women's health AUSTRALIA | Australian Longitudinal Study on Women's Health

Reproductive health: Contraception, conception and change of life - Findings from the Australian Longitudinal Study on Women's Health

Report prepared for the Australian Government Department of Health

May 2021

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10. FAMILY PLANNING AND USE OF CONTRACEPTIVES DURING THE COVID-19 PANDEMIC

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10.1 Key messages

Quantitative findings

- 10% of women aged 25-31 years changed their pregnancy plans during the pandemic, compared to less than 1% of women aged 42-47 years.
- 11% of women aged 25-31 years were either pregnant or trying to fall pregnant, compared to 2% of women aged 42-47 years.
- 14% of women aged 25-31 years and 3% of women aged 42-47 years indicated that their contraception use had changed since the pandemic began.
- Very few women reported difficulties in accessing contraception during the pandemic.

Qualitative findings

- The pandemic introduced challenges in accessing reproductive health services and adhering to regular contraceptive methods.
- Women described changes to sexual activity during the pandemic, such as having limited opportunities for sexual activity, or a reduced interest in sex.
- Women wrote of limited maternal health service use, economic instability, additional stress, and uncertainty as reasons contributing to their change of mind on pregnancy and having children.

10.2 ALSWH fortnightly COVID-19 pandemic surveys

As with the rest of the population, the women in the ALSWH have never lived through anything like the COVID-19 pandemic. To capture this moment in time, a series of short fortnightly online surveys was deployed via email to women in the three younger ALSWH cohorts (born 1989-95, 1973-78, and 1946-51), with the first survey sent out in April 2020. The purpose of these surveys was to learn about the women's experiences during the pandemic. These surveys were designed to be brief and succinct, with the online surveys taking 1-2 minutes to complete.

Each fortnight, the same questions were asked concerning COVID-19 symptoms, testing, general health, and stress. Brief questions on specific topics were also included, with the topics changing each fortnight. At the tenth COVID-19 survey (2-15 September 2020), women from the two youngest cohorts (aged 25-31 years and 42-47 years) were asked about the impact of the pandemic on their plans for pregnancy and about contraceptive use during the pandemic. The following two sections present summary findings from this survey. COVID-19 Survey 10 also invited women to write about their concerns or experiences during the pandemic. After identifying those free text responses that were pertinent to family planning, a qualitative analysis was undertaken, the results of which are presented in Section 10.5.

10.3 Pregnancy plans during the COVID-19 pandemic

Around 10% of women aged 25-31 indicated that their plans for pregnancy had changed since the pandemic started, with 6% delaying pregnancy and 4% planning to become pregnant sooner than they had planned prior to the pandemic. Less than 1% of women aged 42-47 reported changing their plans for pregnancy since the pandemic started (Table 10-1).

Around 11% of women aged 25-31 and 2% of women aged 42-47 were either pregnant or trying to fall pregnant at the time of the survey.

Table 10-1 Pregnancy intentions since the COVID-19 pandemic started and current pregnancy status among women aged 25-31 years and 42-47 years

	Aged 25-31 (N = 1,972)		Aged 42-47 (N = 2,253)	
	N	%	N	%
Have your plans for pregnancy changed since the COVID-19 crisis began? (Mark one only)				
No, my plans have not changed	1,698	86.11	2,169	96.27
Yes, I plan to have a child later than I had planned prior to COVID-19	125	6.34	9	0.40
Yes, I plan to have a child sooner than I had planned prior to COVID-19	79	4.01	3	0.13
Other	66	3.35	63	2.80
Missing	4	0.20	9	0.40
Are you currently pregnant or trying to get pregnant? (Mark one only)				
Yes, I am currently pregnant	117	5.93	7	0.31
Yes, I am trying to get pregnant	98	4.97	31	1.38
No	1,750	88.74	2,207	97.96
Missing	7	0.35	8	0.36

Since the start of the COVID-19 crisis, reported pregnancy intentions were similar for women aged 25-31 years who had either a university qualification, a trade certificate or equivalent, or who had completed Year 12 or less, with 85-88% of women born 1989-95 indicating that their pregnancy intentions were unchanged during the pandemic (Figure 10-1). Pregnancy intentions were similar for women who lived in major cities versus women who lived in regional and remote areas. Women aged 25-31 who indicated that their available income was manageable were more likely to report that they planned to have children earlier than they originally planned when compared to women who found it difficult or impossible to manage on their available income (5.0% versus 2.1%, respectively).

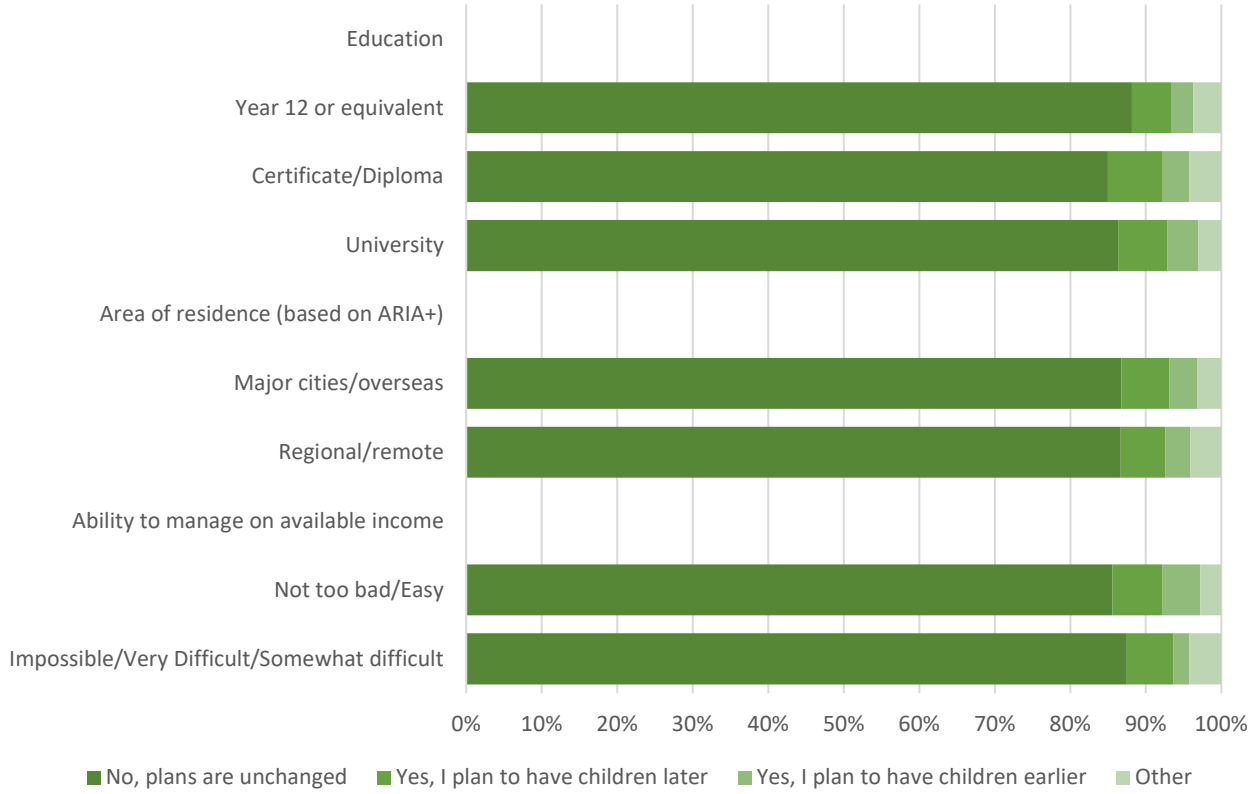

Figure 10-1 Pregnancy intentions since the COVID-19 pandemic started, among women aged 25-31 years, according to socio-demographic factors at most recent main survey.

Six months into the COVID-19 pandemic, 6.4% of women aged 25-31 with a university qualification had reported being currently pregnant, compared to 4.9% of women with a trade certificate or equivalent and 3.0% of women who had completed Year 12 or less (Figure 10-2). A higher proportion of current pregnancies were reported by women living in regional and remote areas, compared to women living in major cities (8.5% versus 5.6%). Women aged 25-31 who managed on their income were also more likely to report currently being pregnant during the pandemic (7.1%) than women who reported that their available income was not manageable (3.8%).

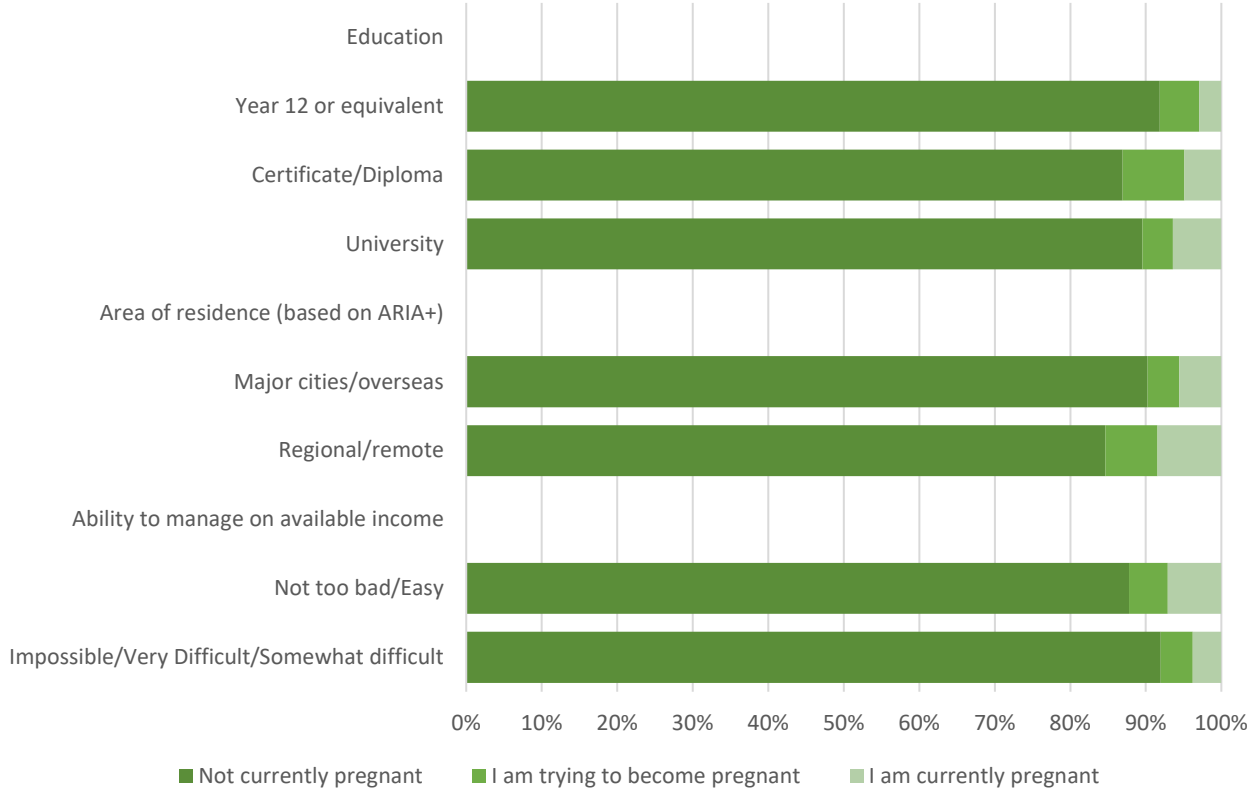

Figure 10-2 Current pregnancy status among women aged 25-31 years, according to socio-demographic factors at most recent main survey.

Only 12 women (0.5%) aged 42-47 years reported changing their pregnancy plans, and less than 40 women (1.6%) indicated that they were currently pregnant or trying to become pregnant at the COVID-19 Survey 10. As a result of these low numbers, no detailed examination of socio-demographic factors for women aged 42-47 was conducted.

10.4 Contraceptive use during the COVID-19 pandemic

10.4.1 Change in contraception use

Among women aged 25-31 years, 14% indicated that their contraception use had changed since the pandemic began, with 6% indicating that they no longer used contraception and 8% indicating that they had changed their contraception method. Among women aged 42-47, the majority of women indicated that their contraception use had not changed since the pandemic started, with only 3% indicating that their contraception use had changed, including 1% who indicated that they no longer use contraception and 2% who indicated that they had changed contraception.

Table 10-2 Change in contraception use during the COVID-19 pandemic (at September 2020) for women aged 25-31 and 42-47 years

Has your contraception use changed since the COVID-19 crisis began? (Mark one only)	Aged 25-31 (N = 1,972)		Aged 42-47 (N = 2,253)	
	N	%	N	%
Missing	7	0.35	12	0.53
Yes, I have changed the contraception I use	159	8.06	50	2.22
Yes, I have stopped using contraception	122	6.19	22	0.98
No, the method of contraception I use has not changed	1,300	65.92	1,186	52.64
No, I still do not use contraception	384	19.47	983	43.63

10.4.2 Type of contraceptives used during the COVID-19 pandemic

Women were asked about their use of 13 types of contraceptive methods during the COVID-19 pandemic, which were classified into the following groups (Harris et al; 2020):

- short-acting contraceptives (i.e., the combined OCP, the progesterone only pill, an unknown type of OCP, vaginal ring, and hormone injection);
- condoms;
- emergency contraception;

- LARCs (i.e., contraceptive implant, copper IUD, and progesterone IUD);
- natural methods (i.e., withdrawal method and fertility awareness period method); and
- other (any contraceptive method not listed).

Among women aged 25-31 who indicated that they were not currently pregnant or trying to become pregnant (N = 1,750), short-acting contraceptive methods were the most common contraceptive method used since the beginning of the COVID-19 crisis. Around one in three women (37%) indicated they used this option, which was most commonly the combined OCP, but also included the progesterone-only pill (the 'mini-pill'), the hormonal injection, and the vaginal ring. More than a quarter of women aged 25-31 reported using condoms (28%) and LARC (28%). Natural methods were reported by 16% of women aged 25-31, while 2% reported that they had used emergency contraception since the beginning of the pandemic (Figure 10-3).

Compared to data collected at the last main ALSWH survey of women born 1989-95 (2019), women during the pandemic were less likely to use condoms, more likely to use LARC, and more likely to use no contraception. Overall, the differences were minimal and reflect changes that occurred both within the context of the pandemic and those changes in use that ordinarily occur as time passes.

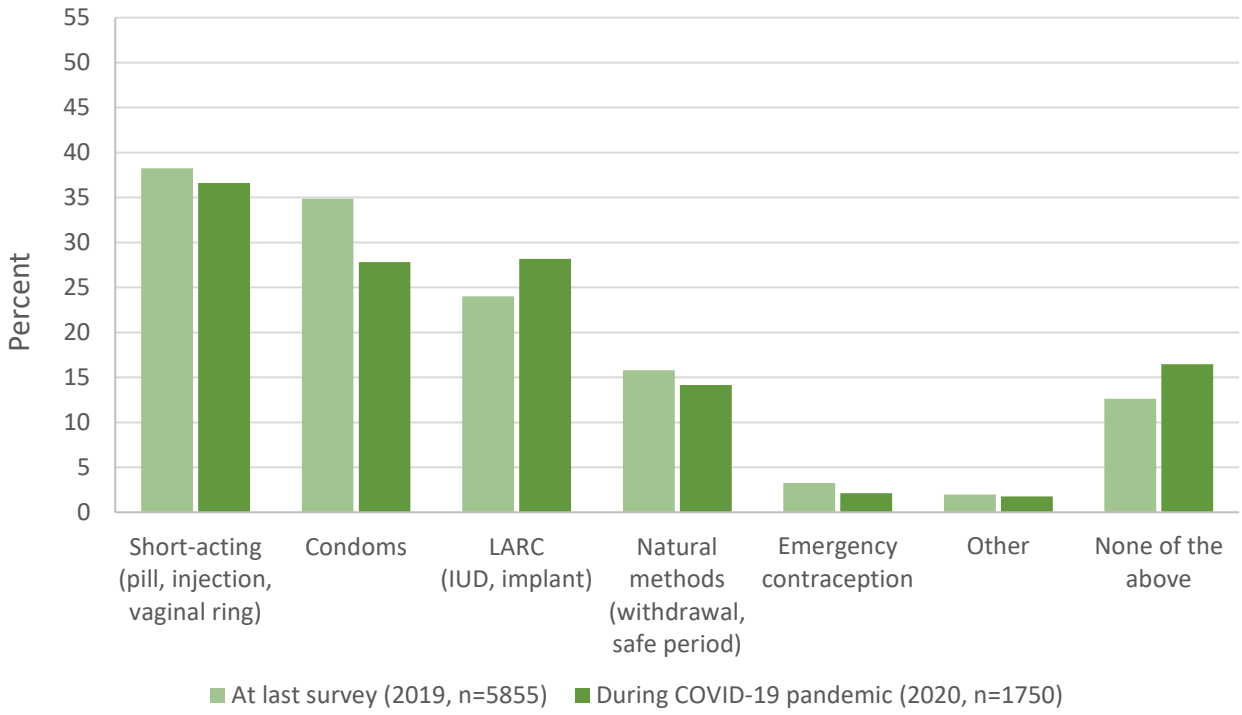

Figure 10-3 Contraceptive methods used among women aged 25-31 years, as reported at last main ALSWH survey (2019) and during the COVID-19 pandemic (at September 2020).

Among women aged 42-47 who indicated that they were not currently pregnant or not trying to become pregnant during the pandemic (N = 2,207), 50% indicated that they were using none of the listed contraceptives (Figure 10-4). The most common contraceptive methods reported include LARC (18%), short-acting methods (12%), and condoms (9%). Less than 1% of women aged 42-47 reported using emergency contraception. During the COVID-19 pandemic, women were less likely to report using condoms (9% versus 15%), and more likely to use no contraception (49% versus 46%), compared to contraceptive methods reported before the pandemic (reported at the last main ALSWH survey in 2018).

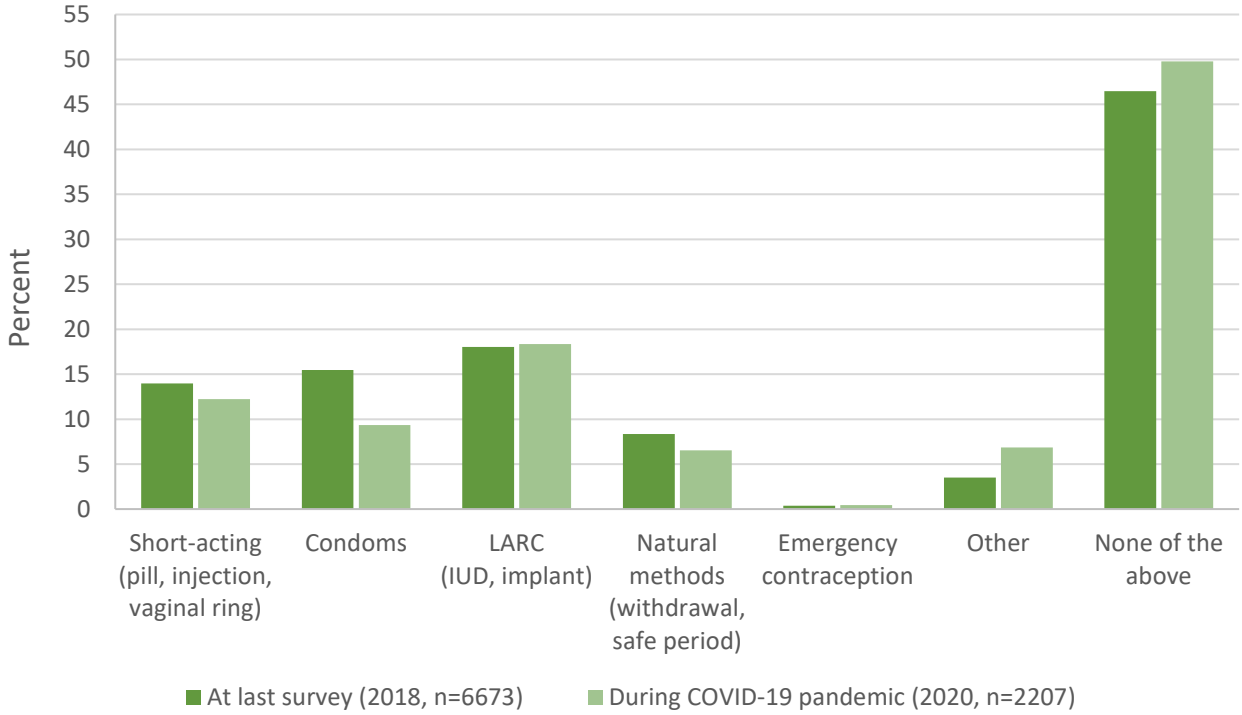

Figure 10-4 Contraceptive methods used among women aged 42-47 years, as reported at last main ALSWH survey (2018) and during the COVID-19 pandemic (at September 2020).

10.4.3 Number of contraceptive methods used during the COVID-19 pandemic

The number of contraceptive methods used differed between cohorts (Figure 10-5), with women aged 25-31 more likely to report using multiple contraceptive methods than women aged 42-47. Among women aged 25-31 who were using contraception, 70% used one type of contraceptive only, 24% used two contraceptive types (condoms were most commonly used with either a short-acting contraceptive like the OCP, or with a LARC), and 6% used three or more types of contraceptives. Among women aged 42-47 who were using contraception, 91% reported using one type of contraceptive only, with 8% using two types, and 1% using three or more types of contraception.

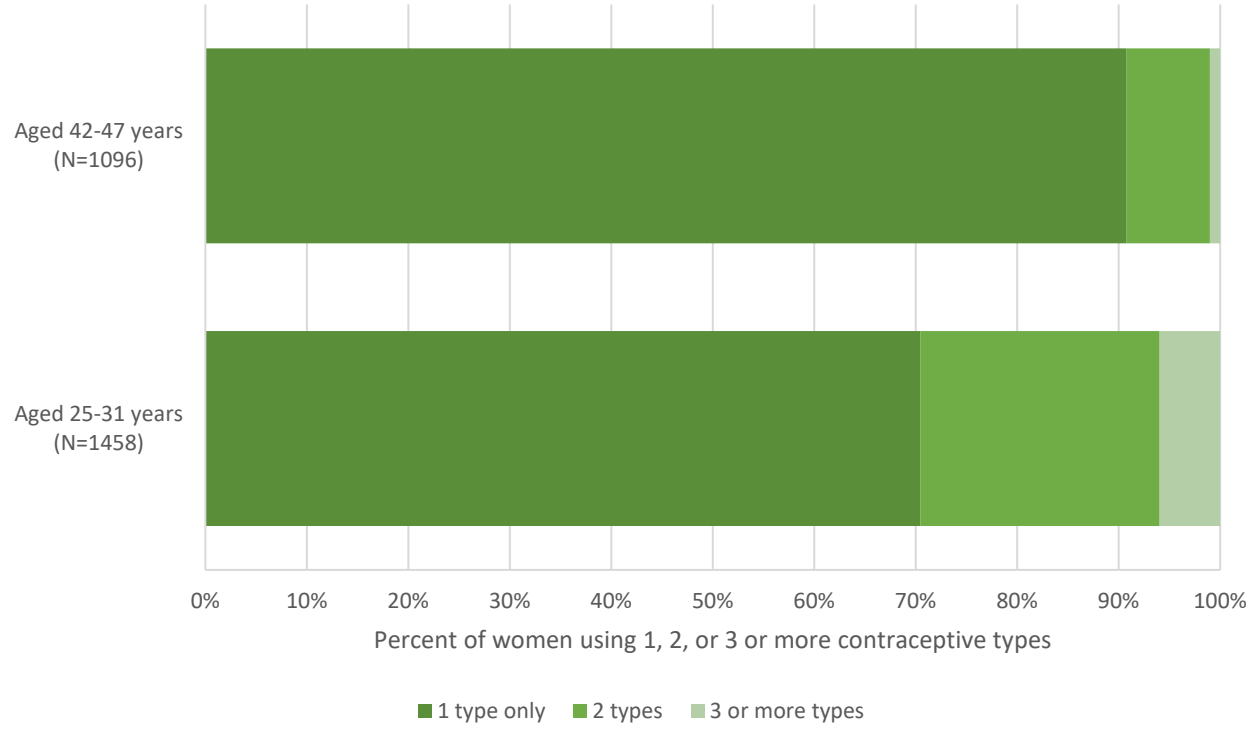

Figure 10-5 Number of contraceptive types used by women during the COVID-19 pandemic (at September 2020), among women aged 25-31 years and 42-47 years.

10.4.4 Difficulties accessing contraception during the COVID-19 pandemic

Among women aged 25-31, 6% reported difficulty accessing contraception, most commonly the OCP (4%) and the progesterone IUD (1%). Of women aged 42-47, 2% reported difficulty accessing contraception, most commonly the OCP (1%). Women elaborated on their experiences in obtaining contraception during the pandemic in the qualitative section of the survey. The results of these data are presented in the next section.

10.5 What women said about the impact of the COVID-19 pandemic on their contraception use, pregnancy plans, and sexual and reproductive health: A qualitative analysis

A total of 328 participants from the 1989-95 and 1973-78 cohorts provided free text comments in the COVID-19 Survey 10. Of the 328 comments, 178 women (39 from the 1989-95 cohort and 139 from the 1973-78 cohort) provided comments about their

sexual and reproductive health. Comments which were not specific to experiences during the COVID-19 pandemic were excluded (e.g. *'My husband had vasectomy years ago'* or '*I have had a hysterectomy so not relevant'*). Therefore, the following qualitative thematic analysis includes comments from 150 participants: 118 women from the 1989-95 cohort and 32 women from the 1973-78 cohort.

Comments were coded using a thematic analysis technique. Thematic analysis, as detailed by Braun & Clarke (2006), is a flexible analysis technique which has successfully been applied to free-text analysis. Thematic analysis involves familiarisation with the data, generation of initial codes, developing themes, reviewing themes, defining and naming themes, and producing the report.

10.5.1 Results

Two major themes were generated from the qualitative analysis. The first of these was practices of contraception use, and reproductive and sexual health. This theme included four subthemes: reproductive and sexual health service use, contraceptive practices, sexual activity, and fertility issues. The second major theme was attitudes and beliefs towards contraception, reproductive and sexual health. This theme included two subthemes: attitudes towards having children, and pregnancy and birth.

Practices

Reproductive and sexual health service use

In adhering to COVID-19 restrictions and social distancing measures, reproductive and sexual health services were offered in a limited capacity during the COVID-19 pandemic. Women noted limited availability of services, as well as self-limiting their use of services. Women from both cohorts discussed difficulty in accessing appointments for sexual health screening, contraception upkeep, and other reproductive health services:

> *Very hard to get a GP face to face visit for a* [Pap] *Smear.* (1989-95 cohort participant)

Covid has impacted accessibility of maternity and GP services in our small rural town - it has been more difficult to engage with services. (1989-95 cohort participant)

Difficulty in sourcing elective surgery to have Mirena replaced due to limited elective surgery options. (1973-78 cohort participant)

IVF during Covid has another layer of complexity. With the first wave the service was on hold for 2 weeks. Covid adds another layer of stress. (1973-78 cohort participant)

For some women, limited access to reproductive and sexual health services created unintentional consequences, including additional stress and costs, and prolonged pain or side effects:

I use an IUD for managing the symptoms of my endometriosos. Due to COVID-19, I have had to delay the plans I had to go back to my gyno and get my endometriosis removed, so I still live with a considerable amount of pain. (1989-95 cohort participant)

I was still able to access a contraceptive implant but the supplier did change as well as the cost. My appointment with Family Planning was cancelled with no replacement appointment offered. Fortunately my local health centre offered to put in for me instead. The cost difference was about $150… (1973-78 cohort participant)

Many women spoke of their personal choice to limit their reproductive and sexual health service use during the COVID-19 pandemic, particularly their use of contraceptive and sexual screening services. Adhering to social distancing and lockdown regulations, fear of catching COVID-19, and avoiding the additional barriers and stress in accessing services were some of the reasons women gave for limiting their health service use:

I technically can get my IUD replaced- but the barriers are higher eg more difficult to access appointments, and the risks are greater. I am avoiding it... (1989-95 cohort participant)

I am overdue for a pap test because of Covid/fear of covid. (1973-78 cohort participant)

Throughout the COVID-19 pandemic, many health services offered telehealth appointments (e.g., phone or video calling) as an alternative to face to face appointments. A few women from the 1989-95 cohort commented on the challenges in using telehealth for reproductive and sexual health services:

My GP has not been doing any face to face consults so I haven't been able to have my routine [cervical screening test] (1989-95 cohort participant)

I recently delayed seeking an appointment for a routine Pap smear due to limited availability of face to face appointments. (1989-95 cohort participant)

Contraceptive practices

Women offered insight into the impact of the COVID-19 crisis on the availability of contraception at pharmaceutical dispensaries and the ability to see a healthcare provider for contraceptive health care, in addition to the impact on their own comfort levels in seeking contraceptive health care. All of these factors impacted their contraceptive practices.

A number of women described having difficulty accessing their regular OCP during the COVID-19 crisis, due to a shortage in supply. Some indicated that they had gone without their medication for a period of time:

…The pill I was [supposed] to get is out of stock australia wide and will take a few weeks to get shipped in so am without for a few weeks. (1989-95 cohort participant)

Searching for the oral contraceptive I'd been on for years due to lack of supply was quite stressful. (1989-95 cohort participant)

I prescribe contraception - there is no Norimin and Norimin-1 available in our town and this has caused some trouble for people who suffer significant side effects with other COCPs! (1989-95 cohort participant)

While some women reported going without the OCP, others indicated that they had obtained new prescriptions and were using different pill varieties. One woman highlighted the potential adverse consequences of this, describing the side effects that she had experienced from the different pill. It was also clear that changing from their regular contraceptive pill was stressful for these women, many of whom indicated that they had previously used the same pill for a long time:

Changing contraception due to lack of availability of the pill I was on before has had a massive negative impact. I tried a number of pills before settling on a pill. The pills I initially tried had massive side effects on my mental health. Having to move to another pill thus caused a large amount of stress and anxiety and the new pill has again caused negative side effects and severe anxiety. (1989-95 cohort participant)

Had to get different script as the brand I was on is out of stock until November. That 3 months waiting. I have been using the same brand for over 20 yrs. (1973-78 cohort participant)

Aside from the shortage in supply of contraceptive medications, an additional barrier to accessing contraception was the difficulty in accessing an appointment with a health practitioner during the COVID-19 crisis. Many women indicated a desire to change their contraceptive method, however a lack of available appointments with healthcare providers was a barrier to making this change:

I have commenced a new relationship during COVID -19 and would like to use a method of contraception other than condoms but without easy access to a GP to discuss it with am not sure what would be suitable (I was last on the combined pill approximately 4 years ago). (1978-78 cohort participant)

Before covid I had a referral to get the IUD, but due to restrictions and cancelled appointments I have not had it done, and just staying on the pill. (1989-95 cohort participant)

The difficulty in accessing health services extended to those with hormonal implants and IUDs. There was a large number of women who indicated that they were overdue for the removal or replacement of their implant or IUD. As women explained, this left them at risk of side effects, in addition to a potential unplanned pregnancy. Further, some women indicated that they had been very stressed by this:

GP treatment/procedure room was closed during COVID restrictions and I an overdue for new implanon insertion. (1989-95 cohort participant)

Due to COVID-19 the removal of my mirena was delayed possibly prolonging serious side effects. (1989-95 cohort participant)

I had to get my Mirena replaced during Stage 4 lock down in Melbourne. It was okay and my doctor was great but it definitely had an impact on the process. The last one I got, I had done at a specialist clinic but this time I just went to my doctor because it felt safer. It added a lot of stress to the process having to deal with restrictions on top of an already difficult thing. (1989-95 cohort participant)

Another barrier to accessing contraception was women not wanting to seek contraceptive health care during the COVID-19 crisis. It was clear that many women did not feel comfortable leaving home to see a health care provider during the pandemic and so they limited their own access to services. Self-limiting was

particularly evident for those facing strict lockdown conditions in locations in which high COVID-19 case numbers were recorded. There was also some uncertainty surrounding recommendations to stay at home, as well as whether or not contraceptive procedures were considered elective:

> *I am due for a change of my Mirena IUD but I don't feel comfortable doing this during stage 4 restrictions in Melbourne - in fact I'm pretty sure I couldn't do this as I need a light general anaesthetic (due to previous complications) and this is not a category 1 or 2 surgical procedure so not allowed.* (1973-78 cohort participant)

> *I would like to have another discussion with a practitioner at Royal Women's Hospital about changing my birth control because I am having issues with it again. I have delayed this discussion and am making-do with the side-effects, when I probably would have made active plans had the COVID-19 pandemic not affected Victoria like this.* (1989-95 cohort participant)

> *While my access to obtaining the Mirena hasn't changed, I haven't been in for a followup partially as a result of a reluctance to go to a doctor surgery for a non-vital service.* (1989-95 cohort participant)

Although the majority of comments about contraception described barriers to use, it must be noted that a minority of women reported no difficulty in accessing contraception during the pandemic (as reported in Section 10.4.4). A small number of women wrote that they had not experienced or perceived any difficulties accessing their regular contraception and contraceptive care during the COVID-19 crisis:

> *No issues with contraceptives access.* (1989-95 cohort participant)

> *Had to change my mirena over - quite straight forward to do during COVID.* (1973-78 cohort participant)

Women also described using online services to both obtain their prescriptions and order their medications during the COVID-19 crisis. These services were spoken about positively, with women highlighting the convenience of not having to visit a GP and chemist and the increased ease of access:

> *I have changed the way I get my pill. I have swapped to an online Dr to have the pill sent to me in the mail so I can avoid the GP and chemist. I also don't have to worry about the availability of my pill.* (1989-95 cohort participant)

> *I started using a pill delivery service. It meant that I didn't need to go to my gp to get a script. I had been thinking about this pre Covid but Covid did impact my decision to use the service.* (1989-95 cohort participant)

Sexual activity

Women described a range of ways in which the COVID-19 had impacted their sexual activity. The impact of the COVID-19 crisis on single women's sexual activity was apparent. Many women, particularly from the 1989-95 cohort, explained that they had not been sexually active during the COVID-19 crisis. Some explained that this was due to social distancing recommendations:

> *In the context of these questions, I am not sexually active (no partner and currently social distancing).* (1989-95 cohort participant)

> *I'm single and not currently sexually active and that's unlikely to change while socially distancing is still recommended*. (1989-95 cohort participant)

Moreover, those living in areas with strict lockdown policies described having no opportunity for sexual relationships:

> *Single. Stage 4 lockdown. No sexual prospects possible.* (1989-95 cohort participant)

A number of women from the 1973-78 cohort described changes to their sexual activity within their relationships during the COVID-19 crisis. Some reported having a reduced interest in sex due to stressors associated with the pandemic:

> *I feel like my libido is in quarantine!* (1973-78 cohort participant)

> *I have not been intimate with my husband during covid, I think we are just too stressed and too tired. And he goes to bed early and gets up early (4:30am) and I go to bed late and get up late (7am), this is just so we can get through looking after 5 kids and running our business which has been able to continue to trade, but the cost of exhaustion is mounting with all the additional paperwork and homeschooling.* (1973-78 cohort participant)

Some women offered insight into those working on the frontline of the pandemic, or with family participants in health care. Concerns about spreading the COVID-19 virus seemed to affect sexual behaviours within these relationships:

> *No energy for intimacy with partner and concerned about possible risks as well since he also works in front line as a GP.* (1973-78 cohort participant)

> *Covid has likely contributed to having sex less due to me working in a hospital and being worried about possible spread of covid to my husband.* (1973-78 cohort participant)

<u>Fertility issues</u>

Women reflected on the additional challenges faced by those experiencing fertility issues during the COVID-19 crisis. These included restricted access to fertility services and the associated mental health costs. Further, this subtheme relates to attitudes towards pregnancy, which is discussed later in this chapter:

My partner wants to begin the process of IUI and then IVF if unsuccessful but she wants to carry the baby. However due to IVF being an elective surgery that has been cancelled, it has been postponed. (1989-95 cohort participant)

I was accessing fertility treatment prior to covid restrictions and this did mean a period of not having access. However, living in SA I was able to recommence treatment recently which luckily resulted in pregnancy. (1989-95 cohort participant)

Extended stress and experienced depression due to ivf treatment being postponed. (1973-78 cohort participant)

Attitudes and beliefs

Attitudes towards having children

Women from the 1989-95 and 1973-78 cohorts wrote about their attitudes toward pregnancy and having children, and the ways in which the COVID-19 crisis impacted their beliefs and decisions.

A few women born 1989-95 and 1973-78 spoke about their increased desire to have children during the COVID-19 pandemic. Fertility issues, changes to employment, and the strengthening of relationships were some of the factors which contributed to this increased desire to have children:

This year has been intense in so many ways and I think just seeing how our relationship has held strong, and we've survived what has happened personally, and throughout the world, that has helped confirm the decision to have kids. (1989-95 cohort participant)

Bringing pregnancy plans forward due to feeling less tied to work. (1989-95 cohort participant)

I'm actually doing IVF as a single person because I've had a frozen embryo in storage for several years. There seemed like no better time than to give this one last go. (1973-78 cohort participant)

In general, women with fertility issues did not appear to change their pregnancy plans during the COVID-19 crisis. These women described continuing to try to start a family, despite the pandemic:

> *Due to my own ongoing chronic health issues impacting on our ability to conceive we decided not to take a break during Covid. I have fewer viable cycles than a healthy woman and we don't want to miss those opportunities as it would cause much longer delays for us than for others trying to conceive.* (1989-95 cohort participant)

Some of these women acknowledged the complex circumstances under which they were trying to start a family due to the COVID-19 pandemic:

> *We had been trying to conceive for a year prior to the start of COVID-19. We had been struggling to conceive, and decided not to stop trying despite the pandemic. We finally managed to fall pregnant in June, and it feels like the timing isn't great given the increasing restrictions and second [wave] in Victoria where we live, but we didn't want to take any longer to get pregnant than absolutely necessary, since it had been so hard.* (1989-95 cohort participant)

Many women from the 1989-95 cohort wrote about feeling highly reluctant about becoming pregnant or having children. Some women attributed this to the unforeseen circumstances resulting from the pandemic, including economic instability, limited maternal health services, and additional stress and uncertainty as reasons for the change in their stance on pregnancy and having children:

> *On the topic of pregnancy, if I was to fall pregnant (unplanned), I feel like I would be more inclined to get a TOP due to COVID than prior to COVID. This is due to the change in the public maternity system and lack of support for women in the perinatal period because of COVID.* (1989-95 cohort participant)

> *I got pregnant about 5 weeks prior to Covid getting serious in WA. Had Covid had happened earlier, we probably would have stopped trying to get pregnant. It is a very stressful time to bring a baby into the world not knowing what is going to happen and the financial uncertainty that comes with that.* (1989-95 cohort participant)

For other women, the COVID-19 pandemic validated their pre-existing desire to not have children. Overpopulation concerns, public health issues, and climate change were some of the concerns women had prior to the COVID-19 crisis:

> *If anything, I want a child even less than I did at the start of the pandemic. I already felt that I should not bring a child into the world due to climate change. I think having a child right now is doubly selfish and irresponsible.* (1989-95 cohort participant)

Unpredictability was widely discussed as a major impact of the COVID-19 pandemic. Some women from the 1989-95 cohort wrote about their increased uncertainty surrounding the desire to have, or not have, children. A few women discussed the uncertainty around their ability to meet a partner during the pandemic whilst adhering to social distancing and lockdown requirements. Other women spoke of the uncertainty surrounding the virus more broadly, and whether it is appropriate to have children:

> *Regarding fertility plans COVID adds to my already long list of cons about having a baby. I remain undecided if i would like to have children one day or not.* (1989-95 cohort participant)

> *My plans have not changed around pregnancy (I am still unsure about ever having children) and in fact this crisis has given me further reason not to become a mother. It seems very counterintuitive to bring another person I love into a world like this one.* (1989-95 cohort participant)

> *The pandemic gives me another reason to worry about whether or not it is right to ever have children.* (1989-95 cohort participant)

There was a consensus that pregnancy and having children during the pandemic was increasingly difficult and complex. Some women from the 1973-78 cohort discussed their relief and gratitude for having children prior to the COVID-19 pandemic:

> *Often reflect on how fortunate we are to have had our children prior to covid as I would have been terribly stressed about all the restrictions and ramifications if I was pregnant in this current time.* (1973-78 cohort participant)

> *Who would like to bring a kid into this shitstorm.* (1973-78 cohort participant)

Pregnancy and birth

One of the most prominent themes drawn from the comments concerned the difficulties associated with being pregnant and giving birth during the COVID-19 crisis. This included the multifaceted struggle of many women from the 1989-95 cohort experiencing pregnancy and the postpartum period while living through a pandemic. One woman from the 1989-95 cohort highlighted this concurrent adversity:

> *I gave birth in March 2020 to my first baby. So I've been navigating COVID alongside navigating post-partum, often it's hard to tell which major event has affected me more.* (1989-95 cohort participant)

Women also wrote about the impact of the COVID-19 pandemic restrictions on mothers and pregnant women, including the isolation associated with travel and gathering restrictions, the limitations of health care during pregnancy and the postpartum period, added financial and economic stressors, and the impact on women's mental health.

A number of women identified the challenges associated with travel and gathering restrictions for women who had given birth during the COVID-19 crisis. Women from the 1989-95 cohort described being isolated at home, many unable to have family members visit during this time. This was associated with feelings of stress and depression:

> *my baby was born at the start of the pandemic. It really impacted my mental health as I was isolated and only had my partner and baby.* (1989-95 cohort participant)

> *…none of our family will get to meet our newborn until well who knows..... it is depressing thinking about it.* (1989-95 cohort participant)

Additionally, with family members unable to visit, many mothers explained that accessing emotional and practical support was difficult during this time:

> *There was a time when I was pregnant since covid began and covid made keeping the baby impossible as my family are in NSW and I'm Victoria and I couldn't see there being any support to do it on my own.* (1989-95 cohort participant)

> *I had a baby in the height of COVID 19. It was hard to access family support in the early days. Things are now relatively normal in WA for which I am grateful.* (1989-95 cohort participant)

An overwhelming number of comments were made about shortfalls of perinatal health care during the COVID-19 crisis. Several women reported having perinatal appointments cancelled, leaving them feeling unsupported and unprepared for pregnancy and motherhood:

> *Covid has affected my antenatal appointments and potential for meeting other pregnant mothers via antenatal classes.* (1989-95 cohort participant)

> *covid caused me to have less prenatal visits throughout my pregnancy. My birth class was also cancelled so I felt I didn't receive the knowledge people normally would for birth.* (1989-95 cohort participant)

Pregnant women described a number of changes to regular care during the COVID-19 crisis. Some women wrote about appointments being replaced by telehealth sessions, or having face-to-face appointments which were quite short in duration. A large number of women commented on the restrictions to the number of people allowed in consultation rooms during the pandemic. These women explained that their partners were unable to attend many appointments, leaving them without a source of support. The stress associated with this was particularly evident:

> *Husband has not been able to attend most obstetrician appointments (based at private hospital), which has been pretty upsetting as were are first-time parents.* (1989-95 cohort participant)

> *Partner hasn't been allowed to attend appointments. I was admitted to hospital this week due to reduced movement of baby and my partner was not allowed to enter the hospital with me. This was extremely stressful and difficult for us both.* (1989-95 cohort participant)

> *I have PTSD from my first pregnancy/birth, and have found the differences in antenatal care this time around quite challenging and anxiety inducing. Not all appointments are face to face, the appointments I do have seem quite brief to try and limit the time spent with each patient.* (1989-95 cohort participant)

The economic impact of the COVID-19 pandemic was also described in relation to pregnancy and newborn babies. Women described struggling financially during this time, including facing the impact of the COVID-19 pandemic on their employment and maternity leave plans:

It's becoming more and more stressful with a baby at home and not being able to see family. I am also really struggling financially we have no income right now. (1989-95 cohort participant)

COVID-19 has impacted on the amount of time I will be able to spend with my baby as my husband has lost his job but I still have mine. I will not be able to spend the planned year with my baby and will likely stop breastfeeding earlier than 12 months as well. (1989-95 cohort participant)

The profound impact of the concurrent stressors on mothers and pregnant women during the COVID-19 crisis was clear. Women from the 1989-95 cohort described major deficits in their mental health during this time, including experiencing stress, depression, and anxiety.

These ridiculously strict restrictions imposed on us for extended periods of time in Vic is ruining my mental health dramatically. I am not able to enjoy this pregnancy or any aspect of life as I normally would. (1989-95 cohort participant)

I have developed diagnosed post natal depression during covid and believe without the stage 4 restrictions in Melbourne I may not have. (1989-95 cohort participant)

10.6 Conclusion

Most women indicated that they could access their usual contraception during the pandemic. Nevertheless, the qualitative data suggest that difficulty with accessing contraception was distressing for the 6% of women aged 25-31 and 2% of those aged 42-47 who reported this experience. Some women (14% of women aged 25-31 and 3% of women aged 42-47) reported changing their contraception during the pandemic, with qualitative data indicating a number of reasons beyond access issues, including the desire to have children sooner and becoming less sexually active.

The impact of the pandemic on family planning decisions was noted by a minority of women. One in ten women aged 25-31 indicated that they had reconsidered when, or if, to have children, demonstrating the disruption of the pandemic to life plans. The qualitative data revealed the depth of feeling evoked by the pandemic with regard to having children, with the COVID-19 crisis seen as a catalyst for delaying pregnancy, deciding to never have children, confirming the desire to have children, or deciding to have children earlier than originally planned.

10.7 References

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