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Anti-Abortion Crisis Pregnancy Centers in Central Florida

Isabel Adamus

April 2022

Rollins College

Department of Anthropology

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Abstract

Anti-abortion crisis pregnancy centers, also known as CPCs, are nonprofit organizations that target pregnant women and aim to dissuade them from considering abortion. In the U.S., CPCs are increasing in prevalence, accumulating government/state funding and support, and becoming more medicalized. Medicalization includes offering limited medical services, such as pregnancy testing, limited ultrasounds, and testing for sexually transmitted infections (STIs). CPCs are largely unlicensed and unregulated, frequently advertising in misleading ways and providing inaccurate health information. The goal of this research is to (1) understand how CPCs in Central Florida utilize rhetorical strategies to frame their services and health information as credible, legitimize their work, and discourage abortion, and (2) understand the role of faith in the services CPCs provide and in establishing identity and community among staff and volunteers at CPCs.

A thematic analysis of fifteen client-facing CPC websites in Central Florida was conducted to identify the rhetorical strategies CPCs use to position themselves as credible. Additionally, two semi-structured interviews were conducted with individuals who volunteer and work at CPCs in Central Florida, and three with individuals who are reproductive justice advocates in Florida. This research is informed by critical medical anthropology, activist anthropology, and reproductive justice. The main findings were that CPCs use strategies of promotion, space, and language use to frame their services as credible. CPCs do this by sharing health misinformation and promoting abstinence and reducing the credibility of abortion clinics/providers and ways to control reproductive health. Faith has a significant role in the ways in which CPCs frame their services and establish identity and community through the framework of lived religion. This research provides evidence to how CPCs operate in Central Florida and

areas for improvement in delivery of services and evaluation, and potential regulation of the accuracy of information and services CPCs provide.

CHAPTER 1: Introduction and Literature Review

Anti-Abortion Crisis Pregnancy Centers in the United States

History of Anti-Abortion Crisis Pregnancy Centers and the CPC Movement

Anti-abortion pregnancy centers, more commonly known as crisis pregnancy centers (CPCs) are nonprofit organizations that target pregnant women and aim to dissuade them from considering abortion (Swartzendruber et al. 2018). CPCs are referred to by many names such as anti-abortion centers, pro-life pregnancy centers, abortion alternatives, pregnancy resource centers (PRCs), pregnancy care centers, anti-choice centers/clinics, fake women's health centers, and fake clinics.[1] The many names lead to confusion surrounding the CPC movement in the U.S. and is a result of it being unclear what services these organizations provide and how they operate.

The primary missions of CPCs are to dissuade individuals from seeking or obtaining an abortion, promote sexual abstinence before marriage, spread Christian evangelism, and promote patriarchal, heteronormative ideals (Swartzendruber et al. 2018). People working at CPCs refer to people with unintended or "crisis" pregnancies as "abortion vulnerable" and those considering abortion as "abortion minded." This provides insight to how CPCs label and profile people seeking their services and the critical role dissuading people from abortion is to their mission.

In the United States, most CPCs are affiliated with national organizations, such as Care Net, Birthright International, Heartbeat International, National Institute of Family and Life Advocates (NIFLA), and Ramah International (Swartzendruber et al. 2018). These organizations moderate the anti-abortion movement by creating standards for CPC operations and have policies against promoting contraception and a pro-life agenda (Swartzendruber et al. 2018). In the U.S,

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[1] Anti-abortion crisis pregnancy centers will be referred to as 'CPCs' throughout the paper. It is important to highlight that anti-abortion or pro-life pregnancy centers is a more accurate description of these organizations.

CPCs are increasing in prevalence, accumulating government funding and support, and becoming more medicalized. Medicalization of CPCs is defined as increasingly presenting themselves as clinics, offering medical services such as ultrasounds and pregnancy tests, and offering health information both in-person or on their websites.

CPCs have operated in the United States since the 1960s and have generally offered pregnancy testing and counseling to discourage individuals from seeking abortions (Swartzendruber et al. 2018). CPCs are often unlicensed and unregulated in the U.S. (Swartzendruber and Lambert 2020). This means CPCs are not privy to oversight by local or state governments like comprehensive reproductive clinics are, even though they often present as clinics.

The anti-abortion and CPC movement is predominately led by white, evangelical women, and their work focuses on pregnant women. The CPC movement represents a modern form of pro-life activism in the U.S. (Kelly 2014). While the CPC movement has significant support from the evangelical community in the U.S., it has limited success in meeting its primary goals of targeting clients that are abortion minded and dissuading them from abortion (Kelly 2014).

Research on CPCs in the U.S. has been done by a small group of researchers in the past decade, such as Dr. Andrea Swartzendruber, Dr. Danielle Lambert, Dr. Kimberly Kelly, Dr. Bryan Swartz. These scholars study CPCs from their prospective discipline ranging from public health, sociology, and medicine. The lack of CPC researchers represents the importance for more research to be conducted on this topic. Numerous reasons could be attributed to the limited research such as the polarization and politicization of pregnancy and abortion in the U.S., limitations in funding for academia, and antagonization by organizations such as Live Action News, a pro-life news source (Williams 2021).

CPCs often advertise in misleading ways and provide inaccurate and false health information (Swartzendruber et al. 2018). Researchers at the University of Georgia created a web-based geolocated database of all CPCs currently operating in the United States (Swartzendruber and Lambert 2020). The goal of their project was to inform the public about the location and services offered by CPCs (Swartzendruber and Lambert 2020). According to 2019-2021 data from CPC Map Database:

- There are 2,546 total CPCs operating in the U.S.
- 39% of CPCs (994 CPCs) in the U.S. are in the South.
- The South has two times as many CPCs as the West and almost three times as many as the Northeast.
- 1,966 CPCs (77.2%) offer limited ultrasounds, representing an 11% increase from 2018.
- 580 CPCs (22.8%) offer pregnancy testing and information only.

There are CPCs in every state, but they are most prevalent in the South and Midwest (Swartzendruber and Lambert 2020). The distribution of CPCs is associated with state funding and legislation related to abortion and reproductive health restrictions. States in the South and Midwest have greater funding and more restrictive reproductive legislation which results in a greater prevalence of CPCs in the state. The presence and way in which CPCs operate impact public health and policy as well as individual and community health since individuals are not able to access unbiased, accurate health information or timely comprehensive reproductive healthcare services.

Common Services Offered by CPCs

CPCs are increasingly becoming medicalized in the United States. This includes offering limited medical services, such as pregnancy testing, limited ultrasounds, and testing for some sexually transmitted infections (STIs). These services are often offered for free, but usually with a caveat that individuals sit through counseling or programming the center utilizes influence individuals' pregnancy decisions (Swartzendruber et al. 2017). Additionally, the limited ultrasounds are not diagnostic, and often used to merely confirm pregnancy. CPCs use ultrasounds as a strategy to make women think differently about their pregnancy. Medical anthropology research has shown that nondiagnostic ultrasounds are profoundly social and political in the U.S. today and incite a pro-life perspective to care (Taylor 2008).

The services offered by CPCs do not align with national family planning service recommendations and often fail to comply with standard medical and ethical principles (Swartzendruber and Lambert 2020). The CDC and U.S. Office of Population Affairs states quality family planning services include pregnancy testing, unbiased options counseling and referrals, comprehensive contraceptive counseling, provision of one or more contraceptive methods, STI testing and treatment, condom use promotion, and easy and affordable condom access (Swartzendruber and Lambert 2020). However, of these services CPCs often only offer pregnancy testing and very few offer STI testing or treatment. The information shared with clients at CPCs is often inconsistent with scientific information regarding women's reproductive health. Additionally, many CPCs claim to offer a full range of services and options to pregnant women but the closest thing most CPCs have to medical professionals are sonographers. CPCs do not offer Pap smears, contraceptive advice or implantation, cancer screenings or prenatal care and very few offer STI tests (Swartzendruber and Lambert 2020). This demonstrates the failure

of CPCs to comply with standard medical and ethical practices which is problematic if they are receiving federal or state funding for family planning services.

Funding

While most CPCs operate as 501 (c) (3) nonprofit organizations, relying on private donations, CPCs have increasingly gained federal and state funding and support in the past few decades. The Title X Family Planning Program was originally established by Congress in 1970 with the intent to support clinics and organizations that provide low-income women birth control and other reproductive health care services (Swartzendruber and Lambert 2020). However, changes to Title X in recent years have placed emphasis on providing funding to faith-based family planning clinics and organizations that do not offer abortion services or comprehensive reproductive health care services (Swartzendruber and Lambert 2020). Abortion services are defined as offering medication or surgical abortion, and information or referrals for abortion.

Clinics and organizations that receive federal funding through Title X are prohibited from using funding for abortions; however, sites that do not offer contraceptives like birth control pills, condoms, and IUDs and do not refer patients to clinics that provide these services, *have* been granted funding. This allocation of funding is antithetical to the goals of Title X. These funds have also been used for abstinence education and to promote a natural family planning program called Fertility Education and Medical Management (FEMM). FEMM teaches women to monitor their hormonal cycle to identify ovulation to manage their fertility. Studies have shown FEMM is not as effective as other forms of education or prevention for pregnancy (Andaya and Mishtal 2016).

The Trump Administration appointed supporters of CPCs to leadership positions such as the Deputy Assistant Secretary for Population Affairs (DASPA) in the Department of Health and

Human Services who was previously President and CEO of a network of CPCs (Swartzendruber and Lambert 2020). In 2018, the DASPA was granted financial decision making over which organizations receive Title X grants. These grants provide funding for family planning and preventive services to low-income and uninsured individuals (Swartzendruber and Lambert 2020). In 2019, CPCs became eligible for federal grants based on changes the Trump Administration made to the Title X program (Swartzendruber and Lambert 2020). Even though CPCs do not provide contraception or preventive services, they were able to be awarded these grants. Additionally, CPCs were granted federal funding through the Teen Pregnancy Prevention Program in 2019 (Swartzendruber and Lambert 2020).

Predominantly in the South and Midwest, states budgets established by conservative legislatures have put funding towards "Alternatives to Abortion" programs which are often run through state health departments. This includes money from the federal Temporary Assistance for Needy Families (TANF) program and state taxpayer dollars to fund CPCs (Glenza 2021). The sale of *Choose Life* license plates in certain states, such as Florida, also directly fund CPCs through specific grant programs ("Choose Life" 2021). This represents the inclusion of religious ideologies which is promoted by states when they allow the issuance of vanity, or position, plates.

Marketing Strategies Employed by CPCs

CPCs use targeted marketing strategies to further their mission. Organizations dedicated to furthering the mission of pregnancy centers and other pro-life organizations such as *Choose Life Marketing* state they can "Help you [CPCs] reach the abortion-minded women who need your services the most" ("Choose Life Marketing" 2021). CPCs also employ emotional and

moral appeals. Their main platforms for marketing include websites and social media, advertisements in print, and billboards.

Lay Counseling and Abstinence-Only Sex Education

CPCs are mostly staffed with volunteers who are not medical professionals and are trained under the principle of "lay counseling," which involves training lay people to provide counseling (Bryant and Swartz 2018). CPCs cannot be legally held to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and are protected by the First Amendment, which allows counseling to be provided by volunteers and staff who are not medical professionals (Bryant and Swartz 2018). Lay counselors at CPCs are often trained to promote abstinence-until-marriage and encourage individuals to keep their pregnancy. They are trained by curriculum often from national pro-life organizations, meaning the information is rooted in religious ideologies.

In Florida, sex education in K-12 schools has been taught by faith-based organizations linked to CPCs (Newby 2017; Hollenbeck 2018). Often, religious, and conservative values are intertwined with their messaging. State policy that promotes abstinence-only education is ineffective and may contribute to the high teenage pregnancy rates, STI rates, and birth rates in the U.S., which are substantially higher compared to other developed countries (Stanger-Hall and Hall 2011). Studies have found that teens in states that teach abstinence education are more likely to become pregnant. Not only is there growing public support for comprehensive sex education, but the failures of abstinence-only education indirectly and directly cost funding at the federal and state level (Stanger-Hall and Hall 2011). Rates of abortion have declined over the past three decades with the increasing availability of sexual education and safe and effective contraception (Guttmacher 2013).

Abstinence-only sex education is ineffective, unreliable, and a discriminatory way to teach sex education. In the state of Florida, local school boards decide what to teach in public schools, and a lack of comprehensive sex education is harmful to the community (Newby 2017). Abstinence-only sex education promotes abstinence until marriage and frames the idea that family structures are hierarchical and based on stringent, heteronormative gender roles.

Health Misinformation

Abortion misinformation adversely impacts individuals' abilities to make informed decisions about their health (Patev and Hood 2020). The World Health Organization describes access to accurate reproductive health-related information as a basic human right (WHO 2017). CPCs provide partisan information regarding abortion, which can include misinformation on the danger of abortion compared to childbirth, and the spurious risks of breast cancer (abortion and breast cancer 'ABC link') and infertility (Patev and Hood 2020). Studies have shown that mortality rates for abortion are lower than childbirth; when legal abortion procedures are performed by trained providers it rarely results in fertility issues; and the causal link between abortion and breast cancer have been debunked (Bartlett et al. 2004; Grimes 2006; Frank et al. 1993; Beral et al. 2004; Reeves et al. 2006). There are also numerous inaccurate psychological consequences that have been attributed to abortion such as negative mental health outcomes and the creation of social diagnoses such as "Post Abortion Syndrome" (PAS) that further frame abortion as dangerous and risky (Kelly 2014; Kelly 2019).

In addition to abortion misinformation, there is a general lack of knowledge about abortion. A qualitative study found that individuals seeking abortion struggled to find accurate information, which creates barriers to accessing abortion services (Kavanaugh, Jerman, and Frohwirth 2019). CPCs outnumber facilities that provide abortion services nearly two to one in

the U.S. and represent a significant source of reproductive health information for individuals who visit them (Chakravarthy 2020). CPCs representing a major source of health information is an area of concern to evaluate the credibility and validity of health information shared at these facilities.

Researchers in North Carolina and Georgia have analyzed the health information presented on CPCs' websites in their respective states and found that CPCs provide biased, misleading, and inaccurate health information in person and on their websites (Bryant and Levi 2012). For example, of the CPCs they analyzed, they found CPCs provide inaccurate information regarding abortion, overstating the risks, and spread misinformation regarding contraception and condom effectiveness. CPCs overemphasize and misstate risks related to abortion and provide scientifically inaccurate health information (Bryant and Levi 2012; Swartzendruber et al. 2017). Additionally, sites commonly demonstrated an underlying assumption that pregnancy begins at fertilization rather than at implantation, as medically defined (Bryant and Levi 2012). CPC websites also inaccurately described emergency contraception (EC) and the most effective methods of contraception as abortifacient (Bryant and Levi 2012). However, EC is not an abortifacient, representing a contradiction presented by these websites (WHO 2021).

Joint position statements by the Society for Adolescent Health and Medicine (SAHM) and the North American Society for Pediatric and Adolescent Gynecology (NASPAG) state that (Swartzendruber et al. 2019):

1. CPCs pose risk by failing to adhere to medical and ethical practice standards.
2. Governments should only support health programs that provide accurate, comprehensive information.

3. Professional boards should hold CPCs to established standards of ethics and medical care.
4. Schools should not outsource sexual education to CPCs or other entities that do not provide accurate and complete health information.
5. Search engines and digital platforms should enforce policies against misleading advertising by CPCs.
6. Health professionals should educate themselves, and young people about CPCs and help young people identify safe, quality sources of sexual and reproductive health information and care.

Overall, this demonstrates how a lack of access to accurate health information makes it easier for CPCs to misinform or not correct misinformation that people have. CPC researchers have analyzed the health information on CPCs websites in other states and identified instances of false or misleading health information which can result in negative health outcomes for people with this information. Major medical organizations have criticized CPCs, the support they receive by federal and state governments, and the risks the present by falsely advertising their services and presenting health misinformation.

Reproductive Rights Legislation in the United States

Abortion has been highly contentious throughout the history of reproductive rights. The criminalization of abortion in the United States is largely influenced by political, religious, and social factors. Given the introduction of legislation that restricts and polices reproduction at unprecedented rates, it is important to understand the landscape of restrictions and protections in the United States. In 1973, the Supreme Court case *Roe v. Wade* overturned state laws that

criminalized abortions and constitutionally protected an individual's right to abortion (Center for Reproductive Rights 2021). Reproductive legislation often makes claims to protect women's health, assume fetal personhood, restrict funding for abortion in federally financed health care, and support religiously based conscientious objections (Andaya and Mishtal 2016). *Roe v. Wade* ruled that states could prohibit abortion only after presumed fetal viability (24-28 weeks) and that exemptions must be allowed to preserve women's health, which is defined broadly (Andaya and Mishtal 2016). Recently, proposed legislation reduces abortion access to either 15 weeks or 6 weeks goes against Roe v. Wade, having little do to with fetal viability.

CPCs have won legal protections in addition to government support and funding. CPCs are widely unregulated and not held to the same regulatory requirements as health care facilities (Swartzendruber and Lambert 2020). The 2015 California Reproduction Freedom, Accountability, Comprehensive Care, and Transparency Act mandated that unlicensed CPCs disclose that they are not health facilities and licensed CPCs provide information regarding state programs that provide abortion, prenatal, and family planning services at little or no cost to eligible individuals (Swartzendruber and Lambert 2020). California was the first state to pass legislation at the state-level to regulate CPCs (Spencer 2019). However, this legislation was struck down in 2018 in the *National Institute of Family and Life Advocates (NIFLA) v. Bacerra* Supreme Court case which ruled in favor of CPCs' First Amendment rights stating the state could not force CPCs to post signs that state they do not offer abortion or contraception information or referrals (Schweikart 2018; Spencer 2019).

In addition to discussing the legality of abortion, it is also important to look at abortion access and the factors that influence access. Access to abortion has been limited by the eradication of public funding for abortion care. In 1976, the Hyde Amendment limited federal

spending for abortion (Center for Reproductive Rights 2021). While there are exceptions to this and implementation varies by state, many states do not provide funding for abortion care (Kelly 2012). These restrictions on state and federal public funding for abortion disproportionately impact low-income women (Kelly 2012).

Federal lawmakers have restricted federal funding of abortions and some state legislatures have restricted access to abortion by requiring parental consent for minors, counseling, waiting periods, strict licensing requirements for facilities, and other mandates (Center for Reproductive Rights 2021). The 1992 Supreme Court Case *Planned Parenthood v. Casey* struck down state regulations on abortion, including spousal consent, by creating an "undue burden" standard (a legislature cannot make a particular law that is too burdensome or restrictive of one's fundamental rights) (Joffe 1995). While it upheld abortion rights, the language moved from requiring "strict scrutiny" of laws that may infringe on the right to abortion to tests of "undue burden" (Joffe 1995). This dictates that laws should not be too burdensome on the right to abortion (Joffe 1995). This decision established a foundation for greater state legislative restrictions on abortion including mandated counseling, waiting periods, and parental consent for minors which altered abortion care from state to state (Joffe 1995).

Targeted Regulation of Abortion Provider (TRAP) Laws

A report by the Guttmacher Institute found that more abortion restrictions were implemented in the past decade than at any time since *Roe v. Wade* (Andaya and Mishtal 2016). The introduction of Targeted Regulation of Abortion Provider (TRAP) laws has resulted in abortion being more closely regulated than many surgical procedures (Andaya and Mishtal 2016). Currently more than half of all U.S. states have legislation that either:

1. Impose restrictions on abortion providers through TRAP laws.

2. Mandate waiting times, ultrasound viewings and/or reading of scripts written by legislators about fetal development before receiving an abortion.
3. Reduce the gestational age for legal abortion.

Since the 1980s, the number of abortion providers has declined about a third due to legislative pressures, limitations on abortion training for physicians, and harassment and violence experienced by abortion providers, staff, and clinics that provide abortion care (Andaya and Mishtal 2016). Supporters of TRAP laws claim they ensure women's safety by regulating abortion providers and/or their clinics more strictly (Andaya and Mishtal 2016). However, the requirements make it more difficult for providers to care for patients such as requiring abortion providers to hold hospital privilege and clinics to be located no more than 30 miles from a hospital, which results in rural clinics closing (Andaya and Mishtal 2016). Legislators and supporters justify increased regulation based on the claim that abortion is dangerous; however, studies have shown that less than 0.3% of U.S. abortion patients experience a complication that requires hospitalization and the risk of death from childbirth is roughly 14 times higher than that from abortion (Henshaw 1999; Raymond and Grimes 2012). These restrictions are important to note in relation to the increasing presence and medicalization of CPCs in the U.S. While CPCs are increasingly offering medical services and health information, they are not regulated nor licensed medical clinics (Swartzendruber and Lambert 2020). This represents inconsistencies in regulation of facilities presenting or operating as "clinics."

Legislation that mandates wait periods and required counseling have been implemented, and some states require counseling to be conducted in person (Andaya and Mishtal 2016). Anti-abortion organizations argue that mandatory waiting periods and counseling provide women with information about abortion risks and allow them time to reconsider their decision (Andaya and

Mishtal 2016). On the other hand, abortion rights supporters argue that the information provided at counseling sessions can be misleading or false, with the goal of discouraging women from having an abortion (Richardson and Nash 2006).

Ultrasound Viewing Laws and Reproductive Technologies

The Women's Right to Know Act requires the non-medically indicated use of ultrasound technology during an abortion procedure (Andaya and Mishtal 2016). Reproductive technologies encompass tools and methods used to monitor and assist with reproduction such as ultrasounds, medication treatments, contraception, etc (Rapp 2000). Politicians utilize reproductive technologies to advance partisan political agendas that restrict access to abortion and comprehensive reproductive health care. For example, there is legislation that requires women to get external and/or transvaginal ultrasounds before having an abortion (Andaya and Mishtal 2016). Ultrasounds are typically used to estimate the gestational age of a fetus and, during an abortion, ensure all tissue is removed; however, this act requires providers to perform ultrasounds to display and describe the images to people seeking abortions (Andaya and Mishtal 2016). Reproductive technologies such as ultrasounds are also strategically used by CPCs as an emotional tool to dissuade women from seeking an abortion. Certain states also require providers to read patients' scripts about fetal development written by legislators which are not informed by medical providers (Andaya and Mishtal 2016). The use of reproductive technologies to as tools to delay or influence individuals' decision regarding their pregnancy represents the role of ideology in legislation and delivery of healthcare services, specifically by organizations such as CPCs.

Reproductive Rights Legislation in Florida

Abortion Restrictions in Florida

In Florida, the following abortion restrictions were in place as of January 1, 2022 (Guttmacher 2022):

1. Requirement of state-directed counseling that includes information designed to discourage an individual from having an abortion (biased counseling).
2. Health insurance plans offered under the Affordable Care Act and the state's health exchange can only cover abortion in cases of life endangerment, rape, or incest, unless individuals purchase an optional rider at an additional cost.
3. Public funding is only available for abortion in cases of life endangerment, rape, or incest.
4. The Florida Constitution requires parental notification for minors, and Florida law requires that a parent or legal guardian be notified of and consent prior to a minor's abortion; however, a judge can approve a minor's petition without parental notification and consent through judicial bypass
5. Required ultrasounds before obtaining an abortion. The provider must offer the individual the option to view the ultrasound image.
6. An abortion may be performed at 24 or more weeks after the last menstrual period (LMP) only in cases of life or health endangerment.

Florida legislation prohibits abortion at viability. Recent legislation passed in March of 2022 by the Florida Senate March 2022 enacted a 15-week abortion ban, and a 24-hour waiting period mandate may also go into effect in 2022 further restriction abortion access (Center for Reproductive Rights 2021; Guttmacher 2022). Florida's TRAP law includes requirements related

to facilities that provide second-trimester procedures, admitting privileges, and reporting (Center for Reproductive Rights 2021). Florida law also restricts the provision of abortion care to licensed physicians, and providers who violate these abortion restrictions may face civil and criminal penalties (Center for Reproductive Rights 2021).

Abortion Protections in Florida

Florida law includes state constitutional protections for abortion (Center for Reproductive Rights 2021). If *Roe v. Wade* were to be limited or overturned, pre-*Roe* bans for Florida were repealed in 1972, so abortion is likely to remain legal in Florida (Center for Reproductive Rights 2021). However, constitutional protections for abortion does not prevent legislation from being introduced that further restricts and presents obstacles to accessing abortion and other healthcare services. It is important to recognize that given the current political landscape, the future of reproductive rights, access, and protections could greatly change in the next few months to years.

It is important to recognize that this legislation is informed by cultural, political, and religious ideologies which shape the way they are written, passed, and implemented. The landscape of reproductive legislation is constantly changing, and several new bills were introduced that restrict access to abortion and reproductive healthcare services during the writing of this thesis. This literature review has presented an introduction to the establishment of CPCs in the U.S., the limited existing research on CPCs, and provided background information on the services CPCs offer, their funding sources, and operations which lays the groundwork for research on CPCs in Central Florida.

CHAPTER 2: Methods and Research Setting

While existing literature has identified instances of health misinformation and deception by CPCs, there is limited research on CPCs in Central Florida. Research has also focused on the public health and sociological aspects of CPCs. Therefore, there is a need to analyze the impact of CPCs on communities in Central Florida and provide an anthropological perspective that incorporates ethnography. To do this, I advanced the following research questions:

1. What rhetorical strategies do CPCs use to position themselves as credible resources for health information and convince people to utilize their services?
2. What role does faith have in shaping identity and community among people involved in the CPC movement as well as the services CPCs provide?

Approach: Critical Medical Anthropology

My research is informed by critical medical anthropology and activist anthropology. Critical medical anthropology allows us to examine how cultural norms and institutions, macro and micro level factors, globalization, and interactions among humans play a role in individual health and well-being (Singer 1995). It utilizes ground-level ethnographic approaches and theory to understand and analyze the upstream factors and social and political phenomena that drive health, recognizing that western biomedicine is not the only solution to our concepts of health and healing (Singer 1995). For CPCs, examples of upstream factors include pro-life and religious ideologies that shape beliefs surrounding pregnancy and abortion and restrictive legislation related to reproduction.

Critical medical anthropology serves to not only understand, but challenge and change culturally inappropriate, oppressive, and exploitative patterns in healthcare and society (Singer

1995). Health is inherently political, as it is shaped by political processes and policies. Critical medical anthropology offers a perspective that allows anthropologists to best address the impact health misinformation, restrictive legislation, and the policing of bodies has on the reproductive and overall health of individuals and how to determine solutions to address the root causes of these inequalities by examining social, political, and historical factors. Additionally, activist anthropology will be used to spread awareness about the ways in which CPCs operate, so individuals can make informed decisions about where to seek services.

The concept of medical ecology plays a role in understanding the growing establishment of CPCs in the U.S. and the impact they have on communities. Medical ecology usually refers to the impact the environment has on shaping individual and community health, but it can also be used to understand the political and social factors shapes the ecology of health in a community or population (King 2009). With the introduction of restrictive legislation related to abortion and reproduction, there has been a decrease in number of abortion clinics and providers in the U.S. and limitations in access to comprehensive reproductive healthcare services. Medical ecology explains how CPCs essentially serve to fill the niches created by the lack of reproductive and abortion healthcare services. This perspective can also be used to help understand why CPCs are low-income, BIPOC communities and near abortion clinics. The significance of a growing number of CPCs is that they represent a source of health information and services to reproductive age individuals, meaning there is a need to look at the accuracy or the information they provide and qualifications to provide certain services.

This thesis also uses reproductive justice as a framework to analyze the impact CPCs and health misinformation have on communities. Reproductive rights are focused on the legal right to access reproductive health care services like abortion and contraception. Reproductive justice

links reproductive rights with the social, political, and economic inequalities that affect an individual's ability to access reproductive health care services and includes contraceptive and abortion justice (Sister Song 2021). The framework of reproductive justice also includes the idea that people have the right to or not to have children, and either path should be a choice. Equal access to safe abortion, critique of the pro-choice/pro-life debates that structure claims for abortion access, affordable contraceptives, comprehensive and inclusive sex education, and freedom from sexual violence are also central to the framework of reproductive justice. When CPCs present health misinformation, shame or fear women to dissuade them from seeking abortion and impose their own religious ideologies or values on clients, this represents an injustice.

Additionally, intersectionality as a theoretical framework is useful in understanding how multiple identities intersect to create unique forms of vulnerability (Crenshaw 1991). Intersectionality was coined by Kimberlé Crenshaw in the late 1980s, and her work primarily focuses on structural violence women experience—more specifically, women of color (Crenshaw 1991). Crenshaw's work is directly related to that of Dorothy Roberts, who studies gender, race, and class in legal issues, specifically focusing on policy related to reproductive health, child welfare and other ethical issues rooted in biosocial cultural factors (Roberts 1991). Roberts' article *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy* discusses the prosecution of drug-addicted mothers representing a larger scheme of increased state intervention and control over the lives and bodies of pregnant women under the guise of protecting a fetus from harm (Roberts 1991). This relates to themes this thesis will discuss regarding how political, social, and economic factors influence regulation of CPCs which directly impact the health and well-being of pregnant and reproductive age individuals.

Anti-Abortion Pregnancy Centers through an Anthropological Lens

Based on the gaps in CPC research in the U.S. and the lack of an anthropological perspective in existing CPC research, this represents a critical need for the goals of this thesis. An anthropological lens allows this topic to be analyzed from a holistic, comparative perspective in the context of Central Florida. An anthropological approach to abortion and CPC research will contribute to our understanding of why reproduction in some groups is encouraged and enabled while that of other groups is devalued, or stratified reproduction (Colen 1995). The framework of stratified reproduction is useful in understanding how inequalities in access to reproductive health care, race/ethnicity, class, region, religion, socioeconomic status, and other factors impact reproduction (Colen 1995). These inequalities perpetuated through state and morality politics need to be better understood and an anthropological lens is effective for analysis (Marsland and Prince 2012).

Anthropology has focused on the cultural and social aspects of reproduction, such as the medicalization of pregnancy and childbirth and the effects of biomedical prenatal interventions and reproductive technologies (Mitchell 2001; Oaks 2001; Taylor 2008). This anthropological research has contributed to the understanding of the connection between medical procedures and scientific thought with the cultural construction of fetal personhood. This frames the discussion about the morality of abortion, as well as policy and public attitudes related to reproduction and abortion. The stigma surrounding abortion makes it difficult to study. In the U.S., abortion research has shifted to fields such as public health, sociology, and legal studies (Ibis Reproductive Health 2021). The visibility of men in these discourses is often limited, and by historically framing abortion as a women's rights issue, this potentially reinforces gendered ideologies that associate women with reproduction and reinforce the assumption that only

women are affected by access to safe and legal abortion. This potentially impacts public attitudes towards legal abortion. Given the shifting landscape of reproductive politics, an anthropological perspective can provide unique methods for applied and policy-oriented ethnographic research to study reproductive and abortion politics in the U.S.

The *Politics of Reproduction* establishes reproduction at the intersection of politics and power (Ginsburg and Rapp 1995). The work of Faye Ginsburg and Rayna Rapp provides a theoretical framework for anthropological research on abortion and related areas. Reproduction is greatly situated in cultural and historical ideas concerning motherhood, gender, religion, and personhood (Inhorn and van Balen 2002). Anthropologists such as Lynn Morgan and Elizabeth Roberts have also examined reproduction in context with religious, moral, economic, and political agendas through the theoretical framework of reproductive governance (Morgan and Roberts 2012). Reproductive governance explores the relationship between abortion policy and the state's views on natalism which also has implications on legislation. Reproductive governance is useful in understanding the mechanisms in which political, religious, economic, social, and other factors interact to produce, monitor, and control reproductive behaviors. Reproductive discourses are often framed through morality and debates over 'rights' (Morgan and Roberts 2012).

Medical anthropologists have also studied political subjectivities of doctor-patient interactions which provides a foundation for understanding this in relation to interactions between clients and staff at CPCs (Singer 2017). Additionally, anthropologists have examined the numerous factors that contribute to morbidity and mortality consequences of pregnancy and how race, class, socioeconomic status and more intersect to disproportionately burden specific groups (Lerman et al. 2017). Building off the work of researchers such as Rayna Rapp, in *Stigma*

Syndemics: New Directions in Biosocial Health, anthropologists discussed the stigmatization of adolescent childbearing, social stigmatization of abortion, and how pregnancy becomes pathologized and something to be managed (Lerman et al. 2017). The stigmatization of reproductive options coupled with the economic, logistical, and social barriers people experience when seeking abortion care can result in negative health outcomes and represents a critical area for research (Lerman et al. 2017; Ostrach and Cheyney 2014).

Overall, not only is there a lack of research on CPCs from an anthropological perspective, but there is also limited research related to abortion or early pregnancy in anthropology. This thesis seeks to address the gap in research and provide an understanding of CPCs in Central Florida, rhetorical strategies CPCs use to position themselves as credible and legitimate sources for health information, and the ways in which faith plays a role in the services they provide and sense of identity and community among staff and volunteers at CPCs.

Methods

This study uses a thematic analysis of client-facing CPC websites in Central Florida and semi-structured interviews with staff and volunteers at CPCs as well as reproductive justice advocates in Florida to examine the rhetorical strategies CPCs use to position themselves as credible sources for health information and services and to understand the role of faith in services provided.

Thematic Analysis

To evaluate the rhetorical strategies utilized by CPCs, a thematic analysis of client-facing CPC websites in Central Florida was conducted. A thematic analysis is a qualitative research technique that involves identifying recognizable reoccurring ideas and patterns within the data

(Bernard 2018; Emerson 2011; Pelto 2013). This method is useful for this project since there is limited research on CPC websites and no research on CPC websites in Central Florida. In my literature review and preliminary research, I identified key concepts were used as initial codes. An incognito browser was used to search terms such as “abortion near me” or “pregnancy centers” since my google algorithm is biased and I wanted to simulate how it would be for someone to search for reproductive healthcare services on their own.

A comprehensive list of all anti-abortion pregnancy centers within Central Florida was compiled utilizing a report by the Floridians for Reproductive Freedom and cross-referencing with the CPC Map Database (Floridians for Reproductive Freedom 2021; Swartzendruber and Lambert 2020). Of the 30 websites identified for CPCs in Central Florida, 20 were client-facing and 10 were donor-facing sites. Donor-facing sites are classified as such based on the presence of fundraising information and a lack of resources or information about services for prospective clients. Donor-facing sites were excluded from the study.

Inclusion Criteria

CPCs were included if they were currently in business and classified as an anti-abortion or “crisis” pregnancy center which means they advertise free pregnancy tests/testing and counseling on a live proprietary domain site, or the center confirms the availability of free pregnancy tests/testing and if it was identified from one of the directories of the main national organizations that support CPCs. CPCs were included in the study if they were in Central Florida and a client-facing site. The counties included in Central Florida are Seminole, Orange, Volusia, Lake, Osceola, and Brevard.

Selection Process

Each of the 20 client-facing CPC websites was assigned a number and a random number generator was used to randomly select 15 of the 20 CPC websites in Central Florida for analysis. Random selection was used to eliminate sampling selection bias and increase generalizability of the results.

Procedures

An excel sheet was used to organize information about each center based on the county it is in, name of facility, website, classification on search engine, address, and whether it is classified as offering "Pregnancy Tests & Info", or "Limited Medical Services" based on criteria by the CPC Map Database (Swartzendruber and Lambert 2020). This preliminary data was collected from 10/1/2021 to 12/15/2021. IRB approval was not needed for the thematic analysis since the websites contain publicly available information and did not involve human subjects. A Qualtrics survey was used to conduct data entry from 2/6/2022 to 3/12/2022. The Qualtrics survey included information from the about page, mission statements, services offered, and information related to abortion or health. I also took screenshots of certain tabs on the websites to supplement the data collection for analysis.

Data Analysis

Thematic coding is a systematic approach to qualitative data analysis that involves identifying broad themes or patterns of cultural meaning (Gibbs 2007). Data downloaded from the Qualtrics survey went through several cycles of open coding based on Strauss and Corbin's (1998) "open coding" method which identifies broad patterns in the data to identify emergent themes. Themes and concepts identified in the literature review were connected to emergent themes identified from the data which focused on information from the websites about page,

mission statements, services offered, and information related to abortion or health. The text was reduced to categories where patterns were identified among the websites (Content Analysis 2019). Specific quotes were included to represent major themes in the Findings section.

Semi-Structured Interviews

Semi-structured interviews allow the use of an interview guide with open-ended questions that allow for more fruitful dialogue (Bernard 2018; Pelto 2013). Interviews provided insight to the demographic background of the individual, how they became involved in the work they do and their role, how they perceive the work they do, and their personal values and beliefs on the topic.

Participants

The participants in this study included three individuals that work as reproductive justice advocates or at an abortion clinic in Florida, and two that are staff or volunteers at anti-abortion pregnancy centers in Central Florida. All individuals are residents of Florida. All five interviewees were white women. The interviewees connected to CPCs were Christian and pro-life. Since this study involved interviewing people at CPCs, there was potential to encounter pregnant individuals which are a vulnerable population; however, I did not interview or interact with any pregnant individuals.

Procedures

IRB approval was obtained on 2/15/2022 and interviews took place from 2/28/2022 to 3/16/2022. Participants were recruited by reaching out to anti-abortion pregnancy centers or individuals involved in reproductive justice work via email or Instagram direct message. One interviewee was recruited through a personal connection. Interviews were conducted in person (n

= 2), via phone (n = 2), or over Zoom video conferencing platform (n = 1). Each participant was provided an informed consent document that was signed and returned to be before the interview. Each participant was briefed on the goals of the research before the interview began (See Appendix A). I was very open about my personal beliefs and positionality given the nature of the topic which I explain in the Positionality section (pg 32).

I made the decision to not audio record the interviews because I felt it would hinder rapport and that participants were more likely to openly share their views with me and feel less pressure when not being recorded. Given the social context, I felt choosing to not record minimized a feeling of threat for participants since I was entering their space as a researcher. I designed two interview guides, one for interviews at CPCs and one for reproductive justice advocates and related individuals (See Appendix B).

The interview guide for CPCs included questions like: What is your role with X organization? What services do you provide? How do you discuss options with women? What role does faith play in your work? Interviews with reproductive justice advocates were more open-ended to get a sense of the current activist efforts, research, and knowledge of CPCs in Florida. The interview guide for non-CPC interviews included questions like: What is your knowledge and experience with CPCs? Could you reflect on how your work or organization is impacted by CPCs? Could you generally explain the impact of CPCs on the communities you work with? How do CPCs contribute to barriers to abortion and/or reproductive healthcare access? These two sample populations representing opposite ends of the spectrum on the topic provided a wider range of perspectives to inform my research questions.

Detailed notes from each interview were taken by hand and added to after the interview ended. Interviews averaged 45 minutes. All identifying information was removed and each

interviewee assigned a pseudonym to maintain confidentiality. All electronic content was kept on Rollins OneDrive servers.

Data Analysis

The research questions were used to guide the direction of the conversation, given the semi-structured nature. This led to the emergence of additional questions during the interviews. The data was analyzed using Strauss and Corbin's (1998) "open coding" method which identifies broad patterns in the data. Preliminary themes identified in the concurrent thematic analysis and literature review phase were used in the primary open coding of the interviews to organize chunks of the text. I used these broad themes as "sensitizing concepts" (Bowen 2019). Transcripts were annotated and went through multiple rounds of open coding and axial coding to identify themes. Axial coding identified connections between the open codes to sort the data into categories relevant to the themes. The secondary-cycle coding phase focused on identifying additional themes and examples of how these themes are used to support specific goals. The constant comparative method was used to analyze and synthesize data and emergent themes from the literature review, thematic analysis, and interviews since little is known about CPCs in Central Florida and the CPC movement this was the most appropriate approach (Glasser and Strauss 1967).

Figures and Tables

The figures and tables included in this thesis include images I have taken in Florida, graphics I have created, and an image from online. A frequency table was used to determine the frequency of certain words in the names of CPC facilities such as "choices", "medical", "resources", "life", "women's", etc. to create a word cloud (See Figure 9). The word cloud was

created to visually represent the names of CPCs in Florida based on the Floridians for Reproductive Freedom report (Floridians for Reproductive Freedom 2021). The comprehensive list of CPCs in Central Florida was also used to create the CPC count map (See Figure 3). U.S. Census data was used to create the population by county table for Central Florida (See Figure 3).

Methodological Challenges

Due to the complexity of this research topic, there are methodological challenges worth noting. The current political climate has contributed to legislation that restricts abortion access being introduced at unprecedented rates which means the nature of how CPCs operate could change drastically over the course of the next few months. I also experienced difficulties securing interviews. Additionally, I experienced challenges building rapport and had to navigate complex conversations. My positionality played an important role in the data I was able to collect from interviewees. There are certain variables that are difficult to measure or define because they are charged with emotion and political import. Topics related to this research are also very polarized and it is difficult to ascertain the truth which makes it challenging to present this information in a neutral way that demonstrates all perspectives in a fair and equitable way. Including perspectives from both sides of the issue and incorporating a thematic analysis with ethnography allowed some of these issues to be addressed.

Positionality

Positionality is a fundamental part of anthropology since it considers individuals identify in relation to the group and/or topic they study by acknowledging gender, race, socioeconomic status, citizenship, place of origin, and more (Sánchez 2010). Additionally, it considers the personal biases and viewpoints that shape the way the individuals perceive the issue and world

(Sánchez 2010). I am a Hispanic, cisgender woman from Sanford, Florida. Florida is a state which lacks comprehensive sex education and teaches abstinence only. This has not only harmed me growing up, but I have seen how it has impacted my friends and community. I grew up not understanding my body and struggling to navigate topics such as menstruation, masturbation, sex, sexual assault, and more. I plan to become an OB/GYN and work as a physician researcher in the South. I do not identify as religious but grew up in a Christian household. My mother was raised Catholic and, like most of my cousins and women before me, experienced what CPCs would call a "crisis pregnancy" as a teenager.

Each day, my school bus would pass the Pregnancy Center of Sanford, located near Historic Goldsboro which is the second black incorporated city in the U.S. I remember reading the signs and the exterior of the building looking very welcoming and like a place I would go to seek help. However, what I did not know at the time was the mission of this center and how it operated. On January 16, 2021, I saw a Facebook post shared by a conservative elementary school teacher. As someone who aspires to be a doctor, I was shocked to see an ultrasound being shared on social media, "The Pregnancy Centers" tagged in the post who market themselves as a medical clinic, the labels of "baby", the use of emojis and hashtags, and people sounding off in the comments praying for a "mama" who probably does not know and did not give permission for their ultrasound to be shared. Around that same time, a church I regularly pass in downtown Sanford had a display up for "Sanctity of Life" representing the "babies lost to abortion since 1973" when Roe v. Wade was passed (See Figure 1). I am openly pro-choice. I believe that abortion is healthcare, that people have the right to protected health information and to make informed decisions about their bodies and health free of coercion, shame, or deceit. These

messages I saw on social media and my community led me to question exactly what a “crisis” pregnancy center and their role in Central Florida is, specifically.

I was open with my identify and personal beliefs with interviewees. Even though my research questions focused on the rhetorical strategies used by CPCs, the nature of the topic leads into discussions about abortion, life, pregnancy, etc. This made it important to be incredibly mindful of the way I asked questions and led the conversation with interviewees to make sure I was respectful of personal beliefs.

Figure 1 Display at Connect Church in Sanford, FL

At the end of February, I had the opportunity to present my preliminary research at the Florida Undergraduate Research Conference (FURC) at UCF. This conference is for undergraduate students across the state of Florida to present their research in a variety of disciplines. To provide context, the title of my poster was “Crisis Pregnancy Centers, Misinformation, and the Future of Abortion Care.” Participants were required to wear masks inside and there were three poster sessions set up throughout the day to accommodate the students. Because this was an academic conference, I was not expecting to be harassed by other undergraduate students, people to block my poster, violate my personal space, nor ask inappropriate questions. I presented at FURC before I began conducting interviews and this experience helped inform my approach to ethnography and ultimately influence by decision to

decide to not record interviews. Presenting my research and explaining my findings and goals to audiences that have very different opinions on this topic helped me to learn how to better approach participants and members of the community and refine the language I use. I also had the opportunity to present my research at the Anthro+ Conference, a virtual conference in March hosted by the Practicing Anthropologist Student Association (PASA) at the University of Maryland, College Park. A department chair at UMD was listening in with her mother who is a retired OB/GYN that worked at Planned Parenthood for several years and they both were supportive of my research and were surprised to learn about this issue. This experience validated my work as a researcher and provided me the encouragement to keep going. This topic is emotionally taxing, and it was my first-time doing ethnography. I was pushed outside of my comfort zone and think it is important as an anthropologist to reflect on these experiences.

Research Setting

Anti-Abortion Pregnancy Centers in Central Florida

While existing literature has addressed the topic of CPCs and instances of false or misleading information in states such as North Carolina and Georgia, there is limited information on how they operate in Florida (Swartzendruber et al. 2018; Bryant and Levi 2012). The limited and conflicting information online about what CPCs are and the services they provide coupled with legislation that restricts access to reproductive healthcare services is the driving force behind this study. The counties focused on in this study were Seminole, Orange, Volusia, Lake, Osceola, and Brevard. The 2020 Census population data was used to identify the population size of each county (Figure 3). The list of CPCs was generated from a Floridians for Reproductive Freedom report that compiled a list of CPCs in the state of Florida which I cross referenced with

the CPC Map Database, a list of CPCs in the United States created by researchers in Georgia (Figure 2). However, the list is not comprehensive due to limitations in the accuracy of publicly available information about CPCs and their locations. Also, the sources used are not updated continuously which could pose gaps if a CPC closed or opened recently. Therefore, these limitations are considered in analysis.

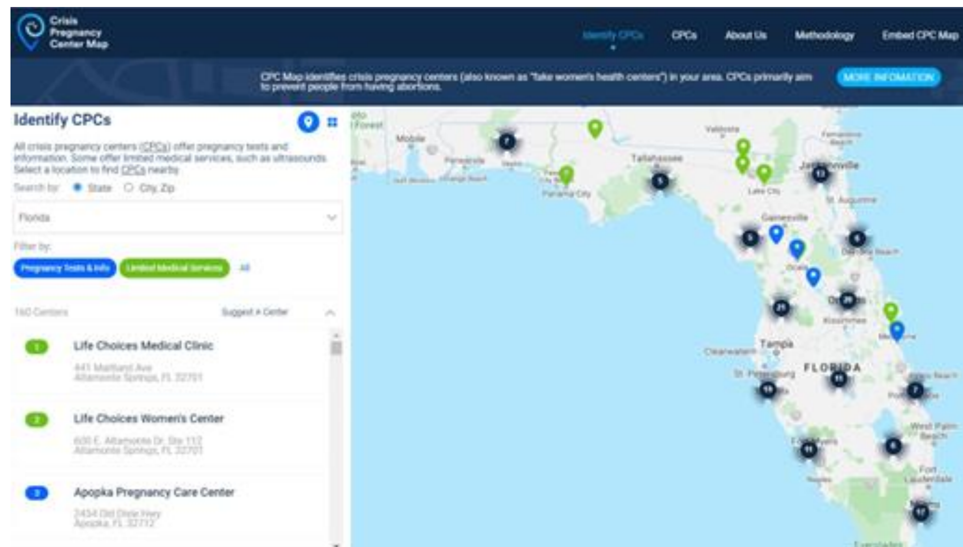
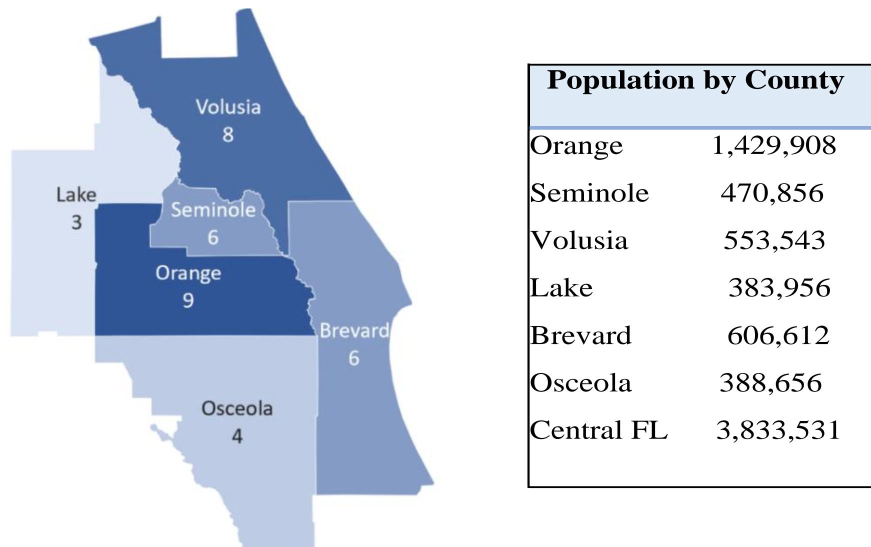


Figure 2 Crisis Pregnancy Center Map for Florida (Swartzendruber and Lambert 2020). Blue represents CPCs that offer pregnancy tests and information. Green represents CPCs that offer limited medical services, such as ultrasounds.



Population by County	
Orange	1,429,908
Seminole	470,856
Volusia	553,543
Lake	383,956
Brevard	606,612
Osceola	388,656
Central FL	3,833,531

Figure 3 Number of CPCs per county in Central Florida (Floridians for Reproductive Freedom 2021; Swartzendruber and Lambert 2020). Population by county in Central Florida (Census 2021).

In 2017, 89% of U.S. counties had no clinics providing abortions and 73% of Florida counties had no clinics that provided abortions, and 24% of Florida women lived in those counties (Jones et al. 2021). In 2017, there were 65 abortion providers in Florida. This number has steadily declined in the past decade with the introduction of abortion restrictions (Jones et al. 2021). In FL, CPCs outnumber abortion clinics and providers by a factor of 2.7 (Swartzendruber and Lambert 2020). Also, a greater number of CPCs in a state predicts the introduction of state legislation restricting abortion (Swartzendruber and Lambert 2020). The number of people of reproductive age seeking services at CPCs could be higher in Southern states where they have not expanded Medicaid and have the greatest number of CPCs.

Florida is one of the top 5 states with the most CPCs (Swartzendruber and Lambert 2020). There are roughly 151 CPCs in Florida which has state programs that directly fund and raise revenue for CPCs such as “Alternatives to Abortion” and “Choose Life” license plates

(Wormer 2021). There are about 36 CPCs in Central Florida which has a total population of 3,833,531 (Figure 3).

Florida Pregnancy Care Network

The Florida Pregnancy Care Network (FPCN), a 501(c)(3) organization, was established in Florida in 2005 and their mission “is to enhance the efforts of Florida pregnancy resource organizations that deliver wellness services to qualifying women, and that provide emotional and material support to pregnant women in need, enabling them to carry their pregnancies to term and choose parenting or adoption.” The Florida Department of Health contracts with FPCN for funding distribution to anti-abortion pregnancy centers. From 2017 to 2018, the FPCN reported distributing funds to 56 organizations, almost all of which were religiously affiliated or anti-abortion pregnancy centers. The issue with contracts between DOH and FPCN is there is a lack of public data on the number of people their subcontractors, such as anti-abortion pregnancy centers, serve, and a total lack of wellness services which is antithetical to the goals of these funds.

Furthermore, FPCN and its subcontractors experience limited oversight by the Florida Department of Health without clear evaluation standards or reviews (Floridians for Reproductive Freedom 2021). In contrast, there are strict oversight and regulatory requirements for legitimate medical clinics and abortion providers that provide abortion information and referrals (Wormer 2021). Additionally, the Board of Directors for FPCN have no expertise in reproductive or public health. Since 2009, Florida has granted FPCN over $30 million in tax dollars for distribution to subcontractors. However, despite state funding to subcontractors, the majority of which are faith-based or religiously affiliated, there is little oversight or monitoring of performance to measure impact.

The contracts require subcontractors in the program to provide accurate medical information and resources to clients. Also, any references to medical or health statements they make must be accurate. FPCN's website provides information for "Emergency Pregnancy Services" that links to the website abortionpillreversal.com which promotes "abortion reversal" which is not effective and has been rejected by the medical community. Abortion reversal rhetoric will be discussed more later. The FPCN's contract with the DOH also prohibits religious coercion the ensure all services provided do not include religious content. Despite this, many CPCs use religious values to underpin the counseling they provide and share resources from faith-based organizations. For example, the "Earn While You Learn" program is a religious curriculum that CPCs use to provide classes and materials to women. Overall, the FPCN demonstrates several issues with funding and lack of oversight of CPCs in Florida. While not all CPCs receive funding through FPCN, it is important to recognize that the lack of regulation of CPCs and their presentation as clinics and credible sources for health information is problematic if they are not offering medical services or accurate health information to clients.

CHAPTER 3: Findings

Based on the thematic analysis of 15 client-facing CPC websites in Central Florida and 5 semi-structured interviews with people that work or volunteer at CPCs in Central Florida and reproductive justice advocates in Florida, three strategies have been identified for CPCs which include strategies of (1) promotion, (2) space, and (3) language use.

Strategies of Promotion

Promotional strategies represent techniques to market a business or service to a target audience. CPCs promote their services through several channels of communication such as client-facing and donor-facing websites, billboards predominately funded by national pro-life organizations, and social media, such as Facebook. This section will describe the main channels of communication employed by CPCs and the strategy of search engine optimization to ensure engagement with their client-facing websites.

Channels of Communication

The main channels of communication for CPCs are billboards/advertisements, social media (primarily Facebook), and websites. The role of social media and websites will be discussed more in-depth in the Digital Space section. Billboards and advertisements are included online and in-print. Billboards are strategically placed on highways in communities to reach target audiences. The billboards included are pictures I took while driving in North Central Florida and depict how national pro-life organizations that support CPCs use emotional appeals to target specific populations through billboards. The three billboards are by ProLife Across America. The first was in a community with a large immigrant population. It depicts a woman that looks Hispanic with a baby and includes an emotional appeal message that there is a

"heartbeat 18 days from conception" (Figure 4). The second depicts a Black, pregnant woman and the uterus is in the shape of a heart (Figure 5). It is another example of an emotional appeal stating "Two Hearts. Two Souls. Two Lives!" and represents religious idioms such as "soul." The last billboard shows a white baby and states "One Life Can Change The World!" (Figure 6). Each billboard contains a phone number that directs you to a pro-life hotline. The diversity in the billboards also represent the importance of targeting specific populations with images.

Figure 4 FL Billboard by ProLife Across America "Cherish Life…Heartbeat 18 days from conception 800-366-7773". Image of a woman and baby.

Figure 5 FL Billboard by ProLife Across America "Two Hearts. Two Souls. Two Lives! Pregnant? 800-848-LOVE". Image of a black woman and fetus in her womb shown.

Figure 6 FL Billboard by ProLife Across America "One Life Can Change the World! Pregnant? Call 800-848-LOVE". Image of smiling white baby.

Search Engine Optimization

"Abortion is a pricey word"

Search engine optimization (SEO) is the practice of increasing online visibility for search engine results. National pro-life organizations, such as Care Net, offer support and guidelines for CPCs in the U.S. This includes information and resources to set up websites and SEO strategies. The Floridians for Reproductive Freedom have studied the SEO strategies used by anti-abortion pregnancy centers in Florida and have identified the use of geo targeting technology where centers are able to target independent abortion providers with anti-abortion ads.

When asking Shelly Aaron, staff at a CPC, about who manages their client-facing websites and increase engagement, she said "abortion is a pricey word." CPCs are aware of the SEO strategies needed to ensure their websites and services are seen by target audiences, such as low-income BIPOC women. Shelly framed the use of SEO strategies as a valuable tool to "compete" with abortion clinics. SEO strategies lead to inconsistencies in the web indexing of CPCs. For example, CPCs will appear in a search before abortion clinics, such as Planned Parenthood, if you search "abortion near me" or some variation of abortion services (See Figure 7). Since CPCs are paying to stay higher in the search results and appear before abortion providers and reproductive healthcare clinics, this means people seeking abortion services or

information or more likely to end up on a CPC website which do not refer for or provide abortion services and present health misinformation.

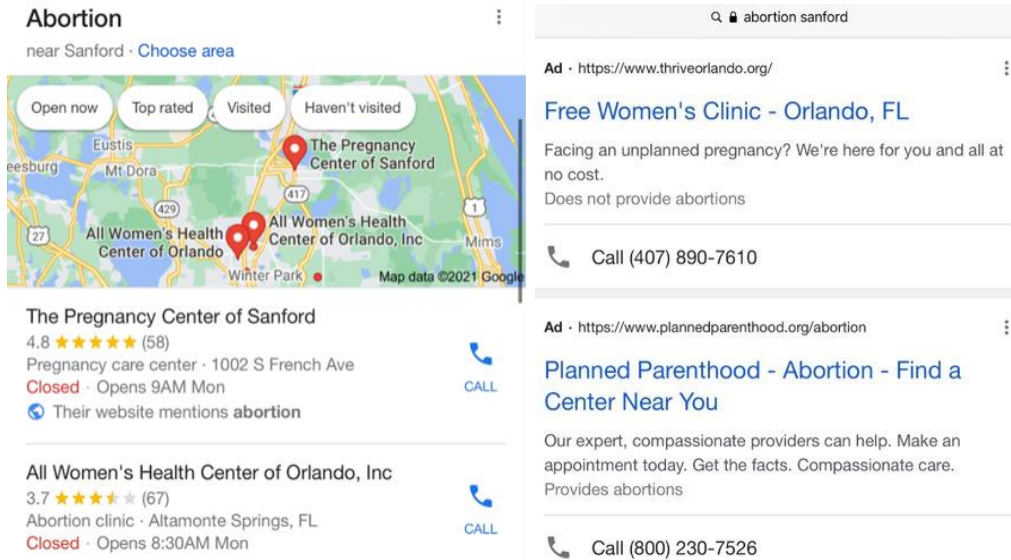


Figure 7 Search of "abortion near me" and "abortion Sanford." The Pregnancy Center of Sanford and Thrive Orlando are CPCs in Central Florida. All Women's Health Center of Orlando, Inc and Planned Parenthood are abortion clinics in Central Florida.

Strategies of Space

Analysis of CPC websites in Central Florida were supplemented by ethnographic data obtained from staff and volunteer interviews at two CPCs in Central Florida. In this section, I will describe the design of the digital space (websites) and physical space (CPC facilities), based on analysis of CPCs in Central Florida. It is important to recognize that not all CPCs are at the same level in terms of resources, funding, and set up so these findings cannot be generalizable to all CPCs.

Design of the Digital Space

There is wide variation to the organization of CPCs in Central Florida. While most are affiliated with national pro-life organizations, some are directly and openly affiliated with faith-

based organizations or churches whereas others are discreetly faith-based. CPCs that identify as "medical clinics" typically offer limited ultrasounds and pregnancy tests, with very few offering STI testing.

Based on the thematic analysis, the most common search tabs on CPCs client-facing websites in Central Florida were: "(Informed) Choices," "(Free) Services," "(Support) For Men," "Contact Us, and "Information and Resources." These were often separated into more specific tabs that included "Pregnancy," "What to Expect," "Adoption," "Parenting," and "Abortion." The images on the client-facing sites typically were of young women of color and babies. Women were shown in distress/worried or happy. The tabs that targeted "Support for Men" or "Guys" demonstrated the heteronormative ideals of CPCs. Figure 9 represents an example from a CPC in Central Florida. Other examples from the thematic analysis included, "It's hard to realize that women can choose abortion without the permission of the baby's father."; "Don't run from your responsibilities"; and, "The world says that abortion is "a woman's choice" but the woman in a crisis pregnancy rarely wants to make that choice alone. She is looking to you for support because she can't confide in many people about this crisis situation." This language demonstrates ways that CPCs appeal to men and giving them agency in this situation.

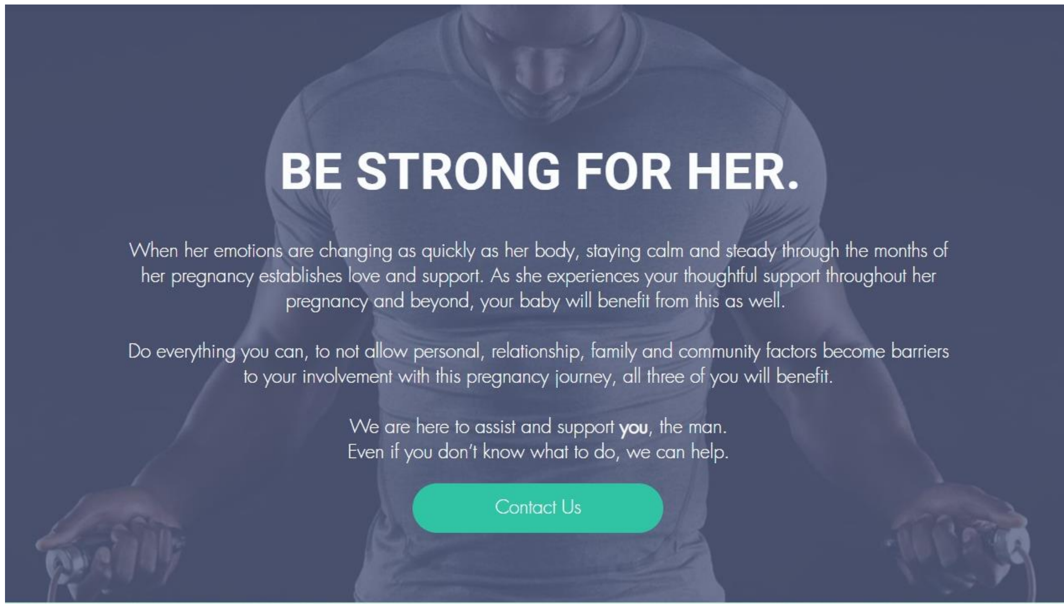


Figure 8 Image from Central Florida CPC "Support for Men" tab. Features a muscular black man with a jump rope with the title "Be Strong For Her."

Another important aspect of the websites I noticed was the presence of a "Support Agent" where you could directly engage with someone to discuss your situation or schedule an appointment. As mentioned earlier, CPCs are increasingly becoming medicalized and use SEO strategies to appear in search engines ahead of abortion clinics/providers. On the CPC websites analyzed, several included disclaimers that they did not refer for or provide abortions, but these disclaimers were often very small and discretely positioned on the website.

Donor vs Client-Facing Sites

The thematic analysis focused on client-facing CPC websites in Central Florida. While gathering background information and preliminary data on the websites in Central Florida before I began standardized data collection with the survey, it was difficult to find and recognize CPC websites despite knowing the key features of these sites. I identified donor-facing and client-facing sites for CPCs in Central Florida. Several CPCs had multiple client-facing sites with slightly different layout of the website and different URLs. This means when you search terms

such as “pregnancy” or “abortion” you are more likely to end up seeing a CPC. Additionally, while searching for CPCs in Central Florida, when I searched phrases such as “abortion near me” a range of one to three CPCs would populate before an actual abortion provider/clinic.

The inconsistencies between the donor and client-facing sites demonstrate how there are two target audiences: the clients they serve and donors and supporters of the centers. They strategically curate their images, information, and website layout to market towards each audience, clients, or donors. Donor-facing sites are openly faith based with religious language, provide resources for how to donate and get involved, and provide information on the impact of the CPC in the community. The images included on donor-facing sites are vastly different from client-facing sites. Client-facing sites include images of young, BIPOC women to appeal to their target audiences. Client-facing sites sometimes have directions to the CPC populated in the browser to direct you from local K-12 schools and colleges.

Design of the Physical Space

I was nervous to enter the CPC for my interview with Shelly, staff at a local CPC. When I walked in, I was greeted by a friendly, white, middle-aged woman in the waiting area. I asked for Shelly who came out from her office. She offered to give me a tour of the facility. It was relatively small, and they were preparing to expand their facility. Shelly showed me the counseling rooms, the ultrasound room which was spacious and had a flatscreen TV next to the bed, a private bathroom for clients, an area for staff and volunteers, and the offices of several staff including the social worker which had a wall full of pamphlets and fetal development models. I was unable to take pictures, but the models resembled ones I have seen sold by pro-life organizations which do not accurately present fetal development (Heritage House 2022). While

researching these models, I saw comments such as “We have a set in each one of our counseling rooms in our pregnancy center and they are very powerful in changing people’s mind about abortion.” demonstrating how these models are strategically used in counseling at CPCs (Heritage House 2022).

The physical space is designed to be persuasive and establish credibility. Based on analysis of websites and interviews, CPCs have a similar structure. This includes a waiting area, counseling rooms, a private bathroom for pregnancy tests, if they offer limited ultrasounds there is a sonographer room with a TV screen, an area for baby and maternity items or other resources, and a space for the staff and volunteers. Some CPCs are openly faith-based, such as the ones directly connected to or affiliated with a church. However, there are CPCs that have transitioned to a more objective presentation, as described earlier, but based on interviews they are still faith-based, it is just more discrete. This is to position themselves in a way that is more inviting and inclusive for people seeking services. The CPCs that are openly faith-based will sometimes have religious artifacts in the space and Biblical quotes on the walls. The CPCs that are not openly faith-based present the physical space in a more clinical way. Staff or volunteers may wear scrubs or white coats to frame the CPC as a medical space and focus on the use of scientific and medical-based language when counseling rather than faith-based language.

When you enter a CPC, they often have intake forms where they collect basic demographic information about individuals. While some CPCs state they abide by HIPAA and offer “confidential” services, because they are not licensed medical clinics and unregulated, they are not beholden to HIPAA nor confidentiality. It is also common for CPCs to require you to share information online or over the phone to make an appointment. CPCs refer to individuals seeking services at their facilities as clients, not patients. Additionally, CPCs are strategically

located near abortion clinics/providers. They are also often located in low-income, BIPOC communities, and near schools

Common Services Offered by CPCs in Central Florida

This section will describe the common services offered at CPCs in Central Florida (Table 1). Compared to the common services offered by CPCs in the literature review, the services discovered for Central Florida are very similar such as pregnancy tests and non-diagnostic, limited ultrasounds.

Table 1 Common Services Offered by CPCs in Central Florida

Services
o Free “Limited” Ultrasounds
o Free Pregnancy Tests
o Pregnancy Confirmation Letters
o Options (Lay) Counseling
o Pregnancy Education
o Parenting Education
o Post-Abortion Counseling
o Abortion Information
o Abortion Pill Reversal
o Adoption Counseling
o Community Referrals
o Baby Clothing/Items
o “Earn While You Learn” Programs
o Support for Men
o Limited STI Testing/Information

Pregnancy Tests

CPCs advertise “medical grade” or “lab quality” pregnancy tests; however, they are no different than the home pregnancy tests that rely on a urine sample. A positive pregnancy test at the CPC allows them to provide a confirmation letter of pregnancy for clients to file for Medicaid if they qualify. CPCs are often not staffed with medical professionals. When there is a medical professional, such as a sonographer/ultrasound technician, those individuals are not qualified to diagnose or provide medical advice.

Limited Ultrasounds

"We show her the truth – I don't make this up"

The "limited" ultrasounds offered by CPCs are not diagnostic, medically unnecessary, and not a substitute for prenatal or abortion services. To classify as a "medical clinic" the centers will have a licensed ultrasound technician/sonographer that performs non-diagnostic ultrasounds. Very few have connections to providers, such as in the form of a medical director, that will view these ultrasounds to provide feedback on a pro-bono basis. A 2018 study found that an increasing number of CPCs have obtained licenses to conduct non diagnostic ultrasounds (Bryant 2018; Wormer 2021). One center that I interviewed had a clinic manager that oversees compliance, HIPAA, and OSHA guidelines for the facility. When a client has a positive pregnancy test in the facility, the centers that offer ultrasounds will provide the client one.

Limited ultrasounds are designed to determine: (1) viability, (2) presence of a heartbeat, and (3) gestational age. If a pregnancy is not viable, for instance if the fetus is in the fallopian tube, CPCs will refer the client to the ER. For CPCs, because the ultrasound is non-diagnostic it is serving as a social and political tool to influence people's decision to keep a pregnancy or not. Ethnographic data demonstrated that the ultrasound holds significant weight in the counseling process for clients that are labeled as abortion-vulnerable or abortion-minded. The label of abortion-vulnerable or abortion-minded is determined by the lay counselors. An ultrasound typically has the monitor for the technician to view, but at CPCs that offer ultrasounds, there is usually a flatscreen TV. Clients are encouraged to look at the image, but often do not have a choice when the TV is right there. Shelly Aaron, staff at a CPC in Central Florida, described that when clients see the images they are in "disbelief of the lies they have heard," "they thought it was just a blob of tissue," or they realize what they thought was "9 weeks was actually a

developed baby." Shelly also described how ultrasounds are "showing her [the client] the truth – I don't make this up" and that "it [the ultrasound] will change her mind." This demonstrates the strategic use of ultrasounds in CPCs.

In contrast to abortion clinics and providers, while an ultrasound is also used to determine viability and location of the fetus in the uterus, the setup of the room is not the same as CPCs, providing patients more control over choosing to see the image or not. From analysis of websites, some CPCs market false information about ultrasounds stating that an ultrasound can check if you will miscarry; however, ultrasounds cannot predict miscarriages.

Community Referrals and Resources

CPCs provide community referrals for services such as adoption, housing, and to the Florida Department of Health. The quality and/or accuracy of the referrals were not evaluated. CPCs also have some version of a "Baby Boutique" or "Wee Boutique" where they provide baby and maternity items. Clients can earn "boutique bucks" to purchase gently used and/or new items that or donated to the center. They earn these by participating in parenting and education classes that the CPC provides.

Options Counseling

"He doesn't call the qualified, He qualifies the called"

CPCs present three options: (1) Parenting, (2) Adoption, or (3) Abortion. Most have a discrete disclaimer somewhere on the website stating: "We do not offer, recommend or refer for abortions or abortifacients, but are committed to offering accurate information about abortion procedures and risks."

Lay counseling, as described earlier, involves training lay people to provide counseling. CPCs provide counseling primarily by volunteers trained based on various curriculums created

by national pro-life organizations. After analyzing websites for volunteer requirements and discussing with volunteer and staff at CPCs, it is often required that volunteers attend church regularly. On a Central Florida CPC website, their staff and volunteer tab include the quote *"He doesn't call the qualified, He qualifies the called."* This demonstrates the role of faith in shaping the work of staff and volunteers at CPCs.

Shelly Aaron described the training process for volunteers with the curriculum they have used for over the past decade called "Equipped to Serve." This is an 18-hour training for volunteers that take a "lay person to a lay counselor." I did not see the videos or materials that are provided to clients, but I did get to see a model and these resources are purchased from pro-life organizations. "Equipped to Serve" first provides individuals a worldview about the issue of abortion and legislation, then it discussed "God's position" on the issue, next the role of Christian volunteers, and finally "Who is she [the client]." This involves learning about how the psychological profile of someone experiencing what they call a "crisis" pregnancy, stressors, internal and external struggles, and the phases of a crisis. They also learn how to be a neutral advocate as well as communication, listening, and confrontation skills. Allison Smalls, lay counselor volunteer at a local CPC, describe the training to be like what was described above. In the counseling process, she speaks with the client in a private room about her situation and presents her with information and support. It was clear from her interview in explaining how she counsels clients that her faith and personal experiences shape the way in which she presents information to clients.

Volunteer lay counselors are also taught how to explain abortion procedures and have models of the development of fetus, types of abortions and the risks and complications associated with each. Shelly stated that they do not talk about abortion in a graphic way, nor do

they over sensationalize it. If someone is considering abortion, they are charted in their file as "abortion minded." Shelly described the three major complications associated with abortion as: (1) physical or medical, (2) psychological, and (3) spiritual. In the interview, she focused on the psychological and spiritual aspect of abortion stating "1 out of 4 abortions are women of faith…Christian girls have the most to lose. They experience shame from the church, stigma…" She also discussed the spiritual consequences and how girls and young women "wrestle with God" and become "distant from God." An important aspect of their work at CPCs is providing support and counsel to these clients.

Lay counseling also involves the strategic use of language when providing information to clients. Shelly stated that counselors will use more medical or scientific language with clients that are not faith based. Also, if a client comes in abortion-minded, all the volunteers will be told and they "will take time to pray she [the client] makes the right decision." This shows the role of faith in the work they do and services they provide.

An important part of the lay counseling training is learning to profile a client. It is important to note that because CPCs are not licensed clinics, they cannot be legally held to the provisions of HIPAA. Analysis of websites demonstrated that they contain privacy policies and market their services as "confidential." Shelly stated that their CPC has clients that come in with records of prostitution, drug use, and mental health issues. She stated in the volunteer and staff common area there is a sign with pictures of about 20 women in the community that are known prostitutes and/or drug users to "look out for." In addition to that, their public Facebook page for the center often shares ultrasounds and stories of clients, with no mention of consent being obtained. The primary goal of the Facebook accounts for CPCs is to market to their donors and supporters by sharing stories. Stories and testimonials are strategically shared on both social

media and their websites. Related to the profiling and criminalization of clients was a post by Shelly's CPC where they admitted to calling the police on a client:

> UPDATE: "Little One" is now 23 weeks old and still holding on in the womb of her heroine addicted mother. Her situation hasn't improved much other than her mom doesn't have $2,700 to abort her at an Orlando abortion clinic. Sadly Little One's mom has been offered our help and refuses. Her addiction is so strong and all she wants is drugs. It is difficult to watch, as we feel so helpless. We've called authorized [authorities] and there's nothing that can be done unless she's caught in the act. And there's protection for Little One because legally (thanks to Roe v. Wade) she is not warranted protection until after she's born. Our sincere prayer is that Little One's mother is picked up for prostitution and/or drug possession and put in jail for the duration of her pregnancy. This way, Little One is protected from the drugs, streets and is given some pre natal care. This is Little One's only hope. Join us in prayer. We will keep you posted of her progress. [Heart emoji] #ministryismessy

This Facebook post demonstrates several contradictions and critical markers of how CPCs operate which were discussed previously or will be discussed later. To highlight a few, there is humanization of the fetus with naming it "Little One" and gendering it as "her." They profile and speak ill of the mother and label themselves (staff and volunteer at the CPC) as "helpless." They state that the only way this mother would be able to receive prenatal care, is if she were incarcerated. This speaks to the state of healthcare in the U.S. and the limitations of CPCs which do not provide comprehensive healthcare services nor adequate support to their clients. It also demonstrates a potential violation of HIPAA, sharing personal health information online without recognizing that they obtained consent from the client. At the end of the post, there is also the hashtag "#ministryismessy" representing that the role of faith in the work of CPCs, which has been referred to on websites and in interviews as "pro-life ministry" or "life-affirming ministry" work. This post summarizes several of the key issues with the ways in which CPCs in Central Florida share information.

Measuring Impact

Based on my research, it is unclear if or how CPCs collect data to measure their impact on communities and effectiveness of their services and resources. Success is defined as someone choosing to continue their pregnancy. However, there is no standard data collection for CPCs to measure impact. CPCs primarily rely on anecdotal stories of success. During my interview with Shelly, she shared a few client stories who represented a success where they decided to keep their pregnancy. Based on ethnographic data, I was told various numbers regarding how they measure success such as "92% choose life" after visiting our center but could not get an answer as to how those numbers were determined. It was difficult to find any data or information about their impact and it is unclear if they did not have numbers because they do not collect them, client outcomes are difficult to obtain, or if they were not deemed important to measure their impact. A CPC in Central Florida, Choices Women's Clinic posted data quantifying their impact for 2020 in the form of a pie chart (Figure 9). They refer to abortion minded individuals as client that are "determined to abort" and abortion vulnerable individuals as "factors in her life are influencing her to abort." This CPC's data is separated by initial intentions (before counseling) and final intentions (after counseling and seeking services). Individuals are separated into three categories for initial intentions (Figure 9): (1) likely to carry, (2) abortion minded, or (3) abortion vulnerable; and three categories for final intentions: (1) Choose Life, (2) undecided, (3) abortion. Based on their data, 77% of clients choose life after seeking services, meaning they successfully convince abortion minded and abortion vulnerable clients to continue with their pregnancy. The lack of standard data collection and limitations in the way they are presented demonstrates how it is unclear exactly how CPCs are helping the communities they serve.

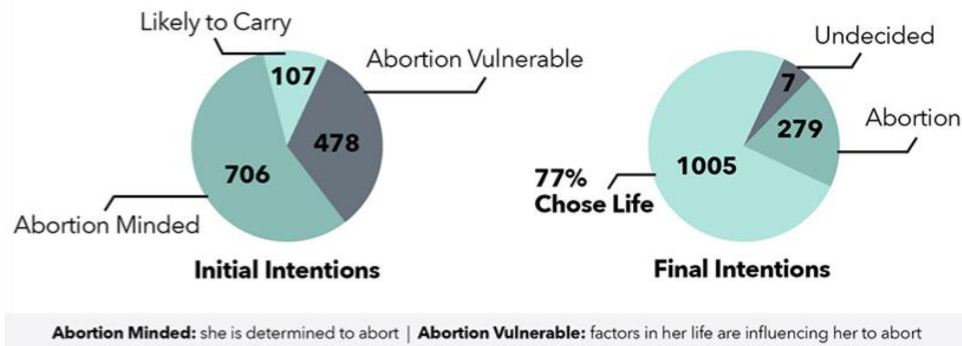


Figure 9 Choices Women's Clinic 2020 Life Impact data

Strategies of Language Use

The following strategies for language use have been identified for CPCs in the thematic analysis and semi-structured interviews: (1) choosing a name, (2) reframing empowerment, (3) misuse of scientific and medical language, (4) reducing credibility (e.g. reducing credibility of abortion clinics/providers), and (5) faith based language.

Strategy 1: Choosing a Name

"We are the ER of the crisis"

CPCs emulate the design and feel of abortion clinics through their centers' names, logos, websites, and services offered. CPCs do not provide abortion or refer people seeking abortion. In the past decade, most CPCs have transitioned to more objective names that are not faith-based and do not include the word "crisis" because of the negative connotations surrounding the term. Shelly Aaron described the term "crisis" as old school in nature and that there is potential stigma attached with the term and negative stereotypes associated with religion. Shelly stated framing it as a "crisis" made "her [the client] feel weak, helpless…the term crisis demeans her. We want to empower her." This has led CPCs to distance themselves from the term. Despite moving away from the term "crisis" to be more welcoming and inclusive to people seeking services, CPCs still

very much align with the idea that they are addressing crises in the community. Shelly referred to the center she works at as the “ER of the crisis.”

In addition to more objective naming that also works to separate CPCs from an openly faith-based position, there has also been a transition to changing the design of the centers to resemble clinical or medical spaces. A frequency table was used to create a word cloud representing the most common words in CPC names in the state of Florida (Figure 10). Some of the terms that were most common include: “care”, “life”, “clinic”, “choices”, “medical”, and “services” (Figure 10).

With the transition to names that are more removed from faith-based language and “crisis”, there is also the use of words and design of logos that are similar to comprehensive reproductive healthcare clinics and abortion clinics/providers. Figure 11 shows a comparison of facility logos for CPCs and abortion clinics/providers in the state of Florida. Of the eight CPCs in the graphic, five include the word clinic whereas none of the abortion clinics/providers include the word clinic. There are also similarities in the color palettes and design of logos. As you can see these logos side by side, it can be difficult to discern the services that would be offered at each based on the name of the facility alone. By adopting names that mimic actual reproductive health centers this leads to the confusion surrounding CPCs and plays into a key rhetorical strategy used to position their services as credible and legitimate.

Figure 10 Word Cloud based on frequency of terms in Florida CPC names

Figure 11 Facility Names/Logos for Anti-Abortion Pregnancy Centers versus Abortion Clinics/Providers in the state of Florida.

Strategy 2: Reframing Empowerment

From the thematic analysis, I identified 3 words/phrases that are commonly used across client-facing CPC websites and in discourse for lay counseling: (1) "empower women," (2) "all options," and (3) "confidential." Additionally, there is the use of religious ideologies and scripts to inform the work of CPCs and the services they provide which will be explained in this section.

Rhetoric of Empowerment and Choice

CPCs state they seek to "empower women," but there are inconsistencies in this statement. They tell women and clients they are here to "empower" while also profiling and labeling. CPCs sell a sense of empowerment and choice to individuals who do not have many choices in their situation. There is also inconsistency in their statement that they offer "all options" when they do not refer or provide abortion services, nor do they provide healthcare services beyond a pregnancy test or ultrasound. CPCs advertise "unbiased information about all pregnancy options," but promote childbirth only. CPCs are pronatalist and when a client is pregnant, they frame that individual's lack of choice as an opportunity they can turn to their benefit stating there is "blessing in the challenge [of pregnancy and parenting]" and that you will "come out a better person" if you choose to keep your pregnancy. Because their goal is to ensure people continue with their pregnancy and operate from a pronatalist, pro-life perspective it is misleading to state they offer "all options."

Rhetoric of Control

For CPCs, the major assumptions when it comes to control are: (1) that controlling your body is deal, (2) control means abstinence, and (3) that you can control your body. Regarding sex and sexuality, CPCs push the narrative of "self-control over birth control" and abstinence.

National pro-life organizations', which provide guidelines and resources to CPCs, position on contraception do not adhere to medical standards. Care Net's position on contraception:

> The pregnancy center does not recommend, provide, or refer single women for contraceptives. (Married women and men seeking information should be urged to seek counsel, along with their husbands, from their pastor and/or physician.) (Care Net 2022)

Another national pro-life organization, Heartbeat International's position on contraceptives states:

> Heartbeat International does not promote birth control (devices or medications) for family planning, population control, or health issues, including disease prevention. All Heartbeat International policies and materials are consistent with Biblical principles and with orthodox Christian (Catholic, Protestant, and Orthodox) ethical principles and teaching on the dignity of the human person and sanctity of human life (Heartbeat International 2022).

These pro-life organizations provide standard guidelines, resources such as curriculum to train lay counselors, and support to CPCs in the U.S. Their positions against contraceptives are rooted in religious ideology representing the role of faith in the services CPCs provide.

Strategy 3: Misuse of Scientific and Medical Language

"If you have sex with 16 people, you have had sex with 65,000 people"

This section will describe examples of the misuse of scientific and medical language as well as health misinformation based on ethnographic data and analysis of CPC websites. CPCs sate they present information in an unbiased way but actively promote the idea that life begins at conception which is rooted in religious beliefs. Health misinformation serves to delay people seeking services elsewhere or an abortion and question their decision. Medical and scientific language is used to frame the information and services CPCs provide as legitimate and credible.

Examples of misuse of health information include fearmongering that abortion is related to an increased risk of breast cancer and mental health conditions. CPCs additionally share

narratives that choosing to have an abortion will destroy relationships and will often include "testimonials" or short stories on these sections of their websites to further scare people. By providing inaccurate information to dissuade people from considering or seeking abortion, this further places limitations on the "medical services" CPCs claim to provide.

CPCs advertise sexual and reproductive health education services but frequently provide inaccurate and misleading information, they hide or attempt to make as discrete as possible their anti-abortion, anti-contraception, and abstinence-only-before-marriage perspectives. While interviewing Shelly, I asked if the CPC ever provides information to clients about contraceptives or STIs. She stated it goes "against Biblical teachings…and we do not want to promote sex outside of marriage…most of our clients are single women." Shelly began to elaborate on how she teaches abstinence only sex-education in private schools. She highlighted the power of fear in discouraging young people from having sex. She explained the use of the "Sexual Exposure Chart" which calculates the number of people you have been exposed to based on the number of sexual encounters you had, for example "If you have sex with 16 people, you have had sex with 65,000 people."

CPCs oppose and often discourage condom use and market false information about contraception stating the emergency contraception is an abortifacient and that methods of contraception such as condoms are not that effective. Emergency contraception prevents pregnancy and has no effect on an existing pregnancy; therefore, it does not cause abortion. While some CPCs offer STI testing if someone also has a positive pregnancy test in their facility, they often do not also test for HIV nor provide STI treatment.

Additional examples of medical language to frame their services as credible and necessary include: "We offer lab grade pregnancy tests" and "[We can] Medically confirm your

pregnancy." There is also inconsistency in language used. For example, they will say "fetus" or "baby" interchangeably depending on the context.

Spreading Misinformation and Overstating Risks

Analysis of CPCs websites and ethnographic data demonstrated several instances of false or misleading health information, some listed in Table 2. This information poses potential to be harmful to clients or people searching for information about sexual and reproductive health if they have an inaccurate perception of what sex is or believe that condoms are not effective in protecting against STIs. As stated earlier, this language is consistent with the national pro-life organizations' position on contraception and promotion of abstinence which aligns with the views of CPCs.

Table 2 Examples of False or Misleading Health Information

"Condoms are not as effective as you may think in protecting against sexually transmitted diseases."
"First, let's define sex. Sex is when any part of you touches the sexual part (genital) of someone else."
"Both medications [Plan B/Ella] may also prevent a newly formed life from implanting in the uterus and continuing to develop, thus ending the life via an abortive effect."
"We can teach you a way you can be 100% sure that you will not get pregnant or get an STI. AND…this method works 100% of the time"
"Abortion leads to infanticide, suicide & euthanasia"

Persuading People to Delay Decision Making

"Approximately 1 out of 4 pregnancies miscarry on their own.

Your pregnancy could be one of these."

False or misleading health information also leads to delayed decision making. Using information that is aligned with religious beliefs and against standard medical guidelines is inconsistent with the goals of CPCs. Several CPC websites in Central Florida under their pregnancy information tab state "Approximately 1 out of 4 pregnancies miscarry on their own. Your pregnancy could be one of these." This statement was often accompanied by information urging clients to visit the CPC to have an ultrasound to confirm their pregnancy, even though their ultrasounds are non-diagnostic and cannot predict miscarriages. This is a strategy to create a sense of urgency and credibility regarding seeking services at a CPC, and delay decision making regarding pregnancy.

Abortifacient and Abortion Pill Reversal Rhetoric

CPCs also refer to emergency contraceptives as abortifacient, even though they are not as mentioned earlier (Table 2). Most of the CPC client-facing websites analyzed included resources to access abortionpillreversal.com to reverse the effects of abortion pills which has not been medically proven or shown to be safe. Websites state, "there is an effective process called Abortion Pill Reversal* that gives your unborn child a second chance at life" and provide the link to the website. This quote also demonstrates humanization of the fetus as an "unborn child" and supports the primary goal of CPCs to dissuade people from seeking an abortion.

Ascribing Personhood: Humanizing the Fetus

Throughout the interviews and analysis of websites, there have been terms that have gendered the fetus and made claims on behalf of the fetus. This is a process of humanizing the fetus that is strategically used to shape the perception of the issue. During an interview with Shelly, she shared the "bread" analogy with me:

> Shelly: "[Holding up yellow sticky note] Let's say this sticky note is a piece of bread and I were to ask you what ingredients are in this piece of bread…you would tell me?"

Interviewer: “I would say yeast, water, salt, flour…”
Shelly: “…and if I tear off a piece [rips corner off] what ingredients would you tell me are in this piece [the ripped off corner]?”
Interviewer: “The same ingredients.”
Shelly: “Exactly!

This example shows how the concept of life is shaped and framed by religious beliefs that “life begins at conception.” CPCs also use ultrasound images and refer to the fetus as a “baby,” name the fetus, and describe what it is doing and how it would feel/is feeling. A CPC website in Central Florida stated, “It [abortifacient] destroys the connection of the embryo with the uterus, causing his or her death” which represents humanization of the embryo by stating referring to it at “his or her” and ascribing it life. Humanization of the fetus is an example of an emotional appeal CPCs use which is rooted in religious ideologies that dictate beliefs regarding when life begins.

Strategy 4: Reducing Credibility

The final strategy identified was ways that CPCs establish their credibility and reduce the credibility of others. CPCs place advertisements under internet searchers for “abortion.” Staff or volunteers may pose as medical professionals and wear scrubs or white coats and frame their centers as clinical spaces and often try to not be openly faith based to come off as more objective.

Reducing Credibility of Abortion Clinics/Providers

“Abortion clinics are selling abortions”

A common theme in my interviews was how staff and volunteers at CPCs attack the credibility of abortion clinics and providers. Shelly, staff at a CPC, stated that abortion clinics are

“not objective,” are “selling abortions,” and “do not present all options.” Kelly Forester holds an executive management position at an abortion clinic in Florida. A few years ago, an anti-abortion pregnancy center opened a few spaces down from the abortion clinic that has a name similar to their abortion clinic and uses the same two colors for their logo. This is confusing for patients, and it is common for the abortion clinic to have patients go to the anti-abortion pregnancy center and not realize they are in the wrong place. Kelly shared a story with me to demonstrate the confusion that occurs:

> Last week two patients went to the fake clinic. They were locked away with a lay counselor for 30 minutes. When they were able to leave, they were greeted by clinic escorts who stated she [the patient] was young and visibly shaken, concerned she was late for her appointment. That’s not healthcare...deceiving people into what you think is best.

This experience is common among patients of this abortion clinic based on the misleading presentation and location of the CPC. It is difficult for abortion clinics to combat the misinformation and deception of CPCs. I also asked Kelly if seeing an ultrasound influence someone’s decision to not have an abortion. CPCs use ultrasounds has a tool to influence the way people perceive their pregnancy, as discussed earlier. Kelly stated:

> It changes things for few people if anything it becomes a little more real. People change their mind especially if they’re significantly further than they thought they were or if there are multiples [twins]… The patient knows what’s best for them and they should have the ability to make that choice.

Kelly described how abortion clinics are regulated by the state whereas CPCs are not since they are not medical clinics. We also discussed the options that abortion clinics provide patients which are adoption, parenting, or abortion. Most adoption agencies are connected to faith-based institutions such as churches. There are five pro-choice adoption agencies in the U.S., one being Choice Network which Kelly’s clinic works closely with for their patients choosing that option.

Overall, this demonstrates how CPCs are designed to cause confusion for patients and perpetuate fear and stigma related to abortion.

Reducing Credibility of Ways to Control Reproductive Health

"You can survive pregnancy, but you may not survive an STI."

Additionally, CPCs reduce the credibility of ways to control reproductive health. This includes marketing condoms and barrier methods as not effective and being openly against contraception, stating they can be harmful or not effective (See Table 2). Also, as stated earlier, national pro-life organizations such as Care Net which provide guidelines for CPCs in the U.S. are against contraception and promote abstinence. In my interview with Shelly and Allison, they both stated how the CPCs promote abstinence to their clients. Shelly also told me "You may survive pregnancy, but you may not survive an STI." I found this statement shocking based on the high maternal and infant mortality rates in the U.S. compared to other industrialized nations and the fact that STIs such as chlamydia, gonorrhea, and syphilis are treatable and other STIs such as HIV can be managed with medications. Framing STIs as deadly discourages people from getting tested or seeking treatment which results in poor health outcomes.

Strategy 5: Faith-Based Language

Throughout the findings section, I have included references to faith-based language that presented in the interviews and thematic analysis. The more openly faith-based CPCs have mission statements and quotes on their websites with similar messaging such as:

Table 3 Examples of Faith-Based Language

"Helping women in unexpected pregnancy situations is a special way of sharing Christ's compassion, love, and hope."

“Babies in the womb have no voice but ours”
“[We have] resources that explain the truth about life”

Faith-based language is less present on client-facing websites for some CPCs. Based on the two interviews I conducted with staff and volunteers at CPCs in Central Florida, faith plays a significant role in Shelly and Allison’s motivation to enter this work and shapes the information they share with clients. On the other hand, interviews with reproductive justice advocates also demonstrated the role of faith in their activist efforts, similar to pro-life activists at CPCs. Alex Henson is a reproductive justice advocate in Florida. As a person of Jewish faith, she described how her religious and personal beliefs led her to activist work in Florida. She described that in Judaism, life begins when “the head emerges, and the first breath is taken.” This demonstrates the role of faith in work on both sides of this topic and how varying religious ideologies clash when it comes to the topic of abortion, pregnancy, and when life begins.

Sanctity of Human Life

> *Ministry to the abortion-vulnerable is challenging: it’s private and hidden; further, it’s been politicized and disconnected from the gospel, discipleship, and grace. If things are going to change, the church must pray and be equipped to lead. Please pray this with us: God, we can’t decrease the number of abortions in a transformative way without you working behind the scenes to change the human heart...*

Sanctity of Human Life (SOHL) Sunday occurs annually in January. It marks the anniversary month of Roe v. Wade, the Supreme Court case that made abortion legal in 1973. SOHL is referred to as “an opportunity to focus our time and attention on God’s true plan and purpose for each and every human life.” CPCs in Central Florida during this time market their services to the community, congregations, and potential donors to fundraise. The quote above is

from a CPC website in Central Florida representing prayer call for SOHL Sunday. This further highlights the influence of faith-based language and religious ideologies on the work and identity of CPCs.

CHAPTER 4: Discussion

CPCs strategically frame their digital and physical space as credible and legitimate sources of health information and services. The location, service limitations, and public health implications of CPCs is problematic. CPCs target low-income, pregnant women of color and their failure to adhere to standard medical and ethical standards nor provide evidence-based care may exacerbate health disparities and creates barriers to abortion and healthcare access. Marginalized communities disproportionately experience barriers to healthcare and adverse health outcomes. CPCs share false health information that asserts links between abortion and mental health issues or breast cancer as well as reduce the credibility of ways to control reproductive health such as the effectiveness of condoms. It is also common for CPCs to provide false information about how far along people are in their pregnancy since their ultrasounds are non-diagnostic which results in people delaying seeking abortion or healthcare services. In my interviews at CPCs, the way in which they talked about their clients made me feel uncomfortable, shame, and guilty. The stigma perpetuated in the interviews related sex before marriage, pregnancy, being single, etc. is incredibly harmful. I found it very difficult to maintain a neutral position during interviews hearing the way they talked about women and specific clients in derogatory and negative ways.

CPCs receive millions in government funding from both federal and state sources such as the Title X Family Planning Program, the Teen Pregnancy Prevention Program, "Choose Life" license plates, and state grant programs such as the Florida Pregnancy Care Network Syndicate. National medical and public health associations state the government should only support programs that provide accurate, comprehensive, and unbiased information and care, which CPCs fail to do. In states such as Florida where Medicaid has not been expanded and access to

reproductive healthcare services are shrinking, not expanding, and CPCs are directly funded, this presents a significant area for change. CPCs do not provide accurate health information and present themselves and their services in misleading ways to manipulate clients that visit their websites or facilities. Counseling people with information from a religious perspective is extremely myopic and from a place of power and privilege. It is important that individuals are educated about the reality of CPCs, the services they provide, and the limitations of those services and information.

Lived Religion

"God has given us another opportunity to be the hands and feet of Jesus in an area of great need!"

The theoretical perspective of lived religion explores the relationship between religious practices and idioms of belief (Yeager 2021). Lived religion focuses on people's behaviors and the meaning they ascribe to them. This relates to symbolic anthropology and the emphasis on studying behaviors and belief systems rather than theology to understand religion (Yeager 2021). The framework of lived religion is useful in understanding how staff, volunteers, and supporters for CPCs draw on inherited, appropriated, and improvised idioms of belief to use and discard as fit (Orsi 1997). Faith plays a significant role in the formation of identity and community for staff and volunteers at CPCs.

Part of the framework of lived religion involves rituals and cultural scripts as symbolic enactments of beliefs and values (Yeager 2021). Cultural scripts and social factors shape cultural norms, values, and practices. They act on social, emotional, and spiritual levels (Yeager 2021). Cultural scripts are influenced by idioms of belief which arose during my analysis of CPC websites and interviews. Shelly Aaron repeatedly referred to the role her faith played in her work

at the CPC. She referred to herself as a "vessel of God…doing His work." Shelly's faith was critical in leading her to open a CPC in the Central Florida community and teach abstinence-based sex education at schools. Shelly discussed how supporters of the CPC could sign up for "real-time prayer texts" to pray for clients, shared narratives that reinforced "life begins at conception" and the role of the CPC as a pro-life, or life-affirming ministry. Several idioms of belief were represented in my interview with Allison Smalls, volunteer at a CPC. Allison described her motivation for being a volunteer at a local CPC: "I want them [clients] to feel God's love through me." Lived religion helps explain how staff and volunteers at CPCs enact their faith in this space.

CPCs represent the way ordinary people 'live' their religion through actions. From my thematic analysis, CPCs are often Christian-based, life-affirming non-profits. Examples of faith-based language demonstrate how religion and faith are a key part of the work of CPCs (See Table 3). Religious scripts are also present in the way information is shared and framed when counseling clients that visit CPCs. For instance, language that ascribes personhood and humanizes the fetus represents the way in which the symbolic concept life, personhood, and soul are framed to mean more. Based on my interviews, I also learned the importance of religion both for people that work and volunteer at CPCs, but also those working in opposition to CPCs. I want to recognize that on both sides of this issue, people can be considered activists. This was seen in the variation of faiths present in individuals I interviewed which shaped beliefs surrounding when life begins.

Furthermore, religious scripts intersect with gendered and racial scripts present in the language CPCs use on their websites and in-person. For example, pronatalist encourage carrying a pregnancy to term, focusing on the baby rather than the mother. Heteronormative scripts

encourage heterosexual, monogamous relationships and promote abstinence-until-marriage. These scripts also shape the reduction of credibility of ways to control reproductive health and the emphasis of natural family planning methods that are aligned with religious ideologies. Gendered scripts are present in the use of "her" and "she" and information to support men on CPC websites which depict that gendered, stereotypical roles. CPCs shared information encouraging men to support the woman and stay with her during her pregnancy. There are also racial scripts present in the images shared by CPC websites which feature low-income, BIPOC women. Racial scripts were also seen in the interviews where one CPC admitted to profiling women in the community that seek services at their CPC.

Communicative Inversions

Communicative inversions are conceptualized by Mohan Dutta as "the use of communication to shift symbolic representations to signify the opposite of the material formations that communication seeks to represent" (Dutta 2011). In *Communicating Social Change: Structure, Culture, and Agency*, Dutta investigated the use of communication to transform local, national, and global power structures that created and sustain oppressive conditions (Dutta 2011). The framework of communicative inversions is useful to explain how CPCs strategically invert concepts, ideas, and/or information to frame it in a way that supports their goals which is ultimately misleading.

Ethnographic data demonstrated several strategies CPCs use that represent communicative inversions: differences in donor versus client-facing sites, inconsistency in services advertised, and health misinformation. These strategies serve to frame CPCs as credible and legitimate sources for health information and services.

White-Savior Complex: Localized Missionary Work

Throughout the interviews and thematic analysis, there were so many comments that made me uncomfortable and seemed problematic. Staff and volunteer at CPCs believed they do "saves babies" and anecdotally referenced that same few success stories. I kept coming back to the idea of what it means to do good work in this space and the goals of these organizations. CPCs state they provide unbiased, all options counseling that is confidential, yet I saw multiple instances in-person and online where they presented health misinformation, religious ideologies infiltrated the information and services they provided, and they violated confidentiality of their clients. The women I interviewed and saw at the CPCs were predominately middle-aged, Christian white women. Because these CPCs are strategically located in low-income, BIPOC communities which represent their target audiences, this results in the imposition of white, religious, Eurocentric, and traditional gendered norms on communities that do not embrace or identify with those identities or values. CPCs have entered an intersectional space, yet do not take an intersectional or inclusive approach to the services or information they provide. Based on my research, I believe CPCs are exporting religious and cultural scripts in communities to discourage abortion, like what happens in missionary work abroad. The ways CPCs operate and provide services in the U.S. is like organizations and people that do mission work in the Global South, except localized. Religious values are driving the need to "save babies" taking a white savior approach to this work. Targeting communities that are vulnerable based on political, economic, and social factors and imposing their own beliefs is an injustice.

CPCs perpetuate and reinforce false beliefs that people of color need to be "saved" by acting as agents of change for BIPOC individuals. Staff and volunteers at CPCs are enacting white religious womanhood via relationships and interactions with non-white clients. Imposing

values on marginalized communities which CPCs target is an illustration of modern whiteness and colonialism. CPCs essentially make assumptions and stereotype people that are not white which is rooted in themes of power, religion, and oppression.

The framework of critical medical anthropology provides insight as to how pro-life and religious ideologies influence the services and information CPCs provide to clients and the introduction of restrictive legislation related to reproduction. Health misinformation and legislation that restricts access to reproductive healthcare services, such as abortion, creates differential access to care for marginalized populations, which are the target populations for CPCs. CPCs locate themselves in or near low-income, BIPOC neighborhoods which disproportionately experience health inequalities in the U.S. It is important to recognize that structural historical, political, social, and economic factors shape the way CPCs operate in the U.S. Specifically in Central Florida, CPCs position themselves as credible sources for health information and services by presenting themselves as healthcare spaces, which can be misleading, and using deceptive tactics to dissuade and shame people from seeking abortion.

Implications and Recommendations

Overall, not only is it difficult to identify and recognize CPCs, but it is also difficult to understand the background of people at CPCs. CPCs operate from their own assumptions about what communities and clients need. Ethnography is incredibly powerful in demonstrating the goals of CPCs and provides insight to both sides of the issue and activist anthropology could serve to better address the needs of the community in response to CPCs and restrictive legislation limiting access to abortion and reproductive healthcare services. In my interviews with reproductive justice advocates, I was able to learn about other activists raising awareness about

CPCs in Florida and across the U.S. and how the research can serve to inform policy change related to CPCs as well as educate providers, reproductive justice advocates, and members of the community.

Based on my research findings, I would recommend the creation and implementation of comprehensive, inclusive, age-appropriate sexual and reproductive health education in K-12 schools. I would also encourage people to vote and learn more about social justice issues and community-based and advocacy organizations in their community that they can get involved in. Within the framework that CPCs currently operate in, I would suggest that CPCs review the information they present on their websites and in-person to more accurately reflect up to date scientific and medical recommendations that are unbiased. Federal, state, and local governments should not provide funding to organizations that provide health misinformation, mislead people as to the services they provide, or are faith-based in nature as it violates the separation of church and state. Organizations, such as certain CPCs in the state of Florida, which receive such funding should have the information and services they provide thoroughly regulated to make sure they are compliant standard guidelines for organizations claiming to provide health information or services. If the goal of CPCs truly is to improve the health outcomes for women and support women, they should work to provide unbiased health information that is not rooted in any religious or personal beliefs, truly present all options counseling to clients, and work to expand the services they provide so they can provide adequate support to women for the duration of their pregnancy and post-partum to better align with their goals.

Limitations and Directions for Future Research

Beyond the methodological challenges I discussed earlier, I also had trouble in securing interviews based on time constraints which resulted in my small interview sample. This was my first-time doing ethnography and the sensitive nature of this topic presented challenges in the interviews. While I was open about my positionality with interviewees, it is important to recognize that it is difficult to collect objective data or understand to what extent what I share impacts the answers provided. Since the websites are regularly updated and there is more than one client-facing site for CPCs, this could lead to limitations in reproducibility and generalizability of this project.

I also did not have time to analyze all CPC client-facing websites in Central Florida. I would like to do a more thorough comparison of client-facing versus donor-facing websites as well as analyze the images more in-depth. Discourse analysis of CPC social media pages, such as Facebook could also provide information about how they present information about their clients. Based on research projects in Georgia and North Carolina, I would like to translate this project to a content analysis of all CPC websites in the state of Florida to analyze the health information presented to inform awareness campaigns for individuals seeking reproductive health information online. There is also very little understanding about the location of CPCs in reference to schools or abortion clinics/providers which would be interesting to study. Based on my findings, it is common for CPCs to be in low-income, BIPOC communities as well as abortion clinics and if they conduct outreach to position themselves in these areas.

Conclusion

CPCs are nonprofit organizations that target pregnant women and aim to dissuade them from considering abortion. In the U.S., CPCs are increasing in prevalence, accumulating government/state funding and support, and becoming more medicalized. Medicalization includes offering limited medical services, such as pregnancy testing, limited ultrasounds, and testing for sexually transmitted infections (STIs). CPCs are largely unlicensed and unregulated, frequently advertising in misleading ways and providing inaccurate health information. This research sought to (1) understand how CPCs in Central Florida utilize rhetorical strategies to frame their services and health information as credible, legitimize their work, and discourage abortion, and (2) understand the role of faith in the services CPCs provide and in establishing identity and community among staff and volunteers at CPCs.

A thematic analysis of fifteen client-facing CPC websites in Central Florida was conducted to identify the rhetorical strategies CPCs use to position themselves as credible as well as two semi-structured interviews were conducted with individuals who volunteer and work at CPCs in Central Florida, and three with individuals who are reproductive justice advocates in Florida. The frameworks of medical anthropology, activist anthropology, and reproductive justice informed this work. The main findings were that CPCs use strategies of promotion, space, and language use to frame their services as credible. CPCs share health misinformation, promoting ideas rooted in religious ideologies such as abstinence, and reduce the credibility of abortion clinics/providers and ways to control reproductive health. Faith has a significant role in the ways in which CPCs frame their services and establish identity and community through the framework of lived religion.

CPCs promote themselves as unbiased medical clinics that target and exploit BIPOC individuals using a broken health system to reach these vulnerable populations who experience the greatest burden of legislation that restricts abortion and reproductive healthcare access. This research provides evidence to how CPCs operate in Central Florida and areas for improvement in delivery of services and evaluation, and potential regulation of the accuracy of information and services CPCs provide.

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Acknowledgements

I am incredibly grateful to my thesis committee Dr. Shan-Estelle Brown, Dr. Rachel Newcomb, Dr. Ashley Kistler, and Dr. Todd French for their support throughout this process. To Dr. Brown, thank you for always challenging and supporting me throughout my time at Rollins. I am incredibly honored to have you as my thesis advisor. To Dr. French, thank you for making me rethink my entire college plans in your RCC class. I would not have decided to take an anthropology class with Dr. Newcomb my freshman year without your encouragement. To Dr. Sarah Parsloe, thank you for providing me guidance throughout the thesis process and invaluable advice. To Dr. Sydney Yeager, thank you for sharing your perspectives on the anthropology of religion which helped me understand the critical role of religion in the work CPCs. Also, thank you to Amy Weintraub at Floridians for Reproductive Freedom for providing me resources and support at the beginning of my thesis journey. This thesis in no way encompasses everything I wish I could say about anti-abortion pregnancy centers and the state of sexual and reproductive healthcare in the U.S., but I hope it inspires people to think more critically about how these organizations operate and the impact a lack of separation of church and state and bias in the delivery of healthcare and social services can have on the health of individuals and our communities.

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Appendix A

Informed Consent

Title of Study: Pregnancy Centers in Central Florida
Description of the Study: The goal of this research is to understand what pregnancy centers are and their role in the Central Florida community. You are invited to participate in this study if you are 18 years or older. If you agree to participate, the interview will last no more than 1 hour.
Risks: There are no reasonably foreseeable risks involved in taking part in the study.
Benefits: There are no expected direct benefits to you for taking part in this study. There is no compensation or other payment to you for taking part in this study.
Confidentiality: Only the interviewer and the faculty supervisor of this project will be aware of your identity. Any written product (research report or presentation) will keep your identity confidential. You will be assigned a pseudonym and all identifying information will be removed from interview transcripts and the final report.
Consent to Participate: I voluntarily consent to participate in this study. I understand that I can decline to answer any questions and withdraw my consent at any point. I also understand that any information obtained from me will remain confidential and will be used solely for research purposes.

☐ I understand that any information given by me may be used in future research, reports, or presentations by the researcher.

☐ I have been given a copy of this consent form.

By signing this form, I am attesting that I have read and understand the information above, and I freely give my consent to participate.

Participant's Signature: ______________________________ Date: ________________
Printed Name: ________________________________

Consent for Audio Recording

Explanation of Request: The interviewer would like to audio record this interview, so they are better able to analyze your responses. Only the interviewer will listen to the recording and only for the purposes of transcribing the content to written format. Personal identifiers such as your name will not appear on the recording or transcripts. The recording will be erased once your data has been transcribed. Consent for recording is completely voluntary – you can decline to be recorded or ask the researcher to stop recording at any time during the interview.
Consent to Record: I voluntarily consent to have my responses audio recorded as part of this research under the conditions explained above.
Participant's Signature: ______________________________ Date: ________________

If you have questions or concerns about the study, please contact:

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Rollins College Institutional Review Board	**Dr. John Houston, IRB Chair, Rollins College, 1000 Holt Avenue, Winter Park, FL 32789-4499** jhouston@rollins.edu, (407) 646-2099

Appendix B

Interview Guide Questions

Start by providing overview of research

Hello ___________. Thanks again for agreeing to participate in this interview. As you know, I am interested in learning about your experiences as a [volunteer or staff member] at [pregnancy center] and the services you provide. You've read through the consent form, and you know you can decline to answer any questions or end the interview at any time. Do you have any questions before we begin?

For CPCs

Primary Questions

- How did you get involved in this work?
- What do you see as your role with the Pregnancy Center?
- How do you refer to people that visit the center (patients, clients, customers)?
- What is a typical day at the center?
- What is your mission? Could you briefly summarize how you fulfill that mission?
- How do you discuss options with women? What are their options? (What options or resources do you direct people to? How do you connect them with resources in the community (mention resources I am aware of)?)
- What role does faith play in your work?
- How do you see the role/work of pregnancy centers changing if abortion becomes illegal?
- How do you counsel someone who is considering an abortion versus someone who is not?
- What does a successful interaction look like? How do you measure success?
- How do you market your services in the community?
- What role does faith play in your work?
- Website – who manages and how has it changed over time?
- Medical licensed vs unlicensed?
- Funding?
- Mobile medical unit?

- Larger organizations you are connected to?
- Education in the community (abstinence/sex education)
- Client vs. Business facing sites
- Lay counseling
- For someone involved in social media:
- How do you decide what you post on your social media? Who is your target audience?
- How do you decide which images to use on your website?

Secondary Questions

(If time and convenience permit)

- What does your intake form look like?
- What does counseling look like?
- Can you explain how the Earn While You Learn program works?
- How do you keep track of your impact?
- How did you become a medical clinic?
- What do you find most challenging about the work you do? The most rewarding?
- What are your funding sources?
- Where do you get your counseling videos and materials from?
- Are there standard guidelines for how pregnancy centers operate in the US?
- Could you provide some background information about pregnancy centers in the US and Florida more specifically? How were they created?
- How do the services you provide here and work you do compare to other clinics (OB/GYN clinic)?

For Non-CPCs

- Could you tell me about your role?
- How did you get involved in this work?
- What is your knowledge of and experience with crisis pregnancy centers?
- Could you reflect on what you notice about how CPCs frame their services and how your [work, research, organization] responds to this framing?

- If you could speak with individuals who volunteer or work at CPCs, what would you want to ask them? What would you want to tell them?
- What is some advice or guidance you would give to pregnant individuals who are considering visiting a CPC?
- How would you advise someone to navigate reproductive health resources online?