

Barriers To Accessing Contraception and Cervical and Breast Cancer Screening During COVID-19: A Prospective Cohort Study



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ABSTRACT

Objective: This study sought to examine how access to contraception and cervical and breast cancer screening in British Columbia, Canada, has been affected by the COVID-19 pandemic.

Methods: From August 2020 to March 2021, 3691 female residents of British Columbia (age 25–69 y) participated in this study. We used generalized estimating equations to analyze the proportion of females accessing contraception and the proportion having difficulty accessing contraception across the different phases of pandemic control measures, and logistic regression to analyze attendance at cervical and breast cancer screening. We added sociodemographic and biological variables individually into the models. Self-reported barriers to accessing contraception and attending screening were summarized.

Results: During phases with the highest pandemic controls, self-reported access to contraception was lower (OR 0.94; 95% CI 0.90–0.98;

$P = 0.005$) and difficulty with access was higher (OR 2.74; 95% CI 1.54–4.88; $P = 0.001$). A higher proportion of adults aged 25–34 years reported difficulty accessing contraception than those aged 35–39 years ($P < 0.0001$), and participants identifying as Indigenous had higher odds of access difficulties (OR 5.56; 95% CI 2.44–12.50; $P < 0.001$). Of those who required screening during the COVID-19 pandemic, 62% and 54.5% did not attend at least one of their cervical or breast screening appointments, respectively. Those with a history of breast cancer had significantly higher odds of self-reporting having attended their mammogram appointment compared with those without a history of breast cancer (OR 5.62; 95% CI 2.69–13.72; $P < 0.001$). The most common barriers to screening were difficulty getting an appointment and appointments being considered non-urgent.

Conclusions: The COVID-19 pandemic has uniquely affected access to contraception and cancer screening participation for various subgroups. Self-reported data present potential avenues for mitigating barriers.

RÉSUMÉ

Objectif : Cette étude visait à examiner à quel point la pandémie de COVID-19 a nui à l'accès à la contraception et au dépistage des cancers du sein et du col de l'utérus en Colombie-Britannique (Canada).

Méthodologie : Pour la période d'août 2020 à mars 2021, 3 691 résidentes de la Colombie-Britannique (âgées de 25 à 69 ans) ont participé à cette étude. Nous avons utilisé des équations d'estimation généralisées pour analyser les proportions de femmes ayant eu accès à la contraception et de femmes ayant éprouvé des difficultés d'accès pendant les différentes phases de mesures de gestion pandémique. Nous avons aussi effectué une analyse de régression logistique concernant le dépistage des cancers du sein et du col de l'utérus. Nous avons ajouté des variables

Keywords: contraception; early detection of cancer; COVID-19; breast neoplasms

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Disclosures: Funding for this project was from a Michael Smith Foundation for Health Research Grant (19055) and a BC Women's Health Foundation Grant (LRZ30421) both awarded to Dr. Lori A. Brotto and Dr. Gina S. Ogilvie.

All authors have indicated they meet the journal's requirements for authorship.

Received on February 1, 2022

Accepted on May 25, 2022

Available online June 20, 2022

sociodémographiques et biologiques individuellement dans les modèles. Les obstacles autodéclarés concernant l'accès à la contraception et au dépistage ont été résumés.

Résultats : Pendant les phases où les mesures de gestion pandémique étaient les plus contraignantes, l'accès autodéclaré à la contraception s'est avéré inférieur (RC : 0,94; IC à 95 % : 0,90–0,98; $p = 0,005$) et les difficultés d'accès ont été plus élevées (RC : 2,74; IC à 95 % : 1,54–4,88; $p = 0,001$). Les difficultés d'accès à la contraception ont été déclarées davantage chez les 25 à 34 ans que chez les 35 à 39 ans ($p < 0,0001$). Les participantes s'identifiant comme autochtones avaient le plus grand risque de difficultés d'accès (RC : 5,56; IC à 95 % : 2,44–12,50; $p < 0,001$). Chez celles devant subir un dépistage pendant la pandémie, 62 % et 54,5 % ne se sont pas présentées à au moins un de leurs rendez-vous pour le dépistage du cancer du col de l'utérus ou du cancer du sein, respectivement. Celles ayant un antécédent de cancer du sein étaient significativement plus susceptibles d'autodéclarer s'être présentées à leur rendez-vous de mammographie que celles sans antécédent (RC : 5,62; IC à 95 % : 2,69–13,72; $p < 0,001$). Les obstacles au dépistage les plus fréquemment rapportés étaient la difficulté à obtenir un rendez-vous et les rendez-vous considérés comme non urgents.

Conclusions : La pandémie de COVID-19 a eu une incidence unique sur l'accès à la contraception et la participation au dépistage du cancer pour diverses classes démographiques. Les données autodéclarées présentent des solutions potentielles pour remédier aux obstacles.

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J Obstet Gynaecol Can 2022;44(10):1076-1083

<https://doi.org/10.1016/j.jogc.2022.05.011>

INTRODUCTION

Internationalement, l'accès des femmes à la contraception et au dépistage du cancer du col de l'utérus et du cancer du sein a été perturbé^{1–3} en raison de la pandémie associée aux mesures de santé publique conçues pour limiter la propagation du SARS-CoV-2.^{4,5} L'accès interrompu à la contraception peut entraîner des conséquences telles que des grossesses non désirées.⁶ Des retards dans le dépistage du cancer peuvent entraîner une détection plus tardive de la maladie et une morbidité et une mortalité excessives. Par exemple, le taux de survie à 5 ans pour le cancer du col de l'utérus diminue de 93 % (stade 1A) à 80 % (stade 1B) et encore à 15 % (stade 4B) lorsque le diagnostic et le traitement commencent à des stades plus avancés.⁷

Malgré les données internationales, l'effet de la pandémie sur la contraception et l'accès au dépistage du cancer n'a pas été bien caractérisé pour les femmes au Canada. D'autres sujets actuellement sous-explores incluent si l'accès à la contraception et au dépistage du cancer a été différenciellement affecté en fonction de facteurs sociodémographiques, et si les résultats de la santé physique et mentale ont été affectés pendant la

pandémie,^{8,9} et les barrières à la recherche de soins de santé. De plus, à travers les juridictions, la réponse de santé publique a été adaptée pour prévenir les hospitalisations et les taux d'infection,¹⁰ résultant en une série de fermetures suivies de périodes de restrictions relâchées. Peu de recherches ont exploré l'impact de ces différentes « phases » de mesures de contrôle sur l'accès aux services de soins de santé et de dépistage.

Pour combler ces lacunes, nous avons examiné l'accès à la contraception et à la planification familiale à travers différentes phases de la pandémie, et la participation au test de dépistage du cancer du col de l'utérus et à la mammographie pour le dépistage du cancer du sein sur une période d'un an en Colombie-Britannique (BC). Basés sur la littérature publiée,^{1–3} nous avons hypothéqué une diminution de l'accès et de la participation, spécifiquement pendant les phases de contrôles de pandémie renforcés. Nous avons hypothéqué que des facteurs tels que l'âge plus jeune, l'ethnicité non blanche, le mode de vie rural, le revenu plus faible, le niveau d'éducation plus bas, le statut d'immigrant, l'ascendance autochtone, l'orientation sexuelle non hétérosexuelle, l'identité de genre binaire/trans, ainsi que l'absence d'histoire de cancer du sein ou du col de l'utérus, seraient des prédictors de difficultés d'accès. Enfin, nous nous attendions à ce que la difficulté d'obtenir un rendez-vous et les craintes quant à l'exposition au SARS-CoV-2 seraient couramment rapportées comme des barrières à l'accès.¹⁴

METHODS

Setting and Participants

La présente étude faisait partie d'une étude plus large menée par l'Institut de recherche en santé des femmes (full study methods reported elsewhere^{15,16}), qui a invité des résidentes de BC âgées de 25 à 69 ans à participer à un sondage en ligne sur l'impact de la pandémie de COVID-19 entre août 2020 et le 1^{er} mars 2021.¹⁷ Les participantes ont été stratifiées en 9 strates d'âge de 5 ans et le recrutement a continué jusqu'à ce qu'un objectif de $n = 750$ soit atteint pour chaque strate. Le recrutement public a eu lieu à travers les médias sociaux et les plateformes de recherche. Le recrutement a pris fin pour les participantes âgées de 45 à 64 ans en novembre 2020 et pour celles âgées de 40 à 44 ans en décembre 2020 après que les objectifs aient été atteints pour ces strates. L'approbation éthique a été obtenue auprès du Comité d'éthique de la recherche des enfants et des femmes de la BC (numéro d'approbation H20-01421).

Survey Design and Measures

Nous avons demandé aux participantes de répondre rétrospectivement à travers cinq phases de la pandémie, délimitées par les mesures de contrôle de pandémie, et pré-pandémique pour certains éléments. Les phases étaient les suivantes : pré-COVID (décembre 2019 à fin mars 2020), phase 1 (fin mars 2020 à

mid-May 2020), phase 2 (mid-May 2020 to November 30, 2020), phase 3 (mid-May 2020 to August 31, 2020), phase 4 (September 1, 2020 to October 31, 2020), and phase 5 (November 1, 2020 to March 1, 2021).¹⁰ The participants who completed the survey before November 30, 2020, were asked to respond based on pre-COVID outcomes as well as phase 1 and phase 2. On November 30, 2020, phase 2 was removed and phases 3 to 5 were added.

For each phase, the participants responded to 4 contraception outcome measures: (1) regularly accessed birth control methods (e.g., birth control pill), (2) accessed emergency contraception (e.g., Plan B), (3) had difficulty accessing birth control methods, and (4) had difficulty accessing emergency contraception. Those who indicated that they had difficulty accessing contraception at any point during phases 1 through 5 were asked “What made accessing birth control or emergency contraceptives difficult during COVID-19?” and selected all that applied from a list of options (Table S1). The participants were eligible for contraception outcomes analysis if they responded to ≥ 1 outcome measure across all phases and were of female sex, not postmenopausal, and not pregnant. Although it is possible for females >55 to still be menstruating, we also restricted contraception analyses to those aged ≤ 55 years.

We asked all survey participants to report on their attendance (attended all, some, or none) at cervical or breast screenings during the pandemic. The participants who reported that they only attended some or none of their appointments were asked “Why did you not attend the appointment(s)” and were able to select from a list of reasons (options were mutually exclusive). The listed reasons included: my doctor or clinic was not accepting in-person appointments, my appointment was considered “nonurgent,” worried about visiting doctors or doctors’ office, and other. The participants who selected “other” were able to provide a free-text response. For the analyses of cervical (Pap) and breast (mammogram) cancer screening outcomes, the eligibility was restricted to female sex and those who responded that during the COVID-19 pandemic (mid-March to now) they were due for, or in need of, a Pap test/mammogram.

We collected sociodemographic information including sex assigned at birth, postmenopausal status (have not had a period in ≥ 1 year), age, ethnicity (White and non-White), Indigenous ancestry, and other demographics (online Appendix). Indigenous ancestry was self-reported and assessed separately from ethnicity.

Data Analysis

All analyses were carried out in R v. 4.0.3.¹⁸ The significance threshold was set at $P < 0.05$. Missing data were excluded from analyses.

Access to birth control/emergency contraception was pooled due to a small proportion of respondents indicating accessing emergency contraception (1.7% pre-COVID, dropping to $<1\%$ in the later phases). By using generalized estimating equations with a first order autoregressive /correlation structure using the “geepack” package^{19,20} to account for the repeated measures and including age as a covariate, we estimated both the proportion accessing contraception and the proportion having difficulty with access across the phases. We investigated the relationships between access, having difficulty accessing contraceptives, and sociodemographic variables by adding them individually to the models.

Attendance at required cervical or breast screening was dichotomized into attendance at none/some versus all appointments. The proportion attending all visits was analyzed using logistic regression. The reasons for nonattendance were reported as the percent of those who attended some/none of their appointments. We conducted thematic analyses on the open-ended responses for reasons for nonattendance at breast and cervical screening. We used a deductive, essentialist approach and constructed themes around semantic content by analyzing the surface meaning of each response.²¹

RESULTS

In total, 3691 participants who provided informed consent for our larger survey were eligible for this study, and among these, we had sample sizes $n = 2542$ for contraception outcomes, $n = 1077$ for Pap test outcomes, and $n = 1226$ for mammogram outcomes (online Appendix). A participant could fall in more than 1 of these 3 cohorts.

Access to Contraception During COVID-19

After controlling for age, there was a significant relationship between the pandemic phase and both the proportion of females that accessed ($P < 0.02$) and that had difficulty accessing ($P < 0.001$) birth control/emergency contraception. During phase 1, fewer people accessed contraception ($P = 0.005$), and during phases 1 and 2 more people had difficulty accessing contraception (both $P = 0.001$) than during pre-COVID. Across all phases, we found a significant effect of age, with younger participants (25–34 years) proportionately more likely to report that they were accessing contraception ($P < 0.0001$) and had difficulty accessing contraception ($P < 0.0001$). Across the phases, $<3\%$ of those

aged 35 to 55 years reported difficulties with access (Table 1, Supplemental Figures S1 and S2).

After controlling for age and phase, we found a significant relationship between Indigenous status and the proportion who had difficulty accessing contraception, with self-identified Indigenous participants having significantly higher odds of experiencing difficulty than non-Indigenous participants ($P < 0.001$). Further, we found that non-heterosexual participants had a significantly lower prevalence of accessing contraception than heterosexual respondents across all phases ($P = 0.001$), but there was no impact of sexual orientation on difficulties accessing (Table 2).

For those who had difficulty accessing contraception at any point (78 respondents), difficulty getting an appointment (37%) and worries about COVID-19 exposure (28%) were the top barriers to access. Other barriers to access endorsed by respondents are reported in, Table S1 in online Appendix.

Cervical Screening Attendance Throughout the Pandemic: Factors and Barriers

Of the sample who self-reported requiring a cervical screening (Pap test), 37.0% attended all, 9.9% attended some, and 52.1% attended none of their appointments. None of the sociodemographic factors nor history of cervical cancer affected the attendance at the cervix screenings (all $P > 0.05$).

For the respondents who indicated that they attended some or none of their cervical screening appointments (668 respondents), primary endorsed reasons were as

follows: my doctor or clinic was not accepting in-person appointments (32.5%), my appointment was considered nonurgent (25.3%), worried about visiting doctors or doctors' office (24.6%), other (17.7%). For the 17.7% of respondents (118) who endorsed "other" and provided an open-ended response, thematic analysis revealed 2 overarching theme categories of "personal barriers" and "pandemic control measures," each with several themes and subthemes (Figure 1).

Breast Screening Attendance Throughout the Pandemic: Factors and Barriers

Of the sample who self-reported requiring breast screening (mammogram), 44.8% attended all, 10.7% attended some, and 43.8% attended none of their appointments.

Those with a history of breast cancer had significantly higher odds of self-reporting attending their mammogram during COVID-19 compared with those who did not (odds ratio 5.62; 95% CI 2.69–13.72; $P < 0.001$). There was no significant relationship between the mammogram attendance and any sociodemographic factor analysed (all $P > 0.05$). Appointments being considered "nonurgent" was the most endorsed primary reason for nonattendance at mammogram (30.1%), followed by: other (27.4%), worried about visiting doctors or doctors' office (23.1%), my doctor or clinic was not accepting in-person appointments (19.3%).

For those that selected "other" and provided an open-ended response (183 respondents), thematic analysis revealed overarching theme categories of "personal barriers" and "pandemic control measures," each with several themes and subthemes (Figure 2).

Table 1. Impact of age and COVID-19 phase on contraception access

| Predictor | Using contraception | | Difficulty accessing contraception | |
|---------------------|------------------------------|----------------|------------------------------------|----------------|
| | Adjusted odds ratio (95% CI) | <i>P</i> value | Adjusted odds ratio (95% CI) | <i>P</i> value |
| Age group, y | | | | |
| 25–29 | Reference | | Reference | |
| 30–34 | 0.70 (0.47–1.02) | 0.065 | 0.63 (0.25–1.58) | 0.325 |
| 35–39 | 0.37 (0.26–0.53) | < 0.001 | 0.40 (0.18–0.89) | 0.025 |
| 40–44 | 0.31 (0.22–0.44) | < 0.001 | 0.24 (0.10–0.59) | 0.002 |
| 45–49 | 0.26 (0.18–0.38) | < 0.001 | 0.18 (0.06–0.52) | 0.002 |
| 50–55 | 0.14 (0.08–0.22) | < 0.001 | 0.00 (0.00–0.00) | < 0.001 |
| Phase | | | | |
| Pre-COVID | Reference | | Reference | |
| Phase 1 | 0.94 (0.90–0.98) | 0.005 | 2.74 (1.54–4.88) | 0.001 |
| Phase 2 | 0.96 (0.90–1.02) | 0.218 | 3.20 (1.66–6.18) | 0.001 |
| Phase 3 | 0.99 (0.90–1.08) | 0.761 | 1.75 (0.68–4.48) | 0.243 |
| Phase 4 | 1.09 (0.96–1.24) | 0.206 | 1.59 (0.59–4.27) | 0.359 |
| Phase 5 | 1.18 (1.02–1.36) | 0.025 | 2.14 (0.89–5.15) | 0.090 |

Table 2. Bivariable results of sociodemographic factors assessed individually on the proportion using/with difficulty accessing contraception

| Predictor | Using contraception | | Difficulty accessing contraception | |
|--------------------------------|------------------------------|---------|------------------------------------|---------|
| | Adjusted odds ratio (95% CI) | P value | Adjusted odds ratio (95% CI) | P value |
| Geographic region | | | | |
| Fraser | Reference | | Reference | |
| Interior | 1.33 (0.85–2.08) | 0.213 | 1.09 (0.40–2.93) | 0.868 |
| Northern | 0.75 (0.36–1.57) | 0.444 | 2.14 (0.47–9.70) | 0.324 |
| Vancouver Coastal | 1.32 (1.03–1.70) | 0.028 | 0.60 (0.29–1.25) | 0.172 |
| Vancouver Island | 1.13 (0.83–1.53) | 0.433 | 0.68 (0.29–1.60) | 0.374 |
| Ethnicity | | | | |
| White | Reference | | Reference | |
| Non-White | 1.32 (0.97–1.79) | 0.073 | 0.78 (0.37–1.64) | 0.506 |
| Household income, CAD\$ | | | | |
| <10 000–20 000 | Reference | | Reference | |
| 20 000–40 000 | 0.7 (0.37–1.31) | 0.265 | 0.64 (0.19–2.14) | 0.465 |
| 40 000–60 000 | 1.09 (0.61–1.97) | 0.764 | 0.73 (0.23–2.31) | 0.594 |
| 60 000–80 000 | 0.98 (0.55–1.75) | 0.938 | 0.38 (0.09–1.60) | 0.186 |
| 80 000–100 000 | 0.57 (0.32–1.01) | 0.055 | 0.18 (0.03–0.98) | 0.047 |
| 100 000–150 000 | 1.06 (0.62–1.82) | 0.828 | 0.50 (0.15–1.67) | 0.260 |
| >150 000 | 0.94 (0.55–1.61) | 0.835 | 0.36 (0.11–1.20) | 0.096 |
| Education | | | | |
| More than high school | Reference | | Reference | |
| High school or less | 0.82 (0.58–1.17) | 0.278 | 0.97 (0.34–2.75) | 0.955 |
| Gender identity | | | | |
| Cis-gender | Reference | | Reference | |
| Non-cis-gender | 0.53 (0.22–1.29) | 0.160 | 0.51 (0.06–4.03) | 0.524 |
| Sexual orientation | | | | |
| Heterosexual | Reference | | Reference | |
| Nonheterosexual | 0.62 (0.46–0.82) | 0.001 | 0.79 (0.39–1.61) | 0.519 |
| Immigrant status | | | | |
| Immigrated <5 y ago | Reference | | Reference | |
| Immigrated ≥5 y ago | 1.24 (0.52–2.93) | 0.632 | 1.47 (0.18–12.32) | 0.721 |
| Nonimmigrant | 1.24 (0.64–2.39) | 0.521 | 1.38 (0.25–7.66) | 0.713 |
| Indigenous status | | | | |
| Non-Indigenous | Reference | | Reference | |
| Indigenous | 0.95 (0.58–1.56) | 0.849 | 5.56 (2.44–12.50) | < 0.001 |

Note: All sociodemographic variables were adjusted for phase and age.

DISCUSSION

Our study showed a correlation between high levels of pandemic controls and a higher prevalence of difficulty accessing contraception, which continued even once the pandemic control measures loosened. This finding is unlike past findings¹ and may have important implications for the longer-term effects of strict controls on female public health. Our findings did not support the notion that nonheterosexual women are more likely to face barriers to contraception access during COVID-19 than heterosexual women.¹ Rather, we found that nonheterosexual females

reported accessing birth control less, consistent with the generally lower prevalence of contraception use among LGBTQ women.²²

Our study also described the low rates of breast and cervical screening. Before the pandemic, between 2017 to 2019, participation in the BC Cancer Breast Screening Program was approximately 50% and cervical screening participation was approximately 68% (corrected for hysterectomy rate).^{23,24} Therefore, our data suggested 9% and 93.75% increases in nonparticipation in breast and cervical cancer screening during COVID-19, respectively. To clear

Figure 1. Thematic map of free-text responses to the question “Why did you not attend the (Pap test) appointment(s)?”
Note: n values represent the number of participant responses within subthemes.

| Theme categories Total n=120 | Themes | Sub-themes | Participant response excerpts |
|--|--|--|--|
| Personal barriers n=72 | Lack of resources n=33 | No family doctor n=27 | “I don’t have a family doctor”; “Family doc left practice in Feb and no replacement hired due to COVID” |
| | | Lack of knowledge or physical barriers n=6 | “I moved to another region”; “I am unsure of the immediacy of the tests” |
| | Choice/prioritization n=32 | Lack of time n=17 | “Have no time” |
| | | Procrastination n=15 | “Just never bothered to book an appointment”; “Procrastination” |
| | Health and anxiety n=7 | | “I was afraid of doing Pap test, it was not due to any reasons related to the pandemic” |
| Pandemic control measures n=48 | Difficulty getting an appointment n=37 | Scheduling problems/delays n=19 | “Unable to get an appointment”; “I never received an appointment”; “Hard to book” |
| | | Considered “non-urgent” n=12 | “I just figured the doctor would be busy with more important matters at the time, so I’ve been putting it off until all this COVID business calms down”; “I assumed it qualified as a non-essential activity”; “As per my telephone appointment with my GP I was told it was not needed” |
| | | Closures/cancellation n=6 | “Clinic cancelled” |
| | Infection control n=11 | Worried about COVID exposure n=6 | “Didn’t want to visit a clinic due to COVID-19”; “Worried about crowded labs” |
| | | COVID screening n=5 | “Symptomatic day of appointment” |

the large queue of missed screenings and support participation during future disruptions, clear communication around scheduling, messaging on the importance of timely screening, and guidance on screening participation for individuals without a family doctor are points to consider. The barriers to cervical screening attendance identified in this analysis highlighted an opportunity for innovative approaches that minimize in-person contact, such as telehealth with self-collected screening options.²⁵ Those without a history of breast cancer may have been less likely to seek breast screening during the COVID-19 pandemic due to less motivation among cancer-free populations to be screened for cancer.²⁶ Mammography participation may have also been disrupted due to deferrals of radiology appointments perceived as “less urgent,”²⁷ which is consistent with other findings that show larger volume drops for screening mammography compared with diagnostic mammography during COVID-19.²⁷

Others have documented both within and outside of the COVID-19 pandemic that other sociodemographic factors, such as ethnicity, are predictors of health care access.^{1,11–13} Future research should assess the impact of

the pandemic on groups previously demonstrated to face inequitable health care access using representative samples to the overall target population.

The limitations of our study were the retrospective nature of the questions, which could have introduced recall error, and the confinement of this study to the BC population. This study included a population with a higher percentage of respondents who identified as White, with more than a high school education, and who were more likely to live in the southern part of the province compared to the general population of BC ([online Appendix](#)),²⁸ limiting the generalizability to similar populations. As well, the level of contraception access was not specified, which could have limited interpretability. For example, we do not know whether “difficulty getting an appointment” occurred at the level of initial contact with a clinic or due to clinics being over capacity. It is also unclear whether respondents may have changed the type of contraception they used, such as turning from contraception methods that require insertion (e.g., intrauterine devices) or hormonal methods that require a prescription to nonhormonal contraception (e.g., barrier methods). Because the question about birth

Figure 2. Thematic map for free-text responses to the question “Why did you not attend the (mammogram) appointment(s)?” *Note:* n values represent the number of participant responses within subthemes. Responses were excluded (cervical analysis: n = 11, breast analysis: n = 7) if respondents used the free-text space to discuss something other than barriers to attendance.

| Theme categories Total n=201 | Themes | Sub-themes | Participant response excerpts |
|---|--|---|---|
| Personal barriers n=98 | Lack of resources n=26 | No family doctor n=14 | “Don’t have a doctor”; “Doctor retired” |
| | | Lack of knowledge or physical or social barriers n=12 | “I was out of town”; “I am unsure of the immediacy of the tests”; “Family reasons” |
| | Choice/prioritization n=72 | Lack of time n=25 | “Very busy at work, can’t afford to miss work for appointment”; “Lack of time” |
| | | Procrastination n=47 | “Laziness”; “Thought it best to wait given the pandemic” |
| Pandemic control measures n=103 | Difficulty getting an appointment n=79 | Scheduling delays n=43 | “The screening department rescheduled my appointment”; “No appointments available until April (I was due in Jan)”; “Back log tests until November 2020” |
| | | Poor communication n=15 | “No reminder sent to me”; “Assumed tests were not being done”; “I forgot to contact my doctor to get a requisition and my doctor did not contact me” |
| | | Considered “non-urgent” n=13 | “I consider it non-urgent”; “My doctor felt these can wait” |
| | | Closure/cancellation n=8 | “My clinic shut down”; “Mammogram clinic cancelled the appointment” |
| | Infection control n=24 | Worried about COVID exposure n=16 | “Didn’t want to expose myself to COVID-19 positive people or situations that put me at risk”; “Worried about attending crowded labs” |
| | | COVID screening n=8 | “The clinic cancelled the appointment because the tech called in sick”; “Not feeling well” |

control was in brackets (“e.g., birth control pill”), respondents may have assumed that it was referring to hormonal methods as opposed to all methods. Of note, it would still be an issue if females turned to less effective contraception such as nonhormonal methods, but this was not captured by our survey. The use of self-reported data was another limitation. For example, respondents may have self-reported requiring screening when in fact they were not due for an appointment as per BC guidelines.^{29,30}

CONCLUSION

This study provided critical data on the barriers to females’ access to contraception and cancer screening in Canada during a year of unprecedented health care disruptions. Self-reported barriers to screening attendance presented in this study offer potential avenues for increasing cervical and breast cancer screening participation. These data can inform health leadership on the impacts of restricting health service delivery and of demographics warranting thoughtful consideration as they navigate pandemic recovery and future planning.

Acknowledgements

The authors wish to thank Falla Jin at the BC Children’s Hospital Research Institute for her assistance with data collection.

SUPPLEMENTARY DATA

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jogc.2022.05.011>.

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