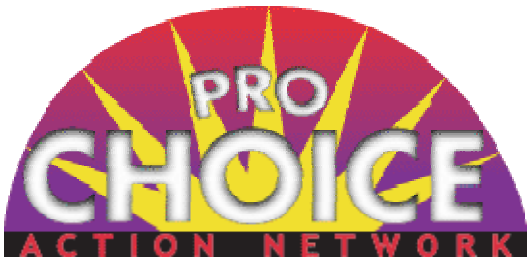
Exposing Crisis Pregnancy Centres in British Columbia



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A Research Project for the Pro-Choice Action Network

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The Project: Exposing Crisis Pregnancy Centres in BC

Introduction

In 2005, we began a project to research anti-abortion counselling centres, or "fake clinics" in British Columbia (BC). These centres are actually anti-choice Christian ministries, often pretending to be non-biased medical clinics or counselling centres. Their main goal is to stop women from having abortions and to convert women to Christianity.

Some of these centres are called Crisis Pregnancy Centres or "CPCs", although many of them have different names. However, we adopted the term "CPCs" to refer to all of them, because they are commonly known by that term in North America.

CPCs far outnumber abortion clinics. There are 4,000 CPCs in the United States, compared to about 800 abortion clinics.[1] In Canada, there are about 200 CPCs and roughly 25 abortion clinics. In BC, there are about 30 CPCs and 6 abortion clinics.

We wanted to find out what these centres were doing and saying to women in BC, and whether they were engaging in deceptive or harmful practices. If so, such practices need to be publicized in order to reduce the harms.

Infiltration

We found a university student who wanted to research CPC tactics and operations. She signed up to train as a volunteer counsellor at a CPC that was under the umbrella of the Canadian Association for Pregnancy Support Services (CAPSS). The training consisted of a few group seminars, some reading and videos, and "on-the-job" training at a CPC. Our volunteer sat in on a few real counselling sessions with women, but decided to quit the training program at the point where she would have to start counselling women herself.

Before being fully accepted into the training program, our volunteer was carefully screened. The application she filled out asked for her church affiliation and past pro-life activities. Since she wasn't attending church at the time, she was required to join a fundamentalist Christian church for two months, so she could obtain a character reference from the pastor there.

Our volunteer had to sign a Code of Counselling Ethics, which stipulates that counsellors must "not provide, recommend, or refer clients for abortion or abortifacients." In fact, in the first interview, volunteers are asked: "Under what circumstances would you consider counselling for an abortion as an alternative for a woman experiencing a crisis pregnancy?" Only if you answer "Never an option" are you accepted into the program. During training, volunteers are given scenarios where fetuses have extreme medical problems where it cannot survive outside the womb, or might even be in pain inside the womb. However, ending the pregnancy still can't be considered, because "life is sacred". (Executive Director of Christian Advocacy Society, fundraising letter).

Our volunteer was also required to abide by the CAPSS Statement of Faith, a Sanctity of Life Statement (see Appendix 5), and a Statement of Principles.[2] These statements required belief in fundamentalist Christianity, including the sanctity of life from "conception to natural death", an infallible Bible, the Trinity, Jesus' virgin birth and miracles, and heaven and hell.

Researching CPCs

During the training, our volunteer was given copies of their Volunteer Training Manual and other literature.

The Training Manual was an eye-opening look at the religious basis upon which CPCs operate, their strategies and counselling techniques, and the information they provide to clients. The very first chapter of the manual is called the "Biblical Basis for the Sanctity of Human Life." Some of their counselling principles are found in chapters called the "Biblical View of Sexuality", and the "Role of the Gospel".

CPCs pretend to have a woman-centred view, but in reality, they promote outmoded ideals of traditional femininity. For example, their manual states that women look for long-term commitment much more than men, and that sex outside marriage is "intrinsically wrong" and has "grievous consequences." It also says that people who are sexually active outside marriage have a "deep void of intimacy," and people who live common-law "lack commitment" to each other.

Their counselling techniques are designed to induce guilt and emotional stress in the woman for even considering an abortion. If she's coming to the CPC for post-abortion counselling, the counselling technique makes a woman feel guilty for killing her baby, and requires her to personify and mourn her fetus before she can obtain forgiveness from God.

We hired a family doctor who provides abortions, a medical researcher, and a professional counsellor to go through the CPC Training Manual and identify and refute any medical errors, scientific distortions, or unprofessional counselling methods. They produced reports (see Appendices 1 and 2) critiquing and refuting many aspects of the manual. There were serious inaccuracies and distortions in most areas. These errors are taught to the counsellors, who pass them on to unsuspecting women. Here are some examples:

- All abortion methods are described incompletely and inaccurately to at least some degree, and usually in inflammatory ways. Several methods are described that are not used in Canada, such as dilation and curettage without suction, saline, and hysterotomy. There is an over-emphasis on later abortion methods, which are always rare.
- Abortion results in many serious physical complications, including perforation of the uterus, laceration of the cervix, infection, and hemorrhage. It's strongly implied that these complications are routine and frequent, with no mention that the probability of a serious complication is very low.
- Abortion leads to a higher risk of breast cancer and infertility.
- In future pregnancies, abortion leads to higher rates of miscarriage.
- In most women, abortion causes "post-abortion syndrome", a form of post-traumatic stress that leads to such things as depression, nightmares, and suicidal thoughts.
- Contraception has a high failure rate, and condoms do not protect adequately against sexually transmitted diseases.
- Selective information on contraception and STDs is provided not to educate, but to induce fear and loathing of sex.
- Counselling strategies and objectives have one goal – to dissuade women from abortion – and are based on religious doctrines and beliefs, not on medical or psychological expertise.
- Giving up a baby for adoption causes less grief for women than having an abortion.

We conducted various other activities to find out more about CPCs and their influence in communities across BC.

- We researched CPC presence in BC by compiling a list (Appendix 3), researching charity status, obtaining CPC literature, collecting examples of CPC advertising (Appendix 4), and creating digital maps of BC (Appendix 10) highlighting locations of CPCs, women's centres, family planning clinics, and abortion clinics/hospitals in order to show the distribution of services.
- We called and visited a number of CPCs posing as pregnant women or mothers of pregnant women. They provided us with the same types of misinformation on abortion as in the Training Manual.
- We sent out a survey to women's centres and other community groups for women to find out how much people knew about their local CPCs, and what impact they had on women and communities. Many centres were unaware of the CPCs and their agenda. Those that knew

about them often reported that their clients had had negative experiences there.

- We phoned almost 300 walk-in medical clinics, doctor's offices, and hospitals throughout BC, posing as a pregnant woman who wants an abortion, to test if they referred appropriately to an abortion clinic or a pro-choice family planning service. The majority did not, and a few even referred our caller to a CPC.

- We visited Women's Centres, family planning clinics, and public health nurses across the province. We talked to them about the local availability of abortion and family planning services, the political atmosphere in the community around these services, and if women encountered problems finding services.

- We created a poster and distributed it to abortion clinics and women's centres, to invite women to share their experiences with CPCs (see Appendix 7).

- We created and distributed a resource and referral kit for clinics, doctors, hospitals, and women's centres (see Appendix 8 for a sample of abortion information).

- Through our extensive networking (calls, visits, letters etc), we raised awareness about the overall significance of abortion rights and care to women, and the dangers of CPCs, thereby leading to a more unified consensus and approach in communities across BC. Our outreach efforts included First Nations groups, immigrant groups, GLBT groups, and other cultural minority groups serving women in a social service or advocacy capacity.

- We created a pro-choice post-abortion support group in Vancouver, through which we found that most women had never talked to anybody before; they felt silenced. We saw a need to create opportunities for women to access pro-choice post-abortion counselling. Such counselling was previously only available in abortion clinics to a limited extent (or by referral to a professional psychologist or psychiatrist). Our service provided a safe, non-biased, and completely non-judgmental place for women to share information, and try to resolve any outstanding issues and emotions arising from their abortion. (Unfortunately, we have not had the resources to sustain this service over the long-term.)

Surveys

We mailed 115 surveys to women's centres and service agencies that helped women in any way across British Columbia. (see next page for the survey questions). We wanted to find out how familiar these centres were with abortion services in their own communities, and how knowledgeable they were about Crisis Pregnancy Centres and their effects on women's sexual health.

Knowing the level of knowledge helps develop a baseline of what information women's resource centres need in order to supply women with the information and support required for optimal sexual and reproductive health, including the right to choose abortion.

On each survey (before mailing), we filled in by hand the name of a CPC in their community, and directed the respondents to consider that CPC when answering applicable questions. After follow-up, a total of 21 surveys were returned from a variety of groups that connect with women in the community, an 18% response rate. Responses came from 15 separate communities, with every area of the province represented (six responses came from Vancouver).

The following is an overview of the most salient issues and responses, including stories of personal experiences within these centres.

Survey Form on CPCs

	Description
1.	What percentage (roughly) of your clients and callers asked for information about abortion or help in accessing one, in the last year?
2.	Could you please describe how you normally help or refer these women?
3.	Are abortion services available in your community, or a nearby community? If so, what hospital or clinic, and in which community?
4.	Have you ever heard women clients cite or ask about inaccurate or dubious information about abortion, such as that abortion leads to infertility or breast cancer? (That is, are women in your community absorbing anti-abortion propaganda?) If so, how often has this happened?
5.	Could you please describe what you know about this CPC and its services?
6.	With whom is this CPC affiliated with (groups or churches), and where does it gets its funding from?
7.	Has your agency had any experiences with this CPC or do you have any concerns about it? If so, please describe briefly.
8.	About what percentage of your women clients in the past year have told you they've visited the CPC (or any other CPC)?
9.	Can you relate to us any CPC experiences and stories from your clients?
10.	How often do you hear something about the CPC? (e.g., in your local media or through the grapevine)
11.	Have you ever seen ads from the CPC in your local papers, radio, bus benches, etc. (If so, could you please send us copies or pictures of some of these ads, if feasible?)
12.	In your opinion, what role does the CPC play in your community or region? That is, are they influential? Well-accepted? Or not?
13.	Does any clinic, hospital, or health professional inyour community refer women to the CPC, to your knowledge? If so, who?
14.	Do you know what is being taught in your local public schools on sex education? If so, can you briefly describe the curriculum? (comprehensive sex-ed, abstinence-based, etc.)
15.	Do you know if CPC staff have ever gone into public schools to distribute literature, or to talk to classes?
16.	How culturally diverse is your clientele? What percentage of your clientele is First Nations? What percentage is of other ethnic minorities?
17.	Is there a local group (besides yourself) that provides social support services to First Nations women? If so, could you please provide its name and contact information?
18.	Who else in the community can you suggest we talk to, to get more information or another perspective on the CPC?

Survey Results

- 12 knew who CPCs were, 8 did not. There was no pattern to this response in terms of a urban/rural split or a professional/grassroots split.
- 10 said abortion services were available in their community, 8 said they were not, and 2 did not know. The "no services" and "did not know" answers were mostly in rural areas. There was also a professional/grassroots split; professional women's services did have abortion services available in their areas.
- 10 said their clients had previous experience with CPCs, 9 said no, 1 was not sure. This reveals the extent to which CPCs have spread throughout BC, as the Yes response was evenly spread between urban and rural areas.
- Most of the respondents did not know whether women were being referred to CPCs by local medical agencies, but 3 rural and 1 urban respondents said Yes.

Many CPC clients later come to women's centres with inaccurate information about having an abortion. One Vancouver abortion clinic dealt with a client's boyfriend who was very upset.

> *"He had been shown an anti-choice video in school in Abbotsford. He began yelling about doctors killing babies while he was in the clinic's waiting room. After he received accurate information about the abortion procedure and was treated with compassion (he had underlying fears about his girlfriend rejecting him), he was able to go back inside and be supportive of his girlfriend through the therapeutic abortion, which they both felt grateful for, as she had wanted him there."*

At another Vancouver abortion clinic:

> *"A patient had been told by a CPC that she could only access abortion services after 16 weeks of pregnancy. Luckily the clinic saw her in time."*

A community health centre and youth clinic in Vancouver responded:

> *"Inaccurate information was seen mostly in 13 to 15 year olds who believe that therapeutic abortion causes infertility, mental illness, depression, and breast cancer. This happens 5 to 10 times a year especially when the girl has been to a CPC because of the advertised free pregnancy tests and was then swamped by the guilt-inducing counselling. They are in tears here. They use guilt and tell them abortion is illegal and causes infertility. One therapeutic abortion means never having children ever."*

A youth clinic in Vancouver said:

> *"One young teen went to a CPC for a pregnancy test, she saw it advertised on the bus. She was traumatized by negative counselling, guilt, and inaccurate information; it is against the law. In tears, she had no idea what to do, or how to make a decision re pregnancy. She found our clinic through a friend, saw a doctor, a nurse, and a counsellor. I don't remember her ultimate decision re the pregnancy, but I do remember that when she left her session with us she was no longer traumatized and was able to think/plan her decision."*

Abortion clinics in Vancouver reported that:

> *"An unusual experience would be to hear from a woman who was puzzled by info she received by phone from a CPC, and then called us to clarify the information received. Or a woman will call and state she was upset by counselling she received which seemed biased. When asked, she would report a visit to a CPC for options counselling."*
>
> *A 17 year old was misled to believe she could get information about obtaining an abortion at a CPC. Her sister contacted the [abortion clinic] when her younger sister became overwhelmed with fear and anxiety after visiting a CPC, thinking she was going to a women's clinic. What she was told by the "counsellor" at the CPC put her in a state of such agitation and fear that her sister did not know what to do for her.*

From Vernon:

> *"The anti choice group in town, about 7 years ago, had pamphlets citing studies linking abortion to breast cancer. They tried to hand them out at a local 'Run for the Cure' fundraiser. CPCs play a large role in creating a hostile, if not unsafe environment to address reproductive options for women in the North Okanagan. A large faith oriented population fuels this voice."*

Phone Calls to Health Centres

During our outreach to women's groups and other community agencies, we discovered a frequent lack of accurate information on how to refer women for abortion. Therefore, we conducted phone inquiries to doctor's offices, hospitals, and walk-in medical clinics to test the extent of this lack of knowledge.

We made 284 calls to walk-in medical clinics, doctor's offices, and hospitals ("health centres"), throughout BC, posing as a pregnant woman who wants an abortion. We asked for information on how to get an abortion, and asked for a referral if that place didn't do abortions. Responses received from front-line personnel varied widely and were frequently wrong.

We tended to assume that professional healthcare workers on the frontlines of patient service would be more aware of available abortion services, and more able to help patients, than they in fact were. While some health centres responded helpfully with accurate information, the majority did not. For example, on Vancouver Island, there are two clinics to which health centres should refer for services or information—one abortion clinic and one family planning and sexual health clinic. Of 43 health centres contacted on Vancouver Island:

- 15 (35%) either gave no information or misinformation.
- 18 (42%) were unaware of existing services on the Island and referred our caller to clinics in Vancouver (a 3-4 hour trip away).
- Only 10 (23%) correctly referred our caller to one of the two clinics.

At one point during the project, we also discovered that the BC government, through the Vancouver Island Health Authority, puts out a pamphlet called "*For Teens Concerned About a Possible Pregnancy.*" This pamphlet did not list either the abortion clinic or the family planning/sexual health clinic. It did list three different CPCs under "Other Pregnancy Support."

This pattern of misinformation and lack of information was similar for other areas of BC, including metropolitan Vancouver. One of the most common examples of misinformation that our caller encountered was being told by health centres that she needed a doctor's referral to get an abortion at an abortion clinic. This is simply untrue—women can call up abortion clinics and book their own appointments, so this misinformation can pose an unnecessary and potentially serious barrier to women seeking services. Even in Vancouver, where there are four abortion clinics, about 20% of health centres were unaware of them and either referred our caller elsewhere or could not help her at all. Of those that did know about the abortion clinics, about half told our caller that she needed a doctor's referral first. Another example of misinformation we were given included a referral to BC Women's Hospital in Vancouver with a warning that there would be a two-day stay in hospital.

Staff at walk-in clinics and hospitals may be anti-choice. One young woman who attended our secular post-abortion support group told us how she went to a public walk-in clinic to ask about an abortion. After doing a pregnancy test, she went to the waiting room to wait for the pregnancy test results. The doctor followed her and in front of other patients, yelled out: "You'll need a referral to get an abortion!" The receptionist then admonished her, saying: "You don't really want to get an abortion, dear." The young woman was horrified by the experience, but too afraid to report the doctor for breaking doctor/patient confidentiality.

A few health centres referred our caller to CPCs. In some cases, the staff member doing the referring was anti-abortion, but in most cases, the staff person was well-meaning and unaware that CPCs have an anti-abortion agenda. Many of the health centres that were unable to provide any help or information were also unhelpful in attitude, even hostile at times. Several times, our caller was greeted with curt statements such as "I can't help you with that" or treated rudely with abrupt hang-ups.

At some hospitals that definitely do abortions, or which are required by law to perform abortions, staff said on the phone that they don't do abortions.

There were some bright spots – BC has public health nurses working in most regions who are readily available to the public, and these nurses were generally very knowledgeable and supportive to women seeking abortions. However, a toll-free Nurses' Hotline (a government-funded service), denied our caller anonymity and requested various personal information before referring her reluctantly to a Pregnancy Options hotline. The nurse warned our caller that "they tend to be pro-choice there, but can give you other options".

Medical organizations such as hospitals, medical clinics, and doctor's offices, most of whom are not directly involved in abortion care, generally support the right to abortion care, but frequently do not have complete or accurate information on the services available or how women can access them. They also operate more from a clinical/medical perspective, and not a feminist perspective, which can result in patients being subjected to subtle (and not so subtle) negative judgments or misleading information.

We also called Crisis Pregnancy Centres all over BC and asked if they could refer us to doctors who would not give contraceptives or information about abortion to our teenage daughters if we took them into their office. Each CPC had a list of doctors in their area who were "pro-life" and they were pleased to refer us to them.

BC Road Trips

We visited most areas of the province in 2006 — Lower Mainland, Fraser Valley, Vancouver Island, and the Interior — to meet with staff at feminist Women's Centres and family planning clinics and with public health nurses (called "pro-choice services" in the following discussion). We inquired about local availability of abortion and family planning services, the political atmosphere in the community around these services, and if women encountered problems finding services. We also visited several CPCs and anti-choice groups to gather literature and information on their tactics— our volunteer posed as a mother who was worried about her pregnant daughter.

In most cases, it's difficult for women outside Vancouver and Victoria to access services. Pro-choice services informed us that health centre personnel (i.e., at hospitals and clinics) are often anti-choice and try to obstruct women, or make them feel guilty. Women's centres are not funded anymore by the government and have few resources. Some have closed and others have had to cut down their hours. In most communities, the public health nurse was often the only supportive voice and resource for these women. Many communities also have a family planning clinic, but it's usually volunteer run and only open one or two days a week. Outside Vancouver and Victoria, there are almost as many CPCs as there are pro-choice family planning clinics. Sometimes, information is lacking and even pro-choice nurses and counsellors can give out erroneous information. One self-described feminist counsellor at a women's centre in Powell River was using anti-choice guidelines around "post-abortion syndrome" to talk to women who had had an abortion.

In areas outside Vancouver and Victoria, therefore, staff at pro-choice services work under difficult and isolating circumstances, and are unable to help all women who need help, or help them properly. Pro-choice services reported that many of their clients seeking abortions had visited CPCs and were traumatized there, especially teenaged women. There is only one abortion clinic outside Vancouver and Victoria (in Kelowna); therefore, many women have to travel to get an abortion, or jump through

hoops to get referred to a doctor who will perform an abortion at a local hospital.

Abortion clinics reported that many patients have heard or have been fed anti-abortion propaganda about the "dangers" of abortion, leaving them frightened and confused. Clinics constantly have to correct this misinformation from CPCs and reassure patients.

In one Options for Sexual Health clinic (formerly Planned Parenthood) in the Lower Mainland, our volunteer found CPC literature in the waiting room. Anti-choice people apparently had put it there without the knowledge of the clinic staff. It was very deceptive-looking, since a naïve person would not know it was from an anti-abortion CPC.

During our trips, we provided all pro-choice services with information on where to refer for abortions and pro-choice post-abortion counselling, since most services either did not have any information at all, or it was not up-to-date or complete.

We found there is good feminist awareness amongst a range of progressive community service groups, such as women's groups, First Nations groups, and youth groups, of the importance of abortion rights to women's lives and health. This was somewhat less the case with other community service groups, such as for immigrant women, although no such groups seem to hold official anti-abortion positions except the CPCs themselves.

The Liberal government cuts to women's centres and other women's services and resources have contributed to women's isolation and ignorance, especially outside larger centres. This has created a gap that some CPCs exploit. Many centres "co-opt" feminist language in an effort to promote a progressive and secular image to the average woman, an image that does not match the reality of their agenda. For example, using this pseudo-feminist approach, the CPCs have expanded into post-abortion counselling, rather than simply trying to dissuade women from abortions.

Following are some selected highlights from the road trip.

Merritt

The public health nurse was unavailable during our trip, so our volunteer spoke to a pharmacist at a local drugstore. The pharmacist said that all seven doctors in town referred or prescribed emergency contraception. Apparently, there used to be two anti-choice doctors that refused to refer or prescribe it, but they are now gone. The pharmacist said there was no activity from anti-choice groups and no literature; it was very quiet in Merritt.

Kamloops

Here is an account from our volunteer who visited the office of the Kamloops Pro-Life Society and spoke to a woman staffer there.

> *"She mentioned that they have counsellors (not herself), but when I asked what kind of degree/training they had, she let that question slide without an answer. I picked up a lot of literature. While I was admiring all of their glossy pamphlets, I asked how they were funded and she said by donations only. She told me the health hazards of my daughter having an abortion, breast cancer, infertility, and of course post-abortion syndrome, making that sound very ominous. She gave me a little plastic 2-½ inch long fetus, perfectly formed right down to his testicles in a little teddy bear bunting bag to show my daughter exactly what she would be killing. 'It's not just a little blob like they tell you, you know?' I also received the little ten-week feet pin to wear."*

Salmon Arm / Revelstoke

Nurses from Options for Sexual Health in Revelstoke, Sicamous, and Salmon Arm said that there was a very active anti-choice movement in the area. They hold an annual Mother's Day march, and badger local physicians about abortion. The nurses reported that at three area walk-in clinics, doctors block access to abortion and do not provide referrals, although at one clinic, front-line staff would try to get information to women on where to go and what to do.

Vernon

An center that helps refer women for abortions reported the following:

- CPCs used to be listed under abortion services in the Yellow Pages. Bus stop ads and large billboards advertising CPCs are common, as are large print ads in local newspapers.
- When women have gone to the local Birthright office, some have had to wait an hour and a half before being given a pregnancy test, during which time they were put in a room to watch anti-abortion videos like the "Silent Scream".
- The Salvation Army started providing counselling in the community. It took one woman three weeks before she was able to come to a pro-choice service for help after being completely traumatized by the Salvation Army counsellor. The client was a young mother with two small children and was told it was a sin against God to even consider having an abortion.
- A 15-year old girl went to her family doctor and told him she thought she was pregnant. He phoned her parents. Another girl wanted to get the birth control pill but her doctor told her that she needed her mom and dad's permission. One woman showed up at the pro-choice service because she had been refused a referral by her family physician. She said: "I don't know what to do, who to see, where to go."
- There are two drop-in medical clinics in Vernon, but neither will give out emergency contraception. There are no abortion services at Vernon Hospital. If you call the hospital to ask about abortion, they don't return calls.
- An anti-choice teacher at a local high school started an essay contest, apparently sponsored by the Vernon Teachers' Association. The essay question was, "Why is Abortion Wrong? The pro-choice service called local trustees and the contest was eventually pulled.

Castlegar

Nurses at the Options for Sexual Health clinic reported that the Castlegar Hospital's Emergency is non-responsive to women coming for emergency contraception. Anti-choice groups do a lot of advertising, as well as some post-abortion counselling, but they don't have an office in town.

Sunshine Coast

Medical clinics from Gibsons to Madiera Park were positive and open to receiving our volunteer's abortion resources and info services. In Sechelt there was a strong Planned Parenthood presence, and St. Mary's hospital was a trusted facility for abortion services.

The Women's Centre in Sechelt had an extensive display of brochures on all areas of sexual health. They did not know anything about CPCs, as there is no CPC presence in the community. The Public Health nurse has found little opposition to the issues of choice.

In Powell River, there was no facility to obtain an abortion. It was not a subject that comes up according to the local physician we spoke to, because of the dominant anti-choice attitudes in the community. The public health nurse also found it difficult to communicate to the young women in the community about the options around sexual health because of the control of the Catholic Church in the community.

The Coastal Health office displayed extensive information on posters and in brochures about sexual health, safety, and choice. The public health nurses are aware of the CPC activity because the Pro-Life Society is around the corner. It houses one of the fundamentalist Christian CPCs that uses high-pressure techniques and is connected to the larger network of North American CPCs. They display high-quality printed pamphlets and books supplied by the American-based Focus on the Family.

Powell River also has a Birthright office, but the approach is less organized and aggressive than the Fundamentalist-run CPC. However, they work together, with the Birthright office referring clients to the Pro-Life Society in Powell River for "counselling."

Squamish, Whistler, Pemberton

The Howe Sound Women's Centre serves the entire corridor. They did not know about CPCs or the services they offer. In Squamish, the public health nurses supply women with information on where to call for info on pregnancy options. They did not know anything about CPCs and their misinformation.

A CPC beside a walk-in medical clinic in Esquimalt

In Whistler and Pemberton, the public health nurses are trained to offer the SAFE info sessions that are part of the Options for Sexual Health outreach program to smaller communities. These sessions offer information on sexual health and options one night a week. They also refer to the Facts of Life line where more specific info about pregnancy options can be obtained. They did not know anything about CPCs.

Vancouver Island

We visited the Island Sexual Health Authority, which offered the same kind of services and support as Options for Sexual Health in the Lower Mainland. They were aware of CPCs but did not know about their tactics. Due to funding cuts, they could no longer offer sex-ed support to the local schools. (Fortunately, they were able to reinstate their sex-ed educator shortly after our visit.)

At the Admiral Way Shopping Centre in Esquimalt, a CPC was found sandwiched between a walk-in medical clinic and a medical lab. The signage for the clinic, CPC, and lab were the same size, colour, and typeset, which implied the same degree of medical authority for all three. At the walk-in clinic, we asked for information on getting an abortion and were given the card for the CPC next door. When we told them the CPC was an anti-abortion centre with a policy of not providing information about obtaining an abortion, they were adamant that that was the only referral they would give, and said that the medical clinic owners and the doctors at the clinic didn't agree with abortion.

In Nanaimo, we visited the Wellington Medical Clinic. The public health nurse was aware of CPCs in a general way, but was surprised to hear they counsel youth that abstinence is the only way to avoid STDs and that condoms and other contraceptive devices do not protect.

In Duncan, the Family Life Association was the local anti-choice centre. It was listed in the telephone book under "Family Violence Intervention", demonstrating that some Christian agencies offer services and counselling that encompasses all aspects of women's sexuality and personal lives. However, the counselling is not based on medical, psychological, or sociological expertise, but on the values and morals of a literal interpretation of Christian Scripture.

Misinformation and Deceptive Tactics from CPCs

The following activities and strategies are common to many or most CPCs throughout North America.

- **Deception:** CPCs hide their true agenda and deceive women. They gain the trust of public, government, funders, and women by pretending to be medical clinics, or professional counselling centres. They don't say upfront they're anti-abortion or religiously-affiliated. Instead they imply in ads and on the phone they'll help any woman with problem pregnancies, including abortion ("Pregnant? Scared? We can help."). They entice a woman into their office under the pretence they will help with an abortion and give her safe, unbiased, professional counselling. But when she gets there, they keep her "captive" for as long as possible to try and steer her away from abortion. E.g., they provide a simple drugstore pregnancy test and make the woman wait half an hour for the results, while subjecting her to anti-abortion propaganda or videos.

  Often they are not upfront with clients, e.g, they won't say directly whether she's pregnant or not, and may lead women to believe they are pregnant when they're not (to indoctrinate them), or not pregnant when they are (to delay them seeking abortion care). In California, two weeks after a woman was led to believe by a centre that she wasn't pregnant, her ectopic pregnancy burst, almost killing her.[3] In Canada, they may assure women they can get abortions right up to 9 months of pregnancy, because "there's no law" in Canada.

  > Example of deception: The Fraser Valley Pregnancy Centre says they are "*not a medical facility; therefore, the centre neither performs nor refers for abortion, and does not provide birth control instructions*." Of course, this is not the real reason they don't provide those services, since anyone can refer for an abortion.

  CPCs will also spread false and defamatory information about abortion providers and clinics. Staff at CPCs portray abortion clinics as money-driven, and claim that they aggressively push abortion and lie to women to pressure them into abortions. They say that the procedure and the equipment used will hurt women, and that abortion clinics are filthy and the doctors use dirty instruments. They say that providers do not inform women of the medical risks of abortion.

- **Proximity to Abortion Clinics:** CPCs locate themselves near abortion clinics to lure in clients trying to get to the abortion clinic. CPC staff will even sometimes hang out in the hallway or outside the abortion clinic to try and capture women going there and redirect them to the CPC. Often the CPC name will be deceptively similar to the abortion clinic, or be vague and sound woman-friendly, giving no indication of their anti-abortion agenda (e.g., Choices Resource Center, Everywoman's Help Centre).

- **Only Goal to Prevent Abortion:** CPCs exist to prevent abortion, and their primary target is "abortion-minded women". They are not really interested in helping women who just want to have babies. In the U.S., a report by the Family Research Council cautioned against the trend of diverting resources to helping women have their babies, because "these trends could threaten the primary mission of the centres – to reach women at risk for abortion."[4] Also, once women give birth, or are past the point where they can get a legal abortion, they are generally left to fend for themselves.

- **Lack of Medical Training:** CPCs use authoritative voices in literature and videos (men, doctors, etc.) to persuade women against abortion. Most CPCs have no medically trained or medically supervised personnel. Many are volunteer-staffed, and volunteer counsellor training is limited to a few hours or days, or two or three weeks at most. In the U.S., counsellors can get an "accredited" counselling certificate from a Baptist seminary in two weeks. All staff and volunteers must be Christians and sign/abide by a statement of faith (Appendix 5).

- **Promoting Negative Emotions:** CPCs induce guilt, confusion, anxiety, and emotional trauma in women considering abortion. Everywhere she looks in a CPC, the woman sees baby pictures and baby supplies, and anti-abortion literature. Bathrooms may be baby-changing rooms. In one centre in the U.S., staff were hanging banners in the staff room with lists of names of "Babies Saved from Abortion" and "Salvations."[5]

- **Inducing Guilt:** CPCs conduct unprofessional post-abortion counselling, based on a guilt / forgiveness / redemption model. Many centres have expanded into post-abortion counselling. They induce guilt in the woman for killing her baby, help her personify the fetus and grieve for it, help her obtain forgiveness from God and from herself. This expands their pool of supporters and future leaders/trainers/ counsellors/activists. They use these "aborted women" to speak out about their bad abortion experiences and lobby for abortion to be illegal, to save other women from the "trauma" and "guilt" of abortion.

- **Pathologizing Abortion:** CPCs pathologize abortion by making it very negative. E.g., abortion is linked to "killing" and "murder". The CPC pamphlet *Making an informed Decision About Your Pregnancy,* says that having an abortion causes stress, sadness, long-term grief, anger, sexual dysfunction, guilt, flashbacks, memory repression, anniversary reactions, hallucinations, suicidal ideas, increased alcohol and drug use, and difficulty keeping close relationships. Such words connect abortion to pathology and the impression of a legitimate disorder called "post-abortion syndrome".

- **Shock Tactics:** CPCs use graphic videos and pictures to shock and horrify young women about abortion. They also use testimonials from distraught women who regret their abortions. This is practically a form of terrorism, because it induces fear and emotional trauma.

- **Medical Misinformation:** CPCs provide misinformation about abortion and its risks, designed to scare, confuse, and dissuade.[6] For example, breast cancer causes abortion, abortion leads to infertility, abortion has serious physical and emotional side-effects, such as higher suicide rates, uterine scarring, higher risk of subsequent miscarriage and premature birth. Videos are shown to women describing abortion procedures and possible complications in often horrific detail, using inflammatory language and unpleasant medical descriptions. They imply complications are common and serious, and that providers are callous and careless. In the U.S., a government study found that 20 out of 23 federally-funded anti-abortion counselling centres provided false or misleading information about the effects of abortion.[7]

- **Never Abortion, No Matter What:** CPCs persuade women against abortion regardless of their needs, desires, or circumstances, including imposing judgmental values onto women. Their bottom line is to prevent abortion in any way possible, not help women or "do no harm." If a woman is intent on abortion, the CPC counsellor may say things like "You'll always be the mother of a dead baby." Even if a woman has been raped, or if her fetus has grave deformities and won't survive after birth, she will be urged to carry to term.

  Example: Brian Norton, Executive Director of the Christian Advocacy Society that oversees the CPCs, wrote this story in a newsletter.

  "This month I was distraught and humbled while providing crisis support to a married couple. They were facing a heart-wrenching 'decision' – should they abort their severely disabled baby? Their unborn daughter at 23 weeks was diagnosed with Cytogenesis Imperfecta (Brittle Bone disease). This horrible rare disease is an abnormal fragility of bones causing on-going fractures and deformity – there is no cure. Their baby's prognosis is most severe. If Lucy (her real name) were to survive to delivery, her life expectancy will be only a day or two. And now while in the womb, kicking, Lucy's bones are starting to break. The family physician and the

perinatal specialist advised termination. The hearts of this couple were sick. Through their pastor, our Center [a CPC] was contacted for help. Questioning my adequacy as a helper I listened to their fears and their questions. They are Christian. This is a worst case situation. Where is God in this? They were favoring abortion, not because their child is disabled and in pain. Lucy was not going to survive anyway. Perhaps termination is best, at least permissible – to alleviate suffering for Lucy. When asked I replied (with pained apprehension) that I could not support the recommendation to abort Lucy. I shared that from all Biblical accounts, human life is sacred. All human life has intrinsic value because we are created in God's image. And what about the severely handicapped pre-born child? My belief is that God loves 'the least of these.'"

- **Anti-Contraception:** CPCs counsel against contraception, and refuse to provide information, except for misinformation about its efficacy. E.g., condoms don't protect against HIV or STD's, contraception is unreliable and "against God's plan," safe sex is impossible.

- **Promoting Abstinence:** CPCs promote abstinence except outside of marriage, regardless of the woman's situation or needs. E.g., a woman living with her boyfriend is unlikely to practice abstinence, but that's the only option given. CPCs promote an ideology that paints sex as dangerous, limiting women's sexual choices and sexual enjoyment, and turning sex into a duty to procreate instead.

- **Proselytizing Christianity:** CPCs disrespect own women's spiritual values and impose fundamentalist Christianity. They won't say upfront they are religious, and will lie about being religiously-affiliated to get a woman into the centre. Once she's there, they will engage her in discussion about her religious views, and preach fundamentalist Christianity to her, regardless of her own expressed wishes and beliefs.

  Example: A woman who attended our secular (pro-choice) Post Abortion Support group found a CPC pamphlet which had been "planted" at Options for Sexual Health in Vancouver (formally BC Planned Parenthood). The pamphlet did not identify the CPC, but merely offered free post-abortion counselling. When our client called, she specifically asked if it was religiously-based counselling. She was told "No, it was not." This woman was angry and hurt when she attended the CPC post-abortion counselling and found that it was indeed a religiously-based service. She was pressured to fill in forms revealing her identity and the volunteer "counsellor" actually kneeled next to her and asked if she could pray with her for her dead baby. This "counselling" was not only deceitful in its misrepresentation, but was designed to instill guilt and trauma based on the moral narrative of the fundamentalist beliefs of the CPC.

- **Abuse of Trust:** CPCs abuse a woman's trust and take away her emotional safety net by exploiting her vulnerabilities and private stories, and using them against her, breaking her confidentiality. For example, they may use elements of her story in spoken prayers, call her at home afterwards to apply pressure, inform her parents or her doctor about her intent to get an abortion, or harass her later if she has an abortion.

- **Exaggerated Promises of Help:** CPCs tend to imply in ads and on the phone that their range of services and ability to help are greater than they really are. They promise financial assistance, medical treatment, prenatal and postpartum care, adoption or child-care arrangements, and/or psychological counselling to convince women to carry their pregnancies to term. In reality those services are not offered or are very limited.

- **Limited Services:** CPCs provide limited services. They provide no pregnancy prevention services, except sometimes Natural Family Planning for married women only. They

offer limited pregnancy testing (drugstore kits), biased options counselling by anti-choice volunteers (including abortion misinformation), "post-abortion stress" counselling, and limited information about community resources. Abortion clinics offer a much wider range of services.[8] Many CPCs provide prenatal services and baby supplies only up to 24 weeks, the cutoff point for abortion in the U.S. They actually have a limited supply of free prenatal and baby supplies, which they don't really like to give out to women planning to have their babies, since their main target is "abortion-minded" women. In the U.S., "Earn while you learn" programs require women to go to church and Bible study classes, and report back what they learned, in exchange for "free" baby services and supplies.[9]

- **Abuse of Ultrasound:** CPCs use ultrasounds as a common tool to dissuade women from abortions, even though non-clinical use should be avoided. Studies have repeatedly demonstrated that prolonged exposure to ultrasound can damage fetal tissue.[10] New research shows that overexposure to ultrasound can affect fetal brain development, and probably contributes to a range of disorders, including mental retardation, childhood epilepsy, autism, dyslexia, and schizophrenia.[11] Also, prenatal ultrasounds expose a fetus to sound levels registering at 100 decibels, as loud as a subway train coming into a station. At CPCs, prolonged and repeated ultrasound exposure is common. Technicians are often not fully or properly trained (e.g., not trained to identify fetal anomalies), and centres are often not regulated or licensed, or they try to get around medical guidelines or regulations. One centre's sole criteria for the "medical necessity" of ultrasound is whether the woman is "abortion-minded."[12] Many centres get their ultrasound machines through government funding, or by subsidized donation from Focus on the Family, who helps them through the whole process.

- **Separating Woman from Fetus:** CPCs separate the woman from the fetus. Woman becomes the invisible container, the fetus becomes the future citizen. For example, pictures of fetuses in utero erase the uterus and the woman. An anti-abortion bumper sticker says: "Support our future troops." This language makes women invisible, reducing them to receptacles for cannon fodder.

- **Patriarchal Language / Anti-Feminism:** CPCs use language and assumptions of patriarchy, male dominance, and women's oppression to frame their position and ethics around abortion. They also use fundamentalist Christianity to pit women against their own rights and equality. For example, on a training chart for counsellors, beliefs are divided into two categories: Christian and feminist. Feminists are pro-women's rights, Christians are pro-babies' rights, feminists are for equal pay, Christians are for family values, and so on. This tactic divides women, using peer pressure as a way of alienating women away from identifying with feminism. The CPCs use the language and authority of the dominant patriarchal ideology, while loading emotional baggage of shame, blame, and fear onto the feminist message of women's rights to sexual autonomy and health.

- **Preventing Proper Medical Care:** CPCs may inadvertently prevent women from obtaining real pre-natal care, because they lead women to believe the centre is giving them such care, i.e., by providing a sonogram, by implying they are a medical clinic with medical professionals, and by telling them the local abortion clinic will hurt them and the baby. Therefore, women may neglect or avoid getting proper healthcare. CPCs only "treat" for post-abortion syndrome, which doesn't even exist. They don't provide proper mental health services either; in fact, they may induce mental trauma in women.[13]

- **Misuse of Charity Status:** Many CPCs have charitable tax status (in Canada), but at least some appear to devote more than 10% of their resources to political activities rather than actual support services. This is against federal charity laws. As well, they provide false information and propaganda, rather than true counselling or education. About 19 CPCs in BC have charitable tax status (and about 90 in Canada as a whole).[14]

Adoption

Adoption is heavily promoted by CPCs as an alternative to abortion. This requires ignoring the fact that adoption is a very difficult choice that few women are willing to consider. There are no recent Canadian statistics, but in 1989, only 2% of single pregnant women under age 25 gave up their babies for adoption (compared to 5% in 1981), with 60% raising the child and 38% opting for an abortion.[15] Abortion became easier to access in 1988 after Canada's abortion law was struck down, so it's possible that the percentage of women opting for adoption today has decreased even more since 1989. When abortion services are legally available, most women who cannot or do not want to have children will choose abortion over adoption. In the United States, an estimated 4% of non-marital births result in adoption, and there are about 20 abortions for every baby given up for adoption.[1617]

Some CPCs in the U.S. have been sued due to adoption irregularities. Women have reported the withholding of medical care unless they sign adoption papers, lying about the significance of the adoption forms, prioritizing the interests of adoptive parents over the birth mother, and trying to isolate pregnant minors from their parents or the newborn child. Adoptive parents usually are born-again Christians, financial donors to the centre itself.[18] Many American CPCs run the equivalent of illegal adoption rackets, charging adoptive parents thousands of dollars.[19]

CPC Structure and Hierarchy

CPCs are unregulated and unlicensed, while abortion clinics are accredited, licensed, and subject to inspections and other legal requirements (especially in the US). CPCs don't have to be regulated because they don't offer medical services.

Most CPCs in BC belong to the umbrella group Christian Association of Pregnancy Support Service (CAPSS), which equips and provides consultation to existing CPCs and helps develop new ones. CAPSS was co-founded by the Christian Advocacy Society of Greater Vancouver, which uses the same address as the main Burnaby CPC.

CAPSS includes board members from James Dobson's Focus on the Family in Colorado (a very powerful and wealthy right-wing religious group). Much of the support and resources for CPCs are supplied from this group and other Religious Right and anti-abortion groups in the U.S. The two main organizations in the U.S. are Heartbeat International and Care Net, with CAPSS closely tied to both.

Focus on the Family supplies Canadian CPCs with expensive pamphlets, videos, and books. Other anti-abortion groups supply TV commercials, a 24-hour crisis pregnancy hotline, and an established hierarchy of authoritative voices. For example, CPC training is standardized into videos and manuals that are the same or similar throughout North America (in Canada, materials are produced in Calgary).

Also, all CPCs in Canada are linked to a 24-hour toll free crisis help line out of Ohio that connects women to a volunteer in their area. The National Help Line Statistics (See Appendix 6) shows the total number of calls Canadian CAPSS affiliates received during 2004.

Television commercials advertising the toll-free 24-hour phone line reach millions of women in North America, who are directed to a CPC in their own community. These anti-choice commercials are seen on popular TV shows during the day (such as Dr. Phil and Ellen) and in primetime on CTV. These TV ads cost tens of thousands of dollars, the funds for which are raised mostly by the annual "Focus on Life" fundraising dinner held in Vancouver, sponsored by the BC Pro-Life Society and the Vancouver Archdiocese.

Most CPCs in Canada follow Care Net guidelines. Birthright is also a major player and founded the first anti-abortion centre in Toronto in 1968. Today they have 400 chapters mostly in the U.S. and Canada. In comparison to other CPCs however, Birthright tends to be much milder in terms of tactics and counselling techniques.

Funding of CPCs

CPCs in the U.S. have been receiving increasingly large amounts of funding. Since 2001, they have received over $30 million in federal funding from programs promoting abstinence/only education.[20] Additional federal funding has been distributed as capacity-building" grants to 25 centres in 15 states, and extra funding via appropriations bills. Many states provide millions more in state funding[21]. About a dozen states have "Choose Life" licence plate programs, which are government administered and generally give funds raised to CPCs.

Centres are using this funding to expand services and clientele, professionalize themselves, buy ultrasound machines, and advertise. Some centres are adding services like rape relief counselling, battered women's shelters, testing for STDs, pap smears, Natural Family Planning, prenatal care, birthing centres, parenting classes, and even well-baby care. Ironically, they are taking on some traditionally feminist services, while operating on anti-feminist ideology. In a way, they are trying to replace feminist women's centres, who struggle for funding. In the U.S., funding is being redirected to CPCs and away from critical family planning services and reproductive health services offered by Planned Parenthood and other clinics.

In BC in 2002 (or 2003), at least one or more CPCs belonging to CAPSS got a $64,000 grant from the BC Liberal government's Ministry of Community, Aboriginal and Women's Services. In the same year, the government cut 100% of funding to feminist women's centres. It is difficult to verify whether CPCs in BC have received any other government funding. However, at the federal level, Status of Women Canada changed their mandate and funding criteria in 2006. For the first time, this made it possible for non-equality-seeking groups and faith-based groups to secure funding.

In the U.S., anti-choice federal legislators have repeatedly sought direct funding for CPCs through various bills, including bills to fund purchase of ultrasound machines. No doubt, Canadian CPCs are benefiting at least indirectly from this American largesse, including the ability to use large amounts of professionally-produced literature, videos, and other materials from the U.S.

Conclusion

The research undertaken in this project revealed a strong need for public education about CPCs. It is important to educate women, the public, media, and government about the true CPC agenda to ensure that they are not trusted under their false pretences. Also, women's centres, medical clinics, and even abortion clinics need education, because they are often not familiar with the CPC agenda, and may not know how to respond when women describe their treatment there. Some well-meaning healthcare professionals refer to CPCs without realizing who they are. Others are confused by the stories women tell about the CPCs they've visited, and don't know how to undo the damage done, or can't provide the accurate information to overcome the misinformation from the CPCs. Governments may provide funding to CPCs without being aware of the centre's religious anti-abortion agenda.

As a result of the findings, suggested recommendations and future goals include:

- Stop deceptive advertising and false representations of CPCs in the media.
- Remove CPCs from referral lists used by the medical profession or social services.
- Ensure that the medical profession and social services have accurate information so they can refer women for abortion appropriately.
- Create more pro-choice counselling in communities, both options and post-abortion.
- Lobby governments and public foundations to stop funding CPCs.
- Ask Canada Revenue Agency to revoke the charity status of CPCs that have it.

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Appendix 1: Correcting Medical Misinformation

We hired a family doctor and a medical researcher to go through the *Volunteer Training Manual for the Crisis Pregnancy Centre Ministry,* and identify and refute any medical errors or scientific distortions. They produced a detailed report critiquing and refuting many aspects of the manual, and providing support from the scientific literature. There were serious inaccuracies and distortions in many areas. These errors are taught to the counsellors, who pass them on to unsuspecting women.

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Dawn Fowler, Vancouver Island Women's Clinic (in 2006)
With editing by Joyce Arthur

Introduction

The *Volunteer Training Manual for the Crisis Pregnancy Centre Ministry* (published by CAPSS) has factually correct information in many places, but it's presented in a slanted way or written with value judgments. The position of the Crisis Pregnancy Centres and their Ministries will never change. There is no common ground because what they say is based on their beliefs and morals. They take fact and weave a story that supports their anti-choice position.

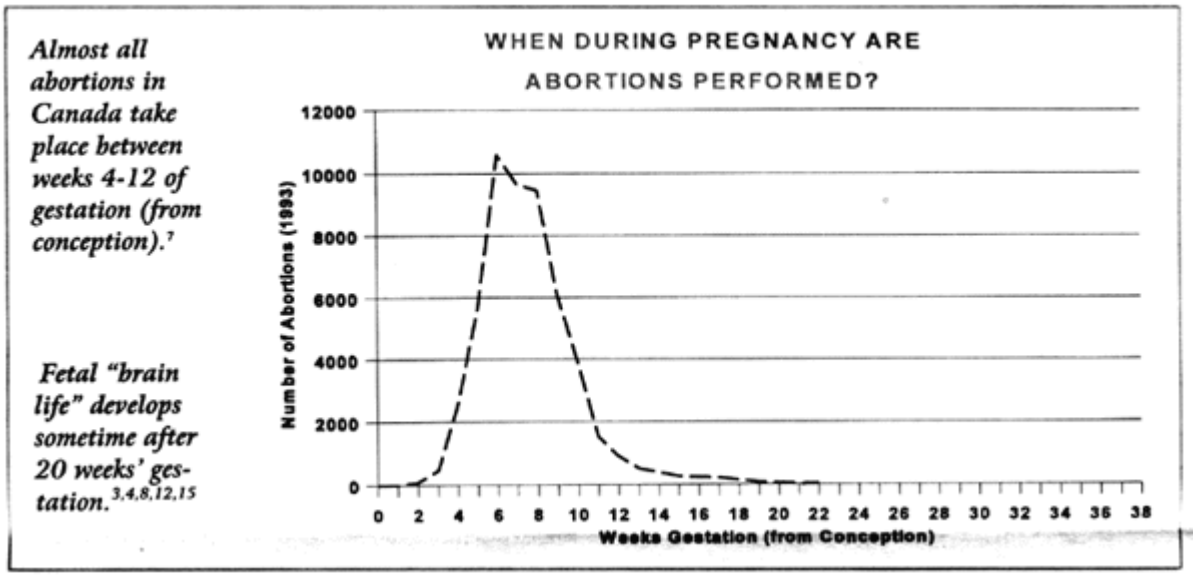
As healthcare professionals, we have tried to address any factually incorrect statement and offer what the evidence says, including abstracts and supporting references. We found it is critically important to question the evidence whenever the manual says something based on fact. For example, sources and statistics cited are often solely taken from anti-abortion literature, with no scientific evidence cited from a reputable source (e.g., *High Rate of Condom Failure*, page 152 of the manual). When references are cited from reputable sources (e.g., *Sexually Transmitted Diseases*, page 163), they are used selectively, misrepresented, or taken out of context to support anti-abortion claims.

Pregnancy and fetal development

CPC Training Manual Excerpts	Physician Rebuttal
Conception: Pregnancy can be detected within days of conception. Many women do not seek out confirmation of a pregnancy until after their first missed period. A missed period is one of the first early signs of pregnancy. *(page 40)* **Determining Due Date:** The medical model counts 40 gestational weeks in a pregnancy. Thus the count begins on the first day of the last menstrual period (LMP). Confusion occurs for clients and volunteers around literature and due dates, particularly if a client knows the exact day she conceived. Her calculations and the doctor's may contradict, since she is counting from fertilization and he is counting from LMP. Literature explaining fetal development begins its count at fertilization, which is generally the second	The sources they use for their information are not from any reputable, non-biased scientific source – what they offer is thus subject to question as it is not supported by the research community. The section on conception is accurate, with the exception that pregnancy can be detected "within days of conception". Actually, it is usually a week to ten days after conception that a pregnancy can be detected and this is through a blood test. The earliest a urine test can detect a pregnancy is about 20 days after conception. (Source: University of Michigan Health System http://www.med.umich.edu) The section on determining the due date is accurate. Note that the materials refer to the doctor as "he". More than 50% of graduates from medical school are

Pregnancy and fetal development

CPC Training Manual Excerpts	Physician Rebuttal
gestational week of a pregnancy. *(page 40)* **Landmarks of Fetal Development**[36]: By 13 days after fertilization: every part of the body has begun to form. By the 18th day: the heart is beating. By 42 days: brain activity can be recorded using an EEG device. By 7 weeks: the fetus has the same fingerprints which it will carry for the rest of his or her life. By 8 weeks: the fetus begins to respond to touch and moves away from painful contact. Between 8 and 13½ weeks: the brain and nervous system of the fetus are able to send and receive pain messages. By 9-10 weeks after fertilization: the body is virtually complete. The arms, legs, fingers, toes, and internal organs of the fetus are present and functioning. Changes subsequent to the ninth month are primarily changes in size, rather than appearance. *(page 41)* [36] From Pregnancy Resource Centre, Making an Informed Decision About Your Pregnancy, Grand Rapids, Michigan: Frontline Publications, 1988, p. 2.	female. (Source: Burton, K & Wong, I. CMAJ, April 17, 2004; 170(9)) The extent of fetal development is exaggerated and false. It is not possible to record fetal brain activity before 20-24 weeks, and fetuses cannot feel pain until at least the third trimester. (Sources: *'Brain Waves'* http://eileen.250x.com/Main/Einstein/Brain_Waves.htm and *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence,* http://jama.ama-assn.org/cgi/content/short/294/8/947) We took the following graph from Childbirth by Choice material showing when most abortions occur. Please note the X-axis, which refers to weeks from conception. In the medical field, pregnancy dating is never from gestation but from LMP (last menstrual period – two weeks prior to conception).



Abortion Procedures	
CPC Training Manual Excerpts	**Physician Rebuttal**
Menstrual Extraction (Manual Vacuum Extraction): This procedure is performed very early in the pregnancy, within the first 50 days after the last menstrual period (LMP). At present this method has limited use, but is increasing in popularity since the advent of accurate early pregnancy testing. Women prefer it because it can be done so early in the pregnancy. The procedure can be done in abortion clinics or a gynecologist's office in several minutes. It requires no special equipment, only a syringe, a short length of tubing and a manually operated vacuum source. *(page 46)* The 50-cc syringe is inserted into the cervix and the uterus is vacuumed out. Because this procedure is performed so early, little or no dilation of the cervix is needed. No anesthetic is used. *(page 46)* The major disadvantage of this method is that there is a higher rate of continued pregnancy than in abortions performed later in pregnancy.[37] The retained tissue rate is also higher. *(page 46)* [37] Warren M. Hem, M.D., M.P.H., Abortion Practice, Boulder, Colorado: Alpenglo Graphics, 1990, p.178.	• 50cc syringe is not inserted into the cervix • anaesthetic is used • done in 2-3 minutes (not several) • up to 9 weeks (63 days after LMP) • more popular because it's quiet and because it's done in the office • commonly done in developing world as it doesn't require electricity
Suction Curettage: This is the most common method used in first trimester abortions. The procedure may be painful, so it is most frequently done under local anesthetic. General anesthetics are rarely used because of the greater risks associated with this anesthetic (convulsions, cardiorespiratory arrest, heavier bleeding; the risk of perforation is greater, as is the risk of patient inhaling vomitus, causing suffocation or even death). *(page 47)* In a suction abortion, the doctor dilates the cervix with mechanical dilators or laminaria (a porous substance that is inserted hours or days before the abortion and absorbs moisture, gradually dilating the cervix). *(page 47)* The cannula (a hollow tube attached to a vacuum source) is then inserted into the uterus through the dilated cervix. The suction created by the vacuum then detaches the placenta from the uterine lining, dismembering the fetus and tearing the placenta into small pieces, which are then sucked through the cannula. The size of the cannula is determined by the size of the fetus at the time of abortion. Pieces of the fetus that are too large to fit through the cannula are then removed with instruments. *(page 47)*	• 90% of all 1st trimester abortions • local anesthetic AND conscious sedation • general anesthetic increases risk • childbirth is painful • suction does not detach placenta as there is none • the fetus is not torn apart • instruments are rarely used • risks are less than 1%
Dilation and Curettage (D&C): This procedure is often used in second trimester miscarriages to ensure that no fetal tissue is left behind following a spontaneous abortion. In an elective abortion procedure, the cervix is dilated in the same way as in the suction curettage method. Then a curette or loop-shaped knife is inserted to	This procedure is not used. Presumably, they mean "dilation, suction-curettage." The facts are: • <1% hemorrhage needing treatment • <1% infection requiring antibiotics

Abortion Procedures	
CPC Training Manual Excerpts	**Physician Rebuttal**
remove the fetus and scrape the uterine lining to detach the placenta. This method takes longer and requires more dilation. It is considered a higher risk than suction curettage. *(page 47)* First trimester risks: Cervical tearing and laceration. Perforation of the uterus (subsequent damage to other internal organs). Scarring of the uterine lining. Infection. Hemorrhage and shock. Anesthesia toxicity. Retained tissue: incomplete abortion (symptoms: high fever, infection, cramping, heavy bleeding). *(page 48)* Postabortal syndrome: Uterine atony (enlarged, tender, boggy uterus retaining blood clots). This risk factor increases if patient is not monitored for several hours post-operatively. When this complication arises standard treatment is resuctioning and medication. If not treated promptly, the patient can experience sepsis (generalized infection), excessive blood loss and even possibly a hysterectomy. *(page 48)*	• <0.1% perforate, cervical tear • <0.01% lose uterus • <0.01% post abortal syndrome
Dilation and Evacuation: Between 13 and 14 weeks from the LMP, fetal weight doubles. At this point in the development of the fetus, it has grown too large to be broken up by suctioning, and can no longer pass through the cannula. In this procedure, the doctor grasps body parts with an instrument and detaches them off inside the uterus. Usually the skull must be crushed in order to remove it. Skeletal structures, which were cartilage, are now calcifying and turning into bone. Particularly in later second trimester abortions (after 20 weeks) this issue of bone calcification may be dealt with by softening fetal tissues through an infusion of urea into the amniotic fluid. Another method is to rupture the membranes and to cut the umbilical cord 24 hours before the abortion. Both of these techniques cause breakdown of the baby's tissues. To insure all body parts have been removed, an ultrasound is sometimes performed after the abortion procedure is done. A reassembling of body parts further confirms that all parts of the fetus have been removed. *(page 49)* Specific complications of this method are: greater risk of cervical laceration because of the larger instruments used and uterine perforation by the instruments or by the long-bones and skull. Perforation of the uterus could result in hemorrhage or infection. *(page 49)*	• does not detach instruments inside uterus • rupture of membranes 24hrs prior is extremely rare • laminaria are always used to open the cervix overnight prior to the procedure • complication risk still less than 1%
Saline: …. This procedure, though common in the past, is rarely used today. *(page 49)* **Prostaglandin • Hysterotomy • Partial-birth Abortion (Dilation and Extraction or D&X)**	• saline, hysterotomy, and prostaglandin no longer done in North America • partial-birth abortion not a medical term • D&X not done in Canada; performed rarely in U.S.

Abortion Procedures

CPC Training Manual Excerpts	Physician Rebuttal
RU-486: (Currently this drug is undergoing clinical trials in Canada) *(page 51)* Mifepristone (RU 486) is used in conjunction with the hormone prostaglandin. The window of opportunity for this method is limited. The drugs must be given to women who are between 30 and 49 days from LMP. *(page 51)* The complications can include: continued pregnancy requiring surgic al abortion (I percent), retained tissue (2 percent), and excessive bleeding (1 percent). Side effects that can occur are nausea, vomiting and diarrhea. *(page 52)*	• RU-486 not in Canada • no current clinical trials • common in US and Europe • used up to 63 days • pills are given 24 hours later at home
Methotrexate: This chemotherapy drug is licensed for use in Canada in the treatment of certain types of cancer. It acts to stop cell division in tumors. In certain communities physicians use it to terminate pregnancy. This drug, given to a pregnant woman, will cause cell division in the developing embryo or fetus to stop, thus killing it. The woman is then given drugs to cause contractions of the uterus and the expulsion of the fetus. *(page 52)* If an abortion is not accomplished by this method, and the pregnancy carries to term, the medication may cause fetal abnormalities. *(page 52)*	• careful follow-up to ensure completion • 95% effective Grimes, D.A. *Obstetrics & Gynecology* 1997;89:790-796. Medical abortion in early pregnancy: a review of the evidence. *Conclusions:* Medical abortion with mifepristone or methotrexate in combination with a prostaglandin is safe and effective. Hausknecht, Richard U., M.D. Methotrexate and Misoprostol to Terminate Early Pregnancy. *Journal of Medicine.* Volume 333 Aug. 31, 1995, Number 9. *Conclusions.* The combination of methotrexate and misoprostol represents a safe and effective alternative to invasive methods for the termination of early pregnancy.
Emergency Contraceptive Pills (The "Morning After Pill"): This method probably does not prevent conception. Rather, it most likely works by preventing the implantation of a fertilized egg. It is taken so close to the possible time of conception that no one knows whether or not the woman is actually pregnant when she takes the drug. *(page 52)* The "morning after pill" is not one single pill, but several doses of birth control pills taken at prescribed times within 72 hours of unprotected intercourse. … Nausea and vomiting are common side effects. These side effects can generally be managed by prescribing Gravol (dimenhydrinate) with the oral contraceptives. This procedure does fail in some instances. *(page 52)* Of particular concern is the misuse of the "morning after pill" by the adolescent population. Misuses recounted by adolescents include: self-medicating (using their friends' birth control pills) and frequent usage (after each occurrence of unprotected sex). *(page 52-53)*	• a contraceptive, not an abortion method • works primarily by preventing or delaying ovulation; little evidence that it interferes with implantation • 85% effective • not several, just two pills, progesterone only, with few side effects • no evidence that adolescents misuse

Abortion Risks	
CPC Training Manual Excerpts	**Physician Rebuttal**
Introduction: The medical community, in many instances, may fail to educate women adequately about how abortion procedures are performed and about the risks involved. They don't wish, they say, to make an already painful situation more difficult for the woman. In some instances the medical community will educate adequately about the procedure. In other instances patient education will not include abortion procedures and risks, but rather will look at contraceptive counselling in an attempt to proactively prevent further unplanned pregnancies. *(page 45)* The fact remains that all women deserve to have complete and accurate information on abortion before undergoing the procedure. Because some in the medical community are not explaining procedures adequately, CPC volunteers must take seriously the responsibility of informing all clients about the realities of abortion, as the volunteer counsellor may be the only one who discusses these important issues with them. *(page 46)*	Abortion providers give accurate informed consent and risk information to patients, as is required by any doctor for any treatment. Contraceptive and other counselling is often given in addition. CPC literature often falsely accuses secular women's health clinics of pushing abortions and not offering counselling of alternatives. In fact, it is CPCs that deny women access to not only the facts about abortion but also information about contraception and protection from STDs, which counsellors are also not allowed to offer.
Hospital Complication Rates: Every year each of the following physical complications of abortion are documented in Canadian hospitals: hemorrhage, infection, retained products of conception, laceration of the cervix and perforation of the uterus.[38] Over the last 20 years these complications have ranged annually from 3.3 percent (1976) to 1.1 percent (1995) of the number of abortions performed in Canadian hospitals.[39] For teenagers, complications always occur at a higher rate.[40] *(page 53)* These hospital complication rates, abortion advocates are quick to point out, are similar to or even less than the complication risks inherent in carrying a fetus to term. However, sometimes statistics conceal more than they reveal. What frequently fails to be mentioned is that these figures pertain only to abortion complications discovered while the patient is in the hospital.[41] For teen girls and women procuring an abortion, the average length of the hospital stay is less than one day.[42] When patients are readmitted hours or days later for abortion-related complications, these statistics are not recorded by Statistics Canada.[43] Later-occurring abortion complications, pelvic inflammatory disease and infertility, are also not recorded. Not even when discharged patients have died from abortion are the deaths noted as a complication of the procedure. *(page 53)* With the above in view, we must also look at long-term medical studies in determining an accurate account of abortion risk. Instances of ectopic pregnancies, for example, which cause 12 percent of all maternal deaths in the United States, are approximately double for women who have one abortion, and up to 4	Doctors have developed methods to make abortion very safe. A medical or surgical abortion is a very safe procedure if done by a trained professional and done according to the abortion protocol established by the National Abortion Federation. Abortion procedures do occasionally have complications, as does any medical procedure or treatment, and so does childbirth. Less than one in 100 abortions result in serious complications. The Canadian maternal mortality rate for 2001 was 7.8 per 100,000 live births or 26 maternal deaths. The infant mortality rate is 5.2 per 1,000 live births. A "maternal death" is the death of a woman while pregnant or within one year after the pregnancy. (Source: The Daily, Statistics Canada, Sept 23, 2003) There were no recorded deaths as a result of surgical abortion performed by an accredited physician. Thus, as medical procedures go, abortion is far safer than carrying a pregnancy to term and giving birth. Abortion is safest during

Abortion Risks

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times greater for those who have had 2 or more abortions.[44] The infectious complications of pelvic inflammatory disease can lead to fever and cause infertility. One medical researcher warns: "Pelvic infection is a common and serious complication of induced abortion and has been reported in up to 30% of all cases."[45] Other infections such as endometriosis are found to occur in 5 percent of women after an abortion. The risk is double for teenagers.[46] *(page 53-54)* 38 Statistics Canada, Therapeutic Abortions, 1995, Ottawa, Ontario: Health Statistics Division, 1997, Table 14, pp. 24-25. 39 Ibid. 40 Ibid., Table 2 1, p. 42 See previous years of Statistics Canada reports for comparisons. 41 Laura Fellenz, M.D., "Abortion Techniques and Risks," Crisis Pregnancy Centre Volunteer Training Seminar, Lecture presentation, Burnaby, British Columbia, 29 September 1992, passim. 42 Statistics Canada, ibid., Table 18, pp. 36-37. 43 Fellenz, ibid. 44 Pregnancy Resource Centre, Making an Informed Decision About Your Pregnancy, p. 4. 45 Ibid. 46 Ibid.	the first 12 weeks of pregnancy, when 88% of all abortions occur. • complication rate improving since 1988 • 1.1% is good • data on full-term pregnancy complications also not properly recorded by Stats Can • no evidence that abortion increases risk of ectopics Ferris LE et al. 1996. Factors associated with immediate abortion complications. *CMAJ*. 1996 Jun 1;154(11):1677-85. *Conclusion*: The risk of immediate complications from induced abortion is very low. Unlike in previous studies, the woman's age, parity and history of previous spontaneous or induced abortions were not found to be risk factors.
Second Trimester Abortion Risks: *(page 50)* • Toxicity to the mother due to the pharmacological agents used in abortion. • Failed abortion: live birth (A 1978 study revealed that 7 percent of prostaglandin-aborted fetuses showed signs of life.) • Retained tissue, including placenta • Uterine rupture - major surgery (possible hysterectomy) • Cervical laceration • Infection • Hemorrhage	• no toxicity as those methods are not used • no failed abortion as all tissue is seen Actual risks: • 1% retained tissue • 1% infection • <.1% cervical tear • <.1% hemorrhage
Future Childbearing Risks: The number of miscarriages is doubled for one abortion and tripled following two or more abortions.[48] Infant early death is multiplied between 2 and 4 times for abortive women .[49] There is also an increased risk of major and 50 minor malformations of future wanted children.[50] Infertility complications occur in up to 30 percent of	There is no documented evidence to suggest there is any impact on a woman's ability to conceive and carry a pregnancy to term based on her therapeutic abortion history. Inability to conceive or carry a pregnancy to term is based on many factors (e.g., genetics, environmental, etc.), but abortion is not a known risk factor for infertility or miscarriage. Parazzini F. et al. 1998. Induced abortion in the first trimester of pregnancy and risk of miscarriage. *Br J Obstet Gynaecol.* Apr;105(4):418-21. *Conclusion*: This study did not find any strong association between induced and spontaneous abortion. Kline J. et al. 1986. Induced abortion and the chromosomal characteristics of subsequent miscarriages (spontaneous abortions). *Am J Epidemiol*. Jun;123(6):1066-79. *Conclusion:* For both private and public patients, neither single nor multiple induced abortions as now

Abortion Risks	
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abortive women. A number of studies reveal that "between 3 and 5% of women are unable to conceive following abortion.[51] *(page 54)* 48 Pregnancy Resource Centre, Making an Informed Decision About Your Pregnancy, p. 5. 49 Ibid. 50 Ibid. 51 Ibid.	performed are likely to increase the risk of miscarriage in subsequent pregnancies. Xiong X, Fraser WD, Demianczuk NN. History of abortion, preterm, term birth, and risk of preeclampsia: a population-based study. *Am J Obstet Gynecol.* 2002 Oct;187(4):1013-8. *Results*: No significant difference was found in the incidence of preeclampsia in nulliparous women with previous abortion (2.6%) as compared to nulliparous women without previous abortion (2.9%). There was no increased risk of preeclampsia with multiple abortions, and a single previous abortion was associated with a slightly decreased risk of preeclampsia (0.84). 0.21 (95% confidence interval, 0.12-0.35), respectively. *Conclusion*: A history of term pregnancy (> or =37 weeks) conveys a substantial "protection" against preeclampsia in the subsequent pregnancy. Atrash HK, Hogue CJ. 1990. The effect of pregnancy termination on future reproduction. *Baillieres Clin Obstet Gynaecol*. 1990 Jun;4(2):391-405. *Conclusion*: Except for the association between pregnancies following dilatation and evacuation procedures and premature delivery and low birthweight, no significantly increased risk of adverse reproductive health has been observed following induced abortion. Harlap S et al. 1979. A prospective study of spontaneous fetal losses after induced abortions. *N Engl J Med*. Sep 27;301(13):677-81. *Conclusion*: These findings indicate that there is little or no risk of spontaneous abortions after induced abortions when performed by current techniques. Lao TT, Ho LE. 1998. Induced abortion is not a cause of subsequent preterm delivery in teenage pregnancies. *Hum Reprod.* Mar;13(3):758-61. *Conclusion*: Our findings indicate that previous induced abortion is not a significant cause of preterm labour and delivery in teenage pregnancies. Frank P et al. 1993. The effect of induced abortion on subsequent fertility. *Br J Obstet Gynaecol.* Jun;100(6):575-80. *Conclusion:* Induced abortion does not appear to have an important effect on future fertility.

Abortion and breast cancer	
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Before concluding our investigation of the data on medical complications, we need to address the current controversy of whether there is also a breast cancer link to induced abortion. Many prochoice advocates argue that any such alleged risk is simply an anti-abortion bias, used as a scare tactic. Prolife advocates claim otherwise. The politics of abortion must not be permitted to cloud this important and, if true, potentially life- threatening issue. We need to go where the evidence leads. *(page 54)* Statistics Canada reports that 1 in 9 Canadian women develop breast cancer, 52 and 25 percent of these women will die from their cancer. Decades of epidemiological research do suggest that women who procure an abortion are at an even greater risk of	Breast cancer is a very important health concern for women. For all women, the risk of breast cancer increases with age. According to the National Cancer Institute, this risk rises from about 1 in 252 for a woman in her thirties, to about 1 in 27 for a woman in her sixties, to a lifetime risk of about 1 in 8. Discovering the causes of this disease is a high priority for research scientists around the world. In March 2003, the National Cancer

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developing breast cancer.[52] A recent study, conducted by scientists at the Fred Hutchinson Cancer Research Centre in Seattle, revealed a 50 percent higher risk of breast cancer for women who had an abortion than women who have been pregnant and never had an abortion.[53] This study corroborates similar published reports, some of which found breast cancer risk to increase by greater than 100 percent.[54] *(page 55)* The Seattle study revealed a most provocative finding. For teenagers under the age of 18, the procuring of an abortion after 8 weeks gestation increases the risk of breast cancer before the age of 45 by 800 percent.[55] Incredibly, this information (though documented as data in a table) was not included in the summary report because, as one co-author put it: "We didn't want to alarm anyone before more research is done."[56]. *(page 55)* What do the other epidemiological studies suggest? New York City endocrinology professor, Joel Brind, Ph.D., in collaboration with Vernon Chinchill, Ph.D., Walter Severs, Ph.D., and Joan Sunny-Long, Ph.D., has reviewed and summarized all the medical research ever published on the subject. Dr. Brind's conclusion: "Putting it all together, the latest count of all published worldwide data specifically relating to induced abortion and breast cancer incidence has 24 out of 29 studies showing increased risk overall in the population studied."[57] On average, the data reveals a 30 percent higher risk of developing breast cancer for abortive women; the risk can be as much as 50 percent if the abortion occurs before the woman has had a full term pregnancy. *(page 55)* As induced abortion is one of the most common elective surgical procedure performed in North America, Dr. Brind and his team of researchers argue that health care professionals must inform their patients about what is currently known. "While other elective, risk-enhancing matters of choice, such as cigarette smoking, require thousands of exposures to produce detectable increases in cancer incidence, the induced abortion patient's risk of breast cancer in life is measurably increased after a single exposure."[58] *(page 56)* In the United States, as of 1996, three states have now enacted laws requiring that women be informed of the breast cancer risk before an abortion is procured. Other states are also considering mandating warnings. In Canada, to date our Federal Health Minister has decided not to instruct the Department of Health to consider such advisement. *(page 56)* 52 Jennifer Bradbury, Information Specialist, Canadian Cancer Society, British Columbia and Yukon Division Head Office, telephone interview by CAPSS, Vancouver, British Columbia, 18 December 1997. Also see Statistics Canada and National Cancer Institute of Canada, Canadian	Institute (NCI) declared emphatically that "newer studies consistently showed no association between induced and spontaneous abortions and breast cancer risk." NCI convened a symposium of over 100 of the world's leading experts, including epidemiologists, clinicians, and breast cancer advocates to review existing studies on the relationship between pregnancy, abortion, miscarriage, and breast cancer risk and concluded that having an abortion does **not** increase a woman's subsequent risk of developing breast cancer. Thus, while no causal relationship between abortion and breast cancer has been scientifically established, the anti-choice community continues to claim an association between abortion and an increased risk of breast cancer. Through propaganda, poorly designed and interpreted research studies, and misinformation, anti-choice groups attempt to dissuade women from choosing abortion by exploiting their fear of breast cancer. While anti-choice groups continue to wage well-publicized campaigns to spread misleading information, these groups were also behind attempts to pressure the NCI to change its patient information on abortion and breast cancer. NCI ultimately realized the need to base policy decisions on science and not political pressure, but other agencies may not be so vigilant. Armed with data from flawed or inappropriately interpreted research studies, anti-choice forces are lobbying politicians in the US for laws that mandate discussion of an increased risk of breast cancer as a recognized risk of abortion. Women deserve accurate information, not anti-choice scare tactics.

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Cancer Statistics, 1997, Ottawa, Ontario: Health Statistics Division, 1997, p. 11. 53 Gary Thomas, "Breast Cancer Coverage," Care Net Communications Brief, Sterling, Virginia: Christian Action Council, December 1994, p. 2. 54 Joel Brind, Ph.D., "The ABC Link" Putting It Ali Together," in Judith E. Koehler, Esq., Abortion-Breast Cancer Act Legislation Guide, Chicago, Illinois: Americans United for Life, October 1996, Forward [n.p.]. See Dr. Joel Brind et al., "Induced Abortion as an Independent Risk Factor for Breast Cancer: A Comprehensive Review and Meta-analysis," Journal of Epidemiology and Community Health 50, British Medical Association, October 1996, pp. 481-496. 55 Thomas, ibid., citing Rosenburg and Weiss, ibid. 56 Ibid. 57 Brind, ibid. 58 Brind, et al., "Induced Abortion as an Independent Risk Factor for Breast Cancer: A Comprehensive Review and Meta-analysis," p. 495.	Tavani A et al. 1996. Abortion and breast cancer risk. *Int J Cancer.* Feb 8;65(4):401-5. *Conclusion*: Results indicate a lack of association between induced and spontaneous abortions and breast cancer risk. Brewster DH et al. 2005. Risk of breast cancer after miscarriage or induced abortion: a Scottish record linkage case-control study. *J Epidemiol Community Health*. Apr;59(4):283-7. *Conclusion*: These data do not support the hypothesis that miscarriage or induced abortion represent substantive risk factors for the future development of breast cancer.

Post Abortion Counselling

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What Is Post-Abortion Stress?: *(page 59)* Post abortion stress is the chronic inability to: • Process the painful thoughts and emotions about a crisis pregnancy and subsequent abortion(s) - the guilt, anger and grief. • Identify (much less grieve) the loss that was incurred. • Come to peace with God, herself and others.[59] Abortion is a child-bearing loss. With any childbearing loss there is a natural grieving process that	Any life decision can cause feelings of regret, joy, relief or sadness. Some women do regret having an abortion, just as some women regret placing their child for adoption, and some regret that they had a child when they weren't ready. An unwanted pregnancy is a stressful and emotional situation, no matter what the outcome. There is no evidence to suggest that women who have abortions experience any more or less sadness and regret than women who complete an unwanted pregnancy. What is important to remember is that each woman is the best judge of what is the best decision for her. The CPC tactic of sharing "post-abortion syndrome" with the client overloads the woman with images and words that are meant to elicit an emotional fear reaction, when what should be important is honesty and truthfulness. Many people are interested in learning about the possible effects of abortion on women's emotional well-being, and several hundred studies have been conducted on this issue since the late 1970s. Unfortunately, much of the research on women's psychological responses to abortion can be confusing. Nonetheless, mainstream medical opinions, like that of the American Psychological Association, agree there is no such thing as "post-abortion syndrome." (The label was created by two members of the Christian ministry Focus on the Family.) The list of symptoms for PAS comes from many varied and disconnected diagnoses, where most people will find some recognition or connection to their lives. To have such a list used by untrained volunteer counsellors to pathologize a

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brings healing. When that grieving process is denied, healing is denied. Delayed post abortion grief results in a collection of symptoms known as "Post abortion Stress". *(page 59)* **Psychological Symptoms:** *(page 59-60)* • Distress when reading or seeing abortion related articles or programs • Guilt • Anxiety • Depression and thoughts of suicide • Anniversary syndrome • Psychological 'numbing' • Preoccupation with becoming pregnant again • Preoccupation with the aborted child • Anxiety over fertility and childbearing issues • Interruption of the bonding process with present or future children • Development of eating disorders • Alcohol and drug abuse • Nightmares and flashbacks • Self-punishing or self-degrading behaviours • Troubled relationships 59 Anne Speckard, Ph.D., Post Abortion Counselling: A Manual for Christian Counsellors, Alexandria, Virginia: Family Systems Centre, 1987, p. 2.	woman's emotions after an abortion is irresponsible and lacks professional authority. The rest of this section is taken from the National Abortion Federation fact sheet *Post-Abortion Issues* (www.prochoice.org/about_abortion/facts/post_abortion_issues.html) **Summary of the Scientific Research** Since the early 1980s, groups opposed to abortion have attempted to document the existence of "post-abortion syndrome," which they claim has traits similar to post-traumatic stress disorder (PTSD) demonstrated by some war veterans. In 1989, the American Psychological Association (APA) convened a panel of psychologists with extensive experience in this field to review the data. They reported that the studies with the most scientifically rigorous research designs consistently found no trace of "post-abortion syndrome" and furthermore, that no such syndrome is scientifically or medically recognized.(1) The panel concluded that "research with diverse samples, different measures of response, and different times of assessment have come to similar conclusions. The time of greatest distress is likely to be before the abortion. Severe negative reactions after abortions are rare and can best be understood in the framework of coping with normal life stress."(2) While some women may experience sensations of regret, sadness or guilt after an abortion, the overwhelming responses are relief and happiness.(3) In another study, researchers surveyed a national sample of 5,295 women, not all of whom had had abortions, and many of whom had abortions between 1979 and 1987, the time they were involved in the study. The researchers were able to learn about women's emotional well-being both before and after they had abortions. They concluded at the end of the eight-year study that the most important predictor of emotional well-being in post-abortion women was their well-being before the abortion. Women who had high self-esteem before an abortion would be most likely to have high self-esteem after an abortion, regardless of how many years passed since the abortion.(4) In a commentary in the *Journal of the American Medical Association*, Nada Stotland, M.D., former president of the Association of Women Psychiatrists, stated: "Significant psychiatric sequelae after abortion are rare, as documented in numerous methodologically sound prospective studies in the United States and in European countries. Comprehensive reviews of this literature have recently been performed and confirm this conclusion. The incidence of diagnosed psychiatric illness and hospitalization is considerably lower following abortion than following childbirth...Significant psychiatric illness following abortion occurs most commonly in women who were psychiatrically ill before pregnancy, in those who decided to undergo abortion under external pressure, and in those who underwent abortion in aversive circumstances, for example, abandonment."(6)

Post Abortion Counselling	
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	Henry P. David, PhD, an internationally known scholar in this area of research, reported the following at an international conference. "Severe psychological reactions after abortion are infrequent...[T]he number of such cases is very small, and has been characterized by former U.S. Surgeon General C. Everett Koop as 'minuscule from a public health perspective'...For the vast majority of women, an abortion will be followed by a mixture of emotions, with a predominance of positive feelings. This holds immediately after abortion and for some time afterward...[T]he positive picture reported up to eight years after abortion makes it unlikely that more negative responses will emerge later."(7) Russo and Dabul reported their conclusions of an eight-year study in *Professional Psychology*: "Although an intensive examination of the data was conducted, controlling for numerous variables and including comparisons of Black women versus White women, Catholic women versus non-Catholic women, and women who had abortions versus other women, the findings are consistent: The experience of having an abortion plays a negligible, if any, independent role in women's well-being over time, regardless of race or religion. The major predictor of a woman's well-being after an abortion, regardless of race or religion, is level of well-being before becoming pregnant...Our findings are congruent with those of others, including the National Academy of Sciences (1975), and the conclusion is worth repeating. Despite a concerted effort to convince the public of the existence of a widespread and severe postabortion trauma, there is *no scientific evidence for the existence of such trauma*, even though abortion occurs in the highly stressful context of an unwanted pregnancy."(8) (emphasis added) 1. American Psychological Association. "APA research review finds no evidence of 'post-abortion syndrome' but research studies on psychological effects of abortion inconclusive." Press release, January 18, 1989. 2. Adler NE, et al. "Psychological responses after abortion." *Science*, Apr.1990, 248: 41-44. 3. Adler NE, et al. "Psychological factors in abortion: a review." *American Psychologist*, 1992, 47(10): 1194-1204. 4. Russo NF, Zierk KL. "Abortion, childbearing, and women's well-being." *Professional Psychology: Research and Practice*, 1992, 23(4): 269-280. 5. Russo NF. "Psychological aspects of unwanted pregnancy and its resolution." In J.D. Butler and D.F. Walbert (eds.), *Abortion, Medicine, and the Law* (4th Ed., pp. 593-626). New York: Facts on File, 1992. 6. Stotland N. "The myth of the abortion trauma syndrome." *Journal of the American Medical Association*, 1992, 268(15): 2078-2079. 7. David HP. "Comment:post-abortion trauma." *Abortion Review Incorporating Abortion Research Notes*, Spring, 1996, 59: 1-3. 8. Russo NF, Dabul, AJ. "The relationship of abortion to well-being: Do race and religion make a difference?" *Professional Psychology: Research and Practice*, 1997, 28(1): 1-9.

High Rate of Condom Failure

CPC Training Manual Excerpts	Physician Rebuttal
In both Canada and the United States, condoms are being hailed as the means to "safe sex" or "safer sex." However, "safe sex" is a myth. Federal authorities in the United States have now directed the manufacturers of condoms to stop advertising their product as a birth control device. The reason? Too high a failure rate."[83] *(page 152)* The pregnancy failure rate of condoms for teenagers is an alarming 18.4 percent per year, according to Planned Parenthood's own figures.[84] This translates to mean that in three years, over half of teenagers using condoms regularly will become pregnant. This high failure rate is particularly sobering when one remembers that conception from intercourse usually can occur only three to four days per menstrual cycle. However, sexually transmitted diseases and AIDS can be contracted at any time of sexual activity. *(page 152)* 83 Marilyn Bergeron et al., Prolife News, Toronto, Ontario: Alliance for Life, June 1994, p. 8. 84 Stephen Genuis, M.D., Risky Sex: The Onslaught of Sexually Transmitted Diseases, Edmonton, Alberta: Keg Productions, 1991, p. 70.	The references used are not from a non-biased, scientifically reputable source. No credibility should be given to their references. (Note: Ref 84 is not to a Planned Parenthood source, but to a book by an anti-choice researcher.) The following is from the Health Canada website: http://www.hc-sc.gc.ca/iyh-vsv/prod/condom_e.html "Increased use of condoms would greatly reduce unwanted pregnancies, the risk of sexually transmitted disease (STDs) and the human immunodeficiency virus (HIV), which causes AIDS." "Used properly, condoms can greatly reduce the risk of pregnancy and disease. You protect yourself and help prevent the spread of disease." "In Canada, condoms are considered medical devices and are therefore regulated by Health Canada. These regulations outline the conditions that condom manufacturers and importers must meet. Strict standards are set for latex condoms regarding design, length, width and tests for leakage and bursting. Condoms made from other materials must be evaluated before being marketed to prove that they are effective against disease and sperm. These regulations also include packaging, labelling and other quality measures." Some relevant articles: Crosby RA et al. 2005. Condom failure among adolescents: implications for STD prevention. *J Adolesc Health.* Jun; 36(6):534-6. *Conclusion*: This study of 921 adolescents found condom failure (past 90 days) was experienced by at least one-third of the sample, regardless of gender. Frequency of condom failure was positively associated with STD diagnosis, with the odds of testing positive increasing 22% for each added event of failure. Grimley DM, Lee PA. 1997. Condom and other contraceptive use among a random sample of female adolescents: a snapshot in time. *Adolescence*. 1997 Winter;32(128):771-9. *Conclusion*: Despite the availability of newer contraceptive methods (e.g., Depo-Provera), most sexually active adolescents were least resistant to using condoms and were further along in the stages of change for condom use as compared with other contraceptive methods. Moreover, the females perceived the male condom as an acceptable method for prevention of both pregnancy and STDs. These findings suggest that interventions designed to target consistent and correct condom use may result in better compliance, reducing the number of unintended pregnancies and STD cases among this populations. Macaluso M et al. 1999. Mechanical failure of the latex condom in a cohort of women at high STD risk. *Sex Transm Dis.* Sep;26(8):450-8. *Conclusion*: User characteristics and experience are determinants of breakage and slippage, which are often regarded only as the effect of product design flaws. Attention to modifiable determinants of failure may improve user counselling and product labeling. Richter DL et al. 1993. Correlates of condom use and number of sexual partners among high school adolescents. *J Sch Health.* Feb;63(2):91-6. *Conclusion:* Risky sexual behavior

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	appears to be correlated with a complex of other behaviors that place students at risk. A pattern of declining condom use with increasing number of partners was evident, especially for White students. Paz-Bailey G et al. 2005. The effect of correct and consistent condom use on chlamydial and gonococcal infection among urban adolescents. *Archives of pediatrics & adolescent medicine.* Vol. 159, n°6, pp. 536-542. *Conclusion:* After adjusting for confounders, correct and consistent use was protective for Chlamydia, and highly protective for gonorrhea. Findings indicate that assessing both correctness and consistency of use is important for evaluation of condom effectiveness.

Appendix 2: Counselling Abuses in the Volunteer Training Manual

We hired a professionally trained counsellor to evaluate training given to CPC volunteers, as well as sections of the *Crisis Pregnancy Centre Ministry Volunteer Training Manual*. The manual is used as a text to teach volunteers fundamentalist Christian values and rules that must be strictly adhered to at CPCs, while inserting the vocabulary and basic approach found in a secular university counselling course. These two ingredients of the manual often create a dissonance, because the CPC's true agenda is based on scriptural interpretation, not the mental health and well-being of the women.

By Lynn Hudson, BA in Psychology and Women's Studies, UBC (with editing by Joyce Arthur)

Misunderstanding the Client	
CPC Training Manual Excerpts	**Counsellor Rebuttal**
Frequently Observed Characteristics of Women Experiencing Crisis Pregnancies: She often comes from a single-parent home. Research shows that children from broken families have lower self-esteem and are more prone to promiscuity. … Coupled with the negative effects of 'father-absence', many teenagers will pursue premature sexual activity in an attempt to meet a deficiency of love and intimacy. … The majority of teenage mothers come from homes where they were physically or sexually abused and where there were drug and alcohol problems and divorce. *(page 30)*	In the chapter *Understanding the Client*, the CPC manual sets up a stereotypical psychological picture of the woman who has an unplanned pregnancy. The trainee is shown a profile demonstrating that women who have unplanned pregnancies have troubled backgrounds. This encourages the volunteer to see the women as damaged and not in a position to make an important decision, which helps to justify the aggressive anti-abortion tactics that CPCs employ. The profile also sets up an unbalanced relationship between the volunteer and the client by creating a moral high ground from which to judge the client's situation. These generalizations negate the manual's attempt to mimic the university counselling training, which adamantly warns against making such moral judgments and expectations about the woman. The CPC manual goes on to encourage volunteers to view clients as God views them, removing the volunteer counsellors from the rules and values of a secular system, and sanctioning their fundamentalist Christian narrative and its 'built-in' hierarchical system of moral and value judgments. This excuses the volunteer counsellors from a secular, academic responsibility but imitates the secular narrative enough to give the volunteer counsellor a false security of academic legitimacy.
Feelings: Because she may not know that it is indeed life that she nurtures within her…joy may not be evident. … She may have suffered from a poor self image…she may be unable to be objective and can act out of fear or impulse. The degree of crisis she experiences will affect her ability to make well	The manual then proceeds to interpret the feelings of women experiencing an unplanned pregnancy, again not from unbiased research, but from a religious view. These descriptions portray the woman as unable to understand her own experience, infantilizing her when

Misunderstanding the Client	
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thought-out decisions. … The feeling of guilt can be an overwhelming experience to the client. *(page 31)* True moral guilt is meant to cause change. …God allows us to feel guilty in order to lead us to repent once and to restore our relationship with Him. …Christian clients…will undoubtedly be pursued by our adversary, Satan, who stands ready to accuse. For non-Christian clients, Satan continues to use guilt to convince them that they are not worthy of God's love and acceptance and that God's grace is a myth. The CPC volunteer is in a strategic position to be used by the Father to show and tell them the truth. *(page 32)*	seen from Kohlberg's stages of moral development. This implies to the volunteer counsellor that the woman should be treated as a child who cannot make informed decisions about her future. This infantilizing of a woman would further encourage the counsellor to feel justified in trying to manipulate the woman's feelings and decisions to comply with the male-centred patriarchal narrative that is literally interpreted by the Fundamentalist beliefs.
Potentials: Most people instinctively know that life is worth protecting and nurturing. The degree to which this is true for your client, however, involves how she views various stages of life. If our client honestly does not know that what is growing within her is a life worth protecting, she may not sense the need for protection as greatly. You may be the only person who encourages that nurturing instinct and offers her support. *(page 34-35)*	This description of the client within the Christian ministry atmosphere of the CPC makes the volunteer counsellor responsible for saving the "unborn baby." At this point the counsellor is supplied with tools to help her reach the woman at an emotional level. The plastic uterus and fetus figures are used to present a physical representation, but these plastic figures are four times the size of an actual fetus. This is explained on the back of the uterus, but the counsellors are told not to let the client see this. The plastic figures also show the fetus as much more developed than the gestational time frames they are said to represent. During counselling, the woman may be given a pamphlet produced that shows the *Life* magazine images of the fetus in utero. In this way the woman is forced to see the fetus she carries as no longer a part of her body. The counsellor proceeds to insert herself between mother and fetus, speaking for the fetus in the narrative voice of the fundamentalist male-centred authority.
Definition of Crisis Pregnancy: A crisis pregnancy is one in which the woman perceives the people or circumstances in her life to be so threatening that abortion may be considered the best way to cope with the situation. Even if she does not like the thought of having an abortion, she does not know how she can carry through with an alternative. *(page 101)* **Parenting:** Women often consider abortion because they are overwhelmed by the responsibility of parenting or are secretly afraid that they will be bad	This approach encourages the volunteers to assume the woman is confused and helpless, and looking for abortion information only because she cannot see any alternatives. Abortion can never be the "right" choice, regardless of the woman's circumstances. This approach also encourages the volunteer counsellor to assume that their clients have the same interpretation of their situation as the fundamentalist Christian view, and that this view and its values are the only "right" values for everyone. This tramples on and disrespects the client's beliefs and values and has no place in a

Misunderstanding the Client	
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parents. Encouraging them and offering them guidance and referrals regarding parenting issues may help them choose life. … [The] client should also be given information about abortion and its risks. A client who wants to carry to term may go home and find everyone pressuring her to choose abortion. If she has not been given good information about abortion, she may succumb to pressure out of ignorance. *(page 67)*	counselling service that is not transparent about its religious and moral agenda.
Ambivalence: Ambivalence is characterized by the existence of conflicting feelings or thoughts. The ambivalent person vacillates between two opposing choices. … Look and listen for evidence of ambivalence during your time with clients. *(page 103)*	During the training, volunteers are shown how to interpret the clients' emotions to fit with the CPC agenda. The volunteers are supplied with labels that subsequently justify the volunteer counsellor's use of manipulative and abusive tactics that are euphemistically referred to as accurate information and educating clients about their 'ambivalence.' Of course, any ambivalence must be resolved not by determining the client's real needs or feelings as in professional counselling, but by exerting an authoritative voice over the client to urge them to carry to term. This authority is based in the religious hierarchy taught to the volunteers.

Religiously-Based Counselling and Proselytizing	
CPC Training Manual Excerpts	**Counsellor Rebuttal**
Role of the Gospel: All ministry at the CPC is rooted in the Great Commission. … Any approach to serving CPC clients that separates the woman's decision about abortion from her regard for Christ is self-defeating. … It is only through the power of Christ that many women will be able t make a decision for life and persevere in that decision. *(page 179)* In making known the truth of Jesus Christ, the message should not be restricted to the central elements of the Gospel or to a certain set of New Testament verses. The whole counsel of God is fit for the message of evangelism. *(page 180)* Don't assume a woman's lifestyle, behavior, or speech signals unresponsiveness to the Gospel. Conduct or appearance may be calculated to intimated or give an air of self-sufficiency, when in fact the individual feels insecure and frightened. In	All CPC volunteer counsellors in training must prove their faith in and allegiance to the CPC belief system by signing agreements and creeds, as well as providing a letter of recommendation from the pastor of a fundamentalist evangelical Christian church. The Evangelical mission to proselytize fundamentalist beliefs with their clear anti-abortion and anti-feminist values, biases the volunteers from being legitimate counsellors. Spiritual counselling that clearly explains their religious affiliations and mission would be a different matter, but CPCs actively hide their religious affiliations and use deception to encourage women to use their services. When answering the phone volunteers are instructed to say that "Yes, we offer abortion information." Referrals are made only to "pro-life" doctors that are affiliated with the fundamentalist faith and do not give contraceptives or information about abortion under any conditions. The right-wing fundamentalist war on abortion

Religiously-Based Counselling and Proselytizing	
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sharing Christ with the client, use common sense and prayer in discerning when a teachable moment is present. *(page 183)*	is also a war on feminism, and its narrative of women's rights as implicit in any discussion of human rights.
Self-Concept: Problems of self concept are practically universal. … It's no wonder, really. In a world where the vast majority *[of people in general]* have no relationship (or a distorted relationship) with their Creator, on what is there to base a 'healthy self-concept'"? ... Without God's redeeming plan, lasting self-esteem is elusive *(page 81)* This is the case because those most at risk for crisis pregnancy (i.e. those involved in a promiscuous lifestyle) very often have poor self esteem… Most tragically, women sometimes recognize abortion as a self-destructive decision, yet do not have enough regard for themselves to steer away from something they know will torment them. *(page 81)*	This belief-based literalist fundamentalism is framing the discourse very narrowly. The volunteer counsellors are not allowed any leeway to see the women's situation in a perspective other than good or bad, black and white. This dualistic world view is the basis of the CPC's moral authority to deny women the basic human right to control decisions about their own bodies. Whether it is abortion, birth control, or contraceptive protection against STDs, women are denied making choices that could ultimately save their lives. Instead, women's self-esteem is made dependent on a "relationship with their Creator," which in turn restricts her control and her choices. This tautological discourse is used to deny the idea that women's rights are human rights. Instead, their value is contingent on their child-bearing capacity, upon which their self-esteem depends.
A Biblical View of Sexuality: To understand sexuality we must first appreciate our Creator's view of sexuality. Before addressing contemporary sexual ethics and practice, we must also know what God says concerning these matters in order to establish correct and healthy sexual expression. For this understanding we look to the Bible. *(page 145)* With the Fall, sin entered the human race, bringing the possibility of the perversion of all good things including sex. … Sexual expression outside of God-given boundaries will become distorted, even idolatrous. … Sin does not come from the existence of sex itself, but from its misuse: Marriage should be honored by all, and the marriage bed kept pure, for God will judge the adulterer and all the sexually immoral' (Hebrews 13:4) We need to follow God's sex-affirming instructions for responsible sexual practice. Sex outside of marriage is intrinsically wrong, and has grievous intra and interpersonal consequences. However, sex inside of marriage, as we have seen, is wonderfully right. *(page 148)*	The CPC training manual outlines God's narrow view of sexuality, one which most people in our secular society do not choose to live by, and even fewer people are capable of living by. Volunteer counsellors bring to a counselling session their baggage of predetermined rules and judgment around sexuality derived from a fundamentalist Christian religious narrative. This dramatically changes the counselling relationship to one of authoritarian manipulation. These attitudes cannot help but create a skewed interpretation of how the client's own thought and values should be respected in the sessions. The CPCs maintain a belief in the authority of their standpoint as being God-ordained, and use this belief to justify misrepresenting who they are when advertising free pregnancy tests and counselling about the choices available to women. As a woman who attended our secular post-abortion counselling group related, "I specifically asked on the phone when I first contacted her, 'Do you have any affiliations with a church or religious group'? She said 'no'."

Rape and Abortion	
CPC Training Manual Excerpts	**Counsellor Rebuttal**
All human life has intrinsic value. …foundational to this view of the sanctity of human life is the *imago dei*. Genesis, in Chapter 1, lays down a worldview upon which the rest of the Law and the Scriptures are based: 'So God created man in His own image, in the image of God He created them; male and female He created them.' (Genesis 1:27). *(page 83)*	The male-centred narrative of the CPC assumes an authority for the volunteer counsellors based on "It is written." It may well be written, but by whom and for whose benefit? One of the tenets of Evangelical Christianity is "reliance on the Bible as ultimate religious authority." This is a different reality than that relied on by medical and government institutions. The Evangelical "reality" is based on interpretation of scripture, divorced from a historical context that designates truth as based on medical facts and universal human rights. When groups use this kind of authoritarian language that claims to be above secular laws and human rights, it is inappropriate in our multicultural and varied society to give them government funding or charitable tax status to carry out services such as pregnancy counselling, post abortion counselling, rape victims support network, or abused women safe houses.
The question remains: Is the unborn child conceived by the horror of rape devoid of value? Or the other "hard case": Is the severely handicapped unborn child also devoid of value? Our belief is that God loves even the "least of these." *(page 84)*	This part of the training poses a moral test for the volunteer. Volunteer counsellors must agree that even in cases of rape or abuse, they would never counsel for abortion. They are also trained to believe that raped women who have abortions always regret their decision, while those who carry to term never regret it.
Rape survivor Kay Scott says that the "abortion solution" only begets more violence: "In a rape, the woman is the victim, but in an abortion, she is the aggressor." Further, Scott believes that in the underlying prochoice message is a false view that the "rape victim is in a shameful state and so is the life she is carrying, so surely she must want to dispose of it." *(page 84)*	This double-edged sword strikes at both the woman who chooses to end her pregnancy and at the pro-choice movement. There is a moral outrage at the pro-choice community for the "underlying message" that the "rape victim is in a shameful state" when this is not the pro-choice message at all. This misinformation is used aggressively to deter the client from approaching a pro-choice clinic, where she will get factual medical information about the abortion procedure and her other choices. To compare the woman who chooses to end her pregnancy with the rapist is deplorable emotional manipulation. To misrepresent the pro-choice message in this way comes from the moral justification that you can say anything to get the ending they believe is God-ordained. They get away with this kind of deceitful propaganda by ascribing it to the words of a victim.

Abortion Procedures and Risks	
CPC Training Manual Excerpts	**Counsellor Rebuttal**
Menstrual Extraction: The 50cc syringe is inserted into the cervix and the uterus is vacuumed out. … No anesthetic is used. *(page 46)*	The false claim that no anesthetic is used instills a fear of pain, as well as implying a mechanical and heartless attitude by the doctor and staff who may perform the procedure. This repeated insinuation throughout the CPC counsellor training works to increasingly undermine the motives and integrity of the secular women's health providers.
Suction Curettage: The procedure may be painful, so it is most frequently done under local anesthetic. General anesthetics are rarely used because of the greater risks associated with this anesthetic (convulsions, cardio respiratory arrest, heavier bleeding; the risk of perforation is greater, as is the risk of patient inhaling vomitus, causing suffocation or even death). *(page 47)*	This description of the suction curettage procedure done after the first six weeks is intended to cause panic. The woman who continues to want an abortion may be referred to a physician working in concert with the CPCs. (They have a list of anti-abortion doctors that they use for referrals.) The waiting time to get the appointment is often extended so the physician can cause more delay with testing and waiting for results, intentionally increasing the pregnancy time, past the first trimester if possible.
Saline Abortion: The fetus ingests the solution, which causes burning, hemorrhage, edema, shock and eventually death. Fetuses aborted in this way are sometimes described as 'Candy Apple Babies' because the surface layers of skin are burned off by the corrosive saline solution leaving the fetus red in colour. The mother goes into labor and delivers her dead fetus. With a saline abortion, often the woman will feel her unborn child struggle as it dies in utero. *(page 49)*	This is a description of a saline abortion, a late-term abortion technique that has long been abandoned in North America. This depicts nurses and doctors who do abortions as being without humanity. Calling a fetus a "Candy Apple Baby," is very insidious, thrown in offhandedly to create a horror story that does not soon leave the mind. A well-known tactic in war is turning the enemy into an inhuman monster, and no longer allowing any kind of empathy or understanding of the enemy as another human being. And, as often seen with religious wars, the religious person wraps themselves in a God-ordained justification for dehumanizing their opponent.

Other Unprofessional Counselling Techniques	
CPC Training Manual Excerpts	**Counsellor Rebuttal**
Performing the Pregnancy Test: In the staff [pregnancy] testing model, the volunteer performs the test without the client present, and then gives the client's test results at an appropriate time during her counselling session. *(page 132)* **Using Educational Presentations:** Educational	One of the tactics that the CPCs use to entice clients is to advertise (hiding their religious agenda) free pregnancy tests, and support and information about *all* options. This offer is especially appealing to women in low-income situations or who do not have access to their own money even for a pharmacy pregnancy test, which is what the CPC uses.

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presentations are used to provide the client with information on a specific subject, such as fetal development, abortion, adoption, or the Gospel. A wide range of media may be used, including verbal descriptions, educational brochures, fetal models, books, and videotapes. *(page 131)* An educational presentation can be used whenever the client recognizes the need for information. For example, if the client mentions abortion as an alternative, the volunteer may ask her what she knows about the abortion procedure. If the client indicates that she knows very little about it, the volunteer may offer to give a presentation describing the procedure and the possible risks. *(page 131)*	Even though the test takes only a few minutes, the volunteer counsellor is instructed to use the excuse of waiting for the test results to launch into the fear and anxiety-producing lecture on abortion, linking it to breast cancer (which has been medically shown to be not true), as well as an exaggerated list of horrific risks and potential side effects. There are also videos that the volunteer may show while the client is waiting for results. Such videos are shocking, and are meant to be.
Fostering the Reality of Pregnancy: Unless the client has internalized the fact that a child is growing within her, she cannot relate to what an abortion really is. … The volunteer should also be prepared to affirm the reality of pregnancy with the client in a calm tone of voice, expressing genuine concern. *(page 133)* Possible approaches might be: "Marjorie, the fact that your test is positive can't be reversed. You may think that if you have an abortion it will be just as if you were never pregnant. But you may always remember this pregnancy, and nothing can take the experience away. The decision you make to carry your baby to term or to have an abortion will always be with you. It can affect your feelings about yourself and about the people around you. *(page 133)*	The volunteer counsellor is trained to amplify the crisis and instill in the woman a sense of impending doom if she chooses not to carry the pregnancy to term. We must remember that while waiting for the results, the woman has been given a lecture and possibly shown videos on abortion procedures and risks that are designed to terrify her with inflammatory language and misinformation. The CPCs attempt to induce distress and long-lasting guilt in women who might go on to have abortions by forcing them to "affirm the reality of pregnancy." This also patronizes women by assuming they don't even know what a pregnancy is. In reality, women have abortions because they know they are not ready to have a baby (or another baby).
Communication Skills: The effectiveness of counselling will depend largely on the accuracy of the communication that goes on within the counselling relationship. It shouldn't be assumed that a message sent in words will automatically be received accurately. Communication is a process of coding and decoding messages. *(page 105)*	In the CPC discourse, words associated with pregnancy and abortion derive their "accurate" meanings from "Pro-Life" discourse. Words connected to abortion are pathologized to imply a negative meaning. For example, the CPC pamphlet *Making an informed decision About your Pregnancy* combines abortion with stress and the description: *sadness, long term grief reactions, anger, sexual dysfunction, guilt, flashbacks, memory repression, anniversary reactions, hallucinations, suicidal ideas, increased alcohol and drug use, difficulty keeping close relationships.* This creates the impression of a legitimate disorder from an implied connection to these words. The more fear created around the word abortion when the volunteer counsellor is talking with the client, the more

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	the fear will be retained as a shadow association with the word in the future. This manipulation is an example of religious terrorism that can cause reactions of trauma and nightmares. For example, we received a call from a counsellor at the CARE program at Women's Hospital in Vancouver who needed information about CPC counselling techniques. A 17 year old girl was in a state of extreme trauma and frozen with fear about the abortion procedure because of what the CPC "counsellor" had told her.
Discussing the Pregnancy Test Results with the Client: If the test results are negative, discuss what the client's feelings would have been had the results been positive. This is likely a good opportunity to begin a discussion about abstinence as a life style. *(page 132)* **Counselling the Negative Test Client:** Approximately 50% of women who come into a CPC will have a negative test. A truly concerned counsellor has a unique opportunity to assist a client in evaluating her sexual lifestyle choices. … We have a duty and a responsibility to use this teachable moment. Destructive physical, emotional and spiritual consequences of a client's choices offer the volunteer three different approaches to lifestyle abstinence counselling. The **physical** consequences allow the volunteer counsellor to focus on the client's physical risks in sexual activity: unplanned pregnancy, abortion and sexually transmitted diseases. The **emotional** consequences allow the counsellor to focus on relationships, intimacy and self concept. The **spiritual** consequences allow the counsellor to focus on the counterfeit intimacy of sexual intercourse outside of marriage and the need for a personal relationship with Jesus Christ. *(page 151)*	This "opportunity" for counselling is actually not requested by the client but imposed by the CPC as the client waits for the results of the free pregnancy test. Results take only a few minutes, but the client may be kept for over half an hour, trapped in the volunteer's presence. The scriptural approach of the CPCs blinds counsellors to the fact that most people will not abstain from sexual intimacy outside of marriage for long, especially if they're already sexually active, as pregnant women obviously are. Many women also have boyfriends or common-law husbands, and counselling such women to abstain from sex is unrealistic and very unhelpful, even carrying the potential to damage women's relationships. To counsel about the "counterfeit intimacy" of sexual intercourse outside of marriage is a judgment based solely on the morality and values of the fundamental Christian narrative. Most pre-marital sex is with one's future spouse, and to say this is not true intimacy and that pledges of love outside religious sanction are not true reveals an arbitrary and judgmental ideology. It is not the place of the counsellor to project their own religious beliefs onto a client's situation, and it is a superficial, fabricated standpoint when a counsellor assumes moral superiority over a client. This seems especially hypocritical when we consider that up to 50% of marriages end in divorce. CPCs exploit a woman's vulnerability during the emotionally charged times of unplanned pregnancy, post-abortion, domestic abuse, or rape – they offer free counselling for each of these situations – by using religiously-based scare tactics and misinformation around sexual health issues as tools of proselytizing. This is not

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	only unconscionable, but unethical and destructive. Using scare tactics to tear down a women's agency to act in her own best interest is an attack on her emotional well-being if she is persuaded to make a choice that she is not emotionally or physically able to manage.
Contraceptive Counselling—CAPSS Policy: Volunteers of Crisis Pregnancy Centers are never to advise or refer a single woman or man for contraceptives. The seeming pragmatism of contraceptives does not dilute the clear command in Scripture to abstain from sexual intimacy outside of marriage. (1 Timothy 3:1-5) *(page 156)* CPC counsellors are committed to presenting the truth and caring for clients. When a volunteer counsels for contraceptives she communicates that the client cannot control herself. The counsellor also puts the client at risk for sexually transmitted diseases and unplanned pregnancy. Only abstinence is 100 percent effective. The volunteer counsellor could also be denying the emotional bonding that women experience in sexual intercourse. *(page 156-7)*	The refusal to counsel the use of contraceptives does nothing to inform sexually-active clients who actually need such information to help them avoid future pregnancies and abortions. Ironically, therefore, the CPC stance against birth control may actually increase unintended pregnancies and abortions.
Sexually Transmitted Diseases: The spread of sexually transmitted diseases is epidemic and unprecedented – and teenagers have the highest susceptibility. The numbers are staggering: ... Centers for Disease Control reports that one in every 5 Americans is now infected with an incurable viral STD. Two thirds of all newly infected individuals are adolescents, aged 12 to 24. *(page 163)* STD infections are transmitted primarily by intimate physical sexual contact (not necessarily restricted to only vaginal intercourse, anal sex or oral sex). There are currently more than 30 significant sexually transmitted diseases, "some fatal, a few relatively harmless, all humiliating." … Thus, having sex outside of marriage is particularly dangerous today due to the proliferation of STD infected people. *(page 163)*	The aim of this section on STDs is not to educate counsellors (or women) about the real risks of STDs, but to induce a strong fear and loathing of sex. The overall message given is that STDs are so ubiquitous, so horrible, and so dangerous, that it would be far preferable to avoid sex entirely. The ethical approach would be to teach responsible sex and the proper use of condoms, but as we have seen, CPCs discourage clients from using condoms, even though they are the most common and effective means of preventing STDs.
Adoption: When women are surveyed on adoption as an option in unplanned pregnancies, it is often seen as the worst of the three options, because women perceive it to be the option without	Pregnant women rarely choose adoption, for a wide range of reasons. Married women and women with children constitute the majority of women facing unintended pregnancies, and adoption is not a realistic

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resolution. In our first counselling session on options we must be careful to explain how adoption resolves itself. Explain that grief is intense for a year or so, but not all consuming for a lifetime. *(page 68)* After facing grief honestly in post-adoption counselling, there is hope for a relationship with the child and a future for the child. This is absent in the post abortion grief cycle. Comparing adoption grief and abortion grief in an initial counselling session can be helpful in illustrating to a young woman the emotional repercussions of an abortion decision. *(page 69)*	option for most of them. The rest generally prefer to raise the child themselves or have an abortion, because of the emotional difficulty of going through pregnancy and childbirth, only to relinquish the child to an uncertain future. There has not been much scientific research about the psychological consequences of adoption, but researchers state "that the psychological risks for adoption are higher for women than those for abortion because they reflect different types of stress. Stress associated with abortion is acute stress, typically ending with the procedure. With adoption, as with unwanted childbearing, however, the stress may be chronic for women who continue to worry about the fate of the child." Abortion Rights Coalition of Canada. *Why Few Pregnant Women Choose Adoption.* Position Paper #41. January 2006. http://www.arcc-cdac.ca/postionpapers/41-Why-Few-Women-Choose-Adoption.pdf Russo NF. "Psychological aspects of unwanted pregnancy and its resolution." In J.D. Butler and D.F. Walbert (eds.), *Abortion, Medicine, and the Law* (4th Ed., pp. 593-626). New York: Facts on File, 1992.

Appendix 3: List of CPCs in British Columbia

The list is alphabetical according to city. (It was last updated in January 2009.)

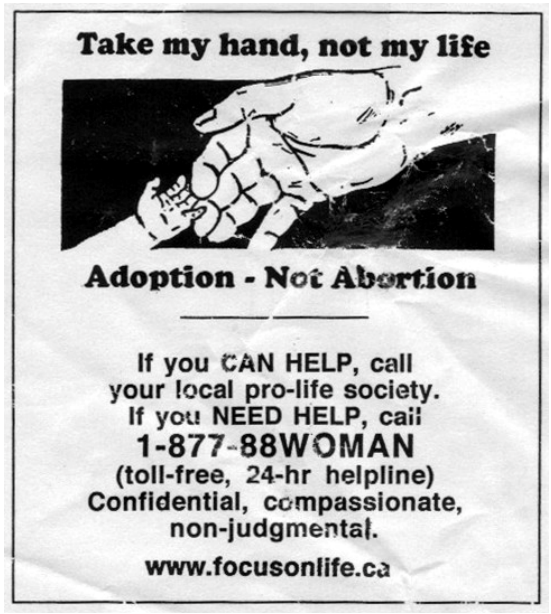
Name	Address	Phone / Email / Web	Charity	Comments
Hope Adoption Services	200 – 2975 Gladwin Road Abbotsford, BC V2T 5T4	604-850-1002 / 1-800-916-4673 www.hopeadopt.org	Yes	Offers pregnancy counselling.
Fraser Valley Pregnancy Centre	27028 Fraser Highway POB 374, Aldergrove, BC, V4W 2T9	604-856-9151 www.fvpc.ca/	Yes	
Birthright Burnaby	#12A – 4012 E. Hastings St. Burnaby, BC V5C 2H9	604-291-9818 www.birthright.org	No	
Crisis Pregnancy Centre of Burnaby/New Westminster	7416 Edmonds St. Burnaby, BC V3N 1A8	604-525-0999	No	Head office for CAPPS, also run training and post-abortion counselling
Campbell River Birthright	Suite 211, 437 10th Ave. Campbell River, BC , V9W4E4	250-286-1712 / 1-800-550-4900	Yes	
Chilliwack Crisis Pregnancy Centre	9301 Nowell St. Chilliwack, BC, V2P4V8	604-795-3043 www.chilliwackprolife.com/crisis.html	No	
Pregnancy Concerns	203 – 1108 Austin Ave. Coquitlam, BC, V3K 3P5	604-939-2633 www.pregnancyconcerns.org	No	
Comox Valley Pregnancy Care Centre	785 – 6th St. Courtenay, BC V9N 1M8	250-334-0058	Yes	
Birthright	#E – 9557 – 120th St. Delta, BC V4C 6S4	604-584-7311 www.birthright.org	Yes	
North Peace Pregnancy Care Centre	#208, 10139 – 100 Street Fort St. John, BC V1J 3Y6	250-787-5584 / 250-262-1280 (hotline) www.pregnancycare.pris.ca	Yes	
Kamloops Family Resources Society	283 West Victoria Street Kamloops, BC, V2C 1A5	250-377-6890 www.kfrs.ca	Yes	
Pregnancy Care Centre	# 200 – 535 Tranquille Road Kamloops, BC, V2B 3H5	250-376-4646 / 250-376-4646 (hotline) www.pregnancycarekamloops.com	Yes	
Okanagan Valley Pregnancy Care Centre	#201, 2622 Pandosy Street Kelowna, BC, V1P 1V6	250-763-2112 www.ovpcc.com	Yes	
Pregnancy Problem Services	20645 Douglas Crescent Langley, BC, V3A 4B7	604-533-3736	No	
Woman Care Crisis Pregnancy Centre	3 – 22374 Lougheed Highway Maple Ridge, BC V2X 2T5	604-463-5513 www.womancare.ca	No	

Name	Address	Phone / Email / Web	Charity	Comments
Crisis Pregnancy Centre of Nanaimo	1717b Kerrisdale Road Nanaimo, BC V9S 1N4	250-716-1633 / 1-866-714-2191 www.islandnet.com/~cpcns	Yes	
Nelson Crisis Pregnancy Centre	3 – 577 Baker St. Nelson, BC V1L 4J1	250-354-1199	Yes	
Powell River Birthright	4130 Brunswick Ave. Powell River, BC, V8A3E1	604-485-2832	Yes	
Prince George Crisis Pregnancy Centre	206 – 2289 Westwood Dr. Prince George, BC V2N 4V6	250-562-4464 www.pgcrisispreg.ca	Yes	
Crisis Pregnancy Centre	5460 Floyd Rd. Richmond, BC, V7E 5M1	604-272-3111	No	
Smithers Pro Life Society (Care Centre)	1316 Main St., Box 3252 Smithers, BC V0J 2N0	250-847-2475 / 1-800-665-0570	No	
Crisis Pregnancy Centre	306 – 7337 – 137th St. Surrey, BC V3W 1A4 (White Rock)	604-596-3611	Yes	
Pregnancy Options Centre	#5 - 13634 104th Avenue Surrey, BC, V3T1W2	604-584-4490 www.pregnancyoptionscentre.com	No	
Birthright	4546 Park Avenue Trigo Bldg #203 Terrace BC V8G 1V4	250-635-3907 www.birthright.org	Yes	
Vancouver Birthright	1107 – 207 W. Hastings St. Vancouver, BC V6B 1H7	604-687-7223 / 1-800 550-4900 www.birthright.org	Yes	
Vancouver Crisis Pregnancy Centre	101 – 5701 Granville Street Vancouver, BC V6M 4J7	604-731-1122	Yes	
Birthright Victoria	516 – 620 View St. Victoria, BC V8W 1J6	250-380-0305 www.birthright.org	Yes	
Options Pregnancy Centre	#4-855 Caledonia Ave Victoria, BC, V8T 1E6	250-380-6883 www.optionspregnancy.org	No	
CAPSS Christian Assoc. of Pregnancy Support Services (Head office)	17 McCune Avenue. Red Deer, AB, T4N 0H3	1-866-845-2151 www.capss.com	Yes	

Appendix 4: Examples of CPC Advertising

Billboards in Surrey

This ad was found on a Pay phone in Abbotsford.



CRISIS PREGNANCY CENTRE

All services are free and confidential

• Pregnancy Tests • Crisis Counselling • Maternity and Baby Clothes • Accommodation Help • Prenatal Instruction • Post Abortion Trauma Counselling • Referrals • Friendship

By means of the resources of the local church and the community, the Crisis Pregnancy Centre purposes to provide alternatives to abortion for pregnant women who find themselves in distress.

You share the commitment.
Can you share in the work?

Each Centre needs:

- **Volunteers**
  (Counsellors, Receptionists, Admin./Support staff)
- **Financial Supporters**

Please call your local CPC for more information.

Vancouver	**Burnaby**	**Surrey**
731-1122	525-0999	596-3611
320 - 1675 W 8th Ave. Vancouver, BC V6J 1V2	Suite F - 7487 Edmonds Street Burnaby, BC V3N 1B3	7234 King George Hwy. Surrey, BC V3W 5A5

BIRTHRIGHT

EMERGENCY PREGNANCY SERVICE

Love and support

for women and their families facing an untimely pregnancy.

Free and confidential pregnancy tests
Discussion of options
Maternity and baby clothes
Referral to relevant agencies

Vancouver	687-7223
N. Vancouver	987-7313
Surrey - Delta	584-7311
Burnaby	291-9818
Mission	826-3904
Abbotsford	859-1551
Squamish	892-9329
Powell River	485-2832

Toll Free: 1-800-328-5683

808 - 207 West Hastings Street, Vancouver, B.C. V6B 1H7

Older ads from the *Christian Info News*

Appendix 5: CAPSS Statements

CAPSS Statement of Faith

We believe that:

1. The Holy Scriptures as originally given by God are divinely inspired, infallible, entirely trustworthy, and constitute the only supreme authority in all matters of faith and conduct.
   2 Timothy 3:16-17; 2 Peter 1:19-21

2. There is one God, eternally existent in three Persons: Father, Son, and Holy Spirit.
   Exodus 15:11; Psalm 83:18; Matthew 28:19.

3. Our Lord Jesus Christ is God manifest in the flesh; we affirm His virgin birth, sinless humanity divine miracles, bodily resurrection, ascension, ongoing mediatorial work, and personal return in power and glory.
   Matthew 1:18-25; Hebrews 1:1-3; 1 Thessalonians 4:13-17; Titus 2:13

4. The salvation of lost and sinful humanity is possible only through the merits of the shed blood of the Lord Jesus Christ, received by faith apart from works, and is characterized by regeneration by the Holy Spirit.
   Ephesians 2:8-9; Titus 3:4-7; Acts 4:12

5. The Holy Spirit enables believers to live a holy life, to witness and work for the Lord Jesus Christ.
   Acts 1:8; Romans 8:1-27

6. The Church, the Body of Christ, consists of all true believers.
   1 Corinthians 12:1-27; Colossians 1:18

7. Ultimately God will judge the living and the dead, those who are saved unto the resurrection of life, those who are lost unto the resurrection of damnation.
   John 5:28-29; 2 Corinthians 5:10; Revelation 20:15

CAPSS Sanctity of Life Statement

Human beings are made in the image of God, therefore all humankind has intrinsic value and significance from conception to natural death. We affirm the sacredness and dignity of all persons: male and female, unborn, aged, physically challenged, mentally handicapped, and any person who is devalued — "*the least of these*" — in our society.

Statement of Faith: page 201-202 of the Training Manual.
Sanctity of Life Statement: page 199.

Appendix 6: CAPSS Statistical Report Summary

The reports on the following two pages list the number of clients served by CPCs in various ways. It reveals the goals and main activities of CPCs. For example, it lists the number of clients who received: “Abstinence Counsel”, “Gospel Presentations”, and “Bible or New Testaments Handed Out.” It lists the number of clients with “Live Births Reported”, “Adoptions”, and “Decisions for Christ.” Out of 13 “Ministry Activities” on the list, only two are related to actual support: “Material Support” and “Prenatal Instruction.”

CAPSS Statistical Report Summary

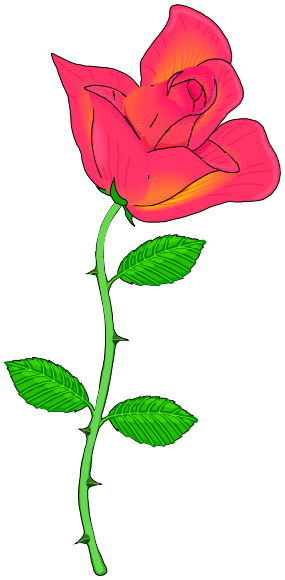
Ministry Activity	1997	1998	1999	2000	2001	2002	Total	Average
New Clients	5,343	5,927	6,867	6,532	5,700	6,452	36,821	6,137
Return Clients	2,967	3,904	4,740	6,665	5,544	6,596	30,416	5,069
Pregnancy Tests	3,182	3,301	3,740	3,497	3,164	3,133	20,017	3,336
Material Support	3,830	4,149	6,725	6,441	6,575	8,192	35,912	5,985
Prenatal nstruction	393	386	676	604	520	643	3,222	537
Post Abortion Counsel	271	469	273	415	465	228	2,121	354
Abstinence Counsel	1,421	1,623	2,372	1,381	2,040	1,611	10,448	1,741
Abstinence Presentations	492	671	735	770	808	862	4,338	723
- estimated attendees	17,230	22,791	23,377	25,520	25,777	32,926	147,621	24,604
- reporting centres	22	28	36	40	38	34	—	—
Live Births Reported	1,132	1,422	1,352	1,583	1,284	1,445	8,218	1,370
Adoptions	102	76	101	154	79	110	622	104
Gospel Presentations	1,070	1,229	1,624	1,607	1,376	1,667	8,573	1,429
Decisions for Christ	110	167	231	192	156	134	990	165
Bible or New Testaments Handed Out	not reported	850	1,004	1,231	1,113	991	5,189	1,038
Bible Study Attendees	not reported	349	443	357	324	322	1,795	359
In Discipleship or Mentored	not reported	534	1,540	728	657	852	4,311	862
Reporting CAPSS Centres	**45**	**50**	**55**	**59**	**58**	**57**	—	—

CAPSS

1-800-665-0570 National Help Line Statistics — 2004

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
BC	250	12	5		14	10	9	15	18	4	7	10		104
	604	88	7	20	4		1	2	4	2	1	1		130
AB	403		2	2	1	1	1		2	2	4	5		19
	780				2	1	1	1						6
SK	306	7	5	6	4	6	2	8	3	4	3	6		54
MB	204	40	40	56	49	40	23	25	53	41	42	38		347
ON	416	1	2	1		2	3	3	1	3	1			17
	519	19	12	12	7	11	11	67	32	10	23	17		221
	613		5		2	1	1	3	1	2	2	4		21
	705				2	2		3	2	3	2			18
	807					1			1					2
	905				3	4	4	3	2	7	5	4		35
PQ	418	3		1						1				5
	450													
	514		1		2				1					4
NB	506	9		2	2	1	3	4	4		2			27
NF	709							1				1		3
NS/PEI	902				3	1				5	1			11
NWT	819					2				1				6
	867													
Total Calls		179	89	94	95	83	59	135	124	85	93	86		1,122
Total Minutes		655	380	455	412	429	265	328	634	325	387	470		4,740
Longest Call (min.)		48.1	64.2	40.0	52.1	88.0	35.5	54.0	89.0	51.0	32.9	68.0		89.0
Average Call (min.)		3.7	4.3	4.8	4.3	5.1	4.5	2.4	5.1	3.8	4.4	5.5		4.4

Appendix 7: CPC Poster



Have you had a negative experience at a

Crisis Pregnancy Centre

or at

Birthright?

These centres are anti-choice counselling agencies. They are against abortion and try to persuade pregnant women to continue their pregnancies.

Some women have reported that these centres use deceptive practices, such as providing misinformation about abortion, making women feel guilty and afraid, and trying to delay women from seeking an abortion until it's too late.

We're looking for women who are willing to speak about their experiences at these agencies. **Confidentiality is assured**—you don't have to give us your name or phone number unless you want to.

We can also refer you to counselling services if you feel you need support in dealing with your experience.

To help us with this project, please contact:

Pro-Choice Action Network
512 - 1755 Robson Street, Vancouver, BC, V6G 3B7
Toll-free (BC): **1-888-522-3389** Lower Mainland: **604-736-2800**
(dial *67, then the number, to shield your number from call display)
Email: info@prochoiceactionnetwork-canada.org

Appendix 8: How to Access Abortion in BC

(Adapted from http://www.prochoiceactionnetwork-canada.org/abortioninfo/bc.shtml)

Where can I get more information or counselling about abortion and pregnancy?

- Pregnancy Options Line: 604-875-3163. Outside Lower Mainland: 1-888-875-3163
- Facts of Life Line: 604-731-7803. Outside Lower Mainland: 1-800-739-7367
- Options for Sexual Health (formerly Planned Parenthood): 604-731-4252
- any of the clinics listed below that provide abortions

What if I've just had unprotected intercourse?

Emergency Contraception (sometimes called the Morning After Pill) can be taken up to 72 hours after unprotected intercourse. It works by preventing fertilization or implantation of a fertilized egg in the uterus wall.

In BC, you can now get Emergency Contraception across the counter at pharmacies. About 1000 pharmacists in all areas of BC are certified to prescribe it directly and immediately, without a doctor's intervention. You can also get emergency contraception from hospital emergency departments, Options for Sexual Health clinics, some medical clinics, and sympathetic doctors.

For more information on Emergency Contraception, call 1-888-NOT-2-LATE (1-888-668-2528). Or go to the website http://ec.princeton.edu/ This site also has a search feature that will list pharmacies and clinics that supply EC in your area (click on "Get Emergency Contraception in Canada".)

Clinics That Provide Abortions

There are six clinics in BC that provide abortions: four in the Lower Mainland, one in Victoria, and one in Kelowna. Each of them offer pre- and post-abortion counselling, and can help you decide the best decision for you. You don't need a doctor's referral; just call to make an appointment. You will probably be required to have an ultrasound, which the clinic can either do for you, or arrange for you. Waiting time for a clinic abortion may vary between one and three weeks. Note: Clinics can perform surgical abortions as early as 5-6 weeks gestation.

- **Everywoman's Health Centre**: 2525 Commercial Drive, Vancouver. **604-322-6692** (surgical abortions up to 13 weeks, 6 days) www.everywomanshealthcentre.ca/
- **Elizabeth Bagshaw Women's Clinic**: Ste. 200 – 1177 W. Broadway, Vancouver. **604-736-7878** (surgical abortions up to 16 weeks, 6 days) www.elizabethbagshawclinic.ca/
- **C.A.R.E. Program**, BC Women's Hospital: 4500 Oak Street, Vancouver. **604-875-2022** (surgical abortions up to 18 weeks) www.bcwomens.ca/care
- **Willow Women's Clinic**: Ste. 1013 – 750 W. Broadway, Vancouver. **604-709-5611** (medical abortions up to 7 weeks, using methotrexate) www.medicalabortion.ca/
- **Vancouver Island Women's Clinic**: Victoria. **250-480-7338** (medical abortions up to 7 weeks in-office, surgical abortions up to 22 weeks) www.viwomensclinic.ca/

- **Women's Services Clinic**, Kelowna General Hospital: 2268 Pandosy Street, Kelowna. **250-979-0251** (surgical abortions up to 14 weeks)

Hospitals in BC that Perform Abortions

If you can't go to one of the clinics listed above, you must obtain a referral to a doctor who performs abortions in a local hospital. If your own doctor won't refer you, or if you don't want to go to your family doctor, call the Pregnancy Options line at 1-888-875-3163 to obtain a referral or more information (604-875-3163 in the Lower Mainland).

There are over 30 hospitals in BC that are specially designated (required) by the provincial government to perform abortions, although other hospitals often perform them, too. To find a hospital in your area that performs abortions, please call the Pregnancy Options line at 1-888-875-3163 (604-875-3163 in the Lower Mainland).

Abortion Costs

Abortions are free in BC if you have BC medical coverage. (There may be a charge for medications not covered by MSP.) As long as you are a Canadian citizen or landed immigrant, and have lived in BC for the last three months, you can get medical coverage. It's a lot cheaper than an abortion.

If you are covered under someone else's medical plan and don't want them to find out, information on abortions is kept strictly confidential by the Ministry of Health. Hospitals and clinics are also obligated to keep secret the names of patients who have abortions.

If you've lived in BC for less than three months (or you're not a resident), the cost for an early abortion is about $450 to $600. Some of that may be reimbursable once you qualify for BC's medical plan. Also, some but not all provinces will reimburse former residents who have abortions in BC, but who have lived in BC for less than three months.

If you can't afford to pay up front, talk to one of the clinics, or contact the Pregnancy Options Line (1-888-875-3163). Clinics may be able to help with funding or payment plans in special circumstances.

2nd and 3rd Trimester Abortions

Most abortions are done in the first 12 weeks of pregnancy—the first trimester. A few doctors in BC do abortions on request up to about 20 or 22 weeks, as well as a few clinics in Ontario, Quebec, and Washington State. Abortions are also available after 22 weeks in the rare event that your life or health becomes seriously threatened by the pregnancy, or in cases of serious fetal abnormality.

Contact the Pregnancy Options Line (1-888-875-3163) for more information on 2nd and 3rd trimester abortions, and for assistance in obtaining such abortions out-of-province, as well as help or advice in covering costs.

Where can you get accurate information and referrals?

You can call the Options Hotline run by a national pro-choice group in Ottawa, Canadians for Choice. Call toll-free anywhere in Canada, 24 hours a day, 7 days a week - **1-888-642-2725** for unbiased information about abortion services or counselling centres.

The National Abortion Federation (NAF) in Washington DC, also has a toll-free Hotline. Call **1-800-772-9100** for information and referrals to NAF abortion providers in the United States and Canada.

How can you counter CPCs?

If you've had a first-hand experience with CPCs, we encourage you to report and document your encounter. You can remain anonymous, but stories of actual encounters help tell the truth about CPCs, and can be effective in educating the media and policy makers. Please send your story to the address on this leaflet.

You can check local Yellow Pages or other advertising venues to see if CPCs in your area are using false or deceptive advertising, such as listing themselves under "abortion services" or "abortion," presenting themselves as pro-choice, or offering "accurate" or "unbiased" information on "all options." If so, contact the Yellow Pages or advertiser to request they change or stop the ad.

You can also help educate the public by submitting opinion pieces or letters to the editor, making a poster, distributing brochures, or speaking to others informally or formally. If you are interested in finding out more about any of these activities, please contact us.

References

National Abortion Federation. 2006. *Crisis Pregnancy Centers: An Affront to Choice.* www.prochoice.org/pubs_research/publications/downloads/public_policy/cpc_report.pdf

Waxman. Henry A. July 2006. United States House of Representatives, Committee on Government Reform – Minority Staff, Special Investigations Division. *False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers*. www.democrats.reform.house.gov/Documents/20060717101140-30092.pdf

Marcotte, Amanda. May 1, 2006. Exposing Anti-Choice Abortion Clinics. www.alternet.org/story/35545

Contact us!

This leaflet was prepared by the:

Pro-Choice Action Network

512 – 1755 Robson Street
Vancouver, BC, V6G 3B7

Email: info@prochoiceactionnetwork-canada.org

Web: www.prochoiceactionnetwork-canada.org

Beware of "Crisis Pregnancy Centres"

Many agencies that counsel pregnant women are actually anti-abortion Christian ministries. Their main goal is to stop women from having abortions. Most of these centres are not medical facilities, and most of their "counsellors" are volunteers who are not medical professionals and have no recognized training in counselling.

Some of these centres are called Crisis Pregnancy Centres or "CPCs" – although many of them have different names. This leaflet refers to all of them as CPCs.

Studies have shown that most CPCs misinform and try to intimidate women out of having abortions. Women describe being harassed, bullied, and given blatantly false information. Many women say their confidentiality has been violated, and that mistreatment by CPCs has threatened their health.

How Do CPCs mislead women?

CPCs have a long history of deception. Listed below are common tactics that centres have been known to use (not every centre may use all of these tactics):

- ❑ Give the impression they are medical clinics or professional counselling centres.
- ❑ Give themselves names that sound pro-choice and secular, or imply they are abortion clinics.
- ❑ Tell women they will provide information on all options, but then refuse to refer for abortion care or birth control.
- ❑ Do not say upfront that they are anti-abortion or religiously affiliated.
- ❑ Locate themselves near abortion clinics to attract clients looking for abortion services.
- ❑ Make exaggerated promises of help, such as financial assistance, medical treatment, and prenatal and postpartum care. In reality, those services are often very limited.

How do CPCs Mistreat Women?

CPCs often provide misinformation or withhold information, or even mistreat women. Listed below are common tactics that centres have been known to use (not every centre may use all of these tactics):

- ❑ Provide misinformation about abortion and exaggerate its risks. Abortions may be described as painful and life-threatening, causing long-term emotional, physical, and psychological damage. Women are often told that abortion increases the risk of breast cancer, future miscarriage, post-traumatic stress disorder, infertility, and other serious medical conditions. (All such claims are scientifically false.)
- ❑ Counsel against contraception, and refuse to provide information, except for misinformation about its efficacy (such as saying that condoms don't help to prevent sexually transmitted infections).
- ❑ State that birth control methods, such as emergency contraception, IUDs, and the birth control pill, are actually abortifacients.
- ❑ Use methods and language that are designed to scare, horrify, and confuse women considering abortion, which can induce guilt, anxiety, and emotional trauma.
- ❑ Persuade women against abortion even in the most desperate or compelling circumstances, such as a lethal defect in the fetus, in cases of rape, or where the woman's health is at risk.
- ❑ Delay the pregnancy test results, and use the time to expose women to anti-choice or religious propaganda, such as showing graphic videos and pictures about abortion.
- ❑ Present the pregnancy results in ways that are ambiguous or even false, in order to delay or prevent an abortion.
- ❑ If the woman turns out not to be pregnant, detain her at the CPC to give her an abstinence lecture, and present premarital sex as wrong and dangerous.
- ❑ Promote abstinence except within marriage, regardless of the woman's situation or moral values. For example, CPCs may counsel women to withhold sex from their boyfriends.
- ❑ Disrespect women's own spiritual values by trying to impose fundamentalist Christian and patriarchal values.
- ❑ Abuse a woman's trust by breaking confidentiality, such as by making unwanted phone calls at home urging her not to abort, or calling her parents or other family members.
- ❑ Provide limited services. For example, CPCs provide no pregnancy prevention services, except sometimes Natural Family Planning for married women.
- ❑ Perform an ultrasound to dissuade women from abortions, even though non-clinical use should be avoided.
- ❑ Conduct unprofessional post-abortion counselling, using a religiously based model of guilt, forgiveness, and redemption.

Appendix 10: Maps of BC Services

The following maps highlight locations of CPCs, women's centres, family planning clinics, and abortion clinics and hospitals in order to show the distribution of services.

There is a map for each of the following areas:

- Vancouver, Sunshine Coast, Mountains
- BC Rockies
- Northern BC
- Cariboo, Chilcotin, (northern) Coast
- Thompson, Okanagan
- The Islands

Map Legend

- Options for Sexual Health clinics (formerly Planned Parenthood)
- Women's Centres
- Clinics and Hospitals
- CPCs
- Other Anti-Choice Centres

Note: Data was collected in 2006.


VANCOUVER, COAST & MOUNTAINS
Ts'yl-os Pk.
TOBA INLET
SETON PORTAGE
LILLOOET
BIRKEN
D'ARCY
99
PEMBERTON
FRASER
97C
SPENCES BRIDGE
Desolation Sound Marine Pk.
WHISTLER
Stein Valley Pk.
LYTTON
MERRITT
LUND
99
Garibaldi Pk.
NAHATLACH R
POWELL RIVER
5
BOSTON BAR
EARLS COVE
SALTERY BAY
COMOX
GARDEN BAY
SQUAMISH
HARRISON LAKE
SPUZZUM
MADEIRA PARK
LANGDALE
BRITANNIA BEACH
YALE
19
HALFMOON BAY
SECHELT
99
Golden Ears Pk.
PRINCETON
PARKSVILLE
GIBSONS
HORSESHOE BA
HARRISON HOT SPRINGS
5A
4
MAPLE RIDGE
HOPE
Vancouver Island
VANCOUVER
MISSION
AGASSIZ
NANAIMO
CHILLIWACK
Skagit Valley Pk.
TSAWWASSEN
LANGLEY
ABBOTSFORD
WHITE ROCK
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U S A


B. C. ROCKIES
Hamber Pk.
93A
KINBASKET LAKE
93
Banff Nat. Pk.
Yoho Nat. Pk.
LAKE LOUISE
22
2
Alberta
23
ROGERS PASS
GOLDEN
COLUMBIA R
BANFF
Mount Revelstoke Nat. Pk.
Glacier Nat. Pk.
Kootenay Nat. Pk.
Mt Assiniboine Pk.
CALGARY
REVELSTOKE
Bugaboo Pk.
TROUT LAKE
SHELTER BAY
RADIUM HOT SPRINGS
40
Height of the Rockies Pk.
Silver Star
23
INVERMERE
PANORAMA
FAIRMONT HOT SPRINGS
22
NAKUSP
6
Purcell Wilderness Conservancy
NEW DENVER
93 95
ELKFORD
SKOOKUMCHUCK
6
KASLO
FAUQUIER
Kokanee Glacier Pk.
Valhalla Pk.
AINSWORTH HOT SPRINGS
Top of the World Pk.
SPARWOOD
Granby Pk.
6
KIMBERLEY
WINLAW
3A
BALFOUR
3
Gladstone Pk.
NELSON
CRANBROOK
FERNIE
CASTLEGAR
3A
6
ELKO
SALMO
CRESTON
GRAND FORKS
ROSSLAND
TRAIL
KINGSGATE
ROOSVILLE
U S A
©DAVENPORT MAPS LTD


NORTHERN BC
Yukon
WATSON LAKE
ATLIN
LIARD RIVER
COAL RIVER
TOAD RIVER
FORT NELSON
Alberta
MUNCHO LAKE
DEASE LAKE
JUNEAU
TELEGRAPH CREEK
ISKUT
Atlin Pk. & RA
Tatshenshini Alsek Wilderness Pk.
Northern Rocky Mtns Pk.
PROPHET RIVER
BUCKINGHORSE RIVER
PINK MOUNTAIN
Mt. Edziza Pk.
Spatsizi Plateau Wilderness Pk.
Tatlatui Pk.
Alaska
WRANGELL
MEZIADIN JUNCTION
FORT ST. JOHN
HUDSON'S HOPE
TAYLOR
DAWSON CREEK
HYDER
STEWART
CHETWYND
MACKENZIE
PACIFIC
OCEAN
KITWANGA
HAZELTON
GRANISLE
TUMBLER RIDGE
SMITHERS
FORT MCLEOD LAKE
TERRACE
ST. JAMES
PRINCE RUPERT
HOUSTON
PRINCE GEORGE
MASSET
BURNS LAKE
Queen Charlotte Islands
Naikoon Pk.
KITIMAT
FRASER LAKE
VANDERHOOF
SKIDEGATE
Kitlope Pk.
MCBRIDE
QUEEN CHARLOTTE CITY
SANDSPIT
QUESNEL
Tweedsmuir Pk.
Gwaii Haanas Nat. Pk. Reserve
BELLA COOLA
WILLIAMS LAKE
Wells Gray Pk.
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CARIBOO
CHILCOTIN, COAST
PRINCE GEORGE
16
C.N.R.
WELLS
BARKERVILLE
QUESNEL
FRASER
Kluskoil Lk.
Pk.
Itcha
Ilgachuz
Pk.
Tweedsmuir
Pk.
KLEMTU
HAGENSBORG
OCEAN FALLS
ANAHIM LAKE
NIMPO LAKE
Nazko Lks.
Pk.
LIKELY
QUESNEL
LAKE
Wells
Gray
Pk.
HORSEFLY
BELLA BELLA
SHEARWATER
BELLA
COOLA
20
PUNTZI
LAKE
ALEXIS
CREEK
WILLIAMS
LAKE
150 MILE HOUSE
NAMU
Hakai
RA
KLEENA KLEENE
97
LAC LA HACHE
TATLA LAKE
HANCEVILLE
RISKE
CREEK
LONE
BUTTE
100 MILE
HOUSE
TATLAYOKO LAKE
24
Big Creek
Pk.
Ts'yl-os
Pk.
BIG BAR
70 MILE HOUSE
CLINTON
5
PACIFIC
OCEAN
PORT HARDY
CACHE CREEK
LILLOOET
KAMLOOPS
99
19
LYTTON
CAMPBELL RIVER
POWELL RIVER
Garibaldi
Pk.
Vancouver
Island
Strathcona
Pk.
VANCOUVER
HOPE
3
4
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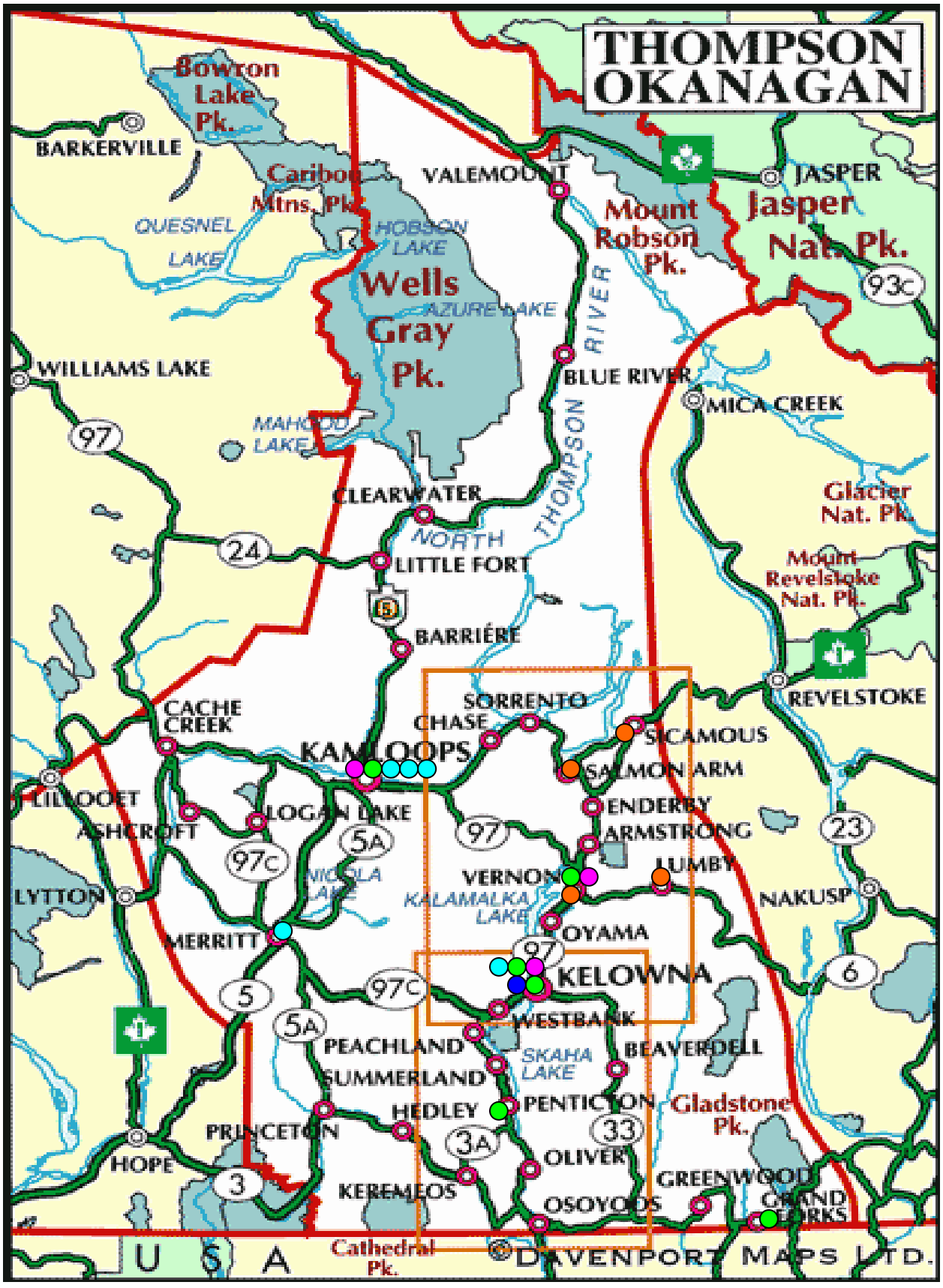
THOMPSON
OKANAGAN
Bowron Lake Pk.
BARKERVILLE
Cariboo Mtns. Pk.
VALEMOUNT
JASPER
Mount Robson Pk.
Jasper Nat. Pk.
QUESNEL LAKE
HOBSON LAKE
Wells Gray Pk.
AZURE LAKE
THOMPSON RIVER
WILLIAMS LAKE
BLUE RIVER
MICA CREEK
MAHOOD LAKE
CLEARWATER
NORTH THOMPSON RIVER
Glacier Nat. Pk.
LITTLE FORT
Mount Revelstoke Nat. Pk.
BARRIÈRE
REVELSTOKE
CACHE CREEK
SORRENTO
CHASE
SICAMOUS
KAMLOOPS
SALMON ARM
LILLOOET
ENDERBY
LOGAN LAKE
ASHCROFT
ARMSTRONG
LUMBY
VERNON
KALAMALKA LAKE
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