

An Analysis of Attempts to Minimize Abortions: Defunding Planned Parenthood, State-level Restrictions, and LARCs

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Executive Summary

In the wake of undercover videos released by the pro-life group Center for Medical Progress in 2015 which the group claimed showed Planned Parenthood officials negotiating the sale of aborted babies, there were renewed calls in legislative circles to “defund Planned Parenthood.” Planned Parenthood likely serves as a stand-in for all organizations that perform abortions because it is the most prominent of such organizations. (It should be noted that, due to the Hyde Amendment, federal funds already cannot be used for abortions, though pro-life groups argue funding can indirectly support abortions by paying for other expenses, like overhead.)

If one’s primary goal is to reduce the number of abortions performed in the United States, then it is important to consider whether such plans to “defund Planned Parenthood” would have the intended effect of reducing abortions (such as by making access to abortion more difficult) or instead increase abortions (by potentially reducing access to family planning).

This briefing paper first provides background information on abortion in the United States. Second, it presents conservative criticisms of Planned Parenthood and attempts to defund it. Third, it describes increasing access to long-acting reversible contraceptives (LARCs) as an evidenced-based means of reducing abortion; this provides an alternative to which attempts to defund Planned Parenthood can be compared. Fourth, it provides evidence suggesting that defunding would unintentionally lead to abortions that otherwise would have been prevented by access to family planning. Fifth, it considers other pro-life efforts, specifically the effects of Texas’ reduction of funding for family planning and unconstitutional barriers to abortion. It finds that the increased barriers delay abortions and can cause women to consider self-inducing an abortion. Finally, it examines the effect of the Mexico City Policy, which cuts funding in an attempt to reduce abortions abroad. It presents evidence that the policy under George W. Bush actually increased the abortion rate in sub-Saharan African countries affected by the policy.

Overall, the US’ abortion rate is already relatively low. Increasing access to and provider education about more effective forms of contraception (like LARCs) provides a better, evidence-driven approach to reducing abortions. Unfortunately, it is likely to be unacceptable to some conservative, pro-life groups that have non-abortion-related concerns, like teenage sexuality; facilitating access to contraception might come across to some as promoting or facilitating promiscuity. Regardless, attempts to defund organizations like Planned Parenthood are likely to result in an unintentional increase in abortions, and attempts to erect

barriers to abortion (as Texas did) might increase self-induction of abortion. An approach focused on family planning is thus the best means to reduce abortion without jeopardizing the safety of women.

Background

The Centers for Disease Control and Prevention (CDC) state: “For the purpose of surveillance, a legal induced abortion is defined as an intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) that is intended to terminate an ongoing pregnancy.”¹ Induced abortions can be either medical or surgical. Based on this definition, self-induced abortions are not captured in the CDC’s statistics.

It is also worth noting that some pro-life organizations suggest emergency contraception can, in some cases, cause abortion. A Family Research Council issue brief, for example, notes “Emergency contraception, such as Plan B, can cause abortion by destroying a human embryo if fertilization has already occurred.”² Thus, they might consider any approach to reducing abortions that focuses on increasing access to emergency contraception to be ineffective and misguided. However, the scientific consensus is increasingly that emergency contraception does not induce abortions because the contraception works before implantation of the fertilized egg in a woman’s uterus (which is when pregnancy begins). In short, the discrepancy appears to be that some pro-life groups are focused on fertilization, whereas the scientific community focuses on implantation (which only begins 5-7 days after fertilization).³ For these reasons, this brief does not consider them to be abortions.

The abortion rate in the US was falling as of 2012. In the United States in 2012, the most recent year for which their data is available, 699,202 abortions were reported to the CDC.⁴ (This included 47 out of 52 reporting areas that reported data from 2003 to 2012.) The CDC’s surveillance summary notes:

“Among these same 47 reporting areas, the abortion rate for 2012 was 13.2 abortions per 1,000 women aged 15–44 years, and the abortion ratio was 210 abortions per 1,000 live births. From 2011 to 2012, the total number and ratio of reported abortions decreased 4% and the abortion rate decreased 5%. From 2003 to 2012, the total number, rate, and ratio of reported abortions decreased 17%, 18%, and 14%,”

¹ Centers for Disease Control and Prevention, “CDCs Abortion Surveillance System FAQs,” http://www.cdc.gov/reproductivehealth/data_stats/abortion.htm (Accessed 30 September 2016)

² Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

³ For more information, see: “How Emergency Contraception Works,” <http://ec.princeton.edu/questions/ecabt.html> (Accessed 9 October 2016); Ruth Moon, “Does Plan B Cause Abortion,” *Christianity Today*, 5 April 2013, <http://www.christianitytoday.com/ct/2013/may/does-plan-b-cause-abortion.html>, (Accessed 9 October 2016); “Morning-After Pills Don’t Cause Abortions, Studies Say,” *NPR*, 21 February 2013, <http://www.npr.org/sections/health-shots/2013/02/22/172595689/morning-after-pills-dont-cause-abortion-studies-say>, (Accessed 9 October 2013)

⁴ Karen Pazol, Andreea A. Creanga, Denise J. Jamieson, “Abortion Surveillance--United States, 2012,” *MMWR Surveillance Summaries*, Vol. 64, No. 10, 27 Nov 2015, <http://www.cdc.gov/mmwr/pdf/ss/ss6410.pdf> (Accessed 7 October 2016)

respectively, and reached their lowest level in 2012 for the entire period of analysis (2003–2012).”

For comparison, the “global annual rate of abortion” was estimated to be “35 abortions per 1,000 women of childbearing age (i.e., those 15–44 years old)” from 2010 to 2014, down from 40 per 1,000 from 1990 to 1994.⁵ About 25% of pregnancies in 2010–2014 ended in abortion, for an estimated 56.3 million induced abortions each year.⁶ North America had the lowest abortion rate of any region from 2010–2014 at 17 abortions per 1,000 women aged 15–44; the highest was Latin America and the Caribbean at 44 per 1,000.⁷

As of 2009, the “average cost of first-trimester abortion was \$470 (Jones and Kooistra, 2011), and most women obtaining abortions were poor or low income (Jones et al., 2010).”⁸ Since 1976, the Hyde Amendment has prevented federal Medicaid funds from paying for abortions with a few exceptions (rape, incest, life of the mother). However, states can allow state Medicaid funding to pay for abortions, and seventeen states allowed this as of 2008.⁹ As a result, this Medicaid coverage paid for 20% of US abortions in 2008.¹⁰ In states that allow Medicaid to pay for abortions, “92% of patients with Medicaid coverage made use of this payment method.”¹¹ Meanwhile, for 2014–2015, “some 25 states had laws essentially banning abortion coverage in plans offered through the health insurance marketplaces, including 10 that banned such coverage more broadly in all private insurance plans regulated by the state,” according to the Guttmacher Institute.¹²

⁵ “Induced Abortion Worldwide,” *Guttmacher Institute Fact Sheet*, May 2016, <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide> (Accessed 7 October 2016) Pg. 1

⁶ Gilda Sedgh et. al., “Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends,” *The Lancet*, Vol. 388, No. 10041, 16 July 2016, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30380-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30380-4/fulltext) (Accessed 7 October 2016)

⁷ “Induced Abortion Worldwide,” *Guttmacher Institute Fact Sheet*, May 2016, <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide> (Accessed 7 October 2016) Pg. 1

⁸ Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, “At What Cost? Payment for Abortion Care by US Women,” *Women’s Health Issues*, Vol. 23, No. 3, [http://www.whijournal.com/article/S1049-3867\(13\)00022-4/fulltext?mobileUi=0](http://www.whijournal.com/article/S1049-3867(13)00022-4/fulltext?mobileUi=0) (Accessed 6 October 2016)

⁹ Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, “At What Cost? Payment for Abortion Care by US Women,” *Women’s Health Issues*, Vol. 23, No. 3, [http://www.whijournal.com/article/S1049-3867\(13\)00022-4/fulltext?mobileUi=0](http://www.whijournal.com/article/S1049-3867(13)00022-4/fulltext?mobileUi=0) (Accessed 6 October 2016)

¹⁰ Rachel K. Jones, Ushma D. Upadhyay, and Tracy A. Weitz, “At What Cost? Payment for Abortion Care by US Women,” *Women’s Health Issues*, Vol. 23, No. 3, [http://www.whijournal.com/article/S1049-3867\(13\)00022-4/fulltext?mobileUi=0](http://www.whijournal.com/article/S1049-3867(13)00022-4/fulltext?mobileUi=0) (Accessed 6 October 2016)

¹¹ Rachel K. Jones, Lawrence B. Finer, and Susheela Singh, “Characteristics of U.S. Abortion Patients, 2008,” *Guttmacher Institute*, May 2010, https://www.guttmacher.org/sites/default/files/report_pdf/us-abortion-patients.pdf (Accessed 6 October 2016) Pg. 11

¹² Jenna Jerman, Rachel K. Jones, and Tsuyoshi Onda, “Characteristics of US Abortion Patients in 2014 and Changes Since 2008,” *Guttmacher Institute*, May 2016, <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014> (Accessed 6 October 2016) Pg. 8

Conservative Views of Planned Parenthood

Pro-life Depictions of Planned Parenthood

Pro-life advocacy groups and legislators have long been opposed to Planned Parenthood for a variety of reasons. Planned Parenthood is frequently mentioned by name (and is often the only group mentioned) in the pro-life materials I reviewed. For example, the Family Research Council suggests Planned Parenthood, among other practices besides abortion itself:

- has sold “organs harvested from aborted babies,”
- has repeatedly failed to report statutory rape despite mandatory reporter requirements,
- has circumvented state parental involvement laws,
- has supported sex-selective abortion (“gendercide” against girls),
- has been responsible for waste and fraud, and
- targets minority communities for the placement of its abortion facilities and the performance of abortions¹³

Focus on the Family has similar complaints, as well as a few additional ones, such as Planned Parenthood’s promotion of “so-called ‘safer-sex’ education in public schools,” and alleged lobbying against abstinence-centered approaches, pro-life restrictions on abortion, parental notification for abortions and contraception, conscience clauses for healthcare providers in regards to abortion, and the Mexico City Policy (which prohibits federal funds going towards promoting or performing abortions internationally).¹⁴ For its part, pro-life group Alliance Defending Freedom (formerly the Alliance Defense Fund) accuses Planned Parenthood of “promoting risky sexual behavior in children,” such as by “hand[ing] out condoms packaged to look like candy and even buil[ding] a website where college students can brag about where and when they had sex.”¹⁵

Pro-life groups emphasize abortion as a defining aspect of Planned Parenthood, even referring to it as “Leading the Culture of Death.”¹⁶ The Family Research Council notes that Planned Parenthood’s provision of cancer screening and prevention programs, breast exams, and prenatal services have all decreased from 2009 to 2014 (by 63%, 56%, and 57%, respectively).¹⁷ It criticizes Planned Parenthood’s low number of adoption referrals (2,024 in 2014) relative to its high number of abortions (323,999 abortions in 2014, i.e. “888 babies

¹³ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

¹⁴ Carrie Gordon Earll, “A Case to Defund Planned Parenthood,” Focus on the Family. <http://www.focusonthefamily.com/socialissues/life-issues/a-case-to-defund-planned-parenthood> (Accessed 3 October 2016)

¹⁵ Alliance Defending Freedom, “Promoting risky sexual behavior in children,” <https://www.adflegal.org/issues/sanctity-of-life/beginning-of-life/investigate-their-plan/key-issues/creating-customers> (Accessed 30 September 2016)

¹⁶ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

¹⁷ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

every single day”).¹⁸ Similarly, Focus on the Family notes, “For every adoption referral that was made, Planned Parenthood performed 174 abortions. While the number of abortions [in 2013] increased, Planned Parenthood’s adoption referrals fell more than 14 percent.”¹⁹ Using statistics from Planned Parenthood’s annual report for 2014-2015, the Family Research Council estimates “12% of all their [2.7 million] patients received abortions.”²⁰

A recurring theme in conservative critiques of Planned Parenthood is language that suggests criminality, financial motivation, and industry primacy. For example, a Family Research Council brief says Planned Parenthood “committed 323,999 abortions in 2014” and is “the primary provider of abortions in the U.S.”²¹ (Pro-choice or neutral sources are more likely to say abortions are “performed” or “provided” rather than “committed” or “sold.”) A post on Focus on the Family’s website calls it an “abortion giant” and “the nation’s largest abortion seller” and also says it “commits abortions.”²²

Efforts to Defund Planned Parenthood

Pro-life opponents of Planned Parenthood were galvanized when the Center for Medical Progress started releasing undercover videos in July 2015 that purported to show Planned Parenthood employees discussing the possible sale of fetal organs harvested during abortions. Numerous pieces of legislation were soon introduced in Congress to defund and/or investigate Planned Parenthood, including (but not necessarily limited to):

Bill/Resolution	Date Introduced	Summary
H.R. 3134	September 21, 2015	<ol style="list-style-type: none"> 1. Removes federal funding from Planned Parenthood for a year unless it agrees not to perform abortions (with a few exceptions) 2. Appropriates an additional \$235 million for community health centers
H.R. 3301	July 29, 2015	<ol style="list-style-type: none"> 1. Prevents federal funds from going to Planned Parenthood 2. Shifts those funds from Planned Parenthood “to other eligible entities to

¹⁸ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

¹⁹ Carrie Gordon Earll, “A Case to Defund Planned Parenthood,” Focus on the Family. <http://www.focusonthefamily.com/socialissues/life-issues/a-case-to-defund-planned-parenthood> (Accessed 3 October 2016)

²⁰ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

²¹ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

²² Carrie Gordon Earll, “A Case to Defund Planned Parenthood,” Focus on the Family. <http://www.focusonthefamily.com/socialissues/life-issues/a-case-to-defund-planned-parenthood> (Accessed 3 October 2016)

		provide women’s health care services”
S. 1836	July 22, 2015	<i>Same as H.R. 3134, except without any appropriations because it’s a Senate bill</i>
S. 1877	July 28, 2015	<ol style="list-style-type: none"> 1. Directs the Attorney General to appoint a special prosecutor to investigate Planned Parenthood and other “covered entities” (abortion providers) 2. Rescinds funding from Planned Parenthood and makes it available to the special prosecutor
S. 1881	July 28, 2015	<i>Same as H.R. 3301</i>

These pieces of legislation reflect two key themes from pro-life materials, which I will discuss in more detail below:

1. Any funding for Planned Parenthood is tantamount to funding abortion.
2. Other medical entities offer a viable--better, even--alternative to Planned Parenthood.

In regards to funding, Focus on the Family demonstrates this argument when it notes that organizations like Planned Parenthood “can still use the tax dollars for non-abortion related expenses, such as overhead and operational costs, thus freeing up other funds to promote and provide abortions.”²³ Similarly, Dr. Michael J. New of the pro-life Charlotte Lozier Institute writes this while discussing the potential impacts of expanded Medicaid coverage in Alaska: “Medicaid expansion would indirectly subsidize abortion by increasing the amount of taxpayer funding for Planned Parenthood, the nation’s largest abortion provider.”²⁴

H.R. 3134, H.R. 3301, and S. 1881 include the wording below that reflects the pro-life belief in viable and preferable alternatives to Planned Parenthood:

- (1) State and county health departments, community health centers, hospitals, physicians offices, and other entities currently provide, and will continue to provide, health services to women. Such health services include relevant diagnostic laboratory and radiology services, well-child care, prenatal and postpartum care, immunization, family planning services including contraception, sexually transmitted disease testing, cervical and breast cancer screenings, and referrals.

²³ Carrie Gordon Earll, “A Case to Defund Planned Parenthood,” Focus on the Family <http://www.focusonthefamily.com/socialissues/life-issues/a-case-to-defund-planned-parenthood> (Accessed 30 September 2016)

²⁴ Michael J. New, “An Analysis of How Medicaid Expansion in Alaska Will Affect Abortion Rates,” Charlotte Lozier Institute, 13 May 2015, <https://lozierinstitute.org/an-analysis-of-how-medicaid-expansion-in-alaska-will-affect-abortion-rates/> (Accessed 4 October 2016)

- (2) Many such entities provide services to all persons, regardless of the person's ability to pay, and provide services in medically underserved areas and to medically underserved populations.
- (3) All funds no longer available to Planned Parenthood will continue to be made available to other eligible entities to provide women's health care services.

H.R. 3134 makes that intended shifting of funding from Planned Parenthood to other entities explicit by appropriating \$235 million for community health centers.

This legislative approach is in line with the recommendations of groups like the Family Research Council and Focus on the Family. Here is the Family Research Council's presentation of this argument:

“There are 13,540 federally-qualified, low-cost, high quality health care clinics and rural health centers. They outnumber Planned Parenthood 20 to 1 nationally...These federally-qualified health centers not only offer screenings and prevention services, pap smears, cancer screenings, breast exams, and prenatal services, but they also offer a full spectrum of other primary care services that Planned Parenthood fails to provide...Federally-qualified health centers offered services for 21.7 million patients in 2013 compared to Planned Parenthood who served 2.7 million. That's over 8 times as many patients...With an extra half a billion in taxpayer funds that currently goes to Planned Parenthood, these federally-qualified health centers could grow and expand their reach.”²⁵

Focus on the Family similarly presents other health centers as viable alternatives, noting that they are in every state and provide a wider range of services than Planned Parenthood.²⁶ (There is a minor discrepancy: the Family Research Council references 13,540 centers, whereas Focus on the Family refers to “more than 8,000.” They also reference differing numbers of Planned Parenthood locations, which in turns leads to varying ratios of Planned Parenthood to alternative locations.)

An Evidence-Based Alternative to Defunding Planned Parenthood: LARCs

Before directly addressing the possible effects of defunding Planned Parenthood in the next section, I think it is important to address the extent to which family planning can reduce unintended pregnancies--and consequently abortions. In my review of the literature, long-acting reversible contraceptives (LARC) methods kept coming up as a prominent success story. Because it could reduce abortions, I believe expanding access to and awareness of LARCs constitutes a preferable and evidence-based means of reducing abortions. Such

²⁵ Family Research Council, “The Real Planned Parenthood: Leading the Culture of Death 2016 Edition”, <http://www.frc.org/plannedparenthoodfacts> (Accessed 3 October 2016)

²⁶ Carrie Gordon Earll, “A Case to Defund Planned Parenthood,” Focus on the Family <http://www.focusonthefamily.com/socialissues/life-issues/a-case-to-defund-planned-parenthood> (Accessed 30 September 2016)

efforts to reduce abortions by increasing access to effective family planning can thus serve as a baseline: if efforts to ban or create barriers to obtaining abortion (such as by defunding Planned Parenthood) produce worse outcomes than increasing access to family planning, then the former should be rejected in favor of the latter.

LARCs (contraceptive implants and IUDs) could reduce abortions by significantly reducing unintended pregnancies. Unintended pregnancies include both unwanted pregnancies (the mother does not want another child) and mistimed pregnancies (the pregnancy occurred earlier than desired).²⁷

Both types of LARC are cost-effective and effective. Donna Shoupe writes: “LARC methods are around 20 times more effective than any other type of reversible birth control excluding the DMPA injection [1-3]. In a 2012 study over 7400 participants, the failure rates in participants using oral contraceptive pills, birth control patch, or the vaginal ring was 17-20 times higher than the risk of those using LARC methods.”²⁸ Furthermore, unlike many other contraceptive methods, LARC methods are not more likely to fail for young users due to misuse; according to Shoupe, “For those under 21 using the pills, patch or ring, the risk of failure was almost twice as high as the older participants. But rates of unintended pregnancy regardless of age remained low in the LARC (and depo-provera group) [1].”²⁹

The Contraceptive CHOICE Project--a program in St. Louis that offered “9,256 adolescents and women at risk for unintended pregnancy” the reversible contraceptive method of their choice at no cost--demonstrates how family planning can reduce unintended pregnancies and abortion.³⁰ Using teen births as a proxy for unintended pregnancies, the authors found their study cohort had a birth rate far below the national average. They estimate that “one abortion could be prevented for every 79-137 women and teenagers provided the CHOICE intervention” and that “changes in contraceptives policy simulating the Contraceptive CHOICE Project would *prevent as many as 41% to 71% of abortions performed annually in the US.*” [emphasis mine]³¹ Though the project’s success may be partially due to the study participants’ surprisingly high use of LARC methods, the authors point to a similar program

²⁷ Amy O. Tsui, Raegan McDonald-Mosley, and Anne E. Burke, “Family Planning and the Burden of Unintended Pregnancies,” *Epidemiologic Reviews*, Vol. 32, 2010, Pg. 156 <http://epirev.oxfordjournals.org/content/32/1/152.abstract> (Accessed 7 October 2016)

²⁸ Donna Shoupe, “LARC methods: entering a new age of contraception and reproductive health,” *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016)

²⁹ Donna Shoupe, “LARC methods: entering a new age of contraception and reproductive health,” *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016)

³⁰ Jeffery F. Peipert, Tessa Madden, Jenifer E. Allsworth, and Gina M. Secura, “Preventing Unintended Pregnancies by Providing No-Cost Contraception,” *Obstetrics and Gynecology*, Vol. 68, No. 4., <https://www.ncbi.nlm.nih.gov/pubmed/23168752>

³¹ Jeffery F. Peipert, Tessa Madden, Jenifer E. Allsworth, and Gina M. Secura, “Preventing Unintended Pregnancies by Providing No-Cost Contraception,” *Obstetrics and Gynecology*, Vol. 68, No. 4., <https://www.ncbi.nlm.nih.gov/pubmed/23168752>

in California (Family PACT) that also significantly reduced unintended pregnancies, even though LARC usage was much lower.³²

A later study in Colorado found similar results when Colorado Family Planning Initiative (CFPI) provided LARC methods at no-cost to low-income women age 15-24.³³ Although the abortion rate declined for women age 15-19 in both counties with and without CFPI funding from 2008 to 2011, the drop was more pronounced in the counties benefiting from the program: a 34% drop in counties with funding and a 29% drop in counties without funding.³⁴ The abortion rate for 15-19 year olds in CFPI counties went from 10.9 abortions per 1,000 women in 2008 to 7.2 per 1,000 in 2011.³⁵ The difference was more obvious among 20-24 year old women. While the abortion rate for counties without CFPI funding increased by 6% from 2008 to 2011 (not a statistically significant change, so roughly stable), it dropped from 22 abortions per 1,000 women to 18 per 1,000--a statistically significant drop of 18%.³⁶

From a public policy perspective, it's worth noting that paying for unintended pregnancies is expensive. A 2011 Guttmacher Institute study estimated that the cost of births that were publicly funded (by public insurance programs) and resulted from unintended pregnancies in 2006 was \$11.1 billion.³⁷ It notes, "In 2006, 64% of births resulting from unintended pregnancies were publicly funded, compared with 48% of all births and 35% of births resulting from intended pregnancies."³⁸ In Mississippi, 81% of births from unintended pregnancies in 2006 were publicly funded--the highest of any state.³⁹ A journal article from

³² Jeffery F. Peipert, Tessa Madden, Jenifer E. Allsworth, and Gina M. Secura, "Preventing Unintended Pregnancies by Providing No-Cost Contraception," *Obstetrics and Gynecology*, Vol. 68, No. 4., <https://www.ncbi.nlm.nih.gov/pubmed/23168752>

³³ Sue Ricketts, Greta Klingler, and Renee Schwalberg, "Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women", *Perspectives on Sexual and Reproductive Health*, Vol. 46, No. 3, September 2014. <http://onlinelibrary.wiley.com/doi/10.1363/46e1714/abstract>

³⁴ Sue Ricketts, Greta Klingler, and Renee Schwalberg, "Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women", *Perspectives on Sexual and Reproductive Health*, Vol. 46, No. 3, September 2014. <http://onlinelibrary.wiley.com/doi/10.1363/46e1714/abstract> Pg. 129

³⁵ Sue Ricketts, Greta Klingler, and Renee Schwalberg, "Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women", *Perspectives on Sexual and Reproductive Health*, Vol. 46, No. 3, September 2014. <http://onlinelibrary.wiley.com/doi/10.1363/46e1714/abstract> Pg. 129

³⁶ Sue Ricketts, Greta Klingler, and Renee Schwalberg, "Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women", *Perspectives on Sexual and Reproductive Health*, Vol. 46, No. 3, September 2014. <http://onlinelibrary.wiley.com/doi/10.1363/46e1714/abstract> Pg. 129

³⁷ Adam Sonfield, Kathryn Kost, Rachel Benson Gold, and Lawrence B. Finer, "The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates," *Perspectives on Sexual and Reproductive Health*, Vol. 43, No. 2, June 2011, <https://www.guttmacher.org/sites/default/files/pdfs/pubs/psrh/full/4309411.pdf> pg. 94.

³⁸ Adam Sonfield, Kathryn Kost, Rachel Benson Gold, and Lawrence B. Finer, "The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates," *Perspectives on Sexual and Reproductive Health*, Vol. 43, No. 2, June 2011, <https://www.guttmacher.org/sites/default/files/pdfs/pubs/psrh/full/4309411.pdf> pg. 94.

³⁹ Adam Sonfield, Kathryn Kost, Rachel Benson Gold, and Lawrence B. Finer, "The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates,"

Brookings analysts estimates the average (mean) “taxpayer cost per publicly subsidized pregnancy is \$9,000.”⁴⁰

Although a pre-ACA study indicates the cost of LARC methods can be over \$1,000 for uninsured women,⁴¹ they are nevertheless highly cost effective. Shoupe summarizes the findings of other scholars’ study in California: “The authors found that public cost-savings for each dollar spent on contraception ranged from \$1.58 for barrier methods to approximately \$5 for LARC methods...Most significantly, this study demonstrated use of LARC methods is cost-effective even if methods are not used for their full durations of efficacy.”⁴²

A small group of at-risk women account for many unintended pregnancies, according to their contraceptive use. According to data from the Guttmacher Institute, women at risk for unintended pregnancy who use contraceptives regularly account for just 5% of unintended pregnancies, despite being 68% of the at-risk population (see Table 1 below).⁴³ Conversely, the 14% of at-risk women who do not use contraceptives or have long gaps in use account for 54% of unintended pregnancies.⁴⁴

	Women at Risk	Unintended Pregnancies
Consistent use	68%	5%
Inconsistent use	18%	41%
Nonuse or long gaps in use	14%	54%

Perspectives on Sexual and Reproductive Health, Vol. 43, No. 2, June 2011, <https://www.guttmacher.org/sites/default/files/pdfs/pubs/psrh/full/4309411.pdf> pg. 94.

⁴⁰ Emily Monea and Adam Thomas, “Unintended Pregnancy and Taxpayer Spending,” *Perspectives on Sexual and Reproductive Health*, Vol. 43, No. 2, June 2011, <https://www.guttmacher.org/sites/default/files/pdfs/pubs/psrh/full/4308811.pdf> pg. 88

⁴¹ Trussell J. “Update on and correction to the cost effectiveness of contraceptives in the United States,” *Contraception*. 2012;85(2):218. **Cited in** Kirsten M. J. Thompson, Corinne H. Rocca, Julia E. Kohn, Suzan Goodman, Lisa Stern, Maya Blum, J. Joseph Speidel, Philip D. Damey, Cynthia C. Harper, “Public Funding for Contraception, Provider Training, and Use of Highly Effective Contraceptives: A Cluster Randomized Trial,” *American Journal of Public Health*, Vol. 106, No. 3, March 2016, <https://www.ncbi.nlm.nih.gov/pubmed/26794168> (Accessed 7 October 2016) Pg. 541

⁴² Donna Shoupe, “LARC methods: entering a new age of contraception and reproductive health,” *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016) Pg. 6

⁴³ Joerg Dreweke, “New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines,” *Guttmacher Policy Review*, Vol. 19. 2016. <https://www.guttmacher.org/about/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent> pg. 19

⁴⁴ Joerg Dreweke, “New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines,” *Guttmacher Policy Review*, Vol. 19. 2016. <https://www.guttmacher.org/about/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent> pg. 19

Table 1. Contraceptive use and unintended pregnancies⁴⁵ (Note: this is based on pie graphs from the Guttmacher source)

In 2008, 40% of unintended pregnancies ended in abortion; in 2011, 42% did so.⁴⁶ Coupled with the statistics from Table 1, this indicates that increased use of LARC methods could help avert numerous abortions. Because LARC methods are long-lasting, they can help address the 95% of unintended pregnancies that result from inconsistent use, nonuse, or long gaps in use. This lends further credibility to the Contraception CHOICE Project study authors' claims that further adoption could avert 41% to 71% of abortions in the US.⁴⁷

Increased public funding, such as through Medicaid family planning expansion programs, and provider training can increase women's access to and use of LARC.⁴⁸ These are essential due to a knowledge deficit among health professionals about LARCs, including a lack of training.⁴⁹ Donna Shoupe notes, "Although a large majority (92%) [of obstetrician gynecologists] reported IUD insertion training during residency, only 50% reported training on implants. Continuing education within the past two years was, in fact, the best predictor of implant provision."⁵⁰ The guidelines and contraindications for LARCs have evolved rapidly based on recent research, so women who previously would not have been considered for LARCs ought to be now.⁵¹ Because of this, provider education about LARC methods is critical for patients to be aware of (and potential interested in using) them.⁵² A majority of

⁴⁵ Joerg Dreweke, "New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines," *Guttmacher Policy Review*, Vol. 19. 2016. <https://www.guttmacher.org/about/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent> pg. 19

⁴⁶ Joerg Dreweke, "New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines," *Guttmacher Policy Review*, Vol. 19. 2016. <https://www.guttmacher.org/about/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent> pg. 17

⁴⁷ Jeffery F. Peipert, Tessa Madden, Jenifer E. Allsworth, and Gina M. Secura, "Preventing Unintended Pregnancies by Providing No-Cost Contraception," *Obstetrics and Gynecology*, Vol. 68, No. 4., <https://www.ncbi.nlm.nih.gov/pubmed/23168752>

⁴⁸ Kirsten M. J. Thompson, Corinne H. Rocca, Julia E. Kohn, Suzan Goodman, Lisa Stern, Maya Blum, J. Joseph Speidel, Philip D. Damey, Cynthia C. Harper, "Public Funding for Contraception, Provider Training, and Use of Highly Effective Contraceptives: A Cluster Randomized Trial," *American Journal of Public Health*, Vol. 106, No. 3, March 2016, <https://www.ncbi.nlm.nih.gov/pubmed/26794168> (Accessed 7 October 2016)

⁴⁹ Donna Shoupe, "LARC methods: entering a new age of contraception and reproductive health," *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016) Pg. 4-5

⁵⁰ Donna Shoupe, "LARC methods: entering a new age of contraception and reproductive health," *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016) Pg. 6

⁵¹ Donna Shoupe, "LARC methods: entering a new age of contraception and reproductive health," *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016) Pg. 2-3

⁵² Donna Shoupe, "LARC methods: entering a new age of contraception and reproductive health," *Contraception and Reproductive Medicine*, 23 Feb 2016,

obstetrician gynecologists (unnecessarily) “require two or more visits” for patients to obtain IUDs.⁵³ This could prevent some women from obtaining them.

Statistics from the CDC’s National Survey of Family Growth indicates increasing percentages of women have used LARC at least once. For example, while only 0.9% of women in 2002 had used the contraceptive patch and only 5.8% had used an intrauterine device, those rose to 11.0% and 14.3% for 2011-2013.⁵⁴ The Affordable Care Act’s guarantee of coverage of contraceptives (for most, though not all, women) has played an important role in expanding access to LARC.⁵⁵ Existing efforts should be expanded further in order to avert abortions.

Reducing Access to Family Planning Could Increase Abortion

Having examined the evidence that methods like LARCs can reduce abortions, we can now evaluate the likely effect of defunding Planned Parenthood (and organizations like it). It bears repeating that because the Hyde Amendment bans federal funds from paying for abortions (in most cases), Planned Parenthood’s ability to provide family planning would be directly affected by defunding. This would similarly be the case if other organizations that provide both family planning and abortions were to be defunded.

University of Texas demographer Joseph Potter summarizes the argument succinctly for *The Washington Post* when discussing Texas’ defunding of Planned Parenthood: “You’re removing contraception with this [defunding], and if you remove contraception, you get unintended pregnancies, which means more abortion.”⁵⁶

Despite legislators’ and pro-life advocates’ insistence that other health providers could fill the gap left by Planned Parenthood, a letter from Keith Hall (director of the Congressional Budget Office) to Senator Mike Enzi (chairman of the Senate Budget Committee) suggests this is not entirely accurate. Hall writes:

<https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016) Pg. 6

⁵³ Donna Shoupe, “LARC methods: entering a new age of contraception and reproductive health,” *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016) Pg. 6

⁵⁴ CDC, National Survey of Family Growth, http://www.cdc.gov/nchs/nsfg/key_statistics/c.htm#contraception (Accessed 6 October 2016)

⁵⁵ Donna Shoupe, “LARC methods: entering a new age of contraception and reproductive health,” *Contraception and Reproductive Medicine*, 23 Feb 2016, <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-016-0011-8> (Accessed 7 October 2016)

⁵⁶ Ruth Marcus, “Defunding Planned Parenthood would actually increase abortions,” *The Washington Post*, 31 July 2015. https://www.washingtonpost.com/opinions/dont-cut-planned-parenthoods-funds-increase-them/2015/07/31/fe66aad8-379e-11e5-b673-1df005a0fb28_story.html?utm_term=.ef86385db9b3 (Accessed 30 September 2016)

“CBO expects that if S. 1881 was enacted, most of the Medicaid services that would have been obtained from Planned Parenthood Federation of America would instead be obtained from other health clinics and medical practitioners--but not all of them. As a result, there would be some decline in the use of Medicaid services.

...CBO also expects that some of the services that would not be used if S. 1881 was enacted would include those that help women avert pregnancies and deliveries. Reduced use of such services would be expected to lead to additional births, increasing federal spending, primarily for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs.”⁵⁷

There are two takeaways based on this letter that are relevant to this brief. First, the CBO expects that defunding Planned Parenthood would lead to an increased number of births because not all women who would have accessed services from Planned Parenthood will access services from an alternative provider. (Though not stated here, there are a variety of understandable reasons for this, such as geographical distribution of centers, greater awareness of Planned Parenthood’s services versus other locations, etc.) Second, because many (perhaps even most) of these births would be unintended pregnancies, it is likely this would increase the abortion rate since unintended pregnancies frequently end in abortion. As the Guttmacher Institute has noted, about 40 and 42% of unintended pregnancies in 2008 and 2011 resulted in abortions, respectively.⁵⁸

For the sake of argument, let us imagine that Planned Parenthood were defunded. Planned Parenthood estimates in its 2014-2015 annual report that its provision of contraceptive services averted 578,681 unintended pregnancies.⁵⁹ Because the CBO predicts not all women would seek services at an alternative, let us assume that 5% of these pregnancies would not be averted if Planned Parenthood were defunded. There could be several reasons for such a drop: women who could previously access a Planned Parenthood clinic might not be able to reach an alternative; there could be a delay in expansion of services for other organizations even if greater funding (shifted from Planned Parenthood were to be made available to them); even with other sources of revenue, Planned Parenthood’s ability to provide effective services (such as the most effective forms of contraception) would be harmed by the loss of a significant source of its revenue. I use 5% as I expect it to be a fairly conservative estimate.

In this scenario, there would be 28,934 more unintended pregnancies than if Planned Parenthood had not been defunded ($578,681 * 0.05$). If 40% of these end in abortion (the rate

⁵⁷ Keith Hall writing to Honorable Mike Enzi, “Re: Budgetary Effects of S. 1881.” *Congressional Budget Office*, 3 August 2015, <https://www.cbo.gov/publication/50700>

⁵⁸ Joerg Dreweke, “New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines,” *Guttmacher Policy Review*, Vol. 19. 2016. <https://www.guttmacher.org/about/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent> pg. 17

⁵⁹ Planned Parenthood, “2014-2015 Annual Report,” https://www.plannedparenthood.org/files/2114/5089/0863/2014-2015_PPFA_Annual_Report_.pdf (Accessed 4 October 2016)

from 2008), then there would be 11,573 additional abortions resulting from the defunding ($28,934 \times 0.4$) because of the imperfect transfer of services from Planned Parenthood to other providers. This suggests that even if there were almost perfect substitution (95%) between Planned Parenthood and other providers after a defunding, there would still be an increase in abortion, *ceteris paribus*. Furthermore, this is before accounting for self-induced abortions. Thus, based on the assumptions in the CBO director's letter to Congress, it seems reasonable to expect that defunding Planned Parenthood would result in abortions that otherwise would have been averted.

State-level Defunding Efforts Can Also Increase Abortion

Many restrictions on abortion and defunding efforts are occurring at the state level. According to the Guttmacher Institute: "In the 43 years since the U.S. Supreme Court handed down *Roe v. Wade*, states have enacted 1,074 abortion restrictions. Of these, 288 (27%) have been enacted just since 2010. This gives the last five years the dubious distinction of accounting for more abortion restrictions than any other single five-year period since *Roe*."⁶⁰ One of the most prominent examples of states enacting such restrictions is Texas.

Texas has significantly cut family planning funding in recent years. For example, in 2011 it cut "funding for family planning services by two thirds--from \$111 million to \$37.9 million for the 2-year period."⁶¹ Because of these cuts, many organizations struggled to provide the most effective (but expensive) types of contraceptives, like LARC methods. Instead, they had to often resort to providing contraceptive pills, and even fewer of those per visit than previously. This is troublesome, as a study published in March 2011 indicated that dispensing larger quantities of oral contraceptives at a time (like a year's supply versus three or one cycles' worth) reduced the odds of an unplanned pregnancy by 30% and abortion by 46%.⁶² Thus, providing fewer contraceptives due to budget cuts might also unintentionally increase abortions.

An interview-based study of women in Texas seeking abortions after the clinics stopped providing those services (due to restrictive laws purportedly about safety) examined the outcomes.⁶³ The closure of clinics led to a delay in obtaining an abortion, and greater travel distances and abortion later in the pregnancy increased their costs. For example, one woman

⁶⁰ Guttmacher Institute, "Last Five Years Account for More Than One-quarter of All Abortion Restrictions Enacted Since *Roe*," 13 January 2016.

⁶¹ Kari White, Daniel Grossman, Kristine Hopkins, and Joseph E. Potter, "Cutting Family Planning in Texas," *New England Journal of Medicine*, 27 September 2012, <http://www.nejm.org/doi/full/10.1056/NEJMp1207920#t=article>

⁶² Foster DG, Hulett D, Bradsberry M, Darney P, and Policar M., "Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies," *Obstetrics and Gynecology*, <https://www.ncbi.nlm.nih.gov/pubmed/21343759>

⁶³ Liza Fuentes, Sharon Lebenkoff, Kari White, Caitlin Gerds, Kristine Hopkins, Joseph E. Potter, and Daniel Grossman, "Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas," *Contraception*, Vol. 93, No. 4, April 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4896137/pdf/nihms-788814.pdf> (Accessed 7 October 2016), Pg. 7

in the study was only able to obtain an abortion three weeks later than desired; the abortion procedure cost more than \$200 more than it would have if she had been able to obtain it when she first sought one--she even had to take out a loan to cover the this additional expense.⁶⁴

Besides being more expensive, abortions later in a pregnancy (though still quite safe) are more likely to be fatal; the mortality rate is more than 22 times greater for a procedure performed at 18 weeks or later versus 8 weeks or earlier (6.7 deaths per 100,000 procedures versus 0.3 deaths per 100,000, respectively).⁶⁵ The Texas Policy Evaluation Project, which examines the effect of Texas' restrictions on abortion from House Bill 2, estimates that "the number of abortions performed in the second trimester in the state would nearly double" due to the increased wait times at Texas' remaining facilities.⁶⁶ In short, restrictions purportedly about making women seeking abortions safer actually make them less safe by delaying the procedure.

Other complicating factors included arranging child care, taking time off of work, and in some cases even revealing one's pregnancy status to others due to an inability to make it to a geographically distant clinic by oneself. Two women in the aforementioned interview-based study ultimately decided to carry their pregnancy to term because they could not obtain the desired abortion due to such barriers and insufficient information to overcome them.⁶⁷ While some pro-life advocates might consider this to be a success (after all, at least 2 abortions out of 27 were averted), one must also consider the possibility of self-induced abortion; the study found that 5 out of the 23 interviewees had considered and researched self-inducing an abortion, though none ultimately followed through due to concerns about safety and efficacy.⁶⁸

⁶⁴ Liza Fuentes, Sharon Lebenkoff, Kari White, Caitlin Gerdt, Kristine Hopkins, Joseph E. Potter, and Daniel Grossman, "Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas," *Contraception*, Vol. 93, No. 4, April 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4896137/pdf/nihms-788814.pdf> (Accessed 7 October 2016), Pg. 7

⁶⁵ Zane S., Creanga AA, Berg C.J., Pazol K., Suchdev D.B., Jamieson D.J., Callaghan W.M., "Abortion-Related Mortality in the United States: 1998-2010," *Obstetrics and Gynecology*, Vol. 126, No. 2, August 2015, <https://www.ncbi.nlm.nih.gov/pubmed/26241413> (Accessed 7 October 2016)

⁶⁶ "Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics," *Texas Policy Evaluation Project Research Brief*, http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf (Accessed 7 October 2016) Pg. 1

⁶⁷ Liza Fuentes, Sharon Lebenkoff, Kari White, Caitlin Gerdt, Kristine Hopkins, Joseph E. Potter, and Daniel Grossman, "Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas," *Contraception*, Vol. 93, No. 4, April 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4896137/pdf/nihms-788814.pdf> (Accessed 7 October 2016), Pg. 6

⁶⁸ Liza Fuentes, Sharon Lebenkoff, Kari White, Caitlin Gerdt, Kristine Hopkins, Joseph E. Potter, and Daniel Grossman, "Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas," *Contraception*, Vol. 93, No. 4, April 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4896137/pdf/nihms-788814.pdf> (Accessed 7 October 2016), Pg. 7

Another study in Texas based on interviews with women who had tried to self-induce an abortion found:

“four primary reasons why women tried to self-induce their abortion: 1) they did not have the money to travel to a clinic or to pay for the procedure; 2) their local clinic had closed; 3) a close friend or family member recommended self-induction, and 4) to avoid the stigma or shame of going to an abortion clinic, especially if they had had prior abortions. No single one of these reasons was sufficient for a woman to consider self-induction; while women in our study were diverse in many ways, a common thread was that poverty layered upon one or more additional obstacles left them feeling that they had no other option.”⁶⁹

As one might expect given all these restrictions on abortion, the attempted self-induction rate in Texas is much higher than the national average. A study from 2012 “found that 7% of women reported taking something [such as the abortion-inducing drug misoprostol or herbs] on their own in order to try to end their current pregnancy before coming to the abortion clinic. This proportion was even higher — about 12% — among women at clinics near the Mexican border.”⁷⁰ For comparison, a study published in 2011 found that only 2.6% of abortion patients in the US had ever attempted to self-induce an abortion by taking misoprostol or other substances.⁷¹ (It should be noted that the figure for Texas could be even higher comparable to the US figure, because the Texas figure only includes self-induction before visiting the clinic; it would thus miss out on any patients who visited a clinic but ultimately decided against obtaining an abortion there, though this number is likely small.)

The situation in Texas may change in the wake of the US Supreme Court’s 5-3 decision in *Whole Woman’s Health v. Hellerstedt*, released on June 27, 2016. This decision strikes down two provisions from the Texas Legislature’s House Bill 2 (enacted 2013): (1) that abortion providers must have admitting privileges at a nearby hospital, and (2) that abortion facilities must meet the standards for “ambulatory surgical centers.” The Supreme Court held, “neither of these provisions offers medical benefits sufficient to justify the burdens upon access that each imposes. Each places a substantial obstacle in the path of women seeking a previability abortion, each constitutes an undue burden on abortion access, Casey, *supra*, at 878 (plurality opinion), and each violates the Federal Constitution.”⁷²

⁶⁹ “Texas women’s experiences attempting self-induced abortion in the face of dwindling options,” *Texas Policy Evaluation Project Research Brief*, http://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf (Accessed 7 October 2016)

⁷⁰ Daniel Grossman, Kari White, Kristine Hopkins, Joseph E. Potter, “The public health threat of anti-abortion legislation,” *Contraception*, Vol. 89, No. 2., February 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418533/> (Accessed 7 October 2016)

⁷¹ RK Jones, “How commonly do US abortion patients report attempts to self-induce?” *American Journal of Obstetrics and Gynecology*, Vol. 204, No. 1, January 2011, <https://www.ncbi.nlm.nih.gov/pubmed/20863478> (Accessed 7 October 2016)

⁷² *Whole Woman’s Health v. Hellerstedt*, https://www.supremecourt.gov/opinions/15pdf/15-274_p8k0.pdf pg. 2

Family Planning Aid and Abortion Outside the United States

US policies can also affect abortion rates in other countries. A study looking at abortion in sub-Saharan Africa confirms not only this, but also that defunding organizations in the family planning sector can unintentionally increase abortion. Eran Bendavid, Patrick Avila, and Grant Miller used survey data from 20 sub-Saharan African countries to see what impact the reinstatement of the Mexico City Policy under George W. Bush had on abortion rates. (As described by the study's authors, that policy "requires all nongovernmental organizations operating abroad to refrain from performing, advising on or endorsing abortion as a method of family planning if they wish to receive federal funding."⁷³) They find that the abortion rate in the studied countries was stable from 1994 to 2001 (while the Mexico City Policy was not in place under Bill Clinton), then "rose steadily from 2002 to 2008."⁷⁴ They write, "Overall, the induced abortion rate increased significantly from 10.4 to per 10 000 woman-years for the period from 1994 to 2001 to 14.5 per woman-years for the period from 2001 to 2008 (P=0.01)."⁷⁵ The increase was particularly pronounced in countries that received more than the average amount of financial assistance (per capita) from the US "for family planning and reproductive help between 1995 and 2000."⁷⁶

Put simply, when countries that received relatively large amounts of family planning aid from the US from 1994 to 2001 lost it under the Bush administration, abortions went up significantly. The authors note that this finding is not necessarily generalizable to other countries, so it might not apply to the US; nevertheless, it's important to keep in mind as debates on abortion as a domestic issue can easily carry over to abortion in US foreign policy. Also, the authors note that their "findings are consistent with those of previous studies on the relationship between family planning activities and abortion."⁷⁷

The effect of US policies on abortion rates is particularly relevant since the abortion rate is already higher in developing countries versus developed ones; from 2010-2014, they were 37 per 1,000 women of childbearing age and 27 per 1,000, respectively.⁷⁸ In 2008, 49% of

⁷³ Eran Bendavid, Patrick Avila, and Grant Miller, "United States aid policy and induced abortion in sub-Saharan Africa," *Bulletin of the World Health Organization*, 2011. <http://www.who.int/bulletin/volumes/89/12/11-091660/en/> (Accessed 30 September 2016). Pg. 873

⁷⁴ Eran Bendavid, Patrick Avila, and Grant Miller, "United States aid policy and induced abortion in sub-Saharan Africa," *Bulletin of the World Health Organization*, 2011. <http://www.who.int/bulletin/volumes/89/12/11-091660/en/> (Accessed 30 September 2016). Pg. 876

⁷⁵ Eran Bendavid, Patrick Avila, and Grant Miller, "United States aid policy and induced abortion in sub-Saharan Africa," *Bulletin of the World Health Organization*, 2011. <http://www.who.int/bulletin/volumes/89/12/11-091660/en/> (Accessed 30 September 2016). Pg. 876

⁷⁶ Eran Bendavid, Patrick Avila, and Grant Miller, "United States aid policy and induced abortion in sub-Saharan Africa," *Bulletin of the World Health Organization*, 2011. <http://www.who.int/bulletin/volumes/89/12/11-091660/en/> (Accessed 30 September 2016). Pg. 874

⁷⁷ Eran Bendavid, Patrick Avila, and Grant Miller, "United States aid policy and induced abortion in sub-Saharan Africa," *Bulletin of the World Health Organization*, 2011. <http://www.who.int/bulletin/volumes/89/12/11-091660/en/> (Accessed 30 September 2016). Pg. 877.

⁷⁸ Gilda Sedgh et. al., "Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends," *The Lancet*, Vol. 388, No. 10041, 16 July 2016,

abortions worldwide were unsafe--more than the 44% in 1995.⁷⁹ As of 2006, about 97% of unsafe abortions--the then 19-20 million abortions each year “done by individuals without the requisite skills, or in environments below minimum medical standards, or both”--were performed in developing countries.⁸⁰

Thus, if the US adopts supposedly anti-abortion policies that actually increase the abortion rate in developing countries, it is doing so in the very places where the abortion rate is already higher and abortions are most likely to be unsafe. In other words, the stakes are even higher in other countries. If we do not recognize the effects of US policies, we may unintentionally both increase the number of abortions globally and endanger more women who still choose to undergo unsafe abortions.

Conclusion

Overall, the US’ abortion rate is already relatively low. Increasing access to and provider education about more effective forms of contraception (like LARCs) provides a better, evidence-driven approach to reducing abortions. Unfortunately, it is likely to be unacceptable to some conservative, pro-life groups that have non-abortion-related concerns, like teenage sexuality; facilitating access to contraception might come across to some as promoting or facilitating promiscuity. Regardless, attempts to defund organizations like Planned Parenthood are likely to result in an unintentional increase in abortions, and attempts to erect barriers to abortion (as Texas did) might increase self-induction of abortion. An approach focused on family planning is thus the best means to reduce abortion without jeopardizing the safety of women.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30380-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30380-4/fulltext) (Accessed 7 October 2016)

⁷⁹ Sedgh G., Singh S., Shah I.H., Ahman E., Henshaw S.K., Bankole A., “Induced abortion: incidence and trends worldwide from 1995 to 2008,” *The Lancet*, Vol. 379, No. 9816, 18 Feb 2012, <https://www.ncbi.nlm.nih.gov/pubmed/22264435> (Accessed 7 October 2016)

⁸⁰ Grimes D.A., Benson J., Singh S., Romero M., Ganatra B., Okonofua F.E., Shah I.H., “Unsafe abortion: the preventable pandemic,” *The Lancet*, Vol. 368, No. 9550