ABORTION IN NC

March 2022

NORTH CAROLINA
Right To Life
WWW.NCRTL.ORG

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Definitions[1]

Abortion This report includes non-spontaneous abortions that are reported to the North Carolina State Center for Health Statistics. The NC State Center for Health Statistics define abortion as "the premature termination of a pregnancy, resulting in or caused by death of the fetus or embryo." It does not include stillbirths, nor miscarriages.

Abortion Occurrence Abortions that occurred in a given area.

Education of Mother Level of schooling completed by the mother at time of the birth.

Gestation Age of unborn child determined by the last Menstrual Period of the mother.

Married Mother who is legally married or is separated but not legally divorced.

Previous Number of Abortions "The number of previous induced abortions [of] the abortee... The current procedure is not included."

Resident Abortion Abortions of unborn children that would have resided in a given area. "College students and military personnel are considered residents of the college or military community. For deaths of inmates of long-term institutions, the institution is considered the residence if the [descendant] has lived there at least one year. For births, residence is that of the mother, regardless of the place of occurrence."

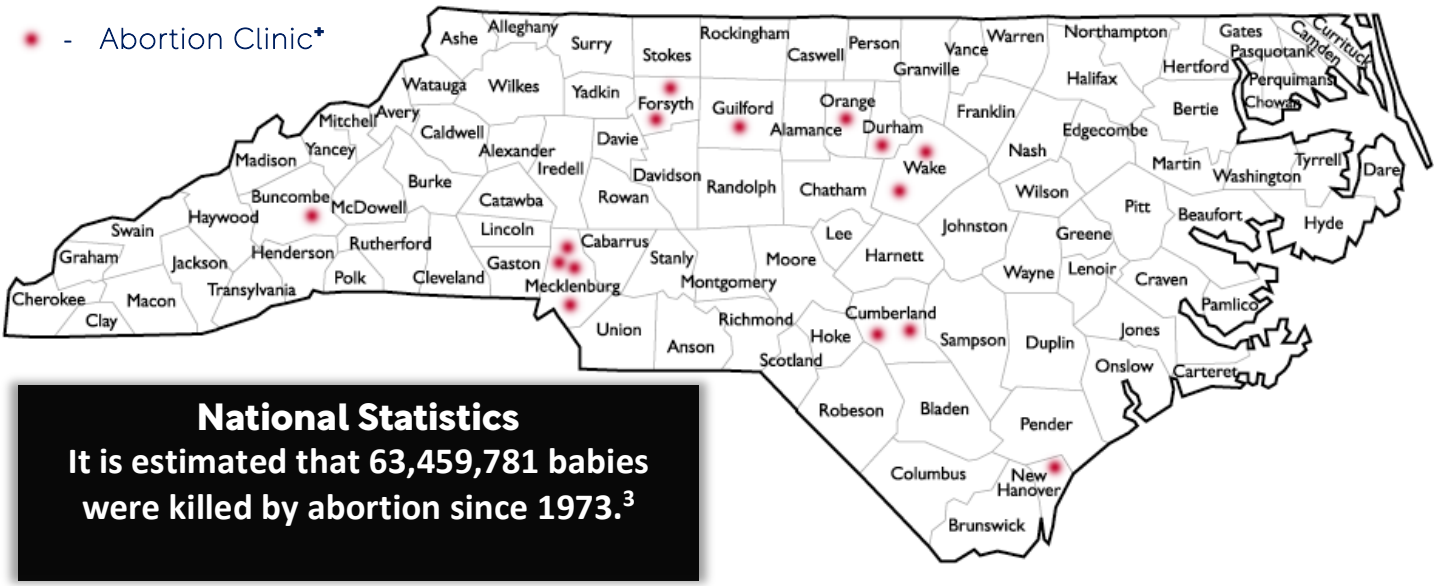
Spontaneous Abortion "An interruption of pregnancy for some reason other than human choice, i.e., a miscarriage or stillbirth."

[1] **"**Glossary of Terms.**"** N.C. Department of Health and Human Services. Available at https://schs.dph.ncdhhs.gov/data/glossary.htm

Incidence of Abortion

In North Carolina…

30,004 abortions occurred within the state in 2020 (Occurrence Abortions).[2] That is about 83 NC abortions per day on average in 2020. 25,058 abortions were reported performed on women with known addresses in NC (Resident Abortions).[2] The number of abortions occurring in NC increased from the previous year.



National Statistics
It is estimated that 63,459,781 babies were killed by abortion since 1973.[3]

Where do North Carolina's Abortions Occur?

Although most abortions occurred in 9 counties in 2020, all counties have resident abortions. This means that mothers are traveling out of counties without an abortion clinic to counties that have abortion clinics. Mecklenburg County had the highest total number of reported abortions with 11,098 occurring in 2020. The table below indicates the six counties with the most abortions in 2020.[2]

North Carolina Counties with Highest Occurrences of Reported Abortion in 2020[2]

County	Mecklenburg	Wake	Orange	Cumberland	Guilford	Forsyth
Total Occurrence Abortions	**11,098**	**6,752**	**2,499**	**2,911**	**2,800**	**1,517**

[2] 2020 North Carolina Reported Induced Abortions by County of Occurrence and Residence. pg.1. Reported Pregnancies. North Carolina State Center for Health Statistics NC Department of Health and Human Services. https://schs.dph.ncdhhs.gov/data/vital/pregnancies/2020/reportedabortionscounty.pdf

[3] "State of Abortion in the United States". National Right to Life Committee. Available at http://www.nrlc.org/uploads/communications/stateofabortion2022.pdf

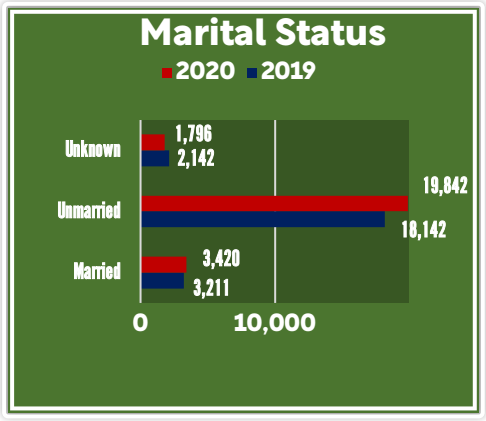
+ Location is accurate in county location only and not exact latitude & longitude coordinates

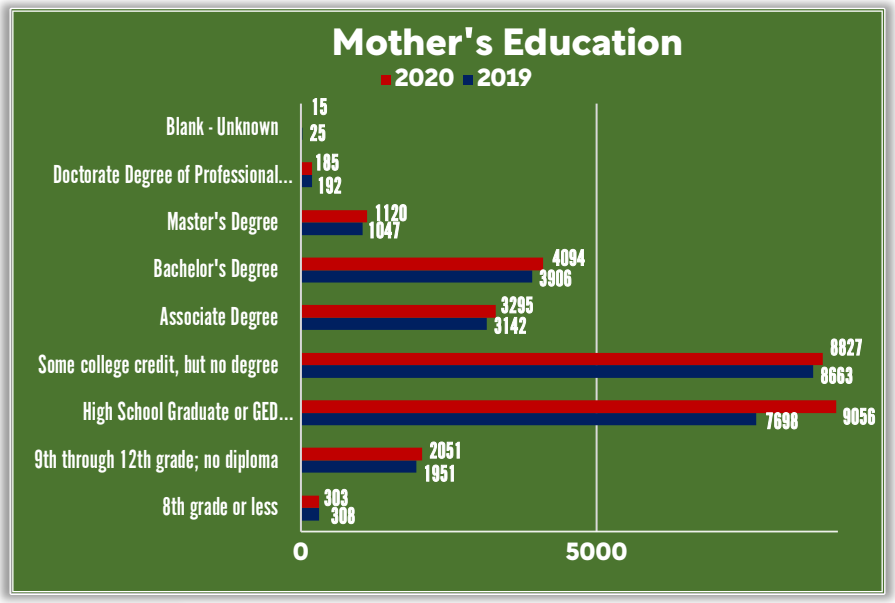
	Reported Abortion Occurrences (Change from 2019)	Reported Resident Abortions
Alamance	0	422
Alexander	0	28
Alleghany	0	7
Anson	0	64
Ashe	0	9
Avery	0	17
Beaufort	0	52
Bertie	0	39
Bladen	0	62
Brunswick	0	134
Buncombe	(+238) 817	449
Burke	0	69
Cabarrus	0	447
Caldwell	0	75
Camden	0	6
Carteret	0	77
Caswell	0	21
Catawba	0	209
Chatham	0	75
Cherokee	0	15
Chowan	0	15
Clay	0	4
Cleveland	0	164
Columbus	0	71
Craven	0	186
Cumberland	(+250) 2911	1,475
Currituck	0	28
Dare	0	28
Davidson	0	191
Davie	0	41
Duplin	0	96
Durham	(-99) 907	1,046
Edgecombe	0	157
Forsyth	(+273) 1517	1,083
Franklin	0	141
Gaston	0	478
Gates	0	8
Graham	0	3
Granville	0	123
Greene	0	41
Guilford	(+250) 2800	2,023
Halifax	0	170
Harnett	0	270
Haywood	0	42
Henderson	0	91
Hertford	0	33
Hoke	0	128
Hyde	0	1
Iredell	0	274
Jackson	0	34
Johnston	0	411
Jones	0	18
Lee	0	125
Lenoir	0	133
Lincoln	0	83
McDowell	0	29
Macon	0	27
Madison	0	17
Martin	0	32
Mecklenburg	(+244) 11,098	4,569
Mitchell	0	3
Montgomery	0	37
Moore	0	158
Nash	0	287
New Hanover	(+172) 703	582
Northampton	0	41
Onslow	0	530
Orange	(+341) 2499	253
Pamlico	0	14
Pasquotank	0	55
Pender	0	67
Perquimans	0	13
Person	0	91
Pitt	0	493
Polk	0	14
Randolph	0	176
Richmond	0	97
Robeson	0	268
Rockingham	0	132
Rowan	0	277
Rutherford	0	108
Sampson	0	111
Scotland	0	58
Stanly	0	65
Stokes	0	44
Surry	0	71
Swain	0	16
Transylvania	0	24
Tyrrell	0	4
Union	0	310
Vance	0	142
Wake	(-115) 6,752	3,313
Warren	0	39
Washington	0	18
Watauga	0	50
Wayne	0	304
Wilkes	0	61
Wilson	0	249
Yadkin	0	38
Yancey	0	13
Unknown	0	266

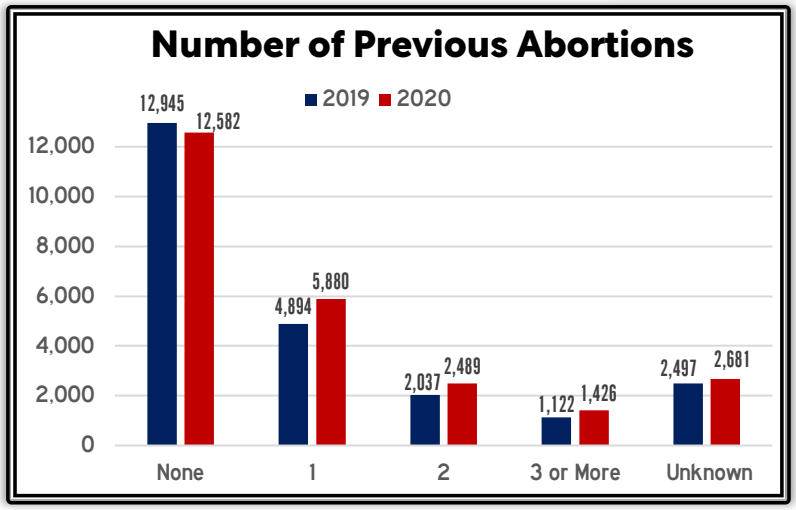
[2] 2020 North Carolina Reported Induced Abortions by County of Occurrence and Residence. pg.1. Reported Pregnancies. North Carolina State Center for Health Statistics NC Department of Health and Human Services. https://schs.dph.ncdhhs.gov/data/vital/pregnancies/2020/reportedabortionscounty.pdf

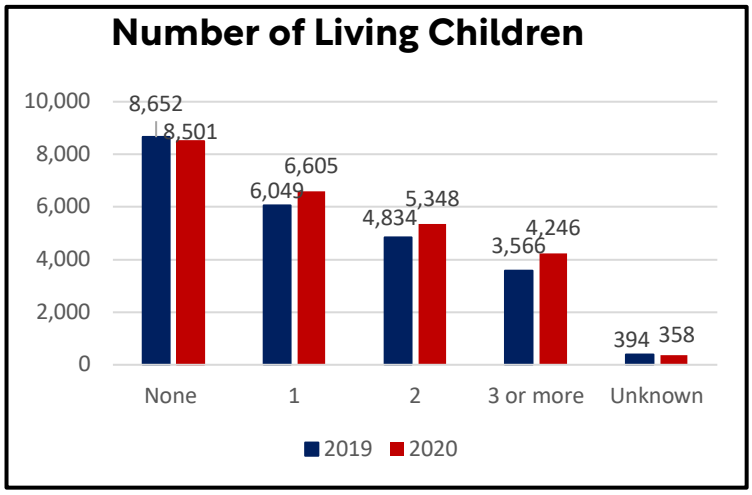
Who has Abortions? [4]

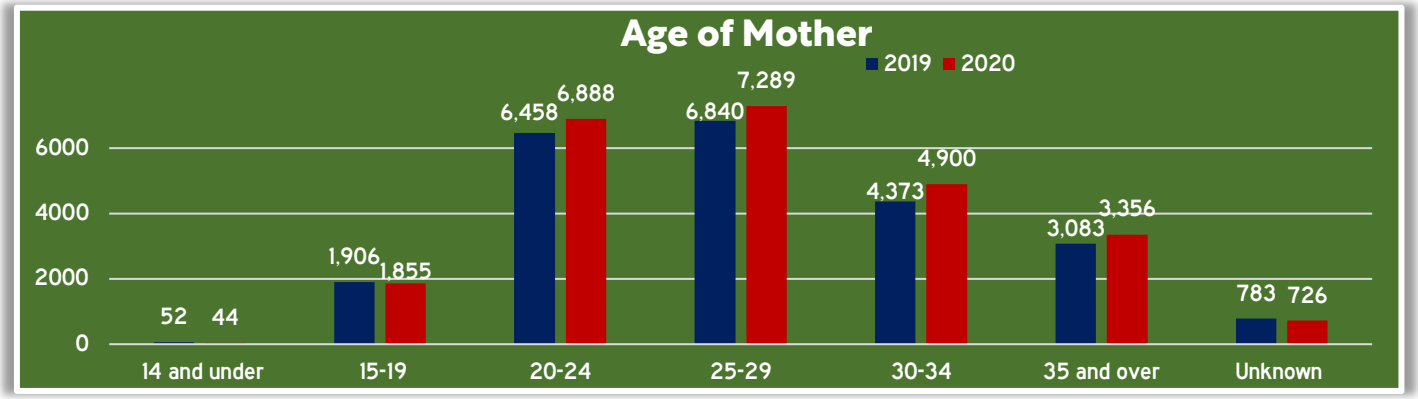
These graphs show characteristics of the reported resident abortions from 2019 & 2020. [4]











[4] "NC RESIDENT ABORTIONS: CHARACTERISTICS OF WOMEN RECEIVING ABORTIONS NORTH CAROLINA RESIDENTS, 2011 - 2020*"., NC State Center for Health Statistics., Division of Public Health, NC Department of Health and Human Services.
https://schs.dph.ncdhhs.gov/data/vital/pregnancies/2020/abortioncharacteristics.pdf

Abortion Methods

The method of abortion depends in part upon the age of the unborn child. The number of total abortions performed at various weeks of gestation is provided, in the chart on the right.[4]

Nonsurgical (called "Medical" by state) Abortions are more accurately called chemical abortions by pro-lifers because the chemicals used by the mother kill the unborn child. According to the NC State Center for Health Statistics, "Medications (e.g., methotrexate, mifepristone/RU 486, misoprostol) are used most frequently early in the first trimester of pregnancy. However, some medications (e.g., prostaglandin suppositories, injectable prostaglandins) may also be administered during the second trimester of pregnancy to induce abortion."[1] Chemical abortions involves administering drugs orally, intravenously, or intravaginally. Solely nonsurgical abortions typically take place within the earlier trimesters.[1]

Dilation and Curettage (D&C) procedure involves dilating a woman's cervix, and removing the unborn child using suction and scraping. [1]This is the most common surgical procedure, typically done during the first trimester.

During the Dilation and Evacuation (D&E) procedure, an abortionist dilates a woman's cervix and inserts sharp instruments, as well as suction devices and forceps, which are then used to cut up and extract her unborn baby, piece by piece.[1]

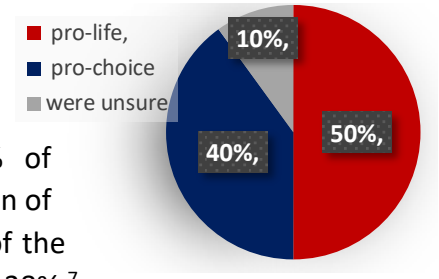
Other surgical and chemical abortion methods were also used. There also were 1672 unknown abortion types done in 2019 and 1167 in 2020 .[5]

Weeks of Gestation	2019	2020
8 and Under	15,453	17,371
9-12 Weeks	4,762	4,682
13-15 Weeks	1,215	1,113
16-20 (In-State)	732	668
16-20 (Out-of-State)	37	12
21+ (In-State)	8	30
21+ (Out-of-State)	36	18
Unknown	1,252	1,164

Abortion Procedure Protocols	2019	2020
D&C/D&E	870	903
D&C/Hys.	3	3
D&C/Other Surg.	2	5
D&C/Mifepristone	23	26
D&C/Misoprostol	7	0
D&C/Other Medication	2	0
D&C / Intrauterine Installation	1	0
D&C (Dilation and Curettage)	8,504	5,660
D&E/Hys.	6	6
D&E/Other	5	8
D&E/Mifepristone	24	32
D&E/Misoprostol	4	15
D&E/Methotrexate	2	1
D&E/ Other Medication	0	1
D&E (Dilation and Evacuation)	4,872	4,957
Hysterotomy/Hysterectomy	6	2
Other Surg./ Mifepristone	0	2
Other Surg./Other Medication	1	0
Other Surgical Procedure	6	11
Mifepristone/Misoprostol	10,921	15,671
Mifepristone/ Methotrexate	49	75
Mifepristone/ Other Medication	0	2
Mifepristone/ Intrauterine Installation	1	0
Mifepristone (RU-486 or Mifeprex)	1,373	1,182
Misoprostol/ Methotrexate	4	21
Misoprostol (Cytotec or another prostaglandin)	87	251
Methotrexate (MTX, Amethopterin)	1	0
Other Medication	4	2
Intrauterine Installation	0	1
Unknown/Unknown	1,672	1,167

[5] Re: [[External] Re: Request: 2020 Abortion Statistics [E-mail to the author]., (03-21-22)., NC Department of Health and Human Services.,

Polling on Abortion



A March 2019 Civitas/Harper Poll surveyed likely voters in North Carolina and found an estimated 50% identify as pro-life, while 40% of respondents said they're pro-choice and 10% were unsure (with a 4.38 margin of error). [6] The pro-life group was larger than any current statewide percent of the registered Democratic-33.23%- Republican-30.63%- or Unaffiliated voters-33.38%.[7]

The pro-life identity should not be assumed to be represented in just the Republican Party. The Civitas/Harper Poll also found that 24.22% of registered Democrats identified as pro-life. 48.23% of registered Unaffiliated voters identified as pro-life. This was in comparison to the 33.65% registered Unaffiliated voters that identified as pro-choice. [7]

The pro-life identity should not be assumed to relate to just one racial group. The Civitas/Harper Poll had 39.79% African Americans identified as pro-life. 55.17% Whites identified as pro-life in this poll. 30.81% of any other race or ethnicity identified as pro-life.[8]

There was also a similar representation of those who wanted certain pro-life bills to be passed. The Civitas/Harper Poll asked, "A bill has been proposed in the North Carolina General Assembly to prohibit an abortion from being performed after 13 weeks of pregnancy unless there is a medical emergency. In general, do you favor or oppose this bill?" Of those who responded, 50% either "strongly favor[ed]" or "somewhat favor[ed]" the legislation and 37% either "strongly oppose[d]" or "somewhat oppose[d]" this legislation.[8]

Q. A bill has been proposed in the North Carolina General Assembly to prohibit an abortion from being performed after 13 weeks of pregnancy unless there is a medical emergency. In general, do you favor or oppose this bill?	
Strongly Favor 33%	Strongly Oppose 27%
Somewhat Favor 17%	Somewhat Oppose 10%
Unsure/Refused 12%	
Total Favor 50%	Total Oppose 37%

Each poll show support for legislation protecting unborn children as well as indicate the many hearts and minds that need swaying on the abortion issue. The power of education is important. That is why we prepare these reports and do so much more through the North Carolina Right to Life Education Fund. Our chapters are across the state educating on the grassroots level. We sponsor and coordinate informational booths, hold presentations, organize youth camps, hold rallies, and are available to do additional educational work at our state headquarters.

6. Byers, Leah. Extreme pro-Abortion Voices in North Carolina Loud, but Few. 3 June 2019, www.nccivitas.org/civitas-review/extreme-pro-abortion-voices-north-carolina-loud/.

7. North Carolina State Board of Elections. Voter Registration Statistics. 20 Feb. 2021, vt.ncsbe.gov/RegStat/Results/?date=02%2F20%2F2021.

8. Harper Polling/Civitas. Crosstabs: Half of North Carolinians Are Pro-Life. 6 Mar. 2019, 1ttd918ylvt17775r1u6ng1adc-wpengine.netdna-ssl.com/wp-content/uploads/2019/03/AbortionQs.2_xtabs_3.19poll.pdf.

Federal Policy on Abortion

The following is a summary of NRLC's "Federal Policy and Abortion: A Synopsis." Read the Full Version at nrlc.org/uploads/communications/stateofabortion2022.pdf

In the United States, the basic legal framework governing the legality of abortion and the legal status of unborn human beings has been "federalized" primarily by decisions of the United States Supreme Court, rather than by acts of Congress. There have been many proposals in Congress since the Roe v. Wade & Doe v. Bolton rulings to overtly challenge or overturn this doctrine by statute or constitutional amendment, or conversely to ratify and reinforce it by federal statute, but neither approach has ever been enacted into law. That doesn't mean that Congress hasn't played an important role in shaping abortion-related public policies.

President Biden's Food and Drug Administration (FDA) suspended protections established for women undergoing chemical abortions, such as seeing the abortionist in person. The in- person requirement ensured that complications, such as an ectopic pregnancy, are ruled out in advance of a woman undergoing a chemical abortion. Mifepristone, the "abortion pill," has no effect on an ectopic pregnancy and leaves the woman with this life- threatening medical condition.

Congress has enacted laws that have impacted the number of abortions performed. Additionally, the U.S. Senate has played and will continue to play a pivotal if indirect role in determining abortion policy, through confirmation or rejection of nominees to the U.S. Supreme Court and the circuit courts of appeals.

Abortion advocacy groups have often campaigned for enactment of federal "abortion rights" statutes (like the "Women's Health Protection Act" and the "Freedom of Choice Act"), which have had endorsements from presidents Clinton and Obama, but have never been able to move through Congress.

On February 28, 2022, the so-called "*Women's Health Protection Act*" (S.R. 1975) failed to continue passage in the U.S. Senate. The U.S. House counterpart (H.R. 3755) passed the House with 218 "Yays" and 211 "Nays" in September 24, 2021. If enacted, this legislation could be used as a powerful tool to challenge any and all state abortion protections for the unborn.

Judicial Federalization of Abortion Policy

Until the 1960s, unborn children were protected from abortion by laws enacted by legislatures in every state. Some states weakened those protections, beginning with Colorado in 1967. During that era, the modern pro-life movement formed to defend state pro-life laws, and the pro-life side had turned the tide in many states when the U.S. Supreme Court in effect "federalized" abortion policy in its January 1973 rulings in *Roe v. Wade* and *Doe v. Bolton*. Those rulings effectively prohibited states from placing any value at all on the lives of unborn children, in the abortion context, until the point that a baby could survive independently of the mother ("viability"). Moreover, these original rulings even effectively negated state authority to protect unborn children after "viability." As *Los Angeles Times* Supreme Court reporter David Savage wrote in a 2005 retrospective on the case:

" [Supreme Court Justice] Blackmun wrote, doctors may consider 'all factors – physical, emotional, psychological, familial and the woman's age – relevant to the well- being of the patient.' It soon became clear that if a patient's 'emotional well-being' was reason enough to justify an abortion, then any abortion could be justified."

(See "*Roe* Ruling More Than Its Author Intended," *Los Angeles Times*, Sept. 14, 2005, nrlc.org/communications/resources/savagelatimes091405)

A majority of Supreme Court justices enforced the Roe & Doe doctrine aggressively for many years after its ruling, striking down even attempts by some states to discourage abortions after "viability." The Court eventually stepped back somewhat from this approach, tolerating some types of state protection of unborn children, while continuing to deny legislative bodies the right to place "undue burdens" on abortion prior to "viability." In *Gonzales v. Carhart* (2007), a five-justice majority upheld the federal Partial-Birth Abortion Ban Act, which placed a prohibition on use of a specific abortion method either before or after "viability."

The Supreme Court declared a portion of Texas' laws requiring abortion clinics to meet surgical center standards, requiring abortionists to have admitting privileges at a hospital within 30 miles in the 2016 Whole Women's Health v. Hellerstedt ruling unconstitutional. The majority ruled that these requirements constituted an "undue burden" on access to pre-viability abortions.

Federal Subsidies for Abortion

As early as 1970, Congress added language to legislation authorizing a major federal "family planning" program, Title X of the Public Health Service Act, providing that none of the funds would be used "in programs where abortion is a method of family planning." In 1973, Congress amended the Foreign Assistance Act to prohibit the use of U.S. foreign aid funds for abortion.

After *Roe v. Wade* was handed down in 1973, various federal health programs, including Medicaid, simply started paying for elective abortions. In 1976, the federal Medicaid program alone was paying for approximately 300,000 abortions a year. Congress responded by attaching a "limitation amendment" to the annual appropriations bill for health and human services—the Hyde Amendment—prohibiting federal reimbursement for abortion, except to save the mother's life. In a 1980 ruling (*Harris v. McRae*), the U.S. Supreme Court ruled, 5-4, that the Hyde Amendment did not contradict *Roe v. Wade*.

After the Roe v. Wade ruling in 1973, various federal health programs, including Medicaid, simply started paying for elective abortions. By 1976, The federal Medicaid program alone was paying for approximately 300,000 abortions a year. Congress responded by attaching a "limitation amendment" to the annual appropriations bill for health and human services – the Hyde Amendment – prohibiting federal reimbursement for abortion, except to save the mother's life. The U.S. Supreme Court ruled, 5-4, In Harris v. McRae (1980) that the Hyde Amendment did not contradict Roe v. Wade.

The Hyde Amendment was later expanded to explicitly prohibit any federal Medicaid funds from paying for any part of a health plan that covered abortions (with narrow exceptions) as Medicaid moved more into a managed-care model. Thus, the Hyde Amendment has long prohibited not only direct federal funding of abortion procedures, but also federal funding of abortion covering plans.

Congress enacted a number of similar laws to prohibit abortion coverage in other major federally subsidized health insurance plans, including those covering members of the military and their dependents, federal employees, and certain children of parents with limited incomes (S-CHIP) after the Supreme Court decision upheld the Hyde Amendment. By 2008, this array of laws had produced a nearly uniform policy that federal programs did not pay for abortion or subsidize health plans that included coverage of abortion, except when necessary to save the life of the mother, or in cases of rape or incest.

The Obamacare health law enacted in 2010 contains provisions that sharply depart from the Hyde Amendment principles, primarily by authorizing federal subsidies for the purchase of private health plans that cover abortion on demand.

The No Taxpayer Funding for Abortion Act and Abortion Insurance Full Disclosure (H.R. 18) would apply the full Hyde Amendment principles in a permanent, uniform fashion to federal health programs, including those created by the Obamacare law. With respect to Obamacare, this would mean that private insurance plans that pay for elective abortions would not qualify for federal subsidies, although such plans could still be sold through Obamacare exchanges, in states that allow it, to customers who do not receive federal subsidies. The U.S. House of Representatives passed this legislation in 2011, 2014, 2015, and 2017.The U.S. Senate in the 116th (2019-2020) Congress voted on this legislation with a vote of 48-47, but 60 votes were required, so the bill did not advance.

The OPM (under instructions from the Obama White House) went forward with this plan despite a longstanding law (the Smith Amendment) that explicitly prohibits OPM from spending one penny on administrative expenses connected with the purchase of any health plan that includes any coverage of abortion (except to save the life of the mother, or in cases of rape or incest). The Smith Amendment continues to prohibit inclusion of abortion coverage in the health plans of more than 8 million federal employees and dependents–a limitation that does not apply to members of Congress or their staffs, solely because of Obamacare.

One policy at issue was originally announced by the Reagan Administration in 1984 at an international population conference in Mexico City, and therefore until now it has been officially known as the Mexico City Policy. That policy required that, in order to be eligible for certain types of foreign aid, a private organization must sign a contract promising not to perform abortions (except to save the mother's life or in cases of rape or incest), not to lobby to change the abortion laws of host countries, and not to otherwise "actively promote abortion as a method of family planning." The Mexico City Policy has been adopted by each Republican president since and rescinded by each Democrat president.

When President Trump reinstated the Mexico City Policy, now called the Protecting Life in Global Health program, he also widened its reach. The expanded policy will reach to a substantially expanded array of overseas health programs, including those dealing with HIV/AIDS, maternal and child health, and malaria, and including some programs operated by the Defense Department. The Biden Administration has reversed this policy.

Federal Conscience Protection Laws

Various federal laws seek to prevent discrimination against healthcare providers who do not wish to participate in providing abortions (often called "conscience protection" laws), but the Obama Administration severely undermined enforcement of those laws and pursued various policies that are directly contrary to the principles they embody.

Congress has repeatedly enacted federal laws to protect the rights of health care providers who do not wish to participate in providing abortions, including the Church Amendment of 1973 and the Coats-Snowe Amendment of 1996. One of the most sweeping such protections, the Hyde-Weldon Amendment, has been part of the annual health and human services appropriations bill since 2004; this law prohibits any federal, state or local government entity that receives any federal HHS funds from engaging in "discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

The law defines "health care entity" as including "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

Various pieces of remedial legislation were proposed during the 114th Congress, including the Conscience Protection Act and it is anticipated such legislation will be re-introduced and receive active consideration during the 116th (2019-2020) Congress.

Congressional Action on Direct Protection for Unborn Children

Forty-Eight years after Roe v. Wade, it does not violate any federal law to kill an unborn human being by abortion, with the consent of the mother, in any state, at any moment prior to live birth. However, the use of one specific method of abortion, partial- birth abortion, has been banned nationwide under a federal law, the Partial-Birth Abortion Ban Act (18 U.S.C. §1531), that was enacted in 2003 and upheld by the U.S. Supreme Court in 2007.

During the Reagan Administration there were attempts to move legislation to directly challenge Roe v. Wade, but no such measure cleared either house of Congress. After the Republicans took control of Congress in the 1994 election, Congress approved for the first time a direct federal ban on a method of abortion – the Partial-Birth Abortion Ban Act. President Clinton twice vetoed this legislation. The House overrode the vetoes, but the vetoes were sustained in the Senate. After the election of President George W. Bush, the Partial-Birth Abortion Ban Act was enacted into law in 2003. This law was upheld 5-4 by the U.S. Supreme Court in the 2007 ruling of Gonzales v. Carhart, and is in effect today. The law makes it a federal criminal offense to perform an abortion in which the living baby is partly delivered before being killed, unless it was necessary to save the mother's life. The law applies equally before and after "viability" (and most partial-birth abortions were performed before "viability"), and it does not contain a broad "health" exception such as the Court had required in earlier decisions.

On February 25, 2020, fifty- six (56) senators voted to consider the Born-Alive Abortion Survivors Protection Act but 60 votes were required, so the bill did not advance.

Additionally, House Republican leadership filed a discharge petition for H.R. 962 on the same legislation in an attempt to force a vote against the wishes of Democrat leadership. The petition fell short of the needed majority of signatures (217), and a similar bill and discharge petition are planned for the 117th Congress. This legislation would enact an explicit requirement that a baby born alive during an abortion must be afforded "the same degree" of care that would apply "to any other child born alive at the same gestational age," including transportation to a hospital, and applies the existing penalties of 18 U.S.C. § 1111 (the federal murder statute) to anyone who performs "an overt act that kills [such] a child born alive."

In response to the Gonzales ruling, North Carolina Right to Life, in union with the National Right to Life Committee, began efforts on passing the Pain-Capable Unborn Child Protection Act. This bill declares that capacity to experience pain exists at least by 20 weeks fetal age, and generally prohibits abortion after that point. A federal version of the legislation was approved by the U.S. House of Representatives in May, 2015, 242-184; the Obama White House issued a veto threat on the bill. Another attempt to move the House-passed bill to the Senate floor was blocked by a Democrat senator's filibuster. The legislation (H.R. 36) was reintroduced in January 2017.

Under the 2002 Born-Alive Infants Protection Act, babies who are born alive before or after "viability" are recognized as full legal persons for all federal law purposes. Much stronger federal protection would be provided by the Born-Alive Abortion Survivors Protection Act. This legislation would enact an explicit requirement that a baby born alive during an abortion must be afforded "the same degree" of care that would apply "to any other child born alive at the same gestational age," including transportation to a hospital, and applies the existing penalties of 18 U.S.C. § 1111 (the federal murder statute) to anyone who performs "an overt act that kills [such] a child born alive."

Babies carried in the womb "at any stage of development" who are injured or killed during the commission of certain violent federal crimes are fully recognized as human victims under the Unborn Victims of Violence Act, enacted in 2004.

During the 117th (2020-2021) Congress, the Dismemberment Abortion Ban Act was introduced in Congress. The legislation is based on a model state-level bill developed by National Right to Life, which was enacted in 6 states. The federal bill would prohibit nationally the performance of "dismemberment abortion," defined as "with the purpose of causing the death of an unborn child, knowingly dismembering a living unborn child and extracting such unborn child one piece at a time or intact but crushed from the uterus through the use of clamps, grasping forceps, tongs, scissors or similar instruments that, through the convergence of two rigid levers, slice, crush or grasp a portion of the unborn child's body in order to cut or rip it off or crush it." This prohibition would apply to many applications of the method referred by abortionists as "dilation and evacuation" (D&E), which currently is the most common second-trimester abortion method, employed starting at about 14 weeks of pregnancy.

North Carolina Policy on Abortion

Previous Laws in NC that still apply [9]

1839- Unborn child can take property by a will

1853- Court recognized that unborn child may take property by a will

1860- Unborn child could be beneficiary of an active trust

NC General Statue 14-45.1, "When abortion not unlawful": Mandates that the NC Department of Health & Human Services inspect any clinic where abortions are occurring, and report that information. It states that "no physician, nurse, or any other health care provider who shall state an objection to abortion on moral, ethical, or religious grounds shall be required to perform or participate in medical procedures which result in an abortion."

It also states that "[a] qualified physician who advises, procures, or causes a miscarriage or abortion after the sixteenth week of a woman's pregnancy shall record all of the following: the method used by the qualified physician to determine the probable gestational age of the unborn child at the time the procedure is to be performed; the results of the methodology, including the measurements of the unborn child; and an ultrasound image of the unborn child that depicts the measurements. The qualified physician shall provide this information, including the ultrasound image, to the Department of Health and Human Services..."[10]

- Due to the *2019 Bryant v. Woodall* Federal Court ruling, an abortion may be done at any time the abortionist decides that the child would not live if delivered at that time.

NC GS 90-21.7 Parental Consent required: Mandates that abortions on unemancipated minor have to have consent from a parent with legal custody or legal guardian. It also says that the minor, or guardian, can petition a district judge in the matter.

NC GS 14-322.3 Abandonment of an infant under seven days of age: When a parent abandons an infant less than seven days of age by voluntarily delivering the infant as provided in. [10]

SL 2011-60: Unborn Victims of Violence Act/Ethen's Law: Creates criminal offenses for acts committed against pregnant women without consent that cause the death or injury of an unborn child.[11]

SL 2011-145: Appropriations Act of 2011, Sec. 29.23(a)-(c): Limits state abortion funding in the state health plan. No state funded abortions except in cases of rape, incest, or to save the life of the mother. Previously funding was only limited for welfare abortions on a year-to-year basis. [11]

SL 2011-392: Authorize Various Special Plates (Choose Life): Division of Motor Vehicles to issue "Choose Life" plates. The money raised will go to Carolina Pregnancy Care Fellowship. The injunction has been dissolved and license plates are now available online through NC DMV. [11]

9. Made in conjunction with previous NC Representative Paul "Skip" Stam's website. http://paulstam.info/pro-life-legislation-litigation-in-north-carolina/

10. "NC General Statue 14" , General Assembly of North Carolina, https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_14/Article_11.pdf

SL 2011-405: Woman's Right to Know: Requires a 24 hour (now 72 hour) waiting period and the informed consent of a pregnant woman before an abortion may be performed. **CHALLENGED IN COURT. LOST ONE SECTION CONCERNING ULTRASOUND. THE REMAINDER OF THE LAW WAS CHALLENGED BUT UPHELD.**

SL 2013-307: Health Curriculum/Preterm Birth: Requires instruction in school health education on preventable causes, including induced abortion, of preterm birth in subsequent pregnancies.

SL 2013-366: Health and Safety Law Changes: Limits abortion coverage to rape, incest, or to protect the life of the mother under the federal health benefit exchange or insurance offered by a county or city. Prohibits sex selection abortions. The Department of Health and Human Services is directed to amend rules pertaining to abortion clinics. Prohibits abortions if a doctor is not present. Conscience Protection extended to all health care providers, not just doctors and nurses.

SL 2015-62: Women and Children's Protection Act of 2015: Changes the 24-hour waiting period to 72 hours for informed consent before an abortion. Protects health care providers who object on moral, ethical or religious grounds in situations not covered in 2013. Increases statistical reporting requirements to the Department of Health and Human Services and enhances clinic standards and inspections. Abortionists must be an OB-GYN or equivalent. It also tightens standards for post 20-week abortions.

SL 2015-265: Disposition of Unborn Children's Remains: Prohibits the sale of the remains of an unborn child resulting from an induced abortion. In the case of a miscarriage, the mother may donate the remains for research.

SL 2021- Appropriations Act of 2021, Pregnancy Care Center Funding [12]

SECTION 9G.4- LifeLink Carolina/Carolina Pregnancy Care Fellowship Funds/Grants: The NC Department of Health & Human Services (NC DHHS) will grant $500,000 in annual funding and $1,203,437 through the 2021-2022 fiscal year to the Carolina Pregnancy Care Fellowship (LifeLink Carolina). LifeLink Carolina options education provide pregnancy testing, pregnancy & parenting education, referrals to community resources, maternity & infant clothing and supplies, post abortion recovery support programs, and in most centers – medical services such as limited ultrasound and STI testing.

The NC DHHS will also grant $500,000 in annual funding and $2,479,904 to pregnancy care centers which are grant-level members of LifeLink Carolina who apply. LifeLink Carolina is responsible for reporting to the state government and will contact every CareNet/ LifeLink Carolina pregnancy care center about the program. $750,000 in the 2021-2022 & 2022-2023 fiscal year will go towards medical equipment. Only 10% of these funds can go towards administrative funding.

SECTION 9G.5- Mountain-Area Pregnancy Services Funds: Only 15% of state funding to the Mountain Area Pregnancy Services can go towards administrative funding. The rest will be used for direct services.

SECTION 9G.6- Human Coalition: The NC Department of Health & Human Services (NC DHHS) will grant $3.2 million through the 2021-2022 & 2022-2023 fiscal year to the Human Coalition. The

program is designed to encourage healthy childbirth, support childbirth as an alternative to abortion, promote family formation, assist in establishing successful parenting techniques, and increase the economic self-sufficiency of families. Beneficiaries will be birth-parents, guardians, and adoptive parents who live in North Carolina. The program also serves NC mothers who had had an abortion. They are required to do reporting to the state government and only 10% of the state funds can go towards administrative funding.

North Carolina Administrative Code Subchapter 7-L:[13] The North Carolina Pregnancy Services provides support in solving social, educational, psychological, and medical problems related to unplanned pregnancies. These services could include counseling, information to help recipients make voluntary choices regarding adoption, parenting, or terminating the pregnancy, and/or assistance in arranging other needed services like residential care.

Residential placements that may be acceptable include boarding arrangements for women 18 and older, licensed family foster homes, placement with non-legally responsible relatives, and licensed NC maternity homes may be eligible for the State Maternity Fund (SMF). The SMF is available to supplement approved residential placements for up to six months (183 days) for pregnant women and youth who are North Carolina residents, provided there is sufficient funding available.

Court Ruling Synopsis[3,9]

Roe v. Wade (1973) Relying on an unstated "right of privacy" found in a "penumbra" of the 14th Amendment, the Court effectively legalized abortion on demand throughout the full nine months of pregnancy in this challenge to the Texas state law regarding abortion. Although the Court mentioned the state's possible interest in the "potentiality of human life" in the third trimester, legislation to protect that interest would be gutted by mandated exceptions for the "health" of the mother (see Doe below).

Doe v. Bolton (1973) A companion case to Roe, which challenged the abortion law in Georgia, Doe broadly defined the "health" exception so that any level of distress or discomfort would qualify and gave the abortionist final say over what qualified: "The medical judgment may be exercised in the light of all factors–physical, emotional, psychological, familial, and the woman's age–relevant to the well-being of the patient. All these factors may relate to "health." Because the application of the health exception was left to the abortionist, legislation directly prohibiting any abortion became practically unenforceable.

Bigelow v. Virginia and Connecticut v. Menillo (1975) Bigelow allowed abortion clinics to advertise. Menillo said that despite Roe, state prohibitions against abortion stood as applied to non-physicians. Menillo also said states could authorize non physicians to perform abortions.

Planned Parenthood of Central Missouri v. Danforth (1976) The court rejected a parental consent requirement and decided that (married) fathers had no rights in the abortion decision. Furthermore, the Supreme Court struck down Missouri's effort to ban the saline amniocentesis abortion procedure, in which salt injected into the womb slowly and painfully poisons the child.

Maher v. Roe and Beal v. Doe (1977) States are not required to fund abortions, though they can if they choose. A state can use funds to encourage childbirth over abortion.

Poelker v. Doe (1977) The Supreme Court ruled that a state can prohibit abortions in public hospitals.

Colautti v. Franklin (1979) Although Roe said states could pursue an interest in the "potential life" of the unborn child after viability (Roe placed this at the third trimester), the Supreme Court struck down a Pennsylvania statute that required abortionists to use the abortion technique most likely to result in live birth if the unborn child is viable.

Bellotti v. Baird (II) (1979) The Supreme Court struck down a Massachusetts law requiring a minor to obtain the consent of both parents before obtaining an abortion, and insisted that states needed to offer a "judicial bypass" exception by which the child could demonstrate her maturity to a judge or show that the abortion would somehow be in her best interest. *In Bellotti v. Baird (I) 1976, the Court returned the case to the state court on a procedural issue.

Harris v. McRae (1980) The Supreme Court upheld the Hyde Amendment, which restricted federal funding of abortion to cases where the mother's life was endangered (rape and incest exceptions were added in the 1990s). The Court said states could distinguish between abortion and "other medical procedures" because "no other procedure involves the purposeful termination of a potential life." While the Court insisted that a woman had a "right" to an abortion, the state was not required to fund it.

Williams v. Zbaraz (1980) The Supreme Court ruled that states are not required to fund abortions that are not funded by the federal government, but can opt to do so.

HL v. Matheson (1981) Upholding a Utah statute, the Supreme Court ruled that a state could require an abortionist to notify one of the minor girl's parents before performing an abortion without a judicial bypass.

City of Akron v. Akron Center for Reproductive Health (1983) The Supreme Court struck down an ordinance passed by the City of Akron requiring: (1) that abortionists inform their clients of the medical risks of abortion, of fetal development and of abortion alternatives; (2) a 24-hour waiting period after the first visit before obtaining an abortion; (3) that second- and third-trimester abortions be performed in hospitals; (4) one-parent parental consent with no judicial bypass; (5) and the "humane and sanitary" disposal of fetal remains. The Court later reversed some of this ruling in its 1992 decision in Casey.

Planned Parenthood Association of Kansas City v. Ashcroft (1983) The Supreme Court upheld a Missouri law requiring that post-viability abortions be attended by a second physician and that a pathology report be filed for each abortion.

Simopoulous v. Virginia (1983) The Supreme Court affirmed the conviction of an abortionist for performing a second-trimester abortion in an improperly licensed facility.

Thornburgh v. American College of Obstetricians and Gynecologists (1986) The Supreme Court struck down a Pennsylvania law requiring: (1) that abortionists inform their clients regarding fetal development and the medical risks of abortion; (2) reporting of information about the mother and the unborn child for second- and third-trimester abortions; (3) that the physician use the method of abortion most likely to preserve the life of a viable unborn child; and (4) the attendance of a second physician in post-viability abortions. They later reversed some of this ruling in its 1992 Casey decision.

Webster v. Reproductive Health Services (1989) The Supreme Court upheld a Missouri statute prohibiting the use of public facilities or personnel for abortions and requiring abortionists to determine the viability of the unborn child after 20 weeks.

Hodgson v. Minnesota and Ohio v. Akron Center for Reproductive Health (1990) In Hodgson, the Supreme Court struck down a Minnesota statute requiring two-parent notification without a judicial bypass, but upheld the same provision with a judicial bypass. In the same decision, the Court allowed a 48-hour waiting period for minors following parental notification. In Ohio v. Akron, the Court upheld one-parent notification with judicial bypass.

Rust v. Sullivan (1991) In Rust, the Supreme Court upheld a federal regulation prohibiting projects funded by the federal Title X program from counseling or referring women regarding abortion. If a clinic physically and financially separated abortion services from family planning services, the family planning component could still receive Title X money. Relying on Maher and Harris, the Court emphasized that

the government is not obliged to fund abortion-related services, even if it funds prenatal care or childbirth.

Planned Parenthood of Southern Pennsylvania v. Casey (1992) To the surprise of many observers, the Supreme Court narrowly (5-4) reaffirmed what it called the "central holding" of Roe, that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." However, the Court also indicated a shift in its doctrine that would allow more in the way of state regulation of abortion, including pre-viability regulations: "We reject the rigid trimester framework of Roe v. Wade. To promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion. These measures must not be an undue burden on the right." Applying this "undue burden" doctrine, the Court explicitly overruled parts of Akron and Thornburgh, and allowed informed consent requirements (that the woman be given information on the risks of abortion and on fetal development), a mandatory 24-hour waiting period following receipt of the information, the collection of abortion statistics, and a required one-parent consent with judicial bypass. A spousal notification requirement, however, was held to be unconstitutional.

Mazurek v. Armstrong (1997) Supreme Court upheld a Montana law requiring that only licensed physicians perform abortions.

***Rosie J. v. N.C. Department of Human Resources* (1997),** the North Carolina Supreme Court held that there was no state constitutional right to state funded abortions. In 1995, the General Assembly restricted eligibility for the state abortion fund to cases where the pregnancy resulted from "cases of rape or incest, or to terminate pregnancies that, in the written opinion of one doctor licensed to practice medicine in North Carolina, endanger the life of the mother."

***Manning v. Hunt* (4th 1997),** The 4th Circuit Court of Appeals sustained the position of that State & the amicus brief submitted by Stam & Danchi PLLC, for NCRTL in support of the state Parental Consent law.

Gonzales v. Carhart (2007), By a vote of 5-4, the Supreme Court in effect largely reversed the 2000 Stenberg v. Carhart decision, rejecting a facial challenge to the federal Partial-Birth Abortion Ban Act, enacted by Congress in 2003. This law places a nationwide ban on use of an abortion method—either before or after viability—in which a baby is partly delivered alive before being killed. In so doing, the Court majority, in the view of legal analysts on both sides of the abortion issue, opened the door to legislative recognition of broader interests in protection of unborn human life, and signaled a willingness to grant greater deference to the factual and value judgments made by legislative bodies, within certain limits.

Whole Woman's Health v. Hellerstedt (2016), By a vote of 5-4, the Supreme Court declared unconstitutional Texas laws requiring abortion clinics to meet surgical-center standards, and requiring abortionists to have admitting privileges at a hospital within 30 miles. The majority ruled that these requirements constituted an "undue burden" on access to pre-viability abortions. In his dissent, Justice Clarence Thomas wrote, "[T]he majority's undue-burden balancing approach risks ruling out even minor, previously valid infringements on access to abortion."

***June Medical Services LLC v Russo* (2020),** In a 5-4 decision, the Supreme Court struck Louisiana's 2014 "Unsafe Abortion Protection Act" or Act 620 that required abortionists to have admitting privileges to a hospital within 30 miles of an abortion clinic — similar to the requirement already in place for doctors who perform surgery at outpatient surgical centers. The majority declared it "an undue burden" and likened it to their decision in *Hellerstedt*. However, the Court seemingly restored the "undue burden" precedent established in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.

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