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### Background and methods

As of July 1<sup>st</sup> 2020, the Coronavirus disease (COVID-19) has [resulted](#) in more than 6,000 confirmed cases and led to 148 deaths in Kenya. As evidence continues to be generated around the impacts of the infection during pregnancy and the postpartum period, it is expected that the outbreak's indirect effects will exceed the direct impacts of infection among women and newborns. This document summarises the findings from a global online survey of maternal and newborn health professionals working in Kenya, and includes responses received between March 27 and May 19, 2020. This brief presents challenges experienced by healthcare providers during the early stages of the pandemic, as well as applied and suggested solutions to overcome them and ensure that care continues to be provided to women and newborns.

The survey collected data on the respondents' background (country and region, qualification and work responsibilities, gender, and basic characteristics of the health facility in which the respondents worked, if any). To avoid concerns over confidentiality, we did not collect names of health facilities. The questionnaire included three core modules focusing on preparedness for COVID-19, response to COVID-19, and health workers' own experience of work during the COVID-19 pandemic. In the fourth, optional module, we asked respondents to elaborate on adaptations to 17 care processes (timing, frequency, modality of contact with patients during various types of outpatient and inpatient care) and to comment on whether they perceived that the uptake of care by the population they serve has changed and, if it had, how. The live version of the survey is available through this [link](#) and a summary of global responses is published [here](#) (survey questionnaire is provided as supplementary material).

### Respondents' characteristics

We use 21 responses collected from healthcare professionals working in Kenya, eight of whom agreed to answer the optional module. Respondents belonged to various specialties including nurse-midwives (n=5) and obstetricians/gynaecologists (n=3), and were equally distributed by gender. Around half were team members (n=10), and mainly provided antenatal care, childbirth and postnatal care. Around half of respondents provided care in referral hospitals and in public sector facilities (n=10 and n=13, respectively). Most of the facilities where participants worked provided caesarean sections (n=16) and accepted maternity patients referred from other facilities (n=18). Only one respondent reported that their facility had seen maternity patients with suspected SARS-CoV-2 infection.

### Part 1. Preparedness for COVID-19

<p><b>Access to information</b></p>	<p>19 respondents reported receiving information on COVID-19 from their facilities.</p> <p>Covered themes included general guidance about prevention measures (e.g., hand hygiene, disinfecting surfaces and equipment, personal protective equipment (PPE) use, social distancing and isolation), patient screening and triaging, case reporting and referral, as well as information about COVID-19 during pregnancy and the absence of transmission through breastfeeding.</p> <p>Almost all respondents searched for guidance themselves and took part in informal sharing with colleagues.</p>
<p><b>Trainings and drills</b></p>	<p>10 respondents received training on providing care during COVID-19.</p> <p><b>Recommendation from respondents:</b> More training and drills to support health professionals in providing care for women and newborns.</p>
<p><b>Updated guidelines</b></p>	<p>10 respondents received updated guidelines on care provision to pregnant, laboring or postpartum women and their newborns in the context of COVID-19. Respondents mentioned the Ministry of Health (Government of Kenya) and the WHO as sources of guidelines.</p>

**Part 2. Response to COVID-19 at the facility level**

<p><b>Screening of patients</b></p>	<p>Almost all facilities had established a sign-posted entrance and COVID-19 screening area.                  14 respondents reported that their facilities screened maternity patients for COVID-19 symptoms.</p> <p><i>“Team members on the screening desk [are] very irritable and anxious.”</i></p>
<p><b>SARS-CoV-2 testing capacity</b></p>	<p>Eight respondents reported being able to order a RT-PCR test for the SARS-CoV-2 virus test for maternity patients.                  Range of time periods to receive results was 6 hours to 3 days.</p> <p><i>“We are not routinely testing all pregnant women. [I am] fearful there may be an exponential increase in community cases that will also affect pregnant women.”</i></p> <p><b>Recommendation from respondent:</b> <i>“Increased prioritization of testing in level V facilities with the growing number of in country transmission cases”</i></p>
<p><b>Isolation space availability</b></p>	<p>Almost all respondents reported that their facilities dedicated isolation rooms for suspected patients.</p> <p>Some reported concerns over the lack of space to manage COVID-19 patients in light of other patient load.</p> <p><i>“Pregnant women who may need c-section done to them... what will happen since there is only 1 theatre.”</i>  <i>“If there is neonatal pneumonia or Respiratory Distress Syndrome we will run out of space to cater for such babies”</i></p>
<p><b>Infection prevention</b></p>	<p>Not all of the 21 respondents had sufficient gloves (n=13), face masks (n=5), and aprons (n=4).                  Two out of 21 respondents felt well protected from COVID-19 in the workplace.</p> <p><i>“Maternity units are not well supplied with proper PPEs.”</i>  <i>“There is stigma due to the wearing of PPEs.”</i></p> <p>15 participants reported an increase in routine cleaning in their facility’s maternity ward.</p>

### Part 3. Personal experience and work

<p><b>Staff workload</b></p>	<p>Respondents reported a shortage of healthcare workers resulting from staff re-allocation to COVID-19 wards:</p> <p><i>“The health care providers have been deployed to the CORONA VIRUS isolation centers and not allowed to come back and mingle with the patients and other health care workers, there is an acute shortage of health care workers.”</i></p> <p>Respondents also mentioned a change to longer working hours  <i>“Night shift longer than day to adjust for curfew hours and safe transport.”</i></p> <p><b>Recommendation from respondent:</b> <i>“Allow a flexible time for our health workers to work two weeks off and two weeks on so that the two weeks one is off serves as a quarantine period, allow relieve of stress and nutritional support to the staff.”</i></p>
<p><b>Stress levels and concerns</b></p>	<p>18 out of 21 respondents reported that their stress levels were somewhat or substantially higher than usual.</p> <p>Few respondents reported that their concerns about COVID-19 had been addressed well by the facility where they work (n=5).</p> <p>Fear of becoming infected and about own and family’s safety and livelihood  <i>“Clients are not disclosing their movements or contacts up front in this regard health workers should be provided with complete PPEs on a daily basis to be able to handle each client as a suspect hence reduce the fear in case a client turns positive.”</i></p> <p>Concern about patients’ non-compliance with infection prevention measures  <i>“Patients disregard and contempt for regulations getting worse, putting healthcare workers in more danger.”</i></p> <p>Uncertainty about information related to risk of transmission during childbirth and breastfeeding and uncertain long-term risks for newborns:  <i>“Is there possibility of vertical transmission from either vaginal delivery, breastfeeding? If yes, based on population dynamics substitute feeds are too expensive, implying mass malnutrition risks.”</i></p> <p>Fear of disease spread among vulnerable communities  <i>“In the event that COVID-19 gets into the slums where social distancing is a challenge and sanitary conditions are poor, nutrition support is wanting especially at this time when economy is grossly affected people have lost their jobs what will happen, how will we manage?”</i></p> <p><b>Recommendations from respondents</b> on how to better support health providers:</p> <ul style="list-style-type: none"> <li>- Provision of psychological support</li> <li>- Securing accommodation for healthcare workers near facilities to avoid curfew and travel</li> <li>- Extra ‘risk’ allowances in addition to salary</li> <li>- Compensation for the increased cost of transportation to workplace</li> </ul>

#### Part 4. Changes to the care provided to women and newborns

The table below reports responses from eight health professionals who completed the optional module.

<p><b>Women's use of care</b></p>	<p>Fewer women were seeking services from health facilities either because of fear of contracting the illness, or because of lockdown measures. Respondents reported that:</p> <ul style="list-style-type: none"> <li>- Fewer routine antenatal and postnatal checks were taking place</li> <li>- There was an increase in home-based childbirth</li> <li>- They noticed reduced attendance for immunization visits</li> </ul> <p><i>"Women fear to get infected with COVID-19 if in hospital. Most of them keep off from hospital even when they are sick."</i> <i>"Difficulty of reaching facility so fewer women."</i></p>
<p><b>Intrapartum care</b></p>	<p>Fewer pain relief options: <i>"To minimize contact, use of epidural blocks being discouraged to avoid involving anesthetist"</i> <i>"Non-medication options: reduced movement, water baths, back massage"</i></p> <p>Labour induction and augmentation: <i>"Likely most women have labour induced or augmented to accelerate it and get them out of hospital"</i></p> <p>Reduced elective caesareans: <i>"To reduce patient contact hours in hospital and facilitate rapid discharge, elective caesarian sections only performed for previous scars, no longer for cosmetic purposes"</i></p>
<p><b>Availability of support to women</b></p>	<p>Shortening of visiting hours, cancelling visits altogether or reducing the number of allowed visitors: <i>"Only one visitor allowed to visit the mother. No visitors the baby."</i></p> <p>Respondents reported limiting the number of birth attendants to one or two, depending on the extent of complications: <i>"Maximum of one doctor and one midwife for uncomplicated delivery and two midwives with no companion in the room for any complications."</i></p>
<p><b>Postnatal care</b></p>	<p>Shorter length of stay in facility postpartum: <i>"If possible discharge within 48hours for caesarian and 24 hours for vaginal delivery."</i></p> <p>Postnatal follow-up delayed or cancelled, including home visits: <i>"Patients are given a longer period for return dates not unless they have health issues that would warrant them to come earlier"</i> <i>"Follow-up visits to women's homes not available/allowed"</i></p>
<p><b>Prioritising at-risk or emergency cases</b></p>	<p>Prioritizing emergency cases: <i>"Patients advised to stay home if their medical needs are not so urgent... which might worsen in time."</i></p>

**Key challenges to and solutions for maintaining provision of maternal and newborn care: In respondents' words**



Pregnancy  
Antenatal care

Labour &  
Childbirth

Postnatal &  
newborn care



**Closures of health facilities means that some women are denied the care they need**

*"Many pregnant woman will not access health care services especially routine antenatal care since most of the primary (low) health facilities have been closed. The high level health facilities are no go zones and outpatient/clinics have been closed. Most probably, women will TBA or CHWs when in labour because of challenges accessing skilled health care"*

*"Very minimal outpatient antenatal care being provided. The ordinary women who cannot afford to seek private services go unattended to."*

*"The common rural woman is unlikely to access skilled health care because most of the rural primary facilities have been closed."*

**Strict precautionary measures affect care quality and utilisation**

*"As much social distancing is important to help stop/slow down the rate of transmission of COVID-19, let us remember babies will be born when their time comes. Pregnant women should receive the care when they need it, especially skilled care."*

*"I am worried about mothers opting to give birth at home because of fear that has been brought about by COVID-19 and as a result of restricted movement; also many women will not attend the required number of ANC visits."*

**Scarcity of available resources**

*"Number of beds are always fewer than number of patients. Economic pressure on public facilities is impacting negatively on availability of supplies, equipment and medications."*

*"The current COVID-19 pandemic has prompted an increase in attention paid to infection prevention and control measures in hospitals. This has resulted in improved collaborations between lower health facilities and higher referral hospitals. Adversely, there has been greater strain on an already resource -deficit health system resulting in increased workload for health providers without appropriate equipment."*

**Solutions**

**Multi-sectorial response to ease travel restrictions for those who need emergency care**

*"Public means of transport negatively affected. Private transport expenses beyond ability of common woman. However, government using communities leaders to reach out to people. Special identifiers put in place for sick people to identify themselves with to the security officers (police, GSU) to avoid arrest for breaking the 7:00pm curfew. Thus, they are able to reach to the health care facilities for treatment even at night. Health care leaders have stationed ambulance in strategic areas to attend to those in need of emergency services even at night."*

**Care and training provided remotely**

*"I have to work remotely which was not the case before but I'm happy about our institution on the training they're giving us online. They have been of more help to me."*