ALLEVIATING STRIKE ACTIONS IN KENYA'S HEALTHCARE SECTOR THROUGH POLICY AND SYSTEM REFORMS

By

Esendi Lynda Frida

Submitted to

Central European University

Department of Economics

In partial fulfilment of the requirements of the degree of Master of Arts Economic Policy in Global Markets

Supervisor: Professor Peter Mihalyi

CEU eTD Collection

Budapest, Hungary

2017

CEU eTD Collection

Abstract

A review of the Kenya healthcare system shows that new policies as well as management practices are required to solve the problems that currently plague the sector. Recently, the frequent strikes by health workers have brought to light the fact that as a country we have an inefficient system that has gone unchecked for such a long time. It also highlights that the country's priorities are not aligned with the global development agenda where improving health is one of the key pillars. In this paper, I elaborately paint a picture of the country's healthcare system with special focus on the increasing frequency of health worker strikes. The country's political climate in the recent past has been tense and implementing processes geared towards change is taking longer than expected. Considering this, I highlight the problems that the country is facing focusing on the collective bargaining agreement that has long been ignored and delve deeper into how this fits into the global picture. While doing so, I discuss in detail the shortcomings of the system, the reasons for these shortcomings and what has been done so far to address the existing problems. In addition to this, the paper gives policy recommendations drawn from systems around the world. Some of the cited recommendations have been implemented in other developing countries and have proven effective.

Key words: *Healthcare, strikes, collective bargaining agreements*

CEU eTD Collection

Acknowledgements

First, I would like to thank the Almighty God for the strength he has given me to be able to complete this project.

My thesis supervisor, Professor Peter Mihalyi. Your door was always open whenever I ran into a wall. You steered me in the right direction while at the same time allowing this paper to be my own work.

To my best friend, life-coach and pillar of strength, my late mother, Ruth Mbayi Ambatsa, I owe this to you. Thank you for staying alive long enough to see me through my second year and partly through this research. I am eternally grateful for the words of encouragement and wisdom that have always echoed in mind whenever I feel like my strength is failing. Even though you may not be physically here to see me accomplish this, I hope I made you proud.

Dad, thank you for holding my hand and helping me keep it together to be able to finish this project. For reminding me what mom would have wanted and helping me focus. Always keen on the progress I was making and providing invaluable insights as a medical worker.

Sylvia, my younger sister, thank you for always being the cheerleader on my team. You cheering me on has always given me a reason to push myself to be better. To my family and friends in the medical profession and respondents in the questionnaires of this research who have been with me on this journey, many thanks.

To my daughter Eleanor, you are the reason I push myself to be better.

A very special gratitude to the Central European University for the opportunities and resources afforded to me without which I wouldn’t be able to achieve the much I have and obtain the exposure and diversity that I have. I would not trade the past two years for anything.

CEU eTD Collection

Table of Contents

Abstract i
Acknowledgements ii
Abbreviations used v
List of tables vi
List of figures vi
Introduction 1
1. Labor Conflicts 4
1.1. Labor conflicts in Africa 4
1.2. Labor Conflicts in Kenya 7
2. Literature Review 9
2.1. Health care in Kenya 9
2.2. Percentage spent on healthcare 10
2.3. Doctor-patient ratio 14
2.4. Healthcare delivery 15
2.5. Doctor training in Kenya 17
2.6. Political, Economic and Cultural Surrounding 18
2.6.1. Poor working conditions 18
2.6.2. Corruption in healthcare 21
2.6.3. Ethnicity in healthcare 23
3. Physician Strikes 24
3.1. Physician strikes around the world 24
3.2. Justification of Industrial Action by Doctors and Other Healthcare Workers 26
3.3. ILO on the right to strike 27
3.4. Major Themes Present in the Context of Striking Physicians 29
3.4.1. Organization changes in healthcare services over the years 29
3.4.2. Failure of employers to honor the collective bargaining agreements that detail improved wages and working conditions 31
3.4.3. Disempowerment 32
3.5. 2016/2017 The Kenyan healthcare strikes scenario 32
3.5.1. Who were the striking physicians? 35
3.5.2. An Unfulfilled Collective Bargaining Agreement 37
3.5.3. Effects of Industrial Actions on Patients 39
3.6. Effects of Industrial actions on Doctors 44
3.7. The 2013 Collective Agreement 45
3.7.1. What hinders effective implementation of collective agreements? 47

CEU eTD Collection

3.7.2. Key areas of interest in the CBA 48
3.7.3. Union and Doctor Rights 49
3.7.4. Remuneration 53
3.7.5. Work conditions 57
4. Data Analysis 63
4.1. Population and Sample 63
4.2. Response rate data 64
4.3. Analysis, Findings and Discussion 65
4.3.1. Job Satisfaction: Poor Pay, Promotions and Allowances 65
4.3.2. Decentralization of health care 67
4.3.3. Physicians on the right and ethics to strike 68
4.4. Conclusions 70
5. Conclusions and Policy Recommendations 71
5.1. Brain Drain and Typical Migration Risks Posed by Doctors 71
5.2. Fiscal Decentralization and Rural Inclusivity Policies 72
5.3. The Economic Policy on Financial and Non-Financial Incentives 74
5.3.1. Target Payments 75
5.3.2. Special Payments 76
5.4. Pay-for-Performance Policy 77
5.5. The Additional Duty Hours Allowance Policy as Utilized in Ghana 79
5.6. Alternative Skill Mixes Policy and Possible Effectiveness in Kenya 80
Appendix: Status Update 81
Bibliography 83

CEU eTD Collection

Abbreviations used

ADHA	Additional Duty Hours Allowance
CBA	Collective Bargaining Agreement
CBHF	Community Based Health Financing
EAC	East African Community
FBOs	Faith Based Organizations
GMC	General Medical Council
HCWs	Health Care Workers
ILO	International Labor Organization
KHIS	Kenya Health Information System
KMPPDU	Kenya Medical Practitioners, Pharmacists and Dentists Union
KNH	Kenyatta National Hospital
KNUN	Kenya National Union of Nurses
KNUT	Kenya National Union of Teachers
KUPPET	Kenya Union of Post Primary Education Teachers
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NHIF	National Health Insurance Fund
OOP	Out-Of-Pocket
PAC	Public Accounts Committee
TSC	Teacher's Service Commission
WHO	World Health Organization

CEU eTD Collection

List of tables

Table 1: Healthcare spending as a percentage (%) of GDP

Table 2: Statistical summary of some of the responses form the questionnaire interviews

List of figures

Figure 1: Kenya’s expenditure on healthcare (2008-2014)

Figure 2: Country comparison of healthcare expenditure as a percentage (%) of GDP

Figure 3: Trends in Health Expenditure by Financing Schemes

Figure 4: Physicians per 1000 patients (Average line shows the recommended number by WHO)

Figure 5: Percentage share of insurance spent in the different sectors

Figure 6: Data on emigrated doctors from Kenya in 2013

CEU eTD Collection

Introduction

Countries around the world work hard towards meeting the health as well as medical needs of their populations without having to go bankrupt or draining the resources that are there to serve the needs and purposes of the humans (Morrissey et al., 2015). Faced with varying economic, political, cultural and environmental changes amongst others, every country tailors their healthcare systems to suit the specific needs of their population. For example, countries that are prone to epidemics such are Ebola are more inclined to investing in measures that will prevent the escalation of future epidemics than in cancer prevention technologies. Not to say that cancer prevention technologies are irrelevant in these countries but to indicate the importance of prioritizing. While these differences exist, the building blocks are for the most part the same. That is, every country is in need of a basic public health infrastructure that is functional and efficient (Morrissey et al., 2015, pp.75). Developing countries heavily rely on community health workers for this and developed nations have a more complicated system that requires nurses, doctors and other healthcare professionals, insurance, hospitals and clinics.

It is important for countries to measure how effective the care they provide is so that improvements and regulations can be carried out to make sure that the care being provide meets the demand. There is the need for treatment evaluation and healthcare interventions, training of physicians, education of the public on leading healthy lives, educating them on making wise health decisions and be a big part of their maintaining their own health (Adams, 2010). Countries need ways to pay for these needs. Effectiveness of these systems extends to the healthcare workers. If the doctors are effective in their service provision, then this contributes immensely to the end goal. However, if there is a disconnect in any one of these sectors then the overall systems suffer because of the intertwining of the several sectors of

CEU eTD Collection

health care. Given this view, the health sector in developing countries has often suffered setbacks because of the lacking in one sector. For example, when doctors go on strike, this paralyzes operations and prevents the public from getting access to these services. The dissatisfaction that physicians show, has cumulatively resulted into strike actions; something that has become a common occurrence in countries like Kenya.

This research focuses on health worker's strikes in Kenya with special focus on the 2016/2017 strike that was the longest strike in the history of the country. The first chapter will provide an overview of labor conflicts in general and discuss in detail conflicts in Africa and narrow down to Kenya. The second chapter then talks about healthcare in Kenya. Through literature review, it will give a layout of the healthcare system from the percentage of GDP spent on healthcare to doctor-patient ratio to doctor training as well as the political, economic and cultural surroundings. Chapter three discusses in detail the doctor's strike focusing majorly on the collective bargaining agreement which, due to it not being implemented, culminated into a 100-days doctor strike. Chapter four will present a data analysis. Through questionnaires, targeted questions are asked. For the most part, the view presented in the paper is from a citizen's perspective that is the media and other sources. The questionnaires target physicians and ask questions that aren't otherwise answered in the available literature and media. The final chapter in will be on policy recommendations for the Kenyan healthcare sector that can be implemented to alleviate or eliminate strikes by health workers. Aside from eliminating health worker strikes, this policy recommendations target the improvement of the health care system while drawing comparisons from developing and developed countries' systems that work with efficiency.

Considering the nature of the subject and how current it is, most of the information is collected from newspaper articles, one-on-one interviews with patients and health workers. The literature review is supported by scholarly articles but for the most part, the data

CEU eTD Collection

collected is from the author's interaction with some of the physicians and reports by the media. The limitations of this will be that considering the political climate of the country and that it is an election year, there are mixed feelings with people taking a side, which means that some of the respondents may be bias in their answers. However, like every other research, this is expected.

CEU eTD Collection

1. Labor Conflicts

Conflicts in the workplace often go hand in hand with the central processes with regards to the people and how they relate to their surroundings. There are several reasons as to why conflicts in the work place arise and over the years, resolving them has often fallen on the shoulders of management who most of the time have made tough solid decisions on how the situations should be handled (Oni-Ojo & Osibanjo 2014). However, employers who resolve matters in this way fail to recognize that, disputes are part of the natural processes of the workplace and often, workers will voice out what is unsatisfactory about their working conditions. Such disputes cause a disruption in operations and prevent the achievement of organizational goals. The one question that economists have often sought to answer is are more labor conflicts in some countries than others. The effects of strikes have received a lot of literature attention; however, there is a clear gap in systematic scholarly attention. The explanation that has often been given for industrial conflicts operates under the assumption that strikes are independent isolated events. That is, the bargaining that occurs between negotiating partners in no way affected by conflict elsewhere and that whatever conflict happens, it has no influence on other events of bargaining (Akkerman & Torenvlied, 2012). The frequency of labor conflicts in a country narrows down to how management or the government handles them. In some situations, however, the behavior of the political opposition parties may also matter a lot.

1.1. Labor conflicts in Africa

Every year, millions of civil servants across Africa boycott duties for days, weeks and even months to present their grievances to their employers. Experience has shown that labor strikes are often an aftermath of failed negotiations between employees and their employers. Over the years, the number of strikes by workers *both* in the public and private sector has

CEU eTD Collection

consistently increased across Africa. Kamau (2012) notes that to a large extent, strikes in Africa are centered on wage disputes. Different countries have been affected economically and politically due to these strikes.

In 2013, operations in **South Africa**'s mining sector were immensely slowed down when over a thousand Lonmin company workers went on a six-week strike (Maylie, 2013). Media reports indicated that aside from causing a global increase in the prices of platinum by 1.3%, this strike also resulted in the death 45 people, of which 34 deaths were because of the confrontations between the police and protestors. The strikes all over South Africa have resulted in the closing down of all seven Anglogold's mines as well as two of Gold Field's mines.

Namibia also experienced work disruptions in many sectors in 2011 ranging from fishing industry to mining. In the banking sector, Agribank workers downed their tools in demand for a 12 % wage increase (Smith, 2012). Initially, they had been offered a six % increase, which they declined vehemently through strike action. In the same year, not a few months later after the Agribank workers' strike, workers in the mining sector took to the streets in protest. Rossing uranium mine is the third in the world in the production of uranium oxide. In September 2011, in protest of the lack of incentives for both management and workers in the mine, workers did not report to work. In his address to the government, Ismael Kasuto, union spokesperson of mine workers in Namibia, noted that out of the 1055 workers in Rossing Uranium mine, 800 had gone on strike and the situation was likely to remain that way if the government did not act fast. Another mining company that was part of the industrial disputes was NAMDEB. The firm is one of Namibia's leading diamond producer and it is estimated that for every day that the workers are on strike, it costs the country 775,000 US dollars (Tjihenuna, 2014). The 2014 NAMDEB strike was because of a disagreement over housing

CEU eTD Collection

benefits concerning workers who were moved from one mine to another. Despite this problem affecting only a section of the workers, the disagreements led to a full-blown strike that lasted a month. During the strike, aside from the disagreements on housing benefits, it also became clear that workers were not comfortable with the management. These series of strikes in the different sectors resulted in loss of investor confidence which subsequently affected the economic climate of the country (Kamau, 2012).

Sub-Saharan Africa is not the only part affected by these strikes. The textile industry is a major income earner for the **Egypt** (Joffé, 2013, 16). In 2015, 30000 workers in Egypt's textile industry went on a week-long strike over the very low wages and unpaid bonuses (Masr, 2015). These strikes adversely affected the economy. Egypt, has recently embraced organized labor and unions and this has emboldened workers. The strike by ceramic industry workers coincided with that of the textile industry over the same issues. If this are the problems that plague the private sector, how much worse can it be in the public sector?

It is important to note that despite these strikes for the most part focusing on wage disputes, sometimes, wage is not the major driver. In **Nigeria**, Exxon Mobil oil workers went on strike in protest of the sacking of their fellow workers. The union of oil workers officials criticized oil companies over the unlawful firing of workers without notice or a severance package (Owolabi et al., 2017). The union demanded that the oil companies either hire back the employees or provide a severance package as compensation. Other reasons that often drive strike actions are mismanagement of resources and unfair working conditions. The increased number of strikes, more especially in the public sector raises a lot of concerns considering their operational scale, the costs involved and how long they last.

CEU eTD Collection

1.2.Labor Conflicts in Kenya

Labor conflicts are present in almost every sector of the Kenya system. From the education sector, healthcare to the transport industry amongst many other sectors, strike actions have become a norm in the country. While this may have a detrimental effect to the country's image and economy, it is important that the country prioritizes its operations and manages the situation before it is too late. Industrial disputes have often turned ugly or the resolution has always been less than amicable which explains their recurring nature in the country.

Every year, **students** in their final year of high school sit a national qualifying exam into university. When the Kenya National Examination Council released the results of the 2011 candidates in February of 2012, there was a recorded massive drop in performance following the 2011 teacher's strike that happened in the months leading to the students sitting their national exams.

Year in year out, **teachers** and **lecturers** in Kenya boycott duties for months on over wage disputes. The Teachers Service Commission (TSC), Kenya's largest employer of teachers has often been at an impasse with teachers unions- Kenya National Union of Teachers (KNUT) and Kenya Union of Post Primary Education Teachers (KUPPET) (Ngugi, 2015). These strikes however are not only confined to the primary and secondary schools, it extends to our universities as well. The sad reality of our universities is that the strikes involving lecturers often lead to prolonged studies. More time is spent at home than in classrooms and programmes that are supposed to take three to four years often go for as long as five years. In 2012, a six-month long strike in Kenya universities resulted in the class intended to graduate in 2012 graduating in 2013.

Kenya Airways is one of Africa's largest airline carriers. It has over the years won awards for outstanding service provision in Africa, but in the recent past, clients have shown

CEU eTD Collection

dissatisfaction and now it is no longer the “pride of Africa”. In 2016, the airline pilots went on a go slow and delayed their intended strike action only if the top executives in management resigned. Over the past five years, the airline has been making massive losses (Anglionby, 2016) that have resulted in job loss, poor pay and poor airline services. Additionally, as a result of poor services, the airline has lost most of its clientele (Muthoki & Mutegi 2016). About the same time that the pilots went on a go slow, the airline’s engineers refused to report to work citing no allowances, poor salaries and incompetent management as their cause of dissatisfaction.

Strikes in other sectors such as **motorists** striking as a result of harassment by city council workers and the police and industries over wages and benefits though not massive in scale in but their effects detrimental all the same, cannot compare to that of healthcare workers which is the focus of this paper.

CEU eTD Collection

2. Literature Review

2.1.Health care in Kenya

In terms of development, Kenya is ranked among the top 10 fast developing economies in Africa along with Nigeria, South Africa, Angola and Ethiopia amongst others (Pham, 2017). Nonetheless, **Kenya is still a poor country.** As of 2016, the World Bank's estimate for the country's per capita GDP (at current US dollar prices) is about 1 600$, which means that in terms of worldwide ranking, Kenya is on the 144th place on a list of 185 countries. Furthermore, Kenya is a huge country with a territory of almost 600 thousand km^2 (like France or the Ukraine) and the population of 49 million. These basic facts determine almost all the relevant factors which shaped the 2016/2017 strike.

The country's health system is divided into three sectors: public, commercial private and Faith Based Organizations. According to the Netherlands Enterprise Agency (2016), in terms of provision of provision of healthcare services, the **public sector** is the largest. Commercial **private sector** comes next then **Faith Based Organizations** (FBOs). There exists a large disparity in the presence of healthcare facilities especially in the rural areas.

Over the years, the total expenditure on healthcare has increased by about 33%. Currently it stands at around 2.7 billion $. Funding healthcare is mixed. Money comes from:

- employer schemes,
- taxation,
- Community Based Health Financing (CBHF),
- the National Health Insurance Fund (NHIF),
- private health insurance,
- out of pocket expenses,

CEU eTD Collection

- Kenya's international donors and
- Foreign Non-governmental organizations (NGOs).

2.2.Percentage spent on healthcare

According to World Bank statistics, as of 2014, Kenya allocates approximately 5.6% of its GDP to healthcare (Health Policy Project, 2016). Out-of-pocket expenditures make at least three-quarters of the private expenditure on health. In spite of the increased contributions to health over the years (see figure below), Kenya's health budget heavily relies on development partners.

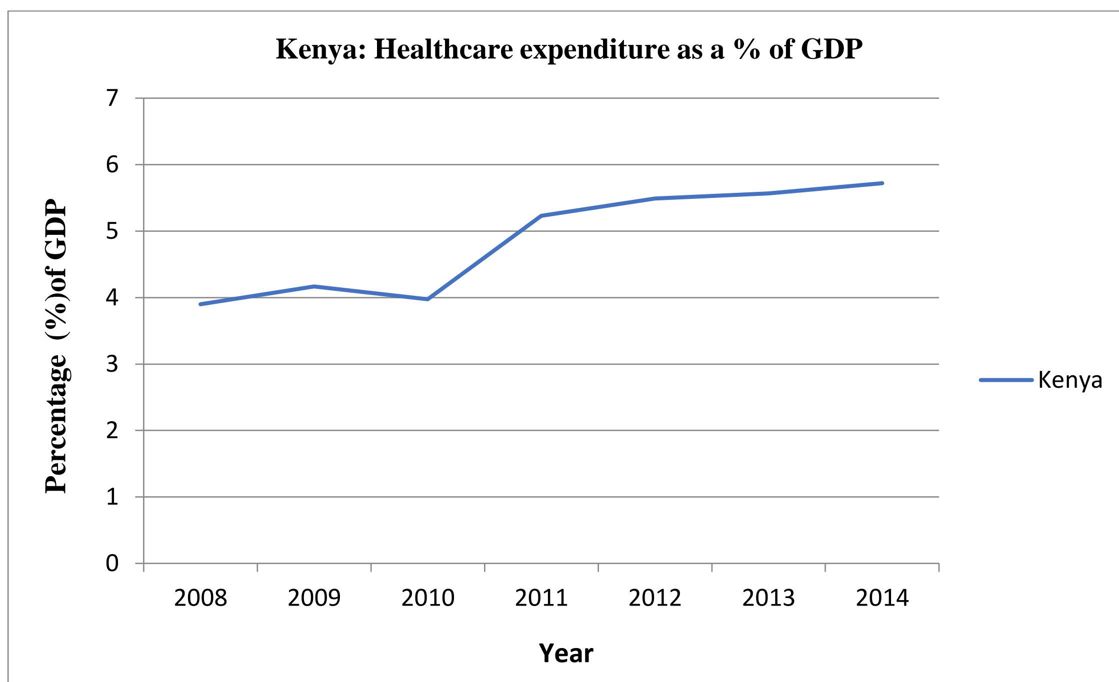

Figure 1: Kenya's expenditure on healthcare (2008-2014) (World Bank Site: www.worldbank.org)

This number is low in comparison to its African counterparts such as South Africa which allocates 8.8 percent (Health Policy Project, 2016b), Malawi 11.7 % (Health Policy Project 2016b) and Liberia which allocates 10 % ("WHO | Countries" n.d.). The table below shows a sample of the health care expenditure as a percentage of GDP of selected countries (both developed and developing).

	2012	2013	2014
Kenya	5.5	5.6	5.7
Rwanda	7.7	7.7	7.5
Tunisia	7.2	7.3	7.0
South Africa	8.8	8.8	8.8
Botswana	6.3	5.8	5.4
India	4.4	4.5	4.7
Malawi	12.1	11.0	11.4
Ethiopia	5.8	5.2	4.9
Hungary	7.7	7.5	7.4
United States	17.0	16.9	17.1
France	11.4	11.6	11.5
United Kingdom	9.4	9.3	9.1

Table 1: Healthcare spending as a percentage (%) of GDP (World Bank Site: www.worldbank.org)

In comparison to other countries, Kenya still performs poorly in terms of allocating the budget for healthcare. Almost 25 % of the population is covered by either a public, private or community based health insurance scheme. However, the amount of money spent on out-of-pocket payments remains relatively high in the country (Netherlands Enterprise Agency, 2016). Based on experience, it is common for people at the bottom of the pyramid (a large portion of the remaining 75 percent) to pay out of the pocket. This is mainly because; most of them are self-employed and not subscribed to the NHIF or not part of any employer-based schemes. Additionally, they are not able to afford the private health insurance because the premiums are rather expensive. While community-based health insurance schemes are meant to cater to this part of the population, the local governments have been discriminatory in subscribing the people to these schemes and often these results in a significant percentage of the population missing out on the benefits of such schemes.

CEU eTD Collection

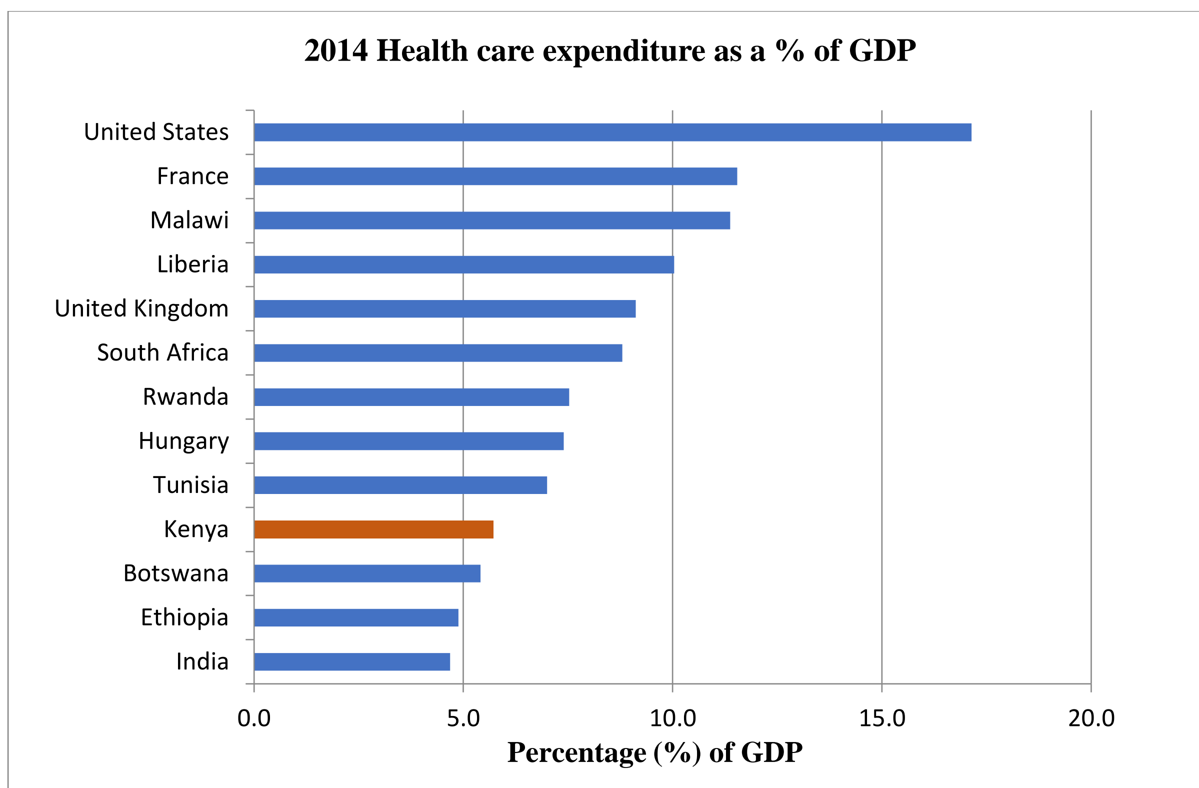

Figure 2: Country comparison of healthcare expenditure as a percentage (%) of GDP (World Bank Site: www.worldbank.org)

The figure 3 below shows the trends in health expenditure by financing schemes. From the figure, central government schemes such as the NHIF and out of pocket expenditures are the largest financing schemes in healthcare in Kenya. Enterprise financing schemes, often referred to as employee based schemes, local government schemes and voluntary health insurance schemes are a very small percentage of health care expenditure. There is no predefined percentage of GDP that has been stated by the WHO that every country should spend on healthcare because every country has unique conditions (Savedoff, 2007). The one question that the WHO has highlighted that countries should ask before they set aside a budget for expenditure on healthcare is:

> How much should my country spend on health, given our current epidemiological profile relative to our desired level of health status, considering the effectiveness of

CEU eTD Collection

health inputs that would be purchased at existing prices, and taking account of the relative value and cost of other demands on social resources? (Savedoff, 2007)

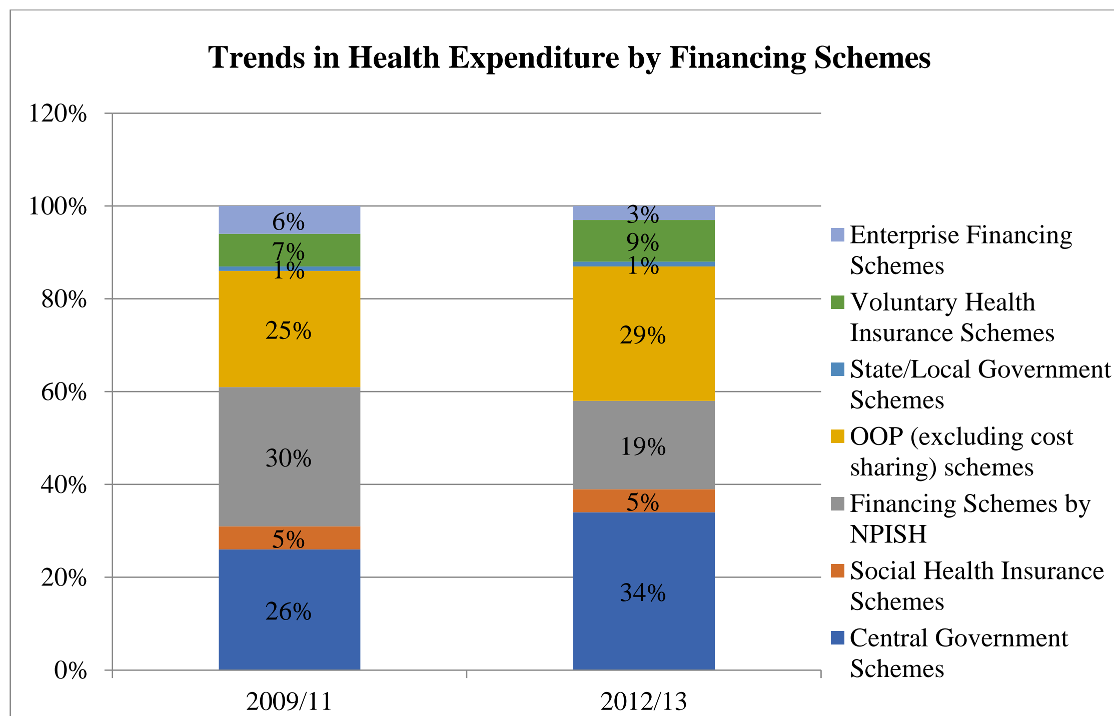

Figure 3: Trends in Health Expenditure by Financing Schemes (Source: Netherlands Enterprise Energy Report)

In setting aside a budget for expenditure, there are five fundamental questions that every country ought to ask:

i. What are the health problems that the country is facing?

ii. What health status does the country hope to have?

iii. In analyzing our current policies, services and activities, how effective are they?

iv. What are the prices of the inputs?

v. Do the funds allocated for this have better use elsewhere? (Savedoff, 2007)

In the author's opinion, when a country can satisfactorily answer them keeping in mind all the fact and figures, then decisions can be made. Prioritizing what the country needs is an

CEU eTD Collection

important step that the stakeholders in a country need to keep in mind as this goes a long way in the processes of a country.

2.3.Doctor-patient ratio

WHO recommends that for every 10000 inhabitants, there should be 23 doctors (Gross et al., 2011). Kenya, however, has only 2 doctors. Most countries in Africa are also way below the WHO recommended number. The US has 26 doctors for every 10000 patients, Canada 25, Brazil, though below the recommended number still has 18 and Argentina records the highest number of 37 doctors per 10000 patients ("WHO | Density of Physicians (Total Number per 1000 Population, Latest Available Year)" n.d.). The **doctor shortage** is a problem not only for the population. It often becomes problematic because it results in overworked doctors. This has often been mentioned as one of the cause of strikes. In a press interview, the KMPPDU secretary general Ouma Oluga informed the public that the country needed 83000 more doctors to meet the WHO standard. "We are doing very poorly in terms of the doctor to patient ratio, in relation to the World Health Organization standard, and the situation is getting worse as more doctors resign," he said.

CEU eTD Collection

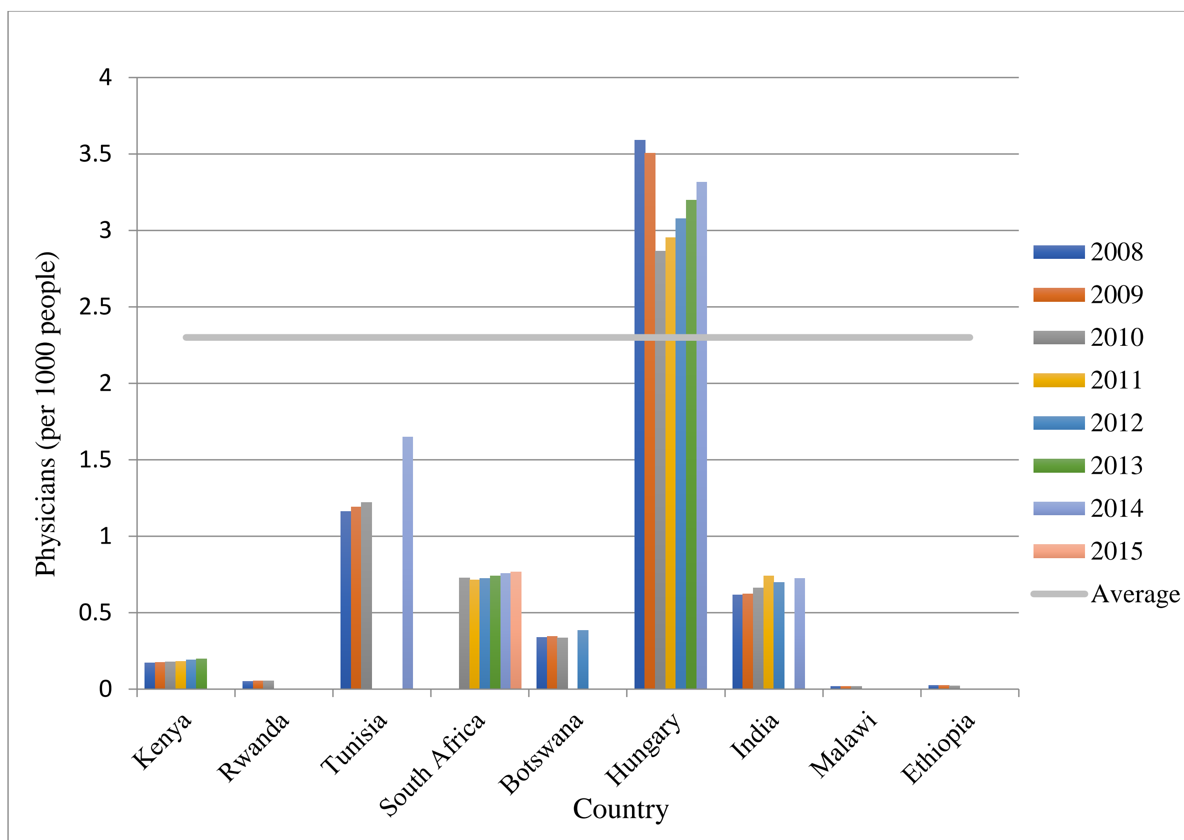

Figure 4: Physicians per 1000 patients (Average line shows the recommended number by WHO) (World Bank Site: www.worldbank.org)

2.4.Healthcare delivery

In 2010, a new Kenyan constitution was put in place. This new constitution created a provision for a **decentralized government.** Political power and material resources are now devolved into 47 counties. The whole devolution process took effect after the March 2013 general elections; power and resources were devolved from the national government to the county governments. Decentralization as a process, if done right, brings a lot of services to close to the people and comes with a lot of advantages. However, if done over-ambitiously and in a short time span is bound to bring about a lot of unprecedented opportunities as well as challenges. In the views of the World Bank, Kenya's decentralization was among the most rapid and most ambitious, in comparison to any other country in the world.

CEU eTD Collection

In 2013, with the new devolved government, the public health services were moved from the central national government and the Ministry of Health (MoH) to the county governments. The involvement of the MoH has now been limited in operation. Its duties are now confined to providing regulating the health care sector and county governments are now tasked with providing healthcare services to the locals including hiring and payments to staff. Under the devolved health services, the county governments had the power to:

1. Design innovative county healthcare models and interventions that would uniquely suit their needs
2. Determine the scope of their health system in accordance to the priorities of the people
3. Make fast independent decisions in terms of mobilization of resources, allocation of resources to the different healthcare subsectors and deal with any arising issues.

Aside from this, the county governments oversaw the salary payments of the medical practitioners who worked in the county medical facilities. The aspiration was to **bring the services closer to the people**.

While devolution may have been well intended, it did not have the expected results. Its vision was to make sure that every county had a referral hospital that had adequate staff, equipment and was fully functional. By mid-2014, it became clear that the devolution of health care was not a well thought plan. First, county governments were not ready in that they did not have the necessary infrastructure to shoulder such responsibility. For example, some countries did not have a hospital big enough to serve as a county referral hospital as well as satisfactorily meet up to the pre-defined standards of a county referral hospital. Second, the problem of

CEU eTD Collection

ghost workers[1] worsened and this subsequently resulted in shortage of funds (Mutai 2015) making the county governments completely running out of money to pay out as salaries. This problem has always been there but it has been worsened by the devolution process (Hope Sr. 2014). Finally, the poor harmonization that existed between the county governments resulted in a spur of strikes all over the counties and close to 189 doctors resigning. Months after devolution, nurses all over several counties claimed that they had either not received their pay or the pay was delayed. County governments pointed a finger at the central government that the disbursement of funds from the national government was slow and delayed.

In mid-March of the 2014, there were heated debates in parliament on whether the county governments should be stripped of their roles in the healthcare sector. This debate came after 189 doctors resigned. The Departmental Committee on Health in the house recommended that a special task force be formed to reverse the devolution of health services and stated that this process of devolution should be done on phases and not in the hurried way it was initially conducted (Oyomo 2015). Some counties with visionary leaders have seen a successful implementation and installation of good county referral but other are still struggling which at the end of the day still does not fulfil the goal of devolution.

2.5.Doctor training in Kenya

Kenya boasts of some of Africa's well renowned medical universities such as the University of Nairobi, School of Medical Sciences. In total, there are 11 approved medical schools in the country and 7 of them have been approved and awarded recognition at East African Community (EAC) partner states. Most of the doctors and nurses are educated locally and a small percentage of these doctors obtain education internationally and return to practice.

[1] A **ghost** employee is someone recorded on the payroll system, but who does not work for the business. The **ghost** can be a real person who knowingly or not is placed on the payroll, or a fictitious person invented by the dishonest employee. The fraud attacks the payroll system with false **employees**. This is a problem experienced by many other developing countries (e.g. India).

Every doctor and nurse is expected to have a year of internship at a public hospital after graduation. While undertaking their studies, they are exposed to the Kenyan healthcare system through rotations in several fields such as pediatrics, midwifery, emergency rooms and trauma amongst many others.

Medicine is considered one of the toughest courses that one could and undertake and a good percentage of those who enroll for medical school do not make it to the end. However, what's commendable is the fact that Kenya produces well rounded doctors and nurses. It is estimated that over 600 doctors graduate from medical school every year (Firshing, 2016) and despite this, the country still experiences a shortage of doctors because most of the counties are not hiring. For the sake of comparison, it is worth noting, that Hungary, a country of 10 million, forms also about 600 new doctors for its economy, and this number is regarded as critically low by the Hungarian experts.

2.6.Political, Economic and Cultural Surrounding

Developing nations often, due to their economic status suffer from issues such as poor infrastructure, lack of facilities and equipment, unemployment and poor economic health amongst other issues. These issues often pose a problem to the overall performance of the country and at the micro-level, play an influencing role in the work place. While some issues may extend to more than one sector, some are uniquely found in the different sectors. Healthcare delivery in Africa has often been plagued by many issues. The political, economic and cultural surrounding plays an influential role in overall healthcare delivery.

2.6.1. Poor working conditions

The modern working environment is changing fast and one thing that organizations struggle with is satisfying their employees so that they can keep up with the ever-changing business

CEU eTD Collection

environment and remain in business. Raziq and Maulabakhsh (2015) acknowledge that for there to be efficiency, effectiveness, productivity as well as commitment to the job, it is important for businesses to meet satisfactorily the needs of its employees through providing favorable working conditions. Satisfaction in the workplace often translates into good work and quality output and every business environment in the modern world strives to achieve this by implementing strategies that create a conducive work environment for its employees (Raziq & Maulabakhsh, 2015). In a research conducted on a shipbuilding company to determine the relationship between working conditions and job satisfaction, it was discovered that workers who worked under normal conditions were more satisfied on the job than those who were subjected to difficult working conditions. Working conditions are an important contributor to overall job satisfaction which subsequently translate to job quality (Bakotic & Babic, 2013).

Many doctors attest to the fact that the conditions under which they work are difficult and often result in them straining and in more cases, affects their overall health and mental wellbeing. One of the reasons for the poor working conditions is the absence of adequate equipment required for the daily operation of a hospital. Kenya has been cited as a trendsetter in adopting information technology into business and service operations (Bright, 2017). This being the case, not much progress has been made in integrating this technology the health care sector. It is important that the government put in a lot of effort to make sure that the use of this said technology is implemented in all sectors including healthcare. Walking into hospitals all over the country it is common to see wards/rooms equipped with outdated blood transfusion equipment or ultrasound machines. The country has an insufficient number of dialysis equipment and in more than one cited incidences, patients have been turned away because of either the absence of the required equipment, equipment malfunction or referred to other hospitals since equipment in the current hospitals are in use (BBC News, 2017).

CEU eTD Collection

Kenyatta National Hospital (KNH) is the Nation's referral hospital. Patients from all over the country are referred here by their county hospitals for further treatment. Many county government hospitals refer patients here because they do not have the equipment required for a certain treatment for example dialysis or cancer treatment. One of the interviewees for this research was a cancer patient from Nyeri who travels every Thursday to Nairobi so that she can receive her radiation treatment. It is about a two to three hours' drive to Nairobi. In order to arrive at the hospital early and be among the first in the queue for treatment, she leaves her home at 02.00 a.m. She said that on several occasions, she arrived at the hospital and was told that there was a breakdown in the equipment and had to reschedule her appointment. On the days that she receives treatment, she waits for a long time before she can receive it. The trips and treatment have drained her financially and the insurance company no longer helps in the payments. Now she has to depend on well-wishers to pay for treatments.

Aside from the absence of equipment, most hospitals lack some of the basic services such as ambulances, gurneys and wheel chairs. Some hospitals are forced to depend on the charity of the community around them because their ambulatory services have been out of service for months on. In reaching out to the local governments to find a solution to these, the answer has always been that there are no enough funds to help deal solve this crisis. Some patients are said to even have died because of the delay in ambulance service or lack thereof (Ombuor, 2016). This is tragic, but the hardships will not go away until the country will reach a much higher level of economic development (GDP/head). It is the task of the Kenyan government to explain this to the people at large, and the medical community. There is no way to create satisfactory material conditions for the healthcare sector within a generation.

CEU eTD Collection

2.6.2. *Corruption in healthcare*

Anecdotal evidence suggests that corruption is more prevalent in developing nations than it is in the developed ones. Being aware of the magnitude of corruption does not necessarily explain how serious the problem is until one looks at the underlying effects (Olken & Pande, 2011). In many countries around the world, people have been denied access to the most basic needs because of corruption. For example, some citizens go to bed hungry and others do not have access to proper healthcare while the elite in society live lavish lifestyles and seek expensive treatment abroad. In 2016, out of the 196 countries in the world Kenya was ranked 26 by Transparency International's corruption index (Transparency International, 2017).

Like most developing nations, corruption in Kenya infiltrates almost all sectors including the healthcare sector. The recent major corruption scandals in the country[2] that have gathered a lot of media attention and sparred the anger and tension among the citizens are just some among the many things that indicate an inefficient system. The infiltration of corruption into healthcare can be very devastating and its effects detrimental to human and economic progress and international security including population health (Mackey et al. 2016). Just like cancer, corruption in healthcare comes in in different ways, ranging from the absenteeism from work (Chattopadhyay, 2015, pp. 154) to 'systematic' corruption in the very institutions of healthcare. Aside from corruption, there are forms of crime which include non-governmental organizations and multinational companies participating in fraud and abuse in the highest echelons of government that contribute negatively to the Kenyan healthcare system.

The major scandal involving healthcare is the 2012 story of NHIF (National Health Insurance Fund) where around 9 million US dollars went "missing". Investigations revealed that a large

[2] One example is the National Youth Service scandal where approximately sh.791 million (US$7.91 million) was embezzled by the Ministry of Devolution and it resulted in the resignation of the Cabinet Secretary Anne Waiguru amongst other key

CEU eTD Collection

sum of this money had been paid out to “phantom” hospitals. The Public Accounts Committee (PAC)[3] in their report noted that millions in Kenyan shillings were spent on medical claims by NHIF to hospitals and other health facilities that had not yet been established or rather did not exist (Kenya Forum, 2012). It’s not clear how the scandal was resolved but, however, no one was charged and the officials who were named in the scandal were reinstated and like every other scandal it was swept under the rug.

In accordance to the NHIF rules, there are specific selected hospitals that the funds can cover medical services rendered to patients. Therefore, to get hospital expenses paid by this fund, one has to get treatment at NHIF approved hospitals. In this scandal, some of the hospitals not covered under this insurance received payments from the health insurance fund. This depleted the money in the fund and for some time, people were not able to clear their hospital bills through NHIF. Reports cite that the corruption that exists in the top management of the MoH and NHIF management as one of the reasons for the 2016/2017 health workers’ strike because payments were not being made out to the hospitals.

As most African countries Kenya is also governed by autocratic leaders who use coercive power[4] to get the public to comply (Lunenburg, 2012). For example, aside from jailing union officials who instigated the strike, the country’s President announced plans to hire doctors from Cuba, Tanzania and India to replace those who had gone on strike. He also passed a directive that no salaries should be paid out to doctors who were on strike. Coercive power often has its limits as well us undesirable consequences. For example, there tends to be a backlash effect (Dugan, 2003) as people do not like being forced into doing things. As a result, there is more and more rebellion which prolongs the problem as no solution can be

[3] This is a parliamentary watchdog charged with tracking government spending
[4] Coercive power is defined as a person’s ability to influence others’ behavior by punishing them or creating a perceived threat to do so.

CEU eTD Collection

found when it is a tug of war. In most cases, the nature of the threats is implausible. Citing one example, it is quite illogical for a doctor in Tanzania working under better conditions with a better pay to quit their job to come and work in Kenya under unfavorable conditions. Additionally, it is more expensive to get services from outside when you can find them locally because on top of being paid salaries, the government would have to pay them expatriate allowances which will drive up the salaries paid out to them.

2.6.3. Ethnicity in healthcare

Kenya as a country has several ethnic groups and in comparison, to other countries in the east African area, Kenya has been identified as a *"tribalist"* country. It is common to find the tendency to relate to people from the same tribe and ethnicity as yours and this is in every sector including healthcare. Ethnical background has become more pronounced in the workplace with devolution. The Kenya Anti-corruption commission reports that, many health workers are hired based on ethnicity and this created a lot of bitterness among staff at the hospitals and many doctors are unable to provide services in areas where they were considered ethnic "outsiders". Instead of working together, they were working against each other at the expense of the patients. Ethnicity infiltrates every sector of the Kenyan public sector and becomes problematic affecting the delivery of services.

CEU eTD Collection

3. Physician Strikes

3.1.Physician strikes around the world

In the recent years, strikes involving health workers have become a common phenomenon around the world. For example, in the past 10 years health worker strikes have taken place in developed countries such as the **United Kingdom** (January 2016 and March 2016 which mainly involved junior doctors), **France** (November 2015), **Germany** (March 2006 and March 2012), **Slovenia** (2016) (Sta, 2016), **Czech Republic** (February and March 2007) (Vagramova, Peradze, and Morrow 2009) and developing countries such as **India** (June 2012 and 2017), **Nigeria** (between 2013 and 2015, there have been a number of health workers strikes. The most recent strike in September 2017 involved resident doctors) (Oleribe et al. 2016) and **Kenya** (2012 and 2017)[5] amongst others. It is interesting to note that physician's strikes are not exclusive to developing nations. Against the backdrop of having increased physicians strikes, there is also an increase in them being affiliated to trade unions and dissatisfaction towards the kind of working conditions that they work under. These strikes often are as a result of the burden of work and low salary amongst other things.

In 2004, surgeons in **France** declared a strike to have the working conditions improved as well as have the amount paid for surgeries increased. They claimed that this rate had not been revised for over 15 years (Spurgeon, 2004). In their demands, they threatened to leave the country in search of greener pastures in Britain. Lots of patients from Britain were said to go to France in search of medical treatment and the demand for surgeons in Britain was high. According to the French employment law, they could be forced to work by the police and they intended to seek refuge in London (Henley, 2004). However, before they could make good on their threat, an agreement was signed that purposed to improve the working

CEU eTD Collection

[5] There have been more strikes in the previous years but the above mentioned are among the most recent

conditions especially install better equipment in the operating theaters and increase their salaries with extra benefits for being on call.

In March 2017, doctors in Mumbai, **India**, went on strike following an assault on three junior doctors. According to media reports and witnesses, one of the junior doctors was assaulted by the relatives of a patient suffering from chronic kidney failure who was in his care (Doshi, 2017). This incident was not the first of its kind and the news of it spread throughout the country causing a massive disruption in provision of healthcare services as over 2000 junior doctors from 17 government hospitals took to the streets in protest of the violence against them. While some of them testified that in the past they have been harassed by relatives of patients, it only extended to verbal abuse and that the physical harassment is something that had just started happening. Doctors who work at hospitals that are run by the state in Mumbai were reported to work for an average of 14-18 hours a day and at least one non-stop shift of close to 36 hours every week. Appreciation on the part of the customer for their efforts and their sacrifice is what they sought for in their strike. The strike was not centered on wage disputes but in demand for more security at the hospital for the physical safety of the doctors (Doshi, 2017).

Physician strikes have often centered on the needs of the doctors, however, there are instances where doctors have gone on strike on behalf of their patients. In 2010 the government of **Luxembourg** (one of the world's richest country in terms of GDP/capita), made the decision to reduce the budget towards healthcare funding. To protest this decision doctors and dentists downed their tools. Health care providers all over the world have often been under pressure to cut costs (Israel Medicine Association, 2011). Many of their attempts to do so have often been counterproductive resulting in higher costs and for the most part low quality health care (two things that directly affect the patients). Following the strike action,

CEU eTD Collection

the government negotiated with the physician's representatives and the decision by the government was reversed.

The government of **Greece** in March 2011 also proposed cut in budgets and privatization measures in the Greek national healthcare system. This would have meant underpaid and overworked physicians but for the most part, it would have resulted in the increased prices of providing healthcare because of privatization (eub2, 2011). In a stormy confrontation with the police in Athens, physicians strongly protested this move that also encompassed a public protest the severe cuts in the public service to deal with the economic crisis that the country was facing.

The examples cited above indicate that it is not possible to separate why physicians strike from the welfare of their patients since all of them unite so that we can have a strong, efficient and functional healthcare system. By putting pressure on senior stakeholders, employers and decision makers, physicians in countries around the world have been successful in getting the government to increase the resources devoted to healthcare and hence improving the quality of both treatment and services provided. These strike actions also play a huge role in preventing any reforms that target to undermine services in healthcare for reasons of savings on the budget (Kaplan & Haas, 2014).

3.2. Justification of Industrial Action by Doctors and Other Healthcare Workers

CEU eTD Collection

The right to engage in a strike elicits a myriad of interpretations, but they have mutated across the years. International experience in industrial action reveals that different countries have different ways of regulating strikes. In simpler terms, no two nations exhibit identical mechanisms of curbing industrial action by doctors and other workers. The right to engage in a strike is also not clearly stated in any typical international code. International standards portray flexibility and an open-ended approach in terms of limiting a worker's right to strike.

Countries employ diversified political, economic, and social inclinations, many of which have furthered the agenda of making strikes legal. Generally, the right to engage in industrial action stems from the tendency of political powers to surpass their economic authority (Dhai et al., 2011). Strikes in the health sector have a profound effect on the masses as indicated in many studies. Whereas most developed nations report minimal effects of strikes on the population, developing nations indicate huge suffering by the people as a result of strikes by doctors. It affects people from different socio-economic classes differently. In the Israeli case, strikes affect people from lower economic groups in major ways as opposed to those from higher socio-economic status. This emanates from the availability of healthcare alternatives for the rich, and the situation is reflective of many developing countries including Kenya. Strikes in developing countries cause increased patient deaths and the impact on the wider population is severe. Many patients from developing countries fall under vulnerable categories as stated in the UNAIDS criteria for the same (Dhai et al., 2011). There is need to advocate for minimum service agreements in developing nations in a bid to lessen the effects of strikes by doctors and other healthcare workers (HCWs).

3.3. ILO on the right to strike

While striking of workers in collective bargaining agreements may be presented as a right, it is easy to misuse this right. For this reason, there must be restrictions to this right that makes sure that there is no abuse of right that result in personal gains that are contrary to the needs of the patients and public. The International Labor organization (ILO) may not have clearly defined the right to strike in its conventions and recommendations but however acknowledges that one cannot be subjected to compulsory labor "as a punishment for having participated in strikes" (ILO, 1996b, p. 89 and 1996a, p. 660). It also states that striking is not just a social act but a right. The demands pursued via strike actions can be broken down into three broad categories. The first category is occupational; which seeks to improve the working or living

CEU eTD Collection

conditions of workers. The second category is trade union strike actions that fight to guarantee the rights that trade unions and their leaders have and the third and final category is political strike actions (Gernigon et al., 2000).

The first two categories do not often cause unnecessary problems and the Committee on Freedom of Association acknowledges these strike actions as legitimate. Political strike actions are often bigger in scale and unions and employees are often encouraged to create clear distinction lines between their strike action and this one. The right to strike that is molded and confined along the lines of industrial disputes likely to be resolved through signing of the collective bargaining agreement (CBA) is condemned by the Committee of Freedom of Association. The committee also has warned that strikes actions that are taken along political lines do not fall under the freedom of association and in most cases, violates human rights. Gernigon et al. (2000) presents the arguments of the committee that the occupational as well as economic interests that workers fight for through strike actions do not only touch on better working conditions or collective claims relating to occupational nature but also seek solutions to questions relating to economic and social policy. Further, it encourages that, workers and their unions should look beyond solving industrial disputes by striking but find alternative ways to solve disputes such as signing collective agreements.

The ILO, however, puts limits on who can strike and who cannot. This group that is excluded from strike action is often referred to as "essential workers" (Gernigon et al., 2000, p.20). Essential workers are defined as public sector employees who provide essential services. Essential services are those services that the public cannot do without. According to the law, essential workers are not prohibited by the state from striking but there should be minimum operational services provided in the event that there is a strike. Simply put, they are not allowed under any circumstance to withdraw their labor completely; they must make sure that

CEU eTD Collection

whenever strike action is called for, then there should be minimum services provided for example in the case of doctors, first aid and other basic services need to be provided.

3.4.Major Themes Present in the Context of Striking Physicians

The reasons for the strike actions usually are not any different from the causes that result in the disaffection of doctors towards their work or brain drain. Most doctors who have left South Africa's public sector before for greener pastures either overseas or in private practice have always cited poor working conditions, challenges with infrastructure, management issues and poor salaries. There are major themes that are present in the context of striking physicians that will be discussed below.

3.4.1. Organization changes in healthcare services over the years

The practice of medicine has over the years transformed from its Hippocratic roots. While competence is expected to remain or rather improve over the years, the doctor patient-relationship has changed as the patients are much more demanding and knowledgeable (especially in the developed countries). Overall, the face of delivery of healthcare along with the environment in which it is undertaken is fast changing giving rise to several challenges for healthcare workers. One of the main challenges is the rise in 'consumerism'(Chima, 2013). Consumerism is defined as the protection of consumer interests. Due to consumerism, the role of physicians is changing from purely professional based on charitable paternalism to service provision and like every other employee in a managed setting. Further, the laws that govern the welfare of the patient are often complex and most of the time contested. This obligates the physician to look after the best interests of the patient and this even gives rise to shared decision making.

CEU eTD Collection

In the past, the physician was the sole arbiter over a patient's health. However, with the increase in technology, the doctor's advice is often challenged and they are expected to support their decisions with evidence. The shared decision making not only applies to the demands of the patient but also extends to the decrees of the employer, insurance in the health care industry and regulations by the government. Under this new set up, doctors have become disempowered as well as frustrated because their role once considered prestigious and held in high regard has now been reduced to that of any other ordinary employee (Charles et al., 2013). This also extends to doctors in the private sector. Because of this regulatory framework coupled with modern society demands, the doctor, like any other employee must occasionally initiate negotiation for increased wages or payments by the third party to meet their personal and economic needs. On more than one occasion, such negotiations usually lead to an impasse and resolution for this is often hoped to be achieved through withdrawal of labor (Cruess & Cruess 2011).

Evidence suggests that, about forty years ago, before managed care[6] came into play, provision of healthcare could be likened to a retail transaction. Here, a patient would go to a doctor of their choice and their employers would pay the physicians through the pooled company insurance policy. The payments were proportional to the cost of the procedure carried out on a patient. If more services were rendered, the payments would be more to either the physician- for those in private practice or the hospitals. Here the physicians or hospitals had more control as they were in a better position to pay their employees and get better equipment as this would attract more patients (Chima, 2013). However, with the birth of managed healthcare, services are charged at a fixed rate regardless of the number of

[6] Managed care or often referred to as managed healthcare describes a group of activities that are apparently aimed towards reducing the costs of providing healthcare while at the same time improving the quality of the services being provided. According to the Merriam Webster definition, managed care is a system of health care such as Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) that controls costs by placing limits on physician's fees and restricting patient's choice of physicians.

CEU eTD Collection

procedures carried out. This has immensely limited the income stream of health care organizations and physicians. While this may not be true for all sectors, there are other factors changes in the industry that have resulted in a change in the way the doctor and patient relate (Williams, 2004). For example, there is an increasing number in malpractice suits in the UK against health care workers. In addition to this, the allocations that have been made for clinical negligence have reduced the share of money available for patient care services in the NHS. The political environment, poor leadership and the increased competition for limited resources in developing nations such as Nigeria, South Africa and Kenya amongst others are limiting the ability of governments to allocate enough funds for delivery of health care services (Nnamuchi, 2008).

3.4.2. Failure of employers to honor the collective bargaining agreements that detail improved wages and working conditions

Another more frequent source of friction that often results in striking workers is the failure of the employers-government or private- to honor already drafted collective bargaining agreements and negotiated wage agreements. In a strike by health care workers in the USA state of California, nurses and hospital assistants initiated strike action when the employers failed to give them the 10% salary increase that they had initially been promised. The failure on the employee to implement the salary changes as well as implement a 25% increase in the charges for healthcare services made the physicians feel cheated ultimately resulting in a strike (Chima, 2013). In addition to that, 1500 striking HCWs in **Philadelphia** (USA) claimed that the employer for a long time had failed to honor a CBA that was meant to address problems of understaffing, patient care as well as working conditions.

Public workers' strikes in the different ministries in **South Africa** in 2010 resulted from the failure of the government to put in place the agreements that were signed in the previous

CEU eTD Collection

years-1997 and 2007 respectively (Herskovitz, 2010). The HCWs strike in 2007 came about as a result of shoddy implementation of the agreements and the introduction of salary scales that were unfavorable. The most recent example is the doctor's strike in Kenya that was a result of the government failing to honor the collective bargaining agreement drafted in 2013 between KPMDU and the Government of Kenya through the MoH. The doctors felt cheated and their decision to go on strike was to put pressure on the government so that the CBA can be implemented.

3.4.3. Disempowerment

Physicians often feel that they are unable to best cater to the needs of the patients because of poor facilities, inadequate drugs and inadequate support from employers more so those in the public service. Another reason why physicians strike is in the quest of improved delivery of healthcare for everyone. In a certain sense, physicians are ethically obligated to provide the best service for their patients. This is the so-called Hippocratic Oath; a social norm formulated 2000 years ago at a time, when the Greek cities though of themselves as the most developed entities of the world they knew.[7] Hence, in a situation where the wellbeing of a patient is threatened through the absence of drugs or medical facilities, doctors feel stress and demotivation. Such feelings can also lead to either strike actions or service withdrawal.

3.5.2016/2017 The Kenyan healthcare strikes scenario

In 2016, the government failed to implement the CBA that was agreed upon in 2013. The agreement stemmed from another strike that took place in 2011, and the government negotiated with the doctors' union, hence a collective bargaining agreement was discussed. The doctor's union has unsuccessfully reached out to various organs of the current regime

[7] The Hippocratic Oath to which doctors are required to adhere carries the injunction: "*The health of my patient will be my first consideration*"

CEU eTD Collection

with an aim of its implementation. The organs include the courts, parliament, and the Salaries and Remuneration Commission. The country has experienced several strikes since the advent of devolved governments. Since the inception of devolved governments most health functions were devolved from the national government into counties in accordance with the new constitution that was promulgated in 2010 (KIPPRA, 2012). The two tiers of government have always collided in matters health, and this points out to the hasty nature in which health functions were devolved. Proper structures in the county governments were not initiated before health was devolved. The health bill is a typical example of bills that were supposed to direct the sector after the new constitution (KIPPRA, 2012). However, the bill is yet to be approved into law. County governments also face poor resource management issues and this has caused poor wages, delays in salary, inadequate structures, and discrimination. It is evident that the national government has done too little in terms of aligning the health sector with the spirit of devolution.

The two levels of government continue to fight on a regular basis; an issue that only frustrates the medics in the country. Industrial action remains the last resort in such scenarios, and it is evident that medics have exhausted countless avenues without success. They presume that the government only procrastinates over the collective bargaining agreement that it signed with the doctor's union in 2013. The government insinuates that all health functions were devolved, but ironically, county governments have to depend on the national government for resources. For instance, the national government leased expensive machinery on behalf of the county governments and this caused further upheavals between the two levels of government. Such actions are a breeding ground for conflicts and chaos in the health sector. The collective bargaining agreement contains several issues, but poor pay tops the list of doctors' grievances.

CEU eTD Collection

A newly employed Kenyan doctor earns 59% of the Gross Domestic Product per capita as opposed to 86% for a new Malawian doctor. Doctors in the Democratic Republic of Congo earn 154% of the same. The net income of a Kenyan doctor is US$ 800 yet colleagues in South Africa earn US$2500 (KIPPRA, 2012). These figures represent a higher incentive for brain drain and industrial action in Kenyan doctors as opposed to doctors from other parts of Africa. The Kenyan government needs to implement policies that address the plight of healthcare workers to stem migration and a continuous cycle of strikes in the country's health sector. Health facilities in the country remain understaffed and workers are faced with long hours of duty. Most facilities in the country also have little or no equipment and this affects the quality of service delivery. The government needs policies and strategies that will retain doctors and HCWs because the healthcare sector is significant in any country. Kenyan doctors who work in rural setups receive little or no perks to motivate their struggles. The country has 10,000 doctors and more than 50% serve in the private sector (KIPPRA, 2012). The public service accounts for a smaller number of doctors and most of them are found in the capital, Nairobi. It is important to note that Nairobi hosts less than 10% of the entire population (KIPPRA, 2012).

Southern African countries represent a reverse scenario and most Kenyan doctors have migrated south (Sidley 2007). The Kenyan government needs to promote harmony in the healthcare sector because strikes in this sector are distasteful. Fair labor initiatives are unavoidable, and they should be implemented on a continuous basis as opposed to periods of industrial action. Industrial unrest can be tackled effectively if the three major players in the sector engage on a continuous basis in terms of formulating solutions and policies. They include the government, employers and the unions representing doctors. Employers and the government will easily retain or motivate HCWs and doctors if they offer decent wages, adequate training, a good environment for career advancement, and reasonable working

CEU eTD Collection

hours. The collective bargaining agreement tackles most of these issues and its implementation will lead to doctor satisfaction, retention, and quality healthcare.

3.5.1. Who were the striking physicians?

The strike affected all hospitals that were run by the national government as well as those run by the regional governments commonly known as counties. Following the day of the strike, hundreds of members of KMPPDU marched through the city of Nairobi to the headquarters of the MoH and then to the Ministry of Finance. Despite this being a peaceful protest, the police fired tear gas to disperse the crowds. In the wake of the strike, every public health worker despite the rank from clinical officers, nurses, junior doctors to doctors and surgeons did not report to work (Ombuor, 2016). To worsen the situation, the Kenya Medical Association (KMA) held a press conference and stated that doctors in private hospitals would also go on a 48-hour strike as a show of solidarity. Hospitals were abandoned and those who had patients in the public hospitals checked their patients out. While some were able to afford care at private hospitals, others could not so they either took their patients to mission run hospitals or home to wait the strike out.

The number of patients at private hospitals tripled overnight and the physicians at these hospitals were working double time to make sure that the patients were being taken care of. Those without serious medical conditions were triaged and sent home. With the occurrence of this, the physicians at private hospitals were unable to honor their promise to join the public-sector physicians in the strike. However, since physicians are essential workers, some of the hospitals had a few nurses' report to work to give the first aid treatment and make referrals to other hospitals. Some hospitals however were completely abandoned with no sign of life and the doors were shut forcing those who needed immediate medical attention to travel over long distances and queue for hours to get medical attention.

CEU eTD Collection

21 days prior to the strike, KMPPDU and KNUN issued a warning during a press conference after industrial court proceedings. The unions had taken the MoH and the government to court for failing to honor the 2013 collective bargaining agreement between them. The union which is made up of over 5000 members, claimed that the agreement was meant to give doctor's a salary raise, review and improve the working conditions, revise the job structure and promotion criteria and address the problem of understaffing in state run hospitals, had not been acted upon since is drafting and signing in 2013 (Ombuor, 2016). It is not clearly stated what percentage of salary increase the doctors were demanding for. Some sources state that doctors were demanding a 300 % raise and others stated they were demanding for a 180 % raise. Two separate CBAs were drafted in 2013, one that explicitly defined the demands of the nurses and the other the demands of medical practitioners, pharmacists and dentists. These two agreements are different in their content. While that of the nurses mainly talks about wages, the other CBA touches on issues such as staffing, the rights of unions, rights of doctors, wages and the working conditions under which physicians operate.

One week into the strike, the government had negotiated with the KNUN a package deal that was accepted and the nurses were asked to report back to work. An interview with a respondent, who is a nurse by profession, revealed that nurses were offered an additional 200 US dollars on top of their monthly salary that would be disbursed in two phases. 80 % of this increase would be added to their next month's salary and they would start receiving the full amount by June. Under these new terms, the KNUN called off the nurses' strike. To the doctors, the government offered a 40% salary increase. Through their spokesperson, the doctors decided to carry on with the strike stating that they would not report to work for anything less than the initially agreed upon percentage increase.

CEU eTD Collection

3.5.2. *An Unfulfilled Collective Bargaining Agreement*

A collective agreement as defined by the Labor Relations Act refers to a written agreement that highlights the terms and conditions of employment that are made between a trade union and an employer, a group of employers or an organization of employers. The birth of the 2013 CBA between KMPPDU and the government through the MoH was preceded by a health workers strike. The consequences of this strike caused the industrial court to initiate negotiations between the government and the unions and as a result, terms and conditions of work were laid out in the CBA that was signed by both parties. The government then promised to implement the required changes started out in the CBA in phases over the next four years. However, as of 2015 December, none of the agreed upon changes had been implemented. The unions took the government to the industrial court for failing to honor their agreement. The government spokesperson, in defense of the government's decision not to implement it, stated that the government would not honor the agreement as it was "illegal" in nature. He went further to dismiss the physician's union as an organization that was looking to benefit from an illegal arrangement.

According to sources, the government had several reasons to disregard the CBA. First, it stated that the CBA was illegal because it had not been registered with the court as per Section 60 of the Kenya Labor Relations Act which requires that any CBA that is drafted between a trade union and an employer needed to be submitted to the national court of labor for registration. Second, the CBA had laid out unreasonable and illogical demands especially in terms of salaries demanded. For example, as the spokesperson highlighted, it was illogical for a medical intern to earn a lot more than a civil servant in another sector with more than ten years of experience. Third, even if the implementation of the CBA was legal, it would not be considered by the government unless it had been reviewed and approved by the Kenya Salaries and Remuneration Commission (SRC). Fourth, since the signing of the CBA, a new

CEU eTD Collection

permanent secretary had been sworn to office and he could not be held accountable for the actions of his predecessor. “The collective bargaining agreement was signed by an officer who had since left the ministry as Permanent Secretary and as such the collective bargaining agreement is invalid, has no legal force and cannot be enforced” (Kenya MoH, 2015). Finally, the government through their spokesperson insisted that health was now a function of the devolved government with exception of the Kenyatta National Hospital and Moi Teaching and Referral Hospital which were the responsibility of the national government. A larger percentage of the medical staff was now being paid by the county government and hence the national government could not be held accountable. If there was to be any collective agreement, it should exist between the workers and their respective county governments. The remarks by the spokesperson sparked a lot of anger among the employees and the unions claimed that the government was using every means possible to avoid responsibility.

Was the government right in dismissing the legality of this agreement they had initially agreed to? The question of how binding a collective agreement is, has often been asked. Several authors agree that it is legally binding to the parties involved and is punishable by law in case any of the parties in agreement are found in breach of the agreement. Despite this consensus, the laws that govern collective agreements vary from country to country. For example, in the UK, collective agreements enjoy a unique status in that they are not legally binding. That is, if any of the parties involved in the agreement acts contrary to what has been included in the agreement, then the other party cannot in any way enforce the rights that are stated in the agreement through the courts. In every other society that boasts of democracy, collective agreements between the unions and their employers are often legally binding (Gennard & Judge, 2005).

Often, a CBA details the policies and terms agreed upon between employers and employees who in most cases are represented by their union. A collective contract bargains only for its members and the collective agreement creates rights as well as duties for its members. The policies that unions seek to employ stretch only to its members and employees who do not belong to the union have their rights and duties based on the contract that exists between them and their employer. This document is a bargain between employers and employees and the final policies agreed on and signed off by both parties, legally binds them. It should be noted that, individual contracts, cannot be subtracted from the collective ones (Carlson & Moss, 2013). For example, if an employee who belongs to a union agrees with his or her employer to work for a less wage than the wage that is prescribed in the collective agreement, and there exists a collective agreement between the union and the said employer, then the employer can be sued for breach of contract. This particular employee has to exit the union to be able to make individual agreements with the employer. A collective agreement draws parallel to a legislative act, that is, it imposes compulsory terms of the employment contract of an individual. Simply put, all members of the union are seen as one person (Summers 1963). Following this logic, it is safe to say that, the signed 2013 CBA between Republic of Kenya and KMPDU through the MoH, was a legally binding agreement that obligates the government to fulfill the agreed upon terms and conditions within the given time frame.

3.5.3. *Effects of Industrial Actions on Patients*

CEU eTD Collection

Labor strikes always have unprecedented side effects. When workers down their tools, it denies the public of their services that they so much need. For example, when teachers and lecturers go on strike it denies students of the right to an education and as a consequence, students' grades are affected. This then translates into lowering their career prospects as the grades at a high school level influence the programs that one gets selected into at university. Over the years, lecturers in Kenyan universities have gone on strike and the end result has

been that degree programs that are supposed to last for about three years drag on for about four to four and a half years. In south Africa, the strike of miners resulted in extensive economic loses and a global drop in mineral prices (Kamau, 2001). The strike of motorists in Nairobi in 2013 over the increase in fuel prices and in protest of harassment by city council workers forced a lot of the city dwellers to either miss work, trek home or depend on the kindness of those with personal vehicles. These said, the magnitude of the doctor's strike was felt all over the country and some of the consequences are highlighted below.

3.5.3.1. Increased deaths

The media did report of deaths all over the country and random interviews with interviewees indicated that they had either lost a relative as a result of the strike or knew someone who had lost a loved one. Some of the sick died while on their way to private hospitals, others died while waiting in line to see specialists and others, under the care of their families because they could not afford private hospitals. For example, Dorcas Kitenge's story as followed and narrated by Al Jazeera, gives an account of a 25-year-old cancer patient who finally succumbed to cancer after failing to get proper cancer treatment. In January, she was pictured with her husband and sister-in-law outside Kijabe hospital hoping that they would find an oncologist who would perform a life-saving surgery that she so desperately needed (Kushner, 2017). Like many other Kenyans, Dorcas was seeking alternative medical attention after most public hospitals failed to have doctors to attend to the patients. She had taken ill in December in the early stages of the doctor's strike. On visiting the nearby public hospital, only staffed by nurses, the nurses who examined her told her that she had diabetes despite her and her family suspecting that there was more to her symptoms. She couldn't afford a private hospital to ascertain and confirm what she was ailing from. The nurses, not aware that Dorcas had a cancerous tumor and with no doctors at work to help her further, she was led to an early grave as she died a month later due to lack of proper care. Barely four weeks into the strike,

CEU eTD Collection

40 deaths had already been reported and this number was expected to rise for as long as the doctors were on strike.

3.5.3.2. Lack or declined access to health care services

It is acknowledged that health workers are an important part of the health system and whenever strikes happen even for a few days, the public suffers. A case study was conducted in Mombasa county of Kenya during the 2014 health worker's strike. The following table highlights the percentage decline in the services that are usually offered.

Health Care Service	Percentage (%) Decline
Outpatient attendance	64.4
Special Clinics Attendance	74.2
Deliveries	53.5
Inpatient admissions	57.8
Inpatient deaths	26.3

Table 2: Percentage decline in healthcare services in Mombasa County

From this data in the table, the percentage decline in the services is huge and a clear indication that services was adversely affected indeed. There was a sharp decline in most services but the most interesting fact about these numbers were the decline in in-patient deaths. This resulted from the fact that most patients were discharged to be cared to by their families; while some of them may have died in the care of their families, those who died under the care of the hospitals reduced in number. The deaths that happen outside the premises of the hospitals usually are not captured by the Kenya Health Information System (KHIS), which largely explains the decline in the number of recorded in-patient deaths. The attendance in special clinics recorded the highest decline (Njuguna, 2015). This was an

CEU eTD Collection

indication that patients who had conditions like tuberculosis, diabetes and hypertension had disrupted treatment and other patients such as those with STIs had delayed treatment.

In June 2013, Kenya introduced the free maternal healthcare policy. There were sufficient budgetary arrangements to make sure that pregnant women across the country could access free maternity services in any public health facilities. Under the free maternity policy, public health facilities provide maternal services to pregnant women and are later paid by the national government depending on the number of deliveries. This package came with other services such as no charge for antenatal as well as postnatal care to six weeks post-delivery. The strike adversely affected this timely intervention as it was highly likely that women who were unable to afford private medical care sort the services of traditional birth attendants[8] and relatives. These other options came with dangers such as the death of the child or the mother.

One among the many pregnant women turned away because of the strike was Rosemary Achieng'. Because there was no doctor on site to help with the delivery, she was asked by the nurses on duty to go to the nearby private hospital. She was in no condition to drive and was in excruciating pain but the nurses were adamant that they could not help her. According to her statement, she was able to deliver with the help of the security guard on duty that night. With no experience in midwifery, she could only hope for the best. The security guard was able to keep her calm and successfully deliver the baby. She was lucky to have had the baby without any complications. However, the same cannot be said for many women who went through the birthing process without specialized care.

Friedman and Keats (2014) examined the health impacts of such a health workers' strike by studying babies born during health worker strikes in Kenya. In their findings, it became clear that there was an impact of such strikes on the general health and survival of children born

[8] Commonly referred to as "*Mkunga*" in Swahili

CEU eTD Collection

during this time. The study concluded that babies born during strikes were less likely to survive and less likely to receive valuable early-life health inputs. For example, in the case that a mother is HIV positive and delivers from home, there is no qualified personnel to explain that Post-Exposure Prophylaxis (PEP) needs to be administered to the child to protect it against infection and because there is no access to proper medical care a child born under these circumstances is put at risk. Additionally, the person conducting the delivery at home may not aware of the patient's condition and is equally exposed. There also is no doctor to examine the baby and detect any issues pertaining to the health of the child that if caught early can help save the child from future complications. This in the long run affects the quality of life of the child into adulthood. In their research, Friedman and Keats (2014) acknowledge that, while there is no quantifiable data that exists on the impact of the strikes on health, qualitative studies have tried to help us understand the underlying consequences.

3.5.3.3.Increased admission to faith based institutions

In an effort to ensure that Kenyans still had access to basic medical care and to cushion patients from the effects of the strike, the health cabinet secretary issued an advisory to Kenyans in December that they should take advantage of the faith based institutions that were under the national health insurance fund. The hospitals that are covered by NHIF accept payments from the NHIF. This still limited the choices that people had to choose from and still meant that there was overcrowding at such institutions. Most of the doctors here were working overtime and still were not able to cover all the patients. A range of services were offered at these institutions from medical emergencies for example road injuries to maternity services. According to the MoH, despite there being a shortage of doctors, there were close to 500 doctors who were working across the counties were just as qualified to give proper

CEU eTD Collection

services[9]. This number still is minimal and was a clear indication that the country was facing a health crisis.

3.5.3.4.Increased sign up for private health insurance

Over the years, Kenyans have always depended on employer based health insurance or the NHIF. While these health insurance covers may provide for basic services in healthcare, it does not cover a wide range of services. In the recent past, having a private health insurance alongside the one provided by the employee or the national government has become popular. The limited scope of the NHIF cover made it very difficult for Kenyans to access medical services during the strike. There exists no data or extensive research to quantify the increased sign up for private health insurance, however, one-on-one interviews among friends, former colleagues and random questions to strangers revealed that many people decided to take a proactive role in safeguarding the future of their health. With private health insurance, people are assured of access to better health services at designated private hospitals and at good and well equipped public hospitals. Out of pocket payments make health quite expensive especially for those with terminal illnesses. The suffering that people were subjected was a wakeup call to many that having a private health insurance would present one with more options in terms of hospital services. Insurance companies that offer private insurance cover took advantage of this to sign on more clients.

3.6.Effects of Industrial actions on Doctors

Strikes not only have an impact on patients, but doctors and HCWs also bear the brunt. They have a deleterious effect of doctors in comparison with what patients undergo. Striking

[9] "The clinical officers and nurses are back to nearly 6,000 health facilities and they are skilled to give health services unless there is a need for specialized medical care. But we are working to ensure that more specialists are available as soon as possible." (Health Cabinet Secretary's speech on the crisis)

CEU eTD Collection

doctors encounter loss of income, emotional effects, and lack of job security in the course of a strike. Doctors and HCWs who opt to stay away from the strike are faced with tedious long working hours and increased bulk of work. Apparently, working relationships are also greatly affected during a strike, and loss of reputable leadership is also evident. Regardless of whether their demands are met in the end, doctors always feel disillusioned and may opt for alternative sources of employment in other countries. Brain drain is the resultant case in such scenarios and it can be either internal or external. Typical movements by doctors can portray severe implication for the profession including loss of GMC accreditation for medical institutions in a country. Brain drain always affects countries and regions in terms of disrupting healthcare provision. New Zealand and Malta are typical examples where brain drain caused major upheavals in the healthcare sector.

3.7.The 2013 Collective Agreement

The three-month strike was as a result of the unfulfilled CBA in 2013. Through comparative analysis, this section will provide an insight into the contents of the agreement and assess their viability. Of interest, are Article I through V that basically highlight the themes of the 2016/2017 health worker's strike.

Before getting into the finer details of the CBA, it is important to try and answer the question, "*Do collective bargaining rights allow employees to negotiate more generous pay and benefits packages or higher employment than they would obtain in the absence of such rights?*" (Frandsen 2016). Experience shows that the strength of collective bargaining laws determines the number of unions and how extensive they are in their coverage. The stronger the laws, the more the unions and the higher the union coverage. In addition to this, these laws have a modest impact on the wages of employees. Aside from focusing on collective bargaining rights, literature has also focused on the impact that collective bargaining has.

CEU eTD Collection

Even though collective bargaining is not the only channel through which collective bargaining rights affect outcomes, one must acknowledge its significance. However, studies on the impact of collective bargaining rights have produced mixed results.

(A. W. Smith 1972) in his study discovered that collective bargaining did not have a significant impact on the increment in salaries of school teachers. Valletta (1993), concluded in his research that union contracts have a positive impact on the employment of several departments in the municipal government. While the results on wages were inconclusive, it was clear that collective bargaining rights were important. As mentioned earlier, collective bargaining laws are not the only channels through which outcomes are achieved. For example, the mere presence of a union has always played a role in determining the wages of employees. Baugh and Stone (1982) in their research discovered that there was a large union/non-union gap of about 10% citing an example that firefighters often had a higher wage when they were affiliated to a union than when they were not-they had shorter weeks and more benefits[10]. The results may be mixed depending on the different professions. Generally, there is a positive correlation between unions and employment in the public sector.

Opponents of collective bargaining in the public-sector state that if collective bargaining rights give employees the right to negotiate better pay packages than they would in the absence of these laws, then it strains state budgets and therefore call for the revocation of such rights. Proponents of the collective bargaining rights, on the other hand, argue that revoking them could result in unfair pay and poor benefits and this subsequently results in the reduction in quality of public services that are important. All in all, collective bargaining has been put in place by a few developed countries to reduce the incidence of strikes (Frandsen 2016). A collective bargaining agreement presents the package demands of striking workers

[10] Basically, the working conditions were much better than when they individually fought for their rights.

CEU eTD Collection

altogether. It breaks down what the workers need to work efficiently and increase productivity. Unlike in the past where every problem was a separate agenda, this agreement collectively presents grievances subject to sit-downs and negotiations and binds the parties of which failure to implement the agreed upon changes results in strikes amongst other unpleasant outcomes.

3.7.1. What hinders effective implementation of collective agreements?

Quantitative data on the impact of collective bargaining agreements in the African context is minimal or non-existent. However, through case studies such as the case of South Africa, one can conclude that collective bargaining has been instrumental in protecting the wages of employees and ensuring that the working conditions are favorable (Grawitzky 2011). The role of this collective agreements has however, been limited when it comes to saving jobs or improving employment. There are several issues that have placed constraints on the outcomes of collective bargaining such as lack of trust, poor access to information, capacity issues and limited resources. First, the parties that are getting into agreement do not trust each other. For example, doctors do not trust the government to honor the agreement and implement the necessary changes and this has been proven by the fact that the 2013 CBA has not yet been implemented. The government on the other hand does not trust that the agreement will last and anticipate that despite giving the doctors what they are demanding for, soon, they are bound to ask for more and more and hence they do nothing about it.

Second, access to information. The public in many instances has always been in the dark about a lot of information including that of the yearly budget. While the health workers may have an overall picture of what has been allocated towards health care, the breakdown of how much is allocated towards the individual items is not public knowledge. In demanding for a salary raise, the government has often highlighted that doctors are being unrealistic in their

CEU eTD Collection

demands and that the government does not have the money to meet their demands. The corruption scandals that plague the nation especially the MoH does not help the situation (Hope Sr. 2014). When the government openly declares that they are not able to meet the demands of the striking workers, it causes an uproar and intensifies the strikes. It may be true that there are no available funds to deal with some of the emerging issues but without the information required, collective bargaining cannot be effective.

Finally, the limited resources. In their CBA, doctors demanded for better working conditions such as upgrade of hospital equipment and increased number of vital equipment in the major hospitals, better structured hospitals that make a place for doctors on call to rest and availability of the very basic tools such as gloves and syringes. Some of these machines are not on the Kenyan market and the budget set aside every year on health is not sufficient enough to import such machines. This makes it difficult for the respective employers to implement the demanded changes. There is also the issue of the experts required to operate these machines. Experience has shown that the government installs a machine at a referral hospital but there is no one with the required skill to operate it. The machine then stays there for months on and eventually gets damaged despite not being used.

3.7.2. Key areas of interest in the CBA

CEU eTD Collection

The CBA explicitly defines the terms of agreement under which the parties will operate. For example, it states the 2013 agreement prevails over any other previous agreements in case there is a conflict between the current and the old CBA. In addition to this, the CBA shall be valid for two years after which if the current one works, it will be renewed or if it is not favorable after two years, it will be amended. It allows for flexibility on both sides as it does not make demands as well as enforce the conditions and terms under which the demands should be met. Aside from this, Article I of the CBA acknowledges that both parties will

agree upon which is the most effective method that the required goals will be achieved. It makes provision for dialogue and debate in order to come to a mutual agreement that is beneficial to both the parties. The CBA may explicitly define the demands of the physicians but Article I stresses that these demands should be well within the laws of Kenya and any demands that violate these laws will be deemed void without necessarily affecting the integrity of the rest of the document. This severability clause allows for 30 days, in case there is section that violates the current laws of the country, for the involved parties to come up with a suitable replacement that is mutually satisfactory. These are among the other rules that protect the integrity of both parties so that one party is not considered unfair by the other party. The formation of a labor management commitment[11] is included in this section to oversee the implementation of the CBA through resolving of disputes that could probably arise from the implementation or interpretation of the CBA.

3.7.3. Union and Doctor Rights

Unions usually have rights depending on the different contexts and these rights should clearly be stated and the limits to such rights clearly defined to avoid instances where such rights are abused. Article II of the CBA dictates the limits within which the KMPDU should operate in. For example, like any other union, KMPDU must pay the necessary fee to the MoH. Additionally, it protects the rights of any physician's affiliation to unions. It forbids the MoH from discouraging anyone from joining the union and actively calls for the involvement of the ministry in the running of the union. In this way, the CBA acknowledges that physicians are not the sole responsibility of the unions but a collective responsibility of the MoH and the union. It also obligates the MoH to provide any information that concerns the union in a timely and organized manner.

CEU eTD Collection

[11] Made up of three members from the MoH and three from the Union (KMPDU 2013)

Doctor's rights often touch on the job groups, promotions, resignation as well as transfer laws. In a country plagued by tribal discrimination, there are cases where such rights are violated. Experience shows that some doctors get promotions or transfers based on their tribes and not merit. Under article III, the CBA provides binding laws and set that a doctor cannot be transferred in under 2 years at a post. In this way, despite the differences that exist in the work place, a doctor's interests are protected. This responsibility has been charged to the Ministry Posting Committee and the transference includes a relocation package- something that was not seriously enforced in the past.

Given the country's low level of development, the current medical budget does not make *enough* provision for research and development in the medical field as well as training of doctors. It does not, and it cannot. Very few benefit from the amount that is allocated and for most doctors, furthering their education or getting additional training means that they must set aside funds from their salaries to do so. In the fast-paced world that we are living in, it is important to keep up with the trends, especially in medicine. Those who are unable to fund their further training are often stuck in the same position or job group with the same salary scale. This demotivates them and in many cases, they are pushed towards seeking scholarship funding abroad subsequently draining the country of the so much needed manpower.

Article III stipulates that "All doctors employed by the government shall be eligible for sponsorship to postgraduate training after completion of two years of service after internship" (KMPPDU 2013). This sponsorship includes fully paid course fees, research and thesis funds, monthly allowance equivalent to the salary they are already earning and other allowances excluding responsibility allowance[12]. Other educational benefits are to be awarded on the basis of merit and without prejudice or favoritism. Developed nations have programs put in

[12] The Collins dictionary defines this as payments made to someone who has special responsibilities

CEU eTD Collection

place that enables doctors to attend postgraduate training without paying any tuition fees or without incurring heavy student loans. Take the United States of America as an example, instead of students paying their way through postgraduate medical school, there are universities that offer scholarships and merit scholarships as an alternative. The government gets involved by offering federally funded scholarships which are full scholarships awarded to medical students who agree to be a part of the public service for a stipulated period to cater to shortages in physicians or commit to work in active military duty as physicians. While this may be binding in one way, it immensely benefits the students because once their tenure is over, they are free to work in any place they please and apply the invaluable skills that they have learned throughout their course. While other countries around the world have in place a funding pool that enables doctors to continuously train and specialize, very little funding has been set aside for such purpose in Kenya. The efficiency and quality of a country's healthcare system primarily depends on how much is put into medical research and advancement of doctor's skills. To improve the quality of service in the health industry in Kenya, the MoH and the government in Kenya need to revise their priorities and invest much more in health care.

Kenya has a shortage of physicians, and this contradicts the fact that thousands graduate from medical schools around the country every year. Doctors provide essential services and to this effect, there should be measures put in place to guarantee the jobs right after school. If the government was to put in place a strategic program that would ensure that medical graduates are hired right after school into public service, this would take care of the physician shortage problem that the country has been experiencing since time immemorial. The current doctor to patient ratio creates a strain on the already existing doctors resulting in unfavorable working conditions which then translates into the frequent strikes. Recognizing this, the CBA obligates the MoH to create 400 new residency positions every year. The uptakes of these

CEU eTD Collection

positions will be dependent on how available training positions are at public universities where the applicants should have obtained admission into postgraduate training programmes. The time limit attached to this program obligates doctors to complete their programmes in the required time hence creating opportunities for the next rotation of students. Failure to complete the program in the stipulated time results in termination of the residency position and the position given to someone who can benefit from it. These conditions hold both parties accountable and ensures that no one stays in these programs for extended periods of time. Additionally, as per the stipulation in the CBA, while in these positions, these doctors are bound to provide their services only to public universities and hospitals and are only allowed to move to the private sector if they provide their services to the government for a minimum of three years after graduation.

The government puts a lot of emphasis on improving the educational level of workers in the country and offers incentives through scholarships to help achieve this. While other sectors have heavily benefitted from these incentives, the medical profession is sidelined. Year in year out, the government has gone into bilateral agreements with developed countries and one of the ways in which they facilitate good relations is through education. Most of these countries often offer fully paid scholarships to Kenyans in other fields aside from medicine. One major reason for this is the fact that training doctors in very expensive and most countries shy away from providing this as an option for Kenyan students to study abroad. For example, in 2016, Kenya entered a bilateral agreement with Hungary which saw close to 50 students get admitted to universities all over Hungary under scholarships. Most of the students came to study engineering, business and other fields. The government does not necessarily have to enter bilateral agreements to provide scholarships to its citizens. It could partner up with banks and other microfinance businesses to provide scholarships that specifically target those intend to further their education in medicine. Additionally, through

CEU eTD Collection

exchange programs with countries like India, well known for the good doctors or Hungary, which is a worldwide dental tourism destination, it can be able to improve the quality of doctors available on the Kenyan market.

Article III also sets terms for the job groups that doctor interns assume during and after their internship period and protects their pay. As has always been the case, the internship period lasts for one year. It has happened in the past that, doctor interns and generally interns in the medical filed have worked for months on without pay and being on internship, they are more or less bound and are not allowed to go on strike. To avoid this, under this article requires the MoH to pay the doctor interns promptly at the end of every full calendar month, failure to do so indicates breach of the said agreement. Aside from a breach of contract, it portrays lack of good will on the part of the government and this plays a major role in the future aspirations of the doctors in question. It is such inconsistencies that contribute majorly in the decision of doctor interns towards looking for greener pastures abroad or in the private sector.

3.7.4. Remuneration

Remuneration has always been a key reason behind labor strikes in Africa and around the world. It is safe to say that it precedes every other reason for strikes. History shows that most of the strikes that have happened in Kenya over the last decade have been over disputed wages. From the public to the private sector, most of the workers have always shown dissatisfaction in the pay. The CBA drafted in 2013, demanded a 180% increase in the doctor's wages. As per the current statistics, starting doctors in the public healthcare sector make as little as $14800 per year. The 180% pay rise demanded by the doctors would see the starting doctors get paid $37700 per year and mid-level doctors who now earn $15700 US dollars would get paid $40000 per year (Jamah n.d.). These current figures are relatively low when compared to their other African counterparts. For example, a starting doctor in Cameroon has an annual net salary of US$25000 and a doctor in the same level in South

CEU eTD Collection

Africa makes an annual net salary of US$30000. In African countries such as the above mentioned, doctors are offered better salaries in order to retain them. however, it is very different in the case of Kenya as the wages offered are not attractive enough to ensure high job retention.

Remuneration does not only refer to the monthly pay but also covers other benefits. As per the working time directive in Kenya, any work done outside he usual working hours needs to be counted as overtime and accordingly awarded bonuses. Normal working hours are a total of 45 hours per week from Monday to Friday with each day having a total of 8 hours each. An employee can work a maximum of hours on the weekend under special order. Any employee working the night shift cannot work for more than 60 hours per week and they are entitled to a period of rest (International Labor Organization, 2011). These regulations apply to every employee under the Kenyan law and any work done that exceeds the stipulated hours is considered overtime and should be paid. Many doctors work for prolonged hours with no breaks between one working day and another and very little or no compensation exists. Due to the shortage of doctors in the country, there are cases when doctors in some hospitals work for 48 to 72 hours nonstop. The current structure of hospitals does not provide a resting area for doctors which make the work environment more strenuous and unfriendly. Despite this input, most doctors have often mentioned that they are not compensated for the extra hours they put into service to others.

There exists a large disparity in wages between compensation for doctors in the public and the private sector. This disparity has often resulted in tension between the two sectors with blame going back and forth (Jamah n.d.). According to the Kenyan salary scale, private sector doctors, depending in their level of education and job grade, get paid between 18000-72000 US dollars per year. The perks that come with working in the private sector have often

CEU eTD Collection

attracted graduates and most of them work hard so that they can obtain employment in the private sector. Over the course of the strike KPMDU officials accused the influential hand of the private sector healthcare as being responsible for the impasse between them and the government. As per the union's secretary Ouma Oluga, the private sector, in trying to make sure that their business interests are protected, was "arm-twisting" the government to make sure that the demands of the striking doctors were not met. Their accusations were further supported by the statement made by the Cabinet Secretary of the National Treasury, Mr. Henry Rotich, that by giving the doctors what they wanted, the private sector would collapse with a mass movement of staff. That is, if doctor's in the public sector were compensated as well as those in the private sector, many doctors would move to the public sector as it provided more flexibility and time. Following this, the private sector would suffer massive shortages in manpower (this works against the goal of privatization).

Data indicates that of the US$550 million collected in insurance from the tax payers, US$330 million went to private hospitals in bills, even though private hospitals only serve one % of the entire population, 100 million US dollars was used to fund treatment outside the country in countries like India, US$70 million goes to public hospitals and $42 million towards free maternity care. The pie chart below gives a graphical representation of these figures and clearly shows that in as much as the public sector serves the larger percentage of the country, there are very little funds that flow into it to be able to give a decent pay to the doctors. The vested interests of the private sector are blamed for resulting in the government mishandling the strike by using courts to punish union officials for ordering their members not to report to work (Kajilwa n.d.). The events that happened in the duration of the strike reflected the lack of judgement and poor decision making on the part of the government in handling sensitive matters. When workers are intimidated and threatened with some sort of punishment, it builds

CEU eTD Collection

resentment and alleviates strike actions and these results in further paralysis of service administration.

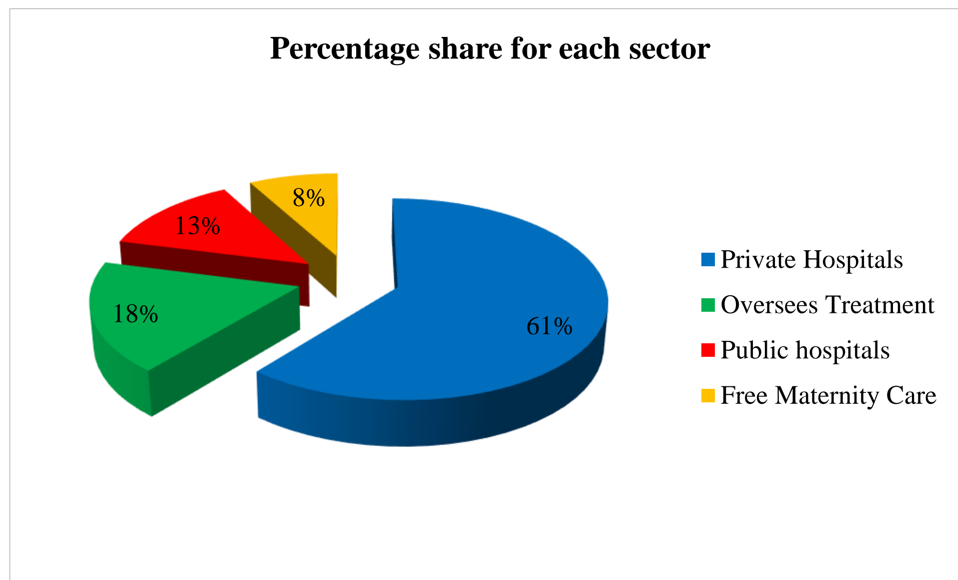

Figure 5: Percentage share of insurance spent in the different sectors

As a result of the strike, some low level-level hospitals were completely abandoned but other hospitals, especially the level five hospitals put in contingency measures in cases of emergency by having a skeleton staff[13] to take care of the emergency issues. As a justification to why the strike would continue despite the 40% pay rise counter offer by the government, Dr. Davis Ombui, the KPMDU spokesperson addressed the Kenyans and asked them not to be quick to judge doctors because, just like every other citizen, they had ailing relatives who were suffering the same predicament. There was a lot of backlash from the people and a lot of media coverage throughout the country brought out the sentiments of the citizens who felt that the doctors were being selfish in their demands and that they were going against their oath by to preserve human life by striking.

CEU eTD Collection

[13] The minimum number of **employees** needed to operate a business during a vacation, weekend, or other period when people do not normally work, or full staffing is not necessary.

Article IV of the CBA covers remuneration for physicians. Under this article, the issue of wages, which seems to be at the top of the list among the reasons why doctors downed their tools, is addressed. However, at the time of the crafting of the CBA, this article was not to be immediately implemented until the Salaries and Remuneration Committee (SRC) provided clear guidelines on compensation of doctors in public service. The KMPPDU was supposed to have a sit down with the SRC in the weeks following this agreement to negotiate the salaries for physicians and relay back to the MoH and the government the agreed upon terms. In the Kenyan system, the salaries of public servants are determined by the SRC and unless it signs off on it, no salary changes are enforced. The union provided a detailed table of the changes in salaries that they expected to be enforced once the SRC signed off on it. These detailed salary modifications were specific to the job groups and included all the necessary allowances. Doctors in hardship and rural areas were taken into consideration as their package on non-practice allowance was different from the others.

3.7.5. Work conditions

Social media became a very powerful tool during this strike and the doctors took full advantage to sensitize the citizens on the state of the Kenya healthcare system. Through their experiences, the doctors were able paint a picture of what it is to be a doctor in the Kenyan public sector. For example, Onyimbo Kerama- now working in the Democratic Republic of Congo- tells of joining the working world and how his eagerness and desire to transform the healthcare system quickly turned into disappointment and despair. Not even his internship experiences over the years in medical school had prepared him for the horrors he would face in the Kenyan wards. Aside from working eighteen to twenty-four hours, seven days in a week, he and his colleagues had to work with outdated or no equipment (Kerama n.d.). Countless times he had to watch pregnant mothers expecting healthy babies, walk into hospital and their expectations replaced with despair and stress as they left. Some of them

CEU eTD Collection

walked away with their still born babies or babies with cranial palsies[14] due to delayed birthing caused by understaffing or absence of medical personnel to perform cesarean sections.

> *"It eats away at you when you have to explain to a mother who has had a healthy pregnancy that her child has cerebral palsy. You can see the excitement disappear from her face and having the child is no longer a joy when she realizes that this is a lifelong condition. She then asks, sasa tutafanya aje daktari? (Doctor, what do we do now?) and you cannot answer because you know this was a situation that would have been preventable if the right steps were taken at the right time."* (Interviewee 1)

The disappointments they face every day create this vicious cycle where doctors and other professionals in the medical field to quit public service. The trauma that comes with losing a patient knowing fully well that their life could have been saved if they had the right equipment eats away at the doctors and this affects their overall state of mind.

For any Kenyan in need of surgery, the situation is much worse. Even at level 5 hospitals[15], there is only one operating room with less than three assigned surgeons against the thousands of Kenyans in dire need of lifesaving surgeries. Based on a first-hand account of one doctor, what is more frustrating is the fact that there seems to be some semblance of acceptance of the existing conditions among some doctors and some citizens- people have resigned and accepted things the way they are. Another interview with a nurse revealed how she had to help a woman deliver on the floor of a hospital reception because there were inadequate beds and the maternity ward was filled to capacity. To make the whole situation worse, afterwards, she had to put the mother up to share a bed with another mother for recovery. Walking into

[14] This is a brain-damage condition that affects newborns when they are deprived of oxygen during birth.

[15] Commonly known as the Provincial General Hospitals, they are expected to have adequate staffing, better equipment and shorter waiting times.

CEU eTD Collection

the maternity ward of Vihiga County Referral Hospital, it is not unusual to see mothers sharing beds or to see wards that are supposed to have 10 beds accommodate up to 30 beds.

Dr. Elizabeth Wala, a specialist in infectious diseases, worked in the public healthcare sector before leaving to work with an international non-governmental organization. She explained why her resignation had nothing to do with not loving her job but everything to do with frustrations and the pressures that doctors work under. In an interview conducted by BBC Kenya, she said,

> “Doctors don't have oxygen, sutures and sometimes not even electricity. There are cases where doctors operate with just a torch for light. They also have to cope with faulty equipment which could put them at risk of injury or infection.”(BBC News, 2017)

The fact that the working conditions and poor pay of doctors in Kenya is no secret that even other countries have attractive packages that lure them away from the Kenyan market. For example, the shortage of nurses in Malaysia has seen several Malaysian hospitals and nursing agencies hire nurses from Kenya and the packages they offer are extremely attractive. Between 1997 and 2007, approximately 2581 nurses applied to migrate out of Kenya (Gross et al. 2011). For every 4.5 nurses who enters the market, 1 nurse applies to work in other countries. Dahir, in his research *“Emigration contributes to doctor shortages in Kenya”* explains that, graduates hope to find jobs abroad in countries such as the United States, United Kingdom, Canada and South Africa. The better pay amongst other perks greatly appeals to them and those that are lucky to have the opportunity to work abroad do testify that the decision to work out of Kenya was worth it. The figure below shows the number of doctors who moved out of Kenya in 2013 in search of greener pastures. According to Dahir (2017), emigration is one of the leading causes of shortage in medical practitioners in Kenya.

CEU eTD Collection

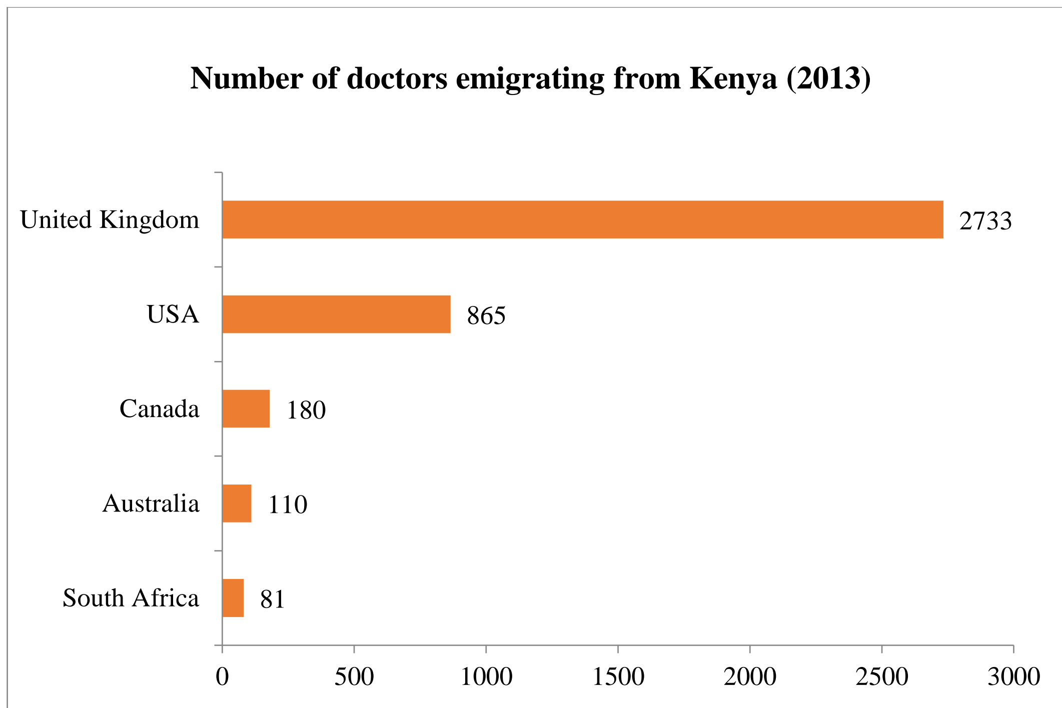

Figure 6: Data on emigrated doctors from Kenya in 2013 (Source: (Dahir, 2017))

Some interesting statistics to note about Kenya are: Kenya ranks as the 6th in Africa to have the highest number of emigrating doctors. In addition to this, the number of doctors born in Kenya that are working abroad is twice as much as the doctors working in the national referral hospitals and as ministers of health. It is estimated that the cost of educating a doctor from their primary education through university is approximately $55,000. When a doctor then emigrates from Kenya, the country loses approximately $434,000 (Kirigia et al. 2006) which could fund about 450 youth groups in the country if each of them is allocated about $1000. The country's public healthcare system is on the verge of collapse and beneath all the problems that plague the system lie poor policies, weak institutions and corruption. While the "quick fixes" by the government may pacify the crowds and deal with the problems in the short-term, without proper reforms, the country-considered one of the fastest growing economies in Africa to watch- cannot boast of an efficient healthcare system.

CEU eTD Collection

To ensure efficient delivery of services to patients, article V of the CBA demands that every doctor should be equipped with the required tools and equipment to ensure efficient delivery of quality services to the public. If it so happens that the doctor does not have the required equipment, appropriate channels should be put in place to present their grievances and have them dealt with in a timely and efficient manner. As always is the case, doctors have to be provided with adequate health professionals and support staff[16]. It is a common scene to see a doctor in a hospital in Kenya playing his role as a doctor, a nurse, an assistant and every other role. When this happens, a shift ends before the doctor can attend to all the patients which creates errors. Understaffing is a major problem in the Kenyan healthcare sector. To take care of the shortage of doctors, the CBA obligates the MoH and the government to hire 1200 doctors every year over a period of four years. It is possible to hear one say that getting that number of graduates is near impossible. Every year, thousands of students graduate from medical school in universities all over the country. A survey done in the Kenyan informal employment sector revealed that there are so many university graduates who have resigned to fate because the government is not encouraging vacancy creation in the public sector. Most of them after searching for jobs for extended periods of time decide to accept whatever jobs that come their way including manual jobs. This recruitment drive will help take care of the problem of unemployment and while it may immensely benefit graduates, it also benefits the healthcare industry by providing the required manpower to cater to the ever-growing Kenyan population.

Besides the above-mentioned issues, this article also touches on staff housing. In most countries, especially developed countries, public servants are provided with affordable housing[17]. Whenever a doctor is transferred to a new place, they are allocated housing in the doctor's quarters. Unfortunately, the ministry does not take any initiative to renovate these

[16] There must be a certain number of nurses and physician assistants allocated to every doctor
[17] In most cases, houses are given to essential workers such as policemen, teachers, doctors, firefighters amongst others.

CEU eTD Collection

houses in preparation for the next occupants. Some of the doctors interviewed for this research mentioned that they could not stay in the houses they were provided by the ministry because they were unfit to live in especially for those with families. Most of them had to seek alternative housing because if they put their own money into renovating these houses it would be a loss on their part especially when they get transferred and they have to go through the whole process again. The CBA stipulates that fit housing shall be allocated to the doctors and they shall be subject to the prevailing government rates on rent. Every year, the government sets aside a part of a budget for health, in breaking down what money goes to what sector; some money should be allocated for renovation of the doctor’s quarters.

CEU eTD Collection

4. Data Analysis

In the preceding chapters, substantial theoretical evidence has been provided to highlight the status of the Kenyan healthcare system and through literature, the negative impacts of frequent labor strikes have been highlighted. I also outlined the major themes that were present in the recent strike which are: organizational changes in healthcare over the years, failure of employers to honor drafted collective agreements and the general idea that physicians feel disempowered. The failure of the implementation of the CBA was the reason as to why the 2016/2017 physician's strike began and this was instrumental in drafting the questionnaires that were sent out to respondents. There were two fundamental goals of this data collection. One of the goals was to get an inside perspective and develop a basis for the problems so often highlighted throughout the strike and touched upon in the CBA. The other goal was to obtain recommendations from the physicians on what needs to be done about the healthcare system to alleviate the strikes. These objectives were accomplished and the findings presented in this chapter demonstrate the potential reforms that need to be carried out in the health care sector in order to improve the system from the physician's perspective.

4.1.Population and Sample

Twenty-five survey questionnaires were initially sent out to physicians and this population comprised of both nurses and doctors who worked in both the private and public sector. In addition to the questionnaires, one on one interviews were conducted and some of the qualitative responses have already been highlighted in the previous chapters of this paper. Considering that the CBA covers doctors, nurses, dentists and pharmacists, most of the respondents were doctors and nurses. In this chapter, I will present some of the data obtained from the questionnaires together with that obtained from one-on-one interviews. Most of the questions were drafted with the demands of the CBA in mind and the answers obtained were based on the fact that most of the respondents were aware of the contents of the CBA and

CEU eTD Collection

clearly understood their implications. The table below is a statistical summary of some of the responses to the questions that were the major focus of this research.

	Total Questionnaires	**Response rate**
Statistics	25 (100%)	17 (68%)
	Nurses	**Doctors**
Response Distribution	82.4%	17.6%
	Years of Experience	
More than 10 years	17.6%	
Between 6 and 10 years	58.8%	
Between 3 and 5 years	17.6%	
Less than 2 years	6%	
	Number of times you have been promoted	
Never been promoted	47.1%	
Once	23.5%	
Twice	23.5%	
Three or more times	5.9%	
	Is it ethical for health workers to go on strike?	
Yes	23.5%	
No	76.5%	
	Choice of work sector	
Public Sector	47.1%	
Private Sector	0.0%	
Work Abroad	52.9%	
	Will implementation of the CBA alleviate some of the issues that plague the Kenyan health care system?	
Yes	41.2%	
No	29.4%	
Maybe	29.4%	

Table 2: Statistical Summary of some of the responses

4.2.Response rate data

With 17 returned and useable questionnaires out of the 25, the response rate was 68 percent. Of the responses 82.4% were nurses and the remaining 17.6% were doctors all working in the public sector. One of the questions in the questionnaire was how many years of experience the respondents had. Of the respondent population, 17.6 % had worked for more than 10 years, 58.8% had worked for more than six years but less than ten years, 17.6 % had experience of between three to five years and the remaining percentage had been in the profession for less than two years. This works well for the research because the feedback of

CEU eTD Collection

those who have been in the profession long enough is invaluable and plays a major role in determining the policies that need to be put in place. In addition to this, 95% of the respondents knew what the CBA was and had read it and more than half clearly understood the role that the CBA was to play in reforming the healthcare system. 67% of the respondents were positive that if the CBA was implemented, it would alleviate the strikes and immensely improve the system.

4.3.Analysis, Findings and Discussion

4.3.1. Job Satisfaction: Poor Pay, Promotions and Allowances

It became quite evident in my research that satisfaction on the job was a problem. It is expected, especially in the developing countries like Kenya, that the promotion at work is directly proportional to the number of years of experience. While this idea may be flawed to a certain level, it plays an important role. Years of experience alone should not be used to determine whether an individual is promoted at work or not. Aside from the years of experience, there are other factors that play a role in determining whether an individual is eligible for promotion or not such as, the additional skills that the individual has obtained both soft and hard, whether the individual is fit for the role based on their track record at work and most importantly, the performance review of the individual. It is a common occurrence in the health care sector for employees undeserving of promotions to be promoted based on prejudices and their affiliations to a certain tribe or group or even their knowledge of a person in a senior position in the MoH while those who put in honest work are left in the same job group for years leading to dissatisfaction with the job and this pushes them to seek better treatment either in the private sector or abroad (Respondent 2). To the question, "In your years of service, how many times have you been promoted?" it was interesting to note that approximately 47% of the respondents had never been promoted. What was more interesting was the fact that some, while some of the respondents who had been in this job

CEU eTD Collection

group for over six years, had obtained invaluable skills and even done short term courses to increase their value and give themselves an advantage over the others, their efforts had not been rewarded.

The CBA, under Article III, pertaining to the doctor's rights, stipulates that "*Doctors shall merit promotion after serving in the same job group for a period of three (3) years in the grades within the common establishment*". The medical profession is very practical and it encourages on-the-job learning, that is, most of the skills are achieved while working and not in a classroom. Every third year in a physician's professional life, the MoH, in conjunction with the respective hospitals, must carry out performance evaluation and promote based on merit. In most developing economies, people often think with their stomach and not the brain (Malik, Danish, & Munir, 2012). The reason for this is that unemployment and destabilization are a common thing in these economies. Having said this, the most efficient way to ensure job satisfaction is to offer good pay and promotions. Job dissatisfaction is a precedent to labor strikes and to prevent this, it is important that employers take steps to improve satisfaction on the job and two major ways to do so is to reward performance through promotions and offering better pay packages. Different organizations use promotions to reward the efforts of their employees and this has been found to further improve productivity and generate good business outcomes.

Aside from promotions low pay packages, it was evident that some of the allowances that physicians were entitled to were not paid out to them. Some of the nurses interviewed, work in hardship areas and this entitles them to a hardship allowance[18]. Working in areas like Mandera, Garissa and Turkana-the northern parts of Kenya- can be a challenge, more so, because of the threat of Al-Shabab and the fact that the facilities are limited. These nurses

[18] **Hardship allowances** are normally calculated as a percentage of salary, sometimes 30 per cent or more in areas where it is particularly difficult or unpleasant to live and work.

CEU eTD Collection

should receive the same basic salary as the other nurses but should also have a hardship allowance attached to their salary. While some respondents received the hardship allowance, it was very little to make a significant difference in their lives and that it was common to find that nurses in same hardship area were earning different hardship allowances and this always led them to question the legitimacy of the allocation of these allowances. Additionally, as per the labor laws in Kenya, every employer should provide medical insurance to their employees and if not, they have to provide a medical insurance allowance that will enable the employee to purchase medical insurance of their choice. Out of the 15 responses, only 2 respondents (13.3%) acknowledged receipt of this medical insurance allowance. What's more, with the decentralization of healthcare, the nurses have only been able to receive their basic pay and the county governments asked for more time so that they can synchronize with the national government before they can disburse the allowances. However, this process is taking too long and the nurses are not getting the allowances they are entitled to.

4.3.2. Decentralization of health care

Most of the physicians agree that the decentralization of healthcare was a poorly thought and implemented plan. 90% of the respondents thought that instead of making the health care situation in Kenya better, decentralization has only made it worse. There is the understanding that devolution makes systems work better and more efficiently, however, the way in which this was carried out by the government was flawed, rushed and corrupt. One of the reasons cited as to why devolving healthcare was the worst idea by the MoH was that those put in charge of managing the whole process were politicians who did not have any background knowledge of how the healthcare system in a country should run. The bottom line, there was no clear strategy that was laid down to ensure the success of the decentralization. Another reason was that the process was rushed and responsibilities are given to the counties which did not have the necessary infrastructure in place. One of the respondents, for example, stated

CEU eTD Collection

that the responsibility of paying employees in the healthcare sector was handed down to the county governments and this led to some of the counties not being able to pay their employees for months because the money intended to pay them was "not available". The payroll is very sensitive and it would have been logical to hand down other responsibilities to the county governments and then slowly and in phases give the responsibility of payments to the county governments.

4.3.3. Physicians on the right and ethics to strike

Throughout the strike, the common citizens lamented on how unfair and selfish the doctors were by refusing to report to work. Their reason for this view was that the doctors had taken an oath to preserve human life no matter the cost. The doctors however felt otherwise. To the question, "Do you think the 2016/2017 health workers strike was justified?", all the respondents, being physicians, said yes. To support their decision, they stated that despite the economic situation of the country, the doctor-patient ratio was low, they were overworked and hence they were justified in making their demands. Additionally, just like everybody else, they felt that they had a right to demand what they were owed because they too had needs and families to take care of. The changes they were asking for, were not only for their benefit but they also had the interests of the patients at heart.

> "A lot of money is paid in taxes and it this money is well managed, it will be enough to compensate the doctors and every other civil servant who is underpaid. The corruption scandals that plague the country are the reason we do not have a well-functioning system" (Respondent 7)

While all the respondents agreed that doctors had every right to strike, they seemed divided on whether it was ethical or not to strike. To the question "In your opinion, is it ethical or not for health workers to go on strike?" 24% of the respondents said no. As discussed in earlier

CEU eTD Collection

chapters, whatever is a right may not necessarily be ethical. Strike action may be the only way in some instances to effect change and it may be presented as a right but the ethics of it are questionable.

> "I feel sorry for the patients and feel terrible that I cannot help when they need us the most but I, just like any other employee have needs and a family to take care of. It is time the government stops treating us like volunteers and pay us what we are worth" (Respondent 2)

The most interesting outcome from the survey was the choice of sector to work in. The question "Given a choice, where would you prefer to work?" was asked and unlike the usually drawn conclusions, the feedback was quite striking. Literature has shown that most of the graduates often prefer to work either in the private sector or abroad. Three choices were offered for this question: private sector, public sector and work abroad. More than half of the respondents (53%) interestingly stated that they would rather work in the public sector and the other 47% opted to work abroad. None of the respondents fancied the private sector. To follow up on the interesting feedback, I asked some of the respondent why they wouldn't opt to work in the private sector despite there being higher pay. My research uncovered that while the private sector jobs may be lucrative and better paying, on a large scale, most of them were contractual and did not offer job security like the jobs in the private sector. When it came to allowances, the private sector did not offer the allowances that the public sector offered and the work load was double with very long work hours. It became evident that working in the private sector was a risk one would have to be willing to take because job security was not assured.

CEU eTD Collection

4.4.Conclusions

The questionnaires were instrumental in uncovering some of facts and obtain more substantial results aside from that portrayed in the media. It is evident that the public sector is favored as compared to the public sector because it offers job security. Most of the graduates would rather have a job outside the country than in the private sector. And despite there being a consensus that every worker had a right to strike action, it is not necessarily ethical. In pursuit for fair working conditions, a physician puts his patients at risk and goes against the ethics of his profession. Aside from this, it was also concluded that if the government would be reasonable enough to implement the changes that were suggested in the CBA, the number of strikes in the public sector would significantly go down. Finally, the decision by the government to decentralize healthcare was not a well thought out plan and is one of the major reasons as why the health care system in the country is deteriorating. To be able to solve some of the problems that plague the healthcare sector, it would be wise to give back management of healthcare back to the national government.

The next and final chapter of this paper is on policy recommendations. The recommendations presented here are for consideration by the government and the MoH. In the author's opinion, if considered, they will goa long way in mending the system and shaping healthcare in Kenya.

CEU eTD Collection

5. Conclusions and Policy Recommendations

Strikes by doctors and other healthcare workers present many challenges to the healthcare sector in many countries. It is evident that strikes are a global occurrence and they negatively affect the quality of healthcare in any setup that portrays a doctor-patient rapport. Strikes serve as the last resort taken by workers in a bid to solve a prevailing impasse that emanates from collecting bargaining arrangements. Doctors and healthcare workers, unlike workers from other fields, usually face a moral dilemma in terms of considering either their own interests or fulfilling their obligation to save lives (Dhai et al. 2011). Many ethical principles come to the fore in such circumstances, but it is evident that doctors are typical human beings with a myriad of needs that should be settled. Doctors are entitled to a justifiable wage that matches their input despite encountering moral obligations in form of saving lives. Governments need to enforce policy solutions that serve the interests of both sides in a collective bargaining agreement (Dhai et al. 2011). Both factions need to strike a balance in securing their best interests. Strikes in the health sector are increasingly becoming a common phenomenon across the world. It is evident that both developing and first world countries have experienced health sector strikes since time immemorial. Kenya, Nigeria and the United Kingdom have experienced strikes by healthcare workers and doctors in the recent past.

5.1.Brain Drain and Typical Migration Risks Posed by Doctors

Brain drain in developing countries is an aspect that cannot be underrated. Disillusioned doctors who must engage frequently in strikes to get their demands met suffer attrition and this then plays a role in brain. Doctors and HCWs therefore create a cycle of shortages in terms of labor when they decide to relocate to other countries. Healthcare workers certainly need motivation and this area should be treated with utmost urgency (Kangasniemi et. al., 2010). The Kenyan government should embrace proactive policies that enhance motivation in order to reduce the incentives of brain drain. The vital statistics in many developing countries

CEU eTD Collection

remain discouraging, and the idea of depriving the masses of required healthcare for months is distasteful. The workforce in the healthcare system across Africa needs to be retained at all costs. Interventions and policies aimed at reducing doctors' immigration to other countries remains inevitable in the African continent. When doctors get wages that reflect their output value, they are likely to stay in their country of origin, and this not only discourages leaving their countries, but also encourages their stay in public health facilities (Kangasniemi et. al., 2010).

Employers need to consider the plight of employees as well as avoid power struggles. These are the main causatives of industrial action by healthcare workers across the continent. Governments tend to engage in threats and mass firing of healthcare workers and doctors in a bid to address the impasse. However, such actions only serve to prolong the strikes and this leads to resentment and brain drain. Threats and punitive measures also serve to deny the population of its right to access medical care as intended by governments. Parties, therefore, need to be ethical in their approach whenever strikes are evident (Kangasniemi et. al., 2010). Setups with an already compromised healthcare system should warrant more ethical considerations in solving labor disputes. Effective policy directions by governments are also significant in regulating and decreasing the number of strikes.

5.2.Fiscal Decentralization and Rural Inclusivity Policies

There is every indication that low staffing in the Kenyan healthcare system serves to disillusion workers and it is a typical causative of industrial unrest (KIPPRA, 2012). Previous policies have attempted to address the issue, but staffing issues, especially in rural areas persist. Policies lack incentives that are effective in ensuring that doctors begin to appreciate working in the rural areas. Under the economic stimulus program, the government resorted to hiring nurses and other medical cadres on contractual basis. There were arrangements to reabsorb the hired workers at the end of their contracts. These initiatives effectively

CEU eTD Collection

mobilized the health sector in a bid to close the gaps, but long-term effects of the plan were absent. The government of Kenya, however, needs to participate actively in the process through allocation (KIPPRA, 2012). Lessons from the plan needed to be implemented in stocking health workers where shortages were conspicuous. The government also had to provide resources that would enable magnitudes of contract healthcare workers to be allocated adequately in donor-funded schemes. These strategies failed to take course largely because of the government's inability to provide support (KIPPRA, 2012).

The issue of providing incentives for workers to work in rural areas can be addressed in certain policies that have proved effective in other countries. Most counties fall under rural healthcare category and the prevailing impasse between the national government and county governments, in terms of limited resources, serves to heighten the need for industrial action. In a bid to address these issues strengthening of the demand for doctors in rural setups is inevitable (Gopalan et al., 2014). This can be done through increasing funds that target rural and county health facilities. Many countries have implemented fiscal decentralization and the results are commendable. Funding for county governments may be done by virtue of transferring block grants. Ethiopia and Uganda are typical examples. Counties like Rwanda funds for rural setups directly to the institution (Gopalan et al., 2014). These funds effectively calculate the needs or poverty of the region in relation to an equity formula. This approach increases the demand for workers in rural areas.

The increase in monetary and other incentives serves as the best policy option in increasing and attracting healthcare workers who cannot be easily convinced to work in rural areas. There are direct financial incentives, indirect incentives and a combination of both is set to increase the demand for workers in rural areas, as well as their satisfaction. Direct financial inducements entail bonuses, hardship allowances, and other financial gains. Housing, spousal

CEU eTD Collection

employment, travel subsidies, and insurance options form the non-financial incentives (Gopalan et al., 2014). These incentives are grouped further into three categories and they include reduced workloads, career development, and lifestyle incentives. It is evident that changing wages to suit the demands of health workers can be difficult due to constraints from the national government and market forces. However, the rural facilities can compensate for this issue through providing essential non-wage incentives. Working conditions, training factors and lifestyle are part of these benefits. Wage bonuses that proportionately satisfy prospective rural workers are associated with increased labor supply in those areas. Doctors and nurses tend to incline towards rural job offers when houses and facility equipment are superior. The Kenyan government can emulate Ethiopia and Zambia in implementing such standards. Sub Saharan countries that implemented these policies mainly observed a mixed approach where both financial and non-financial incentives were used. Many sub-Saharan countries have tested at least one type of incentive policies and Kenya should try them as well.

5.3.The Economic Policy on Financial and Non-Financial Incentives

The economic policy proves effective in determining the correct allocation of funds and the required framework through which healthcare facilities thrive or fail. This policy dwells on financial incentives and disincentives. Studies prove that it effectively influences the decisions made by all calibers of personnel involved in medical practice. Medical personnel highly endeavor to financial gains as an incentive of important decisions concerning their careers. Payment mechanisms should not be ignored because they possess significant implications in terms of policy and the medical practice. They can greatly reduce industrial unrest and worker dissatisfaction if carefully implemented. However, the value system of the doctors and interplay between the incentives and disincentives play a major role in determining its efficacy. Organizations are normally associated with a composition of

CEU eTD Collection

intriguing clusters of people. Therefore, it is challenging to ensure that this group of people within an organization becomes productive. In order to ensure that productivity is achieved, the use of power albeit in its many forms becomes inevitable. The power structures of organizations and systems are embodied in the proper asset's distribution, and financial resources are important in the process (Ben-Ner and Ren 2015).Economic issues in the Kenyan healthcare sector have been avoided for a long time.

The current collective bargaining agreement and its focus on financial incentives have changed the way people view resources and their importance in the healthcare sector. Doctors rarely focus on financial issues and that is the perception that many people carry in relation to the medical profession. A cost-effective implementation of human resources is of great importance in the medical field. The healthcare system should not be neglected when the issue of financial incentives arises. Financial incentives direct the energies and reactions of people in other fields and the healthcare system is not different. Money may rarely present itself as a critical need for HCWs and doctors, but it has always been critical in solving and satisfying everyone's needs including doctors. Research indicates that remunerations costs for doctors mostly account for 26% of all healthcare costs, but their input generates 80% in terms of treatment decisions (Kangasniemi et. al., 2010). Allocation of these funds within the system will therefore determine the effectiveness of the sector and consequent reforms.

5.3.1. Target Payments

Target payments are typical incentives that can boost the morale of Kenyan health workers and avert frequent industrial unrests. These payments are given to medical practitioners after they provide specialized services to a given population size. For instance, the UK offers incentives for general practitioners after they screen a certain percentage of the population for cervical problems. An additional lump sum bonus is given to practitioners who achieve more than 50% of their area of coverage. Additional incentives are rewarded to practitioners who

CEU eTD Collection

surpass the 80% mark (Friedberg et al. 2014). The strategy was effective in increasing the number of cervical cytologists that general practitioners carried out in the United Kingdom. Special payments are also effective in boosting the morale of healthcare workers and increasing their profitability (Ben-Ner and Ren 2015).

5.3.2. Special Payments

Special payments are designed to identify additional workload by medical practitioners in a specific target group. These payments also encourage GPs to increase their targets in order to achieve the designed payments (Friedberg et al. 2014). The UK for instance increased payments for general practitioners who registered new patients and those who took care of the old. Practitioners face difficulties in taking care of patients from marginalized rural and urban areas and they certainly need incentives. Many healthcare systems around the world pay medical practitioners some special allowances for operating in deplorable and difficult conditions. Additionally, medical workers who take care of patients with illnesses that attract stigma from the society also receive special payments (Friedberg et al. 2014). Ebola and mental illnesses are examples of situations that warrant special payments for medical practitioners. Whereas these incentives have improved the medical practice in countries around the world, others have failed to notice their importance.

For instance, Kenyan doctors and health practitioners are rarely paid special incentives before venturing into hazardous areas. Doctors working with stigmatized patients also rarely receive special payments. This implies that the working conditions experienced by these practitioners, attracts disincentives as opposed to incentives. It is important to note that incentives might eat into the nation’s recurrent budget, thus, innovative ideas are needed to compensate for this strategy. Industry players can discourage wasteful use of health resources when treating patients. Reduction of tests and other procedures can be rewarded with bonuses

CEU eTD Collection

because the end results would portray profits (Eijkenaar et al. 2013). Studies indicate that financial incentives directly affect the conduct of doctors in all spheres of their operations.

Profit sharing is another way of ensuring that doctors and other practitioners love their work (Friedberg et al. 2014). The Kenyan government can provide doctors with for-profit health facilities where they can invest in terms of shareholding. Doctors can raise their income through these ventures and contentment within the industry will be achieved. Laboratory and radiology enterprises are typical examples in this case. Doctors will benefit directly in such business ventures and a workable strategy to accommodate this avenue through the government is imperative. Doctors also have privileges in terms of prescription knowledge and selling of medicine under such arrangements will highly boost their income (Ben-Ner and Ren 2015). Measures aimed at eliminating conflict of interest should be implemented in such scenarios.

5.4.Pay-for-Performance Policy

Many policy makers across the world are turning their focus towards pay-for-performance initiatives. This approach is associated with successful outcomes, especially in countries like the US (Eijkenaar et al. 2013). It a fundamental alteration in payment methodology capable of transforming the delivery of healthcare as opposed to current systems of payment. The policy aims at aligning payments in healthcare with quality provision of services and required practices. Financial incentives in the program are linked with commendation and invigorated focus as opposed to other factors of the program. It is, however, evident that indirect benefits like improved outcomes, better alignment of practitioners and their hospitals, and improved public perception are manifest (Eijkenaar et al. 2013). Both financial incentives and indirect advantages of the program need to be understood properly before implementation by

CEU eTD Collection

healthcare providers. Technological aspects as well as available human resources should also be considered in implementing the program.

Pay-for performance entails many forms, but most financial incentives are directed towards rewarding practitioners who adhere to proper service provision. Pundits assert that next generation pay-for-performance programs will effectively reward improved outcomes in patients. Winners in the program receive both basic payments and bonuses while losers only attain basic payment (Eijkenaar et al. 2013). Relationships between physicians and hospitals have not been cordial in the recent past and the same situation is represented in Kenya. Under the pay-for-performance program doctors will find more opportunities to align with their respective hospitals. It is important to note that healthcare outcomes need collaborative instances between hospitals and practitioners. Doctors need to work closely with other hospital staff in a bid to achieve quality healthcare. Hospitals are also required to provide resources and information needed to acquire the best healthcare standards for patients. The program will be effective in providing these resources and a collaborative environment between doctors and hospital workers (Eijkenaar et al. 2013). The program enhances a unified team in expending medical operations and bridges prevalent gaps. Doctors always seek greener pastures even within their own countries and this aspect is reflective of workers across all spheres. Kenyan doctors with greater ambitions can easily identify with performance-rated hospitals and recruitment becomes easier. Under the program, doctors with encouraging performance records in prior positions secure employment in top performance hospitals (Chien et al. 2012).

The program not only enhances patient improvement, but also fosters easy recruitment and hospital-physician collaboration. There are many benefits embedded in the program and financial incentives only form a smaller portion. Apparently, the program would be costly for developing countries because of financial constrains (Chien et al. 2012). However, certain

CEU eTD Collection

portions of the policy can be tailor-made to fit the purpose of the policy. The Kenyan government, among others, may concentrate on hospital-physician collaboration and provision of easier recruitment avenues for doctors with higher ambitions. This will provide greater levels of satisfaction among healthcare providers in the country (Eijkenaar et al. 2013). Governments that clearly understand the implications of pay-for-performance program are likely to succeed in doctor satisfaction, retention, and provision of quality health care.

5.5.The Additional Duty Hours Allowance Policy as Utilized in Ghana

Additional Duty Hours Allowance is an incentive that would benefit many Kenyan doctors as well as improve healthcare provision. ADHA can be consolidated into the salaries of healthcare workers and guarantee satisfaction as witnessed in Ghana. However, the implementation requires additional resources and a lot of time as stated in the Ghanaian case (*"Migration of Health Professionals from Ghana: Trends, Drivers, and Emerging Issues.", 2014*). The Ghanaian government introduced the ADHA for doctors after a series of industrial actions. These allowances targeted doctors in the initial stages of their implementation and critics believed that it was a way of buying time and procrastinating over payment solutions for healthcare in the country. After the doctors began receiving their ADHA, other workers within the healthcare system also began to pressurize the Ghanaian government for the same (Agyepong et al. 2012).The situation became chaotic and the government was forced to include all other medical workers in the program. Issues of delays and overlapping payments were rife amid the implementation of the program to an extent that medical practitioners perceived foul play on the government's side.

This resulted in a series of more industrial actions, but the government stood firm in implementing the program. The program finally took shape in 2006 after many years of disagreements and most health workers and doctors became satisfied with final results (Gyamfi, 2011). The implementation took a lot of time, but it finally benefited Ghanaian

CEU eTD Collection

doctors and HCWs (Agyepong et al. 2012). Ghana falls under the category of developing countries and Kenya can learn a lot from its experiences in the implementation of the ADHA. Many Kenyan doctors work for long hours because of understaffing issues and the introduction of allowances for longer hours will motivate them. This approach may take long before final implementation, but long-term benefits justify the means.

5.6.Alternative Skill Mixes Policy and Possible Effectiveness in Kenya

The Kenyan government also needs to create alternative skill mixes in a bid to increase the workforce in rural areas and counties. It is evident that highly trained and experienced doctors rarely prefer working in the rural areas, thus their retention and deployment is difficult. Skill mixes aim at training professionals at lower levels to perform duties meant for nurses and doctors. This approach does not necessarily increase rural labor force, but it low-level professionals to perform complex medical intervention amid shortages of health workers (Gordon et al. 2015). Training healthcare workers to perform complex duties is a trend that continues to receive high rankings. Low-level professionals are motivated in these cases and the need to increase their professional standings is cultivated further. It is also evident that technological aspects of medical care have rapidly evolved in the recent past and this enables low-level workers to perform duties that they rarely achieve in the past (Gordon et al. 2015). This approach would help motivate Kenyan doctors who always complain of fatigue and long working hours, especially in the rural areas. The program is feasible, practical and attainable, in Kenya, and it would not strain the country's economy to unsustainable levels.

CEU eTD Collection

Appendix: Status Update

The 2017 political situation in Kenya has taken over and the most pressing issues have taken a back seat. Even with the resolution of the nurse's crisis April, there have been subsequent strikes citing that the agreed-on changes were never implemented. The nurses had initially reported to work leaving the strike to the doctors as they had come to an agreement with the Council of Governors (CoG) about their pay. However, nothing has been done yet and the agreement long forgotten, resulting in nurses boycotting their duties once again. The strikes have been as a result of the CoG failing to register with the court the agreed upon CBA with the KNUN. This situation has further deepened the health crisis the country is facing.

The high tensions between the government and the opposition have proved detrimental to the growth of the country and the lowly citizen is left to suffer through the failing healthcare system. Many authors and governments around the world realize that the health if its citizens plays a very important role in the economic growth and development of the country and make efforts to contribute towards better healthcare. The only way to deal with the rising health problems in the country is to make health an agenda and include it as a part of Kenya Vision2030[19]. Healthcare just like infrastructure and technology is a key area for any country. The health of a country's population plays an important role in its economic development and growth. Kenya has seen an important improvement in infrastructure and technology since that launch of Kenya Vision2030. This is due to the fact that resources have been dedicated to reforming the sectors that are the main focus of this vision. This has opened up Kenya to s many opportunities in trade, tourism and forged new partnerships among the East African Community.

[19] A programme launched by the Kenya's former president Hon. Mwai Kibaki which seeks to reform ten key sectors: Infrastructure, Science, Technology and Innovation, public sector, tourism, agriculture, trade, manufacturing, financial services, education and training and Business Process Outsourcing (BPO) and Information Communication Technology (ICT)

CEU eTD Collection

This is to mean that, when healthcare is put on the agenda and considered a priority enough resources are dedicated towards making it better. as it stands, it is categorized as any other sector. This does not mean that other sectors do not carry importance, but prioritizing can go a long way changing the status of a developing nation to a developed one. Without primary focus on healthcare and its subsectors, the problems that plague it will never be resolved and the current major problems that exist such as brain drain and strike actions will carry one from government to government and generation to generation.

CEU eTD Collection

Bibliography

Adams, Robert John. 2010. “Improving Health Outcomes with Better Patient Understanding and Education.” *Risk Management and Healthcare Policy* 3 (October):61–72. https://doi.org/10.2147/RMHP.S7500.

Agyepong, Irene Akua, Augustina Kodua, Sam Adjei, and Taghreed Adam. 2012. “When ‘Solutions of Yesterday Become Problems of Today’: Crisis-Ridden Decision Making in a Complex Adaptive System (CAS)--the Additional Duty Hours Allowance in Ghana.” *Health Policy and Planning* 27 Suppl 4 (October):iv20-31. https://doi.org/10.1093/heapol/czs083.

Akkerman, Agnes, and René Torenvlied. 2012. *Effects of Industrial Conflict between and within Organizations: Contagion in Collective Bargaining and the Deterioration of Work Relations*. http://www.academia.edu/download/31430420/W12-167.pdf.

Anglionby, John. 2016. “Kenya Airways Records Country’s Worst Ever Loss.” *Financial Times*, July 21, 2016. https://www.ft.com/content/006aacfe-4f44-11e6-8172-e39ecd3b86fc.

Bakotic, Danica, and Tomislav Babic. 2013. “Relationship Between Working Conditions and Job Satisfaction: The Case of Croatian Shipbuilding Company.” *International Journal of Business and Social Science* 4 (2). http://search.proquest.com/openview/fa61ca7bdcd93e2ae134447b57522943/1?pq-origsite=gscholar&cbl=646295.

Baugh, William H., and Joe A. Stone. 1982. “Teachers, Unions, and Wages in the 1970s: Unionism Now Pays.” *Industrial and Labor Relations Review* 35 (3):368–76. https://doi.org/10.2307/2522816.

BBC News. 2017. “Kenya Doctors’ Strike: The Cancer Patient and the Medic.” *BBC News*, February 17, 2017, sec. Africa. http://www.bbc.com/news/world-africa-38979953.

Ben-Ner, Avner, and Ting Ren. 2015. “Comparing Workplace Organization Design Based on Form of Ownership: Nonprofit, For-Profit, and Local Government.” *Nonprofit and Voluntary Sector Quarterly* 44 (2):340–59. https://doi.org/10.1177/0899764013512422.

Bright, Jake. n.d. “A Brief Overview of Africa’s Tech Industry – and 7 Predictions for Its Future.” World Economic Forum. Accessed April 21, 2017. https://www.weforum.org/agenda/2016/05/a-brief-history-of-africa-s-tech-industry-and-7-predictions-for-its-future/.

Carlson, Richard, and Scott Moss. 2013. *Employment Law*. Wolters Kluwer Law & Business.

Charles, Anthony G., Shiara Ortiz-Pujols, Thomas Ricketts, Erin Fraher, Simon Neuwahl, Bruce Cairns, and George F. Sheldon. 2013. “The Employed Surgeon: A Changing Professional Paradigm.” *JAMA Surgery* 148 (4):323–28. https://doi.org/10.1001/jamasurg.2013.1013.

Chattopadhyay, Subrata. 2015. “Corruption in Healthcare and Medicine.” *Indian Journal of Medical Ethics* 10 (3):153–189.

Chien, Alyna T., Kristen Wroblewski, Cheryl Damberg, Thomas R. Williams, Dolores Yanagihara, Yelena Yakunina, and Lawrence P. Casalino. 2012. “Do Physician Organizations Located in Lower Socioeconomic Status Areas Score Lower on Pay-for-Performance Measures?” *Journal of General Internal Medicine* 27 (5):548–54. https://doi.org/10.1007/s11606-011-1946-8.

CEU eTD Collection

Chima, Sylvester C. 2013. "Global Medicine: Is It Ethical or Morally Justifiable for Doctors and Other Healthcare Workers to Go on Strike?" *BMC Medical Ethics* 14 (1):S5. https://doi.org/10.1186/1472-6939-14-S1-S5.

Cruess, Richard L., and Sylvia R. Cruess. 2011. "Commentary: Professionalism, Unionization, and Physicians' Strikes." *Academic Medicine: Journal of the Association of American Medical Colleges* 86 (5):548–51. https://doi.org/10.1097/ACM.0b013e318212a93d.

Dahir, Abdi Latif. 2017. "Emigration Contributes to Doctor Shortages in Kenya." Atlas. January 25, 2017. http://www.theatlas.com/charts/HJNU1vUDe.

Dhai, Ames, Harriet Rosanne Etheredge, Merryll Vorster, and Yosuf Veriava. 2011. "The Public's Attitude towards Strike Action by Healthcare Workers and Health Services in South Africa." *South African Journal of Bioethics and Law* 4 (2):58.

Doshi, Vidhi. 2017. "Thousands of Mumbai Doctors Strike after Assaults on Hospital Staff." *The Guardian*, March 21, 2017, sec. World news. https://www.theguardian.com/world/2017/mar/21/doctors-strike-mumbai-assaults-on-hospital-staff-india.

Dugan, Maire A. 2003. "Coercive Power." Beyond Intractability. 2003. http://www.beyondintractability.org/essay/threats.

Ehsan Malik, Muhammad, Rizwan Qaiser Danish, and Yasin Munir. 2012. "The Impact of Pay and Promotion on Job Satisfaction: Evidence from Higher Education Institutes of Pakistan." *American Journal of Economics* 2 (4):6–9. https://doi.org/10.5923/j.economics.20120001.02.

Eijkenaar, Frank, Martin Emmert, Manfred Scheppach, and Oliver Schöffski. 2013. "Effects of Pay for Performance in Health Care: A Systematic Review of Systematic Reviews." *Health Policy (Amsterdam, Netherlands)* 110 (2–3):115–30. https://doi.org/10.1016/j.healthpol.2013.01.008.

eub2. 2011. "Greek Doctors Strike against Revamp — EUbusiness.com | EU News, Business and Politics," 2011. http://www.eubusiness.com/news-eu/greece-government.8ic.

Firshing, Scott. 2016. "How Severe Is Africa's Brain Drain? — Quartz." January 21, 2016. https://qz.com/599140/how-severe-is-africas-brain-drain/.

Frandsen, Brigham R. 2016. "The Effects of Collective Bargaining Rights on Public Employee Compensation: Evidence from Teachers, Firefighters, and Police." *ILR Review* 69 (1):84–112.

Friedberg, Mark W., Peggy G. Chen, Kristin R. Van Busum, Frances Aunon, Chau Pham, John Caloyeras, Soeren Mattke, et al. 2014. "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy." *Rand Health Quarterly* 3 (4):1.

Friedman, Willa, and Anthony Keats. 2014. "What Can We Learn from Babies Born during Health-Worker Strikes?" http://mit-neudc.scripts.mit.edu/2016/wp-content/uploads/2016/03/paper_521.pdf.

Gennard, John, and Graham Judge. 2005. *Employee Relations*. CIPD Publishing.

Gopalan, Saji S., Ronald Mutasa, Jed Friedman, and Ashis Das. 2014. "Health Sector Demand-Side Financial Incentives in Low- and Middle-Income Countries: A Systematic Review on Demand- and Supply-Side Effects." *Social Science & Medicine (1982)* 100 (January):72–83. https://doi.org/10.1016/j.socscimed.2013.10.030.

CEU eTD Collection

Gordon, Morris, Paul Baker, Ken Catchpole, Daniel Darbyshire, and Dawn Schocken. 2015. "Devising a Consensus Definition and Framework for Non-Technical Skills in Healthcare to Support Educational Design: A Modified Delphi Study." *Medical Teacher* 37 (6):572–77. https://doi.org/10.3109/0142159X.2014.959910.

Grawitzky, Renee. 2011. "Collective Bargaining in Time of Crisis: A Case Study of South Africa." http://adapt.it/adapt-indice-a-z/wp-content/uploads/2015/02/grawitzky_2011.pdf.

Gross, Jessica M., Martha F. Rogers, Ilya Teplinskiy, Elizabeth Oywer, David Wambua, Andrew Kamenju, John Arudo, et al. 2011. "The Impact of Out-Migration on the Nursing Workforce in Kenya." *Health Services Research* 46 (4):1300–1318. https://doi.org/10.1111/j.1475-6773.2011.01251.x.

Gyamfi, Gerald Dapaah. 2011. "Assessing the Effects of Industrial Unrest on Ghana Health Service: A Case Study of Nurses at Korle-Bu Teaching Hospital." *International Journal of Nursing and Midwifery* 3 (1):1–5.

Health Policy Project. 2016a. "Health Financing Pofile: Kenya." https://www.healthpolicyproject.com/pubs/7887/Kenya_HFP.pdf.

———. 2016b. "Health Financing Profile: Malawi." https://www.healthpolicyproject.com/pubs/7887/Malawi_HFP.pdf.

———. 2016c. "Health Financing Profile: South Africa." https://www.healthpolicyproject.com/pubs/7887/SouthAfrica_HFP.pdf.

Henley, Jon. 2004. "French Surgeons Walk Out - To London." *The Guardian*, July 22, 2004, sec. World news. https://www.theguardian.com/world/2004/jul/22/france.jonhenley.

Herskovitz, Jon. 2010. "More Than 1 Million South Africa State Workers Strike." *Reuters*, August 18, 2010. http://www.reuters.com/article/us-safrica-strike-idUSTRE67H27I20100818.

Hope Sr., Kempe Ronald. 2014. "Kenya's Corruption Problem: Causes and Consequences." *Commonwealth & Comparative Politics* 52 (4):493–512. https://doi.org/10.1080/14662043.2014.955981.

International Labor Organization. 2011. "National Labour Law Profile: Kenya." Document. June 17, 2011. http://www.ilo.org/ifpdial/information-resources/national-labour-law-profiles/WCMS_158910/lang--en/index.htm.

Israel Medicine Association. 2011. "The Physician's Strike." IMA | Israel Medicine Association. 2011. https://www.ima.org.il/eng.

Jamah, Ally. n.d. "Nurses' Strike Driven by Huge Disparities in Salaries and Allowances." The Standard. Accessed May 29, 2017. https://www.standardmedia.co.ke/article/2000226209/nurses-strike-driven-by-huge-disparities-in-salaries-and-allowances.

Joffé, George. 2013. *North Africa's Arab Spring*. Routledge.

Kajilwa, Graham. n.d. "Doctors: Private Hospitals Arm Twisting the Government on Our Pay." The Standard. Accessed May 29, 2017. https://www.standardmedia.co.ke/article/2001227626/doctors-private-hospitals-arm-twisting-the-government-on-our-pay.

CEU eTD Collection

Kamau, Anne. 2012. “Labor Strikes Are Becoming a Rising Concern across Africa.” *Brookings* (blog). 2012. https://www.brookings.edu/blog/up-front/2012/10/18/labor-strikes-are-becoming-a-rising-concern-across-africa/.

Kangasniemi, Mari, Kirsi Viitalähde, and Sanna Porkka. 2010. “A Theoretical Examination of the Rights of Nurses.” *Nursing Ethics* 17 (5):628–35. https://doi.org/10.1177/0969733010373432.

Kaplan, Robert S., and Derek A. Haas. 2014. “How Not to Cut Health Care Costs.” Harvard Business Review. November 1, 2014. https://hbr.org/2014/11/how-not-to-cut-health-care-costs.

Kenya Forum. 2012. “NHIF: Kenya’s Ailing Medical Scheme.” 2012. http://www.kenyaforum.net/2012/05/28/nhif-the-ailing-medical-scheme/.

Kenya Institute for Public Policy Research and Analysis (KIPPRA), 2012. Kenya Economic Report 2012.

Kerama, Onyimbo. n.d. “Horror of Kenya’s Public Hospitals.” Daily Nation. Accessed May 27, 2017. http://www.nation.co.ke/news/kenya-public-hospitals-horror-doctors-strike/1056-3787936-yuk53n/index.html.

Kirigia, Joses Muthuri, Akpa Raphael Gbary, Lenity Kainyu Muthuri, Jennifer Nyoni, and Anthony Seddoh. 2006. “The Cost of Health Professionals’ Brain Drain in Kenya.” *BMC Health Services Research* 6 (July):89. https://doi.org/10.1186/1472-6963-6-89.

KMPDU. 2013. “Collective Bargaining Agreement Between the Ministry of Health, Republic of Kenya and Kenya Medical Practitioners, Pharmacists and Dentists Union.”

Lunenburg, Fred C. 2012. “Power and Leadership: An Influence Process.” *International Journal of Management, Business, and Administration* 15 (1):1–9.

Mackey, Tim K., Jillian Clare Kohler, William D. Savedoff, Frank Vogl, Maureen Lewis, James Sale, Joshua Michaud, and Taryn Vian. 2016. “The Disease of Corruption: Views on How to Fight Corruption to Advance 21st Century Global Health Goals.” *BMC Medicine* 14 (September):149. https://doi.org/10.1186/s12916-016-0696-1.

Masr, Mada. 2015. “Textile Workers’ Strike,” 2015. http://www.internationalviewpoint.org/spip.php?article4264.

Maylie, Devon. 2013. “Africa Mine Tensions Grow.” *Wall Street Journal*, May 14, 2013. https://www.wsj.com/articles/SB10001424127887323716304578482390329510834.

“Migration of Health Professionals from Ghana: Trends, Drivers, and Emerging Issues.” 2014. In *Ghana: Scial, Economic and Political Issues*, C. Roscoe, 253–74. New York: Nova Science Publishers.

Morrissey, Stephen, David Blumenthal, Robin Osborn, Gregory D. Curfman, and Debra Malina. 2015. “International Health Care Systems.” *New England Journal of Medicine* 372 (1):75–76. https://doi.org/10.1056/NEJMe1415036.

Mutai, Abraham Kiplangat. 2015. “Devolution on Trial in Kenya: Case Study on Isiolo County.” January 12, 2015. https://somalianewsroom.com/devolution-on-trial-in-kenya-case-study-on-isiolo-county/.

CEU eTD Collection

Muthoki, Mumo, and Mugambi Mutegi. 2016. "Kenya Airways Staff Demand Better Pay with Strike Action." Business Daily. 2016. http://www.businessdailyafrica.com/corporate/Kenya-Airways-staff-demand-better-pay-with-strike-action/539550-3476216-474fy5/index.html.

Netherlands Enterprise Agency. 2016. "Kenyan Healthcare Sector: Opportunities for the Dutch Life Sciences & Health Sector." Nairobi. https://www.rvo.nl/sites/default/files/2016/10/2016_Kenyan_Healthcare_Sector_Report_Compleet.pdf.

Ngugi, Brian. 2015. "Teachers' Strike Highlights Kenya's Education Challenges." *Equal Times*, 2015. https://www.equaltimes.org/teachers-strike-highlights-kenya-s.

Njuguna, John. 2015. "Impact of Health Workers' Strike in August 2014 on Health Services in Mombasa County Referral Hospital, Kenya." *Journal of Health Care for the Poor and Underserved* 26 (4):1200–1206. https://doi.org/10.1353/hpu.2015.0106.

Nnamuchi, Obiajulu. 2008. "Kleptocracy and Its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria." *Journal of African Law* 52 (1):1–42.

Oleribe, Obinna Ositadimma, Iheaka Paul Ezieme, Olabisi Oladipo, Ezinne Patience Akinola, Deborah Udofia, and Simon D. Taylor-Robinson. 2016. "Industrial Action by Healthcare Workers in Nigeria in 2013–2015: An Inquiry into Causes, Consequences and Control—a Cross-Sectional Descriptive Study." *Human Resources for Health* 14 (July). https://doi.org/10.1186/s12960-016-0142-7.

Olken, Benjamin A., and Rohini Pande. 2011. "Corruption in Developing Countries." Working Paper 17398. National Bureau of Economic Research. http://www.nber.org/papers/w17398.

Ombuor, Rael. 2016. "Kenya's Doctors, Nurses Strike for Better Pay." *VOA*, 2016. http://www.voanews.com/a/kenya-doctors-nurses-strike-for-better-pay/3623644.html.

Oni-Ojo, Barrister Ebe, and A. O. Osibanjo. 2014. "Managing Workplace Conflicts in Business Environment: The Role of Alternative Dispute Resolution (ADR)." *European Journal of Business and Management* 6 (36):74–82.

Owolabi, Tife, Libby George, and Alexis Akwagyiram. 2017. "Oil Workers Go on Strike at Exxon Mobil in Nigeria: Union." *Reuters*, May 11, 2017. http://www.reuters.com/article/us-nigeria-oil-idUSKBN1871FP.

Oyomo, Samwel. 2015. "Kenya's Devolution; Taking Stock One Year On." Kenya Human Rights Commission. http://resource.khrc.or.ke:8181/khrc/handle/123456789/171.

Pham, J. Peter. n.d. "Africa's Economic Prospects in 2017: Ten Countries to Watch." Atlantic Council. Accessed May 30, 2017. http://www.atlanticcouncil.org/blogs/africasource/africa-s-economic-prospects-in-2017-ten-countries-to-watch.

Raziq, Abdul, and Raheela Maulabakhsh. 2015. "Impact of Working Environment on Job Satisfaction." *Procedia Economics and Finance*, 2nd GLOBAL CONFERENCE on BUSINESS, ECONOMICS, MANAGEMENT and TOURISM, 23 (January):717–25. https://doi.org/10.1016/S2212-5671(15)00524-9.

Savedoff, William D. 2007. "What Should a Country Spend on Health Care?" *Health Affairs* 26 (4):962–970.

CEU eTD Collection

Smith, Allen W. 1972. "Have Collective Negotiations Increased Teachers' Salaries?" *The Phi Delta Kappan* 54 (4):268–70.

Smith, Amy. 2012. "Polytech, Agribank Workers Back at Work." *The Namibian*, September 28, 2012. http://www.namibian.com.na/index.php?id=100548&page=archive-read.

Spurgeon, Brad. 2004. "French Surgeons Call off Strike Action." *BMJ* 329 (7465):530. https://doi.org/10.1136/bmj.329.7465.530.

Sta. 2016. "Slovenian Doctors on Strike, Activities to Be Stepped up." November 8, 2016. http://www.sloveniatimes.com/slovenian-doctors-on-strike-activities-to-be-stepped-up.

Tjihenuna, Theresia. 2014. "Namdeb Strike Costs N$10m a Day." *The Namibian*, August 6, 2014. http://www.namibian.com.na/index.php?id=126513&page=archive-read.

Transparency International. n.d. "Corruption Perceptions Index 2016." Www.transparency.org. Accessed June 4, 2017. https://www.transparency.org/news/feature/corruption_perceptions_index_2016.

Vagramova, Anna, Hatuna Peradze, and Elena Morrow. 2009. "Doctor Statistics in Central and Eastern Europe: Czech Republic." http://www.ephmra.org/user_uploads/dr%20stats%20report%20czech%20rep%20-%20august%202009%20final(1).pdf.

Valletta, Robert G. 1993. "Union Effects on Municipal Employment and Wages: A Longitudinal Approach." *Journal of Labor Economics* 11 (3):545–74.

"WHO | Countries." n.d. WHO. Accessed May 30, 2017. http://www.who.int/countries/en/.

"WHO | Density of Physicians (Total Number per 1000 Population, Latest Available Year)." n.d. WHO. Accessed May 30, 2017. http://www.who.int/gho/health_workforce/physicians_density/en/.

Williams, Kathleen O. 2004. "Ethics and Collective Bargaining: Calls to Action." *Online Journal of Issues in Nursing* 9 (3). http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Columns/Ethics/EthicsandCollectiveBargaining.aspx.

CEU eTD Collection