

U.S. Abortion Rate Reaches Record Low Amidst Looming Onslaught Against Reproductive Health and Rights

By Joerg Dreweke

The U.S. abortion rate reached a record low in 2014, for the first time falling below its level in 1973—the year abortion became legal nationwide.¹ The January 2017 publication of these new abortion data coincides with the arrival of the Trump administration and the 115th Congress, both hostile toward abortion rights and toward programs and policies that ensure access to affordable contraceptive care. The federal government is widely expected to pursue far-reaching policy changes that will have a negative impact on reproductive health and rights. In the daily lives of many women, these changes will be layered on top of the state-level onslaught against abortion access and family planning services that has been ongoing since 2011.²

The U.S. antiabortion movement—which now has well-placed allies in the Trump administration and both houses of Congress—has long focused on reducing abortion incidence at all costs by enacting ever-harsher legal barriers to abortion services. Likewise, many in the antiabortion movement have long opposed efforts to make contraceptive care more accessible, often under the guise of inhibiting abortion access (see “Recent Funding Restrictions on the U.S. Family Planning Safety Net May Foreshadow What Is to Come,” 2016, and “‘Fungibility’: The Argument at the Center of a 40-Year Campaign to Undermine Reproductive Health and Rights,” 2016). By contrast, most supporters of abortion rights believe that policy must focus on providing greater access to the full range of reproductive health services, including affordable abortion and contraceptive care. In their view, reducing abortion incidence should not be the goal, but rather the byproduct of respecting women’s autonomy and empowering women to

HIGHLIGHTS

- *The U.S. abortion rate declined 14% between 2011 and 2014, reaching a record low.*
- *The evidence suggests that contraception and fewer unintended pregnancies played a larger role in these most recent declines than new abortion restrictions. Well over 60% of the decline in the number of abortions occurred in states without new restrictions.*
- *The Trump administration and new Congress broadly oppose reproductive health and rights, and their agenda imperils women’s access to safe, legal abortion and affordable birth control. This could stop or reverse progress in empowering women to meet their childbearing goals, including by avoiding unintended pregnancy.*

meet their childbearing goals, including by avoiding unintended pregnancy.

As they have done in the past, antiabortion groups and policymakers will portray recent declines in abortion as validation of their regressive agenda. They will credit their own efforts for the decline, and deny or minimize the role of contraception in helping to reduce unintended pregnancy and, thereby, women’s recourse to abortion. This strategy aims to justify punitive abortion restrictions and to curtail contraceptive access, while arguing that none of this harms women or public health. Their desired outcomes—less availability of safe, legal abortion and affordable birth control—would be a major setback for U.S. women’s health and rights.

Behind the Declines

The number of U.S. abortions declined by more than 132,000 between 2011 and 2014, to 926,000.¹ The abortion rate fell to 14.6 abortions for every 1,000 women of reproductive age (15–44), a 14% drop from 2011 (see chart). Key data points to help explain these declines—including trends in unintended pregnancy and contraceptive use—are not yet available for this period. Still, available information suggests that both fewer unintended pregnancies and new abortion restrictions contributed to the declines.

Impact of Restrictions

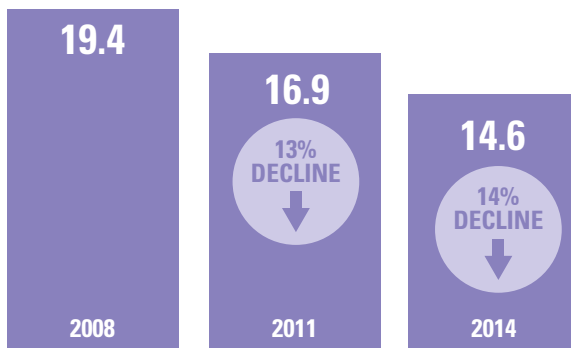
Restrictions that create financial barriers—thereby, significantly increasing the cost of an abortion—can put the procedure out of reach for some women, especially those who are young, poor or otherwise vulnerable to such coercive policies. However, most restrictions do not keep large numbers of women from obtaining an abortion, even when they exact a heavy financial and emotional toll on women, including by causing delays in obtaining an abortion.³ Women have long shown that they will endure significant hardship for themselves and their family to navigate and overcome restrictions, including by diverting money meant for rent, groceries or utilities to pay for the procedure.

The three years for which new abortion data are available (2012, 2013 and 2014) coincided with a

Steady Drop

The U.S. abortion rate has declined significantly in recent years.

Abortions per 1,000 women aged 15–44



Source: Guttmacher Institute.

flood of new restrictions. Twenty-two states had a total of 47 new restrictions that went into effect (for instance, were not blocked by a court) and were significant enough that they could have an impact on women's ability to have an abortion (excluding, for instance, small changes to existing mandatory counseling requirements or to judicial bypass procedures for minors).⁴ Combined, these 22 states accounted for just under 38% of the total 2011–2014 abortion decline.⁵

However, there is no clear pattern linking restrictions and declines in abortion incidence (see chart, page 17). Of the 22 states with major new restrictions in effect, eight had abortion declines that were greater than the national average. But among the 28 states and the District of Columbia that did not have major new restrictions in effect, 10 states had larger-than-average declines as well. In addition, four of the 22 states with new restrictions actually saw increases in their abortion rates, compared with two states and DC in the group without new restrictions.

Although the total effect of all abortion restrictions during this period is unclear, the effect of one specific type of restriction stands out. Targeted regulation of abortion providers (TRAP) laws are onerous regulations that are not needed for patient safety, but are instead designed to make it expensive or outright impossible for providers to come into compliance, often resulting in clinics being forced to close.⁶ TRAP regulations enacted in the three years in question included unnecessary requirements that abortion providers obtain hospital admitting privileges or that abortions be performed only at sites that are the functional equivalent of an ambulatory surgical center. (Notably, both provisions were part of a Texas TRAP law and were struck down in the June 2016 Supreme Court decision *Whole Woman's Health v. Hellerstedt*.)

Of the nine states that implemented new TRAP provisions in 2012, 2013 and 2014, eight had higher-than-average declines in the number of clinics offering abortion care.¹ Clinics accounted for about 95% of all abortions during this period (with hospitals and private physicians making up the rest), and a decline in their number can make

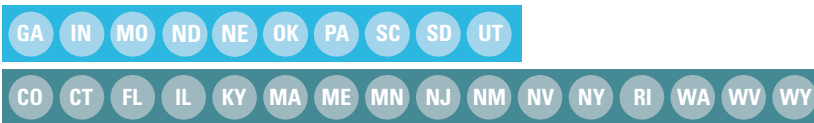
No Obvious Impact

There is no clear pattern linking states with major new abortion restrictions in effect and changes in their abortion rate between 2011 and 2014

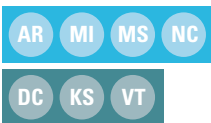
Larger-than-average decline in rate



Decline in rate



Increase in rate



Source: Guttmacher Institute.

abortion care less accessible, especially if there are no other abortion providers nearby. Declines in access spurred by TRAP laws may have contributed to lower abortion incidence: Of the nine states with new TRAP restrictions in effect during this period, six had larger-than-average abortion declines, while one state—Michigan—saw a slight increase.

In short, while there is no clear overall relationship between newly effective abortion restrictions and lower abortion incidence in 2011–2014, there may be a relationship between one specific type of restriction—TRAP laws—and declines in both the number of clinics and abortion rates.

Declines in Unintended Pregnancy

Even though restrictions likely contributed to the 2011–2014 abortion decline, they alone cannot explain all of it, even in states that enacted the harshest types of laws. For one, most of the restrictions did not go into effect until 2013 or 2014⁴ and, therefore, could not have had an impact over the entire period. And even once in effect, restrictions would not be expected to crowd out other factors entirely. Most importantly, new restrictions can be ruled out as having had any

impact in 28 states and the District of Columbia, given that they did not put any new measures into effect. Of those 29 jurisdictions, all but three saw abortion declines in 2011–2014, and combined they accounted for 62% of the total decline in the number of U.S. abortions.⁵

In the absence of sudden, dramatic changes in levels of sexual activity or women's ability to become pregnant (and there is no evidence of either), the most likely explanation for these broad-based abortion declines is a decrease in unintended pregnancy. This explanation is buttressed by strong evidence from the years preced-

ing the most recent declines. The abortion decline during the 2008–2011 period was driven entirely by a steep drop in unintended pregnancy, which in turn is most plausibly explained by improved contraceptive use (see "New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines," 2016). It is reasonable to believe that, to some extent, the momentum behind the 2008–2011 abortion decline carried through into the 2011–2014 period.

Several data points support this hypothesis. Births do not appear to have replaced most abortions in the most recent period: The number of abortions declined by a little over 132,000, whereas the number of births increased by only about 35,000^{7,8} (some of which could represent more intended births, as happened between 2008 and 2011⁹). Antiabortion activists routinely fail to acknowledge that abortion declines can result from fewer unintended pregnancies, and instead pretend that any decline in the number of abortions is the result of women opting, or being compelled, to give birth rather than have an abortion.¹⁰ These activists often seize on declines in the abortion ratio—the proportion of all pregnancies ending

in abortion—to showcase the supposed impact of their efforts. Although the abortion ratio fell 11% between 2011 and 2014,¹ such a decline could occur if the proportion of pregnancies that are unintended decreases and, in turn, fewer pregnancies end in abortion. This likely happened to some degree during the most recent period.

Evidence suggests that contraceptive use contributed to the decline in abortion. In the previous period (2008–2011), the steep drop in unintended pregnancy—including births and abortions—was likely driven by improved contraceptive use, in particular, use of IUDs and implants, which are collectively known as long-acting reversible contraceptives (LARCs).¹¹ LARC use continued to rise through at least 2012, providing women who choose to use these methods with multiple years of very effective protection against unintended pregnancy.¹² Various provisions of the Affordable Care Act (ACA) that have increased insurance coverage and access to affordable contraceptive care appear to have spurred continued improvements in contraceptive use beyond 2012.^{13,14} Recent research also shows that improved contraceptive use accounted for the entire decline in teen pregnancy risk between 2007 and 2012,¹⁵ a trend that likely persisted beyond 2012, as teen birthrates have continued to plummet.¹⁶

A Conservative Agenda

Social conservatives hostile to women’s health, rights and autonomy will have powerful levers at their disposal in 2017 and beyond—ranging from the White House, both houses of Congress and federal agencies to judicial appointments, including to the U.S. Supreme Court. Even as many specifics are still emerging, abortion rights and contraceptive access will be targets of sweeping and sustained attacks that could roll back decades’ worth of progress.

When it comes to restricting abortion, Congress and the Trump administration have ready-made options that have either already been attempted at the federal level in recent years or were pioneered in the states. Some of these measures would make abortion care more difficult and expensive for women to obtain, especially for groups like minors and poor women. Others would make it harder for

providers to offer the procedure or would otherwise reduce the availability of services. And collectively, they would further stigmatize abortion and continue to isolate it from other health services. These measures include limits on later abortion, such as a ban at 20 weeks postfertilization or a ban on certain abortion methods—for instance, a procedure commonly used in the second trimester known as dilation and evacuation (D&E). Antiabortion policymakers will likely also attempt once more to impose abortion bans disguised as antidiscrimination measures, for instance to ban abortion for supposed reasons of sex or race selection. In addition, they are expected to push for additional restrictions on public and private insurance coverage of abortion, including writing the discriminatory Hyde amendment into permanent law.

The impact of restrictions on access to high-quality, affordable contraceptive care could likewise be staggering, with multiple angles of attack. Among them is full repeal of the ACA, which—without timely and adequate replacement—would mean the loss of private or public insurance coverage for the millions of women who gained it under the law.¹⁷ Conservative policymakers have also vowed to roll back the ACA’s contraceptive coverage guarantee, which has bolstered coverage for privately insured women.¹⁸ In addition, they have long sought to dismantle the nation’s family planning safety net and programs critical to its existence, such as Title X and Medicaid. Finally, defunding Planned Parenthood, a critical source of contraceptive care and other health services for many women, has become a veritable obsession for the antiabortion movement.¹⁹ All of this would result in many reproductive-age women losing insurance coverage altogether or seeing their health plan’s contraceptive coverage severely degraded. Many of them might then seek out care from a family planning safety net that will itself be fighting for survival, even as it already struggles to serve those who remained uninsured under the ACA, including many immigrant women.

Taken together, this looming federal onslaught against a broad spectrum of reproductive health services threatens a massive rollback of women’s health, rights and autonomy. It is sure to be further

magnified by continued state-level attacks along similar lines, as well as the possibility of an anti-abortion majority on the Supreme Court that could endanger *Roe v. Wade* itself.

Many of the coming national and state-level attacks on abortion access and contraceptive services will be conducted under the banner of countering and reducing abortion. But the question is not and should never be whether coercive approaches “work” in reducing abortion incidence. Rather, these coercive approaches are unacceptable in principle. More so, even within the anti-abortion movement’s framework of prioritizing fewer abortions above all else, there is strong evidence from recent abortion declines that supporting women’s decision-making across the spectrum of reproductive health care is very much compatible with reducing abortion incidence. Undoing the progress made on affordable contraceptive care could well stop or reverse recent progress in reducing unintended pregnancy—the likely main driver of the 2008–2014 drop in abortion incidence.

The evidence supports what reproductive health and rights advocates have long argued: that policies must be grounded in voluntarism and informed consent, and that they must support all of a woman’s pregnancy decisions. That includes promoting affordable, high-quality contraceptive care to prevent unintended pregnancy; helping women with planned and unplanned pregnancies alike to achieve healthy pregnancies and to raise their children with dignity; and improving access to safe, affordable and timely abortion care in the event of an unwanted pregnancy. These principles will be ever more important in 2017 and beyond. ■

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