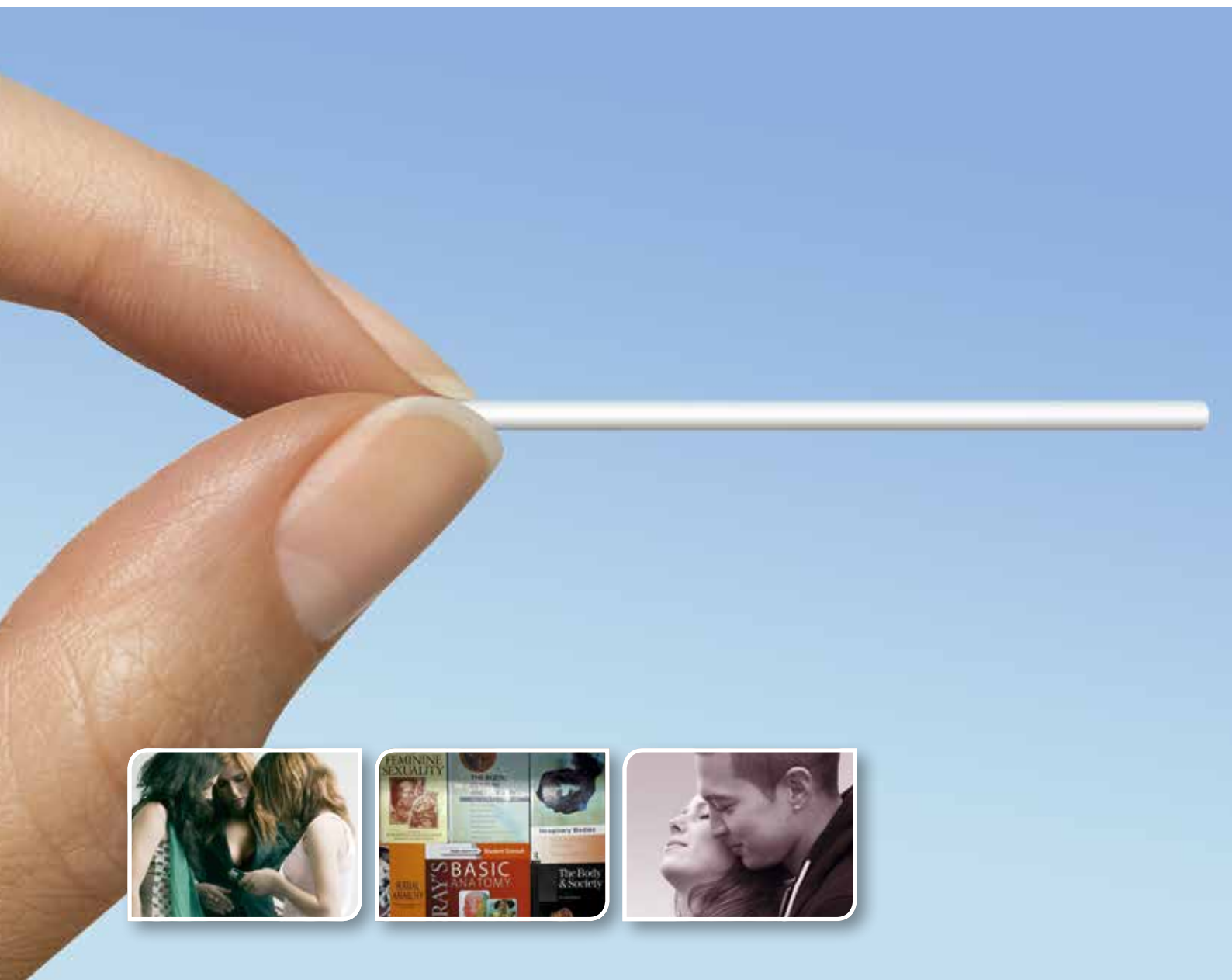


# Full Report

Understanding Long-Acting Reversible  
Contraception: An In-Depth Investigation into  
Sub-Dermal Contraceptive Implant Removal  
Amongst Young Women in London

**A Report for the London Sexual Health Commissioning Programme**



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Contraception: An In-Depth Investigation into  
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Amongst Young Women in London

**A Report for the London Sexual Health Commissioning Programme**

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# Executive summary

## Background

There has been significant focus in recent years, in the UK, on long-acting reversible contraception (LARC) and the impact that LARC use could have on reducing rates of unwanted and unintended pregnancy (NICE 2005). Long-acting reversible contraceptives (IUD, IUS, contraceptive implant, contraceptive injection) are highly effective methods of contraception. In addition they are discreet and do not require daily user compliance. However, despite these apparently positive features, LARC methods are less popular than might be expected, and there has been considerable discussion about why these seemingly convenient and effective methods have had such a low user uptake (Williamson *et al* 2009, Glaiser *et al* 2008, Tanfer *et al* 2000). With respect to the implant, an expensive form of contraception, work undertaken by NICE (2005) had shown geographical inconsistencies suggesting uneven access to the method. More recently, data suggest that women continue to experience uneven access, with London having the second lowest uptake of the implant in any English region.<sup>1</sup> The current research project was funded by the London Sexual Health Commissioning Programme from 'improving access to contraception funds', and is therefore located within a framework of seeking to improve all women's contraceptive choices.

Concern has also been raised about continuation rates of the contraceptive implant, and this research was commissioned in order to learn more about why some young women have their implants removed within one year of insertion. Although economic evaluation has been performed which demonstrates that the cost effectiveness of LARC methods is dependent upon the length of time that they are retained by the contraceptive user (Mavranezouli 2008), there are few studies examining the continuation rates. In small scale studies, Smith and Reuter (2002) report continuation rates of between 67% and 78% at 12 months; and Lakha and Glasier (2006), report continuation rates for the implant to be 89% at 6 months and 75% at one year. The limited evidence available therefore suggests that most women who select the implant appear to be satisfied with their choice of contraception. Research on women of all ages has indicated that the most common reason given for discontinuation of this form of contraception is bleeding problems; followed by acne, weight gain, depressive moods and insertion site problems (NICE 2005). Little is known about how and why these side effects lead to discontinuation of the method of contraception, or about the specifics of how these issues relate to young women. Understanding more about what may help young women select and retain a form of contraception that suits them is particularly important at a time when contraceptive services are being transferred to local authorities.

## The study

This research project therefore sought to identify factors associated with the removal of the implant by young women (under 23). It had two main research aims: to gain a fuller understanding of why some young women have their implants

removed; and to understand what may help them maintain this method of contraception, if they wish to do so.

A qualitative methodology was employed. We conducted twenty semi-structured interviews with young women aged 16-22 who had had their implant removed, and nine interviews with practitioners working in contraceptive and sexual health (CASH) services. Participants were recruited from four health authorities across London: Greenwich; Haringey; Hounslow; and Lambeth, Southwark and Lewisham (LSL). Data was analysed using thematic analysis (Braun and Clarke 2006), with the help of NVivo Software.

## Key findings – reasons for choosing the implant

- **The young women had made a considered choice in favour of the implant.** After weighing up the pros and cons of different methods of contraception they had selected the implant as the most suitable method for them at that particular point in time. Many had struggled with other forms of contraception, and were attracted by the low failure rate and freedom from having to manage a user-dependent method.
- **Young women gained information about different contraceptive methods from a variety of sources. The knowledge and experience of friends was particularly influential in their decision making process.** Contraceptive decision-making is complex, and has many influencing factors. Young women spoke about balancing their needs and wants for a contraceptive method with their lifestyle and sexual relationships. Their views about the different methods of contraception were highly influenced by their informal knowledge. In the process of weighing up the possible positives and negatives of different forms of contraception, the views and experiences of their friends, and sometimes family members, were especially important.
- **Young women felt that they had to be responsible in seeking contraception.** Participants talked about the need to look after their bodies and avoid pregnancy. Partners were rarely active participants in the decision making process. The implant was seen as a responsible choice, particularly for those in what they described as a 'steady relationship'.

## Key findings – experiences with the implant and reasons for removal

- **The reasons given for removal were overwhelmingly because of what were perceived as intolerable side effects of the implant.** The most common of these was bleeding irregularities. Hormonal side effects such as mood swings, headaches and weight gain were also given as reasons for removal.
- **The women had not been prepared for the lived experience of prolonged bleeding, or irregular bleeding patterns.** Although most participants had been told about possible disruption to bleeding patterns, many had hoped

<sup>1</sup> <https://catalogue.ic.nhs.uk/publications/public-health/contraception/nhs-cont-serv-comm-cont-clin-eng-2011-2012/nhs-cont-serv-comm-cont-clin-eng-11-12-rep.pdf>. Accessed 9 January 2013.

that it would not happen to them or had not anticipated the everyday reality of living with unpredictable bleeding.

- **Young women tolerated the implant for some time.** Many persevered with the method, hoping the bleeding (and other side effects) might 'settle', and tolerated a significant amount of discomfort and inconvenience before deciding they wanted the implant removed.
- **Other (non side-effect) reasons for removal revolved around individual circumstances, in particular relationship changes.** Once a relationship ended the young women saw no need to continue with their contraception. This was linked to their sexual identity since the removal was seen as indicating that they did not intend to be sexually active in the immediate future, and was perceived by them as being sexually responsible.
- **Generally more than one reason for removal was given.** Sometimes this was more than one side effect; or it could be a combination of side effect(s) with other factors. For example, a young woman might tolerate side effects that she was not particularly happy about, but then have the implant removed when her relationship ended.
- **Many participants had not felt sufficiently warned about all the side effects of the implant.** Some young women did not feel that there had been a full enough discussion about all the possible side effects of the implant at their contraceptive consultation. A smaller number felt they had been misinformed by the practitioner at the consultation, in particular if they had been assured that side effects they later experienced were not associated with the implant. In some consultations there appeared to have been an over-reliance on written materials or leaflets.
- **The young women eventually reached a 'tipping point' when they were no longer prepared to tolerate the implant.** For many of the participants it was a combination of factors (especially side effects) that contributed towards a 'tipping point' that caused them to ask for their implant to be removed. At this point they had made a final decision that they wanted their implant removed and were not prepared to tolerate it any longer, or accept delays to removal.

## Key findings - removal and after

- **Many participants still thought of the implant as a good method of contraception (in theory) and were disappointed that it had not worked for them.** Some saw it as a failure of their body to accept the implant rather than any limitations with the product itself. Thus participants viewed the implant as a good method for 'other people', even though it had not worked for them personally.
- **Some women in the study were left with concerns about the effect of hormones on their body.** This was either because they interpreted disrupted bleeding patterns as possible evidence of interference with fertility, or else their experience of mood swings and other hormonal side effects had convinced them that hormonal contraception must be harming them in some way.

- **On a number of occasions young women experienced what they thought was practitioner resistance to their request for a removal.** These young women talked about having to be assertive and push for a removal and found this frustrating and a challenge to their bodily autonomy.
- **Young women's negative experiences with the implant, and their disappointment with the services can affect their future contraceptive choices.** If they felt they had been misinformed by the practitioner about the side-effects of the implant, this could lead to disengagement with services and a loss of trust. If they experienced resistance to removal, or tolerated significant discomfort with side effects (e.g. prolonged bleeding) this experience of loss of bodily autonomy often discouraged them from wanting to try another LARC method in the future.

## Implications for practice

We have identified three points at which changes in practice might make a positive difference to the contraceptive pathways of young women who become dissatisfied with the implant.

## The contraception consultation

- **Clients need to be adequately prepared for the possibility of experiencing side effects.** Although participants did acknowledge that they were alerted to possible disruption to bleeding patterns, other hormonal side effects of the implant were discussed less often during the initial consultation. This is something which could be addressed. It would also be possible to discuss from the outset how things can be done to help with irregular bleeding if it becomes problematic (e.g. also taking the combined oral contraception for a short period of time in the absence of contraindications).
- **Provision of a leaflet should not be seen as acknowledgement that young women have been given all the necessary information.** The study highlights an 'over-dependence' of practitioners on written support, particularly 'the leaflet'. Also, the information leaflets are very general, and this study has shown that contraceptive advice may need to be tailored to individual needs and experiences.
- **Clients should be told that they can return to their implant provider, whenever they wish, should they experience side effects with which they need support.** In effect, this means the service should have an 'open door' policy, and not discourage clients from contacting them in the first few months following implant insertion.

## Providing support once the implant has been fitted.

- **Although participants acknowledged that they were given advice before having the implant fitted, they need to receive more support once the implant is in place.** Participants were told to keep the implant for varying lengths of time (usually six months) in order for their body to 'adjust'. Some felt unable to return to the clinic during this time, despite experiencing problems with the implant. It should be made clear that young women can come back to the clinic to discuss their options if side effects become problematic. The aim of this is to intervene before they reach a 'tipping-point'.

- **Young women should be able to return to the clinic at any time if they are unhappy with the implant.**

Practitioners need to be aware that encouraging retention of the implant, without dealing with side effects that young women may find distressing, may be counter-productive. Rather than expecting young women to cope with side effects because they have been forewarned, they should be encouraged to return to the clinic and therapeutic interventions offered if available.

## Requests for removal and future contraception

- **In supporting women's contraceptive choice practitioners need to accept that some women are unable to tolerate the side effects of the implant.** If the women's individual experiences are appreciated and their wishes respected, practitioners may be better placed to be trusted with regard to recommendation of further methods. This study demonstrates that attempts to encourage retention may not only be futile, but can subsequently undermine the patient's trust in her practitioner. It should also be recognised that the 'end of a relationship' is a valid reason for discontinuing contraception

- **Commissioners and practitioners should be aware that resistance to implant removals may have unintended consequences.** When participants reached their 'tipping point' they were less receptive to further forms of LARC and /or hormonal contraception. Additionally, trying to persuade a young woman to persevere with a form of contraception that she is unhappy with is not respectful of bodily autonomy and could be viewed as unethical.

- **If the implant does not suit a young woman, it is therefore important to remove it and move her on to new contraception quickly. Implant removal should be easily available when other avenues for support are not acceptable to the young woman.** Even though there are therapeutic options available to help with bleeding problems, there are no therapeutic options to help with other hormonal side effects. In these instances support and reassurance may not suffice and practitioners should be prepared to remove an implant when requested, regardless of the length of time it has been in place. Principles of contraceptive choice should include implant removal, and removal services therefore need to be available and accessible, ideally wherever implants are fitted. Removal should be combined with further contraceptive advice.





# Chapter One: Introduction

In October 2005, the National Institute for Health and Clinical Excellence (NICE) published a guideline for 'the effective and appropriate use of long-acting reversible contraception' (NICE 2005). The NICE guideline was aimed at promoting wider contraceptive choice by encouraging uptake of what became known as 'LARCs' (long-acting reversible contraceptives which include the IUD, IUS, contraceptive implant, and contraceptive injection) as viable and reliable contraceptive methods for women. The NICE guideline also highlighted the role LARCs could play in the reduction of unintended pregnancies (especially unintended teenage pregnancies) by providing statistical information concerning this, coupled with repeated affirmation of their low failure rate. LARCs were presented as a cost-effective, and highly reliable, form of contraception that should be more widely accessible to women.

The sub-dermal contraceptive implant (hereafter 'implant') and the IUD were shown to be the most cost effective forms of LARC (NICE 2005, Blumenthal *et al* 2010). Economic analysis, however, has demonstrated that the cost effectiveness of LARC methods is dependent upon the length of time they are retained (Mavranzezouli 2008). After 2 years or more, all LARC methods are more cost effective than the contraceptive pill and the male condom, with the implant – though an expensive form of contraception – being one of the most cost effective methods (Blumenthal *et al* 2010). These calculations naturally lead to a concern to learn more about: how to increase uptake of these contraceptive methods; what may prompt 'early' removal; and what might encourage retention.

Although many women who use the contraceptive implant are happy with their choice, a minority choose the method and then request 'early' removal. Understanding more about what may help young women retain an effective form of contraception, of their choosing, is particularly important at a time of change in the provision of sexual health services. Changes initiated by the Health and Social Care Act 2012<sup>2</sup> mean that from April 2013 local authorities will have to pay for complex or high cost contraception (including the implant), whilst general practitioners will only have to provide basic contraception (essentially the contraceptive pill), which will be financed through the national commissioning board. If they do provide more, this will need to be financed through either the local authority or the local clinical commissioning group. It is hoped that both these bodies will benefit from research focused on understanding more about why young women select an implant, and what may help them retain their contraception of choice. The research was commissioned by the London Sexual Health Commissioning Programme, and funded from 'improving access to contraception funds'. It commenced with a review of existing research on women's views on, and experiences of, long-acting reversible contraceptives (LARCs).

## Literature Review

This review comprises two main sections: the first is concerned with factors influencing the uptake of LARC methods of contraception; the second considers the research evidence on satisfaction and continuation of LARC methods.

### Factors influencing the uptake of LARC methods: attractions and barriers

LARCs are highly effective methods of contraception that do not require daily user compliance; and increased uptake of the methods could potentially help reduce rates of unintended and unwanted pregnancies (NICE 2005). Whilst they are suitable for women of any age, researchers have pointed out that LARCs are viewed as especially appropriate for certain groups of women, i.e. young women at risk of teenage pregnancy and teenage abortion (Stevens-Simon *et al* 2001, Lewis *et al* 2010), and as an alternative to sterilisation for women who have completed their families and do not wish to have any more children (Kane *et al* 2009, Haimovich 2009).

Despite these positive features, LARC methods are less popular than might be expected, and there has been considerable discussion in research literature about why these seemingly convenient and effective methods have had such a low user uptake. Research has reported that despite the known benefits and efficacy rates of LARC methods, there is uneven access to these types of contraceptives in some areas (NICE 2005; Wellings *et al* 2007). The high cost of the implant is a significant barrier to individual women in many other countries, but this is not an issue in the UK where contraception is provided free at the point of delivery. The extent to which costs (to local providers) may help to explain uneven provision across the UK is not known. Research, however, has shown that there is inconsistent access to these types of contraceptives across different services, and they are less likely to be suggested in general practice consultations than in specialist sexual health services (Wellings *et al* 2007). This could be due to a lack of confidence in fitting the implant, in addition to women requesting the (contraceptive) pill from their GP, rather than alternative forms of hormonal contraception (Wellings *et al* 2007; Williamson *et al* 2009). Efforts have been made, since 2008, to increase the uptake of LARC in GP services, with the GP Quality Outcomes Framework allocating points to GPs for promoting LARC.

Contraceptive decision-making is often characterised by an expectation to use 'normal' methods, and going on the pill is seen as the usual method of avoiding pregnancy (Williamson *et al* 2009:168). None of the young women in the study by Williamson *et al* 'expressed any expectation of using an alternative LARC method' (2009:168). Some women, particularly young women, may feel embarrassed when they seek out contraception, and are uncomfortable at having to express the fact that they are sexually active. This situation can be regarded as one of contraceptive 'language barriers', whereby women feel uneasy talking about contraception with their doctor, and opt instead to 'talk around' the subject, and ask for the pill, or cite period problems as their reason for wanting the pill (Glasier *et al*

<sup>2</sup> <http://www.legislation.gov.uk/ukpga/2012/7/enacted>



2008). The result of this is that they are given the method they ask for, and as a consequence other methods of contraception (such as LARCs) may not be taken into consideration. In addition, LARC methods involve invasive procedures administered by a healthcare practitioner, and this breach of the body's boundaries is also seen as off-putting to some women (Glasier *et al* 2008).

Lack of (accurate) knowledge about what can be perceived as 'alternative' methods of contraception can also influence the likelihood that LARCs may be overlooked or refused (Rose *et al* 2011). Informal discourses can play a significant role in the way women articulate their knowledge about contraception, since a great deal of what we know about health and the body comes from friends, family, and peers. The reporting of negative experiences from these sources can influence a young woman's decision not to use certain methods of contraception (Williamson *et al* 2009, Kuiper *et al* 1997). In addition, there is a relationship between contraceptive use and self-identity. Kuiper *et al* (1997) suggest that there is a perceived hierarchical relationship between contraceptive choice and sexual behaviour: the less autonomous the method, the more sexually active the woman is assumed to be.

Misunderstandings about how unfamiliar contraceptive methods work means that concerns about the impact of LARCs on future fertility are a common theme, especially since side effects include unpredictable changes in uterine bleeding patterns or prolonged break-through bleeding. Although 'long-acting' can be seen as a beneficial aspect of contraception by practitioners, a study by Glasier *et al* (2008) found the phrase 'long-acting' caused trepidation in women, who were concerned that 'long-acting' methods could have implications for their future fertility.

Personal values and wants are also very important in decision making. In a study by Cheung and Free (2005) concerning the inconsistent use of hormonal contraception, some women saw delaying childbearing as most important, and consequently 'put up' with undesired side effects. Other women decided not to continue with contraception precisely because of these side effects. In addition, some women manipulated contraception in order to bring about desired effects, such as menstrual control. Ultimately, women in all these cases wanted control over their functioning bodies, but what they deemed 'control' was variable and dependent on personal values. Bodily control could be non-pregnancy, predictable bleeding, lack of monthly bleed, or a 'natural' state (when no hormones are added to the body). These personal attitudes were similarly reported by Kuiper *et al* who found that 'for implant users, the method allowed them to assert control over their futures, while for many others the implant threatened that control. Thus, both the selection and the rejection of a method were viewed as affirmations of control' (1997:170). Women thus combine considerations of bodily concerns (physical functioning and experience) with personal values and beliefs in their contraceptive choices.

### **Experiences with LARC: satisfaction, toleration and reasons for removal**

There are relatively few studies examining the continuation rates of the contraceptive implant in the UK. Smith and Reuter (2002) in their study of three community services, which involved a retrospective review of client records, comparison with audit data and postal survey, report continuation rates between

84% and 88% at 6 months and between 67% and 78% at 12 months. Lakha and Glasier (2006), in their observation study of 324 women choosing Implanon in a community family planning clinic in Scotland, report continuation rates for the implant to be 89% at 6 months and 75% at one year. Blumenthal *et al* 2008 reported an overall discontinuation rate of 32.7% (within five years) for Implanon based on an integrated safety analysis of 11 international clinical trials. The evidence from these studies suggests that the majority of women do retain their implant for at least one year.

Quantitative research has shown that satisfaction levels with a contraceptive method are influenced by many factors. Sangi-Haghpeyker *et al* (2000) examined women who had used the implant for at least 4 years and explored the range of factors that influence women's satisfaction and their continued use of the contraceptive implant. The women in the study were in the main satisfied with their chosen method of contraception implant (Norplant) because of its 'convenience, effectiveness, and ability to free them from the everyday worry of pregnancy and pregnancy prevention [...] For some, this freedom resulted in a fuller more enjoyable sex life' (2000:98).

There is a difference, however, between satisfaction with a method, and tolerance. 'Satisfaction' is not the same as 'putting up with method' simply because positives outweigh negatives. Wong *et al* (2009), compared users of the IUD with users of the implant. After 6 months, 89.4% of women who chose the IUD were still using it, and 83.4% of women who chose the implant were still using that (2006:454). This difference was not deemed to be statistically significant. There was, however, a statistically significant difference between the satisfaction levels of IUD and implant users. 74.3% of IUD users reported being satisfied with their chosen method, compared with only 57.5% of Implanon users (2009:455). These results not only show a much higher level of satisfaction with the IUD than with the implant, but also indicate that women who were not satisfied with the implant were nevertheless prepared to continue with the method. They were therefore tolerating the side effects because of the perceived advantages of the implant.

The Sangi-Haghpeykar *et al* (2000) study showed that side effects were still being reported in the first year of use, and these usually comprised unexpected or prolonged bleeding. For many of the women, the first year was problematic, but compliance with the method was shaped by users' attitudes towards hormones and their bodies, as well as a desire to avoid pregnancy. In their review of eleven international studies (942 women), Blumenthal *et al* (2008) point out that the first six months in particular are associated with an increased incidence of side effects, particularly bleeding irregularities. The users reported in Sangi-Haghpeykar *et al* (2000) did attribute the side effects to their bodies "getting used to" this new hormone, and perceived the benefits offered by the method to be greater than the inconvenience of menstrual irregularities (2000:105). Furthermore, the majority of satisfied implant users in this study 'had definite long-term personal and career goals, and perceived the implant as a tool of achieving those goals' (2000:101). Thus these users were willing to tolerate side effects in exchange for control over their reproductive bodies.

Not all women who experience side effects are prepared to tolerate side effects, however. Studies report irregular bleeding

as the main side effect of the implant (Power *et al* 2007, NICE 2005), and this is often given as the most common reason for removal (Wong *et al* 2009, Jeffreys and Clark 2012). It has been calculated that 60% to 64% of implant removals are for irregular/unpredictable bleeding (Harel *et al*, 1996 = 64%; Rai *et al*, 2004 = 60%; Lakha and Glasier, 2006 = 62%). However, irregularities of bleeding are not the only reason for removal given in these studies. Harel *et al* report that in their study the most common reasons for discontinuation of the implant [Norplant] and injection [Depo-Provera] included not only irregular bleeding (64%), but also weight gain (41%), and increased headaches (30%) (1996:118), whilst Lakha and Glasier (2006) report weight gain and mood changes. What is not known is why these side effects may be tolerated by some women, and yet prompt discontinuation by others.

One further area in which information has been sought is around women's attitudes to future contraceptive use once a LARC method is discontinued. Lakha and Glasier (2006), report that almost half of the women in their study switched to a less-effective method of contraception, once they stopped using the implant. They conclude that this is problematic since the use of the pill or male condom carries a higher risk of unintended pregnancy than the contraceptive implant.

## Conclusion

The contraceptive decision-making process is complex and needs to be contextualised within a framework of different influences, some of which may be particularly powerful for young women. There are practical issues, such as barriers to access, lack of information and concerns about invasive procedures. There may also be cultural issues, for example a resistance to 'alternative' methods of contraception, or anxieties about possible side effects. There are social influences including the attitudes and experiences of peer-networks and family members. Finally, there is the individual: what the young woman wants for her body, her future aspirations and what she expects from her contraception. It is therefore necessary to take into consideration social and cultural contexts, as well as the living, breathing, reproductive body and women's different experiences of it when considering contraceptive choices. This summary of existing research has suggested that the reasons given for implant removal are intolerance of side effects, primarily bleeding irregularities; but there is still much to be learnt about what might tip the balance between continuing with the method whilst tolerating side effects, and deciding in favour of implant removal. Additionally, little is known about how negative experiences of the implant may affect future contraceptive choices.

This project was designed to provide insights into what may influence these contraceptive choices. It took into account personal, social and cultural factors, and sought to locate patterns in the complex processes involved in individual contraceptive decision-making. In addition to analysing the discontinuation of the contraceptive implant, the project also explored what happens when the method is discontinued.

## Chapter Two: Research methodology

This research project thus sought to identify factors associated with the removal of the implant by young women. It had two main research aims: to gain a fuller understanding of why some young women have their implants removed; and to understand what may help them maintain this method of contraception if they wish to do so.

### Research design

In order to address the research aims, it was decided to examine the contraceptive pathways taken by young women who had decided to have their implants removed. The study, utilising a qualitative methodology, focused on learning about their sexual relationships, history of contraceptive use, reasons for selecting the implant, reasons for removing the implant; and changing contraceptive decision-making. In total twenty young women were interviewed. Qualitative interviews were also conducted with sexual health practitioners with extensive experience of contraceptive counselling with young people, and of inserting and removing implants. This sample comprised a mixture of nine nurses and doctors. The study was located in four health authorities spread around London: Greenwich; Haringey; Hounslow; and Lambeth, Southwark and Lewisham (LSL). The results from these have been combined. All the interviews were semi-structured. This allowed us to ask each participant a set of pre-defined questions developed from the research aims, but also allowed participants to raise other issues during the course of the interview.

### Sampling

Potential participants for the one-to-one interviews with young women were identified with the help of the local sexual health service providers. We had originally intended to confine the research to teenagers, but difficulties recruiting participants prompted the Advisory Committee to decide to increase the upper age limit to 24. When someone met the inclusion criteria (below) they were asked, by practitioners, if they would like to take part in a research interview, and given an information sheet. If they expressed an interest they were then asked for written consent for their contact details to be given to one of the researchers (Hoggart and Newton). The researchers contacted the young women and arranged to interview them at a place where they felt comfortable. These participants were given a £20 high street voucher as an appreciation of their time and contribution.

The inclusion criteria for the one-to-one interviews with young women were:

- 16 years or over. This helped us to avoid any legal issues arising from the possibilities of hearing about sexual activity whilst the participant is under the age of legal consent. It also meant that there was not an issue over parental consent being needed for the research interview.
- Have had an implant removed less than one year following insertion<sup>3</sup>.
- That they are judged, by the researchers, to be competent to grant informed consent for the interview. Both researchers are experienced in judging, and continually monitoring, such competence.

The sample of young women was monitored to ensure as diverse a sample as possible, particularly in relation to socio-economic background, 'race' and ethnicity; but also taking into consideration age, and length of use of the implant. The aim was not to ensure representation but to capture a range of experiences. The following information is given in order that readers may know a little more about the young women interviewed. Aliases are used.

| Alias    | Age | Ethnicity                                 |
|----------|-----|---|
| Emily    | 18  | White British                             |
| Shelley  | 17  | White British                             |
| Naomi    | 16  | Caribbean                                 |
| Fatima   | 17  | Black African                             |
| Aysa     | 17  | Black African                             |
| Neema    | 19  | British Black African                     |
| Jo       | 20  | White British                             |
| Ella     | 22  | White British                             |
| Katie    | 22  | White British                             |
| Janey    | 18  | Black British Caribbean                   |
| Zahra    | 16  | White and Black Caribbean British (mixed) |
| Reta     | 19  | Black African (British)                   |
| Tasmin   | 21  | White British                             |
| Shani    | 19  | Black African                             |
| Grace    | 19  | Latino                                    |
| Jata     | 17  | Mixed-race                                |
| Kia      | 16  | Mixed-race                                |
| Daniella | 19  | White British                             |
| Stacey   | 19  | White British                             |
| Lucy     | 17  | English (White)                           |

### Research ethics

The research gained pan-London approval from an NHS Research Ethics Committee. All the participants were given appropriate information leaflets and were also given the opportunity to ask questions about the study and their involvement before being asked for written consent. It was recognised that the research could be considered to be sensitive and that many of the topics to be discussed had the potential to be embarrassing, or upsetting, for the young women. Every effort was made to try to avoid any negative outcomes for the young women involved. The researchers sought to ensure that they fully understood what issues they would be asked questions about; they emphasised that the young women did not need to answer any questions that they did not wish to, and that they could withdraw at any time. The researchers also had the details

<sup>3</sup>A few oversights were made in participant recruitment. Six of the participants had actually kept the implant for over a year, but we did not learn about this until towards the end of the interviews.

of referral routes to sources of help and support (social workers; sexual health advisers; child and adolescent counsellors) that could be left with participants.

The anonymity of all the participants has been preserved in the report. This means that descriptions of practitioners' work, and their location, are not included. The individual young women interviewed have been given aliases that bear no relation to their real names and have been used for stylistic reasons, mainly for ease in referring back to particular accounts at different points in the report.

## Data protection

The following measures were taken to protect personal data:

- The electronic recordings of the interviews were sent to transcribers via a secure website. Transcripts had personal data removed. Each interview was given a unique code and only this code was used when transmitting the recordings and transcripts.
- The data were kept at the University of Greenwich on a private computer, in password protected folders.
- The researchers only used personal telephone numbers of the research participants (one-to-one interview) in order to arrange the interview. If they agreed, their address was obtained and kept in order to send out copies of the draft report, and final report. These were held on a password protected Excel spreadsheet, in a different location to the transcripts.
- Publication of direct quotations has been undertaken very carefully, and only when there is no possibility of the quotation leading to the participant being identified.

## Data analysis

A number of measures were taken to facilitate reliability and validity. The data analysis was undertaken independently by the two researchers (Hoggart and Newton); and it was analysed in two different ways. First, with the help of NVivo software, the interviews were coded to broad themes, adopting a form of thematic analysis (Braun and Clarke 2006), then each theme was further explored. This facilitated comparison of issues across respondents and allowed emerging issues to be explored across the whole data set. Alongside this process, each transcript was re-read as a whole and profiles of each of the participants were developed. This ensured that the findings could be located within the context of the interview as a whole and also allowed researchers to check for inconsistencies in the narratives. Results were compared in order to test the validity of the emerging findings. The findings were grounded in the data, and firmly based upon what the young women, and the practitioners, told us. Unless otherwise stated, quotations and examples are selected to indicate broader opinions and patterns of behaviour amongst the group rather than those of any one respondent. The two data sets (young women and practitioners) were then combined and compared.

The rest of the report comprises a further three chapters. Chapters three and four are devoted to presenting the research findings. These discuss the decision-making processes of young women looking first at the reasons for selecting the implant, then moving, in chapter four, to the removal, to retrospective reflection on implant experiences and to post-removal contraceptive choices. The final chapter draws conclusions and discusses the implications of the research for clinical practice.

# Chapter Three: Reasons for choosing the implant

## Introduction

This chapter focuses on young women's reasons for choosing the implant as their method of contraception, and the various influences on their decision-making. Participants discussed gaining information about sex and contraception from a variety of sources, and many of them were concerned to gather as much information as they could before making their decision. The chapter begins by looking at informal sources of information, primarily family and friends. The second section looks at more intimate influences on their decision-making by considering their sexual and contraceptive relationships. It then moves on to a consideration of the formal contraceptive consultation, the setting where their final decision takes place. Finally, the chapter focuses on the individual at the centre of the decision – the young woman – and summarises the main reasons given for selecting the implant. Contraceptive decision-making is thus understood as a process through which – to varying degrees – each individual is swayed by existing states of knowledge and the views of those around them, before making their own decision.

Most participants had selected the method for themselves by one of three different pathways. Some participants sought out the implant and attended the clinic with the intention of having one fitted. Other interviewees had attended the clinic with the intention of accessing contraception, but had been less sure about which method they wanted and had selected the implant from the range of contraceptives presented by the practitioner. The final group attended the clinic for reasons other than contraception, such as screening for sexually transmitted infections (STIs), pregnancy tests or abortion, and contraception was discussed at the appointment and the implant selected<sup>4</sup>. Allowing for these different pathways, the decision to have an implant was generally a considered choice and one which the young women felt they had made for themselves after weighing up the pros and cons of the different methods available to them. This is an important starting point, as, in the main, they recognised the advantages of long-acting reversible contraception for themselves. Most participants were attracted to the method because it had a low failure rate and they did not have to remember to use it.

## Informal knowledge: the influence of family and friends

The participants' views about the different methods of contraception were highly influenced by their informal knowledge. In the process of weighing up the possible positives and negatives of different forms of contraception, the views of their friends – and sometimes family members – were especially important. The participants in our study valued their friends' opinions and listened to the experiences that other people had with the implant (and other contraceptive methods). This was an important part of the process through which they considered

the pros and cons of different methods in order to select a contraception they thought was right for them. The knowledge that a friend liked a particular method and that it worked for them was a key reference point in the young women's decision-making processes:

*I was just thinking the pill was really the only option for me at my age at the time, then after I think about six months that's when I decided to get the implant because I heard more about it and my friend told me and you keep it for three years and then get it replaced and I thought that was really good, because it's there so you don't have to worry.*

(Emily 18)

By way of contrast, a bad experience for someone else was often seen as a reason not to try a particular method themselves. One participant, Reta (19), for example, talked about people she knew who had become pregnant whilst using the pill: 'everyone I know that's got a baby now was on the pill when they had a baby so I just thought, forget that.' The IUD, was a method which appeared to be intuitively disliked by many informants who recalled hearing about negative experiences and spoke about it in negative terms. The process of rejecting other methods could thereby push young women towards trying the implant.

The influence of peers in contraceptive decision-making was also noted by practitioners:

*Well, the big one is their peers. 'My friend is using the method, she likes it'. 'My friend is using the method, she does not like it'. So the big thing is trying to get the peers onside. If you can explore with a youngster what methods they have knowledge about already and quite often young people will come in groups and I have no objection to seeing young people in groups because sometimes, I mean that sometimes is actually quite helpful because they're more likely to accept the information from a young person and I remember hearing information has been passed on so I can correct it if it's wrong or encourage it if it's right. So the big one is peers, is what their peers are using.*

(District 2, Interview 2).

In this study, some participants had indeed attended with friends in order to have an implant fitted.

*I spoke to my friends about it like, what do you lot think about the implant, they were like oh yes I've been thinking about getting it done actually, and I was like oh, so then me and my friend, we went together, we went to go get it.*

(Aysa 17)

Information gleaned from family members was less evident, in this project, than peer influence, and by and large the knowledge they collected related to the anecdotes of family members about

<sup>4</sup> The clinic where the implant was fitted is not necessarily the same place where participants had it removed (and were recruited to the study). The fitting clinic could be an abortion clinic.

unsatisfactory experiences with different forms of contraception. Although some of the young women had the support of family members, mainly their mothers, in their decision to try the contraceptive implant, mostly they had not felt they could have frank or open discussions at home. This was likely to be because of a reluctance to reveal themselves as sexually active, rather than a reluctance to discuss contraception per se. In Aysa's case this was associated with the ethnicity of her family: *'when you come from an African family it's expected that you be a virgin until you get married, there is a massive taboo if you have a child before you get married.'* (Aysa 17)

There can thus be a split between the presentation of the individual to their peers as a member of the group and a sexual being, and the presentation of the self in the family environment. These young women were more likely to turn to their friends for support in their decision making rather than their immediate family members. In general, their sexual partners played a limited role in the contraceptive decision-making process, though what the young women felt about their sexual relationship was an important part of the context for their final choice.

## Sexual and contraceptive relationships

The young women's sexual relationships were very important influences on their contraceptive decision-making, and most participants discussed their decision to select the implant within the context of their sexual relationship. Two themes were particularly evident, and these both incorporate notions of risk and responsibility. The first concerns gendered roles: some participants spoke about contraception being perceived by their sexual partner as women's responsibility: *'That's your problem. It's your body'*. The second theme concerns the way they perceived and balanced the risk of becoming pregnant and the risk of contracting a sexually transmitted infection (STI), in their selection of a contraceptive method.

Practitioners recounted examples of young men sending their girlfriends into the clinic to get condoms, and thought that young women generally assume contraceptive responsibility within a relationship:

*They do take responsibility for it rather than expecting the boys and you'll quite often get the teenagers coming, the boys have sent them to get the condoms, you know, rather than having to come for them themselves so you have to say "look, they've got to be involved and they've got to do the hard work, they need to come as well or even both come and get condoms" but yeah, they feel it's up to them, the girls obviously 'cause it affects them more maybe.*

(District 4, Interview 1)

In the scenario thus described, the young women are being sent in to obtain a male method, but there has been consultation. In the implant study, although respondents' partners had rarely been present during the contraceptive consultation, they may have some limited involvement in discussions about different forms of contraception. The young women, however, invariably felt they had to look after their own bodies.

### **Q: Do you find it easy to talk to your boyfriend about contraception?**

*Yes, we talk about it every day because I feel like it's easy for you [partner] to sit there and be like, oh get this or get that, because it's not you, you're not doing it, you're not coming to the clinic and people are looking inside you. So we have not arguments but we have debates about it all the time because obviously it's about my health, at the end of the day. I can't be 100% that I'm going to be with you in the future and I might have affected my fertility and then you won't be there, sort of thing. So we do talk about it a lot.*

(Reta 19)

There were thus some tensions between gender roles and responsibility within relationships, as indicated in Reta's comments, and there often appeared to be ambivalence and uncertainty in their accounts. Reta seems troubled that she has to take responsibility, whilst at the same time stressing the importance of bodily autonomy, an assessment echoed by Tasmin (21): *'I do think that it should be both people's [responsibility] but I don't think that it works out, I think it just ends up being put on the girl's situation, that's your problem. It's your body'*. Some participants described reluctance by their partner to want to use contraception and expressed concern that the responsibility for contraception was left to young women. For Daniella, her partner understood that a form of contraception was needed, but rather than be involved in the decision-making process, told her that she *'had to get something'*. Here is a clear indication that she was expected to take responsibility. In this respect Daniella felt that the implant was a good choice:

*He just didn't want to use anything [condoms] so it was up to my choice to say no or go and get some other contraception because there was other contraception available. I did try it. I didn't want to get pregnant and he didn't want me to get pregnant and he wasn't going to be responsible enough to do something about it, so I had to take the responsibility and do it. He had no control over what I was using but he said I basically had to get something. So that's what I went and did.*

(Daniella 19)

Some participants recalled not using contraception for a period of time and not becoming pregnant. They interpreted this as their own invulnerability to pregnancy, and for a while this belief affected their perceived risk of pregnancy.

*I suppose the person I was with before, we were trying for a baby and I wasn't on any contraception but it wasn't working for the whole year that I was with him, we never used contraception and I never got pregnant. So I thought it was very hard to get pregnant, but then when I had a new boyfriend I didn't really use any contraception but then I got pregnant very easy with him and then that's when I had the baby.*

(Stacey 19)

## Using condoms

The perception of the need to take personal control over contraception, generally when their male partners were reluctant to assume responsibility, was most evident with respect to condom use. For many of our participants condoms had proved a difficult method of contraception to maintain.

*He'd never really wanted to use condoms and I think that was a lot of pressure as well which I think most girls have because obviously guys don't like to use condoms but I was a firm believer in them until we got together and after a while we just stopped using them ... but he didn't ask what kind of contraception I was on or using so I don't think he was really worried or bothered.*

(Emily 18)

Shani (19) was the only participant to discuss awareness of her reproductive cycle and report that she was (in part) using natural family planning as a method of preventing pregnancy. When she thought she was at risk of becoming pregnant, Shani wanted to use condoms, but she found it difficult to negotiate this with her boyfriend, and later got the implant: *'Every time we were using condom he was just complaining that he can't feel anything! [laughs] So we have to get over it.'*

Practitioners were also aware of the frequent reluctance of the male partners in the use of condoms, and the difficulty the young women experienced in trying to negotiate condom use:

*I think there's, in relationships, with young people particularly there, there is issues around condom use and, and the difficulty of negotiating that and I think unless that is done earlier and they've [been] able to, kind of negotiated that, at a first relationship, I think it's a very difficult one to kinda take through.*

(District 1, Interview 3)

The sexual gratification of the male partner was sometimes discussed by the young women, and condoms were viewed (as in Shani's case) as a barrier to intimacy. Although condoms protect against STIs and pregnancy, avoiding pregnancy was conceptualised as the major concern and as a result the implant was seen by a few participants as one solution to the 'problem' of using condoms. It was not, however, always simply a response to their male partner's reluctance to use condoms. Neema implied that she also considered her own sexual pleasure, when saying that both she and her partner wanted to try what she describes as 'unprotected sex' (sex without condom). They had taken care to rule out the possibility of sexually transmitted infection:

*Yes, another reason why I got the implant, when I was in the relationship we wanted to try unprotected sex so before that even happened we spoke about me getting the implant and obviously he went and got himself checked, I got myself checked so that's it.*

(Neema 19)

## Sexually Transmitted Infections

It was generally recognised that the implant would not protect the user against STIs, and this limitation was discussed by some of the participants.

*When it comes to not worrying about getting pregnant, I think it's amazing but then obviously it does influence you in other ways and I don't know, makes you a bit more relaxed about the whole idea of not getting pregnant, so you're less likely to use condoms which obviously raises the worry of catching a sexually transmitted infection which is you know, not good.*

(Emily 18)

This quotation shows an understanding that the implant may only be a sensible choice of contraception when there are no concerns about contracting STIs. This study only interviewed young women who had tried the implant, so it would have been expected that the participants were more concerned about pregnancy avoidance than STI transmission. The implant was seen as a reliable method for avoiding pregnancy, and these particular young women presented this as a responsible choice if STIs were not perceived to be a risk for them at that particular point in time, generally because they were in a long-term relationship. Protection against STIs was thus viewed as an additional – often irrelevant – consideration. This was when they thought there was no STI risk, sometimes because they had both been tested.

This was not the case for all the participants. A small number appeared to have a reactive approach to managing risks they identified with their sexual behaviour. This meant, getting screened for STIs rather than use a condom; and waiting for their period or having a pregnancy test if they had had unprotected sexual intercourse. Naomi, for example was the only participant who talked about sexual relationships with different partners, and she was worried about contracting STIs. She tried to manage this risk, however, after sex since she preferred sex without using a condom, and this is something she could do while using the implant. She states that sex is *'always better'* without condoms but also says *'I'm scared that that I might catch something'*. Referring to her partners, she makes it clear that they assumed that she was taking responsibility for contraception and that the implant also suited them:

*'Coz they're like make sure you go to clinic to get checked ... Coz they're not ready for babies innit, I'm like, "I got the implant in", and they're like "alright then".'*

(Naomi 16)

With some of her partners, Naomi went to be checked for STIs after sex without a condom, but for others she assumed that if she had been checked and cleared once with that particular partner she did not need to use a condom on other occasions, or to be checked for STIs again.

For many young women, weighing up the risk of pregnancy and the risk of contracting an STI is a complex process. With the participants in this study, the desire to avoid pregnancy overrode any concerns they might have about contracting an STI. A few were concerned that this could leave them vulnerable:



*You know they always say you shouldn't always trust what someone says because you know how guys always say, oh yes I've got checked, this that, this that, but really and truly they haven't, they just lie to you to get you in bed, which is bad.*

(Neema 19)

This potential risk was also recognised by practitioners, with some concern being expressed about the messages that implant use might convey about sexual availability:

*As soon as the girl, they know that she, she's got the implant, then they can't be bothered to use the condoms kind of. So what sort of message are we putting across to the young men?*

(District 1, Interview 2)

There was thus a level of consensus in this study that young women were obliged to take responsibility to protect themselves against pregnancy and STIs. Young men were often perceived as problematic participants in these interactions.

## Institutional sources of information: the contraceptive consultation

The data in this study indicate that the main formal source of information about the implant came from the participants' interactions with sexual health practitioners, and this was often at the consultation at which they also had the implant fitted. This was the setting in which they finally processed the external influences, and pinned down their choice. As noted earlier, they had arrived at the clinic with different levels of awareness and knowledge about the implant. Many of the participants had turned to the implant because other methods had not worked for them.

Those who had prepared themselves for the consultation by doing some additional research to supplement the knowledge they had acquired informally, often used the internet.

*Yes. Before I do anything I always like to check up on it, just to make sure that to be 100% sure that to know what I'm going into and if any risks I'm taking, it's all going to be down to me. So I think the internet is really useful for stuff like that. I did go and talk to my doctor about it, I talked to a friend who had it and my mum who also had it but I think the internet was definitely the best research that I did get.*

(Fatima 17)

Fatima drew on these sources and, in common with many of the young women, spoke about receiving little guidance at school. The young women noted that they had learnt about a limited number of contraceptive methods at school: these were generally just condoms and the contraceptive pill. Fatima had been well-prepared for the consultation, having also discussed the implant with her friends and her mother, before making up her own mind (against the advice of her mother) to have the implant fitted.

The quality of the contraceptive consultation was important for all participants, but clearly especially important for those who were undecided, or had not thought about their future contraception. Whilst many were satisfied with the information that they had received, some of the participants had difficulty recalling what they had been told at their consultation, and others felt they had not been fully informed about the possible side effects. Their retrospective concern about the quality and completeness of the information often centred upon side effects other than disrupted bleeding patterns. The participants often acknowledged that they had received information about how the implant might affect their bleeding patterns, and also, sometimes about other side effects. In most cases, however, the only possible side effect that they recalled being advised about at the consultation was how the implant might change their bleeding patterns.

*She said it can stop your period or slow it down and I thought yes, slow it down, that's fine, even if it was a lighter ... because I got heavy periods anyway so if it was a lighter period I would have been happy with that, that's why I said yes, I'll take that because it either slows it down or it stops it full stop and I thought yes, I hopes it stops it.*

(Janey 18)

Janey is here voicing a common sentiment. She was focusing on what she sees as positive possibilities associated with the implant and had hoped that the implant might stop her bleeding altogether, or at least lead to a 'lighter period'. Indeed, this was one of the reasons she had selected the implant. Many of the participants made it clear that when they had been told that their bleeding might be heavier they had approached this information with a hopeful attitude of 'it won't happen to me'.

Whilst most participants did recall being aware that their bleeding pattern might change, there appeared to be much more uncertainty, and lack of knowledge, about other possible side effects.

Overall, there were mixed experiences of the contraceptive consultation at the time of implant insertion in terms of what they were told, but also what they could remember being told. The method by which information was communicated was also important. Most interviewees recalled that they had been given a leaflet to refer to, or that the practitioner had read from a leaflet. In a small number of cases, participants recalled being unhappy about what they viewed as an over-reliance on written information in the consultation. This could be particularly problematic with young women, like Jo (20), who struggled with the written word: 'She gave me a leaflet, I'm dyslexic so I need someone to talk to me in person and be honest with me.'

Many of the practitioners appeared to rely heavily on printed information. Some talked about giving their clients the leaflet to take away with them because they might not be able to retain all the verbal information of a consultation, but others seemed to rely upon the leaflet in the consultation itself:

*I give the leaflet which is, have you seen that yellow leaflet, yeah? 'Choice of Contraception' leaflet [...] I give them, I give it to them and give a minute<sup>5</sup> for them to go through then I'll ask, and then make them lead which one they want to ask about.*

(District 3, Interview 1)

<sup>5</sup> We have seen the leaflet and feel that it is not possible to read it within a few minutes.

Although it is important to acknowledge that the young women's recollections of the consultation may be imperfect, several were able to point to specific examples where they felt they had been misinformed. Some participants recounted that they had explicitly asked about the possibility of particular side effects that they had heard about, and recalled being assured that these were not associated with the implant:

*Then I said I had heard that it can cause weight gain, she said no it doesn't cause weight gain, that's never been a side effect of the implant.*

(Fatima 17)

Fatima was one of the few participants who had the implant removed because of weight gain. Jo was concerned about how the implant might affect her emotionally:

*I said, will it change my mood swings because I suffered with depression in the past you see, when I was on the pill and stuff like that, so I don't really want a lot of stuff in my body that's going to affect me. She said no, she said there is no record of anyone having mood swings.*

(Jo 20)

The accounts of participants, such as Jo, who felt they had been misinformed indicate how important it is to communicate honest, open information and try to stress the possible realities of having such a method of contraception. It is likely that Jo would have benefitted from a longer, more thorough, discussion at the time of her contraceptive consultation.

The mental preparation of the young woman for accepting the implant was also discussed in the interviews with practitioners, as was the view that the young woman would need to persevere with the implant for a certain amount of time in order for her body to 'accept' it:

*I think we need to study individuals before putting in implants. If they're not prepared mentally then they will have some pain so just come a week later, 2 weeks later, to take it out. I think careful counselling is very much necessary for the side effects of implant and also telling them, we can't say no to them anyway ok, for implant removal and that, but we need to encourage them to keep an implant for at least 6 months I say for the body to accept it.*

(District 3, Interview 1)

This practitioner is expressing the difficulty of the entire consultation process, talking about the need to inform participants about the possible side effects of the implant, and thus preparing them for any eventuality, then also trying to encourage them to persevere with the method for at least six months, whilst simultaneously acknowledging their right to have the implant removed at any time if that is what they wish. The practitioners interviewed for this study had differing approaches to the contraceptive 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 these young women's retrospective 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. What was of concern to many practitioners, however, was the feeling that they were being overly influenced by LARC targets rather than responding to women's needs. Some encouraged the consultation to be led entirely by the young woman herself and thought practitioners should respond to their client's needs and preferences rather than being too prescriptive, or driven by 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 I think, you know 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)

This tailoring of the advice to understandings of individual needs is the approach that seems to correspond most closely to the preferences of the young women.

## The final decision: individual choices

This section analyses the main reasons given by the participants for selecting the implant. In making their decision they have taken into consideration the various influences already discussed; weighed up the pros and cons of different methods and decided in favour of the implant. Of particular importance was their individual previous experience of different types of contraception.

*I decided to get it because I did keep forgetting to take the pill some days and at the end of every month it would be that panic, of my god, am I going to get my period, am I not*

(Fatima, 17).

*I got it because I was kind of scared I was gonna get pregnant 'cause what happened was we were using, every time we used condoms my man was just telling me to take it off*

(Shani 19)

Personal views on the advantages and disadvantages of different methods of contraception were influenced by a range of factors, and participants were quite autonomous in their decision making, expressing a preference for being presented with a range of options from which they could make their choice. Overall there was a high level of autonomy in their choice of contraception. The only exception to this was perhaps when the implant was administered post-abortion at an abortion clinic. This was the case for two of the twenty study participants:

*I guess when I was ... the whole contraception thing, because at first I didn't always have an implant, my first was using condoms with my previous partner and then everyone was like, get the implant, get the implant, because it's safe and blah, blah, blah, and I didn't get it, and I got pregnant and then yes, he was just not the way I thought he should have behaved so I had an abortion, and then after that I was like, I never want to go through that sort of experience again, so at the clinic they were like, you have to get some form of contraception today, so I was like all right, put the implant in.*

(Reta, 19)

There were a number of specific factors which influenced contraceptive choice among our sample. As expected, the main reason the implant was selected was the desire to avoid pregnancy. Reliability and ease of use were paramount. The young women in our study were aware of the efficacy of the implant for preventing pregnancy: *'it's 99.9% effective isn't it, that's what I heard so that was just, it was just a relief to know that I'd be protected in that way'.* (Emily 18)

Another perceived advantage was the benefit of having a method which they did not need to remember to use – *'I didn't have to remember oh yes my implant, my implant, it was just there'* (Fatima, 17) – and did not need to return to the clinic on a regular basis for a new supply. This was particularly important for participants who lived busy lives or worked long hours. By selecting the implant the young women avoided the need to return to the service on a regular basis: *'I thought if I just get the implant then I don't have to keep coming back to, you know, getting the pill every 3 months and that'.* (Shelley 17)

A number of participants had previously experienced difficulties with the implant, but having tried other methods they then felt that the positives might outweigh the negatives. They then returned to the implant after trying other methods, even though they had not been wholly satisfied with the method the first time.

*[I] got the implant taken out because it wasn't working right for me, because of the hormones which is why I had it taken out, which is why the coil was suggested because it didn't have extra hormones and stuff so they said try that, so I just tried it but had problems with that. So went back to the implant because I never had problems as such with it, it was just the added hormones that made me upset all the time, but I would rather be crying every day than pregnant, that's why I went back onto [the implant].*

(Daniella 19)

In addition to pregnancy avoidance, choice is complicated by a number of secondary factors. Some participants wished to control, or limit heavy menstrual periods with one participant, Zahra (16) selecting the method for this reason alone since she was not yet sexually active. Zahra and Tasmin spoke about trying the implant to control their periods, after having experienced difficulties with the pill and forgetting to take it. Tasmin (21) had tried a range of methods.

*When I first started I was 16 and I went on pill [...] and that was fine but I just kept forgetting to take it so then I went on to the injection and that was fine, and then I went back onto the pill and it made me fall pregnant so then I went back on the imp ... no, then I went on to the injection again and it made me go on my period for six months and then I decided to go on the implant.*

(Tasmin 21)

Some young women's views on abortion meant that they were especially concerned to use what they understood was a reliable form of contraception. Reta conceptualised the use of contraception as a way of avoiding a second sin:

*I do go to church and I'm very, very into it. I think that was contradicted when I had an abortion because it's against my religion ... Most religions you shouldn't be having sex before marriage anyway, if you are you're better off using contraception so you're not committing two sins rather than one, as bad as that sounds. I think it would be better to use contraception if you could avoid having an abortion*

(Reta 19)

Such moral beliefs influenced choices of contraception, pushing young women towards what was viewed as a highly reliable contraceptive method.

## Conclusion

The decision making process can be seen more as a matrix of influencing factors with the young woman at the centre. Although she ultimately has the last say, the experiences of others, and information gained from other informal sources, friends and relationships, as well as past experience with different methods are all highly influential in her choice of contraception. Many of the young women in this study had made a positive decision to 'give it a go', often after struggling with other forms of contraception. That struggle, however, means that the decision could also be interpreted as being pushed forward by negative experiences or attitudes towards other methods, rather than solely by what were viewed as the positive attributes of the implant. Often the final decision did involve weighing up the possible pros and cons of the method in comparison to other forms of contraception. The next chapter considers what may cause that balance to shift in favour of implant removal.

# Chapter Four: Experiences of the implant; and reasons for removal

## Introduction

Chapter three has shown how the young women mainly made a considered choice in favour of the implant. And yet within one year (apart from a few exceptions) they had requested a removal. The reasons given for removal were overwhelmingly because of what were perceived as side effects of the implant, and the most common of these, as in other studies, was bleeding irregularities. Other (non side-effect) reasons were more about individual circumstances, in particular relationship changes. It is worth noting that generally more than one reason for removal was given; sometimes this was more than one side effect; or it could be a combination of side effect(s) with other factors. For example, a young woman might put up with side effects that she was not particularly happy about, but then have the implant removed when her relationship ended.

We will consider the side effects to the implant, and then go on to look at other reasons given for removal. We will then show how for many of the participants it was a combination of factors, contributing towards a 'tipping point', which caused them to ask for their implant to be removed. These included overarching concerns around bodily control. The final section of the chapter continues their implant journey through requesting removal, interpreting and understanding their experiences, and post-implant contraception. It ends by suggesting possible relationships between young women's implant experiences and future contraceptive choices.

## side effects

### Bleeding

Although what was perceived as excessive bleeding was the most commonly stated reason for removal, there are several issues worth highlighting. First, the young women had not been prepared for the actuality of prolonged bleeding, or irregular bleeding patterns, even when they could recall being informed of the possibility at their consultation. Second, they often maintained that they had really tried hard to wait, hoping the bleeding would 'settle', so that many of them had tolerated a significant amount of discomfort and inconvenience before deciding they wanted the implant removed on account of their bleeding. Third, some young women who experienced prolonged bleeding did not necessarily describe this as the main reason for removing the implant, but it was combined with other reasons, including non side-effect reasons.

With respect to excessive bleeding, different examples were given by the young women, with several complaining of 'non-stop bleeding' from time periods ranging from one to three months. Sometimes the bleeding was accompanied by severe stomach pains. What seemed to be particularly difficult for many participants to tolerate was the unpredictability of their bleeding, for example having no bleeding for 6 months but then bleeding constantly for 3 months. Such experiences became intolerable for many.

*I can't handle the periods, it was constant, constant just ... and you'd have a two day break and then it would come back on for two months and then you'd have like a week break and then it would come back on for a month and it was just a joke. So that's why I wanted to change it.*

(Janey 18)

Practitioners all spoke about bleeding being one of the main and most commonly experienced side effects of the implant. It was seen as very important that this was communicated to and understood by the young woman at the time of their consultation. Their inability to predict how the implant will affect an individual was one of their frustrations with the product, with many feeling that it was difficult to counsel about something which was so unpredictable:

*The big letdown, which is a real letdown, is the problems with the bleeding because we can't ... because it's so unpredictable and so varied and there is no way ... I can't predict who is going to get what.*

(District 2, Interview 2)

Accounting for the likely negative effect of bleeding on a young woman's relationship with her boyfriend and her body was also understood:

*Some people they just are fed up with the bleeding pattern. The bleeding pattern, that's the one I completely understand because it can be so persistent so much that it affects your sex life and your quality of life and because the bleeding is not like fresh bleeding, it's like old stale blood, it's like you smell all the time. Even if you have had a bath you don't feel fresh, you still feel that gross smell, and it makes you feel low. You know that feeling when you are on your period, if you are having it 20 days in a month it's not the best and if you're like...you don't feel that good about yourself to be around your partner because you feel...you get paranoid that you're smelling and you're not that desirable because of that. If they can solve that then it will be a fantastic method.*

(District 1, Interview 2)

As noted in the previous section, the young women had often been briefed about the possibility of prolonged bleeding at their contraceptive consultation. It seems, however, that they were unprepared for the reality of this and were also inclined to hope that it would not happen to them.

*I thought it won't happen to me. I thought it would be only for a little bit, I didn't think it would be for four months, you know, it's quite a while for bleeding. I just underestimated what she was saying basically, because I will admit she did tell me, she did but I just thought it won't happen to me.*

(Aysa 17)

Several of the participants spoke of being anaemic and their fears that losing the blood made their anaemia worse.

*I just constantly bled for three months straight, I didn't have a days break and that really wore me down, I was constantly tired, the doctors diagnosed me with anaemia so it got to the point it was time to take it out.*

(Ella 22)

*I got more lazy because I'm anaemic already. So the loss of blood was just crazy. No, it's the fact that like I keep bleeding like every day like, for like a month... and its all about necessary like. If I'm like, if I'm not on my period like, there's no point of me bleeding, so I just think, I don't know.*

(Kia 16)

Kia was the only participant who interpreted her continued bleeding as unnecessary, thus indicating an understanding of the menstrual cycle and an acknowledgement that if she used hormonal contraception to control her fertility, she could also avoid a bleed. Indeed, she was keen for this to happen and frustrated when her bleeding continued. There was, though, some anxiety about not bleeding at all amongst other young women. Jo (20) was asked about how she felt when the bleeding stopped completely:

*A bit awful because you're a woman, that's what you're used to and it's quite scary to tell you the truth ... you think where does that blood go or what's happening to your body because it's unnatural, so is it going to mess up having a baby in the future, what's it going to do to you. So it is quite scary, really scary*

Jo (20)

Jo has articulated a number of reasons why she is anxious about not bleeding, and what is happening to her body. She thinks that something is wrong if you do not have a bleed. She also expresses expectations about what it means to be a woman, and worries that the physical changes associated with the implant will upset those expectations – 'is it going to mess up having a baby in the future'.

Apart from their obvious dislike of extensive bleeding, there were a number of additional reasons why their changed bleeding patterns became intolerable for the young women. We asked them what it was about the bleeding that they found difficult to tolerate. Primarily, it was the effect that the bleeding had on their everyday lives that was important. Constant bleeding was exhausting, and was also bad for sexual relationships. They also found it expensive because of the need to buy sanitary supplies. The following quote combines these two themes.

*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, every-day problems.*

(Janey 18)

There was also potential embarrassment when they were not able to predict their bleeding patterns.

*... 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)

Here Grace is expressing a sense of an embarrassing body, a body that is unpredictable, that is leaking, and that she is not able to control. Other participants mentioned being embarrassed about their bleeding. This sense of loss of bodily control (to be discussed in more detail later) was particularly acute with respect to bleeding, but also came into play in the young women's descriptions of other side effects.

## Headaches

Headaches were attributed to the implant, usually in combination with other side effects.

*I had migraines, I'd be sleeping all the time. The headaches were crazy. I could wake up in the night and my head would be banging. I just felt tired all the time. I think it made me lazy as well, probably because I was putting on weight. I've got quite a silly temperament anyway but it made me ... the mood swings. I think the only reason I can blame it on the implant is because I wasn't like that prior to getting the implant. As soon as I got the implant it was like, downhill slope from there. So yes, the headaches and the mood swings.*

(Reta 19)

There were a number of other examples given of this particular side effect including Jo (20) who recalled being hospitalised because of the severity of her headaches. She said that the hospital thought she might have had 'a bleed' on her brain, and then did a lumbar puncture and a brain scan before putting her headaches down to stress. She was certain that the implant had caused these headaches. Lucy (17) reported suffering from migraines since she was about 9; and these came back when she had the implant. Lucy remembered being given Cerazette (a hormonal pill) to control her bleeding, and she thought this had caused her headaches<sup>6</sup>.

<sup>6</sup> Cerazette is the same medicine in pill form that the implant is in a rod. It is sometimes used before an implant in order to see how women would respond to that particular medicine, and it would not help at all with bleeding problems associated with the implant. It is possible that Lucy may not have recalled the medicine that she had been given accurately.

## Mood swings/depression

In this study, several young women talked about experiencing mood swings. They said they often felt confused, surprised, did not understand what was happening to them, and were sometimes scared about how they were feeling and what they were doing. The distress that this caused them sometimes appeared to be related to the question of control. Crying, for example, might be unexpected, and was something they were unable to manage. Whilst some practitioners acknowledged mood swings as a possible side effect, others were rather sceptical about whether emotional turmoil could be attributed to the implant.

*It seems like anything that happens, if you're a woman in this age group, you blame it on the contraception. We get women coming and saying 'oh, I almost killed my boyfriend and I have never been like this. I think it's the implant, it's the side effect. It's made my mood so bad, take it out'. You don't know how far...obviously there are mood swings when you read it on here so you are thinking mmm, does it make it bad really and you get women coming in, in tears, crying and saying, 'this thing is making me so emotional and so moody and I'm so tearful, it's really affected my mood, please take it out' ... anyway I don't know how far true that is but you get those kind of things.*

(District 1 Interview 2)

The young women themselves 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.

*I was in a crap relationship anyway which wasn't helping but I would just cry over anything, I'd talk to my friends and they were like, what have you turned into, you're crying all the time, and 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)

Reta (19) had an implant fitted at the time of her abortion, and she found it especially difficult to understand what was happening to her emotions. As noted above, she had also experienced migraines, and had been putting on weight. In common with many of the participants Reta had described herself as emotional – 'I've got a silly temperament anyway' – and prone to mood swings. Many of the young women described themselves as being aware that they might be emotional, regardless of the implant, during their teenage years, and this was one of the reasons why some of them were uncertain about whether the implant was responsible for their mood swings. However, in the main, their perception was that the implant either caused or exacerbated such feelings. Shelley (17) for example, told us that she locked herself in her room for days, and maintained, 'That's never happened before. I was actually quite frightened'. Jata (17) told us that she had self-harmed and she attributed this behaviour to the implant. Some, such as Daniella (19) concluded that it was not necessarily a

good contraception for women in their situation: 'I wouldn't advise the implant to anybody who was quite emotional and depressed in the first place'.

## Weight gain

Weight gain was often experienced in combination with other side effects, and in these circumstances appears not to have been the main reason for removal. With some of the participants, there was a sense of anger and annoyance, but this did not necessarily lead – by itself – to removal. This may have been self-presentation in the interviews, and weight gain may not be viewed as a 'good' reason for removal. Two participants (Tasmin 21 and Neema 19) gave weight gain as the main reason for removal, with Neema stating that she had gone from 8 stone to 10 1/2 stone in a year and attributing this to the implant. With other participants who talked about weight gain it was often difficult to judge how significant this perceived side effect had been in their decision to have the implant removed. Weight gain was sometimes referred to as the 'only' bad thing about the implant by those who said they had wanted it removed for non side effect reasons; others commented about their 'lucky friends' whose only side effect was weight gain.

Weight gain was often combined with mood swings and again the young women expressed concern about their difficulty in understanding bodily changes. Many noted that the implant made them hungry all the time, and some associated the weight gain with bleeding all the time 'on your period you just want to eat chocolate'. There were different levels of understandings and interpretations of what was happening to them. Neema (19) talks about her own reaction, but also interestingly connects this to a wider group, referring to 'everyone' on a number of occasions.

*The only downside to it is because it's changed my hormones, it's changed my appetite as well so I've in the last year put on weight, so that's the only down for it.. [and later] Everyone keeps complaining or most people keep complaining about putting on weight, that's the only bad thing about it, yes. That's it really, just putting on weight, everyone is a bit angry about that.*

(Neema 19)

There was some scepticism about these claims from some of the practitioners:

*They automatically put it down to their contraception or even the ones who gain weight as well, they always blame it on the contraception and say 'oh since I've had this implant, because I'm not bleeding or nothing is happening I've gained 3 stone' or whatever but actually even if they didn't have it they might just be overweight maybe.*

(District 1, Interview 2)

## Acne

Acne was a minority experience in our sample. It was sometimes mentioned as an additional reason why participants were not happy with the implant, but the main reason for removal was likely to be something else.

Emily (18) gave bleeding as a reason for removal, but skin problems that she associated with the implant were also clearly important. She had been given medication to try to control her acne. This had not seemed to work and in the end she just wanted the implant removed. She was very clear that she had not been prepared to put up with the skin problems if she thought that removal would deal with the issue.

*I've gone back three times to get different types of tablets and they haven't worked so that's why I was so annoyed and so, I was just was so impatient and I just thought I'm having it taken out and I've had enough of this and obviously how it goes and now I've been on that pill for two months and it's still the same. It's not as bad but it is still the same.*

(Emily 18)

### Discomfort

Two young women (Ella 22 and Katie 22) were interviewed on the same day and both had implants close to the surface and said that if they knocked their arms then it was really painful – this was the main reason for removal. They thought it was an excellent method of contraception but just too painful.

### Non side-effect factors: Relationships

The extent to which relationship changes influenced implant removal varied. Some said that their relationship ending made no difference to them having the implant removed, that they had it removed because of the side effects which simply coincided with the relationship breakup. With others the data suggest that they tolerated the side effects whilst they were in a relationship, but when it ended they saw no reason to persevere with the method. It is also worth recalling that one of the reasons given for selecting the implant was their relationship status: they were generally in what were understood to be steady relationships, wished for a reliable contraception and were not especially concerned about STI prevention. As also seen in the previous chapter, more often than not the young women saw contraception as their responsibility. Some would only consider a contraceptive like the implant when they were in a relationship, and interpreted removal as a sign of sexual responsibility. Such reasoning behind the removal echoes some of the drivers towards having the implant in the first instance.

*and when I do decide to get er, contraception, I'm getting the implant again but I took it out because I wasn't with my boyfriend so if, if I had had the implant at this point, I would probably would have had sex by now with somebody ... Yeah, I can't, I can't have sex unless I have contraception so, but I know that if I did have it, then I probably would be a bit wild, a bit more wild so ...*

(Grace 19)

Grace, who had found it difficult to tolerate irregular bleeding, states here that she had the implant removed because her relationship broke up; but note her reference to the possibility of being a 'bit more wild'. We interpret this as meaning that she did not want to see herself as sexually available when she was not in a relationship, and a worry that having contraception in place

might facilitate spontaneous sexual activity, a scenario that she wanted to avoid.

Retrospective reflections on why the implant had not worked for them thus prompted some young women to think about their sexual relationships. Associated with relationships, and bodily control, is the concept of responsibility and also personal autonomy. In their explanations, the young women are drawing connections between using a form of long term contraception, such as the implant, and sexual availability. Several presented implant removal as the responsible course of action if their relationship had ended. They expressed the view that if you are not in a steady relationship but you keep the implant, this can make you more likely to have sex spontaneously, and this was viewed as a sign of sexual irresponsibility.

*I got to a point, because I was with my boyfriend for five years and we ended up splitting up and I thought I'm not bothered with that, I want to concentrate on college, which is what I've done, just concentrated on college. It's a choice I've made for myself so I can concentrate on myself instead of having to think about boys. If I haven't got any implant, if I haven't got any contraception then I know myself that that's going to stop me from doing other stuff. So that's why I did it really.*

(Daniella 19)

There was one case that was quite different. Shani had had her implant removed at her boyfriend's request when he went abroad for a while. Here the driver was her boyfriend's anxiety about her possible sexual behaviour, and he is attempting to control this through re-establishing the connection between non-use of contraception and risk of pregnancy. Here there is an explicit assumption that a fear of becoming pregnant is going to deter Shani from sexual activity with someone else when he is away. In an earlier section, we have shown that one of the reasons why Shani had selected the implant was because her boyfriend had been reluctant to use a condom.

Practitioner encouragement for young women to keep the implant after the end of a relationship was noted in this study: 'sometimes you worry because they're coming in to take the implant out, oh I've just broken up with my boyfriend, so it's an impulse ... And you're thinking, but no don't you want to date again' (District 1, Interview 2); but this was clearly at odds with how the young women viewed their sexual relationships. Whereas practitioners were concerned that not having long-acting contraception in place paves the way to non-use of contraception and risk of unintended pregnancy, the young women themselves interpret this quite differently. They viewed removal of long-acting contraception as an aide to controlling their sexual behaviour, and taking responsibility for their bodies. The starting point is similar in that both are anticipating (and possibly worrying about) the possibility of unanticipated sexual intercourse, being a 'bit wild' as Grace puts it, but there are very different responses to that possibility and very different understandings of what constitutes responsible contraceptive behaviour.



## Multiple reasons for removal and reaching a ‘tipping point’

As noted in the discussion of different reasons for removal, it was not uncommon for the young women to identify two or more side effects; and these might be combined with a relationship change. In fact, it was unusual for only one reason to be mentioned. Analysing cases with multiple reasons for removal is interesting because they indicate young women's tolerance of side effects until a ‘tipping point’ can emerge. What is also of interest is how these processes were perceived as individualised: the young women expressed feelings of being quite alone whilst trying to understand and cope with their bodily changes. What is also evident is that they sought to understand their need for removal in terms of reasserting bodily autonomy.

Sometimes it was not the bleeding itself that prompted removal, but what they viewed as other problems caused by the bleeding. These may have been the difficulties of everyday life; or the perception that secondary side effects were being caused by excessive bleeding.

*I was always on my period, there was not one day I was not on my period so that is June to August, that's about two months of being on my period. I'm anaemic so that just made my anaemia even worse. What else. There was no pain, which I found interesting, it was just blood just coming out, which is interesting. I was a bit moody as well, I was really moody and I gained weight. Not a lot, and I got a lot of acne, so I just said it's better for me to just take it out, and me and my partner discuss and realised it was just best to take it out because it wasn't good for me.*

(Aysa 17)

With Aysa, we have an example of connecting the bleeding with anaemia, but not with the other side effects that she also mentions. Here is a long list of seemingly unconnected side effects, including references to acne, weight gain and ‘being moody’. She tolerated these for three to four months before deciding, in consultation with her boyfriend, that ‘it wasn't good for me’. Others associated their mood swings with having a ‘period’ all the time.

The combination of reasons for removal may be complex and difficult even for the participant to understand. Shani, for example, who had the implant removed at the request of her partner when he went abroad (mentioned earlier) also said she had been unhappy about gaining weight. She seems to switch during the course of the interview to presenting weight gain as the main reason for removal.

Some practitioners interpreted young women's reporting of a number of concurrent side effects as evidence of how they might ‘blame everything’ on their contraception when there may be other factors at play.

*This one lady kind of just blamed everything on the implant, you know, and I kind of did say to her, ‘it seems your implant, get, is kind of getting blamed for lots of things’, ‘cos she kind of just was reeling off, you know, ‘oh I can't, I don't’, something random and I was like ‘it's probably not the implant that's doing that, you know’.*

(District 1, Interview 3)

### Feeling alone

Although there is some evidence of friends influencing the decision in favour of removal, it does not match that observed for the decision to have the implant. This may be because the decision to have the implant removed is centred on the effects on their own person. The processes around removal thereby appear to be much more individualised, and some of the young women talked about feeling very alone in trying to deal with their side effects.

*People shouldn't be alone and feel like they're going mad themselves because my friends were literally were saying, even my partner, you're crazy, you're literally mad, and it's not nice to hear that because you have to question yourself, are you mad, but it's your hormones and your mood swings and stuff like that, so it's not nice so other people should understand and realise they're not by themselves if they're going through the same thing.*

(Jo 20)

The above narrative from Jo describes a sense of aloneness whilst trying to deal with the side effects of the implant. She was not being supported by her friends, her partner or the sexual health services. The peer support that young women may have experienced when selecting the implant is thus no longer straightforward, and peers may even exacerbate anxieties if the experience of the method is not the same for all members of the group:

*Friends can have an impact on, on what a person's choice is, providing it is the right choice for them and that they are happy with it, but if a person, one person has something and then they come back and say ‘Well I've had the same as this person and she's OK and I'm not and why and what's wrong?’, you know, they become stressed out with all those sort of things then, so, you know, it can be difficult.*

(District 3, Interview 2)

If we connect this to their feelings of being out of control then we have individuals attempting to understand what is happening to their body by themselves. During the first few months the young women were struggling to come to terms with changes they attributed to the implant, and were tolerating side effects they were hoping would be temporary. They were not generally in contact with sexual health services during this time.

From the interviews with practitioners, it seems that returning to the clinic during this period was often not encouraged, and advice given was centred on a limited number (often bleeding irregularities alone) of side effects that would (hopefully) ‘settle down’.

*[we] encourage them to give it time, to give it a chance at least up to 6 months and see what happens because if they have the bleeding maybe for a month it's not a true reflection of what might be happening – 6 months down the line.*

(District 1, Interview 2)

Such advice is in line with previous research findings that increased incidence of bleeding irregularities and other side effects were associated with the first six months and might therefore be expected (Blumenthal *et al* 2008). However, this is not a reason for women to stay away from the clinics during that time.

Jo had said she felt alone, and from her account below we can see how a combination of different side effects ultimately culminates in removal, at which point she reports resolution and relief.

*I had really bad mood swings, I had depression with it, I was really angry a lot of the time, I'd switch out completely over stupid little things, really unnecessary, really short attention span, I got really bad spots, I had really bad headaches, didn't have a period at all and as soon as I had it out it was a relief, all of that has gone away, I'm not stressed out, I'm more chilled, I'm calm and it's amazing what something small can do to your body and how effective it really is because you think it's all in your head but everybody around me, my friends, family, they all see a big difference in me.*

(Jo 20)

Many of the practitioners recognised that once a 'tipping point' such as this had been reached, women were unlikely to change their minds:

*The majority of the reasons why people want it removed is because of the kind of irregular bleeding and they may have bled now for six weeks, they're really fed up so then trying to convince somebody, 'keep it in and I'll give you something on top of it and it'll settle' ... sometimes it's very difficult to maybe convince them to go down that route.*

(District 1, Interview 3)

Beyond the immediate reasons for removal – primarily the side effects that became intolerable – when the young women reflected on their experiences, some underlying concerns about the method could be discerned. Participants' experiences led them not only to reconsider their method of contraception, but had also contributed towards their understandings of broader issues, in particular bodily control.

### Bodily control

Retrospective reflections on why the implant had not worked for them prompted the young women to think about their own bodies. Although, as seen, there were mixed views on the implant as a method of contraception, mostly they were not especially negative. Over all, the implant was seen as a good method, and the young women in our study saw its value as a method of contraception. One of the ways in which they accounted for their decision to have the implant removed, that

fitted with their generally positive choice to try the implant, was that the method was a good method, but – unfortunately – had not suited them. A clear theme evident in the young women's evaluation of their experiences with the implant was 'it didn't work for "me" and "my" body'. In other words, their difficulties are phrased almost as a failure of their bodies to accept the implant, rather than any limitations with the product itself.

*In theory I feel it's one of the best ones because obviously it's there three years, there is no having to go there every couple of months, take a pill every day and things like that but at the same time my body doesn't agree with that so that's not something I can do for now.*

(Ella 22)

Ella is voicing a recurrent theme, in reflecting that her body 'doesn't agree with' the implant. The young women often talked about friends for whom the implant had been fine and commented that 'everyone is different'. Individual exceptionalism was thus a strong theme which was mainly expressed by the young women voicing the sentiment (often quite despondently) that 'it's a great contraception, but not for me'.

*Yes. I did get really bad ... one of my friends has it, the only side effect she's got is weight gain. Her periods are two days long and then she's fine for ... so it does work, it's really different for a lot of people. Some people don't get any effects at all, some people get a few, some people like me get all of them at once.*

(Fatima 17)

Some practitioners spoke of trying to help young women understand that it was difficult to predict how the implant might affect them as an individual.

*You're then discussing the advantages and disadvantages and possible side effects of the implant it's important to say that it's very individual so even though your friend's got on really well with it... won't necessarily mean or if your friend's had lots of trouble with it, it won't, you know, you may be absolutely fine.*

(District 1, Interview 3)

Such internalisation and individualisation of these experiences was also discernible in young women's concerns about individual bodily control. As noted in the earlier discussion on side effects, there was a strong theme of their bodies being invaded, out of their control and embarrassing. These themes are running through their explanations on why they wanted the implant removed, as illustrated by Daniella (19): '*I don't want to be in control of anybody else but my own body, I'd like to be able to be sort of in control*'.

Many said they would recommend the implant for older women whom they thought of as more responsible and, crucially, better able to understand their own bodies. This indicated a sense of self-understanding with the notion of not being ready for this type of contraception. It drew on their experiences, discussed earlier, of losing control and not understanding why.

*People who would benefit from the implant are people who are grown-ups, like they know what their body is like because when you're a child or when you're a teenager you have all the mood swings anyway so you're not sure what it's causing and I think that's what the clinic thought, they thought that other things were affecting me and they thought that I was just blaming it on the implant without knowing.*

(Jata 17)

Jata is voicing a sense of confusion here about what happened to her when she had the implant that we have noted for several of the participants. There is also a strong sense in this quote that contraception has to be right for any particular person, at any particular point in time. This was a reflection of the individualism of the way in which they understood the side effects, and can also be connected to their understandings of bodily control. Jata is perhaps expressing the need to have a greater understanding of her body for this type of contraception.

## 'I'm glad I tried it': Removal and after

This study has shown how young women tolerated side effects, which were distressing to them, for varying lengths of time before requesting a removal. In the interviews, they discussed their own reluctance to have the implant removed, and they also talked about the resistance to removal they experienced from practitioners. With respect to their own reluctance, apart from their desire for the implant to work for them because they saw it as a good form of contraceptive, many of them appeared to have accepted two messages from their interactions with sexual health practitioners. These were that the implant is expensive and should not be removed 'lightly'; and, secondly, that they should expect it to take a while for their bodies to 'get used to' the implant. Both of these understandings served to encourage them to tolerate the side effects but also to make some of them feel guilty about having the implant removed, and feel somehow that their body had failed them.

### Requesting removal

The young women felt that their desire to have the implant removed at their request (when they had reached their own 'tipping point') often conflicted with practitioners' advice that they should persevere with the implant for varying lengths of time. Six months to one year were the time periods most commonly cited by the young women.

Many of the practitioners we interviewed were quite keen to justify resisting 'early' removal. This was articulated as being for economic reasons and also to give the young women's bodies time to adjust to the implant (as discussed above).

*I also say to them about, we want to keep the method for at least one year and it's quite important to talk to them about if they er, if their relationship finishes, that we do expect them to sort of carry on with the method, you know, for possible new relationships ... 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)

*We would counsel to say wait four to six months but the truth is there is actually no proper definition of how long the unpredictable bleeding pattern is going to continue, we just don't know. We just don't know.*

(District 2, Interview 2)

Some of the young women in this study talked about feeling that they could not return to the clinic, and being told at the outset that the implant was expensive.

*Really upset because I thought that this place would be really on your side and want to help you. I understand the implants are expensive, £100 or something, but if somebody wants it out then they should be able to get it out.*

(Jata 17)

Many of the young women reported experiencing practitioner resistance when requesting to have their implant removed:

*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. She did explain all the reasons why, she said because girls get it taken out, they get pregnant then they come back and expect the NHS to pay for abortions, which is all a lot of money and I said I understand that but that's not what I'm going to do.*

(Daniella 19)

This sounds quite confrontational, and we can see Daniella's assertion of the right to control her own body in the face of what appears to be consistent resistance. She is also implicitly questioning the correctness of such resistance. Fatima had a similar experience.

*I think she thought that maybe I was going to go out and then like be sexually active and not have any protection then get pregnant and then come back and blame somebody. So I think she was trying to protect herself while doing it, but I don't know, I thought that wasn't really any of her business at that stage in time.*

(Fatima 17)

As has been noted earlier, one of the reasons associated with the desire of some young women to have the implant removed, was because they felt they had lost bodily control; if removal was denied or delayed they then felt very aggrieved. Practitioners were aware that sometimes women – after reaching their 'tipping point' – can become quite desperate:

*I've noticed a lot of them come for removal because they've got really emotional and they're desperate to have it removed and er, there have been cases in other areas where girls have actually tried to remove it themselves.*

(District 4, Interview 1)

Such experiences could then affect young women's views on future contraception and may also contribute towards localised peer-based informal knowledge about implants being difficult to have removed.

There were some examples of good practice outlined in the interviews with practitioners both in respect to trying to help young women avoid reaching a 'tipping point', but also noting the need to proceed to removal when necessary.

*To put it in and take it out and what we find is when their people have had poor counselling, they come and they want it out straight away so you may have a person whose had an implant in for about 6 weeks and she had it put in on her period, her period has continued and so coming up to the 6 weeks she getting anxious, she's getting worried, why is this taking so long, she's getting pressure because she's not able to have sex and this then causes anxieties and worries and this then obviously makes it sort of the immediate thing of, 'I want to take it out, please take it out straight away for me'. Whereas if you're, you give them good guidance, tell them that they can have something to control the bleeding and sometimes that that can actually almost stop the bleeding, not always but it can do and, and, sort of revert the system back to, to sort of being a non-period type method, that they will, they will be happy to continue it. But, you know, sometimes when people have been bleeding extremely heavy, you know, you have to be kind and you have to remove it.*

(District three, Interview two)

However, in order for this to occur, women need to be able to feel comfortable to go back to the clinic.

*I think the work that we do in the young people's service is to build up a relationship with these young people for them to feel that they can come and, and talk to us in confidence.*

(District three, Interview two)

## Post-implant contraception

An important issue to consider is the extent to which the experience of the implant might affect how young women feel about their future contraception. This section explores possible relationships between their experiences of the implant and their feelings about themselves and about contraception following removal. As has been shown, their explanations for the removal indicate complex feelings about how the implant may have affected their bodies and/or their emotions. These feelings, combined with their experiences of having the implant removed, could then influence the way in which they thought about future contraception. For several it was not always easy to think of a new contraception, whilst others just moved swiftly on to try something else. Participants used, or planned to use, a wide variety of different methods of contraception after they had their implant removal. These included the injection, pill, patch, IUD and condoms. However, the majority of participants were not using contraception at the time of their interview, either because they had not accessed the type they wanted, or because they were not currently in a relationship. The most common post-implant contraceptives were user dependent methods (contraceptive pill or condoms).

Some practitioners were aware that a bad experience with the implant may prevent women accessing a similar method of contraception in the future:

*They are just interested in contraception and having sex and now you see, and they're coming back 3 weeks or 4 weeks time, they still bleeding, 3 months they are still bleeding and that kind of thing. The next thing, we don't want to take it out, and to me we've lost that kind of method to that person. She'll probably never use it again.*

(District 1, Interview 1)

The young women's experiences with the implant, particularly their feelings about the side effects, often influenced which type of contraception they were willing to try. This was sometimes rationalised in terms of how they felt about hormones and their bodies:

*To be fair if condoms were 100% ... were as reliable as the implant or as the coil, that would be my best method. I hate using them but there is no after effect, there is no before effect, you take it off, that's it, there is nothing else in your body, nothing.*

(Reta 19)

Condoms were generally seen as a less reliable method, and were not likely to appeal to young women who were very worried about becoming pregnant. For others, although anxiety was expressed about the reliability of condoms, following their experiences with the implant they were seen as a tried and tested, fall-back contraception, especially after unexpected side effects had led to distrust of hormonal methods.

*When I went to the doctors I did say to her specifically about weight gain, I asked her all of the contraceptives which would make me gain weight. She said, none of them are supposed to do that but then they all did, so I'd rather use a condom and stay at a healthy weight than go on contraception then be gaining weight rapidly.*

(Fatima 17)

Such concerns were also noted by several practitioners whose experiences had made them aware that young women often preferred condoms after the implant had not suited them. This was especially if they had experienced hormonal side effects and/or they were no longer in a sexual relationship.

*They tend to just want something that they can just do themselves, so whether it be condoms because they've just had enough of the bleeding ... they want things to get back to normal a lot of the time, they'll say I just want my periods to get back to normal if they're having it removed for bleeding they just want things to get back to normal so they might just want to use condoms for a little bit.*

(District 2, Interview 1)

The young women's feelings about disrupted bleeding patterns also appeared to be tied to how they felt about their bodies in general, for example, whether they felt that not bleeding was 'unnatural'. This was, in turn, related to anxieties about how the implant may affect their own future fertility. One of the reasons that Tasmin (21) had originally been attracted to the implant was because it might stop her menstruation, but reflecting back on her experience she states:

*I don't think it's very healthy not to have a period, I think that's what is needed for us and to be honest I'm a bit worried that it might stop you from having children, not being on your period for a long time and that it something I wanted in the future so I decided that would be best to go on something that is healthy and does still give you a cycle.*

Sometimes, knowledge gained via informal avenues was drawn upon leading to misperceptions or concerns:

*I don't want the situation I get the implant and when I'm older they say that it's going to be hard for me to have kids because I had the implant. That would just be heart-breaking because I want kids when I'm older and if for my own selfish reasons I couldn't have kids that would really, really be upsetting. After all the stories I read on the internet, oh gosh, I was so scared.*

(Aysa 17)

This was often related to anxieties about what the 'chemicals' were doing to their bodies, and appeared to be contributing, and reflecting, informal knowledge – maybe 'urban myths' – about this form of contraception.

*The implant takes a long time for your periods to become stable again and you may want a child really soon after you take it out and you may have a miscarriage or something because the hormones are still in your body and I can't explain it but if I wanted to have a baby I would want it to be all fine, no complications and stuff because of the implant or whatever.*

(Jata 17)

These concerns echo reasons given in other research studies, discussed in chapter one, for not wanting to try the implant. In this study we only interviewed young women who had chosen the implant, so such concerns had not deterred them from trying the implant in the first place, but rather after trying the implant and having it removed. It may be that the experience of the implant had brought what may have been underlying anxieties to the fore, as well as prompting a re-assessment of the method, and of contraceptive methods more generally. It is important to recognise that such poor experiences can then, in turn, contribute towards informal knowledge and attitudes towards this form of contraception.

*Because I had so many problems I wouldn't recommend people to get it. And a lot of my friends have asked me about it and I've told them not to get it and my friends who have had it, because I've lost my hair they've all got theirs taken out as well.*

(Tasmin 21)

Their implant experience had thus led some participants to feel uneasy about the possibility of using other types of hormonal contraception, particularly long-acting methods.

*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, the same as, if you didn't like it, the fact I would have to stick with it and see it through because if it made me bleed for the whole three months, 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 in Daniella's appraisal of the injection was that it could not be taken out. The notion of the invaded body appeared to acquire new resonance after the implant had failed, and then it affected views on post-implant contraception. They mainly spoke about the injection and the IUS (intra-uterine system, usually referred to as the 'coil' by respondents) in these terms, expressing an aversion to these long-acting hormonal methods. That reluctance sometimes extended to the IUD – the copper intrauterine device that does not release hormones. Reta (19), however, selected the IUD precisely 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. As with the decision to use the implant, attitudes towards abortion were important influences on post-implant contraceptive choice. Reta had previously undergone an abortion and talked about her anxieties about becoming pregnant accidentally and not currently wanting a child, or another abortion:

*I still go through phases now where I think I want a kid, I want a kid. Maybe it's just to replace what I feel I've lost but that's what scares me so much about coming off the contraception because I think I don't ever want to be in that position where I'm forced to do something against my own will. 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)

Participants expressed a wide range of views on abortion. Several explained that if they had an unintended pregnancy that they would keep the child because they did not 'believe in abortion':

*I don't want to have a baby now but if it was to happen I couldn't have an abortion so I would be like I was forced into having a baby, do you know what I mean, so I wouldn't want that to happen so I'd rather the most effective sort of contraception so it don't happen.*

(Katie 22)

Others talked about considering an abortion in the event of becoming unintentionally pregnant, but as something they wanted to avoid:

*If god forbid I ever got pregnant I would consider having an abortion just for the fact that as horrible as it is it's still the best option for just save your life, it is definitely a really good option but hopefully having the right decisions, making the right choices, avoid ...*

(Emily 18)

## Conclusion

By and large, the young women in this study had made a considered decision in favour of the implant as their contraceptive of choice at a particular point in time. There was a great deal of disappointment expressed that the implant had 'not worked out' for them. Their experiences were liable to lead them to greater

uncertainty about what type of contraception might be suitable for them. This was especially the case if they had not been fully prepared for the side effects, and if they were not satisfied with the help and advice they had received from practitioners. Above all, after analysing their explanations for removal, what is striking is an understanding that the most effective forms of contraception can have unwanted side effects, and therefore the desire to avoid pregnancy needs to be balanced against tolerance of side effects.

It is important to note that it is not possible to be certain that all – or even most – of the perceived side effects described by the participants had been caused by the implant. However, the young women thought that this was the case, and it was this perception that pushed them towards having the implant removed. It was often a combination of different side effects, following a period of tolerating inconvenience, which had prompted the decision to have the implant removed.



## Chapter five: Conclusions and Implications for practice

There were a number of strong themes that emerged from this research project. These will now be summarised, and then the implications for practice will be discussed.

### Conclusions

- In this study, the young women had generally made a considered decision to try the implant, often after consulting with their friends, because it was viewed as a reliable and easy to use form of contraception. This was often in the context of a 'steady' relationship when they were not worried about STIs. Many had had negative experiences of other forms of contraception. They had wanted the implant to work for them and many were disappointed that their experiences had not matched their expectations.
- The main side effects that led to discontinuation of the method were bleeding irregularities; and a range of hormonal side effects: mood swings, weight gain, headaches and acne. Often, more than one side effect was identified by the participants; and it was likely to be the combination of a number of different side effects that led them to conclude that 'it didn't work for me'. For others, the end of their relationship – often combined with side effects – led them to decide they were not prepared to tolerate the implant any longer.
- Although many participants did acknowledge that they had been alerted to possible disruption to bleeding patterns, the hormonal side effects of the implant had clearly been discussed less often during the initial consultation. The young women felt ill-informed about non-bleeding side effects, but also unprepared for the scale of discomfort irregular bleeding would cause.
- In cases in which the young women felt they had been misinformed in their original contraceptive consultation, this had led to a breakdown in their trust of the provider.
- Although there was some uncertainty about the extent to which their negative experiences could be attributed to the implant, in the main they had concluded that the implant had caused the side effects that troubled them.
- In some cases, the young women had individualised their experience of the implant. This meant that they interpreted their difficulties as the failure of their body to 'adjust' to the implant (rather than the product being imperfect). Their experiences of what they viewed as side effects of the implant led many of them to feel anxious about losing control of their bodies, including their emotions. They often felt alone and unsupported during this time. Although participants acknowledged that they were given advice before having implant fitted, they appeared to receive less support from sexual health services once it was in place.

- Participants did tolerate a number of different side effects, often for a significant period of time, but eventually reached a 'tipping-point' when they were no longer willing to persevere with the implant.
- When they had made the decision that they wanted the implant removed, many of the young women were frustrated, and sometimes angry, with what they interpreted as practitioner resistance to the removal. They felt this resistance challenged their bodily autonomy.
- Negative experiences of the implant, especially when combined with resistance to removal, could lead to women being reluctant to try another long-acting form of contraception.
- There was a strong theme of responsibility in the young women's accounts. This was related to their relationship status. Those who were in a 'steady' relationship felt that the implant was an appropriate form of contraception if, and when, they felt they had no worries about contracting an STI. There were noticeable differences between the views of the practitioners, and those of the young women, on what constitutes 'responsible' contraceptive behaviour. This was most noticeable with respect to some practitioners feeling that the most responsible thing to do when a relationship ended was to retain the implant, whereas most of these particular young women disagreed.

### Implications for practice

Though only a minority of young women may request 'early' implant removal, these women have contraceptive needs and sexual health services should consider how to address these needs. We have identified three points at which changes in practice might make a positive difference to the contraceptive pathways of young women who are unhappy with the implant. Many of these suggestions address research aim two: to understand what may help women maintain this method of contraception if they wish to do so.

The three points are:

- the contraceptive consultation at which young women select the implant as their contraception of choice;
- an indefinite period of time after they have the implant fitted (maybe up to a year);
- the consultation at which a young woman requests that her implant be removed.

The suggestions under each of these headings flow directly from the research findings<sup>7</sup>. We begin each section with case studies that illustrate the issues that need addressing. Our comments on practice follow these case studies.

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<sup>7</sup> These are formulated as bullet point recommendations in the Executive Summary.



## Contraceptive consultation and selecting the implant

**Jo (20)** is in a long term relationship. Previously she was using the contraceptive pill but had difficulty remembering to take it. Avoiding pregnancy was very important to her but at the same time she found it very difficult to find a contraception that suited her. She had previously suffered with depression and traced the start of her illness to around the time she first started using hormonal contraception (the pill) aged 15. Because of this previous experience Jo approached the implant with caution. She wanted to make sure that it would not aggravate her depression or cause mood swings.

*She told me there were no side effects at all, which was wrong because I looked up after and there was side effects so she should have gone through all of that with me.*

Jo was unhappy with her experience of the implant and had suffered from severe mood swings, depression and headaches.

*I had really bad mood swings, I had depression with it, I was really angry a lot of the time, I'd switch out completely over stupid little things.*

Jo persevered with the implant for around 18 months before having it removed. She had tolerated the method, as opposed to being satisfied with it, but had delayed having the implant removed, even after hospital admission for headaches, because she was concerned about becoming pregnant and was unsure about her other options for contraception. In this respect she felt she was being responsible in her attitude towards contraception. As noted in chapter four, Jo also described a sense of aloneness whilst trying to deal with the side effects of the implant. Overall, she evaluated her experience with the implant extremely negatively – she did not feel she was thoroughly warned about the potential side effects of the implant. She felt that there was an overreliance on written information in the consultation. This was problematic for her as she is dyslexic and does not consider herself to be a good reader. Jo had lost faith in contraceptive services generally.

*They don't explain anything to you, how things work, what things do to your body, you can't trust them, you really can't trust them.*

Jo's narrative illustrates how a process of disillusion with services, and potential disengagement, can begin at a contraceptive consultation at which young women feel that their concerns are not being taken seriously enough. This may emerge at a later stage if they are unhappy with their contraception. When she experienced side effects that she felt she had been led to believe were not associated with the implant, Jo felt anxious about being told the truth, and felt reluctant to put anything else in her body.

*It made me feel like I wouldn't trust, even though she's a medical woman and she should know, she's a nurse and whatever, she should be completely honest with you because if they're not telling you the full truth who are you going to trust. You don't want to put nothing else in your body, you're too scared because you're not getting a straight answer off of nobody so who do you talk to? It's very hard, very, very difficult.*

Jo represents young women who feel they have not been given full information at their initial consultation; and maybe even

feel they have been misled. She experienced a number of side effects that she had not expected, and it appears not to have crossed her mind to return to the clinic to discuss these. She has disengaged with the services.

**Stacey (19)** had been trying for a baby when she was 16 with her ex-partner, but had not become pregnant. When she met a new partner she had continued not to use contraception and had become pregnant and had the child. After this pregnancy she was using the pill as her contraceptive but found it difficult to remember to take it. She subsequently stopped taking the pill and became pregnant again. This second pregnancy ended with an abortion. Stacey had the implant fitted at the clinic where her abortion was carried out. While using the implant Stacey experienced irregular bleeding:

*I had the implant for just over a year [...] Since I got it I was bleeding since I had it, sometimes it would be twice a month or all month, I was just constantly on.*

Stacey had no recollection of being told about bleeding as a side effect of the implant:

*They didn't say anything about the bleeding. I didn't get told nothing about that.*

She also found it difficult to control her weight and experienced mood swings:

*The period makes you eat more and I'm trying to lose weight at the moment and it just wasn't helping, on your period you just want to eat chocolate and get in funny moods and I didn't want to keep being in funny moods.*

When Stacey requested a removal she was encouraged by the practitioner who saw her to take the pill as a way of controlling the bleeding. Stacey conceptualised this approach as being 'too much' and insisted on having the implant removed:

*I thought that would be too much, taking the pill as well [...] Taking two lots of contraception and how before with the pill I kept forgetting it so I don't think it would have made much difference because I probably would have forgot it [...] I know the pill makes you put on weight as well and I just didn't feel good about taking it.*

Although Stacey was not currently using contraception, she was not in a relationship. In the future she would like to try the contraceptive patch and would also consider using condoms.

Stacey represents young women who felt they had been poorly prepared for changing bleeding patterns, as well as additional side effects that she connects to being 'on'. She was one of the few participants who thought she had not been forewarned about bleeding, and this may be connected to her having the implant fitted at the same time as her abortion.

## Changing practice

The contraceptive consultation is the place where women should be informed of the possible negatives and positives of the different forms of contraception available to them. Both Jo and Stacey, in common with several other young women in this study, expressed disappointment (retrospectively) with the quality of the information they had been given. The following suggestions for changes in practice may make a difference to the trajectories of women with similar experiences.

Counselling is fundamental to the provision of the LARC methods. However, the LARC guidance, whilst noting irregular bleeding patterns as a side effect, also notes that Implanon use is not associated with changes in weight, mood, libido or headaches (NICE 2005). The interviews with practitioners in this study have indicated that irregular bleeding patterns are felt to be the main side effect of the contraceptive implant and it is this element which is most and more extensively counselled about prior to implant fitting. This research with young women has shown, however, that non-bleeding side effects do appear to be experienced, and it is frequently these side effects which precipitate a request for early removal. Therefore, it is important to forewarn about these as a possibility, just as it is vital to counsel about an irregular bleeding pattern.

The study also highlights an over-dependence of practitioners on written support, particularly 'the leaflet'. Provision of a leaflet should not be seen as acknowledgement that young women have been informed about every eventuality. Also, the information leaflets are very general, and this study has shown that contraceptive advice may need to be tailored to individual needs and experiences.

At this consultation, therefore, it is important to pre-warn women adequately about the possibility of side effects, including hormonal side effects. Whilst it is clearly difficult to strike a balance between avoiding possible undue alarm, and providing accurate information, women should be informed of the possibility of different side effects. They could be told, for example, that the implant might make them hungry and therefore possibly put on weight. It is, however, equally important to talk to women about how they could be helped to manage possible side effects. For example, it would be possible to discuss from the outset that things can be done to help with irregular bleeding if it becomes problematic. It is also important to let women know, at the time of their implant fitting, that if they later experience side effects that they believe are associated with the implant, there is an 'open door' for them. They should be encouraged to return the clinic where they have had their implant fitted, or to their local clinic if they have had an implant fitted at an abortion clinic.

#### After implant has been fitted, before removal is requested

**Reta (19)** had the implant fitted after a termination at an abortion clinic. She was offered the implant when she attended for her termination and agreed to have one fitted. While using the implant Reta had experienced weight gain, headaches and emotional upset. She theorised that these side effects could be caused by hormones in the implant, although she also acknowledged that she was not sure if her emotions were 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 notch, I was a bit more hormonal and stuff.*

Reta kept the implant for 9 months before having it removed. After removal Reta decided to have the IUD fitted because she did not want to 'be forced' to have a child simply because she could not face another abortion.

*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.*

She had a bad experience of having the IUD fitted and bled heavily. She also thought it made sex uncomfortable. She returned to the clinic with the intention of having the IUD removed but had been dissuaded by the practitioner who saw her. She was still unhappy with the IUD and was still bleeding at the time of the interview.

*I just think the whole coil is quite horrendous, to be fair, I would not recommend it to not even my worst enemy I wouldn't recommend it to. I've still got it now and that's because I don't want to get pregnant.*

Reta represents young women who may well benefit from more consultations with sexual health practitioners during the time at which they are experiencing side effects thought to be connected to the implant. In the case of Reta, such meetings might have helped her to disentangle her feelings about her abortion from the side effects of her contraception.

**Janey (18)** had been offered the implant when she had attended the clinic for chlamydia screening. Prior to attending the clinic she knew very little about contraception. Janey preferred not to have periods and hoped that the implant would cause her periods to stop:

*I hate periods, they get in the way of everything, I hate them, they're just horrible, gunky ... yes, so at the time I thought that would be really good because that would slow it down or even stop it.*

However, Janey's experience with the implant did not match her expectations. She experienced unpredictable, and in her view, excessive bleeding throughout the duration of using the implant (2 ½ years). Despite this Janey persevered with the implant because she felt that after agreeing to have the implant fitted and understanding the possible side effects, she could not return for a removal as it was her own choice to have the implant fitted and she had been advised not to have the implant if she was not going to keep it:

*I didn't think it would be right to come in because before I got it she said to me don't have it if you're going to take it out [...] So I thought okay I can't just go back and say look I'm having periods that I don't like.*

The bleeding was a nuisance to her and impacted on her sexual relationship. She felt she could not/did not want to have sex when she was bleeding. Therefore, the implant was 'controlling' if and when she could have sex, whereas she stated '*I just want to have sex when I want to have sex*'.

After having the implant removed Janey had opted for Depo-Provera (contraceptive injection) with the hope that it would cause the bleeding to stop.

Janey demonstrates a case of extended toleration, combined with dissatisfaction with the implant.

#### Changing practice

This study has shown a high level of toleration of side effects, for a while. These young women wanted the implant to work for them, but there was a limit to their tolerance of what they perceived to be side effects of the implant. For practitioners,

there is often pressure to encourage retention of what is known to be an expensive form of contraception. In addition, it is generally understood that side effects do lessen over time (Blumenthal *et al* 2008). This study has shown that the results of the concern to encourage retention can be negative. There is no reason why women should not be encouraged to return to clinics during this time. Rather than hoping that young women will cope with side effects, which might 'settle', there is more that can be attempted to help with side effect problems, particularly bleeding.

There is no guarantee that an irregular bleeding pattern developed with implant use will 'settle down' after a period of months, but what is evident from this study is that young women are very variable in their capacity to tolerate irregular bleeding: what may be unacceptable to one woman at three weeks may be unacceptable to another after 18 months. The participants appear to have a perception that it would be unacceptable for them to return for help with bleeding patterns within a given time-frame. When they finally do return, they have often 'had enough', having reached their own 'tipping point', and the opportunity to provide therapeutic help to manage these side effects has been missed.

One way of addressing this could be through a targeted information card or card holder. After insertion, women are provided with a 'credit-card' with the details of their implant fitting. It may be possible to provide a summary of actions, which the woman could follow should she have problems with the implant. A 'card-holder' similar to a bus pass holder would allow the woman to store her card, with the information that she needs being readily available.

Young women may respond well to offers to help them manage their side effects. An 'open-door' policy should be promoted so they feel they can come back to the clinic if they experience any problems. The aim of this is to intervene before they reach the 'tipping-point'. It is therefore important to encourage women who are having difficulty tolerating bleeding problems to return as soon as they have concerns. It may be that reassurance is all that is needed, but this would also allow the option of trial of therapeutic intervention such as mefenamic acid (Ponstan) or the combined oral contraceptive pill (NICE 2005).

One problem with interventions to manage bleeding is that usually therapeutic options need to be prescribed by a doctor or independent prescriber. Taking into consideration the fact that many services are nurse-led, this may be problematic as someone who is able to prescribe the required therapy may not be available. Often nurses work following 'Patient Group Directions' (PGDs). There are pan-London PGDs available for the supply of all hormonal contraceptives and for the treatment of common STIs. It may be worth exploring whether a PGD could be developed so that nurses have more scope to help young women manage their problems. Services should consider developing a PGD for the use of combined oral contraceptives for women using the implant for unscheduled bleeding where pathology has been excluded.

Finally, it is worth clinicians remembering that even though there are therapeutic options available to help with bleeding problems, there are no therapeutic options to help with other 'hormonal' side effects. In these situations, support and reassurance may not suffice, and implant removal should be easily available.

There is another difficult balance to maintain, and that is between helping women retain the implant when they experience side effects that are unpleasant for them, and being overly persuasive, maybe to the point of actively discouraging removal. At this point women need to be given time to discuss whether or not they wish to try and control the side effects without any undue pressure to retain the implant.

### After removal has been requested

**Aysa (17)** decided to have an implant when she had been with her previous boyfriend for about two years. They had been using condoms, a contraception she thought was the best method when not in a stable relationship. Her contraceptive choices were influenced by her sexual relationship, and the main reason she gave for selecting the implant was that – in the context of a long-term relationship – not using condoms was unproblematic and could increase their sexual pleasure:

*I was with my ex for a couple of years and we just decided to not use any condoms anymore, that we should be more intimate and go without condoms and he was like okay how about you get the implant? I was like okay.*

She experienced numerous side effects that she attributed to the implant. These included weight gain, moodiness and acne. However the most significant side effect was her bleeding:

*I was always on my period, there was not one day I was not on my period from June to August, that's about two months of being on my period. I'm anaemic so that just made my anaemia even worse.*

Aysa felt that the practitioners she came into contact with were resisting her requests to have her implant removed. At first she had phoned and spoken to someone about her bleeding, but had been told 'it's normal, it's normal'. She then retained the implant until she could not tolerate the side effects any more, at which point she insisted on having it removed. After the removal she was anxious that it might have affected her fertility. She had a new boyfriend (three months) and they were practicing withdrawal.

Aysa had clearly reached her 'tipping point', and was frustrated at the delays she has experienced. She was then anxious that something that had affected her so badly, may also affect her fertility. She is not considering another hormonal contraception.

**Lucy (17)** was in an 'open relationship'. She had made a swift 'spur of the moment' decision to have the implant fitted. Once she had made up her mind she booked an appointment and attended the clinic with a friend who was also having the implant fitted. Her main reason for removal was increased headaches, although she also experienced unpredictable bleeding. Although Lucy was aware of the possibility of side effects and had accepted them at insertion, the everyday reality was very different. She suffered very bad headaches while using the implant and this was her primary reason for removal.

*I was in the walk-in centre a while ago because I couldn't walk properly, I couldn't speak at all, with a really bad migraine, I've suffered from them since I was about 9 ... but they stopped for a while and they came back when I got the implant.*

Lucy said she had to persevere to have her implant removed and that it took her approximately six weeks and 'three or four' clinic visits to have the implant removed:

*I had the headache and I went to the centre [...] she refused to remove it saying I should keep it for longer and then, so she sent me off and then went, got another appointment which I thought was for the clinic but it turned out to be something completely else, so I've gone there and the clinic's closed! [laughs] So I came back here but the nurse was off on holiday so I had to wait another three weeks I think it was, so it took me about a month and a half to be able to get it removed.*

Lucy felt 'really irritated' by her experience: 'it's my body, if I don't want it in there, they should take it out'.

Lucy was not using contraception at the time of the interview (she had not been in a sexual relationship since having the implant removed) and was unsure about what types of contraception she would 'be allowed', since she had been advised to avoid hormonal methods because of her migraines. It was suggested that she try the non-hormonal IUD. However, Lucy's mother and grandmother had bad experiences with the IUD and this made her reluctant to try it. Lucy was keen to try the pill again since this was the method she had been most satisfied with.

What Lucy had understood as practitioner resistance led her to feel that her bodily autonomy had been compromised. She became disillusioned and disengaged from the services.

## Changing practice

If the implant is not suiting young women, and these may well be small numbers of young women, it is important for them to move on to a new method of contraception quickly. The evidence from this study suggests that if they feel they are experiencing too many side effects, or face too many obstacles to removal, they are less likely to listen to practitioner advice in the future.

It is clear that some women are unable to tolerate the side effects that they attribute to the implant. Additionally, young women's views on sexual responsibility may indicate that the 'end of a relationship' is a valid reason for discontinuing contraception. The evidence from this study suggests that attempts to encourage retention are often futile and can subsequently undermine the patient's trust in her practitioner. Practitioners therefore need to accept the reality of a range of side effects, and in supporting women's contraceptive decisions they may be better placed to be trusted with regard to recommendation of further methods.

Resistance to implant removals may have unintended consequences. Women who have had a poor experience, compounded by difficulties in accessing someone to remove the device, may become disengaged from sexual health services. Additionally, trying to persuade a young woman to persevere with a form of contraception that she is unhappy with is not respectful of bodily autonomy, and could be viewed as unethical.

This research has shown the importance of an individualised approach to contraceptive counselling, and supporting young women who have selected the implant as their contraception of choice. It is necessary to remember that at the most fundamental level, individual choices, experiences and aspirations, make it necessary to take into account each young woman's opinion about what is best for them, their lifestyle and their body. This principle of contraceptive choice needs to be extended to facilitate implant removal when necessary.

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