Dramatic Decreases in US Abortion Rates: Public Health Achievement or Failure?

See also Jones and Jerman, p. 1904.

Jones and Jerman (p. 1904) present evidence of a dramatic decrease in the US abortion rate between 2008 and 2014 on the basis of reports from abortion clinics. In just six years, there was an unprecedented decrease of 25%, concentrated among young women, women with higher household incomes, and women of color. Among women aged 15 to 19 years, abortion rates dropped by almost half.

The reduction in abortion rates translates into a change in the projected lifetime prevalence of abortion from one in three women in the United States to one in four. Such a rapid reduction is of tremendous public health importance, and careful consideration of the causes of the decline is merited. If the reduction is caused by increased access to and use of effective methods of contraception, we can celebrate the public health achievement and count it as further evidence of the need for insurance coverage for all methods of contraception. However, if the reduction is caused by constraints on access to abortion care or signals an underlying trend toward infecundity, the numbers should prompt public health advocates and researchers to action.

There are some possible causes for a decrease in demand for abortion that we can rule out. Cultural shifts away from abortion might result in women more likely to choose birth when faced with an unintended pregnancy. However, this explanation is not supported by available data—the proportion of unintended pregnancies ending in birth has not increased.[1] Nor is there strong evidence that women are having more intended pregnancies (and therefore fewer unintended ones) considering the significant decreases in the birth rate for women younger than 30 years (bit.ly/2iujpb0).

LONG-ACTING METHODS OF CONTRACEPTION

Jones and Jerman attribute much of the decline in abortion rates to an increased use of long-acting methods of contraception (LARC), such as intrauterine contraceptives and implants. LARC use among contracepting women increased from 8.5% to 11.6% between 2009 and 2012.[2] LARC methods are currently used by a small minority of all women, and, despite the recent increases in use, LARC can explain only a small portion of the reduction in abortion rates.

Adoption of LARC methods has largely, but not entirely, replaced the use of other effective methods of contraception and is not concentrated among the small minority of women who currently use no method—a group that experiences the majority of the country's unintended pregnancies. Casting further doubt on the increase in LARC use as a major cause of the reduction in abortion rates is the fact that the increases in LARC use are not concentrated among the groups who have experienced the greatest reduction in abortion.[2]

ANY CONTRACEPTIVE METHOD

Although the increased use of LARC may have contributed to a drop in demand for abortions, there are additional reasons the incidence of unintended pregnancy may have declined (see the box on the next page). There is evidence that the use of any contraceptive method, not just LARC methods, increased among those groups of women who experienced the greatest reduction in abortions. Among women aged 15 to 19 years, there was a modest reduction in the proportion who were using no method, an increase in the use of any method at last instance of sexual intercourse, and an intriguingly large increase in the use of emergency contraception over the same period.[3]

Improved consistency in using condoms and pills may have had a large impact among women of all ages—even if they did not switch from a less effective to a more effective method—as Jones and Jerman acknowledge. The reasons for the improved use is unclear. Perhaps women have increased motivation to prevent pregnancy at younger ages in a cultural shift toward later childbearing: women older than 30 years are the only ones to experience an increasing birth rate over this period (bit.ly/2iujpb0). Another possibility is that widespread menstrual cycle tracker apps have given women better knowledge of when in their cycle they are most at risk for conception so that they can use a contraceptive method or avoid vaginal intercourse during this period. Policy improvements—contraceptive coverage through the Affordable Care Act in 2012 and access to over-the-counter emergency contraceptive pills—may have also given couples access to and ensured a more continuous supply of contraceptive methods.

Research into changes in sexual behavior, including trends in frequency of vaginal intercourse, might reveal other causes for the decline in unintended pregnancy. Finally, some scientists have raised the possibility that fecundity may be declining because of environmental exposures, which could explain the decrease in

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POSSIBLE CAUSES FOR THE DECREASE IN THE OBSERVED US ABORTION RATE

Cause	Potential Indicators
Use of better methods of contraception (evidence of small changes that may be contributing to the decline)	
Increased use of LARC methods	Widespread LARC use in the general population or concentrated increases among women at high risk
Adoption of any method among women previously using none	Increase in any contraceptive use among women at risk; increase in availability of postabortion contraceptive methods
Widespread switch to more effective methods from less effective methods	Reduction in use of less effective methods of contraception and an increase in highly effective methods
Improved use of contraceptive methods among current users (more research needed)	
Improved consistency of contraceptive use	Reduced births; changes in pregnancy preferences; reductions in observed contraceptive failure rates
Better knowledge of fertile period	Better and more widespread sexual education; widespread use of menstruation tracking apps with accurate data on fertile period
Better access to a consistent supply of contraception	Larger supply of contraceptives dispensed; more frequent prescription filling; lower prices for contraceptives
Change in fertility preferences (no evidence of these changes)	
Women choosing birth over abortion in cases of unwanted pregnancy	Increases in birth rates; changes in attitude toward abortion
Pregnancies more likely to be wanted than unwanted	Increases in birth rates; changes in desire for pregnancy and parenting
Lower exposure to the risk of pregnancy (more research needed)	
Reduced fecundity	Reduced births; greater use of infertility services among young women wanting to be pregnant
Reduced sexual intercourse	Later age at first instance of sexual intercourse; lower coital frequency; substitution of oral or anal sex for vaginal–penile intercourse
Inability to get a clinic-based abortion or preference for self-sourced abortions (more research needed)	
Restrictions and clinic closures	Women denied abortions; women unable to comply with requirements; increases in cost and travel for a clinic procedure; increased birth rates
Abortions occurring outside the medical system	Availability of medications outside the clinic; reports from women who have self-induced; reports of being unable to access clinic-based care; reported preferences for abortions outside the medical system

Note. LARC = long-acting reversible methods of contraception.

both abortions and births over this period.[4]

ABORTION WITH AND WITHOUT MEDICAL ASSISTANCE

Concurrent with reductions in the demand for abortion services, there have certainly been decreases in the supply. Since 2011, hundreds of new state-level regulations of facilities have been implemented. Certain restrictions—particularly those that raise the cost of an abortion or of travel to get to an abortion facility—sharply reduce the chance that women are able to terminate unwanted pregnancies. The recent evidence from Texas, where abortion regulations closed 19 of the 41 clinics and abortions went down by 13%, clearly demonstrates that these restrictions prevent women from accessing care.[5] Even before many states implemented 20-week bans, as many as 4000 women were denied abortions because of gestational age limits each year.[6]

Finally, the measurement of abortion rates by Jones and Jerman rests on data from women who received abortions in clinics. The total number of abortions may not be decreasing if women are increasingly looking outside the medical system to terminate their pregnancies. As legal restrictions have reduced women's ability to access care in a timely manner at nearby clinics, women may be procuring their own abortions without medical assistance. Researchers studying the consequences of Texas's abortion regulations found that one year after the implementation of funding restrictions on family planning in 2011, even before the closure of nearly half of the state's abortion facilities, seven percent of women seeking abortions in medical facilities had attempted to terminate a pregnancy on their own.[7] Those who succeeded may vastly outnumber those who

received an abortion in a clinic considering the effectiveness and availability of misoprostol ordered through the Internet or procured across the border.

ABORTION IS STILL COMMON

Research into the causes of the decline in clinic-based abortions is urgently needed. For decades we have said that one in three American women will have an abortion in her lifetime. Perhaps, it is now the case that one in four will have a traditional abortion in a medical facility and one in 12 will have one on her own. Regardless, abortion is still common, demand may be decreasing, and many women are unable to access care. AJPH

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What Can We Do or Change to Encourage People to Seek Out Preexposure Prophylaxis?

See also Calabrese et al., p. 1883.

Many prevention and treatment successes have been observed in the course of the HIV epidemic. We have seen great strides made in behavioral change interventions, law and policy change interventions, sexually transmitted infection treatment programs, needle exchange programs, programs focusing on the prevention of perinatal HIV transmission, blood supply testing and monitoring services, male circumcision programs, and other initiatives.[1]

More recently, major advances have occurred in biomedical antiretroviral-based prevention, with treatment as prevention and preexposure prophylaxis (PrEP) demonstrating efficacy in preventing transmission of HIV. Much anticipation and excitement exist around the potential for treatment as prevention and PrEP to effectively halt the HIV epidemic, both domestically and internationally.[2] And there is good reason for this positive response: antiretroviral-based prevention, when adhered to, will prevent HIV transmission.

HEALTH CARE SYSTEM BREAKDOWN

As can be expected, however, these advances in prevention options are quickly followed by challenges in implementation. What is repeatedly observed in public health, inclusive of HIV prevention, is the failure of our health care system to provide prevention tools, in a timely manner, to those who are in greatest need. In the United States, Black men who have sex with men (BMSM) are most affected by the HIV epidemic; it is estimated that if current HIV diagnosis rates persist, one of two BMSM could be diagnosed with HIV in their lifetime.[3] Although we make advancements in prevention options, we have repeatedly failed to comprehensively meet the needs of BMSM, and the HIV epidemic continues to persist without abatement. PrEP has great potential to affect the epidemic among BMSM, but the social and structural systems that make up our health care system stymie our ability to link prevention options to people.

ROUTINIZING PREP OFFERINGS

In this issue of *AJPH*, Calabrese et al. (p. 1883) take on this challenge by calling for the routinizing of discussions and offerings of PrEP to all adult patients as part of preventive health care. According to Calabrese et al., this approach would have an impact on observed inequities in the provision of PrEP by shifting the emphasis from a client-initiated model to a provider-initiated model, which evidence suggests would expand reach. In their article, they clearly and convincingly support the case for integrating PrEP into routine health care. They do so by highlighting the potential for this approach to remove challenges in identifying those who are at risk for HIV, destigmatize seeking out PrEP, support a patient-centered model, and transmit PrEP knowledge to a broad base. The presented arguments for routine PrEP lead to the well-reasoned conclusion that this change in administration could reduce inequities in access and, thereby, stimulate PrEP initiation and lead to lower HIV transmission rates.

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