

The ramifications of COVID-19 on maternal health in Kenya

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Introduction

The first case of COVID-19 in Kenya was confirmed on 12 March 2020. As of 25 July 2020, Kenya had 17,603 cases, 280 deaths with a case fatality rate of 1.6.¹ Kenya is in the third epidemic phase.¹

A multisectoral taskforce, the National Emergency Response Committee (NERC) comprising of health, security, education, transport, finance, and trade sectors, coordinates the COVID-19 response. The NERC has identified health facilities, public and private laboratories, and isolation centres, and developed guidelines for case management, infection prevention and control, and surveillance. The Ministry of Health in Kenya has issued guidelines to offer practical preventive and clinical guidance to ensure safe continuity of quality reproductive, maternal, new-born and family planning services during the COVID-19 pandemic.

The Kenyan government has introduced several measures to curb transmission. They include: the ban of international travel, night curfews, mandatory quarantines, mandatory wearing of facial masks in public spaces, closure of schools and institutions of higher learning, closure of clubs, restaurants and non-essential businesses, working in shifts in government institutions, recommendations to work from home for those in the private sector and non-governmental organisations, and hygiene campaigns. In addition, the government has provided tax relief for those working in the formal and informal sector, and tax breaks for small businesses and corporations.

COVID-19 has put strain on the already under-resourced and ill-equipped Kenyan health care system. Barasa and colleagues report that significant gaps exist in Kenya's capacity for hospitals to accommodate a potential surge in caseload due

to COVID-19.² On 14 July 2020, it was reported that 429 healthcare workers in Kenya were infected with COVID-19, accounting for 4.1% of all the cases.³ In mid-July 2020, Kenya lost one health provider to COVID-19.

The aim of this commentary is to highlight the ramifications of COVID-19 on maternal health in Kenya, describe some responses, and make recommendations on areas for improvement.

Consequences of COVID-19 on maternal health services

The emergence and spread of COVID-19 has created medical shortages in health facilities as manufacturers are unable to continue with production and deliver supplies due to physical distancing measures such as working from home and border controls.⁴ Kenya relies on the global market for medical supplies and equipment imports; some of her main suppliers like China and India are experiencing movement restrictions and reduced human resource capacity with in-country restrictions on supply of some commodities negatively impacting the supply chain.

Although temporarily, resources and personnel meant for maternal health are being reallocated to cater to COVID-19 patients,⁴ slowing down service delivery. A maternity wing in Tana River was converted into an isolation ward and in Mombasa County, maternity and other services were suspended when Tudor Hospital, a referral health facility, converted into an isolation centre. These changes have created confusion as pregnant women and mothers do not know where to go to seek maternal health services. The night curfews introduced in Kenya as a measure to reduce COVID-19 transmission restrict pregnant women's

movement, forcing them to seek services from traditional birth attendants or give birth with the help of relatives.⁵ Consequently, some pregnant women have died due to postpartum haemorrhage.⁵ Others have chosen not to seek maternal health care.⁵ For instance, Lamu County reported a reduction in the number of pregnant women attending health facilities since March.⁶ The health facilities used to serve at least 50 pregnant women and young children daily; the number has reduced by half as women fear contracting COVID-19.⁶

Although some healthcare providers have been trained to offer maternal health services, they lack personal protective equipment (PPE), putting themselves and pregnant women and mothers at risk for COVID-19. On 14 July 2020, it was reported that at least 41 employees (19 health care workers and 22 support staff) at the country's largest maternity hospital had tested positive for COVID-19.³ Pregnant women have been advised to seek health services at other health facilities as the hospital will only attend to complicated delivery services. Moreover, there have been reports of healthcare providers fleeing from patients presenting with COVID-19 symptoms due to lack of PPE and lack of training on management of the illness.⁷

Innovative local measures to circumvent COVID-19 related challenges

Some counties in Kenya have come up with measures to address movement restriction. In Kakamega County, for example, the local administrators have registered pregnant women so as to facilitate their movement when in labour during night curfew hours.⁸ Pregnant women in labour during curfew hours can call the local administrators, who link them with licensed *boda boda* riders (motorbike taxis) from their location and issue slips allowing transportation, so the riders can take the women to health facilities. Most women use *boda boda* riders as the few available ambulances serve a vast area.⁸ In Nairobi County, a project dubbed "Wheels for life initiative" has been set up between the Government of Kenya (Ministry of Health), Amref Health Africa, and Bolt (a transportation application) to aid movement of pregnant women at night.⁹ The initiative offers free medical advice and transportation services during curfew hours. To get assistance pregnant women and/or their caregivers have to dial 1196, a toll-free number.⁹ However, the transportation services are mainly offered by taxi drivers who prefer

to operate in affluent neighbourhoods due to perceived fears of insecurity in lower-income areas. This service is also restricted to Nairobi County and as such is inequitable due to limited coverage.

As for antenatal care, the Ministry of Health recommends four face to face and four virtual/tele consultations.¹⁰ Women are advised to call health facilities prior to attendance and to attend facilities unaccompanied and wearing face masks. It is also recommended that all women are given contacts for emergencies and extended (at least three months) prescriptions for supplements and regular medications for chronic illnesses.¹⁰

Health facilities are also using community health workers (CHWs) to distribute contraceptives to women in need. However, some of these CHWs, who play a critical role, have received little training on COVID-19 transmission prevention and are not equipped with PPE or well facilitated (e.g. with transportation costs) to conduct house-to-house visits. Kenya lacks a robust CHW programme that could have effectively spearheaded hygiene campaigns, contact tracing and isolation, and home-based care and as such reduced the burden on formal health care systems and infection transmission.¹¹ Currently, there is a Community Health Services Bill 2020 in Parliament that seeks to entrench CHWs into the health system to ease planning and resource allocation by the Kenyan government. Community health workers in Kenya serve huge populations (over 200 households) due to the vastness of some parts of the country and high attrition, stemming from the lack of financial support and motivation from the government.¹¹

Conclusion

Kenya lacks a robust pandemic emergency preparedness plan as human and financial resources are inadequate to respond to emergencies. Although existing disaster response and risk mitigation committees include stakeholders across different sectors, these positions are politically motivated and lack adequate technical support. Consequently, some responses to disasters (pandemics included) are ill-informed and inadequate with unintended consequences for the health of vulnerable populations. At the national level, there is need for technical expertise across different health fields (e.g. maternal and child health, sexual and reproductive health) amongst stakeholders tasked with emergency preparedness to

ensure a robust response and planning for current and future pandemics. There needs to be reflection on measures put in place and their impact on vulnerable populations such as pregnant women and mothers. Responses to challenges introduced by measures to address pandemics should be equitable. Proper responses increase populations' trust in the government, reduce fear, promote uptake of health services and quality health care, and save lives.

Sick healthcare providers strain an already under-resourced health care system. The Kenyan government's handling of safety concerns of healthcare providers has been poor, putting their lives and those of patients at risk. Consequently, healthcare providers have threatened to go on

strike due to lack of PPE and poor working conditions on several occasions since the first case of COVID-19 was reported. Moreover, CHWs are poorly remunerated, equipped and facilitated to support formal healthcare providers to reduce the health care burden. More advocacy is needed at the national and regional levels to ensure that all healthcare providers, including community health workers, have PPE, are trained on COVID-19 infection prevention and control, equipped, and facilitated to ensure wellbeing of pregnant women and mothers, and society at large.

Disclosure statement

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