Examining the policy climate for HIV prevention in the Caribbean tourism sector: a qualitative study of policy makers in the Dominican Republic

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Background The Caribbean has the highest prevalence rates of HIV/AIDS outside sub-Saharan Africa, and a broad literature suggests an ecological association between tourism areas and sexual vulnerability. Tourism employees have been shown to engage in high rates of sexual risk behaviours. Nevertheless, no large-scale or sustained HIV prevention interventions have been conducted within the tourism industry. Policy barriers and resources are under-studied.

Methods In order to identify the policy barriers and resources for HIV prevention in the tourism sector, our research used a participatory approach involving a multisectoral coalition of representatives from the tourism industry, government, public health and civil society in the Dominican Republic. We conducted 39 in-depth semi-structured interviews with policy makers throughout the country focusing on: prior experiences with HIV prevention policies and programmes in the tourism sector; barriers and resources for such policies and programmes; and future priorities and recommendations.

Results Findings suggest perceptions among policy makers of barriers related to the mobile nature of tourism employees; the lack of centralized funding; fear of the ‘image problem’ associated with HIV; and the lack of multisectoral policy dialogue and collaboration. Nevertheless, prior short-term experiences and changing attitudes among some private sector tourism representatives suggest emerging opportunities for policy change.

Conclusion We argue that the time is ripe for dialogue across the public–private divide in order to develop regulatory mechanisms, joint responsibilities and centralized funding sources to ensure a sustainable response to the HIV-tourism linkage. Policy priorities should focus on incorporating HIV prevention as a component of occupational health; reinforcing workers’ health care rights as guaranteed by existing law; using private sector tourism representatives who support HIV prevention as positive role models for national campaigns; and disseminating a notion of ‘investment’ in safer tourism environments as a means to positively influence tourist demand.

Keywords Caribbean, Dominican Republic, tourism, HIV/AIDS, public–private partnership
KEY MESSAGES

- HIV vulnerability in Caribbean tourism environments urgently needs policy development.
- There is a lack of applied policy research in this area; participatory research with policy makers in public and private sectors provides a basis for developing such an agenda.

Introduction

Throughout the Caribbean region, development efforts since the 1970s have supported a rapid expansion of tourism investment, which has led to the establishment of tourism as the primary industry for nearly every Caribbean nation (World Trade Organization 2001). The growth of tourism is exemplified by the Dominican Republic, which now receives the highest number of tourists in the region (Caribbean Tourism Organization 2009). In 2007, 3,398,374 tourists entered the Dominican Republic, primarily from the United States and Europe (Caribbean Tourism Organization 2009). For 2009, the World Travel and Tourism Council estimated that 546,000 Dominicans, or 13.8% of the employed population, are engaged in some form of tourism labour, and the industry accounts for 15.9% of the country’s GDP (World Travel and Tourism Council 2009).

The Caribbean HIV/AIDS epidemic has expanded in parallel with the tourism industry. The region shows the highest HIV prevalence rates outside sub-Saharan Africa, and approximately 2.4% of the adult population is currently HIV-infected (UNAIDS 2008). At least half a million people are estimated to be HIV-infected in the region, with nearly 200,000 in the Dominican Republic alone (Calleja et al. 2002; UNAIDS/WHO/PAHO 2003). Studies from a range of disciplines suggest a link between HIV risk and the ecological environments of tourism areas in the Caribbean (Padilla et al. 2010). While no epidemiological studies have identified precise mechanisms linking the industry to elevated risk, social science and behavioural research among a broad range of groups has suggested that persons employed in tourism areas are highly vulnerable to HIV infection. Studies among men who have sex with men (MSM) (De Moya et al. 1992; Ramah et al. 1992; Silvestre et al. 1994; De Moya and García 1996; Tabet et al. 1996; Padilla 2007a), female sex workers (De Moya et al. 1992; Kreniske 1997; Kerrigan et al. 2001; Kerrigan et al. 2003; Barrington et al. 2009) and hotel employees (CEPROSH 1997; Forsythe et al. 1998) have all found high rates of sexual risk behaviours with tourists. Anthropological studies have documented the strong preference among local tourism workers—including, but not limited to, formal sex workers—for transactions with tourists, who are often perceived as the most lucrative clients (Kempadoo 1999; Mullings 1999; Schwartz 1999; Padilla 2007b; Cabezas 2009). Ethnographers have also argued that tourism businesses often encourage sexual interactions between tourists and local employees, or facilitate contacts to ‘intermediaries’ who can fulfill tourists’ requests for sex or romance (Mullings 1999; Cabezas 2009).

While this literature provides ample justification for developing HIV prevention policies and programmes in tourism areas, HIV prevention initiatives have consistently neglected the tourism industry. Our review of the literature yielded no evidence of sustained efforts to address the tourism–HIV linkage through health policies at national or regional levels in the Caribbean. We believe that the ability to implement any HIV prevention interventions in the tourism sector first requires the development of research-based strategies to engage public health, civil society, and the private tourism sector in joint policy initiatives and dialogue.

While very few HIV prevention programmes or policies have been developed specifically for the tourism industry, donor funds provided by international health agencies such as USAID and the Global Fund to fight AIDS, tuberculosis and malaria have fostered a number of programmes to serve specific risk groups, such as female sex workers, youth and MSM. Some of these programmes, particularly those among female sex workers, have been shown to be effective in reducing risk behaviours among vulnerable groups, and serve as models for similar prevention programmes globally (Kerrigan et al. 2006). Nevertheless, these programmes have not sought to directly address the institutional, political, economic or industry practices of the tourism industry itself, which may be the primary factors influencing the sexual vulnerability of a growing proportion of the working poor.

As documented in our analysis, many policy makers and community members view this programmatic avoidance of the tourism industry as systematic and intentional, a view that is consistent with much of the global literature on HIV prevention within tourism environments. Prior analyses of HIV prevention in tourism-dependent countries have noted the tendency for the private sector to resist HIV prevention programmes within tourism areas because of the perception that tourists may find such programmes distasteful or avoid vacationing in nations that openly acknowledge a local HIV epidemic (Ford and Inman 1992; Lewis and Bailey 1992; Hawkes and Hart 1993; Ford et al. 1995; Forsythe et al. 1998; Forsythe 1999; Padilla et al. 2010). Nevertheless, most of these analyses lack an empirical analysis that aims to understand how key policy representatives from a range of sectors articulate their perspectives on HIV prevention in the tourism industry, the perceived barriers and resources for such initiatives, or their recommendations for action. This information is necessary as a step in building a roadmap for multisectoral policy strategies for scaling up HIV prevention as a key component of occupational health among tourism industry employees.

Our project sought to initiate health policy dialogue across this public–private divide and to provide empirical documentation of past attempts and future priorities for tourism-based HIV prevention in the Dominican Republic, the nation with the largest tourism industry in the Caribbean. Our project uses a participatory research approach that incorporates representatives from the public sector, civil society and the private tourism sector. Multisectoral coalitions have been shown to be effective in participatory health research addressing public health policy, and in leveraging broad-based structural or community-level change (Israel et al. 1998; Rhodes et al. 2006; Rhodes et al. 2006).
Methodology

Our research aims to examine how key actors in three distinct sectors (government/public health; private tourism industry; civil society) describe the barriers and resources for conducting HIV prevention programmes in the Dominican tourism sector, their past experiences with attempts at implementing such programmes, and priorities for future policies and programmes. For the purposes of our analysis, we define policy makers as any stakeholders from government, civil society or the private sector who occupy a leadership or decision-making role in relation to policies, programmes or regulations that could affect the conditions of health and well-being among tourism industry employees. Selection of participants began with a day-long professionally facilitated workshop in June 2008 to discuss the design, logistics and research questions with the full CAB. During the workshop, CAB members discussed the implementation of the policy study, logistics and the selection procedures for the in-depth interviews with sectoral representatives. The CAB decided to focus interviews on geographic regions in which the government had established significant investment in tourism infrastructure, including the South (cities of Barahona, Bani and Azua), the Distrito Nacional (the metropolitan area surrounding the capital city of Santo Domingo, including the neighbouring beach areas of Boca Chica and Juan Dolio), the East (La Romana and Punta Cana) and the North (Puerto Plata, Sosúa and Cabarete).

During the workshop, members discussed criteria for selection into the study. They determined that a list of key stakeholders should be created, and approached for recruitment, based on: (1) their experience working in the tourism sector; (2) their ability to influence decisions or policies in one or more of the targeted sectors; (3) their geographic location (emphasizing representation across the regions mentioned above); and (4) the diversity of perspectives and political backgrounds of participants. The group identified, discussed and vetted possible candidates collectively. Upon reaching consensus on a final list of 39 participants, we divided tasks for recruitment, such that CAB members with professional ties to a given participant were selected to approach him or her for recruitment into the study.

The targeted recruitment strategy used by the CAB maximized professional connections and relationships to targeted interviewees by designating a specific CAB member as primary recruiter for each participant.

Recruitment began immediately following the meeting, with recruiters contacting their assigned interviewees to summarize the purpose of the study and invite the individual to an in-person meeting for informed consent and interview. Upon acceptance of the meeting, appointments were made with each person by one of six trained interviewers, all members of the CAB. Using this technique, the CAB obtained universal acceptance of the interview and all 39 interviews were completed in June 2008. Table 1 shows the overall structure of the final interview sample, by institution represented, targeted sector, city or specific location, and province. While proper names are not disclosed, interviewees were informed via informed consent that their public positions may not allow for complete anonymity, as in the case of elected government officials.

Interpretation consisted of thematic analysis of narratives in response to a set of semi-structured interview questions designed to explore: (1) the context and scope of the interviewees’ current position; (2) prior experiences in HIV/AIDS prevention programmes, initiatives or research; (3) barriers and obstacles to HIV prevention in the tourism sector; (4) resources or facilities available to support HIV prevention in the tourism sector; (5) priorities for HIV prevention in the tourism sector; and (6) perceptions of the populations or groups most vulnerable to HIV infection in the tourism sectors. Interviews were audio-taped and transcribed. Transcripts were imported into the qualitative analysis software program Atlas-TI for coding. Coding was guided by both our pre-existing interest in the themes included in the interview guide and our concern with identifying emerging topics or issues not previously contemplated by the team. Analysis used a combination of open coding procedures with a sub-sample of interview transcripts, followed by a recoding of all transcripts using a fixed set of validated codebook definitions. Selected CAB members themselves conducted the coding, with training and support by the University of Michigan-based co-investigators, and participated in the interpretation of findings through three participatory analysis discussions held in 2008 and 2009.
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Results

Prior experiences with HIV/AIDS initiatives

Despite the lack of sustained HIV prevention programmes in the Dominican tourism sector, participants in the study described several prior experiences with small-scale HIV prevention efforts or initiatives over the last 20 years. These projects primarily consisted of short-term implementation of educational chats or workshops with tourism employees, as well as condom distribution campaigns. These prior experiences were particularly common on the north coast as a consequence of a short-term pilot programme supported by the United States Agency for International Development (USAID) to conduct educational programmes on HIV/AIDS with employees in certain tourist hotels, for which funding was discontinued in 1998 (CEPROSH 1997). One participant, who directed the USAID pilot programme, described the kinds of activities that were conducted in tourist hotels as follows:

“The project occurred entirely within the hotels. After getting approval from the hotel management, we would work exclusively with human resources, organizing quick educational sessions for employees without taking them out of work. We would talk for 15–20 minutes and then hand out condoms. It really had an impact.”

In the eastern region of the country, where the fastest-growing tourism zone is located, some participants described similar local or short-term attempts at HIV prevention with specific tourism businesses. A private sector representative of the Hotel Association of La Romana and Bayahibe, who had held a temporary position to develop tourism-based HIV prevention programmes, explained:

“My job was to develop a model for the tourism areas, with the idea that every hotel would have an internal policy about AIDS prevention. We wanted to ensure that workers who had HIV wouldn’t lose their job, [and] we also designed educational materials.”

This initiative also lasted less than a year, and then was discontinued.

While participants reported that these experiences had been somewhat successful during their duration, they highlighted several constraints on past programmes that prevented them from having a sustained impact. The primary constraint described was the transitory, migration-based nature of employment in the industry. Constant employee turnover was seen to greatly hinder the ability to incorporate employees into educational interventions involving repeated sessions or allowing follow-up with individuals over time. The continuous flux of employees inherent to the industry made it difficult to maintain a consistent level of HIV prevention services, or to reinforce prevention messages. As explained by the Director of the Asociación de Hoteles y Proyectos de la Zona Este (Association for Hotels and Projects in the Eastern Zone):

“In hotels and other tourism sites there is a constant rotation of employees, so you give a [health] talk today and in 1 or 2 months, you have an entirely new group of people to give the talk to.”

Similarly, the Director of Education at a Dominican NGO based in Santo Domingo noted:

“We see lots of internal migration because there is a demand for workers in the tourism zones and, obviously, there is very little employment opportunity in the communities from which the workers come. The men or women come alone and their family stays at home. This is a pattern that we see in all of the hotels.”

According to interviewees, most local HIV interventions failed to account for the extent of population mobility, which led to a situation in which the most mobile employees were the least addressed by prevention programmes. The lack of national prevention policies to ensure access to HIV prevention services in tourism areas further exacerbated this problem.

HIV prevention programmes within the tourism sector were further compromised by the fact that most funding for small-scale or local programmes had come from temporary grants to non-governmental organizations (NGOs); they were not financed centrally by either the government or tourism businesses themselves. As noted by the education director for an NGO that co-ordinated the only tourism-based HIV prevention initiative conducted on the north coast:

“[Funding] is the major problem . . . where work is done through agencies. They support you for a time, and then close down, and later there are no funds to provide follow-up.”

With no mechanism to ensure centralized investment, creating a sustained prevention programme with the capacity to reach a continuously changing vulnerable population proved to be nearly impossible.

Given this, several interviewees pointed to the need to diversify funding for HIV prevention initiatives, including support from the tourism industry and the Ministry of Health. Nevertheless, they stressed that each of these sectors tended to point to the other as the responsible party. The Director of Education at an HIV prevention NGO in Santo Domingo observed:

“The state doesn’t make a lot of money available to work in this sector. The state believes that the business sector should assume the costs, but the business sector is neither convinced nor willing to do it. So we are still in the middle of the battle.”

In describing his prior involvement in one of the only HIV prevention programmes among hotel employees, the programme manager from an NGO in Puerto Plata commented:

“We had a successful model. Why did it stop working? Because at a certain point, the [USAID] donors began to understand that the Dominican tourism sector should assume the costs of the education interventions and the money required for educators, to maintain a sustainable programme. They attempted to negotiate, to raise awareness in the tourism sector, but that was where the whole thing fell apart.”

Interviewees’ narratives about prior experiences with HIV prevention led many of them to more general discussions of
barriers to HIV prevention in the tourism sector, which were probed extensively by interviewers. The following section describes the primary themes that emerged.

**Barriers to HIV prevention in the tourism sector**

In discussing the challenges of implementing effective HIV interventions in the tourism sector, many interviewees pointed to the fact that managers and business owners within the hotel industry often fail to see HIV prevention as a business-related priority. This barrier was most often described by public health professionals or health educators with direct experience of conducting HIV/AIDS programmes in tourism environments. Participants expressed frustration with how difficult it can be to implement programmes when, as the assistant to the director of a regional hotel association in La Romana explained:

“Hotel owners see HIV as something that won’t affect them.”

The director of an NGO in La Romana expressed her frustration with managers when she joked:

“For me to give a [health] talk at one of the hotels, I have to have 25 000 meetings with the management, send 500 letters to the director, and when they give me the chance to give a talk at the hotel, only 2 or 3 people attend.”

She stressed that middle-level managers and supervisors who might reinforce the urgency of prevention programmes actually undercut their impact by behaving in either an indifferent or an explicitly obstructionist manner.

In discussing this obstructionist attitude toward HIV prevention programmes among some tourism managers, some participants noted the contradictory fact that many of these same individuals supported regular HIV testing among their employees, suggesting that they were, in fact, aware of the vulnerability of their employees to HIV infection. Several participants noted that many hotels conduct mandatory HIV-testing among their employees, who are subsequently terminated if results are positive. According to the manager of a luxury hotel in Puerto Plata, these tests are done “every 3 months and are used to make decisions about employees.” Despite the existence of a national law that forbids compulsory HIV testing of employees (El Congreso Nacional 1993), hotel and tourism managers invested the money and time required to test their employees for HIV, but routinely obstructed prevention activities. This demonstrates that it is not simply that management is unaware that HIV is a problem within the tourism sector; rather, they have not taken a prevention approach that would guarantee HIV prevention services as a component of the occupational health of its employees. None of the participants described any accountability for such practices or enforcement of the anti-discrimination law.

Another major obstacle mentioned by many participants provides an economic explanation for the desire to exclude HIV-positive persons from tourism businesses or areas. Interviewees commented that profitability dominated the logic of every programme or initiative within the industry, and HIV programmes were often seen as either a net loss or even a potential danger to the business. In an industry that relies upon providing pleasurable experiences, tourism businesses feared that the presumably negative perception that tourists would have toward HIV prevention programmes would negatively affect demand. As a private sector representative of a hotel association in Higuey explained:

“The tourism sector is like a crystal ball that can quickly shatter. If you talk about anything negative, we are afraid that levels of tourism will decrease.”

A member of a hotel association in Puerto Plata similarly noted:

“There was a belief [in the tourism industry] that when you talked about AIDS, the tourists would start leaving, and then the industry would go with them.”

Within the context of what has been called ‘romance tourism’—which many analysts describe as a fundamental characteristic of the Caribbean tourism industry (Pruitt and LaFont 1995; Kempadoo 1999; Brennan 2004; Cabezas 2009)—tourists’ perceptions of HIV risk might discourage the sexual escapism that they value and demand. As expressed by a representative of the national Tourism Secretariat:

“The tourist comes to enjoy, comes to visit; he or she does not come here to think about physical harm or contracting some type of disease.”

As a result of such resistance, many interviewees pointed to a general lack of multisectoral collaboration in HIV prevention that would link the tourism industry, the Dominican government and the public health sector. A public health official in the southern town of Barahona spoke of the absence of a national policy “from the top” that would co-ordinate with the hotel industry to take joint responsibility for prevention efforts:

“There needs to be coordination. It is vital that the tourism sector work directly with the health sector to create programming.”

Many participants echoed this perspective, arguing that policymakers from various sectors must work together to address a problem that cannot be addressed by the separation of public and private interests.

**Resources to address HIV prevention in the tourism sector**

While convincing tourism management to take a preventative approach to HIV was considered challenging, interviewees spoke of some successes and existing approaches that provide guideposts for the development of future health policies. The education director at an NGO explained a successful strategy to target tourism managers and supervisors through sensitization programmes as a first step to entry into the hotels:

“Our programmes started with educational sessions for the management. Until we did that, we wouldn’t take another step. The first goal was to make sure that the management was in agreement with what was going to be done, that they understood the objectives and were committed to the programme. When you’ve
achieved that, well, everything else within the hotel is much easier.”

The director of another NGO described a similar strategy, but one which sought to pressure the tourism industry by first lobbying the Hotel Workers’ Union. Since many individual hotel employees desired HIV prevention information, the strategy involved recruitment of employee change agents as unionized representatives of their interests. Then,

“the Hotel Workers’ Union did some lobbying to raise awareness among the directors of the hotels, so that they would provide resources. And later at the national level, they convinced hotel chains to support the project, not with a huge amount of resources, but they were able to get enough to facilitate travel to do the workshops, the talks, the interventions within the hotel industry.”

While this strategy did not lead to long-term programmes, the ability of the union to obtain private sector resources for HIV prevention suggests that persistent lobbying through such channels could be an important component of policies aiming to institutionalize HIV prevention programmes in the future.

Some tourism industry representatives expressed optimism about attitudinal shifts within the private sector which might lend themselves to new opportunities for cross-sectoral collaboration in HIV prevention. A former president of a hotel association in Puerto Plata commented:

“I think that in the current [tourism] associations, the people who are directing them are really open to this [HIV prevention programmes] and I think they have the maturity to understand that this is a problem that needs to be confronted, or it is only going to get worse.”

Echoing this perspective, the general manager at a large hotel in the north-coast town of Sosúa observed quite eloquently:

“If our business is in the community, all of the good and all of the bad that happens to the community is going to affect us. If it isn’t understood like this—well, we are lost.”

Referring to this community-based style of tourism leadership, some participants thus expressed optimism about the possibility of using such exemplary tourism industry representatives to leverage support for HIV prevention policies, a point to which we return in the conclusion.

Some of these exemplary tourism representatives also provided arguments that counter the stereotyped notions of the industry’s resistance to HIV prevention that tend to dominate the scholarly literature. For example, when asked whether an HIV prevention campaign might negatively affect the tourism industry, the former president of an association of hotels and resorts in Puerto Plata responded:

“A destination that is healthy, with a level of control over AIDS, is a destination where a tourist can come with a much lower level of risk. So obviously, you’ll see an increase in the number of tourists. And if more tourists come, your hotel will benefit. You need to view these two issues as related.”

This private sector representative inverted the dominant logic that HIV prevention efforts are damaging to the image of the industry. If tourists perceive such interventions not as an acknowledgement of an ‘AIDS problem’, but rather as the presence of safer environments for a relaxing vacation, HIV prevention can be reframed as an investment that yields greater industry profits. The education manager for a Dominican NGO also spoke of this type of positive publicity for the tourism industry:

“It is in their favour to have this type of work going on within their institutions…when you have a staff that is knowledgeable about this topic, then the employees will protect themselves, they will take care of themselves, and the image of the hotel will be better.”

In addition to the potentially positive results of HIV prevention programmes for tourism businesses, interviewees spoke of more direct economic benefits. The project developer for a Dominican NGO spoke of:

“the beneficial results that it could have for businesses, especially in terms of the costs that could eventually arise, not only related to HIV but to other sexually transmitted diseases. This would lead to absenteeism in work, which would lead to more costs for business.”

Another participant recalled the importance of speaking to the financial manager of a hotel during a previous hotel-based educational programme as a means of convincing him of the investment value of prevention:

“One of our team members would present calculations about the type of investment that would be required, that in fact it isn’t a cost, it is an investment. When you invest in HIV/AIDS prevention, it isn’t a cost. So we had to show examples of the cost–benefit economics so that they would understand…”

The programme manager from a different NGO similarly explained:

“If those who are running the hotels, the associations, decide to invest a few dollars per person in some sort of permanent employee education, it wouldn’t be a loss for them. They wouldn’t spend even half of what they have to spend now to cover the health costs of their employees or the amount of tests they have to do for their employees to see if they are infected.”

Finally, interviewees cited previously successful collaborations linking public health and private industry as a resource in fostering a multisectoral response to HIV/AIDS. In Higuey, a representative of the Hotel Workers’ Union described his local collaboration with the Presidential Council on AIDS (COPRESIDA):

“Our national federation has an agreement with COPRESIDA. We did a campaign for the migrant workers in the tourism centres, at the bus stops. As representatives of the workers, working with COPRESIDA, we promoted the importance of protection and education about HIV/AIDS.”
In La Romana and Bayahibe, the representative of a hotel association described similar collaborations in the popular tourism area of Punta Cana:

“In the case of the Punta Cana Group, we collaborated with the Secretary of Education. We trained teachers, who were then in charge of AIDS prevention education for all of the young people in their schools.”

While such examples involved institutional co-ordination on a local rather than national level, they provide valuable evidence that there are precedents for public–private linkages in HIV/AIDS upon which to draw in developing larger-scale initiatives. The fact that some private sector representatives spoke favourably about such collaborations demonstrates that the obstructionism experienced by some public health representatives is not universal in the tourism sector, and that some ‘positive deviants’ among tourism representatives might be useful as key change agents in fostering policy-level change within the industry.

Future priorities: a need for dialogue
While the barriers to sustained HIV interventions in the tourism sector are substantial, interviewees provided a number of resources that might be used to confront these barriers. Despite extensive previous experience with prevention programmes, interviewees seemed convinced that a long-term and effective strategy would not be possible without sustained commitment on the part of the tourism industry, with support and collaboration from civil society and government. Though attitudinal shifts among tourism managers and an emerging perspective on HIV prevention as an investment in employee health were noted, it was clear that high-level buy-in and collaboration across all three sectors were perceived as the most significant priorities for HIV prevention in the future.

In order to achieve this vision, some participants emphasized the need to create a sense of a shared societal commitment to HIV prevention at a national level. As a tourism industry representative at the hotel association in Higuey explained:

“The motivation to move forward should be shared. It is as much the responsibility of those of us who work in tourism, the upper-level management, as it is the upper-level management in the public sector.”

As a means of realizing this vision, participants emphasized the need to bring all sectors together in a process of policy dialogue and coalition-building to be led by the Ministry of Health. A civil society representative in the southern town of Barahona described this approach:

“There should be leadership within these institutions. The Ministry of Health should try to bring together institutions in order to create an effective campaign.”

The former director of the national HIV/STI programme echoed this sentiment:

“There needs to be a meeting of the different parties. On one side there is the tourism sector, both government and private business. On the other side there is COPRESIDA (Presidential Council on AIDS) and the Ministry of Health. We need to sit down at the same table and all speak a common language.”

As a first step in establishing such dialogue, several participants suggested beginning with consciousness-raising initiatives targeting each sector in order to build support for more intensive policy dialogue on HIV/AIDS. The director of an HIV support group in La Romana, for example, observed that the first priority is “to educate the government representatives and the hotel executives”. The programme manager at another NGO went further:

“I think that there are currently enough resources within the tourism sector and it is the right moment to re-introduce a proposal, one in which the tourism sector takes some responsibility.”

Once upper-level decision makers are on board, many interviewees were confident that meaningful dialogue and substantive policy initiatives could occur. This belief was supported by the positive examples of brief, but somewhat successful, local experiences in tourism-based HIV/AIDS programmes described in previous sections.

Conclusion
Despite strong suggestions of linkages between tourism and HIV vulnerability in the Caribbean, there are no examples of national or regional initiatives aimed at changing the policy climate of the tourism industry as a means of supporting HIV prevention among tourism workers. Our multisectoral coalition and interviews with policy makers in government, civil society and the private sector in the Dominican Republic strongly suggest that the time is ripe for large-scale policy dialogue and sectoral collaboration in HIV prevention in the tourism sector. Such initiatives are particularly critical due to the transient and highly mobile nature of the population, which may not be reached by intermittent, local, temporary, or ad hoc campaigns, and need to be addressed and financed systemically. On a positive note, a recent initiative by COPRESIDA, a technical advising body implementing and advising on HIV prevention policies, has begun conducting workshops and training with private sector representatives, engaging in the kind of dialogue and collaboration that we believe should be prioritized in a more systematic and sustained manner (Dr Luis Alberto Rodríguez Reyes, COPRESIDA, personal communication). If such initiatives prove to be effective in addressing the policy and programmatic concerns identified in our analysis, we advocate for further funding and political support for such public–private partnerships, and for broadening their focus as needed to address the structural barriers to health among tourism industry employees as a whole.

In this study, participants described many lessons learned from prior small-scale or temporary interventions that might serve to guide national or regional strategies. Prior experiences highlight the urgency of obtaining broad-based policy commitment; sharing responsibility for initiatives through public–private partnerships; overcoming the obstructionism of certain tourism managers and owners; reframing the cost and
productivity concerns of tourism representatives as an ‘investment’ in a positive image for the industry; and cultivating public–private collaborations to implement tourism-based interventions.

Despite the promise of such approaches, barriers to sustained prevention efforts continue to exist. These include concerns among tourism representatives about the negative publicity of recognizing a local HIV/AIDS problem; the paucity of funding for such initiatives; and the reluctance of tourism businesses to make joint financial commitments to HIV prevention. Finally, interviews documented troubling business practices involving the mandatory HIV testing of employees in certain tourism businesses, followed by dismissal of those testing HIV-positive. While such practices illustrate the concern among businesses about the linkage between HIV and tourism, they violate the anti-discrimination guarantees of the Dominican HIV/AIDS Law #55-93 and abdicate industry responsibility for protecting the health of their employees. Despite the illegality of HIV-related terminations, cases against violators are not routinely pursued by authorities, a fact that illustrates the lack of state-level regulation of the tourism industry and the reluctance among policy makers to make demands of this critical sector. While there are some indications from interviewees that the attitudes of tourism representatives toward HIV prevention programmes and their relationships with the public sector are improving, legal enforcement of workers’ health rights as protected under existing law should be a fundamental component of future policy dialogue and multisectoral collaboration.

We believe legal and regulatory mechanisms linking public and private sectors are vital to addressing HIV prevention as a joint obligation of both the state and the private sector to guarantee the health of tourism workers. As an initial step in this direction, government, civil society and the private sector should work together to establish contexts for dialogue and exchange by expanding from existing amenable partners—including many of the participants in the present study—to form a national health coalition. Prior successes with HIV prevention using unionized labour groups in the Dominican Republic suggest that this constituency may be a critical part of this coalition. To avoid industry resistance to the ‘image problem’ of HIV/AIDS, emphasis should be placed on the positive qualities of providing safer environments for both tourists and locals, and national sexual health campaigns should disseminate such constructive messages. The use of exemplary change agents—private sector representatives who articulate the benefits of HIV prevention for their businesses and clientele—should be used to invert the stereotyped logic that HIV prevention is a threat to the industry. Multisectoral health coalitions could then capitalize on such initiatives by emphasizing a positive reframing of HIV/AIDS prevention that includes sexual health within an occupational health framework promoting safer and more humane environments for all tourism workers. Such a vision would not only mitigate the risks of HIV infection among the growing population of tourism employees in the Caribbean, but would also provide a starting point for addressing some of the larger structural conditions that threaten the well-being of tourism workers more generally.

While our analysis emphasizes the need to integrate HIV-related services and prevention programmes as a fundamental health protection for tourism industry employees, we are also informed by a rights-based vision of health in which HIV/AIDS is only one vulnerability encountered by tourism industry employees. The regional social science literature on tourism and its local consequences has demonstrated the ways that the industry often functions to exacerbate social and economic inequalities, such as those related to gender, sexuality and race (Kempadoo 1999; Brennan 2004; Padilla 2007a; Padilla et al. 2008; Cabezas 2009). Within this broader context, HIV/AIDS is simply one of the vulnerabilities confronted by the growing population of tourism industry workers, who are often beholden to global forces and industry practices emanating from far beyond the nation’s borders. We therefore advocate for policy change around the occupational climate for HIV-related services in the tourism sector as only one urgent dimension of a broader vision of health that would address the larger social and structural conditions faced by the working population in tourism areas as a whole. Occupational or work-related approaches to HIV prevention will likely have limited impact on overall health and well-being if the broader conditions which individuals face are not acknowledged and addressed. The use of empirical research on the aggregate health-related vulnerabilities faced by tourism employees should inform broad-based policy advocacy aimed at ameliorating the fundamental causes that contribute to multiple health vulnerabilities. Given the pervasive influence of tourism on the social, political and economic structure of contemporary Caribbean societies, a broader vision of health rights among tourism industry workers is long overdue.

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