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Separation of Church and State: Stratified Access to Reproductive Healthcare In The United States

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**SEPARATION OF CHURCH AND STATE:
STRATIFIED ACCESS TO REPRODUCTIVE HEALTHCARE IN THE UNITED
STATES**

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Submitted in partial fulfillment of the requirements for
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ABSTRACT

Reproductive rights continue to be a political issue in the United States, with arguments emanating from various angles - including religious and feminist ideologies. The contentious tone of the recent presidential election did nothing to quell the debate. Recently, attempts to create policy limiting access to contraceptives and comprehensive sex education, are important aspects of reproductive health, but the controversy predominantly lies with access to abortion.

The purpose of this study is to understand if there is a relationship between elected office holders' political party affiliation and the presence or absence of both Planned Parenthood clinics and so-called crisis pregnancy centers. There are implications associated with discrepancies in access to healthcare, especially when access to various medical procedures and medications are not permanently protected under federal law. Ideologically, there are drastic differences between Planned Parenthood and crisis pregnancy centers- thus forcing women to choose between what many consider to be the two extremes of reproductive health care models based on geographic location and accessibility. Analyzing the impacts of both models of reproductive health care by researching rates of teen pregnancy and abortion, to name a few, allows us to rethink the limitations that come with hindering women's autonomy surrounding their own reproductive health care. Comparing the efficacy of both models of reproductive health care gives way for the United States to explore and implement a method that is shown to work to the benefit of women throughout the country instead of women in specific geographic or cultural locations. Lastly, this

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work will conclude with suggestions for positive change regarding reproductive health care as well as future directions.

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INTRODUCTION

Roe v. Wade was the beginning of an ideological evolution. The ability on part of women to make choices regarding their reproductive health was one we would surely see challenged for decades to come, however it enabled populations of people to continue fighting for equality on a variety of women-related issues. Following the United States Supreme Court decision in the seventies, a plenitude of religious ideologies and foundations emerged in antipathy to *Roe v. Wade*, and worked to reinstate the moral compass that was perceived as lost with the decision. Over time, we have seen a rise in organizations working to uphold *Roe v. Wade*, but also those that are in staunch opposition; like the efforts of groups commonly referred to as the religious right. Keeping this in mind, the United States today has an abundance of women's reproductive health care facilities, comprised of both anti-choice and pro-choice organizations. However, while organizations like Planned Parenthood, which was founded in 1916, are dedicated to fighting for women's rights and to preserve *Roe v. Wade* there are still populations of people who parallel that of the resistance following *Roe v. Wade*. Today we see what many would consider two extremes of reproductive health care- a distinct dichotomy within an affluent American institution. My analysis will focus on reproductive health as encompassing of sex education and contraceptives, but primarily abortion access; keeping this in mind, my analysis will be oriented around cisgendered women. I operationalize my analysis by way of comparison between Planned Parenthood and crisis pregnancy centers- two embodiments of the extreme binary of women's reproductive health care options.

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To further explain, Planned Parenthood is a national organization that works to provide education, general reproductive healthcare, and is an organization dedicated to the advancement of women's reproductive rights. Their mission statement, in summary, is that regardless of financial status or ability, they believe in the "fundamental right of each individual, throughout the world, to manage his or her fertility, regardless of the individual's income, marital status, race, ethnicity, sexual orientation, age, national origin, or residence" (Planned Parenthood 2016). There are 650 Planned Parenthood health centers throughout the United States, which are estimated to have served approximately one-fifth of U.S. women at least once in their lifetime as well as educated 1.5 million young people and adults annually (Planned Parenthood 2014). As for cancer detection, Planned Parenthood performs over 270,000 pap tests and 360,000 breast exams annually, as well as provides over 4.2 million sexually transmitted infection tests and treatments every year (Planned Parenthood 2014). Lastly, pregnancy prevention, which is defined as services preventing unintended pregnancies, comprise 80% of all services provided by Planned Parenthood; while abortion services, on the other hand, encompass 3% of all services (Planned Parenthood 2014).

In contrast, crisis pregnancy centers are facilities operating under the guidance of a few umbrella organizations and work through a Christian praxis (NARAL 2016). Heartbeat International and CareNet are two examples of said umbrella organizations. There are approximately 4,000 centers active throughout the United States, and their prevalence within states vary (NARAL 2016). These organizations have been cited as marketing themselves under false pretenses of providing comprehensive reproductive healthcare, when in reality they have

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been shown to use scare tactics, propaganda, and false or misleading information to pressure women into carrying a pregnancy to term. Additionally, they have been shown to withhold information from clients in order to set them back, as certain abortion laws follow a strict timeline and require specific tests and paperwork in order for women to have an abortion (NARAL 2016). While these organizations provide free services like counseling and giving mothers diapers and formula, maternity clothing, referrals to social services, housing, prenatal care, STI testing, and even financial assistance, there are requirements in order for these services to be “free”; for example, women are required to attend mandatory Bible studies, parenting classes, and, in some cases, abstinence seminars (Kelly 2012). In contrast to Planned Parenthood and facilities that provide abortions, these facilities are federally funded through varying processes. Examples include the 2001 allowance for \$20 million for young-adult abstinence-based programs that outlaw discussions of contraception outside of failure rates, and the Missouri bill in 2000 that allocated portions of the state’s tobacco settlement money to CPCs; also, policies that allow financial gain of CPCs from the sale of anti-choice license plates costing anywhere between \$20-50 (Lin 2002).. Another example is in 2000, when Oklahoma allowed for the *direct* funding of CPCs (Lin 2002).

As shown above, there are drastic differences in the services provided by these organizations. Women are not given a spectrum of options that appeal to them, and rather they are faced with two extremely different options, some of which are not given an option at all due to geographic location and financial ability. This limitation on women’s autonomy when choosing health care for reproductive purposes and family planning is highly problematic. While

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there are indeed medical facilities equipped to do many of the same services, they are not geared towards those who have fewer financial privileges and are not available to educate young people in their everyday lives. The conversation surrounding reproductive rights has not quelled since the 1970s. The recent and contentious presidential election has led to fears associated with the presidential election surrounding women's health, insurance, contraception and abortion specifically. Furthermore, political legislation, such as Ohio's Heartbeat Bill and twenty-week ban, (Ludlow 2016) have led to a demand for answers as to what women's reproductive health care and accessibility will look like moving forward.

The purpose of this study is to understand if there is a relationship between elected office holders' political party affiliation and the presence or absence of both Planned Parenthood clinics and so-called crisis pregnancy centers. The implications associated with discrepancies in access to healthcare, especially with a lack of permanent protection under federal law, are immense within economics, family planning, efficacy of social and child services, and much more. Analyzing the impacts of both reproductive healthcare models by researching rates of teen pregnancy and abortion, to name a few, allows us to rethink the consequences that come with limiting women's autonomy surrounding their reproductive healthcare. I hypothesize that this research will show the impact that such drastically different models of reproductive health care will have. Simultaneously, I expect this research to show the influence that political power has over not only the proliferation of anti-choice praxis within women's health, but the degree to which personal ideology and power work in tandem to create an uneven distribution of access to women's reproductive healthcare in the United States.

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Previous research has explored women's access of reproductive health care, crisis pregnancy centers especially, using a variety of praxes and theoretical lenses. The ideological dichotomy presented in comparisons of CPCs and Planned Parenthood parallels that of available information and efficient research methods pertaining to both models. For example, one can research Planned Parenthood's methods and practices through means of observation of their public advocacy and presence in both state and federal politics as they are a single, national organization. Additionally, Planned Parenthood and their services are relatively easy to procure by way of their official website, allowing you to easily find provided services as well as quantifiable measures depicting the frequency of specific services in their clinics. As crisis pregnancy centers do not provide the same services as Planned Parenthood, such as abortion, there are no statistical analyses detailing their interactions with varying communities and identities. With this being said, the use of qualitative analysis is advantageous for understanding the theoretical connections between micro-level interactions within clinics and macro-level happenings in politics, as well as on the front lines of the reproductive culture war; thus the majority of reviewed literature uses a qualitative and theoretical approach to understand crisis pregnancy centers and their role in modern American society.

To understand the qualitative connections between crisis pregnancy center practices and American society, it is imperative that the foundational ideologies that forged modern day crisis pregnancy center practices are acknowledged. Cynthia Burrack's *Tough Love: Sexuality, Compassion and the Christian Right* (2014) as well as her work with Jyl J. Josephson titled *Fundamental Differences: Feminists Talk Back to Social Conservatives* (2003), delves into the

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foundational relationship between not only the religious right and abortion politics, but also the proliferation of neoliberal influences in policies directly impacting women, which strongly parallel the existing structure within crisis pregnancy centers. Burrack analyzes the major claims of Christian compassion within the religious right, which in a way personify the anti-choice movement and arguments up through the current stage that CPCs perfectly embody in their practices. Burrack asserts that Christian compassion has three problematic aspects: 1.) it encourages “moral meddling” within an undemocratic vessel, 2.) it creates a religiously defined system of stratification separating “deserving” and “undeserving” people, and 3.) it neglects the stigmatization that stems from such stratification and further discourages any acknowledgement of harm-doing (Burrack 2014). The othering of those deemed “undeserving” is perceived to be a necessary distinction, a way in which coercion is used to socially discipline and gain control over those considered to be lacking a moral compass- to influence with authoritarian compassion (Burrack 2014). While these claims may seem implausible when viewed through a macro-level lens, the social dynamics are quite visible when analyzing documented patterns of interaction within CPCs.

For instance, the 2016 NARAL report brought to light a variety of practices carried out within crisis pregnancy centers that show ideological consonance. As previously touched upon, CPCs offer free services to women who decide to continue with their pregnancy, such as housing, prenatal care, baby supplies, maternity clothes, and more. However, while these services are free of financial costs, the usage of services offered are many times contingent on mandated attendance and participation in activities like Bible studies, parenting classes, or even

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abstinence seminars (NARAL 2016). Additionally, crisis pregnancy centers have been shown to target areas of lower income and communities of color as these are populations that they perceive to have a more positive abortion attitudes, and are more likely to be persuaded by the benefits that free or low costs services provide despite their contingencies (NARAL 2016). CPC volunteers target such populations by positioning themselves outside of pre-existing abortion providers to engage and redirect women, by developing initiatives with local strongholds, like churches, within communities of color, and by educating volunteers on how to reach those who are dependent on public transportation as well as other variables that are highly intersectional with people of color and of lower-income (NARAL 2016). The ways in which CPCs actively target populations based upon their perceived attitude towards abortion and socioeconomic status strongly resembles Burrack's claim regarding moral stratification within Christian compassion. Furthermore, the promise of "free" services that are conditional on mandated attendance or participation in activities that are many times religious in nature further align with Burrack's analysis of Christian compassion as a framework for compassionate control and discipline (Burrack 2014).

Keeping this in mind, neoliberal principles within women's reproductive health care is exceedingly relevant in the ways that crisis pregnancy centers internally utilize Christian compassion to function alongside the U.S welfare system. As stated by Nancy D. Campbell (2003):

Compassionate conservatism delegitimizes the welfare state by displacing blame from the differential effects of social structure and public policy onto individual attitudes, beliefs, and decisions about family formation and configuration, sexual and reproductive practices, and employment. The deflection from public to private, from macro to micro,

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from social to personal responsibility is useful to the project of restructuring the neoliberal state by scaling back social provision while expanding the penetrating reach of the carceral state. (Campbell 2003:113).

While the relationship that compassionate conservatism has to the American prison system is irrelevant to this work, the repercussions of the religious right and anti-choice movement's neoliberal efforts to shift politics pertinent to female autonomy of sexual and reproductive choices strongly parallels what Campbell argues. To expand, it is necessary to consider the objective of crisis pregnancy centers as entities striving to end abortion by way of personally offering alternatives and resources for women, such as the contingent free resources previously mentioned. While CPCs have more recently expanded their suggested options to include references to social services or perhaps even considering advisement of single parenthood in cases where the woman is strongly leaning towards abortion, it is important to recognize that their immediate hope is to convince a woman to continue the pregnancy and begin a family with the father of the child or to give the child up for adoption to a Christian family (Kelly 2012). The counseling given by CPC workers to women who enter their facility is extremely oriented towards options found within the confines of the private sphere, rather than the public sector and its provided resources, which is quite the opposite from Planned Parenthood. The deflection dynamic within CPCs, the shift from social to personal that Campbell references, is arguably a cornerstone of crisis pregnancy center efforts, thus embodying neoliberal influences in women's reproductive health care throughout the United States.

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Federal and state policies dictating reproductive health care practices further examine and identify the ideological reach that Planned Parenthood and crisis pregnancy centers have within the United States. Both federal and state policies restricting abortion access have become increasingly prevalent within the past twenty years, give or take. Following the US Supreme Court decision in the 1992 case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, in which the court defined “undue burden,” states began developing increasingly restrictive abortion policies within gaps of the interpretative nature that is the policy (Medoff 2016). The defining of undue burden was designed to explain and delegitimize policies enacted as a method of creating substantial obstacles for women seeking abortion services, and as a way to uphold *Roe v. Wade* (505 U.S. 833: 1992). While the court favored Planned Parenthood in a 5-4 vote and defined undue burden as a measure of legal validity, the court also upheld three of the four original policies that Planned Parenthood had been challenging. The three upheld policies included a 24-hour waiting period, parental consent if the woman is a minor, and informed consent; while, on the other hand, the only policy deemed unfit under the scope of undue burden was the spousal consent of a married woman seeking an abortion (Medoff 2016). While the definition of undue burden has several benefits, it has also allowed means of evasion for states seeking restrictive laws; for example policies limiting or denying Medicaid funding for abortion services, parental involvement, mandatory counseling and waiting periods swept the nation (Medoff 2016). Furthermore, restrictive and “Targeted Regulation of Abortion Provider” (TRAP) laws have increased in popularity, as approximately 300 abortion restrictions have been

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enacted in the United States since 2010, 51 of which passed within the first half of 2015 alone (Gerds, et al. 2016).

Restrictive policies and TRAP laws heavily intersect with family planning, welfare, and economic policies (Gerds, et al. 2016). While restrictive policies tend to be discussed on the larger scale as compromise proposals, or perceivably as a tumultuous middle ground for two contrasting ideologies of strong dissonance, they are more often than not situated within the realm of welfare and potential economic variances. With this in mind, a study conducted in 2010 surveyed the degree to which state policies of welfare generosity impacted rates of abortion, as the decision to have an abortion is based on several factors aside from access to abortion providers like Planned Parenthood (Hussey 2010). Laura Hussey (2010) theorized that the expansion of childcare, health care and economic benefits for families should incentivize marginalized women and women of lower income to carry out pregnancies, and that the diminished demand for abortion services would lessen the supply. Results showed that there was little to no relationship between welfare generosity and lower abortion rates, as the ten most generous states exceeded the ten least generous states in abortion rates despite offering cash welfare, child care grant money, and Medicaid eligibility by 61%, 56%, and 21% respectively (Hussey 2010). As for family leave, twelve states with family leave laws that were more expansive had abortion rates 3% higher than other states; on the other hand the 25 states without family cap laws had abortion rates 9% lower than those that did, and the eleven states that enforced parental involvement laws, mandated counseling, and bans on Medicaid funding had nearly 50% fewer abortions (Hussey 2010). These findings, as Hussey explains, are likely

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influenced by geographic and social factors. For example, Norrander's mean abortion legality measure (2001) essentially shows us that geographic areas and communities tend to be more homogeneous in their attitudes of abortion. Social factors could have impacted Hussey's study results as they may stem from communities and geographic regions that were collectively pro- or anti-choice, therefore offering more or less psychological and financial costs to women who may want to have an abortion which further influences results (Hussey 2010). This finding is relevant to the current study, as welfare generosity is frequently called into effect during conversations of restrictive abortion policies and TRAP laws; however, Hussey's findings show that while individual restrictive laws may have an influence on abortion rates, they are contingent on geographically-located social tendencies and whether or not other policies are counteractive when enacted together.

In contrast to Hussey's analysis of abortion rates under restrictive abortion laws, another study evaluated the state of Texas after passing a bill in 2013 that resulted in the closure of over half of the state's abortion providers (Gerdtz, et al. 2016). Texas House Bill 2 mandated the following 4 restrictions on abortions: 1.) Physicians had to obtain privileges at a hospital within 30 miles of their facility, 2.) Medical abortions had to be administered according to labels approved by the Food and Drug Administration, 3.) Abortions, for the most part, were banned at the 20-week gestation point, and 4.) In order to perform abortions, the facility had to meet ambulatory surgical center (ASC) requirements (HB. 2, 2013; Gerdtz, et al. 2016). Following the passage of Texas House Bill 2 a study compared the indicators of burden for women whose nearest clinic was closed compared to those whose were not. Within this study, indicators of

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burden were operationalized by analyzing the prevalence of high out-of-pocket costs, overnight stays, appointment scheduling delays, and the inability to receive the preferred abortion method (Gerdts, et al. 2016). Results showed that clinic closures caused drastic discrepancies in access for the 38% of women whose nearest clinic had closed compared to those who had not. Such discrepancies included the clinic closure group traveling four times the distance of women whose nearest clinic remained open, having a higher probability of experiential hardship in receiving a medical abortion, and needing to travel more than fifty miles to get to a clinic as data showed them having a mean one-way distance of 85 miles compared to the other group's 22 miles (Gerdts, et al. 2016). While two of the Texas House Bill provisions were deemed as an undue burden to women in 2016, this study not only presents emotional, financial, and medical choice difficulties stemming from discrepancies in reproductive health care access, but it also supports the argument that restrictive laws, while bolstering obstacles, fail to discontinue abortion practices (505 U.S. 833: 1992).

While Gerdts, et al.(2016) focused primarily on distance discrepancies, it is conceivable that a similar pattern of discrepancy in accessibility would occur if available reproductive health care models were in staunch ideological opposition: such as Planned Parenthood and crisis pregnancy centers. For example, CPCs have been shown to position themselves nearby abortion providers while simultaneously naming their facility something nearly identical to that of the neighboring abortion provider. These methods of confusion are used to intercept women seeking abortion services, as CPC marketing practices are oriented to persuade women who are interested in abortion services to enter a facility whose mission it is to talk women out of abortion. As an

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illustration, a 2014 quantitative study collected twelve state resource directories for women seeking abortion services and found a high degree of misinformation within crisis pregnancy center websites (Bryant et al. 2014). Researchers found a total of 254 websites that collectively referred to 348 CPCs, in which 203 websites has at least one piece of false or deluded information. More specifically, these sites made references to abortion side effects that have been discredited with scientific studies; out of the 203 websites containing false information, 122 sites stated mental health risks, 54 sites spoke of potential breast cancer, and 32 sites warned of future infertility (Bryant et al. 2014). The use of false medical claims and confusion tactics by CPCs impedes, and potentially obstructs women from being able to receive and make informed decisions regarding their pregnancy with accurate medical information; thus, women are being denied full autonomy and access to their preferred model of reproductive health care.

The choices available to women are being partitioned in more ways than those present within crisis pregnancy centers. Federal programs and the anti-choice movement have evolved to characterize women and their health choices according to carefully crafted narratives. The anti-choice movement specifically began their efforts by focusing on harm to the fetus rather than the criminalization of women following an abortion, which then transitioned to villainizing abortion via the Genocide Awareness Project (GAP) in which they compared America's lack of intervention with Nazi Germany to the practice of abortion. Moving forward, the anti-choice movement implemented "sidewalk counseling" and referring to abortion as child murder and dangerous (Burrack 2014). Within the last fifteen years, these approaches have shifted to one that argues against abortion using erroneous scientific pedagogy. For example, in the early 2000s the

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anti-choice movement claimed “postabortion syndrome,” which is comparable to posttraumatic stress disorder, to be a potential result of having an abortion, and as horrifically harmful to women. However, in both 2004 and 2008 the American Psychological Association released reports that in summary rejected such claims (Burrack 2014). At the end of this long evolution of the anti-choice movement we find crisis pregnancy centers today: Facilities whose mission it is to prevent abortions at all costs including the use of fear tactics and intimidation, propaganda, including what Burrack refers to as “the politics of yuck,” and false medical information and documentation that does not meet federal and state guidelines, all while positioning itself under the guise of medical qualification (NARAL 2016). The history of Planned Parenthood and crisis pregnancy centers is extensive and complex, but historical artifacts and variables that contributed to the development of both forms of reproductive health care are pertinent today in not only their existence but also within ideologies fueling modern day policies.

These stages of the anti-choice movement have limited the options given to women with crisis pregnancy centers, and has led to the formulated perspectives of facilities like Planned Parenthood. While the founder of Planned Parenthood, Margaret Sanger, has been argued to have begun its mission as an effort to aid to the eugenics movement, there is the other perspective that the mission of Planned Parenthood was started to improve women’s health. Abortion was illegal during the mid-to-late 1800s, and it is argued that the American Medical Association aided such efforts to limit the competition provided by non-medical personnel, such as midwives, as abortion was a countermeasure to childbirth, which had a remarkably high mortality rate (National Abortion Federation). The liberalization of abortion laws began as a response to the

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number of illegal abortions, which were estimated to range around 1.2 million annually, and the dangerous consequences women faced as those who provided such services were untrained with limited resources, or abortions were self-induced (National Abortion Federation). Not only did these circumstances lead to the eventual passage of *Roe v. Wade*, but, arguable, Planned Parenthood emerged much further in advance as a way of combating Comstock laws and as a way of providing information and contraceptive to avoid the demand for abortion in the first place and to give women reproductive agency.

In addition to insular movements that have branched out to external, societal factors, there are large scale policies that heavily impact the decision-making of women dependent on them, such as Temporary Assistance for Needy Families (TANF). TANF, for example, is a program developed to aid families in achieving self-sufficiency but is based on ideals of marriage and gender-essentialist roles within the family unit (Mink 2003). Such gender-essentialist roles are an emphasis on “responsible fatherhood” and men being solely responsible for financially supporting a child, impeding unmarried women from having children, and focusing on men when looking at decision making within the family, many of which parallels the crisis pregnancy center approach of offering options to women considering plans of action (Mink 2003). Valerie Lehr (2003) further analyzes the ways in which “wedfare” and the “equality trap” isolates family choices, including reproductive choices, and pushes the private sphere using feminist rhetoric, similar to that of CPCs. Policies have been increasingly promoting “wedfare” over workfare as a way to promote two-parent households via abstinence education and adoption rather than single-parenthood and abortion by limiting benefits to

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mothers of multiple children and making benefits contingent on teen mothers living with their parents (Lehr 2003). Narratives of men in non-nuclear familial relationships paints an image of men as “creatures with uncontrollable passions and little sense of commitment or loyalty,” that can only be reprimanded by legally-induced responsibilities like marriage (Lehr 2003). Such images are not only degrading to the abilities of men, but are demeaning women as incapable of independence, and are further used as tools to persuade women with unintended pregnancies to pursue marriage or adoption, especially when considered alongside the negative rhetoric and propaganda of abortion provided by CPCs.

Despite these sanctions and anti-choice efforts to promote outcomes aside from abortion, it has been shown that anti-abortion activities do not actually hinder abortion rates (Medoff 2003). More specifically, Marshall Medoff showed the lack of impact that abortion harassment has on the demand for abortion services. Harassment policies, especially at the time of Medoff’s research, were highly prevalent to the point of being experienced by 55% of nonhospital workers; additionally, they were highest in urbanized areas, the Midwest region, and in areas with a prevalent abortion provider population (Medoff 2003). By researching vandalism, stalking, and picketing with contact to abortion providers and clients, Medoff found that rather than lessening abortion demand such harassment policies reduced the supply of abortions. This finding is important because a lack of supply with a steady demand of abortion services does not lead to improved women’s health or status of living for those who are in financial need or seeking help and resources.

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Research has shown that rather than limit access to abortion, women especially from marginalized communities need better access to sexual education, contraception, and a multifaceted approach to reproductive health. Santelli, et al. (2007) presents incredibly telling research that shows the importance of contraceptive education and usage. The research, which ranged from 1995 through 2002, analyzed the contraceptive risk index (CRI) and overall pregnancy risk index (OPR; Santelli et al. 2007). Research showed that contraception usage during those years increased by way of condoms, birth control pills, injection, and even withdrawal, as well as a combination of two or methods, all while rates of nonuse decreased (Santelli et al. 2007). Among fifteen to seventeen year olds specifically, CRI declined 34%, while the CRI of eighteen and nineteen year olds decreased by 46%. The introduction of contraceptive and sex education led to the OPR index to decrease by 55% in ages fifteen to seventeen, and by 27% among eighteen to nineteen year olds (Santelli et al. 2007). Change or increase in contraception methods were responsible for 86% of change in (as above) year olds when compared to change due to a decrease in sexual activity, which was 14%; meanwhile reduction was 100% attributed to an increase in contraception use among eighteen to nineteen year olds (Santelli et al. 2007). Such findings promote the importance of comprehensive sex education compared to abstinence-based education, and therefore raises questions regarding the efficiency of CPCs compared to Planned Parenthood's as CPCs do not offer education on sex or contraception outside of abstinence.

The dichotomy that is options of models of reproductive health care and family planning in the United States is not only extreme, but proves to have different degrees of difficulty for

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different populations of people. Dehlendorf et al.(2013) provides one of the most convincing reports of discrepancies among marginalized communities pertaining to reproductive health.

Dehlendorf, et al. begins their research with a valuable disclaimer, as their motivation was not to discover findings that promoted or discredited abortion, but rather emphasize helping women obtain the personal and healthy reproductive options that work for them. Researchers found that people of color and low income or education people face overall worse outcomes when it comes to their health in forms of higher rates of infant mortality, incidence of cancer and lower life expectancy due to decreased access to healthcare, higher levels of stress, poorer living and working conditions, and exposure to discrimination. This prompted further investigation into how these statuses intersected with reproductive health. Additionally, they reference the impact that a history of racial discrimination and racism has had, such as the eugenics movement, on marginalized women's decisions regarding reproduction and their relationship to healthcare professionals (Dehlendorf et al. 2013).

Dehlendorf et al. began by acknowledging the adolescent and non-adolescent unintended pregnancy rate, which was 80% and 51% respectively, and the breakdown of such rates among race and class. For non-adolescents, rates were a staggering: 70% for black women, 57% of non-white Hispanic women and 42% of white women. While adolescents were 124 per 1000 for black girls, 129 per 1000 for Hispanic girls, and only 44 per 1000 for white girls (Dehlendorf et al. 2013). As for class, unintended pregnancies were broken down by federal poverty line (FPL), in which unintended pregnancies among women with the FPL less than 100% was at 64%, compared to those over a FPL of 200% being at 37% (Dehlendorf et al.) Their research was

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conducted by operationalizing women's risk of unintended pregnancy, which promotes findings associated with discrepancies in education or contraception more so than those associated with unintended pregnancies and seeking abortion services, and began by presenting age of onset of sexual activity. It is shown that black adolescents tend to begin earliest, then white adolescents and lastly Hispanic adolescents with a mean age of eighteen years old (Dehlendorf et al. 2013). Risks while having sex without contraception showed racial disparities as black women were shown to have risks around 17.2%, while Hispanic and white women were at 10.4 and 9.5% respectively; as well as a 21% rate of contraceptive failure within one year among black women, 15% rate among Hispanic women, and only 10% among white women (Dehlendorf et al.). The previously studied topics that have been shown to breed such discrepancies are differences in neighborhood-level resources, access and quality of family planning, higher levels of poverty, attitudes surrounding abortion, a lack of opportunities and mistrust of healthcare providers and contraception, which further led to a perceived infertility among women of color (Dehlendorf et al. 2013). Most of these factors are qualities that attract crisis pregnancy centers, which further adds importance to this study analyzing differences in reproductive healthcare in particular.

With these risk factors in mind, Dehlendorf et al. looked at the *quality* of reproductive health care in that non-white women are found to rate their health care less positively, experience more pressure to seek out contraceptive information, limit family size, and receive different recommendations than their white peers. Women of color were also shown to have less knowledge surrounding sex education while having more concerns regarding contraceptive methods. Additionally, women of color held higher levels of mistrust in the healthcare system;

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approximately 52% and 42% of black and Hispanic women believe the government promotes birth control to limit minorities, while only 25% of white women share that same belief (Dehlendorf et al. 2013). Pregnancy reactions were equally shocking, as 66% of white women reported they would become “very upset” if they were to become pregnant, while only 51% and 46% of black and Hispanic women responded similarly. Such statistics show large racially-based gaps in education, trust of medical resources, and, arguably, conditioning surrounding unintended pregnancy.

Continuing with Dehlendorf et al.’s (2013) findings, abortion rates mirrored that of the discrepancies seen above with both race and socioeconomic status, as rates among white women were 12 per 1,000 while rates among black women were 40 and Hispanic women were 29 per 1,000 reproductive-age women. As for socioeconomic status, women with an income falling under 100% FPL were showing abortion rates of 52 per 1000 reproductive-age women while women with incomes greater than 200% were only 9 per 1000 reproductive-age women (Dehlendorf et al.). Following such results, the researchers argue for a multifaceted approach embodying efforts to prevent unintended pregnancy, or primary prevention, while also providing resources for those who do become pregnant, or secondary prevention. Primary prevention is proposed by researchers by increasing insurance coverage for family planning, developing contraceptive services and education, acknowledging historical factors limiting trust within communities of color to improve the relationship, and engaging with communities to expand education access. Additionally, Dehlendorf et al.(2013) argues for treating abortion and negative consequences similarly to how we would approach negative consequences with issues like

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diabetes- by working to improve health outcomes; such ways included preventing maternal and abortion-related mortality, providing both public and private insurance for abortion services, and increasing providers to ensure women seeking abortions receive safe services.

The discrepancies laid out by Dehlendorf et al. (2013) cannot go unnoticed, as it has been shown that efforts to limit access to safe abortions do not hinder the demand for such services. Currently, the United States has implemented an abundance of obstacles for women seeking abortion aside from the existence of facilities promoting such obstacles. NARAL's 2015 report detailing abortion-related measures enacted state by state show that in 2014, 22 pro-choice measures were authorized compared to 27 anti-choice measures; additionally, between 2004 and 2014 there were 373 pro-choice legislatures at the state-level in relation to 835 anti-choice sanctions within the same time frame. As reported by NARAL (2015), 47 states, as well as the District of Columbia, have bans on abortion that are "*unconstitutional and unenforceable*."

Together with the prevalence of facilities like that of crisis pregnancy centers, it is evident why these policies and the research explored thus far are of importance, as well as the research at hand. Anti-choice policies have become more and more powerful within legislation and prevalent throughout the United States, and increasingly limit the options available to women when it comes to their body and family. Crisis pregnancy centers currently embody an ideological compilation of the anti-choice movement, which in turn sheds light on ideologically fueled practices taking place. Furthermore, such findings support the imperative nature that this research presents, as it is expected to show the ways in which state political affiliation intersects

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with access to women's reproductive healthcare, and the efficiency of such health care in the United States.

METHOD

Methods & Materials

Research was conducted as a secondary statistical analysis, and used sources from the U.S. Census Bureau, the Guttmacher Institute, NARAL Pro-Choice America, the Kaiser Family Foundation, and more. Additionally, the use of previous research and other literature developed a theoretical guideline for interpreting data.

Collected data included state party affiliation, assigned NARAL grades depicting access to comprehensive reproductive healthcare, total minority population, the 2013 state population, as well as the number of women within reproductive age (ages 15-40). I obtained state party affiliation by reviewing state electoral data from the 2012 election; the reasoning for using the data from 2012 stems from the increased voter turnout and the additional fact that most of the data and literature used is from approximately the same time. Additionally, variables included the number of unintended births and unintended pregnancies, as both have been used in previous literature, rather than solely relying on abortion rates and statistics, which were listed within my data set as well. Due to the anonymity of medical statistics, we are unaware of why abortions are performed on a case-by-case basis, and are done for a variety of medical reasons. With this being said, reviewing unintended pregnancy and birth rates solely focuses on pregnancies and births that were not intended in the first place, rather than general abortion rates that do not control for

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cases in which abortions took place out of medical necessity or for reasons independent of a woman's desire to continue the pregnancy.

In addition to those listed above, variables included the number of Planned Parenthood's and the estimated number of crisis pregnancy centers per state. Due to the drastic differences in marketing and visibility in the public eye, many statistics were difficult to find. For example, Planned Parenthood and their services are relatively easy to procure by way of their official website, allowing you to easily find provided services as well as quantifiable measures depicting the frequency of specific services in their clinics. Due to the nature of crisis pregnancy centers, it is much more of an approximation when stating numbers of CPC facilities; this is exaggerated by the fact that CPCs do not operate under a single, national organization. As crisis pregnancy centers do not provide various services, such as abortion, there are no statistical analyses detailing their interactions with varying communities and identities. With this being said, the numbers of Planned Parenthoods and CPCs were used as variables for analyzing relationships between other variables. For example, the number of facilities was used as an independent variable when reviewing rates of unintended pregnancies and births, and a dependent factor when reviewing party affiliation of the states. Due to these limitations, a theoretical approach is of importance when analyzing the impacts of both Planned Parenthoods and CPCs.

Analysis

The analytic methods used were primarily correlations and mean-value analyses using IBM SPSS v.24 Statistics Data Editor.

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RESULTS

To start, it has been well documented that the crisis pregnancy centers and Planned Parenthood have drastically different services and ideologies. Due to these drastic differences, it is important that there is an equal distribution of both methods to ensure that women are able to practice their body autonomy by choosing a methods that works best for them. To illustrate, a significant correlation emerged between the number of reproductive-aged women in the United States and the numbers of CPCs ($r = 0.889, n = 50, p < 0.01$), such that the number of crisis pregnancy centers increases with the population of women between the ages of 15-40. Similarly, there was a significant correlation between women within the ages of 15-40 and the number of Planned Parenthoods ($r = .783, n = 50, p < 0.01$), such that the number of Planned Parenthood facilities increase in tandem with the number of reproductive-aged women. However, while there may be a positive correlation between the population of women within reproductive age, quite the opposite is evident after calculating the ratio of Planned Parenthoods to CPC. Nationwide there is a rounded ratio of 1:30, showing that for every Planned Parenthood there are 30 CPCs. Additionally, both blue and red states follow a similar pattern with the ratio of Planned Parenthoods to CPCs being 1:25 among “blue” states, and 1:44 among “red” states. These statistical imbalances between prevalence of CPC facilities and Planned Parenthood facilities imply a similar level of inaccessibility. As discussed in Gerdtts et al. 2016 study, obstacles to comprehensive reproductive health and more specifically abortion do not hinder the demand for such medical procedures; with this being said, it can be theorized that the disproportionality of

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crisis pregnancy centers when compared to the number of Planned Parenthoods' only limits women seeking services such as abortion, contraceptives, and comprehensive sex education.

In order to further explore the ways in which demand for abortion services surpass that of anti-choice efforts, I collected data that detailed the number of unintended pregnancies and births. To reiterate, the reasoning behind focusing on unintended rates stems from a lack of benefit coming from the imprecise nature of general abortion rates, as the number includes the termination of any pregnancy regardless of circumstance or intention to carry out a pregnancy. More specifically, the use of unintended pregnancy and unintended birth statistics allows for a stronger analysis when reviewing the decision-making that goes into potentially deciding to carry-out a pregnancy, while abolishing questions of whether or not a statistic is valid or if a pregnancy was terminated due to sensitive medical reasons or miscarriage, rather than choice. In order to continue analyzing differences between red and blue states, the data set for both unintended pregnancies and births were separated into sets of state statistics based on party affiliation; additionally, both data sets were duplicated and translated to rates per 1000 women within reproductive years of age to allow for more accurate testing later on. From that point, the means of unintended births (Red States $M= 28,910$, $SD= 35,931$; Blue States $M= 37,079$, $SD= 37,872$) were subtracted from the rate of unintended pregnancies (Red States $M= 46,720$, $SD= 59,475$; Blue States $M= 77,840$, $SD= 89,743$) in order to compute an approximate number of abortion procedures for both red ($M= 17,180$) and blue states ($M= 40,761$). There were many more unintended pregnancies that did not result in unintended births in blue states ($M = 40,761$) than their red counterparts ($M= 17,180$).

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Due to the drastic differences in the experiences of women within CPCs, as shown throughout the previous literature, it is important to analyze the ways in which variables impact marginalized communities. For this reason, the total number of minority residents within each state was used as a variable, and showed a significant, positive correlation when analyzed with rates of unintended pregnancies. Within states that are labeled as Democrat, or “blue” states there was a positive correlation between rates of unintended pregnancy and the total number of minority residents ($r = 0.991, n = 25, p < 0.01$), as well as within “red” states ($r = 0.995, n = 25, p < 0.01$). Similarly, both groups showed a positive correlation between unintended births and the number of minority residents; thereby, rates of both unintended pregnancy and unintended births among Democrat and Republican affiliated (BlueUnIntBirths_: $r = 0.988, n = 25, p < 0.01$; RedUnIntBirths_: $r = 0.995, n = 25, p < 0.01$) states increase and decrease in tandem with the minority population. Such findings show a potentially problematic phenomena for women and families of color, as previous literature strongly suggests that this relationship stems from sociocultural variables.

Furthermore, previous literature has shown that not only are there discrepancies between women of color and white women within rates of unintended pregnancy and births, but adolescent females from a variety of racial and educational backgrounds have startling divergence in their mutual experiences as well. Throughout the literature review, both Dehlendorf et al.(2013) and Santelli et al. (2007) delved into the degree to which both race and class impact the sexual wellness of young females. Dehlendorf et al. (2013) specifically acknowledged the disproportionality of unintended pregnancies among adolescent girls; with this

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being said, however, rates of teen pregnancy were somewhat surprising within this data. To start, the average teen birth rate applies to adolescents within the ages of 15-19, and is per 1000 female adolescents. The average teen birth rate among red states is 29.9, while blue states have a smaller rate of approximately 18.8. To further illustrate, if you were to add up the teen birth rates from each state within its respective party affiliation, there would be a sum of approximately 471 among the blue states, and 750 among the red states. It has been established that red states have a higher ratio of CPCs to Planned Parenthood's, as the ratio of 1:44 surpassed even the overall, national scale distribution. Given the nature and goals of CPCs, it is not necessarily surprising to see such variances among teen birth rates. However, given the claims made by previous researchers regarding the privilege of many of those who work within CPCs specifically, it is up for question how race and other marginalized identities intersects with the disproportional rates of teen pregnancy, especially given the positive correlation between minority population and unintended births and pregnancies; additionally, many reproductive health facilities- CPCs especially- target and tend to locate themselves within communities with higher populations of people of color, lower socioeconomic status, a community that may have a greater sense of distrust towards healthcare, less access to resources or high quality modules of family planning. Keeping this in mind, a significant, positive correlation emerged with both Planned Parenthood and CPCs in relation to minority populations within blue (CPC $r = 0.913$, $n = 25$, $p < .000$; PP $r = 0.791$, $n = 25$, $p < .000$) and red (CPC $r = 0.845$, $n = 25$, $p < .000$; PP $r = 0.800$, $n = 25$, $p < .000$) states. These findings indicate support for claims made by many of the researchers previously

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mentioned, as these positive correlations show a sort of action on part of both models of reproductive health care despite their stark ideological contrasts from one another.

DISCUSSION

Reproductive health is arguably one of the most dominant and contentious paradoxes within modern social issues. Women are strongly urged within a cultural paradigm to have children, start families, take sole responsible for maintenance of their “womb” and ability to reproduce- yet despite such autonomous ideals, women are being given incredibly little in terms of options to practice such autonomy if they choose to pursue such experiences. As a culture, we panic if teen pregnancy rates rise but adamantly refuse to make contraceptive easily accessible or universally affordable, despite findings that show drastic decreases in rates of unintended pregnancy and sexually transmitted infections when contraception is taught and used accurately. With the growing dichotomy that is our reproductive health sector, women are having to settle for what is accessible, rather than what is desirable or best for them. To further illustrate, women of marginalized identities are not receiving access to the education and services that they need. Additionally, many of the resources that are available have underlying essentialist notions of womanhood and family order- similar to that of the Temporary Assistance for Needy Families (TANF). What may seem to many as opportunity for aid or for resources can, at times, be quite limiting.

Many of the statistical findings in this research align with that of previous literature and research. The disproportionate rate of unintended pregnancy and births closely aligns with the

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phenomena of which Dehlendorf, et al. (2013) studied, and touched on much of what Santelli, et al. (2007) was investigating.

On the other hand, this research surely had its limitations. By enacting statistical analysis to conduct this research, an entire aspect of the topic is lost; as crisis pregnancy centers are historically religious in nature, one is unable to focus on the driving force of much of the anti-choice movement. On the same token, the use of census data and statistics for demographics and variables, while simultaneously relying on less-esteemed Internet sources to gather quantifiable information about organizations that operate on ambiguity is less than ideal. However, there were surely long-term benefits to researching and understanding the history and mission of both forms of reproductive healthcare, as well as the upbringing of the overall movements they are associated with.

Constructing dialogue and opening up lines of communication is undoubtedly relevant to the topic of reproductive health. The conversations surrounding sex education, abortion, contraceptives, and other medical choices that are individual and private to many, are becoming a conversation in which women are discussed as the object of medical practice, rather than the consumer who chooses what they deem best for themselves. The implications of not receiving adequate access to reproductive health services, education, and more specifically abortion- are massive. There are already evident signs of stratification among women seeking access to reproductive healthcare, whether it be the disproportionate rates of unintended pregnancy and births among women of color, the financial and *psychological* costs associated with pursuing an abortion, or the fact that women of color do not trust their own healthcare providers.

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It is evident that the demand for abortion services has a threshold far beyond that of anti-choice action, that is visible in the rise of dialogue surrounding reproductive health. It is evident in history alongside stories of coat-hanger abortions, and it is quite visible in research that has been done over time in an effort to understand how such stark, dichotomous perspectives have developed. Much of the reviewed research implored education or, as Dehlendorf, et al. (2013) referred to it, “primary prevention” to avoid a need for services like abortion in the first place. Education surrounding reproductive health, contraception, abortion, sexually transmitted infections, and more has been repeatedly shown to improve health and safety. In order to progress, dialogue must be started and there has to be an acknowledgement of communities that need resources to improve their wellbeing, but are not receiving them. In order to ensure that women are receiving adequate reproductive health care we must move away from solely focusing on the single topic of abortion, and turn our attention to those who are in need of health services- regardless of what that service is. To guarantee that women are receiving the care they need, we need to make certain that women are given access to the information they need, and that they are given free rein to practice their medical and bodily autonomy as they see fit for themselves.

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REFERENCES

- Bryant, Amy G., Subasri Narasimhan, Katelyn Bryant-Comstock, and Erika E. Levi. 2014. "Crisis Pregnancy Center Websites: Information, Misinformation and Disinformation." *Contraception*. 90(6): 601-606.
- Burrack, Cynthia, and Jyl J. Josephson, eds. 2003. *Fundamental Differences: Feminists Talk Back to Social Conservatives*. Lanham, MD: Rowman & Littlefield Publishers, Inc.
- Burrack, Cynthia. 2014. *Tough Love: Sexuality, Compassion, and the Christian Right*. Albany, NY: State University of New York.
- Campbell, Nancy D. 2003. "Reading the Rhetoric of 'Compassionate Conservatism'." Pp. 113-126 in *Fundamental Differences: Feminists Talk Back to Social Conservatives*, edited by C. Burrack and J. Josephson.
- Care-Net. care-net.org Retrieved: April 27, 2016
- Center for Disease Control and Prevention. 2016. *Women and Health: Statistics and Services*. U.S. Department of Health and Human Services.
- Dehlendorf, Christine, MD, MAS, Lisa H. Harris, MD, PhD, and Tracy A. Weitz, PhD, MPA. 2013. "Disparities in Abortion Rates: A Public Health Approach." *American Journal of Public Health* 103(10):1772-1779.
- Gerds, Caitlin, PhD/MHS, Liza Fuentes, MPH, Daniel Grossman, MD, Kari White, PhD, MPH, Brianna Keefe-Oates, MPH, Sarah E. Baum, MPH, Kristine Hopkins, PhD, Chandler Stolp, PhD, and Joseph Potter, PhD. 2016. "Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas." *American Journal of Public Health* 106(5): 857-864.

SEPARATION OF CHURCH AND STATE

Gober, Patricia. 1997. "The Role of Access in Explaining State Abortion Rates." *Social Science and Medicine* 44(7):1003-1017.

Gober, Patricia. 1988. "Why Abortion Rates Vary: A Geographical Examination of the Supply of and Demand for Abortion Services in the United States in 1994." *Annals of the Association of American Geographers* 84(2):230-250

Guttmacher Institute. 2017. *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*. Guttmacher Center for Population Research Innovation and Dissemination. Retrieved: March 20, 2017.

Heartbeat International. heartbeatinternational.org Retrieved: April 27, 2016

Hussey, Laura S.. 2010. "Welfare Generosity, Abortion Access, and Abortion Rates: A Comparison of State Policy Tools". *Social Science Quarterly* 91(1):266-283.

Kaiser Family Foundation. 2017. *Rate of Legal Abortions per 1,000 Women Aged 15-44 Years by State of Occurrence*. The Henry J. Kaiser Family Foundation.

Kelly, Kimberly. 2012. "In the Name of the Mother: Renegotiating Conservative Women's Authority in the Crisis Pregnancy Center Movement." *Signs: Journal of Women in Culture & Society*. 38(1): 203-230.

Kirby, Douglas and ETR Associates. 2007. "Abstinence, Sex, and STD/HIV Education Programs for Teens: Their Impact on Sexual Behavior, Pregnancy, and Sexually Transmitted Disease." *Annual Review of Sex Research* 18(1):143-177.

Kirby, Russell S. 1995. "Commentary On: 'Why Abortion Rates Vary: A Geographical Examination of the Supply of and Demand for Abortion Services in the United States in 1988,' by Patricia Gober." *Annals of the Association of American Geographers* 85(3):581-585.

Lehr, Valerie. 2003. "'Family Values': Social Conservatives Power in Diverse Rhetorics." Pp.

SEPARATION OF CHURCH AND STATE

- 127-142 in *Fundamental Differences: Feminists Talk Back to Social Conservatives*, edited by C. Burrack and J. Josephson.
- Lin, Vitoria and Cynthia Dailard. 2002. "Crisis Pregnancy Centers Seek To Increase Political Clout, Secure Government Subsidy." *The Guttmacher Report on Public Policy*. 5(2): 4-6.
- Ludlow, Randy. 2016. "Gov. John Kasich Vetoes Heartbeat Bill, Signs 20-Week Abortion Ban." *The Columbus Dispatch*. Retrieved: March 15, 2017.
<http://www.dispatch.com/content/stories/local/2016/12/13/John-Kasich-acts-on-abortion-bills.htm>
- Medoff, Marshall H.. 2003. "The Impact of Anti-Abortion Activities on State Abortion Rates." *Journal of SocioEconomic* 32(3):265-282.
- Medoff, Marshall H.. 2016. "State Abortion Policy and Unintended Birth Rates in the United States." *Social Indicators Research* 129(2):589-600.
- Mink, Gwendolyn. 2003. "From Welfare to Wedlock: Marriage Promotion and Poor Mothers' Inequality." Pp. 207-218 in *Fundamental Differences: Feminists Talk Back to Social Conservatives*, edited by C. Burrack and J. Josephson.
- NARAL Pro-Choice America. 2015. *Who Decides?: The Status of Women's Reproductive Rights in the United States*. 24th Edition. Retrieved: Feb.21.
<http://www.prochoiceamerica.org/assets/download-files/2015-who-decides.pdf>
- NARAL Pro-Choice America. 2016. *The Truth about Crisis Pregnancy Centers*.
- Planned Parenthood of Southeastern Pennsylvania v. Casey*. 505 U.S. 833 (1992). Oyez: IIT Chicago-Kent College of Law. Retrieved January 24, 2017
<https://www.oyez.org/cases/1991/91-744>.
- National Abortion Federation. 2017. "*History of Abortion*". Retrieved: March 5, 2017.

SEPARATION OF CHURCH AND STATE

Planned Parenthood. 2014. "Planned Parenthood at a Glance". Retrieved Dec. 9, 2016.

<https://www.plannedparenthood.org/about-us/who-we-are/planned-parenthood-at-a-glance>

Santelli, John, MD, MPH, Laura Duberstein Lindberg, PhD, Lawrence B. Finer, PhD, and Susheela

Singh, PhD. 2007. "Explaining Recent Declines in Adolescent Pregnancy in the United States:

The Contribution of Abstinence and Improved Contraceptive Use." *American Journal of Public*

Health 97(1):150-156.

Sherr, Michael E. and Preston M. Dyer. 2010. "Evaluating a Comprehensive Abstinence-Based

Program for Minority Youth: Comparing Church and Public School Outcomes." *Journal of the*

North American Association of Christians in Social Work 37(1):28-44.

Texas House Bill 2, 83(2). 2013. Council Document: 8352 17 JSC-F.

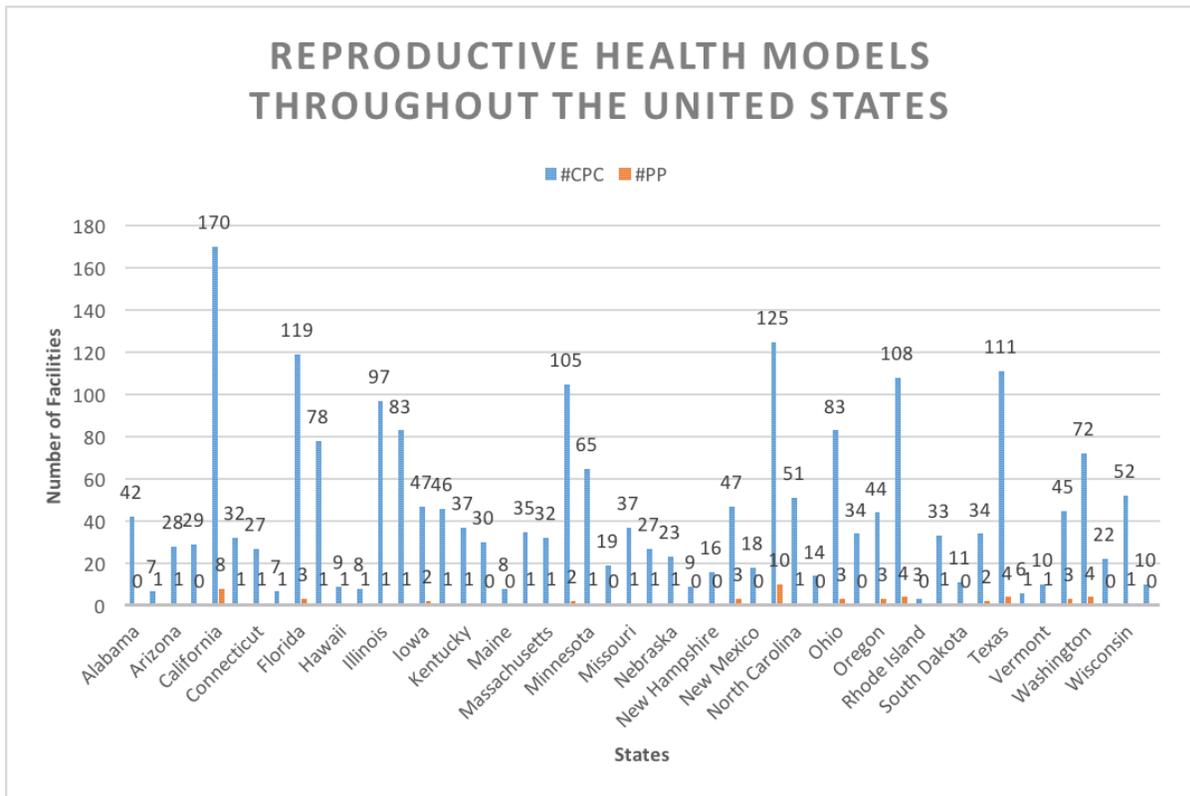
U.S. Census Bureau. 2013. *Annual Estimates of the Resident Population for the United States, Regions,*

States, and Puerto Rico: April 1, 2010 to July 1, 2016. U.S. Department of Commerce.

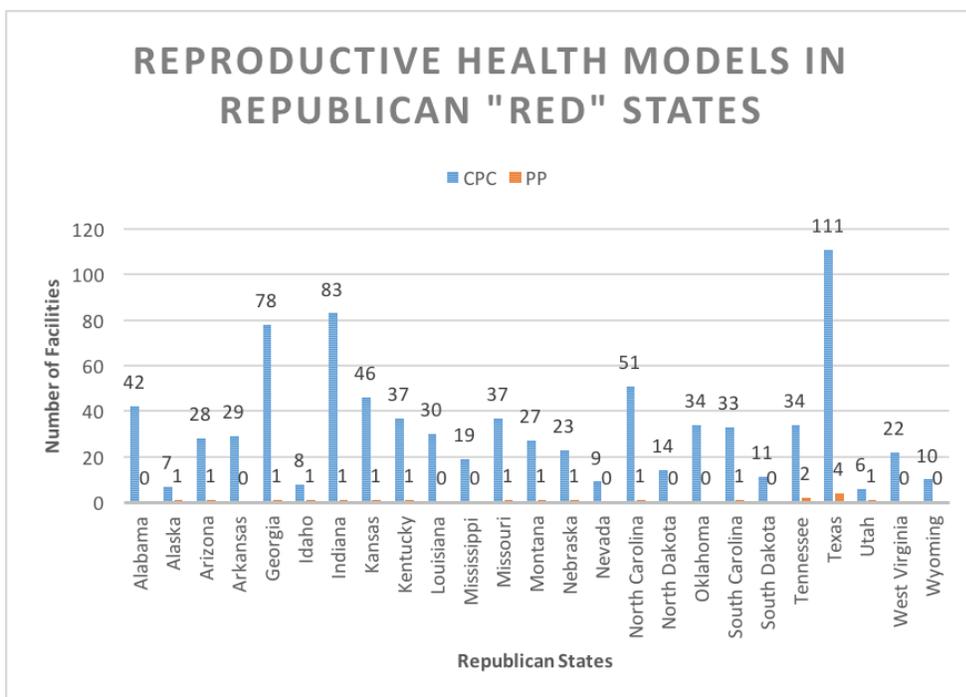
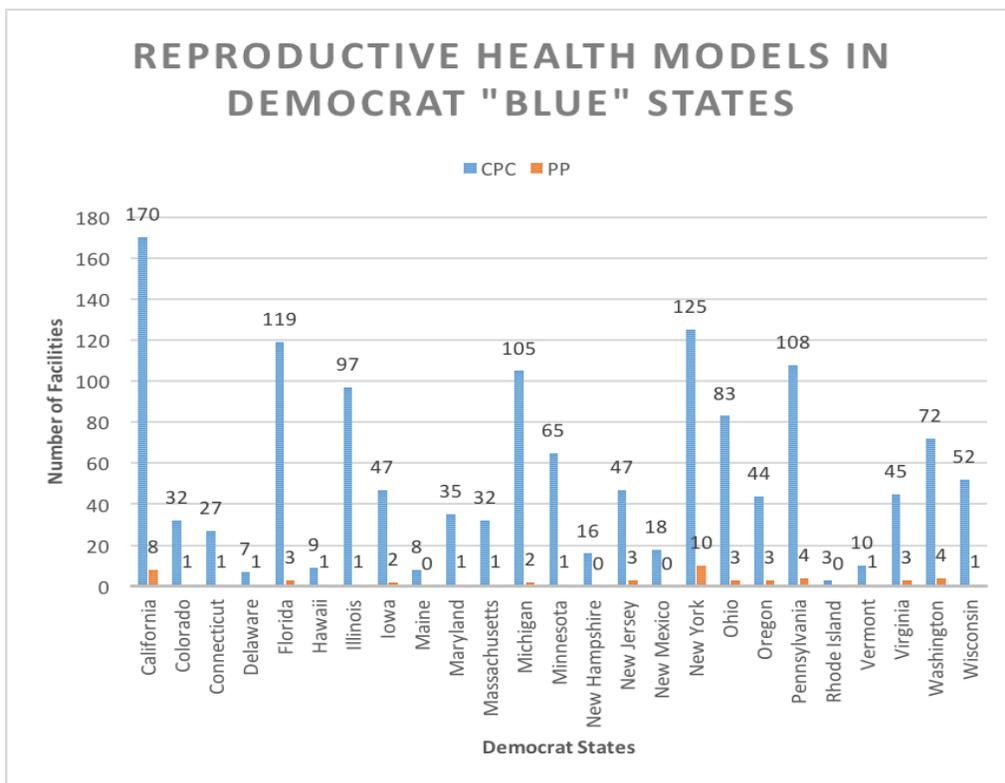
Whole Women's Health v. Hellerstedt 579 U.S. _ (2016). Oyez: IIT Chicago-Kent College of Law.

Retrieved March 6, 2017.

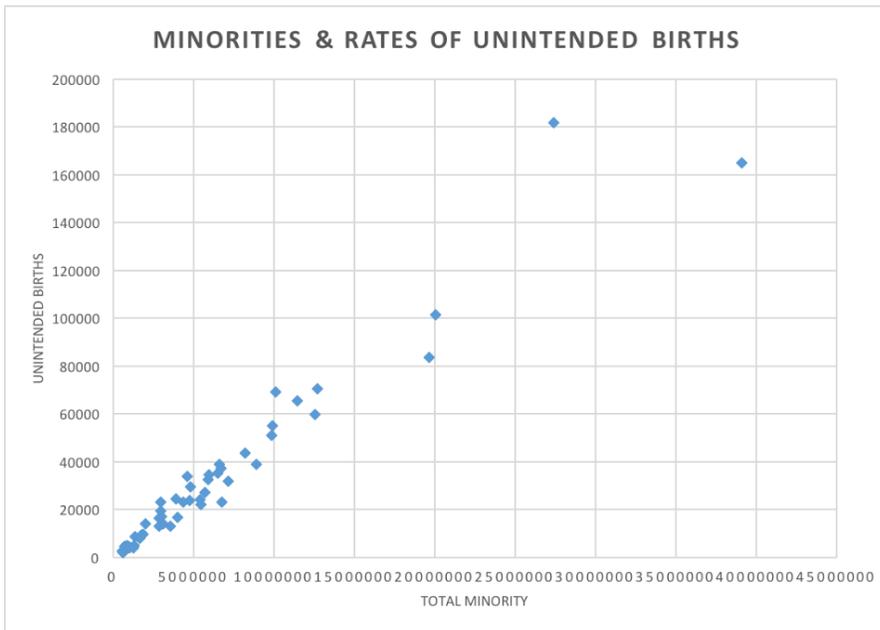
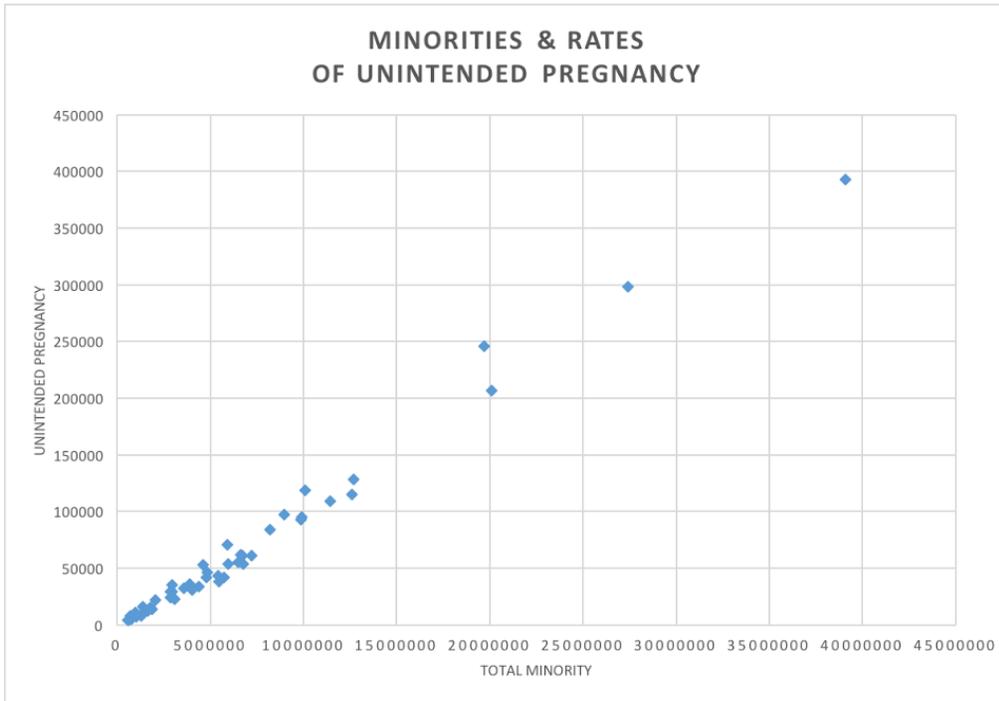
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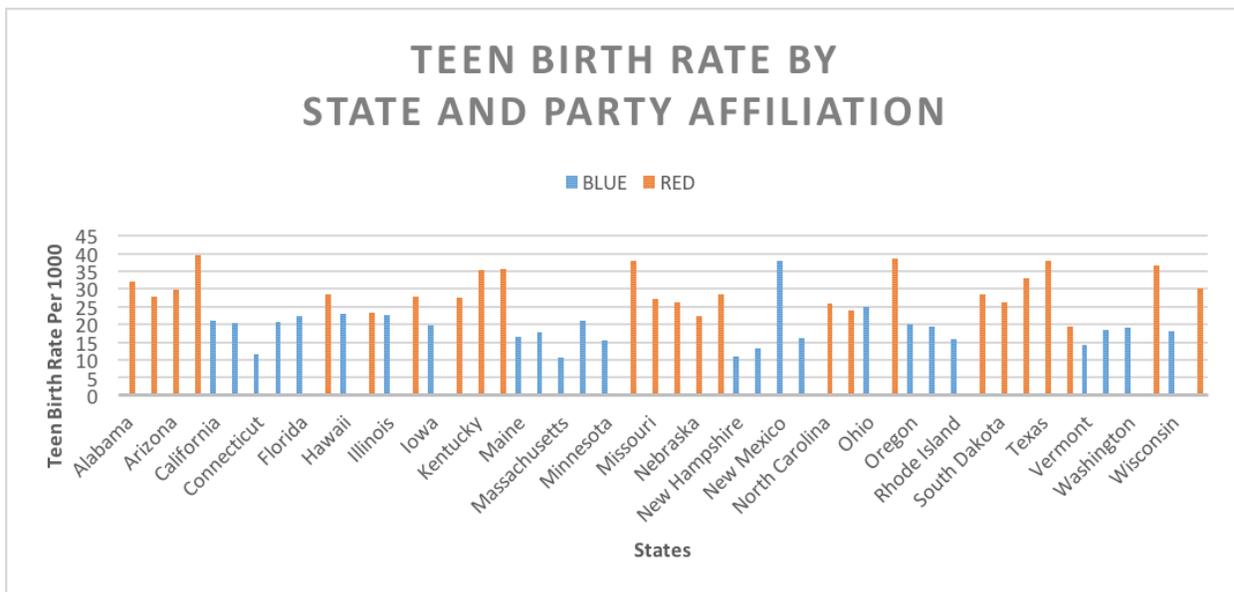
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Correlations

		Teen Birth Rate (Births per 1,000 women 15-19 years)	#CPC	#PP
Teen Birth Rate (Births per 1,000 women 15-19 years)	Pearson Correlation	1	-.077	-.273
	Sig. (2-tailed)		.597	.055
	N	50	50	50
#CPC	Pearson Correlation	-.077	1	.768**
	Sig. (2-tailed)	.597		.000
	N	50	50	50
#PP	Pearson Correlation	-.273	.768**	1
	Sig. (2-tailed)	.055	.000	
	N	50	50	50

** . Correlation is significant at the 0.01 level (2-tailed).