

Abortion incidence and service availability in the United States, 2020

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Abstract

Background: This study provides a baseline assessment of abortion incidence and service delivery prior to *Roe v. Wade* being overturned.

Methods: We collected information from all facilities known to have provided abortion services in the United States in 2019 and 2020. We examined abortion incidence by state, region and nationally and combined data on number of abortions with population data to estimate abortion rates. We also examined the number of abortion clinics, trends in medication abortion and service disruptions and changes in abortion protocols that occurred during the COVID-19 pandemic. We compare these findings to those of our prior Abortion Provider Census, which collected information for 2017.

Results: We documented 930,160 abortions in 2020, an 8% increase from 2017. Between 2017 and 2020, abortion incidence increased in all four regions of the country and in a majority of states. The total number of clinics providing abortion care remained stable nationally but increased in the Midwest and the West and declined in the Northeast and South. There were 492,210 medication abortions in 2020, a 45% increase from 2017. A substantial minority of clinics adjusted protocols in response to COVID, most commonly adopting remote pre- and post-abortion counseling.

Discussion: This study did not address factors behind the increase in abortion. However, this report demonstrates that the need for abortion care was growing just prior to the overturning *Roe v. Wade*, and the impact of this decision will be even more far-reaching than previously expected.

INTRODUCTION

Abortion helps women, transgender men, and gender non-binary individuals with the capacity to become pregnant to control their fertility, thereby maintaining autonomy over their bodies and the trajectory of their lives. The Supreme Court of the United States (US) established the federal constitutional right to an abortion in 1973 in its *Roe*

v. Wade (*Roe*) ruling. However, on June 24, 2022 the Court overturned this decision in *Dobbs v. Jackson Women's Health Organization* (*Dobbs*) ruling that states now have authority to determine the legality of abortion and the circumstances under which it can be provided.

In removing the federal right to an abortion, the *Dobbs* ruling effectively established multiple state-based legal regimes for abortion within one country. In the weeks following the decision, 16 states

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moved to implement near-total or early abortion bans; as of early November 2022 bans were in effect in 14.¹ As many as 26 states are expected to ban abortion, either through laws that will go into effect in the months after the Supreme Court decision or through special legislative sessions during 2022 or 2023.² As of October 2022, legislatures in 17 states that are supportive of abortion rights are enacting protections for abortion providers and expanding access to care.³

It is against this rapidly changing—and diverging—context that we present the most recent comprehensive estimates of abortion incidence for 2019 and 2020. These estimates describe the landscape of abortion provision in the US before the *Dobbs* decision.

Trends in abortion

After *Roe* was handed down in January 1973, abortion increased more or less steadily until 1990, when the number peaked at 1.6 million abortions.⁴ The annual number of abortions then declined for several decades until 2017 when it reached its lowest level since 1973 at 863,320.⁵ Research has not identified any definitive factor or factors responsible for the long-term drop in abortion, but several dynamics that likely contributed include delays in sexual activity among adolescents and young adults^{6,7} and improvements in contraceptive use—including use of long-acting methods,^{8,9} dual method use,¹⁰ and improvements in use of methods such as condoms.¹¹ Additionally, state-level abortion restrictions have proliferated since 2011. While there is no evidence that, these laws were the main driver behind the national decline in abortion,¹² they did prevent some individuals in some states from obtaining care.¹³

Context

Between 2017 and 2020, 18 states passed 75 provisions to protect abortion rights.¹⁴ Some of these expanded access to abortion by requiring Medicaid or private health plans to cover abortion or allowed qualified clinicians such as nurse practitioners, physician assistants, or certified nurse midwives to provide at least some abortion care. During this same period, 25 states enacted 168 abortion restrictions and bans.¹⁴ However, some were met with legal challenges and did not go into effect. In addition, many of these new restrictions were enacted in states where clinics had already been operating in hostile environments, which may have reduced the practical impacts of the new laws.

Clinics are the main source of abortion care in the US, accounting for 95% of abortions in 2017,⁵ and changes to the number of these facilities in a given state or region can impact the availability and accessibility of abortion care. Between 2014 and 2017, the total number of clinics increased from 789 to 808 (2%), but clinic numbers fell 6% in the Midwest and 9% the South, and increased in the Northeast (16%) and West (4%).⁵ A recent report by researchers at Advancing New Standards in Reproductive Health (ANSIRH) suggests some of these regional patterns may have changed.¹⁵ Between 2017 and

2020 ANSIRH researchers documented a 2% national decline in the total number of facilities that provided abortion care, though the number increased in the Midwest (4%) and decreased in the Northeast (6%). They also reported a continued decline in facilities in the South (10%) and an increase in the West (6%). Number of facilities providing abortion care is not the only, or even necessarily the most important, measure of abortion access. However, depending on the location, affordability and type of care provided by the facilities that opened—or closed—in a given state or region, they may have made abortion more—or less—accessible.¹⁶

The COVID-19 pandemic had a wide-ranging impact on all aspects of society, including abortion care availability and accessibility.¹⁷ Governors in several states, mostly in the Midwest and South, issued bans on abortion at the beginning of the pandemic, deeming it non-essential health care.¹⁸ The pandemic also disrupted clinic workforces and patient flow. One national study of independent abortion clinics found that 50% of facilities reported that staffs were unable to work because of childcare responsibilities and 44%–45% were sick or had to quarantine.¹⁹ These factors may have contributed to reduced access to abortion care, particularly at the beginning of the pandemic.

At the same time, one study found that one-third of US women wanted to delay or have fewer children in response to COVID and that a similar proportion reported delays or cancellations of contraceptive and other sexual and productive health care.²⁰ A study of patients at five clinics in the Washington, DC metro area found that 40% of patients calling between September 2020 and March 2021 cited COVID-related disruptions as a reason for having an abortion. Additionally, these patients were much more likely to report financial hardship resulting from COVID than abortion patients who did not include COVID among their reasons for terminating their pregnancies.²¹ These combined dynamics might have contributed to more unintended pregnancies and increased demand for abortion.

This study summarizes findings from the Guttmacher Institute's 2019–2020 Abortion Provider Census, including estimates of abortion incidence and the number of clinics offering abortion care, nationally and by state, as well as other aspects of abortion service provision. The landscape of abortion care is ever evolving and has changed considerably since these data were collected. However, the figures in this article will continue to serve as a baseline for abortion incidence prior to the implementation of state bans on abortion.

METHODS

Survey fielding

Data for this study come from the 19th iteration of the Guttmacher Institute's Abortion Provider Census, which collects data about abortion from all healthcare facilities known or suspected to provide abortion care. The most recent Abortion Provider Census collected data for 2019 and 2020 from facilities across the US and Puerto Rico. This was the first time the Abortion Provider Census included facilities in Puerto Rico and the findings will be summarized in a separate report.

The universe included facilities known to have provided abortions in 2017 (the year of the prior Abortion Provider Census), as well as facilities identified through web-based searches, media reports, and directories of organizations and associations that work with abortion-providing facilities. We asked all facilities to provide their 2019 and 2020 abortion caseloads and requested that clinics and physicians' offices (but not hospitals) provide additional information about their facilities' practices for providing abortion care.

In February 2021 we mailed paper questionnaires to the 2131 health facilities known or suspected to have provided abortion care for any part of 2019 and 2020. In addition to materials for mailing back the completed survey, we provided all sites with a link and unique access code so that they could complete the survey online. In March 2021, we began conducting non-response follow-up (NRFU), reaching out to clinics, physicians' offices, and higher volume hospital facilities* via telephone, fax, and e-mail. Data collection and NRFU ended in May 2022 and the fielding team conducted 7131 phone calls, e-mails, and faxes during the 15-month period.

We also collected data about the number of abortions from state health departments in order to supplement data obtained directly from facilities and to inform estimates for sites that did not respond. We contacted health departments in 44 states, the District of Columbia, New York City, and Puerto Rico.†

During NRFU we determined that 550 health facilities previously known or suspected to provide abortions did not provide abortions in 2019 or 2020; this included low-volume facilities from prior surveys and facilities that we contacted because we suspected they might provide abortions. Among these facilities, over three-quarters (77%) were hospitals, many of which provide abortion occasionally and in low volume. Nearly one-half (47%) of the 1687 facilities performing one or more abortions during the study period provided information using the questionnaire and an additional 5% offered this information by e-mail or telephone during NRFU. We used health department data to determine the abortion caseloads of 17% of facilities and we estimated caseloads for 31%. We adopted a variety of strategies and information sources to make caseload estimates, including responses to prior surveys, key informants, media stories, on-line reviews, and other tools. Some 80% of the facilities for which we had to make estimates were either hospitals (49%) or physicians' offices (31%) (not shown); both of these facility types typically have small abortion caseloads. In turn, 84% of abortions that we counted were based on information obtained from health care facilities: 79% were reported via completed surveys and 5% by e-mail or telephone during NRFU—slightly lower than reported in the last Abortion Provider Census (89%).⁵ We obtained an additional 4% of abortions from state health department data and we estimated the remaining 12% of abortions. This is similar to the 2017 Abortion Provider Census, which used health department data for 2% of abortions and estimated the remaining 9%. The degree to which we estimated data varied by state. We estimated more than 10% of abortions in California (11%), Maryland (14%), Hawaii (20%), New York (30%), Florida (33%) and New Jersey (40%).

The most recent Abortion Provider Census was the first iteration of the survey to have an online option. We used Qualtrics, a secure

online survey platform, and we allowed respondents the option of answering the survey in English or Spanish. One-third (33%) of the 1687 facilities that provided data chose to submit their data online, and an additional 34% submitted paper or PDF surveys. The remaining survey respondents (33%) used an Excel spreadsheet adaptation of the survey, which was made available to respondents providing data for multiple sites.

The Guttmacher Institute's federally registered institutional review board deemed the study exempt.

Analysis

We categorized facilities into four types: hospitals, physicians' offices, specialized abortion clinics, and nonspecialized clinics. Hospitals are sites that typically have operating rooms, emergency departments, and labor and delivery and maternal-fetal departments. We classified hospital-affiliated clinics as specialized or non-specialized clinics. We define physicians' offices as facilities offering fewer than 400 abortions per year whose names suggested they were a private practice. We categorized physicians' offices that provided more than 400 abortions per year as clinics.

We classified clinic facilities where abortion services account for half or more of all patient visits as specialized abortion clinics. Nonspecialized clinics are facilities where fewer than half of all patient visits were for abortion services.

We used data on numbers of women aged 15–44 on July 1, 2019 and July 1, 2020 from the Census Bureau²² to calculate abortion rates.‡ We used our abortion incidence data in combination with US birth data for the 1-year periods following July 1, 2019 and 2020 from the National Center for Health Statistics²³ to calculate the national abortion ratio, or the proportion of pregnancies, excluding miscarriages that ended in abortion.

We also examine incidence of medication abortion. More than two-thirds (67%) of nonhospital facilities provided annual counts of medication abortions including those using mifepristone with misoprostol, methotrexate, or misoprostol alone. More than 98% of medication abortions reported to us were provided with mifepristone and misoprostol. The response rate on this measure varied by facility type and caseload and we constructed weights to account for these differences. When available, we used state health department figures on medication abortion to cross-check the medication abortion figures we generated.

In 2020, COVID disrupted health care systems across the US (and the globe) and we examined several survey items intended to capture this impact. We first asked clinics “At any point in 2020, did this facility stop or ‘pause’ providing the below types of abortion care.” Types of care included medication abortions, first-trimester procedural abortions, and second or later trimester procedural abortions. Some 625 clinic facilities answered this question and our analysis of disruptions around COVID focuses on these facilities. Notably, the item did not specify whether care was paused in response to COVID and some clinics may have reported pauses in abortion care in 2020 for other

TABLE 1 Number of reported abortions, abortion rate, and abortion ratio, United States, 1973–2020

Year	Number	Rate ^a	Ratio ^b
1973	744,610	16.3	19.3
1974	898,570	19.3	22
1975	1,034,170	21.7	24.9
1976	1,179,300	24.2	26.5
1977	1,316,700	26.4	28.6
1978	1,409,600	27.7	29.2
1979	1,497,670	28.8	29.6
1980	1,553,890	29.3	30
1981	1,577,340	29.3	30.1
1982	1,573,920	28.8	30
1983	1,575,000	28.5	30.4 ^c
1984	1,577,180	28.1	29.7
1985	1,588,550	28	29.7
1986	1,574,000	27.4	29.4 ^c
1987	1,559,110	26.9	28.8
1988	1,590,750	27.3	28.6
1989	1,566,900	26.8	27.5 ^c
1990	1,608,600	27.4	28 ^c
1991	1,556,510	26.3	27.4
1992	1,528,930	25.7	27.5
1993	1,495,000	25	27.4 ^c
1994	1,423,000	23.7	26.6 ^c
1995	1,359,440	22.5	25.9
1996	1,360,160	22.4	25.9
1997	1,335,000	21.9	25.5 ^c
1998	1,319,000	21.5	25.1 ^c
1999	1,314,780	21.4	24.6
2000	1,312,990	21.3	24.5
2001	1,291,000	20.9	24.4 ^c
2002	1,269,000	20.5	23.8 ^c
2003	1,250,000	20.2	23.3 ^c
2004	1,222,100	19.7	22.9
2005	1,206,200	19.4	22.4
2006	1,242,000	19.9	22.9 ^c
2007	1,209,640	19.5	21.9
2008	1,212,350	19.4	22.5
2009	1,151,600	18.5	22.2 ^c
2010	1,102,670	17.7	21.7
2011	1,058,490	16.9	21.2
2012	1,011,000	16.1	20.4 ^c
2013	958,700	15.2	19.4
2014	926,190	14.6	18.8
2015	899,500	14.2	18.5 ^c
2016	874,080	13.7	18.3
2017	862,320	13.5	18.4

(Continues)

TABLE 1 (Continued)

Year	Number	Rate ^a	Ratio ^b
2018	885,800	13.8	18.4 ^c
2019	916,460	14.2	19.8
2020	930,160	14.4	20.6

^aAbortions per 1000 women aged 15–44 as of July 1 of each year.^bAbortions per 100 pregnancies ending in an abortion or live birth; for each year, the ratio is based on births occurring during the 12-month period starting in July 1 of that year.^cFigures are estimated by interpolation of numbers of abortions counted by Guttmacher and adjustments made to Centers for Disease Control and Prevention Abortion Surveillance Reports.

reasons. For example 4% of non-hospital facilities reported being unable to provide care on one or more days in 2014 in order to be in compliance with local or state regulations.²⁴

We also adapted items from a prior study²⁵ to assess whether clinics had adopted five potential changes to their abortion protocols: remote pre-abortion visits, remote post-abortion visits, quick pick-up of mifepristone,[§] mailing medications for medication abortion, and using an online pharmacy for prescribing abortion medications. For each item we asked if the service was “offered pre-COVID (before March 2020),” “began offering in response to COVID,” “offering now,” or “never offered.” Between 554 and 573 clinics (69%–71%) answered each item. Some 61 facilities that responded to the items about disruptions (Question 19) did not answer any items about changes in protocols (Question 20) even though the two were next to each other at the end of the survey. Handwritten notes on two paper surveys next to Question 20 indicated that they were not responding to the item(s) because they had never adopted any of these practices. We considered this as a reason that all 61 facilities did not respond to these items and, in turn, our estimates of the extent to which each protocol was adopted are conservative or “lower bound” estimates.

Compared to clinics that responded to the items about service disruptions and changes in COVID protocols, a larger proportion of those that did not ($n = 182$) were located in the Northeast (34% vs 26%) and the South (33% vs. 21%), were categorized as specialized abortion clinics (34% vs. 26%), and in the lowest volume category (14% vs. 5% with caseloads <30). Together, facilities that did not respond to the question about service disruptions or COVID protocols accounted for 20% of abortions in 2020.

RESULTS

Abortion incidence

The total number of abortions, the abortion rate, and the abortion ratio in the US all increased between 2017 and 2020 (Table 1). In 2020, 930,160 abortions were provided in clinical settings, an 8% increase from 2017. The 2020 abortion rate of 14.4 abortions per 1000 women aged 15–44 represented a 7% increase from 2017. The abortion ratio also increased and slightly more than one in five

TABLE 2 Abortion incidence, abortion rates, and change in rates, nationally, by region and by state, 2017, 2019 and 2020

	Number of abortions						Abortion rate					
	2017	2019	2020	% Change			2017	2019	2020	% Change		
				17-19	19-20	17-20				17-19	19-20	17-20
United States	862,320	916,460	930,160	6	1	8	13.5	14.2	14.4	5	1	7
Northeast	224,310	235,920	228,100	5	-3	2	20.5	21.8	21.2	6	-3	3
Connecticut	11,910	11,990	11,170	1	-7	-6	17.7	17.9	16.7	1	-7	-6
Maine	2040	2100	2370	3	13	16	8.8	9.0	10.1	2	12	15
Massachusetts	18,590	19,050	17,060	2	-10	-8	13.5	13.6	12.2	1	-10	-10
New Hampshire	2210	2090	2050	-5	-2	-7	9.2	8.5	8.3	-8	-2	-10
New Jersey	48,110	48,280	48,830	0	1	1	28.0	28.8	29.2	3	1	4
New York	105,380	117,140	110,360	11	-6	5	26.3	30.2	28.8	15	-5	10
Pennsylvania	31,260	31,250	32,260	0	3	3	13.1	13.1	13.6	0	4	4
Rhode Island	3500	2840	2760	-19	-3	-21	16.7	13.6	13.3	-19	-2	-20
Vermont	1300	1190	1230	-8	3	-5	11.4	10.4	10.7	-9	3	-6
Midwest	133,120	143,360	146,540	8	2	10	10.2	10.9	11.2	7	3	10
Illinois	42,080	52,220	52,780	24	1	25	16.6	20.9	21.3	26	2	28
Indiana	7710	7720	7880	0	2	2	5.9	5.9	6.0	-1	2	2
Iowa	3760	3470	3510	-8	1	-7	6.3	5.8	5.9	-8	2	-6
Kansas	6830	6740	8180	-1	21	20	12.2	12.0	14.5	-2	21	19
Michigan	26,630	29,160	31,500	10	8	18	14.2	15.5	16.8	9	8	18
Minnesota	10,740	11,190	11,060	4	-1	3	10.1	10.3	10.2	2	-1	1
Missouri	4710	1520	170	-68	-89	-96	4.0	1.3	0.1	-68	-92	-98
Nebraska	2020	2150	2200	6	2	9	5.5	5.8	5.9	5	2	7
North Dakota	1160	1120	1170	-3	4	1	7.9	7.5	7.8	-5	4	-1
Ohio	20,630	20,400	20,990	-1	3	2	9.4	9.2	9.5	-2	3	1
South Dakota	500	420	130	-16	-68	-74	3.1	2.5	0.8	-19	-68	-74
Wisconsin	6360	7260	6960	14	-4	9	5.9	6.6	6.4	12	-3	8
South	295,290	308,280	320,410	4	4	9	12.1	12.5	12.9	3	3	7
Alabama	6110	5910	5700	-3	-4	-7	6.4	6.2	6.0	-3	-3	-6
Arkansas	3200	2920	3250	-9	11	2	5.5	5.0	5.6	-9	12	2
Delaware	1900	2040	1830	7	-10	-4	10.5	11.3	10.0	8	-12	-5
District of Columbia	5630	9900	9410	76	-5	67	30.2	51.8	48.9	72	-6	62
Florida	71,050	72,210	77,400	2	7	9	18.6	18.5	19.7	-1	6	6
Georgia	36,330	39,980	41,620	10	4	15	16.9	18.3	18.9	8	3	12
Kentucky	3200	3660	4080	14	11	28	3.8	4.3	4.8	13	12	26
Louisiana	9920	8150	7360	-18	-10	-26	10.6	8.8	8.0	-17	-9	-25
Maryland	29,800	30,030	30,750	1	2	3	25.0	25.3	25.9	1	2	4
Mississippi	2550	3190	3560	25	11	40	4.3	5.5	6.1	28	11	42
North Carolina	29,500	29,320	31,850	-1	9	8	14.6	14.2	15.3	-3	8	5
Oklahoma	4780	9070	9690	90	7	103	6.2	11.7	12.4	89	6	100
South Carolina	5120	5000	5300	-2	6	4	5.3	5.1	5.3	-4	4	0
Tennessee	12,140	9970	10,850	-18	9	-11	9.2	7.5	8.1	-18	8	-12
Texas	55,440	59,280	58,020	7	-2	5	9.4	9.8	9.5	4	-3	1
Virginia	17,210	16,470	18,740	-4	14	9	10.2	9.7	11.0	-5	13	8
West Virginia	1430	1170	990	-18	-15	-31	4.4	3.7	3.1	-16	-16	-30
West	209,600	228,900	235,120	9	3	12	13.5	14.5	14.9	7	3	10

(Continues)

TABLE 2 (Continued)

	Number of abortions						Abortion rate					
	2017	2019	2020	% Change			2017	2019	2020	% Change		
				17–19	19–20	17–20				17–19	19–20	17–20
Alaska	1260	1320	1240	5	–6	–2	8.6	9.1	8.6	6	–5	0
Arizona	12,400	13,020	13,320	5	2	7	9.2	9.3	9.3	1	0	1
California	132,680	150,660	154,060	14	2	16	16.4	18.7	19.2	14	3	17
Colorado	12,390	12,410	13,420	0	8	8	10.9	10.5	11.2	–4	7	3
Hawaii	3200	3150	3130	–2	–1	–2	12.0	12.1	12.1	1	0	1
Idaho	1290	1520	1690	18	11	31	3.9	4.4	4.8	13	9	23
Montana	1580	1600	1630	1	2	3	8.3	8.2	8.2	–1	0	–1
Nevada	9690	9920	11,010	2	11	14	16.4	16.4	17.9	0	9	9
New Mexico	4620	4470	5880	–3	32	27	11.7	11.2	14.7	–4	31	26
Oregon	9640	9130	8560	–5	–6	–11	11.9	11.0	10.3	–8	–6	–13
Utah	2990	3030	3120	1	3	4	4.4	4.3	4.4	–2	2	0
Washington	17,740	18,570	17,980	5	–3	1	12.1	12.2	11.7	1	–4	–3
Wyoming	140	90	100	–36	14	–29	1.3	0.8	0.9	–38	12	–31

Note: State-based rates use the population of women of reproductive age (15–44) living in the state as the denominator, however all patients (including those traveling from out of state) are considered part of the numerator.

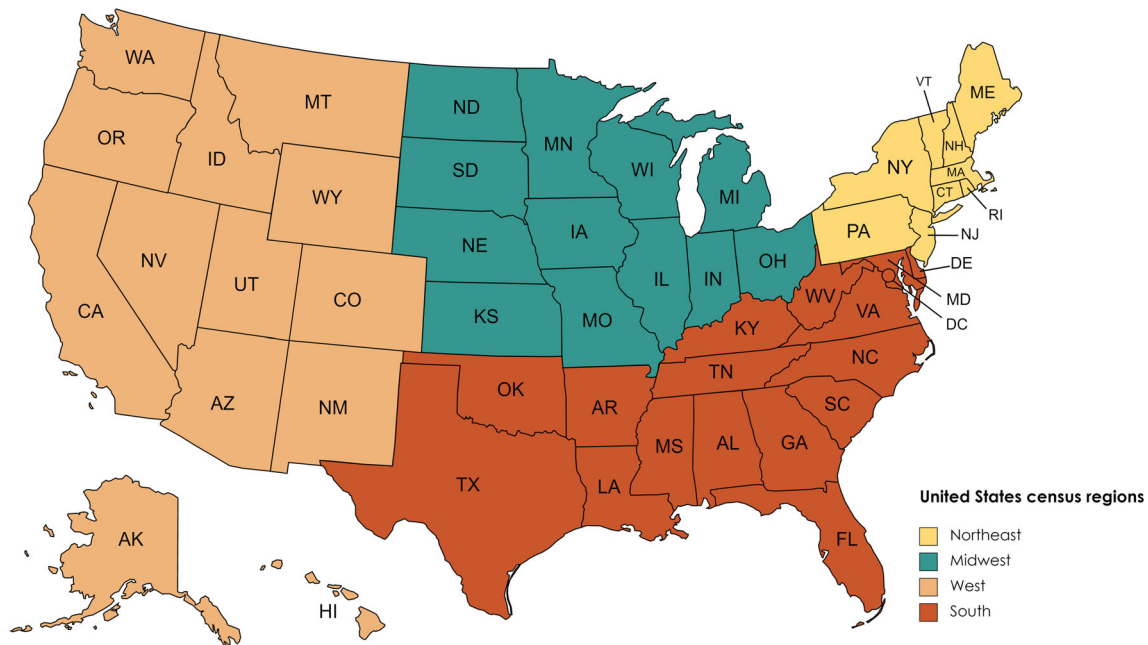


FIGURE 1 United States Census Regions

pregnancies (births and abortions), 20.6%, ended in abortion in 2020, up from 18.4% in 2017.

It is worth noting that patterns in abortion incidence were not uniform across the time periods of 2017–2019 and 2019–2020 (Table 2). Nationally, most of the increase in abortion numbers took place between 2017 and 2019, and only increased 1% between 2019 and 2020.

Between 2017 and 2020, abortion incidence increased in all four regions of the country (Figure 1) and was largest in the Midwest (10%) and the West (12%). Abortion incidence increased in 33 states

and DC and decreased in 17 states. The degree of change varied substantially across states, even within regions. Between 2017 and 2020 abortion incidence increased by more than 10% in 12 states, including large ones such as California, Georgia, Illinois, and Michigan. States where the number of abortions declined by more than 10% included Louisiana, Missouri, Oregon, Rhode Island, South Dakota, Tennessee, West Virginia, and Wyoming.

Changes in state abortion rates between 2017 and 2020 tracked with changes in abortion incidence,[¶] with a few exceptions. In

TABLE 3 Number and percentage distribution of abortion providers and of abortions, by provider type, and caseload, 2017 and 2020

	Facilities				Abortions			
	Number		%		Number		%	
	2017	2020	2017	2020	2017	2020	2017	2020
Total	1587	1603	100	100	862,320	930,160	100	100
Facility type								
Hospital	518	530	33	33	28,760	28,010	3	3
Abortion clinic	253	227	16	14	519,180	499,420	60	54
Nonspecialized clinic	555	580	35	36	302,860	395,550	35	43
Physicians' offices ^a	261	266	16	17	11,510	7190	1	1
Facility caseload								
1–29	609	636	38	40	5310	5610	1	1
30–399	474	432	30	27	75,280	67,220	9	7
400–999	230	241	14	15	148,140	163,600	17	18
1000–4999	255	275	16	17	499,010	555,650	58	60
≥5000	19	19	1	1	134,580	138,080	16	15

^aPhysicians' offices reporting 400 or more abortions a year are classified as clinics.

Montana, North Dakota, and Washington, the number of abortions increased 1%–5% between 2017 and 2020 while abortion rates decreased by 1%–4%. These changes are due to increases in the population of women of reproductive age. Even though there were more abortions, there were also more women 15–44 in 2020 than in 2017. In Utah, abortion incidence increased 4% while the rate remained stable.

Areas with the highest abortion rates in 2020 were the District of Columbia, Florida, Illinois, Maryland, New Jersey, and New York. Rates were lowest in Missouri, South Dakota, Utah, West Virginia, and Wyoming. Notably, our study measures abortion by state of occurrence and does not account for individuals crossing state lines for abortion care. With the exception of Utah, states with the lowest abortion rates in 2020 had anywhere from 52% (West Virginia) to 99% (Missouri) of residents obtaining abortions out of state.²⁶

Abortion facilities

We identified 1603 health care facilities that provided abortions in 2020 (Table 3); in 2017 the comparable figure was 1587. Table A1 shows the number of all abortion providing facilities, including hospitals and physicians' offices, by state. While hospitals accounted for one-third of facilities providing abortion care in 2020, they only accounted for 3% of all abortions. This is because 71% of hospitals provide fewer than 30 abortions per year (not shown), and these are often restricted to high-risk pregnancies and/or those for fetal indications.²⁷

Some 50% of facilities providing abortion care were clinics, but they accounted for 96% of all abortions. While there were more non-specialized ($n = 580$) than specialized clinics ($n = 227$) in 2020, clinics specializing in abortion care provided the majority of abortions (54%).

Still, the share of abortions provided by non-specialized facilities increased from 35% in 2017 to 43% in 2020.

Abortion clinics

The total number of clinics was virtually unchanged between 2017 and 2020, at 808 and 807, respectively, although there were differences by region and state (Table 4). The number of clinics increased in the Midwest (11%) and in the West (6%) and decreased in the Northeast (9%) and the South (3%). The Midwest had 10 more clinics in 2020 than in 2017 and increases were largest in Illinois (5 additional clinics), Michigan (3) and Minnesota (3). The West had 18 more clinics in 2020 than in 2017 with an additional 12 clinics in California and five in Colorado. In the Northeast, New York had nine fewer clinics and, in the South, Florida had seven fewer. The loss of only one or two clinics can have significant impacts on states that had few to begin with. For example, the loss of two clinics in Iowa resulted in 25% fewer clinics in that state and the loss of one clinic had a substantial impact on some Southern states like Arkansas, Louisiana, and South Carolina. In 2020 six states had only one clinic: Mississippi, Missouri, North Dakota, Rhode Island, South Dakota, and West Virginia.

The negligible change in the number of clinics nationwide masks turnover among existing clinics. Of the 807 clinic facilities providing abortions in 2020, 95 had not been providing this care in 2017 (not shown). Similarly, of the 808 clinic facilities providing abortions in 2017, 86 had stopped doing so or had closed by 2020.^{**}

In 2020, 89% of US counties did not have a clinic facility that provided abortion care and 38% of women aged 15–44 lived in these counties (Table 4); these figures are identical to those in 2017.⁵ In six states, fewer than 10% of women lived in a county without a clinic facility: California, Connecticut, Hawaii, Nevada, New York, and

TABLE 4 Total number of clinics providing abortion care, 2017 and 2020; percentage of counties without a clinic and percentage of women living in those counties; all by region and by state

Region and state	Number of clinics			Percentage of counties without a clinic, 2020	Percentage of women in counties with no clinic, 2020
	2017	2020	Percentage change, 2017–2020		
United States total	808	807	–0.1	89	38
Northeast	245	223	–9	52	18
Connecticut	26	20	–23	0	0
Maine	16	17	6	13	16
Massachusetts	19	17	–11	50	14
New Hampshire	4	4	0	60	30
New Jersey	41	37	–10	29	21
New York	113	104	–8	37	6
Pennsylvania	18	17	–6	82	38
Rhode Island	2	1	–50	80	36
Vermont	6	6	0	64	38
Midwest	91	101	11	95	54
Illinois	25	30	20	89	32
Indiana	6	7	17	95	66
Iowa	8	6	–25	95	65
Kansas	4	4	0	98	60
Michigan	21	24	14	86	34
Minnesota	7	10	43	95	58
Missouri	3	1	–67	99	94
Nebraska	3	3	0	97	39
North Dakota	1	1	0	98	72
Ohio	9	10	11	93	55
South Dakota	1	1	0	98	76
Wisconsin	3	4	33	96	68
South	195	189	–3	94	52
Alabama	5	5	0	93	59
Arkansas	3	2	–33	99	86
Delaware	4	3	–25	33	19
District of Columbia ^a	5	5	0	0	0
Florida	65	58	–11	75	25
Georgia	15	14	–7	95	55
Kentucky	1	2	100	99	82
Louisiana	4	3	–25	95	75
Maryland	25	23	–8	63	23
Mississippi	1	1	0	99	92
North Carolina	14	16	14	91	53
Oklahoma	4	5	25	96	53
South Carolina	4	3	–25	93	71
Tennessee	8	7	–13	95	61

(Continues)

TABLE 4 (Continued)

Region and state	Number of clinics			Percentage of counties without a clinic, 2020	Percentage of women in counties with no clinic, 2020
	2017	2020	Percentage change, 2017–2020		
Texas	21	24	14	96	44
Virginia	16	17	6	92	79
West Virginia	1	1	0	98	90
West	276	294	6	78	15
Alaska	4	4	0	87	33
Arizona	8	8	0	80	18
California	161	173	7	38	3
Colorado	18	23	28	77	26
Hawaii	4	4	0	40	5
Idaho	3	3	0	95	67
Montana	5	6	20	91	47
Nevada	7	9	29	88	9
New Mexico	6	6	0	91	48
Oregon	16	17	6	75	22
Utah ^b	2	2	0	97	64
Washington	40	37	–8	56	9
Wyoming	2	2	0	96	96

^a2017 differs from published figure (of 4) as we determined during the most recent round of data collection that a facility had been misclassified in the prior round.

^b2017 differs from published figure (of 3) as we determined during the most recent round of data collection that a facility had been misclassified as a clinic in the prior round.

TABLE 5 Number of medication abortions and share of all abortions provided by medication, by facility type and facility caseload, 2017 and 2020

	2017		2020	
	N	%	N	%
United States total	339,650	39	492,210	53
Facility type				
Abortion clinics	181,280	35	232,240	47
Other clinics	153,350	51	254,870	64
Physicians' offices	5020	44	4960	70
Facility caseload (excluding hospitals)				
1–29	1230	50	1510	55
30–399	39,880	69	39,950	83
400–999	84,330	60	109,330	70
≥1000	214,190	34	341,270	49

Note: 2017 Data from Jones et al.⁵

Washington. In Mississippi, Missouri, West Virginia, and Wyoming, at least 90% of women lived in a county without such a clinic.

TABLE 6 Clinic changes to abortion protocols in relation to COVID

Abortion protocol	N	%			
		Adopted prior to COVID	Adopted in response to COVID	Currently offer	Never offered
Remote pre-abortion visit	625	3	34	22	63
Remote post-abortion visit	625	8	42	30	53
Quick pick-up of mifepristone	625	3	16	11	80
Mailing medications for medication abortion	625	3	5	5	91
Online pharmacy for medication abortion	625	1	3	4	95

Medication abortion

In 2020, 492,210 medication abortions were provided in nonhospital facilities (Table 5), a 45% increase from 2017. Medication abortion accounted for the majority of all abortions in 2020 (53%), compared to 39% in 2017.⁵ It is worth noting that there were 412,130 medication abortions in 2019 (not shown). The relative increase between 2019 and 2020 (19%) was only slightly lower than the one for the two-year period of 2017 and 2019 (21%).

The share of medication abortions increased for all facility types and caseloads. In 2020, the majority of abortions provided by physicians' offices (70%) and non-specialized clinics (64%) were medication abortions, up from 44% and 51%, respectively, in 2017. Among abortion clinics, the number and proportion of abortions that were done with medication increased from 35% in 2017 to 47% in 2020 though in both years the majority of abortions were procedural. Similarly, between 2017 and 2020 the number and share of abortions provided with medication(s) increased across all facility caseloads, but in the largest facilities the majority of abortions in both years were procedural (66% and 51%). In 2020, at least 26% of all nonhospital facilities (including physicians' offices) and 31% of clinics provided only medication abortion (not shown); these figures were very similar to 2017 (25% and 30%, respectively).

Changes around COVID

Among clinics that responded to the items assessing abortion protocols in relation to the pandemic, less than 10% had any of the five practices in place prior to COVID (Table 6). Most commonly, 8% indicated that they had provided remote post-abortion visits prior to COVID and 1%–3% had provided any of the other services.

The most common changes in protocol in response to COVID applied to remote visits: 42% of responding clinics adopted remote post-abortion visits and 34% adopted remote pre-abortion visits. Just under one in five responding clinics, 16%, allowed for people to drop into the clinic to get medication abortion drugs ("quick pick up") and substantially lower proportions reported mailing abortion drugs (5%) or using an online pharmacy to mail medications to patients (3%).

Not all clinics that adopted these protocols were still using them when they filled out the survey (2021 for most of the clinics). Remote post-abortion visits were still offered by 30% and remote pre-abortion visits by 22%. Only 11% were still offering quick pick-up of medication abortion drugs. Four to 5% were mailing medications and/or using an online pharmacy.

Of the 625 clinics that responded to the item about pausing abortion care, 15% reported service disruptions during COVID (not shown). Disruptions were reported by half or more of all clinics in Alabama (5), Arkansas (2), Oklahoma (5), South Dakota (1 clinic in the state), Tennessee (7), West Virginia (1), and Wyoming (2). Among the responding clinics, disruptions were most common in the South (25%) and Midwest (22%) and disruptions were also reported by 16% of clinics in the Northeast (including 35% of clinics in Connecticut and 13% in New York). Some 7% of clinics providing abortions in the West reported service disruptions around the time of COVID.

DISCUSSION

Our findings demonstrate that the long-term decline in abortion in the US had reversed. The number of abortions increased 8% between 2017 and 2020 and the abortion rate increased 7%. The nationwide increase was not uniform and we found heterogeneity across states and across time periods within states: some states saw steady increases between 2017 and 2020 while others saw increases between 2017 and 2019 but decreases between 2019 and 2020, or vice-versa. Below, we provide some contextual considerations and highlight findings that merit further inquiry.

Clinics play an important role in abortion access and, as in the past, we have found that the overwhelming majority of abortions (96%) were provided by these facilities. Notably, the total number of clinics providing this care nationally was stable between 2017 and 2020. While there were changes in clinic numbers for many states, they were not always in ways to suggest increased access to abortion. For example, the number of clinics fell in eight states where the number of abortions increased: Arkansas, Florida, Georgia, Maryland, New Jersey, New York, South Carolina, and Washington. In Oregon the number of clinics increased while the number of abortions declined. Indicators such as percentage of

counties without a clinic and percent of women living in them remained stable nationally and for most states. Still, it is potentially meaningful that the regions that had the biggest increase in abortion incidence—the Midwest and the West—also had increases in number of clinics.

Changes in pregnancy prevention strategies can also impact need for abortion. The most recent available data do not suggest substantial changes in types of contraceptives used. The National Survey of Family Growth for 2015–2017²⁸ and 2017–2019²⁹ reports that 65% of women 15–49 were using contraception at the time they were interviewed and similar proportions during both time periods were using a method of long-acting reversible contraceptives (10%), male or female sterilization (25% and 24%), or oral contraceptive pills (13% and 14%).³⁰ It is possible that individuals and couples used methods less consistently or had more sex more frequently, but these are unlikely to explain the scale of the increase in abortion documented in this study. Along with the increase in abortion, there were 241,600 fewer births in 2020 than 2017 and the birth rate decreased 6%.²³ These trends mean that compared to 2017, fewer people were getting pregnant in 2020 and, among those who did, a larger proportion were having abortions. Abortion is only one piece of a larger, still unclear, story about what drives changes in fertility in the US.

Medication abortion provided in a clinical setting increased substantially during the study period and, for the first time, in 2020 accounted for the majority of abortions. While mifepristone may have made abortion more accessible—for example, allowing abortion to be provided via telemedicine^{31,32}—it is unlikely to have been the primary driver behind the increase in abortion during the time period covered by this study. Medication abortion has been increasing since it was introduced in 2000,³³ even while abortion was declining nationally; greater use of medication abortion does not automatically increase abortion incidence. Additionally, the main increase in abortion incidence nationally, and in many states, was concentrated between 2017 and 2019, but reliance on medication abortion increased about the same over the two periods.

It is likely that the larger increase in medication abortion between 2019 and 2020 was due, at least in part, to COVID. Compared to procedural abortions, medication abortions require less, or even no, face-to-face contact between patient and provider,³⁴ and the drugs can be obtained via quick pick-up or the mail.²⁵ Indeed, we found that a substantial minority of clinics adopted these strategies in response to COVID and some were still offering them in 2021. We also found that the number and share of clinics offering *only* medication abortion remained stable, suggesting changes in the availability of medication relative to procedural abortions was not a primary driver behind the increased reliance on medication abortion.

COVID also impacted abortion care in other ways. States were affected by the pandemic at different times and state government responses varied widely. Some states, mostly in the Midwest and South, implemented temporary bans on abortion by deeming it “non-essential.” While some bans were only in effect for several days or weeks, they created confusion and disruptions to care. They may have contributed to the decreases in abortion between 2019 and 2020 in

Alabama, Alaska, Louisiana, and Texas.^{18,35} It is worth noting that some state’s COVID abortion bans only applied to procedural abortions;¹⁸ limitations on procedural, but not medication, abortions could have contributed to the increase in medication abortions.

It is likely that many facilities—including those in states with abortion bans—still had to reduce services because clinic staffs were dealing with illness, quarantines, remote schooling, and childcare.^{19,36} For example, COVID had intense and early impacts on New York state. At least 13% of clinics in New York reported disruptions and these dynamics might explain why abortion declined 6% between 2019 and 2020 after an 11% increase between 2017 and 2019. Similarly, the one clinic in South Dakota that provided abortion care had to halt services for 7 months in 2020 in response to COVID³⁵ and the number of abortions declined 69%.

In states where abortion care was not severely disrupted by COVID, clinics may have served more people traveling from states where abortion was less accessible. These dynamics may have contributed to increases in abortion between 2019 and 2020 in Colorado, Florida, Kansas, New Mexico, and Oklahoma.^{37,38}

Other factors that may have impacted abortion incidence and provision were unrelated to COVID. In Missouri the number of abortions decreased 96%, from 4710 in 2017 to 170 in 2020. Even in 2017, the majority of Missouri residents went out of state for abortion care.³⁹ This pattern was magnified between 2017 and 2020 in response to intrusive regulation by state health officials and the number of Missouri residents that obtained abortions in Illinois, in particular, increased substantially.²⁶

The overwhelming majority of people with Medicaid coverage use it to pay for their abortions when they live in states with state funding for abortion care.⁴⁰ Changes in Medicaid policy in two states may have made abortion more accessible to residents. In January 2018, Illinois allowed the use of state Medicaid funds to pay for abortion care and the number of abortions rose 24% between 2017 and 2019. Illinois also had five more clinics in 2020 as compared to 2017. Similarly, in January 2020, Maine allowed the use of state Medicaid funds to pay for, and required private health insurance plans to cover, abortion care; this coincided with a 13% increase in abortion between 2019 and 2020 compared to 3% between 2017 and 2019. On a more concerning note, West Virginia stopped allowing Medicaid coverage of abortion in 2018 and this may have contributed to the decline in abortion incidence in the state, 18% between 2017 and 2019 and 31% overall.

Slightly less than half of abortions occur in states that do not have Medicaid funding for abortion.⁴¹ In 2014, one in five people obtaining abortions in these states relied on financial assistance to cover at least some of the costs of this care.⁴⁰ Grassroots organizations and local abortion funds have existed for decades and one large, national fund subsidized more than 10% of abortions that occurred in 2020.⁴² There is some evidence that money distributed by grassroots organizations and local abortion funds, and the number of people who received it, increased substantially between 2017 and 2020.⁴³ If this same dynamic applied to large national abortion funds, this could have allowed more people to access abortions, especially in states where Medicaid could not be used to pay for this care.

LIMITATIONS

This study had a number of limitations. Although 84% of the abortions we counted in 2020 were based on information provided by individuals working at or for the facilities from which the data were collected, we estimated caseloads at facilities that accounted for 12% of abortions and used state health department data for the remaining 4% of abortions. This problem was particularly pronounced in six states, including larger ones such as New York (30%), Florida (33%), and New Jersey (40%). Readers and investigators should keep in mind that abortion estimates are therefore less precise in such states.

Our study underestimates the true amount of the increase in abortion since we only measure abortions that occurred in clinical settings. Research documented that more than 55,000 US residents requested abortion drugs from one online provider during the study period⁴⁴ and many of these requests undoubtedly resulted in self-managed abortions. US residents may also have obtained abortion drugs for self-managed abortion through other websites.⁴⁵

We are aware that our study did not capture some facilities that provide a small number of abortions per year—especially in hospitals and private physicians' offices. This, too, means that our study undercounts that actual number of abortions that occurred.

Our findings on disruptions to abortion services and changes to abortion provision around the time of COVID were obtained using data from the 77% of clinics. Facilities in the South were over-represented among those that did not respond to items about disruptions, but among those that did, clinics in this region reported the highest levels of disruptions. The opposite dynamic applies to clinics in the West. It is possible, then, that the prevalence of disruption in abortion provision is actually higher than our estimates suggest.

These analyses focus on abortion by state of occurrence and, for some states, do not reflect use of abortion by residents. In 2020, 9% of individuals obtaining abortions crossed state lines to obtain care. For example, recently published data show that 26% of abortions reported to have occurred to residents of Idaho and 88% of those to residents of Wyoming were obtained in other states.²⁶ Similarly, although the District of Columbia had the highest abortion rate in the country in 2019 and 2020, the majority of abortions provided in the District of Columbia in 2020 were for nonresidents, most commonly individuals from Maryland or Virginia.²⁶

CONCLUSIONS

This study demonstrates that the 30-year decline in abortion had reversed, underscoring that the need for abortion care had grown just as the US Supreme Court overturned *Roe v. Wade*. State bans on abortion care may decrease the number of abortions that occur but will not eliminate, or even reduce, need or desire for abortion. Further, following the Supreme Court's *Dobbs* ruling the number of clinics (and other health care facilities) offering abortion care undoubtedly dropped and the number of women of reproductive age living in a county without a clinic increased. To compensate for these restrictions, as well as the rapidly

changing landscape, patients may travel to other states for services (which imposes additional cost barriers, already known as a hindrance for accessing care), become increasingly reliant on self-managed care, or forgo care altogether. While abortion can be safely self-managed with medications,⁴⁶ patients deserve access to knowledgeable, non-judgmental, and culturally competent healthcare should they have questions or concerns about their abortion.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ENDNOTES

* Our designation of high volume depended on the total number of abortions in the state but was typically more than 200 abortions per year as recorded in the 2017 Abortion Provider Census.⁵

† We did not contact the Colorado, Kansas, Maryland, New Hampshire, New York state, or South Dakota state health departments, as they either do not collect these data, provide detailed reports online, or have delayed release of data.

‡ While our figures include abortions provided to women, transgender men, and non-binary and other individuals with the capacity to become pregnant, the Census Bureau data count women. We adopt the terminology of “women” when we discuss abortion rates but recognize that this denominator does represent all individuals who obtain abortions.

§ While we did not provide a definition, we intended “quick pick up” to refer to situations where an individual could go to the facility only to pick up medication abortion drugs, without receiving in-person counseling or examination.

¶ Our analysis places more emphasis on abortion incidence as opposed to rates because abortion rates for many states, and perhaps even the nation, will change, at least slightly, when population figures from the Census 2020 become available in late 2022 or early 2023.

** The figures of 95 and 86 do not perfectly align with the overall change of one less clinic in 2020 than 2017 due to change in classification of some facilities. Between 2017 and 2020, 22 facilities classified as clinics in 2017 were reclassified as physicians' offices ($n = 13$) or hospitals ($n = 9$) in 2020 and 12 facilities that were clinics in 2020 had been classified as physicians' offices ($n = 10$) or hospitals ($n = 2$) in 2017. Reclassification of facilities between surveys is standard; it is based on changes in abortion caseloads and, in the case of most hospitals, new information acquired during fielding.

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APPENDIX A

TABLE A1 Total number of abortion-providing facilities, 2017 and 2020, and percentage change, by region and by state

Region and state	2017	2020	% Change
United States total	1587	1603	1
Northeast	518	545	5
Connecticut	54	78	44
Maine	21	24	14
Massachusetts	47	44	-6
New Hampshire	12	12	0
New Jersey	76	75	-1
New York	252	262	4
Pennsylvania	43	36	-16
Rhode Island	3	4	33
Vermont	10	10	0
Midwest	137	150	9
Illinois	40	45	13
Indiana	9	12	33
Iowa	9	7	-22
Kansas	4	4	0
Michigan	30	33	10
Minnesota	11	14	27
Missouri	4	2	-50
Nebraska	7	6	-14
North Dakota	1	2	100
Ohio	14	15	7
South Dakota	2	2	0
Wisconsin	6	8	33
South	314	291	-7
Alabama	7	5	-29
Arkansas	4	2	-50
Delaware	6	5	-17
District of Columbia	8	8	0
Florida	85	76	-11
Georgia	26	24	-8
Kentucky	3	6	100
Louisiana	4	3	-25
Maryland	44	38	-14
Mississippi	3	3	0
North Carolina	26	23	-12
Oklahoma	6	7	17
South Carolina	10	6	-40
Tennessee	12	11	-8
Texas	35	37	6
Virginia	32	31	-3
West Virginia	3	6	100
West	618	617	0

(Continues)

TABLE A1 (Continued)

Region and state	2017	2020	% Change
Alaska	6	5	-17
Arizona	11	16	45
California	419	418	0
Colorado	32	35	9
Hawaii	28	25	-11
Idaho	5	5	0
Montana	5	6	20
Nevada	11	11	0
New Mexico	7	8	14
Oregon	29	29	0
Utah	12	8	-33
Washington	51	49	-4
Wyoming	2	2	0