

Figure 1 Operating status of crisis pregnancy centres during the COVID-19 public health emergency. *Data collection concluded prior to the end of the shutdowns and is included in the sensitivity analysis.

professional medical associations affirming abortion to be essential, time-sensitive healthcare, little attention was paid to crisis pregnancy centres (CPCs). CPCs purport to assist 'vulnerable' pregnant people, but many use medical misinformation and misleading tactics to discourage pregnant people from abortion.¹ Many CPCs attempt to present as medical offices, but most are staffed by unlicensed volunteers who provide over-the-counter pregnancy tests and non-diagnostic ('keep-sake') ultrasounds.¹ Their number is rapidly increasing and fuelled by public funding; CPCs now vastly outnumber abortion clinics nationwide.¹

The Alliance: State Advocates for Women's Rights & Gender Equality is a collaboration of four state-based law and policy centres working for gender equality (Gender Justice, Legal Voice, Southwest Women's Law Center and Women's Law Project). With CPC project partner California Women's Law Center, The Alliance maintains a database of CPCs in nine states (Alaska, California, Idaho, Minnesota, Montana, New Mexico, Oregon, Pennsylvania and Washington) using online searches, CPC network websites and national CPC databases.^{2,3} We documented the operating status of these CPCs from 15 April–5 June 2020, when non-essential services were generally closed^{4,5} due to the pandemic, by reviewing CPC websites and social media.

We collected data from 537 CPCs in eight states. Most data (90.1%) were collected prior to reopening of essential services; collection of the remaining data (9.9%) began during shutdowns and concluded within 18 days of reopening.⁴ We excluded New Mexico because its shutdown was lifted early during data collection.

CPC operating status is shown in figure 1; we found 59.2% of CPCs open for in-person visits. While healthcare services were broadly defined as essential in all study states,⁵ it is unclear whether open CPCs met even broad definitions of essential healthcare. Most provided pregnancy testing (87.4%) and counselling (87.7%), but the urine tests many CPCs provide are available over-the-counter, and most CPC counselling appears to be provided by 'peers' as opposed to licensed professionals. Some open CPCs did not offer even these limited services, and almost none offered well-person care (3.1%), prenatal care (1.7%) or contraception (0.6%). Only 49% of open CPC websites indicated a licensed professional was on staff; thus it is unclear what essential medical services the remaining 51% could provide.

Study limitations include (1) inability to ascertain operating status of nearly 30% of CPCs, (2) lack of generalisability given most study states' location in the western United States, (3) possibility of missed CPCs in project states despite using multiple sources to identify CPCs, (4) difficulty firmly establishing how CPCs were viewed by local lawmakers during the shutdowns and (5) collection of <10% of data after official reopening of non-essential services, though findings were materially unchanged when excluding these data.


In an era defined by urgent debate about what is an essential service, there was no apparent public discussion about CPCs by public officials overwhelmed by the COVID-19 emergency, and decisions to stay open amid the spreading pandemic were evidently left to the CPCs themselves. In light of continued uncertainty about the pandemic's

Essential services? Operating status of crisis pregnancy centres in the United States during the COVID-19 pandemic

In March 2020, as COVID-19 rapidly spread across the United States, a singular question emerged: What are essential services? While anti-choice lawmakers attempted to classify abortion as non-essential despite

trajectory, policymakers should determine whether CPCs provide essential services. Additionally, as some CPCs provided remote-only services during the 2020 shutdown, policymakers should assess investment of public resources in physical CPCs whose services can be provided remotely.

In summary, policymakers seeking to protect public health must assess whether CPCs do indeed provide essential services and, given the trend toward public funding of CPCs, whether they warrant investment of limited public health funds.

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Correction notice This letter has been updated since it was published online. The authors noticed that they had mistakenly included an older set of proportions in the fourth paragraph. The

corrected proportions are very similar to the incorrect ones and do not change any of their interpretations or necessitate any changes to the figure.

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