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Jessica L. Dozier

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**“Even if I deeply disagree...I’m going to continue to love you”: Exploring abortion attitudes and pastoral care among Protestant religious leaders in Georgia**

By

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An abstract of  
A thesis submitted to the Faculty of the  
Rollins School of Public Health of Emory University  
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2019

## **“Even if I deeply disagree...I’m going to continue to love you”: Exploring abortion and attitudes and pastoral care among Protestant religious leaders in Georgia**

By Jessica L. Dozier

**Objectives:** Unintended pregnancy is a common experience in Georgia, USA, where religion plays an influential role in many people’s lives. The purpose of this study is explore attitudes towards abortion amongst Mainline and Black Protestant religious leaders and identify how they communicate, counsel, and provide pastoral care to their congregations regarding abortion.

**Methods:** We conducted qualitative in-depth interviews with 12 Mainline and Black Protestant religious leaders purposively selected from a county in Georgia with high abortion rates, low sexual and reproductive health service access, high religiosity, and denominational diversity. Interview topics included: attitudes toward abortion and pastoral care experiences. Interviews were analyzed using thematic analysis.

**Results:** Attitudes toward abortion ranged from “pro-life” to “pro-choice” and a middle or “gray area” in between these stances. Differences among abortion attitudes were observed in understandings of when life begins, emphasis on moral autonomy, and circumstances in which abortion may be morally acceptable. Across the spectrum of attitudes, participants stressed that they would “journey with” congregants and advise them to make well-informed unintended pregnancy decisions. Participants with “pro-life” attitudes encouraged referral to Crisis Pregnancy Centers and ultrasound viewing/hearing a fetal heartbeat before deciding to have an abortion. Participants with “pro-choice” attitudes and those in the middle of the spectrum advised against the use of abortion as contraception. Across attitudes, emphasis was placed on not using scripture punitively. Participants underscored that even if they personally do not “subscribe to abortion,” they would emotionally support congregants because spiritual leaders are called to love and provide pastoral care. While participants with attitudes in the “gray area” were the only religious leaders who expressed an obligation to confront stigmatizing attitudes and treatment, all participants emphasized the importance of empathy, love, and compassion for people who have unintended pregnancies and abortions.

**Conclusion:** These findings demonstrate that religious leaders provide different advice and recommendations in the form of pastoral care according to their abortion attitudes. Leaders may represent an important resource for empathy, compassion, and affirmation of people’s moral agency regarding abortion. However, several misperceptions that inform religious’ leaders’ pastoral care practices run counter to scientific evidence.

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## Chapter 1: Introduction

### 1.1 Definitions

The term “**unintended pregnancy**” refers to pregnancies that are reported to be unwanted or mistimed (Santelli et al., 2003; Centers for Disease Control and Prevention, 2016; Guttmacher, 2016). Unplanned pregnancy is a related concept that indicates a pregnancy occurred “when the women used a contraceptive method or when she did not desire to become pregnant but did not use a method” (Santelli et al., 2003, p. 94). There has been debate among demographers and researchers in the family planning field about the concept of unintended pregnancy, accurate measurement of pregnancy intention, what the implications of unintended pregnancy are, and whether reduction in unintended pregnancy should be a public health goal (Guttmacher, 2019; Kost, Maddow-Zimet, & Kochhar, 2018; Aiken, Borrero, Callegari, & Dehleendorf, 2016, Santelli et al., 2003). For the purposes of this study, unintended pregnancy refers to pregnancies that are unwanted or mistimed.

**Pastoral care** is a “person-centered, holistic approach to care that complements the care offered by other helping disciplines while paying particular attention to spiritual care. The focus of pastoral care is upon the healing, guiding, supporting, reconciling, nurturing, liberating, and empowering of people in whatever situation they find themselves” (Rumbold, n.d.). According to the Episcopal Church, it may include “hospital visitation, counseling, and ministries of shared presence, listening, and support” (Armentrout & Boak Slocum, 2000).

**Legal induced abortion** is an “intervention performed within the limits of state law by a licensed clinician that is intended to terminate a suspected or known intrauterine pregnancy” (Jatlaoui, 2018).

## 1.2 Problem statement

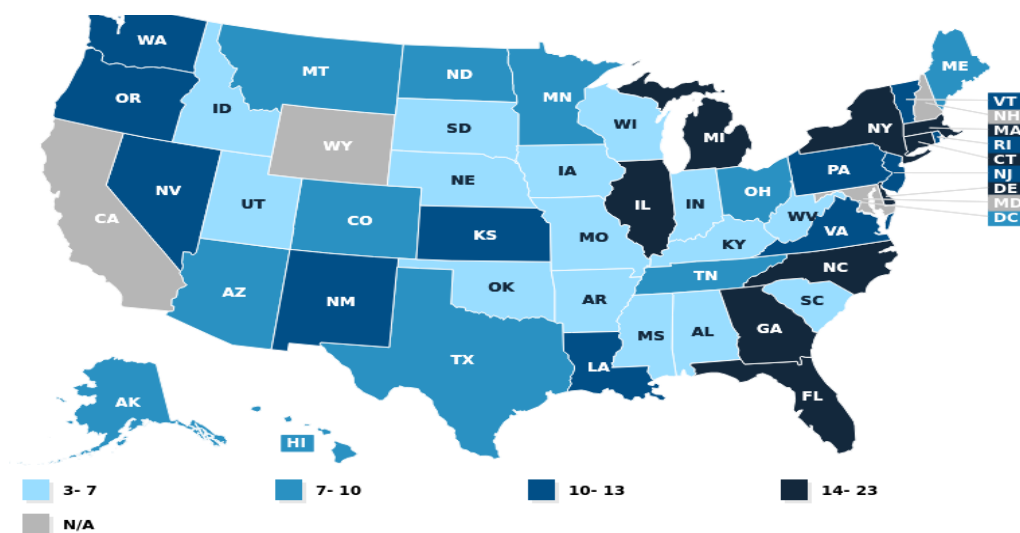
Unintended pregnancy remains an important public health indicator in which geographic, racial/ethnic, and demographic differences are observed (Guttmacher, 2019). In 2011, 45% of pregnancies in the United States were unintended (45 pregnancies for every 1000 women aged 15-44) (Guttmacher, 2016; Finer & Zolna, 2016). Unintended pregnancy is a common experience in the state of Georgia, with 60% of all pregnancies being unintended in 2010 and 28% of these pregnancies resulting in abortion (Kost, 2015). Despite this, women face systemic and sociocultural barriers to their pregnancy decision-making autonomy and subsequent health and well-being.

Unintended pregnancy rates are greatest among poor and low-income, racial minority, and young women. In 2011, the unintended pregnancy rate among women with incomes below the federal poverty level (FPL) was more than five times the rate of women with incomes of at least 200% of the FPL. Racial disparities in unintended pregnancy rates are observed as well, with Black women having more than double the rate of non-Hispanic white women (Guttmacher, 2016). In addition, sexually active women aged 15-19 have the highest unintended pregnancy rates of any age group (Guttmacher, 2016). Further, rates tend to be higher in the U.S. southern states (Kost, 2015).

Legal induced abortion is one outcome of unintended pregnancies. Approximately four in ten unintended pregnancies in the United States result in abortion (Finer & Zolna, 2016). Excluding miscarriages, 19% of all pregnancies, intended and unintended, are terminated (Finer & Zolna, 2016). Based on 2014 abortion rates, 24% of all U.S. women will have an abortion by age 45 (Jones & Jerman, 2017a). These same rates indicate that 39% of abortion patients are white, 28% are Black, and 25% are Hispanic. The majority of abortion patients are never married

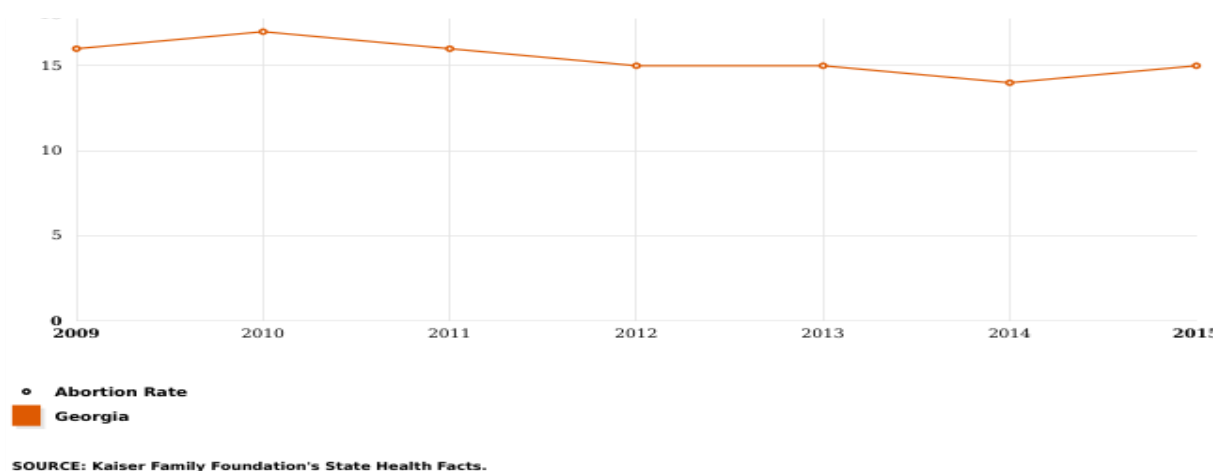
(46%), have had at least one birth (59%), and were using a contraceptive method in the month they became pregnant (51%) (Guttmacher, 2018a). In 2015, the rate of abortion in the United States was 11.8 abortions per 1,000 women aged 15-44 (CDC, 2018). In Georgia, the rate was 15 abortions per 1,000 women aged 15-44 years (See Figure 1; Kaiser Family Foundation, 2019). Georgia's abortion rate has remained relatively steady since 2009 (See Figure 2; Kaiser Family Foundation, 2019).

**Figure 1. Rate of legal abortions per 1,000 women aged 15-44 years by state of occurrence: Abortion rate, 2015**



SOURCE: Kaiser Family Foundation's State Health Facts.

**Figure 2. Rate of legal abortions per 1,000 women aged 15-44 years in GA: Abortion Rate, 2009-2015**



In 2014, only 4% of counties had clinics that provide abortion, leaving 58% of Georgia women without a clinic in their county (Jones & Jerman, 2017b). State legislation may impose additional barriers to reproductive healthcare (Guttmacher, 2018b). For example, in 2019, Georgia legislators introduced HB 481, a bill that would outlaw abortion once a fetal heartbeat is detected—usually around 6 weeks gestation (Georgia General Assembly, 2019). The bill is slated to be signed by the governor (Georgia General Assembly, 2019) and if enacted, would outlaw abortion before most people know they are pregnant (American College of Obstetricians and Gynecologists, 2016).

For women who carry unintended pregnancies to term, health care access issues also affect perinatal care. Georgia has the highest maternal mortality rate in the U.S. (United Health Foundation, 2019), yet access to obstetric services is limited by a waning obstetrician/gynecologist workforce, especially in rural areas (Spelke, Zertuche, & Rochat, 2016). Additionally, half of Georgia counties do not have a single obstetrician/gynecologist, or a

hospital where women can give birth or access basic services (Georgia Obstetrical and Gynecological Society, 2017).

Along with health care systems and policy barriers to reproductive health care access, sociocultural factors such as religion, may also influence Georgia women's ability to exercise reproductive autonomy (Idler, 2014; Patton, Stidham Hall, Dalton, 2015; United Nations Population Fund, 2015). Many religions are perceived to disapprove of abortion (The Pew Forum on Religion and Public Life, 2013), yet religiously affiliated women do have abortions—the majority of women who obtained an abortion in 2008 and 2014 were religiously affiliated (Jerman, Jones, & Onda, 2016). Research has found correlations between religious affiliation or religiosity and abortion stigma (Cockrill et. al., 2014; Cockrill & Nack, 2013) and an association between religious condemnation of abortion and experiencing abortion stigma (Frohworth, Coleman, & Moore, 2018). Previous research indicates that “abortion stigma confounds a woman's decision to terminate a pregnancy due to worries about judgment, isolation, self-judgment, and community condemnation” (Frohworth, Coleman, & Moore, 2018; Cockrill, Upadhyay, Turan, & Green Foster, 2013; Kumar, Hessini, & Mitchell, 2009, Shellenberg et. al., 2011; Cockrill & Nack, 2013; Sorhanindo et. al., 2014).

### 1.3 Significance

Within the southern region of the U.S. especially, religion plays an important and influential role in many people's lives; 62% of adults in this region reported religion is very important in their lives (Pew, 2015). Of adults in Georgia, 64% reported that religion is very important in their lives and 42% attend religious services at least once a week (Pew Research Center, 2015). Overall, the state is tied for 12<sup>th</sup> most religious state in the country (Norman, 2018).

In a recent special section published by the *American Journal of Public Health*, Idler, Levin, VanderWeele, and Khan (2019) wrote, “religion is a social determinant of population health because it operates through the work of social institutions. That is, religious congregations and faith-based organizations are players in their communities; they present a visible, public face to communities by providing leadership and capacity for service to others. These social capital assets are of special value in communities of color and of poverty and elsewhere that social and economic resources are in short supply.” Religious institutions may serve as a determinant of population health by providing social capital to individuals and community, thus multifaceted partnerships between public health and religious institutions are longstanding and of key interest (Idler, Levin, VanderWeele, & Khan, 2019). Successful public health initiatives that have engaged faith-based organizations to promote sexual and reproductive health exist, particularly in regards to HIV/AIDS stigma reduction (Derose et. al, 2016; Payne-Foster et. al., 2018) and adolescent sexuality (Torres, Johnson-Baker, Bell, Freeny, & Edwards, 2017). Notably, many of these initiatives have occurred with African-American churches.

Religious leaders are highly respected in their faith communities (Haffner, 2015) and can be influential in shaping sexual and reproductive health attitudes, norms, and behaviors at the family and community level (Adedini, et. al., 2018; Religious Institute, n.d.; United Nations Population Fund, 2016; Haffner, 2015). Additionally, Mainline Protestant religious leaders have historically played a role in sexual and reproductive health policy, particularly with helping to “legalize and increase access to contraception and then abortion services during most of the twentieth century” (Haffner, 2015, p.5). This political involvement is of interest because 62% of abortion patients in the U.S. reported some religious affiliation, with 17% identifying as Mainline Protestant (Jerman, Jones, & Onda, 2016). At the same time, religious doctrine and

beliefs may come in direct conflict with public health recommendations regarding abortion and contraception and it is “often the religious voices that oppose sexual and reproductive rights that have been the most visible in the media and most influential in policy debates” (Haffner, 2015, p. 5). One of the most prominent examples is the 2014 Supreme Court decision regarding *Burwell v Hobby Lobby Stores, Inc.* The court ruled the Religious Freedom Restoration Act (RFRA) of 1993 allows a for-profit company to deny its employees health coverage of contraception based on religious objections of its owners (Oyez, 2019).

Religious leaders may play an important role in providing sexual and reproductive health pastoral care and resources given that “religions have a venerable tradition supporting healing, health care, disease prevention, and health promotion [and a] commitment to the most marginalized, the most vulnerable, and the most likely to be excluded” (Haffner, 2015, p.28). However, little is known about the pastoral care practices of religious leaders as they relate to reproductive health, especially in the southern states of the U.S. Given their potential reach and influence, there is a need to understand religious leaders’ attitudes toward abortion, how they communicate norms about abortion within their churches, and their pastoral care practices, particularly in Georgia, a state with high religious influence (Pew Research Center, 2015), reproductive health disparities, and gaps in reproductive healthcare.

#### 1.4 Study purpose

This study is part of a larger ongoing, multi-year project conducted by Emory University’s Center for Reproductive Health Research in the SouthEast (RISE) called *Engaging Georgia’s Faith Communities for Promoting Reproductive Health* (EnFaith). The purpose of the EnFaith project is to develop evidence-based strategies to promote nonjudgmental and supportive reproductive health attitudes and norms in faith communities. The first three years of

the project consist of collaborating with communities and organizations to measure community-level norms, beliefs, and institutional polices that are most relevant within the context of Georgia's Protestant churches and creating a menu of intervention strategies. The central question of the EnFaith study is: what existing norms and values should be leveraged in a faith-based program to promote compassionate norms around sexual and reproductive health and wellbeing? The present sub-study was conducted during the second year of the EnFaith project to inform the EnFaith study and intervention development by identifying the social norms that religious leaders promote within their congregations and their pastoral care practices regarding abortion.

This sub-study seeks to understand the abortion attitudes of Mainline and Black Protestant religious leaders in Georgia, their pastoral care practices related to these topics, and the norms they promote within their congregations. The study will address two specific aims:

- 1) To understand Protestant religious leaders' abortion attitudes and
- 2) To explore how Protestant religious leaders communicate, counsel, and provide pastoral care to their congregations regarding abortion.



## Chapter 2: Review of the literature

### 2.1 Protestantism in the United States

Protestantism in the U.S. is not homogenous, but rather it is divided into three culturally and theologically distinct traditions: Evangelical Protestant, Mainline Protestant, and Historically Black Protestant (McKinney, 1998; Pew, 2007). Evangelicals are generally associated with being more theologically conservative and tend to hold more traditional religious beliefs (Pew, 2015a), whereas Mainline Protestants are often labeled as more liberal (McKinney, 1998) and are known for their “generally progressive theology and openness to new ideas and societal changes” (Pew, 2015a). Openness to modernity and belief that the Bible should be interpreted in light of historical context and the present situation, is one defining feature that distinguishes Mainline Protestants from Evangelical Protestants, who believe in the literal interpretation of the Bible (McKinney, 1998; Chan & Ecklund, 2016). The first Historically Black Protestant churches formed in the late 18<sup>th</sup> century—some were formed by free black people (Masci, 2016). Black preachers began preaching to their own people, “drawing on the stories, people, and events depicted in the Old and New Testaments” and established independent black churches that split from white Protestants (Mellowes, 2011).

According to the U.S. Religious Landscape Survey, conducted in 2007 by the Pew Research Center’s Forum on Religion and Public Life, 26% of the total U.S. population belongs to an Evangelical Protestant church, 18% to a Mainline Protestant church, and 7% to a Historically Black Protestant church (See Table 1). From 2007 to 2014, the number of adults who identified as Evangelical Protestant was stable, while Mainline Protestants fell from 18.1% of the U.S. population to 14.7% (Lipka, 2015). Of adults in the U.S., 55% of Evangelicals, 24% of Mainline Protestants, and 59% of Historically Black Protestants reported that Holy Scripture is the “Word of God [and] should be taken literally” (Pew, 2014; See Figure 1).

**Table 1. Religious Composition of U.S. Adults**

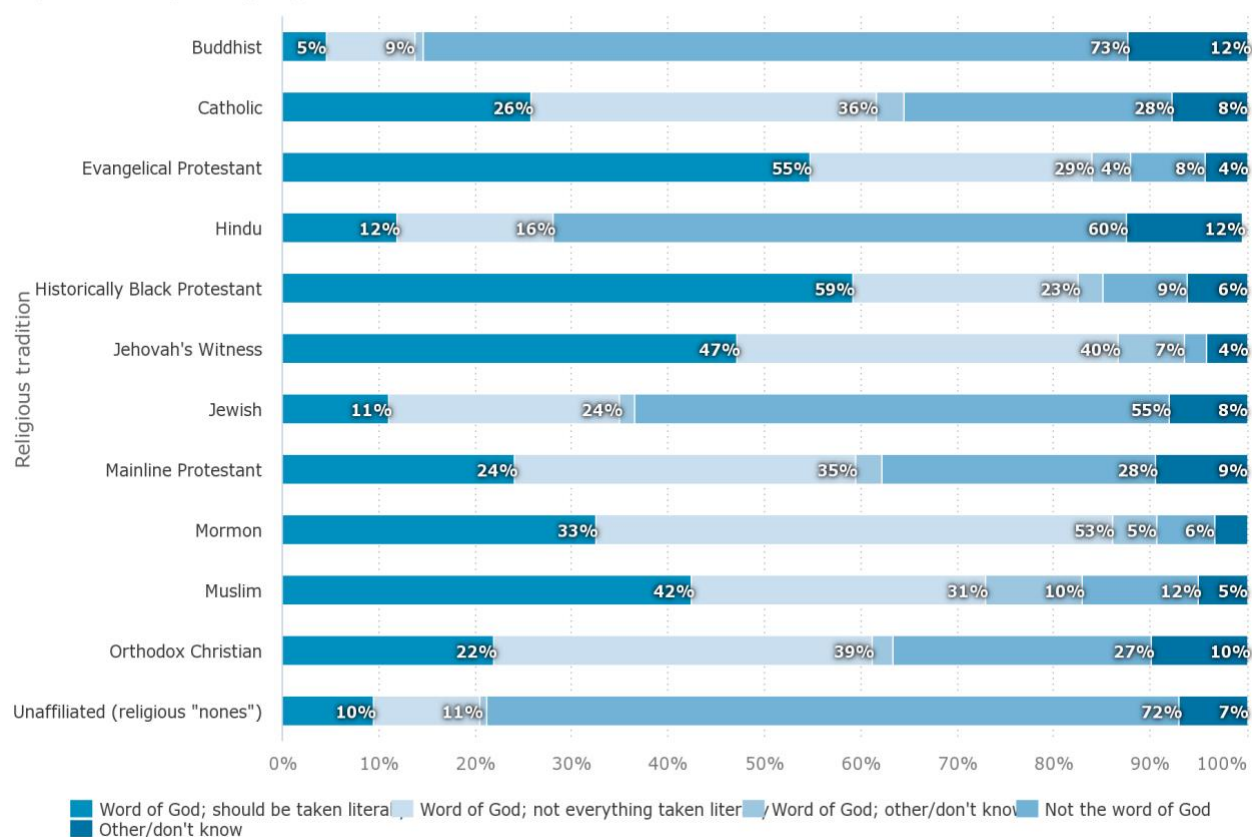
	% of U.S. adult population	
	2007	2014
<b>Mainline Protestant churches</b>	<b>18.1</b>	<b>14.7</b>
Baptist in the mainline tradition	1.9	2.1
American Baptist Churches USA	1.2	1.5
Other Baptist in the mainline tradition	0.7	0.6
Methodist in the mainline tradition	5.4	3.9
United Methodist Church	5.1	3.6
Other Methodist in the mainline tradition	0.4	0.3
Nondenominational in the mainline tradition	0.9	1.0
Interdenominational in the mainline tradition	0.3	0.3
Other nondenominational in the mainline tradition	0.6	0.7
Lutheran in the mainline tradition	2.8	2.1
Evangelical Lutheran Church in America (ELCA)	2.0	1.4
Other Lutheran in the mainline tradition	0.9	0.7
Presbyterian in the mainline tradition	1.9	1.4
Presbyterian Church USA	1.1	0.9
Other Presbyterian in the mainline tradition	0.7	0.5
Episcopalian/Anglican in the mainline tradition	1.4	1.2
Episcopal Church	1.0	0.9
Anglican Church (Church of England)	0.3	<0.3
Other Episcopalian/Anglican in the mainline tradition	<0.3	<0.3
Restorationist in the mainline tradition	0.4	0.3
Disciples of Christ	0.3	<0.3
Other Restorationist in the mainline tradition	<0.3	<0.3
Congregationalist in the mainline tradition	0.7	0.5
United Church of Christ	0.5	0.4
Other Congregationalist in the mainline tradition	<0.3	<0.3
Reformed in the mainline tradition	<0.3	<0.3
Reformed Church in America	<0.3	<0.3
Other Reformed in the mainline tradition	<0.3	<0.3
Anabaptist in the mainline tradition	<0.3	<0.3
Friends in the mainline tradition	<0.3	<0.3
Other/Protestant non-specific in the mainline tradition	2.5	1.9
<b>Historically black churches</b>	<b>6.9</b>	<b>6.5</b>
Baptist in the historically black Protestant tradition	4.4	4.0
National Baptist Convention	1.8	1.4
Progressive Baptist Convention	0.3	0.3
Independent Baptist in historically black Prot. tradition	0.5	<0.3
Missionary Baptist in historically black Prot. tradition	<0.3	0.3
Other Baptist in the historically black Prot. tradition	1.8	1.8
Methodist in the historically black Protestant tradition	0.6	0.5
African Methodist Episcopal	0.4	0.3
African Methodist Episcopal Zion Church	<0.3	<0.3
Christian Methodist Episcopal Church	<0.3	<0.3
Other Methodist in the historically black Prot. tradition	<0.3	<0.3
Nondenominational in the historically black Prot. tradition	<0.3	0.3
Pentecostal in the historically black Protestant tradition	0.9	1.0
Church of God in Christ	0.6	0.6
Apostolic Pentecostal in the historically black Prot. tradition	<0.3	<0.3
United Pentecostal Church International	<0.3	<0.3
Other Pentecostal in the historically black Prot. tradition	<0.3	0.3
Holiness in the historically black Prot. tradition	<0.3	<0.3
Protestant non-specific in the historically black Prot. tradition	0.5	0.4

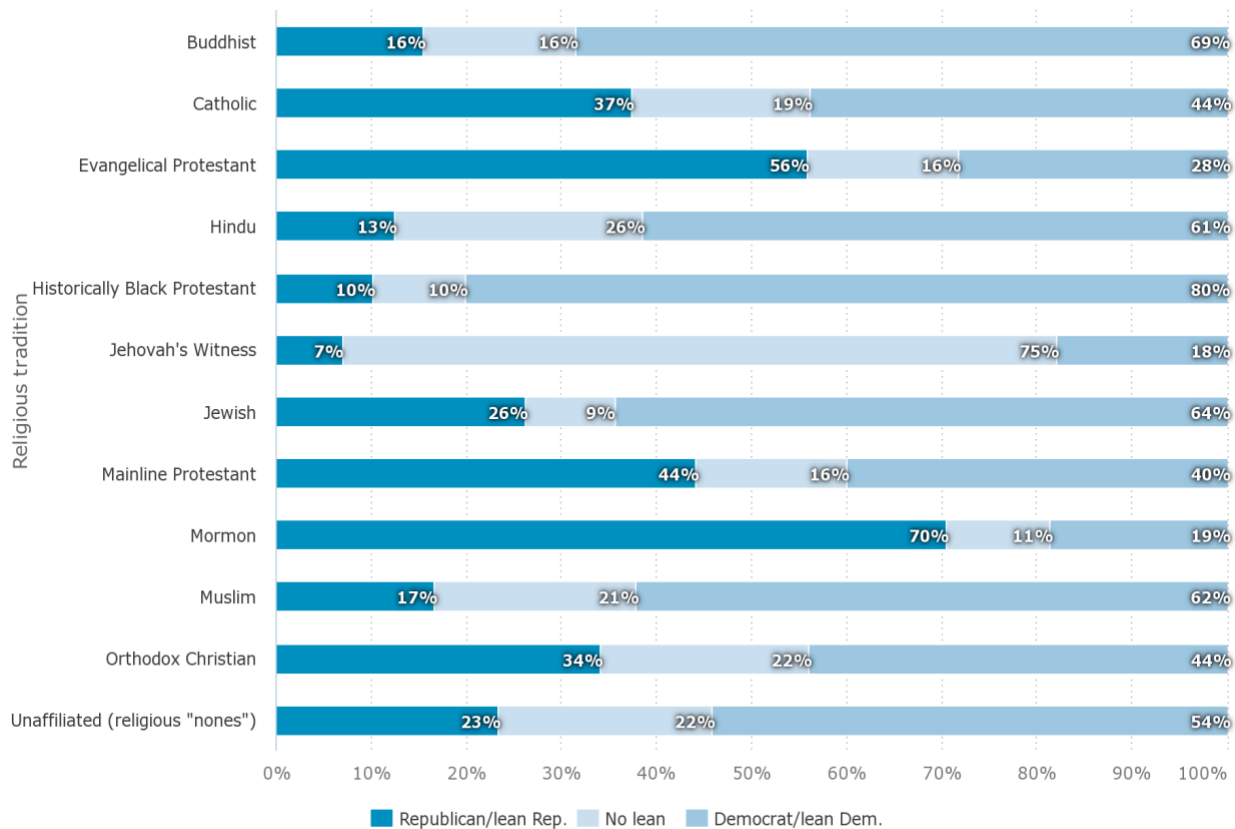
Source: Pew Forum U.S. Religious Landscape Survey, 2007, 2014

Political party affiliation is similarly varied, with 56% of Evangelical adults reporting republican or republican-leaning affiliation, 44% of Mainline adults identifying as republican/republican-leaning, and 80% of Historically Black Protestant adults identifying as democrat (Pew, 2014; See Figure 2.)

**Figure 1. Interpreting scripture by religious group**

*% of adults who say the holy scripture is...*



**Figure 2. Party affiliation by religious group***% of adults who identify as...*

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## 2.2 Mainline Protestant positions on abortion

According to a recent Gallup poll, Protestants who identify with a mainline denomination are more likely to hold more liberal views on moral issues such as such as abortion and premarital sex, than other Protestants. Compared to other Protestants, they are twice as likely to say abortion is morally acceptable (Newport, 2017). Compared to other religious groups overall, some Mainline Protestant denominations support abortion rights with some limits or few or no limits (Masci, 2016; See Figure 3).

**Figure 3. Major religious groups' positions on abortion**

Opposes abortion rights, with few or no exceptions	Supports abortion rights, with some limits	Supports abortion rights, with few or no limits	No clear position
<ul style="list-style-type: none"> <li>• African Methodist Episcopal Church</li> <li>• Assemblies of God</li> <li>• Roman Catholic Church</li> <li>• Church of Jesus Christ of Latter-day Saints</li> <li>• Hinduism</li> <li>• Lutheran Church-Missouri Synod</li> <li>• Southern Baptist Convention</li> </ul>	<ul style="list-style-type: none"> <li>• Episcopal Church</li> <li>• Evangelical Lutheran Church in America</li> <li>• United Methodist Church</li> </ul>	<ul style="list-style-type: none"> <li>• Conservative Judaism</li> <li>• Presbyterian Church (U.S.A.)</li> <li>• Reform Judaism</li> <li>• Unitarian Universalist</li> <li>• United Church of Christ</li> </ul>	<ul style="list-style-type: none"> <li>• Islam</li> <li>• Buddhism</li> <li>• National Baptist Convention</li> <li>• Orthodox Judaism</li> </ul>

Source: Pew Research Center review of outside literature

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Several Mainline denominations have released policy statements which suggest abortion may be allowable in certain circumstances. Some of the religious authorities who released such statements include, the National Episcopal Church (1967), the Board of Social Ministry of the Lutheran Church in America (1967), the United Presbyterian Church (1962)” (Price-Bonham, Santee, & Bonham, 1975) and the United Methodist Church (United Methodist Church, 2016). For example, the Evangelical Lutheran Church in America adopted a social statement on abortion in 1991 that states ‘abortion ought to be a last resort [...and] abortion is morally responsible in those cases in which continuation of a pregnancy presents a clear threat to the physical life of the woman. A woman should not be morally obligated to carry the resulting pregnancy to term if the pregnancy occurs when both parties do not participate in sexual intercourse. This is especially true in cases of rape and incest. This can also be the case in some situations in which women are so dominated and oppressed that they have no choice regarding

sexual intercourse and little access to contraceptives. Some conceptions occur under dehumanizing conditions that are contrary to God's purpose. . . . after competent medical consultations [in cases of extreme fetal abnormality], the parent(s) may responsibly choose to terminate the pregnancy." Similarly, a 1987 resolution before the Christian Church (Disciples of Christ) to affirm the sanctity of life and "convey its grief over the widespread practice of abortion" failed to pass because the church "has traditionally affirmed freedom of individual choice in all moral issues," the General Assembly previously affirmed freedom of individual choice for abortion, "the resolution assum[ed] that the Supreme Court should be persuaded by public opinion when, in fact, the Constitution of the United States removes the court from the political arena in order to protect the rights of every individual, [and the] resolution [did not] express pastoral concern or offer a word of grace for those who deal with unwanted or problem pregnancies as they make and live with difficult decisions" (Christian Church (Disciples of Christ), 1987). In a 1994 resolution, the Episcopal Church stated that abortion should be "used only in extreme situations [and the Episcopal Church] emphatically oppose[s] abortion as a means of birth control, family planning, sex selection, or any reason of mere convenience" (General Convention, 1995). In the United Methodist Church's (UMC) *Social Principles*, a document outlining the denominations view on social issues, the UMC affirms "[the] belief in the sanctity of unborn human life [which makes the UMC] reluctant to approve abortion. But [the UMC is] equally bound to respect the sacredness of life and well-being of the mother and the unborn child" (UMC, 2016).

Additionally, at its onset in 1973, the Religious Coalition for Reproductive Choice, (RCRC, formerly "The Religious Coalition for Abortion Rights") was largely comprised of Mainline Protestants (Evans, 2002). According to the coalition's website, the RCRC is a "broad-

based, national, interfaith movement that brings the moral focus of religion to protect and advance reproductive health, choice, rights and justice through education, prophetic witness, pastoral presence, and advocacy.” (RCRC, 2017). However, there has been some shift in Mainline Protestant support over the years. In 2016, the United Methodist Church, one of the founding members of the coalition, officially announced its decision to withdraw from the RCRC (Religious Coalition for Reproductive Choice, 2016; United Methodist Church, 2016).

### 2.3 Historically Black Protestant positions on abortion

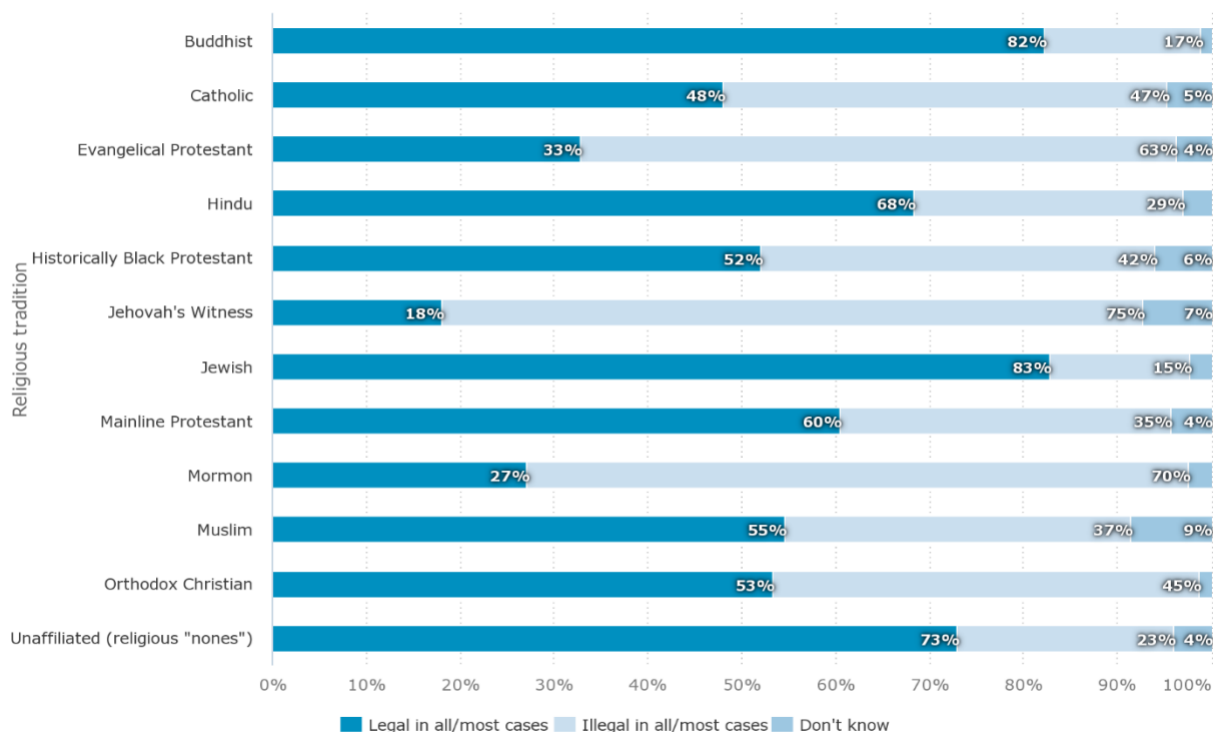
Historically, the Black Church has been composed of seven denominations: the African Methodist Episcopal Church (AME), the African Methodist Episcopal Zion Church, the Christian Methodist Episcopal Church (CME), the Church of God in Christ (COGIC), the National Baptist Convention, U.S.A., Inc., the Progressive National Baptist Convention, Inc., and the National Baptist Convention of America (Center for Religion and Civic Culture, 2016). The National Baptist Convention U.S.A., Inc. is currently the largest historically black church in the U.S. Other large historically black churches include the COGIC, the AME, the National Baptist Convention of America, and the Progressive National Baptist Association, Inc. (Center for Religion and Civic Culture, 2016). Among U.S. adults in the Historically Black Protestant tradition, 52% said that abortion should be legal in all/most cases and 42% reported that abortion should be illegal in all/most cases (Pew, 2014; See Figure 4).

Searches through Historically Black Protestant denominational policy and publications uncover little about reproductive health and abortion, indicating that few denominations have clear public stances on abortion. In the book, *Long March Ahead: African American Churches and Public Policy in Post-Civil Rights America*, R. Drew Smith writes the only “African American denominational journal carrying such discussion has been the A.M.E. Zion Quarterly

Review—and this has been limited to two articles published in 1991.” According to the late Bishop John H. Adams (AME, 2018), then senior bishop of the Atlanta-based AME, there many different viewpoints within the church and the church as a body has no official position on abortion. He expressed that most members believe that “abortion is usually wrong in except where a great wrong would be involved, such as the cases of rape, incest, and when the life of the mother is in jeopardy...[however] people have the right to control their own bodies [and abortion is] a decision of the woman and her family and not of the government” (Weston, 1990).

**Figure 4. Views about abortion by religious group**

*% of adults who say abortion should be...*



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Some denominations indicate their stance on abortion through their political activism and partnerships with outside organizations. For example, in 2016, the COGIC partnered with the Human Coalition, a nation-wide pro-life organization committed to end abortion (Human



Coalition, 2019), on *The Family Life Campaign*, a three year campaign to make “abortion unthinkable and unavailable in America” (COGIC, 2016). The goal of this campaign is to “rescue children and serve families in abortion-riddle communities nationwide” (COGIC World Missions, 2016).

## 2.4 Mainline and Black Protestants in Georgia

In 2014, 12% of the adults in Georgia identified as Mainline Protestant (Pew Research Center, 2015b) and 17% identified with a Historically Black Mainline denomination (Pew Research Center, 2015c). The majority of Mainline Protestant adults are over the age of 29: 12% are between the ages of 18-29, 34% are between the ages of 30-49, and 54% are 50-65+. Of these adults, 52% are women and 86% are white. The majority are married (58%) and do not have children under 18 (74%) (Pew Research Center, 2015b). Twenty-one percent of adult Black Protestants are between the ages of 18-29, 39% are between the ages of 30-49, and 40% are over the age of 50. Nearly two-thirds of adults are women. One-third are never married and 38% are married (Pew Research Center, 2015b). Based on church number, the most numerous Mainline denominations in Georgia include United Methodist (1150 churches), followed by Presbyterian (296 churches), and Episcopal (166 churches). The most abundant Black Protestant denominations include African Methodist Episcopal (540 churches), followed by National Baptist Convention (272 churches), and Christian Methodist Episcopal Church (144 churches) (Association of Religious Data Archives, n.d.).

Views about abortion are split nearly equally among Black Protestants in Georgia, 48% believe that abortion should be legal in all or most cases while 46% believe it should be illegal in all or most cases (Pew Research Center, 2015b). Among Mainline Protestants, 62% reported that

abortion should be legal in all or most cases and 33% reported that it should be illegal in all or most cases (Pew Research Center 2015d).

## 2.5 Clergy abortion attitudes

There is little recent literature describing clergy attitudes toward abortion. Jelen (1992) conducted 17 in-depth interviews with male Mainline and Evangelical Protestant clergy in a rural Midwestern county and found that differences in abortion attitudes between clergy across traditions were minimal. Clergy from both traditions affirmed abortion was too common, decided upon frivolously, and required restriction. Mainline Protestant clergy expressed approval of the need for legal abortion, stating that it is necessary in some circumstances, like rape or incest or when the health of the mother is at risk. However, they qualified this approval with the desire for restrictions and criticism of “casual” and “abortion on demand.” Evangelical clergy were more likely to communicate a “pro-life” stance to their congregations as a result of their high regard for the authority of Scripture, whereas Mainline clergy were less likely to attempt to socialize their members and “tend(ed) to be more tentative in their judgments and more sensitive to the possibility of violating the mores of their membership” (Jelen, 1992, p.139).

In an earlier study, ninety-four male clergy from a southwest metropolitan area were randomly selected from a membership list of the Council of Churches and surveyed on abortion attitudes, politics, sex, and women (Price-Bonham, Santee, & Bonham, 1975). A wide range of religious traditions and denominations were represented in the sample, including: Seventh-Day Adventist, Assembly of God, Independent Bible Church, Church of God, Pentecostal, Baptist, Church of Christ, Church of the Nazarene, Christian (Disciples of Christ), Methodist, Roman Catholic, Jewish, Lutheran, Non-denominational (community), Presbyterian, and Episcopal. Researchers found that age, region of the United States the participant was reared in, length of

time in ministry, size of church membership, and income were related to clergy attitudes toward abortion. For example, older clergy tended to have more liberal abortion attitudes. Clergy who were reared in conservative regions of the country tended to have more conservative attitudes. More liberal abortion attitudes were associated with longer time serving in ministry. Additionally, larger church membership size was related to more liberal attitudes. Finally, clergy with high incomes tended to have more conservative abortion attitudes. Further, the findings suggest that “conservative attitudes toward sex and women were more highly related to attitude toward abortion than either political attitudes or selected demographic variables” and “a more liberal attitude toward women has the strongest relationship with a more permissive attitude toward abortion” (Price-Bonham, Santee, & Bonham, 1975, p. 25).

## Chapter 3: Manuscript

### 3.1 Author affiliation

#### **“Even if I deeply disagree...I’m going to continue to love you”: Exploring abortion attitudes and pastoral care among Protestant religious leaders in Georgia**

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### 3.2 Contribution of the student

My contribution to this project began in fall 2017 as a graduate research assistant working with The Center for Reproductive Health Research in the SouthEast (RISE) on the study, *Engaging Georgia's Faith Communities for Promoting Reproductive Health* ("EnFaith"). With the EnFaith team, I conducted the initial literature review and drafted the initial study design for this qualitative research sub-study. Additionally, I designed the original in-depth interview guide and submitted the IRB protocol for the sub-study. In collaboration with the team, I made iterative refinements to the interview guide and participant recruitment process, recruited participants, conducted interviews, developed a preliminary codebook, and conducted analysis for this thesis. Finally, I wrote the initial manuscript draft in its entirety.

### 3.3 Abstract

**Objectives:** Unintended pregnancy is a common experience in Georgia, USA, where religion plays an influential role in many people's lives. The purpose of this study is explore attitudes towards abortion amongst Mainline and Black Protestant religious leaders and identify how they communicate, counsel, and provide pastoral care to their congregations regarding abortion.

**Methods:** We conducted qualitative in-depth interviews with 12 Mainline and Black Protestant religious leaders purposively selected from a county in Georgia with high abortion rates, low sexual and reproductive health service access, high religiosity, and denominational diversity. Interview topics included: attitudes toward abortion and pastoral care experiences. Interviews were analyzed using thematic analysis.

**Results:** Attitudes toward abortion ranged from "pro-life" to "pro-choice" and a middle or "gray area" in between these stances. Differences among abortion attitudes were observed in understandings of when life begins, emphasis on moral autonomy, and circumstances in which abortion may be morally acceptable. Across the spectrum of attitudes, participants stressed that they would "journey with" women and advise them to make well-informed decisions. Participants with "pro-life" attitudes encouraged referral to Crisis Pregnancy Centers and ultrasound viewing/hearing a fetal heartbeat before deciding to have an abortion. Participants with "pro-choice" attitudes and those in the middle of the spectrum advised against the use of abortion as contraception. Across attitudes, emphasis was placed on not using scripture punitively. Participants underscored that even if they personally do not "subscribe to abortion," they would emotionally support women because spiritual leaders are called to love and provide pastoral care for people. While participants with attitudes in the "gray area" were the only religious leaders who expressed an obligation to confront stigmatizing attitudes and treatment, all participants emphasized the importance of empathy, love, and compassion for people who have unintended pregnancies.

**Conclusion:** These findings demonstrate that religious leaders provide different advice and recommendations in the form of pastoral care according to their abortion attitudes. Leaders may represent an important resource for empathy, compassion, and affirmation of people's moral agency regarding abortion. However, several misperceptions that inform religious' leaders' pastoral care practices run counter to scientific evidence.

### 3.4 Introduction

Unintended pregnancy remains an important public health indicator in which geographic, racial/ethnic, and other reproductive health disparities are observed (Guttmacher, 2019). In 2011, 45% of pregnancies in the United States were unintended (45 pregnancies for every 1000 women aged 15-44) (Guttmacher, 2016; Finer & Zolna, 2016). Unintended pregnancy is a common experience in the state of Georgia, with 60% of all pregnancies being unintended in 2010 (Kost, 2015). Despite this, women face systemic and sociocultural barriers to their pregnancy decision-making autonomy and subsequent health and well-being.

Legal induced abortion is one outcome of unintended pregnancies, with approximately four in ten unintended pregnancies in the United States resulting in abortion (Finer & Zolna, 2016). In 2015, the rate of abortion in the United States was 11.8 abortions per 1,000 women aged 15-44 (CDC, 2018). In Georgia, USA, the rate was 15 abortions per 1,000 women aged 15-44 years (Kaiser Family Foundation, 2019). In 2014, only 4% of counties had clinics that provide abortion, leaving 58% of Georgia women without a clinic in their county (Jones & Jerman, 2014). State legislation may impose additional barriers to reproductive healthcare access. For example, in 2019, Georgia legislators introduced HB 481, a bill that would outlaw abortion once a fetal heartbeat is detected—usually around 6 weeks gestation (Georgia General Assembly, 2019). The bill is slated to be signed by the governor (Georgia General Assembly, 2019) and if enacted, would outlaw abortion before most people know they are pregnant (American College of Obstetricians and Gynecologists, 2016).

Research following legislative restriction of abortion in Texas, indicates that women may be more likely to carry an unintended pregnancy to term in the event of more restrictive abortion policies (Grossman, Baum, Fuentes, White, Hopkins, Stevenson, & Potter, 2014). In addition to

gaps in family planning access, women who carry unintended pregnancies to term are subject to barriers in access to perinatal care. Georgia has the highest maternal mortality rate in the U.S. (United Health Foundation, 2019), yet access to obstetric services is limited by a waning obstetrician/gynecology workforce, especially in rural areas (Spelke, Zertuche, & Rochat, 2016). Half of Georgia counties do not have a single hospital where women can give birth or access basic services or even one obstetrician/gynecologist (Georgia Obstetrical and Gynecological Society, 2017).

Along with health care systems and policy barriers to reproductive health care access, sociocultural factors such as religion, may also influence Georgia women's ability to exercise reproductive autonomy (Idler, 2014; Patton, Stidham Hall, Dalton, 2015; United Nations Population Fund, 2015). Many religions are perceived to disapprove of abortion (The Pew Forum on Religion and Public Life, 2013), yet religiously affiliated women do have abortions—the majority of women who obtained an abortion in 2008 and 2014 were religiously affiliated (Jerman, Jones, & Onda, 2016). Research has found correlations between religious affiliation or religiosity and abortion stigma (Cockrill et. al., 2014; Cockrill & Nack, 2013) and an association between religious condemnation of abortion and experiencing abortion stigma (Frohworth, Coleman, & Moore, 2018). Previous research indicates that “abortion stigma confounds a woman's decision to terminate a pregnancy due to worries about judgment, isolation, self-judgment, and community condemnation” (Frohworth, Coleman, & Moore, 2018; Cockrill, Upadhyay, Turan, & Green Foster, 2013; Kumar, Hessini, & Mitchell, 2009, Shellenberg et. al., 2011; Cockrill & Nack, 2013; Sorhanindo et. al., 2014).

Religious leaders are highly respected in their faith communities (Haffner, 2015) and can be influential in shaping sexual and reproductive health attitudes, norms, and behaviors at the



family and community level (Adedini, et. al., 2018; Religious Institute, n.d.; United Nations Population Fund, 2016; Haffner, 2015). For example, Mainline Protestant religious leaders have historically played a role in sexual and reproductive health policy, particularly with helping to “legalize and increase access to contraception and then abortion services during most of the twentieth century” (Haffner, 2015, p.5). This political involvement is of interest because 62% of abortion patients in the U.S. reported some religious affiliation, with 17% identifying as Mainline Protestant (Jerman, Jones, & Onda, 2016). At the same time, religious doctrine and beliefs may come in direct conflict with public health recommendations regarding abortion and contraception and it is “often the religious voices that oppose sexual and reproductive rights that have been the most visible in the media and most influential in policy debates” (Haffner, 2015, p. 5). One of the most prominent examples is the 2014 Supreme Court decision regarding *Burwell v Hobby Lobby Stores, Inc.* The court ruled the Religious Freedom Restoration Act (RFRA) of 1993 allows a for-profit company to deny its employees health coverage of contraception based on religious objections of the Hobby Lobby owners (Oyez, 2019).

Religious leaders may play an important role in providing sexual and reproductive health pastoral care and resources given that “religions have a venerable tradition supporting healing, health care, disease prevention, and health promotion [and a] commitment to the most marginalized, the most vulnerable, and the most likely to be excluded” (Haffner, 2015, p.28). However, little is known about the pastoral care practices of religious leaders as they relate to reproductive health, especially in the southern states of the U.S. Given their potential reach and influence, there is a need to understand religious leaders’ attitudes toward unintended pregnancy and abortion, how they communicate norms about these topics within their churches, and their pastoral care practices, particularly in Georgia, a state with high religious influence (Pew

Research Center, 2015), reproductive health disparities, and gaps in reproductive healthcare.

This study aims to qualitatively explore the abortion attitudes of Mainline and Black Protestant religious leaders in Georgia and how they communicate, counsel, and provide pastoral care regarding abortion.

### 3.5 Materials and methods

#### **Study design**

A cross-sectional study design was used to explore religious leaders' attitudes toward abortion and experiences with providing pastoral care regarding reproductive health. Thematic analysis was used to understand how religious leaders' abortion attitudes influence their provision of pastoral care. In-depth interviews were chosen to elicit individual-level data from religious leaders about their own experiences with study topics and the experiences of their congregations and to provide a confidential setting to collect data, given that discussion of abortion may be sensitive in nature.

#### **Sample and recruitment**

Study participants were religious leaders serving in Mainline and Black Protestant churches in Georgia, USA. Mainline and Black Protestant denominations were selected because nearly 30% of adults in Georgia identify with one of these traditions (Pew, 2015.) We selected participants from an urban geographic area outside the metropolitan area of Atlanta because we wanted to select a city<sup>1</sup> that was representative of Georgia across multiple criteria, including high abortion rates, low sexual and reproductive health service access, high religious adherence, denominational diversity, and an abundance of Mainline Protestant and Black Protestant churches.

Religious leaders were eligible to participate if they were currently serving in a Mainline Protestant or Black Protestant church as a clergy member or lay leader for at least 6 months prior to the interview, were over 18 years old, and spoke English. Purposive sampling techniques were used to recruit a diverse sample of religious leaders by Protestant tradition (e.g. Mainline Protestant and Black Protestant), denomination (e.g. United Methodist Church, Congregational

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<sup>1</sup> City name omitted to protect participant confidentiality

Methodist Church, National Baptist Convention, USA, Inc., Evangelical Lutheran Church in America, African Methodist Episcopal), and gender. Religious leaders were recruited via a publicly available list published by The Association of Religious Data Archives that included of all Mainline Protestant and Black Protestant churches within a 5-mile radius of the metropolitan county where the study was conducted. Names and contact information for the primary religious leader were obtained from church websites and social media. Lay leaders were recruited via snowball sampling because their contact information was not publicly available on church websites, and because senior religious leaders sometimes serve as gatekeepers to accessing these individuals.

Religious leaders were contacted by email, phone, and social media message using standard IRB-approved scripts, identifying the study as a graduate student thesis project that was being conducted as part of a larger study by the Center for Reproductive Health Research in the SouthEast (RISE) at Emory University. Up to five total attempts per church to schedule an interview were made via email, telephone, and social media.

### **Participant characteristics**

Sociodemographic characteristics of study participant are presented in Table. 1. Participants included 10 clergy members and 2 lay leaders, of which encompassed 8 senior pastors, 2 associate pastors, 1 regional minister, and 1 First Lady. The ages of participants ranged from 28 to 72 years, with a mean age of 49. Ten of the participants were male, reflecting the male dominance of senior leadership roles in churches. Ten participants were married, one participant reported being single, and one reported being divorced and re-married. The majority of participants were highly educated, with the nine holding a graduate degree, most commonly a Masters of Divinity. Eight participants identified as democrats, 2 as independents, and 2 as republicans. Among the participants interviewed, ten different denominations were represented,

and church membership sizes ranged from less than 50 to over 1000 people. The length of time that religious leaders served in their current role ranged from 6 months to over 40 years.

**Table 1. Participant characteristics.**

Participant	Age (years)	Sex	Race	Marital status	Highest level of education completed	Political affiliation	Tradition	Denomination	Length of time in current role (months)	Church membership size
1	37	Male	White	Married	Graduate Degree	Independent	Mainline Protestant	United Methodist Church	6	Between 251-1000
2	51	Male	White	Married	Associate Degree	Republican	Mainline Protestant	Congregational Methodist Church	60	Between 251-1000
3	31	Male	White	Married	Graduate Degree	Democrat	Mainline Protestant	United Methodist Church	18	More than 1000
4	28	Male	White	Married	Graduate Degree	Democrat	Mainline Protestant	United Methodist Church	>6	Between 101-250
5	59	Female	Black	Single	Graduate Degree	Democrat	Mainline Protestant	Christian Church (Disciples of Christ)	54	Between 51-100
6	61	Man	Black	Married	Graduate Degree	Democrat	Black Protestant	National Baptist Convention, USA, Inc.	180	Between 251-1000
7	63	Female	Black	Married	Graduated College	Republican	Black Protestant	National Missionary Baptist Convention, Inc.	228	Between 101-250
8	43	Male	Black	Married	Graduate Degree	Democrat	Black Protestant	Non-Denominational	72	Between 101-250
9	30	Male	White	Married	Graduate Degree	Democrat	Mainline Protestant	Evangelical Lutheran Church in America	13	<50
10	72	Male	Black	Married	Graduate Degree	Independent	Black Protestant	Baptist-Other	552	Between 251-1000
11	59	Male	White	Married	Graduate Degree	Democrat	Mainline Protestant	Episcopal Church (Anglican)	>6	Between 251-1000
12	56	Male	Black	Married	Graduated College	Democrat	Black Protestant	African Methodist Episcopal (AME)	132	Between 101-250

### Data collection

Data were collected between October 2018 and March 2019 using a semi-structured interview guide developed in collaboration with two religious leaders. The guide included questions on participants' views about unintended pregnancy and abortion, pastoral care on these

topics in their congregations, and their suggestions for discussions and programming around unintended pregnancy and abortion in church settings. Some of the questions included, “*What are your personal views on abortion? How do your current views on abortion compare to your views on abortion at the beginning of your career? What happens to someone as a result of an abortion?*” Participants were also asked about how they would provide pastoral care for congregation members experiencing unintended pregnancy, for example “*Can you describe a time you provided pastoral care to someone seeking your advice because they experienced an unplanned pregnancy? Imagine a young person in your church had an unplanned pregnancy and sought your advice. What would you say? What advice would you give someone in your congregation considering abortion?*” In the event that religious leaders did not have pastoral care experience related to unintended pregnancy and abortion, they were asked about how they would respond to such situations if they arose. Interviewers probed for barriers and facilitators to providing pastoral care on these topics and specific resources and scripture religious leaders would rely on during these conversations.

Data were collected by a team of four interviewers (JLD, EM, SN, JP), trained on qualitative research methods, the study protocol, and ethics. Prior to data collection, the interviewers discussed reflexivity to minimize researcher bias and potential influence on the data collected. All interviewers were female, three women of color and one white woman, ranging in age from 24-36 years old, and were a graduate student (JLD), postdoctoral fellows (EM, SN), and the project director (JP). Interviewers had varying religious backgrounds and experience attending Christian churches.

The interview guide was pilot-tested in four interviews with clergy members serving in Mainline and Black Protestant churches in metro-Atlanta. Following the pilot interviews,

refinements were made to the interview guide to clarify key concepts and improve question flow. After each interview, interviewers practiced reflexivity by journaling their impressions of each interview and noting potential biases on a standard form, which was used in debriefing sessions with the research team. Iterative refinements to the interview guide and recruitment process were made throughout the data collection period. For example, after a theme of referral to Crisis Pregnancy Centers emerged in several interviews, we added a probe about the availability of local resources for support surrounding an unintended pregnancy to the question eliciting the advice that religious leaders would give to a congregant considering abortion. In addition, the majority of Black Protestant churches used Facebook pages in place of traditional websites, so social media outreach via Facebook was added a strategy for participant recruitment.

Given the potentially sensitive nature of the study topic, researchers obtained verbal consent in-person prior to the interview, rather than seeking written consent. Participants were read an IRB-approved script, invited to ask follow-up questions, and then asked if they agreed to take part in the study. If religious leaders verbally agreed to participate, researchers signed the consent form on the participant's behalf with their permission. A short demographic survey was administered after the informed consent process. Interviews were conducted at the church of the participant, at Emory University, or another public location (e.g. shopping mall) of the participant's choosing, digitally audio-recorded, and lasted between 48 and 90 minutes. Each participant received a \$50 gift card for their participation. The study was approved by the institutional review board (IRB) at Emory University (IRB 00106069).

### **Data analysis**

Interviews were transcribed verbatim by a professional transcription company and de-identified by the research team. Data were managed and analyzed using Dedoose software version 8.0.35 (SocioCultural Research Consultants, 2018). Data collection, coding, and analysis

occurred simultaneously to assess data saturation. Meaning saturation, or a “richly textured understanding” (Hennink, Kaiser, & Marconi, 2017) was achieved for some issues, but not all, thus results are preliminary. Codes were determined both inductively (emerging from the data) and deductively (pre-determined from the interview guide), building upon a preliminary codebook created by JLD.

An inter-coder agreement exercise was conducted to ensure consistency on coding data, whereby three researchers (JLD, JEP, SN) individually coded two transcripts and coding was reviewed for discrepancies. Weekly team meetings were held from January 2019 to April 2019 to refine code definitions, resolve discrepancies in coding strategy, and discuss reflexivity and bias. The remaining transcripts were coded by JD, WSR, SN, and JP. Memos were used during analysis to facilitate code development and note key findings and connections between concepts. The research team explored data using salient codes and created descriptions of all codes. This analysis focuses on codes that were central to the research question: *abortion, attitudes & beliefs, and pastoral care*. We conducted structured comparisons by sociopolitical attitudes, denomination, and gender, in addition to comparisons within these groups. Data were reread iteratively to ensure validity in the emerging themes and conceptual model. Illustrative quotes were selected for salient themes and presented with participant’s demographic information.



### 3.6 Results

When asked about their views on abortion, most participants identified a spectrum of attitudes toward abortion. Responses ranged from “pro-life” (abortion is “killing” or “murder” and all life created by God should be protected) to “pro-choice” (“a woman makes the choice”), with a middle or “gray area” in between these stances (“people have to make decisions on their own,” but “all life is sacred”). The results of this study are presented to compare moral and religious beliefs along the spectrum of abortion attitudes identified by participants and the resulting pastoral care practices of participants who hold each attitude.

#### **Moral & religious beliefs and abortion attitudes**

Differences among attitudes were observed in participant’s understanding of when life begins, affirmation of a women’s moral agency, and expression of the circumstances in which abortion may be morally acceptable. All participants across the spectrum of attitudes identified at least one circumstance where abortion may be the best decision for a pregnant person. Participant’s views on the moral acceptability of abortion ranged widely, with those identifying as “pro-life” having fewer moral exceptions for abortion because they believe the circumstances of most unintended pregnancies are surmountable, and therefore do not need to be resolved by abortion.

Participants were prompted to identify scripture that influenced their attitudes about abortion. All participants expressed that their attitudes are influenced by their understanding and interpretation of Christian scripture and doctrine; most participants referenced the influence of beliefs about the sanctity and sacredness of all life. They explained that people are created in God’s image, therefore human life has sacred worth which should be protected. Many participants across the attitude spectrum expressed the perception that abortion is ending life.

However, participants had mixed views about when life begins and starts to bear the image of God.

Participants with a “pro-life” attitude towards abortion described the beginning of life at early stages in fetal development, with some reporting life begins at conception, and others explaining that life begins when there is a fetal heartbeat. Participants in the “gray” middle of the attitude spectrum did not have a consensus about when life begins, or, in other words, whether an abortion would end life that was created in God’s image. One senior pastor in the middle of the attitude spectrum stated that he rejects the notion that “a fetus is just a grouping of cells.” Another senior pastor also in the middle of the attitude spectrum stated that he was not qualified to state when life begins, but he was confident it was not conception. He expressed uncertainty about when a fertilized egg starts “bearing the image of God,” but expressed that it was sometime between conception and birth. One female participant with a “pro-choice” attitude toward abortion expressed beliefs about the beginning of life which were unique among other participants. She explained that Jesus Christ came through the birthing process, the time when God blessed the birthing journey. She described that un-lived life has potential and sacred life is comprised of the spirit and the flesh. According to her, life begins when God’s spirits are brought into “our earthly journey” through the process of birth. She explained, spirits that are not birthed “stay up there (with God) or get in line and wait for the next chance,” in other words, the spirit (the sacred part of God) lives on, even as the flesh dies, even in abortion. She expressed this happens because God is loving:

*“If God is a God of love, why would God punitively respond to that entity of life that has no choice? I think God is bigger than that ...”* (59 year old female, Christian Church (Disciples of Christ))

Most participants stated public and pastoral care conversations about abortion should include recognition of the sacredness of life because Christian believers walk that experience, or in other words, it is fundamental to Christian beliefs. One participant in the middle of the abortion attitude spectrum expressed his tension between his belief in sanctity and the sacredness of all life, and holding non-Christians to these beliefs because they do not understand them in the same way as Christians:

*“So I believe in the sanctity and the sacredness of all life. I believe that all human beings are made in the image of God, that we all have a divine fingerprint on each of us and that leads me to want every life to be lived, right? Every aspect of the image of God to be lived out in this world because I believe in the sacredness of it. However, I also don't believe in theocracy. I don't believe in Christian rule of law and it's like I think Paul talks about it in the New Testament basically like you can't hold people who are not Christians to Christian law, to Christian rules and standards because I think he sort of caches it in a sense of like they don't know the law, they're ignorant of the law ... I would say like you can't hold them to it because they haven't committed to it. They don't understand it the same way you do.”* (28 year old male, Senior Pastor from a United Methodist Church)

Many participants expressed that there is a process of healing, redemption, or becoming “whole” that women must undergo following abortion to resolve adverse psychological and spiritual effects. Most participants describe these effects, such as emotional guilt, regret, and spiritual effects, such as questioning whether God would forgive them. They expressed that these effects are often lasting and lifelong for those who cannot or will not “do the work [of] resolving their own minds.” Across abortion attitudes, participants expressed that adverse psychological effects are especially salient for women who never end up having children or learn later that they are infertile. In addition, some participants from Black Protestant churches expressed that there may be guilt, condemnation, criticism, and judgement from members of their congregation

towards people who have an abortion. These participants expressed that stigmatizing responses from members of the congregation would continue to distress women after abortion until they sought spiritual and emotional healing. Participants explained the process of redemption and healing after having an abortion involves women reckoning with ending a life, recognizing they are covered by God's grace and God does not condemn them, even if they may condemn themselves for their decision to terminate a pregnancy.

### **Pastoral care is influenced by religious leaders' abortion attitudes**

#### **“Pro-life” religious leaders**

Participants with a “pro-life” attitude described that abortion is too common and should be a last resort that is not rushed into or taken lightly. Additionally, they perceived that abortion is too often discussed in a “sterilized way” in which “the concept of life and sacred worth is detached from it.” They emphasized the importance of sharing these religious beliefs when providing pastoral care for someone considering abortion. They expressed perceptions that people too often think of abortion as a first resort, and explained that they would encourage congregants to make well-informed decisions that were carefully considered. Participants with a “pro-life” attitude acknowledged abortion as a legal option, but explained they would only counsel women to consider this legal option in cases of risk to their life or in some cases of incest. Some participants with a “pro-life” attitude were less decided about the acceptability of abortion in cases of rape, stating tensions between the view that God allowed the assault to happen and therefore, something good might come out of it, and concerns for the mental health of the mother. One pastor from a Congregational Methodist Church who identified as “pro-life” raised concerns about abortion in cases of rape. He expressed that abortion may be allowable only when the woman has no shared “responsibility for [the pregnancy]” (e.g. a woman going to a grocery store and getting “attacked by an evil person” versus a young girl drinking too much at

a party). The same participant explained that abortion is not morally acceptable in cases of fetal anomaly. He explained fetal anomalies are the result of “the sinful nature that we’re born into” because of the original sin of Adam and Eve, and God does not make mistakes.

Other participants who identified with a “pro-life” attitude shared this belief that regardless of the intendedness of pregnancy, there are no “accidental children” because “God does not make mistakes.” They explained that they would draw upon this belief when providing pastoral care and would advise congregants considering abortion to first consider what God is calling them to do and consider the potential of their unborn child. A senior pastor from a non-denominational Black Protestant church described how he would counsel someone considering abortion,

*“I would first of all just tell them, ‘Let’s really think about what honors God in this situation.’ If it’s an issue of economics or whatnot, ‘hey, we’ll be here as much as we can and deal with you. It’s going to be tough. I’m not going to lie to you, it’s going to be tough. But we’re going to be here. This child has a destiny. You know we don’t know what may come out of this situation.’ So I think that would be [the] thing as a pastor—I believe my thing [is] to get up with them as God biblically and theologically, which is this child here, something great can come out of something bad. Well, let’s not say it’s bad; let’s not label it. Something great can come out of this.”* (43 year old male, Senior Pastor at a Black Protestant Church)

Another explained he would encourage congregants to consider the positive potential in their situation, he explained,

*“God can transform and change any situation, any circumstance. And, matter of fact, he specializes in that. He specializes in that. ‘So young lady, I understand you made a mistake. I get it. I’m not here to beat you up. I want to help you make wise decisions going forward. You don’t know that that baby in in your stomach won’t be the next president of the United States ... you don’t know that that baby might not be the next*

*doctor that discovers some cure for cancer. You don't know. But just because the child was conceived in these circumstances, just because I was raised like that, doesn't mean that good can't come out of it.' And so I want 'em to know that... listen, a bend in the road – which is what this is – is not a end in the road. We just gotta deal with it. Yogi Berra says, 'What do you do when you come to a fork in the road? You pick it up.' ... In other words, you just deal with – and we just gonna keep going, you know?" (Male Pastor from a Congregational Methodist Church)*

Participants with a “pro-life” attitude expressed that they would encourage people to first see an ultrasound or hear a fetal heartbeat before deciding on abortion. They cited examples of knowing people and hearing stories of young women who were decided on abortion until they saw an ultrasound or heard a fetal heartbeat. “Pro-life” participants expressed they would encourage pregnant women to seek healthcare services, namely prenatal care, to take care of themselves and their babies. Without being prompted, male and female “pro-life” participants from Mainline and Black Protestant denominations cited close ties to Crisis Pregnancy Centers and local Pro-Life advocacy groups that they would refer people dealing with unplanned pregnancies to. One senior pastor from a United Methodist Church explained his process in providing pastoral care to a young woman and making an appointment for her at a Crisis Pregnancy Center:

*“She didn't want to acknowledge that she was pregnant, so I set up with a crisis pregnancy center a time for her to go in for an ultrasound, start receiving prenatal care, and then she didn't show up ... she didn't show up for the ultrasound, and all that. I was put in the awkward position of having to be a little bit aggressive with them, ‘Look, this is your life, and the child's life are at stake if you don't receive any prenatal care.’ ... That was kind of a strange situation that I felt at some times like maybe I was overstepping my bounds by being pushy, but they weren't even talking to their parents about it. They weren't talking to anybody. ... That involved not just counseling but a lot of, I don't know*

*what you would say, arm-twisting like, 'You need to go get checked out,' so that was kind of my role in all that. It was a strange role, one of those they don't train you for in seminary, that's for sure.*" (37 year old male, Senior Pastor at a United Methodist Church)

### **Religious leaders in the middle of the abortion attitude spectrum**

Participants in the middle of the abortion attitude spectrum included a senior pastor from an AME church and senior pastors from a United Methodist Church and an Evangelical Lutheran Church in American (ELCA) congregation, denominations that have passed policies in support of family planning and legal abortion (Haffner, 2015). Such participants were tentative about making strong statements about what the ideal resolution of unplanned pregnancies should be. They explained that they were not "qualified" to make such determinations and one participant explained that he was in a "gray area" between "pro-life" and "pro-choice." Participants with attitudes in the middle of the spectrum expressed the importance of individual autonomy to make abortion decisions and careful consideration of the context of an unplanned pregnancy in deciding on the ideal resolution of the pregnancy; however, most of these participants expressed that they would prefer abortions be less common. Participants cited tension between belief in the sanctity of life and respect for individual autonomy. One participant expressed this tension:

*"So I don't believe that it's my right as a human being to tell a woman what they're going to do with their body because a woman and a child are literally inexorably linked as far as being in utero and in womb. And so I have no right to say to someone who's carrying a child that you can or cannot do this or that or the other because that child is your body and you have the right to see your body. But at the same time, there is also the potential for a life being carried inside of that body. And the part of me that values the sacredness of all life says, 'Oh, but look at the potential there. Look what good that future human being could do in the world.' So I sort of stand at a very strange gray area and crossroads with abortion."* (28 year old male, Senior Pastor at a United Methodist Church)

Some participants in the middle of the abortion attitude spectrum cited that abortion may be the best decision for some people if having an abortion would alleviate potential suffering or in cases in which a mother is not able to care for herself or for a child. An ELCA senior pastor described wrestling with his views about abortion in cases of fetal anomaly after reading literature about the rights of disabled persons published by disability activists. Another senior pastor explained his personal view on abortion,

*“My personal views on abortion is that I believe that in some cases, abortion could be the best option for that individual, if they come to that conclusion, such as poorly – development of a fetus that does not have, medically speaking, the chance for – productive or normal life outside of the womb. Okay? People make those decisions on their own. One of the more sensitive issues is having a healthy child, but if that child is the result of rape or incest, I don't believe that God cannot forgive anyone for any decision that possibly could be against his will. His will of course is that we have life, but I also hold to this belief that every, every, every – conceivable sin is forgivable by God, except for blasphemy...”* (Senior Pastor from an African Methodist Episcopal church)

Most participants in the middle of the attitude spectrum and participants with “pro-choice” attitudes stated that abortion should be legal and some expressed concerns about legislative influence on abortion and reproductive health. These participants expressed they did not believe morality should be legislated and the decision to terminate a pregnancy is a private matter between a woman and God. A senior pastor of a United Methodist Church with an attitude on the middle of the spectrum expressed his view on legislative influence:

*“[It is too] gray an area for the government to rule on...at the same time, government has to protect the practice of abortion because if abortion is outlawed then we'd go back to the days pre-Roe vs. Wade where we'd have sketchy, unsanitary clinics, and abortions being performed improperly that are then not only ending the potential for life but also*



*causing harm to a living, breathing human simply because they don't have access to proper healthcare"* (28 year old male, Senior Pastor from a United Methodist Church)

Another participant in the middle of the attitude spectrum said abortion should be *"safe, legal, and rare."* (Male senior pastor from an ELCA church).

These participants discussed providing pastoral care for people experiencing an unplanned pregnancy and following a completed abortion. Further, these participants described the need to provide pastoral care in the form of protection of the pregnant woman or women who has had an abortion, and prevention of stigmatizing treatment from other members of the congregation. A male senior pastor from an African Methodist Episcopal church described how he would act to influence the congregation who learned of a woman with an unplanned pregnancy to prevent her from leaving the church,

*"I won't let my officers beat them up, either, because we have old school folk that, you know, that will try to beat up folks, and I'm the one that has to come to the defense, but no, we're not going to put this person out of the choir. We're not going to take them off of the usher board. We're not going to do any of those things. And some preachers I've heard will have that young person stand before the congregation and commit their sin and all this kind of stuff. Well, you know, I've committed [chuckles]— you know, all of us have come short, as the Bible say, have sinned and come short of the glory of God. So, when is my turn to stand up and say I've been wrong? You know? And so no, I don't see a need to do that. That confession is between – it's between that individual and God. I've got nothing to do with that, but just sort of lead them there, you know, so it doesn't have to be a public thing. But a lot of other preachers will try to make that person feel shame and feel disgraced and all this, to prove the point that I won't do it again. You know? And that doesn't work to me. But what I've seen happen is when the church pastor and the congregants of that church ridicule such a young person, even a mature person that is not married, they give them so much ridicule, that person ends up leaving that church and going somewhere else."*

Other participants in the middle of the attitude spectrum explained that part of their pastoral care would be to encourage their congregations to love and support someone considering abortion or who has had an abortion.

### **Pro-choice participants**

Participants who identified themselves as “pro-choice” explained that they cannot make decisions for people or for their bodies. They explained that pregnancy-related decision making should rest with a pregnant person and God, but they would try to guide people in their decision-making about abortion to the best outcome for the mother and the baby. They emphasized that their pastoral care would consist of much listening and understanding. A “pro-choice” senior pastor at an Episcopal Church explained that he could not make these decisions for people because to do so would be “treading on a violation of the relationship between [them] and God.” “Pro-choice” participants expressed that abortion is a psychologically difficult decision that they wished people did not have to go through, but they underscored that it may be the best option for some people. Participants explained that abortion may be the best decision if there is risk to the life of the mother, in cases of rape or incest, and in cases of fetal anomaly. Additionally, some “pro-choice” participants expressed that abortion should not be used as a primary means of birth control or contraception. Another senior pastor at an Episcopal church who identified as “pro-choice” expressed that abortion should not be allowed for sex-selection, although he did not believe this was a common occurrence. Another participant who identified as “pro-choice” acknowledged abortion as a legal option, but emphasized the importance of supporting women and providing children the care they need so people have other options in addition to abortion. All participants with a “pro-choice” attitude expressed that they did not prefer abortion as an option and would express their own attitudes in pastoral care conversations, but would also emphasize that the pregnancy-related decision was the congregant’s to make. One participant

described providing pastoral care to someone considering abortion:

*“And I think what I said to her is that I, personally, did not subscribe to abortion. But my position does not hinder somebody else from making a decision for themselves. And so, whatever you do, I will support you. I think that where I wanted her to understand – and she asked, ‘What’s your position?’ I’m going to be honest with, ‘This is what I believe but this is not based on what I, the ways on which God judges us. This is not God standard. This is from me and you must make your own decision. And in that, God is not an either/or God. God is not gonna condemn you to Hell but you have to be able to live with your decisions.’ And she eventually decided to abort. And from what I understand, had a happy life.”* (Regional Minister from a Mainline Protestant church)

### **Pastoral care across the abortion attitude spectrum**

A comparison of pastoral care across sociopolitical attitudes is shown in Figure 1. Many participants have had little or no experience providing pastoral care related to abortion in their careers. In such cases, they responded to hypothetical situations in which they would provide pastoral care to congregants seeking abortion. Many felt they were not properly qualified to provide this type of pastoral care or lead faith-based health programs that included discussions of unintended pregnancy and abortion.

All participants expressed they would not counsel someone to have an abortion and it would not be their preferred resolution of an unplanned pregnancy, considering the value they placed on the sacredness of life. However, some “pro-choice” participants and those with attitudes in the middle of the attitude spectrum expressed that they would be empathetic and understand why abortion may be the best option in some cases. Both “pro-life” and “pro-choice” participants expressed disapproval toward abortion for primarily economic reasons or out of “mere convenience,” and stressed that these were not “good” reasons to have an abortion. They explained that they would counsel women to carefully consider why they wanted to have an abortion. One participant explained,

*“Again, if it's just mere convenience, because you've got another year of college, I will advise you against having an abortion, acknowledging that this is your decision, and that – Don't enter into it lightly.”* (Male senior pastor from an Episcopal Church)

When asked about how they would provide pastoral care for abortion, “pro-life” participants and those on the middle of the abortion attitude spectrum cited examples of instrumental support that they would provide as part of their pastoral care for unplanned pregnancies and emphasized providing support for continuing a pregnancy. For example, a senior pastor who identified as “pro-choice” explained how he and his congregation would provide support,

*“We have responded to unplanned pregnancies by doing I think what we feel we're called to do, to make sure that the woman is getting health care, and provide the essentials for bringing a new baby – at least the physical part. You know, the crib, making sure they have – if they're not going to be able to breastfeed, that they have formula, blankets, all those things. And that's how we've responded in the past.”* (Male senior pastor from an Episcopal Church)

### **Emphasis on love and supporting congregants across abortion attitudes**

Across the spectrum of attitudes, participants expressed the importance of supporting a person facing an unplanned pregnancy and “journeying with” them in their decision-making (see Figure 1). Participants expressed that they were called to respond in this way and love people who had or were considering abortion, as part of their duty as spiritual leaders. They emphasized the importance of expressing love and understanding when providing pastoral care for someone considering abortion, even if their theology led them to be morally opposed to abortion. Some participants expressed that the woman is loved by them, the congregation, and God. A senior pastor from an African Methodist Episcopal (AME) church in middle of the attitude spectrum explained how he would talk to someone considering abortion who came to him,

*"Well, Pastor's still going to love you just like he did yesterday, you know. That kind of thing. I'm not going to preach anybody into hell for an unplanned pregnancy. Life happens in so many other kinds of ways that anyone can be condemned for anything, and that's just not what I'm about. My thing is really telling someone their worth, you know, and making sure that they do those things that's proper. But when we fall, we fall, and God gives us an opportunity to get up again."*(Senior Pastor at an AME church)

Many participants across the spectrum of attitudes expressed the importance of not condemning a person because of abortion, citing scripture punitively, or passing judgment. A male senior pastor from an Episcopal church who identified as “pro-choice” said,

*"And I think also – and listening, but also journeying with the person as best you can. I mean, sometimes you only see a person once. I also think it's letting them know that they're loved. I go back to that, with – that's – love will win. I know it's become sort of a moniker and nobody takes it seriously, but – ...It will. So how do we love? How do we love that woman who didn't plan, and that baby that's going to result from it? Or the woman that planned, and still she got pregnant. It's not what do we with them. It's how do we love them, and make sure they know they're loved? That's the part I see my role as."*

Additionally, participants across the attitude spectrum expressed that people who have abortions are covered by God’s grace and forgiveness, religious beliefs that they would convey in their pastoral care. Many participants expressed that abortion will not separate women from the love of God, or the love of the participant, even if the decision to abort is not pleasing to God. Some participants equated abortion to sin such as divorce, but explained that every sin, except blasphemy, is forgivable by God. Therefore, these participants believed it was not their job to judge someone who has an abortion, even if they believe that abortion is ending a life. Some across the attitude spectrum expressed that God’s view of the sanctity of life is not punitive, therefore it is not appropriate for religious leaders to condemn women who have

abortions to Hell or require them to publically confess this sin. A female lay leader who identified as “pro-life” expressed,

*“We don’t hold anybody in condemnation because you woke up one morning and did something crazy. God—there’s forgiveness for that. But we need to spread that abortion is not the way. It’s killing a mosquito with a candle. It’s just a baby. It’s another human life. It’s gonna be productive, hopefully, in somebody else’s life.”* (First Lady from a National Missionary Baptist Convention)

Another participant in the middle of the attitude spectrum explained that he would be a source of support for someone who has had an abortion, despite common perceptions of religious leaders and churches,

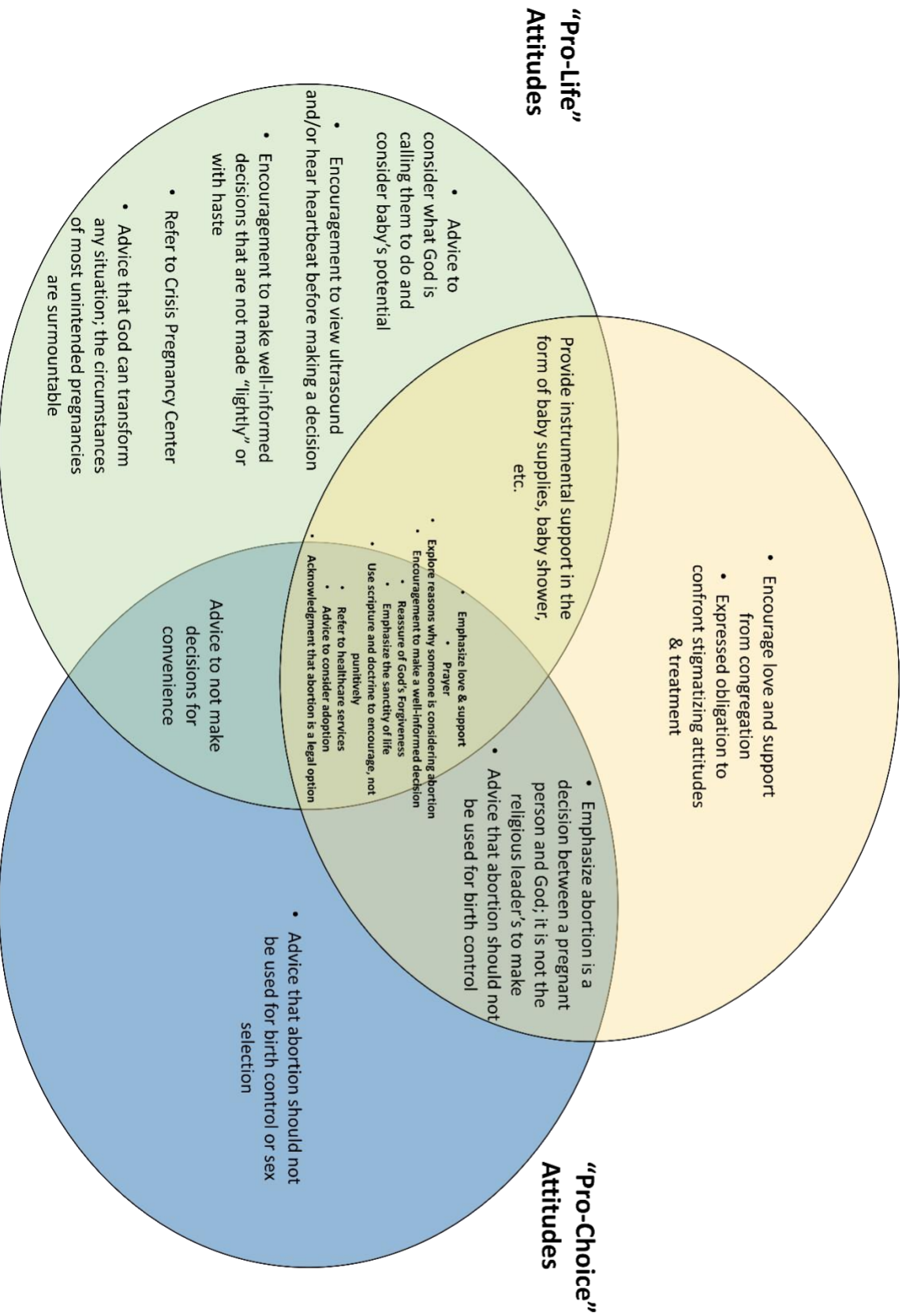
*“I probably know someone who’s had an abortion but none of them have ever told me. And I’m just thinking about this in terms of pure statistics and the amount of people that I know and interact with. It seems statistically improbable that I haven’t met someone. But because I wear this stupid little shirt with a plastic collar, that puts me in a different category. That puts me in someone that they may have grown up knowing will judge them rather than someone who will support them or love them and the same goes for the people in the pew. So many people come from churches that have inflicted trauma upon them either through abusive theology or covering up abuse that the church, which should be a social network of support, becomes kind of a risky community and that you have to wonder if you’re gonna get kicked out for violating certain taboos.”* (Male senior pastor from an ELCA church)

A senior pastor who identified as “pro-life” explained the role of religious leaders in pastoral care for abortion,

*“I think that the main role a religious leader can play is to assure the person that they are not going to have to be alone, they’re not going to have to go through this alone, that there are resources to pull from, there are people that you can talk to, people you can*

*rely on. There is information out there that can be handed on to you. I think, across the board, regardless of the churches, where they stand or where the pastor stands, I think that's the most important thing to do, is to say, "Hey, somebody is in your corner. Somebody is here with you." Then, from a theological standpoint, to me personally, I would highlight just the sacred worth that everybody has, that your life is important, the life of the unborn child is important. Every situation is different, but what we're trying to do here is preserve God's creation the best that we can in a very healthy way."* (Senior Pastor from a United Methodist Church)

**Figure 1.** Attitudes toward abortion and pastoral care  
**Attitudes in the middle of the spectrum**





### 3.7 Discussion

This study provides insight into complex religious and moral perspectives on abortion and how these attitudes influence the provision of pastoral care by Mainline and Black Protestant religious leaders in Georgia. One of the key aims of this analysis was to develop an understanding of how religious leaders' abortion attitudes influence their provision of pastoral care in order to inform intervention development for a larger study that seeks to understand what existing norms and values should be leveraged in a faith-based program to promote compassionate norms around sexual and reproductive health and wellbeing.

All participants agreed that they would have some part in providing pastoral care for abortion if congregants sought them out. Key similarities in pastoral care across the spectrum of attitudes toward abortion include: recognition of the importance of the sanctity of life, emphasis on using scripture to encourage, and not in a punitive manner, and acknowledgement that spiritual leaders are called to love and care for people, regardless of the decisions they make. In addition, many participants across all abortion attitudes and denominations described psychological effects of abortion and the need for spiritual healing after abortion. Differences among participants' abortion attitudes were observed in their understanding of when life begins, acknowledgement of moral agency to make pregnancy- and abortion-related decisions, and the circumstances that abortion may be morally acceptable. For example, participants with "pro-choice" attitudes and participants with abortion attitudes in the middle of the attitude spectrum emphasized a preference against abortion, but recognized women's moral agency, whereas participants with "pro-life" attitudes did not express recognition of this concept.

The results from this study demonstrate that religious leaders may provide social support in the form of pastoral care differently according to their abortion attitudes. However, several misperceptions that inform religious' leaders' pastoral care practices run counter to scientific evidence. For example, the idea that there are adverse psychological effects of having an abortion is refuted by thirty years of research has shown that legal induced abortion of an unwanted pregnancy does not pose significant mental health problems for women (American Psychological Associations Task Force on Mental Health and Abortion, 2008; Adler, 1990; AMRC, 2011), except in cases where the pregnancy was wanted, such as with abortion after discovery of a fetal anomaly. Unwanted pregnancy, however, may have psychological effects on women. In a review of the emotional effects of abortion from 1990 to 2011, the Academy of Medical Royal Colleges (AMRC) found that an unwanted pregnancy increases women's risk of mental health issues (AMRC, 2011).

In addition, some religious leaders with "pro-choice" attitudes and participants in the middle of the attitude spectrum stated they would advise against, or provide informational support to prevent, the use of abortion as contraception. However, unintended pregnancy prevention guidelines clearly distinguish contraception as a form of primary unintended pregnancy prevention, and abortion as a form of secondary unintended pregnancy prevention (Taylor & James, 2012). Further, there is evidence to suggest that women do not use abortion as a primary unintended pregnancy prevention method. In particular, evidence suggests that use of contraception contributed to a 13% drop in U.S. abortion rates from 2008 to 2011 (Jones & Jerman, 2014) and over half of U.S. abortion patients were using a contraceptive method when they became pregnant (Guttmacher, 2018). Similarly, both participants in the middle of the attitude spectrum and participants with "pro-life" attitudes expressed the same views that they

would advise women against having abortions for “convenience.” However, a 2005 study found that women have abortions for diverse and interrelated reasons; 73% cited inability to afford a child and 74% cited having a baby would interfere with work, education, or ability to care for dependents (Finer, Frohworth, Dauphinee, Singh, & Moore, 2005).

Participants who identified a “pro-life” attitude towards abortion cited informational support that encouraged women to continue their pregnancies and carefully consider the potential of the unborn child. Many of these participants expressed that their pastoral care would include instrumental support in the form of making referrals to Crisis Pregnancy Centers (CPCs) and Pro-Life advocacy organizations. Those with a “pro-life” attitude explained that CPCs were reliable sources of information and would help women to get prenatal care. They explained that women could go to a CPC to see an ultrasound or hear a fetal heartbeat. Some participants with a “pro-life” attitude explained that they would advise women to seek these services before deciding to have an abortion. Religious leaders may view CPCs as reliable healthcare services because of their emphasis on religious ideology; however, women seeking care at these clinics “do not receive comprehensive, accurate, evidence-based clinical information about all available options” (Bryant & Swartz, 2018).

Those in the middle of the attitude spectrum expressed obligations to encourage empathy and dispel stigmatizing attitudes and treatment within their congregations. While participants with abortion attitudes in the middle of the attitude spectrum were the only religious leaders who expressed these views, all participants emphasized the importance of empathy, love, and compassion for others. Thus, religious leaders may be key players in confronting abortion stigma in Mainline and Black Protestant churches and should be involved at the onset of efforts to destigmatize abortion and “shift the cultural conversation from one of judgment to one of

empathy, compassion, and affirmation of people's moral agency" (Haffner, 2015). While preliminary, these findings hold promise for informing the development of multi-level faith-based interventions and secular and faith-based partnerships to reduce abortion stigma.

Many religious leaders cited that they had not had formal training on providing pastoral care for any sexual and reproductive issue, let alone abortion. Pastoral care training and interventions should be developed that emphasize Christian beliefs and value the sanctity of life and integrate public health recommendations. Key intervention components should: include information on evidence-based healthcare services and local supports, address beliefs about both the psychological and the spiritual effects of abortion, dispel misinformation, and integrate strategies to reduce abortion stigma. Some religious scholars are already considering faith-based, reproductive justice, and moral arguments for supporting abortion (Parker, 2017; Peters, 2018). Existing moral arguments for legal abortion and this qualitative evidence could be used to inform intervention development.

These findings should be interpreted in context of the limitations of the study. Meaning saturation, or a "richly textured understanding" (Hennink, Kaiser, & Marconi, 2017) was achieved for some issues, but not all, thus results are preliminary. More data are needed to confirm these preliminary results. Additionally, it is important to note that many of the Mainline denominations represented in the sample have passed policies in support of legal abortion and family planning (Haffner, 2015), this could represent a potential selection bias if leaders from progressive denominations are more likely to participate. However, we believe we were able to capture diverse attitudes of religious leaders from such denominations. For example, three leaders from the United Methodist Church, a denomination that has passed policies in support of family planning and abortion (Haffner, 2015), expressed attitudes across the spectrum, ranging

from “pro-life” to “pro-choice.” Additionally, the number of females sampled was low, potentially given that senior leadership positions in Protestant religious institutions are often held by males. It is possible that female lay leaders are providing pastoral care to congregants as well and may have different insights on the provision of pastoral care for abortion. Future research should seek to recruit a diverse sample of Mainline and Black Protestant female leaders.

Further research should seek to understand congregant’s perspectives of their pastoral care needs for unintended pregnancies and abortion, and investigate the barriers and facilitators to receiving support from their religious communities. Public health initiatives should embrace the influence of religion in Georgia to promote reproductive health, rights, and justice for all Georgians. Interventions should have solid theological grounding, articulate moral frameworks for providing access to sexual and reproductive education and health care services, and create pastoral care resources for religious leaders.

The insights provided by this study help provide an understanding of how Mainline and Black Protestant religious leaders in Georgia provide pastoral care to congregants regarding moral decision-making for unintended pregnancies, including abortion decisions. While only the person who is pregnant can decide on the ideal outcome of pregnancy, religious leaders may play an important role in providing social support, and facilitating access to information and healthcare services. Finally, these findings help us to understand complex religious and cultural perspectives on abortion and how these attitudes influence pastoral care. This is an important step towards creating partnerships between public health and religious organizations that improve reproductive health outcomes, reduce abortion stigma, and respect the intrinsic value of religious traditions on their own terms.

### 3.8 Manuscript references

- Adedini, S.A., Babalola, S., Ibeawuchi, C., Omotoso, O., Akiode, A., & Odeku, M. (2018). Role of religious leaders in promoting contraceptive use in Nigeria: Evidence from the Nigerian Urban Reproductive Health Initiative. *Global Health: Science and Practice*, 6(3), 500-514.
- Adler, N.E., et. al. (1990). Psychological responses after abortion. *Science*, 248(4951), 41-4.
- AMRC – Academy of Medical Royal Colleges. (2011). Induced abortion and mental health – A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors. London: Academy of Medical Royal Colleges/National Collaborating Center for Mental Health.
- American College of Obstetricians and Gynecologists. (2016). *Your Pregnancy and Childbirth: Month to Month, Sixth edition*. American College of Obstetricians and Gynecologists.
- Bryant, A.G., & Swartz, J.L. (2018). Why crisis pregnancy centers are legal but unethical. *AMA Journal of Ethics*. 20(3): 269-277.
- Centers for Disease Control and Prevention. (2018). CDCs abortion surveillance system FAQs. Retrieved from [https://www.cdc.gov/reproductivehealth/data\\_stats/abortion.htm](https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm)
- Cockrill, K. & Nack, A. (2013). “I’m not that type of person”: managing the stigma of having an Abortion. *Deviant Behavior*, 34(12), 973–990
- Cockrill, K., Upadhyaya, U.D., Turan, J. & Greene Foster, D. (2013). The stigma of having an abortion: development of a scale and characteristics of women experiencing abortion stigma. *Perspectives on Sexual and Reproductive Health*. 45(2), 79-88.
- Dedoose. Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC [www.dedoose.com](http://www.dedoose.com).
- Finer, L., Frohworth, L.F., Dauphinee, L.A., Singh, S., Moore, A.M. (2005). Reasons U.S. women have abortions: Quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, 37(3), 110-118.
- Finer, L.B., & Zolna, M.R. (2016). Declines in unintended pregnancy in the United States, 2008-2011. *New England Journal of Medicine*, 374(9), 843-52. Doi:10.1056/NEJMsa1506575
- Georgia General Assembly. (2019). 2019-2020 Regular Session-HB 481 Living Infants Fairness and Equality (LIFE) Act; enact. Retrieved from <http://www.legis.ga.gov/legislation/en-us/display/20192020/hb/481>
- Georgia Obstetrical and Gynecological Society, Inc. *OBGyn News, Promoting excellence in*

- women's healthcare in Georgia. Retrieved from <https://gaobgyn.org/gaobgyn/wp-content/uploads/2016/08/OB-GYN-Newsletter-August-2017.pdf>
- Grossman D, Baum S, Fuentes L, et al. Change in abortion services after implementation of a restrictive law in Texas. *Contraception*. 2014;90(5):496-501
- Guttmacher Institute. (2016). *Unintended pregnancy in the United States*. Retrieved from <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- Guttmacher Institute. (2018). *Induced abortion in the United States*. Retrieved from <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>
- Guttmacher Institute. (2019). *Unintended pregnancy in the United States*. Retrieved from <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- Haffner, D.W. (2015). *A time to embrace: why the sexual and reproductive justice movement needs religion*. Westport, CT.: Religious Institute.
- Hennink, M.M., Kaiser, B.N., & Marconi, V.C. (2017). Code saturation versus meaning saturation: How many interviews is enough? *Qualitative Health Research*, 27(4), 591-608.
- Idler, E.L. (2014). Religion as a social determinant of public health. Oxford Scholarship Online. Retrieved from <http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199362202.001.0001/acprof-9780199362202>
- Jerman, J., Jones, R.K., & Onda, T. (2016). *Characteristics of U.S. abortion patients in 2014 and changes since 2008*. Retrieved from <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>
- Jones, R.K., & Jerman, J. (2017). Population group abortion rates and lifetime incidence of abortion: United States, 2008-2014. *American Journal of Public Health*, 107(12), 1904-1909. Doi: 10.2105/AJPH.2017.304042.
- Jones, R.K., & Jerman, J. (2014). Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health*. 46(1), 3-14. doi: 10.1363/46e0414
- Kaiser Family Foundation. (2019). Abortions per 1,000 women aged 15-44 years by state of occurrence. Retrieved from <https://www.kff.org/womens-health-policy/state-indicator/abortion-rate/?currentTimeframe=0&selectedDistributions=abortion-rate&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- Kost, K. (2015). *Unintended pregnancy rates at the state level: Estimates for 2010 and trends*

- since 2002. Retrieved from <https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002>
- Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, 11, 625–639.
- Oyez. (11 Apr. 2019). *Burwell v. Hobby Lobby Stores*. Retrieved from <https://www.oyez.org/cases/2013/13-354>.
- Parker, W. (2017). *Life's Work: A moral argument for choice*. New York, New York: Atria.
- Patton, E.W., Stidham Hall, K., & Dalton, V.K. (2015). How does religious affiliation affect women's attitudes toward reproductive health policy? Implications for the Affordable Care Act. *Contraception*, 91(6), 513-519.
- Peters, R. (2018). *Trust women: A progressive Christian argument for choice*. Boston, MA.: Beacon Press.
- Pew Research Center. (2015). Adults in Georgia: Religious composition of adults in Georgia. Retrieved from <http://www.pewforum.org/religious-landscape-study/state/georgia/>
- Religious Institute. (n.d.). Time to Embrace Executive Summary. Retrieved from <http://religiousinstitute.org/time-to-embrace/executive-summary/>
- Shellenberg, K.M. et al., (2011). Social stigma and disclosure about induced abortion: results from an exploratory study. *Global Public Health*. (Suppl. 1):S111–S125.15.
- Sorhaindo, A.M. et al. (2014) Qualitative evidence on abortion stigma from Mexico City and five states in Mexico. *Women & Health*, 54(7):622–640.
- Spelke, B., Zertuche, A.D., & Roachat, R. (2016). Obstetric provider maldistribution: Georgia, USA, 2011. *Maternal Child Health Journal*, 20(7), 1333-40.
- Taylor, D. & James E.A. (2012). An evidence-based guideline for unintended pregnancy prevention. *J Obstet Gynecol Neonatal Nurs*, 40(6), 782-793.
- United Health Foundation. *America's Health Rankings*. Retrieved from [https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal\\_mortality/state/GA](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/GA)
- United Nations Population Fund. (2015). Religion, women's health and rights: points of contention and paths of opportunities. Retrieved from [https://www.unfpa.org/sites/default/files/pubpdf/Religion\\_Womens\\_Health\\_and\\_Rights.Pdf](https://www.unfpa.org/sites/default/files/pubpdf/Religion_Womens_Health_and_Rights.Pdf)



## Chapter 4: Conclusion and public health recommendations

A Unitarian Universalist minister wrote, “deciding to have an abortion is a moral decision [and] only the person who is pregnant can decide how to respond to an unwanted pregnancy in each particular circumstance, [and it is] unethical and immoral to deny people access to life-saving information, education, or safe and timely health care services” (Haffner, 2015). Religion is a powerful force in the lives of many people globally and religious leaders may play an important role in providing sexual and reproductive health pastoral care and resources given that “religions have a venerable tradition supporting healing, health care, disease prevention, and health promotion [and a] commitment to the most marginalized, the most vulnerable, and the most likely to be excluded” (Haffner, 2015, p.28). At the same time, religious doctrine and beliefs may come in direct conflict with public health recommendations regarding abortion and contraception. The findings from this study demonstrate that some religious leaders’ abortion attitudes are informed by misperceptions which run counter to scientific evidence; these misperceptions translate into religious leaders’ provision of pastoral care. Public health professionals must lean into this challenge and work to further understand complex religious and cultural perspectives on abortion and how these attitudes influence pastoral care. This is an important step towards creating partnerships between public health and religious organizations that improve reproductive health outcomes, reduce abortion stigma, and respect the intrinsic value of religious traditions on their own terms.

The following recommendations are based on the findings of this study:

- Pastoral care resources and trainings should be developed that provide information on evidence-based healthcare services and local supports, address beliefs about psychological and spiritual effects of abortion, dispel

misinformation, and integrate strategies to reduce abortion stigma. Training resources could include recorded webinars and informational materials, such as booklets.

- Faith-based public health interventions initiatives should embrace the influence of religion in Georgia to promote reproductive health, rights, and justice for all Georgians. Interventions should have solid theological grounding, articulate moral frameworks for providing access to sexual and reproductive education and health care services, and create pastoral care resources for religious leaders. In particular, pastoral care resources should be developed that provide comprehensive education on family planning, including abortion, and dispel misinformation. Examples of interventions include women's Bible study groups, interfaith training of religious leaders, and sermons. Resources should be developed in partnership with Mainline and Black Protestant leaders and be mutually beneficial to achieve positive health outcomes.
- Additionally, these findings hold promise for informing the development of multi-level faith-based interventions to reduce abortion stigma. Examples of interventions could include Bible study groups, sermons, pastoral care training, and storytelling. Religious leaders should be engaged to create such interventions.
- Further research should seek to understand congregant's perspectives of their pastoral care needs for unintended pregnancies and abortion, and investigate the barriers and facilitators to receiving support from their religious communities.

## Thesis references

### Chapter 1

- Adedini, S.A., Babalola, S., Ibeawuchi, C., Omotoso, O., Akiode, A., & Odeku, M. (2018). Role of religious leaders in promoting contraceptive use in Nigeria: Evidence from the Nigerian Urban Reproductive Health Initiative. *Global Health: Science and Practice*, 6(3), 500-514.
- Aiken, A., Borrero, S., Callegari, L.S., & Dehlendorf, C. (2016). Rethinking the pregnancy planning paradigm: Unintended conceptions or unrepresentative concepts? *Perspet Sex Reprod Health*. 48(3), 147-151.
- American College of Obstetricians and Gynecologists. (2016). *Your Pregnancy and Childbirth: Month to Month, Sixth edition*. American College of Obstetricians and Gynecologists.
- Armentrout, D.S. & Boak Slocum. (2000). *An Episcopal dictionary of the church*. New York, NY: Church Publishing.
- Centers for Disease Control and Prevention. (2016). *Unintended pregnancy prevention*. Retrieved from <https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm>
- Centers for Disease Control and Prevention. (2018). CDCs abortion surveillance system FAQs. Retrieved from [https://www.cdc.gov/reproductivehealth/data\\_stats/abortion.htm](https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm)
- Cockrill, K. & Nack, A. (2013). “I’m not that type of person”: managing the stigma of having an Abortion. *Deviant Behavior*, 34(12), 973–990
- Cockrill, K., Upadhyaya, U.D., Turan, J. & Greene Foster, D. (2013). The stigma of having an abortion: development of a scale and characteristics of women experiencing abortion stigma. *Perspectives on Sexual and Reproductive Health*. 45(2), 79-88.
- Derose, K.P., Griffin, B.A., Kanouse, D.E., Bogart, L.M., Williams, M.V., Haas, A.C., Florez, K.R., Owens Collins, D., Hawes-Dawson, J., Mata, M.A., Oden, C.W., & Stucky, B.D. (2016). Effects of a pilot church-based intervention to reduce HIV stigma and promote HIV testing among African Americans and Latinos. *AIDS Behav*, 20(8), 1692-1705.
- Finer, L.B., & Zolna, M.R. (2016). Declines in unintended pregnancy in the United States, 2008-2011. *New England Journal of Medicine*, 374(9), 843-52. Doi:10.1056/NEJMsa1506575
- Georgia General Assembly. (2019). 2019-2020 Regular Session-HB 481 Living Infants Fairness and Equality (LIFE) Act; enact. Retrieved from <http://www.legis.ga.gov/legislation/en-us/display/20192020/hb/481>
- Georgia Obstetrical and Gynecological Society, Inc. *OBGyn News, Promoting excellence in*

- women's healthcare in Georgia. Retrieved from <https://gaobgyn.org/gaobgyn/wp-content/uploads/2016/08/OB-GYN-Newsletter-August-2017.pdf>
- Guttmacher Institute. (2016). *Unintended pregnancy in the United States*. Retrieved from <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- Guttmacher Institute. (2018a). *Induced abortion in the United States*. Retrieved from <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>
- Guttmacher Institute. (2018b). *State facts about abortion: Georgia*. Retrieved from <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-georgia>
- Guttmacher Institute. (2019). *Unintended pregnancy in the United States*. Retrieved from <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- Haffner, D.W. (2015). *A time to embrace: why the sexual and reproductive justice movement needs religion*. Westport, CT.: Religious Institute.
- Idler, E.L. (2014). Religion as a social determinant of public health. Oxford Scholarship Online. Retrieved from <http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199362202.001.0001/acprof-9780199362202>
- Idler, E., Levin, J., VanderWeele, T.J., & Khan, A. (2019). Partnerships between public health agencies and faith communities. *American Journal of Public Health*, 109(3), 346-347.
- Jatlaoui, T.C., Shah, J., Mandel, M.G., Krashin, J.W., Suchdev, D.B., Jamieson, D.J., & Pazol, K. (2018). Abortion Surveillance—United States, 2014. *Surveillance Summaries*, 66(25), 1-44.
- Jerman, J., Jones, R.K., & Onda, T. (2016). *Characteristics of U.S. abortion patients in 2014 and changes since 2008*. Retrieved from <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>
- Jones, R.K., & Jerman, J. (2017a). Population group abortion rates and lifetime incidence of abortion: United States, 2008-2014. *American Journal of Public Health*, 107(12), 1904-1909. Doi: 10.2105/AJPH.2017.304042.
- Jones, R.K., & Jerman, J. (2017b). Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health*, 46(1), 3-14. doi: 10.1363/46e0414
- Kaiser Family Foundation. (2019). Abortions per 1,000 women aged 15-44 years by state of occurrence. Retrieved from <https://www.kff.org/womens-health-policy/state-indicator/abortion-rate/?currentTimeframe=0&selectedDistributions=abortion-rate&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

- Kost, K. (2015). *Unintended pregnancy rates at the state level: Estimates for 2010 and trends since 2002*. Retrieved from <https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002>
- Kost, K., Maddow-Zimet, I., & Kochhar, S. (2018). *Pregnancy desires and pregnancies at the state level: Estimates for 2014*. Retrieved from <https://www.guttmacher.org/report/pregnancy-desires-and-pregnancies-state-level-estimates-2014>
- Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, 11, 625–639.
- Norman, J. (2018, April 6). The religious regions of the U.S. *Gallup, Inc.* Retrieved from <https://news.gallup.com/poll/232223/religious-regions.aspx>
- Oyez. (11 Apr. 2019). *Burwell v. Hobby Lobby Stores*. Retrieved from <https://www.oyez.org/cases/2013/13-354>.
- Patton, E.W., Stidham Hall, K., & Dalton, V.K. (2015). How does religious affiliation affect women's attitudes toward reproductive health policy? Implications for the Affordable Care Act. *Contraception*, 91(6), 513-519.
- Payne-Foster, P., Bradley, E.L.P., Aduloju-Ajijola, N., Yang, X., Gaul, Z., Parton, J., Sutton, M.Y., Gaskins, S., (2018). Testing our FAITHH: HIV stigma and knowledge after a faith-based HIV stigma reduction intervention in the Rural South. *AIDS Care*, 30(2), 232-239.
- The Pew Forum on Religion and Public Life. (2013). *Abortion*. Retrieved from <https://www.pewforum.org/topics/abortion/>.
- Pew Research Center. (2015). Adults in Georgia: Religious composition of adults in Georgia. Retrieved from <http://www.pewforum.org/religious-landscape-study/state/georgia/>
- Religious Institute. (n.d.). Time to Embrace Executive Summary. Retrieved from <http://religiousinstitute.org/time-to-embrace/executive-summary/>
- Rumbold, (n.d.). Pastoral care centre. Retrieved from <https://www.sarmy.org.au/en/Ministry/Officer-Development--Support/Pastoral-Care-Centre-/>
- Santelli, J., Rochat, R., Hatfield-Timajchy, K., Colley Gilbert, B., Curtis, K., Cabral, R., ... Schieve, L. (2003). The measurement and meaning of unintended pregnancy. *Perspectives on Sexual and Reproductive Health*, 35(2), 94-101.
- Shellenberg, K.M. et al., (2011). Social stigma and disclosure about induced abortion: results from an exploratory study. *Global Public Health*. (Suppl. 1):S111–S125.15.

Sorhaindo, A.M. et al. (2014) Qualitative evidence on abortion stigma from Mexico City and five states in Mexico. *Women & Health*, 54(7):622–640.

Spelke, B., Zertuche, A.D., & Roachat, R. (2016). Obstetric provider maldistribution: Georgia, USA, 2011. *Maternal Child Health Journal*, 20(7), 1333-40.

Torres, J., Johnson-Baker, K., Bell, S., Freeny, J., & Edwards, S. (2017). Working with faith-based communities to develop an education tool kit on relationships, sexuality, and contraception. *Journal of Applied Research on Children: Informing Policy for Children at Risk*, 8(1), 1-15.

United Health Foundation. *America's Health Rankings*. Retrieved from [https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal\\_mortality/state/GA](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/GA)

United Nations Population Fund. (2015). Religion, women's health and rights: points of contention and paths of opportunities. Retrieved from [https://www.unfpa.org/sites/default/files/pubpdf/Religion\\_Womens\\_Health\\_and\\_Rights.Pdf](https://www.unfpa.org/sites/default/files/pubpdf/Religion_Womens_Health_and_Rights.Pdf)

## Chapter 2

African Methodist Episcopal Church. (2018). Funeral arrangements for Bishop John Hurst Adams (1927-2018). Retrieved from <https://www.ame-church.com/news/funeral-arrangements-bishop-john-hurst-adams-1927-2018/>

Association of Religious Data Archives. (n.d). State membership report: Georgia. Retrieved from [http://www.thearda.com/rcms2010/r/s/13/rcms2010\\_13\\_state\\_name\\_2010.asp](http://www.thearda.com/rcms2010/r/s/13/rcms2010_13_state_name_2010.asp)

Center for Religion and Civic Culture. (2016). *Engaging Black Church Protestant Leaders*. Retrieved from <https://crcc.usc.edu/report/disaster-tips-sheets-on-engaging-faith-communities/engaging-black-church-protestant-leaders/>

Chan, E., & Ecklund, E.H. (2016). Narrating and navigating authorities: Evangelical and Mainline Protestant interpretations of the bible and science. *Journal for the Scientific Study of Religion*. 55(1), 54-69.

Christian Church (Disciples of Christ). (1987). *Resolution concerning the sanctity of life*. Resolution No. 8749. Retrieved from <http://disciples.org/wp-content/uploads/2015/09/8749SanctityofLife.pdf>

Church of God in Christ. (2016). *Human Coalition launches three-year initiative with Church of God in Christ*. Retrieved from <http://www.cogic.org/blog/human-coalition-launches-three-year-initiative-with-church-of-god-in-christ/>

- COGIC World Missions. (2019). Rescuing children and serving families in abortion-riddled communities nationwide. Retrieved from <https://familylifecampaign.org/>
- Evans, J.H. (2002). Polarization in abortion attitudes in U.S. religious traditions. *Sociological Forum*. 17(3), 397-422.
- General Convention. (1995). *Journal of the General Convention of...The Episcopal Church*. Indianapolis, 1994. New York: General Convention, 1995, 323-25.
- Human Coalition. (2019). Our Story. Retrieved from <https://www.humancoalition.org/who-we-are/>
- Jelen, T.G. (1992). The clergy and abortion. *Review of Religious Research*. 34(2), 132-151.
- Lipka, M. (18 May 2015). Mainline Protestants make up shrinking number of U.S. adults. Retrieved from <https://www.pewresearch.org/fact-tank/2015/05/18/mainline-protestants-make-up-shrinking-number-of-u-s-adults/>
- Masci, D. (2016). Where major religious groups stand on abortion. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2016/06/21/where-major-religious-groups-stand-on-abortion/>
- McKinney, W. (1998). Mainline Protestantism 2000. *The Annals of the American Academy of Political and Social Science*. 558, 57-66.
- Mellowes, M. (2011). The Black Church. *God in America*. Retrieved from <http://www.pbs.org/godinamerica/black-church/>
- Newport, F. (2017, Sept 8). On moral issues, not all Protestants are created equal. *Gallup Inc*. Retrieved from <https://news.gallup.com/poll/218204/moral-issues-not-protestants-created-equal.aspx>
- Pew Research Center (2014). Religious Landscape Study. Retrieved from <https://www.pewforum.org/religious-landscape-study/>
- Pew Research Center (2015a). Appendix B: Classification of Protestant Denominations. Retrieved from <https://www.pewforum.org/2015/05/12/appendix-b-classification-of-protestant-denominations/>
- Pew Research Center (2015b). Mainline Protestants who are in Georgia. Retrieved from <http://www.pewforum.org/religious-landscape-study/state/georgia/religious-tradition/mainline-protestant/>
- Pew Research Center (2015c). Members of the Historically Black Protestant Tradition who are in Georgia. Retrieved from <http://www.pewforum.org/religious-landscape-study/state/georgia/religious-tradition/historically-black-protestant/>

Pew Research Center (2015d). Views about abortion among Mainline Protestants by religious denomination. Retrieved from <http://www.pewforum.org/religious-landscape-study/compare/views-about-abortion/by/religious-denomination/among/religious-tradition/mainline-protestant/>

Price-Bonham, S., Santee, B., & Bonham, J.M. (1975). An analysis of clergymen's attitudes toward abortion. *Review of Religious Research*. 17(1), 15-27.

Religious Coalition for Reproductive Choice (2016, Mar 20). *RCRC statement on UMC decision to sever ties*. [Press Release]. Retrieved from <http://rcrc.org/rcrc-statement-on-umc-decision-to-sever-ties/>

Religious Coalition for Reproductive Choice (2017). *Pro Faith. Pro Family. Pro Choice*. retrieved from <http://rcrc.org/>

R. Drew Smith. (2014). *Long march ahead: African American churches and public policy in post-civil rights America*. Duke University Press Books.

United Methodist Church. (2016). *The book of discipline of the United Methodist Church*. Retrieved from <http://www.umc.org/what-we-believe/the-nurturing-community#abortion>

United Method Church. (2016). RCRC Withdraw Letter. Retrieved from <https://www.unitedmethodistwomen.org/news/rcrcwithdrawalletter.pdf>

Weston, M. (23 Jan 1990). Faith Abortion. Retrieved from [https://www.washingtonpost.com/archive/lifestyle/wellness/1990/01/23/faith-abortion/e0e28bd6-a8cf-43a1-96e1-ed1d367d5439/?utm\\_term=.8fa07898c5ba](https://www.washingtonpost.com/archive/lifestyle/wellness/1990/01/23/faith-abortion/e0e28bd6-a8cf-43a1-96e1-ed1d367d5439/?utm_term=.8fa07898c5ba)



## Appendix

### Interview guide

#### **SECTION 1: Warm-Up Questions**

1. What are your daily responsibilities in your church?
2. What responsibilities do you have in your church involving matters of reproductive health, including family planning, sex, pregnancy, and birth control?
3. Think about the people your church, what are their biggest concerns involving reproductive health?

#### **SECTION 2: Unplanned Pregnancy**

*Now, I'd like to ask you about unplanned pregnancies. It is important to us to gain a better understanding of how religious leaders in Georgia think about these issues. There are no right or wrong answers here we are most interested in your views.*

4. Can you describe a time you provided pastoral care to someone seeking your advice because they experienced an unplanned pregnancy?
  - a. Probe: What options did you recommend? What advice did you give? What scriptures or doctrine did you share?
5. Imagine a young person in your church had an unplanned pregnancy and sought your advice. What would you say?
  - a. Probe: What options would you recommend? What advice would you give? What scriptures or doctrine would you share?
6. What happens to someone as a result of an unplanned pregnancy?
  - a. Probe: spiritual effects, economic effects, health effects, effects on family and relationships
7. How appropriate are programs and services that discuss the topic of unplanned pregnancy for church settings?
  - a. Probe: Role of religious leaders, Role of congregants

**SECTION 3: Abortion** *Now, I would like to talk about abortion. It is important to us to gain a better understanding of how religious leaders in Georgia think about abortion. Again, there are no right or wrong answers.*

8. What are your personal views on abortion?
  - a. Probe: Moral acceptability? Legality?
  - b. Probe: What guides (or influences) your views?
9. How do your current views on abortion compare to your views on abortion at the beginning of your career?
  - a. Probe: Causes of change?
10. What happens to someone as a result of having an abortion?

- a. Probe: spiritual, social, health, fertility effects
- 11. What advice would you give someone in your congregation considering abortion?
  - a. Probe: What would you tell them that their options are?
  - b. Probe: What scriptures or doctrine would you share?
- 12. How do you think other members of the congregation treat someone who was considering abortion?
  - a. How would you respond?
- 13. How appropriate are programs and services that discuss abortion for church settings?
  - a. Probe: Role of religious leaders, role of congregants

#### **SECTION 4: Perspectives on Faith-Based Strategies on Addressing SRH**

*Next, I'd like to get your suggestions on the best strategies for addressing reproductive health concerns.*

- 14. What is the best way for your congregation to receive support on issues related to family planning, sex, pregnancy, and birth control concerns?
- 15. If you were in charge of developing a program for Georgia's Protestant churches related to reproductive health, what would this program look like?
  - a. Probe: What topics would it cover? What messages are important?
  - b. What do you think are some challenges to implementing such a program?

#### **SECTION 5: Wrap-Up**

- 16. What advice would you give the research team about working with churches to address congregants' reproductive health concerns?
- 17. Of all the things we've discussed today, what do you think is the most important to help us understand the reproductive health needs of Georgia's churches?
- 18. What other thoughts would you like to share related to what we discussed?

*That completes the interview. Thank you for taking the time to share your thoughts with me! Your responses are invaluable to us learning about the reproductive health concerns important to Georgia's churches.*