dom. For these methods, failure rates range from 11% among users of the implant to 72% among condom users. In fact, the failure rate for implants in this subgroup is so much higher than those derived from clinical trials that it may indicate pregnancies in the month of implant removal before another method was begun (since fertility returns immediately after removal). The relatively high failure rate associated with injectable use may reflect the experience of women who did not return for their next injection on schedule. Similarly, the very high failure rates for the pill and the condom undoubtedly reflect high levels of inconsistent or incorrect use of these methods, as well as condom use for STD protection rather than pregnancy prevention.

Overall, failure rates among users of long-acting reversible methods were very low in most subgroups—2% or less for implants and 4% or less for injectables during the first 12 months of use, except among low-income cohabiting users younger than 25. Rates of 3–8% for the pill were seen among all higher income married and unmarried women, as well as among older cohabiting women with a higher income and in the oldest group of married and unmarried lower income women.

In contrast, in some subgroups, 30% or more women became pregnant over the first 12 months of use. These include pill and condom users who were cohabiting and were younger than 20, as well as condom users who had a low income, were cohabiting and were 20–24 years of age. Failure rates among women using spermicides, withdrawal and periodic abstinence are at least 30% in 14 of the 19 age–union status subgroups of women with incomes less than 200% of poverty and with at least five method-use segments, as well as for two of five subgroups of higher income cohabiting women.

*Failure rates by age and union status. Table 3 summarizes the differences in failure rates by age and union status. These rates reflect the effects of age and union status, as well as differences among contraceptive users in each subgroup according to various characteristics.

Both age and union status have significant effects on contraceptive failure. Unmarried cohabiting women exhibit the highest overall failure rate (22%) during the first 12 months of use. Unmarried, noncohabiting women are much less likely to experience an unintended pregnancy while practicing contraception (14%), but are more likely to have done so than are married women (10%). Overall failure rates are highest for women younger than 20 (16%), and decrease steadily with age, to 9% for women aged 30 and older.

While age and union status are each significantly associated with the likelihood of contraceptive failure, their effects are interactive—i.e., the effect of age tends to vary by union status, and vice versa. For example, among adolescents and women in their early 20s, failure rates for unmarried, noncohabiting women are comparable to those for married women, and both groups are much less likely to experience contraceptive failure than are unmarried women cohabiting with a partner (12-month rates of 47% for cohabiting women younger than 20 and 25% for those aged 20–24). At ages 25–29, contraceptive failure is most likely among unmarried women, whether or not they are cohabiting, while for those aged 30 and older, failure rates are again highest among cohabiting women.

Across all union subgroups, however, women 30 or older have the most success using their contraceptive methods. There are only small differences in failure rates across age-groups less than 30 years of age for unmarried noncohabiting women, but steep decreases are seen for cohabiting women and somewhat smaller decreases are found for married women. Across all age-groups, failure rates for unmarried,