KELIN
Reclaiming Rights, Rebuilding Lives

KUCO
Kenya Union of Clinical Officers

# HEALTHCARE WORKERS (CLINICAL OFFICERS) LEVEL OF PREPAREDENESS IN RESPONSE TO COVID-19

## ASSESSMENT REPORT

# CONTENTS

# LIST OF FIGURES



# LIST OF TABLES

# ACRONYMS

CSO-Civil Society Organization
HIV- Human Immunodeficiency Virus
AIDS- Acquired Immune Deficiency Syndrome
KELIN-Kenya Legal & Ethical Issues Network on HIV and AIDS
KUCO-Kenya Union of Clinical Officers
M&E-Monitoring and Evaluation
PPE-Personal Protective Equipment
PPS-Population Proportion Sampling
WHO-World Health Organization
WIBA- Work Injury Benefits Act

# ACKNOWLEDGEMENTS

Healthcare workers (clinical officers) level of preparedness in response to COVID-19 assessment was made possible due to coordinated efforts by various stakeholders including KELIN, Kenya Union of Clinical Officers, Civil Society Organization amongst other like-minded stakeholders.

The partners acknowledge contributions from other stakeholders throughout the survey process, including:

- All clinical officers (respondents) for collaborating and undertaking the assessment despite their hectic schedule during this time of COVID-19.
- Health care workers sub-committee of the COVID-RBA consortium coordinated by KELIN.
- Kenya Union of Clinical Officers leadership structure.
- Kenya Legal and Ethical Issues Network on HIV & AIDS entire team particularly the Monitoring and Evaluation team and the communications team.

# EXECUTIVE SUMMARY

Kenya Legal and Ethical Issues Network, an Kenyan NGO working on promoting and protecting the health rights and Kenya Union of Clinical Officers, an association that promotes the welfare of Clinical Officers and advocate for the professional development through training and advocacy and other like mind stakeholders in the health sector developed a working relationship through a consortium to enhance monitoring of health rights and collectively advocate for the health related rights of the healthcare workers during this period of COVID-19 and develop strategies to address rights issues during and after COVID-19 pandemic. The assessment was designed to support the two organizations and the consortium on evidence building of healthcare workers level of preparedness to respond to COVID-19 and provide recommendations on areas of improvement through collective advocacy to the respective agencies.

This partnership seeks to strengthen governance, promote equity, and build capacities to demand health related rights during the COVID-19 pandemic through developing collecting advocacy.

The aims of the assessment were to determine the level of preparedness to respond to COVID-19 in context of Occupational Health and Safety. Specific objectives were to:

i. Assess the status of environment and level of preparedness to provide services during COVID-19 period
ii. Assess experiences and challenges faced and major concerns from the health perspective during the COVID-19 period

## STUDY DESIGN

The assessment was informed by a WHO report on health workers EBOV infections in Guinea, Liberia and Sierra Leone from January 2014 through March 2015 which concluded that, depending on their occupation in the health service, health workers were at 21 to 32 times greater risk of contracting EVD[1].

The online assessment targeted healthcare workers (clinical officers) across all the 47 counties working in the public and private sector. Data collection was completed with 601 healthcare workers sampled from 47 counties. The assessment questionnaire was digitized through KOBO collect platform and shared in respective clinical officers' platform under the leadership of clinical officers' union secretary general and other elected leaders of the union.

## KEY FINDINGS

### Safe Working Environment

*Patients Screening at Entry*

In assessing the health facility preparedness, the findings show that 43% of the facilities are not screening clients at entry and not separating those with respiratory symptoms.

*Staffing and ventilation*

Further results show that 63% of the facilities lack adequate staff to handle the client flow, only 57% of the facilities are well ventilated. These results demonstrate contrary results from what the government has shared with the public. More measures must be put in place by the Ministry of Health to prevent and control the spread of COVID-19.

[1]*Preferred product characteristics for personal protective equipment for the health worker on the front-line responding to viral hemorrhagic fevers in tropical climates. Geneva: World Health Organization; 2018*

*Availability of Personal Protective Equipment*

The results show that 93% of the healthcare workers do not have personal protective equipment (PPE) with more than 90% citing lack of eye protection gear, isolation gowns and protective suits as required by WHO standards[2], while 82% lack N95 respirators. Only 18% of respondents lacked gloves and 30% lacked surgical masks. Further, the findings established that 82% of the assessmented healthcare workforce are forced to reuse PPEs because of irregular supply of the equipment.

This is against the occupational safety and health standard provided by WHO that all healthcare workers should have this equipment to prevent exposure to the COVID-19 virus. The government must prioritize access to the above as soon as possible as the healthcare providers are at the epicenter of response and can be agents of COVID-19 spread to the rest of the population due to their position as frontline responders.

*Cleanliness and Waste Management of the health facility*

The findings show majority of the health facilities have waste management equipment but only 40% of the health facilities waste management are cleaned and disinfected. This implies that though measures have been put in place to have the equipment, very little has been done to ensure they are clean and safe which exposes more the healthcare workforce to COVID-19.

## Capacity and wellbeing of Healthcare Workers to Respond to COVID-19

*Training*

The findings show that 58% of the healthcare workers have not been trained on preparedness and response of corona virus indicating that the level of preparedness to response to the virus as well as provision quality of health services to patients is not up to the expected WHO standards thus jeopardizing the health of patients as well as the healthcare workers as result of lack/insufficient knowledge or skills to provide better healthcare for the patients. Further the findings show that 90% of the healthcare require refresher and additional training.

*Accommodation/Isolation centers for Healthcare Providers*

Results established that (94%) of healthcare workers are not provided alternative accommodation/isolation so as to minimize the risk of exposing their family members. This further demonstrates poor level of preparedness by the government in protecting the health of healthcare workers and their immediate families which is a heightened risk factor of exposure to other non-healthcare workforce.

*Alternative Transport to and from Work*

Findings showed that (42%) of healthcare workers have no transport to and from work and with the curfew and partial lockdown. This has led to difficulties in accessing health facilities due to constant inquiries by police at various road blocks hence creating barriers to access of health care for the patients who would have been served by the healthcare workers.

*Testing of Health Care Workers*

Findings established that 97% of the healthcare workers feel more exposed to COVID-19 due to lack of enough PPE equipment and preparedness of the health facilities. This reiterates low levels of preparedness by the health sector which may hinder provision of quality healthcare services by health workforce because of fear. Recent data has shown I UK 16% of the healthcare workforce while in US more than 9,000 healthcare workforce have tested positive for COVID-19 [3].

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[2]*Infection prevention and control of epidemic-and pandemic-prone acute respiratory infections in health care. Geneva: World Health Organization; 2014*

[3]*The Centre for Evidence-Based Medicine*

Further findings established that 98% of assessmented healthcare workers have not been tested for COVID-19 as at (17th April 2020). The results demonstrate the level of unpreparedness since the health workforce is at the epicenter of this pandemic being first responders which makes more exposed since they interact with clients yet they have not been tested to assess if they will continue to provide medical health care or they should be isolated and receive medical care. This takes into account the fact that National Government (PS Health) announced testing for Healthcare workers on 15th April[4].

## Life Insurance Cover & Work Injury Benefits Act

The results established that only 11% of the respondents have life insurance cover. This is a worrying statistic since the healthcare workers are at the frontline in responding to COVID-19 which makes them more vulnerable to the virus hence this is a key requirement for the workforce.

## Conclusion

The findings show the level of preparedness towards response to COVID-19 is poor, particularly issues have been cited on lack of personal protective equipment, lack of COVID-19 testing for health care workers, lack of training amongst other key underlying issues which the government and private sector need to immediately address to enhance preparedness.

## Recommendations

### Recommendation to the National Government

i. There is need to review the laws and policies that govern protection of healthcare workers in matters pertaining preparedness of epidemics and occupation safety and health of healthcare workers. This should include life insurance, compensation in regards to accidents/incidents at work.
ii. Resources and mechanisms to capacity build healthcare workforce for epidemics and emergencies. This should include review of the medical curriculum to include compulsory training using case studies like COVID-19. There is a clear capacity gap in regard to response to COVID-19 hence a training must be provided for all healthcare workers as part of preparedness mechanisms.
iii. Strengthen all health facilities to have the capacity to handle all diseases by equipping them with proper medical equipment, medical staff and medication which should be accessible and available. This should include isolation centres for respiratory diseases as captured in the TB guidelines on management of the disease.
iv. Develop post COVID-19 strategies to ensure the workforce and resources are not overstretched not to care of other health care needs.
v. Have regular conversations with healthcare unions to understand their level of preparedness to address future epidemics.
vi. Provide enough test kits and prioritize testing of the healthcare workers.
vii. Ensure healthcare workers have personal protective equipment that are in line with WHO standards which are regular supplied to enable them provide quality health services to patients in epidemic periods.
viii. Provide regular and accurate information pertaining preparedness and response to COVID-19 and epidemics, e.g trainings conducted , number of people trained and in which regions, quantity of equipment supplied and which regions etc.
ix. Develop policies geared towards construction of consultation rooms with adequate ventilation.
x. Urgent need to conduct mass testing rather than targeting testing since majority of the cases are asymptomatic-Do we really know about Kenya COVID-19 curve?
xi. Innovation through cross learning from countries able to produce quality and cheap test kits or get cheaper rapid test kits in order to enhance mass testing, or purchase

*[4]Mass testing of health workers for COVID-19 to begin. KTN News YouTube Channel (https://www.youtube.com/watch?v=K3P6zBx7knY)*

cheap but quality test kits.

xii. Proper disposal of used PPE since if not well handled after putting on (donning) Personal Protective Equipment and removal of(doffing) Personal Protective Equipment they can lead to spread of the virus.

xiii. Protect healthcare workforce from infection by protecting the general population from infection-Increased positive cases in informal settlements because of lack of masks, water, sanitizers.

xiv. Breastfeeding healthcare workers/Healthcare workers with pre medical conditions how are they been protected- not to expose their infants, are there measure to ensure they do not engage in COVID-19 response.

**Recommendation to the County Governments**

i. County health committee team to work closely with healthcare unions and map out the needs, preparedness to respond to COVID-19 and future epidemics.

ii. Ensure the health care services at the facilities are available and accessible at all times with proper medication, medical personnel and medical equipment.

iii. Review Laws and policies that hinders accessibility of healthcare services to all through the epidemic and post COVID-19.

iv. Ensure attractive remuneration, allowances and pay outstanding salaries and benefits including life cover are part of the healthcare workers package.

v. For facilities with poor ventilated consultation rooms, provide alternative consultation areas or tents and work towards improving ventilation in all consultation rooms.

vi. Ensure all healthcare workers employed are included in a uniform benefit package since some healthcare workers are missing out on the benefits entitled to healthcare workers.

**Recommendation to the Healthcare Workers Union**

i. Sensitize members on their rights to health to demand for compensation in relation to occupation safety and health.

ii. Ensure health care workers mainstream rights-based approach in their work.

iii. Continuous collaboration with like-minded institutions working on health rights issues to come up with collective advocacy measures for their workers through identification of gaps in health laws and policies that are retrogressive.

**Recommendation to the Civil Society Organizations**

i. CSOs should work closely with healthcare union to ensure they deliver on health rights issues of the clients they serve.

ii. CSOs to work with other like-minded institutions to ensure the laws and policies developed towards preparedness and responding to COVID-19 and other epidemic reflect rights based approach and have factored the needs of the vulnerable and marginalized communities.

iii. CSOs and other like-minded institutions to ensure the vulnerable communities are able to receive quality COVID 19 healthcare and any future epidemics.

iv. CSOs and other like-minded organizations to develop mechanisms for monitoring, documentation the level of preparedness towards responding to COVID-19 and other epidemics.

**Development Partners and Multinational Organizations**

i. Ensure measures are put in place to ensure realization of right to health to all through continuous supporting the global health initiatives through increased funding in addressing epidemics.

ii. Document lessons learnt out of COVID-19 epidemic to influence review of the current global disaster management plans as well be better prepared for future epidemics.

**Media**

i. Engage more on fact finding about the level of preparedness beyond what is provided during press conferences and counter the facts if they are contradicting the information they have.
ii. Highlight stories on the plight of healthcare workers during the COVID-19 period.

**National Assembly**

i. There is need to review the laws and policies that govern protection of healthcare workers in matters pertaining preparedness of epidemics and occupation safety and health of healthcare workers. This should include life insurance, compensation in regards to accidents/incidents at work.
ii. To review the current national health budget allocation and ensure there is an increased budgets assigned to health

**County Assembly**

i. There is need to review the laws and policies that govern protection of healthcare workers in matters pertaining preparedness of epidemics and occupation safety and health of healthcare workers. This should include life insurance, compensation in regards to accidents/incidents at work.
ii. To review the current county health budget allocation and ensure there is an increased budget assigned to health.

**All Health Stakeholders**

i. Ensure there is continuous access to health services for all despite the COVID-19 outbreak through provision of health services for service providers and demand for health services by service users.

# CHAPTER ONE - INTRODUCTION

## SITUATION ANALYSIS

Corona virus disease 2019 (COVID-19) is a new respiratory illness that can easily be spread from person to person. Globally they are 3,066,417 COVID-19 positive cases, and 211,660 deaths. [5]In Kenya the first case was reported on 13th March 2020 and the cases have currently risen to 363 with 14 deaths.

## 1.1 ABOUT THE SUB COMMITTEE

KELIN, KUCO and other consortium members are working in partnership to strengthen governance, promote equity, and build capacities to demand health related rights during the COVID-19 pandemic through developing collecting advocacy.

KELIN has been tasked with providing technical assistance and guidance on rights based approaches by ensuring appropriate adaptation and high-quality implementation of health rights by documenting the situation analysis and collectively develop strategies to address these issues through advocating for laws, policies, and system gaps to be addressed.

## 1.2 PURPOSE AND OBJECTIVES OF THE SURVEY

The assessment aimed to determine the level of preparedness respond to COVID-19 in context of Occupational Health and Safety. Specific objectives were to:

i. Assess the status of environment and level of preparedness to provide services during COVID-19 period.
ii. Assess experiences and challenges faced and major concerns from the health perspective.

## 1.3 SURVEY METHODOLOGY

The online assessment targeted healthcare workers (clinical officers) across all the 47 sub counties. The. sampling frame consisted of the healthcare workers (clinical officers) in the counties with use of PPS applied to cater for the population size (clinical officer) difference spread across the counties. The survey questionnaire was developed, tested and digitized through KOBO collect platform and shared in the respective clinical officers' platforms under the leadership of clinical officers' union secretary general and other elected leaders of the union.

## 1.4 TIMEFRAME

The survey was conducted from 9th April to 20th April 2020.

## 1.5 QUALITY CONTROL

The data collection forms in Kobo collect contained data validation checks and skip logics that decreased human error in data entry. KELIN M&E/Statistician checked for duplicate entries in the Kobo toolkit system as well as outliers throughout the data collection exercise. A daily check of survey time stamps and analysis of average completion time was shared out with the respective coordination team, flagging any outliers for follow-up.

## 1.6 DATA ANALYSIS

Quantitative analysis was done using STATA while qualitative analysis was done using Atlas.ti

[5]*https://www.health.go.ke/press-releases/*

# CHAPTER TWO - BASELINE FINDINGS

## 2.1 BACKGROUND INFORMATION

### 2.1.2 Response Rate

The target sample for this survey was 630 health care workers which included 5% non-response rate. Nevertheless, at the end of the survey 601 respondents undertook the assessment which translates to a response rate of 95% which is satisfactory since the 5% non-response rate is less than what had been projected. Findings show Nairobi and Machakos had the highest number of respondents at 13.5% and 7.3% respectively.

*Table 1: Response Rate*

| County | Frequency | Percentage (%) |
|---|---|---|
| Baringo | 4 | 0.7 |
| Bomet | 9 | 1.5 |
| Bungoma | 17 | 2.8 |
| Busia | 10 | 1.7 |
| Elgeyo/Marakwet | 7 | 1.2 |
| Embu | 17 | 2.8 |
| Garissa | 7 | 1.2 |
| Homa Bay | 8 | 1.3 |
| Isiolo | 2 | 0.3 |
| Kajiado | 11 | 1.8 |
| Kakamega | 16 | 2.7 |
| Kericho | 3 | 0.5 |
| Kiambu | 33 | 5.5 |
| Kilifi | 21 | 3.5 |
| Kirinyaga | 2 | 0.3 |
| Kisii | 21 | 3.5 |
| Kisumu | 12 | 2.0 |
| Kitui | 12 | 2.0 |
| Kwale | 25 | 4.2 |
| Laikipia | 5 | 0.8 |
| Lamu | 4 | 0.7 |
| Machakos | 44 | 7.3 |
| Makueni | 31 | 5.2 |
| Mandera | 5 | 0.8 |
| Marsabit | 1 | 0.2 |

| County | Frequency | Percentage (%) |
|---|---|---|
| Meru | 17 | 2.8 |
| Migori | 6 | 1.0 |
| Mombasa | 18 | 3.0 |
| Murang'a | 12 | 2.0 |
| Nairobi City | 81 | 13.5 |
| Nakuru | 11 | 1.8 |
| Nandi | 4 | 0.7 |
| Narok | 2 | 0.3 |
| Nyamira | 13 | 2.2 |
| Nyandarua | 4 | 0.7 |
| Nyeri | 13 | 2.2 |
| Samburu | 1 | 0.2 |
| Siaya | 7 | 1.2 |
| Taita/Taveta | 15 | 2.5 |
| Tana River | 8 | 1.3 |
| Tharaka-Nithi | 26 | 4.3 |
| Trans Nzoia | 3 | 0.5 |
| Turkana | 2 | 0.3 |
| Uasin Gishu | 19 | 3.2 |
| Vihiga | 5 | 0.8 |
| Wajir | 6 | 1.0 |
| West Pokot | 1 | 0.2 |
| **Total** | 601 | 100.0 |

### 2.1.3 Sex of the respondents

The results findings show that the majority of the respondents are male (65%) while female (35%).

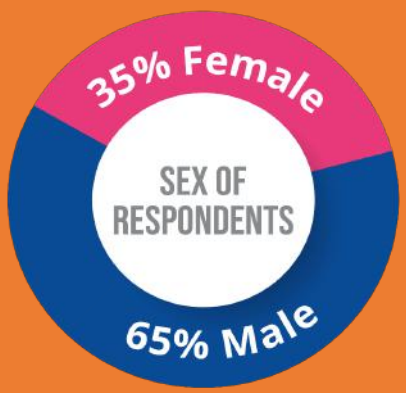


*Figure 1: Sex of the respondent*
*Data Source: Computed by author using survey data*

### 2.1.4 Age of the respondents

The majority (40%) of the respondents are healthcare workers of age (31-35 years), the lowest (1%) number of respondents are of age 18-24 years.

*Table 2: Age Group of the respondents*

| Age | Frequency | Percent |
|---|---|---|
| 18-24 | 9 | 1% |
| 25-30 | 141 | 23% |
| 31-35 | 242 | 40% |
| 36-40 | 93 | 16% |
| 40-45 | 66 | 11% |
| 46-49 | 22 | 4% |
| 50 and above | 28 | 5% |
| **Total** | 601 | 100.0 |

## 2.2 FACILITY THE RESPONDENTS ARE CURRENTLY PROVIDING HEALTH CARE SERVICES

The majority of the respondents are currently providing healthcare services at government health facilities (74%) and private facilities (16.4%).

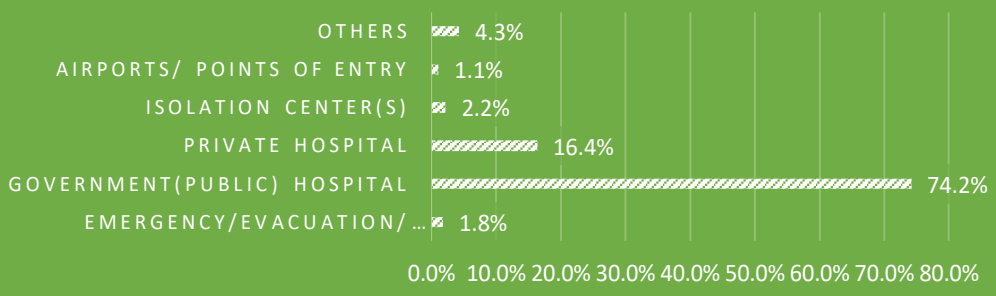


*Figure 2: Respondents where they currently provide health care services*
*Data Source: Nurses data computed by KELIN*

## 2.3 HEALTH FACILITY PREPAREDENESS TO HANDLE COVID 19 CASES

The findings established that 43% of the facilities are not screening clients at entry and separating the ones demonstrating respiratory symptoms as shown in figure 3 below.

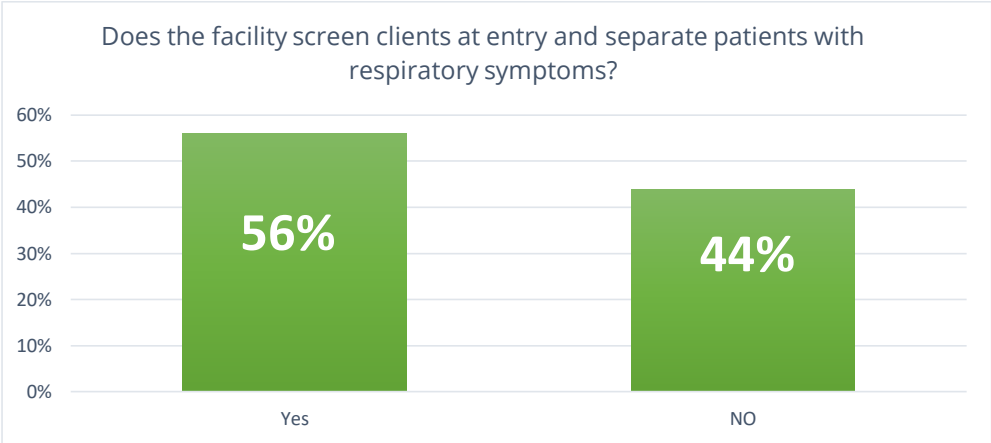


*Figure 3: Screening of client at entry and separation of patients with respiratory symptoms*
*Source: Nurses data computed by KELIN*

Further results show that 64% of the facilities are not having enough staff to handle the client flow as shown in this figure.

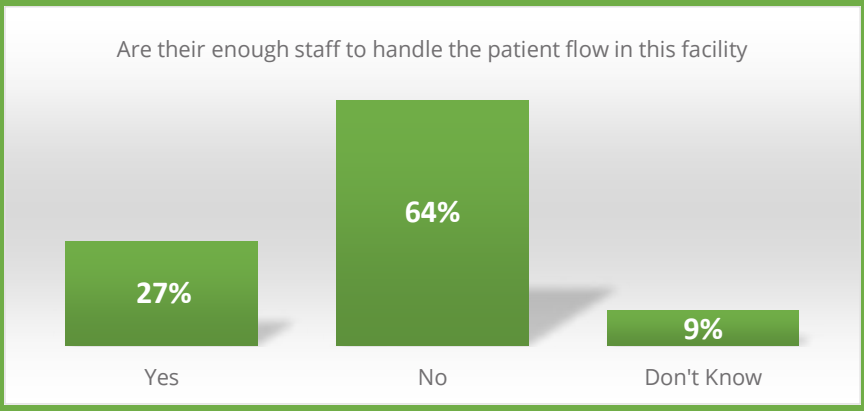


*Figure 4: Staffing of the health facilities to handle client flow*
*Source: Nurses data computed by KELIN*

The findings show only 43% of facilities are well ventilated. According to MOH guidelines on respiratory diseases the facilities need to have natural ventilation; free flow of ambient air in and out through open windows. These results show that as much as the government has stated the level of preparedness has been enhanced, the findings show contrary results meaning a lot still needs to be done for Kenya to be prepared to handle COVID-19 pandemic.

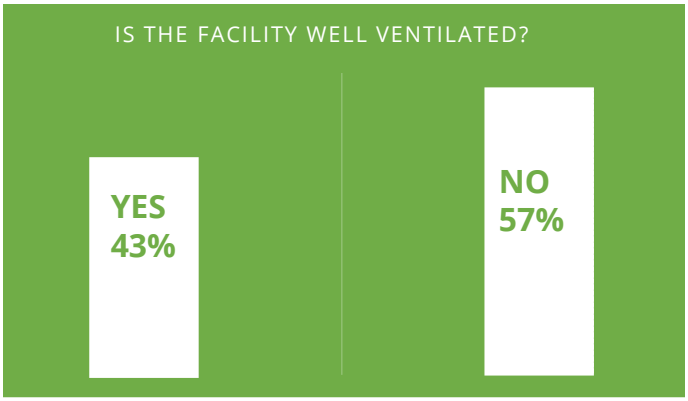


*Figure 5: Facilities Ventilation*
*Source: Nurses data computed by KELIN*

The assessment documented concerns recommendations provided by the healthcare workforce which included;

- "Temperatures to be recorded at entry point and separation of patients with respiratory illnesses";
- "Prompt response to patients with respiratory symptoms";
- "Screening thermometers should be provided to all facilities";
- "Increase healthcare workers because of the client flow";
- "All healthcare workers to be screened since they enter facilities without being triaged"

## Cleanliness and Waste Management of the health facility

The findings show that majority of the health facilities have waste management equipment with only 40% of the waste management in the facilities being cleaned and disinfected. These findings imply that the healthcare workforce is exposed to COVID19 through poor hygiene practices of the health facilities management.

*Table 3: Hygiene of the health facility*

| | | Frequency | Percent |
|---|---|---|---|
| Are waste management equipment available? | No | 108 | 18% |
| | Yes | 493 | 82% |
| | **Total** | **601** | **100%** |
| Are they regularly emptied and the area disinfected? | No | 238 | 40% |
| | Yes | 268 | 45% |
| | Don't know | 95 | 15% |

## Changing Rooms Cleanliness

The findings show that 89% of the healthcare workers stated that the health facilities do not have enough changing area and rest room and further results shows 80% of the respondents mentioned that these changing areas and rest rooms and not regularly cleaned and disinfected putting the healthcare workers more vulnerable to COVID-19 exposure.

*Table 4: Changing Rooms availability and Hygiene Cleanliness*

| | | Frequency | Percent |
|---|---|---|---|
| Do health workers in the facility have sufficient changing area and rest room? | No | 535 | 89.0 |
| | Yes | 66 | 11.0 |
| | **Total** | **601** | **100.0** |
| Are they regularly cleaned and disinfected? | No | 485 | 80.7 |
| | Yes | 116 | 19.6 |
| | | | |

## Availability of Personal Protective Equipment Materials

The results show 93% of the healthcare workers do not have enough/sufficient personal protective equipment.


*Figure 6: Availability of PPEs*
*Source: Nurses data computed by KELIN*

## Specific Personal Protective Equipment Availability

The findings demonstrated that majority of healthcare workers lack PPE equipment. With more than 90% citing they lack eye protection gear, isolation gowns, protective suit as required by WHO standards, while 82% lack N95 respirators. Only 18% of respondents lacked gloves and 30% lacked face masks.

*Table 5: Unavailable PPES*

| PPEs Unavailability | | Responses | |
|---|---|---|---|
| | | N | Percent |
| | Eye Protection | 553 | 92.0% |
| | Isolation Gowns | 567 | 94.3% |
| | Face Masks/face Shields | 183 | 30.4% |
| | N95 Respirators | 498 | 82.9% |
| | Gloves | 113 | 18.8% |
| | Protective suits | 566 | 94.2% |
| | | | |

## PPEs Supply

Results established that majority of healthcare workers (82%) are forced to reuse PPEs because of lack of regular supply of the commodities.

*Table 6: PPEs Supply*

| | | Frequency | Percent (%) |
|---|---|---|---|
| Are the PPE regularly supplied or you have to reuse them? | Forced to Reuse | 494 | 82.2 |
| | Regular supplied | 107 | 17.8 |
| | **Total** | **601** | **100.0** |

## 2.4 CAPACITY AND WELLBEING OF HEALTHCARE WORKERS TO RESPOND TO COVID-19

In assessing healthcare workers capacity on COVID-19 response, the findings show 58% of the healthcare workers have not been trained on preparedness and response of corona virus. Further the findings show that 90% of the healthcare require refresher and additional training.

*Table 7: Capacity Assessment*

| | | Frequency | Percent (%) |
|---|---|---|---|
| In the last two months, Did you received any training on COVID-19 response? | No | 349 | 58.1 |
| | Yes | 252 | 41.9 |
| | **Total** | **601** | **100.0** |
| | | | |
| Do you require refresher training/additional Training? | No | 62 | 10 |
| | Yes | 539 | 90 |

The findings established some of the topics that the healthcare workers require additional training and refresher training included;

- "Case Management of COVID-19 patients"
- "How healthcare workers can best protect themselves"
- "Proper use and disposing PPE"

### Accommodation/Isolation centres for Healthcare Providers

Findings demonstrate that majority of the healthcare workers (94%) are not provided alternative accommodation/isolation so as to minimize the risk of exposing their family members. These findings imply that the healthcare workers are putting their families & loved ones at a risk of exposure since the government and non-state actors in the sector are not providing isolation centres during this pandemic period.

*Table 8: Isolation centres for healthcare workers*

| | | Frequency | Percent (%) |
|---|---|---|---|
| Are you provided with accommodation/Isolation facility if you wouldn't wish to go home as a measure of protecting your family? | No | 567 | 94.3 |
| | Yes | 34 | 5.7 |
| | **Total** | **601** | **100.0** |
| | | | |
| Is the accommodation provided shared with other colleagues? | No | 25 | 73.5 |
| | Yes | 9 | 26.5 |

## Alternative Transport to and from Work

The results show nearly half of the healthcare workers (42%) have no transport to and from work and with the curfew and partial lockdown, this leads to difficulties in accessing health facilities due to constant inquiries by police at various road blocks.

*Table 9: Alternative Transport Provided by Employer*

| | | Frequency | Percent (%) |
|---|---|---|---|
| Can you easily access your work station from your place of residence? | No | 267 | 44.4 |
| | Yes | 334 | 55.6 |
| | **Total** | **601** | **100** |
| Have you been provided with an alternative transport? | No | 253 | 42.1 |
| | Yes | 348 | 57.9 |
| | Total | 601 | 100.0 |

## Healthcare workers exposure to COVID-19

The findings show 97% of the healthcare workers feel more exposed to COVID-19 as a result of their work as first responders and lack of preparedness of the health facilities.

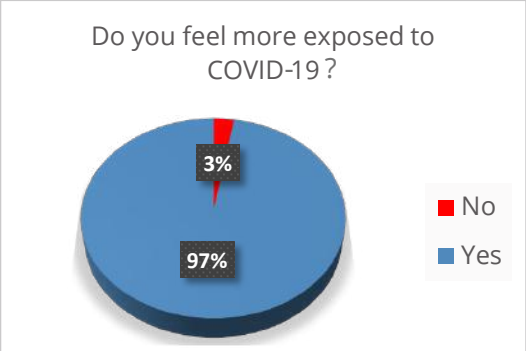


*Figure 7: Exposure to COVID 19*
*Source: Nurses data computed by KELIN*

## Testing of Healthcare Workers for COVID-19

The results shows 98% of the healthcare workers have not been tested for COVID-19. The results demonstrate the level of unpreparedness since the health workforce is at the epicenter of this pandemic being first responders which make them to be more exposed since the interact with clients yet they have not been tested to assess if they will continue to provide medical health care or they should be isolated and receive medical care.

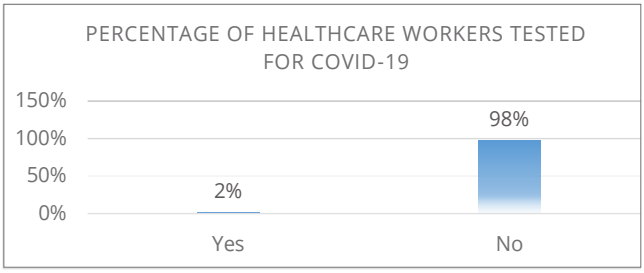


*Figure 8: Percentage of Healthcare workers tested for COVID-19*
*Source: Nurses data computed by KELIN*

## Why have Healthcare Workers not been tested for COVID-19

The results established that majority (66%) of the healthcare workers cited lack of test kits as the reason as to why they have not been tested for COVID-19.

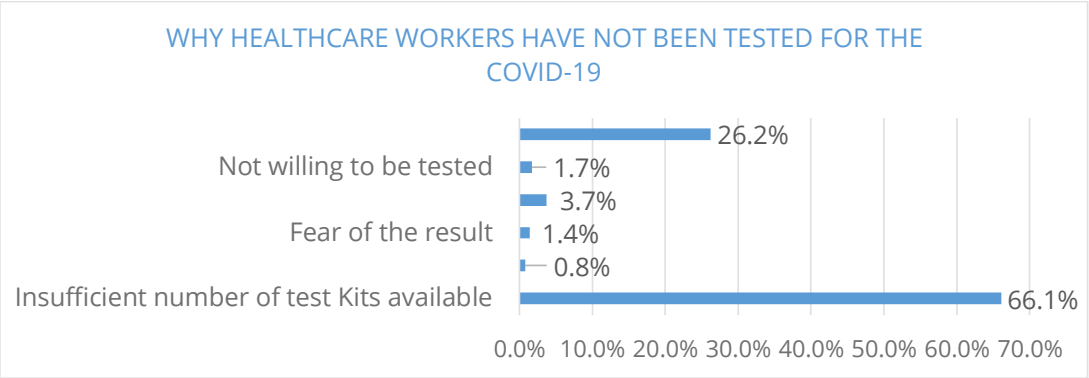


*Figure 9: Why healthcare have not been tested for COVID-19*
*Source: Nurses data computed by KELIN*

## Healthcare Workers Incentive and Motivation

### Life Insurance Cover/WIBA

The results established that only 89% of the respondents do not have life insurance cover. This is a worrying statistic since the healthcare workers are at the frontline in responding to COVID-19 which makes them more vulnerable to the virus hence this is a key requirement for the workforce.

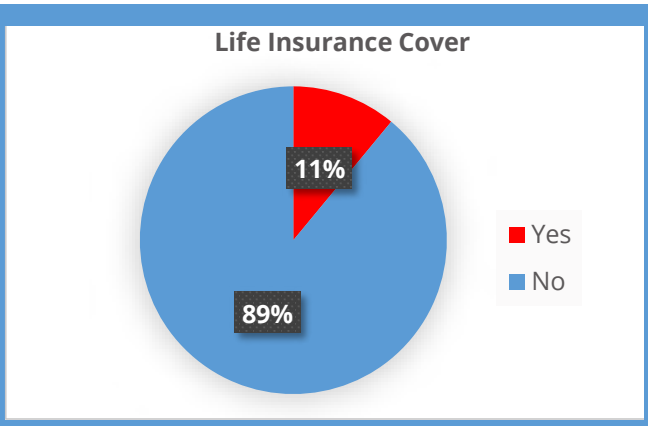


*Figure 10: Healthcare workers on Life Insurance cover*
*Source: Nurses data computed by KELIN*

### Psychosocial Support

The findings established that 91% of the respondents require psychosocial support.

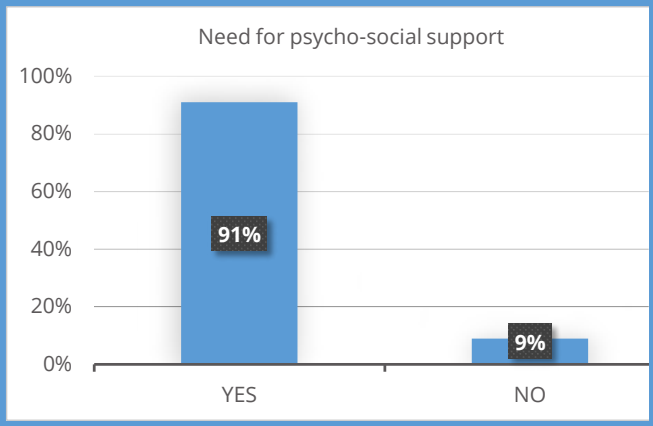


*Figure 11: Need for psychosocial support*
*Source: Nurses data computed by KELIN*

## Key Issues that drive healthcare workers to seek psychosocial support

The findings show various issues that have triggered healthcare workers need for psychosocial support in the COVID-19 period. Majority of the healthcare workers stated they were not prepared for this situation hence the response has brought about a difficult period in the health workforce. Spending many hours at work and overburdened with client flow, stigmatization from community, regular harassments after work by police because of curfew and debriefing on post death were also identified as other key issues affecting the healthcare workers.

*Table 10: Issues driving the need for psychosocial support*

| | Responses | |
|---|---|---|
| | N | Percent (%) |
| Debriefing on Post death | 153 | 27.9% |
| Stigmatization from Community | 244 | 44.5% |
| Hardship situations that we were never prepared for | 432 | 78.8% |
| Spending many hours at work and overburden with client flow | 268 | 48.9% |
| Regular harassments after work by police because of curfew | 194 | 35.4% |
| Other specify | 35 | 6.4% |

# CHAPTER THREE:
# CONCLUSIONS AND RECOMMENDATIONS

## 3.1 CONCLUSIONS

The findings of the assessment suggest that level of preparedness to respond to COVID-19 is still poor given the multiple challenges faced by healthcare workers. In particular, the lack of PPEs, lack of healthcare workers testing as well as insufficient knowledge to respond to COVID-19 brought about by lack of proper training suggest that the government and private bodies still need to do a lot to improve the level of preparedness.

The KELIN team will liaise with the KUCO and other like-minded organizations to examine the results alongside other COVID-19 studies with the aim of prioritizing actions towards addressing healthcare workers challenges by providing a right based response to the management and support being offered to the front-line teams across the country during the COVID-19 epidemic. In particular, "micro trainings" will be provided by the team to provide an opportunity to integrate key messaging on rights-based approaches and demand for occupational safety and health for all healthcare workers. Review of health laws and policies to identify and address gaps in relation to right based approaches for healthcare workers.

## 3.2 RECOMMENDATIONS

**Recommendation to the National Government**

i. There is need to review the laws and policies that govern protection of healthcare workers in matters pertaining preparedness of epidemics and occupation safety and health of healthcare workers. This could include life insurance, compensation in regards to accidents/incidents at work.
ii. Resources and mechanisms to capacity build healthcare workforce for epidemics and emergencies. This could include review of the medical curriculum to include compulsory training using case studies like COVID-19.There is a clear capacity gap in regards to respond to COVID-19 hence a training need to be provided for all healthcare workers as part of preparedness mechanisms.
iii. Strengthen all health facilities to have the capacity to handle all diseases by equipping them with proper medical equipment, medical staff and medication which should be accessible and available. This should include isolation centres for respiratory diseases as captured in the TB guidelines on management of the disease.
iv. Develop post COVID-19 strategies to ensure the workforce and resources are not overstretched not to care of other health care needs.
v. Have regular conversations with healthcare unions to understand their level of preparedness to address future epidemics.
vi. Provide enough test kits and prioritize testing of the healthcare workers.
vii. Ensure healthcare workers have the right personal protective equipment which are regular supplied to enable them provide quality health services to patients in epidemic periods.
viii. Provide regular and accurate information pertaining preparedness and response to COVID-19 and epidemics ,e.g trainings made and how many people trained and in which regions, quantity of equipment supplied and which regions etc.

**Recommendation to the County Governments**

i. County health committee team to work closely with healthcare unions and map out the needs, preparedness to respond to COVID-19 and future epidemics.
ii. Ensure the health care services at the facilities are available and accessible at all times with proper medication, medical personnel and medical equipment.
iii. Review Laws and policies that hinders accessibility of healthcare services to all through the epidemic and post COVID-19.
iv. Ensure attractive remuneration and allowances including life cover are part of the healthcare workers package.

**Recommendation to the Healthcare Workers Union**

i. Sensitize member on their rights to health to demand for compensation in relation to occupation safety and health.
ii. Ensure health care workers mainstream rights-based approach in their work.
iii. Continuous collaboration with like-minded institutions working on health rights issues to come up with collective advocacy measure for their workers through identification of gaps in health laws and policies that are retrogressive.

**Recommendation to the Civil Society Organizations**

i. CSOs should work closely with healthcare union to ensure they deliver on health rights issues of the clients they serve.
ii. CSOs to work with other like-minded institutions to ensure the laws and policies developed towards preparedness and responding to COVID-19 and other epidemic reflect rights based approach and have factored the needs of the vulnerable and marginalized communities.
iii. CSOs and other like-minded institutions to ensure the vulnerable communities are able to receive quality COVID-19 healthcare and any future epidemics.
iv. CSOs and other like-minded organizations to develop mechanisms for monitoring, documentation the level of preparedness towards responding to COVID-19 and other epidemics.

[i] *Burden of endemic health-care-associated infection in developing countries: systematic review and meta-analysis, LANCET 2010*