

# Ohio Crisis Pregnancy Centers Revealed

An investigative report  
and policy suggestions.

January 2013



**NARAL**  
Pro-Choice Ohio Foundation

# Executive Summary

About half (49%) of the 6.7 million pregnancies in the United States each year are unintended.<sup>1</sup> This means that each year, roughly 3.2 million women must make the decision to continue the pregnancy and parent the child, put the child up for adoption, or have a legal abortion. When faced with this decision, women deserve comprehensive, non-judgmental and medically-accurate information and advice in order to make a fully informed decision. Unfortunately, when Ohio's women turn to one of more than 100 crisis pregnancy centers (CPCs) in their state, they get something very different.

After spending decades trying to shut down legitimate reproductive health clinics and failing, anti-choice activists have turned to a new strategy: building a nationwide network of unregulated organizations posing as health care providers and option-comprehensive counseling services. At best, these centers give incomplete information to women facing unintended pregnancies. At worst, they flat-out lie to women, with the intention of coercing them out of having an abortion.

In Ohio, CPCs get support from the State in two ways. First, through financial support via the sale of "Choose Life" license plates (each time a plate is sold, \$20.00 is put into a fund that is then distributed to CPCs in their county or an adjacent county); and second,

prominent inclusion in a resource guide ("Where to Get Help with Your Pregnancy") created by the Ohio Department of Health, which is required to be offered to patients at all abortion clinics in the state.

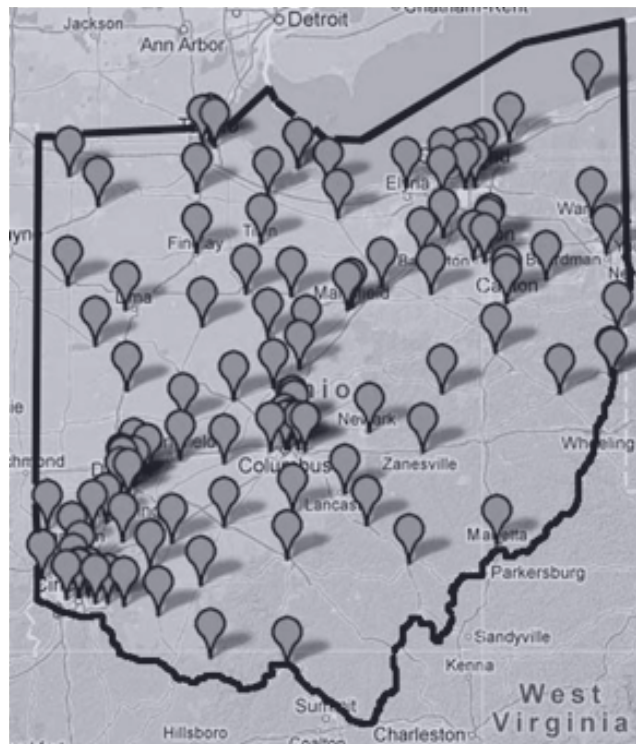


Figure EC-1: Locations of the 107 Ohio Crisis Pregnancy Centers

## THE RESEARCH

Based on information gathered in other states about the operations of these centers, NARAL Pro-Choice Ohio embarked on a yearlong investigation of more than 100 crisis pregnancy centers in Ohio. Our investigation included phone calls to all 107 centers in the state, and in-person visits to a randomly-selected sub-set which represented nearly half of the centers in the state. These visits were divided into five different scenarios portrayed by our investigators, which were randomly assigned to the visit locations. The scenarios included positive and negative pregnancy test results and situations where the investigator indicated they already took a pregnancy test, and included the investigator indicating that she was leaning towards a variety of decisions on what to do with the unplanned pregnancy, from completely undecided to completely convinced that she wants an abortion.

Information was collected about the processes inside the facility, including confidentiality forms and other paperwork, the attitude of the person they interacted with in the facility, and the content of the “counseling session.” The research sought to answer the following questions:

- What was the demeanor of staff or volunteers working in the center;
- What, if any, confidentiality processes did these centers have;
- Is the information presented at the centers medically accurate and comprehensive information as advertised by the centers;
- Is the information being presented in a non-judgmental fashion without bias?

## RESULTS

Most CPCs seemed to have a general script that they followed with clients during the intake process. They most commonly asked about the client’s relationship with the client’s boyfriend (34%), closely followed by the relationship with parents (25%) and religious beliefs (22%). Unfortunately, CPCs rarely ask about sexual violence and relationship abuse (5% and 4% respectively). This is especially concerning since pregnancy is a particularly dangerous time for women.<sup>2,3,4</sup> Less than half of the centers were upfront about who they were and what they stood for, with 42 % stating that they were pro-life, and 60% being unwilling to admit that they were not medical facilities.

Although CPCs advertise non-judgmental and comprehensive counseling about all of a woman’s options regarding unplanned pregnancies, this is not what our investigators found when they walked through the doors. In 34 of the visits the investigator felt that the counselor had a judgment about the decision she indicated, and in 53% of those, the investigator felt that the counselor had a negative reaction to her decision. The untruths counselors told our investigators to try to persuade them to not have the abortion were a host of anti-choice talking points, none of which are backed by scientific evidence, including the high health risks a woman faces when having an abortion, the connection between abortion and breast cancer and the connection between abortion and mental health problems.

In almost 11% of the cases, the CPC worker also used the services that are available

to women at their facility to persuade the investigator to not have an abortion. But less than 2% of the centers actually provided direct medical care to women at their center. The majority of the “service” they provide is limited material support and usually only for a short amount of time.

Free ultrasound services are an emerging trend in CPCs. In 38% of the cases where the investigator presented as if she were pregnant, the CPC offered the woman an ultrasound. The most common reason that the center gave for the patient having an ultrasound was to make sure it was a viable pregnancy. This line of reasoning was also seen in other states. It is part of a larger scheme to delay a woman’s decision to have an abortion by exaggerating the risk of miscarriage and advising her to not make the decision now because she may miscarry later. Although the real rate of miscarriage in the US is 13%<sup>5</sup>, the CPCs that we visited gave a variety of answers on this subject, ranging from 25-33%, figures that more than double the actual rate.

When our investigators inquired on the phone whether or not the CPC would give them a referral to an abortion provider, they were told that they would not provide those services in all cases. But when the investigators asked during their visits, they were told 15% of the time that the CPC would help with that information. As their visits progressed, however, the investigators determined that this was not the case. Ten percent of the CPCs circled back and said that they would only give information about abortion and 5.5% gave the investigators a referral to a post-abortion “healing” organization rather than a qualified abortion provider. Only one center gave out a specific

location.

In the first scenario, where the pregnancy test came back negative, the investigators inquired about access to birth control so that they wouldn’t have another pregnancy scare. Only one CPC told our investigator that they provided birth control services, but as the visit progressed, they learned that they were only willing to discuss natural family planning. When the investigators asked why they didn’t provide birth control, the answers included: the CPC not being a medical facility, that they only recommend abstinence, that they were a Christian facility, that birth control was not effective, and that birth control causes abortions.

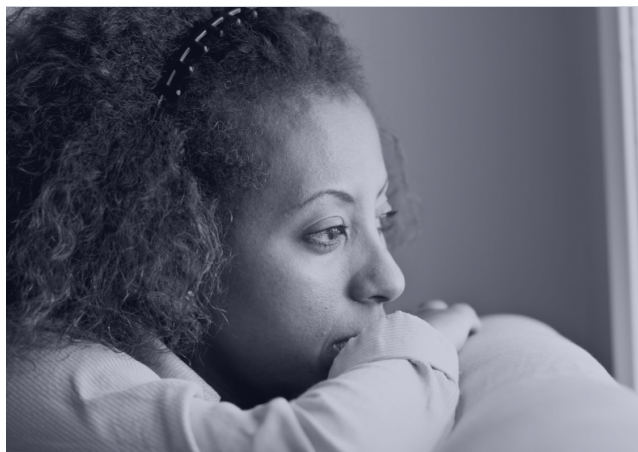


## DISCUSSION & POLICY SUGGESTIONS

This research creates a comprehensive picture of the environment created by crisis pregnancy centers in Ohio. It also creates a compelling case for state and local intervention so that we can ensure that women are aware of the limitations of CPC services

while also ensuring that women receive the medically accurate information that they need to make a decision on what to do with an unintended pregnancy. Based on our research findings, we suggest the following policy changes:

1. Require that in consumer outreach materials, CPCs be honest about the services and referrals they do and do not provide.
2. Require that the Ohio Department of Health Resource Directory “Where to Get Help With Your Pregnancy” list only facilities that provide comprehensive, non-directive, and medically and factually accurate information.
3. Require that facilities that receive funding from the “Choose Life” license plate be required to give medically and factually accurate information to the clients that seek their services.
4. Assess the need for regulation of CPCs by examining the effectiveness, accuracy, and comprehensive nature of the information and services CPCs in Ohio provide. Engage in efforts to educate Ohio citizens about CPCs and the risk they may pose to pregnant women.
5. Support comprehensive family planning programs that reduce the rate of unintended pregnancy in Ohio.



By requiring crisis pregnancy centers to be transparent in their operations and give women information that is medically accurate and free from intimidation and coercion, we can curb CPCs’ deceptive and misleading practices and ensure that women who want accurate information about all their medical options get just that. When women are bullied, manipulated, or misled about their health-care information, they may delay accessing legitimate care. NARAL Pro-Choice Ohio Foundation believes that women must not be misled when trying to make personal medical decisions. These decisions need to be made with factual and unbiased information and counseling so that a woman is equipped to make the best decision for herself and her family.

## NOTES

1. Finer, Lawrence B. and Zolna Mia R., “Unintended pregnancy in the United States: incidence and disparities, 2006,” *Contraception*, 84 (August 2011):478–485.
2. Healthy Teen Network, Making a Difference... Healthy Teen Network Resource Guide, Interpersonal violence and adolescent pregnancy. <http://www.capd.org/pubfiles/pub-2001-11-01.pdf> (August 28, 2012).
3. Chang, Jeani, Berg, Cynthia J., Saltzman Linda, E., Herndon, Joy. “Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999,” *American Journal of Public Health* 95 (March 2005):471-477.
4. Silverman, J.G., Decker, M.R., Reed, E., Raj, A. Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health. *American Journal of Obstetrics and Gynecology* 2006; 195(1): 140-148.
5. Guttmacher Institute, Are you IN THE KNOW? <http://www.guttmacher.org/in-the-know/pregnancy.html> (May 21, 2012).

# Methods

The research began by identifying the centers that were operating in Ohio. To create the most comprehensive list of crisis pregnancy centers possible, we conducted searches online using web-based yellow pages and anti-choice websites such as Ohio Right to Life and Optionline to identify as many CPCs as possible. Initial calls were made to all centers on the list and we found that several had combined with others in their area or simply closed down since the listings were created. Through this process we identified 107 functioning CPCs in Ohio.

All 107 were contacted via a telephone survey process. In this short survey, the person answering the phone was asked what basic services were available, when the facility was open, if an appointment needed to be scheduled, what the visit would entail (including any fees for the services they provide), whether they offered referrals for abortion, and what kind of medical personnel they had on-site.

Of the 107 centers operating in Ohio, we conducted in-person visits to 55. These centers were selected at random using a random number generating feature in Microsoft Excel. To gather as much different information as possible, the 55 CPC visits were also randomly distributed into five different scenarios, using a random number generating program in Microsoft Excel.

The five scenarios were as follows:

1. The investigator posing as the client went to the CPC and asked to have a pregnancy test because she thought she was pregnant. The test results came back negative and the investigator was instructed to ask for birth control information.
2. The investigator posing as the client was instructed to tell the counselor that they already took a home pregnancy test and that it had come back positive. They asked for counseling. They were instructed to tell the counselor that their boyfriend wanted to keep the baby but that the investigator wasn't sure what she wanted to do.
3. The investigator posing as the client was instructed to tell the counselor that they already took a home pregnancy test and that it had come back positive. They asked for counseling. They were instructed to tell the counselor that their boyfriend wanted an abortion and the investigator didn't know what she wanted to do.
4. The investigator posing as the client brought a urine sample from a pregnant volunteer with her to the center and asked for a pregnancy test. The urine sample was used and a positive pregnancy test resulted. The investigator was instructed to tell the counselor that she was undecided and didn't know what to do.
5. The investigator posing as the client brought a urine sample from a pregnant volunteer with her to the center and asked for a pregnancy test. The urine sample was

used and a positive pregnancy test resulted. The investigator was instructed to tell the counselor that she was sure she wanted an abortion.

The in-person survey was a very detailed process and the investigators were tasked with surveying all parts of the CPC visit—from the CPC’s decor and available materials to the content of the conversations. Because the information captured was so detailed, we sent the investigators into the CPCs in teams of two, with one posing as the patient and the other as a friend so there would be two people to provide a comprehensive report of their experiences.

Before the investigators began the research they were fully trained in each scenario and the best practices for collecting research data. They were not given an exact script to follow to allow for a more natural flow for each visit. The data sheet that was completed immediately following each visit provided the investigators with the topics that they should try to cover during each visit or call, but allowed them to do the data collecting in whatever order or format worked best for the individual visit. They were encouraged to create details about their lives in each scenario that would be easy for them to remember but to keep these details the same in each visit in order to be able to compare visits between centers.

The teams recorded information on the visit data sheet detailing the information that they were given by the volunteer or staff member at the facility. This information included details about the appearance of the facility, whether or not it was located near a Planned Parenthood or other comprehensive women’s health center, what kind of people

they interacted with (volunteers, staff, medical personnel), what the “counseling” session included, whether or not they signed confidentiality documentation, whether the center disclosed that they were not a full service medical facility and that they did not refer to abortion providers, whether they identified as religiously-affiliated, as well as other details of the visit. The specific statements made by different locations were grouped into subject areas for data analysis on each area of the investigation.

The investigators also gathered as much information (pamphlets, brochures) as they could from the CPC’s they visited. Several CPCs gave the teams DVDs and videos to watch to help make their decision. All of this information was captured and analyzed.

The researchers had cell phone numbers to leave as contact information at the centers they visited, and used volunteers’ addresses as a mailing address. Very little contact happened after the visit. Less than 10% of the centers followed up, and, for the most part, the follow-up just included a thank you message for visiting the center. Because of this small quantity of follow up communication, these communications were not analyzed for the report.

# Introduction

Each year roughly half of the pregnancies in the United States are unintended.<sup>1</sup> When facing this uncertain time, women and their partners need care and support to help them make the best decision for them and their situation. At this time, it is critical that women can turn to a trusted professional who will provide them with unbiased, non-judgmental, and medically accurate information about their pregnancy and all of their options.

When these women type in “pregnancy support” or “pregnancy counseling” into an internet search engine (like Google) or look in a phone book for help they will most likely find a crisis pregnancy center (CPC) that advertises to provide them with just that, a place where they can go to get counseling and information about all of the options they have.<sup>2</sup> Unfortunately what they find when they walk into these centers could be very different from the services advertised.

## AN OVERVIEW OF CPCs IN OHIO

CPCs are facilities that advertise free services to women facing unintended pregnancies while promoting an anti-choice agenda. Most of these centers provide one or more of the following services: free pregnancy testing, ultrasound services (or referrals), counseling, and some short-term material

assistance for women who intend to give birth (maternity clothing, baby formula and baby supplies).<sup>3</sup> Many of these centers do not employ medically licensed staff, but are volunteer-run and staffed by volunteers with limited training.

State resources in Ohio support CPCs through two main mechanisms: a resource guide produced by the Ohio Department of Health and required to be provided to all women seeking abortion care, and a funding mechanism through the production and sale of “Choose Life” license plates.

Ohio law<sup>4</sup> requires doctors who provide abortion services to offer every patient a state created resource directory titled “Where to Get Help with Your Pregnancy.”<sup>5</sup> This guide, created by the Ohio Department of Health, is supposed to help women find the medical and support services they need to help them through their pregnancy. Unfortunately this is not the case. Seventy-nine percent of the CPCs that were visited in this investigation were listed in this guide, indicating to the women of Ohio that they are legitimate service providers vetted by the Ohio Department of Health.

In May 2005, Ohio began the sale of “Choose Life” license plates. These specialty license plates generate \$20.00 from the sale of each plate which is directed to “eligible private, nonprofit organizations that provide ser-



vices committed to counseling pregnant women about the option of adoption.”<sup>6</sup> Although the funding qualifications do not explicitly mention CPCs, 60% of the income from the 2011-2012 funding cycle went to CPCs, totaling \$30,096.71.<sup>7</sup> Although this is not state funding for these centers, the state produces the license plate, and the Ohio Department of Health is charged with creating the funding requirements, reviewing requests for funding, and collecting and reporting on funding reports from the centers that receive funding through the funding stream. This funding mechanism for CPCs implies that the state has vetted the information given out by these centers while also implying an endorsement of their practices.

In Ohio, comprehensive women’s health clinics that provide abortion services are outnumbered by crisis pregnancy centers seven to one (107 vs. 15). Figure I-1 shows the locations of the CPCs identified by NARAL Pro-Choice Ohio for this study. Figure I-2 shows the locations of comprehensive women’s health clinics.

Because these facilities are not medical clinics and are not regulated as such, it is much easier for one of these volunteer led centers to be created in small towns across the state. In comparison, 91% of the counties in Ohio have no abortion provider.<sup>8</sup> This means that a woman facing an unintended pregnancy is much more likely to find a CPC in her community than a full service women’s health clinic. Many CPCs are affiliated with and receive funding from national anti-choice groups, including Birthright, Heart-beat International, and Care Net.

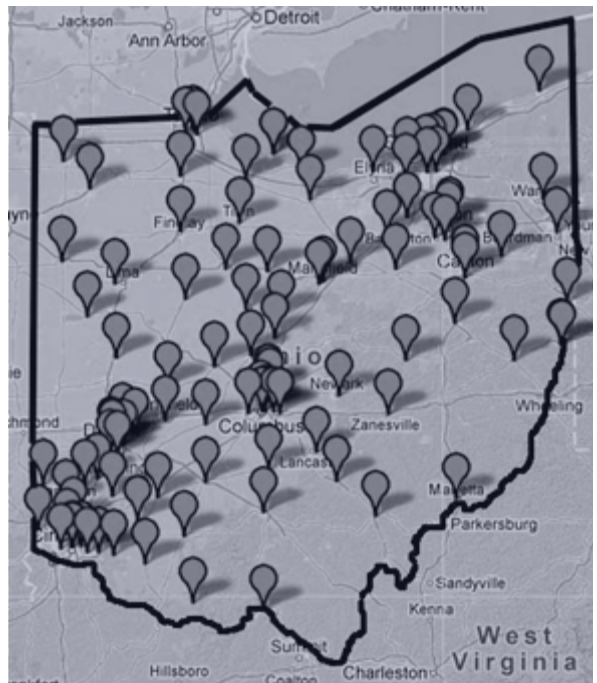


Figure I-1: Locations of the 107 Crisis Pregnancy Centers in Ohio

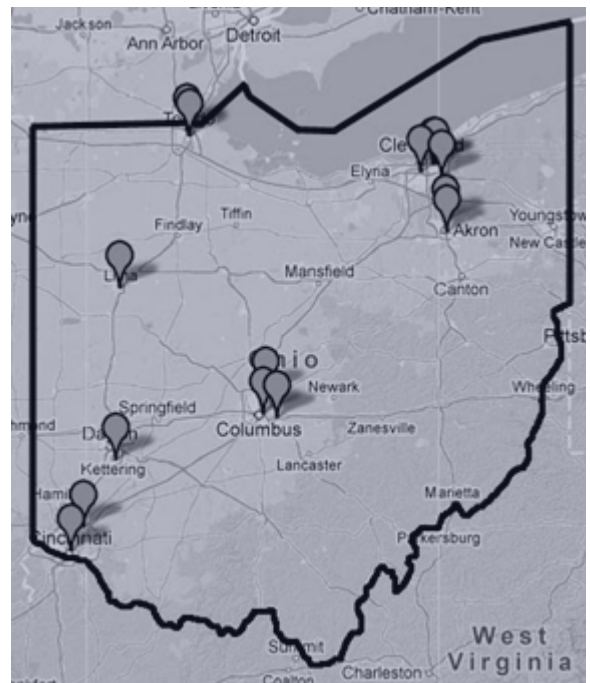


Figure I-2: Locations of the 15 Comprehensive Women’s Health Clinics in Ohio

## CPCs TARGETING VULNERABLE POPULATIONS

CPCs target women in a variety of ways. First, they deceive patients with the images they use to advertise as well as the names given to their facilities. When you look through the list of these centers in Ohio you see names like, “Women’s Care Center”, “A Caring Place Pregnancy Help Center”, “Cleveland Pregnancy Center”, and the “Women’s Clinic of Columbus”. These centers purposely create names similar to comprehensive women’s health centers so that women are confused as to which centers are in fact comprehensive health centers and which centers are these fake clinics.

Second, some CPCs purposely set up their offices near comprehensive women’s health centers so that they can try to convince women to come to the CPC instead of the comprehensive health centers. Of the 15 comprehensive women’s health centers in Ohio, three have a CPC within a block of their location and one has two different CPCs within a block of the health center. In total, seven of the 15 comprehensive health centers in Ohio have a CPC within a one mile radius.

A third tactic CPCs use to target vulnerable populations is locating their centers near college campuses. In fact, one of the national CPC organizations, Care Net, even advertises this targeting on their website:

*Care Net also recognizes the need to offer pregnancy center services to women on college campuses. Therefore, Care Net is developing a college campus initiative that aims to reach these underserved areas.<sup>9</sup>*

This pattern is seen in Ohio. Eleven of the 14 state universities in Ohio have a CPC within five miles of the campus, and all 14 universities have a CPC within 17 miles of the campus.

Over the last few years NARAL Pro-Choice Ohio has received many anecdotal stories about what happens within the walls of a CPC, and several other states have conducted investigations into their practices. We chose to undertake this research to look into how pervasive the use of misinformation and coercion is in CPCs in Ohio and to identify common practices among the centers in our state. The research sought to answer the following questions:

- What was the demeanor of staff or volunteers working in the center;
- What, if any, confidentiality processes did these centers have;
- Is the information presented at the centers medically accurate and comprehensive information as advertised by the centers;
- Is the information being presented in a non-judgmental fashion without bias?

We hope that the contents of this report provide the women of Ohio with an accurate picture of what they will encounter if they go to one of these centers, and the information that they need to be empowered to make the best decisions possible for their lives when facing an unplanned pregnancy.

## NOTES

1. Finer, Lawrence B. and Zolna Mia R., "Unintended pregnancy in the United States: incidence and disparities, 2006," *Contraception*, 84 (August 2011):478–485.
2. For example when "pregnancy counseling Ohio" was typed into a Google search on 8/28/2012 three of the four advertisements on the page are CPCs, and of the 10 listings on the first page of the search results, six of the results were direct links to CPCs, one link was to a student health center at The Ohio State University and the other three were links to directories of local CPCs.
3. For example please see the the following source: CareNet, About Us, <https://www.care-net.org/aboutus/> (August 28, 2012).
4. Ohio Revised Code (ORC) Sec 2317.56(B)2b details out the requirement that the doctor who will perform the abortion must give out the materials created by the Ohio Department of Health. ORC Section 2317.56(C)1 details the requirement that the Ohio Department of Health shall cause to be published "materials that inform the pregnant woman about family planning information, of publicly funded agencies that are available to assist in family planning, and of public and private agencies and services that are available to assist her through the pregnancy, upon childbirth, and while the child is dependent, including, but not limited to, adoption agencies." LAWriter. Ohio Laws and Rules, <http://codes.ohio.gov/nllxml/ohiocodesGetcode.aspx?statecd=OH&codesec=2317.56&sessionYr=2011&Title=23&version=1&datatype=S&cvfilename=OHstatcv2011title23Chapter2317.htm&noheader=0&nojump=0&userid=PRODSG&Interface=OHCODES&filename=OHstatcv2011title23Chapter2317.htm> (August 28, 2012).
5. Ohio Department of Health, <http://www.odh.ohio.gov/odhprograms/dspc/infcons/infcons1.aspx> (August 14, 2012)
6. Ohio Bureau of Motor Vehicles, Choose Life License Plates, [http://bmv.ohio.gov/sp\\_choose\\_life.stm](http://bmv.ohio.gov/sp_choose_life.stm), (August 15, 2012).
7. Ohio Choose Life, Distribution of Funds, <http://www.ohchoose-life.org/distributions.php> (August 15, 2012) .
8. Jones Rachel K. and Kooistra, Kathryn, "Abortion Incidence and Access to Services in the United States, 2008," *Perspectives on Sexual and Reproductive Health*, 43 (2011): 41-50.
9. Care Net, Our Work, [www.care-net.org/ourwork/](http://www.care-net.org/ourwork/) (May 30, 2012)

# Intake Procedures at Crisis Pregnancy Centers

For a pregnant woman, accessing health care is an immediate need, and regardless of the pregnancy outcomes she ultimately chooses, delaying care threatens her health. However, our research found that crisis pregnancy centers (CPCs) in Ohio were not as readily available for walk in visits as they purported to be on their websites and in their voicemail messages. This delay increases the likelihood that a woman will access abortion later in her pregnancy when services are more expensive, more complicated, and more difficult to obtain.<sup>1</sup> It can also result in delayed access to appropriate prenatal care if a woman chooses to carry her pregnancy to term.<sup>2</sup> Further, these delays are compounded by the fact that when a woman does get an appointment at a CPC, she does not get the counseling services the CPCs claim to provide. Instead, as our report's findings also indicate, and as will be discussed in further detail in future sections, she receives biased and medically inaccurate information. Ultimately, we are deeply concerned that these multiple delays are at least in part an effort to cause clients to delay seeking legitimate pregnancy-related care until it was too late to obtain an abortion.<sup>3</sup>

One of the first things we learned in this research was that it was much more difficult to access the CPC services than it appears in their advertising. The investigators had a difficult time reaching the CPCs via phone, and the information CPCs gave on their

websites about their hours of operation and the services they provided was inconsistent with what investigators encountered when they arrived at CPCs in person. In eight percent of our visits, the investigators encountered a center that had changed its hours (in one case the hours were different than the hours given over the phone a few days before the visit) or moved its facility from the location listed on-line, making it difficult to schedule an appointment or find the center. When legislators and leaders in the anti-abortion movement talk about CPCs, they often assert that CPCs are well-run and easily accessible to women. But our investigators' research contradicted those assertions. These findings are of particular concern given that, whichever option a pregnant woman chooses, the sooner she receives care, the better her health outcome.

*"I had called prior to the visit for their hours of operation and was told that they were available on Fridays 10-1pm. We arrived early and waited until 10:15am and no one came to open the center. Their hours were even posted on their door."*

*-CPC investigator comment*

Our findings regarding CPCs' intake procedures also were troubling. When any person walks into any health-care facility, they expect a certain standard of care. This expectation starts with intake, where a reasonable client will enter trusting that the staff will be upfront about their processes, the services they offer, and whether their counseling practices are motivated by an ideological agenda.

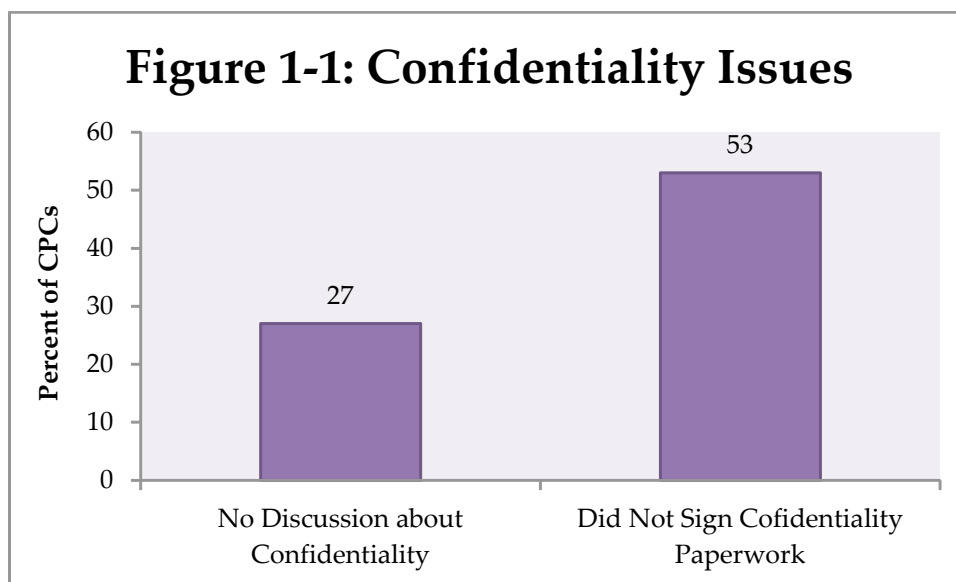
When a patient arrives at a comprehensive health-care clinic, one of the first things they have to do is sign confidentiality paperwork, outlining how and when medical information about the person is released and to whom it is released. Because CPCs are not medical centers, it is unclear what privacy rules they have to follow. Are they governed by the same kind of rules that legitimate providers are held to under federal HIPAA laws? Most likely they are not covered under these same rules, so are there any confidentiality rules that CPCs have to follow to protect the personal and private medical and relationship information they collect from the clients who use their

services? If they are not governed by patient confidentiality rules, it should clearly be communicated to the women using their services.

In more than a quarter (27%) of the visits there was no discussion of confidentiality at all, and in more than half of the visits there was no paperwork signed that outlined what information would or would not be kept confidential (Figure 1-1).

In addition to the basic discussion of confidentiality, we wanted to see what other kinds of questions were asked during the intake process, and what information they gave the investigators about their volunteers, staff, and center policies and procedures.

First, we looked at how or whether CPCs were fully disclosing their true purpose. Our investigation revealed some troubling trends. Only 42 percent openly stated that they opposed abortion. Sixty percent of the centers failed to disclose that they were not a medical facility and 80 percent did



not disclose that the counselor may not be professionally trained and certified. It was only when our investigators directly inquired as to whether or not they could get a direct referral that the CPC volunteer or staff member disclosed that they would not do that (97 percent of centers responded that they would not refer to an abortion provider when asked directly for the referral).

Figure 1-2 shows the nature of the questions counselors asked women during the intake portion of the visit. The intake conversation covered deeply personal topics that, unsolicited, would be inappropriate in a medical environment. Most commonly, investigators were met with questions about boyfriends and parents (34 percent and 25 percent, respectively). Nearly 28 percent of the visits included questioning about the client’s religious beliefs. Noticeably lacking in the intake conversations were questions that you would normally expect in a medical environment. Questions about possible history of sexually transmitted infections was asked in only nine percent of the visits, while questions related to birth control use and

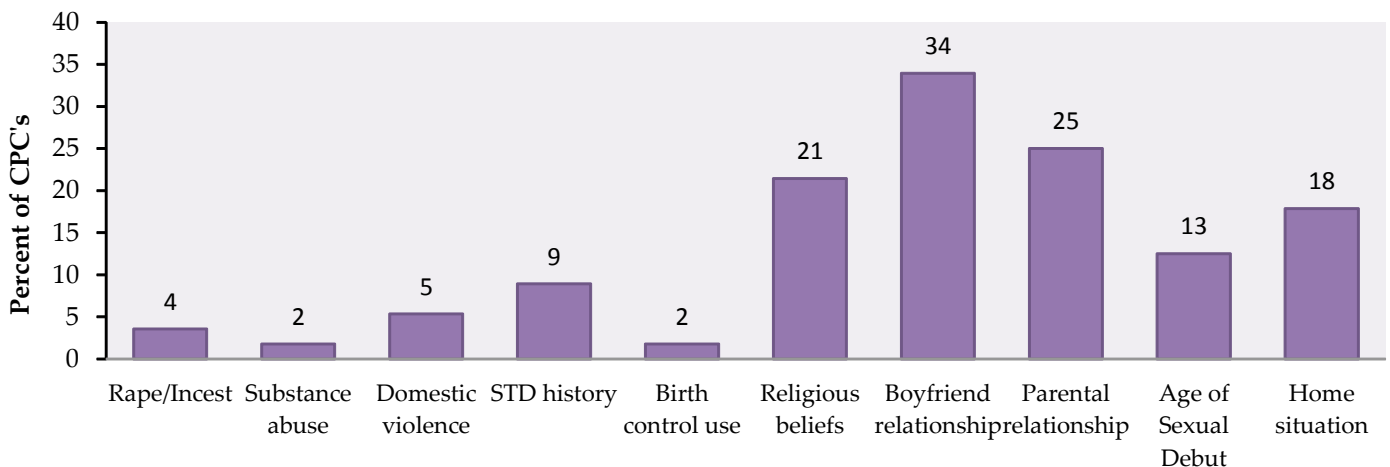
substance abuse were asked in only two percent. Alcohol use, especially in early pregnancy, can cause major developmental issues, making the absence of a discussion about substance abuse especially concerning.

*“She asked multiple questions about my relationship with God and if I had accepted Jesus into my heart. She asked what my plans were, how long I’ve dated my boyfriend, if he and my parents would be supportive, if I had a good home situation. She also asked if I was planning to keep it and tried persuading me with religion.”*

- CPC Investigator

Given CPCs’ willingness to ask such probing and non-medical questions, it was also concerning to us how few CPCs asked questions about whether the women had experienced domestic violence or were survivors of

**Figure 1-2: Intake Conversation Subject Areas**



sexual assault. This part of the intake process is critical to a pregnant woman's health and safety because homicide is the second leading cause of traumatic death for pregnant and recently pregnant women in the U.S.<sup>4</sup> As many as two-thirds of adolescents who become pregnant were sexually or physically abused at some point in their lives,<sup>5</sup> and women experiencing abuse in the year prior or during a recent pregnancy are much more likely to experience complications in their pregnancies.<sup>6</sup>

CPC staff who did not discuss confidentiality or did not provide confidentiality policies to sign, conducted more in depth interviews, asking sensitive information about the client's medical history. The topic of sexually transmitted infections was only discussed in nine percent of the visits overall, but was discussed in 21 percent of the visits where confidentiality was not discussed and in 40 percent of the cases where no confidentiality paperwork was signed. There were also distinct differences between CPCs that received funding from the Choose Life license plates and those that did not. CPCs that did and did not receive funding were equally as likely to ask about religious beliefs and relationships with parents and boyfriends, but none of the CPCs that received funding from the Choose Life License Plate Fund asked about history of rape or incest, substance abuse, domestic or relationship violence, history of sexually transmitted infection or birth control use.

When a person goes into a center for any kind of medical advice or counseling they expect that their information, by law, will be kept confidential. But when a woman in Ohio walks into a CPC for a pregnancy test, ultrasound, or counseling, that is not guar-

anteed. The discussions that occur when a woman is trying to figure out how to deal with an unplanned pregnancy can be some of the most personal conversations she will have, and she deserves for that information to be kept confidential.

## NOTES

1. National Institutes of Health, U.S. Library of Medicine, Abortion--surgical: MedlinePlus Medical Encyclopedia (2009), <http://www.nlm.nih.gov/medlineplus/ency/article/002912.htm> (October 27, 2010).
2. 12th & Delaware Dir. Rachel Grady and Heidi Ewing, Prod. Sheila Nevins. Home Box Office 2010. DVD.
3. 12th & Delaware Dir. Rachel Grady and Heidi Ewing, Prod. Sheila Nevins. Home Box Office 2010. DVD.
4. Chang, Jeani, Berg, Cynthia J., Saltzman Linda, E., Herndon, Joy. "Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999," *American Journal of Public Health* 95 (March 2005):471-477.
5. Healthy Teen Network, Making a Difference... Healthy Teen Network Resource Guide, Interpersonal violence and adolescent pregnancy. <http://www.capd.org/pubfiles/pub-2001-11-01.pdf> (August 28, 2012)
6. Silverman, Jay G., Decker, Michele R., Reed, Elizabeth, and Raj, Anita, "Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health," *American Journal of Obstetrics and Gynecology* 195 (July 2006): 140-148.

# Ultrasound Services at Crisis Pregnancy Centers

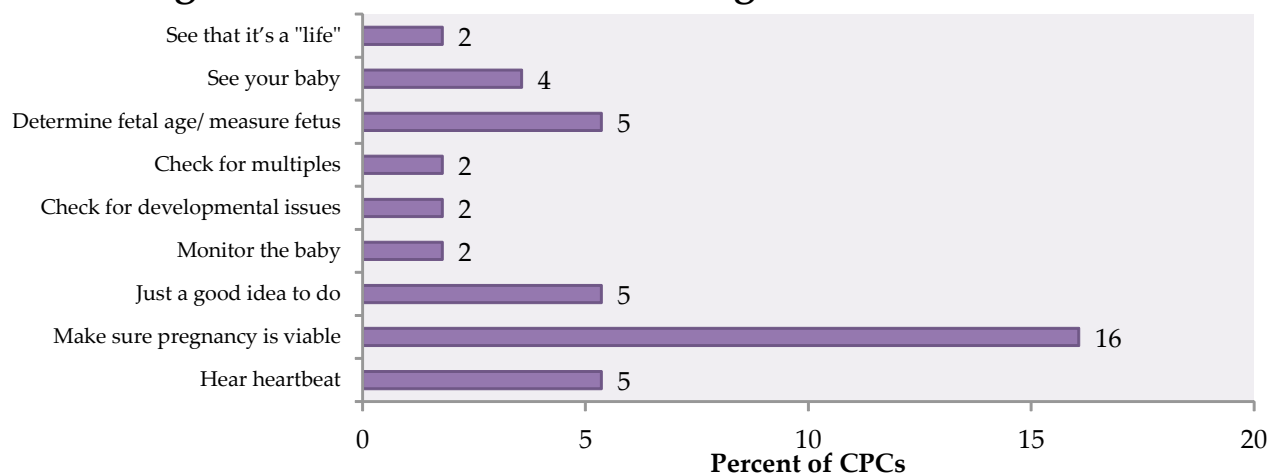
Many CPCs are acquiring limited medical equipment, and, sadly, our findings indicate that this trend has not changed their bad practices. It is of great concern to the NARAL Pro-Choice Ohio Foundation that many CPCs, while presenting themselves as medical facilities, do not disclose the limited nature of their medical services. An increasing number of CPCs are offering ultrasounds to women; however, the impetus behind offering this procedure appears chiefly to be to intimidate and shame women, and ultimately to deter them from accessing safe, legal abortion.

Why do CPCs want women to have an ultrasound? We know from quotes on various websites<sup>1</sup> that these centers were excited to add ultrasounds to their services because they assumed that once a woman saw her

ultrasound she would not have an abortion. According to one CPC's website: "Statistics show that more than 70% of women considering an abortion who see their baby on an ultrasound choose life. That is an amazing success rate. Yet, 86.9% of women considering an abortion who see their baby [at our location] choose life. In our humble opinion, that is God using our ministry with great effectiveness."<sup>2</sup> While an ultrasound can be an important tool for doctors when used for medically necessary reasons, these quotes indicate that their intent is not medical at all, but rather to use ultrasound as a tool of persuasion and manipulation.

But it seems that the reasons given to clients when they visit the CPC do not follow the reasons that CPCs give through their website or in public testimony (Figure 2-1). In

**Figure 2-1: Reasons CPC worker gave for ultrasound need**



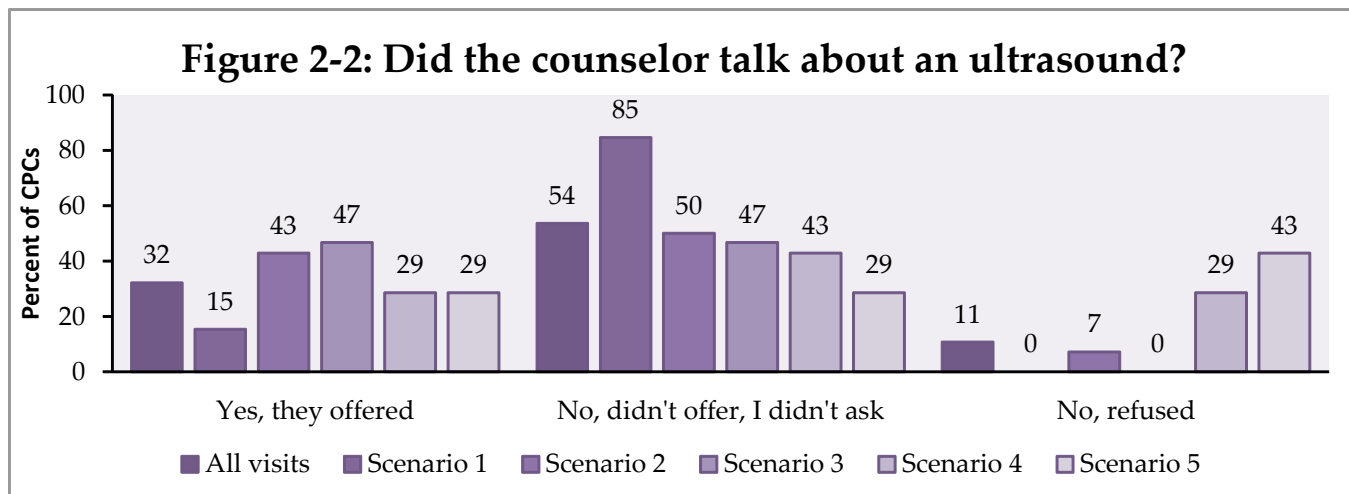


only 11 percent of our visits was the reason given for the ultrasound comparable with statements on a CPC’s website, for example, to “see that it’s a life” (1.8%), “see your baby” (3.6%) or “hear the heartbeat” (5.5%).

Instead, when discussing the need for ultrasound in person, our investigators found that in 27 percent of the cases, the reasons that the counselor told the woman she needed an ultrasound were medical in nature: to “determine fetal age” (5.5%), “see if there were multiples,” “see developmental issues,” “monitor the baby” (all 2%) and “make sure that it is a viable pregnancy” (16%). Thankfully, a small percentage of the counselors were completely open with our investigators, telling them that the ultrasound that was provided in their location was not the same as the one that they would get in a doctor’s office, and that they recommended the woman go to a medical facility to obtain a medical ultrasound to really diagnose potential problems with the pregnancy or development of the fetus. But unfortunately that was not the case in the majority of our visits. Ninety five percent of CPCs did not mention that their ultrasound was non-diagnostic and limited in scope.

Overall, a third of all CPCs we visited talked about an ultrasound (33%). It was most common for the CPC to mention and encourage an ultrasound to investigators who didn’t take the pregnancy test at the CPC. In this scenario, the investigators asked for counseling, saying that they already took a pregnancy test at home (Figure 2-2).

In addition, CPC staff used the ultrasound to disparage abortion providers. For example, CPC representatives at seven percent of the locations we visited stated that the client should have an ultrasound at the CPC because if they go to the abortion clinic, the clinic workers don’t care enough to tell you if the pregnancy is not viable. The CPC counselor also used the ultrasound to reinforce assertions that abortion has a life-long impact on the client’s mental health. For example, CPC staff stated that without an ultrasound the client would never know that the pregnancy was not viable and would have to live with the fact that she killed her baby her whole life, despite it not being viable. CPC rhetoric around ultrasounds is yet another example of dishonesty promulgated by many of the CPCs in our study.



In addition to in-house ultrasound services inside CPCs, the new trend is to offer ultrasounds via mobile RV based units. CPCs are frequently located near legitimate clinics to confuse women and lure them into the CPC rather than the medical clinic. These mobile RVs are an extension of that practice, allowing them to multiply the number of clinics where they can employ this deceptive tactic, and easily move from location to location based on clinic schedules.

Ultrasound services are becoming more and more available in CPCs across the state. Unfortunately the centers are using the availability of these services to continue to delay access to abortion services and mislead and shame women who are considering having an abortion.



Figure 2-3: Image of the Image Clear Ultrasound parked outside of the Preterm Clinic on Shaker Blvd. in Cleveland.

This Ultrasound RV parks outside of various clinics in northeast Ohio. From their website: “It is our mission to provide every single woman experiencing an unplanned pregnancy the free opportunity to confirm that pregnancy via a limited obstetrical ultrasound and see her unborn child in order to make an informed life-affirming decision and hear the good news of the Gospel of Jesus Christ.”<sup>3</sup>

1. For examples please see the following sources: Pregnancy Decision Health Centers, Who We Are, <http://www.pdhc.org/people/who-we-are/> (August 14, 2012); and NARAL Pro-Choice Ohio, Video of testimony delivered by the director of the Ashland Care Center, Ducia Hamm in support of Ohio H.B. 125, <http://vimeo.com/20625873> (August 14, 2012).
2. Image Clear Ultrasound: Our Mission <http://icumobile.org/site/why-mobile/our-mission/> (August 14, 2012).
3. ICU Mobile, Frequently Asked Questions, <http://icumobile.org/site/abouticumobile/frequently-asked-questions/> (August 14, 2012).

# Judgment Towards Client Decisions at Crisis Pregnancy Centers

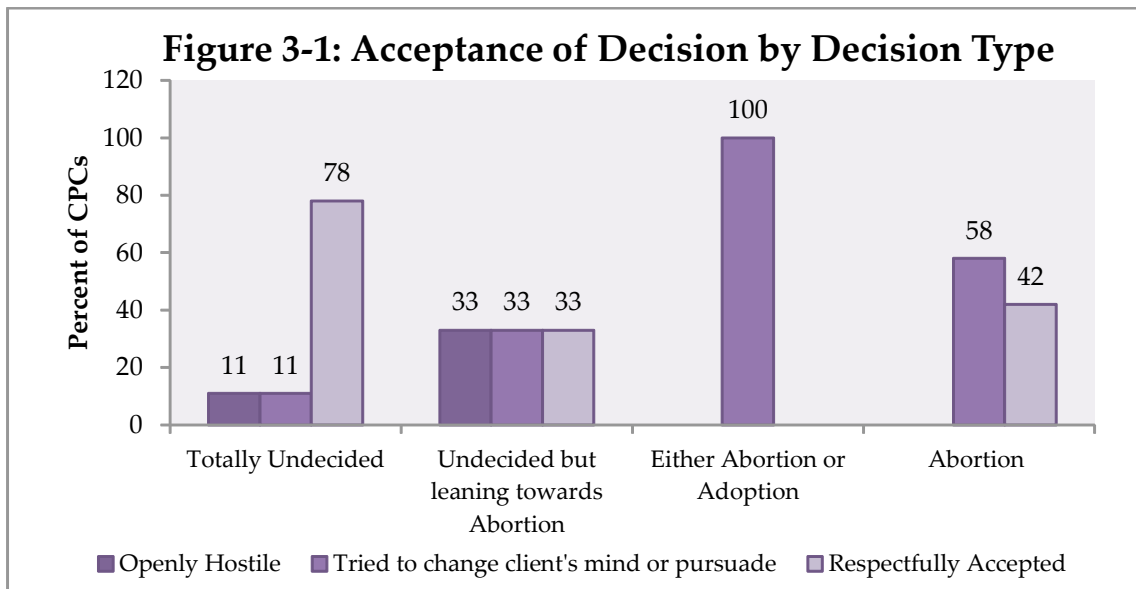
*“We will support you without judging you and provide the encouragement and services you need to take your first steps.”<sup>1</sup>*

Words such as the ones above are frequently highlighted on the websites of CPCs in Ohio. Unfortunately, this non-judgmental environment was not necessarily what our investigators experienced once inside these facilities. Our research showed a variety of reactions, from acceptance to hostility, to the decisions that our investigators indicated they were leaning towards.

During each of the visits, our investigators were instructed to record any feelings of bias or judgment they experienced during the visit. They had four choices to choose from: they felt their decision was respectfully accepted, they felt open hostility to

their decision, they felt pressured to change their mind, or they felt there was no feeling expressed towards their decision. Of the 34 visits where our investigators indicated that the counselor expressed a feeling toward their decision to have an abortion, 53% of the investigators stated that the counselors had a negative reaction to the decision that they were making (indicated by open hostility or pressure to change their mind). Six percent of the counselors were openly hostile toward the decision and 47% tried to convince them to make another decision or change their mind.

We compared CPC staff interactions with investigators based on the decisions investigators indicated they planned to make. You can see the results of this in Figure 3-1. Our investigators indicated a variety of decisions



to the counselors in CPCs. These included completely undecided, leaning towards abortion but also open to adoption, leaning towards adoption but still undecided or being sure they wanted an abortion. In cases where the investigator said that she was completely undecided (not leaning towards any decision) the counselors were more likely to accept respectfully the decision (78%) than when she indicated in some way that she was considering abortion: when she said she was only considering abortion (42%), she was undecided but leaning toward abortion (33%), or she was considering abortion or adoption (0%).

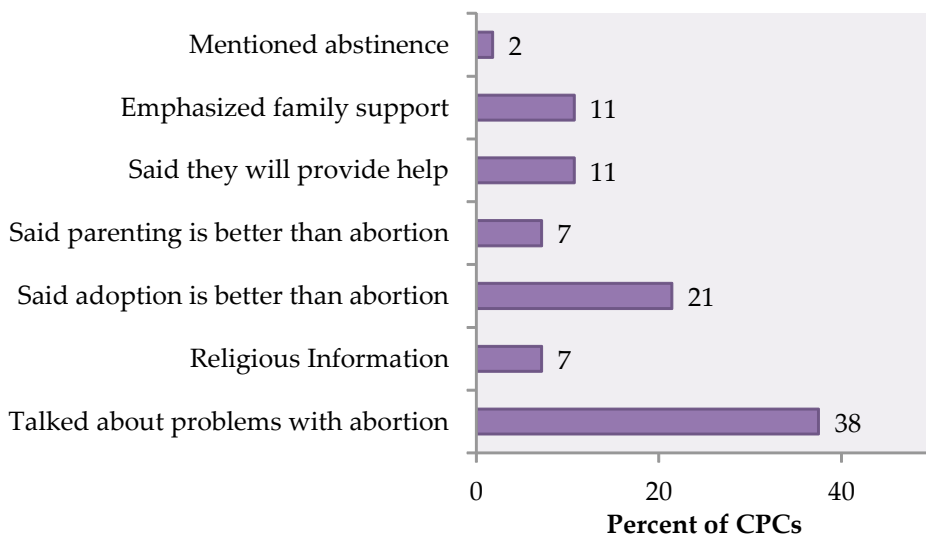
When the counselors at CPCs tried to persuade investigators to make a different decision they used a variety of methods (Figure 3-2). The common ways to persuade the client were to discuss the dangers associated with abortion, 38%, (see the fact sheet on Medically Inaccurate Information for more detailed information on the dangers that were discussed), followed by arguing that adoption was a better choice (22%).

CPC counselors also made the claim that the woman’s family would support her. Additionally, CPC representatives stated that the CPC would provide help to the client, although the services provided are very limited in scope. In fact, in a third of the cases there were requirements that had to be fulfilled in order to receive these services. These requirements ranged from attending counseling sessions or parenting classes to attending church services and volunteering at the center (see the “Services Available” fact sheet for more information on this topic).

**NOTES**

1. This statement was found on the website of the Women’s Centers of Ohio at <http://www.womenscenterohio.com/>, (August 28, 2012). Similar statements can also be found on these websites: Heartbeat International, Our Commitment <http://www.heartbeatinternational.org/hbi-about-us/our-commitment> (August 28, 2012) and A Caring Place, Programs, <http://acaringplace.com/programs.html>, (August 28, 2012).
2. [http://spectsvideo.com/Collateral/view\\_crossroads.html](http://spectsvideo.com/Collateral/view_crossroads.html)

**Figure 3-2: How did CPCs Try to Persuade Client?**



*“No one tells you that you’ll want to kill yourself after you do an abortion... Having had that abortion turned me into a crack head whore.”*

*Quote from CPC provided video, Crossroads of the Heart.<sup>2</sup>*

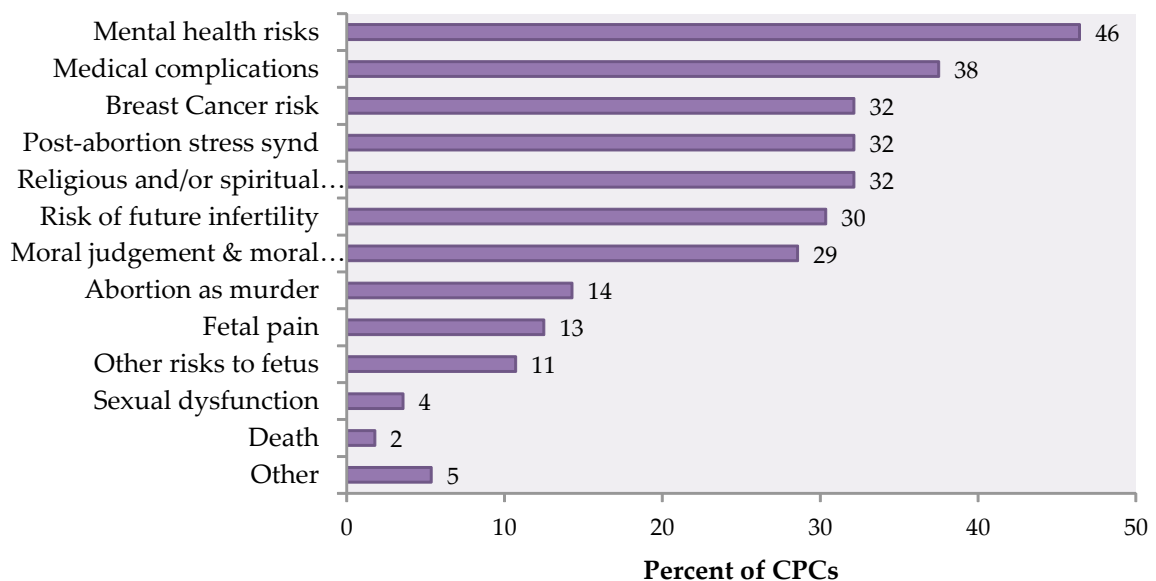
# Medically Inaccurate Information at Crisis Pregnancy Centers

A common thread seen throughout websites of Crisis Pregnancy Centers (CPCs) in Ohio is a statement like this: “Clients of the center receive accurate information about pregnancy, fetal development, lifestyle issues, and related concerns.”<sup>1</sup> Unfortunately, what we found happening inside these centers was not as advertised. In 53 percent of the visits where our investigator felt that their counselor expressed judgment towards their decision, our investigators felt that their counselor had a negative reaction to their decision on what they wanted to do with their unplanned pregnancy. Medically inaccurate information was routinely used to try to persuade women to change their minds, and what we discovered was happening inside of CPCs may surprise you.

**CPCs OVERWHELMINGLY USED FALSE OR INACCURATE INFORMATION WHEN DISCUSSING ABORTION**

The most common tactic used by CPC volunteers to convince our investigators not to access abortion care was to talk about the potential problems associated with the procedure, including false information on medical risks, mental health effects and the connection between breast cancer risk and abortion. A more in-depth analysis of the discussions between the investigators and the CPC volunteers around the abortion procedure highlights the most concerning

**Figure 4-1: Issues discussed about abortion**



information that was gathered in this research. It doesn't matter if the counselor acts non-judgmental or not if the information being presented is biased and inaccurate. The details of the common issues discussed by the counselor are in Figure 4-1. For analysis purposes the information presented by the CPC volunteers was grouped into topic areas, including physical health, mental health, issues with future fertility etc.

None of the claims CPC counselors made are backed by legitimate medical or scientific studies. One of the most common allegations counselors made was that abortion is destructive to mental health (47%). These claims have been disproven by a long line of credible, scientific research. The American Psychological Society conducted a full review of the research associated with mental health and abortion and found that "The best scientific evidence published indicates that among adult women who have had an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy."<sup>2</sup> Additionally, the New England Journal of Medicine published a research article in January 2011 which suggested that "the incidence rate of psychiatric contact was similar before and after a first-trimester abortion does not support the hypothesis that there is an increased risk of mental disorders after a first-trimester induced abortion."<sup>3</sup>

Also included under the umbrella of mental health complications is the mythical disorder- "post-abortion-stress-syndrome." This legitimate-sounding mental health disorder is not recognized by the American Psychiatric Association, the governing body that produces the Diagnostic and Statistical Manual

of Mental Disorders, the reference used to diagnose and treat mental health disorders. In fact, the organization's official position is that "the freedom to act to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications."<sup>4</sup>

The second most frequent topic discussed was the physical health complications associated with abortion, specifically supposed problems with future fertility (discussed in 31% of the visits) and the increased risk of breast cancer (discussed in 33% of the visits). Not surprisingly, none of the CPCs discussed any of the medical risks associated with childbirth, or discussed the risks of post-partum depression in women following childbirth, even though the risk of death is ten times higher for childbirth than it is for abortion.<sup>5</sup>

Anti-abortion activists have long hoped to find scientific support for their claims that abortion causes a range of negative effects on women who choose this reproductive option. However, a long line of medical and scientific research shows that there is no increased risk of suffering major complications, or an added risk of infant mortality in future pregnancies. Nor is there any evidence that abortion increases risk of infertility, ectopic pregnancy or miscarriage.<sup>6</sup>

The link between an increased risk of breast cancer and abortion also is commonly used to deter women from choosing abortion, and, like the purported link between future pregnancy complications and infertility, it is also not based in medical science. A 2006 study published in the International Journal of Cancer reviewed the records of 267,361 women in nine countries and found no link

between abortion and breast cancer.<sup>7</sup> Another large scale review of the literature was published in *The Lancet* in 2004. This research analyzed data from 53 different studies and concluded that women who obtain abortion care do not have an increased risk of breast cancer. In fact, the authors specifically stated that the previous (few) studies that had suggested a possible connection were methodologically flawed.<sup>8</sup>

CPCs also warned of other complications of abortion, including increased bleeding, cervical tearing, uterine puncture, infections, and incomplete abortions. Although all of these complications are possible, they are extremely rare. In 2009, there were complications in only 0.3% of abortions performed in Ohio.<sup>9</sup> However, CPC counselors drastically exaggerated their likelihood, using descriptors like “many”, “frequently”, “most”, and “often.” When our investigators would ask for more information about how frequently it happened, the responses were mixed, with some counselors coming out and saying that in fact it is rare, and others saying things like they “don’t really know exact numbers.” Clearly the rates of complication are exaggerated to pressure women into continuing their pregnancies, regardless of their individual situations.

When the investigators inquired about the abortion procedure itself, the exaggerated claims continued. The ways that the counselors described an abortion procedure were inaccurate and presented in a way to make it sound as bad as possible. One of our researchers explained what she was told by one CPC:

*“When describing abortion she said that it is painful for the baby and that the baby will actually try to crawl away from the suction.”*

*She also said that your cervix will never be the same and that I may never be able to sustain a pregnancy again. She also stated that I could get a perforated uterus and that my bowel can come out due to the force of the suction from the abortion. Also said that many abortionists practice illegally which is why they try to rush you out when the procedure is done.”*

In an additional scare tactic, the counselors painted a gruesome picture of abortion clinics and providers in Ohio. They claimed providers were not licensed, that clinics would be splattered with blood and dirty, and that abortion providers only care about making money, not about taking care of women. One counselor, when talking about a local provider, told our investigators “He’s a butcher.” Another comment from a counselor was “A lot of money is made off of abortions so they don’t want the facts out there. If you have complications, the abortion clinic won’t do much for you.”

**CPCs PROMISED ALL-OPTIONS  
COUNSELING BUT OFFERED  
INACCURATE INFORMATION AND  
SCARE TACTICS**

Before visiting a CPC our investigators conducted phone surveys of each center. Part of the survey script was to ask whether or not they would refer for abortion services; all of the respondents said they would not refer for those services, but 46 percent of the CPCs stated that they offer all-options counseling and information to help make an informed decision. That was not what our investigators found when they visited the centers. Once they arrived at the center they were presented with medically inaccurate

and sensationalized scare tactics to try to persuade them from not making having an abortion. When our investigators asked at the visits for a referral to an abortion provider, almost 15 percent of the CPCs confirmed that they would help with the information. However, 55 percent of the CPCs that offered to help with the referral ended up telling investigators that they could only give information about abortion procedures, not an actual referral, and 33 percent gave the investigators a referral to a post-abortion “healing” organization instead of a qualified abortion provider. Only one center gave out a specific location.

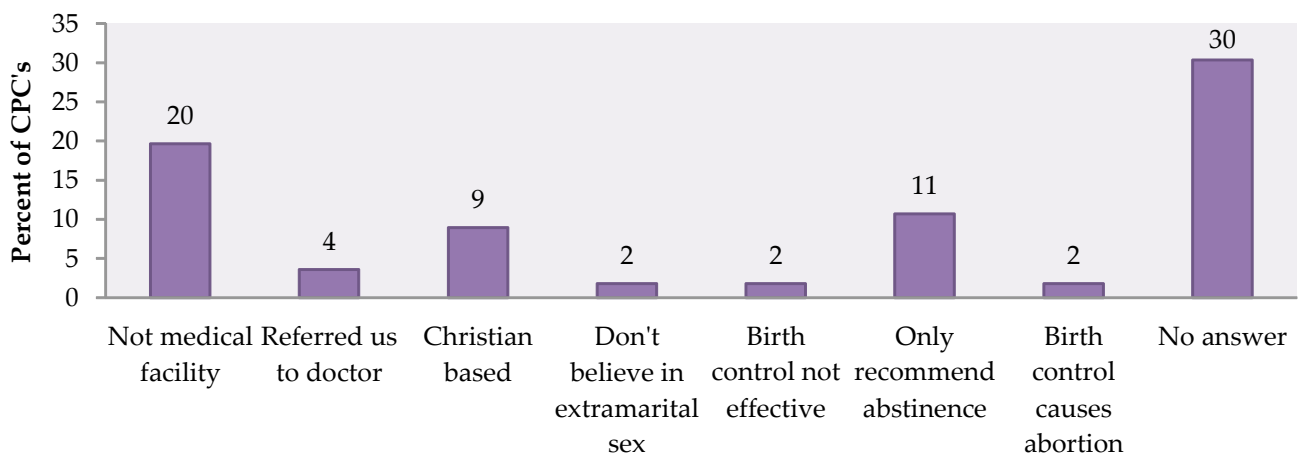
**BIRTH CONTROL INFORMATION AT CPCs**

Let’s examine this scenario: a woman seeks services at a CPC because she believes that she is pregnant. When she takes the pregnancy test and it comes back negative, she may then have questions about preventing a future unintended pregnancy. Because the client is obviously sexually active and not prepared for pregnancy at this time, this is

a perfect opportunity to help her get access to the medical care and information that she needs to prevent future potential unintended pregnancy. To see what kind of information would be given to a woman when the pregnancy test was negative, we applied a visit scenario where our investigators took a pregnancy test and it came back negative so that they could ask about contraceptive options (scenario one).

When our investigators asked, only one CPC told them that they provided birth control services. Upon further questioning, however, they revealed that the only form of birth control they were willing to talk about was natural family planning (also known as the rhythm method or periodic abstinence). When asked why they didn’t provide birth control, the most common answer was that they were a “non-medical facility” (20%), followed by “only recommending abstinence” (11%) and that they are “Christian-based” (9%). This was another place where we found medically inaccurate information, with two percent of CPCs saying that birth control is not effective, and that birth control causes abortions. Figure 4-2 details all of the

**Figure 4-2: Why doesn't the CPC provide birth control?**





responses to this question.

For the most part, CPCs were not equipped to talk about anything other than a positive pregnancy test. In fact, visits where the pregnancy test was negative were on average only a half hour in length, but when the investigator stated she was pregnant or took the test and it was positive the average was just over an hour in length. Our investigators frequently mentioned that even before the test results came back the volunteer started talking to her about her parenting options and what she would do if she were pregnant. Once the test results came back negative there was very little conversation. In one case, the woman at the center told our investigators that there was nothing else that they could do for them.

Women facing an unintended pregnancy or who are looking to prevent pregnancy deserve facts and truth to help them make the best decisions about their reproductive health care. They should not be given misleading and false information aimed at convincing them to make the decision that the volunteer at the CPC wants them to make.

## NOTES

1. This statement was found on the website of the AIM Women's Center at <http://www.aimwomenscenter.com/about-aim/commitment>; similar statements can be found on these websites: <http://www.womenscenterohio.com/about-us> and [http://www.clevelandpregnancyhelp.org/about\\_us/commitment.asp](http://www.clevelandpregnancyhelp.org/about_us/commitment.asp).
2. American Psychological Association, Task Force on Mental Health and Abortion. Report of the Task Force on Mental Health and Abortion, <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf>, (August 28, 2012).
3. Munk-Olsen, Trine, Laursen, Thomas M., Pedersen, Carsten B., Lidegaard, Ojvind, and

Mortensen, Preben B. "Induced First-Trimester Abortion and Risk of Mental Disorder" *The New England Journal of Medicine*, 364 (January 27, 2011): 332-339.

4. American Psychiatric Association, Abortion and Women's Reproductive Health Care Rights, [http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2009\\_Abortion.pdf](http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2009_Abortion.pdf), (August 28, 2012).
5. The Center for Disease Control and Prevention, Pregnancy-Related Mortality Surveillance- United States 1991-1999, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm> (October 24, 2011) and Council on Scientific Affairs, American Medical Association, "Induced Termination of Pregnancy Before and After Roe v. Wade: Trends in the Mortality and Morbidity of Women," *JAMA* 268 (1992): 3231-3235.
6. Hogue, Carol J.R., Cates Jr., Willard, Tietze, Christopher, "The effects of Induced Abortion on Subsequent Reproduction," *Epidemiological Reviews* 4 (1982): 66, 67, 88-89. Boonstra, Heather, D., Benson Gold, Rachel, Richards, Cory I., and Finer, Lawrence B., Abortion in Women's Lives, <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf> (August 28, 2012).
7. Reeves, G.K. et. al., "Breast cancer risk in relation to abortion: Results from the EPIC study," *International Journal of Cancer* 119 (October 2006): 1741-1745.
8. Collaborative Group on Hormonal Factors in Breast Cancer, "Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83,000 women with breast cancer from 16 countries," *The Lancet* 363 (March 27, 2004): 1007-1016.
9. Ohio Department of Health, 2009 Induced Abortions in Ohio, <http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/data%20statistics/vital%20stats/2009abortionreport.ashx> (August 29, 2012).

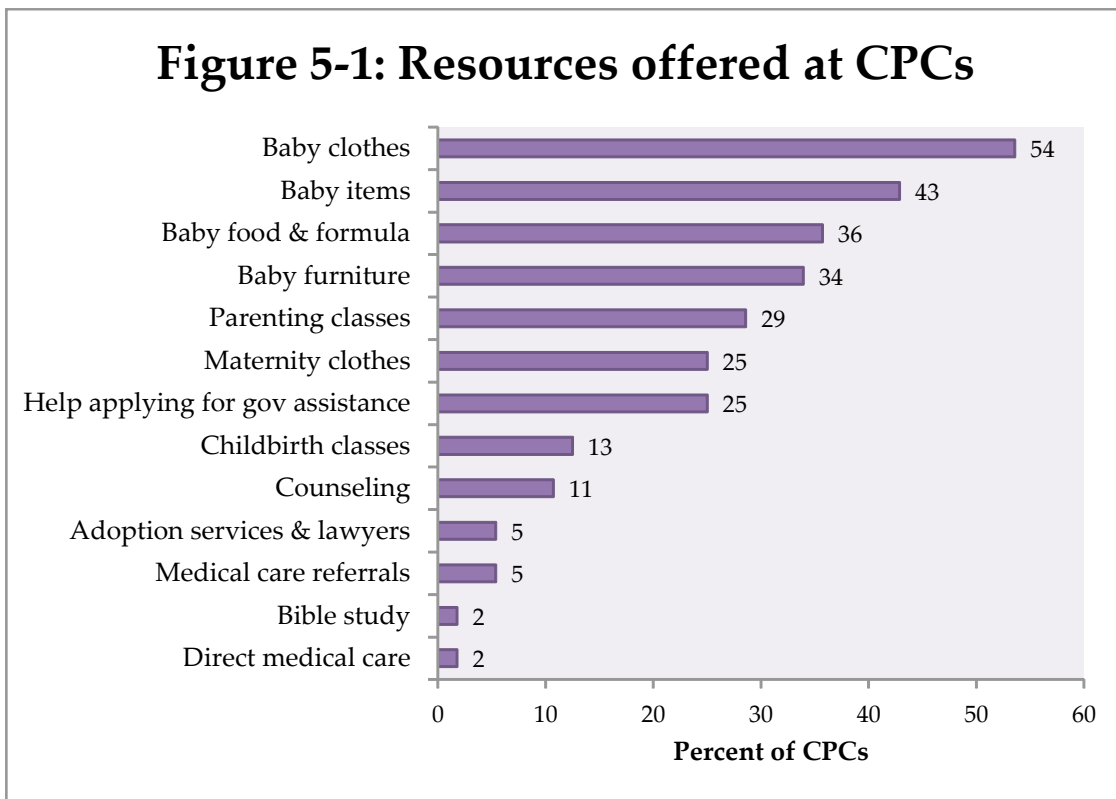
# Services Provided by Crisis Pregnancy Centers: A start but not comprehensive.

We often hear from supporters of CPCs and anti-choice legislators about the helpful services they provide to women. In order to learn more about these services, during their visits our investigators collected information about the resources CPCs offer and what requirements there are to access the services. Information gathered about this subject was either freely offered by the center, or was in response to our investigator's questions about what services are available. Investigators were instructed to ask about what services are available if the information was not volunteered. Figures 5-1 and 5-2 detail the responses to these questions.

## SERVICES OFFERED

Most commonly CPCs had some kind of resource closet that contained limited supplies of used or new baby clothes, maternity clothes, furniture, or other baby supplies. The period of time that aid was available ranged from a one-time offer to multiple visits over the course of two to five years. The least frequently offered services included referrals or direct medical care, Bible study, adoption services, and legal services. These centers advertise themselves as a place to go to get access to the care and services a

**Figure 5-1: Resources offered at CPCs**



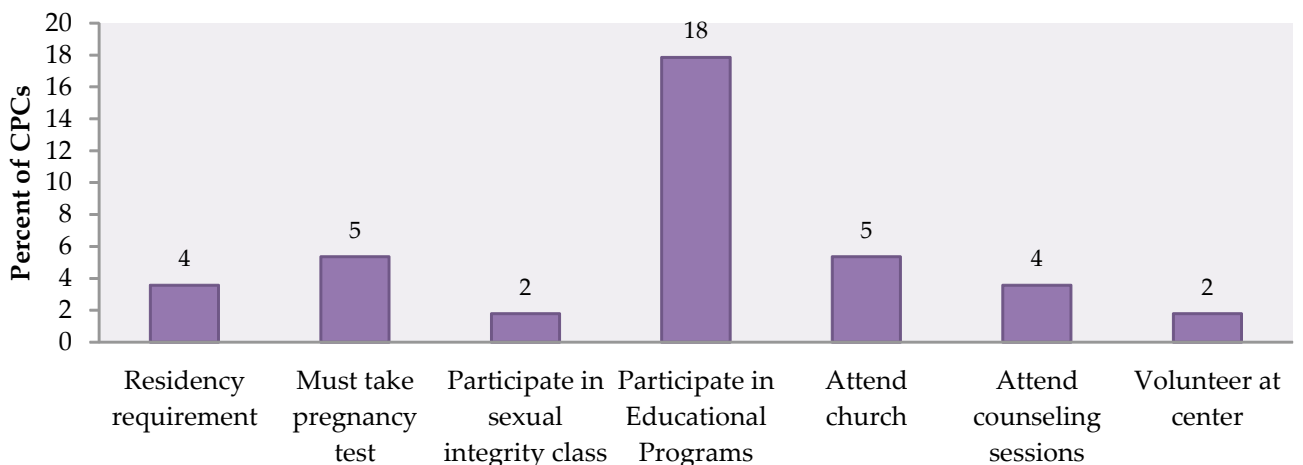
woman would need during pregnancy. The lack of access to medical care is troubling. Research shows that earlier access to pre-natal care reduces pregnancy complications, premature birth, and risk of low birth weight infants.

Every location indicated that the services were provided without a direct fee for the client, but that did not show the complete picture. In 30 percent of the centers there was some kind of program that the client must follow to qualify for the services. Most frequently this was in the form of a “baby bucks” program where the client attended classes, church services, and counseling sessions or performed other tasks like watching training videos or volunteering at the CPC to earn credits that could be spent in the “shop”. The centers may claim everything they offer is “free” to the client but making access to the services contingent on time or work commitments, they still constitute a considerable investment on the part of the client. These require-

ments would be especially burdensome for lower-income women who may have limited access to transportation or a work schedule that would preclude them from being able to attend classes or do volunteer work. Ironically, these are just the population of women who CPCs claim to want to help.

The promise of free services is diminished even more in light of the challenge investigators faced scheduling appointments or even reaching people by phone at many of these centers (see the fact sheet on Confidentiality and Intake Procedures for more detail on this subject). Our researchers found that centers were not always open during the hours that their websites and/or voicemail messages stated, making it even more difficult for women to access these services. A woman needing emergency formula or other baby items doesn’t have the time and resources to track down the volunteers at these centers to get access to the services. Overall, while the promise of free services sounds honorable, given their limited scope

**Figure 5-2: Requirements to be eligible for services**



and accessibility, it appears it is likely intended as a tool to persuade women to carry their pregnancies to term rather than a genuine interest in lending support. In fact, the promise of free services was the third most frequently mentioned argument against abortion by the counselors at CPCs around Ohio. While we support programs that offer pregnant women all the resources they need, we were troubled that 11 percent of CPC counselors used the promise of free services as a method of dissuading women from choosing abortion care.

## NOTES

1. The Center for Disease Control and Prevention, Pregnancy-Related Mortality Surveillance- United States 1991-1999, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm> (October 24, 2011)

# Discussion & Policy Suggestions

NARAL Pro-Choice Ohio Foundation has no objection to a center that offers women who have decided to carry their pregnancies to term any assistance they need. If a woman seeks counseling at a Crisis Pregnancy Center (CPC) with full awareness of its anti-abortion agenda, that is her choice. However, our report indicates that staff and volunteers at CPCs in Ohio were willing to put their anti-choice agenda ahead of women's health—even if it meant delaying women from seeking the health care they need. Many used shame, manipulation, and even coercion to bully women, and often, counselors gave false or misleading information and refused to provide the client information regarding all of her options. None of these practices meet an appropriate standard of care. Our findings are of particular concern because the State of Ohio lists CPCs in their resource guide “Where to Get Help With Your Pregnancy,” which, by law, must be offered to every abortion-seeking patient in the state, as well as distributes funding to CPCs through the “Choose Life” License Plate fund, which may create an impression that the state sanctions the deceptive practices we found many of the CPCs to employ.

During this investigation, we uncovered that a majority of CPCs engage in a pattern of providing medically-inaccurate information, their clear goal to discourage the client from choosing abortion. CPC statements ranged from telling our researcher that abortion causes depression to more severe outcomes

such as breast cancer or suicide. All of these links have been consistently disproven by the medical community. Scare tactics as a tool of persuasion were common as well; for example, CPCs demonized abortion providers and greatly exaggerated the risks of legal abortion. Our findings also indicate that CPCs provide ultrasounds with the intention not of providing women necessary medical care, but instead as a tool to shame and manipulate women.

While some CPCs did disclose (when asked) that they were anti-abortion and that they would not refer to abortion providers, most were not forthcoming that the nature of their information—particularly the “educational” materials—was not based in fact but rather intended to forward an ideological agenda.

CPC representatives also were generally dishonest about why they encouraged women to have ultrasounds. In public, CPC workers frequently talk about the need for ultrasound because they believe that if a woman sees her ultrasound she will not be able to go through with an abortion. But our investigators found that they told clients that the ultrasound was necessary because they needed to know if it was a viable pregnancy. Encouraging clients to schedule an ultrasound at the CPC, rather than going to an abortion provider, allows the CPC to continue to control the woman's decision making process. It also gives them an additional opportunity to give the client medically

inaccurate information, and may be another way that the workers at the CPC can delay a woman from accessing abortion services in a timely manner.

We also learned that CPCs operate in much less of a professional manner than is publicly presented. This is especially concerning with the centers that get financial support from the “Choose Life” License Plate fund or are listed as service providers in the referral guide produced by the Ohio Department of Health. The state is supporting these centers, but is not checking to make sure that they operate when they say they are open, and certainly do not make sure that the information being provided at these centers is medically accurate. If the state is going to support these centers they should, at a minimum, be required to give out medically-accurate information and not lie to the clients who come to them for advice and support.

This research creates a comprehensive picture of the environment created by crisis pregnancy centers in Ohio. It also creates a compelling case for state and local intervention so that we can ensure that women are aware of the limitations of CPC services while also ensuring that women receive the medically accurate information that they need to make a decision on what to do with an unintended pregnancy. Based on our research findings, we suggest the following policy changes:

1. Hold CPCs accountable for false or misleading advertising. Require that in consumer outreach materials, CPCs be honest about the services and referrals they do and do not provide.
2. Require that the Ohio Department of Health resource directory “Where to Get

Help With Your Pregnancy” list only facilities that provide comprehensive, non-directive, and medically and factually accurate information. (<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/dspc/complaints%20-%20nursing%20homes/PregnacyResDirectory2011.ashx>)

3. Require that facilities that receive funding from the Choose Life license plate be required to give medically and factually accurate information to the clients that seek their services.
4. Assess the need for regulation of CPCs by examining the effectiveness, accuracy, and comprehensive nature of the information and services CPCs in Ohio provide. Engage in efforts to educate Ohio citizens about CPCs and the risk they may pose to pregnant women.
5. Support comprehensive family planning programs that reduce the rate of unintended pregnancy in Ohio.

By requiring crisis pregnancy centers to be transparent in their operations and give women information that is medically accurate and free from intimidation and coercion, we can curb CPCs’ deceptive and misleading practices and ensure that women who want accurate information about all their medical options get just that. When women are bullied, manipulated, or misled about their health-care information, they may delay accessing legitimate care. NARAL Pro-Choice Ohio Foundation believes that that women must not be misled when trying to make personal medical decisions. These decisions need to be made with factual and unbiased information and counseling so that she is equipped to make the best decision for her and her family.

The mission of the NARAL Pro-Choice Ohio Foundation is to support and protect the right of every woman to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing safe, legal abortion.

We would like to acknowledge the support of the Sherwick Fund, Mt. Sinai Health Care Foundation, and the George Gund Foundation for their financial support for this research project. We would also like to thank NARAL Pro-Choice America and our sister Affiliates who supported us throughout the research process.



**NARAL**  
Pro-Choice Ohio Foundation

12000 Shaker Blvd.; Cleveland, Ohio 44120

216-283-2180

[www.ProChoiceOhio.org](http://www.ProChoiceOhio.org)