and another 5% said they did not have enough information about it (Table 2). By 1995, the proportion reporting “lack of knowledge” had declined to 9%.* Both in 1993 and in 1995, more than one in four women said they were not using the implant because they were satisfied with the method they were using and did not see a need to switch. Fear of the implant’s side effects was the third most frequently reported reason in 1993. The proportion of women citing “fear” as their main reason for not using the implant had nearly doubled by 1995, however, undoubtedly as a result of the negative publicity it had received in the print and electronic media between the two surveys. Surprisingly, despite the rather high up-front cost of the implant, only a small proportion of women offered cost as a reason for not using it.

The reasons women gave for not using the injectable are not very different from the reasons they gave for not using the implant. In 1995, more than one-third of the women in our sample either had not heard of the injectable method or did not know enough about it to consider it for use. Roughly one-fifth of the women were satisfied with their current method and did not consider switching methods. Fear of the method’s side effects was the third most frequently cited reason for not using the injectable (mentioned by 17%); this was only slightly lower than the percentage who gave “fear” as their reason for not using the implant.

Among women in our sample, reports of side effects among the small group of users of these two methods were commonplace (data not shown). Implant users complained of irregular periods, heavier bleeding, mood swings and depression. Women who reported side effects were also highly likely to report intending to have the implant removed before its five-year period of effectiveness was over: Roughly one-half of the users who reported side effects in 1993 said they were likely to have the implant removed within the next 12 months.

Women using the injectable were even more likely than implant users to report side effects, although they were less likely to describe them as major. Among the side effects that they cited were irregular periods, weight gain and amenorrhea. In contrast to implant users, however, these women were unlikely to report any intention to discontinue using the injectable: Fewer than 5% of users who reported side effects said they would stop using the injectable within the next year. As one would expect, the few former users of these methods in our sample were more likely to complain about the side effects than were current users.

The data in Table 2 suggest that there is ample room to increase use of these methods, if potential users were properly targeted and if interventions were designed to increase women’s knowledge and to dispel their misperceptions about these methods. While most women in the sample can be considered potential candidates for future use of these methods, we focused on three groups in particular: those who professed a lack of knowledge of the methods; those who reported being satisfied with their current contraceptive method (including those who were not using any method at that time); and those who were afraid of the methods’ side effects.

We performed a multivariate analysis of the effect of women’s individual characteristics on their likelihood of having said in 1995 that lack of knowledge, satisfaction with their current method or fear of side effects were their reason for not having used the implant (Table 3, page 180).† Older women (those aged 30 or older) and those with a college education were half as likely as younger women and women with no college education to give fear of side effects as their main reason for not using the implant. Single women, women who had one or more children and women who were using a barrier method were 2–3 times as likely as married women, childless women and those using a medical method to cite fear of the implant’s side effects as the main reason for not using it. Women who were using no method were marginally (p<.10) more likely to give fear as a reason for not using the implant than were users of a medical method.

In addition to the main effects, two significant interactions influenced the model predicting fear of side effects as a reason for not using the implant: an interaction between education and parity, and one between marital status and current contraceptive method. Women who had no college education and no children were significantly more likely to fear the side effects of the implant than were women who had no college education but who had one or more children. Similarly, married women who were using a barrier method were more likely to cite fear as a reason for not using the implant than were married women who were using a medical method.

Satisfaction with their current method was an important reason why women were not using the implant in 1995; this reason was significantly more likely to be reported by women who used medically prescribed methods than by users of any other method (including no method). Married women, women with a college degree, women who had no children and women who did not want any more children were also significantly more likely than their comparison groups to report satisfaction with their current method as the primary reason why they were not using an implant.

There were also strong interactions between education and parity and between marital status and contraceptive method in the model of satisfaction. While barrier method users were less likely to be satisfied with their current method than were users of medical methods, married women who used a barrier method were

*In 1995, unlike in 1993, women were not asked if they had ever heard of the implant; however, women who gave it as a reason for not using the implant are included in the “lack of knowledge” group.

†We present results that are significant at p<.10 when the coefficient (or the odds ratio) is considerably large and stable. While this is not the common practice, there are two reasons for retaining these in the models. First, doing so has a reinforcing effect that either enhances the effects of other variables or reduces the suppressing effects of other variables in the model. Second, we believe that with a larger sample, these statistics would most likely have attained statistical significance at more stringent levels of probability. Moreover, we feel it is important not to ignore such statistics when available evidence is sufficiently convincing to reject a chance occurrence (Type I error).