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

Master's thesis

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Year of the defence: 2022

Declaration

1. I hereby declare that I have compiled this thesis using the listed literature and resources only.
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

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References

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Abstract

This thesis aims to explore the circumstances in Mississippi and shed a light on the pattern of restrictive policies, some of which are in place for decades, that led to the ultimate ban on abortion. The Supreme Court agreed to review a case regarding the constitutionality of Mississippi's 15-week abortion ban from 2018 in *Jackson Women's Health Organization v. Dobbs*. This came as a no surprise – there is a significant conservative majority in the Court and the United States have recorded an unprecedented rise of abortion restrictions across the country. By taking up the case, the Court was expected to rule on the constitutionality of *Roe v. Wade*, a landmark decision from 1973 affirming the women's right to abortion. Mississippi's ban was ground-breaking at the time of passing, being the first state to push the time limit so low. After that, some states went even further, namely Texas and its heartbeat bill, banning abortion after only 6 weeks. This diploma thesis provides an overview of the most important judicial cases preceding *Dobbs v. Jackson*, namely *Roe v. Wade* and *Casey v. Planned Parenthood of Southeastern Pennsylvania*. It also analyses the consequences of the restrictive and discriminatory policies, like the ban on common second-trimester procedures or the federal funding on abortion, requirement of informed and parental consent for minor's abortion, targeted regulations of abortion providers, or mandated waiting period. All of these restrictions cause significant hardships with the goal of preventing women to access abortion care. Last but not least, the thesis examines the arguments used in before the Court.

Abstrakt

Cílem této práce je prozkoumat okolnosti ve státě Mississippi a objasnit vzorec restriktivních zákonů, z nichž některé jsou v platnosti již desítky let, a které vyescalovaly až k celkovému zákazu potratů. Nejvyšší soud Spojených států souhlasil s přezkoumáním případu týkajícího se ústavnosti mississippijského zákazu potratů od 15. týdne těhotenství z roku 2018 ve věci *Jackson Women's Health Organization v. Dobbs*. Nebylo to žádným překvapením - u Nejvyššího soudu je výrazná konzervativní většina a Spojené státy zaznamenaly bezprecedentní nárůst omezení potratů po celé zemi. Očekávalo se, že tím, že se bude Nejvyšší soud případem zabývat, rozhodne tak zároveň o ústavnosti rozsudku *Roe v. Wade*, přelomového rozhodnutí z roku 1973, které potvrdilo právo žen na potrat. Zákaz v Mississippi byl v době přijetí velmi výrazným rozhodnutím, neboť se tak Mississippi

stalo prvním státem, který posunul časový limit pro interrupci tak nízko. Poté šly některé státy ještě dál, konkrétně Texas a jeho zákon o tlukotu srdce, který zakazoval potraty již po 6 týdnech. Tato diplomová práce poskytuje přehled nejdůležitějších soudních případů předcházejících případu *Dobbs v. Jackson*, a to *Roe v. Wade* a *Casey v. Planned Parenthood of Southeastern Pennsylvania*. Analyzuje také důsledky restriktivních a diskriminačních opatření, jako je zákaz běžných zákroků ve druhém trimestru nebo federální financování interrupcí, požadavek informovaného souhlasu a souhlasu rodičů s interrupcí nezletilých, cílená regulace poskytovatelů interrupcí nebo povinná čekací doba před jejím provedením. Všechna tato omezení způsobují značné komplikace, s cílem znesnadnit ženám přístup k interrupční péči. V neposlední řadě práce zkoumá argumenty použité před Nejvyšším soudem.

Keywords

abortion, Dobbs v. Jackson Women's Health Organization, abortion laws in Mississippi, end of Roe v. Wade, reproductive rights

Klíčová slova

interrupce, Dobbs v. Jackson Women's Health Organization, potratové zákony v Mississippi, konec Roe v. Wade, reprodukční práva

Název práce

Konec precedentu Roe? Dlouhodobá politika omezování přístupu k potratům v Mississippi

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Table of Contents

TABLE OF CONTENTS	1
INTRODUCTION	3
<i>Literature review.....</i>	<i>5</i>
1. NATIONAL FRAMEWORK OF THE ABORTION DEBATE.....	6
1.1 Supreme Court rulings.....	6
1.1.1 <i>Roe v. Wade.....</i>	<i>7</i>
1.1.2 <i>Casey v. Planned Parenthood of Southeastern Pennsylvania</i>	<i>9</i>
1.1.3 <i>In-between Casey and Dobbs</i>	<i>10</i>
1.2 Federal legislation.....	11
2. LIMITATIONS ON THE ACCESS TO REPRODUCTIVE RIGHTS IN MISSISSIPPI.....	13
2.1 Ban on partial-birth abortion	13
2.2 Mandated waiting period and informed consent	17
2.3 Parental consent.....	21
2.4 Access to abortion facilities.....	27
2.5 Self-induced abortion and ban on telemedicine.....	30
2.6 Insurance and funding policies.....	33
2.7 Targeted Regulation of Abortion Provider laws.....	36
2.8 Gestational Age Act.....	38
2.9 Trigger law	40
3 FRAMING OF THE ABORTION DEBATE IN MISSISSIPPI	41
3.1 General objectives of the petitioners	42
3.1.1 Amici briefs.....	44
3.2.1.1 Fetal pain.....	45
3.2.1.2 Protecting the woman’s health from late term abortion.....	45
3.2.1.3 Abortion as a minority epidemic.....	47
3.2.1.4 Power back to the states .. and women?	48
3.2.1.5 New roadmap – abandoning viability and undue burden?.....	48
3.2 General objectives of the respondents	49
3.3 <i>Dobbs v. Jackson Women’s Health Organization decided.....</i>	<i>51</i>
CONCLUSION.....	52
SUMMARY.....	55
LIST OF REFERENCES.....	57
Primary sources.....	57
Amicus curiae	59

<i>Secondary sources</i>	60
<i>Books</i> 60	
<i>Articles</i> 61	
<i>Online sources</i>	64
LIST OF APPENDICES	72

Introduction

In recent years, the United States saw an unprecedented increase of abortion restrictions. Some of them were struck down by local courts, but many were left to stand under the undue burden standard introduced in *Casey v. Planned Parenthood of Southeastern Pennsylvania* (1992). Then in 2018, Mississippi passed the most restrictive law for that time, outlawing abortions after 15 weeks of gestational age. The provisions were immediately struck down by lower courts, citing the central holdings of *Roe v. Wade* (1973) that are protecting the right to abortion up until viability, around 23 and 24 weeks. However, Mississippi did not give up and decided to plead the case in front of the Supreme Court. The Court agreed to hear the case, and its decision in *Dobbs v. Jackson Women's Health Organization* on June 24, 2022, changed lives for millions of women. Because of State's trigger law from 2007, overruling *Roe* automatically meant outlawing all most all abortion in Mississippi.

In 1973, the Supreme Court issued its decision in the landmark case *Roe v. Wade*, guaranteeing women the right to abortion based on a constitutional right to privacy. Even though abortion has always been part of women's lives, its criminalization made it a very private issue. Towards the end of 1960s, first states started to legalize the access to abortion, but the majority still outlawed them. *Roe* sparked a controversy that has divided both public and politics onto two camps – pro-life defenders, campaigning for the overruling of *Roe* and a total ban on abortion, and pro-choice advocates, fighting for the right to bodily autonomy and the choice not to continue with an unwanted pregnancy.

Mississippi is a state with one of the most restrictive abortion policies in the United States. These limitations pose a significant hardship on women, especially on the ones coming from low-income background. Jackson Women's Health Organizations was the last abortion clinic in the State, as the others had to end their practice after an increase of targeted regulations on abortion providers. It served as a safe haven for women from the neighbouring states as well, especially after Texas passed its Heartbeat Act, outlawing abortion only after 6 weeks. Due to unnecessary requirements aimed at hindering the access to abortion care, the women have to overcome financial and other barriers on their way.

The paper will be divided into three main sections. The first chapter will revolve around the national approach to abortion issues, focusing on the judicial history of Supreme Court abortion decisions. A short overview of federal policies will mainly focus on restrictions on funding, which has consequences on the accessibility to abortion inside and outside of the United States. The Mexico City Policy in question repeatedly affects the access to financial aid in the reproductive healthcare where it is needed the most.

The second chapter will examine the limitations on the access to abortion. This part will contain all relevant restrictions on abortion care and will put them in perspective. At first glance, the requirements might not seem limiting, but their combination constitutes a discriminatory approach to women seeking abortion care. The third and last chapter will analyse the arguments made by both the petitioners and respondents in their briefs and oral arguments. Amici briefs, letters sent on behalf of one of the sides to help their cause, will be examined as well. Finally, a space will be dedicated to the decision in *Dobbs v. Jackson Women's Health Organization*.

The aim of the thesis is to provide comprehensive picture of abortion limitations in the State that challenged the Court to overrule *Roe v. Wade*. By examining the current restrictions on abortion access, the paper wants to answer the question of how abortion restrictions have evolved in Mississippi since *Roe v. Wade*, and why it makes sense that it was Mississippi that passed what was then the strictest restriction in the United States. That it was the concurrence of long-term goal and convenient composition of the Supreme Court that led to the decision in *Dobbs v. Jackson Women's Health Organization*. The method used in the thesis is a descriptive analysis.

Because the decision in *Dobbs v. Jackson* was reached before submitting my thesis, a short analysis of the ruling was added to the last chapter. The overruling of *Roe* does not delegitimize the work done in the thesis; it completes the path upon which Mississippi embarked on with the first restrictive law.

Literature review

One of the most important sources for my paper was the Mississippi Code. I used the 2020 version of the legal code accessible online. For the completion of the impacts of the restrictive laws, articles from number of journals were used: Family Planning Perspectives, Perspectives on Sexual and Reproductive Health, American Journal of Public Health, Contraception and others. Significant help were the articles published by the Alan Guttmacher Institute, a non-profit organization that raises awareness about important matters of reproductive health and rights. The articles are well researched and provide a good outline. Another important source was Theodore J. Joyce, a research associate at City University of New York, that focuses on state restrictive laws, namely mandatory waiting periods and the requirements of parental consent and their impacts on women and minors.

Hull and Hoffer in their book *Roe v. Wade: The Abortion Rights Controversy in American History* very comprehensibly describe the development of reproductive rights, abortion and contraception. The book provides a perfect outline for everyone interested in the evolution of abortion access in the United States.

For the last chapter, I almost solely used the judicial documents, such as the petition for the writ of certiorari, briefs by both petitioners and respondents, oral arguments, and the Supreme Court decisions, mainly *Roe v. Wade*, *Casey v. Planned Parenthood of Southeastern Pennsylvania*, and *Dobbs v. Jackson Women's Health Organization*.

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 ruling back in 1973. *Roe* guaranteed that the right could never be banned by state legislatures completely but provided them with 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 the Constitution, there were forces that tried to limit the decision’s outcomes and strengthen the power of the individual states, ultimately focusing on abolishing *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.

1.1 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 The burden was therefore shifted from women to the physicians, midwives 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 In 1965, the Supreme Court issued a decision in *Griswold v. Connecticut*, first connecting the right

¹ N. E. H. Hull and Peter Charles Hoffer, *Roe v. Wade: The Abortion Rights Controversy in American History* (University Press of Kansas, 2001): 17 – 21.

² “A History of Key Abortion Rulings of the U.S. Supreme Court,” Pew Research Center, Fact Sheet, January 16, 2013, <https://www.pewresearch.org/religion/2013/01/16/a-history-of-key-abortion-rulings-of-the-us-supreme-court/>.

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 These decisions paved the way to *Roe* and expanded the understanding of reproductive rights as protected under the Constitution.

1.1.1 *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 with 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 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

The Court ruled that restrictive state 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. But the state’s legitimate interest in protecting both the health of the pregnant woman and the potentiality of human life was still acknowledged by the Justices, who set up trimester framework:

³ Nancy Northup, “Estranged Bedfellows: Sexual Rights and Reproductive Rights in U.S. Constitutional Law,” *Human Rights* 38, no. 2 (2011): 2 – 4, 22.

⁴ Hull and Hoffer, *Roe v. Wade*, 135 – 138.

Does’ complaint as not justiciable and irrelevant

⁵ *Doe v. Bolton*, 410 U.S. 179 (1973).

⁶ *Roe v. Wade*, 410 U.S. 113 (1973): 114.

14th Amendment – Section 1: “No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”

- a) “For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician.
- b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
- c) For the state subsequent to viability the State, in promoting its interest in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”⁷

The Court avoided answering the question of when life begins by introducing the viability line as the dividing line for when the access to abortion is restricted and when it is not. According to this framework, the states had relatively free hand in prohibiting abortion after the viability line, which was defined as a point at which the fetus becomes “potentially able to live outside the mother’s womb, albeit with artificial aid” – at that time set to 24 to 28 weeks.⁸

Between Roe and Casey, another landmark case in the abortion debate, the Court decided number of other cases: in *Planned Parenthood v. Danforth* (1976), the Court hold that a married woman does not need her husband consent before undergoing abortion; in *Harris v. McRae* (1980), the Hyde Amendment, a budget rider restricting federal funding of abortion, is uphold; in *City of Akron v. Akron Center of Reproductive Health* (1983), medical provisions, mandated waiting period and informed consent were struck down; in *Thornburgh v. American College of Obstetricians and Gynecologists* (1986), the Court invalidated informed consent and reporting provision, in *Webster v. Reproductive Health Services* (1989), provisions banning public facilities and public health workers from abortion procedures are considered legal; and in *Hodgson v. Minnesota* (1990), minors unable to obtain parental consent before abortion were given the possibility to ask for the so called judicial bypass.⁹ The right to abortion was not overruled, however, as the thesis

⁷ Roe v. Wade, 410 U.S. 113 (1973): 114.

⁸ Roe v. Wade, 410 U.S. 113 (1973): 160.

⁹ *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); *Harris v. McRae*, 448 U.S. 297 (1980); *City of Akwon v. Akron Center for Reproductive Health*, 426 U.S. 416 (1983), *Thornburg v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989); *Hodgson v. Minnesota*, 497 U.S. 417 (1990).

going to show in the next subchapter, the significant changes in Casey were a result of uncertainty resulting from vague set of rules in Roe.

1.1.2 Casey v. Planned Parenthood of Southeastern Pennsylvania

In short, Casey reaffirmed the right to abortion. But it also allowed some new restrictive provisions, abandoned Roe's trimester framework and most importantly, it introduced 'undue burden' standard for identification of allowed limitations on abortion care and those overly restrictive and unconstitutional. The lawsuit was filed against five provisions of the Pennsylvania Abortion Control Act from 1982 which conditioned the access to abortion care by instituting a mandated waiting period of 24 hours, informed and parental consent, and reporting requirements for abortion facilities. The petitioners were abortion clinics and doctors providing abortion care asking the Court to determine the restrictions in question as unconstitutional. On the basis of the stare decisis doctrine¹⁰, Roe and its main holdings were reaffirmed, namely the right of woman to obtain abortion before fetal viability without any significant state restrictions; the power of the State to restrict access to abortion after the viability point (under condition the law contains exception for the health of the pregnant woman); and the legitimate interest in the protection of the woman's health and the fetus' life.¹¹

As have been hinted above, Casey got rid of the trimester framework set up by Roe and instead introduced the undue burden standard that resolves whether state laws in question present a significant obstacle in the access to abortion care before viability. That is important to stress out, because the viability rule central to Roe remained in practice. However, the standard of undue burden was immediately applied to the restrictions introduced by the Abortion Control Act and upheld the requirements of 24-hour waiting period, judicial bypass for minors' abortions, informed consent, and the reporting requirements. By confirming the constitutionality of the mandated waiting period and the provision of informed consent, the Court invalidated its two previous decisions, namely *City of Akron v. Akron Center of Reproductive Health* and *Thornburgh v. American*

¹⁰ Precedent (in this case Roe) serves as a binding framework for deciding any future cases dealing with the same matter (without providing new facts).

¹¹ *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992): 834.

College of Obstetricians and Gynecologists. The introduction of undue burden opened the door for more state restrictions.

In the dissenting opinion by Chief Justice Rehnquist, Justice White, Justice Scalia and Justice White, the constitutionality of Roe is contested due to its difference from other cases decided on the basis of right to privacy. For the Justices, right to abortion is not and cannot be fundamental, because it does not concern only the life of the pregnant woman, but of the fetus as well.¹² This argument was then reproduced many times and can be found in the opinion of the Court in recently decided *Dobbs v. Jackson Women's Health Organization*.

1.1.3 In-between Casey and Dobbs

After Casey, federal courts dealt with rising number of lawsuit and challenges due to differing applicability of undue burden standard.¹³ Only few of them got in front of the Supreme Court. In *Stenberg v. Carhart* (2000), the Nebraska's ban of dilation and extraction, a common second-trimester abortive method, was struck down on the basis of missing exception for the woman's health. However, seven years later, in *Gonzales v. Carhart*, similar provision, this time in federal law, was upheld even without the health exception. More about this specific method of abortion procedure can be found in the chapter 2.1. In the recent decision in *Whole Woman's Health v. Hellerstedt* from 2017, the Court prevented the closure of majority of Texas abortion clinic by striking down provisions requiring admitting privileges for abortion physicians and meeting the standard of ambulatory surgical center in the case of abortion clinics. In doing so, the Court used heightened scrutiny standard to reach its decision, moving away from the standard of strict scrutiny from Casey. During heightened scrutiny standard, the state must show that the law in question would promote a valid state interest and provide evidence that benefits from implementation of the law outweighs the burdens on women. In this case, the State of Texas failed to pass the balancing test, because the laws' requirements did not noticeably benefit the health of the women.¹⁴

¹² Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992): 839.

¹³ Pew Research Center, "A History of Key Abortion Rulings of the U.S. Supreme Court."

¹⁴ Stenberg v. Carhart, 530 U.S. 914 (2000); Gonzales v. Carhart, 550 U.S. 124 (2007); Whole Woman's Health v. Hellerstedt, 579 U.S. 582 (2016).

1.2 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, and the Immigration and Customs Enforcement agency).¹⁵ 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.¹⁶

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.¹⁷ 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

¹⁵ Eli Y. Adashi and Rachel H. Occhiogrosso, “The Hyde Amendment at 40 Years and Reproductive Rights in the United States, Perennial and Panoptic,” *JAMA*, vol. 317, no. 15 (April 18, 2017): 1523.

¹⁶ Deborah Kacanek, Amanda Dennis, Kate Miller, and Kelly Blanchard, “Providers’ Experience with Cases Involving Rape, Incest and Life Endangerment,” *Perspectives on Sexual and Reproductive Health*, vol. 42, no. 2 (June 2010): 79-86; Amanda Dennis, Kelly Blanchard, and Denisse Córdova, “Strategies for Securing Funding for Abortion Under the Hyde Amendment: A Multistate Study of Abortion Providers’ Experiences Managing Medicaid,” *American Journal of Public Health*, vol. 101, no. 11 (November 2011): 2124-26.

¹⁷ Adashi and Occhiogrosso, “The Hyde Amendment at 40 Years and Reproductive Rights in the United States,” 1523.

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.¹⁸ In the 2023 funding bill, the Democrats took a step back and included the restriction right in the first proposal.¹⁹

Ban on funding abortion is not connected only with 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”²⁰. 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”²¹. 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.²² 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.²³ 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 repeal it.

¹⁸ Sarah McCammon, “Biden’s Budget Proposal Reverses A Decades-Long Ban On Abortion Funding, NPR, May 31, 2021, <https://www.npr.org/2021/05/31/1001881788/bidens-budget-proposal-reverses-a-decades-long-ban-on-abortion-funding>.

¹⁹ Brent D. Griffiths, “Biden will be forced to sign a restriction on abortion funding after Democrats caved to Republican demands,” Business Insider, March 9, 2022, <https://www.businessinsider.com/biden-hyde-amendment-repeal-house-spending-plan-ukraine-2022-3>.

²⁰ Ann M. Starrs, “The Trump global gag rule: an attack on US family planning and global health aid,” *The Lancet*, vol. 389, no. 10068 (February 2017): 485-486.

²¹ The White House Office of Policy Development, “Policy Statement of the United States of America at the United Nations International Conference on Population,” *Population and Development Review*, vol. 10, no. 3 (September 1984): 578.

²² Presidential Memorandum Regarding the Mexico City Policy, January 23, 2017, presidential memoranda, <https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/>.

²³ Michael Safi, Liz Ford and Jessica Glenza, “Joe Biden axes ‘global gag rule’ but health groups call on him to go further,” *The Guardian*, January 28, 2021, <https://www.theguardian.com/global-development/2021/jan/28/joe-biden-global-gag-rule-health-groups>.

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.²⁴ 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.

2. 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.

2.1 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.”²⁵ The procedure is effective and overall safe, but can cause some rare complications, such as blood loss, infection or cervix injury.²⁶ In order

²⁴ “U.S. Abortion Patients,” Infographic, Guttmacher Institute, May 9, 2016, <https://www.guttmacher.org/infographic/2016/us-abortion-patients>.

²⁵ Julie Rovner, “‘Partial-Birth Abortion’: Separating Fact From Spin,” NPR, February 21, 2006, <https://www.npr.org/2006/02/21/5168163/partial-birth-abortion-separating-fact-from-spin>.

²⁶ “Dilation and Evacuation (D&E),” Health & Human Services, Michigan.gov, accessed March 15, 2022, <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent/michigans-informed-consent-for-abortion-law/procedures/dilation-and-evacuation-de>.

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.²⁷

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 *Stenberg 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 proponents 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.”²⁸ 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.²⁹ 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.³⁰

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

²⁷ Rovner, “‘Partial-Birth Abortion.’”

²⁸ 18 U.S. Code § 1531

²⁹ *Gonzales v. Carhart*, 550 U.S. 124 (2007)

³⁰ Bonnie Scott Jones and Tracy A. Weitz, “Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences,” *American Journal of Public Health*, vol. 99, no. 4 (April 2009): 626-627.

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.³¹ 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”³², 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.”³³ 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.³⁴ 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 due to Democratic majority, 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

³¹ Mississippi Code Ann. § 41-41-73 (2020).

³² MS Code § 41-41-73.

³³ MS Code § 41-41-73.

³⁴ “Bans on Specific Abortion Methods Used After the First Trimester”, State Laws and Policies, Guttmacher Institute, last modified June 1, 2022, <https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester>.

unborn child's body to cut or rip it off"³⁵. 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.³⁶ Violating the law can result in the maximum of \$10,000 and/or custody for 2 years for the performing physician.³⁷

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"³⁸. 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.³⁹ 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 labour.⁴⁰

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

³⁵ Mississippi Code Ann. § 41-41-153 (2020).

³⁶ MS Code § 41-41-153.

³⁷ Mississippi Code Ann. § 41-41-163 (2020).

³⁸ "ACOG Statement Regarding Abortion Procedure Bans," American College of Obstetricians and Gynecologists, October 9, 2015, <https://www.acog.org/news/news-releases/2015/10/acog-statement-regarding-abortion-procedure-bans>.

³⁹ Megan K. Donovan, "D&E Abortion Bans: The Implications of Banning the Most Common Second-Trimester Procedure," Guttmacher Institute, first published online February 21, 2017, <https://www.guttmacher.org/gpr/2017/02/de-abortion-bans-implications-banning-most-common-second-trimester-procedure>; Justin Diedrich and Eleanor Drey, "Induction of fetal demise before abortion," *Society of Family Planning, Contraception*, vol 81, no. 6 (2010): 463.

⁴⁰ David A. Grimes, "The Choice of Second Trimester Abortion Method: Evolution, Evidence and Ethics," *Reproductive Health Matters*, no. 16 (2008): 185.

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.

2.2 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 1992.⁴¹ 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.⁴² 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 enjoinder 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.⁴³ 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.”⁴⁴

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

⁴¹ Marianne Bitler and Madeline Zavodny, “The effect of abortion restrictions on the timing of abortions,” *Journal of Health Economics* vol. 20 (2001): 1013.

⁴² Frances A. Althaus and Stanley K. Henshaw, “The Effects of Mandatory Delay Laws on Abortion Patients and Providers,” *Family Planning Perspectives*, vol. 26, no.5 (1994): 229.

⁴³ “Counseling and Waiting Periods for Abortion,” *State Laws and Policies*, Guttmacher Institute, as of June 1, 2022, <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>.

⁴⁴ Theodore J. Joyce, Stanley K. Henshaw, Amanda Dennis, Lawrence B. Finer and Kelly Blanchard, “The Impact of State Mandatory Counselling And Waiting Period Laws on Abortion: A Literature Review,” *Guttmacher Institute* (2009): 4.

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.⁴⁵

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.⁴⁶ 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.⁴⁷

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.⁴⁸ 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

⁴⁵ Mississippi Code Ann. § 41-41-33 (2020).

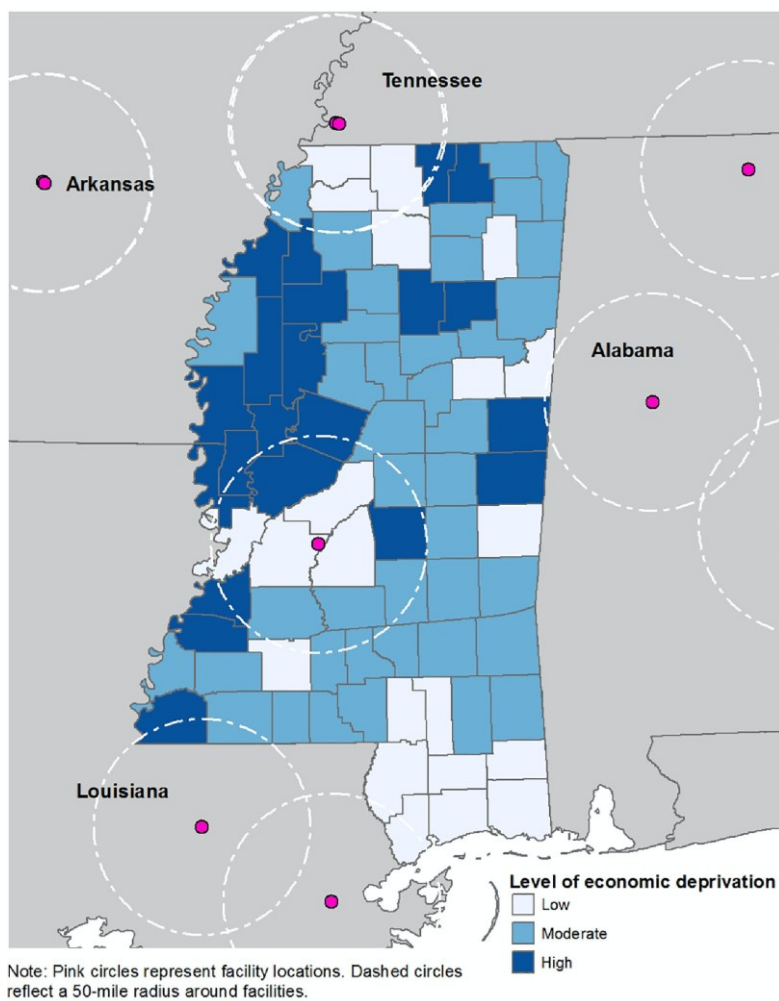
⁴⁶ Mississippi Code Ann. § 41-41-35 (2020).

⁴⁷ "Counseling and Waiting Periods for Abortion," State Laws and Policies, Guttmacher Institute, as of June 1, 2022, <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>

⁴⁸ Mississippi Code Ann. § 41-41-34 (2020), accessed May 13, 2022.

and other logistical reasons.⁴⁹ 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 %

⁴⁹ “State Facts About Abortion: Mississippi,” Fact Sheet, Guttmacher Institute, as of May 2022, <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-mississippi>

in 7-13 days and 9 % in more than 14 days.⁵⁰ 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 1998⁵¹ 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.^{52*} 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,⁵³ and Bitler and Zavodny, who measured the national growth to be at 2.6 percentage points.⁵⁴ 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 %.⁵⁵ 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

⁵⁰ Klaira Lerma, Alexandra McBrayer, and Kari White, "Abortion patients' challenges accessing care in Mississippi," Mississippi Reproductive Health Access Project, September, 2021, <https://sites.utexas.edu/msrepro/files/2021/09/Abortion-Patient-Challenges-brief-MRHAP.pdf>.

⁵¹ In the study, Remez compares the accessible data sets from before and after the implementation of the mandatory waiting period, providing us with unique and Mississippi specific results.

⁵² Lisa Remez, "With Mandatory Delay, Mississippi's Abortion Rate Fell; Out-Of-State and Second-Trimester Procedure Increased," *Family Planning Perspectives*, vol. 30, no. 2 (March/April 1998): 99-100.

* These states were Georgia and South Carolina, chosen due to their socio-economical similarities with Mississippi.

⁵³ Ted Joyce and Robert Kaestner, "The Impact of Mississippi's Mandatory Delay Law on the Timing of Abortion," *Family Planning Perspectives*, vol. 32, no. 1 (2000): 4-13.

⁵⁴ Bitler and Zavodny, "The effect of abortion restrictions on the timing of abortions," 1024.

⁵⁵ Jason M. Lindo and Mayra Pineda-Torres, "New Evidence on the Effects of Mandatory Waiting Periods for Abortion," NBER Working Paper no. 26228 (September 2020): 23.

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.⁵⁶ 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. 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.

2.3 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.⁵⁷ 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 § 41-41-53.⁵⁸ However, under certain circumstances (permanent or temporary absence of the father, or a history of sexual abuse

⁵⁶ J. Thomas, "Mandated State Waiting Periods Linked to Delays In Obtaining Abortion Care," *Perspectives on Sexual and Reproductive Health* 48, no. 4 (2016): 237.

⁵⁷ Stanley K. Henshaw, "The Impact of Requirements for Parental Consent on Minors' Abortions in Mississippi," *Family Planning Perspectives*, vol. 27 (1995): 120-122.

⁵⁸ "Parental Involvement in Minors' Abortions," State Laws and Policies, Guttmacher Institute, as of June 1, 2022, <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions#:~:text=Background,the%20involvement%20of%20both%20parents.>

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 judgement⁵⁹, but not explicitly for the case of abuse, assault, incest or neglect, as in 15 other states.⁶⁰ 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.⁶¹

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.⁶² 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).⁶³ 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) confide 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.⁶⁴

What are the effects of this requirement? Numerous studies have concluded that enforcement of parental consent leads to a raise of second-trimester abortions⁶⁵, an increase of out-of-state abortions and the average travel distance⁶⁶, decrease of abortion

⁵⁹ Mississippi Code Ann. § 41-41-57 (2020).

⁶⁰ "Parental Involvement in Minors' Abortions," Guttmacher Institute.

⁶¹ Mississippi Code Ann. § 41-41-55 (2020).

⁶² Mississippi Code Ann. § 41-41-55 (2020).

⁶³ "Parental Involvement in Minors' Abortions," Guttmacher Institute.

⁶⁴ Kate Coleman-Minahan, Amanda Jean Stevenson, Emily Obront and Susan Hays, "Adolescents Obtaining Abortion Without Parental Consent: Their Reasons and Experiences of Social Support," *Perspectives on Sexual and Reproductive Health*, vol. 52, no. 1 (2020): 15-22.

⁶⁵ Bitler, Zavodny, "The effect of abortion restrictions," 1014, 1021-24; Ted Joyce and Robert Kaestner, "The Impact of Mandatory Waiting Periods and Parental Consent Laws on the Timing of Abortion and State of Occurrence among Adolescents in Mississippi and South Carolina," *Journal of Policy Analysis and Management*, vol. 20, no. 2 (2001): 272; Hyman Rodman, "Should Parental Involvement Be Required for Minors' Abortions?" *Family Relations* no. 40 (1991): 159; Henshaw, "The Impact of Requirements for Parental Consent," 121.

⁶⁶ Caitlin Myers and Daniel Ladd, "Did Parental Involvement Laws Grow Teeth? The Effects of State Restrictions on Minors' Access to Abortion," *IZA Institute of Labor Economics, Discussion Paper Series*, no. 10952 (2017): 11; Henshaw, "The Impact of Requirements for Parental Consent," 121.

rate among teens immediately after the implementation of the requirement⁶⁷ and increase of teen birth-rate⁶⁸ in reverse. Even though the national pregnancy rates among 19 years olds and younger is declining significantly in the last two decades⁶⁹, Mississippi has one of the highest rates of teen pregnancy, and the highest teen birth rate.⁷⁰ 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.⁷¹ 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 1993.⁷²

The overall fertility rate has been decreasing annually in the United States, reaching its historical lows in 2020.⁷³ Last year, in 2021, the birth rate has risen for the first time in seven years, by 1 %.⁷⁴ 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 15-17.⁷⁵ What, other than the general decline of birth rates, stands behind the rapid decrease of teenage pregnancies?

⁶⁷ Theodore J. Joyce, Robert Kaestner, Jason Ward, “The Impact of Parental Involvement Law on The Abortion Rate of Minors,” *Demography*, vol. 57, no. 1 (2020): 3-4; Henshaw, “The Impact of Requirements for Parental Consent,” 121; Bitler, Zavodny, “The effect of abortion restrictions,” 1026.

⁶⁸ Myers and Ladd, “Did Parental Involvement Laws Grow Teeth?” 17.

⁶⁹ Isaac Maddow-Zimet and Kathryn Kost, “Pregnancies, Births and Abortions in the United States, 1973-2017: National and State Trends by Age,” Guttmacher Institute, March 2021, <https://www.guttmacher.org/report/pregnancies-births-abortions-in-united-states-1973-2017>

⁷⁰ “Mississippi Data” Power to Decide, accessed May 23, 2022, <https://powertodecide.org/what-we-do/information/national-state-data/mississippi>.

⁷¹ Maddow-Zimet and Kost, “Pregnancies, Births and Abortions in the United States, 1973-2017.”

⁷² Maddow-Zimet and Kost, “Pregnancies, Births and Abortions in the United States, 1973-2017.”

⁷³ Michelle J.K. Osterman, Brady E. Hamilton, Joyce A. Martin, Anne K. Driscoll, and Claudia P. Valenzuela, “Births: Final Data for 2020,” *National Vital Statistics Reports*, vol. 70, no. 17 (February 2022): 1.

⁷⁴ “Births Rose for the First Time in Seven Years in 2021,” National Center for Health Statistics, Centers for Disease Control and Prevention, May 24, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220524.htm.

⁷⁵ Brady E. Hamilton, Ph.D., Joyce A. Martin, M.P.H., and Michelle J.K. Osterman, M.H.S., “Births: Provisional Data for 2021,” *Vital Statistics Rapid Release*, no. 20 (2022): 3.

According to Pew Research Center, use of contraception, less frequent sexual activity, sex-education and pregnancy prevention information belong among the possible reasons.⁷⁶ 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 education in their curriculum. That changed in 2011, when HB 999 was introduced, regulating the manner in which schools teach and provide information about sex.⁷⁷ 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.⁷⁸ 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.⁷⁹

⁷⁶ Gretchen Livingston and Deja Thomas, "Why is the teen birth rate falling?" Pew Research Center, August 2, 2019, <https://www.pewresearch.org/fact-tank/2019/08/02/why-is-the-teen-birth-rate-falling/>.

⁷⁷ Mississippi House Bill 999 (2011).

⁷⁸ Mississippi Code Ann. § 37-13-171 (2020).

⁷⁹ Mississippi Code Ann. § 37-13-171 (2020).

Unsurprisingly, majority of schools in Mississippi chose to teach abstinence-only approach, providing students with insufficient information about sexual health.⁸⁰ 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.⁸¹ 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.⁸²

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.⁸³ 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.⁸⁴ 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.⁸⁵

⁸⁰ “Mississippi’s Sex Education,” Mississippi State Profile, SIECUS, last updated on June 8, 2021, https://siecus.org/state_profile/mississippi-fy21-state-profile/.

⁸¹ John S. Santelli et al., “Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact,” *Journal of Adolescent Health* 61 (2017): 276;

⁸² “Mississippi Sex Education Law,” Teen Health Mississippi, accessed May 21, 2022, <https://teenhealthms.org/policy-and-advocacy/mississippi-sex-education-law/>; “CHART”, Teen Health Mississippi, accessed May 21, 2022, <https://teenhealthms.org/programs/chart/>.

⁸³ “PREP for Parents,” Mississippi State Department of Health, accessed May 24, 2022, https://msdh.ms.gov/msdhsite/_static/44,0,362,367.html.

⁸⁴ “Parent and Guardian Resources,” Reproductive Health: Teen Pregnancy, CDC, last reviewed May 16, 2022, <https://www.cdc.gov/teenpregnancy/parent-guardian-resources/index.htm>.

⁸⁵ Colleen McKee et al., “What Do Parents in Mississippi Really Think About Sex Education in Schools? Results of a State-Level Survey,” *Journal of Health Disparities Research and Practice* 7, no. 1 (2014): 103.

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).⁸⁶ However, looking at data from years 2011-2013, the rate reached as much as 47.4 percent.⁸⁷ Among teens, contraceptives like pills and condoms are the most used, with third place occupied by long-acting reversible contraceptives (LARCs).⁸⁸ 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 %).⁸⁹

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 %).⁹⁰ 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.⁹¹ 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.

⁸⁶ Kimberly Daniels and Joyce C. Abma, "Current contraceptive status among women aged 15-49: United States, 2017-2019," CDC, NCHS data brief, no. 388 (October 2020): 1; Kimberly Daniels and Joyce C. Abma, "Current Contraceptive Status Among Women Aged 15-49: United States, 2015-2017," CDC, NCHS data brief, no. 327 (December 2018): 1.

⁸⁷ Kimberly Daniels, Jill Daugherty, and Jo Jones, "Current Contraceptive Status Among Women Aged 15-44: United States, 2011-2013," CDC, NCHS data brief no. 173 (December 2014):1

⁸⁸ Daniels and Abma, "Current contraceptive status among women aged 15-49," 3.

⁸⁹ "Mississippi Data" Power to Decide.

⁹⁰ "Mississippi Data" Power to Decide.

⁹¹ "More Than 200,000 Women in Mississippi Live in Contraceptive Desserts," Press Release, Power to Decide, May 20, 2022, <https://powertodecide.org/about-us/newsroom/more-200000-women-mississippi-live-contraceptive-deserts>.

The same percentage (around 15 %) of pregnant teens undergo abortions now as they did 30 years ago.⁹² 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.

2.4 Access to abortion facilities

The state of Mississippi extends over the total area of 125 433 km² with the overall population of 2,949,965⁹³. 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)⁹⁴ and the lowest nominal per capita income (\$42 129)⁹⁵ in 2021.⁹⁶ 44 % of the population are people of colour, out of which Black or African American people comprise around 38 %.⁹⁷ 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.⁹⁸

As of March 2022, the only state-licensed abortion clinic in Mississippi was 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.⁹⁹ The clinic offers surgical abortions up to 16 weeks of pregnancy and medication abortion within the first 11

⁹² Maddow-Zimet and Kost, “Pregnancies, Births and Abortions in the United States, 1973-2017.”

⁹³ Population estimates from July 1, 2021, United States Census Bureau.

⁹⁴ Andrew DePietro, “U.S. Per Capita Income By State in 2021,” Forbes, December 2021, <https://www.forbes.com/sites/andrewdepietro/2021/12/28/us-per-capita-income-by-state-in-2021/?sh=25aa9b2c37be>.

⁹⁵ DePietro, “U.S. Per Capita Income By State in 2021.”

⁹⁶ “Mississippi,” Quick Facts, United States Census Bureau, accessed March 22, 2022, <https://www.census.gov/quickfacts/MS>.

⁹⁷ “Mississippi State,” Data USA, accessed March 19, 2022, <https://datausa.io/profile/geo/mississippi>.

⁹⁸ “The Economic Status of Women in Mississippi,” Status of Women in the States, Fact Sheet, Institute for Women’s Policy Research (March 2018), <https://statusofwomendata.org/wp-content/themes/witsfull/factsheets/economics/factsheet-mississippi.pdf>.

⁹⁹ Jessica Arons, “The last clinics standing,” ACLU, <https://www.aclu.org/issues/reproductive-freedom/abortion/last-clinics-standing>.

weeks.¹⁰⁰ 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).¹⁰¹ 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.¹⁰² 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.¹⁰³ 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 Act came into effect in September 2021, restricting abortion after six weeks of gestational age.¹⁰⁴ 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.¹⁰⁵

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

¹⁰⁰ “Abortion,” Jackson Women’s Health Organization, accessed March 22, 2022, <https://jacksonwomenshealth.com/abortion/>.

¹⁰¹ Alice F. Cartwright, Mihiri Karunaratne, Jill Barr-Walker, Nicole E Johns, and Ushma D. Upadhyay, “Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search,” *Journal of Medical Internet Research* vol. 20, no. 5 (2018): 4-5.

¹⁰² Cartwright et al., “Identifying National Availability of Abortion Care,” 4-5.

¹⁰³ Katherine Kortsmitt et al. “Abortion Surveillance – United States, 2019,” *Surveillance Summaries* 70, no. 9 (November 2019), https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm.

¹⁰⁴ Bethany Dawson, “As Mississippi targets Roe v. Wade in the Supreme Court, Texan women make 1,000-mile journeys to access abortion care,” *Insider*, December 1, 2021, accessed at: <https://www.insider.com/texas-women-1000-mile-abortion-dash-mississippi-targets-roe-wade-2021-11>.

¹⁰⁵ Kari White, Asha Dane’el, Elsa Vizcarra, Laura Dixon, Klaira Lerma, Anitra Beasley, Joseph E. Potter, Tony Ogburn, “Out-of-State Travel for Abortion Following Implementation of Texas Senate Bill 8,” Texas Policy Evaluation Project, Research Brief, March 2022, accessed at: <https://sites.utexas.edu/txpep/files/2022/03/TxPEP-out-of-state-SB8.pdf>.

laws in their home state.¹⁰⁶ Before overturning Roe, the average driving distance for women in Mississippi was 78 miles.¹⁰⁷ Since the end of June, the distance increased to a minimum of 120 miles (from Biloxi, MS to Pensacola, FL) up to 401 miles.¹⁰⁸ 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 25.¹⁰⁹ The closest states protecting the right to abortion under the state's constitution is Illinois.¹¹⁰ 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.¹¹¹ 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,

¹⁰⁶ Jenna Jerman, Lori Frohwirth, Megan L. Kavanaugh and Nakeisha Blades, "Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States," *Perspectives on Sexual and Reproductive Health*, vol. 49, no. 2 (2017): 95.

¹⁰⁷ Elizabeth Nash, Jonathan Bearak, Rachel Jones, Naomi Li, and Lauren Cross, "Mississippi Is Attacking Roe v. Wade Head On – the Consequences Could Be Severe," Guttmacher Institute, August 2021, accessed at: <https://www.guttmacher.org/article/2021/08/mississippi-attacking-roe-v-wade-head-consequences-could-be-severe>.

¹⁰⁸ Alvin Chang, Andrew Witherspoon and Jessica Glenza, "Abortion deserts: America's new geography of access to care – mapped," *The Guardian*, May 5, 2022, <https://www.theguardian.com/world/2022/may/05/abortion-deserts-clinics-access-closed-map>.

¹⁰⁹ "After Roe Fell: Abortion Laws by State," Center for Reproductive Rights, accessed July 29, 2022, <https://reproductiverights.org/maps/abortion-laws-by-state/>; Alison Durkee, "Louisiana Abortion Ban To Go Back Into Effect – Here's Where State Lawsuits Stand Now," *Forbes*, July 29, 2022, <https://www.forbes.com/sites/alisondurkee/2022/07/29/louisiana-abortion-ban-to-go-back-into-effect-heres-where-state-lawsuits-stand-now/?sh=feffd4521a1>; Melissa Brown, Mariah Timms, "Tennessee's abortion ban to take effect Aug. 25," *The Tennessean*, accessed July 29, 2022, <https://eu.tennessean.com/story/news/2022/07/26/tennessee-abortion-trigger-law-ban-2022-expected-august/10061093002/>.

¹¹⁰ "What If Roe Fell?" Center for Reproductive Rights, accessed May 2, 2022, <https://reproductiverights.org/maps/what-if-roe-fell/>.

¹¹¹ Rachel K. Jones and Jenna Jerman, "Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients," Guttmacher Institute (2016): 8.

childcare, and tuition) and another 42 % received financial help from family, friends, the man responsible for the pregnancy, and non-profit abortion organizations.¹¹²

2.5 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.¹¹³

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.¹¹⁴ 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 2021.¹¹⁵ 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

¹¹² Lerma et al., "Abortion patients' challenges accessing care in Mississippi," 2.

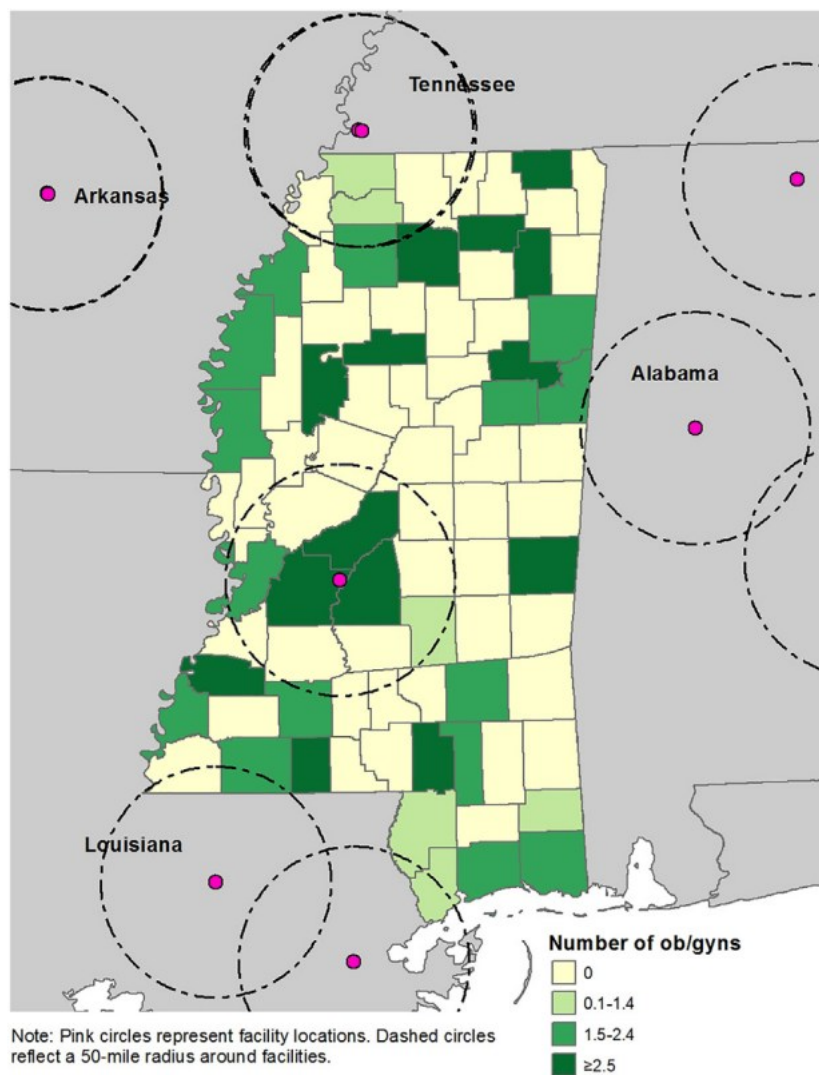
¹¹³ Mississippi Code Ann. § 41-41-107 (2020).

¹¹⁴ Kate Grindlay, Kathleen Lane, and Daniel Grossman, "Women's and Providers' Experiences with Medication Provided Through Telemedicine: A Qualitative Study," *Women's Health Issues* 23, no. 2 (2013): 119 – 120.

¹¹⁵ Rachel K. Jones et al., "Medication Abortion Now Accounts for More Than Half of All US Abortions," Guttmacher Institute, updated March 2, 2022, <https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions>.

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.¹¹⁶ 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.

¹¹⁶ Elizabeth G. Raymond, Erica Chong, and Paul Hyland, "Increasing Access to Abortion With Telemedicine," *JAMA Internal Medicine* (2016): 1.

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”.¹¹⁷ The pills still need to be prescribed by a certified physician but can be collected in pharmacies instead of designed clinics.¹¹⁸ The decision came as number of states specifically outlawed mailed-in drugs, namely Arizona, Arkansas, Texas, Montana, Oklahoma and South Dakota.¹¹⁹ 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.¹²⁰ 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.”¹²¹ 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 (the first one occurred in 2020) that argues the legalization of mifepristone. It bases its argument on that the safety and efficacy of the drug (as stated

¹¹⁷ Pam Belluck, “F.D.A. Will Permanently Allow Abortion Pills by Mail,” *The New York Times*, December 16, 2021, <https://www.nytimes.com/2021/12/16/health/abortion-pills-fda.html>.

¹¹⁸ Belluck, “F.D.A. Will Permanently Allow Abortion Pills by Mail.”

¹¹⁹ In the last three, the law was temporarily blocked by courts.

Jones et al., “Medication Abortion Now Accounts for More Than Half of All US Abortions.”

¹²⁰ “Consultation,” AidAccess, accessed June 29, 2022, <https://aidaccess.org/en/i-need-an-abortion>.

¹²¹ David Ingram, “Dutch doctor and the internet are making sure Americans have access to abortion pills,” NBS News, July 7, 2022, <https://www.nbcnews.com/tech/tech-news/dutch-doctor-internet-are-making-sure-americans-access-abortion-pills-rcna35630>.

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”.¹²² A result that would allow the use of the drug under current abortion bans is rather uncertain.

2.6 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.¹²³ Sixteen states have explicitly ruled that all or most medically necessary abortions are accessible through Medicaid funding.¹²⁴ In Mississippi, however, this is not the case, due to their legal opt-out in § 41-41-99.¹²⁵ 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.¹²⁶ 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 complications¹²⁷, or carrying unwanted pregnancies to term¹²⁸.

¹²² Alison Durkee, “Here’s How a Mississippi Case Could Keep Medication Abortion Legal Even In States That Have Banned It,” *Forbes*, July 7, 2022, <https://www.forbes.com/sites/alisdurkee/2022/07/07/heres-how-a-mississippi-case-could-keep-medication-abortion-legal-even-in-states-that-have-banned-it/?sh=3f703ef82fd7>.

¹²³ Mississippi Code Ann. § 41-41-91 (2020).

¹²⁴ “State Funding of Abortion Under Medicaid,” *State Laws and Policies*, Guttmacher Institute, as of June 1, 2022, <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>.

¹²⁵ Mississippi Code Ann. § 41-41-99 (2020).

¹²⁶ Kendal Orgera, Jennifer Tolbert, and Natalie Singer, “State Health Care Snapshots: Mississippi,” *Health Reform*, KFF, <https://www.kff.org/statedata/election-state-fact-sheets/mississippi/>.

¹²⁷ Bitler, Zavodny, “The effect of abortion restrictions on the timing of abortions,” 1014; Alyssa Engstrom, “The Hyde Amendment: Perpetuating injustice and discrimination after thirty-nine years,” *Southern California Interdisciplinary Law Journal*, vol. 25, no. 451 (2016): 454-455.

¹²⁸ Stanley K. Henshaw, Theodore J. Joyce, Amanda Dennis, Lawrence B. Finer and Kelly Blanchard, “Restrictions on Medicaid Funding for Abortions: A Literature Review,” *Guttmacher Institute*, 2009, https://www.guttmacher.org/sites/default/files/report_pdf/medicaidlitreview.pdf; Sarah C. M. Roberts, Nicole E. Johns, Valerie Williams, Erin Wingo, and Ushma D. Upadhyay, “Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion,” *BMC Women’s Health* vol. 19, no. 78 (2019), 6-7.

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 gap¹²⁹, worsening their access to health services including reproductive health education or family planning services.¹³⁰ 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 2017¹³¹).¹³² 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.¹³³

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.¹³⁴ Second, Mississippi has the highest infant mortality rate in the United States¹³⁵, significant pregnancy-related mortality ratio (between 2013-2016, 33.2 deaths per 100,000 live births,

¹²⁹ their income is above Medicaid eligibility but below the lower limit for Marketplace premium tax credits under ACA in “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,” Medicaid, KFF, accessed May 1, 2022, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

¹³⁰ Rachel Garfield, Kendal Orgera, and Anthony Damico, “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,” KFF, published January 21, 2021, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

¹³¹ “State Health Care Snapshots: Mississippi,” Health Reform, KFF, accessed May 1, 2022, <https://www.kff.org/statedata/election-state-fact-sheets/mississippi/>.

¹³² “Who Qualifies for Coverage?” Mississippi Division of Medicaid, accessed May 3, 2022, <https://medicaid.ms.gov/medicaid-coverage/who-qualifies-for-coverage/>.

¹³³ Emily Wagster Pettus, “Mississippi House leaders kill postpartum Medicaid extension,” AP News, March 10, 2022,

<https://apnews.com/article/health-mississippi-medicaid-c49dcbdc7b356f593485853aee5458c1>; Emily Wagster Pettus and Leah Willingham, “Mississippi: No extension of postpartum Medicaid,” AP News, March 31, 2021, <https://apnews.com/article/mississippi-health-infant-mortality-rate-coronavirus-pandemic-medicaid-49c94fc4053f0b0d56f94afca260e65f>.

¹³⁴ Aaron Bloschichak and Katie Martin, “Most postpartum spending occurs beyond 60 days after delivery, Health Policy and Services Research, May 2020, <https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101769580-pdf>.

¹³⁵ “Infant Mortality Rates by State,” Stats of the States, National Center for Health Statistics, accessed April 28, 2022, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

down to 22.1 in 2020 /US average was 17.3/)¹³⁶, and 25 % of women in reproductive age at the poverty level¹³⁷. 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.¹³⁸ 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.¹³⁹ 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%).¹⁴⁰ 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 \$800.¹⁴¹ 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.¹⁴² 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.¹⁴³ The Access

¹³⁶ “Mississippi Maternal Mortality Report 2013 – 2016,” Mississippi State Department of Health, April 2019, https://msdh.ms.gov/msdhsite/_static/resources/8127.pdf.

¹³⁷ “Public Health Impact: Uninsured Women,” Health Of Women and Children, America’s Health Rankings, accessed May 1, 2022, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/Uninsured_women/state/MS.

¹³⁸ “Mississippi Maternal Mortality Report 2013 – 2016,” Mississippi State Department of Health.

¹³⁹ “2019 & 2020 Infant Mortality Report,” Mississippi State Department of Health, accessed March 18, 2022, https://msdh.ms.gov/msdhsite/_static/resources/18752.pdf.

¹⁴⁰ “2019 & 2020 Infant Mortality Report,” Mississippi State Department of Health.

¹⁴¹ “Fee Schedule,” Patient info, Jackson Women’s Health Organization, accessed March 4, 2022, <https://jacksonwomenshealth.com/fee-schedule/>.

¹⁴² Shefali Luthra, “The last abortion clinic in Mississippi is at the center of a Supreme Court case that could end Roe v. Wade,” The Guardian, November 22, 2021, <https://www.theguardian.com/world/2021/nov/22/mississippi-clinic-fighting-future-abortion-rights-us>.

¹⁴³ “Abortion Funding,” The Pink House Fund, accessed May 3, <https://thepinkhousefund.com/abortion-funding/>.

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.¹⁴⁴ 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.¹⁴⁵ 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.

2.7 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.¹⁴⁶

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

¹⁴⁴ “Get Abortion Assistance,” ARC Southeast, accessed May 3, <https://arc-southeast.org/get-abortion-assistance/>.

¹⁴⁵ “Seeking Abortion Funding?” Need Help? Mississippi Reproductive Freedom Fund, accessed May 3, 2022, <https://www.msreprofreedomfund.org/news>.

¹⁴⁶ Rachel Benson Gold and Elizabeth Nash, “TRAP Laws Gain Political Traction While Abortion Clinics – and the Women They Serve – Pay the Price,” *Guttmacher Policy Review* 16, no. 2 (Spring 2013): 9.

or eligible in obstetrics and gynecology”¹⁴⁷. 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.¹⁴⁸

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.¹⁴⁹ According to the then-vice-governor Tate Reeves, it was a bill that would “effectively end abortion in Mississippi”¹⁵⁰. Elizabeth Nash from the Guttmacher Institute had called it “an attempt to eliminate access without taking on Roe directly”¹⁵¹. 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.¹⁵² 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.¹⁵³

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.¹⁵⁴ 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

¹⁴⁷ Mississippi Code Ann. § 41-75-1 (2020).

¹⁴⁸ Mississippi Code Ann. § 41-75-1 (2020).

¹⁴⁹ “Center for Reproductive Rights Takes Legal Action to Keep Last Abortion Clinic in Mississippi Open,” Center for Reproductive Rights, June 27, 2012, <https://reproductiverights.org/center-for-reproductive-rights-takes-legal-action-to-keep-last-abortion-clinic-in-mississippi-open/>.

¹⁵⁰ Joe Sutton and Tom Watkins, “Mississippi legislature tightens restrictions on abortion providers,” CNN, April 5, 2012, <https://edition.cnn.com/2012/04/04/politics/mississippi-abortion>.

¹⁵¹ Sutton and Watkins, “Mississippi legislature tightens restrictions on abortion providers.”

¹⁵² Debbie Elliott, “Sole Abortion Clinic in Miss. Fights Law To Stay Open,” NPR, June 29, 2012, <https://www.npr.org/2012/06/29/155976574/sole-abortion-clinic-in-miss-fights-law-to-stay-open>.

¹⁵³ Gold and Nash, “TRAP Laws Gain Political Traction While Abortion Clinics – and the Women They Serve – Pay the Price,” 10.

¹⁵⁴ Emily Wagster Pettus, “Judge upholds Mississippi mandate on doctors who do abortions,” AP News, March 17, 2018, <https://apnews.com/article/abee337786ee45ebb79b238804f86255> ; “Federal Judge Blocks All Enforcement of Mississippi Admitting Privileges Requirement,” Center for Reproductive Rights, April 16, 2013, <https://reproductiverights.org/federal-judge-blocks-all-enforcement-of-mississippi-admitting-privileges-requirement/>.

beneficial for women’s health and rather present an undue burden.¹⁵⁵ 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.¹⁵⁶ 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.¹⁵⁷

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.¹⁵⁸ 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.

2.8 Gestational Age Act

Gestational Age Act, passed in 2018, is at the heart of *Dobbs v. Jackson Women’s Health Organization*. Mississippi Code § 41-41-191 prohibits all abortions after 15 weeks of gestational age with the exception of cases of medical emergency or severe fetal abnormality. These cases have to be reported no later than fifteen days from the procedure, and the reports collect various information, like the date of the abortion, probable gestational age, the diagnosis, and a statement in which the operating physician declares the abortion was necessary.¹⁵⁹ At the time of passing, the Act was the most restrictive abortion law in the United States, but was since then passed by the wave of the so-called heartbeat bills, first of which was introduced in Texas in 2019. The law was then also

¹⁵⁵ Michael D. Regan, “Court blocks Mississippi law that would have shuttered state’s abortion clinic,” PBS, March 18, 2017, <https://www.pbs.org/newshour/nation/court-blocks-mississippi-law-shuttered-states-abortion-clinic>; Arons, “The Last Clinics Standing.”

¹⁵⁶ “Federal District Court Permanently Blocks Mississippi’s Clinic Shutdown Law,” Center for Reproductive Rights, March 18, 2017, <https://reproductiverights.org/federal-district-court-permanently-blocks-mississippi-clinic-shutdown-law/>.

¹⁵⁷ Pettus, “Judge upholds Mississippi mandate on doctors who do abortions.”

¹⁵⁸ Marshall H. Medoff, “State Abortion Policies, Targeted Regulation of Abortion Provider Laws, and Abortion Demand,” *Review of Policy Research* 27, no. 5 (September 2010): 579 – 580.

¹⁵⁹ Mississippi Code § 41-41-191 (2020).

passed in Mississippi but was quickly challenged and blocked by the 5th Circuit Court of Appeals.¹⁶⁰

Gestational Age Act bases its validity on the fact that the United States belong among the minority that offers abortion past the 20th week. It continues by listing the developmental stages of the fetus, such as the start of organ function, movement, sense of stimulation, or the assumed heartbeat. By arguing that most after-15-weeks abortions are done through dilation and evacuation (whose use was restricted in 2016), and describing the procedure as barbaric, it sends a message than any later abortion is ultimately a bad thing, if only because of the method. The Act then cites Casey and Roe, proving that Mississippi has the right to restrict abortion on the basis of protecting the life of the unborn, and the women's health that could be disturbed by the assumed dangerous second-trimester abortion. And while it is true that the later the abortion, the bigger the risks, the prohibited methods of D&E and D&X objectively limit the health risks connected to the procedure. In the case of violating the Act, the physician at fault will have their professional license revoked and face a fine up to \$500,000.

While it is true that most states in the world have earlier bans on the access to abortion, the crucial information is what limitations the states implement prior to the legal limit. Let us take the Czech Republic as an example – there, the pregnant woman can undergo abortion up until 12 weeks without any limitations. It is possible to abort until 24 weeks under certain circumstances – in case of genetic abnormality and on the prescription from OB-GYN. Should the woman's health be in danger, or should the fetus suffer from abnormality incompatible with life, those are relevant exceptions for abortion up to birth. However, the restrictions outlined in this chapter result in considerable barriers to timely access to abortion care. The Gestational Age Act would not cause any commotion should they pass it in Europe. Would the Supreme Court only chose to upheld the Act, the response might no been so harsh. According to a poll conducted in 2021, majority of Americans said second-trimester abortion should be illegal in most or all cases.¹⁶¹ The problem occurs

¹⁶⁰ Caroline Kelly, "Block on Mississippi's fetal-heartbeat abortion bill is upheld," CNN, February 20, 2020, <https://edition.cnn.com/2020/02/20/politics/abortion-mississippi-heartbeat-bill-blocked-circuit-court/index.html>.

¹⁶¹ David Crary and Hannah Fingerhut, "AP-NORC poll: Most say restrict abortion after 1st trimester," AP News, June 25, 2021, <https://apnews.com/article/only-on-ap-us-supreme-court-abortion-religion-health-2c569aa7934233af8e00bef4520a8fa8>.

when we look at a state like Mississippi. A state with one last clinic standing, with number of restrictions making it difficult for women to access the care in time, and with leading politicians owning up to their mission to make Mississippi the “safest place in America for an unborn child”¹⁶². But the Act was just a mean to push the abortion issue back in front of the Supreme Court, to overrule Roe and ultimately ban abortions.

2.9 Trigger law

In 2007, a bill authored by a Republican senator Joey Fillingane¹⁶³ 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.¹⁶⁴ 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.¹⁶⁵ 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.¹⁶⁶

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

¹⁶² Phil Bryant, Twitter Post, March 19, 2018, 10:12 p.m., https://twitter.com/PhilBryantMS/status/975842416287715328?s=20&t=s9opneXi3IYHuPtV2_A2eQ.

¹⁶³ Courtney Ann Jackson, “How would Mississippi’s trigger law work if SCOTUS overturns Roe v. Wade?” WLBT, May 4, 2022, <https://www.wlbt.com/2022/05/05/how-would-mississippi-trigger-law-work-if-scotus-overturns-roe-v-wade/>.

¹⁶⁴ Mississippi Code Ann. § 41-41-45.

¹⁶⁵ Jackson, “How would Mississippi’s trigger law work if SCOTUS overturns Roe v. Wade?”

¹⁶⁶ Mississippi Code Ann. § 41-41-45.

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.¹⁶⁷ 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 and moved to New Mexico to continue its mission.¹⁶⁸

3 Framing of the abortion debate in Mississippi

The Gestational Age Act that is in question in *Dobbs v. Jackson Women’s Health Organization* was drafted by a group of 16 Republican Representatives and passed the Mississippi 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 and banned the provisions of the Act. Mississippi then proceeded to appeal to the Court of Appeals for the Fifth Circuit, which retained the ruling of the lower court. In June 2020, the State of Mississippi, represented by Attorney General Lynn Fitch and her office, filed a 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.¹⁶⁹ The Supreme Court admitted the case to deal with the first question regarding the constitutionality of pre-viability prohibitions.

¹⁶⁷ Elizabeth Nash and Isabel Guarnieri, “13 States Have Abortion Trigger Bans – Here’s What Happens When Roe is Overturned,” Guttmacher Institute, published on June 6, 2022, <https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned>.

¹⁶⁸ Katie Shepherd, “Mississippi’s last abortion clinic will shutter as trigger ban begins,” The Washington Post, July 6, 2022, <https://www.washingtonpost.com/nation/2022/07/06/mississippi-abortion-clinic-closure/>; Jolie McCullough, “After losing battle to preserve Roe v. Wade, Mississippi’s last abortion clinic is moving to New Mexico,” The Texas Tribune, June 29, 2022, <https://www.texastribune.org/2022/06/29/mississippi-abortion-new-mexico/>.

¹⁶⁹ *Dobbs v. Jackson Women’s Health Organization*. Petition for a Writ of Certiorari.

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 Mississippi. Firstly, the main arguments made by the petitioner’s side will be presented. Secondly, the counter-arguments of the respondents will follow. And last but not least, the final decision in *Dobbs v. Jackson Women’s Health Organization* will be analysed.

3.1 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 subsequent 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”¹⁷⁰. 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.”¹⁷¹ 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 in protecting the women’s health and life of the unborn fetus damages the suitability of the undue burden standard as well. “If a State’s interests are “compelling” enough after viability to support a

¹⁷⁰ *Dobbs v. Jackson Women’s Health Organization*. Petition for a Writ of Certiorari.

¹⁷¹ *Dobbs v. Jackson Women’s Health Organization*. Brief for Petitioners.

prohibition, they are “equally compelling before” then.”¹⁷² 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.¹⁷³

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 intimate 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

¹⁷² *Dobbs v. Jackson Women’s Health Organization*. Brief for Petitioners, 41.

¹⁷³ *Dobbs v. Jackson Women’s Health Organization*. Brief for Petitioners, 7 – 23.

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.

3.1.1 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 States¹⁷⁴,
- 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 List¹⁷⁵,
- and the March for Life Education and Defense Fund.

¹⁷⁴ *Dobbs v. Jackson Women's Health Organization*. Brief amicus curiae of the states of Texas, Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, Tennessee, and West Virginia. 20 Jul 2020. https://www.supremecourt.gov/DocketPDF/19/19-1392/148156/20200720160750082_19-1392%20Amicus%20Brief.pdf. PDF download.

¹⁷⁵ Susan B. Anthony List, currently Susan B. Anthony Pro-Life America, is a non-profit organization financially supporting anti-abortion politicians.

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.

3.2.1.1 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.”¹⁷⁶ 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 States¹⁷⁷, The March For Life Education and Defense Fund¹⁷⁸, and the National Right to Life Committee¹⁷⁹. 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.¹⁸⁰ 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.

3.2.1.2 Protecting the woman’s health from late term abortion

¹⁷⁶ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the Roman Catholic Diocese of Jackson and Roman Catholic Diocese of Biloxi. 14 Jul 2020. [Supremecourt.gov](https://www.supremecourt.gov).

¹⁷⁷ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the states of Texas, Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, Tennessee, and West Virginia. 20 Jul 2020. [Supremecourt.gov](https://www.supremecourt.gov).

¹⁷⁸ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the March for Life Education and Defense Fund. 29 Jul 2020. [supremecourt.gov](https://www.supremecourt.gov).

¹⁷⁹ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the National Right to Life Committee and Louisiana Right to Life Federation. 23 Jul 2020. [supremecourt.gov](https://www.supremecourt.gov).

¹⁸⁰ “Mississippi initiative 26, definition of person amendment (2011),” *Ballotpedia*, [https://ballotpedia.org/mississippi_initiative_26_definition_of_person_amendment_\(2011\)](https://ballotpedia.org/mississippi_initiative_26_definition_of_person_amendment_(2011)).

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.¹⁸¹ 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’.”¹⁸² 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

¹⁸¹ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the 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. 20 Jul 2020. [supremecourt.gov](https://www.supremecourt.gov).

¹⁸² *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the 375 women injured by second and third trimester late term abortions.

were waiting for adoption, and only 597 of them got adopted.¹⁸³ 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.¹⁸⁴

3.2.1.3 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.¹⁸⁵ She was connected with the eugenics movement, however, PP has denounced and distanced itself from her beliefs in the racist ideology.¹⁸⁶ 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 color, 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.

¹⁸³ “Mississippi,” Child Welfare Outcomes Report Data Site, accessed June 2, 2022, <https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/mississippi.html>.

¹⁸⁴ Sarah Catherine Williams, “State-level Data for Understanding Child Welfare in the United States,” Child Trends, February 28, 2022, <https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states>, <http://childwelfaresparc.org/wp-content/uploads/2015/02/Mississippi-ADOPTION-FACTS.pdf>

¹⁸⁵ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the African American, Hispanic, Roman Catholic and Protestant Religious and Civil Rights Organizations and Leaders. 26 Jul 2020. supremecourt.gov.

¹⁸⁶ “Opposition Claims About Margaret Sanger,” Planned Parenthood, current as of April 2021. https://www.plannedparenthood.org/uploads/filer_public/cc/2e/cc2e84f2-126f-41a5-a24b-43e093c47b2c/210414-sanger-opposition-claims-p01.pdf.

3.2.1.4 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 female representation as sufficient, even though it is still only 30 % on the national level. 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.”¹⁸⁷ 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.

3.2.1.5 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.¹⁸⁸ The brief by three physicians and the Catholic Association Foundation argues

¹⁸⁷ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the women legislators and the Susan B. Anthony List.

¹⁸⁸ *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the National Right to Life Committee and Louisiana Right to Life Federation; *Dobbs v. Jackson Women’s Health Organization*. Brief amicus curiae of the American Association of Pro-life Obstetricians & Gynecologists; *Dobbs v. Jackson*

that the viability standard is outdated and lacks relevance in today's world, where the scientific and medical discoveries change the perceptions people once had. In 1993, at the time of Casey, the fetus was not viable outside of the womb at 22 weeks, while in 2017, the survival rate at the same week reached 64.4 %. ¹⁸⁹

3.2 General objectives of the respondents

Lawyers representing Jackson Woman's Health Organization started by reminding the Court that the question of constitutionality of Roe was already settled thirty years ago in Casey. While admitting that Casey did implement significant changes to the original ruling, the essential holding was reconfirmed, that even if States are given more interest in protecting woman's health and the possibility of future life, they cannot "resolve the personal, family, and medical implications of ending a pregnancy in such a definitive way that a woman lacks all choice in the matter"¹⁹⁰. The brief addressed Mississippi's criticism of viability by returning to the central holdings of Casey that provided more workable framework around viability than Roe and admitted legitimate state interests like the protection of fetal life. Given the history of conforming to stare decisis, overruling 50 years-old precedent would, according to the lawyers, make the Court look ideological. This comment hints at the fact that the current composition of the Court is leaning conservative, for whom overruling Roe has been the for the past fifty years.

Respondents held that there is no justification for overruling the two precedents. Millions of women were born into a world in which the right to abortion was constitutionally safeguarded. These women, the lawyers argue, consider this right as inherently theirs, considering it as one of the choices women can make for their reproductive health. And for that reason, the possibility of someone else's life cannot be held as more important than the free choice of women. It is important to note that the respondents do not attack the principles set by Casey – restrictions on abortion after the viability line are deemed

Women's Health Organization. Brief amicus curiae of the Right to life of Michigan, inc., and the National Catholic Bioethics Center.

¹⁸⁹ *Dobbs v. Jackson Women's Health Organization*. Brief amicus curiae for Monique Chireau Wubbenhorst, M.D., M.O.H., Grazie Pozo Christie, M. D., Colleen Malloy, M.D., and the Catholic Association Foundation. 29 Jul 2021. [supremecourt.gov](https://www.supremecourt.gov), 5 – 7.

¹⁹⁰ *Dobbs v. Jackson Women's Health Organization*. Brief for Respondents, 2.

constitutional, however, anything before the point when the fetus is able to survive outside of the womb is a serious impediment to women's rights.¹⁹¹

Mississippi's lawsuit did not bring any new factual reasons for overturning Roe than it did in Casey. And while the Constitution does not contain the word abortion or any explicit mention of the procedure, the lawyers went back to the reasoning used first in Casey then the right to abortion was deduced from the right to bodily integrity. Abortion was common in the history as much as it is now, and the state's interest in fetal life was acknowledged by Casey. The argument of protecting the woman's health falls on short given the risks connected to pregnancy, childbirth as well as self-managed abortion, especially in a state where "it is about 75 times more dangerous to carry a pregnancy to term than to have an abortion"^{192, 193} This fact was repeated during oral arguments as well, in a response to the question about safe haven laws by the Justice Amy Coney Barrett. These laws provide pregnant women with the possibility to give up their child after birth by giving it to the State, which in turn pledges to take care of the baby. But as has been outlined in the brief, carrying a child to term is rather dangerous in Mississippi. These laws, along with adoption, do not serve as an alternative to abortion.¹⁹⁴

The petitioners' claim that abortion is not necessary anymore due to accessibility of contraception fall short of the reality. First, contraception's access is limited, depending on the socio-economic status and county of residence, and second, contraception does not represent a 100% protection from pregnancy. Another argument used by the petitioners claim that women have reached gender equality and having a child does not represent a hardship anymore, at which the respondents respond with data proving that false.¹⁹⁵

The respondents also addressed the frequently used argument of fetal pain as the drawing line of abortion restrictions, claiming that the medical consensus rules out the possibility of fetal pain until viability, as well as the ability of conscious awareness. Again, arguments

¹⁹¹ *Dobbs v. Jackson Women's Health Organization*. Brief for Respondents, 12 – 17.

¹⁹² *Dobbs v. Jackson Women's Health Organization*. Brief for Respondents, 28.

¹⁹³ *Dobbs v. Jackson Women's Health Organization*. Brief for Respondents, 21 – 28.

¹⁹⁴ Transcript of Oral Argument, *Dobbs v. Jackson Women's Health Organization*, 56. Oyez. <https://www.oyez.org/cases/2021/19-1392>.

¹⁹⁵ *Dobbs v. Jackson Women's Health Organization*. Brief for Respondents, 30 – 36.

like these revolve around the question of when life starts, which is highly philosophical and cannot and should not be answered by the Court.¹⁹⁶

3.3 *Dobbs v. Jackson Women’s Health Organization* decided

On June 24, 2022, the Supreme Court decided *Dobbs v. Jackson Women’s Health Organization* and practically outlawed abortion for millions of women. Almost two months prior to the decision, a draft of Justice Alito’s opinion presenting the opinions of the Court was leaked and published in Politico. This event caused commotion both inside (leaks like this are very scarce, almost unique) and outside (people protesting the proposed decision) the Court.¹⁹⁷

The Gestational Age Act was upheld (with a 6:3 majority) and *Roe v. Wade* and *Planned Parenthood v. Casey* were overturned (with a 5:4 majority). The Court ruled that upholding *Casey* by applying *stare decisis* was wrong, that the Constitution nor Fourteenth Amendment do not explicitly mention the right to abortion, and that the right also cannot be interpreted from the concept of liberty, according to the decision, because it does not have deep roots in history and tradition. This argument is derived from the evidence that “no state constitutional provision has recognized such a right”¹⁹⁸ before the 1960s, and that “majority of States criminalized abortion at all stages of pregnancy”¹⁹⁹. Both respondents and the briefs filed in their favor provide weak evidence of historical abortion tradition, according to Justice Alito.²⁰⁰ For the Justices, the right to bodily autonomy does not contain the right to abortion. This right is inherently different from the precedents cited in *Roe* because it incorporates a moral question connected to the “potential life”. *Roe* and *Casey* came up with a drawing line between the interests of a woman and the interests of a potential life, but the public does might not agree with this balance and should be given the power to do so.²⁰¹

¹⁹⁶ *Dobbs v. Jackson Women’s Health Organization*. Brief for Respondents, 31 – 34.

¹⁹⁷ Nina Totenberg, “After the leak, the Supreme Court seethes with resentment and fear behind the scenes,” NPR, June 8, 2022, <https://www.npr.org/2022/06/08/1103476028/after-the-leak-the-supreme-court-seethes-with-resentment-and-fear-behind-the-sce>.

¹⁹⁸ *Dobbs v. Jackson Women’s Health Organization* (2022): 2.

¹⁹⁹ *Dobbs v. Jackson Women’s Health Organization*. Opinion of the Court, 597 U. S. ____ (2022): 25.

²⁰⁰ *Dobbs v. Jackson Women’s Health Organization*. Opinion of the Court, 597 U. S. ____ (2022): 15 – 30.

²⁰¹ *Dobbs v. Jackson Women’s Health Organization* (2022): 1-4.

In the opinion of the Court, Justice Alito notes that the right to address abortion issue has been for the most part in the hand of the individual states, and that Roe cut that process short. Joining with amici briefs, 26 states asked the Court to give the power back to the states and the elected representatives.²⁰²

The Court pays significant attention to the concept of *stare decisis*. In the opinion of the Court, the doctrine “does not counsel continued acceptance of Roe and Casey”. The Justices use the example of overruling *Plessy v. Ferguson*, a precedent at the time, to show that abandoning stare decisis is in some cases legitimate. The example is skilfully chosen, because not many people would argue that Plessy had any floor to stand on. Roe is labelled as being “egregiously wrong” from the beginning, and Casey was wrong to carry on. Not only because the presumed lack of historical evidence, but because the trimester framework did not do justice to the viability line. Casey’s undue burden method is deemed unworkable, since according to the Court, the line “between permissible and unconstitutional restrictions has proved to be impossible to draw with precision”^{203, 204}

Any future abortion case should be decided by rational-basis review standard, meaning that the law has to have a relation to legitimate state interest. The standard of heightened scrutiny that was used in Roe is considered irrelevant because abortion is a medical procedure that does not require this overwhelming testing.²⁰⁵

Conclusion

Abortion has always been part of women’s lives. It is a choice that has been repeatedly made by millions of women every day, every month, and every year for centuries. The safety of the procedure has evolved and reached a point where there are minimum risks and complications. The majority of the public agrees with the existence of the right to abortion. And for the past 49 years, Americans considered it to be an inherent part of their reproductive health choices. Roe v. Wade and subsequently Casey v. Planned Parenthood built a framework upon which could people and states lean on questions about access to

²⁰² *Dobbs v. Jackson Women’s Health Organization*. Opinion of the Court, 2.

²⁰³ *Dobbs v. Jackson Women’s Health Organization* (2022): 6.

²⁰⁴ *Dobbs v. Jackson Women’s Health Organization* (2022): 1-6.

²⁰⁵ *Dobbs v. Jackson Women’s Health Organization* (2022): 7.

abortion and/or restrictions on it. This framework was abandoned on June 24, when the Supreme Court issued its decision in the Mississippi case *Dobbs v. Jackson Women's Health Organization* and taken the power of the choice away from women to the States.

This rather descriptive thesis aimed at providing a compact picture of the state of abortion rights in Mississippi. The State became a leader in anti-abortion movement after passing the Gestational Age Act, a law banning abortion after 15 weeks of gestational age. At the time of passing, in 2018, it was the most restrictive law in the United States. The provisions were quickly challenged by the only remaining clinic in Jackson, Jackson Women's Health Organization. The lower courts suspended the law from going into effect and subsequently struck down the provisions due to their direct impediment to Roe's and Casey's central holdings which prohibited any major restrictions on abortion before 23rd or 24th week.

Mississippi belonged among the number of states with excessive abortion restrictions, such as ban on D&X and D&E methods, safe and common procedures during second-trimester abortions; parental consent, requiring signed consent by the minors' parents or judicial bypass prior to minor's procedure; ban on obtaining abortion pills through telemedicine, that would solve the hardship connected with travels to the clinic; mandated waiting period of 24 hours between visits, which limits those who are traveling from afar; inability to draw federal nor state funds to cover abortion costs; and targeted regulations of abortion providers, demanding physicians to be licensed OB-GYNs, even though it has not been proved as overly beneficial for the patient. In 2007, Mississippi also passed the so-called trigger law that would outlaw abortion in the case Roe was overruled.

The first chapter provided a short overview of relevant cases and federal laws. Since the thesis focuses on Mississippi, it was important to provide basic information and furthermore present central holdings of Roe and Casey, the two landmark decisions for the abortion right debate. In essence, Roe changed the country. It gave women the right to make choices about their bodies without anyone else making the decision for them. It publicly placed abortion as one of the reproductive choices women can make for their health. However, it also sparked debate on the morality and constitutionality of the decision. Before Roe, it was very common that abortion was criminalized, somewhere for

the whole duration of pregnancy. In the late 1960s, first states started to reconsider their approach to abortion and enabled legal way to obtain one. Roe forced all states to legalize abortion access during the first trimester, but allowed States to restrict it after that, and even completely ban (with the exception of protecting the woman's life) it after viability. The concept of viability was then expanded in Casey, which abandoned the trimester framework and introduced undue burden standard as a guiding principle for future restrictive laws. Casey also admitted to States the legitimate interest in protecting the woman's health prior to the viability line – but had to pass the undue burden test detecting whether the provision does not cause disproportionate difficulties.

The second chapter revolved around the restrictions that were in place at the time of writing. They significantly limited the access to abortion. If look at individually, one could argue that the provisions are not that strict. But if we put them together, one right next to the other, we find out that the right of choice was severely limited in Mississippi for decades. Targeted regulations of abortion providers slowly drove the number of abortion clinics and facilities to one. Having only one clinic for the whole State resulted in worsened access for those outside of the capital. Requiring women to pass a visit of minimum 24 hours before the procedure in person, when the information can be provided by phone or internet, forces women to make two journeys instead of one. For some, that means missing out on work or other responsibilities for at least two days. Given the costs of the procedure, of the journey, and of the carer for their children, for many women, the hardship is too high. Because the State prohibited federal funding on abortion, low-income women are affected the most, taking longer time to collect funds, which results in receiving abortion care later in term. Each of these restrictions were aimed at making the access to abortion care more difficult than before. Passing the 15 weeks ban would not prevent all abortions, but many of those, who are made by the system to reach the care later in term, would not have another choice than being forced into continuing with the pregnancy or resolving it in other way.

The third and last chapter focused the arguments used in front of the Supreme Court in *Dobbs v. Jackson Women's Health Organization*. The lawsuit was admitted to the Court with the question of “whether all pre-viability prohibitions on elective abortion are unconstitutional” with the petitioners (Mississippi) asking the Court to overrule Roe and

Casey. The Mississippi lawyers claimed that Roe was wrong from the beginning by deriving the right to abortion from the right to privacy. For them, it had no standing in tradition or history, two important components that would have to be met. Amici briefs filled out in support of Mississippi argued with data proving fetal ability to feel pain prior to viability, state interest in protecting the woman's health from late-term abortion and the need to abandon the undue burden framework by Casey. While the respondents (Jackson Women's Health Organization) tried to disprove the arguments laid out by the petitioners, ultimately, they did not convince the Court, which ruled contrary to stare decisis and stroke down the 49 years old precedent.

The future of abortion rights in the United States is uncertain. The Conservative approach to restricting the access can be visible in the majority of Republican-led States. As of July 29, abortion is banned in Arkansas, Alabama, Louisiana, Mississippi, Texas, Oklahoma, Montana, Wisconsin, South Dakota, and Kentucky; in Idaho and Tennessee it is expected soon; and in Arizona, Utah, Wyoming, North Dakota and West Virginia, the ban has been temporarily blocked by the court.²⁰⁶ Mississippi reached its goal. The restrictive policies were always intended to limit access to abortion to a minimum. The State's representatives have been very open for a very long time about their intentions to make Mississippi the first safe haven for unborn children. It is no coincidence that it was Mississippi that led the battle to the Supreme Court. The Gestational Age Act was passed solely for the reason that it would reach the conservative Court. It did and it won. It was never about giving the power back to the people, for them to debate and decide on the issue. The existence of the trigger law always presumed that abortion will be outlawed in Mississippi.

Summary

The right to abortion has been guaranteed to women in the United States for the past 49 years as their reproductive health choice. While the Supreme Court rulings of *Roe v. Wade* and *Casey v. Planned Parenthood* guaranteed the right publicly recognized abortion as one of the reproductive options available to women, it was also debated whether the decision is moral and constitutional.

²⁰⁶ "Tracking the States Where Abortion Is Now Banned," *The New York Times*, accessed July 29, 2022, <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html>.

The state of Mississippi was one of the leaders in the anti-abortion movement. Since *Roe v. Wade*, the state of Mississippi has been a significant factor in the abortion debate. Even while the supreme court ruling of *Roe v. Wade* guaranteeing the right to abortion was in place, the state of Mississippi belonged to the number of states with excessive abortion restrictions and trigger laws resulting in a complete ban of abortions in the light of the recent Supreme Court decision *Dobbs v. Jackson Women's Health Organization*. The case that was argued in Mississippi ended the period of women's right to choose whether to carry their pregnancy to term.

While *Roe v. Wade* legalized abortion during the first trimester in all United States, the states were still allowed to restrict abortions that would be performed after the first trimester. To protect fetal life, the states could completely ban abortion after it was determined that the fetus is viable outside of the mother's womb. The pre-fetal viability was also one of the key arguments used in the Supreme Court case of *Dobbs v. Jackson Women's Health Organization*. The case argued that the viability component argued in *Roe v. Wade* was unconstitutional pointing out the misconception of the right to privacy being the basis for the right to abortion as there was no connection in tradition or history. The position of the state of Mississippi was justified based on the Amici briefs that supported the arguments confirming the fetal ability to experience pain before viability.

The recent Supreme Court ruling that leans towards the Conservative approach gives way to increasingly limiting abortion restrictions in the majority of Republican-led states. All things considered, state representatives of Mississippi have been clear about their intentions regarding the precedent. The existence of the trigger law gives evidence of the premeditation of their actions with the implication that abortion would be illegal in Mississippi.

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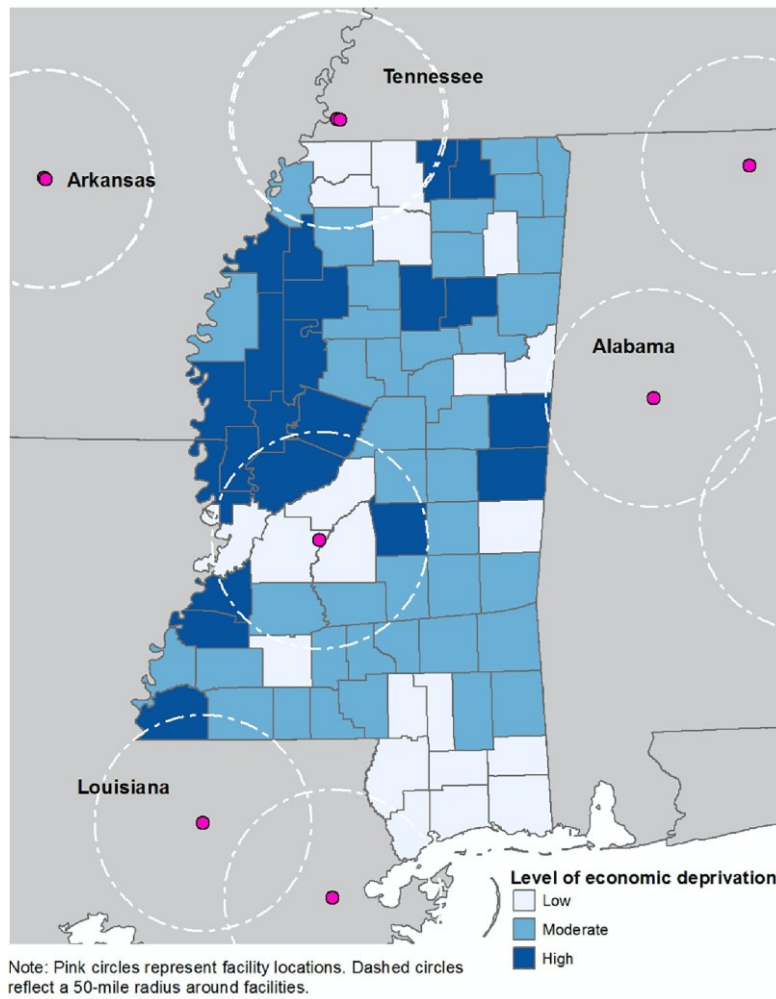
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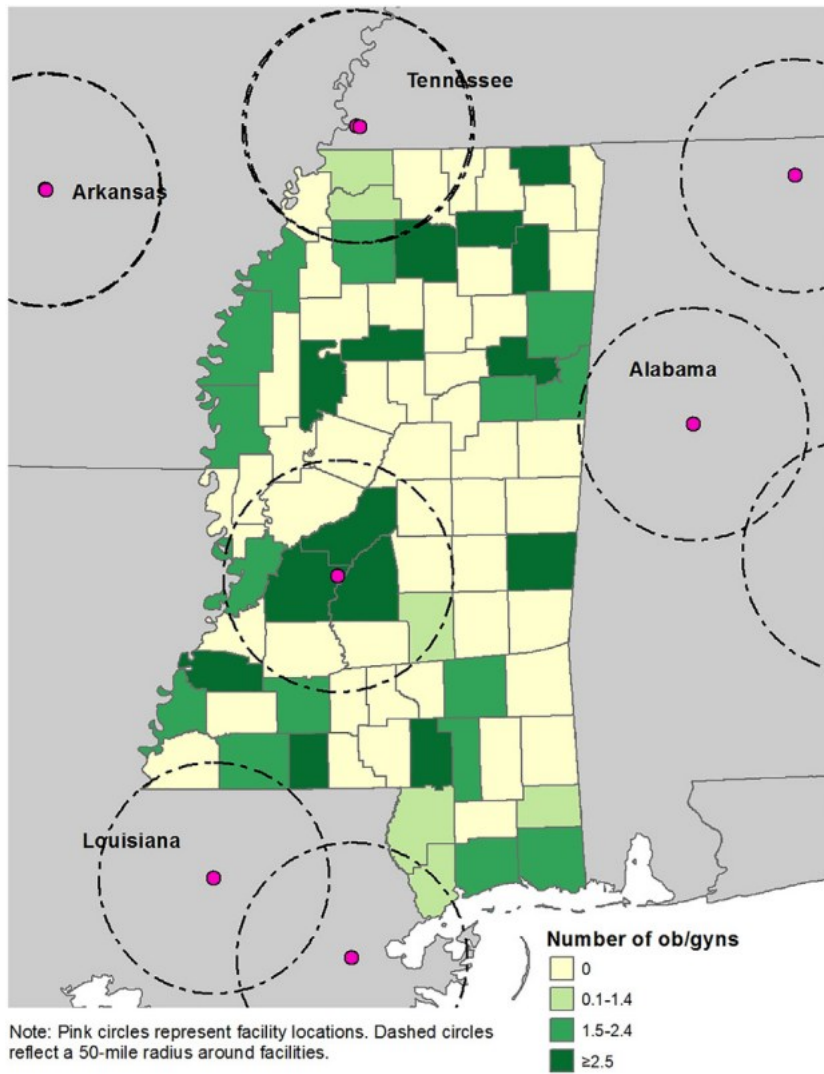
List of Appendices

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.

ZÁVĚREČNÉ TEZE MAGISTERSKÉ PRÁCE NMTS	
Závěrečné teze student odevzdává ke konci Diplomního semináře III jako součást magisterské práce a tyto teze jsou spolu s odevzdáním magisterské práce do SIS předpokladem udělení zápočtu za tento seminář.	
Jméno:	Andrea Žižková
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Specializace (uveďte zkratkou)*:	SAS
Semestr a školní rok zahájení práce:	ZS 2021/2022
Semestr a školní rok ukončení práce:	LS 2021/2022
Vedoucí diplomového semináře:	Lucie Kýrová, M.A., Ph.D.
Vedoucí práce:	Mgr. Jana Sehnálková, Ph.D.
Název práce:	The end of Roe? Mississippi's decades-long restriction politics
Charakteristika tématu práce (max 10 řádek):	In 2018, Mississippi passed the Gestational Age Act, a law banning abortion after the first 15 weeks of pregnancy. Few other countries soon followed the suit, challenging Roe's central provisions of the right to abortion. In 2020, the Supreme Court picked up the case, overturning Roe v. Wade and Casey v. Planned Parenthood on June 24, 2022. Mississippi had a history of restrictive abortion laws, resulting in socio-economic hardships for women seeking abortion care.
Vývoj tématu od zadání projektu do odevzdání práce (max. 10 řádek):	The research scope of the thesis has not changed much since the beginning. After the Supreme Court's ruling in Dobbs v. Jackson, a subchapter analysing the final decision was added.
Struktura práce (hlavní kapitoly obsahu):	Introduction 1. National Framework od the abortion debate 2. Limitations on the access to reproductive rights in Mississippi 3. Framing of the abortion debate in Mississippi Conclusion
Hlavní výsledky práce (max. 10 řádek):	The thesis provided a comprehensive insight to the the state's abortion politics. In juxtaposition with the federal laws that relied on the Supreme Court decision of Roe v. Wade, the state of Mississippi uses restrictive and discriminatory policies targeting not only women but also abortion providers. By imposing requirements of informed and parental consent, mandated waiting periods, or banning common abortion procedures Mississippi aimed to prevent access to abortion for women. The state also used several tactics such as cutting the federal funding to abortion clinics or targeting regulations on abortion providers to further restrict the access to abortion in the state. The subsequent decision in Dobbs v. Jackson Women's Health was the culmination of anti-abortion politics that has been in place for decades.
Prameny a literatura (výběr nejpodstatnějších):	Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992). Roe v. Wade, 410 U.S. 113 (1973).

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Etika výzkumu:**

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Jazyk práce:
anglický jazyk

Podpis studenta a datum
Bc. Andrea Žižková, 2. 8. 2022

Schváleno	Datum	Podpis
Vedoucí práce		
Vedoucí diplomového semináře		
Vedoucí specializace		
Garant programu		

