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Who has second-trimester abortions in the United States?

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Abstract

Background: Little is known about the characteristics of second-trimester abortion patients.

Study design: Data come from a national sample of 9,493 women obtaining abortions in 2008. Chi-square statistics and logistic regression were used to examine demographic characteristics of women having abortions at 13 or more weeks since last menstrual period (LMP) and women having abortions at 13-15 weeks LMP compared to 16+ weeks LMP.

Results: In 2008, 10.3% of abortions were 13 weeks LMP or later, including 4.0% at 16+ weeks. Groups most likely to have abortions at 13 weeks or later included black women, women with less education, those using health insurance to pay for the procedure and those who had experienced 3 or more disruptive events in the last year. Groups more likely to have an abortion at 16 weeks or later included black women, higher income women and those paying with health insurance.

Conclusions: Black women and those with less education would most benefit from increased availability of first-trimester abortion services.

1. Introduction

The overwhelming majority of abortions in the United States, 88% in 2006, are in the first trimester, occurring at or before the 12th week of pregnancy [1]. Second-trimester abortions cost more than first-trimester procedures [2], pose more health risks [3], are offered by fewer providers [2] and, in turn, are harder for women to access. But little is known about the population of women who have second-trimester abortions.

To date, the only national source of information about the characteristics of second-trimester abortion patients is the Centers for Disease Control and Prevention (CDC), and demographic breakdowns are limited to age and race and ethnicity. Reports suggest that a higher proportion of teen abortions than adult abortions are in the second-trimester. In 2006, 16% of abortions to adolescents aged 15-19 were at 13 weeks or later, compared to 12% of all patients [1]. Black and Hispanic women were slightly more likely to have second-trimester abortions, with 13% and 12% occurring at 13 weeks or later compared to 10% for white women. Abortions within the second trimester are clustered at earlier gestations; of the 12% of abortions at 13 weeks or later in 2006, 57% were at 13-15 weeks and 31% at 16-20 weeks and 11% at 21 weeks or later [1]. Within second-trimester abortion patients, the proportion of adolescents aged 15-19 obtaining abortions at 16 weeks or later, 46%, was slightly higher than that for women aged 20 and older (43%). The proportion of abortions at 16 weeks or later, 43%, was the same for black, white and Hispanic women. In addition to providing only limited information, the Abortion Surveillance Reports published by the CDC are incomplete. For example, California, which accounted for 18% of all abortions in the United States in 2008 [2], is not included.

This study provides the first comprehensive national profile of second-trimester abortion patients in the United States. Using data from a national sample of 9,493 women obtaining abortions in 2008, we examine the characteristics of women having abortions at 13 weeks or later,

and, within second trimester abortion patients, we compare abortion patients at 16 weeks or later to those obtaining terminations at 13-15 weeks.

2. Methods

We rely on data from our 2008 Abortion Patient Survey (APS). Several studies using these data have been evaluated and published [4-6]. However, because it is a unique dataset, we provide somewhat detailed information about the data collection techniques.

2.1. Study design

Our study design was intended to generate a nationally representative sample of abortion patients. In addition to assessing the characteristics of women obtaining abortions, the sample needed to be large enough to measure the number of abortions resulting from method-specific contraceptive failures. These estimates can be used to calculate contraceptive failure rates among all U.S. women [7], corrected for the number of method failures ending in abortion, which are underreported in the data needed for these rates, the National Survey of Family Growth [8]. In 2008, a sample of 107 facilities was randomly selected from the universe of all U.S. hospitals, clinics and physician's offices where at least 25 abortions were known to be performed in 2005 [9]. The universe was stratified by provider type (hospital or non-hospital) and abortion caseload, and then listed by census region and state within each stratum. Clinics with large caseloads were over-sampled to obtain adequate representation of the variety of facilities in the sample. If a facility declined to participate or did not obtain usable questionnaires from at least half of the target population, it was replaced by the next facility in its stratum. Facilities distributed the questionnaire, available in both English and Spanish, to all women who obtained an abortion during the fielding period; each facility was assigned a sampling period that was inversely proportional to its probability of being selected; for example, surveys were administered for 12 weeks at smaller facilities and two weeks at larger facilities. We were able to obtain data from abortion patients at 95

facilities. Of the 12 facilities that could not be replaced, 7 were in the smallest stratum (30-399 abortions in 2005), but hospital and non-hospital facilities were equally likely to participate.

Participating facilities reported performing 12,866 abortions during the sampling period, which extended from April 2008 to May 2009; usable data were collected from 9,493 women, for a response rate of 74%. Facility staff supplied information about age, race, ethnicity, insurance coverage and method of payment for 1,162 of the women who did not complete the questionnaire. No information was available for the remaining 2,210 women.

We adopted a three-stage weighting process to correct for any bias produced by deviation from the original sampling plan and for nonresponse. First, individual weights were developed to adjust for the demographic characteristics of the 1,162 nonrespondents for whom the facility staff provided information. Second, facility-level weights adjusted for the other 2,210 nonrespondents for whom no demographic data were available. Third, stratum weights were constructed to correct for departures from the number of facilities to be sampled in each grouping by caseload and provider type. Because women of the same race and ethnicity tend to be clustered within clinics, the confidence intervals for these characteristics were larger. The data are considered to be representative of abortion patients nationally.

2.2. Dependent variables

Our analysis focuses on three gestational groups: second-trimester abortions, defined as those occurring at 13 weeks or later, and, within second-trimester abortions, those occurring at 13-15 weeks versus 16 weeks or later. Several questionnaire items were used to calculate gestational age including first day of last menstrual period (LMP), number of weeks pregnant (both reported by respondents) and date the survey was filled out. The difference between LMP and survey date was converted to weeks pregnant; gestational weeks were truncated and, for example, 8 $^{6}/_{7}$ weeks was truncated to 8 weeks. Twenty-two percent of women did not provide, or indicated they did not know, the date of their last period. For most of these women (18% of all respondents), we were

able to use their responses on numbers of weeks pregnant. The remaining 4% of women (n=397) for whom gestational age was not available were excluded from the analysis.

Some women, particularly those who had never been pregnant, may have reported weeks pregnant in reference to fertilization as opposed to LMP, which would have resulted in an over-representation of abortions at earlier gestations. To address this concern, we compared the (weighted) gestational distribution of abortions on the 2008 APS to those in the 2006 CDC Abortion Surveillance Report [1]. The distribution by gestation between the two data sources is largely comparable (Table 1). Some 4.0% of abortion patients reported that they were 16 or more weeks pregnant compared to 4.8% of those reported to state health departments, and it is possible that abortions at 16 weeks and later are underrepresented on the APS.

2.3. Independent variables

We identify associations between gestation and a number of characteristics. In addition to the standard demographic characteristics of age, race/ethnicity, marriage and cohabitation status, education, poverty status, prior births and prior abortions, we examine associations between second-trimester abortion and source of payment for abortion services, intendedness of the pregnancy and exposure to intimate partner violence (IPV).

Women were asked whether they used private health insurance, or Medicaid, relied on financial assistance (i.e., abortion funds or discounted fees) or paid out of pocket for the abortion. Nationally, 20% of all abortions were paid for by Medicaid in 2008 [10], and 95% of these procedures were to women residing in states that use their own funds to pay for abortion services. (This means that 5% of procedures paid for by Medicaid were likely for reasons of life endangerment, rape or incest.) In these states, the program essentially serves the same role as private health insurance, and we collapsed women who used either Medicaid or private health insurance to pay for their abortion into the same category. We also generated models that examined Medicaid and private health insurance separately and found that both statuses had

similar impacts, or associations, with the outcomes. Private health insurance includes women who reported that they would be reimbursed by their insurance company as well those who indicated the facility accepted their private insurance plan. The 228 women who did not provide information about payment method were excluded from relevant analyses.

The 2008 APS asked women whether they had experienced any of 11 potentially disruptive life events in the last 12 months, including falling behind on rent or mortgage, unemployment of a month or more, separating from a partner, having a baby, moving two or more times, having a serious medical problem, having a friend or family member with a serious medical problem, death of a close friend, being the victim of robbery or a burglary or having a partner incarcerated. We expected that disruptions could both delay access to abortion services or lead some women to change their mind about the pregnancy after the first trimester, and we measure whether women who reported experiencing 0, 1, 2 or 3 or more disruptive events in the past year were more likely to have second-trimester abortions.

Women in abusive relationships may have had to hide the abortion or had partners who attempted to prevent them from obtaining abortions [11, 12], resulting in delays. We measured IPV using two items: “Has he [the man with whom you became pregnant] ever hit, slapped, kicked or otherwise physically hurt you?” and, “Has he ever forced you to do anything sexual when you didn’t want to?” The 212 respondents who did not answer these questions were excluded from relevant analyses.

At least a small number of second-trimester abortions are for reasons of fetal or maternal indications, and many of these pregnancies are presumably wanted and intended. Women who reported that their pregnancy was “at the right time” or “later than I wanted” were considered to have intended pregnancies and were compared to those who indicated the pregnancy was “too soon,” that they “didn’t care” about the timing of the pregnancy or that they had not wanted to have any (more) children.

2.4. Analytic strategy

We first examine characteristics associated with second-trimester abortion patients (13 or more weeks LMP) compared to women obtaining abortions in the first trimester. Chi-square tests were used to assess for bivariate associations, and logistic regression was used for the multivariate analysis. We next limit our analysis to abortions within the second trimester and use chi-square tests and logistic regression to evaluate patient characteristics associated with abortions at 16 or more weeks LMP compared to those at 13-15 weeks LMP. Two logistic regression models were preferable to a single ordinal logistic regression model because we expected, and the analyses confirmed, that the effects of some of the independent variables were not consistent across the two comparisons. All analyses rely on weighted data and are adjusted for the complex sampling design of the survey.

3. Results

3.1. First- vs. second-trimester abortion patients

A number of groups were overrepresented among the 10.3% of women obtaining abortions at 13 weeks or later (Table 2). Age was inversely associated with having an abortion in the second trimester; patients under age 18 (14.0%) and older adolescents aged 18-19 (13.8%) had the highest proportion of abortions at 13 weeks and later, and this decreased as age increased (p=.001). While minors accounted for 6.5% of all abortion patients in 2008, they represented 8.9% of second-trimester abortions, and comparable figures for 18-19 year olds were 10.8% and 14.6% (see Appendix Table 1). Among black abortion patients, 13.4% terminated pregnancies at 13 weeks or later, and this was a higher proportion than among women in the three other racial and ethnic groups we analyzed (p<.001, Table 2).

Second trimester abortions were inversely associated with education and poverty status. Among women aged 20 and older, those without a high school degree had the highest proportion of abortions at 13 weeks and later (13.1%) while women with college degrees had the lowest (5.8%;

p<.001). The proportion of second trimester abortion patients was highest for poor women (12.6%; p<.001). Both of these variables reflect a "dose-response" relationship, where higher education or income level was associated with a lower likelihood of having a second-trimester abortion.

Almost one-third of abortion patients (32.2%, see Appendix Table 1) relied on health insurance to pay for the procedure; 13.6% of those were obtaining second-trimester abortions, and this was higher than among women who paid out of pocket (8.2%; p=.001).

Several circumstances were associated with second-trimester abortions. The proportion of abortions in the second trimester increased with exposure to more disruptions; for example, it was 14.8% among those exposed to three or more events compared to 8.9% among those who reported none (p<.001). Women who had been exposed to IPV by the man who got them pregnant were more likely to be 13 or more weeks pregnant (13.7%) compared to other women (10.0%; p= 0.004). Though the proportion of abortions in the second trimester was higher among women who reported that the pregnancy was intended (13.5% compared to 10.1%), this association was not statistically significant in the bivariate analysis (p=.126).

Many of the above associations were maintained in the multivariate model, though the associations were not particularly strong, and many of the lower and upper bounds of the confidence intervals approached 1. Older adolescents (aged 18-19) were significantly more likely than 20-24 year olds to be obtaining a second-trimester abortion (odds ratio 1.36, 95% confidence interval 1.05-1.75); the association for younger adolescents, while positive, was no longer significant. We considered that some 17-year old-teens who found out they were pregnant within a few weeks or months of their 18th birthday may have accounted for this pattern and examined 18 and 19 year olds separately. But, in fact, it was 19-year-olds in particular who were significantly more likely than 20-24-year-olds to obtain an abortion at 13 weeks or later (odds ratio 1.44, 95% confidence interval 1.04-1.99, not shown).

Black women were more likely than white women to be obtaining a second-trimester abortion by a factor of 1.50 (95% confidence interval 1.20-1.87). Relative to women with some college or an associate's degree, those with less education were more likely to have an abortion at 13 weeks or later while college graduates were less likely to do so (odds ratio 0.70, 95% confidence interval 0.51-0.96). Women who used health insurance to pay for the procedure were more likely than women who paid out of pocket to be obtaining an abortion at 13 weeks or later (odds ratio 1.60, 95% confidence interval 1.21-2.10) as were women who experienced 3 or more disruptive events in the last year (odds ratio 1.52, 95% confidence interval 1.14-2.04). Once other characteristics were taken into account, women exposed to IPV were no more or less likely to be obtaining a second-trimester abortion than those who were not exposed, but women who reported that the pregnancy was intended were more likely to be doing so (odds ratio 1.63, 95% confidence interval 1.04-2.55).

3.2. Patients at 13-15 weeks LMP vs 16+weeks

The 4.0% of all women obtaining abortion at 16 weeks or later accounted for 39.2% of all second-trimester abortions in our sample (Table 3). Only two characteristics were associated with gestation in the bivariate analyses. The proportion of abortions at 16+ weeks was higher among those using health insurance to pay for the procedure (49.5%) relative to those who relied on financial assistance or paid out of pocket ($p<.001$). Slightly more than half of women who had an intended pregnancy were having an abortion at 16+ weeks (52.5%) compared to 38.3% who did not indicate that the pregnancy was intended ($p=.018$); notably, however, only 7.9% of abortions at 16 weeks or later were intended (Appendix Table 1).

Additional associations emerged in the logistic regression models. Once income and other factors were taken into account, black women were almost twice as likely as white women to have obtained an abortion at 16+ weeks (odds ratio 1.90, 95% confidence interval 1.18-3.06) than at 13–15 weeks. Women with family incomes 200+% of poverty were more likely than poor women to be

obtaining abortions at 16+ weeks (odds ratio 1.57, 95% confidence interval 1.06-2.32), and women using their health insurance to pay for the procedure were more than twice as likely to have an abortion at 16+ weeks than were women paying out of pocket (odds ratio 2.58, 95% confidence interval 1.66-4.01). The association between intendedness and gestation was only marginally significant likely due to the small number of women in this group (N=54). With the possible exception of health insurance, the associations, as expressed in the odds ratios, were relatively weak.

4. Discussion

Our analysis shows that black women and adolescents were overrepresented among second trimester abortion patients, and these findings correspond with information compiled by the CDC [1]. Our multivariate analysis suggests that it is adolescents aged 18-19, in particular, that are more likely to have second-trimester abortions.

Women with less education were more likely to obtain an abortion at 13 weeks or later, even after controlling for characteristics such as income and age. This association could be due to several conditions. Less educated patients may have had less knowledge about reproduction and taken longer to recognize they were pregnant. Similarly, they may have had lower levels of health literacy and a harder time figuring out options, tracking down information about abortion or finding a provider. Finally, even though we controlled for income and life circumstances, lower levels of education in this context could still serve as proxy for financial difficulties such as obtaining money to pay for an abortion during the first trimester.

Several dynamics could contribute to the association between health insurance and second-trimester abortions. Women who lack health insurance, or who have insurance that does not cover abortion, may be unable to afford a second-trimester procedure. Most women who have private health insurance do not use it to pay for abortion services [10, 13], perhaps due to concerns about confidentiality and lack of knowledge about whether abortion services are covered [13]. However,

because second-trimester abortions cost more, women may be motivated to seek out information about coverage as well as decide that confidentiality is a secondary concern. As of June 2011, 15 states had passed laws that would limit abortion coverage in health plans that will be offered in the upcoming health exchanges; eight of these states have limited abortion coverage more broadly in all private health plans they regulate. These restrictions, especially if adopted by more states, may prevent some women from obtaining second-trimester abortions, and the characteristics of this population may change in the coming years.

Women who experienced multiple disruptive events in the last year were more likely to be obtaining abortions at 13 weeks or later. It is possible that these events led to delays in recognizing the pregnancy as well as delays in accessing services. Alternately, some women who initially decided to carry a pregnancy to term may have changed their minds when confronted by events such as losing a job or separating from a partner.

Only a small proportion of abortion patients indicated that their pregnancies were intended, but these women were more likely to be obtaining second-trimester abortions. It is possible that many of these women had developed health problems or had been diagnosed with a fetal anomaly only after the pregnancy was in the second trimester.

Within the population of second-trimester abortion patients, a slightly different set of characteristics and circumstances were associated with abortions at 16 weeks or later. Age and education were not associated with abortions at later gestations, though black women were more likely than white women to have abortions at 16 weeks or later. Women with incomes 200+% of poverty actually had a relatively higher risk of having an abortion at 16+ weeks compared to poor women, as did those who used insurance to pay for the procedure. The higher cost and decreased availability of abortion services at later gestations may make them less accessible to poor women and those paying out of pocket.

We are aware that our study has several potential shortcomings. Our estimate of the proportion of abortions at 16 weeks LMP and later in 2008 is slightly lower than that published by the CDC 2006, and it is possible the these abortions are underrepresented in our dataset. While only 4% of all abortions in 2008 occurred in hospitals [2], we expect that a majority of these procedures consisted of abortions late in the second trimester, most likely for fetal and maternal indications. Staff at facilities that performed these procedures may have been reluctant to ask women in these situations to fill out a survey. As a result, our findings regarding the characteristics of abortion patients at 16 weeks and later may be less precise than those of abortions at earlier gestations. Alternatively, the CDC reports, which are incomplete, could under-represent abortions at earlier gestations.

The overwhelming majority of second-trimester patients would have preferred to have had their abortion earlier [14], and our findings suggest that black women and those with less education would most benefit from increased access to early abortion services. While expanded services could reduce the number of second trimester abortions, the need cannot be eliminated. Some women having abortions in the second trimester take longer to recognize they are pregnant and to decide that they are going to have an abortion relative to first-trimester abortion patients [14, 15]. We expect that these factors contributed to associations between education and second - trimester abortion in our study. And diagnoses of fetal anomaly and maternal health indications often do not occur until the second trimester.

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Table 1. Gestations of abortions on the 2008 Abortion Patient Survey and 2006 CDC Abortion Surveillance Report

	2008 APS		2006 CDC	
	Unweighted N	%	Number	%
Weeks LMP				
≤12	8163	89.7	574497	88.7
13-15	570	6.2	41859	6.5
≥16	363	4.0	31264	4.8
Total	9096	100.0	647620	100.0

Table 2. Distribution of abortions >12 weeks LMP by selected characteristics and logistic regression models predicting abortions >12 weeks LMP

	% distribution of abortions >12 weeks		Odds ratios		
	(N=933)	p	(N=8729)	95% CI	p
All abortions	10.3				
Age group		0.001			
<18	14.0		1.22	0.83 - 1.80	0.307
18-19	13.8		1.36	1.05 - 1.75	0.021
20-24	10.0		1.00	(reference)	
25-29	9.6		1.02	0.82 - 1.27	0.846
30-34	8.8		1.00	0.76 - 1.31	0.995
35+	8.8		1.04	0.76 - 1.43	0.803
Union status		0.029			
Married	8.1		0.90	0.66 - 1.22	0.481
Cohabiting, not married	11.4		1.09	0.88 - 1.36	0.411
Never married, not cohabiting	10.7		1.00	(reference)	
Previously married, not cohabiting	8.7		0.87	0.64 - 1.17	0.340
Race and ethnicity		<.001			
Non-Hispanic white	8.5		1.00	(reference)	
Non-Hispanic black	13.4		1.50	1.20 - 1.87	<.001
Non-Hispanic other	8.2		0.90	0.62 - 1.32	0.597
Hispanic	9.9		1.00	0.76 - 1.31	0.997
Prior births		0.187			
0	9.5		1.00	(reference)	
1	10.8		1.07	0.89 - 1.30	0.470
2 or more	10.8		1.12	0.87 - 1.45	0.366
Prior abortions		0.940			
0	10.3		1.00	(reference)	
1 or more	10.2		0.94	0.78 - 1.13	0.509
Education†		<.001			
<12th grade	13.1		1.42	1.07 - 1.89	0.017
HS grad or GED	11.2		1.23	1.04 - 1.47	0.018
Some college or associate degree	9.1		1.00	(reference)	
College graduate or above	5.8		0.70	0.51 - 0.96	0.027
Poverty status		<.001			
<100% poverty	12.6		1.00	(reference)	
100-199% poverty	9.5		0.86	0.72 - 1.04	0.114
200+% poverty	7.7		0.85	0.69 - 1.04	0.115
Payment method		0.001			
Private insurance or Medicaid	13.6		1.60	1.21 - 2.10	0.001
Financial assistance	10.6		1.04	0.72 - 1.52	0.821
Out of pocket	8.2		1.00	(reference)	
N of disruptive events		<.001			
0	8.9		1.00	(reference)	
1	10.2		1.05	0.86 - 1.28	0.639
2	11.0		1.19	0.91 - 1.56	0.191
3+	14.8		1.52	1.14 - 2.04	0.005
Intimate partner violence		0.004			
Exposed to physical abuse or coerced se	13.7		1.26	0.95 - 1.68	0.103
Neither	10.0		1.00	(reference)	
Pregnancy intention		0.126			
Unintended/ambivalent	10.1		1.00	(reference)	
Intended	13.5		1.63	1.04 - 2.55	0.032

†Bivariate analysis limited to women aged 20 and older.
Chi-square statistics were used to test bivariate associations.

Table 3. Proportion of second-trimester abortions at 16+ weeks LMP by selected characteristics and logistic regression models predicting abortions at 16+ weeks LMP

	% abortions 16+ weeks among second- trimester procedures		Odds ratios		
	(N=363)	p	(N=890)	95% CI	p
Second trimester abortions	39.2				
Age group		0.807			
<18	34.9		0.70	0.41 - 1.21	0.198
18-19	36.9		0.77	0.45 - 1.30	0.321
20-24	39.5		1.00	(reference)	
25-29	38.0		0.88	0.55 - 1.41	0.591
30-34	45.0		1.12	0.64 - 1.99	0.683
35+	41.4		0.82	0.44 - 1.53	0.530
Union status		0.780			
Married	43.2		1.08	0.50 - 2.33	0.846
Cohabiting, not married	39.9		1.11	0.59 - 2.10	0.744
Never married, not cohabiting	37.2		1.00	(reference)	
Previously married, not cohabiting	41.4		1.53	0.82 - 2.89	0.181
Race and ethnicity		0.060			
Non-Hispanic white	30.9		1.00	(reference)	
Non-Hispanic black	42.8		1.90	1.18 - 3.06	0.008
Non-Hispanic other	46.4		1.59	0.82 - 3.07	0.165
Hispanic	41.4		1.57	0.99 - 2.50	0.057
Prior births		0.870			
0	38.1		1.00	(reference)	
1	39.3		0.97	0.67 - 1.39	0.851
2 or more	40.1		0.98	0.61 - 1.58	0.938
Prior abortions		0.925			
0	39.4		1.00	(reference)	
1 or more	38.9		0.86	0.62 - 1.20	0.378
Education†		0.378			
<12th grade	40.9		1.02	0.67 - 1.57	0.912
HS grad or GED	37.0		0.82	0.61 - 1.12	0.205
Some college or associate degree	40.1		1.00	(reference)	
College graduate or above	47.7		1.44	0.77 - 2.69	0.256
Poverty status		0.136			
<100% poverty	37.3		1.00	(reference)	
100-199% poverty	37.2		1.25	0.89 - 1.76	0.202
200+% poverty	45.3		1.57	1.06 - 2.32	0.025
Payment method		<.001			
Private insurance or Medicaid	49.5		2.58	1.66 - 4.01	<.001
Financial assistance	33.8		1.44	0.82 - 2.52	0.200
Out of pocket	30.2		1.00	(reference)	
N of disruptive events		0.357			
0	41.7		1.00	(reference)	
1	38.3		0.83	0.58 - 1.17	0.281
2	40.5		0.93	0.60 - 1.45	0.758
3+	33.9		0.71	0.46 - 1.11	0.135
Intimate partner violence		0.920			
Exposed to physical abuse or coerced sex	39.1		1.23	0.79 - 1.91	0.354
Neither	39.6		1.00	(reference)	
Pregnancy intention		0.018			
Unintended/ambivalent	38.3		1.00	(reference)	
Intended	52.5		1.69	0.96 - 2.97	0.068

†Bivariate analysis limited to women aged 20 and older.

Chi-square statistics were used to test bivariate associations.

Appendix Table 1. Characteristics of abortion patients by gestational groups, 2008 Abortion Patient Survey

	All women (N=9096)	≤12 weeks (N=8153)	>12 weeks Total (N=933)	13-15 (N=570)	≥16 weeks (N=363)
Total abortions	100	100	100	100	100
Variables					
Age group					
<18	6.5	6.2	8.9	9.5	7.9
18-19	10.8	10.4	14.6	15.2	13.7
20-24	33.3	33.4	32.3	32.1	32.6
25-29	24.6	24.8	23.0	23.5	22.5
30-34	13.5	13.7	11.5	10.4	13.2
35+	11.3	11.4	9.8	9.3	10.1
Union status					
Married	14.8	15.2	11.7	10.9	12.9
Cohabiting, not married	29.2	28.9	32.3	31.9	32.9
Never married, not cohabiting	45.0	44.8	46.7	48.2	44.4
Previously married, not cohabiting	11.0	11.2	9.3	9.0	9.9
Race and ethnicity					
Non-Hispanic white	36.3	37.0	29.9	34.0	23.6
Non-Hispanic black	29.7	28.7	38.8	36.5	42.5
Non-Hispanic other	9.3	9.5	7.4	6.5	8.8
Hispanic	24.7	24.8	23.9	22.9	25.2
Prior births					
0	39.0	39.3	35.9	36.5	34.9
1	26.4	26.3	27.7	27.7	27.8
2 or more	34.6	34.4	36.4	35.8	37.3
Prior abortions					
0	50.3	50.3	50.4	50.3	50.7
1 or more	49.7	49.7	49.6	49.8	49.3
Education†					
<12th grade	12.2	11.7	16.9	16.6	17.1
HS grad or GED	28.2	27.6	33.1	34.9	30.4
Some college or associate degree	39.6	39.7	38.0	37.9	38.1
College graduate or above	20.0	20.9	12.0	10.5	14.3
Poverty status					
<100% poverty	42.3	41.1	52.0	53.6	49.6
100-199% poverty	26.4	26.6	24.4	25.2	23.3
200+% poverty	31.3	32.2	23.6	21.2	27.1
Payment method					
Private insurance or Medicaid	32.2	31.0	42.7	35.2	54.3
Financial assistance	13.1	13.0	13.5	14.6	11.6
Out of pocket	54.8	56.0	43.9	50.2	34.1
N of disruptive events					
0	42.2	42.8	36.4	34.9	38.9
1	32.2	32.2	32.0	32.4	31.2
2	14.4	14.3	15.4	15.1	15.9
3+	11.2	10.7	16.2	17.6	14.0
Intimate partner violence					
Exposed to physical abuse or coerced sex	6.9	6.7	9.2	9.3	8.9
Neither	93.1	93.3	90.8	90.9	91.1
Pregnancy intention					
Unintended/ambivalent	95.5	95.7	94.1	95.4	92.1
Intended	4.5	4.3	5.9	4.6	7.9

†Among women aged 20 and older.