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Understanding the State and Local Policies Affecting Abortion Care Administration, Access, and Delivery

A Case Study in North Carolina

In *Roe v. Wade*, the U.S. Supreme Court held that the Constitution protects the right to pre-viability abortion throughout the United States, but states could regulate abortion to some extent during the second trimester.¹ Until the 2022 Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, states retained the power to enact and enforce such policies as mandatory waiting periods and targeted building code requirements.² These restrictive laws meant that, in many states, abortion was technically legal but feasibly challenging for both patients and providers.³ By the middle of June 2022, right before the *Dobbs* decision, a total of 1,381 statewide abortion restriction laws had been enacted. Almost half (46 percent) of these policies had been implemented since 2012, and many involved gestational limits or medication abortion restrictions.⁴

In *Dobbs*, the Supreme Court overturned *Roe v. Wade*, holding that there is no constitutionally protected right to an abortion in the United States. As a result, abortion access is now determined state by state, and states were granted the authority to ban abortion at any point in pregnancy, exacerbating the significant variation between states in terms of laws and policies affecting abortion care that already existed prior to *Dobbs*. Total or near-total abortion bans have been implemented primarily in the Southeast and South Central United States; 14 states implemented full (or nearly full) restrictions on abortion, with Texas, Georgia, Tennessee, Louisiana, and Alabama experiencing the steepest declines in abortion volume over the first 15 months post-*Dobbs*.⁵ Other states protect abortion as a right in their statutes, prohibit cooperation with out-of-state investigations related to abortion, and require private insurance to cover abortion care.⁶

Examining abortion access and law and policy implementation at the level of the county, city, or individual health facility can reveal significant within-state variation. Research has highlighted how bureaucratic discretion can lead to variation (and, oftentimes, additional restrictiveness) in

KEY TAKEAWAYS

The implementation and enforcement of state and local abortion policy can vary significantly between medical clinics and depend on the context and the individual decisionmakers involved. Research conducted prior to the U.S. Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization* showed that, when providers are unclear about potentially conflicting or changing local and state policies (formal and informal) or enforcement, many err on the side of caution and become more restrictive in their practices.^a However, it is unknown whether and to what extent state and local policies and practices in the wake of *Dobbs* have influenced practices at facilities.

We conducted an initial study of laws and policies post-*Dobbs* in one state, North Carolina, to better understand the policy landscape and gather perspectives from staff working in facilities or for organizations providing or supporting abortion care. This study served as a unique opportunity to explore laws and policies, as well as implementation experiences, given North Carolina’s Senate Bill 20, which instituted a gestational limit of 12 weeks and 6 days, among other provisions. We found the following:

- Of the provisions in Senate Bill 20, the reduced gestational limit and the 72-hour in-person consent requirement were the most-restrictive components.
- Local laws did not appear to play a large role in abortion provision, although noise ordinances influenced access at clinics with protesters.
- Individual facilities adapted policies and workflows to align with their organizations’ interpretations of Senate Bill 20 and its provisions, such as stipulating that two providers must agree on medical exceptions or implementing a referral system for people who are 12 weeks and 3 days pregnant or later at the time of their ultrasounds because of the in-person consent requirement.
- The impacts of laws and policies were reported at three levels (i.e., facilities, providers, patients):
 - Facilities reported reorganizing or changing clinical workflows, adjusting staffing, facing increased costs for providing abortion care, losing patients, and physically relocating some of clinics to adapt to Senate Bill 20 provisions.
 - Providers reported increased time on administrative tasks, frustration with new required consent forms, feelings of anxiety and burnout, and fears for the provider pipeline in the state.
 - Providers reported that patients faced increased resource and time burdens, particularly with the in-person consent requirement, with a disproportionate impact for more historically marginalized populations. Additionally, providers reported that individuals seeking care faced limitations on decisionmaking inputs, combined with high levels of confusion and misinformation.

^a Czarnecki et al., “State of Confusion.”

implementing state abortion regulations.⁷ For example, abortion clinics in Ohio are required to obtain written transfer agreements with nearby hospitals or obtain approval for an exemption from the state Department of Health. State employees are responsible for county-level implementation and have full discretion to determine whether a clinic meets the exemption requirements. In other words, despite clinics meeting written state requirements, individuals can determine that a component of a clinic’s application is insufficient and reject the exemption.

However, other local leaders have implemented more-supportive measures for abortion, such as the district attorney in Travis County, Texas, refusing to prosecute criminal cases involving abortion or the mayor of St. Louis, Missouri, signing a bill that directs \$1.5 million to cover “logistical support,” such as travel costs and lodging, for residents who must leave the area to get an abortion.⁸ Still, it is unclear how local providers may change their practices as a result of these promised protections.

Finally, some facilities might restrict abortions further than the state or local municipalities. For example, some facilities might have policy restrictions beyond what the state requires to garner a positive image in the surrounding community or avoid any potential room for accusation.⁹ Furthermore, religiously affiliated hospitals often require an ethics board to review all abortion requests (medically necessary or otherwise), which can further delay or impede care,¹⁰ and some hospital staff have discouraged referrals for abortion care, kept them hidden, or generally offered minimal support.¹¹ At the same time, some facilities may explicitly support providers and patients by outwardly backing increased access. For example, the CEO of Planned Parenthood League of Massachusetts stated her intent to increase protections and access by expanding telehealth services, training more providers, and reducing the minimum age required for parental consent.¹²

Given this variation in both policies and potential enforcement, we set out to better understand experiences with these policies, particularly in states that have or are likely to have significant abortion policy changes in the next few years. We selected North Carolina as the first state to examine, given the recent passage of Senate Bill (S.B.) 20, which reduced the state’s gestational limit for legal abortions to 12 weeks and 6 days.¹³ North Carolina is important to examine because of its location in the United States as one of the only states in the South providing abortion care beyond 6 weeks. We sought to answer two research questions:

1. What policies further restrict abortion provision in addition to this gestational limit, and how are these policies enforced?
2. What are the potential impacts of these different types of policies?

Methods

To answer these research questions, we used a mixed-methods approach consisting of a landscape review of state and local laws and policies in North Carolina and interviews with various stakeholders involved in providing or supporting abortion care in the state. The brief landscape review was of peer-reviewed and

Abbreviations

12,6	12 weeks and 6 days
DHHS	Department of Health and Human Services
NC	North Carolina
OB-GYN	obstetrics-gynecology
S.B.	Senate bill

grey literature, as well as news articles, and then we reviewed and summarized policies and supporting documentation. This effort helped create a more informed picture of how local policies and their enforcement may affect abortion delivery and access in the state. The analysis of North Carolina laws proceeded in two steps:

1. *Locating relevant laws:* We used the Westlaw database to search North Carolina laws using the keyword “abortion,” and then the Westlaw database for secondary sources using the terms “abortion” and “North Carolina” within 25 words of each other. This was followed by a Google search for “North Carolina abortion laws” to gather publicly available information, as well as a review of publications by sources that provide lists of North Carolina abortion laws (e.g., the American Civil Liberties Union, University of North Carolina at Chapel Hill, Planned Parenthood, the *Charlotte Observer*, the Guttmacher Institute). Finally, we used the North Carolina General Assembly website to locate pending bills.
2. *Analysis:* We downloaded the text of relevant laws and recent lawsuits and created an Excel database of North Carolina laws (including summaries of each law and lawsuit) and recent legal actions shaping abortion policies in the state. One researcher reviewed the laws and lawsuits to identify key themes, such as gestational limits, and applied a coding scheme to categorize each law and lawsuit accordingly.

Although laws and policies are of critical interest, on-the-ground experiences around implementation and if, and where, discretion is exercised that may affect abortion access were also important to understand. To identify clinicians and support staff, we

used websites such as AbortionFinder and a registry from the North Carolina Department of Health and Human Services (DHHS) to identify facilities providing abortion care.¹⁴ Using publicly available contact information, existing connections, and snowball sampling, we contacted organizational representatives from facilities that explicitly advertised abortion services. According to AbortionFinder and the DHHS registry, North Carolina has 16 clinic locations providing abortion care: two affiliated with hospitals, six affiliated with Planned Parenthood, and eight independently owned. These clinics are located in nine counties (out of 100 counties): Buncombe, Cumberland, Durham, Forsyth, Guilford, Mecklenburg, New Hanover, Orange, and Wake. We also searched for other organizations across the state that may facilitate access to abortion by providing direct support to patients or organizing for policy change. Once we identified these support organizations ($N = 6$), we contacted representatives using publicly available email addresses.

All study materials, including the interview guide and outreach materials, were approved by RAND's institutional review board—the Human Subjects Protection Committee—and participants were provided a \$50 e-gift card as a token of appreciation for their time. We completed 13 virtual interviews in March and April 2024, approximately an hour in length each, and recorded, with permission, to verify notes before deleting the recording. To reduce identifiability, we did not ask participants to self-report gender, race, or other sociodemographic characteristics. We conducted a rapid analysis of interview findings to triangulate with learnings from the landscape review to inform answers to the identified research questions.

Findings

Our sample of 13 participants consists of six clinicians who regularly provide abortion care and seven nonclinicians who work at facilities that provide abortion care (in three counties out of nine) or organizations that support abortion access. Participants worked at different types of clinics (i.e., independent,

Planned Parenthood, and hospital based) or support organizations (e.g., policy advocacy, abortion funds).

Research Question 1. What Policies Further Restrict Abortion Provision in Addition to This Gestational Limit, and How Are These Policies Enforced?

The implementation of S.B. 20 in July 2023 limited abortion to 12 weeks and 6 days, with exceptions to the gestational limit for cases of rape, incest, or medical emergency. Along with reducing the gestational limit, this 47-page bill introduced in-person counseling requirements for both surgical and medical abortions on top of the 72-hour waiting period, modified consent-language and signature requirements, mandated detailed reporting requirements for abortions performed after the 12th week, and established penalties for physicians and health care providers who violate these new regulations. In addition, there is a provision that requires abortions to be conducted in a hospital setting after 12 weeks and 6 days, which was blocked by a preliminary injunction.¹⁵ Prior to S.B. 20 taking effect, abortions were broadly lawful in North Carolina “during the first 20 weeks of a woman’s pregnancy” and lawful until viability from 2019 until 2022.¹⁶ In addition, in-person consent counseling was not required, patient consent and provider reporting requirements were less extensive,¹⁷ and there was no prohibition on abortions based on race or (presumed) presence of Down syndrome. (The appendix presents a more detailed description of S.B. 20, including comparisons between S.B. 20 and prior North Carolina abortion laws.)

Table 1 provides an overview of current laws and policies noted as further restricting abortion provision beyond the gestational limit of 12 weeks and 6 days. All identified laws were at the state level, except local noise ordinances, which were raised by some participants as affecting clinics with protestors. Although certain counties (e.g., Yadkin) passed resolutions expressing views against abortion (e.g., recognizing “the full humanity of the preborn child” and declaring the county to be a “Sanctuary for Preborn Children”),¹⁸ these resolutions did not appear to have an enforceable mechanism. In October 2023,

TABLE 1

Summary of Laws and Policies Noted as Further Restricting Abortion Access Beyond Gestational Limits

Area	Law or Policy Summary	Implementation Experiences and Enforcement	Sample Quotes from Interviewees
State laws (e.g., S.B. 20)			
Consent timing and location	<ul style="list-style-type: none"> The consent procedure must happen in person with a licensed clinician rather than over the telephone or through mailed materials. The consent process must happen 72 hours before the abortion unless it is a medical emergency (continued from original law enacted in 2015). 	<ul style="list-style-type: none"> Clinics created specific days and times for the consent to occur. Clinicians did not see patients changing their minds between consent and the abortion. 	It's based on nothing but sexist ideas that women can't make up their minds, and that we're flighty and don't know what we're doing. We've had that 72 hours for a long time, and it's the longest waiting period. ^a — <i>Nonclinician</i>
Consent process	<ul style="list-style-type: none"> The consenting provider must verbally acknowledge the benefits available for prenatal care and childbirth, the father's liability for child support, and an attestation that the woman is not being forced to have an abortion and that the woman has a private right of action to sue the physician under state law if she feels that she has been coerced or misled prior to obtaining an abortion. Physicians must sign the declaration form confirming that they have explained the procedure, provided all the information required in the statute, and answered all of the woman's questions. For medication abortions, the consent form contains information about the possibility of seeing fetal remains during the abortion process. 	<ul style="list-style-type: none"> The clinician and patient must sign the paperwork in multiple places.^b Slightly different consent forms are used for procedural and medication abortions. When patients are undecided about their preferred type of abortion, they complete both forms. Clinicians may supplement discussions to describe procedure or clarify inaccurate information. 	<p>With the 72-hour counseling, patients have to initial every single line of the counseling. It's extremely patronizing. —<i>Clinician</i></p> <p>We have people coming in and initialing 42 times, and if there's an anomaly, there's even more, so there are a bunch of other initials. And it's all just meant to fluster us and to get us to feel like we're not complying with all of these laws. And we do everything we can to make sure we have every <i>i</i> dotted and every <i>t</i> crossed, because we're not going to stop providing care. —<i>Clinician</i></p> <p>[The completed form] says what gestational age you are and what the medical risks are of the procedure, but [the forms are] not really filled out fully, in a way that is helpful for patients. —<i>Clinician</i></p>
Additional requirements for medical abortions	<ul style="list-style-type: none"> For medical abortions, the consent form requires the clinician to inform the patient that they will be required to attend an additional appointment seven to 14 days after the provision of medication (i.e., the third appointment). Physicians must document all attempts to reach the patient for the follow-up. A prescribing physician (not a pharmacist) must administer medication to the patient in an in-person setting (continued from the original law enacted in 2013). 	<ul style="list-style-type: none"> Clinics make appointments for these patients, but the appointments are rarely attended. 	The third in-person visit is an extra hurdle for abortion seekers that is particularly cruel for the South. ^c This means another day possibly missing work, needing child care, traveling to the clinic and back home for a medically unnecessary check-in. — <i>Nonclinician</i>

Table 1—Continued

Area	Law or Policy Summary	Implementation Experiences and Enforcement	Sample Quotes from Interviewees
Additional abortion provision requirements	<ul style="list-style-type: none"> • Before an abortion can take place, a physician must verify the pregnancy, determine the woman’s blood type, and verify that the gestational age is no more than 70 days. The method used to determine gestational age and the results must be reported to DHHS. • Before the procedure, the patient’s Rh factor and hemoglobin levels are required to be tested. • Physicians must provide care to “infants” who are “born alive” from an abortion attempt. 	<ul style="list-style-type: none"> • Clinicians expressed that requirements (e.g., testing Rh factor for medication abortions) were not aligned with standard of care. • Clinicians felt that the idea that infants could be born alive after an abortion procedure was biologically very unlikely, especially as most procedures occur before viability. 	<p>There are numerous exceptions and provisions around the timing of ultrasounds, ultrasounds being performed, Rh testing. . . . There are many, many hurdles that clinicians, schedulers, everyone has to go through to make sure that patients can jump through all those hoops before they reach 12,6 [12 weeks and 6 days]. —<i>Clinician</i></p>
Exceptions for abortions happening after 12 weeks and 6 days	<ul style="list-style-type: none"> • Abortions occurring past 12 days and 6 weeks are allowed in cases of rape, incest, life-limiting fetal anomaly, or medical emergency (excluding mental health emergencies). • Abortions that meet one of the (above) exceptions and happen after 12 days and 6 weeks must occur in a hospital facility (this requirement is currently under preliminary injunction). 	<ul style="list-style-type: none"> • Clinics and hospital systems sometimes required a two-physician or a committee system to sign off on procedures related to a medical health emergency. • Although the hospital requirement is under a preliminary injunction, some other facilities stopped providing abortions to cases falling under the exception. 	<p>The medical exception is very vague about how imminent the threat needs to be and how serious it has to be. There is some room for medical judgment, but it also leaves a lot of fear, because you don’t know if others would agree with your judgment. —<i>Clinician</i></p> <p>S.B. 20, when they talk about medical emergencies, they explicitly exclude mental health. . . . That really is very dismissive of people’s mental health and issues around mental health, and it paints women as being hysterical and overly emotional. I remember that as standing out as particularly horrible. —<i>Nonclinician</i></p>
Other facility requirements ^d	<ul style="list-style-type: none"> • Facilities must document and report summary statistics regarding the medical and demographic characteristics of abortions provided after the 12th week. • DHHS is required to annually inspect abortion facilities. • The facility must have a transfer agreement with a hospital and have established provisions for emergency intervention. • New facilities are subject to building code requirements (e.g., an area for snacks, elevators that can accommodate a stretcher). • At least one registered nurse must be in the building at all times patients are in the clinic. • Clinics providing abortions below 12 weeks and 6 days cannot be physically attached to a hospital. 	<ul style="list-style-type: none"> • Clinics adapted to facility requirements and noted inconsistency with requirements for other outpatient health facilities. • Some facilities were forced to close for a period if a registered nurse was not in the building. 	<p>Like it says in the state regs, for instance, in NC [North Carolina], we have to have an area to provide refreshments and snacks after their procedure. We do that anyway, but you can’t tell me that a hospital is like, “Okay, let’s reserve this section just for patient snacks.” It’s not as heavily regulated, but there are unnecessary laws that are making it harder. They’re just trying to trip us up, trying to find ways to make it harder for us to provide care. —<i>Clinician</i></p> <p>This [is] very specific to my practice and a hospital, and it’s basically that the law states that you can’t have a freestanding abortion clinic that’s adjacent to a hospital, so it’s confusing. We don’t fully understand what this policy is supposed to mean. —<i>Clinician</i></p>

Table 1—Continued

Area	Law or Policy Summary	Implementation Experiences and Enforcement	Sample Quotes from Interviewees
Limitations	<ul style="list-style-type: none"> Abortion cannot be performed for reasons of race or racial makeup or presence or presumed presence of Down syndrome (or sex selection, which was previously prohibited). 	<ul style="list-style-type: none"> Patients were referred out of state if a positive test of Down syndrome was documented. There was some confusion between the exception for life-limiting fetal anomaly and Down syndrome. 	<p>We don't want to know if there's someone who's been diagnosed with Down syndrome. We just don't ask, and we don't want people to tell us anything. We don't ask people why they're there. Ever. Anyone. —<i>Clinician</i></p>
Conscientious objection	<ul style="list-style-type: none"> Clinicians, other staff, and pharmacists are allowed to refuse to provide abortion care. 	<ul style="list-style-type: none"> There was a need to ensure that those who would be involved in abortion care were comfortable providing the care, particularly in hospital settings. 	<p>We need staff that are okay with it, period, and staff that aren't okay with it, period, and then we need to make changes based on that and not judge every patient's reason for why they're doing this to decide whether you're going to participate or not. —<i>Clinician</i></p>
Violations	<ul style="list-style-type: none"> It is a felony to provide an abortion that is later than 12 weeks unless it is a medical emergency. Personal representatives beyond the father can seek damages in cases of wrongful death of the pregnant person. 	<ul style="list-style-type: none"> Health care providers who did not regularly provide abortion care did not always understand the new laws and were sometimes reluctant to provide needed care because of the possibility of a felony. 	<p>We're able to perform medication and procedural abortion in the hospital really without restriction as long as it's in line with S.B. 20. . . . Any time we need to do one for a reason that's not considered medically indicated, we tend to get pushback from staff to the point where it feels like we need to get authorization for every single one, just to get people out of our way and do our job. —<i>Clinician</i></p>
Local (e.g., city) laws			
Noise ordinances	<ul style="list-style-type: none"> Local jurisdictions had limitations placed on magnified noise. Some municipalities (e.g., Chapel Hill, Fayetteville, Wilmington) require an application, while others (e.g., Asheville, Charlotte) prohibit the use of amplified sound outside health clinics or hospitals (e.g., Durham, Raleigh); others (e.g., Greensboro, Hillsboro) seem to have few restrictions on amplified sound. There are allowances for the dispersion of protesters based on noise. 	<ul style="list-style-type: none"> Only one side of protesters would have magnified sound (that side tended to be antiabortion). There has been a general reluctance to engage police to enforce, given the police's varying levels of knowledge and willingness to intervene with disruptive protesters and preferences for less law enforcement presence. 	<p>You don't want a bunch of police standing in front of the clinics, because it doesn't make everyone feel safe, and even for populations who haven't had bad relationships with the police, it doesn't look great to have a bunch of police standing outside the clinic. You don't want to deliver a battle zone. —<i>Nonclinician</i></p>
Institutional policies (varies institution by institution, so summaries are examples)			
Gestational age	<ul style="list-style-type: none"> Clinics implemented earlier gestational limits (i.e., 12 weeks and 3 days) to account for in-person consent requirements. 	<ul style="list-style-type: none"> There are formal and informal policies to ensure alignment with state requirements. 	<p>If you're 12 weeks and 4 days at the time of your ultrasound, you have to be referred out [of state]. But that's not really a written policy; that's just how we have to do things. —<i>Clinician</i></p>

Table 1—Continued

Area	Law or Policy Summary	Implementation Experiences and Enforcement	Sample Quotes from Interviewees
Navigating exceptions and determining medical necessity	<ul style="list-style-type: none"> For more-complex cases, institutional policies may require at least two providers “sign off” before performing the procedure. Institutions attempted to define medical emergencies (e.g., anything causing significant morbidities in patients). 	<ul style="list-style-type: none"> There have been confusion and challenges with vague language, particularly around medical exceptions. There has been more reliance on “group” determinations. 	<p>I think our team sort of has parameters, and if there’s a patient who, if it’s for a maternal health indication, usually it’s the provider and the MFM [maternal fetal medicine specialist] that are making that decision together, so it’s usually two providers that are saying that it’s medically necessary. —<i>Clinician</i></p>
Sedation	<ul style="list-style-type: none"> A patient may be required to have someone give them a ride after a procedure if they elected certain types of sedation (e.g., conscious sedation). 	<ul style="list-style-type: none"> Some clinics allowed for taxis and rideshares, while others required someone to stay with the patient. Some clinics offered other sedation procedures, such as nitrous oxide. 	<p>Usually, we will try to make sure that it’s someone who’s coming with them, like a friend or family member or partner. . . . If that is not an option for the patient, we would typically set them up with a hotel and an Uber, so they can park their car at the clinic or park their car at the hotel, whatever is better. —<i>Nonclinician</i></p>

NOTE: This table includes language in bills or policy documents and does not reflect the preferred nomenclature regarding abortion (e.g., *medication abortion* as opposed to *medical abortion*) (see Upadhyay, Coplon, and Atrio, “Society of Family Planning Committee Statement”).

^a In the United States, the longest waiting period between consent and an abortion is 72 hours.

^b The procedural abortion consent form requires patients to sign or initial 21 times and clinicians to sign once. The medication abortion consent requires patients to sign or initial 25 times and the clinician to sign once.

^c This participant emphasized the South because the combination of a lack of abortion providers in the region and the lack of public transportation made it especially difficult to reach abortion clinics.

^d These requirements are specified in the administration code (10A NCAC 13S).

North Carolina Session Law 2023-134 provided \$6.25 million in recurring funds for the fiscal year to crisis pregnancy centers, nonmedical centers that attempt to discourage or prevent abortions and often are not regulated.¹⁹ Previously, North Carolina repealed the state abortion fund,²⁰ prohibited the use of state funds to be used to perform abortions (except in cases of rape, incest, or medical emergency),²¹ and established the use of funds for crisis pregnancy centers.²²

In addition to the above, Governor Roy Cooper issued an executive order in 2022 that provided specific protective actions for cabinet agencies or employees to take related to reproductive health services.²³ There are also pending bills in the 2023–2024 session, with some intending to provide more protections for abortion access and others seeking to further restrict access (see the appendix for more details on the executive order and other pending legislation).

Research Question 2. What Are the Potential Impacts of These Different Types of Policies?

Interview respondents shared various examples of the impact of laws and policies, most notably with changes instituted through S.B. 20’s implementation and stressed how they felt that these changes did not align with medical best practices or patient-centered care. Participants’ unique experiences were largely shaped by the facility or organization in which they provided abortion care or support; however, all participants suggested that S.B. 20 restricted abortion access and made it more challenging to provide care and support to individuals seeking abortion services. Below, we describe the impacts of such policies on facilities and operations, providers, and patients.

All participants suggested that S.B. 20 restricted abortion access and made it more challenging to provide care and support to individuals seeking abortion services.

Impacts on Facilities and Operations

All participants noted that facilities had to adapt their operations, personnel, and physical infrastructure to meet the requirements of S.B. 20, but each facility changed in slightly different ways. Some clinics reported increased costs because of the greater number of appointments, and some, particularly those clinics no longer seeing patients whose fetuses had significant fetal anomalies, observed that there was a patient makeup change. Given national clinician shortages, facilities, especially independent clinics, noted that they had to navigate these increased demands while also struggling to find enough providers to provide care:

Although we can provide care beyond 12 weeks, it's a functional ban [on abortions]. We were doing that [providing abortion care to people with fetal anomalies] regularly prior to S.B. 20, and now, even though there are folks out there who would have an "exception," it's really hard for them to find us, and the administrative work to achieve an abortion that's beyond 12,6 under the state requirements is oppressive. —*Clinician*

If a nurse calls out sick, or they're late, we literally can't check patients in, we can't bring them back, we can't start any of their intake, we can't take their blood pressure, we can't do Rh typing. Even if there's a physician in the clinic, we still cannot do it without a nurse [because of S.B. 20]. That is a huge, absolutely unnecessary barrier for people seeking care. If we had one person call out sick, we have to shut down care and we wouldn't be able to see patients. —*Nonclinician*

To manage the increased number of appointments based on the in-person consent requirements, some clinics found themselves reorganizing their patient waiting areas to improve the workflow of the clinic or setting aside specific days and times for consent visits:

We had to start a Friday clinic. We had to start mixing up how we add in medical abortions so that people can get in and be seen and have the 72-hour waiting period and still get their care in a timely way. That's been very disruptive and medically unnecessary. —*Clinician*

We had to create a whole bunch of capacity for the consent visits, and that actually meant eliminating some access, unfortunately, for actual abortion days because of that shifting. —*Clinician*

It's really pushed out the availability of our appointments because it's so much more resource intensive to do that in-person consent. —*Clinician*

The clearest example of infrastructure impact was for hospital-adjacent clinics that had to physically relocate to comply with provisions that required procedural abortions performed after 12 weeks under a medical exception to happen within a hospital or at a stand-alone clinic (i.e., facilities that were attached but not within a hospital were required to relocate to a clinic that was either within the hospital itself or completely separate). Independent and Planned Parenthood clinics also continued to experience challenges with their local health departments. For example, some participants reported policy enforcement by DHHS inspectors, which influenced abortion

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care provision; however, some facility representatives suggested that DHHS's enforcement did not always seem to be clearly tied to actual policy documents or language but rather inspectors' preferences and understandings. For example, one facility representative shared that a DHHS inspector noted that minors were required to bring their birth certificates to obtain abortion care, but the inspector could not provide any documentation of where this was required.²⁴ Another representative noted the importance of relationship building with DHHS inspectors and the need to ensure that inspectors understood differences between types of facilities (i.e., independent, Planned Parenthood, hospital based).

Interview participants also reported that administrators and legal staff at facilities were affected by S.B. 20 changes, noting that attention and time had shifted to interpreting the law and creating policies to ensure compliance, such as guidelines for determining medical emergencies. These tasks were seen as taking away time from already-busy individuals without providing any benefit to patients:

We have plenty of other issues to deal with—our hospital leadership team—to have to waste our time to think about ways to provide the same care to our patients just in different settings and acquiesce to a new law was just such a royal waste of time for so many people.
—*Clinician*

Impacts on Providers

As noted earlier, some participants remarked that their facilities needed to reorganize staffing to ensure

that a clinician was available for obtaining consent from patients. This led to some clinicians spending a significant amount of time on more-administrative tasks (e.g., reading and signing consent documents) and less time on direct patient care (e.g., performing abortions, administering sedation). This shift to having more-administrative functions, replacing time for the direct provision of patient care, was frustrating given how much the increased burden of going through the new consent forms was not seen as improving care:

The fact that it ties up a nurse to complete that 72-hour consent also means that in the sites where we offer higher levels of sedation, we have to minimize that, and we can only offer that to a certain number of patients, instead of anybody who needs or wants it. —*Clinician*

[Providers] don't get the same satisfaction they used to when they could just show up and care for patients. . . . Everyone is just working harder and running faster on the treadmill, and you have so much more to do just to provide the same care. —*Clinician*

Participants also described a feeling of anxiety about the consent forms. They were nervous about missing a signature, filling out the wrong form (e.g., filling out a consent form meant for procedural abortion for a patient who wanted a medication abortion), and misplacing or not filing the forms correctly. Although most facilities used nursing staff to help with these requirements, staff at independent clinics often struggled to find enough licensed clinicians to

fulfill this need. Further, the required consent forms contained inaccurate (e.g., the fetus might be born alive) or incomplete information (e.g., risks not correctly compared), which representatives reported needing to further supplement with information to correctly outline the abortion process. Changes to consent forms and processes, and the general increase in the number of appointments, left many providers feeling burned out, frustrated, and stressed, especially as they saw the requirements not affecting the procedure's safety:

I think just on a personal level for clinic staff, it's a lot of frustration. I don't think there's anything that feels worse than a patient coming in and they're one day over the limit.
—*Nonclinician*

The fact that you can't edit [the consent] and you can't fit it on fewer pages; you have to write the name of the doctor before the patient knows what day they're coming, and you have to photocopy it in real time. . . . It's so transparent that they're trying to make your life harder, to no benefit. —*Clinician*

Providers described feeling anxious about making determinations for medical exceptions. These concerns were somewhat alleviated by policies or procedures their clinics had established, including having multiple physicians sign off on a reason for a medical exception. Despite these established processes, providers and other participants suggested that it was the intent of the vague language of the law to make providers feel unsafe and fearful of providing medically necessary care:

One is to make sure that one doctor isn't singled out for making that decision but also to make sure there's a corroboration among two doctors that this is a threat to maternal health or life. —*Clinician*

Any time we have a patient now, even with a medical indication for abortion, before [S.B. 20] we wouldn't think twice about providing that service, but there's a lot of confusion now on what needs to be filled out, and how, and can we actually do this and is this legal. —*Clinician*

Participants noted the likely downstream impacts on future providers, suggesting that providers might not continue to practice because they are fearful of doing something wrong, that doctoral residents and fellows may no longer want to train in the state, and that clinicians looking for a job in abortion care may seek to practice in a less restrictive state. Some participants spoke to a need for health care systems to publicly commit to delivering legal and safe abortion care to ensure that providers who do not regularly offer this care felt comfortable doing so:

It's more that the onus is on the provider to make sure you're following all the rules. That has made a lot of providers less inclined to even wanting to provide this, especially if they're not super high volume and not as comfortable with those requirements as I am. They just don't want to even . . . mess with it because they're afraid they're going to do something wrong and going to be locked away.
—*Clinician*

It's been too much of a hurdle to try to figure out how to get [residents] more-advanced training. [Academic institutions] are doing it to the extent they can, but I do worry that it's not quite enough. I think there can be long-term consequences to that if people don't have the knowledge and skills. —*Clinician*

Impacts on Patients

Interview participants spoke to a variety of patient impacts based on state laws (particularly the implementation of S.B. 20), local laws, and institutional policies. Society of Family Planning data show that, in the 12 months prior to S.B. 20, there were on average 4,200 abortions per month in North Carolina, with 4,660 taking place in June 2023. In July 2023, with the implementation of S.B. 20, this number dropped to 3,130 abortions, although this number increased to 3,550 in December (the last date tracked in the report).²⁵ Participants particularly emphasized the disproportionate impact S.B. 20 had on individuals who were already marginalized, including low-income patients, immigrants, persons of color, adolescents, and rural patients:

Most respondents said that these law and policy changes did not affect the decision to have an abortion, just when and where.

People who just have very limited networks [would be most affected]. For me and a lot of people, you would be able to find someone who could drive you, or loan you \$100, or watch your kid for you, but some people literally do not have anyone to do that, and it can be really hard to find solutions in those cases. —*Clinician*

Rural people, people of low income, young folks, and immigrant communities, particularly if they are undocumented, they may not feel comfortable going to clinics and if they see police around. People of color typically are always overburdened by these restrictions as well. —*Nonclinician*

Certain laws and policies were viewed as particularly burdensome for patients. The 72-hour in-person consent requirement placed additional time and resource burdens on patients in terms of the amount of time patients would spend traveling for multiple appointments, time needed away from work (which could be unpaid), the need to find and pay for child care for those with other children, and so forth. Representatives pointed to a disproportionate impact of this provision on those who did not have an abortion facility in their area, were traveling to North Carolina from a state where abortion was banned, or were from a more rural area:

Ninety-one of our state's 100 counties don't have an abortion provider. Generally, you're traveling anyway, depending on where you are. Now, not only do you have to travel, you

have to travel and do this 72-hour wait period that has no clinical benefit. And to put a point on it, if I'm an hourly worker, and remember our minimum wage in NC is \$7.25 an hour, a day away from wages. . . . That is a crushing experience for someone who is on the margins. —*Nonclinician*

We see terrible situations. . . . There's a lot of military women in our area. Child care, jobs, people are often on the margins, on the cusp of being fired, and if they miss another day, they're not going to have a job. We see it all the time. —*Clinician*

Respondents also spoke to impacts on timelines for decisions around having an abortion. Most respondents said that these law and policy changes did not affect the decision to have an abortion, just when and where. Specifically, respondents reported seeing patients earlier in their pregnancies than they might otherwise have or patients choosing to seek an abortion out of state:

It's ironic to me that what has happened is that so many people are just coming so much earlier in their pregnancy now than they used to, so we are seeing some earlier gestational ages, but I think it's definitely a barrier for many people that aren't getting in to see us. —*Clinician*

Even in having the people I work with after, who come in after they've made their decision, that is the biggest topic. "I *had* to make this decision. I was running out of time. I didn't have any longer." —*Clinician*

Folks who need abortions have much less time from when they find out they're pregnant, especially people who need to leave home and arrange child care. —*Clinician*

In general, participants mentioned the amount of confusion and misinformation for patients when S.B. 20 was passed. Respondents said that the new consent requirements in S.B. 20 did not seem to improve this confusion, as the forms do not describe procedural or medication abortions in any real terms or incorporate places for the patient to ask questions. For instance, S.B. 20 prohibits abortions for fetuses

diagnosed with trisomy 21 (i.e., Down syndrome). Participants, especially those who practiced in hospital systems, reported that some individuals who had ultrasound results suggestive of a fetal anomaly would forgo genetic screening that may diagnosis a fetus with trisomy 21 or another genetic abnormality to ensure that they had an option to obtain an abortion in the state. Thus, this provision may further restrict the ability of patients to make fully informed decisions, as their decisions may be made on incomplete or nondiagnostic information:

I think there's some distrust or hesitation because they [the patients] don't know what they're allowed to say or if something will get them in trouble. I've seen that happen a handful of times since S.B. 20. —*Clinician*

At the same time, even though clinicians reported that getting care was more challenging for patients, they also talked about the systems implemented to ensure that individuals were still able to receive care. These systems included partnerships with other abortion facilities and funds in and out of the state, as well as the creation of new roles, such as patient navigators, to ultimately help patients make appointments and travel to receive timely care:

I guess necessity is the mother of all invention. . . . We've figured out some ways to help patients and create a system to make it a little bit better, and I guess that is something that needs to be understood. —*Clinician*

Limitations of the Study

This study focused on the experiences of clinicians and others actively involved in abortion provision and advocacy in North Carolina. We did not speak to individuals who were opposed to providing abortion care or were unwilling to provide abortion care for personal reasons. We did not contact all outpatient obstetrics-gynecology (OB-GYN) facilities and hospitals in the state, as the number ($N > 100$) and lack of direct contact information made it difficult to reach individuals who might be or might have been providing abortion care on a semiregular basis. Since the number of outpatient OB-GYN facilities and hospital-based clinics was large ($N > 100$) and many of these clinics did not have publicly available information for the providers, we did not contact or interview providers who provided abortion care on a semiregular basis or who might have provided abortion care prior to S.B. 20. These individuals might have experienced greater impacts than participants in our sample, including the possibility of institutional policies entirely restricting abortion care. We also did not attempt to interview providers outside North Carolina who may be offering medication abortion via telehealth services to North Carolina patients to better understand how S.B. 20 might have affected their ability to continue to provide their services.

Finally, we did not speak to individuals about their experiences seeking or receiving an abortion with these restrictions. Thus, our findings around patient impact are limited to perceptions among

Participants . . . reported that some individuals who had ultrasound results suggestive of a fetal anomaly would forgo genetic screening that may diagnosis a fetus with trisomy 21 or another genetic abnormality to ensure that they had an option to obtain an abortion in the state.

providers. It is possible that some individuals may appreciate the consent requirements (e.g., having more time to make a decision regarding their abortion) or other aspects of S.B. 20. However, given that our participants shared that patients did not change their minds after the consent process, and previous research on patients' experiences suggests that wait times and other restrictive policies make it more difficult to receive care,²⁶ we would expect that interviews with individuals who have sought or received abortion care to further highlight the impacts of these laws on restricting (rather than improving) abortion care access. Although we did not speak directly to patients, most of the participants we spoke with worked at high-volume clinics across the state. In addition, the data collected by the Society of Family Planning suggest that the prevalence of abortion in North Carolina has decreased since S.B. 20 was implemented.²⁷

Conclusions

S.B. 20 restricted abortion access in North Carolina. The bill was passed in 2023, a year after the governor's executive order that signaled specific protections for people in North Carolina around abortion care and in a state where the gestational limit to abortions was recently (i.e., from 2019 to 2022) the point of *viability* (a nonmedical term used to describe the point at which a fetus can survive outside the uterus, estimated to be 24–26 weeks).²⁸ These legal changes

Policies around consent were cited by all interview participants as creating new barriers to abortion access, particularly in-person consent.

created additional volatility around abortion access after the overturning of *Roe* and therefore the reliance on states to determine abortion access. In North Carolina specifically, our findings highlight that state-level restrictions may make it difficult for local governments to create policies that further restrict or expand access. Restrictive state policies may also influence institutional policies that prioritize legal requirements that can undermine patient needs or organizational objectives.

Policies around consent were cited by all interview participants as creating new barriers to abortion access, particularly in-person consent (as opposed to over the phone or through telehealth); these policies have come at a time when telehealth for other medical visits that do not require in-person examination have been on the rise. Further, clinician respondents viewed the consent process and forms required by S.B. 20 as creating additional hurdles for them and their patients and that the forms often contained misleading information that could hinder patients' ability to make fully informed decisions.

Facilities with supportive administrators, more personnel and financial resources, or practices not solely devoted to abortion care tended to report being able to adapt more easily to changing state laws than facilities with different circumstances. For example, representatives from independent clinics in our sample noted that they did not have the resources to maintain legal counsel on staff and often relied on a smaller number of providers (including nurses) for care, which could affect day-to-day operations (particularly with the new legal requirement for a registered nurse to always be in the clinic). At the same time, many independent clinics' purpose and physical construction were aimed at providing abortion care and therefore tended not to have to adapt their physical spaces, or they might have been able to rearrange schedules more easily to meet requirements.

The study also highlighted consequences of S.B. 20 on the larger North Carolina health care system. Participants in this study spoke to such impacts as staff (e.g., administrators, legal professionals, clinicians) reallocating time and effort to implement new requirements and more-taxing and more-stressful work environments for providing abortion care. Some also spoke to the potential impact of

The reported impacts on patients as articulated by providers, especially those patients already experiencing social, economic, and health disparities, were particularly concerning, both immediately and in the longer term.

state-level restrictions on education for residents and fellows (who may or may not provide abortion care in the future). In other words, S.B. 20 and other similarly restrictive policies may have long-term consequences on health care provider training, burnout, and availability.

Finally, the reported impacts on patients as articulated by providers, especially those patients already experiencing social, economic, and health disparities, were particularly concerning, both immediately and in the longer term. Before S.B. 20, individuals were already traveling within the state for abortion care; however, the 72-hour in-person consent requirement now means that many people who are seeking abor-

tion care are likely spending more time and resources traveling for this care.

This study of North Carolina highlighted some intricacies of laws and policies in the state and ways that abortion care access and delivery have changed as a result. Such state-by-state examinations can offer lessons learned for other jurisdictions as they evaluate policies and their intended impacts. This work is especially important in light of the frequently changing legislative landscape at the state level for abortion care post-*Dobbs*. As state policymakers and constituents consider proposed legislation, an understanding of the underlying provisions is critical to ensure a complete picture of implementation factors and potential impacts.

Appendix. Summary of North Carolina Abortion Laws and Pending Bills

On May 16, 2023, in the wake of *Dobbs v. Jackson Women’s Health Organization*, the North Carolina General Assembly enacted S.B. 20 (Session Law 2023-14), which significantly restricted abortion access in North Carolina. Most of the provisions of S.B. 20 took effect on July 1, 2023. This appendix presents summaries of key provisions of S.B. 20 (most notably the gestational limit of 12 weeks and 6 days and the 72-hour waiting period) and descriptions of how these provisions compare with pre-S.B. 20 abortion-related laws.

S.B. 20 made it unlawful for abortion to occur after the 12th week of pregnancy, except in cases of medical emergency, rape or incest, or when there is a life-limiting fetal anomaly.²⁹ This new law significantly reduced the gestational limit from after the 20th week to after the 12th week.³⁰ Historically, North Carolina had limited abortion to 20 weeks, except for a period between 2019 and 2022 in which a North Carolina federal judge enjoined a decision that allowed access to abortion up until the point of viability.³¹ Thus, the recent changes to the gestational limits have significantly altered the abortion landscape in North Carolina by restricting legal abortions to the first trimester.

Requirements for a Medical or Surgical Abortion in S.B. 20

In-Person Counseling and 72-Hour Consent

S.B. 20 amended a previous statute to require that the consent procedure happen in person rather than over the telephone or through mailed materials.³² The bill continues to require that the consent process happen 72 hours before the procedure, unless the procedure is being done as a result of a medical emergency. However, the in-person consent requirement also requires the consenting provider to verbally acknowledge the benefits available for prenatal care and childbirth, the father’s liability for child support, an attestation that the woman is not being forced to have an abortion, and that the woman has a private

Definitions of *abortion* according to S.B. 20

Medical abortion: “[t]he use of any medicine, drug, or other substance intentionally to terminate the pregnancy”

Surgical abortion: “[t]he use or prescription of any instrument or device intentionally to terminate the pregnancy”

The following are not defined as an abortion under S.B. 20: (1) increasing probability of live birth; (2) preserving the life or health of the child; (3) removing a dead, unborn child who died as a result of natural causes in utero, accidental trauma, or a criminal assault that causes premature termination of the pregnancy; and (4) removing an ectopic pregnancy.

right of action to sue the physician under state law if she feels that she has been coerced or misled prior to obtaining an abortion. Medical abortions require slightly different information to be conveyed (including information about the possibility of seeing fetal remains during the process) and the location of a hospital within 30 miles of the procedure where the performing physician has clinical privileges, and there is a requirement that an additional appointment be made seven to 14 days after the provision of medication. Physicians must sign the declaration form confirming that they have explained the procedure, provided all the information required in the statute, and answered all of the woman’s questions.

Limitations

Sex selection continues to be prohibited under S.B. 20.³³ The law also makes it illegal to perform or attempt to perform an abortion if the person “has knowledge” that the woman is seeking an abortion because of the (1) actual or presumed race or racial makeup of the fetus or (2) the presence or presumed presence of Down syndrome.

Other Requirements

For medical abortions, in addition to the consent requirements and gestational limits, a physician must verify that the pregnancy exists and determine the

Definition of *medical emergency* according to S.B. 20

A condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including any psychological or emotional conditions. For purposes of this definition, no condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function.

woman's blood type.³⁴ Currently, the requirement that the physician document the probable gestational age and existence of an intrauterine pregnancy before the administration of an abortion drug has been enjoined by a federal judge.³⁵ Another provision that has not gone into effect because of a preliminary injunction is the requirement that surgical abortions that happen after the 12th week of pregnancy because of an exception (e.g., rape or incest, fetal anomaly) happen within a hospital rather than an outpatient facility.³⁶ Medical abortions must also happen in the presence of the prescribing physician, as patient provision and telemedicine for abortion-inducing drugs have been banned since 2013.³⁷

There is also a "born alive" provision that penalizes health care providers who fail to provide care for an infant who is born alive from an abortion attempt.³⁸

Violations

Physicians and pharmacists found in violation of S.B. 20 are subject to discipline from their licensing agency or board. The current law also makes it a felony to provide an abortion that does not fit within the exceptions to the ban after 12 weeks and 6 days.³⁹ S.B. 20 also broadened the ability to seek damages in cases of wrongful death to representatives of the abortion-seeking individuals (beyond the fathers).⁴⁰

Facility, Licensure, and Reporting Requirements

The following is required to be reported to DHHS: the method used to determine gestational age and the results of said method, including measurements and ultrasounds, and statistical summary reports concerning the medical and demographic characteristics of abortions provided after the 12th week from hospitals, ambulatory surgical facilities, or licensed clinics.⁴¹ Physicians are also required to sign a report that contains information about the woman, including her county, state, and country of residence; age; race; number of live births; number of previous pregnancies; number of previous abortions; and preexisting conditions.⁴² Reporting requirements also include information about adverse events, including the facility and the physician responsible for the abortion.

Facilities are required to be inspected annually by DHHS, and reports of the findings are required to be published on the state website.⁴³ Clinics are also required to have a transfer agreement with a hospital and established provisions for emergency intervention (e.g., maintaining airway support, using an automated external defibrillator) in case of complications.⁴⁴ New clinics are subject to specific building code requirements that include elevators that are large enough to accommodate a stretcher,⁴⁵ as well as a station that allows for serving meals and snacks.⁴⁶

Funding for Crisis Pregnancy Centers

Session Law 2023-134 provides \$6.25 million in recurring funds for the 2023–2024 fiscal year to crisis pregnancy centers through the Carolina Pregnancy Care Fellowship.⁴⁷ The bill also prohibits the use of state funds for the provision of family planning services, pregnancy-prevention activities, or adolescent parenting programs for providers who also provide abortion care.⁴⁸ Previously, North Carolina had repealed the state abortion fund,⁴⁹ prohibited the use of state funds to be used to perform abortions (except in cases of rape, incest, or medical emergency),⁵⁰ and established the use of funds for crisis pregnancy centers.⁵¹

Supports for Abortion

Along with vetoing S.B. 20 and refusing to sign House Bill 259,⁵² Governor Cooper issued an executive order in 2022 that provides the following:

- protection of people or entities seeking reproductive health care in North Carolina
- prohibition of state employees and representatives from cooperating with out-of-state investigations and legal action related to reproductive health care
- a commitment to declining requests for the extraction of individuals charged in violation of receiving reproductive health care services that are lawful in North Carolina
- the ability of cabinet employees to refuse to travel to states that have limited reproductive health care services
- protection for access to and egress from health care facilities involved in abortion provision.⁵³

North Carolina Bills Pending (2023–2024 Session)

Some North Carolina bills pending in the 2023–2024 session seek to increase access to abortion and protect individuals seeking abortion. The RBG Act (House Bill 439/Senate Bill 353) would amend North Carolina law to permit abortion until viability,

permit postviability abortions for medical emergencies, authorize advanced practice clinicians (e.g., nurse practitioners, physicians’ assistants, and certified nurse midwives) to provide abortions, eliminate special parental consent for minors seeking abortions, and repeal insurance and funding restrictions on abortion coverage in various health plans in North Carolina.⁵⁴ House Bill 740 would prohibit “an entity or person” (e.g., crisis pregnancy centers) from advertising that the “person or entity” provides or offers referrals to abortions or emergency contraceptives when the person or entity does not provide those services or referrals.⁵⁵

Other bills pending in the 2023–2024 session seek to add further restrictions to abortion care. The Human Life Protection Act of 2023 (House Bill 533) would ban all abortions, starting from conception, with one exception for cases in which the pregnant person’s life or health is at risk.⁵⁶ The Second Chances Act (House Bill 788) would require providers to inform an individual seeking a medical abortion that medical abortions can be reversed if the individual changes their mind before the drug regimen is complete.⁵⁷ The Medical Ethics Defense (MED) Act (House Bill 819/Senate Bill 641) would require that health care providers give written consent before they may be “scheduled for, assigned, or requested to directly or indirectly perform, facilitate, refer for, or participate in an abortion.”⁵⁸

Notes

¹ *Roe v. Wade*, 410 U.S. 113 (1973).

² *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022).

³ Crookston, "Navigating TRAP Laws, Protesters, and Police Presence at a Midwestern Abortion Clinic in the United States."

⁴ Guttmacher Institute, "US States Have Enacted 1,381 Abortion Restrictions Since *Roe v. Wade* Was Decided in 1973." *Gestational limits* refers to the duration an individual can be pregnant before receiving an abortion (Guttmacher Institute, "State Bans on Abortion Throughout Pregnancy"). *Medication abortion* refers to an abortion using medication, including mifepristone and misoprostol together and misoprostol alone, regardless of the setting, context, gestational duration, or legal status (Upadhyay, Coplon, and Atrio, "Society of Family Planning Committee Statement"). *Procedural abortion* refers to an abortion primarily performed with instrumentation and includes (manual or electric) uterine aspiration, dilation and curettage (D&C), dilation and evacuation (D&E), or dilation and extraction (Upadhyay, Coplon, and Atrio, "Society of Family Planning Committee Statement").

⁵ Guttmacher Institute, "State Bans on Abortion Throughout Pregnancy"; Society of Family Planning, #WeCount Report.

⁶ National Conference of State Legislatures, "State Abortion Laws."

⁷ Heymann et al., "Unlimited Discretion."

⁸ Matusek, "How Blue—and Red—Cities Are Resisting State Abortion Laws"; Nichols, "These Texas DAs Will Refuse to Prosecute Women If *Roe* Is Overturned."

⁹ Czarnecki et al., "State of Confusion."

¹⁰ Zeldovich et al., "Abortion Policies in U.S. Teaching Hospitals"; Czarnecki et al., "State of Confusion."

¹¹ Stulberg, Jackson, and Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities."

¹² Dayal McCluskey, "Mass. Enacted Strong Abortion Protections."

¹³ North Carolina Senate, Care for Women, Children, and Families Act; North Carolina General Assembly, Session Law 2023-14.

¹⁴ AbortionFinder, homepage; North Carolina Division of Health Service Regulation, "Reports of Surveys for Abortion Clinics."

¹⁵ N.C. Gen. Stat. § 90-21.82A(c).

¹⁶ North Carolina General Assembly, Session Law 1973-711; *Bryant v. Woodall*, 363 F.Supp.3d 611 (M.D.N.C. 2019).

¹⁷ See N.C. Gen. Stat. § 90-21.82, prior to S.B. 20 amendments; N.C. Gen. Stat. § 14-45.1, which was repealed by S.B. 20.

¹⁸ Yadkin County Board of Commissioners, Resolution of the Yadkin County Board of Commissioners, Declaring the County of Yadkin, North Carolina to Be a Sanctuary for Life and Urging the Citizens of the County of Yadkin to Promote and Defend the Inalienable Right to Life and the Inherent Dignity of All Human Beings, Including the Pre-Born, from Conception or Fertilization Through All Stages of Development.

¹⁹ American College of Obstetricians and Gynecologists, "Issue Brief."

²⁰ North Carolina General Assembly, Session Law 2006-203; N.C. Gen. Stat. §§ 143-16.6 to 143-23 (repealed).

²¹ North Carolina General Assembly, Session Law 2011-145.

²² See North Carolina General Assembly, Session Law 2013-360.

²³ Cooper, "Protecting Access to Reproductive Health Care Services in North Carolina." The executive order provided the following:

- Cabinet agencies will coordinate to protect people or entities providing or seeking reproductive health care services in North Carolina.
- No representatives or employees of the governor's office and cabinet agencies may cooperate with out-of-state legal actions relating to reproductive health care services that are legal in North Carolina.
- The governor will decline requests for extradition of any person charged with a criminal violation in another state where the violation arises out of the provision or receipt of reproductive health care services that are lawful in North Carolina.
- Cabinet employees who are pregnant shall not be required to travel to states that have limited reproductive health care services.
- The North Carolina Department of Public Safety will "work with law enforcement agencies and reproductive health care services facilities to ensure the enforcement of N.C. Gen. Stat. § 14-277.4, which protects access to and egress from health care facilities" (§ 6).

²⁴ Although there are provisions that affect minors seeking an abortion, these provisions do not include bringing a birth certificate to a clinic.

²⁵ Society of Family Planning, #WeCount Report.

- ²⁶ See, e.g., Carpenter et al., “Seeking Abortion Care in Ohio and Texas During the COVID-19 Pandemic.”
- ²⁷ Society of Family Planning, *#WeCount Report*.
- ²⁸ See Guttmacher Institute, “State Bans on Abortion Throughout Pregnancy.”
- ²⁹ N.C. Gen. Stat. § 90-21.81A.
- ³⁰ North Carolina General Assembly, Session Law 1973-711; N.C. Gen. Stat. § 90-21.81A.
- ³¹ *Bryant v. Woodall*, 1:16CV1368, 2022 Order.
- ³² N.C. Gen. Stat. § 90-21.82.
- ³³ N.C. Gen. Stat. § 90-21.121.
- ³⁴ N.C. Gen. Stat. § 90-21.83B.
- ³⁵ September 30, 2023, order granting preliminary injunction in *Planned Parenthood S. Atl. v. Stein*, No. 1:23-CV-480 (M.D.N.C. 2023) (litigation is ongoing as of the time of this writing in May 2024).
- ³⁶ September 30, 2023, order granting preliminary injunction in *Planned Parenthood S. Atl. v. Stein*, No. 1:23-CV-480 (M.D.N.C. 2023).
- ³⁷ North Carolina General Assembly, Session Law 2013-366, enacting N.C. Gen. Stat. § 90-21.82(1)(a): “the physician prescribing, dispensing, or otherwise providing any drug or chemical for the purpose of inducing an abortion shall be physically present in the same room as the patient when the first drug or chemical is administered to the patient.”
- ³⁸ N.C. Gen. Stat., Chapter 90, Article 1M.
- ³⁹ N.C. Gen. Stat. §§ 14-44, 14-45, 90-21.81A, 90-21.81B.
- ⁴⁰ S.B. 20 amended N.C. Gen. Stat. § 90-21.88 to allow the personal representative of any person on whom an abortion is performed, in cases of wrongful death, to seek damages against the person who performed the abortion.
- ⁴¹ N.C. Gen. Stat. § 90-21.81C.
- ⁴² N.C. Gen. Stat. § 90-21.9.
- ⁴³ N.C. Gen. Stat. § 90-21.81C.
- ⁴⁴ 10A NCAC.
- ⁴⁵ 10A NCAC 13S .0209.
- ⁴⁶ 10A NCAC 13S .0207.
- ⁴⁷ North Carolina General Assembly, Session Law 2023-134.
- ⁴⁸ N.C. Gen. Stat. § 143C-6-5.5.
- ⁴⁹ North Carolina General Assembly, Session Law 2006-203; see N.C. Gen. Stat. §§ 143-16.6 to 143-23.
- ⁵⁰ North Carolina General Assembly, Session Law 2011-145.
- ⁵¹ North Carolina General Assembly, Session Law 2013-360.
- ⁵² North Carolina House of Representatives, 2023 Appropriations Act.
- ⁵³ Cooper, “Protecting Access to Reproductive Health Care Services in North Carolina.”
- ⁵⁴ North Carolina House of Representatives, RBG Act; North Carolina Senate, RBG Act.
- ⁵⁵ North Carolina House of Representatives, Unfair/Deceptive Healthcare Advertising.
- ⁵⁶ North Carolina House of Representatives, Human Life Protection Act of 2023.
- ⁵⁷ North Carolina House of Representatives, The Second Chances Act.
- ⁵⁸ North Carolina House of Representatives, The Medical Ethics Defense (MED) Act; North Carolina Senate, The Medical Ethics Defense (MED) Act.

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About This Report

This report presents findings from a qualitative study examining policies in North Carolina that may further restrict abortion access beyond the state's current gestational limit of 12 weeks and 6 days. Specifically, the authors detail current laws and policies, how these policies are implemented in North Carolina across a variety of abortion provider types, and the reported impacts of these types of policies on abortion access and care in North Carolina.

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