The Role of Crisis Pregnancy Centers in Fertility Decisions

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Abstract

In this paper, I study the location choice of Crisis Pregnancy Centers (CPCs) and how they shape fertility decisions. CPCs provide counseling services from a "pro-life" (anti-abortion) perspective. I integrate a 30-year panel of CPCs and abortion providers with demographic group-level fertility outcomes in North and South Carolina. I find that, prior to 1990, CPCs located near abortion providers and in counties with higher teen abortion rates. Subsequently, CPCs prioritized locating in counties without CPC presence. Results from a 2SLS estimation show that, among teenage girls and women between 10 and 24 years of age, CPCs increase the local birth rate by 10 percent and lower the abortion rate by 8.6 percent. The abortion rate effect fades with age and reaches zero for women older than 30. The birth rate effect monotonically increases with age. Driving distance estimates are less precise but mirror these results. These findings suggest that CPCs are effectively carrying out their mission to alter abortion preferences and promote childbirth. The observed changes in teenage and young adult fertility point to a potentially broader impact of CPCs on other policy-relevant outcomes, such as educational attainment.

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I. Introduction

The legalization of induced abortion in the United States in 1973 fundamentally changed women's ability to make reproductive choices. It has also met much opposition and spurred the growth of a nationwide social and political movement rooted in religious beliefs: The "pro-life" movement. This anti-abortion movement has achieved legislative milestones at the state and federal level, notably, with the passing of the Hyde Amendment in 1980 that prohibits the use of certain federal funds for pregnancy termination. Alongside political efforts to overturn legalization, activists in the "pro-life" movement have opened Crisis Pregnancy Centers (CPCs) in communities across the country. CPCs provide counseling services from a "pro-life" perspective, and abortion alternatives, to pregnant women. Accordingly, CPCs do not provide abortion services and do not refer clients to abortion providers. The overall impact of CPCs on fertility outcomes is potentially large, because there are between 2,500 and 4,500 CPCs across the United States, at least four times as many CPCs as abortion service providers (Jones & Jerman, 2017; McVeigh, Crubaugh, & Estep, 2017; Swartzendruber & Lambert, 2020). Despite the presence of CPCs in every state, to date there is no evidence on the extent to which CPCs are able to achieve their core objectives. First, CPCs want to reduce the number of pregnancy terminations. They primarily try to achieve this through counseling. Second, CPCs want to delay the onset of sexual activity among. To this end, CPCs provide sexual abstinence programs.

In this paper, I describe the CPC location decision and show that CPCs have a significant impact on women's fertility outcomes. I construct a 30-year panel of CPCs and abortion providers and use vital statistics records from North and South Carolina to analyze how CPCs affect birth and abortion rates. Estimates from a Two-Stage Least Squared regression show that, among teenage girls and women between the ages of 10 to 24, CPCs increase the county birth rate by 10 percent and lower the abortion rate by 8.6 percent. The abortion rate effect is smaller for women of age 25 to age 29 and fades to zero for women older than 30 years. In contrast, the effect of CPCs on the birth rate increases monotonically with age. This documented impact on fertility outcomes is of direct relevance to public health policy, particularly in states that provide funding to CPCs. The increase in the teenage birth rate suggests that fertility decisions made under the guidance of CPCs could shape the lives of

teenagers and young women more broadly.

II. Background

II.A. Crisis Pregnancy Centers

Crisis Pregnancy Centers are at the center of the "pro-life" movement. According to Munson (2010), the number of CPCs exceeds the sum of all other "pro-life" organizations. CPCs also attract the greatest number of volunteer hours, compared to other "pro-life" outreach, because one-on-one counseling is very labor-intensive. One goal of CPCs is to ensure that every woman visiting a CPC carries her pregnancy to term. A second objective, for many CPCs, is to delay onset of sexual activity and discourage pre-marital sexual relationships. To this end, CPCs provide sexual abstinence programs. For decades, CPCs have received federal and state funding in support of their mission. Federal funding has historically been tied to the provision of abstinence programs.

II.A..1 Services

CPCs offer a number of services relating to sexual behavior, pregnancy and relationships. Almost all CPCs offer free over-the-counter pregnancy tests (Swartzendruber et al., 2018). Pregnancy counseling typically involves non-medical ultrasounds that show the embryo or fetus. Beyond these services, centers provide ongoing classes on pregnancy, relationships, and parenting. CPCs also offer material services, like baby clothes, cribs, diapers, as well as direct financial assistance. Some CPCs provide, or assist in obtaining, homes for single mothers. A significant share of CPCs, more than a third in the analysis sample, provide abstinence education. Sexual abstinence education is aimed at teenagers and takes place either at the CPC or in schools. Finally, in a few cases, CPCs are staffed by volunteer physicians and licensed midwives that provide services such as prenatal care, routine checkups, immunizations, and tests for STIs. This is not the case for CPCs in the analysis sample. Table 1 shows the share of CPCs in the sample providing various types of service.

II.B. Federal Teen Pregnancy Prevention Policies

Since the 1980s, Congress has recognized the long-term and social consequences of teenage pregnancy. Consequently, Congress has authorized the U.S. Department of Health and Human Services (HHS) to administer programs with a focus on teen pregnancy prevention. Similarly, The Centers for Disease Control and Prevention (CDC) has identified teen pregnancy as a major public health concern. Over the past decades seven federal programs addressing teenage pregnancy have been implemented, four of which are currently in place (Fernandes-Alcantara, 2018). The discontinued programs are the Adolescent Family Life (AFL) program, the Community-Based Abstinence Education (CBAE) program, and the Competitive Abstinence-Only program.[1]

II.B..1 Abstinence Education Programs

In 2000, Congress created the Special Projects of Regional and National Significance Community-Based Abstinence Education Program, which became later known as the Community-Based Abstinence Education (CBAE).[2] The CBAE program was supported from 2001 to 2010, with funding ranging from $20 million to $108.9 million per year. Under CBAE funding for abstinence education has been directed at CPCs and other public and private organizations. The program specifically excludes any organization that offers sex education programs that promote the use of contraceptives. Under CBAE provisions, grantees have to provide programs to adolescents ages 12 to 18 and cannot provide positive information about contraception. From fiscal years 2012 to 2015, the Competitive Abstinence-Only program appropriated funding with an exclusive focus on abstinence education, providing between $4.7 million and $10 million annually (Fernandes-Alcantara, 2018).

Abstinence education is controversial because of a body of research showing that it is ineffective or even increases risk of pregnancy (see for example, Chin et al., 2012; Ott & Santelli, 2007; Trenholm et al., 2008). When a CPC provides abstinence education it may,

[1] Congress appropriated annually between $1.4 million and $30.4 million to the the AFL program, which was established in 1981 and funded through the fiscal year 2001. The AFL program focus was initially on pregnancy and parenting. Abstinence education was added in 1998 (Fernandes-Alcantara, 2018).

[2] The CBAE program was a competitive grant authorized under Title XI, 1110, of the Social Security Act. Funding recipients had to conform to the eight-point definition outlined in 510 of Title V of the Social Security Act. Initially, CBAE was administered by the Maternal and Child Health Bureau. In 2005, control over CBAE shifted to the Administration for Children, Youth, and Families (ACF). My FOIA request for records on CPCs funded by the ACF is pending since 09/2019.

inadvertently, increase the chance of pregnancy among teenagers and young adults. This is a potentially important channel through which CPCs affect fertility outcomes.

II.C. Medical and Legal Controversies

CPCs have received some attention in the public health literature. This research has focused on the nature of the services and information that CPCs provide. Swartzendruber et al. (2018) find that CPC websites contain high levels of false and misleading health information and the advertised services do not align with prevailing medical guidelines. Further, 58% of CPC websites do not indicate that CPCs are neither abortion providers nor referrers. Some of these findings are corroborated by Rosen (2012), who identified that CPC websites commonly provide inaccurate information on the medical risks of abortions. According to a survey conducted in the State of Georgia, most adults who had visited a CPC held misconceptions about CPC policies and practices (Swartzendruber, Solsman, & Lambert, 2021). Some of the individuals did not fully understand the services provided by CPCs until after their visit. This is concerning, even if an individual decides to visit a healthcare provider after visiting a CPC. Abortion services, for example, are only provided up to a certain number of weeks of gestation, which varies by state, and a CPC visit may lead to a delay in accessing abortion services. Moreover, a number of states impose waiting periods between the first abortion consultation with a physician and the pregnancy termination. Miller, Wherry, and Foster (2020) show that many women are denied access to abortion services because of legal limits, which has negative long-term economic consequences.

Some states have made attempts to oversee or regulate CPCs. In the early 2000s, the Office of the Attorney General of the State of New York investigated CPCs in the state in regard to misleading advertising and inappropriate medical counseling. A preliminary investigation raised concerns that CPCs advertising and practices could lead women to believe that they provide medical services, in particular, that they provide abortion services. Several CPCs were issued subpoenas. In 2002, an agreement was reached with one CPC. The outcome of similar cases is not documented. The consent decree imposed a number of requirement on the CPC. Among other items, the CPC is required to inform persons who inquire about abortion or birth control that it does not provide (or refer) those service. Fur-

ther, the CPC has to inform that it is not a medical facility and that only medical providers can confirm a pregnancy and provide medical advice (Office of the Attorney General, New York, 2002).[3]

In 2015, California passed the Reproductive FACT Act (Reproductive FACT Act., n.d.). This legislation intended to limit CPC practices that were deemed deceptive, particularly in regard to anti-abortion counseling. The law required CPCs to disclose to their clients in writing, or post a sign, that the center is not a licensed medical facility and has no medical staff to provide services. The disclosure requirement extended to advertising. Some CPCs in California are, however, licensed as medical providers. The FACT Act required licensed CPCs, who do not provide a full range of reproductive care, to post a sign that says that the state provides free or low-cost access to reproductive care, including abortions. The Supreme Court deemed the FACT Act unconstitutional on the grounds that it violates the First Amendment, which protects free speech (*National Institute of Family & Life Advocates v. Becerra*, 2018).

II.D. CPCs and Abortion Access

Cartwright, Tumlinson, and Upadhyay (2021) recruited pregnant people who searched for abortion services online for a survey. They found that 13.1 percent of respondents visited a CPC during their pregnancy. Living closer to a CPC was associated with greater odds of visiting a CPC. Respondents who had visited a CPC were 21 percentage points less likely to have had an abortion. Lastly, respondents who visited a CPC had higher odds of being pregnant and still seeking abortion services. This last result suggests that some women visited a CPC and did not find the services they desired, rather, it is likely that they were looking for abortion services. This is suggestive evidence of an interplay between CPCs and abortion providers, and that CPCs may delay access to healthcare services. Because CPCs offer pregnancy-related services and compete with abortion providers, this paper complements the recent literature on abortion access, which has focused on abortion providers and abortion

[3]It is important to note that although CPCs provide some services that appear to be medical in nature, such as pregnancy tests and ultrasounds, that does not imply that CPCs provide medical services. Some of the existing literature has referred to these types of services as "medical services." The consent decree in the State of New York required the CPC to clarify that over-the-counter pregnancy tests are not a medical service (Office of the Attorney General, New York, 2002). Therefore, in this text, I add the prefix "non-medical" to services performed by CPCs that might otherwise appear to be medical in nature.

restrictions. Fischer, Royer, and White (2018) found that reduced access to abortion and family planning services lowered the abortion rate and Lu and Slusky (2019) showed that increases in travel distances to providers increases the birth rate. Studies by Cunningham, Lindo, Myers, and Schlosser (2017) and Quast, Gonzalez, and Ziemba (2017) also show that greater distances to abortion clinics reduce the abortion rate. I contribute to this literature by showing the joint effect of women's access to CPCs and abortion providers.

III. Data

III.A. CPC and Clinic Data

I construct a data set of addresses of crisis pregnancy centers and abortion clinics, as well as information on the dates of their operation. The dataset contains 288 CPC locations (addresses) associated with 138 CPC organizations, and 43 abortion provider locations (and referrers) in North Carolina and South Carolina. The number of locations exceeds the number of CPC organizations because some organizations operate at multiple facilities. Further, I observe when a CPC is relocated.[4] There are CPCs are typically 501(c)(3)) nonprofit organizations. For almost every organization addresses and foundation dates ("ruling dates") were obtained from financial disclosure forms. I validate this data against information from a database maintained by the umbrella organization Birthright that contains the majority of CPCs, both its affiliates and independent CPCs. I further cross-check this information using internet research for websites of each facility and phonebook entries. In the case of CPCs, I also can observe some address changes and closures in financial fillings from news articles too. Between 1990 and 2019, the period for which fertility data is available, I observe the opening of approximately two-thirds of the CPCs in North and South Carolina. Figures 1 to 4 show CPCs and abortion providers over time, overlayed on a map of county-level abortion rates in NC and SC

Data on abortion clinics (and referrers) is sourced from records of Title X grant recipients, which includes many abortion providers, is was provided by the United States Department of Health and Human Services (HHS) for the years 2013 to present. I categorize some clinics as

[4]For a given CPC organization, a relocation ("move") is defined as the closure of a facility at one address and the opening of a facility at a location in the same county within a year.

"referrers" if they do not provide abortion services but have provided them at some point in time or are part of a network, such as Planned Parenthood, of abortion providers. This data allows me to observe address changes and closures for the years 2013 - 2018. Further, I obtain state licensing information on abortion clinics in NC and SC. I cross-check this information with the provider list of the National Abortion Federation, Planned Parenthood, and generic online search of newspaper reports. The resulting data set provides the precise geographic location of each facility and allows me to track at what point in time facilities open and close.

III.B. Outcome Data

The primary outcome considered here is the abortion rate in a county , defined as the abortion count per 1000 women age 10 to 44, in years 1990 to 2019. Further outcomes are the birth rate and the pregnancy rate. The number of pregnancies is defined as the sum of births, abortions and fetal deaths. Both the birth and pregnancy rate are defined as the count per 1000 women age 10 to 44. The fertility counts were obtained from administrative and vital records provided by vital statistics offices in North Carolina and South Carolina. Note that all males and females below the age of 10 or above the age of 44 are excluded from the analysis.[5] Rates are constructed using Census data that contains demographic information on age groups, ethnicity, and county of residence. The data on abortions, births, and fetal deaths was provided by county of residence of the women, aggregated by age groups and ethnicity (white/non-white).[6] In most states, including North Carolina and South Carolina, abortion providers are required to submit regular and confidential reports to the state. The patient's address are self-reported to the abortion service provider, who provides this information to the state as well. Birth count data is sourced from birth certificates, and fetal deaths are covered by mandated reporting laws. The year 1995 saw 29,938 abortions to North Carolina residents and 11,075 abortions to South Carolina residents. This number had dropped to 23,018 in North Carolina in 2018 (a 28 percent change), and 10,716 in South Carolina in

[5]The total number of pregnancies is an undercount, because a significant share of pregnancies go unreported, for example due to miscarriage, which occurs in approximately 13 percent of all pregnancies (Andersen, Wohlfahrt, Christens, Olsen, & Melbye, 2000).

[6]In the case of North Carolina, resident abortion data includes abortions that occur in any state. In the case of South Carolina, resident abortion data are limited to abortions that occur in South Carolina, North Carolina or Georgia to South Carolina residents.

2016 (a 3 percent change).

III.C. Construction of Key Variables

This study has two main goals: First, to understand the opening decision of a CPC. Second, to understand how CPCs affect the abortion and birth rates. To study the questions, two key variables are needed. The first variable of interest is CPC, which is defined as the number of CPCs per 1000 women of age 10-44 in a county in a given year. CPC is a continuous variable constructed using the information on the number of CPCs in a county and Census population data. The second variable is the driving distance from a population-weighted county centroid to the nearest CPC, which is represented by $Dist$. This variable is a proxy for how far women have to travel to reach the closest CPC. It is well-established that driving distance is relevant to the decision of an individual to utilize a provider, in this case, a CPC. Because distance matters to the client, it is plausible that a CPC location is chosen in such a way as to minimize the distance to the population that is being served. The driving distance was obtained from the HERE geolocation and routing service using an API.[7]

IV. The Location Choice of Crisis Pregnancy Centers

Few researchers have studied the location choice of non-profit organizations (Bielefeld & Murdoch, 2004). We know from this literature that non-profits are often established to serve particular constituencies. Moreover, the non-profit sector is primarily community-based and locally operated (Wolpert, 1993). Therefore, needs and resources in a particular region (i.e. county or city) determine the number of non-profit organizations. Wolch and Geiger (1983), for example, found that community needs and resources determines the the distribution of social welfare and community service non-profits across municipalities in Los Angeles County. Higher rates of generosity are positively related to income and negatively related to population and distress levels. In the sociology and economics literature, some attention has been paid to the location choice of CPCs. Two cross-sectional studies investigated whether CPC location is related to the prevailing religious affiliation of a local population. Yuengert and Fetzer (2010) found that CPC locate near population centers and in counties

[7]Since routing is only available for the 2021 road network, the true shortest route in previous years may have been different from the observed route.

with a high share of Catholics, whereas McVeigh et al. (2017) found that CPC location is associated with the share of evangelical and catholics in a county. All of the studies discussed are cross-sectional, providing a snapshot of CPC locations and operations at one point in time. What we lack to date is evidence from longitudinal data on the location choice of CPCs.

CPCs want to support women during pregnancy and dissuade women from terminating their pregnancy if they are considering abortion. For a new CPC to be established, there need to be individuals who want to open one. CPCs are religious non-profit organizations, so I propose that CPCs are more likely to be founded in areas that have a higher share of individuals with common beliefs. Specifically, I test whether CPCs are more likely to be founded in a county with a higher share of religious adherents of christian denominations that reject abortion in principle (for example, evangelicals, catholics). For many Americans, religious belief and voting in political elections go hand-in-hand. The Republican Party seeks to reduce access to abortion services. Therefore, I test if a higher share of votes for the Republican Party in federal elections predicts CPC openings. It is reasonable to assume that the founders would want to locate their CPC where there is a perceived need for their services. The umbrella organization Care Net advises individuals who wish to open a CPC to find out if any other CPCs already exist. If there are existing CPCs, the need for a new CPC depends on the number of people already served and the overall population in the area. Importantly, although CPCs are independently operated, they do not compete with each other and most belong to one or more large umbrella organizations. Non-profits, like any other organization, operate under cost constraints. CPCs thus need consider the operating costs associated with a potential location. The two largest cost items for CPCs are mortgages or rents (proxied by real estate prices), and wages (proxied by the wage cost of other social service non-profits in the area). In sum, I propose that the location decision is based on the perceived need for a CPC in the area, proximity to potential clients, and cost.

To understand the strategic decision of CPC founders in a county, let us consider Alamance County in NC in 1998. This county has a female population of 31,952 in the age group 10 to 44, and an abortion rate of 24 per 1000 women in the same age group. Alamance county had one abortion provider in 1998. It has a CPC, which is located three miles

from the population weighted centroid of the county. Individuals in the local community consider these and other characteristics of their community in their decision to open a CPC. I am using a logit model to explain the resulting incentives for the opening of an additional CPC that a decision-maker faces in Alamance County. Because opening a CPC requires time to plan and prepare, the predictors of a CPC opening are set to $t-1$. Part of the utility that the decision-maker obtains from opening a CPC is the result of observable factors, another part is not observable to the researcher. It is assumed that the observed part of the utility of opening a CPC is a linear function of observed factors and that the unobserved part is random. The utility of opening a CPC in Alamance County in 1998 is conceived as follows. The same logic applies to all counties and years.

$$U_{c,t} = \theta_1 CPC_{c,t-1} + \theta_2 Dist_{c,t-1} + \theta_3 AR_{c,t-1} + X_{c,t-1} + \epsilon_{c,t}$$

CPC is a variable that records that Alamance county had a CPC at $t-1$, that is in the year prior to the current year t. This is readily observable and individuals planning on opening a CPC are advised to check if CPCs exist in the community (see CareNet guide). $Dist$ captures the distance from the existing CPC to the population weighted centroid of Alamance County. If people have to travel farther to a CPC, there is a greater incentive to open a new CPC. CPCs care about fertility outcomes. Therefore, the abortion rate in a county, AR, is likely to factor into the opening decision and is included in this model. Observable time-varying county characteristics are captured by X. The unobserved component of the utility of opening a CPC – $\epsilon_{c,t}$ – varies over counties, depending on how decision makers in each county view the benefit and costs of opening a CPC. For example, the individuals that open a CPC observe, to some extent, the unmet demand for abortions and abortion alternatives. They also consider costs, such as the difficulty of finding a suitable building to rent or purchase. In this model, the opening decision is made in all counties and every year between 1990 and 2019. In some counties and years the utility of opening a CPC is greater than the alternative, in others it is not. Since a county may experience more than one CPC opening, the CPC location choice is modeled as a renewal process (that is, a repeated hazard). The probability of a CPC opening in county c in year t is determined by estimating the following equation:

$$CPCopens_{ct} = \theta_0 + \theta_1 CPC_{ct-1} + \theta_2 Dist_{ct-1} + \theta_3 AR_{ct-1} + \theta_4 X_{ct-1} + \gamma_c + \alpha TimeTrend + \epsilon_{ct} \quad (1)$$

This equation is estimated using maximum likelihood. The outcome variable is binary, indicating the opening of a new CPC in a given county and year. Relocations within a county are excluded. CPC_{ct}, $Dist_{ct}$, and AR_{ct} are key factors hypothesized to be relevant for the opening of a new CPC, as explained above. X_{ct} contains a series of county characteristics, such as the unemployment rate and the prevailing wage of similar non-profits. X_{ct} also contains the distance from a given county centroid to the nearest abortion provider (or referrer), as well as the distance of the existing CPC to the nearest high school. Because CPCs aim their services at teenage girls and young women, they may want to open in a location that is convenient to this population. γ_c is a county fixed effect. Including county fixed effects in the logit model implies that if a county did not open a CPC in 30 years, the estimated probability of a CPC opening is zero. The number of observations used in the estimation is adjusted accordingly.

What can we learn about the location choice of CPCs? Results from the preferred fixed effect specification are in column 2 of Table 4. CPCs choose to locate in counties that have no CPC or fewer CPCs in the year prior to opening. The average marginal effect of the number of CPCs on the probability of a new CPC is - 7.6 percent. CPCs prefer to locate in counties with greater population. If a given county had a population that is 10 percent higher, the probability of a new CPC would increase by 3.9 percent. However, there is no clear indication that CPCs strategically locate in counties with a large share of young people or non-white people. $DistNearestClinic$ is estimated to be zero, indicating that CPCs do not open in a location to reduce the distance between existing abortion providers and CPCs. This is misleading because in 1990, at the beginning of the time period under consideration, all but one abortion provider already had a CPC nearby. Thus, locating near abortion providers was likely a top priority for the first CPCs that opened prior to 1990. Similarly, the teenage abortion rate in counties that had a CPC in 1990, 19.9 per 1000, is significantly higher than in counties without a CPC, 14.6 per 1000 (see Table VIII.B.). A higher vote share of the GOP in elections to the House of Representatives is associated with

a lower probability of a CPC opening. This is surprising because GOP policies align with CPC values and goals. There is also no clear sign that the share of adherents to a particular faith increases the probability of a CPC opening (the reference category is the population share that is not a member of a church).

V. The Impact of CPCs on Fertility Outcomes

V.A. Mechanism

Unintended pregnancies pose a difficult and uncertain decision for many women. According to one survey, 42% of unintended pregnancies are terminated (Finer & Zolna, 2016). How do women arrive at their decision? Where do they get information and support? We know that the distance women have to travel to access abortion services matters (Fischer et al. (2018), Lu and Slusky (2019), etc). I propose that a woman who has access to a CPC in her community is less likely to terminate her pregnancy. This hypothesis is motivated by the mission of CPCs – to reduce the number of abortions – and CPC statements on their effectiveness in realizing this objective. The CPC umbrella organization Care Net claims that 8 out of 10 women who considered abortion when they visited an affiliated pregnancy center chose not to have an abortion after their visit. Further, 18% of callers to Care Net's national pregnancy helpline reportedly moved from being committed to an abortion to being undecided (Care Net, 2018). Whether women carry an unintended pregnancy to term is, in part, a question of what services – abortion providers and CPCs –are easy to access.

CPCs provide two services that are key to fertility outcomes: Abstinence education and pregnancy counseling. The first channel, abstinence education, is about the role of CPCs before a pregnancy occurs. CPCs may plausibly increase or decrease the rate of unintended or unwanted pregnancies and is it difficult to investigate this channel empirically. It should be noted that CPCs typically emphasize abortion alternatives and services for mothers in their advertising, which suggest that the first channel is less important. Comparing CPCs that do (and do not) offer abstinence education will provide some insight into this question. Further, any observed difference in the magnitude of the effect of CPCs on the abortion and birth rates provides clues on the role of CPCs in shaping pregnancy rates.

The second channel concerns how CPCs influence a woman's decision to seek abortion

services once an unintended pregnancy occurs. I propose that CPCs shape women's beliefs, preferences and decisions, and thus impact the demand for abortion services, in two main ways. Both of these suggest that CPCs lower the abortion rate. First, a CPC may alter women's beliefs and preferences toward abortion, for example, by conducting an ultrasound and providing educational material about abortion risks.[8] Second, a CPC may provide a meaningful alternative to abortion, for example, by arranging an adoption or referring to adoption services).

V.B. Identification Challenge

Given the available data, what is the ideal scenario to study whether CPCs change fertility outcomes? Ideally, we could observe two identical counties over time. One county receives a CPC, the other does not receive a CPC. In reality, counties vary along many dimensions and CPCs are opened strategically in response to observed and unobserved county features. The location choice model discussed above captures key factors that explain the CPC location choice. Further, I can control for unobserved time-invariant county characteristics and secular fertility shocks. Still, one identification challenge remains: Unobservable factors may affect CPC location and fertility outcomes. Let us consider a hypothetical scenario: A group of individuals have learned that high schoolers in their communities are increasingly engaging in risky sexual behavior. The women decide to open a CPC to address this by offering abstinence education and pregnancy counseling. The fertility outcomes of students are, in part, determined by the likelihood of pregnancy, preferences and beliefs, and how the students respond to a CPC. For example, a teenage girl with a strong Christian faith may have a lower risk of pregnancy but a higher chance of visiting a CPC if a pregnancy occurs. The complex interrelationships between the individual response to a CPC and the factors that lead to the CPC opening remain largely unobservable to the researcher. Identifying the causal effect of CPCs on fertility outcomes thus requires addressing potential endogeneity due to unobservable factors. To this end, instrumental variables are used.

[8]The vast majority of CPCs do not employ medical staff.

V.C. Estimation Strategy

The goal is to to identify the causal effect of CPCs on the log of the abortion, birth and pregnancy rates.[9] The structural equation is as follows, where Y_{ict} represents the fertility outcome of interest:

$$Y_{ict} = \theta_0 + \theta_1 CPC_{ct} + \theta_2 Age_{ict} + \theta_3 CPC \times Age_{ict} + \theta_4 NonWhite_{ict} + \theta_5 Age_{ict} \times NonWhite_{ict} +$$

$$+ \theta_6 DistClinic_{ct} + \theta_7 X_{ct} + \gamma_c + \alpha_t + \epsilon_{ict} \quad (2)$$

In this specification, the unit of observation is a demographic age-ethnicity group i in county c in year t. The groups are women age 10-19, 24-29, 30-34, and 35-44, for whites and non-whites. The collection of dummy variables represented by Age_{ict} captures these age groups. The excluded category are women in the age range 20 to 24. $NonWhite_{ict}$ is an indicator variable that takes value zero if the population group is white and value 1 if the group is not white. There are a total of 10 age-ethnicity groups. The effect of CPCs on a fertility outcome Y_{ict} is given by θ_1, the number of CPCs per 1000 women age 10-44 in a county, and θ_3, the interaction of the number of CPCs and one of the five age groups. This allows for the effect of CPCs to vary by age. CPC_{ct} is potentially endogenous because the CPC location choice in time and space may be systematically related to unobserved factors that also affect the fertility outcomes of interest. Therefore, CPC_{ct} is instrumented by an exogenous variable. The instrumental variable is constructed using a simulation approach. A separate specification uses the driving distance from county centroids to the nearest CPC, $Dist_{ct}$, instead of CPC_{ct}. The construction of both instruments for CPC_{ct} and $Dist_{ct}$ is discussed below.

[9] A small share of the population groups in some counties and years have an abortion rate (or birth rate) of zero. To account for zero values, an inverse hyperbolic sine transformation is applied to the abortion, birth and pregnancy rates. The inverse hyperbolic sine function is defined at zero. This function closely approximates the natural log transform, which is why "log" is used throughout to describe the outcome variables.

V.C..1 Construction of Instrumental Variables

In order to estimate the structural equation, I construct instrumental variables. Two instruments are needed, one for CPC_{ct} and one for $Dist_{ct}$. The instruments are the "Expected number of CPCs" and the "Expected distance from a county centroid to the nearest CPC."[10] The instruments are constructed as follows: From the logit model of CPC location choice, I obtain the probability of a CPC opening in each county in 1990. These values serve as initial conditions. Consider Alamance County in NC, which never had a CPC by the year 1990. What is the probability that a CPC opens in Alamance County in 1991? The probability of a CPC opening is given by $logit(X\beta)$. Thus, a random draw is taken from the probability distribution of a new CPC opening in Alamance County in 1991.[11] Once a CPC opened in 1991, the probability of a CPC opening in 1992 needs to reflect this changed county environment. Three key variables are updated to reflect the change resulting from a CPC opening. These variables are the "Number of CPCs", (which is increased by 1 if a CPC opened at $t-1$), the "Distance from the County Centroid to the Nearest CPC" (a new CPC opening closer to the centroid reduces this distance), and the "Abortion Rate" (updated using an exogenous rule). The logit model is simulated once again, using the updated variables, to obtain the probability of a CPC opening in Alamance County in 1992. Another random draw is taken to determine if a CPC opens in 1992. This process is repeated for each county and year, and repeated a large number of times to allow the estimates to converge to the expected value. The same approach applies to the County-CPC distance variable. Finally, I generate the "Expected number of CPCs" for each county and year, and construct the instrument used in equation (1): the "Expected number of CPC per 1000 women age 10-44." This variable is called $Exp(CPC)$. As a result of this process, the number of CPCs, how the abortion rate changes, and how the distance from a county centroid to a CPC changes, is unrelated to the unobserved propensity of a CPC opening in the county. The desired outcome is an exogenous instrument, that is, the expected number of CPCs in a county, conditional on observables, affects fertility outcomes only through the timing of the exogenous determinants of the number of CPCs, but not through endogenous channels. By construction,

[10] The IV used in the estimation, "Expected number of CPCs per 1000 women age 10-44," is constructed using "Expected number of CPCs" and population counts.

[11] In more detail, this probability is obtained by taking a random draw from a uniform distribution. If the draw is smaller than $e^{(X\beta)}/[1+e^{(X\beta)}]$, a CPC opens in Alamance County in 1991.

the instrument is relevant because the expected number of CPCs is related to the observed number of CPCs. See figure 5 and figure 6 for histograms of the instrumental variables and the variables being instrumented.

V.C..2 Two-stage Least Squares Regression

The variable $Exp(CPC)_{ct}$ is used to instrument for CPC_{ct}. The first-stage is as follows:

$$CPC_{ct} = \theta_0 + \theta_1 Exp(CPC)_{ct} + \theta_2 Age_{ict} + \theta_3 Exp(CPC)_{ct} \times Age_{ict} + \theta_4 NonWhite_{ict} +$$
$$+ \theta_5 Age_{ict} \times NonWhite_{ict} \ + \theta_6 DistClinic_{ct} + \theta_7 X_{ct} + \gamma_c + \alpha_t + \epsilon_{ct} \quad (3)$$

In this first stage, CPC_{ct}, the number of CPCs in county c and year t, is a function of the instruments $Exp(CPC_{ct})$, and the interactions of $Exp(CPC_{ct})$ with each age-group, as well as Age_{ict}, $NonWhite_{ict}$, $DistClinic_{ct}$, and X_{ct}. County fixed effects are denoted by γ_c and time fixed effects are denoted by α_t. See table 8 for the first-stage estimation results. The second stage is:

$$Y_{ict} = \theta_0 + \theta_1 \widehat{CPC}_{ct} + \theta_2 Age_{ict} + \theta_3 \widehat{CPC \times Age}_{ict} + \theta_4 NonWhite_{ict} +$$
$$+ \theta_5 Age_{ict} \times NonWhite_{ict} + \theta_6 DistClinic_{ct} + \theta_7 X_{ct} + \gamma_c + \alpha_t + \epsilon_{ict} \quad (4)$$

In this specification, Y_{ict} is the log of the abortion rate (the birth rate or pregnancy rate). The unit of observation is a demographic age-ethnicity group i in county c in year t. The age groups are women age 10-19, 24-29, 30-34, and 35-44. The variable Age_{ict} captures these age groups. The excluded category are women in the age range 20 to 24. $NonWhite_{ict}$ is an indicator variable that takes value zero if the population group is white and value 1 if the group is not white. There are a total of 10 age-ethnicity groups. The effect of CPCs on a fertility outcome Y_{ict} is given by θ_1, the number of CPCs per 1000 women age 10-44 in a county, and θ_3, the interaction of the number of CPCs and one of the five age groups. This allows for the effect of CPCs to vary by age.

VI. Results: Fertility Outcomes

The average female population age 10-44 in NC and SC counties is approximately 20,000. Going from zero CPCs in a county to 1 CPC per 20,000 women age 10-44, decreases the abortion rate by 8.6 percent among white teenage girls and 20 to 24-year-old white women. Women between the ages of 20 and 24 have the highest fertility rates. Non-white women in each age group have a higher abortion rate than white women. These results are in table 5. However, a separate specification that includes an interaction of CPCs and ethnicity shows no meaningful difference in effect size by ethnicity. For older women, the effect monotonically decreases with age. The coefficient remains negative but is no longer distinguishable from zero for women older than 30. We also see that the greater the distance that women travel to abortion providers, the lower the abortion rate in the county. Though this distance coefficient is not precisely estimated, the negative sign is in line with the existing literature (Cunningham et al., 2017; Fischer et al., 2018; Lu & Slusky, 2019). The 2SLS estimates of the coefficient of interest, CPC_{ct}, generally lie between the OLS estimates (lower bound) and the reduced form estimates (upper bound)(see tables 6 and 7. Results from a two-way fixed effect event study of staggered CPC openings also corroborate these results. See Figure 7. This event study takes into account the first, second, and third opening of a CPC in a county. This specification produces unbiased estimates if the treatment effect is homogenous across units and time (Baker, Larcker, & Wang, 2021). Further event study specifications that relax these assumptions to follow. The alternative specification that investigates the effect of the distance from the population weighted county centroids to the nearest CPC on fertility outcomes validate the results reported above. The distance variable coefficient indicates that a one mile increase in driving distance from a CPC increases the abortion rate by 1.3 percent. This effect decreases with greater distance but at a very small rate (see squared distance term). Note that the nearest CPC may be in a county different from the resident county of an individual that experiences a fertility outcome. Counties range in area from 172 to 1133 square miles, with most in the 300 to 700 square mile range. This suggests that the geometric distance from one border of a county to the opposite border is in the range of 15 to 30 miles. Population weighted county centroids are a fairly crude measure of where people live, resulting in the measurement error in the driving distance. This is a

plausible explanation as to why the distance coefficients are estimated with less precision than the estimates of the effect of CPCs per 1000 women age 10-44. The separate analysis using Zipcode-level population and fertility data will provide more reliable estimates of how the effect of CPCs varies with driving distance.

The results for the impact of CPCs on the birth rate is roughly symmetric to the abortion rate results for teenage girls and women age 20-24. Going from zero CPCs in a county to 1 CPC per 20,000 women age 10-44, increases the birth rate by 6.4 percent among white girls age 10 to 19, and by 10 percent among 20 to 24 year old white women–the latter is the reference population group. In the case of the birth rate, we observe that the magnitude of the effect increases monotonically with age.

To illustrate the magnitude of the results, let us translate the estimated percentage changes into absolute numbers. A typical county has approximately 3,000 girls between 10 and 19 years of age. The average abortion rate for this age group is 7.7 and the average birth rate is 26.9. This means 23 abortions and 81 births occur in a given year. An increase in the abortion rate of 8.6 percent is equivalent to two additional abortions. Similarly, an increase in the birth rate of 6.4 percent is equivalent to five additional births in this age group.

VII. Discussion

The 2SLS estimation results show that CPCs lower the abortion rate and increase the birth rate. For teenage girls, the increase in the birth rate is more than twice as large, in absolute terms, as the reduction in the abortion rate. The increase in the number of births, relative to the reduction in abortions, is even greater for older women. The overall rise in the pregnancy rate is best explained by CPCs causing an increase in the likelihood of pregnancy. It is difficult to pin down by how much CPCs increase the risk of a pregnancy occurring because the observed pregnancy outcomes (birth, abortion, fetal death) do not capture all pregnancies. Notably, miscarriages are not recorded in vital statistics data. The risk of a miscarriage may be related to CPCs and could thus affect the observed effects. A possible channel is that individuals who visit CPCs are less likely to visit healthcare providers, which may increase risks associated with the pregnancy. However, the overall risk of miscarriage

of approximately 13 percent is unlikely to meaningfully alter the fertility outcome estimates (Andersen et al., 2000). A plausible explanation for the greater absolute increase in teenage births is that CPCs, via abstinence education, contribute to risky sexual behavior and more unintended pregnancies. Only a share of these additional pregnancies are terminated. The observed increase in the teenage birth rate suggests that fertility decisions made under the guidance of CPCs could shape the lives of teenagers and young women more broadly. Educational outcomes are particularly relevant, because pregnancy and parenthood increase the risk of dropping out of high school. Only 40 percent of teenage mothers graduate from high school (Perper & Manlove, 2010). This is an area for further research.

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VIII. Appendix

VIII.A. Figures

Figure 1: CPCs, Abortion Providers and Abortion Rate (NC & SC): 1990

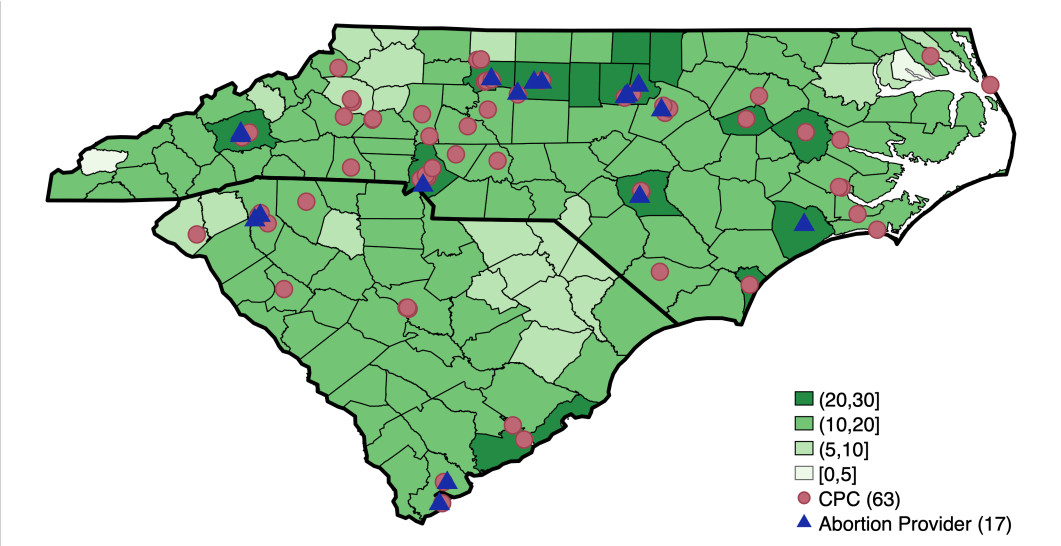


Figure 2: CPCs, Abortion Providers and Abortion Rate (NC & SC): 2000

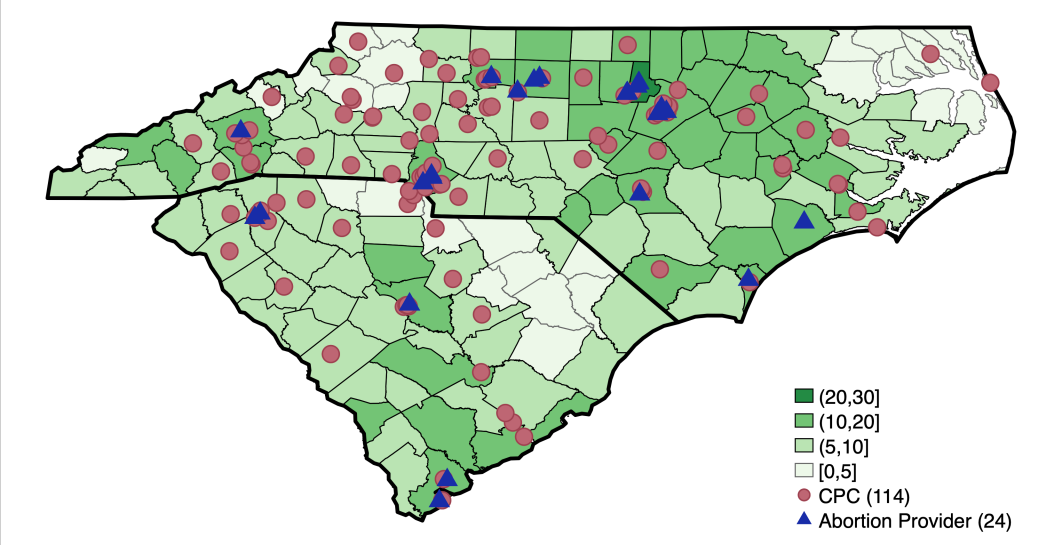


Figure 3: CPCs, Abortion Providers and Abortion Rate (NC & SC): 2010

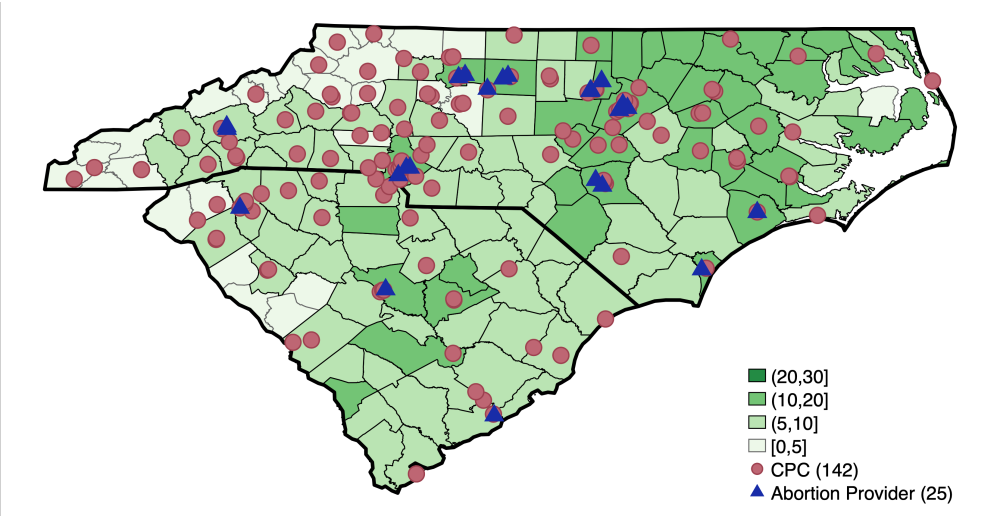


Figure 4: CPCs, Abortion Providers and Abortion Rate (NC & SC): 2019

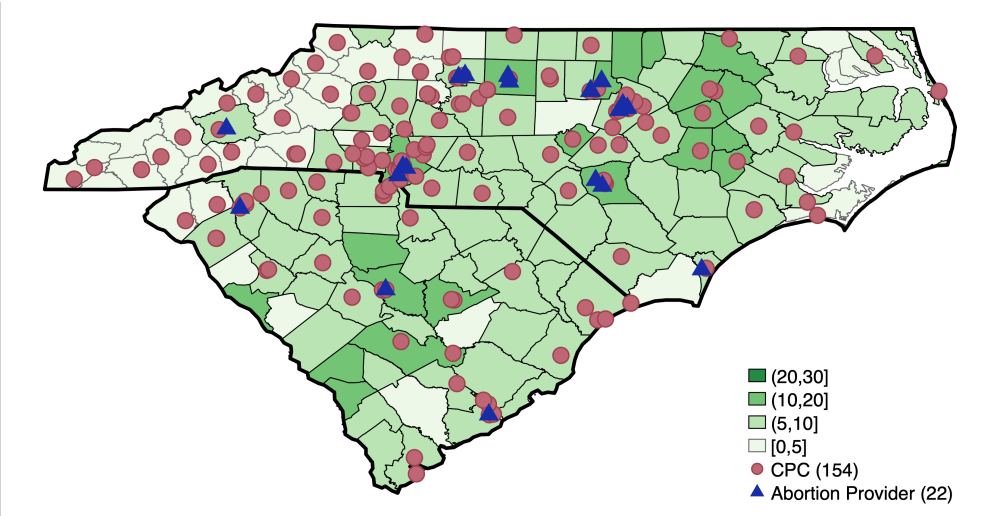


Figure 5: CPC Count Per 1000 Women Age 10-44 (County)

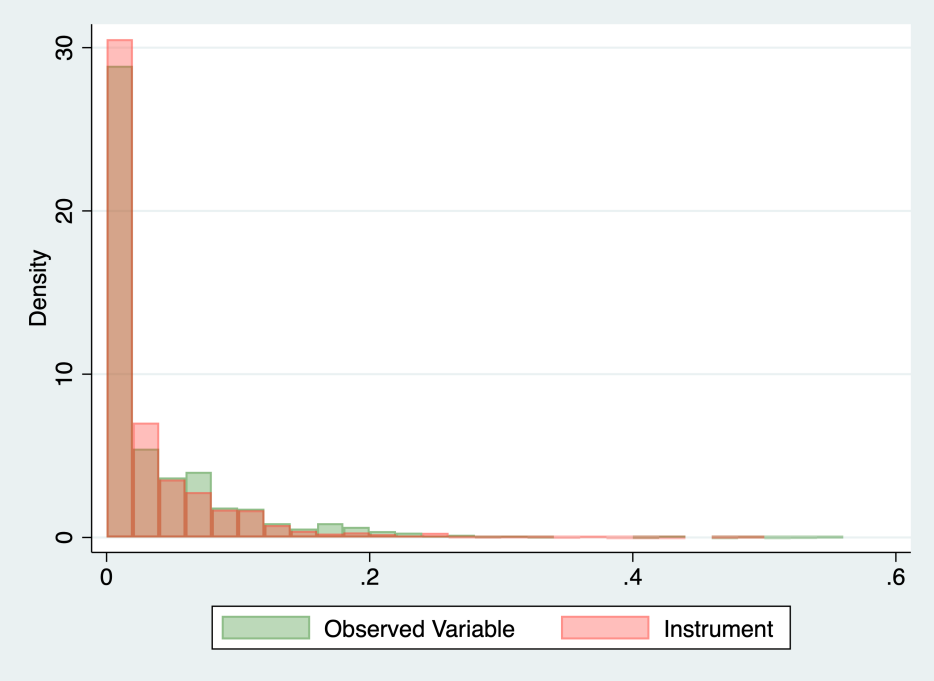


Figure 6: Distance County Centroid to Nearest CPC

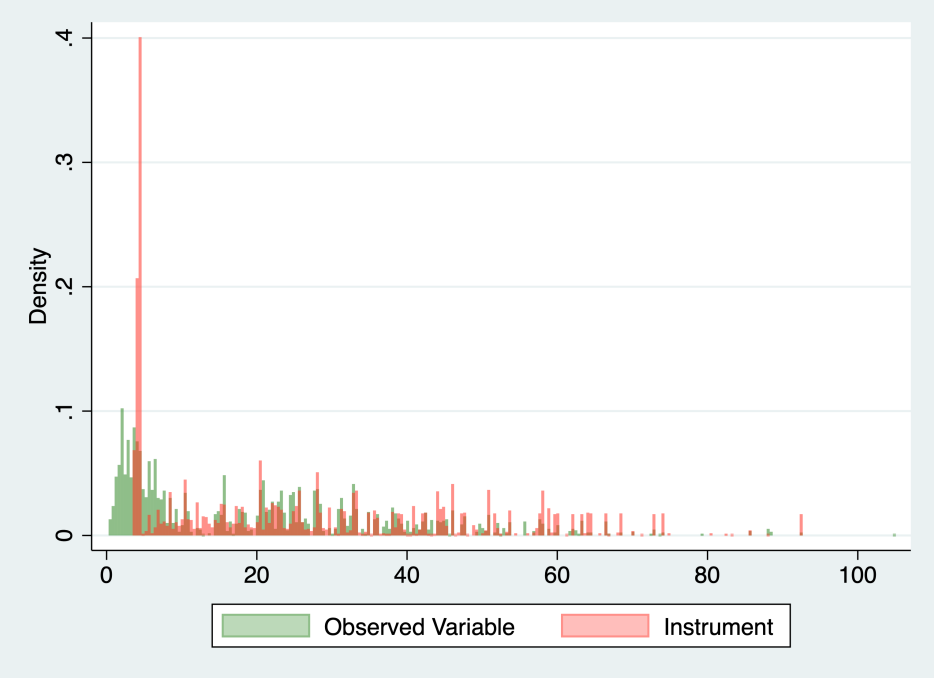
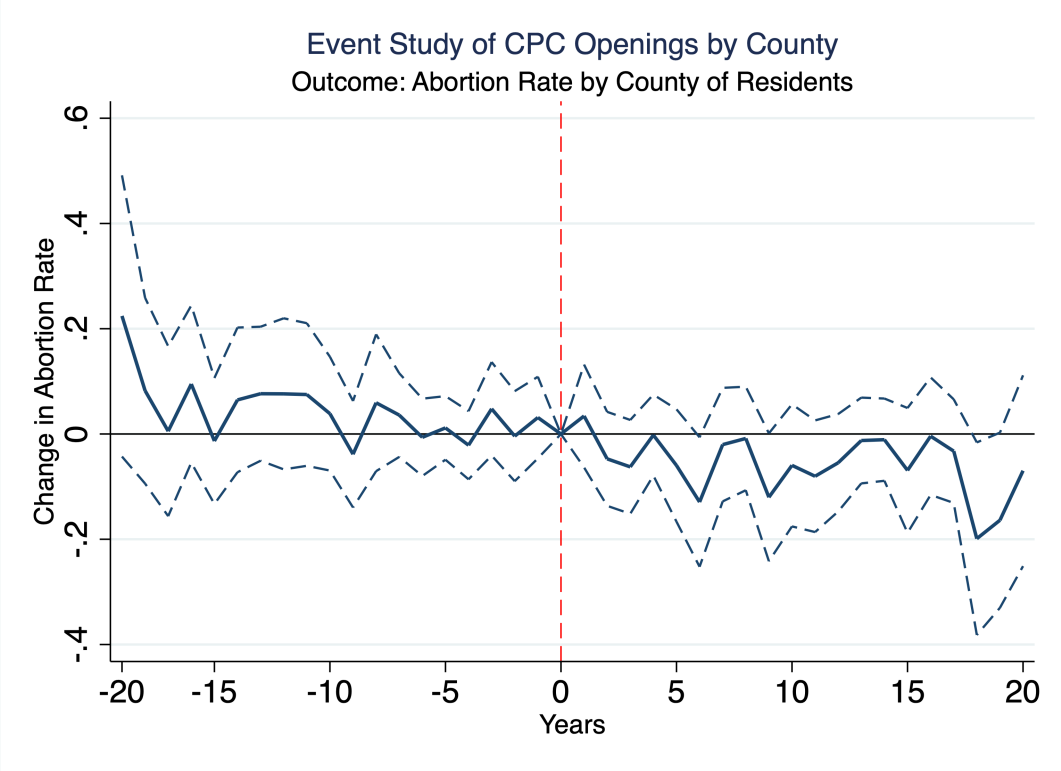


Figure 7: Event Study: CPC Opening in County (1st, 2nd, 3rd CPC)



VIII.B. Tables

Table 1: CPC Services

	No. of CPCs	% Share
Over-the-Counter Pregnancy tests	93	0.80
After abortion support	76	0.66
Ultrasound services	65	0.56
Adoption agency or adoption support	52	0.45
Abstinence education in schools	42	0.36
Abortion reversal pill consult/provison.	29	0.25
Off-site partnership with physician	25	0.22
STI testing	20	0.17
N	116	

Table 2: County Characteristics: NC & SC 1990

	All		No CPC		CPC only	
	Mean	SD	Mean	SD	Mean	SD
Female Population Age 10-44	18,493	(21,183)	12,676	(12,058)	37,378	(35,841)
Share age 10-19	0.15	(0.07)	0.15	(0.07)	0.15	(0.06)
Non-white share	0.31	(0.20)	0.34	(0.21)	0.25	(0.14)
Unemployment rate	5.23	(2.01)	5.57	(2.12)	4.14	(0.77)
House Price Index (County)	100	(0)	100	(0)	100	(0)
No. of CPCs	0.39	(0.80)	0.00	(0.00)	1.71	(0.96)
Non-profit Avg. Pay (1000s)	19.00	(1.48)	18.91	(1.60)	19.33	(0.97)
One or more abortion providers	0.31	(0.47)	0.30	(0.46)	0.00	(0.00)
Pregnancy count	122	(151)	83	(96)	257	(254)
Pregnancy rate	6.48	(1.34)	6.40	(1.35)	6.83	(1.14)
Abortion count	30	(45)	17	(22)	73	(81)
Abortion rate	19.55	(14.18)	18.80	(15.69)	21.31	(6.31)
Abortion rate girls age 10-19	16.03	(8.04)	14.63	(7.30)	19.85	(7.71)
Birth count	91	(107)	65	(75)	182	(174)
Birth rate	64.10	(14.36)	64.38	(14.31)	63.05	(14.68)
Birth rate girls age 10-19	39.24	(19.88)	39.58	(19.04)	32.08	(21.14)
Mainline protestant share	0.17	(0.08)	0.16	(0.08)	0.22	(0.08)
Evangelical protestant share	0.32	(0.13)	0.33	(0.13)	0.26	(0.11)
Catholic share	0.01	(0.01)	0.01	(0.01)	0.03	(0.02)
Black protestant share	0.14	(0.11)	0.15	(0.11)	0.12	(0.09)
U.S. House GOP vote share	0.39	(0.23)	0.36	(0.24)	0.49	(0.16)
N	137		104		21	

Table 3: County Characteristics: NC & SC 2019

	All		No CPC		CPC only	
	Mean	SD	Mean	SD	Mean	SD
Female Population Age 10-44	24,744	(39,978)	8,640	(9,475)	29,324	(29,822)
Share age 10-19	0.15	(0.07)	0.16	(0.06)	0.14	(0.08)
Non-white share	0.33	(0.19)	0.41	(0.20)	0.27	(0.17)
Unemployment rate	3.97	(0.94)	4.26	(1.09)	3.83	(0.75)
House Price Index (County)	211	(31)	211	(22)	208	(39)
No. of CPCs	1.02	(1.40)	0.00	(0.00)	1.66	(0.99)
Non-profit Avg. Pay (1000s)	36.38	(3.81)	36.65	(3.37)	35.72	(3.52)
One or more abortion providers	0.25	(0.44)	0.23	(0.42)	0.00	(0.00)
Pregnancy count	125	(226)	44	(44)	141	(142)
Pregnancy rate	5.19	(1.25)	5.27	(1.05)	5.18	(1.28)
Abortion count	21	(45)	6	(8)	23	(31)
Abortion rate	10.40	(3.25)	9.64	(2.99)	10.54	(3.41)
Abortion rate girls age 10-19	3.00	(2.69)	2.80	(2.87)	3.14	(2.68)
Birth count	104	(181)	37	(38)	118	(113)
Birth rate	65.80	(24.16)	63.27	(19.20)	67.43	(23.13)
Birth rate girls age 10-19	14.52	(10.38)	14.92	(10.72)	14.42	(9.25)
Mainline protestant share	0.19	(0.08)	0.17	(0.07)	0.21	(0.08)
Evangelical protestant share	0.30	(0.12)	0.28	(0.12)	0.31	(0.11)
Catholic share	0.02	(0.02)	0.02	(0.02)	0.03	(0.02)
Black protestant share	0.04	(0.04)	0.06	(0.05)	0.03	(0.03)
U.S. House GOP vote share	0.60	(0.19)	0.58	(0.20)	0.63	(0.18)
N	142		61		59	

Table 4: Predicting the Opening of Crisis Pregnancy Centers

	(1)	(2)
No. of CPCs (lagged)	-0.0108	-0.0764**
	(0.00561)	(0.0239)
Dist. Nearest CPC (lagged)	0.000278	0.000834
	(0.000146)	(0.00108)
Dist. Nearest Clinic (Lagged)	0.0000194	0.00105
	(0.0000665)	(0.000775)
Abortion rate 1000 women 10-44 (lagged)	0.0000216	-0.0000962
	(0.000158)	(0.000350)
CPC Dist. Nearest High School	0.000874	0.00494
	(0.000654)	(0.00257)
Log. Population (lagged)	0.0174***	0.385
	(0.00323)	(0.203)
Pop. share age 10-19 (lagged)	-0.00765	-0.0393
	(0.0233)	(0.0629)
Non-white share (lagged)	-0.0798***	0.921
	(0.0223)	(0.747)
Unemployment rate (lagged)	0.000408	-0.000927
	(0.000921)	(0.00321)
U.S. GOP vote share (lagged)	-0.0116	-0.0900*
	(0.0134)	(0.0398)
Main. protestant share (lagged)	0.0164	0.0646
	(0.0267)	(0.391)
Evang. protestant share (lagged)	0.0217	-0.0410
	(0.0190)	(0.215)
Catholic share (lagged)	-0.0461	-0.0958
	(0.122)	(1.187)
Black protestant share (lagged)	0.00783	-0.0787
	(0.0365)	(0.115)
Other religious affil. share (lagged)	0.0208	2.305
	(0.247)	(2.119)
N	4280	1623
State-County FE	No	Yes
Time Trend	Yes	Yes

Standard errors in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 5: 2SLS: Impact of CPCs on (Log) Fertility Rates

	Abortion Rate		Birth Rate		Pregnancy Rate	
	(1)	(2)	(3)	(4)	(5)	(6)
No. of CPCs per 1000 women age 10-44	-1.711**		2.003***		1.737***	
	(0.573)		(0.500)		(0.476)	
No. of CPCs per 1000 X Age 10-19	0.231		-0.759*		-0.792**	
	(0.681)		(0.300)		(0.285)	
No. of CPCs per 1000 X Age 25-29	0.863***		1.478***		1.338***	
	(0.239)		(0.437)		(0.385)	
No. of CPCs per 1000 X Age 30-34	1.148*		2.095***		1.878***	
	(0.550)		(0.594)		(0.544)	
No. of CPCs per 1000 X Age 35-44	1.473**		2.295***		1.905***	
	(0.553)		(0.638)		(0.516)	
Dist. Nearest CPC		0.0134		-0.0124		-0.00980
		(0.00903)		(0.00849)		(0.00842)
Sq. Dist. Nearest CPC		-0.000172		0.000217*		0.000181
		(0.000169)		(0.000107)		(0.000103)
Dist. CPC X Age 10-19		0.00464*		-0.000750		-0.000469
		(0.00182)		(0.00143)		(0.00148)
Dist. CPC X Age 25-29		-0.00159		-0.00780***		-0.00637***
		(0.00119)		(0.00179)		(0.00150)
Dist. CPC X Age 30-34		-0.00308		-0.0147***		-0.0125***
		(0.00175)		(0.00251)		(0.00198)
Dist. CPC X Age 35-44		-0.0000163		-0.0182***		-0.0160***
		(0.00292)		(0.00307)		(0.00250)
Dist. Nearest Clinic	-0.000274	-0.000131	0.00159*	0.00144	0.00155**	0.00138*
	(0.000536)	(0.000811)	(0.000665)	(0.000849)	(0.000561)	(0.000692)
Log Female Population Age 10-44	0.312***	0.311***	0.266***	0.268***	0.231***	0.232***
	(0.0412)	(0.0411)	(0.0532)	(0.0531)	(0.0549)	(0.0548)
Age 10-19	-1.266***	-1.350***	-1.827***	-1.842***	-1.691***	-1.712***
	(0.0562)	(0.0564)	(0.0502)	(0.0518)	(0.0514)	(0.0530)
Age 25-29	-0.565***	-0.500***	-0.239***	-0.0246	-0.275***	-0.0950
	(0.0240)	(0.0326)	(0.0397)	(0.0598)	(0.0342)	(0.0491)
Age 30-34	-1.000***	-0.894***	-0.731***	-0.352***	-0.748***	-0.423***
	(0.0379)	(0.0428)	(0.0547)	(0.0844)	(0.0469)	(0.0676)
Age 35-44	-2.047***	-1.990***	-2.494***	-2.038***	-2.377***	-1.980***
	(0.0572)	(0.0790)	(0.0802)	(0.113)	(0.0724)	(0.0978)
Non-white Pop. Share	1.011***	1.010***	0.483***	0.485***	0.564***	0.566***
	(0.0416)	(0.0417)	(0.0360)	(0.0363)	(0.0368)	(0.0370)
Non-white Share X Age 10-19	-0.377***	-0.377***	0.168***	0.167***	0.0665**	0.0656**
	(0.0396)	(0.0397)	(0.0220)	(0.0222)	(0.0206)	(0.0207)
Non-white Share X Age 25-29	0.252***	0.252***	-0.129***	-0.129***	-0.0857**	-0.0856**
	(0.0355)	(0.0355)	(0.0312)	(0.0312)	(0.0264)	(0.0264)
Non-white Share X Age 30-34	0.0157	0.0155	-0.271***	-0.272***	-0.233***	-0.233***
	(0.0404)	(0.0403)	(0.0371)	(0.0369)	(0.0313)	(0.0312)
Non-white Share X Age 35-44	-0.257***	-0.257***	-0.118*	-0.118*	-0.128**	-0.128**
	(0.0490)	(0.0490)	(0.0485)	(0.0484)	(0.0413)	(0.0411)
Unemployment rate	-0.0174**	-0.0126	-0.0125*	-0.0148	-0.0155**	-0.0180*
	(0.00586)	(0.0121)	(0.00546)	(0.00842)	(0.00544)	(0.00779)
U.S. House GOP vote share	0.0845*	0.0843*	-0.000780	-0.00462	0.0130	0.0106
	(0.0385)	(0.0418)	(0.0269)	(0.0298)	(0.0249)	(0.0263)
Protestant Share	0.273	0.423	0.473	0.339	0.446	0.333
	(0.309)	(0.372)	(0.466)	(0.499)	(0.480)	(0.507)
Other Religion Share	-0.904***	-0.968***	-0.0981	0.0931	-0.259	-0.0839
	(0.247)	(0.245)	(0.181)	(0.171)	(0.186)	(0.174)
N	41787	41787	41787	41787	41787	41787
R^2	0.437	0.437	0.594	0.599	0.609	0.614
Dep. Var. Mean	2.629	2.629	4.353	4.353	4.592	4.592
State-County FE	Yes	Yes	Yes	Yes	Yes	Yes
Year FE	Yes	Yes	Yes	Yes	Yes	Yes
Kleibergen-Paap rk LM statistic	6.175	13.88	6.175	13.88	6.175	13.88
Kleibergen-Paap rk Wald F statistic	15.93	16.89	15.93	16.89	15.93	16.89

Standard errors in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6: OLS: Impact of CPCs on (Log) Fertility Rates

	Abortion Rate		Birth Rate		Pregnancy Rate	
	(1)	(2)	(3)	(4)	(5)	(6)
No. of CPCs per 1000 women age 10-44	-1.261**		0.476		0.352	
	(0.436)		(0.444)		(0.461)	
No. of CPCs per 1000 X Age 10-19	-0.431		-0.751*		-0.802**	
	(0.571)		(0.288)		(0.289)	
No. of CPCs per 1000 X Age 25-29	0.682***		1.057***		1.027***	
	(0.198)		(0.268)		(0.233)	
No. of CPCs per 1000 X Age 30-34	1.170**		1.912***		1.821***	
	(0.409)		(0.384)		(0.357)	
No. of CPCs per 1000 X Age 35-44	1.359***		2.235***		2.045***	
	(0.398)		(0.449)		(0.392)	
Dist. Nearest CPC		0.00183		0.00449		0.00418
		(0.00253)		(0.00258)		(0.00239)
Sq. Dist. Nearest CPC		-0.0000117		-0.0000125		-0.0000228
		(0.0000541)		(0.0000447)		(0.0000427)
Dist. CPC X Age 10-19		0.00593***		0.00108		0.00177
		(0.00137)		(0.00122)		(0.00123)
Dist. CPC X Age 25-29		-0.00280**		-0.00658***		-0.00569***
		(0.00101)		(0.00131)		(0.00113)
Dist. CPC X Age 30-34		-0.00578***		-0.0127***		-0.0112***
		(0.00131)		(0.00181)		(0.00146)
Dist. CPC X Age 35-44		-0.00383*		-0.0159***		-0.0144***
		(0.00179)		(0.00212)		(0.00174)
Dist. Nearest Clinic	-0.000233	-0.0000941	0.00133	0.00138	0.00133*	0.00143
	(0.000525)	(0.000548)	(0.000770)	(0.000884)	(0.000648)	(0.000740)
Log Female Population Age 10-44	0.312***	0.311***	0.267***	0.268***	0.232***	0.232***
	(0.0412)	(0.0412)	(0.0533)	(0.0530)	(0.0550)	(0.0547)
Age 10-19	-1.241***	-1.377***	-1.828***	-1.879***	-1.691***	-1.758***
	(0.0530)	(0.0489)	(0.0508)	(0.0519)	(0.0526)	(0.0532)
Age 25-29	-0.558***	-0.475***	-0.223***	-0.0495	-0.264***	-0.109*
	(0.0236)	(0.0302)	(0.0383)	(0.0540)	(0.0325)	(0.0449)
Age 30-34	-1.001***	-0.839***	-0.724***	-0.393***	-0.746***	-0.449***
	(0.0344)	(0.0350)	(0.0529)	(0.0748)	(0.0448)	(0.0604)
Age 35-44	-2.043***	-1.912***	-2.493***	-2.086***	-2.382***	-2.012***
	(0.0528)	(0.0580)	(0.0794)	(0.102)	(0.0725)	(0.0887)
Non-white Pop. Share	1.011***	1.010***	0.484***	0.486***	0.565***	0.566***
	(0.0416)	(0.0416)	(0.0361)	(0.0363)	(0.0369)	(0.0370)
Non-white Share X Age 10-19	-0.377***	-0.376***	0.168***	0.167***	0.0660**	0.0654**
	(0.0396)	(0.0397)	(0.0221)	(0.0222)	(0.0206)	(0.0207)
Non-white Share X Age 25-29	0.252***	0.252***	-0.129***	-0.129***	-0.0855**	-0.0856**
	(0.0355)	(0.0355)	(0.0313)	(0.0313)	(0.0265)	(0.0264)
Non-white Share X Age 30-34	0.0158	0.0156	-0.272***	-0.272***	-0.233***	-0.233***
	(0.0403)	(0.0403)	(0.0371)	(0.0370)	(0.0313)	(0.0312)
Non-white Share X Age 35-44	-0.257***	-0.257***	-0.118*	-0.119*	-0.128**	-0.128**
	(0.0490)	(0.0490)	(0.0485)	(0.0483)	(0.0413)	(0.0411)
Unemployment rate	-0.0173**	-0.0165**	-0.0128*	-0.00931	-0.0158**	-0.0118*
	(0.00586)	(0.00602)	(0.00534)	(0.00614)	(0.00523)	(0.00591)
U.S. House GOP vote share	0.0841*	0.0825*	0.00164	-0.00204	0.0151	0.0108
	(0.0385)	(0.0389)	(0.0247)	(0.0242)	(0.0228)	(0.0214)
Protestant Share	0.269	0.272	0.497	0.555	0.467	0.533
	(0.314)	(0.312)	(0.467)	(0.501)	(0.479)	(0.503)
Other Religion Share	-0.930***	-1.004***	0.0662	0.144	-0.117	-0.0604
	(0.241)	(0.242)	(0.162)	(0.126)	(0.168)	(0.128)
N	41787	41787	41787	41787	41787	41787
R^2	0.540	0.541	0.636	0.641	0.646	0.651
Dep. Var. Mean	2.629	2.629	4.353	4.353	4.592	4.592
State-County FE	Yes	Yes	Yes	Yes	Yes	Yes
Year FE	Yes	Yes	Yes	Yes	Yes	Yes
Kleibergen-Paap rk LM statistic						
Kleibergen-Paap rk Wald F statistic						

Standard errors in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 7: Reduced Form: Impact of CPCs on (Log) Fertility Rates

	Abortion Rate		Birth Rate		Pregnancy Rate	
	(1)	(2)	(3)	(4)	(5)	(6)
Exp. No. of CPCs per 1000 women age 10-44	-1.884**		2.553***		2.210***	
	(0.659)		(0.518)		(0.571)	
Exp. No. of CPCs per 1000 X Age 10-19	0.232		-0.756*		-0.789**	
	(0.676)		(0.299)		(0.290)	
Exp. No. of CPCs per 1000 X Age 25-29	0.860***		1.482**		1.342***	
	(0.242)		(0.453)		(0.397)	
Exp. No. of CPCs per 1000 X Age 30-34	1.146*		2.094***		1.877**	
	(0.552)		(0.620)		(0.567)	
Exp. No. of CPCs per 1000 X Age 35-44	1.470**		2.292***		1.903***	
	(0.551)		(0.675)		(0.548)	
Exp. Dist. Nearest CPC		0.0101		-0.00867		-0.00695
		(0.00759)		(0.00652)		(0.00637)
Exp. Sq. Dist. Nearest CPC		-0.000109		0.000106		0.0000921
		(0.000147)		(0.0000672)		(0.0000640)
Exp. Dist. CPC X Age 10-19		0.00320**		-0.000516		-0.000323
		(0.00122)		(0.000988)		(0.00102)
Exp. Dist. CPC X Age 25-29		-0.00109		-0.00538***		-0.00440***
		(0.000832)		(0.00128)		(0.00106)
Exp. Dist. CPC X Age 30-34		-0.00213		-0.0101***		-0.00861***
		(0.00125)		(0.00173)		(0.00136)
Exp. Dist. CPC X Age 35-44		-0.00000882		-0.0126***		-0.0110***
		(0.00202)		(0.00213)		(0.00176)
Dist. Nearest Clinic	-0.000159	-0.000263	0.00123	0.00145	0.00124*	0.00140
	(0.000513)	(0.000574)	(0.000677)	(0.000864)	(0.000568)	(0.000721)
Log Female Population Age 10-44	0.312***	0.310***	0.267***	0.265***	0.232***	0.230***
	(0.0413)	(0.0413)	(0.0532)	(0.0534)	(0.0550)	(0.0551)
Age 10-19	-1.264***	-1.338***	-1.833***	-1.842***	-1.697***	-1.712***
	(0.0532)	(0.0529)	(0.0491)	(0.0505)	(0.0505)	(0.0516)
Age 25-29	-0.559***	-0.504***	-0.229***	-0.0447	-0.266***	-0.111*
	(0.0236)	(0.0307)	(0.0390)	(0.0568)	(0.0334)	(0.0467)
Age 30-34	-0.992***	-0.902***	-0.716***	-0.390***	-0.735***	-0.455***
	(0.0356)	(0.0399)	(0.0537)	(0.0794)	(0.0459)	(0.0637)
Age 35-44	-2.036***	-1.989***	-2.479***	-2.083***	-2.364***	-2.020***
	(0.0551)	(0.0733)	(0.0800)	(0.108)	(0.0725)	(0.0946)
Non-white Pop. Share	1.011***	1.009***	0.483***	0.484***	0.564***	0.564***
	(0.0416)	(0.0416)	(0.0361)	(0.0363)	(0.0369)	(0.0371)
Non-white Share X Age 10-19	-0.377***	-0.376***	0.169***	0.167***	0.0667**	0.0657**
	(0.0397)	(0.0397)	(0.0220)	(0.0222)	(0.0206)	(0.0207)
Non-white Share X Age 25-29	0.252***	0.252***	-0.128***	-0.129***	-0.0851**	-0.0858**
	(0.0355)	(0.0355)	(0.0313)	(0.0313)	(0.0265)	(0.0265)
Non-white Share X Age 30-34	0.0157	0.0154	-0.271***	-0.272***	-0.232***	-0.234***
	(0.0404)	(0.0403)	(0.0371)	(0.0370)	(0.0314)	(0.0313)
Non-white Share X Age 35-44	-0.257***	-0.257***	-0.117*	-0.119*	-0.127**	-0.129**
	(0.0490)	(0.0490)	(0.0486)	(0.0485)	(0.0414)	(0.0412)
Unemployment rate	-0.0174**	-0.0164**	-0.0123*	-0.0133*	-0.0154**	-0.0163**
	(0.00586)	(0.00584)	(0.00498)	(0.00556)	(0.00502)	(0.00544)
U.S. House GOP vote share	0.0844*	0.0788*	-0.000474	0.00698	0.0132	0.0198
	(0.0386)	(0.0395)	(0.0244)	(0.0257)	(0.0227)	(0.0233)
Protestant Share	0.268	0.283	0.489	0.496	0.460	0.465
	(0.321)	(0.318)	(0.450)	(0.492)	(0.465)	(0.500)
Other Religion Share	-0.893***	-0.916***	-0.132	0.0316	-0.288	-0.136
	(0.248)	(0.245)	(0.177)	(0.172)	(0.185)	(0.176)
N	41787	41787	41787	41787	41787	41787
R^2	0.539	0.539	0.637	0.639	0.647	0.648
Dep. Var. Mean	2.629	2.629	4.353	4.353	4.592	4.592
State-County FE	Yes	Yes	Yes	Yes	Yes	Yes
Year FE	Yes	Yes	Yes	Yes	Yes	Yes
Kleibergen-Paap rk LM statistic						
Kleibergen-Paap rk Wald F statistic						

Standard errors in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 8: First Stage: No. of CPCs Specifications

	(1)	(2)	(3)	(4)	(5)
	No. of CPCs per 1000 women age 10-44	No. of CPCs per 1000 X Age 10-19	No. of CPCs per 1000 X Age 25-29	No. of CPCs per 1000 X Age 30-34	No. of CPCs per 1000 X Age 35-44
Exp. No. of CPCs per 1000 women age 10-44	1.181***	0.0388	0.0339	0.0384	0.0371
	(0.133)	(0.0239)	(0.0243)	(0.0229)	(0.0251)
Exp. No. of CPCs per 1000 X Age 10-19	0.0000462	0.998***	0.000244	0.000278	0.000258
	(0.00142)	(0.0399)	(0.000160)	(0.000167)	(0.000169)
Exp. No. of CPCs per 1000 X Age 25-29	0.00186*	0.000219*	1.000***	0.000119	0.000161*
	(0.000767)	(0.0000919)	(0.0404)	(0.0000718)	(0.0000645)
Exp. No. of CPCs per 1000 X Age 30-34	0.000457	0.000179	0.0000870	0.999***	0.000133
	(0.000574)	(0.000149)	(0.000106)	(0.0405)	(0.000110)
Exp. No. of CPCs per 1000 X Age 35-44	0.000581	0.000360	0.000259	0.000287	0.998***
	(0.00166)	(0.000212)	(0.000167)	(0.000162)	(0.0399)
Dist. Nearest Clinic	-0.000119	-0.0000237	-0.0000239	-0.0000237	-0.0000237
	(0.0000702)	(0.0000140)	(0.0000141)	(0.0000140)	(0.0000140)
Log Female Population Age 10-44	0.000328	0.000201	-0.00000328	-0.0000305	0.0000982
	(0.000352)	(0.000153)	(0.0000885)	(0.000102)	(0.0000859)
Age 10-19	-0.000241	0.00683***	-0.00000490	0.0000139	-0.0000795
	(0.000264)	(0.00119)	(0.0000644)	(0.0000721)	(0.0000636)
Age 25-29	-0.0000769*	-0.0000183	0.00691***	-0.00000163	-0.0000105
	(0.0000381)	(0.0000120)	(0.00121)	(0.00000760)	(0.00000686)
Age 30-34	-0.0000509	-0.0000276	-0.00000208	0.00695***	-0.0000148
	(0.0000541)	(0.0000218)	(0.0000115)	(0.00121)	(0.0000119)
Age 35-44	-0.000310	-0.000190	-0.00000484	0.0000185	0.00688***
	(0.000324)	(0.000142)	(0.0000795)	(0.0000897)	(0.00120)
Non-white Pop. Share	0.000185	0.000122	-0.0000512	-0.0000797	0.0000341
	(0.000308)	(0.000120)	(0.0000817)	(0.000102)	(0.0000781)
Non-white Share X Age 10-19	0.000000650	-0.00000245	0.0000403	0.0000461	0.0000358
	(0.0000591)	(0.0000447)	(0.0000256)	(0.0000296)	(0.0000270)
Non-white Share X Age 25-29	0.000158	0.0000443	0.000209*	0.00000965	0.0000287
	(0.0000958)	(0.0000327)	(0.000106)	(0.0000151)	(0.0000203)
Non-white Share X Age 30-34	0.000116	0.0000755	0.0000320	0.0000648	0.0000542
	(0.000105)	(0.0000469)	(0.0000265)	(0.0000977)	(0.0000287)
Non-white Share X Age 35-44	0.000161	0.0000914	0.0000405	0.0000386	0.0000897*
	(0.000139)	(0.0000569)	(0.0000311)	(0.0000286)	(0.0000420)
Unemployment rate	0.0000524	0.0000132	0.00000834	0.00000823	0.0000116
	(0.000730)	(0.000145)	(0.000147)	(0.000147)	(0.000144)
U.S. House GOP vote share	0.0000764	0.00000544	0.0000511	0.0000210	0.0000161
	(0.00384)	(0.000769)	(0.000762)	(0.000760)	(0.000772)
Protestant Share	0.00541	0.00125	0.00116	0.000904	0.00119
	(0.0406)	(0.00812)	(0.00808)	(0.00812)	(0.00814)
Other Religion Share	-0.0111	-0.00236	-0.00225	-0.00210	-0.00233
	(0.0214)	(0.00428)	(0.00433)	(0.00425)	(0.00429)
N	41787	41787	41787	41787	41787
R^2					
Dep. Var. Mean					
State-County FE					
Year FE					
Kleibergen-Paap rk LM statistic					
Kleibergen-Paap rk Wald F statistic					

Standard errors in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 9: First Stage: Distance Specifications

	(1) Dist. Nearest CPC	(2) Sq. Dist. Nearest CPC	(3) Dist. CPC X Age 10-19	(4) Dist. CPC X Age 25-29	(5) Dist. CPC X Age 30-34	(6) Dist. CPC X Age 35-44
Exp. Dist. Nearest CPC	0.419	-26.13	-0.0521	-0.0592	-0.0517	-0.0527
	(0.241)	(17.80)	(0.0464)	(0.0445)	(0.0465)	(0.0464)
Exp. Sq. Dist. Nearest CPC	0.00797*	1.250***	0.00157*	0.00165*	0.00158*	0.00158*
	(0.00366)	(0.223)	(0.000740)	(0.000713)	(0.000736)	(0.000742)
Exp. Dist. CPC X Age 10-19	0.000122	-0.00316	0.690***	0.0000235	-0.0000766	-0.000122
	(0.000297)	(0.0215)	(0.0333)	(0.0000860)	(0.000109)	(0.000107)
Exp. Dist. CPC X Age 25-29	-0.000311	-0.0464	0.0000157	0.690***	-0.0000258	-0.0000423
	(0.000279)	(0.0432)	(0.0000508)	(0.0332)	(0.0000661)	(0.0000851)
Exp. Dist. CPC X Age 30-34	0.000341	0.0194	-0.00000129	-0.0000117	0.690***	-0.0000567
	(0.000308)	(0.0231)	(0.0000736)	(0.0000736)	(0.0333)	(0.000111)
Exp. Dist. CPC X Age 35-44	0.000102	-0.00447	0.0000664	0.0000439	-0.0000201	0.690***
	(0.000250)	(0.0154)	(0.0000946)	(0.0000953)	(0.000123)	(0.0333)
Dist. Nearest Clinic	0.0416	4.006	0.00829	0.00841	0.00825	0.00830
	(0.0268)	(2.211)	(0.00537)	(0.00538)	(0.00535)	(0.00535)
Log Female Population Age 10-44	0.00616	2.583	-0.0252	-0.00514	0.0617	0.0959**
	(0.149)	(13.50)	(0.0424)	(0.0369)	(0.0452)	(0.0362)
Age 10-19	-0.00748	-1.810	2.613***	0.00319	-0.0431	-0.0669**
	(0.104)	(9.408)	(0.656)	(0.0256)	(0.0311)	(0.0252)
Age 25-29	0.00781	1.043	0.00110	2.606***	-0.00292	-0.00450
	(0.00979)	(1.240)	(0.00258)	(0.651)	(0.00303)	(0.00347)
Age 30-34	-0.00931	-0.790	0.00286	0.000909	2.581***	-0.00918
	(0.0152)	(1.133)	(0.00562)	(0.00448)	(0.652)	(0.00544)
Age 35-44	-0.00794	-2.186	0.0207	0.00348	-0.0543	2.516***
	(0.130)	(11.75)	(0.0374)	(0.0320)	(0.0386)	(0.651)
Non-white Pop. Share	-0.00448	2.287	-0.0212	-0.00411	0.0546	0.0838**
	(0.129)	(11.58)	(0.0374)	(0.0323)	(0.0390)	(0.0298)
Non-white Share X Age 10-19	0.0111	0.0254	0.00574	-0.000763	-0.00594	-0.00794
	(0.0141)	(0.966)	(0.00851)	(0.00404)	(0.00486)	(0.00435)
Non-white Share X Age 25-29	-0.0178	-1.381	-0.00331	-0.0341	0.00963	0.0148*
	(0.0256)	(2.571)	(0.00669)	(0.0261)	(0.00704)	(0.00580)
Non-white Share X Age 30-34	0.0170	1.126	-0.00576	-0.00169	0.0180	0.0186*
	(0.0319)	(2.590)	(0.00987)	(0.00834)	(0.0155)	(0.00861)
Non-white Share X Age 35-44	0.0121	0.839	-0.00434	0.000518	0.0153	0.0141
	(0.0373)	(3.247)	(0.0112)	(0.00945)	(0.0104)	(0.0104)
Unemployment rate	0.855***	88.56***	0.171***	0.170***	0.171***	0.170***
	(0.241)	(26.17)	(0.0483)	(0.0482)	(0.0481)	(0.0483)
U.S. House GOP vote share	-1.255	-66.27	-0.254	-0.249	-0.248	-0.252
	(1.551)	(116.2)	(0.310)	(0.311)	(0.310)	(0.310)
Protestant Share	5.070	1206.3	1.020	0.906	1.054	1.058
	(15.43)	(1603.8)	(3.083)	(3.067)	(3.115)	(3.096)
Other Religion Share	-0.938	-377.7	-0.177	-0.169	-0.243	-0.205
	(7.889)	(718.0)	(1.573)	(1.585)	(1.572)	(1.585)
N	41787	41787	41787	41787	41787	41787
R^2						
Dep. Var. Mean						
State-County FE						
Year FE						
Kleibergen-Paap rk LM statistic						
Kleibergen-Paap rk Wald F statistic						

Standard errors in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$