



## Secretariat of Pro-Life Activities

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### Fact Sheet: Emergency Contraception Fails to Reduce Unintended Pregnancy and Abortion

Supporters of Plan B and other types of “emergency contraception” (EC) used to claim that easier access to EC could “result in a greater than 50% reduction in abortion rates.” **J. Trussell et al.**, “**Emergency Contraception: A Simple Proposal to Reduce Unintended Pregnancies,**” *Family Planning Perspectives* 24 (Nov/Dec 1992): 6.

However, that estimate came from a hypothetical “modeling exercise.” In 2006, Plan B supporters began to admit that the hard data tell a different story:

“[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.**

The following year even the author of the “greater than 50% reduction” claim, James Trussell, 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. **E. Raymond et al.**, “**Population Effect of Increased Access to Emergency Contraceptive Pills,**” *Obstetrics & Gynecology* 109 (2007): 181-8.

Some of these 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.

These 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 at 361 ([www.cwfa.org/images/content/scotland0905.pdf](http://www.cwfa.org/images/content/scotland0905.pdf); visited Apr. 6, 2011).

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 at 61 (<http://jama.ama-assn.org/content/293/1/54.full.pdf>; visited Apr. 6, 2011).**

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: “The EBC [emergency birth control] scheme had no impact on conception rates.” However, “the presence of a pharmacy EBC scheme in a local authority is associated with an increase in the rate of STI diagnoses amongst teenagers of about 5%. The equivalent figure for [children under-16] is even larger at 12%.” This “is consistent with the hypothesis that greater access to EBC induces an increase in adolescent risky sexual behavior.” **S. Girma and D. Paton, “The Impact of Emergency Birth Control on Teen Pregnancy and STIs,” *Journal of Health Economics* (2011), doi:100.1016/j.healeco.2010.12.004.**

EC researcher Anna Glasier seconds that observation 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/downloads/publications/morning-after\\_pill.pdf](http://www.schb.org.uk/downloads/publications/morning-after_pill.pdf); visited Apr. 6, 2011).

“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/pubmed/12523048](http://www.ncbi.nlm.nih.gov/pubmed/12523048); visited Apr. 6, 2011).

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 at 174-5** ([www.guttmacher.org/pubs/journals/3317201.pdf](http://www.guttmacher.org/pubs/journals/3317201.pdf); visited Apr. 6, 2011). *Note*: The Guttmacher Institute reported a 5% decline nationally in the abortion rate between 1996 and 2000, compared to a drop of only 3% in Washington state.

Anna Glasier concedes in her above-cited study that “EC may be less effective than we believe [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**, *Contraception*, *op. cit.*, at 365.

The 2007 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.

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