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Reproductive Health Law and Policy in the Deep South and Recommendations

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An abstract of
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Abstract

Reproductive Health Law and Policy in the Deep South and Recommendations
By Ruth W. Dawson

The Southeastern region of the United States, or the "Deep South," has long been marked by conservative social policies and resulting poor health indicators. The Deep South has a troubled and complex history, riddled with racial, gender, and social inequities that are very much alive today. Women's reproductive lives represent a particularly charged sociopolitical issue, complicated by ideas about traditional gender roles, racial prejudices, and culturally religious morality.

This analysis focuses on reproductive health law and policy of three neighboring states in the heart of this region: Louisiana, Mississippi, and Alabama. This study represents a systematic review of the state codes via the LexisNexis legal database. The goal of this thesis is to fill the dearth of practical guides to the legal situation in these states. Those that exist rarely cite to codified law, and often misinterpret the law. This project also looks into policies of state agencies, such as health departments, and how their policies may impact reproductive health. The analysis includes cultural and historical background, to help advocates contextualize the origins of these restrictive policies.

The purpose of this thesis is to increase access to reproductive health and reproductive health services in these three states in the Deep South, through reducing barriers and promoting positive reproductive health policies. The hope is that organizations, health departments, or other advocates will use this guide to increase access to reproductive and sexual health services in these states.

Due to entrenched legislative and organizational adversaries, it is unrealistic to expect the strong tide against reproductive rights to reverse in any major way. Instead, reproductive justice advocates can redirect this negative attention to common goals of health - contraception, safe motherhood, prevention of abortion, etc., and leverage existing community structures to do so. Advocates can utilize a multipronged strategy: engage in careful legislative advocacy, generate a community base of first responders, focus on moderate policy goals, and implement practical health interventions under existing law.

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Introduction

The Southeastern region of the United States, often termed the "Deep South," has long been marked by conservative social policies and resulting poor health indicators. The Deep South has a troubled and complex history, riddled with racial, gender, and social inequities that are still very much alive today. Women's reproductive lives represent a particularly charged sociopolitical issue, complicated by ideas about traditional gender roles, racial prejudices, and culturally religious morality.

In the ever-polarizing political atmosphere of the 21st century, women's reproductive health has been used as a political tool nation-wide, seemingly at risk of sacrifice at every turn. This treatment of reproductive health as a bargaining chip has been especially pronounced in recent years, and in more conservative regions. In the 2010 midterm elections, conservative legislators unfriendly to reproductive health swept into state and federal legislatures.[1] With them, they brought momentum and an anti-choice social agenda, and managed to propose over 1,100 state provisions meant to restrict reproductive or sexual rights from coast to coast in 2011.[2] This was a record number of restrictions, and represented a huge increase in these laws from past years. The Southeast struggle with reproductive issues came into sharp focus with the ballot initiative on Mississippi's 2011 ballot that would have redefined life as beginning at fertilization, thus outlawing abortion for any reason and ostensibly many forms of contraception.[3] Blatantly contrary to constitutional jurisprudence, the Mississippi personhood amendment was rejected by

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[1] Tim Storey, *GOP Makes Historic State Legislative Gains in 2010*, RASMUSSEN REPORTS, Dec. 10, 2010. http://www.rasmussenreports.com/public_content/political_commentary/commentary_by_tim_storey/gop_makes_historic_state_legislative_gains_in_2010

[2] Guttmacher Institute, *States Enact Record Number of Abortion Provisions in 2011*, January 5, 2012. http://www.guttmacher.org/media/inthenews/print/2012/01/05/endofyear.html

[3] Gary Pettus, *Personhood Rejected*, CLARION-LEDGER, Nov. 9, 2011, at A1.

a whopping 16 points - 42% for and 58% against - when put to a popular vote.[4] Despite this victory for reproductive health - women retained rights to contraception, in vitro fertilization, and medically indicated abortions - advocacy against reproductive health in the Southeast remains.

Though 2011 was truly the record-breaking year, these countrywide trends in restrictive reproductive legislation have continued, albeit more weakly, into the 2012 legislative session. In the Deep South, the crusade against reproductive rights continued: Alabama passed one provision related to reproductive health, Louisiana passed four, and Mississippi passed five in the 2012 session.[5] Though some of these provisions are neutral to reproductive health service provision, in the main, they are part of this restrictive trend.

For example, the Louisiana state legislature passed a slew of restrictive anti-abortion provisions, including restricting provision to physicians (rather than other skilled clinicians).[6] It also banned abortion after 20 weeks gestation and passed a provision requiring abortion providers both to make the fetal heartbeat audible and to display and describe the fetal ultrasound image to a woman before an abortion.[7] In May, Alabama passed a preemptive law that will prohibit insurance plans in state health exchanges (mandated under the Patient Protection and Affordable Care Act of 2010) from covering abortion except in the cases of a threat to the mother's life, or if the pregnancy is a result of rape or incest.[8]

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[4] Id. (The article cites 346,699 votes for and 476,178 votes against.)
[5] Guttmacher Institute, *State Legislation Enacted in 2012 Related to Reproductive Health,* November 2012. http://www.guttmacher.org/statecenter/updates/2012newlaws.pdf
[6] Guttmacher Institute, *State Legislation Enacted in 2012 Related to Reproductive Health,* November 2012. http://www.guttmacher.org/statecenter/updates/2012newlaws.pdf
[7] Guttmacher Institute, *State Legislation Enacted in 2012 Related to Reproductive Health,* November 2012. http://www.guttmacher.org/statecenter/updates/2012newlaws.pdf
[8] Guttmacher Institute, *State Policies in Brief: Restricting Insurance Coverage of Abortion*, November 1, 2012. http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf

Problem Statement

Unfortunately, the restrictive reproductive health laws in these states are compounded by the lack of reproductive health services and poor reproductive health indicators that result. The Deep South also struggles with general demographic indicators, as a higher percentage of their populations experience poverty and other structural issues. The restrictive laws and policies can scare away reasonable service providers and organizations from operating in this hostile environment.

This analysis will focus on three neighboring states in this region: Louisiana, Mississippi, and Alabama. These three states form a strong belt in the Southeast, and form a large part of the the North American equivalent of the "Global South."[9] They share a similar troubled history and demographic make up, and face many of the same challenges today.[10]

Nearly across the board, these three states have higher percentages of their populations with problematic demographics than the national average. For example, all three states have a higher percentage of the population with no higher than a high school education, and a higher percentage of the population with a yearly income under $25,000 (Table 1). They also have a higher percentage of their countrymen reporting no health care coverage, and a higher percentage reporting a substandard health status than the national average (Table 1).

*Table 1: Population characteristics of this Southern belt (Alabama, Mississippi, Louisiana) compared to the United States national average, in 2010**

	Alabama	Louisiana	Mississippi	National Average**
% Population with no	45.7%	44.2%	47.1%	39.1%

[9] See Rafael X. Reuveny & William R. Thompson, *The North-South Divide and International Studies: A Symposium*, 9 INT'L STUD. REV. 556 (2007) (Explaining the divide between the Global North and Global South).
[10] For a fuller discussion of this region's fraught relationship with race, gender, and structural inequity surrounding reproduction, please see: Lisa Cardyn, *Sexualized Racism/ Gendered Violence: Outraging the Body Politic in the Reconstruction South*, 100 MICH. L. REV. 675, 675-867 (2002), and Mary Ann Castle, *Abortion in the United States bible belt: organizing for power and empowerment*, 8 REPRODUCTIVE HEALTH 1 (2011).

higher education				
% Population with yearly income < $25,000	33.1%	29.5%	38.8%	24.0%
% Population who report no health care coverage	16.2%	20.8%	21.6%	15.0%
% Population who report general health as Fair or Poor***	21.2%	21.1%	23.7%	14.9%
% Population living in rural areas	40.96%	26.81%	50.65%	19.3%

* All data from *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010, except the fifth indicator regarding rural population, which is from the US Census Bureau, 2010 Census Urban and Rural Classification and Urban Area Criteria, 2011, available at: http://www.census.gov/geo/www/ua/2010urbanruralclass.html.
** National average includes 50 United States and Washington, DC.
*** As opposed to Excellent, Very Good, or Good.

In addition to challenging general demographics, the Deep South generally experiences poor reproductive health indicators as well. When mapping indicators in the United States, the darker colors representing higher prevalence of negative health outcomes tend to cluster in the Southeast region. Alabama, Louisiana, and Mississippi have some of the country's highest rates of Chlamydia, the most common sexually transmitted infection in the country, and gonorrhea, the second most common (Table 2). The teenage birth rate among women aged 15-19 years is higher than the national average in all three states. In fact, Mississippi has the highest teen pregnancy rate in the country, at 65.7 births per 100,000 women (Table 2).

The roughly-estimated unmet need for contraception in Mississippi (59.6%) is fairly consistent with the national average (59.2%), and unmet need in Alabama (50.0%) is actually lower than the average. It is in Louisiana that we see the largest unmet need for contraception (75.5%), representing approximately 3 in 4 women in need (Table 2). In terms of abortion, nine out of ten of women (91%) of reproductive age in Mississippi live in a *county* without an abortion provider (Table 2). The cervical cancer rates are also higher in all three states.

Table 2: Reproductive health indicators of this Southern belt (Alabama, Mississippi, Louisiana) compared to the United States national average

	Alabama	Louisiana	Mississippi	National Average
# Women in need of contraceptive services and supplies*	276,850	297,060	197,050	n/a
% Rough unmet need for contraception**	50.0%	75.5%	59.6%	59.2%
% Women aged 15-44 living in a county w/o abortion provider***	61%	65%	91%	35%
Chlamydia rate, per 100,000 population****	574	649	726	422.6
Gonorrhea rate, per 100,000 population****	168.5	198.4	209.9	99.6
Teenage (15-19 years) birth rate, per 100,000 population*****	52.9	54.1	65.7	41.5
Cervical cancer rate, per 100,000 women******	8.2	10.7	10.3	7.8

* Data from Guttmacher Institute, State Data Center (2008, 2010). Women are considered to be "in need" if they are sexually active, they are fecund, and they are neither pregnant nor desiring to be so.
**2008 Guttmacher data. Rough estimate of unmet need for contraception as measured by percentage of need for publicly supported care that is not met by public-sector providers. These numbers represent the highest possible unmet need, then, as they do not take potential private providers into consideration.
***2008 Guttmacher data. An abortion provider is considered a hospital, clinic, or physician's office where abortions are performed.
****Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2010. Atlanta: U.S.
***** Mathews TJ, Sutton PD, Hamilton BE,Ventura SJ. State disparities in teenage birth rates in the United States. NCHS data brief, no 46. Hyattsville, MD: National Center for Health Statistics. 2010. (Using 2008 data.)
******Via The Henry J. Kaiser Family Foundation statehealthfacts.org: U.S. Cancer Statistics Working Group. *United States Cancer Statistics*: 1999-2008 *Incidence and Mortality Web-based Report*. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2012. (Using 2008 data.)

Purpose Statement

There seems to be a dearth of practical guides to the legal and policy situation in these Southeastern states. This is especially problematic, given the environment hostile to reproductive rights, the low levels of reproductive health service provision, and the poor reproductive and sexual health indicators. Those guides that do exist do not reference a legal citation for precise interpretation. The hope behind this project is that organizations or health

departments in these states will use this work product as a guide for increasing much-needed reproductive health service provision.

The purpose of this project is to increase access to reproductive health and reproductive health services in these three states in the Deep South, through reducing barriers and promoting positive reproductive health policies. This project will compile a handbook of current laws and policies that promote or inhibit optimal reproductive health in these three key Southeastern states of Alabama, Louisiana, and Mississippi. It will create a framework of both barriers to and facilitators of reproductive health service provision, and general reproductive health. It will also identify obvious restrictions and facilitations (e.g. those dealing with abortion provision) and those that are less obvious (e.g. restrictions on telemedicine). Further, it will suggest short-term solutions to provide quality reproductive and sexual health care within current legal barriers, and long-term strategies to eliminate them.

This project will suggest a multi-level, systemic approach to improving the reproductive health in these Deep Southern states. Along with how to make inroads in direct service, this project will examine ways to improve the culture surrounding reproductive and sexual health (e.g. sex education, community support for services, etc.) in these states. Practically speaking, communities will be more apt to support service providers, and individuals will be more likely to utilize these services, if they are de-stigmatized at the local level. To borrow a term from public health, these strategies will mostly focus on harm mitigation, rather than focus on a drastic shift to embracing reproductive health. Given the particularly difficult environments in these states, incremental change is the most feasible.

Definition of Terms

In 1994 at the International Conference on Population and Development in Cairo, a modern and comprehensive definition of reproductive health was established. It is this widely read and commonly accepted definition of reproductive health that this paper will use. The term "sexual and reproductive health" is often used, but to keep in line with the other frameworks here of rights and justice, this paper will only use the term "reproductive health," as shorthand. It can be inferred that this term covers components of sexual health as well. The Cairo definition of reproductive health is of such primacy that it bears highlighting here:

> "*a state of complete physical, mental and social well-being and...not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (para 72).*"[11]

For a more in-depth analysis of the interplay among the reproductive health, rights, and justice frameworks, please see Asian Communities for Reproductive Justice: *A new vision for advancing our movement for reproductive health, reproductive rights, and reproductive justice*, pg. 2 (2005).

Practically speaking, reproductive health in these Deep South states could translate, for example, into reproductive health centers becoming integral (or at least accepted) parts of the

[11] UN, Department of Public Information, *Platform for Action and Beijing Declaration. Fourth World Conference on Women, Beijing, China, 4-15 September 1995* (New York: UN, 1995), para. 94.

community, and becoming seen as accepted resources and part of the health care infrastructure. More tangibly, it could translate into concrete measures of women choosing freely among contraceptive methods (and increase usage of long-acting reversible contraceptives, or LARCs). It could also mean a decrease in the high prevalence in these states of Chlamydia, gonorrhea, cervical cancer, and unplanned pregnancy, thereby keeping sex "safe," as outlined above.

Methodology

This project looks at laws and policies that can discernibly affect reproductive health in Alabama, Louisiana, and Mississippi. While federal law and courts have major implications for reproductive health, laws at this level are simply fewer and farther between. Still, there is no doubt that they are of huge importance when they do arise. For example, federal reimbursement for Planned Parenthood became a sticking point in the 2011 federal budget negotiations among the Senate, the House, and President Obama. The federal government actually faced a shutdown until all parties reached a late-night compromise, which eventually saved the organization's funding for their reproductive health services.[12] Despite the wide-reaching importance of federal laws and policy, public health policies are traditionally the domain of state and local government. This distinction has come into sharper focus in recent years, with the aforementioned nationwide trends in restrictive reproductive state laws.

For this reason, this project will examine state laws in these Deep South states. Since all people living in these states are theoretically likely to be affected by one or more of these laws or policies, the entire population of these states is involved. This study conducted a systematic review of the state codes via the LexisNexis legal database. It also looked into policies of state agencies, such as Departments of Health, and how their policies may impact reproductive health. Sources for these policies include administrative agency websites, the Henry J. Kaiser Family Foundation, and the Guttmacher Institute. Further, it examined local and national press outlets for analysis and public opinion surrounding measures that may have been considered and ultimately rejected.

[12]Jennifer Steinhauer, *House republicans seek to remove federal funding for Planned Parenthood*, N. Y. TIMES, April 11, 2011.

The major limitation in this study is that it represents a snapshot in time. While the state-level laws outlined below will be static for the rest of 2012 (as the state legislatures have adjourned), the administrative policies may change in that time. And in the next state legislative session, beginning early 2013, these states will likely see new challenges to reproductive health via the introduction of restrictive laws. Further, while this project attempts to give a comprehensive picture of the major laws and policies affecting reproductive health, reasonable people can differ as to where exactly the dividing line between what does and what does not affect reproductive health lies.

Results

Alabama (See Pg. 32, Alabama Catalog of Reproductive Health Laws)

Context

Alabama has a messy history with reproductive health, which lies at the intersection of race, gender, and religiosity. Smack in the middle of the Bible Belt, 86% of Alabamans identified as Catholic (6%) or Christian (80%) in 2008.[13] Like much of the Deep South, Alabama has voted solidly Republican since 1976, when it voted for Democrat Jimmy Carter's first term.[14] Polling company Gallup Inc. found Alabama to be the third most conservative state in the union, based on self-reported identification in 2010.[15]

Opponents

Those opposed to comprehensive reproductive health services in the Deep South are many. The advocacy environment leaves little room for progressive policies, and necessitates defense of the protections that exist. Alabama in particular has encountered Live Action, a California-based anti-choice group that performed a "sting operation" against an Alabama Planned Parenthood clinic in 2008. Partially as a response to this event, U.S. Representatives Diane Black [b. 1951, Registered Nurse] and Martha Roby [b. 1976, daughter of judge, member Trinity Presbyterian Church & Montgomery Sav-A-Life, staunch conservative] sponsored a bill to defund Planned Parenthood.[16] The first bill Black introduced as a member of Congress, this bill passed the House, but ultimately failed in the Senate. Both women are members of the Pro-

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[13] Barry A. Kosmin & Ariela Keysar, *American Religious Identification Survey (ARIS 2008) Summary Report,* Institute for the Study of Secularism in Society & Culture (2009), Hartford, CT.
[14] John Woolley & Gerhard Peters, *The American Presidency Project,* United States Library of Congress (2012), *available at* http://www.presidency.ucsb.edu/elections.php.
[15] Jeffrey M. Jones, *State of the States: Mississippi Rates as the Most Conservative U.S. State*, Gallup Politics (Feb. 25, 2011), *available at* http://www.gallup.com/poll/146348/mississippi-rates-conservative-state.aspx.
[16] HConRes36 (2011)

Life Caucus, and have spoken out against Planned Parenthood receiving Title X funding. If extrapolated, these representatives would be against any other comprehensive (in other words, including abortion) reproductive health service provider.

Sex Education

In Alabama, providing HIV education in public schools in mandated, while sex education is not. Parents can opt out of having their children in class for HIV education. At the same time, there is no requirement that parents be notified or that they consent for their children to attend sex and/or HIV education classes. If a school does teach sex education, the curriculum must include information on contraception, privilege sex within marriage, warn of the negative outcomes of teen sex, and provide skills to avoid sexual coercion. HIV and sex education both must stress abstinence. There is also a required emphasis "in a factual manner, and from a public health perspective," that homosexuality is neither "acceptable to the general public" and that homosexual acts are criminalized under Alabama law.

Abortion

Alabama criminalizes abortion providers, under certain circumstances. Providers risk a Class A misdemeanor and forfeiture of professional license if they perform an abortion on a minor in violation of the state's parental notification law. They risk a Class A felony if they intentionally, knowingly, or recklessly perform or induce the abortion of a viable pregnancy, except in the most dire of medical emergencies, and they risk a Class C felony if they do not abide by procedural rules (e.g. certifying in writing why the abortion fits into the exception, getting a second doctor to concur with this exception in writing, etc.) when aborting a non-viable fetus. Unless it's an emergency, post-viability abortion must be done in a hospital. While

"emergency" seems much more stringent for abortions for adults, Alabama has a seemingly broad definition of medical emergency exception for abortion for minors.

Abortions are banned after 20 weeks gestation, measured from fertilization. Most of the state's abortion laws measure gestational age from last menstrual period (LMP), which is often weeks before a woman actually becomes pregnant. This may have negative implications for the 20 week abortion ban, effectively making the ban even earlier.

Obtaining late abortions has several roadblocks. The Alabama Code makes no mention of a *mental* health exemption for abortion post-viability. The only exceptions for aborting a viable fetus are "death of the pregnant woman or serious risk of substantial and irreversible impairment of a major bodily function."[17] This is patently unconstitutional, in that mental health was contemplated as part of the health exception in *Roe v. Wade*, its companion case *Doe v. Bolton*, and their progeny.

Sexually Transmitted Infections (STIs)

Alabama does not allow for expedited partner therapy, the CDC-recommended treatment for the partner of an infected person without the partner being seen by the health care provider. Medical providers must test a pregnant woman for syphilis and other STIs, and if she refuses, repeatedly offer testing throughout her pregnancy. Young people may undergo STI testing, including HIV, at the age of 12 without parental consent. However, the testing physician may inform the minor's parents of the test. Several bills about the human papillomavirus have been introduced, but none have passed.

Contraception

[17] Code of Ala. § 26-22-3(c)1

The sole mention of contraception in the Alabama Code is that schools that teach sex education must include statistics of the "reliability and unreliability of various forms of contraception."[18] The code has no obvious restrictions on emergency contraception or providing it without a prescription. In fact, despite the vehement anti-choice political atmosphere, the Alabama Department of Public Health requires that its 89 clinics offer emergency contraception to patients.[19]

Medical services (which assumedly include contraception) can be provided to minors who are married, who are parents, who are currently pregnant, a high school graduate, or are over age 14. As no law on the books characterizes teens who do not fit into one of these categories, we infer that these teens do need parental consent to access services.

In Alabama, all Title X family planning funding passes through one grantee, the State Department of Public Health, Family Planning Programs, which disperses funds to county health departments, and 8 state-run clinics.[20]

Teen Pregnancy

The law treats a minor carrying a pregnancy to term differently than a minor who chooses an abortion. Minors may consent to prenatal care without their parents' permission or notification, but they must get consent (not just notification) from their parents to legally have an abortion.

Health Care Financing

[18] Code of Ala. § 16-41A-2(c)1
[19] Alabama Department of Public Health, http://www.adph.org/familyplanning/
[20] Office of Population Affairs, *Family Planning Grantees, Delegates, and Clinics: Region IV*, updated Nov. 18, 2012, *available at https://opa-fpclinics.icfwebservices.com/pdf/dynamic/region.cfm?regionID=4&pdf=1*

Health care plans within the state exchange mandated by the Affordable Care Act will not cover abortion except for the following narrow exceptions: the woman's life is in danger, the pregnancy was a result of rape or incest, or the pregnancy is ectopic.

Alabama has a Medicaid family planning expansion program called "Plan First." The program takes women over 19 years whose income is up to 133% of the Federal Poverty Level and expires at the end of 2013. Nearly 4/5, or 78%, of women accessing the state family planning program self-reported their income at 100% of the Federal Poverty Level or below (80,911/ 103,799), per Public Health of Alabama County Operations Network (PHALCON) data.[21] The program is run through the Alabama Medicaid Agency. Women can apply online at https://insurealabama.adph.state.al.us, and the application takes approximately 30 minutes to complete. The online application immediately tells a woman if she seems eligible for the program, but it can take up to 8 weeks for her to receive confirmation. Plan First automatically enrolls women if they have children who qualify for the program, but does not otherwise seem to have presumptive eligibility. Women who have access to a computer will likely find enrollment straightforward, but the potential 8 week waiting period to receive confirmation may be a precariously long period of time for a woman seeking family planning services.

Alabama recently passed a strict anti-immigration law to encourage "self deportation," which included a provision making undocumented immigrants ineligible for Medicaid reimbursement.[22] Aside from preventing undocumented women from getting health care, this hostile environment may scare documented immigrants away from accessing the program.

[21] Unpublished PHALCON Data, 2011 Alabama statewide, Alabama Department of Public Health. Data on file with the Department, contact (334) 206-5300.
[22] Code of Ala. § **31-13-7**

Telemedicine & Medication Abortion

In 2011, the Alabama legislature enacted an omnibus abortion bill, AL H.B. 18, which included the requirement that physicians physically examine patients and determine gestational age before prescribing medication abortion. Though this bill does not directly outlaw telemedicine in the context of medication abortion, it can be inferred that the law effectively bans. Previously, laws required special licenses to conduct telemedicine across state borders, which allowed more wiggle room for the provision of medication abortions via telemedicine.

In terms of general telemedicine, a provider cannot engage in medicine across state lines unless they have been issued a special purpose license to do so. This opening may allow non-abortion services to be completed over the phone or video communication. Practically, however, this may prove difficult, as the state licensing board has discretion as to who is awarded a license.

Louisiana (See Pg. 34, Louisiana Catalog of Reproductive Health Laws)

History

Also a strong Bible Belt player,[23] 88% of Louisianans identified as Catholic (31%) or otherwise Christian (57%) in 2008.[24] Louisiana differs from its two neighbors to the East by having this considerably larger percentage of Catholics. Louisiana voted for a Democrat (Bill Clinton) in the 1992 and 1996 presidential elections, but hasn't otherwise done so since the

[23] Richard Florida, *The Real Boundaries of the Bible Belt*, ATLANTIC CITIES, Mar. 29, 2012, *available at http://www.theatlanticcities.com/politics/2012/03/real-boundaries-bible-belt/1617/#*

[24] Barry A. Kosmin & Ariela Keysar, *American Religious Identification Survey (ARIS 2008) Summary Report,* Institute for the Study of Secularism in Society & Culture (2009), Hartford, CT.

1970s.[25] Though not as high as Alabama or Mississippi, Louisiana comes in at #7 in the top ten self-identified conservative states in the country.[26]

Though not the only state with a history of slavery and subjugation of peoples of color, Louisiana's capitol city of New Orleans was the slave trade hub of North America, and experienced a particularly amplified cruelty.[27] Slave traders sold black women as "breeders valued for their reproductive as well as productive capacity."[28] The oppressive spirit of commoditization of black women's reproduction has changed target over time (e.g. into forced sterilizations), but many would argue vestiges still exist in today's law.

Opponents

Louisiana has anti-choice groups typical to the Southeast region, such as the Louisiana Right to Life Federation, which hosts "Louisiana Camp Joshua," a training camp for young pro-life leaders. Participants interact with high level anti-abortion state legislators and the Governor's wife.[29]

State Representative John LaBruzzo (Republican, b. 1970) was perhaps the most unequivocally anti-choice legislator in the state, in the purest sense of the term, until his primary defeat in 2011. In 2011, LaBruzzo proposed a bill that would totally ban abortions, declaring his intent that the ban work its way up through federal courts and ultimately overturn *Roe v. Wade*.[30] LaBruzzo also proposed a bill to encourage poor women to get sterilized, by offering to pay

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[25] John Woolley & Gerhard Peters, *The American Presidency Project,* United States Library of Congress (2012), *available at* http://www.presidency.ucsb.edu/elections.php.
[26] Jeffrey M. Jones, *State of the States: Mississippi Rates as the Most Conservative U.S. State*, Gallup Politics (Feb. 25, 2011), *available at* http://www.gallup.com/poll/146348/mississippi-rates-conservative-state.aspx.
[27] Jan Doherty, *Louisiana Black Women: An Ignored History,* 17 STUDENT HISTORICAL J., 1985-1986, at 1-2.
[28] Id. at 2.
[29] See http://prolifelouisiana.org/
[30] Bill Barrow, *Bill to Outlaw Abortion is Direct Challenge to Roe v. Wade, Rep. John LaBruzzo Says*, TIMES-PICAYUNE, May 24, 2011. http://www.nola.com/politics/index.ssf/2011/05/rep_john_labruzzo_bill_to_outl.html

women who receive public welfare benefits $1,000 to undergo a tubal ligation.[31] LaBruzzo also considered proposing tax incentives for college-educated, wealthier families to have more children.

Despite LaBruzzo's absence, the Louisiana legislature is solidly anti-choice, which likely extrapolates to being anti-reproductive health generally. The Louisiana Right to Life Federation gave 29 out of 44 state senators and 75 out of 109 state representatives an approval rating of 100% on their pro-life voting records for 2008-2011.[32] That's 68% (104/153) of state lawmakers with a totally anti-choice score, and that's not even accounting for the other imperfect, yet passing, scores.

Sex Education

Louisiana does not require sex education or HIV education to be offered in public schools. But when sex or HIV education is provided, the law requires it to be age appropriate and it may not promote religion. Schools must give parents notice of sex and/or HIV education, and they can opt out of having their children attend the class. If a school teaches sex education, it must stress abstinence and privilege sex within marriage.

In 2010 a bill to require public school districts to offer comprehensive sex education passed the House Education Committee, but was ultimately defeated on the House Floor to a

[31] Kate Shepherd, *Louisiana v. Roe*, MOTHER JONES, Apr. 25, 2011, *available at* http://www.motherjones.com/politics/2011/04/louisiana-v-roe

[32] See http://www.prolifelouisiana.org/legislation/scorecard/senatescorecard.html, http://www.prolifelouisiana.org/legislation/scorecard/housescorecard.html

vote of 67-23.[33] Perhaps in part because no law requires teaching any sex education, only 17 of the state's 69 school districts were doing so in early 2010.[34]

Abortion

As one attorney working with the Center for Reproductive Rights in Louisiana stated, "Louisiana has probably passed the most unconstitutional laws involving *Roe v. Wade*."[35] In the LexisNexis Louisiana Annotated Statutes, 117 enacted statutes mention abortion, so this analysis will focus on those most likely to impact service provision.

Citing widely discredited studies and concern for the woman seeking an abortion, the "Woman's Right to Know" is multifaceted. A woman must undergo state-approved counseling and wait twenty-four hours before obtaining an abortion. A woman also must undergo an ultrasound, and must listen to the required counseling, only able to opt out if she certifies that she has filed a report with law enforcement of rape or incest.

A minor is allowed abortion services if she is married or otherwise legally emancipated. Otherwise, she must obtain written, notarized consent from one parent or guardian. A minor woman may petition the court for a waiver from this requirement. She must show by clear and convincing evidence that she is sufficiently mature to choose abortion, and that obtaining parental consent is not in her best interest. If the court determines consent to be in her best interest, another hearing including her parents or guardians is triggered.

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[33] Sexuality Information and Education Council of the United States, *Comprehensive Sex Education Legislation Progresses in Pennsylvania and Louisiana*, May 2010, available at http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureID=1898#_edn8

[34] Id.

[35] Kate Shepherd, *Louisiana v. Roe*, MOTHER JONES, Apr. 25, 2011, *available at* http://www.motherjones.com/politics/2011/04/louisiana-v-roe

Advertising abortion services is punishable by imprisonment, with or without hard labor, up to a year, or a fine of up to five thousand dollars. Health centers in Louisiana public schools are prohibited from counseling, advocating, or referring any student for an abortion.

STIs

Louisiana allows providers to prescribe expedited partner therapy, drug treatment for the potentially infected partner of someone with an STI, without a visit to the provider. It only allows expedited partner therapy for Chlamydia and gonorrhea, and requires the provider to send information about the STI to the absent partner, along with medication.

The law provides no minimum age for minors to consent to STI testing, but HIV testing is not explicitly offered. The testing physician may inform the minor's parents of the test under his/ her discretion.

The Louisiana legislature has considered several bills that would have required insurance providers to cover the cost of the HPV vaccine, but none of these has passed. In 2008, the legislature passed a law requiring schools that send vaccine information to parents to include information on the availability, effectiveness, and known contraindications of the HPV vaccine. The information must be sent to parents/ guardians of students in grades 6 through 12.

Contraception

Minors who are married, already parents, currently pregnant, or high school graduates can access contraceptive services, as the state confers majority and adult rights based on these statuses. The law does not require emergency rooms to provide information about emergency

contraception or the medication itself upon patient request, in effect permitting religious hospitals to refuse this treatment.[36]

Teen Pregnancy

Louisiana requires parental consent before a minor can obtain an abortion, but not before a minor can obtain prenatal care. Though this is not explicitly in the state code, the Louisiana Attorney General has, in a 2001 opinion, interpreted a section of the code to mean that pregnant minors can seek prenatal care.

Minors who are married have adult status, and thus can consent to prenatal care without parental involvement. (The same does not seem to hold true with accessing abortion.) Minors can seek to avoid parental consent by applying for judicial bypass, but Louisiana courts have found it constitutional to deny a petitioner who meets bypass requirements, solely based on the judge's discretion.

Health Care Financing

A woman may secure public funding for abortion only if her life is in danger, or the pregnancy is a result of rape or incest. The essential health benefits package that the state will set for health care plans under the Affordable Care Act mandated exchange will not include abortion services.

The Louisiana state code provides that Medicaid will pay for family planning information and services, excepting abortifacients (which the law does not define). Louisiana secured a Medicaid family planning waiver in 2005. Its "Take Charge" program accepts women up to 200% of the Federal Poverty Level, and accepts women who have private insurance, if that

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[36] Henry J. Kaiser Family Foundation, June 1, 2001, *available at http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=10&rgn=20&ind=497&sub=115*

insurance does not cover family planning services.[37] Despite too frequent misunderstanding of contraception as prohibited "abortofacients," Take Charge does include contraceptives such as the pill and the intrauterine device (IUD). The program does not appear to offer presumptive eligibility at a health care center. Instead, women can apply online, by mail, by fax, or in person at a Medicaid office.

Telemedicine & Medication Abortion

Physicians must acquire a special license to practice telemedicine. The State Office of Rural Health gives grants for telemedicine to improve rural health access, which may be an avenue to explore. A licensed health care professional must be in the examination room with the patient, even if the patient is conferencing with a physician via telemedicine. The licensing board has discretion to approve or deny applications for permits as they wish. The Louisiana Rural Health Exchange is a coordinating body that may be useful for family planning providers.

Mississippi (See Pg. 36, Alabama Catalog of Reproductive Health Laws)

History

Mississippi has perhaps the most complicated history with the politics of reproduction among the three states. In the 1960s and 1970s, Mississippi had such an aggressive involuntary and coercive sterilization program that the practice was labeled the "Mississippi appendectomies."[38] Due to stereotypes and oppressive social conditions, this program most frequently targeted women of color and other "undesirables," such as those women deemed

[37] See: Department of Health and Hospitals, State of Louisiana, http://www.dhh.louisiana.gov/index.cfm/page/232
[38] Sue Thomas, Lisa Rickert, & Carol Cannon, *The Meaning, Status, and Future of Reproductive Autonomy: The Case of Alcohol Use During Pregnancy,* 5 UCLA Women's L.J. 1, 11-13 (2006).

mentally unfit. Mississippi also has the dubious distinction of having the highest teen pregnancy rate in the country, at 65.7 births per 100,000 women (Table 2).

A near universal 91% of Mississippians identified as Catholic (11%) or otherwise Christian (80%) in 2008.[39] Mississippi has voted solidly Republican since 1976, when it lent its Electoral College votes to Son of the South Democrat, Jimmy Carter.[40] Mississippi leads the country in self-identified conservatism: it ranks #1 of all states, according to Gallup, Inc. data from 2010.[41]

Opponents

Anti-choice advocacy organizations Pro-Life Mississippi and Personhood Mississippi are both strong in the state, though somewhat at odds in terms of strategy. Personhood Mississippi sponsored the constitutional Amendment 26 initiative on the 2011 ballot that would define life as starting at the moment of conception, practically outlawing abortion and many common forms of birth control.[42] Though it did not pass into law, 2012 personhood legislation was supported by both the Republican and Democrat gubernatorial candidates. On a positive note, voters did not support personhood legislation; 58 percent of voters rejected it.[43]

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[39] Barry A. Kosmin & Ariela Keysar, *American Religious Identification Survey (ARIS 2008) Summary Report,* Institute for the Study of Secularism in Society & Culture (2009), Hartford, CT.
[40] John Woolley & Gerhard Peters, *The American Presidency Project,* United States Library of Congress (2012), *available at* http://www.presidency.ucsb.edu/elections.php.
[41] Jeffrey M. Jones, *State of the States: Mississippi Rates as the Most Conservative U.S. State*, Gallup Politics (Feb. 25, 2011), *available at* http://www.gallup.com/poll/146348/mississippi-rates-conservative-state.aspx.
[42] Mississippi Secretary of State Delbert Hosemann, Initiative Measure 26, *available at* http://www.sos.ms.gov/page.aspx?s=7&s1=1&s2=50 "Section 1. Article III of the constitution of the state of Mississippi is hereby amended BY THE ADDITION OF A NEW SECTION, to read: 'Section 33. Person defined. As used in this Article III of the state constitution, "The term 'person' or 'persons' shall include every human being from the moment of fertilization, cloning, or the functional equivalent thereof."'"
[43] Jeff Amy, *Gov. Bryant: Left's mission is to 'kill children in the womb,'* OXFORD EAGLE (MISS.), Apr. 26, 2012, at 5.

Mississippi's current governor, Phil Bryant (Republican, b. 1954, assumed office January 10, 2012) is a staunch personhood supporter. Before the personhood vote, he declared that if the amendment were to fail, "Satan wins."[44]

Sex education

In Mississippi, the legislature only recently passed a requirement for abstinence-only or abstinence-plus education. No requirement exists that that HIV education be offered in public schools at all, and prohibition exists against sex education that promotes religion. In line with neighboring Louisiana, schools must give parents notice of sex and/or HIV education, and parents can opt out of having their children attend the class.

Abortion and TRAP laws

The Mississippi Code has 84 provisions that regulate or otherwise mention abortion in. The state has a strict informed consent provision that requires a physician or a designated agent to perform an ultrasound on a woman before the procedure. With the ultrasound, the woman must be offered three things: to view the ultrasound, to listen to the fetal heartbeat (if there is one), and a physical copy of the ultrasound itself. An unemancipated minor (in other words, unmarried) is required to obtain consent from *both* parents (with few exceptions), or go to court to obtain a judicial bypass.

The Mississippi legislature recently passed a TRAP (targeted regulation of abortion providers) bill, HB 1390, with the intention of causing the only remaining abortion clinic in the state, Jackson Women's Health Organization, to shut down. With the stated goal of protecting women's health, the law would require all abortion doctors to have admitting privileges at a local

[44] Id.

hospital, and to arrange them quickly. Clinic representatives countered the safety concern with its arrangement with a local obstetrician/gynecologist to transfer admitting privileges.[45] With no requirement that hospitals comply, the Jackson's Women Health Organization stated that two of its four providers were unable to secure the privileges. This law was blocked on July 1, 2012, by a temporary injunction in federal district court.

STIs

Mississippi does not explicitly allow for expedited partner therapy, the CDC-recommended treatment for the partner of an infected person without the partner being seen by the health provider. There may be room to provide it nonetheless, as the state code does not require a prescription to bear a patient's name. The law does not require a minimum age for young people to consent to STI or HIV testing. However, the law does not seem to prohibit these medical providers (physicians, nurse practitioners) from requiring parental consent or informing the minor's parents of the test, per the provider's prerogative. The Mississippi legislature has not passed any legislation particular to the HPV vaccine.

Contraception

Mississippi allows providers, pharmacists, and institutions (e.g. pharmacies, hospitals) to refuse to provide contraception, or other health care services, if to do so would violate his/ her/ their conscience. The law also allows both pharmacists and pharmacies to refuse to dispense emergency contraception. Minors can access contraceptive information and services with parental consent, or without it in certain instances, such as if they are married or already have a child. The state code also allows contraceptive services if a minor has been referred by another

[45] Staff and Wire Reports, *Judge continues to block Mississippi abortion law*, MERIDIAN STAR (MISS.), July 12, 2012.

physician, clergyman, family planning clinic, school, or state agency. Perhaps the key in this state is to set up a referral mechanism that would automatically meet this requirement, thereby bypassing parental permission.

Teen Pregnancy

Mississippi minors must secure consent from both parents (consent from other adult relatives does not satisfy the law) to obtain an abortion. Minors can only bypass this requirement by applying for judicial bypass, or when a pregnancy must be terminated because of a medical emergency. On the other hand, minors can access prenatal care or other care having to do with pregnancy without parental notification or permission.

Health Care Financing

Women who will have health coverage under the state health exchange will only be able to have abortion services covered in the case that their life is at risk, or if the pregnancy is a result of rape or incest. Insurance plans for state employees only cover abortion in the aforementioned three cases and in the case of fetal impairment.

Mississippi has a Medicaid waiver program, "Care for Yourself," which accepts documented Mississippi women, aged 13-44 years, up to 185% of the federal poverty level. The program only covers family planning services, but notably does not cover condoms, emergency contraception, or medically indicated abortion. The Mississippi State Department of Health operates the program, and women must contact their local Medicaid office directly. Though the program has an online presence, it does not provide an online application, which presents a barrier to care.

Telemedicine & Medication Abortion

The Mississippi state code contains some general telemedicine provisions. For example, telemedicine has been contemplated as a practice for mental health services and children's health services. Oddly, the code defines telemedicine as medicine practiced across state lines, but does not define it to be within the state. The Mississippi legislature had a broader abortion bill in the 2012 session that included a prohibition against medication abortion via telemedicine. The bill passed the House but stalled in the Senate, and will likely be reintroduced in the next session.

Recommendations and Conclusion

The appropriate strategy to improve reproductive health in the Deep South is not aiming for drastic change, but rather (to borrow from the broader world of public health) is aiming for harm reduction. With such entrenched legislative and organizational adversaries, to expect the strong tide against reproductive rights to reverse in any major way is unrealistic. Instead, reproductive justice advocates can redirect this negative attention to common goals of health - contraception, safe motherhood, prevention of abortion, etc., and leverage existing community structures to do so.

Legislative advocacy

Currently, most members of both parties vote for anti-reproductive rights provisions. Though delicate, the goal of pro-choice Democratic candidates who take pro-choice stances on state legislation is not unrealistic.

Creating a grassroots support of community "first responders" who can call on their more progressive legislators to support incremental change (e.g. telemedicine) or to stop more egregious policies (e.g. the recent Mississippi TRAP law) would show the legislature that there is a more diverse constituent base than they currently identify.

Generate community base

Part of this advocacy strategy should be to create a strong community base, including religious leaders and followers, to advocate for policies supportive of reproductive health. Though the majority of people in these states identify as Christian or Catholic, there is a wide diversity within these faith traditions. Tapping into the elements more friendly to reproductive

health may make these issues more palatable to the general public, and putting them in a spiritual framework could encourage empathy.

Moderate policy goals

Given the extreme imbalance of anti-choice v. pro-choice (in the broadest sense) provisions, there is a lot of room to make incremental gains in provision of and access to reproductive health services. For example, one worthy goal is to change state sex education policies from being sex-negative and abstinence-only to being sex-positive, or at least abstinence-plus and neutral. Another is simply for the state to offer presumptive eligibility for Medicaid family planning expansions, so that women can apply for state family planning services at the clinic where they want to obtain them. None of the three states currently have presumptive eligibility, and instead require women to communicate with their local Medicaid office directly. Advocates can make strong arguments that presumptive eligibility would increase access, and cut down on bureaucracy.

Another tactic is to preempt targeted regulation of abortion provider with general pro-business ordinances, which can prevent pointless requirements for all renters or enterprises. In these more conservative states, wide-ranging pro-business, libertarian ordinances could preempt TRAP laws related to building code, etc.

On an even more local level, municipal codes might provide a foot in the door to change policies such as compulsory attendance policies at public schools (which prevents youth from leaving to obtain medical services without parent knowledge/permission), or advertising laws. The municipal level is also the appropriate place to propose bubble ordinances around any the front doors of organizations, which could protect all sorts of organizations from entrance

obstruction, from the local chapter of the National Rifle Association to reproductive health providers.

Special consideration: Youth

In these states, as in the rest of the nation, much of reproductive health boils down to minors' ability to make reproductive health choices with autonomy under the law. In other words, the level of parental control around decision-making, especially in these more conservative communities, can have a gatekeeper effect on teen health. Components of this include sexual and HIV education offerings in public schools; the legal ability for minors to consent to reproductive health services (e.g. contraception, STI testing, abortion); and accessibility of condoms (under pharmacist control - physically behind the counter, in locked case, etc. - or freely accessible). Other considerations include a minors' (17 year old women's) access to emergency contraception without a prescription, and how this access practically unfolds, and the distinction between how the law treats a teen who wants to parent, versus a teen who chooses an abortion or contraception.

Practical health interventions

The law as it stands leaves room for the implementation of a handful of creative and practical public health interventions. For example, where the law in these states addresses certainty or identification of pregnancy, menstrual regulation may be an appropriate intervention before a pregnancy test. This would get around "clinically diagnosable pregnancy" language and intent behind most laws. Another example could be expanding expedited partner therapy, or a similar model, in states that do not explicitly prohibit it.

Conclusion

The reproductive health in the Deep South is informed by its history of racial tensions, conservative political character, and high religiosity. The states of Louisiana, Mississippi, and Alabama in particular, have poor general and reproductive health indicators. It is imperative that advocates for improved reproductive health services both work within existing law, and advocate for incremental policy change where this change is possible. This guide should assist advocates to those ends.

TABLES

Alabama: Catalog of Reproductive Health Laws

Category	Citation	Provisions
Sex Education		
	Code of Ala. § 16-40A-2	If a public school district offers sex education, it must: • include information on contraception • privilege sex within marriage and stress abstinence • warn of the negative outcomes of teen sex • provide skills to avoid sexual coercion • emphasize that homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense under the laws of the state.
	Code of Ala. § 16-41-8	Sex education in public schools is not authorized or required.
Abortion		
Parental consent	Code of Ala. § 26-21-1	Minors require parental *consent* to have an abortion. The code cites state interest in (1) protecting minors against their own immaturity, among other things. Notable cases: • Court granted waiver when minor showed maturity, and nothing else. (Ex parte Anonymous, 595 So. 2d 499, 1992 Ala. LEXIS 97 (1992)) • Court did not grant waiver, despite minor threatening suicide. (In re Anonymous, 869 So. 2d 498, 2003 Ala. Civ. App. LEXIS 491 (Civ. App. 2003)) • Parent of a minor can bring a lawsuit against anyone who provides an abortion without consent or a court waiver. (Boykin v. Magnolia Bay, Inc., 570 So. 2d 639, 1990 Ala. LEXIS 765 (1990))
Waiver of parental consent	Code of Ala. § 26-21-3, § 26-21-4(f)	A minor may petition the court to waive the parental consent requirement. The required consent shall be waived if the court finds either: (1) That the minor is mature and well-informed enough to make the abortion decision on her own; or (2) That performance of the abortion would be in the best interest of the minor.
Exception: emergencies	Code of Ala. § 26-21-5	A minor does not need parental consent or a waiver when in the best clinical judgment of the attending physician on the facts before him, that a medical emergency exists that compromises the health, safety, or well-being of the mother as to require an immediate abortion. This reason must be stated in the patient's medical record.
Legal penalty	Code of Ala. § 26-21-6	Any person who intentionally performs or causes to be performed an abortion in violation of the provisions of this chapter or intentionally fails to conform to any requirement of this chapter, shall be guilty of a Class A misdemeanor. Any person found guilty under this section shall immediately forfeit any professional license they may hold.
Statistical information	Code of Ala. 26-21-8	Abortion providers must furnish to the Bureau of Vital Statistics the number of abortions performed on minors with written consent, how many were performed pursuant to court waivers, and how many were performed because of medical emergencies.
Second opinion	Code of Ala. § 26-22-3(c)2	For post-viability abortion, physician must get second opinion in writing from another physician.
Hospital	Code of Ala. § 26-22-3(c)3	Unless it is an emergency, post-viability abortion must be done in a hospital.
Post-viability	Code of Ala. § 26-22-1	Subject to life and [narrow] health exceptions to the mother, it is the intent of the Legislature to ban abortions of any unborn child that is capable of

		living outside the womb. To permit otherwise is a wanton disregard of human life.
Post-viability	Code of Ala. § 26-22-3	No person shall intentionally, knowingly, or recklessly perform or induce an abortion when the unborn child is viable, except if the physician reasonably believes an abortion is necessary: • to prevent death of the woman, or • to prevent substantial and irreversible impairment of a major bodily function. Two physicians must certify this opinion in writing, and the abortion must be performed in a hospital. A second physician must be on hand to provide medical assistance to the fetus. A claim or diagnosis that a woman will engage in conduct which would result in her death or substantial and irreversible impairment of a major bodily function is not a valid exception.
Sexually Transmitted Infections (STIs)		
Pregnant women	Code of Ala. § 22-11A-16	Medical providers must test a pregnant woman for STIs, and if she refuses, repeatedly offer testing throughout her pregnancy.
Minors	Code of Ala. § 22-11A-19	Minors may consent to STI testing and treatment as young as 12 years old. The testing physician *may* inform the minor's parents of the test results.
Contraception		
Contraception ed	Code of Ala. § 26-22-3(c)1	Schools that teach sex education must include statistics of the reliability and unreliability of various forms of contraception.
	Code of Ala. § 22-8-4	Minors who are married, who are parents, who are currently pregnant, a high school graduate, or are over age 14 can obtain any legally authorized medical service (which assumedly include contraception).
Teen Pregnancy		
		[Does not appear to be a specific law on the books.]
Health Care Financing		
Health exchange	Code of Ala. § 26-23C-2	The state opts out of allowing qualified health plans that cover abortions to participate in exchanges, except if the woman's life is in danger, the pregnancy was a result of rape or incest, or the pregnancy is ectopic.
Immigrant care	Code of Ala. § 31-13-7	Undocumented immigrants who are not eligible for public benefits under 8 U.S.C.S. § 1621(a) or 8 U.S.C.S. § 1641 shall not receive any state or local public benefits. Except as otherwise provided in subsection (e) or where exempted by federal law, commencing on September 1, 2011, each agency or political subdivision of the state shall verify with the federal government the lawful presence in the United States of each alien who applies for state or local public benefits.
Telemedicine		
	Code of Ala. § 34-24-502	A provider cannot engage in medicine across state lines unless they have been issued a special purpose license to do so.

Louisiana: Catalog of Reproductive Health Laws

Category	Citation	Provisions
Sex Education		
	La. R. S. §17:281	No requirement that sex education or HIV education be offered in public schools. When it is offered • It must be age appropriate • It must stress abstinence and privilege sex within marriage • It cannot promote religion • Schools must give parent notice and an opt out policy
Abortion		
	La. R.S. § 40:1299.35.6	This "Woman's Right to Know" provision requires the following before an abortion: • Woman must state-approved counseling • Woman must wait 24 hours to have abortion or any medication which may start the abortion process
	La. R.S. § 40:1299.35.2	Abortion can only be performed by a physician licensed in the state of Louisiana. • Physician or physician's agent (only after completing ultrasound course) must perform ultrasound • Ultrasound must be displayed to woman, description of fetus provided • Picture of ultrasound, including any visible limbs, must be offered to woman • Fetal heartbeat must be made audible, unless woman opts out in writing • Woman may only opt out of counseling if she certifies she has filed a report of rape or incest with law enforcement
	La. R.S. § 40:1299.35.5	A minor may only have an abortion if • She is married or otherwise legally emancipated OR • She obtains a notarized document with a parent/ guardian's consent OR • She petitions the court for a waiver, which will be heard within four days of petition. A minor may obtain a waiver if she shows herself sufficiently mature OR that not telling her parent/ guardian is in her best interest.
	La. R.S. § 14:87:4	Publicizing the availability of abortion services is a crime. The penalty is imprisonment, with or without hard labor, for a maximum of 1 year, or a fine of up to $5,000.
Sexually Transmitted Infections (STIs)		
	La. R.S. § 40:1064.1	Expedited partner therapy authorized, absent doctor-patient relationship and absent clinical assessment of infected person's partner.
	La. R.S. § 17:170.3	Schools that send out information about vaccines must include information about HPV, its risks, and the availability of the vaccine.
Contraception		
		Does not appear to be a specific law on the books. See "Health Care Financing" below.
Teen Pregnancy		
	La. Atty. Gen. Op. No. 2001-398; 2001 La. AG LEXIS 525	Minor may give her consent to prenatal care, which may not be subject to a later disaffirmance because of her minority. Interpreting La. R.S. 40:1095
Health Care Financing		

	La. R.S. § 22:1014	Limits plans on state exchange (under the Affordable Care Act) to cover abortions.
	La. R.S. § 40:1299.34.5	No public funds may be used to pay for abortion, except when necessary to save the life of a woman, or if the pregnancy is a result of rape or incest. The woman must either report the rape/ incest to law enforcement, or get a doctor's note certifying her as incapable to do so.
	La. R.S. § 46.447.1	Medicaid shall provide contraceptive services.
Telemedicine		
	La. R.S. § 40:2195:1	Creates the State Office of Rural Health, which is tasked with providing technical assistance to those applying for telemedicine grants to service rural populations.

Mississippi: Catalog of Reproductive Health Laws

Category	Citation	Provisions
Sex Education		
	Miss. Code Ann. § 41-79-51	Creates the Teen Pregnancy Prevention Task Force to, among other things, • Study and make recommendations to the legislature about abstinence-only or abstinence-plus education • Evaluate the effective of a required sex education program on teen pregnancy rates
	Miss. Code Ann. § 37-13-171	Mandates every public school district to adopt an abstinence-only or abstinence-plus sex ed curriculum by June 30, 2012. • Neither curriculum permits condom instruction and demonstrations • Boys and girls must be separated at all times
	Miss. Code Ann. § 41-79-5	Each public school district shall have a nurse that provides, among other things, reproductive health education and referral to to prevent teen pregnancy and STIs.
Abortion		
	2012 Miss. ALS 331	Requires all physicians who provide abortions in ambulatory centers to have admitting privileges at a local hospital. [Injunction in place.] Requires all abortion providers to be board certified in OB/GYN.
	Miss. Code Ann. § 41-41-33	Informed consent provision • Women must meet with abortion providing physician 24 hours before procedure (waiting period) • Requires communication of "medically accurate" risks of abortion to women • Women must be provided printed materials with descriptions of the "unborn child" and alternatives to abortion • Women must provide written consent
	Miss. Code Ann. § 41-41-34	Physician or attendant must perform an ultrasound and offer the patient the ability to • view the ultrasound • listen to the fetal heartbeat (if existing) • have a physical picture of the ultrasound Physician must obtain signed certification that all three things were offered.
	Miss. Code Ann. § 41-41-51	A minor is emancipated if she is married, or has obtained judicial emancipation.
	Miss. Code Ann. § 41-41-53	To obtain an abortion, a minor must obtain the written *consent* of *both* parents, or that of a legal guardian. She may also seek a judicial waiver, which will be waived if the minor proves • She is mature and well-informed enough to make the decision OR • The abortion would be in her best interests
Sexually Transmitted Infections (STIs)		
	Miss. Code Ann. § 73-21-119	Prescription labeling: prescriptions not required to bear patient's name.
	Miss. Code Ann. § 41-41-13	Physician or nurse practitioner who tests minor for STI need not get parental consent, or notify parents (but does not seem to be prevented from requiring consent or disclosing)
Contraception		
	Miss. Code Ann. § 41-41-215	A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-

		care standards applicable to the health-care provider or institution.
	Miss. Code Ann. § 41-107-5	A health-care provider has the right not to participate, and no health-care provider shall be required to participate in a health-care service that violates his or her conscience.
	Miss. Code Ann. § 41-42-7	A minors can obtain contraceptive supplies and information if the minor • Is a parent • Is married • Has consent from a parent/ guardian • Has been referred for the service from another physician, clergyman, family planning clinic, school, or state agency.
Teen Pregnancy		
	Miss. Code Ann. § 41-41-3	Any female, regardless of age or marital status, is empowered to give consent for herself in connection to pregnancy or childbirth.
Health Care Financing		
	Miss. Code Ann. § 41-41-97 § 41-41-99	The state affirmatively opts out of allowing qualified health plans that cover abortions to participate in exchanges mandated by the Affordable Care Act. Plans are allowed to cover abortion under certain exceptions: life of woman endangered, when the pregnancy is a result of rape/ incest.
	Miss. Code Ann. § 43-13-121	Extends Medicaid eligibility to all women of reproductive age up to 185% of the federal poverty level, who would not otherwise qualify. Only covers family planning services, excluding emergency contraception and condoms. Excludes undocumented immigrants.
Telemedicine		
	Miss. Code Ann. § 41-3-15	The State Board of Health has the power to promulgate rules and regulations on the delivery of health services through telemedicine.
	Miss. Code Ann. § 73-25-34	Telemedicine from within Mississippi across state lines is prohibited.