Maintaining Access to Contraceptives During COVID-19 Disruptions
Potential impacts and mitigation in Morocco

Analysis based on MICRO v2 (June 18, 2020)

The impact of COVID-19 on contraceptive use will vary depending on the severity and duration of disruptions. Without efforts to mitigate, it is estimated that between 122,000 and 486,000 women could be unable to use contraception resulting in 3,050 to 146,000 unintended pregnancies in Morocco.

**Women unable to use contraception:**
- Low: 122,000
- Medium: 244,000
- High: 486,000

**Resulting unintended pregnancies:**
- Low disruption for 3 months: 3,050
- Moderate disruption for 6 months: 36,500
- High disruption for 12 months: 146,000

What are the risks?
Risk factors for contraceptive access include frequency of contact (how often a method needs to be re-supplied) and the intensity of contact (length of time a client needs to spend in a health facility and interacting with a provider). This risk varies widely by method:

**High frequency and medium intensity**
- Unless self-injection is available, women using injectables are at high risk as they require regular visits for re-injections.

**High frequency but low intensity**
- Women using these methods need re-supply, however methods can be obtained with little face to face contact and advance provision can limit frequency.

**Low frequency but high intensity**
- Women already using these methods have low risk as they can continue to be protected without interaction with the healthcare system.

Share of users falling into each category:
- Condom: 93%
- Pills: 0%
- Injectable (especially provider-administered): 6%

*Total includes women using other modern methods.

There also may be different impacts based on source of method: whether women get access in the public or private sector. In Morocco, the public sector serves 52% of FP users, the remaining 48% get their method from the private sector.

What can be done to mitigate the risks?
Strategies like advance provision of short-term methods like oral contraceptive pills help reduce frequency of contact but this could increase the number of oral contraceptive pills dispensed by 1.7x over the next 6 months and dramatically increase out-of-pocket costs for users. Planning and coordination are needed to avoid stock-outs.

Women may also defer using methods like IUDs and implants if they are worried about visiting healthcare facilities. In Morocco, 4% of users are already covered by a long-acting FP method and do not need resupply. Another 1% of users are due for a replacement method but could continue using their current method to avoid unintended pregnancy. However, before COVID-19, we would have expected a -13% increase in use of LARC over the coming year. These women may need a bridging method if they are unable or unwilling to get their preferred method during the crisis.

Because the private sector delivers 50% of short-term methods in Morocco, it may prove a more convenient and acceptable source for women to resupply or find bridging methods. However, user fees and the distribution of private facilities may limit this option to wealthier women unless subsidies can be used to address affordability.

Demand-side financing or public purchasing of services from the private sector are strategies that have been successful for improving equity in private-sector FP services. Other strategies for ensuring equity may include the use of mobile outreach or community health workers to bring services closer to clients who face restricted mobility or are experiencing declining house-hold income.

Results in this brief are based on the default assumptions in the MICRO model developed by RHSC in collaboration with the Global Financing Facility (GFF) and Avenir Health.
For more information visit: https://www.rhsupplies.org/activities-resources/tools/micro/