



Maintaining Access to Contraceptives During COVID-19 Disruptions

Potential impacts and mitigation in Zimbabwe

Analysis based on MICRO v2 (June 18, 2020)

The impact of COVID-19 of contraceptive use will vary depending on the severity and duration of disruptions. Without efforts to mitigate, it is estimated that between 88,300 and 371,000 women could be unable to use contraception resulting in 2,210 to 111,000 unintended pregnancies in Zimbabwe.

	Low	Medium	High
 Women unable to use contraception:	88,300	183,000	371,000
 Resulting unintended pregnancies:	2,210	27,400	111,000
	<i>low disruption for 3 months</i>	<i>moderate disruption for 6 months</i>	<i>high disruption for 12 months</i>

Impact numbers account for declines among current users and loss of additional growth in users that would be expected without COVID-19 disruptions.

What are the risks?

Risks to maintaining access to contraceptives are likely related to 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.



Injectable (especially provider-administered)

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.



Condom



Pills

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.



Implant



IUD



Sterilization

Share of users falling into each category:



*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 Zimbabwe the public sector serves 74% of FP users, the remaining 26% 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 2x 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 Zimbabwe 16% of users are already covered by a long-acting FP method and do not need resupply. Another 5% 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 10% 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 28% of short-term methods in Zimbabwe 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.