MINISTRY OF HEALTH

GUIDANCE ON CONTINUITY OF ESSENTIAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC

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JULY, 2020
Updated Version 2

FOREWORD

Kenya is currently facing an unprecedented challenge, the COVID-19 Pandemic. Even as we enact measures to contain the transmission of the virus and reduce the numbers affected by the pandemic, we need to ensure that the many who rely on our health services do not suffer. During the Ebola pandemic in West Africa, there was a higher number of deaths caused by measles, malaria, HIV/AIDS, and tuberculosis, than deaths caused by Ebola. Special groups such as pregnant women, children, people living with disabilities, people with chronic illnesses and older people, may experience increased interruption of care caused by COVID-19, leading to high morbidity and mortality in the Country.

We need to ensure that our mothers and children continue to get the critical services that they require; and that those who require medication to manage chronic conditions such as Diabetes and Hypertension, do not suffer due to lack of access to services. Programme data is already showing low coverage of key interventions such as immunization, antenatal care, skilled birth attendance, children services etc. Which will result in poor outcomes for women and children.

Therefore, we have released this interim guidance to support the counties in provision of these essential services. Counties are advised to have a focal point to coordinate maintenance of essential health services in their COVID 19 emergency coordination structures.

As the COVID-19 pandemic in Kenya evolves, this interim guidance will be revised periodically to reflect emerging evidence and updates on the continuity of essential services.

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1.0 INTRODUCTION

This interim guidance seeks to advise healthcare managers and healthcare workers on the provision of Essential health care services during the COVID-19 pandemic in Kenya. This guidance should be used alongside all existing COVID-19 Infection prevention and control guidelines[1] and Case Management guidelines[2]. This document provides guidance on immediate actions that should be considered for the health system to reorganize and maintain access to essential healthcare services for all.

Specifically, the purpose of this guidance is to advise healthcare managers and workers to do the following during the COVID-19 pandemic:

Support healthcare facilities to maintain Essential health care services during the COVID-19 pandemic

Give practical solutions to challenges facing provision of health care services during the COVID-19 pandemic

Monitor Essential health care service provision throughout the COVID pandemic

Ensure continued supply and prevent stock outs of essential medicines, commodities and technologies, including those for chronic diseases and non-communicable conditions

Communicate appropriately to health care workers and the public regarding access to Essential health care services

As the COVID-19 pandemic in Kenya evolves, this interim guidance will be revised periodically to reflect emerging evidence and updates on the continuity of essential services.

1 https://www.health.go.ke/wp-content/uploads/2020/06/Updated-Case-Management-Guidelines-26_03_20-1.pdf
2 https://www.health.go.ke/wp-content/uploads/2020/06/Updated-Case-Management-Guidelines-26_03_20-1.pdf

2.0 BACKGROUND

Corona virus disease (COVID-19) is a highly infectious respiratory disease caused by a newly discovered coronavirus (severe acute respiratory syndrome coronavirus 2 or 'SARS-CoV-2'). The first case of the novel Corona Virus disease was reported in China in November 2019, first appearing as a cluster of atypical pneumonia cases and deaths[3]. COVID-19 was first identified in Wuhan, China in December 2019 and was declared a global pandemic by the World Health Organization (WHO) on 11 March 2020. COVID-19 is spread from person to person through small droplets from the nose or mouth expelled when one coughs or exhales droplets. The most common symptoms of COVID-19 include fever, dry cough, body aches/ pains, sore throat and diarrhoea. Since then, the disease has spread to 209 countries, with 10,185,374 cases, 503,862 deaths recorded worldwide as at 30 June 2020[4]. The first COVID-19 case in Kenya was confirmed on 13th March, 2020[5] and we have since recorded 6,366 cases, 148 deaths and 2,039 recoveries (as at 30th June, 2020)[6].

Measures taken to contain the pandemic have included banning of public gatherings (including religious sites) and meetings, wearing of masks in public places, stopping flights, enforced quarantine of international travelers, curfew and restricted movement of people in the COVID-19 high-incidence counties of Nairobi, Mombasa, Kilifi, Mandera and Kwale[8].

These Interventions have been hitherto successful and have slowed down the rate of SARS-COV-2 transmission in the community, but unfortunately, have come with a different set of challenges. These include;

- Suspension of elective surgeries and procedures- 25th March, 2020(9)
- A drop in outpatient visits in most health facilities
- Reported cases of maternal and children's deaths occuring due to the curfew
- Cases of health care workers afraid of serving patients suspected of having COVID-19
- Disruption to routine health services such as Immunization and antenatal clinics
- Disruption of routine management services for persons living with non-communicable diseases such as cancers, diabetes, chronic respiratory diseases, heart diseases including hypertension, mental health, violence and injuries.
- Diversion of Human resource and commodities to deal with the COVID-19 pandemic
- Income and job losses reducing access to some healthcare services
- Food insecurity resulting in increase in cases of Severe Acute Malnutrition
- Restriction of movement and the Stay at Home recommendations

may result in increased food intake among those with access, which may result in increase in overweight/ obesity and the resultant diet-related Non-communicable Diseases

The SARS-COV-2 transmission and mitigation measures may subsequently place vulnerable people seeking health care services at greater risk. Analysis of the 2014-2015 Ebola outbreak suggest that deaths caused by measles, malaria, HIV/AIDS, and tuberculosis, attributable to health system failures, exceeded deaths from Ebola(10,11). Special groups such as pregnant women, children, people living with disabilities, people with chronic illnesses and older people, may experience increased interruption of care caused by COVID-19, leading to high morbidity and mortality in the Country. Furthermore, COVID-19 symptoms are noted to be more severe in older persons as well as persons with pre-existing medical conditions, in particular non-communicable conditions (such as high blood pressure, heart disease, lung disease, cancer or diabetes). This therefore means that there is need for health care workers to purposely screen clients for any underlying non-communicable conditions or exposure to major risk factors such as tobacco use, alcohol use, physical inactivity and poor nutritional diets and manage them appropriately.

A system's ability to maintain delivery of essential health services will depend on the baseline capacity of the health system, burden of disease and the COVID-19 transmission context.

It is therefore critical to ensure that Kenyans don't suffer more morbidity and mortality from the lack of access to Essential health services(12).

This explains the need to put measures in place to guide continuity of Essential health service provision at health care facilities.

3.0 ESSENTIAL HEALTH SERVICES

3.1 Definition of Essential Health Services

Essential health services are designed to prevent communicable disease, avert maternal and child morbidity and mortality, prevent acute exacerbations of chronic conditions by maintaining established treatment regimens, and manage emergency conditions that require time-sensitive intervention.

In the context of the COVID 19 pandemic, the Kenya health system is confronted with a rapidly increasing demand for care and treatment. This burden is expected to continue as more people require treatment and care for the disease. The increasing demand has the potential to overwhelm the system leading to increase in both direct mortality from the pandemic and indirect mortality from vaccine-preventable and treatable conditions. To mitigate and cushion the health care system, the Country has identified and prioritized a package of essential health services. Counties should plan to ensure that these services are maintained even during the COVID-19 response.

Table 1: List of Essential Health Services

SERVICE AREA	ESSENTIAL SERVICES
Trauma Care Services	· Co-ordination with the pre-hospital care team · Clinical and radiological diagnosis of trauma and basic laboratory services · Basic first aid, Emergency Trauma care · Minor surgery · Rehabilitative services and application of plaster/ splints · Appropriate referral following pre-determined algorithmic referral protocols · Counseling and psychosocial services
Inpatient services	· Management of the acutely ill patient
Vaccine and immunization services	· Routine immunization services - on appointment where possible · Mass vaccination campaigns (outreach, mobile or similar) should be temporarily suspended**
Family Planning services	· Counselling and provision of FP methods including emergency contraceptives

Antenatal, maternity and postnatal services	· Screening and assessment · Supplementation (Iron and Folic acid, calcium) · Intermittent Presumptive Treatment for Malaria-endemic areas · Pre-term labour management (Corticosteroids, antibiotics for pPROM, tocolytics) · Complications during pregnancy (Pre-eclampsia, fever (due to infections) · Abnormal pregnancy management (Ectopic pregnancy, molar pregnancy, spontaneous abortion) · Labour induction and monitoring · Normal Vaginal Delivery and Caesarean Section · Obstetric emergencies (Eclampsia, Shock, Post-Partum Hemorrhage, Premature Rupture of Membranes) · Counselling on infant feeding: Exclusive Breastfeeding, and complementary feeding
Newborn and child health services	· Neonatal care services · Management of common childhood illnesses (pneumonia, malaria, diarrhoea) · Management of chronic illnesses (e.g. Diabetes, Asthma, etc.) · Growth monitoring · Deworming · Identification of delayed developmental milestones and children with special needs, including rehabilitation
Nutrition services	· Early detection of acute malnutrition and referral · Management of acute malnutrition and other nutrition related disorders · Hospital inpatient nutrition services · Nutrition counseling using no risk delivery methods e.g telephone · Vitamin A Supplementation · Iron and Folic Acid Supplementation · Issuance of Micronutrient Powders (MNPs) · Growth monitoring and promotion · · Healthy diet promotion · Integrated outreach services in arid and semi-arid counties
Auxiliary services	· Basic diagnostic imaging · Laboratory services · Blood bank services

Chronic non communicable disease services; including mental health services	· Provision of medication (drug refills) · Nutritional management of NCDs · Exacerbation and complications to be managed as per emergency care · Renal dialysis · Outpatient clinics should continue running · Counselling on avoidance of risk factors including tobacco cessation services · Continued provision of cancer treatment to patients in need as safely and as justly as possible, including Chemotherapy & Radiotherapy

3.2 Provision of Essential health services at Different Stages of the Pandemic

It is expected that different counties in the country will be at different stages of the pandemic at different points in time. This will necessitate that provision of essential services is phased, according to the stage of the pandemic, and may occur in two different scenarios;

3.2.1 Current scenario

Ongoing community transmission but with few predominantly mild cases in key hotspots.

In this case, all health services should be maintained as much as possible, since there are practical ways of separating COVID-19 cases at this stage without overwhelming the health system.

3.2.2 Scenario 2-Rising number of cases

In this scenario, as number of cases rise, reassign facilities and staff to deal with surge in suspected COVID-19 cases. This should be planned in advance using analysis of caseload and capacity of health facilities to deal with the increase in morbidity.

In case of scenario 2, Level 4 facilities may reassign HR, space etc. to deal with a surge in moderate and severe cases of COVID-19 which may not be the case in lower level facilities.

Sub-county and county HMTs should have the overall picture of the load and capacity of health facilities. Information sharing mechanisms should be enhanced to direct patients in case some facilities are already overloaded. In addition, CHMTs should plan for catch-up campaigns that will be required for services that are suspended e.g. immunization

3.3 Considerations for Resumption of Normal services and elective surgeries

Timing of resumption: There must be a sustained reduction in rate of new COVID-19 cases in the relevant

geographic area for at least 14 days before resumption of elective surgical procedures and normal services, and the facility shall have appropriate number of intensive care unit (ICU) and non-ICU beds, personal protective equipment (PPE), ventilators and trained staff to treat all non-elective patients without resorting to a crisis standard of care.

The following should be considered;

- Does the facility have appropriate number of ICU and non-ICU beds, PPE, ventilators, medications, anesthetics and all medical surgical supplies?
- Does the facility have available numbers of trained and educated staff appropriate to the planned surgical procedures, patient population and facility resources?
- Can the facility perform planned procedures without compromising patient safety or staff safety and well-being?

4.0 STRATEGIES TO ENSURE CONTINUITY OF ESSENTIAL HEALTH SERVICES

4.1 Coordination and planning

The National Covid -19 response has established an incident management team (IMT) to coordinate and guide the outbreak response. Also established at the national level is the maintenance of essential health services (MEHS) working group to guide the continuity for essential services.

The MEHs working group has designated focal persons who report back to the IMT for coordination and communication purposes between the 2 teams. Counties are advised to establish similar coordination structures within their existing HMTs. HMT meetings should be virtual and more frequent to address any issues that may arise. They should also provide a manager to be on call to address any challenges in service delivery.

The coordination teams should support visits to the facilities and allow for faster modes of communication from facilities where possible.

Other additional responsibilities will include: review of data collection mechanisms to ensure optimal collection and use of the data to inform decision making; discussions on pre-position of medical supplies due to movement restrictions and availability

should be held, so that stock outs are not experienced.

The team should also establish and maintain coordination mechanism between finance and health authorities to ensure adequate financing for essential services and facilitate responsive adaptation and restoration of services.

4.2 Delivery of Essential health Services in different contexts

The settings where specific services are delivered may need to be modified to ensure safe provision of routine services It is recommended that counties designate teams that can ensure that routine health services continue, preferably in the primary care facilities. Some services such as radiotherapy, dialysis etc. may need to be provided in higher level facilities. Below are additional points to consider:

- It is important that the healthcare workers in these facilities are also trained on COVID-19, case management and referral of patients. This is because as community transmission of COVID-19 increases, patients will present to facilities that are not designated as 'COVID-19 isolation' sites, with other conditions.
- Adequate supplies of PPEs at all health facilities should be ensured to protect health workers and the community. (Refer to the Guidance on Rational Use of PPEs)
- All health facilities should designate triage area and respiratory cohort areas.
- The triage area should be located in an open area preferably at the entrance to the facility. This will require at a minimum an infrared thermometer, surgical masks for patients with respiratory symptoms and PPE for the health workers (surgical mask, face shield). Will also requires job aides (posters, triage forms that reflect the case definition), patient information material (posters, pamphlets etc.)
- The respiratory cohort area should be in an open area or a room with good ventilation. It will ideally be a waiting area for those who fit the COVID-19 definition to be reviewed by county Rapid response Teams. All patients in this area must be in surgical masks. The area should have its own sanitation facilities.
- Ensure staffing of the primary care facilities with cadres that can support the provision of chronic care in the e.g. Medical officers in the health centers. These areas can be covered by medics who are unable to be at the frontline for medical, health reasons or age.
- Healthcare workers should be supported at this time to ensure their safety even as they are at work. Ensure that the primary care facilities have triage areas, donning/doffing area for staff as well as call room for staff who are on night call.
- Public health messages need to be adapted to make sure that people

do not delay seeking care for potentially life threatening illnesses especially in settings where high-burden infectious diseases have signs and symptoms overlapping with Covid-19 case definitions e.g. malaria, pneumonia or TB.

Different methods of delivering services have been proposed; these may be tailored to the local context;

- Appointment-based clinics- contacts may be given to the community to schedule appointments
- Increase operational hours for the clinics in facilities and encourage shifts for the health-workers
- Staff may work in teams to ensure adequate support
- Telephone consultations and follow-ups e.g. the HIV *m-shauri*
- Longer duration between appointments
- Dispensing larger quantities of drugs, community ART group distribution
- Emergency referral- CHVs working with security personnel, NGAO to support clients during curfews
- Outreaches- with a minimal/no touch policy; especially for special groups who may be unable to access health facilities and require isolation, like the elderly or in special considered areas such as the Arid and Semi-arid regions.

Rapid assessments at both the national and county level are recommended to guide strategic choices about policy and protocol changes, taking into account that pre-existing gaps in service delivery may be exacerbated during the outbreak.

4.3 Reorganization of Patient Flow

Health facilities are advised to organize patient flow to ensure physical distancing and provide guidance for patients and staff e.g. through drawings of clear areas. Maintenance and enhancement of IPC measures e.g. handwashing stations at entrance and exit of health facilities, routine environmental decontamination e.g. around the health facility and in key areas and physical distancing measures are to be put in place.

Health facility staff are also advised to change protocols for key groups to allow for reduced patient-doctor contact e.g. giving longer duration between clinical appointments for patients with stable chronic conditions including HIV, giving prescriptions to last longer periods of time as well as to avoid group counselling sessions.

Other measures that facilities and private clinics should implement include those for isolation sites as mentioned in the Case management guidelines and include:

- Avoid crowding at the patient waiting area ensuring the 1-meter distance between patients is maintained.
- Ensure the waiting area is well

ventilated.

- Any over-flow of patients should be advised to wait outside in an open space until their appointment time arrives.
- The clinicians, nurses and receptionist staff must avoid shaking hands with the patients and each other.
- Encourage use of electronic money transfer services for payment of clinical services
- The clinician must wash his hands thoroughly with soap and water, before and after coming into contact with each patient.
- Frequently decontaminate all surfaces and equipment using 0.5% chlorine

4.4 Referral systems

Counties should ensure that Referral services are available within communities for those who need to access emergency care at night. Partners can support specific population like pregnant women by mapping out -with the support of community health workers -those who may require these services.

All sites need to be ready to assess and refer patients appropriately to reduce the transmission and ensure the rational use of scarce advanced-care resources.

Referral systems should be organized away from COVID-19 isolation facilities:

a. All persons within county with COVID-19 symptoms should be encouraged to call 719 or the county rapid response team/disease surveillance officer

b. The RRT should go to the persons home to assess for COVID-19 symptoms

c. Where patients present at non-COVID-19 facility

   i. They should be identified at the triage area and held in the respiratory cohort area for review by the RRT

   ii. If identified in the facility, the clinician should immediately leave the room, perform IPC/ hand-washing; continue communication while outside the room, and call the RRT to retrieve the patient. The clinician/facility may then be quarantined in keeping with agreed guidelines

There may be need to separate ambulance services so that vehicles used for COVID-19 response are not used for other response. If the same vehicles have to be used, ensure adequate disinfection as per IPC guidelines(1).

Health facilities should establish clear criteria and protocols for targeted referral and counter-referral pathways within the public system and among public and private providers

4.5 Sensitization and Training of all Staff on COVID-19 Preparedness

Many counties could be faced with health workforce challenges, which may limit their availably to provide essential health services during the outbreak. Mechanisms to identify additional health workforce capacity should be identified. Some of these have already been instituted, including the hiring of additional health workers.

Health workers capacity in both the pandemic response and provision of essential health services should be strengthened and optimized.

Counties should initiate rapid training mechanisms and provide job aids for key capacities including screening, triage, clinical management, supply chain management, use of digital tools and essential IPC measures.

In training:

- Counties should leverage on internet/mobile-based platforms to avoid gatherings as they train staff on new triage measures and preparedness for COVID-19. A lot of virtual trainings are currently running at the national level, supported by the Ministry of Health and various professional associations. County health departments, with the support of implementing partners should support health-workers to log in to these trainings. Time should be allocated to these virtual learning sessions.
- Practical sessions to demonstrate important skills such as donning and doffing Personal Protective Equipment and handwashing may be required and can be carried out for small groups of health care workers in the facilities.
- Highlight the need to purposely screen for any underlying non-communicable conditions or exposure to major risk factors such as tobacco use, alcohol use, obesity, physical inactivity and poor nutritional diets and manage them appropriately.
- Ensure that support staff such as security, catering teams and cleaners are included in the sensitizations.

Healthcare professionals with pre-existing chronic conditions such as diabetes, hypertension, renal disease, etc. should be deployed away from frontline COVID-19 clinical duties where possible. Counties should map need for health workers and align rosters and plans for different pandemic scenarios.

Critical support measures include ensuring appropriate working hours and enforced rest periods; providing guidance, training and supplies (including PPE in appropriate sizes for women) to limit health worker exposures; monitoring for illness and stress; ensuring physical security; providing access to mental health care and self-help materials; and ensuring timely payment of salaries, sick leave and overtime, including to temporary staff to eliminate perverse incentives for staff to report to work while ill. Offering accommodation to reduce

staff travel time and protect health workers' families from exposure may be appropriate.

(Refer to the Human Resource for Health Guidance during the COVID Pandemic[3]) for more details on the human resource for health.

4.6 Adequate Supplies and Commodities

Counties need to map supplies and supply chains for essential medicines, and other health products and technologies. Counties should ensure that forecasting and quantification of essential drugs and nutrition commodities is done to ensure minimal disruption of essential services. Facility SOPs on drug refills for NCDs should be adjusted in consideration of need for bigger refills and longer periods between clinic visits. In addition, counties should adequately quantify and make available supplies of PPEs, sanitizers, soap and disinfectants for the Primary care facilities is done. Frequent checks should be made to ensure availability of health products.

4.7 Financing health services

The goal of Health Financing for the health system in this period of COVID-19 pandemic is to ensure that enough resources are mobilized for provision of health services to the population be it those affected by COVID -19 as well as for continued provision of Essential Health services. Additionally, the aim is to ensure financial protection to the population as they seek essential health services.

As such critical priorities for the health system to enhance health financing at both National and county level shall include;

- Mobilization of financial resources from Government (National and county level) and from other stakeholders working in Health
- Redistribution of the financial resources. This may call for adjustment of work-plans in-order to prioritize critical areas of service delivery including services related to COVID-19 as well as other essential Health services. The health facilities shall require additional funds to be able to run efficiently as they provide essential health services as well services to the COVID patients
- County Governments need to Ensure that finances flow to the point of Use. This calls for ensuring that there is timey release of funds to the health facilities; -Health centers; dispensaries and hospitals
- The Government both National and counties need to ensure that any barriers that may hinder budget execution are removed.
- The National Health Insurance Fund (NHIF) will play a critical role in ensuring continued provision of essential health services. NHIF continues to provide insurance cover to the Kenyans in the different schemes such as the National scheme and the managed schemes. NHIF being a membership health insurance organization pays

3 https://www.health.go.ke/wp-content/uploads/2020/06/PROTOCOL-HRH-for-COVID_Draft-with-digital-signature.pdf

facilities for treating members who are hospitalized. The Fund shall continue paying declared and contracted healthcare facilities for services offered to active beneficiaries in line with procedures and contracts.

- NHIF should also ensure that reimbursements to the health facilities are done in an efficient and timely manner. The NHIF has provided guidance on the access to pre-validation of procedures during this period. As the country gears up to scale up Universal Health Coverage, the defined Essential Health services need to be included as part of the UHC benefit package so that Kenyans continue accessing the services without the risk of financial hardship.

4.8 Strengthen Monitoring and Evaluation

A team should closely monitor essential health services at both the national and county level. This team should advise the COVID-19 Rapid response team to ensure that measures are taken to maintain essential health services based on available data and health information. Both the national and county health authorities should regularly track, analyze and report on the utilization and delivery of agreed essential health services.

The provision of essential health services should be tracked, as far as possible, using indicators from existing health information platforms, including routine health information systems (DHIS II), rapid health facility assessments, vital statistics system (including mortality registers) and modelling efforts. Rapid assessments may be carried out as is necessary to ensure that services are carried out as efficiently as possible. Reports should highlight any service disruptions and adjustments to be made, such as planning catch-up strategies etc.

Counties should continue tracking service data and sharing their service delivery score cards with all stake holders to flag any issues and inform the provision of essential services

(Refer to Standard operating procedures for handling Health Record and Information Management during the Pandemic[4])

4.9 Communication

Specific communication should be made by the county health management teams regarding availability of Essential health services. Successful implementation of these guidelines will require frequent communication with the public, and active engagement of communities and other stakeholders.

- Ensure there is adequate communication from the top and all the way the community, on the continuity of standard services – in liaison with the Communication and health promotion sub-committee

4 https://www.health.go.ke/wp-content/uploads/2020/05/Guidelines_HRIO-Management-COVID-19-final-28.04.2020-1-1.pdf

- Support the Cabinet secretary's office to infuse in the daily announcements, the call for communities to seek essential services as per the guidelines developed by the Ministry
- County health management teams should continue to provide clear information and reassurance to the public about the availability and safety of standard health services, using diverse communication channels such as radio, TV, video messages that can be shared via WhatsApp, SMS and direct follow up with patients/clients.
- Enhance community feedback mechanisms to inform communication messaging
- Track rumors linking health services and health facilities to COVID-19 and reinforce existing risk communication mechanisms
- Address any concerns related to the stigmatization of health workers, COVID-19 clients, survivors and their families
- Leverage current communication opportunities on COVID prevention to share information on specific standard health services.

4.10 Use of digital platforms

Exploration on the use of available and innovative digital platforms is recommended to allow health systems better manage Covid-19 and maintain essential health services. Digital modalities can be used to rapidly share and exchange targeted information, whether for training, enabling peer-to-peer communication or implementing surveys.

Such include:

- Telemedicine solutions for clinical consultations conducted via video chat or text messages
- Digital applications (such as zoom, Teams, webex, ECHO) for rapid in-service training in key areas for health care workers
- Mechanisms to implement electronic prescriptions (e-prescriptions) among public and private pharmacies and suppliers
- Creating a central, up-to-date and reliable website or digital messaging portal for disseminating information to both the health care workers on key guidance (such as shared folder on available guidelines and job-aids) and to the public on providing guidance on safe care-seeking behavior.

4.11 Summary on Preparedness for COVID-19 for Health facilities

General guidelines for preparedness, as stated in the COVID-19 case management guidelines [2] should apply to all health facilities, including those not designated as COVID isolation sites.

Where appropriate, facilities should ensure the following:

- Establish clear screening, isolation

and referral of presumptive COVID-19 patients using existing MOH COVID-19 guidelines

- HCW and the clients should strictly follow the IPC and Physical Distancing guidelines to prevent transmission of COVID 19 during provision of these services
- Limit number of healthcare worker encounters (e.g: appointment-based services, supply chain management for medications etc)

Health system managers should ensure that the following steps are taken in the course of preparation;

- Coordination mechanisms at the sub county level that should include continuity of services
- Form a coordination mechanism for service delivery that includes state and non-state actors and stakeholders.
- Map health facilities: both public and private, that can be used to access Essential health care services. Identify which facilities are COVID-19 case-management facilities and which are not. A county directory may be prepared, including where specialized health services may be obtained and emergency contacts to use. This should be availed to all health managers in the county.
- Map health workers (including unemployed or retired) and other staff (e.g. from the military, police, Red Cross etc.) who could be mobilized for the response
- Ensure efficient communication between health care managers at the facility level as well as county and subcounty
- Establish linkages where necessary with other counties or with national level to address capacity gaps including establishing evacuation plans
- Allocate resources to key expenditures including;
  - Payment of salaries, allowances, incentives, and salaries for temporary workers
  - Medicines and consumables including PPEs
  - Referral systems e.g. fuel for ambulances
  - Tents for triage areas, respiratory cohort areas
  - Handwashing stations at entrance/exit to all health facilities
  - Environmental decontamination (knapsacks, disinfectant)
  - IPC materials for health facilities: chlorine tabs etc.
  - Key utilities e.g. water
- Lab referral systems and logistics,
- HIS systems to ensure continued reporting and monitoring of Essential health services

5.0 LIFE COURSE AND DISEASE CONSIDERATIONS DURING THE COVID-19 PANDEMIC

5.1 Newborn and Child Health Services

The Division of Neonatal and Child Health has given guidance highlighting management of COVID-19 in pediatrics[13]. Studies have shown that children get less severe COVID-19 disease than adults and that mortality and critical illness are rare (Dong et al., 2020). The highest risks that children will face during this period will be from lack of access to the routine child health services. Health workers should encourage all mothers to breastfeed their babies, even as they adopt all Infection, prevention and control measures and reduce visitors to the new-born units. Children with chronic health conditions such as heart disease, asthma, sickle cell disease should be closely monitored and followed up routinely.

It is important to ensure that child health services such as immunization continue through this period, and immunization campaigns are organized after the pandemic in order to ensure fully immunized children. A fully vaccinated child is also more likely to be protected from vaccine preventable diseases and possible complications of COVID-19.

5.1.1 Recommendation for infants and children

1. Children with indrawing pneumonia as per Integrated Management of Childhood Illness (IMCI) should be prioritized for COVID-19 testing. This should not delay the management of the indrawing pneumonia .
2. Routine paediatric outpatient clinics may be postponed but ensure that those who can get refills for medications of chronic illnesses are well covered.
3. Vitamin A supplementation and issuance of Micronutrient Powders should be integrated with other health care services
4. Where possible, a designated caregiver should refill the prescription of the child without going with them to the health facility. Where the child is unwell:
    a. One designated caregiver should bring the child to the hospital.
    b. The contact time with the child should be as minimal as possible but adequate for quality service provision.
    c. There should be provision of protective gear for all the

health care workers attending to children in line with the IPC guidelines.

d. Provision of hand hygiene and disinfectants for equipment/ devices and surfaces/ examination areas.

5. Routine immunization services should continue countrywide with preferential use of smaller less crowded levels 2 and 3 facilities to reduce exposure of children and care givers.

6. High volume health facilities that are not being used as COVID isolation centres may continue to provide routine immunization services. To minimize SARS-COV-2 transmission risk, these facilities should set up separate space for routine immunization akin to an out-reach post service

7. As much as possible, mothers should be given specific scheduled appointments for routine immunization.

8. Infants and caregivers coming for immunization services should be triaged for possible exposure and appropriately directed to a point of care. (See attached algorithm- Appendix 8)

9. Community Health Volunteers (CHVs) should be deployed to mobilize mothers to continue seeking immunization services.

10. Preparation for possible catch-up immunization activities upon the end of COVID- 19 pandemic should be done.

11. There should be continuous communication on availability of health services as well as emergency immunization strategies at all levels.

(Please refer to the Kenya pediatric COVID-19 guidance[5] for more details)

5.2 Reproductive and Maternal Health Services

The Division of Reproductive and maternal health has provided guidance on services for women that must continue through this period(14).

The following is included in the guidance:

1. Access to antenatal, labor and postnatal services should be supported by all county health teams, in collaboration with administration (Min. of interior and Coordination of National government) to ensure security.

2. Clinic visits for antenatal care may be reduced to 4 face to face visits where feasible, supplemented by telephone consultations.

3. Emergency services should include support for Sexual and gender-based violence, cases which have notably increased during the COVID-19 pandemic.

(Please refer to the RMNH COVID-19 guidance[6] for more details)

5 https://www.health.go.ke/wp-content/uploads/2020/06/PAEDIATRIC-Covid-Guidelines-Final.pdf
6 https://www.health.go.ke/wp-content/uploads/2020/04/KENYA-COVID19-RMNH.pdf.pdf.pdf

5.3 Nutrition and Dietetics Services

Nutrition plays a key role in improving immunity of an individual, lowering the risk of chronic illnesses and infectious diseases and in speeding recovery from illnesses including, COVID-19. Therefore, during the COVID-19 pandemic it is important to maintain delivery of essential nutrition services such as nutrition counselling, growth monitoring promotion, micronutrient supplementation (Vitamin A and micronutrient powders for children, Iron and Folate for pregnant women) early detection of acute malnutrition and referral, management of acute malnutrition and other nutrition disorders and integrating nutrition and dietetics care in the management of the diseases.

The Division of Nutrition and Dietetics has developed guidance on maintaining healthy diet during the COVID-19 pandemic and nutrition management of nutrition relevant signs, symptoms and conditions. Additionally, Interim guidance for Continuity of nutrition services delivery provides direction for delivery of the following nutrition services:

1. Inpatient and outpatient care for severe and moderate acute malnutrition
2. Hospital inpatient nutrition services
3. Targeted supplementary feeding programme
4. Micronutrient supplementation
5. Maternal, Infant and Young Child nutrition services
6. Health diets promotion
7. Integrated outreach services

(Please refer to the INTERIM GUIDANCE ON CONTINUITY OF NUTRITION SERVICES[7] for more details)

5.3 Health services for Older Persons

Persons aged 60 years and above have a higher risk of becoming severely ill with the Covid-19 virus. The reasons why some older adults are particularly vulnerable during and after disasters include their impaired physical mobility, diminished sensory awareness, chronic health conditions, and social and economic limitations that prevent adequate preparation and hinder adaptability during disasters.

During an infectious disease pandemic, like Covid-19, malnutrition rates can increase sharply, leading to even higher mortality rates. Where physical distance policies do not consider the specific challenges and conditions faced by older persons, food insecurity becomes a key concern, especially for older persons who are quarantined, isolated and without safety nets and with limited funds to access the market. Older people, especially in isolation and those with cognitive decline, dementia, and those who are highly care-dependent, may become more anxious, angry, stressed, agitated, and withdrawn during the

7 https://www.health.go.ke/wp-content/uploads/2020/06/INTERIM-GUIDANCE-FOR-CONTINUITY-OF-NUTRITION-SERVICES-IN-THE-CONTEXT-OF-COVID-19-PANDEMIC-_APPROVED.pdf

pandemic or while in isolation.

Physical, sensory and cognitive impairments become more prevalent and older people can develop complex health states, such as frailty, urinary incontinence and an increased risk of falling.

Some of the factors associated with the aging process that might affect an older adult's ability to respond in an event are described below.

Sensory, Physiological, and Cognitive Changes: An older person's sense of smell, touch, vision, or hearing likely has declined over time. This can make it difficult for the older person to communicate and for emergency responders to understand the older person's needs. People with visual impairments are often reluctant to leave familiar surroundings which may be necessary during this period. People with dementia may become agitated during a crisis, especially if they must leave their usual environment or get their services interrupted.

Chronic Conditions: Older adults are more likely than younger people to have chronic diseases, functional limitations, or a weakened immune system. Conditions such as arthritis make it difficult to stand in line or walk very far in search of essential services. To treat chronic conditions, older adults tend to take multiple medications. Interruptions in medication regimens can exacerbate underlying conditions and increase the risk of morbidity or mortality. Older adults who take several medications are at increased risk of drug interactions if they also receive antibiotics or other medications following a public health crisis.

Risk of Trauma: A lifetime of accumulated losses — such as deaths of family members and friends, declines in physical capabilities, losses of vital roles in the workplace and community, and reduced incomes — can make older adults more vulnerable to trauma during a crisis. Post-traumatic Stress Disorder (PTSD) is common and characterized by severe anxiety, significant sleep problems and nervousness, functional impairment, and avoidance of anything connected with the event. Because older adults are often reluctant to seek or accept mental health services — which they tend to associate with spiritual or personal failure, they may not obtain the needed assistance in good time.

Transportation: Many older adults are unable to move in search of basic needs. Some are unable to drive or no longer own a car. Others live alone or in rural areas with inefficient public transportation. Even if older people live in areas with public transportation, some are unable to use available transport which is not age friendly.

Limited Resources: Many older adults living on fixed incomes or living from hand to mouth may not be able to seek basic services due to lack of resources due to the need to stay at home for prevention during this period. This means that older persons could die due to other reasons like lack of food.

Nutrition: Older adults face health risks from inadequate nutrition during public health events like the

current pandemic. When providing pre-packaged food to older adults, responders need to offer shelf-stable meals.

Fraud and Abuse: Fraudulent contractors and "con men" who exploit victims financially during a public health event often target older people. In addition, older adults are particularly susceptible to physical and mental abuse as family stresses increase in later stages of such unexpected events.

5.3.1 Recommendations for care of Older persons

a. **Communication:** Older persons face barriers to community engagement, whereby they may not be able to gain access to information about protecting themselves and accessing relevant services, which can aggravate exclusion or marginalization experienced by some older persons. Such barriers include language barriers, especially among speakers of minority languages or older persons with high levels of illiteracy, or lack of access to technologies. Such segregation also has the potential to accelerate cognitive decline hence activities that are engaging should be maintained during the public health event.

b. **Supplies:** Uninterrupted provision of drugs for chronic conditions, adult diapers, assistive devices among others need be maintained.

c. **Surveillance:** Behavioral Risk Factor Surveillance System (BRFSS), a random, digit-dialled telephone survey of noninstitutionalized adults, to collect data on health conditions, treatments, supplies of medicines on hand, and access to health services or treatment facilities.

d. **Outreach and training:** Outreach services for older persons will include a rapid geriatric assessment and care plan that will be done while maintaining both physical and social distancing and not social isolation. This is important so as to support the older persons remain healthy and perform early diagnosis.

e. **The Rapid Geriatric Assessment** should include;

- Frailty
- Sarcopenia
- Nutrition status
- Depression
- Cognitive decline
- Incontinence
- Hearing and sight challenges
- Advance directive

6.0 CONSIDERATIONS FOR SPECIFIC HEALTH SERVICES

6.1 Mental health Services

As COVID-19 continues to spread, the main psychological impact is elevated rates of stress or anxiety. Measures such as movement restrictions have effects on many people's activities and levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behaviour may rise. Mentally ill persons form a population of vulnerable groups and their care during this pandemic shall require special consideration. In addition, the mental health and well-being of frontline workers is now a major concern.

In light of the COVID-19 pandemic and restrictions imposed by the Government;

1. Out-patient services for stable patients should be minimized and widely spaced by providing long term prescriptions of 3 to 6 months, to reduce exposure. These medications should be issued by pharmacies as per the clients' order within the prescription valid duration.
2. A call to the health care provider/ health facility is preferable. In case this is not possible, the client should go to the hospital alone, or with a preferred supporter, relative or care-giver well versed with the patient's condition, all of whom should wear masks.
3. Referrals can also be done by telephone, video or electronically.
4. All records of visits/consultations of the patient should be well kept, whether face to face or electronic.
5. The Methadone Assisted Therapy (MAT) Clinics which are stationed in selected health facilities within the country, are run daily and have specific guidelines tailored to each facility.
6. There is currently access to telephone counseling through the 719 and 1190 contacts for the general public as well as health workers who are affected by the pandemic. These services should be linked to county facilities where emergency psychiatric services are available to clients.

See list of hotlines and contacts to check available mental health services in Annex 3

(Further guidance may be found in the following documents: Final guide for mental and psychosocial services during the COVID-19 pandemic, Mental Health Guide for COVID19 response in Kenya[8] and SOPs for Psychologists and Counsellors during the COVID-19 Pandemic[9])

8 https://www.health.go.ke/wp-content/uploads/2020/05/GUIDE-ON-MENTAL-HEALTH-AND-PSYCHOSOCIAL-SUPPORT-DURING-THE-COVID-19-PANDEMIC-compressed.pdf

9 file:///C:/Users/rakuomi/Desktop/COVID Resources/Guidance/Current Document/SOPs for Psychologists and Counsel-

6.2 Communicable Diseases

6.2.1 HIV Services

The management of HIV as a chronic care model may place them at a better place in regards to service provision during the COVID-19 Pandemic. Differentiated service delivery, models that assist service delivery such as follow up of clients through mobile phone such as m-shauri and community ART delivery for groups have been adopted in many HIV clinics. Characterization of clients into stable and unstable has been done in most centers and would guide follow up of these clients.

Guidance has been given by the Division of National AIDS and Sexually Transmitted Illnesses Programme (NASCOP)[15] and includes;

a. Increase duration between appointments

b. Give clients prescriptions including commodities for managing malnutrition for longer durations.

c. Any unnecessary ARV regimen switches should be suspended for this duration.

d. Pharmacists should ensure that stocks of ARVs are sustained through this duration through reports and adequate quantification to adhere to the guidance.

e. Support groups for certain clients like adolescents and pregnant women can be encouraged to continue via virtual methods.

6.2.2 Respiratory Infections such as Pneumonia and Tuberculosis

A lot of delays in attending patients presenting with symptoms of acute respiratory infections are being experienced, which may lead to higher mortality from diseases such as Pneumonia and Tuberculosis. All healthcare managers should ensure that healthcare workers have access to adequate PPE to manage patients presenting with all other respiratory illnesses. Adequate history should be obtained in these patients in order to adequately manage them.

TB: Currently, there are no studies for COVID among patients infected with TB, but chronic respiratory illnesses, which may be caused by delay in treatment of TB, are a known risk factor for morbidity and mortality from COVID-19. Presently, delays caused by testing patients presenting with symptoms of acute or chronic respiratory illness for COVID-19 may result in delays in diagnosing and treating Tuberculosis. Guidance has been given by the Division of tuberculosis and lung diseases on management of TB during COVID-19 and should be used to support services [16].

6.2.3 Recommendations for persons with respiratory infections;

a. All patients being evaluated for acute respiratory infections such as Pneumonia, and Tuberculosis should also be evaluated for COVID-19.

b. COVID-19 Testing and results should not delay management of acute respiratory infections.

c. Stability of TB patients should be assessed using set criteria

lors during the COVID-19 Pandemic

so as to determine frequency of hospital visits

d. Reduction of frequency of monitoring visits for TB patients who have completed at least 1 month of treatment

e. Follow ups-through telephone consultations for clients already on TB treatment, or patients with other conditions and moderate symptoms who have been sent home.

6.3 Non Communicable Diseases

6.3.1 Cardiovascular diseases- Coronary artery disease, Diabetes, Hypertension and Cerebrovascular diseases and Chronic Obstructive Pulmonary Disease

It is well known that people living with non-communicable diseases such as cardiovascular disease (CVD, such as hypertension), diabetes, chronic respiratory conditions as well as those with CVD risk factors such as smoking and obesity are at a higher risk of severe disease and mortality from COVID-19. This may be due to advancing age, functionally impaired immune system and elevated expression of Angiotensin-converting-enzyme 2 (ACE2) receptors. The imposed movement restrictions, increased stress levels and disruption of healthy diets and physical activity, coupled with interruption of routine care pose a multifaceted challenge and risk of worsening outcomes for persons living with NCDs.

In addition to addressing their increased vulnerability to COVID-19, it is also necessary to safeguard other aspects of NCD management. This population usually require multiple encounters with the health facilities due to the frequent monitoring of their conditions. However, patients perceive hospitals as places where they can be "infected". Hospital admissions of patients with CVD have reduced drastically in our hospitals, and it is likely that even during the current pandemic, more people will die from CVD complications than with COVID-19. With the increase in focus towards response to COVID-19, there is potential for compromise in the rapid triage of non-COVID-19 patients with acute exacerbations of NCDs. It needs to be clearly communicated that "don't come to hospital" does not apply to patients with acute CV events or complications or other acute medical problems.

It is important to ensure that patients with these underlying comorbidities continue to access to their regular medications and essential health services such as monitoring and management of their illnesses. Hence the MOH guidance from the Division of NCDs on keeping NCD outpatient clinics operational [17]. It is recommended that persons living with non-communicable diseases who are in stable condition have longer periods between their clinic appointments and hence bigger drug refills. Many of these clients lack the funds to purchase large quantities of their prescribed medication. It is therefore necessary for health facilities to ensure adequate supply and prevent

stock outs of essential medicines, commodities, and technologies, such as blood sugar testing kits and insulin.

6.3.2 Recommendations for persons with NCDs:

a. Ensure outpatient clinics run on an appointment basis to minimize crowding at the facilities.

b. Ensure a separate triage site for persons living with NCDs

c. Sensitize patients with diabetes on the importance of optimal control of their blood sugar and adequate control of blood pressure and lipids through strict adherence to medications

d. Support clients to increase use of interventions that contribute to better outcomes such as practicing consumption of healthy diverse diets and engaging in sufficient physical activity.

e. Communication and counseling should be available to this population, even via telephone consultations, especially to help them monitor their conditions

f. Give longer return dates and longer prescriptions & drug refills for stable clients (minimum of 1 month)

g. Ensure clients at risk of poor compliance and complications of CVDs have access to medication, accompanied by constant follow-ups.

h. Patients defaulting on appointments should be contacted and encouraged to reschedule via telehealth approach wherever feasible.

i. Utilization of telemedicine models where possible to maintain maximal self-containment.

6.3.3 Cancer Care

Cancer care is complex, expensive, often prolonged and difficult for patients and their families even at the best of times. Job losses, economic uncertainty, curfews and movement restrictions have complicated this further. Curtailment of the "normal" clinic activity due to the need to implement COVID-19 prevention measures such as social distancing has complicated provision of chemotherapy services especially in high volume facilities. There is an urgent need to constantly evaluate and minimize the effect of diagnostic and treatment delays for cancer patients.

The Division of the National Cancer Control Program has issued guidance to ensure cancer care continues to be provided as safely and justly as possible for patients at all cancer centers (see Annex 4). Currently, there is no evidence to withhold cancer diagnosis or treatment and delaying treatments can have negative effects for cancer patients.

6.3.4 Recommendations for Cancer management:

1. Consider cancellation of all elective procedures (those procedures

where a delay of 6-8 weeks will not lead to a detrimental effect on the health of the patient)

2. Prioritize urgent/emergency surgical procedures (those that absolutely need to be performed in 24-48 hours)
3. For those who still need to attend, particularly for treatment, schedule appointments to reduce waiting times. Encourage patients not to arrive too early – consider measures such as contacting them when ready to see them.
4. Consider whether systemic therapies can be given in alternative regimens, different locations or via other modes of administration including:
    a. Changing intravenous treatments to subcutaneous or oral if there are alternatives.
    b. Selecting regimens that are shorter in duration.
    c. Consider using 4-weekly or 6-weekly immunotherapy regimens rather than 2-weekly and 3-weekly.
    d. Dispensing longer periods for oral medications.
5. For patients undergoing radiotherapy:
    a. As much as possible, all patients on radiotherapy must complete their treatment
    b. Explore options for hypo-fractionation where possible
    c. Consider delaying radiotherapy for palliative/non-curative purposes
6. Consider deferring supportive therapies such as zoledronic acid treatment (except for hypercalcaemia).
7. Consider referring patients to their nearest county cancer center for care that can be provided there to reduce unnecessary travel
8. Consider home delivery of oral medication where possible and provide stocks for one extra month or more
9. Use of GCSF as primary prophylaxis to protect patients and reduce admission rates is encouraged for those at risk of febrile neutropenia
10. Consider integration of counselling for optimal nutrition to facilitate boosting the immunity of the patients that can contribute to positive outcomes.

6.4 Services for Persons with Disability

Persons with Disability such as the deaf community on a normal day experience difficulty in accessing all essential services. Ensure that they have access to all measures such as IPC like handwashing stations and access to communication material. At this time, it is crucial to support the access toservices as well as ease their communication with health care workers.

6.5 Management of Injuries

The evaluation of patients with injuries should not be delayed to determine COVID-19 status but appropriate precautions should be taken;

1. Ensure strict use of PPE for droplet contact precautions for ALL patients.
2. If a patient has upper respiratory symptoms (URS), immediately place a face mask on the patient.
3. For potential COVID-19 patients requiring emergent intubation, ensure strict IPC measures are observed.
4. If referral to higher heath facility is required, consultations with the receiving facility must be made prior to transfer of patient.
5. Limit the number of healthcare providers involved in the patient care.
6. Provide care in the emergency department on an outpatient basis wherever possible. This will reduce the consumption of PPE.
7. Reduce the overall patient time in the hospital

6.6 Surgical Services

Elective Surgeries had been put on hold on 25th March, 2020 by the Ministry of Health[9] to prepare facilities prepare for management of COVID-19 cases . On 29th May 2020, the Director General for health, through a circular, reinstituted elective surgical procedures in facilities(18), emphasizing that this should be done judiciously and that high standards of infection, prevention and control should be maintained.

It is recommended that health facilities should put in place a protocol for assessing urgency especially if waiting will lead to harm to the patient. ***(See Appendix 3- Acuity table for operative procedures and Appendix and 4: Algorithm for Emergency Surgery)***

Elective surgeries should resume when new cases of COVID-19 are steadily decreasing and would not affect the bed capacity of the county and human personnel required in the management of the Covid-19 cases as well as emergency surgical cases.

There will be need to consider capacity to test clients and get results within 72 hours. This is to enable preoperative testing of all elective patients. However, where such capacity does not exist, it should be assumed that all patients and the healthcare worker are positive and appropriate PPEs are donned.

Regarding Urgent /emergency surgery, facilities should establish a surgical team to consider prioritization of surgeries consisting of surgery, anaesthesia and nursing leadership to have a strategy appropriate to the immediate patient needs.

The surgical team decisions should address case scheduling and prioritization and should account for the following:

- List of previously cancelled and postponed cases and use objective priority scoring for prioritization (e.g., MeNTS instrument)

- Consider the cases by specialties and their urgency (cancer, organ transplants, cardiac, trauma, infection)
- Strategy for allotting daytime "OR/ procedural time" (e.g., block time, prioritization of case type [i.e., Abscess, necrosis, potential cancer, living related organ transplants, etc.]).
- Identification of essential health care professionals and medical device representatives per procedure.
- Strategy for phased opening of operating rooms.
- Identify capacity goal prior to resuming 25% vs. 50%
- Outpatient/ambulatory cases start surgery first followed by inpatient surgeries.
- Consider number of operating rooms available and number of personnel and ability to use all rooms simultaneously.
- Strategy for increasing "OR/ procedural time" availability (e.g., extended hours before weekends).
- Issues associated with increased OR/procedural volume.

Ensure primary personnel availability commensurate with increased volume and hours (e.g., surgery, anaesthesia, nursing, housekeeping, engineering, sterile processing, etc.). Ensure adjunct personnel availability (e.g., pathology, radiology, etc.). Ensure supply availability for planned procedures (e.g., anesthesia drugs, procedure-related medications, sutures, disposable and non-disposable surgical instruments). Ensure adequate availability of inpatient hospital beds and intensive care beds and ventilators for the expected postoperative care.

6.6.1 Recommendations for Clinic Visits

a. Consider setting up telemedicine options for screening outpatient elective patients

b. Reschedule patients who do not have urgent indications for in-person clinic reviews

c. For patients who have to come for clinic reviews, COVID-19 screening is to be done prior to clinician seeing them and appropriate action taken

d. Have appropriately spaced seating arrangements in the waiting room areas.

e. Provide hand hygiene facilities for patients

f. Patients to adhere to current government guidelines for mask use. Consider having masks available for patients who do not have a mask of their own

g. A surgical mask should be worn by the clinician during the clinic interaction while maintaining prescribed social distancing

h. Wash hands with soap and water in between patients

6.6.2 Perioperative considerations

Patients who have been triaged and deemed fit to undergo urgent

planned surgery should be assessed for potential exposure to COVID-19 and appropriate precautions taken for emergent surgery. However, if there is inadequate capacity to test, it would be prudent to consider every patient as a potential COVID-19 case, and then wear appropriate PPEs during evaluation and surgery. Develop a clear plan for providing essential operations. Preserve hospital capacity and resources. Consider each hospitals patient needs and staffing capacity before hand. The need for surgery should be reviewed by a surgeon with relevant expertise in that specialty. The risk to the surgical patient should include a combined assessment of the real risk of proceeding and the real risk of delay.Preferably a pre-identified OR should be identified and appropriate signage and labelling of various zones(Green,Yellow and Red) as well as the donning and doffing zones and pre-rehearsals of the teams as part of optimisation of the surgery.

6.6.3 Operative considerations

Anaesthesia considerations: True rapid sequence intubation should be performed. Intubations are considered high risk procedures. All personnel not required should remain outside the Operation Room until after induction and intubation. For urgent elective procedures, the personnel can re-enter the room once the airway is secured and at an interval of approximately 20 minutes.

It is important to have only the bare minimum number of personnel in the operating room. It is also key that the entire team is prepared in advance for handling Covid-19 patients. We recommend that the team does in situ simulations and drills to get the team familiar with process flow. These will include: donning and doffing simulations and also the operating room flow. There should be clear signage showing each of these areas. These simulations will help to identify site specific challenges. If possible, a dedicated theatre room should be prepared and used for Covid-19 patients. The operating room should be stripped of all non essential equipment or material. Suction or a smoke evacuator should be used whenever the electrocautery is used. Patients who have tested negative for COVID-19 should be managed in the standard manner before the Covid-19 era.

Personnel and equipment use during surgery

- 2 surgeons -Operating Surgeon and Assistant (Competent and with an aim to use the shortest time possible)
- 3 nurses- Scrub nurse; Circulating nurse in the OR and the Runner nurse (outside the OR)
- 1 Anaesthesiologist + Anaesthetist assistant
- 1 cleaning personnel
- (PPE need estimate: 14 gloves, 7 gowns, 7 face shields, 7 masks)

6.6.4 Post procedure

The patient may be recovered in the operating room. Consider having the

recovery room as close as possible to the operating room or joined to it. In case transport of a suspected Covid-19 patient to an outside recovery room or intensive care unit has to be done, the same team should transport the patient or hand over the patient to a minimum number of transport personnel who have been pre-identified. PPE as recommended should be used, which should not be the same as that used for the procedure. Patients who have tested negative for COVID-19 should be managed in the standard manner before the Covid-19 era.

6.7 Dental services

6.7.1 Definition of Dental Emergencies

In the dental environment, the generation of aerosols from most clinical procedures puts patients, clinicians, all support staff and hence the general public at high risk. Therefore, triaging of cases as per urgency should be done and only emergency and urgent cases attended in situations with high transmission of cases.

Emergencies are conditions that require immediate dental attention while urgent cases are severe or uncontrolled symptoms that cannot be managed by the patient and require the patient to be seen by a dental practitioner.

These emergencies and urgent clinical cases are:

a. Uncontrolled Bleeding in the mouth and orofacial region.
b. Cellulitis and soft tissue infections intraorally or extra orally that can potentially compromise the airway.
c. Oro-facial trauma that potentially compromises the airway.
d. Dental pain not amenable to pharmacotherapy.
e. Dental trauma resulting in fracture or avulsion of anterior teeth in permanent dentition.
f. Cancer patients and patients with compromised immune systems in need of urgent care.

6.7.2 Facilities where the emergencies and urgent cases are attended

The facilities where the above cases are attended should have the following;

a. Capacity to triage
b. Provide PPEs listed below
c. Meet the World health organization standard of infection prevention and control with regards to COVID-19

6.7.3 Personal Protective Equipment

All dental practitioners and the assistants attending to these patients should have the following personal protective equipment to protect themselves and the patient:

a. Single use disposable gowns.
b. Single use N 95 Masks.
c. Goggles.
d. Single use face shield.

e. Single use disposable head caps.

f. Surgical gloves

6.7.4 Performance of clinical procedures

a. Initial assessment/ triage of the patient should be done over the telephone before arrival at the facility. Where this is not possible, screening including temperature checks with a contact free thermometer is recommended.

b. Upon arrival at the facility reception, have the patient use an alcohol-based hand sanitizer and rub their hands for 20 seconds.

c. When entering the surgery ask the patient to wash their hands in the surgery hand washing sink, prior to sitting on the dental chair.

d. No intra-oral examination should be done unless the case falls in the above category of emergencies or urgent cases.

e. While the efficacy of this approach cannot be guaranteed to have a significant effect on viral load in a patient with COVID-19, we recommend that prior to commencing treatment all patients should be asked to undertake a 20-30 second pre-procedural mouth-rinse with either:

- 1% hydrogen peroxide
- 0.2% povidone iodine
- 0.2% chlorhexidine rinse (alcohol free)

f. All procedures should be performed where both high volume and low volume suction is available. Rubber dam use is indicated for all endodontic procedures.

6.7.5 Decontamination

a. Regularly wipe down surfaces with >60% alcohol-based wipes or 0.1% sodium hypochlorite solution, including door handles, reception desks, phones, pens, computers and any other gadgets.

b. Standard infection control practices of the dental unit in line with the CDC guidelines of dental chair decontaminants are applicable.

c. Consider longer appointments to allow enough time between treatments to enable additional infection control measures including environmental cleaning.

d. Observe the recommended physical distancing in the waiting area

6.8 Opthalmic Services

Eye care professionals are among health care providers at greatest risk of contracting the disease because of a number of factors; examining the patient at close proximity and the necessity to place hands on the patients' face and eyelids. Furthermore, elderly patients and those with comorbidities make a significant proportion of patients seeking eye

care and thus are at increased risk of acquiring and developing severe COVID –19.

Some of the observed ocular signs of COVID-19 include, epiphora and Conjunctival Congestion/Chemosis, especially in patients with other comorbidities.

All the eye care professionals and eye hospitals should observe the following measures:

a. Where possible, eye clinics should provide a phone number/contact for patients who may wish to consult before visiting the eye unit or on refill of medication for chronic conditions

b. Prioritize urgency of cases

c. Observe Vigilance in respect to conjunctivitis; because about 1-3% of COVID-19 patients may first present with conjunctivitis.

d. The following are recommended measures to reduce the risk of transmission;

   i. Patient triage.

   Screening of patients

   Patients with conjunctivitis or an ophthalmic emergency should be seen by staff geared in personal protective equipment in an isolated designated examination room with an isolated waiting area.

   ii. Barrier care including N95 masks should be used for all physically close ophthalmic procedures and apply universal precautions for all patients; decontamination of applanation prisms, contact gonioscopes, laser contact lenses, B-scan, and ultrasonic biomicroscope probes, etc.

   iii. Direct and manage client/ patient flow

   - Have a suitable waiting room to filter patients
   - Ensure adequate distance between patients at all times.
   - Identify elderly patients (>60 years) and those with co-morbidities as they are high risk. Their consultations need to be rapid and carried out with maximum protective measures.
   - Patients presenting with conjunctivitis should be isolated and seen swiftly with minimal time on the slit lamp and at the clinic.

   iv. Environmental control

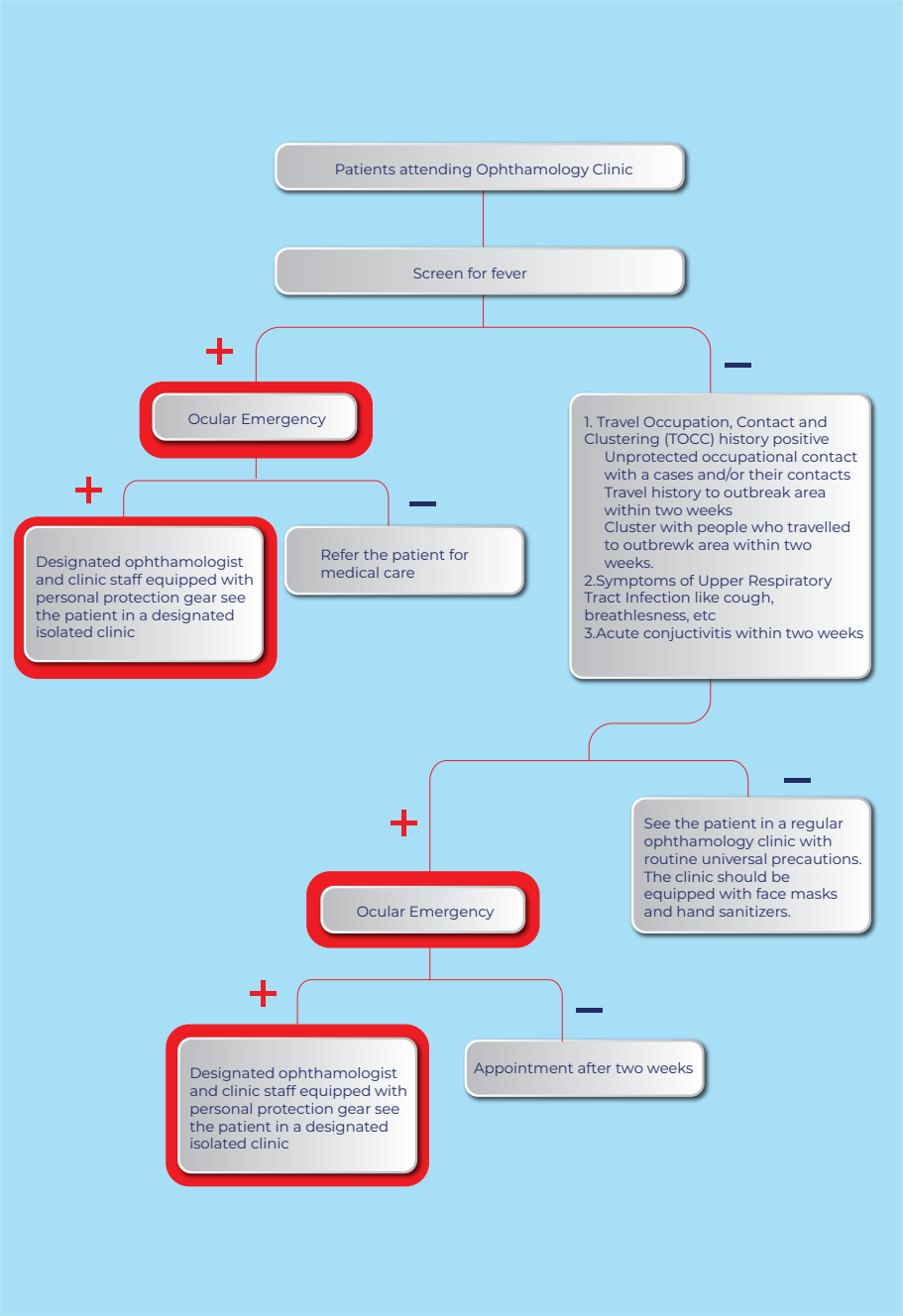
   - Alert all entrants to the department/unit on washing & sanitization points. Ensure that there is adequate water and soap for hand washing.
   - Provide appropriate disposal methods in line with the Infection Prevention Control guidelines.
   - Ensure you sanitize your hands and the tools

(including the slit lamps) used to examine the patient, before and after examining each patient. Wash hands with soap that foams for at least 20 seconds.

- Always when in the hospital/examination room, remain in a face mask, protecting the mouth, nose, with eye protection-googles/ shields, besides the usual dust/white coat.
- Use material available to you/in your context (e.g. laminated materials, transparencies or old X-ray Films) to create a good barrier between the health worker and the patient while using a slit Lamp (see Figure 56 below). Encourage minimal talking when using the slit lamp and remember to sanitize the barrier too. Where possible, use a head-mounted light source to do indirect ophthalmoscopy.
- Ensure cleaning & disinfection of all surfaces/ equipment / tools every morning and evening with solutions that have at least 65% alcohol. This includes the furniture, light switches, door handles and door knobs.
- Apply barrier and reverse barrier nursing principles for suspected/confirmed cases. Patients with proven COVID-19 who need urgent ophthalmic care may be examined in a separate isolated special examination room with preferably a separate waiting area manned with doctors and staff equipped with appropriate personal protective equipment which must include gloves, N-95 mask, gown and protective eyewear. All personnel coming in contact with a COVID-19 patient must be listed and followed up as per government protocol.

v. Maintain patient records daily and report any incidences/ issues of concern to the authorities at the end of every shift.

The following flow chart summarizes the patient flow for ophthalmic services and may be used;



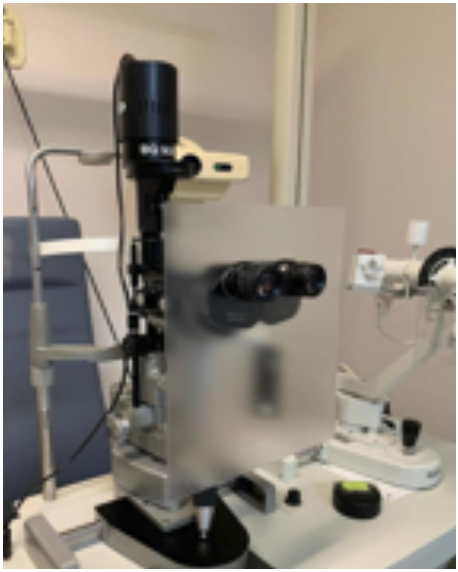


Figure 2: Creating a slit lamp barrier

6.9 Rehabilitation Services

The Physiotherapy Division has given guidance on Physiotherapy services on management and recommendations to clinical practice for COVID 19 . In order to support clients who require occupational therapy e.g. Children with disabilities, it is recommended that physiotherapy staff take the necessary precautions.

It is recommended that;

a. All occupational therapists must undergo sensitization on COVID 19 and stay updated on latest guidelines

b. Sensitize clients on precautions taken for prevention of COVID-19

c. Reschedule any non-urgent care/ interventions

d. Handle one client at a time, who may be accompanied by only one care giver and maintain physical distance

e. Ensure the caregiver has a mask

f. Clean and disinfect therapy area and equipment before and after each session.

g. Avail all the equipment needed in reach.

h. Emphasize on hand hygiene

i. Be in correct PPE i.e. disposable gown, a mask, gloves, goggles

j. In case of contact with saliva, immediately wash thoroughly with running water and soap and disinfectant.

k. Give directions to the caregiver all through therapy.

l. Train on home program to reduce frequency of hospital appointment where feasible

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APPENDIX 2: CONTACTS FOR MENTAL HEALTH REFERRAL FACILITIES

Mathari National Teaching and Referral Hospital (MNTRH)

Inquiries on continuity of care and Psychiatric emergency crisis:0721336017. This call shall be connected to Consultant on call if there is need.

Moi Teaching and Referral Hospital (MTRH), Eldoret

Hotline: 0110052150 – This shall connect to the Mental Health Unit

Kenyatta National Hospital (KNH)

Hotline: 0729 406939, 0733 333013, 020 4243000 Ext. 43136, 44101, 44719

APPENDIX 3: TABLE OF ACUITY FOR PROCEDURES

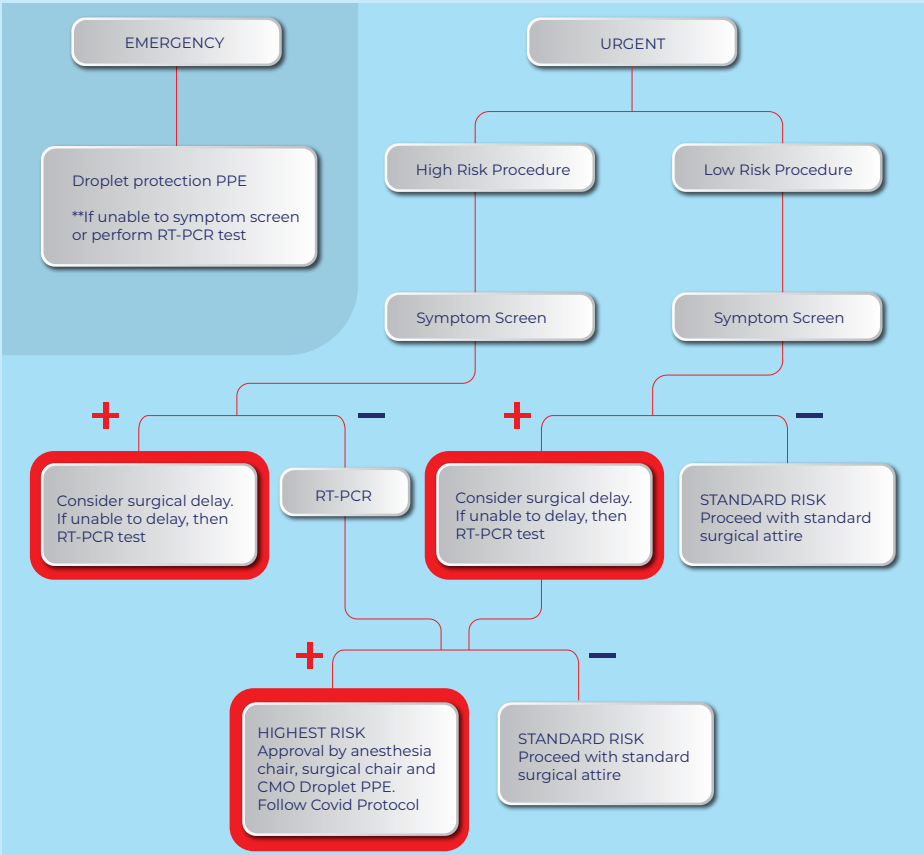
Level	Acuity	Description	Example	Action
Level 1	Low acuity	Healthy patients Not life threatening Surgery can be post-poned for 6 months with no effect on life or limb	Hernia	Post-pone
Level 2a	Moderate Acui-ty-Environment 1	Healthy patient Usually would be elective but patient can advance if not treated	Biopsy for cancer sus-pects Oncologic surgery	Operate
Level 2b	Moderate Acui-ty-Environment 2	Healthy patient Usually would be elective but patient can advance if not treated	As above	Postpone
Level 3	High Acuity	Highly symptomatic Emergency cases	Obstruction Trauma	Operate

Moderate Acuity-Environment 1: Low number of cases of covid-19. Few or no patient admitted in your locality or hospital. Supplies available for surgery

Moderate Acuity-Environment 2: Covid-19 patient increases, PPEs required for Covid-19 patients,

- Hospitals and surgery centres should consider both their patients' medical needs, and their logistical capability to meet those needs, in real time.
- The medical need for a given procedure should be established by a surgeon with direct expertise in the relevant surgical specialty to determine what medical risks will be incurred by case delay.
- Logistical feasibility for a given procedure should be determined by administrative personnel with an understanding of hospital and community limitations, taking into consideration facility resources (beds, staff, equipment, supplies, etc.) and provider and community safety and well-being.
- Case conduct should be determined based on a merger of these assessments using contemporary knowledge of the evolving national, local and regional conditions, recognizing that marked regional variation may lead to significant differences in regional decision-making.
- The risk to the patient should include an aggregate assessment of the real risk of proceeding and the real risk of delay, including the expectation that a delay of 6-8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent.

APPENDIX 4: ALGORITHM FOR EMERGENCY SURGERY



****HIGHEST RISK PROCEDURES**

ENT procedures
Bronchoscopy
Endoscopy of the GI tract
Bowel surgery with gross contamination

Any provider operarting on a high-risk patient must have training in appropriate donning and doffing PPE. All persons cleaning the operating room should wear droplet protecting PPE.

APPENDIX 5: MOH GUIDANCE FOR CANCER CARE IN COVID-19

Coronavirus disease 2019 is a new infection caused by a coronavirus type that has previously not been seen in humans. It was first identified in Wuhan, China. Early published reports from China indicate that patients living with cancer are at a higher risk of being infected with COVID-19 and having complications from COVID-19 if infected as compared to patients without cancer.

1. Which cancer patients are at particularly higher risk of COVID-19?

The following cancer patients are at a higher risk of being infected with the novel SARS-COV 2 virus:

- Those who are undergoing active chemotherapy, immunotherapy or radiotherapy
- Those with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma at any stage of treatment
- Those receiving other targeted cancer treatments which can affect the immune system,
- Those who have had recent surgery, bone marrow or stem cell transplants, or those still taking immunosuppression drugs.
- Those advanced in age (age over 60 years)
- Those with pre-existing cardiovascular, respiratory or kidney diseases.

2. How can I protect myself from COVID-19?

1. Follow all the standard infection prevention recommendations issued by the Ministry of Health.
    a. Frequent cleaning of hands preferably with soap and running water,
    b. If soap and water is not available, use a hand sanitizer with 60% alcohol
    c. Avoid shaking hands
    d. Avoid touching your face, eyes, nose and mouth
    e. Practice social distancing; avoid close contact with people
    f. Don't touch objects or surfaces that you don't need to.
2. Stay home, except to get medical care. Avoid unnecessary visits to the hospital- Consider making consultations via telephone or video consultation whenever possible.
3. If currently undergoing active treatment:

i. Stay at home in between sessions; if you need to go out strictly adhere to infection prevention guidelines

ii. Monitor your temperature (keep a thermometer at home). If you detect a fever above 380C call your oncologist, don't rush to the hospital.

iii. If you need to re-fill your drugs, ask a family member to collect your medications

iv. Consider self-injection of your immune booster or have a family member or health worker carry out the injection at home

4. Cancer patients should continue to maintain a healthy lifestyle including eating a balanced diet, getting at least 8 hours of sleep and avoiding stress as much as possible.
5. If you get flu-like symptoms and suspect you may have contacted a COVID-19 patient please call 719 for advice.
6. Do not wear a face mask if you are NOT sick.

3. What can I do about my clinic visits and medications?

1. As much as possible, limit non-essential travel and arrange to pick your medicines from your nearest cancer centre.
2. Ensure adherence to your medications unless advised otherwise by your oncologist.
3. If you are taking tablet chemotherapy or non-chemotherapy anticancer drugs like Tamoxifen, Letrozole, Zoladex, Xeloda, etc, please arrange to collect two to three months' supply early enough to avoid repeated hospital visits
4. Ensure to stock up on pain medications and supportive commodities such as stoma bags.
5. If you are on long-term follow-up and stable, arrange with your oncologist to reschedule routine appointments by at least 3 more months.
6. Cancel all non-urgent doctor visits and arrange for telephone consultation with your oncologist.
7. While at the clinic, sanitize and ensure social distancing. Your care provider will arrange for you to be seen in small batches to enable social distancing.
8. If you are using a shared wheelchair or stretchers insist that it is sanitized before use.
9. Any cancer patient diagnosed with COVID-19 must inform the attending doctor about their cancer history and treatment and immediately alert their primary oncologist

4. What should I do if I suspect I have COVID-19?

- Call your oncologist if you develop symptoms consistent with COVID-19
- Stay home except to get medical care and separate yourself from other people in your home
- Wear a facemask
- Clean your hands often or use a hand sanitizer
- Monitor your symptoms and call 719 for any further advice.

APPENDIX 6: PAEDIATRIC ALGORITHM

COVID 19 Response: Triage and assessment of the young infant age up to 2 months

General Measures to Minimize Exposure of young infants, caregivers and health care providers

1. All caregivers should maintain 1.5 - 2m apart distance
2. All caregivers should wear face masks correctly
3. Instruct all caregivers on cough etiquette and hand hygiene
4. Healthcare workers should have appropriate PPE and donn/doff as per the national PPE guidelines
5. Handwashing should be done at every entry point for ALL (caregivers/visitors/support staff/health care workers)
6. Effective IPC measures should be undertaken at every entry point, every service point and before and after every service has been provided
7. Disinfect all surfaces and equipment before use, after use and in-between patient care as per the IPC guidelines

SCREEN young infants and caregivers FOR COVID- 19 symptoms / exposure as per the MOH COVID- 19 paediatric guidelines

SUSPECTED COVID-19 (TRANSFER TO RED ZONE)

Triage the young infant:
- Check airway, breathing, circulation, and movement only when stimulated or no movement at all and intervene as per ETAT+ and IMNCI guidelines
- Capture vital signs (Temperature, Respiratory rate, SpO_2)
- Check for feeding problem, low weight or low birth weight

TEST the caregiver and young infant for COVID-19

COVID-19 NOT SUSPECTED (TRANSFER TO GREEN ZONE)

Triage the young infant:
- Check airway, breathing, circulation, and movement only when stimulated or no movement at all and intervene as per ETAT+ and IMNCI guidelines
- Capture vital signs (Temperature, Respiratory rate, SpO_2)
- Check for feeding problem, low weight or low birth weight

Assess the young infant and classify IF:

1) Signs of hypoxaemia: SpO_2 < 90 or based on clinical signs and symptoms (Central cyanosis, Nasal flaring and grunting) if the young infant is presenting any of these clinical signs give oxygen therapy and refer or admit .
2) Not able to drink or breastfeed at all, or not feeding or breastfeeding well or history of convulsions or convulsing now or severe chest indrawing or high body temperature (38°C or above) or low body temperature (<35.5°C) or movement only when stimulated or no movement at all or fast breathing (60 breaths per minute or more in infants less than 7 days old, CLASSIFY as POSSIBLE SERIOUS BACTERIAL INFECTION OR VERY SEVERE DISEASE and intervene as per IMNCI guidelines.
3) Fast breathing(60 breaths per minute or more) in infants 7-59 days old CLASSIFY as PNEUMONIA3)
4) Red umbilicus or draining pus or skin pustules and none of the signs of very severe disease, CLASSIFY as LOCAL BACTERIAL INFECTION and intervene as per IMNCI guidelines.
5) No signs of bacterial infection or very severe disease, CLASSIFY as INFECTION UNLIKELY

Note: - Rule out the existence of congenital conditions, HIV exposure, TB exposure,sickle cell disease, cancer.

Refer or Admit ALL suspected cases into PAEDIATRIC HOLDING AREA awaiting COVID-19 test results

COVID- 19 Positive:
- Prioritize hospital care for young infants with possible serious bacterial infection, critical illness and those with mild disease and risk for poor outcome due to comorbidity
- Assess the feasibility of homebased care for clients with no or mild symptoms as per the National Homebased Care Guidelines
- INITIATE CONTACT TRACING

COVID- 19 Negative

Hospital care:
- Admit clients in the paediatric isolation ward and treat / manage as per the paediatric COVID 19 guidelines
- Follow the COVID- 19 standard operating procedures in performing confirmatory tests prior to discharging the clients
- Maintain Infection Prevention and control measures while in the ward as per the COVID- 19 guidelines
- Once the confirmatory test is negative, follow the discharge procedures and advice on when to return for review

Homebased care:
- Advise on the procedures for homebased care and on the referral system if progression of symptoms is noted
- Establish a communication link for the duration of the homecare period. Monitor the patient until the symptoms are completely resolved.
- Advise on personal hygiene, basic IPC measures, and how to care for the person with COVID- 19 to prevent the infection from spreading
- Advise on when to return for follow up care / review
- Emphasize on Exclusive Breastfeeding (EBF) and how to keep the young infant warm

For a sick young infant, manage as follows.

Possible Serious Bacterial Infection or Very Severe Disease
- If convulsing now give phenobarbitone.
- Give first dose of intramuscular gentamycin and benzyl penicillin.
- Treat to prevent low blood sugar and advise the mother on how to keep the infant warm.
- Refer urgently to hospital or if referral is not possible, treat in the facility until referral is possible

No

Pneumonia (in infants 7-59 days old)

Give oral Amoxicillin Dispersible Tablets(DT) for 7 days. Advise the mother to give home care and follow up in 3 days

No

Local Bacterial Infection

Give oral Amoxicillin Dispersible Tablets(DT) for 5 days. Advise the mother to give home care and follow up in 3 days

No

Infection unlikely

Advise the mother on giving home care to the young infant

- Check for special treatment needs (including congenital conditions) and treat as per the MOH guidelines

ENSURE CONTINUITY OF ESSENTIAL SERVICES FOR ALL PAEDIATRIC CASES

1 Check on the following and intervene as per the IMNCI guidelines:
- Jaundice
- Eye infection
- Signs of Dehydration
- HIV infection/ Exposure
- Breastfeeding/ Feeding and Counsel caregiver
- Special treatment needs
- Immunization status
- Other problems the infant might have

2 Counsel the caregiver on the following:
- Prevention of infections including COVID-19
- Early recognition of danger signs and when / where to seek care
- Routine child health services including immunization
- Care for development, play & communication
- Caregiver's on their own health, correct use of face masks, handling and disposal

VERSION1: JUNE 2020

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