PERFORMANCE MONITORING FOR ACTION

GENDER & COVID-19: ACCESS TO HEALTH AND CONTRACEPTION

Access to health and contraceptive services among adolescents and young adults in Nairobi during the COVID-19 pandemic

November 2020

GENDER

Why This Matters

- Global concern exists for disruption to a range of necessary health services in the COVID-19 pandemic.
- Evidence from recent epidemics shows substantial decreases in contraceptive use due to stock-outs, facility closures, and fear of accessing services.[1]
- COVID-19 projections estimate that 15 million additional unintended pregnancies could occur over one year if COVID-related service disruptions affected 10% of women in need of sexual and reproductive health (SRH) services in low- and middle-income countries.[2]
- Urban youth are more prone to rely on coital-dependent contraceptive methods, including condoms and emergency contraception, which may be more susceptible to COVID-related access and service disruptions and are less effective in preventing pregnancy.
- Prior to COVID-19, young women living in Nairobi's informal settlements experienced cost barriers to accessing sanitary pads[3]—loss of income is expected to exacerbate affordability issues, especially as households prioritize other basic needs.

Spotlight on Gender Analysis

A gender analysis is critical, inclusive of gender-stratified quantitative analysis and attention to gendered social and economic power dynamics, norms, and underlying inequities.

Understanding the Context

Data from 2019 Baseline

- Over half (53%) of males and 37% of females aged 15-24 years living in Nairobi county were using a modern contraceptive method at baseline survey (June-August 2019).
- Coital-dependent methods were most common, specifically male condoms (91% among male users, 36% among female users).
- Youth most frequently accessed primary contraceptive methods from pharmacies (35.7%).

COVID-19 Restrictions in Nairobi

- As of 2 November 2020, there were 55,877 COVID-19 cases and 1,013 confirmed COVID-related deaths in Kenya.[4]
- The first case of COVID-19 was detected on March 13, 2020.[5] School closures, national lockdown, and mandatory curfew immediately followed. As of October, mandatory curfews were relaxed and schools began to partially re-open.[6] However, a second wave of COVID-19 cases may result in a rollback of Kenya's reopening.[6]
- These restrictions, while essential to curbing the spread of COVID-19, could decrease access to essential general health and SRH services.

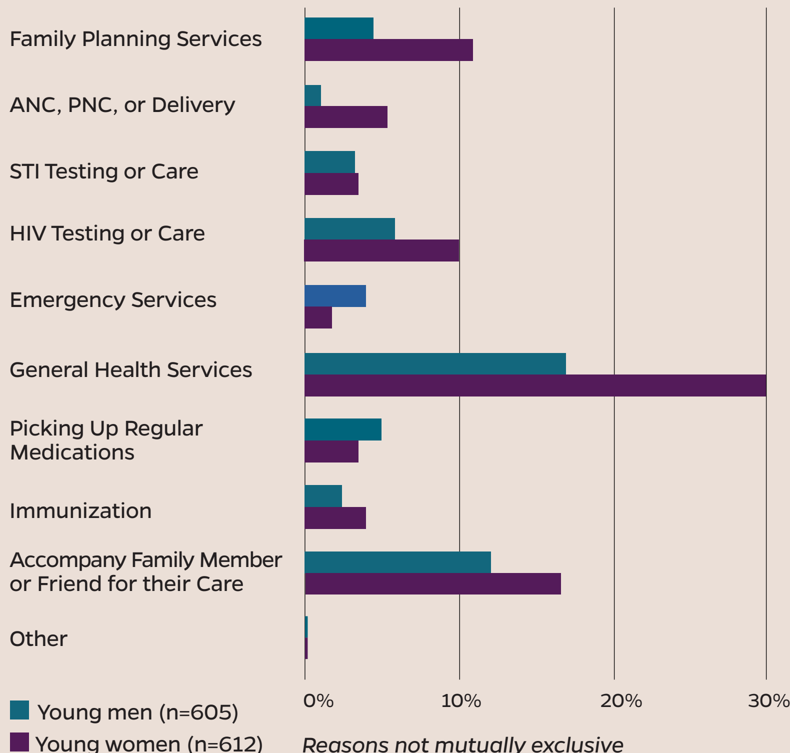
PMA | GENDER PERFORMANCE MONITORING FOR ACTION
ICRH Kenya International Centre for Reproductive Health
KENYATTA UNIVERSITY
JOHNS HOPKINS SCHOOL of NURSING
JOHNS HOPKINS CAREY BUSINESS SCHOOL
JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH
Bill & Melinda Gates Institute for Population and Reproductive Health

Key Findings: Access to Health Services

- Fear of being infected with COVID-19 at health facilities was the primary difficulty in accessing any health service for both genders, though young men disproportionately reported difficulty accessing due to government restrictions.

- Attempted to access health services since COVID-19 restrictions began.
- Young men reported difficulty accessing due to government restrictions:

Reasons Needed to Visit Health Facility since COVID-19 Restrictions

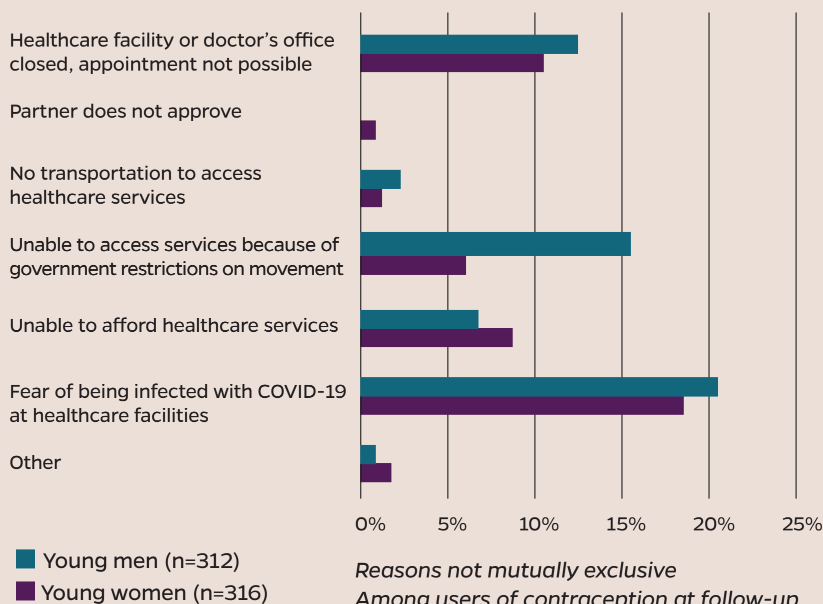


Reasons not mutually exclusive

Key Findings: Contraceptive Disruptions

- Difficulty accessing contraception was common for current users of contraception (34.6% of young women; 40.4% of young men).
  - Fear of being infected at health facilities was the greatest disruption for both groups (20.7% young men, 18.7% young women).
- Difficulty accessing contraception was most likely to occur for current users of coital-dependent methods, who are already at increased risk of unintended pregnancy.

Disruptions to Contraception Since COVID-19 Restrictions



Reasons not mutually exclusive
Among users of contraception at follow-up

PMA | GENDER
PERFORMANCE MONITORING FOR ACTION

Key Findings: Contraceptive Disruptions

Experienced Any Difficulty Accessing Contraception

Access to condoms, both due to stockouts and money constraints, was a key issue discussed within focus group discussions (FGDs):

> “So you find like that... 50 shillings to go to buy [a] condom [but] **you find that also to get job is hard at the moment. So, that 50 [shillings] you will think of food [rather] than [a] condom.**”
> *– 22-year-old male FGD participant*

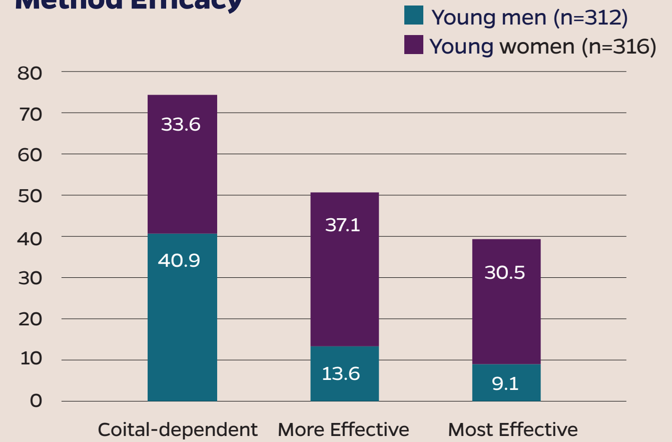
Fear of infection remained a key barrier to accessing SRH services specifically:

> “**Most right now that were using [contraception] fear to go to hospital**, why? You can go to the hospital you [will] be tested and be told you have Corona, you [will] be told to go to quarantine. No one wants to go to quarantine.”
> *– 23-year-old female FGD participant*

While accessing more effective methods was not particularly problematic for young women already using these methods, young women reported difficulty accessing adequate counseling:

> “[I] have been having some discussions with young women and young girls, who had previously received a contraceptive service and especially LARC services. During that period of lock down, they were experiencing side effects, and **because of the restrictions in movement they were unable to access further counseling on side effects which they were experiencing.**”
> *– 30-35 year-old male Officer at Contraceptive service provider*

Difficulty Accessing Contraception by Method Efficacy



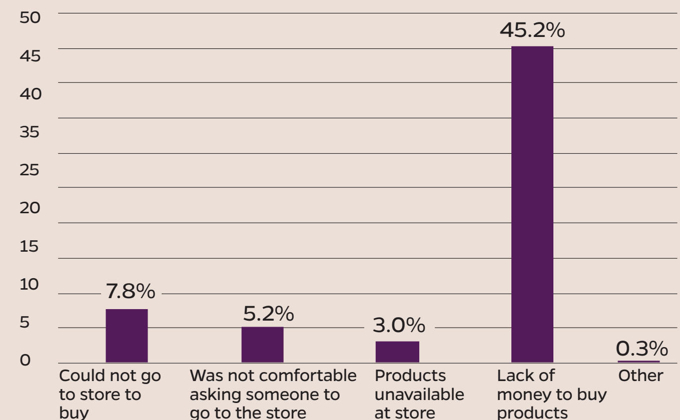
Among users of contraception at follow-up

Method Effectiveness: Coital-dependent=Emergency contraception, male condom, female condom; More Effective=Injectables, oral contraceptive pills; Most effective: Implant, IUD

Over half of young women (52%) experienced disruptions to accessing menstrual hygiene products since the start of COVID-19 restricts, with cost indicated as the primary barrier.

Barriers Accessing Menstrual Hygiene, Among Young Women (n=612)

Over half of young women experienced disruptions to accessing menstrual hygiene products since the start of COVID-19 restricts (52%) experienced disruptions to accessing menstrual hygiene products since the start of COVID-19 restrict, with cost indicated as the primary barrier.



Reasons not mutually exclusive

Action Steps

- Pandemic-related disruptions to sexual and reproductive health include those to contraception as well as menstrual hygiene, creating clear risks for young women.
- Media campaigns should balance safety measures while guiding youth to continue to access essentials services.
- Contraceptive services can be reallocated to easier to access points of provision, including pharmacies and over-the-counter services, to support youth and combat fears of seeking formal services. Pharmacies are essential for ensuring young women and young men's continued access to coital-dependent methods, specifically male condoms.
- Quality contraceptive counseling in the midst of COVID-19 is necessary for youth to select their preferred contraceptive methods and be informed of potential side effects.
- Access to low-cost menstrual hygiene products for young women remains a key priority.

Faced with restricted household income due to COVID-19, menstrual hygiene products were not considered essential needs:

> "You find jobs have been terminated and then adolescent girls have been challenged as you can find **like in slums most of them are dependent on those NGOs [nongovernmental organizations] to get pads [sanitary towels]**, but you find right now they are suffering a lot because most of them [NGOs] have been closed."
> *– 17-year-old female FGD participant*

Methods

In 2019, Performance Monitoring for Action (PMA) Agile carried out a Youth Respondent-Driven Sampling Survey (YRDSS) among adolescents and youth ages 15-24 (N=1357, male N=690 and female N=664) in Nairobi, Kenya between June and August. In 2020, a fully remote follow-up study was conducted with the study cohort (now ages 16-26) to track changes in contraceptive dynamics, and assess the gendered impact of COVID-19. The quantitative surveys were conducted by phone in two distinct sessions to limit participant burden: YRDSS Follow-up (N=1223, male N=610 and female N=613) and Gender/COVID-19 Survey (N=1217, male N=605 and female N=612). Sampling weights accommodate the RDS study design, post-estimation adjustment and non-response adjustment. Virtual qualitative methods included focus group discussions (FGDs) with unmarried youth ages 15-24 (N=64, over 8 groups), FGDs with youth-serving stakeholders (N=32, over 4 groups), and key informant interviews with higher-level stakeholders (N=12). Data collection was conducted from August to October 2020.

Suggested Citation

PMA Agile/Gender & ICRHK. [Brief Title]. 2020. Baltimore, Maryland, USA: Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins University Bloomberg School of Public Health.

References

[1] Bietsch K, Williamson J, Reeves M. Family Planning During and After the West African Ebola Crisis. Stud Fam Plann. 2020;51(1):71–86.

[2] Riley T, Sully E, Ahmed Z, Biddlecom A. Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health In Low- and Middle-Income Countries. Int Perspect Sex Reprod Health. 2020;46:73–6.

[3] Crichton, J et al. "Emotional and Psychosocial Aspects of Menstrual Poverty in Resource-Poor Settings: A Qualitative Study of the Experiences of Adolescent Girls in an Informal Settlement in Nairobi." Health Care Women Int. 2013;34(10): 891-916.

[4] WHO. Kenya: WHO Global Health Observatory. "The current COVID-19 situation." https://www.who.int/countries/ken/. Accessed Nov 2, 2020.

[5] Quaife M et al. "The Impact of COVID-19 Control Measures on Social Contacts and Transmission in Kenyan Informal Settlements." BMC Med. 2020;18(1): 1-316.

[6] Yusuf M. Voices of America. "Kenya Sees New Surge of Coronavirus After Easing Restrictions." https://www.voanews.com/COVID-19-pandemic/kenya-sees-new-surge-coronavirus-after-easing-restrictions Accessed Oct 19, 2020.

PMA | GENDER
PERFORMANCE MONITORING FOR ACTION