No. 19-1392

IN THE

Supreme Court of the United States

THOMAS E. DOBBS, M.D., M.P.H., STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, *et al.*,

Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICI CURIAE* BIRTH EQUITY ORGANIZATIONS AND SCHOLARS IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are the National Birth Equity Collaborative (NBEC) and other organizations and individuals that focus on improving maternal health outcomes. *Amici* are committed to combating the maternal health crisis gripping the United States, a crisis that disproportionately affects Black people. *Amici* believe that advancing maternal health requires that pregnant people have the ability to make their own decisions about reproductive health, weighing risks and deciding on the path that is best for themselves, their families, and their communities, including the option of ending a pregnancy.

NBEC is a non-profit organization dedicated to creating global solutions that optimize Black maternal, infant, sexual, and reproductive well-being. NBEC is committed to shifting systems and culture through training, research, technical assistance, policy, advocacy, and community-centered collaboration, with the goal of improving the health and well-being of Black pregnant people, their children, and their communities.

The remaining *amici* are the following organizations and individuals:

Ancient Song Doula Services

Birth in Color RVA

Birthmark Doulas Collective

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[1] Pursuant to Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part, and that no person other than *amici* or its counsel made any monetary contributions intended to fund the preparation or submission of this brief. Blanket Consent to all *amicus* briefs has been filed by both parties.

Black Mamas Matter Alliance

HealthConnect One

National Black Midwives Alliance

National Perinatal Task Force

Restoring Our Own Through Transformation (ROOTT)

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INTRODUCTION AND SUMMARY OF ARGUMENT

Mississippi's 15-week abortion ban is particularly indefensible in light of one key fact—there is a maternal health crisis in the United States that disproportionately affects Black women. That crisis reflects the continuing legacy of state-sanctioned, racially-motivated policies and practices, and makes it all the more imperative that this Court invalidate Mississippi's ban, as well as others like it that may soon follow. At heart, this case presents an issue of fundamental human rights—the autonomy of pregnant persons to make their own decisions about whether to continue a pregnancy. Pregnant persons themselves, not the State, are in the best position to weigh the risks of proceeding with a pregnancy and make the best decision about reproductive care for their individual circumstances.

The Court must evaluate the constitutionality of Mississippi's prohibition on the termination of a pregnancy after 15 weeks' gestation, as well as the constitutionality of pre-viability abortion prohibitions more generally, in light of the current maternal health crisis in the United States and in Mississippi. That crisis disproportionately affects Black women, who are more likely to experience adverse maternal health outcomes than any other group, both in Mississippi and in the United States more generally. These disparate outcomes reflect a lengthy history of state-sanctioned, racially-motivated policies and practices that have affected Black communities, reducing their access to quality health care, education, jobs, and other resources Mississippi takes for granted in its brief before this Court.

In that context, it is especially important that this Court protect the autonomy of pregnant persons (and Black women in particular) to make reproductive healthcare decisions, including whether to utilize abortion care. In effect, Mississippi's ban is an exercise of State control over Black bodies and decisions, discounting Black women's ability to make the best decision for themselves and their families in their individual circumstances. As such, the ban violates the due process rights guaranteed to Black women under the Constitution, as well as their fundamental human right to bodily autonomy.

Mississippi's claims to the contrary lack merit. There is no evidence that Mississippi's ban would further maternal health, and the state's assurances to the contrary ring hollow in light of its failure to enact other policies that would support maternal and infant health in Mississippi. In fact, Mississippi has pursued policies that would further worsen maternal health, such as imposing work requirements for Medicaid participants. A state that prioritized maternal health would enact policies to support pregnant persons and their families, not limit access to the full range of reproductive care, including abortion care.

Amici urge the Court to reject Mississippi's ban, as well as similar bans on abortion care that may follow, as harmful to maternal health and inconsistent with the autonomy to which pregnant persons are entitled as a matter of both constitutional due process and fundamental human rights.

ARGUMENT

Pregnancy involves substantial risks, particularly for Black women, whose negative maternal health outcomes are rooted in longstanding racist policies and practices stretching back to slavery. Pregnant persons, especially Black women—not the State—must have the autonomy to weigh risks and make the decision whether or not to continue a pregnancy, based on their individual circumstances. Mississippi's ban, and others like it,[2] would disproportionately harm Black women and their families, representing yet another failure to prioritize and support Black maternal health.

I. A MATERNAL HEALTH CRISIS EXISTS IN THE UNITED STATES, WITH A DISPROPORTIONATE EFFECT ON BLACK WOMEN.

Pregnancy and childbirth involve significant risks to the pregnant person. In the United States and in Mississippi, those risks have been particularly dire, disproportionately affecting Black women due to the ongoing legacy of systemic racism. This maternal health crisis makes it especially important that states respect the bodily autonomy of pregnant persons, allowing them to make personal decisions about reproductive health care, including abortion care.

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[2] The Court asked the parties to address a question concerning pre-viability bans. While *amici*'s brief bears on that question, the position of NBEC and other *amici* is that, whatever the stage of a pregnancy, the pregnant person (not the State) should make the decision about what type of reproductive health care is appropriate in light of the individual's circumstances.

A. Pregnancy and Birth Entail Significant Risk.

During pregnancy, labor and childbirth, and also in the postpartum period, an individual is at risk of serious medical complications, some of which are life-threatening.[3] For example, pregnant persons may experience preeclampsia (dangerously high blood pressure that can damage organ systems), eclampsia (a potentially fatal seizure condition), pregnancy-related hypertension, and a host of other potentially life-threatening conditions. *See*, *e.g.*, NIH, *What are the risks of preeclampsia & eclampsia to the mother?*, https://www.nichd.nih.gov/health/topics/preeclampsia/conditioninfo/risk-mother; MAYO CLINIC, *Preeclampsia*, https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745; MARCH OF DIMES, *High Blood Pressure During Pregnancy*, https://www.marchofdimes.org/complications/high-blood-pressure-during-pregnancy.aspx; CDC, *Pregnancy Complications*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-complications.html.[4]

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[3] Abortion, on the other hand, is a safe medical procedure. *See generally* NAT'L ACADS. OF SCI., ENG'G & MED., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES (2018). Major complications are rare—an analysis of 2009–2010 abortion data for women covered by the fee-for-service California Medicaid program found that major complications occurred less than one quarter of one percent of the time overall, and less than one half of one percent of the time for second trimester or later procedures. *See* Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181 (2015).

[4] All internet sources cited in this brief were last visited on September 14, 2021.

Labor and birth also present the risk of severe, potentially life-threatening complications. Such complications may include heart attacks, aneurysms, cardiac arrest, and heart failure. *See* CDC, *How Does CDC Identify Severe Maternal Morbidity*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm. Labor also frequently involves surgical intervention and its associated risks—roughly one-third of deliveries in the United States occur via Caesarean section, and two-thirds of pregnancy-related deaths in Mississippi occur among women who had a repeat Caesarean delivery. *See* CDC, *Births – Method of Delivery*, https://www.cdc.gov/nchs/fastats/delivery.htm; MISS. STATE DEP'T OF HEALTH, MISSISSIPPI MATERNAL MORTALITY REPORT 2013–2016*,* at 14 (Apr. 2019, amended March 2021), http://www.mspqc.org/wp-content/uploads/2020/10/Mississippi-Maternal-Mortality-Report-2013-2016-1.pdf (hereinafter "MISSISSIPPI MATERNAL MORTALITY REPORT 2013–2016").

The postpartum period also involves serious risks to physical and mental health. These medical complications, which can arise hours or even months after delivery, include postpartum hemorrhage (heavy uncontrolled bleeding that can require blood transfusions or even a hysterectomy); long-term pelvic floor damage (pregnancy-induced weakening of the pelvic floor that can result in uterine prolapse); and postpartum depression, anxiety or psychosis. *See*, *e.g.*, Ylenia Fonti et al., *Post Partum Pelvic Floor Changes*, 3(4) J. PRENATAL MED. 57–59 (2009); Mattea Romano et al., *Postpartum Period: Three Distinct but Continuous Phases*, 4(2) J. PRENATAL MED. 22–25 (2010); MARCH OF DIMES, *Postpartum Hemorrhage*, https://www.marchofdimes.org/pregnancy/postpartum-hemorrhage.aspx; MAYO CLINIC, *Postpartum depression*, https://www.mayo

clinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617.

B. The United States and Mississippi Face a Maternal Health Crisis.

The Court must take into account the serious maternal health situation in the United States and in Mississippi. In addition to the high rates of negative maternal health outcomes described below, the current pandemic has deepened the maternal health crisis in the United States, including because pregnant and recently pregnant people are at increased risk of severe illness due to COVID-19. *See*, *e.g.*, CDC, *Pregnant and Recently Pregnant People: At Increased Risk for Severe Illness from COVID-19*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnant-people.html (last updated Aug. 16, 2021). As a result, the analyses discussed below likely understate the severity of the current maternal health crisis—for example, the Mississippi Department of Health recently reported that based on preliminary data, fetal deaths after 20 weeks' gestation were twice as likely for women infected with COVID-19. *See* Leah Willingham, *Mississippi closes field hospitals, reports baby COVID death*, ASSOCIATED PRESS (Sept. 8, 2021), https://apnews.com/article/business-health-coronavirus-pandemic-mississippi-976cb220a93ccf00339f27387c782572.

The state of maternal health in a country or state is generally evaluated using two measures: the maternal mortality ratio, reflecting the number of maternal deaths for every 100,000 live births; and the prevalence of severe maternal morbidity, i.e., pregnancy outcomes that significantly affect a person's health. *See* WORLD HEALTH ORG., *Indicator Metadata Registry List*, https://www.who.int/data/gho/indicator-metadata-

registry/imr-details/26 (defining maternal mortality ratio); CDC, *Severe Maternal Morbidity in the United States*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#anchor_References (hereinafter "*Severe Maternal Morbidity in the United States*"). On both measures, the situation in the United States and Mississippi is grim.

According to a 2020 study, the rate of maternal mortality in the United States is 17.4 deaths per 100,000 live births—more than double the rate of most other high-income countries. *See* Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries. The United Kingdom, for example, has a maternal mortality ratio of 6.5; Norway's ratio is 1.8. *Id*.

Mississippi's outcomes are even worse than those for the United States overall—between 2013 and 2016, the maternal mortality rate in Mississippi was 20.2 deaths per 100,000 live births (excluding deaths with undetermined cause). *See* MISSISSIPPI MATERNAL MORTALITY REPORT 2013–2016, *supra*, at 10. As of 2020, 270,000 women in Mississippi lived in a "maternity care desert." MARCH OF DIMES, HEALTHY MOMS, STRONG BABIES: MISSISSIPPI 1, https://www.marchofdimes.org/peristats/tools/ReportFiles/HMSB/Healthy%20Moms%20Strong%20Babies_Mississippi.pdf; *see also* MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S.: 2020 REPORT 7, https://www.marchofdimes.org/materials/2020-Maternity-Care-Report.pdf (explaining underlying methodology).

Maternal mortality in the United States is getting worse, not better. *See* WORLD HEALTH ORG. ET AL., TRENDS IN MATERNAL MORTALITY: ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE UNITED NATIONS POPULATION DIVISION 42 (2019), https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf. Between 2000 and 2017, the number of maternal deaths per 100,000 births in the United States increased by 58%. *Id*. at 104.

The United States also exhibits high rates of severe maternal morbidity. In 2014, the most recent year for which national data are available, severe maternal morbidity affected more than 50,000 women in the United States. *See Severe Maternal Morbidity in the United States*, *supra*. As with maternal mortality, the state of maternal morbidity is worsening. From 1993 to 2014, the overall rate of severe maternal morbidity in the United States increased by 200%. *See id*.

C. The Maternal Health Crisis in the United States and in Mississippi is Particularly Acute for Black Women.

The maternal health crisis disproportionately affects Black women, who comprise a substantial percentage of pregnant persons in Mississippi.[5] Black persons

[5] Maternal health outcomes are also disproportionately negative for Indigenous women and low-income women. *See* Emily E. Petersen et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, 68(18) MORBIDITY & MORTALITY WKLY. REP. 423–429 (May 10, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm (American Indian/Alaska Native women are two and a half times more likely to die in connection with pregnancy than non-Hispanic white women); Elena Fuentas-Afflick et al., *Optimizing Health And Well-Being For Women And Children*, 40(2) HEALTH AFF. 212 (2021), https://www.health

make up 37.8% of Mississippi's population, and 43.2% of live births in Mississippi during 2017–2019 were to Black women. *See* U.S. CENSUS BUREAU, *Quick Facts: Mississippi*, https://www.census.gov/quickfacts/MS; MARCH OF DIMES, *Peristats: Mississippi*, https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=28&top=2&stop=4&lev=1&slev=4&obj=1#:~:text=Of%20all%20live%20births%20in,%25%20were%20Asian%2FPacific%20Islander.

It is critical to note at the outset that the higher prevalence of certain conditions and negative maternal health outcomes for Black women is tied to racism. As discussed further in section I.D. below, it is well-documented that racist policies and practices have shaped the neighborhoods where Black women live, the schools they attend, the air they breathe, and the hospitals they access, among many other aspects of their lives affected by racism, and that these legacies have led to poor health among Black people. In other words, it is racism, not race, that places Black women at greater risk of negative maternal health outcomes.

Thus, in 2019, the maternal mortality ratio for Black women in the United States was 44.0 deaths per 100,000 live births, compared with 17.9 for non-Hispanic white women. *See* DONNA L. HOYERT, NAT'L CTR. FOR HEALTH STATISTICS, MATERNAL MORTALITY RATES IN THE UNITED STATES, 2019, at 1 (Apr. 2021), https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/E-Stat-Maternal-Mortality-Rates-H.pdf (hereinafter "MATERNAL MORTALITY RATES IN THE UNITED STATES, 2019"). In other words, Black women were nearly two and a half times more likely to die from

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affairs.org/doi/pdf/10.1377/hlthaff.2020.01504 (maternal mortality is associated with socioeconomic disparities).

childbirth than were white women. *Id*. Mississippi's outcomes show an even greater disparity—from 2013–2016, the pregnancy-related mortality ratio in Mississippi was three times higher for Black women than for white women. *See* MISSISSIPPI MATERNAL MORTALITY REPORT 2013–2016, *supra*, at 12.

Black women are more likely than white women to die from pregnancy or childbirth regardless of income, education, or geographic location. *See* Monica R. McLemore & Valentina D'Efilippo, *To Prevent Women from Dying in Childbirth, First Stop Blaming Them*, SCI. AMERICAN (May 1, 2019), https://www.scientificamerican.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them/. For example, between 2007 and 2016, the maternal mortality ratio for Black women with a college education was 40.2 per 100,000 births; for white women with less than a high school education, it was only 25. *See* COMMONWEALTH FUND, MATERNAL MORTALITY IN THE UNITED STATES: A PRIMER (Dec. 16, 2020), https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer. These outcomes make clear that "the factors that typically protect people during pregnancy are not protective for black women." McLemore & D'Efilippo, *supra*.

For similar reasons, Black women are significantly more likely than others to experience maternal morbidity. Black women are more likely to experience conditions such as certain types of hemorrhage, preeclampsia, asthma, cardiac events, and infections. *See* Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS & GYNECOLOGY 387–399 (June 2018). Additionally, Black women are less likely to have their

conditions adequately managed and more likely to experience complications from these conditions. *See id.*

As with maternal mortality, Black women face increased risk of maternal morbidity regardless of educational level and other circumstances. For example, Black college-educated women who gave birth in New York City hospitals between 2008 and 2012 were more likely to suffer serious pregnancy- or childbirth-related complications than women of other races who never graduated from high school: The rate of severe maternal morbidity for Black women with a college degree was 333 per 10,000 deliveries, while the rate for white women with less than a high school education was 137.7. *See* N.Y. CITY DEP'T OF HEALTH & MENTAL HYGIENE, NEW YORK CITY, 2008–2012: SEVERE MATERNAL MORBIDITY 17 (2016), https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf.

D. The Disproportionately Negative Maternal Health Outcomes Black Women Experience are Tied to Racism.

Racism is the cause of Black women's especially poor maternal health outcomes. Studies have shown that racist, State-sanctioned policies such as those underlying residential segregation have led to the poor health outcomes Black persons have long experienced, and continue to experience, in the United States. *See*, *e.g.*, Hope Landrine & Irma Corral, *Separate and Unequal: Residential Segregation and Black Health Disparities*, 19(2) ETHNICITY & DISEASE 179–84 (2009); Zinzi D. Bailey et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 LANCET 1453 (2017). For example, as a result of residential segregation, Black neighborhoods experience greater "exposure to pollutants and toxins,

limited opportunities for high-quality education and decent employment, and restricted access to quality health care." Bailey et al., *supra*, at 1456. More broadly, the continuing legacy of racist policies and practices has caused Black women to face a combination of factors that undermine health, including poverty, racial inequality, inadequate access to high-quality healthcare services, and lack of health insurance. *See* MARCELA HOWELL ET AL., IN OUR OWN VOICE: NATIONAL BLACK WOMEN'S REPRODUCTIVE JUSTICE AGENDA: OUR BODIES, OUR LIVES, OUR VOICES: THE STATE OF BLACK WOMEN & REPRODUCTIVE JUSTICE 55 (June 27, 2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf (hereinafter "IN OUR OWN VOICE"); *see also Birthing While Black: Examining America's Black Maternal Health Crisis, Hearing Before H. Comm. on Oversight & Reform,* 117th Cong. 2–3 (2021) (statement of Joia Crear-Perry, M.D.), https://docs.house.gov/meetings/GO/GO00/20210506/112580/HHRG-117-GO00-Wstate-Crear-PerryJ-20210506.pdf (hereinafter "Dr. Crear-Perry Congressional Testimony"). As the CDC has explained, "[s]ocial determinants of health have historically prevented many people from racial and ethnic minority groups from having fair opportunities for economic, physical, and emotional health." CDC, *Health Equity: Working Together to Reduce Black Maternal Mortality*, https://www.cdc.gov/healthequity/features/maternal-mortality/index.html (last updated Apr. 9, 2021).

Due to these policies and practices, Black women in Mississippi are disproportionately likely to have lower income and/or to lack health insurance. As of 2014, 34.7% of women who live below the poverty line in the State were Black, compared with 15.5% who were white women. ASHA DUMONTHIER ET AL., INST. FOR

WOMEN'S POLICY RESEARCH, THE STATUS OF BLACK WOMEN IN THE UNITED STATES 86 (2017), https://iwpr.org/wp-content/uploads/2020/08/The-Status-of-Black-Women-6.26.17.pdf. Almost 25% of Black women in Mississippi between the ages of 18 and 64 lack health insurance. *See id.* at 66.

Residential segregation has also resulted in limited access to high-quality health care in Black neighborhoods. Across the United States, predominantly Black neighborhoods are more likely to lack access to primary care providers and other healthcare services. *See* Darrell J. Gaskin et al., *Residential Segregation and the Availability of Primary Care Physicians*, 47 HEALTH SVCS. RES. 2353, 2354, 2361 (2012) (collecting literature finding association between residential segregation and lack of access to healthcare services; finding that "odds of being a PCP [primary care provider] shortage area were 67 percent higher for majority African American zip codes").

Racism within the healthcare system also plays a role in the disproportionately negative maternal health outcomes Black women experience. Black women are more likely to experience racially-biased, substandard treatment by medical providers, making it more difficult for those who become pregnant to receive high-quality health care. *See* Veronica Zaragovia, *Trying to Avoid Racist Health Care, Black Women Seek Out Black Obstetricians*, NPR (May 28, 2021), https://www.npr.org/sections/health-shots/2021/05/28/996603360/trying-to-avoid-racist-health-care-black-women-seek-out-black-obstetricians; INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 1 (2003), https://doi.org/10.17226/10260. Healthcare providers frequently disregard troubling symptoms among Black pregnant

women, even when the women specifically report those symptoms. *See, e.g.*, Amy Roeder, *America is Failing Its Black Mothers*, HARVARD PUB. HEALTH (2019), https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers. In one well-known example, tennis star Serena Williams experienced a life-threatening series of complications after childbirth, the risk of which was compounded by medical staff initially dismissing her concerns. *See* P.R. Lockhart, *What Serena Williams's scary childbirth story says about medical treatment of black women*, VOX (Jan. 11, 2018), https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women.

Additionally, the long-term psychological effects of racism include chronic stress, which places Black women at increased risk for a range of conditions that can complicate pregnancy, including eclampsia and embolisms. *See* Jamila Taylor et al., *Eliminating Racial Disparities in Maternal and Infant Mortality*, CTR. FOR AMERICAN PROGRESS (May 2, 2019), https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality.

II. ADVANCING MATERNAL HEALTH REQUIRES THAT PREGNANT PERSONS HAVE AUTONOMY TO MAKE REPRODUCTIVE HEALTH DECISIONS FOR THEMSELVES AND THEIR FAMILIES.

A. Black Women Must Have Autonomy to Make Reproductive Health Decisions.

In order to advance maternal health in the United States, all pregnant persons must have autonomy to weigh the risks and benefits of pregnancy and make

their own judgments about which reproductive health decision fits their individual circumstances. It is particularly important that Black women have that autonomy in light of the continuing impact of racist policies and practices on their health, and the correspondingly greater health risks they face from pregnancy and childbirth. Pregnant Black women—not State officials—are in the best position to decide among reproductive health alternatives to identify the path that will be best for themselves and their families.[6] Ensuring that Black women have personal bodily autonomy to decide what reproductive care they need, including abortion care, will advance maternal health. There is no reason the State should make that decision for a Black woman.

Historical context is significant here. Black women have long been deprived of control over their own bodies. During slavery, Black women were impregnated and forced to carry children for the benefit of their oppressors, who sought to generate more forced labor and perpetuate the cycle of enslavement. *See* Melissa Murray, *Race-ing* Roe*: Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade*,* 134 HARV. L. REV. 2025, 2034 (2021). Later, in the early part of the last century, thousands of Black women were subjected to forced sterilization by the State. Alexandra Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those with Disabilities—*

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[6] Most pregnant persons who utilize abortion care already have one or more children. *See* JENNA JERMAN ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008, at 1, 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf (59% of abortion patients in 2014 had at least one previous birth).

and Lasted into the 21st Century, INST. FOR HEALTHCARE POLICY & INNOVATION (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-polici es-us-targeted-minorities-and-those-disabilities-and-lasted-21st. In Mississippi, as recently as the last century, forced sterilizations were so common they were referred to as "Mississippi appendectomies." *See* Lisa Ko, *Unwanted Sterilization and Eugenics Programs in the United States*, PBS (Jan. 29, 2016), https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-sta tes. As the District Court explained, the Mississippi statute is "closer to the old Mississippi—the Mississippi bent on controlling women and minorities . . . . The Mississippi that, in Fannie Lou Hamer's reporting, sterilized six out of ten black women in Sunflower County at the local hospital—against their will." Pet. App. 47a n.22. The Court cannot ignore that historical context in assessing the constitutionality of Mississippi's ban.

The attempt by some of the State's *amici* to equate abortion care with modern-day eugenics makes no sense. *See* Br. of African-American, Hispanic, Roman Catholic and Protestant Religious and Civil Rights Organizations and Leaders as Amici Curiae in Supp. of Pet., *Thomas E. Dobbs*, No. 19-1392 (June 26, 2021). Preserving the ability of Black women to decide on abortion care when they identify this as the best path for themselves and their families is not eugenics. Instead, it reaffirms the agency and moral capacity of Black women to decide which reproductive health service is most appropriate for them and their families in their individual circumstances.

To characterize abortion as a "tool of modern-day eugenics," *Box v. Planned Parenthood of Indiana &*

Kentucky, Inc., 139 S. Ct. 1780, 1783 (2019) (Thomas, J., concurring), ignores the central question of who is exercising agency in deciding to terminate a pregnancy. Whereas eugenics was about State control of Black bodies (among others), *see* Mary Ziegler, *Essay, Bad Effects: The Misuses of History in* Box v. Planned Parenthood, 105 CORNELL L. REV. ONLINE 165, 200 (2020), ensuring that pregnant persons have access to abortion care enables Black people to become parents only when they choose to do so. Particularly because of the increased health risks that pregnant Black women face, it is imperative that they have autonomy to make their own reproductive health decisions.

B. Denying Pregnant Persons the Autonomy to Make Reproductive Health Decisions Is Inconsistent with Constitutional Due Process and Fundamental Human Rights.

A State ban that denies pregnant persons the autonomy to make reproductive health decisions based on their individual circumstances—including abortion care after 15 weeks' gestation—is inconsistent with the right to due process under the U.S. Constitution. This Court has repeatedly affirmed that decisions about reproduction and child bearing are among the fundamental personal decisions that receive constitutional protection. *See, e.g.*, *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (procreation); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception). These cases are rooted in the Court's longstanding recognition of the right to liberty guaranteed by the Constitution.

In *Bolling v. Sharpe*, this Court explained that liberty is "not confined to mere freedom from bodily

restraint" but rather extends to "the full range of conduct which the individual is free to pursue, and it cannot be restricted except for a proper governmental objective." 347 U.S. 497, 499 (1954). The right to liberty similarly requires that pregnant persons be free to make personal decisions about whether to continue a pregnancy, free of State control.

At the same time, the right to make individual reproductive health decisions is a fundamental human right, protected under international law.[7] The international community has recognized the maternal health crisis in the United States and has called on this country to take action to address the high rate of maternal mortality, particularly among Black women. *See, e.g.*, U.N. General Assembly, *Report of the Working Group of Experts on People of African Descent on its mission to the United States of America*, A/HRC/33/61/Add.2 22 (Aug. 18, 2016), https://undocs.org/A/HRC/33/61/Add.2 (recommending that the U.S. expand access to quality and affordable health care to reduce maternal mortality among Black women). Mississippi's ban, or any other roll-back of a pregnant person's right to decide whether or not to continue a pregnancy, would both undermine maternal health and deprive Black women of a fundamental human right—the autonomy to make reproductive health decisions for themselves and their families.

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[7] *See generally* Br. of Int'l Human Rights Experts as Amici Curiae in Supp. of Resp., *Jackson Women's Health Org.*, No. 19-1392.

III. MISSISSIPPI'S BAN WILL DISPROPORTIONATELY HARM BLACK WOMEN.

Mississippi's ban will disproportionately affect Black women. As a result of the systemic racism and related policies described above, Black women are more likely to have lower income and to lack access to safe and effective contraception. *See generally* Br. of Reproductive Justice Scholars as Amici Curiae in Supp. of Resp., *Jackson Women's Health Org.*, No. 19-1392. As a result, Black women are three times as likely as white women to experience an unintended pregnancy. *See* Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11(3) GUTTMACHER POL'Y REV. 2 (Aug. 6, 2008), https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture.

Given these circumstances, Black women in Mississippi have accessed abortion care more often than white women. In 2019, there were 4,838 induced terminations in Mississippi, of which 3,573 were undergone by Black women. MISS. STATE DEP'T OF HEALTH, *Mississippi Statistically Automated Health Resource System (MSTAHRS), Pregnancies*, https://mstahrs.msdh.ms.gov/forms/pregtable.html (data for induced terminations in 2019). In Mississippi, the abortion rate for Black women is over four times higher than for white women. *See id.* Plainly, banning abortion after 15 weeks will disproportionately affect Black women in Mississippi.

Mississippi's assertion that women no longer need access to abortion ignores the circumstances of many pregnant persons in Mississippi. For those who lack the resources and advantages that Mississippi's brief takes for granted (who are disproportionately likely to be Black), it is especially important to have the bodily

autonomy to decide for themselves whether to use abortion care.

Mississippi claims that abortion is no longer necessary because women can have both a fulfilling career and a rich family life due to laws that require employers to provide leave and increased access to child care. Brief for Petitioners (hereinafter "Pet. Br.") at 29.[8] However, these laws are less robust than the State suggests, and the benefits are not equally available to persons with low income. As noted above, more than a third of Black women in Mississippi live below the poverty line. The impact of Mississippi's ban will be felt primarily by these women.

For example, the State cites the Family and Medical Leave Act of 1993 (FMLA) as evidence that abortion care is unnecessary because pregnant women can take employment leave after giving birth. Pet. Br. at 35. However, the FMLA requires only *unpaid* leave for pregnant people. *See* U.S. DEP'T OF LABOR, *Family and Medical Leave (FMLA)*, https://www.dol.gov/general/topic/benefits-leave/fmla. This leaves low-income women with the untenable choice between taking time off to recover from pregnancy and childbirth, and pursuing income they need to support their family. Similarly,

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[8] The State also asserts that women should no longer be concerned about giving birth to unwanted children because all states now have "safe haven" laws that allow them to leave newborns in the State's care. Pet. Br. at 29. That argument disregards the significant health risks associated with pregnancy, labor, and the postpartum period, none of which are removed by the ability to surrender a child after birth. Moreover, the decisions to carry a pregnancy to term and what to do with the child after birth are deeply personal decisions that affect physical and mental health. The availability of an option to surrender a child after birth does not justify depriving people of the autonomy to decide *not* to carry a pregnancy to term.

access to child care in the United States is woefully inadequate—not just unaffordable for many parents, but often unavailable. *See* Steven Jessen-Howard et al., *Costly and Unavailable: America Lacks Sufficient Child Care Supply for Infants and Toddlers*, CTR. FOR AMERICAN PROGRESS (Aug. 4, 2020), https://www.americanprogress.org/issues/early-childhood/reports/2020/08/04/488642/costly-unavailable-america-lacks-sufficient-child-care-supply-infants-toddlers. The yearly cost of childcare exceeds the yearly price of public college in 33 states, and there are only enough licensed childcare centers nationally to serve 23% of infants and toddlers. *Id*.

Banning abortion after 15 weeks in Mississippi effectively means that only those who can afford to travel out of state will be able to access abortion care after that period. In practice, then, Mississippi's ban will most affect the State's marginalized and vulnerable communities, including Black women, who are disproportionately likely to lack the resources to access safe abortion care in another state. In effect, the ban will ensure that the ability of Mississippi residents to obtain abortion care will turn on race and class.

IV. MISSISSIPPI'S INVOCATION OF MATERNAL HEALTH TO JUSTIFY BANNING ABORTION CARE IS BASELESS.

A. Mississippi's Ban Does Not Further Maternal Health.

Mississippi claims that its statute furthers valid State interests in protecting women's health. Pet. Br. at 5, 37. But there is no evidence that the State's ban does any such thing. Rather, the ban undermines maternal health by denying pregnant persons the autonomy to weigh the risks of pregnancy and

childbirth and make personal health decisions. As discussed above, the interest in maternal health is best served by ensuring that pregnant persons have the autonomy to decide what reproductive health care best fits their individual circumstances.

According to Mississippi, its ban protects maternal health because the risks of abortion increase after 15 weeks of gestation. Pet. Br. at 37. Even apart from our point that denying pregnant persons autonomy to decide for themselves necessarily harms maternal health, the State's argument founders on the fact that its prohibition will force pregnant persons who wish to terminate their pregnancies after 15 weeks' gestation to instead carry those pregnancies to term, thus incurring significantly greater maternal health risks, including nearly doubling their risk of death. *Compare* HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES 16 (2006), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/05/04/AiWL.pdf (risk of death for abortions after 20 weeks is 8.9 deaths per 100,000 legally induced abortions), *with* MATERNAL MORTALITY RATES in the United States, 2019, *supra*, at 1 (maternal mortality rate in the U.S. was 20.1 deaths per 100,000 live births in 2019).

B. Mississippi, Like Other States Seeking to Limit Abortion Access, Has Chosen Not To Enact Measures To Protect Maternal Health.

The District Court noted that "the Mississippi Legislature's professed interest in 'women's health' is pure gaslighting" because "its leaders . . . choose not to lift a finger to address the tragedies lurking on the other side of the delivery room: [Mississippi's] alarming infant and maternal mortality rates." Pet. App. at 47a n.22.

The District Court was correct. If Mississippi really cared about maternal health, it would take effective steps to protect maternal and infant health, steps that would address the negative maternal health outcomes described in parts I.B. and I.C. of this brief, as well as its high infant mortality rate, especially for Black infants.

Mississippi has failed to provide meaningful support to women who carry pregnancies to term, including by failing to protect infant health and support families. Mississippi ranks last among all fifty states in public health measures and outcomes for women, infants, and children. *See* UNITED HEALTH FOUND., AMERICA'S HEALTH RANKINGS: HEALTH OF WOMEN AND CHILDREN REPORT 8 (2019), https://assets.americashealthrankings.org/app/uploads/health-of-women-and-children-2019.pdf (ranking states based on a variety of metrics, including the percentage of uninsured women, the presence of publicly-funded women's health services, and maternal mortality rates). The State has consistently had one of the highest infant mortality rates in the country, with nearly nine infant deaths for every 1,000 live births. *See* MISS. STATE DEP'T OF HEALTH, INFANT MORTALITY REPORT 1 (2018), https://msdh.ms.gov/msdhsite/_static/resources/8015.pdf (hereinafter "MISSISSIPPI INFANT MORTALITY REPORT"). These dire outcomes disproportionately affect Black infants—Mississippi's mortality rate for Black infants is nearly twice the rate for white infants, and while the white infant mortality rate is declining, the Black infant mortality rate is increasing. *Id.* at 1–2.

Faced with this maternal and infant health landscape, Mississippi has failed to enact initiatives to

advance health and birth equity.[9] For example, Mississippi has not extended postpartum Medicaid coverage to one year—a particularly critical measure given that more than one-third of pregnancy-related deaths in Mississippi occur more than six weeks postpartum. *See* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *Extend Postpartum Medicaid Coverage*, https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage; MISSISSIPPI MATERNAL MORTALITY REPORT 2013–2016, *supra*, at 14. Mississippi also does not provide reimbursement for doulas (health workers hired to provide guidance and support to pregnant persons and new mothers) and other community-based birth workers, despite the fact that the leading cause of infant death in Mississippi is preterm birth. MISSISSIPPI INFANT MORTALITY REPORT, *supra*, at 3. Doula support is associated with a 22% lower probability of preterm birth, among multiple other health benefits for mothers and infants. *See* Kathy B. Kozhimannil et al., *Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery*, 43(1) BIRTH 20–27 (March 2016); Getty Israel, *Mississippi Needs to Integrate Doulas Into Health Care System. Here's Why*, CLARION LEDGER (July 17, 2021), https://www.clarionledger.com/story/opinion/2021/07/17/miss

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[9] Crisis Pregnancy Centers do not meet the need for services supporting maternal health and childbirth. Such Centers often provide misinformation to women seeking prenatal care by having them meet with religious counselors and other non-medical staff. *See* Br. of 51 Reproductive Rights, Civil Rights, and Social Justice Orgs. as Amici Curiae in Supp. of Resp., *Nat'l Inst. of Family Life Advocates*, No. 16-1140 (Feb. 27, 2018) (collecting testimonials).

issippi-integrate-doulas-into-health-care-system-opinion-getty-israel/7931148002/.

Mississippi's failure to fund community-based birth workers such as doulas is particularly harmful to pregnant persons who live in communities that lack clinics and other healthcare resources, including many Black women. Improving access to community-based birth workers would help to address these shortfalls, and would create more pathways for people of color to enter the field, all while bolstering community buy-in and incentivizing high-quality maternity care. *See* Dr. Crear-Perry Congressional Testimony, *supra*, at 4.

Mississippi also has not increased income limits for Medicaid eligibility as permitted by the Affordable Care Act, disproportionately harming Black women, who are more likely than others to fall into the coverage gap between the maximum income to qualify for Medicaid coverage and the minimum income needed to qualify for Marketplace premium tax credits. *See* IN OUR OWN VOICE, *supra*, at 14–15. Mississippi's failure to close the coverage gap effectively places health insurance out of reach for many Black women.

In addition to its failure to implement measures to improve maternal health outcomes, Mississippi has affirmatively pursued policies that will harm maternal health. For example, Mississippi has filed for a waiver that would permit the State to add work requirements as a component of Medicaid eligibility. GEORGETOWN UNIV. HEALTH POLICY INST., HOW MISSISSIPPI'S PROPOSED MEDICAID WORK REQUIREMENT WOULD AFFECT LOW-INCOME FAMILIES WITH CHILDREN 1 (Aug. 2018), https://ccf.georgetown.edu/wp-content/uploads/2018/08/Propsed-Medicaid-Work-Requirement-Mississippi.pdf. Medicaid work requirements disproportionately harm women and mothers—

more women than men enrolled in Medicaid are unemployed, and a majority of such women are unemployed because they are taking care of children and other family members. Ivette Gomez et al., *Medicaid Work Requirements: Implications for Low Income Women's Coverage*, KAISER FAMILY FOUND. (Mar. 4, 2021), https://www.kff.org/womens-health-policy/issue-brief/medicaid-work-requirements-implications-for-low-income-womens-coverage.

Mississippi's failure to protect maternal health is part of a pattern. States that have enacted a greater number of abortion restrictions also tend to lack meaningful, supportive policies for maternal and infant health (such as expansion of prenatal and postpartum care under Medicaid). *See, e.g.*, TERRI-ANN THOMPSON & JANE SEYMOUR, IBIS REPRODUCTIVE HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN'S AND CHILDREN'S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES 12, 15 (June 2017), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf (hereinafter "EVALUATING PRIORITIES"). For example, many of these states have instituted Medicaid work requirements (as Mississippi seeks to do) and restricted the types of providers that are eligible for reimbursement for maternity care services, thus harming women and mothers. *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).

Women's health outcomes tend to be worse in states that have enacted a greater number of abortion restrictions. *See* EVALUATING PRIORITIES, *supra*, at 16–17. In particular, research has shown that maternal mortality rates increase when states impose certain

abortion restrictions and when abortion clinics close. *See* Summer Sherburne Hawkins et al., *Impact of State-Level Changes on Maternal Mortality: A Population-Based, Quasi-Experimental Study*, 58(2) AM. J. PREVENTATIVE MED. 165–174 (Dec. 16, 2019); *see also* Dovile Vilda et al., *State Abortion Policies and Maternal Death in the United States, 2015–2018*, AM. J. PUB. HEALTH e1–e9 (Aug. 19, 2021) (finding that states with a greater number of abortion restrictions in 2015 saw a 7% increase in total maternal mortality compared with states with fewer abortion restrictions, after adjusting for state-level covariates).

A state that truly prioritized maternal health would instead enact an array of policies to support pregnant persons and their families, including policies supporting the ability of pregnant persons to access abortion care services if they choose to do so. Such policies would include, among other things, expanding insurance coverage for lower-income persons, providing reimbursement for community-based prenatal care, enacting paid family leave and subsidized childcare programs, and facilitating access to abortion care for pregnant persons at all income levels. In other words, far from banning abortion care (as Mississippi seeks to do), a state that prioritized maternal health would not enact barriers to abortion care access. Truly supporting pregnant persons requires providing them more support, not less, so they can make the decisions that are best for themselves and their families free from the compulsion of the State.

CONCLUSION

Pregnant persons must have autonomy to decide what type of reproductive health care, including abortion care, is best for them and their families. Due process and fundamental human rights require that the pregnant person—not the State—make that decision. Such autonomy is also essential to maternal health. Black women in particular, who continue to experience the effects of racially-motivated policies and practices that impact their maternal health, must have the right to decide whether to continue a pregnancy to term. Because Mississippi's ban and others like it would deprive pregnant persons of autonomy and harm maternal health, the Court should rule against Mississippi in this case.

Respectfully submitted,

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