A consideration of the ethical challenges raised by healthcare worker strikes

Kenya's long running strike by doctors has concentrated minds on all sides. Pre-eminent physician, Dr. J A Aluoch, considers the dynamics involved

'I am staring death in the face; we are dying one by one.' That was the heartfelt cry of a doomed patient at a Kenyan public hospital at the height of the ongoing doctors' strike.

'My friend, a cancer patient like me was buried today! I am stuck in this private hospital now with astronomical bills that I cannot pay!' This was yet another desperate cry. Whence will it all end?

These sad tales of suffering and desperation in Kenyan hospitals have been repeated by many patients during the ongoing strike by doctors in public health institutions in Kenya that started in early December 2016. As the strike continues, patients are forced daily to languish without hope, abandoned in run-down public hospitals unattended, or to raise huge sums of money to access treatment in private institutions. And doctors are forced to scrounge to make ends meet. Looks like a dead giveaway lose-lose situation to me!

Medical doctors' strikes are a common global phenomenon. In the recent past, a number of strikes have been reported in various countries in Africa. In Kenya, the first strike by doctors in the post-independent era occurred in 1971. The writer was among those who took part and were crammed into police vehicles and unceremoniously bundled into police cells for three days without any pretence at judicial niceties. Now, as then, the doctors claim that access to acceptable healthcare in Kenya has seriously deteriorated due to massive corruption in the sector. But that's just part of the story.

Strikes are collective actions that occur in all democratic societies, where organised interest groups are both recognised and entertained by the state for the pursuit of common goals of a professional- or trade-related nature, among others. Professional associations and trade unions are among such forms of collective interest organisation meant to consolidate power for the purpose of negotiations with government. Health is a very important human value and hence healthcare is a paramount 'social good'. In a general sense, social goods, also known as collective or public goods, are goods or services that benefit the largest number of people in the largest possible way. Some classic examples of social goods are clean air, clean water and literacy; in addition, many economic proponents include access to services such as healthcare in their definition of the social or common good.

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Photo credit: The Star/Monicah Mwangi

In many countries, especially in the African continent, healthcare workers (HCWs), including doctors, are often dissatisfied with their working conditions and terms of service. This includes monetary aspects such as payments and non-monetary factors such as healthcare policy issues, security and safety, better working conditions, and hospitals' physical and administrative infrastructure. Doctors argue, and rightly so, that they are often compelled to take forceful action to make their voice heard and have their needs or demands met, and that strike action may legitimately be deployed as one of the ultimate resorts. Such collective actions by practicing doctors are occurring with increasing frequency across the African continent, perhaps pointing to a deeper malaise in the general public service system that is crying out for reform.

This lack of proactive engagement with healthcare workers, of not responding until people's lives are at stake, is a major concern in healthcare, where both human dignity and life are among the first casualties, however unintended. Sadly, for the disgruntled HCWs of Africa, strikes are perhaps the only real bargaining chip remaining, the others having been steadily whittled away by state interference and runaway economic pressures. Faced with intractable and unresponsive African governments whose stock in trade to the raising of any grievances is heavy-handed repression, arrests, threats, and intimidation, doctors are either forced to stay put and lose whatever power they have to shape the realities and future of their profession, or to dissent and face the full wrath of the state, both judicial and extra-judicial. After many years of forbearance, it looks like the Kenyan doctors have finally resolved to take the bull by the horns.

Doctors' strikes, regardless of the reason behind them, receive a lot of media attention and meet with a great deal of public commentary. This censure often holds among the intelligentsia as well, and even the medical profession itself is commonly divided as well on such an emotive and consequential step. At the root of this debate lies fundamental issues and concerns

about the ethical and philosophical meaning and consequence about medical professionals failing to prioritise human life and dignity, for whatever reason. Why can't the doctors find other less harmful ways of negotiating for their own needs and interests, without harming those of their patients? This is an emotional response, but it is also understandable. For humans treasure life above all else, and no sane living person would ordinarily welcome the yawning mouth of the abyss; the unknown darkness that looms large at the end of life as we know it.

Not surprisingly, therefore, doctors' strikes seldom get the same rational and critical consideration that other issues, say the teachers strike, may be accorded. In reality, it is quite difficult to separate fact from fiction or half-truth from hyperbole in discussions of the doctors' strikes due to media hype and the diversity of players, interests and perspectives involved. What is beyond doubt is the fact that, in most instances, medical services are badly affected by the doctors' strikes. Objections against HCWs strike range from arguments about causing harm to patients, deterioration of the physician-patient relationship, and decrease of public approbation for the medical profession. Indeed, the impact of HCWs strikes is very destructive, especially in Africa, where medical insurance and healthcare systems are very poor and precarious. Thus, although the doctors and their union leaders are often at pains to justify their strikes, their actions still call for close ethical scrutiny.

Proximity to life and death, and contractual obligations are often cited as some of the reasons why doctors are judged by standards higher than ordinary mortals. And then there is the Hippocratic Oath, whereby doctors are guardians of good health and abiding friends of the sick and infirm. Thus, are doctors' strikes ever ethically justifiable?

There are ongoing discussions and debates regarding the ethical justification of doctor's strike around the world. Most early literary writings on the ethics of physician strikes were analysed in terms of justice, rights, or moral duties. In addition to these, recent debates and literature on doctors' strikes put more emphasis on the need to maintain the trust-relationship, non-maleficence, autonomy, and medical professionalism. However, the bedrock ethical basis for these arguments can be found in the formulation of the categorical imperative: always treat other persons as having individual moral worth and dignity, and never treat them merely as a means to one's own ends.

Thus, at all times and regardless of the circumstances, adherence to a few basic ethical principles is required for any protest action that impacts patient care. Otherwise, the lay individual cannot be expected to empathise with the notion that highly educated and literate individuals, such as medical doctors, deign to take industrial action. In theory, the medical profession fundamentally differs from others in that their primary goals is (or ought to be) not making money, but safeguarding the very lives, health, and welfare of patients with whom they have a fiduciary commitment. Therefore physicians should serve the interests of their patients according to their professional commitments above and beyond their own personal and immediate interests. In that case, the event of a physicians' strike for personal financial gain, even if it were possible to delude patients that such a strike was really for 'their own good', would go against the collective conscience of the profession.

No one can reasonably argue that healthcare providers do not deserve fair terms of employment, nor can it be disputed that the treatment of the sick and the infirm should always be paramount for those charged with their care. At the same time, the failure of a hospital or other healthcare institution to act ethically (by unfairly or inadequately providing for its employees) cannot be corrected by serving injustices to patients. Only when the benefit of the patient is the ultimate goal, and only after all other avenues of negotiation have been exhausted, can healthcare providers ethically leave their patient's bedsides to go on strike. If we as a society allow, abet or force those who care for our sick to abandon their oaths and their duties as readily as this, then we too have absconded our solemn duty and abandoned our sick. The entire social contract must be dangerously teetering on the edge of a precipice.

Healthcare providers are entitled to a voice in the terms of their employment, just as employees in any industry are. However, much like firefighters and police officers, these workers provide an essential public service that can hardly sustain a disruption, no matter how short. In fact, the doctors' service is even more critical than these, for it is in continuous need, and any interruption can only lead to disastrous consequences on a geometric scale. Without hospital staff to care for them, patients may languish in their pain and suffering with nowhere to go. Accident and assault victims may face a worsening of their condition, or find their injuries becoming irreversible or vastly more complicated. Why, then, are medical strikes and industrial action by other unionised HCWs not only legal but even commonplace?

Rather than delve into the nuances of labour law in the face of rampant public suffering and worsening healthcare outlook, it is far better for all of us to explore the ethical dilemmas presented by the decision of HCWs to go on strike and seek foundational and durable solutions. On one hand, the unjust treatment of employees is intolerable and indefensible, and this is aggravated if duplicity and outright bad faith is thrown into the mix. On the other hand, using innocent patients, who are not even parties to the industrial disputes, as pawns in the game is both inhuman and unprofessional and, for enlightened leadership in a democratic society, suicidal. In the healthcare context, unjust treatment often means understaffing, overworking, and underpaying employees not only to their detriment, but also to the detriment of patients who depend on the attentive care of their medical providers. Thus, without compromise, nurses, doctors, and other healthcare providers must abide by recognised ethical guidelines. One ethical principle in particular is imposed universally on all healthcare providers in all jurisdictions: their first duty is to care for the patient. We must insist on the doctors holding aloft this defining ideal, even as we work together in helping them sustain it.

From high-tech bunkers to best-buys: why African countries should prioritise primary prevention of non-communicable diseases

Catherine Kyobutungi reports on how poor life style choices are bringing an epidemic of non-communicable disease to the region

In late 2015, a state of panic gripped Kenya after the country's lone functioning radiotherapy machine at the national referral hospital broke down, leaving hundreds of cancer patients without access to treatment in the public system. One year later, the same crisis confronted Kenya's neighbours in Uganda after a decades-old machine gasped its last breath. Fortunately, both governments acted swiftly; in Kenya, a new, high-tech machine was installed in Kenyatta National Hospital at a cost of KES 300 million (about US$3 million), while in Uganda, the government released a whopping UGX 30 billion (approximately US$9 million) to build seven bunkers to house even more sophisticated machines, each with a price tag of millions of dollars.

The need for these machines indicate that, unfortunately, cancer is becoming commonplace in the region; few households can claim to not be touched by the disease. Whether celebrity or politician, grandmother, uncle or child, the chronicles of pain, struggle, hope and triumph end with frightening similarity: too few of these stories have a happy ending.

Of the thousands of cancer cases recorded annually in Kenya and Uganda, the vast majority (70–80%) are diagnosed at either stage 3 or stage 4, when they have spread too far or into other organs, too late for a chance at a cure. This late diagnosis can partially explain why sub-Saharan Africa has the worst cancer survival rates in the world: another deplorable topping of the global charts for a region in dire need of improved investment in stronger health systems, improved health education and awareness, better data systems to capture what really ails its people and better understanding of the epidemiology of diseases.

But with cancer, like with many other non-communicable diseases (NCDs), there are things that we can do to slow its relentless march into our homes and communities. Cancers, diabetes, cardiovascular diseases, and chronic respiratory diseases are the Big Four, accounting for more than 70% of deaths and disability caused by NCDs. The Big Four, fortunately, share a set of risk factors. Mitigating the common risk factors of unhealthy diets; tobacco use; misuse of alcohol, and inadequate physical activity can go a long way in turning the tide of NCDs. By committing to changing these behaviours we have the chance to hit four big birds with one big stone.

Newly released nationwide surveys in both Kenya and Uganda on NCD risk factors provide an opportunity to reflect and, more importantly, to act. The 2015 Kenya STEPs Survey and 2014 Uganda STEPs Survey paint a shocking picture of how we are exposing ourselves to mounting risks of NCDs; we eat and drink more, we move less and we are taking up smoking in far greater numbers.

These surveys must be a wake-up call for the citizens and, more importantly, for the two governments to find better solutions to the growing crisis of NCDs. The cost of doing nothing, or of only investing in expensive end-stage treatments, is too high for our populations. The pipeline of people with early and late stage NCDs is too big to expect that countries will afford the kind of investments in tertiary care to significantly improve clinical outcomes and population health in general.

So where should we start? If we know that mitigating the risk of NCD starts with healthy and smart choices, we might have to go back to the beginning, back to when our mothers wouldn't let us up from the table until we finished our veggies.

These days we have replaced healthy with tasty and, most often, with easy. Grabbing food on the run means that an anaemic 6% of Kenyan adults get their recommended five-a-day fruits and vegetables. In Uganda the figure is 13% for women and 12% for men.

Maintaining that healthy diet can help to reduce the risk of some cancers, as well as the chances of being obese, which itself is a precursor for other NCD, including heart disease and diabetes.

A healthy diet also entails restricting salt intake, which for Kenyans is even more of a challenge than eating enough fruits and vegetables. One in four Kenyans and Ugandans add salt to their food before they even taste it. Every shake of that shaker carries with it a risk of high blood pressure and in the long-term, damage to heart, kidneys and brain.

High consumption of alcohol can also have an effect on weight and the organs most vulnerable to disease: the heart, the liver, the stomach and the pancreas. One in four Kenyan men drink alcohol daily and one in eight are heavy drinkers: so half of men who are daily drinkers are heavy drinkers. Beyond the long-term damage of over-

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consumption, heavy drinking can also mean you—and others who share the road with you—are at higher risk of traffic accidents leading to serious injury or death.

Another risk factor is tobacco—smoking or being around smokers. The Tobacco Control Act in Kenya has been around since 2013, yet one in four Kenyans is still exposed to tobacco in the workplace or in the home. Passive smoking—when you're with someone who smokes, even if you don't smoke yourself—has been found to be equally dangerous in terms of heightening the risk of cancer, chronic respiratory conditions or heart disease. The Tobacco Control Act in Uganda is more recent and was enacted after the latest risk factor survey.

What all these figures mean is that we as individuals have the responsibility to remove the risks from our lifestyles, but that our governments also have the responsibility to develop systems to help us mitigate these risks. Without concerted action at the systems level, the burden on our overstretched health services will be even greater, and the costs of inaction will stymie economic growth and development. Damage to a person's health and body happens over the long-term; it may manifest itself as a treatable condition, such as overweight and obesity, high blood pressure or diabetes. These conditions, if left untreated silently damage the body until diseases that can only be managed, not cured, emerge.

The STEPs surveys in both countries also showed that the population is not getting the regular health check-ups and screenings to make sure they are healthy. More than half of adult Kenyans have never had their blood pressure tested, yet one in four have high blood pressure. The same holds true in Uganda. Diabetes screening was even worse—with only one in 10 adults having ever been tested. While close to half of women in the reproductive age were aware of cancer screening services, only about 10% had been screened for cervical cancer in the months leading up to the survey.

There is a danger that these undetected and hence untreated conditions will over the next few years develop into untreatable diseases. Cancers that could be detected at treatable stages will develop into the stages 3 and 4—where chances of survival are slim.

The World Health Organization has developed a list of best buys: tried, tested and feasible interventions with the strongest potential to save lives. These aren't high-tech machines or radiotherapy bunkers, larger intensive care units or dialysis units: they are regular screenings; immunisation against Hepatitis B; higher so-called 'sin taxes' on alcohol and tobacco to reduce access; and education and awareness about healthy lifestyles. In all these, individuals have a responsibility to make the right choices, but the government has an even greater responsibility to provide the right legislative frameworks, regulation and enforcement that lead to a conducive environment within which individual choices can be exercised.

Better investment in education, awareness and prevention is a best buy for government; buying a bicycle, and throwing away the salt shakers is a best buy at home. We owe it to ourselves to live healthier lives, and to demand better from our governments. It's a better deal than expecting salvation from a high-tech machine that is likely to breakdown right when you need it the most.

Risk factor/disease	Interventions
Tobacco use	• Tax increases • Smoke-free indoor workplaces and public places • Health information and warnings • Bans on tobacco advertising, promotion and sponsorship
Harmful alcohol use	• Tax increases • Restricted access to retailed alcohol • Bans on alcohol advertising
Unhealthy diet and physical inactivity	• Reduced salt intake in food • Replacement of trans fat with polyunsaturated fat • Public awareness through mass media on diet and physical activity
Cardiovascular disease (CVD) and diabetes	• Counselling and multi-drug therapy for people with a high risk of developing heart attacks and strokes (including those with established CVD) • Treatment of heart attacks with aspirin
Cancer	• Hepatitis B immunisation to prevent liver cancer (already scaled up) • Screening and treatment of pre-cancerous lesions to prevent cervical cancer

Table 1. The World Health Organization best-buys for Non-Communicable Disease prevention and control

Exceptional progress in pushing back the HIV tide

Columbia University study finds that current antiretrovirals are providing 90 per cent viral suppression

National surveys in Zimbabwe, Malawi and Zambia reveal exceptional progress against HIV, with decreasing rates of new infection, stable numbers of people living with HIV, and more than half of all those living with HIV showing viral suppression through use of antiretroviral (ARV) medication. For those on ARV medication, viral suppression is close to 90%. Thirty-five (35) years into the global HIV epidemic, these findings are a clear sign of progress and source of hope for the rest of the world.

These data are the first to emerge from the Population HIV Impact Assessment (PHIA) Project, a unique, multi-country initiative funded by the US President's Emergency Plan for AIDS Relief (PEPFAR). The Project deploys household surveys, which measure the reach and impact of HIV prevention, care and treatment programmes in select countries. ICAP at Columbia University is implementing the PHIA Project in close collaboration with the US Centers for Disease Control and Prevention (CDC), and in partnership with the respective Ministries of Health (MOH).

Importantly, the data positively demonstrate that the 90-90-90 global targets set forth by UNAIDS in 2014 are attainable, even in some of the poorest countries in the world. According to these ambitious targets for 2020, the goal is for 90% of people with HIV to be diagnosed, 90% of those diagnosed to receive HIV treatment, and 90% of those on treatment to be effectively treated and achieve suppression of their infection. This would translate to 73% of all HIV-positive people being virally suppressed. The data showed that once diagnosed, individuals are accessing treatment, staying on treatment, and their viral load levels are suppressed to levels that maintain their health and dramatically decrease transmission to others.

'The effects of HIV have been far-reaching. But these outcomes affirm that global, country, and US-supported HIV efforts have been successful to date, and that strong progress is being made across the entire HIV continuum of care, including excellent durability of first line treatment regimens with high adherence to medications,' said Ambassador Deborah Birx, US Global AIDS Coordinator.

The PHIA Project surveys describe national HIV epidemics by looking at HIV incidence (the rate of new infections), HIV prevalence (the percentage of the population living with HIV), and the prevalence of viral load suppression (a measure of a well-controlled HIV infection), all through a nationally-representative sample of the population. Additional measures in the surveys look at the proportion of those with HIV who have been tested and who are on treatment.

The household surveys of approximately 80 000 adults and children in Zimbabwe, Malawi and Zambia were conducted in 2016. Results show that the rate of new infections is less than one percent per year. HIV prevalence, at 10–14%, is similar to 2010 estimates, and more than half of all adults living with HIV have viral load suppression. Compared to 2003 incidence estimates for the same three countries of between 1.3–1.5% per year, the current rate of new HIV infections has been cut in half during the past 13 years, when effective HIV treatment became available in sub-Saharan Africa largely through support from PEPFAR.

'The survey was designed to identify the rate of new infections at the national level, as well as to estimate the number of people living with HIV,' said Dr. Jessica Justman, PHIA Principal Investigator and Senior Technical Director at ICAP. 'This information is critically important to determining future resource needs.'

Preliminary data analysis show that, as of 2016:

- In Zimbabwe, among adults aged 15–64, HIV incidence is 0.45%; HIV prevalence is 14.6% (16.7% among females and 12.4% among males); 60.4% of all HIV-positive people are virally suppressed, and 86% of those on treatment are virally suppressed.
- In Malawi, among adults aged 15–64, HIV incidence is 0.37%; HIV prevalence is 10.6% (12.8% among females and 8.2% among males); 67.6% of all HIV-positive people are virally suppressed, and 91% of those on treatment are virally suppressed.
- In Zambia, among adults

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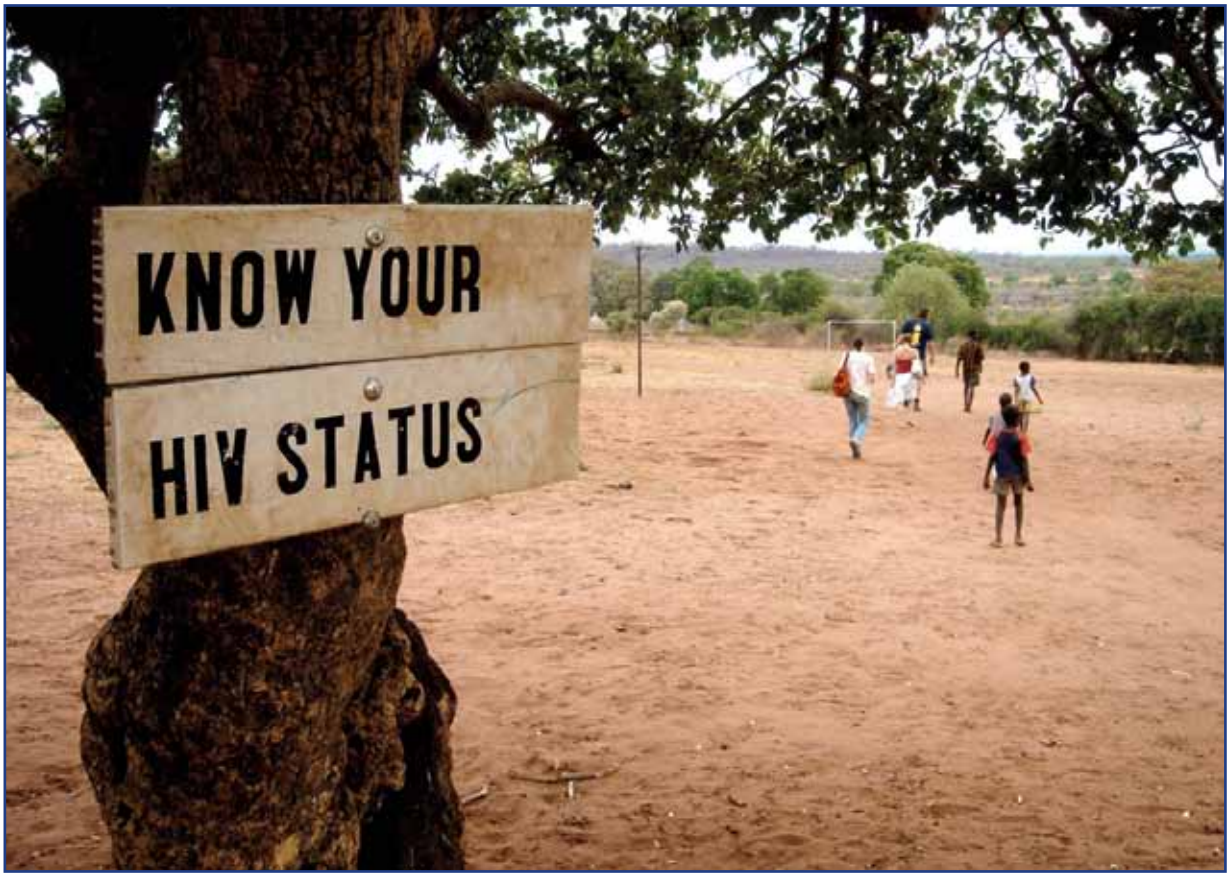

aged 15–59 years, HIV incidence is 0.66%; HIV prevalence is 12.3% (14.9% among females and 9.5% among males); 59.8 percent of all HIV-positive people are virally suppressed, and 89% of those on treatment are virally suppressed.

'The partnership with the MOH has been fundamental to the success of the surveys,' said Dr. Shannon Hader, Director of the Division of Global HIV and Tuberculosis at CDC. 'This kind of information has not been available before and the ministries are eager to use the survey results to inform their policies and programmes.'

With high HIV prevalence estimates of 10–14%, these three countries continue to bear a substantial HIV burden. Nonetheless, with prevalence stabilising and incidence falling, the PHIA survey results suggest that people living with HIV are living longer thanks to effective and accessible treatment.

'It is heartening to see the impressive viral suppression noted in the three countries among those on treatment,' said Dr. Wafaa El-Sadr, Global Director of ICAP. 'Viral suppression is critical for the well-being of people living with HIV and for preventing HIV transmission to others.'

The results from the first three PHIA surveys compel the global community to strengthen its efforts to reach those who have yet to receive an HIV test and to engage, support, and enable those who test HIV-positive to start and stay on effective treatment in order to achieve long-term viral suppression.

'Importantly, the PHIA surveys point to what still needs to be done, who we need to reach, and where we must focus our efforts, in order to build on these achievements,' Ambassador Birx added. 'The findings will guide an effective response to the epidemic.'

Detailed data are available in country-specific summary sheets released by the MOH in each country and available on the PHIA Project website: phia.icap.columbia.edu.

About the PHIA Project

The PHIA Project is a five-year, multi-country initiative funded by PEPFAR through the CDC, and conducted by ICAP at Columbia University, CDC, and local governmental and non-governmental partners. The PHIA Project consists of household-based, population surveys that will collect information related to HIV in 13 countries.

About ICAP

ICAP was founded in 2003 at Columbia University's Mailman School of Public Health. Now a global leader in HIV and health systems strengthening, ICAP provides technical assistance and implementation support to governments and non-governmental organisations in more than 21 countries. ICAP has supported work at more than 5300 health facilities around the world. More than 2.3 million people have received HIV care through ICAP-supported programmes and over 1.3 million have begun ARV therapy. Online at icap.columbia.edu

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