of preventing a pregnancy and believe that a particular method is most likely to lead to the best outcome. These needs and attitudes affect behavioral intention, which is the most important determinant of behavior.

Given this conceptualization of the problem, we confine our analysis to sexually active women who are not sterile, who are fecund and who are not pregnant or trying to become pregnant. These women constitute a potential pool of users of long-acting contraceptives. Three variables are available to measure the need for contraception: current parity (with higher parity positively associated with a need for effective contraception), intention to have another child in the future and a scale of pregnancy disutility.*

We use current contraceptive method as a proxy for method satisfaction, based on the assumption that behavior reveals preferences. If a woman continues to use a particular method, she must be relatively satisfied with it. The measures of attitudes toward the implant and the injectable were based on a six-item, five-point scale.† The respondents' intention to use the implant and the injectable was based on their self-reported likelihood of using either method in the next 12 months.

### Results

**Implant and Injectable Use**

In 1993, only 1.2% of all women in the sample reported currently using the implant; by 1995, this proportion had shrunk to 0.9%. (This proportion is the same as that seen in the 1995 NSFG among women aged 15–44 who reported the implant to be their current method.) Injectable use was also very low (1.2%) in our sample in 1995. It was slightly lower than the level reported in the 1995 NSFG (1.9%). When we confined the sample to women who were at risk of an unintended pregnancy, the proportions using the implant were 1.8% in 1993 and 1.7% in 1995, while injectable use was reported by 2.8% of at-risk women in 1995.

With such low rates of use, it is difficult to reliably distinguish the characteristics of users from those of nonusers. While our primary focus here is on nonusers and their reasons for not using the implant or the injectable, a brief description of the users is helpful for a full understanding of the nonusers’ perspectives.

In 1993, implant use appears to have been relatively more prevalent among women who were young (2.6%), who did not have a college degree (2.7%), who were formerly married (9.6%), who were Hispanic (2.8%), who were Catholic (3.2%), who had two or more children (5.6%) and who did not want any more children (4.0%). Between 1993 and 1995, implant use either declined or remained unchanged across most categories of individual characteristics. The main exception was among Hispanic women, whose reliance on the implant doubled (to 6.0%).

The use pattern for the injectable more or less mirrored that for the implant, with two exceptions. Unlike the implant, injectable use was more prevalent among black women (5.8%) and among women who had attended college but who did not have a college degree (5.6%). The injectable was also popular among formerly married women (11.5%), and the increase in injectable use among this group seems to have occurred at the expense of the implant, the use of which declined from 10% in 1993 to 4% in 1995. The injectable seems also to be relatively widely used among women who live in the West.

### Reasons for Nonuse

In both the 1993 and 1995 surveys, women were asked why they did not use the implant, and in 1995 why they did not use the injectable.† In 1993, the three major reasons for not having used the implant were women’s knowledge (i.e., not having heard of it or not knowing enough about it), satisfaction with their current method and fear of the method’s side effects (or other medical reasons).

Two years after the implant’s introduction, more than one-fourth of the women in our sample had not heard of it, but dissonant with her current contraceptive method (including no method), believe that switching to a long-acting method will be instrumental to attaining her goal.

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*In 1993, pregnancy disutility was measured on a five-point scale, ranging from “strongly agree” to “strongly disagree,” for the following five items: A pregnancy would bring joy to my life; a pregnancy would cause me emotional difficulties; a pregnancy would interfere with my education or my work; I would experience financial strain if I became pregnant; and a pregnancy would totally disrupt my life. The measure is the sum of the scale scores of the five items, ranging from –10 to +10. In 1995, the first item in the pregnancy disutility scale (a pregnancy would bring joy to my life) was dropped from the scale, and therefore the scale score for that year runs from –8 to +8.

†Attitudes toward the implant in 1993 were measured with six questions using a five-point scale, ranging from agreeing strongly with the first phrase to agreeing strongly with the second. The six questions ran as follows: “Would your using Norplant in the next 12 months be: good or bad? painful or not painful? difficult or easy? healthy or unhealthy? comfortable or uncomfortable? necessary or unnecessary? expensive or inexpensive?” Each item was coded so that the most positive response got five points, then the items were summed. We used the same approach to coding attitudes toward the injectable in 1995. However, in 1995, the scale contained the following seven questions: “Would your using Depo-Provera in the next 12 months be: good or bad? painful or not painful? difficult or easy? healthy or unhealthy? convenient or inconvenient? expensive or inexpensive? effective or ineffective?”

‡Women who were sterile, women who were pregnant or postpartum, women who were trying to become pregnant and women who were not sexually active were not asked these questions.