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Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States

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BACKGROUND: Transgender, nonbinary, and gender-expansive people who were assigned female or intersex at birth experience pregnancy and have abortions. Scarce data have been published on individual abortion experiences or preferences of this understudied population.

OBJECTIVE: This study aimed to fill existing evidence gaps on the abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States to inform policies and practices to improve access to and quality of abortion care for this population.

STUDY DESIGN: In 2019, we recruited transgender, nonbinary, and gender-expansive people who were assigned female or intersex at birth, at the age of ≥18 years from across the United States to participate in an online survey about sexual and reproductive health recruited through The Population Research in Identities and Disparities for Equality Study and online postings. We descriptively analyzed closed- and open-ended survey responses related to pregnancy history, abortion experiences, preferences for abortion method, recommendations to improve abortion care for transgender, nonbinary, and gender-expansive people, and respondent sociodemographic characteristics.

RESULTS: Most of the 1694 respondents were <30 years of age. Respondents represented multiple gender identities and sexual orientations and resided across all 4 United States Census Regions. Overall, 210 respondents (12%) had ever been pregnant; these 210 reported 433 total pregnancies, of which 92 (21%) ended in abortion. For respondents’ most recent abortion, 41 (61%) were surgical, 23 (34%) were medication, and 3 (5%) were another method (primarily herbal). Most recent abortions took place at ≤9 weeks’ gestation (n=41, 61%). If they were to need an abortion today, respondents preferred medication abortion over surgical abortion in a 3:1 ratio (n=703 vs n=217), but 514 respondents (30%) did not know which method they would prefer. The reasons for medication abortion preference among the 703 respondents included a belief that it is the least invasive method (n=553, 79%) and the most private method (n=388, 55%). To improve accessibility and quality of abortion care for transgender, nonbinary, and gender-expansive patients, respondents most frequently recommended that abortion clinics adopt gender-neutral or gender-affirming intake forms, that providers use gender-neutral language, and that greater privacy be incorporated into the clinic.

CONCLUSION: These data contribute substantially to the evidence base on individual experiences of and preferences for abortion care for transgender, nonbinary, and gender-expansive people. Findings can be used to adapt abortion care to better include and affirm the experiences of this underserved population.

Key words: abortion, abortion method preference, induced abortion, intersex, medication abortion, sexual and gender minorities, surgical abortion, transgender persons

Introduction

Transgender, nonbinary, and gender-expansive (TGE) people experience pregnancy and need abortions. Transgender is an umbrella term that describes a person whose gender identity (eg, man, nonbinary, woman) differs from the sex they were assigned at birth (ie, female, intersex, male), which is typically based on external genitalia. Cisgender describes a person whose gender identity aligns with the gender identity commonly associated with the sex they were assigned at birth. Nonbinary and gender-expansive are also umbrella terms that describe gender identities that are not limited to man or woman—they could be a combination of both or neither. Transgender people are thought to make up at least 0.6% of the total United States population or 1.4 million people. This proportion may be higher among younger people, especially when including nonbinary and gender-expansive identities: a recent study found that 2% of 18- to 34-year-olds identified as transgender; 8% identified as agender, bigender, genderfluid, or genderqueer; and another 2% identified as unsure or questioning. In short, 12% of those in this age group identified as transgender or gender nonconforming. Population-level data do not exist on the number of TGE people in the United States capable of pregnancy. Most TGE individuals who were assigned female sex at birth do not have surgeries to remove their internal reproductive organs (ie, uterus, ovaries, and fallopian tubes), and some report having sperm-producing sexual partners. Therefore, a substantial proportion of TGE individuals who were assigned female sex at birth may need pregnancy and/or abortion care during their lives. Similarly, people with intersex conditions or differences in sex development—a heterogeneous group that may or may not also be TGE identified—may also need pregnancy and/or abortion care during their lives.
Although current studies estimate that one-quarter of all (presumably cisgender) women will have an abortion in the United States,12 no corresponding population-level data exist on the abortion rate among TGE people who can get pregnant. The best approximation, from all known abortion-providing facilities in the United States, estimated that there were between 462 and 530 transgender and nonbinary abortion patients nationwide in 2017.7 However, this incidence estimate is likely an underestimate because not all providers collected data on the patients’ gender identities and/or sex assigned at birth—necessary to identify TGE people.2,13

Several studies have published data on abortions experienced by TGE people in the United States.1,14 A survey of 450 transgender and gender nonconforming adults who were assigned female sex at birth found that 28 (6%) reported having at least 1 unplanned pregnancy, and of these, 10 (32%) ended in abortion.14 In a mixed-methods study of 197 masculine-identified people who were assigned female sex at birth, 32 participants (16%) reported 60 lifetime pregnancies, of which 7 (12%) ended in abortion.1 We are not aware of any studies that describe the types of abortion that TGE patients have had, the gestational ages at which abortion care was accessed, or preferences for abortion care.

There are well-established barriers to general healthcare for TGE people, including discrimination based on gender identity in clinics, limited provider knowledge, refusal of care provision, lower levels of insurance coverage than the general United States population, and frequent discrepancies between gender presentation/identity and sex/gender indicated on administrative documents.15–22 These barriers result in delays, denials, and extra charges for care.17,20,21,25 These same barriers likely hinder access to abortion care.7,23–27 To begin addressing these barriers to care, foundational epidemiologic data on abortion—a major pregnancy and reproductive health outcome—among TGE individuals are needed to inform the adaptation of abortion care. Stakeholders, including researchers, healthcare providers, and community members, have called for these data.23,29,30 To address this gap, we conducted a national survey to measure experiences with, preferences for, and recommendations toward improved abortion care among TGE people who were assigned female or intersex at birth in the United States.

Why was this study conducted?
This study aimed to fill gaps in the evidence base on abortion experiences of transgender, nonbinary, and gender-expansive (TGE) people.

Key findings
TGE people have abortions, and many prefer medication abortion over surgical abortion because medication is viewed as less invasive, offers greater privacy, and does not require anesthesia. Abortion providers can improve care for TGE people by adopting gender-neutral intake forms and inclusive language.

What does this add to what is known?
Compared with cisgender women, TGE people may prioritize different factors in determining abortion method preference. With relatively simple changes to intake forms and staff and clinician language, providers can improve the accessibility and quality of abortion care for TGE people.
advisory team that comprised TGE individuals and the Research and Participant Advisory Committees of The PRIDE Study; the survey design and format have been described in detail elsewhere.33 All survey questions allowed for a “ Prefer not to say” or “ I don’t know” response option to ensure completeness of responses. To reduce the risk of multiple responses from any participants, we enabled the “Prevent Ballot Box Stuffing” feature in Qualtrics. Participants who completed the survey were entered into a randomized drawing to win a $50 electronic gift card ($5000 in gift cards were distributed to TGE respondents in total).

Study measures
Key variables included experiences with abortion, recommendations for improving abortion care, measures of abortion method preference, and respondent sociodemographic characteristics. To evaluate experiences of abortion, the survey included a pregnancy history module that prompted respondents to enter each pregnancy they had experienced. For each pregnancy, participants were asked whether they were trying to get pregnant and to indicate how each pregnancy had ended. For respondents who reported a previous abortion, survey questions assessed how many abortions and the types of abortions that they had experienced. For a respondent’s most recent abortion, additional survey questions inquired about the abortion type and gestational age at which the abortion took place. Among those who reported a previous abortion, respondents had the opportunity to indicate recommendations for improving abortion care from a list of 10 options, including the option to write in a recommendation. To measure abortion method preference, all respondents were asked “ If you needed an abortion now, what type of abortion would you prefer? ” The response choices included “medication abortion,” “surgical abortion,” “not listed” (with an option to write in a method), or “I don’t know.” The survey then prompted respondents to answer the question “What are the main reasons that this is your preferred method of abortion?” Respondents could select up to 3 options from a multiple-choice list of reasons related to method privacy, cost, accessibility, pain, familiarity, and more, including a write-in response. The full text of the survey has been published elsewhere.33 Specific sociodemographic characteristics included age at the time of survey initiation, gender identity, sex assigned at birth, intersex identity, sexual orientation, race/ethnicity, education level, health insurance coverage, and region of residence. For gender identity, sexual orientation, and race/ethnicity, respondents could select all options that applied or write in their own option. Region of residence is defined in accordance with the United States Census Bureau’s 4 regions.34

Analysis
We analyzed respondent answers to closed-ended survey questions using Stata 15.1 (StataCorp LLC, College Station, TX). We calculated frequencies and percentages for all study measures defined earlier for the full study sample or among those who reported an abortion, as appropriate. We cataloged open-ended survey responses in Microsoft Excel to group similar write-in responses and to tabulate frequencies across groups.

Ethical review
We obtained ethical review and approval for this study from the Institutional Review Boards of Stanford University and the University of California, San Francisco. Review and approval of this study were also provided by The PRIDE Study Research Advisory Committee and The PRIDE Study Participant Advisory Committee (pridestudy.org). All participants provided informed consent before beginning the survey.

Results
Characteristics of the study population
Overall, 5005 people initiated the survey: 798 from the general population (an unknown proportion of the total number exposed to study information) and 4207 from The PRIDE Study (35.3% of PRIDE participants were likely eligible owing to reporting female sex assignment at birth or with missing data for the assigned sex at birth). In response to a question on the sex assigned at birth in this current survey, 2704 of these 4207 PRIDE participants reported having had female sex assigned at birth, 1400 reported male, 8 each reported neither or preferring not to say, and 87 did not respond to the question. Approximately half of the PRIDE participants who responded to this survey and reported having had female sex assigned at birth (50.8%) identified as cisgender sexual minority women, and thus, their results are not presented here. Among all respondents to the survey, 1694 expressed a gender identity that aligned with the larger umbrella of TGE and were female or intersex assigned at birth. Most of these participants (n=1281, 76%) were recruited through The PRIDE Study, and the rest from the general public (n=413, 24%). The details of study screening and recruitment are reported elsewhere.33 Among the 1694 participants, most were <30 years old (median, 27) (Table 1). The most common gender identity was nonbinary (51%), followed by transgender man (39%) and gender-queer (39%); 61% of respondents reported having >1 gender identity. Most respondents (99%) reported having had female sex assigned at birth, with 4% identifying as intersex. Respondents reported a range of sexual orientations, most frequently queer (68%), followed by bisexual (34%) and pansexual (25%). Respondents were primarily white (87%) and well educated, and most (89%) had health insurance coverage.

Abortion experiences
For the 433 lifetime pregnancies reported across 210 respondents (12%), 233 (54%) were retrospectively reported as unintended. Of these 210 ever-pregnant respondents, 67 (32%) reported at least 1 pregnancy ending in abortion. These 67 respondents reported a total of 92 abortions. Notably, 52 respondents reported a single abortion, 9 reported 2 abortions, and 6 reported ≥3 abortions (Table 2). For respondents’ most recent abortion, 41 (61%) were surgical, 23 (34%) were medication, and
TABLE 1
Respondent sociodemographic characteristics, overall and by abortion history among an online sample of transgender, nonbinary, and gender-expansive individuals who were assigned female or intersex at birth in the United States (N = 1694)

| Sample characteristics                      | All respondents (N=1694) | Respondents who reported an abortion (n=67) |
|--------------------------------------------|--------------------------|--------------------------------------------|
|                                            | n | % | n | % |
| Median age in y, IQR                       | 27 | 23–33 | 33 | 27–41 |
| Age categories, y                          |      |    |     |    |
| 18–19                                      | 150 | 9 | 2 | 3 |
| 20–24                                      | 469 | 28 | 7 | 10 |
| 25–29                                      | 447 | 26 | 15 | 22 |
| 30–34                                      | 284 | 17 | 12 | 18 |
| 35–39                                      | 149 | 9 | 12 | 18 |
| 40–44                                      | 88 | 5 | 7 | 10 |
| 45–49                                      | 38 | 2 | 3 | 5 |
| 50–54                                      | 31 | 2 | 3 | 5 |
| 55–59                                      | 20 | 1 | 3 | 5 |
| 60–78                                      | 18 | 1 | 3 | 5 |
| Missing                                    | 0 | 0 | 0 | 0 |
| Gender identitiesa                         |      |    |     |    |
| Agender                                    | 226 | 13 | 16 | 24 |
| Cisgender man                              | 1 | 0 | 0 | 0 |
| Cisgender woman                            | 0 | 0 | 4 | 6 |
| Genderqueer                                | 655 | 39 | 34 | 51 |
| Man                                        | 293 | 17 | 5 | 8 |
| Nonbinary                                  | 868 | 51 | 42 | 63 |
| Transgender man                            | 662 | 39 | 26 | 39 |
| Transgender woman                          | 4 | 0 | 0 | 0 |
| Two-spirit                                  | 26 | 2 | 1 | 2 |
| Woman                                      | 204 | 12 | 4 | 6 |
| Additional gender identity                 | 197 | 12 | 7 | 10 |
| Multiple gender identities                 | 1036 | 61 | 42 | 63 |
| Prefer not to say                          | 2 | 0 | 0 | 0 |
| Missing                                    | 0 | 0 | 0 | 0 |
| Sex assigned at birth                      |      |    |     |    |
| Female                                     | 1684 | 99 | 67 | 100 |
| Not listed                                 | 10 | 0.6 | 0 | 0 |
| Missing                                    | 0 | 0 | 0 | 0 |
| Identifies as intersex                     |      |    |     |    |
| Yes                                        | 69 | 4 | 1 | 2 |
| Prefer not to say                          | 21 | 1 | 2 | 3 |
| Missing                                    | 0 | 0 | 0 | 0 |

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### TABLE 1
Respondent sociodemographic characteristics, overall and by abortion history among an online sample of transgender, nonbinary, and gender-expansive individuals who were assigned female or intersex at birth in the United States (N = 1694) (continued)

| Sample characteristics                              | All respondents (N = 1694) | Respondents who reported an abortion (n = 67) |
|-----------------------------------------------------|----------------------------|---------------------------------------------|
|                                                     | n  | %   | n   | %   |
| Sexual orientation**a                               |    |     |     |     |
| Asexual                                             | 252| 15  | 5   | 8   |
| Bisexual                                            | 571| 34  | 24  | 36  |
| Gay                                                 | 348| 21  | 16  | 24  |
| Lesbian                                             | 218| 13  | 6   | 9   |
| Pansexual                                           | 418| 25  | 29  | 43  |
| Queer                                               | 1150| 68 | 50  | 75  |
| Questioning                                         | 69 | 4   | 3   | 5   |
| Same-gender loving                                  | 111| 7   | 2   | 3   |
| Straight or heterosexual                            | 61 | 4   | 1   | 2   |
| Another sexual orientation                          | 129| 8   | 6   | 9   |
| Multiple sexual orientations                        | 1010| 60 | 44  | 66  |
| Missing                                             | 21 | 1   | 0   | 0   |
| Race/ethnicity**b                                   |    |     |     |     |
| American Indian or Alaska Native                    | 42 | 3   | 1   | 2   |
| Asian, Central                                      | 0  | 0   | 0   | 0   |
| Asian, East                                         | 41 | 2   | 3   | 5   |
| Asian, South                                        | 19 | 1   | 1   | 2   |
| Asian, Southeast                                    | 25 | 2   | 1   | 2   |
| Black or African American                           | 67 | 4   | 2   | 3   |
| Hispanic or Latinx                                  | 101| 6   | 6   | 9   |
| Middle Eastern or North African                     | 24 | 1   | 1   | 2   |
| Native Hawaiian or Pacific Islander                 | 5  | 0.3 | 0   | 0   |
| White                                               | 1472| 87 | 65  | 97  |
| Unknown                                             | 12 | 1   | 1   | 2   |
| Another race                                        | 41 | 2   | 2   | 3   |
| Multiple racial and ethnic identities               | 202| 12  | 13  | 19  |
| None of these                                       | 4  | 0   | 0   | 0   |
| Missing                                             | 79 | 5   | 1   | 2   |
| Education level                                     |    |     |     |     |
| High school degree or less                          | 141| 8   | 6   | 9   |
| Some college, trade or tech school                  | 410| 24  | 18  | 27  |
| College degree                                      | 644| 38  | 18  | 27  |
| Graduate or professional degree                     | 410| 24  | 23  | 34  |
| Missing                                             | 89 | 5   | 2   | 3   |
| Health insurance coverage                           | 1512| 89 | 62  | 93  |

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3 (5%) were another method (primarily herbal). Nearly two-thirds of respondents’ most recent abortions took place at \( \leq 9 \) weeks’ gestation (\( n = 41, 61\% \)) (Table 2).

**Respondent’s recommendations to improve abortion care**

The 67 respondents who reported a pregnancy ending in abortion offered gender-related recommendations to improve the abortion care experience as a TGE person. In particular, respondents most frequently recommended that clinics adopt gender-neutral intake forms that are gender and sexual orientation affirming and that the staff use gender-neutral language (Table 3). Other recommendations were related to specific ideas for increasing the availability of affirming abortion care and increasing patient privacy within and outside of abortion facilities.

**Abortion method preference**

When asked about the abortion method preference, 703 respondents (42%) preferred medication abortion over surgical (\( n = 217, 13\% \)) or an unlisted method (\( n = 28, 2\% \)) (Figure), whereas 514 respondents (30%) did not know what type of abortion they would prefer. Among the 28 respondents who wrote in an unlisted method, 12 indicated that they would never get an abortion because of their opposition to abortion or inability to get pregnant; 5 indicated that they would base the decision on the provider’s recommendation; 2 stated that either method was fine; and 2 indicated a preference for an herbal method.

Although medication abortion was the most preferred method among both those who had experienced an abortion and those who had not (45% vs 41%, respectively), a higher proportion of respondents who had experienced abortion reported a preference for surgical abortion than among respondents who had not experienced abortion (28% vs 12%, respectively), a lower proportion of those who had experienced abortion did not know what type they would prefer (13% vs 31%). Among the 67 most recent abortions, 89% of people who preferred surgical abortion had obtained a surgical abortion, whereas only 50% of those who preferred medication abortion had obtained a medication abortion.

Overall, the most common reasons given for preferring medication abortion included “This method is the least invasive” (\( n = 553, 79\% \)); “This method feels the most private” (\( n = 388, 55\% \)); and “This method does not require anesthesia” (\( n = 231, 33\% \)) (Table 4). A total of 31 respondents wrote in a reason for preferring medication abortion, which included a desire to avoid interactions with medical providers where they could be misgendered or traumatized (\( n = 9, 1.3\% \)) and the ability to manage the abortion themselves in the privacy of their own homes without having to face protestors (\( n = 6, 0.8\% \)).

Among the 217 respondents who indicated a preference for surgical abortion, the most common reasons included “I feel most comfortable with the type and number of medical staff present for this option” (\( n = 105, 48\% \)); “This method would take the least amount of time (is fastest)” (\( n = 88, 41\% \)); and “The method is the least painful” (\( n = 40, 18\% \)) (Table 4). Write-in responses from 38 participants who preferred surgical abortion included an aversion to the hormones contained in medication abortion (\( n = 10, 5\% \)), a greater certainty that the abortion would be a success (\( n = 7, 3\% \)), a desire to avoid passing the pregnancy at home (\( n = 7, 3\% \)), and a fear of the long-term effects of medication abortion (\( n = 6, 3\% \)).
Comment

These results demonstrate that TGE people who were assigned female or intersex at birth in the United States have medication, surgical, and herbal abortions. Respondents reported nearly 1 in 5 abortions occurring past the gestational limits for medication abortion (10 weeks),35 which may account for the higher number of surgical abortions reported than medication abortions, despite a 3:1 preference for medication abortion. Notably, nearly one-third of respondents did not know what type of abortion they would prefer if they were to need 1 today. To improve abortion care for TGE patients, respondents recommended that abortion providers incorporate affirming intake forms into clinics and that staff and clinicians use gender-inclusive language.

Strengths and limitations

The primary limitation of this study is the lack of representativeness of the study population. Because no known sampling frame exists for recruiting TGE people who were assigned female or intersex at birth, we relied on convenience sampling. The extent to which these findings are generalizable to all TGE people who were assigned female or intersex at birth is unknown. In addition, although 381 respondents (22%) indicated a race or ethnicity other than “white,” some racial and ethnic groups had low representation, and more specific studies focused on the experiences of TGE people of color and the intersection of various sociodemographic characteristics is warranted. The lower number of participants from multiple racial groups precluded our ability to assess whether and how these abortion experiences and preferences represent a diversity of experiences—particularly when disparities in abortion care along racial lines are well established.36

These limitations are balanced by strengths. This quantitative study reports on abortion experiences and preferences of TGE people in the United States. Furthermore, the large number of respondents, which is several orders of magnitude larger than previous SRH studies among this population,1,14,27,37 provides more descriptive information than previously available. The study was performed in a community-dwelling sample rather than a clinical sample. The survey instrument and recruitment efforts were cocreated by our interdisciplinary research team in close collaboration with a community advisory team33; community engagement was essential to reaching respondents and to ensuring that the survey centered the experiences of the target populations.

Clinical implications

The implications of these findings are that people of various gender identities and experiences have abortions, and thus, abortion providers must ensure that systems serve the abortion needs of people with varying gender identities and experiences. Revising clinic intake forms to assess capacity and desires for pregnancy in a gender-neutral way and systematically incorporating similar questions into conversations between providers and patients may help to identify patients capable of pregnancy and prompt pregnancy options counseling.38,39 Several studies evaluating
clinician knowledge and comfort with care provision for TGE populations found self-identified gaps in provider knowledge about TGE healthcare, and a lack of confidence, sense of preparedness, or experience with providing care to these populations. Therefore, clinicians should seek out training on how to provide gender-affirming sexual and reproductive healthcare for TGE patients to improve the appropriateness and quality of care. Perhaps relatedly, many respondents in this study did not know which abortion type they preferred, suggesting that clinicians and counselors should incorporate more information about abortion options in conversations with TGE patients, including advocating for and distributing abortion education materials that are inclusive of many genders, not only cisgender women.

Clinicians should also consider that the reasons for preferring 1 method of abortion over another may differ for TGE patients compared with cisgender women patients. Previous studies of abortion method preference among (presumably) cisgender women, although most were published soon after the introduction of medication abortion in the United States, found that women’s preferences for abortion method were motivated primarily by fears of bleeding, complications, or anesthesia, beliefs about which method was more “natural,” and the time involved for either method. Although TGE respondents shared some reasons consistent with those reported by cisgender women previously, the importance of privacy and minimizing the invasiveness of the experience emerged more strongly among those who preferred medication abortion—considerations central to TGE patients, a community commonly subjected to unnecessary medical questioning, examinations, or even assault on the part of providers. That medication abortion does not require a physical procedure, can be offered via

### TABLE 3
Recommendations for improving abortion care, from an online sample of transgender, nonbinary, and gender-expansive individuals who had ≥1 abortions in the United States (n=67)

| Recommendations                                      | Respondents who reported an abortion (n=67) |
|------------------------------------------------------|--------------------------------------------|
|                                                      | n  | %  |
| Intake forms that are gender-neutral or gender-affirming | 35 | 52 |
| Gender-neutral language used by staff                 | 32 | 48 |
| Intake forms that are affirming of all sexual orientations | 24 | 36 |
| Closer clinic/office location to my home              | 20 | 30 |
| More privacy outside of the clinic                    | 16 | 24 |
| More support from the clinic staff                    | 10 | 15 |
| More privacy within the clinic                        | 9  | 13 |
| More support from my provider                         | 9  | 13 |
| Better pain management during abortion                | 1  | 2  |
| More time in recovery                                 | 1  | 2  |
| None of these                                         | 14 | 21 |

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teledemecine, and can be completed privately, at home, or in other preferred setting may add to the appeal as an abortion method of choice for TGE people. Furthermore, recent shifts in the United States toward ‘no-test’ medication abortion protocols in response to the novel coronavirus disease 2019 reduce or remove the requirement for in-person clinic visits and physical examinations, experiences known to be dysphoria inducing for some TGE patients.

Research implications

Despite a strong preference for medication abortion, more than twice as many respondents had accessed surgical abortion than medication abortion. These data highlight a gap between preferred abortion method and obtained abortion method—a gap that future research should explore. Furthermore, although most respondents obtained an abortion before 10 weeks’ gestation, 1 in 5 obtained an abortion at 10 weeks’ gestation or later. Future research should explore barriers and facilitators to abortion care generally and potential delays throughout the process of obtaining an abortion. Finally, most abortion care research in the United States focuses almost exclusively on the experiences of cisgender women, despite these and other recent findings that demonstrate that TGE people want, seek, and obtain abortions. These results emphasize the need for greater awareness and sensitivity to the inclusion of TGE people in the research on abortion preferences and experiences, and there is growing operational guidance toward these aims.

Conclusions

These data provide much needed insight into the abortion experiences and preferences of TGE people—a population that has been excluded from or marginalized in most research on abortion. These findings offer insight into how abortion care, an essential component of comprehensive reproductive healthcare, can be improved to be inclusive of their needs and preferences.

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| TABLE 4 |
| Reasons given for abortion method preference among an online sample of transgender, nonbinary, and gender-expansive individuals who were assigned female or intersex at birth in the United States (N=1694) |

| What are the main reasons this is your preferred method of abortion? | Overall* | Medication | Surgical |
|---------------------------------------------------------------|--------|-----------|----------|
| This method is the least invasive | 556 | 553 | 1 | 79 | 1 |
| This method feels the most private | 422 | 388 | 32 | 55 | 15 |
| This method does not require anesthesia | 233 | 231 | 33 | 1 | 1 |
| I feel most comfortable with the type and number of medical staff present for this option | 227 | 122 | 17 | 105 | 48 |
| This method would take the least amount of time (is fastest) | 157 | 69 | 88 | 10 | 41 |
| This method costs the least amount of money | 143 | 138 | 3 | 20 | 1 |
| This method is the least painful | 123 | 83 | 40 | 12 | 18 |
| This method is easier to schedule | 101 | 84 | 17 | 12 | 8 |
| This method is the only method with which I am familiar | 93 | 56 | 36 | 8 | 17 |
| This method requires the fewest visits | 90 | 61 | 28 | 9 | 13 |
| Only method known | 48 | 10 | 38 | 1 | 18 |
| I have had this type of abortion before and know what to expect | 32 | 15 | 17 | 2 | 8 |
| This method does require anesthesia | 22 | 6 | 16 | 1 | 7 |
| This is the only method available in my area | 5 | 3 | 1 | 0 | 1 |
| None of the above capture my reasons for preferring this method | 27 | 1 | 1 | 0 | 1 |
| Write-in option specified | 93 | 31 | 53 | 4 | 24 |

* Respondents could select up to 3 reasons.

* The overall total includes responses from 28 respondents who indicated a preference for a method other than medication or surgical; thus, the overall total does not always equal the sum of the medication and surgical responses.

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