

December 15, 2021

*Eastern Africa Regional Office*

### EDITORIAL NOTE:

It is with great pleasure that I share with you the first issue of this Newsletter, developed by the Association of Academic Health Centers International ([AAHCI](#)) Eastern Africa Regional Office ([AAHCI-EA](#)).

AAHCI-EA is commendably led by AAHCI Regional Ambassador [Prof. William Macharia](#), who oversees an outstanding team that encourages opportunities for shared knowledge, capacity-building, and collaborative initiatives and efforts across regional academic health centers. The EA office is committed to working with academic health centers in the region to identify and respond to pressing issues that challenge academic health centers, to facilitate the discussions on these matters, as well as exchange experiences and best practices.

As you may know, AAHC was founded in 1969 to advance health and well-being through the dynamic leadership of academic health centers in the United States. AAHCI was founded in 2008 as an integral part of AAHC to bring together institutions around the world that serve the academic health center mission and share a global vision of enhancing health and well-being worldwide.

In January 2021, AAHCI announced the opening of the new EA Regional Office, hosted by Aga Khan University – East Africa ([AKU](#)) in Kenya, to facilitate

progress in healthcare delivery, health sciences research, and health professions education throughout the EA region.

In this inaugural Newsletter issue, AAHCI-EA will share how members in the region have responded to the impact of the ongoing COVID-19 pandemic on mental health. Future issues will highlight key activities and share news across the region to encourage collaboration among members.

Congratulations on your commitment to advance the missions of academic health in the EA region and around the world!

*Enjoy the read.*



**Steven L. Kanter, MD**  
*President and CEO  
Association of  
Academic Health  
Centers/International*

### IN THE SPOTLIGHT:

## The Aga Khan University Medical College, East Africa

### 1) When was the Aga Khan University (AKU) Medical College, East Africa established?

The AKU Medical College in East Africa was established in 2004, after meeting all requirements for issue of letter of interim authority to operate as a university in Kenya. The new entity, the Aga Khan University, Nairobi, started offering Postgraduate Medical Education Programs (PGME), with the goal of training all rounded specialists to bridge regional needs and provide a pool of competent future faculty for a growing medical school.

### 2) What are the overall goals of the AKU Medical College, East Africa toward providing high quality education for health professional leaders in the region?

Our goal is to produce health professional leaders through our unique training programs, building strong research programs, supporting best practice in the delivery of health services, and contributing to the broader community through strategic partnerships regionally and globally. We aspire to build for East Africa a medical college of international quality, providing trainees with the opportunity to receive the best health professional education that is relevant and that has impact across East Africa and beyond. Currently, with approximately 160 faculty members on two

campuses in Nairobi and Dar es Salaam, we have graduated 261 residents in nine specialties with many supported to take fellowships in international programs and with a higher retention rate of our graduates within the region.

### 3) What programs do you currently offer?

The AKU Medical College offers Postgraduate Medical Education (PGME) programs in nine areas of specialization in Nairobi Campus, and five in Dar es Salaam Campus. The programs consist of four years of training by course work and dissertations, leading to a Master of Medicine (MMed) degree. The curriculum and training is developed to provide relevant and contextual learning for practice in Africa and globally, with the goal of nurturing specialists who will positively impact the development of health systems in their respective countries.

Areas of clinical specialization include:

- Anaesthesiology – Nairobi Campus
- Anatomic Pathology – Nairobi Campus
- Clinical Pathology – Nairobi Campus
- Family Medicine - Nairobi and Dar es Salaam Campus
- Internal Medicine - Nairobi and Dar es Salaam Campus



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- Obstetrics and Gynaecology - Nairobi and Dar es Salaam Campus
- Paediatrics and Child Health – Nairobi and Dar es Salaam Campus
- Radiology – Nairobi Campus
- Surgery - Nairobi and Dar es Salaam Campus

#### 4) What are some of the future plans for AKU Medical College, East Africa?

In the coming years, we intend to expand our academic offerings, including the expansion of our postgraduate programs with additional Residency, Masters, Doctorate and Post-doctoral programs. Importantly, we seek to complete the evolution of our College into a modern Medical School located in a vibrant academic health center with the introduction of the Bachelor of Medicine and Bachelor of Surgery program in the near future.

Our promise is that our MBChB program will represent the latest iteration of innovative competence- based medical education, or what we are christening Medical Education 3.0. We are taking the best content from the first and second generation medical schools that many of our faculty attended, and infusing them with a new philosophy and implementation paradigm including interprofessional education, social science grounding, learner-centeredness, a focus on solving real problems of communities, and leveraging technology to deliver on our promise.

#### 5) What are the focal areas of research for AKU Medical College, East Africa?

The AKU Medical College, East Africa seeks to demonstrate excellence in research, service, and scholarship through Centres of Excellence (CoE) in the health subject areas of:

- Diabetes, cardiovascular, and cancer disorders
- Early Childhood Development (ECD)
- Infections, immunity, and inflammation (III)
- Molecular genetics
- Neurosciences
- Women, Neonatal, and Child Health (WNCH)

We aim to inculcate a rich scientific research culture that impacts delivery of clinical and population health services in the East Africa region. Our broad overarching research theme of “socio-economic determinants of health” accommodates diverse interests and sustainable collaborations across academic and service disciplines for superior impact.



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## **Mental Health Crisis of the COVID-19 Pandemic: A Global Perspective**

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Globally, about 268 million people were infected by COVID-19, and over five million people lost their lives as of December 9, 2021. The pandemic not only saw a high mortality from the infection but also psychological unrest and mental health problems globally. Uncertainties and the unpredictable nature of the pandemic led to mental health problems such as depression, anxiety, sleep problems, and post-traumatic stress disorder.

Communities are at a high risk for psychological disturbances and mental health problems such as depression, anxiety, suicide, and posttraumatic stress disorder due to stress related to the disease, loss of employment, fear of acquiring the disease, separation from families, lack of proven treatment, fear of death, and loss of loved ones. Furthermore, social exclusion and stigma pose a major impact on the mental and psychological wellbeing of the community.

Healthcare workers who are fighting the pandemic are at a high risk of psychological disturbances and mental health problems due to stress related to the disease, death of patients, lack of adequate personal protective equipment, lack of proven treatments, long shifts without sleep, separation from family, and fear of getting or dying from the infection.

The increase in fear and stress among healthcare workers exposed some to mental health and psychological crises.

### **The Ethiopian Situation**

Ethiopia reported its first COVID-19 case on March 13, 2020. The country took immediate public health measures that included closure of schools and universities, a partial lockdown that involved temporary suspension of public transport, 14-day quarantine requirements for international arrivals, and a five-month state-of-emergency. The actions prevented an early surge in the number of cases.

However, most of the actions were relaxed after six months due to collateral damage caused by the restrictions. As a result, the country witnessed a gradual rise in the number of cases, critical care admissions, and COVID-19-related deaths that peaked in the first few months of 2021. As of December 9, 2021, the country reported 372,888 cases and 6,816 COVID-19-related deaths. However, the true burden of the pandemic is most



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likely underestimated due to limited testing and weak contact tracing system.

Several studies from Ethiopia have reported mental and psychosocial crises related to the pandemic among community and health professionals. Healthcare workers (HCWs) in the country reported a high rate of perceived vulnerability for COVID-19 infection and were worried about the risk of becoming infected with the virus and the risk of transmitting it to their families. As a result, most of the HCWs reported that they were not ready to provide care for COVID-19 patients.

Frontline healthcare workers in Ethiopia suffered from a major mental health and psychological crisis. The first few months of the pandemic created the worst challenges as healthcare workers were stigmatized by their communities due to exposure to infected patients.

## **The Experience of Jimma University**

To address the mental health need of quarantined people, patients with COVID-19, and healthcare workers, Jimma University Psychiatry Department worked with the Oromia Regional Health Bureau and the Federal Ministry of Health of Ethiopia. A plan included creating awareness among communities regarding the mental and psychological crises related to COVID-19 and mitigation strategies.

The department used local FM radios to disseminate information to the public regarding how and where to get treatment. A team from the department of psychiatry also led the mental and psychosocial consultation team for the Oromia Region and provided various trainings for healthcare workers. Training was also provided for selected healthcare workers working in Jimma Zones so that each health facility in the zone has at least one trained professional who can provide mental health counselling and psychosocial support for the community.

During the lockdown, it was not easy for patients with mental health problems to attend to their follow-up. Some patients who were attending psychiatric follow-up got the opportunity to consult clinicians by phone regarding their treatment. Phone numbers of clinical psychologists working at Jimma University Medical Center were also made available through social media platform so that people in southwest Ethiopia who needed COVID-19 related psychosocial support could contact them. Additionally, mental health professionals were assigned to quarantine and treatment centers to provide one-to-one and group mental health and psychosocial support. Mental and psychosocial support was also given to families of COVID-19 patients.

To reduce the mental health impact of COVID-19 among healthcare workers, the Jimma University



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Psychiatry Department provided psychological first aid training for frontline health workers so that they could support each other and their patients. Support included one-to-one counseling and emergency psychiatry service.

In summary, to tackle the mental health toll of the pandemic, the hospital took proactive measures by training healthcare workers and extending these services to the community and healthcare workers early during the pandemic.

## COVID-19 Pandemic and Mental Health in a Large Informal Settlement in Nairobi, Kenya

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*Kibra informal settlement, Nairobi County, Kenya*

The first case of COVID-19 was reported in Kenya on the 12<sup>th</sup> of March 2020. Within a fortnight the government imposed a raft of containment measures to reduce the spread of the disease. Among these was the application of a nationwide curfew, the suspension of international travel, and the prohibition of public gatherings. With time, social distancing and the wearing of face masks in public spaces, coupled with mandatory handwashing and sanitizing using alcohol-based sanitizers, became the norm. Further, in four counties of Kenya (Nairobi, Mombasa, Kwale, and Kilifi) – which bore the brunt of the first wave – domestic travel into and out of these counties was limited through lockdown procedures.

The “new normal” that resulted from these measures was an unprecedented stressor for ordinary Kenyans, and resulted in changes that affected the way that people interacted with one another. Social distancing was one of the key



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measures the Kenyan government implemented to help halt and manage the spread of the virus.

This was expected to be a challenge to implement in informal settlements such as Kibra—home to over one million poor and middle-class households and characterized by overcrowding. Within one month of the first case, the Kibra sub-county accounted for more than 25 percent of cases in Nairobi County, which many attributed to the challenge in implementing social distancing, the expense of face masks, as well as insufficient water supply and sanitation facilities to support handwashing—leaving the community more vulnerable to the spread of coronavirus.

Against this backdrop, the Kenya Medical Research Institute's Centre for Public Health Research (KEMRI-CPHR) commissioned a study to explore community perceptions, challenges, and coping mechanisms of social distancing regarding COVID-19 in Kibra informal settlement. Using a convergent parallel mixed-methods approach, quantitative and qualitative data were collected from 354 respondents, who are residents in the Kibra informal settlement.

More than one-third of respondents screened positively for depression (34.7 percent) and generalized anxiety disorder (36.7 percent). Depression and anxiety co-occurred among the respondents and were significantly associated with

employment status at the univariate level – with unemployed respondents almost twice as likely as those who were employed to experience anxiety and depression.

This was corroborated by findings of the psychosocial effects of COVID-19, which included: fear of infection (91.2 percent); safety concerns for children/adolescents (77.7 percent); lack of sleep/irregular sleep patterns (77.1 percent); experiencing fear and anxiety (75.7 percent); children affected by school closure (74.9 percent); and lack of personal space at home (69.8 percent). Key informant interviews revealed that respondents experienced hopelessness, depression, and suicidal ideation because of job losses.

Experiences shared included intimate partner violence attributed to frustration with job losses and the inability to provide financially, among others. The situation was exacerbated by breakdown in social support systems—where neighbors could not rely on each other for support and each household was left to bear the brunt of the pandemic alone.

While commendable efforts have been made both at national and county levels to combat COVID-19, more remains to be done. The mental and psychosocial trauma caused by the pandemic is yet



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to be fully characterized and its effects will be felt in Kenyan society for a long time to come.

In informal settlements, where basic services are lacking – this trauma is amplified; and there is a need for concerted multi-stakeholder efforts to assess, intervene, and, where possible, prevent mental and psychosocial challenges caused by the pandemic.

## Effects on Mental Health for Healthcare Workers during the COVID-19 Pandemic. An experiential journey at the Aga Khan University Hospital, Nairobi

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### Global Scenario

Since 2019, millions have been infected with COVID-10, with more than four million having lost their lives around the world.<sup>1</sup> In Africa, about five million cases of infections have been reported.<sup>1</sup> Kenya presently reports a loss of more than 5,000 lives. With the huge number of people impacted by this virus, it is reasonable to state that many more have directly or indirectly felt the psychological impact—leading to detrimental effects on their mental and emotional health.

Health measures taken in Kenya aimed to curb the spread of COVID-19 include national quarantines, closure of schools, limited travel, and curfews. Arising from the ashes of this pandemic, some vulnerable populations are at an increased risk of having significant mental health effects and possible deterioration. This includes those who already have been pre-disposed to mental health issues as well as the vast number of healthcare workers (HCWs) who have been serving at the frontline at great risk to themselves and their family members.

The team at our counselling and psychology departments worked tirelessly to provide as much support as possible to affected staff and their family. This was in addition to the daily workload of providing psychological support to in- and out-patients seeking psychological support. Additional voluntary support was sought to help with virtual counselling support to the staff, which took many forms:

- One-to-one psychological support was offered to every single affected staff.
- Weekly virtual staff forums were organized to allow opportunities for expression and comfort.
- Individual and group therapeutic and counselling sessions were arranged for those returning to work and for those staff working in the frontline.



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- Counselling support was provided for all infected staff, through individual contact for supportive therapy.
- Those returning to work underwent a physical and mental health assessment of their ability to return to work.

Psychologists at the front line performed psychological first-aid therapy, instilled hope, and, as the losses became more apparent, helped patients and families prepare for eventualities. In keeping with restrictions in place, many family members were not able to say their goodbyes and could not attend final rituals.

This increased the instances of prolonged or complicated grief, which is becoming more apparent. Technology was adapted and counsellors prepared and enabled family members to connect with their loved ones and participate in funeral ceremonies.

Unlike hospitalization before the emergence of COVID-19, patients were unable to have family members or caretakers visit and support them during their hospital stay. Counselling helped to bridge the gaps by becoming “family” to the sick.

HCWs who were infected with COVID-19, and their loved ones, were more susceptible to developing mental illness or experience worsening of already poor mental wellbeing. As a result, many of the

HCW’s on the COVID-19 frontline needed supportive therapy as they witnessed daily tragedy.

The HCWs witnessed death among children, young and old adults, and the expectant. Some of them lost close acquaintances, family members, and relatives. The HCWs were confronted by their own fears of contracting the disease and bringing it home to families. In addition, they worried about the accessibility of protective equipment, the scarcity of resources available to themselves and the patients, and determining the best course of action during triage if those resources became scarce.

Those HCWs who tested positive to COVID-19 had to face their own mortality and experienced the highest levels of stress. This resulted in an urgent need for first-aid psychological support. This was even more so for those with pre-existing mental and emotional issues, as this triggered early onset of mental health conditions.

Staff who tested positive for COVID-19 had to isolate from family, friends, and other colleagues. This was especially challenging given the lack of facilities at their homes. Despite the support being given by the organization, many showed signs of anxiety and depression.

Many who recovered from being infected faced internal and external stigmatization, leading to



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feelings of alienation. Anger, fear, and guilt affected other HCWs, which resulted in depression, anxiety, insomnia, and post-traumatic stress disorder (PTSD). Some sought psychiatric assessment and, in some cases, were prescribed medication.

HCWs who were quarantined experienced acute feelings of loneliness, hopelessness, social disconnectedness, anxiety and depression. Those who were very sick feared the possibility of their own death and for their family members, having witnessed first-hand the losses, extended hospital stays, and prolonged recovery of their patients. They worried about potential long-term consequences of the disease for their jobs, their family members, and their financial responsibilities, even if they would survive their infection or the pandemic.

Those HCWs who returned to work after recovery or self-isolation had to receive counselling due to stigma associated with being infected, which led to feelings of resentment along with the adjustment challenges of being re-integrated into their workplace. Counselling support was given to help the HCWs deal with their own fears arising from the experiences and effects on their mental and emotional health so that they could heal and return to work.

## Delivering News of Positive COVID-19 Test to Healthcare Workers: Experiences of two psychiatrists in Uganda

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Recent studies have linked testing positive for COVID-19 with acute and long-term psychological distress<sup>1</sup>. The psychological distress is reported worse in Healthcare Workers (HCWs). A review of literature revealed consistent reports of stress, anxiety, and depressive symptoms in HCWs as a result of COVID-19<sup>2</sup>. In order to minimize psychological distress associated with receiving positive COVID-19 results, the Ministry of Health (MOH) identified two senior psychiatrists to carry out therapeutic communication of distressing news to fellow health workers.

This article details the experiences of two psychiatrists who were tasked by the MOH to deliver bad news to healthcare workers following COVID-19 positive testing. Bearing bad news is considered one of the most difficult scenarios in healthcare.



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Breaking bad news by telephone is particularly difficult as the bearer would be unsure of whether they are speaking to the right person and of the reaction of the recipient. There are four steps to delivering bad news: 1) preparation; 2) delivering the message 3) working with subsequent emotions 4) further guidance and planning for next steps.

**Preparation:** The setting of the caller and the receiver are considered. The receiver's perception of the caller can be affected by the emotional state of the caller. For example, if the caller is anxious, depressed, irritated, or pressured, the receiver may be less positive. We prepared by reviewing all steps.

These steps were written down. We agreed that the best time to call would be in the evening, when both us and the recipients would likely be at home. We agreed we would make calls after freshening up and made sure we were not hungry or thirsty or in any form of discomfort. The calls were made in private, with no possibility of interruption from bleeps, colleagues, patients, or relatives. We did deep breathing exercises to relax just before the calls.

**The Message:** We introduced ourselves on the call, and then confirmed the identity of the receiver and whether we had met/spoken before and where. Most receivers were known to us, having been involved in the COVID-19 task force response team

at various levels. We asked whether it was a good time to talk. If it wasn't, we would ask for the best time to call them back.

Further, we clarified if the person was alone or with other people at home. This would give us an idea about available support, in case there was a sudden drop in the call. Fortunately, this did not occur, probably because the message began with a warning shot, a statement to convey the gist of the call. For example, a statement such as, "I am calling on behalf of MOH with regard to the COVID-19 test you took two days ago..." helped in preparing the person.

**Manage emotions:** This involves listening attentively, eliciting concerns, managing resistance, responding to questions, and being generally supportive. Listening intently allowed us to hear and recognize the emotions behind the voice in order to respond appropriately with an empathetic tone of voice. From experience, the most likely reaction is shock, which is experienced as confusion, denial, anger, bargaining, and acceptance. Anticipating some reactions helps in prior understanding of how to respond in a therapeutic manner. In addition, it is important to distinguish one's own emotions from those of the person being contacted.

Examples of some of the responses we had included: "it's not true" or "it cannot be". Our



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response would be along the lines of: “I appreciate it is very difficult for you to take this in, especially as it seems you can’t recall any immediate possible contact”. Others would go silent or simply say “thank you for letting me know”.

Our response then would be: “It seems like this news has shocked you. Perhaps we could talk through the next steps?” Some individuals became upset and quarreled, ending the call and shutting down their phone for days. Some individuals were heard crying or shouting in response to the news. We would respond, “I recognize that it is very distressing for you to hear this news, particularly by telephone”.

This supportive use of acknowledgement would serve to replace the gentle touch or eye contact that we would otherwise use to reassure in a physical setting. Acknowledging the emotion gives it legitimacy demonstrates support. If strong emotions are not acknowledged by the caller, it would appear insensitive and this would render further interaction a challenge. Reflecting back can help to break the silence, e.g., “it seems that this is overwhelming for you”.

Some HCWs resisted anything to do with going for treatment at the COVID-19 treatment units (CTU). We had a stepwise way of dealing with this. At one extreme end were those HCWs who voluntarily accepted to be taken to CTU while at the other

extreme were those who so resisted that we had to invoke the Presidential directive that all people who tested positive should be treated at the CTU, regardless of whether one had symptoms or not.

Between the extremes were those who were convinced with explanations and negotiations. For example, one HCW requested us to have the ambulance parked far away from their home and the sirens switched off in order not to alert the neighbors. To manage subsequent emotions even further, we offered to stay on call in case a HCW indicated that they still needed our support.

**Guidance and Planning:** Our goal was to get the COVID-19 positive HCW to the CTU. However, the HCWs needed guidance on what to expect during their stay at the CTU. This provided focus and a sense of control of a situation that was clearly overwhelming to them. It is the responsibility of the caller to help the receiver make plans after receiving distressing news.

For example, offering to link them with psychosocial support in the CTU or offering to contact a significant person on their behalf can be helpful. An employee of a high ranking official had plans to go with his boss for a meeting the following day at 8:00 am, and he was being informed that an ambulance was picking him up at 10:00 pm the night before. He requested that we first talk to his boss and arrange how the next day’s



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plans would be handled without him. We supported him with his request and he agreed to go to CTU.

There were some challenges: some calls were long and emotionally taxing, even to the caller, and some HCWs needed support by the caller well beyond the calls. Other recipients of our calls were rude and unreceptive. Despite these challenges, we believe that this intervention reduced psychological distress associated with getting distressing news of being COVID -19 positive and having to be isolated in a CTU.

**Conclusion:** Healthcare workers can be as psychologically distressed as everyone else when receiving news of a COVID-19 positive test result. They need special support to help them overcome this challenge. We recommend that pre- and post-test counselling be incorporated in COVID-19 testing programs for HCW in order to minimize their distress.

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## UPCOMING MEETINGS

### 2022 EA Regional Forum

Aga Khan University Medical College – East Africa

Nairobi, Kenya

February, 2022

### 2022 Global Innovation Forum (GIF)

Bethesda North Marriott Hotel & Conference Center

Washington DC, USA

May 1-3, 2022

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