

## Article

# Effects of COVID-19 on Kenya's Healthcare System: Healthcare Providers' Experiences with Maternal Health Services Utilization in Coastal Kenya

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**Abstract:** The COVID-19 pandemic overstretched health systems in developed and developing nations. Like other African nations, Kenya has a frail health system, making responding to the pandemic a problem. Recent studies during COVID-19 have shown that Kenya's health systems were either strained to their maximum capability or worse in handling patients. Therefore, citizens were advised not to go to the hospital unless necessary. This advice applies to all, including pregnant mothers. This article utilized the anthropological description of the healthcare system, viewed as a cultural system attached to particular provisions of social institutions and forms of social connections. It is a social and cultural system in origin, structure, function, and significance. In every society, healthcare systems are forms of social reality in which they embody specific social roles and relationships between these roles. There is a dearth of information on how healthcare providers experienced the effects of COVID-19 on Kenya's healthcare system, which this study addresses for those in Coastal Kenya. This rapid qualitative study utilized data from sixteen purposefully selected healthcare providers in charge of various departments in Kilifi County of Coastal Kenya. We utilized thematic analysis and textual description to present our findings. It emerged that there was a diversion in resources allocated for maternal health programs, health facilities were temporarily shut down due to inadequate resources and equipment for health workers, there was a lack of preparation by health workers, there was a reduced flow of pregnant mothers and missing scheduled appointments for ante- and postnatal clinics, maternal mortality increased, and mothers resorted to traditional midwives for deliveries. These findings show that maternal health services were negatively affected. Thus, the government needs to institute alternative measures for continued access to maternal health services during pandemics. We recommend expanding and supporting the existing community midwifery model (CMM). For instance, incorporating community health workers (CHWs) and other local health institutions in the community, such as traditional birth attendants (TBAs), and creating midwifery centers managed by trained midwives in communities.

**Keywords:** anthropology; COVID-19; healthcare system; Kilifi County; maternal health services



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## 1. Introduction

Access to reproductive and maternal healthcare leads to healthier lives for women and girls and increases the likelihood of staying in school and contributing to their communities. Globally, Africa has the highest maternal death rates, linked to poorly functioning healthcare systems [1]. During pregnancy and childbirth, complications are the primary cause of disability and death in developing nations [2]. However, over the past three decades, access to healthcare has significantly improved in Sub-Saharan Africa (SSA). Despite efforts toward attaining universal health coverage (UHC), the health systems of countries in Sub-Saharan Africa are overwhelmed by numerous challenges that have been further aggravated by the COVID-19 pandemic [3].

The World Health Organization declared coronavirus disease (COVID-19) a pandemic spreading to over 200 countries and territories worldwide. The coronavirus overburdened health systems worldwide, disrupting regular care [4]. Maternal health was directly and indirectly affected by the COVID-19 pandemic, leading to intertwined direct and indirect effects [5]. Many changes, therefore, had to take place in providing healthcare and pregnancy and childbirth care [6–9]. Maternal health services and other sexual and reproductive healthcare services such as the treatment of sexually transmitted diseases, emergency contraception, family planning, safe abortion, and post-abortion services, to the full extent of the law, were to remain core health services. Data from the United Nations Population Fund (UNFPA) suggested a drop in facility-based care in many countries due to COVID-19, projecting a rise in maternal mortality [10].

Pregnancy and childbirth are delicate moments in a woman's life because they carry key threats for both the newborn and the mother [11]. Maternal health, in particular, is serious because it impacts the functioning of current and forthcoming generations [12,13]. Maternal deaths remain a global public health challenge, with recent statistics indicating a lag in its improvement [14]. In the developing world, maternal mortality rates are significantly high, particularly in Sub-Saharan Africa (SSA), where most maternal deaths are due to obstetric complications [15–17]. In 2015, approximately 303,000 women passed away during pregnancy and childbirth, representing a significant improvement over earlier maternal mortality rates; however, most of the deaths occurred in low-resource settings [18]. Most of these maternal losses could have been prevented or dealt with successfully by providing timely access to quality maternity care to women and infants.

Epidemics in the past interfered with health systems, disrupting the provision of routine services. This was mainly due to the sudden upsurge in demand and the redistribution of the health personnel toward the management of epidemics, thus interfering with maternal health [19–21]. This is evident in low- and middle-income countries, where the provision of basic healthcare services was a challenge even before the COVID-19 pandemic [21,22]. The extent of the COVID-19 pandemic created extraordinary encounters for healthcare providers, as well as concerns about interrupting the provision of and access to healthcare [23,24]. COVID-19 impacted many African countries, interrupting maternal, neonatal, and child healthcare [25].

With the emergence of the COVID-19 outbreak, access to and the provision of quality antenatal care services was further threatened in East Africa due to the scramble for limited healthcare resources. This was exacerbated by the global containment measures, which led to health centers being overstrained with efforts to respond to COVID-19 cases; an inadequate supply of personal protective equipment due to the interrupted supply chain; and a shortage of skilled midwives, as health providers needed to respond to COVID-19 [7,8,26]. The healthcare system in Africa has numerous challenges. This includes a shortage of specialists qualified in life-threatening care and insufficient tertiary care services (specialized health facilities) furnished with intensive care units (ICUs). Moreover, previous studies have noted that resource scarcity could hamper compliance with WHO COVID-19 containment measures in regions such as Africa, even when people would be willing to abide by COVID-19 rules [27,28]. The pandemic has also led to governments, donors, and stakeholders redirecting funds and attention toward COVID-19 containment efforts, hence diverting attention from other vital issues such as sexual and reproductive health. This has led to limited accessibility to essential healthcare services for women and girls [26,29].

The catastrophic consequences of COVID-19 on maternal health were predicted by [30]. Quality maternity healthcare services were inaccessible, unreachable, or unaffordable for many pregnant mothers worldwide, especially in low-resource countries [7–9,31]. COVID-19 further negatively impacts women's health due to restrictions on travel and gatherings, partial infection deterrence, supplies, untrustworthy infection control practices at health facilities, and disrupted health worker routines [7,8,32]. Maternal mortality persists as the biggest challenge to the health system in Kenya [33]. Recent studies from Kenya have

reported a decline in maternal health services during COVID-19 due to restricted access to health facilities arising from government COVID-19 containment measures [7,8,33–35].

In Kenya, there is inequality in health service uptake despite the introduction of free maternity services (FMS) in 2013. The introduction of FMS boosted hospital births, averted catastrophic health expenses, and ensured rightful access to MHS for all mothers, including those from vulnerable populations [36]. The free maternity care (FMC) policy introduced in June 2013 has partly led to an increase in facility-based deliveries, from 44% in 2008 to 61%, and an increase in skilled care deliveries in 2015 [37]. In Kenya, the first case of COVID-19 was reported on 13 March 2020. Studies from Kenya show that, due to containment measures and government interventions, health systems were either stressed to their maximum capability or overwhelmed [7–9,35]. Therefore, COVID-19 threatened the hard-won achievement of addressing maternal death and associated issues in Kenya.

The health workforce for vital health services was negatively affected in several ways, including but not limited to fear of infection with COVID-19 among health workers, mainly because of inadequate medical equipment [38]. For this article, a healthcare system refers to a cultural system anchored in particular social institution arrangements and interpersonal interaction patterns. It is a societal and social system in function, structure, origin, and significance. In whatever society they appear, healthcare systems are a form of social reality in which they embody specific social roles and relationships between these roles [39]. This article explores healthcare providers' experiences in providing maternal health services in the coastal part/region of Kenya during the COVID-19 pandemic. It is a follow-up to the first author's (S.O.) Ph.D. research on local perceptions of social protection schemes in maternal health in Kenya, March–July 2016 and February–July 2017 [31]. "Social protection schemes" refer to free maternity services, and maternal vouchers were provided by recognized private and public hospitals [7,8]. This paper employed a qualitative approach involving the experiences of frontline healthcare professionals in maternal health services provisions, providing further evidence of the impact of the pandemic on maternal health services. The findings from this study may help improve policies and practices.

## 2. Materials and Methods

### 2.1. Design and Setting

The current study employed a rapid qualitative approach with a cross-sectional design conducted by S.O. Cross-sectional studies serve many purposes, including being the most relevant design when assessing the prevalence of disease, attitudes, and knowledge among patients and health personnel [40,41]. Cross-sectional studies are characterized by collecting relevant information (data) at a given time. Hence, there is no time dimension involved in cross-sectional studies, as all data are collected and mostly refer to the time at or around the time of the data collection [41]. The study area was Kilifi County in Coastal Kenya. Kilifi is a desert and semi-desert area. Approximately 65% of Kilifi County has been struck by long droughts and floods, leading to low productivity and food insecurity. The dependency ratio in the county stands at 101.45 percent, with high poverty levels at 66.7% and widespread food insecurity affecting approximately 67% of the households. According to the Kenya National Bureau of Statistics and ICF International (2015) [37], most of the population is rural-based. The predominant community is the Giriama sub-tribe of the larger Mijikenda community. The primary source of livelihood for the Giriama is subsistence farming and animal husbandry. Kilifi is among the top 15 counties contributing to Kenya's maternal and perinatal death burden [42]. Kenya's maternal mortality rate is still high at 342 per 100,000, and Kilifi County is among the top 7 counties leading in maternal mortality rates in Kenya, with a mortality rate of 289 per 100,000 (Kenya National Bureau of Statistics and ICF International, 2015).

### 2.2. Participants and Data Collection

This study was conducted between June–July 2020 and September–October 2020. S.O. led phone interviews with twenty-one healthcare matrons (nurse-midwives who

serve as heads of departments) and administrators in charge of maternal health services. Kilifi County has two referral health facilities. The healthcare matrons and administrators were purposely selected from two health facilities that handle referrals and complicated emergencies, whom S.O. had contact with during primary fieldwork. The first author had previously met the health providers in 2016 and 2017. The study utilized two online group discussions in September and October 2020 through Google Meet, moderated by S.O. Each discussion group had 7 participants of both genders and lasted for approximately 91 min. Before conducting the research, S.O. obtained informed consent from all the participants to record the online meeting. Moreover, we conducted 21 in-depth interviews in English. The in-depth interviews stopped at saturation since no additional relevant categories emerged from our data. The interviews lasted for a minimum of 45 min (Table 1).

**Table 1.** The sociodemographic characteristics of the participants.

Age	18–30	4
	31–43	14
	44–56	3
SEX	Male	7
	Female	14
Department	Maternal Child Health	10
	Maternity	8
	Administration	3

### 2.3. Interview Guidelines

Sample questions that formed the discussions included the following (for additional research questions, see Supplementary Materials):

How do health providers deal with COVID-19 measures to provide essential services?

Where do pregnant mothers go to give birth, and who provides services throughout the COVID-19 pandemic?

What was the prevalence of antenatal plus postnatal clinic attendance during the COVID-19 pandemic?

What do health providers think were the major drawbacks of the COVID-19 pandemic on maternal health?

What do healthcare providers think could be done in the future for continuous access to maternal well-being during pandemics?

### 2.4. Data Analysis

The recorded discussions were transcribed verbatim in English. Data analysis began while the fieldwork was in progress. All authors participated actively in the analysis. We took note of emerging themes and how they developed in the course of the research. We utilized a contextual thematic analysis, and recurring themes were teased out for this article. The first author (S.O.) transcribed the recorded interviews using the computer-aided transcription software F5. The interview transcripts were reviewed for accuracy by the second author. Coding was performed manually without the aid of software. S.O. read through the transcripts repeatedly to identify and list inductive codes and then used them to develop a codebook flexible enough to include new codes as they emerged and delete or merge other codes as the analysis continued. After a review of the transcripts and the codes by all the authors, themes were identified in line with the primary aim of the study by all the authors. The findings are presented in textual descriptions and illustrated using verbatim quotes.

### 2.5. Reflexivity

Reflexivity is important in all qualitative research and enables the reader to consider the validity of any qualitative analysis by better understanding the composition and position of the research team that produced it. This research team comprises career-stage anthropologists specializing in different sub-disciplines. S.O. is a medical anthropologist specializing in the anthropology of maternal health and birthing processes; A.N. is also a medical anthropologist, who focuses on the health system and the integration of mobile phones in case-seeking. Therefore, we bring a mix of different perspectives and experiences to this topic.

### 2.6. Ethical Considerations

Ethical authorization was sought from the Maseno University Ethical Clearance Committee (MUERC). Participants were assured of confidentiality during the research process. This was achieved by not using names in any instance while collecting data. No identifying name tags were used to ensure the privacy of the participants. Participants were further assured of anonymity and confidentiality for the recorded interviews. During the recorded interviews, the names of the participants were anonymized, and the data was kept safe and only accessible to the researchers.

## 3. Results

### 3.1. Diversion of Resources Allocated for Maternal Health Programs

Governments, donors, and stakeholders are redirecting funds and attention from other programs to COVID-19 control efforts, thereby distracting focus from other essential healthcare issues, including sexual and reproductive health. This has inhibited access to important healthcare services for women and girls. Moreover, it was commonly mentioned during the interviews that money allocated for health services was mainly channeled to deal with the COVID-19 pandemic. This redirecting of funds to COVID-19 negatively affected supplies for maternal health and other reproductive health programs. Despite the diversion of resources, the health workers did not have adequate personal protective equipment (PPE). This was mostly due to a lack of sufficient emergency preparation response for pandemics such as COVID-19 in the Kenyan healthcare system.

“As you are aware, a lot of funds allocated for other health programs, including maternal health were diverted to help deal with the COVID-19 pandemic. Maternal health programmes suffered like other programs, too. However, the government thought of pregnant mothers later (Interview with health worker 16).”

“When funds are diverted and there is no alternative for the health workers, expectant mothers suffer the most. Even with the diversion of the funds, the health workers do not have adequate personal protective equipment (Group Discussion, Matron 2).”

“It is in the public domain that funds from every programme including maternal health were diverted to manage this COVID-19 pandemic. It was terrible you know our health workers lacking PPE but had to report to work because this hospital handled referred cases for both maternal health and other health complications (Interview with hospital administrator 01).”

### 3.2. Reduced Antenatal and Postnatal Clinic Attendance

There was a reduced flow of pregnant mothers to local health facilities and major health facilities such as county referral hospitals. Mothers missed scheduled appointments for ante- and postnatal clinics. Health workers commonly mentioned that a reduction in available healthcare services, restrictions on movement, and a lack of health workers due to responses to COVID-19 containment measures led to a decrease in clinic attendance. Moreover, health workers also reported that women feared taking tests for COVID-19

because a positive result meant being sent to a compulsory quarantine away from their homes and families. For instance,

“We have a decrease in the in-flow of mothers attending maternal health clinics. Since there is a restriction in movement and the government has also prioritized COVID-19 cases, it is challenging to prioritize maternal health services (Interview with health worker 15).”

Another health worker added that

“It is true women, especially the ones from poor backgrounds, do not have options. They also fear being tested for COVID-19 in health facilities around. Fear has negatively impacted clinic attendance in some of the health facilities providing maternal health services (Interview with health worker 12).”

“COVID-19 contributed to low antenatal and postnatal clinic attendance. This could have negative implications on the unborn babies and mothers’ health. Low clinic attendance is closely linked with fear of being tested and also COVID-19 containment measures that restricted movement (Interview with health worker 19).”

### 3.3. Increase in Home Deliveries

The reduction in maternal health clinic attendance meant that women had to find alternatives to give birth. Findings from the health workers show that, due to the need to ensure global COVID-19 containment measures, mothers and newborns were met with the harsh realities of COVID-19. According to health providers, some pregnant women feared contracting COVID-19 in hospitals. Other pregnant women, however, could not visit health facilities due to restrictions on movement by the government. Thus, they chose to give birth at home with traditional midwives, also referred to as traditional birth attendants (TBAs). A good number of operating health facilities were overstrained with response efforts and inadequate equipment supply due to the interrupted supply chain. Mothers could, therefore, not receive adequate help from the hospitals. Economically less privileged mothers mainly resorted to home delivery, as compared with economically empowered women, who had higher bargaining power and could afford to give birth in private health facilities, which were very expensive.

“We had a severe disruption in our maternity. I am confirming the time hospital was shut down; many mothers delivered but not in the hospital. I am talking about the poor mothers who could not afford private hospitals. The only solution was to deliver at home, assisted by the traditional birth attendants (TBAs) (Discussant, health worker 11).”

“Yes, mothers delivered at home, and traditional midwives assisted them. The poor mothers suffered the most because they had no alternatives. I got reports from the community health volunteers about mothers who delivered at home because hospitals were closed due to Corona (Interview with Female Midwife 4 in a public hospital).”

“We cannot ignore the fact that most mothers delivered at home and TBAs were very helpful. I think we need to include these TBAs in the community midwifery model and also in the healthcare policy. We need to tap the skills from TBAs. This is only possible if we include them as part of the healthcare staff with some stipend from the government (Interview with Male Midwife 18 in a public hospital).”

### 3.4. Increased Maternal Mortality

Some mothers giving birth at home developed complications and lost their lives during or after delivery. According to health workers, some of the maternal deaths could have been avoided if all health facilities were operating. They argued that most traditional midwives cannot handle complications during birth. They rely on their day-to-day experiences in

assisting women with delivery in villages. Still, due to the closure of some hospitals, TBAs could not refer mothers with complications to health facilities. The participants commonly mentioned that such complications sometimes resulted in undesirable outcomes, such as stillbirths and neonatal and maternal death. Thus, an upsurge in maternal mortality was experienced during the COVID-19 pandemic.

“We could avert more maternal deaths during COVID-19 if hospitals were not shut down. TBAs have little experience in handling complicated pregnancies. If worse comes to worst we lose the mother and I mean in cases where there are no referrals (Interview with health worker 8).”

“Maternal mortality increased sharply only because I don’t have accurate data. I get reports from the community health volunteers that some mothers had breached labours some had a haemorrhage and all of these led to deaths. I wish we could train the TBAs on handling complications (Discussant, health worker 9).”

“From the records it is true there was increase in maternal mortality. Shutting down of hospitals during the COVID-19 rendered pregnant mothers vulnerable with no alternatives, it means some had to go to TBAs or got assistance from immediate relatives, in worse cases some lost lives due to complications (Interview with hospital administrator 03).”

#### 4. Discussion and Conclusions

This paper sought to describe health providers’ experiences with the effects of COVID-19 on Kenya’s healthcare system, specifically on maternal health services utilization.

##### 4.1. Funds Reallocation and Impact on Maternal Health Services

Health systems in Africa have a limited capacity to absorb the pandemic [43]. Findings from this study reflect how the healthcare system in Kenya was not prepared for emergencies such as the COVID-19 pandemic. This is evident in how the COVID-19 containment measures disrupted Kenya’s healthcare system. This study shows that funds from maternal health programs were reallocated to boost the containment of COVID-19. The participants argued that such reallocation negatively impacted maternal health services in Kilifi County. However, a previous study in Kenya shows that, despite some reallocation and re-prioritization of donor funding, this did not distress the delivery of health services because the reallocation was performed on savings. The funds were replenished [38]. Evidence from other countries has also shown a reallocation of resources.

For instance, Inzaule et al. (2021) [44] noted that countries such as Nigeria and South Africa adjusted the budget for COVID-19 by cutting health budgets. Ogunkola et al. (2021b) [26] echoed that the pandemic also led to the diversion of funds by governments and other stakeholders in healthcare, such as donors who were key in the efforts to contain COVID-19. This led to the redirection of focus from women and girls to COVID-19. Thus, it became difficult for women and girls to access essential healthcare services. Moreover, the World Bank (2021) [45] has also reported that COVID-19 caught many nations off-guard. This interfered with existing budgets, leading to a reallocation of funds to sponsors and the funding of essential relief and recovery efforts. While such arrangements are necessary, they overlook other significant intended public expenditures, incurring an opportunity cost due to omissions or delayed returns. Thus, such reallocations interfered with the smooth operation of other health sectors, such as maternal healthcare. Additionally, Busch-Hallen et al. (2020) [46] and Robertson et al. (2020) [47] have also noted that COVID-19 fund reallocations have negative impacts on maternal healthcare.

##### 4.2. Decrease in Skilled Deliveries

There were also indirect consequences due to the pandemic, such as an inadequate capacity for public health investigations, which lowered the use of healthcare. These

findings are in tandem with recent studies that have shown that COVID-19 and the response to it potentially interrupted the use of and access to reproductive, maternal, and newborn health (RMNH) services [7–9,35,47,48]. These findings also show a drastic decrease in the number of health facility deliveries, occasioned by restrictions on movement and the fear of contracting the COVID-19 virus in mothers who could not seek maternal health services in private health facilities. This means there were many home births. Moreover, studies in India [49] and a recent review study by [50] have reported a reduction in facility deliveries due to COVID-19, as traveling to health facilities was restricted to avoid the spread of infections.

#### *4.3. Increase in Maternal Mortality and Decrease in Antenatal Services*

This study also shows an upsurge in maternal mortality and reduced facility deliveries. Previous studies in Kenya have also reported declining immunizations, antenatal attendance, and hospital deliveries, as well as a surge in stillbirths during COVID-19 [7,8,51]. To reiterate the study findings, the decline in facility deliveries resulted from restricted access to health facilities due to lockdowns and controls passed by the government. Thus, pregnant mothers and their friends feared aggravation and arrest by the police [34]. Kimani et al. (2020) [34] and Dzinamarira et al. (2022) [50] also noted that the COVID-19 pandemic disrupted essential maternal health services, eventually leading to increased maternal and neonatal mortality and morbidity. Thus, this calls for adopting new strategies to prevent a decline in maternal and child outcomes in already stressed health systems in Kenya. Although Kenya has never experienced cases of Ebola, the current study findings are consistent with the negative impact of the Ebola outbreak in West Africa on maternal health effects documented by several studies [52–54]. In previous studies, an upsurge in maternal mortality and a decline in facility deliveries were due to the disruption of the healthcare system caused by the pandemic [55], for instance, analyzed the unintended effects of the Ebola epidemic on maternal and neonatal health in Sierra Leone. Their findings projected a significant decrease in antenatal coverage and facility deliveries. Gizelis et al. (2017) [53] also established a decline in births in public health facilities. This study showed a decrease in skilled care deliveries courtesy of the COVID-19 pandemic and how this had an overwhelming consequence on health systems in Kenya.

Additionally, the study findings show a fall in the uptake of ANC services during the pandemic. Women were less likely to attend the eight visits recommended by the WHO due to fear and the government lockdown, which saw the interruption of health services. These findings concur with a study by [56], who reported that half of the women who gave birth during COVID-19 said that the pandemic affected their ability to access or attend ANC. Antenatal services are essential during pregnancy, as they can discover adverse intrauterine growth, congenital malformations, chromosomal abnormalities, and eclampsia [57]. Therefore, throughout a pandemic, consideration must be given to constant access to MNCH health services to ensure the continuity of care. This could be achieved using CHVs to identify women in need of ANC and PNC and reach out to them with tailored services. Moreover, TBAs should be trained continuously to refer pregnant women for ANC and birth in health facilities.

#### *4.4. Fear of Contracting Other Diseases*

Previous studies have shown that the fear of contracting the disease, restricted movement, and transportation challenges acted as obstacles to seeking treatment. This was even more evident for pregnant mothers who were faced with a choice of remaining at home and avoiding exposure to the virus to avert complications associated with pregnancy and birth [7–9,35,58]. In 2014/2015, there was a drop in maternal and delivery care by approximately 80% during the Ebola outbreak in West Africa [52,59]. Thus, during COVID-19, this study reports that inadequate antenatal care led to poor effects on neonatal and maternal care, and the consequences were catastrophic, such as maternal deaths or stillbirths. Ameyaw et al. (2021) [60] also reported that COVID-19 disrupted skilled birth,



antenatal, postnatal, and family planning services. Therefore, reinforcing or fostering new social bonds during pandemics will likely bring positive experiences. The latter is central to human health and well-being and has the potential to contribute greatly to enhancing maternal health and quality of life for mothers [61,62].

#### 4.5. Traditional Birth Attendants

The study also shows that, notwithstanding the national health policy encouraging hospital delivery under the care of skilled midwives, including affordable care, women still delivered their babies at home. Though there were no reliable statistics, health workers mentioned that home deliveries may have multiplied and were likely to escalate due to COVID-19 restrictions. Recent studies on maternal health during COVID-19 have reported similar scenarios [7–9,57,63]. This study shows that there was a likelihood that, during the period of COVID-19, a majority of pregnant mothers in Kilifi County gave birth in their homes assisted by TBAs. The women trusted the TBAs as an alternative for birth amid the COVID-19 pandemic. Recent studies also show that, indeed, during COVID-19, pregnant women resorted to TBAs for birth [7–9,57]. These findings are in agreement with previous studies in Liberia [64], Sierra Leone [65], and Guinea [52], which indicated that women are less likely to have hospital births during health crises such as pandemics. This means that access to healthcare for non-COVID-19 interrelated health issues, such as sexual, reproductive, and health services, including maternal health services, were negatively impacted.

#### 4.6. Conclusions

In conclusion, this study is significant as it highlights health providers' perspectives on how COVID-19 negatively affected Kenya's healthcare system. Pregnancy and childbirth are continuous events during infectious disease emergencies and other catastrophes, such as Ebola, Zika, and COVID-19. Thus, plans must be in place to ensure that all pregnant women have access to quality maternal health services during disasters such as pandemics. Delays in receiving adequate reproductive healthcare are significant elements of preventable maternal and adverse perinatal outcomes, particularly in low-resource settings and health systems. However, there is a need for long-term studies to explore the experiences of health workers and pregnant mothers in accessing and utilizing maternal health services during pandemics yet to come, as well as COVID-19.

### 5. Policy Implications

This article recommends an intentional response to maternal and newborn care in Kenya and the setting of COVID-19. We recommend increasing and strengthening the existing community midwifery model (CMM). For instance, integrating community health volunteers (CHVs) and other trusted community networks, such as traditional birth attendants (TBAs), and creating midwifery centers run by qualified midwives closer to communities. We believe these strategies can offer a feasible long-term plan that will reduce the burden on hospitals and decrease infection rates during pandemics among pregnant mothers and newborns. Moreover, TBAs should be integrated into the healthcare system and utilized during health crises. They should be an essential part of Kenya's maternity healthcare system. Moreover, for the COVID-19 pandemic and other future pandemics to be overcome, Kenya must be ready and prepared to significantly increase public health spending.

**Supplementary Materials:** The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/world4010010/s1>, Qualitative Research.

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