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**THE EFFECTS OF HIV/AIDS ON HUMAN RESOURCE OPERATIONS
IN THE HOSPITALITY INDUSTRY.
“A CASE STUDY OF THE COASTAL REGION OF KENYA”**

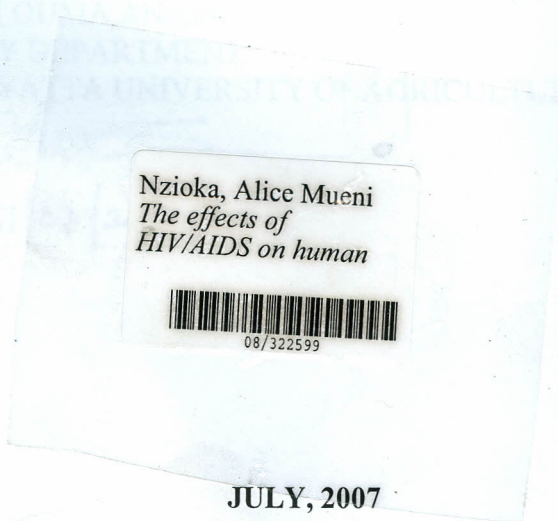
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“A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in the School of Environmental Studies and Human Sciences of Kenyatta University”



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DECLARATION

“This thesis is my original work, and has not been presented for a degree in any other University or any other award.”

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There is a growing concern that people globally have been affected by HIV/AIDS. Africa has the highest prevalence of HIV/AIDS. Kenya has approximately 10% of the population infected. The World Health Organization estimated that 25 million people are infected with HIV/AIDS in Kenya, providing the largest industry in Kenya, providing 10% of the country's GDP. There is no study in Kenya on the impact of HIV/AIDS on the labour market. The purpose of this study was to investigate the impact of HIV/AIDS on the human resource operations in the hotel industry in Kenya. The study examined HIV/AIDS related variables such as labour costs, and labour turnover, and their effect on the hotel industry. Stratified random sampling was used to select 100 respondents from 10 hotels. The data were analyzed using a regression model. The results showed that HIV/AIDS had a significant effect on labour costs and labour turnover. The study also found that HIV/AIDS had a significant effect on the hotel industry. The study also found that HIV/AIDS had a significant effect on the hotel industry. The study also found that HIV/AIDS had a significant effect on the hotel industry.

DEDICATION.

To my parents Mr. Daniel Maundu and Grace Mbithe for bringing me up.

ABSTRACT

There are about 39.5 million people globally living with the human immunodeficiency virus (HIV). Sub-Saharan Africa has the highest prevalence with just over 24 million people who are HIV positive. Kenya has approximately 1.3 million people infected. The International Labour Organization estimates that 28 million workers are HIV positive. Tourism is the second largest industry in Kenya, providing jobs, tax, revenue, and foreign currency to this country. There is no study in Kenya on the effects of HIV/AIDS in the hospitality industry. The purpose of this study was to examine the extent to which HIV/AIDS has affected the human resource operations in the hotel sector in the Coast region of Kenya. The study examined HIV/AIDS related absenteeism, loss of productivity, labour costs, and labour turnover, and their effects on human resource operations in the hotel sector. Stratified random sampling was employed to select 57 hotels out of the 76 classified hotels in the region. Questionnaire, focus group discussion and a retrospective analysis of document were used for data collection. The Spearman Rank Correlation Coefficient, the Pearson Correlation Coefficient and the Chi-Square were used. The results were presented in charts, frequency tables, percentages, and histograms. The Spearman Rank Correlation Coefficient indicated a positive relationship between absenteeism and labour costs. The Pearson Correlation Coefficient indicated a positive relationship between HIV/AIDS related health care costs and hotels clinic attendance. Significance was accepted at $p < 0.05$. The Chi-Square Test indicated a $X^2_{\text{calculated}} > X^2_{\text{tabulated}}$ at 95% confidence level and hence rejecting the hypotheses. The results showed that absenteeism due to morbidity and mortality of HIV/AIDS related illnesses was significant. Further operational costs rose from Ksh. 532,000 in 2000 to Ksh.819, 000 in 2004. The death rate rose by 2% between 2000 and 2004 while funeral costs rose by 2% within the same period. Employee absenteeism rose from 1,560 labour days in 2000 to 3,446 labour days in 2004. Hotels experienced attrition in skills, increase in labour costs as well as reduced performance levels. All these affected productivity and profits. From the findings of this study it is concluded that HIV/AIDS appears to have impacted negatively on the hotels in terms of absenteeism of workers, loss of skills and knowledge, increase in operating costs as well as reduced performance levels. It is recommended that all hotels should have well-elaborated HIV/AIDS prevention programmes and concerted mitigation strategies. The hotels should develop HIV/AIDS workplace policies and intensify awareness and prevention campaigns.

ACKNOWLEDGEMENTS.

I thank God for his faithfulness and for giving me the opportunity to take up this course.

Were it not for His strengths, I would not have made it this far.

I am grateful to my husband Mr. Raphael Nzioka with whose encouragement I was able to take up this course. I appreciate his financial, moral and spiritual support.

I am truly grateful to Professor Judith Waudo for her wisdom, encouragement, and support during the entire period of the study. I appreciate Professor Moni Wekesa, my lead supervisor. He was always available, even at the shortest notice. I value his understanding, patience, encouragement, support and guidance in the supervision of this study. I wish to thank Dr. Anam Onditi my second research supervisor for his commitment, availability and guidance during the entire period of this work. I would also like to thank, the Management of the hotels visited and especially the respondents who were co-operative during data collection for this study. I sincerely appreciate my children, Timothy, Brian, and Jennifer, for their unfailing support and encouragement; their words gave me the strength to continue.

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Acronyms and Abbreviations

ACU	-	AIDS Control Unit.
AIDS	-	Acquired Immunodeficiency Syndrome.
AMREF	-	African Medical Research Foundation.
EHM	-	Epos Health Management.
FKE	-	Federation of Kenya Employers.
GBC	-	Global Business Council on HIV/AIDS.
GDP	-	Gross Domestic Product.
HIV	-	Human Immunodeficiency Virus.
HRF	-	Human Resource Functions.
HRM	-	Human Resource Management.
HRO	-	Human Resource Operations.
ILOAIDS	-	International Labour Organization Programme on HIV/ AIDS.
ILO	-	International Labour Organization.
KANCO	-	Kenya Aids Non-governmental Organization Consortium.
NASCOP	-	National Aids and Sexually Transmitted Infections Control Programme.
NHIF	-	National Hospital Insurance Fund.
G.O.K	-	Republic of Kenya.
R.O.T	-	Republic of Thailand.
SPSS	-	Statistical Package for Social Sciences.
STI	-	Sexually Transmitted Infections.
TBCA	-	Thailand Business Coalition on AIDS.

- UNAIDS - Joint United Nations Programme on HIV/AIDS.
- UNESCO - United Nations Educational Scientific and Cultural Organization.
- UNDP - United Nations Development Programme.
- WHO - World Health Organization.

CHAPTER ONE

INTRODUCTION

1.0 Introduction.

Since the mid 1980's HIV has spread to almost every country in the world. One of the most devastating aspects of HIV is that it tends to kill young people, who are at the heart of both economic and social activity (United Nation's Programme on AIDS, 2003b). The disease and its consequences present a major obstacle and challenge to economic growth and stability of the workforce for both the public and the private sector.

This chapter presents the background to the study, statement of the problem, justification, objectives, hypotheses, significance and the anticipated outputs, limitations and the operational definitions of terms for the study.

1.1 Background for the Study.

Acquired Immune Deficiency Syndrome (AIDS) has become an extremely serious problem in many countries around the world. It is causing a myriad of devastating health, social-economic and developmental problems (World Health Organization, 2003). In many countries, according to the World Bank (2003), it is recognized that HIV/AIDS threatens profits, productivity, and human welfare advances achieved over several decades. Thus private and public sector organizations have strong economic and social reasons for vigorously promoting HIV/AIDS prevention and care activities (Global Business Council on Aids, 2004).

The total number of people living with the HIV/AIDS rose in 2006 to reach its highest level ever: an estimated 39.5 million (35.9 million - 44.3 million) people are living with the virus (UNAIDS, 2007). The global AIDS epidemic killed 2.9 million (2.8 million –

3.5 million) in 2005. The number of people living with HIV has been rising in every region, compared with two years ago (UNAIDS, 2006) with the steepest increases occurring in East Asia, Eastern Europe, and Central Asia.

Table 1. Global summary of the HIV/AIDS Prevalence December 2006

Number of people living with HIV/AIDS in 2006	Total	39.5million (35.9 - 44.3 million)
	Adults	37.2 million (33.8 - 41.7 million)
	Women	17.7 million (16.3 - 19.5 million)
	Children under 15 years	2.3 million (2.0 - 2.6 million)
People newly infected with HIV in 2006	Total	4.3 million (4.3 - 6.4 million)
	Adults	4.3 million (3.7 - 5.7 million)
	Children under 15 years	640 000 (570 000 - 750 000)
AIDS deaths in 2006	Total	2.9 million (2.8 - 3.5 million)
	Adults	2.6 million (2.3 - 2.9 million)
	Children under 15 years	510 000 (460 000 - 600 000)

Source: AIDS epidemic update 2007.

The epidemic appears to remain extremely dynamic as the virus exploits new opportunities for transmission. Virtually no country in the world remains unaffected (WHO, 2003). Some countries that have let down their guard are seeing a renewed rise in numbers of people infected with HIV. Most of the new infections occur mostly in the productive age segment of 15- 49 years. In 2005 alone, an estimated 4.3 Million people (range 4.2 – 6.3 million) became infected with HIV. This

is more than any one-year before. By the end of 2005 some 39.5 million people (range 34.6- 42.3 million) were living with HIV, which killed 2.9 million (range 2.6million – 3.3 million) (UNAIDS 2006).

Since the start of the epidemic an estimated 24.7 million people living in the Sub-Saharan Africa have been infected with HIV. The region has the highest prevalence in the world with an average of 8.4 % of the population infected (UNAIDS 2006). It is estimated that between the year 2000 and 2020, sixty-eight million people will die pre-maturely as a result of AIDS (NAS COP, 2002).

Sub Saharan Africa has just over 10% of the world's population, but is home to more than 60% of the people living with HIV – some 24.7 million (23.4 million-28.4 million) (AIDS epidemic update 2006).

In Sub-Saharan Africa the overall percentage of adults with HIV infection has remained stable in recent years, but the number of people living with HIV is still growing. Although prevalence is stable in most countries, it is rising in countries such as Madagascar and Swaziland and is declining in Uganda (UNAIDS, 2004a).

AIDS was first reported in Kenya in 1984 (KANCO, 2002). Since then, 1.3 million people are living with HIV/AIDS and over 140,000 have already died (G.O K, 2005). Kenya, according to NASCOP (2004) is ranked 5th in the world, among the countries that have the highest number of people living with AIDS.

The 2006 Kenya Demographic and Health Survey indicate that 6.1 per cent of Kenyan adults are infected with HIV. Women are particularly vulnerable to HIV infection. About 740,000 women are infected with HIV compared with 4.6 percent of men.

Simulation results by Hancock et al. (1996) on the Micro-Economic Impact of HIV/AIDS in Kenya reveal that the impact of AIDS could be substantial, given that 80 percent of

HIV infection occurs in the economically active age group (15-49) years. With high mortality and morbidity of the most productive labour force, AIDS would lower economic performance.

These authors projected that G.D.P would be 14.5 percent lower in the year 2005 while the per capita income would drop by 10%. These developments are detrimental to the Kenyan economy, which is currently in a recession with low economic growth, low savings and investments.

The challenge that AIDS poses is real and requires deliberate effort if the effects are to be contained (World Bank, 2002). HIV/AIDS remains a major concern in Kenya because of relatively high prevalence rates reported among adult populations and significantly higher rates among younger ages (ROK, 2001).

1.1.1 HIV/AIDS Pandemic and the Hospitality Industry.

The initial development of Kenya as a tourist destination started at the turn of the 20th century (Akama, 2002). Thus between 1900 and 1940, the development of tourism in Kenya was characterized by individualized forms of travel by affluent visitors from western countries and was mainly based on 'Big Game' safari hunting. In order to promote the development of organized tourism, the government in collaboration with the private sector initiatives established the East Africa Travel and Tourism Association (Ouma, 1982).

Between 1970 and 1980, Kenya experienced growth in the development of tourist and hospitality facilities and more especially at the coast. Over 10,000 hotel beds in 500 hotels were added to the existing tourist establishments (Sinclair, 1990). Tourism is

currently the second largest industry in Kenya providing the needed jobs, tax, revenue and foreign currency to this country (G.O.K, 2003).

The hospitality Industry is a service industry and has no doubt acted as a reliable pedestal on which the tourism sector has rested over in the past years. It has strived to keep pace with the needs of the ever demanding and sophisticated clientele, majorities of who are tourists.

Epos Health Management (2004) found a positive relationship between tourism and increased risk of contracting HIV/AIDS. Behavioral linked risks such as unprotected casual sex were the most cited factors that lead to high risk of contracting HIV/AIDS among the hotel workers.

A study conducted by Watson (2004) found that sex was important in choosing Bahamas as a tourist destination. Forty four percent of the interviewed tourists said that they visited the Bahamas to find new sex partners, while the hotels promoted guest-staff liaison. The study concluded that tourism does promote interaction in ways that other industries do not, and this was found to be a contributing factor to the high HIV/AIDS infection rate in the tourist belt (Watson, 2004).

A study in Devon and Cornwall in the United Kingdom found that both male and female tourism workers have greater numbers of sexual partners (especially with tourists) and have more casual sexual relationships than the resident population (Ford, 1990).

According to Boella (1996) Human Resource, in the hospitality industry tends to represent one of the single biggest costs for the enterprise, furthermore, the human resources are usually the first point of contact between the enterprise and the customer.

Tracy and Nathan (2002) found that effective human resource management is one of the most important considerations in creating and maintaining a competitive advantage for a hotel.

It is important therefore to gain understanding of the possible effects of HIV/AIDS pandemic on the hotel's workforce in order to encourage an appropriate response.

1.2 Statement of the Problem

HIV/AIDS deals its most direct impact to businesses by attacking their workforce. Current indicators show that the size of labour force will be between ten and thirty percent smaller by the year 2020, than it would have been without AIDS. HIV/AIDS pandemic has a devastating impact on economic security, markets and workforces in heavily affected countries.

Businesses are experiencing low productivity due to employee absenteeism, staff turnover, loss of skills with training, recruiting and health care costs rising due to HIV/AIDS.

Tourism is affected by HIV/AIDS, due to the mobility of the workers, the nature of the industry and the presence of "sex tourists". This has caused the hotel industry to be under threat from HIV/AIDS pandemic by possible loss of experienced personnel. Transmission of skills and knowledge may become difficult with high levels of staff turnover, while declining profits and investment may affect consumer and business confidence.

Typically, AIDS is a protracted illness and workers are likely to become less productive, and take time off. More broadly, guest services may be affected, and this may create a

mismatch between human resource and labour requirements. This study therefore sought to examine the effects of HIV/AIDS on human resource operations in the hotel industry.

1.3 Justification of the Study

An investigation into the effects of HIV/AIDS on the human resource operations in the hospitality sector will fill the gap in the existing literature in the subject of HIV/AIDS and the hospitality industry.

1.4 Hypotheses.

The study examined the following null hypotheses.

Hypothesis 1: The effects of HIV/AIDS related absenteeism on labour costs is not statistically significant.

Hypothesis 2: Loss of skilled and experienced workers does not affect profits for the hotel industry in the coast region of Kenya.

Hypothesis 3: HIV/AIDS related illnesses have no effect on health care costs for the hotel industry in the coast region of Kenya.

Hypothesis 4: Labour turnover due to HIV/AIDS infection does not affect profits for the hotel industry in the coast region of Kenya.

1.5 Objectives of the study

General Objective

To investigate the extent to which HIV/AIDS has affected the human resource operations in the hotel industry in the coast region of Kenya.

Specific Objectives.

1. To establish whether HIV/AIDS related absenteeism affects operational costs in the hotel industry in the Coast region of Kenya.

2. To determine the effects HIV/AIDS related loss of Productivity on hotel operations in the hotel industry in the Coast region of Kenya.
3. To determine the effects of HIV/AIDS on labour costs for the hotel industry in the coast region of Kenya.
4. To establish the effects of HIV/AIDS on labour turnover in the hotel industry in the coast region of Kenya.

1.6 Significance and anticipated output.

The results of this study will be useful to the hotels in Kenya, The Kenya Tourism Board, The Ministry of Tourism and other stakeholders in the industry. Information from this study will be made available to other researchers. Furthermore, it is hoped that the results obtained from the study of the hotels at the coast region can be generalized to all hotels in Kenya, and that the hotels would react if the HIV/AIDS epidemic affected them.

From the findings of this study it will be possible to make recommendations to the hotel management on how to manage HIV/AIDS in the workplace.

1.7 Limitations

The following limitations were encountered in the study.

- Public transport to various parts of the region was very inefficient due to poor infrastructure, and this took the researcher too long to reach the respondents, this slowed down the study.
- Information on income and profits was considered confidential and was not made available to the researcher.

1.8 Operational Definitions of Terms.

Absenteeism:	Term used to refer to unscheduled employee absence from the workplace
AIDS:	Condition in which the body immune system is so weak that the body becomes susceptible to attacks by various diseases the latter, which are called opportunistic infections.
Epidemic:	The appearance of a particular disease in a large number of people in the same period of time.
Health care costs:	Cost of clinical care, drugs, and laboratory services.
HIV:	The Human Immune Deficiency Virus, a virus that weakens the body's immune system ultimately causing AIDS.
Hospitality Sector:	A section of the tourism industry that provides accommodation food and beverage to visitors, tourist away from their homes.
Hotel:	A premises on which accommodation is supplied or available for supply, with or without food or services to five or more adult persons at one time in exchange for money. Includes town hotels, resorts and game lodges.
Human Resource Operations:	Functions and duties performed by the hospitality employees.
Labour Costs:	The costs incurred by an organization in employee maintenance in the work place. Includes salaries, medical cover, and other allowances.
Labour force:	The sum of the people of working age who are available for work or participating in productive work.

- Labour Turnover:** The rate at which employees leave a company and are replaced by new people.
- Loss of Productivity:** The inability of employees to produce due to sickness, death or absenteeism.
- Pandemic:** A disease existing in almost all of an area or in almost all of a group of people.
- Prevalence:** Total number of cases of a disease in a given population at a specific time.
- Skill:** Proficiency or dexterity that is acquired or developed through training or experience.
- Syndrome:** A set of symptoms that occur together.
- Tourism** Activities of persons traveling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business or other purposes.
- Work place policy:** A Policy that provides guidelines on employer Employee rights and responsibilities in the context of HIV/AIDS

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction.

The HIV/AIDS epidemic is the greatest social challenge facing this generation, and the worst public health disaster in six hundred years (UNAIDS, 2003a).

The International Labour Organization (2002) estimates that at least 28 million people infected with HIV worldwide are workers, aged 15 to 49 years, and in the prime of their working life. This is about three quarters of all adults living with HIV/AIDS (ILO, 2002). From the standpoint of its economic impact, HIV/AIDS has become a major threat to employment objectives and labour market efficiency.

The loss of workers and workdays due to AIDS related illnesses, or demands for caring for the sick can result in significant declines in productivity, loss of earnings, and attrition in skills and experience (Pramautrana, 1996). The effects of HIV/AIDS on employment and workforce are therefore a major concern of the ILO, which views the epidemic as a workplace issue and a major development challenge (ILO, 2003). An obvious impact of HIV/AIDS on Labour is on the growth of the population. This according to World Bank (2002) has been greatest in Sub-Saharan Africa.

Within this region, the highest rate of infection is in South Africa. UNAIDS (2003a) estimates that 36 % of the adult population in Botswana, 25% in Zimbabwe and Swaziland and 20% in South Africa and Zambia are infected. This compares with the prevalence rate of 8.4% for Sub-Saharan Africa and 1.2% for the world as a whole. The

United States Census Bureau has projected that by 2010 life expectancy will fall from 60 years to around 30 years in the worst affected countries (cited in Bloom et al., 2001).

Projections made by ILO for the 29 African countries with prevalence rates above 2 % in 1999 shows that the total population for these countries was projected at 773 million by 2020 i.e. 8% smaller than in the absence of HIV/AIDS (International Labour Organization Coalition on AIDS, 2002). In countries with a higher prevalence rate, the impact is even greater: for instance, by 2020 Zimbabwe's population is expected to be 20 % smaller than it could be without AIDS.

These projections and available evidence on the impact of HIV/AIDS suggests that the economic and social impact of the epidemic will be far reaching and long lasting, through the toll in human lives and particularly the loss of people of working age (ILO, 2000a). The impact of HIV/AIDS is manifest in its effects on the labour force and on working age men and women as shown in figure 1

According to ILO (2000b) the majority of countries affected by HIV/AIDS are in Africa, where the regional average prevalence among 15-49 year olds is 7%. The ILO has gone beyond the estimate of labour force participants who are HIV-positive to make short-term projections of the number of persons who are of working age (and therefore engaged in productive activity).

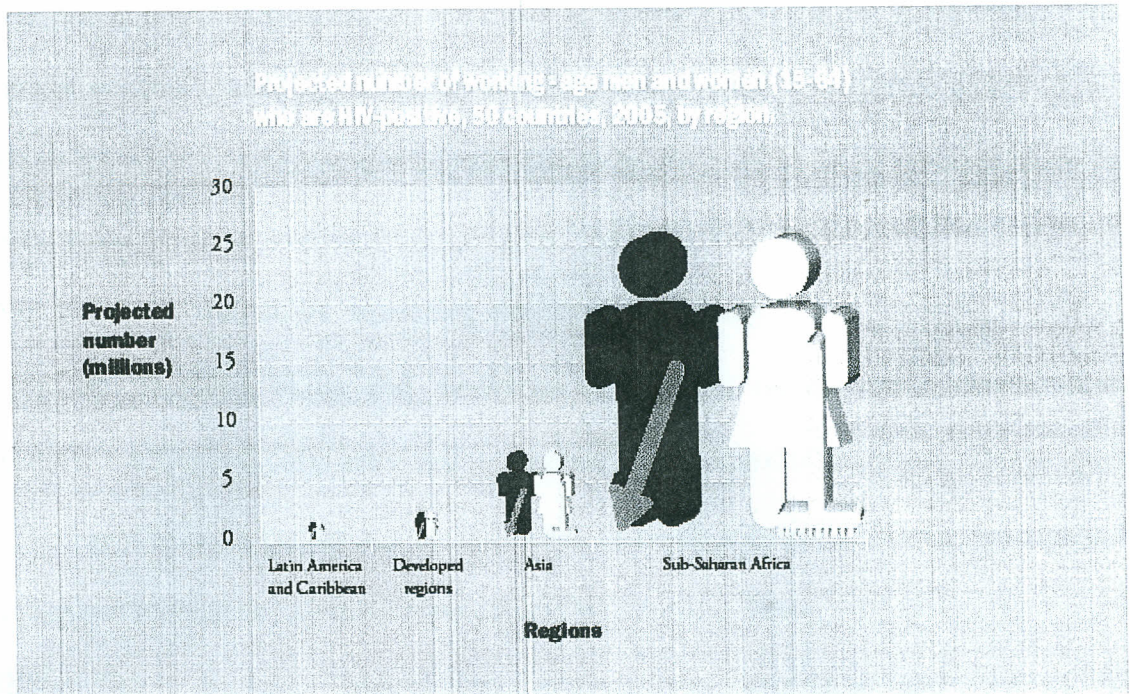


Figure 1. Projected number of working-age men and women (15-64) who are HIV- positive, 2005, by region (Source: Global Estimates 2004).

In the 50 countries of the world affected by HIV/AIDS, the prevalence rate in persons aged 15 to 49 was estimated to range from under 1% to nearly 40% at the end of 2003 (ILO, 2004). The vast majority of persons in the labour force who are HIV positive (over 70%) live in Africa.

In several African countries, there are over a million economically active persons who are HIV positive. Kenya has 1million, Mozambique 1.1 million, Ethiopia and Zimbabwe has 1.3 million each and the United Republic of Tanzania 1.4 million. In Nigeria, 2.4 million workers are HIV positive and in South Africa, nearly 3.7 million workers are infected (UNAIDS, 2004b). According to (ILO, 2000b), nearly 36.5 million persons worldwide who are engaged in some form of productive activity are HIV positive.

This figure exceeds by nearly 800,000, the global estimates of 35.7 million adults aged 15 and 49 living with HIV. By 2020, according to UNAIDS (2003b) assuming a

continual absence of treatment, 16 African countries will have lost more than 10% of their labour force, and by 2015 the number of persons in the labour force projected to be lost in the absence of treatment is expected to be 50 million in Africa and 74 million worldwide.

AIDS reduces output by squeezing productivity, adding costs, diverting productive resources, depleting skills and distorting labour. For employers, employee health expenses and funeral costs are rising as productivity and profits decline, while the loss of supervisory workers can have a harsh impact, since their acquired knowledge and skills are seldom replaced by simply hiring others (Williamson, 2004).

The epidemic increases absenteeism, organizational disruption and loss of skill (ILOAIDS, 2003a).

According to ILO (2004) at some point in the deterioration caused by the disease, persons living with AIDS may cease to be able to work, first intermittently and then increasingly until entirely unable to work. At some point also, persons living with AIDS drop out of the labour force and are no longer economically active, eventually lose their capacity to contribute to productive activities (Biggs and Shah, 2002). HIV/AIDS hits the world of work in numerous ways.

In badly affected countries, it cuts the supply of labour, absenteeism raises labour costs for employers while valuable skills and experience are lost (UNAIDS, 2000). Research at Boston University in 2001 found that AIDS related costs in the companies studied ranged from 3% to 11% of the annual salary bill in 1999-2000.

The difference between enterprises depends on each company's production structure and human resource policies (UNAIDS, 2002).

A Thai government study showed that the direct and indirect cost of HIV/AIDS to the nation was US\$ 1.2 billion in 2000 (Republic of Thailand, 2002). A major transport company with 11,500 workers in Zimbabwe found that 3,400 of them were HIV positive in 1996. Costs for the company related to HIV/AIDS amounted to more than US \$ 1 million or 20% of the company's profits (UNAIDS 2002).

A study by The Federation of Kenya Employers in (2000) for the Kenya's Agricultural sector, showed a drop in work performance standards, leading to a decline in profits, due to loss of skilled labour (Cited in GBC, 2003c). The effects of HIV/AIDS on the labour force and on all persons of working age are measurable in their impact on economic growth and development. By causing the illness and death of workers, HIV/AIDS reduces the stock of skills and experience of the labour force, and this loss of human capital is a direct threat to goals for poverty eradication and sustainable development (ILO, 2004).

In recognition of the possible consequences of HIV/AIDS in hotels in Kenya, a literature review of the existing information on the impact of HIV/AIDS and the workplace has been conducted. The epidemic already has devastating impact on economies and is threatening the security and prosperity of the global society (World Bank, 2002). For companies operating in hard hit regions, HIV/AIDS will have major consequences on profitability and productivity (Global Business Coalition on Aids, 2004).

The economic impact of HIV/AIDS on companies is manifested by reduced labour productivity, through AIDS related deaths, absenteeism and loss of skilled workforce (ILOAIDS, 2003). Other important effects include increased expenditure on staff

recruitment and training, funeral expenses, and increased medical costs (World Bank, 2003). AIDS is a workplace issue not only because it affects labour and productivity, but also because the workplace has a vital role to play in the wider struggles to limit the spread and effects of the epidemic (ILOAIDS, 2003). Enterprises and national economies as well as workers and their families feel the effects.

According to Family Health International (2002), the link between HIV/AIDS and business is no longer conceptual. Areas worst hit by the epidemic provide myriad examples of productivity loss of at the industry, business sector and country levels. Factors that may make the tourism sector's workforce particularly susceptible to HIV or make the sector financially vulnerable to the loss of a significant number of infected employees includes that tourism industry hires a large number of young, single employees who are frequently mobile and away from their families for prolonged periods of time. There is also a significant access to commercial sex, both by employees and tourists (EHM, 2004).

The literature review focused on the past relevant studies on the impact of HIV/AIDS on the work place. It has particularly focused on absenteeism; loss of productivity, increased labour costs, and labour turnover.

2.1 Absenteeism

Absenteeism is a cost in the sense that absent workers continues to be paid for the job they did not perform (FHI, 2001). According to ILO (2002), increased absenteeism is one of the primary drivers of rising visible costs, and declining productivity in businesses as a consequence of HIV/AIDS. A study conducted for a large cement company in Zambia showed that absenteeism for funeral attendance had increased by 15 times

between 1992 and 1995 period (UNAIDS, 2003a) while in the mid 1990's Uganda Railways reported steep increase in absenteeism and annual staff turnover (ILO, 2002).

The Standard Chartered Bank's response to HIV/AIDS stemmed largely from the realization that, HIV/AIDS had started to impact on the Bank's profitability through loss of personnel, absenteeism, medical and welfare costs (GBC, 2003c).

Studies by United Nations (Bloom and Mahal, 2001) conducted on 14 firms in Benin found that, 50% of those identified as HIV positive held positions considered 'important' by the firms. The firms held salary levels constant while the workload reduced leading to reduced profits. This was also reported in a study by G.B.C (2004) that, absenteeism affects businesses through the disruption of the production cycle, the under utilization of equipment and the use of temporary staff. Records of labour time lost from morbidity kept by a company in Nyanza showed that between 1995 and 1997, the company lost a total of 8,007 labour days from employee illness. A significant portion of this time lost was attributed to HIV/AIDS related illness (Rugalema et al., 1999 and cited in Daly 2000).

At the same time another company in the same region reported having lost a total of 600 labour days between 1995 and 1997, because of sick employees affected by HIV/AIDS (NAS COP, 2000b). The indirect effect of absenteeism is that it means extra work for health employees, who have to stand in for sick colleagues. In some of the companies healthy employees were increasing working hours to compensate for the time lost by their sick or absent workmates (NAS COP, 2000b). In so doing not only did companies pay more in overtime, but also workers interviewed pointed out that they were overworked and exhausted. According to the Engineering manager of one of the

companies, long working hours had produced stress among employee, and were responsible for decline of both quality and quantity of the final product.

A South African sugar milling company found that HIV positive employees took on average 55 additional sick days during the last two years of their lives (GBC, 2003a). In 1996 studies conducted for Makandi Tea Estate in Malawi, showed six- folds increase in mortality between 1991 and 1995, the death rate was 4 per 1000 workers to 23 per 1000 workers. HIV/AIDS cost the company 6 percent of its annual profits (GBC, 2003a).

Recent comparative studies of East African business have shown that absenteeism accounts for between 25-54 per cent of costs. The observed increase in absenteeism is a result of employees becoming ill due to HIV and its associated opportunistic infections, the demand of caring for family members who are ill, and the need to attend funerals (ILO, 2002). According to UNAIDS (2002) absenteeism directly affects the quality of products and services, leading to loss of reputation and ultimately a reduction in customers.

2.2 Loss of Productivity.

The inability of persons in the labour force, who are HIV positive to continue to work when they become ill, has consequences for every aspect of social and economic context of business (UNAIDS 2001). In labour intensive industries such as Agriculture and Tourism, productivity is the most important determinant of output (UNAIDS, 2003a).

Illness compromises labour productivity because a sick person is unable to work. Even when the person works, physical and psychological factors lower performance, thus the cost of illness does not end by paying an employee who is not working; it includes other

costs related to delays in the production process and loss of quality and quantity of final product. Workers interviewed pointed out that, when they had a sick family member (spouse or child), it was unlikely that they could be as productive as was expected, because their presence at work was more physical than mental and, hence, they performed poorly (ILOAIDS, 2003).

Tyler et al. (1997) found that nearly a thousand firms in Sub-Saharan Africa, had difficulties in replacing professional staff to be one of the most significant problems, with firms taking 24 weeks to replace a deceased professional compared to 2 or 3 weeks for less skilled staff. Other smaller studies have shown how, at exactly certain stages in the epidemic, HIV infection can be disproportionately concentrated among the skilled workers (United Nations Development Programme 1999).

The epidemic may become concentrated among economically-disadvantaged populations, but only because the wealthier and better educated have been in a position to take preventive action. A Kenyan company manager puts it thus: *"If you lose someone you have trained for twenty years that is a loss. Condoms and AIDS education cost peanuts* (Bloom et al., 1993). The concern is not only with reduction in the size of labour force, but also its quality (World Bank, 2000). Many of those infected with HIV are experienced and skilled workers in their productive prime, representing significant human capital losses (ILOAIDS, 2003).

At the same time loss of workers to AIDS is creating a generation of orphans, which by 2010 could reach up to 10% of the population in some Sub-Saharan African countries, and may grow up without support and guidance of adults and enter the labour force

prematurely and with no skills (World Bank, 2000). The epidemic not only reduces the stock of professional and managerial workers, it also reduces the capacity to maintain the future flow (Cuddington and Hancock, 1995).

The implications of HIV/AIDS for GDP growth will clearly be substantial both through the direct impact on labour supply, human capital and savings, as well as through a decline in total factor productivity (World Bank, 2002). The prospect, then for high prevalence countries is much lower GDP and employment growth rates, decline in output per head and average earnings. Moreover, poverty is likely to increase as a result of the impact of HIV/AIDS (UNDP, 2003).

According to Nabila, Antwi, Kwaku and Kwankye (2003). *'The HIV/AIDS epidemic creates a vicious cycle which leads to increased absolute poverty which, in turn facilitates the rapid spread of AIDS as household expenditure on health and nutrition declines, thereby reducing resistance to opportunistic infections. In addition, the epidemic is likely to increase income inequality by increasing the supply of scarce skilled labour, leading to higher wages for skilled workers vis-à-vis unskilled and unemployed labour'*

According to Bloom and Mahal (1999) and Farmar (1999), the loss of a staff member has effects on a firm's stock of "know-how", the morale of other workers, as well as imposing recruitment costs. Declining levels of productivity lead to declining profits additionally with declining and fluctuating products. This has impact on the present and future reputation of the enterprise and thus on its future profitability.

At the enterprise level AIDS related deaths reduce productivity and increase labour costs (ILO, 2003). Loss of skills and knowledge make it difficult to replace staff, even where

there is a pool of unemployment, the workload of non-affected workers rises, to the detriment of their morale (UNAIDS, 2003b).

Demographic survey conducted for South Africa in (2002) by UNAIDS estimated that there would be an 18% fall in the estimated workforce owing to HIV/AIDS. According to the study it would result in the loss of 386,000 highly skilled workers, 984,000 skilled workers and 4.3 million semi/unskilled workers between 2000 and 2005.

In another study conducted for the GRANT HYATT Hotel in Erawn Bangkok in 1993 it was found that, the hotel would loose a big number of skilled and experienced employees to HIV/AIDS and this would impact negatively on the hotel's productivity (Pramautrama,1996). Loss of skills from the workforce is the most obvious and most cited disruption with clear resultant training costs (UNAIDS, 2000).

Transmission of skills and knowledge becomes more difficult with high levels staff turnover (UNAIDS, 2002). These losses of intellectual capital have become increasingly important with the progressive changes in the way companies are valued, strength of intellectual capital is becoming increasingly important relative to financial capital (GBC 2003b). The study on productivity loss has not been done in Kenya in relation to the hotel industry.

2.3 Increased Labour Costs.

The business sector where management of cost has a critical role is faced with increasing levels of AIDS related costs. AIDS related illness and death of workers affect employers by increasing their costs and reducing revenue (ILOAIDS, 2002). They have to spend more in areas such as health care, funerals, training and recruitment of employees.

Revenue may be decreased because of absenteeism due to illness or attendances at funerals as well as time spend on training.

A study conducted on selected business organization in Ghana in – showed that Health care cost and direct cost of the epidemic to the companies were visible. The cost of out patient care (which includes drugs and laboratory services) to the company ranged between 36,308 and 380, 350 Cedes (Ksh3, 859 and Ksh 35,177) per episode of illness (Nabila et al., 2003). In Tanzania, one company experienced a five fold increase in its medical care cost per employee during 1993-97 and has now instituted a cap on expenditures per employee.

At Tanzania–Zambia Railway Authority, Medical costs associated with AIDS related illnesses increased in one year in 1995 by 63% (G.B.C, 1996). Medical bills if paid for by the companies also increased the cost of health care. Farnham and Gorsky (1994) have argued that in the USA for example, a significant proportion of the costs of the epidemic are bone by the business community, due to the employer based system of health insurance and the provision to many employees of the health – related benefits.

A reduction in the rate of growth of the labour force, combined with falling productivity, mean less government revenue from individuals and enterprises. Botswana's government expenditure for instance is expected to shrink by more than 20 percent over the next 20 years, as revenue bases are eroded. At the same time the costs to government of dealing with the epidemic account for an increasing proportion of budgets (World Bank, 2002). Estimates by IMF for HIV/AIDS – related services in some of the affected countries account evidence form 20% and 90% of health budgets.

The World Bank suggests that both government and private savings are squeezed by the HIV/AIDS epidemic. In the government, it is by the pressure of its lower revenues of epidemic related expenses; while in the private savings by the need to devote an increased share of a reduced income to health care (UNAIDS 2003a). At the same time incentives to private investments are significantly reduced. Some private companies may try to shift epidemic related- costs to others by contracting services with high risk workers out to other companies, or to eliminate such costs by replacing workers by equipment or machinery (UNAIDS, 2001).

A study of several firms in Kenya including Muhoroni Sugar Company showed that one of the firms spent Ksh.1.1 Million on HIV/AIDS related costs, another firm spent 2 million, while yet another spent 3.1 million and Muhoroni 2.9 Million. (Roberts and Rau, 1994). Medical costs paid by employers in the agro-estate surveyed rose from a modest Ksh.300, 000 in the 1980 to 8.1 million in 1997 while employees paid cost also rose from a mere 1.5 million in 1989 to 11.3 million in 1997. Had HIV/AIDS not been present most of these resources could have been channeled to other important needs (Cited in Management for health, 2003).

In a study on economic impact of HIV/AIDS on selected business organizations in Ghana, employers in the studied organizations were expected to provide free medical facilities to their employees, their spouses and children below 21 years (Nabila et al., 2003). According to Studies conducted for three countries (Ghana, Burundi and Thailand) by Heineken International in 2002, it was concluded that HIV/AIDS is not a just a medical issue, but one with enormous economic implications that cannot be ignored (UNAIDS, 2003a),

A Thai Government study found that direct and indirect cost of HIV/AIDS to the nation were US\$1.2 billion in 2002 (TBCA, 2002). The economic impact of HIV/AIDS on companies includes both internal and external effects (GBC, 2003b). A study conducted for Barclays Bank Zambia in 2000, showed that, the death rate among the employees rose from 0.4% in 1987 to 2.2% in 1992. Ex gratia payments to families increased by nearly 350 % with the Bank paying increased funeral costs (Bollinger and Stover, 2000).

Demand for recruitment and training rises as a result of increased staff turnover and loss of skills (ILOAIDS, 2003). This may include employing extra labour to cope with staff fluctuations and losses, widening the skill base, through multi-skilling and succession strategies of extensive human resource monitoring (GBC 2003b). In addition, within a situation of scarcity, skilled labour not only increases training costs, but also results in demands for higher wages (ILOAIDS, 2002).

Death itself can also impose significant costs on business. Many firms in Sub-Saharan Africa are responsible for funeral costs and face additional costs as other workers attend funerals (World Bank, 2002). Zambia's largest cement factory, for example, saw a 15-fold increase in funeral related absenteeism between 1992- 1995. As a result, the company restricted employee absenteeism for funerals to only those for a spouse, parent or child (Farnham et al., 1994). Death at Barclays bank Zambia increased funeral costs. More than 70% of the deaths occurring in those under 40 years (Bollinger and Stover, 1999).

In companies heavily affected by AIDS, death is either the leading or one of the leading causes of employee exit from the company (ILOAIDS, 2003). Illness is the second most important. Before 1990's (NAS COP, 2002b) when deaths were few records in two of the

surveyed companies in Nyanza (where the death rate is high) companies lost an average of 2 to 5 employees per year. The most important reasons for employee exit were old age, retirement, resignation, termination dismissal, illness and death, in that order. Today, the order has clearly changed, as illness and death have become the leading causes of exit.

A study conducted in six large enterprises in the retail, agriculture, media, mining and heavy industry sectors in South Africa and Botswana found that the direct costs associated with HIV/AIDS varied considerably. The cost per HIV/AIDS infection of unskilled worker ranged from US\$ 1,500 to US\$2,094, while the costs of a Manager ranged from US\$8,736 to US\$65,000 (G.B.C, 2003d). Average companies in Kenya incur mean annual costs associated with HIV/AIDS of approximately US\$ 140,000, (Ksh.10,920,000.00) and are expected to rise to US\$ 403,000 (Ksh.33,540,000.00) by the year 2005 (World Bank, 2003). It will be interesting to find out the situation in the hotel industry.

2.4 Labour Turnover

The high rate of Morbidity and Mortality from HIV/AIDS generates increasing disorganization within the workforce as a result of rising staff turnover (Sokal et al., 2000). According to ILOAIDS (2003), some companies in South Africa believe that 40% of their workforce may have HIV/AIDS. This may increase labour turnover by 3% to 6%, while a study conducted in an agricultural firm in Kenya showed that 41% of the employees left the company because of AIDS related illness or death (Bollinger et al., 1999). Healthier workers had to work overtime, increasing direct overtime costs and

possibly indirect costs such as stress and reduced efficiency among overworked employees (World Bank, 2002).

The Uganda Railways in 1990's reported an annual staff turnover rate of 15%, with more than 10% of the workforce dead from AIDS related illness (ILOAIDS, 2003).

The costs of turnover include costs incurred to acquire and develop human resource and replacement costs (Pratt and Bennet, 1990).

Preliminary research shows that providing treatment and care to employees in the workplace is often less expensive than the cost of labour turnover (Sokal et al., 2000).

According to Bollinger et al. (1999) it should be noted that the effects of HIV/AIDS on firms mainly are on costs and productivity and this in turn may affect services and profits.

The major concerns of businesses are reduced productivity and raised labour costs.

The hotel sector is a labour intensive industry, where productivity level is measured in average revenue per man hours worked. Although labour costs can be reduced in many industries by developing a machine to do the job this is not easily done in the hospitality industry where the guests expect human interaction (Coltman, 1987).

Labour turnover can lead to less experienced and therefore less productive workforce (Biggs and Shah, 1997). This study will establish the effects of HIV/AIDS related labour turnover on the human resource operations in the hotel industry in the coast region of Kenya.

2.5 Summary

The effects of HIV/AIDS related illness and deaths reduce productivity and increase costs. Enterprises have reported increase in absenteeism (due to illness and bereavement, in labour turn over (due to illness and deaths), and in costs of recruitment, training and staff welfare. Health care costs increase particularly fast in enterprises which extend medical services to employees' dependants.

It is costly to ignore prevention and to fail to provide care, support and treatment for persons who are HIV positive and have symptomatic AIDS. Comprehensive approaches to HIV/AIDS are not cost free, but more work places have come to realize that the cost of inaction is far greater. The hospitality industry is susceptible to HIV/AIDS due to the mobility of the work force and the characteristics associated with HIV/AIDS.

Clearly not much has been done on HIV/AIDS and the hospitality industry. This study looked at the extent to which HIV/AIDS pandemic has affected the hotel operations in the Coast region of Kenya.

CHAPTER THREE

METHODOLOGY

3.0 Introduction.

This chapter describes the study area, method of study, research design, target population, study sample and sampling procedures. It describes the research instruments, their validity and reliability, pre- testing of the instruments, instrument administration, data collection procedures, data analysis techniques and data presentation.

3.1 Study Area.

The study was conducted in the Coastal region of Kenya. The region is made up of seven districts namely: Mombasa, Kilifi, Malindi, Kwale, Lamu, Tana River, and Taita Taveta, (Appendix A). The coastal strip can be divided into four areas: the North Mainland, Mombasa Island, the South Mainland, and Lamu.

The Coastal climate is tropical, but the sea breeze prevents it from becoming oppressive. The coolest months are from July to November. Communication is excellent with daily overnight coaches and taxis to and from Nairobi. The airport at Mombasa can cope with large aircrafts, providing easy International connections to the area. Light aircrafts operate from the many airstrips and landing grounds along the coastline.

Lamu is perhaps one of the most interesting places in this region. It is very Arabic with very little modern civilization. Two Marine National parks have been established within the Marine National Reserve, affording complete protection for all marine life. There are coral gardens within the park. The Coastal region is becoming important for its "Big game" and fishing in the Indian Ocean. Hotels in this region provide facilities for water-skiing, sailing, goggling, scuba diving, and underwater photography among others.

There are 159 classified hotels in Kenya of which 76 (48%) are at the coast (Appendix B). Seventy eight percent of the tourist activities in Kenya are conducted in the coastal region, and 79.5% of Kenya's tourists Investments are also in this region (Nzioka, 2001). According to R O K (2005) most visitors to Kenya preferred to stay at the Coastal region hotels as depicted in the share of bed nights occupancy rate, which stood at 51.2% in the country during 2004. Therefore the most important criterion in selecting this area was that it is a good representation of the tourism and hospitality sector in Kenya.

3.2 Research Design

This study employed both the descriptive survey study and the historical method of data collection.

3.2.1 Descriptive Survey Study

The descriptive survey study was used because it allows generalization of the results to the population (Mugenda and Mugenda, 1999). The study sought to address the variables that will enable the researcher to answer the question: How has HIV/AIDS affected the human resource operations in the hotel sector?

3.2.2 Retrospective Method.

The retrospective method was used to provide the secondary data required for the study. It was used in the analysis of the previous records and the interpretation of trends. Records from the hotels personnel department were reviewed for the period 2000 - 2004. Also reviewed were the records of staff that died and the hotels expenditure on funerals for the same period. Information on finances and especially profits was considered confidential by most hotels and could not be released. Expenditure on training and recruitment could not be ascertained. Records from the hotel clinics were evaluated to

determine the numbers and the disease patterns of the employees seen at the clinics and the health care costs for the period under review. This helped the researcher understand the previous history and the trends of the impact for the specified period.

3.3 Target Population.

The target population for this study was all the Human Resource Managers in the classified hotels in the Coast region of Kenya.

Validation of data was achieved through the use of questionnaires FGD and retrospective analysis of certain documents.

3.4 Sampling Design and Procedure.

The Kenya Tourism Board hotel classification of June 2003 was used to get a list of all classified hotels in the Coast region. This formed the sampling frame for the study. In the hotel classification, hotels are categorized in five groups according to star rating. There are 76 classified hotels in the Coast region (Appendix B). The desired sample size for this study was computed using the Stratified random sampling procedure to select 75% from the target population. This procedure made it possible for the study to achieve representation from all the classified hotels in the region. The study used hotel classification as the sampling frame.

Target Population = 76 hotels. $75\% \times 76 \text{ hotels} = 57 \text{ hotels}$. Desired sample size = 57 hotels.

Formula for Stratified Random Sampling.

Sample size/ population = $57/76 = 0.75$ multiply each member of the strata by 0.75 to get the sub-samples.

$$3 \times 0.75 = 2 \text{ five star hotels}$$

$$7 \times 0.75 = 5 \text{ Four-star hotels}$$

$$21 \times 0.75 = 16 \text{ three star hotels}$$

$$40 \times 0.75 = 30 \text{ two star hotels}$$

$$5 \times 0.75 = 4 \text{ one star hotels}$$

Add the sub-samples to get the sample size Total = 57 hotels

Table 2 Sampling Frame of classified hotels at the coast region

Hotel Classification	5*****	4****	3***	2**	1*
Number of Hotels in the coast region	3	7	21	40	5
Sub-samples	(2)	(5)	(16)	(30)	(4)

Note: An asteric * indicates Hotels Star Rating

3.5 Sample Size

The sample size consisted of 57 classified hotels from the coast region of Kenya.

Hotels for the study were randomly selected. This gave the hotels in each classification an equal chance to be selected. Each hotel was considered to have the potential of providing the researcher with viable information concerning the study.

3.6 Research Instruments.

3.6.1. Questionnaire.

Data were collected using questionnaires (Appendix D) which were both structured and unstructured. They were meant to solicit information on the effects of HIV/AIDS on the hotels human resources operations. The questionnaires particularly focused on the effects of employee absenteeism, loss of productivity, labour costs, and labour turnover and their effects on human resource operations. In addition the questionnaire was kept brief and precise to ensure comprehensiveness of data.

The questionnaires were used to collect the primary data for this study and they were designed in such a way that the questions were in conformity and relevant to the study, guided by specific research objectives. These were administered to the respondents by the researcher personally.

3.6.2 Retrospective analysis of available records.

This was taken from all secondary sources containing relevant information in respect to the study. These included hotels medical records, and personnel records and reports that had relevant literature on the effects of HIV/AIDS in the hotels for the period 2000 – 2004.

3.6.3 Focus Group Discussion (FGD)

A focus group discussion was held with 10 human resource managers from the sub-regions: Mombasa Island, Lamu, North Mainland, and South Mainland. Two managers represented each hotel classification; this brought together 10 Human Resource Managers from the selected hotels. The discussion focused on how employee absenteeism and

employee sickness, has effected the hotel operations. Additionally the discussion centered on whether HIV/AIDS had increased employee maintenance costs and if the hotels were experiencing labour turn over due to HIV/AIDS pandemic.

3.7 Pre Testing.

This was conducted in three classified hotels from the study region which were not part of the study sample. The pre- tests helped in enhancing the validity and reliability of the research instruments and improve the questionnaire in both consistency and clarity.

3.8 Data Collection procedures.

Data collection took a three-pronged approach. Firstly, questionnaires were administered to Human Resource Managers in the selected hotels. In the absence of a human resource manager, the required information was sought from either the General Manager or the Resident Manager.

Secondly, hotel records over a five-year period were studied. Lastly, a focus group discussion (FGD) involving 10 Human Resource Managers from some of the selected hotels was used to provide further information. All 57 the questionnaires distributed were returned to the researcher, giving a response rate of 100%.

3.9. Data Analysis.

Data collected from the field were organized in a systematic manner that facilitated analysis. Quantitative data in the questionnaire was coded then analyzed using the Statistical Package for Social Sciences (SPSS) and Microsoft Excel package. Spearman's Rank Correlation Coefficient was used to determine whether a relationship existed between absenteeism and costs for paying casuals and overtime.

The Pearson Correlation was used to test if there was a relationship between funeral costs incurred by the hotels and number of deaths for hotel workers. The Pearson Correlation was again used to test if there was a relationship between clinic attendance and health care costs. The Chi-Square Test was used to check the validity of the respondent's assumptions that HIV/AIDS related absenteeism of workers and Loss of productivity had affected hotel operations. Significance was accepted at 95% confidence level. Qualitative data from the FGD was analyzed by use of descriptive statistics such as percentages, charts and frequencies.

Results were presented by use of descriptive statistics such as frequency tables, charts, graphs and percentages.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

In this chapter, the collected data are interpreted and presented in the following order. Profile of respondents, Characteristics of the sampled hotels, Absenteeism, Loss of Productivity, Increased Labour costs, Labour turnover and Mitigating the impact of HIV/AIDS pandemic in the hotel sector. The analyzed data are based on findings from a total of 57 respondents in the study.

4.1 Profile of the Respondents.

Table 5 shows the frequency distribution of respondents according to gender, age, religion and academic qualifications. The results indicate that 78.9% of the respondents were male while 21.1% were female. The ages ranged from 20 – 30 (12.3%), 31 – 40 (75.4%), and 41 – 50 (12.3%). Christians in this study were 59.6% of the respondents, while Muslims made up 38.6% and 1.8% was Hindu.

On education, 68.4 % of the respondents held a diploma in hotel management, 15.8% held a first degree and 3.5% held masters' degree in business administration. The respondents were human resource managers (86.0%), resident managers (10.55%) and general managers (3.5 %).

The length of service for the respondents varied from 2 to 14 years with a mean of 6.54 years. The longest serving employee had worked for 14 years. These findings do support the fact that labour turnover is quite high in the hospitality sector.

Table 3 Profile of the respondents at Coastal hotels.

Age		Frequency	Percent	Cumulative Percent
	31-40	43	75.4	75.4
	20-30	7	12.3	87.7
	41-50	7	12.3	100.0
	Total	57	100.0	
Gender				
	Male	45	78.9	78.9
	Female	12	21.1	100.0
	Total	57	100	
Religion	Christian	34	59.6	59.6
	Muslim	22	38.6	98.2
	Hindu	1	1.8	100.0
	Total	57	100.0	
Highest Academic Qualification				
	Diploma	39	68.4	68.4
	Degree	9	15.8	84.2
	Form Four	7	12.3	96.5
	Masters	2	3.5	100.0
	Total	57	100.0	

4.2 Characteristics of Sampled Hotels.

The characteristics of the sample hotels are displayed in table 6. About 86% of the hotels are rated as three star and below. Over 75% of the sampled hotels have bed occupancy of 300 beds or less. The number of employees was distributed between the class intervals of 50 with a mean percentage of 2.35% giving an average of 92 employees per hotel and an

approximate total of 5,244 employees. The findings do support the contribution of the tourism sector in provision of jobs, tax, and revenue to this country (GOK, 2002).

Table 4 Characteristics of the sampled coastal hotels

Hotels		Frequency	Percent	Cumulative percent
	1- STAR	4	7.0	7.1
	2-STAR	30	52.6	59.7
	3-STAR	15	26.3	86.0
	4-STAR	6	10.5	96.5
	5-STAR	2	3.5	100.0
	Total	57	100.0	
No of Staff				
	1-50	16	28.1	28.1
	51-100	21	36.8	64.9
	101-150	8	14.0	78.9
	151-200	9	15.8	94.7
	201-250	2	3.5	98.2
	251-300	1	1.8	100.0
	Total	57	100.0	
No of beds				
	1-50	29	50.9	50.9
	51-100	16	28.1	78.9
	101-150	8	14.0	93.0
	151-200	2	3.5	96.5
	201-250	2	3.5	
	251-300	1	1.8	100.0
	Total	57	100.0	

4.3. Absenteeism.

Employee attendance registers were reviewed to determine the trend in employee absenteeism. Results indicate that the rate of absenteeism increased by 7.8% from 1,560 labour days in 2000 to 2,600 labour days in 2001. There was a decline of 2% from 2,600 labour days in 2001 to 2,340 labour days in 2002. In 2004 alone the hotels lost 3,446 labour days. The study hotels lost a total of 13,326 labour days between 2000 and 2004 to absenteeism.

Records of labour time lost from morbidity kept by a company in Nyanza showed that between 1995 and 1997, the company lost a total of 8,007 labour days from employee illness. A significant portion of this time lost was attributed to HIV/AIDS related illness (Rugalema et al, 1999 and cited in Daly, 2000).

At the same time another company in the same region reported having lost a total of 600 labour days between 1995 and 1997 because of sick employees affected by HIV/AIDS (NASCOP, 2000b). Hotels in this study lost a total of 13,326 labour days during the period under review.

Result also indicates that absenteeism is on the upward trend and that there is a significant increase in labour days lost between 2000-2004 (figure2).

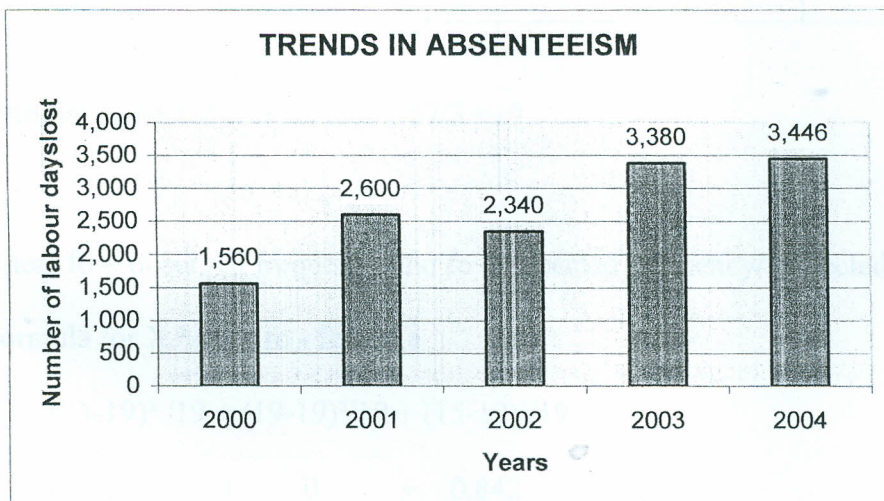


Figure 2. Trends in Absenteeism at the classified Coastal hotels 2000-2004.

Figure3 displays the reasons given by the respondents for employee absenteeism. These reasons include: to attend to sick relatives (41%), HIV/AIDS related illnesses (33%) and to attend funerals 26%. The figure shows that although there were other reasons for

absenteeism in the hotels HIV/AIDS related absenteeism due to workers illnesses was significant.

To test the validity of these assumptions the study employed a Chi- Square Test

Null hypothesis.

The effects of HIV/AIDS related absenteeism on labour costs is not statistically significant.

Table 5 Chi- Square Test

Frequency	Attend to sick Relatives	HIV/AIDS related illnesses	Attend funerals
fo	23	19	15
fi	19	19	19

Formula: Expected frequencies $57/3 = 19$

$$X^2 = (fo - fe)^2 / fe$$

Where fo = observed frequency and fe = expected frequency/ expected frequency.

Formula for $X^2 = \sum (fo - fe)^2 / fe$

$$X^2 = (23-19)^2 / 19 + (19-19)^2 / 19 + (15-19)^2 / 19$$

$$= 0.842 + 0 + 0.842$$

X^2 calculated = **1.64**

X^2 tabulated = **5.99** at degree of confidence 2 at 95% confidence level

X^2 calculated < X^2 tabulated (critical value) at 95% confidence level. Reject the Ho.

The null hypothesis that states that the effects of HIV/AIDS related absenteeism on labour costs is not statistically significant is rejected.

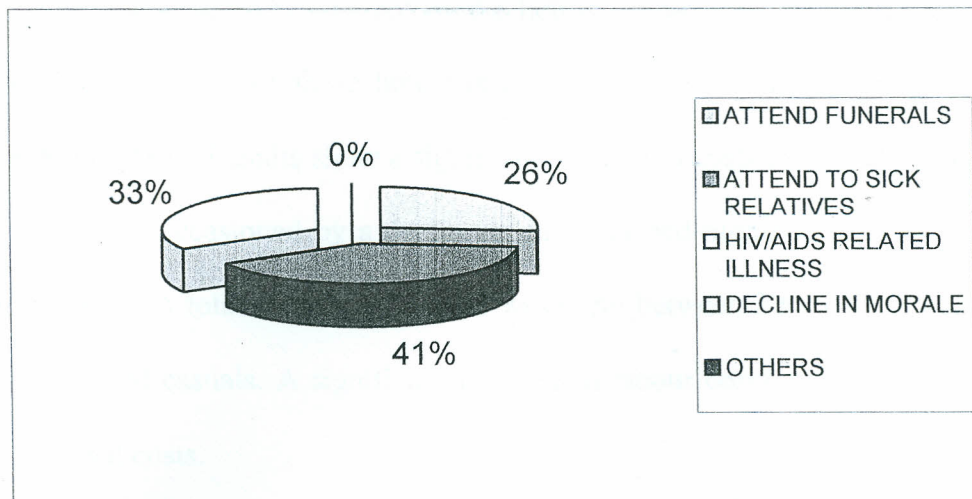


Figure 3. Most frequent reasons for employee absenteeism at the Coastal hotels

The trend in absenteeism was seen as extremely serious (3%), serious (7%) and fairly serious (66%) (Figure 4). These responses correspond with records held by the hotels that show that absenteeism has been on the upward trends for the last 5 years. Overall, 75% of the respondents consider absenteeism as a serious problem.

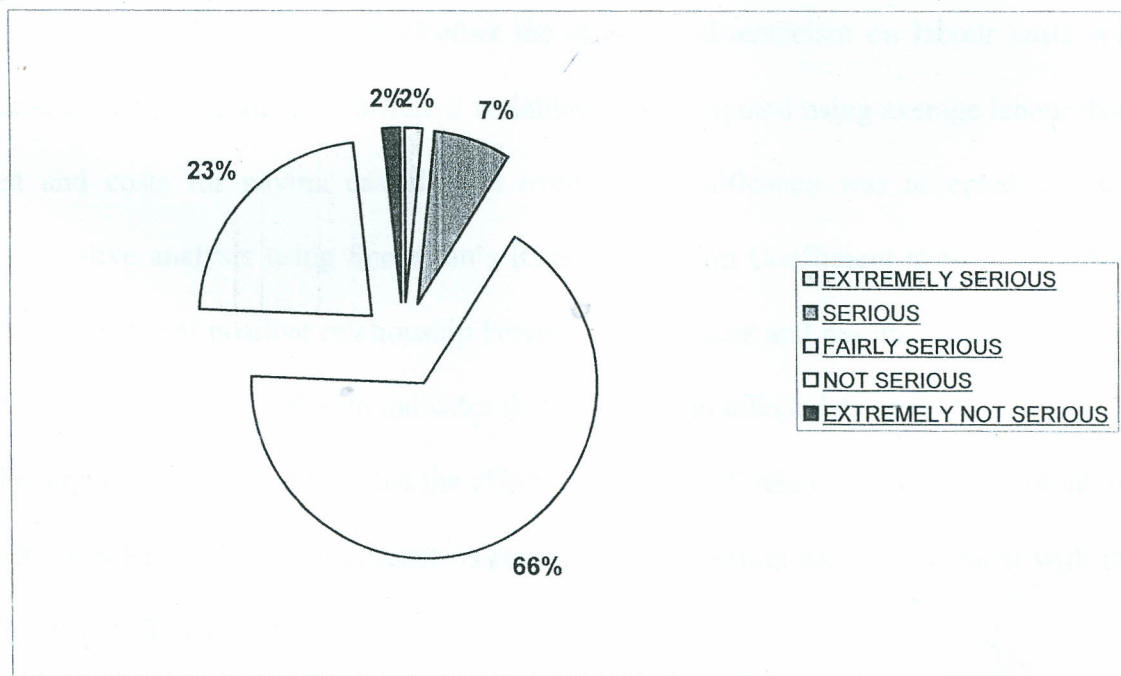


Figure 4 Reported Trend of absenteeism at the sampled coastal hotels between 2000-2004.

Table 6 details the costs incurred by the hotels for payment of casuals and overtime by year. Labour costs for these hotels rose by 6 % from Ksh.532, 950 in 2000 to Ksh 819,000 in 2004. Results show a significant decline in costs during 2002. This is thought to have been occasioned by a decline in the total bed-nights occupancy rate during the same period. A total of Ksh.2, 825,958 was spent between 2000 and 2004 in payment of overtime and casuals. A significant increase in labour costs results in increase in direct operational costs.

Table 6. Average Costs of paying Casuals and Overtime between 2000-2004 among the sampled Coastal Hotels

Year	Average Cost
2000	532,950
2001	702,000
2002	162,008
2003	810,000
2004	819,000
TOTAL	2,825,958

This study sought to establish whether the effect of absenteeism on labour costs was statistically significant. Two different variables were computed using average labour days lost and costs for paying casuals and overtime. Significance was accepted at 0.05. Quantitative analysis using Spearman's Rank Correlation Coefficient showed that there was a significant positive relationship between labour costs and absenteeism ($r = 0.9$, $p < 0.05$). The positive correlation indicates that absenteeism affects labour costs.

The hypothesis, which states that the effects of HIV/AIDS related absenteeism on labour costs is not statistically significant, is rejected. These results are in agreement with the Chi-Square Test results.

Table 7. Statistical Analysis for checking the how absenteeism effects labour costs.**Correlations**

			Labour days lost	Labour costs for casuals & Overtime pay
Spearman's rho	Labour days Lost	Correlation Coefficient	1.000	.900
		Sig.(1-tailed)	.	.019
		N	5	5
	Labour costs for casuals & overtime pay	Correlation Coefficient	.900	1.000
		Sig.(1-tailed)	.019	.
		N	5	5

***Correlation is significant at the 0.05 level (1-tailed)**

Qualitative analysis indicates that, 80% the hotels acknowledge that HIV/AIDS pandemic is an issue of serious concern. Majority of the respondents (73.7%) agreed that HIV/AIDS had increased absenteeism for the hotels. Results in this study indicate that when a skilled worker is absent 30% of the hotels contract the services of a casual, 35% share the work between other workers, 15% assign the work to another skilled worker and pay overtime while 20% assign the work to another skilled worker but don't pay overtime.

The focus group discussion (FGD) revealed that 80 % of the managers think that HIV/AIDS had increased the rate of employee absenteeism in the hotel sector. There was agreement that absenteeism forces the hotels to incur extra costs on overtime and casual workers. The expenses incurred on casual workers and overtime reflected in table 8 indicate that the hotels experienced high expenditure levels of which part of these expenses were on casuals and overtime to cover for possible HIV/AIDS related absence.

Findings from this study have shown that absenteeism has impacted on both the hotel operations and the labour costs. It is noted that although there are other reasons for

employee absenteeism HIV/AIDS related sickness is a significant reason for employee absenteeism (figure 4). Paying of casuals and overtime to cover for an absent worker contributes to the total costs for hiring casuals and paying overtime (Table 6).

Such findings suggest that HIV/AIDS related absenteeism affects labour costs for the hotels. The cost of paying temporary workers and overtime reduces revenue and lowers profits for the hotels. This has implications on productivity and profits. Bloom et al. (1993) found that increased absenteeism was one of the primary drivers of rising visible costs, and declining productivity in business as a consequence of HIV/AIDS.

In a study conducted by UNAIDS and cited in (ILO 2002), it was found that absenteeism affects business through the disruption of the production cycle, and the use of temporary staff. Results in this study indicate that absenteeism due to HIV/AIDS related illnesses, funeral attendance and caring for sick relatives has resulted in significant loss of productivity and has affected costs which has resulted in profit losses for the sector.

A study of 15 different establishments in Ethiopia found that, companies were experiencing considerable absenteeism. The number of HIV/AIDS related illnesses were 53% of all the reported cases, totaling to 15,363 incidents over 5years (Bollinger et al., 2001).

In a large cement company in Zambia, a study showed that absenteeism for funeral attendance had increased by 15 times between 1992 and 1995 (UNAIDS, 2003a), while in the mid 1990's Uganda Railways reported steep increases in absenteeism and annual staff turnover (ILO, 2002). Results in this study have shown that there was a steep

increase in absenteeism between 2000 – 2004. HIV/AIDS is thought to have contributed significantly to this increase considering the risk factors found in the sector (EHM, 2004). The Standard Chartered Bank's response to HIV/AIDS stemmed largely from the realization that, HIV/AIDS had started to impact on the Bank's profitability through loss of personnel, absenteeism, medical and welfare costs (G.B. C, 2003c).

Studies by United Nations and cited by Bloom and Mahal (2001) conducted on 14 firms in Benin found that, 50% of those identified as HIV positive held positions considered 'important' by the firms. Increased absenteeism was noted. The firms held salary levels constant while the work output reduced leading to reduced profits. Hotels in this study contracts the services of temporary workers or pays overtime while salaries for absent workers are held constant and this has effects on work output and profits.

Studies conducted for Makani Tea Estate Malawi in 1996 showed the observed increase in absenteeism was a result of employees becoming ill due to HIV and its associated opportunistic infections, the demand for caring for family members who are ill and the need to attend funerals.

The results in this study are in agreement with studies done elsewhere with respect to absenteeism and increased costs. Given these findings, the study concludes that HIV/AIDS has increased absenteeism for the hotel sector, and this has impacted negatively on the hotels' operations in the Coast region of Kenya.

4.4 Loss of productivity.

Data on the number of deaths in the selected hotels is displayed in table 9 by year between 2000 and 2004. Results indicate that the death rate increased by 1.8% between 2000 and 2001. A decline in 2002 was noted then an increase in the years following. A total of 437 employees were reported dead between 2000-2004. Of the respondents in this study 40% were on the opinion that deaths are caused by HIV/AIDS related sicknesses, 20% Natural deaths, 10% accidents, and 15% die from malaria while other causes contribute 15 % (figure 5). The study used the Chi- Square Test in order to check the validity of the assumptions made by the respondents.

Null hypothesis

Loss of skilled and experienced workers does not affect profits for the hotel industry in the coast region of Kenya

Table 8 Chi- Square Test for Loss of productivity.

Frequencies	HIV/AIDS related illnesses	Natural deaths	Accidents	Malaria	Others
F _o	22	11	6	9	9
F _e	11	11	11	11	11

Formula: Expected frequencies $57/5 = 11$

$$X^2 = (f_o - f_e)^2 / f_e$$

Where f_o = observed frequency and f_e = expected frequency/ expected frequency.

Formula for $X^2 = \sum (f_o - f_e)^2 / f_e$.

$$X^2 \text{ calculated} = \sum (f_o - f_e)^2 / f_e = [(22 - 11)^2 / 11] + [(11 - 11)^2 / 11] + [(6 - 11)^2 / 11] + [(9 - 11)^2 / 11] + [(9 - 11)^2 / 11]$$

X^2 calculated = $11 + 0 + 2.2 + 0.8 + 0.8 = 14.8$

X^2 tabulated at degree of freedom = 4 is **9.49** at 95% confidence level.

X^2 calculated > X^2 tabulated (critical value) at 95% confidence level. Reject H_0 .

The null hypothesis which states that the loss of skilled and experienced workers does not affect profits for the hotel industry in the coast region of Kenya is rejected.

These results are consistent with studies done by ILOAIDS (2003) which found that illness compromises labour productivity because a sick person is unable to work. Studies conducted in Zaire found that when workers had a sick family member (spouse or child) it was unlikely that they could be as productive as was expected, because their presence at work was more physical than mental, and, hence, they performed poorly (Tyler et al., 1997).

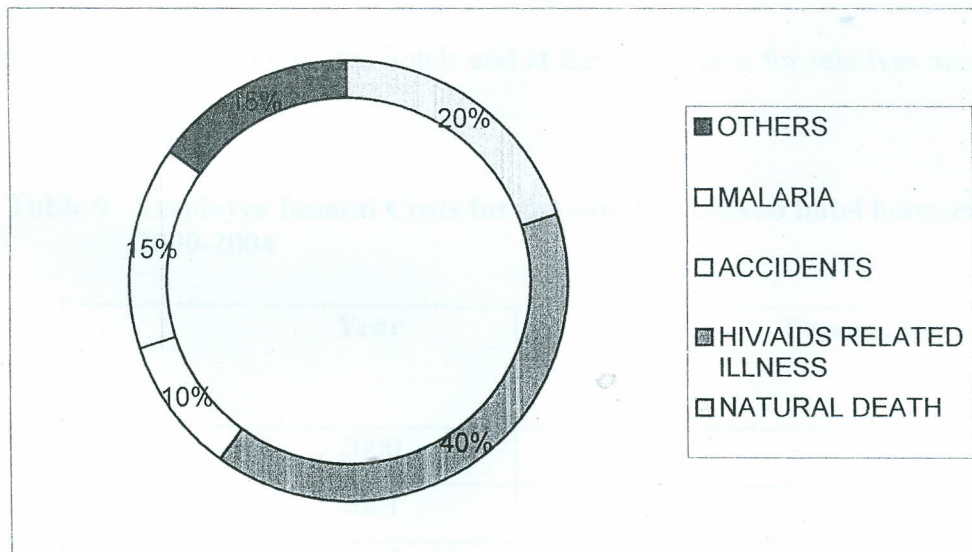


Figure 5. Reported causes for employee deaths among hotel staff in hotels

The number of deaths increased from 84 in 2000 to 93 in 2004. Records obtained from the hotels show that the rate of employee death is on the upward trend (figure 6)

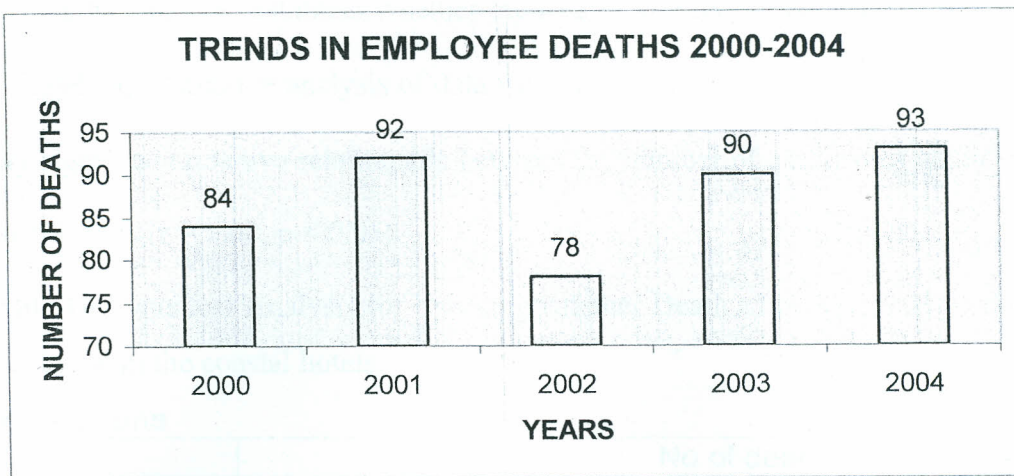


Figure 6 Trends in employees' deaths in coastal hotels (2000-2004)

Funeral costs in the sampled hotels increased by 1.8% from Ksh.1, 680,000 in 2000 to Ksh. 1,840,000 in 2001. Results also indicate that funeral costs rose by (Ksh. 60,000) 0.68% from Ksh 1,800,000 in 2003 to Ksh. 1,860,000 in 2004. The study hotels spent a total of Ksh.8, 740, 000 on funerals during the period under review. Funeral costs include a fixed amount given by the hotels and at times transport for relatives accompanying the body for burial.

Table 9. Employee funeral Costs for the sampled coastal hotel between 2000-2004

Year	Funeral Costs (ksh.)
2000	1,680,000
2001	1,840,000
2002	1,560,000
2003	1,800,000
2004	1,860,000
TOTAL	8,740,000

Source – Sampled coastal hotels accounts records 2000-2004

This study sought to establish whether the loss of workers (death) does affect profits for the hotels. Quantitative analysis of data using Pearson Correlation shows that there was a very significant positive relationship between the number of employees who died and the funeral costs ($r = 1.00$, $p < 0.05$).

Table 10 Statistical Analysis for checking whether Death of experienced workers affects operations in the coastal hotels.

Correlations

		No of deaths	Funeral Costs
No of deaths	Pearson Correlation	1.000	1.000
	Sig.(1-tailed	.	.000
	N	5	5
Funeral costs	Pearson Correlation	1.000	1.000
	Sig.(1-tailed)	.000	.
		5	5

***Correlation is significant at the 0.05 level (1-tailed)**

These results suggest that as more workers die and the hotel spend revenue on funerals profits are affected.

The null hypothesis which states that the loss of skilled and experienced workers does not affect profits for the hotel industry in the coast region of Kenya is rejected.

Qualitative analysis indicates that 96.5% said that the hotels had suffered loss of productivity. Such a loss was said to have been occasioned by death (64.9%), absenteeism (31.6%), increased staff turnover (1.8%) and declining morale (1.8%). Majority of the respondents (68.4%) felt that HIV/AIDS was a threat to the sector in that it was threatening to rob the sector of skilled workers.

Results from the focus group discussion indicate that the listed possible causes of morbidity and mortality among hotel employees are mainly opportunistic infections

associated with AIDS such as diarrhea and gastroenteritis, malaria, pneumonia and tuberculosis. Over 87% of the hotels said the trend in productivity loss was fairly serious figure 7.

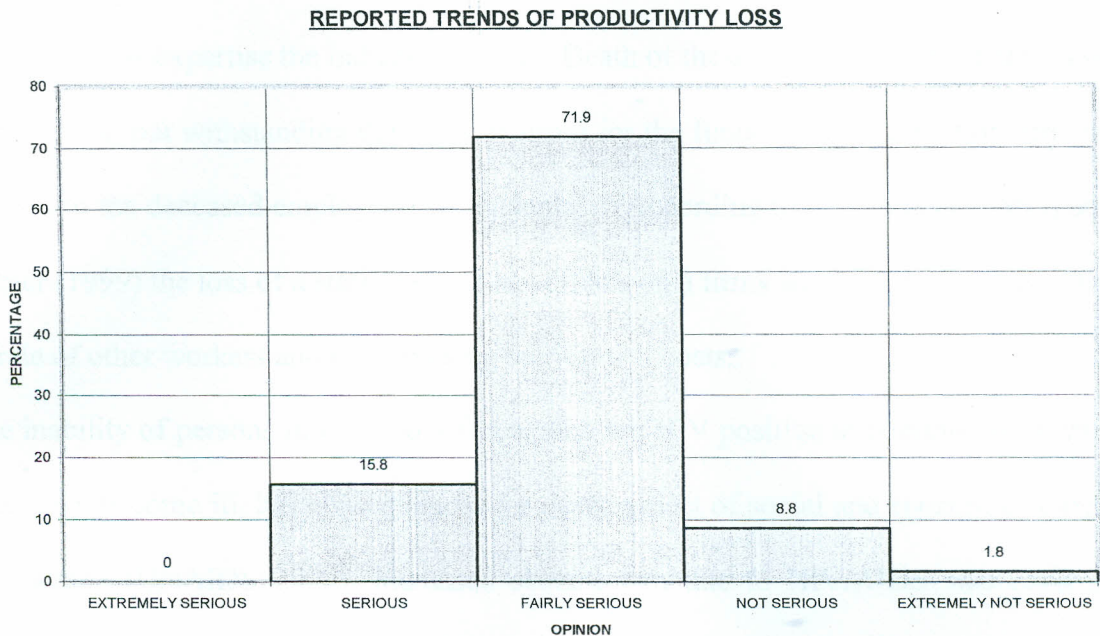


Fig 7 Trends in Productivity loss for coastal sampled hotels for the period 2000-2005.

In the focus group discussion 96.5% of the respondents said that their hotels had suffered loss of productivity due to the onset of HIV/AIDS through loss of staff, employee illnesses and absenteeism.

Death of staff is said to be a major component of productivity loss (64.0%) while according to 40% of the respondents HIV/AIDS related illnesses is a significant cause of death in the hotels. Results indicate that hotels in this study lost a total of 437 employees among them are those who died from opportunistic infections (figure 6).

Findings reveal that hotels meet the funeral expenses for their employees and that between 2000 and 2004 over Ksh 8.7 million was spent on funerals. These findings suggest that loss of workers affects profits for the hotels. Guest services are critical and the hotels depend on skilled and experienced workers. The people who die may be skilled workers whose expertise the industry requires. Death of these workers deals a major blow to the hotels, notwithstanding the costs incurred for the funeral and payment of terminal benefits to the deceased employee's dependants. According to Bloom et al. (1993) and Farmer (1999) the loss of a staff member has effects on a firm's stock of "know-how," the morale of other workers and the imposing recruitment costs.

The inability of persons in the labour force, who are HIV positive to continue with work when they become ill, has consequences for every aspect of social and economic context of business (UNAIDS 2000). Increased absenteeism due to HIV/AIDS was cited by 31.6% of the respondents in this study. Out of 88,920 labour days (which is the total available labour days for 57 hotels) a total of 13,326 labour days were lost due to absenteeism and this affected hotel operations. Other studies conducted for East African business have shown that absenteeism accounts for between 25-54 percent of costs (GBC, 2002).

The observed increase in absenteeism in this study is a result of employees becoming ill due to HIV and its associated opportunistic infections, the demand for caring for family members who are ill, and the need to attend funerals. Absenteeism directly affects products and services and ultimately affects profits.

Studies by ILO (2000) found that specific skills needed for business are now available in limited supply. Shortage of special skills translates to a high cost of hiring. Further, it is

postulated that HIV/AIDS could deplete the already available limited supply of these skills and push the cost of hiring up. This would increase the cost of production and decrease competitiveness (Tyler et al., 1997). Majority of the respondents in this study (68.4%) felt that HIV/AIDS was a threat to the sector in that it was threatening to rob the sector of skilled workers. The trend in loss of productivity in this study was seen as fairly serious by 71.9% of the respondents (Figure7)

From the results of this study, it is concluded that the hotel sector has suffered loss of productivity by death of staff, leading to loss of skill and knowledge, absenteeism, illnesses, and reduced morale by the workers. Our findings are therefore in line with studies done elsewhere.

4.5 Increased Labour Costs.

Two important areas of employee maintenance were examined by this study. These included health care costs and funeral costs. Table 11 shows responses when the respondents were asked what item had increased costs for the hotels. Results show that health care was a cited by (59.6%), funeral (28.1%), training costs (7.0%) and recruitment (1.8%) while other items took 3.5%.

**Table 11 Items that has increased costs for hotels at the coast region
between 2000-2004**

Item	Frequency	Percent	Cumulative Percent
Health care costs	34	59.6	59.6
Funeral costs	16	28.1	87.7
Training costs	4	7.0	94.7
Others	2	3.5	98.2
Recruitment costs	1	1.8	100.0
Total	57	100.0	

Data related to clinic attendance of patients with AIDS related opportunistic infections was obtained from the hotels and results indicate that a total of 11,2191 cases were attended to in the hotel clinics between 2000-2004. Attendance at the clinics rose from 1,748 patients in 2000 to 2,840 patients in 2004. Records obtained from 57 hotel clinics show that most of the hotels have seen an appreciable increase in patient attendance, and that the trend is on the increase. Health care costs rose from Ksh 1,965,120 in 2000 to Ksh 2,690,420 in 2004.

The hotels spent a total of Ksh.11, 806,880 on health care for the period under review.

The trend in the health care costs for managing AIDS related illnesses are illustrated in figure 8.

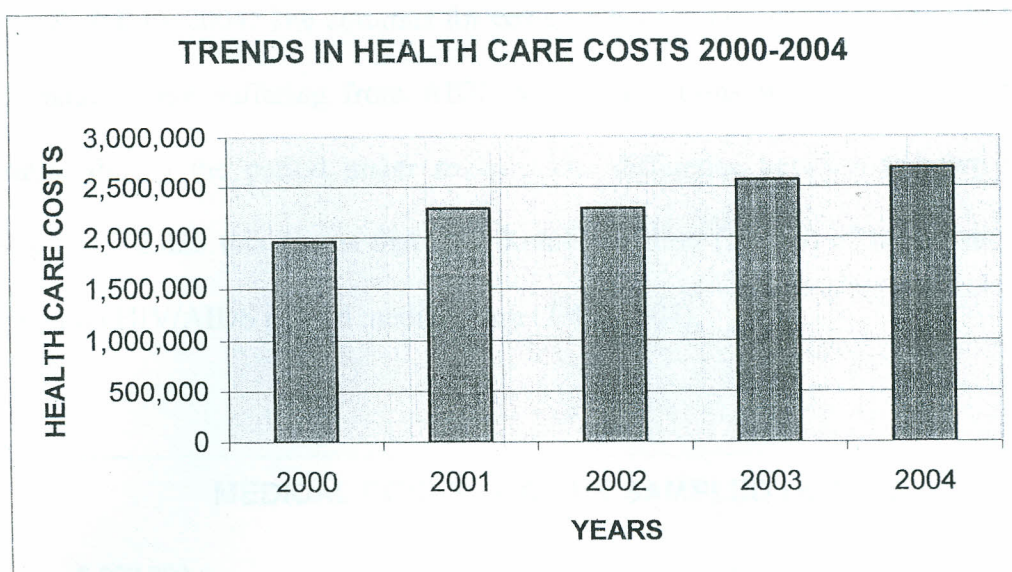


Figure 8. Trends in Health Care Costs at the Coastal hotels between 2000-2004

This study sought to establish whether HIV/AIDS related sickness has had effects on health care costs for the hotels. Quantitative analysis of data using Pearson Product Moment Correlation shows that there was a significant positive relationship between the patients seen at hotel clinics and health care costs $r = 0.958$, $p < 0.05$ (Table 12)

Table 12. Statistical Analysis to check whether HIV/AIDS related sickness have effect on health care costs for the hotels at Coast region of Kenya.

Correlations

		Health care costs	Clinic attendance
Health care costs	Pearson Correlation		.958
Array 1 – B1:B5	N	5	
Clinic attendance	Pearson Correlation	.958	
Array 2 - A1:A5	N	5	5

* Correlation is significant at .05 level.

The costs *with* AIDS related illness columns in figure 9 illustrates normal expenditure on health care for all patients attended to in the clinics which rose to a total of Ksh

23,379,700 by 2004. The columns for costs *without* AIDS related illness illustrates costs for patients not suffering from AIDS related infections who were attended to in the clinics during the period under review. The difference between the two columns is Ksh.11, 572,820 this means that over Ksh.11 Million (50.5%) of health care costs was spend on HIV/AIDS related medical care (2000-2004).

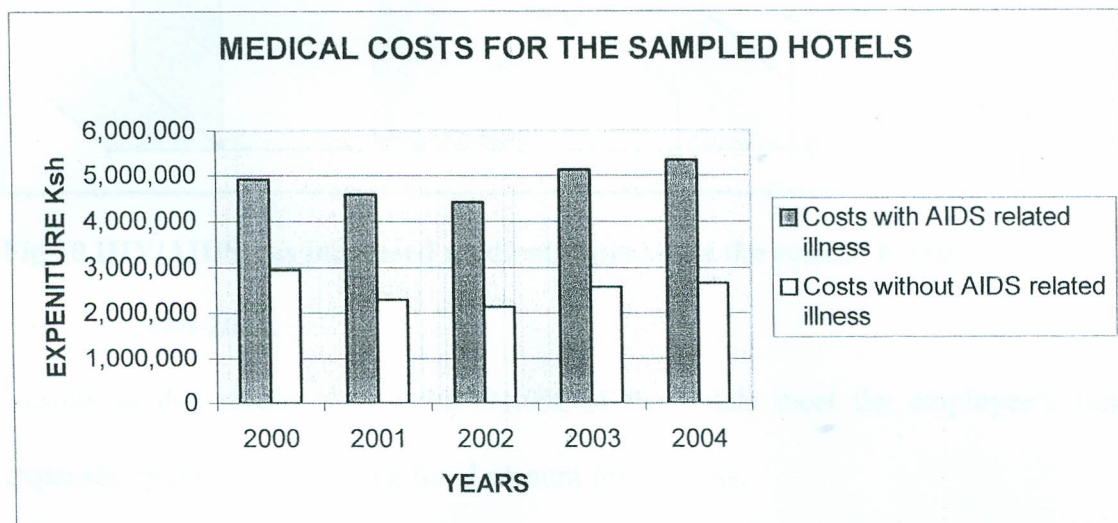


Figure 9. Medical expenditure for 57 hotels (*with and without* HIV/AIDS related illnesses between 2002-2004

Results in Figure 10 indicate that 78.9% of the respondents indicated that HIV/AIDS had increased medical expenses for the hotel sector while 12.3% said that HIV/AIDS has not increased medical expenses 8.8% of the respondents were non committal on whether or not HIV/AIDS had increased health care costs for the hotels. On medical cover, more than (50%) of the hotels include immediate family members in the medical scheme.

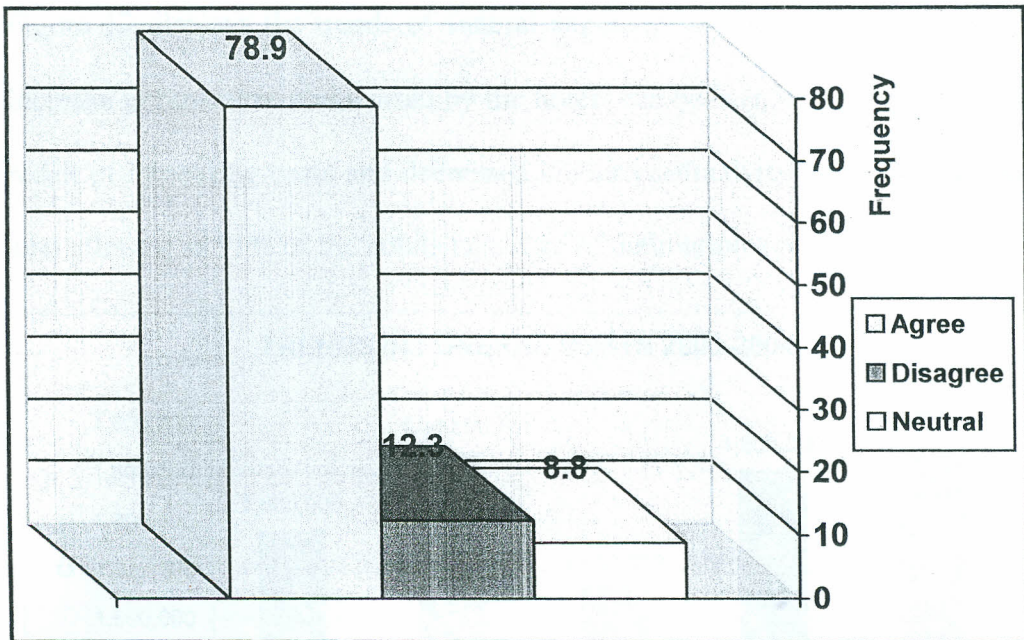


Fig 10 HIV/AIDS has increased medical expenses at the coastal hotels between 2000-2004.

Results in this results shows that 91.0% of the hotels meet the employee's funeral expenses by provision of some fixed amount for funerals.

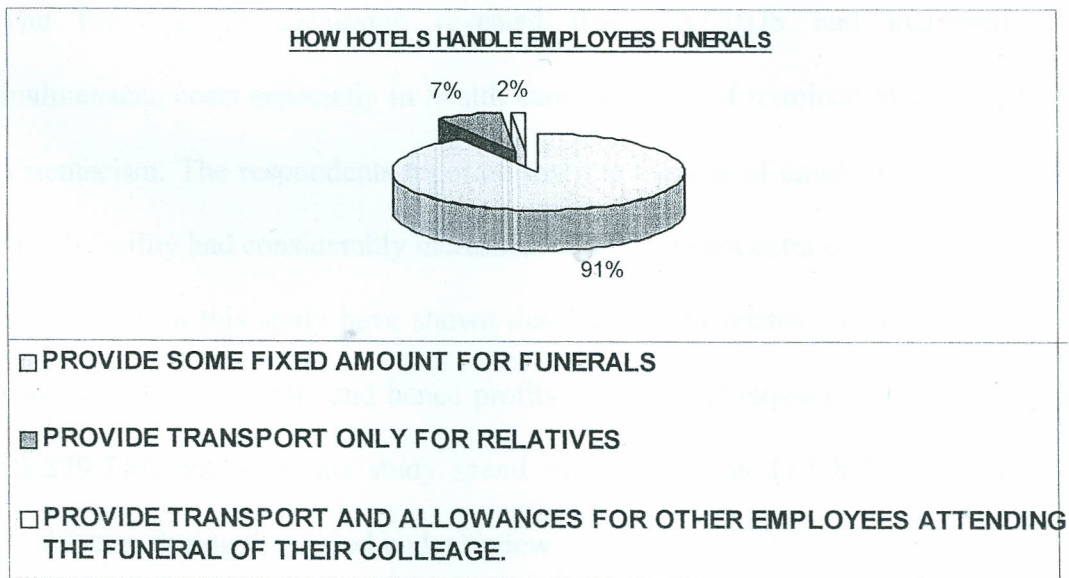


Figure 11. How classified sampled coastal hotels handle funerals.

Figure 12 displays the trends of funeral expenses for the sampled hotels. A significant increase in funeral costs incurred by the hotels can be seen. Hotel profits are affected as a result of increasing costs and decreased labour productivity. Direct operational costs are also affected as 91% of the hotels take care of their employee's funerals.

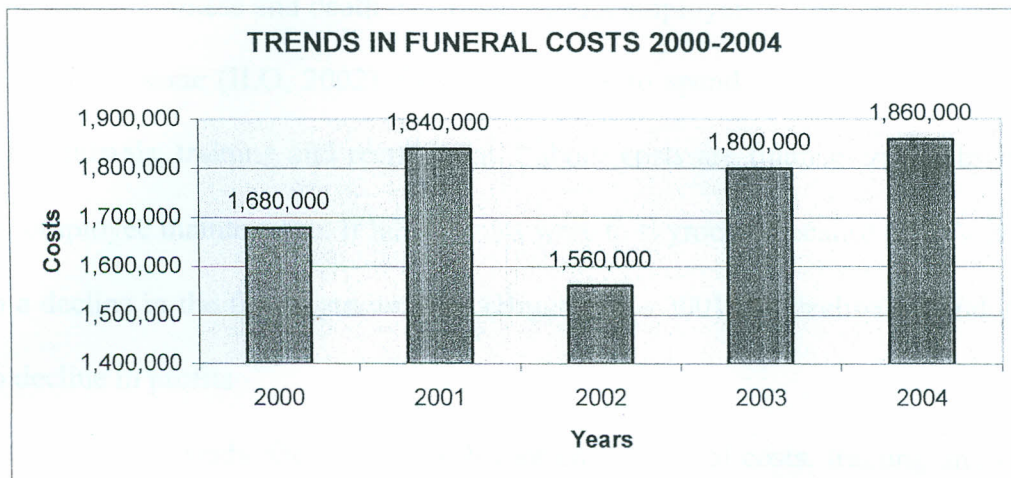


Figure 12. Trends in Funeral costs for the coastal sampled hotels between 2000-2004

The focus group discussion revealed that HIV/AIDS had increased employee maintenance costs especially in health care, payment of termination dues and employee absenteeism. The respondents reported that the number of employees seen at the hotels health facility had considerably increased, and that meant extra costs to the hotel.

Findings from this study have shown that HIV/AIDS related illness has affected health care costs for the hotels and hence profits. Of the total expenditure on health care (Ksh 23,379,700) hotels in this study spend over 50% (Ksh 11,806,880) on AIDS related health care during the period under review.

Results from the focus group discussions indicate that the listed possible causes of morbidity and mortality among hotel employees are mainly opportunistic infections

associated with AIDS such as diarrhea and gastroenteritis, malaria, pneumonia and tuberculosis. These results suggest that out of the total costs for funerals a significant portion of the costs is spent on HIV/AIDS related deaths. This has affected labour costs and reduced revenue for the hotels.

AIDS related illness and death of workers affect employers by increasing their costs and reducing revenue (ILO, 2002). Companies have to spend more on areas such as health care, funerals, training and recruitment. Labour costs are finances spend by a company for employee maintenance. If labour costs were to skyrocket because of HIV it could lead to a decline in the firm's productivity (Biggs et al., 2001). A decline in production leads to decline in profits.

Results of this study show that health care costs, funeral costs, training and recruitment have increased both the operating costs as well as employee maintenance costs. These results seem consistent with studies conducted by (Nabila et al., 2003) in selected firms in Ghana that showed an increased cost of health care to be responsible for increased costs of employee maintenance. Many other authors agree that medical bills if paid for by the employer will increase costs (Farnham and Gorsky, 1994).

In this study 50% of the hotels pay medical bills for their employees as well as their dependants. In Tanzania, one company experienced a five-fold increase in its medical care cost per employee during 1993–1997. At Tanzania–Zambia Railway Authority, results showed that medical costs associated with AIDS related illnesses increased in the year 1995 by 63%.

Death itself can impose significant costs on business. According to Farnham et al. (1994) many Sub-Saharan Africa countries are responsible for funeral costs and face additional costs as other workers attend funerals. Findings in this study show that the hotels are responsible for funeral costs and spend even more as workers attend funerals. The cost of HIV/AIDS to companies depends on the type of company. A study conducted for Barclays Bank Zambia in 2000, showed that, the death rate among the employees rose from 0.4% in 1987 to 2.2% in 1992. Ex gratia payments to families increased by nearly 350 % with the Bank paying increased funeral costs (Bollinger and Stover, 2000).

In Kenya the AIDS Control and Prevention Project (AIDSCAP) found that not only do firms lose their workers as a result of absenteeism or AIDS related deaths, but they also experience increase in medical costs (ILOAIDS, 2003). A study of Lonrho Companies found that death service benefits increased by more than 100% between 1991-1996 (World Bank, 2003). The results in this study show conformity to previous studies done on increased costs.

Demand for recruitment and training rises as a result of increased staff turnover and loss of skills (ILOAIDS, 2003). Studies by GBC (cited by World Bank, 2003) found that companies in Kenya incur mean annual costs associated with HIV/AIDS of approximately US\$ 140,000 (Ksh.10, 920,000) and these costs were expected to rise to US\$ 403,000 (Ksh 31,434,000) by the year 2005.

AIDS related illnesses and death of workers affect employers by increasing their costs and reducing revenue. The results of this study support the view that, HIV/AIDS pandemic has increased the employee maintenance costs and especially in health care, funeral costs and recruitment.

In this study all the results for 2002 stand out uniquely to be low. This can be explained by the fact that 2002 was a year for elections, which in western circles is equated to political instability. Additionally, there were threats of terrorist activities on foreign enterprises. As a result USA and the United Kingdom sent out travel advisories discouraging their citizens from visiting Kenya. Since Kenya's tourism largely depends on foreigners, this explains the slop experienced in 2002.

4. 6 Labour turnover.

The reasons given for employees leaving the hotels were voluntary resignation (17.5%), dismissal (33.3%), deaths (28.0%), sickness (17.5%) and (3.7%) retirements (Table 13).

Table 13 Reasons given for employees leaving Coastal classified Hotels

	Frequency	Percentage	Cumulative Percentage
Dismissal	10	17.5	17.5
Voluntary Resignation	19	33.3	50.8
Deaths	16	28.0	78.8
Sickness	10	17.5	96.3
Retirements	2	3.7	100.0
Total	57	100.0	

Respondents were asked questions on whether their hotels were experiencing poor skill transmission due to high labour turnover. Majority of the respondents (82.5%) said there was no poor skill transmission, (10.5%) agreed and (5.3%) strongly disagreed. Increased disorganization within the workforce (24.6%) and loss of skill and knowledge (43.9%)

and increased payment of termination benefits (21.1%) were the three indicators that labour turnover is a problem in hotel operations (Table14).

Table. 14 Effects of labour turnover on operations at the classified coastal hotels

Indicators	Frequency	Percent	Cumulative Percent
Increased disorganization within the work force	14	24.6	24.6
Loss of skill and knowledge	25	43.9	68.4
Increased direct overtime costs	1	1.8	70.2
Reduced efficiency among over worked employees	1	1.8	71.9
Increased payment of termination benefits.	12	21.1	93.0
Don't Know	4	7.0	100.0
Total	57	100.0	

About 82.5% said that it takes six months for a new employee to become fully functional and effective, while 17.5% said that it takes them only one month. When asked whether their hotels had experienced increase in labour turnover due to the onset of HIV/AIDS epidemic, 82.5% said that HIV/AIDS had not increased labour turnover while 17.5% said it had.

This study sought to establish the effects of HIV/AIDS on Labour turnover in the study hotels. Results indicate that increased disorganization within the workforce (24.6%), loss of skill and Knowledge (43.9%) and increased payment of termination benefits (21.1%) are the three indicators that labour turnover is a problem in hotel operations.

NASCOP (2002) found that the high rate of morbidity and mortality from HIV/AIDS generates increasing disorganization within the workforce as a result of staff turnover. Results show that voluntary resignation (17.5%), dismissal (33.3%), deaths (28.0%) and sickness (17.5%) are the significant reasons for employees leaving the hotels. Data related to profits was considered confidential by most of the hotels and could not be released to the researcher. The data was required for conducting a relationship test for hypothesis 3. This was considered a limitation of the study.

The costs of labour turnover include costs incurred to acquire and develop human resource and replacement costs (Mobley and Hall, 1973). Several authors have found that HIV/AIDS had caused high levels of staff turnover (Bollinger et al., 1999; Farnham and Gorsky, 1994., Over, 1992). According to ILOAIDS (2003) some companies in South Africa believe that 40% of their workforce may have HIV/AIDS. This may increase labour turnover by 3% to 6%.

A study conducted in an Agricultural firm in Kenya showed that 41% of the employees left the company because of AIDS related illness or death (Bollinger et al. 1999). Healthier workers had to work overtime, increasing direct overtime costs and possibly indirect costs such as stress and reduced efficiency among overworked employees (World Bank, 2002). The Uganda Railways in 1990's reported an annual staff turnover rate of 15%; with more than 10% of the workforce dead from AIDS related illnesses (ILOAIDS, 2003). A study in Namibia's largest water purification company announced that HIV/AIDS was crippling its operations.

The study reported a high staff turnover from HIV related deaths, increased absenteeism and a general loss of productive hours (Morgan et al., 2002). However, the results of this

study are similar to findings by Bloom et al (1993) where there was absence of up to date and robust evidence on the overall effects of the epidemic on staff turnover.

Tyler et al (1997) in a survey of nearly a thousand firms in Sub-Saharan Africa concluded that the impact of HIV /AIDS on staff turnover was minimal, although the situation could change as the epidemic matures. The results of this study are in contrast to those obtained from similar studies. Although the respondents in this study were in agreement that HIV/AIDS may have caused an increase in labour turnover, they could not associate employee mobility in the hotel sector with HIV/AIDS epidemic.

Findings in this study show that limited number of staff work until retirement as only 3.7% of the respondents attributed retirement to employee exit. This view supports Boela (1996) who noted that the hotel sector is famous for excessive staff mobility.

The study therefore concluded that labour turnover in the hospitality sector is not necessarily due to HIV/AIDS.

4.7 Mitigating the effects of HIV/AIDS in the Hospitality Industry

This study also sought to investigate the measures that should be put in place to mitigate the effects of HIV/AIDS in the hospitality industry. Figure 13 shows the responses of the respondents when their opinions were sought on whether HIV/AIDS had affected the human resource operations in the hotels. About 95% of the respondents said that HIV/AIDS had affected the human resource operations. The results support studies conducted by ILO in (2003) that found effects of HIV/AIDS are manifested by reduced productivity and increased costs. The figure shows that HIV/AIDS has affected the human resource operations in the study hotels.

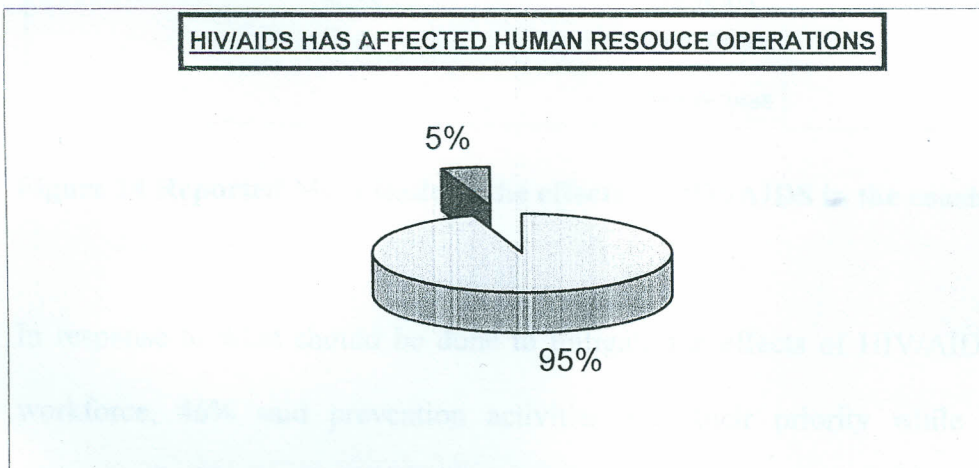


Figure 13 HIV/AIDS has affected human resource operations in coastal classified hotels

Respondents were asked for their opinion on the magnitude of the effects (figure 14).

Over 84% of the respondents thought that the magnitude of the impact was serious.

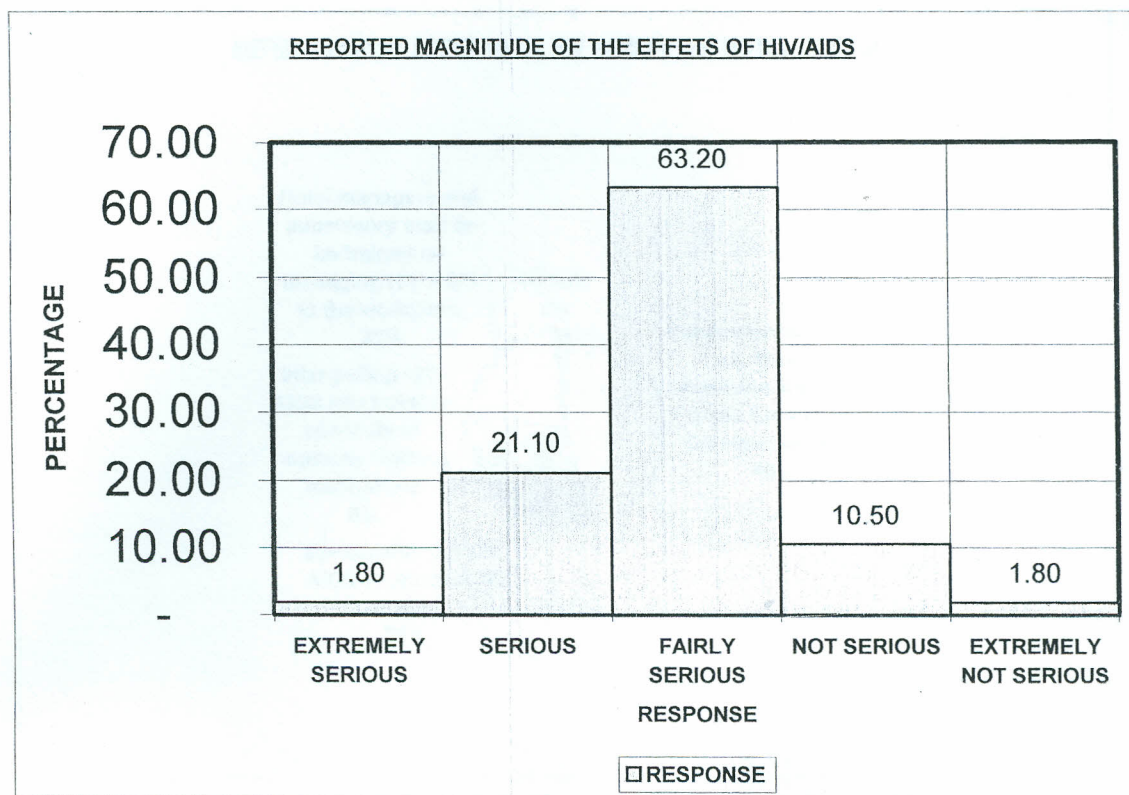


Figure 14 Reported Magnitude of the effects of HIV/AIDS in the coastal hotels

In response to what should be done to mitigate the effects of HIV/AIDS on the hotel workforce, 46% said prevention activities was their priority while 26% said the development of HIV/AIDS workplace policy was their option and 21% said that hotel managers should be trained on managing HIV/AIDS in the workplace (figure 15).

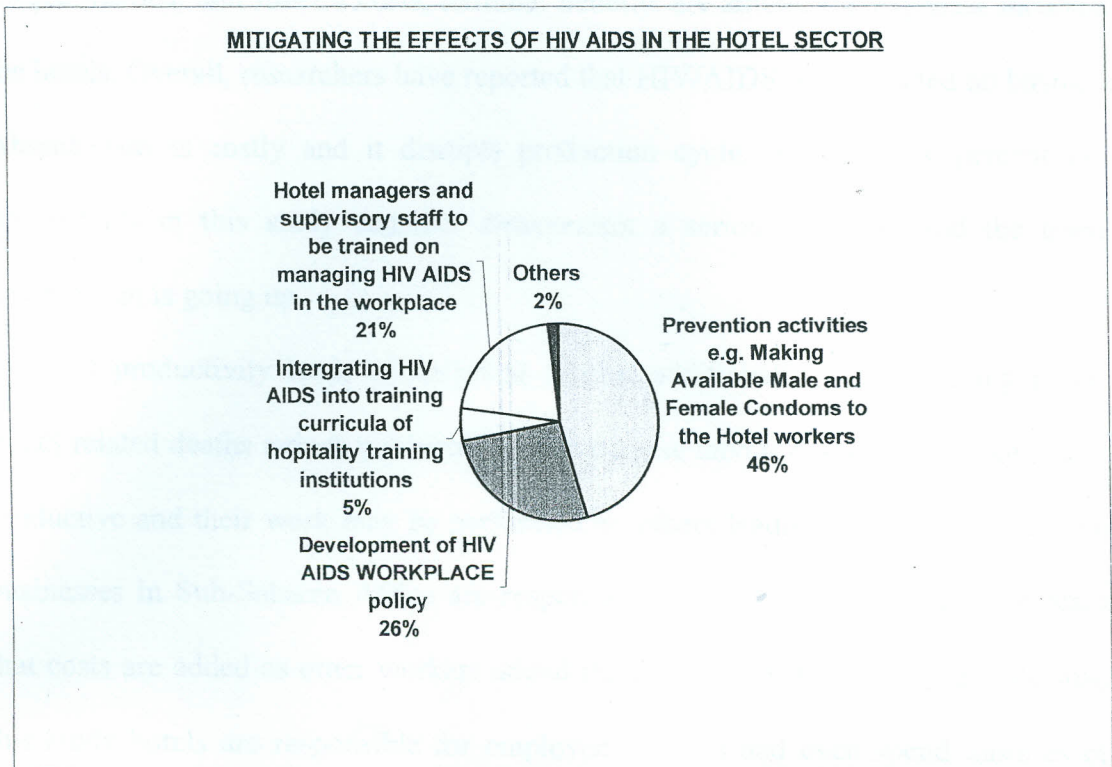


Figure 15. Mitigating the effects of HIV/AIDS in the hotel sector.

Hotel workers are highly susceptible to the transmission of HIV/AIDS because their social and economic environments constitute a risk. Results in this study indicate that HIV/AIDS has affected the hotel operations and that the hotels are ready to action in order to mitigate these effects. The effects of HIV/AIDS on employment and workforce are a major concern to the ILO, which views the epidemic as a workplace issue and a major development challenge (ILO, 2003). The challenge posed by AIDS is real and requires deliberate effort if the effects are to be contained (World Bank, 2002).

4.8 Summary

The findings of this study have shown that the hotels have felt the effects of HIV/AIDS. There is a significant increase in absenteeism due to workers illnesses and funeral attendance, which has resulted in loss of productivity and has affected profits. HIV/AIDS

related medical and funeral costs, terminal benefits are among the expenses incurred by the hotels. Overall, researchers have reported that HIV/AIDS has impacted on businesses. Absenteeism is costly and it disrupts production cycle. Seventy five percent of the respondents in this study consider absenteeism a serious problem and the trend in absenteeism is going up.

Loss of productivity leads to declining profits, additionally with declining products. AIDS related deaths reduce productivity and increase labour costs. Sick workers are less productive and their work may be performed by others leading to fatigue. Indeed many businesses in Sub-Saharan Africa are responsible for their worker's funeral costs, and that costs are added as other workers attend the funereal of their departed colleague. In this study hotels are responsible for employee funerals and even spend more as other workers attend funerals.

Death itself can impose significant costs on businesses. Employees who die have to be replaced and this may mean less skilled workers. The matching of skills to labour needs is complex and it becomes even more expensive as turnover of staff increases and productivity is lost in an enterprise. Most hotel managers (93%) appreciate the seriousness of HIV/AIDS at the workplace and they are ready to take measures to mitigate such effects. To cope with the situation involves replacing missing workers, and reorganization of production. From the findings of this study it is concluded that HIV/AIDS has impacted negatively on human resource operations in the hotel sector, and that the hotels should organize to provide prevention activities to the workforce,

CHAPTER FIVE

CONCLUSIONS AND RECOMENDATIONS

5.0 Introduction

It is noted that HIV/AIDS is a serious problem in the hotel industry. Several conclusions touching on absenteeism, productivity loss, costs and mitigation have been made. Recommendations on the way forward for the sector and directions for further research are also given.

5.1 Conclusions

The hotel sector is experiencing increased absenteeism not only because of HIV/AIDS related illness but workers also take time off to care for their sick family members and to attend funerals. This has impacted negatively on labour costs and affects the quality of the products the hotel offers. The hotels in Kenya are spending lots of money to pay casuals and over time, as they have to cover for HIV/AIDS related employee absences while the trend of absenteeism are increasing. It is therefore concluded that HIV/AIDS has increased absenteeism and this has affected the hotel operations.

The quality and quantity of labour provided by an employee is reduced when they are sick or caring for sick dependants. Sick workers are less productive. Employees who die or retire on medical grounds have to be replaced; this may mean less skilled workers who may require training and these calls for extra cost for the hotel. The hotel industry has suffered loss of productivity by, death of staff leading to loss of skill and knowledge, workers illnesses and absenteeism. The trend on loss of productivity is serious and HIV/AIDS poses a threat to the sector.

It is also concluded that HIV/AIDS has affected labour costs in the hotel sector as most hotels provide health care to their workers, and the immediate family members. Management of HIV/AIDS related illnesses have affected health care costs and hence profits. Almost all the hotels meet their employee's funeral expenses by providing some fixed amount for the funeral, and at times provision of transport and allowances for relatives and colleagues attending the funerals. HIV/AIDS has increased employee maintenance costs through increase in health care due to opportunistic illness, funeral attendance, training and recruitment of new employees.

Labour turnover is not perceived as a threat to the sector; since with or without HIV/AIDS the industry is known for the mobility of its workforce. In mitigating the effects of HIV/AIDS in the hotel sector it is concluded that most hotel managers appreciate the seriousness of HIV/AIDS at the workplace and that prevention activity should be integrated into the hotel management,

HIV/AIDS workplace policy should be to be developed by the hotels and the managers trained on managing HIV/AIDS in the workplace.

From the findings of this study, it is concluded that the impact of HIV/AIDS is already felt in the hotel industry in terms of absenteeism of workers, loss of skills and knowledge, increase in labour costs as well as reduced productivity.

5.2 Recommendations.

Based on the findings this study has the following recommendations:

If the hotels are to remain viable businesses, it is necessary and urgently to approach the HIV/AIDS epidemic with the seriousness it deserves. It is therefore recommended

that the hotels should monitor HIV/AIDS pandemic on the workforce in order for hotels to collect baseline data required to help them predict changes in labour force demand and supply. It is also recommended that hotel managers and supervisory staff should be trained on managing HIV/AIDS in the workplace. Additionally, hotels need to set up HIV/AIDS policies at the workplace that should include a heavy dose of awareness and preventive education.

5.3 Suggestion for Further research.

This study has the following suggestions for further research.

1. A study of Management challenges inflicted by HIV/AIDS in the Tourism sector.
2. Study to predict change in labour force demand and supply in relation to HIV/AIDS in the hotel industry.

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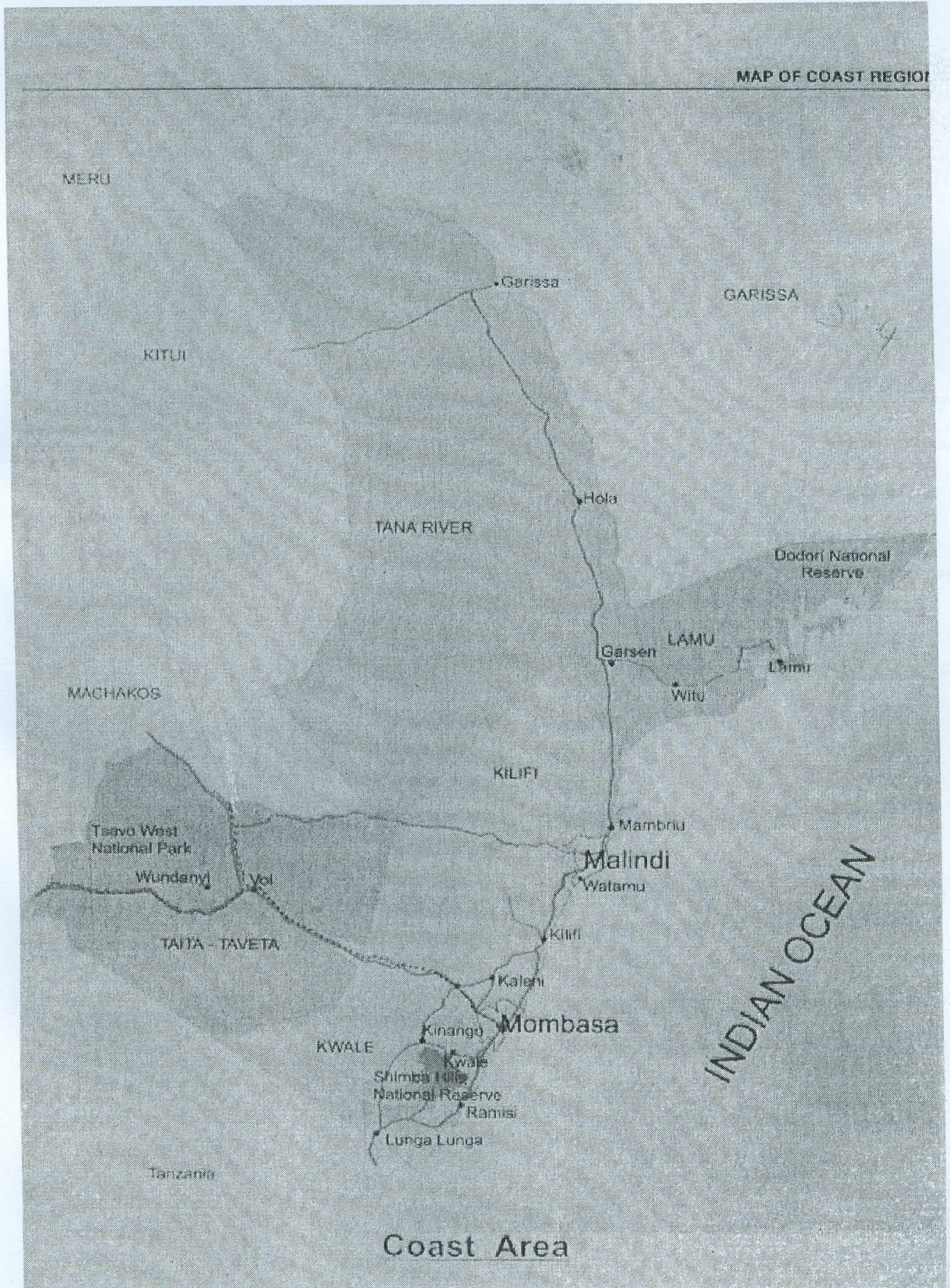
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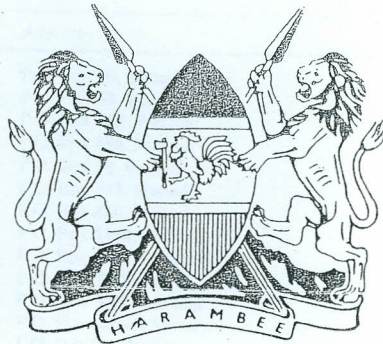
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7.0 Appendices

Appendix A. Coast Region Administrative Boundaries.





THE KENYA GAZETTE

Published by Authority of the Republic of Kenya

(Registered as a Newspaper at the G.P.O.)

Vol. CV—No. 62

NAIROBI, 13th June, 2003

Price Sh. 40

GAZETTE NOTICE No. 3976

THE HOTELS AND RESTAURANTS (CLASSIFICATION OF HOTELS AND RESTAURANTS) REGULATIONS, 1988

CLASSIFICATIONS

IN EXERCISE of the powers conferred by regulations 2 and 7 of the Hotels and Restaurants (Classification of Hotels and Restaurants) Regulations, 1988, the Hotels and Restaurants Authority classifies the hotels and restaurants listed in the schedule in the manner specified.

SCHEDULE

Name of hotel	Address	No. of beds	Location
TOWN HOTELS			
<i>Five Star:</i>			
Hotel Intercontinental	P.O. Box 30353-00200, Nairobi	770	Nairobi
Grand Regency Hotel	P.O. Box 57549, Nairobi	388	Nairobi
Hilton Hotel	P.O. Box 30624-00100, Nairobi	353	Nairobi
The Norfolk Hotel	P.O. Box 40064	334	Nairobi
Nairobi Serena	P.O. Box 46302, Nairobi	283	Nairobi
The Stanley	P.O. Box 30680, Nairobi	434	Nairobi
Safari Park Hotel	P.O. Box 45038, Nairobi	285	Nairobi
<i>Three Star:</i>			
The Bounty Hotel	P.O. Box 75200, Nairobi	100	Nairobi
Fair View Hotel	P.O. Box 40842, Nairobi	163	Nairobi
Marble Arch Hotel	P.O. Box 12224, Nairobi	77	Nairobi
Landmark Hotel	P.O. Box 14287, Nairobi	242	Nairobi
Holiday Inn	P.O. Box 66807, Nairobi	342	Nairobi
Windsor Golf Country Club	P.O. Box 45587, Nairobi	260	Nairobi
Nairobi Safari Club	P.O. Box 43564, Nairobi	282	Nairobi
Utalli Hotel	P.O. Box 31052, Nairobi	105	Nairobi
Outspan Hotel	P.O. Box 24, Nyeri	90	Nyeri
Ambassadeur Hotel	P.O. Box 30399, Nairobi	190	Nairobi
Sportsman Arms Hotel	P.O. Box 3, Nanyuki	125	Nanyuki
<i>Two Star:</i>			
Panafric Hotel	P.O. Box 30486, Nairobi	46	Nairobi
Silver Springs Hotel	P.O. Box 61367, Nairobi	188	Nairobi
Midland Hotel	P.O. Box 908, Nakuru	65	Nakuru
Tea Hotel	P.O. Box 75, Kericho	77	Kericho
Hotel Sirikwa	P.O. Box 3361, Eldoret	210	Eldoret
Hotel Kunste	P.O. Box 1369, Nakuru	146	Nakuru
Hotel Boulevard	P.O. Box 42831, Nairobi	140	Nairobi
Eel Hotel	P.O. Box 36, Elburgon	78	Elburgon
Six Eighty	P.O. Box 43436, Nairobi	680	Nairobi
Sports View Hotel	P.O. Box 74194, Nairobi	104	Nairobi
Kakamega Golf Hotel	P.O. Box 118, Kakamega	124	Kakamega
Lotus Hotel	P.O. Box 90193, Mombasa	64	Mombasa
Hotel Genevieve	P.O. Box 127, Nakuru	46	Nakuru
Lakeside Tourist Lodge	P.O. Box 894, Naivasha	65	Naivasha

Appendix B continued.

<i>Name of hotel</i>	<i>Address</i>	<i>No. of beds</i>	<i>Location</i>
Hotel Baracuda	P.O. Box 59, Watamu	99	Malindi
Malindi Beach Club	P.O. Box 68, Malindi	52	Malindi
Blue Bay Village	P.O. Box 162, Watamu	213	Malindi
Karibuni Villas	P.O. Box 840, Malindi	300	Malindi
Coconut Village	P.O. Box 68, Malindi	90	Malindi
Stephanie Sea House	P.O. Box 583, Malindi	100	Malindi
Mwembe Resort	P.O. Box 426, Malindi	60	Malindi
Seahorse M. Club	P.O. Box 81443, Mombasa	80	Kilifi
Domina Palm Tree Club	P.O. Box 1463, Malindi	90	Malindi
Peponi Hotel	P.O. Box 24, Lamu	48	Lamu
Bush Baby Resort	P.O. Box 5760, Malindi	87	Malindi
Giriama Beach Hotels	P.O. Box 86693, Mombasa	184	Mombasa
Acquirius Beach Resort	P.O. Box 96, Watamu	120	Malindi
<i>One Star:</i>			
Royal Reserve Safari Club	P.O. Box 34190, Nyali	168	Kilifi
Watamu Beach Hotel	P.O. Box 1, Watamu	280	Malindi
LODGES			
<i>Five Star:</i>			
Mara Simba Lodge	P.O. Box 84334, Mombasa	168	Narok
Mpata Safari Club	P.O. Box 58402, Nairobi	46	Narok
Mt. Kenya Safari Club	P.O. Box 35, Nanyuki	230	Nanyuki
Mara Serena Lodge	P.O. Box 48690, Nairobi	148	Narok
Amboseli Serena Safari Lodge	P.O. Box 48690, Nairobi	182	Kajiado
<i>Four Star:</i>			
Oi Tukai Lodge	P.O. Box 47557, Nairobi	160	Kajiado
Finch Hattons Tented Lodge	P.O. Box 24423, Nairobi	70	Taita/Taveta
Shaba Sarova Lodge	P.O. Box 72493, Nairobi	170	Isiolo
Kichwa Tembo Camp	P.O. Box 74957, Nairobi	80	Narok
Olonana Camp	P.O. Box 59749, Nairobi	32	Narok
Mountain Lodge	P.O. Box 48690, Nairobi	81	Nyeri
The Ark	P.O. Box 449, Nyeri	122	Nyeri
<i>Three Star:</i>			
Severin Safaris Camp	P.O. Box 82169, Mombasa	50	Taita/Taveta
Mara Sopa Lodge	P.O. Box 72630, Nairobi	200	Narok
Voi Safari Lodge	P.O. Box 863, Voi	104	Voi
Greater Rift Valley Lodges Golf Resort	P.O. Box 227, Naivasha	62	Naivasha
Sweetwaters Tented Camp	P.O. Box 763, Nanyuki	60	Laikipia
Siana Springs Camp	P.O. Box 74888, Nairobi	80	Narok
Samburu Lodge	P.O. Box 47557, Nairobi	120	Samburu
Baringo Island Camp	P.O. Box 1141, Nakuru	51	Baringo
Tree Tops Lodge	P.O. Box 24, Nyeri	100	Nyeri
Samburu Serena Safari Lodge	P.O. Box 48690, Nairobi	124	Samburu
Voyageur Safari Lodge	P.O. Box 74888, Nairobi	165	Narok
Samburu Intrepids	P.O. Box 74888, Nairobi	54	Samburu
Mara Safari Club	P.O. Box 58581, Nairobi	100	Narok
Lake Baringo Country Club	P.O. Box 33, Kampi ya Samaki	96	Baringo
Sarova Lion Hill Lodge	P.O. Box 7094, Nakuru	134	Nakuru
Sattick Safari Lodge	P.O. Box 30624, Nairobi	192	Taita/Taveta
Taita Hills Safari Lodge	P.O. Box 30624, Nairobi	120	Taita/Taveta
Lake Naivasha Country Club	P.O. Box 15, Naivasha	102	Naivasha
Kitaguni Serena Lodge	P.O. Box 48690, Nairobi	112	Taita/Taveta
Sarova Mara-Camp	P.O. Box 855, Narok	155	Narok
Keekorok Lodge	P.O. Box 40075, Nairobi	168	Narok
Lake Nakuru Lodge	P.O. Box 561, Nakuru	140	Nakuru
<i>Two Star:</i>			
Little Governors Camp	P.O. Box 48217, Nairobi	24	Narok
Voyage Safari Camp Ziwayi	P.O. Box 74888, Nairobi	50	Narok
Rondo Retreat Centre	P.O. Box 2153, Kakamega	35	Kakamega
Lake Elementaita Lodge	P.O. Box 66, Gilgil	70	Gilgil
Amboseli Lodge	P.O. Box 30139, Nairobi	224	Kajiado
Tortilis Camp	P.O. Box 39806, Nairobi	34	Kajiado
Travellers Mwaluganje El. Camp	P.O. Box 87649, Mombasa	40	Kwale
Aberdare Country Club	P.O. Box 449, Nyeri	82	Nyandarua
Safari Gordon Blue	P.O. Box 312, Naivasha	16	Naivasha
Voi Wildlife Lodge	P.O. Box 603, Voi	48	Voi
Naro Moru River Lodge	P.O. Box 18, Naro Moru	133	Laikipia
Shimba Rain Forest	P.O. Box 83, Kwale	62	Kwale
Westermans Safari Camp	P.O. Box 5, Voi	40	Voi
Ngulia Safari Lodge	P.O. Box 42, Mtito Andei	104	Taita/Taveta

Appendix B continued.

<i>Name of hotel</i>	<i>Address</i>	<i>No. of beds</i>	<i>Location</i>
Mara Hipo Tented Camp	P.O. Box 69513, Nairobi	64	Narok
Mara Intrepids Club	P.O. Box 74888, Nairobi	60	Narok
Governors Camp	P.O. Box 48217, Nairobi	66	Narok
Fig Tree Camp	P.O. Box 40683, Nairobi	130	Narok
RESTAURANTS			
<i>Five Star:</i>			
Tamarind Restaurant	P.O. Box 88785, Mombasa		Mombasa
Nairobi Tamarind Restaurant	P.O. Box 74493, Nairobi		Nairobi
The Carnivore Restaurant	P.O. Box 56685, Nairobi		Nairobi
Tratoria Restaurant	P.O. Box 4059, Nairobi		Nairobi
Pavement Restaurant	P.O. Box 72228, Nairobi		Nairobi
The Lord Errol Restaurant	P.O. Box 999, Village Market		Nairobi
Shehnaï Restaurant	P.O. Box 81676, Mombasa		Mombasa
<i>Four Star:</i>			
Rudys Restaurant	P.O. Box 26023, Nairobi		Nairobi
Tamambo Restaurant	P.O. Box 1131, Sarit Centre, Nairobi		Nairobi
Minar Restaurant (Argwings Kodhek Road)	P.O. Box 41869, Nairobi		Nairobi
Simba Restaurant (NAS)	P.O. Box 19098, Nairobi		Nairobi
China Jiangsu Restaurant	P.O. Box 66912, Nairobi		Nairobi
China Plate Westlands	P.O. Box 10271, Nairobi		Nairobi
Kengeles-Koinange Street	P.O. Box 25289, Nairobi		Nairobi
Nairobi Mamba Village	P.O. Box 74760, Nairobi		Nairobi
Berbers Oasis Restaurant (Jamhuri Showground)	P.O. Box 57144, Nairobi		Nairobi
Nairobi Nihonjin Club	P.O. Box 47718, Nairobi		Nairobi
Rangers Restaurant	P.O. Box 63539, Nairobi		Nairobi
Tin Tin Restaurant	P.O. Box 58077, Nairobi		Nairobi
Kowloon Restaurant	P.O. Box 22635, Nairobi		Nairobi
Alan Bobies Bistro	P.O. Box 44991, Nairobi		Nairobi
Haandi Restaurant	P.O. Box 13855, Nairobi		Nairobi
<i>Three Star:</i>			
Green Corner Restaurant	P.O. Box 61479, Nairobi		Nairobi
The Porter House	P.O. Box 42023, Nairobi		Nairobi
The Mara Restaurant	P.O. Box 48608, Nairobi		Nairobi
Hongkong Restaurant	P.O. Box 48255, Nairobi		Nairobi
Chorna Zone	P.O. Box 49842, Nairobi		Nairobi
Erusha Restaurant	P.O. Box 38965, Nairobi		Nairobi
Moonsoon Ventures	P.O. Box 1108, Sarit Centre		Nairobi
Singh Restaurant	P.O. Box 83860, Nairobi		Mombasa
The Horseman	P.O. Box 24360, Nairobi		Nairobi
Racecourse Restaurant	P.O. Box 40373-00100, Nairobi		Nairobi
Kengeles Restaurant (Nairobi West)	P.O. Box 25282, Nairobi		Nairobi
Churrascos	P.O. Box 54474, Nairobi		Nairobi
Boko Boko Restaurant	P.O. Box 5144, Diani		Kwale
Theos Restaurant	P.O. Box 14427, Westlands		Nairobi
Tanager Bar & Restaurant	P.O. Box 58836, Nairobi		Nairobi
Kengeles (Lavington)	P.O. Box 25289, Nairobi		Nairobi
Moatens Bar & Restaurant	P.O. Box 21915, Nairobi		Nairobi
Red Bull Restaurant	P.O. Box 21915, Nairobi		Nairobi
Stavrose Restaurant	P.O. Box 50449, Nairobi		Nairobi
Garden Square Restaurant	P.O. Box 73489, Nairobi		Nairobi
Conference Caterers	P.O. Box 73487, Nairobi		Nairobi
Ali Barbours C. Restaurant	P.O. Box 53, Ukunda		Kwale
Hongkong Chinese-Bamburi	P.O. Box 82881, Mombasa		Mombasa
China Plate Restaurant	P.O. Box 10271, Nairobi		Nairobi
Roro Chinese Restaurant	P.O. Box 689, Village Market		Nairobi
Furusato Japanese Restaurant	P.O. Box 38965, Nairobi		Nairobi
Home Park Caterers	P.O. Box 26035, Nairobi		Nairobi
Yuls Restaurant Aquandrom	P.O. Box 10286, Bamburi		Mombasa
Minar Restaurant (Nyali)	P.O. Box 83167, Mombasa		Mombasa
Mapango Reef Restaurant	P.O. Box 96, Watamu		Malindi
Hunters Steak House	P.O. Box 90574, Mombasa		Mombasa
Minar Restaurant (Loita Street)	P.O. Box 41869, Nairobi		Nairobi
Berbers Oasis Restaurant (Harambee Avenue)	P.O. Box 57144, Nairobi		Nairobi

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THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss ALICE
MUENI NZIOKA

KENYATTA UNIVERSITY
of (Address).....
P.O. BOX 43844 NAIROBI

has been permitted to conduct research in
PERMANENT SECRETARY
MINISTRY OF EDUCATION
SCIENCE AND TECHNOLOGY
District,

COAST Province,

on the topic.....
A STUDY OF THE IMPACT OF
HIV/AIDS ON THE HUMAN RESOURCE
FUNCTIONS IN THE HOSPITALITY
INDUSTRY

for a period ending 31ST JANUARY, 20⁰⁸

Research Permit No. MOST 13/001/37

Date of issue 23.7.2007

Fee received SHS.500.00



M.O.
Applicant's
Signature

M.O. ONDIEKI
FOR Permanent Secretary
Ministry of
Science and Technol

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 without 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



REPUBLIC OF KENYA

RESEARCH CLEARANCE
PERMIT

Appendix D. Questionnaire.

INTERVIEW SCHEDULE FOR HUMAN RESOURCE MANAGERS

Thank you for accepting to take part in this research.

This study is intended to solicit information on the EFFECTS OF HIV/AIDS on Hotel's Human resource Operations. The information you give will be treated with maximum confidence; hence your ultimate co-operation is highly appreciated.

Please follow the instructions

- Read the questions carefully.
- Answer all the questions
- **Do not write your name**
- Tick the appropriate answer [s] []
- Write the answers and the comments where indicated.

SECTION A: PROFILE OF THE RESPONDENT

1. Age of respondent

1. 20 – 30 Years []

2. 31 – 40 Years []

3. 41 – 49 Years []

4. Over 50 Years []

2. Gender: Male [] Female []

3. Highest Academic qualification

4. Religion.....

5. Position.....

6. Length of service with this hotel.....

SECTION B: CHARACTERISTICS OF THE SAMPLED HOTELS

1. Administration code {For official use only}.

2. Hotel category.....

3. Number of Employees

4. Number of Beds.....

SECTION C – ABSENTEEISM

The following questions are intended to solicit information on how absenteeism affects hotel operations.

Direction: **Please tick []** the response that best fits your answer.

1. HIV/AIDS pandemic among the workers is an issue of serious concern to the hotel Management.
 1. Strongly Agree [] 2 Agree [] 3. Neutral [] 4.Disagree [] 5. Strongly disagree []

2. This hotel monitors HIV/AIDS related absenteeism
 1. Strongly agree [] 2. Agree [] 3 Neutral [] 4.Disagree [] 5. Strongly Disagree []

3. HIV/AIDS pandemic has increased absenteeism for this hotel.
 1. Strongly agree [] 2. Agree [] 3. Neutral [] 4. Disagree [] 5 Strongly Disagree []

4. Please indicate the most frequent reason for employee absenteeism in your hotel
 - 1 .Attend funerals.
 - 2 Attend to sick relatives.
 3. HIV/AIDS related sickness.
 - 4 Declining morale due to overworking.
 5. Others; Specify

1. [] 2 [] 3. [] 4 [] 5 []

5. Use of temporally staff in hotel operations affects the quality of products.
 1. Strongly agree [] 2 Agree [] 3 Neutral [] 4.Disagree [] 5.Strongly Disagree []

6. How does the hotel cover for absent skilled workers?
 1. Contract the services of casual worker
 2. Divide the work among other workers
 - 3 Assign the work to another skilled employee and pay overtime.
 - 4 Assign the work to another employee but do not pay over time

7. What is the trend of employee absenteeism for the last five years in this hotel?
 - 1 Extremely serious [] 2. Serious [] 3fairly serious [] 4.Not serious [] 5.Extremely not serious

SECTION D – PRODUCTIVITY LOSS

This section intended to solicit information on Productivity loss on the hotel industry.

Direction: **Please tick** [] the response that best suits your answer

8. What cadre of your staff is mostly infected with HIV/AIDS?

1. Highly skilled. [] 2. Skilled [] Unskilled [] 4. Don't know []

9 Guest service is critical and the hotel depends on highly skilled and experienced personnel to provide such services

1. Strongly agree [] 2 Agree [] 3 Neutral [] 4. Disagree [] 5. Strongly Disagree []

10. The quality and quantity of labour provided by an employee may be reduced when they are sick or caring for sick dependants.

1. Strongly agree [] 2 Agree [] 3 Neutral [] 4. Disagree [] 5. Strongly Disagree []

11. Has your hotel suffered any productivity loss due to onset of HIV/AIDS on the work force?

1. Yes [] 2 No. []

If yes, please answer question 12.

12. What are the most common causes of deaths among the hotel employees?

(Rank from highest)

1. Natural death
 2. HIV/AIDS related sicknesses
 3. Malaria
 4. Accidents
 5. Others.....(Please specify)
1. [] 2. [] 3. [] 4. [] 5. []

13. How has HIV/AIDS pandemic affected your human resource Productivity?

1. Increased absenteeism
2. Death of staff leading to loss of skill and tacit knowledge
3. Increased staff turnover due to HIV/AIDS

4. Declining employee morale due to HIV/AIDS

5. Others (specify).....

1 [] 2 [] 3 [] 4 [] 5 []

14. What is the trend of productivity loss for your hotel for the last five years?

1 Extremely serious [] 2 Serious [] 3 Fairly serious [] 4 Not serious [] 5 extremely not serious []

15. HIV/AIDS is threatening to rob your hotel of skilled workers

1. Strongly Agree [] 2 Agree [] 3 Neutral [] 4. Disagree [] 5. Strongly disagree []

SECTION D- LABOUR COSTS

This section is intended to solicit information on the effects of HIV/AIDS on labour costs for the hotel industry

Direction: **Please tick** [] the response that best suits your answer.

Health care costs

16. This hotel provides medical scheme to all the workers inclusive of HIV/AIDS related illness.

1. Always [] 2 Sometimes [] 3. Occasionally [] 4. Not at all []

17. Are the immediate family members included in the scheme?

1. Always [] 2 Sometimes [] 3. Occasionally [] 4 Not at all []

18. HIV/AIDS pandemic has increased medical expenses for this hotel for the past five years

1 Strongly agree [] 2 Agree [] Neutral [] 4 Disagree [] 5. Strongly disagree []

Funeral costs

19 This hotel meets the employee's funeral expenses.

1. Strongly agree [] 2 Agree [] 3. Neutral [] 4. Disagree [] 5. Strongly Disagree []

20. How does this hotel handle the funeral of its employees?

1. Provide some fixed amount for funerals
 2. Provide transport only for relatives
 3. Cater for all funeral expenses.
 4. Provide for transport and allowances for other employees attending funeral of their departed colleague
 - 5..... Others (specify)
1. [] 2. [] 3. [] 4. [] 5 []

21. Has your hotel experienced increase in operating cost due to the onset of HIV/AIDS?

- Yes [] No []
- If yes, please answer question 22

22. Please indicate the most prevalent item that ha greatly increased operating costs for your hotel.

1. Funeral cost
 2. Recruitment cost
 3. Health care cost
 4. Training cost
 5. Others..... (Specify)
- [] [] [] [] []

SECTION F – LABOUR TURNOVER

This section will solicit information on labour turnover or the hotel industry.

Direction: **Please tick** [] the response that best suits your answer.

23. Due to high labour turn over, this hotel is experiencing poor skill transmission

1. Strongly agree [] 2. Agree [] 3 Neutral [] 4 Disagree [] 5, strongly disagree []

24. What is the typical length time for new employees to become fully functional and effective?

1. one month
 2. six month
 3. one year
 4. Others)..... (Specify)
- [] [] [] []

25. Please indicate reasons for employees leaving your hotel.

1. Dismissal [] 2. Voluntary resignation [] 3. Death [] 4. sickness [] 5. Retirement []

26. Salaries for sick employees are held constant while the work output is reduced and this affects productivity and profits.

1. Strongly agree [] 2. Agree [] 3. Neutral [] 4 Disagree [] 5 strongly disagree []

27 Has your hotel experienced labour turn over due to the onset of HIV/AIDS pandemic?

- Yes [] No []

If yes, please answer question 28

28. Please indicate how labour turnover affected the hotel operations

1. Increased disorganization within the work force
2. Loss of skill and knowledge
3. Increased direct overtime cost
4. Reduced efficiency among over worked employees
5. Increased payment of termination benefits, and ex-gratia to employees dependants
6. Other (specify)

- [] [] [] [] []

29. What is trend labour turn over for this last 5 years?

- 1 Extremely serious [] Serious [] 3. Fairly serious [] 4. Not serious [] 5. Extremely not serious []

SECTION – G MITIGATING THE EFFECTS OF HIV/AIDS IN THE HOTEL INDUSTRY

30 .In your opinion has HIV/AIDS pandemic affected the human resource operations in the hotel sector?

- Yes [] No. []

If yes, please answer question 31

31. What is the magnitude of the effect?

1. Extremely serious [] Serious [] 3. Fairly serious [] 4. Not serious [] 5. xtremely not serious []

32. In your opinion what should be done to mitigate the effects of HIV/AIDS among the hotel work force in order to stop further spread of the epidemic?

- 1 Prevention activities to be undertaken by hotel e.g. making available both female and male condoms to the hotel workforce.
- 2. Development of HIV/AIDS work place policy by each hotel
- 3. Integrating HIV/AIDS into training curriculum of the Hospitality Training Institutions
- 4. Hotel managers and supervisory staff to be trained on managing the HIV/AIDS in the work place.
- 5. Others (specify).....

1 [] 2. [] 2 [] 4 [] 5 []

Thank you for your co-operation