

HIV Knowledge, Attitudes, and Sexual Behaviour among Tourism Workers in Gauteng Province, South Africa

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ABSTRACT The aim of this study was to determine tourism workers' knowledge, attitudes, and sexual behaviour related to HIV and AIDS. A survey was administered to tourism workers (n=338) from all the hotels and resorts randomly sampled in Gauteng Province, South Africa. Results indicate a medium level of HIV transmission knowledge and high HIV risk behaviour (lack of condom use, casual and multiple sexual partners). Half of the study participants (49.7%) had made sexual advances or moves to tourists or guests while tourists/guests had also made sexual advances/moves to 55% of the participants. A very large proportion of the participants (82.2 percent) either strongly agreed or agreed that HIV education programmes would help them to get educated about HIV/AIDS. The study confirms high HIV risk behaviour in the tourism sector, willingness to get educated and consequently comprehensive HIV prevention programmes are recommended for tourism workers.

INTRODUCTION

Southern Africa is home to two-thirds of the more than 33 million people living with HIV/AIDS in the world. Although only 10% of the world's population lives in Sub-Saharan Africa, more than 85% of the world's AIDS-related deaths have occurred in this region. The Republic of South Africa's HIV/AIDS epidemic has only recently matured, and yet 11% of South Africans are infected with HIV (Shisana et al. 2009). Sexually transmitted diseases (STDs), especially HIV/AIDS remain an important cause of high morbidity and mortality among men and women over the world, predominantly Africa. In order to institute appropriate preventive measures, there is need to establish the profile of knowledge of the predisposing factors, attitude and behavioural patterns among the most likely to be susceptible people, focusing especially on the tourism employees because of the nature and conditions surrounding their work environment. Tourism is one of the largest and fastest growing industries in many countries (Fridgen 1991). Tourism accounts for 35% of global service ex-

ports and the fastest tourist destination is Africa, with tourist arrivals increasing by 6.4% (Medical Tourism 2004). The tourism activities evolve within 4 groups of populations namely, the tourists, the tourism workers, sex workers and the host populations (Clift and Grabowski 1997). The tourism sector is associated with casual sex frequently unprotected, drugs and alcohol use – all factors linked to an increased risk of HIV transmission, which affect or predispose tourism workers to HIV/AIDS infections (Bloor 1998). The tourism industry often hires a large number of young, single employees, who are frequently mobile and away from their families for prolonged periods of time. Tourism workers frequently have contact with both tourists and other visitors in their working communities. This makes them a risky group that might disproportionately expose themselves and their families to the vulnerability of HIV/AIDS infection (Bloor 1998).

In a study comparing the tourism workers' and industrial workers' knowledge, attitude and practices (KAP), El-Sayyed et al. (2009) found that tourism workers reported a significantly higher percentage of behavioural changes concerning avoidance of extra marital sexual relations and adherence to religious beliefs; while minor cases of avoidance of illicit drugs, limiting number of sexual partners, getting married or using condoms. A study in the Dominican Republic also confirmed sexual relations among hotel employ-

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ees and also between these workers and foreign guests. Apart from that, many hotel employees and the international visitors also patronized sex workers. About 17 percent of the hotel workers reported that they had had sexual relations with tourists, 39 percent of all hotel employees reported having had multiple sexual partners, 55 percent of the entertainment workers had had more than one partner (Family Health International 2000). Bisika (2009) examined the knowledge, attitudes, practices and behaviour as well as risk perceptions associated with HIV/AIDS, sexually transmitted infections and unwanted pregnancies among staff in the tourism industry and communities around tourist facilities in Malawi, and found that people in the tourism sector are at high risk of HIV/AIDS, sexually transmitted infections and unwanted pregnancies and should be considered as a vulnerable group. The study further observed that this group of people had not adopted behaviours that can protect them from HIV/AIDS, sexually transmitted infections and unwanted pregnancies. Despite good knowledge, some common misconceptions about HIV/AIDS were found among tour guides in Turkey, indicating that tour guides required additional training in the mechanisms of HIV transmission (Avcikurt et al. 2011). Ketshabile (2007) found that many tourism and hospitality companies in Southern Africa do not have HIV/AIDS educational programmes for their employees and do not provide HIV/AIDS preventive measures like condoms to their workers at workplace. Failure to be proactive in the fight against HIV/AIDS may threaten the future of many tourism businesses (Ketshabile 2010).

The aim of the study is to investigate the HIV knowledge, attitudes and sexual behaviour of tourism workers at selected hotels and resort centres in Gauteng province, South Africa, regarding HIV/AIDS.

METHODOLOGY

Sample and Procedure

A cross-sectional descriptive study of knowledge, sexual behaviour and attitude of tourism workers about HIV/AIDS using a self-administered structured questionnaire was carried out in about 30 tourists' centres including hotels, resorts and airport. The accurate figure of tourism workers/employees was not available at the time

of this report. However, of the 986 registered hotels and resorts in South Africa (South-Africa Tourism), 82 are situated in Gauteng. Assuming an average of twenty-five (25) entertainment workers in each hotel or resort, give a total of about 2050, this was round-up to 2,100 entertainment employees in Gauteng. Hence, the estimated target population was 2,100 tourism workers. Of the 82 hotels and resorts in Gauteng, 26 are in Pretoria, 20 in Johannesburg, and 9 in Sandton (South Africa-Tourism.com), totalling 55 hotels and resorts in these three big cities were the representative sample. The reason why these cities were selected for the study is that, they have the highest concentration of hotels individually and collectively from the total figure in Gauteng. From all the hotels and resorts randomly sampled, 30, 15 in Pretoria, 11 in Johannesburg, and 4 in Sandton gave approval for the study. In addition, airline staffs and crew were also included in the study as most foreign tourists come through the airport into the country; hence it was inevitable to include the airport staffs and crew members in this study. The employees that their daily activities involve direct contact with tourists/guests/passengers, such as receptionists, waiters/waitresses, domestic workers and assistants, airline crew members and other entertainers, were randomly sampled through a self-administered 4-section questionnaire. This technically excludes the cooks and others whose routines are tailored by "rigid" protocol, away from tourist contact exposure. The respondents whose ages were below 15 or above 45 were also excluded from this study. In some hotels, the questionnaires were distributed to the employees during their lunch time at the canteen, some at the staff entrance during shift period, while in other places the questionnaires were left for the supervisor to effect the distribution and collection for about 3 days to a week. Of the over 650 questionnaires distributed, 531 were returned, 51 incomplete and 480 completed. Of the 480, 142 did not meet the selection criteria, due to age group or work did not involve direct contact with tourists, hence the sample size for this study was 338.

The study was granted ethical clearance from Medical Research and Ethics Committee (MR-EC) of the University of Limpopo, Medunsa Campus. The necessary authorities of the selected hotels approved the study and individual consent was sought from participants.

Measure

A questionnaire of four sections, measuring demography-10 items, HIV knowledge-19 items, sexual behaviour-15 items, and attitudes towards HIV/AIDS-15 items, totalling 59 items was used for the study.

Data Analysis

Six hundred and fifty (650) questionnaires were distributed across the study population and 531 were received back, giving a response rate of 81.7%. Out of 531, 51 were incomplete, 18 did not meet age criteria and 124 were also excluded as they did not have direct contact with tourists. Only 338 (63.7%) met the criteria for the study to be analyzed. The statistical package of Social Sciences (SPSS) software version 18.0 was used for data analysis, that is, descriptive statistics and Pearson correlation for variables of interest.

RESULTS

Demographic Information of Tourism Workers in Gauteng

The total number of participants was 338. Half (50.3%) of the participants were between the age group of 31-45 years, 52.1% were female, 47.9% single, 77.2% had a post-matriculation educational qualification and half (50%) were from the Black African population group. The majority of participants (74.6%) were permanently employed, followed by casual workers (19.8%) and contract workers (4.7%). A large proportion of the participants (44.7%) had been working in the leisure/tourism industry for more than 5 years (see Table 1).

HIV/AIDS Knowledge

The majority of the tourism workers (97.0%) were aware of the HIV/AIDS prevalence. Moreover, 92% indicated that HIV/AIDS has no cure yet, while 8% of the tourism workers believed that HIV/AIDS can be cured. Majority of the participants (94.7%) had knowledge about sexually transmitted infections (STIs), 87.3% knew the symptoms of STIs while 12.7% did not know any symptoms of STIs (see Table 2).

Table 1: Demographic characteristics of participants

Variables	N	Percentage
<i>Age (in years)</i>		
15-30	168	49.2
31-45	170	50.8
<i>Gender</i>		
Male	162	47.9
Female	178	52.1
<i>Marital Status</i>		
Single	162	47.9
Married	154	45.6
Separated/divorced, widow/er	12	3.6
Same sex partner	10	3.0
<i>Ethnicity</i>		
Black	169	50.0
White	80	23.7
Indian	20	5.9
Coloured/Others	69	20.4
Work Permanent	252	74.6
Contract	18	5.3
Casual	67	19.8
<i>Period at Work</i>		
6-12 months	68	20.1
> 1year	118	34.9
>5 years	151	44.7
<i>Closeness to Spouse</i>		
Stay together	111	32.8
Visit regularly	101	29.9
Seldom visit	72	21.3
Never visit	26	7.7
Not applicable/No response	27	7.9
<i>Distance Away From Spouse</i>		
Near (0-50km)	204	60.4
Far (50-100km)	89	26.3
Very far (>100km)	45	13.3
<i>Highest Educational Qualification</i>		
Primary	4	1.2
Secondary (Matric)	73	21.6
College/Technical	134	39.6
Graduate	104	30.8
Post graduate	23	6.8
<i>Monthly Income</i>		
R1,500-2,500	6	1.8
R2,501-3,500	27	8.0
R3,501-4,500	57	16.9
R4,501-5,500	43	12.7
R5,501-6,500	36	10.7
R6,501-7,500	49	14.5
>R7,500	120	35.5

Sexual Behaviour

Table 3 shows the sexual behaviour of the participants. It is indicated that only 60.4% of the participants had used a condom at their last casual sexual intercourse, 39.6 % had not used a condom. Most (81.1%) sought for prompt medical treatment of STIs while about 10.9% never sought for treatment of STIs. Moreover, tourists/guests made sexual advance/moves on 55% of participants, while 49.7% of the tourism work-

Table 2: The knowledge of the tourism workers about HIV/AIDS

Variables	True		False	
	<i>n</i>	%	<i>n</i>	%
Awareness of HIV/AIDS prevalence	328	97.0	10	3.0
HIV/AIDS has no cure yet	311	92.0	27	8.0
Knowledge of any STIs	320	94.7	18	5.3
HIV and STIs are mostly transmitted through unprotected sexual intercourse	321	95.0	17	5.0
Children may be born with HIV if their mothers have HIV	301	89.1	37	10.9
HIV can be contracted by using contaminated intravenous drug needles	309	91.4	29	8.6
HIV can be contracted during unprotected anal intercourse	295	87.3	43	12.7
HIV can be contracted by donating blood	265	78.4	73	21.6
HIV can be cured by having sexual intercourse with a virgin	71	21.0	267	79.0
HIV virus can be found in blood	263	77.8	75	22.2
Unprotected sexual intercourse with an infected person is risky to contract HIV	317	93.8	21	6.2
A person can be HIV positive and still feel healthy	338	100	0	0
Condoms help to protect against HIV	338	100	0	0
HIV/AIDS can be transmitted through casual sexual contact without condom	334	98.8	4	1.2
One can practice safe sex with HIV positive person	299	88.6	39	11.4
Male circumcision reduces the risk of contracting transmitting HIV/AIDS	192	56.8	146	43.2
Do you know any of the symptoms of any STIs	295	87.3	43	12.7

ers made sexual advances on tourists/guests, 46.2% had engaged once in sexual intercourse with only one tourist/guest and 31.4% had engaged in a sexual relationship more than once with more than one tourist/guest.

One quarter (25.5%) of the participants constituted a high risk group, having had three or more sexual partners in the past 6 months. Moreover, 37% of the participants involved in casual sex when they were pressurized financially and 10.3% indicated that they had engaged in casual

sex as compliments from tourists/guests. On substance use, 63% of the participants did not use any substance that is invariably risky to the transmission of HIV. However, 11.3 % were taking/using all the substances risky to HIV infection.

Attitudes towards HIV/AIDS and Persons Living With HIV/AIDS (PLWHA)

Table 4 represents the response of the study participants towards HIV/AIDS and PLWHA.

Table 3: The sexual behaviour of tourism workers

Variables	True		False	
	<i>n</i>	%	<i>n</i>	%
Used condom at last casual sexual intercourse	204	60.4	134	39.6
Seek for prompt treatment of STIs	274	81.1	64	18.9
Do you have regular contact with tourists/guests	338	100	0	0
Tourists/guests made sexual advance(s) to me	186	55.0	152	45.0
I had made sexual advance(s) on tourists/guest	168	49.7	166	49.1
I engaged once in sexual intercourse with only one tourist/guest	156	46.2	182	53.8
I engaged in sexual intercourse more than once with more than one tourists/guests.	106	31.4	232	68.6
I frequently change partners	87	25.8	251	74.2
I am always faithful to my partner	220	65.1	118	34.9

Table 4: The attitude of tourism workers towards HIV/AIDS

<i>Attitude questions/Statements</i>	<i>Responses (%)</i>				
	<i>Strongly agree</i>	<i>Agreed</i>	<i>Not sure</i>	<i>Disagree</i>	<i>Strongly disagree</i>
Tourism industry exposes its employees to high risk of HIV	15.1	32.2	28.4	16.6	7.7
HIV infected should be blame for their status	11.8	16.0	37.6	19.2	15.4
AIDS is from self destructive behaviours	7.7	32.0	19.8	28.4	12.1
HIV infected person can share eating utensils, bathroom and toilet facilities with other family members and colleagues	21.6	37.0	22.8	13.6	5.0
Making any physical contact with HIV infected person is high risk to contract HIV	12.7	26.0	27.5	10.7	23.1
HIV/AIDS infected people/staffs should be separated and not mix other staffs and customers/clients	7.7	12.4	22.2	35.5	22.2
HIV/AIDS infected staffs/employees should disclose their status	13.0	38.8	23.1	17.5	7.6
Body fluids found or perceived in some hotel materials such as beddings and spread are highly risky to HIV infection	32.5	31.7	20.1	12.4	3.3
Sharing seats, bed or room with HIV infected is risky to HIV	13.3	38.8	19.2	11.8	16.9
Discussing HIV/AIDS issues openly should be avoided because it is sensitive	10.9	39.9	21.3	11.5	16.4
HIV/AIDS education among colleagues, family members and health practitioners helps to educate people about the disease	39.6	42.6	13.0	1.8	3.0
Accepting and helping PLWHA is advisable	26.5	51.5	17.2	1.5	3.3
Declaring one's HIV status should be made compulsory for all tourism employees, tourists and guest.	13.3	45.0	21.9	14.5	5.3
Routine HIV test, awareness and education should be prioritize in tourism industry	21.6	39.9	21.9	13.0	3.6
If I get to know who infected me, I will sue him/her	45.6	37.9	12.1	2.6	1.8

Fifteen percent of the participants strongly agreed that tourism industry exposed them to high risk of HIV and 64.2% believed that body fluids found or perceived to be on some hotel materials such as beddings and spreads were highly risky to HIV infection. More than one in five (21.6%) of the participants strongly agreed to sharing eating utensils, bathroom and toilet facilities with HIV infected people while 5 % strongly disagreed to sharing the materials, 22.8% were not sure if they could share these materials when confronted with the situation and 37% agreed to share the eating utensils, bathroom and toilet facilities. Furthermore, 38.7 % agreed that making any physical contact with HIV-positive or AIDS infected individual is high risk to contract HIV. Almost one in ten (7.7%) participants strongly agreed that AIDS/HIV infected people should be separated and not mixed with other staffs and customers/clients. Almost half of the participants (45%) agreed that declaring one's HIV status should be made compulsory to all tourism employees, tourists and guests. Furthermore, 61.5% strongly agreed or agreed with prioritizing HIV routine test, awareness and education in the tourism industry.

Relationship between Age, Knowledge, Sexual Behaviours, Risky Behaviour and Attitude of Tourism Workers

Table 5 presents the correlation or association between some selected variables, the age, knowledge, sexual behaviour, risky behaviour and attitude of tourism workers about HIV/AIDS. The number of sexual partners and sexual activities practiced has significant relationship or association with all other variables. Moreover, age also had a significant relationship with all other variables, although from little to fair degree which is a perfect negative linear relationship, except one variable blame PLWHA that has a perfect positive linear relationship with variable age.

DISCUSSION

The study findings among tourism workers in Gauteng province in South Africa indicate medium level of HIV transmission knowledge. Most of the participants knew or got information about HIV/AIDS through all the necessary available media or network of information dissemination,

Table 5: The Pearson correlation coefficient of age, knowledge, risky behaviour, sexual practice and attitude of tourism workers

	1	2	3	4	5	6	7	8
1. Age	1							
2. HIV/AIDS awareness	-.141(**)	1						
3. Used condom at last casual sex	-.174(**)	.180(**)	1					
4. Substance use	-.025	-.101	.389(**)	1				
5. Number of sexual partners	-.134(*)	.142(**)	.467(**)	.633(**)	1			
7. Sexual activities practiced	-.169(**)	-.283(**)	.372(**)	.468(**)	.623(**)	1		
8. Blame PLWHA	.042	-.263(**)	-.106	.100	.084	.036	1	
9. Separate PLWHA	-.048	.056	-.106	-.059	-.121(*)	-.219(**)	.486(**)	1

** Correlation is significant at the 0.01 level (2-tailed).

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

while a sizable minority received information via little or few information network available to them especially in the rural areas. This findings were in accordance with the results and report of the studies that confirmed that quite often, HIV/AIDS awareness is low in districts and rural areas partly because of poor flow of HIV/AIDS information to the grassroots level in Africa (UNAIDS 2008). A number of participants also had misconceptions about HIV and AIDS such as believing in a cure of HIV/AIDS. In line with this finding, a study carried out in Africa reports that many Africa people incorrectly believed that AIDS can be cured while many even have the misconception that having sex with virgin could cure AIDS. The finding in the African study also discovered that 21% of the participants indicated/belief that HIV/AIDS can be cured (Burgoyne and Drummond 2008). Among tour guides in Turkey, some common misconceptions about HIV/AIDS were also found (Avcikurt et al. 2011) indicating the required need for additional training in the mechanisms of HIV transmission.

The study found high HIV risk behaviour; only 60.4% of the study participants had used a condom in the last casual sexual intercourse. Practices and behaviours that are risky to the transmission and contraction of HIV/AIDS which dominate tourism industry is casual sexual relationship. This study found that 49.7%, almost half of the study participants had made sexual advances or moves to tourists or guests while tourists/guests had also made sexual advances/moves to 55%, (over half) of the participants. From these figures, 46.2% of the participants had engaged once in sexual intercourse with only one tourist/guest while almost a quarter, 31.4% engaged more than once in sexual intercourse with more than one tourist/guest. Hence, this result confirms the belief of some authors that tourism sector is

associated with casual sex frequently unprotected to some extent (Clift and Grabowski 1997). Another study in Dominican Republic also confirmed sexual relation among hotel employees and also between those workers and foreign guests (Family Health International 2000). Among staff in the tourism industry and communities around tourist facilities in Malawi, Bisika (2009) also reported having casual sex without using condoms. Multiple sexual partners are believed to be one of the predisposing risk factors to HIV and STIs. The study found that 18% of the participants had/kept two sex partners in the past 6 months prior to this study, while 25.5%, over a quarter of the participants had kept three or more sex partners within 6 months prior to this study. A sizeable number also engaged in substance use in the context of sexual intercourse. This finding supports the belief that international travel in connection with drug use and prostitution can influence AIDS epidemic (Clift and Grabowski 1997). On the reasons why some of the participants engaged in casual sex, 37% indicated financial pressure as one of the reasons they engaged in casual sex and 10.3% engaged in casual as compliments to tourists/guests. Apart from the 37% that indicated direct financial pressure as reason to engaged in casual sex, other reasons too given have or are directly or indirectly related to financial pressure or gain, or might finally have resulted in financial gain to cater for one or two of the pressures outlined as a result of lack of or for monetary gain. The majority of the participants were poorly paid and could struggle to make ends meet or maintain their family, most especially if they are bread winners. This finding supports the report that salaries of the employees in tourism sectors are frequently too low to cover the cost of living. Thus, in particular, employees in the entertain-

ment sectors, room service additionally finance themselves and their families through sex with tourist (Clift and Grabowski 1997).

Almost half of the tourist workers (47.3%) agreed that the tourism industry exposes them to high risk of HIV. Furthermore, some attitudes and characters that promote stigmatization and ostracism were observed to exist among the study participants. Surprisingly, almost half (45%) of the participants agreed that declaring one's HIV status should be made compulsory to all tourism employees, tourists and guests, and over 60% of the participants responded positively or supporting the suggestion that HIV routine test, awareness and education should be prioritized. A very large proportion of the participants (82.2%) either strongly agreed or agreed that HIV education programme help to educate individual about AIDS. This can be ascribed to their willingness and readiness to improve their knowledge and awareness about HIV/AIDS. There is an urgent need for tourism and hospitality companies in Southern Africa to introduce HIV/AIDS educational programmes for their employees and to provide HIV/AIDS preventive measures like condoms to their workers at workplace (Ketshabile 2007, 2010).

CONCLUSION

The study found medium level of HIV transmission knowledge, high HIV risk behaviour (lack of condom use, casual and multiple sexual partners) and some poor HIV/AIDS attitudes among tourism workers in Gauteng Province in South Africa. The study confirms willingness to get educated and consequently comprehensive HIV prevention programmes are recommended for tourism workers.

RECOMMENDATIONS

Decrease risky environments for tourists and tourism workers by developing structural and environmental HIV prevention interventions through the promotion of inter-governmental departments and community collaborations. The tourism and environmental sectors and the Department of Health can jointly create health initiative that can help to promote needed HIV prevention programmes that will involve the grassroots between health services providers and

administrators, tourism sector stakeholders, policy makers and politicians.

Behavioural change, communication aimed at reducing high risk behaviour by promoting sex workers and their clients, tourism workers, and the population at large to negotiate for safer sex, use of condoms, early and effective treatment of STIs and reducing stigma and discrimination through increased access to behaviour change information.

Condom promotion and distribution aimed at providing an alternative protective mechanism for those populace and their clients or partners who cannot limit themselves to abstinence or faithful sexual partnership, and those commercial sex workers who cannot quit the trade through improved availability and accessibility of condoms. This program should be mandated to distribute both male and female condoms in the sex tourism "hot spots" and tourists' facilities such as beach hotels, villas, bandas, disco halls, airports, public toilets and work place, and massage parlours.

Tourism business operators/directors/executives should ensure that workers who interact directly with visitors/tourists/guests have a comprehensive knowledge of HIV/AIDS and if possible their salaries and wages should be improved and reviewed regularly.

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