

Recurrent Public Health Care Sector Strikes in Nigeria: Understanding the Causes and Taming the Tide

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ABSTRACT

Nigeria is one of the unhealthiest countries in sub-Saharan Africa due in part to the chronic human resource for health challenges of inadequate critical health professionals, inappropriate skill mix, mal-distribution and persistent emigration of highly skilled health professionals. Since the advent of democracy in 1999, the country has been thrown into cycles of crippling health workforce strike actions in the public health care sector. A number of interventions by governments have failed to stem the tide of strikes. The study examines why the rampant nature of these strikes and recommend actionable strategies to mitigating their frequency. The study adopted a mix method approach to collect quantitative and qualitative data, using questionnaires and key informant interviews. Qualitative interviews were analysed by content analysis and interpretation, and descriptive statistics applied to quantitative information. We established that epidemic of strikes crippling public health facilities have multiple origins, which range from agitations for improved welfare, inter-professional health leadership rivalries, conflicting professional regulatory policies and a lack of honest collective bargaining with unions and political will to faithfully implement agreements. To halt the slow, but steady slide of the public health care into a state of collapse, government must let go its current fragmented approach to resolving industrial disputes in the public health sector for multi-prong strategy that recognizes the interrelationships in the health terrain.

Key words: Public health care sector, recurrent strikes, industrial disputes, collective bargaining, health professionals, government

BACKGROUND

Health is central to human existence and value of life, hence its integration in the United Nations constitution as a fundamental right.¹ Good health is basic for personal and economic development, and poverty reduction, as well as an essential ingredient for intellectual,

emotional and physical advancement.² Disease control efforts therefore, now top developmental agenda of all societies, and reflected in numerous health related international declarations, such as the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs), among others.^{3,4} The Federal Republic of Nigeria also constitutionally guarantees its citizens the right to health, and is signatory to several international treaties and agreements targeting improved population health outcomes.⁵ However, despite several decades of health policy implementation efforts, the country remains one of the unhealthiest nations, with a weak health system incapable of ensuring adequate access to needed health care services for its citizens.^{6,7}

The WHO recommends a balanced mix of health workforce, health financing, leadership and governance, health information system, medical products and service delivery for building, strengthening and sustaining a robust health system capable of providing essential health care services and guarantying universal health coverage.⁸ The stock of human capital is the most central to any health system, and evidence has revealed a strong positive association between health workforce related variables and improved health outcomes.^{8,9} Health care workers are gatekeepers into the health system, and pivotal to the efficient or wasteful deployment of health system resources. Nigeria has one of the largest human resource for health in Africa, surpassed only by South Africa and Egypt,⁹ with above average scores for both physician and nurse/midwife densities for Africa.¹⁰ Despite the impressive statistics, its population health levels remain one of the worst in sub-Saharan Africa.¹¹ The blend of shortages of critical health professionals, inappropriate skill mix of health teams, mal-distribution of available work force, and persistent exodus of highly skilled health professionals have consistently undermine the system.^{9,12} Compounding these problems and challenges lately is the cycle of crippling strike actions, like never before, since the country gained independence in 1960. Recurrent health worker strikes in public health care facilities is becoming a permanent feature on the health terrain, and a growing concern to governments and citizens alike, given its dominance, preference, and affordability relative to the private markets. The intensity and frequency of these strikes have made many to argue that the health sector of the economy has witnessed more strikes in terms of scope and scale than any other segment.^{13,14} For example, since the advent of democracy in the country in 1999, there have been no fewer than 70 strike actions in the public health sector. Various interventions by governments focused on improving the health sector, in terms of sharp increases in budgetary allocations, enactments of national health policy and national health act, have all failed to stem the tide of strikes. Further, two presidential committees to unearth and proffer solutions to the root causes of frequent disruptions in public health care services have also not yielded the desired outcomes. It would appear the government is simply overwhelmed. Nigerians have continued to be confronted with having health facilities abruptly shut against them cyclically, denial of access to medical care and deteriorating health status. The situation continues to undermine the nation's efforts towards universal health coverage (UHC), population health status improvements and sustainable development, as envisaged in the SDGs. This study therefore, seeks to systematically explore strikes in public health care institutions in Nigeria, in order to understand the drivers and their interactions, and what best actionable policy interventions government may adopt to effectively address the conundrum of incessant strikes. The study will also determine the perceptions and attitudes of public health workers towards strikes. The utility of the study resides in the insight it will generate and the potential to serve as reference

material for future research. In addition, the findings will serve as information repertoire for civil society organizations advocating for health services planning and delivery in Nigeria.

METHODS

The study was conducted at the Jos University Teaching Hospital (JUTH), owing to its general and specialist services structure, thus presenting a good approximation of the typical setting for the usual interactions among the mix of health care workers in Nigerian health system. The diverse and rich pool of professionals in the hospital was further adjudged to offer a perfect context for in-depth analysis of inter-professional influences in the health care work environment, which the study targeted.

The targeted population for this study was all unionized employees of the hospital, comprising doctors, nurses, pharmacists, technologists, therapists and administrative staff and adopted a cross-sectional descriptive research strategy.

The exact number of health workers in JUTH could not be determined as the information was said to be restricted. However, it was estimated there were about 250 health care employees all together and the minimum sample size of participants for the study was determined by Taro Yamane formula,¹⁵ as shown below.

$$n = \frac{N}{1 + Ne^2}$$

Where; n= minimum sample of health workers to be surveyed
 N= total number of health workers in the facility to be studied
 e= error margin of 0.05 based on 5% significance level

Thus,

$$\begin{aligned} n &= \frac{250}{1 + 250 \times (0.05)^2} \\ n &= \frac{250}{1 + 250 \times 0.0025} \\ n &= \frac{250}{1 + 0.625} \\ n &= \frac{250}{1.625} \\ &= 153.8 \\ n &= 154 \text{ (approx.)} \end{aligned}$$

The study deployed a mix method approach to collect quantitative and qualitative data, relying on single measurement instruments or triangulating methods, in relation to the objective or subjective nature of a particular variable. For example, the set of variables that make up the concept of demographic data are fairly stable and a single measurement approach (self-administered questionnaire) was deemed sufficient for gaining valid data. Knowledge and practices as individual variables however, vary widely among participants and even in the same individual in different contexts, hence, data falling under these categories were triangulated.

The design of the questionnaire used to collect primary self-reported data in this study from participants was informed by literature review of previous quantitative and qualitative work in the study area and in relation to the study objectives. It covered demographic data, socio-economic characteristics, knowledge and attitudes towards strikes by health care workers in public health care facilities.

In-depth structured key informant interviews were used to collect a rich amount of data, based on emergent themes from questionnaires and apriori themes identified. The main domains

interrogated focused on causes of strikes, previous attempts to prevent strikes and why they failed and the way forward. Although these key areas formed the basis of the interview guide, useful insights arising during the interview process were further explored in detail. Key informants interviewed included chairmen of all public sector health workers' unions; Medical and Dental Consultants Association of Nigeria (MDCAN), Association of Resident Doctors (ARD), Joint Health Sector Union (JOHESU), a senior management staff at JUTH (policy implementers) and a senior policy maker at the federal ministry of health, Abuja.

All interviews were conducted in English by the researcher and recorded with a digital recorder between the working hours of 8 am to 4 pm. Interviews lasted between 30 and 40 minutes. During each interview, notes were also made about the interviewee's attitudes and non-verbal languages, and ways of asking clearer questions in subsequent interviews noted.

The general approach adopted in data analysis was one of thorough familiarization with the data, content analysis and generation of a coding framework and data interpretation, all in relation to the study objective. Content analysis of nominal data from structured interviews was undertaken to structure and categorize the information gathered. The interview data were transcribed and the transcription notes reviewed for accuracy by comparison with two reviewers. The contents were then re-read systematically and coded line by line into structured categories manually, using a two level coding approach. First, an apriori set of codes was generated from related literature reviewed before the data was collected. For example, broad categorical codes as causes of strikes, unionization in health care sector and health management derived from empirical and theoretical reviews. In the careful reading and analysis of data, new ideas, relationships and meanings emerged through inductive reasoning processes, which gave rise to a number of emergent codes, some of which included ideas as motivation, professional expert, and mutual respect. The fit of these structuring codes to the data and objectives of the study was ensured through constant comparison of newly coded texts with previous similar codes, which allowed for consistency of coding, data interpretations and visualization of patterns.

Quantitative data were double-checked and entered into Microsoft Excel version 2010 and imported into SPSS version 19.0. Descriptive statistical analysis was performed on demographic data, and relationships between variables explored through cross tabulations. Key findings were isolated and summary data described and displayed as charts and tables to aid visualization of relationships between factors.

This study involved a well educated population and not associated with harm both in the short and long terms. Therefore, institutional ethical clearance was deemed not mandatory. However, permission to undertake the study was obtained from the leaderships of the various health workers associations. Thus, only oral consent was obtained in the study, so as to create an informal situation that supported more honest information sharing. Anonymity of participants was ensured by treating all information obtained with strict confidence, and by transcribing the data using code numbers, storing the interview tapes and transcribed notes in locked cabinets. Furthermore, the research laptop holding participants' information was secured by personalized password.

RESULTS

The study results present a synthesis of a wide range of evidence generated from questionnaire and key informant interviews. 196 questionnaires were administered to health care providers and 186 responses retrieved, yielding a 94.89% response rate. 104 (55.9%) were males, while 82 (44.1%) were female respondents. The mean age of participants was 30 years, with a range of 25-45 years. About 70% of the sampled population were married, as depicted in Table 1 below.

Table 1: Socio-demographic Characteristics of Respondents

Variables	Frequency	Percentage
Age group(years)		
25-29	44	23.7
30-34	61	32.8
35-40	43	23.1
≥41	38	20.4
Sex		
Male	104	55.9
Female	82	44.1
Marital status		
Married	130	69.9
Single	55	29.6
Others	1	0.5
Total	186	100.0

The study found that 64 (34.4%) of the participants had less than 5years work experience, while 59 (31.7%) had worked for between 5 and 9 years. Doctors, nurses and pharmacists formed the most dominant professional groups constituting 28.5%, 28.0% and 17.7% respectively, and a total of 74.2%. 64.9% of respondents were not satisfied with their current earnings, 66.7% were not fulfilled by their work conditions and 84.9% said the health system in Nigeria is understaffed, and shown in Table 2.

Table 2: Occupational Characteristics of Participants

Variables	Frequency	Percentage
Number of Years in Service		
<5	64	34.4
5-9	59	31.7
10-14	32	17.2
15-19	11	5.9
20-24	6	3.2
>24	14	7.5
Occupational Status		
Administration Officer	16	8.6
Doctor	53	28.5
Laboratory Scientist	21	11.3
Nurse	52	28.0
Pharmacist	33	17.7
Physiotherapist	7	3.8
Radiographer	4	2.2
Staff Adequacy		
No	28	15.1
Yes	158	84.9
Income Satisfaction		
No	120	64.9
Undecided	28	15.1
Yes	37	20.0
Work Condition Satisfaction		
No	124	66.7
Undecided	22	11.8
Yes	40	21.5
Total	186	100.0

These findings reveal a workforce dominated by relatively early career workers (less than 10 years in service), with doctors, nurses and pharmacists being the main stakeholders. It also shows high level of dissatisfaction with remunerations, overworked staff and weak infrastructural support.

When asked about their attitudes to strikes, 54.3% did not favour industrial actions in the health sector, and 46.5% said strikes never achieved their intended outcomes. Only 42.1% agreed to want to participate in strike actions, implying that most health workers have no propensity for strikes.

The commonest reported means of work-place dispute resolution channels were negotiations 30.3%, collective bargaining 21.6% and strikes 19.6%. Other dispute resolution mechanisms identified were persuasion, arbitration and mediation as depicted below.

Table 3: Knowledge of Dispute Resolution Mechanisms among Health Workers

Response	Frequency	Percentage
Negotiation	56	30.3
Collective Bargaining	40	21.6
Strikes	37	19.6
Persuasion	22	12.0
Arbitration	19	10.2
Mediation	12	6.3
Total	186	100.0

A large number of health workers are unaware of conflict resolution approaches, with some erroneously seeing strike as a tool for resolving industrial disputes.

The most common causes of strikes by public health sector workers was non-implementation of agreements entered with government and management 63.3%, followed by demand for improved remuneration 43.6% and poor government policies 37.1%. Other drivers of public sector health worker strikes include infrastructural deficit, inter-professional rivalries, funding gaps, inadequate workforce numbers, and lack of training opportunities.

Table 4: Common Causes of Health Workforce Strike in Nigeria

Common Causes of Strikes	Frequency	Percentage
Non-implementation of Agreements	127	63.3
Demand for higher salaries and wages	80	43.6
Poor Policies	69	37.1
Worker inadequacy	63	33.9
Insufficient funding	51	27.4
Poor Infrastructure	46	24.4
Inadequate working tools	34	18.3
Lack of Trainings	30	16.1
Inter-professional Rivalry	20	10.8

Multiple responses were allowed

The result indicates strike aetiologies can be classified as institutional (policy and management factors); individual (demand for salary increases and staff shortages); funding gap (poor infrastructure, inadequate tools and lack of staff trainings) and inter-professional competition. Key informant interviews corroborated questionnaire findings about the causes of strikes in the public health care sector. Interviewees identified inter-professional rivalry, non-implementation of extant civil service rules during strikes, and unrealistic concessions to

striking unions by governments to end strikes. Other causes found were persistent underfunding of the health sector, intractable infrastructural decay and local management issues. Inter-professional rivalries between diverse professionals emerged as the commonest reason for strikes by health workers. These competitive behaviours were framed differently as exemplified below:

"The biggest problem in the health sector in Nigeria today is inter-professional rivalries between doctors and the others (all other health workers and administrators). They perceive that doctors are highly paid, and they too should be paid professional allowances" (KII ... 3) "Doctors have monopolized all leadership positions in the public health sector to themselves. Take for example; the minister of health must be a doctor, if the minister is not a doctor, like when a pharmacist was appointed, doctors won't agree. Doctors head all health Parastatals, to the exclusion of other health professionals. This is not fair." (KII 1)

Another dimension of rivalry among health workers lay in conflicting government policies.

"Government is sometimes the cause of problems in the health sector by making laws that conflict with one another. A good example is the law establishing the Medical Laboratory Science Council of Nigeria, which encroached on the earlier law establishing the Medical and Dental council of Nigeria"

The role of government loomed large in trying to understand the incidence and prevalence of strikes in the health sector. Governments were blamed for keeping incomes of health workers sticky, as well as applying divide and rule tactic in handling labour grievances, where a union's ability to agitate seem to determine the welfare improvement it got. The perception was that government tended to favour one union over others.

"The government has not reviewed CONMESS salary scale since 2009, but inflation has eaten into our salaries." (KII 1)

"Government must be objective in policy making, which is holistic, not responding to one union to the detriment of others." (KII 2)

Additionally, government was said to enter into collective agreements that were not realistic and un-implementable just to ease the pressure of striking unions and non-adherence to civil service rules and regulation. For example, it was pointed out that although trade legislations stipulate no-work, no-pay to deter strikes, this is often always overlooked.

"Government signs MoUs with unions, which are not implementable, and when that happens, the unions resumes strike again, since strikes are usually suspended, not called off." (KII ... 4)
"..., at the end of a strike, government and unions agree to no victor, no vanquish and withheld salaries are paid back to striking workers, and so they keep going on strike." (KII ... 3)

Political expedience is another behavior of government that fingered by participants as driving and reinforcing strike actions. In a bid to enhance its electoral performances, governments were said to accede to demands of striking workers that it cannot fulfil.

“Sometimes, government ponders on political needs of the moment, especially when elections are approaching, they fear of taking far reaching decisions, because of electoral vote loses.” (KII ... 5)

These findings have highlighted government’s role in the perpetuation of strikes in public health institutions in Nigeria, in relation to conflicting health laws and policies, lack of systems that periodically improve worker remunerations in line with inflationary trends in the economy and concessions to unrealistic demands from unions. Other factors include lack of commitment to MoUs entered with striking unions, fragment approach to systemic problems and political expediencies.

Although public health sector strikes in Nigeria are often nationally coordinated, occasionally local institutional governance issues trigger strikes. Commonest causes discovered were, lack of clear and timely communication from hospital administrators, non-engagement of workers in the policy making processes, long delays in payment of salaries and allowances, poor state of infrastructure, non-availability of equipment and consumables in hospitals and irregular staff promotions.

“You see most of the causes of local strikes by health workers are as a result of poor management. Management staff isolates themselves from the workers. They don’t communicate openly with workers; they don’t carry other staff along in policy making and all that. So, how do you expect that there will be no strikes?” (KII.... 5)

Another respondent said:

“..., when hospital administrators do not constantly engage with unions and workers, people develop opinions and perceptions, which they hold tenaciously as real and act based on these impressions.” (KII ... 3)

“It is common sense that where there lack of equipment and drugs to work with and hospitals become mere consulting clinics, it demoralizes worker and reduces their productivity. The same thing happens when the infrastructure is allowed to rot away, or promotions are delayed, workers are regularly trained, or retrained. All of these make workers prone to going on strikes.” (KII... 1)

These findings indicate that health system governance issues are equally important in the incidences of strikes and their recurrence in public hospitals in Nigeria. Management actions or inactions impact negatively on staff welfare, thereby, lowering morale and satisfaction, and threshold for strikes.

KIIs interrogating solutions to rampant strikes revealed suitable ways of solving the lingering strike conundrum in the public health care sector. These strategies are; formation of an all-encompassing conflict resolution committee, re-orientation of all health workers (medical and non-medical) about the team nature of health care and mutual respect and adoption of objective and balanced approach to policy making that meets global best practices. Other responses elicited include firm implementation of extant labour laws, creation of special health intervention fund, performance based payment of health workers under a public-private-partnership arrangement and strengthening of the overall economy, which health care is integral to. These opinions are exemplified below:

“The health system is weak because of our economy is weak. To find sustainable solution to the health sector problems is first improving the overall economy and the improvement will trickle down to the health system.” (KII ... 4)

Performance based payment of health workers was also advocated as a sustainable approach to halting the spiral of strikes in the public health sector. This was argued as the reason for stability and better productivity seen in the private health sector, as exemplified below.

“Why are there no strikes in the private health sector? There you earn only when you are productive. So, if that principle is introduced to the public sector, that will end strikes, since if don’t work you don’t get pay.” (KII ... 4)

System approach to the strike conundrum in public health care sector was also canvassed as a panacea for the repetitive work stoppages. This concept encompassed ideas such neutrality of conflict resolution committee membership that involved all stakeholders in the health sector, as well as health system reforms along improving health financing, health institutional restructuring to improve governance, and policy and regulatory recalibration. These thoughts are reflected in the following excerpts:

“Most of the management staff of our hospitals have low managerial capacity and are not managing effectively. In the circumstance, doctors do better job of managing; however, adopting professional health managers will address the leadership tussle between the unions.” (KII ... 4)

Concerning regulatory reforms, an interviewee said:

“The government must be firm in the implementation of no-work, no-pay law whenever workers embark on strike. Government must not be seeing as encouraging lawlessness by waiving this clause as concession for striking unions” (KII ... 2)

Finally, the need to re-orientate all health workers (medical and non-medical) to the team nature of health services delivery also emerged as a way to ending incessant strikes by public health workers.

“All health workers should be made to understand that every effort must be patient centred and need teamwork, in the spirit of mutual respect and recognition.” (KII ... 2)

DISCUSSION

Health worker strikes are global phenomena, and Nigeria has had more than its fair share of this problem. Strikes have become so rampant to the extent that on the average, there is the likelihood of strike every month of the year. At any point in time, one or the other of the several professional unions in the public health sector is likely to be on strike.¹⁶

The socio-demographic findings that the typical health worker is youthful and more likely to be married may have important influence on strikes. These factors may act through economic pressures on health workers, which may intensify strikes. The high cost of living can serve as drivers for health workers to demand higher wages and ultimately strikes, if their demands are not met.

Public health sector workforce is dominated by relatively early career workers (less than 10 years in service), with doctors, nurses and pharmacists being the main stakeholders. It also reflects a high level of dissatisfaction with remunerations, overwork and weak infrastructural support as also reported by Oleribi and colleagues¹⁷ in a cross sectional study of health care workers industrial action in Nigeria. This cause is particularly pertinent given the highly lucrative incomes of these categories of professionals in other climes.¹⁸

Majority of participants in this study did not favour strikes as an effective tool for resolving industrial actions in public health sector, which corroborates the findings by Oleirbi et al.,¹⁷ who also showed that most health workers in Abuja, Nigeria, did not favour embarking on frequent strike. This aversion may provide a basis for legislation that makes membership of health unions optional, thereby mitigating the incidence and impact of health worker strikes. This freedom of association aligns with the practice in the United Kingdom as an example.

We found that a large number of health workers were unaware of conflict resolution techniques, to the extent that some erroneously saw strike as a way of resolving industrial dispute. This perception has the potential of priming health workers to seeing strikes as a first approach to conflict resolution in work places. This tendency can be halted through the training of health workers in industrial relations and conflict resolution strategies.^{17,19} The strategy may also correct the notion among public health workers in Nigeria that the only language governments understand is strike.²⁰ This perception is rooted in the observation that in most situations, employers or governments will yield to employee demands, only when a strike occurs.²¹

The common causes of strikes in the public health sector arose mainly from government/management related factors, then worker variables and policy related issues. These findings are supported by insights from several authors,^{17,19} who also reported this hierarchical causal ordering of strikes in public health facilities in Nigeria. Adebimpe and colleagues²² on the other hand found the demand for better salary and welfare was the commonest cause of strikes among health workers in Lagos, Nigeria, followed by disagreement on a variety of work-related principles. International studies reveal that the foremost reason for strikes in the medical field is poor working conditions, followed by wage, and other incentives.²³ Overall, the causes of public health sector identified in this study can be analyzed at four basic levels of institutional factors, comprising policy and management causes; individual factors made up of demand for salary increases and staff shortages; funding deficit, exemplified by poor infrastructural support base, inadequate tools and lack of staff trainings, and inter-professional rivalries. Alubo and Hunduh²⁰ have argued that the main issues in public health sector disputes relate less to availability of properly equipped facilities and adequate consumables for the delivery of quality services, rather, the main concerns revolve around union welfare benefits, leadership competition and career progression. Our study has also highlighted the role of these determinants in strike onset and perpetuation in Nigeria. The authors argued further that heavy emphasis of Nigeria's health policies on medical care to the detriment of other vital dimensions of health such as public and environmental health, which makes medical care providers exert an overbearing influence on the system. They also cited the country's overly centralized federal system of governance as giving impetus for frequent strikes, as states have minimal control over wages and emolument determination.

At the base of inter-professional rivalry between doctors and non-doctors in the health sector is a perception of dominance by doctors of the health sector to the exclusion of other professional entities in the system.²⁰ This monopoly of power is traceable to pre- and early post- independence era, when the non-medical health workers were relatively few and never opposed the towering influence of medical doctors in the sector.^{24,25} It has been argued however, that with the large numerical strength and increasing specialization, non-medical professionals in the health sector are now resisting the perceived medical dominance and demanding greater participation in health system governance structures.^{20,26} These political structures include leadership of the health team, consultant designation, health ministerial appointment, wage parity and career progression. Leadership issues at various levels of the system was particularly emotive in our findings as well.

The cyclical shutting of public health facilities impacted negatively the strikers themselves, health institutions and consumers of health care. Patients in particular, faced sub-optimal quality of care, lower health outcomes and higher financial costs, largely due to resort to the poorly regulated private health market for care.²⁷ This in turn may have important implications for future utilization of public health institutions. The loss of consumer confidence and patronage may result in system failure and threat to universal health coverage.²⁸ Other researchers have also reported the impacts of health worker stoppages to include increased mortality, disruption of healthcare services delivery, discharge of patients from hospital without completeness of care, limited care to clients, high rate of referrals to private hospitals and revenue losses to the health system as we also found in this study.^{16,22} These authors also found economic and psychological costs of health system strikes such as, work loss, transport costs, treatment delays, prolonged suffering, irreversible damage to health (morbidity) and death (mortality).

CONCLUSIONS AND RECOMMENDATIONS

Industrial conflicts in public health care sector in Nigeria are to be expected, given its complex workforce structure and labour-intensive production processes. The current epidemic of strikes crippling public health facilities spring from agitations for improved welfare, inter-professional health leadership rivalries, conflicting professional regulatory policies and a lack of political will from government to negotiate realistic collective bargaining agreements and faithfully implement them. To halt the slow, but steady slide of the public health care into a state of labour militancy, where strikes become weapons in the bargaining arsenal of unions, government should adopt remuneration and emoluments policies in the health sector that vary directly with inflationary trends in the economy, address overlapping and conflicting areas of professional jurisdictions in the sector, and review current health personnel training curricula to integrate inclusive leadership, team work and inter-professional collaboration. Further, health management capacity building trainings should be created to produce a pool of skilled healthcare leaders and managers. Finally, government must show requisite political will going forward by implementing collective bargaining agreements honestly entered into with health labour unions.

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