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Slate

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Does Contraception Reduce Abortions?

The Republican Party says it's against abortion. But now Republican governors, members of Congress, and presidential candidates are trying to defund Planned Parenthood. Some are threatening to shut down the government if they don't get their way. If you're against abortion, this should worry you.

The ostensible basis for this attack is a series of undercover videos in which pro-lifers, posing as buyers for medical research, try to bargain with Planned Parenthood officials over fetal tissue. But if you're interested in preventing abortions, the videos are irrelevant. They depict conversations about how, not whether, abortions will be done. If such discussions were outlawed, not one abortion would be prevented.

Defunding Planned Parenthood makes even less sense. Federal law prohibits the use of public money for elective abortions, by Planned Parenthood or anyone else. Instead, these funds go to Planned Parenthood's contraceptive services. Planned Parenthood is the world's leading provider of birth control. By undercutting this work, Republicans are threatening to cause an increase in the number of unintended pregnancies. And that, in turn, would lead to more abortions.

That's an awkward position for a party that claims to be pro-life. In the past couple of months, several pro-choice writers—Conor Friedersdorf, Damon Linker, Ruth Marcus, Dana Milbank, Katha Pollitt, and others—have called out the GOP for this paradoxical behavior. They've been answered by a phalanx of conservative critics, led by Ross Douthat, Callie Gable, Megan McArdle, and Michael New. The conservatives question whether policies promoting contraceptive access can significantly reduce the abortion rate.

The idea that contraception wouldn't prevent unintended pregnancies strikes many people as absurd. But these conservatives have a point. Beyond a certain level of saturation, the availability of pills and condoms affects pregnancy rates less than one might expect. McArdle, echoing Douthat, rejects the idea that "the main thing standing between America and fewer abortions is better government birth-control policy."

In the course of this debate, I've been name-checked as somebody who used to believe in a contraceptive approach to reducing abortion but no longer does. That's not quite right. What I've learned is that contraceptives can make a big difference—bigger, I suspect, than abortion laws can—but it matters enormously which contraceptives we're talking about. Some, such as pills and condoms, require repeated, consistent application. Others, such as intrauterine devices and hormonal implants, don't. The latter methods—long-acting reversible contraceptives, or LARCs—have a much lower failure rate. And we now have very good evidence that they can prevent millions of abortions.

Critics of contraception point to several studies in which access to birth control increased, or more people claimed to be using it, while the abortion rate held steady or went up. The U.S. Conference of Catholic Bishops cites one study in Spain, another in England, and another in Sweden. But there's a common thread in these and other episodes of birth-control failure: The contraception that was distributed or selected—condoms in Spain, pills in Sweden—required diligent use.

This kind of birth control often fails. It's usually not the device that fails. It's the user. You neglect to take the pill or put on the condom. In the heat of excitement, you forget or screw up. The authoritative table of failure rates, published four years ago by James Trussell of Princeton University, shows an enormous gap between "perfect use" and "typical use." The pill, when perfectly applied, has a failure rate of 0.3 percent. But in real life, its failure rate is 9 percent. Over the course of a year, in a pool of 1,000 women, that's the difference between three pregnancies and 90. Among teenagers, the real-world failure rate is a whopping 20 percent. Condoms, when used perfectly, have a 2 percent failure rate. But in normal use, their failure rate is 18 percent.

This gap accounts for the disappointing results noted by birth-control skeptics. Take Spain. According to the conference of bishops, from 1997 to 2007, "a 63 percent increase in the use of contraceptives was accompanied by a 108 percent increase in the rate of elective abortions." But when you look more closely at the data, you find that Spaniards chose the least effective contraceptives. Reliance on condoms nearly doubled. Reliance on pills, patches, and vaginal rings increased by about 70 percent. The most reliable methods, IUDs and female sterilization, actually declined in use.

A year after that study came out, the same researchers published a report on Spanish women who sought abortions in 2007. They asked the women what birth-control methods they had been using when they conceived. Thirty-six percent said they had used no method. Forty percent said they had used condoms. Twelve percent said they had been on the pill. Fewer than one percent said they had used an IUD or implant. Compared with other Spanish women of childbearing age, women who got abortions were 15 times less likely to have used IUDs, vasectomy, or tubal ligation. Birth control hadn't failed in Spain. Inferior birth control had failed. The best birth control had worked.

According to Trussell's table, the real-world failure rate for LARCs is less than 1 percent. That's 10 times better than pills and 20 times better than condoms. Yet only about 7 percent of American women use LARCs. Why? For one thing, they're expensive. Their cost—$300 to $1,000 up front—deters clinics from stocking them, insurers from subsidizing them, and women from buying them. The Affordable Care Act requires insurers to cover all Food and Drug Administration–approved forms of birth control, as do Medicaid guidelines. Insurance reforms are improving LARC access, but some insurers have resisted full coverage. Another problem is that many doctors and nurses haven't been trained to insert, remove, and provide counseling for LARCs. Many women don't know much about them, and some are misled by outdated fears from an earlier generation of IUDs.

Since 2007, researchers have launched at least five projects to promote LARCs. Their goal has been to make the devices more widely available, affordable, familiar, and popular. In each case, unintended pregnancies and abortions have come down. Here's what the studies show.

Iowa: From 2007 to 2013, the state pumped extra money into family planning for low-income women. Among other things, the project subsidized LARCs, promoted them through media campaigns, and funded training in LARC insertions. From 2005 to 2012, the percentage of Iowa family planning clients using LARCs increased from less than 1 percent to 15 percent. Statewide, the proportion of women using LARCs rose from 1 in 1,000 to 15 in 1,000. Meanwhile, the abortion rate fell from 8.7 per 1,000 to 6.7 per 1,000, a decline of more than 20 percent. The number of LARC users increased by about 8,000, and the number of abortions fell by about 1,300. Unintended pregnancy decreased in Iowa while it rose in Minnesota and Nebraska. When the researchers compared data across the state's 26 regions, they found that each 1-percent increase in LARC use correlated, on average, with a 4-percent drop in the abortion rate.

New Zealand: In 2008, for 10 weeks, a clinic promoted LARCs and offered them for free to women who had come for abortions. By the end of this period, the percentage of women choosing post-abortion LARCs had increased from 45 to 61. The efficacy of LARCs was diluted, because the project's managers included a less reliable method in this category—depot medroxyprogesterone acetate (sold as Depo-Provera), an injection that lasts 12 weeks—didn't provide implants, and counted women as LARC users even if they got rid of the device during the next two years. Nevertheless, the subsequent abortion rate—the percentage of women who returned for a second abortion within two years—was 55 percent lower among LARC users than among non-LARC users. Among the 310 women who chose LARCs, only 20 returned for an abortion, and 18 of these women had either stopped using a LARC method within six months or had not reported whether they were still using the LARC. Among the 106 women who chose and stuck with a hormonal IUD, not one returned for an abortion.

Colorado: Beginning in 2009, the state's family planning clinics conducted a program much like Iowa's. From 2008 to 2011, the percentage of women aged 15 to 24 who chose LARCs at these clinics quadrupled, from 4.5 to 19.4. Meanwhile, the percentage of women who chose pills declined from 49 to 36. From 2008 to 2013, the teen birth rate fell more sharply in Colorado than in any other state. An analysis by the National Bureau of Economic Research concluded that in four years, the LARC initiative cut the teen birth rate in Colorado's poorer counties by 6 to 8 percent. From 2008 to 2011, the teen abortion rate in Colorado counties targeted by the initiative plummeted 34 percent. This drop exceeded the 29 percent decline in outlying counties, and researchers believe some of that 29-percent decline was due to teens from outlying counties using clinics in the targeted counties. Among women aged 20 to 24, the abortion rate increased by 6 percent in outlying counties but fell 18 percent in targeted counties.

St. Louis: From 2007 to 2011, more than 9,000 women in the St. Louis area, nearly all of them sexually experienced, were offered any contraceptive of their choice at no cost. They were told each method's failure rate, and LARCs were available for immediate insertion. Seventy-five percent of the women chose LARCs. Over the next five years, the pregnancy rate among teens in the program was 40 percent lower than the rate among all U.S. teens. It was nearly 80 percent lower than the rate among sexually experienced U.S. teens. The abortion rate among women in the program was 60 percent lower than the rate among other women in the St. Louis region. At the city's main abortion clinic, from 2008 to 2010, the number of abortions performed on local women fell 20 percent, while the number of abortions performed on women from outside the metro area didn't change.

The St. Louis study also tracked each participant and calculated how many teens got pregnant for every 1,000 who used a given birth-control method over the course of a year. For the pill, the number of annual pregnancies was 57. For the hormonal IUD, it was 5. For the copper IUD and the hormonal implant, it was zero. Overall, compared to women who chose LARCs, those who didn't were 22 times more likely to become pregnant unintentionally.

Planned Parenthood: In 2011, researchers undertook a randomized controlled trial at 40 Planned Parenthood clinics across the United States. At some clinics, staffers received training in LARCs and their effectiveness. At other clinics, they didn't. The program offered no discount for LARCs, but it still made a difference. At the program sites, 28 percent of young women who received contraceptive counseling chose LARCs. At the nonprogram sites, 17 percent chose LARCs. A year later, the pregnancy rate was 19 percent lower for women who had attended program sites than it was for women who had attended nonprogram sites.

These projects differed in some respects. Some offered LARCs for free; others subsidized them; others just paid for promotion or training. Nevertheless, all of them produced significant increases in LARC use and declines in abortions or, when that wasn't directly measured, unintended pregnancies. On these indices, the study populations outperformed comparable neighboring states, counties, or clinics. The more that was done to teach about LARCS, subsidize them, and make them immediately available, the greater the uptake and benefits. Studies that tracked conceptions by method confirmed vastly lower failure rates for LARCs than for condoms, pills, or other user-dependent methods.

You can quibble with aspects of each study, and the critics have. But collectively, the success of the five projects is hard to explain away. The Planned Parenthood study provides a randomized controlled trial. The Iowa study provides comparative data on LARC use and abortion trends among regions within a program. The New Zealand study specifically tracks abortion patients and repeat abortions.

The Colorado and St. Louis studies also assessed whether women protected by LARCs respond by having more sex with more partners. The St. Louis project found an increase in sexual frequency in its study population (unsurprisingly, since this was a sample of women who intended to have sex or begin having sex) but no net increase in the number of partners. Colorado found no significant change in sexual behavior statewide. Both projects confirmed that any pregnancies caused by more sexual activity were overwhelmed by the pregnancy-prevention effects of LARCs.

The strangest criticism of these studies is that the reductions in unintended pregnancy and abortion are too big to be explained entirely by the number of women who got LARCs. That's true, but it's not an argument against LARCs. What matters is that the studies show reductions where LARCs are used, and two studies confirm this effect at the individual level. Broaden the use of LARCs, and you'll see bigger reductions. If you can combine LARCs with other abortion-reducing factors, such as delayed sexual initiation and a healthy economy that makes it easier for women to decide to raise children, so much the better.

If you're pro-life, the LARC studies should make you think hard about how you've approached this issue and whether there's a better way. First, if you've ever stood outside a clinic and tried to talk patients out of going through with their abortions, you've seen how hard that is. Women arriving for abortions rarely change their minds. They're almost never persuaded by strangers who beg them to reconsider. But the LARC studies suggest that these women—perhaps because they've just learned the hard way that they're vulnerable to pregnancy and have been using inadequate birth control—are particularly open to long-acting contraceptives. If you can't stop this abortion, you can prevent the next one. Do what you can, financially and educationally, to help women get LARCs before they leave the clinic, so they won't have to come back to end another pregnancy. The best way to put a clinic out of the abortion business is to pull it into the LARC business.

Second, if you tend to argue for abstinence instead of contraception, the LARC debate should prompt you to rethink what abstinence is. Douthat, McArdle, and other skeptics are right about the unreliability of pills, condoms, and other user-dependent contraceptives. But what's unreliable is the user, not the technology. And the most user-dependent method of birth control, by definition, is abstinence. That's why it yields the biggest gap between perfect and typical use. With perfect use, the failure rate of abstinence is zero. But in the real world, kids who receive abstinence-only education, unlike those who get "comprehensive" sex education, are just as likely to report vaginal sex or pregnancy as kids who get no sex education. If you believe it's wrong to promote birth-control methods that fail 10 or 20 percent of women, how can you, in good conscience, counsel reliance on a method that shows no efficacy at all?

Third, if you'd rather prevent abortions than use them to stir outrage and raise money, the war on Planned Parenthood should trouble you. Politicians are using videos about alternative abortion methods—a question which, no matter how it's resolved, wouldn't preserve a single pregnancy—to draw you into a campaign that would defund contraception and thereby increase the abortion rate. In 2013, according to its most recent annual report, Planned Parenthood provided 3,500,000 contraceptive services and 327,000 abortions. That's a ratio of more than 10 to 1. Nearly 9 percent of its patients chose LARCs.

Planned Parenthood aggressively promotes LARCs and has doubled LARC use among its clients. You can argue, as Douthat does, that Planned Parenthood's contraceptive and abortion work shouldn't be a package deal. But as a matter of law, it isn't. If you defund Planned Parenthood, what you're gutting is contraception. And what you're causing is more abortions—if not by Planned Parenthood, then by somebody else.

Fourth, the pro-contraception legislation some Republicans are peddling as a sop to women is a sham. The bill, which would invite manufacturers to submit contraceptives to the FDA for approval to be sold over the counter, would apply only to "a drug intended for routine use." That means the pill. The proposal wouldn't subsidize any contraceptives, and, as Planned Parenthood has pointed out in two blistering critiques, it wouldn't cover LARCs. If Republicans repeal the contraceptive coverage in Obamacare (which, in principle, includes LARCs) and steer women toward the pill instead, they could cause a greater number of unintended pregnancies and abortions.

LARCs work. They explain why inferior contraception sometimes fails, why superior contraception succeeds, and why, if you're a practical pro-lifer, you'll get better results from today's Democrats than from today's Republicans. You can wait till a woman is unhappily pregnant and then try to thwart her will, or you can work with her before she's pregnant—when she doesn't want an abortion any more than you do—to avert that crisis.