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Does Body Mass Index or Weight Perception Affect Contraceptive Use?

Kalpesh Bhuva, MPH^b, Jennifer L. Kraschnewski, MD, MPH^{a,b}, Erik B. Lehman, MS^b, and Cynthia H. Chuang, MD, M.Sc.^{a,b}

^aDivision of General Internal Medicine (Department of Medicine), Penn State College of Medicine, Hershey, PA USA 17033

^bDepartment of Public Health Sciences, Pennsylvania State College of Medicine, Hershey, PA USA 17033

Abstract

Objective: Overweight and obese women may avoid contraceptive methods they believe are associated with weight gain. The objective of this study was to examine the role of weight and weight perception on contraceptive use.

Study Design: Using cross-sectional data from the MyNewOptions study, we analyzed contraceptive use among 987 privately-insured, sexually active women aged 18–40. Contraception was categorized into 3 groups: (1) long-acting reversible contraceptives (LARCs), (2) non-LARC prescription methods, and (3) non-prescription methods/no method. Multinomial logistic regression was used to model the effect of BMI category and weight perception on contraceptive use while controlling for pregnancy intentions, sexual behavior, and sociodemographic characteristics.

Results: Eighty-three (8.4%) women were using LARCs, 490 (49.6%) women were using non-LARC prescription methods, 414 (42.0%) were using non-prescription methods or no method. In the adjusted multinomial model, overweight (aOR 3.84, 95% CI 1.85, 7.98) and obese women (aOR 2.82, 95% CI 1.18, 6.72) were significantly more likely to use LARCs compared to normal weight women. There were greater adjusted odds of overweight and obese women using non-prescription methods/no method compared with non-LARC prescription methods, but this finding did not reach statistical significance. Weight perception was not associated with contraceptive use.

Conclusion: In this study sample, overweight and obese women were more likely to use LARCs than normal weight women. It will be important to further understand how weight influences women and providers' views on contraception in order to better assist women with individualized, patient-centered contraceptive decision making.

Keywords

overweight; obesity; weight perception; contraception; long-acting contraceptive methods

1. Introduction

More than half (58.5%) of U.S. reproductive age women are overweight or obese,¹ heightening the need to understand contraceptive decision making in this population. Overweight and obese women may be less likely to use oral contraception or depot medroxyprogesterone acetate (DMPA) due to concerns about weight gain.² Weight gain is a commonly cited reason for discontinuation of hormonal contraception; thus, weight may play a role in the risk of unintended pregnancy.³ It is unknown whether perceiving oneself as overweight, independent of actual weight, may affect choice of contraception.

In this study, we sought to understand the relationship between weight, weight perception, and contraceptive use using baseline data from the MyNewOptions study, a randomized controlled trial of privately-insured women. We hypothesized that overweight and obese women and women who perceive themselves as overweight would avoid certain hormonal methods and in turn, be at risk for choosing less effective contraceptive methods.

2. Materials and Methods

2.1. Study Sample

Data for these secondary analyses are from the MyNewOptions study, an ongoing randomized controlled trial testing the effectiveness of web-based reproductive life planning interventions to assist women in making patient-centered contraceptive choices in the context of contraceptive coverage without cost sharing under the Patient Protection and Affordable Care Act ([ClinicalTrials.gov](https://clinicaltrials.gov/ct2/show/study/NCT02100124) Identifier: NCT02100124). Details regarding the MyNewOptions study protocol are published separately.⁴ The analyses reported here are from the baseline survey, which included 987 privately insured women ages 18–40 not intending pregnancy for at least the next 12 months. Randomization to the study intervention occurred after completion of the baseline survey.

Study participants were members of Highmark Health Plans in Pennsylvania. Invitations to participate in the MyNewOptions study were mailed to a random sample of 15,000 women in the target age group from the Highmark enrollee database. Women were enrolled over four months in spring 2014; the study was closed to further enrollment when the target sample size was met. Women were screened for eligibility and consented on-line. Women were included who were aged 18–40 with access to the Internet, who were currently sexually active or planned to be with a male partner within the next 6 months, not intending pregnancy in the next 12 months, not surgically sterile or with a current partner with vasectomy, and able to read and write English. The baseline survey assessed self-reported height, current weight and weight perception, contraceptive use and behaviors, future fertility intentions and attitudes, health status, and sociodemographic data. The survey was distributed through Research Electronic Data Capture (REDCap). The MyNewOptions study was approved by the Penn State College of Medicine's Institutional Review Board.

2.2. Measures

2.2.1. Current contraceptive method.—The primary outcome measure was current method of contraception. The survey measured current use of a full range of contraceptives,

including prescription and over-the-counter methods, as well as natural family planning and withdrawal. Contraceptive types were categorized into three groups based on contraceptive efficacy: (1) long acting reversible contraceptives (LARCs—i.e., IUDs and the contraceptive implant), (2) non-LARC prescription methods, and (3) non-prescription methods or no method. LARCs are the most effective reversible contraceptive methods with typical use failure rates of less than one percent in the first year of use.⁵ Non-LARC prescription methods included those that require a prescription or health care visit with typical use failure rates of 6–9% in the first year of use (i.e., birth control pills, injectables, patch, diaphragm, cap and ring).⁵ The non-prescription methods include less effective methods with typical use failure rates of 18–24% (e.g., condoms, foam, sponge, natural family planning, withdrawal).⁵

2.2.2. Weight category and weight perception.—The main independent variables in this analysis were weight category and weight perception. Using body mass index (BMI) calculated from self-reported height and weight, participants were classified as underweight or normal weight (BMI less than 25 kg/m²), overweight (BMI 25 to less than 30 kg/m²), or obese (BMI greater or equal to 30 kg/m²). Weight perception and recent weight loss efforts were assessed using standard items from the National Health and Nutrition Examination Survey (NHANES) weight history questionnaire: “Do you consider yourself now to be overweight, underweight or about the right weight?” and “During the past 12 months, have you tried to lose weight?”

2.2.3. Covariates.—Other variables hypothesized to influence choice of contraceptive method were also included in the analysis. These variables included intentions for future pregnancy (intending pregnancy in the next 1 to 2 years, 2 to 5 years, 5 or more years, never, or not sure),⁶ number of prior live births (zero, one, or 2 or more), frequency of sex (two or more times a week, two to four times a month, or once a month or less), and sociodemographic characteristics (age category, relationship status, education (some college or no college), and employment (employed or not employed)).

2.3. Statistical Analysis

All variables were summarized with frequencies and percentages for categorical variables or with means, medians, and standard deviations for continuous variables. Multinomial logistic regression was used to make bivariate comparisons to search for significant associations between the multinomial dependent variable, contraceptive method category, and independent variables (including BMI weight category and weight perception). Within the multinomial logistic regression, each contraceptive method category (i.e., LARCs and non-prescription methods/no method) was compared against women using non-LARC prescription methods. This approach was chosen for added efficiency over individual binomial logistic regression models after considering and rejecting the use of an ordinal logistic regression model for not meeting the proportional odds assumption. Multivariable multinomial logistic regression was conducted to provide adjustment for all variables. Prior to multivariable analysis, the independent variables were checked for multicollinearity using variance inflation factor (VIF) statistics and Cramer’s V statistics. Because methods to assess the fit of a multinomial logistic regression model are lacking, the fit of the

multivariable model was determined via Pearson and Deviance statistics and the Hosmer-Lemeshow goodness-of-fit test generated from models based on the individual binomial components of the multinomial dependent variable. Odds ratios with 95% confidence limits were used to quantify the magnitude and direction of any significant associations. All analyses were performed using SAS software version 9.4 (SAS Institute, Cary, NC).

3. Results

3.1. Sample Characteristics

There were 987 women between 18–40 years of age who completed the baseline survey. The characteristics of the participants are shown in Table 1. Approximately half of women were 18–25 years of age and most were white, employed, and had completed some college education. The majority of the sample (57.9%) was under- or normal weight, 22.4% were overweight, and 19.7% were obese. Half of the women perceived themselves to be overweight, including 3.7% of underweight, 21.3% of normal weight, 82.2% of overweight, and 99.5% of women with obesity (data not shown). Two-thirds of women (68.3%) tried to lose weight in the past year, including 18.5% of underweight, 60.8% of normal weight, 79.7% of overweight, and 83.0% of women with obesity (data not shown).

3.2. Weight and Contraceptive Use

Only 83 (8.4%) of the women in the study were currently using a LARC, which included 6.0% (n=34) of under/normal weight women, 23.0% (n=28) of overweight women, and 20.6% (n=21) of obese women. There were 490 (49.6%) were using another prescription methods, 301 (30.5%) were using a non-prescription method of contraception, and 113 (11.5%) were using no method. The unadjusted multinomial odds ratios (OR) describing contraceptive method use compared with the non-LARC prescription methods are shown in Table 2. Overweight women were more likely than normal weight women to use LARCs (OR 2.75, 95% CI 1.59, 4.77) and non-prescription methods/no method (OR 1.48, 95% CI 1.06, 2.06) compared with non-LARC prescription methods. Similarly, obese women were also more likely than normal weight women to use LARCs (2.39, 95% CI 1.32, 4.35) and non-prescription methods/no method (OR 1.61, 95% CI 1.14–2.28) compared with non-LARC prescription methods. Women who perceive themselves as overweight were also more likely to use LARCs (OR 1.73, 95% CI 1.08, 2.78) and non-prescription methods/no method (OR 1.39, 95% CI 1.07, 1.81). Women who have been trying to lose weight were less likely to use non-prescription/no method (OR 0.66, 95% CI 0.50, 0.88).

The adjusted odds ratios describing the relationship between weight category, weight perception, and current contraceptive method are shown in Table 3. After adjustment for the other variables in the models, being overweight (aOR 3.84, 95% CI 1.85, 7.98) and obese (aOR 2.28, 95% CI 1.18, 6.72) remained associated with greater likelihood of using LARCs compared with non-LARC prescription methods; however, the association of weight category and use of non-prescription/no method was no longer significant. In adjusted analysis, perceiving oneself as overweight was no longer associated with contraceptive use. Women who have been trying to lose weight remained less likely to use non-prescription/no method (aOR 0.63, 95% CI 0.46, 0.87).

3.3. Covariates and Contraceptive Use

Future pregnancy intentions predicted contraceptive use – women not intending future pregnancy and not sure about future pregnancy were more likely to use LARCs compared with non-LARC prescription methods by nearly 4-fold. Women with prior live births were significantly more likely to use both LARCs and non-prescription methods/no method, compared with nulliparous women. Women who reported having sex more frequently (2 or more times a week and 2–4 times a month) were less likely to non-prescription methods/no method compared with women who had sex less frequently. Cohabiting and employed women were less likely to use non-prescription methods/no method, compared with non-LARC prescription methods. Age category was not associated with contraceptive category use.

4. Discussion

In this study sample, overweight and obese women were significantly more likely to use LARCs compared with normal weight women. Although there was also a greater adjusted odds of using non-prescription methods or no method compared with normal weight women, these findings did not reach statistical significance. Data from the 2006 Behavioral Risk Factor Surveillance System similarly showed that 50.5% of obese women were using the most effective methods (i.e., sterilization and LARCs) compared to only 36.2% of normal weight women and 45.8% of overweight women.³ Kohn, et al. reported that obese women had higher odds of using LARCs (as well as non-prescription methods) in a large national sample of Planned Parenthood clients.⁷ Other studies have also demonstrated that women with a higher BMI have higher rates of more effective contraceptive method use.^{3,8}

Overweight and obese women may have concerns of weight gain in mind when they make contraceptive choices. Due to unwanted weight gain perceived to occur with oral contraceptives and DMPA, we expected that overweight and obese women may avoid non-LARC prescription methods and preferentially choose LARCs, less effective non-prescription methods, or no method. Although the association between overweight/obesity and increased use of non-prescription/no method was not significant, there was a trend in this direction. Historically, women of all weight categories may have been reluctant to consider LARCs due to the high out-of-pocket expense. Currently, the Patient Protection and Affordable Care Act mandates most health plans offer coverage of all FDA-approved contraceptive methods with no cost sharing. It is hoped that the removal of the cost barrier will lead to an increase in LARC use for women who desire these methods, however whether there is adequate awareness of coverage changes or an adequate LARC provider workforce to realize these changes is unknown.^{9,10}

Family planning is particularly relevant in overweight and obese women given the increased risk of adverse pregnancy outcomes related to excess weight and co-morbid conditions. Providers may need to focus on prevention and treatment of chronic conditions associated with excess body weight, leaving less time for contraceptive management. Knowing that LARCs are acceptable to overweight and obese women may increase provider willingness to inquire about pregnancy intentions and contraceptive needs. Health care providers may also be reluctant to discuss contraception with overweight and obese women, because

contraception trials have typically excluded obese women resulting in less data on the safety, efficacy, and side effect profile of various contraceptives in this population.¹¹ Whether or not excess weight significantly affects the effectiveness of hormonal contraceptives is not entirely clear – in a Cochrane review of five recent studies from 2002 – 2012, only one demonstrated a higher pregnancy risk in obese women using oral contraceptives as compared to their normal weight counterparts. The efficacy of the implant and injectable contraception has not been shown to be affected by patient weight.¹² Conversely, other studies concluded that oral contraceptives, the patch, and emergency contraceptive pills have been shown to have increased failure rates in women with obesity compared with women of normal weight, with the risk of failure greatest in women with BMI of more 35 kg/m².^{13–15}

A limitation of this study is it only included privately-insured women from one state, so results may not be generalizable to different populations with greater socioeconomic and race/ethnic variation. Second, survey measures are subject to self-report bias, although they remain the standard methodology for contraceptive research. Third, this study was cross-sectional and only represents a woman's contraceptive use at one point in time. Finally, we are unable to determine from our study the reasons why overweight and obese women in our study made the contraceptive choices that they did.

In conclusion, we found that overweight and obese women preferentially use LARCs compared with normal weight women. Future research on the role of weight, weight perception and contraceptive choice will be of interest as we see the effects of the contraceptive coverage mandate under the Affordable Care Act roll out over time. Understanding the relationship between weight and contraceptive methods may provide important insight on how to better provide patient-centered contraceptive care to women across all weight categories.

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IMPLICATIONS

Overweight and obese women may be reluctant to use contraceptive methods they believe are associated with weight gain (i.e., pills, shot), but how that affects contraceptive use is unclear. Compared with normal weight women, overweight and obese women in this study were more likely to use LARCs than non-LARC prescription methods.

Table 1.

Characteristics of sexually active women not intending pregnancy in the next year (N = 987).

Characteristics	N (%)
BMI weight category (kg/m ²)	
Underweight/Normal (<25.0)	569 (57.9)
Overweight (25.0–30.0)	220 (22.4)
Obese (≥ 30.0)	194 (19.7)
Perceives overweight	
Yes	492 (50.0)
No	492 (50.0)
Trying to lose weight	
Yes	669 (68.3)
No	310 (31.7)
Future pregnancy intention	
Not sure	228 (23.1)
Never	153 (15.5)
1 to 2 years	132 (13.4)
2 to 5 years	249 (25.3)
5 or more years	224 (22.7)
Prior live births	
None	665 (67.4)
One	148 (15.0)
Two or more	174 (17.6)
Frequency of sex	
2 or more times a week	299 (30.5)
2–4 times a month	453 (46.3)
Once a month or less	227 (23.2)
Age category	
18–25 years	449 (45.5)
26–33 years	365 (37.0)
34–40 years	173 (17.5)
Relationship status	
Married	369 (37.5)
Living with partner	166 (16.9)
Partnered	295 (30.0)
Not partnered	154 (15.6)
Race	
Non-White	50 (5.1)

Characteristics	N (%)
White	931 (94.9)
Education	
Some college	913 (92.9)
No college	70 (7.1)
Employment	
Employed	717 (72.9)
Not employed	267 (27.1)
Contraceptive category	
LARCs	83 (8.4)
Other prescription method	490 (49.6)
Non-prescription methods or No method	414 (42.0)

Table 2.

Unadjusted odds of contraceptive method choice compared with non-LARC prescription methods in sexually active women not intending pregnancy in the next year.

Independent Variables	Contraception method (N=490)	
	LARCs vs. Non-LARC prescription methods (N=83)	Non-Prescription or No Method vs. Non-LARC prescription methods (N=414)
BMI category (kg/m ²)		
Underweight/Normal (<25.0)	Reference	Reference
Overweight (25.0–30.0)	2.75 (1.59, 4.77)	1.48 (1.06, 2.06)
Obese (≥ 30.0)	2.39 (1.32, 4.35)	1.61 (1.14, 2.28)
Perceives overweight (vs. does not perceive overweight)	1.73 (1.08, 2.78)	1.39 (1.07, 1.81)
Trying to lose weight (vs. not trying to lose weight)	1.16 (0.68, 1.97)	0.66 (0.50, 0.88)
Future pregnancy intentions		
Not sure	3.10 (1.13, 8.53)	0.91 (0.58, 1.42)
Never	3.47 (1.24, 9.74)	0.67 (0.41, 1.09)
1 to 2 years	Reference	Reference
2 to 5 years	1.72 (0.62, 4.78)	0.52 (0.34, 0.81)
5 or more years	0.68 (0.21, 2.17)	0.50 (0.32, 0.78)
Prior live births		
None	Reference	Reference
One	3.66 (1.89, 7.07)	3.51 (2.35, 5.22)
Two or more	4.91 (2.79, 8.64)	2.92 (2.01, 4.23)
Frequency of sex		
2 or more times a week	1.81 (0.90, 3.63)	0.48 (0.33, 0.69)
2–4 times a month	1.25 (0.62, 2.52)	0.74 (0.53, 1.03)
Once a month or less	Reference	Reference
Age group		
18–25	Reference	Reference
26–33	2.75 (1.59, 4.76)	1.52 (1.14, 2.04)
34–40	3.36 (1.74, 6.48)	1.99 (1.37, 2.89)
Relationship status		
Married	Reference	Reference
Living with partner	0.38 (0.19, 0.75)	0.31 (0.20, 0.46)
Dating	0.46 (0.27, 0.81)	0.39 (0.28, 0.54)
Not partnered	0.30 (0.13, 0.70)	0.60 (0.41, 0.89)
Education		
Some college (vs. no college)	0.90 (0.34, 2.41)	0.58 (0.34, 0.96)

Contraception method (N=490)		
Independent Variables	LARCs vs. Non-LARC prescription methods (N=83)	Non-Prescription or No Method vs. Non-LARC prescription methods (N=414)
Employment		
Employed (vs. not employed)	3.01 (1.47, 6.19)	0.83 (0.62, 1.10)

* Odds ratios from a multinomial logistic regression

Table 3.

Adjusted odds of contraceptive method choice compared with non-LARC prescription methods in sexually active women not intending pregnancy in the next year.

Independent Variable	Contraception method (N=479)	
	LARCs vs. Non-LARC prescription methods (N=81)	Non-Prescription or No Method vs. Non-LARC prescription methods (N=398)
BMI category (kg/m ²)		
Underweight/Normal (<25.0)	Reference	Reference
Overweight (25.0–30.0)	3.84 (1.85, 7.98)	1.47 (0.95, 2.28)
Obese (≥ 30.0)	2.82 (1.18, 6.72)	1.54 (0.94, 2.51)
Perceives overweight (vs. does not perceive overweight)	0.60 (0.29, 1.25)	1.12 (0.74, 1.68)
Trying to lose weight (vs. not trying to lose weight)	1.07 (0.59, 1.94)	0.63 (0.46, 0.87)
Future pregnancy intentions		
Not sure	3.96 (1.35, 11.66)	0.86 (0.51, 1.43)
Never	3.97 (1.26, 12.48)	0.51 (0.28, 0.93)
1 to 2 years	Reference	Reference
2 to 5 years	2.73 (0.91, 8.18)	0.78 (0.47, 1.30)
5 or more years	1.88 (0.49, 7.17)	0.74 (0.41, 1.33)
Prior live births		
None	Reference	Reference
One	3.24 (1.46, 7.16)	2.66 (1.64, 4.32)
Two or more	4.02 (1.79, 9.03)	2.57 (1.51, 4.37)
Frequency of sex		
2 or more times a week	1.66 (0.74, 3.72)	0.46 (0.30, 0.72)
2–4 times a month	0.94 (0.42, 2.08)	0.63 (0.42, 0.94)
Once a month or less	Reference	Reference
Age group		
18–25	Reference	Reference
26–33	1.35 (0.64, 2.85)	0.96 (0.63, 1.46)
34–40	0.83 (0.31, 2.17)	1.13 (0.64, 1.98)
Relationship status		
Married	Reference	Reference
Living with partner	0.60 (0.26, 1.36)	0.56 (0.35, 0.91)
Dating	1.18 (0.57, 2.46)	0.67 (0.42, 1.06)
Not partnered	0.93 (0.32, 2.67)	0.74 (0.43, 1.28)
Education		
Some college (vs. no college)	1.25 (0.39, 4.03)	0.57 (0.33, 1.00)

Contraception method (N=479)		
Independent Variable	LARCs vs. Non-LARC prescription methods (N=81)	Non-Prescription or No Method vs. Non-LARC prescription methods (N=398)
Employment		
Employed (vs. not employed)	1.89 (0.86, 4.15)	0.68 (0.48, 0.97)

* Odds ratios from a multinomial logistic regression adjusted for all other variables in the table