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Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women

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Authors

Roberts, Sarah CM
Turok, David K
Belusa, Elise
[et al.](#)

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Peer reviewed

Abstract

Introduction: This study investigates women's experiences with Utah's 72-hour waiting period and two-visit requirement for abortion.

Methodology: Participants include 500 women presenting at an abortion information visit at one of four family planning facilities in Utah. Participants completed baseline surveys at the information visit and follow-up telephone interviews three weeks later.

Results: Among participants completing follow-up, 86% had had an abortion, 8% were no longer seeking abortion, 3% had had a miscarriage or discovered that they had not been pregnant, 2% were still seeking abortion, 0.3% were still deciding whether to have an abortion, and 0.3% had not had an abortion because the waiting period pushed her beyond the gestational limit at the facility where she sought care. Most were not conflicted at the information visit; being unconflicted was the strongest predictor of having had an abortion at follow-up. Participants spent a mean of \$44 on information-visit-related costs; 6% had to disclose that they were seeking an abortion to make logistical arrangements; and participants waited, on average, 8 days between the information visit and the abortion.

Discussion: This study demonstrates that the vast majority of women presenting for an abortion information visit are certain about their decision and go on to have an abortion. Furthermore, encouraging individual women who are conflicted about their decision to take more time to make their decision is a common component of abortion care. Thus, a law requiring all women to make two visits and wait 72 hours appears to be an unnecessary burden for women seeking abortion.

Introduction

State-level abortion restrictions such as parental involvement laws, restrictions on public funding for abortion, and waiting periods for abortion have been in place in some U.S. states for almost 40 years . Recently, there has been a dramatic increase in the number of abortion restrictions, with more state-level abortion restrictions enacted between 2011 and 2013 than in the entire previous decade . There has also been a change in the severity of restrictions, with 24-hour waiting periods lengthened to 48 and 72-hours . To contribute to the literature on these new, more severe, restrictions, this study seeks to understand women's experiences with Utah's 72-hour waiting period.

Waiting periods require women to wait a specified amount of time between receiving state-mandated abortion information and having the abortion procedure. Waiting periods are often accompanied by two-visit requirements, whereby women must receive the state-mandated abortion information in person as opposed to the phone. Previous research on effects of waiting periods has found that 24-hour waiting periods do not affect abortion rates. However, this research has shown that two visit requirements are associated with a decrease in the abortion rate, increase in travel out of state for abortion, and an increase in second trimester abortions .

A few studies examine women's experiences with waiting periods and two visit requirements. A study of Tennessee's two day waiting period and two visit requirement in 1979 and 1980 found that more than three-fourths of abortion patients reported no benefit to waiting while almost 60% reported experiencing one or more problems due to waiting . While women in the Tennessee study did cite some possible benefits to waiting, women reported experiencing fewer benefits, and more problems, than anticipated. Women also paid an additional \$24 because of the waiting period, which increased costs by 48% for low-income and 14% for higher income women. A more recent study in Arizona of how women anticipate a 24-hour waiting period would affect them found similar findings, with most women

expecting considerable additional financial and logistical hardships due to waiting and only a minority expecting benefits .

The public conversation about effects of waiting periods focuses largely on the extent to which the logistical difficulties of waiting periods and two-visit requirements make women unable to have abortions and whether waiting periods lead women to change their minds about having an abortion . Little research directly investigates how many women do not have abortions under waiting periods or the reasons that women do not have abortions when required to wait between receiving abortion information and having an abortion. Previous research has found that 2-7% of women presenting for abortion care in settings with no to minimal (i.e. 2 hour) waiting periods do not have the procedure . This research has identified a number of reasons that women do not have an abortion after presenting for one, including having miscarried or discovered that they had not been pregnant, having decided to continue the pregnancy, and being unable to have the abortion due to gestational age limitations at the facility . With the exception of one recent paper , this previous research has notable gaps that include not assessing the characteristics of women who do not have an abortion after presenting for one and the reasons women altered their plan.

This study follows a cohort of women who presented for an in-person abortion information visit in Utah under the state's 72-hour waiting period, which went into effect in May 2012. Utah was the first state in which a 72-hour waiting period went into effect. Utah requires women to have a face-to-face abortion information visit at least 72-hours prior to having the abortion , which has required women to make at least two visits for an abortion. The information visit does not need to be with a physician.

The primary purpose of the study was to examine women's reasons for not having an abortion under a 72-hour waiting period and two-visit requirement. In addition, to extend previous research that has focused largely on anticipated consequences rather than women's experiences , we also examined financial and social costs associated with the abortion information visit, assessed the actual wait time

between the information visit and the abortion, and asked women to identify the hardest part of waiting and making two visits.

Methods

We recruited women who presented for an abortion information visit at four family planning facilities in Utah, one of which provided abortions. Women who read English or Spanish and were older than 15 were eligible. Minors under age 18 were eligible with their assent and consent from one parent. At the information visit, facility staff informed women about the study and invited them to participate. Women who were interested in participating completed informed consent and a baseline iPad-based survey *prior* to receiving state-mandated abortion information or any abortion counseling provided as part of routine care. University of California, San Francisco research interviewers completed a follow-up telephone interview with participants three weeks later. Participants were remunerated with \$10 for the baseline survey and \$20 for the follow-up interview. This study was approved by the University of California, San Francisco Committee on Human Research.

Variables based on data collected via the baseline survey included *age* (continuous), *race* (White, Black, Hispanic, Other), *parity* (nulliparous vs. one or more previous births), *gestational age discovered pregnancy* (continuous), *religion* (Protestant, Catholic, Mormon, Other religion, No religion), *public assistance receipt* (yes vs. no over the past 12 months), *household income* (past 12 month household income), *employed* (full or part time versus not employed), *mental health history* (any prior diagnosis of depression, anxiety, or both vs. no prior diagnoses), *risky drinking* (yes vs. no based on AUDIT-C scores ≥ 3 for 12 months prior to pregnancy recognition), *drug use* (yes vs. no for 12 months prior to pregnancy recognition), and *violence from the man involved in the pregnancy* (yes vs. no). To measure *abortion knowledge*, participants were asked to choose which of two statements were closer to the truth for five common abortion myths (e.g. abortion is safer than childbirth versus childbirth is safer than abortion), and were offered a “don’t know” option in each case. Myths included: *childbirth is safer than abortion*,

abortion causes depression/anxiety, abortion causes breast cancer, most women experience regret after abortion, and abortion causes infertility. For each myth, women received 0 points for endorsing the myth, 0.5 for a don't know response, and 1 point for selecting the more accurate statement. Scores were summed and then divided by 5, for a range of 0 – 1, with lower scores indicating endorsing more myths and therefore lower knowledge). To measure *decisional conflict* we used a continuous, 16 item scale ranging from 0 – 100 that examines how conflicted patients are about their health care decision; items are assessed on a Likert scale and include: “I know which options are available to me,” “I feel sure about what to choose,” and “I expect to stick with my decision.” Lower scores on the decisional conflict scale indicated less conflict; scores <25 are associated with implementing a decision and scores >37.5 are associated with decision delay or feeling unsure about implementation . Prior to being asked these 16 items, women were asked which option they preferred for this pregnancy: having an abortion, having the baby and raising it, and having the baby and placing it for adoption). Other variables included *abortion information visit financial costs* (sum of costs associated with attending the information visit, including transportation, missed work, staying overnight, childcare, and other costs), and *disclosure* (yes vs. no, yes indicates that the woman had to tell someone who did not previously know about her pregnancy that she was seeking an abortion in order to make logistical arrangements to attend the information visit; this was assessed for people including employers, child care providers, coworkers, family members, friends, and others).

The follow-up telephone interview included both closed-ended and open-ended questions. The main purpose was to assess whether women had had an abortion by about three weeks after the information visit and, if not, her reasons for not having an abortion. The main outcome was *abortion* (yes vs. no). Those who had not had an abortion were further classified into miscarriage/discovered that she had not been pregnant, still seeking abortion, still deciding whether to have an abortion, no longer seeking abortion, and being unable to have an abortion because of the waiting period. To be classified in

this last category, she needed to have been pushed beyond the gestational limit at the facility where she sought care because of the waiting period. *Still pregnant* at follow-up includes women who had not had an abortion, had not had a miscarriage, and who did not report they had later discovered that they had not been pregnant. *Reasons for not having the abortion* were assessed with open-ended questions, followed by closed-ended questions. Cost related factors included: *abortion visit financial costs* (sum of the costs associated with attending the abortion visit, including transportation, missed work, staying overnight, childcare, and other costs), *payment for the abortion procedure* (how much money the woman had to pay the abortion facility for the abortion), *source of formal financial assistance* (insurance, Medicaid, abortion funds, and other sources), *financial help from other people* (open-ended as to who helped pay for the abortion), and *disclosure when using own money* (yes vs. no, woman had to tell someone else they were spending the money, and open-ended as to who they had to tell). *Actual wait* is days between the information visit and the abortion for women having the abortion; women who waited longer than 72-hours were asked an open-ended question about reasons for waiting longer than 72-hours. Women were asked open-ended questions about the *hardest part of waiting 72-hours* and the *hardest part of two visits*.

Most analyses were descriptive. Predictors of still being pregnant at follow-up were assessed through multivariable logistic regression. Because of the rarity of the outcome, a directional acyclic graph was used to identify the variables to include in the model ;decisional conflict and socioeconomic status were considered as the main predictors of interest and a sufficient set that included both of these variables was selected. Facility site where women presented for the information visit was considered as a fixed effect, although it was not retained in the model because the likelihood ratio test did not indicate that it improved model fit. Analyses were conducted in Stata 13.0 (StataCorp, LP, College Station, Texas).

Open-ended responses were coded inductively. Reasons for not having an abortion and the reasons for waiting longer than 72-hours were coded by SR; questions about codes were resolved

through consensus between SR and EB. Hardest part questions were coded by EB after EB and SR achieved >80% interrater reliability on 10% of responses.

Results

Facility staff approached 691 women for participation, representing 74% of women who presented for an information visit during the study period. Eight women who were approached were ineligible because they were too young, or did not read English or Spanish. A total of 500 women consented to participate and completed the baseline interview, for a response rate of 73%. Due to problems with wifi connectivity and the software used for the baseline survey, data for six participants who completed the baseline survey were lost. Three hundred and nine participants (63% of those who consented) completed the follow-up interview [See Figure 1].

Sample description

Characteristics of study participants are in Table 1. The average age was 25.6 years old. Almost two-thirds were White, and over half had no religion. Most were employed, but one-third had received public assistance in the past year. Mean annual household income was \$22,000. More than one-fourth reported history of depression or anxiety; almost half reported risky drinking in the past year, 17% drug use in the past year, and 9% violence from the man involved in the pregnancy.

The mean score on the abortion knowledge scale was 0.62 (range 0 – 1), indicating that women tended to reject more abortion myths than they endorsed. The alpha for all of the decisional conflict items in our sample was 0.93, indicating high internal consistency. The mean decisional conflict score was 15 (range 0 – 69), a score indicating low decisional conflict.

Among those who completed the baseline survey, 95% indicated that the option they preferred at the information visit was having an abortion, 4% indicated having the baby and raising it, and <1% indicated having the baby and placing it for adoption. Looking at both baseline option preferred and decisional conflict together, 70% preferred abortion and were not conflicted, 25% preferred abortion and

were somewhat or very conflicted, and 5% preferred having the baby and either raising it or placing it for adoption.

Status at follow-up interview

At follow-up, 86% (n=267) had had an abortion, 3% (n=8) had had a miscarriage or discovered that they had not been pregnant, 2% (n=7) were still seeking abortion, 0.3% (n=1) were still deciding whether to have an abortion, 8% (n=25) were no longer seeking abortion, and 0.3% (n=1) had not had an abortion because of the waiting period (had she been able to have her abortion the day of her information visit or had she only had to wait 24-hours, she would have been within the facility's gestational limit).

Reasons for not having an abortion

Among the 8% (n=27) no longer seeking an abortion at follow-up, still deciding, or pushed beyond the gestational limit, 11 (4% of those completing follow-up) had indicated at baseline that the option they preferred was having the baby, nine (3% of those completing follow-up) had indicated at baseline that the option they preferred was abortion and were conflicted, and seven (2% of those completing follow-up) had indicated at baseline that the option they preferred was abortion and were not conflicted .

In bivariable analyses, lower abortion knowledge, higher decisional conflict, discovery of pregnancy at earlier gestations, and public assistance receipt were positively associated with still being pregnant at follow-up [See Table 2]. In a multivariable model, only greater baseline decisional conflict and discovery of pregnancy at earlier gestation were associated with still being pregnant at follow-up [See Table 2]. For each one point increase in decisional conflict at baseline, the odds of still being pregnant increased by 6%.

In response to closed-ended questions [Table 3], the top two reasons for not yet having an abortion at follow-up were having changed her mind (71% of those still pregnant, n=24) and cost of the

procedure (47% of those still pregnant, n=16) [See Table 3]. The next four reasons related to other people, i.e. other people not wanting her to have an abortion, needing to keep her abortion secret from other people, and needing someone else to help with a logistical component of her being able to have an abortion.

In response to open-ended questions [Table 3], the most common reason for not yet having an abortion was that she “just couldn’t do it” (53%, n=18). This included having changed her mind; however, the nuance tended more towards having been conflicted to begin with and then deciding to not have the abortion.

“I have always been against abortion. This would be my third child, which is why I considered it. I just couldn’t find myself to do it.”

“It was a hard decision for me to make in the first place, and once I made the appointment it kind of hit home. About two days after the [abortion information] appointment, I cancelled the [abortion] appointment, I couldn’t do it. It’s something that I’ve always been against. I had my reasons that I thought were good reasons and then I re reasoned myself out of it.”

Again, similar to the closed-ended responses, the next most common reason was financial.

“[I] have not been able to get to [Salt Lake City] for the appointment. Also, [I] get paid every week, but every time I think I have enough money, it all gets taken out in taxes, so I’m just under the amount I need. Every time I try to make an appointment, something else comes up that I have to pay.”

In contrast to the closed-ended responses that described other people as not wanting them to have an abortion as the reason they have not had an abortion, when women described the reasons in their own words, they described it more as other people in their lives coming through for them (mentioned by 12%).

“My boyfriend got his shit together.”

Three participants reported being too far along in their pregnancies to have an abortion. This included women feeling like they were too far along for their own comfort:

“Well, had I not had to do the first appointment, I would have been able to have the abortion earlier, but because I had to wait so long to schedule the first appointment, by the time I was able to gather funds, get childcare, and find a way to get to the second appointment, I was 13 weeks and I wasn’t comfortable with getting the abortion any more. It was just ridiculous that I had to go through that. I had to wait so long that I wasn’t comfortable doing it any longer. I felt like I was too far along.”

One woman discovered that she was 20 weeks rather than 14 weeks pregnant at her abortion appointment and was past the gestational limit at the facility where she sought care. Finally, one woman passed the gestational limit at the facility where she sought care because of the 72-hour waiting period.

Two participants mentioned having made the first visit as part of exploring options and two mentioned wanting more time to think. One reported logistical challenges scheduling the appointment.

Effects

Concrete costs

Participants spent a mean of \$44 (range \$0 - \$590) on abortion information visit-related costs. This \$44 represents a median of 1.2% of women’s monthly household income. Of participants who had an abortion, participants spent a mean of \$103 (\$0 - \$1330) on abortion visit-related costs and paid a mean of \$387 (\$0 - \$2280) to the facility where they had the abortion. The information visit costs thus represent 11% of the cost of the abortion and 9% of the total costs of the abortion plus abortion visit-related costs. Among those who had an abortion, 20% received financial help from a formal source, mostly (19%) from abortion funds or clinic discounts; 42% received financial help from another person, mostly (76%) from the man involved in the pregnancy, boyfriend, or partner.

Even when women used their own money, one-fourth (26%) had to tell someone else they were spending the money. Among the 64 women who had to tell someone else they were spending the money, more than three-fourths (77%) had to tell the man involved in the pregnancy, boyfriend, or partner.

To make logistical arrangements to attend the information visit, 6% had to disclose that they were seeking abortion to one or more people, including bosses, co-workers, men involved in the pregnancy, family members, friends, or child care providers.

Women who had an abortion waited an average of eight days (8.8 mean, 8 median, 8 mode) between the information visit and the abortion. The four most common reasons for waiting more than 72-hours included appointment availability (48%), her own logistics (19%), making financial arrangements (9%), and wanting more time to think (6%).

Hardest part

Women noted multiple difficult aspects of having to wait and make two visits. The 10 most commonly cited difficult aspects are listed in Table 4. The most common difficulty with waiting was wanting the abortion to be over with. Women who reported wanting it to be over with expressed knowing what they wanted to do, but feeling like they could not move on until they had the abortion.

“It definitely made me more anxious. It was time consuming because I had already made my decision and I wanted to get it over with instead of having extra time. I didn't want the extra time to think about it.”

“Waiting, basically. That was the hardest part. I had to wait like a week and a half. That was killing me. I'm a person that wants to get everything over and done with once I've made a decision so that was hard. I wanted it over and done with to move on with my life.”

For some, this was expressed as frustration, being powerless to implement their decision.

Three of the top 10 difficult aspects of waiting focused on the abortion decision. These included feeling sure about the decision, dwelling on the decision, and questioning the decision. The distinction between feeling sure, dwelling on, and questioning the decision is that feeling sure refers to explicitly expressing that she was feeling sure while waiting, dwelling involves thinking about the decision without necessarily expressing either certainty or uncertainty, and questioning involves expressing uncertainty about the decision. One described dwelling as:

"You're just thinking about it. It didn't change my decision, It was more making your decision feel like a weight on you. You made the decision, but you're just stuck with it for three days."

Others expressed some uncertainty, questioning their decision:

"Having all the time to think is really what it was. I knew what I wanted to do or what I felt was the best decision but having all that extra time to think made me question it more and more."

Also common was feeling nervous about the procedure.

"Just stress of how the procedure is going to go because you just want to get it over with. I couldn't sleep for 3 nights."

For some, the nervousness about the procedure related to their advancing gestation, as they feared that they would have to have an aspiration abortion rather than a medication abortion because of gestation.

"I was just anxious to go in for the procedure. I was more nervous that I was maybe more than 9 weeks along and that I would have to have the surgery."

For others, advancing gestation also included concern about the fetus getting bigger, developing an attachment to the fetus, worrying that she would be beyond her comfort zone for abortion in terms of gestation, and concern about cost going up.

"Just being ready to do it and still having the baby grow while you're trying to wait. And you don't want to be any later than you are. When you want to do it, you don't want to wait for it to develop even more."

“I kept on thinking that it was taking me that many days further along in my pregnancy. And I knew the longer it took, the more money it would cost. They had told me the costs would increase, and we are living pay check to pay check as it is, and if I gone 1 week sooner, it would have been \$100 less. The cost just went up.”

Feeling physically sick, with ongoing nausea and other pregnancy symptoms, was also difficult.

Some also mentioned logistical difficulties with waiting, i.e. difficulty scheduling the abortion appointment and having to miss work, although these were not typically mentioned in relation to waiting.

Almost all of the top 10 hardest parts of having to make two visits related to logistics and costs associated with logistics. Most common was having to miss work, but women also mentioned difficulties with logistics of travel, cost of travel, actual travel, and arranging for other people to travel with them, with scheduling the appointment and arranging childcare, and with the amount of time the different components took. Costs were also a significant part of the difficulties with the two visit requirement.

“Financially it was just hard- it's hard to take time away from things I could be doing. It made it inconvenient. I could have stayed in Utah in between, but I have 3 children, so I couldn't stay there. I had to make the trip, come back home and do the regular stuff, and then plan another trip.”

Discussion

Under a 72-hour waiting period and two-visit requirement, more than 8.5 out of 10 women who had an abortion information visit obtained an abortion. The vast majority of participants were not conflicted about their decision to have an abortion at the abortion information visit and almost all of these women went on to have an abortion within three weeks of the information visit. The waiting period prevented one woman from having an abortion by pushing her past the gestational limit at the facility at which she sought care.

Of the small minority (8%) no longer seeking abortion at follow-up, most had expressed at the information visit that they were conflicted about their decision. The 8% no longer seeking abortion at follow-up is in the range of estimates of women who did not have an abortion after seeking one in one published study , but higher than another ; these settings had either no or minimal (i.e. 2 hour) waiting periods. It is worth noting that the proportion who were conflicted about their decision at the information visit in our study is higher than the proportion conflicted when seeking abortion care in other studies . One possible explanation supported by our data is that some of the women who presented for the abortion information visit – such as those who indicated at the information visit that they preferred having the baby – were just exploring options. Notably, the 2% who were not conflicted in their decision at the information visit who were no longer seeking abortion at follow-up is in the range of multiple other studies in settings with no waiting period, a minimal (i.e. 2 hour) waiting period, and a two-day waiting period .

Results from quantitative analyses indicate that decisional conflict at the information visit was the strongest predictor of whether a woman was still pregnant at follow-up, while socioeconomic status was not a significant predictor. This replicates previous research that has found decision certainty to be a major predictor of whether or not a woman seeking abortion has an abortion . Reasons women reported in open-ended responses paint a similar picture. Women’s own decision-making was the main reason they had not had the abortion, with changing mind (closed-ended) and not being able to go through with the abortion (open-ended) as the most commonly cited reasons. While these reasons seem similar, the nuance in open-ended responses is less about being sure and changing one’s mind and more about having been conflicted to begin with and then not going through with the abortion. In contrast to quantitative findings, financial reasons and procedure cost was the second most common reason for not having had the abortion in open-ended responses. Because the information visit increased costs by about 10%, the additional costs resulting from the two visit requirement could have played a role in

some of these women not having an abortion. However, in considering participant's income status and previous research finding that lack of Medicaid coverage for abortion prevents women from having abortions, it appears more likely that lack of Medicaid funding for abortion played a larger role than the waiting period and two visit requirement in preventing women from having an abortion. We had expected to find that other people tried to prevent women from having an abortion. Yet, when we examined open-ended responses, we found a more complicated story. Some women reported that other people came through for them after the information visit. Other people coming through allowed them to decide to continue the pregnancy, which was sometimes the option they expressed a preference for at the information visit.

Financially, women reported spending an average of \$44 on logistics of attending the information visit. For this low-income population, this represents 1.2% of monthly household income. For a household making \$60,000 per year (slightly above the median income in the U.S.), this would be the equivalent of \$75. Similar to other studies of women seeking abortion, many in our sample needed assistance paying for the abortion, indicating that the cost of the abortion was already out of reach. Thus, these additional costs for the information visit are not necessarily negligible for this low-income population. Socially, about 6% of women had to disclose that they were seeking abortion in order to make the logistical arrangements for the abortion information visit. Timing-wise, in practical terms, the 72-hour waiting period was more like an 8-day waiting period. For women earlier in gestation and without pregnancy symptoms, this extra wait may not have had consequences. However, for women who preferred a medication abortion and women further along in gestation, this wait potentially contributed to not being able to have their preferred type of abortion and potentially contributed to extra costs. For one woman, the waiting period put her beyond the gestational limit at the facility where she sought care and thus made her unable to have an abortion; for another, the waiting period pushed her past the point at which she felt comfortable having an abortion.

Some limitations are worth noting. First, we only collected data after the 72-hour waiting period went into effect. Thus, we are unable to make comparisons with experiences in Utah under the 24-hour waiting period. Second, only a small number of participants were still pregnant at follow-up, which limits predictors we could consider in multivariable analyses. Third, while our response rate was very good, our follow-up rate was lower than we had hoped, although still within the range of other longitudinal abortion studies. Also, our overall proportion of women who had had an abortion at follow-up was within the range of statewide estimates during this same time period. Fourth, this study was conducted in Utah, a state with a high Mormon population that is primarily White. Also, Utah's abortion information requirement differs from requirements in other states such as South Dakota that require women to have the information visit with the same physician who will provide the abortion, thus, in practice, likely limiting the visit to the same facility where they have the abortion. Thus, waiting period/2-visit requirement laws such as South Dakota's could impose greater travel and financial burdens than those found in our study. All of these factors may limit applicability of our findings to other states.

This study also has strengths. First, this study makes an important contribution to understanding women's experiences with newer, more severe, types of abortion restrictions. Second, we used an innovative approach to identify and interview women who do not have abortions after seeking them in the context of abortion restrictions. Rather than speculating about how restrictions affect women – especially those who do not have abortions – we have women's own descriptions of these experiences. Third, by collecting data at two time points, one prior to the information visit, we prospectively examine how factors that pre-existed the information visit contributed to women's experiences. Had we only asked women at follow-up, their retrospective responses may have been biased by what they eventually ended up doing. Fourth, we include both closed and open-ended responses and find that the open-ended responses add important nuance to responses to the close-ended questions.

This study demonstrates that the vast majority of women presenting for abortion are certain about their decision and go on to have an abortion. Furthermore, encouraging individual women who are conflicted about their decision to take more time to make their decision is a common component of abortion care. Thus, a law requiring all women to make two visits and wait 72 hours for an abortion appears to be an unnecessary burden for women seeking abortion care.

Figure 1. Flow diagram of the progress through the phases of recruitment for the study.

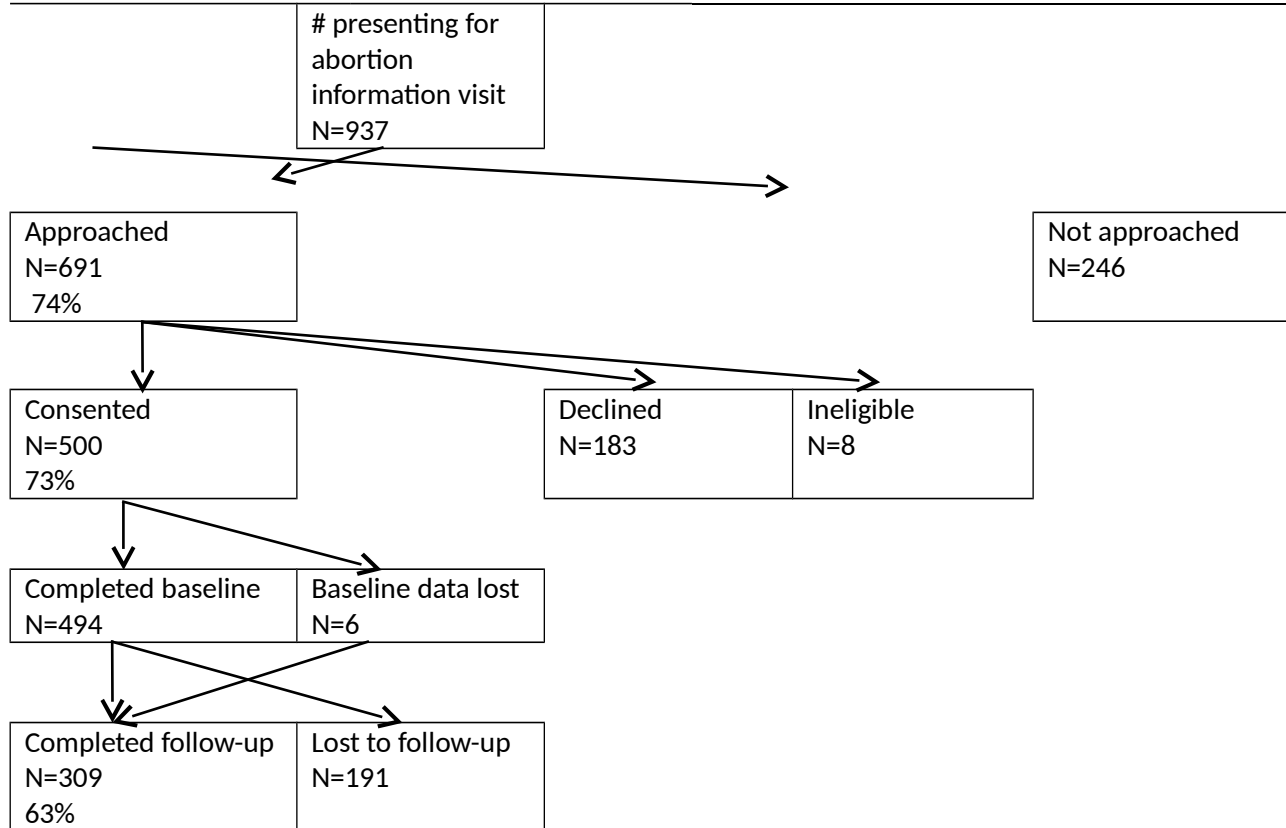


Table 1. Sample description n=500

Variable	n (%) or mean
Age	25.6 (mean)
Race	
White	323 (65)
Black	14 (3)
Hispanic/Latina	118 (24)
Other/mixed race	39 (8)
Parity	
Gestational age discovered pregnancy	
Religion	
Protestant	51 (10)
Catholic	58 (12)
Mormon	94 (19)
Other religion	23 (5)
No religion	266 (54)
Public assistance	159 (32)
Household income	\$21,761 (mean)
Employed	342 (69)
Hx depression/anxiety	132 (27)
Risky drinking	235 (48)
Drug use	81 (17)
Violence from the man involved in the pregnancy	44 (9)
Abortion knowledge	.62 (mean)
Decisional conflict	15 (mean)
Option preferred at info visit	
Having an abortion	467 (95)

Having the baby and raising it	22 (4)
Having the baby and placing it for adoption	1 (<1)

Table 2. Bivariable and multivariable analyses predicting still pregnant at follow-up

	Bivariable analysis (n=300)				Multivariable analysis (n=278)			
	OR	P	95% CI		aOR	p	95% CI	
Abortion knowledge	0.06	<.01	0.01	0.40	0.55	ns	0.05	5.73
Age	1.01	Ns	0.95	1.08	1.02	ns	0.94	1.10
Risky drinking	0.49	Ns	0.23	1.05	0.50	ns	0.20	1.29
Drug use	0.63	Ns	0.21	1.88	0.75	ns	0.21	2.75
Public assistance	2.97	<.01	1.43	6.14	1.70	ns	0.68	4.26
Decisional conflict	1.06	<.001	1.04	1.09	1.06	<.001	1.03	1.10
Employment	0.54	Ns	0.26	1.13	0.79	ns	0.31	2.03
Gestational age discovered pregnancy	0.81	<.05	0.65	1.00	0.79	<.05	0.63	1.00
Any mental health	1.89	Ns	0.89	3.98	1.73	Ns	0.67	4.44

Note: Gestational age discovered pregnancy was the variable missing the most data (n=16); in a model with a categorical gestational age discovered pregnancy variable that also included a missing category, the main substantive findings did not change.

Table 3. Reasons for not having an abortion (among those still pregnant at follow-up, n=34)

Closed-ended reason	N (%)	Open-ended reason	N (%)
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Changed mind about wanting an abortion	24 (71%)	Just couldn't do it	18 (53%)
Cost of the procedure	16 (47%)	Financial reasons	6 (18%)
Person/people in my life don't want me to have the abortion	13 (38%)	Other people coming through	4 (12%)
Keeping my appointment secret from my family	13 (38%)	Too far along	3 (9%)
Keeping the appointment secret from my employer	9 (26%)	Had been exploring options	2 (6%)
Having to get my partner or family member to help with childcare, transportation, cost, or something else	8 (24%)	Wanting more time to think	2 (6%)
Insurance coverage	8 (24%)	Logistical	1 (3%)
Still thinking about whether I want an abortion	5 (15%)		
Finding time/getting time off to get the abortion	5 (15%)		
Keeping my appointment secret from my partner	5 (14%)		
Travel costs to get to the clinic	4 (12%)		
Arranging childcare	4 (12%)		
Getting time off work or school	3 (9%)		
Not knowing where to go	2 (6%)		
Figuring out how to get to the clinic	2 (6%)		
Other	2 (6%)		
Not being able to find a doctor who would do my abortion this far along	1 (3%)		
Arranging care for someone else (elder or other family member)	1 (3%)		

Table 4. 10 most common hardest parts of waiting and having to make two visits (n=309)

Waiting period code	N	%	2 visit code	N	%
Wanting it to be over with	69	22%	Time off work	67	22%
Gestational age	34	11%	Distance to clinic ("drive)	49	16%
Feeling sure re: decision	32	10%	Time	39	13%
Nervous about procedure	27	9%	Scheduling apt	25	8%
Questioning decision for ab	24	8%	Childcare	23	7%
Physically sick	21	7%	Cost	18	6%
Frustration	20	6%	Waiting	17	6%
Scheduling apt	19	6%	Travel costs	17	6%
Dwelling on decision	19	6%	Travel arrangements	15	5%
Missing work	17	6%	Friend/companion	14	5%
			logistics		

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References