
WHEN THE STATE FAILS:

Maternal Mortality & Racial Disparity
in Georgia



Yale Global Health Justice Partnership

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Executive Summary

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

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

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.

“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.

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

⁸ Ibid.

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.

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 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.

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.

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

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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. (Pages 24-37)*
 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)*
 3. *Georgia's current policies on funding (from both public and private sectors) are implicated in its profile on maternal health. (Pages 49-55)*
 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)*

Finally, we suggest:

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

What follows is an elaboration of these key points and policy takeaways from our analysis to support the specific recommendations in the final section of this report. While the Executive Summary includes relevant research to support our conclusions and recommendations, we encourage readers to use the complete report 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)**

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

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

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

- **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

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.

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*.

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 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

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.

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

³⁹ Nuru-Jeter, Amani, Tyan Parker Dominguez, Wisdom 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.

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}

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)

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 particularly 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 poor⁵⁶ 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

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.

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.)

“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 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)

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 disbursement 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

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.

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.

- **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

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)

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

⁶⁹ "About Title X Grants." *HHS.gov*. US Department of Health and Human Services, 31 Aug. 2016. Web. 27 Sept. 2017.

⁷⁰ "Georgia Family Planning System." *Georgia Family Planning System*. Family Health Centers of Georgia, Inc., 2014. Web. 14 Apr. 2017.

⁷¹ *Medicaid Capped Funding: Findings and Implications for Georgia*. State Health Reform Assistance Network, 2017. Web.

⁷² Sonfield, Adam. "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health". *Reproductive Health in Crisis*. Guttmacher Institute. Washington, 20 (2017): 39-43. Web.

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 MacDonman, 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.

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.

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.

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

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}

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.

⁸³Lipka, 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.

⁸⁴Ibid., 2.

- **The Black Church⁸⁵ 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.

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.

Introduction: Background and Scope of Research

Maternal Health and Maternal Death: Regression and Racial Disparity in the U.S.

Black women are three to four times more likely to die from pregnancy-related complications than white women in the United States.⁹² Maternal deaths are traditionally measured by reference to a maternal mortality ratio, which compares the number of maternal deaths to the number of successful live births. Today, in the United States, the maternal mortality ratio, deaths per 100,000 live births, is 43.5 for Black women and 12.7 for white women.⁹³ In 1940, when the Centers for Disease Control and Prevention (CDC) began to collect and compile maternal mortality data, Black women were twice as likely to die from pregnancy-related complications as white women.⁹⁴ By 1990, Black women were approximately three times as likely to die from pregnancy-related complications.⁹⁵ The racial divide between the maternal mortality ratios of Black and white women in the United States has steadily widened since the CDC started collecting data and shows few signs of decreasing.

This growing racial disparity is situated in the midst of another startling paradox: worsening maternal mortality overall. Notably, the United States is currently one of only thirteen countries in the world where maternal

mortality is worse now than it was fifteen years ago, placing it outside the patterns in all other post-industrial ‘developed’ countries.⁹⁶ The national maternal mortality ratio has increased from 12 maternal deaths per 100,000 live births in 1990 to 28 in 2013. Racial disparities are magnified by the overall high rates of maternal mortality in the United States. While research shows a substantial decrease in maternal mortality due to conditions such as hemorrhage, hypertensive disorder and amniotic fluid embolism since 1987, recent reports suggest dramatic increases in maternal deaths from cardiovascular conditions, cardiomyopathy, and other medical conditions, which have more than tripled in the last twenty years (Figure 1).⁹⁷

This report acknowledges the increasing contribution of chronic medical conditions (e.g. hypertension, obesity, diabetes) to maternal mortality and morbidity in the U.S. While the increased prevalence of these conditions is often used to shift the responsibility of poor maternal outcomes to women for so-called personal “lifestyle” decisions, it is important to note that globally no parallel rise in maternal deaths has been seen alongside increasing rates of obesity and other risk factors; on the contrary, the global maternal mortality ratio has been on a decline for the past several decades.^{98,99}

⁹² “Pregnancy Mortality Surveillance System.” *Reproductive Health*. Centers for Disease Control and Prevention, 2017. Web. 5 Oct 2017.

⁹³ *Ibid.*

⁹⁴ “Differences in Maternal Mortality Among Black and White Women -- United States, 1990.” *Morbidity and Mortality Weekly Report*. Centers for Disease Control and Prevention, 1995. Web. 24 Apr. 2017.

⁹⁵ *Ibid.*

⁹⁶ *Trends in Maternal Mortality: 1990 to 2015*. Geneva: World Health Organization (WHO), 2015. Web. 24 Apr. 2017.

⁹⁷ Creanga, “Maternal Mortality and Morbidity in the United States: Where are We Now?,” 3-9.

⁹⁸ Hogan, “Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5,” 1609-1623.

⁹⁹ Morton, “The Problem of Increasing Maternal Morbidity: Integrating Normality and Risk in Maternity Care in the United States,” 119-121.

Lifestyle decisions, risk factors, and outcomes are influenced by context-dependent socioeconomic, cultural, and political environments, which in turn are shaped by policy-level decisions.¹⁰⁰ As such, this report focuses on contextualizing risk factors, such as obesity and diabetes, 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.”¹⁰¹

While instances of maternal mortality markedly dropped in the U.S. during the first part of the 20th century, in large part due to general advances in obstetrics and medical care, national improvements plateaued in the 1980s, and have since reversed. The continued rise in preventable and adverse pre-existing conditions that result in maternal death makes clear that many women are not getting the care they need before, during or after their pregnancy.¹⁰² Moreover, the retrogression of the data suggest that women are dying due to policies and practices that have changed in the 21st century. 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.

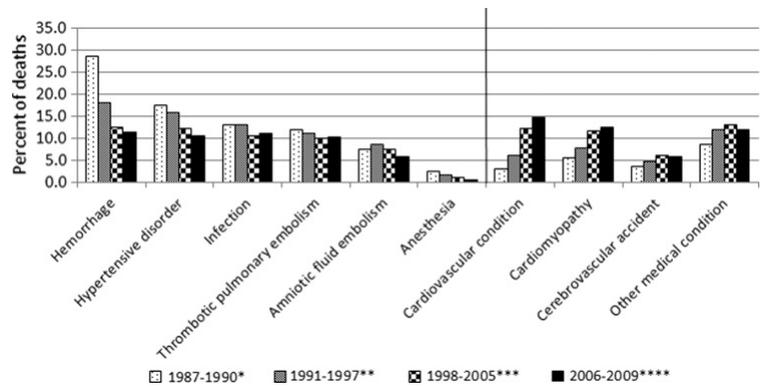


Figure 1: Causes of pregnancy-related mortality in the United States, 1987–2009¹⁰³

*Data from Berg et al., 1996. **Data from Berg et al., 2003¹; ***Data from Berg et al., 2010; **** Data from Centers for Disease Control and Prevention.

Georgia and Maternal Health and Death

In Georgia, the situation for maternal mortality, and the racial disparity within that crisis, is grim. In 2010, Amnesty International flagged Georgia as the state in the United States with the worst maternal mortality.¹⁰⁴ 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.¹⁰⁵ According to the Georgia Department of Health, in 2016, the pregnancy-related maternal mortality ratio was 40.8 per 100,000 live births overall, with disaggregated ratios of 27.1 for white women and 62.1 for Black women.¹⁰⁶

In thinking about the statistical significance of that racial disparity, a 2016 study analyzed pregnancy-related deaths in the state between 2010-2012 according to race and geographical location (rural, non-rural, and

¹⁰⁰ Link, “Social Conditions as Fundamental Causes of Disease,” 80-94.

¹⁰¹ Ibid.

¹⁰² Naderi, Sahar and Russell Raymond. *Pregnancy and Heart Disease*. Cleveland Clinic Center for Continuing Education, 2014. Web.

¹⁰³ Creanga, “Maternal Mortality and Morbidity in the United States: Where are We Now?,” 3-9.

¹⁰⁴ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

¹⁰⁵ *2016 Health of Women and Children Report*. United Health Foundation, 2016. Web. 24 Apr. 2017.

¹⁰⁶ “Maternal Child Health – Maternal Death Query.” Georgia Department of Health Online Analytical Statistical Information System. Web.

Metropolitan Atlanta).¹⁰⁷ In the overall population and in each geographic area, Black women were found to have a higher pregnancy-related mortality ratio (PRMR) than white women (Table 1).¹⁰⁸ The difference in PRMR between Black and white women was statistically significant for all categories, except rural areas, although the small sample size for women in the rural stratum limits the strength of that finding. Moreover, data from the Georgia Department of Health, via their online information system, does suggest a sharp difference in maternal mortality ratio between rural Black and rural white women.¹⁰⁹ For instance, for the year 2015, the system reports that the state's PRMR in rural areas was 78.3 per 100,000 live births for white women and 126.7 for Black women.¹¹⁰ Though no analysis was conducted to test the statistical significance of the difference, these data indicate that an appreciable discrepancy in MMR may exist between Black and white women across the state. While the racialized mortality disparity may persist regardless of geographic location, this report will also seek to highlight when and how the underlying drivers of mortality may differ along lines of geography and race.

Georgia is ranked 50th in terms of the percentage of the population that has health insurance coverage¹¹¹ and 41st for overall health outcomes.¹¹² Notably, Georgia ranks extremely low on excessive drinking, smoking and drug

abuse amongst women, 11th and 12th in the United States.¹¹³

Many observers note Georgia's poor health rankings more likely are a close reflection of the poverty in the state. Nationally, Georgia is the 5th poorest state, with 18% of the population living below the federal poverty level.¹¹⁴ A variety of poor health outcomes in the U.S. are correlated with socioeconomic position, which has "continuous and graded effects on health that are cumulative over a lifetime."¹¹⁵ For example, in Amnesty International's review of the literature, states with high rates of poverty were found to have 77% higher maternal mortality ratios than states with fewer residents below the federal poverty level.¹¹⁶ Poverty in Georgia, as with poverty in the nation as a whole, is also disproportionately concentrated in Black communities and communities of color; there are more Black people (31%) and Hispanic people (27%) living below the poverty line than whites (9%).

One of the outstanding red flags, however, is that racial disparities in maternal health outcomes, particularly between Black and white women, persist even after controlling for poverty, education, and unemployment.^{117,118} Poverty is only part of the equation, as further demonstrated by studies showing that internationally-born Hispanic women with low socioeconomic status have birth outcomes comparable to white infants.¹¹⁹

¹⁰⁷ Platner, Marissa, Tammy L. Loucks, Michael K. Lindsay, Jane E. Ellis. "Pregnancy-Associated Deaths in Rural, Nonrural, and Metropolitan Areas of Georgia." *Obstetrics and Gynecology* 128.1 (2016): 1-8.

¹⁰⁸ Note that PRMR calculations in this study included all pregnancy-related deaths that occurred during or within one year of pregnancy, which differs from the 42-day cut-off utilized by the Georgia Department of Health.

¹⁰⁹ "Maternal Child Health – Maternal Death Query." Georgia Department of Health Online Analytical Statistical Information System. Web.

¹¹⁰ *Ibid.*

¹¹¹ "Health Insurance Coverage of the Total Population." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

¹¹² *America's Health Rankings: Annual Report*. United Health Foundation, 2016. Web. 24 Apr. 2017.

¹¹³ *2016 Health of Women and Children Report*. United Health Foundation, 2016. Web. 21 Aug. 2017.

¹¹⁴ *Poverty Rate by Race/Ethnicity*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

¹¹⁵ "CDC Health Disparities and Inequalities Report: Education and Income." *Centers for Disease Control and Prevention*. 2013. Accessed October 2, 2017.

¹¹⁶ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

¹¹⁷ See, e.g. Chih, *The Colors of Poverty: Why Racial & Ethnic Disparities Persist*.

¹¹⁸ *Severe Maternal Morbidity in New York City, 2008-2012*. New York, NY: New York City Department of Health and Mental Hygiene, 2016. Web.

¹¹⁹ Blumenshine, Philip, Susan Egerter, Colleen J. Barclay, Catherine Cubbin, and Paula A. Braveman. "Socioeconomic Disparities in Adverse Birth Outcomes: A Systematic

As such, while these social factors play an important role, they do not account entirely for the inequities in health status and outcomes between Black and white women. As others have noted, past and present social and economic deprivation, lifelong exposure to racism, institutional discrimination, and contemporary policy decisions must also be taken into consideration when analyzing health risks.^{120,121} Thus, this report seeks to identify some of the current policy and institutional factors that should be considered as state-level policy makers and advocates seek to respond to Georgia’s crisis in maternal health.

Defining Maternal Mortality for this Report

The definition and understand of what constitutes a maternal death has changed over time; this matter for how information is collected and analyzed. In 1870, maternal deaths were generally understood to include only deaths occurring within one month of the end of a pregnancy, by the early 20th century, that time frame was increased to six weeks, or 42 days.¹²²

	Overall	White women	Black women	X ² P* (White vs. Black women)
Overall	26.5 (21.9–32.1)	14.3 (9.9–20.7)	49.5 (38.9–63.1)	<.001
Rural	27.1 (16.9–43.4)	17.4 (8.5–36.0)	22.5 (8.7–57.9)	.746
Non-rural	24.4 (17.4–34.3)	8.0 (3.7–17.5)	27.5 (15.7–48.0)	<.001
Metropolitan Atlanta	27.7 (21.3–36.1)	8.7 (4.2–17.9)	40.1 (27.8–58.0)	<.001

*a P value <.05 was considered significant using Fisher exact test.

Table 1. Pregnancy-related mortality ratio (95% Confidence Interval) for Georgia per 100,000 for years 2010–2012¹²³

Today, although many U.S. and global data are still based on a 42-day standard, key players and experts in reproductive health reject this approach as leading to the undercounting of relevant deaths.

A new standard, initiated in 1987 by the CDC in partnership with the American College of Obstetricians and Gynecologists (ACOG), expanded the scope of maternal death research to one year after the end of a pregnancy (whether as a result of delivery or

Review.” *American Journal of Preventative Medicine* 39.3 (2010): 263–272.

¹²⁰ Dominguez, Tyan, Emily Ficklin Strong, Nancy Krieger, Matthew W. Gillman, Janet W. Rich-Edwards. “Differences in the self-reported racism experiences of US-born and foreign-born Black pregnant women.” *Social Science and Medicine* 69.2 (2009): 258–265.

¹²¹ Jackson, Fleda M., Mona T. Phillips, Carol J. Rowland Hogue, Tracy Y. Curry-Owens. “Examining the burdens of gendered racism: implications for pregnancy outcomes among college-educated African American women.” *Maternal and Children’s Health Journal* 5.2 (2001): 95–107.

¹²² Platner, “Pregnancy-Associated Deaths in Rural, Nonrural, and Metropolitan Areas of Georgia,” 1–8.

termination).¹²⁴ In their 2016 report, the Texas Maternal Mortality and Morbidity Task Force and the Department of State Health Services found that the majority (~60%) of maternal deaths between 2010-2011 occurred post-delivery.¹²⁵ This policy paper takes the position that the correct classification of maternal death should follow the CDC and ACOG standard, as 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 that research suggests are linked to poor health outcomes.

Maternal deaths also are classified based on whether they are pregnancy-related (caused directly by a condition or complication arising from the pregnancy) or pregnancy-associated (occurring within a year of pregnancy, but not caused by the pregnancy itself).¹²⁶

It is important to note that the state of Georgia has not adopted the CDC and ACOG standard in its calculation of the state's maternal mortality ratio. The Georgia Department of Health continues to include only pregnancy-related deaths that occurred during or within 42 days of pregnancy; however, the state's Maternal Mortality Review Committee did analyze deaths that occurred within one year of the end of pregnancy in their 2015 case review.^{127,128}

In addition to maternal mortalities, cases of severe maternal morbidity also raise great concern within a health disparities analysis. For each case of maternal mortality, there are 100 cases of severe maternal

morbidity¹²⁹, often called “near misses” by researchers and providers.¹³⁰ If we understand near misses to track the same racially disparate pathways as mortalities, this also should trigger significant concerns for policy makers. Although this paper focuses on mortality, we encourage readers to keep the connections between unnecessary and preventable morbidity and mortality in sight.

Driving Questions

This report by GHJP is framed by a recognition that racial disparities in maternal health are key components of the unacceptably high rates of maternal mortality and morbidity in the United States. GHJP based the research and policy analysis in this paper on an understanding that law and policy play key roles in creating and remedying many of the conditions that produce inequitable health disparities.¹³¹

Formulating this concern as a question, 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

¹²⁴ Berg, *Strategies to Reduce Pregnancy-related Deaths: From Identification and Review to Action*.

¹²⁵ *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report*. Austin: Texas Department of State Health Services, 2016. Web.

¹²⁶ Ibid.

¹²⁷ “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.

¹²⁸ Lindsay, “Georgia Maternal Mortality: 2012 Case Review.”

¹²⁹ Callaghan, William M., Andreea A. Creanga, and Elena V. Kuklina. "Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States." *Obstetrics & Gynecology* 120.5 (2012): 1029–1036. Web.

¹³⁰ Chhabra, Pragti. "Maternal Near Miss: An Indicator for Maternal Health and Maternal Care." *Indian Journal of Community Medicine* 39.3 (2014): 132-37. Web.

¹³¹ Braveman, Paula and Sofia Gruskin. "Defining Equity in Health." *Journal of Epidemiology & Community Health* 57.4 (2003): 254-58. Web.

ameliorate racial disparities in maternal outcomes?

The Shape of this Report: Frames, Methodology and Scope

When positioned against the simple fact that the United States has the medical knowledge and resources for a woman to give birth successfully, the regressively high rates of death and within them, these racial disparities, represent failures of a state to meet its human rights obligations regarding a right to 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. While a formal international human rights vocabulary may not be useful for generating policy change in Georgia (as state legislatures are not necessarily concerned with whether or not state practices adhere to human rights principles), this paper argues that looking at maternal mortality through a lens of the state’s obligation to uphold a right to health and redress racial inequality within this right can help identify governmental and other targets for advocacy and intervention.

The lens of state obligation and human rights is situated within an intersectional reproductive justice framework. Reproductive justice, a term with a history within Black women’s organizing and continued development across many communities of women of color,¹³² is 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.”¹³³ The reproductive justice framework represents a paradigm shift from reproductive health and

reproductive rights to a more inclusive agenda that intervenes against inequitable power systems, centers marginalized people, and addresses how intersecting identities influence experiences of reproductive oppression.¹³⁴ With its multi-issue analysis, reproductive justice demands conditions that enable women to realize their right to “1) decide if and when she will have a baby and the conditions under which she will give birth, 2) decide if she will not have a baby and her options for preventing or ending a pregnancy, and 3) parent the children she already has with the necessary social supports in safe environments and healthy communities, and without fear of violence from individuals or the government.”¹³⁵

Using this reproductive justice framework that is based on a human rights-influenced idea of state obligation and accountability, we focused on the interconnected ways in which state-level systems fail women, and particularly Black women, thereby contributing both to racial disparities in maternal mortality and to high overall rates of maternal mortality.

The structure of the report came out of findings suggested by 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, we identified four interconnected state-level system failures, listed below, as contributing to maternal health disparities in Georgia.

1. [Access to and quality of care,](#)
2. [Insurance access and pricing,](#)

¹³² *A New Vision for Advancing our Movement for Reproductive Health, Reproductive Rights, and Reproductive Justice*. Atlanta: Asian Communities for Reproductive Justice, 2005. Web.

¹³³ Ross, “What is Reproductive Justice?” 4-5.

¹³⁴ Ibid.

¹³⁵ Ibid.

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 committees.

The role of religious communities, and particularly Christian group, in the U.S. 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. In this report, we specifically consider the landscape and potential engagement of Christian churches in Georgia, primarily those within Black communities. This section considers 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, functioning as a form of informal structural intervention.

This report offers an overview, analysis, and recommendations for action that are specific to these system failures and possible social/structural connections. Together, these sections identify substantive and procedural shortcomings in Georgia-specific policy (often linked to federal policy) that contribute to racial disparities in maternal health outcomes in Georgia, and flag opportunities for change.

The analysis in each of these sections are inter-connected, as both individualized and system failings lead to poor health outcomes, including race- specific inequities in maternal health outcomes. For example, gaps in insurance and funding can lead to inadequate care from providers or inability to access care for pregnant women or new mothers. Collecting and appropriately analyzing adequate data and developing substantive recommendations depends on state awareness

of (and relationships with) communities affected by maternal mortality; religious ones are among the key existing social structures that can respond to gaps in care on both individual and structural levels.

Between February and May of 2017, the GHJP clinic team conducted interviews with 20 key informants in Georgia – most interviews were carried out in-person during two trips to Georgia to meet with key stakeholders. These interviews supported GHJP's drawing attention to the issues in the five sections as well as providing important insights for the analysis in each area. A complete list of key informants, including their institutional affiliation, is attached as Appendix A.

Limitations of this Mapping

This report focuses on maternal mortality in part because it represents a serious rights issue related to maternal health. However, this report's focus on *mortality* also reflects the paucity of research into maternal *morbidity*, despite the fact that more than a third of all women who give birth in the United States experience some pregnancy complication. Maternal mortality can be understood as the tip of the iceberg—death is the most extreme outcome of health inequities affecting thousands of similarly situated women, not all of whom die but all of whom experience health disparities.

Moreover, this report acknowledges that gender operates on a spectrum more complex and fluid than a male/man and female/woman binary. The experiences and concerns of transgender, gender nonconforming, and other gender variant communities with regards to pregnancy and health outcomes are not made explicit in this analysis of racial disparities and maternal mortality. The information and recommendations offered here therefore are largely directed towards people who identify as

women and were assigned the female sex at birth, in part due to the limited scope of this analysis and the data available at present on the situation in Georgia.

Although the strategies explored in this report could potentially lower maternal mortality rates for all women, those that might help eliminate the racial discrepancies in maternal mortality are prioritized. Some strategies, if not reviewed with this critical lens, might be more politically feasible, but likely to ignore or increase racial disparities. This prioritizing approach is consistent with contemporary global health justice practice which notes that many interventions work to improve median health by benefitting only certain parts of the population, leaving the most marginalized untouched.¹³⁶ At the same time, the scope of this project is limited by practical necessity. We recognize that life-long and historical experiences with racism and other systems of oppression shapes health outcomes in myriad ways, only some of which are captured in this mapping. Whether and to what extent a woman is healthy going into and

stays healthy throughout a pregnancy is deeply linked to social and structural stressors, which are in turn created through daily experiences of racism as well as misogyny and classism, a point which many of our informants raised.¹³⁷ However, we have focused the scope of our recommendations on a limited pool of systems and policy changes that affect maternal health outcomes associated with prenatal, delivery, and immediate postpartum care, while recognizing that many other stressors and barriers remain to be identified and addressed.

We hope the focus of this report allows our work to be put in productive coalition with other efforts seeking to reduce or eliminate other social policies and structures affecting maternal health, such as employment policies around parenthood, sex education and access to comprehensive sexual and reproductive health services.

¹³⁶ Freedman, Lynn P., Ronald J. Waldman, Helen de Pinho, Meg E. Wirth, A. Mushtaque R. Chowdhury, and Allan Rosenfield. *Who's Got the Power? Transforming Health Systems for Women and Children. Achieving the Millennium Development Goals.*

New York: UN Millennium Project: Task Force on Child Health and Maternal Health, 2005. Web.

¹³⁷ Bailey, "Structural racism and health inequities in the USA: evidence and interventions," 1453-1463.

Application of *Three Delays* Model to Georgia

Although the United States is one of the world's wealthiest countries in terms of GDP and, in several regards, has a technically advanced medical system, many women, particularly women in poverty and women of color, do not have adequate or equitable access to care.

By applying to the United States context some of the global analytical frameworks developed to understand barriers to maternal health, this section aims to highlight potential strategic priorities for advocates for health and racial justice as they work to address access to, utilization of, and quality of health care. This section first describes the globally utilized *Three Delays* model, then it applies it to the Georgia context. Finally, the section discusses potential high-impact advocacy strategies to target the weaknesses in service provision identified using the *Three Delays* model.

The Three Delays Model

The internationally-recognized *Three Delays* model was originally developed by researchers to better understand the types of barriers that prevent women from accessing quality obstetric care in the developing world.¹³⁸ The model's core insight is that there are three distinct phases that may impact maternal outcomes: when first deciding to seek care, when attempting to reach an adequate healthcare facility, and when receiving care.¹³⁹ Each of these delays can result in health deficits.

The *Three Delays* model, although developed for a non-U.S. context, can still be helpful in thinking about maternal health in the state of Georgia.¹⁴⁰ Politicians often debate how to allocate scarce financial and material resources across the various services and conditions linked to maternal outcomes. The *Three Delays* model can help policy-makers identify the specific needs of their communities and develop multi-faceted responses that recognize the inter-connectedness of the factors contributing to maternal mortality. The *Three Delays* framework also considers and implicates both structural aspects of health care and specific individualized practices and health-seeking behaviors—therefore reinforcing the need for changes at multiple socioecological levels. As long as women face delays in all three identified phases—which in Georgia they (especially Black women) do—any effective maternal mortality prevention strategy must target multiple potential underlying causes (Figure 2).

¹³⁸ Thaddeus, Sreen, and Deborah Maine. "Too Far to Walk: Maternal Mortality in Context." *Social Science and Medicine* 38.8 (1994): 1091-110. Web.

¹³⁹ Ibid.

¹⁴⁰ Some researchers have already begun, applying this model to studying access to prenatal care in rural and semi-rural

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

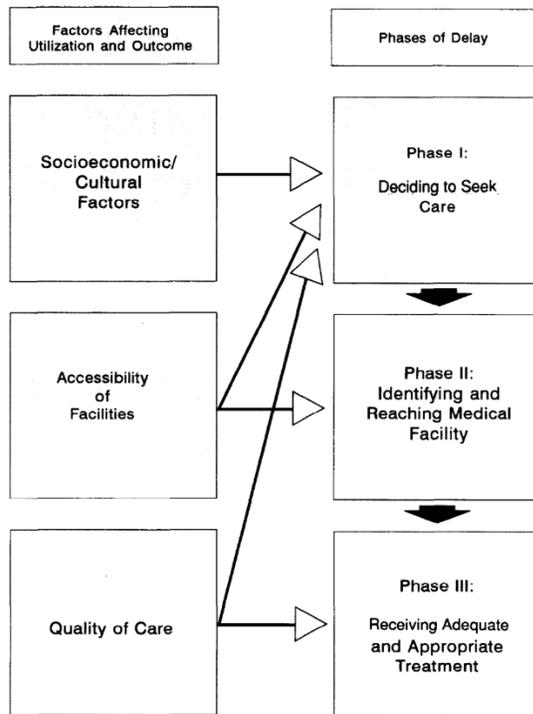


Figure 2: *The Three Delays Model*
 Source: “Too Far to Walk,” Screen Thaddeus and Deborah Maine

First Delay: *Deciding to Seek Care*

Accessing appropriate and good quality prenatal care early on in a pregnancy can help improve birth outcomes for both mother and child.¹⁴¹ Doctors generally recommend that women schedule their first prenatal appointment for approximately six to eight weeks after conception.¹⁴² However, some women may not realize they are pregnant until they are past the first trimester of pregnancy.¹⁴³

¹⁴¹ Chang, Jeani, Laurie D. Elam-Evans, Cynthia J. Berg, Joy Herndon, Lisa Flowers, Kristi A. Seed, and Carla J. Syverson. “Pregnancy-Related Mortality Surveillance — United States, 1991–1999.” *Morbidity and Mortality Weekly Report*. Centers for Disease Control and Prevention, 23 Feb. 2003. Print.

¹⁴² “Guideline Summary: Routine Prenatal Care.” *National Guideline Clearinghouse (NGC)*. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ), 2012. Web.

¹⁴³ Meyer, “Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia”, 1358-365.

¹⁴⁴ *Maternal Health in Georgia*. Black Mamas Matter Alliance and The Center for Reproductive Rights, 2016. Web.

¹⁴⁵ Daniels, Pamela, Godfrey Fuji Noe, and Robert Mayberry. “Barriers to Prenatal Care among Black Women of Low

As of 2010, 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.¹⁴⁴ This pattern is observed nationally, with Black women, as compared to white women, having fewer overall prenatal care visits and being more likely not to initiate care in the first trimester of pregnancy.¹⁴⁵ The Georgia Department of Public Health notes that over 50% of maternal mortality records in the state have significant “missing, unknown, or invalid entries” around prenatal care in particular, making it difficult to characterize if and how often women who died due to pregnancy-related reasons accessed prenatal care.¹⁴⁶

For many women in Georgia, the first step in their process toward seeking care is a positive result from a home pregnancy test.¹⁴⁷ Their next step depends on what they know – and feel empowered to seek – from friends, relatives, popular culture, existing medical advisors,¹⁴⁸ and the internet.¹⁴⁹ Research with Georgia health care providers has found that publicly distributed information on reproductive health is lacking in many communities, and many women do not realize they need – or could have access to – prenatal care.¹⁵⁰ The lack of public information is especially notable if there is not also a robust network of women with childbirth and parenting experience in the community who can pass on advice to younger women.¹⁵¹

There are a number of federal and state government programs available to pregnant

Socioeconomic Status.” *Health Behavior* 30.2 (2006): 188-198. Web.

¹⁴⁶ Lindsay, “Georgia Maternal Mortality: 2012 Case Review.”

¹⁴⁷ Meyer, “Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia”, 1358-1365.

¹⁴⁸ *Ibid*.

¹⁴⁹ Lagan, Briega M., Marlene Sinclair, and W. Georgie Kernohan. “What Is the Impact of the Internet on Decision-Making in Pregnancy? A Global Study.” *Birth: Issues in Prenatal Care* 38.4 (2011): 336-45. Web.

¹⁵⁰ Meyer, “Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia”, 1358-365.

¹⁵¹ *Ibid*.

women, but, in part because of unequal distribution of information, many women may not realize they are eligible to participate. Some county public health offices offer various services designed to reduce this information barrier, such as assistance in applying for Medicaid, referrals to medical care providers who will take their insurance, information about The Women Infants and Children (WIC) Program, and tobacco counseling.¹⁵² However, women without access to an information “hub” in their county have to piece this information together on their own and may miss out on programs that could have helped them during their pregnancy.

It is important to note that women who are aware of pregnancy services may intentionally decide not to seek care given histories of negative interactions with the healthcare system.^{153,154} Experiences of stigma and discrimination, including racism, in clinical settings from healthcare professionals can be a deterrent in seeking care for low-income and non-white racial and ethnic groups.¹⁵⁵ This has been found to be a particularly important factor inhibiting low-income and pregnant Black women in Georgia from initiating prenatal care.¹⁵⁶

One of the consequences of this failure to initiate early care and unequal distribution of information is that women may not recognize, and therefore may not respond to, important warning signs during their pregnancies.¹⁵⁷ Of the 25 cases of pregnancy-related maternal mortality in 2012 that were analyzed by the Georgia Department of Public Health, the leading causes of death were hemorrhage, hypertension, and cardiac disorders.¹⁵⁸ The report analyzing these cases noted that major

contributing factors in these deaths were delays in seeking medical attention by women who were not aware of their risk factors and need for certain treatments.¹⁵⁹

In addition, some women, particularly adolescent women, may delay seeking prenatal care and other services because they feel ashamed of their pregnancies and are stigmatized by their communities, especially if the communities are small, rural, or politically or religiously conservative.¹⁶⁰ Women who may consider an abortion but then end up carrying their pregnancy to term may also delay seeking care.¹⁶¹

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

Once a woman has decided to seek care during her pregnancy, on paper there may be a variety of care providers, but in practice, affordable, accessible, and appropriate options may be limited. Barriers can arise at multiple levels, from the individual to the systemic.

Adequate care for pregnant woman, particularly important in the first trimester, may be provided by family physician, a doctor who practices both obstetrics and gynecology (OB/GYN), a gynecologist who does not practice obstetrics, a hospital-based obstetrician who does not practice gynecology, a nurse practitioner, a physician’s assistant, a maternal-fetal specialist, a certified nurse midwife (CNM), a direct-entry midwife,¹⁶² or a doula.

Over 98% of women who give birth in the U.S. do so in a hospital, but in some states (and with some limitations relative to predicted or diagnosed risks), women may be able to

¹⁵² For example, see “Pregnancy Assistance.” *Services*. Cobb & Douglas Public Health., 2017. Web.

¹⁵³ Daniels, “Barriers to Prenatal Care among Black Women of Low Socioeconomic Status,” 188-198.

¹⁵⁴ Novick, “Women’s Experience of Prenatal Care: An Integrative Review,” 226-237.

¹⁵⁵ *Ibid.*

¹⁵⁶ Daniels, “Barriers to Prenatal Care among Black Women of Low Socioeconomic Status,” 188-198.

¹⁵⁷ Lindsay, “Georgia Maternal Mortality: 2012 Case Review.”

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid.*

¹⁶⁰ Meyer, “Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia”, 1358-365.

¹⁶¹ *Ibid.*

¹⁶² Direct-entry midwives current cannot legally practice in Georgia. See “Georgia Legal Status of Direct-Entry Midwives.” *Citizens for Midwifery: Learn, Connect and Take Action*. Georgia Citizens for Midwifery. Web.

choose to give birth at a birthing center or at home.¹⁶³ As we discuss later, the Georgia legislature has put in place many limitations which add complexity to available birth options--favoring hospitals and doctors over birthing centers, home births and other trained delivery professionals.

In Georgia 17% of white women and 24% of Black women report not having a personal doctor or healthcare provider.¹⁶⁴ Equally important for the health outcomes associated with continuity of care, as well as the overall lack of accessible options, is that standard hospital-based maternity care is often fragmented, meaning that many women do not experience continuity of care between their pregnancy and childbirth and may receive care from a number of clinicians whom they did not elect.¹⁶⁵

Additionally, the reproductive justice framework posits that once a pregnant woman has decided to seek care, the ideal of 'having options' is eclipsed by structural and other barriers to utilizing those options – or, as stated on the SisterSong website, “there is no choice where there is no access.”¹⁶⁶ Thus, it is important to consider prohibitive conditions that limit one’s ability to realize a right, even when choices are available.

Insurance coverage may be one such barrier in accessing healthcare providers. In Georgia, 19% of women overall and 27.6% of women of color are uninsured.^{167,168} Additionally, financing can be a barrier, even when if state policies make insurance formally available. For instance, between 50% and 60%

all births in Georgia are financed by Medicaid.¹⁶⁹ However, for women with Medicaid, their provider choices can be constrained, as not all providers accept Medicaid-funded patients. Even identifying which providers accept Medicaid can be a frustrating, logistical challenge despite the state’s effort to maintain a centralized database. Once a physician is located, it may also be the case that they only see a limited number of Medicaid patients because of the low reimbursement rates (50%-60% the rate of private insurance) and cumbersome reimbursement processes as compared to private insurance.¹⁷⁰ Although reimbursement rates should be updated annually by the Georgia Legislature to keep pace with inflation, between 2001 and 2015, the Georgia legislature failed to make any changes, causing, effectively, a 27% decrease in the reimbursement rate.¹⁷¹ With pressure from advocates, starting in 2015, the Georgia legislature and Department of Community Health have begun to increase Medicaid reimbursement rates by adjusting several medical services codes, including many pertaining to obstetrical-gynecological care, to match Medicare fee schedules, which are still lower than private insurance.^{172,173} Lastly, although Georgia presumes Medicaid eligibility for pregnant women in order to speed them through the enrollment process, it can still take weeks for some women to actually start receiving coverage.¹⁷⁴

Black women may be disproportionately impacted by these challenges in receiving and utilizing Medicaid coverage; examining 2011

¹⁶³ Andrews, Michelle. “Struggling Rural Hospitals Close Labor and Delivery Units.” *PBS*. Public Broadcasting Service, 23 Feb. 2016. Web. 5 Apr. 2017.

¹⁶⁴ “State Profiles for Women’s Health.” *Women’s Health Policy*. The Henry J. Kaiser Family Foundation, 2015. Web.

¹⁶⁵ Novick, “Women’s Experience of Prenatal Care: An Integrative Review,” 226-237.

¹⁶⁶ Ross, Loretta. “What Is Reproductive Justice?” *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*. 2007. Web.

¹⁶⁷ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

¹⁶⁸ “State Profiles for Women’s Health.” *Women’s Health Policy*. The Henry J. Kaiser Family Foundation, 2015. Web.

¹⁶⁹ Zertuche, “Georgia’s Obstetric Care Shortage.”

¹⁷⁰ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

¹⁷¹ Zertuche, “Georgia’s Obstetric Care Shortage.”

¹⁷² Zertuche, Adrienne D., Bridget Spelke, Zoe Julian, Meredith Pinto, and Roger Rochat. “Georgia Maternal and Infant Health Research Group (GMIHRG): Mobilizing Allied Health Students and Community Partners to Put Data into Action.” *Maternal and Child Health Journal* 20.7 (2016): 1323-332. Web.

¹⁷³ *Public Notice: Medicaid Physician Rate Increase for Obstetrical-Gynecological Care*. Georgia Department of Community Health, 2017. Web.

¹⁷⁴ Pinto, “Bridging the Gaps in Obstetric Care,” 1349-357.

Medicaid enrollment in Georgia by race, Black people are overrepresented, constituting 47% of all Medicaid recipients but only 30% of the general population.¹⁷⁵

Community health centers (CHCs), also classified as federally qualified health centers,¹⁷⁶ also play a key role. Funding for CHCs can come from both state and local grants as well as the federal government under section 330 of the Public Health Service Act.¹⁷⁷ Georgia has a number of CHCs supported by these funding streams, including nearly 200 federally-funded service delivery sites, primarily in medically underserved areas of the state, all of which offer prenatal care and accept patients covered by Medicaid.^{178,179} While CHCs represent an important source of primary healthcare and culturally competent social services for many marginalized populations, including non-white racial and ethnic groups and people who are uninsured, homeless, and on Medicaid, their potential is often constrained by workforce and funding shortages.¹⁸⁰ Moreover, by design, CHCs are focused on providing primary healthcare, not specialized care, which means they are often not an adequate replacement for specialty healthcare providers who are specifically trained to attend to complications among a diverse pool of pregnant women.¹⁸¹ Though CHCs are well-situated to deliver care early in pregnancy and provide referrals to higher

levels of care when needed, they often encounter difficulties in securing these specialty referrals because of geographic isolation and increases in the number of providers who do not accept uninsured patients or those on Medicaid.¹⁸²

As will be discussed further in the section on maternal health funding, the state of Georgia also provides funding for Crisis Pregnancy Centers (CPCs) using taxpayer funds.¹⁸³ One major coordinator of CPCs, Georgia Right to Life, describes these centers as places that can help women with “free pregnancy services” and “sort[ing] out their options.”¹⁸⁴ With their promise of free services and, at times, misleading or false advertising, women may visit a CPC hoping for appropriate medical care and counseling.¹⁸⁵ Unfortunately, although some women may receive some services of limited value, such as free verification of pregnancy (needed for a Medicaid application) or some nominal material support, CPCs are not medical facilities, and generally do not provide accredited medical care or information necessary for accessing comprehensive pregnancy care,¹⁸⁶ including diagnostic testing adequate to address pregnancy-related complications. CPCs generally align themselves with pro-life and evangelical Christian movements, promoting the continuation of pregnancy and paths toward

¹⁷⁵ “Medicaid & CHIP Beneficiaries.” *State Health Facts*. The Henry J. Kaiser Family Foundation, 2017. Web.

¹⁷⁶ To receive the federally qualified health center designation that entitles them to receive special payment rates under Medicare, Medicaid, and the Children’s Health Insurance Program, CHCs must target medically underserved communities and provide a range of sliding-scale primary healthcare services, amongst other requirements (“Community Health Centers.” *Medicaid*. The Henry J. Kaiser Family Foundation, 2009. Web.)

¹⁷⁷ “Community Health Centers.” *Medicaid*. The Henry J. Kaiser Family Foundation, 2009. Web.

¹⁷⁸ “Community Health Center Delivery Sites and Patient Visits.” *State Health Facts*. The Henry J. Kaiser Family Foundation, 2017. Web.

¹⁷⁹ *Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services Medicare Benefit Policy Manual*. Centers for Medicare and Medicaid, 2016. Web.

¹⁸⁰ Adashi, Eli Y., H. Jack Geiger, and Michael D. Fine. “Health Care Reform and Primary Care and The Growing Importance of the Community Health Center.” *New England Journal of Medicine* 362.22 (2010): 2047-2050. Web.

¹⁸¹ Branum, Ian. “The Surprising Things Going on in Community Health Centers.” *GeorgiaHealthNews.com*. Georgia Health News, 05 Apr. 2013. Web. 8 Apr. 2017.

¹⁸² Adashi, “Health Care Reform and Primary Care – The Growing Importance of the Community Health Center,” 2047-2050.

¹⁸³ “State Government: Georgia.” *Naral*. Naral Pro-Choice America. Web.

¹⁸⁴ “Pregnancy Centers.” *Grtl.org*. Georgia Right to Life, 2017. Web.

¹⁸⁵ Bryant, Amy G., Subasri Narasimhan, Katelyn Bryant-Comstock, and Erika E. Levi. “Crisis Pregnancy Center Websites: Information, Misinformation and Disinformation.” *Contraception* 90.6 (2014): 601-605. Web.

¹⁸⁶ *Ibid*.

child birth grounded in anti-abortion ideologies. For women seeking credible prenatal advice and counseling, time spent at CPCs primarily serve as another unnecessary delay to meaningful care. In extreme cases, women may not realize that most CPCs do not have medical professionals on staff, and that they should be independently counseled on their medical risks.

Many of these issues related to finding an appropriate care provider are exacerbated for women in rural parts of the state. When thinking about rural demographics, it is interesting to note that Georgia is one of the states with the highest density of non-metro Black people, which helps explain why the racial composition of the population (~65-70% white and ~25-30% Black) does not vary considerably between metro and non-metro areas.^{187,188} Strikingly, although nearly half of the 130,000 projected deliveries in Georgia in 2015 were expected to occur in rural parts of the state,¹⁸⁹ most of the specialized, as well as the wide range of alternative, care providers are concentrated in the metropolitan Atlanta area.¹⁹⁰

Women who live in rural areas, therefore, may find their options particularly constrained.¹⁹¹ While the state has attempted to strategically locate six designated regional perinatal centers with large, technologically advanced obstetrics departments capable of handling the most high-risk patients,¹⁹² these

centers are not spread geographically equally throughout the state.¹⁹³

Some of the problems affecting rural areas have worsened and show no signs of improving. In 1946, Georgia used matching federal funds from the Hill-Burton Act to construct new hospitals, particularly in rural counties. In the East Georgia region, for example, by 1971, 21 of 24 counties had hospitals that provided inpatient obstetrical care. However, the past few decades have seen significant reductions in these facilities. In the last 21 years, at least 31 Labor and Delivery units in Georgia have been closed, 19 of which were in rural counties.¹⁹⁴ By 2015, only 3 of 24 counties in the East Georgia region had hospitals with inpatient obstetrical services.¹⁹⁵ Today, over 80% of women living in rural areas must travel outside of their county to deliver,¹⁹⁶ a figure that is made all the more startling given studies suggest that longer travel distance is correlated with higher rates of infant mortality¹⁹⁷ and preterm birth.¹⁹⁸ The poor outcomes associated with travel time suggest the need for more strategically placed high-risk and specialized patient services.

Figure 3 is a population-density map produced by the Huffington Post that demarcates rural hospital closures between 2010 and 2017 as well as areas where hospital is accessible within a 30-minute drive.¹⁹⁹

¹⁸⁷ Probst, Janice C., Michael E. Samuels, Kristen P. Jespersen, Karin Wilbert, Suzanne R. Swann, and Joshua A. McDuffie. *Minorities in Rural America*. Columbia, SC: South Carolina Rural Health Research Center, 2002. PPT.

¹⁸⁸ *Demographic and Economic Profile: Georgia*. Atlanta: Rural Policy Research Institute, 2006. Web.

¹⁸⁹ Browne, Paul C. *Current Status of Obstetrics in Georgia 2015*. Augusta, GA: Medical College of Georgia, August University. PPT.

¹⁹⁰ "Best Hospitals in Atlanta, Ga." *Healthcare*. U.S News and World Report. 2016. Web.

¹⁹¹ Browne, Paul C. *Current Status of Obstetrics in Georgia 2015*. Augusta, GA: Medical College of Georgia, Augusta University. PPT.

¹⁹² "Regional Perinatal Centers." *Georgia Gov*. Georgia Department of Public Health, 2016. Web. 2017.

¹⁹³ Ibid.

¹⁹⁴ *Maternal Health in Georgia*. Black Mamas Matter Alliance and The Center for Reproductive Rights, 2016. Web.

¹⁹⁵ Browne, Paul C. *Current Status of Obstetrics in Georgia 2015*. Augusta, GA: Medical College of Georgia, August University. PPT.

¹⁹⁶ Ibid.

¹⁹⁷ Grzybowski, Stefan., Kathrin Stoll, and Jude Kornelson. "Distance Matters: A Population Based Study Examining Access to Maternity Services for Rural Women." *BMA Health Services Research* 11.1 (2011): 147-154. Web.

¹⁹⁸ *Maternal Health in Georgia*. Black Mamas Matter Alliance and The Center for Reproductive Rights, 2016. Web.

¹⁹⁹ Weber, Lauren, and Andy Miller. "A Hospital Crisis Is Killing Rural Communities. This State Is 'Ground Zero.'" *Listen to America*. The Huffington Post, 22 Sept. 2017. Web. 26 Sept. 2017.

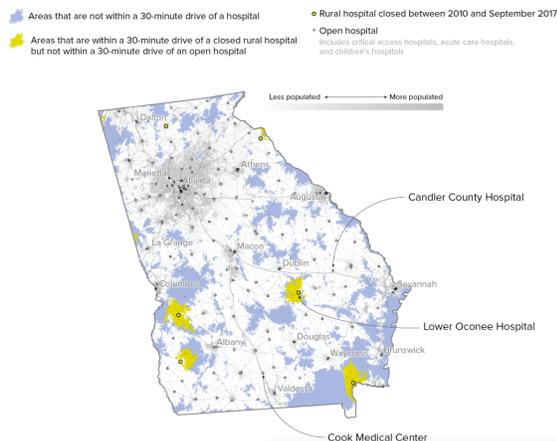


Figure 3: "Rural Georgia's Dwindling Access to a Hospital"²⁰⁰

Source: Cecel G. Sheps Center for Health Services Research at UNC, Center for International Earth Science Information Network, Mapzen isochrones service, Georgia Department of Community Health.

Georgia's rural care deficit is mirrored elsewhere in the country. One study estimated that 179 rural counties nationally lost hospital-based obstetric services between 2004 and 2014, even though over 98% of women in the United States give birth in a hospital.²⁰¹

The concerns faced by urban hospitals, such as low Medicaid reimbursement rates, are often amplified in rural hospitals due to demographics. While the metro areas of Georgia have higher absolute numbers of Medicaid enrollees, rural counties have higher proportions of their populations on Medicaid (20-30+% in some rural counties vs. 10-20% in most Metro-Atlanta counties).²⁰² Compounding the reimbursement issue, obstetric units also have high fixed costs, especially when they are operated to the

standards necessary to provide the signal functions of emergency obstetrical care (EmOC), which keep women alive and healthy in the event of an emergency intervention. Low birth rates in many counties suggest payments (whether Medicaid or private insurance) would not generate enough money to financially sustain the Obstetrics department and may put a financial drag on the rest of the hospital.²⁰³ Obstetric units close, either because clinic or hospital administrators recognize their deficits compared to national guidelines,²⁰⁴ or medical malpractice insurance companies will no longer insure doctors at affordable rates.²⁰⁵ Individual doctors may make similar calculations and, if they are OBGYNs, they may drop their obstetrics practice even while continuing to practice gynecology.²⁰⁶

Unfortunately, other health care providers are not able to fully compensate for a lack of OBGYNs in rural areas. Outside of metropolitan Atlanta, 89% of counties lack a delivering family practitioner, and 70% of counties lack certified nurse-midwives (CNMs).²⁰⁷ Although CNMs, if deployed as independent service delivery professionals, could help alleviate overburdened practices in urban areas, under Georgia law CNMs are not fully autonomous and be supervised by physicians, leading most to deliver only in hospital settings.²⁰⁸ In rural areas without those resources, they cannot take their own patients. In addition, CNMs are highly concentrated in Atlanta. Augusta, Georgia's second-largest city, has only two CNMs, neither of whom deliver babies.²⁰⁹

²⁰⁰ Ibid.

²⁰¹ Macdorman, Marian F., and Eugene Declercq. "Trends and Characteristics of United States Out-of-Hospital Births 2004-2014: New Information on Risk Status and Access to Care." *Birth* 43.2 (2016): 116-124. Web.

²⁰² "Snapshot: Georgia's Medicaid Enrollment and Spending." *Center for State and Local Finance*. Georgia State University Center for State and Local Finance, 2017. Web.

²⁰³ Hung, Peiyin, Katy B. Kozhimannil, Michelle M. Casey, and Ira S. Moscovice. "Why Are Obstetric Units in Rural Hospitals Closing Their Doors?" *Health Services Research*. 51.4 (2016): 1546-1560. Web.

²⁰⁴ "Cesarean Delivery: Resource Overview." *Acoq.org*.

American Congress of Obstetricians and Gynecologists. Web.

²⁰⁵ Andrews, "Struggling Rural Hospitals Close Labor and Delivery Units," 2016.

²⁰⁶ Spelke, Bridget, and Adrienne D. Zertuche. "Obstetric Provider Maldistribution: Georgia, USA, 2011." *Maternal Child Health Journal*. 20.7 (2016): 1333-1340. Web.

²⁰⁷ Zertuche, "Georgia's Obstetric Care Shortage."

²⁰⁸ "Subject 290-5-41 Birth Centers." *Rules and Regulations of the State of Georgia*. Georgia State Department of Human Services. Web.

²⁰⁹ Romain-Lapeine, Fabiola. "Increasing Access to Maternity Care in Rural Georgia Through Public Health Advocacy."

In Georgia and the southeastern United States, health departments and providers have experimented with mobile clinics and home visitation programs, especially for postpartum women and their babies. These programs may prove effective for addressing certain health care needs, but so far, their geographical reach is limited.²¹⁰

All women, no matter where their health care provider is located, can struggle to take time off from work or find childcare so that they can reach medical appointments. These barriers are often more salient for lower-income women whose jobs are less flexible and rural women who must travel greater distances.²¹¹ If providers drop patients because of policy changes on accepting patients with Medicaid, or their offices close altogether, these women often must travel even further and spend more time and money on appropriate health care.²¹² Women with high-risk pregnancies, who may require weekly or bi-weekly ultrasounds or blood tests, may end up making the same difficult trip many times over the course of a pregnancy.²¹³

Third Delay: Barriers in Receiving Adequate and Appropriate Care

Even if a woman can identify and access a care provider, she may not receive adequate or appropriate care. Our research and discussions with key informants suggest powerful structural inequities may affect women, particularly Black women and low-income women, once they reach a care provider.

Black patients often report feeling undervalued, disrespected, and discriminated

against in the healthcare setting.^{214,215} There is a growing body of scholarship linking interpersonal racism, both implicit and explicit, to health factors such as psychosocial trauma, substandard medical treatment from health professionals, and stereotype threats (e.g. stigma of inferiority).²¹⁶ Understanding interpersonal racism and its potential role in Georgia's racialized mortality disparity, however, demands a larger examination of the historical and contemporary systems of structural racism in which interpersonal racism is rooted. According to a 2017 article published in *The Lancet*, structural racism is "the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems [...] that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes."²¹⁷ Structural racism operates in many interrelated domains, from housing and employment to incarceration.

When Black people in the United States experience discrimination from healthcare providers, the negative interaction is compounded by other (often, chronic) racist experiences they may have been subjected to throughout the course of their lives. Research has demonstrated that these kinds of racialized interactions – both interpersonal and at the hands of faceless bureaucracies – can be internalized and exacerbated by legacies of historical injustices.²¹⁸ Moreover, for Black women, racism operates in synergy with misogyny and classism. As such, it is important to flag that many racialized injustices have been enacted in the name of medical practice, and in the context of this report, have been designed

Scholar Works at University of Massachusetts, Amherst. (2015): 1-48. Web.

²¹⁰ Pinto, "Bridging the Gaps in Obstetric Care," 1349-357.

²¹¹ Oller, Beth. "Shutting Rural Labor and Delivery Units Threatens Access, Health." *Fresh Perspectives: New Docs in Practice*. American Academy of Family Physicians, 6 Apr. 2016. Web.

²¹² Meyer, "Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia", 1358-365.

²¹³ Ibid.

²¹⁴ Kaplan, "Racial and Ethnic Disparities in Health: A View from the South Bronx," 116-127.

²¹⁵ Kressin, "Perceptions of Race/Ethnicity-Based Discrimination: A Review of Measures and Evaluation of their Usefulness for the Health Care Setting," 697-730.

²¹⁶ Bailey, "Structural racism and health inequities in the USA: evidence and interventions," 1453-1463.

²¹⁷ Ibid.

²¹⁸ Ibid.

to control the reproductive health and lives of Black women.²¹⁹ During slavery, Black women's fertility was controlled by slave masters, and this practice of reproductive oppression has continued with population-control strategies, such as coercive sterilization, welfare reform, and targeted family planning, that target and harm Black people and people of color.²²⁰ For instance, in the 1970s, federal officials were known to force illiterate Black women on welfare (and their daughters) into "consenting" to sterilization.²²¹

In the U.S., legal segregation reached into health care: many medical accommodations were segregated, and even if not formally 'whites only', were often out of reach for Black Americans, such that in 1946, 87% of white babies and only 46% of Black babies were born in hospitals.²²²

Structural racism compounding historical violations of trust between providers and patients carries present-day material consequences for quality of care and healthcare service delivery. There is a substantial body of research that Black people and people of color receive lower quality and/or intensity of care (including obstetrical) than white patients, even when both groups have the same insurance. Among pregnant women covered by Medicaid, racial and ethnic disparities have been found in the use of every prenatal health service.²²³ Notably, these disparities are largest and most consistent for Black women, who, compared to non-Hispanic white woman, are less likely to

receive services that the woman initiates, discretionary services, and services that might require specialized follow up care.²²⁴ They are also more likely to receive screening for diseases related to high-risk behaviors.²²⁵ Moreover, research has shown that so-called "Black-serving" hospitals have worse delivery-related performance indicators than hospitals with fewer Black patients.²²⁶ In line with this, a recent ProPublica analysis found that women who hemorrhage while giving birth in medical facilities serving disproportionately more Black than white patients were much more likely to experience severe maternal and birth complications.²²⁷ These research suggest an overall lower performance and quality of care at hospitals that predominately serve Black patients.

Other examples of studies on racial disparities in healthcare show that insured Black patients are less likely to receive high-tech (and more costly) interventions like cardiac catheterization, bypass graft surgery,²²⁸ and kidney transplantation.²²⁹ Even for routine, low-stakes care, Black patients are less likely to receive aspirin when they leave the hospital after a heart attack.²³⁰ More information on racial disparities in health care provision needs to be gathered with a gender- as well as pregnancy-specific analytic frame.

Communication between patients and providers is another underappreciated factor that may influence maternal outcomes. Compromised quality of care within healthcare

²¹⁹ CERD*HealthEnvironmentReport*. U.N. Committee on the Elimination of Racial Discrimination, Jan. 2008. PDF.

²²⁰ *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*. University of California, Berkeley, 2007. PHP.

²²¹ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

²²² *Ibid*.

²²³ Gavin, Norma., E. Kathleen Adams, Katherine E. Hartmann, M. Beth Benedict, and Monique Chiereau. "Racial and Ethnic Disparities in the Use of Pregnancy-Related Health Care Among Medicaid Pregnant Women." *Maternal and Child Health Journal* 8.3 (2004): 113-126. Web.

²²⁴ *Ibid*.

²²⁵ *Ibid*.

²²⁶ 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.

²²⁷ Waldman, Annie. "How Hospitals are Failing Black Mothers." *ProPublica*. 27 Dec 2017. Web.

²²⁸ *Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence*. The Henry K. Kaiser Family Foundation & American College of Cardiology, Oct. 2002. PDF.

²²⁹ Klassen, Ann C., Allyson G. Hall, Brit Saksvig, Barbara Curbow, and David K. Klassen. "Relationship Between Patients' Perceptions of Disadvantage and Discrimination and Listing for Kidney Transplantation." *American Journal of Public Health* 92.5 (2002): 811-17. Web.

²³⁰ Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." *The National Academies Press*. Washington, DC: 2003. Web.

settings may 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.^{231,232} Recognizing that providers' inadequate and often dismissive responses to mothers' concerns can lead to serious maternal harm, the Tara Hansen Foundation and Robert Wood Johnson Medical School launched the *Stop. Look. Listen!* campaign targeting healthcare providers.²³³ The campaign advocates for healthcare environments in which women feel safe and encouraged to ask questions, express their concerns, report problems, and in turn, are met with respect and responsiveness from providers.²³⁴ Black women report that they want providers who show an interest in them as individuals, convey information in a clear way, are aware of their body language and are responsive to it,²³⁵ and give them decisional control over their care.²³⁶ Specifically in prenatal care, Black women expressed desires that their prenatal care providers listen attentively, ask thoughtful questions, and understand the context of their lives.²³⁷ Multiple studies have shown that when women trust their providers, they are more likely to follow their recommendations.²³⁸

An analysis of quality of care within the medical establishment must consider how structural racism often interacts with classism

and a patient's real or perceived socioeconomic status. As noted above, over 50% of births in Georgia are financed by Medicaid.²³⁹ The share of the population on Medicaid tends to be highest in rural areas,²⁴⁰ and in certain urban areas such as Atlanta, greater income inequality can mean starker contrasts in the beliefs about patients with private insurance and those without.²⁴¹

Doctors in Georgia have reported belief that patients of lower socioeconomic status are less likely to follow pregnancy education guidelines and refrain from risky behavior.²⁴² They also report, in studies regarding health provider perceptions, their belief that these patients are more likely to arrive to appointments late or miss them altogether, and that because low-income people move frequently and change phone numbers, they can be hard to contact.²⁴³

From the patients' perspective, women living in Georgia who are enrolled in Medicaid sometimes report "feeling less worthy" to use parts of the health care system.²⁴⁴ Doctors will sometimes make patients on Medicaid wait longer for appointments, or schedule them all on one day of the week.²⁴⁵ Women report that their doctors do not take enough time to discuss with them their preferences for delivery and what interventions they want, if any.²⁴⁶ Nationally, organizations like Amnesty

²³¹ 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.

²³² *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.

²³³ *Ibid.*

²³⁴ *Ibid.*

²³⁵ Dale, Helen E., Barbara J. Polivka, Rosemary V. Chaudry, and Gwenneth C. Simmonds. "What Young African American Women Want in a Health Care Provider." *Qualitative Health Research* 20.11 (2010): 1484-1490. Web.

²³⁶ Dahlem, Chin Hwa Y., Antonia M. Villarruel, and David L. Ronis. "African American Women and Prenatal Care: Perceptions of Patient-Provider Interaction." *National Institutes of Health* (2015): 217-235. Web.

²³⁷ Lori, Jody R., Chin Hwa Yi, and Kristy K. Martyn. "Provider Characteristics Desired by African American

Women in Prenatal Care." *Journal of Transcultural Nursing* 22.1 (2010): 71-76. Web.

²³⁸ O'Malley, Ann S., Vanessa B. Sheppard, Marc Schwartz, and Jeanne Mandelblatt. "The role of trust in use of preventive services among low-income African-American women." *Preventive Medicine* 38.6 (2014): 777-785. Web.

²³⁹ "State Profiles for Women's Health." *Women's Health Policy*. The Henry J. Kaiser Family Foundation, 2015. Web.

²⁴⁰ "Snapshot: Georgia's Medicaid Enrollment and Spending." *Center for State and Local Finance*. Georgia State University Center for State and Local Finance, 2017. Web.

²⁴¹ Browne, Paul C. *Current Status of Obstetrics in Georgia 2015*. Augusta, GA: Medical College of Georgia, August University. PPT.

²⁴² Meyer, "Working Towards Safe Motherhood: Delays and Barriers to Prenatal Care for Women in Rural and Peri-Urban Areas of Georgia," 1358-1365. Web.

²⁴³ *Ibid.*

²⁴⁴ *Ibid.*

²⁴⁵ *Ibid.*

²⁴⁶ *Ibid.*

International report that women may feel that they are treated with disdain by health workers who know, or just assume, that they are uninsured or on Medicaid.²⁴⁷

The stress induced by these exposures to oppression carry mental and physical health consequences. Persistent and chronic activation of physiological stress processes arising from negative stereotypes of one's social identities can have a "weathering" effect, meaning increased vulnerability to health risks and accelerated deterioration of body systems.²⁴⁸ In fact, as reported in a 2017 ProPublica and NPR investigation into Black maternal death, research on chromosomal markers of aging indicate that Black women ages 49-55 appear on average 7.5 "biological" years older than white women.^{249,250} Self-reported experiences of racism over the lifecycle 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.²⁵¹ Racism as a social stressor is thought to operate through several different stress pathways, and there is increasing evidence of associations between systems of oppression and the body's stress management systems and biomarkers of disease, such as allostatic load.^{252,253} Moreover, in addition to being correlated with mental health outcomes such as depression and anxiety, chronic oppression can impact the

adrenal system, thereby contributing to conditions such as obesity, hypertension, and diabetes that are connected to poor maternal outcomes.²⁵⁴

A study of pregnancy-related deaths in Georgia (2010-2012) demonstrated that cause of death varied by geographic area.²⁵⁵ Hypertensive disorders of pregnancy (HDP) and hemorrhage were more common causes of death in rural areas as compared to non-rural and metropolitan Atlanta. Specifically, HDP accounted for 29.4% of pregnancy-related deaths in rural areas, but only 3% and 12.7% in non-rural areas and metropolitan Atlanta, respectively.²⁵⁶ Moreover, cardiac causes accounted for 42.4% and 23.6% of pregnancy-related deaths in non-rural areas and metropolitan Atlanta, respectively, compared to only 17.6% in rural areas.²⁵⁷ This stratification of cause of death by location suggests that while the pregnancy-related maternal mortality ratio may be similarly high across all geographic regions, the factors leading to mortality may differ geographically.

A 2015 study of pregnancy-related maternal mortality in California found that hemorrhage and HDP were the two causes of death most linked to healthcare provider and facility-related factors, including delayed provider response to clinical warning signs and inadequate services, equipment, and knowledge.²⁵⁸ Death caused by cardiovascular

²⁴⁷ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

²⁴⁸ 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.

²⁴⁹ Martin, Nina and Montagne, Renee. "Nothing Protects Black Women From Dying in Pregnancy and Childbirth." *ProPublica and NPR*. 7 Dec 2017. Web.

²⁵⁰ Geronimus AT, Hicken MT, Pearson JA, Seashols SJ, Brown KL, Cruz TD. "Do US Black Women Experience Stress-Related Accelerated Biological Aging?: A Novel Theory and First Population-Based Test of Black-White Differences in Telomere Length." *Human nature (Hawthorne, N.Y.)* 21.1 (2010): 19-38. Web.

²⁵¹ Nuru-Jeter, Amani, Tyan Parker Dominguez, Wisdom 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.

²⁵² Bailey, "Structural racism and health inequities in the USA: evidence and interventions," 1453-1463.

²⁵³ McGibbon, Elizabeth and Charmaine McPherson. "Stress, Oppression & Women's Mental Health: A Discussion of the Health Consequences of Injustice." *University of Toronto* 12.2 (2013): 63-81. Web.

²⁵⁴ Ibid.

²⁵⁵ Platner, "Pregnancy-Associated Deaths in Rural, Nonrural, and Metropolitan Areas of Georgia," 1-8.

²⁵⁶ Ibid.

²⁵⁷ Ibid.

²⁵⁸ Main, Elliot K., Christy L. McCain, Christine H. Morton, Susan Holtby, and Elizabeth S. Lawton. "Pregnancy-Related Mortality in California: Causes, Characteristics, and

disease, however, was more strongly related to patient factors, such as delays in seeking care and underlying medical conditions.²⁵⁹ More research is needed to understand the heterogeneity of pathways contributing to maternal mortality in Georgia and how they may operate differently according to factors such as location of residence, race, and class.

Potential Advocacy Strategies in Georgia for Reproductive Justice

Some of the Georgia legislature's most notable advancements to access and quality of health care in recent years have been in the realm of increased access in rural areas. Some of this attention is attributed to the impact of research-based advocacy carried out by the Georgia Maternal and Infant Health Research Group (GMIHRG).²⁶⁰ Action is also enabled by the appeal rural health care has to both sides of the political aisle. Since its recent founding, GMIHRG has focused on generating timely empirical research on factors affecting maternal and child health, presenting its research to both chambers of the Georgia Legislature several times. These efforts have been credited with legislative expansion of eligibility requirements for scholarships and a loan repayment program targeted at doctors willing to serve rural patients.²⁶¹ In partnership with others, GMIHRG also advocated for an increase in Medicaid reimbursement rates for several maternity-care related billing codes for the first time in fourteen years.²⁶²

There are other programs under the legislature's purview relating to maternal

health, with particular relevance for rural areas. For example, legislative decisions govern (and could increase) the number of OBGYNs accepted through the J-1 Visa Waiver Program.²⁶³ Legislators could also review and increase FLEX funding given to support hospitals in rural areas.²⁶⁴ These may be some of the relatively easier issues to advocate for, especially in coalition with the many potentially interested partners including GMIHRG and the Georgia Office of Rural Health.

These changes, while they may help Georgia's maternal health outcomes, primarily address the second delay of accessing and getting to care. To reduce maternal mortality overall and diminish the racial disparity in outcomes, targeting the first phase of deciding to seek care and the third phase of quality of care will also be critical. Reforming medical institutions to combat the structural racism embedded in them, through strategies such as providing critical training and education to health professionals, may lower patient reluctance to seek care and improve quality of care over time.²⁶⁵ Additionally, advocacy for improved access to care should be crafted in ways that also addresses issues unique to urban areas; for example, by pushing for more patient navigators to help women choose between many poorly explained options, rather than working solely to increase the number of options across disparate settings. Patient navigator programs have been in place since around 2014, since the Affordable Care Act was passed, and early studies suggest they are particularly helpful in targeting health disparities.²⁶⁶

Improvement Opportunities." *Obstetrics and Gynecology* 125.4 (2015): 938-47. Web.

²⁵⁹ Ibid.

²⁶⁰ Zertuche, "Georgia Maternal and Infant Health Research Group (GMIHRG): Mobilizing Allied Health Students and Community Partners to Put Data into Action," 1323-1332. Web.

²⁶¹ Ibid.

²⁶² Ibid.

²⁶³ Owens, Charles F. *Presentation on Georgia Department of Community Health*. Statesboro, GA: Georgia's State Office of Rural Health, 11 Feb. 2011. PDF.

²⁶⁴ Zertuche, "Georgia Maternal and Infant Health Research Group (GMIHRG): Mobilizing Allied Health Students and Community Partners to Put Data into Action," 1323-1332. Web.

²⁶⁵ Bailey, "Structural racism and health inequities in the USA: evidence and interventions," 1453-1463.

²⁶⁶ Natale-Pereira, Ana, Kimberly R. Enard, Lucinda Nevarez, and Lovell A. Jones. "The role of patient navigators in eliminating health disparities." *Cancer* 117.15 (2011): 3543-3552. Web.

One change that rural- and urban-focused advocates can work together on is further increasing Medicaid reimbursement rates and changing the rules for when certain services can be charged together. Although GMIHRG successfully advocated for rates associated with certain billing codes to increase, with inflation, those gains will soon be lost. Even with those gains, Medicaid still paid less to doctors than most private insurance companies. Because many doctors in rural areas rely heavily or even almost exclusively on Medicaid-funded patients, increasing Medicaid reimbursement is a priority for rural-health advocates who want to keep rural offices open. However, increasing reimbursement rates may help decrease racial disparities in urban areas as well if doctors become less inclined to exclude patients covered by Medicaid who are not considered to be “cost-effective.” Finally, advocates can work together on changes to Medicaid policies that do not involve merely increasing reimbursement rates. A group in Connecticut, for example, recently advocated for the state to change its guidelines on which billing codes could be used during a traditional postpartum check-up.²⁶⁷ Before their advocacy, doctors could not get reimbursed for offering contraceptive coverage during a postpartum visit, even though early family planning counseling may help women prevent closely-timed pregnancies, a risk factor for poor maternal health.²⁶⁸

Finally, it is worth noting that Georgia’s legal requirements are stricter than

other U.S. states for midwives, home births, and birthing centers, which means that direct-entry midwives cannot legally practice in the state, CNMs can practice but without full autonomy, home births must be done in cooperation with a physician, and birthing centers are tightly circumscribed by extensive regulations and requirements.^{269,270,271} Very few (1-2) operational birthing centers could be identified at the time of writing.^{272,273}

Advocates for reproductive rights and justice have argued for the inclusion of alternative maternity and birth services for multiple reasons. For starters, expanding options allows women greater autonomy in deciding where, how, and with whom they would like to receive maternity care and give birth. Secondly, these options include community models and forms of care that may be more acceptable and can be organized to be medically appropriate to women most at risk of poor maternal outcomes, including Black women. CNM-led care, birthing centers, and doula support are examples of birthing practices that have become increasingly accepted in the medical community over the past several decades, and which several reproductive justice platforms consider vital to ensuring that those who have been marginalized in mainstream medical systems have options that are safe and respectful.^{274,275}

Studies show that doulas can improve quality of care and reduce health disparities by serving as patient advocates, providing culturally and structurally competent services, and bridging barriers between mothers and

²⁶⁷ Nunez Smith, Marcella. “GHJP Presentation to the Equity Research and Innovation Center at the Yale School of Medicine.” Personal Interview. 26 Apr. 2017.

²⁶⁸ Conde-Agudelo, Agustin, Anyeli Rosas-Bermudez, and Ana C. Kafury-Goeta. “Effects of birth spacing on maternal health: a systematic review.” *American Journal of Obstetrics and Gynecology* 196.4 (2007): 297-308. Web.

²⁶⁹ “Subject 290-5-41 Birth Centers.” *Rules and Regulations of the State of Georgia*. Georgia State Department of Human Services. Web.

²⁷⁰ “Georgia.” *Status of Midwives and Midwifery*. Citizens for Midwifery. Web.

²⁷¹ “State Fact Sheets.” *State Resource Center*. American College of Nurse-Midwives. Web.

²⁷² “About Us.” *Atlanta Birth Center*. Atlanta Birth Center. Web.

²⁷³ Ibid.

²⁷⁴ Galewitz, Phil. “Not a Hospital, Not a Home Birth: The Rise of the Birth Center.” *CNN Health*. Cable News Network, 12 Oct. 2015. Web.; Hartocollis, Anemona. “Doulas, a Growing Force in Maternity Culture, Seek Greater Acceptance.” *N.Y./Region*. The New York Times, 10 Feb. 2015. Web.; “My Birth Options: Water Birth, Birth Ball Labor, Doula Childbirth and Special Requests.” *Labor & Delivery*. Missouri Baptist Medical Center. Web.

²⁷⁵ *A State Policy Framework for the Right to Safe and Respectful Maternal Health Care*. Center for Reproductive Rights, 2016. Web.

physician providers.²⁷⁶ Additionally, doulas can improve maternal outcomes via reducing the likelihood of surgical interventions and non-beneficial procedures, which can be medically unnecessary and very costly.²⁷⁷ Similar evidence exists for midwifery-led care, which is when states allow CNMs to practice autonomously, without a collaborative agreement or supervision from a physician who delineates their authority.²⁷⁸ As compared to obstetrician-led care, midwifery-led care has been found to lower odds of cesarean delivery and preterm birth, as well as increase communication and patient-centered care.²⁷⁹ Moreover, states with regulations permitting autonomous CNM practice have nearly doubled the supply of CNMs as compared to states, such as Georgia, with stricter policy requirements. Thus,

liberalizing regulations may also help address access issues in Georgia by ameliorating provider shortages.²⁸⁰

Each of these alternatives must be carefully structured to ensure good and safe practices, as well as the appropriate continuity with more conventional medical support, so that complications that arise can be quickly and effectively addressed by transport and collective responses as needed. The question of ‘decent’ and respectful treatment of women is not automatically fixed by these alternatives: in all cases, appropriate standards of training and evaluation, and methods of accountability to the women most affected must also be included. [See also Recommendations section]

²⁷⁶ *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*. National Partnership for Women and Families, 2016. Web.

²⁷⁷ *Ibid.*

²⁷⁸ Reed, Alyson, and Joyce Roberts. "State Regulation of Midwives: Issues and Options." *Journal of Midwifery & Women's Health* 45.2 (2000): 130-149. Web.

²⁷⁹ Yang, Y. Tony, Laura B. Attanasio, and Katy B. Kozhimannil. "State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes." *Women's Health Issues* 26.3 (2016): 262-267. Web.

²⁸⁰ *Ibid.*

Insurance Access and Maternal Health Disparities

In the United States, insurance access must be addressed, alongside poverty and unequal resource distribution, in connection to the racial disparities that arise in maternal health outcomes. The United States currently stands the only high-income country within the Organization for Economic Cooperation and Development (OECD)^{281,282} without a publicly-financed universal health care system.^{283,284} Access to health care services and coverage itself in the United States is massively fragmented.²⁸⁵ Health care services are covered and provided by a diverse array of state and federally-regulated public and private entities, whose fragmented structure leaves considerable gaps in care.²⁸⁶ Gaps in care unsurprisingly are linked to other gendered and racialized patterns of resource distribution. Thus, insurance access and coverage are central to discussions on maternal health disparities and race.

Health Insurance Types

Among individuals in the United States who have health insurance, 55.7% are insured

through an employer or a union, 16.3% are insured with coverage purchased directly from a private company, 16.3% are insured through the government-sponsored Medicare program, 19.6% are insured through the government-sponsored Medicaid program, and 4.7% receive military health care benefits.^{287,288} Because individuals in the insured groups have the ability to hold multiple types of coverage, there are overlaps. Nationwide, the uninsured rate is 9.1% and approximately 29 million people are uninsured.^{289,290}

Necessity of Health Insurance and Existing Disparities in Access

Health care 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. On average, medical procedures and medications are considerably more expensive in the United States than in other countries (Figures 4 and 5).²⁹¹

²⁸¹ The OECD is an intergovernmental body of 35 member countries that share a commitment to democracy and the market economy. ("About the OECD." *OECD*. The Organization for Economic Co-operation and Development (OECD). Web. 23 Apr. 2017.)

²⁸² The thirteen high-income countries are Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. (Ibid.)

²⁸³ In a universal health care system, all individuals and communities receive the health services they need without suffering financial hardship. Universal health care includes the full spectrum of essential, quality health services, including health promotion, prevention, treatment, rehabilitation, and palliative care. ("Universal Health Coverage (UHC)." *Media Centre*. World Health Organization, 2016. Web. 23 Apr. 2017.)

²⁸⁴ "United States: International Health Care System Profiles." *International Health Care System Profiles*. The Commonwealth Fund, 2017. Web. 23 Apr. 2017.

²⁸⁵ Ibid.

²⁸⁶ Ibid.

²⁸⁷ Includes TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), as well as, care provided by the Department of Veterans Affairs and the military. (Barnett, Jessica C., and Marina S. Vornovitsky. "Health Insurance Coverage in the United States: 2015." *United States Census Bureau*. US Department of Commerce, Sept. 2016. Web. 23 Apr. 2017.)

²⁸⁸ Ibid.

²⁸⁹ Individuals are considered to be uninsured if they do not have health insurance coverage for the entire calendar year. (Ibid.)

²⁹⁰ (Ibid.)

²⁹¹ Squires, "U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries."

With medical technologies steadily advancing and medical costs continually rising, individuals in the United States rely heavily on insurance to be able to afford care.²⁹²

2012 Total Hospital and Physician Cost: Normal Delivery

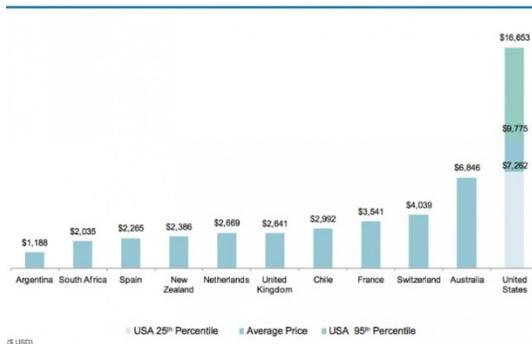


Figure 4: Normal Baby Delivery Cost Comparison²⁹³

²⁹² "Questions and Answers About Health Insurance." *Agency for Healthcare Research and Quality*. US Department of Health and Human Services. Web. 23 Apr. 2017.

²⁹³ Klein, Ezra. "21 Graphs That Show America's Health-care Prices Are Ludicrous." *Wonkblog*. The Washington Post, 26 Mar. 2013. Web. 24 Apr. 2017.

²⁹⁴ Ibid.

²⁹⁵ The US Census report "Health Insurance Coverage in the United States: 2015" does not specifically delineate between the insurance rate of women as compared to men, however the report does speak to the insurance rates for those at varying levels of poverty, with those with higher levels of poverty having lower rates of insurance, and the US Census report "Income and Poverty in the United States: 2015" shows that women (13.4%) are more likely to live in poverty than men (9.9%). (Barnett, "Health Insurance Coverage in the United States: 2015.")

²⁹⁶ Hispanics (16.2%), Blacks (11.1%) and Asians (7.5%) had higher uninsured rates than Non-Hispanic Whites (7%). (Proctor, Bernadette D., Jessica L. Semega, and Melissa A. Kollar. "Income and Poverty in the United States: 2015." *United States Census Bureau*. US Department of Commerce, Sept. 2016. Web. 23 Apr. 2017.)

2012 Total Hospital and Physician Cost: C-Section



Figure 5: C-Section Delivery Cost Comparison²⁹⁴

However, costs associated with the purchase of private insurance prevent many from being able to acquire it. The most recent data from the United States Census shows that women²⁹⁵, various communities of color²⁹⁶, young people of all colors²⁹⁷, unmarried individuals²⁹⁸, individuals with lower levels of educational attainment²⁹⁹, individuals with lower household incomes³⁰⁰ and individuals living below the poverty line³⁰¹ are less likely to be insured, as compared to their counterparts.³⁰²

²⁹⁷ Working-age adults (individuals aged 19 to 64) had a higher uninsured rate (12.6%), when compared with children and older adults. Within that population, individuals aged 26 to 34 were most likely to be uninsured (16.3%). (Ibid)

²⁹⁸ Separated (20.6%), never married (16.8%), divorced (14.9%), widowed (14.2%) individuals, ages 19 to 64 years, had higher uninsured rates than married individuals. (Ibid)

²⁹⁹ Individuals with no-high school diploma (27.6%) and individuals with a high school diploma (15.6%) had higher uninsured rates than individuals with a bachelor's degree (7%) or individuals with a graduate or professional degree (4.8%). (Ibid)

³⁰⁰ Individuals with annual household income of less than \$25,000 (14.8%) had a higher uninsured rate than of individuals with annual household income ranging from \$75,000 to \$99,999 (7.3%) and individuals with annual household income of \$100,000 or more (4.5%). (Ibid)

³⁰¹ Individuals living below 100 percent of poverty had the higher uninsured rates (17.4%), than individuals living at or above 400 percent of poverty line (4.5%). (Ibid)

³⁰² (Ibid)

Insurance Disparities in Georgia

The same insurance trends hold true in Georgia. Black people (16%) and Hispanic people (30%) have higher uninsured rates than non-Hispanic whites (12%).³⁰³ Working age adults³⁰⁴ (19%) have a higher uninsured rate than children (8%) and the elderly.^{305,306} Individuals living below the poverty line (28%) have a higher uninsured rate than individuals living at or above 400 percent of the poverty line (8%), with uninsured rates decreasing as poverty levels decrease.³⁰⁷ In a slight variation, the uninsured rates among women and men between the ages of 18 to 64 are approximately the same in the state.³⁰⁸

Insurance Disparities and Poverty

The differences in health insurance coverage between groups of varying ages, races, genders, socioeconomic statuses, and marital statuses at the national and state levels predict the pervasive inequalities in health care access, which, in turn, significantly impact maternal health. With the before-mentioned astronomical costs of care in the United States, millions rely on health insurance to avoid becoming overburdened and impoverished through unexpected medical costs. Yet, for those already in poverty, health insurance premiums and out-of-pocket costs, like copays, which pale in comparison to the full price for medical procedures and pharmaceuticals, are not financially accessible,³⁰⁹ as families and individuals struggle to afford day-to-day

necessities such as food, clothing, housing and utilities. Those in deep poverty tend to be less healthy than their counterparts,³¹⁰ given that socioeconomic status often influences access to resources, and the cycle of poor health and poverty only continues if they later find themselves in need of care for deteriorating health.³¹¹ As time goes by, worsening health conditions can implode into life-threatening and expensive emergencies that prove to be further impoverishing. Conversely, with health insurance comes access to basic treatment and preventative services that can lead to better health and longevity.

The relationship between poverty and adverse pregnancy outcomes is not linear or direct: in fact, it is often confounded by race and gender, and mediated by a complex array of other factors. These risk factors often interact with one another and include but are not limited to: less access to and utilization of preventative and treatment health care, higher rates of underlying risk factors (e.g. obesity, diabetes, chronic hypertension) for pregnancy-related conditions such as preeclampsia, greater incidences of clinical depression as well as intimate partner violence, and poorer nutritional status during pregnancy.³¹²

Women of Reproductive Age in Poverty

For women of reproductive age, basic treatment and preventative care can serve as a boundary between safe motherhood and maternal mortality or serious morbidity.

³⁰³ “Uninsured Rates for the Nonelderly by Race/Ethnicity.” *Kff.org*. The Henry J. Kaiser Family Foundation, 2016. Web.

³⁰⁴ Working age adults refers to individuals between the ages of 19 and 64. (Ibid.)

³⁰⁵ State specific data was not available, but the most recent national statistics show that the uninsured rate for individuals, age 65 and over, was 1.1%. (Barnett, "Health Insurance Coverage in the United States: 2015.")

³⁰⁶ “Uninsured Rates for Nonelderly Adults by Gender.” *Kff.org*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

³⁰⁷ “Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL).” *Kff.org*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

³⁰⁸ “Uninsured Rates for Nonelderly Adults by Gender.” *Kff.org*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

³⁰⁹ *Financial Condition and Health Care Burdens of People in Deep Poverty*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services, 2015. Web.

³¹⁰ Ibid.

³¹¹ Ibid.

³¹² Nagahawatte, N. Tanya and Robert L. Goldenberg. “Poverty, Maternal Health, and Adverse Pregnancy Outcomes.” *The New York Academy of Sciences*. 1136. (2008): 80-85. Web.

The CDC Foundation, the nonprofit arm of the CDC created by Congress, reported that 59% of pregnancy-related deaths in the United States are preventable.³¹³ Moreover, other research indicates that a higher percentage of pregnancy-related deaths are preventable for Black women than for white women.³¹⁴ Those that cannot be prevented or predicted can, for the most part, be treated by appropriate emergency obstetrical care.

However, if not properly managed, pre-existing complications often become worse during pregnancy.³¹⁵ Thus, women need appropriate care at all stages of maternity: they need prenatal care, which among other things would do the work of assessing complications and the risks of a variety of conditions; skilled care during birth, including care that manages complications known in advance or responds appropriately to complications that arise during birth; and care after birth, including managing complications associated or resulting from the pregnancy and child birth itself.³¹⁶ Care at all stages should be accessible through adequate health insurance. Note that insurance and care are needed before, during and after pregnancy: gaps or absences during any of these periods contribute to maternal ill health.

Georgia Health Outcomes

Out of fifty states and the District of Columbia, Georgia has some of the worst indicators related to health insurance coverage,

maternal health, and overall health outcomes. As noted, Georgia also is the 5th poorest state in the United States,^{317,318} and is ranked 50th for overall health insurance coverage, with the second highest uninsured rate (14%).^{319,320} It also bears repeating that Georgia was ranked 48th in 2016 with respect to maternal mortality³²¹ (up from 50th in 2011) and 41st for overall health outcomes.³²² It is notable that the only states with rankings lower than Georgia for overall health outcomes were in the Southeast and Southwest. Black women of reproductive age are some of the most poorly served in Georgia's health care landscape with diminished access to care due to the increased likelihood of being uninsured. An intersectional analysis, considering the impact of being a 'member' of several disadvantaged groups allows us to see the ways that income, sex/gender, marital status, race and educational attainment work together such that poor, single, and less-educated Black women of reproductive age in Georgia are placed in dire health predicaments through the health systems poor response to their maternity.

Insurance Coverage of Women of Reproductive Age in Georgia

Poor³²³ women of reproductive age in Georgia have four main insurance options: coverage through employer plans; through non-group (private purchase) plans³²⁴, military or Veterans Administration, or by the

³¹³ Brantley, *Report from Maternal Mortality Review Committees: A View into Their Critical Role*.

³¹⁴ Berg, J., Margaret Harper, Samuel Atkinson, Elizabeth Bell, Haywood Brown, Marvin Hage, Avick Mitra, Kenneth Moise Jr., and William Callaghan. "Preventability of Pregnancy-Related Deaths: Results of a State-Wide Review." *Obstetrics and gynecology* 106.6(2006): 1228-34. Web.

³¹⁵ "Maternal Mortality." *Media Centre*. World Health Organization, Nov. 2016. Web. 24 Apr. 2017.

³¹⁶ *Ibid*.

³¹⁷ 18% of the population lives below the federal poverty level. ("Poverty Rate by Race/Ethnicity." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.)

³¹⁸ *Ibid*.

³¹⁹ "Health Insurance Coverage of the Total Population." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

³²⁰ *Ibid*.

³²¹ *America's Health Rankings: 2016 Health of Women and Children Report*. Minnetonka, MN: United Health Foundation, 2016. Web.

³²² *Ibid*.

³²³ Under 100% of the federal poverty line (FPL). ("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.)

³²⁴ Non-group plans are plans that have been purchased individually and outside of an employment or public coverage setting (*A 50-State Look at Medicaid Expansion*. Washington, DC: Families USA, Apr. 2017. Web.)

government-sponsored plans such as Medicare, Medicaid and Children's Health Insurance Program (CHIP).^{325,326} Within this latter group, the largest proportion are covered by Medicaid (32%).³²⁷ Note, however that a sizable proportion of this population remains uninsured (42%).³²⁸

Georgia's Medicaid Program

As the primary insurance option for approximately one-third of all poor non-elderly women in Georgia, Medicaid is an incredibly important program in the state. Medicaid is the joint federal and state program that assists individuals with limited income and resources with medical costs.³²⁹ In 1965, it was established through legislation signed by President Lyndon B. Johnson, which also included provisions for Medicare, the government-sponsored coverage program which mostly covers people ages 65 and older and those with certain disabilities.³³⁰ Although Medicaid was initially focused on only low-income individuals, it has grown to include pregnant women of moderately higher income levels, low-income families with children, people of all ages with disabilities and people who need long-term care.³³¹ Medicaid programs are administered by state governments. Georgia's Medicaid program uses federal and state tax money to pay for the medical bills of low-income families and populations that include pregnant women,

women with breast or cervical cancer, foster and adoptive children, non-elderly blind and other persons with disabilities.³³² The entire Georgia Medicaid program is led by the Georgia Department of Community Health.³³³

Coverage eligibility is pegged to an assessment that their income is insufficient to meet the cost of necessary medical expenses. Abortion is not covered by Medicaid unless in instances of life endangerment, rape or incest.³³⁴ Therefore, no post-abortion care is covered. In Georgia, pregnant women and their infants are covered at or below 220% of the federal poverty level.³³⁵ However, pregnant women are only eligible for two months of care after giving birth or miscarriage.³³⁶ This is concerning because 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 (discussed later in this section) who are not eligible for premium tax credits may then be completely uninsured.^{337,338} 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, CDC/ACOG guidance recommends monitoring for death for up to a year, as this extended post-birth period can be critical for accessing lifesaving care, as many pregnancy-related deaths happen after the 42nd

³²⁵ Dual eligible or those with more than one type of government-sponsored coverage are included in this group. ("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.)

³²⁶ *Ibid.*

³²⁷ *Ibid.*

³²⁸ Includes those without health insurance and those who have coverage under the Indian Health Service only. (*Ibid.*)

³²⁹ "History: CMS' Program History" *CMS.gov*. Centers for Medicare & Medicaid Services, 14 Sept. 2017. Web. 24 Apr. 2017.

³³⁰ *Ibid.*

³³¹ *Ibid.*

³³² "Medicaid FAQs." *Georgia Gov.* Georgia Department of Community Health, 2017. Web.

³³³ *Ibid.*

³³⁴ *Ibid.*

³³⁵ *Ibid.*

³³⁶ Under Georgia's Planning for Healthy Babies program, women at or below 211% of the Federal Poverty Line who deliver a very low birth weight baby are eligible to continue receiving coverage for certain types of care for a limited duration of time. See "Planning for Healthy Babies: Eligibility." *Georgia Gov.* Georgia Department of Health. Web.

³³⁷ "Medicaid FAQs." *Georgia Gov.* Georgia Department of Community Health, Web.

³³⁸ *Many Working Parents and Families in Georgia Would Benefit from Extending Medicaid Coverage*. Washington, DC: Georgetown University Health Policy Institute, 2015. Web.

day post-delivery.^{339,340} Yet, there is minimal continuity surrounding pregnancy and post-birth care under Georgia's Medicaid Program.

Approximately 66% of all women in the United States enrolled in Medicaid are in their reproductive years, with Medicaid currently financing about 45% of all births.³⁴¹ About 54% of all births are financed by Medicaid in Georgia.³⁴² Georgia's Medicaid Program plays a major role in the delivery of maternal health care to communities in poverty, and a well-administered program has the ability to monumentally improve overall health outcomes. But research and evaluation make it clear that Georgia's Medicaid program has yet to be fully optimized.

Affordable Care Act Insurance Expansions

In 2010, the Affordable Care Act (ACA) (Public Law 111-148) was enacted by the 111th United States Congress and signed into law by President Barack Obama. The comprehensive health care reform law aimed to make health care more affordable and accessible, while improving overall health outcomes.³⁴³ It had numerous provisions for improving maternal health and alleviating poverty through the provision of insurance,

including the expansion of the Medicaid program.³⁴⁴ Other provisions intended to improve maternal health outcomes included the increase of community health center funding and clinical oversight, the inclusion of a mandated pregnancy, maternity and newborn care essential health benefit³⁴⁵ in all new health plans, setting limits on cost-sharing provisions, establishing an individual mandate, creating health insurance subsidies for the purchase of individual health insurance plans, prohibitions on using pre-existing conditions to deny insurance eligibility, eliminating gender discrimination in coverage, and mandating that preventative health services be completely covered in most health insurance plans.³⁴⁶

When passed, the ACA had the potential to extend health insurance coverage to approximately 47 million non-elderly individuals in the United States, including 1.8 million non-elderly individuals in Georgia, improving health care outcomes for those populations and millions more at low, moderate, and high income levels.³⁴⁷ Since its passage, the law has impacted the nation's overall health outcomes on a significant level, specifically increasing the health and health care access of women of reproductive age.³⁴⁸ The uninsured rate among nonelderly women

³³⁹ "Pregnancy Mortality Surveillance System." *Reproductive Health*. Centers for Disease Control and Prevention, 2017. Web. 5 Oct 2017.

³⁴⁰ *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report*. Austin: Texas Department of State Health Services, 2016. Web.

³⁴¹ "Maternal and Infant Health Care Quality" *Medicaid.gov*. Centers for Medicare and Medicaid Services, 2017. Web. 24 Apr. 2017.

³⁴² "Births Financed by Medicaid." *Kff.org*. The Henry J. Kaiser Family Foundation, 2017. Web. 24 Apr. 2017.

³⁴³ "State Profiles: How Will the Uninsured Fare Under the Affordable Care Act?" *Kff.org*. The Henry J. Kaiser Family Foundation, 2014. Web.

³⁴⁴ *Financial Condition and Health Care Burdens of People in Deep Poverty*. Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services, 16 July 2015. Web.

³⁴⁵ The pregnancy, maternity and newborn care essential health benefit requires maternal health services to be incorporated into all plans sold in the health insurance exchanges created by the ACA, as well as, in all new individual and small group plans sold separately. The pregnancy, maternity, and newborn care

essential health benefits eliminated gaps left by the Pregnancy Discrimination Act and the Medicaid program, even with expansion, to establish a basic standard of maternal care (Sonfield, Adam. *The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes*. Guttmacher Institute, 12 Aug. 2016. Web.). The Pregnancy Discrimination Act requires that health insurance provided by an employer must cover pregnancy related conditions on the same bases as expenses for other medical conditions ("EEOC Compliance Manual: Chapter 3: Employee Benefits." *The US Equal Employment Opportunity Commission*. The US Department of Labor, 3 Oct. 2000. Web.)

³⁴⁶ Simmons, Adelle, Katherine Warren, and Kellyann McClain. *The Affordable Care Act: Advancing the Health of Women and Children*. Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services, 2015. Web.

³⁴⁷ "The Georgia Health Care Landscape." *Kff.org*. The Henry J. Kaiser Family Foundation, 30 Sept. 2014. Web. 24 Apr. 2017.

³⁴⁸ Simmons, Adelle, Katherine Warren, and Kellyann McClain. *The Affordable Care Act: Advancing the Health of Women and Children*. Office of the Assistant Secretary for Planning and

has declined by 5.5%, preventative care has become more common with an estimated 48.5 million women benefiting from preventative services with no out-of-pocket costs and millions of women of reproductive age have gained access to insurance through Medicaid expansion or the individual mandate with cost assistance.³⁴⁹ The national uninsured rate has decline by 4.3%, putting it at its lowest level in U.S. history.³⁵⁰

Although multiple efforts to repeal (or reform and/or replace) the ACA have been introduced since the legislation became law in 2010, none have been successful at time of writing. One of the recent failed repeal bills, the American Health Care Act of 2017 (HB 1628), included the elimination of the expansion of the Medicaid program, the restructuring of the Medicaid program, the allowance of a state mandated work requirement for Medicaid-based assistance, the elimination of the individual mandate, the replacement of ACA health insurance subsidies with limited refundable tax credits, the elimination of cost-sharing subsidies that can be used to lower deductibles and co-pays, the elimination of federal funding for Planned Parenthood, the elimination of funding for the CDC Prevention and Public Health Fund, and the allowance of less comprehensive insurance plans, among other harmful provisions.³⁵¹

The ACA has been the key factor in significant coverage gains and reductions in uninsured rates. Recent studies have also found improvements in self-reported health outcomes following Medicaid expansion, although more research and time is still needed to determine the full effects on health

outcomes in the United States.³⁵² Maternal mortality in the U.S. so far remains high, but the access to care that has been granted by the ACA has led to a surge in care options for women of reproductive age, particularly those in poverty and whose benefits will require further study.

The possible retraction of the community health center funding, essential maternal health benefit, cost-sharing limits, individual mandate, health insurance subsidies, pre-existing condition protections, gender discrimination coverage and preventative health service alliance would not only be negative impacts in themselves, but would likely have a specific detrimental impact on young Black women, particularly those with low socioeconomic status—in part through the collision of multiple new and persisting barriers to care for this population.

More attention to the snowballing potential of these different practices is needed. Moreover, should the ACA be repealed, community health center access will become even more critical for individuals without health insurance.

Non-Medicaid Expansion

Although there have been overall gains in coverage and access and strides in maternal health under the ACA, the results have not been distributed equally, and maternal mortality rates are still too high for a technologically advanced nation that spends more than any other on health care expenses (Figure 6).³⁵³

Evaluation in the US Department of Health and Human Services, 2015. Web.

³⁴⁹ *Financial Condition and Health Care Burdens of People in Deep Poverty*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services, 2015. Web.

³⁵⁰ "Income, Poverty, and Health Insurance in the United States in 2015." *United States Census Bureau*. US Department of Commerce, 2016. Web. 24 Apr. 2017.

³⁵¹ Ridgway, Nicole, and Tami Luhby. "What's inside the Republican Health Care Bill?" *CNNMoney*. Cable News Network, 22 Mar. 2017. Web. 23 Apr. 2017.

³⁵² Antonisse, Larisa, Rachel Garfield, and Robin Rudowitz. *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*. The Henry J. Kaiser Family Foundation, 25 Oct. 2017. Web.

³⁵³ In 2014, the United States spent approximately \$9,024 per capita on health care while the average OECD country spent approximately \$3,620 per capita ("Health Spending."

Continued poor outcomes for low-income women can, at least in part, be attributed to action and inaction at the state level, specifically in regard to Medicaid. With most of the other maternal health provisions in the ACA geared towards women with moderate means who had health insurance or who had the ability to purchase health insurance with some cost assistance, *Medicaid expansion* was intended to directly impact and provide support for low-income women. When Congress passed the ACA, Medicaid expansion was mandatory. All states were required to expand coverage to all individuals making less than 138% of the poverty level or lose federal Medicaid funding.³⁵⁴ However, the Medicaid expansion mandate became optional after a challenge in the U.S. Supreme Court.³⁵⁵ Along with 19 other states, Georgia has not expanded Medicaid (see Figure 7) and there is no substantial Medicaid expansion legislation in progress.³⁵⁶ Although Governor Nathan Deal recently began to reassess the prospect of Medicaid expansion, because of the ongoing national battle over health care reform, there are still no formal plans in place.³⁵⁷

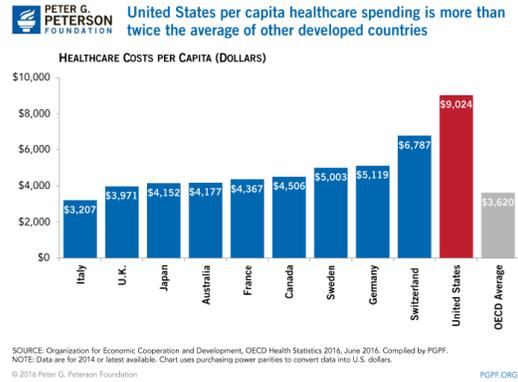


Figure 6: Per Capita Spending Comparison³⁵⁸

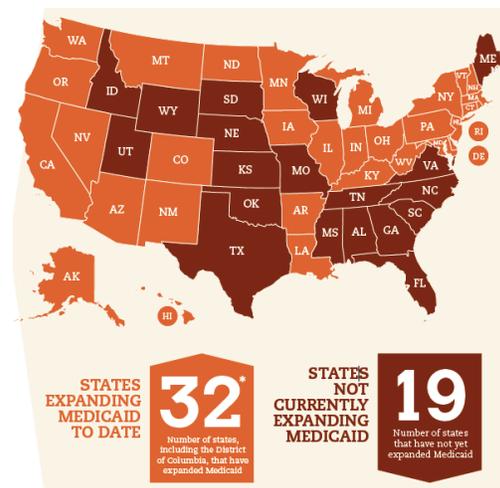


Figure 7: Medicaid Expansion Status Map³⁵⁹

³⁵⁴ The OECD. Organisation for Economic Co-operation and Development (OECD), 2016. Web. 24 Apr. 2017.

³⁵⁵ Musumeci, Mary Beth. *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion*. The Henry J. Kaiser Family Foundation, 2012. Web.

³⁵⁶ "The Georgia Health Care Landscape." *Kff.org*. The Henry J. Kaiser Family Foundation, 30 Sept. 2014. Web. 24 Apr. 2017.

³⁵⁷ Bluestein, Greg, and Misty Williams. "After GOP Health Plan Fails, Georgia Explores Medicaid Changes." *Politically Georgia*. The Atlanta Journal Constitution, 28 Mar. 2017. Web. 24 Apr. 2017.

³⁵⁸ "Per Capita Healthcare Costs - International Comparison." Peter G. Peterson Foundation, 17 Oct. 2016. Web. 24 Apr. 2017.

³⁵⁹ *A 50-State Look at Medicaid Expansion*. Washington, DC: Families USA, Apr. 2017. Web.

As a result of Georgia’s inaction, uninsured adults in the state who would have been newly-eligible for Medicaid have remained without a coverage option. Insurance coverage—and the structural components associated with access to quality care, not merely care—can be understood as comprising one of the social determinants of health. In the U.S., and in Georgia, this resource is inequitably distributed. Moreover, social gradients also matter in complex ways to health (meaning that health outcomes tend to improve with rising socioeconomic position).³⁶⁰ Georgia’s high rates of poverty, as well as its racially disparate distribution of poverty, figures here. Thus, a pairing of Georgia’s low health insurance ranking with poor health outcomes is predictable. In the current climate, neither the state legislature nor the Governor have ensured the minimum with regards to necessary provisions for the most marginalized individuals. If Medicaid were to be expanded, 682,000 additional low-income individuals in the state would be eligible for health insurance coverage and thus access care (Figure 8).³⁶¹ The ten states ranked highest in overall health outcomes have expanded Medicaid programs, while Georgia and more than half of the states ranked below Georgia in health outcomes have not.³⁶² The majority of those non-Medicaid expanding states are in the South (Figure 9).

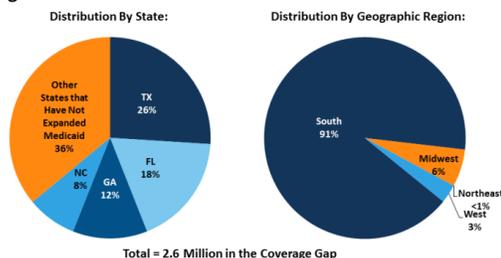
NOT YET EXPANDED

Number of residents who won't gain access to Medicaid and are likely to remain uninsured, in states that have not yet expanded Medicaid



Figure 8: Residents Without Access Without Medicaid Expansion³⁶³

Figure 2
Distribution of Adults in the Coverage Gap, by State and Region



Note: Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.



Figure 9: Geographical Representation of the Medicaid Coverage Gap³⁶⁴

Medicaid expansion has increased access to and utilization of health care across the United States especially within poor communities—the intended beneficiaries.³⁶⁵ Because poverty in Georgia is concentrated among Black communities and communities of color, the expansion of Medicaid in Georgia

³⁶⁰ Marmot, Michael. “Social Determinants of Health Inequalities.” *The Lancet*. 365.9464 (2005): 1099-1104.

³⁶¹ *A 50-State Look at Medicaid Expansion*. Washington, DC: Families USA, Apr. 2017. Web.

³⁶² “Current Status of State Medicaid Expansion Decisions.” *Kff.org*. The Henry J. Kaiser Family Foundation, 2017. Web. 24 Apr. 2017.

³⁶³ *A 50-State Look at Medicaid Expansion*. Washington, DC: Families USA, Apr. 2017. Web.

³⁶⁴ Garfield, “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.”

³⁶⁵ *Medicaid Expansion Impacts on Insurance Coverage and Access to Care*. Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services, 2017. Web. 24 Apr. 2017.

would be especially beneficial to these populations. Black residents have the highest poverty rate in Georgia with 31% living below the poverty line. Hispanic residents have a 27% poverty rate and White residents have the lowest poverty rate at 9%.³⁶⁶

Within those communities of color, Medicaid expansion would have a great impact on women of reproductive age who are considering pregnancy. Notably, this includes poor women, and women who are ‘not poor enough’ to qualify for Medicaid under the present eligibility criteria. Currently, Georgia residents who live between 44% and 100% of the federal poverty level³⁶⁷ find themselves in the Medicaid coverage gap (Figures 10 and 11), as they make 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.³⁶⁸ They are thus often left without viable coverage options. While Georgia’s Medicaid program covers pregnancy care for women living on incomes up to 220% of the poverty line, those non-pregnant women in the ‘gap’ category, who may become pregnant, are left behind. Moreover, mothers who qualified for Medicaid during pregnancy, but lose that coverage 60 days post-delivery, may find themselves completely uninsured if they fall in the coverage gap and are not eligible for premium tax credits.³⁶⁹ In fact, uninsured parents with children in the home account for nearly 30% of the population that would be eligible for coverage if Georgia expanded Medicaid, suggesting that the coverage gap is sizeable.³⁷⁰

The lapses in insurance coverage is significant when considering the rise in chronic conditions and the importance of care for women across the life course, including before and after pregnancy.³⁷¹ Non-pregnant women in the coverage gap may miss opportunities for timely intervention, early diagnosis, and proper management of chronic and other health conditions that shape women’s health and can influence maternal outcomes.³⁷²

As the preceding section on quality of care and maternal health stressed, early and regular prenatal care improves the chance of a healthy pregnancy, which, in turn, improves the likelihood of a healthy birth for woman and child.³⁷³ However, care before pregnancy has many benefits:³⁷⁴ Preconception visits allow women to prepare for pregnancy by minimizing risky behaviors and maximizing positive behaviors in order to reduce overall risk of maternal mortality and morbidity.³⁷⁵ Coverage through Medicaid expansion would allow women, including those in the Medicaid coverage gap, to take advantage of preconception care options, thereby averting many of the detrimental outcomes associated with the *Three Delays* Model.

³⁶⁶ “Poverty Rate by Race/Ethnicity.” *State Health Facts*. The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

³⁶⁷ Garfield, “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.”

³⁶⁸ *Ibid.*

³⁶⁹ *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.

³⁷⁰ *Ibid.*

³⁷¹ Collins, Janet, John Lehnerr, Samuel F. Posner, and Kathleen E. Toomey. “Ties That Bind: Maternal and Child

Health and Chronic Disease Prevention at the Centers for Disease Control and Prevention.” *Preventing Chronic Disease*. 6.1 (2009). Web.

³⁷² “Medicaid FAQs.” *Georgia Gov.* Georgia Department of Community Health, 2017. Web. 24 Apr. 2017.

³⁷³ “What is prenatal care and why is it important?” *Eunice Kennedy Shriver National Institute of Child Health and Human Development*. National Institutes of Health, 2017. Web. 23 Apr. 2017.

³⁷⁴ *Ibid.*

³⁷⁵ *Ibid.*

Figure 1

Gap in Coverage for Adults in States that Do Not Expand Medicaid under the ACA

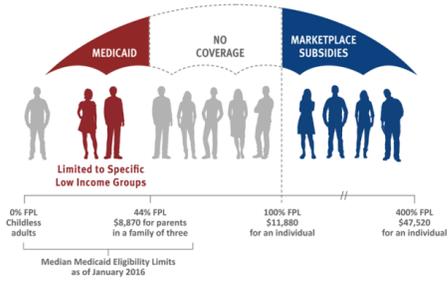
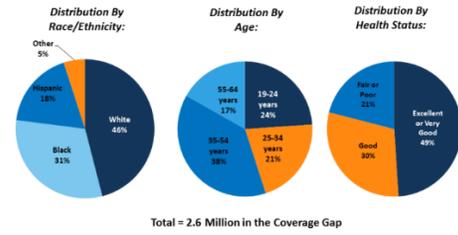


Figure 10: Medicaid Coverage Gap³⁷⁶

Figure 3

Demographic Characteristics of Adults in the Coverage Gap



Note: Totals may not sum to 100% due to rounding. Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.



Figure 11: Coverage Gap Demographics³⁷⁷

³⁷⁶ *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.* The Henry J. Kaiser Family Foundation, 2016. Web. 24 Apr. 2017.

³⁷⁷ Ibid.

Funding for Maternal Health from Public and Private Sectors

Overview of Maternal Health Funding

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, and³⁷⁸ federal funding specifically for health services accounts for 20% of the state's total spending.³⁷⁹ The federal government gave nearly \$4.5 billion in 2017 to the three state agencies³⁸⁰ that deliver the majority of public health services in Georgia.³⁸¹ Although Georgia's reliance on federal funding for its public health programs is not unique, the magnitude highlights the crucial role of federal funding in maternal health outcomes in Georgia, particularly among low-income women.

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 dispersal of these funds has been variable.³⁸² The Title V block grant, in particular, has been an important, but limited, stream of HHS funding for maternal health services. If a state is awarded Title V funds, the federal government provides funds for maternal and child health programs.³⁸³ The state has

significant flexibility to spend this money in a way that they feel best suits their state, so long as it is directed to help women and children.³⁸⁴ In Georgia, the Department of Public Health (GDPH) administers Title V funds. GDPH received \$16.6 million in Title V funds in 2015.³⁸⁵ The majority of Title V funding is currently allocated to 10 state programs.³⁸⁶ Among these 10 programs, only two (perinatal health and family planning) are related to maternal health.³⁸⁷ Pregnant women only made up 5.8% of individuals served by Title V funds to Georgia in 2014.³⁸⁸

The marginal role of maternal health in Title V-funded programs in Georgia may be related to state requirements for Title V funds, which specify that 30% must be spent on children with special health care needs and another 30% must be spent on primary/preventative health services of children.³⁸⁹ These requirements reflect the state of Georgia's decision to assign heightened importance to children's health relative to maternal health in this major federal funding program.

Notably, Title V provides the funding for Georgia's Maternal Mortality Review Committee, a legislatively mandated committee that reviews cases to determine causes of maternal death and provide recommendations

³⁷⁸ Sweeney, Timothy. "Georgia Health Budget Primer for State Fiscal Year 2017." *GBPI*. Georgia Budget and Policy Institute., 20 July 2016. Web. 22 Apr. 2017.

³⁷⁹ *Ibid.*

³⁸⁰ These three state agencies are the Department of Community Health, the Department of Public Health, and the Department of Behavioral Health and Developmental Disabilities.

³⁸¹ Sweeney, "Georgia Health Budget Primer for State Fiscal Year 2017."

³⁸² *Georgia Maternal and Child Health Block Grant 2013*. Washington D.C.: Association of Maternal & Child Health Programs (AMCHP), 2017. Web.

³⁸³ *Ibid.*

³⁸⁴ *Ibid.*

³⁸⁵ *Ibid.*

³⁸⁶ *Maternal and Child Health Services Title V Block Grant: Georgia FY 2015 | Application/ FY 2014 Annual Report*. Atlanta: Georgia Department of Public Health, 2016. Web.

³⁸⁷ *Ibid.*

³⁸⁸ *Ibid.*

³⁸⁹ *Ibid.*

for mortality reduction (for more information about the Committee, see section on State-Level Data Collection and Accountability below).³⁹⁰ In their 2017 Title V grant application, GDPH listed the prevention of maternal mortality as one of their ten priority needs.³⁹¹

Title X, a federal grant program focused on family planning and related preventative services, is the other major HHS funding stream for maternal health in Georgia.³⁹² In 2015 alone, 86,309 Georgians used Title X funds to pay for their family planning services.³⁹³ Of these family planning users, 78% were women and 46% were living under 101% of the Federal Poverty Level.³⁹⁴ 36% of Title X family planning users had an unknown or unreported income level.³⁹⁵

It is important to note that local and regional entities may also apply directly to the Secretary of HHS for the federal family planning services funds, independent of state level Title X requests or funding.³⁹⁶ Notably, faith-based organizations are also eligible to apply for Title X family planning service grants.³⁹⁷ In 2014, HHS granted a three-year Title X grant of \$7.8 million to a coalition led by a Georgian community health center consortium and not the traditional recipient, GDPH.^{398,399} The coalition included Planned Parenthood, the Grady Health System, and Family Health Centers of Georgia, a private group of federally qualified health centers. In

general, this funding decision was supported by many rights advocates who recognized the coalition's ability to deliver family planning services.

The next Title X funding cycle began in 2017, and while GDPH has submitted an application to HHS,⁴⁰⁰ it is possible that grant will be given to the consortium that received funding in 2014, and whose leadership is on the record with strong positions on the importance of reducing not only maternal mortality but also the racial disparities in it, through community health centers and life cycle engagement of services and care.^{401 402}

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is another important federal funding source of maternal health initiatives in Georgia. The program, housed by the United States Department of Agriculture (USDA), provides federal grants to, inter alia, promote maternal health among low-income pregnant and postpartum women in Georgia through health care referrals, supplemental foods, and nutrition education.⁴⁰³ In 2015, the USDA gave \$263.5 million to Georgia WIC and 18,865 pregnant women participated in Georgia's WIC program.⁴⁰⁴

Georgia's health budget also relies heavily on federal funding for Medicaid. Medicaid made up nearly half (\$6.6 billion or 49%) of all federal funding to Georgia in 2015.⁴⁰⁵

³⁹⁰ *Georgia Maternal and Child Health Block Grant 2013*. Washington D.C.: Association of Maternal & Child Health Programs (AMCHP), 2017. Web.

³⁹¹ *Maternal and Child Health Services Title V Block Grant: Georgia FY 2015 | Application/ FY 2014 Annual Report*. Atlanta: Georgia Department of Public Health, 2016. Web.

³⁹² "About Title X Grants." *HHS.gov*. US Department of Health and Human Services, 31 Aug. 2016. Web. 27 Sept. 2017.

³⁹³ Fowler, Christina, Julia Gable, Jiantong Wang, and Beth Lasater. *Title X Family Planning Annual Report 2015 National Summary*. Research Triangle Park, NC: RTI International, 2016. Web.

³⁹⁴ *Ibid.*

³⁹⁵ *Ibid.*

³⁹⁶ *Ibid.*

³⁹⁷ *Ibid.*

³⁹⁸ "Georgia Family Planning System." *FHC Georgia*. The Family Health Centers of Georgia, Inc., 2014. Web. 14 Apr. 2017.

³⁹⁹ The 2014 grant was the first time in the nation that a community health center received funding to administer statewide family planning services (*Ibid.*)

⁴⁰⁰ *Maternal and Child Health Services Title V Block Grant: Georgia FY 2015 | Application/ FY 2014 Annual Report*. Atlanta: Georgia Department of Public Health, 2016. Web.

⁴⁰¹ Miller, Andy. "State Agency Loses Federal 'Family Planning' Grant". *The Pulse*. Georgia Health News, 18 July 2014. Web. 27 Mar. 2017.

⁴⁰² *Ibid.*

⁴⁰³ "Georgia WIC". *Georgia Gov*. Georgia Department of Public Health, 2017. Web. 27 Mar. 2017.

⁴⁰⁴ *Ibid.*

⁴⁰⁵ *Medicaid Capped Funding: Findings and Implications for Georgia*. State Health Reform Assistance Network, 2017. Web.

This amount is above the median among states that chose to not expand Medicaid.⁴⁰⁶ As discussed in the sections above, prenatal and postnatal care are important factors in maternal health, especially for women who are poor and therefore at higher risk for adverse pregnancy outcomes.^{407 408} Thus, Medicaid is an important funding source for helping some of the most vulnerable women in Georgia access services vital for better maternal health outcomes.⁴¹¹

In the Medicaid partnership, Georgia is required to use its own dollars to match federal funding for Medicaid and many other human services in its state budget. Consequently, cuts in state funds for a particular service area, like reproductive health care, can lead to a corresponding cut in federal funding.⁴¹² Georgia's great reliance on federal funds for Medicaid means that any federal funding reductions will have a greatly negative impact on Georgia—perhaps more than other states who are less reliant on federal funding.

Georgia's history of fluctuating approaches to state funding for reproductive health care suggests that reproductive health is widely politicized, with legislative and religious ideologies taking precedence over patient-specific care. One example is Senate Bill 308, which became effective July 1, 2016. SB 308 established the Positive Alternatives for Pregnancy and Parenting Grant Program, which created a state fund administered by

GDPH that financially supports crisis pregnancy centers (CPCs) throughout Georgia.⁴¹³ CPCs, as described earlier, are pro-life and anti-abortion institutions that are generally a part of evangelical Christian networks.⁴¹⁴ They purport to provide free services and alternatives to abortion, such as motherhood or adoption, for pregnant women.⁴¹⁵ These centers rarely have staffing with medical training or licensure, so women may be misled into believing that they have received meaningful diagnostic information or health services.⁴¹⁶ Moreover, CPCs often provide misinformation around abortion risks and contraceptives, which may have serious public health consequences such as delaying access to proper reproductive health services and possibly increasing the number of unintended births.⁴¹⁷

The Positive Alternatives grant program can receive up to \$2 million in state funding, as well as unlimited private donations.⁴¹⁸ By state mandate, GDPH is required to ensure that none of these grant funds are given to organizations that provide either abortion care, referrals to abortion providers, or abortion counseling unless there is life endangerment.⁴¹⁹

Moreover, the Family and Youth Services Bureau of the U.S. Department of Health and Human Services awarded over 2.5 million to Georgia in 2017 through the Title V State Abstinence Education Program Grant.⁴²⁰

⁴⁰⁶ Ibid.

⁴⁰⁷ Conway, Karen Smith, and Andrea Kutinova. "Maternal Health: Does Prenatal Care Make a Difference?" *Health Economics* 15.5 (2006): 461-488. Web.

⁴⁰⁸ Cheng, Ching-Yu, Eileen R. Fowles, and Lorraine O. Walker. "Postpartum maternal health care in the United States: A critical review." *The Journal of Perinatal Education* 15.3 (2006): 34-42. Web.

⁴⁰⁹ Tagahawatte, "Poverty, maternal health, and adverse pregnancy outcomes," 80-85.

⁴¹⁰ de Graaf, Johanna P., Eric A.P. Steegers, and Gouke J. Bonsel. "Inequalities in perinatal and maternal health." *Current Opinion in Obstetrics and Gynecology* 25.2 (2013): 98-108. Web.

⁴¹¹ Gober, Merrilee. *2016 State of The State of Maternal & Infant Health in Georgia: Where We Have Been, Where We Are Now, And What We Can Do*. Healthy Mothers, Healthy Babies Coalition of Georgia, 2016. Web.

⁴¹² Sonfield, Adam. "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health". *Reproductive Health in Crisis*. Guttmacher Institute. 2017. Web. 9 Apr. 2017.

⁴¹³ Georgia State. Senate. SB. 308. Atlanta: Georgia State Government, 2016. *Georgia General Assembly Legislation*. Web. 12 Apr. 2017.

⁴¹⁴ Rosen, "The Public Health Risks of Crisis Pregnancy Centers," 201-205.

⁴¹⁵ Ibid.

⁴¹⁶ Ibid.

⁴¹⁷ Ibid.

⁴¹⁸ Ibid.

⁴¹⁹ Georgia State. Senate. SB. 308. Atlanta: Georgia State Government, 2016. *Georgia General Assembly Legislation*. Web. 12 Apr. 2017.

⁴²⁰ "2017 Title V State Abstinence Education Program Grant Awards." *FYSB*. Family and Youth Services Bureau of the

This grant is specifically intended to promote “abstinence from sexual activity, with a focus on those groups that are most likely to bear children out-of-wedlock, such as youth in foster care, runaway and homeless youth, and minority youth populations.”⁴²¹ A 2015 CDC report found that over two-thirds of schools in Georgia did not teach all recommended sexual health topics, with particularly low rankings for education on condom use.^{422,423} Research shows that comprehensive sex education lowers the risk of pregnancy among adolescents as compared to abstinence-only or no sexual education,⁴²⁴ and that an increasing focus on abstinence education is positively correlated with teenage pregnancies and births.⁴²⁵ At present, Georgia has a teenage pregnancy rate of 47 pregnancies per 1,000 girls, higher than the national rate of 13 per 1,000, and 75% of those pregnancies in the state were unintended.⁴²⁶ Adolescent pregnancy, in turn, has been identified by the WHO as a major contributor to maternal mortality, as younger pregnant women face higher risks of complications and death.^{427,428}

Private foundations and funders play a smaller, but nonetheless important role in funding efforts to reduce maternal health disparities in Georgia. For example, the pharmaceutical company, Merck, provides financial support to the Association of Maternal and Child Health Programs’ *Every*

Mother Initiative through its Merck for Mothers branch.⁴²⁹ Georgia is one of 12 states that participated in the *Every Mother Initiative* from May 2013 to April 2016, which helped the state strengthen its maternal mortality surveillance and review processes.⁴³⁰ Merck for Mothers is also currently supporting the Association of Women’s Health, Obstetric, and Neonatal Nurses on a dual-fold mission of training nurses to educate new mothers about warning signs after birth, as well as supporting hospitals in reducing clinician errors associated with obstetric hemorrhage.⁴³¹

Legislative Committees & Players

The Health and Human Services Committees in the Georgia House of Representatives and State Senate are key legislative committees for state funding for maternal health care. These House and Senate committees are responsible for legislation which affects health and safety regulations for Georgia citizens. Thus, these committees are instrumental in determining which programs are eligible for state funding and influential in deciding how state health expenditures are allocated.

Recent leadership of the House Health and Human Services Committee has been open about their support of CPCs and the use of state funds to back the centers.⁴³²

U.S. Department of Health and Human Services, 19 Jan. 2017. Web. 28 Sep., 2017.

⁴²¹ Ibid.

⁴²² Swartzendruber, Andrea. “Sex Education in Georgia: Failing the Grade and Students.” *myAJC*. The Atlanta Journal-Constitution, 19 Dec. 2015. Web. 28 Sep. 2017.

⁴²³ Demissie, Zewditu, Nancy D. Brener, Tim McManus, Shari L. Shanklin, Joseph Hawkins, and Laura Kann. *School Health Profiles 2014: Characteristics of Health Programs Among Secondary Schools*. Centers for Disease Control and Prevention, 2015. Web.

⁴²⁴ Kohler, Pamela K., Lisa E. Manhart, and William E. Lafferty. “Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy.” *Journal of Adolescent Health* 42.4 (2008): 344-351. Web.

⁴²⁵ Stanger-Hall, Kathrin F., and David W. Hall. “Abstinence-Only Education and Teen Pregnancy Rates:

Why We Need Comprehensive Sex Education in the U.S.” *PLoS ONE* 6.10 (2011). Web.

⁴²⁶ “State Facts About Unintended Pregnancy: Georgia.” *Fact Sheet*. Guttmacher Institute, 7 Sept. 2017. Web. 28 Sept. 2017.

⁴²⁷ “Adolescent Pregnancy.” *Media Centre*. World Health Organization, Sept. 2014. Web. 28 Sept. 2017.

⁴²⁸ “Maternal Mortality.” *Media Centre*. World Health Organization, Nov. 2016. Web. 24 Apr. 2017.

⁴²⁹ “Every Mother Initiative.” *AMCHP*. Association of Maternal and Child Health Programs (AMCHP), 2017. Web. 16 Apr. 2017.

⁴³⁰ *Understanding Why Women Die During Pregnancy and Childbirth*. Merck for Mothers and AMCHP, 2016. Web.

⁴³¹ *Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care*. The Center for Reproductive Rights, June 2016. Web.

⁴³² Elloy, Michelle. “Ga. House Passes Anti-Abortion Pregnancy Center Funding.” *Politics*. WABE 90.1 FM, 2016. Web. 9 Apr. 2017.

The same Senator who sponsored the CPC bill also played a primary role in creating the Senate Women's Adequate Health Care Study Committee in 2015.⁴³³ The resolution for this committee spoke extensively about the maternal mortality rate in Georgia and a state crisis in adequate health care for women.⁴³⁴ Thus, the Senate offers a paradoxical site for policy reform: possibly supportive of funding for efforts to decrease maternal mortality in Georgia, but also proponents of state funding for CPCs.

One point of intersection of Georgia and national health politics comes to the fore in Tom Price, former U.S. Representative for Georgia's 6th congressional district and former United States Secretary of HHS. Though he has resigned since his appointment amid controversy over his travel expenses, Price has opined that neither government, employers, or insurers should be required to provide coverage for preventative women's health services like contraception.⁴³⁵ In 2012, Price was quoted in an interview stating, "Bring me one woman who has been left behind. Bring me one. There's not one."⁴³⁶ Price also introduced a 2015 budget reconciliation bill, which would have prevented Planned Parenthood from receiving federal funding, as well as repealed the Affordable Care Act.⁴³⁷ These postures reflect the anti-reproductive health funding posture of many at the national level in HHS, as well as many in Georgia, which suggests that advocates for adequate funding at

the state level will need to keep HHS in their sights.

State Comparisons

In 2011, the Texas legislature removed two-thirds of the budget for its state family planning program and created a tiered funding system which prioritizes state health departments for the remaining one-third of funds.⁴³⁸ By 2013, Texas' family planning program served less than a quarter of the women that it did in 2011.⁴³⁹

Texas' move to defund reproductive health care and deprioritize community health centers may prove to be a cautionary tale for other states. A 2016 study of maternal death rates by state singled out Texas for its unparalleled and alarming upward trend: after remaining fairly constant between 2000 and 2010, the maternal mortality rate doubled in Texas between 2010 and 2014, reaching 35.8 deaths per 100,000 births by 2014.⁴⁴⁰ The Texas Maternal Mortality and Morbidity Task Force and the Department of State Health Services published a joint report that also found that, similar to Georgia, there is a disproportionately high risk of maternal death among Black women.⁴⁴¹ As a result, Democratic representative Shawn Theirry has filed a bill directing the Texas Maternal Mortality and Morbidity Task Force to focus specifically on maternal mortality among Black women and the causes behind the disparities in the state.⁴⁴²

⁴³³ Georgia State. Senate. *Resolution to Create Senate Women's Adequate Healthcare Study Committee*. SR. Atlanta: 560. *Georgia General Assembly Legislation*. Web. Atlanta: Georgia State Government, 1993. 17 Apr. 2017.

⁴³⁴ *Ibid.*

⁴³⁵ Pear, Robert. "Tom Price, Obamacare Critic, Is Trump's Choice for Health Secretary." *New York Times*. 28 Nov. 2016. Web. 1 Apr. 2017.

⁴³⁶ Keyes, Scott, and Travis Waldron. "House Republican Leader Price: 'There's Not One Woman' Who Doesn't Have Access To Birth Control." *ThinkProgress*. N.p., 10 Feb. 2012. Web. 19 Apr. 2017.

⁴³⁷ United States. Cong. Senate. *Restoring Americans' Healthcare Freedom Reconciliation Act*. 114th Cong. S. 3762. Washington: GPO, 2016. *Congress.gov*. Web. 9 Apr. 2017.

⁴³⁸ Hasstedt, Kinsey. "The State of Sexual and Reproductive Health and Rights in The State of Texas: A Cautionary Tale." *Reproductive Health in Crisis*. Guttmacher Institute. 16 Mar. 2014. Web. 8 Apr. 2017.

⁴³⁹ *Ibid.*

⁴⁴⁰ 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.

⁴⁴¹ *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report*. Austin: Texas Department of State Health Services, 2016. Web.

⁴⁴² State of Texas. Cong. House of Representatives. 82nd sess. HB 2403. Austin: 2012. *Texas Legislature Online*. Web. 17 Apr. 2017.

Other states, such as Oklahoma and North Carolina, identified the reduction of their state's maternal mortality as a priority in their Title V applications to HHS for the 2017 fiscal year.⁴⁴³ ⁴⁴⁴ Merck for Mothers has also provided private funding to strengthen maternal mortality surveillance systems and "data-to-action" projects in several states over the past few years.⁴⁴⁵

Neighboring South Carolina recently launched the Nurse-Family Partnership, a pay-for-success model, as a new approach to improving maternal health in their state. The state initiative uses \$30 million in private and public funds to improve health outcomes for low-income mothers and children.⁴⁴⁶ Public funds (\$13 million) are contributed by HHS in the form of Medicaid funding.

In this model, private funders cover the upfront cost of a program that is designed to improve the health outcomes of low-income women and children.⁴⁴⁷ If a third-party evaluation finds that the program yields positive results, the government will take over part or all of the cost for the program.⁴⁴⁸ Although still early in its implementation, this new pay-for-success approach to funding maternal health programs may prove to be worth consideration in Georgia.

While funding indisputably matters to maternal health outcomes, it is challenging to conduct research that could isolate a direct association between increases in funding for maternal health-related services to reductions in maternal mortality. This is not surprising, as money itself is not a determinant of health, but rather its impact on health is informed by the ways in which it is distributed amongst communities and interventions.⁴⁴⁹ Maternal mortality is a multidimensional health outcome that is associated with a number of complex social, economic, and biological factors.⁴⁵⁰ ⁴⁵¹ Moreover, mortality, as a measure, is itself only one indicator, lying at the end of the spectrum of health outcomes. Mortality data does not include "near misses" of death nor the wide range of less severe pregnancy-related outcomes leading to ill health that are disproportionately experienced by women of color in the United States.⁴⁵² ⁴⁵³

Health economists are still attempting to explain the unique and paradoxical relationship between health expenditures and a range of health outcomes in the United States as a whole, as high spending on healthcare in the U.S. has not been positively correlated with better health outcomes.⁴⁵⁴ The complexity of the health delivery system contributes to the difficulty in definitely characterizing the association between spending overall and

⁴⁴³ *Oklahoma State Snapshot FY 2017 Application / FY 2015 Annual Report: Title V MCH Block Grant Program*. US Department of Health and Human Services, 2016. Web. 22 Apr. 2017.

⁴⁴⁴ *North Carolina State Snapshot FY 2017 Application / FY 2015 Annual Report: Title V MCH Block Grant Program*. US Department of Health and Human Services, 2016. Web. 22 Apr. 2017.

⁴⁴⁵ *Ohio Department of Health: Bureau of Maternal and Child Health. Ohio Pregnancy-Associated Mortality Review (P-AMR)*. Ohio Department of Health, 2015. Web. 24 Apr. 2017.

⁴⁴⁶ "South Carolina Nurse-Family Partnership. *Pay for Success*. Nonprofit Finance Fund, 7 Dec. 2017. Web. 17 Apr. 2017.

⁴⁴⁷ Waters, Joe. "South Carolina's Pay for Success Improves Maternal Health, Child Well-Being". *The State* N.p., 20 Mar. 2016. Web. 17 Apr. 2017.

⁴⁴⁸ *Ibid*.

⁴⁴⁹ "NCHHSTP Social Determinants of Health." *Centers for Disease Control and Prevention*. US Department of Health and Human Services Centers for Disease Control and Prevention. 10 Mar. 2014. Web. 28 Sept. 2017.

⁴⁵⁰ *Deadly Delivery: The Maternal Health Care Crisis in the USA*. New York City: Amnesty International, 2011. Web.

⁴⁵¹ "Health Expenditures". *National Center for Health Statistics*. Centers for Disease Control and Prevention. 20 Jan. 2017. Web. 18 Apr. 2017.

⁴⁵² *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization and Commission on Social Determinants of Health, 2008. Web. 10 Apr. 2017.

⁴⁵³ "Disparities." *Healthy People 2020*. Office of Disease Prevention and Health Promotion, 2010. Web. 10 Apr. 2017.

⁴⁵⁴ Bradley, Elizabeth H., and Lauren A. Taylor. *The American Health Care Paradox: Why Spending More Is Getting Us Less*. New York, NY: PublicAffairs, 2013.

outcomes in the United States, but this complexity should not be allowed to obscure the clear evidence of racialized disparities in health outcomes across Georgia.⁴⁵⁵ Some specialized services are medically needed and must be funded. Moreover, political choices at

the state level determine spending decisions on specific practices or operations, such as CPCs and task forces (our next topic), that can reveal ideological, rather than evidence based motivations.

⁴⁵⁵ Singh, Simone R. "Public health spending and population health: a systematic review." *American Journal of Preventive Medicine* 47.5 (2014): 634-640. Web.

Maternal Mortality Review Committees: State-Level Data Collection and Accountability

In light of significant gaps in access to care, insurance, and funding to address maternal mortality, Georgia has both the opportunity and legal responsibility to act. Tied to this accountability for health outcomes is a parallel responsibility to ensure that state-level health policy is guided by clear and accountable data. States can and should be held accountable for the integrity of data collection procedures, as well as for ensuring that decision makers respond to the failures that are identified through the data. Ultimately, meaningful governmental accountability for health must include “collaborative solutions,” between state actors, institutions and affected populations.⁴⁵⁶ In the case of maternal health in Georgia, this meaningful accountability requires specific state action, which demands attention to the unequal power dynamics present in this context.⁴⁵⁷ Data accessibility on health and informational transparency are key components of this form of accountability. In this section, we employ the principles of effective task forces on maternal data, as well as a discussion of core rights and accountability, to inform our analysis and subsequent recommendations.

At a national level, two separate systems compile maternal mortality data.⁴⁵⁸ However, these national-level statistics do not by themselves offer much in the way of

understanding issues surrounding maternal mortality, in part “because of the lack of diagnostic nuance allowed by the coding rules of the ICD.”⁴⁵⁹ An ICD (International Classification of Diagnosis) Code does not communicate the interconnected stressors and system failures, often community-specific, that contributed to a particular maternal death.

Because state-level efforts are theoretically able to access considerably more information about each case of maternal death, including individual medical records, state-level maternal mortality reviews are a critical complement to national level reviews.⁴⁶⁰ When well-designed and functional (as rights obligations demand, and best practices nationally and within the U.S. demonstrate), state-level reviews have the unique capacity to develop case-level context-specific narratives in addition to raw data.⁴⁶¹ Furthermore, in the absence of nation-wide health policies, state-level review efforts are critical to helping develop policies that respond to state-specific needs. This section outlines a history of state-level maternal mortality review, provides an overview of best practices for maternal mortality commissions as well as a human rights framework for data collection and accountability, and evaluates Georgia’s Maternal Mortality Review Commission against these standards.

⁴⁵⁶ George, Asha. “Using Accountability to Improve Reproductive Health Care” *Reproductive Health Matters* 11.21 (2003): 161-170. Web.

⁴⁵⁷ Ibid.

⁴⁵⁸ The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics collects a list of maternal deaths from death certificate ICD-10 codes (The latest edition of the International Statistical Classification of Diseases and Related Health Problems, released by the World Health Organization). The CDC Division of Reproductive Health manages the Pregnancy Mortality Surveillance System,

which collects data on maternal deaths from a checkbox on death certificates indicating pregnancy within the year preceding death and cross-references death certificates against fetal death and birth certificates.

⁴⁵⁹ Callaghan, William M. “State-based Maternal Death Reviews: Assessing Opportunities to Alter Outcomes.” *American Journal of Obstetrics and Gynecology* 211.6 (2014): 581-582. Web.

⁴⁶⁰ Brantley, *Report from Maternal Mortality Review Committees: A View into Their Critical Role*.

⁴⁶¹ Callaghan, William. Personal Interview. 15 Mar. 2017.

History of State-Level Surveillance

States began collecting data on maternal mortality in the early 20th century. The American Medical Association Committee on Maternal and Child Health Care released a first set of guidelines for state-level review committees in the 1950's.⁴⁶² In 1968, forty-five states had maternal mortality review committees (MMRCs) of some form.⁴⁶³ Two developments led to a subsequent decline in statewide maternal mortality review. First, the decline in overall incidence of maternal mortality during the 20th century led many to think the problem was solved. Second, Dr. William Callaghan, Chief of the CDC's Maternal and Infant Health Branch, hypothesizes that a conceptual change in care in the 1960s led to an increased emphasis on the fetus as a patient, leading to a corresponding (though not inevitable) decline in focus on the mother.⁴⁶⁴ By 1975, 38 states had review committees; by the turn of the millennium, that number was closer to 20.⁴⁶⁵

As national rates of maternal mortality began to increase again in the early 1990s, statewide review gained renewed interest and momentum. Today, 34 states have some form of a functioning maternal mortality review commission.⁴⁶⁶ While these various state-level MMRCs have the same primary functions (reviewing, analyzing, and proposing interventions to reduce cases of maternal death), they may vary with respect to several factors: whether they were established through legislative or administrative action; the frequency and location of meetings; the process by which the committee identifies maternal deaths; the extent to which outside partners beyond state agencies are involved; the level of confidentiality and legal protections; the transparency of the process;

and the ability of the committee to make and implement recommendations. Given the ebb and flow in the existence of MMRCs over time, concerns of sustainability—and ad hoc-ery as antithetical to meaningful accountability—represent another key issue for states to address. For more discussion on state and federal maternal health funding, see the “Funding” section above. As with all funding decisions, political concerns (both politics as ideology and politics regarding protection of strong institutional players) matters greatly for MMRCs.

National MMRC standards emphasize values of confidentiality, immunity, and nondisclosure. Human rights standards, on the other hand, while recognizing privacy rights also prioritize community participation, transparency, and access to information when dealing with state institutions control of information. Applying national standards to Georgia's MMRCs, while paying keen attention to human rights requirements, will help produce reports more accountable to affected communities (particularly Black women) and facilitate systemic change that will be more responsive to their needs.

National MMRC Standards

In recent years, the CDC has pushed for a standardization of state-level reviews both to ensure consistent quality across states and to create the possibility for regional and national analysis of state data. There are five key tasks, primarily procedural, for a MMRC: to identify the scope of the committee through defining and identifying maternal deaths; to develop the committee structure and membership; to define the process for review; to ensure legal protections are in place; and to

⁴⁶² Wright, Ronald F., and Jack C., Smith. “State Level Expert Review Committees: Are They Protected?” *Public Health Reports*. 105.1 (1990): 14. Web.

⁴⁶³ *Ibid.*

⁴⁶⁴ Callaghan, William. Personal Interview. 15 Mar. 2017.

⁴⁶⁵ Naqvi, Meera. “Specter of Maternal Mortality Remains Grim.” *Georgia Health News* 14 June 2016. Web.

⁴⁶⁶ A 50-state survey found maternal mortality review committee information on the websites of 34 states; more research would be needed to assess the level of activity of each of those committees.

create mechanisms for implementing and evaluating recommendations.⁴⁶⁷

Definition and Identification

The first step to creating an MMRC is deciding on what is being measured. As mentioned in the Introduction's discussion on defining 'maternal death', the CDC advocates tracking all deaths within a year of pregnancy. While the identification process will gather both pregnancy-related and pregnancy-associated cases, most MMRCs perform the bulk of analysis on pregnancy-related deaths.⁴⁶⁸

Related to defining maternal deaths, identifying deaths relies on the accuracy of death certificates. Unfortunately, death certificates are often incomplete or inaccurate.⁴⁶⁹ Therefore, it is important for state-level reviews to corroborate death certificates with other available evidence, including fetal death and birth certificates and interviews with friends, families, and communities. State legislatures are able to imbue maternal mortality review committees with enormous legal power—state statutes can grant access to a wide range of records, from prescription histories to police reports to internal hospital and clinic reviews.

Structure and Composition of the Committee

Academics, researchers, and the CDC argue that maternal mortality review committees should be housed in a state agency or department. This helps institutionalize the committee and facilitates the transition from data collection and review to implementation of policy changes.⁴⁷⁰ (This presumes, however,

that State Departments of Public Health are responsive to policymakers and communities.) Best practices for maternal mortality review committees involve including as broad of a range of stakeholders as possible in designing and implementing the review process. While membership varies from state to state, it is important to include experts from outside of the medical fields who can help provide context for the medical details of each case.⁴⁷¹ Possible examples include representatives of community organizations, faith-based organizations, social workers, law enforcement, women's health advocates, and domestic violence advocates.⁴⁷²

It should be noted that despite being housed in and funded by state agencies, most MMRCs rely on in-kind donations of labor and resources to function. The kind of information that is required for understanding maternal death is labor intensive. Appropriating funds to provide staff time for coordination of the in-person 'detective work' can enhance the review process.⁴⁷³ Developing relationships with local institutions, including medical and public health schools, can also increase the capacity of MMRC's to do investigative and on-the-ground work.⁴⁷⁴

Framing the Review Process to Determine Preventability

Core to a MMRC's purpose is evaluating the preventability of each maternal mortality through reviewing each case. The definition of preventability can change depending on the frame a particular committee has adopted. Committees can apply a public health frame, which involves focusing on questions of

⁴⁶⁷ "2017 Overview of Maternal Mortality Review Committees." American College of Obstetricians and Gynecologists., 2017. Web.

⁴⁶⁸ Berg, Cynthia J. "From Identification and Review to Action: Maternal Mortality in the United States." *Seminars in Perinatology* 36.7 (2012): 7-13. Web.

⁴⁶⁹ Callaghan, William. Personal Interview. 15 Mar. 2017.

⁴⁷⁰ Berg, "From Identification and Review to Action: Maternal Mortality in the United States," 7-13.

⁴⁷¹ Bacak, *State Maternal Mortality Review: Accomplishments of Nine States*.

⁴⁷² Ibid.

⁴⁷³ *Health for Every Mother: A Maternal Health Resource and Planning Guide for States*. Washington, DC: Association of Maternal and Child Health Programs (AMCHP), 2015. PDF.

⁴⁷⁴ Georgia's MMRC might consider, for example, developing a relationship with the Center for Reproductive Health in the Southeast (RISE) house at Emory University Rollins School of Public Health.

demographics and social and structural determinants of health, a medical frame, which looks at understanding the specific cause of death, or a quality improvement frame, which entails focusing on identifying breakdowns in the delivery of care.⁴⁷⁵ The CDC recommends using all three frames. It defines a death as preventable “if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, community, provider, facility, and/or systems factors.”⁴⁷⁶

In 1997, UNICEF, WHO, and UNFPA jointly released a set of UN guidelines around data collection pertaining to maternal mortality. The guidelines recommended moving beyond the medical facts of each individual case to assess the health system as a whole, through asking questions about the distribution and quality of health facilities in a given region and exploring issues of access to those health facilities.⁴⁷⁷ In 2012, the WHO and partners launched the Maternal Death Surveillance and Response approach, which attempts to build on existing maternal death review guidelines by creating technical processes for a continuous cycle of identification, review, action, and monitoring of maternal deaths.⁴⁷⁸

In 2013, the International Federation of Gynecology and Obstetrics (FIGO) also published an updated guide for maternal death reviews, which emphasizes comparing maternal death narratives from communities

and health facilities to provide both a broad and context-specific frame through which each case can be understood.⁴⁷⁹ Engaging in this multi-frame analysis requires compiling as broad a record as possible, through supplementing available records with other forms of information gathering, like family interviews.⁴⁸⁰ FIGO recommends identifying the “two or three people with the most direct knowledge of the case” as well as broader community data.⁴⁸¹ Maternal mortality review in the United Kingdom, for example, relies on performing a “social autopsy,” a process of interviews with friends, family, and community members aimed at identifying the “social, behavioral, and health systems contributors to maternal and child deaths.”⁴⁸² In the United States, the collection of more qualitative data can provide insights into how racial discrimination impacts both the delivery of care and Black women’s perceptions of the care they receive.⁴⁸³ The breaches of trust flagged in section 2 – both as a matter of racism’s legacies and as a matter of present day realities – will play a role here.

Confidentiality and Legal Protections

Given the sensitive nature of the data involved and the fact that any maternal mortality by definition concerns a death, it is important for the MMRC process to be reasonably protected, with due regard for the rights of all affected. Personal and identifying

⁴⁷⁵ Main, Elliot. “Decisions Required for Operating a Maternal Mortality Committee: The California Experience.” *Seminars in Perinatology*, 36.1 (2012): 37-41. Web.

⁴⁷⁶ Brantley, *Report from Maternal Mortality Review Committees: A View into Their Critical Role*.

⁴⁷⁷ Yamin, Alicia Ely and Deborah P. Maine. “Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations.” *Human Rights Quarterly* 21.3 (1999): 563-607. Web.

⁴⁷⁸ “Maternal Death Surveillance and Response – Background.” *Maternal, newborn, child and adolescent health*. World Health Organization, n.d. Web. 30 Nov. 2017.

⁴⁷⁹ De Brouwere, Vincent, Veronique Zinnen, Therese Delvaux, Gwyneth Lewis, Veronique Filippi, and Alberta Bacci. “How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Organizing and Conducting

Maternal Death Reviews.” *International Journal of Gynecology & Obstetrics* 127(2013): 7-45. Web.

⁴⁸⁰ *Health for Every Mother: A Maternal Health Resource and Planning Guide for States*. Washington, DC: Association of Maternal and Child Health Programs (AMCHP), 2015. PDF.

⁴⁸¹ De Brouwere. “How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Organizing and Conducting Maternal Death Reviews,” 24.

⁴⁸² Kalter, Henry D., Rene Salgado, Marzio Babilio, Alain K. Koffi, and Robert E. Black. “Social Autopsy for Maternal and Child Deaths: A Comprehensive Literature Review to Examine the Concept and the Development of the Method.” *Population Health Metrics* 9.45 (2011): 1-13. Web.

⁴⁸³ *A State Policy Framework for the Right to Safe and Respectful Maternal Health Care*. Center for Reproductive Rights, 2016. Web.

information produced for the MMRC should be made confidential and protected from discovery or admissibility during a lawsuit. According to legal experts, good practices for MMRC's include granting appropriate immunity from liability for committee members and consultants as well as for anyone who provided data or records used for the MMRC analysis.⁴⁸⁴ Ultimately, the goal of MMRC review is not to assign blame to a particular individual or institution; instead, it is to develop insights on what changes can be made to reduce the risk of maternal death in the future.⁴⁸⁵ As one study of maternal mortality in Peru highlighted, an overemphasis on individual fault can actually detract from identifying system failures, which are central to the project of identifying underlying factors that contribute to maternal mortalities.⁴⁸⁶ Legal protections thus help the committee maintain a broader focus than just identifying medical causes of death and personnel-specific instances of breakdowns in care. And because so much of the MMRC process relies on volunteers and in-kind donations, concerns around lawsuits or insufficient legal protections can act as a deterrent to participation.⁴⁸⁷

Creating Recommendations

Collecting and analyzing data around maternal mortalities is only part of the job for an MMRC. Once a set of cases has been analyzed and systemic contributors to maternal death identified, an MMRC will make recommendations for both policymakers and health care providers.⁴⁸⁸ Ensuring

accountability in this step is as important as accountability in the data collection itself. The CDC advocates for MMRCs to work directly with both policymakers and providers.⁴⁸⁹ Successful recommendations will name specific actors responsible for their implementation.⁴⁹⁰ Subsequent years of committee review will help evaluate the efficacy of those recommendations, and over time the committee can develop an understanding of effective interventions and necessary structural changes. It is important that attention to identified racial disparities helps guide proposed solutions as part of system-wide critiques; isolated collection of data on racial disparities alone will not alleviate systemic barriers around access to and quality of care.⁴⁹¹

For Georgia, it is not enough to meet the legal standards for MMRCs. To ensure accountability through the process and to facilitate systems change that will both include marginalized communities and be responsive to their needs, the above best practices should be implemented with a human rights framework in mind.

State Obligations and Human Rights Framework

Though not specific to maternal mortality, human rights standards around data collection offer another important lens through which to evaluate state-level MMRCs. MMRCs deal with sensitive information from cases involving the loss of life, and it is critical that the rights of both researchers and subjects remain protected throughout the process. An overview of relevant human rights research and writing

⁴⁸⁴On the other hand, this interest should be balanced against holding those accountable through a malpractice or other tort claim. (See Wright, "State Level Expert Review Committees: Are They Protected?," 16.)

⁴⁸⁵Berg, "From Identification and Review to Action: Maternal Mortality in the United States," 7.

⁴⁸⁶Yamin, *Deadly Delays: Maternal Mortality in Peru: A Rights-Based Approach to Safe Motherhood*.

⁴⁸⁷Goodman, David. Personal Interview. 15 Mar. 2017.

⁴⁸⁸Berg, "From Identification and Review to Action: Maternal Mortality in the United States," 7.

⁴⁸⁹Bacak, *State Maternal Mortality Review: Accomplishments of Nine States*.

⁴⁹⁰De Brouwere. "How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Organizing and Conducting Maternal Death Reviews," 36.

⁴⁹¹Ver Ploeg, Michele, and Edward Perrin. *Eliminating Health Disparities: Measurement and Data Needs*. National Academies, 2004. Web. (See Appendix D, "The Role of Racial and Ethnic Data Collection in Eliminating Disparities in Health Care.")

highlights four principles that drive a truly accountable MMRC: community participation, transparency, access to information, and data protection. Imbuing data collection procedures with these values will help develop the accountability that can lead to collaborative solutions.

Community Participation

As with any research project concerning marginalized populations, it is crucial that those populations are involved in every step of the process to ensure that oppressive methods or systems are not re-enacted through the research process and to ensure the integrity and relevance of the data collected. Participation involves access to every step of the data collection process, from establishing data needs, to analysis, and ultimately to the dissemination of findings.⁴⁹² Means of participation need to be “free, active and meaningful,” so as not to tokenize participants or preclude participation because of cost.⁴⁹³ In the case of maternal mortality, this could mean involving women who survived ‘near misses’ in the review process (while ensuring their involvement doesn’t lead to re-traumatization), engaging the families and communities of victims of maternal mortality, and, given the existing racial disparities, directly involving communities of color, particularly Black communities, in both gathering data and assessing responses. Furthermore, a human rights framework acknowledges that addressing maternal mortality will not just involve education, training, or prevention around specific causes of death; it will require concerted efforts “to eliminate cultural,

religious, and social discrimination that devalues women’s health and well-being,” phenomena that can only be understood through hearing the stories of those affected.⁴⁹⁴

Transparency and Access to Information

To meet human rights standards for participation, an MMRC must also embody the values of transparency and access to information. The process by which researchers and participants are selected should be made clear. Without transparency, it is difficult to meet standards of participation and accountability.⁴⁹⁵ Multiple international treaties and agreements recognize the right to access information is a prerequisite of many other human rights, particularly meaningful participation.⁴⁹⁶ Furthermore, authentic evaluation of recommendations and program implementation requires access to a wide array of information, including, for example, “budget numbers and health statistics.”⁴⁹⁷

Privacy and Confidentiality

Finally, given the sensitivity of the data being collected, analyzed and disseminated, human rights frameworks emphasize the need for privacy and confidentiality for both researchers and participants, or in this case, victims of maternal death and their families. Access to information should be balanced against the right to privacy, and data should not

⁴⁹² *A Human Rights-Based Approach to Data: Leaving No One Behind in the 2030 Development Agenda*. Office of the United Nations High Commissioner for Human Rights.

⁴⁹³ *Ibid.*

⁴⁹⁴ Yamin, “Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations,” 11.

⁴⁹⁵ *A Human Rights-Based Approach to Data: Leaving No One Behind in the 2030 Development Agenda*. Office of the United Nations High Commissioner for Human Rights, 5.

⁴⁹⁶ *See* International Covenant on Civil and Political Rights Article 19 (noting the right to expression includes a right to receive and impart information); *see also* 1946 U.N. Resolution 59 (I) (acknowledging that “freedom of information is a fundamental human right and the touchstone of all the freedoms to which the United Nations is consecrated”) (*Ibid.*).

⁴⁹⁷ Yamin, *Deadly Delays: Maternal Mortality in Peru: A Rights-Based Approach to Safe Motherhood*, 116.

be released in a way that makes possible the identification of individuals.⁴⁹⁸

Moving Beyond Tensions between MMRC Guidelines and Human Rights Standards

There might be tensions between MMRC guidelines and human rights standards, leading to inefficiency or inactivity. Specifically, MMRC best practices stress nondisclosure and confidentiality, while human rights standards emphasize transparency, access to information, and participation. But emphasizing the incongruities between these two frameworks distracts from the ways that human rights can bring accountability to every step of the MMRC process. There is growing pressure for MMRCs to expand their scope to increase participation and community involvement. Human rights frameworks recognize the need for privacy and protection of those involved. Furthermore, transparency of decision-making processes and analysis of recommendations need not involve disclosure of sensitive information. Thus, human rights frameworks help MMRC best practices answer the critical question of accountability—that is, how can data collection systems not just respond to the needs of communities but be driven by them while also connecting that data collection to timely intervention into identified failures?

Both MMRC best practices and human rights standards also agree on the ultimate goal of maternal mortality review, which is not to assign blame for individual deaths, but rather to engage in a system-wide analysis of health care to engage with structural and societal problems.⁴⁹⁹ In the unlikely case of true impasse, it will be up to those involved in the process to ensure meaningful review is made

possible in the way that best upholds the human rights of all involved.

Georgia Maternal Death Surveillance

Information could not be found as to when Georgia first established a maternal mortality review process, but evidence suggests that data collection and review at a state level existed prior to the year 2000, stopped in 2000, and remained dormant for 12 years.⁵⁰⁰ In 2013, the State Legislature passed a bill, SB 273, creating a new Maternal Mortality Review Committee, to be housed in the Georgia Department of Public Health that would review cases of maternal death in Georgia annually and create recommendations to the legislature and health providers.⁵⁰¹ SB 273 mandated several aspects of the soon-to-be-created MMRC, but left much to the discretion of the Department of Public Health.⁵⁰² Specifically, the bill instructs the MMRC to “identify maternal death cases,” “review medical records and other relevant data,” “contact family members and other affected or involved persons,” “consult with relevant experts,” “make determinations regarding the preventability of maternal deaths,” “develop recommendations,” and “disseminate findings.” Nearly all aspects of the MMRC’s functioning is left to the discretion of the department.

In addition to the MMRC reviewing cases of maternal death in Georgia, the Department of Public Health’s Office of Health Indicators for Planning manages Georgia’s Online Analytical Statistical Information System (OASIS), which also compiles and displays statistical information on maternal death in Georgia that can be broken down across age, race, geography, and other demographic indicators.⁵⁰³ However, OASIS records only

⁴⁹⁸ *A Human Rights-Based Approach to Data: Leaving No One Behind in the 2030 Development Agenda*. Office of the United Nations High Commissioner for Human Rights, 9.

⁴⁹⁹ Yamin, “Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations,” 15.

⁵⁰⁰ Platner, “Pregnancy-Associated Deaths in Rural, Nonrural, and Metropolitan Areas of Georgia,” 1-8.

⁵⁰¹ See Georgia State. Senate. SB. 273. Atlanta: Department of Public Health, 2014. *Georgia General Assembly Legislation*. Web.

⁵⁰² *Ibid.*

⁵⁰³ “OASIS Web Query – Maternal Child Health (MCH) – Maternal Mortality.” *Online Analytical Statistical Information*

those maternal deaths that occur during or within 42 days after a pregnancy as identified by ICD-10 codes⁵⁰⁴, and thus will likely neither reflect all maternal deaths that occur in the state nor match perfectly the data released by the MMRC.

In June 2015, the MMRC released its first and only report to date, an analysis that will be discussed in coming sections of pregnancy-related deaths in Georgia from 2012.⁵⁰⁵ The report identified and analyzed 25 pregnancy-related deaths and 60 pregnancy-associated deaths. 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.

Evaluating Georgia's Efforts and Recommendations

Measuring Georgia's MMRC against national best practices and human rights standards reveals that while the MMRC meets national minimums for competency, it nonetheless does not accomplish basic tasks critical to meaningful investigation and intervention into maternal deaths. The committee could be positioned for success, but to date, weaknesses in framing, capacity, transparency, and community involvement have limited the MMRC's development of appropriate and effective public health solutions.

The committee uses a multipronged identification approach to tally potential cases of maternal death. First, it compiles cases from death certificates that have the box indicating pregnancy up to one-year prior than death checked; second, the Department of Public Health matches death certificates against fetal death and birth certificates from the previous year; finally, the committee receives a list of cases from mandated reporters in the state,

which include hospitals, healthcare providers, and law enforcement.⁵⁰⁶ By having multiple simultaneous avenues for case identification, Georgia's MMRC is meeting national MMRC standards for identification. However, much data are missing from the cases, indicating that while the committee can identify some cases, it lacks the forensic and research capacity, funding, and/or effective processes to collect meaningful and relevant information. For multiple factors of analysis, a significant percentage of cases lacked the relevant data. For example, while the committee report makes conclusions around weight as a factor, the mother's pre-pregnancy weight was marked "unknown" in 70 percent of cases. In 40 percent of cases, the quality of prenatal care was unknown, and in 45 percent of cases it was unknown when the woman began receiving prenatal care. These gaps are only some examples of a consistent pattern of critical missing information.

On paper, Georgia's MMRC may appear well-structured. It is housed, pursuant to the legislative mandate, in Georgia's Department of Public Health, and has built strong relationships with both the Georgia OBGyn Society and the CDC.⁵⁰⁷ This multi-institutional framework can provide both stability and longevity. When the DPH undergoes staff changes or structural transitions, the OBGyn Society is able to carry the administrative load.⁵⁰⁸ Indeed, to date the DPH has contracted with the OBGyn Society to handle the abstraction, case summaries, and coordinating for the committee.⁵⁰⁹ However, for accountability purposes it is important that ownership of the project is clear. While the committee's enacting statute allows for the contracting out of key responsibilities, a well-functioning and successful MMRC is ultimately the responsibility of the state and DPH. This

System. Georgia Department of Public Health Office of Health Indicators for Planning (OHIP), n.d., Web.

⁵⁰⁴ Gober, "2016 State of the State of Maternal and Infant Health in Georgia," 25.

⁵⁰⁵ Lindsay, "Georgia Maternal Mortality: 2012 Case Review."

⁵⁰⁶ *Ibid.*

⁵⁰⁷ Fernandez, Maria. *Maternal Mortality in Georgia: Through the Public Health Lens*. Atlanta: Georgia Department of Public Health, 7 Oct. 2014. PPT.

⁵⁰⁸ Callaghan, William. Personal Interview. 15 Mar. 2017.

⁵⁰⁹ Lindsay, "Georgia Maternal Mortality: 2012 Case Review," 4.

includes not just hosting the MMRC but producing timely and substantive reports and managing relationships with other key stakeholders. One concern that arises out of this structure is DPH's unresponsiveness to legislative and community outreach. Both Georgia state legislators and the authors of this report experienced difficulty in contacting the DPH, which operates behind the firewall of its Government Relations office.

Unfortunately, it is impossible to evaluate the membership of Georgia's MMRC against national standards because of a lack of transparency. The committee consists of 45 members who volunteer to serve three-year terms and who are "geographically diverse" and who "represent various specialties, facilities, and systems that interact with and impact maternal and child health,"⁵¹⁰ but neither DPH, the OBGyn Society nor the committee itself has published a list of members or the process through which members are recruited and selected. A PowerPoint presentation available online suggests committee members are divided roughly into clinicians, public health practitioners, and mental health providers⁵¹¹—a combination of experts that neither meets standards of community participation or likely has the skillset to apply a non-medical lens to mortality cases. Furthermore, any committee members who began their three-year term in 2013 (when the committee was established) would have phased out of the committee unless they signed on for a second-term. No information is publicly available regarding this transition. Furthermore, given that the MMRC members are primarily volunteers, it is unclear whether the MMRC has the capacity to ensure the data collection process allows for meaningful review.

A lack of transparency is also evident in the committee's communications (or lack thereof) with the public. Since the committee produced its first report in 2015, it has not released any other form of communication. The maternal mortality section on DPH's website has not been updated since May of 2016.⁵¹² The coordinator of Georgia's MMRC said in March of 2017 that the committee was busy undergoing case review.⁵¹³ But even if the committee publishes a report analyzing 2013 deaths in 2017, the time lag between the deaths in a given year and the corresponding review will have widened, making it harder for the committee to catch up.

The overall lack of transparency stems directly from the legal protections in the enacting statute. SB 273 does meet standards of confidentiality and immunity outlined above, but it does so to an excessive degree that compromises human rights standards, signaling a failure to balance appropriate protections for investigations with practices upon which practical and publicly accessible policy reform can be based. Specifically, the statute makes not just the substance of the reviews confidential, but also "all proceedings and activities of the committee."⁵¹⁴ Furthermore, SB 273 exempts committee meetings from open meetings and open records requirements.⁵¹⁵ To balance confidentiality and immunity desires with human rights standards of participation, transparency, and access to information, Georgia's MMRC should find ways to maximize transparency around the process (particularly the selection and composition of the committee) and create avenues for feedback from relevant stakeholders while still preserving strict confidentiality of case information.

⁵¹⁰ Ibid.

⁵¹¹ Fernandez, *Maternal Mortality in Georgia: Through the Public Health Lens*.

⁵¹² "Maternal Mortality." *Georgia Gov*. Georgia Department of Public Health, n.d., Web.

⁵¹³ Sibley, Debbie. "Re: Meeting to Discuss Maternal Mortality in Georgia." Message to Elizabeth Villarreal. 8 Mar. 2017. E-mail.

⁵¹⁴ Georgia State. Senate. SB. 273. Atlanta: Department of Public Health, 2014. *Georgia General Assembly Legislation*. Web.

⁵¹⁵ Ibid.

Process and results go hand in hand. If Georgia's MMRC was to produce substantive reports and recommend clear state interventions to address poor health outcomes, it might be likely that the committee was meeting best practices and human rights standards around committee membership and community participation, despite a lack of transparency. However, a review of the MMRC's available work reveals gaps in data and analytic approach that make this unlikely.

The MMRC, in order to target the root causes of maternal mortality, must expand its framing and analysis of the issue beyond a biomedical approach to include equity, structural factors, and social determinants of health.⁵¹⁶ The June 2015 Report reveals that the committee deploys only a medically focused lens to evaluate maternal mortalities. To analyze each case, the committee relies exclusively on a number of medical reports: specifically, prenatal visit history, hospital and clinic medical records, prescribed medication history, coroner/autopsy reports, emergency medical services transport records, and police reports.⁵¹⁷ These reports together can only paint a clinical picture of each maternal death. Key findings of the report were limited to identifying the most common causes of death and highlighting the related factors of obesity and chronic medical conditions. The only mention of systemic or structural factors affecting cases of maternal death was a short note on general provisions of care, which mentioned possible gaps in rural health care systems. The committee then tied opportunities for prevention to the specific causes of death without exploring the impact of social determinants of health, including structural factors such as social supports, socio-economic status, and other determinants described above in our section on intersectional and the *Three Delays* analysis.⁵¹⁸

Finally, recommendations to address preventable deaths only involve the education of providers and changes to the delivery of care.⁵¹⁹ The report shows a failure, however, to provide a broader context for each woman's life and to help understand the maternal death through a social determinants of health framework.

Finally, while the report identified large racial disparities in incidents of maternal mortality, it failed to explore those racial disparities in its analysis. The committee found that Black women represented 68 percent of the 25 pregnancy-related deaths in 2012 (and 40 percent of the 60 pregnancy-associated deaths).⁵²⁰ However, inter-related systems of oppression, such as racism and inequitable distribution of resources and wealth, are not mentioned in the discussions about causes of death, key findings, or recommendations, either in an individual capacity or a societal level. This means that all the benefits of the embedded analysis flagged in the opening sections on assessing access and quality of care are missed in the MMRC analysis.

The committee did address some of these shortcomings in its recommendations section with proposals to increase the depth of review for each case. Specifically, the committee recommended implementing family and relative interviews into the review process and expanding the body of records gathered to include pharmacy information. While these amendments will provide some context, and may fill some information gaps, more changes are required to understand the breadth of factors that contribute to any case of maternal death. Moreover, without changes to the staffing structure and accountability processes of the MMRC, it is not clear who will be responsible for carrying out these processes. At this time, there is no clear mechanism by which

⁵¹⁶ "Brantley, *Report from Maternal Mortality Review Committees: A View into Their Critical Role*.

⁵¹⁷ Lindsay. "Georgia Maternal Mortality: 2012 Case Review," 8.

⁵¹⁸ *Ibid*, 17.

⁵¹⁹ *Ibid*, 20.

⁵²⁰ *Ibid*, 11.

recommendations from case reviews will be implemented or evaluated.

Moving Forward

Any advocacy efforts around a reframing of the committee should be mindful of the fact that the CDC is working closely with MMRCs to standardize state review practices through the development of the Maternal Mortality Review Information Application (MMRIA).⁵²¹ This new system recommends that states include geocoding (linking maternal deaths to their geographic location) and other contextual level variables in the review process.⁵²² And while the June MMRIA 2015 report acknowledges that racial disparities exist, it does not include specific recommendations to analyze or address the

scope and impact of those disparities beyond incorporating spatial analysis such as geocoding. Furthermore, it does not advocate for understanding social, structural or historical context through community participation such as interviews. The extent to which Georgia's MMRC has implemented these recommendations will need to be explored through conversations with committee leaders or DPH.

Moreover, in March 2017, the *Preventing Maternal Deaths Act of 2017* was introduced in the U.S. House of Representatives.⁵²³ This bipartisan legislation seeks to strengthen and expand state maternal mortality reviews by assessing and developing interventions around factors that may contribute to maternal deaths, including: quality of care, racial disparities, and systemic problems with healthcare delivery.

⁵²¹ “Brantley, *Report from Maternal Mortality Review Committees: A View into Their Critical Role*.

⁵²² *Ibid*.

⁵²³ United States. Cong. House of Representatives. *Preventing Maternal Deaths Act of 2017*. 115th Cong. H.R. 1318. Washington, DC.: House Energy and Congress Committee, 2017. *Congress.gov*. Web.

The Potential Role of Religious Communities in Addressing Maternal Racial Disparities

Religion, particularly Christianity, has on-going and undeniable impact on culture, politics, and the economy in the U.S. A number of our informants stressed that religious institutions can be a productive and powerful force for change as well as a facilitator in the dissemination of resources and educational initiatives.⁵²⁴ This report views actions by religious leadership in supporting individuals to access medically appropriate care as part of community networks that bridge individual ability to act with advocacy for more effective and accessible care.

In the U.S., religious organizations can and have served as both positive and negative influences in public health discourse. Just as we find religious voices positing support for a comprehensive approach to women's health choices, we also find religious voices with opposing positions and narrower constructions of what is 'good health.' Through interviews, existing survey data, and academic research, this section details the current role of religious leadership in Georgia and builds a case for its role as a critical partner in alleviating racial disparities in the maternal health crisis in Georgia.

Religion and State Level Politics

In Georgia, religion and politics are deeply entwined, as demonstrated in earlier sections by the continuation of state funding

for Crisis Pregnancy Centers, which are pro-life and anti-abortion centers with ties to evangelical Christian networks.^{525,526} While the focus of this section is on mobilization of religious leaders to help respond to the racial disparity in maternal death, we flag some examples of invocations of religion as a regular component of state policy-making to highlight the background against which religious leadership might engage on behalf of women's health and rights.

Recent notable cases demonstrating the on-going invocation of religion in state policies include litigation in *Selman v. Cobb County* (2006) on the teaching of evolution in schools,⁵²⁷ and SB 233 (2017) commonly known as the "Religious Freedom Bill."⁵²⁸ When discussing an earlier version of the Religious Freedom Bill from 2016 (HB 757), both supporters and detractors of the bill cited personal religious beliefs as influencing their vote. While those who supported the bill saw it as necessary to protect conservative Christians who do not believe in same-sex marriage, Governor Nathan Deal cited his Baptist faith as a factor in his decision to veto the bill saying, "we do not have a belief, in my way of looking at religion, that says that we have to discriminate against anybody...I think what the New Testament teaches us...is that Jesus reached out to those who were considered outcasts."⁵²⁹

⁵²⁴ Campbell, Marci Kramish, Marlyn Allicock Hudson, Ken Resnicow, Natasha Blakeney, Amy Paxton, and Monica Baskin. "Church-Based Health Promotion Interventions: Evidence and Lessons Learned." *Annual Review of Public Health*. 28.1 (2007): 213-34. Web.

⁵²⁵ Rosen, "The Public Health Risks of Crisis Pregnancy Centers," 201-205.

⁵²⁶ "State Government: Georgia." *Naral*. Naral Pro-Choice America. Web.

⁵²⁷ "Selman v. Cobb County: The Textbook Disclaimer Case." *National Center for Science Education*. National Center for Science Education. Web. 1 Apr. 2017.

⁵²⁸ Georgia State. Senate. SB. 233. Atlanta: State Government, 2017. *Georgia General Assembly Legislature*. Web. 1 Apr. 2017.

⁵²⁹ Botelho, Greg, and Doug Criss. "Governor Cites Jesus in Talk over 'Religious Freedom' Bill." *Cable News Network* N.p., 17 Mar. 2016. Web. 1 Apr. 2017.

Religious Landscape in Georgia

According to data collected by the Pew Research Center in the 2014 Religious Landscape Study, 79% of adults in Georgia identify as Christian.⁵³⁰ Nationally, Georgia ranked as the eighth most religious state.⁵³¹ While Georgia is home to a number of religious communities including a growing Muslim and Hindu population, Christianity predominates.⁵³² Protestant denominations such as the Southern Baptist Convention, Methodist and non-denominational churches continue to hold a majority.⁵³³ Today, the state's Christian population is mainly divided between Evangelical Protestants (38%), Historically Black Protestants (17%), and Mainline Protestants (12%).⁵³⁴

The prominence of varying Christian groups creates a diverse theological culture. From denominations that support a conservative reading of the Bible and espouse doctrinal purity (Southern Baptist Convention) to those that welcome more varied perspectives on Christian texts (United Methodist Church), it is clear that Georgia cannot claim one singular Christian identity. It is important to note that many of Georgia's churches continue to be segregated along racial lines. While there are efforts to integrate historically Black and white Christian congregations, much of this work has failed outside of major cities.⁵³⁵

⁵³⁰Lipka, "How Religious Is Your State?"

⁵³¹Ibid.

⁵³²Wormald, Benjamin. "Adults in Georgia: Religious Composition of Adults in Georgia." *Religious Landscape Study*. Pew Research Center's Religion & Public Life Project, 11 May 2015. Web. 1 Apr. 2017.

⁵³³Ibid.

⁵³⁴Wormald, "Adults in Georgia: Religious Composition of Adults in Georgia."

⁵³⁵Ware Carter, Ethel. Telephone interview. 6 Apr. 2017.

⁵³⁶For 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

Christianity in the Black Community

Christianity has had significant cultural and communal impact amongst Black communities in the United States. The Black Church,⁵³⁶ in particular, has been recognized for its potential to be responsive to the needs of its community members and promote and deliver relevant resources.⁵³⁷ The Black Church maintains a high level of influence in the community,⁵³⁸ and many have promoted social justice in talk and practice, although each social justice issue has its own trajectory within the Church. In this way, the Church has shown its concern for Black people's "whole being" rather than the individual beliefs of its members.⁵³⁹

The influence of the Black Church on social structures can be seen particularly in Georgia through the legacy of the work of religious leaders such as Dr. Martin Luther King Jr., who not only spoke from a Christian perspective but worked with the Black Church to enact change. These considerations make Black churches an important site to consider for interventions against health disparities.

Health Promotion in the Black Church

Current trends in public health practice have emphasized community-based public health promotion. This community driven approach moves beyond top-down, individual behavior change strategies, to recognizing the important role of local actors as well as social and environmental structures in shaping community health.⁵⁴⁰ This approach has been

encompass Historical Black Protestant groups as well as more contemporary Pentecostal and Evangelical groups with a majority Black population.

⁵³⁷"Black Congregational Development." *North Georgia UMC*. North Georgia United Methodist Church, N.p., Web. 1 Apr. 2017.

⁵³⁸Camara, *Holy Lockdown: Does the Church Limit Black Progress?*

⁵³⁹Rowland, "As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church," 1091-1101.

⁵⁴⁰Butterfoss, Frances D., and Michelle C. Kegler. "Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory." *Emerging Theories in Health*

accompanied by a shift in public health thinking from solely a deficit-based model to incorporating an asset-based model, which aims to map and maximize existing strengths and health-promoting resources in communities, rather than focus on problems.⁵⁴¹ In this vein, churches and faith-based organizations can be, when identified and led by community, harnessed as local strengths and equal partners.

Black congregations, specifically, have been a significant site of outreach for health promotion. Recognizing the health disparities that impact their community, many pastors have supported programs to improve health outcomes for Black people.⁵⁴² Although numerous studies have explored the role of the Black Church in improving community health, many in the medical and public health communities have yet to implement such religious institution-based health initiatives on a wide scale.⁵⁴³ The success of these programs can be tied to the churches existing role in providing social services,⁵⁴⁴ communal trust of the institution,⁵⁴⁵ and the social support found within the congregation.⁵⁴⁶ In the U.S., churches have at times held a reputation as a form of “social welfare agency” providing different types of assistance to individuals in need, which relies on a system of trust that has built up over time.⁵⁴⁷ As previously referenced, trust is particularly important in Black communities given that the historically-

justified distrust of medical professionals and healthcare systems contributes to health inequities.⁵⁴⁸ As such, partnerships with a trusted religious institution or leader can lead to improved implementation of health mechanisms, which in turn can help mitigate certain delays to care.⁵⁴⁹ Additionally, the presence of Black Churches in urban and rural areas allows for wide programmatic reach, even in areas that lack substantial social services. Combined, these elements have made churches an institutional resource as providers of education to bridge the gaps in the unequal distribution and disparities of information in the communities.

Health Ministries

A number of churches throughout Georgia have adopted health ministries as part of their larger ministerial outreach. While they may have similar titles, health ministries can manifest in a variety of forms and are not always direct-service programs. For some congregations, a health ministry simply refers to a staff of nurses or other health care practitioners that provide medical services as needed throughout worship services or special events.⁵⁵⁰ In other churches, health care ministries can be more comprehensive and involve educational programming around health issues. They can also be outreach ministries designed to alleviate stress for those with

Promotion Practice and Research. Ed. Ralph J. DiClemente, Richard A. Crosby, and Michelle C. Kegler. San Francisco: Jossey-Bass, 2009. 157-193. Print.

⁵⁴¹ Morgan, Antony, and Erio Ziglio. "Revitalising the Public Health Evidence Base: An Asset Model." *Health Assets in a Global Context*. 14.2 (2007): 3-16. Web.

⁵⁴² Rowland, "As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church," 1091-1101.

⁵⁴³ Giger, Joyce. N., 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): 376.

⁵⁴⁴ Johnson, Byron. *The Sociological Study of Faith-Based Communities and their Activities in Relation to the Spiritual Ideal of Unlimited Love*. Philadelphia: University of Pennsylvania Institute for Research on Unlimited Love Altruism, Compassion, Service., 2002. Web.

⁵⁴⁵ Giger "Church and Spirituality in the Lives of the African American Community," 377- 379.

⁵⁴⁶ 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): 511-527. Web. 1 Apr. 2017.

⁵⁴⁷ Abdul, A. *Religion and the Black Church: Introduction to Afro-American Studies*. Chicago: Twenty-First Century, 1991. Print.

⁵⁴⁸ Jacobs, Elizabeth A., Italia Rolle, Carol Estwing Ferrans, Eric E. Whitaker, and Richard B. Warnecke. "Understanding African Americans Views of the Trustworthiness of Physicians." *Journal of General Internal Medicine* 21.6 (2006): 642-47. Web. 1 Apr. 2017.

⁵⁴⁹ Rowland, "As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church," 1091-1101.

⁵⁵⁰ Ware Carter, Ethel. Telephone interview. 6 Apr. 2017.

health problems by providing transportation to doctor's visits, prepared meals, financial and spiritual support. In some churches, a health ministry could also focus on larger advocacy issues such as the availability of care to community members.

Notably, one example of a health ministry in Georgia that has taken hold on both a denominational and local level is that of HIV/AIDS ministries, albeit mostly in white dominated churches. While the needs, prevention measures, and services of HIV/AIDS are different than those of maternal mortality and morbidity, the ministries that have been formed in response to the HIV/AIDS epidemic in Georgia can shed light on the potentiality of programs to improve maternal health. More research is needed to understand how and such programs could be harnessed to include maternal health and provide outreach to pregnant women. Health ministries that deliberately target the needs of Black women are especially important given the compounding structures of oppression they face due the intersections of their social identities – including, race, gender, and class – which form structural forces that can undermine their health and lead to increased risk of morbidity and mortality.⁵⁵¹

Many of the current health ministries work in conjunction with local nonprofits, community health clinics, and public health departments to make sure that people are receiving adequate medical treatment and care.⁵⁵² Studies have shown that collaborative efforts between churches and public health programs can be more beneficial in addressing

health inequalities in the Black community.⁵⁵³ Collaboratively, the church and health practitioners can develop holistic strategies to improve the health of individuals and communities whether through direct service, education, financial or emotional support.⁵⁵⁴

It is important to note that different ministries and Christian traditions may have differing views on what health practices to support. Even within the same national denomination, practices and beliefs may be localized. Particular attention must be paid to these regional variations when considering partners for health promotion. This may be particularly noticeable on issues of sexual and reproductive health. There are long historical roots to stigmas in some Black Christian communities surrounding sexual matters (both non-heterosexual sex and sex outside of marriage), as well as sexually transmitted infections. There is growing awareness of the ways in which ideas of race, gender and sexuality fuse, such that white supremacy, patriarchy and the demonization of any sexuality outside of heterosexuality operate together to construct ideas of Black hypermasculinity. This formation, in turn, carries both homophobic and conservative gender ideas that help contextualize stigma that may exist in some Black Christian communities around sexual matters.^{555,556}

While Black Churches have successfully led other health initiatives on issues such as diabetes, and heart disease, the slowness to hold discussion of sexual practices (especially related to men who have sex with men), given legacies of these formations of

⁵⁵¹ Thomas, Veronica G. "Using Feminist and Social Structural Analysis to Focus on the Health of Poor Women." *Women & Health* 22.1 (1994): 1-15. Web. 1 Apr. 2017.

⁵⁵² Nelson, Andrew. "Ministries Refocus on Helping Those Living with HIV." *The Georgia Bulletin*. Archdiocese of Atlanta, 6 Dec. 2013. Web. 1 Apr. 2017.

⁵⁵³ Rowland. "As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church," 1091-1010.

⁵⁵⁴ Taylor, Beverly D., Ayanna V. Buckner, Carla Durham Walker, and Daniel S. Blumenthal. "Faith-Based Partnerships

in Graduate Medical Education." *American Journal of Preventive Medicine* 41.4 (2011): S283-S289. Web. 1 Apr. 2017.

⁵⁵⁵ Amola, Oluwakemi and Marc A. Grimmatt. "Sexual Identity, Mental Health, HIV Risk Behaviors, and Internalized Homophobia Among Black Men Who Have Sex With Men." *Journal of Counseling and Development* 93.2 (2015): 236-246. Web.

⁵⁵⁶ Wilson, Patrick A., Natalie M. Wittlin, Miguel Muñoz-Laboy, and Richard Parker. "Ideologies of Black Churches in New York City and the Public Health Crisis of HIV among Black Men Who Have Sex with Men." *Global Public Health* 6.2 (2011): S227-242. Web. 9 May 2017.

Black hypermasculinity, can be a barrier.⁵⁵⁷ Some efforts have been made to combat this stigma in Georgia, most notably using male leaders of the church. For example, the pastor of Ebenezer Baptist Church, Rev. Raphael Warnock, took an HIV test in front of the congregation in order to shed light on the disease and reduce negative perceptions of those infected.⁵⁵⁸

Though maternal mortality and morbidity may not have the same stigma associated with it as HIV, issues surrounding reproductive justice and abortion services may provoke resistance when working with more conservative denominations.

Additionally, when discussing the potential of developing health ministries for pregnant women, organizations should consider the congregational response to pregnancy. Although studies have noted the importance of social support from churches on the emotional well-being of pregnant Black women, a teen pregnancy or a pregnancy outside of marriage may result in adverse and harmful social stigma. There is little research in this area but it would be pertinent for community health and nonprofit organizations understand denominational stances and localized beliefs on issues related to pregnancy before attempting to establish religious partnerships.

[See Recommendations section for potential strategies for engagement of religious institutions and leadership.]

⁵⁵⁷ Barnes, Sandra L. *Live Long and Prosper: How Black Megachurches Address HIV/AIDS and Poverty in the Age of Prosperity Theology*. New York: Fordham University Press, 2013. Print. 102.

⁵⁵⁸ McCoy, Darlene. "Ebenezer Baptist Church Pastor Takes HIV Test During Sunday Service." *MyPraise*. MyPraise 102.5, 15 Mar. 2010. 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)⁵⁵⁹ to generate new research to better support advocacy around funding

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^{560, 561}
- Congress should closely examine and consider 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 process⁵⁶²
- 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

⁵⁵⁹ 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.

⁵⁶⁰ De Brouwere. “How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Health Professionals.”

⁵⁶¹ “Maternal Death Surveillance and Response – Background.” *Maternal, newborn, child and adolescent health*. World Health Organization, n.d. Web. 30 Nov. 2017.

⁵⁶² The Center for Reproductive Rights is currently working with advocates to create tools that promote the incorporation of human rights principles into MMRC processes.

agencies, and evaluated in a cyclical manner⁵⁶³

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.

⁵⁶³ De Brouwere. "How to Conduct Maternal Death Reviews (MDR): Guidelines and Tools for Health Professionals."

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