

No. 19-60455

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

JACKSON WOMEN’S HEALTH ORGANIZATION, on behalf of itself and its patients; SACHEEN CARR-ELLIS, M.D., M.P.H., on behalf of herself and her patients,

Plaintiffs – Appellees,

v.

THOMAS E. DOBBS, M.D., M.P.H., in his official capacity as State Health Officer of the Mississippi Department of Health; KENNETH CLEVELAND, M.D., in his official capacity as Executive Director of the Mississippi State Board of Medical Licensure,

Defendants – Appellants.

On Appeal from the United States District Court
for the Southern District of Mississippi, Jackson Division

BRIEF OF *AMICI CURIAE* MISSISSIPPI IN ACTION, WOMEN WITH A VISION, BLACK WOMEN’S HEALTH IMPERATIVE, IN OUR OWN VOICE: NATIONAL BLACK WOMEN’S REPRODUCTIVE JUSTICE AGENDA, LIFT LOUISIANA, NATIONAL ASIAN PACIFIC AMERICAN WOMEN’S FORUM, NATIONAL BIRTH EQUALITY COLLECTIVE, SISTERREACH, SISTERSONG, THE AFIYA CENTER, THE REPRODUCTIVE JUSTICE ACTION COLLECTIVE

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Defendants – Appellants.

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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Pursuant to Fifth Circuit Rule 28.2.1 and Federal Rule of Appellate Procedure 26.1(a), counsel certifies that *Amici Curiae* in Support of Plaintiffs-Appellees listed above: 1) are not publicly-held corporations; 2) do not have a parent corporation; and 3) that no publicly-held corporation owns ten percent or more of *Amici*'s respective stock.

Date: October 4, 2019

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STATEMENT REGARDING *AMICI CURIAE*

People of color in the United States founded and lead the Reproductive Justice movement, which promotes the human right to control our own bodies, sexuality, gender, and reproduction. *Amici* are Reproductive Justice organizations which collectively share an interest in protecting the constitutional right to abortion, and therefore have a strong interest in this case. *Amici* respectfully ask this Court to consider how the six-week ban at issue will disproportionately impact low-income pregnant people of color and other marginalized populations in Mississippi and Louisiana, who already face deeply embedded structural barriers to self-determination. *Amici* urge the Court to reject the State's arguments and uphold the right to abortion by affirming the District Court's decision.

Amici are: Mississippi in Action, Women With a Vision, Black Women's Health Imperative, In Our Own Voice: National Black Women's Reproductive Justice Agenda, Lift Louisiana, National Asian Pacific American Women's Forum, National Birth Equality Collective, SisterReach, SisterSong, The Afiya Center and The Reproductive Justice Action Collective (ReJAC).¹

¹ For a more full description of *Amici*, please see the Addendum. No counsel for any party authored the brief in whole or in part, no party or party's counsel contributed money intended to fund preparing or submitting the brief, and no person other than *Amici* and their counsel contributed money intended to fund preparation of the brief. Pursuant to Fed. R. App. P. 29(a)(2), by email, all parties have consented to the filing of this brief.

SUMMARY OF THE ARGUMENT

Mississippi’s law prohibiting nearly all abortions after six weeks of pregnancy² (the “six-week ban”) is an unconstitutional ban on abortion during the period before fetal viability and is impermissible under *Roe v. Wade* and *Planned Parenthood v. Casey*.³ Mississippi’s interests, therefore, have no bearing on the outcome of the case. Nonetheless, because Mississippi invokes its purported interest in maternal health, *Amici* set forth the real-life consequences of this near total ban, and specifically, how it will disproportionately affect low-income people, who are predominantly women of color, and other marginalized populations.⁴

Mississippi’s professed interest in maternal health is disingenuous and it has done little to advance this asserted interest. Mississippi singles out one area for regulation—abortion—but ignores other aspects of women’s health, and pursuant to *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), this inconsistency warrants judicial skepticism of the State’s asserted interest.

For decades, Mississippi lawmakers have publicly pronounced their antipathy towards abortion rights, have enacted restrictions seeking to end access to abortion services, and have limited abortion services to one clinic in the State.

² Miss. Code Ann. § 41-41-34.1 (2019) (S.B. 2116).

³ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992); *Roe v. Wade*, 410 U.S. 113, 163-64 (1973).

⁴ While this brief uses the term “women,” the denial of reproductive and abortion care also affects transgender men and some gender non-conforming people.

Mississippi's abortion restrictions already disproportionately affect pregnant people living in poverty, including people of color, undocumented immigrants and incarcerated women. Costs and logistics such as travel, lodging, child care, and the procedure itself make it exceedingly difficult for those living in poverty to obtain an abortion prior to six weeks, and the six-week ban will extinguish their constitutional right to decide whether to terminate a pregnancy prior to viability.

At the same time, Mississippi does little to affirmatively promote women and marginalized people of color's health. Mississippi ranks among the states with the most medical challenges for women, infants and children nationwide. Mississippi's infant mortality rate is the highest in the country and its maternal mortality rate is nearly the highest, with the rate for Black women drastically higher than for white women.

The six-week ban continues Mississippi's legacy of discriminatory state action. Historically, the Mississippi Legislature has promoted and enacted policies that restrict the rights of women and minorities. With the six-week ban, Mississippi perpetuates its agenda of controlling the bodies of people in marginalized communities.

This case, however, not only affects Mississippi; Louisiana enacted a six-week ban that could become effective upon this Court's final decision. Like Mississippi, among the people in Louisiana most burdened by the six-week ban

will be low-income people, people of color, and other marginalized populations, who also face significant barriers to accessing reproductive health care.

Far from promoting maternal health, the brazenly unconstitutional bans enacted in Mississippi and Louisiana will inflict serious harm on people in marginalized communities in those states. We urge this Court to vindicate the rights of low-income people, people of color and others by affirming the decision of the District Court invalidating the six-week ban.

ARGUMENT

As the District Court correctly concluded, Mississippi’s six-week ban, like its proposed fifteen-week ban, is an unconstitutional ban on abortion during the period before fetal viability, and is impermissible under *Roe* and *Casey*, and therefore, a preliminary injunction is warranted.⁵ Accordingly, the Court need not take into account any of the State’s asserted interests. However, because the State invokes its interest in maternal health, *Amici* provide this Court with the reality—on the ground—for millions of pregnant people in historically-marginalized populations in Mississippi and Louisiana (and other states), as their constitutional right to access abortion care hangs in the balance.

I. Mississippi’s Professed Interest in Women’s Health Is Not Credible

Mississippi attempts to justify the unconstitutional six-week ban by, *inter alia*, claiming an interest in promoting maternal health. However, this interest is not credible given the notable inconsistency between the State’s willingness to invoke maternal health to regulate abortion, and the little it does to affirmatively protect pregnant people’s health. Singling out one disfavored area for state

⁵ *Jackson Women’s Health Org. v. Dobbs*, 379 F. Supp. 3d 549, 552-553 (S.D. Miss. 2019) (“The State also conceded at oral argument that this Court must follow Supreme Court precedent.”); *see also Jackson Women’s Health Org. v. Currier*, 349 F. Supp. 3d 536 (S.D. Miss. 2018) (citing *Planned Parenthood of Se. Pa.*, 505 U.S. at 844; *Roe*, 410 U.S. at 163-64); *accord Jackson Women’s Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014) (“Pre-viability, a woman has the constitutional right to end her pregnancy”); *Sojourner T v. Edwards*, 974 F.2d 27, 31 (5th Cir. 1992) (striking down ban on all abortions with exceptions).

intervention to allegedly protect maternal health warrants searching judicial scrutiny.⁶ In *Whole Woman's Health*, the Supreme Court looked beyond the abortion context and examined how Texas regulated in the interest of women's health. In striking Texas's ambulatory surgical center requirement for abortion providers, the Supreme Court noted that:

Nationwide, childbirth is 14 times more likely than abortion to result in death, but Texas law allows a midwife to oversee childbirth in the patient's own home Medical treatment after an incomplete miscarriage often involves a procedure identical to that involved in a nonmedical abortion, but it often takes place outside a hospital or surgical center. And Texas partly or wholly grandfathered (or waives in whole or in part the surgical-center requirement for) about two-thirds of the facilities to which the surgical-center standards apply. But it neither grandfathered nor provides waivers for any of the facilities that perform abortions. **These facts indicate that the surgical-center provision imposes "a requirement that simply is not based on differences" between abortion and other surgical procedures "that are reasonably related to" preserving women's health, the asserted "purpos[e] of the Act in which it is found."**⁷

⁶ See Reva B. Siegel, *ProChoiceLife: Asking Who Protects Life and How—And Why It Matters in Law and Politics*, 93 IND. L.J. 207 (2018) (demonstrating that states with the most restrictive abortion laws fail to protect life through sexual education, contraception, health care, and job protections for pregnant people).

⁷ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016), *as revised* (June 27, 2016) (emphasis added) (citations omitted); *see also Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 920-21 (7th Cir. 2015) (Posner, J.) ("Opponents of abortion reveal their true objectives when they procure legislation limited to a medical procedure—abortion—that rarely produces a medical emergency. A number of other medical procedures are far more dangerous to the patient than abortion, yet their providers are not required to obtain admitting privileges anywhere, let alone within 30 miles of where the procedure is performed.").

The same discrepancy the Supreme Court identified in Texas’s regulation in the name of women’s health is present here. Mississippi expends substantial governmental energy limiting access to abortion, yet does little to resolve its maternal mortality crisis, improve its infant mortality rate, or otherwise protect women’s health.⁸ This Court should not credit Mississippi’s asserted interest when the State fails to demonstrate a genuine commitment to promoting maternal health beyond restricting abortion.

A. Mississippi Continues to Act Aggressively to Restrict Abortion Access

As with its fifteen-week ban, Mississippi’s purported interest in maternal health to justify the six-week ban is undermined by the State’s historic hostility toward abortion services, and its implementation of legislation designed to make obtaining an abortion increasingly difficult for pregnant people in Mississippi, particularly those in marginalized communities.⁹

(i) *Mississippi’s six-week abortion ban is in addition to multiple aggressive interventions by the State to restrict abortion access.*

⁸ Center for Reproductive Rights & Ibis Reproductive Health, *Evaluating Priorities: Measuring Women’s and Children’s Health and Well-being against Abortion Restrictions in the States*, Vol. II, 10-19 (2017), <https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf>. (ranking Mississippi as one of the states with the most abortion restrictions, but with low scores for women’s health).

⁹ See *Jackson Women’s Health v. Currier*, 349 F. Supp. 3d at 540 n.22.

Mississippi has repeatedly enacted targeted regulations of abortion providers (“TRAP”)¹⁰ laws which purport to advance maternal health and safety by regulating who can perform an abortion and in what setting, but actually unduly burden a pregnant person’s right to decide to terminate their pregnancy. Among other barriers, Mississippi’s TRAP laws: compel a twenty-four-hour waiting period between a consultation and an abortion;¹¹ require minors to obtain written parental consent;¹² mandate physicians providing an abortion, and certain aspects of pre-abortion care, to be licensed to practice specifically in Mississippi;¹³ and obligate providers to distribute biased and inaccurate medical information to their patients,¹⁴ including the shibboleth that abortions cause an increased risk of breast cancer, which is patently inconsistent with evidence-based practice.¹⁵

Furthermore, despite Mississippi’s highly permissive laws on the practice of

¹⁰ Miss. Code Ann. § 41-75-1 (2017), *invalidated by Jackson Women’s Health Org. v. Currier*, 320 F. Supp. 3d 828 (S.D. Miss. 2018).

¹¹ See Miss. Code Ann. § 41-41-33 (2019); see also *id.* § 41-41-39 (2019) (punishable by six months imprisonment, a \$1,000 fine, or both).

¹² Miss. Code Ann. §§ 41-41-31, 41-41-51, 41-41-53, 41-41-55, 41-41-57 (2019).

¹³ See Miss. Code Ann. § 41-75-1(f) (2017), *invalidated by Jackson Women’s Health Org.*, 320 F. Supp. 3d at 828. Violation of either law constitutes a misdemeanor. Miss. Code Ann. §§ 41-41-107(1), 41-41-111(1) (2019); *id.* §§ 41-75-26, 41-41-34 (2019).

¹⁴ Miss. Code Ann. §§ 41-41-33, 41-41-35 (2019).

¹⁵ National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States, A Consensus Study Report*, 161 (2018), <http://nap.edu/24950> (concluding based on a rigorous study of published research on potential long-term risks of abortion, that “having an abortion does not increase a woman’s risk of . . . breast cancer”).

“telemedicine,” which enables patients to access medical care without traveling great distances, the State prohibits such practice for abortion.¹⁶

In 2003, the Legislature effectively cut all public funding available for facilities providing abortion care.¹⁷ Because of the State’s unnecessarily high and costly facility standards, only one clinic providing abortion services remains open in Mississippi today. In 2012, the Mississippi Legislature further targeted the functioning of the remaining clinic by requiring physicians performing abortions to be board-certified or board-eligible in obstetrics-gynecology and to hold admitting privileges at a local hospital.¹⁸ The admitting privileges requirement portion was invalidated after *Whole Woman’s Health*, but the obstetrics-gynecology requirement is still enforced.¹⁹

Mississippi’s six-week ban, which follows its fifteen-week ban, is yet another attempt to eviscerate access to abortions and undermine pregnant people’s

¹⁶ See Miss. Code Ann § 41-127-1 (2019).

¹⁷ Sarah Fowler, *A Look Back in Time: Mississippi’s Abortion History*, CLARION LEDGER (Aug. 17, 2018), <https://www.clarionledger.com/story/news/2018/08/17/mississippi-abortion-law-and-abortion-clinic-u-s-supreme-court/781127002/>.

¹⁸ Bryce Covert, *Mississippi Abortion Ban Endangers Low-Income Women, Women of Color*, REWIRE NEWS (Mar. 21, 2018), <https://rewire.news/article/2018/03/21/mississippi-abortion-ban-will-absolutely-affect-low-income-women-women-color/>; see *Jackson Women’s Health Organization v. Currier*, 760 F.3d 448, 459 (5th Cir. 2014).

¹⁹ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2314 (2016). While similarly portrayed as protecting women’s health, Representative Sam Mims, author of the Mississippi bill, said, “The intent of the legislation is to cause fewer abortions. So if the clinic in Jackson had to shut down, then I think it is a positive day for the unborn.” MJ Lee, *Bill Dooms Only Miss. Abortion Clinic*, POLITICO (Apr. 5, 2012), <http://www.politico.com/story/2012/04/bill-dooms-only-miss-abortion-clinic-074871>.

constitutionally protected rights. For nearly a decade, Mississippi Governor Phil Bryant has made his intent to eliminate legal abortion in Mississippi abundantly clear, stating:

- “I hope at some point, Mississippi is free of abortion completely. And I hope it is before I leave office.”²⁰
- “On this unfortunate anniversary of *Roe vs. Wade*, my goal is to end abortion in Mississippi.”²¹
- “My goal, of course, is to shut [Jackson Women’s Health] down”²²
- “We will all answer to the good Lord one day. I will say in this instance, ‘I fought for the lives of innocent babies, even under threat of legal action.’”²³

While Jackson Women’s Health Organization (“JWHO”) remains open, since the obstetrics-gynecology requirement went into effect, the pool of providers from which the clinic can draw qualified clinicians has shrunk. The Mississippi Department of Health further inhibits women from accessing JWHO by failing to

²⁰ Kristi Burton Brown, *Federal Judge Strikes Down Mississippi’s 15-Week Abortion Ban*, Live Action (Nov. 21, 2018), <https://www.liveaction.org/news/federal-judge-mississippi-ban-abortion/>.

²¹ *Gov. Bryant: ‘My Goal Is To End Abortion In Mississippi,’* CBS DC (Jan. 23, 2014), <https://washington.cbslocal.com/2014/01/23/gov-bryant-my-goal-is-to-end-abortion-in-mississippi/>.

²² *Legal Woes for Mississippi’s Only Abortion Clinic*, AP NEWS (Jan. 11, 2013), <https://www.usatoday.com/story/news/nation/2013/01/11/abortion-mississippi-women-clinic/1828289/>.

²³ Phil Bryant (@PhilBryantMS), TWITTER (March 20, 2019, 3:58pm), <https://twitter.com/philbryantms/status/1108503101781262336?lang=en>.

list it amongst family planning clinics on the Department's website,²⁴ even though the clinic provides family planning services, including pregnancy testing and contraception counseling, in addition to abortion services.²⁵

(ii) *Mississippi's abortion restrictions disproportionately burden people facing significant socioeconomic barriers.*

Mississippi's abortion restrictions disproportionately burden people facing significant socioeconomic barriers. Women in Mississippi face higher poverty levels and have grimmer employment prospects as compared to women living in other states. In 2016, 22% of Mississippi women ages 18-64 lived below 100% of the Federal Poverty Level,²⁶ compared to 13% of women ages 18-64 nationally.²⁷ Among women of reproductive age in Mississippi, 17.2% do not have health insurance.²⁸ There are fewer opportunities for women in Mississippi to advance in the workforce compared to other states; women in Mississippi have the lowest

²⁴ Mississippi State Department of Health, *Informed Consent Resources List* (2017), https://msdh.ms.gov/msdhsite/_static/resources/1426.pdf.

²⁵ Jackson Women's Health Org., About Us, <https://jacksonwomenshealth.com/about-us/> (last visited Oct. 1, 2019).

²⁶ Kaiser Family Foundation ("KFF"), *State Profiles for Women's Health* [Miss.] (July 25, 2018), <https://www.kff.org/interactive/womens-health-profiles/?activeState=Mississippi&activeCategoryIndex=0&activeView=data>.

²⁷ KFF, *State Profiles for Women's Health* [U.S.] (July 25, 2018), <https://www.kff.org/interactive/womens-health-profiles/?activeState=USA&activeDistributionIndex=0&activeStateDistributionIndex=0&activeView=chart&activeCategoryIndex=0/>.

²⁸ National Women's Law Center, *Mississippi is Shortchanging Women* (Jan. 2018), <https://nwlc-ci49tixgw5lbab.stackpathdns.com/wp-content/uploads/2018/01/MS-Is-Shortchanging-Women-Fact-Sheet.pdf>.

median annual earnings of women in any state, and the third-lowest rate of participation in the workforce.²⁹

A greater percentage of people seeking abortions now live below the poverty line. In 2014, “[f]orty-nine percent of [abortion] patients had family incomes of less than 100% of the federal poverty level,” compared to 42% in 2008.³⁰ Moreover, “[a]n additional 26% of patients in 2014 had incomes that were 100-199% of the poverty threshold.”³¹ Notably, over the same time period, the percentage of abortion patients with family incomes of 200% or more of the federal poverty level decreased by six percentage points, to 25%.³²

Approximately 37.8% of Mississippi’s population is Black or African-American and 3.2% of Mississippi’s population is classified as Hispanic or Latinx.³³ Mississippi is also home to approximately 20,000 undocumented immigrants,³⁴ and more than 1,200 incarcerated women.³⁵

²⁹ *Status of Women in the States*, Fact Sheet, IWPR # R532 (Mar. 2018), https://iwpr.org/wp-content/uploads/2018/03/R532-National-Fact-Sheet_Final.pdf.

³⁰ Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INST. 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

³¹ *Id.*

³² *Id.*

³³ U.S. Census Bureau QuickFacts, Mississippi (July 1, 2018), <https://www.census.gov/quickfacts/ms?>.

³⁴ Pew Research Center, *Hispanic Trends, U.S. unauthorized immigrant population estimates by state, 2016* (Feb. 5, 2019), <http://www.pewhispanic.org/interactives/u-s-unauthorized-immigrants-by-state/>.

Women of color are disproportionately represented amongst the number of people seeking abortion services. Although Black women comprise 14.9% of the country's female population, they obtain 27.6% of abortions,³⁶ which has been attributed to factors including “Black women’s greater likelihood of being poor, unemployed, or working in low-wage jobs without insurance coverage.”³⁷ Moreover, in 2014, “[Latinas] accounted for 25% of abortion procedures[.]”³⁸

These patients face a variety of barriers to accessing reproductive health care due to both socioeconomic and structural barriers. An abortion at JWHO costs between \$600 to \$800,³⁹ and because of state and federal restrictions, Medicaid will not pay for most abortions, leaving most Mississippi women paying out of pocket for the procedure.⁴⁰ In 2014, nationally, “53% of patients reported that they paid for the abortion themselves.”⁴¹ However, given that the majority of

³⁵ Prison Policy Initiative, Mississippi prison population 1978-2015: Women, https://www.prisonpolicy.org/graphs/MS_Women_Counts_1978_2015.html (last visited Oct. 1, 2019).

³⁶ Note that “Black Women,” in this statistic, includes “cis, femme, trans, binary and gender non-conforming individuals.” In Our Own Voice: National Black Women’s Reproductive Justice Agenda, *Our Bodies, Our Lives, Our Voices: The State of Black Women & Reproductive Justice* 6, 22 (June 2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf (hereinafter, *State of Black Women*).

³⁷ *Id.*

³⁸ Forward Together, *Reproductive Justice Media Reference Guide: Abortion and the Latinx Community*, 4 (2017), <https://forwardtogether.org/wp-content/uploads/2017/12/RJ-Media-Guide-English-FINAL.pdf>.

³⁹ Jackson Women’s Health Org., Fee Schedule, <https://jacksonwomenshealth.com/fee-schedule/> (last visited Oct. 1, 2019).

⁴⁰ *State of Black Women*, *supra* note 36, at 22-23.

⁴¹ Jerman, *supra* note 30, at 9.

abortion patients are poor or low income⁴² people, paying for an abortion out-of-pocket is a near-prohibitive burden for many.

In addition to the cost of the procedure itself, obtaining an abortion in Mississippi has significant attendant financial and logistical costs. Because JWHO is the sole abortion provider in Mississippi,⁴³ the overwhelming majority of abortion patients in Mississippi must travel—often significant distances—to receive care. Traveling to obtain an abortion not only forces patients to incur the financial costs of transportation, lodging, and expenses, but also the added costs of missing work and child care, in addition to the price of the procedure itself.⁴⁴ Mississippi already requires abortion patients to abide by a 24-hour waiting period between their initial clinic visit and the procedure, ultimately requiring them to either stay overnight in Jackson and incur two days of missed work and child care costs, or to make two separate hours-long trips back and forth to the clinic over two days and incur additional transportation costs.⁴⁵ Furthermore, undocumented

⁴² Guttmacher Institute, *Abortion patients are disproportionately poor and low income* (2016), <https://www.guttmacher.org/infographic/2016/abortion-patients-are-disproportionately-poor-and-low-income>.

⁴³ Guttmacher Institute, *State Facts About Abortion: Mississippi* (2019), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-mississippi>.

⁴⁴ Covert, *supra* note 18.

⁴⁵ *Id.*

immigrants and incarcerated people face legal risks and other barriers to traveling long distances and obtaining abortions generally.⁴⁶

Many women may not know that they have the right to an abortion while incarcerated, nor do they know that they may need to seek a court order to approve the procedure, which would involve publicizing their decision.⁴⁷ Although incarcerated women have the right to seek an abortion, the financial and logistical costs they must endure to obtain abortion services are heightened by their limited earning capacity while incarcerated and their inability to travel to an abortion services provider without the cooperation and assistance of the facility in which they are held.⁴⁸

For undocumented immigrants, access to reproductive health care is thwarted by a lack of health insurance, legal obstacles, traveling difficulties, and the threat of U.S. Immigration and Customs Enforcement raids at health care centers and deportation.⁴⁹ The inability to safely access reproductive health care centers is particularly concerning for low-income undocumented immigrants who

⁴⁶ As discussed *infra*, should Louisiana's six-week ban take effect, the closest state to Mississippi will have an identical restriction, forcing women to travel even further to exercise their constitutional right to a pre-viability abortion.

⁴⁷ Rebecca Grant, *Abortion behind bars: Terminating a pregnancy in prison can be next to impossible* (Mar. 16, 2017), VICE, https://news.vice.com/en_us/article/3kp9b5/abortion-behind-bars-terminating-a-pregnancy-in-prison-can-be-next-to-impossible.

⁴⁸ *Id.*

⁴⁹ See Jessica Gonz  les-Rojas, *Immigrant Women Aren't Getting Access to Health Care Due to Fears*, THE HILL (Jul. 29, 2019), <https://thehill.com/opinion/healthcare/455189-many-immigrant-women-arent-getting-access-to-health-care-due-to-fears>.

rely on these centers for their only regular doctor visit and source of preventative care.⁵⁰

At the same time as these existing restrictions are forcing pregnant people to wait longer to have abortions, the State now prohibits abortion entirely after six weeks. By layering a six-week ban on top of Mississippi's pre-existing web of abortion restrictions, the State exacerbates existing burdens by virtually eliminating abortion access in the state altogether.

B. Mississippi Has Done Little to Affirmatively Promote Maternal Health, Sexual Education or Family Planning

Mississippi has done little to address actual and urgent threats to pregnant people's health, including the well-documented dangers of giving birth in Mississippi.⁵¹ In 2016, 40% of Mississippi adult women reported having a poor mental health status and 26% reported having a poor health status overall—health risks that were each even more acute for Black women than white women.⁵² While the State touts its concern about protecting the unborn, Mississippi's infant mortality rate is the highest in the country at 8.8 deaths per 1,000 live births.⁵³

⁵⁰ *Id.* Undocumented immigrant minors face further restrictions by the Office of Refugee Resettlement's (ORR) mandate that they must obtain consent from a parent or potential sponsor to be eligible for an abortion, as well as approval from the ORR, whose former director failed to approve a single abortion request, including when the pregnancy resulted from rape or was privately funded. Ann E. Marimow, *Trump Administration Cannot Block Abortions for Immigrant Teens in Custody, Court Rules*, WASH. POST (Jun. 14, 2019), https://www.washingtonpost.com/local/legal-issues/trump-administration-cannot-block-abortion-for-immigrant-teens-in-custody-court-rules/2019/06/14/5ad50812-8eb9-11e9-adf3-f70f78c156e8_story.html.

Mississippi's maternal mortality rate is one of the highest in the country, with an average of approximately 27 deaths for every 100,000 live births.⁵⁴ The rate for Black women, 28.7 per 1,000 live births, is drastically higher than that for white women (18 per 100,000 live births).⁵⁵

When pregnant people have access to regular health care and checkups, maternal and infant deaths can be reduced by up to 60%.⁵⁶ Access to preventative health care is largely dependent on income and health insurance coverage.⁵⁷ Mississippi, however, chooses to erect barriers around the State's health care programs, endangering Black people's lives while forcing them to give birth. For example, Mississippi refused to expand Medicaid under the Affordable Care Act (ACA), leaving more than 100,000 people who would otherwise be eligible for

⁵¹ Getty Israel, *Mississippi More Concerned With Ending Abortion Than Infant, Maternal Deaths*, CLARION LEDGER (Apr. 22, 2018), <https://www.clarionledger.com/story/opinion/columnists/2018/04/23/mississippi-more-concerned-ending-abortion-than-infant-maternal-deaths/537859002/>.

⁵² KFF [Miss.], *supra* note 26.

⁵³ KFF [U.S.], *supra* note 27.

⁵⁴ United Health Foundation, *2019 Health of Women and Children Report, Mississippi*, <https://www.americashealthrankings.org/learn/reports/2019-health-of-women-and-children-report/state-summaries-mississippi> (last visited Oct. 1, 2019).

⁵⁵ United Health Foundation, *2018 Health of Women and Children Report, Mississippi*, <https://www.americashealthrankings.org/learn/reports/2018-health-of-women-and-children-report/state-summaries-mississippi> (last visited Oct. 1, 2019).

⁵⁶ March of Dimes, *March of Dimes Position Statement* (June 2018), <https://www.marchofdimes.org/materials/March-of-Dimes-Maternal-Mortality-and-SMM-Position-Statement-FINAL-June-2018.pdf>.

⁵⁷ Sarah Varney, *How Obamacare Went South in Mississippi*, THE ATLANTIC (Nov. 4, 2014), <https://www.theatlantic.com/health/archive/2014/11/how-obamacare-went-south-in-mississippi/382313/>.

Medicaid without health coverage.⁵⁸ Moreover, this absence of additional federal health care funding has caused Mississippi hospitals to lay off medical staff and close entire departments.⁵⁹ Mississippi is also now asking the federal government to approve an additional work requirement for some of the lowest-income people already eligible for Medicaid.⁶⁰ If approved, an estimated 5,000 additional people will lose health coverage each year, 91% of whom are low-income mothers, and two-thirds of whom are Black.⁶¹ Mississippi is also the only state to require face-to-face meetings for initiating and continuing Medicaid eligibility, a hurdle that removes otherwise qualified people from Medicaid coverage.⁶² Without access to

⁵⁸ Rachel Garfield et al., *The Coverage Gap : Uninsured Poor Adults in States that Do Not Expand Medicaid*, Kaiser Family Foundation, (Mar. 21, 2019), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>. By rejecting Medicaid expansion, Mississippi has denied approximately 210,000 residents the opportunity of coverage and left another 99,000 without access to health insurance. Louise Norris, *Mississippi and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Sept. 16, 2018), <https://www.healthinsurance.org/mississippi-medicaid/>.

⁵⁹ See Varney, *supra* note 57.

⁶⁰ Norris, *supra* note 58.

⁶¹ Anna Wolfe, *Mississippi Medicaid Work Requirement: Twisting Arms or Giving a Leg-Up?*, CLARION LEDGER (Apr. 12, 2018), <https://www.clarionledger.com/story/news/politics/2018/04/12/mississippi-medicaid-work-requirement-twisting-arms-giving-leg-up/505755002/>.

⁶² Sandhya Somashekhar, *How Mississippi Could End Up Killing Medicaid*, WASH. POST (June 13, 2013), https://www.washingtonpost.com/news/work/wp/2013/06/13/how-mississippi-could-end-up-killing-medicaid/?utm_term=.42c52781c40c.

health care, pregnant people are more likely to suffer from high blood pressure, heavy bleeding, and obstructed labor—all common causes of maternal death.⁶³

The Legislature’s insistence on promoting abstinence has detrimental consequences for young people and minority communities in Mississippi. Instead of enacting laws geared towards comprehensive sexual health education and medical accuracy, the Mississippi Legislature chooses to mandate an abstinence-based curricula,⁶⁴ despite evidence that such approaches fail to reduce HIV or STD transmission⁶⁵ and prevent unintended teenage pregnancies.⁶⁶ Furthermore, HIV education is not mandated in Mississippi.⁶⁷ Unsurprisingly, Mississippi’s teenage birth rate is more than one and a half times the national average.⁶⁸ Mississippi also has alarmingly high rates of HIV infection, which is a particularly acute issue for

⁶³ See Danielle Paquette, *Why Pregnant Women in Mississippi Keep Dying*, WASH. POST (April 24, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/04/24/why-pregnant-women-in-mississippi-keep-dying/?utm_term=.f0c17f6f6ac3.

⁶⁴ In 2016, five bills seeking to amend the sex education curriculum failed in the Legislature. Four bills included provisions to ensure the curriculum was “medically accurate.” See The National Conference of State Legislatures, *State Policies on Sex Education in Schools* (March 21, 2019), <http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx> (citing 2016 Mississippi House Bill 756; 2016 Mississippi Senate Bill 2413; 2016 Mississippi House Bill 932; 2016 Mississippi House Bill 992; 2016 Mississippi Senate Bill 2594). See also Miss. Code Ann. § 37-13-171 (2019).

⁶⁵ See J.S. Santelli et. al., *Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact*, 61 J. OF ADOLESCENT HEALTH 273 (2017), [https://www.jahonline.org/article/S1054-139X\(17\)30260-4/pdf](https://www.jahonline.org/article/S1054-139X(17)30260-4/pdf).

⁶⁶ Kathrin F. Stanger-Hall & David W. Hall, *Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S*, PLOS ONE, 6(10), e24658 (2011) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3194801/>.

⁶⁷ Guttmacher Institute, *Sex and HIV Education* (2019) <https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education>.

⁶⁸ Mississippi State Department of Health, *Personal Responsibility Education Program (PREP)* (2015), <https://msdh.ms.gov/msdhsite/index.cfm/44,11790,362.html>.

minority communities. For example, African Americans are only 37.8% of the state's population,⁶⁹ but comprise 78% of those newly infected with HIV.⁷⁰

The Mississippi Legislature has further curtailed access to birth control by enacting contraception refusal policies which allow certain employers and insurers to refuse to provide their employees and beneficiaries with contraception coverage as mandated by the ACA.⁷¹ Mississippi is one of eight states that allows religious groups, including hospitals and insurers, to refuse to provide contraception coverage, and one of six states that allows pharmacists to deny people emergency contraception.⁷² According to the World Health Organization, access to preferred contraceptive methods and the ability to choose if and when to become pregnant is essential to secure the well-being and autonomy of women and has a direct impact on maternal health.⁷³ Meanwhile, there is an increasing trend amongst law enforcement officials in parts of Mississippi to interpret the definition of “child,”

⁶⁹ See U.S. Census Bureau QuickFacts, Mississippi, *supra* note 33 (as of July 1, 2018, approximately 37.8% of Mississippi's population is Black or African-American and 3.2% is classified as Hispanic or Latino).

⁷⁰ Mississippi Center for Justice, *HIV/AIDS*, <http://www.mscenterforjustice.org/our-work/access-healthcare/hiv/aids> (last visited Oct. 1, 2019).

⁷¹ See Guttmacher Institute, *Refusing to Provide Health Services* (2019), <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>.

⁷² *Id.*

⁷³ World Health Organization, *Family Planning/Contraception* (2018), <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception>.

under the state’s felony child abuse law,⁷⁴ to include a fetus, thus permitting them to prosecute and criminalize pregnant people for drug use.⁷⁵ Instead of focusing its policy on family planning and supporting pregnant people, Mississippi funnels its resources into punishing those who become pregnant.

C. Mississippi’s Six-Week Ban Continues Its Legacy of Past Discriminatory State Action

With its six-week ban, Mississippi continues its legacy of policies controlling the bodies of women in marginalized communities, gender non-conforming people and people of color. Woven into the fabric of Mississippi’s history and culture are policies, laws and regulations which reflect discriminatory sentiment toward women, the LGBTQ+ community, and people of color. Just a few decades ago, Mississippi barred women from serving on juries “so they may continue their service as mothers, wives, and homemakers.”⁷⁶ Moreover, Mississippi became the last state to guarantee women the right to vote just thirty-five years ago.⁷⁷ In 2016, in response to federal rulings in support of same sex

⁷⁴ The statute defines “child” as a person who has not reached their eighteenth birthday. Miss. Code Ann. § 97-5-39(b) (2019).

⁷⁵ Erica Hensley & Michelle Liu, *Delivering Justice*; MISSISSIPPI TODAY (May 12, 2019), <https://mississippitoday.org/2019/05/11/delivering-justice/> (identifying that since 2015, 18 cases where pregnant people using illegal drugs were prosecuted in Jones County under this law, regardless of the effect on the fetus and before childbirth).

⁷⁶ *State v. Hall*, 187 So. 2d 861, 863 (Miss. 1966).

⁷⁷ See Marjorie Julian Spruill & Jesse Spruill Wheeler, *Mississippi Women and the Woman Suffrage Movement*, MISSISSIPPI HISTORY NOW (Dec. 2001), www.mshistorynow.mdah.ms.gov/articles/245/mississippi-women-and-the-women-suffrage-amendment.

marriage, Mississippi enacted anti-LGBTQ+ legislation, House Bill 1523 (“H.B. 1523”), which grants broad exemptions for businesses and individuals to discriminate on the basis of sexual and gender stereotypes. During that same year, Governor Bryant declared April Mississippi’s “Confederate Heritage Month,” ignoring the history of slavery and its current racial implications.⁷⁸ Furthermore, Mississippi is one of a handful of states without legislation terminating or limiting parental rights when a child is born from rape.⁷⁹ If this Court reverses the District Court, a person in Mississippi pregnant from rape will not only be forced into motherhood after six weeks of pregnancy, but also likely forced to continuously confront her attacker in custody hearings, parenting and/or child visitations.⁸⁰

These policies demonstrate Mississippi’s pattern of denying individuals, and especially people of color, their constitutional right to control their own bodies, and are crucial to understanding the dire state of women’s health in Mississippi today. For example, in the early 1960s, Mississippi forced six out of ten Black

⁷⁸ Donna Lad, *Mississippi Governor Declares April ‘Confederate Heritage Month,’ No Slavery Mention*, Jackson Free Press, Feb. 24, 2016; *see also* Andrew Koppelman, *Forced Labor, Revisited: The Thirteenth Amendment and Abortion*, in *THE HISTORY AND CONTEMPORARY RELEVANCE OF THE THIRTEENTH AMENDMENT, THE PROMISES OF LIBERTY* 237 (Alexander Tsesis ed., 2010).

⁷⁹ *See* Breeanna Hare & Lisa Rose, *Where Rapists Can Gain Parental Rights*, Nov. 17, 2016, <https://www.cnn.com/2016/11/17/health/parental-rights-rapists-explainer/>; *see also* Ashton Pittman, *Dem Lt. Gov. Hopeful Voted for Abortion Ban So White Dems Don’t Go Extinct*, JACKSON FREE PRESS (Feb. 14, 2019), <http://m.jacksonfreepress.com/news/2019/feb/14/dem-lt-gov-hopeful-voted-abortion-ban-so-white-dem/> (Legislature defeated amendments allowing victims of rape or incest to have an abortion past heartbeat detection).

⁸⁰ Hare & Rose, *supra* note 79.

women in Sunflower County to undergo involuntary sterilizations, a practice so common that it was called a “Mississippi Appendectomy.”⁸¹ Even in the 1990s, the Mississippi Legislature continued to debate coercive reproductive policies, including a bill conditioning women’s welfare benefits on inserting a contraceptive implant, which would effectively sterilize them for up to five years.⁸² The six-week ban continues this long-held and persistent agenda to control the bodies of women and people in marginalized communities in Mississippi, despite the Legislature’s purported interest in protecting maternal health.

II. The Reproductive Autonomy of Pregnant People in Louisiana Is Also at Stake

In addition to Mississippi, the rights of pregnant people in Louisiana hang in the balance in this litigation. Louisiana has also enacted a six-week ban⁸³, however, that law only becomes effective “upon a final decision of the United States Court of Appeals for the Fifth Circuit upholding [Mississippi’s six-week ban].”⁸⁴

⁸¹ See Rickie Solinger, WAKE UP LITTLE SUSIE: SINGLE PREGNANCY AND RACE BEFORE ROE V. WADE 57 (1992); Fannie Lou Hamer, *American Experience: Freedom Summer*, <https://www.pbs.org/wgbh/americanexperience/features/freedomsummer-hamer/> (last visited Oct. 1, 2019).

⁸² Rachel Benson Gold, *Guarding Against Coercion While Ensuring Access: A Delicate Balance*, GUTTMACHER POL’Y REV. 17, No. 3, 10 (2014), https://www.guttmacher.org/sites/default/files/article_files/gpr170308.pdf.

⁸³ 2019 La. Sess. Law Serv. Act 31 (S.B. 184)(West).

⁸⁴ *Id.*

Pregnant people in Louisiana, therefore, will be directly affected by the outcome of this Court’s decision. Like women in Mississippi, the people in Louisiana who will be most burdened by the six-week ban are low-income women, women of color, and other marginalized populations: in 2017, 69% of women who had abortions in Louisiana were women of color.⁸⁵

Louisiana already severely restricts abortion, which has caused many of Louisiana’s abortion clinics to close.⁸⁶ Presently, there are only three abortion clinics in the entire state.⁸⁷ Two of those three clinics remain open for now because of a temporary stay issued in February by the Supreme Court.⁸⁸

Furthermore, as in Mississippi, any patient seeking an abortion in Louisiana is also

⁸⁵ See Tara C. Jatlaoui et al., *Abortion Surveillance – United States, 2015*, 67 MMWR SURVEILLANCE SUMMARIES 13, Nov. 23, 2018, Table 13 (data showing that 70.4% of reported abortions in 2015 in Louisiana were obtained by women of color); Guttmacher Institute, *State Facts About Abortion: Louisiana* (2018), (copy attached hereto) (in 2014, 62% of those obtaining abortions in Louisiana were nonwhite); see also *State of Black Women*, *supra* note 36, at 22 (disproportionately high abortion rate driven by the increased likelihood for Black women to be poor, unemployed, or uninsured, creating barriers to accessing high-quality reproductive health care).

⁸⁶ See Lift Louisiana, *Abortion Restrictions*, <https://liftlouisiana.org/issues/abortion-restrictions> (last visited Oct. 1, 2019) (outlining all current restrictions on abortion in Louisiana); Center for Reproductive Rights & Ibis Reproductive Health, *supra* note 8 (ranking Louisiana as tied for second most restrictive state for abortion with thirteen abortion restrictions, and finding that Louisiana also scored very low on indicators of women’s and children’s well-being).

⁸⁷ Lift Louisiana, *Abortion Information and Resources*, <https://liftlouisiana.org/content/abortion-information-and-resources> (last visited Oct. 1, 2019); see also Guttmacher Institute, *State Facts About Abortion: Louisiana* (2019), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana> (in 2017, Louisiana had four abortion-providing facilities, which represented a 20% decline since 2014, and “[i]n 2017, some 94% of Louisiana counties had no clinics that provided abortions, and 72% of Louisiana women lived in those counties”).

⁸⁸ *June Medical Services, L.L.C. v. Gee*, 139 S. Ct. 661 (2019).

required to wait 24 hours after consulting with a doctor before they can have the procedure.⁸⁹

These restrictions mean that any pregnant person seeking an abortion in Louisiana is already burdened with the same additional costs, including: traveling far distances; paying for accommodations for at least one night; missing at minimum two days of paid work; and paying for child care.⁹⁰ Plus, the typical price of an abortion at ten weeks in Louisiana is upwards of \$500, an out-of-pocket expense not covered by Medicaid.⁹¹ For low-income patients, these costs impose heavy, and in some cases, insurmountable burdens.⁹² These costs often mean that pregnant people in Louisiana must choose between terminating an unwanted pregnancy or paying for rent or food.⁹³ A six-week ban will only exacerbate those already high burdens.

Indeed, in Louisiana, it is clear that the State has chosen one course for pregnant people, and that is childbirth, “ultimately making the decision for what a

⁸⁹ 2019 La. Rev. Stat. Ann. § 40:1061.17 (West).

⁹⁰ Gina Pollack, *Undue Burden: Trying to Get an Abortion in Louisiana*, N.Y. TIMES (May 16, 2017), <https://www.nytimes.com/2017/05/16/opinion/abortion-restrictions-louisiana.html>. See also *supra* Section I(A)(ii).

⁹¹ *Id.*

⁹² *Id.*; see also *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2313 (2016) (recognizing the concrete hardship of increased travel distances which, combined with other burdens, contributes to undue burden finding); *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 919 (7th Cir. 2015).

⁹³ See Valeria Perasso, *On the battle lines over US abortion*, BBC NEWS (May 18, 2018), <https://www.bbc.com/news/world-us-canada-43966855>; see also *State of Black Women*, *supra* note 36, at 33.

woman's reproductive future will be.”⁹⁴ Louisiana's Department of Health “Abortion Facts” resoundingly encourages women to bring their pregnancies to term.⁹⁵ However, the Louisiana Department of Health also recently acknowledged the State is in the midst of a maternal mortality crisis, with 47 deaths occurring between 2011 and 2016, a ratio of 12.4 deaths per 100,000 births.⁹⁶ The maternal mortality rate increased at a higher rate than that of the U.S.,⁹⁷ which itself is extremely high and rising.⁹⁸ The number of maternal deaths in Louisiana has skyrocketed, and in 2018 there were 44.8 maternal deaths per 100,000 births, more than double the national average of 20.7 maternal deaths per 100,000 births.⁹⁹

Like Mississippi, maternal mortality in Louisiana disproportionately impacts Black women; between 2011 to 2016, Black women were 4.1 times as likely to die

⁹⁴ Michele Goodwin & Erwin Chemerinsky, *Pregnancy, Poverty and the State*, 127 YALE L.J. 1106, 1309 (2018).

⁹⁵ State of Louisiana Department of Health, *Abortion Facts*, <http://ldh.la.gov/index.cfm/page/914> (last visited Oct. 1, 2019) (“There are many public and private agencies willing and able to help you carry your child to term. They will also assist you and your child after your child's birth, whether you choose to keep your child or to place him or her up for adoption.”).

⁹⁶ Lyn Kieltyka et al., *2011-2016 Maternal Mortality Report*, Louisiana Department of Health (Aug. 2018), http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/maternal/2011-2016_MMR_Report_FINAL.pdf.

⁹⁷ *Id.*

⁹⁸ See *State of Black Women*, *supra* note 36, at 51 (U.S. maternal death rate in 2015 on par with rates in Afghanistan and El Salvador); Liz Ford, *Number of women dying in childbirth way off track to meet worldwide targets*, THE GUARDIAN (Sept. 19, 2019), <https://www.theguardian.com/global-development/2019/sep/19/number-women-dying-childbirth-off-track> (“The US has seen maternal deaths rise from 12 per 100,000 live births in 2000 to 19 in 2017.”).

⁹⁹ United Health Foundation, *2018 Health of Women and Children Report, Louisiana*, <https://www.americashealthrankings.org/learn/reports/2018-health-of-women-and-children-report/state-summaries-louisiana> (last visited Oct. 1, 2019).

of pregnancy-related deaths as white women.¹⁰⁰ The leading cause of all maternal deaths in Louisiana was lack of access to health care providers or facilities—a risk factor that is especially prevalent among low-income people of color.¹⁰¹

Similar to Mississippi, the realities of a six-week ban on abortion in Louisiana mean that low-income people of color will be even more restricted from exercising their constitutional right to an abortion.

If the judgment of the District Court is reversed, an entire region of the southern United States will become an abortion desert for people needing to terminate a pregnancy prior to viability, creating a geographic outlier where the “central holding of *Roe v. Wade*”¹⁰² no longer applies. The burdens from such a departure from longstanding precedent should not be inflicted upon some of the country’s most vulnerable people.

¹⁰⁰ Kieltyka et al., *supra* note 96; *see also* United Health Foundation *supra* note 98.

¹⁰¹ Kieltyka et al., *supra* note 96; *State of Black Women*, *supra* note 36, at 14-15 (noting Black people are twice as likely than whites to be uninsured, and are less likely to receive timely medical treatment, compared to their white counterparts), 32 (experience of one indigent Louisiana Black woman who reported “seeing preventive and prenatal care providers is nearly impossible...She attributes much of it to racism.”).

¹⁰² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992).

CONCLUSION

For the foregoing reasons, the judgment of the District Court should be
AFFIRMED.

Dated: October 4, 2019

Respectfully submitted,

STROOCK & STROOCK & LAVAN LLP

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National Birth Equality Collective
SisterReach
SisterSong
The Afiya Center
The Reproductive Justice Action Collective
(ReJAC)

CERTIFICATE OF SERVICE

I hereby certify that on October 4, 2019, I electronically filed a true and correct copy of the foregoing Brief of *Amicus Curiae* Reproductive Justice Groups in Support of Plaintiffs-Appellees with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit, using the CM/ECF system. I certify that all parties in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Date: October 4, 2019

STROOCK & STROOCK & LAVAN LLP

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National Asian Pacific American Women's Forum

National Birth Equality Collective

SisterReach

SisterSong

The Afiya Center

The Reproductive Justice Action Collective
(ReJAC)

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. 32(g), I certify that this document complies with the type-volume limitations of Fed. R. App. P. 29(a)(5) and Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,463 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) and the Addendum. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally-spaced typeface using Microsoft Word Version 1808, in 14 point font, Times New Roman.

Date: October 4, 2019

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ADDENDUM: LIST OF *AMICI*

Mississippi in Action (“MIA”) was founded in 2009, after noticing a lack of holistic advocacy and education pertaining to HIV/AIDS, birth control, comprehensive sex education, and homelessness. Through advocacy and education, MIA focuses on the social justice and equality in sexual and reproductive health and rights among its communities. MIA works with the whole person, not just a part of the person. Using the Maslow hierarchy of needs, MIA works diligently to ensure that every aspect of a person’s well-being is met. MIA’s mission is to promote holistic sexual and reproductive health by incorporating advocacy, education and housing; thereby enhancing the rights and dignity of all Mississippians.

Women with a Vision, Inc. (“WWAV”)’s mission is to improve the lives of marginalized women, their families, and communities by addressing the social conditions that hinder their health and well-being. WWAV accomplishes this mission through relentless advocacy, health education, supportive services, and community-based participatory research. WWAV is a community-based organization, founded in 1989 by a grassroots collective of African-American women in response to the spread of HIV/AIDS in communities of color. Created by and for women of color, WWAV is a social justice non-profit that addresses

issues faced by women within our community and region. Major areas of focus include Sex Worker Rights, Drug Policy Reform, HIV Positive Women's Advocacy, and Reproductive Justice outreach. WWAV envisions an environment in which there is no war against women's bodies, in which women have spaces to come together and share their stories, in which women are empowered to make decisions concerning their own bodies and lives, and in which women have the necessary support to realize their hopes, dreams, and full potential.

Black Women's Health Imperative ("Imperative") is a non-profit advocacy organization with a history of more than 35 years of dedication to promoting optimum health for Black women across the life span. Women have long faced great difficulty obtaining comprehensive, affordable health coverage. The Imperative is profoundly concerned about the impact that the Court's decision will have on low-income women of color who face barriers to obtaining reproductive health care.

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national-state partnership with eight Black women's Reproductive Justice organizations: The Afiya Center, Black Women for Wellness, Black Women's Health Imperative, New Voices for Reproductive Justice, SisterLove, Inc., SisterReach, SPARK Reproductive Justice Now!, and Women with a Vision. The organization is focused on lifting up the voices of Black women leaders on

national, regional, and state policies that impact the lives of Black women and girls.

Lift Louisiana works in diverse ways to advance the interests and well-being of pregnant and parenting women and their families and to protect their constitutional and human rights including the constitutional right to end a pregnancy. Lift Louisiana's mission is to educate, advocate and litigate for policy changes needed to improve the health and well-being of Louisiana's women, their families, and their communities. Lift Louisiana, members of its Advisory Board, volunteers, and donors, are deeply interested in the ways an unconstitutional ban on the right to abortion would impact low-income women of color and other marginalized populations in Mississippi and Louisiana.

National Asian Pacific American Women's Forum ("NAPAWF") is the only national, multi-issue Asian American and Pacific Islander (AAPI) women's organization in the country. NAPAWF's mission is to build the collective power of all AAPI women and girls to gain full agency over our lives, our families, and our communities. With a large member base organized into chapters across the country, NAPAWF engages in community organizing at the state and local levels, including in Georgia. NAPAWF's work, which is centered in a reproductive justice framework, includes advocating for the reproductive rights and health care needs of AAPI women.

The National Birth Equity Collaborative (“NBEC”)’s mission is to create solutions that optimize Black maternal and infant health through training, policy advocacy, research, and community-centered collaboration. NBEC’s vision is to see all black mothers and babies thrive and its core values are leadership, freedom, wellness, black lives and sisterhood.

SisterReach, founded October 2011, is a Memphis, TN based grassroots 501(c)(3) non-profit organization supporting the reproductive autonomy of women and teens of color, poor and rural women, LGBT+ and gender non-conforming people and their families through the framework of Reproductive Justice. SisterReach’s mission is to empower its base to lead healthy lives, raise healthy families and live in healthy communities.

SisterSong is a Southern based, national membership organization; Sistersong’s purpose is to build an effective network of individuals and organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities. SisterSong Women of Color Reproductive Justice Collective was formed in 1997 by sixteen organizations of women of color from four mini-communities (Native American, African American, Latina, and Asian American) who recognized that they have the right and responsibility to represent themselves and their communities, and the equally compelling need to advance the perspectives and needs of women of color.

The Afiya Center (“TAC”) was established in response to the increasing disparities between HIV incidences worldwide and the extraordinary prevalence of HIV among Black women and girls in Texas. TAC is unique in that it is the only Reproductive Justice organization in North Texas founded and directed by Black women. TAC’s mission is to serve Black women and girls by transforming their relationship with their sexual and reproductive health through addressing the consequences of reproduction oppression.

The Reproductive Justice Action Collective (“ReJAC”) is a New Orleans network that aims to share information, resources, ideas, and human power to create and implement projects in their community that operate within the reproductive justice framework. ReJAC envisions a world in which all Southerners are able to access reproductive health care without judgement and with dignity; have free access to accurate health information, resources, and organizing opportunities in their communities; and have a space to organize about issues that are important to them.

No. 19-60455

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

JACKSON WOMEN’S HEALTH ORGANIZATION, on behalf of itself and its patients; SACHEEN CARR-ELLIS, M.D., M.P.H., on behalf of herself and her patients,

Plaintiffs – Appellees,

v.

THOMAS E. DOBBS, M.D., M.P.H., in his official capacity as State Health Officer of the Mississippi Department of Health; KENNETH CLEVELAND, M.D., in his official capacity as Executive Director of the Mississippi State Board of Medical Licensure,

Defendants – Appellants.

On Appeal from the United States District Court
for the Southern District of Mississippi, Jackson Division

***AMICI CURIAE* MISSISSIPPI IN ACTION, WOMEN WITH A VISION,
BLACK WOMEN’S HEALTH IMPERATIVE, IN OUR OWN VOICE:
NATIONAL BLACK WOMEN’S REPRODUCTIVE JUSTICE AGENDA,
LIFT LOUISIANA, NATIONAL ASIAN PACIFIC AMERICAN WOMEN’S
FORUM, NATIONAL BIRTH EQUALITY COLLECTIVE,
SISTERREACH, SISTERSONG, THE AFIYA CENTER, THE
REPRODUCTIVE JUSTICE ACTION COLLECTIVE**

SOURCE FOR FOOTNOTE No. 85

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State Facts About Abortion

Louisiana

National Background and Context

Each year, a broad cross section of U.S. women obtain abortions. As of 2014, some 60% of women having abortions were in their 20s; 59% had one or more children; 86% were unmarried; 75% were economically disadvantaged; and 62% reported a religious affiliation. No racial or ethnic group made up a majority: Some 39% of women obtaining abortions were white, 28% were black, 25% were Hispanic and 9% were of other racial or ethnic backgrounds.

Contraceptive use is a key predictor of whether a woman will have an abortion. In 2011, the very small group of American women who were at risk of experiencing an unintended pregnancy but were not using contraceptives accounted for the majority of abortions. Many of these women did not think they would get pregnant or had concerns about contraceptive methods. A minority of abortions occurred among the much larger group of women who were using contraceptives in the month they became pregnant. Many women who fall into this category have reported difficulty using contraceptives consistently.

Abortion is one of the safest surgical procedures for women in the United States. Fewer than 0.05% of women obtaining abortions experience a complication.

Since recognizing a woman's constitutional right to abortion in 1973 in *Roe v. Wade*, the U.S. Supreme Court has in subsequent decisions reaffirmed that right. The Court has held that a state cannot ban abortion before viability (the point at which a fetus can survive outside the uterus), and that any restriction on abortion after viability must contain exceptions to protect the life and health of the woman. Furthermore, any previability abortion restriction cannot create an "undue burden" on a woman seeking an abortion. This "undue burden" standard was established in *Planned Parenthood v. Casey* in 1992 and clarified in the 2016 decision in *Whole Woman's Health v. Hellerstedt*. The latter held that scientific evidence must be considered when evaluating the constitutionality of abortion restrictions. Some of the most common state-level abortion restrictions are parental notification or consent requirements for minors, limitations on public funding, mandated counseling designed to dissuade a woman from obtaining an abortion, a mandated waiting period before an abortion, and unnecessary and overly burdensome regulations on abortion facilities.

Since 2010, the U.S. abortion landscape has grown increasingly restrictive as more states become hostile to abortion rights. Between 2010 and 2016, states enacted 338 new abortion restrictions, which account for nearly 30% of the 1,142 abortion restrictions enacted by states since the 1973 Supreme Court decision in *Roe v. Wade*.

Pregnancies and Their Outcomes

In 2011, the 63 million U.S. women of reproductive age (15-44) had six million pregnancies. Sixty-seven percent of these pregnancies resulted in live births and 18% in abortions; the remaining 15% ended in miscarriage.

Approximately 926,200 abortions occurred in the United States in 2014. The resulting abortion rate of 14.6 abortions per 1,000 women of reproductive age represents a 14% decrease from the 2011 rate of 16.9 per 1,000 women.

In 2014, some 10,150 abortions were provided in Louisiana, though not all abortions that occurred in Louisiana were provided to state residents, as some patients may have traveled from other states; likewise, some individuals from Louisiana may have traveled to another state for an abortion. There was a 18% decline in the abortion rate in Louisiana between 2011 and 2014, from 13.1 to 10.8 abortions per 1,000 women of reproductive age. Abortions in Louisiana represent 1.1% of all abortions in the United States.

Where Women Obtain Abortions

In 2014, there were 1,671 facilities providing abortion in the United States, representing a 3% decrease from the 1,720 facilities in 2011. Sixteen percent of facilities in 2014 were abortion clinics (i.e., clinics where more than half of all patient visits were for abortion), 31% were

nonspecialized clinics, 38% were hospitals and 15% were private physicians' offices. Fifty-nine percent of all abortions were provided at abortion clinics, 36% at nonspecialized clinics, 4% at hospitals and 1% at physicians' offices.

There were 5 abortion-providing facilities in Louisiana in 2014, and 5 of those were clinics. These numbers represent a 29% decline since 2011 in overall providers, and a 29% decline in clinics from 2011, when there were 7 abortion providers overall, of which 7 were clinics.

In 2014, 90% of U.S. counties had no clinics providing abortion. Some 39% of women of reproductive age lived in those counties and would have had to travel elsewhere to obtain an abortion. Of patients obtaining abortions in 2008, one-third had to travel more than 25 miles one way to reach a facility.

In 2014, some 92% of Louisiana counties had no clinics that provided abortion, and 63% of Louisiana women lived in those counties.

Restrictions on Abortion

- Abortion would be banned if Roe v. Wade were to be overturned.
- A woman must receive state-directed counseling that includes information designed to discourage her from having an abortion, and then wait 24 hours before the procedure is provided. Counseling must be provided in person and must take place before the waiting period begins, thereby necessitating two trips to the facility.
- Health plans offered in the state's health exchange under the Affordable Care Act may not provide coverage of abortion.
- The use of telemedicine to administer medication abortion is prohibited.
- The parent of a minor must consent before an abortion is provided.

- Public funding is available for abortion only in cases of life endangerment, rape or incest.

- A woman must undergo an ultrasound at least 24 hours before obtaining an abortion; the provider must show and describe the image to the woman.

References for information contained in this fact sheet are available at <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana>

United States Court of Appeals

FIFTH CIRCUIT
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October 07, 2019

Mr. Claude Szyfer
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No. 19-60455 Jackson Women's Health Orgn, et al v. Thomas
Dobbs, et al
USDC No. 3:18-CV-171

Dear Mr. Szyfer,

You must submit the 7 paper copies of your brief required by 5th Cir. R. 31.1 within 5 days of the date of this notice pursuant to 5th Cir. ECF Filing Standard E.1. Failure to timely provide the appropriate number of copies may result in the dismissal of your appeal pursuant to 5th Cir. R. 42.3. Exception: As of July 2, 2018, Anders briefs only require 2 paper copies.

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Sincerely,

LYLE W. CAYCE, Clerk



By: _____
Monica R. Washington, Deputy Clerk
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cc: Mr. Paul Eldridge Barnes
Mr. Stephen James Carmody
Mr. Aaron Sean Delaney
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United States Court of Appeals

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No. 19-60455 Jackson Women's Health Orgn, et al v. Thomas
Dobbs, et al
USDC No. 3:18-CV-171

Dear Mr. Szyfer,

The following pertains to your brief electronically filed on
October 4, 2019.

You must electronically file a "Form for Appearance of Counsel" by
October 18, 2019. You must name each party you represent, see FED.
R. APP. P. 12(b) and 5TH CIR. R. 12 & 46.3. The form is available
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Sincerely,

LYLE W. CAYCE, Clerk



By: _____
Monica R. Washington, Deputy Clerk
504-310-7705

cc: Mr. Paul Eldridge Barnes
Mr. Stephen James Carmody
Mr. Aaron Sean Delaney
Ms. Karli Eisenberg
Ms. Caitlin Grusauskas
Ms. Claudia Hammerman
Ms. Crystal Johnson
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