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Ma, Richard; Foley, Kimberley; Saxena, Sonia

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Experiences of access and use of contraceptive care during covid-19 lockdown in the United Kingdom: a web-based survey

Dr Richard Ma MRCGP DrPH

Dr Kimberley Foley PhD

Professor Sonia Saxena FRCGP MD

Child Health Unit, Department of Primary Care and Public Health, Imperial College London, Charing Cross Campus, Reynolds Building, St Dunstan's Road, London W6 8RP

Corresponding author: r.ma@imperial.ac.uk

Twitter: @Richard_GP @GP_SexualHealth

Abstract

(250 words)

Background

The first wave of lockdown measures to control the covid-19 pandemic in the United Kingdom (UK) resulted in suspension of "non-essential" services including contraception.

Aim

To examine women's perceptions and experiences of contraceptive care in the UK during the first lockdown.

Design & setting

Cross-sectional survey during lockdown period from March to June 2020.

Method

We designed an online questionnaire asking women aged 16 to 54 their experiences of contraceptive care during lockdown. Questions were based on Maxwell's evaluation framework on access, acceptability, relevance, and equity. It was promoted on social media from 27th May to 9th June 2020. We conducted descriptive analysis of quantitative data and thematic analysis of free text data.

Results

214 responses were analysed. General practice was the source of contraception for 43% and 52% of respondents before and during the lockdown respectively. 55% (118/214) of respondents including regular and new users were uncertain where or

how to get contraception during the pandemic. Respondents reported reduced access to contraception during lockdown, some thought sexual health clinics and general practices were closed.

Remote consultations and electronic prescriptions facilitated contraceptive access for some respondents. Long-acting reversible contraception (LARC) was unavailable in some areas due to restrictions, alternatives were not acceptable to those who used methods for non-contraceptive benefits to treat medical conditions e.g., menorrhagia.

Conclusions

Our study highlighted the need for better information and signposting for contraception during lockdown. Contraception including LARC should be reframed as an essential service with robust signposting for pandemic planning and beyond.

Keywords (MeSH):

SARS-CoV-2, covid-19, contraception, general practice, health services research, surveys and questionnaires

How this fit in:

- Lockdown measures to contain covid-19 reduced access to routine health services globally, including contraceptive care which was not regarded as “essential service” in some countries such as the UK.
- This is a survey of women’s perceptions and experiences of contraceptive care during the first UK lockdown from March to June 2020.
- We found over half (55%, 118/214) of respondents were unclear about how to access contraception during lockdown as they thought general practices and sexual health clinics were closed.
- Remote contraceptive consultations were helpful during the lockdown, but women wanted better signposting for contraception and access to long-acting reversible contraception (LARC).

Background

Widespread containment measures such as national lockdowns to control the SARS-CoV-2 pandemic resulted in reduced access to routine health services globally, including contraceptive care. In many countries including the United Kingdom (UK), much of primary care including contraception and long-term conditions management were deprioritised. A systematic review of over 20 countries reported healthcare use fell by about a third during the pandemic. (1, 2)

The UK government introduced the first national lockdown measures from 23rd March 2020 to deal with the first wave of SARS-CoV-2 infections spreading in the community. Each of the devolved UK nations applied different measures and eased them at different times; the restrictions in England were eased in June 2020.(3-5) General practices were advised to use total triaging and remote models to assess clinical need for face-to-face consultations in the first wave of lockdown.(6) The triaging measures resulted in one third fewer appointments in general practices in April and May 2020 overall compared with the previous year as more remote consultations were adopted.(7) These restrictions were relaxed in subsequent lockdowns. Among the advice from the UK Royal College of General Practitioners and British Medical Association on reprioritisation of clinical services was contraception could continue “if possible” and provision of long acting reversible contraception (LARC) such as injections and implants should stop.(8)

Before the pandemic, the proportion of conceptions leading to abortions had been increasing, suggesting unmet need and access to contraception were already a problem for women of reproductive age (16 to 54 years) in the UK.(9) Further disruption to contraceptive provision would have had adverse impact on unwanted pregnancies particularly among young and vulnerable groups, not least because general practice had always been a significant provider of contraceptive services.(10, 11) This concern was not unique to the UK as a global survey of health providers, researchers and policy makers conducted in May 2020 reported women’s health would suffer because of reduced contraceptive provision.(12)

A survey of women’s access to female healthcare services in the UK conducted during the pandemic reported poor signposting about which contraception and sexual health (CASH) clinics were open and what was available in their area.(13) However, it did not specifically report access to LARC, and responses were limited to structured survey questions. In addition to reduced access to contraception in general, we speculated the curtailment of LARC and recommendations to use different methods such as condoms led to unmet contraception needs for some women during lockdown. Little is known about the impact of lockdown for women of reproductive age (16 to 54 years) and their experiences on contraceptive access, especially LARC. The aim of this study therefore was to examine the impact of the first wave of covid-19 lockdown on access and experience of obtaining contraception from providers in the UK, especially primary care. This survey was conducted in a short time frame to submit to a UK Cross-Party Parliamentary Inquiry into contraceptive care during the pandemic.(14)

Method

We designed a semi-structured online questionnaire which included free text comments to examine contraceptive care experienced by our target population of women aged 16 to 54 years who were using or seeking contraception during the first covid-19 pandemic lockdown (Supplementary Figure 1). We developed questions on access, acceptability, relevance, and equity (Table 1), based on Maxwell's dimensions of quality; this framework has been used to evaluate contraceptive services in the past.(15, 16) We speculated three scenarios when women would need contraceptive care from providers during the pandemic: women who were not on contraception at the time of the survey but were considering their options; those who obtained contraception before the lockdown and needed a change or repeat prescription; and those who obtained contraception during the lockdown. Using adaptive questioning (where the sequence of questions depended on the answers given), respondents were streamed to one of these three mutually exclusive groups according to their contraceptive use at the time of the survey to ensure the questions were relevant.

We used Qualtrics software (version May 2020, copyright © 2020 Qualtrics, Provo, UT, USA https://www.qualtrics.com) to create questionnaire materials and piloted the draft survey with several members from a patient and public involvement (PPI) group. After feedback we made changes including addition of lactational amenorrhoea method (LAM) and correction of an adaptive question. We separated the depot progestogen contraceptives "Depo Provera" and "Sayana Press" because the latter could be self-administered, so did not require a face-to-face appointment with a healthcare professional. Further information about the survey is in the CHERRIES (Checklist for Reporting Results of Internet E-Surveys) reporting checklist.(17) No incentives were given for completion, participation was voluntary, and respondents could withdraw at any time. We promoted the survey on social media (Twitter, Facebook, and Instagram) (Supplementary Figure 2, Supplementary Figure 3 and Supplementary Figure 4). The survey went live for two weeks from 27th May 2020 until 9th June 2020.

We analysed data using Microsoft Excel and NVivo to organise free text data for thematic analysis (NVivo 12, 2019 QSR International). RM and KF analysed the free text data independently, then compared the findings noting any convergence, complementarity or discrepancy.(18) We prepared our manuscripts using two reporting frameworks – CHERRIES and STROBE (Strengthening the Reporting of Observational Studies in Epidemiology).(17, 19)

Results

Respondent profile

There were 363 visits to the survey site from 352 unique IP addresses between 27th May 2020 and 9th June 2020. 277 respondents consented and agreed to participate, 59 did not answer the demographic questions, resulting in completion rate of 78.7%

(218/ 277); we excluded 4 cisgender men from this sample to make 214 eligible respondents (Supplementary Figure 5).

Respondents were aged between 16 to 54 years (Supplementary Table 1); the largest age group was 16 to 18 years (n=70, 32.7%), smallest was 45 to 54 years (8, 3.7%); there were respondents from all UK regions with largest from South East England (31, 14%) and smallest number from Northern Ireland (6, 3%).

We analysed responses based on three groups of respondents as described earlier: those looking to start contraception during lockdown, those who needed a repeat supply or change of methods and those who obtained contraception during lockdown. Figure 1 summarises contraception methods sought or used by these three groups; the size of each box corresponds to the number of women using or seeking that method. Over half of the respondents (55.1%, 118/214) anticipated or experienced contraceptive supply problems during the lockdown. Importantly, these women were from all three mutually exclusive groups as shown in Figure 2 (Sankey diagram) and Table 2.

Respondents looking to start contraception during lockdown

36 out of 214 respondents (16.8%) were not using contraception at the time of the survey and were seeking a contraceptive method (Figure 1 and Table 2). The combined oral contraceptive pill (COCP) and male condoms (both n=8, 22.2%) were the most sought methods; 39% (14/36) seeking LARC. Two thirds (n=24) perceived or had difficulties getting their preferred contraceptive methods during lockdown (Figure 2 and Table 2); reasons given included CASH clinics or general practices were not offering appointments to administer LARC, no option for remote consultations, and not being in their usual area of residence.

Respondents on contraception before lockdown needing a change or repeat prescription

178 out of 214 respondents (83.2%) reported using at least one method of contraception at the time of the survey (Figure 1 and Table 2). The COCP was the most used method (55/178, 30.9%), 29% were using a form of LARC.

63.5% (113/178) had obtained contraception before the lockdown and were looking for repeat prescription or change of method (Table 2). They obtained their contraception before lockdown from general practices (43.4%, 49/113) and contraception and CASH clinics (38, 33.6%). 67 (59.3%) anticipated or reported problems getting further supplies during the lockdown (Figure 2 and Table 2); reasons given include: their general practice/clinic was not offering appointments, not knowing how to arrange a consultation and not able to justify it as an “emergency” to use health services during lockdown.

Respondents on contraception obtained during lockdown

36.5% (65/178) of the respondents who were using contraception at the time of the survey obtained it during lockdown (Figure 1 and Table 2); these included new or repeat prescriptions. COCP was most used method (30/65, 46.2%), followed by POP (17/65, 26.2%) and male condom (10/65, 15.4%). Fewer respondents reported using LARC during lockdown than before (11% vs 40%). Over half of this group obtained contraception from general practice (34/65, 52.3%); CASH clinics dropped from most common source of contraception before lockdown to fourth during lockdown (Table 2).

Importantly, even though this group obtained contraception during lockdown 41.5% (27/65) were uncertain where or how to get their next repeat prescription (Figure 2); reasons included general practice/clinic was not offering any appointments (9, 33.3%), general practice/clinic was not offering remote consultations, not knowing how to get a check-up (e.g., blood pressure) and prescription.

Free text analysis

We received a total of 59 free text responses to the survey; the text is summarised as a word cloud (Supplementary Figure 6) and they are divided into the following themes: access, acceptability, relevance/appropriateness, and equity.

Access

Respondents, especially those staying away from their usual residence during lockdown, reported how useful it was that general practices and CASH services offered remote consultations for assessment and mailed or used Electronic Prescription Service (EPS), this is a paper-free method to send prescriptions to a nominated pharmacist to issue contraceptives.(20) Just under half of the free text comments on access were about poor signposting as they did not know who to call or contact to get contraception. One had to travel a longer distance to obtain LARC due to closure of nearby clinic.

Acceptability

A couple of respondents were unhappy about changing from their usual and reliable methods to condoms. Respondents who wanted LARC reported clinics were suspended so had to use other less preferred contraceptive methods.

Relevance/ Appropriateness

Getting contraception was challenging for those staying away from their usual residence who were unfamiliar with local services, those with anxiety who were unable to go out, and young people staying with parents during lockdown.

Respondents using methods with non-contraceptive benefits to treat medical conditions (e.g., COCP for acne and IUS for heavy menstrual bleeding) were unable to access them and that meant their symptoms were prolonged or untreated.

Equity

A couple of respondents felt it was unfair when blood tests and childhood immunisations continued during lockdown but not contraceptive injections or implants. Four reported paying for contraception from online pharmacies; two had to buy their own condoms which would have been free from CASH clinics before the lockdown.

Discussion

To our knowledge, this is the first peer-reviewed study of women's access and experiences of contraceptive care during the first wave of covid-19 lockdown in the UK. We found over half of all respondents reported perceived or actual difficulties in obtaining contraception during the pandemic; some reported clinics were shut, and remote consultation was not available. Some of those who obtained contraception during the lockdown were not able to get their preferred method or had to use less reliable methods. General practice was an important source of contraception during the first lockdown. Remote consultations and prescriptions sent by mail or electronically to a pharmacy were especially welcome for those staying away from their usual residence during lockdown.

In the early phase of the pandemic, professionals and policy makers reported concerns regarding the impact of covid-19 on access to sexual and reproductive healthcare globally in high-, middle- and low-income countries. Our study validated this concern but also gave examples of how access could be maintained and improved.

Findings compared with previous studies

Our findings are consistent with reports from other countries that access to contraception was challenging for women during covid-19 pandemic. That some of the respondents were unsure how to access contraception, thought clinic were shut and methods such as LARC were unavailable, were similar to those from an online survey of young people aged 16 to 24 years in Scotland who also thought they could not justify their reproductive needs as "essential"; remote consultations also raised privacy concerns while residing with their parents.(21) Another from Australia reported lack of access to methods due to restrictions, particularly LARC products.(22) Over half of women surveyed in USA experienced barriers to accessing their preferred contraception method as some facilities were closed; the pandemic also worsened existing inequalities to contraception in a country with no universal access to healthcare, particularly for women from Black and Hispanic communities and with lower income.(23, 24)

Strengths and limitations

Online surveys are subject to selection bias and validity of questionnaires used, especially so during this pandemic.(25) Our findings need to be interpreted with caution as we did not use a probability sample that was representative of the UK population; there was underrepresentation of respondents from outside London and

South East England as well as those aged 35 and over. Adolescents between ages of 16 and 18 years old were overrepresented and might have had different contraceptive needs to other age groups.(26, 27) The use of an online survey might have excluded those who might not have used social media regularly, who had sensory impairment or language difficulties. It is possible our findings underestimated the true extent of the issues.

Despite a small non-probability sample, we captured women's experiences from four countries of the UK and from a wide age range. The use of descriptive and free text analysis also offered first-hand insights into the experiences of women getting contraception during the lockdown including both actual and perceived difficulties with access. The high completion rate reduced the risk of reporting bias and reflected the survey's relevance for respondents and the ease of administration. Our findings were also consistent with women's experiences from surveys conducted in other countries during this pandemic.

Implications for policy and practice

Our findings might have useful contributions to the planning of future pandemics. We found the impact of poor signposting was not unique to just one or two groups and perceived problems with access could be a barrier to contraceptive care. A recent study reported higher proportions of unplanned and ambivalent pregnancies conceived during compared with before lockdown in the UK. (28) More effective campaigns about access to contraception and support could have prevented some of these unplanned pregnancies; this includes awareness of other venues for advice such as community pharmacies, which has played an important role during lockdown in the US.(29)

Digital access has emerged as an important innovation to meet the challenge of healthcare during this covid-19 pandemic; our study findings suggest it is also relevant for reproductive health and access for young people.(30-32) However, they do not offer solutions to those unable to use digital technology due to language or sensory barriers, and for LARC access.

Lastly, the lockdown measures produced a situation where women in postnatal period could not get a contraceptive injection, but their babies were able to get their vaccinations. This illustrated how the pandemic has exacerbated inequalities as healthcare assess for some groups were prioritised over women and other vulnerable groups; for example, there was unequal access due to affordability and those with long distances to travel and those who are less likely to use digital access.(23) Mitigation measures also need to be consistent and fair to different population groups to reduce further inequalities.

Conclusions

Our study highlighted the need for better information and signposting to obtain free contraception during lockdown restrictions. Contraception including LARC should be reframed as an essential service with robust signposting for pandemic planning and beyond.

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Ethical approval

This survey was deemed to be a service evaluation by the UK Health Research Authority so did not require formal ethics approval.

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Competing Interests

The authors have no interests to declare.

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Table 1. Maxwell's evaluation dimensions and related sources of data from survey

Dimension	Survey questions
Access	"Where did you get your method of contraception?" "Do you expect any problems getting future supplies?" "Were you able to obtain contraception that you wanted (before/after lockdown)?"
Acceptability	"Did you have any problems getting your supply?" "Were you happy with the alternative method?"
Relevance/ appropriateness	Survey question: "Did you get the method you wanted/needed?
Equity	Demographic data e.g., age, sex, location and if this was the usual place of residence during lockdown.

Table 2. Summary of respondents' contraceptive use and needs

Respondents grouped by contraceptive use at time of survey	Using contraception method		Not using contraception method
	Obtained before lockdown, n (%)	Obtained during lockdown, n (%)	Sought during lockdown, n (%)
Method used or sought			
COCP	25 (22.1)	30 (46.2)	8 (22.2)
Male condoms	25 (22.1)	10 (15.4)	8 (22.2)
Implant*	23 (20.4)	0 (0)	5 (13.9)
IUD*	5 (4.4)	1 (1.5)	5 (13.9)
POP	14 (12.4)	17 (26.2)	3 (8.3)
IUS*	13 (11.5)	2 (3.1)	2 (5.6)
Depo Provera*	3 (2.7)	4 (6.2)	2 (5.6)
Patch	1 (0.9)	0 (0)	1 (2.8)
NFP	2 (1.8)	0 (0)	1 (2.8)
Sterilisation	0 (0)	0 (0)	1 (2.8)
Sayana Press*	1 (0.9)	0(0)	0 (0)
EHC	1 (0.9)	1 (1.5)	0 (0)
LAM	0 (0)	0 (0)	0 (0)
Total	**113 (100)**	**65 (100)**	**36 (100)**
Source of method			
General practice	49 (43.4)	34 (52.3)	N/A
CASH clinics	38 (33.6)	6 (9.2)	N/A
Supermarket	11 (9.7)	4 (6.2)	N/A
Online	8 (7.1)	9 (13.8)	N/A
Hospital	3 (2.7)	1 (1.5)	N/A
Abortion clinics	2 (1.8)	1 (1.5)	N/A
Pharmacists	1 (0.9)	10 (15.4)	N/A
Other	1 (0.9)	0 (0)	N/A
Total	**113 (100)**	**65 (100)**	**N/A**
Concerns about supply	67/113 (59.3)	27/65 (41.5)	24/36 (66.7)
Reason			
No LARC at clinic/general practice	0 (0)	0 (0)	14 (58.3)
Other reasons (free text comment)	13 (19.4)	7 (25.9)	5 (20.8)
Not familiar with local services	6 (9.0)	5 (18.5)	2 (8.3)
No remote consult at clinic/ general practice	0 (0)	9 (33.3)	2 (8.3)
No contraceptive injection at Clinic/general practice	0 (0)	0 (0)	1 (4.2)
No appointments at clinic/ general practice	48 (71.6)	6 (22.2)	0 (0)
Total	**67 (100)**	**27 (100)**	**24 (100)**

COCP: combined oral contraceptive pill, POP: progestogen-only pill, IUD: intra-uterine device, IUS: intra-uterine system, NFP: natural family planning, EHC: emergency hormonal contraception LAM: lactational amenorrhoea method

*Long-Acting Reversible Contraceptive (LARC) methods

Figure captions:

Figure 1. Tree diagram summarising contraception used or sought by respondents at the time of survey. Size of each box corresponds to the number of women using or seeking that method.

Figure 2. Sankey diagram summarising concerns about contraceptive supplies among the three groups of respondents: those using contraception obtained before or during lockdown, and those not using but were seeking a method

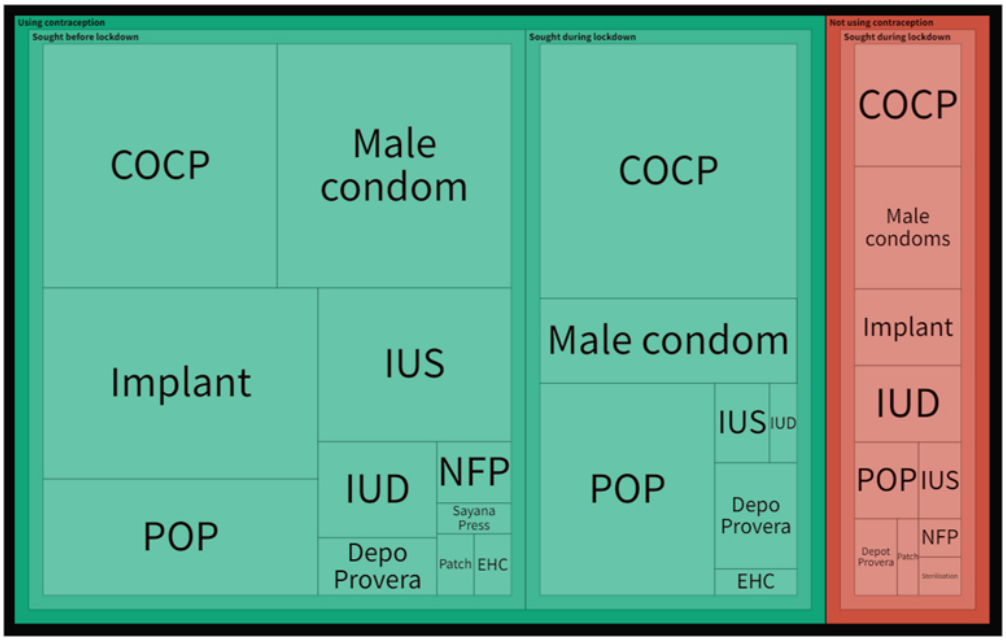

Figure 1. Tree diagram summarising contraception used or sought by participants at the time of survey. Size of each box corresponds to the number of women using or seeking that method.

COCP: combined oral contraceptive pill, POP: progestogen-only pill, IUD: intra-uterine device, IUS: intra-uterine system, NFP: natural family planning, EHC: emergency hormonal contraception LAM: lactational amenorrhoea method. Long-Acting Reversible Contraceptive (LARC) methods include: implant, IUD, IUS, Depo Provera/Sayana Press

515x326mm (38 x 38 DPI)

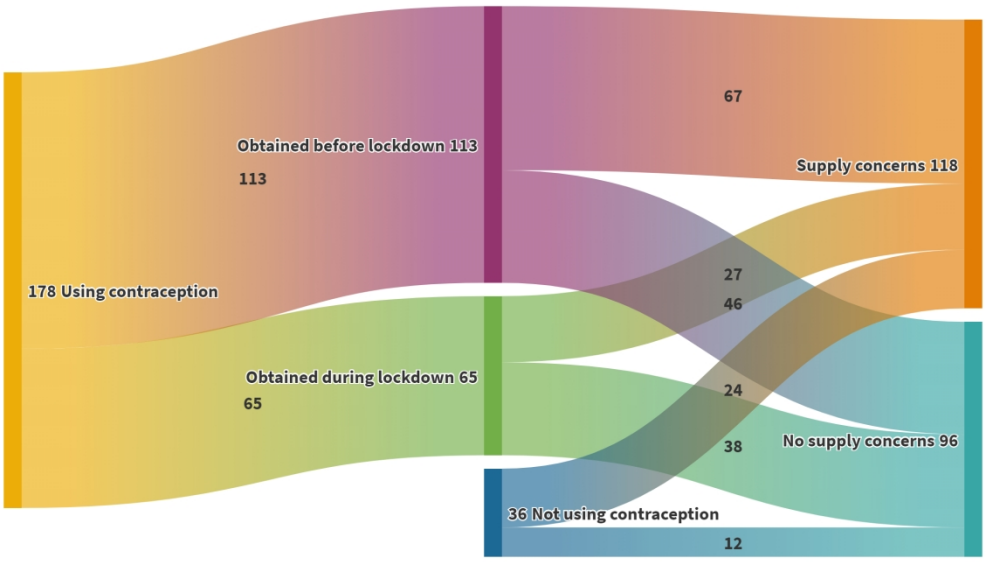

Figure 2. Sankey diagram summarising concerns about contraceptive supplies among the three groups of respondents: those using contraception obtained before or during lockdown, and those not using but were seeking a method.

788x458mm (72 x 72 DPI)