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Philosophy and Theology: Does Greater Access to Contraception Reduce Abortion?

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PHILOSOPHY AND THEOLOGY

In February 2020, the Secretariat of Pro-Life Activities of the United States Catholic Conference of Bishops released a fact sheet titled, “Greater Access to Contraception Does Not Reduce Abortions.”¹ The text provides a response to a common objection: Those who oppose abortion are inconsistent if they do not also support contraception to limit unwanted pregnancy, which leads to abortion. How does the Secretariat defend the thesis that greater access to contraception does not reduce abortion?

First, the Secretariat notes that “contraception is already widely available, and experts have reported that ‘contraceptive use in the United States is virtually universal among women of reproductive age,’ at times when many millions of abortions were performed” (1).² In every state and in every city, public schools, family planning clinics, pharmacies, grocery stores, and gas stations provide contraception. According to the US Centers for Disease Control and Prevention, the most common contraceptive methods are female sterilization (18.6%), the oral contraceptive pill (12.6%), long-acting reversible contraceptives (LARCs, 10.3%), and the male condom (8.7%).³ Despite accounting for less than 10 percent of contraception use, about 450 million condoms are sold yearly in the United States alone.⁴ (Of course,

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1. US Conference of Catholic Bishops (USCCB), Secretariat for Pro-Life Activities, “Fact Sheet: Greater Access to Contraception Does Not Reduce Abortions,” February 7, 2020, <http://www.usccb.org/issues-and-action/human-life-and-dignity/contraception/fact-sheets/upload/Contraception-fact-sheet.pdf>.
 2. William D. Mosher et al., “Use of Contraception and Use of Family Planning Services in the United States: 1982–2002,” *Advance Data from Vital Health Statistics* no. 350 (December 10, 2004): 1.
 3. Kimberly Daniels and Joyce C. Abma, “Current Contraceptive Status among Women Aged 15–49: United States, 2015–2017,” *NCHS Data Brief* no. 327 (December 2018): 1.
 4. Jamie Kravitz, “9 Condom Facts You Didn’t Know That Will Actually Blow Your Mind,” *Elite Daily*, March 22, 2018, <https://www.elitedaily.com/p/9-condom-facts-you-didnt-know-that-will-actually-blow-your-mind-8449566>.

some of these condoms are not purchased for purposes of contraception, at least if *contraception* is defined as any action before, during, or after sexual intercourse that is intended to make the sexual act nonprocreative.)⁵ Ninety-nine percent of sexually experienced women have used contraception at some time in their lives.⁶ Yet despite the ubiquity of contraception, more than 61 million abortions have been performed since 1973.⁷ In recent years, abortion has become less common, but it still is performed in numbers that place it among the most common surgeries.⁸

Still critics of the fact sheet could argue that *even greater* access to contraception would reduce abortions. What if every can of Coca-Cola came with contraceptives in it? What if teachers began every high school class by passing out condoms? At some point, the law of diminishing returns indicates that greater access to contraception would make little if any difference for the numbers of abortions. But have we reached that point? Are we already past that point? How would we know?

Second, the Secretariat's text emphasizes that with typical use, contraception often fails to prevent pregnancy. In arguing for this proposition, they draw on research from abortion providers such as the Guttmacher Institute, the research arm of Planned Parenthood, and the British Pregnancy Advisory Service, the leading provider of abortion in the United Kingdom. The Secretariat notes that about half of women who get abortions in the United States and in Great Britain were using contraception in the month they conceived. Surprisingly, 24.2 percent of women were using hormonal contraceptives or long-acting reversible contraceptives, which are recommended to women as the most effective methods of avoiding pregnancy. A chief executive of the British Pregnancy Advisory Service noted, "Our data shows women cannot control their fertility through contraception alone, even when they are using some of the most effective methods."⁹

The high failure rate of contraception is partly explained by cumulative probability. In their *New York Times* article, "How Likely Is It That Birth Control Could

5. Paul VI, *Humanae vitae* (July 25, 1968), n. 14.

6. Kimberly Daniels, William D. Mosher, and Jo Jones, "Contraceptive Methods Women Have Ever Used: United States, 1982–2010," *National Health Statistics Reports* no. 62 (February 14, 2013): 4.

7. For an estimate of the total number of abortions in the United States, see National Right to Life Committee, "Abortion Statistics: United States Data and Trends," *NRL News Today*, January 2020, <https://www.nationalrighttolifenews.org/2020/01/abortion-statistics-united-states-data-and-trends-4/>.

8. See Guttmacher Institute, "Induced Abortions in the United States," fact sheet, September 2019, https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; and Mary Elizabeth Dallas, "The 10 Most Common Surgeries in the U.S.," *Healthgrades*, August 28, 2019, <https://www.healthgrades.com/right-care/tests-and-procedures/the-10-most-common-surgeries-in-the-u-s>.

9. USCCB, "Greater Access to Contraception," 1–2; and British Pregnancy Advisory Service, "Women Cannot Control Fertility through Contraception Alone: BPAS Data Shows 1 in 4 Women Having an Abortion Were Using Most Effective Contraception," news release, July 7, 2017, <https://www.bpas.org/about-our-charity/press-office/press-releases/women-cannot-control-fertility-through-contraception-alone-bpas-data-shows-1-in-4-women-having-an-abortion-were-using-most-effective-contraception/>.

Let You Down?,” Gregor Aisch and Bill Marsh explained, “When failure rates of contraceptives are mentioned, they usually refer to a given year of use. Less understood is that the risk of failure is compounded over time. The longer any method of contraception is used, the greater the probability of unplanned pregnancy—the same way that any small risk, taken repeatedly, grows in likelihood. This is true for all contraception methods, even in the highly unlikely event that they are used perfectly, every time.”¹⁰ Even a contraceptive with a 99 percent rate of preventing pregnancy is highly likely to fail over time. As John Ross noted, “That one percent risk taken monthly over ten years, accumulates to a 70% probability that an unwanted pregnancy will occur during that period.”¹¹ That is worth considering. Over time the use of contraceptives, even those considered highly reliable, leads to unwanted pregnancy, and unwanted pregnancy leads to abortion.

Third, and perhaps most importantly for its thesis, the Secretariat points out that the promotion of contraceptives leads to risk compensation, or “the greater likelihood of engaging in potentially risky sexual behavior when one believes risk has been reduced.”¹² For example, when cigarette filters were widely adopted in the 1970s, people learned that smoking a filtered cigarette was less risky than smoking an unfiltered cigarette. Unfortunately, people in reaction to this news changed the way they smoked. The Surgeon General pointed out that smokers took more frequent and longer puffs on filtered cigarettes. As a result, neither the dose of smoke nor the risk of disease decreased.¹³ For this reason, “safe cigarettes” did not lead to fewer deaths from smoking. Risk compensation also explains why the rate of fatalities in skydiving did not go down despite safety improvements in equipment: skydivers took advantage of the safer equipment to perform riskier jumps.¹⁴ During the spring 2020 coronavirus lockdown in Los Angeles, fewer cars were on the road than normal. Paradoxically this led to an increase in car fatalities. With fewer drivers around and seemingly less risk of hitting another car, people began to drive faster, which led to more fatalities on the road.¹⁵

Risk compensation may also lead to behavioral disinhibition when “safe sex” programs promote contraceptives. For example, economics professor David Paton found “no evidence” that family planning initiatives reduce rates of unplanned

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10. Gregor Aisch and Bill Marsh, “How Likely Is It That Birth Control Could Let You Down?,” *New York Times*, September 13, 2014, <https://www.nytimes.com/interactive/2014/09/14/sunday-review/unplanned-pregnancies.html>.
 11. John A. Ross, “Contraception: Short-Term vs. Long-Term Failure Rates,” *Family Planning Perspectives* 21.6 (November–December 1989): 275.
 12. USCCB, “Greater Access to Contraception,” 2. See also Michael M. Cassell et al., “Risk Compensation: The Achilles’ Heel of Innovations in HIV Prevention?,” *British Medical Journal* 332.7541 (March 11, 2006): 605–607, doi: 10.1136/bmj.332.7541.605.
 13. US Department of Health and Human Services, *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General* (Atlanta: HHS, 2014), 158.
 14. Andrew Stewart, “On Risk: Perception and Direction,” *Computers and Security* 23.5 (July 2004): 364–365, doi: 10.1016/j.cose.2004.05.003.
 15. CBS Los Angeles, “‘Please Slow Down’: LA Seeing High Number of Fatal Crashes despite Lockdown,” May 14, 2020, <https://losangeles.cbslocal.com/2020/05/14/please-slow-down-la-seeing-high-number-of-fatal-crashes-despite-lockdown/>.

pregnancy or abortion among minors. According to Paton, “It is clear that providing more family planning clinics, far from having the effect of reducing conception rates, has actually led to an increase. ... The availability of the morning-after pill seems to be encouraging risky behaviour. It appears that if people have access to family planning advice they think they automatically have a lower risk of pregnancy.”¹⁶ In other words, safe sex programs may lead some people to take more risks in their sexual behavior, which leads to more sexually transmitted infections, more unwanted pregnancies, and more abortions.

Fourth, the Secretariat argues that programs promoting emergency contraception do not reduce the rate of unintended pregnancy or abortion. This conclusion is supported by a large body of research, including twenty-three studies conducted over eight years by John Trussell’s research team at Princeton University.¹⁷ In his 2016 article “Population, Reproductive, and Sexual Health: Data Are Essential Where Disciplines Meet and Ideologies Conflict,” Joseph Stanford supports these findings, noting that they contradict the “[confident and] widespread dissemination and promotion of emergency contraception.”¹⁸ Moreover, if emergency contraception prevents implantation of the human embryo,¹⁹ then emergency contraception cannot be said to *reduce* abortion rates, because its use *causes* abortion, the ending of a prenatal human life by means of preventing implantation.

The view that emergency contraception does not cause abortion is sometimes based on defining *abortion* as “termination of pregnancy” and then defining *pregnancy* as “the implantation of the embryo in utero.” Both definitions are problematic. Some cases of termination of pregnancy involve no induced abortion, such as delivery by cesarean section, involuntary miscarriage, and vaginal birth. Some cases of abortion involve no termination of pregnancy, such as the selective abortion of just one twin. Likewise, the word *contraceptive* is sometimes misapplied. For example, Celia Matyanga and Blessing Dzingirai observe that this term conventionally is applied to any drug or device that does not dislodge the fetus after implantation. However, it is more accurate to use the term *abortifacient* rather than *contraceptive*

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16. David Paton, quoted in Kamal Ahmed, “Abortions Rise in Under-Age Sex Crisis,” *The Guardian*, March 17, 2002, www.guardian.co.uk/uk/2002/mar/17/medicalscience.socialsciences. See also David Paton, “The Economics of Family Planning and Underage Conceptions,” *Journal of Health Economics* 21.2 (March 2002): 207–225, doi: 10.1016/S0167-6296(01)00115-1.
 17. Elizabeth G. Raymond, James Trussell, and Chelsea B. Polis, “Population Effect of Increased Access to Emergency Contraceptive Pills: A Systematic Review,” *Obstetrics and Gynecology* 109.1 (January 2007): 181–188, doi: 10.1097/01.AOG.0000250904.06923.4a; and USCCB, Secretariat of Pro-Life Activities, “Emergency Contraception Fails to Reduce Unintended Pregnancy and Abortion,” April 1, 2020, <http://usccb.org/issues-and-action/human-life-and-dignity/contraception/fact-sheets/upload/contrafactsheet.pdf>.
 18. Joseph B. Stanford, “Population, Reproductive, and Sexual Health: Data Are Essential Where Disciplines Meet and Ideologies Conflict,” *Frontiers in Public Health* 4 (2016): 1, doi: 10.3389/fpubh.2016.00027.
 19. Chris Kahlenborn, Rebecca Peck, and Walter B. Severs, “Mechanism of Action of Levonorgestrel Emergency Contraception,” *Linacre Quarterly* 82.1 (February 2015): 18–33, doi: 10.1179/2050854914Y.0000000026.

to describe drugs and devices that have any post-fertilization method of action.²⁰ This view does not accord with the root sense of the word *contraceptive* as acting against (*contra*) the conception of a new human being. If a new human being has come into existence, if conception has actually taken place, then contraception has already failed. Even if we were to adopt what Matyanga and Dzingirai consider to be the conventional use of the term *contraceptive*, what matters is not what prevention of implantation is conventionally called, but whether prevention of implantation is ethically justified. We do make an act permissible by calling it by a conventional name that obfuscates the reality, namely, the ending of a prenatal human life by preventing implantation.

Fifth, the Secretariat responds to an objection. Contraception program advocates point out that long-acting reversible contraceptives such as the intrauterine device (IUD) or hormonal implants are much more likely to prevent pregnancy than are forms of contraception like the pill or condoms, which depend on repeated human choice and behavior. So if critics of abortion want to reduce abortion, contraception advocates argue, they should promote long-acting reversible contraceptives.

The Secretariat responds to this argument by noting significant problems that long-acting reversible contraceptives raise for medical ethics and women's health. In one study, participants were given directive counseling emphasizing the benefits of long-acting reversible contraceptives rather than the standard nondirective counseling, which maximizes patient autonomy and minimizes medical paternalism. Moreover, policy makers and clinicians who advocate for long-term contraception focused in particular on women of color and poor women rather than on white women and rich women. Even some feminists have expressed concern over how low-income and minority women are aggressively encouraged to undergo sterilization or use long-acting contraceptives. For example, Jenny Higgins writes, "Though few US citizens have been forcibly sterilized in recent years, rates of tubal ligation are enormously stratified by both education level and race. . . . Policy makers and professionals have exhibited more enthusiasm about LARC than contraceptive users themselves . . . [and] have suggested incentive programs in which poor women receive cash in exchange for having a LARC method inserted and such programs may be in practice already. Evidence also exists that clinicians recommend LARC more to women of color than white women and more to socioeconomically disadvantaged women compared to socioeconomically advantaged."²¹ Both the targeting of minorities and the paternalistic counseling violate norms of medical ethics.

In addition, the Secretariat argues that long-acting reversible contraceptives have adverse effects on women's health both directly and indirectly. They have many direct side effects, including headaches, acne, and weight gain. They also can lead to dangerous complications such as uterine perforation and pelvic inflammatory

20. Celia M.K. Matyanga and Blessing Dzingirai, "Clinical Pharmacology of Hormonal Emergency Contraceptive Pills," *International Journal of Reproductive Medicine* 2018 (October 4, 2018): 3, doi: 10.1155/2018/2785839.

21. Jenny A. Higgins, "Celebration Meets Caution: LARC's Boons, Potential Busts, and the Benefits of a Reproductive Justice Approach," *Contraception* 89.4 (April 2014): 239, 10.1016/j.contraception.2014.01.027, cited in Secretariat for Pro-Life Activities, "Greater Access to Contraception," 5.

disease. Indirectly, long-acting reversible contraceptives can lead to risk compensation and behavior disinhibition, such as having sex without condoms or other barrier methods, leading to an increase in sexually transmitted infections. This shift in behavior is thought to have contributed to a twenty-year high in sexually transmitted infection rates that occurred in California during 2016. Most importantly for the thesis of the fact sheet, long-acting reversible contraceptives, especially copper IUDs, can have an abortifacient effect—namely, preventing the implantation of an embryo—a risk that women should be made aware of if they are to give informed consent. Causing abortion is not preventing abortion.

How do these problems with long-acting reversible contraceptives relate to the Secretariat's thesis? Even if the people responsible for the studies on long-acting reversible contraceptives violated medical ethics by exercising unjust paternalism, these infringements on patient autonomy are not directly relevant for the thesis that long-acting reversible contraceptives do not reduce rates of abortion. Similarly, it may be true that policy makers and clinicians who advocate for long-term contraception focus disproportionately on women of color and poor women rather than white, rich women. But, in itself, the nondiscriminatory promotion of contraception surely makes no difference to the thesis that greater access to contraception does not reduce abortions. It is true also that long-acting reversible contraceptives can have adverse side effects. But the level of risk would not (presumably) make a difference to the question of whether greater access to contraception reduces abortion.

By contrast, the Secretariat makes a point directly relevant for its thesis in pointing out that long-acting reversible contraceptives like the copper IUD can prevent a newly formed human embryo from imbedding into the uterus. As James Trussell, Elizabeth Raymond, and Kelly Cleland note, implantation occurs six to twelve days after ovulation, and copper IUDs are highly effective if inserted as many as five days after ovulation. The timing strongly suggests that to be so effective these devices have a post-fertilization effect.²² Long-acting reversible contraceptives do not *reduce* abortion in those cases in which taking them *causes* abortion, bringing about the death of the prenatal human embryo by preventing implantation.

The last section of the fact sheet pushes back on claims that lower numbers of abortions in recent years in the United States are best explained by greater use of contraception—in particular, that the widespread use of contraceptives has led to fewer unintended pregnancies.²³ The Secretariat, however, argues that the reduction in rates of abortion, especially among teenagers, cannot be attributed to greater use of contraceptives but rather is more probably caused by lower rates of teen sexual activity. It cites the declining prevalence of sexually active high school students from 54% in 1991 to 41% in 2015.²⁴ In fact, the Youth Risk Behavior Survey indicates that

22. James Trussell, Elizabeth G. Raymond, and Kelly Cleland, "Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy," Princeton University, Office of Population Research, January 2019, 2, 8, <https://ec.princeton.edu/questions/ec-review.pdf>.

23. Joerg Dreweke, "New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines," *Guttmacher Policy Review* 19 (March 2016): 16.

24. Jean M. Twenge and Heejung Park, "The Decline in Adult Activities among U.S. Adolescents, 1976–2016," *Child Development* 90.2 (March–April 2019): 638–654, doi: 10.1111/cdev.12930.

this decrease in sexual activity accounts for 53 percent of the reduction in pregnancy rates in this population between 1991 and 2001.²⁵ A 2015 British study downplayed the association between long-acting reversible contraceptives and decreased rates of teen pregnancy, instead attributing the decline to higher educational achievement and demographic changes, including the immigration of young people from religious cultures that discourage premarital sex.²⁶

A question then arises, What has caused this great decrease in sexual activity? I suspect the lower rate of sexual activity, and therefore the fewer abortions resulting from unwanted pregnancies, is due to massive increases in the amount of time young people spend online, away from the face-to-face, body-to-body contact that gives rise to unplanned pregnancies. Psychologist Jean Twenge in her book *iGen* documents that young people today are in no hurry to grow up. In fact, in comparison with previous generations, they are delayed in terms of many behaviors, from having sex and drinking to getting a driver's license and moving out on their own.²⁷ It is not the condom but the iPhone that has reduced the number of abortions.

There is, of course, another response to the common objection that those who oppose abortion are inconsistent if they do not also support contraception. This response depends not on empirical data, but rather on ethical principle. It may seem advantageous for attaining a noble goal to lie, to cheat, to steal, or to murder. But if we accept the ethical principle that intrinsically evil acts ought never to be done, then we hold that an illicit means ought never to be used to attain even the most legitimate end.²⁸ No one charges pacifists with inconsistency if they do not try to stop a war by using violence against those serving in the armed forces. Pacifists oppose both war and the use of violence (even to stop war). Catholic teaching opposes both abortion and contraception (even to stop abortion). If you oppose abortion, it does not follow that you are inconsistent if you do not use all available means to oppose abortion, since some of these means are themselves ethically objectionable. So another way to answer the charge of inconsistency is to question the permissibility of contraception in itself, in addition to or in lieu of answering the numerous empirical questions that arise about what means are most likely under what circumstances to obtain the end of reducing the number of abortions.

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25. John S. Santelli et al., "Can Changes in Sexual Behaviors among High School Students Explain the Decline in Teen Pregnancy Rates in the 1990s?," *Journal of Adolescent Health* 35.2 (August 2004): 80–90, doi: 10.1016/j.jadohealth.2004.05.001.
 26. Sourafel Girma and David Paton, "Is Education the Best Contraception: The Case of Teen Pregnancy in England?," *Social Science and Medicine* 131 (April 2015): 1–9, doi: 10.1016/j.socscimed.2015.02.040.
 27. Jean M. Twenge, *iGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy—and Completely Unprepared for Adulthood—and What That Means for the Rest of Us* (New York: Atria Books, 2017).
 28. John Paul II, *Veritatis splendor* (August 6, 1993), n. 67.