INFLUENCE OF INDUSTRIAL ACTION ON PROVISION OF MEDICAL SERVICES BY NURSES IN PUBLIC HOSPITALS: A CASE OF RIFT VALLEY PROVINCIAL GENERAL HOSPITAL, NAKURU COUNTY, KENYA.

BY

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This research project has been submitted for examination with my approval as University Supervisor.

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ANF	Australian Nurses Federation
ANU	Australian Nurse Union
COTU	Central Organization of Trade Unions
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HWG	Health Workers Group
ILO	International Labour Organization
KMPDU	Kenya Medical Practitioners, Pharmacists and Dentists Union, Kenya Health
KNUN	Kenya National Union of Nurses
MDG	Millennium Development Goals
MRI	Magnetic Resonance Imaging
NLA	National Labour Unit
PGH	Provincial General Hospital
RVPH	Rift Valley Provincial Hospital
SPSS	Statistical Packages for Social Science
WHO	World Health Organization

medical services, to investigate the influence of walk out strikes on the provision of medical services, to identify the influence of go slow strikes on the provision of medical services and to establish the influence of picketing on the provision of medical services. The theoretical framework of this study was derived from conflict and functional theories. The study used an ex post facto design. The population of the study was 540 nurses from the hospital and a sample of 225 nurses were selected using simple random sampling. A structured questionnaire was used to collect data. Data analysis was done using Statistical Package for Social Sciences (SPSS) version 19. Descriptive statistics was computed and data was presented using tables. The findings indicated that most (89%) of the respondents noted that the number of outpatients in the hospital drop. The study also revealed that walkout strikes may cause the risk of hospitals being closed down; this was supported by 89% of the respondents, majority (87%) of the respondents also agreed that, during this period, the management is put under pressure thus unable to effectively manage and the whole process disrupts general work operations in the hospital and finally the findings indicated that most (73%) of the respondents strongly agreed that picketing disrupts daily hospital routine. It was concluded that strike activity clearly affected to a large extend the provision of medical services in the industry. Participants reported that sit in strikes, walk out strikes, go slow strikes and picketing gives employees the opportunity to occupy the work place, continue or perhaps stop work but deny the employer access to or control of the production process. The employees remain on the employer's premises, taking possession of the property and preventing the employer from entering is per se unlawful. This affects the running of the hospital activities. The study recommended that workers should be well paid so that they can meet up with their daily needs and it should not be delayed for any reason at all and that the government should stop using threats to the employee as a solution to strike action rather they should use dialogue to bring a lasting solution.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Industrial action refers collectively to any measure taken by trade unions or other organized labour meant to reduce productivity in a workplace (Hardiningtyas, 2007). Quite often it is used and interpreted as a genteelism for strike or mass strike, but the scope is much wider. Industrial action may take place in the context of a labour dispute or may be meant to effect political or social change (Rood, 2001). Provision of services has long been altered by upcoming industrial actions in organizations. According to Velden (2006) industrial action is portrayed when employees perform work in a manner different to how it is normally performed, employees adopting a practice that restricts limits or delays the performance of work, ban, limitation or restriction by employees on performing or accepting work, a failure or refusal by employees to attend work or perform any work the lockout of employees from their employment by their employer thus affecting the normal work routine and the provision of quality services.

Steve (2006) observed that the health sector and industrial action in international perspective have stated that labor's strike effectiveness and organizational strength have long been connected. Throughout history, work stoppages have been used for economic and political purposes, to alter the balance of power between labor and capital within single workplaces, entire industries, or nationwide. Industrial action has further fostered new forms of worker organization such as industrial unions that were badly needed because of corporate restructuring and the reorganization of production. Brenner(2011) reported that strikes have acted as incubators for class consciousness, rank-and-file leadership development, and political activism. In other countries, strikers have challenged and changed governments that were dictatorial and oppressive (plus union leadership no longer accountable to the membership). Brenner (2011) further indicated that in nations like Korea, France and Spain where strike action helped democratize society; general strikes are still being used for mass mobilization and political protest. In Europe, millions of workers have participated in nationwide work stoppages over public sector budget cuts, labor law revisions, or pension plan changes sought by conservative governments.

Industrial action has also been noted to influence operations in many organizations in Africa, for example in Nigeria, doctors issued a threat of strike to protest the lack of commitment of

the government to the payment of outstanding salaries and arrears(Shosanya,2013).According to National Association of Rudimental Drummers (2005), weeks after the suspension of the last strike in 2004, the health workers in most of the teaching hospitals and federal medical centres were not paid. The workers had to contend to the anti-workers policy of no work, no pay as they were only paid few days out of the period of the strike (Edward, 2006). In Chad, there is in place a complete and functional regulatory framework on industrial actions in their organizations. This framework however is only partially implemented with the contracting agreements made before 2001 having not been revised. Informal relationships continue to exist in the field on the basis of framework agreements signed on central level (Thomas, 2008).

Nyakwara (2014) pointed out that the history of industrial unrest in East African countries is relatively undocumented with only the most recent cases of industrial unrest receiving major attention both in the media and other economic forums. In Kenya, there have been spontaneous industrial unrest cases in the recent past, most notably in the early 21st century with most of these unrest cases involving employees and the government (Lukoye, 2003). Atwoli (2003) argues that most of the strikes and other forms of industrial action in Kenya have been mainly due to failure by the government and other private sector employers. He further argues that most employees revert to strikes or other alternative forms of unrest to air their grievances over unfulfilled promises by employers. Most employers, especially the government, sign agreements with employees that their demands will be met the term the sitting government is in power. However, towards the end of the term or towards the general elections, most employees realize that the deals or agreements they entered into with the employer are yet to be met and it is likely that the coming government may not honor what it did not enter into with the employees. Atwoli (2003) further argues that most trade unions in Kenya opt to push the government to fulfill its promises before the general elections are held. Consequently, it is common to experience major industrial unrest cases before or immediately after general elections, all in an attempt to force the government to honor its pledges.

1.2 Statement of the Problem

This research sought to investigate that influence of industrial action on provision of services by nurses at the Rift Valley Provincial General Hospital (RVPH)-Nakuru. There have existed several strikes by nurses at RVPH either because of working conditions, work overload

(understaffed), among other factors With strike action becoming a persistent factor in the medical sector in Kenya, it becomes a matter of importance following the significance of the sector services in realizing a better and healthy population. There is need to better understand the dynamics facing the medical practices in relation to service delivery. There is therefore a need to better understand the causes resulting to industrial action in the medical sector. This study therefore sought to determine the influence of industrial action on provision of medical services citing the case of the Rift Valley provincial Hospital in Nakuru.

1.3Purpose of the study

The purpose of this study was to investigate the influence of industrial action that is sit in strikes, walkout strikes, go slow strikes and picketing on provision of medical services by nurses in public hospitals, a case Rift Valley Provincial General Hospital Nakuru.

1.4.1 Objectives of the study

The study was guided by the following objectives

i. To determine how sit in strikes as an industrial action influence the provision of medical services in public hospitals at RVPH

ii. To assess how walk out strikes as an industrial action influence the provision of medical services in public hospitals To establish how strikes go slow as an industrial action influences the provision of medical services in public hospitals at RVPH

iii. To establish how go slow strikes as industrial action influence the provision of medical services in public hospitals at RVPH

iv. To establish how picketing as an industrial action influence the provision of medical services in public hospitals at RVPH

1.5 Research questions

The study was guided by the following research questions:

i. To what extent does sit in strikes influence provision of medical services in public hospitals at RVPH?

ii. To what extent do walk out strikes influence provision of medical services in public hospitals at RVPH?

iii. How does go slow strikes influence provision of medical services in public hospitals at RVPH?

iv. How does picketing influence provision of medical services in public hospitals at RVPH?

1.6 Significance of the study

The research findings sought to generate new information which will help the medical practitioners and other government hospitals understand the influence of industrial action of on provision of medical services in by nurses in public hospitals. The generated information will also help government departments and policy makers in the Ministry of Health to come up with interventions which will prevent industrial actions in future. The study also will provide knowledge to the other related organizations in Kenya on how to manage risks related to industrial action and finally it will assist other researchers and scholars in the field of academics. Those who wish to pursue other studies in the global arena will get literature from this study hence assist them in their research.

1.7 Limitations of the Study

Limitations that posed a threat to the internal validity of research. They were the potential weaknesses in a study but at the same time, they provide useful guidance to improve the quality of research for future studies

The limitations that were encountered in this study include; inadequate resources such as finance that facilitate the movement from location to location in search of the needed data. Resources were borrowed from friends whenever there was a short fall.

Time constraint also affected the research, more time was needed to gather information from the relevant resources compared to the time given to do the research. This was solved by distributing the questionnaires and later collecting them rather than moving around with each and every questionnaire.

1.8 Delimitation of the Study

The study focused on the influence of industrial action on provision of medical services by nurses in public hospitals and was conducted at Rift Valley Provincial General Hospital Nakuru. The study population were 540 nurses from the hospital.

1.9Assumptions of the Study

The study was conducted with the following assumptions in perspective:

i. That respondents sampled for the study would answer questions correctly and truthfully and in a timely manner to aid in the efficient data analysis.

ii. That management of the RVPH would offer all the support necessary, to researcher in reaching out to the target population of nurses at PGH in Nakuru.

1.10 Definition of significant terms

Industrial Action	Industrial action refers to action in which nurses work in a manner different from the customary manner. It includes restrictions, limitations, or bans upon work. Failing to attend for work can constitute industrial action, as can a refusal to perform work while at the workplace.
Lock-Out	A management action resisting employee's demands; Employees are barred from reporting to workplace until they agree to terms.
Medical Service	This refers to services that are offered in the hospital by nurses which include administering drugs, counseling and other services.
Motivation	The ways in which hospital management promote productivity of their employees (nurses)
Nurses	A qualified person who provides medical services to patients in a hospital
Perception	the way nurses think about or understand industrial action
Sit in	An industrial action where the nurses report to job but do not offer their or if they offer at a slow rate.
Strike:	This refers to the situation where the conflict between the medical staff and the regulating bodies like the government becomes rife to the point where the medical staffs down their tools.

1.12 Organization of the study

This study has five chapters. Chapter One covers the background of the study, statement of the problem and purpose of the study. This is followed by research objectives, research questions, justification of the study, limitations of the study, delimitations of the study, significance of the study, definition of significant terms and concludes with the organization of the study.

Chapter Two covers literature review from various sources to establish work done by other researchers, their findings, conclusions and identification of knowledge gaps which forms the basis of setting objectives and research questions of the study. The theoretical and conceptual frameworks are also explained.

Chapter Three covers the research design, target population of the study, sample size and sampling procedures. This is followed by data collection procedures, data collection instruments, validity of instruments, reliability of instrument, data analysis techniques, ethical considerations and concludes with operational definition of variables.

Chapter Four covered findings from data analysis, presentation of findings and interpretation of findings. It was concluded with summary of the chapter.

Chapter Five covered summary of findings, discussion, conclusions and recommendations of the study. It was concluded with suggested areas for further research and contribution to the body of knowledge.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of empirical literature on industrial action on provision of medical services in by nurses in public hospitals. The themes explained include: the concept of industrial action, perception of nurses towards their work place and the motivation levels of nurses in relation to service provision in public hospitals.

2.2 Concept of Industrial Action

Strike action is only one manifestation of industrial conflict; however, because of its overt and collective nature, it has a higher profile and is more discussed than other examples of conflict (Rigby and Marco, 2009). As pointed out by Blyton and Turnbull (2004), strike statistics provide only a partial view of collective industrial conflict. Strike includes a cessation of work or a refusal to work or to continue to work by employees, in combination, in concert or in accordance with a common understanding, a slowdown of work or other concerted activity on the part of employees in relation to their work that is designed to restrict or limit output. Ankomah (2010) also sees strike as a concerted withholding of labour supply in order to bring economic pressure to bear upon the employees and /or the unions demand. It is simply a refusal by employees to work.

Consequently, work stoppages involving nursing personnel have the potential to significantly disrupt hospital operations, with potentially serious consequences for patients. Furthermore, the complex nature of health care delivery necessitates the close coordination of workers who exhibit a great degree of interdependence (Cebul, 2008) and whose tenure in a hospital unit can affect patient outcomes (Bartel, 2009). Healthcare institutions may thus be particularly susceptible to labor unrest that disrupts these complex processes. A change in the intensity and quality of nursing inputs brought about due to strikes also has the potential to adversely affect patient outcomes. A number of studies have suggested that a decrease in the nurse-to-patient ratio is associated with increases in mortality and other adverse inpatient events (e.g., Aiken, 2002; Needleman, 2002), though recent work by Cook, (2010) suggests that legally mandated increases in nurse staffing at California hospitals had no discernable effect on patient safety. Moreover, even if staffing ratios are maintained during a strike through the use of replacement workers, the quality and familiarity of these replacement workers with

hospital processes may affect the care delivered to patients during strikes. For example, the results in Aiken (2003) suggest that higher quality workers (as measured by education level) are associated with lower mortality rates, while Phibbs (2009) document increases in length of stay for hospitals employing temporary contract workers.

2.3Forms of Industrial Action

The study was dealing with the four forms of strikes namely: sit-in strikes, walk out strikes, go slow strikes and picketing.

2.3.1 Sit-in strikes and service provision

A sit-in- strike is a strike in which employees stop working and refuse to leave the employers premise. A sit in strike is the work stoppage or concerted refusal of employees to perform work that their employer has assigned to them in order to force the employer to grant certain demanded concessions, such as increased wages or improved employment conditions. Baah (2006), pointed out that the sit down strike may be caused by workers feeling that their pay is not sufficient to provide their families with a reasonable standard of living. Workers are not only concerned with the levels of their pay but equally importantly, they are concerned about relative pay because they are key indicator of social status and esteem for workers. These explain why workers and their unions are so passionate about pay rated issues. In the public health sector, pretty much of the reasons why health workers embark on strike actions rest on pay issues. Health workers have over the years been dissatisfied with their working conditions and pay which they perceive as low and leading to a fall in their living standard. Apart from the low level of pay, one critical issue is the unfairness in the health sector pay. Some professional groups are given preferential and better treatment when it comes to pay and conditions of service even though health service delivery is considered as a team work. This practice has had a demoralizing effect on other health workers and serves as a precipitating factor for strike actions in the public health sector. An example is what happened in 2006 where HWG expressed dissatisfaction about the new health sector salary scale. Two pay scales were designed, one for doctors and directors and the other for the rest of health workforce. The doctors' salaries were placed so high at the expense of the rest of the staff and HWG has to resort to various means including strike actions to seek redress. The effects of labor unrest in the health care industry may be particularly pronounced, given its labor-intensive production process, and the potentially serious consequences of substandard health care production. Health care production is particularly labor intensive, with labor's share of production accounting for nearly 60 percent of hospital costs. Nurses in particular

constitute the largest group of workers in a hospital, and often have a considerable impact on a hospital patient's experience. Hospital administrators acknowledge that nurses are the safety net. They are the folks that are right there, real time, catching medication errors, catching patient falls, recognizing when a patient needs something and avoiding failure to rescue.

At the same time, a large body of research suggests that patients may be overtreated in the hospital. As a result, the reductions in care that result from sit down strikes may not be particularly harmful on the margin. Fisher(2003) show that in regions with high rates of inpatient care utilization, quality of care, functional status and patient satisfaction are no better than in low utilization regions. Baicker and Chandra (2004) control for within-state variation and find that states with higher Medicare spending per beneficiary have lower-quality care. Fisher . (2004) extend this analysis to academic hospitals and find no association between increased treatment intensity across medical centers and improved long-term survival for three of their measured outcomes, while finding a small increase in the risk of death as intensity increased for two other conditions analyzed.

Despite the increased role of organized labor in the health care industry, few studies have examined the role of labor unrest on health care production, and the results of these studies offer no clear conclusions as to the effect of these strikes on patients. Early work on health care strikes by James (2009) and Pantell and Irwin (2009) examines the effects of physician strikes on patient care. James (2009) investigates the impact of a physician work slowdown tied to increased malpractice rates in Los Angeles. He finds that causes of death shifted over the course of the slowdown, with decreases in deaths from elective surgery and increases in deaths associated with emergency room transfers.

Industrial actions are recognized as an inevitable product of the conflict of interest between management, or government and unions (Fudenberg, 2005). According to Blanchflower and Cubbin (2006), strikes have variously been attributed to mistakes, malice, political opportunism, weak management, militant unions, poor institutional arrangement and so on.Access to quality health services is crucial for the improvement of health outcomes, such as those targeted by the Millennium Development Goals (MDGs) adopted by the international community in 2000 (Koblinsky, 2009).For example, the 75% reduction of maternal mortality by 2015 depends on access to skilled care at birth and during the pregnancy (Koblinsky, 2009).

A health workforce crisis (such as strike action and brain drain) therefore has the potential of crippling healthcare delivery in many low-income countries. Various estimates have been undertaken on how many workers are required to achieve essential health interventions. Based on a threshold of 2.3 doctors, nurses and midwives per 1000 population needed to do essential health interventions, World Health Organisation (WHO) has estimated that about 4.3 million health workers are lacking (WHO, 2006). In absolute terms, the greatest shortage is in South-East Asia, but in relative terms the need is greatest in Sub-Saharan Africa. While South-East Asia requires an increase of 50% to meet the threshold, Sub-Saharan Africa requires a 139% increase. Thus, 36 of the 57 countries with critical shortage of doctors, nurses and midwives are located in Sub-Saharan Africa (WHO, 2006). Low-income countries are making efforts at retaining their health workers by providing financial and other incentive schemes. The scheme rapidly expanded across all workers in the health sector, and within a few years it had effectively increased take-home pay by between 75 and 150% depending on cadre and location (Ruwoldt ., 2007).

2.3.2 Walk out strikes and service provision

A walk out strike is an unannounced refusal to perform work. A walk out may be spontaneous or planned in advance and kept secret. If the employees conduct is an irresponsible or indefensible method of accomplishing their goals, a walkout is illegal. In other situations courts may rule that the employees have a good reason to strike.

In South Africa, strike action by nurses refers to the withholding of nursing/midwifery care in accordance with the legal requirements of Labour Relations Act in relation to a protected strike (Muller and Cur, 2001).Employees can undertake a walk out strike for economic reasons, for improvement of their working conditions, or for the mutual aid and protection of employees in another union. In addition, even if they do not have a union, employees can properly agree to stop working as a group; in that case they are entitled to all the protections that organized strikers are afforded. In most cases, numerous economic barriers and constraints are encountered during negotiations particularly for increase in pay. These include the public service arrangements that govern salary payments, the potential spillovers that increases in pay in the health sector might have on other sectors such as teachers, public wage bill expenditure ceilings, and other fiscal constraints. The presence of these constraints and lack of willingness sometimes on the part of professional associations to compromise during negotiations lead to agitations and strike actions by health workers in the public health sector. Long Delays in Promotions and Payment of Salaries for Newly Recruited Health Workers

Another major issue that has attracted complaints and contributed largely to strike action by health workers relates to long delays in promotion and payment of salaries for newly recruited health workers.

Under the National Labour Act, 2003 (Act 651)of South Africa, the NLC is given power to regulate relations between workers and employers and make provision for prompt and time-based settlement of disputes in an attempt to avoid the occurrence of strike actions or lockout. This notwithstanding, health workers continue to embark on strike actions regardless of the provisions in the Act and they do that with impunity. The inability of the authorities to be bold and firm and impose the appropriate sanctions to health workers when they embark on illegal strikes obviously contributes to the rampant strike action in the public health sector. While this is the case, it is equally important to point out that sometimes the inaction of authorities to promptly resolve the dispute of health workers as required under the Labour Act of 2003 (Act 651) for essential services also gives rise for health workers to resort to strike actions.

2.3.3 Go-Slow Strike and service provision

An intermittent work stoppage by employees who remain on the job. Slowdowns are illegal because they give the employees an unfair bargaining advantage by making it impossible for the employer to plan for production by the workforce. An employer may charge an employee for a work slowdown.

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Baah (2006), pointed out that the sit down strike may be caused by workers feeling that their pay is not sufficient to provide their families with a reasonable standard of living. Workers are not only concerned with the levels of their pay but equally importantly, they are concerned about relative pay because they are key indicator of social status and esteem for workers. These explain why workers and their unions are so passionate about pay rated issues. In the public health sector, pretty much of the reasons why health workers embark on strike actions rest on pay issues. Health workers have over the years been dissatisfied with their working conditions and pay which they perceive as low and leading to a fall in their living standard. Apart from the low level of pay, one critical issue is the unfairness in the health sector pay. Some professional groups are given preferential and better treatment when it comes to pay and conditions of service even though health service delivery is considered as a team work. This practice has had a demoralizing effect on other health workers and serves as a precipitating factor for strike actions in the public health sector. An example is what happened in 2006 where HWG expressed dissatisfaction about the new health sector salary scale. Two pay scales were designed, one for doctors and directors and the other for the rest of health workforce. The doctors' salaries were placed so high at the expense of the rest of the staff and HWG has to resort to various means including strike actions to seek redress. The effects of labor unrest in the health care industry may be particularly pronounced, given its labor-intensive production process, and the potentially serious consequences of substandard health care production. Health care production is particularly labor intensive, with labor's share of production accounting for nearly 60 percent of hospital costs. Nurses in particular constitute the largest group of workers in a hospital, and often have a considerable impact on a hospital patient's experience. Hospital administrators acknowledge that nurses are the safety net. They are the folks that are right there, real time, catching medication errors, catching patient falls, recognizing when a patient needs something and avoiding failure to rescue.

2.3.4 Picketing and service provision

When a legal strike or lockout is in progress, the Code allows employees to picket. Picketing is a peaceful means by which employees can increase the pressure on their employer to agree to terms and conditions of employment favourable to them. The purpose of the picket line is to persuade persons not to do work for, or do business with, the employer. A picket line, however, cannot be used to forcibly prevent persons from entering an employer's premises.

Striking or locked-out employees are entitled to picket where they normally perform work that is an integral and substantial part of the employer's operation and which is under the control and direction of the employer. Other operations of the employer may not be picketed. For example, if the employer operates at more than one location, the striking or locked-out employees can picket only the location for which their union is certified and at which they perform their work.

With the permission of the Board, picketing may also be conducted at other sites; for example, where an employer attempts to have "struck work" performed away from its own premises. Striking or locked-out employees may also picket the place of business of an "ally" of their employer. An ally is a person who assists an employer in a lockout or in resisting a lawful strike. Ally picketing is restricted to the site at which the ally performs work for the benefit of the employer who is directly involved.

Where more than one employer carries on business at the same site (referred to as a "common site"), the Board generally restricts picketing so that it affects only the employer involved in the labour dispute or the ally of that employer. The Board has the discretion to regulate picketing at a common site to ensure that the union has a way to picket in pursuit of legitimate objectives. This means that in some circumstances the Board can allow regulated picketing at a common site that affects third parties. Such circumstances occur when the union has no other way of picketing at the workplace of the striking or locked-out employees.

Just as the picketing provisions limit the lawful things employees can do during a strike or lockout, the replacement worker provisions of the Code limit what an employer can do. Employers are prohibited from using newly hired employees to replace employees who are engaged in a legal strike or who are locked out.

An employer can continue to operate during a labour dispute by using non-bargaining unit personnel at that operation. Management staff cannot be transferred or used from other operations or facilities of the employer, however, unless they were transferred before the notice to commence collective bargaining for the new agreement was given.

Any person who is not in the bargaining unit at the operation has the right to refuse to do work of bargaining unit members during a strike or lockout. To protect this right, employers are not allowed to penalize or discipline employees who refuse to do such work.

2.4 Medical services

Globally, health expenditures rose from an average of 3 percent of GDP in 1950 to 8 percent (US$3 trillion) in 2009 (WHO 2000). The increase in spending has been driven by rising income, changing demographic and epidemiological trends and costly new pharmaceuticals and technology. Although technology is allowing a shift to outpatient care, hospitals still account for 30–50 percent of health expenditures. Public funding has not kept pace with the growth in spending. Much of the increase has been financed from private sources (out of pocket payments and private insurance), while the share funded publicly (by tax revenue and national insurance) declined by 6 percent between 2007 and 2007. Constraints on public funding, combined with rising costs, have forced public hospitals to cut costs wherever possible while still endeavoring to guarantee universal (and often free) access to public patients. Governments have used different strategies to financing from general tax revenue to payroll-financed national health insurance, narrowing the basic package of services available to all citizens, linking hospital funding to outputs and efficiency, amalgamating hospitals into networks, increasing autonomy and incentives for management, and reducing the number of hospital beds. Some governments have also turned to public-private partnerships to bring private sector efficiency into public hospitals.

Taylor and Blair (2002) reported that Australia federal and state governments have introduced private participation in more than 50 public hospitals through several different mechanisms. They have completed 15 transactions (in which a private firm builds, owns, and operates a public hospital), 4 conversions (in which a hospital is sold to a private operator as a going concern), 4 transactions involving private management of a public hospital that the government continues to own.

In Kenya, the public health system consists of different levels of health facilities namely national referrals hospitals, provincial general hospitals, district hospitals, health centres and dispensaries. National referral hospitals are at the apex of health care system, providing sophisticated diagnostic, therapeutic and rehabilitative services. There are two national referral hospitals namely Kenyatta national hospital in Nairobi and Moi referral and teaching hospital in Eldoret. The Provincial hospitals act as referral hospitals to their district hospitals, acts as an intermediary between the national central level and the districts. They also provide very specialized care and oversee the implementation of health policy of the district level, maintain quality standards and coordinate and control all district health activities. District

hospitals concentrate on the delivery of health care services and generate their own expenditure plans and budget requirements based on guidelines from headquarters through the provinces. On the other hand, Pantell and Irwin (2009) find no significant effects on appendectomy outcomes during a one-month anesthesiologist strike in San Francisco. In the only study of the impact of a nurses strike on patient care, Mustard (2005) report a 15 percent decrease in the caesarian birth rate, as well as an increase in the rate of adverse newborn outcomes during a month-long Ontario nurses strike.

They conjecture that the result "is most plausibly attributed to disruption in the normal standards of care rather than to the change in the rate of operative management" (Mustard 2005, 636). Finally, Salazar (2001) examine the effect of an emergency room residents strike at a Spanish hospital during which staff physicians filled in for the striking residents. They find decreases in the number of tests ordered, as well as a decrease in patient length of stay compared with the same hospital during a nonstriking period, with no significant changes in mortality or readmission rates. Multi- industry studies such as Neumann (2000), Neumann and Reder (2004), Becker and Olson (2006), and Kramer and Vasconcellos (2006) find that strikes lead to a 2–4 percent decline in firm market value. McHugh (2001) examines the productivity of struck firms in nine manufacturing industries and finds a negative direct impact of strikes on average labor productivity. Similar findings are echoed in studies of specific industries such as the airline industry, where De Fusco and Fuess (2001) find stock market returns of negative 2.6–5.3 percent during strikes, and Kleiner Leonard, and Pilarski (2002) find that productivity fell greatly at commercial aircraft manufacturing plants during strikes. These effects did not persist in the longrun, however, with their plant returning to pre-strike levels of productivity within one to four months. Schmidt and Berri's (2004) study of professional sports strikes indicates that strike costs are significant during the strike period, but are limited to the strike period, with almost immediate return to pre-strike levels of consumer demand for sporting events.

Krueger and Mas (2004) examined a long strike which involved the hiring of replacement workers at a tire plant between 2004 and 2006. They found that tires produced during these years were more likely to be defective, with particularly pronounced increases in defective units coinciding with periods when replacement workers worked together with returning strikers. Mas (2008) found that workmanship for construction equipment produced at factories that experienced contract disputes was significantly worse relative to equipment

produced at factories without labor unrest, as measured by the resale value of the equipment. His estimates indicate that equipment produced in facilities undergoing labor disputes were discounted in the resale market by approximately five percent.

According to ILO, the health services are one of the fundamental sectors of society and the economy. This results from the fact that they directly influences the health of the people as the health practitioners also try to maintain their own individual and personal health. ILO recognizes that those working in the health sector are most prone to contagious diseases and should thus be given the utmost care and security at the place of work (ILO, 2014). This would go a long way in protecting them in their roles thus improving their continued involvement in the provision of work. In addition, it encourages the fundamental principles of the human right to health and social security. It provides for decent working conditions for health workers as those who provide health services to the people. In addition, ILO aims to ensure that all members of society have access to social health protection. It also recognizes the lack of capacity to provide health services in many developing countries. It goes ahead to state that this has significant effects on individual and public health, poverty, income generation, labour market productivity, economic growth and development (ILO, 2014). It recognizes the need to have a well-structured health workers development, training and motivation. According to the international body, promoting social health protection for all workers is core component of the health workers working environment. Therefore, it supports better working conditions for health workers through the possible and available sect oral labour standards and social dialogue.

One important factor that affects the health factor across the globe, and that has hit hardest to RVPH is the shortage of trained health workers. According to ILO, this particular challenge coincides with longer life expectancies, increasing use of specialized medical technology and the rise of new and drug resistant diseases. Finally, ILO recognizes the health workers and medical practitioners menace. ILO As the demand for health services grows and the shortage of qualified health personnel becomes more severe, working conditions deteriorate and the quality of health care may be jeopardized (International Labour Organization, 2014).

As of November 2011, ILO prescribed a doctor to patient ration of 1: 1250. This means, that every one doctor should be able to handle a population of 1250. This is the best average that should apply to all the health workers in both the rich and the poor countries. However, as of the same date, the doctor to patient ratio at the RVPH, alongside other public hospitals across

the country stood at 1:17,000 (The Standard Group, 2014). This represents a 1200% negative disparity on the number of people a doctor should handle. According to ILO, the critical shortage of health workers in the poor countries is further aggravated by wealthier countries offering better working conditions to migrant health workers in the form of green pastures. This has led to many emigrant qualified personnel from the less economically stable countries to the more stable countries that can offer them better packages.

Ministry of Health (2011) reported that Nakuru General Hospital is a Level 5 referral hospital located in Nakuru, one of Kenya's agricultural hubs and the bread basket for production of wheat and other cereals. The Nakuru provincial hospital started its operations at independence in 2003 with 14 districts in the province then. By 2007, the districts had risen to 19 with a total of 15 Provincial Medical Officers having been in the office. In 2008, the parent ministry of health was divided into the Ministry of Medical Services and the Ministry of Public Health and Sanitation; with all the structures rolling down to the provinces. Consequently, the post of provincial Medical Officer was abolished and replaced with Provincial Directors of Medical Services and Public Health and Sanitation. Presently, there are 61 hospitals under the Ministry of Medical Services in the province and 67 districts under the ministry of Public and Sanitation with about 800 rural health facilities. The Ministry of Health (2011) further reported that the hospital is the biggest and the only state approved hospital in the Rift Valley Province. It has the responsibility to look after about 800000 people in Nakuru city another few million in the whole province. Most of the patients are from the lowest socioeconomic classes. The facility has 25 wards with 588 beds and 68 cots. There are a total of 800 staff among them 460 nurses and 80 doctors receive about 1700 patients from Nakuru, Bomet, Baringo, Laikipia among other regions. The hospital provides all major services including Antenatal care, Antiretroviral Therapy, Basic Emergency Obstetric Care, Caesarean Section, Comprehensive Emergency Obstetric Care, Curative In-patient Services, Curative Outpatient Services, Family Planning, HIV Counselling and Testing, Home Based Care, Immunization, Integrated Management of Childhood Illnesses, Prevention of Mother to Child transmission of HIV, Radiology Services such as X-ray, UltraScan, MRI, Tuberculosis Diagnosis, labs & treatment and Youth Friendly Services.

2.7Theoretical Framework

The study was guided by the following theories

Conflict theory is derived from the classical work of Karl Marx. The root of conflict is social inequality in the society. Social conflict emerged as a result of struggle among segments of society over valued resources. Social conflict is the outcome of struggle among social groups. This study focuses on inter union conflict in organizations and its implications on industrial harmony. The conflict theory is useful for this study as it reveals causes of conflict among competing groups which industrial unions represents as in the case of this analysis in healthcare institutions. This study hopes to discover how industrial harmony can be enhanced in the face of possible conflict between and among industrial unions which conflict theory may be inadequate. In view of the inadequacy noted above, the study also made use of functional theory in terms of Merton's dynamic equilibrium postulation (Merton, 2008).

Health organizations are open social systems and can be analyzed using the structural functional theory. Hospitals which are health institutions are formal organizations with various parts (Departments and Units, as well as work groups and unions). These parts interact in their daily activities and relate with one another for the hospital to achieve its objectives. These groups are structures within the hospital and can be studied functionally. Merton (2008) considered function as objective consequences of pattern of action or activities on the system in which it takes place. In this regard, inter union conflict is a pattern of action and industrial harmony is the manifest expected function.

The theoretical framework in the study consequently involves a synthesis of conflict and functional theory. Conflict theory guide analysis of inter union relationship; while functional theory presents the expected consequence of inter union relation or conflict on the organization which is industrial harmony. The trade unions that represent the medical practitioners have been agitating for better working conditions, improve remunerations, rationalized workload and balance distribution of the workforce. These agitations have led to industrial actions that eventually lead to poor service delivery in the public hospitals in Kenya. The study will endeavor to collect and analyze data to support this theory.

2.8 Conceptual Framework

According to Bogdan and Biklen (2003), a conceptual framework is a basic structure that consists of certain abstract blocks which represent the observational, the experiential and the

analytical or synthetically aspects of a process or system being conceived. The interconnection of these blocks completes the framework for certain expected outcomes.

An independent variable is that variable which is presumed to affect or determine a dependent variable. It can be changed as required, and its values do not represent a problem requiring explanation in an analysis, but are taken simply as given (Florian, 2006). The independent variables in this study were various forms of industrial action, perception of nurses towards industrial action and nurse's level of motivation towards duty. A dependent variable is what is measured in the experiment and what is affected during the experiment. The dependent variable responds to the independent variable. The dependent variable in this study were provision of medical services in Rift Valley provincial general hospital.

A conceptual framework on which this study is based appears as Figure 1

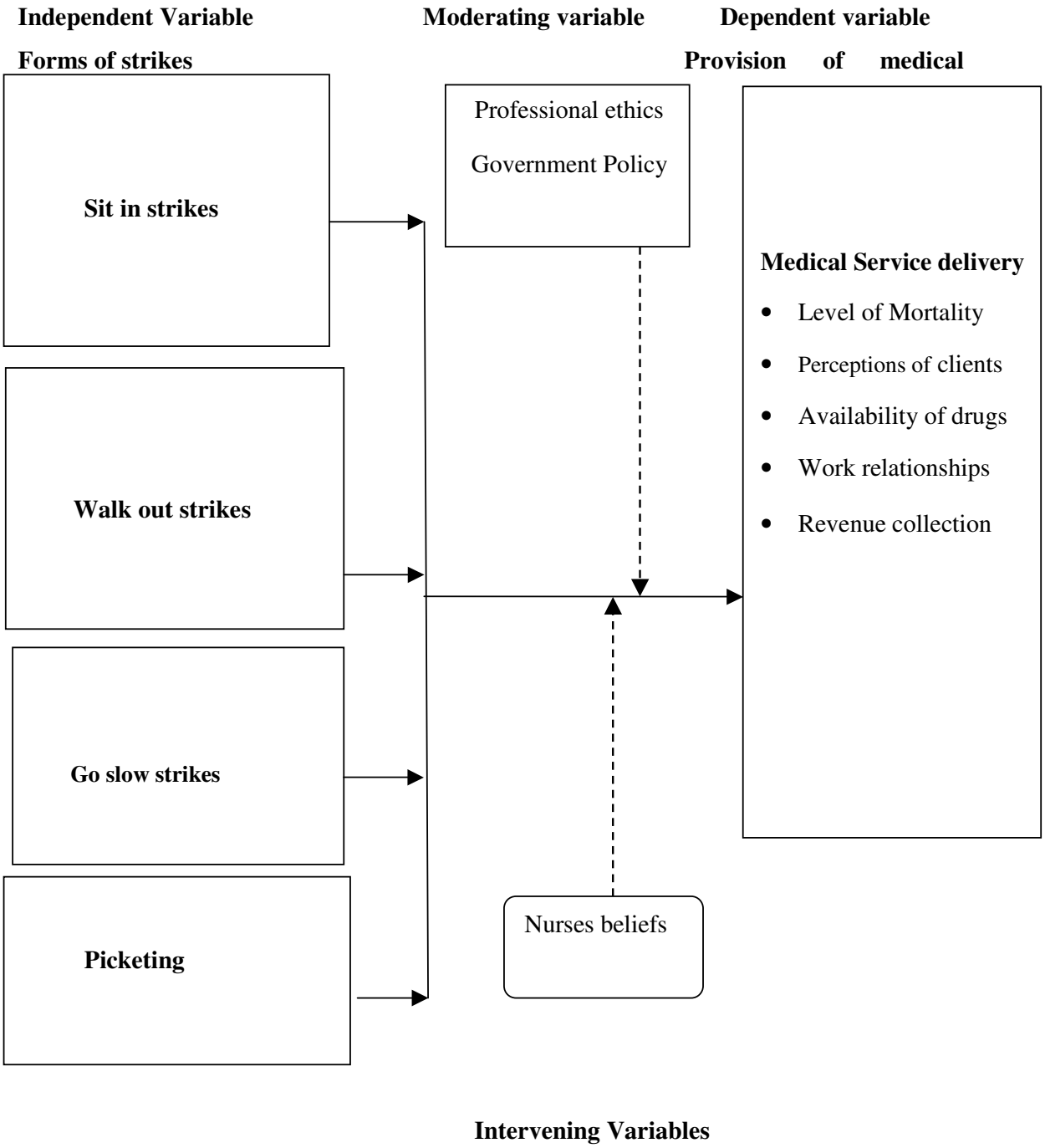

Figure 2.1 Conceptual framework

2.9 Summary of Literature Reviewed

Some of the possible influence of industrial actions elicited in the literature reviewed include poor working environment that might expose nurses to terminal diseases, poor remuneration in terms of compensation, changes in labor laws, and change in government policy such as constitutional changes and taxation regime, failure of government to honor collective bargain agreement among others. Nurses' industrial action may lead to poor service delivery hence causing loss of life, unavailability of medical services, inadequate or lack of medical staff to attend to patients and counseling services, poor revenue collection will also be affected among others.

The literature reviewed in this study fails to reveal the influence of industrial action among the nurses in Kenya. It is known that industrial action leads to poor delivery of medical services within the organization. Nurses in Kenya public hospital have been involved in a number of industrial actions as recently witnessed because of either poor working conditions, lack of commitment to collective bargaining agreements, poor compensation and increased work load (understaffing among others).The literature reviewed has shown that there is no study that has been carried out to reveal how industrial action has been affecting service delivery in Kenya public hospitals.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodology which was used to find answers to the research questions. The research design, target population, sampling procedures and sample size, data collection methods, instruments of data collection, reliability and validity of the data collection instruments and finally the data analysis are presented in the chapter and ethical considerations.

3.2 Research Design

The study employed the *Ex post Facto* research design. In this research design, the researcher does not have control over the variables but only reports what is happening. This research design preferred over other design because it assisted in measuring such items as the frequency of strikes, perceptions of nurses or other similar data such as motivation levels (Kothari, 2004). The design type was also used because it has enough provision for protection against bias and will maximize reliability, with due concern for economical completion of the research study

Ex post facto design is a non-experimental research technique in which preexisting groups are compared on some dependent variable. This experiment appears to be a true experiment because of the way the groups are separated and the way the analysis is performed, but it is still subject to the same limitations as non-experimental research. The assignment of participants to the levels of the independent variable is based on events that occurred in the past. This non experimental research is similar to an experiment because it compares two or more groups of individuals with similar backgrounds who were exposed to different conditions as a result of their natural histories (McMillan, 2014).

3.3 Target Population

The target population for this study were 540 nurses from Rift valley provincial hospital in Nakuru town. According to the ministry of health, the number of nurses as at January 2014 was 540.

Table 3.1 number of nurses per section at RVPH

Section	Number of nurses
Causality	50
Amenity	142
Staff clinic	20
Radiology	34
General wards	190
Apathy	48
Ent.	26
Dental	30
Total	540

3.4 Sample Size and Sampling Procedures

The researcher used the simple random sampling technique. This is where the researcher selected sampling units in an attempt to a sample that appears to be representative of the population. Ideally, it was preferable to collect data from nurses at the facility. However, as a result of several constraints like time availability to both the researcher, the nurses and the research time, insufficient money for the research among other contingent factors. The study employed simple random sampling in selecting the sample of the study. According to Krejcie and Morgan (2000) as shown in Appendix 5, a total of 540 nurses require a sample of 225 nurses who were represented from all the sections proportionally.

Table 3.2 proportionality of sample size per every section

Section	Number of nurses
Causality	22
Amenity	58
Staff clinic	9
Radiology	15
General wards	78
Apathy	19
Ear, Nose throat	11
Dental	13
Total	225

3.5 Data Collection Procedures

The researcher was issued with a letter from National Commission for Science, Technology and Innovation introducing him, this enabled RVPH to facilitate in the provision of the

required information. This was followed by acquiring conduct research from the Director of Medical Services and from ministry of higher education before commencing the study. This was followed by visiting of the study area to meet hospital administration and other leaders and brief them of the intended research. During this period, questionnaires were pretested and ambiguous questions clarified. Any omissions made were inserted and irrelevant questions omitted. The actual field work was carried out which entailed collecting primary data from the respondents using drop and pick method. Some questionnaires were filled and collected while others were collected after two days. Responses to questionnaires were recorded objectively and accurately.

3.6 Data Collection Instruments

Data was collected by use of structured questionnaires. Questionnaires are cheap to administer to respondents who are scattered over a large area. It was convenient for collecting information from a large population within a short span of time. The questionnaires had both open and closed ended questions. The structured questions were used in an effort to conserve time and money as well as to facilitate in easier analysis as they are in immediate usable form; while the unstructured questions were used to encourage the respondent to give an in-depth and felt response without feeling held back in revealing of any information. This included the concept of industrial action, forms of strikes and service delivery, nurses' perception and nurses level of motivation

3.7 Validity of Research Instrument

Validity is the accuracy, soundness or effectiveness with which an instrument measures what it is intended to measure (Kumar, 2005). In this study, the instruments were thoroughly discussed between the researcher and the supervisor who provided his expertise and ensure that the instruments measure what they intend to measure as recommended. The lecturers ensured that the items adequately represented concepts that cover all relevant issues under investigation, which comply with recommendations of Mugenda and Mugenda (2008).

3.8Reliability of Research Instrument

Shuttleworth (2009) stated that in test retest method, the instrument is administered at two different times and then the correlation between the two sets of scores computed. This research study used test-rest method which involves administering the same scale or measure to the same group of respondents at two separate times. This was after a time lapse of one week. A pilot study was conducted with 10 nurses working at the PGH that did not form part of the sample. Pilot sampling was done to assist in the modification of the final instruments to

be used by the researcher. Reliability of the instruments was computed using Pearson's Product Moment correlation coefficient Formula as follows:

$$r = \frac{[\Sigma xy - (\Sigma x)(\Sigma y)]}{\sqrt{\left[\Sigma x^2 - \frac{(\Sigma x)^2}{N}\right]\left[\Sigma y^2 - \frac{(\Sigma y)^2}{N}\right]}}$$

The number of respondents sampled based on the formula was 225 nurses. A correlation coefficient of 0.86 was established; this meant that the instrument was reliable and measurable.

3.9 Data Analysis Techniques

The questionnaires were edited for the purpose of checking on completeness, clarity and consistency in answering research questions. The data were coded, tabulated and analyzed using Statistical Package for Social Sciences version 19. Descriptive statistics were computed and study findings were presented using percentages and tables and interpretations made.

3.10 Ethical Considerations

All respondents in this study were treated with courtesy and respect in order to avoid misunderstanding between the enumerators and respondents and they were informed of the purpose of the study. Each respondent was politely requested to fill the questionnaire and assured of confidentiality with regard to any information they provided.

3.11 Operational definition of variables

The operational definition of variables is given in Table3.2.

Table 3.3: Operational definition of variables

Research Objectives	Type of Variables	Indicator(s)	Measure(s)	Measurement scale	Type of analysis Tools
To determine how sit in strikes as an industrial action influence the provision of medical services in public hospitals at RVPH	**Independent** Sit in strikes	Nurses not working	Number of nurses working	Nominal	Percentages means
To assess how walk out strikes as an industrial action influence the provision of medical services in public hospitals at RVPH	**Independent** Walk out strikes	Non attended to attended patients	Number of nurses supporting industrial action	Ordinal	Percentages means
To establish how strikes go slow as an industrial action influences the provision of medical services in public hospitals at RVPH	**Independent** Go slow strike	Output	Number of patients treated	Interval	Percentages means
To establish how picketing as an industrial action influence the provision of medical services in public hospitals at RVPH	**Independent** Picketing	Working conditions	Number of nurses experiencing poor working condition	Ordinal	Percentages means

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND PRESENTATION

4.1 Introduction

Following completion and collection of the questionnaires by the target population of the study, the researcher developed a comprehensive qualitative and quantitative data analysis as indicated by the results discussed below. A total of 230 questionnaires were distributed to the target population, 200 of them were positively filled and returned. This makes a response rate of 87 % which is excellent for an equitable analysis (Peil, 2005). According to Peil, (2005), a response rate of 85% is good for making generalizations for a study.

4.2 Demographic characteristics of the respondents

The study sought to investigate the demographic characteristics of the respondents based on the age, gender, work experience and term of employment. The demographic information would assist in establishing if the information given by the respondents would be in any way related to the characteristics of the respondents.

4.2.1 Gender of the respondents

The researcher used the answers the respondents gave to the questions that were asked in the questionnaire. The answers they provided to the questions were checked and the correct responses noted. The researcher classified the respondents into two groups based on gender; this was to obtain responses from both male and female and to avoid gender imbalance. The results obtained were represented in table 4.1:

Table 4.1 Gender of the Respondents

Gender	Frequency	Percentage (%)
Female	120	60
Male	80	40
Total	200	100

The results show that 60 % of the respondents were female while 40% were male. This implies that there were more female than male hence implying that there were gender imbalances. The

highest percentages of the respondents were female, which implies that most women were employees of the company.

4.2.2 Age of the Respondents

The researcher used the respondents' age groups in order to find answers to the questionnaire; this was to establish answers from different age groups so as to avoid age biasness across the different age groups. The findings are then presented in Table 4.2:

Table 4.2 Age of the respondents

Age	Frequency	Percentage (%)
19-25 years	60	32
26-30 years	90	44
31-40 years	30	15
41-50 years and above	20	9
Total	200	100

The research shows that 44% of the respondents were between the ages of 26-30 years, 32% were between 19-25 years, 15% were between the age of 31-40 years and 9% were the age of 41-50 years and above. The highest percentages of the respondents were between the ages of 26-30 years and the lowest percentage was those with the age of 41 years and above.

4.2.3 Employee term of employment

The study sought to investigate the employee term of employment. The findings are presented in Table 4.3

Table 4.3 Term of employment

Employment term	Frequency	Percentage (%)
Permanent	100	50
Part time	60	30
Contract	40	20
Total	200	100

It can be depicted from the table 4.3 that 50% of the nurses were in a permanent basis of employment, 30% were part time employees and 20% were on contract basis. This implied that the most of the nurses in the hospital were in their permanent term of employment thus have enough knowledge on industrial action.

4.2.4 Number of years Worked

The researcher used the number of years worked by the respondents to find answers to the questionnaire. The findings are presented in Table 4.4

Table 4.4 Number of years worked

Number of years worked	Frequency	Percentage (%)
0-5 years	60	32
5-10 years	90	44
10 years and above	50	24
Total	200	100

The study noted that 32% of the respondents had worked for 0-5 years, 44% had worked for 5-10 years and 24% had worked for 10 years and above. This implies that most of the respondents had worked for 5-10 years the best experience to respond on the topic of study.

4.3 Analysis of Research Questions

4.3.1 Influence of Sit in strikes as an industrial action on the provision of medical services

The study sought to investigate the influence of sit-in strikes, walk out strikes, go slow strikes and picketing on the provision of medical services. The findings are presented in Table 4.5

Table 4.5 Sit in strikes

Statements	Descriptive	SA	A	UD	D	SD	Totals	Mean
Sit in strikes cause inconvenience to actual and potential patients	Frequency	40	40	30	50	40	200	2.94
	Percentage	21	18	15	29	18	100	59%
Patients are put at risk	Frequency	50	40	80	30	0	200	3.65
	Percentage	29	21	35	15	0	100	73%

The number of outpatients drop	Frequency	120	50	30	0	0	20	4.47
								89%
	Percentage	59	29	12	0	0	100	
Patients are evacuated	Frequency	110	70	10	10	0	200	4.35
								87%
	Percentage	53	35	6	6	0	100	
Many patients are left to die and they generally jeopardize the quality of hospital services	Frequency	30	40	10	50	70	200	2.53
	Percentage	15	18	6	29	32	100	
								51%

The results revealed that 89% strongly agreed that the number of outpatients drop, 87% strongly agreed that patients are evacuated, when they were asked if patients are put at risk 73% of the respondents strongly agreed, 59% strongly agreed that sit in strikes cause inconvenience to actual and potential patients and 51% of the respondents strongly agreed that many patients are left to die and they generally jeopardize the quality of hospital services. From the findings it is evident that strikes really affect the provision of services in hospitals. Most of the respondents noted that, most of the outpatients drop. Hospital administrators acknowledge that "nurses are the safety net. They are the folks that are right there, real time, catching medication errors, catching patient falls, recognizing when a patient needs something and avoiding failure to rescue. When this assistance fails, then patients seek other alternatives, thus reduced number of patients in the hospital.

This can be interpreted to mean that sit in type of strike has a great impact on the provision of medical services in hospitals, when employees dominate the place; they give no room for any medical operations, in this case affecting the provision of services. This may leas to lack of attention to patients thus putting them at a risk of death; outpatients will try to get medical attention from other hospitals.

4.3.2 Influence of Walk out strikes as an industrial action on the provision of medical services

The study sought to establish the influence of walk out strikes on the provision of medical services. The results are presented in Table 4.6

Table 4.6 Walk out strikes

Statements	Descriptive	SA	A	UD	D	SD	Totals	Mean
Hospitals are closed down	Frequency	120	60	20	0	0	200	4.47
	Percentage	59	29	12	0	0	100	89%
Daily hospital duties are disrupted and Medical equipment are put at a risk of being destroyed	Frequency	60	30	0	50	60	200	2.85
	Percentage	29	15	0	24	32	100	57%
Tension is experienced in the surrounding	Frequency	20	40	20	60	60	20	2.59
	Percentage	15	18	9	29	29	100	52%
Doctors are unavailable for consultation	Frequency	20	30	0	60	90	200	2.09
	Percentage	9	15	0	29	47	100	42%
Inability of management to make decisions	Frequency	30	40	0	80	50	200	2.56
	Percentage	15	18	0	44	24	100	51%

From the study results 89%, strongly agreed that hospitals are closed down, 57 % of the respondents strongly agreed that daily hospital duties are disrupted and medical equipment are put at a risk of being destroyed, 51% strongly agreed that there is inability of management to make decisions, 52% of the respondents strongly agreed that tension is experienced in the surrounding and 42% strongly agreed that doctors are unavailable for consultation. To a great extent, walk out strikes leads to closure of hospitals, disruption of hospital operations definitely leads to closure of hospitals; there may also be a lot of tension in the surrounding as more destruction can be made through anger from involved persons.

The findings can be interpreted to mean that walk out strikes destructs the normal working conditions of the hospital, though nurses can be replaced for that striking period, the hospital will

incur a lot of costs of replacement, the management are put in a pressure which may not allow them to make serious decisions hence affecting the provision of medical services.

4.3.3 Influence of Go slow strikes on the provision of medical services

The study sought to identify the influence of go slow strikes on the provision of medical services in hospitals. The results are presented in Table 4.7

Table 4.7 Go slow strikes

Statements	Descriptive	SA	A	UD	D	SD	Total	Mean
The management are put under pressure thus unable to effectively manage	Frequency	100	70	20	10	0	200	4.33
	Percentage	50	37	10	3	0	100	87%
The employees work to rule the hospital thus affecting productivity	Frequency	60	90	20	20	10	200	4.07
	Percentage	37	47	7	7	3	100	81.%
makes it very difficult for employer to defy the union and take the workers place	Frequency	80	60	40	10	10	200	4.00
	Percentage	40	30	23	3	3	100	80%
Employees restrict their work output thus affect production	Frequency	60	53	34	40	13	200	3.53
	Percentage	30	30	19	22	7	100	71%
There is inability to meet the patients demands on schedule	Frequency	74	47	47	13	20	200	3.70
								74%
	Percentage	37	23	23	7	10	100	

It was depicted from table 4.7, the study showed that 87% of the respondents strongly agreed that the management are put under pressure thus unable to effectively manage, 81% of the respondents were of the opinion that the employees work to rule the hospital thus affecting productivity, 80% noted that it makes it very difficult for employer to defy the union and take the workers place, 71% agreed that employees restrict their work output thus affect production and 74% noted that there is inability to meet the patients demands on schedule.

This means that this kind of strike makes the general operations of the hospital difficult, when employees restrict their output, they put those being attended in a risk especially in a hospital, the patients are unable to get what they are intended thus being put in a risk of death. When the

employees take charge of everything in the hospital, then the managers are not given room to decide on what will assist in the patients' attention.

4.3.4 Influence of picketing on the provision of medical services

The study sought to investigate the influence of picketing on the provision of medical services. The findings are presented in Table 4.8

Table 4.8 Picketing

Statements	Descriptive	SA	A	UD	D	SD	Total	Mean
Daily hospital routine is disrupted	Frequency	76	40	42	18	24	200	3.53
	Percentage	37	17	23	10	13	100	71%
There may be a complete shutdown of the hospital	Frequency	54	34	34	54	24	200	3.17
	Percentage	27	17	17	27	13	100	63%
There is no work done thus no delivery of services	Frequency	54	47	24	24	47	200	3.17
	Percentage	27	23	13	13	23	100	63%
The cost of management of the hospital becomes high	Frequency	87	34	24	24	24	200	3.63
	Percentage	43	17	13	13	13	100	73%
Replacement of workers becomes difficult	Frequency	54	47	24	24	47	200	3.17
	Percentage	27	23	13	13	23	100	63%

The findings from table 4.8 indicates that 71% of the respondents strongly agreed that picketing disrupts daily hospital routine, 63% agreed that there may be a complete shutdown of the hospital and thus no work is done thus no delivery of services, 63% also strongly agreed picketing does not allow replacement of workers, 73% of the respondents noted that the cost of the management becomes high.

This was interpreted to mean that picketing as an industrial action greatly influences the hospital operations, as noted from the findings there is a complete disruption of hospital duties. There are fewer nurses than the normal levels which often are already less than adequate for providing optimum care. Replacement nurses whether newly hired or shifted from other positions are plopped onto units with little time to get to know the patient or families, thus poor production of hospital services.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The findings presented in chapter four were further summarized here so that specific findings can be obtained clearly in relation to the research objectives. The findings are presented, interpreted and conclusions drawn based on the findings in order to show the research objectives. The recommendations are made on what should be done to improve the medical services in the medical industry.

5.2 Summary of findings and Discussion

From the findings the researcher was able to collect information from different background without biasness across diverse backgrounds for example, age, gender, level of employment and the lengthy of work of the respondents.

Most of the respondents (89%) (Table 4.5) noted that the number of outpatients in the hospital drop. According to earlier studies, it is revealed that sit in strikes inconvenience work in the hospital, they give no room for other workers to be replaced thus outpatients choose to seek for alternatives to access medical attention. Other respondents noted that sit in strikes inconvenience potential patients; patients are also put at risk. Many patients are left to die and they generally jeopardize the quality of hospital services.

These findings are inline with a study done by Wright (2008), the study noted that the poor health outcomes increased for both emergency and non-emergency hospital patients, even as admissions of both groups decreased by about 28 percent at hospitals with strikes. The poor health outcomes were apparent on the period of strike in the striking hospitals, suggesting that they are attributable to the strike itself. And, the poor health outcomes appeared to be due to different types of patients being admitted during strike periods.

The study revealed that walkout strikes may cause the risk of hospitals being closed down; this was supported by 89% (Table 4.6) of the respondents. Other respondents noted that walk out strikes may lead to destruction of medical equipment while others noted that doctors are even not available for consultation.

This study is mostly related to other past literature. McHugh (2001) examines the productivity of struck firms in nine manufacturing industries and finds a negative direct impact of strikes on average labor productivity, walk out strikes leading to closure of industry premises. Similar findings are echoed in studies of specific industries such as the airline industry, where De Fusco and Fuess (2001) find stock market returns of negative 2.6–5.3 percent during strikes, and Kleiner, Leonard, and Pilarski (2002) find that productivity fell greatly at commercial aircraft manufacturing plants during strikes.

Schmidt and Berri's (2004) study of professional nurses strikes indicates that strike costs are significant during the strike period, but are limited to the strike period, with almost immediate return to pre-strike levels of consumer demand for medical services.

The majority (87%) (Table 4.7) of the respondents agreed that, during this period, the management is put under pressure thus unable to effectively manage and the whole process disrupts general work operations in the hospital. Consequently, work stoppages involving nursing personnel have the potential to significantly disrupt hospital operations, with potentially serious consequences for patients. Furthermore, the complex nature of health care delivery necessitates the close coordination of workers who exhibit a great degree of interdependence and whose tenure in a hospital unit can affect patient outcomes. Healthcare institutions may thus be particularly susceptible to labor unrest that disrupts these complex processes.

The findings in this study are similar to that of James (2009) who investigated the impact of a physician work slowdown tied to increased malpractice rates in Los Angeles. He finds that causes of death shifted over the course of the slowdown, with decreases in deaths from elective surgery and increases in deaths associated with emergency room transfers.

The findings from the table indicate that most (73%) (Table 4.8) of the respondents strongly agreed that picketing disrupts daily hospital routine. This implies that this type of strike arouses a lot of public awareness which carries the element of conduct and thus destructs the whole process of smooth running of an organization. When a strike occurs, a hospital might cut down on its activities, canceling elective surgeries, and move some patients to other hospitals. The position normally taken by unions, by governments, and even by hospital management is that, while hospital strikes cause inconvenience to actual and potential patients, serious harm to

patients is avoided. Skeptics find such claims implausible, as reduced staffing levels and increased pressure on the available staff might put patients at risk.

Samuel Kleiner (2012) examined strikes by nurses in New York State, comparing patient outcomes at hospitals where strikes occurred to those without strikes. They found that strikes increase patient mortality rates by about 20%. In the 43 hospitals in their sample, this percentage translates to an estimated 138 patient deaths over a 12-year period that would otherwise not have occurred. Further, hospital readmission rates were 6% higher, indicating that patients were more likely to have complications or other follow-up problems if they receive care in a strike situation. For the hospitals in the study, an estimated 344 additional readmissions were due to strike activity. Bargaining inefficiency in the form of nurses' strikes would seem to have high costs for consumers of medical services.

As much as all the kinds of strikes happened o take place, in the hospital, there were some which seriously affected the provision of medical services that others but in all, the facility was affected negatively.

From the above analysis, the correlation to determine the type of strike that affected much the provision of medical services from the four seen to be that of the walk-out strike which resulted into the closure of the hospital 89% (Table 4.6) and the medical equipment put at risk of being destroyed. This also resulted into the unavailability of doctors for consultation, thus turning away of patients and the management being unable to make fruitful decisions for the facility.

This was followed by the sit-in strike where the patients were put at risk because of not being attended to, a drop of the number of patients 89% (table 4.5) which resulted into patients being evacuated from the hospital.

The third kind of strike that affected the provision of services was seen to be that of picketing which disrupted the hospital daily routine. This also brought about high cost of managing the hospital 73% (table 4.8). Finally, the go slow strike was, the least in effecting the provision of services in the hospital. This was seen to be where nurses took possession to rule the authority some essential services were being taken care of.

5.3 Conclusions

The long-standing concern with strikes as a means of resolving labor disputes is that they may be unproductive. It is revealed from the study that strike activity clearly affected to a large extend the provision of medical services in the industry. Participants reported that sit in strikes, gives employees the opportunity to occupy the work place, continue or perhaps stop work but deny the employer access to or control of the production process. The employees remain on the employer's premises, taking possession of the property and preventing the employer from entering is per se unlawful. This affects the running of the hospital activities. Walk out strikes on the other hand as well affect the provision of medical services, as noted in the study, it creates tension among other members of the community giving a complete standstill of organizational operations. Finally, from the findings it is clear that strike actions threaten the existence of organization and create havoc to the employee performance of workers in the hospital. The adoption of strike actions therefore is a step in the wrong direction. It is an enemy of progress. The result of strike action is better imagined than described.

It is better to take a stand now to change the status quo so that, ultimately, patient care and working conditions and staffing improve and thus, in the long run, more patients get better care. These strikes may, however, contribute to long-run improvements in hospital productivity and quality driven by union-related workplace improvement initiatives.

5.4 Recommendations

Based on the findings, the following recommendations are strongly made by the researcher.

i. Workers should be well paid so that they can meet up with their daily needs and it should not be delayed for any reason at all.

ii. The government should stop using threats to the employee as a solution to strike action rather they should use dialogue to bring a lasting solution.

iii. Government should examine the issue of allowance to workers so that there will be social justice and equity in allowance granted to various cadres of staff. Workers should see their employers as role models and not as paupers. The employers will make the employers help the workers consider their plight and soft-pedal whenever they want to think of any strike.

iv. Finally, the researcher admits that strike actions do not create conducive and healthy ground for workers viable performance in their working conditions. However, the management has a major role to play so as to avert possible strike action the management should be responsive considerate and be ready to understand the plight of the love of the workers at heart. An atmosphere of cordiality should exist between the worker and the management. This will guarantee employee performance and effective implementation of government working policies.

5.5 Suggestions for Future Study

The project has been written comprehensive but not exhaustive, many areas exist within the Kenyan environment which require further studies.

1. More research should be conducted further in other hospitals in Kenya.
2. More research should also be conducted to find out whether strike action influences the economy of the whole country.

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APPENDICES

APPENDIX 1: LETTER OF AUTHORIZATION FROM THE NATIONAL COUNCIL OF SCIENCE, TECHNOLOGY AND INNOVATION

APPENDIX 1: LETTER OF AUTHORIZATION FROM THE NATIONAL COMMISSION OF SCIENCE, TECHNOLOGY AND INNOVATION

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

16th December, 2014

NACOSTI/P/14/7539/4279

Shitsinzi Ronald Shikuku
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"An investigation of industrial action on provision of medical services by nurses in public hospitals: A case of Rift Valley Provincial General Hospital, Nakuru County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Nakuru County** for a period ending **31st March, 2015.**

You are advised to report to **the Medical Superintendent, Rift Valley Provincial General Hospital, the County Commissioner, the County Director of Education and the County Coordinator of Health, Nakuru County** before embarking on the research project.

On completion of the research, you are required to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. S. K. LANGAT, OGW
FOR: SECRETARY/CEO

Copy to:

The Medical Superintendent
Rift Valley Provincial General Hospital.

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APPENDIX 2: LETTER OF INTRODUCTION

RONALD SHIKUKU SHITSINZI
L50/84418/2012
P.O Box ……
Nakuru.
19/05/2014

THE DIRECTOR,
RVPH,
PO BOX
NAKURU

Dear Sir/Madam,

RE: PERMISSION TO CARRY OUT ACADEMIC RESEARCH

I am a post graduate student undertaking a Masters of Arts Degree in Project Planning and Management at the University of Nairobi. I am intending to carry out research on the influence of industrial action on provision of medical services by nurses in public hospitals: a case of Rift Valley Provincial General Hospital Nakuru. I am kindly requesting to conduct an academic survey research of the consequences of strike on the medical service delivery in your institution.

The purpose of this letter is to request for permission to interview nurses using the attached questionnaire. The information obtained is strictly for academic purpose and shall be treated with utmost confidentiality.

Thank You

Yours faithfully

RONALD SHIKUKU SHITSINZI
L50/84418/2012

APPENDIX 3: QUESTIONNAIRE FOR NURSES

Kindly take a few minutes to complete this questionnaire. The information you will provide will remain confidential and the results will be analyzed and reported collectively your responses will go a long way to inform the management of Rift valley Provincial Hospital in making informed decisions about the clients.

SECTION A: Background characteristics of the nurses

1. Your age (in complete years)

21-30 years ( )

31-40 years ( )

41-50 years ( )

51-60 years ( )

Over 61 years ( )

2. Gender Male Female

3. Term Employment?

□Permanent employment □Part-Time employment □Contract

4. Number of years worked

0-5 ( )

5-10 ( )

10 and above ( )

SECTION B: Influence of Industrial Action on the Provision of Medical Services

1. Use the rating below to give your opinion on the influence of sit in-strike on the provision of medical services. Key: SA - Strongly agree, A - Agree, U - Undecided, D - Disagree, SD - Strongly disagree

Item No	Sit in strike	SA	A	U	D	SD
1	Sit in strikes cause inconvenience to actual and potential patients					
2	Patients are put at risk					
3	The number of outpatients drop					
4	Patients are evacuated					
5	Many patients are left to die					
6	They generally jeopardize the quality of hospital services					

2. Use the rating below to give your opinion on the influence of walk out strikes on the provision of medical services. Key: SA - Strongly agree, A - Agree, U - Undecided, D - Disagree, SD - Strongly disagree

Item No	Walk out strikes	SA	A	U	D	SD
1	Hospitals are closed down					
2	Daily hospital duties are disrupted and medical equipment are put at a risk of being destroyed					
3	Tension is experienced in the surrounding					
4	Doctors are unavailable for consultation					
5	Inability of management to make decisions					

3. Use the rating below to give your opinion on the influence of go slow strikes on the provision of medical services. Key: SA - Strongly agree, A - Agree, U - Undecided, D - Disagree, SD - Strongly disagree

Item No	Go slow strikes	SA	A	U	D	SD
1	The management are put under pressure thus unable to effectively manage					
2	The employees work to rule the hospital thus affecting productivity					
3	makes it very difficult for employer to defy the union and take the workers place					
4	Employees restrict their work output thus affect production					
5	There is inability to meet the patients demands on schedule					

4. Use the rating below to give your opinion on the influence of picketing strikes on the provision of medical services. Key: SA - Strongly agree, A - Agree, U - Undecided, D - Disagree, SD - Strongly disagree

Item No	**Picketing**	**SA**	**A**	**U**	**D**	**SD**
1	Daily hospital routine is disrupted					
2	There may be a complete shutdown of the hospital					
3	There is no work done thus no delivery of services					
4	The cost of management of the hospital becomes high					
5	Replacement of workers becomes difficult					

APPENDIX 4: DETERMINATION OF SAMPLE SIZE FOR A GIVEN POPULATION BY KREJCIEANDMORGAN

Table for Determining Sample Size for a Given Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size
"S" is sample size.

Source: Krejcie & Morgan, 1970

APPENDIX 5. RESEARCH BUDGET

Items/particulars Cost	**Quantity**	**Unit cost (Ksh)**	**Total (Ksh)**
Proposal Development			
Computer services	Prepare 6 drafts	500	3,000
Travel and accommodation	4 times for one person	3,000	12,000
Stationery and photocopy	3 reams of printing and photocopies		2000
Sub-total			**17,000**
Proposal Defence			
Photocopy services	photocopies		3,000
Computer services	6 copies	500	3,000
Travel and accommodation	2 times for one person	3,000	6,000
Telephone services	Calls		1,000
Sub-total			**13,000**
Data Collection			
Telephone services	Calls		2,000
Travel and accommodation	4 times for one person	3,000	12,000
Stationery and photocopy	6 reams of duplicating papers and photocopies		4,000
Sub-total			**18,000**
Data analysis and project Report Writing			
Computer services	Typesetting		2,000
Telephone services	Calls		2,000
Travel and accommodation	2 times per one person	3,000	6,000
Stationery and photocopy	4 reams of duplicating papers and photocopies		3,000
Sub-total			**13,000**
Defense of Final Report			

Computer services	Typesetting and printing		2,000
Photocopy services	Photocopies		2,000
Travel and accommodation	2 times for one person	3,000	6,000
Telephone services	Calls		2,000
Sub-total			**12,000**
Correction of the report			
Computer services	Typesetting and printing		2,000
Sub-total			**2,000**
Preparation /Submission of the Final Report			
Photocopy services	Photocopies		2,000
Computer services	Typesetting and printing		3,000
Travel and accommodation	2 times for one person	3,000	6,000
Telephone services	Calls		2,000
Sub-total			**13,000**
		Grand total	**88,000**