"STILL IN NEED OF A WIDESPREAD REVOLUTION":

North Carolina's Social and Political Landscape Allows Gaps in the State's Sexual and Reproductive Health System to Persist

BACKGROUND

In 2021, researchers in Columbia University's Global Health Justice and Governance (GHJG) Program began a qualitative study to understand the effects of the Title X Gag Rule in Maine, Wisconsin, and North Carolina. Title X is a federal grant program that provides affordable birth control and preventive health services to people with low incomes who are underinsured or uninsured. Implemented by the Trump Administration in August 2019, the Title X Gag Rule banned healthcare providers who participate in the program from providing abortion counseling or referrals. In November 2021, new regulations implemented by the Biden Administration reversed these restrictions (Guttmacher Institute).

We wanted to understand how, if at all, the Title X Gag Rule compounds other socioeconomic and political trends that threaten sexual and reproductive health, rights, and justice in already marginalized communities. In partnership with Maine Family Planning, the Foundation for Black Women's Wellness, and SisterSong, GHJG conducted key informant interviews with 36 clinical, advocacy, and community-based organizations in Maine, Wisconsin, and North Carolina. Interviewees included sexual and reproductive health service providers that do and do not receive Title X funding, as well as local non-governmental organizations that promote health equity and reproductive justice by providing referrals and direct services at the community level and advocating for structural change. This brief presents findings gleaned from interviews in North Carolina.

POLITICAL CONTEXT

After four years under Republican governor Pat McCrory, North Carolina elected a Democratic governor, Roy Cooper, in 2016. Cooper narrowly defeated McCrory, winning 49.02% of the vote to McCrory's 48.80%. Despite the election of a Democratic governor, North Carolina's state legislature remains Republican-controlled, with strong majorities in both the State Senate and Assembly. If Republicans win key races in the next election cycle, the party could have a supermajority in the State Senate (Carolina Journal). Advocates fear that this will become a reality, as North Carolina has received national attention for its heavy gerrymandering and voter suppression laws. With limited opportunities for local legislative and policy change, many progressive advocates and sexual and reproductive health (SRH) clinicians rely on federal protections for family planning and abortion care. This places them in precarious position, as federal laws and funding sources can be subjected to equally volatile shifts.

This divided political environment has stymied efforts to pass legislation that would increase access to healthcare or work to reduce persistent health disparities. North Carolina is one of only 12 states that has not expanded Medicaid since the passage of the Affordable Care Act; non-disabled, childless adults in the state cannot qualify for Medicaid no matter how low their income is. Gov. Cooper has included Medicaid expansion in several state budget proposals, but the Republican-controlled state legislature has never included expansion in their final budget (KFF). As of 2020, 1 in 7 women of reproductive age in North Carolina were uninsured, a fact that contextualizes state's poor maternal and child health indicators. Overall, North Carolina has the 11th highest preterm birth rate in the country, with 1 in 9 infants born prematurely, and its high maternal mortality rate ranks 30th out of the 50 states (CDC). Moreover, the maternal mortality rate for Black women is twice as high as for white women, and the mortality rate for Black infants is 2.5 times the rate for white infants.

IMPACTS OF THE TITLE X GAG RULE ON NORTH CAROLINA

Before the Trump Administration initiated the Gag Rule in 2019, Title X funded both Planned Parenthood sites and North Carolina Department of Health and Human Services (NC DHHS) clinics. Title X funding helped support healthcare providers who fill gaps in access to sexual and reproductive health services throughout the state, which is especially critical in North Carolina, where significant rural and urban disparities persist. Planned Parenthood has only nine clinics in the state, mostly in large cities, and respondents noted that urban areas have better access to comprehensive sexuality education and contraception. Because of this landscape, NC DHHS clinics, located in each of the state's 100 counties, are heavily relied upon for SRH services, particularly among low-income and rural patients.

Following the 2019 Gag Rule, NC DHHS became the only Title X recipient in the state after Planned Parenthood became ineligible for funding. Recognizing that Planned Parenthood's loss of Title X funds weakened the state's health system, NC DHHS ensured that Title X funding was distributed to local health departments in the counties where Planned Parenthood previously offered Title X-funded services. However, the Gag Rule also forced NC DHHS to change their service provision to be in line with the new regulations, which barred staff from conducting options counseling with patients.

By eliminating the ability of a registered nurse to practice within her scope and counsel clients seeking pregnancy testing services about the options that were available to them for that pregnancy, either carrying the child and parenting, carrying the child and adopting the child to another, or terminating the pregnancy, that was the biggest – that had a big impact in that clients then, if they were interested in hearing about their options, in many cases, would have to have a subsequent follow-up appointment with the clinic. ***It [the Title X Gag Rule] was a burden on the patients, I would say, that they probably didn't even know they were going to experience until they wound up in a scenario where they wanted options counseling.***

Respondents also described how the Gag Rule led county health departments to implement new workflows to ensure patients could still access essential information about abortion. As one respondent described, some sites moved pregnancy testing from a Title X clinic to a general primary care clinic, thus allowing providers to continue offering comprehensive options counseling:

Because our local health departments offer other kinds of clinical services, they can also – some of them moved pregnancy testing to a general clinic. Since it wasn't under the rubric of family planning and since, theoretically, Title X funding wasn't supporting the services provided in the general clinic, the Title X rule pertaining to no nurse counseling about pregnancy termination would not apply.

Other organizations noted how the Gag Rule weakened the relationships between SRH-focused organizations in the state, as the complex administrative and logistical challenges of complying with the Gag Rule meant that NC DHHS and its local health departments sometimes over-interpreted its stipulations. One clinical respondent described how their organization established contraceptive service referrals between Title X and non-Title X health facilities, which were then unnecessarily stopped:

In our clinic initiatives, we had set up referral networks between providers. Maybe it was that you called the health department to set up an appointment to get an IUD, but the health department couldn't see you for six months, which is not atypical in North Carolina. The health department, through our initiative, set up a network so they could say, "Oh, but we can make you an appointment at Planned Parenthood or at a pediatrician's office, and you can get it next week." ***When [the Gag Rule] happened, some health departments stopped doing that. They weren't engaged in our initiatives. The ones who were engaged in our initiative had to do all of this back-end work so that a different nurse who wasn't funded with Title X funds would come in and make that referral. It resulted in some weird staffing, labor allocation changes, and our partners really had to jump through lots of hoops.***

Advocates in the state also expressed concern over the long-term health effects of the Gag Rule, which make accessing essential SRH services in a state with limited resources and political support for SRH even more challenging:

Not having access to family planning or birth control services will result in unplanned pregnancies; higher rates of STIs; less access to preventive care, which I think results in people dealing with the consequences of not taking care of, not addressing their health needs, because they can't really afford it. ***It becomes a luxury. Having access to birth control, it ends up being a luxury.***

"HOLDING THE LINE" ON ABORTION ACCESS

For many years, North Carolina was viewed as a moderate Southern state when it came to abortion rights, but that position has become precarious. Over the last decade, anti-abortion legislation proliferated as conservatives made significant gains. Many SRH advocates in North Carolina feel that the state's significant gerrymandering has led to a state legislature that does not reflect constituents' attitudes toward abortion: despite recent polling that shows a majority of people in North Carolina think abortion should be legal, advocates have not been able to make meaningful gains in protecting or expanding abortion rights due to the state's highly conservative legislators (Meredith Poll). Because of the state's polarization, advocates have been forced to focus their efforts on ensuring that abortion remains legal in North Carolina, as well as preventing new abortion restrictions from being passed. With the support of the governor's veto, advocates describe being able to "hold the line" on abortion rights, but recognize that this defensive advocacy limits their ability to push for new progressive policies.

Persistent barriers to abortion remain in North Carolina as a result of the state's increasingly conservative political landscape: more abortion restrictions were passed between 2011 and 2015 alone than in the 30 years prior. Today, North Carolina still has a number of anti-abortion laws in place, including TRAP laws, a 72-hour waiting period, a prohibition on the use of telemedicine to provide medication abortion services, and mandatory parental consent for minors seeking abortion care (Guttmacher Institute). These laws have contributed to the difficulty in accessing abortion in the state: as shown in the figures on page 4 and 5, many people in North Carolina, especially those in more rural areas, live hours from the nearest abortion provider.

Despite the presence of these many restrictions, abortion is still easier to access in North Carolina than in many neighboring states, including South Carolina and Tennessee; fourteen clinics provide abortion services throughout the state. As a result, many respondents felt that North Carolina would become a "safe haven" for people seeking abortion care following the probable overturning of *Roe v. Wade* by the U.S. Supreme Court, and are preparing to support a future influx of patients from states that ban or more heavily restrict abortion.

In addition to limiting access to abortion care, North Carolina's legislature enables anti-choice organizations. Crisis pregnancy centers, or CPCs, receive millions of dollars in state funding in North Carolina, which SRH advocates and providers see as a harmful waste of resources. While funding remains limited for evidence-based healthcare services throughout the state, CPCs – which do not provide medical care but market free health-related services, such as pregnancy tests and ultrasounds – are included in the state budget each year. Advocates described this as one of many attacks on vulnerable communities' access to high-quality healthcare, which become more apparent as other policies – such as the Gag Rule – remove funding from legitimate healthcare providers:

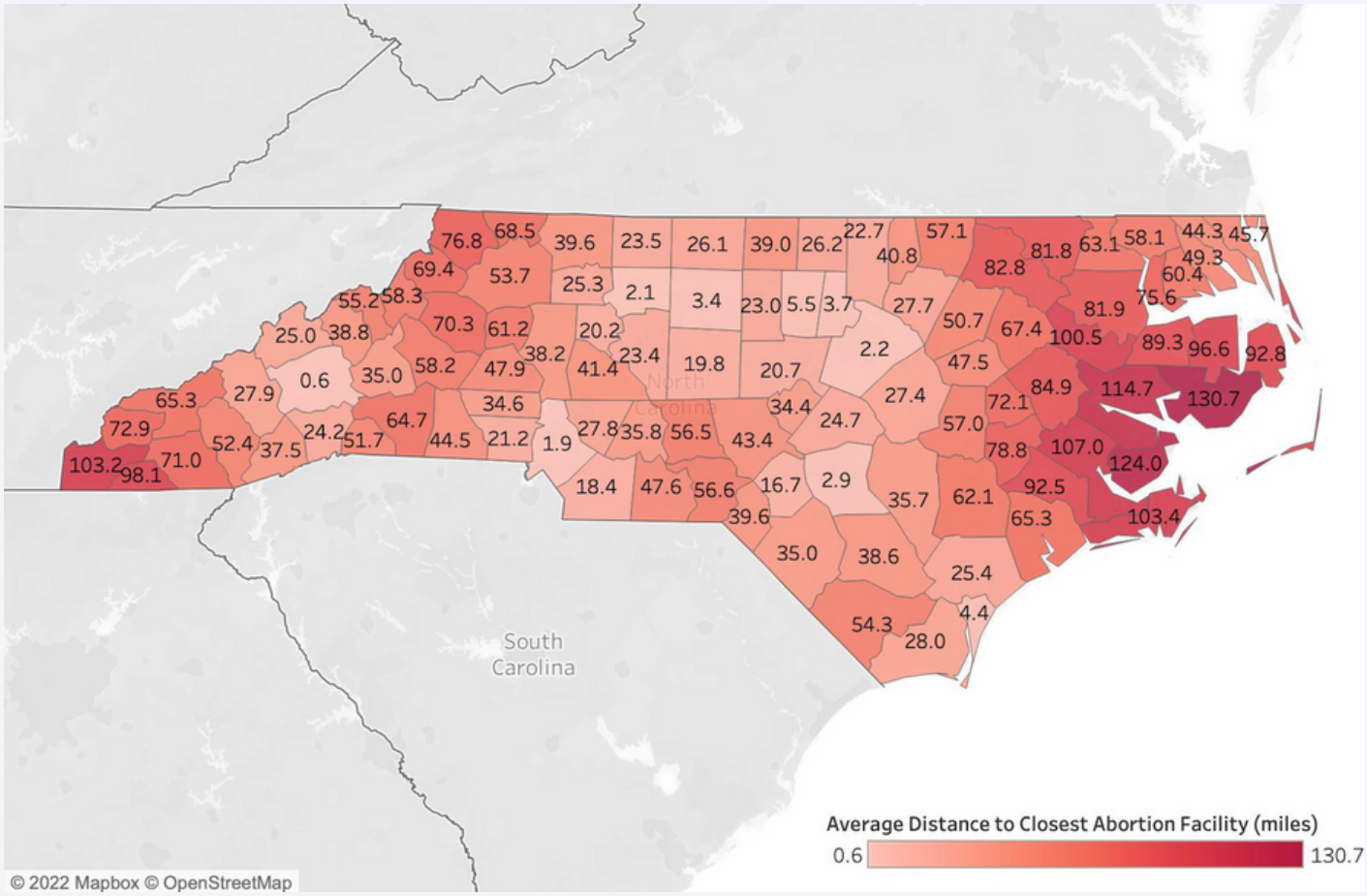
You really are creating such a perfect storm, people just not getting good healthcare information, because they're [prevented by the Gag Rule from] going to somebody who will give them accurate, comprehensive information, and instead, because they don't necessarily have access to healthcare, they'll be directed to these so-called free services of places that are putting out misinformation, not providing healthcare... ***We saw that as just another way of really doubling down on vulnerable populations who already don't have the net access to care, and then cutting off places that can provide them that access, while at the same time building up places that just can provide them [with] misinformation.***

Recognizing that North Carolina's governor does not have a budget line-item veto, some respondents describe the sustained funding for CPCs as a political consolation for anti-choice legislators in the statehouse:

We feel like, in some ways, it's been the political trade-off for some of the anti-abortion folks. ***They're not getting the restrictions that they want to see pass, but they can get a whole bunch of money given to this fake clinic that doesn't actually provide any health care,*** *but does spend a lot of time telling people a lot of misinformation about abortion.*

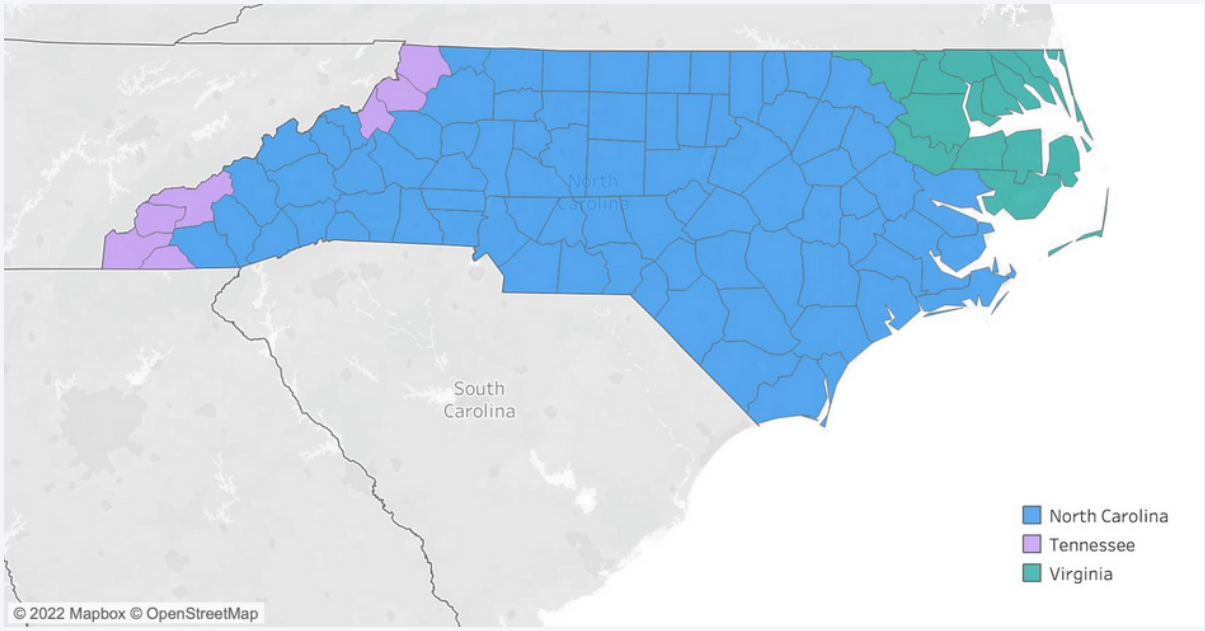
As others explained, this politicization of abortion plays out in the lives of patients. NC DHHS providers differ in their willingness to refer patients to abortion care, which presents an immediate obstacle for many people in the state who rely on NC DHHS providers for SRH information, care, and referrals. CPCs, on the other hand, are well-established in certain communities and even have relationships with some county health departments, who invite them to hold classes or share information in clinics. One respondent shared anecdotal evidence that certain NC DHHS providers will refer patients to CPCs, which further normalizes these fake clinics.

AVERAGE TRAVEL DISTANCE TO CLOSEST ABORTION PROVIDER



Source: Caitlin Myers, 2021. County-by-month travel distances to nearest abortion provider, Vintage June 1, 2021. Retrieved from https://doi.org/10.17605/OSF.10/8DG7R

STATE OF CLOSEST ABORTION FACILITY



Source: Caitlin Myers, 2021. County-by-month travel distances to nearest abortion provider, Vintage June 1, 2021. Retrieved from https://doi.org/10.17605/OSF.10/8DG7R

UNRELIABLE BIPARTISAN SUPPORT FOR REPRODUCTIVE HEALTH AND EQUITY

The Title X Gag Rule and related anti-abortion policies are part of a larger social and political landscape that has allowed gaps in the state's SRH system to persist. Though advocates have worked hard to garner support for progressive policies that would improve the health and wellbeing of vulnerable communities, few successes have occurred in this highly partisan environment. As one advocate lamented, "*The biggest piece of our advocacy agenda during every legislative session ends up being defensive and trying to stop bad bills from becoming law*."

For example, efforts to expand Medicaid and/or Medicaid coverage of contraception have stalled, despite long-term, concerted advocacy from a number of organizations throughout the state. In the current legislative session, a pregnant worker fairness act failed to pass, and a package of bills known as the "Momnibus Act," which would ensure continued insurance access for pregnant people after birth, as well as coverage for doula services and breastfeeding accommodations, has been stalled in committee for over a year. Several respondents noted that gaining bipartisan support for bills intended to protect vulnerable populations and reduce racial disparities in healthcare and health outcomes has been particularly challenging, even when they do not include the "lightning rod issue" that is abortion.

Despite these challenges, some bipartisan successes for SRH have occurred in North Carolina. A recent law expanded access to birth control by allowing pharmacists to dispense oral contraceptives as well as pre- and post-exposure prophylaxis to prevent HIV; another bans the shackling of incarcerated pregnant women beyond the second trimester (in most instances). The state will also soon be expanding Medicaid coverage for pregnant people through one year postpartum, and a few respondents noted growing bipartisan support for policies that prioritize serving teen parents. Though advocates are encouraged by these successes, many respondents expressed concerns that some seemingly progressive policies have "no teeth," or infrastructure

to support them. This creates a gap between the passage of a new law and its impact on people's lives, which has the potential to erode its meaning. Respondents discussed North Carolina's family planning-focused Medicaid program, Be Smart, as an example of this phenomenon. Though the program is designed to provide contraceptive care and other reproductive health services to low-income people in the state, there has not been sufficient uptake relative to the number of North Carolinians eligible to participate. Respondents attributed this challenge to postpartum women not being informed of the program, as well as the burdensome yearly re-enrollment requirements.

THE IMPACT OF STRUCTURAL RACISM ON REPRODUCTIVE JUSTICE

When asked what was most needed to reduce longstanding health disparities in North Carolina, one respondent noted that *"We are still in need of widespread revolution in terms of reproductive justice and rights."* Several respondents echoed this sentiment as they discussed the myriad ways that North Carolinians of color face inequities in access to resources as a result of discriminatory policies and structural racism. Many specifically highlighted how this environment disproportionately impacts pregnant people of color in the state. Advocates and grassroots organizations interviewed described the intersectional work that they do to improve housing conditions and access to food, support economic development and Black birthing people, and advocate for in-state tuition and drivers licenses for undocumented people – all of which require combatting racist and discriminatory policymaking and affects the realization of reproductive justice. One respondent explained the connection between structural racism and health and wellbeing as follows:

We here in the American South have always had a problem with discrimination, bias, and racism, so that's translated into what we see happening with redlining the neighborhoods and the quality of housing that folks have access to. We see that with predatory lending and loans. We see environmental factors. ***We literally see areas with less trees having poorer air quality and causing more at-risk births [and poor] outcomes.*** *We see disproportionate access to job training and higher education, and jobs in general.*

Reproductive justice organizations and their allies have brought attention to the intersecting structural factors that contribute to persistent maternal and infant health disparities, such as the state's refusal to expand Medicaid and lack of paid family leave. Further, since 2005, 11 rural hospitals have closed (Sheps Center), leaving rural birthing people – who are also more likely to have low incomes – with less access to maternal and child healthcare:

There [have] been some hospitals in rural areas where their labor and delivery department has closed down. Meaning, people have to drive further to access care, prenatal care, or their labor and delivery care. I mean, there's like at least a quarter of the North Carolina counties, we have 100 counties... I think at least a quarter of them don't have a practicing OB-GYN. People are presumably still getting pregnant in those counties and need to access care...

Like other Southern states, North Carolina has a history of grand midwives: Black birth workers who, for centuries, were the sole healthcare providers in their communities. In the early 20th century, as the field of obstetrics became institutionalized in hospitals, Black birth workers were pushed aside by racist, anti-midwife policies that invalidated their credentials, decimated this professional community of caregivers, and left Black and Brown birthing people in the care of racially biased medical systems. Several respondents discussed the medical racism that birthing people of color continue to face in North Carolina; one recounted the experiences of several clients who delivered stillborn infants after seeking medical attention for pain that was either dismissed or not prioritized by health providers. Another discussed the inaccessibility of North Carolina's best research hospitals to communities of color, and particularly birthing people of color. They went on to hypothesize that racial health disparities emerge where systems prioritize and fund innovation and research above serving communities in need:

Quite frankly, North Carolina puts a lot of value on academia and research institutions. There's a time and place for all of that, but when our families are struggling and in need of direct support, direct education, and direct resources, we should also invest in those methods and organizations as well.

In recent years, Black and Brown doula practices have grown in the state, implementing holistic, community-centered care models that follow the tradition of grand midwives. Though there is a clear need for programs that support birthing people of color in North Carolina, especially given the lack of political will needed to pass new legislation that supports this population, birth justice groups are critically under-resourced. A few respondents talked about *"a great burden, particularly on Black and Brown birth workers in North Carolina"* who are fighting for Medicaid reimbursement for their services, while also working to improve the birth outcomes and livelihoods of their clients. One respondent elaborated:

We don't get the financial support from the major institutions and agencies [like Medicaid] that our clients are [dependent on], but ***we are dealing with the burden of the fact that these institutions don't see these birthing people as whole persons,*** *and [we are] really trying to make sure that they are healthy – of sound mind and physically [healthy] as well.*

While advocates face a stalemate at the statehouse, grassroots groups like these are championing reproductive justice at the community level. The care and social support they provide meets a spectrum of needs for birthing people of color, which lays the groundwork needed to ensure a healthy future for the pregnant person, and their child, family, and community. This holistic vision for the treatment of individuals and their families needs consistent and increased resources and political support to realize reproductive justice for all in North Carolina.

For us, because we know that communities of color, and particularly low-income communities of color, see higher rates of morbidity early, it's our goal to work with people as soon as they find out they're pregnant to provide them with the resources, to provide them with food. If they need help with housing, how can we pull our village together to support these folks? ***We typically work with people up to a year or two after their child has been born because we want to make sure that they're thriving after their childbirth, and it's not – the focus is not just on the child, but on the whole person.***