CHAK TIMES
"FOR THE HEALING OF THE NATION"
A PUBLICATION OF THE CHRISTIAN HEALTH ASSOCIATION OF KENYA

In this issue....

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CHAK TIMES
"For the Healing of the Nation"
A publication of the Christian Health Association of Kenya

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The many facets of COVID-19 in Kenya

The first case of COVID-19 in Kenya was announced on March 13, 2020, in Nairobi County. Kenya's first COVID-19 patient was a 27-year-old lady who had travelled from the US via London and on to Nairobi.

Since then, the pandemic has spread to nearly all of Kenya's 47 counties. It has caused enormous health, socioeconomic and psychological impact on the population.

The MOH provides daily COVID-19 briefings and has been a reliable source of information, given the many reliable and not so reliable information avenues available in the country, especially with widespread social media use.

Information overload and fatigue was evident by the third month of the pandemic. It is around this time that Kenyans received a rude wake up call. By the fourth month, the country began reporting rising infections, hospitalizations and deaths.

Prevention practices such as hand washing, mask wearing and social distancing have been widely adopted by the population but with concerning gaps.

With about 60 per cent of Nairobi's population living in informal settlements where the majority of households occupy a single room, social distancing remains a middle and upper class privilege.

Despite laws making mask wearing compulsory in public, it was back to business as usual following relaxation of COVID-19 containment measures by the Government, including opening up of three most affected counties. Among the reasons cited by some Kenyans for not wearing a mask are that they are uncomfortable (majority) and unaffordable.

The economic impact of COVID-19 has been severe and probably led to relaxation of some of the containment measures intended to slow down the pandemic. Some reports indicate that at least one million Kenyans have lost their jobs or have been put on indefinite unpaid leave as a result of the Covid-19 pandemic.

According to a study done by the Population Council in five informal settlements in Nairobi (Kibera, Huruma, Kariobangi, Dandora, Mathare) in April 2020, 68 per cent of those interviewed had skipped a meal or eaten less in the past two weeks because they did not have enough

COVID-19 prevention practices have been widely adopted by the population but with concerning gaps.

money to buy food. Participants said that their single biggest unmet need was food (74 per cent) followed by cash (17 per cent).

Another casualty of the COVID-19 pandemic has been mental health. The MOH has been providing mental health and psychosocial support strategies and measures in the short and long term response to COVID-19. The Taskforce on Mental Health in July recommended that mental illness be declared a national emergency of epidemic proportions and be prioritized as a priority public health and socioeconomic agenda. The Taskforce also recommended the establishment of a mental health commission to advise, coordinate and continuously monitor the status of mental health, and report on the annual National Happiness Index.

The pandemic continues to affect essential health services with many people who feel unwell opting to forgo hospital visits due to fear of contracting the disease from health facilities. Family planning services, immunization and treatment for people with chronic illnesses are some of the health services that have been affected. Reduced income and economic hardships during COVID-19 has further exacerbated the situation and many private and faith based health facilities have been forced to lay off staff or effect pay cuts.

COVID-19 has also led to a surge in domestic violence, which is now being referred to as the shadow pandemic. The current lock downs, isolations, quarantine, restricted movement and social distancing have caused women and girls to spend more time with potential or known abusers.

Socio-economic challenges and other inequalities have resulted in a significant rise in incidences of rape, defilement, domestic violence and intimate partner violence. Limited access to service providers such as health facilities, police stations, and access to courts due to social distancing and curfew measures have hampered redress to affected victims of abuse. Indeed, President Kenyatta in July 2020 ordered an investigation into rising reports of violence against women and girls - including rape, domestic violence, female genital mutilation (FGM) and child marriage - as a result of coronavirus restrictions.

Kenya has also faced an outbreak of teenage pregnancies due to prolonged closure of schools. Among the reasons for the rising teen pregnancy numbers are rape, defilement, poverty and lack of proper sexual education. A report recently released by National Council on Population and Development (NCPD) shows that two out of five teenagers in the country are either young mothers or are pregnant. Since the pandemic hit, 20,828 girls aged between 10 and 14 years have become mothers while the older girls aged between 15-19 years, 24,106 are either pregnant or mothers already.

Myths and misconceptions continue to hamper the fight against COVID-19. One of the most dangerous myths has been that Corona Virus does not exist in Kenya with patients being accused of faking the illness for financial gain.

These and many others are the different facets of the fight against COVID-19 in Kenya. Clearly, as health workers continue to fight the disease on the frontline, they must prepare to face the many other health issues that will surely arise out of the different facets of the pandemic.

We invite our readers to send feedback on our social media platforms or by writing to the editor: communications@chak.or.ke.

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Contents

Source: MOH Home based Isolation and Care Guidelines for COVID-19 patients (popular version)

Exercise prudence and common sense

When Satan tempted Jesus to jump off the temple, Jesus countered the suggestion by quoting Deut. 6:16. Jesus said, "You shall not tempt the Lord your God" (Luke 4:12). To force God's hand by doing something so foolish is to tempt or test God.

Campbell Morgan wrote, "The moment we do something to prove God, we are proving that we are not sure of God. Trust never employs tricks to find out whether the one trusted is trustworthy."

It is one thing to take a bold step of faith in obedience to God; it is another to initiate the same action for our own purposes as satan suggested.

When Israel came to Kadesh-Barnea in Numbers 13, God had given them the land (Num. 13:2) and they we told to possess it.

When the twelve spies came back from searching out Canaan, Caleb and Joshua insisted that they obey God and boldly enter into Canaan.

Doing that would have been an act of faith because God had told them to do it and had promised to be with them. It was an act of unbelief when the nation decided to not trust God and not do what He had told them to do.

But the same action became presumption, not faith, when God said they would not enter the Promised Land (Num. 14:22-30), and they tried to do so on their own initiative. That was disastrous (Num. 14:39-45).

In John 8 the Jews picked up stones to throw at Jesus to kill Him. Jesus's response was interesting. He could have worked a miracle. He could have paralyzed those people. He could have struck them down dead. What did He do? He hid Himself. He slipped through the crowd and got away.

We see something similar in Paul's life when the authorities were trying to arrest him. He did something very practical. In a conversation about humility, Paul told the story including how he escaped. In 2 Corinthians 11:33 he said, "but I was let down in a basket through a window in the wall, and escaped from his hands." Surely God could have done something more impressive. No, in this case Paul was to use the practical means available to him.

In the absence, therefore, of a divine command to do otherwise, we simply act with prudence. We do not act in presumption. Presumption is driven by subtle pride. Faith acts in humble obedience.

Doctors and governmental authorities are providing some guidance and practical tips on what we should do in the face of the current pandemic. We carry on our lives, but simply use common sense.

Two extremes should be avoided. One is the presumption that because we're the King's children that we would not have to deal with any of this. Belonging to God does not exempt us from the human experience. God will take care of us as we trust and obey Him. But we are still in mortal bodies.

Our complete salvation has not yet arrived. We are looking forward to being clothed with a glorified body. In the meantime, we do some groaning along with the rest of creation (Rom.8:23).

The other extreme is panic. God has not given us the spirit of fear (2 Tim. 1:7).

Listen to David's confidence in Ps 27: "The LORD is my light and my salvation; whom shall I fear? the LORD is the strength of my life; of whom shall I be afraid?

If you feel yourself becoming anxious, go to passages like this and let the Holy Spirit bring assurance and comfort to your heart. The fruit of the Spirit is not fear, but faith and peace.

We do not have to react to problems the same way the world reacts. God is with us. If we will look to Him as our source and protection, we will be fine. - *sermoncentral.com*

To force God's hand by doing something foolish is to tempt or test God

Equipping CHAK health facilities for the fight against the COVID-19 pandemic

Despite a seemingly flattening COVID-19 curve by the end of August 2020, the Government has continued to announce a daily increase in the number of infections and deaths. The months of June-August 2020 were especially trying for the country as infections rose exponentially.

In the last two weeks of August, Kenya recorded over 4,000 new infections with the total number of cases standing at 34,201 as at August 30, 2020.

CHAK member health units have responded to the challenge of COVID-19 by taking various measures including establishment of isolation centres, well-equipped COVID-19 wards with oxygen supply, community sensitization, seeking support from different partners, among others.

It is against this backdrop that CHAK re-doubled its efforts to build the capacity of its member units to deal with the pandemic, reaching over 450 of the health facilities under its umbrella with these efforts.

MEDS warehouse staff packing a PPE consignment destined for a CHAK member health unit. CHAK has reached over 450 member units with COVID-19 interventions.

Categories of PPEs procured and distributed to CHAK member health units under the CHAK/ACHAP and CHAK/IMA COVID-19 projects*

	PPE Type	Quantity
1.	KN95 masks	720
2.	Surgical masks	10,000
3.	Non sterile Latex gloves (L)	28,000
4.	Non sterile Latex Gloves (M)	5,000
5.	Surgical gloves	8,500
6.	Hand sanitizer (Litres)	900
7.	JIK (Litres)	400
8.	Biohazard bin liners (black)	6,000
9.	Biohazard bin liners (Red)	6,000
10.	Hand washing soap (litres)	5,000
11.	Infrared thermometer	30
12.	Disposable caps	100
13.	Disposable shoe covers	100
14.	Googles	100

Posters and brochures

Among the measures undertaken by CHAK to support its membership in the fight against the pandemic is the identification and sharing of posters with COVID-19 messaging with the facilities. In the early stages of the pandemic, posters with prevention, case definition and support messages were printed and disseminated to the membership. Electronic versions were also disseminated as were posters with support messages for special groups including health workers and people living with chronic conditions.

Brochures with community messaging were also developed and distributed to CHAK member health facilities under the CHAK-IMA World Health-ACHAP project.

Personal Protective Equipment (PPE)

CHAK with funding from development partners supporting various projects management to procure and distribute PPE to over 400 of its member health units. The PPE were procured from MEDS, which in turn distributed them to the beneficiary health facilities. Among the partners who were able to support these efforts were Bread for the World and IMA-World Health. The PPE purchased and delivered to CHAK MHUs included:

a) Masks (Surgical, N95, KN95, cloth)
b) Latex gloves (surgical, sterile and non-sterile)
c) Hand sanitizer
d) Jik
e) Bio-hazard bin liners (black and red)
f) Hand washing soap
g) Infrared thermometers
h) Googles
i) Disposable caps
j) Disposable shoe covers

CHAK continues to advocate for more resources to support member units with these essential items.

Training

CHAK supported an on-line TOT training for 20 member health facilities on Infection Prevention and Control through funding from IMA World Health. A total of 30 health care workers, mainly drawn from hospitals and health centres, were trained as TOTs during the 10-day exercise.

The health care workers were drawn from health facilities that were most likely to come into contact with COVID-19 cases due to high patient numbers or positions as referral centres. Among the hospitals that participated in the TOT training were AIC Litein, SDA Nyanchwa, PCEA Chogoria, Jumuia Kaimosi, Maua Methodist, Kendu Adventist, Sagam Community, Lighthouse for Christ, AIC Githumu, Maseno Mission, Nairobi Adventist, COG Mwihila, St Lukes Kaloleni and NCCK Huruma.

Health workers are taken through donning and doffing procedures during an IPC cascade at Friends Lugulu Hospital.

Cascades

The 30 TOTs have managed to cascade the IPC training to over 180 staff in their health facilities and surrounding CHAK member units. The training included a practical aspect in which the health workers were able to identify areas in their health facilities where infection prevention and control could be achieved with minimum investment.

Training and learning resources

CHAK has continued to disseminate information on free COVID-19 training webinars from NASCOP, University of Nairobi and WHO as well as MOH updates on COVID-19. E-resources to support religious communities following the re-opening of places of worship were also disseminated. Earlier in the pandemic, CHAK held weekly COVID-19 webinars targeting health workers in member facilities, which, however, faced the challenge of very low turnout. Links to videos, e-learning modules and MOH COVID-19 e-resources have also been disseminated.

Advocacy

CHAK has been advocating with MOH, COG, Private Sector and Development Partners for support with essential commodities for PPEs and infection prevention and control (IPC). CHAK is encouraging member health facilities to continuously engage with their County Governments since PPEs and other resources from Government and donors are being channeled through the devolved units.

**More PPE were also procured and distributed to CHAK MHUs through other funding including Bread for the World, Germany and projects.*

Cover photo: Internet sources

Know the facts about COVID-19 to help curb pandemic spread in the community

What is COVID-19?

The coronavirus disease 2019 (COVID-19) is a communicable respiratory disease caused by a new strain of coronavirus that causes illness in humans.

Scientists are still learning about the disease, and think that the virus began in animals. At some point, one or more humans acquired infection from an animal, and those infected humans began transmitting infection to other humans.

Who is most at risk?

We are learning more about how COVID-19 affects people every day.

Although for most people COVID-19 causes only mild illness, it can make some people very ill. More rarely, the disease can be fatal.

Older people, and those with pre- existing medical conditions (such as high blood pressure, heart problems or diabetes) appear to be more vulnerable.

It is possible for people of any age to be infected with the virus, but so far there are relatively few cases of COVID-19 reported among children.

Symptoms of COVID-19 infection

The virus can cause a range of symptoms, ranging from mild illness to pneumonia. Symptoms of the disease are fever, cough, sore throat and headaches. In severe cases difficulty in breathing and deaths can occur.

Other symptoms are:

- Tiredness
- Aches and pains
- Diarrhoea
- Conjunctivitis
- Headache
- Loss of taste or smell
- A rash on skin, or discolouration of fingers or toes

Isolation

People who test positive should be isolated and the people they have been in close contact with up to two days before they developed symptoms sought out. The contacts should also be isolated and tested if they show symptoms of COVID-19.

The WHO also advises that all confirmed cases, even mild cases, should be isolated to prevent transmission and provide adequate care.

However, many countries have already exceeded their capacity to care for mild cases in dedicated health facilities, hence homebased isolation and care.

What is the treatment for COVID-19?

There is no currently available treatment or vaccine for COVID-19. However, many of the symptoms can be treated and getting early care from a healthcare provider can make the disease less dangerous. There are several clinical trials that are being conducted to evaluate potential therapeutics for COVID-19.

Prevention of COVID-19

To prevent the spread of COVID-19:

1) Clean your hands often. Use soap and water, or an alcohol-based hand rub.
2) Maintain a safe distance from anyone who is coughing or sneezing.
3) Wear a mask.
4) Don't touch your eyes, nose or mouth.
5) Cover your nose and mouth with your bent elbow or a tissue when you cough or sneeze.
6) Stay home if you feel unwell.
7) If you have a fever, cough and difficulty breathing, seek medical attention. Calling in advance allows your healthcare provider to quickly direct you to the right health facility. This protects you, and prevents the spread of viruses and other infections.

Source: MOH Home based Isolation and Care Guidelines for COVID-19 patients (popular version)

Masks

Masks can help prevent the spread of the coronavirus from the person wearing the mask to others.

Masks alone do not protect against COVID-19 and should be combined with physical distancing and hand hygiene. Follow the advice provided by your local health authority.

Your mask should cover your face from the bridge of your nose to under your chin. It should be loose fitting but still secure enough to stay in place.

Masks for health workers

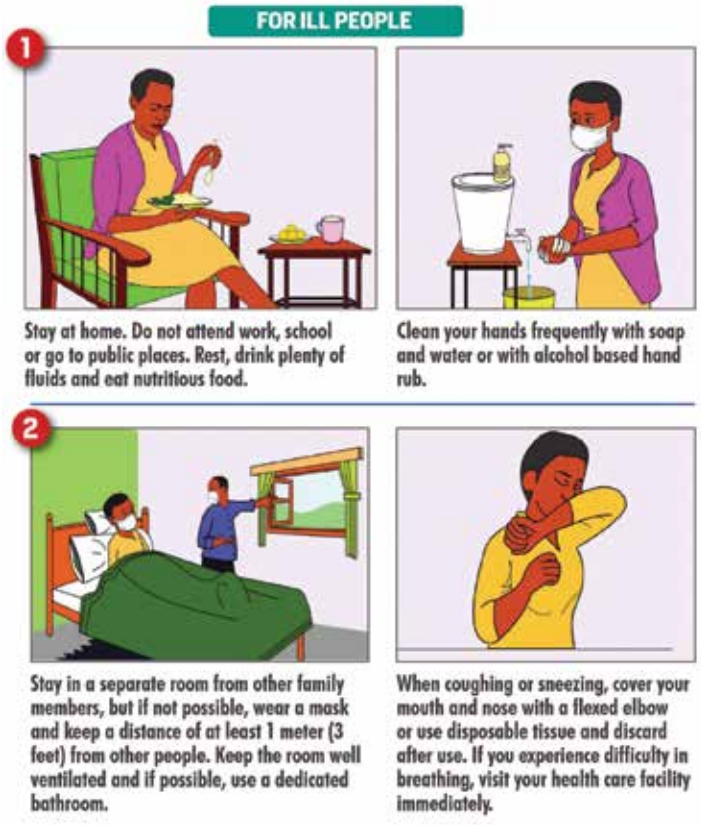
Anyone interacting directly with people ill or suspected to be ill with COVID-19 needs professional respirators, such as N95 respirators, which are designed for medical use. N95 respirators fit the face snugly and filter the air to stop respiratory droplets from getting through or around the device.

In addition, care teams treating patients with COVID-19 need to wear added protective gear, including face shields that protect the eyes, nose and mouth from contamination from respiratory droplets, along with masks or respirators.

For health care workers in patient areas, but not working directly with COVID-19 patients, procedural, surgical and cloth face masks can help guard against the possible spread of COVID-19. These masks don't have a tight seal and are made of different types of materials. Surgical or procedural masks provide protection against respiratory droplet spread.

Source: MOH Kenya

While cloth masks are not medical-grade, they may be helpful in non-patient settings to contain coughs and to remind people to not touch their face, but they are not suitable for providing medical care to patients.



Guidelines for patients in home based care. (Source: MOH Home based Isolation and Care Guidelines for COVID-19 patients (popular version)

Testing

Testing leads to quick identification of cases, quick treatment for those people and immediate isolation to prevent spread. Early testing also helps to identify anyone who came into contact with infected people so they too can be quickly treated.

Two kinds of tests are available for COVID-19: viral tests and antibody tests.

While a viral test tells you if you have a current infection, an antibody test tells you if you had a past infection. An antibody test might not show if you have a current infection because it can take 1–3 weeks after infection for your body to make antibodies.

If you test positive for COVID-19 by a viral test, know what protective steps to take if you are sick or caring for someone. If you test negative for COVID-19 by a viral test, you probably were not infected at the time your sample was collected. However, that does not mean you will not get sick. The test result only means that you did not have COVID-19 at the time of testing.

You might test negative if the sample was collected early in your infection and test positive later during your illness. You could also be exposed to COVID-19 after the test and get infected then.

Survivor's struggle with severe symptoms of disease that has stopped the world

On the morning of July 7, 2020, Wycliffe Asilwa was at his work station in Karen, Nairobi, when he started feeling feverish. As he had left his house that morning in good health, he ignored the fever and went on with his usual business.

However, the fever soon became impossible to ignore, turning into severe cold and hot spells.

He therefore decided to contact his friend, a medic working at Kenyatta National Hospital, for advice. After explaining his symptoms over the phone, Wycliffe and his friend agreed to meet in Waithaka area of Nairobi where the medic ran a private clinic.

Antibiotics

By the time Wycliffe arrived at the clinic later in the day, he had developed excruciating pain in his ribs that ran down to his legs and was experiencing an on and off headache in addition to the fever. His friend gave him an anti-biotic jab and advised him to go home and rest.

However, by the following morning, Wycliffe, 48, was still feeling very sick. He returned to his friend's clinic where he was given another jab and returned home. By July 9, which marked the third day of his illness, Wycliffe felt very sick. He decided to go back to the clinic in Waithaka where he was given yet another jab. However, his friend told him that he would not get any more jabs as the anti-biotic was quite strong and had the potential to harm him.

Even after the three jabs, Wycliffe did not get better; in fact, he felt a lot worse than he had at the beginning of the illness.

Wycliffe at his rural home in Kakamega County.

He therefore decided to visit a bigger hospital on Nairobi's Ngong Road to find out the root cause of his ill health. After describing his symptoms to the doctor, going through malaria and pneumonia tests and having a chest x-ray done, she informed him that he needed admission urgently.

The doctor also asked Wycliffe to do a COVID-19 test but he declined as he did not believe he had contracted the disease given that he had taken all precautions including wearing a mask and sanitizing his hands religiously.

The test and x-ray results showed that Wycliffe had severe pneumonia. Given that he works as a driver, the doctor attributed his sickness to exposure to cold conditions by keeping his window lowered while driving. He however declined admission due to what he terms as 'male ego'.

The doctor therefore decided to prescribe strong anti-biotics to clear the pneumonia. After collecting his medication, Wycliffe once again headed to his house.

It was at around 11pm that night that all hell broke loose. Despite taking the anti-biotics he had been given earlier in the day at the hospital, Wycliffe felt extremely sick. Fearing the worst, he called one of his two sons and asked him to take the keys to his bedroom so he could secure it in case things got out of hand. Wycliffe felt so sick that he thought he would not make it to the morning.

By God's grace, he says, he did make it to the morning, marking the fourth day of his symptoms. On the morning of July 11, he went back to the hospital on Ngong Road where the doctor repeated what she had said the previous day – he needed to be admitted, and urgently.

COVID-19 diagnosis

However, due to problems with his insurance cover, the hospital did not admit him. The doctor therefore asked him to call his employer and sort out the insurance issue to enable the hospital to assist him.

The doctor asked Wycliffe to take a COVID-19 test but he declined as he did not believe he had contracted the disease given that he had taken all precautions

Wycliffe and the human resources office at his work place agreed to seek admission at Aga Khan University Hospital, in Parklands, Nairobi. However, there was no bed available at the hospital but a promise was made that one would be found by morning.

A concerned human resources office therefore inquired if Wycliffe would be able to hold on till morning. Despite feeling very, Wycliffe made a decision to wait and once again returned home.

By the morning of July 12, Wycliffe's employer had secured a bed for him at Aga Khan Hospital. He called an Uber taxi and was accompanied to the hospital by one of his sons. However, as if by a miracle, on the way to the hospital, Wycliffe began feeling better.

This was confirmed by the doctor at Aga Khan who told him he did not need admission because his condition was not serious and just needed to continue with his medication.

He was once again asked to take a COVID-19 test and this time, he agreed. While waiting for the test, he met two of his colleagues on the long queue, confirming the fast spreading nature of the virus. After the test, he once again left for his home, this time feeling a lot better.

The medical staff at the facility had informed him that his COVID-19 test results would be sent to him via email or he would be informed of the outcome through a phone call.

A doctor called Wycliffe at around 7.30pm and asked if he was comfortable discussing his health on the phone. The doctor sounded hesitant, making Wycliffe immediately alert for the bad news he suspected was coming. He was informed without further ado that his test had returned positive results for COVID-19 and asked to self-isolate immediately.

The doctor advised Wycliffe to request his employer to cater for his isolation costs and also directed that Wycliffe's two sons be tested for COVID-19 the following morning.

Isolation

After speaking to the HR department in his workplace, he was advised to prepare to go into isolation the following morning.

The HR office also asked him to call an Uber taxi for transport since transporting him in an ambulance would stigmatise his family. As his son rolled his suitcase down the stairs the following morning, Wycliffe had only one prayer; that God would return him to his house and his bedroom safe and sound after completing isolation.

He was advised to go to a Nairobi hotel where he was received by a team of medics from MOH. After registering at the reception, he was taken up to his self-contained room which had already been fumigated.

While in isolation, the health workers would take his temperature every morning at around 10am and record any symptoms he was experiencing.

The diet in isolation is balanced, says Wycliffe, with plenty of protein, especially non-fatty meat and fruits and vegetables such as oranges and spinach.

'Dawa', a concoction of garlic, turmeric, ginger, honey and lemon was served to patients every evening and they were also advised to drink warm water instead of cold. Each of the rooms had an electric kettle which the patients used to warm the drinking water. They were advised to drink water 30 minutes after a meal. Each patient was supplied with three bottles of water daily.

Food was served on disposable plates which Wycliffe and the other patients were required to throw into a trashcan placed outside their doors, once they had eaten to their fill. The patients would pick their food at the door of their rooms from the attendants.

While in isolation, Wycliffe says that his faith kept him going. "I told God that I had been a believer for many years and asked him to return me home safe and alive after isolation," he says, thanking God that he was strong throughout.

Stress and depression are real in isolation, he says, adding that there is no freedom in the facilities. Every patient was required to stay in his or her room and alert the reception if they wanted to leave the room, even to bask on the balcony. Loneliness is real, he adds, saying it felt like being thrown into the flames like Shadrach, Meshach, and Abednego with Jesus as the fourth man. Only Jesus can save you in those circumstances. Wycliffe says, one of his sons was so worried that he found his way into the facility to check on his father.

Wycliffe still experienced some discomfort and continued to feel ill during his isolation at the hotel but

An Uber taxi was a better transport option since collecting the patient in an ambulance would stigmatise his family

got better with time. He was relieved when the medical team informed him that according to the MOH monitoring tools, they had not seen any worrying symptoms that necessitated holding him for a further period of time.

Negative test results

On July 25, 2020, Wycliffe underwent a second COVID-19 test which came back negative. An overjoyed Wycliffe was released to home-based isolation for a further 14 days on July 27, 2020.

After signing a quarantine discharge summary and a quarantine declaration form, Wycliffe was ready to return to his house, this time healed. He was given rules to follow during his home quarantine and advised on the symptoms to look out for.

He was also given an MOH daily monitoring form which he was asked to fill, scan and send to the discharging doctor daily via WhatsApp. Additionally, he was advised to buy a thermogun, which his insurance readily supported. He would use the instrument to monitor his temperature every day and WhatsApp a photo of the reading to the discharging doctor.

According to Wycliffe, his highest temperature reading since his illness began is 36.70C.

Coming out of an isolation centre is not easy, he adds, as the patient must show no COVID-19 symptom whatsoever before being allowed to leave. You learn a lot of things-like freedom is precious, he adds.

Wycliffe says that he was assured by doctors that COVID-19 was not a death sentence. Although he had carried the book 'Purpose Driven Life' by Rick Warren to isolation, he was too distracted to read.

Following the rules

Wycliffe says he cannot pinpoint where or how he contracted COVID-19. He always had hand sanitizer in any car he was driving and masks were provided by his employer. His workplace vehicles are fumigated after every 14 days as per MOH guidelines.

He however says that all the keys to the office vehicles were placed in a common container and may not have been sanitized after use by the drivers.

He adds he always thought that COVID-19 was not real but now knows better.

Contact tracing

Before isolation, Wycliffe was asked to mention everybody he had been in contact with so they could be tested for the virus. He mentioned a total of seven people, two of who tested positive for Coronavirus.

Two people he had come into contact with were hospitalized while the others were placed in home-based care. One of the patients who were hospitalized has since come out of isolation while the other one is in home-based care.

Both his sons were tested for the virus and one turned positive after a second test at KEMRI. He was also put on home-based care and has not had any symptoms.

Wycliffe says that whenever he got into an Uber, he would sit alone on the back seat and always wore a mask. He thanks God that the drivers who ferried him to various points always had their masks on.

He also informed the driver who took him to the isolation centre of his condition and advised him to fumigate the car after the trip. Although the driver looked scared, he drove Wycliffe to his destination without hesitation, thanking him for being truthful. The driver is one of the contacts traced by MOH from interactions with Wycliffe.

Stigma

News of Wycliffe's Coronavirus infection shocked his family. Many of his family members thought he was dying and there was a lot of crying and confusion. Some of the family members agreed not to visit his rural and Nairobi homes until there was "new feedback".

News of his illness was broken to his wife, who was then in their rural home in Kakamega, by the family. Relatives and friends alike did not visit her during the duration of his illness but would speak to her on the phone. He says he would video call his wife every evening during the period of his isolation to assure her he was okey even when he was in pain.

His friends and relatives would call him frequently when he was in isolation. If he failed to answer their phone calls, they would not call again until he picked somebody else' call.

He laughingly admits they thought he was dead whenever he failed to answer their phone calls.

It took two days for his relatives and friends to begin visiting him when he went to stay for a few days in his rural home after completing the 14-day home-based isolation period. Even then, the visitors would first stop by his father's house for a 'briefing' before heading for Wycliffe's house. Wycliffe observed that the visitors would sanitize their hands frequently when talking with him.

The Church

According to Wycliffe, only about eight people from his church home group knew he had contracted COVID-19. They prayed with him and for him and encouraged him as he got better. He observes that there is need for more awareness creation on COVID-19 in order to get rid of stigma.

I have learned that the way you see yourself will determine how your life will be, Wycliffe says.

Tackling the double challenge of COVID-19 in people living with diabetes

By Dr. Stella Njagi - NCD Programmes Technical Advisor, CHAK

Introduction

COVID-19 (Coronavirus Disease-2019) is caused by the coronavirus SARS-CoV-2 (severe acute respiratory syndrome coronavirus-2). People of all ages can be infected.

For many (more than 80 per cent of cases), COVID-19 is mild, with minimal flu-like symptoms. Some people have not shown symptoms or only very mild symptoms, more like a common cold.

The majority of people who have caught the virus have not needed to be hospitalised for supportive care. However, in up to 15 per cent of cases, COVID-19 has been severe and in around 5 per cent of cases it has led to critical illness. The vast majority (around 98 per cent) of people infected to date have survived.

Risk factors for disease severity

Older people and people with pre-existing medical conditions (such as diabetes, heart disease and asthma) appear to be more vulnerable to becoming severely ill with the COVID-19 virus.

The most frequent comorbidities to COVID 19 are hypertension and diabetes. In Kenya, 15 per cent of persons who died due to COVID-19 had diabetes.

COVID-19 deaths due to diabetes and hypertension combined account for 47 per cent of deaths in those with comorbidities[1].

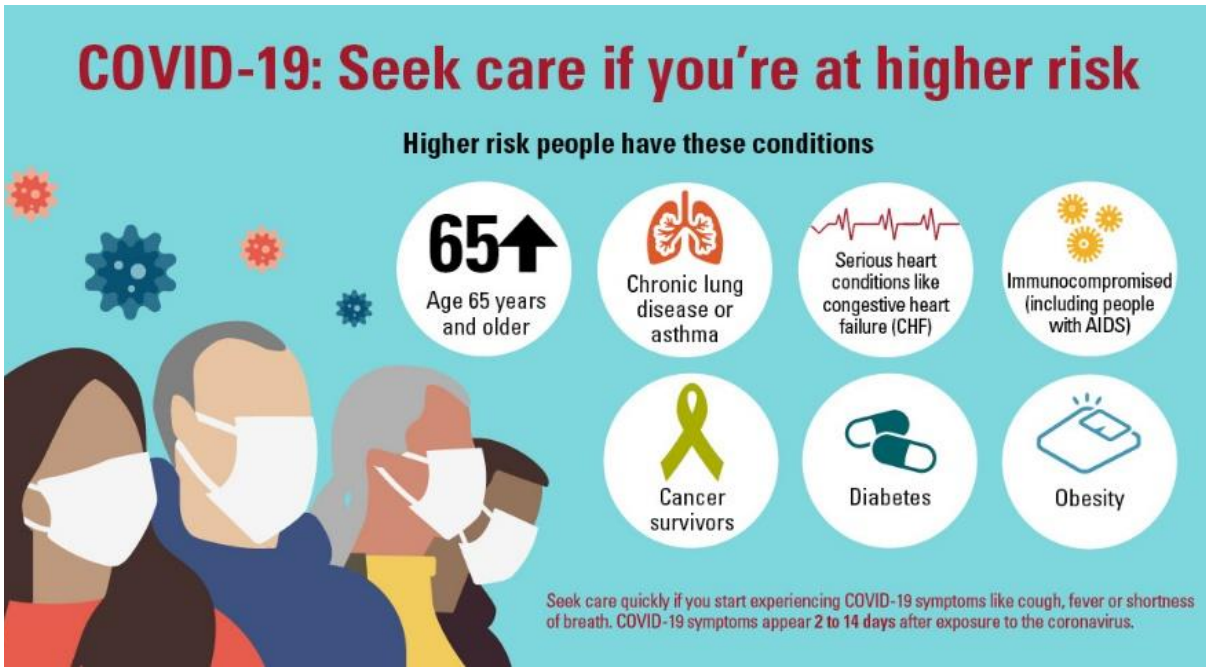
Both diseases are often treated with what are called ACE inhibitors.

Coronavirus binds to target cells through ACE2, which expressed in the epithelial cells in the lungs, blood vessels and in the intestine.[21,22]

In patients treated with ACE and angiotensin II receptor blockers, expression of ACE2 is increased.[23] Therefore, it has been suggested that ACE2 expression may be increased in these two groups of patients with hypertension and diabetes, which could facilitate infection with COVID-19 and increase the risk of severe disease and fatality.

The COVID-19 infection is a double challenge for people with diabetes. Diabetes has been reported to be a risk factor for the severity of the disease and at the same time patients have to control glucose in a situation with a decreased and more variable food intake. There appears to be several reasons for this:

1. The immune system is compromised, making it harder to fight the virus and likely leading to a longer recovery period.
2. The virus may thrive in an environment of elevated blood glucose.
3. Many patients with type 2 diabetes are obese and obesity is also a risk factor for severe infection.
4. Late diabetes complications such as diabetic kidney disease and is-



chaemic heart disease may complicate the situation for people with diabetes, making them frailer and further increasing the severity of COVID-19 disease and the need for care such as acute dialysis.

What people living with diabetes should know and do

For people living with diabetes, it is important to take precautions to avoid the virus if possible. The recommendations that are being widely issued to the general public are doubly important for people living with diabetes and anyone in close contact with people living with diabetes.

- Wash hands thoroughly and regularly.
- Try to avoid touching your face before you have washed and dried your hands.
- Clean and disinfect any objects and surfaces that are touched frequently.
- Don't share food, glasses, towels, tools etc.
- When you cough or sneeze, cover your mouth and nose with a tissue or use the crook of your arm if you don't have a tissue at hand. (Dispose of the tissue appropriately after use).
- Try to avoid contact with anyone showing symptoms of respiratory illness such as coughing.
- Think whether you can make changes that will help protect yourself or loved ones. For example, can you avoid unnecessary business travel? Can you avoid large gatherings? Can you avoid public transport?
- If you are ill with flu-like symptoms, stay at home.

If you have diabetes:

- Prepare in case you get ill.
- Make sure you have all relevant contact details at hand in case you need them.
- Pay extra attention to your glucose control. Regular monitoring can help avoid complications caused by high or low blood glucose.
- If you show flu-like symptoms (raised temperature, cough, difficulty breathing), it is important to consult a healthcare professional. If you are coughing up phlegm, this may indicate an infection so you should seek medical support and treatment immediately.
- Any infection is going to raise your glucose levels and increase your need for fluids, so make sure you can access a sufficient supply of water.
- Make sure you have a good supply of the diabetes medication you need. Think what you would need if you had to quarantine yourself for a few weeks.
- Make sure you have access to enough food.
- Make sure you will be able to correct the situation if your blood glucose drops suddenly.
- If you live alone, make sure someone you can rely on knows you have diabetes as you may require assistance if you get ill.
- Keep a regular schedule, avoiding overwork and having a good night's sleep.

Illnesses most likely to have an effect on blood glucose levels:

- Common cold or flu, including COVID-19
- Sore throat
- Urinary tract infections
- Bronchitis or chest infections, stomach upsets and diarrhea
- Skin infections such as abscesses (especially if these conditions are followed by a fever or high temperature)

Ketoacidosis symptoms

–Blood glucose over 15 mmol/l

–Ketones in urine

–Thirst

Seek urgent help if:

–Vomiting

–Rapid breathing with fruity-smelling breath

–Abdominal pain

–Reduced level of consciousness (drowsiness)

How to manage diabetes during an illness

"Sick day rules"

When people living with diabetes are ill, their bodies react by releasing hormones to fight the illness. These hormones can be triggered by any number of conditions, such as infections, cardiovascular ischaemic events, gastroenteritis, dehydration etc.

The hormones released during an illness raise blood sugar levels and at the same time make it more difficult for insulin to lower them. For people living with diabetes, even a minor illness can lead to dangerously high blood sugar levels.

This may cause life-threatening complications such as diabetic ketoacidosis or a hyperosmolar hyperglycaemic state.

Planning ahead

People living with diabetes, their carers, and parents of children living with diabetes should work with their healthcare team to make an illness plan. They should discuss:

• Their target blood sugar goal during

an illness

- How to adjust their medicines (for example how to adjust their insulin dosage and when to take insulin)
- When to contact their healthcare team for help
- How often to check their blood sugar and ketone levels.

When ill, extra insulin might be necessary as blood glucose levels may rise even if patients are unable to eat or drink normally.

When to contact a doctor

People living with diabetes should contact their healthcare team if:

- They are not sure what to do
- They vomit repeatedly (not able to hold down any food or drink for more than six hours), as they can quickly become very dehydrated
- Their blood glucose stays high for more than 24 hours
- They develop symptoms which could be indicative of their developing diabetic ketoacidosis

Healthy nutrition and home-based exercise

Healthy nutrition is an essential component of diabetes management. It is therefore important for people with diabetes to eat a varied and balanced diet to keep their blood glucose levels stable and enhance their immune system. It is recommended to:

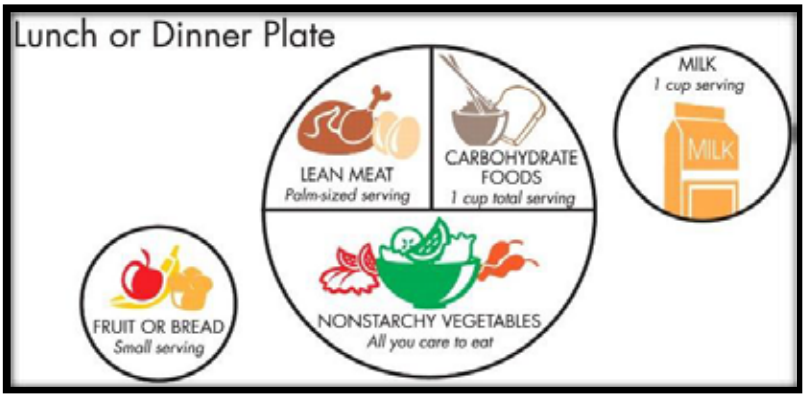
- Give priority to foods with a low glycaemic index (e.g. vegetables, whole wheat pasta/noodles)
- Avoid excessive consumption of fried foods e.g. chips, mandazi
- Limit consumption of foods high in sugar, carbohydrates and fat
- Choose lean proteins (e.g. fish, meat, eggs, milk, beans, which are fully cooked).
- Eat green, leafy vegetables
- Eat fruits in two or three servings

In response to the COVID-19 pandemic, governments in many countries have restricted the movement of their citizens, confining them to the home environment.

Regular physical activity is of great benefit to the general population and even more for people living with diabetes. Daily physical activity is an integral part of diabetes management, helping to maintain blood glucose at recommended levels.

Physical activity should be seen as a hobby and a valuable tool to overcome the monotony of the difficult confinement that many people around the world are currently experiencing. Ways to train at home include:

- Walk up and down eight sets of stairs, for at least six floors. This is not recommended for people with type 2 diabetes who do not exercise regularly.
- Jump rope
- Use small weights and home fitness accessories such as rubber bands, wrist weights, and pockets filled with heavy objects. Makeshift objects can also be used, such as buckets, cases, bottles filled with water or even small backpacks filled with objects of different weight.
- Bodyweight exercises such as push-ups, squats, deep stationary lunges, sit-ups or crunches (to strengthen the abdomen) and forward flexes (to strengthen the lower-back muscles). This help maintain muscle tone and, when performed correctly, can have excellent results.
- Joint mobility and stretching exercises that can be sourced from common workout, yoga and pilates' routines.



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Effects of COVID-19 on programme and facility-based health service delivery

By Dr. Catherine Njigua - Project Director, CHAP Uzima

On March 11, 2020, the World Health Organization (WHO) declared Coronavirus Disease (COVID-19) outbreak a global pandemic. As of August 6, 2020, there have been over 19 million confirmed cases globally with over 712,000 deaths with Kenya reporting over 24,000 confirmed cases and 399 deaths.

Prior to the COVID-19 pandemic, health service delivery in Kenya was faced with a dual burden of disease with increasing prevalence of Non-Communicable Diseases (NCDs) amidst a high prevalence of communicable ailments such as HIV (also a global epidemic).

Since the onset of the COVID-19 outbreak, most countries have put in place several containment measures such as lock downs, curfews, travel restrictions, restrictions on social gatherings, closing of places of worship and eateries, mandatory quarantine for contacts of confirmed cases, and isolation of confirmed cases.

These interventions while well intended, have also had untoward effects on the general population such as job losses, mental stress, increased reported cases of sexual and gender-based violence and COVID -19 related fear and stigma.

In Kenya, the COVID-19 pandemic and related containment measures has further exacerbated the challenges faced by the health sector leading to both negative direct and indirect effects on health service delivery.

Christian Health Association of Kenya (CHAK) has also grappled with the effects of COVID-19 on health service delivery. These effects have been felt at both member health facility level and in various health programs implemented by the organization. Some of these effects have included:

Effects at health facility level

- Inadequate supply of Personal Protective Equipment (PPEs) for frontline health care workers (HCWs). This has led to increased fear of exposure to COVID-19.
- Interrupted service delivery due to HCWs testing positive for COVID-19 with those infected or exposed being placed in isolation or quarantine respectively.
- Inadequate specialized staff (ICU, respiratory and infectious disease units).
- Scaling down of elective procedures and specific clinics at the beginning of the pandemic to allow health facilities to realign to required MOH IPC recommendations.
- Reduced uptake of both preventive and curative health interventions. This is largely attributed to patients shying away from health facilities due to fear of being exposed to COVID-19 within health facilities and also due to travel restrictions in and out of high burden COVID-19 areas such as the Nairobi metropolis and Mombasa.
- Loss of hospital revenue leading to salary cuts and redundancies.This has been associated with reduced morale and increased stress among Health Care Workers (HCWs).
- Late presentation of severely ill patients to health facilities with patients opting to defer seeking treatment and poor adherence to clinic appointments for patients with chronic ailments on long-term follow up
- Vicarious trauma among front line HCWs managing COVID-19 patients
- Stigma towards HCWs that have been infected with COVID-19 by their colleagues

Effects on program implementation

CHAK supports implementation of both communicable and non-communicable diseases health programs.

One of CHAK's communicable diseases programmes is the CHAK-CHAP Uzima which supports HIV prevention and treatment interventions in 79 faith-based and affiliated health facilities as well as the Faith and Community Initiative (FCI), aimed at finding men and children living with HIV and supporting justice for children through the inter-faith networks.

Since the onset of the COVID-19 pandemic, some of the effects on the HIV program and FCI service delivery have included:

- Increased number of transfer outs from the supported clinics to facilities in other counties. This has mostly been attributed to travel restrictions, curfew and job losses (layoffs) necessitating relocation to the rural counties
- Increased turn around for viral load and early infant diagnosis testing (EID) due to the national testing labs being overburdened with COVID-19 testing
- Patient support groups to promote adherence and retention to care put on hold due to the ban on community gatherings

- Reduced uptake of assisted partner notification services at community level for contacts of confirmed HIV positive index clients
- Reduced home visits for case management to households with supported Orphans and Vulnerable Children (OVCs)
- Closure of churches with ban on congregational and community gatherings affecting HIV self-testing uptake among congregants. This also delayed the implementation of FCI community and congregational related trainings.
- Reduced hospital visits for clinical systems mentorship by the program staff due to travel restrictions within some counties and hotel closure in most counties

To overcome these challenges, some of the mitigation measures that the program put in place include:

- Collaboration with health facilities outside catchment areas for ART refill to ensure continuity of care among Persons Living with HIV (PLHIV) that have been unable to access the health facilities where they are enrolled for follow up.
- Scaling up of community ART distribution to minimize hospital visits for clients and time of contact with the client.
- Scale up of multi-month dispensing of ARVs to enrolled clients to reduce frequency of hospital visits, therefore decongesting the clinics while ensuring that the supported clients have adequate supply of ARVs
- Capacity building for hospital staff and clients on COVID 19 and Infection Prevention and Control (IPC) measures
- Remotely calling clients to space timing and minimize crowding at the clinic
- Re-invention of smaller member support groups for newly identified clients and clients with high viral load to promote adherence to ART
- Food support and enrollment to cash transfer schemes for highly vulnerable households enrolled for OVC support
- Scale up of virtual health facility clinical systems mentorship by the program teams via online platforms such as Zoom, Google Meet and Microsoft teams

Drawing by Valerie Choge, 16 years. Valerie is a form two student at Kabarak High School.

Hospitals record reduced patient numbers after COVID-19 cases reported in Kenya

It is ironic that the Coronavirus pandemic has affected all facets of our lives, not even sparing the health sector under which it directly falls. The health sector has been negatively affected by the pandemic, leaving policy makers and health managers to go back to the drawing board.

Whereas under normal circumstances one would have expected an increase in the number of patients seeking health services, on the contrary, people have become scared of visiting hospitals for fear of contracting the Coronavirus. This reduced uptake of services has affected majority of hospital departments.

Kendu Adventist Hospital is located in Homabay County, many kilometres away from Nairobi, the centre of the Coronavirus pandemic in Kenya.

The hospital responded swiftly to comply with Government infection prevention and control (IPC) guidelines for health facilities from the beginning of the pandemic.

The staff were provided with the available limited PPEs and hand sanitizers. There are spread-out hand washing points from the gate to the entry of every ward and office within the hospital premises.

Everybody (staff, patients and visitors) is expected to wear a face mask while within the hospital premises. At the gate, every person coming in has their temperature checked and recorded in a book. Visitors to the wards have been limited to only one and the client waiting areas have clear demarcations of where to sit to promote social distancing.

The hospital administration is very keen on updates from the MOH which are usually followed by staff meetings to keep the health workers informed.

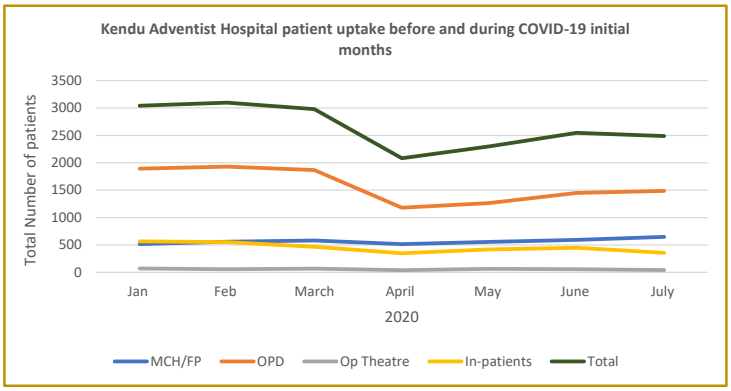
However, even with all the measures in place, the hospital experienced a drop in patient numbers especially in April 2020, soon after the Government announced the presence of Coronavirus in Kenya in March and stringent measures to curb its spread.

The decrease led to reduced income coupled with increased cost of supplies (hand sanitizers, different types of face masks), affecting hospital operations and human resources.

There are regular consultative meetings within the hospital to chart the best way forward with regard to management of the available resources. There have been discussions about a reduction in staff allowances in-case a significant drop in patient numbers is experienced.

The hospital's operating theatre was authorized by NHIF to handle emergency cases only from March to June. This directive significantly affected the surgical ward. The MCH/FP department briefly suspended outreach services as it monitored COVID-19 trends in Homabay County. Encouragingly, patient response is improving as the population gets to understand prevention of COVID -19.

Staff continue to receive updates from MOH and the Nursing Council CME platform for the nurses. An on-line infection prevention and Control (IPC) seminar was also organized by CHAK. Staff trained during the CHAK seminar carried out an in-house training for 10 staff. However, the information needs to be disseminated to all KAH health care providers and further to the hospital-affiliated education centers.



Month→ Department ↓	January	February	March	April	May	June
MCH/FP	515	560	580	516	555	593
OPD	1891	1930	1867	1180	1265	1450
Operating Theatre	70	58	66	39	62	57
In-Patients	565	550	468	348	419	448
TOTAL	**3041**	**3098**	**2981**	**2083**	**2301**	**2548**

Patient numbers at Kendu Adventist Hospital before and at the beginning of the COVID-19 pandemic. As with many health facilities around the country, the numbers dropped in April following the announcement by the Government that the pandemic had reached Kenya but are picking as people understand how to prevent COVID-19.

Have people living with disability been forgotten in the war against COVID-19?

Article based on an interview with Winnie Adoyo, Secretary General, Inclusion Champions Society (ICS)

John* was walking home from work a few minutes before the 7pm night time curfew imposed by the Government in efforts to slow down the spread of the COVID-19 pandemic when he felt a debilitating blow land on his back.

Due to his hearing disability, John did not hear the police coming after him for being outside during the curfew hours and had no chance to run.

The police who did not realise he was deaf savagely beat him, leaving him with severe injuries, especially because he 'rudely refused' to answer any of their rapid and breathless questions.

Like the rest of the population, persons with disability have been greatly affected by the COVID-19 pandemic in nearly all aspects of their lives - psychologically, economically, spiritually and worst of all, health wise.

However, there have been limited efforts to reach this group of the population with interventions specifically tailored for them.

Even more disheartening is the lack of public sensitization about the special needs of this population during the pandemic, which in John's case had distressing consequences.

COVID-19 measures

The challenged community has continued to take many of the COVID-19 prevention measures seriously.

However, such measures like staying at home and social distancing have led to isolation for some people in this group, affecting their mental health. This is especially difficult in instances where the mental health of such a person has not been optimal as a consequence of the disability.

A person who is physically challenged needs a lot of sanitizer not only for their hands but also the wheelchair, crutches, white cane and other assistive devices.

People with disability have therefore tried as much as possible to maintain their social networks virtually.

COVID-19 messaging

A lot of messages on COVID-19 have been developed targeting the general public. However, these public health messages may not be accessible to the hearing and visually impaired.

According to Winnie, COVID-19 messaging targeted at the challenged community is very minimal. So far, there is no information written in braille, for example, to take care of the blind. Additionally, some websites or social media are not screen reader enabled, which means they are inaccessible to the blind.

For our deaf brothers and sisters, the situation is no better. A few organizations and individuals have attempted to translate COVID-19 messages to sign language. However, these translated messages can only be accessed by those who have access to electronic gadgets and internet.

It took a lot of lobbying from the deaf community for a sign language interpreter to be included during daily briefings on the COVID-19 situation in Kenya and the captions at the bottom of the screen removed.

However, media houses still do not capture the sign language interpreter during the live events. This means the deaf have to wait for prime time television news to watch the interpreter and even then he or she occupies a very small part of the screen at the bottom and is unclear.

The challenge is similar for other disabilities like cerebral palsy and down syndrome. These groups need to have the information packaged with illustrations and bright colors among other specific requirements for their consumption.

For the mentally challenged, it would be easy for their teachers to

pass the COVID-19 information to them. This is because their teachers have been trained and have the skills to easily pass information to their students.

Unfortunately, schools have had to be closed to slow down the spread of the pandemic. The mentally challenged are home with their families and care givers many of who lack the skills to pass such information to their charges.

This group has therefore been totally left out and outside of keen attention by their care givers, it is very easy for them to fall ill with COVID-19 due to lack of information.

Unfortunately, more than 90 per cent of parents and caregivers lack the required expertise to pass these messages and a good number are also too busy fending for the family to have time to give the extra attention to their mentally challenged charges.

However, with proper sensitization, such care givers would be best placed to pass COVID-19 messages to the mentally challenged.

Depending on whether or not the caregiver is also a person with disability, the information can be passed just as happens with the general public. Where the care giver is living with a disability, such information needs to be packaged in a format that is easily accessible to them.

However, care givers can help by simply following the Government measures as they assist the people under their care to adhere as well whenever possible.

PPEs

As the world suffers shortage of personal protective equipment including masks and hand sanitizers and installations such as hand washing stations to curb the spread of COVID-19, the special needs community has been even more affected.

For instance, a person who is physically challenged needs a lot of sanitizer not only for their hands but also the wheelchair, crutches, white cane and other assistive devices.

Many hand washing stations both in public and private spaces do not take into consideration the special needs community.

On a positive note, there has also been development of clear masks for the deaf and gloves for the visually impaired who depend on holding the hands of sighted guides for their day to day movement.

Role of the family

Families of people living with disability can help such a person cope better during this difficult season by:

- Loving them unconditionally
- Trying as much as possible to involve them in family activities
- Not doing things that make them feel different or lesser than other family members

The above measures are especially critical because many people are either working from home, have lost their gainful employment or are home from school or college.

Due to the mental stress of being cooped up at home, it would be easy to exclude people living with disability or even feel overwhelmed by the extra attention that they need.

It is however critical to offer all the support needed to these members of our society.

Many parents with special needs children have talked of being overwhelmed by the responsibilities that come with caring for them.

For the longest time, these children have been spending most of their time in school, rehabilitation centers and other institutions. However, they now must stay home with their families.

Parents need to keep looking on the positive side. This is not the time to agonize or engage in blame games.

Such a parent can take this as an excellent opportunity to bond with their child or children, create lasting memories and learn more about their offspring. The joy that will result from this improved relationship can only be priceless.

Churches

Many churches have been holding on-line services to avoid gatherings which the MOH has advised against due to the highly contagious nature of COVID-19.

Few churches have included sign language interpreters as a way of involving the hearing impaired. Following the re-opening of the churches, Government regulations require that not more that 100 congregants gather per services.

It is critical that churches consider involving the challenged community in their services.

Access to health care

Access to health care has and continues to be a huge challenge for persons with disability. Physical, institutional, communication and attitudinal barriers make access to healthcare hard for persons with disability and even harder when it is COVID-19.

There are no specific provisions in isolation/quarantine centers in the country that can accommodate the peculiar needs of this group of people. Some people in the challenged community may need constant assistance from a care giver, some special diet, special medication for other conditions, special toilet and bathroom, physically accessible buildings among other infrastructure.

The government is now talking of home-based care. Most people with disability together with their families are considered poor. It is almost impossible to get an extra room, toilet, utensils, and the long list of requirements to make home-based care possible.

CHAK workshop specialising in installing and maintaining critical care equipment

CHAK National Health Care Technical Services (NHCTS) workshop sets up state-of-the-art medical equipment laboratory

CHAK has set up a state-of-the-art medical equipment laboratory to ensure proper maintenance of radiology, anesthesia and ICU equipment in member health facilities.

The facility set up with funding from Bread For The World, Germany, will provide services that are critically required during the COVID-19 pandemic, including accurate calibration of equipment, radiology dosimetry reading and radiation surveillance through the CHAK National Health Care Technical Services (HCTS) program.

Procurement of the equipment was done through WEM, Germany, as part of the CHAK Health Systems Strengthening (HSS)-Medical Equipment Enhancement project.

COVID-19

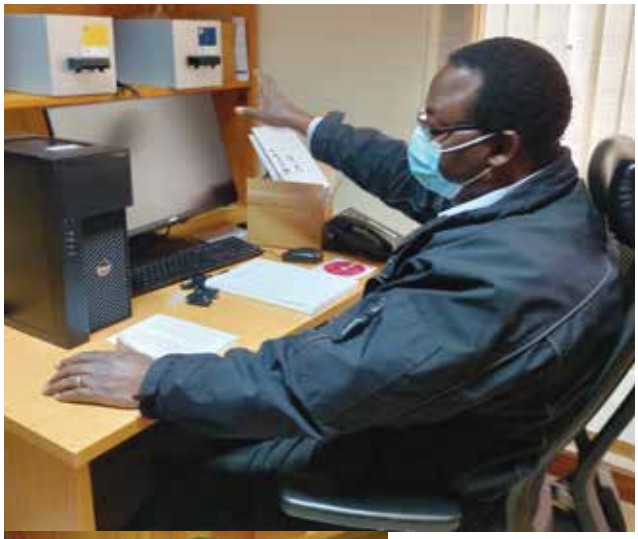
COVID-19 cases require radiology, especially for patient management.

Where ventilation is done, it is important to monitor the operation and maintain the machines to optimal operating conditions to be able to detect the slightest infection.

If the machine is in top condition, it is able to detect even the slightest infection.

There are many machines in the market that are not able to do quality readings and hence cannot detect the finer details of pathology or diagnostics.

Some x-ray machines, for example, are not able to detect the finer details of COVID-19 unless well calibrated. Proper calibration will therefore ensure greater efficiency in detection of COVID-19 and its complications.



CHAK NHCTS technicians Julius Nkandika and Kenneth Njeru showing dosimetry equipment (top) and A CT head and body phantom with the attendant cables, part of the QA QC portable unit for radiology equipment (bottom).

Machines that monitor blood pressure, heart rate and oxygen levels all need to be properly calibrated for accurate readings.

On ventilators, one can accurately monitor the quality of ventilation to ensure well-being of the patient.

Dosimetry equipment

The medical equipment laboratory has come with a useful addition to the CHAK NHCTS services – dosimetry equipment.

This is a new service in the CHAK medical equipment programme and will enable the NHCTS workshop to perform radiology dose analysis for hospital staff.

The equipment which is from the BeOSI, Germany, brand, consists of a computer with the necessary software, calibration kit and 520 personal radiation monitoring badges.

The BeOSI, Germany, brand offers superior technology and will be greatly beneficial in protecting radiology staff in hospitals seeking the service.

The technology is the only one of its kind in Kenya and only the third such installation in Africa with the others being in South Africa and Egypt. It offers superior protection for radiology staff compared to other

radiation badges and TLDs used locally.

It is expected that once a hospital has entered into a contract with the CHAK NHCTS workshop for this service, the hospital will send its radiology staff personal radiation monitoring badges to the CHAK laboratory for analysis, receive fresh ones for continued use with the service cycle continuing as long as there is a standing contract.

This would ensure hospital radiation staff have their badges with them at all times in compliance with Government regulation.

QA QC for radiology equipment

Also among the key equipment in the laboratory located at CHAK main offices is a portable QA QC unit for radiology equipment.

The unit is expected to cater for a wide range of equipment including general x-ray, dental x-ray, mobile x-ray, mammogram and c-arm. The kit is able to measure MAs, time, KVP radiation dose and MA. It has various detector attachments to be able to perform these functions.

A CT head and body phantom will ensure CT scan equipment in CHAK hospitals and other facilities receiving services from NHCTS is able to give accurate diagnosis.

Other equipment in the laboratory include a centric cross used in x-ray beam alignment and checking radiation sources and a radiation survey metre with German calibration.

This equipment will be used for analysing radiation leakage from the hospital radiology departments to safe guard the public, staff and patients from harmful exposure to the rays.

Radiation protection for the public is required by the Kenya Nuclear Regulatory Authority (KENRA) formerly Radiation Protection Board (RPB) which has set standards for health facilities in the country.

ICU and anesthesia machines calibration equipment in the CHAK lab.

The equipment will ensure that all hospitals seeking services from CHAK NHCTS are compliant to the set Government standards.

Calibrating ICU and anesthesia equipment

Also included in the donation is ICU and anesthesia machines calibration equipment.

The equipment is able to analyse the flow of various sedating media, pressures, tidal volume, minute volume, frequency of ventilation or breaths per minute, among others.

The equipment is designed to work with a wide range of machines including:

- Patient monitors
- Blood pressure machines
- ECG

This is in addition to callibration of temperature, oxygen readings and invasive blood pressure.

Licensing

CHAK through the NHCTS workshop is awaiting licensing of the medical equipment laboratory to begin operations.

The licensing process has already commenced and the Kenya Nuclear Regulatory Authority (KENRA) formerly Radiation Protection Board (RPB) have already done an assessment of the lab and processed the invoicing documents for payment of the licensing fee.

Giving oxygen to COVID-19 patients in Kenya

The CHAK NHCTS workshop is working with Emergency Medicine Kenya Foundation through DAK Foundation to install oxygen gas manifolds in emergency care centres around the country.

According to the WHO, oxygen therapy is recommended for all severe and critical COVID-19 patients. Installation of the oxygen equipment is therefore a big step forward in the fight against the pandemic.

The CHAK NHCTS workshop has already installed the oxygen equipment in county referral hospitals in Machakos, Kiambu (COVID-19 isolation centre) and Kajiado counties and at the Alupe Sub-County Hospital COVID-19 isolation centre in Busia county on contract basis.

Mitigating the risks and effects of COVID-19 on Church operations

By Omasso So - Deacon, Christco Central Church, Kisumu

The Covid19 pandemic by any scale is monumental and its effects will be with us for the long haul. Some experts observe that since the Second World War, nothing has completely disrupted both human life and institutions, in one stroke, like COVID-19. Everything seems to have changed and the Church has definately not been spared.

When our places and ways of worship becomes a risk

In the unrelenting war against this pandemic, authorities have singled out social gatherings as high risk in the spread of the coronavirus.

However, what is disturbing are emerging cases of congregational church services spreading the virus and fueling a second wave of infections. There is no doubt that houses of worship and religious gatherings have contributed to the spread of COVID-19.

So, why is congregational church such a high risk for Coronavirus spread?

There are many answers to this question. However, the underlying principle in attempting to address this question is understanding what the church is and why it exists.

In my life, as a believer, I have found no single simple befitting definition of what the term church (as used in our day to day language) means than this: "a body of Christian worshippers." In this regard church is a congregation of people and is public in nature and primarily exists "to minister both (Acts 6:2), the Word of God and to the tables of needs" of this body of Christian worshippers.

From the aforesaid, at its very core design and existence, the church, intrinsically is social and local - built on foundations of relationship and interaction with God and with interconnected people, at minimum by faith.

Here lies the reason the Church is high risk in respect to the spread of Coronavirus.

Congregations are based on relationships and love. In human relationships, we don't ordinarily run away from the people we love – that is not just who we are as humans. In fact we run to them, just like the Good Samaritan (Luke 10:34), to bind up their wounds when they are hurting.

Then comes the war against COVID-19 that makes a 'strange call of duty' - social distance; run away from those you love. This is a difficult call because it tells us, the congregants, to deconstruct and detach from an entire framework of fact – who we are as the Church – and why we exist.

The real question is if we as the Church can adjust to the "the new normal and its requirements for isolation and distancing" and still remain true to who we are and why we exist.

The church therefore is a high risk not solely because of what it commits or omits. But, largely because of what it is and why it exists.

Risk management and behavioral control classes teach that it is easier to learn to be afraid of snakes than of flowers. In this pandemic, the Church is being asked to fear the beautiful flowers of congregational worship.

Our church operations – places of worship and ways of worship, like many other people activities - carry the risk of infection. The reality is that we cannot just worship; we must also think, with a risk mitigation eye, about how to worship.

The thorn in my flesh

On March 22, 2020, Kenya declared immediate closure of all places of worship in a bid to contain the spread of the COVID-19 pandemic.

As a consequence, the Church in the country went into "the wilderness of separation". The clergy were separated from the flock, the flock from one another, sanctuaries from both the flock and the clergy. Congregational ways of worship were separated from the worshippers.

Those in support of such containment measures say that they are necessary to protect lives. However, they also emphasize that these measures are not meant to seal us from the virus but help us prepare for the journey ahead.

John Giesecke, a Swedish expert in infectious diseases observed that countries need not lockdown except for one reason: to protect the vulnerable and try slow down the pandemic so that the healthcare system may be able to prepare.

Dr Anthony Fauci, the Director of the USA National Institute of Allergy and infectious Diseases also told reporters: "What we needed was delay to essentially prepare better."

In my article "COVID-19: The risk of the new normal and why nations are opening up despite rising cases and deaths", I note that governments are not opening up as sign of either victory or defeat against the virus. They simply feel a little more

prepared and more willing to take risks.

One of the risks is the assumption that citizens will be responsible enough to follow laid down prevention and care guidelines and are prepared to constantly wage war against this virus. As the Government allows us back to our places of worship, I hope for two things: One, the Church will not be the new hotspot for infections and two, it took time to prepare for what appears now, (2rd Cor 12:9) to be the thorn in its flesh.

Following the opening of places of worship a few weeks ago, many of us went to church for the first time in months. We all wore masks as per Government requirements and the ushers in addition wore gloves. We sanitized, washed hands, kept social distance, avoided hugs and physical greetings.

We were just a handful of us, from the hundreds we usually are. We sang, but so different from our norm, there was no praise and worship as we know it, but, just choruses from the hymn book. We prayed, but again, so distinctly different from our norm of calling upon the heavens. There were no testimonies of what God has done and His greatness in our lives. Our Sunday service was slightly under one hour.

In all ways the church was and felt different and abnormal, if not strange. On my part, I felt the Church, to some extent, had detached and deconstructed the framework of who we are and why we exist.

I was not alone; one brother from a neighboring church expressed how disappointing the first Sunday congregational service after the lockdown was to him.

He said, "When you go to church, you just want to worship, not to think about how to worship".

Beyond COVID-19

I believe the single most important impact of COVID-19 to the church is that it has exposed both the vulnerabilities and capabilities of the church.

The interventions many churches put in place not only served to solve the problem of not meeting as a congregation but also offered a glimpse into the future of the church and its capability to live into that future.

When the world was hard hit by scarcity of PPEs, commercial companies re-purposed their operations to produce the most critical item of the day - PPEs. We are also going to see this with church organizations as we go through and beyond this pandemic. The church will re-purpose and re-tool to effectively meet the needs of the people in the current time.

In 2013/2014 while working in CITAM, we were tasked to automate the church process. Part of the automation project was what at the time we called "the CITAM limitless church" where the "church any time and church anywhere" concept was envisioned.

We are going to see more of such projects across churches. Digital and online churches are not going to be "alternative church" but capabilities in doing ministry.

This is due to two reasons: One, the zoom church concept has created believers who will still enjoy its convenience, comfort and consumerism way after COVID-19. Two, some church members such as the elderly and very young ones have been identified as as most vulnerable and are not permitted to go to places of worship.

It would be irrational to argue that church in its entirety can be remote. In the same breath it would also be irrational to assume that church, moving forward, in its entirety will be in-person. On a similar note, you can imagine the EPL football fraternity making an assumption that "all our fans and followers must be those who come personally to the stadiums."

Certainly, in the future, the Church will in some part be remote and in another part the traditional brick and motar. The choice for the church now is not whether it should be in-person or digital but coming up with a working balance of the two, fashioned around individual assemblies' doctrine, needs, context, and, more importantly, level of exposure to the risk of infection.

COVID-19 has also exposed the Church' infrastructural, administrative and financial inefficiencies. We witnessed, for example, in the news media, some clergy either line up for subsidies or take up very menial jobs.

The pandemic has triggered a ripple effect from individual financial struggles to a global economic downturn. Individual and corporate financial stability has been destabilized and the most natural response is for people to tighten their purse strings. This will definately affect churches' revenue streams.

In the immediate, this development will inform churches' spending power and shift in spending patterns.

In the long range; churches will put deliberate effort on financial management with focus on contingent planning and financial reserves for difficult times.

What must be done now?

With Government having lifted the ban on accessing places of worship, churches must open their doors for worship. Some churches opted not open up their doors for worship. This was neither right nor wrong but the sensible thing to do at a time when infections and mortalities were rising both nationally and internationally. It was out of a genuine need to protect lives.

However, in risk management principles, any given risk poses either or both a threat and an opportunity. In

the period of the lock down we were focused on the threat and how to mitigate its impact, and rightly so.

It is now time to pursue the opportunity of "moving forward with the gospel of Christ" even with the still present threat of COVID-19.

So how then do we do this and what must we do?

1. Institute a robust church membership management system that at minimum identifies the member and his exact location of residence and work. Through this, it would be possible to set up a localized monitoring and surveillance system for COVID-19 to enable the Church to immediately advise its membership from a high risk area not to attend in-person church service or suspend church activities.
2. Set up a COVID-19 communication and crisis management strategy focused on "worst case scenarios" such as: what if our member is infected or suspected to have been infected in church? What if our member dies of COVID-19, or is hugely affected? How do we play our part as a ministry?
3. Holistically consider the risk of COVID-19, i.e., beyond disruption of our normal church service and operations what else (financially and strategically) has been or is going to be impacted for us? What legal and regulatory exposures do we face in our compliance or non-compliance to the laid protocol? Even so, what decisions must we make? What action must we take?
4. Emphasize to its members, in such a time as this, the good news of the gospel and God's faithfulness over the history of the church. The good news here is that in the entirety of its existence, the church is not short of accounts of its ability to seek God and wait on God in times of crisis and calamity and COVID-19 is not any different. As the Church, the Body of Christ, we must do what we must do; call on God, the God of Abraham, Issack, Jacob and now the God of me and you! The same yesterday, today and forever more, (Heb 13:9)! When COVID-19 changed everything for everyone, only God did not change. - *aboveboardprocurement@gmail.com*

Dealing with the far reaching psychological effects of the COVID-19 pandemic

Based on an interview with Florence Ambayo – Counseling Psychologist

COVID-19 has had serious mental health implications for all segments of the world's population with fear and worry the main emotions being experienced by most people. Kenya, like most of the world, is mentally ill equipped to deal with the pandemic. To compound matters, the mental health aspect of the pandemic has hardly been dealt with.

Reports of patients dying suddenly, sometimes even while looking at their mobile phones, or talking to the doctors have become common. The high risk of infection is also causing anxiety among front-line workers.

The Government seems to have left Kenyans to their own devises. President Uhuru Kenyatta has been clear that it is every Kenyan's responsibility to reduce infections, which while being a worthwhile call also indicated that the State could no longer control infections as they were already steadily rising in the community.

Experts who have studied pandemics say that their effects can be felt for many years, even five years after the last case has been reported.

Stigma

The disease has come with a lot of stigma, causing undue stress to the people on the receiving end, whether patients, their relatives, friends and colleagues, or health care workers. A common reference for those in the front lines is 'Corona'. Even Health Cabinet Secretary Mutahi Kagwe is now known as 'the Corona guy', especially to the younger generation. This reference is deeply stigmatizing.

Residents in many of Kenya's rural areas do not want to interact with city dwellers due to fears they will contract the virus from them.

Funerals of COVID-19 fatalities being conducted by people in plastic white garb and the attendant spraying to avert potential infections are also stigmatizing especially for the family that is left behind.

COVID-19, by its very nature, lends itself to stigma

When traced as contacts, patients were initially collected by an ambulance with fully kitted health workers who sprayed the area once the patient was safely in the vehicle, leaving a very scared batch of neigh-

bours behind.

COVID-19, by its very nature, therefore lends itself to stigma.

To address stigma, we need to learn to be kinder to one another, stemming from the realization that anybody can be afflicted with the virus. It is important to normalize the condition and spread the message that it is manageable.

Stigma has caused much fear around COVID-19 and this may have serious consequences in the fight against the disease.

Pandemic fatigue

Six months after the first case of Coronavirus infection was announced in Kenya, the population is showing signs of pandemic fatigue. The population is seemingly getting tired of the new normal.

Majority of the population are now focusing on meeting their daily needs amidst a major economic downturn. Some people also continue believing that COVID-19 is a fabrication of the Government in order to access donor funding, with emerging corruption allegations in the use of funds meant for fighting the pandemic only serving to cement this belief.

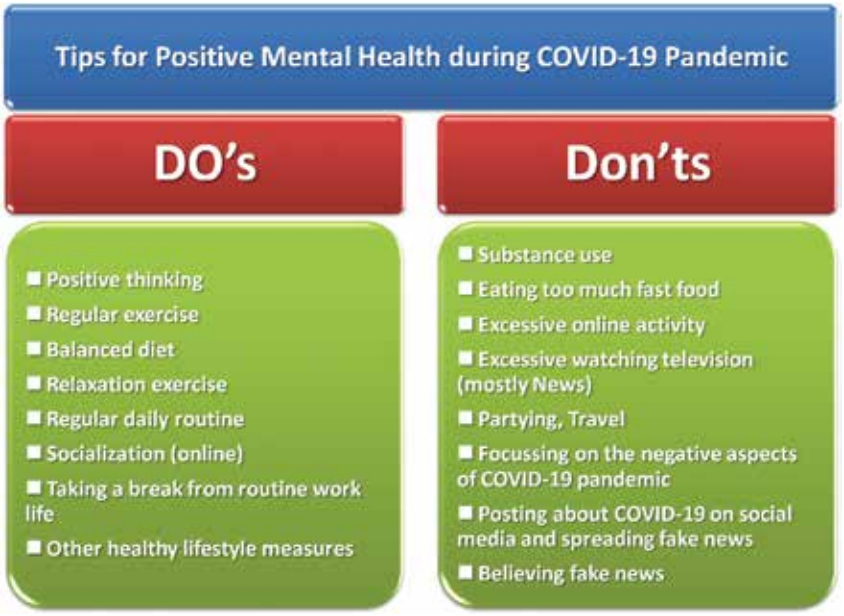
To succesfully deal with pandemic fatigue, it is important to acknowledge that change is never comfortable. We need to accept the new normal which will likely be long term. It may not be possible to go back to the normal that we had before March 2020 when the first Coronavirus infection was announced in Kenya.

We will therefore need to adapt to our new circumstances.

Other countries have experienced an upsurge in infections after returning to normal life. We therefore need to be careful as we deal with pandemic fatigue.

Dealing with fear

Anxiety and fear are real for many people during this COVID-19 season. This is a normal reaction because we are dealing with a new situation with none of us knowing what will happen tomorrow. It is healthy to allow ourselves to experience anxiety.



In cognitive behaviour therapy, people are advised to change their problematic thinking and replace it with a different thought process.

As Kenyans, we have managed to overcome many difficult situations. To overcome COVID-19, we need to go back and reflect on where and how we overcame these situations and support one another.

To overcome fear, it is important to identify the things that are under our control and the ones that are not, then proceed to do whatever we are able to change things. For example, flattening the curve is within our control as we can wear masks and keep our hands clean to reduce infections. However, the economy is not in our control.

Worrying about our situation will do us more harm than good. We need to create support systems and begin to speak to one another during this pandemic.

Getting the facts right is critical as is avoiding lies and half truths and frequent bad news in the media. Exercise some positive psychology by looking at the situation critically and doing a self analysis.

Look at what is being done worldwide and follow the laid-down guidelines for control of infections.

Loss of income

Many people have lost their sources of income in this period. This can be especially devastating for men. Where one finds himself in such a situation, the choice is between mourning, taking drugs and alcohol and becoming violent or taking up an activity that one is able to do and bring in income. The best way forward in case of income loss is to look for the next productive option.

Additionally, a person who has lost income needs to adjust his way of living to reflect the new circumstances. Even relocating upcountry is an option, if only for this season. It is important to shed pride, cut expenses and ask God for wisdom.

Where children are involved, such a situation presents a change of lifestyle and environment for them. Explain the situation to them and talk about the income loss as a family. It takes humility to put food on the table and live within your means

in such an eventuality.

Effects on marriages and homes

The first few months of the lock down were difficult for many homes and marriages. Families were locked up in small spaces, getting into each other's way and causing a lot of frustration.

The lockdown was a total disaster for some marriages and relationships. For those who were experiencing violence before COVID-19, things became worse. Increase was reported in intimate partner violence, not only in Kenya, but worldwide.

This kind of violence can cause lasting trauma for the people experiencing or witnessing it, especially children.

Loss of income and salary cuts have caused additional stress on families. Some family members have been quarantined, are in isolation, hospitals while some have lost close relatives. This has come with great emotional and financial stress.

Loneliness has been real for some people as social channels such as churches, parties, family visits, etc. came to an end. Some people have gone into depression as a result of this loneliness.

Just as adults were working from home, children were also not going to school. Children are especially frustrated because they are not seeing their friends or doing the things they like to do, a situation that is likely to extend until January 2021. They are bored, missing their friends and missing school, which is crucial in building relationships, talents and gifts.

Yet relationships with friends are very important in teenage and peers play a critical part in their development.

Social distancing, as many parents can attest, is difficult, even strange, for teenagers and young people. The world today is full of young people who partied endlessly despite the ravages of COVID-19 and the potential danger to the older members of their families.

Some teenagers have been known to lock themselves in their rooms, some times developing depression and anxiety, when asked to social distance from their friends. The WHO reports that teenage suicide is the third highest killer of teenagers due to depression.

Many teenagers and young adults have turned to drugs and alcohol to kill boredom while hue and cry due to high rates of teenage and underage pregnancies has been a running feature of the COVID-19 period.

The provincial administration and policy makers have had to go back to the drawing board to seek new strategies for dealing with this issue with no less than President Uhuru Kenyatta directing that any person found to have impregnated a school girl be dealt with the full force of the law.

For some students, repeating a class due to the loss of an entire school year as a result of the pandemic is simply too stressful to bear. Some experts have opined that the effects of missing one school year will be felt for the next 65 years.

Teenagers and young people need a lot of support to go through this period. The family is called upon to support this vulnerable group during this period, let them know that they are not alone.

On the positive side, many families have benefitted from additional time together. They have taken time to know and understand one another, started projects together, identifying and developing talents during this period.

Such developments will have a life-long impact on those who have been fortunate enough to experience them, especially children and the youth. During this period, it is important to pick a gift, talent or challenge and work on it.

The Church

The Church is very therapeutic and many have argued that pastors should be recognized as frontline workers.

Closure of churches meant many people were without spiritual nourishment and encouragement from their pastors. While on the one hand this has had a negative psychological impact on society, it has also helped some families bond together, especially where services have been broadcast on television or are accessible online.

For pastors, ministry is a source of income and some have suffered terribly during this time. Adjustment to this development may involve coming to terms with the realization that church on-line and on air may be here to stay. Our bible study groups may well become our new pastors.

For people whose loved ones have died from COVID-19, there has been no closure as they are not allowed to view the body and some have been unable . to attend funerals of their loved ones.

COVID-19 has therefore not spared us spiritually, either. However, with the number of infections seemingly declining towards the end of August 2020, there is hope that we will be successful in flattening the curve.

This is a ray of hope for Kenyans and the world at large.

The best way forward in case of income loss is to look for the next productive option

Medical training calendar disrupted as learning institutions are ordered closed

BY ANGELLAH OMONDI - KENDU ADVENTIST SCHOOL OF MEDICAL SCIENCES

The announcement of the first COVID-19 case in Kenya was quickly followed by the closure of all learning institutions.

At Kendu Adventist Hospital, there are two learning institutions namely Ruby Kraft Adventist Primary school (RKPS) and the Kendu Adventist School of Medical Sciences (KASMS).

The primary school pupils departed by March 17, 2020, with high hopes that the situation would be in control by May 2020.

The teachers ventured into online teaching through WhatsApp to keep pupils engaged. The Government has announced that schools will re-open in January 2020 and the situation is especially tough for the staff.

The primary school is fully dependent on tuition fees remitted by parents. Discussions are ongoing on whether to continue paying staff salaries for the remaining months and the source of such monies.

Owners and staff of private schools across the country continue to struggle as the COVID-19 pandemic hits the education sector hard.

Kendu Adventist School of Medical Sciences (KASMS)

The KASMS immediately responded to the Government directive to close all learning institutins.

By March 17, 2020, the students vacated the premises. The school had received new students the previous week and learning had already kicked off. Others had promised to join the institution the same week.

Other students were on clinical placement in various counties. They were recalled and asked to go home. Another group of students had one month to go before sitting for the Nursing Council Licensing examination. The exam has since been postponed until further notice.

Another group of students who were scheduled to sit for end of semester examinations the following week also left for home.

The entire students' program has therefore been completely messed up, especially with regard to rotation. This will obviously affect the training period for all the students in the college.

The students will not complete their traning as earlier projected because the time lost has to be compensated. Both theory and practical training for student nurses and clinical medicine have been adversely affected.

The teaching staff have had to go back to the drawing board and re-plan for all classes. Students are also anxious about resuming their studies as the Ministry of Education has made it clear that learning institutions will not re-open unless COVID-19 cases take a downward trajectory.

The KASMS staff have therefore opted for on-line teaching. On-line teaching is done through various channels including Zoom, WhatsApp, e-mails or You Tube videos. However, this mode of teaching has been a challenge due to the diverse economic status of the students. Some of the students are from very remote areas, others do not have smartphones, among other challenges. However, majority of the students are able to access these channels.

The lessons may have to be repeated when the school reopens to cater for the disadvantaged students. It is not clear yet when examinations will be done.

The KASMS is fully dependent on tuition fees paid by the students. By the time the college closed in March, majority of the students had not paid their fees.

On July 1, 2020, the college staff were advised to consider redeployment at the Kendu Adventist Hospital for sustainability until the school reopens. This advice was taken positively. It is the desire of KASMS lecturers to help scale up quality of care at the hospital which is the main clinical practice site for the students.

The KASMS administration has also been busy ensuring the requirements stipulated by the MOH and Ministry of Education for re-opening of schools and colleges are met.

The areas of emphasis are hand washing points, social distancing in classes and areas of residence, availability of hand sanitizers and face masks as part of school uniform and staff dressing code.

Lessons learned

- KASMS should identify other sources of income to cushion itself in case of similar challenges in the future.
- The school needs to establish an e-learning or media centre to complement virtual learning. The media centre should also administer examinations in the future.
- There is need for staff training on effective e-learning techniques and approaches.

Ensuring a safe environment for children during the COVID-19 pandemic

BY WIRY ASIGE- 3K ADS SOUTH RIFT PROJECT, NAROK COUNTY

Narok County has high rates of child abuse. FGM and forced child marriages are among the leading forms of child abuse in the county, while child labour in the form of herding is a common practice that denies the children access to education.

Children in the county become vulnerable to abuse due to domestic challenges like poverty, domestic violence, FGM, pupil-teacher relationships, rape and forced early marriage, and discrimination against children with disability.

Some members of the community still practice FGM and early marriage, forcing girls out of school. Teenage pregnancy is as high as 40.4 per cent higher than the national average of 18 per cent. Other challenges facing the girl child are threats from parents if they report the violations to the authorities. Both girl and boy children are engaged in child labour due to poverty.

All these factors reduce the quality of education for the affected children, dragging the achievement of the SDG4 at the county, national and the global level.

What is child protection?

Child protection are measures and structures to prevent and respond to abuse, neglect, exploitation and violence affecting children. In essence, child protection means safeguarding children from harm. Harm includes violence, abuse, exploitation and neglect.

Why is it important to protect a child?

In the family, school and community, children should be fully protected so they can survive, grow, learn and develop to their full potential.

Infectious diseases like COVID-19 can disrupt the environments in which children grow and develop

Millions of children are not fully protected. Many of them deal with violence, abuse, neglect, exploitation, exclusion and/or discrimination every day.

Infectious diseases like COVID-19 can disrupt the environments in which children grow and develop. Disruptions to families, friendships, daily routines and the wider community can have negative consequences for children's well-being, development and protection.

In addition, measures used to prevent and control the spread of COVID-19 can expose children to risks. Home-based, facility-based and zonal-based quarantine and isolation measures can all negatively impact children and their families.

COVID-19 can quickly change the context in which children live. Quarantine measures such as school closures and restrictions on movements disrupt children's routine and social support while also placing new stressors on parents and caregivers who may have to find new childcare options or forgo work.

Stigma and discrimination related to COVID-19 may make children more vulnerable to violence and psychosocial distress.

Disease control measures that do not consider the gender-specific needs and vulnerabilities of women and girls may also increase their protection risks and lead to negative coping mechanisms.

Children and families who are already vulnerable due to socio-economic exclusion or those who live in overcrowded settings are particularly at risk.

Child protection-sensitive response to a pandemic

Health

- Advocate for vulnerable children and their families' to have free access to health care (if it is not universal).
- Collaborate to include child protection concerns in health sector assessment and monitoring tools.
- Develop common standard procedures for documenting and referring children's cases between child protection and health services to ensure children receive safe, appropriate, family-based care if separated.
- Advocate for clear and child-friendly intake and discharge procedures to promote family unity and reduce the risk of separation.
- Facilitate safe and regular communication between children and parents/caregivers who are temporarily separated.
- Collaborate to ensure child-friendly health facilities/access to health care, including guidance for health staff on child-friendly communication and special measures to support children's psychosocial well-being when undergoing treatment and quarantine.
- Support child safeguarding train-

Stigma and discrimination related to COVID-19 may make children more vulnerable to violence and psychosocial distress

ing for health workers (particularly where children are separated from their families or caregivers).

- Establish safe, child-friendly complaints and feedback mechanisms in health care facilities.
- Strengthen capacity on clinical management of rape (CMR) and ensure minimum CMR supplies are available in key facilities to appropriately respond to sexual violence.
- Collaborate on mental health and psychosocial support (MHPSS) care and messaging for children and caregivers affected by COVID-19.
- Include measures to protect children during a COVID-19 outbreak in contingency plans.
- Ensure that information, education and communication (IEC) materials, including information on available services, are produced and displayed with limited text in child-friendly versions.

WASH

- Collaborate to ensure child-friendly hand-washing stations are available at health facilities, schools, child care centres, alternative care centres, and other locations children are likely to visit.
- Collaborate to provide safe, child-friendly hygiene promotion activities before and during outbreaks, including the development of posters and infographics targeting children, parents/caregivers and teachers.
- Collaborate on safety audits to assess and address any safety needs at WASH facilities.

Nutrition

- Ensure children and families in quarantine, self-isolation or health facilities have access to adequate nutritional support.
- Collaborate on safety audits to assess and address any safety needs at nutrition centres.

Education

- Limit the impact of school interruption by using child-friendly distant education methods such as TV, radio or online learning.
- Advocate with government and private employers for flexible working arrangement for parents and caregivers who may have lost access to childcare to enable them to continue care and education of their children.
- Work with schools to ensure that protection and safety messages are delivered to parents and children in a way that limits panic and distress, reassures, and encourages adherence to health messaging.
- Train teachers and other school staff on signs of distress to enable them to identify and refer children who may have specific child protection needs.
- Ensure teachers and volunteers have necessary knowledge and skills related to GBV risk mitigation, Prevention of Sexual Exploitation and Abuse (PSEA), child safeguarding, and safe referral practices.
- Support the development and roll-out of child-friendly complaints and feedback mechanisms.
- Develop, disseminate or display messages in schools about child protection and available services including case management and family tracing and reunification.
- Work with education actors to address stigma and social exclusion in schools.

About the Anglican Church of Kenya 3K Narok project

The Anglican Church of Kenya (ADS-South Rift-NIDP) is implementing a project dubbed 3K (Kuboresha,Kudumisha na Kulinda) Narok project.

One of the objectives of the project is child protection. The NIDP has been able to carry out several activities in order to strengthen child protection within the county, particularly in Narok North and East sub-counties. The activities include:

- Organization of training sessions for children on life skills and raising awareness on child protection issues
- Sensitization of caregivers on child rights issues
- Formation of and strengthening the capacity of five locational committees on identification and reporting of child abuse cases and support to the county committee on the same.
- Support to the annual Sub-county Children Assembly
- Training of paralegals on identification and reporting of child abuse cases.
- Referral and linkage of abused children to service providers to access legal care and support
- Organization of international celebration days to support awareness raising for children, their families and community
- Organization of men's fora to address child protection and retrogressive cultural practices

Risks presented to children by the COVID-19 pandemic

Some of the child protection risks below are observed in the current COVID-19 pandemic and some are potential risks observed in previous infectious disease outbreaks.

Risks presented to children by COVID-19	Causes of risks
• Reduced supervision and neglect of children • Increase in child abuse and domestic/interpersonal violence • Poisoning and other danger and risks of injuries to children • Pressure on or lack of access to child protection services	• Childcare/school closures, continued work requirements for caregivers, illness, quarantine/isolation of caregivers • Increased psychosocial distress among caregivers and community members • Availability and misuse of toxic disinfectants and alcohol • Increased obstacles to reporting incidents
• Increased risk of sexual exploitation of children, including sex for assistance, commercial sexual exploitation of children and forced early marriage • Pressure on or lack of access to child protection/GBV services	• Reduced family protection of children • Reduced household income and/or reliance on outsiders to transport goods and services to the community • Girls' gender-imposed household responsibilities such as caring for family members or doing chores • Increased obstacles to reporting incidents and seeking medical treatment or other supports
• Distress of children due to the death, illness, or separation of a loved one or fear of disease • Worsening of pre-existing mental health conditions • Pressure on or lack of access to Mental Health and Psychosocial services (MHPSS)	• Increased stress levels due to isolation in treatment units or home-based quarantine • Children and parents/caregivers with pre-existing mental health conditions may not be able to access usual supports or treatments • Quarantine measures can create fear and panic in the community, especially in children, if they do not understand what is happening.
• Increased engagement of children in hazardous or exploitative labour • Loss or reduction in household income	• Opportunity or expectation to work due to school closure
• Separation • Becoming unaccompanied or child head of household • Being placed in institutions	• Loss of parents/caregivers due to disease • Isolation/quarantine of caregiver(s) apart from child(ren) • Children sent away by parents to stay with other family in non-affected areas
• Social stigmatization of infected individuals or individuals/groups suspected to be infected • Increased risk/limited support for children living/working on the street and other children already at risk • Increased risk/limited support to children in conflict with the law, including those in detention	• Disproportionate impact on more disadvantaged and marginalized groups • Closure/inaccessibility of basic services for vulnerable children and/or families • Disruption to birth registration processes due to quarantine

MESSENGER OF HOPE COVID-19

POSITIVE ROLE MODELS

- Lead by example ! (I) Encourage community members to serve as role models for their family, friends, and the community by following the advice on COVID-19 from the doctors, local health authorities, and the government.
- (I) Encourage your (my) children to practice healthy habits through songs and dances – This is helping them to feel more secure; to better understand how important is their action to prevent the spread of COVID-19; and to learn what meaningful connection is.
- We Youth Faith Leaders stand strong for health.
- Strong men stand – together in health for body and soul. As we pursue our dreams for ourselves, our family, our faith community, our nation!
- Love thy neighbour as yourself!

HOPE

- In the face of any challenge, we stand – in compassion, hope and love
- Be strong, courageous and hopeful! Tens of thousands of scientists are working around the clock; researchers are finding creative ways to donate their time, supplies and expertise to defeat COVID-19.
- The search for a COVID-19 vaccine has united the planet's scientific and medical communities in unprecedented ways. Let's unite in prayer to support their efforts!

LIFE

- We can have real hope in the face of COVID-19! Most cases of COVID-19 are mild; most people who contract COVID-19 recover; and every person can contribute to preventing new cases by taking simple steps like physical distancing, hand hygiene, covering the mouth and nose when coughing or sneezing, and wearing a face mask.
- Life is a gift of God that we have the privilege to share, protect and celebrate with and for our brothers and sisters.

CELEBRATION

- (We) Share the beautiful stories of health care workers, volunteers, and people who are recovering from COVID-19.
- There are ever stronger signs of hope and solidarity, a sense of, and desire for togetherness – This has to be celebrated! Share your stories of hope!
- Life is a precious gift from God. Seize every opportunity to cherish the life of those who have recovered from COVID-19

- In our faith community we welcome and celebrate health workers and people who have recovered from COVID19.
- Life is a precious gift of God and we are honoured to have people who have recovered from COVID-19 as members of our faith community !
- Real men celebrate health in body and soul!
- We celebrate your victory from recovery!
- We celebrate all front line workers!
- We share compassion and love for those who are ill: they are God's children who are to be celebrated. NEVER to be stigmatized.

CARING

- We all need to stay informed of the risks of COVID-19 so that we can protect and care for each other.
- Love your neighbor as yourself! By respecting governments' dispositions to stop the spread of COVID-19, we are loving our neighbor as God does.

- Don't' forget: by following the recommendations and measures to protect ourselves, our loved ones and our community from COVID-19, we help those working on the frontline such as nurses and doctors to better support people in need of care
- When I engage in visiting people who are sick, I make sure to wash my hands before and after the visit, and to keep physical distance, even when praying for others. National guidance for facial coverings are essential and we all must follow them!

INFLUENCE

We faith leaders are sharing prevention messages to stop the spread of COVID19. Let's live, hope, connect, care and celebrate together!!!

Lead from the front!

CONNECTION

- God is everywhere, He is not quarantined!
- We can be both physically distant AND socially connected – using phones, digital and virtual options.
- If you feel alone, contact us: in our faith community we have set up a support group where people can share their challenges and, together, we identify some solutions to help each other.
- Let's organize ways for community members to reach out to those who live alone or may be in need of food, water, or other supplies.
- In the time of COVID-19, it is the spirit of global togetherness that gives us hope – COVID-19 will be defeated once all people, in all countries, are protected – through our joint actions - from the novel coronavirus.

- Speak words of kindness and encouragement to your children. They have been heroes during these times!
- Your life matters! Safeguard it.
- Life is a precious gift; treat it as such – we protect ourselves and the members of our faith communities from COVID-19 by wearing face masks; practising regular hand washing; and avoiding large gatherings.
- Let's speak out against violence and abuse in our faith communities. Life is a Gift from God.

Preach hope messages!