VIEWPOINT

The Public Health Risks of Crisis Pregnancy Centers

By Joanne D. Rosen

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Crisis pregnancy centers are organizations that provide counseling and other prenatal services from an antiabortion (prolife) perspective.[1,2] According to a report prepared for Rep. Henry Waxman (D-CA) in 2006, they seek "to persuade teenagers and women with unplanned pregnancies to choose motherhood or adoption."[2] Many of these centers—which are also known as pregnancy resource centers, pregnancy support centers and limited-service pregnancy centers—are affiliated with national antiabortion organizations and belong to evangelical Christian networks.

Crisis pregnancy centers have been the focus of investigation by federal, state and local lawmakers, as well as by reproductive choice (prochoice) advocacy groups, and have been subject to attempts at municipal regulation.[3–8] However, they have received little attention in the public health literature.

The women who visit these centers to obtain free pregnancy tests or seek abortions are in need of accurate medical information and prompt medical attention. However, the centers often provide inaccurate information that may delay or interfere with women's access to abortion and contraceptive services, improperly influence women's reproductive health decisions and potentially increase the number of unintended births.

BACKGROUND

The first crisis pregnancy center in the United States opened in Hawaii in 1967, after that state legalized abortion. Since then, crisis pregnancy centers have continued to open across the country. An estimated 2,500–4,000 centers currently operate in the United States.[1,9]

These centers are typically staffed by volunteers and employees who lack medical training or licensure. For example, only 18% of Maryland crisis pregnancy centers in a 2007 survey conducted by the NARAL ProChoice Maryland Fund reported employing staff with medical training.[10] Centers provide free pregnancy tests and may offer free prenatal ultrasounds; some offer free testing for STDs. They do not offer abortions or referrals to abortion providers, and contraceptive services, if available, are restricted to abstinence-only counseling for unmarried women and counseling about natural family planning methods for married women. The centers typically offer classes in prenatal development, parenting, life skills and Bible study.[11] Many advertise their services on their Web sites, in high school and college newspapers, on buses and subways, and on billboards.[2,3,10]

Women who seek care at crisis pregnancy centers are disproportionately young, poorly educated or poor.[9,10] This is unsurprising, since unintended pregnancy rates are highest among these groups.[12,13] In 2001 and 2006, the rate of unintended pregnancy was higher among U.S. women aged 18–24 than among those of any other age-group.[12,13] It was three times as high among women who had not completed high school as among college graduates,[12] and it declined as years of education increased.[13] Women living below the poverty line had five times as high a rate as women in the highest income bracket.[13] In addition, young, poorly educated or poor women are likely to be drawn to crisis pregnancy centers' prominent advertisements of their free services.

CENTERS' PRACTICES

The practices of crisis pregnancy centers have attracted scrutiny at the federal, state and local levels.[1–8,14] In addition, investigations by several prochoice organizations have focused on centers' Web sites, written materials and practices.[9,10,15–17] While centers have not been subject to systematic evaluation by nonpartisan investigators, the prochoice investigations have consistently found practices common among crisis pregnancy centers that raise particular health concerns for the women who visit them, as well as broader public health concerns.

Misinformation About Abortion Risks

Through written materials, Web sites, telephone interviews and in-person visits, crisis pregnancy centers disseminate medical information about the risks of abortion that lacks scientific validity. Eighty-seven percent of centers contacted for the Waxman report provided false or misleading medical information.[2]

The medical misinformation falls into three general categories. First, many crisis pregnancy centers inform women that abortion significantly increases their risk of breast cancer.[2,9,10] This is inaccurate. In fact, since a 1982 study found a possible link between pregnancy termination and breast cancer,[18] that relationship has been investigated extensively. In 2003, the National Cancer Institute examined all available population-based, clinical and animal data, and concluded that induced abortion was not associated with an increased risk of breast cancer;[19] findings of subsequent studies have been consistent with those of the 2003 report.[19]

Second, many crisis pregnancy centers inform women that abortion can make it difficult to become pregnant in

the future, can cause a significant increase in the risk of ectopic pregnancy and miscarriage, and can cause scarring and permanent damage to the uterus.[2] These claims, too, are inaccurate. First-trimester abortions, which constitute approximately 92% of all abortions,[20] do not increase the risk of secondary infertility; of subsequent ectopic pregnancy, miscarriage or preterm delivery; or of future pregnancies' ending in the birth of infants with low birth weight or congenital malformations.[21,22] Second-trimester abortions that are performed through dilation and evacuation are associated with an increased risk that women will subsequently have a premature delivery or a low-birth-weight baby.[22] Crisis pregnancy centers do not distinguish between the differential risks.

Third, many crisis pregnancy centers inform women that abortion may have a deleterious effect on long-term mental health. This is not accurate. While the existence of a psychologically distinct "postabortion syndrome" has been much debated among prochoice and prolife advocates, numerous methodologically sound studies have failed to find an identifiable postabortion trauma syndrome[23,24] or elevated rates of long-term psychological distress among women who have had an abortion.[25,26]

The provision of misinformation about the risks of abortion accords with the centers' goal of dissuading teenagers and women with unplanned pregnancies from having abortions, and is contrary to the legal and ethical standards of informed consent. A properly informed decision about medical treatment requires the provision of accurate and relevant information on the benefits, risks and costs of treatment.[27,28] While crisis pregnancy center staff may not be bound by the standards of informed consent when providing information about medical services they do not provide, such as abortion, the possibility that their inaccurate medical information could influence a woman's decision about whether to terminate an unintended pregnancy raises ethical and public health concerns.

Additional adverse health issues arise if centers' interventions result in an increase in the number of unintended births. The negative outcomes associated with unintended or unwanted pregnancy are well documented. Women with unintended pregnancies are more likely than others to delay the initiation of prenatal care or receive no care, use tobacco and alcohol during pregnancy, experience postpartum depression, deliver preterm, continue to smoke after giving birth, and not breast-feed or breast-feed for a relatively short period; their children are more likely than others to be low-birth-weight and are at increased risk for negative physical and mental health outcomes.[29–34] Consequently, practices that potentially increase the number of unintended births pose a public health risk.

Other Misinformation About Abortion

Inaccurate information that some crisis pregnancy centers disseminate about the need for, or availability of, abortion appears to be aimed at delaying or interfering with women's access to services. For example, the Web sites of two centers in New York State have advised women that they may be at risk for miscarriage and that abortion may therefore be unnecessary.[9] However, the information was misleading because it failed to distinguish between the risk of pregnancy loss at the earliest stages of pregnancy and the substantially reduced risk in later weeks.[35]

At some centers in Maryland and New York, staff have advised women that abortions are legal throughout pregnancy and told women they can take their time to decide whether to undergo an abortion.[9,10] While abortion laws vary by state, no state allows unrestricted access to abortion throughout pregnancy, and all states prohibit late-term abortions except where required to protect the life or health of the woman.[36,37] Abortions are least complicated and more accessible, both legally and medically, within the first trimester.

The introduction of a delay in obtaining access to abortion services can have an especially harmful impact on young and socioeconomically disadvantaged women. Teenagers, on average, take longer to suspect pregnancy than do older women; teenagers, poorly educated and poor women take longer than older, better educated and higher income women to confirm a pregnancy once they suspect one.[38] In addition, women aged 18–21 and lower income women generally have abortions later than do older and higher income women.[38–40] Consequently, the women who seek care at crisis pregnancy centers are likely to be farther along in their pregnancies than women who seek abortions elsewhere, and if they wish to terminate their pregnancy, they require immediate referral to a facility that provides abortions.

More generally, while abortion-related deaths are rare, the risk factor most strongly associated with maternal mortality is gestational age at the time of abortion.[40] Abortions performed in the second trimester are associated with higher maternal mortality rates than abortions performed within the first trimester, and the risk of maternal death attributable to delaying abortion by just one week increases sharply with increasing gestational age.[40]

In addition to being associated with higher mortality rates than early abortions, second-trimester procedures are more expensive,[41] involve more complex procedures,[38,39] and carry greater surgical risks and higher risks of complications.[38,39] They also are more difficult to obtain than first-trimester abortions in many parts of the United States because of a dearth of trained practitioners.[39,42]

For all of these reasons, crisis pregnancy centers' practices that delay access to abortion present a public health concern.

Misinformation About Contraceptives and Condoms

Clinics that offer pregnancy tests are well positioned to provide information about contraception and STD prevention to a sexually active clientele. However, most crisis pregnancy centers do not provide such information. In two investigations, the centers that did discuss

contraceptives provided inaccurate information about the failure rate of condoms and their permeability to STDs, as well as misinformation about the harmful effects of hormonal contraceptives.[10,11]

Crisis pregnancy centers' provision of inaccurate information about contraceptives and condoms raises additional concerns. The majority of teenagers who visit clinics to get a pregnancy test are not pregnant.[43] However, some of them are engaging in high-risk sexual behavior and are at significant risk of contracting STDs and of becoming pregnant. In one study, 33% of teenagers who had a negative pregnancy test at a community clinic became pregnant within 18 months.[44]

When informing clients of a negative pregnancy test, community clinics have a brief window in which to provide contraceptive information and STD counseling to a population in need of these services. From a public health perspective, as others have also noted, the failure to take advantage of this window is a crucial missed opportunity.[43–46]

WHAT CAN BE DONE?

Crisis pregnancy centers argue that they provide useful and necessary services to pregnant women, that their prolife message is protected by the Constitution's First Amendment protection of free speech, and that they have been targeted by state and local legislatures and prochoice organizations for their prolife views. They also argue that the information they convey about abortion is scientifically accurate. The American Center for Law and Justice, which has represented organizations that operate crisis pregnancy centers, asserts that the prochoice organization NARAL "is trying to make a mountain out of a nonexistent molehill."[47] As detailed here, however, many crisis pregnancy centers engage in practices that pose health risks to their clientele.

Three possible approaches might be effective in addressing these potentially harmful practices. They are not mutually exclusive and could be pursued in concert.

One response to some of the centers' practices would be to enact laws requiring crisis pregnancy centers to disclose that they do not offer or provide referrals for abortion or contraceptive services and, if applicable, that they do not have medically trained staff on-site. Such laws, probably best enacted at the local level (to facilitate prompt response to community-level public health concerns), would ensure that women who are seeking abortion or contraceptive services are able to discuss their reproductive health needs with appropriately trained or licensed health care providers. However, laws that impose disclosure obligations on crisis pregnancy centers can be difficult to draft because they must comply with the First Amendment's free speech requirements. Since 2009, at least five municipalities have enacted laws in an attempt to regulate allegedly misleading or deceptive practices of crisis pregnancy centers. Four of these laws have been challenged in court by crisis pregnancy centers.[11,48–50] As of May 2012, two have been invalidated on First Amendment grounds, and one has been partially upheld; those decisions are all under appeal. The fourth has not yet gone to trial.

Another way to respond to the practices of crisis pregnancy centers might be through the enforcement of state consumer protection laws that prohibit false advertising or deceptive practices by service providers. The enforcement of these laws requires state attorneys general to investigate the practices of particular service providers. If they find sufficient evidence of a deceptive practice, they can commence a prosecution to halt it. Attorneys general have taken this approach against crisis pregnancy centers in several states.[1,3,14] Consumer protection laws also might be applied to potentially deceptive or misleading information that is posted on crisis pregnancy center Web sites.

The problematic practices of crisis pregnancy centers could also be addressed through public education. For example, lawmakers or health departments could initiate a public awareness campaign to educate women about centers' practices. Health departments could disseminate clear and detailed information about the contraceptive, abortion, pregnancy and STD services available at the centers, as well as about the actual risks related to abortion and the likelihood of these risks. Finally, public health departments could provide materials to physicians and other health care providers to educate them about the limited services provided by the crisis pregnancy centers in their areas so that they can provide appropriate referrals to patients.

CONCLUSION

Debate over the moral, religious and legal propriety of abortion has a long and heated history. Crisis pregnancy centers have participated in this debate, and their entitlement to communicate and promote a prolife perspective is not in question. However, when these centers disseminate inaccurate information to women seeking reproductive health care services, and blur the line between prolife advocacy group and health care provider, their practices risk delaying or interfering with women's access to abortion and contraceptives, improperly influencing women's reproductive health decisions and potentially increasing the number of unintended births. Collectively, these practices jeopardize the health of women and their children, and a public health response is warranted.

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