Journal of Public Policy & Governance

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ISSN: 2616-8413

Stratford Peer Reviewed Journals and Book Publishing
Journal of Public Policy & Governance
Volume 7||Issue 1||Page 26-57||January||2023|
Email: info@stratfordjournals.org ISSN: 2616-8413

Policy Guidelines to Mitigate the Effects of Covid-19 Pandemic towards the Reproductive Healthcare System in Kenya: A Review

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***How to cite this article*: Omari, A., Kurniawan, N. B., & Ramdhan, D. (2023). Policy Guidelines to Mitigate the Effects of Covid-19 Pandemic towards the Reproductive Healthcare System in Kenya: A Review. Journal of Public Policy & Governance, 7(1), 26 - 57. https://doi.org/10.53819/81018102t2117**

Abstract

The first case of COVID-19 emerged in Wuhan, China in December 2019. The virus was declared a global pandemic by the World Health Organization in March 11, 2020. In East Africa, Kenya was leading with 250,000 cases as at October 30th 2021. The Ministry of Health (MoH) was tasked with responding to the pandemic to contain the spread. This was a qualitative study and the study objectives included; determining how decision-making process occurs, strategies to mitigate the effects of COVID-19 to the reproductive health care system, exploring the role of the ad-hoc committee of experts and the COVID-19 Task Force in the response and finding out the factors that policy actors consider when formulating policies. Taguette Software was used to analyze the data qualitatively. The study findings from key informants and document analysis established that, leadership, coordination and collaboration from the different sectors for the COVID-19 response was key. Societal values influenced policy

Stratford Peer Reviewed Journals and Book Publishing
Journal of Public Policy & Governance
Volume 7||Issue 1||Page 26-57||January||2023|
Email: info@stratfordjournals.org ISSN: 2616-8413

decisions. The study established that, where major political elites had most power, policy was actioned. The MoH should develop contextualized mitigation plans to sustain service provision; focusing on capacity strengthening of providers on emergency responses, task shifting and tele-health. Policy guidelines should be continuously updated to reflect the current status at the national and sub-national levels. In conclusion, the health policy triangle provided a framework for simplifying the complex and dynamic nature of policy making but little consideration to other aspects that describe how and why policies are modified were considered. This needs to be exhaustive.

Keywords: *COVID-19, Reproductive Healthcare System, Guidelines, Mitigation, Decision Making, Policy Action, Kenya & Task Force*

1.1 Background

World Health Organization (WHO) confirmed the novel coronavirus (COVID-19) on March 11, 2020 as a global pandemic. This came after its declaration on January 31, 2020 as a Public Health Emergency of International Concern (PHEIC). As noted by Mullen *et al*., 2020 preceding this, were five major PHEIC diseases which included H1N1 flu (Swine flu) in 2009, Polio in 2014, Zika in 2016 and the Kivu Ebola virus outbreak in 2018. Wuhan, Hubei in China is where the first COVID-19 case emerged in December 2019 and later on spread to the different countries (Varsha et al., 2020) . Like many other countries in the world, Kenya experienced the highest burden of the corona virus outbreak in the East Africa region and it was leading with over 250 thousand cases in East Africa as at October 31st, 2021(NERC, 2020a). The Ministry of Health (MoH) was tasked with the mandate of responding to the pandemic to contain the spread at the onset.

In April 2020, the Ministry of Health in Kenya through the Division of Reproductive and Maternal Health (DRMH) developed a practical guide to inform continuity of quality reproductive and maternal health care and services. Commonly referred to as 'The Kenya Covid-19 Reproductive, Maternal, newborn and Family Planning Care and Services Guidelines', these guidelines were developed to counter the corona virus pandemic by an ad hoc committee of experts with guidance from the Head of the DRMH. On 1st April 2020, the President of Kenya then; convened the first meeting of the National COVID-19 Task Force to mobilize funds for combating the corona virus disease. These team was instituted to implement the COVID-19 Contingency Plan by reviewing the evolving threat from the COVID-19 epidemic, coordinating and mobilizing and monetary resources and it comprised of: MoH, other government agencies, diplomatic core, development and implementing partners. Several sub-committees were set up under the Task Force but of importance is the Case management and capacity building for health workers sub-committee that was formed to coordinate the formulation of health procedures, policy guidelines and training content for service providers on COVID-19 and vital services such reproductive and maternal health (NERC, 2020a)

In 2020, WHO warned that 'limitations in the availability of essential Sexual Reproductive Health (SRH) and Maternal and Newborn Health (MNH) Services would lead to high mortality for mothers and newborns as of additional risks of unplanned pregnancies, botched abortions and obstructed labor without access to critical care. WHO defines reproductive health as the physical, mental and social well-being of an individual in all matters related to the reproductive system, its functions and processes. WHO gave temporary direction on sustaining essential services during an epidemic in March 2020, which entailed giving direction regarding reproductive healthcare and how to avert maternal and child mortality and morbidity in its response to COVID-19. (WHO, 2020a). UNFPA approximated about seven million unplanned

pregnancies globally due to corona virus, with a likelihood of many deaths from botched abortion and birth complications due to restricted access to obstetric care (UNFPA, 2020a) .

A study on challenges of responding in a global pandemic indicated that multiple service delivery channels were affected and the policy directive to close most static clinics while others operated under reduced hours. There was disruption in the worldwide shipping of SRH commodities due to closure of production plants and delays in importation(Church et al., 2020). The corona virus outbreak resulted in global interruption of vital reproductive health care service delivery including in low- and middle-income countries (LMICs) like Kenya.

According to Nicola *et al.* (2020) South Korea is recognized internationally as one of the countries that had a prompt and efficient response against the virus. Regardless of emerging as the second biggest hit country besides China, South Korea had a robust inter-sectoral response and a strong national leadership which strengthened its healthcare system. South Korea's healthcare system was categorized into: pandemic healthcare system and non-pandemic healthcare system in order to make sure that non-COVID-19 healthcare needs had continuous attention while COVID-19 was being managed. In addition the country was prepared, acted quickly, carried out rapid testing, tracing of contacts using technology, effective triaging and resource allocation (Nicola et al., 2020a) .

Women, girls, and marginalized groups were likely to experience the heaviest burden and countries globally, including Kenya had to institute actions to lessen the potentially disturbing effect on health, economic and social consequences of COVID-19 to these groups. (Hall et al., 2020). Women and young girls face a myriad of issues which includes unsafe abortions, sepsis infections, postpartum hemorrhage among others and with COVID-19, these disparities were expected to be on the rise. Experts had predicted that pandemic was going to harshly affect women's health due to the interruption of the formalized and non-formalized social and health care systems (Gausman & Langer, 2020; Wenham et al., 2020) .

A review article by Sánchez *et al*. (2020) that reviewed 38 articles found out that violence to women worsened in the course of the lockdown period then recommended reproductive health policy strategies to focus on integration . This was to help mitigate the violence during the pandemic and beyond based on evidence. Interruption of services and deviation of resources away from indispensable sexual and reproductive health care because of fronting the corona virus response increased risks of maternal and child deaths (UNFPA, 2020b) . The early indirect study indicated that pandemic may have resulted in the upsurge of teenage pregnancies, adolescent mortality rates in-country and if the trend persists, recent advances attained in maternal and perinatal health in Kenya will be lost (Shikuku et al., 2020) .

A systematic review by Mukherjee *et al*. (2021) on the indirect impacts of COVID-19 on SRH from 24 studies indicated that indeed COVID-19 had contributed to service distractions that impacted access to safe motherhood, family planning, HIV/STI counselling and menstruation, and pregnancy desires by women . The study findings suggested that reproductive health policies ought to be enacted so as to assure equitable and immediate access to quality and acceptable SRH services for girls and women. A scoping review study by Tolu *et al.* (2021) found out that associations and global organizations working on SRH had consistent statements and recommendations regarding access to SRH services like prenatal care, postnatal care (PNC), family planning, safe motherhood and clinical management of sexual and gender based violence survivors during the COVID-19 pandemic. The reproductive health policy responses entailed instituting innovative ways such as telehealth and self-care to strengthen the health system and minimize patient and staff exposures.

1.2 Problem Statement

The corona virus pandemic compelled governments to make difficult decisions which affected the health, wealth and freedom of its citizens. In order to deal with the global public health emergencies generated by the virus, high-stakes decisions were made hurriedly, with little or no involvement of stakeholders in the deliberation about which policies to undertake (Norheim et al., 2021). In a study conducted by Raoofi *et al.*, 2020 in Iran, it was noted that the government had developed setting-based policies, guidelines and strategies to fight COVID-19 pandemic before and after its entry in Iran. Despite this, there was insufficient multi-government and multi-sectoral approach in managing the virus as well as inadequate lifesaving and protective equipment which made it difficult to timely combat COVID-19.

Reproductive Health policy learning and response is critical in formulating timely and fitting guidelines and their implementation. With the wide spread COVID-19 pandemic evidence-based policy making and guidelines issuance is very crucial (Raoofi et al., 2021a). Uncertainty on some values, causal mechanisms and people's responses require that the public is informed. Open and transparent dialogues between scientists, policy makers and the public can help mitigate 'infodemic' of misinformation that was spread on social media (European Commission. Joint Research Centre, 2020) .

Access to high-quality SRH services remains vital, during and even beyond the pandemic. Hall *et al.* (2020) recommended that a sexual and reproductive health and justice framework is critical for tracking and addressing the inequitable gender, health, and social effects of the pandemic. Some of the existing gaps in literature that the study addressed were on applying the multi-sectoral approach to manage outbreaks and outlining the specific roles for each actor on agenda setting. Social behavior change for the community is another critical that needed to be addressed especially when a new approach such as tele-health is introduced and most researchers had not addressed this despite the studies acknowledging innovation and development potential benefits.

1.3 Research Questions

1. How is the decision-making process when developing reproductive health policies, guidelines and strategies to mitigate the effects COVID-19 to the reproductive health system in Kenya?
2. What is the role of the ad hoc committee of experts and COVID-19 Task Force for reproductive health policy response Kenya?
3. Which factors does the ad hoc committee of experts and COVID-19 Task Force in Kenya consider when executing their role on policy formulation?

1.4 Research Objectives

Broad Objective

To identify the reproductive health guidelines, policies and strategies developed and adopted by Kenya to mitigate the effects of COVID-19 to the reproductive health system

Specific objectives

1 To determine how decision-making process occurs when developing reproductive health policies, guidelines and strategies to mitigate the effects COVID-19 to the reproductive health system in Kenya.

2 To explore the role of the ad hoc committee of experts and COVID-19 Task Force for reproductive health policy response Kenya.

3 To find out what factors the ad hoc committee of experts and COVID-19 Task Force in Kenya consider when executing their role on policy formulation.

2 Literature Review

2.1 World Health Organization's Response to COVID-19

2.1.1 International Coordination and Support

WHO and the United Nations Secretary General embarked on ambitious journey of updating the world regarding the progress of the pandemic. WHO launched daily reports and COVID-19 Strategic Preparedness and Response Plan (CPRP) to provide guidance to member states to adopt and develop Country Preparedness and Response Plan (CPRP) (WHO, 2020b). In February 2020, WHO initiated a joint mission that provided support to China and other countries that had reported COVID-19 cases. The joint mission was also supposed to alert countries that had not reported any cases and prepare them for the outbreak. WHO in conjunction with the World Trade Organization (WTO) also realized the guidelines to regulate the international travel in response to COVID-19. On 12 February 2020, WHO issued the Operational Planning Guidelines to support the development of COVID-19 National Plans and the COVID-19 Partners Platform which serves as a coordination and governance tool.(WHO, 2020a). According to Aluga (2020), the WHO strategies including but not limited to the – interruption of human to human transmission is essential to reduce secondary infections among close contacts were recommended for adoption and execution.

2.2 COVID-19 in Kenya

2.2.1 Measures Before and After the Official Declaration of the COVID-19 Outbreak in Kenya

2.2.1.1 Preparedness

Kenya like the rest of the world experienced challenges with the pandemic. Before the first case was announced in Kenya, the Ministry of Health had advised Kenyans on 2nd February 2020 to maintain high standards of hygiene, remain alert and avoid coming into contact with persons who had respiratory symptoms. Further to this, on 13th February 2020, Kenyans were advised against non-essential travel to the countries that had been affected (NERC, 2020b).

On 28th February 2020, an executive order No.2 of 2020 was communicated by the National Emergency Response Committee (NERC) and they resolved to escalate the measures. These measures stated that: All entertainment, bars and other social spaces, were to close their businesses by 7.30pm every day until further notice, social distancing of 1.5 m was to be observed during allowed periods, all supermarkets were required to limit the number of shoppers inside the premises at any given time, the management of local markets were directed to ensure that the premises are disinfected regularly to maintain high standards of hygiene (NERC, 2020a).

The County Governments were requested to prioritize garbage collection and cleanliness of all markets as well as ensure provision of soap and clean water in all market centers. Employers were encouraged to allow their staff to work from home while for those that had to work in the manufacturing industries, they were urged to maintain the 24 hours shift system. In the Public transport sector, vehicles were only allowed to carry 60% of the seating capacity in order to observe the social distancing and they had to provide handwashing facilities and conduct temperature checks at the boarding points. All international travelers whether citizens or foreigners were required to mandatory self-isolate for 14 days (NERC, 2020b) .

2.2.1.2 Response

On 12 March 2020, MOH through the Health Cabinet Secretary then, Hon. Mutahi Kagwe announced the first corona virus case in Kenya. MOH announced various policy measures and behavioral protocols to limit the spread of the disease. Other state agencies and the private sector complemented the response efforts to fight what was referred to as 'an invisible enemy' by the President. On 25 March 2020, all Kenyans experienced what has never been experienced before. The President arrived at the Harambee Annex with his motorcade but didn't arrive with his usual car but rather a different vehicle which had its number plate turned upside down. Everyone was surprised why that was the case however the military group later informed Kenyans that ''that's a sign that the Head of State wasn't coming with good news'.

Governments across the world instituted various fiscal and monetary measures to mitigate the impact on households and businesses. The President of the Republic of Kenya on his first Presidential Address on COVID-19 to the nation announced a number of measures aimed at cushioning Kenyans against the economic effects of COVID--19 pandemic. (Deloitte, 2020). The National Treasury was directed by the President with immediate effect to; introduce 100% tax relief for persons earning gross income of up to USD 240, reduce the income tax rate from 30% to 25%, reduce resident income tax from 30% to 25%, reduce the turnover rate from 3% to 1% for small and medium enterprises, appropriation to the elderly , orphans and vulnerable members through cash transfers, reduction of value added tax from 16% to 14% , reallocation of the Universal Health Coverage (UHC) kitty to recruit more health workers to respond to the pandemic among other orders (Government of Kenya, 2020).

The figure below from Johns Hopkins University is real time and indicated the number of confirmed COVID-19 cases per day. This is shown as the seven-day rolling average. It is worth noting that the reported numbers on a given date do not necessarily show the exact numbers on that date due to delays in reporting. The actual confirmed number of cases is also estimated to be much higher due to limited testing.

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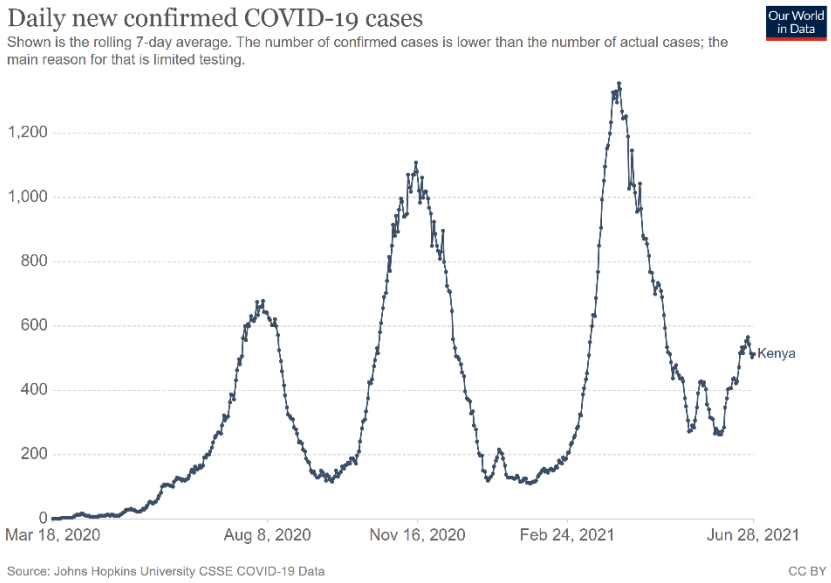

Figure 1: Seven-day rolling average of confirmed COVID-19 cases in Kenya

Source: Johns Hopkins University CSSE COVID-19 Data

The figure indicates that Kenya had already experienced 3 waves, with peaks in August 2020, November 2020 and March 2021 and was to experience a 4th wave if the Delta variant had persisted in Western Kenya. The corresponding number of deaths is shown in figure 2 below;

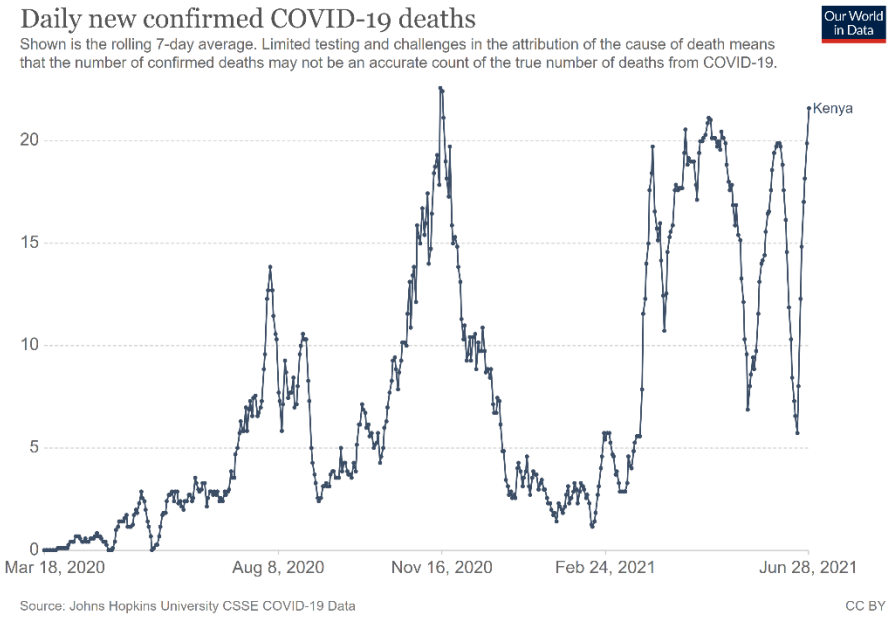

Figure 2: Seven-day rolling average of confirmed COVID-19 Deaths in Kenya

Source: Johns Hopkins University CSSE COVID-19 Data

https://doi.org/10.53819/81018102t2117

The actual deaths from COVID-19 were likely to be higher than the number of confirmed deaths due to limited testing and the attribution factor. In Kenya both hospital deaths and the deaths in homes for the patients who were under home-based care were classified as COVID deaths. According to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) 2020, the COVID-19 pandemic is considered to be more than just a health crisis; it is a human crisis in every country in the world claiming many lives and threatening the health, social and economic spheres of society.

2.3. Reproductive Health Policy Guidance and Response

Policy learning occurs through the very practice of policy making which call for reforms in health care delivery (Thunus & Schoenaers, 2017). In a comprehensive study by Norheim *et al.* (2021) the use of emergency powers by some governments was seen as sideling the democratic and inclusive process and hence the pandemic exposed and expanded the existing social inequalities. According to Dunlop *et al*. (2018) and Moyson *et al*. (2017), 'policy learning' is defined as adjusting understandings and beliefs related to public policy. Learning is a critical component that can spur progress towards global development. Two scientists, Dunlop and Radaelli identified four learning modes that can be applied in a policy process and these are: epistemic learning, learning in the shadow of hierarchy, learning through bargaining and reflexive learning (Kiendrébéogo et al., 2020) .

Policy and decision-making processes have been known to be routinely affected by the multifaceted and dynamic nature of societal health problems (Currie et al., 2018). For reproductive health policies to be effective, they must be transparent, based on accurate knowledge and adherence to public health recommendations since policy decisions have an impact on the distribution of risks and benefits. Norheim et al. (2021) argue that deliberative decision making which is inclusive, transparent and accountable can contribute to more trustworthy and legitimate decisions on difficult ethical questions and political trade-offs during the pandemic and beyond.

The figure below by shows the timeline on mitigation of the effects of COVID-19 towards the Reproductive Health System in Kenya from January 2020 to September 2020. The timeline ends in September 2020 because that’s the period when reproductive health measures and guidelines were being instituted and updated. The period between October 2020 and May 2021 was all about monitoring and adhering to the set maternal and reproductive health measures before the country started rolling out the vaccination campaigns. Vaccination commenced in June 2021.

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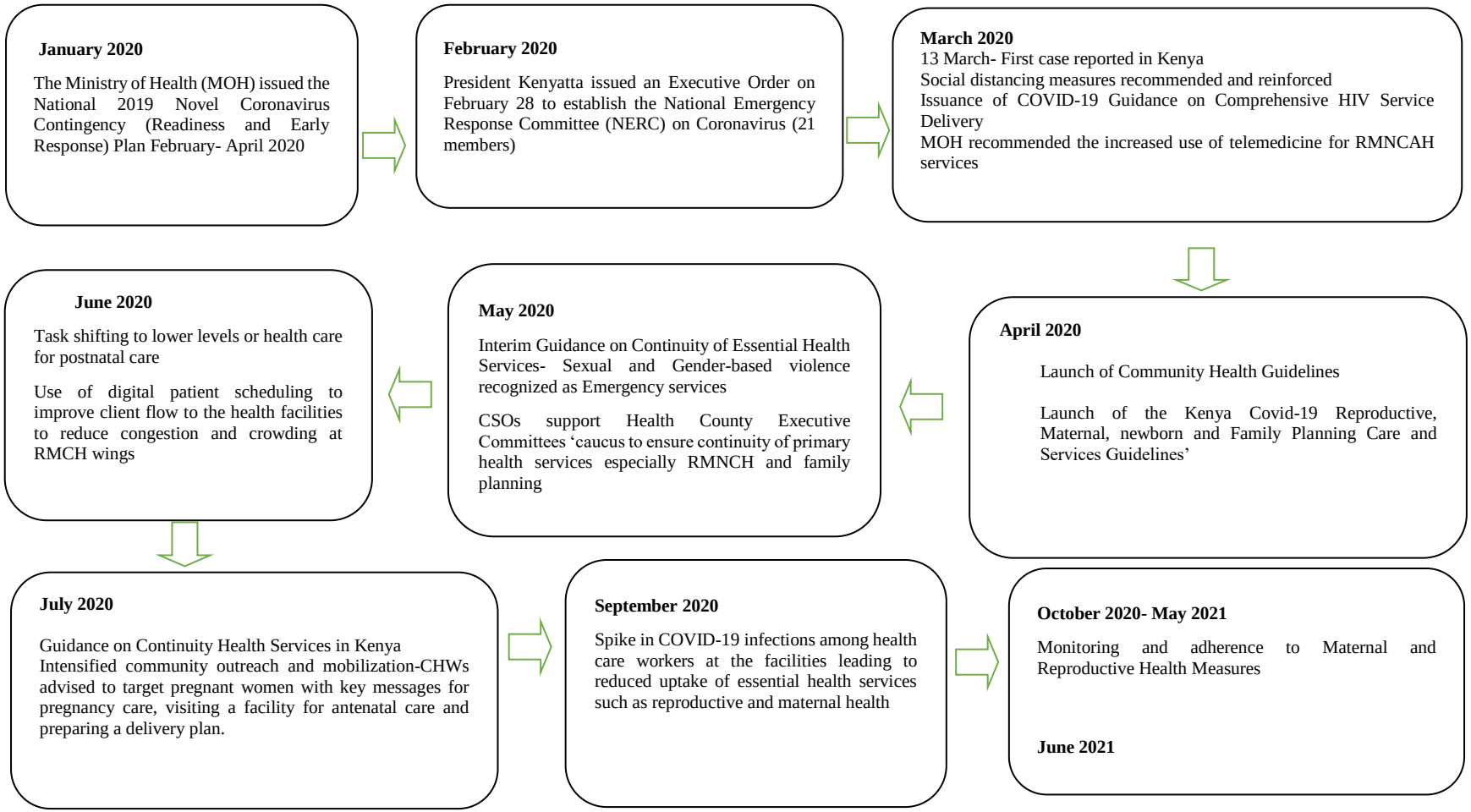

Figure 2: Mitigation of the Effects of COVID-19 towards the Reproductive Health System in Kenya timeline

2.4 Policy Analysis

The outcome of a policy making process are choice options. Health can be influenced by policies when decisions taken by those with responsibility for a particular policy area are made. Dye (2013) argued that public policy is whatever a government chooses to do or not to do. Health policy covers the actions (or inactions) which influence health care institutions, health care organizations, health services and financial regulations of the health care system (Buse et al., 2005) .

The formulation and implementation of policies and guidelines in Kenya in addressing the COVID-19 concerns on the reproductive health system is very critical. Policy analysis not only provides a step-by-step monitoring and review of the stages is the policy making process but it also helps in identifying the opportunities and gaps through modelling to inform policy making.

2.5 Theoretical Framework

Different theories were described to help answer the research questions. The main focus was on the process, content and context in which policy and decisions are made. In addition, theories about health policy, agenda setting and window of opportunity are described.

Previous studies such as the COVID-19 Pandemic and Comparative Health Policy Learning in Iran by Raoofi *et al.*(2020a) have applied the health policy triangle and the Hall Model to analyze policies and to describe agenda setting respectively. In the implementation of policies, a combined synthesizing approach that includes the top-down and bottom-up principle-agent theory was applied. Atkinson *et al.* (2015) argues that a modelling tool is essential for policy analysis in order to design efficient and effective policy responses for complex public health problems. Mzumara *et al.* (2021) applied the policy triangle framework to analysis the health policy response to COVID-19 in Malawi.

The health policy triangle gives a description of the content, process, context and actors who are involved in policy formulation. Actors who are centered in the health policy triangle and are critical in the policy process. As Buse *et al.* (2005) described it: “Actors were seen to influence policy, but the length to which they will be able to do so depends on many things, thus their perceived and actual power. The process gives an analytical look at the initiation, development, negotiation, communication, implementation and evaluation of the policies. The content section describes the policy outcome which refers to the kind of policy that is endorsed and the actions taken.

The Kingdon policy model addresses the role of policy actors and the agenda setting opportunities which open policy windows. The actors can be state or non-state. Kingdon (2014), argues that the linking of issues, situations, possible solutions and political good will can open or close a window of opportunity which can propel agenda focused policy issues. A government acts when the policy, political and problem streams are grouped together. Perceived problems requiring government action makes the problem stream and the government’s previous actions are taken into consideration. The ongoing analysis of problems and possible solutions and the ongoing discussions makes the policy stream. The description of the political will and the events that affect it which include changes in government and campaigns by interest groups makes the political stream and is seen to be separate from the first two.

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2.6 Conceptual Framework

The below conceptual framework was applied to determine the actors, the policy decision making process and their role in mitigating the effects of COVID-19 towards the reproductive health system in Kenya.

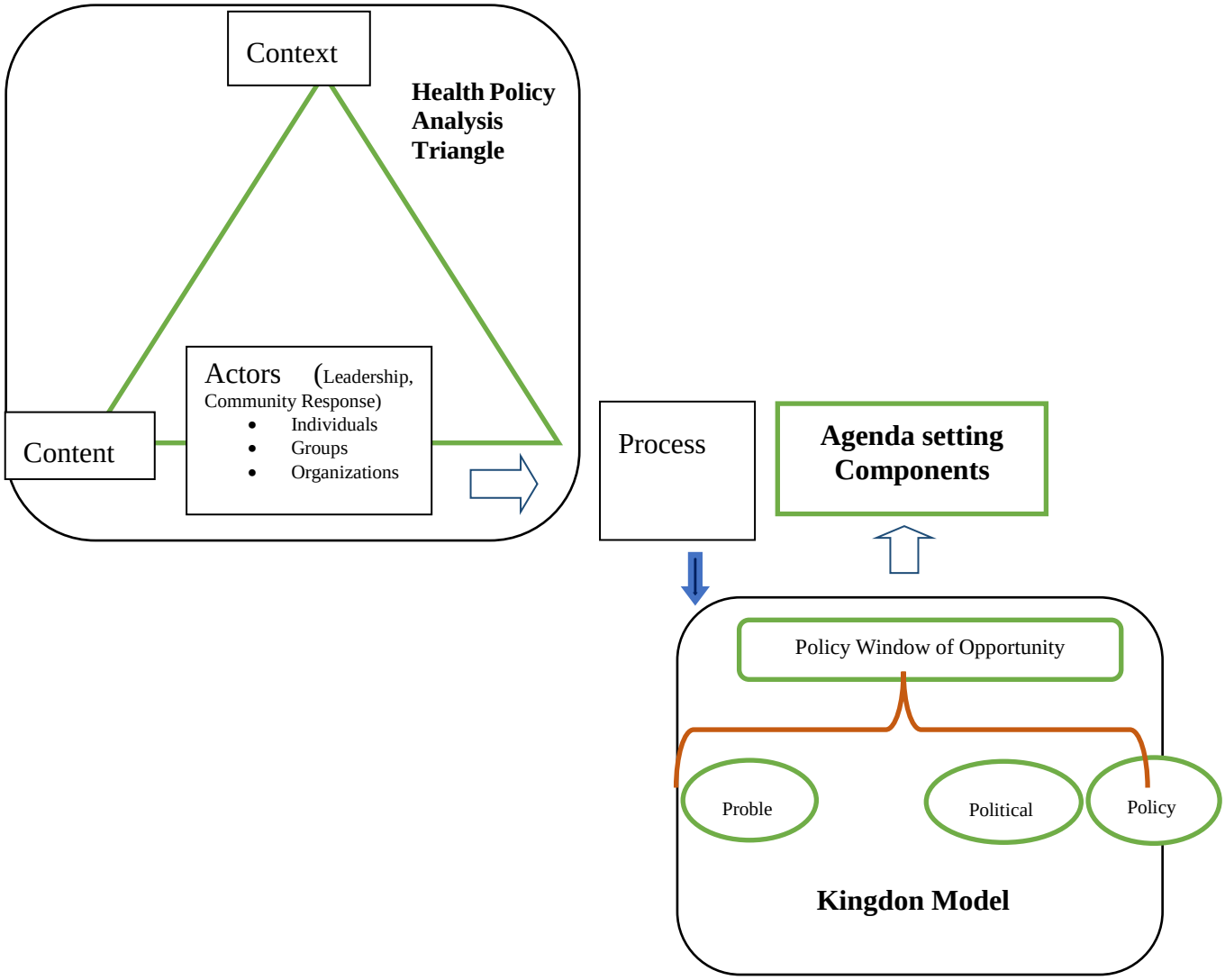

Figure 3 Applied Conceptual Framework

Sources: Modified from Walt & Gilson (1994) and Kingdon (1994)

2.6.1 Policy Content

As noted earlier, the government prioritizes a policy decision when the three streams are addressed. Agenda setting and the policy making process can be influenced by different actors. According to Wu et al.(2018), the two important features that affect the ability of the government to make and influence policy are autonomy and capacity. The ability of government to making own policy without reacting to interest groups but with the best interest of the community is the autonomy, whereas capacity refers to the expertise, resources and structure of government.

According to the health policy triangle framework, some external groups are more influential than others due to different to power resources (Walt, 1994). Interest groups have a goal to promote a certain issue or cause. These groups should have three features; membership is

voluntary, desired goals have to be achieved and they have no intention of taking formal political power (Walt & Gilson, 1994). The policy analysis for the case of Kenya entailed identifying the issues, establishing context and outlining the process that was involved in response to COVID-19 from a reproductive health perspective. With the above description, my study applied a modified model by jointly examining the health policy analysis triangle and the Kingdon model above to conduct my review.

3 Methodology

3.1 Study Design and Approach

This was a qualitative study where I interviewed key informants and applied the systematic document content analysis approach through a side-by-side health policy triangle framework to scrutinize the reproductive health guidelines, policies and strategies adopted by Kenya to sustain service access and mitigate the effects of COVID-19 to the reproductive health system in Kenya. Using a descriptive explorative approach, I extracted and analyzed data which was further evaluated by a policy and reproductive health who gave his opinion in line with components of the adopted conceptual framework which helped refine the findings. Categorical content analysis methodology was used to extract data, and this incorporated the key informant views and the documents analysis which were coded into categories related to the subsets of the applied conceptual framework to refine the study concept and theme. The documents analyzed from the databases included policy documents, guidelines, frameworks, action plans, rapid response initiatives (RRI), WHO health reports, website updates and official news on COVID-19 by the Ministry of Health in Kenya. These were benchmarked against the WHO recommendations.

3.2 Study Population

The study was conducted in Kenya and targeted the Ministry of Health, the ad hoc expert committee, the COVID-19 Task Force- Case management and capacity building for health workers' sub-committee and other interest groups such as subject matter experts as described in the model. The target audience were the policy makers, technical advisors and other stakeholders mandated to provide COVID-19 reproductive health response guidance.

3.3 Sampling Techniques

For the Key Informant Interviews, purposive sampling was conducted in selecting key informants from the Ministry of Health, ad hoc expert committee and representatives of the COVID-19 Task Force case management and capacity building for health workers sub-committee to provide the expert opinions. For the document desk research, a screening eligibility criterion was applied to determine the records that were considered in the review for the Qualitative Synthesis.

3.4 Data Collection and Study Selection

A qualitative approach was used where a total of 6 experts were interviewed as Key Informants using the key informant guide. These experts or policy actors were the representatives of the ad hoc expert committee (3) and COVID-19 National Task Force (3)- case management and capacity building for health workers sub-committee. The experts were identified through a snowballing approach with the first point of contact being the Head of Division of Reproductive Maternal Health at the Ministry of Health. The COVID-19 reproductive health ad hoc expert committee had 11 members while Task Force- case management and capacity building for health workers sub-committee had 9 members. The sample was representative with 3 from each group.

Document data collection had seven databases (PubMed, ScienceDirect, Proquest, Mendeley Data, ERIC, Embase, Elsevier) searched for content, information from COVID-19 specific databases which include (WHO COVID-19 Dashboard, Devex COVID-19 timeline, Johns Hopkins Coronavirus Resource Center, Amref COVID-19 Africa Information Centre, The Lancet- COVID-19 Resource Centre) were also identified as additional information. Additional records were identified through Google Search, Google Scholar, WHO website, MoH Kenya website, Presidential Executive Orders, documents, reports, news briefings, webinars and newspaper articles.

The table below shows the inclusion and exclusion criteria, which were applied to all reviewed documents.

Table 1 Inclusion and Exclusion Criteria of reviewed documents

Criterion	**Inclusion**	**Exclusion**
Timeframe	March 2020- June 2021 (1st case in Kenya was announced on March 2020 and robust vaccination campaign commenced in June 2021	Articles outside the set time frame
Language	English articles	Non-English articles
Source	Articles/ papers hosted in the 7 key databases in medical and social sciences, articles in the COVID-19 specific databases, articles/documents from Google Search, Google Scholar, WHO website, MoH Kenya website, Presidential Executive Orders, documents, reports, News Briefings, Webinars, News Paper Articles	Magazines, Books, Drawings. Photographs, Videos
Location	Kenya	All other countries apart from Kenya
Setting	National level	Sub- national
Participants	Policy actors / Decision makers	Studies only focusing on service providers and patients
Focus	Policy guidelines to mitigate the effects of Covid-19 pandemic towards the Maternal/ Reproductive Healthcare System	Studies not related to the study focus

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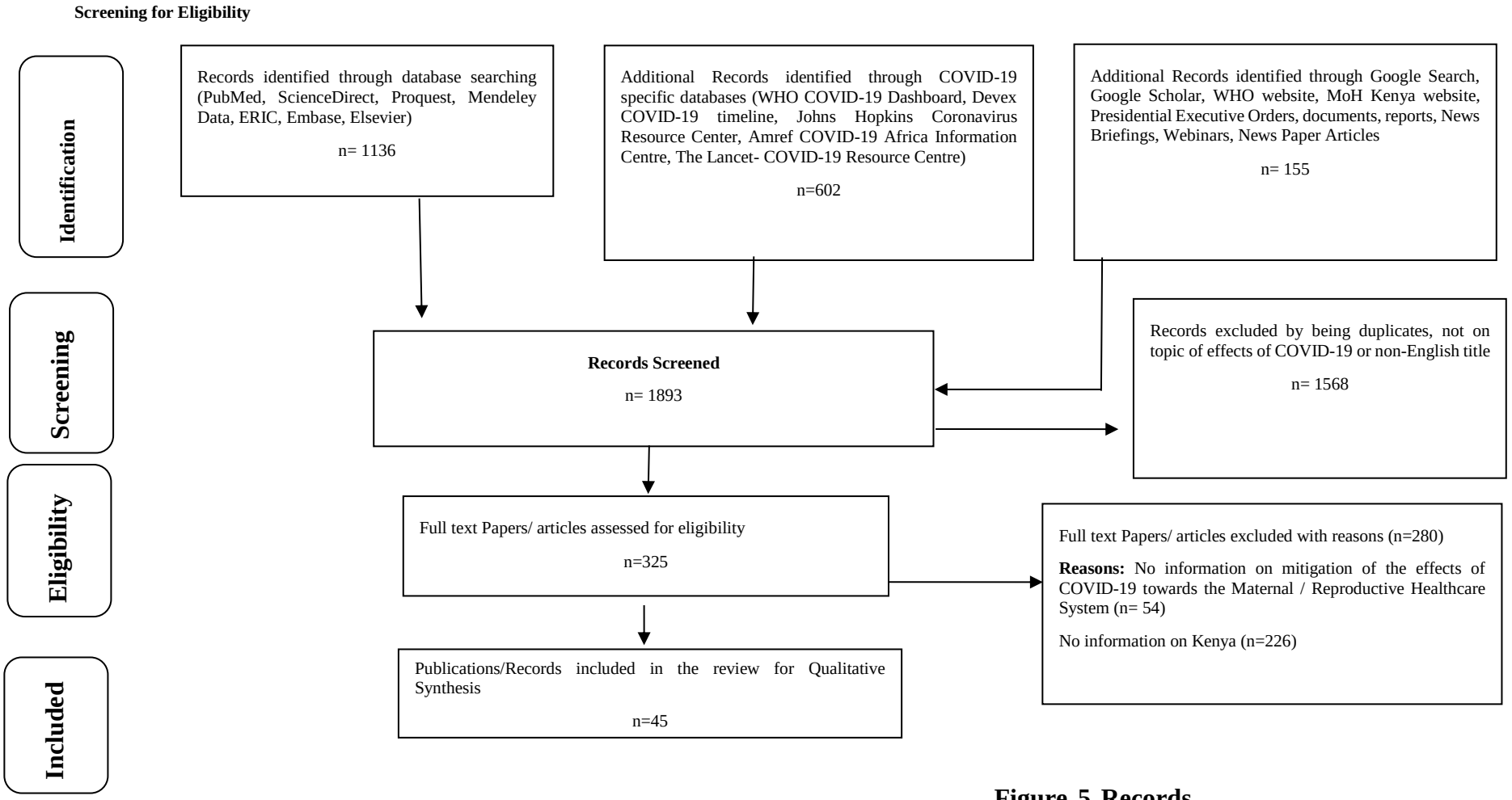

Figure 5 Records

The figure illustrates the eligibility screening where a total of 45 documents were included in the policy review. I reviewed national policies, frameworks and guidelines that provided guidance on RMNCAH-N services during COVID-19, and which were available on Ministry of Health (MOH) or national government websites or were publicly provided by governments through other mechanisms

3.5 Data Analysis

Qualitative data collected from key informants was transcribed and the document data with the screened records were considered for Qualitative Synthesis review. The two data sets were uploaded into the Taguette Qualitative Analysis Software for coding and analysis. A project was initiated, tags were created from the documents and they collectively generated a codebook summary which was exported for thematic and categorical content analysis review. The information collected from the experts included, finding out the role of the ad hoc expert committee and COVID-19 Task Force- case management and capacity building for health workers subcommittee, the decision-making process regarding policies and criteria applied when instituting response measures. All this information was triangulated with the secondary data from documents to generate the codebook as earlier stated.

3.7 Ethical Considerations

Permission to conduct the study was sought from Indonesia's Higher Education through the School of Government and Public Policy, Indonesia (SGPP) which is accredited under the code 033205. Secondary data document analysis didn't need any ethical approval but informed consent was sought from the Key Informants and the research protocol was approved by the Amref Ethics and Scientific Review Committee (ESRC) under approval number ESRC-P1248/2022.

4 Results and Discussions

4.1 Policy Process

In this study I established that the National COVID-19 Task Force team led the planning, coordination and implementation of the contingency plan and the Office of the Director General at the Ministry of Health was heavily involved. Decision-making was inclusive, transparent and evidence-informed. Collective responsibility and accountability were called for and this contributed to more trustworthy and legitimate decisions being made on difficult ethical questions and complex political trade-offs during the pandemic. One of the key informants noted that below '*Despite being the technical team, COVID really hit us hard, we didn't know where to start but I appreciate we had already seen some content from WHO which we considered in our response work. The guidelines provided some setting for us to get things moving and this because the pandemic was a new thing for us all. (KII, 3)*

In a letter addressed to the editor, Osseni (2020) noted that across sub-Saharan Africa (SSA), many governments created presidential task forces for public health responses and in February 2020, Africa Health Ministers during a meeting convened by the African Union Commission with collaboration between Africa Centers for Disease Control and Prevention (Africa CDC) supported this policy initiative to strengthen Africa's Health System.

The Ministry of Health through the ad-hoc committee of experts acted quickly to develop policies to maintain essential health services during the pandemic by emphasizing the importance of continuity of care. The Head Division of Reproductive and Maternal Health issued a circular to all reproductive health stakeholders in the country but pertinent questions raised by one of the partners which needed further deliberation were on - while many of the

policies and guidelines were directed towards the county health level, to what extent were all 47 counties (sub-national levels) following the policies comprehensively and how were the guidelines translated into action?. Bennett and Carney (2015) noted that policy making during a pandemic poses two main challenges; one being that its very complex in that the policy address multiple policy fields and the policy has to be implemented in a variety of administrative levels. Keller (2009), had her concept which had included the multi-sectors which are affected by a single policy decision. The sectors include; health care, social, economic and public security policy fields.

From the analysis, the decision-makers put the political, faith, ethical and societal values into consideration when advising on a policy decision. The policy-makers applied values in the decision-making process to translate the policy problems in meaningful ways which in turn guided the policy development process. Values and morals were being viewed as critical aspects to legitimize the decisions made. Comparatively, Kenya like Mozambique, Uganda and Zimbabwe had their country policy guidelines consider antenatal care, intrapartum care and family planning as essential services and issued policy guidance for continuation of these critical services. Social values play a critical role in policy analysis and understanding how they are incorporated into health policy decision-making is essential. Baltussen *et al.* (2017) acknowledged that politics play a central role in health policy and it helps define problems within the existing social conditions and policy context when looking at public health interventions. As I noted from my study, the needs of the population and country citizens can be very demanding and a technical, social and political values know how is important especially when formulating these policies.

With the issuance of the RMNCH guidelines in April 2020 by the Ministry of Health through the ad-hoc committee of experts, evidence-based adaptations in task shifting, appointment scheduling and telemedicine were instituted. The policy guidance further recommended that specific reproductive health services—which included counseling for new users of contraception such as those who were using condoms, oral contraceptives and skin patches to be administered via telemedicine without needing in-person referrals.

When the problem has a solution that can be actioned and is likely to solve the problem even is not fully solved, then policy is likely to be developed and action. Policies, guidelines and frameworks were adapted from global guidance such as WHO recommendations as well as lessons from countries that had already experienced the pandemic from the onset and these include China, USA, Italy, Germany, Spain and Iran. The RMNH Kenya guidelines were heavily informed by the policy responses from WHO and China which seemed to have worked in containing the virus spread while sustaining reproductive health service access.

Policy-making is a very complex process and sometimes it can lead to team disagreements especially when we had to consider the difficult tradeoffs. How do you tell people to close their businesses and remain healthy? Between life and live hoods which one comes first and how to you measure this. These were big questions that needed balancing. Public diplomacy, negotiation and evidence mattered at the end of the day. (KII, 5)

According to Raoofi *et al.*(2020b), Iran formulated contextual and evidence-based policies to mitigate the risk of COVID-19 before and after the virus entered the country. The study acknowledged that the response policies were of public health concern and called for advocacy and lobbying approaches through multi-sector collaborations and coalitions. The recommendations were in line with my study findings that found out that the Kenya government embraced the multi-sector approach in responding to COVID-19 and that the country had learned from responses in USA and China being the first countries to be hit by the pandemic.

Hood *et al.* (2021) noted national policy responses to pandemics vary a lot and this is supported by Migone (2020) indicated that policies are politically, culturally and historically mediated . This argument is concretized by Gadarian *et al*.(2021) who found out that policy responses can be highly affected by partisan politics. There were great calls for political will in Kenya from the government to support the sustenance and advancement of SRHR within the COVID-19 pandemic due to its severity. The policy decisions were made within the institutional system of the country which support from the sub-national leaders in the Counties. A systematic review study by Liverani *et al.*(2013) indicated that there needs to be a more explicit engagement with the political and institutional sections affecting the use of health evidence in decision-making.

Policy content describes the policy aim and objectives. It represents a framework or set principles of how actions fit together. From the analysis, I noted that the content was universalist and upstream; meaning that the content focused on high level factors and targeted the whole community pre-epidemic, during and after the pandemic. The policy documents indicated that, most of the policy content was guided by WHO guidance which served as the benchmark on matters related to RMNCH essential services during COVID-19. Majority of the elements of WHO's 2020 recommendations were included in country policies including Kenya. With the WHO guideline adaptations, each policy guideline was more context specific for instance in Kenya, the guidelines gave a laser focus on Family Planning service provision while Uganda's guidelines targeted breastfeeding strategies. The advocacy around the policy content was geared towards partnership building, promoting healthy behaviors through community empowerment, capacity strengthening and disrupting the social and economic norms.

One of the first responses that were taken by the Kenyan government was to establish a National Emergency Response Committee on Coronavirus before the first case was confirmed in Kenya so as to promote and accelerate action preparedness. Kenya having a devolved governance system, the county governments held a lot of decision-making responsibilities, functions as well as the budget lines. The Council of Governors (CoG) was very instrumental in having a coordinated function sub-nationally. In response, Kenya hired additional health care workers to boost the stretched health workforce. Government proposed to recall the retired critical care staff for supporting the COVID19 response. In addition to using CHWs to generate service demand, there were limited exemptions from epidemic response protocols to ensure safe health care access at the community level.

Africa invested heavily in preparedness and response efforts geared toward various outbreaks on the continent to mitigate the effects of Ebola virus disease, Lassa fever, polio, measles, tuberculosis and human immunodeficiency virus and this technical know-how was adapted to COVID-19. Networks of community health agents that supported the response to polio and other diseases were leveraged on for sensitization (Massinga Loembé et al., 2020). As at July 2020, 42 African countries had imposed lockdowns on movements and activities. Global experience suggested that these interventions had effectively suppressed the spread of COVID-19. (Kitara & Ikoona, n.d.)

In this study, COVID-19 pandemic was of concern and many efforts were being instituted to address the effects the outbreak to the reproductive health system in a more coherent, timely and efficient manner. The Kenya Practical Guide for Continuity of Reproductive, Maternal, Newborn and Family Planning Care Services during the pandemic was formulated with support from many individuals and organizations that were geared towards ensuring effective continuity of RMNCH in the country. This was a great sign of synergy and collaboration for a common cause. COVID 19 was seen as a wakeup call and not only a gamer changer for many African governments because it presented a window of opportunity of fronting Africa as

leaders in global affairs. Many nations had made use of the previous lessons of dealing with Ebola in West Africa and the Democratic Republic of Congo. (Nyadera et al., 2021)

When conducting policy analysis, we keenly looked at the issue at hand and our individual roles in that process. What was our value add really mattered at that time against all odds, we had to ensure that measures were evidence-based. (KII,6)

According to Umviligihozo et al.(2020), seven SSA countries; Uganda, Kenya, Rwanda, Cameroon, Zambia, South Africa and Botswana had shown the strengths of early initiated interventions that may have to slower COVID-19 progression in-country. The countries introduced screening techniques, closed their boarders and airports and training health care workers and the public engagement and awareness sessions were initiated. In addition, the SSA countries issued national guidelines on recommended safety measures, initiated immediate contact tracing, prevented mass gatherings, instituted national lockdown and curfew, closed schools and urged the private sector and the government personnel to work from home. de Villiers et al.(2020) noted that the South African government's initial health response got a lot of praises from the international community due to the early lockdown and extensive testing initiatives even though the lockdown devastated the economy. According to Qarnain et al.(2021), many G20 countries-imposed curfew, mandatory stay-in-home orders and lockdown of cities and countries. Gupta et al., 2021 found out that, that state and local policies did have an independent effect on mobility even after the large initial reductions occurred. Initial measures such as first case announcements, emergency declarations, and school closures reduced mobility by one to five percent after five days.

As much as acting fast was important with establishing the COVID-19 response guidance, the creation of awareness and dissemination of the guidelines was a shortfall which led to a lot of confusion at the facility and care levels. Implementation of the policy guidelines was another major challenge due to lack of capacity especially on human and financial resources to help with the set-up of telemedicine consultations. Task shifting as much as it's a good practice seemed to be a great challenge. Shifting the care to lower level facilities for maternal health care caused a lot of staff strain and put the quality of care at risk due to capacity challenges especially in cases that needed emergency or what is termed as 'high-risk pregnancies. Lack of confidence and trust, being that the tele-health was a new approach that was introduced which lacked the physical presence, there were many questions around awareness and comfortability of the services especially for reproductive and maternal health concerns. The tele-health innovation was prioritized in many of the Kenya's policies however little information and few details were available to describe the implementation process especially in low-resource settings that didn't have the digital scheduling capabilities. Accessibility was another point of concern in regards to high-quality and acceptable care, patients and some providers had difficulties accessing and utilizing the virtual channels.

COVID-19 containment and mitigation measures negatively affected the sexual reproductive health of girls. In Kenya, media reported a spike in teenage pregnancies as a result of the containment measures during the lockdown period within majority of them reporting heightened sexual debut and this resulted into limited economic opportunities for them beyond the pandemic. Experts warned that these same students were to be most hit by the social and economic costs that came as a result of them dropping out of school.

4.1.1 Policy Learning

Policy learning is a cognitive concept and it's dynamic socially. It was crucial in developing appropriate measures in mitigating the effect of the pandemic. This informed formulation and effective implementation of policies. Policy learning is analyzed in three categorical levels;

micro-level approaches at the individual level, meso-level approaches at the organization level, and macro-level approaches at the system level. The learning has been acknowledged for spurring progress towards universal health coverage (UHC) in low-and middle-income countries (LMICs) such as Kenya.

During the pandemic era, countries were required to adopt appropriate and tailor policies to deal with this crisis decisively through the policy learning approach which called for timely and appropriate response mechanisms. In Kenya, the government formulated the isolation and care protocols for health care workers. Identifying strategic areas of improvement on the human resource for health (HRH) data and the rationalization processes are among the lessons learned for Kenya during the pandemic response. Many adaptations were implemented based on evidence-informed interventions that reflected best practices that could be leveraged on but one major weakness that was witnessed was that there was limited published evidence back then on their effectiveness, cost, value for money, acceptability, feasibility, sustainability and equity when it comes to access and utilization of care. The notable adaptations included task shifting, appointment scheduling and telemedicine.

4.2 Policy Actors

Policy actors are individuals, organizations and groups. They include the think tanks, political leaders, state officials, private sector, civil societies and researchers among many more. Vélez *et al.* (2020) in their 'understanding the role of values in health policy decision-making from the perspective of policy-makers and stakeholders' study noted that policy-makers are known to simplify the complex interplay of technical, social and political values by prioritizing only those considered essential for the policy process. The pre-existing beliefs and plans about disease severity and its impact on the health care system deeply affects the choices made (Rosella et al., 2013).

4.2.1 Leadership

The global public health crisis created a series of challenges for the leadership and this threatened both the health and economic social progress. Several recommendations were proposed at the national level and they included staying calm, maintaining constant communication, partnering, co-planning and all these was supported by effective coordination. Successful leaders were noted to be effective in communication and that they had a centralized communication location. The measures to mitigate the effects of COVID-19 towards the reproductive healthcare system need to have communication pathways that are targeted at reaching every community and individual households. Non- governmental organizations in Kenya working in SRH programming played significant roles to sustain SRH at different service levels encouraging collaboration. In responding to COVID-19, global leaders leveraged on 'best practice' models and leadership strategies mitigate and contain the pandemic by re-aligning financial resources to the areas of need, this is because they had acknowledged that it was a major problem. They embraced adaptive capacity in evidence-based strategies for resilience. (Nicola et al., 2020b)

External donors have control of financial resources and they also have greater perceived technical expertise. Their power in influencing decisions, particularly during the final stage of a policy process (monitoring and evaluation) was visible because of their ability to control indirect financial and political incentives. (Khan et al., 2018) . In a health equity study, Baum *et al.*(2020) noted that public health policy actors may create political will through working with sympathetic political forces committed to fairness and framing policy options that makes them to be easily adopted. In Uganda, the maternal health policies were seen to be mainly influenced by the elites' personal interests rather than by the goal of reducing maternal

mortality and this was because the policy-making guidance gave the elites a lot of power and control over the policy process. (Mukuru et al., 2021)

4.2.2 COVID-19 Task Force Team

The COVID-19 Task Force team is one of the teams that was very instrumental in Kenya's preparedness and response to COVID-19. They coordinated the capacity strengthening of health service providers, surveillance at points of entry, coordinated the supply of critical medical products and had an economic outline impact assessment. The team formulated, enforced and reviewed protocols, guidelines and training materials for COVID-19 response. Technical reproductive health policy experts from notable organizations like ThinkWell and PATH supported with the reviewing and dissemination of national guidelines. To ensure continuity, they also trained county pharmacists on the use of RMNCH and family planning services tools to track commodity distribution. The Task Force decision-makers played a critical role and in containing the state of affairs whereby they were involved in conducting the situational analysis, monitoring and assessments. The COVID-19 Task Force team coordinated the technical assistance support, mobilization of financial resources and advised on re-instituting de-escalation strategies. The team also managed the ethical dilemmas, realigned emergency budgets and led the mitigation and containment measures by initiating strategy development using the predictive mathematical models.

A study by Etiaba *et al.* (2015) on developing an oral health policy showed that three groups of actors; namely academics/researchers, development partners and policy makers played crucial roles. Through their decision-making powers, they influenced policy through funding and technical ability to generate credible research evidence. My study indicated that when that policy actors have a lot of power in shaping the policy decisions, such was the case for the COVID-19 Task Force and the ad-hoc committee of experts.

4.2.3 Ad-hoc Committee of Experts

The ad-hoc committee of experts relied available evidence, and many adaptations to digitize services focusing on taking SRH services closer to women. A top priority for the ad-hoc committee of reproductive health experts was to ensure that the SRH services are sustained and that there were no disruptions. From the key informants' information one of them actually stated that *'The country was at that time experience high rates of teenage pregnancy and as we developed strategies to counter this, COVID came and it actually made it worse within the first three months, many young girls had gotten pregnant based on the reported numbers and even this feature was aired on television. This was a double tragedy because health centers closed, girls were highly exposed and we needed to act by providing leadership and guidance to the country on this matter. The concerted efforts were at least progressive. (KII, 1)*

Herberholz (2020) noted that provision of financial support however small it was, enabled external actors to have a lot of say in influencing and identifying policy gaps. This was in contrary to his literature that had indicated that technical expertise was the perceived role of international organizations. My study noted that the technical expertise was provided by the ad-hoc committee of experts while international organizations such as World Bank, the European Union and many others provided financial support. Koduah *et al.* (2015) also noted that politicians participated in the policy process to direct and set the agenda while donors leveraged on their financial power to be part of the agenda setting process.

4.2.4 Community Response

In mitigating demand-side barriers, community members were mobilized for preventative services. These included working with community health workers (CHWs) for intensified community outreach and mobilization. The CHWs were deliberately requested to target

pregnant women with key messages for pregnancy care, pre-natal care and birth preparedness delivery plan. One of policies formulated directed the village chiefs and county health chief executives to activate "county specific mechanisms" to enforce health service access for all pregnant mothers at night and lockdown hours. In collaboration with the Ministry of Interior and Coordination of National Government, the county health teams supported access to antenatal, labor, and postnatal services as one way of taking the recommended policy action. In addition, the communities were given a bigger responsibility of ensuring that women in labor or those emergency pregnancies safely reached the nearest health facilities with any delays. This required the communities to be innovative enough in ensuring that the pregnant women accessed quality care. The community noted that cases of Gender-Based Violence (GBV) were on the rise and they instituted public education campaigns during lockdowns. The health impacts of this kind of violence, on women and children can be life threatening.

4.2.5 Reproductive Healthcare System Strengthening

The healthcare system in Kenya was divided into categories; COVID-19 healthcare system and non-COVID-19 healthcare system. The two health systems were strained by the increasing demand due to the pandemic. Kenya enacted several policies to support the healthcare system, this is in addition to general pandemic response. A resilient health system assures the continuity of essential health services and also mitigates secondary effects.

As part of Kenya's response, a dedicated HRH sub-committee in the COVID19 taskforce was set to address the challenges and to improve the capacity of its health care workforce. The case management and capacity building for resource mobilization sub-committee was tasked with reviewing and supporting the dissemination of national guidelines to ensure continuity of reproductive, maternal newborn, child health (RMNCH) and family planning service. Some members from this team, equally represented the Council of Governors (CoG) in analyzing the utilization of RMNCH services and advised counties accordingly. In mitigating the dire effects of the virus, the policy actors recommended four antenatal care visits and clinic visits for pregnant women instead of the initial six visits and even with the four, teleconsultations were highly encouraged to reduce the number of contact times. One policy also indicated that if a woman didn't experience suspected COVID-19 symptoms, her postnatal follow-up or newborn visits were to be completed by phone.

4.2.5.1 Reproductive Autonomy

Reproductive autonomy is having the power to decide and control contraceptive use, pregnancy, and childbearing. It's a human rights imperative to protect the lives, bodily autonomy, and reproductive autonomy of women. In this study, I discovered that even with the pandemic some things didn't change. For instance, pregnant women continued to experience labor and pregnancy related emergencies. This was also echoed by a key informant who highlighted that *'With or without COVID-19, there are some things that didn't change and they still can't change. Teenagers will continue having sex and women will still be pregnant. Let's appreciate that sex had no lockdown and the most important thing was for the COVID-19 Task Force team to address the unique needs of this group and our sub-committee was tasked in providing technical advice for such. This is one thing that I am proud to have contributed to as a member (KII, 4)*

4.2.5.2 Preparedness and Public Health Measures

Suspension of services: The policies suggested that for removal of long-acting methods to be deferred while elective surgical contraception such as interval tubal ligations and routine vasectomies were suspended until regular hospital services resumed. Back then, condoms were offered in plenty while community family planning outreaches, community surgical services,

and group counseling were also suspended until a safer time. It was noted that women who delivered during COVID-19 had significantly higher odds of delayed ANC initiation.

Staggered telephone scheduling of clinic returns dates (TCA) to avoid crowding was enforced. Condoms and oral contraceptive pills were extended to three months with refills instead of the initial one month so as to ease administration and minimize the physical contact sessions between the client and the provider. Emergency contraceptive pills were to be availed to survivors of sexual and gender-based violence promptly as part of standard post exposure prophylaxis. Clients seeking non-assault emergency contraceptives were discouraged from repeated use of emergency contraceptives.

To reduce workload on family planning service delivery points, institutions are advised to offer family planning services on a 24-hour basis. Visits to Family planning clinics are to be scheduled through telephone calls and planned so that only a small number attends at any given time. Unnecessary method switches are strongly discouraged as they deplete commodities and place extra burden on the health system. New recruits to a particular method must be thoroughly counselled and guided to make informed choices of the ideal method for their needs to reduce suboptimal early removals, method discontinuations and method switches that are wasteful and put enormous pressure on the health system. Care for SGBV survivors remained a priority and essential service and was required to be offered as other essential services. All new cases of SGBV needing the health services were to visit the health facility as soon as possible and within 72 hours of the occurrence of the incident.

We highly advised on people relying on tele-medicine rather than the in-person consultations so as to minimize the risk of getting infected and spreading the virus. We boosted the toll-free numbers and recommended that some back up staff to be placed at the contact centers to offer the tele -consultations. Digitizing was aimed at getting the SRH services closer to women (KII, 1)

4.2.5.3 Leveraging on Technology

Across many health areas, the Kenya MOH recommended the increased use of telemedicine with recommendations on evaluating the innovation to understand implementation challenges and lessons learned, patient satisfaction, and consequences on health outcomes and costs. Appointment scheduling by using digitized patient scheduling is an innovation that improved patient flow at health facilities and reduced congestion and crowding. This had dual benefits as it also reduced the risk of getting infected with COVID-19. All clients were to be given a service/method card that had the provider or clinic telephone number to call back should there be need and all visits to Family planning clinics were scheduled through telephone calls and planned so that only a small number attended at any given time.

Contraception adaptation of services which involved the use of telemedicine and virtual methods were encouraged for screening and counseling. By use of technology for contraception counseling, staggered appointment scheduling worked for facilities that had advanced services was noted for multiple health services. For screening for maternal care, patients were encouraged to call a government 24-hour call center, which provided a link between patients and care within their locality. The policy suggested that contact information for the centers to be widely circulated through various media. The tele contact centers such Aunty Jane, LVCT Health, Kenya Red Cross, MSF Nairobi and the Gender Violence Recovery Centre were manned by appropriately trained persons on matters of reproductive health as well as COVID-19.

Stratford Peer Reviewed Journals and Book Publishing
Journal of Public Policy & Governance
Volume 7||Issue 1||Page 26-57||January||2023|
Email: info@stratfordjournals.org ISSN: 2616-8472

4.2.5.4 Challenges with Tele-Medicine

Whenever a new concept is introduced, it always raises a few questions on its effectiveness. For tele-medicine, one of the biggest challenges was staffing at the call centers so as to have capacity to handle high volumes of calls and provide the appropriate guidance and linkage to care. While telephone and virtual methods were highly encouraged, another point of concern was internet connectivity in remote areas and whether the virtual quality of care was of the same standards as that of in-person care.

4.3 Policy Context

The COVID-19 pandemic extremely disrupted the health system including the reproductive healthcare system. Several contextual factors gave context and criteria for policy action during the response.

4.3.1 Structural factors

4.3.1.1 Income

Some women faced a lot of difficulties accessing maternity services because they had lost their jobs during the pandemic and had no income to cater for their needs. Some actually mentioned that they were not allowed in the maternity wings if they had no money. Despite the closure of borders and movement restrictions adversely affecting the tourism sector and contributing to the loss of income, well-coordinated prevention and control measures seemed to be promising solutions to mitigate the spread of COVID-19 in Africa. (Rutayisire et al., 2020) . According to Rutayisire *et al*.(2020), the COVID-19 pandemic was recognized to pose a great threat to most African countries, from cities to rural areas and hence that created more demand on already scarce resources. More additional resources were recommended to be mobilized for emergencies.

4.3.1.2 Mistreatment of Women and Partner Violence

Some couples reported high levels of intimate partner violence (IPV) that was heavily aggravated by the severe economic and social challenges. The SGBV survivors had limited in-person support sessions with all services being re-routed to online and hot line channels. The pandemic exposed families to intimate partner violence (IPV) and made access to essential reproductive health services such as abortion a challenge. Generally, cases of gender-based violence (GBV) increased, with one in two women reporting that they had or knew a woman who had experienced violence. Kenya experienced some (RMNCAH-N) service disruptions during the pandemic and this was aggravated by initial government lockdowns, curfews and movement restrictions. Many school girls became pregnant during the lockdown period.

4.3.2 Situational factors

Social distancing and the disruption caused by the pandemic created physical and economic barriers to contraception and other SRH services. Intentional disruption of the provision health (SRH) services; maternal health; services of safe and legal abortion services, created a violation of human rights to rights-based contraceptives. Kenya witnessed fewer RMNCAH-N service disruptions than other countries during the pandemic due to its timely action in formulating and enacting policies to maintain essential health services (EHS). As mentioned by a key informant from the ad hoc technical group,

'*The COVID-19 pandemic affected maternal health to a great extent, both directly and indirectly, for instance the mothers who were meant to attend the ANC clinics were prevented from doing so and for the women at home, the country reported increased cases of SGBV. (KII, 3)*

Findings from the Bangladesh, Nigeria and South Africa study found out that between March and May 2020, there was a reduction in utilization of basic essential MNCH services such as antenatal care, family planning and immunization due to a number of measures that were put in place to contain the virus and they included; the implementation of lockdown, a shift of focus towards pandemic and resource constraints. (Ahmed et al., 2021) . According to Banke-Thomas and Yaya (2021b), the available data across LMICs suggested that there was a reduction in access to SRH services, including family planning (FP) counselling and contraception access and safe abortion during the early phase of the pandemic when movement restrictions were put in place. This is in line with my study findings that revealed that the social distancing and lock downs disrupted provision of SRH services in Kenya.

4.3.3 Global or exogenous factors

COVID-19 was a global pandemic that affected all countries if not majority in the world. WHO was tasked with providing guidance to countries on how to appropriately respond to this pandemic. WHO advised countries to adapt the global response guidelines and implement them based on the context and Kenya incorporated this guidance to formulate the MNH policy guidelines to sustain access to Maternal and SRH services. A comparative study of health policy responses to the pandemic in Canada, Ireland, UK and USA in 2020 indicated that all countries faced common challenges which include procurement of personal protective equipment and testing capacity limitations. Despite this, the health system governance, innovation and political leadership in these countries shaped the responses. (Unruh et al., 2022)

5.1 Conclusion

Being a matter of public health concern, COVID-19 reproductive health policy and guideline response require demonstrated leadership, great coordination and professional joint advocacy efforts through appropriate inter-sectoral collaboration and whole-government coalitions to make them highly effective. When an issue is seen as a big problem that most people acknowledge as a big problem, then this can prompt policy development and action. One of the most strategic and ideal measure the government of Kenya did was communicating with the public by issuing daily news briefs regarding the status of the pandemic in-country and positioning of health more so reproductive and maternal health. Acting early and making decisive calls were very beneficial in containing the spread as well as promoting reproductive health service uptake. No sections of the community were ignored during the response.

The COVID-19 pandemic disrupted the provision of essential reproductive, maternal, newborn, and child health (RMNCH) services in sub-Saharan Africa to varying degrees. Anecdotal evidence showed that in any emergency or humanitarian crises, women and girls faced a lot of health challenges. The imposed lockdowns and curfew limited access to maternal health services and may have disproportionately affected those that were living in informal settlements. One of the most important policy directives made by Kenya in advancing access towards universal health care (UHC) and strengthening the health work force was requesting the County governments to hire community health volunteers (CHVs) in large numbers and provide for their stipends and realign budgets towards the response to COVID-19. This showed a coordinated function.

Kenya highly prioritized three components of the health care system during the pandemic and they include; human resources for health (HRH), healthcare delivery and supply chain management for contraceptives. The minimum deliverables in family planning that continued to be observed under the pandemic were; comprehensive counselling, full accurate disclosure of method information, access to quality services, informed consent, respect for choice, privacy, confidentiality and dignified care.

Policy formulation is fully a complex iterative and non-linear process which is affected by interests and the more actors that are involved in the process, the more difficult decision-making becomes. Societal values and morals are highly influential in a community setting and many a times the community would like to conform to them. As noted, the health policy triangle provided a useful framework for simplifying the extremely complex, inter-active and dynamic nature of the policy making process though slight consideration to other aspects that describe how and why policies are modified were considered. This needs to be exhaustive. Policy processes don't function in isolation. They consist of politically engaged individuals who interact to influence government decisions. When the major political elites/parties/ sections that have the most power and are well represented support the policy, then policy is likely to be developed and actioned.

5.2 Recommendations

5.2.1 Recommendations from the Study

i. A contextualized mitigation plan to sustain SRH services should developed and it should focus on capacity strengthening of SRH service providers on emergency responses, outlining the task shifting protocols and training on the use of tele-health innovations

ii. Kenya's RMNH policy guidelines should continuously be updated by the Ministry of Health with support from the technical working group (TWG) to reflect the status of the situation both at the national and sub-national levels.

iii. A reproductive health challenge as a result of the worldwide pandemic was witnessed and the epidemic unveiled major health system weaknesses which also revealed that SRH services were highly neglected, especially those that targeted GBV. SRH should be recognized as an essential service by the Ministry of Health and the adaptations tested from time to time for scale up.

5.2.2 Recommendations for further study

The study priority implementation research questions include:

Policy Questions

i. How to position health policy coordination for reproductive health in future pandemics?
ii. What does it take to handle the difficult tradeoffs in reproductive health policy learning?
iii. How to manage the political elites' interests for informed reproductive health policy action?

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