

**EFFECTIVENESS OF AAR HEALTH KENYA'S SOCIO-ECONOMIC  
SUPPORT IN ADDRESSING HEALTHCARE WORKERS' CHALLENGES  
DURING AND POST- COVID-19 PANDEMIC**

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## DECLARATION

I declare that this research proposal has not been previously submitted and approved for an award of any degree by this or any other university. To the best of my knowledge and belief, this research proposal contains no materials previously published or written by another person except where due reference is made in the research proposal itself:

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## ABSTRACT

The COVID-19 pandemic significantly disrupted the healthcare sector, placing immense socio-economic strain on frontline workers. This study examined the impact of the pandemic on the quality of life of healthcare workers at AAR Healthcare Kenya, focusing on their lived experiences and organizational responses. Specifically, it assessed the socio-economic challenges encountered by staff, explored their perceptions of fairness and justice in relation to salary adjustments and financial measures, and evaluated the effectiveness of institutional support systems provided during and after the pandemic. Guided by the Job Demands-Resources model and Social Exchange Theory, the study adopted an interpretive paradigm. It employed a qualitative approach through Key Informant Interviews (KIIs) with healthcare staff and members of the Senior Management Team (SMT). Thematic analysis revealed that while employees experienced heightened financial insecurity, mental strain, and work-family imbalances, they also acknowledged valuable organizational support such as COVID-specific leave, isolation accommodation, transport facilitation, and ongoing mental health counseling. Despite these efforts, perceptions of fairness around salary cuts varied, with some workers expressing dissatisfaction over the lack of transparency and communication. The study concludes that while AAR Healthcare Kenya provided commendable interventions, gaps remain in how support is communicated and perceived. These findings provide crucial insights for healthcare institutions seeking to enhance workforce resilience and institutional responsiveness in crisis contexts, thereby contributing to the broader discourse on employee welfare and healthcare system preparedness in Kenya and similar settings.



## DEDICATION

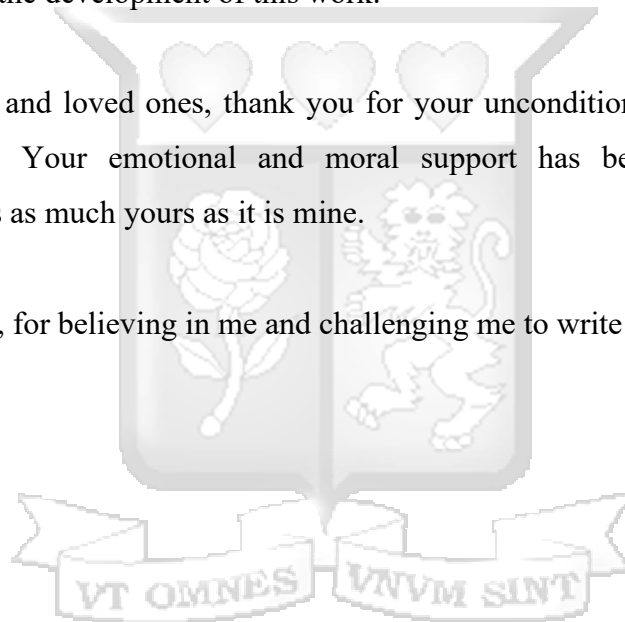
I would like to dedicate this dissertation to those who have been instrumental in my academic journey and personal growth.

To my supervisor, Dr. Kivuli, your unwavering support has been invaluable throughout this research. Your insightful feedback and encouragement have motivated me to strive for excellence and have significantly shaped this work. Every feedback I have received from you has greatly improved this work, and I appreciate it.

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To my family and loved ones, thank you for your unconditional love, patience, and understanding. Your emotional and moral support has been my anchor. This achievement is as much yours as it is mine.

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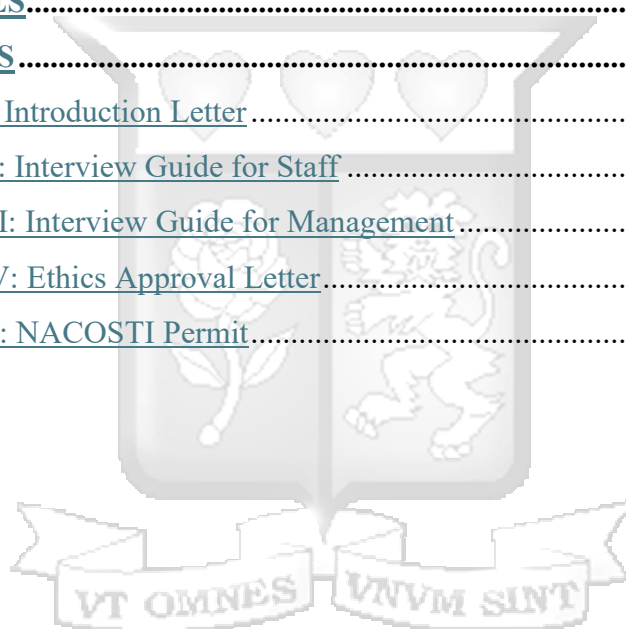


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# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the Study

This chapter introduces the research by providing a background to the study variables, stating the problem, outlining the objectives, and posing the research questions. The chapter also covers the scope of the study, the operational definitions of terms, as well as the study's significance.

The outbreak of the novel coronavirus (SARS-CoV-2) in late 2019 in Wuhan, China, brought immense challenges to the healthcare system, compelling healthcare workers to navigate both clinical and non-clinical stressors. These included shortages of personal protective equipment, the high rates of illness and death linked to COVID-19, the fear of transmitting the virus to their families, and the loss of colleagues to the disease (Hall, 2020).

Throughout and beyond the pandemic, healthcare workers (HCWs) have endured significant physical, psychological, and socio-economic hardships. They also face a heightened risk of infection, with COVID-19 now classified as an occupational disease (Smallwood et al., 2022). They experienced persistent fears related to job security, stigmatization, and infecting family members (Majid et al., 2023). Mental health burdens, ranging from anxiety to burnout and PTSD, are prevalent among HCWs (Abd Rahman et al., 2020; Majid et al., 2023). Various risk factors, such as job-related stressors and inadequate coping strategies, contribute to these outcomes (Majid et al., 2023). To support HCWs, comprehensive approaches addressing physical protection, mental health, education, financial support, and family welfare are necessary (Mohammaddockht et al., 2022). As the pandemic transitions to a "COVID normal" phase, safeguarding healthcare workforces remains critical, requiring better preparedness and protective measures from governments and healthcare organizations (Smallwood et al., 2022).

Beyond the immediate crisis, the post-pandemic period presents new challenges for healthcare workers. Many continue to grapple with the economic consequences of the pandemic, including salary reductions, increased workloads, and reduced career advancement opportunities (Malhotra & Singh, 2020). The restructuring of healthcare systems, shifting employment policies, and increased patient care demands have further

exacerbated workplace stress and financial insecurity (Sultana et al., 2020). The long-term psychological impact of the pandemic persists, with some healthcare workers experiencing prolonged burnout, symptoms of PTSD, and decreased job satisfaction, ultimately affecting retention rates and performance in the sector (Mushtaq et al., 2022). While initial interventions focused on immediate crisis response, the effectiveness of long-term socio-economic support programs remains an area of concern, particularly as institutions shift their focus from emergency relief to sustainability and workforce recovery.

Beyond clinical challenges, healthcare workers also encountered socio-economic difficulties that compounded their stress. Research has highlighted increased cases of stress, anxiety, depression, and PTSD among healthcare professionals (Koontalay et al., 2021; Kotijah & Wahyuni, 2022). Contributing factors to these mental health struggles included inadequate preparedness, emotional strain, limited resources, and work-related burnout (Koontalay et al., 2021). Additionally, concerns over virus transmission, its effects on family life, personal safety, and social stigma further intensified their burden (Iskandarsyah et al., 2021).

These psychological challenges were linked to a decline in overall health and self-perceived well-being (Iskandarsyah et al., 2021). The pandemic significantly impacted the physical and mental well-being of healthcare workers, leading to emotional distress and potential long-term effects such as burnout and post-traumatic stress disorder (Koontalay et al., 2021). In response, they adopted coping strategies such as religious practices, social support, commitment to their professional duties, adherence to safety measures, and maintaining a positive outlook (Iskandarsyah et al., 2021). Scholars emphasize the urgent need for further research to enhance mental health support and preventive strategies for healthcare professionals (Kotijah & Wahyuni, 2022).

Against this backdrop, examining effectiveness of AAR Health Kenya's socio-economic support in addressing healthcare workers' socio-economic challenges during and post- COVID-19 Pandemic is not only timely but imperative for understanding the full extent of the impact of this crisis on those who have been instrumental in combating it. This study focuses on AAR Healthcare Kenya, a hospital with branches across different Kenyan counties that implemented financial adjustments and, more importantly, salary cuts. While healthcare workers have transitioned out of the peak pandemic phase, the financial and workplace changes introduced during the pandemic continue to shape their professional and personal lives. This study will investigate the

long-term effects of salary reductions, workplace restructuring, and organizational support systems on the socio-economic well-being of healthcare workers in the post-pandemic period.

### **1.1.1 AAR Healthcare**

AAR Healthcare is a leading private healthcare provider in East Africa, with operations in Kenya, Uganda, and Tanzania. Originally founded as a health insurance provider, AAR later expanded into outpatient healthcare services, offering a wide range of medical solutions, including general consultations, specialized care, diagnostic services, vaccination programs, and wellness initiatives. In Kenya, AAR Healthcare has established itself as a key player in the healthcare sector, providing accessible and quality outpatient medical care.

AAR Healthcare operates under a structured leadership model designed to ensure efficiency in service delivery and strategic management. At the helm of the organization is the Chief Executive Officer (CEO), who provides overall leadership and strategic direction. The Medical Director oversees clinical operations to ensure adherence to medical standards and the delivery of high-quality care. The Chief Financial Officer (CFO) manages financial planning, budgeting, and resource allocation, while the Human Resources Director is responsible for employee welfare, recruitment, training, and workplace policies. The Operations Manager ensures the smooth running of all healthcare facilities, focusing on operational efficiency and patient satisfaction. Each medical center is managed by a facility head who is responsible for the day-to-day operations, staffing, and service quality. Additionally, various department heads oversee key service areas such as nursing, pharmacy, and laboratory services.

Recognizing that a healthy and motivated workforce is crucial for maintaining high-quality healthcare services, AAR Healthcare has implemented several strategies to support employee well-being. Comprehensive healthcare coverage is provided to employees and their families, ensuring they have access to medical services at AAR facilities while reducing financial burdens associated with healthcare. The organization also promotes work-life balance through flexible work schedules and leave policies that allow employees to effectively manage their professional and personal responsibilities. To address mental health challenges, AAR Healthcare offers counseling services, wellness workshops, and employee assistance programs, fostering a culture that

encourages open discussions about mental health while reducing stigma. Furthermore, the organization invests in professional development, providing employees with training, upskilling programs, and leadership coaching to enhance career growth and job satisfaction.

AAR Healthcare aims to enhance employee satisfaction, improve retention, and ensure organizational stability. These efforts are particularly crucial in the face of challenges such as the COVID-19 pandemic, which has tested the resilience of healthcare systems globally. Through its comprehensive approach to employee well-being and structured leadership, AAR Healthcare continues to position itself as a leading provider of quality outpatient healthcare services in Nairobi and beyond.

## **1.2 Statement of the Problem.**

The COVID-19 pandemic placed an unprecedented strain on healthcare systems worldwide, exposing frontline workers to significant socio-economic challenges that extended beyond the immediate health crisis. Healthcare workers faced increased workloads, heightened psychological distress, financial instability, and disruptions in career progression due to institutional responses to the pandemic, such as salary adjustments, staffing shortages, and resource constraints (Søvold et al., 2021; Bundi et al., 2023). While many studies have examined the psychological toll of the pandemic on healthcare workers, there remains a critical gap in understanding how socio-economic support mechanisms implemented by healthcare institutions—particularly in the private sector—have addressed these challenges during and after the pandemic (Lee, 2023; Nizigiyimana & Pöder, 2021).

Globally, healthcare institutions employed various support strategies to mitigate the socio-economic effects of the pandemic. In the United States and Europe, financial aid packages, mental health initiatives, and professional development programs were introduced to sustain the workforce (Sheraton et al., 2020). However, these interventions varied in effectiveness, with some studies indicating that healthcare workers continued to experience financial insecurity and burnout despite institutional support (Lee, 2023). In Africa, research has shown that while governments provided emergency funding and risk allowances for public healthcare workers, private-sector employees did not always receive similar support, leading to disparities in economic stability and job satisfaction (Moyo & Sibanda, 2023; Chemali et al., 2022).

In Kenya, the pandemic exacerbated existing healthcare workforce challenges, particularly in private health institutions such as AAR Health Kenya. While government-employed healthcare workers received incentives such as risk allowances and psychosocial support, the extent and effectiveness of socio-economic support for private-sector employees remain unclear (Kamondo et al., 2024; Karienyé et al., 2024). Reports indicated that some private healthcare institutions implemented salary reductions and cost-cutting measures due to financial constraints, but empirical studies examining the impact of these measures and the effectiveness of institutional responses are scarce. Furthermore, while AAR Health Kenya provides healthcare services to a significant portion of the population, there is limited research on the adequacy of its socio-economic interventions in supporting its workforce during and after the pandemic.

This study sought to bridge this gap by evaluating the effectiveness of AAR Health Kenya's socio-economic support initiatives in addressing healthcare workers' challenges during and post-COVID-19. Additionally, the study explored healthcare workers' perceptions of justice and fairness regarding these interventions and their overall impact on job satisfaction and professional well-being.

### **1.3 Objectives of the Study**

#### **1.3.1**

#### **Main**

#### **Objective**

The main objective of this study was to assess the effectiveness of AAR Health Kenya's socio-economic support initiatives in addressing healthcare workers' socio-economic challenges during and post-COVID-19 pandemic.

#### **1.3.2 Specific Objectives**

- i. To assess the socio-economic challenges faced by healthcare workers at AAR Health Kenya during and after the COVID-19 pandemic.
- ii. To examine healthcare workers' perceptions of fairness and justice regarding salary adjustments and financial measures implemented by AAR Health Kenya.
- iii. To evaluate the effectiveness of AAR Health Kenya's support systems and interventions in addressing the socio-economic challenges faced by healthcare workers during and after the COVID-19 pandemic

### **1.4 Research Questions**

- i. What socio-economic challenges did healthcare workers at AAR Health Kenya face during and after the COVID-19 pandemic?
- ii. How did healthcare workers at AAR Health Kenya perceive the fairness and justice of salary adjustments and financial measures implemented during and after the COVID-19 pandemic?
- iii. How effective were the support systems and interventions provided by AAR Health Kenya in addressing the socio-economic challenges faced by healthcare workers during and after the COVID-19 pandemic?

## **1.5 Significance of the Study**

This research holds critical implications for policy, industry, and academic scholarship by providing insights into the socio-economic challenges faced by healthcare workers at AAR Health Kenya during the COVID-19 pandemic.

### **1.5.1 Significance to Policy**

At the national level, the study's findings can guide policymakers in formulating responsive labor policies for healthcare workers during crises. Insights from this research can inform regulations on salary adjustments, workforce protections, and crisis preparedness in the healthcare sector. By understanding the socio-economic impact of the pandemic, policymakers can develop targeted interventions to support both employees and employers during public health emergencies.

For AAR Health Kenya, the study provides evidence-based recommendations to enhance internal policies on crisis management, salary structures, and employee support systems. The findings can help refine strategies for fair compensation, mental health support, and workload management, ensuring organizational resilience and employee well-being during future disruptions.

### **1.5.2 Significance to Industry**

The healthcare sector can use this research to assess how private health organizations manage workforce challenges during crises. The findings offer practical insights into effective crisis response strategies, particularly in mitigating financial strain, maintaining employee morale, and sustaining service delivery. By identifying best practices in organizational change management, the study can help healthcare institutions strengthen their preparedness for future health crises.

### **1.5.3 Significance to Academics**

From a scholarly perspective, this study contributes to the broader discourse on organizational behavior, crisis management, and employee well-being in healthcare settings. It provides empirical data on the socio-economic effects of the COVID-19 pandemic on healthcare professionals, offering a foundation for further research on labor dynamics in crisis contexts. Additionally, the study enhances understanding of change management strategies, particularly in private healthcare institutions, and serves as a reference for future studies on workforce resilience.

### **1.6 Scope of the Study**

This research examines the socio-economic challenges faced by healthcare workers at AAR Health Kenya during the COVID-19 pandemic, specifically from March 2020 to April 2021. The study aimed to explore the financial, occupational, and psychological stressors that affected these workers, with a particular focus on salary reductions, job security concerns, and workload increases. Additionally, it assessed the perceived fairness of AAR Health Kenya's salary adjustments and evaluate the effectiveness of the organization's support systems and interventions in mitigating these challenges.

The research adopted a qualitative approach, with in-depth interviews applied which provided deeper insights into their lived experiences. The target population included healthcare workers employed at AAR Health Kenya during the study period.

The study's findings informed recommendations for improving healthcare workers' socio-economic well-being and quality of life in the post-pandemic period, offering strategies that organizations can implement to better support their workforce during future crises.

### **1.7 Chapter summary**

This chapter introduced the study by providing background on the socio-economic challenges faced by healthcare workers during and after the COVID-19 pandemic. It outlined the research problem, emphasizing the need to evaluate AAR Health Kenya's support systems. The study's objectives and research questions were formulated to assess these challenges, perceptions of salary cuts, and the effectiveness of AAR's interventions. The chapter also highlighted the study's significance in informing policy and improving healthcare workforce resilience.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction.**

This chapter provides a comprehensive review of the existing literature relevant to the study. It explores key theoretical foundations, critically analyzes empirical studies on the subject, summarizes current findings, identifies gaps in the research, and presents the conceptual framework that guides this study.

#### **2.2 Theoretical Framework**

This study developed a theoretical framework by incorporating key theories from the existing literature on the socio-economic impact of the COVID-19 pandemic on the quality of life of healthcare workers. The selected theories, the Job Demands-Resources (JD-R) Model and the Social Exchange Theory, were chosen for their relevance and applicability to the study's context. The JD-R model is instrumental in understanding how job demands and resources influence stress and well-being, which are critical factors for healthcare workers during the pandemic. Meanwhile, the Social Exchange Theory provides insight into the social interactions and power dynamics within the organization, which can affect job satisfaction and commitment. A detailed discussion of these theories follows below.

##### **2.2.1 Job Demands-Resources (JD-R) Model**

Developed by Arnold Bakker and Evangelia Demerouti in the early 2000s, the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2007) explains how job strain arises from the interaction between job demands and available resources. Introduced as an alternative to earlier models of employee well-being, such as the demand-control model and the effort-reward imbalance model, the JD-R model stands out for its broad applicability. Unlike previous frameworks that focused on a limited set of predictors, the JD-R model encompasses a wide range of workplace conditions, making it a comprehensive tool for analyzing employee experiences across various organizational settings (Bakker & Demerouti, 2007).

The JD-R model, developed by Bakker and Demerouti in the 2000s, suggests that all occupations involve specific risk factors related to job stress, which fall into two broad

categories: job demands and job resources (Bakker & Demerouti, 2007). Job demands refer to physical, psychological, social, or organizational aspects of work that require sustained effort and may lead to physiological and psychological strain. In contrast, job resources are elements that support goal achievement, reduce job demands, and foster personal growth and development (Demerouti et al., 2001).

Within the context of the COVID-19 pandemic, healthcare workers faced heightened job demands, including increased workload, shortages of personal protective equipment, and the emotional burden of treating patients with a highly contagious and potentially fatal illness (Bakker et al., 2020). These demands contributed to burnout, manifesting as emotional exhaustion, depersonalization, and diminished personal accomplishment (Schaufeli & Taris, 2014). Conversely, job resources such as social support, autonomy, and opportunities for professional development played a crucial role in mitigating these challenges and promoting well-being (Xanthopoulou et al., 2007). However, the pandemic also disrupted these resources—social distancing limited interpersonal support, increased workload reduced autonomy, and changes in healthcare delivery altered professional development opportunities (Bakker & de Vries, 2021).

The JD-R model offers a valuable framework for examining how job demands and resources influenced the stress and well-being of healthcare workers at AAR Health Kenya during the COVID-19 crisis. Using this model, interventions can be developed to reduce excessive job demands, enhance job resources, and strengthen coping mechanisms, ultimately supporting healthcare workers' well-being and improving patient care quality (Bakker & Demerouti, 2017).

While the Job Demands-Resources (JD-R) model is widely recognized for its flexibility and broad applicability across various work environments, it has also faced criticism. One key limitation is its tendency to oversimplify complex work dynamics by categorizing all job characteristics into just two broad groups—job demands and job resources—without fully accounting for the nuanced interactions between them (Bakker & Demerouti, 2017). Critics argue that not all job demands are inherently negative, as some may be challenging yet motivating, while not all job resources necessarily buffer against strain (Schaufeli & Taris, 2014). Additionally, the model lacks a clear explanation of causality; it assumes that job demands lead to burnout and job resources promote engagement but does not adequately address potential reverse causation or individual differences in coping mechanisms (Brauchli et al., 2013).

Furthermore, the JD-R model focuses heavily on work-related factors, often overlooking the broader socio-cultural, economic, and personal contexts that can influence employee well-being (de Jonge & Dormann, 2017). Despite these criticisms, the model remains a valuable framework, though researchers continue to refine it to better capture the complexity of workplace experiences.

In this study, personal factors refer to individual-level characteristics that influence how healthcare workers perceive, experience, and respond to workplace stressors. These include demographic variables such as age, gender, marital status, and education level, as well as psychological and behavioral attributes like personality traits (e.g., resilience, neuroticism), coping styles (e.g., problem-focused vs. emotion-focused coping), prior trauma exposure, and overall mental health status. Such variables are well-documented in occupational health literature as moderators or mediators of stress and burnout (Lazarus & Folkman, 1984; Carver et al., 1989). Including these personal factors in the study allows for a more nuanced understanding of differential vulnerability or resilience among healthcare workers facing similar job demands. Their role is especially important when applying the JD-R model, which acknowledges that the impact of job demands and resources can vary depending on personal characteristics (Bakker & Demerouti, 2017).

### **2.2.1 Social Exchange Theory**

Social Exchange Theory (SET) posits that human behavior is based on exchanging rewards between individuals (Ali & Warner, 2017; Cook & Hahn, 2021). This theory provides a framework for understanding social interactions, power dynamics, and the formation of social structures (Cook & Hahn, 2021). SET has become a prominent paradigm in sociology, anthropology, and social psychology (Zafirovski, 2005). Social Exchange Theory provides frameworks for understanding relationship dynamics. The Comparison Level (CL) serves as a benchmark for expected rewards in a relationship, while the Comparison Level for Alternatives (CL<sub>alt</sub>) represents the minimum acceptable rewards in a relationship (Stafford, 2017; Kim & Auh, 2019). These concepts influence relationship stability and satisfaction, with CL having a larger effect than CL<sub>alt</sub> (Kim & Auh, 2019). The focus of comparison moderates the impact of comparison standards on relationship satisfaction, as individuals tend to be more satisfied when they assimilate their relationship outcomes to high standards or contrast them with low standards (Broemer & Diehl, 2003). Commitment to a relationship is

influenced by relationship outcome value, quality of alternatives, and investment size (Rusbult, 1980). Increases in investment size and relationship value, along with decreases in alternative value, contribute to increased commitment (Rusbult, 1980). These theories provide valuable insights into the complex dynamics of romantic relationships and their maintenance. Several key principles underpin Social Exchange Theory, including rationality, reciprocity, human interactions, and dependency. Rationality suggests that individuals aim to maximize their rewards while minimizing their costs in any given relationship. At the same time, reciprocity expects people to respond in kind, maintaining a balance in the exchange of benefits and costs.

However, the theory faces criticisms, particularly regarding its economic-behaviorist formulations and the treatment of social interaction as purely exchange-based (Zafirovski, 2005). Cropanzano and Mitchell (2005) identify four key areas requiring further research: the roots of conceptual ambiguities, norms and rules of exchange, the nature of exchanged resources, and social exchange relationships. Despite these challenges, SET has practical applications, such as enhancing the success of Extension programs by promoting clientele participation and behavior change (Ali & Warner, 2017).

### **2.2.3 Nexus between JD-R and Social Exchange Theory**

Together, the JD-R model and Social Exchange Theory offer a comprehensive lens through which to understand the interplay between workplace stressors and relational dynamics in shaping the well-being of healthcare workers during the COVID-19 pandemic. The JD-R model captures the dual influence of job demands and job resources on burnout and engagement, highlighting how excessive workloads, emotional strain, and limited support mechanisms undermined healthcare workers' psychological resilience. In parallel, Social Exchange Theory complements this by illuminating how perceived organizational support, fairness, and reciprocal exchanges influence workers' sense of commitment, motivation, and job satisfaction. By integrating these two frameworks, the study will evaluate not only how structural and operational pressures (as conceptualized in the JD-R model) affected healthcare staff at AAR Health Kenya but also how the quality of organizational relationships and support (as described in SET) moderated these effects. This dual-theory approach aligns with the research objectives of assessing how workplace stress and organizational support systems jointly influence the well-being of healthcare workers during crises such as the COVID-19 pandemic.

## **2.3 Empirical Review**

This section of the study summarizes the current empirical literature, focusing on the interaction of the variable adopted in the study. This empirical review aims to identify common themes related to the challenges faced by healthcare workers, support systems and strategies during the pandemic, and perceptions of justice and fairness regarding salary cuts.

### **2.3.1 Challenges Faced by Healthcare Workers**

The socioeconomic effects of COVID-19 on healthcare workers (HCWs) have been multifaceted and profound, impacting various aspects of their well-being and work environment. Research conducted among healthcare workers in the United States and the United Kingdom, and published in *The Lancet* highlighted that racial minorities were more likely to work as frontline healthcare workers (HCWs) and have personal contact with COVID-19 compared to their White counterparts (Lo, Nguyen, Drew, Warner et al., 2021). The authors argued that this disparity in exposure to the virus based on race and ethnicity underscored the complex interplay between socioeconomic factors and the risk faced by HCWs. Healthcare workers from racial and ethnic minority backgrounds faced additional challenges in accessing healthcare services and resources. They were more likely to experience discrimination, have lower incomes, and live in crowded or substandard housing conditions, all of which increased their risk of exposure to COVID-19. Further, healthcare workers from low-income backgrounds are more likely to work in settings with limited access to personal protective equipment (PPE) and other resources needed to protect themselves from COVID-19. They may also be more likely to live in multigenerational households or have dependents, which can increase their risk of exposure to the virus (Lo, Nguyen, Drew, Warner et. al, 2021).

The economic implications of HCW infections extended beyond healthcare settings to encompass various sectors of the economy (Wu Zeng, Kabubei, Rasanthan, Kazungu et. Al, 2023). For example, the temporary closure of healthcare facilities or the redirection of resources to COVID-19 response efforts led to delays or cancellations of non-COVID-19-related healthcare services, impacting patient outcomes and adding to the economic burden in five low- and middle-income sites (Kenya, Eswatini, Colombia, KwaZulu-Natal province, and Western Cape province of South Africa). Furthermore,

the increased demand for healthcare services during the pandemic and the reduced availability of HCWs led to increased workloads and burnout among the remaining healthcare workforce. This, in turn, could have long-term implications for healthcare systems' capacity to meet the healthcare needs of populations, potentially exacerbating existing health inequalities (Wu-Zeng et. al, 2023).

Kenya confirmed its first COVID-19 case on March 13, 2020, prompting the government to implement swift containment measures, including suspending public gatherings and enforcing a dusk-to-dawn curfew (Were, 2020). The pandemic had a significant economic impact nationwide, with informal sector workers, casual laborers, and daily wage earners being among the most affected.

To mitigate these effects, various policy interventions, such as tax relief, were introduced to protect incomes and stabilize the economy. However, while these fiscal measures provided some relief, they fell short of fully addressing the severe challenges faced by the lowest-income households. In response, resource mobilization efforts extended beyond government initiatives to include contributions from non-governmental organizations, multilateral institutions, and the international community. Despite the crisis, it also presented opportunities to rethink and restructure the economy for greater resilience (Barasa, Maloba, Mukuna & Tesfaye, 2022).

Çelmeçe and Menekay (2020) investigated how stress, anxiety, and burnout influenced the quality of life among healthcare professionals treating COVID-19 patients. The study, conducted in Tokat city center, Turkey, surveyed 240 healthcare workers—including doctors, nurses, and healthcare assistants—employed in pandemic hospitals. Using assessment tools such as the Perceived Stress Scale, Spielberger State-Trait Anxiety Inventory, Maslach Burnout Inventory, and Quality of Life Scale, the research adopted a relational screening model to examine these psychological factors.

Findings indicated that female healthcare workers, those who were married, and those with children experienced higher stress and anxiety levels, along with lower quality of life scores, compared to their counterparts. The study also revealed significant correlations among stress, anxiety, burnout, and quality of life, reinforcing previous research that found female healthcare professionals and working parents faced heightened emotional strain. Nurses, in particular, reported higher burnout levels than doctors and healthcare assistants, likely due to their prolonged and direct patient

interactions. To evaluate the quality of life (QoL) of healthcare workers during the COVID-19 pandemic, this study adopts a multidimensional perspective grounded in established literature. QoL is broadly understood as an individual's subjective evaluation of their overall well-being, encompassing physical, psychological, and social dimensions, as well as their working and living environments (Diener et al., 1999; Bowling, 2005). In this study, quality of life (QoL) will be measured using an interview guide developed from previously validated constructs in similar studies of healthcare workers. Key indicators will include physical health (e.g., fatigue, sleep quality), mental well-being (e.g., anxiety, stress), social support (e.g., peer and family relationships), and perceived safety or satisfaction with the work environment. These components reflect both objective and subjective aspects of well-being, aligned with best practices in occupational health research

Additionally, the study highlighted the increased burden on working parents during the pandemic, including challenges related to school closures and childcare, which contributed to elevated stress and anxiety. While these insights provide a crucial understanding of the mental health struggles faced by healthcare workers, the study's cross-sectional design and the evolving nature of the pandemic limited its ability to assess long-term psychological effects. The authors suggested future research should adopt a longitudinal approach to better capture the ongoing impact of health crises on medical professionals' well-being.

Job security is critical to the work environment, particularly during economic uncertainty such as the COVID-19 pandemic. Basyouni and Keshky (2021) found out that employees in both private and government sectors in Saudi Arabia faced heightened levels of job insecurity due to the economic impact of the pandemic. Like many countries, Saudi Arabia faced economic challenges, including a rise in the unemployment rate, reaching 15.4% by September 2020. The pandemic led to a sharp decline in economic productivity and growth, with various sectors experiencing significant downturns. In response to the pandemic, health organizations recommended social distancing measures and the closure of non-essential businesses, leading to widespread economic disruptions. These disruptions resulted in job losses and financial insecurities for many individuals. For instance, in the United States, over 41 million Americans became unemployed between February and May 2020, leading to a significant economic downturn. The study was conducted among 1,195 employees, with 886 females and 309 males, aged between 25 and 60 years. To ensure validity and

reliability, the study utilized standardized measures such as the Financial Anxiety Scale, Work-Related Flow Inventory, and Qualitative Job Insecurity Measures. Structural equation modeling demonstrated a positive relationship between job insecurity and financial anxiety, while work-related flow was negatively associated with financial anxiety and served as a mediator between job insecurity and financial anxiety. These relationships remained statistically significant regardless of demographic factors, including gender, age, marital status, employment sector, income level, self-rated health, and COVID-19 infection status.

The authors emphasized that the economic challenges resulting from the COVID-19 pandemic significantly affected individuals' mental health. Increased uncertainty surrounding job security and financial stability contributed to elevated anxiety and stress levels among employees. Previous studies have linked job insecurity during the pandemic to financial anxiety and broader negative mental health outcomes, underscoring the need for further research in this area.

Additionally, Tang, Veira, and Shearer (2022) conducted a spatial analysis of COVID-19 cases in Orange County (OC), California, from March 2020 to February 2021. Using generalized additive models, they analyzed 221,843 cases at the census tract level, applying a Poisson framework with spatial smoothing over census tract centroids to map COVID-19 risk. The study employed 1,000 random permutations to assess randomness and separated the analysis temporally to examine shifts in risk patterns over time.

The findings revealed that COVID-19 cases, hospitalizations, and deaths were significantly concentrated in northern OC. Although adjusting for demographic factors reduced spatial risk, certain areas remained statistically significant. Key variables such as the percentage of minority populations, average household size, and the proportion of service industry workers were strongly associated with COVID-19 risk even in adjusted models. Notably, risk patterns remained consistent between pandemic surges, with hospitalization and death risk ratios remaining stable. These results highlight the role of social and environmental factors in the spread of COVID-19, emphasizing the importance of targeted interventions to protect vulnerable populations during future public health crises.

Pinchoff, Austrian, Abuya, and colleagues (2020) examined how COVID-19 mitigation measures affected the economic, social, and health well-being of women living in densely populated informal settlements in Nairobi, Kenya. The study, conducted

through mobile phone surveys between April and June 2020, collected data from 2,009 households across five settlements, drawn from two different cohorts. Findings from the study revealed that by May, women experienced more severe negative impacts from these measures compared to men. Women were more likely to go without meals, with a difference of six percentage points between genders. Those who had lost their income entirely had a 15-percentage-point higher likelihood of skipping meals than those still employed. Additionally, women were eight percentage points more likely to report an increased risk of domestic violence and six percentage points more likely to forgo essential healthcare compared to men. The economic consequences of the pandemic led to widespread food insecurity, with nearly 75% of respondents skipping meals. Market closures and job losses contributed to food shortages and price hikes, making access to food more challenging. Divorced women faced an even greater risk of food insecurity, likely due to their role as sole earners while also managing household responsibilities and childcare. Socially, many households experienced heightened risks of domestic violence, potentially due to prolonged periods spent at home and sudden unemployment. In terms of healthcare, more women than men reported skipping medical services, primarily due to financial constraints, underscoring the urgent need for affordable and accessible healthcare solutions.

### **2.3.2 Support Systems Strategies**

Change management in healthcare is a complex process, often challenging due to its impact on both patients and practitioners (Valiee, Jelyani, & Kia, 2023). The COVID-19 pandemic accelerated the need for change in hospitals and healthcare facilities, prompting a shift in their operational strategies (Mohammadinia, Saadatmand, & Sardashti, 2023). This necessitated a revamp of their approach to change management, leading to an exploration of innovative methods to enhance this process. In response to the pandemic, healthcare facilities began to prioritize improving change management practices (Valiee et al., 2023). They started working diligently to ensure their facilities could recruit and retain sufficient staff to meet the evolving demands of the healthcare landscape. This proactive approach is crucial for ensuring effective adaptation to future challenges and maintaining high-quality patient care (Mohammadinia et al., 2023).

During a pandemic, healthcare organizations face the critical task of implementing effective change management strategies to navigate the dynamic and challenging environment while ensuring the safety and well-being of healthcare workers.

Developing human resources in the face of epidemics requires a holistic approach. Focusing separately on each theme is not sufficient. Managers and decision-makers are encouraged to devise strategies that align with their context and cover broader themes to ensure the strength and maintenance of human resources during epidemics (Valiee, Jelyani, Kia et. al 2023).

Valiee et al. (2023) identified five key strategies for strengthening and sustaining human resources during epidemics: Instruction, Protection, Support, Care, and Communication. Within these broad themes, 15 subcategories were highlighted, including the establishment of educational networks, implementation of training programs, virtual practice sessions, provision of protective measures and equipment, adjustments to work shifts, early detection protocols, psychological and peer support, welfare services, professional and workload assistance, psychological and non-psychological care services, and both active and passive support mechanisms.

Similarly, Mohammadinia, Saadatmand, and Sardashti et al. (2023) examined the challenges faced by hospital managers during the initial phase of the COVID-19 pandemic. Their study revealed that many healthcare administrators initially struggled due to limited experience in handling such an extensive health crisis. This lack of preparedness led to systemic challenges, prompting countries, including Iran, to devise strategies tailored to their national policies. The research focused on four urban hospitals, conducting semi-structured interviews with 32 participants, including healthcare managers, nurses, and doctors.

The findings were categorized into four primary themes: capacity expansion, management affairs, diagnostic services, and therapeutic services, each containing multiple subcategories. The study underscored the necessity of equipping hospitals with robust epidemic response plans and optimizing resource allocation.

The COVID-19 pandemic posed significant challenges to health systems worldwide, particularly affecting healthcare workers (HCWs). A scoping review of qualitative studies published during the first year of the pandemic identified factors that affected HCWs' experiences and their support needs (Chemali, Marie-Saez, Bcheraoui, and Weishaar, 2022). HCWs reported various challenges at the individual level, including physical and emotional exhaustion, fear of infection, and impacts on their personal lives. At the interpersonal level, HCWs experienced both supportive and unsupportive

relationships, with some reporting being shunned by family and friends. Organizational factors, such as inadequate personal protective equipment, lack of training, and poor communication, also contributed to HCWs' negative experiences (Eden, DePierro, Marin, 2021). The COVID-19 pandemic emphasized the importance of supporting healthcare workers' (HCWs) mental health and well-being. Eden et al. (2021) highlighted various initiatives developed in response, including expanded access to basic necessities, additional workplace training programs, and psychological support services such as peer support and counseling. However, many of these programs lacked strategies for long-term sustainability. Beyond the immediate crisis, the pandemic also drew attention to the need for ongoing mental health interventions for HCWs. As the situation stabilized, there was a shift toward designing more employee-centered programs rather than those solely focused on pandemic-related stressors. Ensuring that these interventions remain adaptable and responsive to the specific needs of healthcare workers is essential.

Providing mental health support for HCWs was critical to maintaining healthcare system resilience. The World Health Organization recognizes the health workforce as one of the six foundational pillars of a strong healthcare system, with HCWs playing a vital role in responding to external challenges such as disease outbreaks. Moving forward, sustained investment in comprehensive, flexible, and long-term mental health programs will be key to supporting HCWs in their demanding roles (Eden, DePierro, Marin, 2021).

The study *Maternal and Neonatal Health Care Worker Well-Being and Patient Safety Climate Amid the COVID-19 Pandemic*, published in the *Journal of Perinatology*, examined the well-being and patient safety perceptions of maternal and neonatal healthcare workers (HCWs) during the COVID-19 crisis (Haidari, Main, Cui, Cape et al., 2021). Researchers conducted a survey comprising 13 items related to well-being and patient safety, alongside demographic details. Participants were self-selected and completed the survey approximately one month after a webinar, regardless of their attendance. The findings revealed widespread emotional exhaustion among HCWs, accompanied by staffing shortages, health concerns—including COVID-19 infections and burnout—and challenges in accessing their workplaces. In low-income countries, the primary cause of reduced staffing was transportation difficulties, while in middle- and high-income nations, about one-third of respondents attributed staff shortages to reassignments from maternal and neonatal units to COVID-19 care areas. Nearly a

quarter of participants reported workplace accessibility issues in the month preceding the survey.

The study underscored the urgent need for intervention, warning that burnout and its consequences would likely escalate if left unaddressed. Reports of coworker burnout reached 73%, while 66% of respondents experienced personal emotional exhaustion. Many HCWs found it difficult to balance professional and personal responsibilities, expressing concerns that institutional measures were inadequate. Those facing burnout also rated other well-being and safety aspects significantly lower. Compared to previous research, this study identified higher burnout rates among neonatal and hospital-level HCWs, particularly in the early phase of the pandemic in the United States. Contributing factors included increased job demands due to evolving infection control measures, social distancing protocols, additional testing, and isolation requirements. Additionally, reductions in workplace support—such as personnel reassignments and remote work transitions—further exacerbated burnout levels.

A study by Gálvez-Herrer, Via-Clavero, Ángel-Sesmero, and Calle (2021) examined the emotions and coping mechanisms of frontline critical care workers during the early stages of the COVID-19 pandemic. It also assessed their satisfaction with a psychological crisis and emergency intervention designed to support them through the intense physical and emotional strain of the crisis. The research, conducted as a multicenter descriptive study, gathered both qualitative and quantitative data from healthcare and non-healthcare critical care workers.

The intervention involved individual and group psychological crisis assistance sessions, delivered both in person and online by trained psychologists. Key findings highlighted four central themes: an imbalance between job demands and available resources, acute stress reactions, the personal and professional impacts of the crisis, and protective factors such as group cohesion and social support. The study revealed that these psychological support sessions significantly aided participants in processing their experiences, equipping them with effective coping strategies. Participants reported high levels of satisfaction, noting that psychologist-led support groups encouraged reflection on workplace challenges, interactions with patients and colleagues, and overall social support. These sessions played a crucial role in managing stress and fostering emotional resilience throughout the pandemic.

Ogira et al. (2022) conducted a qualitative analysis to assess the effects of the COVID-19 pandemic on Kenya's health system and to derive insights for future emergency preparedness. Through in-depth interviews with 15 key informants between September 2020 and February 2021, the study found that Kenya's initial response was commendable, characterized by effective communication, the establishment of technical working groups, and multisectoral collaboration. However, significant challenges were identified, including disruptions to essential health services such as reproductive health, HIV, TB, and non-communicable diseases; inadequate coordination between national and county governments; shortages of personal protective equipment and testing kits; and strains on human resources for health. The study emphasizes the need for strengthened investments across all health system building blocks—human resources, financing, infrastructure, information systems, leadership, service delivery, and medical products—to enhance resilience and self-reliance, particularly for countries transitioning from donor aid

### **2.3.3 Perceptions of Justice and Fairness**

The COVID-19 pandemic significantly disrupted global healthcare systems, leading to immense operational and financial strain on healthcare institutions. As hospitals and private healthcare facilities grappled with increased patient loads and resource constraints, many implemented cost-cutting measures, including salary reductions, furloughs, and layoffs. While these financial adjustments were often necessary to sustain healthcare services, they had profound effects on healthcare workers, influencing their job satisfaction, motivation, and retention.

A key concern in the implementation of salary reductions and other austerity measures was the perception of fairness and justice among healthcare workers. Research suggests that when employees perceive organizational decisions as fair and transparent, they are more likely to remain engaged and committed to their work. Meese, Dill, and Naik et al. (2022) examined how healthcare systems in the United States navigated compensation reductions and layoffs during the early stages of the pandemic. Their study, conducted in a large academic hospital, found that employees preferred lower salary reductions for frontline workers directly treating COVID-19 patients. Factors such as perceived organizational support, virus exposure, and financial stress influenced how workers responded to these cuts. The study underscored the importance

of transparent communication and equitable resource distribution in maintaining workforce morale during financial crises.

Similarly, Mengstie (2020) explored the relationship between organizational justice and employee turnover in Ethiopia's healthcare sector. The study revealed that perceptions of fairness in salary adjustments and workplace policies significantly influenced healthcare workers' intention to stay or leave. Findings indicated that public hospital employees reported lower levels of distributive, procedural, interpersonal, and informational justice, leading to higher turnover rates compared to their counterparts in private institutions. These results emphasize the role of fair decision-making in fostering employee retention and institutional stability.

Further, Pan, Chen, Hao, and Bi (2017) highlighted the broader implications of organizational justice in shaping workplace behaviors. Their research demonstrated that employees who perceive fairness in organizational processes exhibit higher job satisfaction and commitment, while perceived injustice leads to demotivation and increased turnover intentions.

These studies collectively highlight the critical role of justice and transparency in managing organizational change, particularly during financial constraints. As healthcare institutions continue to navigate economic uncertainties, prioritizing fair and inclusive decision-making processes remains essential in sustaining workforce morale and ensuring effective healthcare service delivery.

Chang and Geng (2024) explored the negative impact of career plateaus on employee satisfaction and performance, emphasizing how psychological distress from career stagnation can hinder progress toward the United Nations' Sustainable Development Goals (SDG-3: Health and Well-being at Work, and SDG-8: Decent Work). They highlighted the importance of mitigating these effects to promote sustainable workplace well-being.

Their study, grounded in equity theory and conservation of resources theory, investigated how career plateaus influence job performance through perceptions of organizational justice, with positive psychological capital acting as a moderating factor. Analyzing data from 368 supervisor–employee pairs (with an average of eight employees per supervisor), the findings revealed that employees experiencing career

plateaus perceived lower levels of organizational justice, which in turn negatively affected their job performance. However, employees with higher levels of positive psychological capital were better able to buffer these negative effects, maintaining a more favorable perception of organizational justice and mitigating the impact on job performance.

An Indonesian study on remuneration policy among doctors study revealed the impact on specialist doctors' income and performance. Implementing the remuneration policy led to a substantial increase in the average income of specialist doctors, with a rise of 42.9% compared to their income before the policy was put in place. Additionally, the study found a positive correlation between the implementation of remuneration policies and the performance of specialist doctors. The research employed a case study method with a qualitative approach, focusing on 11 specialist doctors. Data collection methods included questionnaires and in-depth interviews with informants. The findings underscored the importance of remuneration policies in incentivizing and motivating doctors. By increasing doctors' income, these policies could potentially improve their performance, ultimately benefiting the healthcare system and patients (Suranta, Gani, Bachtiar, 2024).

Ekingen (2023) examined the relationship between organizational justice, job performance, and job satisfaction among 374 nurses in Iranian hospitals. Using structural equation modeling and the bootstrap technique, the study aimed to assess how nurses' perceptions of organizational justice influence their job performance and satisfaction, with a particular focus on the mediating role of job satisfaction. The findings demonstrated that organizational justice significantly affects both job performance and job satisfaction, with job satisfaction partially mediating this relationship. The study reported moderate levels of stress, justice, interactional justice, and informational justice, while self-efficacy was below moderate. Similarly, distributive and procedural justice were also rated as moderate, indicating an overall unfavorable perception of justice and self-efficacy among nurses. Compared to studies in Egyptian and Turkish hospitals—where interactional and informational justice were rated highest, while distributive and procedural justice ranked lowest—the findings suggest contextual differences (Ghasi et al., 2020b; Özer et al., 2017; Seyrek & Ekici, 2017). The moderate rating of distributive justice implies that nurses perceive their compensation and rewards as inadequate, a factor linked to workplace dissatisfaction

in various settings, including industrial sectors in Nigeria. The study highlights the need for human resource management reforms to enhance perceptions of distributive justice in healthcare institutions. Procedural justice was moderate, indicating limited staff involvement in decision-making. This dimension is crucial for career advancement decision-making, particularly in public hospitals where staff may have limited negotiation power. Interactional justice was low, highlighting the need for respectful interaction with subordinates. Informational justice was also low, suggesting that managers have not effectively communicated decisions to staff. Improving communication systems and providing transparent and honest information can enhance informational justice (Ekingen, 2023).

Keramati et al. (2015) examined the relationship between organizational justice and job satisfaction within the Social Security Organization in Iran. The study explored how employees' perceptions of fairness in decision-making processes and outcomes influence their job satisfaction and performance. The findings indicated that organizational justice significantly impacts job satisfaction, with distributive, procedural, and interactional justice positively correlated with higher job satisfaction levels. Distributive justice relates to the perceived fairness of outcomes, procedural justice refers to the fairness of the decision-making process, and interactional justice concerns the fairness of interpersonal treatment during decision-making. The study also found that job satisfaction partially mediates the relationship between organizational justice and job performance, meaning that employees who perceive fair treatment in their organization are more satisfied and subsequently perform better. These findings have several implications for organizations. First, fostering transparent and fair decision-making processes can enhance job satisfaction and performance. Second, ensuring respectful and equitable treatment of employees throughout decision-making can further improve workplace morale and effectiveness. Organizations that prioritize fairness and justice in their policies and interactions can mitigate negative outcomes such as absenteeism, turnover, burnout, and psychological distress, ultimately leading to a more engaged and productive workforce.

In their study, "Managing under austerity: A Qualitative Study of management-union relations during attempts to cut labor costs in three South African public hospitals," Fana and Goudge, (2024) examined the relationship between management and unions during attempts to reduce labor costs in three public hospitals in a largely rural province

in South Africa. An inductive approach was used to analyze the data, with each author conducting the process independently and resolving any differences through discussion. The main finding of the paper was that hospital managers who promote democratic or participatory leadership and management, open communication, teamwork, and trust among all stakeholders will lead to better-functioning organizations in the face of austerity. The study also highlighted the importance of managing different stakeholders well during attempts to reduce labor costs, as poor communication and management can lead to resistance, increased sick leave, and physical fights between managers and staff. Finally, the study recommended the need for leaders to manage actors well during austerity to promote organizational resilience.

The systematic review by Shaibu, Kimani, Ndirangu et al. (2021), published in the *Journal of Psychological Medicine*, examines the psychological impact of the COVID-19 pandemic on healthcare workers. Analyzing 54 studies, including research from low-income countries such as Kenya, the review highlights a significant prevalence of mental health issues among healthcare workers during the pandemic. The findings indicate that 24.2% of healthcare workers experienced depression, 23.5% suffered from anxiety, and 38.9% reported insomnia. Those in direct contact with COVID-19 patients were particularly vulnerable. Factors associated with increased mental health risks included being female, younger in age, working in high-risk environments, and having a history of mental health issues. The review also identifies effective interventions, such as psychological support, training on coping strategies, and promoting self-care. The authors recommend that healthcare organizations prioritize mental health initiatives by implementing these interventions both during and beyond the pandemic. This proactive approach can help mitigate the long-term psychological impact on healthcare workers, ensuring a resilient and supported workforce.

Deressa, Adugna, Bezane et. al (2022) study conducted among 395 healthcare professionals in Ethiopian Jimma Zone public health facilities aimed to explore the relationship between organizational commitment and organizational justice. Organizational justice refers to an individual's perception of fairness in decision-making processes within an organization and its impact on their behavior. The findings revealed that a significant portion of the respondents scored low on organizational commitment, indicating a potential challenge in the healthcare sector. However, approximately half of the participants perceived organizational justice to be fair,

suggesting a mixed perception of fairness within the organizational context. The study utilized a facility-based cross-sectional design, with data collected through self-report questionnaires. The tools used to measure organizational commitment and organizational justice demonstrated good validity and reliability. The analysis showed a strong and positive correlation between overall organizational commitment and organizational justice, indicating that perceptions of fairness in decision-making processes significantly influence healthcare workers' commitment to their organization. Specifically, distributive justice and procedural justice were identified as key factors affecting organizational commitment. Distributive justice refers to the perceived fairness of outcomes, such as resource allocation, while procedural justice relates to the perceived fairness of the decision-making process. These findings highlight the importance of ensuring fairness in resource allocation and decision-making processes to enhance organizational commitment among healthcare workers. The study's results suggest that improving organizational justice can contribute to maintaining healthcare workers' commitment and enhancing healthcare facilities' capabilities. By addressing issues related to fairness in decision-making and resource allocation, healthcare organizations can create a more conducive work environment that promotes employee commitment and ultimately improves the quality of healthcare delivery.

## **2.4 Research Gap**

The existing literature has comprehensively explored the multifaceted challenges healthcare workers (HCWs) faced during the COVID-19 pandemic, including physical and emotional exhaustion, fear of infection, and the impact on personal lives. Additionally, studies have delved into organizational factors like inadequate personal protective equipment, lack of training, and poor communication, all contributing to negative HCW experiences. Interventions to support HCWs' mental health, including expanded basic need resources, additional training programs, and psychological support programs, have been discussed, albeit with limited attention to their sustainability and long-term effectiveness. However, a research gap exists in understanding the specific perceptions of justice and fairness among HCWs concerning salary cuts implemented during the COVID-19 pandemic. While general factors affecting HCWs' well-being and experiences have been studied, there is a lack of focused research on how salary cuts, a critical organizational decision during the pandemic, are perceived in terms of justice and fairness by the affected employees. This

gap is particularly pertinent to the employees of AAR Health Kenya, where such salary adjustments may have unique implications.



**Table 1: Summary of Knowledge Gaps**

Author	Study Objectives	Study Findings	Knowledge Gaps
Geranios, Kagabo and Kim (2022)	Effects of COVID-19 on unemployment and delayed care among minorities and individuals of low socioeconomic status (SES) in the United States	The results showed that the COVID-19 pandemic exacerbated pre-existing disparities in employment and healthcare access among racial minorities and low-income individuals in the U.S., with the most severe impacts observed in those with incomes $\leq$ \$25,000 and rural communities.	The study targeted racial minorities with incomes $\leq$ \$25,000, while the present study will target all healthcare workers regardless of their income level.
Çelmeçe and Menekay (2020)	The impact of stress, anxiety, and burnout levels on the quality of life of healthcare professionals (doctors, nurses, healthcare assistants) caring for COVID-19 patients.	The study identified various correlations among stress, anxiety, burnout, and quality of life variables and highlighted that the stress, anxiety, and burnout experienced by healthcare workers caring for COVID-19 patients significantly impacted their quality of life	The scope of the study did not target all the healthcare workers caring for COVID-19 patients, including lab staff, clinical officers, and pharmacists. There is also a need to find specific stressors and challenges unique to Kenyan healthcare workers, such as resource constraints, patient load, and systemic issues within the Kenyan healthcare system.

<p>Haidari, Main, Cui, Cape et. al, 2021.</p>	<p>Well-being and patient safety climate of maternal and neonatal health care workers (HCWs) during the COVID-19 pandemic</p>	<p>The study found that HCWs experienced emotional exhaustion and reported decreased staffing levels, health-related issues such as COVID-19 illness and burnout, and difficulty in reaching the workplace</p>	<p>The focus of this study was only on maternal and neonatal healthcare workers.</p>
<p>Gálvez-Herrer, Via-Clavero, Ángel-Sesmero and Calle (2021)</p>	<p>Feelings and coping strategies among frontline critical care workers during the initial phase of the COVID-19 pandemic</p>	<p>The results highlighted four main themes: an imbalance between demands and resources, acute stress responses, personal and professional consequences, and protective factors like group cohesion and social support. The study found that the intervention significantly helped critical care workers verbalize and integrate their experiences, offering coping strategies with high participant satisfaction.</p>	<p>The study's timing was during the pandemic's initial phases for healthcare workers in different hospitals.</p>

<p>Deressa, Adugna, Bezane et. al (2022)</p>	<p>To explore the relationship between organizational commitment and organizational justice</p>	<p>The analysis showed a strong and positive correlation between organizational commitment and organizational justice, indicating that perceptions of fairness in decision-making significantly influence healthcare workers' commitment to their organization. Specifically, distributive justice and procedural justice were identified as key factors affecting organizational commitment.</p>	<p>The organizational justice in this study is tied to salary cuts while this study looks at justice with regard to decision making in general.</p>
<p>Ogira D, Bharali I, Onyango J, Mao W, McDade KK, Kokwaro G, et al. (2022).</p>	<p>Health systems and lessons for future emergency preparedness: A stakeholder analysis in Kenya</p>	<p>The study found that Kenya's health system faced significant coordination, resource, and infrastructure challenges during the COVID-19 pandemic, highlighting the need for stronger multi-sectoral collaboration, investment in health workforce capacity, and clearer emergency preparedness plans.</p>	<p>While the stakeholder analysis focused on systemic and policy-level emergency preparedness, it overlooked the lived experiences and socio-economic impact of the COVID-19 pandemic on frontline healthcare workers, particularly within private facilities like AAR Healthcare Kenya.</p>

## 2.5 Conceptual Framework

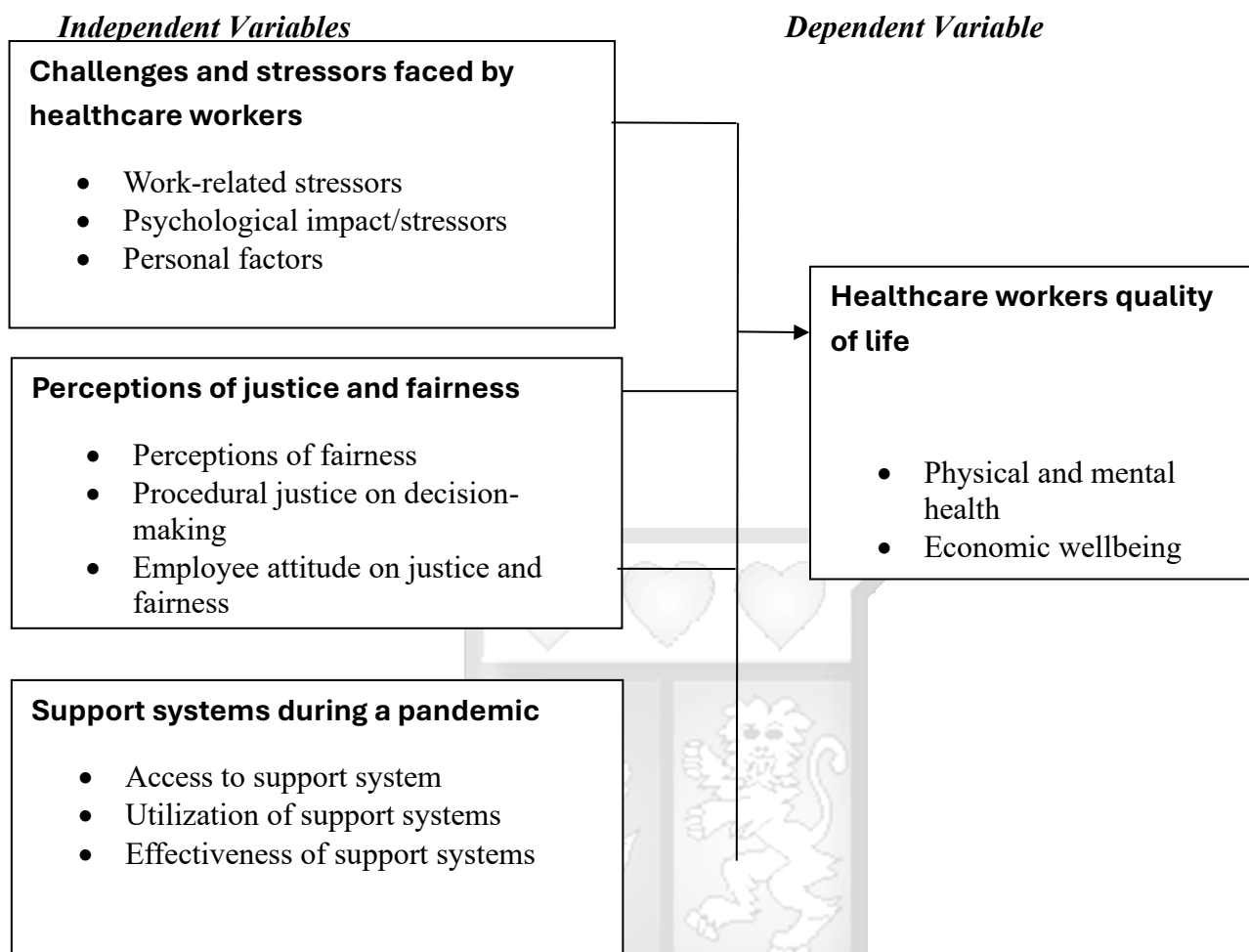


Figure 2.1: Conceptual Framework

The conceptual framework illustrates how socio-economic support programs and work environment factors (independent variables) influence healthcare workers' socio-economic well-being (dependent variable). These factors include financial assistance, fair compensation, workplace policies, and overall job security, which shape employees' quality of life. However, this relationship is mediated by job satisfaction, mental health, and family support, as these factors significantly impact how healthcare workers perceive and respond to their socio-economic conditions. A positive work environment that fosters job satisfaction and mental well-being, coupled with strong family support, enhances resilience and coping mechanisms. Ultimately, the outcome variables—performance and retention in the healthcare sector—reflect the long-term effects of these interactions. When healthcare workers experience financial stability, fair treatment, and a supportive environment, they are more

likely to remain committed to their roles, leading to improved service delivery and workforce sustainability.

## 2.6 Operationalization of Study Variables

Variable name	Type of variable	Indicators	Measurement	Analysis
Challenges facing healthcare workers	Independent	<ul style="list-style-type: none"> <li>• Work related stressors</li> <li>• Psychological impact/stressors</li> <li>• Personal factors</li> </ul>	Quantitative Qualitative	Descriptive
Perceptions of Justice and fairness	Independent	<ul style="list-style-type: none"> <li>• Perceptions of fairness</li> <li>• Procedural justice on decision making</li> <li>• Employee attitude on justice and fairness</li> </ul>	Quantitative	Descriptive, regression
Support systems during the pandemic	Independent	<ul style="list-style-type: none"> <li>• Access to support system</li> <li>• Utilization of support systems</li> <li>• Effectiveness of support systems</li> </ul>	Nominal	Descriptive, regression

## 2.7 Chapter Summary

This chapter provides a review of relevant literature and theoretical frameworks that underpin the study. The chapter examines previous studies and perspectives from scholars are compared and analyzed to provide a balanced understanding of the subject matter. Additionally, the chapter outlines the conceptual framework guiding the study. Finally, it concludes by identifying research gaps. The next chapter focusses on research methodology.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1: Introduction**

This chapter discussed the methodology used in this research, including the research design, population, sampling, data collection methods, data analysis, validity and reliability, and ethical considerations.

#### **3.2 Research Philosophy**

This study was guided by the interpretivism research philosophy. The choice of interpretivism is rooted in the study's focus on understanding the lived experiences and socio-economic effects of the COVID-19 pandemic on AAR Healthcare employees. Given that the research explored the challenges faced, perceptions of fairness, and the effectiveness of support systems, an in-depth, qualitative approach was essential to capture the complexity and subjectivity of these experiences (Saunders et al., 2019).

Interpretivism is particularly suitable because it emphasizes the importance of context, meaning-making, and individual perspectives. Unlike positivism, which relies on objective measurements and statistical analysis, interpretivism values rich, detailed narratives and interactions, making it ideal for studying human experiences in depth (Creswell, 2013). Through qualitative methods such as in-depth interviews, focus groups, and thematic analysis, this study will uncover the nuanced realities of healthcare workers, providing a deeper understanding of their challenges and coping mechanisms (Denzin & Lincoln, 2018).

#### **3.3 Research design**

A research design is a structured plan outlining the methods and procedures for conducting a study (LeCompte & Schensul, 2010). This study adopted a qualitative research design to explore the socio-economic effects of the COVID-19 pandemic on healthcare workers at AAR Healthcare Kenya. The qualitative approach is appropriate for capturing the lived experiences, perceptions,

and coping mechanisms of healthcare workers in response to challenges such as salary cuts, workload changes, and mental well-being.

This study utilized in-depth interviews and focus group discussions as primary data collection methods. These methods allow for rich, detailed narratives that uncover the subjective experiences and perspectives of participants. Additionally, thematic analysis was employed to identify key patterns, themes, and insights from the collected data (Braun & Clarke, 2006).

### **3.3 Target Population**

The target population refers to the specific group of individuals that a research study or intervention is intended to focus on and draw conclusions about. It is a subset of the larger general population (Kothari, 2014). The target population for this study was the healthcare workers employed at AAR Health Kenya. This included a wide range of professionals such as doctors, nurses, administrative staff, and support personnel who have been directly or indirectly affected by the COVID-19 pandemic. The study also collected data from management staff as well and to gather insights from these individuals regarding the challenges they faced, their perceptions of salary adjustments, the effectiveness of support systems provided, and their suggestions for improving socio-economic well-being and quality of life in the post-pandemic period.

### **3.4 Sampling**

Sampling refers to the process of selecting a subset or sample from a larger population for the purpose of making inferences about the characteristics of the entire population. All AAR Healthcare facilities in Kenya will be considered for the study. The total number of employees across all facilities is 15. The study population will include employees at the head office, where strategic decisions are made.

For this study, a stratified random sampling method would be appropriate. This involves dividing the target population (healthcare workers at AAR Health Kenya) into different strata or subgroups

based on specific characteristics such as job role (doctors, nurses, administrative staff, support personnel), department, and length of service.

From each stratum, a random sample would be drawn to ensure that all subgroups are adequately represented in the study. This approach helps in capturing the diverse experiences and perspectives of different types of healthcare workers, ensuring the findings are comprehensive and reflective of the entire population i.e. doctors, nurses, administrative staff, and support personnel. Within each stratum, participants would be randomly selected to participate in the study.

**Table 2: Population Table**

<b>Category</b>	<b>Number</b>
Admin	2
Doctor	2
Laboratory	1
Nursing	2
Other Clinical Staff	2
Pharmacy	1
SMT	4
Support Staff	2
<b>Grand Total</b>	<b>15</b>

### **3.5 Data Collection**

Data for this study was collected using a qualitative approach to provide a comprehensive understanding of the challenges and experiences of healthcare workers at AAR Health Kenya during the COVID-19 pandemic.

The qualitative data collection involved in-depth interviews which were conducted from a sample of healthcare workers from different roles to explore personal experiences, feelings about the fairness of salary cuts, and detailed feedback on support systems and interventions. Key informant interviews with stakeholders and management personnel will also be conducted to gain insights into organizational decisions and strategies implemented during the pandemic.

### **3.6 Data Analysis**

Data analysis for this study combined qualitative methods to provide a comprehensive understanding of the experiences of healthcare workers at AAR Health Kenya during the COVID-19 pandemic.

Qualitative data from interviews, was examined through thematic analysis. This process begun with transcribing the audio recordings verbatim to ensure accuracy. Next, significant statements and recurring themes were identified and coded. These codes were then be grouped into broader themes that reflect the main challenges, stressors, perceptions of fairness, the effectiveness of support systems, and recommendations for improvement. The researcher will use NVIVO software for the qualitative analysis.

To ensure the study remained participatory and responsive, continuous feedback mechanisms was integrated. Participants were invited to review preliminary findings for validation, ensuring their voices are accurately represented. Additionally, the study included a dissemination plan aimed at sharing results with all stakeholders, including the participants. This involved summary reports, presentations, and interactive forums to communicate key findings and gather further insights.

### **3.7 Validity and Reliability**

#### **3.7.1 Validity**

In qualitative research, validity refers to the credibility, trustworthiness, and authenticity of the findings rather than statistical measurement (Lincoln & Guba, 1985). Additionally, member checking was conducted, where participants reviewed preliminary findings to verify the accuracy and representation of their perspectives. Thick description was also used to provide detailed contextual insights, strengthening the transferability of findings to similar settings.

#### **3.7.2 Reliability**

In qualitative research, reliability is assessed through dependability, ensuring the research process is consistent and well-documented (Miles & Huberman, 1994). To achieve this, the study maintained a clear audit trail, detailing all data collection and analysis processes to allow for transparency and consistency.

A pilot study was conducted to ensure the validity and reliability of the study instruments. This pilot study involves pre-testing the questionnaire with a selected sample, allowing the researcher to refine data collection methods and identify potential issues before the main study. Mugenda and Mugenda (2003) recommend validity and reliability testing to ensure the dependability and coherence of research findings.

### **3.8 Ethical Considerations**

Ethical considerations are paramount in conducting research involving healthcare workers, especially in sensitive contexts such as assessing socio-economic challenges during the COVID-19 pandemic. This study will adhere to ethical principles outlined in the Declaration of Helsinki and local regulatory guidelines. Prior informed consent will be obtained from all participants, ensuring voluntary participation, confidentiality, and anonymity of their responses. Measures will be taken to minimize potential harm or discomfort to participants, and steps will be in place to address any adverse effects arising from participation. Data handling will prioritize privacy and security, with only authorized personnel having access to identifiable information. Furthermore, the study aims to contribute positively by potentially improving support systems for healthcare workers and enhancing their socio-economic well-being post-pandemic. Ethical approval will be sought from relevant institutional review boards to ensure compliance with ethical standards throughout the research process.

### **3.9 Chapter Summary**

This chapter has discussed the research methodology including the research philosophy and the data collection and analysis approaches. It has also detailed the validity and reliability and ethical considerations.

## CHAPTER FOUR

### RESULTS AND FINDINGS

#### 4.1 Introduction

This chapter presents the results and findings as guided by the research objectives and methodology. The study assessed the socio-economic challenges faced by healthcare workers during the COVID-19 pandemic, their perceptions of fairness regarding salary adjustments, and the effectiveness of institutional support systems at AAR Healthcare Kenya. The chapter is organized around the study's three core objectives. The first section presents descriptive findings from interview responses across different staff cadres, followed by thematic analysis aligned with each objective. Participant narratives are integrated to enrich the interpretation of the data and provide depth to the findings.

A qualitative approach was employed to gain in-depth insights into the lived experiences, perceptions, and feelings of healthcare workers regarding the socioeconomic impact of the COVID-19 pandemic. This method enabled a rich, nuanced understanding of issues such as fairness, support systems, and organizational responses—factors that are best explored through open-ended, narrative data rather than numerical analysis. To minimize recall bias, participants were selected based on their direct involvement during the pandemic, and interviews were conducted using guided prompts that helped them reconstruct specific events and experiences. Additionally, participants were encouraged to refer to personal records, organizational memos, or timelines where possible to aid memory and enhance the accuracy of their responses.

To protect participant anonymity and uphold ethical standards, all interviewees were assigned unique, non-identifiable codes based on their professional role and a randomized numerical sequence (e.g., EAA1, AAT1). These identifiers do not reflect actual staff designations, departments, or hierarchical levels, and were randomly assigned to avoid any potential traceability. In all transcripts and analyses, personal identifiers such as names, specific job titles, work locations, or references to identifiable incidents were redacted or generalized. This approach ensured that responses remained confidential, while still allowing for meaningful interpretation across staff cadres. Only the principal investigator had access to the original identifier list, which was securely stored and permanently deleted after the analysis phase.

## **4.2 Response Rate**

The researcher administered 12 interview guides, consisting of 9 healthcare workers and 3 Senior Management Team members (SMTs), out of a target of 15, resulting in an 89.7% response rate. This response rate was considered adequate for further analysis, as it surpasses the 50% threshold suggested by Saunders et al. (2009). The high response rate was attributed to the small sample size, which allowed for direct administration and follow-up. The study aimed to capture the perspectives of healthcare workers and administrative staff on the socioeconomic impact of the pandemic.

## **4.3 Socio-Economic Challenges Faced by Healthcare Workers**

During the COVID-19 pandemic, healthcare workers worldwide faced immense socioeconomic challenges. This was no different for employees at AAR Healthcare Kenya, a leading private healthcare provider in the region. Drawing from a series of in-depth interviews with staff members across multiple cadres—including nurses, laboratory scientists, front office staff, general assistants, HR personnel, and medical specialists—it becomes clear that the pandemic tested not only their physical endurance but also their emotional resilience, financial stability, and access to adequate logistical support. The following sections break down these challenges in thematic form, referencing specific feedback using participant codes to maintain anonymity and authenticity.

### **4.3.1. Psychological and Emotional Challenges**

The psychological impact of COVID-19 on healthcare workers was among the most pronounced themes across the interviews. Participants described experiencing constant fear, anxiety, and emotional exhaustion—stemming from the nature of their work on the front lines, the novelty and uncertainty of the virus, and the potential of transmitting the disease to their loved ones. Many healthcare workers reported increased stress levels due to stigma, isolation, and inadequate emotional support during the early phases of the pandemic. In several cases, even those not directly engaged in clinical care mentioned the weight of being in a healthcare setting during such an unprecedented time. The fear of death, the trauma of watching patients deteriorate quickly, and the responsibility of providing accurate information without being well-informed themselves compounded this emotional toll.

**EAA1:** *“It was one of the worst periods of my life... I couldn’t run away from my profession. I was heavily pregnant, and the fear of infecting my family was overwhelming.”*

**FAA1:** *“We were exposed to so many patients... I felt like we were more exposed than anyone else.”*

**AA1:** *“We had to work under very harsh conditions... limited interactions, pay cuts, and fear of the unknown.”*

**AAS1:** *“The therapy sessions really helped, especially because my father was also unwell at the time. It came in handy.”*

**EAA2:** *“There was a lot of stigma. The company gave us a counselor who called us daily while we were isolating.”*

**AA01:** *“I got COVID. There was stigma and fear. But the support from counseling helped me cope.”*

#### **4.3.2. Financial Strain from Salary Cuts**

The COVID-19 pandemic severely impacted the financial stability of many healthcare institutions, resulting in widespread salary reductions. AAR Healthcare was no exception. While some participants expressed understanding of the rationale behind these decisions—recognizing that they were necessary to sustain operations and retain staff—others felt that the salary cuts were unjust, especially considering the high levels of risk they continued to face in the line of duty. Many employees had to revise their budgets, scale back on personal expenses, and make significant lifestyle adjustments. For some, the financial challenges were compounded by the loss of income in their households where spouses or partners were self-employed and similarly affected by economic downturns during lockdown periods.

**EAA1:** *“Cutting salaries was the worst decision. We were more exposed than ever—they should have increased pay!”*

**FAA1:** *“We had to work the same hours, even more, but got paid less. Though it helped retain all staff.”*

**AA1:** *“We took up to a 5% cut for 4 months. At the time it felt unfair, but looking back, it was necessary.”*

**AAS1:** *“I was in management and understood sustainability. The 5% cut for 3 months was okay.”*

**EAA2:** *“I had to adjust my lifestyle. Lost 10% of salary for 3 months. Still, the company did better than others.”*

**EAT1:** *“The pay cut was small, about 5–10%, and only lasted 3 months. It was justified, given our workload drop.”*

**HAA1:** *I saw the need to keep the company afloat. A 5% cut over 6 months was fair.”*

**GA1:** *“No pay cut for me. My salary was intact.”*

### **4.3.3. Burnout and Increased Workload**

Burnout was another critical challenge that emerged during the pandemic. With staff rotations meant to limit exposure, sick leaves due to COVID-19, and the suspension of locum or temporary workers, permanent staff were left to shoulder an unsustainable workload. Many participants reported working extra days, losing rest days, and sacrificing work-life balance to keep operations running. The additional emotional labor of managing frightened patients, implementing new safety protocols, and absorbing the responsibilities of absent colleagues led to deep fatigue. In some cases, shift changes led to feelings of disorientation or dissatisfaction, especially among staff who had to give up night shifts, which previously allowed them more flexibility and rest.

**EAA1:** *“There was staff shortage... sometimes we were completely overwhelmed by patients.”*

**FAA1:** *“We had to work daily without rest to cover shifts. There was real burnout.”*

**EAA2:** *“I lost my night shifts, which gave me rest and time with family. It affected my work-life balance.”*

**GA1:** *“They removed locum staff, so we had to do double the work. It was exhausting.”*

Understanding the experiences of healthcare workers during the COVID-19 pandemic would be incomplete without the insights of decision-makers at the senior management level. While frontline staff bore the brunt of physical and psychological exposure, those in strategic leadership roles were tasked with making difficult and often unpopular decisions to keep the organization afloat amid a global crisis.

*AAT1: During the pandemic, we witnessed firsthand the incredible pressure our frontline staff were under, both professionally and personally. We saw nurses, doctors, and even our non-clinical staff face significant emotional stress due to the fear of contracting the virus and possibly infecting their families.*

*From a socio-economic standpoint, it wasn't just about the emotional toll. There were real challenges like burnout, increased workload, transportation barriers—especially during the curfew periods—and the disruption of family routines. For example, we had staff who were pregnant or had young children, and the isolation protocols separated them from their loved ones. Some had to move between branches, which added commuting stress and cost.*

#### **4.4.4. Logistical Challenges: Transport and Work Access**

Movement restrictions such as curfews and lockdowns made it extremely difficult for healthcare workers to commute. The abrupt introduction of these measures meant that many staff had to navigate their way home during curfew hours or pay for private transport options that were not always available. While the company made some arrangements—such as issuing staff IDs to facilitate movement and, in some cases, providing Uber services—these were often inadequate or inconsistently applied. For workers who were reassigned to branches further from home, the logistical burden increased even further, reducing time with family and increasing stress levels. Accessibility and workplace continuity were, therefore, significant pain points that added to the complexity of an already difficult work environment.

*EAA1: “They gave us staff passes and ambulances during lockdown, which really helped.”*

*FAA1: “Staff IDs were not enough—curfew still made it hard to get home.”*

**AAS1:** *“Public transport was unreliable. Most cars were grounded.”*

**AAT1:** *“I was transferred twice. The second location was far, and transport was a nightmare.”*

**HAA1:** *“We hadn’t explored remote working, so physical presence was hard and stressful.”*

**GA1:** *“Sometimes I left work late, right when curfew started. We needed Uber support.”*

#### **4.4.5. Infection Risk and PPE Shortages**

During the early months of the pandemic, the availability and adequacy of Personal Protective Equipment (PPE) was a significant concern. While the company eventually supplied the necessary gear and enforced protocols, several participants recalled an initial period of confusion, vulnerability, and inconsistent communication regarding safety. Staff expressed frustration over unclear guidelines on what protective gear to use and when, as well as fear of infecting colleagues and family members. Moreover, the physical discomfort of working in PPE for extended hours added to their daily strain. The psychological burden of possibly being vectors of transmission while serving the community was a common theme that deepened their sense of professional vulnerability.

**AAY1:** *“There was a lag before we got proper PPEs. We worked in fear.”*

**AAS1:** *“We weren’t sure what PPE to use—mask or full gown? Eventually, it got sorted.”*

**TAA1:** *“PPEs were expensive. The company still managed to provide them consistently.”*

**EAA2:** *“They made vaccination mandatory for staff and trained us on COVID-19 protocols.”*

#### **4.3.6. Support Systems: Psychological, Medical, and Logistical**

Despite the many challenges, most participants acknowledged that AAR Healthcare made commendable efforts to provide a range of support mechanisms. These included professional counseling services, structured COVID-19 sick leave (not deducted from annual leave), and isolation accommodations for affected staff and their families. The organization also disseminated

continuous information via email and offered Continuing Medical Education (CME) sessions to keep staff informed. Several workers mentioned that psychological support was especially critical in helping them process fear, stigma, and isolation. However, there were calls for improvement in the timeliness, consistency, and inclusivity of these support structures.

**AAS1:** *“We started having online therapy sessions. They came in handy when my father fell ill.”*

**EAA2:** *“They booked a hotel for us to isolate with our babies. The counselor called daily. That helped so much.”*

**GA1:** *“The psychological support helped us overcome stigma. It made a difference.”*

**TAA1:** *“Morning debriefs and sessions helped boost our morale every day.”*

**HAA1:** *“The health education and resource allocation were timely. We remained alert despite the crisis.”*

At AAR Healthcare Kenya, the Senior Management Team (SMT) played a pivotal role in striking a balance between the health and safety needs of employees and the financial sustainability of the business. Their decisions—including temporary salary reductions, staff redeployment, and logistical reorganization—had a profound impact on the lived experiences of workers across various departments. As such, SMT perspectives provide critical insight into the rationale, limitations, and reflective learning that accompany these decisions.

*AAT 3: I think one of the strongest lessons we learned is that socio-economic support during a health crisis must be holistic—it’s not just about PPE or allowances. We responded with interventions such as hotel accommodations for exposed staff, psychological counseling, staff transport facilitation, and dedicated COVID-19 sick leave. However, in hindsight, we realize that some of these came a bit late or may not have reached everyone in the way we had hoped. That’s something we’re actively reviewing in our disaster preparedness framework.”*

#### **4.4 Perceptions of Justice and Fairness on Salary Cuts**

During the COVID-19 pandemic, many healthcare institutions worldwide were compelled to implement salary cuts and cost-containment measures to maintain their operations. At AAR Healthcare Kenya, these measures were introduced as part of the company's response to a decline in patient visits, a shrinking revenue base, and increased operational costs associated with safety equipment and staff protection. While such decisions are often framed as necessary in times of crisis, they carry significant implications for staff morale, perceptions of fairness, and organizational trust.

This section draws upon in-depth interviews with healthcare professionals from multiple departments, analyzing their views on whether salary cuts were justified, fairly communicated, and equitably implemented. Their narratives offer insights into how perceptions of justice—both procedural and distributive—shaped their experience during the pandemic.

### **1. Mixed Perceptions of Fairness and Necessity**

Across the board, participants expressed mixed feelings about the salary cuts. Some saw the decisions as practical and necessary, acknowledging that AAR had managed to retain staff jobs and maintain basic support services despite reduced income. Others, however, viewed the pay cuts as unfair, especially when juxtaposed with the increased physical and emotional demands of their roles.

**EAA1:** *“This was the worst decision the company made. We were risking our lives daily, yet our pay was cut. It wasn't fair at all—they should have added to our salaries instead.”*

#### **FAA1**

*“Yes and no. Yes, because no one lost their job, which was good. But no because our workload didn't change—we were still working long hours, even using our leave days. It felt unbalanced.”*

#### **AA1**

*“At the time, the cuts felt unfair. But looking back, it was a justified measure. Compared to what others in the industry went through, AAR handled it better.”*

**AAS1** *“I understood the business logic behind it. The 5% cut over three months was a reasonable approach. It was important to keep the company sustainable and staff employed.”*

**EAA2** *“I had to change my lifestyle completely. The 10% pay cut was tough—but I think it was fair given that patient visits were low and the company wasn’t making much.”*

**AAT1** *“The cut was around 5–10%, and it didn’t last long. It was reasonable under the circumstances.”*

**HAA1** *“From a business continuity perspective, it was a fair call. It allowed us to retain staff and remain operational. It wasn’t perfect, but it was justifiable.”*

**GA1**

*“I wasn’t affected by a salary cut. But I know others were, and it created tension. Some felt they were carrying the burden unfairly.”*

## **2. Concerns about Distributive Justice: Equal Sacrifice for Unequal Risk**

Distributive justice refers to perceptions of how fairly benefits and burdens are shared. Some participants raised concerns that the salary cuts were applied uniformly despite differences in role-based risk exposure. For instance, those on the frontlines—like nurses and lab staff—felt that they bore disproportionate physical and emotional risk without corresponding financial compensation.

**EAA1:**

*“We were the ones getting exposed every day. How can you cut our salaries instead of compensating us more? It felt like we were being punished for doing our job.”*

**FAA1:**

*“Everyone’s pay was cut, but not everyone was seeing patients or handling emergencies. It would’ve been better to base cuts on the level of exposure or workload.”*

**AA1:**

*“Risk wasn’t evenly distributed, but the cuts were. That’s something that could have been handled with more sensitivity.”*

**3. Procedural Justice: Communication and Transparency**

Participants also evaluated the fairness of **how** decisions were made and communicated (procedural justice). Those who were part of management or who received regular communication expressed greater understanding and acceptance. Others wished there had been more **involvement, explanation, or consultation** in the process.

**AAS1:**

*“Being in management helped me understand the reasoning. We were briefed, and that made it easier to accept.”*

**HAA1:**

*“The conversations with staff were timely and open. That helped maintain trust during a very uncertain time.”*

**EAA2:**

*“We weren’t consulted. We were just told salaries would be cut. A little more openness would’ve helped.”*

**AAT1:**

*“We were advised early. That made it easier to plan. And the cuts were temporary, which helped us stay calm.”*

**4. Impacts of Financial Measures on Daily Life**

Beyond perceptions of fairness, the interviews revealed how salary cuts had a tangible impact on the livelihoods of healthcare workers. Participants spoke of having to scale back on personal expenses, adjust their lifestyles, or defer key family plans due to the financial strain. These personal adjustments added another layer of stress to already demanding professional circumstances.

**EAA2:**

*“I had to stop doing some things I was used to. We had a baby during this time—it wasn’t easy.”*

**EAA1:**

*“My husband lost income as well. We were both affected. Managing a household became very difficult.”*

**FAA1:**

*“We used our leave days to cover shifts, which meant we didn’t even get time off to rest or manage our stress.”*

**What Workers Believed Could Have Been Done Better**

While many acknowledged that salary adjustments were likely inevitable, there was strong consensus that better equity, communication, and flexibility would have made the measures feel more just. Suggestions included scaling cuts based on role, temporarily increasing allowances for frontline risk, and improving two-way communication during policy changes.

**EAA1:**

*“They should have compensated high-risk staff more or at least exempted us from the cuts.”*

**FAA1:**

*“Even if cuts were necessary, it would have helped to reduce our hours. Instead, we worked more and earned less.”*

**HAA1:**

*“Future planning should include better staff engagement. When people understand why something is being done, they’re more likely to accept it.”*

**4.5 Effectiveness of AAR Health Kenya’s Support Systems and Interventions**

The COVID-19 pandemic posed unprecedented challenges for healthcare systems globally, necessitating rapid response measures to support the frontline workforce. At AAR Health Kenya, the organization introduced several support interventions aimed at protecting and sustaining its healthcare workers—emotionally, physically, and financially. This section evaluates the effectiveness of these interventions in mitigating the socio-economic challenges that emerged during and after the pandemic, drawing from both staff interviews and insights from Senior Management Team (SMT) representatives. The evaluation considers both formal organizational responses and employee perceptions of their adequacy, timeliness, and fairness, offering a multi-layered perspective on what worked, what fell short, and what lessons can inform future crisis preparedness.

#### **4.5.1 Staff Perspectives on Support Systems**

Across the interviews conducted with nurses, lab staff, front office personnel, and general assistants, several key interventions were highlighted and evaluated:

##### ***Positive Interventions Noted by Staff:***

Access to counseling and mental health check-ins emerged as one of the most valued and impactful interventions provided by AAR Healthcare Kenya during the COVID-19 pandemic. The intense emotional toll of working in healthcare during a global health crisis—compounded by fear of infection, long hours, social isolation, and the stigma associated with testing positive—made psychological well-being a central concern for many employees.

Participants from both clinical and support roles expressed that the ability to speak to a professional counselor, even over the phone, offered a vital outlet for processing their fears, anxieties, and frustrations. This was particularly important for those who were isolating after exposure to COVID-19 or those who had tested positive themselves. One nurse (N2), who was quarantined with her infant child, shared how the daily calls from a designated counselor helped her remain emotionally grounded during an extremely isolating and vulnerable time:

*“There used to be a counselor who called us every day to check how we were doing... at that time, you had not so many people to talk to, and there was a lot of stigma. Being able to talk to someone confidentially made a big difference.”*

Similarly, (LS1) recounted how the organization facilitated therapy sessions when one of their team members tested positive, which significantly helped in reducing team-wide anxiety:

*“When part of our team got COVID, they organized online counseling. It came in handy. I was also going through some personal stress with my family—so it really helped.”*

The organization’s willingness to invest in psychological support was viewed as a progressive and compassionate step by several employees. It demonstrated recognition that the pandemic was not only a physical health emergency but a mental and emotional one as well. However, while this service was highly appreciated where it was accessed, there were indications that it was not uniformly available across all branches or well-communicated to every staff member. One respondent (FAA1) reflected on this by stating:

*“I think psychological support could’ve been more visible. Some of us didn’t even know how to access it or if it was meant for everyone.”*

Despite this inconsistency, the presence of structured mental health interventions significantly contributed to morale and emotional stability for those who were reached. It also highlighted a key lesson for future crises: mental health support must be embedded, normalized, and equitably accessible—not just during a pandemic, but as a standing pillar of employee welfare.

### **COVID-Specific Sick Leave**

One of the most widely appreciated and effective interventions implemented by AAR Healthcare Kenya was the provision of COVID-specific sick leave. This measure allowed staff who tested positive for COVID-19 to take time off for treatment and recovery without depleting their standard annual or sick leave days. The policy acknowledged the extraordinary nature of the pandemic and demonstrated an organizational commitment to both employee welfare and dignity. For many staff members, this intervention was seen as a compassionate gesture that not only respected their health

needs but also eased the mental and financial pressure of being away from work due to illness. AAT1 expressed this sentiment clearly:

*“They gave us COVID leave, not deducted from normal sick days. That showed they cared.”*

The implementation of this policy meant that staff were not penalized for something beyond their control. It helped protect their earned leave for future personal or family needs, especially critical during a time of uncertainty. Moreover, it reduced the likelihood of employees reporting to work while unwell out of fear of using up their limited leave days—a risk that could have increased transmission within healthcare facilities.

The impact of this initiative extended beyond the individual employee to their families and teams. By legitimizing recovery through a structured, paid leave system, the organization not only reinforced health and safety protocols but also fostered a culture of trust and fairness. Employees felt that the company understood the gravity of the situation and was willing to make policy adjustments that reflected this understanding. Although some employees may not have utilized this leave directly, the mere existence of such a policy created a sense of psychological safety. It served as a clear signal that the organization was responsive and attuned to the unique pressures of the pandemic context.

This intervention is a notable example of how tailored HR policies can significantly influence staff morale and retention during crisis periods. It also points to an important lesson for future preparedness—emergency-specific leave frameworks should be institutionalized as part of organizational contingency planning.

**AAT2** *“We prioritized continuity of employment. We didn’t want to lose a single staff member. That’s why we introduced COVID-specific leave, covered bills, and created flexible redeployment. I believe those were effective in protecting livelihoods. However, the pressure on our internal communication systems became clear. Some staff didn’t understand the rationale behind certain actions, and we’ve learned the importance of not just doing the right thing—but communicating it early, consistently, and compassionately.”*

## **Isolation Accommodation**

To reduce the risk of transmission to family members, especially in households with vulnerable individuals or shared living spaces, AAR Healthcare Kenya introduced an isolation accommodation policy. Staff who had been exposed to or tested positive for COVID-19 were provided with hotel accommodations, fully paid for by the organization. This measure enabled employees to recover or complete their quarantine periods safely, without risking the health of their loved ones at home.

What set this intervention apart was the human-centered flexibility it offered. Staff were allowed to bring family members, including infants, into isolation with them, which helped reduce anxiety and supported caregiving needs. EAA2 shared a particularly touching account:

*“They even allowed us to bring our children. I stayed with my baby in a hotel. That helped a lot.”*

This initiative not only fulfilled a public health function but also served an emotional and logistical need. Many healthcare workers struggled with the prospect of being apart from their children or elderly relatives during illness or exposure. By offering family-inclusive isolation facilities, AAR demonstrated both empathy and a deep understanding of the real-life contexts its employees lived in.

This intervention was particularly effective in mitigating the dual burden of occupational exposure and domestic transmission risks, while also reducing stigma and fear within staff households. It contributed positively to the psychological well-being and loyalty of affected employees. However, future improvements could include standardized access guidelines and a streamlined process for requesting accommodation, ensuring that all staff are aware of the option and know how to access it quickly.

### **Transport and Logistical Support**

With the imposition of curfews and restricted public transport during the peak of the pandemic, healthcare workers across Kenya faced logistical challenges in getting to and from work. In response, AAR Healthcare implemented several measures to facilitate staff mobility, including the issuance of staff IDs for curfew exemption, access to Uber rides or taxis, and, in some cases, the use of ambulances to transport essential personnel.

These interventions helped staff maintain punctuality and presence in their roles, especially during emergencies or late shifts. One GA1 shared their experience:

*“Sometimes we got Ubers or used our staff badges to get home past curfew.”*

While this support was praised by those who received it, feedback from other participants indicated that coverage and consistency varied across departments and locations. Some workers continued to struggle with transport issues, particularly when transfers placed them at a distance from their usual workstations. Nonetheless, the initiative was viewed as a critical component of operational continuity, and in some instances, served as the deciding factor between being able to report to work or not. The effectiveness of this intervention underlines the importance of institutionalized transport plans within emergency preparedness frameworks. This could include partnerships with ride-hailing services, fleet allocation for essential staff, or structured transport allowances during national crises.

### **Medical Coverage for Staff and Families**

Another commendable intervention was the continuation and expansion of medical coverage for staff during the pandemic. Despite widespread financial constraints, AAR Healthcare maintained its staff insurance scheme and, in several cases, fully covered COVID-related medical expenses, including for family members. This was a strong morale booster and reduced out-of-pocket burdens for those infected or needing care.

GA1 described their experience as follows:

*“They paid for my COVID treatment and also checked on my family.”*

This level of support had both practical and symbolic significance. Practically, it ensured that affected staff received timely and quality medical attention. Symbolically, it communicated that the company valued its workforce and was willing to share in the risks and burdens of the pandemic. It also prevented staff from delaying care due to cost concerns—an important public health win, considering the highly contagious nature of COVID-19.

The inclusion of family support in some cases elevated this intervention from standard policy to a gesture of organizational compassion. It highlighted the interconnectedness of healthcare workers’

professional and personal lives and positioned the employer as a true partner in navigating crisis conditions.

### **Information Dissemination and Training**

Effective crisis response relies heavily on the timely and clear dissemination of information, particularly in healthcare settings where protocols and knowledge are rapidly evolving. AAR Healthcare Kenya made concerted efforts to keep staff informed by organizing frequent Continuing Medical Education (CME) sessions, sending email updates, and conducting morning debriefs in select departments.

These sessions not only helped staff stay abreast of new developments related to COVID-19 but also provided a platform to ask questions, share experiences, and clarify evolving safety protocols. EAA2 reflected on how this made them feel better equipped:

*“We had many CMEs and updates on Covid protocols. That made us feel better prepared.”*

In a climate of uncertainty and widespread misinformation, such structured information sharing contributed significantly to reducing anxiety and promoting confidence in the workplace. It ensured that all staff—from clinical teams to front office personnel—were on the same page regarding prevention, diagnosis, and patient interaction protocols.

While most staff praised the quality of the updates, a few indicated that access to these sessions was uneven, especially for non-clinical staff or those working shifts that overlapped with scheduled trainings. This suggests the need for inclusive scheduling, recorded content, and multi-channel communication in future crisis-response communication strategies.

#### **4.5.2 Areas Where Support Fell Short (as Perceived by Staff):**

- **Transport Support Was Inconsistent**  
Not all staff received transportation assistance, and the curfew enforcement varied by location.

**FAA1** *“The staff IDs were not always sufficient. We still struggled to get home.”*

- **Psychological Support Was Not Equally Accessible**

While praised by some, others were unaware of or didn’t access counseling services.

**Faa1:** *“There could have been more visibility for counseling. Not everyone got the help they needed.”*

- **Workload Remained High Despite Support**

With locum and casual staff off-boarded, full-time staff absorbed more duties.

**GA1:** *“We worked double shifts when locum staff were let go. It was too much.”*

#### **4.5.3 Senior Management Team Voices: Evaluating the Interventions**

To complement the voices of staff, feedback was sought from three SMT representatives, each offering strategic insight into the intent, execution, and perceived outcomes of AAR’s pandemic-era interventions.

**AAT1** *“From our side, the goal was to protect our people without losing operational capacity. We knew that PPE and leave days were the basics, but mental health emerged quickly as a major concern. I believe the psychological support was effective where implemented, but we’ve since recognized that making these services visible and accessible across all branches requires further improvement. Counseling shouldn’t just be reactive—it should be part of a long-term employee wellness strategy.”*

**AAT3** *“One lesson is that we underestimated the psychological load of this pandemic. We responded with technical solutions—PPE, transport—but people needed more reassurance and emotional support. The isolation hotels were a lifesaver, and we appreciated our decision to allow family members. But I think we now know we have to build more structured emergency systems—clearer protocols, better digital tools, and a crisis-response playbook that includes equity for all cadres.”*

## 4.6 Discussion

The findings from this study reveal a complex interplay between institutional support and individual resilience among healthcare workers at AAR Healthcare Kenya during the COVID-19 pandemic. While the pandemic introduced severe socio-economic disruptions, AAR's multi-faceted response demonstrated both strengths and gaps that shaped employees' experiences in different ways.

In addressing Objective (i), the study established that healthcare workers faced a wide range of socio-economic challenges, including psychological distress, workload-related burnout, financial strain due to salary cuts, transport difficulties during curfews, and fear of infection. These challenges were particularly pronounced among frontline staff such as nurses, lab technicians, and general assistants. The emotional toll was compounded for those who were pregnant, had young families, or worked in high-risk clinical settings.

With respect to Objective (ii), findings showed mixed perceptions around the fairness of salary adjustments and financial decisions made by the organization. While some staff viewed the salary cuts as necessary for business continuity, others—particularly those at high risk—perceived the decisions as unjust due to the uniform application of pay reductions despite varying levels of exposure and responsibility. The lack of tailored compensation measures for frontline workers emerged as a key point of dissatisfaction. Furthermore, while efforts were made to communicate financial decisions, procedural justice was not felt equally by all cadres.

Under Objective iii, the study found that AAR Health Kenya's support systems were largely well-received, especially the provision of COVID-specific sick leave, mental health counseling, isolation accommodation, and continued medical coverage. These interventions were viewed as compassionate and responsive, helping to protect both staff and their families. However, certain areas—such as equitable access to transport, mental health services, and the retention of locum staff—were flagged as needing improvement. SMT representatives acknowledged these gaps and highlighted lessons learned, particularly in the areas of preparedness, internal communication, and inclusive decision-making.

The findings suggest that while AAR made commendable efforts to support its workforce, the effectiveness of its interventions could have been enhanced through more differentiated support mechanisms, stronger frontline engagement, and a long-term wellness strategy embedded into organizational practice.



## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter provides a comprehensive summary of the key findings, followed by a discussion, conclusions, and practical recommendations based on the study objectives. It also outlines suggested areas for further research. The content is organized thematically in alignment with the stated research objectives.

#### 5.2 Summary and Discussion of Findings

The study explored the socio-economic challenges faced by healthcare workers at AAR Healthcare Kenya during the COVID-19 pandemic, their perceptions of fairness regarding salary adjustments, and the effectiveness of support systems implemented by the organization. Findings revealed that staff experienced psychological stress, financial strain, increased workload, and logistical difficulties. While salary cuts were generally viewed as necessary, concerns were raised about equity and communication. Interventions such as COVID-specific sick leave, counseling services, and isolation accommodation were well-received, though inconsistencies in implementation were noted. This study highlights both the strengths and areas for improvement in AAR's pandemic response strategy.

##### 5.2.1 Socio-economic Challenges Faced by Health workers during COVID-19

The study revealed that healthcare workers at AAR Healthcare Kenya experienced a range of socio-economic challenges during the COVID-19 pandemic. These included psychological distress, fear of infection, increased workload due to staff shortages, limited rest periods, financial pressures arising from salary cuts, logistical challenges related to curfews and transportation, and stigma following COVID-19 diagnosis.

One of the most prominent challenges was psychological stress, largely attributed to the fear of contracting COVID-19 and the emotional toll of caring for severely ill patients. Participants described feelings of anxiety, helplessness, and emotional exhaustion, especially among pregnant staff and those with young families. These findings are consistent with previous research by

Shaukat, Ali, and Razzak (2020), who documented high levels of psychological distress among frontline healthcare workers globally, noting that the fear of infection, long working hours, and insufficient rest were key contributors to burnout. Similarly, Spoorthy, Pratapa, and Mahant (2020) observed that emotional fatigue and anxiety were prevalent among nurses and clinicians during the early stages of the pandemic, especially when adequate psychosocial support was lacking. Workload-related burnout was another recurring issue. Staff noted that the off-boarding of locum and temporary personnel led to increased pressure on permanent employees, forcing them to work extended shifts with limited rest. This finding aligns with observations made by Liu et al. (2020), who reported that many healthcare systems became overstretched due to increased patient numbers, resulting in significant workload burdens on remaining staff. The lack of sufficient human resources during health emergencies has also been highlighted by the World Health Organization (2021) as a critical weakness in healthcare preparedness and response systems.

Financial strain emerged as a significant stressor. While AAR Healthcare implemented across-the-board salary reductions as a cost-containment measure, participants felt the cuts were unfair given the increased risks they faced. These perceptions of injustice were particularly strong among frontline workers. This resonates with findings from a study by Dewey, Hingle, Goelz, and Linzer (2020), who emphasized the impact of perceived organizational injustice on healthcare worker morale and performance during COVID-19. Workers who were exposed to high risk but received inadequate compensation were more likely to report job dissatisfaction and mental health concerns.

Transport and logistical challenges were also frequently cited. Curfews and limited public transport during lockdowns made it difficult for staff to commute. While some participants acknowledged the provision of Uber rides or ambulance services, others reported inconsistent or inadequate support. In line with these findings, Ashinyo et al. (2021) noted similar transport-related challenges in Ghana, where healthcare workers struggled to report to duty due to movement restrictions, exacerbating stress and absenteeism. Lastly, the stigma associated with testing positive for COVID-19 was a deeply personal and social burden. Staff who contracted the virus reported feelings of isolation and discrimination, both within their communities and among peers. This is corroborated by Ramaci et al. (2020), who found that stigma was a common theme among infected healthcare professionals and could lead to long-term emotional distress if not addressed through structured psychosocial interventions.

### 5.2.2 Perceptions of Justice and Fairness

The second objective of the study focused on understanding how healthcare workers perceived the fairness and justice of financial measures—specifically salary adjustments—implemented by AAR Healthcare Kenya during the COVID-19 pandemic. The findings reveal a mixed spectrum of perceptions, shaped by staff roles, levels of exposure to risk, and access to information about the rationale behind the salary changes.

Several participants accepted the salary cuts as necessary, citing the need to maintain organizational sustainability and avoid job losses. This view aligns with the principles of procedural justice, where fairness is perceived not only in outcomes but in how decisions are made and communicated (Colquitt, 2001). Staff who held supervisory or HR roles (e.g., HR1, LS1) noted that the decision was transparently explained and framed as a short-term measure to protect employment across all levels. This echoes findings by Pfefferbaum and North (2020), who emphasize that transparent leadership during a crisis can foster a sense of shared sacrifice and collective resilience among employees. However, many frontline workers, including nurses and general assistants, questioned the equity of the salary cuts, especially in light of their increased workloads and higher risk of infection. From their perspective, the uniform salary reduction across cadres did not account for differences in exposure or responsibility. This concern highlights issues related to distributive justice, where fairness is judged based on the equity of outcomes (Greenberg, 1990). Staff argued that while they bore the brunt of the pandemic—handling high patient volumes and enduring emotional distress—their compensation was reduced alongside roles with comparatively lower risk.

One nurse (N1) pointedly remarked that the cuts felt like punishment rather than support, especially during a time when they needed encouragement. These findings are supported by a study conducted in Nigeria by Ogbonnaya et al. (2021), which found that healthcare workers who perceived unfairness in compensation during the pandemic reported lower job satisfaction and morale. Similarly, a study in South Africa by Pillay (2021) found that frontline workers were demoralized by salary decisions that failed to reflect the risks they undertook, especially in under-resourced settings. Another recurring theme was inadequate staff engagement in decision-making. Some participants reported that salary cuts were introduced without prior consultation or

opportunity for feedback. This lack of inclusion adversely affected perceptions of organizational justice and trust. Research by Farndale et al. (2011) supports this observation, noting that employee involvement in policy formulation—especially during crises—significantly enhances the legitimacy and acceptance of difficult organizational decisions. Interestingly, some staff framed their acceptance of the cuts within the broader context of job security. In an environment where layoffs were common in the healthcare industry during the pandemic, retaining full employment was seen as a relief. This aligns with findings from a multi-country study by Lai et al. (2020), which revealed that healthcare workers were willing to tolerate financial losses if they perceived that their employers were genuinely prioritizing their long-term welfare and job security.

The study reveals that while AAR Healthcare Kenya's financial decisions may have achieved operational goals, the perceptions of fairness were not uniformly positive, particularly among frontline staff. The experience underscores the importance of transparent communication, role-sensitive compensation structures, and participatory decision-making in managing organizational justice during crises. Future policy interventions should consider differentiated risk allowances, enhanced engagement strategies, and more frequent feedback loops to build trust and demonstrate empathy during challenging periods.

### **5.2.3 Effectiveness of AAR Support System**

This objective aimed to assess the extent to which AAR Healthcare Kenya's support systems mitigated the socio-economic impact of COVID-19 on its healthcare workforce. The findings indicate that while several interventions were perceived as highly beneficial, there were notable disparities in access, consistency, and scope that influenced overall effectiveness.

AAR's response was multi-pronged, targeting physical health, emotional well-being, logistical needs, and financial protection. Among the most appreciated interventions was the provision of COVID-specific sick leave, which allowed infected staff to recover without using up their regular sick days. Participants described this as a compassionate and fair policy, especially at a time when uncertainty around income security was prevalent. Similar leave structures were implemented in other contexts, such as in the United Kingdom and Canada, where designated pandemic-related leave improved both compliance with quarantine protocols and mental health outcomes (Dollard & Bailey, 2021; Holroyd-Leduc et al., 2021). Another intervention that received strong positive

feedback was the isolation accommodation for staff and their families. Staff who tested positive were given access to hotel facilities for quarantine, and in some cases were allowed to isolate with their children. This not only addressed infection control concerns but also supported staff emotionally and logistically. Such an initiative aligns with recommendations by the World Health Organization (2020), which advocates for institutional quarantine arrangements to protect households and reduce community spread—especially in settings where home isolation is not feasible.

The psychological support and mental health check-ins provided to staff were also highlighted as effective, particularly by those who accessed counseling services during isolation. Participants acknowledged that having a counselor check in regularly helped reduce stigma and combat loneliness. These findings are consistent with global literature that emphasizes the importance of psychological safety in maintaining morale and reducing burnout among healthcare workers (Greenberg, Docherty, Gnanapragasam, & Wessely, 2020). However, the inconsistency in access to these services—where some staff were unaware or unable to utilize them—suggests a need for better promotion and integration of mental health resources into the organizational culture. In terms of logistical support, AAR’s efforts to facilitate staff mobility through the provision of Uber rides, ambulance pickups, and exemption passes were noted as helpful. However, not all staff benefited from these measures equally. Some reported continued struggles with transport, especially those transferred to branches far from their residences. This reflects a gap in equity and responsiveness, and reinforces similar concerns raised by Sethi et al. (2021), who found that in low-resource settings, the lack of structured staff transport during lockdowns significantly affected attendance and morale.

The maintenance of health insurance coverage and direct payment for COVID-related medical expenses emerged as a key pillar of organizational support. Staff viewed this as a sign that the company prioritized their health and well-being, reducing financial barriers to accessing care. According to Liu et al. (2020), such investments in employee health increase organizational trust and reduce presenteeism, particularly during health emergencies.

AAR Healthcare also implemented regular information sharing through Continuing Medical Education (CME) sessions, emails, and debriefs. Staff generally appreciated being kept updated on evolving protocols and safety measures. However, a few reported that these communications did not always reach non-clinical cadres or were not tailored to specific roles. This limitation echoes findings from a study by Nyashanu, Pfende, and Ekpenyong (2020), who emphasized the need for inclusive communication strategies in multi-cadre health settings.

## **5.3 Conclusions**

### **5.3.1 Socio-economic Effects**

The study established that healthcare workers at AAR Healthcare Kenya encountered multifaceted socio-economic challenges during the COVID-19 pandemic. The most pronounced were psychological distress, fear of infection, increased workload, salary reductions, transport difficulties due to curfews, and social stigma. These challenges were intensified among frontline staff, particularly nurses and laboratory personnel, who were at the highest risk of exposure. Emotional exhaustion, anxiety, and isolation were commonly reported, often accompanied by physical fatigue due to extended shifts and inadequate rest. Staff also faced logistical barriers, with limited public transport options and inadequate access to timely workplace mobility support. Additionally, salary reductions—although temporary—exacerbated financial strain for many employees, some of whom had already experienced household income losses. The study affirms that these socio-economic disruptions were not merely operational inconveniences but deeply personal and structural vulnerabilities that affected staff morale and well-being. While some institutional interventions attempted to address these issues, the findings emphasize that the pandemic exposed systemic weaknesses in healthcare workforce protection and crisis responsiveness. The experiences of AAR staff reflect broader global trends that underscore the necessity of investing in both the emotional and material needs of healthcare workers during emergencies. Moving forward, organizations must prepare holistic response frameworks that acknowledge the lived realities of staff—especially those on the frontlines—by embedding wellness, flexibility, and equity into their operational and human resource policies.

### **5.3.2 Perceptions of Justice and Fairness**

The findings revealed a nuanced understanding of fairness and justice among healthcare workers in response to the salary adjustments implemented during the pandemic. While some staff—particularly those in management or administrative roles—accepted the salary cuts as necessary for the organization’s survival, frontline workers expressed dissatisfaction, citing unequal risk exposure and increased workload that was not reflected in financial compensation. Many felt the salary cuts were applied uniformly, without regard to the differentiated responsibilities and health risks faced by various cadres. These perceptions point to a significant gap in distributive justice, where workers judged fairness based on the equity of outcomes rather than the uniformity of action. Furthermore, several staff members highlighted concerns about procedural justice, noting limited communication and lack of inclusion in decision-making processes. The lack of consultation left many feeling disconnected from the financial measures that directly impacted their lives. Nevertheless, some appreciated that the organization retained all staff and restored salaries within a few months, which helped maintain a degree of organizational trust. This objective reinforces the importance of role-sensitive policy-making and transparent communication during crises. It also highlights that perceptions of fairness are dynamic and are shaped by both material outcomes and the processes by which decisions are made. To foster long-term organizational commitment and resilience, it is essential that institutions move toward inclusive, empathetic, and equity-focused financial decision-making frameworks during emergencies.

### **5.3.3 Effectiveness of AAR Support Systems**

The study concluded that AAR Healthcare Kenya implemented a range of support systems that were timely, relevant, and—according to many respondents—life-saving. Interventions such as COVID-specific sick leave, hotel-based isolation accommodations for infected staff and their families, and the continuation of medical coverage were widely praised. These efforts demonstrated a strong institutional commitment to protecting the health, safety, and dignity of its workforce. Psychological support, in the form of counseling and mental health check-ins, was also acknowledged as an effective response, although some staff reported inconsistent access or limited awareness of these services. Transport support during lockdowns and regular dissemination of COVID-related information through CMEs and debriefs further contributed to operational continuity and staff reassurance. Despite these successes, the study also uncovered disparities in

access and implementation, particularly regarding logistical support, workload distribution, and communication reach across different departments. Not all staff felt equally supported, and some interventions were not systematically applied across all branches or cadres. The findings suggest that while AAR's support systems aligned with many global best practices, future efforts must prioritize consistency, inclusivity, and scalability. Effective crisis response requires not only strategic intent but also operational equity and feedback-driven adjustments. Therefore, building institutional resilience involves embedding these interventions into long-term workforce welfare policies that are proactive, well-communicated, and responsive to the diverse realities of healthcare workers.

## **5.4 Recommendations**

### **5.4.1 Addressing Socio-Economic Challenges Faced by Healthcare Workers**

1. **Develop a Comprehensive Staff Wellness Framework:** AAR should institutionalize a holistic wellness program that includes access to mental health services, psychosocial support, flexible work arrangements, and periodic wellness assessments to monitor stress and burnout levels.
2. **Invest in Crisis-Responsive Staffing Models:** The organization should retain or have standby locum personnel during crises to reduce burnout among core staff. A flexible human resource pool would help ease workload surges in future emergencies.
3. **Improve Emergency Transport Logistics:** Establish a dedicated transport protocol for staff during curfews and lockdowns. This could involve partnerships with ride-hailing services, transport allowances, or a standby vehicle fleet.
4. **Implement Risk-Sensitive Support for Vulnerable Staff:** Staff who are pregnant, immunocompromised, or have caregiving responsibilities should be offered tailored support, including reduced shifts, optional remote duties, or early leave arrangements during future health emergencies.

### **5.4.2 Enhancing Perceptions of Fairness and Justice in Financial Measures**

1. **Adopt Role-Based Compensation Adjustments During Crises:** Instead of uniform salary cuts, AAR should implement a risk-sensitive financial model where staff exposure, workload, and cadre are considered when making compensation decisions during emergencies.
2. **Improve Transparency in Financial Decision-Making:** Management should consistently communicate the rationale, duration, and impact of salary adjustments through town halls, departmental briefings, and accessible policy documents.
3. **Participatory Decision-Making Structures:** Establish mechanisms such as staff councils or cross-functional crisis committees that can provide input on financial or policy changes. This participatory approach would enhance procedural fairness and staff buy-in.
4. **Review and Document Crisis-Era Financial Policies:** Lessons learned from the COVID-19 response should be used to create a reference framework or policy document for future financial decisions, balancing sustainability with fairness.

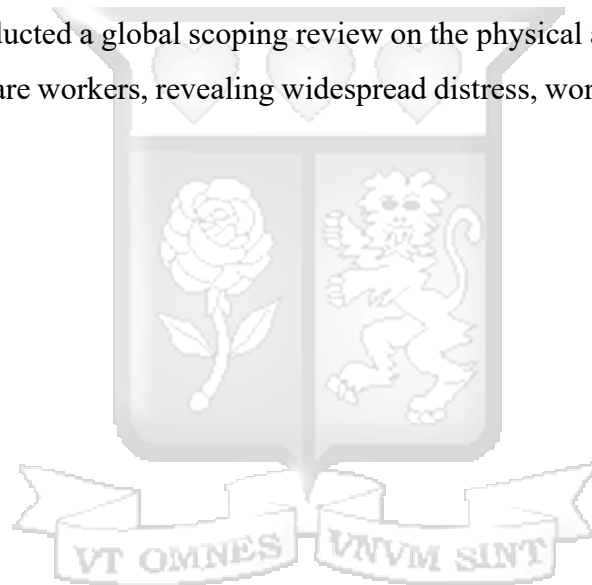
#### 5.4.3 Strengthening the Effectiveness of Support Systems and Interventions

1. **Standardize and Scale Up Support Interventions:** AAR should formalize successful interventions—such as COVID-specific leave, isolation housing, and psychological counseling—as part of its institutional emergency preparedness strategy. These should be accessible across all branches and cadres.
2. **Enhance Visibility and Access to Support Services:** All support systems, especially mental health and counseling services, should be consistently promoted through internal communication channels to ensure every staff member is aware and can access them when needed.
3. **Expand Health Coverage During Emergencies:** Continue and expand the model of full medical cover for staff and dependents during crises, including clear guidelines on claims and benefits related to pandemic-related conditions.

4. **Develop a Comprehensive Emergency Preparedness Playbook:** The organization should create a documented crisis response manual detailing protocols for communication, staffing, financial planning, and welfare management during future pandemics or disasters.

## 5.5 Areas for Further Research

While this study focused on healthcare workers at AAR Healthcare Kenya, there is a need for further research that examines similar socio-economic challenges and organizational responses across multiple healthcare institutions in Kenya or the wider East African region. A comparative approach would provide broader insights into sector-wide preparedness, particularly in private versus public healthcare settings. Future studies could build on the work of Shaukat, Ali, and Razzak (2020), who conducted a global scoping review on the physical and mental health impacts of COVID-19 on healthcare workers, revealing widespread distress, workload strain, and financial uncertainty.



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# APPENDICES

## Appendix I: Introduction Letter

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Cell: +254 703 034 414/6/7  
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Monday, April 14, 2025

To Whom It May Concern,

**RE: FACILITATION OF RESEARCH – NZIOKI, PETER**

This is to introduce Nzioki, Peter who is a Master of Business Administration (MBA) Student at Strathmore University Business School, admission number MBA/121515/19. As part of our MBA Programme, Peter is expected to do applied research and undertake a project. This is in partial fulfilment of the requirements of the MBA course. To this effect, Peter would like to request appropriate data from your organization.

Peter is undertaking a research paper on **“Effectiveness of AAR Health Kenya's Socio-Economic Support in Addressing Healthcare Workers' Challenges During and post-COVID-19 Pandemic.”** The information obtained shall be treated confidentially and shall be used for academic purposes only.

Our MBA Programme seeks to establish links with industry, and one of these ways is by directing our research to areas that would be of direct use to industry. We would be glad to share our findings with you after the research, and we trust that you will find them of great interest and of practical value to your organization.

We appreciate your support and shall be willing to provide any further information if required.

Yours sincerely,

Njoki Kiagiri  
Manager – Graduate Programmes  
Strathmore University Business School.

Association of African  
Business Schools



Strathmore Business School is a Proud member of:



## **Appendix II: Interview Guide for Staff**

### **1. General Impact of COVID-19 on Your Work at AAR Health Kenya**

1.1 How did the COVID-19 pandemic affect your daily work and responsibilities at AAR Health Kenya?

1.2 What were the biggest challenges you personally experienced in your role during the pandemic?

### **2. Challenges and Stressors Experienced by Healthcare Workers**

2.1 From your experience, what were the most difficult challenges and stressors you faced as a healthcare worker during the pandemic?

2.2 How did AAR Health Kenya support you in managing these challenges and stressors?

### **3. Salary Cuts and Perceptions of Fairness**

3.1 How did you experience the salary cuts during the pandemic?

3.2 Did you feel that the salary cuts were fair and necessary? Why or why not?

### **4. Support Systems and Interventions**

4.1 What kind of support (financial, psychological, logistical, etc.) did you receive from AAR Health Kenya during the pandemic?

4.2 How helpful do you think these support systems were in addressing the challenges you faced?

### **5. Recommendations and Strategies for the Future**

5.1 Based on your experience, what changes or improvements would you suggest to better support healthcare workers at AAR Health Kenya in the future?

## **Appendix III: Interview Guide for Management**

### **1. General Impact of COVID-19 on AAR Health Kenya**

- 1.1 How did the COVID-19 pandemic affect the overall operations of AAR Health Kenya?
- 1.2 What were the most significant challenges faced by the organization during the pandemic?

### **2. Challenges and Stressors Experienced by Healthcare Workers**

- 2.1 From your perspective, what were the primary challenges and stressors faced by healthcare workers at AAR Health Kenya during the pandemic?
- 2.2 How did the organization identify and address these challenges and stressors?

### **3. Salary Cuts and Perceptions of Fairness**

- 3.1 Could you describe the decision-making process behind the implementation of salary cuts during the pandemic?
- 3.2 How do you think the employees perceived the fairness and necessity of the salary cuts?

### **4. Support Systems and Interventions**

- 4.1 What support systems and interventions were put in place to assist healthcare workers during the pandemic?
- 4.2 How effective do you believe these support systems were in addressing the socio-economic challenges faced by healthcare workers?

### **5. Recommendations and Strategies for the Future**

- 5.1 Based on your experience, what recommendations would you make to improve the socio-economic well-being and quality of life for healthcare workers at AAR Health Kenya in the future?

## Appendix IV: Ethics Approval Letter



14<sup>th</sup> April 2025

Mr Nzioki Peter,  
petenzioki@gmail.com

Dear Mr Nzioki,

**RE: Effectiveness of AAR Health Kenya's Socio-Economic Support in Addressing Healthcare Workers' Challenges During and post- COVID-19 Pandemic**

This is to inform you that SU-ISERC has reviewed and **approved** your above **SU-masters** proposal. Your application reference number is **SU-ISERC2803/25**. The approval period is from **14<sup>th</sup> April 2025 to 13<sup>th</sup> April 2026**.

This approval is subject to compliance with the following requirements:

- i. Only approved documents including (informed consents, study instruments, MTA) will be used.
- ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-ISERC.
- iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-ISERC within 72 hours of notification.
- iv. Any changes anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-ISERC within 72 hours.
- v. Clearance for the export of biological specimens must be obtained from relevant institutions.
- vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days of completion of the study to SU-ISERC.

Before commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) <https://research-portal.nacosti.go.ke/> and obtain other clearances needed.

Yours sincerely,

**Mr Ambrose Rachier,  
Chairperson; SU-ISERC**



**THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013 (Rev. 2014)**  
Legal Notice No. 108: The Science, Technology and Innovation (Research Licensing) Regulations, 2014

The National Commission for Science, Technology and Innovation, hereafter referred to as the Commission, was established under the Science, Technology and Innovation Act 2013 (Revised 2014) herein after referred to as the Act. The objective of the Commission shall be to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto.

**CONDITIONS OF THE RESEARCH LICENSE**

1. The License is granted subject to provisions of the Constitution of Kenya, the Science, Technology and Innovation Act, and other relevant laws, policies and regulations. Accordingly, the licensee shall adhere to such procedures, standards, code of ethics and guidelines as may be prescribed by regulations made under the Act, or prescribed by provisions of International treaties of which Kenya is a signatory to.
2. The research and its related activities as well as outcomes shall be beneficial to the country and shall not in any way;
  - i. Endanger national security
  - ii. Adversely affect the lives of Kenyans
  - iii. Be in contravention of Kenya's international obligations including Biological Weapons Convention (BWC), Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO), Chemical, Biological, Radiological and Nuclear (CBRN).
  - iv. Result in exploitation of intellectual property rights of communities in Kenya
  - v. Adversely affect the environment
  - vi. Adversely affect the rights of communities
  - vii. Endanger public safety and national cohesion
  - viii. Plagiarize someone else's work
3. The License is valid for the proposed research, location and specified period.
4. Neither the license nor any rights thereunder are transferable.
5. The Commission reserves the right to cancel the research at any time during the research period if in the opinion of the Commission the research is not implemented in conformity with the provisions of the Act or any other written law.
6. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research.
7. Excavation, filming, movement, and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
8. The License does not give authority to transfer research materials.
9. The Commission may monitor and evaluate the licensed research project for the purpose of assessing and evaluating compliance with the conditions of the License.
10. The Licensee shall submit one hard copy, and upload a soft copy of their final report (thesis) onto a platform designated by the Commission within one year of completion of the research.
11. The Commission reserves the right to modify the conditions of the License including cancellation without prior notice.
12. Research, findings and information regarding research systems shall be stored or disseminated, utilized or applied in such a manner as may be prescribed by the Commission from time to time.
13. The Licensee shall disclose to the Commission, the relevant Institutional Scientific and Ethical Review Committee, and the relevant national agencies any inventions and discoveries that are of National strategic importance.
14. The Commission shall have powers to acquire from any person the right in, or to, any scientific innovation, invention or patent of strategic importance to the country.
15. Relevant Institutional Scientific and Ethical Review Committee shall monitor and evaluate the research periodically, and make a report of its findings to the Commission for necessary action.

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Innovation(NACOSTI),  
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