



Original research article

Timing of steps and reasons for delays in obtaining abortions in the United States

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Received 9 November 2005; revised 7 April 2006; accepted 10 April 2006

Abstract

Objective: We studied the steps in the process of obtaining abortions and women's reported delays in order to help understand difficulties in accessing abortion services.

Methods: In 2004, a structured survey was completed by 1209 abortion patients at 11 large providers, and in-depth interviews were conducted with 38 women at four sites.

Results: The median time from the last menstrual period to suspecting pregnancy was 33 days; the median time from suspecting pregnancy to confirming the pregnancy was 4 days; the median time from confirming the pregnancy to deciding to have an abortion was 0 day; the median time from deciding to have an abortion to first attempting to obtain abortion services was 2 days; and the median time from first attempting to obtain abortion services to obtaining the abortion was 7 days. Minors took a week longer to suspect pregnancy than adults did. Fifty-eight percent of women reported that they would have liked to have had the abortion earlier. The most common reasons for delay were that it took a long time to make arrangements (59%), to decide (39%) and to find out about the pregnancy (36%). Poor women were about twice as likely to be delayed by difficulties in making arrangements.

Conclusions: Financial limitations and lack of knowledge about pregnancy may make it more difficult for some women to obtain early abortion.

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Keywords: Delay; Abortion; United States; Timing; Process

1. Introduction

Over the past decade, the timing of abortion in the United States has been shifting to early in pregnancy. Due, in part, to access to medical abortion, which can be used during the first 9 weeks of pregnancy, and improved techniques for early surgical abortion, the proportion of abortions that were performed in the first 8 weeks' gestation increased from 52% to 59% between 1991 and 2001 [1]. Even so, about 11% of abortions took place at 13 weeks' gestation or later in 2001 [2]. Abortion, while in general a very safe procedure, has a higher medical risk when undergone later in pregnancy; compared to an abortion at 8 weeks' gestation or earlier, the relative risk increases exponentially at higher gestations [3]. In addition, earlier abortions are less of a financial burden for a woman (in

2001, the median charge for an abortion was US\$370 at 10 weeks' gestation, US\$650 at 14 weeks' gestation and US\$1042 at 20 weeks' gestation) [4]. An earlier abortion is also less stigmatized both socially and legally. Public opinion polls indicate a lower level of approval of second-trimester abortions [5], and the Supreme Court declared in 2000 that the legislation intended to prohibit so-called "partial-birth" abortions could be interpreted to cover a range of second-trimester abortion procedures [6]. The impact of such a prohibition contrasts with that of laws that are in place in 23 states requiring women to wait for a specified amount of time between receiving counseling and obtaining an abortion [7]; such laws have been shown to lead to a shift towards the performance of abortions later in pregnancy [8]. In addition, the later is a woman's gestation, the fewer are the providers to perform the procedure [4], which can lead to additional delays.

The gestational age at which women typically have abortions varies by several demographic characteristics, and there is some evidence that these variations are due to

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Table 1

The percentage of women (who would have preferred to have had their abortion earlier) reporting specific reasons for the delay in obtaining an abortion, 2004

Reason	All women	First-trimester patients	Second-trimester patients
It took a long time to make arrangements	59	56	67*
I needed time to raise money to have the abortion	26	23	36*
I couldn't get an earlier appointment	18	19	13
I didn't know where to get an abortion	12	10	16
I couldn't find a place to have an abortion near where I live, so I had to arrange for transportation to get here	7	6	9
I needed time to notify or to get consent from my parents	1	1	1
There is a legally required waiting period where I live	2	2	1
I needed time to go to court to get permission to have an abortion	0	0	0
Some other difficulty in making arrangements delayed me	14	13	18
It took a long time to decide	39	35	50
It was a difficult decision to make	27	25	33
I was worried about the cost	12	10	18*
It took time to talk to my husband/partner	11	10	15
I had religious or moral concerns	10	8	15
It took time to talk to my parents	4	3	7*
Some other difficulty in deciding delayed me	4	2	7
It took some time before I knew I was pregnant or how far along I was	36	36	36
I was waiting for my relationship with my husband/partner to change	7	5	9
I was afraid to tell my husband/partner or my parents that I was pregnant	7	6	9
Someone I am close to put pressure on me not to have an abortion	5	5	5
The clinic/doctor made me wait to have an abortion	5	6	1
Something in my life changed since I became pregnant	4	4	5
I didn't know that I could get an abortion	2	2	3
I didn't think that it was important to have it earlier	2	2	2
I found out late in the pregnancy that the fetus has a defect or is not normal	0.2	0	1
I was delayed for some other reason	6	5	11
<i>n</i>	615	441	145

* Significant difference compared to first-trimester women ($p < .05$).

differential access to services. Compared to adults, for example, adolescent women are more likely to have later abortions, and black women are slightly more likely than women of other racial and ethnic groups to have later abortions [9]. Lower-income women are also more likely to have later abortions [10]. Documenting inequities in women's ability to obtain an abortion without delay and understanding reasons for delays and which women are more likely to obtain abortions later than they would have liked is a way to assess why these disparities exist and to determine how and for whom improved access to abortion may reduce them.

One way to assess such delays is to examine the length of time taken in each of the stages in the process of obtaining an abortion — from the woman's last menstrual period to the time she suspects she is pregnant, from suspecting pregnancy to confirming her suspicion via a positive pregnancy test, from confirming the pregnancy to deciding to have an abortion, from deciding to have an abortion to beginning to seek abortion services and from beginning to seek abortion services to actually obtaining an abortion. One 1984 study of 197 women examined the various stages in the process of obtaining an abortion and found that, among abortion patients, the mean number of days between a woman's last menstrual period and the

time she suspected pregnancy was 33 days; the mean time from suspecting pregnancy to confirming it via a test was 20–25 days; the mean time from a positive test to deciding to have an abortion was negligible; and the time from the abortion decision to the procedure was 17–21 days. However, this study is 20 years old, and these findings were based on a small sample of women at one clinic [11]. While there is literature on women's decision-making process when faced with an unwanted pregnancy [12–16], there is less information on both women's satisfaction with the timing of their procedures and the reasons some women delay, or are delayed in, obtaining services. A recent study of patients at one abortion clinic in California addressed timing and delays in the context of second-trimester abortion and found that problems in suspecting or confirming pregnancy and difficulty in getting referrals or public insurance were key factors leading to delays in obtaining abortions until the second trimester [17]. Our study complements and expands on this work in several ways: by examining delays experienced by women of all gestational ages, by utilizing a larger and broadly representative sample from multiple sites and by including both quantitative and qualitative components, which together provide a more complete picture of women's experiences.

2. Methods

2.1. Quantitative component

2.1.1. Survey design

The study was carried out via a self-administered paper-and-pencil questionnaire. A major portion of the questionnaire was dedicated to questions about the timing of steps in the process of obtaining an abortion. With the help of a calendar, the respondent was asked to report the first day of her last menstrual period and how many weeks pregnant she was, as well as the dates she first suspected she was pregnant, had a test that showed she was indeed pregnant, decided to have an abortion and first tried to get an appointment for the procedure. The date of the survey, which was usually equivalent to the date of the abortion and no more than 1 day before or after, was also recorded.

Women were also asked who, if anyone, helped them decide whether to have an abortion, including partners, relatives, friends and relevant professionals. The respondent could indicate as many people as applied and was further asked which of those people was most important in her decision.

The respondent was then asked if she would have preferred to have had the abortion earlier than she did; this was our primary measure of delay. If she said yes, she was asked:

- “Is one reason you are having an abortion now instead of earlier because it took you a long time to decide to have an abortion?”
- “Is one reason you are having an abortion now instead of earlier because it took time to make arrangements for an abortion?”

If the woman answered affirmatively to either of these reasons, she was prompted to indicate whether any of a series of specific subreasons (Table 1) was applicable. Multiple responses and write-in answers were allowed. The questionnaire also listed nine additional possible reasons for delay that a respondent could check off; these are also listed in Table 1. Multiple responses were again allowed. A final space was provided for the woman to write in additional reasons that did not fit into any of the categories provided. We also asked the woman if she first attempted to obtain an abortion at some other facility and, if so, why she did not. Additionally, the questionnaire collected information on demographic and social characteristics.

2.1.2. Survey fielding

A detailed description of our choice of facilities and selection of participants is presented elsewhere [10]. In summary, we surveyed a broadly representative sample of patients by selecting 11 large abortion providers, including one from each of the nine major US geographic regions. The providers also varied by patient demographics and state abortion restrictions. Each woman arriving for a termination

of pregnancy was asked to complete the questionnaire. Participation was voluntary, and responses were anonymous. The fielding protocol, survey instrument and in-depth interview (IDI) guide were approved by our organization's Institutional Review Board. The fielding period ran from December 2003 to March 2004; at each facility, fielding ran until we reached the goal of approximately 100 patients per facility (the actual range was 91–132). A total of 1209 women completed the questionnaire, and the response rate among all abortion patients seen at participating facilities during the fielding period was 58%. The reasons women did not complete the questionnaire included: failure of the clinic to distribute questionnaires on every procedure day, refusal to participate and lack of time to complete the survey. The cover page of the survey indicated that it covered “the reasons women have abortions and how they obtain abortion services.” Because of this general wording, we suspect that nonresponse did not introduce significant bias regarding responses to our key outcome variables. However, we are not able to confirm this due to lack of information about nonresponders. Of the respondents, 171 (15%) were in their second trimester, a percentage slightly higher than the 12% of abortion patients nationwide [9]. While this allows us to perform tests for significant differences between first-trimester and second-trimester patients, the majority of respondents were in their first trimester, and this should be borne in mind when considering our results.

2.2. Qualitative component

We also conducted IDIs with 38 women at four clinics. A detailed description of our choice of facilities and selection of participants is presented elsewhere [10]. Briefly, English-speaking women obtaining abortions or having an abortion follow-up visit at the four sites (three that participated in the survey and one that did not) were recruited for participation in the interviews by the clinic staff and compensated with US\$25 for their participation. No personally identifying information was collected. The interviews were conducted during the end of the survey fielding period and for 2 months afterwards.

Because qualitative participants were selected for their willingness to be interviewed and not on demographic characteristics, this sample was neither comparable to quantitative respondents nor comparable to the national demographic breakdown of abortion patients. Therefore, qualitative information is not presented in this paper as representative of the experiences of a larger sample of women, but is presented to provide a more detailed understanding of the process of obtaining an abortion and to illuminate the nuances of quantitative findings.

2.3. Data analysis

2.3.1. Structured survey

We used chi-square tests to determine significant differences across the proportions of women in each subgroup

giving various responses. To enhance our understanding of the variables related to delay and to reasons for delay, we used multivariate logistic regression models. Individual cases were not weighted; however, significance tests were conducted using techniques that accounted for the clustered sample design in order to calculate accurate standard errors. All analyses were conducted using Stata, version 8.2. Unless otherwise indicated, all associations mentioned were significant at $p < .05$.

To establish gestational duration, we asked women to report the date of their last menstrual period and/or how many weeks pregnant they were at the time of their abortion; 87% of respondents who answered both questions reported dates within 3 weeks of each other for these two measures. Ideally, all women would have received ultrasound confirmation of their gestational age before completing the survey. We were not able to determine the percentage of women who had received this information, but most clinics found it easiest to integrate the survey into their patient flow by administering it during the interval after a patient's ultrasound and before her procedure. As a result, many respondents had likely received ultrasound confirmation before they completed the survey. Among IDI respondents, no woman expressed uncertainty about her gestational duration.

Of the 1209 respondents, 10% did not indicate whether they would have liked to have had the abortion earlier. These women were significantly more likely to be Hispanic and to be earlier in gestation. In addition, many quantitative survey respondents had difficulty completing the section on dates. For each of the five questions in this section, the date was missing for 15–18% of respondents. Hispanic women, low-income women and women later in gestation were more likely to have missing data on date variables. Other respondents reported dates that were logically inconsistent (e.g., trying to get an abortion before suspecting one was pregnant). In many cases, we were able to resolve these inconsistencies based on other survey information. As a result, in our final analysis file, between 11% and 20% of the values for each date differed from what the respondent originally reported. Therefore, the findings relating to timing of events must be considered exploratory, and we show only bivariate tabulations; no multivariate models were fitted using these data.

Nonresponse on demographic variables was 12–14% for age, parity, marital/living status, race and employment and was 26% for poverty level, causing the number of respondents for multivariate models to be lower than those for univariate and bivariate tabulations. We include a category of “missing” under poverty to partly compensate for these missing data.

2.3.2. IDIs

Audiocassettes of IDIs were professionally transcribed, and then the research team edited them for accuracy and stripped them of any information that could potentially

identify the respondents. We used the qualitative data analysis software package N6 to systematically code the data by using categories based on the project focus and other themes that emerged from the data [10].

3. Results

3.1. Respondents' sociodemographic characteristics

As reported elsewhere [10], univariate analysis of the demographic characteristics of structured survey respondents indicated that they were not substantially different from a nationally representative sample of abortion patients surveyed in 2000 in terms of age, marital status, parity, poverty, race, education or religion (not shown) [18]. Twenty percent of respondents were 19 years or younger, and 57% were in their 20s. Seventy-two percent had never been married, and 59% had had at least one child. Some 60% of respondents were below 200% of the federal poverty line, including 30% who were living in poverty. More than half had attended college or had received a college degree. Thirty-one percent of respondents were black, and 19% were Hispanic. (Four percent completed the questionnaire in Spanish.) Forty-nine percent of surveyed women had had a previous abortion, and overall gestational age ranged from 4¹ to 23 weeks. Eighty-five percent of respondents were in their first trimester (defined as <13.0 weeks' gestation), and 15% of respondents were second-trimester patients (13.0 weeks or more).

The IDI respondents were slightly older than the structured survey respondents and were more likely to be living below 200% of the federal poverty level. More than half of these women (53%) had had previous abortions, and nearly three quarters (74%) had children. Almost half of the interview respondents were in their second trimester; a possible explanation for this overrepresentation is that these women were usually in the clinic on two consecutive days for their abortion procedures and, therefore, were more likely to be available to participate in the interviews.

3.2. Timing of steps to obtain an abortion

Fig. 1 provides information on the sequence and timing of the various steps in the decision to have an abortion and in efforts to obtain one. The mean gestation at the time of abortion in the quantitative sample was 9.0 weeks, and the median was 8.0 weeks; the 25th and 75th percentiles were 6.0 and 10.3 weeks, respectively. For the typical woman, a little over a month (just a few days more than one menstrual cycle) passed between her last menstrual period and the date she first suspected she was pregnant: the median time was 33 days, and the mean was 36. The next three steps (confirming the pregnancy, deciding to have an abortion and first trying to get an appointment) generally spanned a much

¹ Of the 1209 respondents, four women reported gestations of 3 weeks and 6 days, and one woman reported her gestation as 3 weeks.

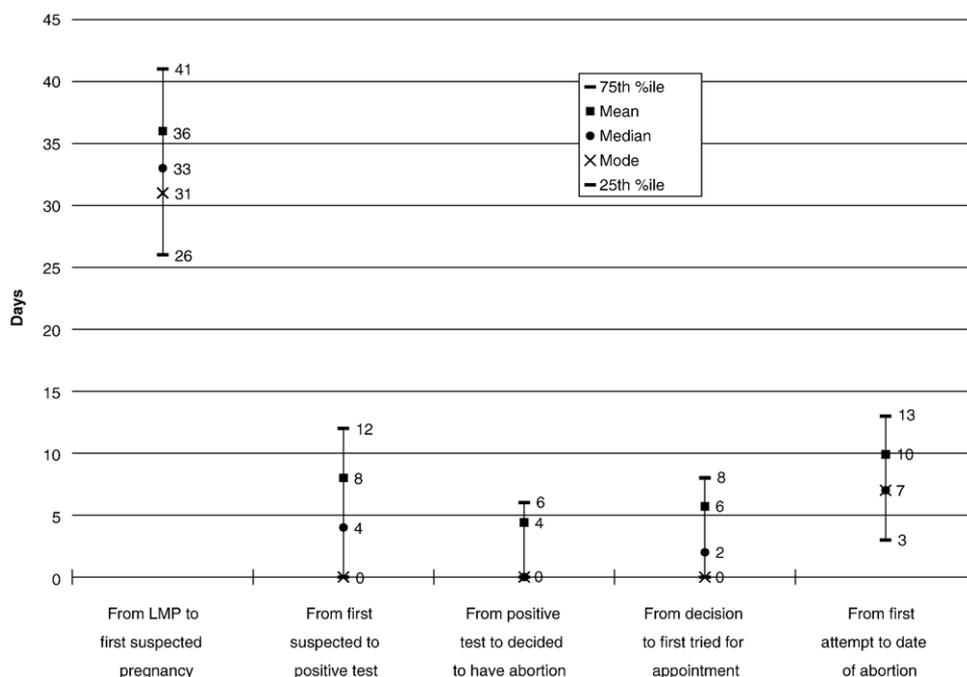


Fig. 1. Timing of steps in the abortion process: median, 25th and 75th percentiles, mean and mode, 2004.

shorter period of time: the median times for these intervals were 4, 0 and 2 days, respectively, and the most common response for each interval was 0 day. The median interval for these three steps combined was 14 days, and the mean was 18 days (not shown). Finally, the median interval between first trying to obtain an appointment and the date of abortion was 7 days, and the mean was 10 days.

The IDIs revealed the difficulty women had in accurately recalling and recording the amount of time that passed between the steps in obtaining an abortion. In about one third of the interviews, one or more approximate dates could not be determined, even with probing and with the aid of a calendar. However, these areas of ambiguity reveal both the intensity and the diversity of the logistical process women go through to abort an unwanted pregnancy.

In the following sections, we examine each step of the process in further detail.

3.2.1. Time from last menstrual period to suspecting pregnancy

Structured survey results show that minors (those <18 years old) took a week longer than all other age groups to suspect they were pregnant (Fig. 2). The experience of one young IDI respondent provides insight into the longer intervals seen in this age group in the survey data; she did not seem to understand that missing a period could be a sign of pregnancy:

When I missed the first one I was just happy, like, “Yes!” Then I missed the second one, then I was just doubting a little bit, like. Then I missed the third one; then it cut right through my head, like, “Oh my god!” Then I started getting scared and stuff. (16 years old, poverty status

unknown, no children, 17 weeks pregnant at the time of abortion)

Almost half of the IDI respondents who did not suspect that they were pregnant until relatively late stated that their periods had been irregular before this pregnancy due to having had a baby or a miscarriage within the last 6 months and/or the use of injectable contraception.

3.2.2. Time from suspecting pregnancy to confirming pregnancy by testing

More-educated women took less time between suspecting pregnancy and confirming it (Fig. 3). The same was true for higher-income women, who had a shorter interval by nearly a week when compared to women below 100% of the poverty level. Black women had a slightly, but significantly, longer interval. Also taking a longer average time to confirm their pregnancies with a test were teens, both minors and older teens. Additionally, women with two or more children reported a significantly longer interval. In general, these differences, while statistically significant, were small (2–3 days).

Many IDI respondents described a process of confirming the pregnancy at a doctor’s office or clinic, rather than (or in addition to) at home; obtaining this confirmation was a source of delay for some of the IDI respondents because of lack of time.

3.2.3. Time from positive pregnancy test to deciding to have an abortion

Married women and women with two or more children reported taking less time to decide than their demographic counterparts. In addition, if a woman took 7 weeks or longer

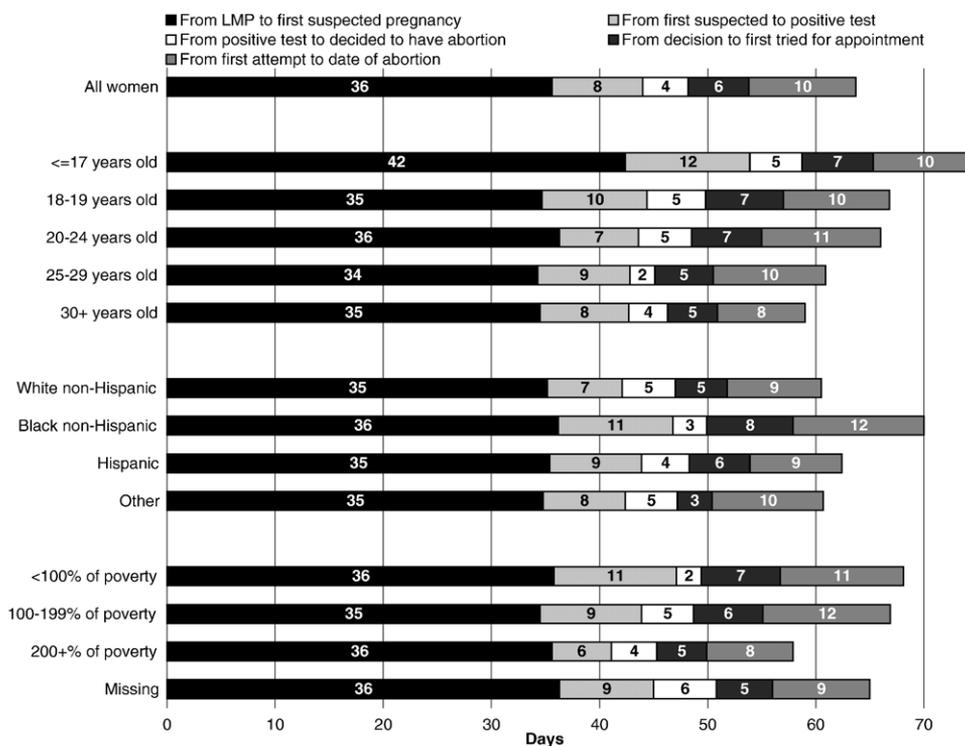


Fig. 2. Mean length of stages in the abortion process, by age, race and poverty level, 2004.

to confirm the pregnancy, her decision-making period was shorter (not shown). In addition, women who talked to a parent about her decision took a significantly longer time to decide to have an abortion (not shown). On the other hand, black women took less time to decide. Again, these

differences were small, reflecting short intervals overall at this stage.

Most women in the IDIs who reported no interval between confirming their pregnancies and deciding on abortion voiced a unified theme: from the time they

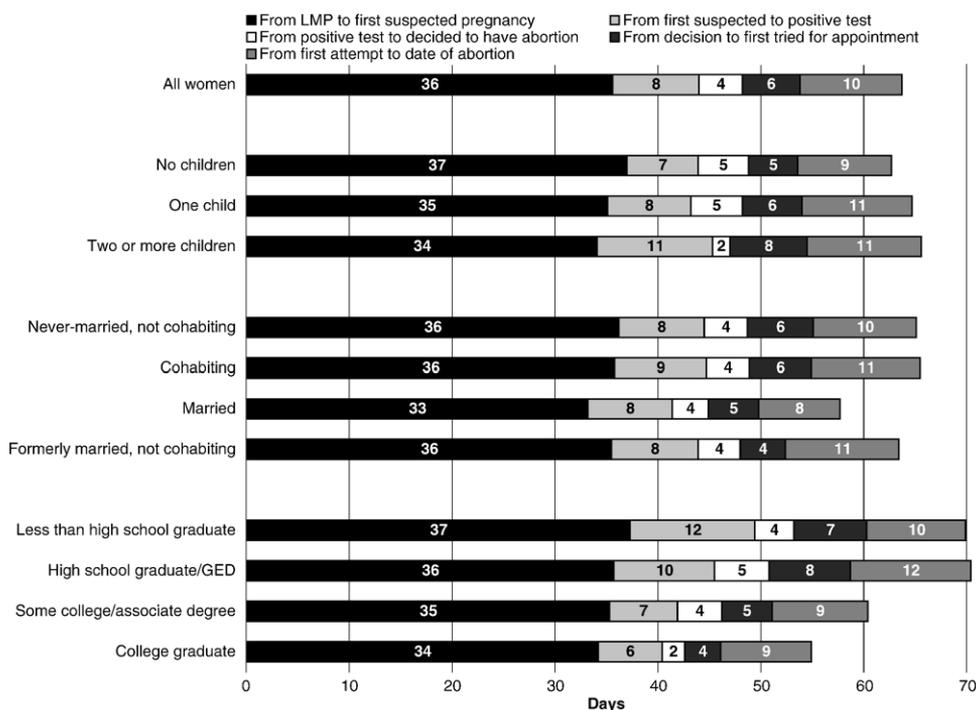


Fig. 3. Mean length of stages in the abortion process, by number of children, relationship status and education, 2004.

confirmed their pregnancy, they knew it would end in abortion, and that the positive pregnancy test was the moment that the decision crystallized:

I pretty much made the decision right away. I found out and took the pregnancy test and I was like, I just saw like my whole life flash in front of me and I was like, what would happen if I had the kid and you know, what would be affected in my life and other people's lives, and that is the first thing that came to my mind was that I need to get an abortion. (*19 years old, above the poverty line, no children, 6 weeks pregnant at the time of abortion*)

The experiences of other IDI respondents may illuminate what happens when women take a longer time at this interval; some interviewees described this decision-making period as ongoing up to the day of their abortion. Most women in the IDIs who took a long time during this interval said that it was a hard decision and that they wanted to think about it and talk to other people so that they were sure. The following woman described the back-and-forth process she went through with her partner after she confirmed her pregnancy:

So we decided that it was too soon [to have a child together]. It just wasn't the right time for neither one of us [...] It was like ... sometimes [my partner] would say yes and I would say no. I would convince him where I would think it's a bad decision and he'll say yes or no. Then [he'd] try to convince me [...] So, it was confusing at first, but we knew that it was going to be a decision that we would have to make. (*27 years old, at or below the poverty line, one child, 15 weeks pregnant at the time of abortion*)

In the structured survey, 60% of women indicated that someone else helped them with the decision to abort. As might be expected, husbands or partners were the individuals most commonly named: nearly half of the women (45%) cited their husband or partner (not shown). Nearly a quarter (23%) named a friend, and 14% of all women (and 40% of minors) cited a parent. Similarly, about half of the women indicated that their husband was the "most important" other person who helped with the decision. About 1 in 10 women indicated that a parent was the most important person; this response was three times as common among those 19 years and younger (21%) than among those 20 years and older (7%). Notably, even though the question asked of women ("Which of those people was most important in your decision?") implied that the woman was to choose from the list in the previous question (which did not include "me"), 28% of those who responded to this question wrote in "me" or "myself."

More than half of the IDI respondents said that they themselves were the most important and influential person in the decision. Their reasons were that this had to be their own decision because it really was up to them and them alone. Many respondents acknowledged the importance of their partners' opinions, but nonetheless emphasized the importance of "controlling their own destiny."

3.2.4. Time from deciding to have an abortion to first trying to obtain an abortion

Women aged 25 years and older had a shorter time period between making the decision to have an abortion and first attempting to make an appointment for the procedure (Fig. 2). Black women took a significantly longer time than white women with this interval. In addition, women who did not talk to anyone in their decision making took longer between deciding to have the abortion and first trying to obtain the abortion (not shown).

As in the quantitative survey, most IDI respondents began trying to obtain an abortion quickly after deciding, sometimes even before they had firmly decided to have an abortion (e.g., locating clinics and finding out prices, gestational limits and appointment availability before mentally committing themselves to having an abortion). However, the interviews also revealed the porousness of the boundaries of these intervals; the idea that a "decision" was a definite moment in time that could be marked on a calendar was not borne out in many of the interviews. Although some IDI respondents had the experience of a discrete moment of decision, many others experienced decision making as a protracted process.

3.2.5. Time from first trying to obtain an abortion to obtaining the abortion

In the structured survey, poor women took a significantly longer time from first trying to obtain the abortion to actually having it. When compared to white and Hispanic women, black women reported significantly longer time periods.

We also examined the last two stages together (i.e., the time from deciding to have an abortion to obtaining it) in order to be able to make summary statements about the full period following the decision to have an abortion. Women with two or more children took more time across these two stages, while higher-income women and women 30 years and over reported less time between deciding to have an abortion and obtaining it.

In the structured survey, we asked a question focusing specifically on women's experiences with other clinics. Eleven percent of women reported that they attempted to go to another clinic or doctor's office before going to the clinic where they actually obtained the abortion. Of these, 32% (or 3% of all women) said that they did not get an abortion at the first facility because they were too far along in pregnancy (not shown). An essentially equal percentage indicated that the clinic was too expensive or that they were unable to receive insurance coverage at the time of their visit. Additional reasons for not having the abortion at the first clinic included abortions not being performed there and not being able to get an appointment at the first location, each reported by 1% of all women. Notably, women who went to another clinic took over twice as long, on average, between initially attempting to make an appointment and obtaining the abortion.

The most common reason that IDI respondents gave for visiting other service sites before having their abortion was to confirm their pregnancy. Some women reported that the clinic where they obtained an abortion required proof of pregnancy from another clinic, and other women said that they wanted to get proof for themselves after getting a positive result from a home pregnancy test before moving forward with their decision-making process. The next most common reason given for visiting another medical site, including hospital emergency rooms, was that the woman did so before she knew she was pregnant (e.g., she was feeling ill and sought medical care and found out she was pregnant at that time). Of the women who sought an abortion at a site other than the one where they actually obtained an abortion, all were found by ultrasound exam to be past the first clinic’s gestational limits.

3.2.6. Timing of steps in the abortion process for first-trimester versus second-trimester patients

Fig. 4 shows that the additional time spent by women who obtain second-trimester abortions is not concentrated in any particular stage in the process. Instead, each stage is longer overall for women at later gestations than those at earlier ones.

3.3. Delays in obtaining abortions and reasons for delays

Nearly three fifths (58%) of women in the structured survey reported that they would have preferred to have had the abortion earlier than they did (not shown). As might be anticipated, this response was more common among women later in gestation: 91% of women in their second trimester said so, compared to 52% of first-trimester patients. However, even among women at 6 weeks or earlier, 32%

said this. Poor women (67%) were also more likely to say that they would have preferred to have had the abortion earlier than women above 200% of poverty (50%). In addition, women who said they wanted to have their abortion earlier reported taking more time at almost every stage of the process.

The IDI respondents were not specifically prompted to explain why they would have preferred to have had their abortions earlier than they did, but they often volunteered this information:

I do [wish I had had the abortion earlier], because when I came here last Friday and they told me, like, “You’re in your second trimester,” and I’m like [...] “Goodness, now what am I going to do?” Because I didn’t want to go into my second trimester, because it’s like, basically, really becoming a baby, you know I just really didn’t want to do it that late. (21 years old, at or below the poverty line, one child, 16 weeks pregnant at the time of abortion)

Of the women in the structured survey who indicated that they would have preferred to have had the abortion earlier than they did, three fifths said that this was because it took them a long time to make arrangements (Table 1). The most common arrangement was raising money; 26% of women said they needed time to do this. As expected, due to their later gestations and lower incomes, the IDI respondents commonly said that a reason for their delay in obtaining an abortion was the need to raise the money for the abortion or to get insurance to cover the abortion:

I mean, when I first found out [that I was pregnant], I had it in my head anyway to have [the abortion], but I did not have the money. It was the money; I did not have no money to come down here and the money to do it [...] It

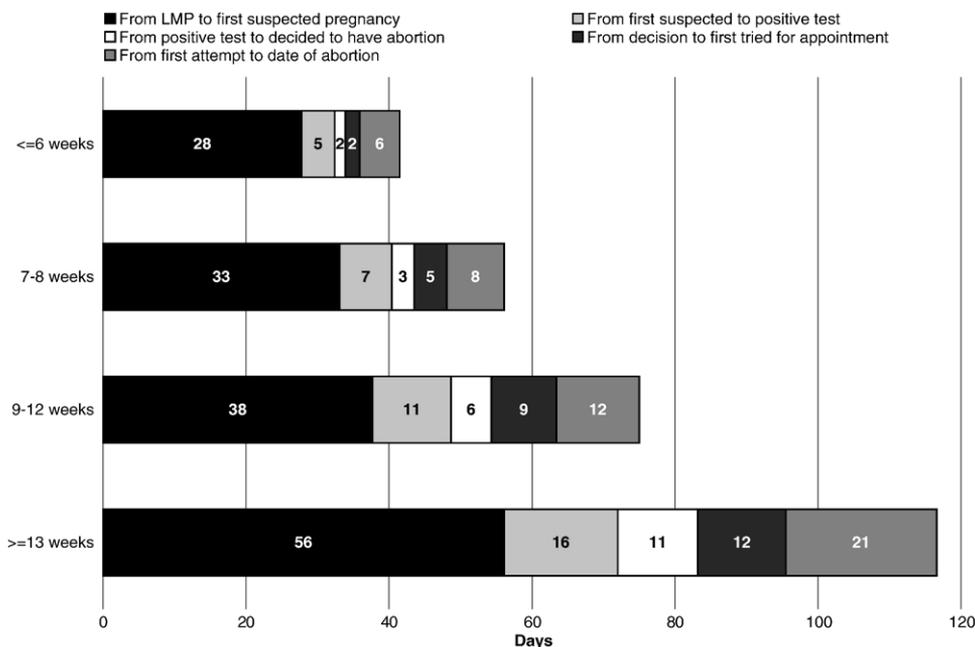


Fig. 4. Mean length of stages in the abortion process, by weeks of gestation, 2004.

is hard to take off work, you know, but it was really the money, because if I were to have it sooner, I would have come sooner, but I did not have it. And everybody was against [me having the abortion] so, there was nobody to help me, you know. (22 years old, below the poverty line, three children, 13 weeks pregnant at the time of abortion)

A few women said that they had made and cancelled multiple appointments because they did not have enough money to cover the procedure, and one woman said that she had waited an entire month for her Medicaid coverage to become active in order to use it to pay for the procedure. They typically described a process of finding a clinic that performed later abortions and accepted Medicaid for payment or was willing to work out a payment plan.

About 4 in 10 women in the quantitative survey cited “it took a long time to decide” and 27% cited “it was a difficult decision to make” as reasons for delay in deciding. Many IDI respondents who wanted their abortion earlier also said that it took them a long time to decide to have an abortion.

Thirty-six percent of women said that it took some time before they knew they were pregnant or how far along they were. Much smaller percentages of women cited partner relationships, fear of disclosure, pressure or clinic-enforced

delays, among other reasons. A few women in the qualitative sample also said that their delay was due, in part, to constraints of their own schedule. They mentioned school or work commitments, combined with raising their children, as contributing factors to their delay in obtaining an abortion.

The previous findings include women at all gestations, including those in the first trimester who, from some perspectives, would not necessarily be considered “delayed.” (A small number of women in the qualitative sample said that they had tried to obtain an abortion earlier, but were told to come back later because they were too early in their pregnancies for a surgical abortion, but this information was not obtainable from the survey data.) For this reason, we looked separately at delays experienced by women who obtained abortions in their second trimester. These women were significantly more likely to say that it took them a long time to make arrangements to have the abortion; two thirds of second-trimester patients said so, compared to 56% of first-trimester patients (Table 1). In addition, second-trimester patients were significantly more likely to indicate that they were delayed because they needed time to raise money for the abortion. Half of second-trimester patients reported that it took them a long time to

Table 2

The percentage of women (who would have preferred to have had their abortion earlier) reporting the most common reasons for delay, and odds ratios from multivariate logistic regressions predicting reasons for delay, 2004

Characteristic	It took a long time to make arrangements		It took a long time to decide		It took some time before I knew I was pregnant or how far along I was	
	Bivariate percentage	Multivariate odds ratio	Bivariate percentage	Multivariate odds ratio	Bivariate percentage	Multivariate odds ratio
Total % reporting reason	59		39		36	
Age (years)						
≤ 17	53	1.00	27	1.00	57	1.00
18–19	58	1.21	44	2.52	26	0.22**
20–24	62	1.34	40	2.21	35	0.32*
25–29	56	1.01	42	2.19	33	0.32*
30+	60	1.33	32	1.67	37	0.34
Relationship status						
Never married and not cohabiting	59	1.00	38	1.00	38	1.00
Cohabiting	53	0.76	37	0.99	35	0.95
Married	63	1.33	39	1.09	33	0.77
Formerly married and not cohabiting	58	1.18	38	1.29	29	0.51*
Race						
White	58	1.00	30***	1.00	42*	1.00
Black	62	1.16	44	1.73***	28	0.47**
Hispanic	55	0.83	47	1.86*	31	0.55*
Other	65	1.54	52	2.33*	48	1.27
Poverty level						
<100%	65	1.00	41*	1.00	38	1.00
100–199%	57	0.77	36	0.86	31	0.61*
200+%	53	0.55**	32	0.79	38	0.82
Missing	63	0.84	47	1.39	36	0.73
<i>n</i>	567	530	585	516	458	433

* Statistical significance at $p < .05$.

** Statistical significance at $p < .01$.

*** Statistical significance at $p < .001$.

decide, while only 35% of first-trimester patients said so; this finding was of borderline statistical significance ($p=.06$). However, second-trimester patients were more likely to cite worries about cost as a reason for delay in deciding. Finally, second-trimester patients were more likely to have indicated that they were delayed because it took time to talk to their parents.

Table 2 includes women of all gestations and shows bivariate percentages and multivariate odds ratios predicting whether women gave any of the three most common reasons for delay. Income is associated with difficulty making arrangements: in the multivariate context, women above 200% of the federal poverty level were only about half as likely to give this as a reason for delay. Being nonwhite was associated with giving “It took a long time to decide” as a reason for delay. Women 17 years and younger were more than three times as likely as older women to indicate that they did not know they were pregnant or how far along they were even after controlling for other characteristics, echoing the finding that this group took more time from the last menstrual period to suspecting pregnancy. White women were more likely than black and Hispanic women to say they did not know they were pregnant, and there is some evidence that both formerly married (and not cohabiting) and lower-income women were more likely to give this reason.

4. Discussion

Our findings suggest that once women suspect pregnancy, most of them who seek an abortion act fairly quickly and are able to obtain an abortion in the first trimester. Most suspect that they are pregnant just a few days after missing their period. They quickly confirm their suspected pregnancies; the average time to do so was about a week. Women typically are able to get an appointment within a week, and the average time from a positive test to an abortion procedure was 3 weeks. A large majority of women report taking little time or no time between suspecting pregnancy and confirming it, between confirming the pregnancy and deciding to have an abortion and between deciding to have an abortion and beginning to seek services.

However, the IDIs indicate that these stages are not so easily quantified, perhaps because women find it difficult to look back and determine specifically when various events occurred. Our data on dates were somewhat incomplete, but in many cases, women who had characteristics associated with delay also had more missing data, suggesting that the results may in fact be conservative. Even so, confirmatory research in this area is needed, and improved methods of data collection, such as computer-assisted survey techniques that can check for inconsistencies, might improve the quality of such data.

We found that minor teens’ interval from the last menstrual period to suspecting pregnancy was significantly longer than adult women’s and that minors were much more likely to report that they were delayed because it took some

time before they knew they were pregnant. Taken together, these findings indicate a clear lack of knowledge among some younger teens about the basic aspects of pregnancy and the specific signs of pregnancy, and imply that increased instruction on such information would be an important addition to sexuality education programs. It is possible that the longer interval among teens reflects greater denial of pregnancy rather than lack of knowledge, but many IDI respondents, particularly those with irregular periods, were also unaware of their pregnancies, suggesting that education about pregnancy awareness would be valuable to women of all ages.

As might be expected, women report that their husbands or partners are heavily involved in the decision to abort. Half of women described their partner as the most important other person they talked to, far more than any other group consulted. Yet the extent to which women independently emphasized their own decision-making autonomy was notable. In both quantitative and qualitative findings, many women described the decision as their own and emphasized the primary role they played. Among minor teens, however, 40% indicated that their parents helped them decide.

The study findings indicate that most women would have preferred to have had their abortions earlier than they did; this was understandably more common for women later in pregnancy. Women with more children take more time to obtain an abortion once they have decided to do so, which, as the IDIs indicate, may be due to the difficulty of scheduling and keeping appointments in light of familial demands.

A variety of measures in our study suggest that women who are financially disadvantaged also have difficulty obtaining early abortions. Lower-income women typically take more time to confirm a suspected pregnancy, which could relate to the cost of a home pregnancy test and the difficulty in getting a test from a clinic or a doctor. They also typically take several more days between deciding to have an abortion and actually doing so than their higher-income counterparts. In addition, the need to take time to make arrangements is the most common reason for delay for the sample as a whole, and low-income women are more likely to have this problem. Similarly, women who had second-trimester abortions were more likely to have concerns about cost or about raising money.

Many of our findings broadly echo those of a recent study in this area [17]. Although our study defined delay in a somewhat different way, in both studies, second-trimester patients reported longer intervals at each stage of the process; in particular, problems in suspecting pregnancy were an important cause of delay. In addition, several logistical and personal factors were reported by a similar proportion of second-trimester patients, and reasons for delay among second-trimester patients were found to differ from those mentioned by first-trimester patients. On the other hand, our study found additional evidence of the connection between financial constraints and difficulties in accessing abortion.

The difficulties that low-income women face when making arrangements underscore the importance of financial support for such women when they seek abortion. Yet, under the Hyde Amendment, which was enacted in 1977, the use of federal funding is prohibited for most abortions, and only 17 states use state funds to cover all or most medically necessary abortions (only four do so voluntarily, while the other 13 do so pursuant to a court order) [19]. Moreover, the clinical and financial implications of second-trimester abortion are greater than those for first-trimester patients. Our findings suggest that gestational age at abortion in the United States could be further reduced if financial barriers faced by disadvantaged groups were removed and if women, especially young women, were better educated about how to recognize pregnancy. However, making these structural changes would require systematic and comprehensive efforts. At the same time, it is important to note that the discovery of fetal anomalies or maternal health problems accounts for some of the abortions that occur in the United States, and the limitations of available technology or access to this technology may not permit earlier identification. Because of these factors, efforts to ensure that abortions happen earlier in pregnancy must be balanced by efforts to maintain the accessibility of second-trimester abortion services.

Acknowledgments

The authors thank the facilities that participated in the research; Suzette Audam for conducting IDIs; and Rachel Gold, Stanley Henshaw and Rachel Jones for reviewing early drafts of this article. The research on which this article is based was funded by the David and Lucile Packard Foundation.

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