# Title

Effects of COVID-19 on contraceptive prescribing in Scottish General Practices.

# Short title

COVID-19 and contraception in Scotland.

# Author information

Elliot Johnson-Halla

ORCID: 0009-0003-5105-034X

[e.johnson-hall.2023@bristol.ac.uk](mailto:e.johnson-hall.2023@bristol.ac.uk)

a Deanery of Biomedical Sciences, University of Edinburgh, Old Medical School (Doorway 3), Teviot Place, Edinburgh, EH8 9AG, Scotland, UK.1

1 Present address: Department of Translational Health Sciences, University of Bristol, Whitson Street, Bristol, BS1 3NY, England, UK.

# Availability of Data & Code

All code and data used are fully available from Zenodo: doi:10.5281/zenodo.8310085

The raw dataset used is also publicly available from the Scottish Health and Social Care Open Data repository (<https://www.opendata.nhs.scot>)

# Keywords

* COVID-19
* Contraception
* General practice
* Scotland
* Prescribing trends

# Abbreviations

|  |  |
| --- | --- |
| BNF | British National Formulary |
| COCP | Combined oral contraceptive pill |
| EC | Emergency contraception |
| IUD | Intra-uterine device |
| IUS | Intra-uterine system |
| LARC | Long-acting reversible contraception |
| NHS | National Health Service |
| POP | Progesterone-only pill |
| UK | United Kingdom |

# Abstract

## Background

In Scotland, the effects of the COVID-19 pandemic on women’s access to contraception are unknown. Globally, it has been seen that COVID-19 restrictions have led to a shift to telehealth service delivery alongside a reduction in contraceptive provision. Moreover, little research has been conducted to analyse the lasting impacts of COVID-19 on contraception after the acute phase of the pandemic is over.

## Methods

This study is a retrospective longitudinal analysis of data from the Scottish Health and Social Care Open Data repository (<https://www.opendata.nhs.scot>) from January 2016 to January 2023. Prescribed contraceptives were isolated using truncated BNF codes through an SQL query to the repository API. Due to inherent differences in contraceptive coverage provided for various forms of contraception, the total quantities dispensed of each method were standardised by dividing by the pack size and then multiplying this by the length of contraceptive coverage provided, giving the months of contraceptive coverage dispensed.

## Results

Contraceptive prescribing in Scottish general practices fell by 60.6% during lockdown compared with pre-COVID-19 levels. This trend was seen even more severely for long-acting reversible contraception (LARC), which generally requires administration by a healthcare professional; LARC prescriptions fell to 28.3% of pre-COVID-19 prescriptions. Prescribing of oral contraceptives also decreased. However, there was a difference between COCP (31.3%) and POP (49.0%), likely due to clinical risk management decisions. After lockdown, the level of contraceptive prescribing is at 98% of its pre-pandemic level. Differences remain, particularly regarding large increases in POP, patch, overall and ulipristal acetate emergency contraception prescribing. As well as moderate increases in IUS and injections. Conversely, COCP, IUD, implant, and levonorgestrel EC prescribing has decreased.

## Conclusions

COVID-19 vastly decreased contraceptive prescribing during lockdowns and has had a lasting impact on contraceptive prescribing trends within Scottish general practices.

# Implications

COVID-19 restrictions changed contraceptive prescribing in Scotland, and these changes have continued after the pandemic has subsided. It is vital clinicians work with patients to ensure that methods of contraception prescribed during the pandemic are suitable and tolerable, particularly for women wishing to access long-acting reversible contraception (LARC).

# Introduction

Restrictions due to COVID-19 changed day-to-day life in many ways, including the format of general practice (GP) consultations. Due to concerns over infection, GPs pivoted to remote consultations such as telephone triage and video-based telehealth appointments [1], the basis for which was already established in Scotland [2].

Given that around 75% of women access contraception through their GP [3] and the expectation that GPs would be unable to deliver some services due to increased demand [4]. Moreover, the FSRH guidance issued during the pandemic did not classify the provision of oral contraception or new LARC fittings as essential services needing face-to-face appointments [5].

Consequently, contraception provision in Scotland is likely to have decreased due to COVID-19, as seen in England [6], the UK as a whole [7,8], and globally [9–11].

Previous studies have found lockdowns decreased contraception dispensed in GP in England [6] and that women in the UK found accessing contraception more difficult due to COVID-19-associated restrictions [7]. However, to the author’s knowledge, no study has yet examined the effects of COVID-19 on contraceptive provision in Scotland.

Additionally, much of the literature published cannot compare the longer-term impacts now that we have left the acute phase of the pandemic. However, a forthcoming systematic review may illuminate these issues [12].

This study will examine the effects of COVID-19 lockdowns on the provision of contraception in Scottish general practices and whether contraceptive provision has changed in the long-term post-COVID-19.

# Materials and methods

This longitudinal retrospective study examines the period of January 2016 to January 2023, utilising data from the Scottish Health and Social Care Open Data repository (<https://www.opendata.nhs.scot>). This aggregated, anonymous dataset is 100% complete for all prescriptions dispensed in the community throughout Scotland. While the overwhelming majority of these are prescribed in general practices, some may be prescriptions from hospitals in community pharmacies. This dataset excludes items dispensed in hospitals, prisons, schools, and private prescriptions, as well as prescriptions not presented for dispensing and those dispensed but not submitted for payment. This is unlikely to be a large enough proportion of these data to impact the observed trends.

R v4.3.0 [13] was used to create a script to access data from the NHS Scotland Open Data API. Initially, the complete dataset is filtered using a SQL query (Supplementary Information) to extract only contraceptive medicines by returning results with truncated British National Formulary (BNF) [14] item codes beginning with 07030\* or 21040\*. Subsequently, these data were categorised by truncated BNF code (Table 1).

**Table 1** Truncated BNF item codes used during data extraction and example medicines in these categories.

|  |  |  |  |
| --- | --- | --- | --- |
| Truncated BNF Item Code | Category | Type | Example BNF Item Description |
| 0703010\* | COCP | Oral | Rigevidon Tablet |
| 0703010E0BG\* | Patch | Other | Evra Transdermal Patch |
| 0703011\* | Ring | Other | NuvaRing 0.12mg/0.015mg per day Vaginal Delivery System |
| 0703021\* | POP | Oral | Desogestrel Tablet 75mcg |
| 0703022M\* | Injection | LARC | Depo-Provera Injection 150mg/ml 1ml Pre-filled Syringes |
| 0703022N\* | Injection | LARC | Noristerat Injection 200mg/ml 1ml Ampoules |
| 0703022P\* | Implant | LARC | Nexplanon Implant 68mg |
| 0703023\* | IUS | LARC | Mirena Intra-uterine System |
| 0703050\* | EC | EC | Upostelle Tablet 1500mcg |
| 21040\* | IUD | LARC | T-Safe 380A QL Intra-uterine Contraceptive Device |

Spermicidal jelly (e.g. Nonoxinol) was removed from this analysis as it is not a contraceptive in its own right as it needs to be employed with a barrier method [14].

Due to inherent differences in prescribing frequencies between contraceptive methods, a standardised metric *months of contraceptive coverage* (MCC) was calculated:

For example, an IUD with a five-year lifespan provides 60 months of contraceptive coverage (1/1 \* 60). In contrast, a six-month prescription of a short-acting COCP offers six months of contraceptive coverage (126/21 \* 1) despite 126 items being dispensed.

Mean months of contraceptive coverage dispensed (MMCC) was calculated by dividing MCC by the number of months in each period to facilitate comparison between forms of contraception and periods of differing durations.

Four different periods were defined. Firstly, *pre-COVID-19* (01/01/2016-23/03/2020). *Lockdown* (24/03/2020-29/05/2020 and 05/01/2021-26/04/2021 ) when Scotland entered the highest level of restrictions on daily activities [15]. Thirdly, *restrictions* (30/05/2020-04/01/2021 and 27/04/2021-31/03/2022) when - due to its geographic diversity - Scotland adopted a phased approach to restrictions based on local epidemiological data [16]. Thus, during this period, Scotland experienced a variety of restrictions on both local and national levels. Finally, *post-COVID-19* (01/04/2022-01/01/2023) when restrictions in Scotland were lifted.

# Results & Discussion

## Overview

During periods of lockdown, contraceptive prescribing in Scotland fell to 17.10% (mean 98,642 MMCC dispensed per month) of pre-COVID-19 levels (576,986 MMCC). Between lockdowns, contraceptive prescribing rose to 76.96% (444,055 MMCC) of pre-COVID-19 levels. The post-COVID-19 period has seen an increase in contraceptive prescribing compared with pre-COVID-19 (108.23% / 624,474 MMCC).

This large decrease was seen across all forms of contraception. LARC fell to 11.80% (19,424 MMCC). Oral fell to 17.64% (54,852 MMCC). Other 24.01% (24,366 MMCC). EC also fell to 13.90% (1,118 dispensed). Restrictions outside the lockdown did allow the resumption of contraceptive dispensing, albeit at a lower rate than pre-COVID-19. LARC: 64.40% (105,964 MMCC), Oral 74.91% (232,923 MMCC), Other 103.62% (105,168 MMCC). EC 84.60% (6,804 dispensed).

Overall, oral contraceptives remained the most popular contraceptives prescribed throughout the period of this study, with a mean of 52.67% (903,036 MMCC) of the total MMCC dispensed (1,744,157 MMCC). Behind this, LARC (24.48% / 451,312 MMCC), and finally, other methods, including the contraceptive patch and ring (22.85% / 389,909 MMCC). However, the proportions and types of contraceptives prescribed in each of the four periods of this study varied (Figure 1).



**Figure 1.** COVID-19 restrictions changed the proportions of categories of contraception dispensed in Scotland. Prior to COVID-19, the combined oral contraceptive pill (COCP), was the most dispensed form of contraception. However, during the COVID-19 pandemic, this changed to the progesterone-only pill (POP), with dispensing of the contraceptive patch also increasing. Dispensing rates of long-acting reversible contraception (LARC) including the IUS, IUD, injection and implant decreased during COVID-19, whilst the contraceptive ring remained relatively stable. Post-COVID-19 shows a lasting change in the prescribing of contraceptives in Scottish general practices.

## Oral contraception

Throughout this study, short-acting oral contraceptive pills, both combined oral contraceptive pills (COCP) and progesterone-only pills (POP) remained the most dispensed form of contraception. This is true when measured by both months of contraceptive coverage dispensed per month and the total number of items dispensed. However, the contraceptive patch increased in popularity in Scotland during and after the COVID-19 pandemic, later overtaking COCP (Figure 1).

Prior to the COVID-19 pandemic, combined oral contraceptives were more frequently prescribed (mean percentage of total months of oral contraception dispensed per month 54.38%) than progesterone-only contraceptives (45.62%). However, during the period from April 2020 to April 2022, this trend was reversed (COCP: 44.03%, POP: 55.97%).

Restrictions on face-to-face medical appointments during COVID-19 meant that the regular monitoring of BMI and blood pressure could not occur. This likely lead to the decrease in COCP prescribing and the growth in dispensing of POPs instead (Figure 2), which do not require the same patient monitoring [17–19]. After this period, the trend has not been restored to pre-COVID-19 levels, but the dispensing of POP has increased (COCP: 41.70%, POP: 58.30%). Intriguingly, the differences in the proportion of COCP versus POP dispensed per month in Scotland have widened even after the lifting of COVID-19-associated restrictions (Figure 2).



**Figure 2.** Prior to COVID-19, COCPs were more prescribed than POPs. However, there was a rough balance between the two methods. During lockdown, POPs were vastly more prescribed, and COCPs decreased. This trend continued during periods of restrictions, and after COVID-19 this gap has only widened.

Some of this increase is likely due to the addition of desoestrogel (a POP) as a bridging method for those with extended use of LARC [20].

## Long-acting reversible contraception

Long-acting reversible contraception (LARC) requires administration by a healthcare professional [18,21,22] – with the exception of Sayana-Press SC injection [23] - unlike oral contraception. Due to the restrictions on face-to-face appointments, LARC administration severely decreased throughout the COVID-19 pandemic (Figure 3).



**Figure 3.** Long-acting reversible contraceptive (LARC) prescribing fell enormously during the first lockdown (red-shaded periods marked L). During periods of restrictions (orange-shaded periods, R) still hampered access to LARC. Post-COVID-19, LARC prescribing is reduced compared with pre-COVID-19, particularly for non-hormonal copper IUDs.

* + 1. **IUD & IUS**

During lockdowns, prescribing IUS sank to 11.07% (6,912 MMCC) of pre-COVID-19 levels, while IUD prescribing decreased to 9.48% (1,482 MMCC). Subsequently, during periods of COVID-19-associated restrictions, IUS prescribing increased to 65.84% (41,102 MMCC) and IUD to 60.45% (9,455 MMCC). Post-COVID-19, IUD prescribing continued to climb to 83.63% (13,080 MMCC) of pre-COVID-19 levels. Conversely, IUS prescribing post-COVID-19 has exceeded that before the pandemic, reaching 112.54% (70,260 MMCC) of pre-COVID-19 levels.

Whilst there is a correlation between the decrease shown in the prescribing of certain forms of contraception post-COVID-19, it is not possible to say that this is a causational relationship. It may be the case that the pandemic accelerated changes already happening before. Women may prefer the added hormonal benefits of IUS such as reducing heavy menstrual bleeding, or its marginally greater contraceptive effectiveness versus Cu-IUDs.

* + 1. **Implant**

Fell to 10.02% during lockdown. And rebounded to 57.17% and 81.10%. The lack of rebound may indicate women choosing other forms of contraception. Pre-COVID-19 implants (59,004 MMCC) were comparable with IUS (62,432 MMCC) in terms of MMCC. However, post-COVID-19, this has not resumed: IUS 70,260MMCC, implant 47,853. This could be an artefact of the lengthy times between prescriptions needed for LARC – may be worth investigating over a longer period.

* + 1. **Injection**

The decrease in injection dispensing throughout COVID-19 is less severe than other forms of LARC, which cannot be self-administered. Whilst subcutaneous injections are licenced for self-administration [23]. There was a change in dispensing type, with Depo-Provera (an intramuscular injection) decreasing to 15.12% (3927 MMCC) of pre-pandemic levels (25979 MMCC) during periods of lockdown, and Sayana Press (a subcutaneous injection) decreasing to 80.06% (1189 MMCC) versus 1485 MMCC. However, during periods of restrictions, the difference becomes apparent: 63.83% (16583 MMCC) versus 343.04% (5092.5); 87.68% (22779 MMCC), 499.05% (7408.5). There has been a rise in mean months of contraceptive coverage dispensed by injection post-COVID-19 (109.91% / 30188 MMCC).

## Ring and Patch

The contraceptive ring remains the least-used form of prescribed contraception within Scotland throughout this study (Table S1, S2). It, too, was subject to the same trends as found with all other forms of contraception as previously described.

The contraceptive patch is a different story. The patch is unique amongst the categories of contraception assessed here as it increased in popularity (107.89% / 95,311 MMCC) compared with pre-COVID-19 levels during the period of restrictions and has increased again in the post-COVID-19 period (165.09% / 145,840 MMCC).

## Emergency contraception

Emergency contraception is available free of charge without a prescription from most Scottish community pharmacies [24]. Due to social restrictions present in Scotland, emergency contraception dispensing was expected to decrease. Indeed, this was the case during both periods of restrictions and lockdowns (Figure 4).



**Figure 4.** Total emergency contraception dispensing declined drastically during periods of lockdown. In the periods between lockdowns, there was still a marked decline in total emergency contraceptive provision. Conversely, after COVID-19 restrictions were lifted, total EC dispensing has exceeded pre-COVID-19 levels. The proportions of ulipristal acetate and levonorgestrel dispensing have reversed.

The increase in EC dispensing post-COVID-19 versus pre-COVID-19 levels potentially points to a lack of effective regular contraception due to disrupted access during COVID-19. However, it is not possible to state this with certainty, as other social factors may underlie this trend.

Another interesting observation is the change in the most dispensed form of EC from levonorgestrel to ulipristal acetate post-COVID-19. There are a variety of factors which may have led to this change. Potentially patients presenting later after UPSI means more likely to be given UPA. UPA is a P medicine, no need to rely on PGD for POM 1.5mg LEVO. However, this warrants further investigation.

## Conclusions

The clear decreases in all forms of prescribed contraceptive provision in Scotland during COVID-19 lockdowns present a myriad of possible outcomes ranging from unintended pregnancies to increases in terminations.

The effects of these restrictions appear to have altered trends in contraceptive prescribing within Scottish general practice. For example, the increasing role of progesterone-only oral contraception is clearly visible. This is also supported by access to short-term supplies of POPs without a prescription within community pharmacies in Scotland.

Telemedicine-based contraceptive prescribing has been demonstrated to be effective and safe at a scale unthought-of before COVID-19. Within Scotland, this has the principal advantage of easier access to sexual and reproductive healthcare professionals for those women living in island and rural communities. Additionally, this may increase the ease of access to Gaelic-speaking healthcare providers.

However, the lack of autonomy regarding LARC

## Limitations

Assumption that any changes observed between 2016 etc are due to lockdown and other restrictions, not due to other unknown factors.

A further assumption is made that the patient population seeking contraception from general practitioners is constant throughout the period of this study, and consequently, variances in prescribing rates between pre and post covid are due to changes in contraceptive prescribing rather than population-level alterations. The female population in Scotland is estimated to have increased by ~ 30,000 people from 2016 to 2021 [25].

Census results come out 14/09. 20 March 2022 = census day.

Finally, it also assumed that the drugs dispensed here are used purely for their licenced indication of contraception, not any alternative off-label uses. However, it is not possible to exclude medicines dispensed for non-contraceptive uses. Regardless, off-label use likely constitutes a minute proportion of this dataset.

## Future directions

Only data from Scotland were included in this study. Future work may explore if these impacts were similar in the other nations of the UK or whether the devolved nature of healthcare policy within the UK created disparities in access to contraception during COVID-19 restrictions. It would be intriguing to see whether other countries have experienced similar shifts in contraceptive prescribing due to COVID-19.x

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# Supporting information

## SQL Query

SELECT \* from "{ResourceID}" WHERE "BNFItemCode” LIKE '07030%' OR "BNFItemCode" LIKE '21040%'

## Table S1

|  |  | LARCs | | | | | Oral | | | Other | | | EC | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Timeframes | *TOTAL* | All LARC | IUS | IUD | Implant | Injection | All Oral | COCP | POP | All Other | Patch | Ring | All EC | Uli | Levo |
| Lockdown | *17.10%* | **11.80%** | 11.07% | 9.48% | 10.02% | 18.63% | **17.64%** | 13.98% | 22.00% | **24.01%** | 24.75% | 19.02% | **13.90%** | 30.11% | 10.22% |
| Restrictions | *76.96%* | **64.40%** | 65.84% | 60.45% | 57.17% | 78.92% | **74.91%** | 60.64% | 91.91% | **103.62%** | 107.89% | 74.95% | **84.60%** | 198.42% | 58.80% |
| Post-Lockdown | *108.23%* | **98.08%** | 112.54% | 83.63% | 81.10% | 109.91% | **97.86%** | 75.04% | 125.07% | **156.45%** | 165.09% | 98.43% | **121.11%** | 357.97% | 67.42% |

Normalised to Pre-COVID-19 levels = 100%.

## Table S2

|  |  | LARCs | | | | | Oral | | | Other | | | EC | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Timeframes | *TOTAL* | All LARC | IUS | IUD | Implant | Injection | All Oral | COCP | POP | All Other | Patch | Ring | All EC | Uli | Levo |
| Pre-Lockdown | *576,986* | **164,543** | 62,432 | 15,641 | 59,004 | 27,466 | **310,952** | 169,096 | 141,855 | **101,491** | 88,340 | 13,151 | **8,043** | 1,486 | 6,557 |
| Lockdown | *98,642* | **19,424** | 6,912 | 1,482 | 5,913 | 5,116 | **54,852** | 23,637 | 31,215 | **24,366** | 21,865 | 2,502 | **1,118** | 447 | 670 |
| Restrictions | *444,055* | **105,964** | 41,102 | 9,455 | 33,730 | 21,676 | **232,923** | 102,547 | 130,376 | **105,168** | 95,311 | 9,857 | **6,804** | 2,949 | 3,855 |
| Post-Lockdown | *624,474* | **161,381** | 70,260 | 13,080 | 47,853 | 30,188 | **304,309** | 126,891 | 177,418 | **158,784** | 145,840 | 12,944 | **9,741** | 5,320 | 4,421 |

Rounded to nearest whole month. Units = MMCC.