

# Health Worker Strikes in Kenya

How can we prevent them and reduce their negative effects when they happen? And what Covid-19 considerations?



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## Key Messages

- Although health worker strikes are a global phenomenon, their effects can be worst in countries with infrastructural and resource challenges, weak institutional arrangements and unaffordable alternative options for the poor
- Health worker strikes cannot be seen in isolation of the prevailing policy and health systems context. In Kenya, the prolonged strikes in 2017 highlighted the underlying and longer-term frustration amongst public sector health workers.
- Reactive responses within the public health system and the use of private facilities in the face of the strike were not enough to support health system resilience. Despite efforts by health managers to keep services running, community members reported missing health care, incurring high costs and losing trust in the public health system.
- Careful planning and monitoring is needed to stop strikes from happening, and to minimise the negative effects of strikes when they occur. At a minimum, essential services should be maintained and threats to both striking and non-striking staff avoided. Health workers should also be supported to make reasonable demands and government to respect and honour agreements made.
- In the current Covid-19 pandemic, attention to health workers' welfare and safety is critical to ensuring an effective response and to minimising the potential for future strikes. Considerations here include ensuring regular and fair pay through the pandemic, adequate personal protective equipment (PPE) and mental health support.

## Introduction

Although health worker strikes are experienced globally, their effects have been argued to be the worst in lower- and middle-income countries (LMICs). Strike actions range from merely halting work for a few hours, through curtailing of non-critical services to complete stoppage of work. Health worker strikers elicit significant ethical debates, because of their ability to harm patients and the broader public. However, strikes do not automatically impact on health outcomes such as mortality or cause a total shut down of health service delivery. Rather, the effects depend on the length of the strike, the specific strike actions adopted, responses by the management and the ability of affected populations to access alternative care.

This research explores the perceptions and experiences of frontline health managers and community members during the 2017 prolonged health worker strikes. We examine their views regarding why the strikes happened, what effects the strikes had on households and health providers and discuss strategies to minimise the potential for further strikes, reduce the negative effects of strikes when they occur, and nurture health system resilience more broadly. This work was conducted in the Kenyan Coast as part of our 'learning site' research, where researchers and health managers have a long-term relationship and work together to decide on research questions and how these questions might be answered.

### **A brief history of health worker strikes in Kenya**

Kenya's health system has experienced many chronic challenges. These include drug shortages, understaffing and underfunding. More recently, the system experienced three additional 'shocks': health worker strikes, devolution and now, the covid-19 pandemic. Between 2010 and 2016 there were six nation-wide strikes and many more regional strikes. Health workers' discontent and unrest seemingly coincided with the devolution of healthcare in 2013, with claims that the devolution process had been rushed resulting in challenges with human resource management functions. Between 2013 and 2017, a pattern had developed in which healthcare workers went on strike but returned to work with their concerns remaining largely unresolved. In 2017, a 100-day doctors strike was followed by a 150-day nurses strike. The reason given by the doctors and nurses for the strikes was the failure by government to implement Collective Bargaining Agreements (CBAs) with their respective unions. While the prolonged strikes ended, it appeared that some issues had not been resolved. Notably, at the time of our interviews -conducted immediately after the nurses' strike- nurses had not received all the agreed allowances, and their CBA had not been signed. Most respondents felt that we should 'expect more strikes', by nurses and other cadres. During the current Covid-19 pandemic, there have been new threats of strikes by healthcare providers who claim that their grievances regarding adequate personal protective equipment (PPE), risk allowances and medical cover have not been addressed.

## **Findings**

### **Perceived causes of the 2017 prolonged nurses strike**

The failure of government to implement the Collective Bargaining Agreements (CBA) for nurses was cited as the main cause of the strike. In addition, the Salaries and Remunerations Commission defined nurses as semi-skilled and thus only eligible for relatively low pay scales. These two issues resulted in feelings of unfairness:

*"So, people were demoralized, they were like there was discrimination: other cadres are important [while] others are not important... So, with that people decided we need to be recognized, let us go on strike and never come back unless our CBA is signed."*

**Hospital Manager-03.**

Further contributing factors included:

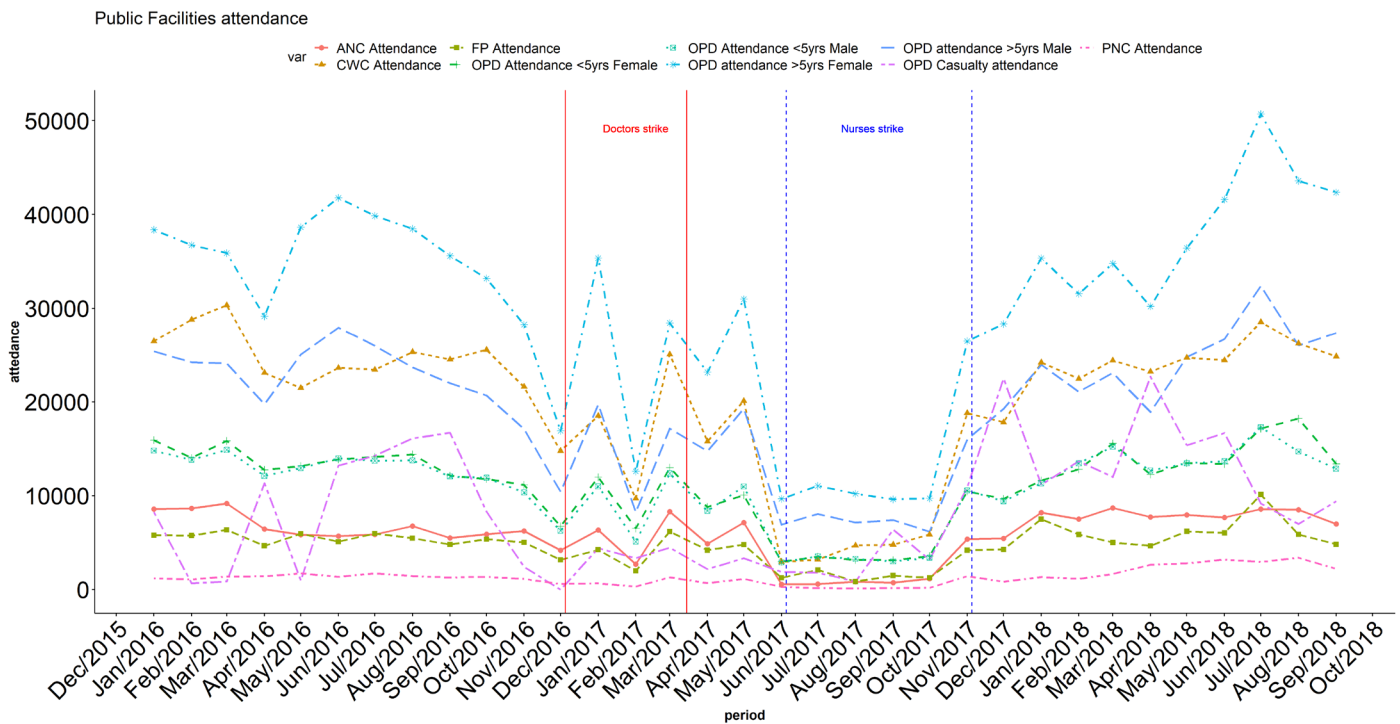
- Politics: Lack of clarity and agreement between national and county levels on how to handle national-wide strikes, and the nurses' strike occurring soon after an annulled national election and organisation of re-elections.
- Hard stances on both sides: Government

issued ultimatums including firing of striking healthcare workers which bred resistance.

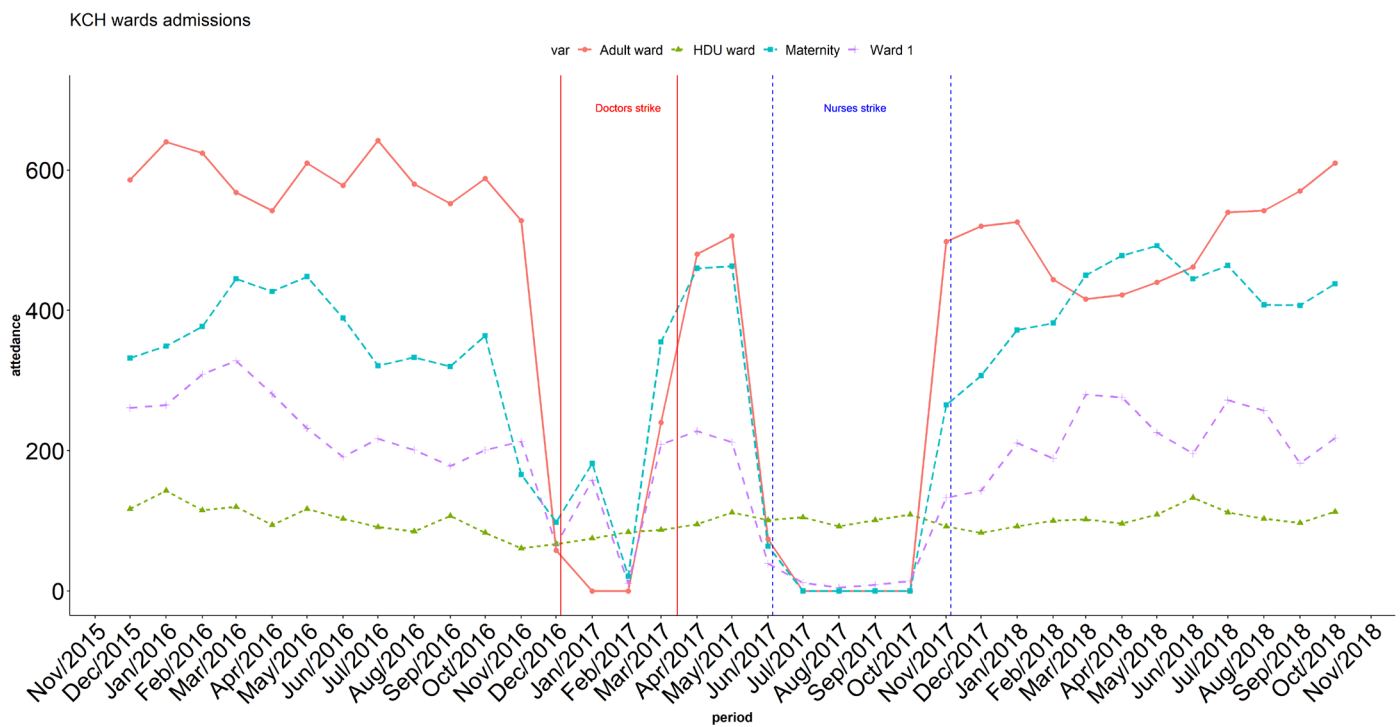
- Decision-makers were not affected: Some respondents felt that those who should have been working to solve the issue did not prioritise it because they could easily afford private care; highlighting feelings of injustice and distrust.

### **Overall perceived effects of the strikes Facility and service-related disruptions and its effects**

All public facilities in the county were severely disrupted by the health worker strikes. The nature of disruptions differed by facility level. During the nurses' strike, most dispensaries –primarily run by nurses– were closed, and many health centres ran on a 'go-slow' basis. Nurse-led services such as maternity, maternal child health and child welfare clinics were particularly affected (Fig 1). Community-based services coordinated by community health workers (CHWs) were also disrupted. During both the nurses' and doctors' strikes, there was a reported decline in hospital admissions (Fig 2) and theatre services given the interdependence across cadres at hospital level.



**Figure 1:** Outpatient services in public facilities showing sustained decline during nurses' strike



**Figure 2:** Inpatient admissions showing decline in admissions during both the doctors' and nurses' strikes



### **Households missed care with health-related outcomes**

Household members were not sure which public services were available and when. This was linked to an assumption among community members that if one cadre was on strike, all facility services would be closed. Interviewees reported significant delays in community members accessing health care due to the time spent looking for services, moving between public and private facilities and negotiating initial deposits at private facilities. Physical health-related effects reported included increased maternal and newborn deaths, long-term complications resulting from no or inadequate treatment, and large numbers of unwanted pregnancies.

### **Households sought alternative sources of care and faced increased costs**

To cope with the widespread closures and uncertainty of public sector services, many households turned to local private facilities or healers. Community respondents reported that household members had to fund raise and borrow funds or sell off precious assets such as domestic animals to afford private healthcare.

*“Now you will find it [strike] also taught people on how to look for alternative ways to coming to hospital, and if it continues that way, others might harm themselves with traditional herbs outside there.”*

**Facility Management Committee FGD-03.**

### **Health system staff felt guilty and demotivated**

Most managers found the situation exhausting and stressful, working longer hours, taking work home, and feeling anxious about where their patients were going. Cadres who continued working when others were on strike felt demotivated by being unable to perform their roles as usual. Doctors and nurses missed salaries for several months and were reported to have suffered guilt and an internal tension between adhering to their oath to do no harm to the patients but at the same time feeling obliged to fight for their interests and stand with their colleagues.

### **Loss of trust in the public health system**

The recurrence of strikes in the public sector and the disruptions brought by the prolonged strikes contributed to a ‘loss of trust’ from the public in the public sector that might have longer term effects on treatment-seeking and ultimately the public health system:

*“No, not everyone has managed to come back [to the public facility], some maybe are still going to private [facilities]. They have had bad experiences here during the strikes and this makes somebody lose trust in the government facilities. We wish our clients could come back.”*

**Peripheral Facility Manager-06.**

### **Efforts to keep services running**

In the face of major facility and service closures and disruptions, health managers enacted a range of strategies in their efforts to continue service delivery. Across these strategies we observed some positive relationships, alliances and effects across the system, but also some tensions and conflicts. Many of the strategies were piecemeal, inconsistent and difficult to sustain.

### **Prioritizing specific services and creatively using available health workers**

At hospital level, emergency services were prioritized, but even these services, were difficult to sustain with depleted human resources:

*“During the doctor’s strike she [nurse manager] had to make sure there were a few nurses, and that the nurses would actually keep the place running ... during the nurses’ strike we were doing emergency services both medical and surgical. But it was very strained because we didn’t have enough nurses to monitor post-operative patients. So, at some point we had to stop doing operations unless it’s a life-threatening case, we had to turn away mothers. It was very painful.”*

**Hospital Manager-07.**

### **Minimising and managing conflict**

During the nurses’ strike, nurses who assisted through the strike reportedly faced threats and intimidation from striking colleagues. This resulted in some nurses withdrawing their help or offering services inconsistently or secretly. In one hospital, striking nurses sent non-emergency cases to overwhelm their working colleagues. The hospital nurse manager had to intervene and calm the situation by informing them that everyone had a right to strike or not to strike:

*“... there was a division, those who were on, and those who were out. It was seen as a betrayal, the ones who were on duty it’s like they were betraying the others. So, I went to their solidarity corner and I told them it is your right to go on strike and it is*

*their right not to go on strike, so everyone to play the ball in his own court and it calmed down and we continued offering services because before I addressed them when they saw each other they were abusing each other live [out loud].*

**Hospital Manager-02.**

### **Drawing on NGO staff, other staff cadres and students**

Some NGOs employed additional staff to cover services such as HIV and TB in peripheral facilities and hospitals. There was also some reliance across the system on support staff (staff not involved in direct patient care) and other cadres. For example, support staff in some peripheral facilities dispensed drugs for minor ailments and refills for TB and HIV clients during the nurses' strike. In one subcounty, public health officers were instructed to offer immunization services (usually run by nurses).

### **Links and interactions with private facilities**

Because the above-mentioned strategies were inadequate, middle level managers used creative strategies to support access to services through local private facilities. For example, all three hospitals developed an informal system whereby

they performed emergency caesarean sections at the public hospital and took the patients to local private facilities for post-operative nursing care. A similar strategy had been employed during the doctors' strike where doctors working in the private-for-profit and NGO sector performed emergency caesarean sections in public hospitals and the public-sector nurses provided post-operative care. This pattern was to ensure the more expensive operations were performed at the public facility, and the cheaper nursing care services at private facilities, and therefore that patients were protected from catastrophic costs.

### **Support and action from the public**

Overall, there was relatively little protest and action by community members to keep public services open. One reason might be that many community members reportedly supported the need for health workers to strike. However, the perceived inappropriate handling of the strike by government leaders contributed to feelings of frustration and disillusionment in the community. In the more urban parts of the county, community members protested and in one case threatened to burn down a private facility.

## **Recommendations**

The recurrent health worker strikes, and the prolonged 2017 strikes highlight the underlying frustration amongst public sector health workers in Kenya. These issues appear to still be unresolved and health workers continue to raise grievances during the Covid-19 pandemic.

Drawing on our findings during the prolonged strike, some recommendations include:

1. National and county governments need to **appreciate the complexity of the health system and adopt systematic monitoring** of different system components and proactive thinking around possible effects of interventions and policies.
2. County and national governments need to **rebuild relationships with healthcare workers' unions** and include them in the development and implementation of policies that affect health workers. Careful consideration of the compensation packages of health workers is necessary to ensure fairness within and across cadres, and the creation of a conducive working environment to offer quality services. During these Covid-19 times, essential considerations include: the **safety of healthcare workers** (which calls for provision of adequate PPE, and **appropriate work spaces** to ensure physical distancing measures), **their mental health** (due to the strain of working long hours in response to Covid-19) and adequate and regular pay.
3. When planning and managing a strike, all parties should **consider prevailing socioeconomic and political circumstances** including avoiding deliberately planning strikes around election times or in other times of predicted disruption and distress, particularly for the poor. To ensure mutually respectful dialogue between parties, discussions may require formal independent mediation.
4. Adequate planning and preparedness is necessary because strikes remain a real possibility. Middle-level managers require **better support from higher system levels** to plan and respond to sudden shocks such as strikes. Responses should not only seek to preserve core services but also to **ensure that the poorest households and communities are protected from health-related and financial losses**. This might include maintaining emergency and essential services throughout a strike and minimizing threats and intimidation of striking and non-striking health workers.

## About this Research

### Related Publication

This brief is adapted from a research paper published under the title, "Prolonged health worker strikes in Kenya perspectives and experiences of frontline health managers and local communities in Kilifi County"  
<https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-1131-y>

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