Original Research Article in *Contraception* – Author Version

Unintended pregnancy in the United States: incidence and disparities, 2006

Lawrence B. Finer,* Mia R. Zolna

Guttmacher Institute, New York, NY 10038, USA

Volume 84, Issue 5, Pages 478-485, November 2011

Received 22 July 2011; accepted 28 July 2011; published online 25 August 2011

doi: 10.1016/j.contraception.2011.07.013

***Corresponding author**

Lawrence B. Finer
Guttmacher Institute
125 Maiden Lane, 7th Floor
New York, NY 10038
E-mail: lfiner@guttmacher.org

Abstract

Background: The incidence of unintended pregnancy is among the most essential health status indicators in the field of reproductive health. One ongoing goal of the US Department of Health and Human Services is to reduce unintended pregnancy, but the national rate has not been estimated since 2001.

Study Design: We combined data on women's pregnancy intentions from the 2006–2008 and 2002 National Survey of Family Growth with a 2008 national survey of abortion patients and data on births from the National Center for Health Statistics, induced abortions from a national abortion provider census, miscarriages estimated from the National Survey of Family Growth and population data from the US Census Bureau.

Results: Nearly half (49%) of pregnancies were unintended in 2006, up slightly from 2001 (48%). The unintended pregnancy rate increased to 52 per 1000 aged 15–44 years in 2006 from 50 in 2001. Disparities in unintended pregnancy rates among subgroups persisted and in some cases increased, and women who were 18–24 years old, poor or cohabiting had rates two to three times the national rate. The unintended pregnancy rate declined notably for teens 15–17 years old. The proportion of unintended pregnancies ending in abortion decreased from 47% in 2001 to 43% in 2006, and the unintended birth rate increased from 23 to 25 per 1000 women 15–44 years old.

Conclusions: Since 2001, the United States has not made progress in reducing unintended pregnancy. Rates increased for nearly all groups and remain high overall. Efforts to help women and couples plan their pregnancies, such as increasing access to effective contraceptives, should focus on groups at greatest risk for unintended pregnancy, particularly poor and cohabiting women.

1. Introduction

Preventing unintended pregnancy is a personal goal for most couples, and reducing the national level of unintended pregnancy is one of the most important reproductive health goals identified by the US Department of Health and Human Services [1]. Women who have an unintended pregnancy are also at risk for unintended childbearing, which is associated with a number of adverse maternal behaviors and child health outcomes, including inadequate or delayed initiation of prenatal care, smoking and drinking during pregnancy, premature birth and lack of breastfeeding, as well as negative physical and mental health effects on children [2-9].

While the unintended pregnancy rate in the United States decreased between the late 1980s and mid 1990s [10], it stalled by 2001, the last year for which estimates are available [11]. Recent decreases in births and abortions have occurred among some population subgroups (e.g., teens) [12], but it is unclear if unintended pregnancy rates have also changed. The recent release of new data on pregnancy intentions has made it possible to determine the incidence of unintended pregnancy for 2006. We calculated unintended pregnancy rates for all women of reproductive age and for key population subgroups, including race and ethnicity and relationship status, because previous studies indicate strong associations among unintended pregnancy and these groups [11]. We also present information on outcomes of unintended pregnancy, including the percentage of unintended pregnancies that ended in abortion and the rate of births that followed unintended pregnancy. These estimates are some of the most essential indicators in the field of reproductive health, and periodic trend assessments provide valuable information for public health officials and policy makers who monitor progress toward reducing unintended pregnancy.

2. Materials and methods

Overview

For all US women and by key population subgroups (age, educational attainment, race and ethnicity, income, relationship status, parity and religious affiliation), we determined the number of pregnancies that ended in birth, induced abortion and miscarriage[1]; calculated the proportion of each of these outcomes that were unintended; and then divided the total number of unintended pregnancies by the population of women aged 15–44 years to obtain an unintended pregnancy rate per 1000 women.

Counts and intendedness of pregnancies by outcome

Births

We relied on data from the National Center for Health Statistics (NCHS) [13-15] to obtain the number of US births that occurred in 2001 and 2006 overall and by the mother's age, educational attainment, race and ethnicity, relationship status (not including cohabitation), and parity (2006 only). We distributed births by other subgroups (including cohabiting status) using the National Survey of Family Growth (NSFG), a nationally representative survey of US women aged 15–44 years conducted by the NCHS.

Women's pregnancy intentions were obtained from the NSFG, which asked women a series of retrospective questions to determine whether each of the pregnancies they had had were intended or unintended at the time it occurred. Intended pregnancies were those that occurred to women who wanted a baby at the time they became pregnant or sooner or were indifferent about conceiving; unintended pregnancies were conceptions that were mistimed (i.e., the woman wanted to become pregnant at some point in the future, but not when she conceived) or unwanted

[1] Miscarriage refers to spontaneous fetal loss or stillbirth.

(i.e., she did not want to become pregnant at the time of conception nor in the future). We focused on the births in the 5 years preceding the 2006–2008 (n=2044) and 2002 (n=2618) interviews.

Abortions

The total number of surgical and medication abortions performed in 2001 and 2006 came from a census of US abortion providers [16] conducted by the Guttmacher Institute. Counts by age came from the Centers for Disease Control and Prevention's 2001 and 2006 abortion surveillance reports [17,18], and estimates for all other subgroups were based on interpolations of distributions from two nationally representative Abortion Patient Surveys (APS) conducted by the Guttmacher Institute in 2000 (n=10,683) [19] and 2008 (n=9493) [20].

Abortions are underreported in the NSFG. Therefore, pregnancy intentions among women obtaining abortions for *both* 2006 and 2001 were based on distributions from the 2008 APS, which, for the first time, asked women the same set of questions that were used in the NSFG. Use of these data enabled us to identify the proportion of abortions that followed *intended* pregnancies, rather than assuming that all abortions followed *unintended* pregnancies, an approach used in previous analyses.[2]

Miscarriages

There is no "gold standard" count of miscarriages. Official statistics are limited to fetal deaths at 20 weeks of gestation or later [21], and, hence, miss those that occur earlier in pregnancy. We estimated the number of miscarriages for 2006 by calculating the ratio of miscarriages to births [22] overall and by subgroup that occurred in the 7 years preceding the last two NSFG rounds (2002 and 2006–2008) and multiplying that ratio by the total number of US births in 2006

[2] This change resulted in lower unintended pregnancy estimates for 2001 than were previously reported [11].

overall and by subgroup. Women in their teens and those 40 years or older had relatively fewer pregnancies, so we increased the sample size by including data from a third round of the NSFG (1995) to improve the validity of the estimate.[3] To estimate the number of miscarriages for 2001, we applied the same ratio calculated from all three NSFG surveys combined to the 2001 birth counts.

Information on the intendedness of pregnancies ending in miscarriage came from miscarriages in the 5 years preceding the 2006–2008 (n=560) and 2002 (n=729) NSFG interviews. In previous analyses, we relied directly on women's reports of intendedness, but subgroup sample sizes for 2006 were inadequate. Because miscarriages are pregnancies that would otherwise end in either birth or abortion, we would expect that the proportion of miscarriages that were intended would fall between the proportion of births that were intended and the proportion of abortions that were intended. For the entire NSFG sample, this assumption was accurate.[4] Therefore, for subgroups, we calculated the proportion of miscarriages that were intended by constraining it to fall between the proportion of births and abortions intended.[5]

Population denominators and calculations

Denominators for pregnancy, birth and abortion rates for all women aged 15–44 years and by age and race and ethnicity were obtained from population estimates published by the US Census Bureau [23]. Population distributions by educational attainment, poverty and relationship status came from the Annual Social and Economic Supplements of the Current Population Survey. The population distributions for women by cohabitation status, religious affiliation and parity were

[3] The ratio of miscarriages to births has not changed much between 1995 and 2006, so use of earlier 1995 data should not be problematic.
[4] In 2006, 57% of miscarriages followed intended pregnancies, compared with 64% of births and 5% of abortions.
[5] For example, in 2006, the proportion of miscarriages that were intended within each subgroup was calculated as $A + (0.884 \times [B - A])$, where A is the proportion of abortions in that subgroup that were intended, B is the proportion of births in that subgroup that were intended, and 0.884 is (57% – 5%)/(64% – 5%), based on the overall proportions for the sample population mentioned in the previous footnote.

based on interpolations of the 1995, 2002 and 2006–2008 NSFGs. Distributions by education were limited to the population of women 20 years and older, who were likely to have completed or mostly completed schooling.

When calculating the percentage of unintended pregnancies that ended in abortion, we excluded miscarriages from the denominator in order to better represent pregnancies with outcomes decided by the woman.

3. Results

Proportion of unintended pregnancies and unintended pregnancy rates

There were 6.7 million pregnancies in the United States in 2006 (Table 1), up from 6.4 million in 2001 (data not shown). Some 3.2 million pregnancies were unintended in 2006, compared with 3.1 million in 2001 (data not shown). The percentage of pregnancies that were unintended increased slightly between 2001 (48%) and 2006 (49%), and the unintended pregnancy rate also increased during this time period: In 2006, there were 52 unintended pregnancies for every 1000 women aged 15–44 years, compared with 50 in 2001. In other words, about 5% of women of reproductive age had an unintended pregnancy in 2006. When looking at unintended pregnancy by timing, 29% of all pregnancies were mistimed and 19% were unwanted (data not shown). The intended pregnancy rate stayed nearly the same, and the overall pregnancy rate increased.

Age. The proportion of pregnancies that were unintended generally decreased with age, with more than four out of five pregnancies unintended among women 19 years and younger. Between 2001 and 2006, this percentage decreased for women 15–17 years and increased or stayed nearly the same for all other women. The unintended pregnancy rate was the highest for women 20–24 years old due to an increase between 2001 and 2006.

Educational attainment. Women with the fewest years of education had the highest unintended pregnancy rate, and rates decreased as years of education attained increased. Unintended pregnancy rates increased the most among women with no college experience.

Race and ethnicity. Black women had the highest unintended pregnancy rate among all racial and ethnic subgroups, more than double that of non-Hispanic white women. Rates changed little between 2001 and 2006.

Income. Poor and low-income women's unintended pregnancy rates increased substantially, while the rate for higher-income women decreased. The rate for poor women was more than five times the rate for women in the highest income level. While there was little difference by education among women in the highest income bracket (Fig. 1A), minorities had the highest unintended pregnancy rates regardless of income level (Fig. 1B).

Relationship status. Unintended pregnancy rates increased among cohabitors and formerly married women. Cohabiting women exhibited both the highest rate and the greatest increase among all individual subgroups measured in this analysis. Rates were even higher among cohabiting women who were under 25 years old (Fig. 2A) or poor or low-income (Fig. 2B).

Parity. Women with one previous birth had an unintended pregnancy rate that was roughly twice as high as the rate for women who had never given birth and women with two or more previous births.

Religious affiliation. Women with no religious affiliation reported the highest unintended pregnancy rate, followed by Catholics, Protestants, and women with other affiliations.

Outcomes of unintended pregnancies

Forty-three percent of unintended pregnancies ended in abortion[6] in 2006, a decline from 47% in 2001 (Table 2). In 2006, the unintended birth rate[7] was 25 per 1000 women aged 15–44 years, up from 23 in 2001.

Age. Between 2001 and 2006, the proportion of unintended pregnancies ending in abortion increased for women aged 15–17 years and declined or stayed the same for all other women. The greatest declines were exhibited among women aged 18–24 years. As a result, the unintended birth rate decreased for women 15–17 years and increased the most for women aged 18–24 years. Rates for women aged 18–24 years were more than twice the national rate.

Educational attainment. Women with some college but no degree were most likely to end an unintended pregnancy by abortion; these women were also more likely to still be enrolled in school. Those without a high school diploma were most likely to continue an unintended pregnancy, and had an unintended birth rate that was almost twice the national rate and nearly four times the rate for college graduates.

Race and ethnicity. The proportion of unintended pregnancies ending in abortion decreased across all racial and ethnic subgroups, with black women most likely to end an unintended pregnancy by abortion. Hispanic women had the highest unintended birth rate, and minority women had rates that were more than twice that of white women.

Income. Compared with higher-income women, poor and low-income women were less likely to end an unintended pregnancy by abortion. Consequently, poor women had a relatively high unintended birth rate. While lower-income women experienced an increase in the

[6] As described above, this calculation excludes miscarriages.
[7] The phrase "unintended birth rate" is shorthand for the rate of births that followed unintended pregnancies.

unintended birth rate, this rate remained relatively stable for women in the highest income category.

Relationship status. Married and cohabiting women were much less likely than other women to end an unintended pregnancy by abortion. The rate of unintended births among cohabiting women increased sharply and was more than three times the rate for other women.

Parity. Women with exactly one previous birth were least likely to end an unintended pregnancy by abortion, and their unintended birth rate was more than twice that of the other groups.

Religious affiliation. Women with no religious affiliation were most likely to end an unintended pregnancy by abortion; they also had the highest unintended birth rate, followed closely by Catholics and Protestants. Evangelicals were least likely to terminate an unintended pregnancy.

4. Discussion

The US unintended pregnancy rate increased slightly between 2001 and 2006, a worrisome trend, and remains significantly higher than the rate in many other developed countries [24]. Population shifts — for example, increases in groups with high rates, such as poor and minority women — may have contributed to the overall increase. In addition, the overall increase could have occurred if the trend toward later childbearing [25] has led to a longer period before childbearing when relatively less-effective methods are used [26] and a shorter period post-childbearing when use of highly effective long-term methods is more common.

During the same period, the overall proportion of women ending an unintended pregnancy by abortion decreased. These changes may have been due to decreased access to abortion in some areas, increased stigmatization of abortion or both.

Among all the subgroups for which we present data, only women aged 15–17 years saw notable improvements since 2001; both their unintended pregnancy rate and unintended birth rate declined by roughly one quarter.

Many disparities among subgroups, already large, grew. In particular, cohabiting women exhibited very high and increasing unintended pregnancy and unintended birth rates. Like married women, cohabiting women are regularly sexually active but are less likely than married women to desire pregnancy and, thus, are at a very high risk for unintended pregnancy. They are, however, more likely to carry a pregnancy — including an unintended pregnancy — to term than unmarried noncohabiting women, perhaps because they have more partner support. In addition, the decline in the proportion of unintended pregnancies ending in abortion may have been related to increased normalization of childbearing among these couples. These findings represent consequences of broad demographic trends — specifically, fewer married women and a greater proportion of childbearing to unmarried women — and also help to explain those trends by showing that cohabiting couples, regardless of marital status, have high pregnancy rates and that a large proportion of those pregnancies are unintended.

Poor and low-income women also experienced some of the greatest increases and highest rates of unintended pregnancy. This finding is consistent with numerous studies that document the association between disadvantage and higher risk for unintended pregnancy [27-29]. While reasons behind this relationship are not fully understood, they are related to the significant life challenges facing many of these women [30,31]. The upward trend in their unintended

pregnancy rate has continued for over a decade [10]. During this time, publicly funded family planning clinics — which have been shown to help low income women achieve their childbearing goals [32] — were only able to meet about 40% of the need for publicly subsidized care [33]. This gap in services, along with rising unintended pregnancy rates, underscores the need to expand programs that could enable low income women and couples to be more consistent and effective contraceptive users.

The disparities by parity are probably explained by the desire for families with two children. In other words, the high intended and unintended rates for women with one birth compared with childless women or those with two or more births may be due to the fact that women reporting only one birth may be more likely to have a second birth but are less likely to progress to a third birth [34]. At the same time, their high unintended pregnancy rate suggests that mothers have difficulties timing births, and their high unintended birth rate suggests less concern about continuing an unintended pregnancy compared with other women.

This is an aggregate-level analysis incorporating data from multiple data sets, which makes statistical testing difficult. One test that can be performed is a comparison based on a subset of our data: the proportion of pregnancies ending in birth (i.e., excluding abortions, which are underreported, and miscarriages) that were unintended in 2006 and 2001. The overall percentage increase, from 35% to 36%, was not significant, although the increase among women aged 20–24 years, from 45% to 53%, was significant at the $p<.10$ level. Nonetheless, we do see substantively significant changes in unintended pregnancy rates in several subgroups. This argues that the limited tests on a subset of our key statistic do not capture the whole picture, and their results should not be considered conclusive.

In conclusion, the United States did not make progress toward its goal of reducing unintended pregnancy between 2001 and 2006. To better understand what drove these rates up, we are currently conducting a demographic analysis of changes in population composition and reproductive health behaviors that have historically affected them. However, given the nation's increasingly high unintended pregnancy rate and the fact that 11% of the population at risk does not use birth control [26], reducing the unintended pregnancy rate requires that we focus on increasing and improving contraceptive use among women and couples who want to avoid pregnancy. Increased use of long-acting and cost-effective contraceptive methods such as the intrauterine device (IUD) could play an important role in such an effort. In particular, the age at which childbearing begins has increased [25], and the length of time from first intercourse to first birth is, on average, 8 years; this is a period of potential risk for women and couples and should be seen as an appropriate time to use long-acting methods. The American Congress of Obstetricians and Gynecologists has indicated that such methods should be "first-line" choices for young women, and coupling IUDs with condoms for additional protection may have the potential to reduce unintended pregnancy even further [35,36]. Although these methods are highly cost-effective over time, even women with health insurance may have difficulty paying for these methods because some plans do not cover the high upfront costs or other charges women often incur to use them [37]. Research indicates that when financial barriers are completely removed and comprehensive information is provided on all methods, women choose long-acting, highly effective methods in large numbers [38].

Acknowledgments

The authors would like to thank Stanley Henshaw, Rachel Jones and Megan Kavanaugh for reviewing the manuscript, as well as Jacqueline Darroch and Susheela Singh for providing guidance on study methodology. This study was supported by award R01HD059896 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). The content is solely the responsibility of the authors and does not necessarily represent the official views of NICHD or the National Institutes of Health.

References

[1] U.S. Department of Health and Human Services. Healthy People 2020 topics & objectives. HealthyPeople.gov.http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist. aspx?. Published December 2, 2010. Accessed March 7, 2011.

[2] Axinn WG, Barber JS, Thornton A. The long-term impact of parents' childbearing decisions on children's self-esteem. Demography 1998;35:435-43.

[3] Barber JS, Axinn WG, Thornton A. Unwanted childbearing, health, and mother-child relationships. J Health Soc Behav 1999;40:231-57.

[4] Dott M, Rasmussen SA, Hogue CJ, Reefhuis J. Association between pregnancy intention and reproductive-health related behaviors before and after pregnancy recognition, National Birth Defects Prevention Study, 1997-2002. Matern Child Health J 2010;14:373-81.

[5] Dye TD, Wojtowycz MA, Aubry RH, Quade J, Kilburn H. Unintended pregnancy and breast-feeding behavior. Am J Public Health 1997;87:1709-11.

[6] Hellerstedt WL, Pirie PL, Lando HA, et al. Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. Am J Public Health 1998;88:663–6.

[7] Mayer JP. Unintended childbearing, maternal beliefs, and delay of prenatal care. Birth 1997;24:247–52.

[8] Orr ST, Miller CA, James SA, Babones S. Unintended pregnancy and preterm birth. Paediatr Perinat Epidemiol 2000;14:309–13.

[9] Taylor JS, Cabral HJ. Are women with an unintended pregnancy less likely to breastfeed? J Fam Pract 2002;51:431–6.

[10] Henshaw SK. Unintended pregnancy in the United States. Fam Plann Perspect 1998;30:24–9 & 46.

[11] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. Perspect Sex Reprod Health 2006;38:90–6.

[12] Kost K, Henshaw S, Carlin L. U.S. teenage pregnancies, births and abortions: national and state trends and trends by race and ethnicity, 2010. New York: Guttmacher Institute; 2010.

[13] Centers for Disease Control and Prevention. Natality information: live births. CDC WONDER online database. http://wonder.cdc.gov/natality.html. Updated 2009. Accessed April 9, 2010.

[14] Martin JA, Hamilton BE, Ventura SJ, et al. Births: final data for 2001. Natl Vital Stat Rep 2002;51(2).

[15] Martin JA, Hamilton BE, Sutton PD, et al. Births: final data for 2006. Natl Vital Stat Rep 2009;57(7).

[16] Jones RK, Zolna MR, Henshaw SK, Finer LB. Abortion in the United States: incidence and access to services, 2005. Perspect Sex Reprod Health 2008;40:6–16.

[17] Pazol K, Gamble SB, Parker WY, Cook DA, Zane SB, Hamdan S. Abortion surveillance — United States, 2006. MMWR Surveill Summ 2009;58:1–35.

[18] Strauss LT, Herndon J, Chang J, Parker WY, Levy DA, Bowens SB, et al. Abortion surveillance — United States, 2001. MMWR Surveill Summ 2004;53:1–32.

[19] Jones RK, Darroch JE, Henshaw SK. Patterns in the socioeconomic characteristics of women obtaining abortions 2000-2001. Perspect Sex Reprod Health 2002;34:226–35.

[20] Jones RK, Finer LB, Singh S. Characteristics of U.S. abortion patients, 2008. New York: Guttmacher Institute; 2010.

[21] MacDorman M, Kirmeyer S. Fetal and perinatal mortality, United States, 2005. Natl Vital Stat Rep 2009;57:1–19.

[22] Ventura SJ, Abma JC, Mosher WD, Henshaw SK. Estimated pregnancy rates by outcome for the United States, 1990–2004. Natl Vital Stat Rep 2008;56:1-28.

[23] Centers for Disease Control and Prevention. Bridged-Race Population Estimates. CDC WONDER online database. http://wonder.cdc.gov/bridged-race-population.html. Updated 2011. Accessed January 10, 2011.

[24] Singh S, Sedgh G, Hussain R. Unintended pregnancy: worldwide levels, trends, and outcomes. Stud Fam Plann 2010;41:241-50.

[25] Mathews TJ, Hamilton B. Delayed childbearing: more women are having their first child later in life. NCHS Data Brief 2009;21:1–8.

[26] Mosher WD, Jones J. Use of contraception in the United States: 1982–2008. National Center for Health Statistics; 2010. Report No.: 23.

[27] Forrest JD, Frost JJ. The family planning attitudes and experiences of low-income women. Fam Plann Perspect 1996;28:246–55, 277.

[28] Frost JJ, Singh S, Finer LB. Factors associated with contraceptive use and nonuse, United States, 2004. Perspect Sex Reprod Health 2007;39:90–9.

[29] Frost JJ, Darroch JE. Factors associated with contraceptive choice and inconsistent method use, United States, 2004. Perspect Sex Reprod Health 2008;40:94–104.

[30] Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report — United States, 2011. MMRW 2011;60 (Suppl):1–116.

[31] McLanahan S, Percheski C. Family structure and the reproduction of inequalities. Ann Rev Sociol 2008;34:257–76.

[32] Frost JJ, Finer LB, Tapales A. The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. J Health Care Poor Underserved. 2008;19:778–96.

[33] Guttmacher Institute. Contraceptive needs and services, 2006, 2009. http://www.guttmacher.org/pubs/win/allstates2006.pdf. Accessed July 1, 2011.

[34] Frejka T, Sardon JP. Cohort birth order, parity progression ratio and parity distribution trends in developed countries. Demogr Res 2007;16: 315–74.

[35] Pazol K, Kramer MR, Hogue CJ. Condoms for dual protection: patterns of use with highly effective contraceptive methods. Public Health Rep 2010;125:208–17.

[36] ACOG Committee on Practice Bulletins. Clinical management guidelines for obstetrician-gynecologists: intrauterine device. Obstet Gynecol 2005;105:223–32.

[37] Sonfield A, Gold RB, Frost JJ, Darroch JE. U.S. insurance coverage of contraceptives and the impact of contraceptive coverage mandates, 2002. Perspect Sex Reprod Health 2004;36:72–9.

[38] Secura GM, Allsworth JE,Madden T,Mullersman JL, Peirpert JF. The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. Am J Obstet Gyn 2011;203:115.e1–7.

Table 1. Number of Pregnancies, Percentage of Pregnancies Unintended and Pregnancy Rate by Intention for All Women and by Demographic Characteristics

Characteristics	No. of Pregnancies (000), 2006		Percentage of Pregnancies Unintended		Total Pregnancy Rate[a]		Intended Pregnancy Rate[a]		Unintended Pregnancy Rate[a]	
	Total	Unintended	2001	2006	2001	2006	2001	2006	2001	2006
All women	6,658	3,240	48	49	104	108	54	55	50	52
Age (years)[b]										
<15	21	21	98	98	3	2	0	0	2	2
15–19	769	629	82	82	82	74	14	13	67	60
15–17	263	209	89	79	47	42	5	9	42	33
18–19	505	420	79	83	133	124	28	21	105	103
20–24	1,716	1,094	59	64	172	168	72	61	101	107
25–29	1,751	715	40	41	171	174	102	103	69	71
30–34	1,334	440	33	33	131	139	88	93	43	46
35–39	832	230	28	28	68	80	49	58	19	22
≥40	235	112	49	48	18	21	9	11	9	10
Educational attainment[c]										
Not HS graduate	853	445	49	52	146	154	74	74	72	80
HS graduate/equivalent	1,709	826	47	48	113	122	60	63	53	59
Some college/assoc. degree	1,565	813	52	52	90	94	43	45	47	49
College graduate	1,742	459	24	26	105	113	80	84	26	30
Race and ethnicity[d]										
White non-Hispanic	3,471	1,392	40	40	87	89	52	53	34	36
Black non-Hispanic	1,193	805	67	67	138	136	45	44	93	91
Hispanic	1,551	824	54	53	147	155	67	72	80	82
Income as a percentage of poverty										
<100%	1,970	1,221	61	62	196	214	77	82	120	132
100–199%	1,786	1,026	54	57	146	157	66	67	79	90
≥200%	2,902	993	37	34	74	70	46	46	28	24

Table 1. Cont.

Characteristics	No. of Pregnancies (000), 2006		Percentage of Pregnancies Unintended		Total Pregnancy Rate[a]		Intended Pregnancy Rate[a]		Unintended Pregnancy Rate[a]	
	Total	Unintended	2001	2006	2001	2006	2001	2006	2001	2006
Relationship status										
Currently married	3,404	966	28	28	120	122	86	88	33	35
Never married and not cohabiting	1,265	1,029	78	81	57	56	13	10	45	46
Formerly married and not cohabiting	388	264	59	68	74	78	30	25	44	53
Cohabiting	1,601	981	65	61	194	248	68	96	126	152
Parity										
No previous births	2,670	1,260	u	47	u	100	u	53	u	47
1	2,030	933	u	46	u	193	u	105	u	88
≥2	1,959	1,048	u	53	u	79	u	37	u	42
Religious affiliation										
Protestant	3,022	1,456	u	48	u	101	u	52	u	48
Mainstream	1,546	774	u	50	u	110	u	55	u	55
Evangelical	1,476	682	u	46	u	92	u	50	u	42
Catholic	1,901	862	u	45	u	120	u	66	u	54
Other	578	207	u	36	u	96	u	62	u	34
None	1,158	717	u	62	u	116	u	44	u	71

Notes: Numbers may not sum to group totals due to rounding. u denotes unavailable; HS, high school.

[a] Rates are per 1000 women aged 15–44 years.

[b] The population denominator for the rates for women aged <15 years is women 10–14 years; the denominator for the rates for women aged ≥40 years is women 40–44 years.

[c] Among women aged ≥20 years.

[d] Excludes women who self-identify as other non-Hispanic race/ethnic groups.

Table 2. Percentage of Unintended Pregnancies Ending in Abortion and Unintended Birth Rate for All Women and by Demographic Characteristics

Characteristics	Percentage of Unintended Pregnancies Ending in Abortion[a]		Unintended Birth Rate[b]	
	2001	2006	2001	2006
All women	47	43	23	25
Age (years)[c]				
<15	50	49	1	1
15–19	39	37	35	32
15–17	37	41	21	16
18–19	40	35	54	57
20–24	47	41	47	56
25–29	49	46	31	33
30–34	47	45	20	22
35–39	56	56	7	7
≥40	47	46	3	4
Educational attainment[d]				
Not HS graduate	34	32	41	46
HS graduate/equivalent	43	40	26	30
Some college/assoc. degree	59	56	17	19
College graduate	54	49	10	12
Race and ethnicity[e]				
White non-Hispanic	42	39	17	18
Black non-Hispanic	57	52	35	37
Hispanic	40	38	42	45
Income as a percentage of poverty				
<100%	40	43	63	66
100–199%	48	38	36	46
≥200%	51	49	11	10

Table 2. Cont.

Characteristics	Percentage of Unintended Pregnancies Ending in Abortion[a]		Unintended Birth Rate[b]	
	2001	2006	2001	2006
Relationship status				
Currently married	24	22	21	23
Never married and not cohabiting	59	61	16	15
Formerly married and not cohabiting	66	60	12	17
Cohabiting	53	39	53	79
Parity				
No previous births	u	44	u	22
1	u	40	u	45
≥2	u	46	u	19
Religious affiliation				
Protestant	u	38	u	25
Mainstream	u	44	u	26
Evangelical	u	32	u	24
Catholic	u	44	u	26
Other	u	47	u	15
None	u	51	u	30

Notes: u denotes unavailable; HS, high school.

[a] Pregnancies exclude spontaneous fetal losses and stillbirths.

[b] Rates are per 1000 women aged 15–44 years.

[c] The population denominator for the rates for women aged <15 years is women 10–14 years; the denominator for the rates for women aged ≥40 years is women 40–44 years.

[d] Among women aged ≥20 years.

[e] Excludes women who self-identify as other non-Hispanic race/ethnic groups.

Fig. 1. Unintended Pregnancy Rates by Income and Demographic Characteristics, 2006

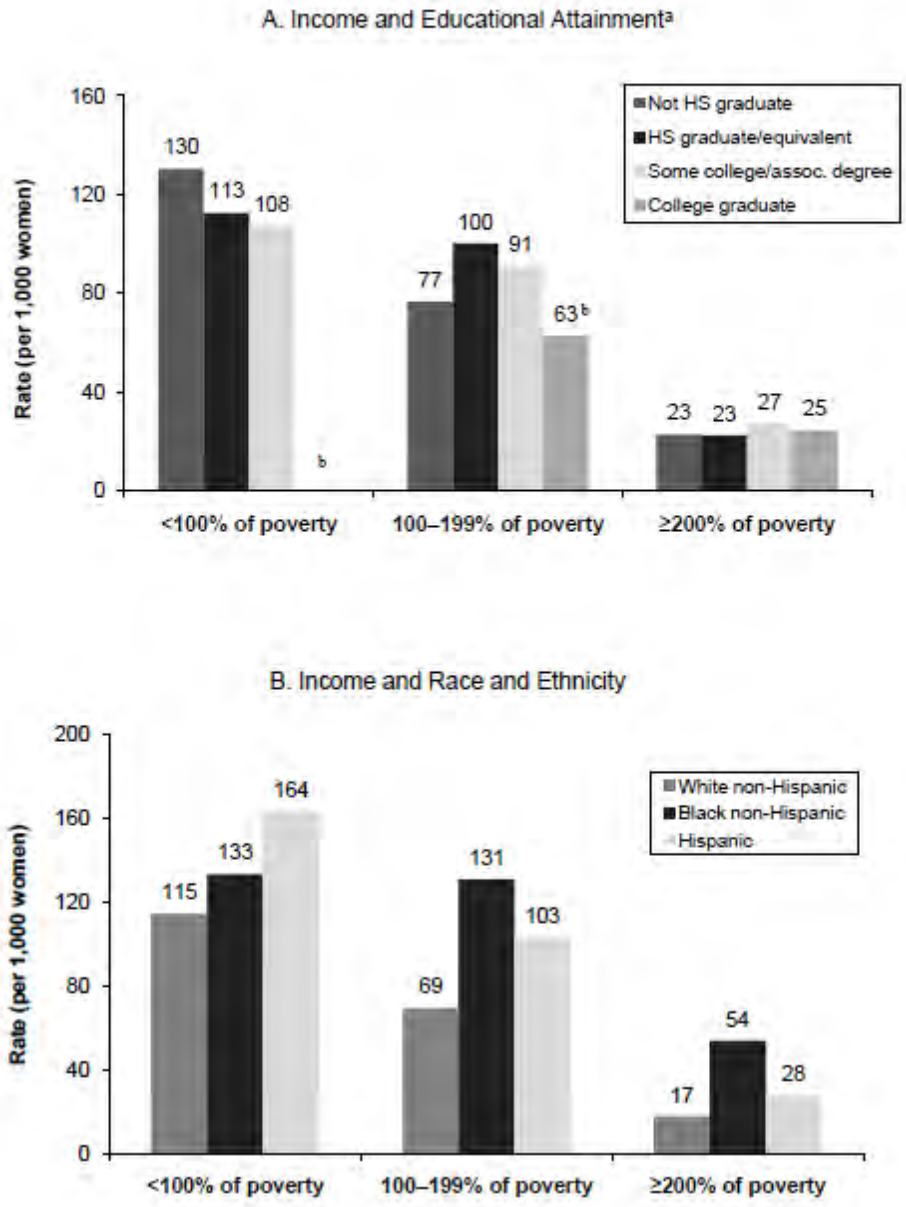

Fig. 1. (A) Unintended pregnancy rates for poor women were inversely related to educational attainment, but rates among women in the highest income bracket varied little across education levels. (a) Rates for educational attainment are among women aged 20–44 years. (b) Rates for college graduates at <100% and 100%–199% of poverty are combined to account for small sample sizes. (B) Among poor women, Hispanics had the highest unintended pregnancy rate, and among the low- and higher-income groups, black women had the highest rate. Note: This figure excludes women who self-identify as other non-Hispanic race/ethnic groups.

Fig. 2. Unintended Pregnancy Rates by Relationship Status and Demographic Characteristics, 2006

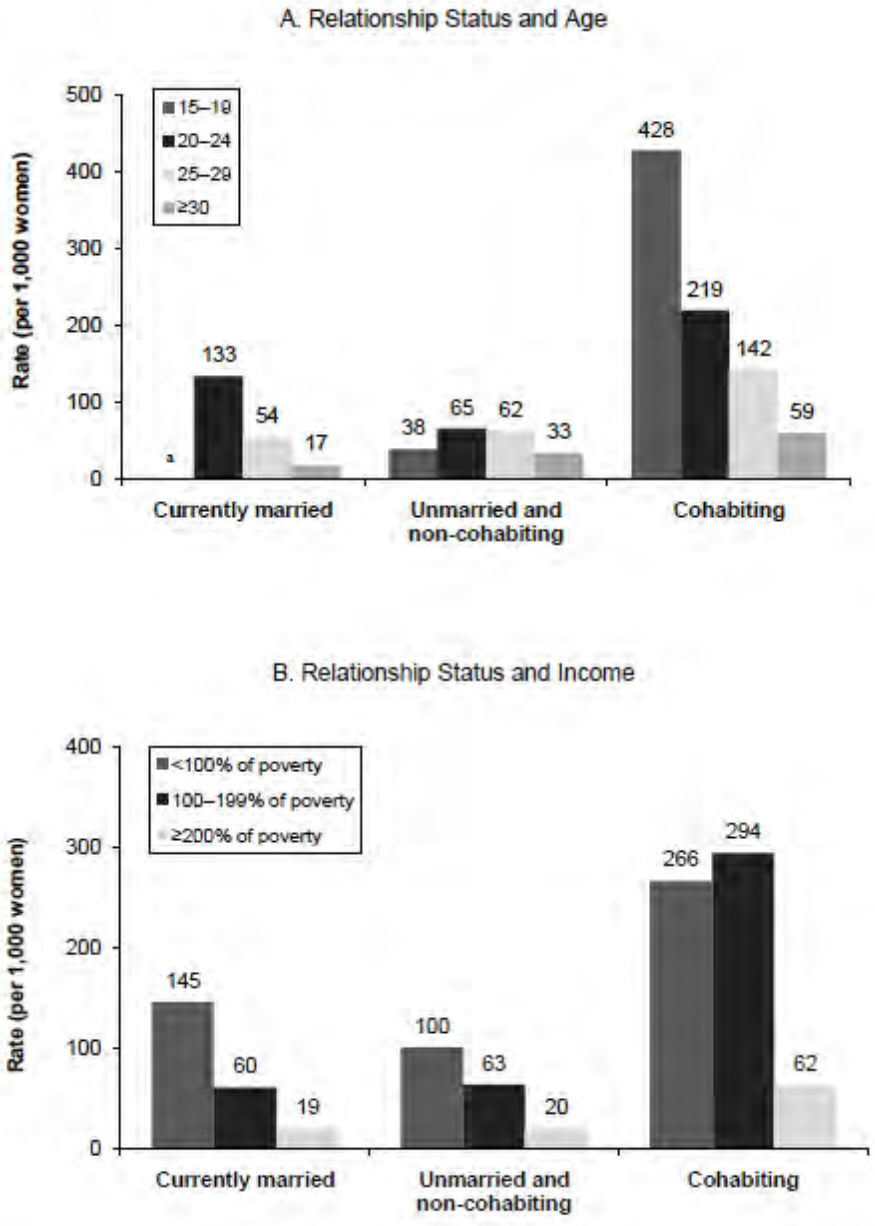

Fig. 2. (A) Teens had relatively high unintended pregnancy rates among married and cohabiting women, but noncohabiting teens had a low unintended pregnancy rate. (a) The rate for married women aged 15–19 years is not available. (B) Women in lower-income groups had relatively high unintended pregnancy rates regardless of relationship status. Cohabiting women had the highest rates across all income levels, and among them, poor or low-income women had very high rates. Notes: Unmarried women include never-married and formerly married women. Cohabiting women were not married.