NIHR Public Health Policy Research Unit

Understanding the impacts of the COVID-19 pandemic on women's access and attitudes to contraception in England

Final report

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Key points

- This study was commissioned by the Department of Health and Social Care through the National Institute for Health and Care Research (NIHR) Public Health Policy Research Unit to understand women's access and attitudes to contraception in England since the start of the COVID-19 pandemic.

- The study examined women's recent experiences of accessing contraception and how the COVID-19 pandemic has impacted on women's attitudes, preferences, and decision-making around contraception. It suggests recommendations for maximising contraception uptake (with a focus on long-acting reversible contraception (LARC)). To address the aims of this work we spoke with 33 women in England. Thirty-one had accessed contraception since the start of the COVID-19 pandemic (March 2020).

- The COVID-19 pandemic made it easier for some women to access contraception through the delivery of free condoms, being able to administer injections themselves at home, and remote consultations. The COVID-19 pandemic made access challenging when a face-to-face consultation was required, due to service closures or appointment difficulties. Some were unable to get the contraception they wanted.

- Women had different preferences for where they accessed contraception and highlighted the benefits and drawbacks of accessing contraception at both the General Practice (GP) and the Sexual Health Clinic (SHC). Experiences at the pharmacy were mostly favourable.

- Women had different preferences for how they access contraception based on their needs and circumstances. Many women had embraced the increased use of remote methods implemented during the COVID-19 pandemic, however, there were reports of remote contraceptive counselling that felt rushed and awkward.

- Women told us their perceived benefits and drawbacks to each contraception method. Benefits of LARC included convenience and longevity, yet many women worried about invasive and painful LARC fitting procedures. Some women were keen to avoid perceived side effects of hormonal contraception and were put off using LARC because they said it might be difficult to get it removed if it did not suit them.

- Women said that the NHS website was useful as a first point of reference to obtaining information on contraception methods and side effects, but they wanted to hear about other women's lived experiences. Many used other online sources, forums, and social media to answer their questions.

- Recommendations included: to ensure systems for booking appointments or remote consultations are user friendly; provide systems for women to express their preferences and receive in-person support where they feel they would benefit; to increase awareness of free services; provide reassurance and support around pain management for LARC fitting; and explore opportunities to communicate with women through social media.

Executive summary

Background

This study was commissioned by the Department of Health and Social Care through the NIHR Public Health Policy Research Unit to understand the factors which affect women's access and attitudes to contraception in England given the shifting landscape of service delivery.

Aims

The research aimed to:

1. Examine women's experiences (and barriers and facilitators) of accessing contraception services since the start of the pandemic, both for new users of contraception and those with prior experience, and to understand any inequalities of access by skewing our sample towards IMD 1 and lower educational attainment.
2. Explore how the COVID-19 pandemic and resultant changes in the landscape of service provision has impacted on women's attitudes, preferences, and decision-making behaviour around contraception.
3. Develop recommendations for maximising contraception uptake, including access, delivery, and communication needs (with a focus on LARC).

Methods

To address the aims of this work we conducted telephone interviews with 33 women aged 17 to 54 years in England. Of these women, 31 had accessed contraception since the start of the pandemic (March 2020). The sample was mixed in terms of age, ethnicity, whether they were new users of contraception or had accessed contraception before the pandemic, contraception methods used, and how they had accessed contraception. The sample was purposely skewed toward women with lower educational attainment and IMD 1.

Key findings

Accessing services

- The pandemic prompted easier access to some methods of contraception, through the delivery of free condoms, pharmacy provision of contraceptive injections for those who were comfortable self-administering at home, and remote consultations for those who were happy with their current method and required no contraceptive counselling.
- The pandemic posed challenges for methods which required a face-to-face consultation such as LARC due to service closures or difficulty in getting appointments. Particular access challenges were faced by women using the injection. Unable to get a GP appointment during lockdown, they either received no signposting to pharmacy provision of injections, ran into issues with pharmacy provision (discontinuation of products), or felt uncomfortable injecting themselves.

General Practice Provision

- Some women reported positive experiences of discussing contraception with their GP. Some said accessing via the GP felt "discreet" and "more familiar" than the Sexual Health Clinic (SHC).
- Some expressed frustration at the complexity of post-pandemic processes, were unable to get their preferred contraception, or described experiences as impersonal.

Sexual Health Clinic

- Those that had experienced SHCs expressed how "comfortable" they had felt, as SHC practitioners took the time to explain different options and listened to their needs.
- Some women felt SHCs were inaccessible for a variety of reasons, or that there was stigma attached, or had little awareness of them.

Pharmacy provision

- Many women liked how "easy" accessing contraception at the pharmacy was. It was described as "quick" and "straightforward" compared to the GP. A few women recalled having helpful discussions with pharmacists about contraception.
- During COVID, a small number of women reported issues around changes to opening hours and being unable to get emergency contraception from certain pharmacies.

Mode of access

- Remote methods were useful for repeat prescriptions. In-person appointments were useful for asking questions and were better suited to women who were accessing contraception for the first time or required contraceptive counselling.
- Many women had embraced the increased use of remote methods to access contraception, reporting that these were convenient to use.
- Some found it challenging to use remote methods and said that appointments felt more rushed over the telephone.

Significant timepoints and life stages

- Some women accessing contraception for the first time, reported challenges getting adequate support and guidance during the pandemic.
- Conversations about contraception following an abortion, STI check, or use of the morning after pill were particularly helpful for some women.
- Older women reported uncertainty about contraception as they faced menopause.

Women's Health Hubs (WHHs)

- The concept of WHHs was viewed positively. Women of all ages perceived WHHs as a safe place, where practitioners would have in-depth knowledge on contraception.
- A small number of women had concerns related to inclusivity and gender identity.

Current attitudes and preferences towards contraception methods

- While easily accessible during the pandemic, some worried about the user-dependent nature of less-effective methods. For instance, remembering to take the pill every day or placing trust in a partner when using condoms.

- Perceived benefits of LARC included convenience and not having to worry about contraception. Many women were concerned about coil fitting procedures. Pain around having a coil fitted was a significant concern among many women.
- Some women were keen to avoid perceived side effects of hormonal contraception but felt there was a lack of non-hormonal contraception options.
- Some perceived that it might be difficult to get a coil or implant removed if it did not suit them due to GP waiting times or practitioners being hesitant to remove.
- Many women had experience of accessing the morning after pill, described as an "easy" process at the pharmacy. Affordability was a particular barrier to access.
- Period tracker apps such as 'Clue' and 'Flow' were popular among the women. A few had used or were interested in using the fertility app 'Natural Cycles' as non-hormonal methods that adopted a more "natural" approach were appealing to them.

Decision making

- Some recalled useful discussions with health practitioners. Others were confident in sourcing information and weighing up the pros and cons of different methods.
- Some women found decision making hard. They felt they had limited options, or that the decision was overwhelming. Women said they felt more confident in discussing contraception as they got older.
- Most women described the importance of their friends, family, or partners in helping them to form their views and decisions.

Sources of information

- Women were proactive in searching for contraception-related information. The NHS website was described as "credible", but impersonal and "dry".
- Women wanted to hear about other women's lived experiences. Many turned to other online sources, forums, and social media to answer their questions.
- Some older women felt that contraception had become less of a taboo subject as society had changed and conversations had become more open.
- Contraception was considered a taboo subject among people from ethnic minority and religious backgrounds.
- Some women from ethnic minority backgrounds highlighted the importance of translating information into other languages and across more traditional formats of communication such as leaflets.

Recommendations for policy

Access

- Improve awareness of the availability of different methods, including LARC, across all ages and advise GPs to discuss a variety of options (not just the contraceptive pill and the implant) to ensure women have access to all methods of contraception.
- Improve awareness about the benefits of accessing contraception at SHCs and how to make an appointment, particularly for younger women or those less likely to attend the GP to access contraception.
- Tackle stigma around SHCs by focusing on the positive accounts of SHCs from women who have used them and framing the SHC as a specialist service that is superior to the GP for accessing all contraception methods, especially LARC.

- Clarify post-pandemic processes on how and where to access contraception to alleviate any confusion caused by COVID-19 related policy and practice changes.
- Increase the availability of appointments for contraception, especially LARC procedures, and have systems in place to ensure women are signposted to a nearby service where they can get a LARC appointment if it is not available or there are long waiting times at their current point of access.
- Review SHC and GP booking systems to make them more user-friendly and create more access points to address barriers associated with lengthy waiting times when booking appointments by phone or attending drop-in centres.
- Policy should consider increasing pharmacy provision of free contraception without a prescription to include emergency contraception. The women expressed how easy and convenient accessing contraception at the pharmacy was and capitalising on this approach to contraception provision could reduce demand at GPs and SHCs.

Delivery

- Invest in education and training for GPs and practitioners to identify significant time points and life stages when women would benefit from increased contraceptive support and improved interactions at these time points. For instance, when accessing contraception for the first time, in the postpartum period, during perimenopause, following an STI test, or after accessing an abortion or emergency contraception.
- SRH services should offer additional support or contraceptive counselling to those who accessed contraception for the first time during the pandemic as restrictions around policy and practice most likely impacted their experience of accessing contraception and they may be unsatisfied with their current method of contraception.
- Invest in education and training for GPs and practitioners to ensure they take symptoms seriously and do not dismiss the concerns of women who are experiencing side effects that may be caused by their contraception. Women with concerns should be offered contraceptive counselling, preferably in-person, and if the GP or practitioner is unable to provide this, a referral should be made to a SHC or specialist service.
- Ensure remote systems and consultations that were introduced during the pandemic remain available for women who favoured the ease and convenience of these modes of access and strive to make these more user-friendly to encourage more women to switch to accessing contraception this way when appropriate.
- GPs and other SRH-related services should continue to provide in-person consultations for women who prefer to access contraception this way. Choice is valuable and it is important that women have the option to receive in-person support when they feel they would benefit from this.
- Build on women's positive experiences in pharmacy settings by increasing pharmacy provision of contraception and utilise staff working in pharmacies as they are more likely to engage with women in the community who may not attend GPs or SHCs.
- Policy should consider how to offer extra support for women who have tried multiple methods of contraception but are unable to find one that has no adverse effect on their physical or mental health and wellbeing and for women with conditions of the reproductive system (e.g., PCOS, endometriosis, fibroids), migraines, or menstrual

disorders, as they face additional challenges when deciding which contraception method is best for them.

Communication

- Consider implementing systems to remind women when replacement contraception is due, especially for LARC, as women were uncertain on the expiry dates of their devices and risk being unprotected from pregnancy.
- Fill the gap in current NHS material to make the information more personal and relatable. Women would like to hear about other women's lived experiences of using each method of contraception and any associated side effects.
- Utilise women's engagement with social media to communicate the benefits of LARC to all women but especially young women and women from ethnic minorities, while providing reassurance and support around pain and pain management of LARC procedures.
- Develop 'myth-busting' information to counter the negative impact of social media on younger women's perceptions of hormonal contraception, especially the contraceptive pill (referred to as the "devil's pill") and increased online content of LARC "horror stories".
- Implement online and traditional marketing campaigns to increase awareness of free contraception services, especially emergency contraception and condoms, with a view to targeting those who may be most affected by cost barriers such as younger women and women living in deprived areas.
- Incorporate a diverse group of contraception 'advocates' and 'ambassadors' into information sources so women from all ages and backgrounds can feel represented in their contraception needs. Women from ethnic minorities were hesitant to use more effective methods of contraception and may benefit from receiving information from an 'advocate' of LARC they can relate to.
- Translate information on contraception methods, how to access contraception services, and postpartum contraception, and make these available to women whose first language is not English. More traditional formats such as leaflets are the preferred method of communication for translated information, and these should be readily available in places the women already access.
- Consider the feasibility of providing interpreters for women whose first language is not English for all contraception appointments, and at antenatal and post-natal appointments to discuss contraception in the postpartum period.
- Schools should review the curriculum to ensure all methods of contraception are discussed with all pupils to tackle the perceived gender imbalance around contraception. Schools should provide practical information on how to access contraception, for instance, where the nearest SHC is and how to make an appointment.

1. Introduction

1.1 Background to the research

Women's access and attitudes to contraception are crucial for their reproductive health and overall health and wellbeing. Access to contraception allows women to make informed decisions about their sexual and reproductive lives, prevent unintended pregnancies, and reduce the risk of sexually transmitted infections (STIs). Contraception can also be used for non-contraceptive purposes to promote menstrual wellbeing and treat reproductive conditions. [1] Women's attitudes towards contraception play a significant role in their use of, and adherence to, contraceptive methods, as well as their overall reproductive health outcomes. Evidence suggests that the need for sexual and reproductive health (SRH) services remained high during the COVID-19 pandemic (hereafter referred to as the pandemic), despite lockdowns.[2,3] However, the pandemic presented significant challenges to the delivery of these services, and led to changes in how they are delivered and used.[4] Whilst service providers in England rapidly adapted to continue to provide services throughout the pandemic response [5], there has inevitably been an impact on women's contraceptive choices and access. The pandemic prompted a shift towards accessing SRH-related services remotely rather than in person, and there is evidence to suggest access has become more challenging for some people.[3] Evidence also suggests that young adults, who experience the greatest burden of STIs and unintended pregnancies, have been disproportionately impacted by service closures and changes.[3]

Before the pandemic, strategies to increase long-acting reversible contraceptive (LARC) prescribing led to increased uptake of this highly effective method.[6,7] Data for LARC prescribing in England 2020/21, however, indicated substantial declines in both GP prescribing and LARC access via specialist SRH services compared with the previous year.[7] The decrease in GP prescribing and LARC access was accompanied by declines in contraception-related contacts with SRH services, declines in prescribing of short-acting hormonal contraceptives and contraceptive injections, [8] and an increase in unplanned pregnancies.[9] During the pandemic, the Faculty of Sexual and Reproductive Healthcare (FSRH) deemed it essential that women be able to access contraception.[10] Depending on the method, women may have been asked to switch to another method temporarily, and some services for LARC removal and insertion were stopped or delayed.[10-12] A study conducted in October 2020 found that just over half (51.1%, 93/182) of contactable clinics in England offered an appointment for LARC fitting within two weeks (as per FSRH standard), with significant regional variation. [13] A change from face-to-face to routine online provision further changed GPs' prescribing. Without patients' blood pressure and weight measurements, GPs reduced prescriptions for oestrogen-containing combined oral contraceptive pills but maintained their prescriptions for the progestogen-only-pill which do not require face-to-face consultation.[14]

Research suggests that women were uncertain where or how to access contraception during the pandemic.[11,15] Young people also reported uncertainty about whether access to SRH care was an 'essential' need during the pandemic, inconsistencies with previous advice, and greater barriers in navigating the system.[12] Increased remote service provision allowed continued access to some contraception methods. While this was important in meeting

some challenges of the pandemic, it may have unintentionally widened health inequalities. Lack of digital access, confidence or literacy, may exclude those most vulnerable and marginalised because of their socio-economic position.[4,16]

1.2 Research aims

The overall aim of the study was to gain an understanding of the factors that affect women's access to, and attitudes towards, contraception given the shifting landscape of service delivery. We were commissioned by the Department of Health and Social Care to explore these factors. Such understanding is essential for developing effective policies and programs that promote women's reproductive health and empower them to make more informed choices about their bodies and lives.

The specific aims were:

1. To examine women's experiences (and barriers and facilitators) of accessing contraception services since the start of the pandemic, both for new users of contraception and those with prior experience, and to understand any inequalities of access by skewing our sample towards IMD 1 and lower educational attainment.
2. To explore how the COVID-19 pandemic and resultant changes in the landscape of service provision has impacted on women's attitudes, preferences and decision-making behaviour around contraception.
3. To develop recommendations for maximising contraception uptake, including access, delivery, and communication needs (with a focus on LARC).

2. Methodology

2.1 Study design

To explore women's access and attitudes to contraception since the pandemic, we aimed to conduct in-depth semi-structured telephone interviews with 30 women in England who had accessed contraception services since the start of the pandemic (March 2020). The study was informed by two online public consultation groups with nine women, conducted in November 2022, split by age (18-24; 25-54). Each group was facilitated by two members of the research team. This allowed vital input from women, provided a preliminary understanding of the main issues from their perspective, and helped inform the interview topic guide. Telephone interviews were selected for effective data-gathering across sample criteria whilst minimising participant burden and offering greater anonymity while discussing a potentially sensitive topic. The study received approval from the Stirling University General University Ethics Panel (GUEP 10259).

2.2 Sample and recruitment

Participants were recruited from the general public through a GDPR compliant market research (MR) agency which operates a research panel with UK adults (aged 16+). To ensure a spread of demographic characteristics, minimum quotas were placed on the following: age group; whether women had only accessed contraception since March 2020 (new users) or

they had accessed contraception services before and after March 2020; educational attainment level; and Index of Multiple Deprivation (IMD) quintile score (skewed towards those with lower educational attainment and IMD 1). We also aimed for diversity in the types of services accessed, contraception method, and ethnicity. (The same MR agency recruited women for the two public consultation groups.)

All recruitment procedures were facilitated by the MR agency. Members of the MR agency's panel who fitted the demographic profile for our study sample were invited by email to take part. A short advert about the study was also posted on the MR agency's webpage. Interest in participating and eligibility were assessed via a short online recruitment questionnaire. Those selected to take part were followed up by the MR agency and invited to complete a copy of the online consent form, and a suitable time for a telephone interview was arranged. Informed participant consent was obtained by the MR agency prior to each interview.

The final achieved sample was 33 women (Table 1). In total, 31 women had accessed contraception since March 2020. Eight were new users of contraception services. During the interviews, it became apparent that two had not accessed contraception since March 2020, and one woman's phone cut off early in the interview. We retained the data for these three participants in the study, however, as their attitudes towards contraception and contraception services were still useful. We spoke with a good mix of women aged between 17 and 54 years in terms of ethnicity, locality, educational attainment, IMD, contraception method since March 2020, usual services accessed, and mode of access.

Table 1 *Sample*

Age	**n**
17-30	18
31-54	15
Ethnicity	
White British	14
White European	1
Other White background	3
African	2
Mixed White and Black African	1
Indian	2
Pakistani	4
Chinese	1
Other Asian background	3
Other ethnic group	1
Prefer not to say	1
Locality	
Urban	16
Suburban	12
Rural	5
Educational attainment	
A-levels or equivalents and above	18

GCSEs or equivalents or below	15
IMD quintile[#]	
1	15
2	5
3	10
4	2
5	1
New user of contraception services since March 2020	
Yes	8
No	23
N/A	2
All contraception methods used since March 2020	
Injection	4
Implant	9
Hormonal coil	8
Non-hormonal coil	1
Condoms	16
Oral contraception pill	12
Contraceptive patch	2
Contraceptive apps (Natural Cycles)	2
Calendar method	4
Withdrawal method	4
Emergency contraception (morning after pill)	12
Emergency contraception (non-hormonal coil)	1
Vaginal ring	1
Diaphragm plus spermicides	1
All services usually accessed	
General Practice	22
Sexual health/family planning clinic	11
Pharmacy	13
Online pharmacy	2
Other online source	2
Retail outlet	3
School/college/university	1
NHS post-natal provision	3
All modes of access since March 2020	
Face-to-face	14
Telephone	14
Online	8

[#]IMD = Index of Multiple Deprivation, 1 = most deprived and 5 = least deprived

2.3 Interview procedure

Interviews were conducted by the University of Stirling research team and lasted between 45 and 75 minutes. One additional interview was seven minutes due to the participant's phone cutting out and despite several attempts, the researcher was unable to reach them again. We retained this participant in the final sample as there were some important issues raised. A semi-structured topic guide was used, informed by the two public consultation groups and the Theoretical Domains Framework, which defines 14 domains of influence on health behaviour.[17,18] This ensured broad coverage of the components that drive attitudes and behaviour. The range of issues and topics explored in the interviews included:

- Participants' current and previous method(s) of contraception
- Experiences of accessing contraception since March 2020, any perceived changes in availability or access, and barriers and facilitators to access
- Knowledge on, and attitudes to, different contraception services
- Experiences of, and attitudes to, different modes of access, e.g., face-to-face and remote methods
- Perceptions of different methods of contraception including LARC, short-acting hormonal contraceptives, and non-hormonal contraception such as condoms and contraception apps
- Participants' sources of information, their influences and decision making around contraception
- Social and community norms
- Thoughts on future service provision including Women's Health Hubs

With participants' consent, interviews were digitally audio-recorded. Participants were given £40 to thank them for their time. Interviews took place in November and December 2022, and January 2023.

2.4 Data analysis

Interview audio-recordings were transcribed verbatim by professional transcribers. The research team checked all transcriptions and removed identifiable information prior to thematic analysis.[19] Analysis was both deductive, informed by the topic guide, and inductive, from participants' accounts. Key themes and issues were initially identified through familiarisation with transcripts and a draft coding framework was developed. Using NVivo12, the coding framework was tested independently by two researchers on a randomly allocated 10% sample of transcripts, then discussed and refined to enable all remaining transcripts to be coded. Transcripts were coded by AF, LM, EG and RH. The lead researcher checked a sample of transcripts to ensure consistency of coding between researchers. Once each transcript had been coded, summaries of the coded data were prepared, including key quotes, followed by further analysis in line with the three study aims. Findings were interpreted through discussion with the wider team.

3. Results

Here we present findings of the 33 qualitative interviews with women. The findings are structured around aims 1 and 2. Section 3.1 explores: women's experiences of accessing

contraception since the start of the pandemic including narratives on specific services; women's experiences and perceptions of different modes of access; accessing contraception at significant timepoints and life stages; and women's perceptions of one future source of service provision - Women's Health Hubs. Section 3.2 explores: women's current attitudes and preferences towards contraception methods; and women's decision making, influences and sources of information. Responses were carefully analysed to explore any demographic differences. Few differences in narratives were found in relation to IMD or educational attainment level; however, where they exist, these are noted in the text.

3.1 Aim 1: To examine women's experiences (and barriers and facilitators) of accessing contraception services since the start of the pandemic, both for new users of contraception and those with prior experience, and to understand any inequalities of access.

3.1.1 Women's experiences of accessing contraception since the start of the pandemic

Women had mixed experiences of accessing contraception since the start of the pandemic. Some reported minimal or no real impact from the pandemic, particularly those who were on repeat prescriptions for the pill or using condoms. Some welcomed the changes that the pandemic brought such as the delivery to their home address of free condoms, being able to administer the injection themselves at home, and the introduction of telephone appointments and online services. Conversely, others had disliked telephone appointments or online consultations (see section on mode of access). Particular access challenges were faced by women using the injection prior to March 2020. These resulted in some women having to switch methods, being unprotected for a period of time, or stopping contraception altogether during the pandemic (all such instances were women from IMD 1 and 2). One woman described the response from her General Practice (GP) surgery:

> *"Basically, 'that's it, we're not giving it [the injection] here. You can give it to yourself, we'll prescribe it, and that's it, bottom line', no other information, or ring this number, or go to this clinic, speak to anybody, no 'that's it. We're not doing it'. Basically, do it yourself or forget it." (Pt26, 40, IMD1, Pakistani)*

Women who had wanted to have a coil fitted during the pandemic faced issues at both the GP as fittings were no longer offered as part of the service and at Sexual Health Clinics, which women often reported as closed. Women frequently described the difficulty they experienced during the pandemic in getting appointments for contraception. Barriers included early morning booking systems or limited time slots that conflicted with work schedules. Multiple failed attempts at getting an appointment at the SHC led one woman to permanently change where she accessed contraception. Some women reported that appointments felt rushed since the pandemic, and one elaborated on how systemic issues contributed to the "rush rush" feeling with staff "completely preoccupied" meaning that some felt they were not listened to. During the interviews, some women suggested that "things are pretty much back to normal now", but others still felt the effects of COVID restrictions, or that opportunities to have "in-depth conversations" had failed to return.

> *"Even though the pandemic last year was…we're still living with the effects of COVID…but the restrictions within the GP surgery still seem to remain…they started,*

during the pandemic…with phone appointments…that hasn't gone away…is that the pandemic or is that just how the system works [now]? I've no idea." (Pt3, 51, IMD3, White British)

Although not linked to the impact of the pandemic, for a few women, the location of services created a barrier to access and one woman explained how this changed when she moved from a rural to an urban area. Another highlighted how language barriers and the lack of information about contraception services disseminated to women from ethnic minority backgrounds meant that the contraceptive needs of these women were being "neglected". Similar barriers were echoed by a woman who faced unfamiliar processes and experienced issues accessing contraception when she moved to the UK.

Attitudes to specific services are considered in turn below.

3.1.1.1 General Practice Provision

Some women reported positive experiences of discussing contraception with their GP, recalling how "easy" and "convenient" it was to access the service. Some preferred to access contraception at their GP as it felt "discreet" and "more familiar" than other types of services such as the SHC.

"I have… a really good relationship with my GP…I'm quite lucky, I've…built a really good foundation with them…they're…easy to talk to, I'm comfortable with it" (Pt33, 25, IMD1, White British)

Many women, however, recalled how "difficult" it had been to get an appointment with their GP. Some expressed frustration at the complexity of post-pandemic processes, while others recalled being unable to get the contraception they wanted. Some women described their recent experiences at the GP as impersonal. Although a few women had been happy with the information provided by their GP, many felt that conversations they had with their GPs provided very little in terms of information and support, that their concerns were not listened to, that the GP had been "disapproving" or "dismissive", and some of the women described being left unsatisfied by the care received.

"The GP has probably been the most unhelpful… there wasn't any information, it's me asking for what I want…there's not a discussion." (Pt30, 37, IMD2, Mixed White and Black African)

Some women noted that some of these issues had existed pre-pandemic.

3.1.1.2 Sexual Health Clinic

Those that had experienced accessing contraception at the SHC expressed how "comfortable" they had felt, as SHC practitioners were described as having a "softer" and "kinder" manner than GPs. Many women felt that the SHC provided a specialist service that was superior to that of the GP for contraception. A few recalled the ease and efficiency of SHCs.

"It [SHC] was a lot more personal…they've got a lot more advice and you actually see someone, and they explain like the before, during and after to you…compared to my GP where it was just like the contraception and a leaflet, a link to a leaflet." (Pt31, 24, IMD2, other Asian background)

Some women reported a lack of awareness of the sexual health services available to them. Others felt SHCs were inaccessible for a range of reasons including "unclear" or difficult booking processes, "annoying" waiting times, age restrictions, no baby policies, and lack of proximity.

"It was impossible to get an appointment in any of the clinics…their online service is just so difficult to use, and I use a computer all the time for work…it was just so frustrating and difficult to even get to the place of the appointments and then when you finally get there they're booked up for weeks." (Pt30, 37, IMD2, Mixed White and Black African)

Some felt there was a stigma attached to SHCs, which made their experiences "embarrassing" or "humiliating". Some perceived the SHC as a service for younger women and one woman described how she had been "too nervous" to go in.

"I just felt too nervous to go in, so I turned around and left…it's the stigma behind sex and just going to a sexual health clinic…I just felt awkward about it." (Pt4, 20, IMD1, other Asian background)

3.1.1.3 Pharmacy provision

Many women liked how "easy" and "convenient" accessing contraception at the pharmacy was. It was described as "quick" and "straightforward" when compared to the GP. Many of our sample positively described experiences of accessing emergency contraception at the pharmacy. Pharmacists were often praised for being "attentive", "professional", and "knowledgeable". Some described the pharmacy as a "positive", "safe" and "comfortable" environment. A few women recalled the pharmacist having helpful discussions with them around other methods of contraception when accessing the morning after pill. One described how the pharmacist had chased up delayed prescriptions which had led to her needing the morning after pill. One of the younger women also liked the signage outside of her local pharmacy close to her university which clearly communicated the availability of free contraception and sent out a welcoming message.

"Right in front of the pharmacy they've got a massive sign that says: 'free morning-after pill, and free condoms,'…and free STI kit as well… they're quite chill…you don't feel uncomfortable 'cause... they also see so many students that you don't feel you're like…some really provocative and sexual creature, you're just a... a person living." (Pt9, 20, IMD3, Indian)

"…the person that I was speaking to was very attentive and…seemed interested …in…what I was saying…it didn't feel as rushed and it felt like a positive environment …a safe environment for me to speak in." (Pt19, 18, IMD1, other Asian background)

Conversely, a small number of women said they had felt “awkward” or “embarrassed” asking for emergency contraception at the pharmacy. The cost of emergency contraception at the pharmacy was a particular issue for many. During COVID, a small number of women had experienced issues around changes to opening hours and being unable to get emergency contraception from certain pharmacists.

> *“Not all clinics were doing morning after pill with the COVID…I tried the Lloyd chemist but they didn’t give me morning after pill then I had to go to the other chemist.” (Pt20, 34, IMD1, Pakistani)*

3.1.1.4 Online pharmacy

Only two of our participants had accessed, or tried to access, contraception via an online pharmacy. In both situations this was for emergency contraception. One had liked how “fast” it was compared to the GP.

> *“… it’s fast, and if I order it… today, it’ll come tomorrow; …whereas with the GP it’s just long... to get an... an appointment, and if I get in the pharmacy…I'll probably have to pay for it; it’s not guaranteed that I'll get it for free.” (Pt4, 20, IMD1, other Asian background)*

Another other had run into some issues with a long delivery time and having to input personal details which were not immediately accessible.

> *“…the delivery time was a bit long…and then something about putting in some details which I could not easily access at that time. So…it’s easier to just go to the pharmacy and sort out everything at once rather than waiting that long because I know that the longer you wait, the less effective the morning after pill is.” (Pt12, 29, IMD3, African)*

There was, however, some receptivity to using online pharmacies to access contraception in the future among other women in our sample. Participants perceived this mode of provision as potentially “convenient”, “easier”, and more “reliable” than other services. A small number, however, said they would be concerned about a lack of person-centred advice.

> *“…even though the online services are anonymous and fast, there’s not a lot of… advice catered towards you in that situation...” (Pt4, 20, IMD1, other Asian background)*
>
> ***Participant**: “When I was having my issues getting my pill I considered going on and using it…*
> ***Researcher:** “Yeah, and why do you think you would consider using it?”*
> ***Participant:** “Just a bit more reliable and…a bit easier because I think it could be delivered to your house from what I can remember and I was so frustrated with my doctor’s surgery having these issues, I thought ‘shall I just go ahead and pay for it instead?’” (Pt23, 25, IMD1, White British)*

3.1.1.5 School, college and university

Some women reported how "easy" and "accessible" it was to access free condoms at college or university, although it was highlighted by one woman that they could often run out. Another perceived the condoms accessed through her university as inferior quality.

> *"I find that getting them through the pharmacy…puts me in a more safer mood because I know what I'm getting. The ones that are provided by the Uni I feel like they might cheap out on them." (Pt19, 18, IMD1, other Asian background)*

A few younger women recalled receiving information and contraception support at school. Contraception conversations in the school environment were described as "tense" and "nerve wracking" and one recalled "cringing with embarrassment". It was more common, however, for women, including younger women, to report receiving "nothing whatsoever" with regards to contraception information at school.

> ***Researcher:*** *"Was there ever any talk about contraception at school?"*
> ***Participant:*** *"No nothing, no nothing, whatsoever, I don't know if Unis got... well, I don't know about the universities, erm, and I didn't at school, so..." (Pt8, 18, IMD1, White British)*

Many highlighted the important role schools should play in discussing contraception with young people. Some viewed schools as an opportunity to have more "open" and inclusive discussions on contraception, especially to make boys more aware of contraception issues, and reduce the perceived gender imbalance around contraception felt by women.

> *"I don't even think they [men] know like how contraception works, apart from the condom…I don't think it's an open conversation in schools…they have a lot of questions and some kids are not comfortable with parents…it should be a more open discussion in a classroom." (Pt10, 26, IMD1, Pakistani)*

3.1.2 Women's experiences and perceptions of different modes of access

When asked about different modes of accessing or discussing contraception with health practitioners, women stressed that their preferences would be based on what their needs were at that time. Women highlighted that accessing contraception via face-to-face, telephone or online approaches, had both benefits and drawbacks. Some women also noted that preferences may change with age and experience. For example, one woman described how a face-to-face appointment was important for accessing contraception for the first time. Another said she only feels comfortable speaking to a practitioner face-to-face now she is older.

> *"If it's my first-time taking contraception... I wanna ask questions, I wanna know all the possible…side effects, which one would be best for me…I don't think I will be able to do, er, an online thing or website." (Pt5, 29, IMD3, other White background)*

"When I was younger… I hated the face-to-face…but as I'm older now, I'm…more confident and more…empowered in my own body…it doesn't really faze me talking about it." (Pt7, 30, IMD1, other ethnic group)

3.1.2.1 Face-to-face appointments

Some women said they would always prefer a face-to-face appointment as it felt "more personal" and "authentic". Being in person made these women "feel more comfortable" and made it easier for them to explain, ask questions, understand, or follow-up on specific points. Others preferred being in person as they could take their time, or health practitioners could pick up on visual cues.

"They will pick up cues from you if you felt uncertain…or that you wanted to say more." (Pt28, 40, IMD 3, White British)

Some felt that that were taken "more seriously" by health practitioners when in-person. One woman explained maximising the value from a face-to-face appointment.

"I can get more information. I ask more questions face to face because I know I'm out and I'm making that effort to actually be at my surgery rather than on a call. I try to get as much as I possibly can from that face-to-face appointment." (Pt34, 48, IMD1, White British)

Negative points about face-to-face appointments focused on their associated waiting times. One participant commented that having to sit in the waiting room, and not knowing when your name would be called, was "draining".

3.1.2.2 Telephone

Many participants had experienced telephone appointments for contraception since the start of the pandemic and expressed how much "easier" and more "convenient" they were. Women said that telephone appointments saved them time and travel, fitted in with schedules, and removed unnecessary trips to the GP, especially when their GP surgery was not easily accessible.

"It's just easier, I'm not really local to my surgery so it's quite a trek." (Pt34, 48, IMD1, White British)

"I didn't have to…miss any lectures…I could just do it…over a lunch break." (Pt14, 23, IMD 1, Indian)

However, some women had found it "difficult" or "awkward" to take calls, especially if they still lived at home with parents or were at school.

"At the time when I started [taking contraception] I was in school so I was leaving lessons to call my doctor to talk about this. I'm just like in the middle of a school corridor…" (Pt18, 18, IMD1, White British)

Others worried that things might go wrong during the call, or they would forget what they wanted to say. Some also felt it was harder to ask questions or explain the issues they were having over the phone. A few women highlighted how "clinical" and "rushed" telephone appointments felt.

> *"…over the phone it's quite hard to...get across how you're feeling." (Pt2, 49, IMD5, White British)*

> *"…there was things that I wanted to ask but was too afraid to ask." (Pt19, 18, IMD1, other Asian background)*

3.1.2.3 Online

Some women described positive experiences of existing services moving online since the start of the pandemic. They found online services "quick", "convenient", and "accessible" to use. One woman liked that there was "no judgement" when ordering contraception online.

> *I…feel more comfortable getting it remotely…there is no judgement it's easier, you don't have to go out of your way to do it… (Pt11, 21, IMD3, Chinese)*

> *…its actually been quite easy…my GP switched everything to EConsult and…as a fairly young person I think an online chat suits me…I've not hit any trouble with that. (Pt31, 24, IMD2, other Asian background)*

However, these women also discussed the limitations of there being no discussion or human interaction. Perceived drawbacks to online methods focused on communication. Participants felt they were less able to explain themselves properly, ask questions, or raise concerns online.

> *"I…wanted to...hear the voice of somebody…I just wanna have that interaction of me being able to ask questions…raise doubts." (Pt5, 29, IMD3, other White background)*

> *"You can misinterpret it, or…it's hard to convey what you are…trying to say." (Pt11, 21, IMD3, Chinese)*

3.1.3 Accessing contraception at significant timepoints and life stages

3.1.3.1 First experiences

Participants described a range of reasons for first accessing contraception. This included to manage heavy, or regulate, periods, and to "take control" of their own healthcare decisions, in addition to wanting to prevent pregnancy. Younger participants who had recently accessed contraception for the first time described a range of emotions for this "big step", for example, feeling "nervous", "confused", "self-conscious", "embarrassed", or "judged".

> *"…because I was 16 I didn't really want to be…judged…because I was younger I felt like 'oh I was getting an implant' and before they put it in they ask you to do a pregnancy test as well…the whole thing was just quite…scary." (Pt27, 18, IMD4, White British)*

> *"When I first went on like the pill…I was…not confident at all…I just didn't know anything about what I was doing…I was very confused…I was still at home and my parents are…super religious…I was like, 'oh God, this is a bit wrong,'…everything was …a bit much…" (Pt9, 20, IMD3, Indian)*

Some recalled being worried that their parents would find out. Having to navigate contraception services discreetly, especially for the first time during the pandemic, was particularly challenging. One participant noted how this had impacted on her wellbeing.

> *"At the time since I was 16. It was…difficult to try and navigate that around my parents because I didn't want them to know…I just wanted it done quickly…and obviously because that didn't happen…waiting for that contraception…put me in a lower mood…" (Pt19, 18, IMD1, other Asian background)*

Others felt that they had needed extra support and more informative discussions with health practitioners, which they couldn't get at that time. For one participant, although she felt her first experiences during the pandemic had been positive, she said she would expect a "proper consultation" next time.

> *"I've had a brilliant experience and I've been heard but…I did get it during COVID times when everyone was really busy, and I didn't really know what I was properly doing…I was letting other people…guide me through it…if it was now and I was to go and get a new contraception I would really want a proper consultation, about what would suit me, and how that would affect how I'm feeling."(Pt27, 18, IMD4, White British)*

Some younger participants felt that health practitioners provided little or no discussion around different contraception, with options being restricted to the pill or the implant. One woman reported that younger women are not "represented" or "heard" in conversations around contraception.

> *"For someone my age…even though there's like a wide variety of contraception… it's either the pill or the implant…. I don't see a lot of like 18-year-olds speaking about it openly, it's more like adult women, which is ok but sometimes it would be nice to see people my age being represented in conversations because we are part of the conversation, but we're not really heard…we're more just seen." (Pt19, 18, IMD1, other Asian background)*

3.1.3.2 Postpartum experiences

Participants described mixed experiences around postpartum contraception. Most of the women with children recalled having discussions with health practitioners. Some described these as brief check-ins or "box-ticking" exercises. Others recalled the helpful and influential role practitioners had played in their decisions to have LARC fitted. All the women who described helpful discussions were from IMD3-5.

"I think it was actually the health visitor…she said, 'Oh, what you gonna do about contraception? I wouldn't use condoms 'cause you might fall pregnant,' type of thing…she said, 'Oh, I'd get the coil, it's great,' and so I got it fitted. (Pt2, 49, IMD5, White British)

In contrast, two women felt the approach taken by practitioners immediately after giving birth was "quite forceful", at a time when they were feeling particularly vulnerable and emotional.

"I just couldn't believe it…you've just had a baby…you're like, 'holy hell, what's going on?'…literally day two, and you're emotional and you're crying…and then someone's talking to you about…'Well, make sure that you're careful when you have [sex] 'cause you can still [get pregnant]' and you're like… 'what are you talking about?'... it went in one ear and out the other, and I didn't have any other discussions about contraception after." (Pt3, 51, IMD3, White British)

Others noted either having received no support or discussion around contraception in the postpartum period, or they described bring proactive in arranging contraception themselves after giving birth, highlighting the importance to them of arranging this quickly. One had planned for postpartum contraception with her midwife when making her birthing plan. All these women were from IMD 1 and 2.

"It was one of the first important things I thought I should find out…" (Pt26, 40, IMD1, Pakistani)

"I did it myself. I rang up very quickly because I wanted to get it sorted." (Pt23, 25, IMD1, White British)

3.1.3.3 Experiences around perimenopause/menopause

Most of the older women in our sample said they wanted more information on contraception in perimenopause and menopause (all from IMD 3-5). They described a "movement" around the menopause, with greater availability of information and content, however a few women had received conflicting information from their health practitioner when getting a Mirena coil fitted or removed about the risk of pregnancy during this timepoint.

"When I had the Mirena coil put in, she...really ticked me off: you know, she was telling me about the number of women my age who came thinking they were in menopause, when actually they were pregnant…that was really scary." (Pt3, 51, IMD3, White British)

"It was the nurse because that was the person who [removes coils] and I think she just said basically 'oh I've just looked and you're over 50 so…' she looked at the policy and it said basically…over 50 can keep it in until they're at least sort of 55 or something… because there's such a low risk I suppose of pregnancy, that it's not worth taking out" (Pt 32, 54, IMD3, White British)

Mostly, women described being unsure whether they had reached the (peri)menopause, and what it meant for their contraception choices. While some had spoken to a health practitioner, others described "putting it off" or feeling a "little lost". One older woman felt that people at her life stage had become "invisible" and suggested that this may have been exacerbated by processes during the pandemic.

> *"I feel like…I've slipped off the scale…I'm…invisible…at my stage…is that our system or…how services are?…it's probably a mix of the fact that there's very little…focus on women at my age... towards the end of their fer-fertility…mixed in with the pandemic restrictions in terms of how the GPs are operating." (Pt3, 51, IMD3, White British)*

3.1.3.4 Other timepoints: Experiences following an abortion, STI check, or use of emergency contraception

Some women recalled having helpful discussions with health practitioners or being signposted to contraception services at other timepoints. For one woman, this was a discussion with a nurse immediately after an abortion. Two younger women described how having an STI check had made them more aware of the importance of contraception. Others were advised to access alternative methods of contraception or the SHC while accessing emergency contraception at the pharmacy.

> *"I have had to take morning after pill two or three times in three or four months and I've been told by the chemist as well – go back to the health clinic and ask them for advice." (Pt20, 34, IMD1, Pakistani)*

> *"I didn't really think about it much until I went to the sexual health clinic…that was more just to check for STIs initially, and then she started talking about pregnancy and that's when I started thinking about it really...the possibilities…she was saying the sort of likelihood and…quite a lot really…I knew that was something I definitely didn't want now, and definitely not for a good few years' time anyway." (Pt8, 18, IMD1, White British)*

3.1.4 Future service provision – Women's Health Hubs

When asked for their thoughts on Women's Health Hubs (WHHs), our sample of women had no prior awareness of this planned service. Women's responses were based on a description of WHHs provided by the sexual and reproductive health policy team as follows:

> Women's health hubs provide integrated women's health services at primary and community care level. The services provided are centred on women's needs across their life course, rather than being organised by an individual condition or issue. For example, women's health hubs can provide someone with contraception and management for their heavy menstrual bleeding in one visit or deliver menopause care at the same time as contraception for women over 40. Healthcare professionals working in Women's Health Hubs tend to have undertaken additional training in delivering women's health services.

Overall, women perceived the service very positively from these descriptions. They felt that a WHHs would offer a "specialist" service, where health practitioners would have more contraception expertise and in-depth knowledge and would take contraception issues more seriously. Some women liked the idea that WHHs would cater to every woman at every stage of her life. They felt it would provide a place where women could obtain a "myriad of information" at any age, making it more accessible.

> *"…it condenses all the information, all life stages into one place and makes it really accessible for people…it would be so much easier for people to find the information that they needed…make them more inclined to seek out information because they know exactly where to find it, exactly what to expect." (Pt11, 21, IMD3, Chinese)*

Many women felt that a WHH would offer a safe space to go, where they would be more likely to feel "listened to" compared to other services, and "empowered". Younger women thought they may benefit as it was perceived to offer a "familiar", "less daunting" place where they would feel "comfortable". WHHs were especially appealing to those who had faced challenges accessing contraception through their GP or SHC during the pandemic.

> *"I'd definitely go there…especially with what the GPs have already done, refused all …contraceptive help in the lockdown…At least this would be reassurance that there's somewhere specifically for these…issues." (Pt26, 40, IMD1, Pakistani)*

> *"A lot of younger girls would be…less scared of…contraception…my experience was quite daunting…if we had access to…a women's health hub it would be…a safer place to go to." (Pt19, 18, IMD1, other Asian background)*

A minority of women expressed concerns about WHHs. This included doubt about whether the service would differ enough from what is currently in place. Two women raised potential issues around gender-recognition, and the potential for people feeling excluded because of the use of "women" in the name.

> *"…say…somebody that was…born a female but they don't identify as a female, maybe …having…a different…name so people feel like, 'oh, I could still go there even though I don't identify as a female,' but you've got like female reproductive system." (Pt6, 21, IMD1, African)*

Some women raised the importance of increased awareness, availability, accessibility, and trust at WHHs compared to current services, that its image would be important in appealing to women, and that a media campaign would likely be needed to ensure people utilise the service.

> *"…it should be really clear and easy to access…that's the only thing that I worry about…. there is a clinic…which is five minutes from me, I…feel like it's some sort of magical place that I'm not allowed to go to…it's just so hard to get in there." (Pt30, 37, IMD2, mixed White and Black African)*

> *"As part of a hospital, it would feel…a bit of a drag to get there, so maybe if they were attached to... a gym or a supermarket…somewhere…more... accessible." (Pt2, 49, IMD5, White British)*

When asked what other services they would like to see offered at a WHH, participants suggested a range of ideas including premenstrual syndrome and mental health support, cervical and breast cancer screening, STI testing and sexual health/healthy relationships education, peer support groups, support for victims of domestic violence, abortion and pre- and post-partum/natal support, and healthy eating advice. A few women said they would like to see WHHs cater to specific issues that mainly affect women such as thyroid health, ovarian cysts, or prolapse. One woman suggested it would be useful for WHHs to provide an anonymous hotline. Another suggested a linked women's health app.

> *"…make an app that all women can use and they can ask confidential questions…Someone can answer or someone can guide. You can trust this service…there should be an app for women's own area…specifically designed for women, or teenagers, or involving other different types of people. (Pt20, 34, IMD1, Pakistani)*

3.2 Aim 2: To explore how the COVID-19 pandemic and resultant changes in the landscape of service provision has impacted on women's attitudes, preferences and decision-making behaviour around contraception.

3.2.1 Women's current attitudes and preferences towards contraception methods

Attitudes and preferences towards different contraception methods varied across the sample and the women expressed a range of benefits and drawbacks for each of the methods. The range of side effects reported were vast and there was no superior method that stood out over other methods. However, some women's preferences centred around whether the method was long or short-term, invasive, or non-invasive, hormonal or non-hormonal.

Attitudes to specific contraception methods are considered in turn below.

3.2.1.1 Long-acting reversible contraception

3.2.1.1.1 Injection

Women with experience of the injection said that the length of time between jabs made it "easier" than remembering to take the pill every day. They liked that it was less invasive and not as long-term as other forms of LARC. If they found that LARC did not suit them, it was described as easier to change than a coil would be.

> *"I didn't want anything left in me, or inserted in me, in my arm or my vagina, uterus. So I felt comfortable like this." (Pt26, 40, IMD1, Pakistani)*

> *"I probably will forget to have a pill every morning, so I was worried and secondly, because it was just easier because its once every 3 months." (Pt21, 40, IMD1, White European)*

Many women with experience of the injection reported side effects. A common side effect was weight gain and "bloating". Others reported "bleeding all the time", poor sleep, and having "really horrible" mental health while using the injection.

> *"I had really horrible…mental health through that time and then it was almost like a veil got lifted and I realised 'oh my, that injection has run out.' So, I don't know, it could not have been that and it could have just been what was going to happen anyway, but that's how it felt like so it put me off." (Pt30, 37, IMD2, mixed White and Black African)*

Some said the process of having to go back every three months for another injection was "inconvenient". One woman explained that she switched to the coil after she "messed up" her appointments. As previously described, a few women were unable to get appointments for the injection in March 2020 leading to frustration and worry. Another woman's experience with the injection during the pandemic was for the most part "easy" but she ran into issues when the pharmacy discontinued certain injections. This led to delays and confusion around how long it had been between jabs.

> *"…if it's been discontinued and then you've been waiting, you don't know how long it's been in between so then you end up having to go to your doctors for the depo and then the chemist will start doing it, so then you've got to remember when you were at the doctors to when you were at the chemist." (Pt21, 40, IMD1, White European)*

For some of those without experience of the injection, the thought of getting regular injections was "daunting". One woman did not like the thought of hormones travelling around her body compared to the "localised" hormones she associated with the hormonal coil. Another woman was dubious about whether it worked. Women had heard stories about the injection such as that it was "more natural" than the pill, it negatively affected mental health, or that it never "got out of" your system.

> *"I wanted to research it, to know a bit more about it, and then you go on these pages where people review them and there were all these scary stories, it's not come out of my system ever. I'm not the same and this happened, that happened." (Pt26, 40, IMD1, Pakistani)*

> *"One of my friends had the injection. Just from, she said she just cries all the time so I would not…" (Pt17, 18, IMD1, White British)*

3.2.1.1.2 Implant

Women with experience of the implant expressed how "easy" and "convenient" the implant was compared to the struggles of remembering to take the pill every day. Similar to the injection, a few highlighted that it was less "painful" or "invasive" compared to other forms of LARC. The "convenience" of not getting a period was also raised as a positive by some.

> *"…not having a period is very convenient, I feel like that's one of the more important things…not having to like go out and buy condoms every…month…the implant is just*

in my arm really, like I don't have to do anything else." (Pt19, 18, IMD1, other Asian background)

"You only have to worry about maybe every three years. I have just found that is the …easiest of method of contraception for me…and the least invasive…" (Pt13, 32, IMD3, White British)

Many women reported experiencing a range of side effects including mood swings, irregular periods/spotting, weight gain, anxiety, depression, low sex drive, and hair loss. For some, the side effects were so severe, they asked to have their implant removed; for others, side effects went away after a period of time.

"I turned into…the Hulk. I was like the most angriest person, which is so unlike me… and at the time there wasn't anything else in my life that I had done differently…I had that taken out as soon as I could 'cause it just made me so angry and psychotic". (Pt7, 30, IMD1, any other ethnic group)

"If it wasn't for having to cut your arm open and getting it out I would have gotten it out then and there. But I was really scared to get it removed…hopefully I'll stick at it for the next three years just to see if it does improve and it did in the end." (Pt19, 18, IMD1, other Asian background)

Some participants worried about the fitting procedure, describing this as "invasive", "painful", or "intimidating". Others were "scared" or "worried" about the removal procedure. A few women had heard negative stories about the implant getting lost in your arm, problems getting it removed, and the impact on mental health, although one described how her friend had been "happier" whilst using the implant. The longer-term "commitment" and it not being a "quick experience" to remove were perceived as negatives by some of the women. A few were put off by believing that if they tried the implant and it did not suit them, it would be difficult to get the GP to agree to remove it. The pandemic, and associated challenges with appointments, appeared to exacerbate this problem.

"…the thought of having…no way of getting it out yourself, the hormones, if you were reacting badly to it, being at the mercy of GP clinic to get it out." (Pt28, 40, IMD3, White British)

"…when I did have a non-stop period, I was like oh my days I just can't deal with it, I hate it...I want to get rid of it…I've heard some bad stories about…the GPs not allowing people to take them out, saying just wait with it in. But considering I haven't got too long left with it in, I just thought 'I'll wait…'" (Pt27, 18, IMD4, White British)

3.2.1.1.3 Hormonal and non-hormonal coil

Women with experience of the hormonal or non-hormonal coil highlighted that it was a good long-term option that you do not have to "worry" about. Some had experienced less side effects on the coil compared to other methods. Women expressed strong preferences

for either the hormonal or non-hormonal option. Those on the hormonal coil liked the idea that the hormones are "localised" to the uterus and not "floating" around their body.

> *"I didn't want anything hormonal, this one is hormonal, but I didn't want anything that would be in my bloodstream and the doctor told me that it would only act on my uterus, so I decided to take one." (Pt24, 17, IMD2, ethnicity unknown)*

> *"…awesome, I wish I'd used it years ago…it was terrible, terrible; no wonder I was anaemic, it was awful. Now... it's been like a discharge rather than a period…it's completely transformational…the period pains, the cramping, the bleeding… " (Pt3, 51, IMD3, White British)*

Those on the non-hormonal coil liked that it gave their cycle "time to regulate" and seeing what their "body is like without any extra hormones".

> *"…because we wanted to…start trying to get pregnant after we got married, I wanted something that…was non-hormonal so it would give my cycle time to…regulate…" (Pt1, 31, IMD4, White British)*

Many of the women reported fitting procedures or aftereffects that were "painful" or "uncomfortable". Some described a lack of discussion around pain management prior to fitting, although others had been advised to take paracetamol.

> *"…the experience itself…she was not very empathetic…They told me it was uncomfortable, but personally I found it painful…I did not expect it, 'cause they just say, "Oh, just take some paracetamol," which I did, "and it will be fine, it will not last long," but it was lasting ages, and it was actually painful… a lot of cramps during the procedure, and straight after the procedure it was terrible." (Pt5, 29, IMD3, other White background)*

For a small number of women, having a coil fitted was described as "traumatic"; one woman went "into shock" and had to have her coil removed 12 hours after it was fitted. While these experiences put some women off having the coil fitted again, others saw the positive in a "brief moment of very bad pain" in exchange for the longer-term benefits.

> *"…it's just a necessary evil isn't it… Its uncomfortable…it's definitely not going to be worse than giving birth so crack on. I've had a couple of iffy experiences with it where it's very painful and I'm bleeding a lot when I come home but you just go home, and you get a hot water bottle, and you just relax or have a hot bath or something." (Pt25, 45, IMD2, White British)*

Some of the women had either experienced or had heard about more frequent bleeding or heavier periods as a negative side effect of the non-hormonal coil. Periods on the non-hormonal coil were described as "unbearable" for one woman, while another weighed up whether having it fitted would be "worth" the side effects, even though other aspects of a non-hormonal coil appealed to her.

> *"I remember I used to work with a girl…mentally…she didn't feel any side effects, but she did have…very heavy bleeding…for me it's like weighing up whether that would outweigh all the mental things…it's something I'd have to really think about." (Pt23, 25, IMD1, White British)*

Similar to the implant, there was some concern that it might be difficult to get a coil removed if it did not suit, especially given how services were perceived to be operating post-pandemic. Some women recounted graphic stories they had heard from others or on social media, such as the coil piercing someone's insides.

3.2.1.2 Short-acting contraception

3.2.1.2.1 Oral contraception pill

Many women held positive attitudes to the pill. Some had noted improvements in mood swings or hormonal acne whilst using it. Others reported that they had experienced reduced heavy bleeding, or that their periods had regulated or stopped altogether. Being less invasive than LARC and the flexibility to switch contraception at any time were also perceived benefits. It was seen as the "easiest thing to get" during the pandemic.

> *"…it's been like the easiest thing to get, I did actually want to get a coil but it was very difficult to try and get an appointment, almost impossible." (Pt30, 37, IMD2, mixed white/African background)*

> *…it was something I could try and then easily stop if it didn't work for me so that's why I didn't go for like a long term method like an implant or an IUD or anything…" (Pt14, 23, IMD1, Indian)*

However, remembering to take the pill every day was seen as a disadvantage for many women, particularly for younger women, new mothers, those with "busy lifestyles", or those with medical conditions.

> *"…I have ADHD and it's…a struggle to remember to…take the pill every day…" (Pt19, 18, IMD1, other Asian background)*

Some also reported a range of negative side effects including spotting, irregular bleeding, period cramps, feeling anxious, mood swings, weight gain, migraines, acne, leg pain, and low libido. For a couple of the women, the side effects were so bad, they were advised to stop.

> *"…the experience with the pills were horrendous, I had just the most terrible time between acne, mood swings, weight gain, you name it, I didn't just try one it was a couple, the mini one, this one, that one, you know so…" (Pt25, 45, IMD2, White British)*

Concerns around blood clots or links between long-term use and cancer were raised by some of the women. The effectiveness of the pill was a concern for three women who said they had fallen pregnant while on the pill. Some said that viewing negative stories online, or the hormonal aspect, put them off using the pill or that there was not enough information and awareness about side-effects or long-term effects of the pill.

"I've had mixed feelings before about…using it for long periods of time…I've... known people that they've come off the pill because…the nurse has said they've been on it for too long and they need to take a break from it, but then I've never encountered that myself, and I've always found mixed information about whether you're actually supposed to do that or not…" (Pt1, 31, IMD4, White British)

"I just saw people calling it the devil's pill and stuff and that really scared me before I started it." (Pt18, 18, IMD1, White British)

3.2.1.2.2 Contraceptive patch

Many women said that they did not know much, or anything, about the contraceptive patch. It was described as a "rogue" or "interesting" method. Some of the women reported that the patch was not mentioned in discussions with health practitioners when seeking contraception or when looking online.

"I think that's quite a rogue one in the sense that compared to these other ones that we've mentioned so far I don't know anyone who's ever used the patch." (Pt14, 23, IMD1, Indian)

"…it's one of those things I've heard good things about but…I don't know too much about it." (Pt27, 18, IMD4, White British)

A few had heard "good things" or thought the patch sounded "easy". One woman liked that it only lasts for a couple of months. Another woman who was using the patch explained that, although she was spotting for longer, it was "quite nice" having lighter periods and less cramps as a side effect. Many women, however, expressed that they would be "scared" or "stressing" about it falling off and that it might not be as "effective" as other methods. One woman who was using the patch had experienced it falling off, which she said was "frustrating".

"I feel like I'd be stressing about it falling off or being in the shower because I feel like even though it is contraception it's still a sticker and I don't know how strong the adhesive would be." (Pt19, 18, IMD1, other Asian background)

A few of the women expressed concerns that the patch was "risky" or "unsafe". Some women raised concerns around mood changes caused by the hormones in the patch. The visibility of the patch on the skin was also mentioned by a few women as a negative.

"*I started looking at the patch as well and how it could have made a difference. But when I looked, when I talked to my nurse about it, I came to know that you have to use the condom as well. It's not very beneficial. It's very risky you know. You have to be very careful. "(Pt20, 34, IMD1, Pakistani)*

3.2.1.3 Other methods

3.2.1.3.1 Condoms

Women described condoms as easily accessible and available from a variety of sources. Many felt that condoms are effective and the form of contraception that offers the "safest" protection against STIs which helped to ease anxiety around this when having sex with a new partner. Some women preferred using condoms over other methods of contraception because they had little to no impact on their bodies or their hormones.

> *"…we used them in between having children… I didn't wanna start going on the pill or anything…and mess my hormones about, and my body too much." (Pt2, 49, IMD5, White British)*

The "user dependent" nature of condoms was raised as a negative attribute by some. Some women had experienced a condom breaking or coming off during sex. Many of these women sought emergency contraception thereafter, sometimes multiple times. One of the women mentioned "stealthing" and this was echoed by others who had concerns around not being "in control" and "trusting" your partner.

> *"…one very manipulative thing that some men do, is… when you're having sex and then they are like, "Oh, can I take the condom off?" and it's like, "Wait...what?"… you're like literally in the middle of things…it makes it awkward…" (Pt9, 20, IMD3, Indian)*

Some described condoms as "a passion killer" or "awkward" to use or said that "sex doesn't feel as good" with a condom, or that men did not like using them. Others felt that condoms provided no added benefits (i.e., lighter periods) unlike other methods of contraception, and some women reported negative side effects or "sensitivities" around using condoms. A few women raised concerns around the cost of condoms, while others expressed the benefits of free condoms and a need for condoms to be free for everyone.

> *"I don't ever want to waste money…you wanna buy condoms that are definitely gonna protect you, but you...think, 'God, 10 quid for five, huh, that's a lot of money.'" (Pt2, 49, IMD5, White British)*

> *"I was buying it, I was spending a lot on these condoms and they were so expensive. Every time you go, the ones you wanted, the cheap ones are out of stock." (Pt20, 34, IMD1, Pakistani)*

3.2.1.3.2 Period-tracking apps

Half of our sample had experience of using period tracking apps, across all ages. Five women had used these apps as a method of contraception (two currently), while a few said they were interested in using an app as a method of contraception in the future. The two women currently using an app as a method of contraception were both using 'Natural Cycles' and expressed how "fascinating" it was "looking at signs from your body", "getting to know your body" more, and highlighted how "empowering" this was.

"…it's fascinating and it's…an untapped source of…knowledge about your body and… it's natural…it's not the rhythm method, it's like more scientific than that, it's not just counting calendar days, you're actually looking at signs from your body, your body is telling you…where you are in your cycle…it's brilliant…" (Pt28, 40, IMD3, White British)

The non-hormonal and "more natural" approach of contraceptive apps was seen as a positive, and a couple of the women who were experiencing side effects had considered switching to an app for this reason.

"…if the side effects of the hormones get unbearable for me, then I think that the period tracker would be the best one. But my only concern about that is that… you can still get pregnant…But I'll probably use that or…condoms." (Pt4, 20, IMD1, any other Asian background)

"…because of the non-hormonal side of it…with my migraines and mental health problems I thought that might actually help me…because its non-hormonal…" (Pt23, 25, IMD1, White British)

Those positive about contraceptive apps perceived them as an "easy" and "convenient" method of contraception. Others said they had used period tracker apps to "keep an eye" on their cycles and avoid "accidents". Many women, however, felt that using apps to prevent pregnancy would be "risky" as cycles can change monthly, and they would not feel comfortable relying on it. One woman recalled her experience of falling pregnant while using an app, although she did not blame the app as she said that she was not tracking "properly". Two women had received a negative response from health practitioners when they brought up using an app, and this "frightened" one woman away from using them.

"…that is a bit risky so and you'd have to deal with the consequences if it didn't work… If you are adamant that you don't want to have kids then I wouldn't do that one." (Pt13, 32, IMD3, White British)

"My doctor… said basically 'if it would be the end of the world for you to get pregnant don't do it'…that sort of frightened me into being like okay I won't try that then but initially I did want to try it, but he put me off. [Laughter] (Pt23, 25, IMD1, White British)

A few of the women raised the issue of reproductive rights in America in relation to apps, but overall, inputting personal data into the apps was not highlighted as a concern.

3.2.1.3.3 Withdrawal

Two women (both IMD 1) were currently using the withdrawal method alongside other methods of contraception, and some had used it in the past. The resounding attitude from most of the women was that the withdrawal method was not an effective method as it was "risky", "silly", and they would never "trust" it to be effective.

"…the withdrawal method is probably madness to rely on…" (Pt13, 32, IMD3, White British)

***"…**there's still sperm in pre come…I think it's quite a silly method." (Pt31, 24, IMD2, other Asian background)*

A few women highlighted that it relies on the man to "do it properly", they thought it could work well if they did.

…it's just risky, isn't it? It's just like now I'm probably gonna have to take morning-[after pill]. I feel like it works relatively well as long as they actually do it straightaway and not …halfway through or something… (Pt9, 20, IMD3, Indian)

I've never used that personally purely because it would feel very unsafe. I know that if it's done properly it's quite effective but it's just a big risk. It puts all the pressure on the man and whether he does it properly or not, I don't know, I wouldn't feel comfortable relying on that. (Pt17, 18, IMD1, White British)

3.2.1.4 Emergency contraception

Many women in our sample had experienced accessing the morning after pill, both during the pandemic and before. One woman had a copper coil fitted as emergency contraception. Many of the women sought out emergency contraception after using other less effective methods such as condoms (that broke during sex) or the withdrawal method. Many of the women recalled how "easy" and "straightforward" it was to access the morning after pill at the pharmacy.

"I find it way easier in England than Italy. In Italy you have to go through…a doctor, you have to be examined…you have to take an appointment…but then here in UK, you just go to the pharmacy and nobody asks you a question, they don't care... they just ask you questions in terms of the best emergency contraception…it's quite straightforward."(Pt5, 29, IMD3, other White background)

"…that was very easy…I just went in and they took me into a side room…we talked about it for a minute…then I took it there and then so that was very easy to do." (Pt23, 25, IMD1, White British)

Some women noted barriers to accessing the morning after pill. A small number said it could be "embarrassing" asking for it, although one woman who had accessed emergency contraception online via the SHC explained how this overcame some of the barriers of getting it in person. Two women expressed concerns over taking it too often and had been told by health practitioners there were potential problems with this. The main concern expressed, however, was around cost. Many of the women had paid for the morning after pill and said how "unfair" this was, discussed barriers around affordability, and the dilemma of whether to risk it or wait for a time when the pill is free. These viewpoints were magnified due to the current cost of living crisis. Young women in particular described difficulties in being able to the pay for emergency contraception.

"I would have just gone and bought [the morning after pill] if this was a year ago. I was excited when they said you can buy the pill over the counter and I would have just done that, to avoid all the other stuff. But now I will go through the admin stuff to get it for free because it is worth saving, I think it's like £15 a month. It's not a lot when you say it like that but yes… to have that extra, or £20 a month… (Pt30, 37, IMD2, mixed white/African background)

"…there was one time when I went and…they had no pharmacist so they couldn't give it to me for free, I would have to pay for it, but... I had no money at the time…They said, 'Come tomorrow, and the pharmacist might be here,'…I came again the next day, and the pharmacist wasn't there again…it was getting to the point where…it's been…a couple of days since I've had sex, and now I am getting very, very worried…the next day I came back…I had to...ditch school…and they had it; the pharmacist was there and he gave it to me for free." (Pt4, 20, IMD1, other Asian background)

3.2.2 Women's decision making, influences, and sources of information

3.2.2.1 Decision making

There were mixed responses on how easy or difficult it was for women to make decisions around contraception. A few women highlighted that having a good knowledge on contraception, or knowing where to find the information, to weigh up the "pros and cons" of each method made it "easy" to decide.

"…there's a lot of information out there, especially like if you go on the websites… you can weigh up yourself what you think the pros and cons would be, so I don't think it's difficult…" (Pt6, 21, IMD1, African)

A few more experienced women referred to a "revelation" when they found what worked for them after trying out different methods when they were younger. For some women, it was more a process of elimination; "ruling out" methods that they did not think would work for them facilitated their decision making.

"It was quite easy actually…for me the main thing was…not having to do it every single day…and then…I didn't want…combined…progesterone, I wasn't that big a fan of having just progesterone. Yeah…just…ruling things out one by one." (Pt31, 24, IMD2, other Asian background)

For others, decisions were more difficult. Following a "process of elimination" left some feeling like they had limited or no options because, for example, they wanted a non-hormonal option, or the methods they had tried had not worked for them. Others described simply having to "deal with" what you have available, or deciding which method would have the least (negative) impact as there is no "perfect" method. The number of different methods made it an "overwhelming" and "tricky" decision for a few of the younger women. A few women questioned whether they had made the right decision and were uncertain about switching methods or whether they should give their body time to get back to where they thought it was "meant" to be.

3.2.2.2 Influences

Some women described positive accounts of discussions with health practitioners which had helped them to confirm their contraception choices. Generally, women said they felt more confident in discussing contraception as they got older. The type of practitioner was important. Most said they would prefer to speak with a female practitioner, although those that had interactions with male pharmacists recalled positive experiences. Generally, women found conversations with practitioners in SHCs, or a nurse at the GP surgery, more helpful than GPs themselves. One participant believed that GPs needed to introduce improvements in their women's health services.

> *"I always say, like, the nurses are better, and I just feel like they're a bit more willing to give you the time… maybe 'cause…, they do it more often, they tend to have more information or they're more up to date on the information, and I know whenever I've seen the GP they've always had to, you know, get the massive book off the shelf and try and find it." (Pt1, 31, IMD4, White British)*

Many women said that they did not want to only hear a health practitioners view, and most women described the importance of their friends, family or partners in helping them to form their views and decisions.

> "*[Speaking with sister and partner] helped me to make the choices. It changed my views as well. I was thinking about the implant as well, but my sister did it before me and she said it was very painful. Then I looked at what it was going to be for my health with the implant with my partner and [we] discuss the consequences. He's happy. We have to look at the disadvantages too…. It changed my opinion… it's my health. I need to take it seriously and think of the options. I decided to not use the hormonal way. (Pt20, 34, IMD1, Pakistani)*

Friends were seen as particularly helpful, and in some instances, more helpful than health practitioners. Some women noted their decisions had been directly influenced by friends' experiences. Others noted that while they appreciated hearing their friends' accounts, they would always make up their own mind, as different methods suit different people.

There was a range of narratives around partner involvement in contraception, from joint decision making, to feeling pressured by partners, to women reporting total control over decisions. There were strong cultural differences in who women discussed contraception with. Women from African, Asian or religious backgrounds frequently described feeling uncomfortable discussing contraception, describing it a "taboo subject".

3.2.2.3 Sources of information

Many women described proactively searching for information around different contraception methods and side effects. The NHS website was seen as a "credible", "trustworthy" and "straightforward" resource. Many women used this as a first point of reference but would follow up with information from other sources. Some women said their preference was information from medical websites and scientific articles; a minority of women were sceptical of information from the medical profession.

> *"I feel quite jaded by health services and so I would usually just do my own research… I would actually take everything that I'm told with a pinch of salt… I tend to get my information from various different sources before making a decision."* (Pt28, 40, IMD3, White British)

Many women spoke of "googling" for further information. Women described searching for more information on alternative or the full range of options, advantages and disadvantages of certain methods, information on hormonal vs non-hormonal contraception, side effects, and lived experiences of other women. NHS sources were criticised by some for being "dry" and impersonal and women believed they had to search elsewhere to answer to some of their questions.

> *"…You know forums, patient forums and, you know, know women's forums and I think they are a really valuable source of information of people's experienced, lived experience."* (Pt28, 40, IMD3, White British)

Similarly, some women, often younger women, were interested and engaged in content on social media. Some valued hearing personal accounts on social media and they liked being able to access different kinds of debates there around themes such as female empowerment. Many women described being mindful about the credibility of social media content, although social media was viewed by many as powerful tool to reach women.

> *Social media for me… I use Instagram… I learn loads on Twitter… I follow some really, really great... some quite hardcore feminist people… I don't agree with everything they say… But there's a lot of social commentators who resonate with me… it's all about safe sex… contraception… women's choices… the misogamy in society… (Pt3, 51, IMD3, White British)*

Some older women fondly spoke of leaflets containing contraception information; they had liked receiving these in the past or saw value in being able to pick leaflets up at other appointments or services. Translating information into other languages was seen as crucial to reach women in different communities. Leaflets were viewed as an easily accessible format for this purpose. One participant reported than women in the Asian community are "not aware" or do not know how to use contraception services and that "feeling shy" or not being confident in discussing the issues raised may create additional barriers.

4. Discussion

This study aimed to gain an understanding of the impact of the COVID-19 pandemic on women's access and attitudes to contraception in England.

We conducted 33 telephone interviews with women in England to explore their experiences of accessing contraception services since the start of the pandemic, both for new users of contraception and those with prior experience, and to understand any inequalities of access. We also explored women's attitudes, preferences, and decision-making behaviour around contraception methods, with a view to understanding the impact of the pandemic and

changes in the landscape of service provision. The final aim was to develop recommendations for maximising contraception uptake, focuses on access, delivery, and communication (with a focus on LARC).

This section first provides a summary of the main findings, followed by recommendations for policy.

4.1 Summary of key findings

Accessing services

- The pandemic prompted easier access to some methods of contraception, through the delivery of free condoms, pharmacy provision of contraceptive injections for those who were comfortable self-administering at home, and remote consultations for those who were happy with their current method and required no contraceptive counselling.
- Particular access challenges were faced by women using the injection prior to March 2020 as they were unable to get a GP appointment during lockdown but either received no signposting to pharmacy provision of injections, ran into issues with pharmacy provision (discontinuation of products) or felt uncomfortable injecting themselves. These barriers resulted in women having to switch methods, being unprotected for a period of time, or stopping contraception altogether.
- The pandemic made access more challenging for other methods of contraception which required a face-to-face consultation such as LARC, due to service closures or difficulty in getting appointments.
- Not linked to the impact of the pandemic, participants also mentioned the location of services, non-English language use, and lack of information specifically for women from ethnic minorities as further barriers to access.

General Practice Provision

- Some women reported positive experiences of discussing contraception with their GP. They preferred to access contraception at their GP as it felt “discreet” and “more familiar” than the SHC.
- Some expressed frustration at the complexity of post-pandemic processes, recalled being unable to get the contraception they wanted, or described their recent experiences at the GP as impersonal.

Sexual Health Clinic

- Those that had experienced accessing contraception at the SHC expressed how “comfortable” they had felt, as the health practitioners took the time to explain and discuss different options, and listened to their needs.
- Some women felt SHCs were inaccessible for a variety of reasons, or that there was stigma attached, or had little awareness of them.

Pharmacy provision

- Many women liked how “easy” and “convenient” accessing contraception at the pharmacy was. It was described as “quick” and “straightforward” when compared to the GP.

- A few women recalled the pharmacist having helpful discussions with them around other methods of contraception when accessing the morning after pill.
- During COVID, a small number of women had experienced issues around changes to opening hours and being unable to get emergency contraception from certain pharmacies.

Mode of access

- Women had different preferences for how they access and discuss contraception based on their needs and circumstances. Remote methods were useful for repeat prescriptions or when the woman was confident in what she wanted. In-person appointments were useful for asking questions and were better suited to women who were accessing contraception for the first time or required contraceptive counselling.
- Many women had embraced the introduction and increased use of remote methods implemented during the pandemic. They reported that these were easy and convenient to use, saving them time and travel, and that they could better fit these into their daily schedules.
- There were some limitations of remote access. Discussing contraception over the telephone was difficult for some women, especially younger women who lived with their parents or who had to take calls while at school. Some women reported that it was more difficult to explain themselves properly using the telephone or online methods and that appointments felt more rushed over the telephone.

Significant timepoints and life stages

- Accessing contraception for the first time was a big step for women. Some younger women reported that it had been challenging for them to access adequate support and guidance during the pandemic, and that they had been presented with limited options.
- Conversations with health practitioners following an abortion, STI check, or use of the morning after pill helped some women to become more aware of the importance of contraception issues and routes of access.
- Older women wanted more information on contraception in perimenopause/menopause and this was highlighted as a period of uncertainty.

Women's Health Hubs

- The concept of WHHs appealed to most women. It was viewed particularly positively by younger women who felt daunted by accessing contraception for the first time or those who had faced challenges accessing contraception through the GP or SHC during the pandemic.
- Women of all ages perceived WHHs as a safe and comfortable place, and that practitioners at WHHs would have specialist expertise and in-depth knowledge on contraception and other women's health issues.
- A small number of women raised concerns related to inclusivity and gender identity.

Current attitudes and preferences towards contraception methods

- Condoms and the contraceptive pill were seen as the most easily accessible forms of contraception since the start of the pandemic, however, some worried about the

user-dependent nature of these less-effective methods. For instance, remembering to take the pill every day or placing trust in a partner when using condoms.

- Some women noted improvements in mood swings, hormonal acne and periods from taking the contraception pill while others reported a range of negative side effects. Some said that there wasn't enough information and awareness about side or long-term effects of the pill.
- Perceived benefits of LARC included convenience and longevity however, many women were concerned about fitting procedures for the coil or implant as they perceived them as painful and invasive. Pain around having a coil fitted was a significant concern among women who had experienced this and those who had heard stories from elsewhere.
- Some women were keen to avoid the perceived side effects of hormonal contraception but felt there was a lack of non-hormonal contraception options.
- Some were put off using some forms of LARC because they worried about the potential impact of hormones on their bodies or mental health. Women perceived that it might be difficult to get a coil or implant removed if it did not suit them due to GP waiting times or practitioners being hesitant to remove, especially given how services were perceived to be operating post-pandemic.
- Many women didn't know much, or anything, about the contraceptive patch.
- Many women had experience of accessing the morning after pill which was mostly described as an "easy" process at the pharmacy. Affordability was raised as a particular barrier to access, especially among women who had faced challenges in being able to pay.
- Some women noted other barriers to accessing the morning after pill. A small number said it could be "embarrassing" asking for it, one woman who had accessed emergency contraception online via the SHC explained how this overcame some of the barriers of getting it in person.
- Period tracker apps such as 'Clue' and 'Flow' were popular among our sample of women but few had used them to aid contraception. Some had used the contraceptive app 'Natural Cycles' as a method of contraception and liked the idea of a non-hormonal and more "natural" approach to contraception. While some were receptive to using contraceptive apps in the future, others felt that using apps to prevent pregnancy would be 'risky' as cycles can change monthly, and they wouldn't feel comfortable relying on it.

Decision making

- There were mixed responses on how easy or difficult it was for women to make decisions around contraception.
- Some women described positive accounts of discussions with health practitioners which had helped them in their decision making. Some were confident in sourcing information themselves and weighing up the pros and cons of different methods.
- Some women found decision making hard, either because that felt they had limited options, or because the decision was overwhelming. Women said they felt more confident in discussing contraception as they got older.
- Many women said that they did not want to only hear a health practitioner's view, and most women described the importance of their friends, family, or partners in helping them to form their views and decisions.

Sources of information

- Women were proactive in searching for contraception-related information. Women said that the NHS website was useful as a first point of reference to obtaining information on contraception side effects and methods. It was described as "credible" and "straightforward", but impersonal and "dry".
- Women wanted to hear about other women's lived experiences. Many turned to other online sources, forums, and social media to answer their questions. Some women were particularly interested in the different kinds of debates and information they could learn about on these platforms compared with more traditional sources.
- Some older women felt that contraception had become less of a taboo subject as society had changed and conversations had become more open.
- Contraception was perceived as a taboo subject among people from ethnic minority and religious backgrounds.
- Some women from ethnic minority backgrounds highlighted the importance of translating information into other languages and across more traditional formats of communication such as leaflets.

4.2 Aim 3: To develop recommendations for maximising contraception uptake, including access, delivery, and communication needs (with a focus on LARC).

The following recommendations are based on the findings of aims 1 and 2, and are structured around themes of contraception access, delivery, and communication.

4.2.1 Access

- Improve awareness of the availability of different methods, including LARC, across all ages and advise GPs to discuss a variety of options (not just the contraceptive pill and the implant) to ensure women have access to all methods of contraception.
- Improve awareness about the benefits of accessing contraception at SHCs and how to make an appointment, particularly for younger women or those less likely to attend the GP to access contraception.
- Tackle stigma around SHCs by focusing on the positive accounts of SHCs from women who have used them and framing the SHC as a specialist service that is superior to the GP for accessing all contraception methods, especially LARC.
- Clarify post-pandemic processes on how and where to access contraception to alleviate any confusion caused by COVID-19 related policy and practice changes.
- Increase the availability of appointments for contraception, especially LARC procedures, and have systems in place to ensure women are signposted to a nearby service where they can get a LARC appointment if it is not available or there are long waiting times at their current point of access.
- Review SHC and GP booking systems to make them more user-friendly and create more access points to address barriers associated with lengthy waiting times when booking appointments.
- Policy should consider increasing pharmacy provision of free contraception without a prescription to include emergency contraception. The women expressed how easy

and convenient accessing contraception at the pharmacy was and capitalising on this approach to contraception provision could reduce demand at GPs and SHCs.

4.2.2 Delivery

- Invest in education and training for GPs and practitioners to identify significant time points and life stages when women would benefit from increased contraceptive support and improved interactions at these time points. For instance, when accessing contraception for the first time, in the postpartum period, during perimenopause, following an STI test, or after accessing an abortion or emergency contraception.
- SRH services should offer additional support or contraceptive counselling to those who accessed contraception for the first time during the pandemic as restrictions around policy and practice most likely impacted their experience of accessing contraception and they may be unsatisfied with their current method of contraception.
- Invest in education and training to GPs and practitioners to ensure they take symptoms seriously and do not dismiss the concerns of women who are experiencing side effects that may be caused by their contraception. Women with concerns should be offered contraceptive counselling, preferably in-person, and if the GP or practitioner is unable to provide this, a referral should be made to a SHC or specialist service.
- Ensure remote systems and consultations that were introduced during the pandemic remain available for women who favoured the ease and convenience of these modes of access and strive to make these more user-friendly to encourage more women to switch to accessing contraception this way when appropriate.
- GPs and other SRH-related services should continue to provide in-person consultations for women who prefer to access contraception this way. Choice is valuable and it is important that women have the option to receive in-person support when they feel they would benefit from this.
- Build on women's positive experiences in pharmacy settings by increasing pharmacy provision of contraception and utilise staff working in pharmacies as they are more likely to engage with women in the community who may not attend GPs or SHCs.
- Policy should consider how to offer extra support for women who have tried multiple methods of contraception but are unable to find one that has no adverse effect on their physical or mental health and wellbeing, and for women with conditions of the reproductive system (e.g., PCOS, endometriosis, fibroids), migraines, or menstrual disorders as they face additional challenges when deciding which contraception method is best for them.

4.2.3 Communication

- Consider implementing systems to remind women when replacement contraception is due, especially for LARC, as women were uncertain on the expiry dates of their devices and risk being unprotected from pregnancy.
- Fill the gap in current NHS material to make the information more personal and relatable. Women would like to hear about other women's lived experiences of using each method of contraception and any associated side effects.

- Utilise women's engagement with social media to communicate the benefits of LARC to all women but especially young women and women from ethnic minorities, while providing reassurance and support around pain and pain management of LARC procedures.
- Develop 'myth-busting' information to counter the negative impact of social media on younger women's perceptions of hormonal contraception, especially the contraceptive pill (referred to as the "devil's pill") and increased online content of LARC "horror stories".
- Implement online and traditional marketing campaigns to increase awareness of free contraception services, especially emergency contraception and condoms, with a view to targeting those who may be most affected by cost barriers such as younger women and women living in deprived areas.
- Incorporate a diverse group of contraception 'advocates' and 'ambassadors' into information sources so women from all ages and backgrounds can feel represented in their contraception needs. Women from ethnic minorities were hesitant to use more effective methods of contraception and may benefit from receiving information from an 'advocate' of LARC they can relate to.
- Translate information on contraception methods, how to access contraception services, and postpartum contraception, and make these available to women whose first language is not English. More traditional formats such as leaflets are the preferred method of communication for translated information, and these should be readily available in places the women already access.
- Consider the feasibility of providing interpreters for women whose first language is not English for all contraception appointments, and at antenatal and post-natal appointments to discuss contraception in the postpartum period.
- Schools should review the curriculum to ensure all methods of contraception are discussed with all pupils to tackle the perceived gender imbalance around contraception. Schools should provide practical information on how to access contraception, for instance, where the nearest SHC is and how to make an appointment.

4.3 Study limitations

This study provides information on women's experiences of accessing contraception since the start of the COVID-19 pandemic. Although representativeness was not the intention of this qualitative study, the sample is diverse in terms of age, ethnicity, contraception methods used, services accessed and mode of access. However, findings may not apply to wider populations of women in England, the UK, or elsewhere. The sample was purposely skewed towards women of lower educational attainment and IMD. We found relatively few differences according to these criteria. Using educational level (GCSEs or equivalent and below) on its own may not be an adequate indicator of lower social grade, especially when speaking with younger women who have not yet taken or received their A-level results, as comprised part of our sample. In addition to educational attainment and IMD, to explore inequalities of access, it may be beneficial to recruit women according to poverty-based factors such as such as receipt of benefits, low paid work, reliance on public transport, or caring responsibilities. While our sample included ethnic diversity, to explore more fully specific barriers related to ethnicity, researchers need to build relationships to establish trust

among, and gain access to, ethnic minority groups, and carefully consider who is best to conduct the interviews. Nonetheless, our findings did highlight certain barriers to access among those from ethnic minority backgrounds, and inequalities of access according to age were prevalent.

The study provides important information on women's current attitudes, preferences and decision making around contraception. It was difficult, however, for women to recognise whether their current attitudes and behaviour were a result of the pandemic and changes to service provision. For example, it is not possible for us to conclude that women's search for, and use of, online information has increased since the pandemic, however, there is evidence from elsewhere that use of the internet for health-related information combined with Cyberchondria (health anxiety) increased during the pandemic.[20] It may also be possible that looking for information online, and valuing family and friends' perspectives on contraception, may be a result of difficulties in accessing health practitioners. Finally, we are unable to comment on why period tracker apps were popular among our women, although only two women were currently using an app (Natural Cycles) for contraception. It may be that women's use of apps increased during lockdowns. Some of our women were particularly interested in non-hormonal options. It will be important to understand whether this is a growing trend and future research should explore messaging around hormonal vs non-hormonal contraception, sources of information, women's use of apps, and the potential impact on women's attitudes and behaviour.

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