media, lectures, group discussions, religious gatherings and visual aids. This paper recommended Asian hospitality managers to conduct HIV education in their workplaces using a combination of the above stated methods and all employees must attend.

The findings can be concluded that most of the Asian hospitality managers were in favour of not disclosing employees’ HIV positive status to co-workers. They believed that this policy and procedure could protect positive workplace morale and harmony amongst employees. On the other hand, the majority of them disagreed to not disclosing employees’ HIV positive status to employers. They believed that this policy and procedure allowed employers to detect those HIV-infected employees and not to extend their work contracts. Therefore, this paper recommends Asian hospitality managers not to disclose employees’ HIV positive status to both co-workers and employers. The HIV positive status of employees should be kept confidential. The managers and employers must not disadvantage HIV-infected employees based on their positive status.

5.3 Limitations, Reflections and Recommendations for Future Research

Due to the complexity of the target population, there was no comprehensive sampling frame available for this study. A non-comprehensive sampling frame may affect the selection of the respondents and indirectly affect the reliability and validity of the primary data. Therefore, the author spent much time compiling current and accurate postal addresses, email addresses and facsimile numbers of Asian hospitality establishments from guide books, commercial listings from the world-wide-web and electronic databases. The non-comprehensive sampling frame may increase the sampling frame error in this study. Future researches in similar areas should target one sector of the hospitality industry at a time. This method may reduce the complexity of the target population and directly reduces the sampling frame error.

The nature of this research topic was sensitive in the context of Asian culture. The Asian hospitality respondents were reluctant to disclose their perceptions in detail or talk about HIV issues, thereby affecting the quality of the collected data. Additionally, the English language was not the mother tongue of the respondents. Thus the Asian hospitality managers felt challenged when attempting the postal questionnaire and responding to the telephone interview questions. They might have contributed more detailed information if they had been asked to participate in this study in their mother tongue. Future researches should target one Asian country at a time. This allows researchers to compare the level of sensitive in discussing HIV issues in different Asian culture. Those less sensitive Asian cultures may provide deeper findings in the context of HIV issues.

With reference to the design of the questionnaire, a five-point Likert scale was employed for the respondents’ to respond to structured statements. Structured statements were employed to reduce surveyor and respondent bias (Zikmund, 2000). However, the respondents were forced to select the five options provided in the questionnaire, and so anchoring bias occurred in this study. In contrast, unstructured questions were employed in the telephone interview schedule. Although this method of data collection can eliminate anchoring bias, there is a possibility for surveyor’s and respondents’ bias. Future researches should use a combination of structured, semi-structured and unstructured items in gathering data from respondents. This method allows different items to complement each other.

Simple random sampling technique was employed to give equal chances for all invitees to participate in this study. However, the number of elements agreeing to participate in the postal questionnaire was fewer than 30. Hence, a snowballing technique was used as a secondary method to increase the number of respondents. This sampling technique succeeded in increasing the number of respondents to more than 30 and allowed the employment of non-parametric quantitative data analytical techniques to analyse the data. However, the snowballing technique, a non-probability sampling technique, did not allow the results to make generalisations about the population and sample,
and the non-parametric data analytical techniques did not allow the assumption of normal distribution of the sample (Saunders et al., 2003). The results and conclusions can only be inferred on the respondents.

REFERENCES


APPENDICES

Appendix A – Asian Hospitality Managers’ Perceptions Questionnaire

Part A: Perceptions on HIV Related Policies and Procedures

*Formal policies are explained as a series of actions strictly observed or endorsed by an organization.

**HIV is the abbreviation for Human Immunodeficiency Virus. Basically, it is the virus that can evolve into AIDS.

To what extent do you agree/disagree with the following statements concerning policies and procedures to address HIV in your workplace? Please select one number to determine the degree of importance from 1 (agree strongly) to 5 (disagree strongly). Select the appropriate number that follows each statement.

1=Agree strongly, 2=Agree, 3=Do Not Know, 4=Disagree, 5=Disagree strongly

In the context of your organisation,

A1. Invoke a formal policy* to address HIV**. 1 2 3 4 5
A2. Counsel all employees to cope with HIV. 1 2 3 4 5
A3. Unnecessary to bring in experts to answer employees’ questions on HIV. 1 2 3 4 5
A4. Invoke formal HIV training cannot assist employees to learn about HIV. 1 2 3 4 5
A5. Keep all HIV-infected employees from physical contact with customers. 1 2 3 4 5
A6. Keep HIV-infected employees from physical contact with other employees. 1 2 3 4 5
A7. HIV education is one of the methods to slow down the spreading of HIV. 1 2 3 4 5
A8. Disclose employees’ HIV positive status to co-workers. 1 2 3 4 5
A9. Disclose employees’ HIV positive status to employers. 1 2 3 4 5

Part B: Demographics and Workplace Attributes

Select only one appropriate response to the following questions or write your answer as applicable.
Appendix B - Hospitality Managers’ Confidential Telephone Interview Schedule

*HIV is the abbreviation for Human Immunodeficiency Virus. Basically, it is the virus that can evolve into AIDS.
**Formal policies are explained as a series of actions strictly observed or endorsed by an organization.
1. Does your company have formal or informal policies to address HIV* related issues in the workplace? Why? Why not? Anything else?
2. How do you view the operation of formal policies** to address HIV related issues in the workplace? How do you view the operation of informal policies to address HIV related issues in the workplace? Anything else?
3. What are your views on HIV education at your workplace? Would you encourage HIV education at your workplace? Why, for whom and How? Why not? Anything else?
4. What are your views on blood testing of potential and existing employees for HIV? Anything else?
5. Do you encourage blood testing for potential and existing employees for HIV? Why and How? Why not? Anything else?

Appendix C – Reliability Measurement of Postal Questionnaire

N of Cases = 31.0
Reliability Coefficients 68 items
Alpha = .7359 Standardized item alpha = .7573

Appendix D – Reliability and Validity Assessment Checklist for Telephone Interviews

1. Are the research questions clear, and are the features of the study design congruent with them?
2. Is the researcher’s role and status within the site explicitly described?
3. Were data collected across the full range of appropriate settings, times, respondents, and so on suggested by the research questions?
4. Was data quality checks made (e.g. for bias, deceit, informant knowledge ability?)
5. Are basic paradigms and analytic constructs clearly specified? (Reliability depends, in part, on the extent to which it is connected to theory.)
6. Were coding checks made, and did they show adequate agreement?
7. Were any forms of peer or colleague review in place?

Appendix E – Summary of Respondents’ Demographic Profiles

<table>
<thead>
<tr>
<th>Most Infected Asian Countries</th>
<th>No Degrees</th>
<th>Male</th>
<th>Below 40</th>
<th>HR Managers</th>
<th>Other HR Managers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>Below 40</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>40 and above</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>Total</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Degrees</td>
<td>Male</td>
<td>Below 40</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Degrees</td>
<td>Male</td>
<td>40 and above</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Degrees</td>
<td>Total</td>
<td></td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Degrees</td>
<td>Female</td>
<td>Below 40</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Degrees</td>
<td>Female</td>
<td>40 and above</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Degrees</td>
<td>Female</td>
<td>Total</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Least Infected Asian Countries</td>
<td>No Degrees</td>
<td>Male</td>
<td>Below 40</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Least Infected Asian Countries</td>
<td>No Degrees</td>
<td>Male</td>
<td>40 and above</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Least Infected Asian Countries</td>
<td>No Degrees</td>
<td>Total</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Least Infected Asian Countries</td>
<td>Degrees Female</td>
<td>Below 40</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least Infected Asian Countries</td>
<td>Degrees Female</td>
<td>40 and above</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least Infected Asian Countries</td>
<td>Degrees Female</td>
<td>Total</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Appendix F – Coded Background Information of Telephone Interviewees

A (male from Cambodia) 2
B (female from China) 1
C (male from India) 2
D (male from Indonesia) 5
E (female from the Philippines) 1
F (female from Thailand) 1

Appendix G – Summary of Responses for Postal Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Agreements</th>
<th>Disagreements</th>
<th>Do not Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2 Counsel all employees to cope with HIV</td>
<td>31</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>A7 HIV education to slow down spread of HIV</td>
<td>30</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>A3 Necessary to bring in experts</td>
<td>26</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>A4 Invoke formal HIV training</td>
<td>25</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
A1 Invoke a formal policy to address HIV 25 4 3
A8 Do not disclose employees’ HIV status to workers 23 6 3
A6 Allow physical contact with employees 16 12 4
A5 Allow physical contact with customers 15 12 5
A9 Do not disclose employees’ HIV status to employers 8 19 5

Appendix H – Final Template for Telephone Interview Schedule

<table>
<thead>
<tr>
<th>First Level Codes</th>
<th>Second Level Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions of HIV education</td>
<td>Strong support and encouragement (1A, 5D)</td>
</tr>
<tr>
<td></td>
<td>Start from home or school (1A, 1C, 1D)</td>
</tr>
<tr>
<td></td>
<td>Responsibility of government and society (1B)</td>
</tr>
<tr>
<td></td>
<td>Employees will find it strange (1B)</td>
</tr>
<tr>
<td>Implementation of HIV education</td>
<td>Mass media (1A, 1B, 1C)</td>
</tr>
<tr>
<td></td>
<td>Lectures (1C, 1D)</td>
</tr>
<tr>
<td></td>
<td>Seminars and forums (1C, 3D, 1E)</td>
</tr>
<tr>
<td></td>
<td>Group discussions (1D)</td>
</tr>
<tr>
<td></td>
<td>Religious gatherings (1D)</td>
</tr>
<tr>
<td></td>
<td>Visual aids (1A, 1D, 1E, 1F)</td>
</tr>
<tr>
<td></td>
<td>All employees must participate (1A, 1D)</td>
</tr>
<tr>
<td>General Policies</td>
<td>No formal policy (1A, 1B, 1C, 5D, 1E)</td>
</tr>
<tr>
<td></td>
<td>No informal policy (2A, 1B, 1C, 4D, 1E)</td>
</tr>
<tr>
<td>HIV blood testing</td>
<td>Positive perceptions (2A, 1B, 2C, 5D, 1E, 1F)</td>
</tr>
<tr>
<td></td>
<td>Negative perceptions (2D 1F)</td>
</tr>
<tr>
<td></td>
<td>Costly (1B, 1C, 3D)</td>
</tr>
<tr>
<td></td>
<td>Incorporated into annual medical examinations (1C, 2D)</td>
</tr>
<tr>
<td></td>
<td>All employees must participate (2D)</td>
</tr>
<tr>
<td></td>
<td>Legislation (1F)</td>
</tr>
<tr>
<td></td>
<td>Company will not pay (1C, 1D,)</td>
</tr>
<tr>
<td></td>
<td>Company will pay (1A)</td>
</tr>
<tr>
<td>Operations and Procedures</td>
<td>Needed cases of HIV (1B, 1D, 1E)</td>
</tr>
<tr>
<td></td>
<td>Difficulty encountered (1D)</td>
</tr>
<tr>
<td></td>
<td>Not important (1D)</td>
</tr>
<tr>
<td></td>
<td>Important (1C, 3D, 1E)</td>
</tr>
<tr>
<td></td>
<td>Legislation should intervene (1C)</td>
</tr>
<tr>
<td></td>
<td>Successful (1F)</td>
</tr>
<tr>
<td></td>
<td>Inexpensive to implement (1E)</td>
</tr>
<tr>
<td>Disclosure of HIV positive status</td>
<td>To Employers (1A, 1B, 4D, 1F)</td>
</tr>
<tr>
<td></td>
<td>Not to Employees (1C, 4D, 1E)</td>
</tr>
</tbody>
</table>