Unplanned Pregnancy and Abortion in the United States and Europe:

Why So Different?

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Acknowledgments

This paper represents the efforts of many talented colleagues and collaborators. Sara Seims, who was the head of the Population Program at The William and Flora Hewlett Foundation at the time this project began, was the driving force in getting this analysis organized and underway. With her leadership and that of her colleague, Peter Belden, also of the Hewlett Foundation, four wonderful European scholars—noted throughout this report and, in detail, in Appendix 1—agreed to put together the data and perspectives summarized in this paper. They did so with great diligence and attention to detail, and kindly answered our many questions with care and good humor. Christine Bachrach took on the task of summarizing the data generated by the four European scholars and did so, as always, with precision, wisdom, and great care. To each of these wonderful colleagues, The National Campaign expresses warm gratitude and admiration.

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Abstract

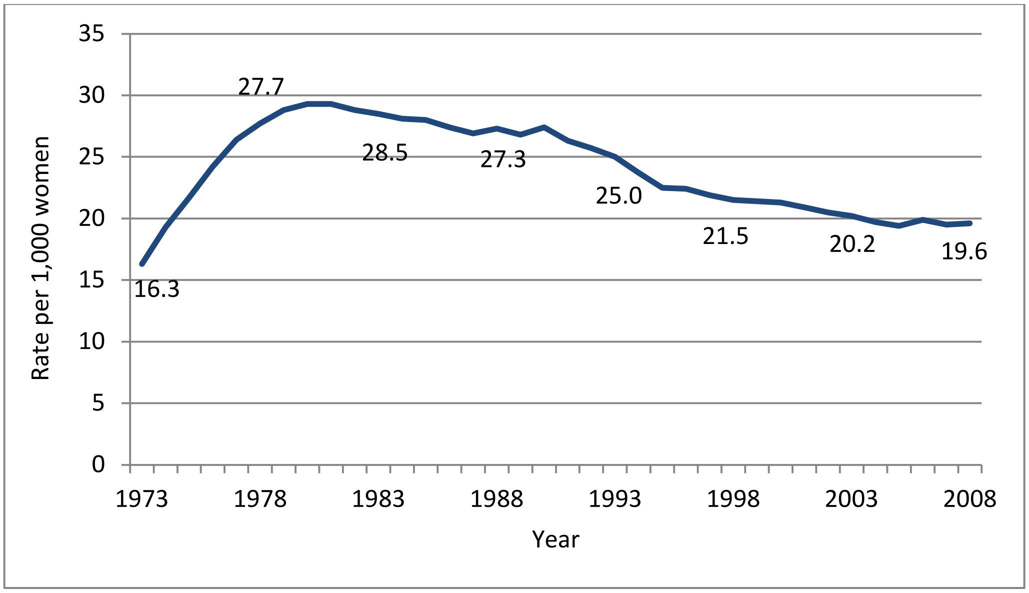
Abortion rates have declined significantly in the United States since 1981, but remain higher than many European countries. In an effort to explore potential barriers to reducing abortion in the U.S., we conducted an exploratory comparative study of the conditions related to contraceptive use, pregnancy, and abortion in the U.S. and in four European countries. Using key informants in each country and publicly available data, we compared the social context, health care systems, access to contraception and abortion, and sexuality education in the five countries. These comparisons suggest that lower levels of contraceptive use in the U.S. during the early reproductive years, combined with lower reliance on the contraceptive pill and, in some instances, IUDs, may help to account for the higher U.S. abortion rate. Other potential contributing factors include higher rates of poverty in the U.S., a problem-focused approach to sexuality education, lack of universal health care, and greater barriers to accessing contraceptive services.

Introduction

Reducing abortion is a widely shared goal in the United States, even though Americans differ sharply on whether legal constraints or improved family planning are the best ways to achieve it.

U.S. abortion rates have declined by 50 percent over recent decades (Figure 1), but still remain higher than in most European countries.[1] Many factors may help to explain these higher rates. The most proximate cause of abortion is, of course, unplanned (especially unwanted) pregnancy, which is the product of patterns of sexual activity, contraceptive use, and sexual partnerships. These in turn are affected by population demographics, legal and health care system environments, cultural norms and values, and social and economic conditions.

Figure 1. Number of Abortions per 1,000 Women age 15 to 44 in the United States, 1973 to 2008, by Year[2]



In 2009, The National Campaign to Prevent Teen and Unplanned Pregnancy, in concert with the Hewlett Foundation, designed a project to explore differences between the U.S. and four European countries that might explain the higher rates of abortion among American women. The study sought to identify differences that could be amenable to policy intervention in the U.S. The study was designed as a preliminary investigation, as the methods relied on publicly available data and key informant reports about individual countries. This report provides a summary of the findings and suggestions for further research. Unless otherwise noted, all results presented here derive from reports written by the key informants for this study. For the sake of simplicity, these papers are fully referenced in Appendix 1 rather than providing individual citations for each finding presented in the summary. Appendix 1 also presents biographical information for each of the authors.

Methods

Four European countries were selected to compare to the U.S.: Belgium, Germany, the Netherlands, and Sweden. Initially, the goal was to choose countries with very low abortion rates. Three of the selected countries—Belgium, Germany and the Netherlands—meet this criterion. Sweden's abortion rate, by contrast, is very similar to that of the U. S. Sweden's higher abortion rate and traditionally liberal approach to reproductive issues provide a useful contrast within the European setting as well as with the U.S.

To gather relevant data about country-specific factors that could influence abortion rates, The National Campaign recruited a collaborator in each European country. Lou Compernolle, a researcher with the Reproductive Health Supplies Coalition provided the report for Belgium; Cornellia Helfferich, a professor with the Protestant University of Applied Sciences at Freiburg, Germany, provided the report for Germany; Ineke Van de Vlugt of the Rutgers Nisso Groep Expert Centre on Sexuality provided the report on the Netherlands; and Katarina Lindahl of RFSU provided the report on Sweden. Collaborators were asked to provide a report on their country's:

- Basic descriptive demography;
- Rates of fertility, pregnancy, and abortion;
- Contraceptive use, including prevalence and method used;
- Access to contraception, including legal restrictions, contraceptive services, availability over the counter, costs, counseling, education of practitioners, and privacy protections for minors;
- Access to abortion, including availability, restrictions, counseling about abortion, and contraceptive counseling for abortion patients;
- Requirements concerning accessibility, content, and staffing of sex education programs for youth as well as accessibility of information about birth control for adults; and
- Social and family policies that provide income and other supports for families.

The initial request to collaborators is included in Appendix 2.

Integration and analysis of the information contained in the resulting reports led to further requests to the European collaborators to fill in gaps and improve comparability of data across the four countries. Once an initial set of tables had been developed that contained reasonably comparable information for the four countries, The National Campaign provided comparable information for the U.S.

The information provided by collaborators is drawn from a wide range of publicly available sources in each country. The time reference for most of the information provided is the late 2000's, and to the extent possible we have centered the focus of this report on the years 2007 and 2008. Obtaining information that was comparable across the countries occasionally proved challenging. In many instances, data were not available for the same years, populations, or outcomes. In other instances, the definitions and methods used to generate estimates differed significantly. We approached these challenges to comparability in several ways. First, when similar information was available from international statistical resources (for example, Organisation for Economic Cooperation and Development, the United Nations Demographic Yearbook, and the U.S. Census international database), we used these estimates instead. Second, in some cases it was possible to improve comparability of estimates by combining age groups or interpolating. Estimates based on either of these two approaches are identified in table footnotes. Where it was impossible to develop comparable estimates, tables include information showing the sources of incomparability among countries. In one case, to provide a comparable estimate of contraceptive costs and access, we asked our collaborators to provide the best information possible on a set of very specific questions about the typical experience in their country. These and other questions we asked sometimes required information that was not documented in official statistics or research; in these instances our collaborators became "key informants" and provided information based on their considerable experience with reproductive health issues in their respective countries.

The comparative methods used in this study cannot provide definitive answers to the question of why abortion rates are higher in the United States than in most European countries. The number of potential explanatory differences far exceeds the number of countries we studied—in other words, we do not have the necessary "degrees of freedom" to permit conventional statistical analysis. The likelihood that the factors influencing abortion in each individual country reinforce each other and interact in unique ways makes the comparison even more challenging. Comparative analyses such as those undertaken here can, however, be useful as exploratory tools for identifying those factors that seem to have the most promise for further analysis, and it is this goal that has guided our analysis.

The context: Demographic and social characteristics of the five countries

Belgium, Germany, the Netherlands, and Sweden are similar to the U.S. in many respects but differ on important dimensions (Table 1). All have substantially smaller populations than that of the United States. Germany is the largest by far, with a population of 82 million in 2008; the other three have populations ranging from 9 to 17 million in size. The U.S. population of 304 million in 2008 is nearly four times as large as Germany's, and over 30 times the size of Sweden and Belgium. The European countries differ in other respects as well: their populations are older, with higher proportions of the population above age 65 (15 to 20 percent vs. 13 percent in the U.S.) and smaller proportions under age 15 (14 to 17 percent vs. 20 percent in the U.S.). All five countries in the study have significant immigrant populations: 14 percent of the U.S. population was foreign-born in 2007 compared with 13 percent in Sweden and Belgium and 9 and 11 percent in Germany and the Netherlands respectively.

One of the key differences often cited as impeding comparison of U.S. and European countries is the racial and ethnic diversity in the United States. Although all countries have nontrivial proportions of foreign-born residents, the U.S. also has a substantial African-American population with origins in slavery and may also have greater racial and ethnic diversity among its native-born population because of its longer history of immigration. Unfortunately, data on racial diversity is not readily available for the European countries we studied in a form comparable to the U.S. In addition, the connection between racial diversity, socioeconomic status, and health disparities is complex and variable across countries.[3] Therefore, exploring this important dimension is beyond the scope of this paper.

All of the countries in the study are wealthy by global standards (Table 2). The U.S. has the highest per capita income of the five (around $47,000 in 2008); income per capita in the four European countries ranges from around $35,000 (Belgium) to $40,000 (Netherlands). The U.S. also has the greatest income disparity (defined as percent with income that is less than one half the median income of the country). The U.S. income disparity rate of 17 percent is more than 50 percent higher than the highest of the European countries (Germany, 11 percent) and over three times the rate in Sweden (5 percent). According to OECD data, all of the countries had similar unemployment rates (6 to 7 percent) except for the Netherlands (at 3 percent).

Education and female employment are important factors influencing the timing and number of births, as are incentives for pregnancy prevention. Average educational attainment among adults is slightly higher in the U.S. (12 years vs. nine to 11 years in the European countries). However, university education appears to be less costly in Europe. Yearly tuitions are under €1000 in Belgium and Germany, and in Sweden tuition is free. Even the €1700 estimate for the Netherlands is low relative to the costs of university education in the U.S., which is over \$17,000 a year (approximately €12,560). In all countries, the majority of women are in the labor force. In Europe, the proportion of women age 15 to 65 who were employed in 2008 ranged from 56 percent in Belgium to 73 percent in Sweden. The U.S. rate was intermediate, at 66 percent.

Family policies differ substantially between the U.S. and the European countries. All of the European countries offer some form of family allowances that provide positive incentives for childbearing. Details are provided in Table 2. There also are a variety of tax benefits associated with parenthood in both the U.S. and Europe. However these vary extensively by income bracket, filing status, and other factors, and they are not summarized here. European countries also offer paid maternity leave, whereas the U.S. does not mandate it. Maternity leave benefits are tied to pre-pregnancy earnings, encouraging women to delay having children until they are earning a good wage. In general, the expectation that childbearing is undertaken only after men and women complete their education and establish their working lives is an important part of the cultural environment related to childbearing in the European countries we studied. Early childbearing, in the words of our Swedish collaborator, is "pitied."

Another key difference among the countries studied is the cultural attitude towards sexuality. Our European collaborators consistently told us that U.S. abortion rates were higher, at least in part, because attitudes towards sex are more repressive in the United States, and this undermines women's ability to avoid unplanned pregnancy. Our collaborators from the Netherlands reflected on the effects of the sexual revolution of the 1960s on their culture, saying that sex is now openly discussed and sexuality is associated with pleasure rather than with shame. We also heard of a positive, non-threatening approach to issues related to sexuality in Belgium. Our Belgian colleagues suggested that many people view the low abortion rate "as a measure of the success of the nation with regard to supporting teenagers in their attitude towards sexuality and the way they handle contraception." In Germany, we were told that sexuality is viewed as an integral part of physical and psychological health. Our Swedish colleague echoed many of these themes, and mentioned that there is no stigma for women who obtain an abortion. The U.S. climate surrounding sexual issues has been far more polarized, as reflected in political struggles over abortion, the content of sex education, and teenager's access to contraception. These differences in cultural environment undoubtedly play a major role in shaping country differences in rates of contraceptive use, unplanned pregnancy, and abortion. They are also likely to play a major role in the policy and access differences that, because they are more amenable to direct influence, form the central focus of this report.

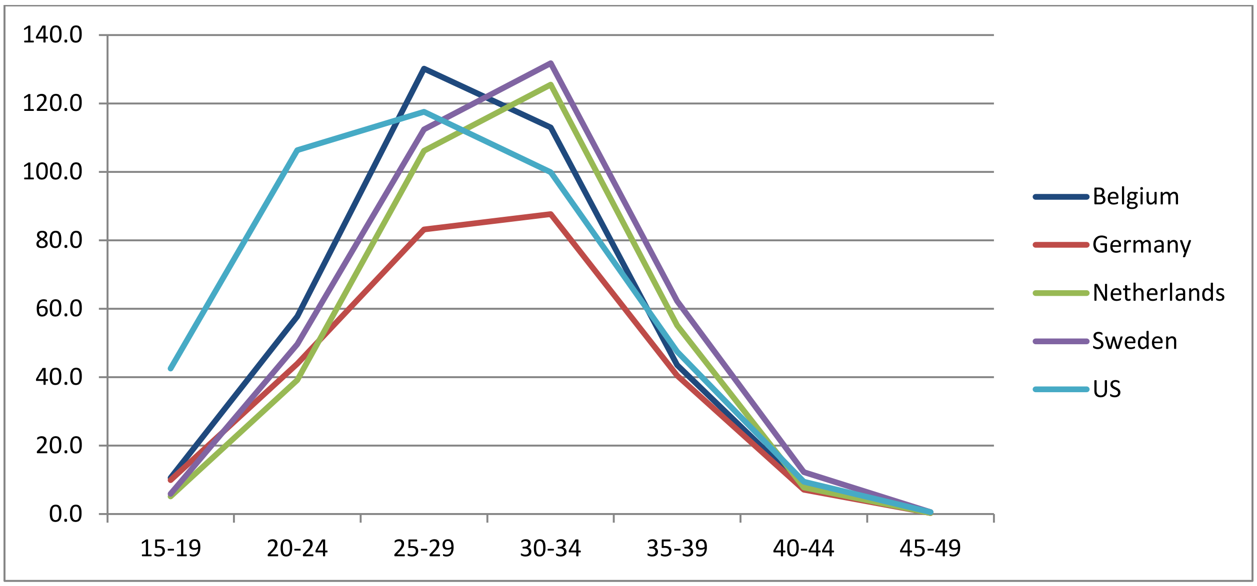
Fertility, pregnancy, and abortion rates

Overall fertility is higher in the U.S. than in any of the four European countries (Table 3). Of the four, Germany had the lowest overall fertility (a TFR of 1.4) in 2008; the others had TFRs of 1.6 to 1.7, substantially lower than the U.S. rate of 2.1. The largest difference in fertility between the U.S. and European countries is in fertility under the age of 25 (Figure 2). U.S. birth rates for women 15 to 19 years of age are four or more times the level in any of the other countries; rates for women 20 to 24 are at least twice as high. Belgium, Netherlands, and Sweden have delayed patterns of childbearing but relatively high rates of childbearing at ages 30 and above; average age at first birth for these countries is 29.

Germany also has a delayed pattern of childbearing but its rates for women 25 to 34 years of age are substantially lower than those observed in the other countries.

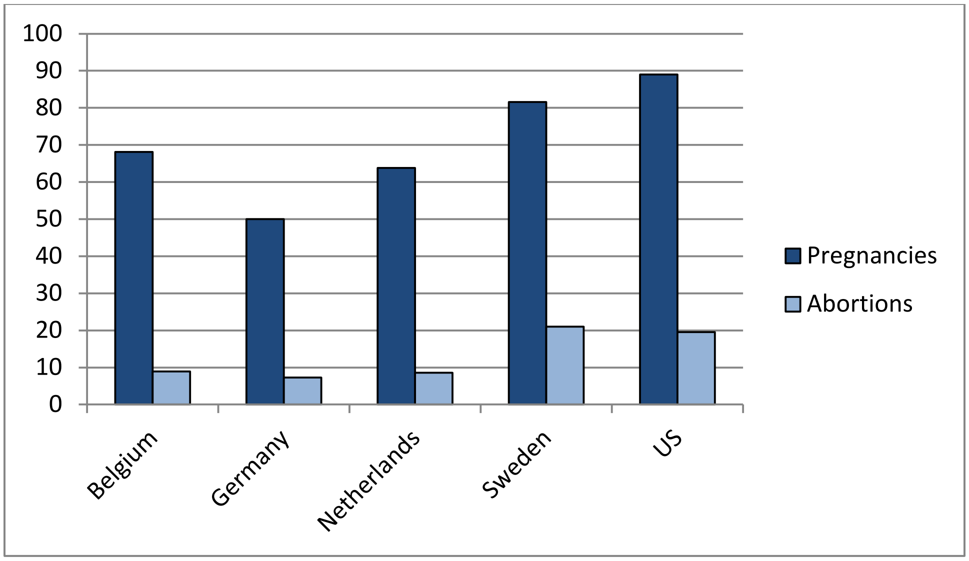
The U.S. also has a higher pregnancy rate than the four European countries, but Sweden's pregnancy rate is almost as high as that of the U.S.[a] (Table 4 and Figure 3). Sweden's high pregnancy rate is accompanied by a high rate of abortion: at 21 per 1000 women age 15 to 44, it is more than twice the level seen in the other European countries and slightly higher than the U.S. rate of 20. Sweden and the U.S. also have high percentages of pregnancies ending in abortion (25 and 22 percent, respectively); the proportions in the remaining three countries are all less than 10 percent. Differences in abortion rates for teenagers parallel the inter-country differences in abortion rates for all women.

Figure 2. Births per 1,000 Women by Age of Mother and Country, 2007



[a] Pregnancy rates include only births and abortions; fetal deaths are excluded to permit comparable estimates among countries.

Figure 3. Pregnancies and Abortions per 1,000 Women Age 15 to 44, 2007



In summary, Sweden and the U.S. both have higher rates of pregnancy and abortion than the other countries. Higher levels of fertility in the U.S. largely reflect high rates of early childbearing (under age 25) not seen in the European countries.

Sexual relationships and sexuality education

As other studies have shown, the differences between Europe and the United States in early pregnancy and abortion do not reflect differences in sexual activity among youth (Table 5). The median age at first sexual intercourse was 17 years for all countries except Germany (median age 16). The U.S. has a higher legal age of consent for intercourse than the European countries (at least 16 and higher in some states, matched only by the Netherlands and only if the partner is an adult rather than an age-peer). Crude marriage rates are higher for the U.S., at seven compared to four to five per 1,000 population in Europe, and women in the U.S. marry substantially earlier than their European counterparts. In 2004, median age at marriage was 25 years in the U.S. compared with 27 to 31 years in the four European countries. Cohabitation of unmarried partners is prevalent in all countries for which we have data; between 1998 and 2000 the proportion of adults age 25 to 34 who were cohabiting with a partner was highest for Sweden (56 percent) and lowest in Belgium (22 percent). The prevalence of cohabitation in the U.S. was 36 percent. However, research suggests that the nature of cohabiting unions in the U.S. is different on average than in Europe, with Americans changing partners more frequently than Europeans.[4] This, in turn, may play a role in contraceptive use and use-effectiveness.

In all countries, most young people receive some form of sex or sexuality education in schools. However, legal requirements and the timing, extent, and content of education vary dramatically both across and within countries. For example, within Belgium sexuality education is required in schools subsidized by the government in the Flanders region, but not in Wallonia. In Germany, concepts, curricula, and guidelines for school sex education are separately determined within each of the 16 federal states. The

Netherlands no longer requires sex education, but it is implemented in many schools using approaches formulated at the school level. Sweden made sex education mandatory in 1955. National policy specifies basic requirements and central school authorities provide curricula, but implementation is delegated to the school level where curricula can be tailored to fit local needs. In the U.S., state-level sex education policies vary widely: only 20 states mandate sex education, but more specify what sex education has to include if it is provided. For example, 36 states require that sex education include abstinence, and 18 require information on contraception.

Given these variations, it was not possible to develop precise metrics for comparing the content of sex education across the five countries studied. However, some common themes recur in most of the European collaborators' descriptions: respectful relationships, communication, decision-making, social and emotional aspects of sexuality and relationships, as well as biological and medical aspects, safer sex and birth control. In the U.S., those aspects of the sex education curriculum that are most frequently regulated and tracked in research are abstinence (saying no to sex), contraception, condoms, HIV and sexually transmitted disease, and the risks of pregnancy. While these elements suggest important differences between the U.S. and Europe in the emphasis given to various aspects of sex education, we do not have information on how these translate into specific curricula or classroom experiences.

In all countries, sex education occurs not only in schools, but also in the home, in youth and family planning centers, and through educational campaigns. In all countries, sex educators are supported with materials and curricula created by organizations that specialize in reproductive health and sexuality issues.

Contraceptive practice in the U.S. and Europe

Comparing rates of contraceptive use across the five countries proved to be challenging. While most countries were able to provide nationally representative data for some time during the 2000's, Sweden's most recent information is from 1996. Germany's data refer to men and women combined, while the other countries report data for women separately. Further, the specific measures used, the age groups for which they were reported, the specific methods reported, and the population considered "at risk" of using contraception also varied from country to country. Because of the importance of contraceptive use in influencing abortion rates, we used the information provided to generate a set of computed estimates that could be roughly compared, but because of the many differences, conclusions are necessarily speculative.

Comparing contraceptive use by age was particularly difficult. Estimates of contraceptive use by five-year age groups were available only from Belgium and the United States. The Netherlands, Germany, and Sweden provided less detail by age. To estimate percentages for five-year age groups for all countries, we interpolated percentages within the age ranges covered by reported data using the age pattern of use in Belgium as a guide. The original reported data are shown in Table 6 and the complete set of rates including interpolated values are shown in Table 6 and Figure 4. We did not adjust for gender, reference date, or risk population.

The differences, however, are striking. The U.S. differs from the four European countries both with respect to the pattern of contraceptive use by age and the methods used (Table 6 and Figures 4 and 5).

Figure 4. Percent of Sexually Active Women Using Contraception by Age and Country

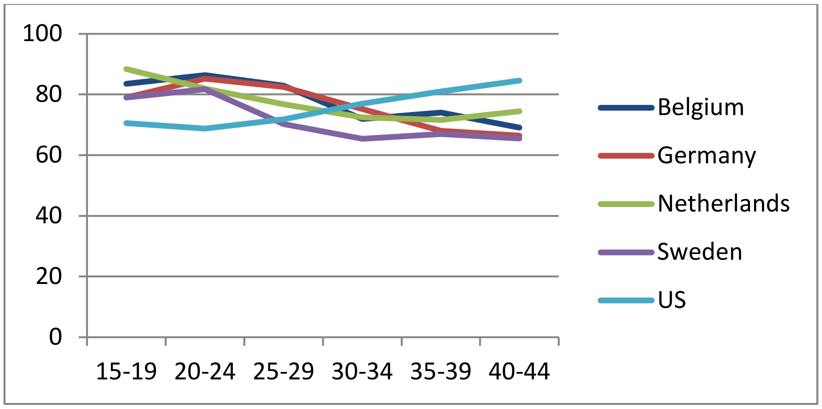
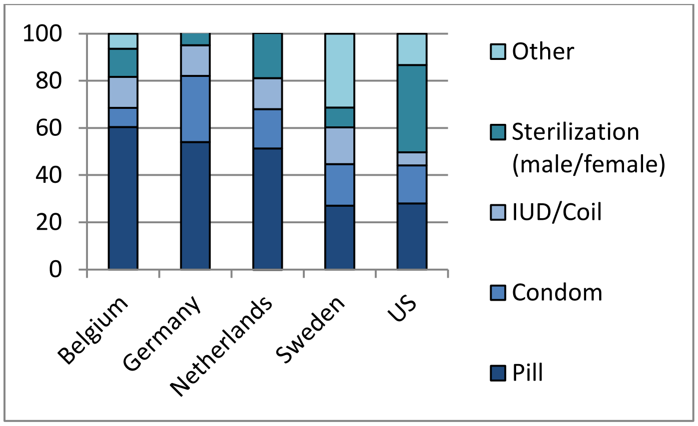


Figure 5. Percent of Women Using a Method of Contraception by Method and Country



Among the European countries, the proportion of sexually active people using contraception is generally higher at younger ages and declines somewhat over time. In the United States, the opposite pattern is evident. Sexually active young women in the U.S. (under age 25) have substantially lower levels of current use than their European counterparts. The most comparable contrast is with Belgium. Among Belgian women who had had sexual intercourse in the last 12 months, the percent who were currently using a method of contraception was 84 and 86, respectively, among women 15 to 19 and 20 to 24. In the U.S., among women who had had sex within the past three months, the percentages were 71 and 69 percent, respectively. Since the denominator for Belgium may include more women who recently became sexually inactive, the comparison may be conservative.

At older ages, sexually active U.S. women are more likely to use a contraceptive method than their European counterparts. The reason for this is clear when one examines the distribution of method use among contraceptors in each country (Figure 5). Sterilization is the most common method of contraception among U.S. women: 37 percent of contraceptors in the U.S. are relying on male or female sterilization, compared with from seven percent (Germany) to 19 percent (Netherlands) in Europe. By contrast, in all of the European countries but Sweden, the oral contraceptive pill and other reversible hormonal methods predominate. The IUD is also more popular in Europe: from 13 to 16 percent of contraceptors in the European countries use an IUD, compared with only six percent in the U.S., although this number is increasing. Condom use in the U.S. is similar to levels reported for Sweden and the Netherlands (16, 18, and 17 percent respectively); low in Belgium (eight percent) and relatively high in Germany (28 percent). Sweden stands apart from its European neighbors in its relatively low reliance on oral contraceptives. Only 27 percent of Swedish contraceptive users report using the pill, closer to the U.S. rate of 28 percent than to the much higher rates (51 to 60 percent) in Belgium, Germany, and the Netherlands. This suggests that the high abortion rate in Sweden may be, in part, a product of lower reliance on either sterilization or hormonal methods.

Inter-country comparisons of contraceptive use at first and last sexual intercourse (shown in Table 6) are limited to men and women in the younger age groups. Among women, the percentage that used a method at first sexual intercourse appears lowest in the U.S. and Sweden. The Swedish estimates, which are available only for men and women combined, suggest a relatively low level of early use in contrast to the higher levels of current use estimated previously for young Swedish women. This may cast doubt on the earlier estimates, or may simply reflect a lower prevalence of use at first sex. These estimates corroborate the low levels of use among young women in the U.S. and the higher levels of use among the remaining three European countries. The estimates pertaining to method use at last intercourse also refer to young age groups, ranging from 14 to 17 years of age in Germany to 18 to 24 in Sweden. The data for the Netherlands are not comparable, referring to the percentage that always used a method with the last partner. These estimates suggest very high levels of use at last intercourse in Germany, and comparable levels of use among females in the U.S., Sweden, and Belgium.

In summary, our data suggest that women in the United States and the four European countries differ substantially in their patterns of contraceptive use. Compared to their counterparts in most European countries, American women are generally less likely to be using methods early in the reproductive years, less likely to rely on hormonal methods, and more likely to rely on sterilization. Sweden seems to conform to the European pattern with high levels of early contraceptive use, but is similar to the U.S. in its low levels of reliance on oral contraceptives. These conclusions must be tempered with the caveat that there are many sources of incomparability in estimates across the five countries such as the differences in the dates and age groups to which they refer.

Access to reproductive health care: The health care system context

Variations in access to contraception and abortion are obvious candidates for explaining inter-country variations in pregnancy and abortion rates. Access is influenced in part by the structure and policies of country-specific health care systems that frame the delivery of contraceptive and abortion services. All of the countries, including the U.S., have some form of publicly-financed health care, but only the European countries have systems in place that essentially provide universal access to health care. Further, the ways in which health care costs are financed, the requirements for co-payments at the time of service, and the relationship of service providers to the state vary significantly:

- In Belgium, health care is financed by compulsory insurance (funded through social security contributions and taxation) covering 99.4 percent of the population. Costs are subsidized for low-income groups. Patients have free choice of service providers, which include independent physicians and specialized clinics. Patients pay a co-payment for each visit to a provider.

- The Netherlands also has a system of compulsory health insurance provided through private insurers; insurance costs are paid mainly by individual and employer contributions, which are linked to income. Private physicians and hospitals are the main sources of health care. No co-payments are collected at the time of service. This system is supplemented by a state-funded program for long-term care.
- Germany has a dual system whereby most of the population is covered under compulsory public insurance, but the self-employed and high earners are privately insured. The government-run compulsory system is financed through self and employer contributions, with premiums scaled according to salary. Health services are provided by independent doctors who contract with the government system. Co-payments are required at the time of service, but no more often than once in every three months to the same physician.
- The Swedish health care system is financed primarily by taxes. Local county councils have responsibility for health care planning and delivery, and care is delivered through physicians, midwives, clinics, and hospitals. Patients pay nominal fees for services and prescriptions up to specified caps on yearly costs; additional health care costs incurred beyond the cap amounts are paid by the government.
- The U.S. has a dual system of private and public insurance for health care.[b] Public programs include Medicaid (for low-income populations) and Medicare (for the population age 65 and older). Private insurance is largely provided through employer and individual contributions. The terms of private health insurance plans vary substantially. Co-payments are generally required at the time of service and plans usually cover costs that exceed predetermined annual amounts. An estimated 17 percent of Americans lacked any health insurance coverage in 2009.[5]

According to OECD data, 45 percent of health care costs were paid with government funds in the U.S.; in Germany and Sweden the comparable proportions were 77 and 82 percent, respectively (data not provided for Belgium and the Netherlands). The greater financial contribution of the state in providing health care access in the four European countries suggests that lower income women may have more reliable access to contraceptive services in Europe than in the U.S.

Contraception: Access to services and costs

We explored several specific aspects of access to contraception, including legal requirements and availability of contraceptive services. Table 7 shows information on legal aspects of access to contraception. Regulations that govern which contraceptive methods may be obtained over-the-counter and which require prescriptions appear fairly comparable across countries (not shown in table). In general, condoms and spermicidal preparations are available for direct purchase, whereas IUDs, oral contraception, and other hormonal methods require a prescription. Emergency contraception is available without prescription in all countries except Germany; in the U.S., those under age 17 must have a prescription. Although the specific language used to define the confidentiality of reproductive services for minors varies across the four European countries, all provide confidential services to youth starting from early adolescence except in cases of serious risk to the minor's health and when the minor is

[b] With a very few exceptions, changes to the U.S. health care system legislated in 2010 are not considered in this summary.

incapable of providing informed consent. In the U.S., each state regulates provisions for providing health services to minors. Only 21 states explicitly require that teens under age 18 be allowed to obtain contraceptive services without parental permission, suggesting that minors in the United States may often face more obstacles than their European counterparts.

Table 8 shows indicators of access to contraceptive services in the five countries in the study. We asked our collaborators to provide information on the types of providers that most commonly provided contraceptive services, information on the number of providers, and typical waiting times for getting an appointment. Figure 6 shows the ratio of the number of providers to the total population in each country. The data on number of providers reflects the top two types of providers that most commonly provide contraceptive services. In all countries but Sweden, these are general practitioners and gynecologists. In Sweden, midwives provide virtually all contraceptive services. The U.S. has the lowest ratio of providers to population (3.9), but the Netherlands is only slightly better supplied, with a ratio of 4.7. The provider-to-population ratio is highest for Belgium, with a ratio of 12.7.

Figure 6. Providers per 10,000 Population (Two Most Common Providers)

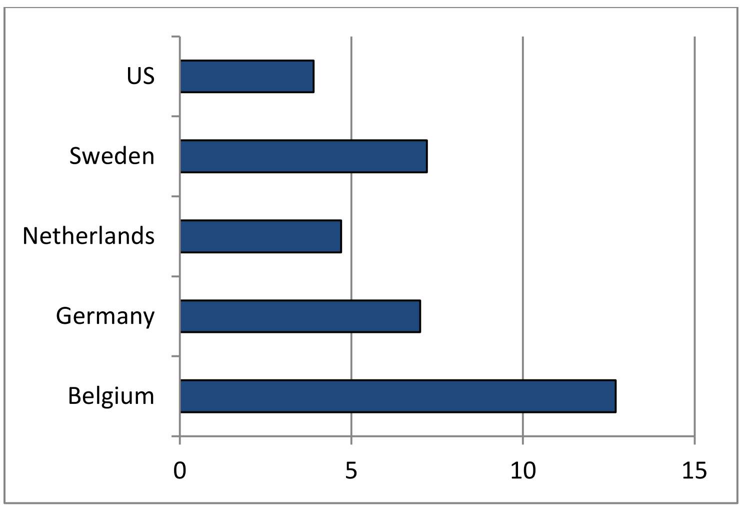
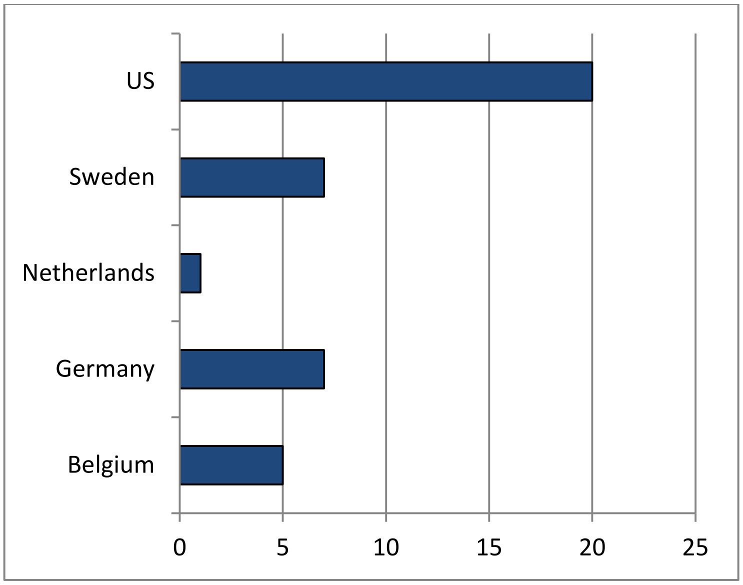


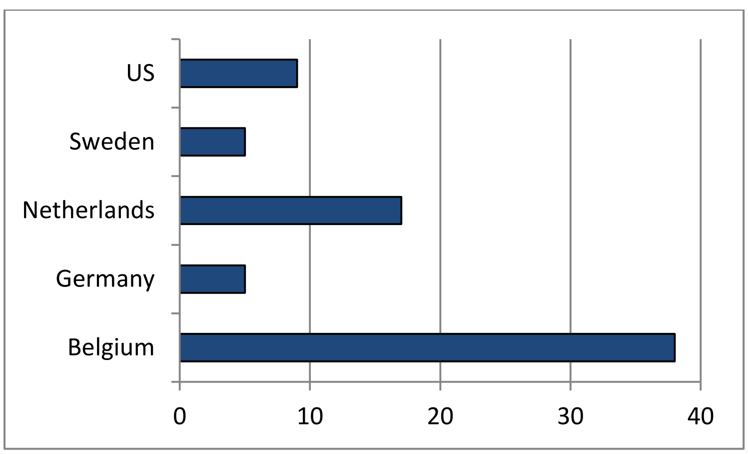
Figure 7 shows the average waiting time to appointment for the type of provider in each country with the shortest waiting time. The U.S. also fares the least well by this measure, as the average waiting time to appointment for general practitioners is nearly three weeks. By comparison, waiting times for midwives in Sweden and general practitioners in the other European countries were a week or less.

Figure 7. Estimated Wait Times (Days) for Provider with Shortest Wait Times



A third comparison relates the total number of clinics providing contraceptive services to the total area of the country (Figure 8). The U.S. fares better than Sweden and Germany on this measure, but worse than the two smallest European countries in the study, the Netherlands and Belgium. In terms of these measures of access, contraceptive services appear to be most accessible in Belgium, and least accessible in the U.S.

Figure 8. Clinics per 10,000 sq. Kilometers



The cost of contraception also varies in the countries we studied. To compare costs, we asked each collaborating country author to provide us with information about out-of-pocket costs to the average adult woman for two specific methods:

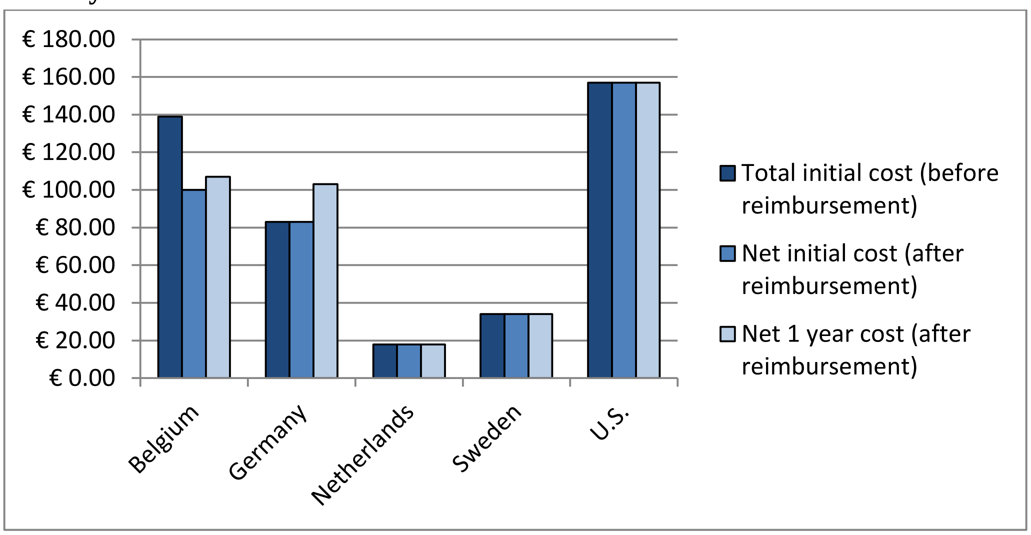
- A basic combined oral contraceptive pill that is typical of those used by women in the country. By basic, we meant to exclude formulations that are multi-phasic or otherwise enhanced to improve performance.

- A hormonal IUD (called Mirena in the U.S.).

For each method, we asked for the costs of a visit with a provider to get a prescription or have an IUD inserted, the IUD itself or a one-year supply of pills, and any follow-up visits routinely required over the course of the initial year of use. We also asked collaborators to differentiate between costs the woman was required to pay at the time of the visit (for later reimbursement) and costs that were not reimbursed. We included the full cost of the IUD in our estimate for first year costs rather than prorating cost over the life of the IUD. The prorated cost may have a significant impact on method choice, but the interest here was in the actual cost to the woman in the first year of use.

Table 9 shows the detailed information on the costs of the two methods by country.[c] Figures 9 and 10 summarize the costs to the woman for initiating the method (including the total cost before reimbursement and the net cost afterwards) and the net costs for one year of use, by country.[d]

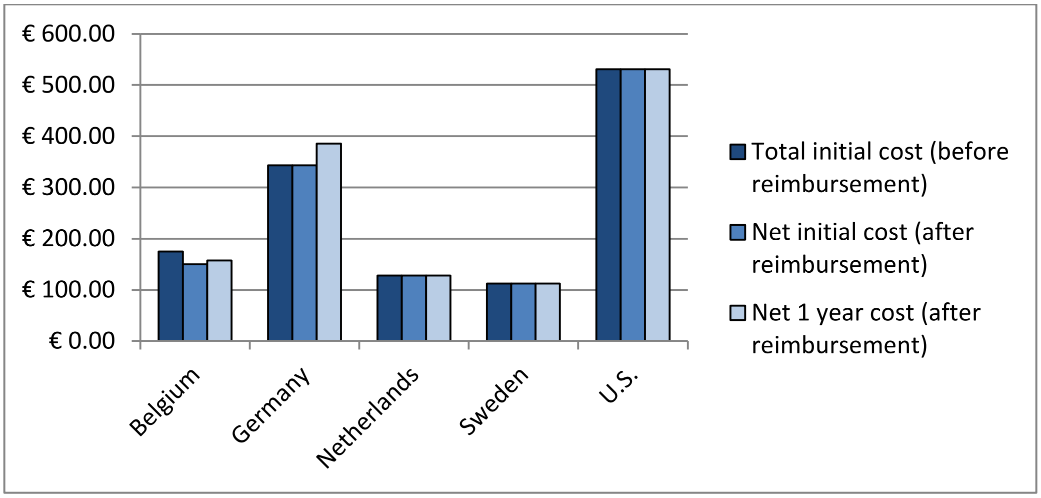
Figure 9. Initial and One-year Costs (Euros) for a Basic Oral Contraceptive Pill Formulation, by Country



[c] Comparable costs in Euros were calculated using currency conversion rates as of July 1 2008: 1 U.S. dollar = .63 Euro = 6.02 SEK.

[d] § Costs for Germany reflect the average of the range of costs given in Table 9.

Figure 10. Initial and One-year Costs (Euros) for a Hormonal IUD (Mirena), by Country



As the figures demonstrate, costs of obtaining contraception vary substantially across European countries, with costs far higher in Belgium and Germany for oral contraceptives, and in Germany for the hormonal IUD. The U.S., however, has by far the highest annual costs for contraception. Even among women with private insurance, the cost of oral contraceptives is 47 percent higher in the U.S. than in the next highest European country, Belgium. Similarly, the price of the hormonal IUD in the U.S. without insurance ($846) is 37 percent higher than even Germany. However, even many insured women in the U.S. do not have adequate coverage for the IUD. As of 2004, only 40 percent of insurance plans covered the IUD, and a recent survey of an urban gynecology practice found that 55 percent of privately insured patients would be required to pay over $500 for an IUD.[6,7] As of August 1, 2012, the Affordable Care Act requires that most new health insurance policies in the U.S. waive all co-pays and deductibles for contraceptive supplies and services.

Abortion: Access and costs

Some form of abortion "on demand" is available within each of the countries studied. However, differences in how abortion is framed in country laws and the regulations governing abortion may play an important role in shaping abortion rates. In Germany, for example, abortion is seen as a legal offense, but is exempted from punishment under certain circumstances (which effectively provide access to abortion on demand up to 12 weeks). In Sweden, the Netherlands, and Belgium, abortion is viewed as legal prior to specific gestational ages. In the U.S., abortion is legal prior to viability.

All European countries impose limits on the gestational ages in which abortions can be obtained on demand (see Table 10). In the U.S., some states specify a specific limit (generally 24 weeks or the third trimester) beyond which abortion on demand is no longer available; others use "fetal viability" as the limit.[e] As noted above, Germany permits abortion on demand only until 12 weeks gestation; Belgium sets the limit at 14 weeks, Sweden at 18, and the Netherlands at 24. Only two clinics in the Netherlands perform abortions beyond 13 weeks, and these have set a "practical limit" of 22 weeks. All countries

[e] While the Supreme Court ruled that women have the right to an abortion before the fetus reaches viability, several states now restrict abortion at 20 weeks, which precedes the general standard of viability of 24 weeks.

provide for legal abortions after mandated limits to save the life and health of the mother. In Belgium and the Netherlands, exceptions may also be made if the child has a serious and irremediable disorder. Two countries (Belgium and Sweden) require approval of late abortions (by a panel and two physicians, respectively); in the remaining countries the decision is left to the judgment of the woman's doctor.

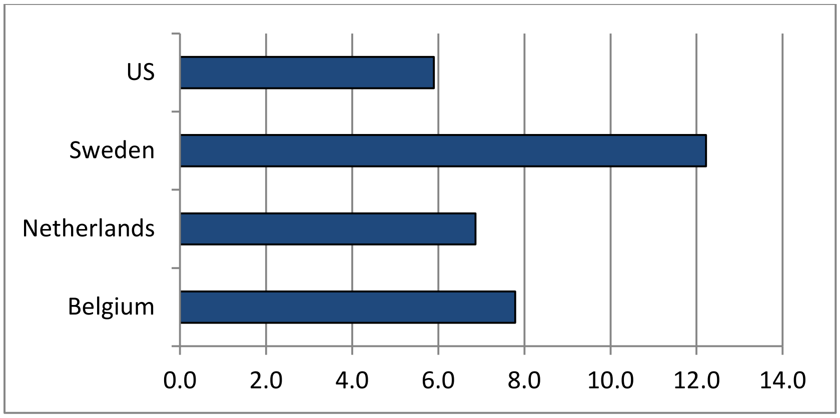
Germany, Belgium, and the Netherlands all require an initial meeting with a physician, counselling, and a waiting period before the abortion is performed—from three days in Germany to six days in Belgium. Sweden requires neither counselling nor a waiting period. In the U.S., 25 states require a waiting period (typically 24 hours), and 34 require counselling. Where required, counselling usually covers information about the procedures and its risks, alternatives to abortion, and often a determination that the woman is sure of her decision. In the U.S., 23 states require that counselling include information on fetal development, and 10 mandate that counselling include information on the ability of a fetus to feel pain.

In the Netherlands and Germany, women under age 16 must obtain parental permission before having an abortion, but in both cases doctors (and/or social workers, in the Netherlands) may make a judgment that the procedure can be done without parental permission. Parental involvement is not mandated (but may still be encouraged) in Sweden and Belgium. In the U.S., 35 states have some requirement for parental notification consent: 20 states require consent, 11 notification, and four require both.

Belgium and Germany have professional conscience laws that permit doctors to refuse to perform abortions. These laws are limited in various ways: in Germany they cannot be invoked if the woman's life is in danger and in Belgium doctors must immediately inform the woman so that she can go elsewhere. No conscience laws exist in Sweden or the Netherlands. Laws permitting doctors to refuse to participate in an abortion exist in 46 out of the 50 states in the U.S.; 43 U.S. states permit institutions to refuse to perform abortions, although some of these limit refusal by institutions to those with religious affiliations or private ownership.

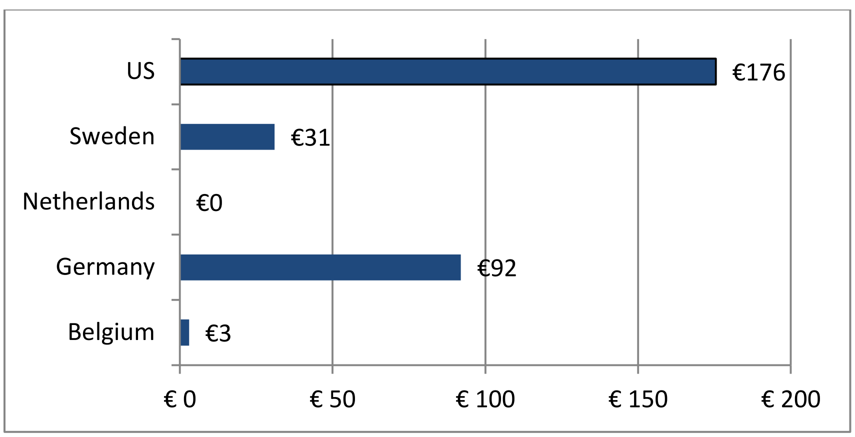
Abortion access is difficult to compare across countries; Table 11 provides selected indicators. In Belgium, the Netherlands, and Sweden, abortions are performed in clinics and/or centers and hospitals. Of these three countries, Sweden appears to have the highest access measured as the ratio of providers per million population (Figure 11). The U.S. has the lowest ratio of providers per million population (5.9). In 2008, 35 percent of U.S. women lived in a county with no abortion provider. The figure does not provide an estimate for Germany because the number of providers is uncertain. Nearly 4 out of 5 abortions in Germany are performed by gynecologists, who are well represented as a ratio to the overall population; however, it is unknown how many of Germany's gynecologists perform abortions.

Figure 11. Abortion Providers per Million Population



The other major dimension of access is cost. Costs of abortion reported by our European collaborators varied substantially across the countries, from no cost in the Netherlands, €3 in Belgium, and €31 or less in Sweden to €460 in Germany. However, when accounting for the costs borne by the state, these differences are greatly diminished. In Germany, for example, most abortions are covered by state funds: less than 20 percent are self-paid. In Sweden, costs of abortion are included in the caps on annual health care expenditures that individuals have to pay. In the U.S., the most recent estimate of the cost of a first-trimester surgical abortion comes from 2001. At that time, the average cost was $372, the equivalent of €234. In contrast to Germany, only one-quarter of abortion clients in the U.S. had their procedures covered by insurance. Figure 12 summarizes costs for the average client across the five countries. Taking differences in reimbursement into account, abortion is most costly in the U.S. and cost-free or low-cost in all European countries except Germany.

Figure 12. Average Out-of-Pocket Cost for Abortion by Country



By most measures, abortion is much less accessible in the U.S. than in Europe. It is more costly, on average, and there are fewer providers in relation to the population. Parental consent and notification requirements for minors' abortions are significantly more restrictive in the U.S. than in Europe. By some measures, however, U.S. women seeking abortion face fewer obstacles: gestational limits for abortion on demand are later in pregnancy, and waiting periods are shorter than in many of the European countries we studied. By nearly all measures, Swedish women experience easier access to abortion than either U.S. women or women in other European countries.

What explains the differences in abortion rates?

This comparative sketch of conditions in four European countries and the U.S. reveals many factors that could help to explain the higher rates of abortion in the United States compared with Germany, the Netherlands, and Belgium, and many factors that are unlikely to help explain differences. Our summary begins by enumerating those factors that do not differ substantially between the U.S. and Europe, or differ in ways that would increase European abortion rates relative to the U.S. These factors are unlikely to account for the lower European abortion rate. It then proceeds to summarize factors for which the U.S. differs from Europe in ways that could elevate the U.S. abortion rate relative to Europe. These can be considered potential levers for reducing abortion rates in the U.S. Finally, it considers the implications of Sweden—with many characteristics similar to the other European countries but an abortion rate higher than that in the U.S.—for the likelihood that manipulation of these potential levers could affect U.S. abortion rates.

What doesn't explain the differences?

Factors affecting access to abortion. There are few indications that greater access to abortion explains the high U.S. rate of abortion. Abortion is costlier in the U.S. than in Europe and there are fewer abortion providers relative to the size of the population. In some respects—the absence of multi-day waiting periods and sharp cutoffs by gestational age—the U.S. does have greater access. In other respects—in the regulation of abortions for minors and the ability of doctors and institutions to refuse to perform abortions—access is equal to or worse than in Europe. Furthermore, for both the U.S. and Sweden, it is not only a greater percentage of pregnancies that end in abortion but also higher pregnancy rates that drive up the rate of abortion relative to the three low-abortion European countries. This suggests that in both Sweden and the U.S., abortion rates are driven by high rates of unplanned (and especially unwanted) pregnancy. Although comparable data on unwanted or unplanned pregnancies were not available for the four countries, recent research estimates indicate that less than one-third of pregnancies in Western Europe are unintended compared to nearly one-half in the U.S. In Northern Europe, the percentage unintended was slightly higher (36%) than in Western Europe.[8]

Patterns of sexual activity. Youth in the United States and the four European countries begin their sexual experience around the same ages. Since marriage occurs at much younger ages in the U.S., and married women are less likely to obtain abortions than single women, this is unlikely to explain a higher U.S. abortion rate. If, as has been suggested by others, Americans switched partners substantially more often than Europeans, this could have some effect on both pregnancy wantedness and use of contraception.

Patterns of education and employment. The U.S. has a higher average level of educational attainment than the four European countries, and levels of female labor force participation that are within the range seen in Europe.

What might explain the differences?

Contraceptive use. Although our information on contraceptive practice suffered from problems of comparability, the data we have suggest important differences among the countries. The three low-abortion countries all show a much higher reliance on oral contraceptives than the U.S. or Sweden; sterilization is the most common method in the U.S., whereas Swedes appear to rely on a diverse mix of methods. The age patterns of contraceptive use also vary significantly. In all of the European countries, women start out their reproductive years with very high levels of contraceptive use; these levels tend to decline gradually after a peak in the early 20s. In the U.S., women in their teens and twenties have lower levels of use than their European counterparts; it is only at the later ages, when sterilization becomes prevalent, that U.S. contraceptive prevalence rises above the levels seen in Europe. Sweden appears to have lower levels of contraceptive prevalence than other European countries at most ages. However, this difference should be interpreted with caution as the data from Sweden are over a decade old. The overall pattern of results suggests that improving contraceptive use among young women in the U.S. might go a long way towards reducing unplanned pregnancy and, in turn, abortion rates.

Sexuality education. The differences between sexuality education in the U.S. and Europe seem to have less to do with the extent of education in the schools and local control over what is taught than with the general cultural approach to sexuality and youth. In the U.S., the emphasis is on the risks of sexual activity, such as non-marital pregnancy and sexually transmitted infections. The U.S. is sharply divided on whether adolescents should only be taught to abstain from sex, or also be given information about contraception. European sex education, based on the accounts from the four countries examined, is more likely to emphasize sexuality as a positive aspect of development and to focus on healthy relationships, as well as preventing pregnancies and infections. We have no way of demonstrating whether these differences play a significant role in improving contraceptive practice among sexually active young people, but a causal link is plausible and a likely candidate for further research.

Health care systems. The European countries we studied have systems that provide universal access to health care; the U.S. did not as of the late 2000's. In the U.S., a significant proportion of the population is uninsured. The greater role of the state in securing health care access in the four European countries suggests that women may have more reliable access to contraceptive services in Europe than in the U.S. This may play a role in the higher levels of contraceptive use among young women in Europe.

Access to contraceptive services. Although our estimates of the numbers of providers in relationship to population size suggests lower access for U.S. women than their European counterparts, access by this measure is almost as low in the Netherlands as in the U.S. The more striking difference is in the waiting time for an appointment with a physician. The estimate for the U.S. is nearly three weeks whereas in all of the European countries it is one week or less. Minors in the U.S. are more likely to be required to get parental consent, or have parents notified, if they want to obtain prescription contraceptives. Both of these factors could easily discourage or delay obtaining contraceptive protection, and help to explain lower rates of contraceptive use among young women in the U.S.

Cost of contraception. The cost of contraception could play a significant role in the high unplanned pregnancy rates in the U.S. Relative to the European countries we studied, the cost of contraception in the U.S. is far higher, even among those with insurance coverage. It costs more to obtain hormonal methods of contraception in the U.S. than in the European countries. Although it is apparent in all countries that the specific out-of-pocket costs encountered by women depend on a host of factors, our estimates for a typical adult, middle-class woman suggest that U.S. women pay substantially more than German women for both a year of protection using a typical low-dose oral contraceptive and for a hormonal IUD. They pay at least three to four times as much for these methods as women in Sweden and the Netherlands. Because our cost estimates are based on key informant information, they should be regarded with some caution. However, the magnitude of the differences suggests that contraceptive costs may be an important factor discouraging effective contraceptive practice in the U.S. With the Affordable Care Act Women's Preventative Services provision implemented on August 1, 2012, copayments for contraceptive services are eliminated for most women with insurance in the U.S., which could potentially play a dramatic role in reducing unplanned pregnancy and therefore abortions in the U.S.

Demographic, economic, and social factors. As mentioned earlier, one potentially important demographic difference between the U.S. and the four European countries we have not accounted for is the racial and ethnic diversity of the population. Although the U.S. and the European countries all have non-negligible proportions of non-native residents, the native-born U.S. population may be more ethnically and racially diverse than in Europe. U.S. abortion rates are substantially higher among African Americans than among women of other races. However, excluding African Americans from calculation of the U.S. abortion rate reduces the rate for women age 15-44 only to 14.4, still substantially higher than the rates observed in Belgium, Germany, and the Netherlands.[9,10]

Another difference that could influence abortion rates is the higher percent of the U.S. population living in poverty. In the U.S., rates of unintended pregnancy are over five times as high among women living in poverty than among those with incomes over twice the poverty level.[11] The proportion living in poverty in the U.S. was from 50 percent as high to three times the levels found among European countries.

A final set of differences that may help to explain the lower abortion rates in Europe as compared to the U.S. are the strong cultural expectations that childbearing be delayed until education is complete and working lives are established. Although Europe has slightly lower levels of educational attainment than the U.S., childbearing is delayed to a much greater extent and early childbearing is strongly discouraged in all four of the European countries. This cultural pattern—and the costs of violating it—may help to explain higher levels of contraceptive prevalence among young women in Europe.

What about Sweden?

Sweden shares many characteristics with the three European countries that have low abortion rates. It has universal health care, offers paid maternity leave and child subsidies, has excellent access to contraceptive providers, low costs of contraception, and universal sex education. Yet, Sweden's rates of contraceptive use fall below those of other European countries at most ages and Swedish women who do use contraception tend to rely on less effective methods. These findings point to the importance of contraceptive use, but also to the possibility that access to contraception is not the main driver of effective use. The fact that Sweden has, overall, more liberal policies concerning abortion than the other European countries may play a role in its poorer contraceptive use. It is possible that high levels of tolerance for abortion lead Swedish women to use abortion as a substitute for contraception, leading to higher rates of unwanted pregnancy and abortion. Does this mean that tightening abortion access in the U.S. would lower its abortion rates? This seems unlikely, since by most measures the U.S. already has poorer access than European countries with substantially lower abortion rates. Rather, it seems likely that the patterns of contraceptive use producing high abortion rates in the U.S. and Sweden are driven by different combinations of factors.

In each of the countries we studied, rates of abortion reflect a complex system of social, cultural, and institutional factors. Change to one part of a system can have ripple and feedback effects that can influence the whole system, and equally plausibly can produce minor or dramatic changes to an outcome such as an abortion rate. Even with a fully developed and adequately powered quantitative study, it would be difficult to discover how big an effect changing just one or two of the factors would make. This means that policy must be guided by "best evidence:" a solid theoretical understanding of the mechanisms linking modifiable predictors to abortion rates and a solid empirical understanding of the characteristics and distribution of these predictors in the population. This report has sought to generate suggestive evidence on which predictors might account for the high rate of abortion in the U.S. relative to Europe, and which might be most fruitfully explored in future research.

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3. See, for example, Darroch, J.E., Frost, J.J., Singh, S. (2001). Teenage Sexual and Reproductive Behavior in Developed Countries. (Occasional Report #3). New York: The Guttmacher Institute. Retrieved from http://www.guttmacher.org/pubs/eurosynth_rpt.pdf and MacArthur Foundation. Reaching for a Healthier Life. Retrieved from http://www.macses.ucsf.edu/whatsnew/default.php.
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10. Tabulation based on unpublished data provided by the Guttmacher Institute. (2010). Available from http://www.census.gov/compendia/statab/cats/births_deaths_marriages_divorces/family_planning_abortions.html.
11. Finer, L.B., & Zolna, M. (2006). Unintended Pregnancy in the United States: incidence and disparities, 2006. *Contraception 84*(5): 478-485.

Table 1. Demographic Characteristics of Countries

	Belgium	Germany	Netherlands	Sweden	U.S.
Population in 2008 (millions)[1]	10	82	17	9	304
Growth rate, 2008 (percent)[1]	0.1	0.0	0.4	0.2	0.9
Percent of population under age 15, 2006[2]	17	14	15	17	20
Percent of population age 65+, 2006[2]	17	20	15	18	13
Percent living in urban areas of 750,000+, 2005[2]	26	9	12	14	47
Percent foreign born[3]	13	9	11	13	14
Infant mortality rate (per 1,000 births), 2008 [1,4]	5	4	5	3	6
Life expectancy at birth, 2008 [1,5]	79	79	79	81	78

Notes to Table 1

[1] U.S. Bureau of the Census, Population Division. (2010). *International Database* [Data File]. Available from http://www.census.gov/population/international/data/idb/informationGateway.php.

[2] Population Reference Bureau. (2010). *Datafinder* [Data File]. Available from http://www.prb.org/DataFinder.aspx.

[3] Estimates for Belgium, the Netherlands, Sweden, and the United States, 2007:
Organisation for Economic Co-operation and Development (OECD). (2010). OECD Factbook 2010: Economic, Environmental, and Social Statistics. Retrieved from http://www.oecd-ilibrary.org/economics/oecd-factbook-2010_factbook-2010-en
(Estimate for Germany, 2008 was provided by a colleague.)

[4] U.S. data from: Tejada-Vera, B., & Sutton, P.D. (2009). Births, Marriages, Divorces, and Deaths: Provisional Data for 2008. *National Vital Statistics Reports, 57*(19). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_19.pdf.

[5] U.S. data from: Xu, J., Kochanek, K.D., Murphy, S.L., & Tejada-Vera, B. (2010). Deaths: Final Data for 2007. *National Vital Statistics Reports, 58*(19). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf.

Table 2. Social and Economic Characteristics of Countries

	Belgium	**Germany**	**Netherlands**	**Sweden**	**U.S.**
Per capita gross national income (US$, 2008) [1]	$35,523	$36,017	$39,983	$37,780	$47,320
Percent below poverty level [2]	9	11	8	5	17
Average years of education (adults > age 15; UNESCO)[3]	9	10	9	11	12
Cost of one year of university education[6]	€564 plus €1921 additional costs for food, transport, materials, etc.	€ 0-1,000 for first course of studies plus € 100-300 for administrative costs	At least € 1700	No cost other than living expenses	$17336 (€12560)
% of women age 15-65 who are employed (2008)[1]	56	64	70	73	66
Unemployed as % of total labor force [1]	7	7	3	6	6
Family allowances					
Annual allowance for 1st child in family	€ 996	€ 2,208	€ 780-1116 (varies with age of child)	12000 SEK (€ 1,312)	
Annual allowance for 4th child in family	€ 2,760	€ 2,280	up to € 1401 (varies with age of child)	12000 SEK (€ 1312)	
Paid until age: [4]	18/25/25	18/21/25	18	NA	
Maternity benefit	€ 850 per birth	up to € 13 per day for employed women taking leave, up to 14 weeks	none	none	
Paid maternity leave: length and average % of earnings paid	15 weeks ; 82% 1st 30 days, 75% thereafter	6 weeks before and 12 months after birth; 14 weeks @ 100%, 67% thereafter; maximum € 1800 per month	16 weeks, 100%	16 months (shared with father, who must use 1 month); 80% of income up to cap, at least 180 SEK per month	None required

Notes to Table 2

[1] Organisation for Economic Co-operation and Development (OECD). (2010). OECD Factbook 2010: Economic, Environmental, and Social Statistics. Retrieved from http://www.oecd-ilibrary.org/economics/oecd-factbook-2010_factbook-2010-en.

[2] Poverty level is defined as one half the median income (mid-2000s), from: Organisation for Economic Co-operation and Development (OECD). (2010). *OECD Stat Extracts* [Data File]. Available from http://stats.oecd.org/Index.aspx.

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[4] Second and third ages refer to age limit if child unemployed and in school, respectively.

[5] Population Reference Bureau. (2010). *Datafinder* [Data File]. Available from http://www.prb.org/DataFinder.aspx.

[6] U.S. cost is based on the average in-state tuition for a public university in 2007-08. From Baum, S., & Ma, J. "Trends in College Pricing 2007." *Trends in Higher Education Series*. Washington, DC: College Board. Retrieved from http://www.careercornerstone.org/pdf/universities/tuition07.pdf.

[7] Converted using 2008 average exchange rates, from: Internal Revenue Service (IRS). (2012). Yearly Average Currency Exchange Rates. Retrieved from http://www.irs.gov/businesses/small/international/article/0,,id=206089,00.html.

Table 3. Indicators of Fertility by Country

	Belgium	Germany	Netherlands	Sweden	U.S.
Total fertility rate (births per woman) 2008 [1]	1.6	1.4	1.7	1.7	2.1
Birth rates by age of mother: 2007 [2,3]					
15-19	10.5	9.9	5.2	5.9	42.5
20-24	57.7	43.9	39.2	49.6	106.3
25-29	130.2	83.2	106.1	112.4	117.5
30-34	112.9	87.6	125.5	131.7	99.9
35-39	43.6	40.5	55.1	62.2	47.5
40-44	7.7	7.1	7.8	12.3	9.5
45-49	0.5	0.3	0.3	0.6	0.6
Total/ women 15-49 [4]	49.8	35.6	46.6	52.2	15-44: 69.5
Average age at first birth [4,5]	29 (2007)	30 (2009)	29 (2008)	29 (2007)	25 (2007)

Notes to Table 3

[1] U.S. Bureau of the Census, Population Division. (2010). *International Database* [Data File]. Available from http://www.census.gov/population/international/data/idb/informationGateway.php.

[2] United Nations, United Nations Statistics Division. (2009). Demographic Yearbook 2007. Retrieved from http://unstats.un.org/unsd/demographic/products/dyb/dyb2007.htm.

[3] Belgian Federal Government (2010). Population – Fertility Figures according to elapsed maternal age. Belgium (1961-2009) and regions (1979-2009). *Statbel*. Retrieved from http://statbel.fgov.be/nl/modules/publications/statistiques/bevolking/downloads/vruchtbaarheidscijfers_volgens_verstreken_leeftijd.jsp.

[4] Calculated for Belgium using age-specific birth rates and population data from Statbel. Available from http://statbel.fgov.be/nl/statistieken/organisatie/adsei/informatie/statbel/index.jsp

[5] Estimate for Germany from Organisation for Economic Co-operation and Development (OECD). (2010). SF2.3: Mean age of mothers at first childbirth. *OECD Family Database*. Retrieved from www.oecd.org/dataoecd/62/49/41919586.pdf.

Table 4. Indicators of Pregnancy and Abortion by Country

	Belgium	**Germany**	**Netherlands**	**Sweden**	**U.S.**
Estimated pregnancies per 1000 women 15-44, 2007 [1,3]	68.1	50.0	63.8	81.6	89.0
Abortions per 1000 women 15-44, 2007	8.9	7.3	8.6	21.0	19.5
% of pregnancies ending in abortion, 2007 [1,3]	13.1	14.6	13.5	25.7	21.9
Trends, 2003-2008: abortions per 1000 women 15-44 [2]					
2003	8	7.6	8.5	20.2	20.2
2004	8.1	7.8	8.7	20.0	19.7
2005	8.6	7.5	8.6	20.2	19.4
2006	8.6	7.3	8.6	20.6	19.9
2007	8.9	7.3	8.6	21.0	19.5
2008	na	7.2	8.7	21.3	na
Abortions per 1000 women 15-19 [4]	8.1 (2007)	5.9 (2008)	7.1 (2008)	24.4 (2008)	19.3 (2006)

Notes to Table 4

[1] Total pregnancies calculated as the sum of birth and abortion rates; estimate does not include fetal deaths.

[2] Data for Belgium from: SENSOA (2009). Facts & Figures: Abortion in Belgium Retrieved December 2010, from http://www.sensoa.be.

[3] Data on 2005 fertility for U.S. from: Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Matthews, T.J. & Osterman, M.J.K., (2010). "Births: Final Data for 2008" *National Vital Statistics Reports (59)*1, Hyattsville MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf.

[4] U.S. data from: Guttmacher Institute. (2010). U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity. Available from http://www.guttmacher.org/pubs/USTPtrends.pdf.

Table 5. Indicators of Sexual Behavior and Intimate Unions by Country

	Belgium	Germany	Netherlands	Sweden	U.S.
Median age at first sex[1,2]	17	16	17	17	17
Legal age of consent for sexual intercourse[3,4,5]	14	14, unless <16 exploited by partner over 21	16, if with adult; 12 if with age-peer	15	16 (average, varies by state)
Crude marriage rate (Demographic Yearbook)[6,7]	4.3	4.5	4.4	5.2	7.1
Mean age of woman at first marriage, 2004[8,9]	27.1	28.1	28.4	30.5	25.4
Crude divorce rate (Demographic Yearbook)[6,7]	2.8	2.3	2.0	2.3	3.6
Percent cohabiting, ages 25-34, 1998-2000[10,11,12]	22	32	28	56	36

Notes to Table 5

[1] Data for the U.S. from:
Martinez, G.M., Chandra, A., Abma, J.C., Jones, J., & Mosher, W.D. (2006). Fertility, contraception, and fatherhood: Data on men and women from Cycle 6 (2002) of the National Survey of Family Growth. *Vital Health Stat 23*(26). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/series/sr_23/sr23_026.pdf.

[2] Data for the U.S. from:
Chandra, A., Martinez, G.M., Mosher, W.D., Abma, J.C., & Jones, J. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. *Vital Health Stat 23*(25). Hyattsville MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf.

[3] Data for Germany: Translation of the German Criminal Code provided by Prof. Dr. Michael Bohlander. (2010). Criminal Code in the version promulgated on 13 November 1998, Federal Law Gazette [Bundesgesetzblatt], last amended by Article 3 of the Law of 2 October 2009, Federal Law Gazette. Retrieved from http://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html#StGB_000P182.

[4] Data for Sweden: The Swedish Penal Code. (1999). Retrieved from http://www.sweden.gov.se/content/1/c6/02/77/77/cb79a8a3.pdf.

[5] Data for Belgium: Criminal Code of the Kingdom of Belgium [French Version] (2010). Retrieved from http://legislationline.org/documents/action/popup/id/16036/preview.

[6] European data from: United Nations, United Nations Statistics Division. (2009). Demographic Yearbook 2007. Retrieved from http://unstats.un.org/unsd/demographic/products/dyb/dyb2007.htm.

[7] U.S. data from: U.S. Census Bureau. (2008). Section 2: Births, Marriages, Divorces, and Deaths. *Statistical Abstract of the United States: 2009*. Washington DC: Author. Retrieved from http://www.census.gov/prod/2009pubs/10statab/vitstat.pdf.

[8] European data from: Kasearu, K. (2007). The case of unmarried cohabitation in Western and Eastern Europe. *Paper presented at the conference of European Network on Divorce Comparative and Gendered Perspectives on Family Structure*, London, England: London School of Economics, September 17-18, 2007. Retrieved from
http://www.eui.eu/Personal/Dronkers/Divorce/Divorceconference2007/Kasearu.pdf.

[9] U.S. data refers to median age, from: Kreider, R.M. (2006). Marital Status in the 2004 American Community Survey (Working Paper No. 83). Washington DC: U.S. Bureau of the Census, Population Division. Retrieved from
http://www.census.gov/population/www/documentation/twps0483/twps0483.html#median.

[10] European data from:
Kiernan, K. E. (2004). Cohabitation and divorce across nations and generations. In Chase-Lansdale, P.L., Kiernan, K. and Friedman, R. (eds.), *Human Development across Lives and Generations: The Potential for Change*. New York, Cambridge University Press.

[11]Note: Data from Germany in Kiernan (2004) is for West Germany.

[12] U.S. data from: Casper, L. M., Bianchi, S. M. (2002). *Continuity and Change in the American Family*. Thousand Oaks, CA: Sage.

Table 6. Contraceptive Use by Country

% of women contracepting[4,5]	Belgium	Germany	Netherlands	Sweden	U.S.
Year	2004	2007	2009	1996	2006-2008
Time reference for method use:	in last 12 months	current use	current use	at last intercourse	current use
Denominator: women sexually active in:	in last 12 months	in last 12 months	in last 6 months	in last 12 months	in last 3 months
Actual data					
15-19	83.5				70.5
15-18			89.0		
18-24				84.0	
19-29			79.4		
20-29		86.0			
20-24	86.4				68.7
25-34				64.5	
25-29	82.9				71.8
30-44		68.0			
30-39			71.2		
30-34	71.9				77.0
35-49				67.0	
35-39	74.0				81.0
40-49			75.2		
40-44	69.1				84.6
45-49	63.4				
Interpolated data[6]					
15-19	84	NA	87	82	71
20-24	86	88	80	85	69
25-29	83	84	77	69	72
30-34	72	68	69	60	77
35-39	74	70	71	72	81
40-44	69	66	79	67	85
% of contraceptors using method					
Pill [1]	60	54	51	27	28
Condom [2]	8	28	17	18	16
IUD/Coil	13	13	13	16	6
Sterilization (male/female)	12	7	19	8	37

Vaginal Ring	NA	2	2		2
Implant/injection/patch	4	NA	3		4
% used a method at first sexual intercourse[7,8]					
Males	79	85	90	71 to 76	82
Females	85	91	93	71 to 76	75
Age range, year	14-20, 2009, Flanders, web survey of students	14-17, 2005	12-25, 2005	various	2002, those with first intercourse 1995-2002
% used a method at last intercourse[3,4,5]					
Males	74	93	(79)	84	90
Females	84	98	(77)	84	83
Age range, year	14-20, 2009, Flanders, web survey of students	14-17, 2005	15-20, 2005	18-24 , 1996	15-19, 2002

Notes to Table 6

[1]In Sweden, includes "stick and spray."

[2]Includes all barrier methods in Belgium.

[3]Separate estimates by sex not available for Sweden; estimates for Netherlands refer to percent that always used a method with the last partner and are enclosed in parentheses to indicate lack of comparability. The Netherlands estimates combine provided estimates for 15-17 and 18-20 age groups.

[4] U.S. data are from Martinez, G.M., Chandra, A., Abma, J.C., Jones, J., & Mosher, W.D. (2006). Fertility, contraception, and fatherhood: Data on men and women from Cycle 6 (2002) of the National Survey of Family Growth. *Vital Health Stat 23*(26). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/series/sr_23/sr23_026.pdf.

[5] U.S. data is from Chandra, A., Martinez, G.M., Mosher, W.D., Abma, J.C., & Jones, J. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. *Vital Health Stat 23*(25). Hyattsville MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf.

[6]Percentages for Germany, Netherlands, and Sweden interpolated using the age pattern of use in Belgium as a guide. Calculations available upon request.

[7] U.S. data calculated from Tables 5, 10, and 12, in: Mosher, W.D., & Jones, J. (2010). Use of Contraception in the United States: 1982-2008. *Vital Health Stat,* 23(29), Hyattsville MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf.

[8] Data for Germany refer to men and women combined

Table 7. Legal Aspects of Access to Contraception, by Country

	Belgium	Germany	Netherlands	Sweden	U.S.
Who provides medical methods?[1]	General medical practitioners (most common), gynecologists, midwives; family planning centers in the Francophone region only.	Medical practitioners (most common) and gynecologists.	General medical practitioners, gynecologists, sexual health clinics.	Midwives (most common), private clinics, private physicians, hospitals, youth clinics, sometimes school health care.	Physicians (general and gynecology), other health care personnel as authorized by individual states.
Legal status of sterilization	No restrictions	Legal on request over the age of 18	No restrictions	Legal on request over the age of 25. Legal before 25 years only with approval from Board on Health and Welfare.	Legal on request over the age of 18
Prescription required for emergency contraception?	No	Yes	No	No	No, unless under age 17
Privacy & confidentiality for minors	Parental notification or consent not required at any age; parental involvement "recommended" and parents may receive insurance statements showing visit.	Parental consent (and notification) required under age 18 if physician determines that patient does not have the capacity to consent. Parental consent "recommended" under age 14.	Treatment is confidential for ages 12 and up. Parental consent is required only for patients under 12 years of age.	Treatment is confidential unless there is an obvious risk that the young person will be harmed; social services may be notified instead of parents.	Twenty-one states explicitly allow all minors (<18) to consent to contraceptive services without parental permission.

Notes to Table 7

[1]Refers to methods requiring a prescription or a medical intervention. In all countries, condoms and spermicidal preparations are available over the counter. In Germany, diaphragms are also available without a prescription.

Table 8. Indicators of Access to Contraceptive Services, by Country

	Belgium	**Germany**	**Netherlands**	**Sweden**	**U.S.**
Most common provider of contraceptive services[1]	General practitioners over 2/3 of prescriptions)	Gynecologists	General practitioners	Midwives (80% of prescriptions)	Gynecologists
Ratio of providers per 10,000 population[2]	11.5	2.4	4.3	7.2	0.7
Time to appointment	within 5 days	34% within 3 days, 45% within 1 week, 28% over 3 weeks	within one day	average 7 days, range same day to 14 days	average 27.5 days
Next most common provider	Gynecologists	General practitioners (much less common)	Gynecologists	N/A	Family & general practitioners
Ratio of providers per 10,000 population[3]	1.2	4.6	0.4	N/A	3.2
Time to appointment[4]	up to 5 weeks	90% within 1 week	1-2 months	N/A	average 20.3 days
Specialized clinics	90 family planning centers in Wallonia; 27 abortion centers in Flanders function also as family planning centers	170 Pro familia centers (largely counseling only)	17 abortion clinics also provide contraceptive services	N/A	8,199 family planning centers—2,741 (33%) were health department clinics, 2,215 (27%) were community or migrant health centers, 1,623 (20%) were other clinics, 868 (11%) were Planned Parenthood centers and 752 (9%) were hospital clinics
Youth clinics	NA	NA	62 youth clinics (Sense): counseling, prescriptions, and referrals for those under age 25	227 youth clinics (about 1 per 5000 young people) provide counseling and contraceptive	NA

				services	
Total clinics per 10,000 km^2	38.3	4.8	16.6	5.0	8.5

Notes to Table 8

[1]Refers to methods requiring a prescription or a medical intervention. In all countries, condoms and spermicidal preparations are available over the counter. In Germany, diaphragms are also available without a prescription.

[2] U.S. data is from: Bureau of Labor Statistics. (2012). Occupational Employment and Wages, May 2011: Obstetricians and Gynecologists (29-1064). *Occupational Employment Statistics.* Retrieved from http://www.bls.gov/oes/current/oes291064.htm#nat.

[3] U.S. data is from: Bureau of Labor Statistics. (2012). Occupational Employment and Wages, May 2011: Family and General Practitioners (29-1062). *Occupational Employment Statistics*. Retrieved from http://www.bls.gov/oes/current/oes291062.htm#nat.

[4] U.S. data is from: Merritt Hawkins & Associates. (2009).*2009 Survey of Physician Appointment Wait Times.* Irving TX: Author. Retrieved from http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf.

Table 9. Costs of Obtaining and One Year Use of Two Contraceptive Methods, by Country

Country, by Method	Payment Method	Initial visit	Method cost	Follow-up visits
Belgium [1]				
Pill (Microgynon 30)	Patient payment to provider	€ 35.00	€ 104.00	€ 23.00
	Reimbursed to patient	€ 25.00	€ 14.00	€ 16.00
Hormonal IUD (Mirena)	Patient payment to provider	€ 35.00	€ 140.00	€ 23.00
	Reimbursed to patient	€ 25.00	No reimbursement	€ 16.00
Germany				
Pill (Femigyne-ratioparm—6 mo pkg) Microgynon (3 mo)	Patient payment to provider	€ 10	€54/ 92 (6 mo/3 mo)	€10/30 (1/3 follow-up visits)
Hormonal IUD (Mirena)	Patient payment to provider	€10; also €55-155 for insertion and €25-40 for ultrasound	€ 195	€10; also €25-40 for ultrasound
Netherlands				
Pill (Microgynon 30)	Patient payment to provider	None	15.69-19.89	None
Hormonal IUD (Mirena)	Patient payment to provider	None	127.55	None
Sweden				
Pill (Trionetta)	Patient payment to provider	No cost	325 sek/year is maximum cost, less as woman approaches cap for all prescription costs	No cost
Hormonal IUD (Mirena)	Patient payment to provider	No cost	1071 sek ($145) is maximum cost	No cost
United States				
Pill [2] (Average Cost)	Patient payment to provider	$62 ($52 with insurance)	$344 ($197 with insurance)	None
Hormonal IUD[3,4] (Mirena)	Patient payment to	$65, also $94 for insertion	$843[5]	None

	provider			

Notes to Table 9

[1] Estimates assume provider is a general practitioner. To obtain a pill prescription, an examination is performed at the initial visit, but not at the follow-up.

[2]Liang, S.Y., Grossman, D., & Phillips, K.A. (2011). Women's out-of-pocket expenditures and dispensing patterns for oral contraceptive pills between 1996 and 2006. Contraception, 83, 528-546.

[3]Trussell, J. et al. (2009). Cost effectiveness of contraceptives in the United States. Contraception, 79(1), 5-14.

[4]Gariepy, A.M., Simon, E.J., Patel, D.A., Creinin, M.D., & Schwarz, E.B. (2011). The impact of out-of-pocket expense on IUD utilization among women with private insurance. Contraception, 84, 39-42.

[5]The average wholesale price of the hormonal IUD increased from $586 to $843 in March 2010.

Table 10. Legal Aspects of Access to Abortion, by Country

	Belgium	**Germany**	**Netherlands**	**Sweden**	**U.S.**
Gestational limit for "on-demand" abortion	14 weeks; pregnant woman must be in a state of ”distress”	12 weeks	24 weeks (but only 2 clinics licensed for 13+ weeks, have set practical limit of 22 weeks)	18 weeks	Fetal viability
Conditions for legal abortion after gestational limit	Two physicians agree pregnancy would endanger woman's health or the child has serious incurable pathological condition.	If danger to life or the danger of a grave impairment to physical or emotional health, with woman's consent.	Allowed on medical grounds; also when child has serious conditions leading to perinatal mortality or irremediable functional disorder with limited survival chances.	"Severe indications, " as decided by an expert group linked to the Board of Health and Social Welfare.	In most states, to preserve the life or health of the mother.
Required waiting period after initial consultation	6 days	3 days	5 days; waived if period less than 16 days late	None	In 25 states, 24 hours
Counseling required?	Yes	Yes	Yes	None required, but available to women.	Yes, in 34 states
Counseling content: legal requirements	Cover "all laws and decrees that may help the woman to overcome her distress," alternatives to abortion, medical risks, and MD must ensure that woman is "determined."	Encourage the mother to continue pregnancy while allowing her to choose; discuss reasons for abortion; offer medical, social, and juridical support to make the continuation of the pregnancy easier.	Address alternatives and assure that the woman is seeking abortion voluntarily and has carefully considered her decision, her responsibility, and the consequences for herself and others.	N/A	Varies by state. Typically includes information about procedure and fetal development, gestational age, risks of procedure.

Other requirements	Carried out by a medical doctor under medically sound conditions in a health facility.	Physician must perform; counseling and abortion may not be conducted by the same person.	Performed at licensed hospital or clinic.	Performed at licensed hospital or clinic.	38 states: performed by a licensed physician; 19 states: performed in a hospital after a specified gestational age.
Parental permission or notification for abortion if minor	No; Doctors notify parent if minors are in extreme danger.	Under age 16 unless doctor decides girl has capacity to consent.	Under age 16 doctor or social worker may provide instead.	None	Typically under age 18: consent only required in 22 states, notification only in 12, both in 4.
Professional conscience laws[1]	Doctors may refuse to carry out an abortion, must inform woman during first consultation.	May refuse to assist with an abortion unless it is necessary to protect the life or health of a patient.	None	None	Doctors may refuse in 46 states; institutions in 43 states.

Notes to Table 10

[1] U.S. information from: Guttmacher Institute. (2011). State Policies in Brief: An Overview of Abortion Laws. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.

Table 11. Indicators of Access to Abortion, by Country

	Belgium	Germany	Netherlands	Sweden	U.S.
# abortion providers [2,3]	35 centers and 46 hospitals	#s of institutional settings N/A. Estimates below for gynecologists (perform 79% of abortions).	17 clinics and 97 hospitals	110 active clinics	1,787 abortion providers. In 2005, 45% were clinics, 35% hospitals, 21% private doctors.
Providers per million population	7.8	480.0	6.9	12.2	5.9
Out-of-pocket cost of abortion[1]	€ 3	€ 360 (medical) to € 460 (surgical as outpatient) unless covered by state because of reasons related to income, health or sex crimes (< 20% self-paid)	None (€450 for first trimester abortion reimbursed by state insurance)	"Ordinary cost for a hospital visit," which varies by County Council; not more than 300 SEK.	In 2001, $372 (self-paid) for a surgical abortion at 10 weeks; 26% of clients received services covered by public or private insurance. Public financing typically only available if to protect life of mother or in case of rape/incest.

Notes from Table 11

[1] U.S. cost and insurance data from: Henshaw, S., & Finer, L.B. (2003). The Accessibility of Abortion Services in the United States, 2001. *Perspectives on Sexual and Reproductive Health, 35*(1), 16-24.

[2] U.S. estimate from: Guttmacher Institute. (2011). *In Brief: Facts on Induced Abortion in the United States*. Retrieved from http://www.guttmacher.org/pubs/fb_induced_abortion.pdf

[3] U.S. data from: Jones, R.K., Zolna, M.R.S., Henshaw, S.K. & Finer, L.B. (2008). Abortion in the United States: Incidence and Access to Services, 2005. *Perspectives on Sexual and Reproductive Health, 40*(1), 6–16.

Appendix 1

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Lou Petronella Compernolle, Belgian by birth, holds an MA in Sinology and an MSc in Health Policy and Population from the London School of Economics. She has more than a decade of experience working in reproductive health and has worked for the Association for Gender Issues, The International Planned Parenthood Federation, and the World Health Organization's Reproductive Health and Research department. She currently works for the Reproductive Health Supplies Coalition where she coordinates the West African Network and the Advocacy Working Group. Her current research interests include reproductive rights and improving access to affordable and high quality reproductive health supplies.

Unpublished report by Compernolle, L.P. (2009). Country Profile, Belgium. Brussels, Belgium. Commissioned by The National Campaign to Prevent Teen and Unplanned Pregnancy.

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Cornelia Helfferich has been a Professor of Sociology at the Protestant University of Applied Sciences in Freiburg, Germany since 1995. She has also served as the head of the Social Science Institute for Research on Women and Gender (SoFFI F), the head of the Institute for Qualitative Research (iqs), as well as the Dean of the Department of Management, Education, and Organization, and was also a Vice Rector. Over the past decade, she has conducted a series of empirical studies with SoFFI F on family planning over the life course. She is currently working on a study on unwanted pregnancy and conflict in four states in Germany. Additional research interests include youth sexuality, sex education, gender-based violence, as well as youth and education. In 2007, she was awarded the Helge-Pross Award of the University of Siegen for outstanding achievement in research in sociology of the family.

Unpublished report by Helfferich, C. (2010). Prevention of Teen and Unplanned Pregnancy in Germany. Freiburg, Germany. Commissioned by The National Campaign to Prevent Teen and Unplanned Pregnancy.

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Unpublished report by Lindahl, K. (2009). Prevention and strategies for Sexual and Reproductive health and rights in Sweden. Commissioned by The National Campaign to Prevent Teen and Unplanned Pregnancy.

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Ineke Van der Vlugt is currently the Programme Coordinator of the Sexual Development and Sexuality Education Programme at Rutgers WPF, a center of expertise on sexual and reproductive health and rights. She guides several projects and is an expert in developing interventions to improve sexual health using a comprehensive approach, particularly for vulnerable groups including youth, migrants, and those with low educational attainment. She also has experience with process evaluations and effect studies of interventions, as well as adoption and implementation strategies in the field of education, public health, and advocacy. She was involved in the WHO expert group on the International Standard of Sexuality Education.

Unpublished report by Van der Vlugt, I. (2010). Unplanned Pregnancies and Abortion in the Netherlands. Rutgers Nisso Groep, Expert Centre on Sexuality. Utrecht, Netherlands. Commissioned by The National Campaign to Prevent Teen and Unplanned Pregnancy.

Appendix 2

Initial Charge to Collaborators

What's the problem? Many of us in the United States are asked why various fertility measures appear to be better in Western Europe. These include teen pregnancy and birth, abortion rates and ratios, and unintended pregnancies and births. Although there is some scholarship in this area, especially the Guttmacher study of well over a decade ago (as well as the advocacy pieces from Advocates for Youth), we know far less than we should about what might account for observed differences.

In particular, we know that abortion rates are lower in many European countries than in the United States. We have good reason to believe that this is due mainly to better use of contraception by European couples (and not to less availability of abortion). So the question then becomes**, why are so many Europeans better at using contraception and avoiding unwanted pregnancy?** And to be clear, we ask this question for both adults and teens.

In the absence of solid information in this area, anecdotes and opinion abound. We hear that the "real reason" is different social norms and values, or the legacy of 20th century (even Napoleonic!) social welfare policies, or pervasive and explicit sex education, or more forms of contraception available in general and over-the-counter, or lower costs for birth control in part because of differing/better health care financing systems, or more stable, accessible health care systems and more, too.

What to do? It would be a lifetime's research project to define the true and complete answer to "why are things better in Europe," but we think that, at a minimum, it would be helpful to get a set of basic facts straight. Doing so might put to rest some of current hypotheses and perhaps also raise some new ones that are more evidence-based.

So, what might we want to learn? To get us started, here is a basic list of the issues for which we would like to get the facts. We will inquire initially into Sweden, Belgium, the Netherlands, and Germany.

1. Basic descriptive demography:

- Overview of population make up by immigrant status, race, etc.
- Current definition of and rates of teen pregnancy, unplanned/unintended pregnancy, and abortion. Perhaps others, too.
- Disparities in these measures by income or a proxy for income.
- These same measures by immigrant/guest worker status.

2. Contraception:

- The contraceptive methods available along with all applicable restrictions (age, whether each requires a doctor/clinical prescription, major restrictions or advice on how to use, ease of obtaining, etc.) .
- Current overall patterns of contraceptive use including method mix.
- Where a person goes to get each method of contraception.
- The costs associated with each method to the consumer and to the provider.

- The nature and extent of contraceptive counseling (if any).
- The extent of education about contraception for primary care and ob-gyn providers.
- Privacy protections for minors who seek/get contraception.

3. Abortion:

- Systems of availability.
- Restrictions, if any (waiting times, parental consent, gestation, other).
- Counseling at time of abortion about future contraceptive use.
- Provision of contraception at time of abortion.
- The management of/attitudes towards repeat abortion.

4. Sex Education:

- What is required/available.
- Taught by whom and with what training.
- Data on results/impact, if available.
- How do adults (not just teens) get information about birth control?

5. Context:

- Extent of financial and social supports (services, daycare, job training) to single mothers who are minors versus those who are not minors.
- Extent of pro-natalist policies.