

1 Introduction

THE TURBULENT STATE OF ABORTION IN AMERICA

In an ideal world, when you need medical care, a somewhat routine series of events takes place: you discover you need help, make a decision about it, find a provider who can care for you, figure out insurance and payment, go to the provider, and then get the care. Because we don't live in an ideal world, familiar hurdles—some often insurmountable—such as health care costs, appointment availability, and family and employer support can interfere, but the goal is for care to be driven by a combination of patient choice and evidence-based medicine.

TALIA

Yet, consider Talia's story of trying to get an abortion. Talia was fifteen years old and had just started getting her period earlier in the year. As happens with many young women, her period was erratic, so she didn't realize she was pregnant until several months had gone by. When she did find out, having just graduated middle school and essentially raising herself thanks to a father who wasn't around and a mother who wasn't dependable, she was certain that she wanted and needed an abortion.

But making the decision herself was not an option for Talia. Like young women in about three-quarters of states, as a minor Talia was not entitled to make her own choice. In Talia's state, one parent had to be notified and give consent to the abortion. The consenting parent had to provide government-issued identification so the consent could be notarized. Talia had the support of an adult in her life—her boyfriend's grandmother—but she didn't qualify under state law as a person who could consent. With one parent missing and the other only sporadically involved in her life, Talia's only option was to go before a judge who could, after a hearing, sign off on her abortion.

Going before a judge in any circumstance is not an experience most people would relish, but doing so when you are a minor faced with an unwanted pregnancy can be terrifying. Thankfully, Talia lived in a state that had a well-run organization whose sole purpose was to assist minors navigating this process. Talia contacted the organization, who connected her with an attorney to help her fill out the paperwork and appear before the judge.

However, before Talia could do that, she arranged to have an initial appointment at the local abortion clinic. Where Talia lived, state law required a minor to make a separate trip to the clinic twenty-four hours before the abortion. She made the appointment and showed up at the clinic for her preabortion counseling and ultrasound.

When she got to the clinic, she realized something was wrong and that the building she had entered wasn't an abortion clinic after all. Rather, she was in a fake women's health center, generically known as a crisis pregnancy center, or CPC, but also sometimes called a fake clinic. This center, which was not a medical facility but rather posed as one, was located directly next door to the real abortion clinic and did everything it could to make itself look like the clinic—the same building design and a similar name. Talia was tricked into going there.

Once Talia was inside, the people there, who wore white coats to look like doctors, pretended that they knew Talia had an appointment. But when Talia told them that she wanted to have an abortion, they tried to persuade her otherwise. They told her that they would help her support her baby with money and other forms of assistance. When Talia remained confident in her decision, they brought someone in who told Talia that she herself had had an abortion and that it had ruined her life. Finally, when Talia said she still wanted an abortion, the people at the center brought

out the most dangerous lie of them all—they told Talia that they could perform the abortion but that Talia had to wait a few weeks because they didn't have an open appointment. Talia was already nineteen weeks pregnant, and waiting a few weeks would have put her over the state's limit on when a woman can have an abortion. In other words, the center lied to Talia so that she would never be able to exercise her right to choose.

When Talia left the appointment at the CPC, she called the organization that helped minors through the process. The people there quickly identified the fake clinic and told Talia that she was at the wrong place. Talia was shocked. "I thought I was in a real doctor's office. I don't get it." Thanks to the help of the organization, the attorney, and then the real abortion clinic, Talia was able to get the judge's approval without any problems.

But Talia's journey to get an abortion wasn't over. She still needed to come up with the money. She didn't have health insurance that covered the abortion, so she had to come up with \$4,000 out of pocket. She and her boyfriend's grandmother pulled together some money, but it wasn't enough. Thankfully, local and national organizations dedicated to helping low-income women pay for abortions stepped in. They made up the difference, and Talia was able to get her abortion just before the state's limit kicked in.

With her abortion behind her, Talia started ninth grade, free to pursue her education without being a parent when she didn't want to be. But for her to get to this point, she had to navigate the complex web of laws that deprive young women of their autonomous decision-making, the deception of fake clinics, the time pressure of a state's gestational limit, and the difficulty that low-income women have in finding money for a procedure many insurance companies don't cover. Talia was successful, but with so many hurdles in place, other women aren't always so fortunate.

BRITTANY

Or take Brittany's story about trying to get in to have an abortion in Colorado. When she was twenty-one, she found out she was pregnant. She had been on Depo-Provera (an injectable contraceptive) at the time, so she was surprised by this development. Brittany knew that, as a college

student who was working full time, she “wasn’t ready physically, emotionally, or financially to be a parent,” so she decided to have an abortion.

When Brittany called the clinic, the woman on the phone asked Brittany if she wanted to have someone walk her from her car into the clinic. Brittany, not realizing why she was asked this question, said no because she already had two companions to accompany her to her appointment. She arrived at the clinic and quickly realized why. Several older men swarmed her car after she parked. When Brittany refused pamphlets that one of the men shoved at her, he screamed, “How can you do this? You’re killing your baby to continue on your whore life, you jezebel!”

Then, the men began tossing baby-doll parts at Brittany. These doll parts, covered in red paint, fell to the ground after hitting Brittany and her companions. While throwing the doll parts, one of the men yelled, “This is what you’re doing to your baby! Look at the street! It’s strewn with the blood of your baby. That’s your baby scattered across the street!” The men in front of the clinic then turned to one of Brittany’s support people, her aunt, and began yelling at her, calling her “Grandma” and asking her how she could let Brittany go through with the abortion.

Brittany had to withstand this harassment while crossing a wide street to get from the parking lot to the clinic. Once inside, she thought it would be over, but while sitting in the waiting room she could hear the protesters yelling the same types of things at every woman coming into the clinic. And, when the doctor came to work, she heard them yell, “Murderer!” and “Butcher!” Brittany was worried that the protesters would still be there after her appointment, but the doctor assured her that they had left after he arrived. Brittany was so shaken up by what happened that she would have waited until they left if necessary. Overall, she called the experience with the protesters “heinous” and used the “horror” she went through as a source of strength. “If I can make it through that, I can make it through the rest of this day.”

WANDALYN

Now consider what it took for Wandalyn to get an abortion. Wandalyn was twenty weeks pregnant when she received terrible news. Her “baby,” using

her word, was diagnosed with trisomy 18, a life-threatening chromosomal disorder that often results in stillbirths or babies who can't survive to their first birthday because of conditions related to breathing problems or heart deformities. It was a devastating diagnosis for Wandalyn and her fiancé, who had been overjoyed about adding a son to their blended family of five—the two of them plus her two daughters and his son.

After quickly learning everything she could about the condition, Wandalyn reluctantly made the decision to have an abortion, calling it “the most painful decision we have ever made.” The closest abortion clinic to Wandalyn had lengthy wait times and told her the procedure would cost \$7,000, time and money that Wandalyn did not have. So, with the help of the doctors who diagnosed the fetal anomaly, she found a different clinic that could perform the abortion the same week as the diagnosis, but that clinic was almost two hours away.

Although the abortion would be less expensive at this other clinic, Wandalyn was told that it would still cost over \$2,000, money she did not have. Wandalyn, a new immigrant to this country who had successfully run a business in her home country and had resources there, had not been able to find work in the United States. Her family lived off her fiancé's meager income, and Wandalyn had no health insurance. What little money they had went to their three children.

As an undocumented immigrant, Wandalyn was ineligible for public health insurance in the state where she lived, so she was responsible for paying for the abortion herself. When she talked with one of the abortion clinic staffers by phone, she explained that she didn't have enough money. The clinic told her that private charities could help, but Wandalyn would have to come up with some of the money herself. She went to work trying to find the money and was able to stitch together seventy dollars, mostly money that her fiancé had put aside for her prenatal care visits. Despite this amount being far short of what the clinic wanted her to contribute, the staff told her that they would waive the remaining portion of the fee.

With the cost of the procedure no longer a problem, Wandalyn had to tackle the next issue—traveling to the clinic. She and her fiancé didn't own a car, so she couldn't drive herself to the appointment two hours away. Help from friends was impossible too, as Wandalyn had been in the United States for only a short time and had not yet developed a supportive

network. The state's public transportation network wouldn't help either, as it was too costly, took too much time, and would only get her as close as several miles from the clinic, not to the clinic itself.

So she once again called the clinic. The clinic itself couldn't help, but the people there connected her to a newly formed volunteer group that helps women travel to abortion clinics and, if needed, hosts them for overnight stays. The two-hour drive for Wandalyn to get to the clinic would mean that each volunteer who helped her would have to drive four hours—two hours to get her and then two hours to the clinic. Wandalyn, who could not afford a hotel, also needed an overnight host and rides to and from the clinic from there because her twenty-week procedure would take two days—the first for dilation of her cervix and the second for the abortion. The volunteer group jumped into action and found five different people to help Wandalyn with each step of the process. The morning drive on day one went off without a hitch, and Wandalyn showed up at the clinic ready for the procedure to start.

Nothing worked easily for Wandalyn, though. When she arrived at the clinic Friday morning, it was closed. Unfortunately, state inspectors had come for a surprise full inspection (such surprise inspections are not an infrequent occurrence for abortion clinics). The clinic protested, but the inspectors prevailed, forcing the clinic to cancel all the patients scheduled for the day. Stuck in the parking lot two hours from home with a volunteer who had just driven for four hours, Wandalyn was one of them. Rescheduling at a clinic in the neighboring state was impossible for Wandalyn because that state would have required her to wait twenty-four hours between her first visit and when she could have had the abortion, which would mean too much time away from her children without any reliable child care backup.

Since she needed a two-day procedure and the clinic was closed Sunday, there was nothing for Wandalyn to do but return home, delaying her procedure even more. Getting home was also tricky, though. Wandalyn was sitting in a stranger's car in a parking lot of a closed clinic. She couldn't stay there forever. The volunteer who had driven her from home that morning didn't have time to drive her home but was able to help Wandalyn a bit more and drove her to another volunteer's house to stay while the group found her a ride home. Luckily, the person who was scheduled to

drive Wandalyn home on Saturday was able to quickly adjust her schedule and drive her home Friday afternoon instead.

All that effort, and Wandalyn was back to square one—carrying a wanted pregnancy with a devastating chromosomal abnormality and having trouble getting the abortion she now sought. She felt bad for the drivers who had wasted their time and frustrated that another hurdle was in her way. But she never reconsidered her decision to have an abortion because she knew too much about trisomy 18 and what that meant for her “already-loved baby.”

The same clinic was able to reschedule her for Tuesday of the following week, a week after the initial diagnosis and now into the twenty-second week of her pregnancy. She just had to, for a second time, get to and from the clinic and find a place to stay overnight for the two-day procedure. The same volunteer group came through once more. A new driver took Wandalyn to the clinic Tuesday morning, another driver took her to a host Tuesday night and back to the clinic Wednesday morning, and two other drivers tag-teaming took her home Wednesday. The Wednesday leg was the hardest part of the trip for the volunteers because it was such a long drive in the middle of a workday. They solved the problem with one driver taking her halfway, then handing her off to a second driver who lived closer to Wandalyn. The second driver, found through networking nationally with like-minded abortion rights supporters, was able to take Wandalyn all the way home.

Wandalyn’s journey from diagnosis to abortion was a constant struggle because of the obstacles thrown her way. All told, she spent more than ten hours in the car, was assisted by almost a dozen volunteers, and utilized charitable funding and clinic discounts that were made available to her. She overcame the absence of available nearby clinics, state insurance barriers, affordability issues, and state inspectors to finally get the medical care she sought—an abortion for her wanted pregnancy.

ABORTION EXCEPTIONALISM AND ITS CONSEQUENCES

Talia’s, Brittany’s, and Wandalyn’s stories are emblematic of the many—though certainly not all—abortion patients who face multiple, compounding

roadblocks in their search for care. What makes these stories important is how they highlight the wide variety of obstacles standing in the way of people accessing abortion.* These struggles to get an abortion differ significantly from the accounts of other Americans' efforts to access health care services. Of course, many people face difficulties getting the health care they need. Too many Americans remain uninsured or underinsured, many who live outside population centers have to travel long distances to reach necessary services, and wait times to be seen by providers can be excessive. These and other problems are endemic to *all* forms of medical care in the United States.

But what these three stories highlight are just a few of the many difficulties that women in the United States have in accessing abortion care because of barriers specific to abortion. These barriers represent *abortion exceptionalism*: the idea that abortion is treated uniquely compared to other medical procedures that are comparable to abortion in complexity and safety. These barriers thwart access to care in ways that compound the other problems that are shared by many people who seek other forms of medical care. These barriers are about abortion and abortion alone, and represent the thorough politicization of this branch of reproductive health care.

That abortion is one of the most divisive issues in American politics and culture is well known. One need look no further than the front page of most media outlets in the first half of 2019 (when this book is being finalized) to see this dynamic. Some of the country's most anti-abortion states are racing one another to ban abortion earlier and earlier

* Throughout this book, we mostly use the word *woman* to describe who receives an abortion, but we recognize the reality that some people who do not identify as women receive abortions, including transgender men and gender-nonconforming individuals. We use gender-neutral language at times, such as referring to *patients* or *people*, but use *women* and similar language more frequently. We believe striking this balance accomplishes the twin goals of being inclusive but also reflecting the reality of who receives most abortions. By using language in this way, we do not intend to erase the experiences of those who do not fit in the category "woman," people who have the right to receive abortion care as unhindered from abortion barriers discussed in this book as anyone else. s.e. smith, "Women Are Not the Only Ones Who Get Abortions," *Rewire*, March 1, 2019, rewire.news/article/2019/03/01/women-are-not-the-only-ones-who-get-abortions/. For further discussion of the use of both *women* and gender-neutral terms in a book about reproductive health, rights, and justice, see Loretta J. Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Oakland: University of California Press, 2017), 6–8.

in pregnancy—Missouri at eight weeks; Georgia, Kentucky, Ohio, and Mississippi at six weeks; and Alabama at conception. Given their obvious unconstitutionality under current law (described in more detail below), it will be years, if ever, before these laws take effect. Yet even though these laws will have no short-term practical or legal effect, they have captured the nation's attention, propelling abortion once again to the front of the national political consciousness.

At the same time, some of the country's most abortion-supportive states are engaged in an opposite endeavor—working to make abortion as safe, accessible, and protected as possible. In the first half of 2019, New York, Rhode Island, Vermont, Illinois, Maine, and Nevada have passed laws that would protect abortion if the Supreme Court ever overruled *Roe v. Wade* and that will expand its accessibility in very concrete ways. These changes will have repercussions not only for pregnant people living in those states but also for those who travel for care. While the media attention has focused mostly on the threats that the anti-abortion states pose, the developments in these abortion-supportive states are arguably just as important, if not more.

In this book, our goal is to discuss something that often gets overlooked in the nation's battle over abortion, even by those sympathetic to abortion rights—the everyday *consequences*, for those who seek abortions and for those who provide them, of the onslaught of the attacks against abortion care since *Roe v. Wade* legalized abortion in 1973. Every step along the way, from the moment someone finds out she is pregnant to the point of getting an abortion, law and politics interfere with the decision and process. In this book, we document the impact of this interference, the lengths to which abortion providers go to nonetheless provide high-quality medical care in this environment, and the tenacity patients must have in order to make the process work for them.

Political attempts to interfere with abortion have been a constant in American political life since *Roe*. The anti-abortion movement has tried almost everything possible to try to stop legal abortion—it has attempted to amend the Constitution, change the composition of the Supreme Court, decrease the number of medical schools teaching abortion, stop women from entering clinics, reduce the number of professionals performing or assisting in the performance of abortions, and promote a culture of shame

and stigma for women considering abortion. The movement's methods to accomplish these goals have ranged from the perfectly legal that are well within the bounds of normal democratic politics (for instance, electing politicians who are opposed to abortion and nominating anti-abortion judges) to those that are blatantly illegal (such as assassinating and targeting abortion providers). In the middle of these two extremes sits another strategy of the anti-abortion movement—enacting new legislation that regulates every aspect of abortion. While passing new laws is certainly a normal part of the democratic principle that “to the victor go the spoils,” laws that restrict fundamental rights are different.

Legislative efforts to restrict abortion ramped up in 2010, after Republicans made significant electoral gains. Altogether, more than 1,200 restrictions of various kinds have been passed by the states since 1973, but over one-third of them have passed since 2010. On the basis of types of restrictions each state has, the Guttmacher Institute, one of the leading research organizations studying reproductive health, classifies states as supportive, middle-ground, hostile, or extremely hostile with respect to abortion. As of the beginning of 2019, there are now twenty-one states that are very hostile or hostile to abortion. Given the population of these states, that means that 43 percent of women live in a state that is hostile or very hostile to abortion, whereas 22 percent of women live in a state that supports abortion rights.

The story we tell in this book conveys the disturbing consequences of these legislative restrictions and the numerous obstacles women face trying to exercise their rights to a legal health care service, as well as the herculean efforts often needed to overcome them. Given that Donald Trump has, thus far in his presidency, been able to add two Supreme Court Justices who are widely suspected of being hostile to constitutional protection for abortion, the attention of many Americans is understandably currently focused on *Roe v. Wade's* fate. While that is certainly a major concern, the reality is that many women in the United States *already* live in a world where the quest to obtain abortion care is enormously challenging, especially when combined with complicating factors such as poverty and racism, as well as special circumstances such as being incarcerated or undocumented.

WRITING THIS BOOK

In spite of the extensive literature that exists on almost every aspect of abortion, relatively little has been written documenting the actual *experience* of getting an abortion amid all the obstacles in America today. Both of us are scholars of abortion, one from the legal world, the other from sociology, and we have long known the difficulties that patients face in accessing abortion and that abortion providers face in providing quality medical care despite political interference. But we both decided that a full accounting of these obstacles— from the moment a woman finds out she is pregnant through, if she is successful, getting the abortion she seeks—is essential to understanding the reality of abortion in contemporary America. For these reasons, we wrote this book telling the story of abortion now, a story that captures the disturbing reality of the sometimes insurmountable barriers women face trying to exercise their constitutional right to a basic medical procedure.

This book is based largely on more than seventy interviews we conducted in 2017 and 2018. We interviewed people working in all fifty states plus the District of Columbia and Puerto Rico. We interviewed *abortion providers*, those who work in various jobs in clinics or hospitals that provide abortions (not just clinicians), and abortion access allies and volunteers. As we use these terms throughout the book, *allies* are people who are not in an abortion facility but instead work for an outside organization that helps patients access abortion, and *volunteers* are people who are not paid to provide this support work but do so on their own time. The people we interviewed spanned the various jobs in the world of abortion provision and represented the various settings where abortions take place—local Planned Parenthood affiliates, independently owned clinics, doctors' offices, and hospitals—though, consistent with abortion provision generally, most were from the first two categories. Our interview subjects were also diverse in age and race (though not in sex, as only two were men).[†]

[†] Throughout the book as we refer to the people we interviewed, for the most part we use names from a website that generates fake names and identify where the people work on the basis of the four different regions of the country (Northeast, South, Midwest, West) used by the Guttmacher Institute in its studies of abortion provision. We do this to protect our interview subjects' identity and safety. However, some of the people we interviewed wanted to be identified by their real name, so we do this when it is appropriate but without flagging the difference.

The interviews with providers, allies, and volunteers covered three main topics. First, we discussed the barriers patients face in accessing abortion where they work. Second, we discussed how quality abortion care or access is made available in light of those barriers. Third, we discussed how these barriers affect the people that they see. By talking with providers, allies, and volunteers from every state and major territory in this country, we were able to get a complete picture of the comprehensive nature of the various barriers that exist across the country, how abortion care manages to be provided despite them, and how they affect abortion-seeking women.

To complement the original interviews, we draw heavily on other sources throughout the book. Increasing numbers of women have been publicly telling their abortion stories, and we have used many of those stories to show a personal side to the barriers that we discuss. Additionally, throughout the book we cite relevant empirical research from many different fields that has documented the barriers patients face as well as the benefits (or lack thereof) that these barriers may have.

Each chapter of this book covers a different step in the abortion process, from learning you are pregnant to, if successful, getting a procedure. In order, the chapters cover making the decision to have an abortion, including special restrictions for minors (chapter 2), finding and getting to an abortion provider (chapter 3), paying for the abortion (chapter 4), getting into the abortion clinic (chapter 5), counseling at the clinic (chapter 6), waiting before the procedure (chapter 7), and the procedure itself (chapter 8). Not every abortion follows this linear progression from start to finish, but this ordering is the most sensible way to convey the entirety of the abortion restrictions a woman faces. By covering abortion barriers in this progression, we are not focusing on any one state or territory, or saying that every—or even any—woman in the United States faces each one of these barriers. There are different abortion paths in different parts of the country based on individual clinic practice and particular state and local laws, with some people facing many of the barriers that we explore and others facing none.[‡]

[‡] In each chapter, we discuss the different types of restrictions and recount the number of states that have each one. The numbers we use are accurate as of the summer of 2019, but given the ever-changing nature of abortion restrictions (more being passed in restrictive states, some being struck down by courts, a small number being removed in liberal states), the exact numbers may not be accurate at the time you read this.

In the end, the book concludes that the myriad barriers that exist around the country—such as those highlighted in the three patient stories that start this introduction—make it extremely difficult for women, particularly those who are poor and racial minorities, to access abortion services. Nonetheless, for the most part, thanks to their own commitment as well as the dedication and innovation of providers, allies, and volunteers, women in America who seek an abortion still, for now, get legal, safe abortions. As one abortion provider we interviewed told us, “Women will walk over hot rocks to find an abortion provider. If you need one, you need one, and you go where you can.”

ABORTION IN AMERICA: A SHORT OVERVIEW

To situate the material in this book, here we offer some basic background about the current landscape of abortion in the United States. Most fundamentally, the story of abortion in this country is impossible to tell without focusing on the demographics of the women who have abortions. A substantial majority of women seeking abortions are low income, with half living below the federal poverty level and another quarter living between 100 percent and 199 percent of the poverty level. Relatedly, more than a quarter of abortion patients have no health insurance at all. Just over a third have Medicaid (though, as discussed in depth in chapter 4, Medicaid pays for abortions in only sixteen of the fifty states, with the result that one in four women receiving Medicaid who would otherwise have an abortion is forced to continue her pregnancy), with the rest having private insurance (including insurance through the Affordable Care Act). About 60 percent of abortion recipients already are parents.

Additionally, while abortion in this country is inescapably linked to poverty, it is also very closely associated with race. Women of color are disproportionately represented among abortion patients. Three in five abortion patients are women of color, with black women representing 28 percent, Hispanic women 25 percent, Asian or Pacific Islander women 6 percent, and women of other races or ethnicities 3 percent. White women make up 39 percent of the women having abortions.

Overall, the demographic breakdown of abortion indicates that the barriers this book discusses largely affect poor women of color. This

racially disproportionate burden is consistent with our country's long history of coercive policies around reproduction and parenting targeted at women of color. As a result, along with other issues related to birthing and parenting, abortion access has been a key component of the reproductive justice movement since its inception in the early 1990s.

Reproductive justice is a newer framework for thinking about and critiquing reproductive politics in the United States. The movement relies on the notion that government and society need to guarantee comprehensive reproductive autonomy for everyone, especially women of color and poor women. In particular, reproductive justice focuses on the right to not have a child (which is where abortion fits), the right to have a child, and the right to parent children in a healthy and safe environment. While this book's focus on abortion alone means that it is not a reproductive justice book, we draw heavily from the principles of the movement, especially its teachings that reproductive policy must be evaluated by paying special attention to race and class.

Though the numbers are declining, abortion is very common in this country. Every few years, the Guttmacher Institute produces the most accurate numbers with respect to abortion. Its most recent count indicates that there were 862,320 abortions performed in clinic settings in 2017. This number has been decreasing for some time, as it is down from 1.21 million in 2008. The abortion rate in this country is now lower than has ever been recorded since *Roe*. Put into more relatable numbers, the Guttmacher Institute has calculated that about one in four women will have an abortion by age forty-five. This is down from what had been a commonly stated mantra of "one in three," a previous rallying cry that emphasized how common abortion is, but it still represents a sizable number of women who will terminate a pregnancy in their lifetime.

Ever since Guttmacher released its most recent numbers, people have debated the reasons for the decline, and the phenomenon is still not fully understood. The anti-abortion movement has tried to take credit by claiming that abortion restrictions and anti-abortion sentiment have combined to produce record-low numbers, but that claim is not supported by the evidence. The abortion rate has declined both in states that have enacted major restrictions on abortion and states that have not. States without any major restrictions, such as California, Hawaii, and Oregon,

are among the states that have seen the greatest decline, while states with the most restrictions, such as Arkansas, Mississippi, and North Carolina, have actually seen an increase in the abortion rate. Studies show that laws that regulate the minutiae of running an abortion clinic, laws called targeted regulations of abortion providers (commonly referred to as “TRAP laws”), are the one type of restriction that may be connected with a decline. But while restrictions per se may play a limited role in the decline in abortion numbers, the difficulty that many would-be abortion patients have in simply reaching an ever-decreasing number of abortion facilities is a likely part of this puzzle, a matter we explore in depth in this book.

Much more likely to have contributed to the declining abortion numbers is a widespread decrease in unintended pregnancy. As the Guttmacher Institute explains, “In the absence of sudden, dramatic changes in levels of sexual activity or women’s ability to become pregnant (and there is no evidence of either), the most likely explanation for these broad-based abortion declines is a decrease in unintended pregnancy.” Births increased over the time frame of the drop in abortions, but by nowhere near the same amount. If the unintended pregnancy rate stayed the same, these numbers would have mirrored one another. Although the most recent data still isn’t available, the best evidence shows that contraceptive use has increased in the past decade, partly because of the contraceptive benefits that are part of the Affordable Care Act (these benefits are, at the time of this writing, being targeted by the Trump administration). The increased use of effective contraceptives, including long-acting reversible contraceptives, often referred to as LARCs, which are subject to less user error, has led to fewer unintended pregnancies, resulting in a decrease in the abortion rate.

The decrease in the published abortion rate could also reflect an increase in the number of women self-managing their abortions. Medication abortion—abortion up to ten weeks gestation that involves the use of a drug called mifepristone, followed by another drug, misoprostol, twenty-four hours later—has become more and more utilized by women since this method was approved for use in the United States in 2000. According to Guttmacher, 39 percent of all nonhospital abortions in 2017 were by medication abortion, compared with 24 percent in 2011. These numbers are reflected in the totals already discussed because these