THE EFFECTS OF ALCOHOL AND DRUG ABUSE ON WORK PERFORMANCE OF EMPLOYEES IN SELECTED STAR RATED HOTELS AT THE KENYAN COAST.

BY

WINFRIDA MILLY A. AGUMBA (HND)
H60/11568/04

A Thesis Submitted in Partial Fulfilment of the Requirements for the Award of Master of Science Degree in Hospitality Management in the School of Hospitality and Tourism of Kenyatta University

JUNE 2011

DECLARATION

This thesis is my own work and has not been presented for the award of degree, diploma or any other certificate in any university.

Signature: ______________________________ Date: _______________

Winfrida Milly A. Agumba (HND; DHRM)

Department of Hospitality Management

School of Hospitality and Tourism Management

This thesis has been submitted with our approval as University supervisors.

1.Prof. Moni Wekesa
Ag. Dean
School of Law.
Mt.Kenya University
Signature: ______________________________ Date: _______________

2.Prof. Judith Waudo
Dean Graduate School and Senior Lecturer
Department of Foods, Nutrition and Dietetics

Kenyatta University.

Signature: ______________________________ Date: _______________

DEDICATION

To my family members for their love, care and understanding during the entire study period. 1 am indebted to my parents: Mr. Alloys Agumba Otiende and Mrs. Jael Aoko Otiende who taught me how to love, tolerate and appreciate alcohol and drug abusers. It is because for their moral support that my brother Michael Otieno - who is now a recovering alcohol addict and in a special way wish to dedicate this work to him. Ideally to some extent he enticed me to undertake this study.

To my Dad you sacrificed your time, resources and adequate literature relevant to this research; all these went a long way to make this work a success. Many a times I wished to give up but there you were uplifting me financially and spiritually. God Bless You Mightily.

ACKNOWLEDGEMENTS

First and foremost, I take this opportunity to express my gratitude to my employer, Laikipia University College (A Constituent College of Egerton University), for creating an enabling environment that facilitates career development of employees through off-the-job and on-the-job training. The employer has been supportive of my academic pursuits and for this reason I was able to successfully undertake the daunting task of balancing my time between academic studies and normal office work. A special tribute to my supervisors: Prof. Moni Wekesa and Prof. Judith Waudo. The two supervisors accorded me tireless assistance, guidance, criticisms and thoughtful comments that hugely contributed to the production of this thesis. I also acknowledge the efforts of my research assistants (Paul, Aaron and Dan) and above all the staff members and classmates at Department of Hospitality and Tourism Management at Kenyatta University, whose incisive observations and criticisms shaped my work. Unwavering gratitude to the respondents who took time off their busy schedules to attend to my research needs. Last but not least, special tribute goes to my family members for their support, moral encouragement and patience during the entire study period. To my siblings; Sister Mary (Texas, USA); Brothers Mike (Nakuru, Kenya), Justus (University of Johannesburg), Peter (Boston, USA), Anthony (Boston, USA); Sisters in Law- Hellen and Ann (Johannesburg - South Africa and Boston, USA respectively) and Cousins; Jectone, Phelistus, Aska and Carol. To Jane who has always been a friend indeed and to Rose my co-wife. Not forgetting my three lovely children: Maurice (Studying in USA- Springfield University and partial sponsor for my studies); Hedina and George and my nephew Mark (Lap Trust – Kenya) for uplifting my spirit whenever I felt demoralized. May the almighty God bless you all abundantly.

TABLE OF CONTENTS

DECLARATION ……. ………………………..……………………………ii

DEDICATION……………………………………………………………...iii

ACKNOWLEDGEMENTS…………………………………………………..iv

TABLE OF CONTENTS…………………………..…………………..v

LIST OF TABLES…………………………………………………..…x

ABBREVIATIONS AND ACRONYMS…………………………………...xiii

ABSTRACT………………………………..……………………………xiv

CHAPTER ONE…………………………………………………….…1

INTRODUCTION……………………………………………………..1

1.1 Background Information……………………………………………………1

1.2 Statement of the Problem……………………………………………………7

1.3 Objectives of the Study……………………………………………………...7

1.4 Null hypothesis…………………………………………………………...8

1.5 Significance of the Study……………………………………………………9

1.6 Scope of the Study…………………………………………………………..9

1.7 Limitations of the Study……………………………………………………10

1.8 Assumptions of the Study…………………………………………………11

1.9 Conceptual Framework……………………………………………………12

1.10 Operational Definitions of Terms……………………………………...14

CHAPTER TWO……………………………………………………..16

LITERATURE REVIEW………………………………………………16

2.1 Introduction……………………………………………………………...16

2.2 Concept of Drug/Substance Abuse……………………………………...16

2.3 Prevalence Rate of Alcohol and Drug Abuse……………………………...18
2.4 Workplace Drug/Substance Abuse……………………………………...22
2.5 Effects Of Drug Abuse in the Hospitality and Tourism Industry…………24
2.5. 1 Alcohol and Drug Abuse and Absenteeism in the Hospitality and Tourism Industry and Other Industries…………………………..….28
2.5.2 Drug Abuse and Accidents in the Hospitality and Tourism Industry and Other Industries……….………………………………..………. 30
2.5. 3 Drug Abuse and Level of Job Productivity in the Hospitality and Tourism Industry and Other Industries…..………………………..……32
2.6 Summary of Literature Review……………………………………………33
CHAPTER THREE………………………………………………………...35
RESEARCH METHODOLOGY……………………………………………35
3.1 Introduction………………………………………………………………..35
3.2 Research Design……………………………………………………………35
3.3 Location of the Study………………………………………………………36
3.4 Target Population of the Study……………………………………………39
3.5 Sample Size and Sampling Procedure……………………………………..39
3.5.1 Sample Size and Sampling Procedure for the Star Rated Hotels……..39
3.5.2 Sample Size and Sampling Procedure for the Hotel Employees……...41
(Operational Staff, Supervisory Staff)……………………………………41
3.6 Data Collection Instruments and Procedures………………………………45
3.6.1 In depth Interview Schedule…………………………………………..45
3.6.2 Focus Group Discussions (FGDs)……………………………………46
3.6.3 Self- Structured Questionnaire………………………………………..46
3.7 Validity of the instruments…………………………………………………48
3.8 Reliability of the Instruments………………………………………………48
3. 9 Data Collection Procedures and Ethical Considerations…………………49

3.10 Data Analysis and Presentation……………………………………….50

CHAPTER FOUR……………………………………………………………52

RESULTS AND DISCUSSION……………………………………………..**52**

4.1 Introduction……………………………………………………………..52

4.2 Demographic Characteristics of the Respondents in the Star - Rated……..53

Hotels……………………………………………………………………53

4.2.1 Age of the Hotel Employees………………………………………..53

4.2.2 Gender of of Employees in Star-Rated Hotels at the Kenyan Coast….54

4.2.3 Level of Education of Employees in Star-Rated Hotels at the Kenyan Coast……………………………………………………………………56

4.2.4 Marital Status and Religion of Employees in Star-Rated Hotels at the Kenyan Coast…………………………………………………………..57

4.2.5 Monthly Income of Employees in Star-Rated Hotels at the Kenyan Coast……………………………………………………………………57

4.2.6 Work Experience of Employees in Star-Rated Hotels at the Kenyan Coast……………………………………………………………………58

4.2.7 Demographic Characteristics of the Hotel Human Resource Managers………………………………………………………………58

4.3 The Extent of Drug Abuse among Employees in Selected Star-Rated Hotels (Prevalence Rate among Employees- Co- Workers Perception)……59

4.3.1 Co – Workers Awareness of Their Colleagues Abusing Alcohol and Other Drugs………………………………………………………………...60

4.3.2 Common Drugs Used by Employees in Selected Star-Rated Hotels….61

4.3.3 Employee’s Self Report of Alcohol and Drug Abuse…………………62

4.3. 4 Frequency of Drug Abuse amongst Employees in the Star Rated Hotels (Co – Worker’s Perception)…………………………………………………64

4.43.5. Gender of the Employees Mostly Using Drugs in Selected Star-Rated Hotels…………………………………………………………………..68

4.3. 6 The Departments with The Most Alcohol and Drug Users………….70

4. 4 Reasons for Using Drugs in Selected Star-Rated Hotels at the Kenyan Coast (Co – workers Perception)..72
4. 5 Effects of Alcohol and Drug Abuse on Behaviours/Moods of Employees.75
4.6 Drug Abuse and Absenteeism in Star-Rated Hotels at the Kenyan Coast...78
4.6. 1 Null-Hypothesis(Ho_1): Significant Relationship between Drug Abuse and Workplace Abesenteesim 82
4.6.2 Estimated Costs of Alcohol and Drug – Related Absenteeism In Selected Star- Rated Hotels at the Kenyan coast...............................83
4.6.3 Employees Self Report On Effects of Drug Abuse On Absenteeism In Selected Star- Rated Hotels at the Kenyan Coast.........................86
4. 7 Impact of Drug Abuse on Accidents in Selected Star-Rated Hotels at the Kenyan Coast...88
4.7. 1 Null-Hypothesis (Ho_2): Significant Relationship between Drug Abuse and Workplace Accidents..90
4.7.2. Estimated Costs of Alcohol and Drug – Related Accidents in Selected Star-Rated Hotels at the Kenyan Coast.....................................93
4.7. 3 Employee's Self Report of Effects of Drug Abuse on Accidents in Selected Star Rated Hotels at The Kenyan Coast. 94
4.8 Influence of Drug Abuse on the Level of Job Productivity in Star-Rated Hotels in Coast Province...97
4.8.1 Employees Self Report of Effects of Alcohol And Drug Abuse On Productivity...102
4.8.2.Null-Hypothesis (Ho_3): Significant Relationship between Drug Abuse and Job Productivity. 106
4.9 Organizational Regulations and Drug Abuse in Selected Star-Rated Hotels..106
4.9.1. Measures Taken by Hotels on Employees Abusing Drugs in Selected Star- Rated Hotels..109

4.9.2 NACADAA and Alcohol and Drug Abuse at the Workplace……….114
4.9.3 Suggested Mitigation Measures of Drug and Substance Abuse In The Selected Star Rated Hotels……………………………………………..114

CHAPTER FIVE……………………………………………………………117

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS……………117

5.1 Introduction……………………………………………………………117
5.2 Summary of the Major Research Findings………………………………118
5.3 Conclusions……………………………………………………………….119
5.4 Recommendations……………………………………………………...120
5.4.1 Suggestions for Further Research…………………………………...121

REFERENCES……………………………………………………………123

APPENDICES……………………………………………………………134

Appendix A: Employee Questionnaire……………………………………….134
Appendix B: In- depth Interview Schedule For Managers…………………...144
Appendix C: Employee Focus Group Discussion Guide…………………….149
Appendix D: Invitation To Focus Group Discussion…………………………154
Appendix E: Informed Consent Focus Group Discussion (FGD)……………155
Appendix F: Classification of Common Drugs and Substances……………...156
Appendix G: Definition of Assorted Drugs…………………………………..157
Appendix H: Summary of Characteristics of the Sampled Hotels and Respondents……………………………………………………………167
Appendix I: Map of the Study Area- Location of Star- Rated Hotels………170
Appendix J : Hotel Classification at The Kenyan Coast………….……….….171
Appendix K: Research Permit………………………………………………..176
Appendix L: Research Authorization Letter…………………..…….……...177

LIST OF TABLES

Table 1: Sampling Frame of the Selected Star Rated Hotels at the Kenyan

Coast……………………………………………………………………………41

Table 2: Distribution of Selected Star-Rated Hotels and the Employees at the Kenyan Coast (Sampling Fraction (sf)= 0.1047)………………………..……..44

Table 3 Age Categories of the Employees in Selected Star- Rated Hotels at The Kenyan Coast………………………………………………….……………….53

Table 4: Level of Education of Employees in Star-Rated Hotels at the Kenyan Coast……………………………………………………………………………56

Table 5 : Common Drugs Used by Employees in Selected Star-Rated Hotels at the Kenyan Coast ………………………………….…………………………61

4.4.3 Employee's Self Report of Alcohol and Drug Abuse in Selected Star-Rated Hotels at the Kenyan Coast……………………………………………………62

Figure 4: Individual Employees Self Report of Alcohol and Drug Abuse in

Selected Star- Rated Hotels at the Kenyan Coast………………………………..63

Table 6: Prevalence rate of Alcohol and Drug use- Employees Self Report…….68

in Selected Star-Rated Hotels at the Kenyan Coast ……………………………68

Table 7: Gender of the Employees Mostly Using Drugs in Selected Star-Rated Hotels at the Kenyan Coast ……………………………………………………69

Table 8: Reasons for Using Drugs in Selected Star-Rated Hotels at the…………72

Kenyan Coast – Co- workers opinions…………………………………………...72

Table 9: Common Moods and Behaviours among Employees Using Drugs…….75

Selected in Star-Rated Hotels at the Coast Province……………………………75

Table 10: Common Actions among Employees Using Drugs in Selected

Star-Rated Hotels at the Kenyan Coast……………………………………………..76

Table 11: Rating of Absenteeism among Employees Using Drugs in Selected Star- Rated Hotels in Coast Province……………………….……………………79

Table 12: Extent of Absenteeism due to Use of Drugs in Star-Rated Hotels…….81

Table 13: Absenteeism by Use of Drugs among Employees in Selected Star-…..82 Rated Hotels in the Kenyan Coast……………………………………………..82

Table 14: Employees Self Report of Effects of Alcohol and Drug Abuse on Absenteeism ……..……………………………………………………………87

Table 15: Rating of Accidents among Employees Using Drugs in Selected Star- Rated Hotels ……………………………………………………………89

Table 16: Frequency of Accidents among Employees due to Drug Use in Selected Star-Rated Hotels……………………………………………………….91

Table 17: Accidents by use of drugs among employees in Selected Star-Rated Hotels at the Kenyan Coast (Co- workers Perception)………...…………………92

Table 18: Employees Self Report Of Effects of Alcohol and Drug Abuse On Accidents . ……………………………………………………………………95

Table 19: Rating of Job Productivity among Employees in Selected Star-Rated Hotels at the Kenyan Coast ……………………………………………………98

Table 20: Job Productivity among Employees using Drugs in Selected Star-Rated Hotels at the Kenyan Coast……………………………………………….....102

Table 21: Employees Self Report of Effects Of Alcohol And Drug Abuse On Productivity ……..………………………………………………………103

Table 22: Measures Taken by Hotels on Employees Abusing Drugs in Selected Star- Rated Hotels ………………………………………………………………109

Table 23: Suggested Mitigation Measures to Curb Drug Abuse in Star-Rated Hotels…………………………………………...………………………………114

LIST OF FIGURES

Figure 1: Conceptual Framework: Effects of Alcohol and Drug Abuse on

Work Performance.……………………………………………………………….13

Figure 2:Map of the Study Area – Kenyan Coast Region ………………………38

Figure 3: Gender of the Employees in Selected Star-Rated Hotels at the Kenyan Coast……………………………………………………………………………56

Figure 4: Aware of Employees Using Drugs in the Selected Star-Rated Hotels at the Kenyan Coast.…………………………………………………………...61

Figure 5: Individual Employees Self Report of Alcohol and Drug Abuse in Selected

Star- Rated Hotels at the Kenyan Coast …………………………………………64

Figure 6: Prevalence rate of Alcohol and Drug use- Employees Self Report in

Selected Star- Rated Hotels at the Kenyan Coast ………… …………………….65

Figure 7: Frequency of Drug Use by Employees in Selected Star-Rated Hotels at

Coast Province ……………………………………………………………...66

Figure 8: Employees Self Report of Alcoholism and Drug Use in Selected

Star- Rated Hotels at the Kenyan Coast by Gender ……………………………..71

Figure 9: Rate of Employees Abusing Drugs by Department in the Star Rated

Hotel the Coastal Region Of Kenya ……………………………………………..72

Figure 10: Awareness of the Regulations on Drug Abuse in Star-Rated Hotels..108

Figure 11: Effectiveness of Regulations on Drug Abuse in Star-Rated Hotels...109

Figure 12: Basic Parts of A Poppy Plant Used to Produce Heroin……………..164

Figure 13: Farm with Poppy Plant ……………………………………..…165

LIST OF ABBREVIATIONS AND ACRONYMS

AUDIT	Alcohol Use Disorders Identification Test
CCOHS	Canadian Centre of Occupational Health and Safety Resource
CCSA	Canadian Centre on Substance Abuse
EAPs	Employee Assistance Programmes
FGD	Focus Group Discussion
FKE	Federation of Kenya Employers
HRMs	Human Resource Managers
ILO	International Labour Organization
KAHC	Kenya Association of Hotel keepers and Caterers
KUDHEIHA	Kenya Union of Domestic, Hotels, Educational Institutions, Hospitals and Allied Workers
NACADA	National Agency for the Campaign against Drug Abuse
NACADAA	National Agency for the Campaign against Drug Abuse Authority
NIDA	National Institute on Drug Abuse
OSHA	Occupational Safety and Health Act
PwCs	Pricewaterhouse Coopers
SPSS	Statistical Package for Social Sciences
ODDCP	The Office for Drug Control and Crime Prevention
UNODC	United Nations Office on Drug and Crime
WHO	World Health Organisation
WIBA	The Work Injury Benefits Act

ABSTRACT

Alcohol and Drug abuse at the workplace poses a great challenge to the growth and development of the hospitality and tourism industry in Kenya. Presently, about 200 million people or 5 per cent of the world's population aged 15 to 64 use drugs. In Kenya it is estimated that 5,835,007 of the youth population abuse drugs. This study sought to assess the effects of drug abuse on work performance of employees in selected star rated hotels at the Kenyan Coast. The objectives of this study were to determine the extent to which drug abuse influences: workplace absenteeism, accidents and the level of job productivity among employees in the hotels. The study adopted a descriptive survey design. A random sample of 373 employees and 25 managers was drawn from 25 randomly selected hotels. Primary data were collected using a questionnaire, interview schedule and Focus Group Discussion. Secondary data were collected from documented information to supplement the primary data. Data were processed and analyzed qualitatively and quantitatively. Quantitative analysis used descriptive and inferential statistics with the aid of a computer programme - Statistical Package for Social Sciences (SPSS) version 15. The study findings indicate that there was a significant relationship between the frequency of use of drugs and extent of absenteeism among employees ($\chi^2 = 28.00$, $p = 0.000 < 0.05$). Consequently, drug abuse - related absenteeism due to lost man hours and labour days costs the employers Ksh. 8,100,000 per year. There was also a significant relationship between the frequency of use of drugs and frequency of accidents among employees ($\chi^2 = 18.619$, $p = 0.001 < 0.05$). Forty point one percent respondents reported average accidents at the workplace as a result of alcohol and drug abuse. The results further revealed that the twenty five hotels spent Ksh. 1,250,000 on workman's compensation due to drug abuse -related accidents at the workplace per year. There was no significant relationship between the frequency of use of drugs and level of job productivity ($\chi^2 = 8.154$, $p = 0.086 > 0.05$). From the findings of this study, it is concluded that alcohol and drug abuse impact negatively on the hotel employees in terms of direct and indirect costs. In view of this, the study recommends that there is need for the hospitality and tourism industry in liaison with stakeholders to institute stringent policy mechanisms and capacity development programmes to curb alcohol and drug abuse among hotel employees.

CHAPTER ONE

INTRODUCTION

1.1 Background Information

The tourism and hospitality industry is an important tool for socio-economic development in Kenya (KNBS, 2007). The industry is by far the single largest source of foreign exchange (Beckerleg, 2002). It contributes to the growth of the Gross Domestic Product (GDP), raises the foreign exchange earnings, creates employment opportunities, and increases economic diversification by reducing over-dependency on the exportation of conventional raw materials (Omondi, 2003; Ondicho, 2000). All this is due to the fact that because the consumption of tourism products occurs at the place of production (the destination), it has, through forward and backward linkages with other sectors, potential multiplier effects (Crawley, 2000; Ondara, 2007).

Drawing heavily from various studies by Frone (2009), NACADA (2006 and 2007) and WHO (2004), a drug can be operationally defined as any chemical substance which when taken into the body can affect one or more of the body's functions. This includes those substances that are useful to the body and those that harm the body. Some are licit drugs i.e. their sales do not violate the law, while others are illicit i.e. their possession, sale, use or purchase is generally prohibited by law. Gmel and Rehm (2003); Moore *et al.,* (2009), and Sanjay

(2001) further distinguish drug abuse from substance abuse and conclude that; whereas drug abuse refers to the use of illegal drugs or the inappropriate use of legal drugs, substance abuse includes a wider range of abused chemicals.

Drug abuse adversely affects workplace performance in any industry. The effects can be felt in terms of real monetary costs from tardiness, sick days, turnover, insurance claims, and the hidden time costs associated with diverted managerial time, co-worker friction and most importantly, the reputation in the public eye (Bayer and Waverly, 2005; Frone, 2006 a). Operations at the workplace require alertness, accurate and quick reflexes. Frone (2006 b) and Ovunga and Madrama (2006) reiterates that any impairment adversely affects performance or safety at work and can cause serious accidents and interferences with accuracy and efficiency. Other effects include after-effects of drug use (hangover or withdrawal) affecting job performance; absenteeism, illness or reduced productivity; preoccupation with obtaining and using drugs, interfering with attention and concentration; illegal activities at work like peddling illicit drugs; and negative psychological effects (CCHOS, 2005; Frone, 2008; Institute Of Alcohol Studies, 2009 and Lehman and Bennet , 2002).

Several factors contribute to the increased use of drugs, alcohol, and substances at the work place (Frone, 2009 and Goodwin, 2004). These include; job related and occupational stress (Hodgin, 2009 and Ndirangu, 2004); socialisation,

leisure, and recreation purposes (Moore *et al.,* 2009); peer pressure, advertisement by media and experimentation (Lehmann and Bennet, 2002); alienation/ isolation (Imbosa, 2002), availability and accessibility of the drugs (Frone and Brown; 2010, Weisner *et al.,* 2005,), religious beliefs and practices (Shauri and Omondi, 2004), cultural attitudes (Ames, Curnadi, Moore and Stern, 2007, Saxena, 2003), unwanted pregnancies (Johnstone, 2000; Liska, 2004 and Von Hertzen, Piaggio and Ding, 2002) and weight management (Ichiro, 2009).

The International Labour Office (ILO, 2003) reiterates that the use of illegal drugs has spread at an unprecedented rate and has permeated every part of the globe. Globally, the United Nations Office of Drug and Crime (UNDOC) estimate that about 155 - 250 million people (3.5 to 5 per cent of the world's population aged 15 to 64 used illicit drugs in 2008 (UNODC, World Drug Report, 2010). Out of these, alcohol causes 1.8 million deaths annually worldwide while tobacco kills 49 million people every year (WHO, 2007). Of this, 55 per cent are men while 45per cent are women. A national research carried out in Columbia in 2003 by students of Columbia University, revealed that drug abuse is lower in women than in men (as cited by NACADA, 2006). Out of the 1,209,938 drug abuse cases reported 553,874 (45 per cent) were women while 656,064 (55 per cent) were men (as cited by NACADA, 2006).

Research shows that drug abuse negatively impact workplace performance. For example, in Costa Rica, 30 per cent of absenteeism and accidents were caused by alcohol dependency (Ames, Grube and Moore, 2000). Whereas drug abuse in France, is considered to cause 10 per cent to 20 per cent of accidents, in Australia, drug abusers were 2.7 times more likely to have injury-related absence than non-drug users (WHO, 2004). In Britain, 90 per cent of personnel directors blamed drug abuse for loss of productivity, health problems, absenteeism, unsafe employee relations, poor behaviour and negative company image. In the same country drug abuse contributes up to 25 per cent of accidents and around 60 per cent of fatal accidents (Hughes and Bellis, 2000). Rohman and Blum (2002) and Trapencieire (2000) estimated that alcohol reduces productivity by 10 per cent. On the overall, the largest economic direct and indirect costs often focus on four major issues: premature death/fatal accidents, injuries/accident rates, absenteeism/extra sick leave, and loss of production (Anderson and Larimer, 2002; Canada Centre for Occupational Health and Safety, 2005; Reinert and Allen, 2002 and Reingman and Gmel, 2001).

Drug abuse is therefore a pervasive problem in the tourism and hospitality industry (NACADAA, 2007; Moore *et al.,* 2009). The quality of service delivery and level of effectiveness, competitiveness, success and profitability in the industry depends on mannerism, perception and face to face interactions

between the clients and employees (Armstrong, 2003 and Johnston and Jones, 2004).

According to the Kenya Economic Survey (KNBS; 2009 and 2010) the total tourism revenues in Kenya increased from Ksh.27 million in 1970 to Ksh.62.5billion in 2009 surpassing earnings from tea and coffee. In addition to local tourists, the industry receives about 780,000 foreign visitors annually and provides over 250,000 direct and 550,000 indirect jobs (Crawley, *ibid*; CBS, 2006; Omondi, 2003; Ondara, *ibid*).

The industry is largely concentrated along the coastal beaches of Kenya, game reserves and national parks (Crawley, 2000). There are at least 238 star rated hotels categorized into: town, vacational, and lodges (Kenya Gazette, 2003 and 2004). Town hotels are situated in the major cities and towns, vacational or beach hotels are located away from towns, specifically along the Kenyan Coast, while lodges are concentrated in national parks and game reserves (Pepela, 2007). The importance of the Kenyan Coast as a key tourist destination is attributed to the fact that an estimated 150 km strip of coastline north and south of Mombasa - lined with beach hotels designed for package tours – receives over 60 per cent of international tourist arrivals and has more than a half of all tourism development in the country (Kibicho, 2003). However, the concentration along the Kenyan Coast has not only limited the benefits (and

costs) of the industry to a small area, but also leaves it vulnerable (Crawley, 2000). This is especially so given existing socio-economic problems and structural deficiencies affecting the industry (Akama and Kieti, 2007). One of the biggest socio-economic problems is drug trafficking, use and abuse (Beckerleg, 2002; Shauri and Omondi, 2004).

The Anti-Narcotic Unit of Kenya (2002 as cited by NACADA, 2003) indicates increasing drug trafficking and abuse over the years. The United Nations Office of Drug and Crime in its World Drug Report of 2010 (UNODC, 2010) ranked Kenya among the four most notorious African nations with drug problems, and the port of Mombasa as a major transit point. In Kenya, alcohol is the most abused drug with a national abuse rate of 36.3 per cent followed by nicotine (17.5per cent), C*annabis Sativa* - *Bangi* (9.9 per cent), heroin (8.0 per cent), *Catha edulis* - *Miraa* (2.7per cent) and cocaine at 2.2per cent (*Ndetei et al.,* 2004). In Kenya, the National Agency for the Campaign Against Drug Abuse (NACADA, 2004), estimates that of the youth population of 5,835,007, 60 per cent abuse drugs, mostly alcohol. The Global Youth Tobacco Survey (GYTS, 2001) adds that drug abuse is really entrenched in Kenya; the study revealed that over one million youths aged 10 – 24 years abuse tobacco. Out of these 13 per cent are primary school pupils. Notwithstanding, none of these local studies addressed the alcohol and drug abuse problem at the workplace.

However, whilst the importance of the industry is widely acknowledged, the impact of drug abuse on incidences of accidents, absenteeism and loss of production at the workplace, requires immediate research attention (ILO and OSHA, 2001 and WHO, 2004). Most of the available researches have concentrated in developed countries with little documentation in developing countries. Although the tourism and hospitality industry contributes about 10 per cent of Kenya's GDP no study has been done to evaluate the effects of drug abuse in this sector. This work seeks to seal this loophole.

1.2 Statement of the Problem

The negative effects of drug abuse at the workplace have been documented elsewhere. There is very little empirical and documented information in developing countries on drug abuse and work performance (ILO and OSHA, 2001; WHO, 2004; NACADAA, 2007). The success of the tourism and hospitality industry depends on mannerism, perception and face to face interactions between the employees and clients. Given the key role that tourism plays in the economy of Kenya, it is therefore imperative to assess the effects of drug abuse on workplace performance in this industry.

1.3 Objectives of the Study

This study sought to assess the effects of drug abuse on work performance amongst employees in the tourism and hospitality industry in Kenya using a

survey of star rated hotels at the Kenyan Coast. This broad objective was guided by the following specific objectives:

(i) To determine the extent to which drug abuse influence workplace absenteeism among employees in the star rated hotels.

(ii) To establish the impact of drug abuse on workplace accidents among employees in the star rated hotels.

(iii) To examine the influence of drug abuse on the level of productivity among employees in the star rated hotels.

1.4. Null Hypotheses:

The study sought to address the following null hypotheses:

(i) HO_1- There is no significant relationship between Drug abuse and alcoholism workplace absenteeism among employees in the star rated hotels at the Coastal region of Kenya.

(ii) HO_2 - There is no significant relationship between Drug abuse and alcoholism workplace accidents among employees in the star rated hotels at the Coast province of Kenya.

(iii) HO_3- There is no significant relationship between Drug abuse and alcoholism the level of productivity of employees in the star rated hotels at the Kenyan Coast.

1.5 Significance of the Study.

In order to consolidate the actual and potential benefits of the tourism and hospitality industry in Kenya, empirical and detailed studies are needed to establish the influence of drug abuse among employees in star- rated hotels various aspects of work performance. This is based on the premise that the quality of service delivery and level of effectiveness, competitiveness, success and profitability in the industry depends on mannerism, perception and face to face interactions between the employees and clients. This study is a contribution to knowledge in this field, more so the academicians. It will add information to literature and seal gap of knowledge and give suggestion for more researches. It provides information to concerned stakeholders/business owners, including the tourism and hospitality industry, the government, all other linked industries and the entire society, with an overview of the real situation of drug abuse in their respective organisations. It will also aid them in assessing the challenges posed by drug abuse to the growth of this vital sector. In addition it will be useful to the various stakeholders and business owners in future in terms of formulating alcohol and drug abuse policy and as such improve the level of productivity.

1.6 Scope of the Study

The study focused on assessing the effects of drug abuse on work performance in the tourism and hospitality industry in Kenya using a survey of star-rated hotels at the Kenyan coast. The Kenyan coast was chosen as a research site

because the coastal region is a key tourist destination receiving more than a half of international tourist arrivals and most tourism development in the country. The region was also considered to be vulnerable to drug abuse with the port of Mombasa being a major transit point for drug trafficking in Africa. The study area had 83 star-rated hotels with an estimated population of 11000 employees.

1.7 Limitations of the Study.

The study encountered a number of limitations which impeded supporting the null hypothesis. These limitations include:

i) Secrecy and criminality of drug abuse: Drug trafficking and use is considered a criminal offence in the country and thus conducted in secrecy. Therefore it was not easy to identify and target actual and potential drug abusers due to fear of criminalization and general stigma. However, the study adopted a more general approach to cases and incidences of drug abuse to simulate the actual picture. The researcher used the third respondent approach to overcome this i.e. the respondents were asked about their own behaviour on drug abuse and alcoholism and that of their co-workers.

ii) Sample size and generalization of the findings: Drug abuse is an issue that had permeated the entire country and affects many people.

Therefore, adequate assessment required a consideration of a large area or the entire tourism sector. However, due to various constraints, only a sample was viable, tenable and possible. Thus, a sample of purposively selected star-rated hotels at the Kenyan coast was involved in this study. The findings of this study were therefore confined to the sampled star-rated hotels at the Kenyan coast and should be used with caution when referring to all other tourist destinations in the country.

iii) There are many other factors that influence absenteeism, accidents and level of productivity (job performance) among employees at the workplace in addition to drug abuse. Collecting data on these other factors could have given a more holistic picture of their contributions to work performance. However, given the prevalence rate of drug use and abuse in the study area, this study limited itself to drug abuse and its effects on work performance.

1.8 Assumptions of the Study.

The study was carried out with the following assumptions in mind:

(i) Employees in the hospitality industry just like other Kenyans abused drugs.

(ii) Drug abusers in the hospitality industry experienced negative effects.

(iii) Drug abuse was responsible for workforce absenteeism, employee accidents and low productivity in the hospitality industry.

1.9 Conceptual Framework.

This study conceptualized that drug abuse (independent variable) influences work performance in terms of direct and indirect costs to the abuser and the industry (dependent variables). The main costs were accidents, absenteeism and loss of production. However, the actual effects of drug abuse depend on the influence of a number of extraneous variables. The extraneous variables influenced and determined the independent variables and were more likely to influence and determine the magnitude and direction of the dependent variables. The extraneous variables were controlled by building them into the study and studied alongside the independent and dependent variables. The above relationships are illustrated in Figure 1.

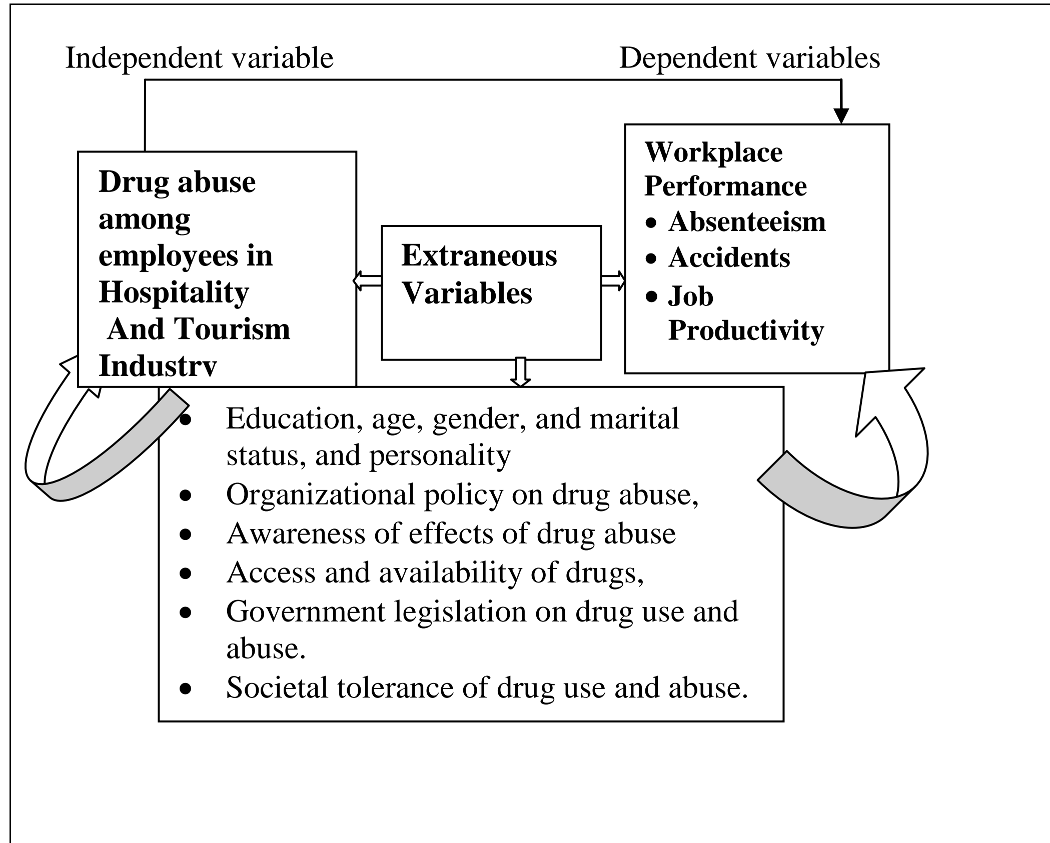


Figure 1: Conceptual Framework: Effects of Alcohol and Drug Abuse on Work Performance of Employees in Hospitality and Tourism Industry in Kenya.

1.10 Operational Definitions of Terms

The following operational definitions are presented as used in the context of this study.

Absenteeism: This refers to failure of employees to be at their place of work for directly or indirectly for avoidable reasons (drug abuse in this case) hospitality and tourism industry(Armstrong, 2003).

Addiction : Involves a compulsion to continue using the substance despite the negative consequences, and may or may not involve Chemical dependency in star- rated hotels (WHO,2004).

Alcohol and Drug Abuse: Refers to consumption of illegal drugs or unhealthy use of legal ones. Drug abuse will often lead to drug dependence (NACADA,2004).

Current Usage: Consumption of drugs in the last 30 days in the hospitality and tourism industry (Frone,2004).

Drug Dependence: A condition in which the abuser is no longer capable to stop using the drug even when the habit is causing serious damage to him or others in the hospitality and tourism Industry (Mosby's Medical, Nursing and Allied Health Dictionary, 2002).

Hotel/Hospitality Industry: This is a collection of businesses organization serving travellers away from home. They provide reception and entertainment and include restaurants, in star rated hotel(Akama, 2007).

Partial Factor Productivity (PFP): Focuses on specific inputs that can be easily identified for a peculiar situation for example serving a given number of customers, cleaning certain guest rooms to expected standards (Jones, P. and Siag, A. 2009).

Prevention: To stop something bad or harmful (e.g drug abuse) from happening or continuing to happen in star rated hotels (Rizzo,2001).

Productivity: The act of doing a role successfully and efficiently at the workplace without being absent, feigning sick leave; causing accidents; injuries and no wastage of resources in the hospitality and tourism industry(Atkinson and Brown, 2001).

Single Factor Productivity (SFP): This is the ratio of the output of one product X over the input resources for product X (Johnstone and Jones, 2004).

Workplace: A star- rated hotel that is classified into in one to five star hotels(International Labour Organisation,2003)

Workplace Policy: A document that provides guidelines on employer/ employee rights and responsibilities in the context of drug abuse in the hospitality and tourism industry (NACADAA,2009)

Total Factor Productivity (TFP) is the ratio of the total output of all products and services to the total resource inputs which can be disaggregated into separate product and service productivity (Johnstone and Jones, 2004).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the literature on the subject of alcohol and drug abuse and work performance in tourism and hospitality industry. The review discusses the concept of drug abuse, extent and nature of drug abuse, drug abuse at the workplace, effects of drug abuse on workplace absenteeism, accidents and job productivity in the tourism and hospitality industry.

2.2 Concept of Drug/Substance Abuse

Drug abuse, also known as substance abuse**,** has a wide range of definitions related to taking a psychoactive drug or performance-enhancing drug for a non-therapeutic or non-medical effect (Rehm, Taylor and Room, 2006 and NACADAA, 2009). In simple terms, Head, Stansfeld and Siegrist (2004) state that it refers to the overindulgence in and dependence of a drug or other chemical leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others. Several studies: Frone, 2006, Moore *et al*., 2009 and Ndetei *et al*.,(2004) have established that some of the most commonly abused drugs include alcohol, amphetamines, barbiturates, benzodiazepines, and opiates (codeine, hydrocodone, cigarettes, heroin, morphine etc) (Appendix F and G). Use of these drugs may lead to criminal

penalty in addition to possible physical, social, and psychological harm, both strongly depending on local jurisdiction (Mosby's Medical, Nursing and Allied Health Dictionary, 2002). Pham-Kanter (2001) adds that although legal substances such as alcohol and nicotine certainly can be and are abused, when we talk about drug abuse, we tend to think of two kinds of situations: use of illegal substances such as marijuana, cocaine, heroin and misuse of legal drugs such as, alcohol, cigarettes, prescription drugs or fumes from household products.

In such situations, even a small amount of an illegal or improperly consumed substance can alter how your brain works, and if you can't function normally under the influence of that substance, its use constitutes abuse (WHO, 2004). More dangerously, the short-term effects of the drug whether they involve euphoria, extra energy, sensory enhancement, or heightened performance - tend to become so alluring that the drug takes over the user's life, disrupting his or her relationships, work, and peace of mind (Shauri and Omondi, 2004).

Drug abuse may lead to addiction or dependence (Frone, 2003 and Substance Abuse and Mental Health Services Administration (SAMHSA), 2007) and Moore *et al.,* 2009). Medically, physiologic dependence requires the development of tolerance leading to withdrawal symptoms. Several studies (French *et al.,* 2001, Mohr, Charles and Truxillo, 2005 and WHO, 2004) have

attempted to distinguish, both abuse and dependence from addiction. On one hand they argue that addiction involves a compulsion to continue using the substance despite the negative consequences, and may or may not involve chemical dependency. However they indicate that dependence almost always implies abuse, but abuse can occur without dependence, particularly when an individual is a beginner. Dependence involves physiological processes while substance abuse reflects a complex interaction between the individual, the abused substance and society (Mosby's Medical, Nursing and Allied Health Dictionary, 2002).

2.3 Prevalence Rate of Alcohol and Drug Abuse in the Hospitality and Tourism industry.

Today drug and alcohol abuse at work affects all countries, regardless of their development, costing enterprises and companies' money and time and endangering workers and their colleagues (Valencia and Gomez, 2005). Moreover, the menace is a very widespread problem in society and addictive substance use rates are higher in labour force than in society as a whole. In fact studies by ILO (2003) and IAS (2009) affirm this statistics and reveal that generally in the world over 40 per cent - 70 per cent of the workforce abuse drugs and alcohol. Recent data show drug and alcohol use in the workforce in various countries as follows: USA 30 per cent (SAMSHA, 2007), UK (Smith et al., 2004) and Australia 50 per cent (ASCC, 2007). Further more the studies

established that though the problem cuts across all the industries, employees in the hospitality and services industry were largely affected.

Alcohol and drug use in the workplace have captured the interest of researchers, managers and policy makers (Frone, 2008). United States of America (USA) national data (Frone, 2006a) reveal that over a 12 - month period, workplace alcohol use and impairment was reported by an estimated 15.3 per cent of the U.S. workforce (19.2 million workers). Turning to illicit drugs U.S. national data (Frone, 2006 b) reveal that over a 12 - month period workplace illicit drug use and impairment was reported by an estimated 3.1per cent of the U.S. workforce (3.9 million workers) and working under the influence of illicit drugs was reported by 2.9 per cent (3.6 million workers) of the workforce. Frone (2006a and 2006 b) further revealed that the prevalence rate of male employees (28 per cent) who abused drugs was higher than that of the female employees (10.6 per cent).

Survey on drugs and substance abuse did not provoke much concern in Kenya probably until the early 1990s. This may have been as a result of the perception that drug abuse was not a major problem among Kenya's populace (NACADA, 2006). The World Health Organization (WHO) Global School-based Student Health Survey (GSHS) is a school based survey of students aged 13-15 years.

Apart from collecting data on health indicators the survey gathered data on tobacco, alcohol and other drug use. The 2003 Kenya GSHS had a total of 3691 students participating. About 14.6 per cent of the students admit drinking alcohol on one or more days in the past 30 days. The corresponding figure for cigarettes is roughly 13.9 per cent. Nearly 20per cent testify that they have drunk at least once in their life. About 13per cent admitted that they had used drugs such as bhang, "mushrooms", "speed", or "cloud 9" one or more times during their life. Notwithstanding these are the potential future employees in Kenya.

The abuse of drugs in Kenya is escalating rapidly from alcohol and cigarettes to the more dangerous drugs such as marijuana, cocaine and heroin among other drugs. In addition, there are marked changes in the demographic profile of users: women and youth are increasingly initiating use of drugs. According to the study of NACADAA (2007), 8 per cent of 10-14 year olds have used some alcohol at least once in their life and about 13 per cent of them have used other drugs or substances such as cigarettes. The same study found that close to 40 per cent of adults aged between 15 and 65 years have used one type of alcoholic beverage or another in their lifetime, with huge variations in the types and the rate of the consumption across regions, rural-urban residence, age, gender, education level, religion and economic status. At least 13 per cent of people

aged 15 to 65 from all provinces in Kenya except North Eastern are current consumers of alcohol.

The Coastal Region of Kenya is considered to be very much affected by drug abuse with the port of Mombasa being a major transit point for drug trafficking in Africa (Beckerleg, 2002, Crawley, 2000; Shauri, 2004). In 2009 alone, 192 cases of drugs involving 49 traffickers were handled by police in the Kenyan Coast. The most prominent one being that of suspects linked to five kilos of heroin worth Ksh. 10 million (Mugusia, 2009). According to the UNODC Report (2009) there are 20,000 heroin and cocaine addicts in the Coast province and between 100,000 and 1,300,000 in East Africa. There has been a remarkable upsurge of heroin and cocaine addicts at the Kenyan Coast from 10,000 in 2002 (Beckelerg, 2002) to the current 20,000 addicts, this for sure is a dangerous trend.

It is worth noting that a heroin addict needs Ksh. 600 a day to satisfy their dependency. This amounts to Ksh.12 million a day for heroin in the region. Studies further indicate that some of the drug users especially become addicts and would as such go to any extent to acquire the drugs. For instance users of narcotics in the community resort to exchanging blood commonly referred to as flashing blood (Mugusia, 2009). Simply put this is a cash saving technique where a user injects himself with heroine or other illicit substances and then

draws a syringe full of the drugged blood which he passes to a second user to inject himself. This is charged at Ksh.50 per dose. It is further estimated that Ksh.5million is spent on *miraa* daily and a further Sh.3million on *Cannabis Sativa (*Mugusia, *ibid*). This worrisome culture brings immense insecurity and poverty to the society and to the tourism industry at large and it is therefore critical that it is addressed urgently.

2.4 Drug Abuse in Hospitality and Tourism Industry and Other Industries

The issue of drug and alcoholism abuse at the workplace has traditionally been met by a dismissive attitude and often overlooked based more on moral precepts than a concern for the health issues involved (Gmel and Rehm, 2003). Yet, it is state that this is not a problem which can be isolated from the workplace. However, ILO (2003) reiterates that it is now more widely understood that drug/substance abuse is harmful at the workplace to both enterprises and workers. The Canadian Centre on Substance Abuse - CCSA (2006) defines workplace drug/substance abuse as the use of a potentially impairing drug or substance to the point that it adversely affects performance or safety at work, either directly through intoxication or hangover, or indirectly through social or health problems. According to the Canadian Centre for Occupational Health and Safety - CCOHS (2005), abuse can occur by using a substance too much, too often, for the wrong reasons, at the wrong time, or at the wrong place.

SAMHSA (2007) add that drug and alcoholism abuse is considered to occur when a drug is taken without medical reasons, or if a substance impairs or jeopardizes the health or safety of oneself or others. Hassan and Atinga(2005) indicate that some of the substances commonly abused drugs include alcohol, cocaine, marijuana, other illicit drugs, solvents, and misuse of prescription drugs or over-the-counter medications. Munne (2005) remarked that it was extremely regrettable that due to their affordability and accessibility, alcohol and cigarettes were most prevalent.

CCSA (2006): Adlaf, Begin, and Sawka (2005); CCOHS (2005) observe that the abuse of drugs and substances may affect the workplace just as the workplace may affect substance abuse. Many aspects of the workplace today require alertness, and accurate and quick reflexes. Any impairment to these qualities can cause serious accidents, and interfere with the accuracy and efficiency of work. Other ways that drug/substance abuse can cause problems at work include:

(i) After-effects of substance use (hangover, withdrawal) affecting job performance
(ii) Absenteeism, illness, and/or reduced productivity
(iii) Preoccupation with obtaining and using substances while at work, interfering with attention and concentration
(iv) Illegal activities at work including selling illicit drugs to other employees,

(v) Psychological or stress-related effects due to substance abuse by a family member, friend or co-worker that affects another person's job performance.

Employees in the hospitality industry are notably heavy users of alcohol (Moore *et al.,* 2009). In fact a nationwide survey conducted in USA indicates that their rates of heavy drinking are among the highest of any occupation (15.2per cent v/s an average of 8.8per cent). The study by Moore, Cunradi, Duke and Ames (2009), analysed dimensions and correlates of problem drinking among young adult food service workers. A telephone survey of National Restaurant chain employees yielded 1,294 completed surveys. Hazardous alcohol consumption were seen in 80per cent of the men and 64per cent of the women. Multivariate analysis showed that different dimensions of problem drinking were associated with the workers demographic characteristics, smoking behaviour and job category. The Hospitality and Tourism industry in Kenya is no exception and therefore the researcher attempts to establish the effects of drug abuse on employees.

2.5 Effects of Drug Abuse in the Hospitality and Tourism Industry and Other Industries.

According to CCSA (2006) and CCOHS (2005), often employees in the Hospitality and Tourism Industry will receive initial benefits from using drugs

such as feeling socially connected, helping them unwind after work or enable them to work longer hours. With such contributing factors, employees begin to use drugs as a way of coping with feelings of exhaustion, boredom, loneliness and isolation. Drug use, initially "enjoyed" with friends or co-workers on a recreational level, becomes increasingly an activity performed alone as a way of coping expresses Kavanaugh and Ninemeir (2001). As it progresses, an employee will have great difficulty keeping it a secret. Studies undertaken by Saxena, (2003) and NACADAA (2007) further established that as a result, relationships at home and work begin to suffer, more money is spent on it and less time is spent at workplace. According to studies by Rehm, Taylor and Room (2006) and WHO (2004) lack of self-care increasingly leads to illness. As a way of coping with such consequences, the drug abuser will reach out for greater amounts of alcohol and drugs and sink further into a pattern of self-destruction.

Once drug abuse develops into a chronic condition, it becomes an addiction which has no cure (Shauri and Omondi, 2004). With treatment, Pham- Kanter (2001) and UNODC (2010) established that the disease can be managed so that a healthy and productive life is possible. Like many chronic conditions, people that have problems with drugs or alcohol do not choose to become addicts or alcoholics. Instead, a combination of genetics, behaviour, emotional stress, and an individual's environment contribute to the development of addiction (Gmel

and Rehm , 2003 and SAMHSA, 2007). They continue to expound that one of the most peculiar aspects of drug and substance abuse is that those affected have great difficulty identifying drugs or alcohol use as the source of their problems, they are hugely in denial. They will blame their spouse, their boss or their circumstances; minimize the impact of drugs or alcohol; or underestimate the amount being consumed. Individuals who abuse drugs or alcohol often fail to notice when the harm caused by substances starts to outweigh the benefits.

CCOHS (2005) observe that the impacts of drug abuse in any workplace especially have been difficult to measure. Many costs are hidden by general absenteeism or illnesses, "unnoticed" lack of productivity, or inability to link drug abuse directly with causes of accidents. Silva *et al*., (2003) in their study amongst 550 industrial workers in Goa, India revealed that drug abuse in the workplace not only affects work performance in general, but also results in higher rates of absenteeism, accidents, illness and mortality, with all their related.

Frone, 2004 argued that abusers are less productive than non-abusers, miss work more often and are much more likely to file worker's compensation claims. According to studies by Bennet, Patterson, Reynolds, Wiitala and Lehman (2004) and WHO (2004) on drug abuse and health promotion, abusers are likely to have health problems that affect their performance, and also lead to

personal problems, distracting them from their jobs. It is therefore an important health and safety issue. CCOHS (2005) observes that over the recent years, studies have shown that:

(i) Absenteeism is two to three times higher for drug and alcohol users than for other employees;

(ii) Employees with chemical dependency problems may claim three times as many sickness benefits and file five times as many workers' compensation claims;

(iii) In many workplaces, 20 to 25 per cent of accidents at work involve intoxicated people injuring themselves and innocent victims;

(iv) On-the-job supplies of drugs and alcohol account for 15 to 30 per cent of all accidents at work.

In general, the economic cost of drug abuse to an economy is high. For example, economic cost in America ranged from $ 60 to $145 million annually (Ames *et al*., 2007), in the United Kingdom it was £6.4 billion (Prime Ministers Strategy Unit, 2003), while in Canada it was more than $18.4 billion in 1992 (CCOHS, 2005). The largest economic costs are for: people missing work because of accidents, disease, people dying, direct health care, police and other types of law enforcement. As such, costs to a business may be both direct and indirect. The impact of substance abuse that has been reported often focus on four major issues: premature death/fatal accidents, injuries/accident rates, absenteeism/extra sick leave, and loss of production. Other additional costs can

include: tardiness/sleeping on the job, theft, poor decision making, loss of efficiency, lower morale of co-workers, trouble with co-workers or tasks, higher turnover, training of new employees, disciplinary procedures, drug testing programmes, medical, rehabilitation and Employee Assistance Programmes (Kirk and Brown, 2003 and Roman and Blum, 2002).

Various studies have demonstrated the effects of drug abuse on work performance in many industries. A summary of some of the previous studies on drug abuse and its effects on work performance, especially absenteeism, accidents and productivity have been discussed below.

2.5. 1 Alcohol and Drug Abuse and Absenteeism in the Hospitality and Tourism Industry and Other Industries.

Many studies have linked workplace absenteeism to background and socio-demographic (Anderson and Larimer, 2002; Miller, 2003); mood and working environment (Bacharach, Bamberger and Biron 2009: Lehman and Bennet, 2002); absence culture (Armstrong, 2003) and economic conditions (Zhang and Snizek, 2003). However, recently several investigations have explored the association between workplace absenteeism and drug abuse (Mohr *et al*., 2005 and Frone, 2009). In general, these studies have found that increased drug use is associated with increased absenteeism.

For instance, Roche and Pidd (2006) conducted a national study to examine the relationship between Australian workers' patterns of alcohol consumption and absenteeism. A total of 13, 582 employees participated in the study and gave self reports of absenteeism due to alcoholism. It was found that more than 40per cent of the Australian workforce abused alcohol. The study established that drug users were 22 times more likely to be absent from work compared to non – users. However, alcohol – related absenteeism is not restricted to small numbers of chronic heavy drinkers, but also involves the much larger number of risky non – dependant drinkers who drink less frequently at risky levels. Another study by Smith *et al*., (2004) on effects of drugs and alcohol in the European workplace established that more than half of the sample were absent from work, and two out of the five organisations had dismissed employees due to absenteeism related to drug abuse. Drug use had a statistically significant relationship with overall absenteeism.

French *et al.,* (2001) analysed the direct impact of substance abuse on the number of days that an employee was absent from work (full absenteeism) and the number of days that an employee either reported late or left early from work (partial absenteeism). The results indicate that smoking, drinking and illicit drug use was significantly related to partial and full absenteeism. The same findings were also found by McFarlin and Fals-Stewart (2002) in a study to examine the day-to-day relationship between alcohol use and workplace

absenteeism. It established a significant relationship between alcohol use and workplace absences. Workers were roughly two times more likely to be absent from work a day after alcohol was consumed.

Locally, Aden *et al*., (2006) carried out a study to describe the socio-economic effects of Miraa chewing in Ijara District in the North Eastern Province of Kenya. The study established that 40per cent of the respondents blamed *Miraa* for low productivity and inefficiency at work and 32per cent for absenteeism. However, forty four percent indicated that Miraa use was socially acceptable and commonly used by workers on night duties and students to keep them alert.

The above studies indicate that drug abuse influence absenteeism at the workplace. However, most of them were conducted in developed countries and did not directly focus on a sensitive industry such as tourism and hospitality. This study will delve into the Kenyan case by focusing on the hotel industry.

2.5.2 Drug Abuse and Accidents in the Hospitality and Tourism Industry and Other Industries.

Drug abuse is a major cause of accidents and injuries in the work place (Armstrong, 2003, ILO, 2003, Kavanaugh *et al*., 2001, Mohr *et al*., 2005, Spicer, Miller and Smith, 2003). For instance, Frone (2004) carried out a study to establish the effects of drugs on workplace safety outcomes. The results

indicated that after controlling for demographic, personality, employment and health characteristics, on-the-job drug use was positively related to work injuries. Other significant predictors of work injuries established were gender, negative affectivity, job tenure, physical hazards, excessive workload, job boredom and poor physical health.

Wickizer *et al*., (2004) evaluated the effect of a publicly sponsored drug-free workplace programme on reducing the risk of occupational injuries. The study established that the drug-free workplace intervention was associated with a statistically significant decrease in injury rates. A study by Watt *et al.* (2005) sought to quantify the relationship between acute alcohol consumption and type of injury, while adjusting for the effect of known confounders (i.e. demographic and situational variables, usual drinking patterns, substance use and risk-taking behaviour). Acute alcohol consumption was measured as drinking setting, quantity, and beverage type consumed in the six hours prior to injury. Type of injury were assessed as nature of injury (fracture/dislocation, superficial, internal and CNS injury) and body part injured (head/neck, facial, chest, abdominal, external and extremities). The study indicated that there was no significant association between any of the three measures of acute alcohol consumption and injury type.

In a local study, Hassan *et al*., (2005) sought to determine the extent and pattern of alcohol use in patients admitted in Kenyatta National Hospital - Nairobi following road traffic accidents. The alcohol-use group of 94.4 per cent registered higher weekend injuries than the no-alcohol-use group of 83.2 per cent. Ultimately the study concluded that a link exists between impairment by alcohol and the risk of road crash as well as the severity of injuries that result from the crash. These results confirm the associative role of drug abuse in accidents in both developing and established economies. Interventions aimed at reducing the incidence of alcohol-related injury should not be targeted at specific injury types. More studies on drug abuse and injuries are needed in Kenya.

2.5. 3 Drug Abuse and Level of Job Productivity in the Hospitality and Tourism Industry and Other Industries.

As indicated earlier, the ultimate effects of drug abuse on various aspects of workplace conditions are reflected in the level of productivity demonstrated by job performance (Frone, 2010 and Lehman and Bennet, 2002). From several researches, it has become increasingly evident that workplace problems are more associated with drug abuse (ILO, 2003, Hodgins *et al.,* 2009).

Drug abuse directly affects productivity at the workplace and studies indicate that even consumption of fairly low quantities of drugs can lead to a relatively

high loss in the level of performance (CCHOS, 2005, Rizzo, 2001 and Roche and Pidd, 2007). Pryce (2008) adds that drug abusers are less productive, miss work more often and are much more likely to file worker's compensation claims. Further, they are likely to have health problems that affect their performance which in turn lead to personal problems and distract them from their jobs. Hughes and Bellis (2000) established that drug abuse in Britain had led to a loss in job productivity in addition to health problems, absenteeism, accidents, unsafe employee relations, poor behaviour and negative company image. Trapencieire (2000) estimated that alcohol reduces job productivity by 10 per cent.

In sum, drug abuse is prevalent and a major contributory factor to absenteeism, accidents, health problems, theft, lower productivity and job loss. For workers, it can result in deteriorating health, injury, disciplinary action, family problems, job loss, and therefore poverty and social deprivation. For employers, it leads to safety problems affecting the enterprise, the workforce and the public at large, and it gives rise to increased costs, lower productivity, comprised quality service and loss of competitive edge (CCOHS, 2005: Parusaman, 2002).

2.6 Summary of Literature Review

The reviewed literature indicates that substance abuse is escalating amongst employees. There has been comparatively little research performed in Kenya on

identifying the patterns and effects of alcohol and drug abuse on the workforce and particularly in the tourism and hospitality industry. Evidently, this disturbing development is a real challenge to the Human Resource Managers and cannot be ignored. Arresting the problem would be in tandem with the new initiatives undertaken by both public and corporate firms in Kenya, whose target is to identify strategies to improve performance. In addition to drug abuse there are many other factors (age, education, family problems, work environment etc.) that influence absenteeism, accidents and level of job productivity among employees at the workplace, however, this study limited itself to drug abuse and work performance in the hospitality industry in the Kenya scenario. Fundamentally, this does not mean that the other factors are not relevant.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodological procedures that were used in data collection and analysis. The discussion include the research design, location of the study, population of the study, sampling procedure and sample size, instruments, data collection and data analysis.

3.2 Research Design

This study adopted a descriptive survey research design. This design involved the selection of a sample of respondents and administering questionnaires or conducting interviews to gather information on variables of interest (Kothari, 2005). Information in this case is collected from respondents about their experiences and opinions in order to generalize the findings to the population that the sample is intended to represent (Kasomo, 2006 and Nachiamas and Nachamias, 2005). The main characteristic of this method is that the researcher has no control over the variables, hence one is able to report what has happened or what is happening (Kothari, *ibid*). This research design is preferred to experimental design because the cause-and-effect relationships to be explored in this study do not permit manipulation of the variables (Mugenda and Mugenda, 2003 and Orodho, 2009). Simply put the researcher is able to discover causes

even when they cannot control the variables. This design was therefore adopted in this study because the cause, i.e. the independent variable (drug abuse), which is assumed to be taking place among the employees in hospitality the and tourism industry, can be studied after it has exerted effect on the dependent variable (work performance). The researcher then proceeded to study the independent variable in retrospect for its possible relationship to, and its effects on, the dependent variable.

In addition, this design is the most appropriate for obtaining factual and attitudinal information for null hypothesis about self-reported beliefs, opinion, characteristics and present or past behaviours (David and Sutton, 2004, Gray, 2004, Neuman, 2000). The survey allowed exposing respondents to a set of similar questions to allow for comparison. It was assumed that all the respondents had information or experience that bears on the problem being investigated (drug abuse and work performance).

3.3 Location of the Study

The study was conducted in selected star-rated hotels at the Kenyan Coast. The coastal region comprises of eleven districts namely: Mombasa; Malindi; Kilindini; Msambweni; Kilifi; Kaloleni; Kwale; Kinango and Taita Taveta. (Kenya Gazette, 2009) (Appendix 1). Irrespective of this, the study only embarked on only nine of them thus Kilindini and Kilifi districts were not

studied. This area was chosen because apart from the population here being cosmopolitan, it has eighty three (34 per cent) out of the two hundred and thirty eight (238) star rated hotels in the country (Kenya Gazette 2003 and 2004). In addition, the star-rated hotels at the Kenyan coast are chosen as a research site because the region is a key tourist destination receiving more than a half of international tourist arrivals and has 50 per cent of all the tourism development in the country. The coastal region has a total of 18,437 beds whose occupancy almost doubled from 1,634.7 thousands in 2008 to 3,011.4 thousands in 2009 (KNBS, 2010). It is also considered to be highly affected by drug abuse with the port of Mombasa being a major transit point for drug trafficking in Africa (Ndetei *et al.,* 2004; UNODC, 2010). The study area has been illustrated in figure 2.

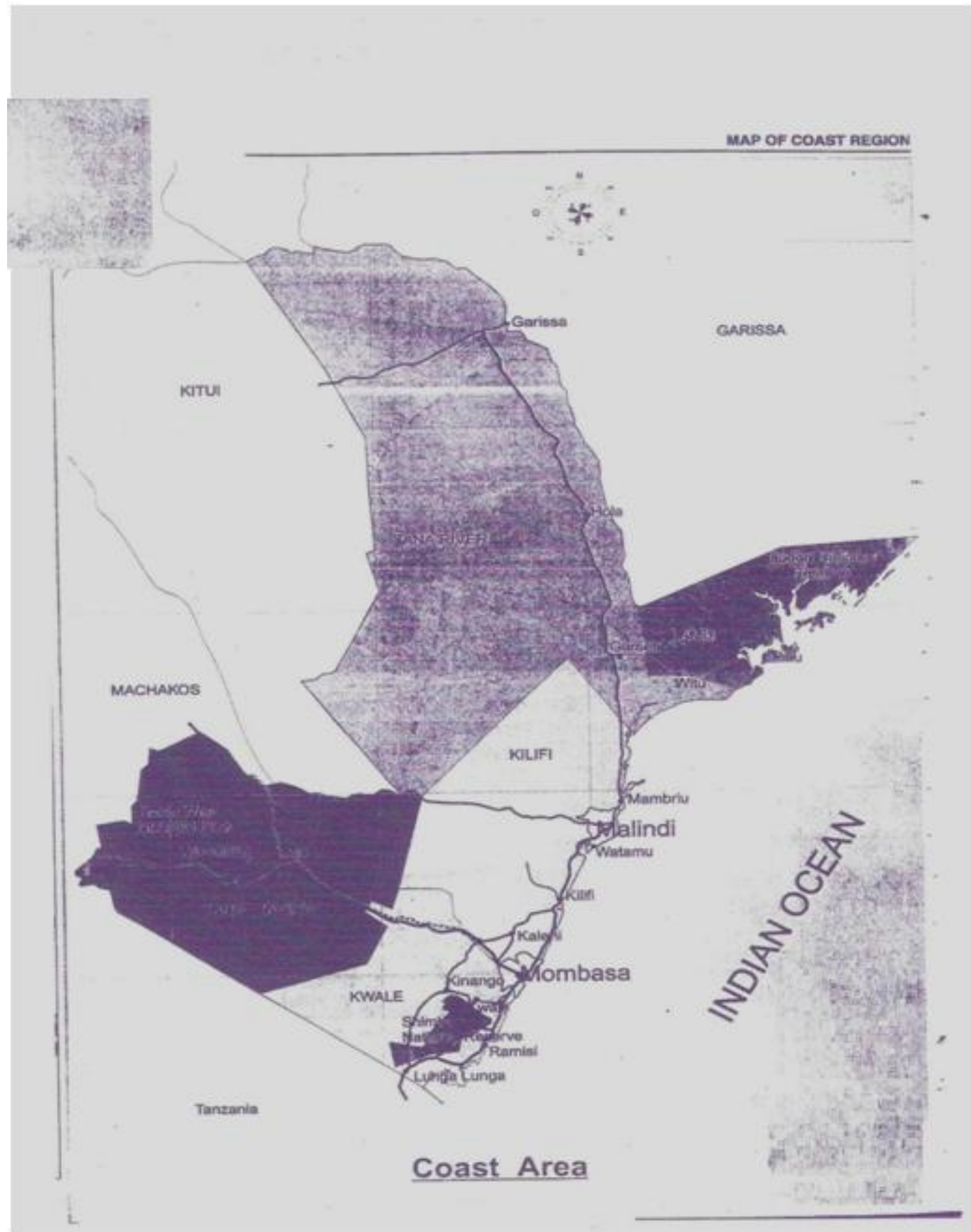


Figure 2: Map of the Study Area – Kenyan Coast Region

3.4 Target Population of the Study.

The target population comprised of all the employees and managers in the 83 selected star-rated hotels at the Kenyan Coast. These hotels have approximately 11,000 permanent employees, several thousands of temporary and casual employees (KNBS, 2009). These hotels are classified into five categories comprising of: three five-star hotels, 10 four-star hotels, 24 three-star hotels, 42 two-star hotels and four one- star hotels. The same hotels are further grouped as follows: *vacational hotels* (68 hotels): three five -star hotels, nine four-star hotels, 18 three-star hotels, 36 two-star hotels and two one- star hotels; *town hotels* (3hotels) : one two-star hotel and two one- star hotels; l*odges* (11hotels): one four-star hotel, five three-star hotels, five two-star hotels (Appendix).

3.5 Sample Size and Sampling Procedure

3.5.1 Sample Size and Sampling Procedure for the Star Rated Hotels

According to Kasomo (2006) and Mugenda and Mugenda (2003) 10 per cent – 30 per cent of the target population is adequate for a descriptive survey design. The researcher therefore, used 30 per cent of the 83 hotels hence sampled 25 hotels. This was assumed to be able to provide sufficient variability in the sample and the concepts under study. Proportionate Stratified sampling was used to select 25 hotels across the five strata i.e. the five hotel classifications. To achieve this sampling fraction (SF) was then calculated as follows:

$$SF = \frac{\text{Sample Size (Number of Hotels to be sampled)}}{\text{Population (Total Number of Star Rated Hotels)}}$$

$$= \frac{\text{25 Hotels to be sampled}}{\text{83 hotels}}$$

$$= 0.3012$$

Therefore, the total number of each category was multiplied by this fraction to obtain the corresponding sample for each category (sub- samples) as indicted on Table 1 below.

- 3 Five star hotels x 0.3012 = one Five Star Hotel
- 10 Four star hotels x 0.3012 = Three Four Star Hotel
- 24 Three star hotels x 0.3012 = Seven Three Star Hotel
- 42 Two star hotels x 0.3012 = Thirteen Two Star Hotel
- 4 One star hotels x 0.3012 = One - One Star Hotel

To derive the total sample size of the 25 hotels, the sub- samples were added. The hotels per category were selected using simple random sampling; in this instance the lottery technique was used.

Table 1: Sampling Frame of the Selected Star Rated Hotels at the Kenyan Coast.

	5 Star Hotels	4 Star Hotels	3 Star Hotels	2 Star Hotels	1 Star Hotels	Totals
Hotel Classification	*****	****	***	**	*	**-**
Star Rated Hotels at the Kenyan Coast	**3**	**10**	**23**	**43**	**4**	**83 Hotels**
Sub Samples Star Rated Hotels at the Kenyan Coast	**(1)**	**(3)**	**(7)**	**(13)**	**(1)**	**(25 Hotels)**

Out of the 25 selected star rated hotels 22 were vacational hotels, one was a lodge and two were town hotels.

3.5.2 Sample Size and Sampling Procedure for the Hotel Employees (Operational Staff, Supervisory Staff)

Ideally, it would have been preferable to collect data from all the employees and their management in all the 83 star-rated hotels. However, only the 11000 permanent employees were purposively involved in the study due to their longer duration of employment in the hotels. The effects of alcoholism and drug abuse could be easily monitored, assessed and reported among permanent employees than their temporal counterparts. In addition, only a representative sample was

used. This study adopted a formula by Kothari (2005) to determine a representative sample size, n, from a finite population, N.

Where:

n = required sample size

N = the given population size of employees, 11000 in this case

p = Sample proportion, assumed to be 0.50, $q = 1 - p = 0.5$

e^2 = acceptable error (the precision), in this case is 0.05 (5per cent of the true value)

z = standard variate at a given confidence level (1.96 at 95per cent confidence level)

Substituting these values in the equation, estimated sample size (n) was:

$$n = \frac{(1.96)^2.(0.5)(0.5)(11000)}{(0.05)^2(11000-1)+(1.96)^2.(0.5)(0.5)}$$

$$n = \frac{10564.4}{27.4975+0.9604}$$

n = 373

After determining the sample, stratified and simple random sampling procedures were used to distribute and select the 373 employees. Records of the total number of employees clearly indicating the employees' gender were retrieved from the Human Resource Managers and the same was used to extract the employee sampling frame. Proportionate stratified sampling was then used to arrive at the sample of 373 employees in the 25 selected hotels.

Once again to determine the sampling fraction: the calculated sample size of the employees was divided by the total target population of the hotel employees in the 25 hotels **i.e. 373 / 3562** (0.1047 of the employees). The sampling fraction was then multiplied by the total number of employees for each hotel. For instance Hotel A1 had a sub-population of 250 employees this was then multiplied by the sampling fraction 0.1047 (250 employees x 0.1047); the result gave a sub-sample of 26 respondents for this particular hotel. To further distribute the same employees in this hotel proportionately by gender the number of male employees was multiplied by the same fraction (i.e.168male employees x 0.1047= 18 male employees) and (82 female employees x 0.1047= 8 female employees). The final sample comprised of 274 male employees and 99 female employees (Table 2).

However though the study targeted 373 employees and 25 Human Resource Managers at the Kenyan Coast and despite assurance of confidentiality, most of the targeted respondents were still very apprehensive of the intentions of the study. Therefore, only 315 out of the targeted 373 subjects correctly filled the questionnaires and were therefore used in data analysis and results. Hence an overall response rate of 84 per cent was realized. On the other hand only 22 HRMs (88 per cent) were interviewed instead of the targeted twenty five.

Table 2: Distribution of Selected Star-Rated Hotels and the Employees at the Kenyan Coast (Sampling Fraction (sf)= 0.1047)

Hotel Classification	Female Employees (f)	Male Employees (m)	Total Employee (t)	Sample size per hotel t x 0.1047	Sample size by Gender	
					Female f x 0.1047	Male f x 0.104
FIVE STAR HOTELS						
A 1	82	168	250	26	8	18
FOUR STAR HOTEL						
B 2	93	106	199	21	10	11
C 3	44	101	145	15	5	10
D 4	35	119	154	16	4	12
THREE STAR HOTELS						
E 5	42	123	165	17	4	13
F 6	53	125	178	19	6	13
G 7	32	136	168	18	3	15
H 8	57	169	226	24	6	18
1 9	45	95	140	15	5	10
J 10	30	102	132	13	3	10
K11	12	81	93	10	2	8
TWO STAR						
L 12	46	137	183	18	5	13
M13	14	89	103	11	1	10
N 14	45	105	150	16	5	11
O 15	36	117	153	14	3	11
P 16	30	85	115	12	3	9
Q 17	41	146	187	20	4	16
R 18	50	80	130	14	5	9
S 19	18	71	89	9	2	7
T 20	45	116	161	17	5	12
U 21	23	127	150	16	2	14
V 22	32	86	1I8	12	3	9
W 23	11	39	50	5	1	4
X 24	10	30	41	4	1	3
ONE STAR						
Y 25	18	54	72	11	3	8
			3562	**373**	**99**	**274**

Simple random sampling using the random numbers table was then used to select the specific number of employees allocated to each hotel. The employees corresponding to the number picked was included in the final sample.

Lastly, purposive sampling was also used to select one hotel manager (preferably from the human resource department) from each hotel. Therefore, the 373 employees and 25 managers from each hotel formed the final sample size.

3.6 Data Collection Instruments and Procedure

The study utilized both qualitative and quantitative data collection methods. Qualitative data were collected by interviewing individuals through discussions in order to gain insights into their subjective experiences and reasons for drug abuse among employees; in depth interviews and Focus Group Discussions were employed in this case. Self administered questionnaires were used to collect quantitative data. All the instruments elicited vital information on drug abuse including its causes and effects.

3.6.1 In depth Interview Schedule

A 24 item semi-structured interview schedule with four sections was developed. (Appendix C). This tool was appropriate given the fact that various managers in the hotels work under busy schedules. This tool was administered to 22 such managers.

3.6.2 Focus Group Discussions (FGDs)

Two FGDs were conducted: one for hotels at the North Coast, Malindi, Kilifi and mainland which was held in hotel D4 and the other for those hotels at the South Coast which was held in Hotel J 10. These star-rated hotels were chosen as the venues so as to motivate the respondents to attend due to the proximity and environment. These were carefully planned and designed so as to obtain relevant information on participant's beliefs, opinions and attitudes about the area of study. Preliminary preparations included developing invitation letters and informed consent forms. In turn various HRMs and the 8 stakeholders were consulted to invite a manager, supervisor or employee who didn't participate in the quantitative survey. Convenience sampling as suggested by Fraenkel and Wallen (2000) was employed to select the participants. Twenty participants were invited for each session. At the South coast eight discussants participated whereas in North Coast 12 did attend. Three specially trained facilitators (a moderator and two recorders) steered and recorded the discussions based on a pre-formulated discussion guide.

3.6.3 Self- Administered Questionnaire

Quantitative data were collected using a self-administered questionnaire (Appendix A). A questionnaire was considered appropriate for this study due to not only the large sample size, the short period of research and it's convenience

in collecting the data, but also because of the length of the questionnaire which had 55 questions, with 75 variables. The present study modified questionnaires used in previous studies in the USA (Ames *et al*., 2007; Frone, 2003, 2004 and 2009). The questionnaires for the mentioned studies incorporated questions assessing employee self-reported and perception of co- workers on prevalence and effects of alcohol and drug use on employees. This was among their unnamed co-workers. However, chemical testing i.e. drug testing analysis using urinalysis, hair and sweat analysis used by previous researchers were not employed in this particular study. The questionnaire consisted of mainly closed-ended items and a few open-ended ones.

After obtaining informed consent from the randomly selected employees, the researcher either personally handed over the questionnaires to the participants or through their Human Resource Managers. The two Research assistants also distributed the questionnaires. They underwent a two day training on how to administer the questionnaires and checking to ensure they were fully completed by the employees before accepting them back. Each questionnaire was accompanied with a covering letter which had an adequate briefing about the research, signed personally by the researcher (Appendix A). The respondents were requested to fill in the questionnaires during their tea or lunch break and hand them back to the HRMs, the researcher or the research assistants.

3.7 Validity of the instruments

'Content Validity' or 'Expert Judgment' proposed by Nachmias and Nachmias (2005) as a successful method of assessing the validity of behavioural variables was used. This is where some experts in the field of research are given the instruments to validate their appropriateness for the study before it can be subjected to the respondents.

Two experts from the Department of Hospitality Management, one lecturer from sociology department and two classmates were consulted to scrutinize the relevance of the instrument items against the set objectives of the study. Their responses were noted in terms of clarity and ease of answering the questions. The resultant suggestions were incorporated in the final drafts of the instruments in order to improve the items and make the results more meaningful.

3.8 Reliability of the Instruments

The instruments were constructed to include all possible opinions that respondents might give on effects of alcoholism and drug abuse on work performance. The instruments were then taken for pre- testinng on a population that was similar to the target population. This was undertaken in any other hotel in the coastal region that was not included in the sample. Each hotel strata (i.e. Hotel A– a Five-star, Hotel B– a Four-star, Hotel C- a three-star, and

Hotel D – a two-star and Hotel E – a One Star Hotel) was represented and from each hotel, five employees and one manager were interviewed.

The purpose of pre-testing was to eliminate some ambiguous items, establish if there were any problems in administering the instruments, test data collection instructions, establish the feasibility of the study, anticipate and amend any logical and procedural difficulties regarding the study, and allow preliminary (dummy) data analysis. Pre- testing also assisted in testing the reliability of the instrument. Cronbach's Coefficient Alpha was computed and reliability coefficient established. The coefficient for the absenteeism Likert scale was 0.8491, for accident Likert scale was 0.9308, and job productivity Likert scale had 0.9417. These reliability coefficients were assumed to reflect the internal reliability of the instruments (Mugenda and Mugenda, 2003; Fraenkel and Wallen, 2000). For purposes of higher reliability and to reduce ambiguity of the data collection tools slight amendments were undertaken.

3. 9 Data Collection Procedures and Ethical Considerations

Permission for the research was granted by the Ministry of Higher Education (National Council of Science and Technology – NCST) through Kenyatta University who facilitated a research authorisation letter (Appendices O and P). Permission was also sought from the managers of the selected hotels. Data were then collected using the mentioned instruments.

Since this study intended to investigate a very sensitive and personal issue that was secretive and criminal, there was a tendency by the targeted respondents to conceal information or deliberately give false information. It ensured that there was informed consent, confidentiality and anonymity, privacy and no harm to the participants. Participation was voluntary and respondents were free to withdraw from the study at will, without any penalty or loss of benefits or privileges. To ensure confidentiality of the results, the sampled hotels were given codes: A 1, B 2, C3, D 4 etc. rather than using their real names.

3.10 Data Analysis and Presentation

Thematic analytical technique procedure (Orodho, 2009) which categorizes related themes was embraced in the present study to analyse qualitative data. This involved data organisation, transcribing, coding, developing a summary report, synthesizing and translating information. The sets of transcripts were reviewed to identify the main themes and sub-themes. Data were then coded according to the themes and categorized accordingly. Ideas and patterns were inferred from the participants' specific responses. These were then used to describe quantitative data.

Quantitative data were edited, coded and entered into SPSS version 15 for windows and cleaned for analysis. This was done using descriptive and inferential statistics. Descriptive statistics of frequencies, percentages, means

and cross-tabulations were used to summarize, organize and analyze data, and describe the characteristics of the sample. Inferential statistics was used in making deductions and generalizations about the whole population. This included Pearson Coefficient of Correlation or Product Moment Correlation, Spearman's Coefficient of Correlation or rank order and chi square statistical tests.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The purpose of this research was to determine the effects of drug abuse on work performance in the tourism and hospitality Industry in Kenya using a survey of selected star- rated Hotels at the Kenyan Coast. This chapter presents research findings and discussions. Results and discussions are presented under the following subheadings:

- Demographic Characteristics of the Respondents
- Prevalence rate of drug abuse in the society and by employees in the hotels
- Extent of Drug Abuse among Employees in Selected Star-Rated Hotels
- Reasons for Using Drugs in Selected Star-Rated Hotels at the Coast
- Effects of Alcohol and Drug Abuse on Behaviours/Moods of Employees
- Drug Abuse and Absenteeism in Selected Star-Rated Hotels at the Kenyan Coast
- Drug Abuse and Accidents in Selected Star-Rated Hotels at the Kenyan Coast
- Influence of Drug Abuse on the Level of Job Productivity in Star-Rated Hotels
- Organisational Policy and drug abuse in selected star rated hotels

4.2 Demographic Characteristics of the Respondents in the Star - Rated Hotels

This section briefly describes the demographic characteristics of the sample. The demographic characteristics included: age, gender, income, marital status, religion and level of education (Appendix H).

4.2.1 Age of the Hotel Employees

The 315 respondents that the researcher successfully interviewed from the 25 selected star rated hotels at the Kenyan Coast were aged between 18 and 60 years (Table 3).

Table 3: Age Categories of the Employees in Selected Star-Rated Hotels at The Kenyan Coast

Age categories	Frequency	Percent
18-30	133	42.2
31-40	114	36.2
41-50	45	14.3
51-60	23	7.3
Total	**315**	**100.0**

Over 70 percent of the sampled employees were aged between 18 and 40 years. These categories suggest that the respondents were in their prime working years and thus relatively young and biologically productive (Armstrong, 2003; Frone, 2009). Price water house Coopers (PwCs, 2010) replicated these sentiments in their study particularly for age bracket 20 -30 Years commonly referred to as “Generation Y” (born 1979 – 1990). They established that such employees were more likely to be energetic, technology savvy, adaptive, receptive and willing to experiment with new ideas and methods of operations, demanded flexible working hours, flexible dress codes and access to on line social networks. Unfortunately, 23 per cent of “Generation Y” wants to change their employer in under a year and 49 per cent will provide their services for between three to five years in a given organisation. The same studies (Frone, 2009; NACADAA, 2009 and PwCs , 2010) established that persons aged 18- 30 were more prone to misuse drugs than the other cohorts in the general population, therefore HRMs have really to be weary about them and have no option but to re – orient management styles to retain and improve their productivity.

4.2.2 Gender of Employees in Star-Rated Hotels at the Kenyan Coast

The number of employees interviewed varied based on the proportionate stratified sampling method that was used. The 315 sampled employees included 222 male and 93 female (Figure 3).

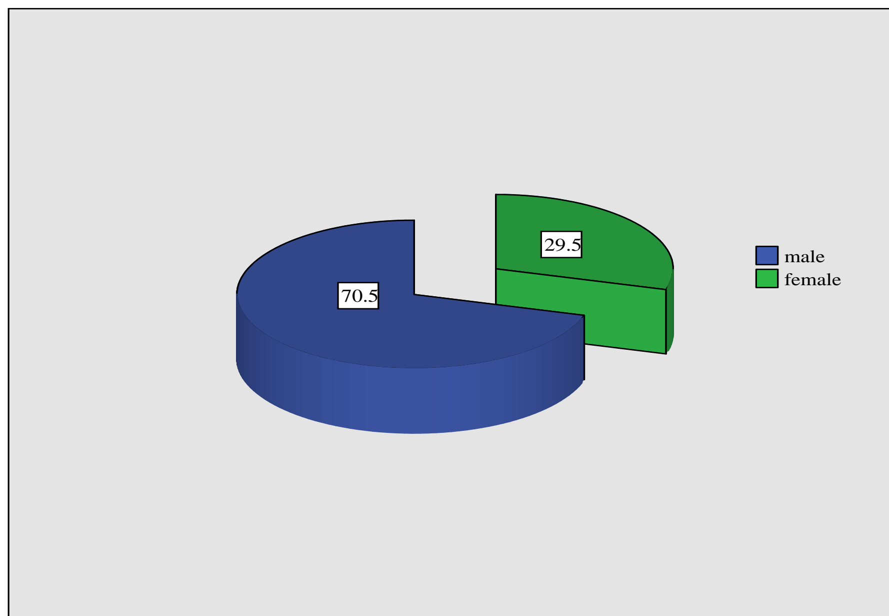


Figure 3: Gender of the Employees in Selected Star-Rated Hotels at the Kenyan Coast

The unequal gender distribution was attributed to the general gender disparities in the formal employment in the country. For example the Kenya Economic Survey (KNBS, 2010) indicates that there were 1391 thousands male employees (69.5 per cent) as compared to 607 thousands (30.5 per cent) of female

counterparts. This was further complicated by the culture of the people in Coast province which relegates a woman to the domestic responsibilities.

4.2.3 Level of Education of Employees in Star-Rated Hotels at the Kenyan Coast.

The study also sought to establish the level of education of the respondents. This was necessitated by the fact that the level of education of an employee determines his/her ability to perform designated roles and responsibilities in the organization. It also influences the ability for career progression in the organization. Table 4 illustrates the distribution of the 315 employees according to their levels of formal education. It shows that over 90 per cent of the respondents had at least completed secondary school level of education.

Table 4: Level of Education of Employees in Star-Rated Hotels at the Kenyan Coast.

Level of education	Frequency	Percent
Primary incomplete	2	.6
Primary complete	8	2.5
Secondary incomplete	22	7.0
Secondary complete	110	34.9
Middle level college	156	49.5
University degree	17	5.5
Total	**315**	**100.0**

4.2.4 Marital Status and Religion of Employees in Star-Rated Hotels at the Kenyan Coast

Majority of the employees were married 55.2 per cent (n= 174); 36.5 per cent (n= 115) were single; 4.8per cent (n= 15) divorced/separated; 1.9 per cent (n=6) remarried and 1.6 per cent (n= 5) widowed. Over 75 per cent of the employees were Christians and 22.5 per cent were Muslims. This was interesting given that Muslim religion is believed to dominate the Coast province. This was explained as one of the negative effects of drug abuse to the society, most of the Muslims had dropped out of school and no wonder professionals for all the sectors were scarce in this community and had to be imported from other parts of Kenya.

4.2.5 Monthly Income of Employees in Star-Rated Hotels at the Kenyan Coast

Majority of the hotel employees 37.4 per cent (116), earn less than 10,000/=. Their monthly income averaged Ksh. 14,202.75 with a standard deviation of Ksh.9767.75.

4.2.6 Work Experience of Employees in Star-Rated Hotels at the Kenyan Coast

More than half of the subjects (54. 3per cent; n= 171) had worked for the hotel for at least 7 years and 45.7 per cent (n= 144) had been in their present job for at least two years. The years of service ranged from 1- 30 years.

4.2.7 Demographic Characteristics of the Hotel Human Resource Managers.

The average age of the 22 Hotel Human Resource Managers interviewed in the study was 40 years. The youngest was aged 30 and the oldest was 52 years. Managers in the hotels were employed on full-time basis and most of them had worked in their respective positions for more than three years. The managers were professionally trained in their jobs, with 30 per cent having attained a Diploma in Hotel Management/ Hospitality and Tourism Management, 15 per cent Diploma in Human Resource Management, 10per cent Bachelors Degree in Human Resource Management, 20 per cent had Bachelors degree in sociology, 20 per cent had Bachelors degree in Tourism and Hospitality Management and 5 per cent had Masters of Business Administration (MBA).

Seventy per cent (70 per cent) of the Human Resource Managers in the hotels were women. This was attributed to the fact that in the recent past most HR duties is normally undertaken by women; admittedly may be due to their

credibility in problem solving and communication effectiveness (Armstrong, 2004; Brownell, 1994). As for the marital status 76 per cent were married and about 23 per cent were single. Eighty four per cent (84 per cent) of the respondents were Christians and 15 per cent were Muslims.

4.3 The Extent of Drug Abuse among Employees in Selected Star-Rated Hotels (Prevalence Rate among Employees- Co- Workers Perception).

The broad objective of the study was to assess the effects of drug abuse on work performance on employees in the tourism and hospitality industry in Kenya using a survey of selected star rated hotels at the Kenyan Coast. To address this objective, the following aspects about drug abuse were assessed: awareness of drug abuse cases in the hotels, common drugs used, frequency of use, reasons for using drugs, and gender of the drug users. Respondents were asked whether they were aware of employees in their hotels using drugs (Figure 3).

In a nutshell, 292 (92.7 per cent) of the respondents (Figure 4) were aware of employees in their hotels using drugs, while only 23 (7.3 per cent) were not. From the in-depth interviews, the managers of the hotels confirmed the use of drugs among employees in hotels. The managers reported that they had witnessed, received reports and/or handled cases of drug abuse in their hotels. All the discussants (100 per cent) in both the FGDs had witnessed about 80per cent of their colleagues abusing drugs either while on duty or after work. This

suggests that majority of the respondents had witnessed their colleagues taking drugs at the workplace or reporting to work under the influence of drugs. Use of drugs was therefore prevalent and common among employees in the hotels, and employees were aware of it. It also indicates that cases of drug use and/or abuse at the workplace were no longer a secret.

4.3.1 Co – Workers Awareness of Their Colleagues Abusing Drugs.

Figure 4: Aware of Employees Using Drugs in the Selected Star-Rated Hotels at the Kenyan Coast.

4.3.2 Common Drugs Used by Employees in Selected Star-Rated Hotels

The common drugs abused by hotel employees are illustrated in Table 5.

Table 5: Common Drugs Used by Employees in Selected Star-Rated Hotels at the Kenyan Coast

Drugs	**Frequency**	**n = 292**
Cigarettes	248	84.9
Alcohol	239	81.8
Marijuana/bhang	102	34.9
Miraa/*khat*	76	26.0
Stimulants	40	13.7
Medicinal Prescribed and over-the counter drugs)	30	10.3
Tranquilizer	28	9.6
Inhalants	22	7.5
Hallucinogens	19	6.5
Heroine	18	6.2
Cocaine	16	5.5

Results indicate that cigarette smoking and alcohol consumption were the common types of drugs used by employees in the hotels. The prevalence in the use of the two drugs was attributed to their legality, availability and accessibility. This is in tandem with the studies undertaken by, Munne (2005);

Frone (2009); Hodgins *et al.,* (2009) and Moore *et al.,* (2009). In addition to alcohol and cigarettes, Marijuana and *Miraa* were also common drugs used. This result was corroborated by all the 22 managers and the discussants in the FGDs.

4.3.3 Employee's Self Report of Alcohol and Drug Abuse in Selected Star-Rated Hotels at the Kenyan Coast.

Respondents were asked to give their self report of drug use. About 36 per cent admitted that they had used drugs in the last one year while 192 (64.1 per cent) reported that they had never abused drugs. Because admission of drug use could potentially have negative results, subjects in such instances tend to underreport their drug use frequency (Frone, 2004) worse still others are in denial. This has been proved in the present study in that the observation made by co –workers on drug use was relatively high (70 -80 per cent) compared to the self report of about forty percent (Figure 5).

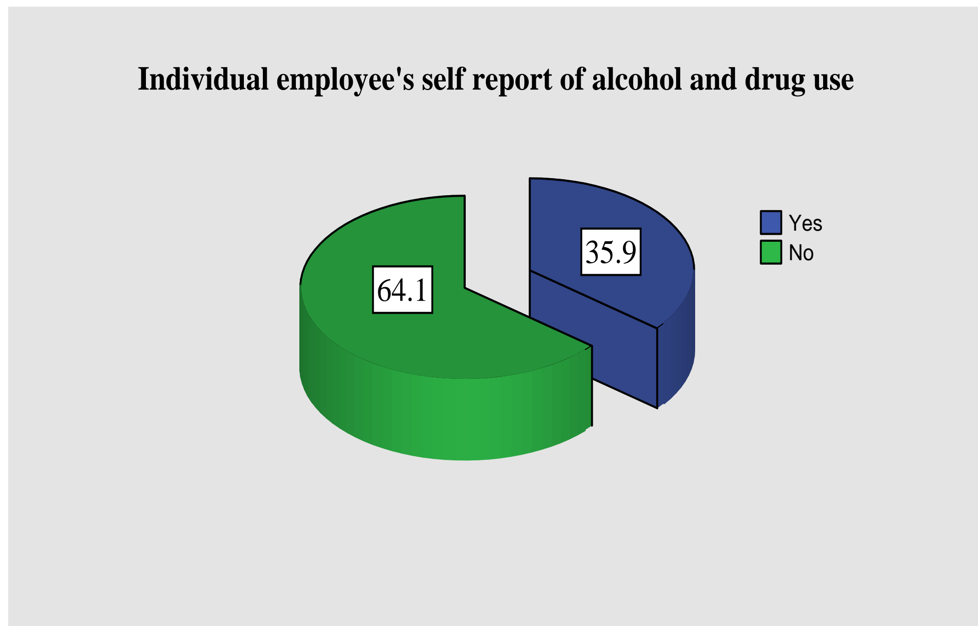


Figure 5: Individual Employees Self Report of Alcohol and Drug Abuse in Selected Star- Rated Hotels at the Kenyan Coast

The types of drugs abused are captured through self reports are shown in figure 6.

drugs used

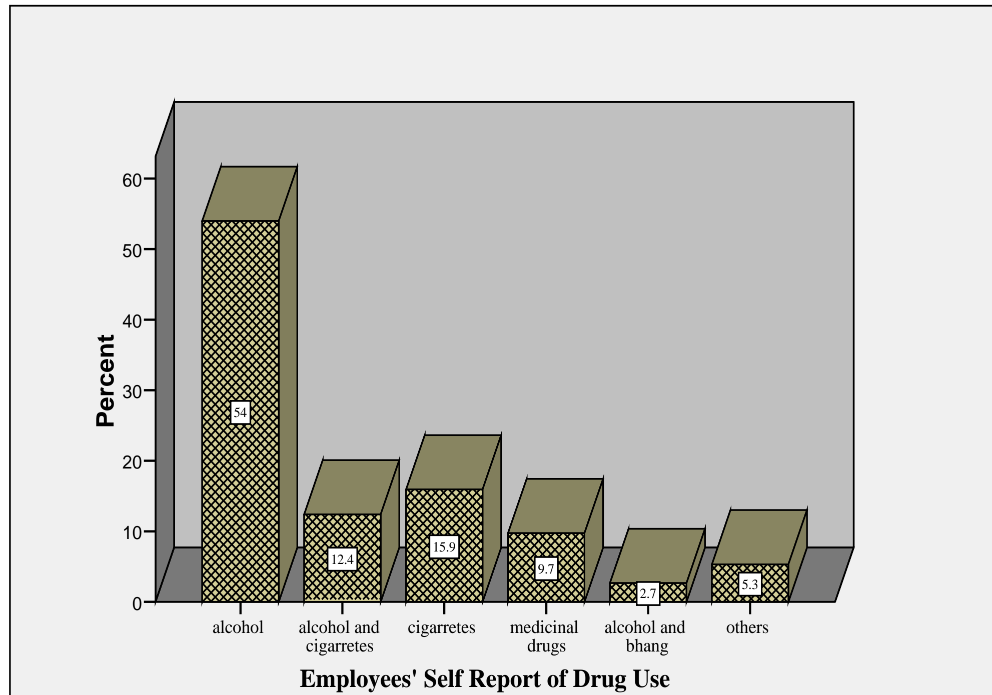


Figure 6: Prevalence rate of Alcohol and Drug use- Employees Self Report in Selected Star- Rated Hotels at the Kenyan Coast

4.3. 4 Frequency of Drug Abuse amongst Employees in the Star Rated Hotels (Co – Worker's Perception)

Figure 7 shows the frequency of use of drugs among employees in the hotels.

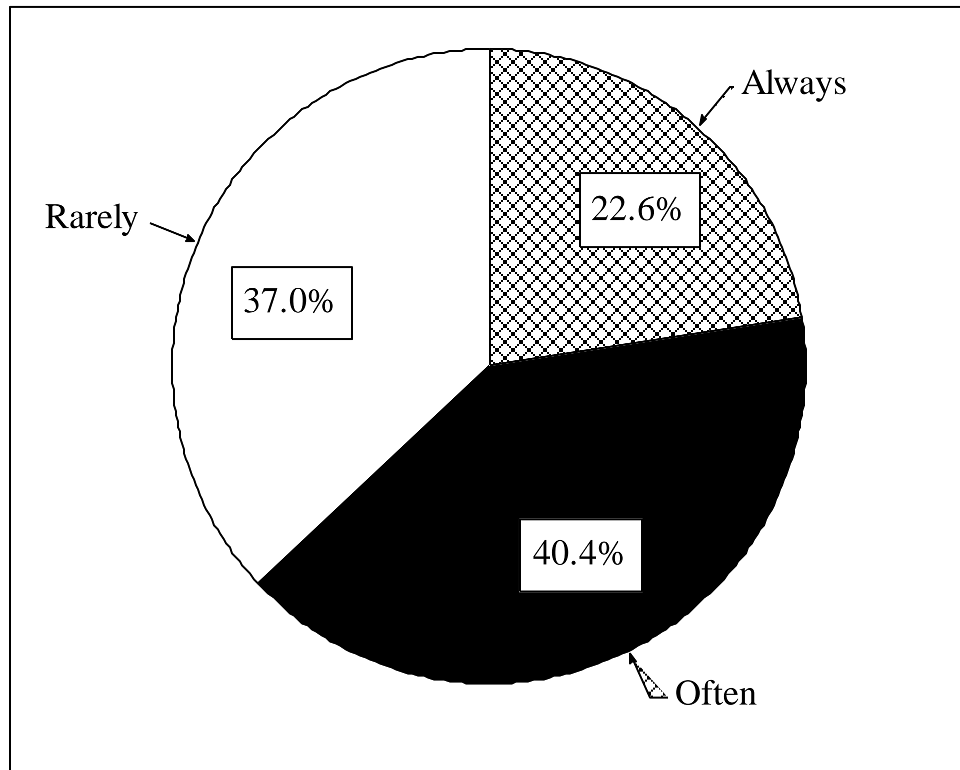


Figure 7: Frequency of Drug Use by Employees in Selected Star-Rated Hotels at Coast Province

Out of the 292 respondent employees, 40 per cent of them had often witnessed employees using drugs in their hotels. The remaining 37.0 per cent and 23 per cent, rarely and always used drugs in the hotels respectively. On the other hand the two FGDs agreed that the frequency of drug abuse was as follows: 60.3 per cent often, 26 per cent rarely and 13.7 per cent always respectively. However, the managers stated that drug abuse was underestimated due to the sanctions in place.

The 113 respondents who admitted drug use were asked the frequency of drug use (Table 6). The 79 respondents who used alcohol alone and alcohol combined with other drugs were asked whether they consumed alcohol in the last one year and the number of standard drinks they drunk per occasion. These were categorised as per the Alcohol Use Disorders Identification Test (AUDIT, Michael *et al.,*2007) 1-2 drinks; 3- 4 drinks ; 5 -6; 7 – 9; 10 drinks or more. The frequency of alcohol and drug use was measured using a 6- point frequency response scale: 0 (never); 1 *(less than monthly)*; 2 *(1-3) days in per month*; 3 *(1-2 days per week);* 4 *(3 to 5days in a week)* and 5*(6-7 days per week).* They were further asked if in the last month they drunk or abused other drugs immediately prior to work, while on duty or after work.

To a large extent, workers typically drunk one to two days per week within the past year, but drinking quantity tended to be heavy, with nearly half of the male employees who use alcohol consuming 5+ drinks and 32.5per cent of the women imbibing 4+ drinks per occasion. WHO (2004) recommends that men should not exceed 22 units of alcohol per week and not more than 14 drinks for women. Only 10 per cent of the drug users reported to have ever drunk alcohol while on duty, the rest 90 per cent indicated that they abused alcohol after work or on non – workday drinking and largely drunk in the company of co-workers. The recommended standard drink by the WHO (2004) is 5 drinks and less for male and 4 drinks or less for female per session. A standard drink is defined as

12 ounces (33cl) of beer, malt liquor; 4 ounces (12cl) of wine or 1.5 ounce (12.8cl) shot of liquor. Better still harmful alcohol consumption, is defined as drinking more than five drinks at a time in five or more days over the past 30 days. Therefore 1unit drink= 1.5cl pure alcohol= 12.8g alcohol.

For the other drugs they were asked the quantity of the drugs that they consumed per any occasion. About 80 per cent of the cigarette smokers stated that they craved for cigarettes almost all the times as a result abused them whether on or off duty. Studies by various researchers establish that cigarettes are six times more addictive than other drugs and would smoke at least 1packet a day. Prescribed drugs were abused at one to two times in a week. The respondents reported low consumption of other drugs like *miraa and bhang.*

Table 6: Prevalence rate of Alcohol and Drug use- Employees Self Report in Selected Star-Rated Hotels at the Kenyan Coast

Drugs Used	**Frequency**	**Percent**	**Cumulative Percent**
Alcohol	61	19.4	54.0
Alcohol and Cigarettes	14	4.4	66.4
Cigarettes	18	5.7	82.3
Medicinal drugs	11	3.5	92.0
Alcohol and bhang	3	1.0	94.7
Stimulants	3	1.0	97.3
Bhang	2	.6	99.1
Cigarette and Miraa	1	.3	100.0
Sub-Total	113	35.9	
No use Drugs	202	64.1	
Totals (No of Employees)	**315**	**100.0**	

The Focus Group Discussions unanimously agreed that alcoholism and drug abuse was a major concern that needed to be addressed.

4.3.5. Gender of the Employees Mostly Using Drugs in Selected Star-Rated Hotels.

Table 7 contains views on the gender of employees in the star- rated hotels who mostly abuse drugs.

Table 7: Gender of the Employees Mostly Using Drugs in Selected Star-Rated Hotels at the Kenyan Coast

Gender	**Frequency**	**Percent**
Male	276	94.5
Female	16	5.5
Total	292	100.0

The respondents cited that male employees used drugs most frequently than their female counterparts in the hotels. In-depth interviews with the managers and the two FGDs revealed a similar gender disparity in the use of drugs. Furthermore this result is in line with the response for question 2 Section F, whereby out of the 113 respondents who alluded to have used drugs, over 70 per cent (81 respondents) were male and about 30 per cent (32 respondents) were female (Figure 8).

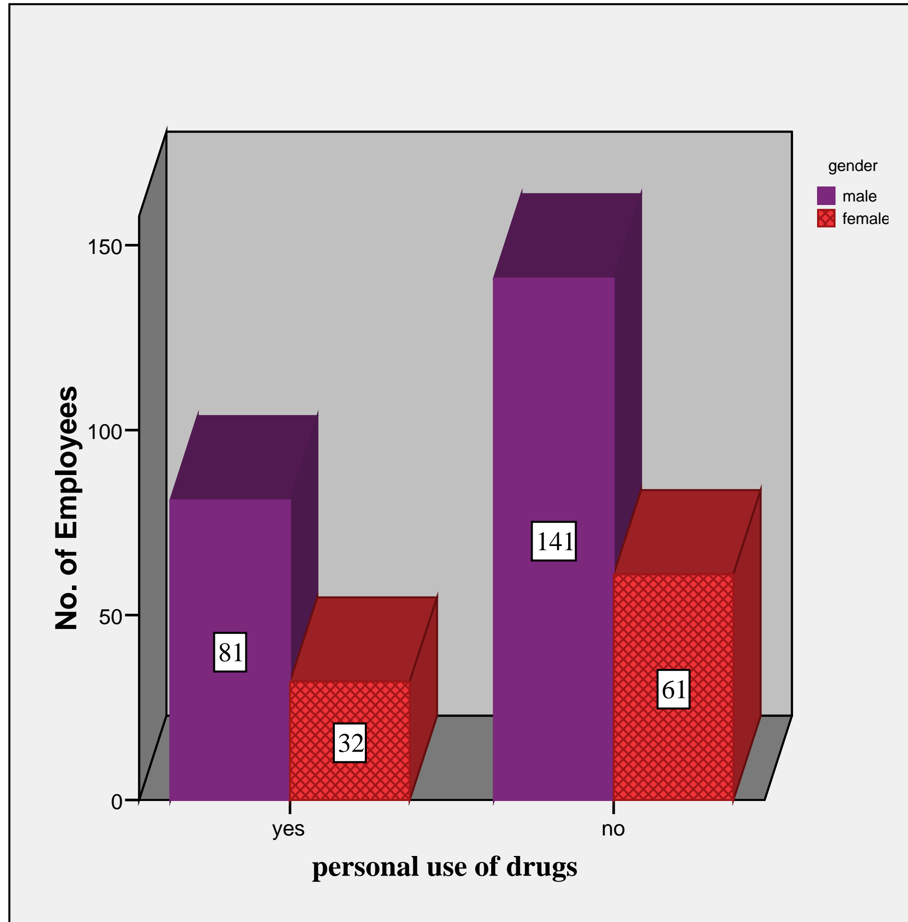


Figure 8: Employees Self Report of Alcoholism and Drug Use in Selected Star- Rated Hotels at the Kenyan Coast by Gender

4.3. 6 The Departments with The Most Alcohol and Drug Users.

The respondents were asked to indicate the departments or sections where they worked; this was further related to their drug use culture. The results explicitly revealed that Food and Beverage section had the highest rate of drug abusers

(16per cent) possibly because it includes the bar section where alcohol and cigarettes are easily accessible.

However, the FGDs negated these results: they virtually reported that it is the Animation and Entertainment sections that were the most affected (Figure 9). According to their observations alcohol and drug abuse was rampant in the hotel industry. Figure (9) depicts that 90 per cent of the employees in animation and entertainment use drugs. The over riding logic is that these workers need to be high so that their entertainment performance can be boosted.

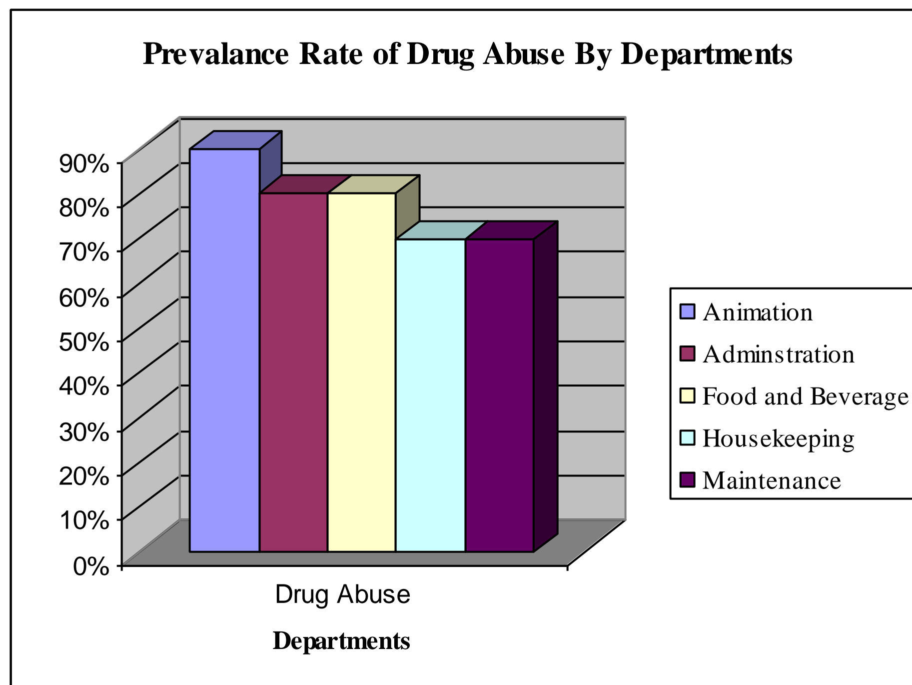


Figure 9: Rate of Employees Abusing Drugs by Department in the Star Rated Hotel the Coastal Region Of Kenya

4. 4Reasons for Using Drugs in Selected Star-Rated Hotels at the Kenyan Coast (Co – workers Perception).

Drugs are used by people for various reasons. In this study, the 292 respondents were asked why employees in their hotels were using drugs (Table 8).

Table 8: Reasons for Using Drugs in Selected Star-Rated Hotels at the Kenyan Coast – Co- workers opinions

Reasons	Frequency	per cent out of 292
Relaxation, leisure and pass time	77	26.4
Reduce/relieve stress	72	24.7
Addiction	46	15.8
Bad company, peer pressure and aping foreign tourists	39	13.4
Others	58	19.7
Total	**292**	**100.0**

Majority of the employees used drugs for pleasure and as a means of relaxing, leisure and pastime after a long day or week's time on duty in addition they believed this was key in building their self- esteem. Others used drugs to overcome or reduce stress and presumed that it was the only way to respond to the heavy demand at the workplace. It was observed that working in a hotel was

very demanding and challenging causing a lot of stress to the employee. Some employees used drugs to stimulate high performance at the workplace. Similarly these opinions given by co- workers were in tandem with the individual employees self report on their reasons for using drugs. Slightly over forty percent pointed out that they used drugs for relaxation, socialisation and most of all some of the drugs were the main products being sold at their workplace ideally such drugs were easily accessible and available.

Further discussions with the Hotel Human Resource Managers and the FGDs revealed that several factors lured the employees' in the hotels to use drugs. Most of them blamed it on the high poverty levels and lack of adequate and reliable information about the consequences. Contrary to this, whereas some hotel employees abused drugs due to inadequate funds others largely misused alcohol and drugs due to the excess and free money that they received; this they acquired from service charge usually at mid month and in some instances they receive extra tips from guests.

Others related it to genetic inheritance and reported that Mombasa port had encouraged easy access and availability of drugs. Fifteen per cent of the Human Resource Managers associated the work environment with drug abuse; they had experienced a higher drug use rate in their lodges visa- a - vis the beach and town hotels. Evidently, lodges are located at the centre of National parks, this

poor proximity prompts workers to abuse drugs at their free time to relax and pass time. Ninety percent of the respondents alluded that there is a misconception by employees and the larger society about the good lifestyle of tourists using drugs who in turn lures many into the habit (Akama and Kieti, 2007).

The two different modes of payment (i.e. *The All inclusive Package* and the *rack rate* systems) embraced by the star-rated hotels for their products and services largely contribute to this menace. The Human Resource Managers and the discussants in the FGDs pinpointed the all inclusive package system as a key ingredient to drug abuse in the hotel industry. In this particular system which is a concept embraced by most hotels (80per cent) all products and services are paid for in advance before the guest checks in. Once they check in they are provided with all they require alcoholic beverages included but normally of cheaper quality e.g. *Keg*. Absolutely, there are no control measures for these drinks and that explains why the employees are able to access the beverages. On the contrary in the *rack rate system* all products and services are paid for as they are consumed as such control measures are in place.

4. 5 Effects of Alcohol and Drug Abuse on Behaviours/Moods of Employees in Selected Star- Rated Hotels at the Kenyan Coast.

Lastly, the study also sought to establish the effects of drug use on the employees involved. The respondents were presented with several likely effects of drug abuse on the user's behaviour and asked to state those that were commonly observed among the employees using drugs (Table 9).

Table 9: Common Moods and Behaviours among Employees Using Drugs Selected in Star-Rated Hotels at the Coast Province

Moods	**Frequency**	**per cent out of 292**
Depression	131	44.9
Anxiety	109	37.3
Complaints about others	99	33.7
Mood changes after lunch or break	82	28.1
Suspicious	79	27.1
Emotional unsteadiness	73	25.0
Irritation	61	20.9

It is worth noting that the most common moods included depression, anxiety, complaints about others, and mood changes after lunch or break, suspicious, emotional unsteadiness and irritation. These results were synonymous with research findings by Hodgins (2009) in Alberta, Canada. In support of the above mentioned behaviours and moods, in-depth interviews with managers revealed that some of the employees show inconsistent behaviours that are almost impulsive in nature. The respondents reported that the above changes in moods make drug users to engage in unproductive actions (Table 10).

Table 10: Common Actions among Employees Using Drugs in Selected Star-Rated Hotels at the Kenyan Coast

Actions	**Frequency**	**per cent out of 292**
Argumentative	174	59.6
Withdrawn or improperly talkative	121	41.4
Over-reaction to real or imaginary criticism	111	38.0
Avoid taking to superior about work issues	106	36.3
Display of violent behaviour	78	26.7
Excess sense of self-importance or inferiority	60	20.5
Spends more time communicating to people outside	54	18.5
Possession of paraphernalia (such as syringe)	15	5.1

The most common of such actions is being unnecessarily argumentative. This is consistent with literature from other disciplines. For instance, Mcfarlin *et al.,* (2001) asserts that drug abuse is associated with increased aggressive behaviour at the workplace. In this study hierarchical analyses was used and it revealed that the 300 civilian employees selected from the US population and interviewed on phone were victims of workplace aggression when intoxicated.

In the self report section individual employees pointed out that generally their behaviour and moods was highly influenced once they used drugs. Thirty one (27.4 per cent) of the 113 respondents who use drugs experience problems such as lack of rational thinking, low morale, poor relationship with management and psychological impairment. Majority of the respondents over (40 per cent) of the respondents were unable to relate well with their bosses and co-workers. Subsequently they indicated that such behaviours contribute to their being too aggressive (20 per cent) to an extent of fighting with their colleagues, while 30 per cent reported that they insubordinate their superiors warranting them to be disciplined for instance being issued with warning letters.

In-depth interviews with managers affirmed that psychological effects were common among drug users. Some managers observed that employees, who are very much involved in drug abuse, tend to make poor judgment by either exaggerating or under-estimating obvious situations, they lack control of their

finances and divert their resources for buying drugs; in a nutshell they become irresponsible and are unable to fend for their families. This has led to precarious scenarios where family members have approached HRMs for intervention, hugely contributing to broken families.

Eight managers reported that some drug abusers react irrationally and violently to even the smallest provocation at the workplace which affects relationships with co-workers. One manager in (Hotel C3) reported that he has had very nasty experiences with the effects of drug abuse with the employees in this industry. When he was asked to share some of these experiences he narrated that: "*In last years staff party an intoxicated employee who had been having strained relations with his immediate supervisor decided to insubordinate him by being argumentative and abusive* (personal interview, manager, coast hotel, 2010).

4.6 Drug Abuse and Absenteeism in Star-Rated Hotels at the Kenyan Coast.

The first objective of this study sought to determine the extent to which drug abuse influences workplace absenteeism among employees in the star rated hotels. The results were collapsed into three categories that is never, rarely and often (Table 11).

Table 11: Rating of Absenteeism among Employees Using Drugs in Selected Star- Rated Hotels in Coast Province

Statement	Response Rate per cent		
	Never	Rarely	Often
Leaving work area more than necessary (eg frequent trips to the bathroom or latrine)	9.9	38.3	51.7
Unreported absence, later explained as 'emergencies"	13.0	55.1	31.9
Unusually high incidence of cold, flu, stomach upset and headache	15.8	55.9	28.4
Unexplained disappearances from the job with difficulty in locating	17.8	52.1	30.2
Reporting late to work for various reasons related to drugs	21.9	52.0	26.0
Frequent use of unscheduled vacation time	23.6	58.2	18.2
Requesting to leaving work early for various reasons related to drugs	27.1	53.1	19.9

Most of the respondents rarely witnessed the above seven aspects of absenteeism among employees taking drugs at the workplace. Overall, the respondents rated the seven aspects just averagely with mean scores ranging between M = 1.93 and M = 2.42. This meant that there was some relationship between absenteeism and drug abuse amongst employees at the Kenyan Coast. The respondents reported that employees using drugs: leave work area more than necessary; have unreported absence; later explained as 'emergencies"; have

unusually high incidence of cold, flu; stomach upset and headache; disappear from the job without explanation and with difficulty in locating; report late to work for various reasons related to drugs; frequently use of unscheduled vacation time; and request to leave work early for various reasons related to drugs. This suggests that even though the respondents were aware of employees in their hotels using drugs, the employment regulations of the organization could not allow them to be frequently absent. Most of the hotels were private investments and therefore employers could not tolerate rampant cases of absenteeism. The respondents agreed that employees using drugs were more likely to engage in aspects of partial and full absenteeism compared to those who do not.

The overall effect of drug abuse on absenteeism was determined by the cumulative interaction of the seven aspects. Therefore, the responses to each constituent statement were scored on a scale of 1, indicating least frequent, to 5, indicating most frequently observed. The overall extent of absenteeism as a result of drug abuse was obtained by summing up the individual scores to form an absenteeism index score for each respondent (reliability coefficient, α = 0.8622). The index score varied between 7, indicating the least absence, and 35, indicating the highest level of absence as a result of using drugs at the workplace. The higher the score, the higher was the extent of absenteeism as a result of employees using drugs while at the workplace in the hotels, and vice

versa. The index score was later collapsed into three ordinal categories in order to differentiate the extent of absenteeism among the sampled respondents. This included a score of 7 -16 meaning rarely, a score of 17 - 25 (occasionally) and a score of 26-35 indicating often absent due to use of drugs (Table 12).

Table 12: Extent of Absenteeism due to Use of Drugs in Star-Rated Hotels

Extent of Absenteeism	**Frequency**	**Percent**
Rarely	87	29.8
Occasionally	151	51.7
Often	54	18.5
Total	**292**	**100.0**

Essentially, the respondents had witnessed cases of absenteeism at the workplace as a result of the use of drugs among employees. About half of the respondents (51.7per cent) indicated that the employees using drugs were occasionally absent from their workplace. The remaining 29.8 per cent and 18.5 per cent considered these employees to be rarely and often absent due to their use of drugs. This suggests that though occasional, the use of drugs influences absenteeism among employees at the workplace.

4.6.1. Null-Hypothesis ($H0_1$): Significant Relationship between Drug Abuse and Workplace Absenteeism.

This study further sought to suggest the first hypothesis that was to establish if there is any significant relationship between *"alcohol and drug abuse workplace absenteeism among employees in the star rated hotel"* Chi square test was used to determine this. Table 13 shows a cross tabulation of frequency of drug use by extent of absenteeism.

Table 13: Absenteeism Due to Use of Drugs among Employees in Selected Star-Rated Hotels in the Kenyan Coast

			Extent of absenteeism			**Total**
			Rarely	Occasion ally	Often	
Frequency of use of drugs	Always	Count	11	30	25	66
		per cent	12.6per cent	19.9 per cent	46.3per cent	22.6 per cent
	Often	Count	32	68	18	118
		per cent	36.8per cent	45.0 per cent	33.3per cent	40.4per cent
	Rarely	Count	44	53	11	108
		per cent	50.6per cent	35.1 per cent	20.4per cent	37.0 per cent
Total		Count	87	151	54	292

$\chi^2 = 28.00$ df = 4 $p = 0.000$

Table 13 suggests that there was a significant relationship between the frequency of use of drugs and extent of drug related absenteeism among

employees in the selected star-rated hotels. Majority of the respondents who were often absent (46.3 per cent) were also always using drugs at the workplace. In contrast, majority of the employees who were rarely absent (50.6per cent) also used drugs rarely at the hospitality and tourism industry. This was further supported by the chi-square value, since p (0.000) < 0.05 significance level indicating that there was a significant relationship between absenteeism and drug abuse in tourism and hospitality industry at the Kenyan Coast. These findings confirm previous studies relating drug abuse and absenteeism at the workplace. For example, Smith (2004) in a study on the effects of drugs in the European workplace found that increased drug use is associated with increased absenteeism at the workplace. In this study more than half of the sampled respondents reported absence from work as a result of drug related problems.

4.6.2. Estimated Costs of Alcohol and Drug – Related Absenteeism In Selected Star- Rated Hotels at the Kenyan Coast

According to the data provided by the HRMs, on average the full absenteeism rate per hotel was 30 labour days per month, this basically included both genuine and feigned sick offs related to alcohol and drug abuse. However, in case of unexplained absenteeism, then the employee's salary is attached. The 25 star rated hotels therefore lost a total of about 30 labour days per hotel due to drug abuse-related absences per month x 12months x 25hotels = 9000 labour

days per year x Ksh. 500 (average daily labour rate for the hotel employees) totalling to Ksh. 4,500,000.00.

In addition, during such absences casual employees are hired or permanent employees are recalled and compensated i.e. 9000 labour days x Ksh. 400 (casual are paid slightly lower) totalling to Ksh.3, 600,000. Therefore full absenteeism related to drug abuse costs the employers about Ksh.8, 100,000 per year. This was confirmed in the FGDs. The lost labour days in this particular study were much higher than that in the study by Nzioka (2008) where one of the objectives targeted to establish whether HIV/ AIDS related absenteeism had any effect on operational costs. She reported a total of 2,400 lost labour days in 2004 as compared to 1560 lost labour days in 2000 in 57 star rated hotels. The upward trend (275 per cent) and the disparity of the two results could easily be attributed to historical trends.

Moreover, two Human Resource Managers reported that in the last three years they had dismissed four employees due to absenteeism related to drug abuse. In another hotel (D4) a very competent employee all over a sudden became quite notorious with alcohol related absenteeism, he was cautioned and transferred to another department but there was no improvement. Management decided to refer him for treatment to a Rehabilitation centre late last year but he succumbed to drug abuse health related problems early this year. The employer therefore,

had to incur a lot of expenses such as medical and funeral costs. Moreover he had to be replaced as such recruitment, induction and training costs were also incurred.

Meanwhile in the two FGDs other experiences of effects of drug abuse on employees' absenteeism were shared by various respondents, they indicated that: *"Alcohol and drug abuse does not always affect employees directly but in most instances they are affected indirectly. The FGDs therefore estimated the man hours lost per hotel due to time wasting at 3hours per hotel per day. This they agreed could be translated to 75 man hours per day; 2,250 man hours per month and 27000 man hours per year for all the 25 hotels being studied. In terms of costs the employers incurred a total cost of about Ksh. 1,350,000 per year for the employees' partial absenteeism* (FGD, North Coast Hotels, 2010)

Generally the above quotation confirm the study by Roche and Pidd (2006a) which established that alcohol and drug abuse is largely attributed to an employees partial or full absenteeism. Pegging drug abuse on absenteeism *per se* is a real challenge to the Human Resource Managers; as such they discipline employees for other hidden reasons such as lateness, insubordination and others. This is because when they subject their employees for blood or urine tests to ascertain alcohol levels the results are always negative. For sure they contemplate foul play in such incidences.

In fact it was revealed in the FGDs that some employees had the audacity to feign sickness and were given official sick offs. One discussant in the FGDs attested that: *"One day he reported to work with a hangover and decided to feign sickness. Unfortunately a manager noticed that he was unwell and rushed him to hospital. Luckily the Doctor requested the manager to wait for this employee outside. At this juncture the employee confessed to the Doctor that he was suffering from hangover. He then bribed the Doctor and pleaded with him to submit a false report to the employer. This was his turning point and indeed at that juncture he quit smoking and drinking"* (FGD, South Coast Hotel, 2010).

4.6.3 Employees Self Report On Effects of Drug Abuse on Absenteeism In Selected Star- Rated Hotels at the Kenyan Coast.

Employees who revealed that they were using drugs were asked to indicate how drugs affected their work attendance. Out of the 113 respondents 36 (32 per cent) virtually reported that they were either totally absent (69.4 per cent) or partially absent (30.6 per cent) as they wasted a lot of the employers time, taking unnecessary long breaks to abuse drugs indeed they admitted being tardy.

(Table 14). Table 14: Employees Self Report of Effects of Alcohol And Drug Abuse on Absenteeism

			Absenteeism		Total
			Time wasting	Absenteeism	Drug Users
Drugs Used	Alcohol	Count	13	8	21
		per cent of Total	36.1per cent	22.2per cent	58.3per cent
	Alcohol and Cigarettes	Count	3	0	3
		per cent of Total	8.3per cent	.0per cent	8.3per cent
	Cigarettes	Count	6	0	6
		per cent of Total	16.7per cent	.0per cent	16.7per cent
	Medicinal drugs	Count	2	1	3
		per cent of Total	5.6per cent	2.8per cent	8.3per cent
	Alcohol and bhang	Count	1	1	2
		per cent of Total	2.8per cent	2.8per cent	5.6per cent
	Stimulants	Count	0	1	1
		per cent of Total	.0per cent	2.8per cent	2.8per cent
Total		Count	25	11	36
		per cent of Total	**69.4per cent**	**30.6per cent**	**100.0per cent**

Somewhat interestingly these results showed a close link between Alcohol and drug abuse and drug related absenteeism. To prove this Pearson Correlation

Moment Product was run and it indicated a relatively positive significant relationship (r= 0.865, p= 0.05) between drug use and the drug related absenteeism.

The results and experiences in the present study replicated other studies: McFarlin and Fals-Stewart (2002) in a study on workplace absenteeism at Ford Motor Company, National Cash Register and General Electric Company, U.S.A., found that workers using drugs were two times more likely to be absent from work a day after consuming alcohol.

4. 7 Impact of Drug Abuse on Accidents in Selected Star-Rated Hotels at the Kenyan Coast.

The second objective of this study sought to establish the impact of drug abuse on workplace accidents among employees in the star rated hotels. They rated the frequency of occurrence of these aspects of accidents among employees on a five-point Likert scale ranging from 1 to 5 (where, 1= never, 2 = very rarely, 3 = rarely, 4 = often and 5 = very often). The higher the score, the more frequent these aspects of accidents occurred among the employees using drugs in star-rated hotels, and vice versa (Table 15).

Table 15: Rating of Accidents among Employees Using Drugs in Selected Star- Rated Hotels

Statement	Response Rate per cent		
	Never	Rarely	Often
Being unnecessarily careless in handling tasks	21.2	53.8	25.0
Taking needless risk in handling tasks	34.2	49.0	16.8
Disregard the safety of others causing accidents or injuries	34.2	48.6	17.2
Being unremorseful even after causing an accident or injury	31.8	50.0	18.1
Higher than average accident rate on and off the job	31.5	57.9	10.6

The current study indicates that majority of the respondents rarely witnessed the above five aspects of accidents among employees taking drugs at the workplace. Overall, the respondents rated the seven aspects just averagely with mean scores ranging between M = 1.79 and M = 2.04. The respondents observed that indeed employees using drugs rarely took needless risk in handling tasks; handled tasks carelessly; disregarded the safety of others causing accidents or injuries; and were unremorseful even after causing an accident or injury. This suggests that even though the respondents were using drugs, they rarely engaged in activities that could expose them to accidents at the workplace. This was attributed to the

stringent rules governing handling of tasks and properties and the associated punishment for employees who flouted the rules against drug abuse.

4.7.1. Null-Hypothesis (Ho_{2}): Significant Relationship between Drug Abuse and Workplace Accidents.

The second null hypothesis was to determine whether there is any significant relationship *between drug abuse and workplace accidents among employees in the star rated hotel.* The overall frequency of the five aspects that determined accidents were then cumulatively interacted. Therefore, the responses to each constituent statement were scored on a scale of 1, indicating least frequent and 5, indicating most frequently observed. The overall impact of accidents as a result of drug abuse was obtained by summing up the individual statement scores to form an accident index score for each respondent (reliability coefficient, $\alpha = 0.9177$). The index score varied between 5, indicating the least accidents, and 25, indicating more accidents as a result of using drugs at the workplace. The higher the score, the more probable the employees were causing accidents as a result of employees using drugs while at the workplace in the hotels, and vice versa. The index score was later collapsed into three ordinal categories in order to differentiate the impact of drug abuse on the frequency of accidents among the sampled respondents. This included a score of 5-11 indicating fewer accidents, a score of 12-18 (average accidents) and a score of 19-25 indicating more accidents due to use of drugs (Table 16).

Table 16: Frequency of Accidents among Employees due to Drug Use in Selected Star-Rated Hotels

Impact	Frequency	Percent
Fewer	142	48.6
Average	117	40.1
More	33	11.3
Total	292	100.0

Out of the 292 employees, 48.6 per cent indicated fewer accidents; 40.1per cent had average accidents while 11.3 per cent reported more accidents at the workplace as a result of drug abuse. Therefore, majority of the respondents had observed fewer accidents at the workplace as a result of drug abuse. Ideally therefore, results do show alcohol and drug abuse caused over 50per cent of work related accidents. These results are much higher than those of the study conducted by Institute of Alcohol Studies (IAS, 2009) in Britain, which show that 20 - 25per cent of workplace accidents and up to 30 per cent of work – related deaths are related to alcohol and drugs. They further argue that even small amounts of drugs taken hours before work are dangerous.

The study further sought to establish whether there was any statistically significant relationship between accidents and drug abuse in star-rated hotels. In

this study, frequency of accidents among employees was measured by the extent to which employees using drugs engaged in various incidences of accidents (Table 15). This relationship was established using Chi square test. Table 17 shows a cross tabulation of frequency of drug use by frequency of accidents.

Table 17: Accidents by use of drugs among employees in Selected Star-Rated Hotels at the Kenyan Coast (Co- workers Perception)

			Frequency of accidents			Total
			Fewer	Average	More	
Frequency of use of drugs	Always	Count	22	31	13	66
		per cent	15.5per cent	26.5per cent	39.4 per cent	22.6 per cent
	Often	Count	52	54	12	118
		per cent	36.6per cent	46.2per cent	36.4 per cent	40.4 per cent
	Rarely	Count	68	32	8	108
		per cent	47.9per cent	27.4per cent	24.2 per cent	37.0 per cent
Total		Count	142	117	33	292

$\chi^2 = 18.619$ df = 4 $p = 0.001$

The results indicate that there was a significant relationship ($p = 0.001 < 0.05$) between the frequency of use of drugs and frequency of accidents among

employees in star-rated hotels. These findings confirm previous studies that relate drug abuse and accidents at the workplace. For example, Frone (2008); ILO (2003); Kavanaugh *et al.* (2001) and Mohr *et al*., (2005) reported that drug abuse is a major cause of accidents and injuries in the work place.

4.7.2. Estimated Costs of Alcohol and Drug – Related Accidents in Selected Star-Rated Hotels at the Kenyan Coast

Employees who are careless and accident-prone are reprimanded, forced to compensate or even sacked. This therefore makes accidents costly. Regardless of this, the respondents agreed that employees using drugs were more prone to cause accidents at the workplace compared to those who do not. For instance cases of broken cutlery and crockery due to carelessness was high, as much as 10 items could be broken on a daily basis per hotel (FGDs, South Coast Hotels, 2010). Out of these 50 per cent of the broken crockery and cutlery are most likely pegged to employees with drug abuse problems. Therefore this further costs management about Ksh. 1, 000 per day, Ksh.30, 000 per month and Ksh. 360, 000 per year per hotel. Ultimately, this translates to Ksh. 9,000,000 per year for the 25 star rated hotels studied.

However, management recovers these costs through employees service charge that is paid at the mid of every month. Ultimately, the workforce has an uphill

task to minimize the breakages so that they can be paid higher service charge. In addition the discussants in the FGDs estimated that on average it costs each of the 25 hotels about Ksh. 50,000 per year for workman's compensation in respect to workplace accidents related to alcohol and drug abuse. This totals to Ksh. 1,250,000 for all the hotels per year.

4.7. 3 Employee's Self Report of Effects of Drug Abuse on Accidents in Selected Star Rated Hotels at The Kenyan Coast.

In order to find out the effects of alcohol and drug abuse on employees who admitted they were abusing drugs, a question was paused to them on how their drugs use impacted on safety at the workplace. Out of the 113 respondents 42.3 per cent categorically said that once they became intoxicated they performed their duties carelessly while 57.7 per cent reported that they became more prone to accidents causing unnecessary costs to their employer (Table 18). Other common drug abuse-related accidents included falls, slips, cutting fingers when preparing food etc.

Table 18: Employees Self Report of Effects of Alcohol and Drug Abuse On Accidents

		Accidents		**Total**
Drug Used		**Carelessness**	**Accidents**	**Drug Abusers**
Alcohol	Count	6	9	15
	per cent of Total	23.1per cent	34.6per cent	57.7per cent
Alcohol and cigarettes	Count	1	1	2
	per cent of Total	3.8per cent	3.8per cent	7.7per cent
Cigarettes	Count	3	2	5
	per cent of Total	11.5per cent	7.7per cent	19.2per cent
Medicinal drugs	Count	0	2	2
	per cent of Total	.0per cent	7.7per cent	7.7per cent
Alcohol and bhang	Count	1	0	1
	per cent of Total	3.8per cent	.0per cent	3.8per cent
Stimulants	Count	0	1	1
	per cent of Total	.0per cent	3.8per cent	3.8per cent
Total	Count	11	15	26
	per cent of Total	42.3per cent	57.7per cent	100.0per cent

Pearson Correlation Moment was used to ascertain these results and the outcome showed that there was a significant positive correlation ($r= 0.911$, $p= 0.05$) between drug use and workplace accidents.

As explained earlier and as echoed by the hotel Human Resource Managers and the two FGDs, hotels are private investments where the management always aims at minimizing the costs and risks to make a profit. Careless employees who are prone to accidents are not tolerated. However, various hotels had their different experiences with drug abuse-related and workplace accidents: "*An employee noticed to be intoxicated the previous night was found dead in the swimming pool; a drank driver almost caused a ghastly road accident; a coconut climber who reported on duty sober sneaked to a mnazi den at tea break and resumed to work tipsy he fell from the coconut tree as he was trimming it and injured his limbs and lastly a professional chef fried his palm instead of steaks*"(personal interview, Coast hotel,2010). Worse still the management of these hotels through their insurance companies and the Directorate of Occupational Health and Safety had to compensate these employees for partial, permanent and fatal disablement (OSHA, 2007).

All the experiences shared from the FGDs and the in depth interviews on drug abuse and work- related accidents with the relevant officers did shed light on the magnitude of drug abuse and accidents in the hospitality industry. Virtually this

is a wake up call and as a result, for the sake of health promotion, safe working environment, reduced economic and human costs this menace needs to be addressed urgently. It was concluded in the two FGDs i.e. one for hotels in South Coast and the other for hotels in North Coast, Malindi, Kilifi, Mainland and Watamu that in the recent past accidents related to alcohol and drug abuse were limited compared to yester years. This is because with the enforcement of the new Occupational Health and Safety Act (OSHA, 2007), the Work Injury Benefits Act (WIBA*, 2007*) *and the New Labour Laws (2007)* stringent health and safety measures were instituted.

4.8 Influence of Drug Abuse on the Level of Job Productivity in Star-Rated Hotels in Coast Province.

The third objective of this study was to examine the influence of drug abuse on the level of job productivity among employees in the star rated hotels. The objective was based on the fact that the ultimate effects of drug abuse on various aspects of work performance are reflected in the level of productivity. To address the objective, the respondents were presented with eight statements indicating common aspects of job productivity of employees using drugs in a workplace. They rated the frequency of occurrence of these aspects of job productivity among employees on a five-point likert scale ranging from 1 to 5 (where, 1= never, 2 = very rarely, 3 = rarely, 4 = often and 5 = very often). The

higher the score, the higher was the level of productivity of the employees using drugs in the hotel, and vice versa (Table 19).

Table 19: Rating of Job Productivity among Employees in Selected Star-Rated Hotels at the Kenyan Coast

Statement	Response Rate per cent		
	Never	**Rarely**	**Often**
Lapses in concentration to work	14.4	50.4	35.3
Poor judgement or more mistakes than usual and general carelessness	13.4	54.5	32.1
Using more time to complete work/missing deadlines	11.3	58.5	30.1
Inconsistency in quality of work	15.4	54.1	30.5
Difficulty in recalling own mistakes	13.7	55.9	30.5
Difficulty in recalling instructions	15.1	55.1	29.8
Inconsistency in the level of productivity of work	16.4	56.2	27.4
Increased difficulty in handling complex situations	16.8	53.4	29.8

Essentially, majority of the respondents considered the eight aspects of job productivity to be rare among employees taking drugs at the workplace. According to the Productivity of Kenya Labour Market Dialogue Manual –

Kenya Chapter (2010), productivity is the relationship between output generated by a production or service system (activities) and input provided to create this output. It is also defined as the ratio of a measure of output to a measure of some or all of the resources used to produce output. Apparently productivity can also be defined as the relationship between results and the time it takes to accomplish them. In summary, productivity is the efficient and effective use of resources, labour, capital, land, materials, energy, information, technology- in the production of goods and service (i.e. the ratio of inputs to outputs over a period of time). Whereas *efficiency* is the performance of a given function in the best possible manner with least waste of resources, time and effort; *effectiveness* refers to the degree to which end results are achieved to the required standards.

Measuring of productivity in the service industry is acknowledged to be particularly difficult (Atkinson and Brown, 2001). This is due to the somewhat intangible, perishability, heterogeneity, simultaneity and complexity nature of the products and services. There are various methods of measuring productivity and these include: Total Factor Productivity (TFP); Single Factor Productivity (SFP) and Partial Factor Productivity (PFP) (Jones and Siag, 2009). The present study therefore adapted partial total productivity method used by Johnstone and Jones, 2004; Jones and Siag, 2009. In this context non financial measurements were used; i.e. a number of factors / aspects that affect productivity were identified such as: quality of customer service, meeting deadlines by achieving

set targets within the given standards and time frame- e.g. number of rooms cleaned within a set time frame, number of customers served, the number of the table turns and repeat guests. These aspects were phrased into 8 statements that were commensurate to measure partial productivity in relation to drug abuse in the hotel industry.

Overall, the respondents rated the eight aspects just averagely with mean scores of between M = 2.13 and M = 2.21. The respondents observed that employees using drugs were rarely inconsistent in their quality of work; inconsistent in the level of performance of work; made poor judgement or more mistakes than usual and general carelessness; lapsed in concentration to work; faced difficulty in recalling instructions; faced difficulty in recalling own mistakes; used more time to complete work/missing deadlines; and increased difficulty in handling complex situations. This suggests that even though the respondents had observed employees using drugs engage in several activities that could affect their productivity; the ultimate magnitude was still very low. This was attributed to the level of job supervision in the hotel where the job survival of employees depends on their level of performance of their duties and responsibilities. However, regardless of the low rating, findings from the in-depth interview schedules with the management and FGDs revealed that drug abuse negatively influence job productivity of the employees in the hotels.

The eight aspects that determine job productivity in the present study were cumulatively interacted. Therefore, the responses to each constituent statement were scored on a scale of 1, indicating least frequent, to 5, indicating most frequently observed. The overall impact on job productivity was obtained by summing up the individual scores to form a job productivity index score for each respondent (reliability coefficient, $\alpha = 0.9510$). The index score varied between 8, indicating the least impact, and 40, indicating the highest impact of drug abuse on job productivity at the workplace. The higher the score, the more was the influence of drug abuse on the level of job productivity of the employees at the workplace in star-rated hotels, and vice versa. The index score was later collapsed into three ordinal categories in order to differentiate the level of influence of drug abuse on the level of job productivity among the sampled respondents. This included a score of 8-18 indicating (low job productivity), a score of 19-29 (average job productivity) and a score of 30-40 indicating (high job productivity) among employees using drugs. Table 20 depicts the influence of drug abuse on the level of productivity of the employees at the workplace.

Table 20: Job Productivity among Employees using Drugs in Selected Star-Rated Hotels at the Kenyan Coast

Level of Job Productivity	Frequency	Percent
Low	75	25.7
Average	146	50.0
High	71	24.3
Total	**292**	**100.0**

Subsequently, the respondents varied in their rating of the influence of drug abuse on employees' job productivity at the workplace. Out of the 292 employees, a half (50.0per cent) of them reported average influence, 25.7 per cent indicated less influence while another 24.3 per cent had more influence. Therefore, majority of the respondents rated the influence of drug abuse on job productivity to be average. These results are affirmed by Frone (2009) study conducted in the USA. These two results clearly underpin that there is a positive relationship between alcohol and drug abuse and work productivity.

4.8.1 Employees Self Report of Effects of Alcohol and Drug Abuse On Productivity in Selected Star Rated Hotels at the Kenyan Coast

To authenticate the above results individual employees who accepted that they either use or abuse drugs were asked to give opinions about their productivity

when under the influence of drugs. Only 19 respondents out of the 113 admitted that their performance was weighed down. Nine (47.3per cent) experienced hangovers and 10 respondents (52.7per cent) were aware that their productivity was below par (Table 21).

Table 21: Employees Self Report Of Effects Of Alcohol And Drug Abuse On Productivity

		Productivity		Total
Drug used		Low Productivity	Hangover	Drug Abuser
Alcohol	Count	4	6	10
	per cent of Total	21.1per cent	31.6per cent	52.6per cent
Alcohol and cigarettes	Count	1	3	4
	per cent of Total	5.3per cent	15.8per cent	21.1per cent
Cigarettes	Count	2	0	2
	per cent of Total	10.5per cent	.0per cent	10.5per cent
Medicinal drugs	Count	0	1	1
	per cent of Total	.0per cent	5.3per cent	5.3per cent
Bhang	Count	1	0	1
	per cent of Total	5.3per cent	.0per cent	5.3per cent
Cigarette and Miraa	Count	1	0	1
	per cent of Total	5.3per cent	.0per cent	5.3per cent
Total	Count	9	10	19

Generally these employees indicated their productivity was highly comprised, due to hangovers, sometimes they gave wrong change to clients forcing them to fleece their employer of resources or another client to repay the shortage. On the other hand, some were unable to meet set targets or deadlines.

In- depth interviews with Human Resource Managers established that drug abuse was associated with low productivity however they said they had in place practical mechanisms to control this. They did staff appraisal regularly at least twice in a year. This tool measured the individual's productivity and most of them scored above 50 per cent an indicator that they achieved their targets. The same was used to promote staff and to reward best performers. However most employees who performed below average had weaknesses such as alcohol and drug abuse and were always given a second chance. Some two hotels affiliated to the government signed Performance Contracts which were evaluated every quarterly (every four months). Management is therefore able to assess productivity using this tool.

The managers also reported that they had integrated Total Quality Management(TQM) programme in their systems, this encouraged close supervision of all assignments, thorough assessments at each stage of operations are undertaken and impresses on ideal; working methods and procedures and clear job descriptions. They further stated that various stakeholders affiliated to the hospitality and tourism industry such as: FKE; KUDHEHIA; KAHC had instituted fundamental strategies to enhance productivity in this sector.

It emerged from the two FGDs that in other instances they had witnessed their colleagues working in the housekeeping department being influenced negatively by alcohol; ideally their productivity was below par after using or abusing drugs while on duty. Some of these employees would steal alcoholic drinks from the guest rooms, drink and become intoxicated hence hampering them from achieving their days target and instead waste a lot of man hours by taking an afternoon nap. Others were lured by guests into abusing drugs and immediately after engaged in intimate relationships with the same guests.

Absolutely these findings confirm those of previous studies relating drug abuse and job productivity of the employees at the workplace. For example, Frone, (2006); Lehman and Bennet (2002); NIDA (2005) and CCHOS (2005), observed that the ultimate effects of drug abuse on various aspects of workplace conditions are reflected in the level of productivity. CCHOS (2005) argue that drug abuse directly undermines productivity at the workplace and studies indicate that even consumption of fairly low quantities of drugs can lead to a relatively high loss in the level of productivity. Valencia and Gomez (2005) attributed an estimated US $ 200 billion in lost productivity and lost employment to alcohol and illicit drug use. Kenya is not any peculiar and is headed towards that direction if intervention measures are not fostered immediately. Pryce (2008) add that drug abusers are less productive, miss work more often and are much more likely to file worker's compensation claims.

Further, they are likely to have health problems that affect their productivity which in turn lead to personal problems and distract them from their jobs.

4.8.2. Null-Hypothesis (Ho2): Significant Relationship between Drug Abuse and Job Productivity.

The third null hypothesis was to determine if there existed any significant relationship between drug abuse and the level of job productivity. Parametric and non -parametric statistical analysis were run and the following results were achieved. The chi-square tests indicated that there was an insignificant relationship (χ^2 = 8.154, df = 4; p = 0.086) between the frequency of use of drugs and the level of job productivity among employees in star-rated. Pearson Coefficient of Correlation or Product Moment Correlation (r= .142 p= 0.05) and Spearman's Coefficient of Correlation or rank order (rho = 0.279 α= 0.05), showed that some positive relationship exists though not quite significant.

4.9 Organizational Regulations and Drug Abuse in Selected Star-Rated Hotels

All the 315 respondents were asked whether they were aware of the existence of regulations to curb drug abuse in their hotels (Figure 10).

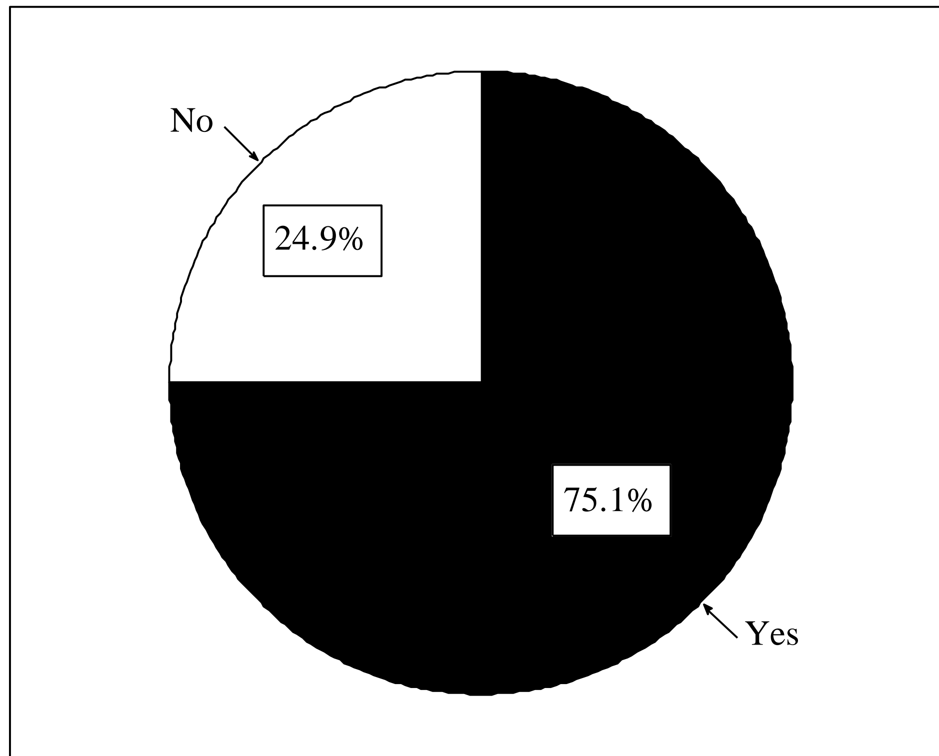


Figure 10: Awareness of the Regulations on Drug Abuse in Star-Rated Hotels

Over 75 per cent of the respondents were aware of regulations on drug abuse in their hotels, while 24.9 per cent were not. This suggests that hotels had come up with regulations on the drug abuse and majority of the employees were aware of them. The drawing of regulations to control drug abuse implies that the hotels were concerned about drug abuse and its associated consequences. The 75.1 per cent respondents were asked about what the regulations say about drug abuse. They reported that regulations state that no drug use and/or abuse while at the workplace or reporting to work under the influence of drug. Further the 280

employees were asked about the effectiveness of these regulations on drug abuse in their hotels. Their responses are summarized in figure 11.

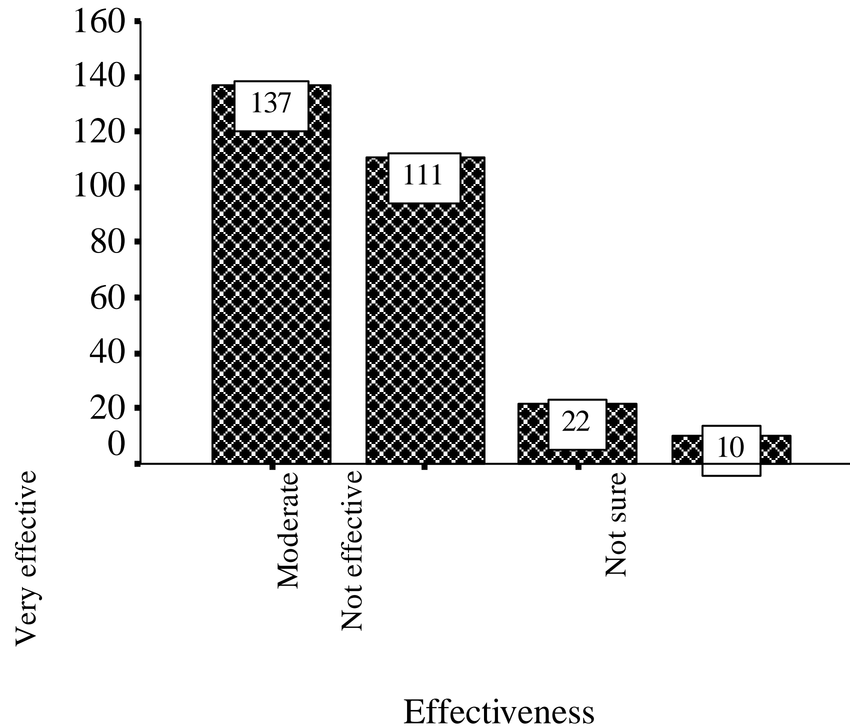


Figure 11: Effectiveness of Regulations on Drug Abuse in Star-Rated Hotels

Figure 10 indicates that majority (88.6per cent) of the respondents considered the regulations on drug abuse to be at least moderately effective. This suggests that majority of the employees considered the regulations to be effective in controlling drug use/abuse cases in the hotels. The managers reported that their organizations had witnessed reduction in the prevalence of drug abuse as a result of implementation of measures to curb drug abuse. Regardless of this there was still room for improvement.

4.9.1. Measures Taken by Hotels on Employees Abusing Drugs in Selected Star- Rated Hotels.

The regulations also stipulate the strict measures and punishment to be taken on people contravening the regulations. But the respondents had contrasting views on the measures that hotels take on employees found using drugs (Table 22).

Table 22: Measures Taken by Hotels on Employees Abusing Drugs in Selected Star- Rated Hotels

Measures	Frequency	Percent
Dismissal/termination of job	142	50.7
Depends on the kind of drug, frequency of use and effects	70	25.0
Warning and demotion	54	19.3
Suspension	13	4.6
Counselling of the victims	1	.4
Total	**280**	**100.0**

Literally, the analysis stipulates that there are several measures taken by hotels on employees caught using or under the influence of drugs while at the workplace. Firstly, most hotels had outsourced security functions; hence, the officers working for the security firms would be rotated frequently and were under strict instructions not to allow any employee suspected to be under the influence of drugs to check in. The common measure was summary dismissal from employment. Being a hospitality industry, success depends on mannerism,

perception and face to face interactions between the employees and clients. Therefore, most hotels do not tolerate any incidence of drug abuse that can negatively affect customer satisfaction that is paramount in this industry. Through the in-depth interviews and the discussions from the FGDs it was established that a number of employees were summarily dismissed as a result of having been found to be using drugs at the workplace or having a hangover. Unfortunately, this contributed to brain drain and high labour turnover in this industry. The hotel management to some extent incurred such costs as advertisement, recruiting, training and induction of new employees.

Other measures include both verbal and written warning, followed by suspension and then dismissal if there is no improvement. However, marijuana and other hard drugs called for more severe disciplinary measures. Other general measures include warning, transferring to another department, demotion, suspension and counselling of the victims. From the enacted Tobacco Control Act (2007), all the hotels had set aside smoking zones for staff and guests failure to which one is supposed to pay Kshs 50,000. Specifically this measure went a long way to prevent Environmental Tobacco Smoke or second hand smoke from affecting hotel patrons and employees (Albers *et al.,* 2006). It was established from the in –depth interviews and FGDs that this law has since been flouted especially for guests; however the hotel employees are still restricted to their smoking zones.

From the in-depth interviews with the managers and the FGDs it was observed that in addition to individual hotels coming up with regulations to curb drug use at the workplace, they had observed that organizations such as the Council of Imams and Preachers of Kenya (CIPK); Supreme Council of Kenya Muslims (SUPKEM); Muslim Education Welfare Association (MEWA); Citizen against Child and Drug Abuse (CICADA) are on the forefront in fighting the drug abuse menace. They have organized workshops with members of the Judiciary urging stiff penalties for drug traffickers and several times Muslim faithful held demonstrations on the streets at the Coast especially on Fridays. On such occasions the women in Mombasa have threatened to strip naked publicly unless the Government moved fast to arrest the escalating narcotics use in the region. In collaboration with the media such as *Radio Rama* in Mombasa, daily newspapers the *Nation* and the *Standard* the community has managed to express their sentiments to the Government to take heed of this menace before it sweeps away an entire generation.

On the other hand, the various hotel Human Resource Managers indicated that the government was also in the forefront to curb the menace. However, they differed in the extent to which the government was doing this. Some reported that through the establishment of the National Agency for the Campaign against Drug Abuse Authority (NACADAA), the government had been sensitizing the people about the adverse consequences of drug abuse. The Tobacco Bill tabled

in parliament in 2004 (enacted in 2007) and the Alcohol law referred to as *Mututho* law which was put to law November, 2010 are some of the fundamental indicators that the government is committed towards mitigating this disaster. The two documents endeavour to regulate the production, advertisement and consumption of alcohol and tobacco are in line with WHO (2004) guidelines.

In addition the government had also come up with an anti-narcotic police unit that is responsible to patrolling drug-prone areas and arresting peddlers and users. The Government is also revamping community policing and to achieve this local leaders are being trained by authorities such as NACADAA to fight/detect drug dealers and crime. Therefore the managers further indicated that there was need for the government through NACADAA to step up their campaigns so as to reach as many people as possible. The Provincial Administration and Police are trying to intensify efforts to curb the menace. They have also acquired speed patrol boats which are able to go a long way in improving the monitoring of creeks and waterways. Nonetheless, measures by government are not restricted to the tourism and hospitality industry.

4.9.2 NACADAA and Alcohol and Drug Abuse at the Workplace.

The Narcotics Drugs and Psychotropic Substances (Control) Act which was enacted in 1994, largely contributed to the formation of NACADA in 2001. Later on in 2007, it was renamed as National Campaign against Drug Abuse Authority (NACADAA) and gazetted as a state corporation (parastatal). Its mandate is to coordinate the activities of individuals and organisations in the campaign against drug abuse in Kenya. It is also mandated to prepare an institutional framework for the enactment of a law setting up a drug and substance abuse control authority in Kenya.

NACADAA strives to achieve the set goals through strong partnership links with families, the media, the clergy, educational and health authorities, policy makers, professionals and law enforcement agents from various sectors and disciplines (NACADAA, 2007). However, they have tended to concentrate their campaigns and baseline surveys on the youth. But the Chief Research officer indicated that they were gradually moving to address this problem at the workplace and currently were conducting baseline surveys in organisations who had requested them to. Generally they concurred that the drug abuse and in particular alcoholism was rampant at the workplace and to mitigate this they have documented a guideline for developing Workplace Alcohol and Abuse Policies (NACADAA, 2009). NACADAA therefore, recommends that all organisations need to develop and initiate Workplace Policy on Drugs; Alcohol

and Drug Abuse Prevention Units (ADA Units) and Employee Assistance Programmes (EAPs). The process of \developing all these should be participatory hence all workers and managers need to be involved.

4.9.3 Suggested Mitigation Measures of Drug and Substance Abuse In Selected Star Rated Hotels at the Coast Province.

The respondents made a number of suggestions that could assist hotel management in curbing drug abuse (Table 23).

Table 23: Suggested Mitigation Measures to Curb Drug Abuse in Star-Rated Hotels

Measures	Frequency	Percent
Sensitization on the effects and counselling of the victims	129	50.0
Strict regulations and punishment	99	31.5
Frequent checks and inspection	28	8.8
Improve working conditions and remunerations	23	7.9
Medical checkups before employment	14	4.4
Involve the employees in the campaign	10	3.2
Install security surveillance equipment e.g Closed Circuit TV	10	3.2
Total	**315**	**100.0**

The respondents cited several suggestions and structures on how hotels could curb drug abuse. The common strategies included sensitizing employees on the

effects of drug abuse and counselling the victims, and applying strict regulations and punishment on the victims of drug use/abuse. Both the in – depth interviews and the Focus Group Discussions pointed that there was critical need for concerted efforts to ensure stringent and stern measures were formulated and enforced as this emulates recommendations given by WHO, 2004 and Hodgins, 2009. The government needs to go a notch higher to facilitate formulation of clear policies and ensure they are not flouted. Relevant stakeholders (KAHC, FKE, NACADAA, Ministry of Tourism and KUDHEHIA) also need to be on the fore front to assist the hotel management to formulate clear workplace Alcohol and drug abuse policies and inclusion of Employee Assistance Programmes in these policies would be ideal.

Alcohol and Drug Abuse is an emotive culture that urgently requires urgent modalities to suppress it (Beckelerg, 2002; Frone, 2009). Subsequently therefore, managers suggested that it was fundamental to have regular sensitization, awareness and campaign to increase the level of awareness of the adverse consequences of drug use. This noble suggestion was in agreement with that of a study by Valencia and Gomez, 2005 in USA. Again just like NACADA had recommended in 2004 the hotel managers also observed that by economically engaging the youth, they will be left with little time to think of engaging in this dangerous trend of drug abuse. In fact some hotels as part of their social responsibility, have embarked on recruiting reformed drug addicts

from the community, train them on the job and encourage them to form football clubs that keep them pre- occupied during their free time.

Many managers suggested that organizations need to inculcate self-discipline among their employees by continuously sensitizing them about the dangers of engaging in drug abuse. It would even be more ideal to refer addicts for counselling and to rehabilitation centres, and support groups (e.g. Alcoholic Annoymous- AA and Narcotics Anonymous -NA). Several studies have supported these fundamental aspects (Imbosa, 2002; Spicer *et al*., 2003 and Mohr *et al.,* 2005). Organizations should further consider rewarding disciplined employees, especially those who do not engage in drug abuse as a way of being role models to others. However, some of them also observed that curbing drug abuse in the hospitality and tourism industry can only succeed if drug abuse in the entire society is controlled. Employees are members of the society and therefore what happens outside their workplace also influences their behaviours and performance.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.

5.1 Introduction.

This chapter presents a summary of the major findings from the study based on the research objectives, conclusions from the findings and recommendations derived from the conclusions. The study sought to assess the effects of drug abuse on work performance in the tourism and hospitality industry in Kenya using a survey of star rated hotels at the Kenyan coast. This broad objective was guided by the following specific objectives:

i) To determine the extent to which drug abuse influence workplace absenteeism among employees in the star rated hotels.

ii) To establish the impact of drug abuse on workplace accidents among employees in the star rated hotels.

iii) To examine the influence of drug abuse on the level of productivity among employees in the star rated hotels.

Both primary and secondary data were used to elucidate drug abuse and its effects on work performance in the study. Primary data were collected using three sets of instruments which included structured questionnaire with employees, in-depth interview schedules with managers and Focused Group Discussions (FGDs) with employees and various stakeholders. A sample of 315

employees was interviewed using the structured questionnaire, 22 in-depth interviews were conducted and two FGDs held. Secondary data were collected from documented information about drug abuse and its effects on work performance from the study area, the country at large and elsewhere. The collected data were analyzed using descriptive and inferential statistics with the aid of SPSS version 15 for Windows.

5.2 Summary of the Major Research Findings

Based on the study objectives, null hypothesis and data analysis; the following major research findings are presented:

(i) There was a significant relationship between the frequency of use of drugs and extent of absenteeism among employees in star-rated hotels. Employees using drugs were involved in various aspects of absenteeism as a result of their habit. However, the extent of absenteeism varied from one aspect to another among the respondents based on the associated consequences.

(ii) There was a significant relationship between the frequency of use of drugs and frequency of accidents among employees in star-rated hotels. Employees using drugs were also prone to causing accidents while at the workplace. However, the extent and magnitude of these

accidents were minimal as a result of the associated repercussions from the management.

(iii) There was no significant relationship between the frequency of use of drugs and level of job productivity among employees in star-rated hotels. Seemingly, Drug abuse moderately but negatively affected various indicators of job productivity of the employees involved.

5.3 Conclusions.

From the foregoing the following conclusions were arrived at:

(i) Although majority of the employees were not fully absent from work as a result of drug abuse, the amount of time that they spent on drug use related activities could impact negatively on the hotels in terms of direct and indirect costs. Therefore it was concluded that partial and full absenteeism (lost man hours/ lost labour days) cost the employers roughly Ksh. 8,100,000 per year.

(ii) Although employees using drugs were more prone to cause accidents at the workplace, the magnitude of the accident incidences were still minimal due to the cost involved and the stringent sanctions adopted by the hotels. For instance crockery and cutlery breakages related to drug abuse estimated to cost Ksh.9,000,000 per year are recovered from the service charge to be paid to the employees. On the other

hand the 25 hotels spend almost Ksh. 1,250,000 for workman's compensation in respect to workplace accidents related to drug abuse.

(iii) The ultimate negative effect of drug abuse on work productivity has been concluded to be quite minimal possibly because hotel management and other arms of Government are really upbeat in designing tools to measure productivity. They have further embraced the concept of Total Quality Management (TQM) whereby the programmes for managing quality, developing human resources, adopting technologies building partnerships and measuring performance have been integrated in the system.

5.4 Recommendations.

In view of the above conclusions, this study makes the following recommendations about drug use and/or abuse at the workplace in the study area and beyond:

(i) Given the critical role the employee's mannerism and behaviour and the need for face-to-face interaction with the clients, there is a need for the tourism and hospitality industry to put in place stringent policy mechanisms to curb drug use and/or abuse among its employees. This would go a long way to minimize the risk of drug

and alcohol consumption that cause professional invalidity and incapacitated employees.

(ii) There is need for hotels to have capacity development programmes to sensitize their employees across the board and increase their awareness of the adverse consequences of drug use, especially in an industry whose success depends on the hospitality of the employees.

(iii) There is a need for the government and the larger society to control availability and access to drugs. This should be addressed from the sources of the drugs to the ultimate users.

(iv) Seemingly the government needs to consider establishing more preventative, treatment and rehabilitation centres. Despite drug abuse being rampant in the Coastal Region of Kenya, there were only four of such facilities.

5.4.1 Suggestions for Further Research.

The subject of drug abuse in the hospitality industry has attracted limited research attention in developing countries, and especially Kenya which relies very much on tourism as a source of foreign exchange. As noted in Chapters One and Two, there has been limited research attention known to this author that has adequately addressed these aspects in the study area and the country. However, from the research findings, it was established that, unless checked, the

issue of drug use and/abuse can negatively affects these gains. This study therefore suggests the following areas for further research:

(i) A similar study should be carried out in all the hotels and tourist destinations in the country to validate the results of this study. More attention could be given to hotels offering *all inclusive Packages* and in addition to lodges.

(ii) In addition to replicating the study, future research should examine other aspects of workplace performance that can also be affected by drug abuse so as to have a holistic approach in addressing this menace- for instance drug related workplace aggression, employee relationships and drug related labour turnover.

(iii) Future researchers could study in more details the relationship between Alcoholism and Job Productivity for hospitality and tourism industry. Total Productivity Factor method would be an appropriate model to use in this case.

REFERENCES

Aden, A., Dimba, O. Ndolo, M. and Chindia, L. (2006). Socio-economic Effects of Khat Growing in North Eastern Kenya. *East African Medical Journal*, 83(3): 69-74.

Adlaf, E.M., Begin, P., and Sawka, E. (Eds.)(2005). Canadian Addiction Survey (CAS): *A national survey of Canadians' Use of Alcohol and other Drugs: Prevalence of Use and Related Harms: Detailed report*. Ottawa: Canadian Centre on Substance Abuse.

Akama, J. S. and Kieti, D. (2007). Tourism and Socio - Economic Development in Developing Countries. A Survey of Mombasa Resort in Kenya. *Journal of Sustainable Tourism*, 15(6): 735 – 738.

Albers, B., Siegel M., Cheng, D., Rogotti N. and Beiner, L (2004). Effects of Restaurant and Bar Smoking Regulations On Exposure To Environmental Tobacco Smoke (ETS) Among Massachusetts Adults. *American Journal of Public Health*, 94 (11): 1959-1972.

Ames, G.,Grube, J. and Moore, R.(2000). Social Control and Workplace Norms: A Comparison of Two Organisational Cultures. *Journal of Studies on]Alcohol*, 61 (2): 203-219.

Ames, G., Curnadi, C., Moore, R., and Stern, P. (2007). Military Culture and Drinking Behavviour Among U.S. Careerists. *Journal of Studies on Alcohol*, 68 (3): 336- 344.

Anderson. K. and Larimer, E. (2002). Problem Drinking and the Workplace: an Individual Approach to Prevention. Pschology of Addictive Behaviours, 16(2): 243 – 251.

Arendt,M., Rosenberg, R., Foildager, L., Pento, G. and Jorgensen, M.(2005). Cannabis Induced Psychosis and Subsequent Schizophrenia-Spectrum Disorders:Follow-up Study of 535 incident Cases. *The British Journal of Psychiatry*, 187: 510-515.

Armstrong, M. (2003). *Human Resource Management Practices.* Norfolk: Bath Press.

Australian Safety and Compensation Council (ASCC, 2007). Work – Related Alcohol and Drug Use. A Fit for Work Issue. http://www.ag.gov.au/cca. Lastly viewed in May,2010.

Bacharach, S., Bamberger, P. and Biron, M. (2009). Alcohol Consumption and Workplace Absenteeism: The Moderating Effect of Social Support. *Journal of Applied Psychology*, 95(2): 334 – 348.

Bayer, J. and Waverly, K. (2005). Tobacco Control Policies. Strategies and Setbacks. Brigden Co-publication of the World Bank and Research for International Tobacco Control.

Beckelerg, S. (2002). Counselling Kenya Heroin Users. *Health Education Journal*, 107 (2): 69-73.

Bennet, B., Patterson, C., Reynolds, S., Wiitala, W. and Lehman, W. (2004). Team Awareness, Problem Drinking and Drinking Climate: Workplace Social Health Promotion in a Policy Context. *American Journal of Health Promotion*, 19(1): 103 - 113

Blume, B. (1998). *Alcohol and Drug Abuse in the Encyclopedia of Occupational Health and Safety*. 4th Ed. Geneva: International Labour Office.

Canadian Centre on Substance Abuse - CCSA (2006). The Costs of Substance Abuse in Canada. Rehm *et al.*

Canadian Centre for Occupational Health and Safety (CCOHS 2005). Substance Use in the Workplace. Ministry of Labour,Canada. On line lastly Reviewed 8th July, 2010. www.ccohs.ca/oshanswers

Crawley, M. (2000). Investigating the Impact of Tourism in Kenya. *IDRC Bulletin*.

David, M. and Sutton, C. D. (2004). *Social Research: The Basics*. London: Sage Publication.

Fraenkel, J. R. and Wallen, N. E. (2000). How to Design and Evaluate Research in Education. London, U.K: McGraw Hill.

French, T., Holtmann, .A., McGeary, A., and Zarkin, A. (2001). Substance Use and Workplace Attendance. The Economic Analysis of Substance Use and Abuse. Massachusetts: Edward Elgar Publishing, inc.

Frone, M. (2003). Predictors of Overall and on- the- Job Substance Use Among Young Workers Alcohol. Journal of Occupational Health Pschycology, 8 (2): 39 – 54.

Frone, M. (2004). Alcohol, Drugs and Workplace Safety Outcomes: a View From a General Model of Employee Substance Use and Productivity. *The Psychology of Workplace Safety* (pp 127- 156). Washington , DC: American Psychological Association.

Frone, M. (2006a). Prevalence and Distribution of Alcohol Use in the Workplace: a U.S. National Survey. *Journal of Studies of Alcohol*, 67 (1) :147- 156.

Frone, M. (2006 b). Prevalence and Distribution of Illicit Drug Use in the Workforce And in the Workplace: Findings and Implications From a U.S. National Survey. *Journal of Applied Psychology*, 91(4): 856-869.

Frone, M. (2008). Employee Alcohol and Illicit Drug Use: Scope, Causes and Organisational Consequences. In J. Barling and C.L. Cooper (Eds), *Handbook of Organisational Behaviour* (Vol, 1pp. 519 – 540). Thousand Oaks , CA: Sage.

Frone, M. (2008). Are Work Stressors Related to Employee Substance Use? The Importance of Temporal Context in Assessment of Alcohol and Illicit Drug Use. *American Psychological Association.*

Frone, M. (2009). Does a Permissive Workplace Substance Use Climate Affect Employees Who Do Not Use Alcohol and Drugs at Work? A U.S. National Study *Psychology of Addictive Behaviours*, 23(2):386-390.

Frone, M. and Brown, A. (2010). Workplace Substance- Use Norms as Predictors of Employee Substance Use and Impairment: A Survey of U. S. Workers. *Journal Studies of Alcohol and Drugs*, 71(4) : 526 – 534.

Gmel, G. and Rehm, J. (2003). Harmful Alcohol Use. *Alcohol Research and Health Journal*.17(5): 520-62.

Goodwin, D. (2004). *Alcoholism: the Facts*. Oxford: University Press.

Gray, D. E. (2004). *Doing Research in the Real World*. New Dehli: Sage Publication.

Hassan, S., Macharia, W.M. and Atinga, J. (2005). Self Reported Alcohol Use in An Urban Traffic Trauma Population in Kenya. *East African Medical Journal*, 82(3): 69-74.

Head, J., Stansfeld, A., and Siegrist, J. (2004). The Psychosocial Work Environment and Alcohol Dependence. *Occupational and Environmental Medicine*, 61(4): 219 – 244.

Hodgins, D., Williams, R. and Munro, G. (2009). Workplace Responsibility, Stress, Alcohol Availability and Norms as Predictors of Alcohol Consumption- Related Problems amongst Employed Workers. *Substance Use and Misuse Journal* : 44(14): 2062 – 2069.

http://www.cdc.gov. Global Youth Tobacco Survey (GYTS, 2001). Report Last Viewed on 2nd July 2010.

http://www.ilo.org/safework/safeday (2005). Safety resource, "Safe work place handout by International Labour Organization" last viewed on 1st March, 2010.Geneva.

Hughes, K. and Bellis, A. (2000). Alcohol; Some Sobering Statistics from the NWPHO (North West Public Health Observatory) Department of Services and Health.

Ichiro Wakabayadi (2009). Influence of Body Weight on the Relationships Of Alcohol Drinking with Blood Pressure and Serum Lips in Women. *Preventative Medicine*, 49 (5): 374 - 379.

ILO and OSHA (2001). *Guidelines on Occupational Safety and Health Management Systems*. Geneva: Directorate of OSHA Services.

International Labour Organisation (2003). Alcohol and Drug Problems at Work: The Shift to Prevention. International Labour Office, Geneva.

Imbosa, M. (2002). An Investigation into the Strategies Used in Addressing Drug Problems. A Survey of Nairobi Provincial Schools" Unpublished Kenyatta University Thesis.

Institute of Alcohol Studies (IAS), (2009). Alcohol and The Workplace. *IAS Factsheet.*

Johnstone, T. (2000). *Adolescence Drug Abuse in Kenya: Impact on Reproductive Health*. Population Communication Africa and Pathfinder International. Nairobi: New World Printers.

Johnstone, R. and Jones, P.(2004). Service Productivity: Towards Understanding The Relationship Between Operational and Customer Productivity. *International Journal Productivity and Performance Management,* 53(3): 201- 213.

Jones, P. and Siag, A. (2009). A Re- examination of the Factors that Influence Productivity in Hotels: A Study of the Housekeeping Function. *Tourism and Hospitality Research* 9 (11) 224 - 234.

Kasomo, D. (2007). *Research Methods in Humanities and Education:* Statistics, Measurements, Evaluation and testing: Njoro: Egerton University Press.

Kavanaugh, R. and Ninemeir, J. (2001). *Supervision in the Hospitality Industry*. Michigan: Educational Institute of the American Hotel and Lodging Association.

Kenya Gazette (2003). Classification of Hotels and Restaurants; Regulations, 1988- Classifications. Cv- No.62. Gazette Notice, 3976: 1321 – 1324.

Kenya Gazette (2004). Classification of Hotels and Restaurants; Regulations,1988- Classifications. Cv- No.64. Gazette Notice, 5693: 1648.

Kenya Gazette (2007). The Occupational Health and Safety Act. Gazette Supplement No. 111(Acts No. 15). Pg 639 - 766. The Government Printers: Nairobi.

Kenya Gazette (2007). The Work Injury Benefits Act (WIBA) . Gazette Supplement No. 109 (Acts No. 13). Pg 449 - 546. The Government Printers: Nairobi.

Kenya Gazette (2007). Tobacco Control Act. Gazette Supplement No. 95 (Acts No. 4). Pg 133 - 176. The Government Printers: Nairobi.

Kenya Gazette (2009). The Alcohol Control Bill . Gazette Supplement No. 70 (Bills No. 21). Pg 647 - 688. The Government Printers: Nairobi.

Kenya National Bureau of Statistics; Ministry of Planning and National Development (KNBS, 2010). *Economic Survey.* Nairobi: Government Printers.

Kenya National Bureau of Statistics; Ministry of Planning and National Development (KNBS, 2009). *Economic Survey.* Nairobi: Government Printers.

Kenya National Bureau of Statistics; Ministry of Planning and National Development (KNBS, 2009). *Statistical Abstract.* Nairobi: Government Printers.

Kibicho, M. (2003). Community Tourism. A Lesson from Kenyan's Coastal Region. *Journal of Vacational Marketing*, 10 (4) 211 – 216.

Klingeman, H. and Gmel, G.(Eds.) (2001). *Mapping the Social Consequences of Alcohol Consumption.* New Delhi: Kluwar Publishers.

Kothari, R. (2005). *Research Methodology*. New Delhi: K.K Gupta for New Age International.

Lehman, W., and Bennet, J. (2002). Job Risk and Employee Substance Use: The Influence of Personal Background and Work Envirnment Factors. *American Journal of Drug and Alcohol Abuse*, 28 (3): 263- 286.

Liska, K. (2004). *Drugs and the Human Body with Implications for Society*. Boston: Pearson Education Prentice Hall.

Loizos, C. and Lycourgos, H. (2005). A Customer's Expectation and Perception of Hotel Service Quality in Cyprus. *Hospitality and Tourism Review*. 23 (2): 43-54.

McFarlin, S. and Fals-Stewart, W. (2002). Workplace Absenteeism and Alcohol Use. A Sequential Analysis. *Psychology of Addictive*, 16(1): 17–21.

Michael W., Levente K., Michael B. and Marter H (2007 . The Alcohol Use Disorders Identification Test (AUDIT) For Detecting At – Risk Drinking: A Systematic Review and Meta- Analysis. *Journal Studies Alcohol and Drugs* 68 (3): 461 – 473.

Mohr, P. Charles, K. and Truxillo, D.(2005). "Perceived Workplace Drug and Alcohol Problem" PHRMA Workplace Substance Abuse Survey of Portland Employers: Portland State University.

Moore, R.S., Cunradi, C.B., Duke, M.R. and Ames, M.G. (2009). Dimensions Of Problem Drinking among Young Adult Restaurant Workers. *The American Journal of Drug and Alcohol Abuse*, 35(5): 329- 333.

Mosby's Medical, Nursing, and Allied Health Dictionary (2002). Drug Abuse Definition 6th Ed., p. 552.

Mugenda, O. and Mugenda, A. (2003). *Research Methods: Quantitative and Qualitative Approaches*. Nairobi: Acts Press.

Munne, I. (2005). Social Consequences of Alcohol Consumption in Argentina. Alcohol, Gender and Drinking Problems. Perspectives from Low Middle Income Countries. WHO, Geneva.

Mugusia,T. (2009). A Rapid Situation Assessment of Injecting Drug Users (IDU) in Mombasa and Kilindini Districts. Unpublished Report For National Aids Control Council (NACC).

Nachmias, C. and Nachmias, D.(2005).5th edn. Research Methods in the Sciences. London: Hodder Arnold.

National Agency for the Campaign Against Drug Abuse (NACADA, 2003). General Information on Drug and Substance Abuse, Preventative Education. Nairobi: NACADA.

National Agency for the Campaign Against Drug Abuse (NACADA, 2004). Annual Report for the office of the National Agency for the Campaign Against Drug Abuse". Mimeo.

National Agency for the Campaign Against Drug Abuse (NACADA, 2004). "Youth In Peril , Alcohol and Drug Abuse In Kenya ". Nairobi: NACADA.

National Agency for the Campaign against Drug Abuse (NACADA) and Kenya Institute For Public Policy Research and Analysis (KIPPRA) (2006). Drug and Substance Abuse in Tertiary Institutions in Kenya: A Situational Analysis. Nairobi: NACADA.

National Agency for the Campaign Against Drug Abuse Authority (NACADAA, 2007). "A Survey of Alcohol and Drug Addiction Treatment and Rehabilitation Facilities in Kenya". Nairobi: NACADAA.

National Agency for the Campaign Against Drug Abuse Authority (NACADAA, 2009). Guidelines For Developing Workplace Alcohol and Drug Abuse Policies. Nairobi.

Ndetei, M., Mutiso, V., Khasakhala, L., Odhiambo,G., Kokonya, D., Sood,M.,*et al.,* (2004). Study on "The Assignment of the Linkage Between Drug abuse And HIV/AIDS in Kenya". A Rapid Situation Assessment.

Ndirangu, M. (2004). *The Drug Abuse Monster*. Thika: Published by Julius.

Neuman, W. L. (2000). Social Research Methods. Quantitative and Qualitative Approach. New York: Allyn and Bacon.

Nzioka, A. (2008). The Effects of HIV/AIDS on Human Resource Operations in The Hospitality Industry. A Survey of The Coastal Region Of Kenya. The Unpublished Thesis, Kenyatta University, Kenya.

Omondi, R. (2003). Gender and the Political Economy of Sex Tourism in Kenyan Coastal Resorts. Unpublished Document. Moi University.

Ondara, R. (2007). Food Safety Status in Chain and Unclassified Fast Food Restaurants in Nairobi City Centre, Kenya. The Unpublished Thesis, Kenyatta University, Kenya.

Ondicho, T.G. (2000). The Problems and Prospects of Sustainable Tourism in Kenya. On line: www.informaworld.com last viewed on 1st September, 2010.

Onyango , K.(2002, July 14th). A Case of Good Laws not Effected. *The Daily Nation*, pp14.

Ovunga, E. and Madrama, C.(2006). Burden of Alcohol Use in the Uganda Police in Kampala District. *African Health Sciences*, 6(1): 14-20.

Pepela, A. (2007). Motivation Perspectives Affecting Adult Participation Leisure and Recreation Activities in Health Clubs within Five Star Hotels in Nairobi, Kenya. Unpublished Thesis, Kenyatta University, Kenya.

Pham-Kanter, G. (2001). Substance Abuse and Dependence. The Gale Encyclopedia of Medicine.

Pricewaterhouse Coopers (2010). Generation Y a Fast Growing Segment of Kenya's Workforce. http://www.pwc.com/en- KE/ke/pdf/pwc. Lastly

Viewed on 30th July,2010

Prime Ministers Strategy Unit (2003) as cited by interim Analytical Report. London.

Productivity Manual Modules (2010). Productivity Measurement. Labour Market Dialogue Kenya Chapter Productivity Centre of Kenya and Federation of Kenya Employers (FKE)

Pryce, Y (2008). Fight Workplace Substance Abuse with Clear Policies. Online. www. business.com/../substance- abuse

Rehm, J., Taylor, B., and Room, R. (2006). Global Burden of Disease From Alcohol, Illicit Drugs and Tobacco. *Drug and Alcohol Review*, 25(6): 503 – 513.

Reinert, F., and Allen, P. (2002) . The Alcohol Use Disorders Identification Test (AUDIT): A Review of Recent Research . *Alcoholism: Clinical and Experimental Research,2* 6 (2): 272 – 279.

Reingman, H. and Gmel, G. (2001). Mapping the Social Consequences of Alcohol Consumption as cited by WHO (2004). Academic Publisher: Dordreenr. Kluwer.

Rizzo, A. (2001). The Labour Productivity Costs of Smoking in the United States. The Economic Analysis of Substance Use and Abuse. Massachusetts: Edward Elgar Publishing, Inc.

Roche, B. and Pidd, K. (2006 b). Workers Alcohol Use and Absenteeism. Workplace Drug and Alcohol Use Information and Data Sheet 2. National Centre for Education and Training on Addiction (NCETA), Adelaide.

Rohman, M. and Blum, C. (2002). The Workplace and Alcohol Problem Prevention. *Alcohol Research and Health*, 26(1): 49 – 57.

Sanjay, S. (2001). Common Dream New Centre. http://www.common.dreams. Last viewed on 15th November 2005.

Saxena, S. Sharma, R. and Maulik , K. (2003). Impact of Alcohol Use of Poor Families. Study from North India. *Journal of Substance Abuse*, 8(22): 78-84.

Shauri, H. (2004). Cocaine, Opium, and Heroin the Deadliest Drugs. Unpublished Document.

Shauri , H. and Omondi, R. (2004). Drug and Abuse Crime in Kenya: A Critical Analysis of the Drug Policy. Unpublished Document.

Silva, M., Gaunekar, G., Patel, V., Kukalekar, D. and Fernandes, J. (2003). The Prevalence And Correlates Of Hazardous Drinking In Industrial Workers: A Study From Goa, India. *Alcohol and Alcoholism*, 38(1): 79–83.

Smith, A., Wadsworth, E., Moss, S.and Simpson, S. (2004). The Scale and Impact of Illegal Drug Use by Workers. *Centre for Occupational and Health Psychology,* Cardiff Unversity, Cardiff.

Spicer, S., Miller, R. and Smith, G. (2003). Worker Substance Abuse, Workplace Problems and the Risk of Occupational Injury. *Journal of Studies on Alcohol,* 64(4): 570 – 578.

Substance Abuse and Mental Health Services Administration (SAMHSA, 2007). Workers Substance Use by Industry among U.S. Workers. Research Findings From SAMHSA 2002, 2003 and 2004 National Surveys on Drug Use and Health(NSDUHs). Accessed on 3rd September, 2010 from http://www.oas.samasha.gov/2k2/workers/workers.pdf

Trapenceire, 1. (2000). Statistics on Alcohol, Drugs Crime in Lativais, Leifman H. andEdgern. Statistics on Alcohol, Drugs and Crime in the Baltic Sea Regions. Helsniki Nordic Council for Alcohol and Drug Research.

Tumwesigye, N. M. and Kasirye, R. (2005). Gender and the Major Consequences of Alcohol Consumption in Uganda. Alcohol, Gender and Drinking Problems. Perspectives from Low Middle Income Countries. Pp 189- 208. Geneva: WHO.

United Nations Office of Drug Abuse and Crime (UNODC) (2010). World Drugs Report. Published by United Nations.

Valencia, J. and Gomez, A. (2005). Workplace Absenteeism and Its Connection With Abuse of Alcohol and Other Psychoactive Substances.

Von Hertzen, Plaggio, G. and Ding, J. (2002). Low Dose Mifstrone and Two Regimens of levonegesting. Lancent.

Watt, K., Purdie, D., Roche, A. and McClure, R. (2005). Relationship Between Acute Alcohol Consumption Consequent Injury Type. *Alcohol and Alcoholism*, 40 (4): 263- 268.

World Health Organization Expert Committee on Problems Related to Alcohol Consumption (WHO , 2007). WHO Technical Report Series, 944: 1- 53 Geneva.

WHO (2004). *International Guide for Monitoring Alcohol Consumption*. Geneva: WHO.

WHO (2004 a). Global Status Report on Alcohol. Geneva: WHO.

WHO (2004). Global Alcohol Database. Geneva: WHO.

WHO (2001). Women and the Tobacco Epidemic, Challenges of the 21st Century. World Health Organization. In collaboration with Institute for Global Tobacco John Hopkins, Control School of Public Health, Edited by Jonathan M.,Soon.

Wickizer, M., Kopjar, B., Franklin, G. and Jutta, J. (2004). Policy: Do Drug- Free Workplace Programmes Prevent Occupational Injuries? Evidence from Washington State. *Health Research Services*, 39 (1): 91-110.

Zhang, C., and Snizek, E. (2003). Occupation, Job Charateristics and the Use of Alcohol and Other Drugs. *Social Behaviour and Personality*, 31 (4): 395 – 412.

APPENDICES

Appendix A: Employee Questionnaire

This questionnaire seeks your opinion on the effects of drug abuse on workplace conditions in the tourism and hospitality industry in star-rated hotels at the Kenyan Coast. This study forms part of the requirements for the researcher's Masters of Science degree in Hospitality and Tourism Management and should help in curbing the negative effects of drug abuse at the workplace in the study are and beyond. You should not write your name on the questionnaire. This guarantees anonymity. Honest responses to all the questions are requested and will be highly appreciated. There are "no right" or "wrong" answers. The researcher is only interested in your opinion. The responses you give will be treated with utmost confidentiality. Thank you for taking time to complete this questionnaire.

Winfrida Milly A. Agumba

Section A: Background Information

1. Name of the hotel ______________________(optional)
2. Hotel classification One-star ☐ Two-star ☐

   Three-star ☐ Four-star ☐ Five-star ☐
3. Age of respondents in years

   20 -30 [ ] 31 – 40 [ ] 41 – 50 [ ] 51 -60 [ ] 61 -70[ ]
4. Gender Male ☐ Female ☐
5. Level of education

   Primary incomplete ☐ Primary complete ☐

   Secondary incomplete ☐ Secondary complete ☐

   Middle level college ☐ University degree ☐
6. Marital status Married ☐ Single ☐

   Widowed ☐ Divorced/separate ☐
7. Religion: Christianity ☐Muslim ☐ Hindus ☐ Buddhist☐ None ☐
8. If married, remarried, widowed, divorced or separated, what is your household size (No of persons in your family)? __________

9. Monthly income (in Kshs) _______________

< Ksh. 10, 000 ☐ Ksh. 11,001 – 20,000 ☐

Ksh. 21,001 – 30,000 ☐ Ksh. 31,001 – 40,000 ☐

Ksh. 41,001 – 50,000 ☐ Ksh. 51,001 – 60,000 ☐

Ksh. > 61,001 ☐

10. Number of years of employment in this hotel __________________

11. Department __________________

Section B: Drug Abuse

1. Are you aware of any employee in this hotel who is using drugs?

Yes ☐ No ☐ (**if No go to Q2 section F**)

2. If yes, what kinds of drugs are you aware of or have witnessed among these employees in the hotel?

Alcohol ☐ Marijuana ☐ Cigarettes ☐

Heroine ☐ Hallucinogens ☐ Inhalants ☐

Stimulants ☐ Tranquilizers ☐ Sedatives ☐

Prescribed/Hospital Drugs ☐ Any other (specify) ________

3. In your own assessment, how can you rate the frequency of use of drugs among employees in this hotel? Always☐ Often☐ Rarely ☐

4. In your own assessment, how can you rate the level of use of drugs among employees in this hotel? High☐ Moderate☐ Low ☐

5. From your experience and opinion, why are these employees using drugs? ____
____
____

6. Considering the gender of the drug users, who uses drugs mostly in this hotel?

   Male ☐ Female☐ Both male and female ☐

<u>Section C: Effects of Drug Abuse</u>

1. Which of the following signs have you noticed among employees using drugs in this hotel?

   <u>Moods</u>

   i. Depression ☐

   ii. Anxiety ☐

iii. Irritation ☐

iv. Suspicious ☐

v. Complains about others ☐

vi. Emotional unsteadiness (eg outburst of crying, laughing) ☐

vii. Mood changes after lunch or break ☐

viii. Any other (specify)____________________

Actions

i. Withdrawn or improperly talkative ☐

ii. Spends more time communicating to people outside ☐

iii. Argumentative ☐

iv. Display of violent behaviour ☐

v. Avoid talking to superior about work issues ☐

vi. Excess sense of self-importance or inferiority ☐

vii. Over-reaction to real or imaginary criticism ☐

viii. Possession of paraphernalia (such as syringe) ☐

ix. Any other (specify)____________________

Section D: Drug Abuse and Absenteeism

1. To which extent have you noticed the following aspects of absenteeism among those employees using drugs in this hotel?

	Very often	Often	Rarely	Very rarely	Never
Unreported absence, later explained as “emergencies”					
Unusually high incidence of cold, flu, stomach upsets and headache					
Frequent use of unscheduled vacation time					
Leaving work area more than necessary (eg frequent trips to the bathroom or latrines)					
Unexplained disappearance from the job with difficulty in locating					
Requesting to leaving work early for various reasons related to drugs					
Reporting late to work for various reasons related to drugs					

Section E: Drug Abuse and Accidents

1. To which extent have you noticed the following aspects of accidents/injuries among those employees using drugs in this hotel?

	Very often	Often	Rarely	Very rarely	Never
Taking needless risk in handling tasks					
Being unnecessarily careless in handling tasks e.g breaking glasses					
Disregard the safety of others causing accidents or injuries					
Higher than average accident rate on and off the job					
Being unremorseful even after causing an accident or injury					
High injury compensation claims by employees					

Section F: Drug Abuse and Job Productivity and Work Patterns

1. To which extent have you noticed the following aspects of absenteeism among those employees using drugs in this hotel?

	Very often	Often	Rarely	Very rarely	Never
Inconsistency in quality of work					
Inconsistency in the level of productivity of work					
Poor judgement or more mistakes than usual and general carelessness					
Lapses in concentration to work					
Difficulty in recalling instructions					
Difficulty in recalling own mistakes					
Using more time to complete work/missing deadlines					
Increased difficulty in handling complex situations e.g. balancing service trays for waiters					

2. Does the hotel have any policy on drug abuse? Yes ☐ No ☐

3. If Yes, what does the policy say about drug abuse? ______________

____

4. In your opinion, rate the effectiveness of the policy in curbing drug abuse cases among employees in this hotel?

Very effective ☐ Moderate ☐ Not effective ☐ Not sure ☐

5. If one is caught taking drugs in this hotel, what measures does the hotel management take? ____________________________________

____

____

6. As a person, do you use or take any drugs? Yes ☐ No ☐

7.Have you ever consumed any of these drugs/ substances			8.How old were you when you used drugs for the first time	9. Have you used it in the past 12months		10.How often have you used it 1=once 2=daily 3=weekly 4= monthly 5=occasionally in the last 12months	11.Have you used it during the past 30days	
	YES	NO		YES	NO		YES	NO
Alcohol (mnazi, beer,Kumi-kumi,spirits								
Cigarettes								
Heroine								
Cocaine								
Stimulants e.g. miraa								
Hallucinogens								
Marijuana								
Prescribed drugs e.g Piriton, Valium								
Tranquilizer								
Inhalants								
Other drugs								

12.Approximately what is your consumption of the drugs on a daily basis

a) Alcohol – 1- 3drinks( ) 4- 6 drinks ( ) 7- 9 drinks ( ) > 10 drinks ( )

b) Cigarettes – 1- 5 pcs( ) 6- 10 pcs ( ) 11- 20 pcs ( ) > 10 pcs ( )

c) Miraa - …………………………gms

d) Cocaine……………………….. gms

e) Heroin……………………….

f) Prescribed/
Hospital Drugs……………………………………………….

13.Why do you use drugs? ____

____

____

____

14. What are some of the effects that you have encountered at the workplace as a result of using drugs? ____

____

____

____

15.Suggest any measures that the hotel management can use to curb drug abuse among its employees? ______________________________________

Appendix B: In- depth Interview Schedule For Managers

DATE _________

This In-depth Interview guide seeks your opinion on the effects of drug abuse on workplace conditions in the tourism and hospitality industry in star-rated hotels at the Kenyan coast. This study forms part of the requirements for the researcher's Masters of Science degree in Hospitality and Tourism Management and should help in curbing the negative effects of drug abuse at the workplace in the study are and beyond. You have been selected as one of our respondent in this survey. Your sincere and correct answers will be important in attaining this goal. It will not be used against anybody. The researcher is only interested in your opinion. All information will be treated with utmost confidentiality and analyzed together with others from other respondents in the area. Thank you for taking time to answer interview schedule.

Section A: Personal Data

1. Name of the hotel ______________________________
2. How many employees do you have in this organisation?
   a)1-50 b)51-100 c)101-150 d)151-200 e)201-250 f) >250
3. Hotel classification One-star ☐ Two-star ☐
   Three-star ☐ Four-star ☐ Five-star ☐
4. Age (in complete years) ________________________
5. Gender Male ☐ Female ☐

6. Level of education

   Primary incomplete ☐ Primary complete ☐

   Secondary incomplete ☐ Secondary complete ☐

   Middle level college ☐ University degree ☐

7. Marital status Married ☐ Single ☐

   Widowed ☐ Divorced/separate ☐

   Remarried ☐

8. Religion: Christianity ☐ Muslim ☐ Hindu ☐ Buddhist ☐ None ☐

   Others (Indicate)________

9. If married, widowed, divorced or separated, what is your household size(Number of people in your house)? ________

10. Monthly income (in Kshs) _______________

    < Ksh. 10, 000 ☐ Ksh. 11,001 – 20,000 ☐

    Ksh. 21,001 – 30,000 ☐ Ksh. 31,001 – 40,000 ☐

    Ksh. 41,001 – 50,000 ☐ Ksh. 51,001 – 60,000 ☐

    Ksh. > 61,001 ☐

11. Number of years of employment in this hotel __________________

Section B: Background of Drug Abuse

1. What are the causes of drug abuse at the Kenyan coast?

…………………………………………………………………………………

…………………………………………………………………………………

2. What kinds of drugs are frequently used at the Kenyan Coast?

…………………………………………………………………………………

…………………………………………………………………………………

…………………………………………………………………………

3. What are the major sources of drug abuse at the Kenyan Coast?

…………………………………………………………………………………

…………………………………………………………………………………

4. Who are the most involved people in using drugs at the Kenyan Coast?

…………………………………………………………………………………

………………………………………………………………………………

5. Who are the most involved people in selling drugs at the Kenyan Coast?

…………………………………………………………………………………

…………………………………………………………………………………

6. What is the government doing in curbing drug abuse at the Kenyan Coast?

…………………………………………………………………………………

…………………………………………………………………………………

Section C: Effects of drug abuse at the workplace

1. What are the effects of drug abuse among employees in the hotels?

……………………………………………………………………………………

……………………………………………………………………………………

2. What are the common warning signs among employees using drugs in this hotel?

……………………………………………………………………………………

……………………………………………………………………………………

3. What are some the common actions among drug users in this hotel?

……………………………………………………………………………………

……………………………………………………………………………………

What are the effects of drug abuse on absenteeism, accidents and job productivity?

……………………………………………………………………………………

……………………………………………………………………………………

Section D: Measures to curb drug abuse at workplace

1. What measures has the hotel put in place to curb drug abuse?

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

2. What are the successes and failures of these measures?

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

………………………………

3. Suggest the way forward in curbing drug abuse among employees in this hotel?..

....

....

....

Appendix C: Employee Focus Group Discussion Guide

DATE ___________

This FGD guide seeks your opinion on the effects of drug abuse on workplace conditions in the tourism and hospitality industry in star-rated hotels at the Kenyan coast. This study forms part of the requirements for the researcher's Masters of Science degree in Hospitality and Tourism Management and should help in curbing the negative effects of drug abuse at the workplace in the study are and beyond. You have been selected as one of our respondent in this survey. Your sincere and correct answers will be important in attaining this goal. It will not be used against anybody. The researcher is only interested in your opinion. All information will be treated with utmost confidentiality and analyzed together with others from other respondents in the area. Thank you for taking time to to participate in this discussion.

Section A: Group Collective Data

Record information on: hotel, hotel classification, date, names of the group members, gender, age, level of education, and marital status.

Subject 1: Background of Drug Abuse

1. In your opinion, what are the causes of drug abuse at the Kenyan coast? ***(probe for kind of drugs, frequency of use, sources, the most involved people in drug use, most involved people in drug selling)***

2. What is the government doing in curbing drug abuse at the Kenyan Coast? ***(probe for the various government arms involved in curbing drug abuse, their role, successes and failures)***

Subject 2: Effects of drug abuse at the workplace

1. What are the effects of drug abuse among employees in the hotels? ***(probe for the warning signs of drug abuse, actions of drug abusers, effects on absenteeism, accidents and productivity at the workplace, effects on general tourism at the Kenyan Coast)***

Subject 3: Measures to curb drug abuse at workplace

1. What measures has the hotel put in place to curb drug abuse? ***(probe for measures put in place, their strength, weakness and way forward)***

	FOCUSED GROUP DISCUSSION SHEDULE/ GUIDE TITLE: THE EFFECTS OF ALCOHOL AND DRUG ABUSE ON WORK PERFORMANCE OF EMPLOYEED IN SELECTED STAR RATED HOTELS AT THE KENYAN COAST.				
	QUESTIONS	RESPONSES	INSTRUTIONS		
1.0	INTRODUCTION				
1.1	Date of FGD		DD/MM/YY		
1.2	VENUE				
1.3	TIME	9.00a.m -11.00 am			
1.4	GROUP	Employee HR Manager NACADA FKE KUHEDHIA Rehabilitation centre	Capture Individual Designation And Experience On A Separate Sheet At The End Of This Tool		
1.5	NO. OF PARTICIPANTS BY GENDER	MALES	FEMALES	TOTAL	
1.6	NAME OF FACILITATOR				
2.0	**DRUG ABUSE PREVELANCE RATE AMONG EMPLOYEES**				
2.1	a) What are the common abuse drugs at the Kenyan Coast? (PROBE FOR EACH DRUG CITED) b) Which people are majorly involved in abusing drugs at the Kenya Coast? c) In your opinion is drug and substance a major problem amongst the Kenyan workforce and in particular in the Hospitality and tourism and to what extent? (0-30per cent:31-50per cent:51-70per cent:71per cent-100per cent) d) What is the prevalent rate of abusing drugs among the star rated hotel employee? e) Which cadre of staff are more associated to drug and substance abuse? f) In your opinion which departments in the hospitality industry have the highest prevalence rates of drug abuse?				

<table>
<tr><td></td><td colspan="7">FOCUSED GROUP DISCUSSION SHEDULE/ GUIDE

TITLE: THE EFFECTS OF ALCOHOL AND DRUG ABUSE ON WORK PERFORMANCE OF EMPLOYEED IN SELECTED STAR RATED HOTELS AT THE KENYAN COAST.</td></tr>
<tr><td rowspan="8">2.2</td><td>Overall, how would you rate prevalence rate of drug abuse among star rated hotel</td><td>Type of drug</td><td>Not abused</td><td>Slightly abused</td><td>Moderately abused</td><td>Highly abused</td><td>Take Tally For Each Criterion</td></tr>
<tr><td rowspan="7"></td><td>Cigarettes</td><td></td><td></td><td></td><td></td><td rowspan="7"></td></tr>
<tr><td>Bhang</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Alcohol</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Khat/Mirungi</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Heroin</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Cocaine</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Others</td><td></td><td></td><td></td><td></td></tr>
<tr><td>3.0</td><td colspan="7">CAUSES OF DRUG AND SUBSTANCE ABUSE
PROBE FOR CONTRIBUTING FACTORS IN THE SOCIETY AT LARGE AND THE WORKFORCE</td></tr>
<tr><td>4.0</td><td colspan="7">THE EFFECT OF DRUG AND SUBSTANCE ABUSE AMONG EMPLOYEES
(PROBE FOR THE EFFECTS AMONG THE EMPLOYEES, WARNING)
{SIGHNS/SYMPTOMS,ACTIONS AND BEHAVIOURS OF SUCH EMPLOYEES}
How is the abuse of drugs affecting the working force</td></tr>
<tr><td>5.0</td><td colspan="7">DRUG ABUSE AND ABSENTEEISM IN WORKPLACE</td></tr>
<tr><td>5.1</td><td colspan="7">How does drug abuse affect working attendance among employees?
[PROBE FOR LATE REPORTING,EARLY DEPARTURE ,ABSENTISM WITHOUT CONCRETE REASON]
a)How irregular attendance of chemical dependence affects the hotel industry financial turnover.
b)To what extent has drug abuse affects the employee in providing quality service?
[PROBE FOR NEGATIVE CHANGES IN THE CAPACITY,WHICH MAY BE ATTRIBUTED TO THE REDUCED SERVICE PROVIDED]</td></tr>
<tr><td>6.O</td><td colspan="7">ACCIDENTS AT THE WORKPLACE</td></tr>
<tr><td>6.1</td><td colspan="7">a)What kinds of accidents are prone in occurrence at the hotel industry? Were these forms of accidents attributed to abuse of drugs ? Explain further.
b)What factors may undermine the sustainability of safety practices within the hotel industry?</td></tr>
<tr><td>7.0</td><td colspan="7">PRODUCTIVITY AND DRUG ABUSE</td></tr>
<tr><td>7.1</td><td colspan="7">a) Is the productivity of hotel industry being hindered by chemical dependant employee ?
[PROBE FOR STAFF PERFOMANCE AND THOSE UNDER INFLUENCE i.e meeting set targets/deadlines, repeat guests served,number of rooms cleaned)
b) to what extent does chemical dependent employee affect the organization financial expenditure?
{PROBE FOR STAFF INSURANCE COVER (MEDICAL, THIRD</td></tr>
</table>

	FOCUSED GROUP DISCUSSION SHEDULE/ GUIDE **TITLE: THE EFFECTS OF ALCOHOL AND DRUG ABUSE ON WORK PERFORMANCE OF EMPLOYEED IN SELECTED STAR RATED HOTELS AT THE KENYAN COAST.**
	PARTY,MACHINES) SUPPORTING STAFF TO FILL IN WHILE ON SICK LEAVE OR ABENT, STAFF DISMISSAL)
8.0	**GENERAL EFFECTS OF DRUG ABUSE ON TOURISM AT THE KENYAN COAST**
8.1	**Generally how is drug abuse at Kenyan coast impacting on this industry**
9.0	**MEASURES TO CURB DRUG ABUSE ON TOURISM AT THE KENYAN COAST**
	a) What is the government doing in curbing drug abuse at the Kenyan Coast PROBE various Government arms involved in curbing drug abuse, their role, success and failure b) What measures have been initiated to improve knowledge on Drug abuse among staff members? PROBE FOR POLICY ON DRUG ABUSE AT THE WORKPLACE, THEIR STRENGTHS, WEAKNESSES AND WAY FORWARD) c) what cadres of staff were targeted by this initiative d) how efficient was the intervention in terms financial costs, against alternative ways that could also be applied to inform staff members? e) To what extent has this intervention helped staff members? f) What factors are likely to undermine the sustainability of the work place program targeting staff with drug addiction problem. g) Besides the above interventions, what other kinds of support services can be provided to staff members, including mangers to curb drug abuse
	THANK YOU

Appendix D: Invitation To Focus Group Discussion

Winfrida Milly A. Agumba
Kenyatta University
School of Hospitality and Tourism Mgt
P. O. Box 43855
Nairobi
7th June 2010

To

....
....
....

Dear Sir/Madam

RE: INVITATION TO FOCUS GROUP DISCUSON

This is to invite you to a FGD to be conducted on Tuesday 22nd June, 2010 at Jacaranda Indian beach at 9; 00am.The discussion will seek your opinion on the effect of drug abuse on workplace conditions (i.e. absenteeism; accidents at the workplace and decline in productivity) in the tourism and hospitality industry in star rated hotels at Kenyan Coast. The study forms part of the requirements for the researchers Masters science degree in Hospitality and Tourism Management and should help in curbing negative effects of drug abuse at the workplace in the study are and beyond. You have been selected as one of our respondent in this survey. Your sincere and correct answers will be important in attaining this goal. It will not be used against anybody. The researcher is only interested in your opinion. All information will be treated with utmost confidentiality and analyzed together with offers from other respondents in the area.Than k you for taking to participate in this discussion.

Winfrida Milly A. Agumba

Appendix E: Informed Consent Form

To:Prof./Mr./Mrs./M/s…………………………………………………

You are being requested to participate in a research thesis entitled *"Effects of Alcohol and Drug Abuse on Work Performance (Absenteeism, Accidents and decline in productivity) of employees in selected Star rated Hotels in the Coastal Region of Kenya.* The objective of the study is to establish the extent to which alcoholism and drug abuse affects the performance and behaviour of the employees in the Hospitality and Tourism industry in selected stars Rated hotels at the Kenyan Coast.

The purpose of the study is to generate information that will allow us to focus prevention programs on different levels, and minimize the risk of drug consumption that cause professional invalidity, or incapacitated workers.

Your participation consists on agreeing to fill out a series of instruments that ask about your professional occupation and poses no cost to you. Travelling expenses shall be reimbursed for participants attending the Focus Group Discussion (FGD). In addition participants consent will be required to video shoot and tape record voices for the session.

All participants are completely free to choose to participate on this study or not. The information resulting from this study will be completely anonymous and will be handled confidentially by the researcher. Hotel Managers will not see the individual information. At any moment the participant may withdraw from the interview, without any effect on their work station

After reading the objectives, purpose and technology of research, and being informed on the risks and benefits of participating in the study, I agree to participate voluntarily and to fill out the questionnaires and participate in FGD that will be used to establish the effects of drugs abuse on employees in the hotel industry and mitigation measures.

Thank you in advance for accepting to participate

Winfrida Milly Agumba (Kenyatta University)
Master of Science in Hospitality and Tourism Mgt
NAME OF PARTICIPANT:………………………………………………
NAME OF HOTEL/ORGANISATION:……………………………………
DESIGNATION…………… …………………………………………………
SIGNATURE…………………… DATE………………………………………

Appendix F: Classification of Common Drugs and Substances

Category	Examples	Some of the general effects
Alcohol	beer, wine, spirits	Impaired judgement, slowed reflexes, impaired motor function, sleepiness or drowsiness, coma, overdose may be fatal
Tranqulizers	Marijuana, hashish(Bhang)	distorted sense of time, impaired memory, impaired coordination
Depressants	sleeping medicines, sedatives, some tranquilizers	Inattention, slowed reflexes, depression, impaired balance, drowsiness, coma, overdose may be fatal
Hallucinogens	LSD (lysergic acid diethylamide), PCP (phencyclidine), mescaline	Inattention, sensory illusions, hallucinations, disorientation, psychosis
Inhalants	hydrocarbons, solvents, gasoline	Intoxication similar to alcohol, dizziness, headache
Nicotine	cigarettes, chewing tobacco, snuff	Initial stimulant, later depressant effects
Opiates	morphine, heroin, codeine, some prescription pain medications	Loss of interest, "nodding", overdose may be fatal. If used by injection, the sharing of needles may spread Hepatitis B, or C and HIV/AIDS.
Stimulants	cocaine, amphetamines, coffee, Tea	Elevated mood, over-activity, tension/anxiety, rapid heartbeat, constriction of blood vessels
Prescribed/ Hospital drugs	Painkillers like Piriton, valium Anabolic steroids Family planning contraceptives (Emergency contraceptive pills)	Decreases the activity of the brain Affects both male and female sex organs Leads to barrenness and infants with deformities.

(Source: Blume, S.B 1998)

Appendix G: Definition of Assorted Drugs

DRUG DEFINITION

A drug is any chemical substance when taken into the body can affect one or more of the body's functions. This includes those substances that are useful to the body. Some are licit drugs i.e. their sales does not violate the law, while others are illicit i.e. their possession, sale, use or purchase is generally prohibited by law.

Drug abuse refers to the use of illegal drugs or the inappropriate use of legal drugs. Commonly abused drugs and substances by Kenyans youth include: alcohol, tobacco, khat, bhang and a host inhalants and prescriptions drugs.

Alcohol

Alcohol means any beverage that contains ethyl alcohol (ethanol). Alcohol is a substance drug obtained by fermentation of carbohydrates using yeast. The active form of alcohol is ethyl alcohol or ethanol. It is sold in many brands. Examples are beer, wine, whisky, chang'aa, busaa, Muratina, and Mnazi.

Almost every system in the body can be negatively affected by alcohol. Effects include impaired visual ability, unclear hearing, slow reactions and dulled smell and taste. Alcohol interferes with the body's ability to absorb calcium resulting

in bones being weak, soft , brittle and thinner (osteoporosis). Long term drinking may result in liver disease (cirrhosis), permanent brain damage, serious mental disorders and addiction to alcohol. Drinking a high concentration of alcohol in short period of time can suppress the centers of the brain that control breathing and cause a person to pass out or even die.

The recommended standard drink per any session is 5 units for male and 4 units for female. Note that 1unit of alcohol= 1.5cl of pure alcohol= 12.8g of alcohol.

Tobacco

It is a legal cash crop and is grown in some parts of Kenya. Tobacco is usually consumed in form of cigarettes or cigars. A part from smoking, it is also sniffed or chewed. It is addictive. Nicotine can cause indigestion, increase blood pressure, dulling of the appetite and constriction of the blood vessels. The smoke from cigarettes has harmful effects on those around the smoke. It is now known that smoking has effects on quality and quantity of life. Cigarettes compose of over 4000 chemicals out of these 40 causes cancer.

Cigarette smoking is a major cause of cancers of the lung, larynx, oral cavity, pharynx and esophagus. It is a contributing cause in the development of the cancers of the bladder, pancreas, liver, uterine cervix, kidney, stomach, colon

and rectum and leukemias. Smoking is also a major cause of heart disease, aneurysms, bronchitis, emphysema, and stroke, and contributes to the severity of pneumonia and asthma. Smoking has also been linked to cataracts, hip fractures, and peptic ulcers.

For women it is associated with reduced fertility and increased risk of miscarriage, early delivery (pre-maturity), stillbirth, and low birth weight of infants. It has also been linked to sudden infant death syndrome (ISDS)

(Bhang) Cannabis Sativa

The hemp plant grows wild throughout most of the tropic and temperate regions of the world. Three drugs that comes from cannabis are – bhang, hashish and hashish oil are discussed below. Cannabis products are usually smoked. High dose may result in image distortion, a loss of personal identity, fantasies, and hallucinations.

Marijuana (bhang) – It is green, brown, or bong. It is an illegal drug. Its active ingredients are called tetrahydrocannabinol (THC). Effects include exhilaration, loss of inhibitions and withdrawal from the normal activities. Hashish or hash consists of the THC – rich resinous material of the cannabis plant, which is collected, dried, and then compressed into a variety of forms, such as balls, cakes or cookies like sheets. Pieces are then broken off, placed in pipes, and

smoked. Hashish oil is produced by extracting the canna binoids from plant material with a solvent. The colour and odour of the resulting extract will vary depending on the type of solvent used.

(Miraa) Khat

It is a naturally occurring stimulant delivered from the Catha edulis shrub. It is legal and an important cash crop in some parts of Kenya. Khat has two active ingredients, cathinone and cathine. Common side effects include anorexia, tachycardia, hypertension, insomnia and gastric disorders. Chronic khat abuse can result in symptoms such as physical exhaustion, violence, and suicidal depression. Khat can induce manic behaviors, hyperactivity and hallucinations. A study by Odenwald et al (2005) in Somalia shows evidence of the relationship between the excessive consumption of khat and the end of psychotic disorders.

Cocaine

It is a white, crystalline, alkaloid, which acts as a local anesthetic. The different forms of cocaine are (i) white crystalline powder and (ii) “crack” or “rock” cocaine. Powder cocaine is generally snorted or dissolved in water and injected. Crack cocaine is usually smoked. Cocaine is a dangerous illegal stimulant that is powerfully addictive. It causes increased heartbeat as well as a rise in blood pressure. Smoking crack can cause severe chest pains with lung trauma and bleeding. Its effects are much more intense and rapid than that of normal

cocaine. The mixing of cocaine and alcohol create coca ethylene while increasing risk of sudden death.

Heroin

Is a semi-synthetic derivative produced by the chemical modification of morphine. Pure heroin is a white powder with a taste. Most illicit heroin varies in colour from white to dark brown. “Black tar heroin is sticky like roofing tar or hard like coal, and its colours may vary from dark brown to black. Heroin is injected, smoked or snorted. It is highly addictive and more potent than morphine. Chronic use may cause collapsed veins, infections of heart lining and valves, abscesses, liver disease, pulmonary complications, and various types of pneumonia. Heroin overdose may cause slow and shallow breathing, convulsions, coma and possibly death. Users risk contracting HIV, hepatitis B and C and other viruses.

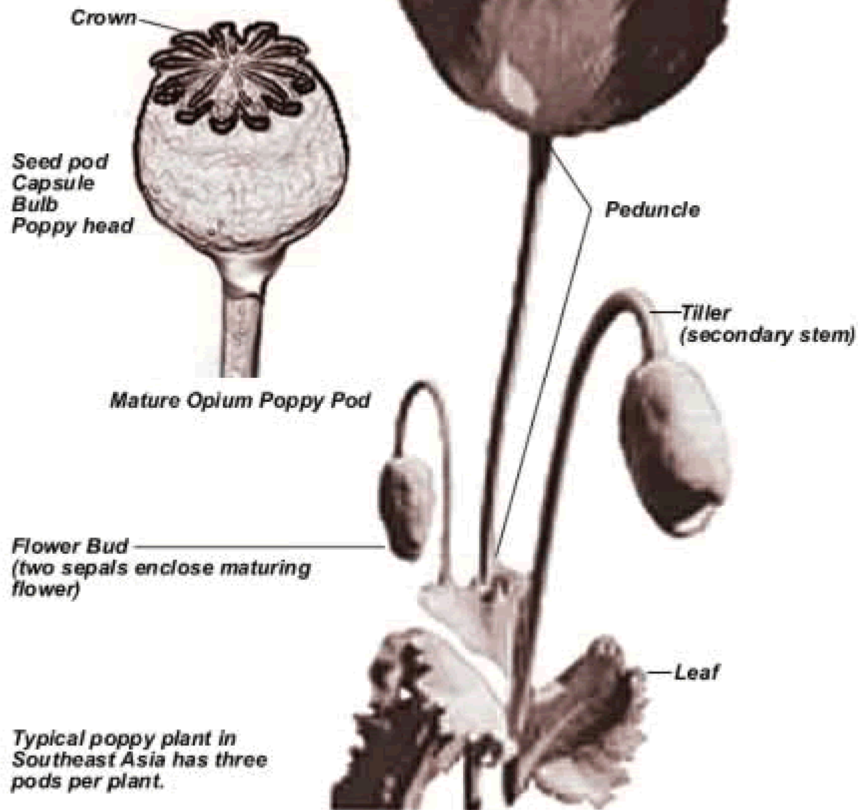


Figure 12: Basic Parts of A Poppy Plant Used to Produce Heroin
Source: Adapted From CICADA (Mombasa) Database

Figure 13: Farm with Poppy Plant
Source: Adapted From CICADA (Mombasa) Database

Inhalants

Inhalants are a diverse group of substances that include volatile solvents, gases, and nitrites that are sniffed, snorted, huffed, or bagged to produce intoxicating effect similar to alcohol. The substances are found in common household products like glues, lighter fluid, cleaning fluids, and plant products. Inhalant abuse is the deliberate inhaling or sniffing of these substances to get high.

Inhalants depress the central nervous system, producing decreased respiration and blood pressure. Many users experience headaches, nausea, slurred speech,

and loss of motor coordination. Mental effects may include fear, anxiety, or depression. The chronic use of inhalants has been associated with a number of serious health problems. Glue and paint thinner sniffing produce kidney abnormalities while the solvents toluene and trichloroethylene cause liver damage. Memory impairment, attention deficits, and diminished non-verbal intelligence have been related to the abuse of inhalants. Deaths resulting from heart failure, asphyxiation, or aspiration have occurred.

Other abused drugs and substances include:

Amphetamines

This is a group of behavioral stimulants that temporarily increase energy and mental alertness. Khat is an example of a substance with such effects.

Narcotic

The term is used in a number of ways. Medically, this is a drug that produces sleep or stupor and also relieves pain. Legally, a narcotic is any drug regulated under the Dangerous Drug Act and can only be obtained with a doctor's prescription. Narcotics are used therapeutically to treat pains, suppress cough, alleviate diarrhoea, and induce anaesthesia. As drugs of abuse, they are often smoked, sniffed, swallowed or injected. The poppy palaver somniferum is the source for non-synthetic narcotics.

Medical complications common among narcotic abusers arise primarily from adulterants found in street drugs and in the non-sterile practices of injecting.

Skin, lung and brain abscesses, endocarditis, hepatitis, and AIDS are commonly found among narcotic abusers.

Codeine

This is the most widely used, naturally occurring narcotic in medical treatment in the world. This alkaloid is found in opium in concentrations ranging from 0.7 to 2.5 percent. Codeine is also produced from morphine. It is medically prescribed for the relief of moderate pain and cough suppression. Codeine products are diverted from legitimate sources and are encountered in the illicit market.

Mandrax

It is found in tablet form. It is ingested in the form of pills or capsules but can also be injected intravenously. It is used for its relaxing effects. Some effects include inability to speak without slurring words, headache, dizziness and loss of appetite. Mandrax can lead to addiction and overdose.

Valium

This is a depressant drug, which calm nerves and induces sleep. It is used to relieve nervousness and tension. It can be taken orally as tablets or capsules or be injected. Short term effects. More long term effects include slurred speech, emotional instability, loss or coordination and awareness and paranoia.

Lysergic Acid Diethylamide (LSD)

LSD is the most potent hallucinogen known to science. LSD is usually sold in the form of impregnated paper, typically imprinted with colourful graphic desighns. It has also been encountered in tablets, thin squares of gelatin, in sugar cubes and, rarely in liquid form. The user may experience visual changes with extreme changes in mood. The user may suffer impaired depth and time perception. The ability to make sensible judgements and see common dangers is impaired, making the user susceptible to personal injury.

Ecstasy

The drug 3-4 Methylenediox methamphetamine(MDMA) is distributed in tablet form. Individual tablets are often imprinted with graphic designs or commercial logos and typically contain 100mg MDMA. Ecstasy is usually ingested in tablet form, but can also be crushed and snorted, injected or used in suppository form. The drug induces chemical stimulation and reprtedly suppresses the need to eat, drink or sleep. An ecstasy overdose is characterized by a rapid heartbeat, high blood pressure, faintness, muscle cramping, panic attacks, and in more severe cases, loss of consciousness or seizures. One of the side effects of the drug is jaw muscle tension and teeth grinding. Ecstasy may cause hyperthermia, muscle breakdown, stroke kidney and cardiovascular system failure, possible permanent damage to sections of brain critical to thought, memory, and death.

Appendix H: Summary of Characteristics of the Sampled Hotels and Respondents

Characteristic	Hotel Classification	Frequency (n)	Distribution per cent	Cumulative per cent
Hotels	1 Star	1	4.0	4.0
	2 Star	13	52.0	56.0
	3 Star	7	28.0	84.0
	4 Star	3	12.0	96.0
	5 Star	1	4.0	100.0
		25 hotels		**100per cent**
No. of Staff	1-50	2	8.0	8.0
	51- 100	4	16.0	24.0
	101- 150	7	28.0	52.0
	151-200	10	40.0	92.0
	201 – 250	2	8.0	100.0
		25 hotels		**100 per cent**
Bed Spaces	1- 100	2	8.0	8.0
	101- 200	6	24.0	32.0
	201- 300	7	28.0	60.0

Characteristic	Hotel Classification	Frequency (n)	Distribution per cent	Cumulative per cent
	301- 400	5	20.0	80.0
Bed Spaces	401 – 500	-	-	-
	501 – 600	3	12.0	92.0
	601 – 700	1	4	96.0
	701 – 800	1	4	100.0
		25 hotels		**100per cent**
	Income Category			
Monthly Income	< Ksh.10, 000	116	37.4per cent	37.4per cent
	Ksh.11,000-20000	78	25.1per cent	62.5per cent
	Ksh.21,000-30,000	42	13.6per cent	76.1per cent
	Ksh.31,000-40,000	30	8.1per cent	84.2per cent
	Ksh.41,000-50,000	22	7.1per cent	91.3per cent
	Ksh.51,000-60,000	15	4.8per cent	96.1per cent
	> Ksh.60,000	12	3.9per cent	100per

Characteristic	Hotel Classification	Frequency (n)	Distribution per cent	Cumulative per cent
				cent
		315		**100per cent**
Gender	Female	222	70.5per cent	70.5per cent
	Male	93	29.5per cent	100.0per cent
		315		**100per cent**

Appendix I: Map of the Study Area- Location of Some Star- Rated Hotels

Appendix J: Hotel Classification at The Kenyan Coast

Vol. CV – 62 and Vol. CV1- No.64 (13th June, 2003 and 23rd July,2004)

Gazette Notice No. 3976 and 5693

The Hotels And Restaurant (Classification Of Hotels And Restaurants) Regulations, 1988 Classifications

In exercise of the powers conferred by regulations 2 and 7 of the Hotels and Restaurants (classifications of Hotels and Restaurants) Regulations, 1988, the Hotels and Restaurants Authority classifies then hotels and restaurants listed in the schedule in the manner specified in the schedule:

LIST OF VACATIONAL HOTELS BY CLASSIFICATION

No	Name of Hotel	Address	Location	Beds	Stars
	FIVE STARS				
1	Hemingways Resort	Po Box 267 Watamu	Malindi	154	Five
2	The White Sands Hotel	Po Box 90173 Mombasa	Kilifi	716	Five
3	Sun N' Sand Beach Resort	Po Box 2 Kikambala	Kilifi	600	Five
	Total Number of 5 star rated hotels		**3 Hotels**	**1,470**	
	FOUR STAR				
4	Travellers Beach Hotel	Po Box 87649 Mombasa	Mombasa	576	Four
5	Severin Sea Lodge	Po Box 82169 Mombasa	Kilifi	380	Four
6	Nyali Beach Hotel	Po Box 90581 Mombasa	Kilifi	240	Four
7	Mombasa Serena Hotel	Po Box 90352 Mombasa	Kilifi	348	Four
8	Indian Ocean Beach Club	Po Box 73 Ukunda	Kwale	200	Four
9	Travellers Tiwi Beach Hotel	Po Box 1877 Ukunda	Kwale	420	Four
10	Leisure Lodge Linited	Po Box 84383 Mombasa	Kwale	506	Four
11	Leopard Beach Hotel	Po Box 34 Ukunda	Kwale	308	Four
12	L.T.I Kaskazi Beach	Po Box 138 ukunda	Kwale	382	Four

No	Name of Hotel	Address	Location	Beds	Stars
	Total Number 4 star rated hotels		**9 hotels**	**3,360 beds**	
	THREE STAR				
13	Voyager Beach Resort	Po Box 34117 Mombasa	Mombasa	462	Three
14	Indiana Beach Apt. Hotel	Po Box 82662Mombasa	Mombasa	81	Three
15	Reef Hotel	Po Box Mombasa	Mombasa	252	Three
16	Bahari Beach Hotel	Po Box 82662 Mombasa	Mombasa	200	Three
17	Turtle Bay Beach Club	Po Box 457 malindi	Malindi	350	Three
18	Lawfords Hotel and Beach Club	Po Box 20 Malindi	Malindi	300	Three
19	Kilifi Baharini Resort	Po Box 93 Malindi	Malindi	54	Three
20	Woburn Residence	Po Box 33 Malindi	Malindi	28	Three
21	Diani Sea Resort	Po Box 37 Ukunda	Kwale	340	Three
22	Diani Reef Grand Hotel	Po Box 35 Ukunda	Kwale	600	Three
23	Baobab Beach Resort	Po Box 99527 Mombasa	Kwale	230	Three
24	Southern palms Beach Hotel	Po Box 363 Ukunda	Kwale	398	Three
25	Leisure Lodge Beach and Golf Resort	Po Box 84383 Mombasa	Kwale	506	Three
26	Safari Beach Hotel	Po Box 90690 Mombasa	Kwale	440	Three
27	Alliance Jadini Beach Hotel	Po Box 84616-8400 Mombasa	Kwale	320	Three
28	Mombasa Beach Hotel	P.o. Box 90352, Mombasa	Kilifi	302	Three
29	Alliance Africana Sea Lodge	Po Box 84717 Mombasa	Kwale	322	Three
30	Papillion Lagoon Reef Limited	Po Box 5292 Diani	Kwale	234	Three
	Total Number of 3 star rated hotels		**18 hotels**	**5,419 beds**	
	TWO STAR				
31	Kasar al Bahir	Po Box 81443	Mombasa	80	Two

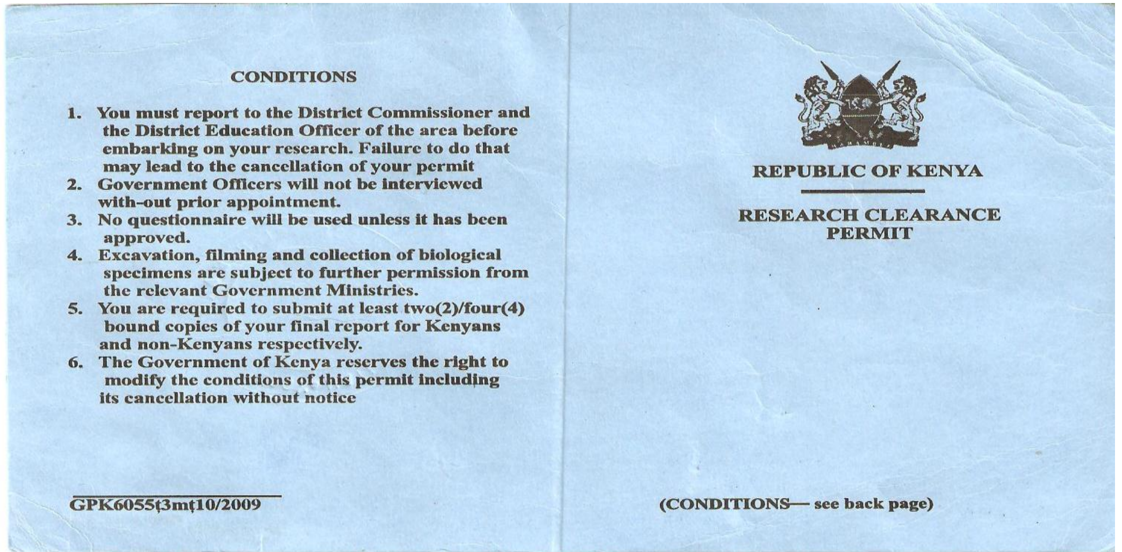
No	Name of Hotel	Address	Location	Beds	Stars
	Hotel	Mombasa			
32	Palm Beach Hotel	Po Box 81443 Mombasa	Mombasa	400	Two
33	Dolphine Hotel	Po Box 81443 Mombasa	Mombasa	225	Two
34	Paradise Beach Hotel	Po Box 81443 Mombasa	Mombasa	308	Two
35	Coral Beach Hotel	Po Box 81043 Mombasa	Mombasa	380	Two
36	Malaika Hotel	Po Box 81443 Mombasa	Mombasa	184	Two
37	Kenya Bay Beach Hotel	Po Box 767 Mombasa	Mombasa	250	Two
38	Giriama Beach Hotel	Po Box 86693 Mombasa	Mombasa	184	Two
39	Neptune Beach Hotel	Po Box 83125 Mombasa	Kwale	516	Two
40	Chale Paradise Hotel	Po Box 4 Ukunda	Kwale	110	Two
41	Ocean Village Club	Po Box 5262, Mombasa	Kwale	138	Two
42	Papillon Lagoon Reef Hotel	Po Box 5292, Diani	kwale	238	Two
43	Diani Sea Lodge	Po Box 37 Ukunda	Kwale	290	Two
44	Baobab Holiday Resort	Po Box 99527 Mombasa	Kilifi	100	Two
45	Bamburi Beach Hotel	Po Box 83966 malindi	Kilifi	300	Two
46	Kilifi BayBeach Hotel	Po Box 537 Kilifi	Kilifi	110	Two
47	Neptune Beach Hotel	Po Box 83125 Mombasa	Kilifi	156	Two
48	Le Soleil Beach Hotel	Po Box 8473 Mombasa	Kilifi	222	Two
49	Mnarani Club	Po Box 1008 Kilifi	Kilifi	168	Two
50	Sea Horse M. Club	Po Box 81443 Mombasa	Kilifi	80	Two
51	Driftwood Beach	Po Box 63 Malindi	Malindi	70	Two
52	Eden Roc Hotel	Po Box 350 Malindi	Malindi	396	Two
53	Tropical Africana Dream Village	Po Box 68 Malindi	Malindi	250	Two
54	Scorpio Villas	Po Box 368 Mombasa	Malindi	94	Two
55	Hotel Baracuda	Po Box 59 Watamu	Malindi	99	Two

No	Name of Hotel	Address	Location	Beds	Stars
56	Malindi Beach Club	Po Box 68 Malindi	Malindi	52	Two
57	Blue Bay Village	Po Box 162 Watamu	Malindi	213	Two
58	Karibuni Villas	Po Box	Malindi	300	Two
59	Coconut Village	Po Box 68 Malindi	Malindi	90	Two
60	Stephanie Sea House	Po Box 583 Malindi	Malindi	100	Two
61	Mwembe Resort	Po Box 426 Malindi	Malindi	60	Two
62	Domina Palm Tree	Po Box 1463 Malindi	Malindi	90	Two
63	Bush Baby Resort	Po Box 5760 malindi	Malindi	87	Two
64	Acquirius Beach Resort	Po Box 96 Watamu	Malindi	120	Two
65	New Lamu Palace Hotel	P.o. Box 421, Lamu	Lamu	44	Two
66	Peponi Hotel	Po Box 24 Lamu	Lamu	48	Two
	Total Number 2 star rated Hotels	**36**		**6,552 beds**	
	One Star				
67	Watamu Beach Hotel	Po Box	Malindi	280	One
68	Royal Reserve Safari	Po Box 41247 Mombasa	Kilifi	168	One
	Total Number one star-rated hotels	**2**		**448 beds**	
	Sub total Vacational Hotels	**68Hotels**	**17,249 Beds**		
LIST OF TOWN HOTELS BY CLASSIFICATION (AT THE KENYAN COAST)					
1.	Lotus Hotel	P.o. Box 90193 Mombasa	Mombasa	64	Two
2.	Royal Court Hotel	P.o. Box 41247, Mombasa	Mombasa	116	One
3.	Quale Hotel	P.o. Box 83924	Mombasa	66	One
	Sub Total Town Hotels	**3 Hotels**		**246 beds**	
LIST OF LODGES BY CLASSIFICATION (AT THE KENYAN COAST)					
1	Finch Hartons Tented Lodge	P.o. Box 24423, Nairobi	Taita/Taveta	70	Four
2	Voi Safari Lodge	P.o. Box 565,Voi	Voi	104	Three

No	Name of Hotel	Address	Location	Beds	Stars
3	Severin Safaris Camp	P.o. Box 82169, Mombasa	Taita Taveta	50	Three
4	Sarova Taita Lodge				
5	Saltlick Safari Lodge	P.o. Box 30624	Taita Taveta	192	Three
6	Taita Hills Safari Lodge	P.o. Box 30624	Taita Taveta	120	Three
7	Kilaguni Serena Lodge	P.o. Box 48690 Nairobi	Taita Taveta	112	Three
8	Travellers Mwaluganje E.Camp	P.o. Box 87649	Kwale	40	Two
9	Voi Wildlife Lodge	P.o. Box 603, Voi	Voi	48	Two
10	Shimba Rain Forest	P.o. Box 83, Kwale	Kwale	62	Two
11	Westermans Safari Camp	P.o. Box 5, Voi	Voi	40	Two
12	Ngulia Safari Lodge	P.o. Box 42, Mtito Andei	Taita Taveta	104	Two
	Sub Totals for lodges	**12 Lodges**		**942 beds**	
	Grand Total of Star Rated Hotels	**83 Hotels**		**18,437 beds**	

Source: Gazette Notice (13th June, 2003): Vol. CV – 62No. 3976(1321- 1324) and Gazette Notice (23rd July, 2004) Vol. CV1- No.64: 5693(1648)

Appendix K: Research Permit



CONDITIONS

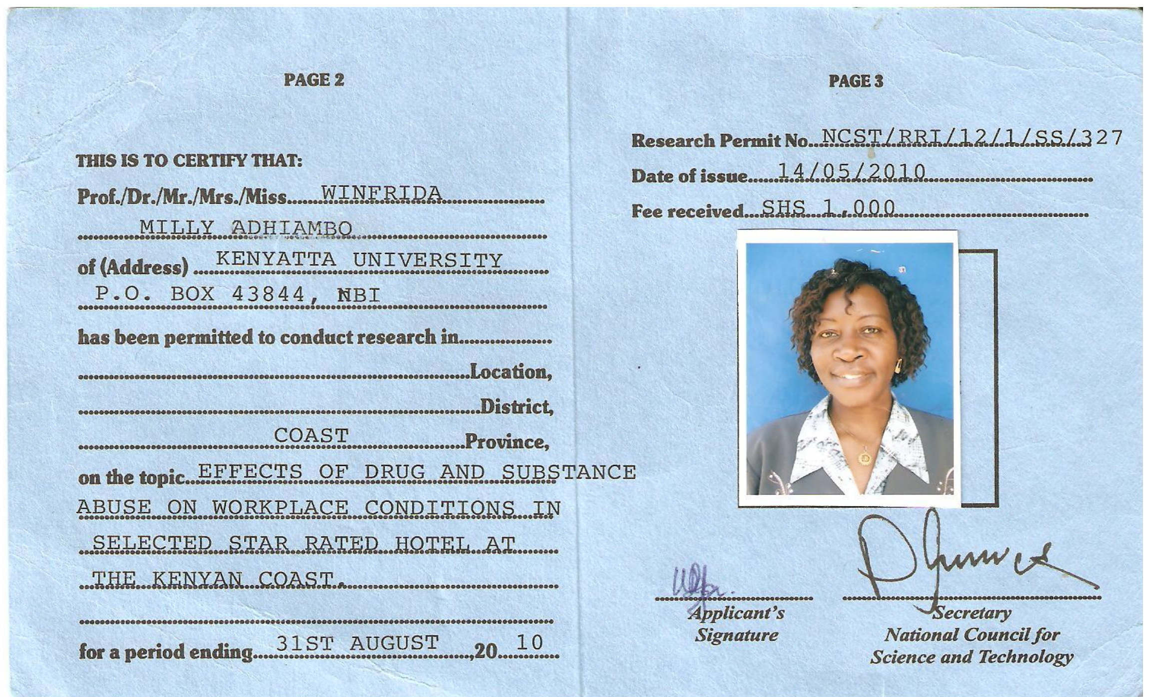
1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed with-out prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2)/four(4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

GPK6055t3mt10/2009

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

(CONDITIONS— see back page)



PAGE 2

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss. WINFRIDA MILLY ADHIAMBO

of (Address) KENYATTA UNIVERSITY P.O. BOX 43844, NBI

has been permitted to conduct research in .... Location, ... District, COAST Province,

on the topic EFFECTS OF DRUG AND SUBSTANCE ABUSE ON WORKPLACE CONDITIONS IN SELECTED STAR RATED HOTEL AT THE KENYAN COAST.

for a period ending 31ST AUGUST, 20 10

PAGE 3

Research Permit No. NCST/RRI/12/1/SS/327

Date of issue 14/05/2010

Fee received SHS 1,000

Applicant's Signature

Secretary National Council for Science and Technology

Appendix L: Research Authorization Letter

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegrams: "SCIENCETECH", Nairobi
Telephone: 254-020-241349, 2213102
254-020-310571, 2213123.
Fax: 254-020-2213215, 318245, 318249
When replying please quote

P.O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref: **NCST/RRI/12/1/SS/327**

Date: **9th June, 2010**

Winfrida Milly Adhiambo
Kenyatta University
P.O. Box 34844
NAIROBI.

Dear Madam,

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Effects of Drug and Substance Abuse on Workplace Conditions in selected Star Rated Hotel at the Kenyan Coast"*** .I am pleased to inform you that you have been authorized to undertake research in ***Coast Province*** for a period ending ***31st August, 2010.***

You are advised to report to the ***Chief Executive Officers of the Star rated Hotels you intend to visit in Coast Province*** before embarking on the research project.

On completion of the research, you are expected to submit two copies of the research report/thesis to our office.

P.N.NYAKUNDI
FOR: SECRETARY
Copy to: