**CHARLES UNIVERSITY**

FACULTY OF SOCIAL SCIENCES

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Department of North American Studies

**Master's Thesis**

**2022** **Bc. Andrea Žižková**

**CHARLES UNIVERSITY**

FACULTY OF SOCIAL SCIENCES

Institute of International Studies

Department of North American Studies

**The end of Roe? Mississippi’s decades-long restriction politics**

Master's thesis

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Year of the defence: 2022

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2. I hereby declare that my thesis has not been used to gain any other academic title.
3. I fully agree to my work being used for study and scientific purposes.

In Prague on August 2, 2022 Bc. Andrea Žižková

**References**

Žižková, Andrea. *The end of Roe? Mississippi’s decades-long restriction politics.* Praha, 2022. 68 pages. Master’s thesis (Mgr.). Charles University, Faculty of Social Sciences, Institute of International Studies. Department of North American Studies. Supervisor Mgr. Jana Sehnálková, Ph.D.

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Keywords

Mississippi, abortion, restrictions, Supreme Court, Roe v. Wade

Klíčová slova

Mississippi, potrat, restrikce, Nejvyšší soud, Roe v. Wade

Title

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Název práce

Konec Roe?

Acknowledgement

I would like to express my gratitude to . And from the bottom of my heart I thank my amazing friends who have kept me safe (even if it was not easy at times).

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Introduction

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Abortion has always been done. As Hull and Hoffer note, abortion “was a subject of everyday life”

1. National framework of the abortion debate

For the past 49 years, the right to abortion was safely ensured by the provisions of Roe v. Wade, the landmark Supreme Court rulings back in 1973. Roe guaranteed that the right could never be banned by state legislatures completely but provided them with a a freer hand in certain ‘restrictive’ imagination for the second and third trimester of pregnancy. But ever since Supreme Court decided to connect the right to abortion to Constitution, there were forces that tried to limit the decision’s outcomes and strengthen the power of the individual states, ultimately focusing on abandoning Roe altogether. This chapter will outline the pivotal precedents, laws, and changes in the abortion debate, starting with Roe v. Wade. Even though the main focus of this work is to explain the role of Mississippi in the subsequent overruling of the landmark abortion decision, it is important to understand the national framework as well.

* 1. Supreme Court rulings

Abortion has always been one of the choices women made for their reproductive health in private. The unwritten rule was that abortion was not prosecuted if it happened before quickening – evidence of life provided by the independent motion in the womb. While the first official British law outlawing abortion was passed in 1803, on the American soil it was Connecticut in 1821 who passed the first anti-abortion act, criminalizing abortions after quickening. Illinois, Missouri and New York soon followed the suit, but without the quickening doctrine. The legislation was promoted as a way to protect women throughout the whole duration of pregnancy from dangers connected with abortive methods. Soon other states implemented similar laws, intended to protecting women and prosecuting ‘abortionists’ – those practicing abortion.[[1]](#footnote-1) The burden was therefore shifted from women to the physicians, midwifes and others.

Jumping to the late 1960s, a first wave of states easing their restrictive laws rushed through the States. The first state to do so was Colorado, followed by eleven other states.[[2]](#footnote-2) In 1965, the Supreme Court issued a decision in *Griswold v. Connecticut*, first connecting the right to privacy with reproductive rights. The case revolved around the constitutional right to use contraception of married couples. This right was then expanded to include all individuals in *Eisenstadt v. Baird* in 1972.[[3]](#footnote-3) These decisions paved the way to Roe and expanded the understanding of reproductive rights as protected under the Constitution.

* + 1. Roe v. Wade

The landmark case Roe v. Wade has changed the course of history. The initial lawsuit challenged a criminal abortion law in Texas banning abortion with only one exception – saving the mother’s life. The lawsuit was brought forward by three plaintiffs: John and Mary Doe, Roe, and Dr. Hallford, but the Court permitted only Roe as having a standing to sue. The challenges brought up by the Does were concerning speculative future possibilities of unwanted pregnancy which would endanger Mary Doe due to her medical condition. Dr Hallford was a licensed physician who two pending abortion prosecutions. And even though Norma McCorvey (the real Roe) was not pregnant anymore at the time Supreme Court decided to hear the case, it did not dispute the main argument of the lawsuit – that Texas law is discriminatory and unlawful for banning abortions.[[4]](#footnote-4) At the same time, similar case was in the Supreme Court dock, *Doe v. Bolton*, challenging law in Georgia that prohibited abortion (except in the case of a threat to the woman’s life, serious defect of the fetus, and if the pregnancy resulted from rape) and posed burdensome procedural conditions.[[5]](#footnote-5)

The Court ruled that restrictive laws criminalizing abortion “violate the Due Process Clause of the Fourteenth Amendment, which protects against state action the right to privacy, including a woman’s qualified right to terminate her pregnancy”[[6]](#footnote-6). [[7]](#footnote-7)

* + 1. Casey v. Planned Parenthood

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* 1. Federal legislation

Roe v. Wade in 1973 caused significant commotion among the anti-abortion conservative public, leading to the passing of an amendment to the Departments of Labor and Health, Education, and Welfare Appropriation Act of 1977, widely known as the Hyde Amendment. The budget rider, in some form annually included in federal spending bills, restricts the use of federal funding for abortion procedures under Medicaid and other public health insurance plans (such as Peace Corps, the Federal Employees Health Benefits Program, the Federal Bureau of Prisons, the Immigration and Customs Enforcement agency, and the D.C.).[[8]](#footnote-8) In theory, the amendment contains three exceptions for which the coverage can be used – abortion in the case of incest, rape or life endangerment. The reality, however, is a little bit more complicated as reported by Dennis et al., who documented numerous barriers to Medicaid reimbursement, such as overwhelming bureaucratic paperwork requirements resulting in increase of staff hours, lack of relationship with Medicaid staff causing poor access to information, low reimbursement finance rates, and in general a difficult process of confirmation of exception-eligibility.[[9]](#footnote-9)

Until recently, there was a bipartisan cooperation in implementing Hyde Amendment into policy every year without officially codifying it. There were some attempts in the past, the first dating back to 1979 with the introduction of Child Health Assurance Act, but none were too significant. Then in 2016 the Republican Party decided to push for the codification once again with a bill called *No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017*. The Democrats were quickly to oppose *with Equal Access to Abortion Coverage in Health Insurance,* but none of these bills were signed into law.[[10]](#footnote-10) The topic of abortion and its federal funding became a hot topic during the presidential race. Joe Biden has reversed his long-time support for the amendment and promised the end of hardships for women connected with the continuation of Hyde. The first budget proposal during his presidency was marked by historical absence of the ban, but ultimately failed to pass Congress without adding the proposition.[[11]](#footnote-11) In the 2023 funding bill, the Democrats took a step back and included the restriction right in the first proposal.[[12]](#footnote-12)

Ban on funding abortion is not restricted just to domestic politics. First practice to do so in foreign policy was introduced by Helms Amendment in 1973, barring money from the Foreign Assistance Act from being used on the procedure of abortion “as a method of family planning”[[13]](#footnote-13). Eleven years later, Ronald Reagan introduced the Mexico City Policy (also known as Global Gag Rule) and stated that “the United States will no longer contribute to separate nongovernmental organizations which perform or actively promote abortion as a method of family planning in other nations”[[14]](#footnote-14). In the past 40 years, the policy was repealed and reinstated with every change in the White House, and with Trump, the ban reached further than ever before by expanding it to include all departments and agencies of the global health assistance.[[15]](#footnote-15) The rule was repealed again by President Joe Biden during his first days in the office. However, the damage such restrictive policies caused women in respective countries led activists to demand for the permanent repeal of the Amendment, so that it could not be brought back again with new Republican president.[[16]](#footnote-16) But chances of any codification are small – foreign aid abortion funding is a partisan issue, and it can be expected to draw backlash of the Republicans if Democrats would aim to repeat it.

Both Global Gag Rule and Hyde Amendment have disproportionate implications on poor women depending on public funds and insurance. In the data collected by Guttmacher Institute in 2014, poor or low-income women represent 75 % of overall U.S. abortion patients.[[17]](#footnote-17) Such numbers highlight the need for better access to clinics and facilities that provide women with assistance when pregnant and/or with the access to contraceptives, and their inclusion in programs covering abortion procedures.

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1. Current limitations on the access to reproductive rights in Mississippi

Mississippi had one of the strictest policies regarding abortion access in the United States. This chapter presents every restriction one by one, providing factual background and outlining the main difficulties that are connected to the strict laws. As this thesis aims to show, and this chapter serves as an evidence, abortion, and the access to it are very complex issues. If reviewed individually, the restrictions might not seem too harsh, however, it is impossible to consider the real consequences for people seeking abortion if we only look on a part of the puzzle. That is why this chapter contains all the restrictions and links them together in order to provide the full picture.

* 1. Ban on partial-birth abortion

The battle to outlaw the so-called partial-birth abortion dates back to 1990s and the beginning of the 21st century. The procedure labelled as such is also known as “dilation and extraction” (D&X) or “intact dilation and evacuation” (intact D&E). Standard D&E has been standardly used in advanced weeks of pregnancy, during the second trimester (around 20th week), as it is more difficult to extract the fetus in another way. During the D&E procedure, the fetus is “dismembered inside the womb so it can be removed without damaging the pregnant woman’s cervix.”[[18]](#footnote-18) The procedure is effective and overall safe, but can cause some rare complications, such as blood loss, infection or cervix injury.[[19]](#footnote-19) In order to prevent involuntary complications, the method of D&X was introduced in 1995 as a way to abort the fetus almost intact, puncturing the skull just before pulling it out.[[20]](#footnote-20)

The method was quickly noticed by National Right to Life Committee, introducing the term ‘partial-birth abortion’. It is then a rather political term, aiming to terrify and disgust the public, building its base for banning the procedure as a whole. A bill preventing the use of D&X procedure had been passed in the House and the Senate in 1995 and 1997 but was vetoed both times by President Clinton. Similar ban was introduced in Nebraska at the turn of the century but was deemed unconstitutional by the Supreme Court in the ruling *Stenburg v. Carhart*. Nebraska’s ban did not include the exception for the health of the mother, which would place an ‘undue burden’ on the woman, which was deemed unconstitutional under *Planned Parenthood v. Casey*. However, the effort of pro-life campaigners and politicians continued after the initial ban-on-ban, resulting in President Bush signing the Partial-Birth Abortion Ban Act in 2003. It defines partial birth abortion as “an abortion in which the person performing the abortion, deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.”[[21]](#footnote-21) The law was addressed by many lower courts, ultimately ending up in front of the Supreme Court. In *Gonzales v. Carhart* (2007), the Court upheld the provisions by the federal law, arguing that it does not impose an undue burden.[[22]](#footnote-22) Even though the provisions of the law were very similar to the ones in Nebraska, the Court ruled that the procedure was not medically necessary, since there were other methods with which pregnancy can be terminated, namely D&E.[[23]](#footnote-23)

In Mississippi, the D&X procedure has been prohibited since 1997, resulting in 25 thousand dollars fine or imprisonment of maximum of two years for the performing physician. Health exception is included but is accompanied by a clause “if no other medical procedure would suffice for that purpose.” This part addresses the pro-life argument that such procedure is not necessary, with the option of using the D&E method.[[24]](#footnote-24) The language used in the law is explicitly hostile towards the procedure, addressing it as “killing” in the introduction of the bill by stating that “any physician who knowingly performs a partial-birth abortion and thereby kills a human fetus”, or in the definition of the procedure: “’partial-birth abortion’ means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.”[[25]](#footnote-25) In the Mississippi Code Ann. § 41-41-73, the woman who receives the procedure will not be prosecuted and the husband (or parents, if the woman is under 18 years old) can receive a relief in the form of money damages for injuries and statutory damages as high as three times the cost of the procedure, but only if the woman did not consent to the procedure.

In the past few years, Mississippi, Nebraska, and West Virginia have decided to go further and follow the model National Right to Life’s legislation to ban the standard dilation and evacuation method that is very commonly used in the second trimester. In five other states, the law is temporarily enjoined by court and in other four it is enjoined permanently.[[26]](#footnote-26) In 2015, a federal bill banning the D&E method was introduced but failed to pass the Congress. In January 2021, Republican Debbie Lesco from Arizona sponsored a Dismemberment Abortion Ban Act in the House of Representative. Its passing is very improbable in the current House, but should it be passed in the future, it would pose significant hardships to all women across the United States.

In Mississippi, the law banning the D&E method is in effect since July 2016 under the title ‘Unborn Child Protection from Dismemberment Action’ and defines the dismemberment abortion as an action “with the purpose of causing the death of an unborn child, purposely to dismember a living unborn child and extract him or her one piece at a time from the uterus through use of clamps, grasping forceps, tongs, scissors or similar instruments that, through the convergence of two rigid levers, slice, crush, and/or grasp a portion of the unborn child's body to cut or rip it off”[[27]](#footnote-27). The procedure can be done under one exception and that is to prevent serious health risks to the pregnant woman, which is defined as death or “risk of substantial and irreversible physical impairment of a major bodily function”. There is no exception for mental health conditions and the procedure cannot be done even if the woman clearly states she would engage in an activity that might result in her death or the impairment of important bodily functions, such as suicide, self-induced abortion or other action resulting in bodily harm.[[28]](#footnote-28) Violating the law can result in the maximum of $10,000 and/or custody for 2 years for the performing physician.[[29]](#footnote-29)

There are some alternatives to D&E and D&X, but their safety is limited. According to the American College of Obstetricians and Gynecologists, “(D&E) is evidence-based and medically preferred because it results in the fewest complications for women compared to alternative procedures”[[30]](#footnote-30). One of the alternative procedures is a modified D&E method during which the woman’s abdomen is injected with intracardiac potassium chloride and intrafetal or intra-amniotic dioxin and causes the demise of the fetus. Another one is a medically induced labor, and as much as it is effective, it is also very stressful and painful procedure that is also much more expensive.[[31]](#footnote-31) This specific method was overwhelmingly overshadowed by the introduction of the D&E method and appealed to women due to its lower cost, better convenience and comfort, and lower emotional toll that is caused by labor.[[32]](#footnote-32)

Overall, both D&X and D&E are very common and safe second-trimester abortion methods. By using sentimental rhetoric instead of medical terminology, the anti-abortion proponents try to influence not only the public opinion, but that of lawmakers as well. By banning the procedures, the state practically outlaws any abortions happening after 13 weeks of pregnancy. In the combination with other restrictive measures that are introduced in this chapter, it negatively influences poorer women who might take longer to collect finances needed for the procedure, pregnant teenagers who in general find out about the pregnancy later in term, and women with health complications of their own or of the fetus that might be detected in advanced pregnancy. There is no medical nor scientific reasoning for these bans, and their existence causes more financial hardships as well as emotional ones.

* 1. Mandated waiting period and informed consent

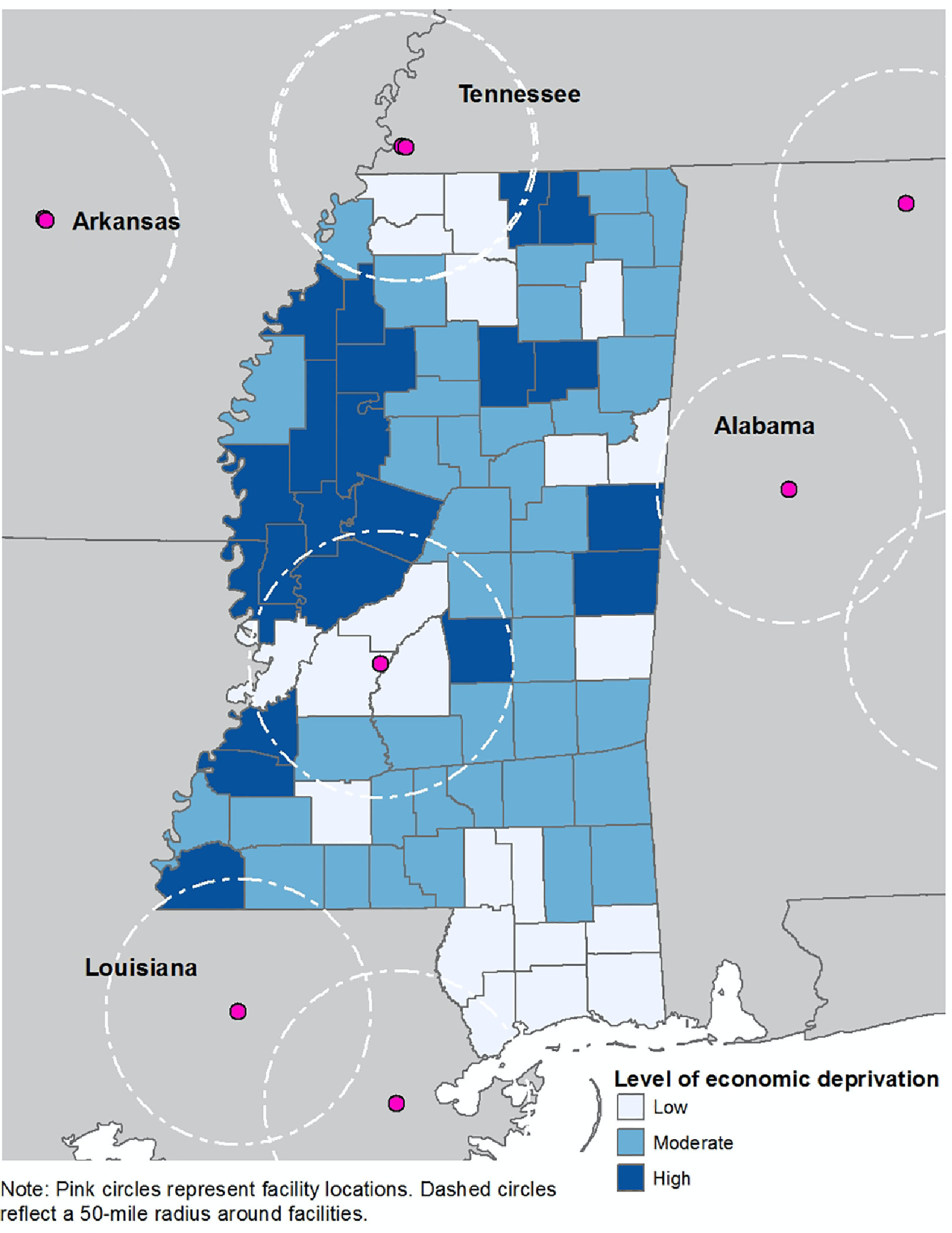
Mississippi has a mandated minimum of 24 hours waiting period between the consultation and the operation that has been in effect since August 1992.[[33]](#footnote-33) It was the first state to enforce such requirement, although the first to pass the law was Pennsylvania in 1989, where it went into effect five years later after being legally challenged.[[34]](#footnote-34) As of June 2022, 25 states in total require some amount of mandated waiting time – the most common being 24 hours but reaching 72 hours in six states. Iowa, Louisiana, Massachusetts, Montana, and Tennessee passed similar laws, but the policy is not in effect due to permanent or temporary enjoinment by court. However, only 11 out of these 25 states require the consultation to happen orally and in-person at the clinic, resulting in no less than two trips to the clinic.[[35]](#footnote-35) According to Joyce, “the two-visit requirement increases not only the cost of the abortion, but also the likelihood that a woman will travel to a nearby state to avoid compliance with the law.”[[36]](#footnote-36)

According to the Mississippi Code §41-41-33, the woman has to be told the following on her pre-abortive consultation: the name of the doctor that is going to perform/induce the abortion; the risks associated with chosen abortion method (such as infection, haemorrhage, infertility etc.); the presumed gestational age of the fetus at the time of the procedure; and the medical risks connected with the continuation of the pregnancy. Apart from that, she is also informed of medical benefits for prenatal, neonatal care and childbirth; the father’s liability to support the child (even in instances when he offered to pay for the abortion); the available public and private services providing pregnancy prevention counselling (including contraceptives); and the right to review printed materials that are provided by the State of Mississippi and contain descriptions and pictures of the fetus, as well as list of adoption agencies. The physician only has to offer these materials but can comment on them in any way they choose.[[37]](#footnote-37)

The documents described in Section 41-41-35 are printed materials published by the State Department of Health and contain information about both public and private agencies and services that can be of use and assistance during pregnancy and after it, such as list of adoption agencies with contact information and toll-free telephone number. The booklet also includes images picturing the ‘unborn child’s development in two-weeks intervals until full term, attached with information about the anatomical and physiological characteristics and the possibility of the fetus’ survival.[[38]](#footnote-38) Mississippi belongs among 17 states that require such materials to be offered to patients, who can reject the offer; 11 others explicitly require the materials to be given to them.[[39]](#footnote-39)

Apart from the signed consent containing information listed in § 41-41-33, the doctor or their assistant is required to perform ultrasound and hearing of the fetal heart tone. The physicians also offer the patient to see, as well as print, the ultrasound image and hear the if-audible heartbeat. This signed form by the patient stating that they have been provided with the possibility to both see the imaging and hear the heartbeat is then added to the signed consent above and shown to the doctor before the procedure.[[40]](#footnote-40) Since the consent needs to be given 24 hours prior the procedure and only in in-person format, it automatically requires women to two visits. Since 91 % of Mississippi women live in counties with no clinics providing abortions, these visits are complicated due to financial and other logistical reasons.[[41]](#footnote-41) As we can see on the map no. 1 below, there is a significant lack of any abortion facilities in the 50-mile radius for most of the counties, but mainly for the ones with a high level of economic deprivation.

**Map no. 1:** *County-level economic deprivation and abortion facility proximity in Mississippi, 2018*



Source: White et al. “Abortion at 12 or more weeks’ gestation and travel for later abortion care among Mississippi residents.” Contraception, vol. 108 (2022): 21.

According to data collected and reviewed for the purpose of the Mississippi reproductive health access project at the University of Texas, the median between patient’s visits was four days. 40 % of women returned for their procedure in 24 hours, 28 % in 2-6 days, 23 % in 7-13 days and 9 % in more than 14 days.[[42]](#footnote-42) This data show that the real waiting period is often longer than just 24 hours, resulting in a significant delay in care. For abortion, as opposite for some other medical procedures, time is a critical component. As this chapter will continue to show, similar restrictions, such as the mandated waiting period and the required in-person consultation harden the access to early (and financially more accessible) abortion. That is why any reduction of the legal time frame (in Planned Parenthood v. Casey set on 23-24 weeks on the merits of viability) in states with numerous abortion restrictions can result in major implications and life-altering consequences for many women, especially to those who cannot afford to travel out-of-state.

Do the mandatory delay statutes decrease the number of abortions, as they are intended to do? A study by Remez from 1998[[43]](#footnote-43) in Mississippi concludes that yes, they do, since the abortion rate decreased by 12-14 % after mandatory waiting period went into effect in August 1992. However, it should be noted that even though the overall rate declined, the number of abortions done out-of-state rose by 6 % than in the pre-restrictive year, and of those performed after 12 weeks of gestational age increased significantly in comparison with two other states without mandated delay.[[44]](#footnote-44)\* This trend in Mississippi was confirmed by Joyce and Kaestner, who estimated an increase of 35 % of second-trimester procedures in years after the enactment of the policy,[[45]](#footnote-45) and Bitler and Zavodny, who measured the national growth to be at 2.6 percentage points.[[46]](#footnote-46) An increase of abortions in the second-trimester as a result of mandated waiting period and in-person appointment was also recorded in Tennessee, where the number rose by 22-43 %.[[47]](#footnote-47) The conditions in Tennessee differ from Mississippi mainly in that the required waiting period is 48 hours. And so, while this variation must be taken into consideration, it provides us with fresh data and confirms conclusions made by authors of the studies conducted in 1998 and 2000. It also leads to an assumption that mandatory waiting periods do not significantly decrease the number of abortions, not as much as they are intended to.

As has been already outlined in the introduction of this chapter, the restrictive character of the mandated waiting period on the time-sensitive procedure of abortion has consequences in terms of financial and logistical hardships. Women living in states requiring in-person counselling were more likely to have a two-week delay of abortion than the others.[[48]](#footnote-48) Any delay causing abortion being done after the first trimester turns into an increase of risks connected to the procedure, as well as the cost of it. On one hand, the states introducing these measures argue that additional time, even if only a day, and providing information about other possibilities other than abortion ensure that the woman makes an informed decision.[[49]](#footnote-49) On the other hand, requiring the counselling to be in-person disproportionately disadvantages those who live far from the clinic, who cannot take that much time out of work, who struggle to pay the additional costs connected to the consultation, and who need to arrange for childcare. Given that the informed consent and delivery of other information can be done via phone or email, as it is being done in many other states, the underlying reason for such measure is only the goal of ending abortions. Even though the abortion rate did decrease after the enactment of these measures, the reduction was not as significant to justify the hardships women have to undergo in seeking the procedure.

* 1. Parental consent

Some type of parental involvement in minor’s decision to have an abortion is required in 37 states. In Mississippi, the law requiring parental consent was passed in 1986, and went into effect in 1993 after its constitutionality was challenged in court.[[50]](#footnote-50) Mississippi belongs among the only three states that require written consent by both parents or a legal guardian of the minor, according to the Mississippi law § 41-41-53.[[51]](#footnote-51) However, under certain circumstances (permanent or temporary absence of the father, or a history of sexual abuse by biological, adoptive, or step- father), consent by just one parent is sufficient. There is an exception for medical emergency that allows the physician to proceed with the abortion if it is in their best clinical judgement[[52]](#footnote-52), but not explicitly for the case of abuse, assault, incest or neglect, as in fifteen other states.[[53]](#footnote-53) A minor also has an opportunity to plead for a judicial bypass procedure that allows a court to give the approval to the abortion without the parents’ knowledge. The law ensures that the minor’s request will be dealt with within 72 hours, as it is highly time-sensitive issue that deserves precedence over other matters.[[54]](#footnote-54)

In order for the minor to receive the consent waiver by the court, she has to provide convincing evidence either of her maturity and awareness of the matter or that the abortion is in her best interest.[[55]](#footnote-55) The “clear and convincing evidence” standard is overall required by fifteen states, and seven of them use additional specific criteria (determining the emotional stability or intelligence).[[56]](#footnote-56) Most minors involve their parent/s in the decision-making process and receive support, but there is and always will be a percentage of those who cannot (or feel that they cannot) confine in their parents and have to obtain the judicial bypass. The reasons for ending pregnancy are not much different to those of older women, with young women realising the pregnancy being an interference with education and career goals, lack of financial stability and unsuitable environment for raising a child.[[57]](#footnote-57)

What are the effects of this requirement? Numerous studies have concluded that enforcement of parental consent leads to a raise of second-trimester abortions[[58]](#footnote-58), an increase of out-of-state abortions and the average travel distance[[59]](#footnote-59), decrease of abortion rate among teens immediately after the implementation of the requirement[[60]](#footnote-60) and increase of teen birth-rate[[61]](#footnote-61) in reverse. Even though the national pregnancy rates among 19 years olds and younger is declining significantly in the last two decades[[62]](#footnote-62), Mississippi has one of the highest rates of teen pregnancy, and the highest teen birth rate.[[63]](#footnote-63) But the trend of decline has been significant there as well – from 87 pregnancies per 1 000 women aged 15-17 in 1993 to 19 in 2017. Abortion among teens under 17 years old then fell from 13 per 1 000 women to 3 in the examined period.[[64]](#footnote-64) The percentual difference between pregnancies and abortions in fact increased – while 14,9 % of teen pregnancies ended in abortion in 1993, 15,8 % did in 2017. Given the national decrease of both overall and teenage pregnancies, Mississippi’s teens follow the suit. The same can be said for abortions, but the proportional number of abortions to pregnancies rose by 0,9 % since 1993.

The overall fertility rate has been decreasing annually in the United States, reaching its historical lows in 2020.[[65]](#footnote-65) Last year, in 2021, the birth rate has risen for the first time in seven years, by 1 %.[[66]](#footnote-66) This increase, however, has not been accounted for by women 24 years old and younger, but mainly by women aged 30-44 (other age groups have gone up as well, but not as significantly). The decreasing trend in teen pregnancies therefore continues, reaching historical lows of 5.8 provisional birth rate of those aged 15-17.[[67]](#footnote-67) What, other than the general decline of birth rates, stands behind the rapid decrease of teenage pregnancies?

According to Pew Research Center, use of contraception, less frequent sexual activity, sex-education and pregnancy prevention information belong among the possible reasons.[[68]](#footnote-68) Since Mississippi has one of the highest birth rates of teenagers in the United States, it is useful to look closely into some of these possible explanations.

The first explanation is the state of Mississippi’s sex education in schools. Up until 2011, there was no requirement for schools to implement any kind of sex ed in their curriculum. That changed in 2011, when HB 999 was introduced, regulating the manner in which schools teach and provide information about sex.[[69]](#footnote-69) The law included a repealer for 2016, but its existence was extended until July 1, 2021, lasting 10 years in total. The individual schools had to choose between abstinence-only or abstinence-plus education, but the emphasis on abstinence-only teaching was clearly visible. Sex education under abstinence-only generally highlights the health and psychological advantages of abstaining, its so-called “harmful consequences” to the minor and their family if a child is born outside of marriage, as well as “inappropriateness of the social and economic burden placed on others”. Under abstinence-only sex ed, some information about contraceptives can be mentioned, but with an emphasis on the risk and failures connected with using them, and no demonstration of their use/application can be showed. Marriage and faithful relationship are promoted as the only “appropriate” space for sex. During these classes, students were separated based on sex, so that they only heard partial information. In general, parents receive a written notice about the presentation taking place and can review the information that will be presented there and decide whether they want their child to attend (“opt-in” policy). Last but not least, the law prohibited mentioning abortion as a possibility for those who wish not to be pregnant.[[70]](#footnote-70) In contrast to abstinence-only, abstinence-plus is more open to the topic of contraceptives and the prevention of sexually transmitted diseases, but the emphasis is still mainly on abstinence.[[71]](#footnote-71)

Unsurprisingly, majority of schools in Mississippi chose to teach abstinence-only approach, providing students with insufficient information about sexual health.[[72]](#footnote-72) Majority of physicians and public health workers have condemned abstinence-only-until-marriage as an inappropriate approach to battle teen pregnancies and risks of contracting STDs.[[73]](#footnote-73) In recent years, the agenda was taken up by activist work such as Mississippi Youth Council (raising awareness about pregnancy and STD’s prevention, educating legislators, lobbying for more comprehensive sex education) or the Creating Healthy and Responsible Teens (CHART) initiative that ensure abstinence-plus approach is evidence-based, age-appropriate and medically accurate.[[74]](#footnote-74)

A lot of responsibility is also transferred to parents, labelled as “the number one influence in your child’s life” on the official website of Mississippi State Department of Health.[[75]](#footnote-75) Sex and related topics are very sensitive subjects to talk about in public, and the family surroundings is often the ideal space to discuss such matters. But not everyone will receive compact information from their parents, or not at the time when they most need it. In the data gathered during the National Campaign to Prevent Teen and Unplanned Pregnancy, around 80 % of teens expressed a desire to talk about these topics with their parents more openly and the same amount said it would be easier to prolong abstinence if these matters were discussed inside the family circle honestly and without judgement. This narrative is also promoted by CDC, claiming that teens start their sexual life later, engage in the sexual activity less often, are able to better communicate with their partners, and use condoms and birth control more often if they talk with their parents openly about these matters.[[76]](#footnote-76) That is why the mandated sex ed for school children was highly popular among Mississippi parents, endorsing information about contraception; transmission, prevention and testing for HIV/STDs; and even demonstration of the right use of contraceptives.[[77]](#footnote-77)

Years 2017-2019 saw a small national increase of women in the age group 15-24 using some kind of contraceptives (38.7 percent) from the previously examined period of 2015-2017 (37.2 percent).[[78]](#footnote-78) However, looking at data from years 2011-2013, the rate reached as much as 47.4 percent.[[79]](#footnote-79) Among teens, contraceptives like pills and condoms are the most used, with third place occupied by long-acting reversible contraceptives (LARCs).[[80]](#footnote-80) Focusing on Mississippi, 81.2 % of those sexually active (29.4 % of the whole teenage population) reported having used any contraceptive method before the last sexual intercourse in 2019, most commonly condoms (48.4 %), LARC (31.2 %) and birth control pill (18.3 %).[[81]](#footnote-81)

There are some visible racial disparities in the use of contraceptives and teen pregnancies. More non-Hispanic Black teens engage in sexual activity but use any contraceptive methods by 10 % less than their non-Hispanic white counterparts. Black teens are more prone to use condoms and LARCs rather than birth control (51.6 %, 22.2 % and 10.0 %), and white teens use condoms (44.5 %) and birth control (24.9 %).[[82]](#footnote-82) This staggering contrast in contraceptive use can be accounted to the fact that 208,400 Mississippi women live in the so-called contraceptive deserts, counties with inadequate access to health centres offering wide range of contraceptive methods; to the general lack of full-time physicians and to the 19.2 % of uninsured women.[[83]](#footnote-83) Given that Black teen birth rate precedes that of white teens by 10.5 births per 1.000 girls, and the fact that around 80 percent of the total abortion rate in Mississippi belongs to Black women in reproductive age shows us a structural problem of insufficient access to prevention and contraception for minority population.

The same percentage (around 15 %) of pregnant teens undergo abortions now as they did 30 years ago. There is a significant national decrease of the procedure, but it copies the decrease of teen pregnancies in Mississippi. Parental consent requirement therefore does not seem to prevent abortions, but only makes the access more burdensome, especially on those coming from financially unstable backgrounds.

* 1. Access to abortion facilities

The state of Mississippi extends over the total area of 125 433 km2 with the overall population of 2,949,965[[84]](#footnote-84). Women make up 51,5 % of the total population, reaching a slight majority in the state. 18,7 % of people reportedly live in poverty, with Mississippi having both the lowest real per capita income ($43,284)[[85]](#footnote-85) and the lowest nominal per capita income ($42 129)[[86]](#footnote-86) in 2021.[[87]](#footnote-87) 44 % of the population are people of colour, out of which Black or African American people comprise around 38 %.[[88]](#footnote-88) These data sets are crucial for understanding the socioeconomic characteristics of Mississippi. Drawing on 2016 data accessed through the Institute for Women’s Policy Research’s Status of Women Fact Sheet, 14.6 % of white women live in poverty while 31.3 % and 32.6% of Hispanic and Black women do. The annual earnings for full-time, year-round women’s workers varies from $35,518 for white women to $28,424 for Hispanic, $26.558 for Black and $26 047 for Native American women.[[89]](#footnote-89)

As of March 2022, the only state-licensed abortion clinic in Mississippi is Jackson Women’s Health Organization, also known as the “Pink House”. In the last 30 years, the number of abortion facilities has been reduced from eight to one.[[90]](#footnote-90) The clinic offers surgical abortions up to 16 weeks of pregnancy and medication abortion within the first 11 weeks.[[91]](#footnote-91) Based on a 2015 population estimates, the Pink House is the only available abortion clinic for 694,045 women in reproductive age (ages 15-49, with Mississippi as their permanent residency). This puts Mississippi at the near bottom of states based on their provision of abortion access and service availability, being preceded only by Kentucky (996 488 women of reproductive age per facility) and Missouri (1,365,575 women per facility).[[92]](#footnote-92) In total, there are six states in the whole United States that only have one abortion clinic – Missouri, North Dakota, South Dakota, West Virginia, Kentucky and Mississippi. [[93]](#footnote-93) It leads to disproportional burden on remaining clinics in these and neighbouring states.

In the last few months and years, Mississippi’s neighbouring states have been enacting more restrictive abortion laws, resulting in the influx of patients to the abortion clinic in Jackson. Data obtained through the CDCs Abortion Surveillance System show that in 2019, out of reported 3,194 abortions obtained in Mississippi, 118 women travelled from Alabama and 160 from Louisiana.[[94]](#footnote-94) However, the list is not complete as the states do not have the obligation to report to CDC, resulting with missing data from fifteen states, including Texas. Texas in particular might modify the data, especially after the so-called Heartbeat bill came into effect in September 2021, restricting abortion after six weeks of gestational age.[[95]](#footnote-95) Although most of Texan women seeking abortion outside of the state went to Oklahoma (45 %) and New Mexico (27 %) in 2021, some percentage of women most likely took on the minimum of 250 miles drive to Mississippi.[[96]](#footnote-96)

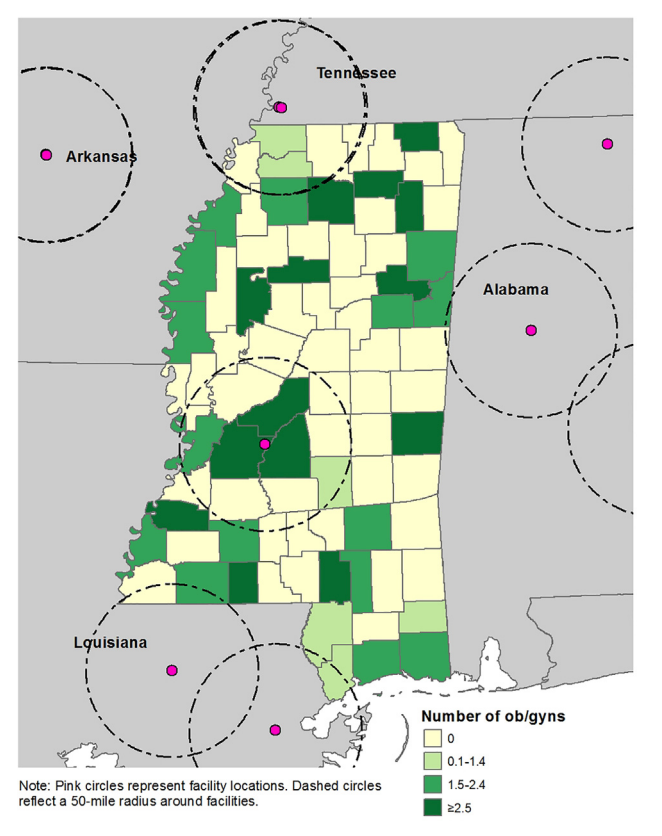
Due to the inadequate availability of access to abortion facilities and clinics, people seeking abortion tend to travel longer distance and even cross borders in case of hostile laws in their home state.[[97]](#footnote-97) Before overturning Roe, the average driving distance for women in Mississippi was 78 miles.[[98]](#footnote-98) Since the end of June, the distance increased to a minimum of 120 miles (from Biloxi, MS to Pensacola, FL) up to 401 miles.[[99]](#footnote-99) All of Mississippi’s neighbouring states are expected to ban abortions or enact laws restricting or criminalizing the access to abortion care at near point in the future. Mississippi was joined by Alabama and Arkansas in enforcing trigger bans that outlaw abortion entirely; in Louisiana, a trigger ban was preliminary enjoined but is expected to go into effect at the beginning of August; and Tennessee, the northern neighbour, enforced its 6 weeks ban and prepares for Tennessee’s Human Life Protection Act (a total abortion ban) to go into effect on August 25.[[100]](#footnote-100) The closest states protecting the right to abortion under the state’s constitution is Illinois.[[101]](#footnote-101) Traveling 50 or more miles for the appointment also results in delaying the care by more than a day, and as much as two day-delay is accounted to the in-person pre-abortion appointment, as is the case in Mississippi.[[102]](#footnote-102) Other than that, the travel length is closely connected to few of the other hardships women have to undergo in search for the access to abortion, such as expenses for the overnight stay in Jackson, travel costs (bus/train tickets, gas in case of car travel) and financial losses due to missed work. In the 2019 study of 215 Mississippi women seeking abortion at the abortion clinic in Jackson, 60 % of them recalled having difficulties with paying the expenses of their abortion care and the additional costs. 49 % reported delaying payment for routine expenses (29 % utilities, 20 % car expenses, 13 % on rent or mortgage, 11 % food and small percent on credit cards, childcare, and tuition) and another 42 % received financial help from family, friends, the man responsible for the pregnancy, and non-profit abortion organizations.[[103]](#footnote-103)

* 1. Self-induced abortion and ban on telemedicine

In some counties in the United States, access to medical care can be scarce, especially in rural areas. An example can be provided by map no. 2, which shows the insufficient number of OB-GYNs in Mississippi’s individual counties.In recent years, the expansion of telehealth has helped to deal with that issue, also abortion-wise. As more and more restrictions were introduced all over the States, making in-person abortion visits significantly more complicated, online medical abortion offered an easy way out. Mississippi, however, dealt with this issue by passing the Women’s Health Defense Act of 2013, ultimately banning the possibility of obtaining medication abortion through telehealth. The law conditions the prescription of abortion pills to be executed by a physician during an in-person visit, with the pregnant woman taking the pill in the same room. There is also a condition of a follow-up visit in about two weeks after the first visit.[[104]](#footnote-104)

As one of the first clinics in the United States, Planned Parenthood of the Heartland in Iowa started offering medical abortion through telemedicine, which helped women with logistical issues such as travel costs, less time spent outside of work, looking for babysitter or the need to explain the absence.[[105]](#footnote-105) Medical abortion (the combination of mifepristone and misoprostol) is a very common method used during the first few weeks of pregnancy (up to 10 weeks of gestational age), first used in 2000. Since then, its usage rose, reaching 54 % of all abortion in the United States in 2021.[[106]](#footnote-106) While its administration had occurred mainly inside clinics with a certified physician on site, because of the advancement of telemedicine, the distribution of abortion drugs could have been done through a collaborating clinic that is closer to the patient. The test needed to assess the state of pregnancy could have been done at that clinic that sends the results to the physician, who then had a consultation with the pregnant woman by videocall, authorizing the collaborating clinic to distribute the pills.[[107]](#footnote-107) Even though the patients still needed to go to a clinic, depending on the State, the distance was significantly smaller than if they had to travel to a certified abortion clinic with a physician on the site.

Map no. 2: *Number of ob/gyns per 10,000 women & abortion facility proximity in Mississippi, 2018*



Source: White et al. “Abortion at 12 or more weeks’ gestation and travel for later abortion care among Mississippi residents.” Contraception, vol. 108 (2022): 22.

This approach has changed during the coronavirus pandemic when the U.S. Food and Drug Administration re-evaluated the mandate to administer mifepristone only after in-person visits. To come to this decision, “the agency conducted a comprehensive review of the published literature, relevant safety and adverse event data, and information provided by advocacy groups, individuals and the applicants”.[[108]](#footnote-108) The pills still need to be prescribed by a certified physician but can be collected in pharmacies instead of designed clinics.[[109]](#footnote-109) The decision came as number of states specifically outlawed mailed-in drugs, namely Arizona, Arkansas, Texas, Montana, Oklahoma and South Dakota.[[110]](#footnote-110) Working around the bans is the non-profit telemedicine service called Aid Access that started its mission in 2018. The fees surrounding abortion are costly. The service provides abortion pills for the cost of $110 – 150, a quarter of what the woman would have to pay at the clinic. In the states where medical abortion is not conditioned to take place at the clinic, the prescription is made by an US based physician and the pills are mailed out in a couple of days. In those with restrictions, there is a loophole that uses Europe-based physicians providing prescriptions that can be then used in Indian pharmacies. The pills then arrive by mail in one to three weeks.[[111]](#footnote-111) There is not much that could be done against Aid Access, due to its residency being outside of the United States. Dr. Abigail Aiken, an associate professor researching Aid Access, has called them “a humanitarian nonprofit, not a business the way an online pharmacy is.”[[112]](#footnote-112) By operating outside the formal health care setting, it can offer services for rather symbolic price and operate in states with restrictive abortion laws.

Because the FDA approved the safe use of mifepristone for self-induction, GebBioPro Inc., a drug company based in Nevada producing mifepristone, filed a lawsuit against Mississippi on the basis of a conflict between the federal agency and state legislation. It is a second lawsuit in Mississippi, first in 2020, that argues the legalization of mifepristone. It bases its argument on that the safety and efficacy of the drug (as stated by FDA) is attacked by the Mississippi’s ban. The general attorney Fitch said herself that “under the trigger law, the State is not regulating as to whether mifepristone is safe (…), instead, the trigger law imposes the conditions upon which an abortion may be performed at all”.[[113]](#footnote-113) A result that would allow the use of the drug under current abortion bans is rather uncertain.

* 1. Insurance and funding policies

No public funds, meaning finances provided by the federal, state, or local governments, are allowed to be used for any activity connected with abortion except for three exceptions: to prevent the death of a pregnant woman; to abort pregnancy caused by rape or incest; and if the fetal malformation is found incompatible with viability.[[114]](#footnote-114) Sixteen states have explicitly ruled that all or most medically necessary abortions are accessible through Medicaid funding.[[115]](#footnote-115) In Mississippi, however, this is not the case, due to their legal opt-out in § 41-41-99.[[116]](#footnote-116) Mississippi has also decided not to expand Medicaid under the Affordable Care Act that would allow around 170.000 adults under 65 years old to be eligible for the program if the insurance covered all those under 138 % of federal poverty rate.[[117]](#footnote-117) The implications of the lack of federal and state funds are felt the most by Medicaid-eligible low-income women whose financial situation forces them to access abortion later in term, only after gathering enough money to pay for the procedure, which leads to the rise of second trimester abortions that are not only more expensive, but also riskier in terms of health complications[[118]](#footnote-118) , or carrying unwanted pregnancies to term[[119]](#footnote-119).

But the coverage issue is much more complex. Since Mississippi refused to expand the scope of people that would fall under Medicaid, around 50,000 of women fell into the coverage gap[[120]](#footnote-120), worsening their access to health services including reproductive health education or family planning services.[[121]](#footnote-121) Pregnant women can get Medicaid if their income is under 194 % of federal poverty level and receive 60 days of postpartum coverage as well as one year of Medicaid coverage for their children (for perspective, 67 % of births in Mississippi were covered by Medicaid in 2017[[122]](#footnote-122)).[[123]](#footnote-123) Physicians and activists have long called for prolonging the covered time up to one year after giving birth. A bill that would extend Medicaid coverage was passed by Mississippi’s Senate in February 2022 but died before being voted on in the House of Representatives. The House Speaker Gunn publicly opposes any expansion of Medicaid, even if majority of its expenses are paid by the federal government. According to Gunn, “we need to look for ways to keep people off (Medicaid), not put them on”, focusing on the financial aspect of the matter.[[124]](#footnote-124)

Why is this important? First, according to a report by Health Care Cost Institute, over 80 % of postpartum healthcare services were used between 60 days and one year.[[125]](#footnote-125) Second, Mississippi has the highest infant mortality rate in the United States[[126]](#footnote-126), significant pregnancy-related mortality ratio (between 2013-2016, 33.2 deaths per 100,000 live births, down to 22.1 in 2020 /US average was 17.3/)[[127]](#footnote-127), and 25 % of women in reproductive age at the poverty level[[128]](#footnote-128). Almost 90 percent of pregnancy-related deaths happened during postpartum, 37 percent of which occurred after six weeks (Medicaid coverage ends after 8 weeks). Mortality of Black women was almost three times the deaths of white mothers.[[129]](#footnote-129) Infant mortality rate of Black infants was 11.8 deaths per 1 000 live births and 5.7 for white children. Although these rates show decreasing tendency over the past few years, there are evident racial disparities – while death of white infants decreased from 2016 to 2020 by 21 percent, it was only 11 percent for Black ones.[[130]](#footnote-130) Leading cause of infant deaths was preterm birth or other complications of pregnancy, labor, and delivery. Mississippi is the leading state of preterm birth rates, and in 2020, 17 % of them were among Black women (non-Hispanic 12 % and Hispanic 13%).[[131]](#footnote-131) Improving access to health care services and expanding Medicaid coverage is imperative to improve the lives of thousands of women.

The fees surrounding abortion are costly. In Mississippi, an ultrasound that is mandatory according to the state law costs $100. Abortion pill (that can be used only up to 11 weeks) costs $600. Abortion from week 12 costs $700, from week 14 a total of $800.[[132]](#footnote-132) Given the mandated waiting period between consultation and operation of 24 hours, women traveling to Jackson from afar must pay additional fees, such as travel and accommodation expenses.[[133]](#footnote-133) The number of organizations based in Mississippi that would provide financial or logistical help with abortions is limited. There is a Pink House Fund, closely working with Jackson Women’s Health Organization, and functioning on individual donations and collaborations with other organizations and funds with the same goal.[[134]](#footnote-134) The Access Reproductive Care-Southeast is one of them, and apart from Mississippi, it provides financial and practical support (such as lodging, rides, or even escort) in Alabama, Florida, Georgia, South Carolina, and Tennessee.[[135]](#footnote-135) Last but not least is the Mississippi Reproductive Freedom Fund, which offers variety of services (transportation, child care, logistics and finance for appointment, and medication assistance) for Mississippians, even outside the state.[[136]](#footnote-136) All of these organizations underline the need for accessible reproductive health care and aim to support women in any decision they might make during their pregnancy. For many women, funds like these are the last resort, helping them from turning to unsafe and self-induced abortions or continuations of unwanted pregnancies. However, not even these additional funds cannot cover the demand.

* 1. Targeted Regulation of Abortion Provider laws

Another way how to regulate abortion access has been hidden under requirements aimed at physicians and facilities offering the procedure, rather than on the pregnant people. These licensing and often unnecessary conditions are known as Targeted Regulation of Abortion Provider laws (short as TRAP), and vary from specifications of size and width of the hallways and procedure rooms; of the clinic or even the physicians themselves to have admitting privileges to a close-by hospital; or the clinics to meet standards intended for surgical centers or sometimes even hospitals, even though the abortion procedure does not require these specific conditions to protect the health and safety of the patient.[[137]](#footnote-137)

In 2012, Mississippi passed HB 1390 which amended the public health section of the Mississippi code by adding requirements for abortion facilities. In the section § 41-75-1, abortion facility is defined as “a facility operating substantially for the purpose of performing abortions and is a separate identifiable legal entity from any other health care facility, (where) all physicians associated with the abortion facility must have admitting privileges at a local hospital and staff privileges to replace local hospital on-staff physicians, (and) all physicians associated with an abortion facility must be board certified or eligible in obstetrics and gynecology”[[138]](#footnote-138). Other than that, the abortion facility has to perform more than ten abortion procedures per month to be considered an abortion facility and has to apply for a license to the State Department of Health. It must also be located further than 1,500 feet from any kindergarten, school, or church.[[139]](#footnote-139)

The requirements concerning admitting privileges and board certification were quickly contested after the bill was signed into law by the Center of Reproductive Rights on behalf of the Jackson Women’s Health Organization.[[140]](#footnote-140) According to the then-vice-governor Tate Reeves, it was a bill that would “effectively end abortion in Mississippi”[[141]](#footnote-141). Elizabeth Nash from the Guttmacher Institute had called it “an attempt to eliminate access without taking on Roe directly”[[142]](#footnote-142). While all physicians working at the clinic at that time were certified, only one of them had admitting privileges at near hospital, which would have ultimately resulted in closing the clinic.[[143]](#footnote-143) It can be quite difficult, often impossible, to obtain admitting privileges in hospitals, which require physicians to pass number of conditions like admitting steady number of patients per year. As abortion physicians generally do not have that need, it would be impossible to execute for many of them.[[144]](#footnote-144)

After having partially blocked the law in July 2012, the federal court barred Mississippi state officials from enforcing admitting privileges as long as the federal lawsuit was pending.[[145]](#footnote-145) This requirement was ultimately stroke down by the court in 2017, shortly after the SCOTUS decision in *Whole Woman’s Health v. Hellerstedt*, where the Texas’ law in question also required admitting privileges and for clinics to meet the standard of ambulatory surgical centers. The Court ruled that such requirements are not specially beneficial for women’s health and rather present an undue burden.[[146]](#footnote-146) Even though the Mississippi’s court was inspired by this decision, the OB-GYN condition was upheld, making Mississippi the only state in which such requirement is enforced. The federal judge Jordan declined the Jackson Women’s Health Organization request to block it after ruling that the requirement is not difficult to fulfil, meaning that there are enough certified OB-GYNs willing to work at the clinic.[[147]](#footnote-147) For Hillary Schneller, an attorney at Center for Reproductive Rights, the law unnecessarily removed “a huge number of qualified physicians” who would otherwise have proper education and training.[[148]](#footnote-148)

TRAP laws are mainly aimed to limit the provision of abortion services. The difficulties and costs connected to complying with the requirements result in the decrease of abortion providers which significantly affect the accessibility of abortion for those who need it. Lower number of certified abortion providers and facilities lead to an increase of travel and costs connected to it.[[149]](#footnote-149) While some abortion restrictions are framed as if with intent to protect women and their health, the motivation behind HB 1390 was loud and clear – close the only abortion clinic in the state and therefore end legal access to abortion.

* 1. Trigger law

In 2007, a bill authored by a Republican senator Joey Fillingane[[150]](#footnote-150) was added to the Mississippi code under the § 41-41-45, outlawing abortions after ten days from the official overruling of Roe v. Wade. The ten-day period will be counted from the day the Attorney General of Mississippi confirms that Attorney General has certified the SCOTUS decision as the law of the land.[[151]](#footnote-151) This provision serves as a check against the limited time Mississippi Congress is in session so that the law can be enacted almost immediately without having to wait to pass the necessary legislative round in the House of Representatives and the Senate.[[152]](#footnote-152) The law bans all abortions except when the procedure is necessary for ‘the preservation of the mother’s life’ or in the case of rape. However, it places additional burden on this exception because it requires the charge of rape to be formally filed out with law enforcement officials. The law also has a provision of the punishment of imprisonment from one to maximum of ten years for anyone (except for the mother herself) who performs or attempts to induce abortion in the state.[[153]](#footnote-153)

Mississippi belongs among the total of 13 states – Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, Wyoming – that have a law like this in place. In majority of these states the ban would not be immediate (only in Kentucky, Louisiana, and South Dakota), requiring certification by attorney general or governor or fulfilment after 30 days from the Court’s official decision. All the bans include an exception for the case of pregnant person’s life being in danger, but anyone performing abortion outside of the exceptions (including rape, incest, lethal fetal abnormality, or irreversible impairment of a major bodily function) would face being charged with felony, fine and even suspension or revocation of their professional license.[[154]](#footnote-154) The law banning abortion in Mississippi went into effect on July 7, 2022, a day after Jackson Women’s Health Organization, the last abortion clinic in the state, closed its doors.[[155]](#footnote-155)

1. Framing of the abortion debate in Mississippi

The Gestational Age Act (Miss. Code § 41-41-191) that is in question in *Dobbs v. Jackson Women’s Health Organization* was drafted by a group of 16 Republican Representatives and passed the Congress in 2018. It was almost immediately challenged by the Jackson’s clinic suing Thomas E. Dobbs, who served as the Mississippi’s state health officer at the Department of Health. The U.S. District Court for the Southern District of Mississippi ruled in and enjoined the provisions of the Act. Mississippi then proceeded to appeal to the Fifth Court, which retained the ruling of the lower court. In June 2020, the State of Mississippi, represented by the Attorney General Lynn Fitch and her office, filed the petition for writ of certiorari at the Supreme Court that included three main questions: 1) whether all pre-viability prohibitions on elective abortion are unconstitutional; 2) whether the validity of a pre-viability law that protects women’s health, the dignity of unborn children, and the integrity of the medical profession and society should be analyzed under Casey’s “undue burden” standard or Hellerstedt’s balancing of benefits and burdens; and 3) whether abortion providers have third-party standing to invalidate a law that protects women’s health from the dangers of late-term abortions.[[156]](#footnote-156) The Supreme Court admitted the case to deal with the first question regarding the constitutionality of pre-viability prohibitions.

Record number of amicus briefs were filed with the Court on both sides. For the purpose of this thesis, I will focus mainly on the arguments and rhetoric presented by the petitioners (the Mississippi State), the respondents (Jackson Women’s Health Organization) and amicus briefs that were passed on behalf of them. Firstly, the main arguments made by the petitioner’s side will be presented. Secondly, the counter-arguments of the respondents will follow. Last but not least, the stance on the abortion issue will be examined among the Mississippi’s highest political representatives – U.S. senators, U.S. House Representatives, governor, attorney general,

* 1. General objectives of the petitioners

In the petition for a writ, Mississippi presented number of reasons upon which the Court should grant an admission of the case. Big emphasis was given to the issue of viability, regarded as very problematic since its introduction in *Roe* and its sequential modification in *Casey*. The petitioners saw the standard as outdated and inappropriate for decisions regarding the constitutionality of abortions, mainly due to the advances in medicine and science that have shaped the knowledge about prenatal development. The petition asked the Court to consider the state’s legitimate interests in “protecting maternal health, safeguarding unborn babies, and promoting respect for innocent and vulnerable life”[[157]](#footnote-157). After the case was admitted, the question of constitutionality of pre-viable abortion prohibitions was more deeply explored in the Brief for Petitioners, where the subject quickly turned to questioning the constitutionality of the right to abortion itself, as introduced by Roe and Casey. According to the petitioners, since the right has no basis in constitutional text, history, structure nor tradition, “the question becomes whether this Court should overrule those decisions.”[[158]](#footnote-158) Both Roe and Casey’s rulings are “egregiously wrong”, not only due to their ‘insufficient’ legal background, but also because it concerns “the purposeful termination of a potential life”, unlike any other law.

Since the lower courts focused mainly on whether the Act in question violated the viability standard, Mississippi argued that the inability to address the state interests damages the suitability of the undue burden standard as well. “If a State’s interests are “compelling” enough after viability to support a prohibition, they are “equally compelling before” then.”[[159]](#footnote-159) But what are the “compelling” state interests in question? According to the brief, it is the protection of the life of the unborn, of the medical profession and of the women’s health that should belong to the states rather than the Court’s precedent. Regarding the protection of the unborn life, a list of weekly changes of the fetus development (such as the start of movement, the functioning of vital organs, the presumed heartbeat, and the contested ability to feel pain) is used to stress the thin line between pre-viability and viability time period. As for the protection of the medical profession, the main issue is the prevalence of D&E method in later abortions that is deemed “barbaric” and “demeaning to the medical profession”. The petitioners also suggested that the procedure has many medical risks that endanger the women’s health, along with the physical and psychological risks from abortion in general.[[160]](#footnote-160)

Mississippi asked the Court to overrule Roe and Casey and return the decisive power back to the states. It did so on very questionable foundation. The arguments presented to the Court were very similar to those presented in Casey, where the Court ruled to sustain the right to abortion with a slight change to the viability standard (from trimester framework to viability line set to 24 weeks of gestational age) and the introduction of undue burden practice. This test is meant to serve as a guideline to pre-viability restrictions, requiring the states to implement only such restrictions that do not cause substantial obstacles in accessing abortion care. But it is the undue burden, among other abortion jurisprudence, that fails to deliver, at least in the petitioners’ eyes. For them it lacks any objectivity in deciding which restriction is undue and leaves that decision on individual courts. Another argument for overturning Roe is the absence of persuasive reasons for retaining it only because of the reliance interest. Mississippi claims that reliance interest used in Casey (for Roe), arguing that for “two decades of economic and social developments, people have organized inti-mate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail,” is less applicable today than 30 years ago due to the legislative actions in protecting equality that provides women with much more guarantees and support pre-, during, and post- pregnancy and maternity.

The main argument for the return of abortion legislature to the states is that such controversial issue should be decided by the people themselves through the democratic process. That giving the power to the Court that cannot react to ever-changing world is wrong and harms both women and unborn children. But while this view is not particularly flawed, its surrounding is. Given that Mississippi had already had a trigger law in place that would ban abortions in 30 days after overruling of Roe, pledges of discussion and compromise fall on short.

* 1. Amici briefs

The amici briefs filed with the Court on behalf of the petitioners chosen for this analysis come from American Center for Law and Justice, the Roman Catholic Diocese of Jackson and the Roman Catholic Diocese of Biloxi, 375 women injured by second and third trimester late term abortions and Melinda Thybault, individually and acting on behalf of 336,214 signers of the moral outcry petition, the Amici States[[161]](#footnote-161), the American Association of pro-life obstetricians & gynecologists, Right to Life of Michigan, Inc., and the National Catholic Bioethics Center, the National Right to Life Committee and Louisiana Right to Life Federation, African American, Hispanic, Roman Catholic and Protestant Religious and Civil Rights Organizations and Leaders, Women Legislators and the Susan B. Anthony List, and the March for Life Education and Defense Fund. The reason for choosing these is their: a) role in the pro-life movement, b) position in the abortion debate, c) relevancy for the given case. There are number of common themes revolving around the state interest in the protection of the unborn child, health of the mother, return of state rights in abortion issues and the racial aspect of reproductive rights.

* + 1. Fetal pain

The Roman Catholic Diocese of Jackson and the Roman Catholic Diocese of Biloxi in their brief cite catechism of the Catholic Church, claiming that human life starts at conception: “From the first moment of his existence, a human being must be recognized as having the rights of a person – among which is the inviolable right of every innocent being to life.”[[162]](#footnote-162) Any interest in protecting those who feel pain at 15 weeks is then deemed a legitimate state interest, and this petitioner’s argument is supported by the Diocese as well as Amici States[[163]](#footnote-163), The March For Life Education and Defense Fund[[164]](#footnote-164), and the National Right to Life Committee[[165]](#footnote-165). The problem with fetal pain is that its identification is quite hard. The pro-life movement itself has no strict and official ‘fetal pain line’, as in most statements by the Mississippi Senator Wicker regarding abortion restrictions, fetal pain was circled around 20 weeks. However, in these cases the relevancy for fetal pain argument is blurred behind the conviction that the human life starts at conception, therefore any abortion is an act of ‘killing of an unborn child’. There was an attempt to codify the life-begins-at-conception belief in Mississippi by constitutional Personhood Amendment initiative in 2011, but more than 57 % of voters opposed it.[[166]](#footnote-166) Relatively strong opposition shows us the public’s stance to this very polarized issue and that implying the embryo in the first few months of pregnancy is a person with the same rights as the woman is not something to be easily accepted.

* + 1. Protecting the woman’s health from late term abortion

A repetitive reason for the need of abandoning the viability standard and banning late-term abortion has been the indicated state interest in protecting the life and health of mothers. All sides agree that the more advanced the pregnancy is, the riskier abortion gets. In the brief by 375 Women injured by second and third trimester late term abortions, the abortion industry has been portrayed as self-interested and inhuman, as if it was persuading women to undergo the procedure later in term.[[167]](#footnote-167) Instead, and Mississippi serves as a good example, the more restrictions are adopted, the higher is the possibility of women reaching out later in term. As I have outlined in the previous chapter, 24 hour mandated waiting period, tougher accessibility to the only abortion clinic in the state, and the opposition of politicians to include abortion costs under Medicaid insurance lead women to postpone their visit. However, these circumstances seem to be irrelevant for the pro-life argument of “maternal health”. Emphasis on “devastating psychological consequences” women might have after abortion then disregards the psychical and physical toll pregnancy can have on the woman, especially in case of an unwanted pregnancy. Drawing on data from the previous chapter, in Mississippi, abortion is less dangerous than giving birth, which undermines another favourite argument – adoption.

As mentioned in the brief, the “State now offers to receive the child from the mother at no cost”, arguing that continuing with pregnancy and giving a child up after birth gives women the sought liberty. Suggesting that a woman “that has waited for fifteen week can simply wait a relatively short while later and place the child with the state after birth at no cost whatsoever. (..) In return for this 18-year complete release of all parental obligation, it is not an ‘undue burden’ to ask the mother to carry the child to term and not ‘terminate the life of a separate, unique, living human being’.”[[168]](#footnote-168) This complete disregard for the woman’s body integrity, serving as a mere incubator, is promoting a view that the life of the unborn fetus is more than a life of a woman capable of conscious decision making about her own body. Moreover, the data on adoption and foster care population do not support the forced-pregnancy argument. Just in 2020, 1 384 children under 17 years old were waiting for adoption, and only 597 of them did.[[169]](#footnote-169) The average age of adopted children was 7.2 years, and the average length of stay in care before the adoption was finalized was 40.3 months. That means that some children are almost four years old before they are placed in a loving family, and majority are much older, not mentioning the racial disparity where perceptually more White children are adopted than those of color.[[170]](#footnote-170)

* + 1. Abortion as a minority epidemic

The amicus brief filed by National Hispanic Christian Leadership Conference, the Frederick Douglass Foundation, Stand for Life, Common Good Foundation, and the Roman Catholic Diocese of Tyler supported Dobbs in its appeal to complete overturn of Roe. They framed the abortion issue as “black genocide”, with Planned Parenthood as the main orchestrator. One of the reasons is the problematic figure of the founder of Planned Parenthood – Margaret Sanger.[[171]](#footnote-171) She has been connected with the eugenics movement, however, PP has denounced and distanced itself from her beliefs in the racist ideology.[[172]](#footnote-172) The brief rightly pointed out the racial disparity in the abortion rate both nationally and in Mississippi. However, connecting the location of PP clinics with intentional genocide is not supported by any data. On the contrary – it would make sense to open clinics at places that have the biggest demands. By blaming PP for abortions of women of colour, we intentionally close eyes to the reasons these women demand abortion much more than their White counterparts. Implying that birth control also serves as an instrument of racial elimination opens the door for any possible future attack on the remaining reproductive rights.

* + 1. Power back to the states .. and women?

That the state should have the sole right to create abortion laws is the underlying argument of the whole case. The brief by women legislators and the Susan B. Anthony List implies that if/when the rights return to the states, women will have the ability to shape the discussion and legislation due to their increased representation in state legislatures. As the case in point is regarded the fact that the Gestational Act was introduced by a female Representatives Becky Currie, Stacey Wilkes and Ashley Henley. The brief views the increase of representation as sufficient, even though it is still only 30 %. The brief states that “because of women’s increased role in the legislative process, this Court can safely defer to the judgements of state legislators on abortion and other issues disproportionately affecting women, to the same extent that it would defer to legislative judgements on other health and safety issues.”[[173]](#footnote-173) The authors continue by saying that Roe in fact harmed female legislators, because it obstructed the way for debate and “persuasion”. The brief sums up with an assertion that “women are much better situated today to protect their own interests through legislation, the Court should give them the opportunity to do so”. What this and other briefs have in common is the unaccountable feeling that the rights Roe shielded were somewhat harmful to women in general and that it somehow attacked their interests. Roe only ensured that women who wanted to have an abortion were free to have it. They had a choice. By taking away that choice, it cannot be expected to be followed by empowerment.

* + 1. New roadmap – abandoning viability and undue burden?

Common theme was also the call for abolition of undue burden standard and pre-viability prohibitions on abortion restrictions. Viability was not to be considered the only relevant scrutiny, but as something merely signifying certain point in the development of the fetus and not as a boundary line in front of which the state cannot reach with its ‘justifiable’ concerns. [[174]](#footnote-174)

* 1. Respondents

Common theme was also the call for abolition of undue burden standard and pre-viability prohibitions on

* 1. Views of the political representatives

Common theme was also the call for abolition of undue burden standard and pre-viability prohibitions on

* + 1. Roger F. Wicker

Common theme was also the call for abolition of undue burden standard and pre-viability prohibitions on

* + 1. Cindy Hyde-Smith

Common theme was also the call for abolition of undue burden standard and pre-viability prohibitions on

Conclusion

Conclusion. Conclusion. Conclusion. Conclusion. Conclusion. Conclusion. Conclusion

Summary

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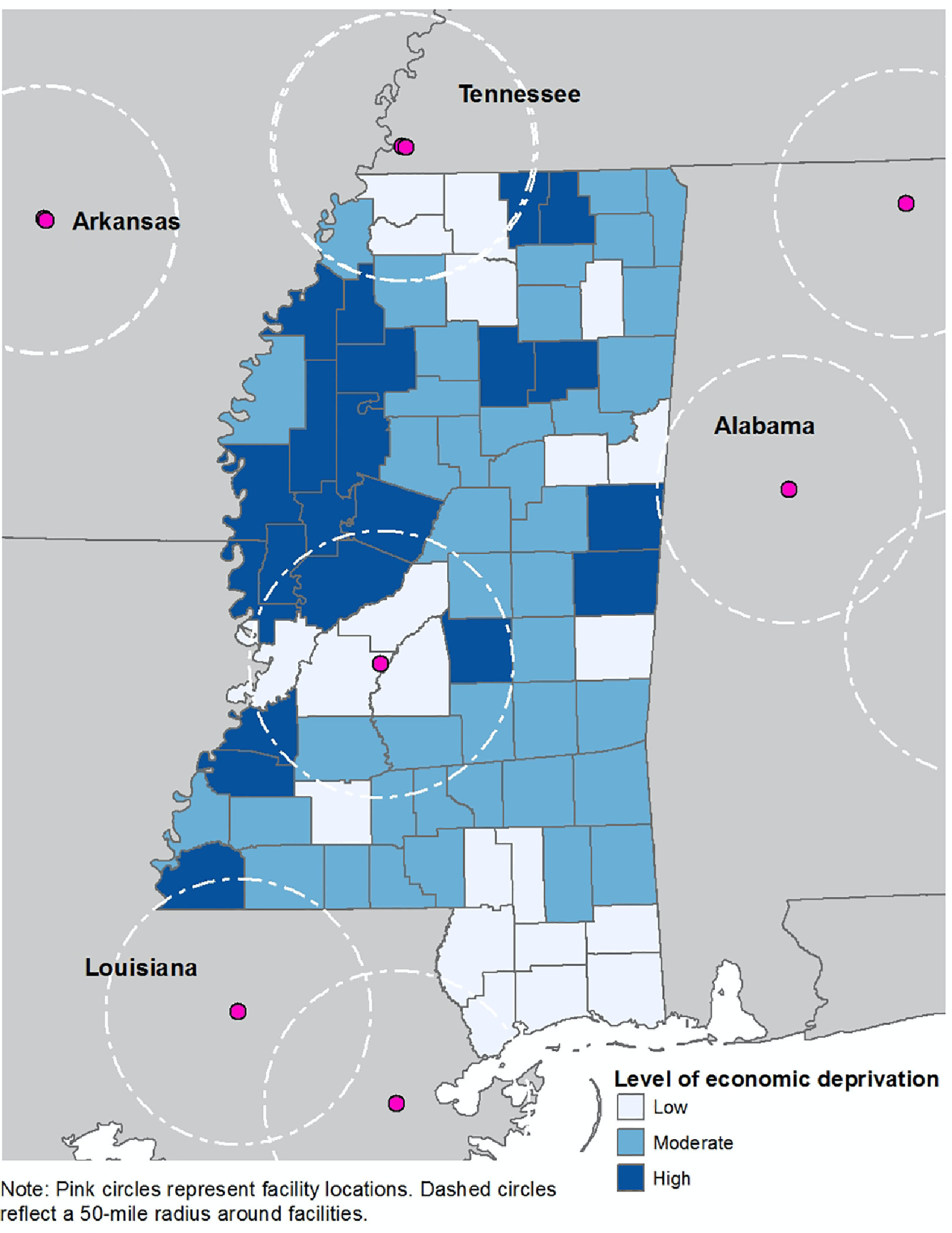
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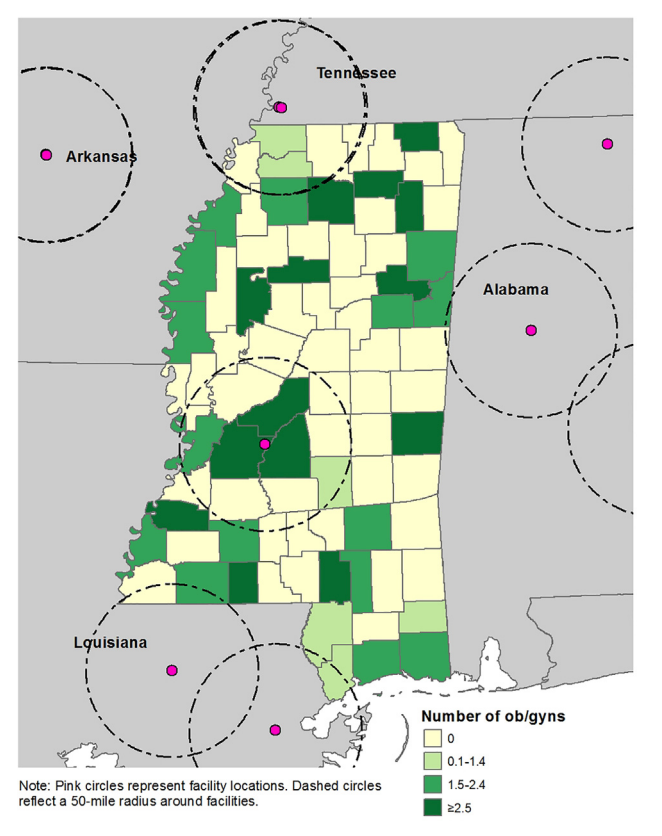
List of Appendices

Appendix no. 1: County-level economic deprivation and abortion facility proximity in Mississippi, 2018 (picture)



Source: White et al. “Abortion at 12 or more weeks’ gestation and travel for later abortion care among Mississippi residents.” Contraception, vol. 108 (2022): 21.

Appendix no. 2: Number of ob/gyns per 10,000 women & abortion facility proximity in Mississippi, 2018 (picture)



Source: White et al. “Abortion at 12 or more weeks’ gestation and travel for later abortion care among Mississippi residents.” Contraception, vol. 108 (2022): 22.

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