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Young women's experiences of side-effects from contraceptive implants: a challenge to bodily control

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Abstract: *In the UK, long-acting reversible contraceptives have been welcomed by sexual health policy-makers and many practitioners as a particularly effective way of preventing unintended pregnancy, especially teenage conception. However, little is known about women's individual experiences of these forms of contraception beyond limited data on retention rates and reasons for discontinuation. The main aims of this research were to gain a fuller understanding of why some young women have their implants removed, and what may help them maintain this method of contraception if they wish to do so. The contraceptive choices of 20 young women (aged 16–22) who had chosen the implant, and later discontinued it, were examined. They had experienced unacceptable side effects that they attributed to the implant, and interpreted as a threat to their bodily control, which they were not prepared to tolerate. These feelings were exacerbated if they then encountered delays after requesting removal. Although they remained concerned to avoid unintended pregnancy, they generally moved to a less reliable form of contraception following implant removal and felt discouraged from trying other long-acting contraception. We suggest that principles of contraceptive choice should include facilitating the discontinuation of unsatisfactory methods; implant removal should therefore be readily available when requested, regardless of the length of time the implant has been in place. Long-acting forms of contraception do not suit all women, and will not obviate the need for other forms of reproductive control, including legal abortion.*

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Keywords: contraception and unwanted pregnancy, long-acting reversible contraception, implants, reproduction, bodily control, United Kingdom

The provision of effective and reliable contraception is vital in enabling women to assert control over their reproductive lives, and reproductive control has long been seen as a central component of feminist calls for women's bodily control.¹ Long-acting reversible contraceptives (intrauterine devices (IUD), intrauterine systems (IUS), implants, and injections) are highly effective methods of contraception that have the potential to contribute substantially towards improving women's reproductive control. The implant is one of the most reliable forms of contraception available, and this – along with its “fit and forget” feature – is its main attraction. Some women, however, experience side effects that they are not prepared to tolerate and which lead to discontinuation of the method. The research reported here was carried out in London (UK), but the research

findings have implications for contraception provision more generally.

Background

In recent years in the UK, there has been a concerted policy drive to reduce the rates of teenage pregnancy,² and also to reduce unintended conceptions by improving women's access to a full range of contraceptive methods.³ The contraceptive implant became a central part of the strategy to reduce unintended conceptions, particularly in the teenage population. In October 2005, the UK National Institute for Health and Clinical Excellence (NICE) published guidelines for “the effective and appropriate use of long-acting reversible contraception”, popularly called LARCs.⁴ In these guidelines, LARCs were presented as a cost-effective,

and highly reliable, form of contraception that should be more widely accessible to all women. Assessing cost effectiveness is part of the remit of NICE, and an economic analysis associated with the LARC guidelines demonstrated that the cost-effectiveness of LARC methods is dependent upon the length of time they are retained.⁵ After two years or more, all LARC methods are more cost-effective than the contraceptive pill and the male condom, with the implant (an expensive form of contraception licensed for three years in situ) being one of the most cost-effective methods in the absence of “early” removal.⁶ For contraceptive providers there is thus a tension between providing an effective contraceptive, with unpredictable side effects, that may or may not prove to be acceptable to women; and financial considerations. For individual women, there is a tension between contraceptive reliability and acceptability. Although all forms of contraception can be obtained at no cost through the National Health Service in the UK, the expense of the implant means cost-effectiveness is important to budget holders⁷; and elsewhere cost is likely to be an important consideration for women.

There are relatively few studies examining the continuation rates of the contraceptive implant. In small scale studies in the UK, Smith and Reuter⁸ report continuation rates (within one year) of the implant of between 67% and 78%, whilst Lakha and Glasier⁹ report 75%. Blumenthal¹⁰ reports an overall discontinuation rate of 32.7% (within five years) based on an analysis of 11 international clinical trials. It has also been calculated that 60–64% of implant removals are for irregular/unpredictable bleeding.^{9,11,12} However, irregularities of bleeding are not the only reason for removal. Other reasons include weight gain and headaches.¹¹ Studies have also shown that side effects (especially irregular bleeding) may be experienced but tolerated in exchange for reproductive control.¹³

Qualitative research has shown how method switching or discontinuation is a very individualised process. In a study about inconsistent use of hormonal contraception, some women saw delaying childbearing as being the most important consideration, and consequently tolerated undesired side effects, whilst others decided not to continue with contraception precisely because of these side effects. Women wanted control over their functioning bodies, but what they deemed ‘control’ was variable and dependent on personal

values.¹⁴ Both the selection and the rejection of methods of contraception can be viewed as affirmations of control.¹⁵ Thus, in their contraceptive choices, women combine considerations of bodily concerns (physical functioning and experience) with personal values and beliefs. One personal value often unacknowledged by providers is some women’s anxieties about hormonal contraception disrupting their “natural” bodies.¹⁶

In a key feminist text, Judith Butler¹⁷ distinguished between the biological processes of the body and how cultural discourses shape understandings of those processes. This distinction is drawn upon in this paper, as is Shildrick’s notion of the “leaky body”,¹⁸ whereby leakage (in this case menstrual bleeding) is seen as symbolic of women’s lack of control over their bodies. Laws has argued that the social significance of having a period is learnt and interacts with the physiological process to produce behaviours influenced by cultural attitudes. Women can feel under pressure to adhere to expectations about how they should feel and behave during their bleeding and to observe a “menstrual etiquette” (i.e. concealment of bleeding, avoidance of sex).¹⁹ In this paper, we understand bodily control as incorporating physical and emotional control, and privilege women’s own feelings about their bodies, and their understandings of bodily control. We also consider how young women’s perceptions of side effects they attributed to the implant reveal tensions between notions of reproductive vs. bodily control.

Methodology

The contraceptive careers of 20 young women (aged 16–22) were examined using semi-structured qualitative interviews. The women were recruited from four London health authorities, and were identified with the help of practitioners at sexual health clinics. They were purposively selected to meet the age and early implant removal criteria. They were also self-selecting: if interested in the research, participants gave their consent to be contacted for interview by the researchers, and were interviewed two to three weeks after implant removal. We attempted to ensure we recruited a diverse sample within the parameters of the research, and sought to identify the main issues of concern to this population. To this end, we continued to recruit to the study until we judged we had reached data saturation, i.e. issues, themes

and phrases were being repeated rather than newly generated. The sample is not a representative sample, however, and therefore generalisations should not be made. Although in places we do note the numbers of participants with particular experiences, this is to indicate the relative strength of a particular theme and should not be seen as an indication of prevalence.

Participants came from a range of different ethnic and class backgrounds: 14 were in secondary education, vocational education, or further education, four were working, one was out of work and the career status of one was not known. Most participants had had the implant removed within a year of insertion, and the longest it had been retained was two and a half years. The study focused on learning about the women's sexual relationships, their history of contraceptive use, reasons for selecting the implant, reasons for removing the implant, and their contraceptive use (or intended contraceptive use) following removal. Interviews were recorded on a digital recorder and later transcribed.

We also interviewed nine implant providers with experience of removals, in order to gain a provider perspective on side effects and discontinuation. However, it is important to point out that we did not match providers to the young women interviewed, who had often had their implants fitted in different locations and may not have returned to the same clinic for the removal.

The study was approved by a Pan London Research Ethics Committee (North London REC1). The data analysis was undertaken independently by each of us, using NVivo software and adopting a form of thematic analysis.²⁰ Transcripts were initially read and broad-coded, then these codes were reconsidered and fine-coded. Results were constantly compared in order to test the validity of the emerging findings. Unless otherwise stated, quotations are selected to indicate broader opinions and patterns of behaviour amongst the group as a whole, rather than being those of any one respondent. Aliases are used. A full research report has been published elsewhere.²¹ In this paper we concentrate on the narratives of the young women.

Selecting the implant: prioritising reproductive control

Participants in this study had generally made a considered choice in favour of the implant. They

were seeking a reliable and convenient method of contraception that would allow them to exert control over their reproductive lives. The majority were in stable relationships, and, for them at that point in time, protection against STIs was not perceived as a significant concern. In selecting the implant as their contraceptive method, participants had assessed the advantages and disadvantages of the various methods available to them. Many had previous negative experiences with other forms of contraception, and this had prompted them to try the implant. A quarter of participants had opted for the implant after experiencing difficulties with using the pill, especially remembering to take it daily. Others had problems consistently using a condom.

“I got it because I was kind of scared I was gonna get pregnant... every time we used condoms my man was just telling me to take it off.” (Shani, 19)

There was an understanding that all methods came at a compromise, whether unwanted side effects or a higher failure rate, and these concerns were weighed up against one another. Most saw the implant as an easy-to-use and reliable, thereby responsible, choice of contraception.

Experiences with the implant

The participants attributed a number of different side effects to the implant. As anticipated, bleeding was the most likely (10 cases). Others were: mood swings and changes (including depression, crying, being emotional) (9), weight gain (9), acne (5), anaemia (3), headaches (3), stomach pains (2), discomfort at the insertion site (2), thinning hair (1), amenorrhoea (1) and increased thirst (1). Most of the women experienced more than one of these side effects. For example, Aysa had bleeding, weight gain and acne; Stacey had bleeding, anaemia and weight gain; and Tasmin had mood changes, weight gain, thinning hair and amenorrhoea. One woman attributed a bout of self-harm to how she felt emotionally on the implant.

Sometimes our participants interpreted irregular bleeding from within the framework of having a period. A primary concern, as shown in the following extracts, was the effect that the bleeding had on their everyday lives, including their relationships. There was also potential embarrassment about their bodily functions when they were unable to predict their bleeding patterns.

“Money for tampons and tampons and tampons. I don’t like being on my period, it’s a really horrible feeling, you get really grouchy and people don’t like you because you’re grouchy so I was constantly grouchy, paid for all these tampons, didn’t have regular sex, normal sex because of periods, and I wouldn’t like to have sex with someone on their period, it’s just not nice so that was pretty much problems, everyday problems.” (Janey, 18)

“... it stopped my periods but then when, once it did start, it didn’t stop for about three months so it, it just, it was worse for my period because although it was irregular, it was even more irregular now so... yeah, and that’s embarrassing because then I have to obviously decide what clothes to wear and you have to be very cautious because I can’t be on the bus with a wet patch, that’s embarrassing.” (Grace, 19)

Other participants mentioned being embarrassed about the smell of their bleeding. A woman’s menstruating body is subject to cultural and attitudinal pressures and menstruation is a felt stigma.²² It involves a process of body watching and management of a “leaky body”. Bleeding whilst using the implant was subject to these same pressures. However, the irregular nature of the bleeding made it harder to manage since it could not be predicted like a monthly period.

This sense of loss of bodily control also came into play in the young women’s descriptions of other side effects. Several young women talked about experiencing swings of mood, which signified a loss of emotional control that was distressing.

“I was in a crap relationship anyway, which wasn’t helping, but I would just cry over anything...even if I was having a good day and everything was great and there wasn’t nothing to get me upset I’d just sit there and start crying. I’d think, why am I crying?” (Daniella 19)

As illustrated in Daniella’s account, the young women were often confused and uncertain about how the implant – or indeed, whether the implant – had affected their emotions. Several spoke of other things happening in their lives that might also be making them feel sad or depressed.

Reta had an implant inserted at an abortion clinic at the same time as she had a termination. It is unclear whether she had wanted to continue with the pregnancy, but her boyfriend wanted her to have an abortion, and she had agreed. Reta found it especially difficult to understand what was happening to her emotions. She theorised

that the side effects she experienced (weight gain, headaches, and emotional upset) could be caused by hormones in the implant, although she also acknowledged that she was not sure if her emotions were also linked to the abortion.

“I don’t know whether it was the abortion that made me emotional or whether... it was difficult to tell because I had an implant... I think the implant just made me a bit more... like it just turned it up a notch, I was a bit more hormonal and stuff.” (Reta, 19)

Many participants described being aware that being emotional, regardless of the implant, might be an expected part of their teenage years, and this was one of the reasons why some of them were uncertain about whether the implant was responsible. However, in the main, their perception was that the implant either caused or exacerbated such feelings. Shelley (17), for example, told us that the implant made her feel depressed and she would lock herself in her room for days. She maintained: *“That’s never happened before. I was actually quite frightened.”* Jata (17), told us that she had self-harmed and attributed this behaviour to the implant. Some, such as Daniella, concluded that it was not necessarily a good method of contraception for women with emotional turmoil:

“I wouldn’t advise the implant to anybody who was quite emotional and depressed in the first place”. (Daniella, 19)

Weight gain was often combined with mood swings, and here again the young women expressed concern about their difficulty in understanding their bodily changes. Many noted that they felt hungry all the time since they had had the implant, and some associated the weight gain with persistent bleeding, since this led them to want to eat comfort food: *“On your period you just want to eat chocolate.”* (Stacey, 19)

Bodily changes were often interpreted as a sign that hormones were affecting their bodies in a negative way. This perception had implications for trying the combined oral contraceptive pill, which can be prescribed in addition to the implant, to alleviate bleeding problems. Many of our participants were worried that additional hormones might only add to the problem.

How the providers thought about side effects

The practitioners interviewed for this study had differing approaches to the initial consultation.

“I don’t really talk much about any of the other possible side effects ‘cause I think if you do talk about the less common ones, you tend to scare people off and I’d say to them, like with any drug, that it has its side effects but not to worry too much about it.” (District 4, interview 1)

The reluctance of some practitioners to explain all the side effects associated with the implant was at odds with the young women’s desire for thorough information about the method. Clearly, achieving a workable balance between providing full information, whilst not unduly alarming women (many of whom will not experience side effects) is not easy. Some encouraged the consultation to be led entirely by the young woman herself, and were concerned that they were being overly influenced by guidance and locally set targets.

“I think it should be around what’s available, around an individual and around getting information and then making an informed choice. You know, I think, personally... policy-makers or commissioners sitting there who have no idea around a young person’s life, making decisions about this is good because it’s going to stop everyone getting pregnant, I think it’s a bit unrealistic.” (District 1, interview 3)

The tailoring of the advice to understandings of individual needs is the approach that corresponds most closely to the preferences of the young women. In common with other research,²³ we found that failing to discuss possible side effects that were then experienced led to distrust of the contraceptive provider.

What was significant in our study was the participants’ toleration of side effects up to a point, until situational change arose. This could simply be an unwillingness to tolerate (often multiple) side effects any longer, or could occur alongside other changes (seven of the participants tolerated side effects until their relationship ended). This then culminated in them reaching a “tipping point”,²¹ at which they wanted the implant removed.

Removal and re-asserting bodily control

Requests for removal were thus made for a number of reasons. These included changes to their physical self (weight gain, acne, bleeding, painful insertion site), and their emotional self (mood swings, crying, self-harm). The young women’s action in having the implant removed

was commonly framed as a way of re-asserting bodily control.

“First of all she tried to trick me and saying I needed to keep it in for more than six months, just while I think about it, but then I just needed it out because I wasn’t feeling comfortable with myself, normal.” (Kia 16)

Kia’s perception of not being her normal self pushed her towards having the implant removed. What is also notable in Kia’s comment was her being told she “needed to keep it in for more than six months”, which indicates an institutional barrier to removal. This was not an uncommon experience; about a third of the participants recalled some resistance to their request to have the implant removed. Whilst some of the providers we interviewed felt that removal should be facilitated as soon as it was requested, many were quite keen to justify resisting “early” removal. This was articulated as being for economic reasons but also to give the young women’s bodies time to adjust to the implant.

“I also say to them about, we want to keep the method for at least one year... Well it’s, it’s all to do really with delay, delay of removal, and I think that’s just down to a cost thing. It doesn’t really work, but it delays removal at least for a bit longer so it makes it a little bit more cost-effective.” (District 4, interview 1)

Such resistance to removal, however, could be perceived as a challenge to the young woman’s bodily autonomy, which led to an assertion of the right to control her own body:

“The first time I wanted to get it removed I went to four appointments, because every time I went they’d talk me out of getting it taken out, and they’d be like, no, you should keep it in, but this time I went and done it, I went back, the woman who took it out was quite adamant she didn’t want to take it out, and I said I’m not being funny but it’s not your body, it’s my body so take it out, I want it out.” (Daniella, 19)

On balancing desires for bodily control with maintaining reproductive control

The young women’s particular experiences of loss of control – the implant taking over their bodies – contributed towards shifting the balance in favour of prioritising bodily control over

reproductive control. This has clear implications for future contraceptive choices, and these were played out in the participants' decision-making on post-implant contraception. Nine participants had not accessed any further contraception at the time of the interview, some because they were no longer in a relationship. Seven were using a less reliable method of contraception (pill, condoms or withdrawal); only three had selected an alternative long-acting contraceptive (injection or IUD).

They were aware that the implant was a particularly effective form of contraception, which had been their main reason for selecting it, but after removal they were not prepared to contemplate further bodily experiences they had associated with the method. This aversion often extended to other long-acting methods, especially the injection and the intra-uterine system, usually referred to as "the coil" by the young women. Daniella speculates about the contraceptive injection:

"If you don't like something and you can't take it out, it's your own body, you should be able to have control over your own body... If you didn't like it, the fact [is] I would have to stick with it and see it through... I've had friends that have had the injection and they've bled the whole time – I wouldn't be able to handle that myself, but there would be nothing I could do to stop it." (Daniella, 19)

Part of the anxiety expressed by Daniella was that an injectable could not be taken out, thus risking inability to regain control. This was something that participants – particularly after their experiences of the implant – were not prepared to consider.

For some of the young women, implant removal coincided with the end of their relationship. Although reproductive control was not an immediate concern, they did still speculate about future contraceptive choices. Fatima was asked whether she was using contraception at the time of the interview. Her reply indicates that she was balancing a number of considerations. She was not sexually active at the time, and seemed to be ambivalent about future contraception, though certain that she would have to experiment to find the contraception that was right for her.

"I'm not sexually active... but I do have the pill, I have four packets of it so if at any point

I do need... I don't think I will use it, but I think if at any point I feel like I should, I will, I can... I think he would prefer it if I went on the pill, if we did, but he would use condoms as well. I think I would probably go back on some form of contraception, not the implant maybe, maybe I'll try something else, like one of the coils or something new, or get the injection more often to see if maybe that was just a one-off effect." (Fatima, 17)

Jo, on the other hand, was sexually active with a long-term partner, and wanted a reliable contraceptive.

"I'm really worried because obviously I don't want to get pregnant and I have got a long term partner so it's very awkward, what do you do... I can't take the pill because that's more hormones in my body... You either stop getting pregnant and be upset, mad, whatever people want to call it, or you take that chance really, but you can't really take a chance on that." (Jo, 20)

This is a snapshot of a dilemma faced by many of the participants. Jo is aware that the implant could stop her becoming pregnant but at the cost of being "upset, mad, whatever people want to call it", and that is a price she is not prepared to pay. Her experience put her off other forms of hormonal contraception, but she also expresses a fear of pregnancy and is therefore reluctant to "take that chance".

Reta selected the IUD as her post-implant contraceptive because it did not release "chemicals": *"I just didn't want anything that gave any chemicals or whatever into my body and that was the only thing, the copper coil."* Reta was actually very unhappy with the IUD. She found it painful and her boyfriend said he could feel it during intercourse, but her fear of pregnancy kept her using that method.

"I feel like if now I came off the contraception and I got pregnant, I wouldn't have an option because I would be having a baby, I wouldn't go through that experience again, but I don't want to be forced into having a child just because I don't want to have an abortion." (Reta, 19)

Reta was not the only participant who was worried about unintended and unwanted motherhood. Several others explained that if they were to become unintentionally pregnant, then they would become mothers only because they did not "believe in abortion".

Discussion and implications for policy and practice

This study has shown that some young women interpret side effects of the contraceptive implant as a loss of bodily control, both physical and emotional. These participants had carefully selected a reliable form of contraception because they were very concerned to avoid pregnancy. Their acceptance of the need to give up what they had initially embraced as an effective form of reproductive control is an indication of the extent of the adverse effects on their bodies, which they associated with the implant: their bodies were leaking, they were embarrassing, not “normal”, and – as noted elsewhere¹⁶ – hormonal contraception was viewed as disrupting the “natural” body. Their experience of loss of control was distressing to them, and propelled them towards requesting implant removal. Many then interpreted any resistance to implant removal as a further challenge to their own bodily autonomy. Although it is not possible to generalise from this small sample, the strength of the theme of loss of bodily control associated with the implant suggests that it is not an uncommon phenomenon. These findings have implications for contraceptive choice and provision everywhere.

The expense of the implant means that what providers perceive as early removal may well be a contentious issue. This is likely to prompt providers to react negatively towards requests for “early” removal, as would research evidence that side effects do lessen over time.⁸ For women who have to pay for the implant themselves, the cost must also generate an imperative towards toleration of any side effects experienced. There are lessons that can be applied from this research to both these scenarios.

Women in our study reported experiencing a number of hormonal side effects, as well as bleeding irregularities. The NICE guidance, however, heavily drawn upon by UK providers, states that implant use is not associated with changes in weight, mood, libido, or headaches.⁴ The Family Planning Association guidance includes headaches, breast tenderness and mood changes as possible temporary side effects. The evidence from our study would suggest that more attention needs to be paid to acknowledging and understanding how side effects identified by users of the method may be affecting women. It seems very odd that there is no clinical evidence that these side effects are caused by the implant,

when there are many research papers that report the experience of such side effects while using the implant.^{9,11,12} And they are mentioned in the manufacturer’s patient Information leaflet.²⁴

Although it is not possible to be certain that the perceived side effects described by women are caused by the implant, the women thought that this was the case, and it was this perception that pushed them towards having the implant removed. Women therefore need to be made aware of all the side effects of the implant, not just irregular bleeding – the main side effect providers said they discussed and that the young women recalled being mentioned. At the same time, women should be informed that these may well be temporary side effects, and that they may not experience any at all. Additionally, in order to support continuation of the method, when women wish, we would suggest that implant providers offer an open-door follow-up service so that women who are unhappy about the way the implant is affecting them can return for advice, and possible therapeutic treatment, if they wish, at any time.

The most important findings relate to implant removal. As we have indicated, the providers had different views and practices with respect to how to discuss possible side effects, and also how to respond to a request for implant removal. Some were prepared to remove an implant upon request, whilst others appeared to be applying a blanket rule of waiting for six months or a year. Such differences came out in the young women’s narratives, and negative experiences, associated with provider resistance, were prominent. Providers should be prepared to remove an implant when requested, regardless of the length of time it has been in place. Among first principles of contraceptive choice are the right to stop using a method, as well as the right to access and use a method, and removal services therefore need to be available and accessible preferably wherever implants are fitted.

Removal services should be combined with further contraceptive advice. This study has shown how women who feel that hormonal contraception has affected their bodies negatively may be reluctant to try further hormonal methods. The availability of non-hormonal contraception is therefore also important.

Their experiences led many of the participants to prioritise bodily control over reproductive control. They remained concerned to avoid

unintended pregnancy, but were prepared to move to a less reliable form of contraception because of the side effects they had experienced. Therefore, although long-acting contraception may be promoted as an “answer” to unintended pregnancy, this could be problematic. As shown in this study, even women who are very concerned to avoid pregnancy, and prepared to try a range of contraceptives, may struggle to find a method that is acceptable to them, which can be used consistently. Unintended pregnancies appear to be unavoidable. Long-acting forms of contraception may suit some women, but are highly unlikely to be acceptable to all women, and therefore cannot be relied upon alone to reduce unintended pregnancies.

In order to establish the unity of reproductive control and bodily control, all women need access

to all available contraceptive methods, without barriers to choice, and equally non-stigmatised access to abortion in the event of an unintended and unwanted pregnancy.

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Résumé

Au Royaume-Uni, les contraceptifs réversibles à longue durée d'action ont été accueillis favorablement par les décideurs en santé sexuelle et beaucoup de praticiens comme moyen particulièrement efficace de prévenir les grossesses non désirées, spécialement chez les adolescentes. Néanmoins, on connaît mal l'expérience individuelle des femmes, à part les données sur les taux de rétention et les raisons de l'interruption de ces formes de contraception. Les objectifs principaux de cette recherche étaient de mieux comprendre pourquoi certaines jeunes femmes se font enlever leur implant et qu'est-ce qui peut les aider à conserver cette méthode de contraception si elles le souhaitent. Les choix contraceptifs de 20 femmes (âgées de 16 à 22 ans) qui avaient sélectionné l'implant, puis l'avaient abandonné, ont été examinés. Ces femmes avaient enregistré des effets secondaires inacceptables qu'elles avaient attribués à l'implant. Elles les avaient interprétés comme une menace pour leur maîtrise corporelle qu'elles n'étaient pas disposées à tolérer. Le fait de devoir attendre après avoir demandé le retrait de l'implant avait exacerbé ces sentiments. Même si elles souhaitaient encore éviter les grossesses non désirées, elles étaient généralement passées à une contraception moins fiable après le retrait de l'implant et n'avaient plus envie d'essayer d'autres contraceptifs de longue durée. Les principes du choix contraceptif devraient inclure des mesures pour faciliter l'abandon de méthodes non satisfaisantes ; l'implant devrait donc être retiré dès que demandé, quelle que soit la durée de sa mise en place. Les formes de contraception de longue durée ne conviennent pas à toutes les femmes et n'élimineront pas la nécessité d'autres méthodes de maîtrise de la fécondité, notamment l'avortement légal.

Resumen

En el Reino Unido, los anticonceptivos reversibles de acción prolongada son bienvenidos por formuladores de políticas de salud sexual y muchos profesionales de la salud como una manera especialmente eficaz de evitar embarazos no deseados, en particular la concepción en la adolescencia. Sin embargo, no se sabe mucho acerca de las experiencias personales de las mujeres con estos anticonceptivos aparte de los datos limitados sobre las tasas de retención y las razones para abandonar el método. Los objetivos principales de esta investigación eran entender mejor por qué algunas jóvenes solicitan que se les extraigan los implantes y qué podría ayudarlas a mantener este método anticonceptivo si así lo desean. Se examinaron las opciones anticonceptivas de 20 jóvenes (de 16 a 22 años de edad), quienes habían elegido el implante y después lo abandonaron. Presentaron efectos secundarios inacceptables, que atribuyeron al implante e interpretaron como un peligro para el control de su cuerpo, lo cual no estaban preparadas para tolerar. Estos sentimientos fueron exacerbados si luego encontraron demoras tras solicitar la extracción. Aunque continuaron preocupadas por evitar embarazos no intencionales, generalmente pasaron a usar un anticonceptivo menos confiable después de la extracción del implante y se sintieron disuadidas de probar otros anticonceptivos de acción prolongada. Sugerimos que los principios de elección de anticonceptivos incluyan facilitar el abandono de métodos poco satisfactorios. Por lo tanto, cuando se solicite la extracción del implante, ésta debe efectuarse con prontitud, independientemente del tiempo que lleva colocado el implante. Los anticonceptivos de acción prolongada no son adecuados para todas las mujeres y no harán innecesaria otras formas de control reproductivo, como la interrupción legal del embarazo.