

# Maintaining Access to Contraceptives During COVID-19 Disruptions: Assessing Risk and Mitigation Strategies for India

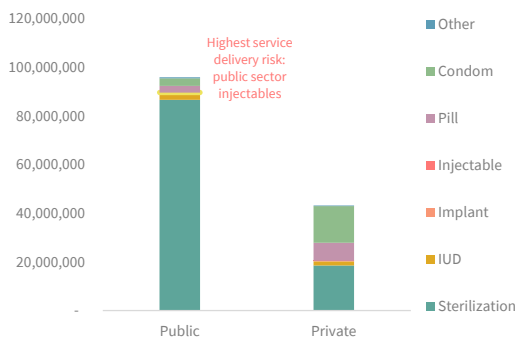
Analysis based on MICRO v2 (June 18, 2020)

## What are the potential risks?

COVID-19 could result in a range of disruptions that may impact contraceptive use: Clinical staff may be reassigned to COVID-19 response activities and may have reduced time or capacity to provide FP services, stay at home orders and social distancing policies may limit the ability of both women and clinical staff to access clinics, women may choose not to come to health facilities due to fears of potential exposure, supply chains may face distributions that limit the availability of supplies. While these disruptions will affect many health services, **family planning has unique considerations because women are able to use a range of different contraceptive methods sourced from different places and COVID-19 is likely to create risks that vary by method and source. Additionally, a rights-based family planning program leaves these choices in the hands of users.**

The graph on the left shows estimated users in March 2020 by method and sector (utilizing data from the CGA2019). The table on the right categorizes the level of risk of different users if COVID-19 disrupts service delivery and the share of users who fall into each risk group. The split of users is also shown by sector the vulnerabilities may be even higher for the public sector. This summary can help highlight where the largest risks are from a service delivery perspective in order to prioritize short-term "bridge" efforts to sustain access to contraception during COVID-19 disruptions.

Users by method and sector, March 2020



Level of risk from a service delivery perspective:

Risk Level	Share of Current Users*			Risk assessment notes
	Total	Public	Private	
Low: LAMP users	79%	64%	15%	existing users may be able to continue to use their methods throughout any disruptions. Women seeking new LAMPs may be advised to use other methods in the short-term if services are not available.
Medium: Pills, Condoms & Other Modern Methods	21%	5%	16%	women can access their method from pharmacies and shops with limited interaction with the health care system. Those accessing from private sector sources may face fewer barriers.
High: Injectables	0%	0%	0%	except in contexts where self-injection is already wide spread injectable users will need regular interactions with health care providers for reinjections.
<b>Total</b>	<b>100%</b>	<b>69%</b>	<b>31%</b>	

\* Programs should also consider the needs of **non-users** who want to adopt a method of contraception during COVID-19 disruptions. Demand may increase beyond current levels if more women seek to delay pregnancies until issues have resolved.

Risk from the perspective of the supply chain must also be considered to ensure that products are available to women. This includes potential supply chain disruptions at the point of manufacturing, shipping product to countries, and distribution of product within a country. Risks also may exist in terms of a mismatch between stock on hand and expected shipments and potential short-term shifts in demand for self-care methods. Countries may need to explore approaches that allow for flexibility and opportunism in responding to the ever-evolving landscape.

## What is the potential impact on women?

The potential impact of COVID-19 on contraceptive use will vary depending on the severity and duration of disruptions. Estimates have been made of the range of potential impacts under different scenarios. Mitigation strategies to ensure women continue to have access to contraception can help reduce these outcomes (see next page for details on these strategies).

**Low**  
**1,640,000**  
**women unable to use modern contraception**  
 resulting in  
**41,000**  
**unintended pregnancies**  
*based on low disruption for 3 months*

**Medium**  
**3,160,000**  
**women unable to use modern contraception**  
 resulting in  
**474,000**  
**unintended pregnancies**  
*based on moderate disruption for 6 months*

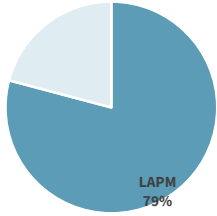
**High**  
**6,200,000**  
**women unable to use modern contraception**  
 resulting in  
**1,860,000**  
**unintended pregnancies**  
*based on high disruption for 12 months*

Impact estimates based on different levels of decline by method and sector. Numbers also account for the loss in additional growth in users that would be expected without COVID-19 (based on pre-COVID-19 patterns of growth in mCPR). The longer disruptions last the more impact in terms of this loss in additional users, as well as the more impact on unintended pregnancy as the longer women are without contraception the higher their risk of experiencing an unintended pregnancy. Default assumptions are aligned to the scenarios used for the UNFPA Impact of the COVID-19 Pandemic of Family Planning. See: <https://www.unfpa.org/resources/impact-covid-19-pandemic-family-planning-and-ending-gender-based-violence-female-genital> for details.

Results in this brief use the CGA 2019 as a starting place and explore different scenarios to quantify potential shifts in contraceptive needs that could result from service delivery disruption and different mitigation strategies. Using the MICRO model scenarios can be developed: <https://www.rhsupplies.org/activities-resources/tools/micro/>

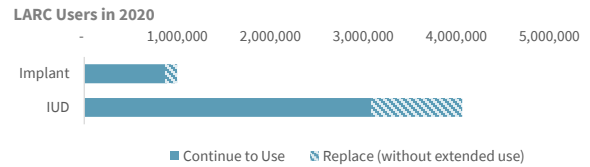
# What are potential mitigation strategies and their implications for supplies & services?

## 1 Existing Implant and IUD users may be advised to continue using their method for the near term (unless a removal is required). Evidence shows that many LARC methods continue to provide protection for pregnancy beyond the labeled use



**79% of current users are already protected by a long-acting or permanent method (LAPM).**

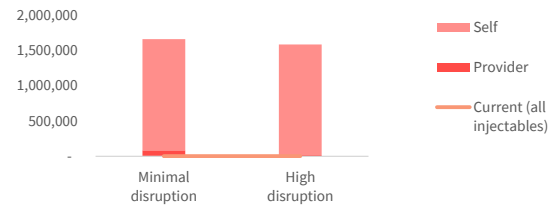
Of these users only a small share are projected to be due for a removal/replacement method within year (see graph to right) as most users will continue to use a method received previously. Furthermore, some of the women needing replacement may be able to safely continue to use their LARC beyond labelled duration. Unless a removal is wanted, most LAPM will continue to be protected from pregnancy without needing any interaction with the health care system.



## 2 Women using injectable contraceptives may be able to switch to self-injection of DMPA-SC if available and if policies permit self-injection. Self-injection reduces the need for face-to-face contact with health care workers, and advance provision of multiple doses at once would limit the need to return for re-supply.

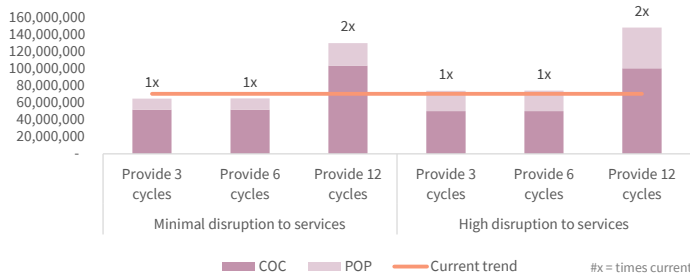
The ability of women to utilize self-injection as a means of self-care will not only depend on the regulatory and policy environment, but also the ability to scale-up self-injection programs. This would include ensuring adequate supply and distribution of DMPA-SC and ensuring that women can get access to training on self-injection and follow up care as needed. If self-injection supplies will primarily be accessed through private channels, affordability must also be considered (see more below).

**Injectables Dispensed over 6 months by scenario (April - September 2020)**



## 3 Women seeking a method that is unavailable or inaccessible due to disruptions may instead seek a self-care method that can be obtained with no or limited face-to-face interaction with a health care provider. This could include pills (likely POP since no blood pressure screening is needed), condoms, EC, LAM, SDM, or other self-care methods.

**Cumulative pills dispensed over 6 months (April - September 2020)**

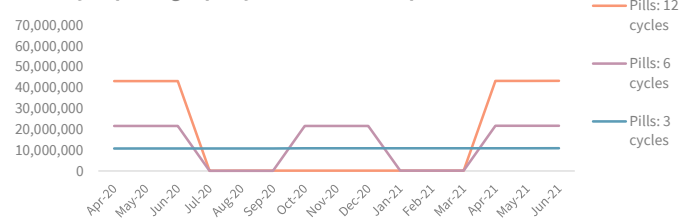


Women switching to contraceptive pills as a self-care alternative, coupled with advance provision of 6 or 12 cycles, could lead to large increase in supplies needed to meet demand. If, as recommended by some institutions, progesterone-only-pills (POP) or "mini-pills" are prescribed for this "replacement" role (due to lack of contraindications thus minimizing the need for blood pressure screening), then much of the pill consumption could be for POP, a method that in most countries has very low procurement volumes. Countries will need to consider if and how increased demand for self-care methods, especially POP, can be met. Further, if these methods will be primarily accessed through private channels, affordability must also be considered (see more below).

## 4 Women seeking self-care methods that require resupply may be provided with advance provision of multiple units (e.g. 6 or 12 pill cycles) in order to limit their need to return for re-supply.

If countries experience substantial user switching to self-care methods while also implementing advance provision policies, they may need to account for increased consumption and front-loaded dispensing. It will be important for countries to balance the benefits of advance provision with the need to ensure access to as many women as possible, especially in contexts where self-care supplies are limited. If supplies are insufficient, advance provision could quickly deplete stocks creating stock-outs that limit access. An example is shown here for pill cycles dispensed based on minimal disruption to services and different levels of advanced provision.

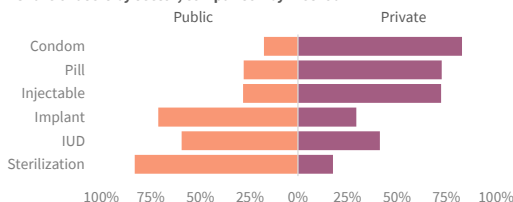
**Monthly dispensing of pill cycles: Minimal Disruption to Services**



## Key Considerations: Ensuring Quality, Accessibility and Equity

Private sector channels are likely to have a large role to play in the distribution of self-care methods. These channels are well placed to be nimble and are often comprised of large networks of pharmacies and shops that allow for easy access particularly in urban and peri-urban areas. In many countries, the private sector was already playing a larger role than the public sector for self-care methods (graph on left). If adopters of self-care methods follow the same sector patterns as existing method users, there would likely be a shift towards the private sector use. Indeed this shift may be even more dramatic as public systems are strained and women opt to visit shops or pharmacies over public facilities. This potential shift towards the private sector presents challenges to ensure quality, accessibility and equity.

**Share of users by sector, comparison by method**



**How can countries address these concerns?**

- Demand-side financing (e.g. vouchers, health wallets, cash transfers) can give users flexibility to choose a method and a source of method that responds to their changing needs during the crisis
- Telehealth and m-health can be utilized to provide information to help women select a method and access follow up for questions about use
- Delivery models such as CHWs, mobile outreach teams, and partnerships with small private health care providers could be utilized to distribute free or subsidized products with more limited face-to-face contact