

Fact Sheet: Studies Show Greater Access to Contraception Does NOT Reduce Unintended Pregnancy and Abortion

Dr. David Paton, the head of the economics division of the Nottingham University Business School, is author of four major studies in this area and has found “no evidence” that “the provision of family planning reduces either underage conception or abortion rates.”

“The Economics of Family Planning and Underage Conceptions,”
Journal of Health Economics, 21.2 (March 2002): 207-225;

In one of his studies, Dr. Paton investigated the impact of family planning on teenage conceptions and abortions by testing data collected over a 14-year period from 16 regions in the U.K. The study “shows that greater access to family planning services in the United Kingdom fails to curb teen sex or abortion rates. The study also finds some evidence that greater access may actually increase underage pregnancy...”

“‘Family Planning’ Fails to Reduce Teen Sex,” *Human Events*, April 8, 2002

K. Edgardh found that despite free abortions, free contraceptive counseling, low cost condoms and oral contraceptives, and over-the-counter emergency contraception (EC), Swedish teen abortion rates rose to 22.5 per thousand from 17 per thousand between 1995 and 2001.

Edgardh, K. *et al.* Adolescent Sexual Health in Sweden, *Sex Trans Inf* 78 (2002): 352-6,
available at <http://sti.bmjournals.com/cgi/content/full/78/5/352>.

Douglas Kirby concluded: “Most studies that have been conducted during the past 20 years have indicated that improving access to contraception did not significantly increase contraceptive use or decrease teen pregnancy.”

Douglas Kirby, “Reflections on Two Decades of Research on Teen Sexual Behavior and Pregnancy,”
Journal of School Health 69.3 (March 1999).

“Our results suggest that increasing access to contraception may actually increase long run pregnancy rates even though short run pregnancy rates fall. On the other hand, policies that decrease access to contraception, and hence sexual activity, are likely to lower pregnancy rates in the long run.”

Peter Arcidiacono *et al.*, “Habit Persistence and Teen Sex: Could Increased Access to Contraception have Unintended Consequences for Teen Pregnancies?,”
Duke University web site, April 7, 2007, www.econ.duke.edu/~psarcidi/teensex.pdf

“The results in this paper do not provide evidence that schemes allowing emergency birth control to be provided in pharmacies free of charge to young people lead to significant changes in teenage pregnancy rates. This result is consistent with previous studies of the impact of emergency birth control, including those based on randomized controlled experiments. Given the hope that many policy makers and health professionals have held out for the potential of EBC in reducing unwanted pregnancies, this finding will be disappointing.”

Sourafel Girma and David Paton, “Matching Estimates of the Impact of Over-the-Counter Emergency Birth Control on Teenage Pregnancy,” Occasional Paper Series, The University of Nottingham, October 2005, p. 17

“[T]he experts had estimated that we would see a drop by up to half in the rates of unintended pregnancy and the rates of abortion. And in fact in the real world we're not seeing that.”

Kirsten Moore, President and CEO of Reproductive Health Technologies Project, quoted in A.W. Schachter,
“‘Plan B’: What Science Can't Tell Us,” *New York Post* Online Edition, Aug. 11, 2006.

Even James Trussell who originated the claim that easier access to emergency contraception could “result in a greater than 50% reduction in abortion rates” has conceded that 23 published studies from 10 countries disprove his claim. According to every one of the 23 studies, published between 1998 and 2006, easier access to EC fails to achieve any statistically significant reduction in rates of unintended pregnancy and abortion.

Raymond, Trussell and Polis, “Population Effect of Increased Access to Emergency Contraceptive Pills,” *Obstetrics & Gynecology* 109 (2007): 181-8.

Some of these 23 studies reviewed country-wide statistics on unintended pregnancy and abortion after EC became inexpensive (or free) and widely available in health clinics or over-the-counter in pharmacies. Other studies compared results between women given packets of EC for future use, and a control group of women who had to acquire EC on their own. In the latter type of study, women given EC in advance were more likely to use it, but no statistically significant difference in unintended pregnancy or abortion was found between the two groups.

The study by Raymond, Trussell and others, cited above, even casts doubt on the usual claims made for EC’s effectiveness for the individual user: “[W]e can be 95% confident that it reduces pregnancy risk by more than 23%. But just how much more remains poorly defined; the published efficacy figures ... – on average, approximately 80% – may overstate actual efficacy, possibly quite substantially. Clearly, if the method is weakly efficacious, it is unlikely to produce a major reduction in unintended pregnancy no matter how often women use it.”

E. Raymond et al., *Obstetrics & Gynecology*, op cit., at 187.

The following studies from the U.S., Europe, and China are among those demonstrating the complete failure of EC to reduce rates of unintended pregnancy and abortion:

Sixteen months after 18,000 sexually active women in a health district in Scotland were each given 5 packets of EC, researchers concluded: “No effect on abortion rates was demonstrated with advance provision of EC. The results of this study suggest that wide-spread distribution of advanced supplies of EC through health services may not be an effective way to reduce the incidence of unintended pregnancy in the UK.”

A. Glasier *et al.*, “Advanced provision of emergency contraception does not reduce abortion rates,” *Contraception* 69 (May 2004): 361-6 (www.cwfa.org/images/content/scotland0905.pdf; visited Feb. 14, 2007).

Anna Glasier concedes in her above-cited study that “EC may be less effective than we belief [sic]. Estimates of efficacy are unsubstantiated by randomized trials. Efficacy is based on rather unreliable data and a great many assumptions and have been questioned both in the past and more recently. ... While advanced provision of EC probably prevents some pregnancies for some women some of the time, the strategy did not produce the public health breakthrough hoped for.”

A. Glasier *et al.*, *Contraception* 69 op.cit., at 365

Over 2,000 women in the San Francisco Bay area were randomly assigned to one of three groups. The first group was given packets of EC; the second was told how to obtain EC free from pharmacies; the third had to return to the clinic for EC. Over 80% of the women were also using another form of contraception. After six months, 7-8% of women in each group were pregnant. “We did not observe a difference in pregnancy rates in women with either pharmacy access or advance provision [of EC]; the adjusted risk of pregnancy for both treatment groups was not significantly less than 1. Previous studies also failed to show significant differences in pregnancy

or abortion rates among women with advance provisions of EC. It is possible that the effect of increased access on pregnancy rates is truly negligible because EC is not as effective as found in the single-use clinical trials, or because women at highest risk do not use EC frequently enough or at all.”

T. Raine *et al.*, “Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs,” *Journal of the American Medical Association* 293 (2005): 54-62 (www.dph.sf.ca.us/sfcityclinic/providers/Directaccesscontraception.pdf; visited Feb. 14, 2007).

Hu *et al.* conducted a randomized, controlled trial of 2,000 postpartum women in Shanghai, China (who would have a strong incentive not to become pregnant within a year of giving birth because this is forbidden by the government). Half were given 3 courses of mifepristone to use at home as emergency contraception (EC) “as needed.” The other half (control group) had to see a doctor to obtain mifepristone. Both groups could also purchase a Plan B-type emergency contraceptive at supermarkets. Women in the first group used EC twice as frequently as those in the control group, but there was no difference in pregnancy or abortion rates after one year. “This study adds to the growing literature casting doubt on the increased use of EC as a quick fix for rising abortion rates. That is not to say that EC will not prevent pregnancy for some women, sometimes, but rather that it may not make much difference to public health.”

Xiaoyu Hu *et al.*, “Advanced provision of emergency contraception to postnatal women in China makes no difference in abortion rates: a randomized controlled trial,” *Contraception* 72 (2005): 111-6.

Examining the impact of free, over-the-counter EC for teenagers in England, researchers reported: “We find little evidence that pharmacy [EC] schemes have led to lower under-18 pregnancy rates in England.”

S. Girma and D. Paton, “Matching Estimates of the Impact of Over-the-Counter Emergency Birth Control on Teenage Pregnancy,” University of Nottingham School of Business Occasional Paper Series, No. 2005-15 (October 2005) (www.nottingham.ac.uk/%7EElizecon/RePEc/pdf/matching.pdf; visited Feb. 14, 2007).

EC researcher Anna Glasier concluded in a September 2006 editorial in the *British Medical Journal*: “[D]espite the clear increase in the use of emergency contraception, abortion rates have not fallen in the U.K. They have risen from 11 per 1000 women ... in 1984 ... to 17.8 per 1000 in 2004.” She adds: “Ten studies in different countries have shown that giving women a supply of emergency contraception to keep at home ... increases use by twofold to threefold ... but [has] had no measurable effect on rates of pregnancy or abortion.” She concludes: “If you are looking for an intervention that will reduce abortion rates, emergency contraception may not be the solution.”

Anna Glasier, Editorial, “Emergency Contraception: Is it worth all the fuss?”, *British Medical Journal* 333 (2006): 560-1.

“Another commonly held view for which there is no documented evidence is that improving knowledge about and access to Emergency Contraception will reduce the number of teenage pregnancies. ... Experience of use so far does not give any evidence of effectiveness. Prescribing rates of the morning-after pill have multiplied steadily in Scotland while there has been no observed decline in the rate of teenage pregnancies or abortions.”

A. Williams, “The Morning-After Pill,” Scottish Council of Human Bioethics (Nov. 2005) (www.schb.org.uk, click on “Publications” then “Sexual Health”).

“Despite the fact that emergency contraceptive pills (ECP) have become easily available across the country during recent years, abortion numbers continue to rise in Sweden, especially in the young age groups (<25).”

T. Tyden *et al.*, “No reduced number of abortions despite easily available emergency contraceptive pills,” *Lakartidningen* 99 (2002): 4730-2, 4735 (abstract at www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids

Summarizing findings of the Washington State Pilot Project, which allowed pharmacies to dispense EC without a prescription from February 1998 to June 1999, researchers noted: “If the increased accessibility of emergency contraception reduces unintended pregnancy, there should be evidence of reduced pregnancy and abortion rates. To be sure, abortions in Washington reached the lowest level in two decades, dropping by 5% from 1997 to 1998. ... However, the national abortion rates also were declining during this period. ... In 1999, both pregnancy rates and rates of induced abortion increased slightly in Washington State.”

J. Gardner *et al.*, “Increasing Access to Emergency Contraception Through Community Pharmacies: Lessons from Washington State,” *Family Planning Perspectives* 33 (2001): 172-5 (www.guttmacher.org/pubs/journals/3317201.pdf; visited Feb. 14, 2007). *Note:* The Guttmacher Institute reports a 5% decline nationally in the abortion rate between 1996 and 2000, compared to a drop of only 3% in Washington state.

In the United States, a *decrease* in contraceptive use in recent years correlates to a *decrease* in the number of abortions. From 1995 to 2002, the rate of contraceptive use decreased from 64 percent to 62 percent,¹ while the number of abortions fell from 1,359,400 to 1,293,000.²

1 "Contraceptive Use," *Facts in Brief*, The Alan Guttmacher Institute (March, 2005), http://www.guttmacher.org/pubs/fb_contr_use.html. These numbers represent use among all women age 15-44, and thus, because many women in this age group would not be sexually active, the rate of use among sexually active women would be higher.

2 L.B. Finer and S.K. Henshaw, "Estimates of U.S. Abortion Incidence, 2001-2003," The Alan Guttmacher Institute (August 3, 2006) http://www.guttmacher.org/pubs/2006/08/03/ab_incidence.pdf

This study was designed to acquire information about the use of contraceptive methods in order to reduce the number of elective abortions. During the study period, 1997 to 2007, the overall use of contraceptive methods increased from 49.1% to 79.9%. The most commonly used method was the condom (an increase from 21% to 38.8%), followed by the pill (an increase from 14.2% to 20.3%). Female sterilization and IUDs decreased slightly and were used by less than 5% of women in 2007. The elective abortion rate increased from 5.52 to 11.49 per 1000 women.

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