EXECUTIVE SUMMARY

WHEN THE STATE FAILS:

Maternal Mortality & Racial Disparity in Georgia

YALE GLOBAL HEALTH JUSTICE PARTNERSHIP

The Global Health Justice Partnership (GHJP) is a program hosted jointly by Yale Law School and Yale School of Public Health that tackles contemporary problems at the interface of global health, human rights, and social justice. The GHJP is pioneering an innovative, interdisciplinary field of scholarship, teaching, and practice, bringing together diverse leaders from academia, non- governmental, and community-based organizations to collaborate on research projects and the development of rights- based policies and programs to promote health justice.

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ACKNOWLEDGMENTS

This report by GHJP was conceptualized in collaboration with the Black Mamas Matter Alliance (BMMA) and the Center for Reproductive Rights (CRR). The BMMA is a Black women-led cross sectoral alliance focused on advocacy, research, building power, and shifting culture for Black maternal health, rights, and justice. The CRR is a legal non-profit organization that seeks to fundamentally transform the landscape of reproductive health and rights worldwide. GHJP worked closely with Kwajelyn Jackson of BMMA and Pilar Herrero and Breana Lipscomb of CRR to develop the research questions that frame this report and are grateful for their insights throughout the research and writing process. We are inspired by and appreciative for BMMA's work and vigilant advocacy on behalf of reproductive justice.

The original authors of this report were Eric Baudry (Yale Law School, 2019), Nicole Gusman (Yale School of Public Health, 2018), Victoria Strang (Yale Divinity School, 2017), Krysten Thomas (Yale School of Public Health, 2018) and Elizabeth Villarreal (Yale Law School, 2019).

Editorial support as well as additional research and writing were carried out by Christine Ricardo, Sarah Aquilla, Poonam Daryani, Serena Ly, and Alice M. Miller of the GHJP.

We are grateful to Mindy J. Roseman, Amy Kapczynski, and Gregg Gonsalves for their support and guidance. We would also like to extend special appreciation to Kwajelyn for her efforts in helping to organize our two research trips to Atlanta.

In addition, we would like to thank a number of people who contributed information, comments, or references in response to our inquiries on matters covered in this report. Key informants consulted by the original student research team, nationally and in Georgia, are listed in Appendix A. We appreciate the valuable feedback on our preliminary findings offered by the team at the Equity Research and Innovation Center (ERIC) at Yale University. The report was also strengthened by the feedback and expertise offered by a number of external reviewers: Allyson McKinney Timm, Founder & Executive Director of Justice Revival; Dr. Andrew Dott, obstetrician-gynecologist in Atlanta, GA; Pilar Herrero, Human Rights Counsel for CRR; and Dr. Saria Hassan, Associate Research Scientist with ERIC. We are grateful for the insights and contributions of all of these individuals; however, all opinions and conclusions and any errors or misinterpretations are our own.

The research for this report was supported by a grant from the Oscar M. Ruebhausen Fund at Yale Law School. Moreover, this work is an initiative of the Gruber Project for Global Justice and Women's Rights.

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INTRODUCTION

Introduction: Background and Scope of Research *(Pages 16-23 of full report)*

This report seeks to contribute to the current— and urgently needed – national conversation about the dismal state of maternal health in the United States and the ways in which the government and its institutions at all levels are failing women, particularly Black women, at every stage of pregnancy and childbirth.

Our focus here is on the choices *states* make in policies, including the use of federal and private monies, as well as the distribution and quality of services, which are implicated in the critical state of maternal health. The risk of death from pregnancy and child birth varies greatly by state, more than is explained by mere demographics, which suggests that this risk of death is not a 'natural' distribution, but that state-by-state policies are implicated.

Maternal Mortality in the U.S.

In the U.S., Black women are three to four times more likely to die from pregnancy-related complications than white women.[1] Nationally, the maternal mortality ratio is 43.5 deaths per 100,000 live births for Black women and 12.7 for white women.[2]

This racial disparity for maternal death is situated within another startling paradox: the U.S. is currently one of only thirteen countries where maternal mortality is worse now than it was fifteen years ago.[3] The U.S.'s worsening profile in maternal death places it outside the patterns in all other post-industrial 'developed' countries. In the past two decades, the percentage of maternal deaths attributable to chronic conditions such as hypertension and diabetes has risen sharply in the U.S.; however, globally no parallel rise in maternal deaths has been seen alongside increasing rates of obesity and other risk factors. [4]

This report highlights questions raised by situating an analysis of the U.S.'s maternal outcomes within a globally accepted body of research that posits that maternal health and death are influenced by socioeconomic, cultural, and political environments, which in turn are shaped by policy-level decisions.[5,6,7] In particular, we focus on contextualizing risk factors within *state-level structures* and systems under the control of *state* policy makers to understand and guide future interventions into "what puts people at risk of risks."[8] Research globally and in the U.S. has made clear that there is nothing inevitable or natural about the U.S.'s maternal mortality crisis, nor its racial aspect: this report begins to connect the dots between maternal mortality in a specific state and key political and structural decisions. Given that preventable death has been produced by policy decisions, this crisis can be ameliorated by, among other things, attention and reform within these policy structures.

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[1] "Pregnancy Mortality Surveillance System." *Reproductive Health.* Centers for Disease Control and Prevention, 2017. Web. 5 Oct 2017.
[2] Ibid.
[3] Alkema, Leontine, Elena Broaddus, Doris Chou, Daniel Hogan, Colin Mathers, Ann-Beth Moller, Lale Say, and Sanquian Zhang. *Trends in Maternal Mortality: 1990 to 2015.* Geneva: World Health Organization (WHO), 2015. Web. 24 Apr. 2017.
[4] Creanga, Andreea, Cynthia Berg, Jean Y. Ko, Sherry Farr, Van Tong, Carol Bruce, and William Callaghan. "Maternal Mortality and Morbidity in the United States: Where Are We Now?" *Journal of Women's Health 23.1* (2014), 3–9. Web.
[5] Hogan, Margaret, Kyle J. Foreman, Mohsen Naghavi, Stephanie Y. Ahn. Mengru Wang, Susanna M. Makela, Alan D. Lopez, Rafael Lozano, and Christopher J.L. Murray. "Maternal Mortality for 181 Countries, 1980–2008: a Systematic Analysis of Progress towards Millennium Development Goal 5." *Lancet* 375.9726(2010):1609-1623. Web.
[6] Morton, Christine. "The Problem of Increasing Maternal Morbidity: Integrating Normality and Risk in Maternity Care in the United States." *Birth Issues in Perinatal Care* 41.2(2014):119-121. Web.
[7] Link, Bruce and Phelan, Jo. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* (1995):80-94. Web.
[8] Ibid.

Georgia and Maternal Mortality

In 2010, Amnesty International flagged Georgia as the state in the U.S. with the worst maternal mortality.[9] At the time of our research and writing in 2017, owing in part to changes in state-level data collection and health surveillance systems, Georgia was ranked 48th in the nation for maternal mortality.[10] In 2016, the pregnancy-related maternal mortality ratio in Georgia was 40.8 per 100,000 live births, with disaggregated ratios of 27.1 for white women and 62.1 for Black women.[11]

Georgia is also the 5th poorest state in the U.S., a situation which disproportionately impacts Black communities.[12] While a variety of poor health outcomes in the U.S. are correlated with socioeconomic status, poverty only accounts for a part of the problem: racial disparities in maternal health outcomes persist even after controlling for poverty, education, and unemployment.[13,14]

The Shape of this Report: Frames, Methodology and Scope

The report examines maternal mortality through a lens of the state's obligation to uphold a right to health and redress racial inequality within this right, in order to identify useful governmental and other targets for advocacy and intervention. This human rights-influenced idea of state obligation and accountability is situated within an intersectional reproductive justice framework, defined as "the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights."[15]

We asked:

- What are the state-level policies and institutional factors that contribute to the practices and pathways associated with poor health outcomes, including maternal death, and to why Black women experience such disproportional risk during pregnancy, childbirth, and in the postpartum period as compared to white women, particularly in Georgia?
- What are strategies (legislatively, as well as in policies and practices) that state-level policy makers and advocates can use to lower maternal death overall and ameliorate racial disparities in maternal outcomes?

We note that definitions for the parameters for counting a death as a 'maternal death' are changing at this time. Although some data sources, including the Georgia Department of Health, only include **deaths occurring within 42-days post-pregnancy** in their calculations of maternal mortality ratio, the CDC and the American College of Obstetricians and Gynecologists' recommendation is that the timeframe most relevant to understanding maternal death (i.e. able to capture the full range of contributing factors to death associated with maternity) is up to **one year** after the end of a pregnancy.[16,17] Expanding the time frame would allow state-level policy makers to collect and analyze data across the range of practices and experiences in pregnancy, delivery, and post-natal care

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[9] *Deadly Delivery: The Maternal Health Care Crisis in the USA.* New York City: Amnesty International, 2011. Web.
[10] *2016 Health of Women and Children Report.* Minnetonka, MN: United Health Foundation, 2016. Web.
[11] "OASIS Web Query - Maternal Child Health (MCH) - Maternal Mortality." *Oasis Online Analytical Statistical Information System.* Georgia Department of Health Online Analytical Statistical Information System. Web.
[12] "Poverty Rate by Race/Ethnicity." *State Health Facts.* The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.
[13] See, Chih Lin, Ann, and David R. Harris. *The Colors of Poverty: Why Racial & Ethnic Disparities Persist.* Ann Arbor: National Poverty Center, 2009. Web.
[14] *Severe Maternal Morbidity in New York City, 2008-2012*. New York, NY: New York City Department of Health and Mental Hygiene, 2016. Web.
[15] Ross, Loretta. "What Is Reproductive Justice?" *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*. 2007. Web. 10 Oct. 2017.
[16] Berg, Cynthia, Isabella Danel, Hani Atrash, Linda Bartlett, and Suzanne Zane. *Strategies to Reduce Pregnancy-related Deaths: From Identification and Review to Action.* Atlanta: Centers for Disease Control and Prevention, 2001. Web.
[17] "OASIS Web Query - Maternal Child Health (MCH) - Maternal Mortality." *Oasis Online Analytical Statistical Information System.* Georgia Department of Health Online Analytical Statistical Information System. Web.

that research suggests are linked to poor health outcomes. Georgia's analysis, and its ability to set policies that would more effectively function to prevent death or morbidity for women, would be improved if the state adopted this definition.

The structure of the report was developed through desk research and collaborative conversations with the Black Mamas Matter Alliance and the Center for Reproductive Rights. The Black Mamas Matter Alliance has developed a national framework for state accountability around issues of maternal health. Applying this framework to Georgia, four interconnected system failures, listed below, were identified as contributing to maternal health disparities.

1. Access to and quality of care,
2. Insurance access and pricing,
3. Funding for maternal health in Georgia, and
4. Accountability around data analysis and use, specifically with regards to the state's maternal mortality review committee.

The report also explores the landscape and potential engagement of Christian churches in Georgia, primarily those within Black communities. We consider the possibility of building transparent and equal partnerships with religious leadership to strengthen social- and environmental-level pathways associated with improvements in maternal mortality, functioning as a form of informal structural intervention.

For each of the system failures and possible social/structural connections outlined above, the report presents overview, analysis, and recommendations for action. In brief:

1. Barriers to accessing necessary and quality care for pregnant women, especially Black women, in Georgia arise as a series of delays related to insufficient distribution of information, distribution of care services, institutional attitudes, and practices at local, municipal, and state level.

2. Insurance access matters for maternal health disparities, and Georgia has made policy decisions that limit the adequacy and consistency of coverage.

3. Georgia's current policies on funding (from both public and private sectors) are implicated in its profile on maternal health.

4. Georgia's maternal mortality review committee, while meeting national minimums for competency, nonetheless does not accomplish basic tasks critical to meaningful investigation and intervention into maternal deaths.

Finally, we suggest:
5. Religious communities in Georgia could play a key role in addressing maternal racial disparities.

What follows is an elaboration of these key points, policy takeaways, and specific recommendations, which are drawn from the analysis in our 77-page report. While this Executive Summary includes relevant research to support our conclusions and recommendations, we encourage readers to use the complete report, available on the Yale Global Health Justice Partnership website (*www.law.yale.edu/GHJP*), as a reference and to support more specific advocacy and policy reform.

KEY FINDINGS

1. Barriers to accessing necessary and quality care for pregnant women, especially Black women, in Georgia arise as a series of delays related to insufficient distribution of information, distribution of care services, institutional attitudes, and practices at local, municipal and state levels. *(Pages 24-37 of full report)*

This section applies an internationally-recognized maternal health framework to Georgia. Known as the *Three Delays* model, it calls attention to barriers to maternal and obstetric healthcare and allows us to highlight potential strategies to address access to, utilization of, and quality of care. The *Three Delays* model posits that there are three distinct phases that may impact maternal outcomes and result in health deficits: when deciding to seek care, when attempting to reach an adequate health care facility, and when receiving care.[18]

First Delay: Deciding to Seek Care

Early and appropriate prenatal care can improve birth outcomes for mother and child, in part through the detection and management of pregnancy complications, including risks from chronic conditions, which increasingly contribute to maternal mortality and morbidity. However, 15.8% of women in Georgia receive delayed prenatal care or none at all, with the percentage rising to 21.9% for women of color (2010 data).[19]

- **Unequal distribution of reproductive health information** across communities in Georgia means women may not realize they need – or could access – prenatal care and therefore do not seek care.[20] Consequently, women may not recognize or respond to important warning signs during their pregnancies.[21]
- **Women, particularly low-income and Black women,** in Georgia may be aware of pregnancy services but intentionally decide not to seek them given histories of negative interactions and discrimination within formal healthcare systems.[22,23]

Second Delay: Getting to Care – Identifying and Obtaining Appropriate Services or Healthcare

Taking race and gender into account alongside social and economic status, as posited by the reproductive justice framework, makes visible the structural and other barriers to reaching and using care options, even after a pregnant woman in Georgia has decided to seek care.[24]

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[18] Thaddeus, Sereen, and Deborah Maine. "Too Far to Walk: Maternal Mortality in Context." *Social Science and Medicine* 38.8 (1994): 1091-110. Web.

[19] *Maternal Health in Georgia.* Black Mamas Matter Alliance and The Center for Reproductive Rights, 2016. Web. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Maternal-Health-and-Georgia-Fact-Sheet.pdf

[20] Meyer, Erika, Monique Hennink, Roger Rochat, Meredith Pinto, Adrienne D. Zertuche, Bridget Spelke, Andrew Dott, and Pat Cota. "Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia." *Maternal and Child Health Journal* 20.7 (2016): 1358-365. Web.

[21] Lindsay, Michael K. *Georgia Maternal Mortality: 2012 Case Review*. Georgia Department of Public Health, 2015. Web.

[22] Daniels, P., Noe, G., and Mayberry, R. "Barriers to Prenatal Care among Black Women of Low Socioeconomic Status." *Health Behavior* 30.2 (2006):188-198. Web.

[23] Novick, Gina. "Women's Experience of Prenatal Care: An Integrative Review." *Journal of Midwifery & Women's Health* 54.3 (2009): 226-37. Web.

[24] Ross, Loretta. "What is Reproductive Justice?" *Reproductive Justice.* Sister Song: Women of Color Reproductive Justice Collective. Web. 27 September 2017.

- **Financing can be a barrier to timely care, even if state policies make it formally available. For example, Medicaid finances** between 50% and 60% all births in Georgia.[25] However, some providers may not accept or may cap the number of Medicaid patients they see due to low reimbursement rates and cumbersome reimbursement processes as compared to private insurance.[26] Moreover, although Georgia presumes Medicaid eligibility for pregnant women in order to speed them through the enrollment process, it can still take weeks to start receiving coverage.[27]

- **Georgia provides funding for Crisis Pregnancy Centers** (CPCs) using taxpayer funds.[28] Predominantly grounded in right-wing Christian and anti-abortion ideologies, CPCs often do not have medical professionals on staff and generally do not provide accredited medical care or dispense the information necessary for accessing comprehensive pregnancy care.[29] For women seeking quality prenatal care and counseling, time at the CPCs can serve as a delay to meaningful care.

- **Georgia's rural care deficit** means that pregnant women in rural areas have particularly constrained options, with over 80% being forced to travel outside of their county to deliver,[30] which is concerning given the correlation between longer travel time and worse birth outcomes.[31,32] Moreover, the share of the population on Medicaid tends to be highest in rural areas, amplifying the problems with Medicaid discussed above. [33]

Third Delay: Barriers in Receiving Adequate and Appropriate Care

Black patients often report feeling undervalued, disrespected, and discriminated against in the healthcare setting.[34,35] These negative experiences are compounded by other racist experiences in their lives. Research has demonstrated that racialized interactions – both interpersonal and at the hands of faceless bureaucracies – are often internalized and further exacerbated by legacies of historical injustices. In this context, it is important to flag the many racialized injustices enacted in the name of medical practice, including reproductive health.[36, 37]

- **Chronic and persistent activation of physiological stress processes can have mental and physical health consequences**, such as a "weathering" effect, meaning increased vulnerability to health risks and accelerated

[25] Zertuche, Adrienne, and Bridget Spelke. *Georgia's Obstetric Care Shortage*. Atlanta: Georgia Maternal & Infant Health Research Group (GMIHRG), 18 Nov. 2013. PPT.
[26] *Deadly Delivery: The Maternal Health Care Crisis in the USA.* New York City: Amnesty International, 2011. Web.
[27] Pinto, Meredith, Roger Rochat, Monique Hennink, Adrienne D. Zertuche, and Bridget Spelke. "Bridging the Gaps in Obstetric Care: Perspectives of Service Delivery Providers on Challenges and Core Components of Care in Rural Georgia." *Maternal and Child Health Journal* 20.7 (2016): 1349-357. Web.
[28] "State Government: Georgia." *Naral.* Naral Pro-Choice America. Web.
[29] Bryant, A., Narasimhan, S., Bryant-Comstock, K., and Levi, E. "Crisis Pregnancy center websites: Information, misinformation, and disinformation." *Contraception* 90.6(2014): 601-605. Web.
[30] Ibid.
[31] Grzybowski, S., K. Stoll, and J. Kornelson. "Distance Matters: A Population Based Study Examining Access to Maternity Services for Rural Women." *BMA Health Services Research.* 11.1 (2011): 147-54. Web.
[32] *Maternal Health in Georgia.* Black Mamas Matter Alliance and The Center for Reproductive Rights, 2016. Web.
[33] "Snapshot: Georgia's Medicaid Enrollment and Spending." *Center for State and Local Finance*. Georgia State University Center for State and Local Finance, 2017. Web.
[34] Kaplan, Sue, Neil S. Calman, Maxine Golub, Joyce H. Davis, Charmaine Ruddock, and John Billings. "Racial and Ethnic Disparities in Health: A View from the South Bronx." *Journal of Health Care for the Poor and Underserved* 17.1 (2006): 116-27. Web.
[35] Kressin, Nancy R., Kristal L. Raymond, and Meredith Manze. "Perceptions of Race/Ethnicity-Based Discrimination: A Review of Measures and Evaluation of Their Usefulness for the Health Care Setting." *Journal of Health Care for the Poor and Underserved* 19.3 (2008): 697-730. Web.
[36] Bailey, Zinzi D., Nancy Krieger, Madina Agenor, Jasmine Graves, Natalia Linos, and Mary T. Bassett. "Structural Racism and Health Inequities in the USA: Evidence and Interventions." *The Lancet* 389.10077 (2017): 1453-463. Web.
[37] Acevedo-Garcia, Dolores, Ana V. Diez-Roux, Jack Geiger, Rachel D. Godsil, Sherman James, Nancy Krieger, Vernellia R. Randall, David Barton Smith, and David R. Williams. *Unequal Health Outcomes in the United States.* CERD Working Group on Health and Environmental Health, 2008. Web.

deterioration of body systems.[38] Self-reported experiences of racism over the lifecourse and prenatal maternal stress have been linked to adverse birth outcomes such as declines in birth weight, increases in low birth weight, and higher rates of preterm delivery.[39]

- **Structural racism compounding historical violations of trust have consequences for quality of care and service delivery.** Research suggests Black people receive lower quality and intensity of care (including obstetrical) than white patients, even when insurance is the same.[40] Moreover, hospitals disproportionately serving Black women have lower delivery-related performance and higher risk of maternal and birth complications than hospitals with more white patients.[41,42] Compromised quality of care within healthcare settings may also be linked to failures by providers to listen and respond appropriately to concerns raised by women, particularly Black women, regarding their bodies, pain levels, and health status.[43,44]

- **Class-based discriminations also arises alongside other forms of discrimination,** meaning that some women report being treated with disdain by health workers who know, or assume, that they are uninsured or on Medicaid.[45] In Georgia, women on Medicaid have reported "feeling less worthy" to use parts of the health care system.[46]

- **Alternative, and often more culturally acceptable, options for maternity care are not widely available** given that Georgia's legal requirements for alternative care are stricter than other states. Certified nurse-midwives can only practice under a collaborative agreement and do not have full autonomy, home births must be done in cooperation with a physician, and extensive regulations and requirements tightly circumscribe birthing centers.[47,48,49]

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[38] Geronimus, Arline T., S.A. James, M. Destin, L.F. Graham, M.L. Hatzenbeuhler, M.C. Murphy, Jay Pearson, Amel Omari, and J.P. Thompson. "Jedi Public Health: Co-creating an Identity-Safe Culture to Promote Health Equity." *SSM Population Health* 2(2016): 105-116. Web.

[39] Nuru-Jeter, Amani, Tyan Parker Dominguez, Wizdom Powell Hammond, Janxin Leu, Marilyn Skaff, Susan Egerter, Camara P. Jones, and Paula Braveman. "'It's the Skin You're In': African-American Women Talk about Their Experiences of Racism: An Exploratory Study to Develop Measures of Racism for Birth Outcome Studies." *Maternal and Child Health Journal* 13.1 (2008): 29-39. Web.

[40] Gavin, Norma, Kathleen E. Adams, Katherine Hartmann, Beth M. Benedict, and Monique Chireau. "Racial and Ethnic Disparities in the Use of Pregnancy-Related Health Care Among Medicaid Pregnant Women." *Maternal and Child Health Journal* 8.3 (2004). Web.

[41] Waldman, Annie. "How Hospitals are Failing Black Mothers." *ProPublica*. 27 Dec 2017. Web.

[42] Creanga, Andreea, Brian Bateman, Jill Mhyre, Elena Kuklina, Alexander Shilkrut, and William Callaghan. "Performance of racial and ethnic minority-serving hospitals on delivery-related indicators." *American journal of obstetrics and gynecology* 211.6(2014): 647.e1-647.e16.

[43] Waldman, Annie. Interviewed by Amy Goodman and Narmeen Shaikh. "Serena Williams Reveals Near-Deadly Birth Experience, Underscoring Growing Risks for Black Mother." *Democracy NOW!,* 11 Jan 2018.

[44] *Stop. Look. Listen! Highlights from To Have and To Hold: Maternal Safety and the Delivery of Safe Patient Care.* New Brunswick, NJ: Rutgers Robert Wood Johnson Medical School, Robert Wood Johnson University Hospital, and the Tara Hansen Foundation, 2013.

[45] *Deadly Delivery: The Maternal Health Care Crisis in the USA.* New York City*:* Amnesty International, 2011. Web.

[46] Meyer, "Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia,"1358-365.

[47] "Subject 290-5-41 Birth Centers." *Rules and Regulations of the State of Georgia.* Georgia State Department of Human Services. Web.

[48] "Georgia Legal Status of Direct-Entry Midwives." *Citizens for Midwifery: Learn, Connect and Take Action*. Georgia Citizens for Midwifery. Web.

[49] "State Fact Sheets." *State Resource Center*. American College of Nurse-Midwives. Web.

2. Insurance access matters for maternal health disparities, and Georgia has made policy decisions that limit the adequacy and consistency of coverage.
(Pages 38-48 of full report)

Healthcare coverage in the form of insurance plays a significant role in determining care within the United States due to the unusually high cost of medical care.[50] Healthcare coverage is particular important for pregnant women as they need appropriate and skilled care at all stages of maternity: prenatal, during childbirth, and after birth.[51]

- **In Georgia, uninsured rates are higher for Black people** (16%) and Hispanic people (30%) than non-Hispanic whites (12%).[52] Overall, Georgia is ranked 50th for health insurance coverage, with the second highest uninsured rate (14%),[53] leaving many without access to healthcare and vulnerable to impoverishment through unexpected medical costs.
- **Medicaid is the primary insurance option** for approximately one-third of all poor non-elderly women in Georgia.[54] Given that Georgia is ranked the 5th poorest state in the U.S.,[55] Medicaid represents a significant source of coverage for poor[56] women of reproductive age.
- **Georgia's decision not to expand Medicaid** under the Affordable Care Act has left 240,000 residents who live between 44% and 100% of the federal poverty level in what is known as the "coverage gap," meaning they earn too much to qualify for Medicaid and too little to qualify for subsidies to purchase individual insurance plans on the health insurance exchanges created by the ACA.[57,58]
- **The coverage gap created by Georgia's decision not to expand Medicaid** includes non-pregnant women of reproductive age who may become pregnant, but do not have coverage that would enable them to receive preconception care, or timely diagnosis and proper management of chronic conditions (such as diabetes and hypertension) that can later influence maternal outcomes.
- **For pregnant women who are eligible** (at or below 220% of the Federal Poverty Line), Medicaid covers prenatal care, care during childbirth, and care for up to 60 days after delivery.[59] However, Georgia's Medicaid program generally only covers parents at or below 133% of the federal poverty level, meaning that many mothers stand to lose Medicaid coverage 60 days post-delivery, and those in the coverage gap who are not eligible for premium tax credits may then be completely uninsured.[60,61] This loss of coverage and resulting disruption of care at 60 days post-delivery is concerning in the context of maternal mortality in Georgia in particular. As noted earlier, Georgia's

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[50] Squires, David and Chloe Anderson. *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries*. New York City: The Commonwealth Fund, 2015. Web.
[51] Ibid.
[52] "Uninsured Rates for the Nonelderly by Race/Ethnicity." *State Health Facts.* The Henry J. Kaiser Family Foundation, 2016. Web. 23 Apr. 2017.
[53] "Health Insurance Coverage of the Total Population." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.
[54] "Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL)." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2017. Web. 24 Apr. 2017.
[55] 18% of the population lives below the federal poverty level. (See, "Poverty Rate by Race/Ethnicity." *State Health Facts.* The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.)
[56] "Under 100% of the federal poverty line (FPL). (See, "Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL)." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2017. Web. 24 Apr. 2017.)
[57] Garfield, Rachel and Anthony Damico. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid." *Kff.org*. The Henry J. Kaiser Family Foundation, 1 Nov. 2017. Web. 24 Apr. 2017.
[58] "The Georgia Health Care Landscape." *Health State Facts.* The Henry J. Kaiser Family Foundation, 2015. Web. 24 Apr. 2017.
[59] "Medicaid FAQs." *Georgia Gov*. Georgia Department of Community Health, 2017. Web. 24 Apr. 2017.
[60] Ibid.
[61] *Many Working Parents and Families in Georgia Would Benefit from Extending Medicaid Coverage.* Washington, DC: Georgetown University Health Policy Institute Center for Children and Families, 2015. Web.

Department of Health only counts deaths occurring 42 days post-pregnancy, but CDC/ACOG guidance recommends monitoring for death for up to a year.[62,63]

3. Georgia's current policies on funding (from both public and private sectors) are implicated in its profile on maternal health. *(Pages 49-55 of full report)*

Georgia has relied heavily on the federal government to fund its public health programs, particularly for low-income citizens. Federal funds in total make up $13.7 billion (31%) of the $43.7 billion 2017 Georgia State Budget;[64] federal funding specifically for health services accounts for 20% of the state's total spending.[65]

- **The United States Department of Health and Human Services** (HHS) has historically been the major federal funder of women's health services in Georgia, but state disbursal of these funds has been variable.[66]
    - **The Georgia Department of Public Health (GDPH) administers Title V grants,** which are an important, but limited, stream of HHS funding for maternal health services. Only 2 of the 10 state programs that receive Title V funding are related to maternal health.[67] Pregnant women were only 5.8% of individuals served by Title V funds in Georgia in 2014.[68]
    - **Title X,** a federal grant program focused on family planning and related preventative services, is the other major HHS funding stream for maternal health.[69] Notably, in 2014, HHS granted a three-year Title X grant to a coalition led by a Georgian community health center consortium and not the traditional recipient, GDPH.[70]
- **Medicaid made up nearly half** ($6.6 billion or 49%) of all federal funding to Georgia in 2015.[71] Cuts in state funds for a particular service area, like reproductive health care, can lead to a corresponding cut in federal funding.[72]
- **Crisis pregnancy centers (CPCs) are financially supported through a state fund** and administered by the GDPH.[73] CPCs purport to provide alternatives to abortion, but often provide misinformation around abortion risks and contraceptives and rarely have staff with medical training or licensure.[74, 75]

State Comparison: While it is challenging to isolate a relationship between funding and maternal outcomes, Texas reported a near doubling in its maternal mortality rate following the 2011 decision by the state legislature to remove two-thirds of the budget for its state family planning program and drastically reduce its number of women's health clinics.[76]

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[62] "Pregnancy Mortality Surveillance System." *Reproductive Health.* Centers for Disease Control and Prevention, 2017. Web. 5 Oct 2017.
[63] *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report*. Austin: Texas Department of State Health Services, 2016. Web.
[64] Sweeney, Timothy. *Georgia Health Budget Primer for State Fiscal Year 2017 - Georgia Budget and Policy Institute.* Atlanta: Georgia Budget and Policy Institute, 2016. Web.
[65] Ibid.
[66] *Best Practices Technical Assistance Replication Project.* Association of Maternal & Child Health Programs (AMCHP), 2016. Print.
[67] Ibid.
[68] *Georgia State Snapshot FY 2016 Application / FY 2014 Annual Report: Title V MCH Block Grant Program*. Atlanta: Department of Health and Human Services, 2016. Web.
[69] "About Title X Grants." *HHS.gov.* US Department of Health and Human Services, 31 Aug. 2016. Web. 27 Sept. 2017.
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[73] Georgia State. Senate. SB. 308. Atlanta: Georgia State Government, 2016. *Georgia General Assembly Legislation*. Web. 12 Apr. 2017.
[74] Rosen, Joanne. "The Public Health Risks of Crisis Pregnancy Centers." *J of Perspectives on Sexual and Reproductive Health* (2012): 201-205. Web.
[75] Ibid.
[76] MacDorman, Marian et al. "Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues." *Obstetrics & Gynecology* 128.3(2016): 1-9. Web.

4. Georgia's maternal mortality review committee, while meeting national minimums for competency, nonetheless does not accomplish basic tasks critical to meaningful investigation and intervention into maternal deaths.

(Pages 56-66 of full report)

State-level maternal mortality review committees (MMRCs**)** occupy a critical role in understanding and building accountability measures to facilitate change in racial disparities and maternal mortality. When well designed and functional (as rights obligations demand, and best practices nationally and within the U.S. demonstrate), MMRCs can carry out on-the-ground inquiries on incidences of maternal death, develop case-level context-specific narratives in addition to raw data, and help create policies that respond to state-specific needs.[77,78] National CDC standards identify 5 minimum tasks for a MMRC, all procedural.[79]

In 2013, the Georgia State Legislature passed SB 273, creating a MMRC housed in the GDPH that meets the minimum CDC procedural requirements: it is supposed to review cases of maternal death annually and create recommendations for the legislature and health providers.[80] While Georgia's MMRC meets these minimums, it has failed to meaningfully build capacity or demonstrate interventions that can affect maternal death.

- **The Georgia MMRC has released only one report to date:** in **2015,** it released a case review of the 25 pregnancy-related deaths and 60 pregnancy-associated deaths that occurred three years earlier, in **2012.** [81] No explanation was provided regarding the significant time delay in reporting, nor is information available on if and when the next case review will be released.
- **Critical data and factors relevant to understanding maternal death are missing** from the cases in the report, indicating that while the committee can identify some cases, it lacks forensic and research capacity, funding, and/or effective processes to collect meaningful information.
- **Ownership over the MMRC is not clear.** The GDPH has contracted out many of its key responsibilities and remains unresponsive to legislative and community outreach.
- **Because of a lack of transparency,** it is not possible to evaluate the membership of Georgia's MMRC, as there is no published list of members or publicly available process through which members are recruited. The MMRC also does not maintain regular public communications.
- **The lack of transparency stems in part from excessive legal protections in the enacting statute**. SB 273 makes all proceedings and activities confidential,[82] signaling a failure to balance appropriate protections for investigations with practices upon which practical and publicly accessible policy reform can be based.
- **The committee uses a narrow medical lens** and does not consider the impact of social determinants of health on mortality nor the drivers of the racial disparities in maternal death.
- **There is no established plan for recommendations** from the case review to be implemented or evaluated. The report lacks mechanisms for accountability.

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[77] Brantley, Mary, David Goodman, Abigail R. Koch, Michael Kramer, Kristin Lieu, Kathryn Mishkin, Jessica Preslar, Amy St. Pierre, Avae Thomas, and Julie Zaharatos. *Report from Maternal Mortality Review Committees: A View into Their Critical Role.* Atlanta: CDC Foundation, 2017. Web.

[78] Callaghan, William. Personal Interview. 15 Mar. 2017.

[79] "2017 Overview of Maternal Mortality Review Committees." American College of Obstetricians and Gynecologists., 2017. Web.

[80] Georgia State. Senate. SB. 273. Atlanta: Department of Public Health, 2014. *Georgia General Assembly Legislation*. Web.

[81] Lindsay, "Georgia Maternal Mortality: 2012 Case Review."

[82] Georgia State Cong. Senate. SB. 273. Atlanta: Department of Public Health, 2014. *Georgia General Assembly Legislation*. Web.

5. Religious communities in Georgia could play a key role in addressing maternal racial disparities. *(Pages 67-71 of full report)*

The role of religious communities, and specifically Christian groups, as factors that influence sociopolitical landscapes is complex and often contradictory, particularly in the domain of gender and sexual and reproductive health. Religious claims have been used to both restrict and uphold women's rights and freedoms around sexuality and reproduction. This report explores the potential for transparent and equal partnerships with accountable religious leadership as a potential opportunity to strengthen social- and environmental-pathways associated with improvements in maternal health outcomes.

- **In Georgia, 79% of adults identify as Christian,** with Protestant denominations holding a majority within the Christian population.[83,84]
- **The Black Church[85] maintains a high level of influence within the Black community** and has been recognized for its potential to be responsive to the needs of its community members, promote and deliver relevant resources, and promote social justice in talk and practice.[86,87]
    - **Recognizing the health disparities that impact their communities,** many pastors from Black Churches have supported programs to improve health outcomes for Black people.[88] The success of these programs can be tied to the churches' existing role in providing social services,[89] communal trust of the institution,[90] and the social support found within the congregation.[91]
- **In Georgia, a number of churches have adopted health ministries** in many differing forms, as part of their larger ministerial outreach. One example of a health ministry in Georgia that has taken hold on both a denominational and local level is HIV/AIDS ministries.
    - **Additional research is needed** to understand how and such programs could be harnessed to include maternal health and provide outreach to pregnant women.
    - **Religious leaders may choose to mediate** linkages between individuals and health systems and advocate for more effective and accessible frameworks of comprehensive care, though there is potential for resistance within some churches to engage with issues surrounding reproductive justice, abortion services, and/or sexuality.

[83] Lipka, Michael, and Benjamin Wormald. "How Religious Is Your State?" *Fact Tank: News in the Numbers*. Pew Research Center, 29 Feb. 2016. Web. 1 Apr. 2017.
[84] Ibid., 2.
[85] For the purposes of this paper the "Black Church" refers to churches with predominantly Black congregations. This does not refer to a specific Christian denomination but can encompass Historical Black Protestant groups as well as more contemporary Pentecostal and Evangelical groups with a majority Black population.
[86] "Black Congregational Development." *Ethnic Ministries*. The North Georgia Conference of the United Methodist Church. Web. 1 Apr. 2017.
[87] Camara, Jeremiah. *Holy Lockdown: Does the Church Limit Black Progress?* Stone Mountain, GA: Twelfth House, 2004. Print.
[88] Rowland, Michael L., and E. Paulette Isaac-Savage. "As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church." *Journal of Religion and Health* 53.4 (2014): 1091-101. Web. 1 Apr. 2017.
[89] Johnson, Byron. *The Sociological Study of Faith-Based Communities and Their Activities in Relation to the Spiritual Idea of Unlimited Love*. Institute for Research on Unlimited Love Altruism, Compassion, Service. Philadelphia: University of Pennsylvania, 2002. Web.
[90] Giger, Joyce Newman, Susan J. Appel, Ruth Davidhizar, and Claudia Davis. "Church and Spirituality in the Lives of the African American Community." *Journal of Transcultural Nursing* 19.4 (2008): 375-83. Web. 1 Apr. 2017.
[91] Holt, Cheryl L., Laura A. Lewellyn, and Mary Jo Rathweg. "Exploring Religion-Health Mediators among African American Parishioners." *Journal of Health Psychology* 10.4 (2005): 511-27. Web. 1 Apr. 2017.

CONCLUSIONS AND RECOMMENDATIONS

This report attempts to identify areas in which state-level action or inaction in Georgia has influenced its high maternal mortality ratio and the racial disparities within it. The Georgia legislature, in particular, has the responsibility to ensure an adequate level of health care for all of its citizens, not differentially distributed according to race.

Addressing the crisis of maternal mortality in Georgia will require concerted effort, political action, and a reframing of the issue. As an alliance of organizations, researchers, and activists, the reproductive justice movement might consider pursuing a strategy that involves advocating with relevant actors (state, county, municipality as well as community actors and as appropriate the federal government) to achieve the following recommendations.

Access to, Quality of, and Research and Monitoring of Care for Pregnant Women

State Entities:

- Evaluate the quality (including the medical and scientific accuracy, ethics, and appropriateness) of counseling and services advertised and offered by Crisis Pregnancy Centers to ensure that all pregnant women are receiving evidence-based health information from qualified personnel
- Expand the role of patient navigators and the availability of referral services from local Department of Public Health offices; (perhaps considering the constructive role of Black churches if committed to comprehensive care) [can also happen at level of municipalities]
- Create, fund, and monitor structures at all levels with a mandate to ensure that current and future health practitioners in Georgia receive comprehensive training and education on the relationship between health and inequity. The goal is to build structural competency and cultural humility within care systems, as well as to equip providers with tools to combat structural and individual barriers to quality, accessible, and equitable care within their practices [State and private health professional schools such as nursing, medicine, public health, etc.; professional associations, etc.]
- Improve the scope, reach and content of locally accessible public health information on women's health, including specific features of pregnancy: pre-natal care, termination of pregnancy, safe maternity and delivery, and postpartum continuity of care [public health agencies at the state, county, and municipality levels]
    - Work with local community structures to ensure its effective distribution [in partnership with community-based organizations, NGOs, community organizers]
- Assess the geographic distribution of facilities and ensure that all pregnant women have access to facilities that offer standard and acceptable maternity care and provide (or have transfer capabilities to other centers that provide) care for high-risk patients and during emergencies
- Review and revise legal and other administrative requirements to enable the expansion and availability of service providers and birthing options in the state, including: birthing centers, certified nurse-midwives, doulas, lactation consultants, and other models that provide acceptable maternity care to women when medically advisable given their circumstances
    - Ensure participation of advocates from these service groups as well as affected populations
    - Ensure that these beneficial services are covered by Medicaid and other insurers

- For certified nurse-midwives, review the current collaborative agreement requirement in light of evidence of positive labor and delivery outcomes with midwifery-led care. Consider liberalizing regulatory environment and granting independent practice to certified nurse-midwives with the goal of improving delivery outcomes and expanding provider options and access

- Build commitments from the state and local authorities to work with researchers. While maternal health researchers in Georgia have been active in pursuing targeted policy changes, the legislature is not actively seeking out research on its own: it both claims to require evidence-based research and does not have regular avenues to obtain it, before it will take action. The Georgia Department of Public Health could serve as a valuable facilitator between researchers and legislators

Insurance Coverage

Federal Government:

- Maintain the ACA at the federal level, with particular attention to the preservation of provisions that support women's healthcare rights, including but not limited to: complete coverage of contraception and contraceptive counseling, preventative services, prenatal care visits, and post-birth care such as breastfeeding support

State Entities:

- Expand Medicaid to cover all individuals up to 138% of the federal poverty level
- Speed the processing of Medicaid applications so that pregnant women do not face delays in receiving coverage
    - Evaluate and consider raising Medicaid reimbursement rates for maternity care to ensure rates are commensurate with other insurance providers and result in appropriate access for people on Medicaid
- Extend the time limits on Medicaid pregnancy benefits to include 1 year of postpartum care for all women postpartum in order to promote continuity of care during the entire time-frame relevant to pregnancy-related deaths as identified by the CDC/ACOG

Funding

Federal Government:

- Continue to provide, and review for adequacy, federal funding of maternal and reproductive health care in Georgia, particularly federally-funded community health centers, Title V, Title X, Medicaid, and WIC funds

State Entities:

- Review current sources and levels of community health center funding to preserve effective state-level support
- Consider restrictions on or elimination of state funding for Crisis Pregnancy Centers if they do not fulfill certain quality of care standards (see recommendation in section on "Access to, Quality of, and Research and Monitoring of Care for Pregnant Women")
- Consult with the Center for Reproductive Health in the Southeast (RISE)[92] to generate new research to better support advocacy around funding

[92] RISE is a center at the Emory University Rollins School of Public Health dedicated to providing new scientific knowledge about the social determinants of reproductive health and finding solutions to adverse outcomes and disparities.

Maternal Mortality Review Committees

Federal Government:

- Strengthen the minimum MMRC standards in the U.S. to be more comprehensive and accountable. This can be achieved through a comparative review of international guidelines and practices, such as (1) the Maternal Death Surveillance and Response guidelines developed by the WHO, or (2) those by the International Federation of Gynecology and Obstetrics – both of which include as fundamentals a multi-frame, continuous cycle of analysis, in addition to the incorporation of medical, non-medical, and systems-level sources of information into maternal death reviews[93, 94]
- Congress should closely examine and considering supporting the *Preventing Maternal Deaths Act*, a bipartisan piece of legislation that proposes the creation of a model for states to conduct maternal mortality reviews and develop appropriate interventions that specifically address quality of care, racial disparities, and systemic problems in healthcare delivery

State Entities:

- Increase transparency and public accessibility of information on the MMRC structure and practices, particularly around membership selection and composition, meeting proceedings, processes for analysis, and timelines for case reviews, while preserving appropriate but limited protections to investigations

  Review and potentially revise the enacting statute (SB 273) so that confidentiality and immunity requirements are balanced with practices upon which practical, transparent, and publicly accessible policy reform can be based

- Adopt a wider lens for MMRC review:
  - Georgia Department of Public Health should redefine its relevant time frame for calculating maternal mortality ratio to match CDC and ACOG guidance, which currently includes pregnancy-related deaths that occurred within 1 year of pregnancy
  - Incorporate equity into case narratives by analyzing drivers of racial disparity and the pathways between social determinants of health and maternal mortality as well as maternal health complications and morbidity
  - Increase funding for the MMRC process to ensure the capacity needed to develop accountability for data collection (e.g. ensure completeness of data and case narratives) as well as the implementation and evaluation of recommendations
- Establish and enforce a mechanism for accountability that ensures that MMRCs are meaningfully involving and prioritizing appropriate community members (such as Black women, women who survived 'near misses,' etc.) in every stage of the process[95]
- Establish and enforce a mechanism for accountability that ensures that recommendations and solutions identified by MMRCs during the review process are properly disseminated, adopted, and implemented by appropriate actors and agencies, and evaluated in a cyclical manner[96]

[93] De Brouwere. "How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Health Professionals."
[94] "Maternal Death Surveillance and Response – Background." *Maternal, newborn, child and adolescent health.* World Health Organization, n.d. Web. 30 Nov. 2017.
[95] The Center for Reproductive Rights is currently working with advocates to create tools that promote the incorporation of human rights principles into MMRC processes.
[96] De Brouwere. "How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Health Professionals."

Religious Outreach

State Entities:

- Explore ways in which religious organizations and leadership, particularly within Black churches, can (in some contexts and when identified by community members) be constitutionally and transparently engaged as local and equal partners in promoting, disseminating, and advocating for quality health education and services
    - Research national denominational beliefs before meeting with faith leaders. This includes understanding the types of programs and health issues, specifically around sexual and reproductive health, that would be effective and accepted by certain denominations and faith communities
    - In addition to researching national denominational policies, hold conversations with community members and leading local clergy to understand localized beliefs and practices and regional variations across Georgia
    - Invest in meaningful relationship-building based on mutual respect and benefit to both partners

Non-Governmental Public Health Organizations, including Reproductive Rights and Justice Groups:

- Engage, as called on by community members, Black churches in political mobilization and advocacy efforts around racialized maternal disparities. Reproductive rights and justice groups can work to partner with local religious leaders to support community-led policy initiatives either through endorsements, lobbying efforts, letters to the editor, or other community-based advocacy strategies

The maternal mortality and maternal morbidity that Black women experience drives the nation's upward maternal mortality trends. In order for maternal mortality in the United States to be adequately addressed, steps must be taken to reduce the disproportionately higher maternal mortality rate of Black women first. Anything less would fail to produce a health care system that sustains the human right to health without discrimination.

APPENDIX A: LIST OF KEY INFORMANTS

Centers for Disease Control and Prevention

William Callaghan, MD, MPH, Director of the Maternal and Child Health branch of the CDC's Division of Reproductive Health

David Goodman, PhD, Senior Scientist with the CDC's Division of Reproductive Health

Julie Zaharatos, MPH, Partnership and Outreach Manager for the CDC Foundation

Victoria Phifer, MPH, Public Health Analyst for the CDC and Former Project Coordinator of the Black Women's Health Imperative

Center for Reproductive Health Research in the Southeast (RISE)

Kelli Stidham Hall, PhD, MPhil, MS, Founding Director of RISE

Emory School of Public Health

Michael Kramer, PhD, Associate Professor of Epidemiology

Sherman James, PhD, former Research Professor of Epidemiology and African American Studies

Dabney Evans, PhD, Director of Center for Humanitarian Emergencies and Assistant Research Professor in the Hubert Department of Global Health

Georgia Health News

Andy Miller, MA, CEO and Editor of Georgia Health News

Georgia Maternal and Infant Health Research Group (GMIHRG)

Adrienne Zertuche, MD, MPH, founder of GMIHRG, ObGyn

Roger Rochat, MD, Research Professor in the Hubert Department of Global Health

Andrew Dott, MD, MPH, ObGyn

Meredith Pinto, MPH, Emergency Management ORISE Fellow at the CDC

Pat Cota, RN, MS, Executive Director of the Georgia ObGyn Society

Lauren Espinosa, MD, ObGyn

Save 100 Babies

Fleda Mask Jackson, PhD, MS, Researcher and Founder of *Save 100 Babies*

Policymakers

Representative Park Cannon
Democrat, District 58

Senator Dean Burke
Republican, District 11

Representative "Able" Mable Thomas
Family Matters Working Group

Representative Stacey Abrams
House Minority Leader Democrat, District 89