Addressing the Intersection of Health and Economic Inequities among Pregnant and Post-partum Women in Kenya during COVID-19

February 2021

RATIONALE OF STUDY

The COVID-19 pandemic disproportionately threatens vulnerable populations, including women and especially pregnant and post-partum women.[1] Early estimates suggests that maternal and child deaths could increase by 8.7-38.6% and 9.8-44.7%, respectively, across low and middle-income countries (LMIC) due to disruptions in healthcare access and food insecurity.[2] A global systematic review of impacts on maternal health found evidence of disruptions to healthcare services, reduced use of antenatal care, decreased access to family planning, and increased stress, anxiety, and depression related in part to isolation and fear of COVID-19 infection.[3] Approximately one year into the COVID-19 pandemic, there continues to be a lack of information on the social, economic, and health impacts of the pandemic on pregnant and post-partum women and their infants, particularly from LMICs. Prior to the pandemic, Kenya, in particular, reported one of the highest rates of maternal and neonatal mortality in the world.[4] Action-oriented research is needed to identify solutions and strategies for national and local government and communities. This policy brief provides information on the experiences of pregnant and post-partum women during COVID-19, with particular attention to healthcare access, maternal and newborn healthcare utilization, and maternal and newborn health.

KEY FINDINGS

- One in 2 women (52%) reported that COVID-19 negatively impacted their ability to receive antenatal care.
- Almost half of women (44%) gave birth outside of their preferred or intended location.
- One-fifth of women (17%) reported avoiding or delaying needed care at least once during COVID-19.
- Nine in 10 women (92%) reported at least one condition indicating household food insecurity in the last four weeks.

ANTENATAL CARE

ANTENATAL CARE USE & TIMING

Among the 1,135 women who gave birth during COVID-19 (on or after March 16th 2020), nearly all (99%) received some antenatal care. About 1 in 3 women (32%) attended fewer than 4 visits, and most (76%) did not initiate antenatal care until the second trimester. Women who were currently married or partnered were more likely to begin antenatal care during the first trimester than those who were single, divorced, or widowed (19% vs. 14%). Further, 13% of women with 4 or more births began antenatal care in their third trimester compared to just 5% of women who had given birth for the first time.

IMPACT OF COVID-19 ON ANTENATAL CARE

One in 2 women (52%) reported that COVID-19 negatively impacted their ability to receive antenatal care. The most reported impacts included those related to a fear of contracting COVID-19 if going into the community or to a health facility, an inability to afford care or transportation to the health facility, and facility factors related to COVID-19, such as being turned away from the facility, the facility being closed or too busy, and restrictions in the types of services being provided at facilities.

INTRAPARTUM EXPERIENCE & CARE

DELIVERY LOCATIONS

Most women delivered in a public (66%) or private (28%) facility, while about 5% delivered at home. Nearly all births (95%) were assisted by a trained professional, such as a doctor or nurse/midwife. Almost half of women (44%) gave birth outside of their preferred or intended location.

IMPACT OF COVID-19 ON INTRAPARTUM CARE

Among those who gave birth in a facility (N=1072), most women reported that facilities required they wash their hands or use hand sanitizer upon arrival (87%), required they wear a mask during labor and delivery (79%), required visitors wear a mask (77%), checked their temperature upon arrival (86%), and screened for COVID-19 symptoms (59%). About 20% of women said facilities separated newborns until the mother could be tested for COVID-19. Nearly 1 in 10 women (7%) were required to pay a fee to cover the cost of PPE during labor and delivery.

DELIVERY EXPERIENCE

Nearly half (45%) of women preferred to have a companion present during labor and delivery. About 60% of women who delivered at home had a companion present during labor/delivery, as opposed to 10% of women who delivered at a facility. About 2 in 10 women (23%) reported experiencing complications during or just after delivery. About half of women felt the doctors, nurses, or other facility staff always treated them with respect (52%) or in a friendly manner (52%). One in every 3 women reported never being involved in decisions about their delivery care (30%) or asked to provide consent for examinations or procedures done to them (29%).

"If there would not have been rules for wearing masks, I could have gone to the hospital and just given birth and other things could have followed thereafter. I could have been having a job, I could have planned myself and have bought those things that were required and I couldn't have given birth in the house...It was difficult because when you are at the hospital and something is not right the doctors can help you. They can take you to the theater and see how to help you. But you see I was alone between death and my God. I saw difficulty but I was grateful because God helped me."

– Age 27, 4th child

POST-PARTUM HEALTH

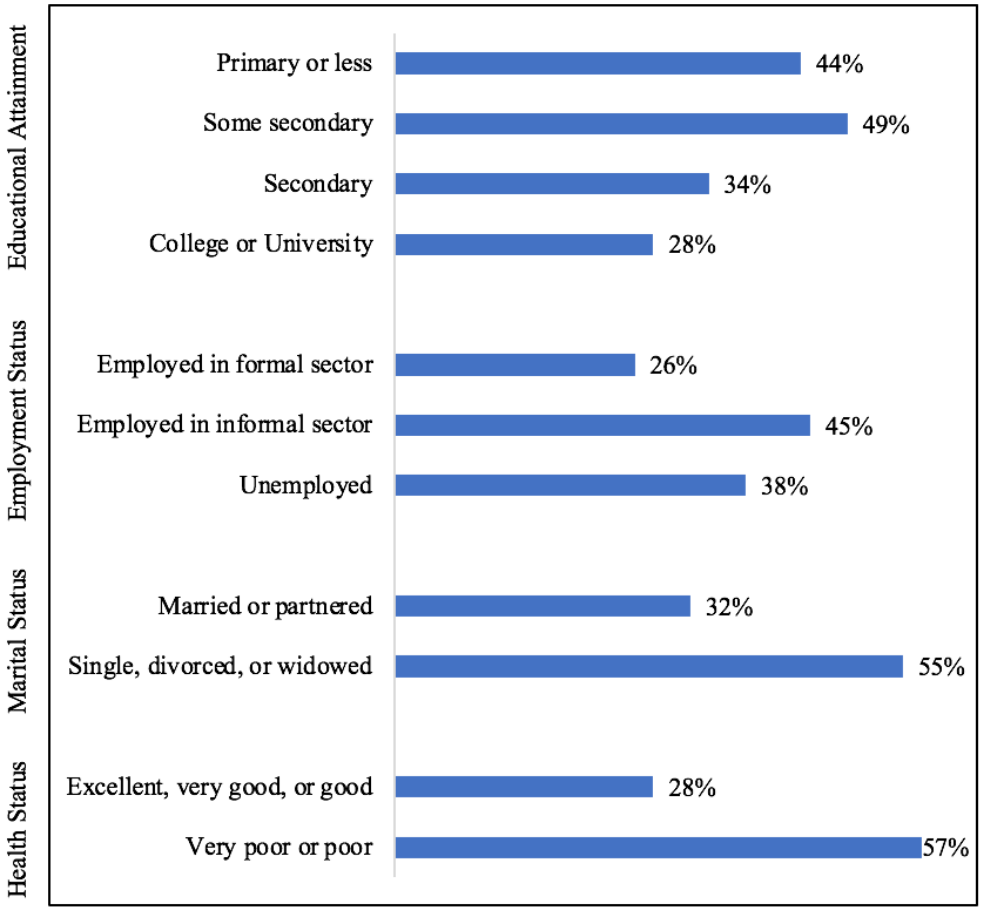
HEALTHCARE USE

About two-thirds of women (65%) were seen by a healthcare provider since their delivery. However, one-fifth of women (17%) also reported avoiding or delaying needed care at least once during COVID-19.

MATERNAL HEALTH

Nearly 4 in 10 women (39%) screened positive for depression. As shown in Exhibit 1, the prevalence of depression was highest among those who completed some secondary education (49%) or primary or less (44%) and employed in the informal sector (45%). Single, divorced, or widowed women were about 1.75 times more likely to screen positive for depression than married or partnered women. Women who rated their current health status as "fair, poor, or very poor" were twice as likely to screen positive for depression than those with "excellent, very good, or good" health. About 4 in 10 ever married or partnered women (36%) reported a history of intimate partner violence. Among these women, 19% reported these behaviors to have increased since the start of COVID-19.

Exhibit 1. Prevalence of maternal depression across demographic characteristics.



NEWBORN HEALTH & BREASTFEEDING

BIRTH OUTCOMES

Nearly one-quarter of newborns (23%) were born premature and about 7% were low weight. Thirteen newborn deaths were reported, representing 1% of all births.

BREASTFEEDING

Most women (80%) received breastfeeding counseling at the time of their delivery. Among these women, only half (48%) reported receiving guidance on breastfeeding if the mother was suspected or confirmed to have COVID-19. About one-fourth of women (23%) said they would continue to breastfeed if they thought they had COVID-19. Nearly all newborns (96%) were breastfed for their first feed and the majority (58%) were exclusively breastfeeding at the time of the survey.

INFANT VACCINATIONS

Most newborns received vaccinations at birth (97%) and 6 weeks (91%). Twenty percent of women said they had to miss or delay at least one immunization for their newborn. The most commonly reported reasons included facility-related factors (e.g., being turned away, facility closure, doctors strike) and an inability to afford care.

COVID-19 EXPERIENCES, EXPOSURES & INFORMATION SOURCES

COVID-19 INFORMATION & TESTING

Most women received information about COVID-19 from news broadcasters (87%), the national government (51%), postnatal medical care providers (27%), and peers or family members (25%). About 7% of women had experienced symptoms consistent with COVID-19 infection. Almost 3 in 10 women (27%) reported to have ever received a COVID-19 test; none of these women reported to have tested positive. Among those who had never been tested, commonly reported reasons included not knowing where to access testing, being afraid to get tested (related to contracting COVID-19 or being stigmatized if testing positive), and feeling it was not necessary to get tested.

FEAR OF COVID-19

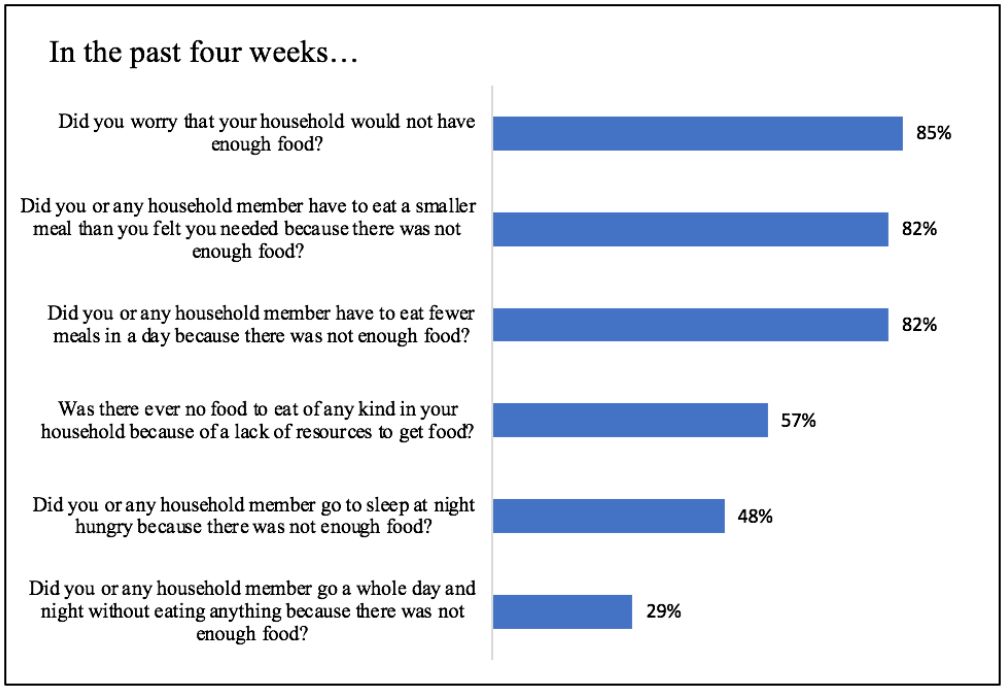
About half of women (56%) reported feeling unsafe going to a health facility because of the COVID-19 outbreak. Almost two-thirds of women (64%) said they worried about being judged or treated unfairly by family, friends, or healthcare providers if they tested positive for COVID-19.

"You are scared even when you are moving around. You are not sure since you might contract it from the places that you go to. You might get it from the people that you greet. Maybe the person sitting next to you has it and you don't know. I therefore I had to stay in the house mostly. I wouldn't greet anyone normally. You instead just wave at them...You are not sure because contracting covid might affect the unborn baby. You might both die. Therefore, I was very scared as a result."
-Age 25, 4th child

ECONOMIC INDICATORS DURING COVID-19

More than three-quarters of women (76%) were not employed. Among those women who were employed at the start of COVID-19 or at the time of the interview, 68% reported losing their job, 37% received decreased pay, 34% had disruptions due to childcare challenges, and 23% reported a loss of hours because of COVID-19. Further, among the women still working at the time of the interview, most (89%) were employed in the informal sector (e.g., self-employed in petty trade or small-scale business). Nine in 10 women (92%) reported at least one condition indicating household food insecurity in the last four weeks (Exhibit 2).

Exhibit 2. Percent of households experiencing conditions of food insecurity.



RECOMMENDATIONS

Pregnant and post-partum women face a number of economic, social, and health challenges as a result of the pandemic. This study has several policy and programmatic implications to support pregnant and post-partum women and families during pandemics and other disruptions. Below, we provide concrete strategies for the Kenya Ministry of Health, local government officials, and health facilities based on these data.

PROVIDE UP-TO-DATE INFORMATION ON COVID-19 AND MATERNITY CARE

- Multi-pronged approaches are needed across government (national and county), communities (e.g., village chiefs and leaders, community health volunteers), and health facilities to educate women and their families regarding the current (and evolving) safety protocols taken in health facilities to mitigate COVID-19 risks. This includes the hours of operation and any operational changes for maternal and newborn care.
- The government, in collaboration with the health system, should provide up-to-date information on the status of COVID-19 to build confidence among the community on the safety of health facilities. This will also help dispel rumors about COVID-19 and address stigma associated with the virus.
- Information-sharing can occur through health care providers during antenatal care visits, community health volunteers, brochures, posters, or SMS messaging.
- Ongoing data collection and monitoring of women is also important in highlighting potential unmet health needs.

PROVIDE UNINTERRUPTED NEWBORN AND MATERNAL HEALTH SERVICES

- Access to maternal and newborn services should be uninterrupted, including family planning services.
- Measures to ensure that newborns do not miss or delay their immunizations against childhood illnesses need to be established, including reminders through SMS messages, community health volunteers, and health providers.
- The government should provide clear guidelines on transportation to health facilities for pregnancy care during curfew. Women in labor and their drivers should have the authorization and security necessary to safely transport to the facility for labor and delivery. Law enforcement should also be clear on these exemptions.

PROVIDE SUBSIDIZED PPE DURING MATERNAL AND NEWBORN CARE

- The government should look into ways of providing subsidized PPE to women during labor and delivery.
- Supplies could include masks, gloves, hand sanitizer, and soap.
- Health facilities should enact standardized prevention measures including screening for COVID-19 symptoms and increased hand washing and hygiene.

STREGNTHEN COMMUNITY HEALTH VOLUNTEER NETWORKS

- The government should invest in and recognize the value of community health volunteers (CHVs). Providing payment for this cadre of health workers is particularly important in densely populated regions, such as Nairobi, to mitigate the spread of disease and improve service uptake.
- CHVs can support with screening for mental health, domestic violence, and food insecurity and provide appropriate referrals.
- CHVs should be trained on COVID-19-related information, identify gaps where CHVs are appointed but inactive, identify geographies where CHVs do not exist, and improve processes between CHVs and their role in educating, coordinating, and connecting women to the broader health system.

LINK WOMEN TO APPROPRIATE REFERRALS AND SOCIAL SUPPORT SERVICES

- Mental health and counseling services should be provided and advertised more broadly to address depression related to the pandemic.
- Screenings can be conducted at antenatal care visits for partner violence with appropriate referrals for women and families. Provide toll-free lines and a list of government facilities offering mental health and domestic violence services.
- Provision of guidance on breastfeeding to mothers suspected to be COVID-19 positive would help reduce anxiety and fear among women while ensuring that newborns do not miss the nutritional benefits provided by breastmilk during their early days of life.
- The government should develop strategies that would ensure low-income women are not at risk of food insecurity due to loss of employment or reduced wages. This includes screening for food insecurity at antenatal care visits and linking women to food pantries and other nutritional resources.

APPENDICES

Appendix A. Distribution of Sociodemographic Characteristics, N=1,135

	N (%)
Mother's Characteristics	
Age, years	
Less than 25	395 (34.8)
25-29	349 (30.8)
30-34	250 (22.0)
35 and older	141 (12.4)
Currently married or partnered	771 (67.9)
Educational attainment	
Primary or less	423 (37.3)
Some secondary	179 (15.8)
Secondary	410 (36.1)
College or University	123 (10.8)
Christian religion, yes	1,098 (96.7)
Employment status	
Unemployed	883 (77.8)
Employed informal sector	225 (19.8)
Employed formal sector	27 (2.4)
Self-rated health status	
Excellent, very good, or good	707 (62.3)
Fair, poor, or very poor	428 (37.7)
Number of births	
1	311 (27.4)
2	360 (31.7)
3	268 (23.6)
4 or more	196 (17.3)
Newborn's Characteristics*	
Sex, male	569 (50.7)
Age, months	
Less than 1	57 (5.1)
1-2	235 (20.9)
3-4	308 (27.5)
5-6	295 (26.3)
More than 6	227 (20.2)

*Among those newborns reported to be alive at the time of the interview (N=1,122)

References

1. Rafaeli T, Hutchinson G. The Secondary Impacts of COVID-19 on Women and Girls in Sub-Saharan Africa. K4D Helpdesk; 2020:24.
2. Roberton T, Carter ED, Chou VB, et al. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. The Lancet Global Health. 2020;8(7):e901-e908.
3. Kotlar B, Gerson E, Petrillo S, Langer A, Tiemeier H. The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review. Reprod Health. 2021;18(1):10.
4. Masaba BB, Mmusi-Phetoe R. Neonatal Survival in Sub-Sahara: A Review of Kenya and South Africa. JMDH. 2020;Volume 13:709-716.

Acknowledgements

This work was funded by the Bill and Melinda Gates Foundation.

Suggested Citation

Sudhinaraset M, Landrian A, Golub G, Mboya J, Kepha S, Gant M, Woofter R, Wambui S, Njomo D. Addressing the Intersection of Health and Economic Inequities among Pregnant and Post-partum Women in Kenya during COVID-19. 2021.