Medicus

KENYA MEDICAL ASSOCIATION

2025 September Issue

10th Edition

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Physician Wellbeing Committee
Dedicated to promoting the mental, emotional, psychosocial and physical well-being of all doctors in Kenya as we champion for their welfare holistically.
Convener - Dr. Ayda Wanjiku

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The committee is responsible for ensuring Health policies being implemented are of standards.
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The Awards Committee is responsible for preparing criteria for Divisional and National Awards to be granted to KMA members and staff. *Convener - Dr. Ramadhan Marjan*

ICT Committee
The committee is responsible to manage and ensure all the standards regarding information, technology and Communication are upheld in the organization.
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Public Health Committee
The committee is responsible in ensuring the association actively participates all public health related awareness and activities.
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East Africa Medical Journal
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Social Responsibility and Welfare Committee
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HALF TIME CESAREAN SECTION

Dr. Simon Kigondu
President, KMA

It was a fine Saturday evening in late December 2002. I had just settled in to watch an English Premier League match between Manchester United and Arsenal. Back then, this was a must-watch game, and all eyes were glued to the screen—tense. I was hosting colleagues at my house within the hospital quarters at Machakos District Hospital. Man-U's Juan Sebastian Verón netted the first goal in the 22nd minute. It was going to be a good night; I could feel it.

At the 30-minute mark, we heard the increasingly loud siren of an ambulance. We could almost intuitively tell it was from Makueni County. It drove straight to the maternity section. Shortly after, my cell phone rang. The midwife's voice deferred all niceties: "Doc! Placenta previa from Makueni. She is pale ++." Her tone was calm and firm, communicating urgency without panic.

Placenta previa is a condition where the placenta lies low and can cause severe bleeding before labour starts. It can lead to maternal and foetal mortality. The standard treatment for an actively bleeding placenta previa is an emergency caesarean section.

"Prepare, and let's meet in the theatre," I said.

As the team in the maternity theatre set up, the first half wore on. Arsenal's trio of Henry, Bergkamp, and Pires tried to equalize in vain. The halftime whistle likely marked the end of the match for me. In no time, I was in the maternity theatre. I lived in the hospital compound—a three-minute dash away. A visibly pale mother lay on the table, anaesthetized. The scrub nurse was ready and gave me a thumbs up. I scrubbed in. The priority was to stop the haemorrhage and save both mother and child—hopefully in time to catch the final minutes of the game.

At Machakos District Hospital, we had seen it all. Few doctors were working in peripheral facilities. On weekends, many would travel to the city for a breather. From Friday to Sunday, the doctor on call at Machakos District Hospital would be put through the wringer, often receiving referrals from across the Lower Eastern Province—from nearby Kangundo to as far as Kitui and Makueni.

As the halftime analysts dissected Arsenal's frailties, I worked to deliver the baby as quickly as possible. The lives of both mother and child depended on it. Back then, I was swift and precise in the operating room. In 15 minutes, flat, the mission was accomplished. The baby was out. The mother was stitched up and receiving a transfusion in the postoperative room. I have yet to achieve that feat again. We had seen a few miracles before, and this was one for the list. Both mother and baby survived.

I unscrubbed, dashed back to the house, and was back on my La-Z-Boy couch by the 63rd minute. My Manchester United team did not disappoint. Paul Scholes scored a second goal in the 73rd minute, sealing a 2–0 win against a full-strength Arsenal side.

Cases like this shaped my future choice of specialization. The number of obstetrics and gynaecology cases I handled as an intern and medical officer was too many to count. The shortage of doctors ensured I had plenty of practice, learning to operate with precision, pace, and efficiency.

Things have changed since then. Healthcare services have improved. More doctors are trained and deployed to counties. The centers that once referred patients to Machakos District Hospital over weekends are now large hospitals offering complex services, improving equity and access for people in those areas. And Manchester United? They have declined to the extent that Arsenal occasionally finishes above them in the league table.

Rising with the Nation: Frontline Leadership and Resilience Through Crisis

Dr. Diana Marion
Secretary General , KMA

In the quiet hum of a hospital ward at midnight, in the dust-choked air of a mobile clinic in Turkana, in the anxious eyes of an intern facing her first COVID-19 patient—and in the acrid sting of coloured tear gas seeping into our field hospitals during Maandamano and Gen Z protests—this is where Kenya's healthcare soul truly lives. For decades, the Kenya Medical Association (KMA) has stood beside you in these crucibles, not as distant administrators, but as fellow travelers breathing the same air: the air of sacrifice, of fear, and of unbroken resolve. We've championed your welfare and fought for quality care because we are you—your exhaustion, your courage, your unwavering commitment to heal anyway when the world outside burns.

I remember the weight of those early pandemic days. A silence thicker than fog settled over our hospitals as we faced a virus the world didn't understand. Fear was a live wire in every corridor. Yet, in Kakamega, Dr. Amina (not her real name) worked by torchlight as floods swallowed roads, her stethoscope a lifeline. In Kibera, Nurse Kamau masked his terror to soothe a child fighting for breath. And across the nation, young interns slept in cars, too afraid to bring death home to their families. These were not extraordinary acts by untouchable heroes—they were your daily choices. Choices that forced KMA into action: transforming boardrooms into war rooms, racing against time to secure PPE that felt like paper armor against an invisible enemy. I'll never forget Dr. Wanjiku's tears when a box of N95 masks reached her rural clinic—"Now I can touch my daughter again," she whispered. But we knew

protection wasn't just physical. Behind every intubated patient was a nurse swallowing panic, a doctor grieving alone. So, we built sanctuaries of words: mental health hotlines where an anesthetist could finally confess at 3 AM, "I've pronounced 12 deaths today. How do I still feel human?"

Yet our battles stretched beyond the covid 19 pandemic. In 2017, as tear gas choked Nairobi's streets and democracy bled, KMA stood where medicine met moral defiance. When police batons fractured the sanctity of our emergency rooms, we didn't just condemn the violence—we stood at the barricades with human rights defenders, declaring hospitals holy ground. In the aftermath, we turned trauma into testimony. Suture kits became forensic tools; intake forms, evidence for justice. We trained you not just to heal wounds, but to document them—for dignity, for truth, for a nation that needed to remember.

And now, this year—as we marked July 7th, 2025—that promise lives louder than ever. Our pact with the National Police Service, forged in the fires of those earlier struggles, is no relic of the past. It's a living covenant renewed in training sessions where young medics and officers learn side-by-side: how to secure a trauma bay during protests, how to read the fear in each other's eyes, how to choose humanity over hostility. "Never again," we vowed. Today, we build that 'again' every single day.
You see this resilience in the community health worker biking through Turkana's dust to vaccinate a child against all odds. In the Mombasa surgeon improvising a device to save a fisherman's hand with nothing but ingenuity and grit. In the KMA technical teams debating policy deep into the night, fueled by chai and the conviction that equitable care is non-negotiable. This is our legacy—written not in grand speeches, but in the calloused hands that hold trembling ones, in the broken sleep sacrificed for strangers, in the mothers who live because you fought for ventilators, and the students who dream of medical school because you demanded fair funding. Even the police officer who now shields a clinic during unrest does so because you taught him healing has no sides.

We are KMA: the steady pulse in Kenya's chest when crisis strikes. The proof that courage isn't the absence of fear, it's showing up anyway. Keep telling your stories. They are the heartbeat of a nation that refuses to break.

Stories Of The Frontline Healthcare Worker

“Lessons from the frontline: The Gen Z protests”

By George Amolo

The story of frontline healthcare workers extends beyond hospital walls, intertwined with the broader narrative of our communities. The challenges brought forth during political unrest reveal critical gaps in emergency response systems, while the documented successes highlight the power of collaboration. By investing in structured models and fostering effective partnerships, we can bolster our ability to serve communities more effectively, paving the way for a healthier society.

Introduction

The recent political unrest in Kenya has underscored both the resilience of our healthcare workers and the systemic challenges they face outside hospital walls. My years of experience in pre-hospital emergency medicine have exposed me to the chaos and danger associated with such environments. Even though I observed the recent events from afar, my past experiences during post-election violence resonate deeply today. It is crucial to highlight the struggles and successes of healthcare professionals as they navigate these tumultuous times, affirming their integral role within a larger community.

Challenges Encountered

One of the most significant hurdles faced during this unrest was the lack of a structured pre-hospital care system. This inadequacy created gaps that hindered timely and effective responses to the injuries sustained during protests.

Resource Constraints

The scarcity of ambulances proved problematic, with only Nairobi managing to organize adequate resources. In many areas, injured individuals were mishandled by bystanders due to a lack of ambulances, further exacerbating injuries, resulting in further harm rather than the assistance they require and revealing the necessity for a better prehospital care system. We must agree that bystanders do not have the necessary knowledge or training to handle injuries like gunshot wounds. Without understanding the anatomy and physiology of such injuries, they might inadvertently cause further harm, such as exacerbating bleeding, causing spinal cord damage, dislodging clots or fragments, and introducing infection. The presence of trained prehospital clinicians and ambulances is essential in such situations. I was following the events live on TV, and I saw a protester shot by the police lying on the ground, and the way the bystanders handled him was shocking, but it was what they could do.

Security Risks and Ambulance Vulnerability

An alarming issue was that many ambulances did not take essential security measures, such as displaying white flags, which signify medical transport. This oversight increased the risk of being targeted by both police and demonstrators who may have suspected that ambulances were carrying law enforcement personnel or other perceived adversaries. Only a few ambulances, such as those from MSF (Doctors Without Borders) and the Red Cross, adhered to this critical safety standard, further emphasizing the need for careful planning, know-how, and coordination before offering medical support during unrest.

Fragmented Support Systems

Centralized treatment zones were established, yet the absence of prior stakeholder arrangements led to operational disarray. This hampered efficient patient triage based on their mechanism of injury, ultimately impacting the quality of care provided.

Limited Activation of Emergency Response Teams

Despite the dire need for immediate assistance, the Ministry of Health's emergency response team was not activated to assist in the field. The absence of the Ministry of Health's emergency response team during this critical time raises important questions about our healthcare system's preparedness for emergencies that occur outside hospital settings. This situation highlights the essential need for a robust pre-hospital infrastructure that aligns with Kenya's vision for universal healthcare coverage, ensuring that every citizen has access to timely medical care, no matter the circumstances.

Collaborative Wins

Despite these challenges, there have been notable triumphs. Field collaboration between pre-hospital clinicians and hospital staff was evident as they united to provide urgent medical care based on the type of injury, ensuring patients receive timely treatment and transport to hospitals.

These collaborative efforts underscore the potential for enhanced partnerships between pre-hospital and hospital personnel during future emergencies. By working together, we can ensure a seamless transition of care, improving outcomes for patients and strengthening the healthcare system.

Building Trust within the Community

By actively engaging in medical response during emergencies, healthcare workers fostered trust within the community. This partnership between prehospital providers and hospital staff not only enhanced credibility but also reinforced local healthcare systems. By stepping forward to support those in need, healthcare

workers not only reinforced their commitment but also solidified the public's confidence in pre-hospital care.

Recommendations for Improvement

Reflecting upon these experiences reveals a crucial need to build a robust prehospital infrastructure integrated into the overall healthcare framework. Such a structure will ensure coordinated emergency responses during political unrest, disasters, or disease outbreaks.

The Need for Structural Improvement

Looking ahead, we must advocate for the establishment of a well-integrated pre-hospital infrastructure within our broader healthcare framework. This structure should be designed to facilitate a coordinated emergency response during crises, whether due to political unrest, natural disasters, or health outbreaks. Such preparedness aligns with the principles of universal healthcare coverage, emphasizing the importance of accessible care for everyone.

Stakeholder Engagement

Post-event evaluations are essential for growth and innovation. Yet, we have not witnessed formal meetings among stakeholders to discuss successes and identify areas needing improvement. Formulating a structured approach supported by the government will help illuminate lessons learned and result in improved preparedness and responsive strategies during future emergencies. Many agencies responded independently, leading to an uncoordinated effort despite healthcare professionals assembling in one centralized area. A structured system supported by government oversight is essential for ensuring we are ready for future crises.

Prioritize safety measures

Ensure that ambulances are marked and that pre-hospital clinicians have the necessary security measures to perform their duties safely.

> "The lessons learned from recent events and our past experiences should guide us toward a more resilient healthcare system—one that embodies the ideals of universal healthcare coverage. By investing in cooperation, coordination, and preparation, we can equip healthcare workers to face any challenge that arises, ultimately safeguarding the health and well-being of the communities they serve."

George Amolo
BSc Paramedicine MMUST.
Founder The Paramedic Association Of Kenya
Registered and accredited Advanced Emergency Medical Technician (Australasian Registry of Emergency
Medical Technician). Professional interest include medicine in motor sport, football medicine, Prehospital research.

Redefining the Frontline: How Everyday Kenyans Are Saving Lives Before the Ambulance Arrives.

By William Kimanzi

"13 people die every day on Kenyan roads." -
National Transport and Safety Authority (NTSA)

This is more than a statistic. It is a preventable national emergency. One of the leading causes of these fatalities? Severe bleeding. And yet, the first person on the scene of most road crashes in Kenya isn't a paramedic or doctor. It's a bystander: a boda boda rider, a market vendor, a teacher. These are our country's real first responders - individuals who are present in the first few minutes when survival often hinges on immediate action.

This is the reality that gave birth to the STOP THE BLEED® Kenya Initiative, a localized, community-first emergency response program designed to train ordinary citizens to take life-saving action when it matters most.

A New Definition of "Frontline Healthcare Worker"

Too often, the term' frontline healthcare worker' is confined to hospitals and health centers. But in Kenya, the frontline is the roadside, the classroom, and the matatu stage.

Since launching just months ago, we have trained over 1,018 people across 5 counties, targeting those who are most likely to witness a medical emergency.

We focus on practical, high-impact skills: how to apply direct pressure, pack a wound, or create a makeshift tourniquet using common materials.

These are not complex medical procedures - they are basic interventions that can mean the difference between life and death

From Awareness to Action: Real Stories, Real Impact

One of the most powerful outcomes of our work has been the real-life stories that emerge after the training sessions. Along Outering Road in Kariobangi, a schoolteacher who had completed our training successfully responded to a playground accident, stabilizing an injured child before further help arrived. In another case, Mark, a trained boda boda rider, provided critical assistance at a crash scene moments after impact – well, before any ambulance arrived on site. These individuals are no longer passive witnesses to emergencies; they are now active, empowered participants in Kenya's emergency response system.

Scaling for Greater Reach

Our model is intentionally simple and scalable. With no external funding to date, we've managed to build traction by partnering with communities directly and adapting to their realities, whether that means training boda riders under a tree or holding sessions after school hours for teachers and caregivers.

The goal is not to wait for funding or policy to catch up; it is to meet Kenyans where they are, with the tools they need to act.

We are now expanding to more counties, guided by local demand and supported by a growing network of volunteers, health educators, and civic leaders who see the value of equipping their people before disaster strikes.

This isn't just training - it's capacity building. It's preparedness. It's resilience.

A Vision for a First Aid Nation

Our ambition is simple yet transformative: to normalize first aid in the same way we do seatbelts and vaccines. To ensure that every Kenyan knows what to do in the first 3 minutes of an emergency.

Because in a country where ambulances are few and delays are common, we cannot afford to treat lifesaving skills as optional. We must redefine healthcare to include the people who are there first.

In doing so, we are not only saving lives - but we are also building a new kind of national confidence, one trained citizen at a time.

> Since launching just months ago, we have trained over 1,018 people across 5 counties, targeting those who are most likely to witness a medical emergency.

William Kimanzi is a certified First Aid Educator and Founder of The QuickFix Learning Hub. He is the National Coordinator of the STOP THE BLEED® Kenya Initiative, a community-first emergency response movement training thousands of Kenyans to save lives outside the hospital setting.

Navigating the Frontlines as a Young Pharmacist in Kenya

By Madeline Iseren

The vibrant hum of a busy hospital pharmacy, the quiet intensity of dispensing life-saving medications, and the meaningful conversations with patients — these are the daily realities of a pharmacist on the frontline. As a young professional with two years of experience post-internship, I have witnessed firsthand the transformative power of healthcare in Kenya and the often-unsung role pharmacists play in this intricate dance of healing. We are guardians of medication safety, educators who empower patients, and the bridge between prescription and recovery. My journey, though relatively short, has been a masterclass in adaptability, resilience, and the impact of holistic patient care.

One of the most significant challenges I have encountered beyond the hospital setting is medication adherence. Dispensing the right drug is not enough; patients must understand why, how, and when to take it. I recall an elderly gentleman with hypertension who, despite receiving his medication regularly, saw no improvement in his blood pressure. A deeper, empathetic conversation revealed he was taking his once-daily medication only when he felt unwell, fearing side effects if taken consistently.

This was not a failure of the drug, but of communication. By explaining the chronic nature of hypertension, the need for consistent medication to prevent long-term complications, and addressing his fears, we saw remarkable improvement in his health. That experience underscored the critical role of pharmacists as communicators — translating medical jargon into clear, relatable language and building trust. We are not merely dispensing agents; we are educators, counsellors, and advocates for our patients' well-being.

Another challenge, particularly prevalent in diverse settings across Kenya, is drug resistance, especially to antibiotics. Easy accessibility without proper prescriptions in some areas fuels this growing global health crisis. As frontline pharmacists, we are often the first point of contact for those seeking relief. It is our ethical responsibility to educate the public on the dangers of misuse and discourage self-medication. I have had countless conversations with patients asking for "something strong" for viral infections, guiding them instead toward appropriate symptomatic relief and explaining why antibiotics would be ineffective and potentially harmful.

This often means navigating cultural beliefs and misconceptions, requiring a delicate balance of respect, persuasion, and evidence-based information. Resistance also stems from patients not completing their prescribed doses, a problem best addressed through consistent education. While time-consuming, these conversations are essential to safeguarding public health and preserving the effectiveness of critical medicines for future generations.

Beyond the daily rhythm of dispensing medicines and counselling patients, another, less visible battle is waged against an unlikely opponent — technology. Kenya's healthcare sector stands at the cusp of a digital transformation, promising seamless prescriptions, instant access to patient records, and smart systems that flag potential drug interactions before a prescription is finalized. This vision holds the potential for faster, safer, and more personalised care.

Yet, the reality can be jarring. Internet connections fail without warning, and power outages can halt operations at the most critical moments. In such instances, adaptability becomes key — pivoting back to pen and paper, tethering a phone to restore access, or finding other creative workarounds. Whatever the challenge, the mission remains the same: keep care flowing and patients safe.

My ultimate hope is to see Kenya adopt robust electronic health records — a digital passport for every patient's medical journey. Imagine a system where, with a few clicks, any clinic in the country can access a patient's complete history: allergies, past treatments, and test results. Such a system would not only speed up care but ensure every decision is informed, safe, and truly tailored to the individual.

And speaking of challenges, one memory replays in my mind like a high-stakes movie scene. A severe medication shortage hit our region, and it felt like a vital organ of our healthcare system had suddenly vanished. Overnight, we weren't just pharmacists — we became strategists, improvisers, stretching every bit of stock we had. It meant endless phone calls, chasing down suppliers, and having heart-wrenching conversations with anxious patients and families about why their essential medication wasn't available. It was draining and, at times, terrifying. Yet

in that pressure cooker, something remarkable emerged — an ingenuity and dedication in our team that turned scarcity into lessons in resourcefulness. We learned to make impossible choices with compassion. That experience cemented my belief: a pharmacist isn't just someone behind a counter; we are problem-solvers, crisis managers, and vital, if often unseen, cogs in the machinery of healthcare.

Being a frontline healthcare worker, especially a pharmacist, is an ever-evolving adventure. You're constantly learning — whether it's the latest breakthrough or the needs of a remote community. The demands are relentless, but the rewards are profound: the relief in a parent's eyes when a child's fever breaks, the gratitude of a patient who finally understands their chronic condition, or the quiet satisfaction of catching a potentially dangerous drug interaction. These moments fuel our passion and remind us why we step onto the frontline.

To my fellow healthcare professionals, especially those starting out: embrace the challenges — they are your greatest teachers. Seek every chance to grow, because medicine never stands still. And never forget the human element at the heart of our work. Every prescription, every conversation, every small act of care can make a profound difference. By sharing our stories — the triumphs and the trials — we strengthen our community and help build a more resilient healthcare system for Kenya and beyond.

DR. MADELINE ISEREN IS A PHARMACIST WITH EXPERIENCE IN COMMUNITY AND HOSPITAL SETTINGS. SHE IS PASSIONATE ABOUT PATIENT EDUCATION, OPTIMIZATION OF MEDICATION THERAPY, AND PROVIDING PERSONALIZED CARE TO IMPROVE PATIENT OUTCOMES.

Letter to My Younger Self: A Doctor's Journey through Growth and Grace

By Dr. Ayda Linda Wanjiku

Dear Younger Me,

I see you—crisp white coat, stethoscope swinging like a badge of honor, heart brimming with lofty dreams, eyes lit with the hope that medicine is mostly about curing, not breaking. You chose this path to heal, to make a difference. What you don't know yet is that medicine will break your heart before it fills it, humble you before it strengthens you, and exhaust you before it renews you. This journey will change you—not just as a doctor, but as a human being.

Right now, you think you have all the answers. Six grueling years of medical school crowned you "Daktari," after all. But here's the truth: medicine is as much about becoming as it is about healing. You'll walk into rooms where hearts have stopped, celebrate new life, and just as often pronounce its end. No textbook will prepare you for the quiet in-between—where healing doesn't mean curing, and sometimes simply showing up is all you can give.

In those early years, you'll learn to hold a hand that's letting go, to say "I'm sorry" without flinching, to walk out of the theatre carrying only heartbreak for an anxious family. These moments will replay in your mind. Some will haunt you, others will guide you. They will shape you more than a clinician—they will remind you you're human. You'll discover that vulnerability isn't weakness, but the birthplace of compassion.

You think medicine is a science, and it is—but the moments that move you most will live outside your pharmacology notes. They'll be in the trembling voice of a mother clutching an ultrasound, the scribbled thank-you from a teenage girl you counseled, the wrinkled hands of an elderly patient bearing a chicken from her farm, the fleeting smile of a postpartum psychotic mother who won't remember your name, only how you made her feel safe. Here, you'll learn that medicine is also a ministry.

Your confidence will be tested—and it should be. Arrogance harms: grace saves. Growth will come not from accolades, but from sitting in silence with a woman who was told that her fibroids stole her womb. That moment will teach you more about presence than any lecture ever could. Over time, you'll measure victories differently—not just in lives saved, but in dignity restored. You'll see listening as a clinical skill and compassion as essential treatment.

You will nearly burn out. Just when you're ready to quit, mentorship and community will find you. You'll learn that rest is resistance, and that doctors, too, deserve care. You'll discover purpose beyond prescriptions, becoming a voice for mental health, reproductive justice, and the well-being of those in white coats Leadership will arrive quietly, asking you to step forward when it matters most. You'll learn it's not a title, but a choice—to advocate when it's unpopular, to hold space in tense rooms, to ask hard questions, and choose integrity over convenience. Opportunities will rarely come neatly packaged—they'll be messy, risky, and demanding. But in facing them, you'll tap into a reservoir of potential you didn't know you had. The best leaders aren't the loudest; they're the most present.

And you'll learn that medicine is a calling, but not your whole identity. The hospital will no longer define your worth. You'll make space for music, writing, dancing, laughter, and friendships that remind you of who you are beyond the badge. Burnout will stop feeling noble; you'll protect your peace. Step away. Breathe. Return whole.

You'll remember the senior who stood beside you when you felt invisible—and you'll become that for someone else. You'll pass on more than knowledge; you'll pass on hope. In time, you'll be known as a mentor, an advocate, and a builder of safe spaces. You'll see that healing happens not only in clinics, but in conversations, communities, and the courage to show up.

One day, you'll look in the mirror and see not perfection, but courage—a doctor shaped by kindness, failure, empathy, and faith. You'll be proud not for knowing everything, but for loving the broken and finding wholeness yourself. You'll lose sleep and naïveté, but gain a life of meaning, a heart that keeps opening, and a grace that refuses to quit.

So, younger me—brace yourself. This path will stretch you, break you, soften you, and rebuild you. You will stumble. You will rise. And through it
all, you will learn the most sacred truth: to be a great doctor, you must remain deeply, fiercely human.

Dr. Ayda Linda Wanjiku is an Obstetrician and Gynaecologist. She is the current Convener of the Kenya Medical Association's Physician Wellbeing Committee.

Inside the System, Outside the Spotlight: The Lives behind Kenya's Frontline

By Seliza Opanga

She was in uniform, but only technically. Her white coat was draped over a plastic chair, and she was barefoot, watering a line of sukuma wiki behind the facility. It was 6:30 a.m., and her shift would start in 30 minutes, but before she could manage patients, she had to tend to her garden. "We eat from here," she told me. "Sometimes staff, sometimes patients. We make stretch."

As a global health student, I am trained to look at systems, workforce ratios, supply chains, and budgets. But at that moment, none of that mattered. I saw a healthcare worker not just as a provider, but as a neighbor, a woman surviving the same economy as her patients, caring both in and out of uniform. We often talk about the frontline as a place. But what if it is also a person, one who lives, loses, builds, and belongs in the same community they serve?

When we speak about frontline healthcare workers, we often imagine them solely through their professional identity, in scrubs, giving immunizations, documenting vitals, and making clinical decisions. What we overlook far too often is that they are not just health workers, they are community members, living through the very same conditions they are trying to improve. The clinical officer who prescribes iron supplements to pregnant women might spend her own evenings queuing for water at a shared borehole. The community health volunteer educating mothers on balanced diets may herself be skipping meals to stretch food for her family. They wait in line for fuel, face the same inflation, and lose relatives to the same diseases they are screening for. And unlike policy designers or health administrators, they cannot insulate themselves from the consequences of system failure. When a facility runs out of gloves, they adjust. When salaries are delayed, they still report. When UHC falls short, they compensate not because it's sustainable, but because someone must.

Their roles do not end with the shift. In many communities, they are trusted voices called to intervene in family disputes, accompany neighbors to clinics, interpret prescriptions for elders, or step in as first responders in road accidents. They give health advice at funerals, mentor youth at churches, and answer calls late at night, not because they are on duty, but because they are known and expected to care. The reality is simple and often ignored: they live within the system they're holding together. They are not outsiders applying interventions to a foreign population. They are embedded into the very fabric of the communities they serve, shaped by its struggles. To design health systems that truly work, we must start here: with the people who live what they are asked to fix.

While the challenges are loud and constant, the wins of frontline healthcare workers are often quiet yet powerful. These are not victories captured in strategic plans or donor reports. They live in conversations, in improvised solutions, in trust built one household at a time. In Siaya County, a CHV I met had transformed her compound into a safe space for teenage girls to talk about menstrual health and relationships, a gap that formal systems had failed to address. She was not trained in adolescent psychology. She just understood that prevention starts with trust, and that girls needed someone who spoke their language. In Kilifi, nurses in a rural dispensary partnered with a local boda boda group to create a referral network for expectant mothers. When ambulances weren't available, these boda riders became lifelines. No official directive or sweeping political statement. Just innovation and collaboration.

These may seem trivial, but in communities where systems are slow and resources thin, they save lives, restore dignity, and deepen public trust. And they are borne not from formal incentives but from proximity, empathy, and a deep belief that healthcare extends far beyond treatment.

For every win carried quietly by frontline workers, there are also burdens they carry in silence. These are the weights that don't show up in reports or budgets, but they are heavy, constant, and often invisible to the systems they sustain. A nurse who loses a mother during childbirth does not just mark it as a statistic; she might see that child again at a village shop, growing up motherless, and carry the pain of what she could not prevent. A CHV who refers a malnourished child to a clinic, only to learn later that the mother could not afford transport, carries that helplessness home.

We cannot continue to build health systems that depend on the quiet sacrifice of people we fail to see fully. Healthcare workers are more than just clinical professionals; they are parents, peers, faith leaders, farmers, and volunteers. They are a part of our communities, not apart from them. And in many places, they are the first and only line of defense, not just against disease, but against despair, disconnection, and delay.

What systems forget must now be remembered not just in funding cycles, but in how we design, support, and celebrate healthcare work as deeply human work. Their well-being should not be an afterthought. Their insight should not be extracted only during crises. And their labor should never be sustained by silence and survival alone. To truly strengthen Kenya's health system, we must center those who keep it alive, not just in hospitals, but in homesteads, in WhatsApp groups, at village meetings, and on dirt roads at dawn.

Because the frontline doesn't just carry syringes and files. They carry children, groceries, funeral costs, and fatigue. They carry communities, even when no one else does.

> When we speak about frontline healthcare workers, we often imagine them solely through their professional identity, in scrubs, giving immunizations, documenting vitals, and making clinical decisions. What we overlook far too often is that they are not just health workers, they are community members, living through the very same conditions they are trying to improve

Seliza Opanga is a dedicated Global Health and Travel Medicine student with a passion for women's health, health systems, and policy. As the Founder of She Matters Alliance and Assistant Secretary of the Global Health Association of Kenya (GHAK), she champions research, advocacy, and community health initiatives. Committed to driving meaningful change, Seliza merges academia, leadership, and hands-on impact to shape a healthier, more equitable world.

Stories of the Frontline Healthcare Worker: A Toxicologist's Tale

By Dr. Mercy Maina

As a toxicologist working in Kenya's bustling healthcare system, my days are a blend of science, urgency, and compassion. The frontline is not just a place of physical healing but a battleground where knowledge meets human resilience. My role is often unseen, tucked away in labs or consultation rooms, yet it's pivotal in saving lives from the invisible threats of poisons, overdoses, and environmental toxins.
One case stays etched in my mind. It was a humid evening when a young woman, barely in her twenties, was rushed into the emergency ward. She was unresponsive, her skin clammy, and her breathing shallow. The paramedics suspected pesticide poisoning, a common yet deadly issue in rural areas where agricultural chemicals are widely used. As the toxicology lead, I was called in to confirm the diagnosis and guide treatment.

The clock was ticking. Pesticide poisoning, particularly from organophosphates, can be fatal within hours if not managed swiftly. I ordered a blood test to check cholinesterase levels, a key indicator of organophosphate exposure, while the team administered atropine to stabilize her. In the lab, I analyzed samples to identify the exact compound, knowing that precision could mean the difference between life and death. The results confirmed my suspicions: a highly toxic organophosphate. I recommended pralidoxime as an antidote, alongside supportive care, and worked closely with the ICU team to monitor her recovery.

What struck me most was not just the science but the human story behind it. The patient, Mary, was a farmer's daughter who had accidentally ingested the pesticide while helping her family in the fields. Her mother's tearful gratitude when Mary opened her eyes after two days in the ICU reminded me why I chose this path. It's not just about decoding toxins; it's about restoring hope to families.

Working as a toxicologist in Kenya comes with unique challenges. Our healthcare system is stretched, and resources are often limited. Antidotes like pralidoxime are not always readily available, forcing us to improvise with what we have. We also face a rising tide of cases snakebites in rural areas, alcohol poisoning from illicit brews, and even carbon monoxide exposure in urban slums. Each case demands quick thinking, collaboration, and a deep understanding of both toxicology and the local context.

Yet, there's a profound sense of purpose in this work. Every day, I'm reminded that toxicology is as much about people as it is about science. Whether it's educating

farmers on safe pesticide use or training nurses to recognize poisoning symptoms, my role extends beyond the hospital walls. We're not just treating patients; we're building a safer, healthier Kenya.

The frontline is relentless, but it's also where heroes are forged. As a toxicologist, I may not wear a cape, but I carry the weight of lives in my hands, and that's a privilege I'll never take for granted.

DR. MERCY MAINA IS A TOXICOLOGIST BASED IN KENYA, DEDICATED TO ADVANCING HEALTHCARE THROUGH EXPERTISE IN ENVIRONMENTAL AND CHEMICAL TOXICOLOGY, AND ADDRESSING CRITICAL ISSUES LIKE PESTICIDE POISONING AND OCCUPATIONAL TOXIN EXPOSURE. DR. MAINA CONSULTS GLOBALLY AS THE DIRECTOR OF TOXICOLOGY EXPERTS LIMITED, OFFERING INSIGHTS INTO PRODUCT SAFETY AND DETOXIFICATION STRATEGIES. SHE EMPOWERS COMMUNITIES WITH KNOWLEDGE TO MITIGATE HEALTH RISKS, BLENDING SCIENTIFIC RIGOR WITH COMPASSION TO TRANSFORM LIVES.

THE SENIOR CITIZENS` CLINIC

By Dr. Miriam Miima

Aging is a natural process of life; a dynamic phase marked by growth and adaptation. 60+ years is a distinctive threshold of these changes. Biologically, the risk of chronic diseases increases as immune and metabolic functions decline. Socially, productivity declines, cash flow declines, and social isolation sets in, worsened by hearing and visual function deficits. Psychologically, cognitive shift sets in with a high risk of dementia and psychological disorders such as depression. Health care response should therefore be preventive, personalized, holistic, coordinated, and continuous.

Shosh is a happy vintage baddie. She has been under my care for 6 months now. She tells me stories about the Mau Mau movement, how she became a nurse, how she lost her child during delivery, how she is a landlord at Gikomba, and why I should not sweat the little stuff. I run a geriatric clinic, so when she did not show up for her usual clinic, I traced her through her church group.

Shosh has hypertension, diabetes, osteopenia, heart failure, insomnia, and chronic kidney disease. She is stable with a hearing aid and prescription glasses; therapeutic control is a moving target, but her activities of daily living are preserved. She is no different from many patients in their 7th decade of life. On a sunny Tuesday morning, Shosh called about her husband. Her silver fox had been vomiting for two days, and his tummy was distended. The doctor said the ultrasound scan was normal, but she knows something is off. He routinely accompanied Shosh to the clinic; she talked more- he only checked in on the important stuff: medical discussions, prescriptions, and the return date. This man`s medical history was uneventful. I asked her to take him to the emergency unit.

Emergency transfer/referral is a wicked systemic problem; it gets worse for elderly people living alone. The ambulance was a “taxi, Shosh`s cognitive astuteness was not at its best, and by the time neighbors and families came to her support, they were way past the 15-minute golden referral time rule; the first delay.

Four hours later, they made it to the nearest hospital; second delay. While she was processing admission for her husband, he died, third & final delay. “They said he was 68, so his death is not a headline.” ……. I guess this is a policy/ ethical reflection for the society……Shosh changed; she refused to eat, she stopped taking her meds, she fired her caregiver and asked her kids to let her die. She was testing Sayuni`s Wi-Fi signal. Grief and loss have theoretical timelines; in practice, grief is a festering gnaw without a timeline.

We formed a medical village around her; family, social services, medical personnel, and the women`s chamaa. The interdisciplinary team deliberated on the goals of care together with Shosh. She no longer smiles as she used to; she occasionally hides food, she is on direct observation therapy for her medication, has panic attacks whenever she gets bloated, and no longer cooks. Some days she agrees to short walks and declines on others. She no longer wears her glasses or her hearing aids. She started giving her money away and hardly remembers her assets. The medical village is running out of patience, carer fatigue is creeping in, and the financial resources are a stark reminder of the proverbial church mouse.

Reflections on the care of older persons in Kenya.

Estimated proportion of the total population (2024).

Estimated proportion of the total population by 2050.

Feminization of aging at 60+ years.

Guides on fostering healthy aging globally.

What is the cost of elderly care?

How can we leverage on inter-generational social synergies?

Kakamega leads with the highest number of 60+ at >128,000 (2019)

Is this a case study on healthy aging?

📈 Healthy aging is a triumph to humanity.

🤝 Collaboration is the cheat code.

🛡️ The aging social risk management framework could use a face lift.

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Dr. Miriam Miima is Family Physician & Gerontologist working in the community oriented primary health care space. She collaborates with stakeholders through governance and policies in co- creating resilient health care systems.

Shadows and Shields: Dr. Auka's Radiology Mission in Somaliland

By Dr. Auka Joash

When Dr. Auka landed in Hargeisa, Somaliland, he came with a mission rooted in science. However, what he encountered called for something far more human.

A veteran radiologist and radiation safety advocate, Dr. Auka had worked in hospitals and interacted with various healthcare providers from across the globe. Yet nothing prepared him for the scene at a bustling clinic nestled on the edge of a market district in the city. It was here that he first noticed something deeply troubling: X-ray procedures were being carried out in rooms adjacent to eateries, with little shielding, inadequate signage, and virtually no regard for the dangers of ionizing radiation.

The hum of imaging machines blended with the clang of pots and the aroma of spices. Patients ranging from young children, pregnant women, and the elderly eagerly waited for their turn to be attended to just steps away from the ionizing radiation exposure zones, unaware of the risks. Worse still, some radiographers operated without protective gear or understanding of exposure limits. It was as if the radiation was invisible not only to the eye but to regulation and awareness.

"I remember stepping into one of those rooms," Dr. Auka recalled. "There was no lead lining on the walls, no ionizing radiation dosimeters, and no lead-impregnated protective aprons. The technician was taking images while a food vendor prepared lunch just meters away. Was it negligence, or a lack of adequate training?"

Rather than condemn, Dr. Auka chose to educate. He began with informal conversations, patiently explaining the basics of radiation safety to the technicians, clinicians, and even the nearby vendors. He then organized a series of hands-on workshops, inviting staff from neighboring clinics and hospitals.

Using simple diagrams, real-life case studies, and translated safety guidelines, he demonstrated the principles of ALARA—As Low As Reasonably Achievable. He introduced shielding techniques, proper room layout planning, and emphasized the importance of wearing lead aprons and using signage. He stressed the cumulative risks of radiation not only to patients, but to workers and the public.

What began as cautious curiosity soon turned into full engagement. Radiographers asked questions, shared concerns, and began modifying their practices. The hospital

administration, moved by Dr. Auka's passion and the clear hazards, committed to relocating the radiology room away from food vendors and high-traffic areas. Protective barriers were installed, protocols were written, and a long-overdue sense of responsibility began to take root.

One technician, Amina (not her real name), said, "We didn't know we were putting ourselves and others at risk. Dr. Auka didn't judge us, but he taught us instead. He gave us a new way to care for our patients."

Before returning home, Dr. Auka left behind not just guidelines and tools, but a legacy of awareness. He partnered with local health authorities to establish ongoing training programs and initiated the first steps toward a national radiation safety framework in Somaliland.

As his plane lifted into the desert sky, Dr. Auka reflected on what he had witnessed. "Safety is not a luxury," he said. "It's a right. And sometimes, it only takes one voice, one workshop, one honest conversation to spark a safer future."

One technician, Amina (not her real name), said, "We didn't know we were putting ourselves and others at risk. Dr. Auka didn't judge us, but he taught us instead. He gave us a new way to care for our patients."

DR. JOASH AUKA, MBCHB, M.MED (DIAGNOSTIC RADIOLOGY), IS A DISTINGUISHED ACADEMIC LEADER IN DIAGNOSTIC IMAGING AND MEDICAL EDUCATION IN KENYA. WITH A ROBUST FOUNDATION IN BOTH CLINICAL PRACTICE AND SCHOLARLY PURSUITS, HE CONTINUES TO ELEVATE PROFESSIONAL TRAINING AND COMMUNITY HEALTH ACROSS THE NATION.

MAKTOOB (IT'S WRITTEN)

By Dr. Ismael Lutta

'If we must die—oh, let us nobly die,
So that our precious blood may not be shed
In vain; then even the monsters we defy
Shall be constrained to honor us though dead!'Claude McKay.

The Gentleman from Khartoum

The gentleman from Khartoum had just finished a sumptuous lunch at a resort perched on the edge of the Rift Valley escarpment. He was seated in his car, about to start the engine and drive away, when he heard the sound of hurried footsteps, followed by a loud, piercing shriek. Moments later, chaos erupted—men and women began leaping over the resort fence to the other side.

Curious, he stepped out of his car, vaulted over the fence, and followed the hotel staff and a few villagers who were running ahead. He soon learned that a man had just jumped off the cliff. Without hesitation, he pulled out his phone and dialed the emergency number. The police asked one question:

"Is the man dead?"
"I don't know," he replied. "But we need your help for extraction."
They promised to call him back. To this day, he is still waiting for that call.

The gentleman asked the villagers how to reach the base of the cliff to check on the man. One villager shrugged and said there was no need—no one could survive such a fall. "Nobody survives that," he said flatly. But the gentleman insisted. Soon, the man's identity became known after a relative arrived. The relative explained that the victim had recently lost two hundred thousand shillings on a gambling app with a popular red plane logo. Distressed, he had consumed organophosphate poison before running toward the cliff's edge.

That red plane—marketed in Kenya with promises of lifting millions of youth out of the proverbial block—had, in reality, become the country's most devastating digital epidemic, leaving behind broken dreams, shattered families, and countless lives lost. Determined, the gentleman joined the villagers in what became the fastest descent he had ever attempted. Reaching the base, they aligned themselves with the presumed jump point and began climbing upward, searching through thick shrubs. Machetes sliced through the vegetation as they pressed on.

They found the man midway between the cliff's base and the jumping point, lying amidst tangled bushes. The gentleman quickly assessed him: airway clear, breathing

adequate, pulse strong—but he was in visible pain, groaning with each movement. Examination revealed tenderness in the pelvic region, a swollen left thigh, a fractured left patella, and bruising on both lower limbs.

The gentleman called the local hospital—no ambulance. He contacted the regional referral hospital—every ambulance was engaged, though they promised to call if one became available. He tried the Red Cross, but was told they had no Memorandum of Understanding with the County and were not operational in that area.

Extraction was proving difficult. Lacking a spine board, they improvised with sacks and blankets to carry the patient down to the base, where the ever-reliable white Probox taxi was waiting to transport him to the hospital.

Upon arrival, the good Samaritan sprang into action. He dashed into the emergency department, fetched a stretcher, and, with the help of villagers, wheeled the patient into the ER. Introducing himself to the staff as a colleague, he assisted in inserting two IV cannulas, took vital signs, initiated fluids, and administered atropine. He then used the suction machine to perform gastric lavage, removing the ingested poison.
It was only then that the villagers and relatives realized—the gentleman from Khartoum was a doctor.

After stabilizing the patient, pelvic, left femur, and left knee X-rays were ordered. The pelvis was normal, but the left patella fracture was confirmed. The patient was admitted, with surgery scheduled for the following day.

The doctor updated the family, then prepared to leave. The patient's uncle stood silently for a moment, then scratched his head in wonder. How had this miracle doctor happened to be at the exact time and place when his nephew attempted suicide—and saved his life?

The gentleman from Khartoum simply smiled.
"It's maktoob," he said softly. "God had written it that way."

KMA Member. Public Health Committee member. Masters of Public Health student in Masinde Muliro University of Science and Technology

Two Minutes to Live: When the Music Was Louder Than the Medicine

Dr Jacqueline Mwanu

A doctor's persistent compassion and the man who finally chose to fight for his health

In the quiet corners of community health work, some stories never make headlines—but they haunt us. They linger not because of dramatic rescues or miraculous recoveries, but because they reveal how easily lives slip through the cracks when urgency isn't loud enough.

"Just two minutes, Doc!" That's all he gave me.

He came in a rush, huffing and puffing into our pop-up medical tent at a free health camp on the outskirts of Nairobi. The air outside pulsed with music from a Mugithi event that pulled crowds and attention away from our white tents. Inside, we were armed with blood pressure cuffs, glucometers, and good intentions. But no one was lining up. In two full days, only five people showed up! And this man, one of the event organizers, only gave me two minutes—an afterthought between managing performers and speakers.

He didn't look worried. But my readings were! Within seconds of checking his vitals, I knew we were racing against time. His blood pressure? A sky-high 170/100+. Blood sugar? 18 mmol/L. These weren't just numbers. They were sirens!
"Has anyone ever mentioned your BP is high?" I probed.

"Yeah," he replied casually. "A pharmacist mentioned it a few weeks ago. I had headaches. I'll handle it," he shrugged." Before I could offer any further counsel, his phone rang. "Doc, can I see you later?" he asked, smiling apologetically & already halfway out the door. I nodded reluctantly, hoping we'd reconnect.

The Patient Who Vanished

I looked for him all weekend & waved when I spotted him across the grounds. I called out. Nothing. I sent messages. Nothing. On our final day, just before we packed up, I pressed a handwritten prescription into his hand and shared dietary guidelines. It felt like whispering against a hurricane.

Weeks evolved to 2 months. Eventually, I called to follow up. He answered. He had stopped taking his meds once they ran out. Diet? Unchanged. Exercise? None. I reminded him, gently but firmly, of the consequences. "I'll try again," he said, promising to restart—but silence followed.

Between my maternity leave and a new business, I was building, I lost touch—until early 2025, when I called him again. This time, he texted back. His readings were worse. Blood pressure: 190/110 & blood sugars are still dangerously high. We restarted treatment, prescribing Triplixam, and again I urged him: "This is not optional. This is your life." He agreed, half-heartedly.

Then, something unexpected happened. A message pinged from an unfamiliar number. It was his wife.

The Voice I Didn't Expect

She had found my number on his phone. "I know you've been checking on him," she said. "He listens to you more than he listens to anyone else." She confessed my fears: He had abandoned the medication again and was drinking heavily. "I'm scared for him," she wrote. "Please help." Her words, which carried the weight of desperation, shattered me.

I realized then that treating chronic illness isn't just about prescribing pills. It's about meeting people in the emotional trenches where denial, shame, culture, and fear live. He hadn't rejected treatment. He had rejected the identity of a sick man. Denial was easier than diagnosis.

From Doctor to Lifeline

That's when I stopped being just his doctor and started being his advocate. I shifted gears & began checking in regularly, calling more frequently & sending shorter, more compassionate messages. He slowly opened up & admitted to being worried about the judgment of his peers, the cost of medication, the life change - he feared a lifetime of pills & hated feeling weak. He was tired of being tired! But he also confessed that the medication had worked. He felt better when he took it. His BP had dropped to 132/85. That one win became a turning point.

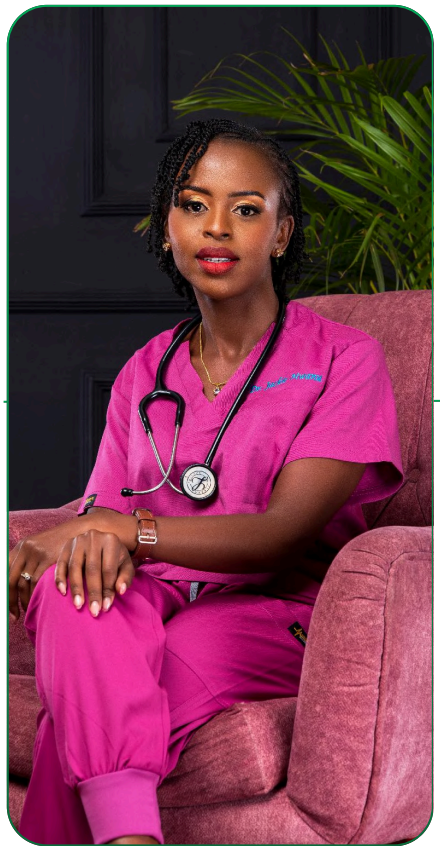
We talked openly about affordability and redesigned his treatment plan to fit his budget. We built in realistic lifestyle changes—not textbook routines, but social activities that doubled as exercise. We addressed his alcohol use gently but firmly. He reduced the intake. And for the first time, we touched on mental health, broaching the subject of therapy. He didn't say yes, but he didn't say no. His journey is ongoing. But he's not hiding anymore. And neither am I.

The Larger Crisis We're Barely Talking About

In Kenya and across Africa, chronic diseases like Hypertension and Diabetes are rising fast —and killing silently. Most patients don't even know they're sick until it's too late. For those who do, the cost of care, stigma, and poor follow-up lead to dropouts for treatment. Every day, I'm reminded: Our job isn't just to diagnose. It's to

walk with people. Even when they don't respond. Even when they forget appointments. Even when they want to give up.
Because sometimes, two minutes is all it takes to change a life.

> In Kenya and across Africa, chronic diseases like Hypertension and Diabetes are rising fast —and killing silently. Most patients don't even know they're sick until it's too late. For those who do, the cost of care, stigma, and poor follow-up lead to dropouts for treatment.



Dr. Jacqueline Wothaya Mwanu is the Founder and CEO of Kay's Wellness Centre, a community-based healthcare hub in Nairobi focused on chronic disease management, patient education, and integrative wellness. With over a decade of experience in frontline medical practice, Dr. Mwanu has become a vocal advocate for accessible, patient-centered care in low-resource settings.

A graduate of the University of Nairobi's School of Medicine, she combines her clinical expertise with a deep passion for health equity and community empowerment. Her innovative approach to care delivery, which integrates telemedicine, lifestyle coaching, and local partnerships, has earned her recognition, including the KEPSA Rising Female Star in Digital Trade Award (2024).

Dr. Mwanu has led health outreach programs across Kenya and continues to mentor young health professionals on the front lines. She is particularly committed to addressing the silent epidemic of non-communicable diseases in underserved communities.

"Healthcare should not just treat illness—it should nurture dignity, purpose, and possibility," she says, a philosophy that continues to shape her mission and impact.

What Medicine Forgot: Restoring Community to the Heart of Care

By Dr. Vosevwa Sylvia

In remote villages across Kenya, medical camps often become more than temporary clinics. They transform into spaces of reconnection, where strangers become neighbors and care extends beyond consultation. It is in these moments that one witnesses patients walking for miles, volunteers uniting across disciplines, and a profound longing for something deeper than medicine—human connection and collective wellbeing.

These frontline experiences offer more than anecdotes. They provide insight into what works, what fails, and where the future of healthcare must be anchored.

The Resilience We Left Behind

Africa once thrived on informal yet deeply effective community-based care models. Healthcare was not restricted to hospital spaces but rather embedded in the fabric of daily life. Elders offered counsel, midwives provided care, and entire villages played a role in healing. There was shared ownership of health and well-being.

With modernization came progress, but also fragmentation. Traditional support systems began to fade, replaced by institutional models that often excluded the very groups they aimed to serve. The result was a shift from communal care to transactional services. This begs the question: how can we restore the resilience of the community without resisting the benefits of modern medicine?

Beyond Symptoms: A Holistic View of Health

Community-based work reveals a recurring truth—illness is never just physical. High blood pressure may be the result of financial stress, food insecurity, or poor housing. Uncontrolled diabetes often points to deeper issues such as a lack of health literacy, malnutrition, or unaffordable medication.

Truly effective care requires a broader perspective. Holistic health approaches that address social, emotional, and environmental factors must be integrated into service delivery. These include not only medical interventions but also education, nutritional support, mental health resources, and community engagement.

When healthcare begins at the community level, it is better tailored to people's realities. It becomes proactive rather than reactive, empowering rather than prescribing.

Prevention as Priority

Globally, non-communicable diseases (NCDs) account for more than 70 percent of deaths. In Kenya, their burden continues to grow, yet national systems remain focused on treating complications instead of preventing them. Clinics are overstretched, emergency rooms are full, and wellness programs often receive minimal support.

However, the evidence is clear. For every dollar invested in prevention, up to seven dollars are saved in treatment costs and lost productivity. Prevention is not a public health luxury—it is a practical, long-term strategy for resilient systems.

To make prevention a priority, both public and private sectors must shift their approach. Hospitals should view early detection, education, and behavioral interventions as essential investments rather than optional services. Policies should support accessible screenings and lifestyle programs. A reimagined health economy must place prevention at its core.

Medical Camps: A Blueprint for Community Health

Despite their temporary nature, medical camps often offer a glimpse into what inclusive, grassroots healthcare could look like. These gatherings are interdisciplinary, low-cost, and rooted in trust. They provide both treatment and education, creating opportunities for patients to learn about their conditions and take an active role in managing them.

Perhaps more importantly, camps bring people together. Volunteers from diverse backgrounds - doctors, nurses, lab technicians, students—work side by side, often rediscovering their original motivation for joining the profession. In these shared spaces, healthcare becomes a collaborative act, not just a professional duty.

Camps also offer a reminder that people crave accessible, dignified care. When patients are listened to, when information is shared openly, and when services are designed with empathy, outcomes improve and trust deepens.

The Growing Threat of Lifestyle and Environmental Change

One of the most alarming trends on the frontline is the rise of lifestyle-related diseases among the rural and urban poor. Diets dominated by processed foods, unsafe drinking water, and a lack of safe spaces for physical activity are contributing to the increase in obesity, diabetes, hypertension, and other chronic illnesses.

Even as wealth increases for some, health outcomes worsen for many. Poor communities are often the most exposed to environmental toxins, food insecurity, and limited access to clean air or safe shelter. These conditions create a new kind of epidemic, one driven not by infection but by inequity.

Addressing this requires more than clinical solutions. It demands policy change, cross-sector collaboration, and long-term investment in education, food systems, and urban planning. It also requires frontline workers to raise their voices—not just as clinicians, but as advocates.

Dr. Sylvia Vosevwa Mugamangi is a Clinical and Public Health Integration Doctor and the Director of Clinical and Community Health Programs at Kwetu Care Foundation. She holds a Master's in Public Health and serves as Vice President of the Kenya Medical Association – Nanyuki Division. She is also the Co-Convenor of the KMA Public Health Committee and leads its Education and Health Promotion Sub-Committee.

Dr. Sylvia is passionate about holistic, preventive, and patient-centred care, with a strong focus on non-communicable disease (NCD) prevention, health equity, policy, and advocacy. Her work bridges clinical medicine with systems-level reform, aiming to advance longevity and sustainable health outcomes across communities in Kenya.

Bridging Classroom and Laboratory: The Path of a Frontline Scientist

By Munyoki Nyamai, PhD

My Journey as a Frontline Scientist

Foundations in Medical Laboratory Science

My journey began in 2010 at Mount Kenya University with a single question: how can what we see through a microscope change the course of a patient's life? Those Bachelor's years taught me more than laboratory techniques. They built discipline, sharpened precision, and impressed on me the responsibility that comes with every result I sign off. Advancing into Histology and Cytology.

After graduating in 2012, I began a Master's in Histology and Cytology, exploring the cellular changes that mark the presence of disease. Each tissue slide felt like more than a specimen; it held part of someone's story. That perspective shaped my approach to research and led me to a PhD at Masinde Muliro University of Science and Technology, where I focused on cancer diagnostics. The work was demanding, but every result carried the possibility of improving diagnostic accuracy and the way patients in Kenya receive care.

Broadening Perspective Beyond the Lab

I strengthened my skills through programs at the University of Washington in leadership, monitoring and evaluation, and economic evaluation in global health. These studies expanded my view beyond the laboratory, giving me the tools to design effective systems, measure their impact, and lead teams in challenging health environments.

Teaching and Mentorship at KMTC

In 2017, I joined Kenya Medical Training College as a lecturer while completing my PhD. Balancing family, studies, and work demanded persistence. My goal was to train scientists who could meet Kenya's diagnostic and public health needs. I taught both theory and practical skills, developed curricula that reflected current science, supervised research on local health challenges, and mentored students to think critically and work with integrity. I also took part in community outreach and institutional planning, helping to strengthen KMTC's role in building the country's healthcare workforce.

Serving on the Frontline During COVID-19

When COVID-19 reached Kenya, the world slowed, but in health sciences everything accelerated. I took on multiple roles—developing short courses for health workers,

Munyoki Nyamai is a medical laboratory scientist and lecturer at Murang'a University of Technology, specializing in histology and cytology. He holds a PhD from Masinde Muliro University and MSc/BSc from Mount Kenya University, with additional training in leadership, monitoring and evaluation, and global health economics from the University of Washington. Formerly at the Kenya Medical Training College, he has authored over 10 peer-reviewed publications, presented at national and international conferences, and supervised numerous student projects. His work focuses on diagnostics, laboratory quality systems, and mentorship, aiming to advance medical laboratory science education and research in East Africa.

leading refresher training on sample collection, PPE use, and triage, and working in labs to support testing while improving biosafety. KMTC partnered with the Ministry of Health, county governments, and the WHO to coordinate responses, gather data, and staff quarantine centers. Those months were exhausting but defining, reaffirming my commitment to applying science where it matters most.

A New Chapter at Murang'a University of Technology

In 2025, I joined Murang'a University of Technology with both academic expertise and the experience of serving on the frontline during a global health crisis. That period changed how I teach. Every lecture and practical session carry the urgency and clarity that comes from knowing science must hold when lives are at stake. I focus on preparing students to meet that reality with competence, critical thinking, and integrity.

Enduring Rewards of Academic Teaching

Academic teaching is fulfilling because it shapes lives in ways that extend far beyond the classroom. Every concept taught, every question answered, and every skill demonstrated becomes part of a student's foundation. The impact multiplies when those students go on to serve communities, solve problems, and train others. Teaching also keeps you learning, as the constant exchange of ideas sharpens your thinking and deepens your expertise. It builds relationships that often grow into professional networks and lifelong mentorships. Most of all, it creates a legacy, with your work living on in the competence, integrity, and achievements of those you have taught.

Lessons learnt.

My journey taught me that precision in diagnostics saves lives, and every sample carries a human story. Adaptability bridges the gap between crisis and response, while teaching shapes the scientists of tomorrow. Collaboration turns individual effort into collective strength, and leadership requires skill, clarity, and courage. Resilience is forged when theory is tested by real-world urgency, and science finds its true purpose in service to people. Knowledge only matters when it is applied where it is needed most. Every challenge offers a chance to strengthen systems, and the measure of science is ultimately its impact on human lives.

Towards Health Equity: Embracing Health Partnership.

By Dr. Ismael Lutta

'What we do in life echoes in eternity,' General Maximus in The Gladiator.
Original quote 'What we do now echoes in eternity' Emperor Marcus Aurelius.

Sickle Cell Disease

Sickle cell disease (SCD) is a group of inherited red blood cell disorders that occur due to the presence of two mutated forms of the hemoglobin gene, hemoglobin S (HbSS). If one affected gene is inherited, it results in Sickle cell trait (HbAS).

Epidemiology

SCD is most prevalent in Africa, the Middle East, and India. The geographical distribution of sickle cell hemoglobin (HbS) often overlaps with malaria endemic zones. Sickle cell trait (HbAS) protects individuals against severe malaria, with those carrying the trait being 90% less likely to experience severe malaria. There are approximately 300 million people with sickle cell trait and 6.4 million people living with Sickle Cell Disease (PLWSCD) globally, and more than 66% live in Africa.

In Kenya, we don't have an SCD disease registry, but it is estimated that 14,000 children are born with SCD every year. It is common across Kenya, affecting 18 counties with high disease burden pockets in Western, Nyanza, and Coastal regions. In the absence of routine newborn screening and appropriate treatment, an estimated 50-90% of those born with the condition die undiagnosed before the age of five.

Initiatives aimed at improving awareness, diagnosis, and treatment are crucial to improving outcomes for individuals affected by this genetic condition. A focus on early detection through newborn screening, enhancing healthcare access, and promoting comprehensive care are key areas for improvement. Additionally, partnerships with non-governmental organizations (NGOs) and community-based organizations (CBOs) enhance care.

Don Amolo Memorial Kid's Ark (DAMKA)

Don Amolo Memorial Kids Ark (DAMKA) is a community-based organization in Western Kenya that has emerged as a vital player in the realm of Sickle Cell Disease. It provides holistic care for children and adolescents living with SCD by offering medical services, supporting psychosocial groups formed by warriors and their caregivers, and integrating nutritional aid through the provision of farm inputs to families before planting seasons. The organization also champions education access for warriors, ensuring that their health needs are addressed alongside their social and educational development.

Despite these efforts, DAMKA has identified several barriers in healthcare delivery for warriors living with SCD. Stigma remains a significant challenge, with some parents choosing to hide their children at home instead of seeking care. In addition, inadequate access to essential medications, particularly hydroxyurea, which is often expensive and subject to frequent stockouts, further complicates treatment and long-term management.

To address these challenges, DAMKA has developed a range of innovative, community-driven solutions. Program field staff conduct village outreach, identify children through testing, enroll them into care, and provide close monitoring. Home visits, facilitation of support groups, and reinforcement of medication adherence have created a model that strengthens community networks and empowers caregivers. On the medication front, DAMKA provides free folic acid and Penicillin V, while offering proguanil and hydroxyurea either at subsidized prices or for free, depending on the socio-economic status of the warriors. The result is healthier children, supported families, and resilient communities.

The Memorandum of Understanding

DAMKA aims to go a step further and establish decentralized sickle cell clinics across Kakamega County. This comes after signing a Memorandum of Understanding with Kakamega County Government, which permits it to set up and operate SCD clinics in the County.

The Role of Hospital Management

As a medical superintendent at Mumias Level IV Hospital and a Sickle Cell Champion, I find partnering with DAMKA has huge potential in the holistic management of children and adolescents living with chronic illnesses such as Sickle Cell Disease.
At an individual level, apart from diagnosing and treating SCD within the hospital setup, I visit community radio stations for media campaigns and also engage in school-based and community-level SCD sensitization.

At an administrative level, our role is to waive registration fees on days when warriors attend their SCD Clinics. This is an attempt to minimize the financial hurdles that discourage warriors from attending clinics or benefiting maximally from health care services.

The hospital is working hand in hand with DAMKA to strengthen care for children living with SCD. Newly diagnosed children will be linked to DAMKA so that both warriors and their caregivers can access psychosocial support. Data from this collaboration will contribute to a local SCD registry, with the goal of eventually feeding into the national database. Beyond treatment, the hospital will open its pediatric playground and dedicate rooms for Saturday support group activities,

creating a safe space where warriors, caregivers, and other stakeholders can meet, share experiences, and learn from one another.

To make care more accessible, the hospital is setting up a standalone Sickle Cell Disease Clinic that will focus exclusively on warriors, sparing them the long waits common in general clinics where they are mixed with adults. Laboratory space will also be shared with the DAMKA team, enabling point-of-care testing, monthly hemoglobin checks, and routine malaria screening. In addition, the pharmacy will dedicate an independent booth to DAMKA pharmacists so that warriors can receive their medicines in a more personalized and efficient way.

In a resource-constrained setting, partnerships hold great potential and ought to be embraced to increase equity in healthcare. It is our conviction that the biological approach to sickle cell disease, while important, is inadequate to address the many needs SCD warriors face. We need a more holistic approach to SCD management, utilizing a multidisciplinary approach to address both the needs and the barriers to care.

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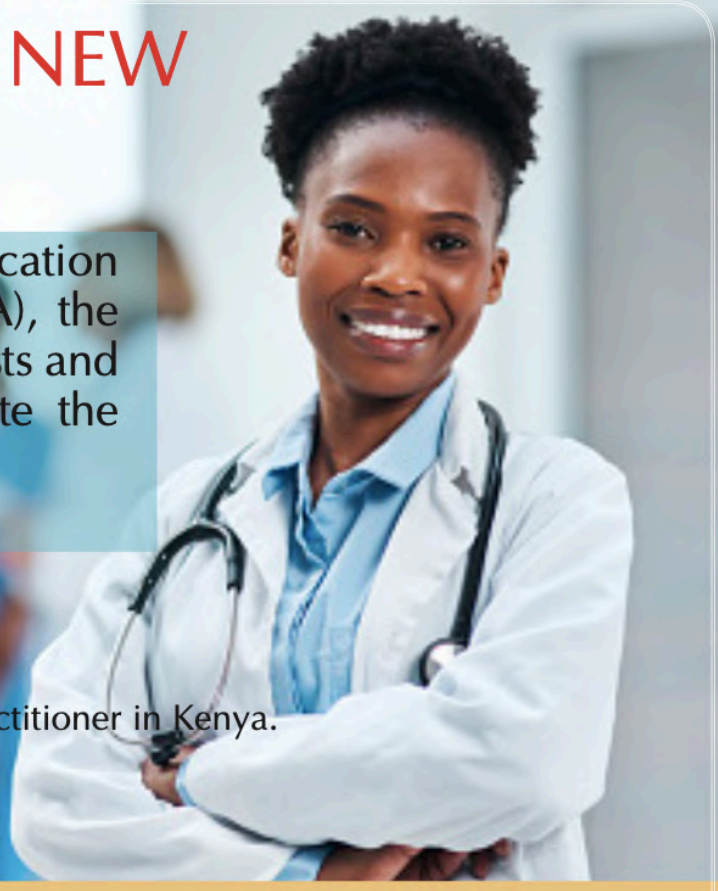

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To reach out to us contact us through the details below.

KMA CENTRE, 4th Floor, Chyulu Road-Upper Hill
P.O Box 48502-00100 Nairobi- Kenya
Tel: +254722275695
Email: info@kma.co.kel Website: www.kma.co.ke

DaktariUp2date

EMAIL
info@daktariup2date.com

PHONE
+254 711 711 766

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Contact Us:
Kenya Medical Association
KMA Centre, 4th Floor Chyulu Road, Uppehill
P.O Box 48502-00100, Nairobi, Kenya

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