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Policy Analysis: Implications of the Abortion Ban in Georgia in Relation to Maternal Deaths

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Abstract

This policy analysis investigates the impact of abortion bans on maternal mortality rates in the United States, emphasizing how restrictive abortion policies correlate with adverse maternal health outcomes. By using a combination of public health data from Georgia OASIS and conducting a literature review based on countries and states with varying levels of abortion access, this analysis highlights how legal constraints around abortion limit reproductive choices and access to critical maternal healthcare services. The findings reveal that states with stringent abortion restrictions tend to experience higher maternal mortality rates, exacerbated by systemic inequities in healthcare access for marginalized communities, including low-income individuals, rural populations, and women of color. Decline in availability of comprehensive prenatal and emergency obstetric care in restricted states is linked to healthcare provider shortages and the closure of clinics previously offering reproductive health services. These shortages contribute to delayed or inadequate care, which can be life-threatening in high-risk pregnancies. The intersectional effects of these policies, such as the overlap of abortion restrictions with existing healthcare disparities, places vulnerable populations at disproportionately higher risk for pregnancy-related complications. The findings propose a set of policy recommendations aimed at addressing healthcare deficiencies, expanding access to reproductive and maternal care, and ensuring that maternal health policies are grounded in evidence-based practices. Suggested interventions include increasing funding for maternal health programs in underserved areas of Georgia, strengthening emergency obstetric services through these funding sources, and enacting protections for healthcare providers offering life-saving interventions. This protection ensures that a healthcare provider is exempt from criminal prosecution if an abortion is performed to preserve the patient's life during a medical emergency. Through these measures, policymakers can work toward a more equitable healthcare landscape that prioritizes the health and safety of all pregnant individuals to reduce preventable maternal deaths and improve overall maternal health outcomes.

Background

Georgia's abortion ban has raised significant public health concerns, particularly in relation to maternal mortality. Georgia has consistently ranked among the states with the highest maternal mortality rates, and research suggests that restrictive abortion policies exacerbate these trends [1]. Studies indicate that states with abortion bans tend to see increased maternal deaths due to limited reproductive healthcare access and increased incidence of unsafe abortion procedures. Additionally, restricted access to abortion forces many women to carry high-risk pregnancies to term, especially in cases of severe medical complications or fetal abnormalities, which increases maternal health risks [2].

In Georgia, where racial and socioeconomic disparities in healthcare access already persist, this policy is expected to disproportionately impact Black women and low-income communities, who face higher maternal mortality rates and often have less access to comprehensive healthcare services [3]. The state's healthcare infrastructure, especially in rural areas where many hospitals have closed, is already struggling to meet the needs of pregnant individuals. Georgia's abortion ban has potential implications beyond individual health, risking further strain on an already fragile healthcare system, driving up maternal death rates, and exacerbating existing inequalities [4]. Addressing these issues involves a multifaceted approach, including considering the financial, social, and public health costs of restrictive reproductive policies, and evaluating avenues

to mitigate maternal health risks in Georgia.

In June 2022, the Supreme Court ruled in the case of Dobbs v. Jackson Women's Health Organizations, deciding to overturn the previous Constitutional right to abortion. It eliminated federal standards on abortion access-standards that had been in place for nearly 50 years. As a result of this decision, states in the Southern and Midwest regions became the most impacted [5].

As of April 2024, more than 10 states have placed abortion bans with 11 of them placing limits on abortions between 6 and 22 weeks [5]. While there are the possibilities of traveling out of state or trying to obtain pills, these options are not highly feasible. People of color especially face disproportionately greater challenges due to the history of this movement embedded in social and economic inequities. Geographical data from the CDC, American Community Survey, Behavioral Risk Factor Surveillance Survey, and the Survey of Household Economics and Decision making, highlight that Black, American Indian, and Alaskan Native women ages 18-49 are more likely than other groups to live in states where abortion bans and restrictions are present [6]. This group also tends to have higher uninsured rates, and, across the country, these rates are significantly higher in states that have more restrictive abortion bans. This leads to a lack of resources for these groups of women, and alongside the limited transportation and financial resources, it eliminates the probability of women of color to look out-of-state for abortion options [7].

Data recorded by the National Institutes of Health already indicates that the health difference between African Americans and white Americans is varied; however, the Black population has been recorded to have more undetected diseases, higher disease and illness rates, more chronic conditions, and shorter life expectancies. Even though black females are less likely to report engaging in risky behaviors (smoking, consuming alcohol, consuming substances, etc.), the findings hold to be true generally [8]. Thus, a health disparity between the two groups is already present and normally attributed to social and physical environments and the healthcare system, among a few factors.

Asian Americans are under a similar impression. The U.S. "model minority" stereotype has direct implications for the health of this group. It suggests that they often can "push through" health problems and are worsened by the numerous barriers to care. With this nation's restrictive immigrant bans as well, those residing illegally may not seek medical care in the fear that it would result in deportation or exploitation. While Asian American women generally exhibit the safest and healthiest lifestyles, there is still a prevalence of illness, and the risk of secondhand smoke and hypertension are high; however, the lack of resources and limited knowledge of this population plays a significant role in the infections that disproportionately affect Asian American women [9].

The state of Georgia is one of 14 that has imposed an abortion ban. In October 2024, the Georgia Supreme Court reinstated the state's six-week abortion ban, meaning that most abortions will be illegal in the state after six weeks of pregnancy. Governor Brian Kemp signed the state's almost-total abortion ban called the LIFE Act in 2019, a ban that didn't take place until July 2022 after Roe v. Wade was reversed on the national level. This policy prevents the possibility of abortion when a fetal heartbeat is detected – as early as 6 weeks and a time even before some women know that they are pregnant. The only exceptions are in situations where the woman's life or health is in danger or in some situation where there are fetal anomalies [10].

Within GA itself, however, there were differences county-to-county. As of September 30th, 2024, a judge in Fulton County struck down the abortion ban and legalized abortion up to 22 weeks of pregnancy [11]. Despite the statewide restriction, this decision indicated that women have autonomy over their own body and allowed the choice of abortion until the fetus reaches viability; however, the Georgia Supreme Court evaluated and reviewed the state's appeal of the lower court opinion and overruled this decision. Thus, the state policy is still functioning in all counties. This exchange alone suggests conflict over proceedings regarding abortion after the Dobbs decision.

Confusion Around Current Policies

The current laws around abortion are written in such a way that are up for interpretation and can be applied to miscarriage as well, as the procedures for an induced abortion and marriage are often quite similar [12]. In some cases, patients who are having a miscarriage may not be able to receive medical care if the fetal heartbeat is still detectable [13], as many abortion-restrictive states only allow for the removal of a dead fetus. As a result, patients may be at heightened risk of infection or severe health complications that put their life at risk.

States with abortion restrictions often state that exceptions in which an abortion can be provided are rape or incest, threat to the mother's heath, or threat to the fetus. However, these laws and exceptions still remain relatively vague, making it more challenging for healthcare workers to provide care to their patients. In particular, the exceptions around the mother's health do not explicitly state the criteria or the scenario in which medical intervention is permissible [13]. The lack of detail and delineation of what constitutes a major health concern makes providing care all the more difficult and puts the patient at risk of further complications.

Furthermore, states that have multiple abortion bans in place, such as Louisiana and Mississippi, lack consistency across each of their bans, making it all the more challenging for providers to act in accordance with the law [13]. States with strict abortion regulations have ultimately hastened to implement restrictions while failing to detail the circumstances in which abortion can be provided, making the providers' job all the more challenging and putting the patient's life at greater risk [13]. Thus, it can be argued that abortion restrictions fall under the void-for-vagueness doctrine, which states that a law cannot be enforced if it is unclear [14].

Forced Pregnancies

With restricted access to medical abortions, which are induced medicinally, there will be an increase in the amount of patients with forced pregnancies that doctors will have to treat, as well as an overall increase in pregnant patients with complications that will be forced to deliver [12]. There are concerns that alternative methods to abortion that are not medically approved will rise, resulting in more infections and complications that put the mother's life at risk [12]. Along with the potential health complications for the mother and the fetus, abortion bans also inadvertently heighten the economic and socioemotional well-being and stability of many patients. It was found that patients forced to carry an unwanted pregnancy were far more likely to remain involved in toxic relationships, experience poverty, or report a worse life satisfaction [15].

Abortion bans disproportionately affect marginalized groups, and in many cases individuals in these populations are more likely to experience adverse health outcomes or death from delivery than from an abortion [12]. Thus, abortion bans and restrictions only serve to further worsen healthcare disparities and deepen systematic racism that contributes heavily to adverse maternal health outcomes in Georgia and across the country. Furthermore, with abortion access being left to the discretion of individual states, those of lower socioeconomic classes will struggle more to access vital reproductive care as opposed to their wealthier counterparts [16]. Abortion is also not a commonly covered medical procedure by insurance companies, and those relying on Medicaid are often unable to cover the cost of abortion as well [16]. This further contributes to pregnancies being forced upon a population of women who are already at risk of adverse maternal health outcomes and cannot afford the care they need.

Effects on Medical Force

A review of the current literature indicates a reduction of maternal health providers in states with abortion bans [17]. March of Dimes had previously identified regions coined as maternal healthcare "deserts" that lack obstetric-gynecological care, and it was later determined that 39% of counties in states with abortion restrictions were also maternal healthcare "deserts" [17]. Abortion restrictions and bans are ultimately exacerbating healthcare disparities in these regions, as providers hesitate to work in areas where their full scope of practice is limited and prefer to move their practice to a state that is supportive of their work. It has been reported that the ratio of OBGYNs to patients is 32% lower in states with abortion restrictions as opposed to states without these restrictions [17]. Furthermore, medical students interested in pursuing a career in OBGYN have reported being less likely to apply to residency programs in states with abortion restrictions and bans, further shrinking the medical workforce trained in this field in the states that need them the most [13].

Additionally, the effects of abortion bans on the curricula for medical students and residency training programs means that many residents in abortion-restrictive states will not be trained in providing all aspects of reproductive care [12]. Given that many states require that abortion only be performed by a physician, a shrinking number of doctors trained in this area further limits access to life-saving reproductive medical care [15]. This ultimately does not bode well for Trauma Centers across the country, which are expected to be equipped with the resources and personnel to treat pregnant patients.

An additional concern outside of a shrinking medical force trained in this area is the closure of clinics around patient populations seeking care [18]. The onset of abortion bans in states across the country means that the medical forces in states that protect the right to an abortion face an overwhelming demand of patients, as more women cross state lines to seek vital medical care [18].

Methods

The Online Statistical Analytical Information System (OASIS) was used to access records from the Georgia Department of Public Health to gain information about maternal mortality in recent years. The amount of induced pregnancy terminations, or abortions, were tracked over several years (2014 - 2023) to observe trends in abortion care which were then compared to the timeline of changing court decisions and laws, such as the Dobbs decision and HB 481 (a 6 week ban which has recently been overturned), surrounding abortion legality and access to care. The amount of induced terminations per year was also compared across several racial groups including White, Black, Asian, American Indian or Alaska Native, Multiracial, and Unknown to determine if race was a determining factor in the number of reported abortions performed [19].

Results

Using the data collected from OASIS, it is shown that the number of induced terminations of Pregnancy in Georgia sharply decreased in 2023 [19]. This aligns with the overturning of the historic court case Roe v. Wade in 2022, which left the legality of abortions up to states, resulting in Georgia passing a 6-week ban on abortion in November 2022. Additionally, the law restricts insurance coverage for abortions, making induced terminations less accessible. This is an indication of decreased reported abortions as a result of the law. Based on data collected by the Guttmacher Institute, there was a 24.3% decrease in clinician-provided abortions in Georgia since 2020, indicating a correlation between the passing of the ban and amount of reported abortions; however, this is likely not due to a decrease in abortions overall, rather it is due to a decrease in reported abortions and an increase in unreported cases [20]. On average, the percentage of people in Georgia traveling to other states to obtain abortion care has increased from 17% to 25% from 2020 to 2024 [20]. This is an indication that the number of abortions reported in Georgia is not necessarily representative of the number of whole saw an 11% increase in abortions in 2023, post Dobbs decision, specifically in states such as Illinois [21,22].

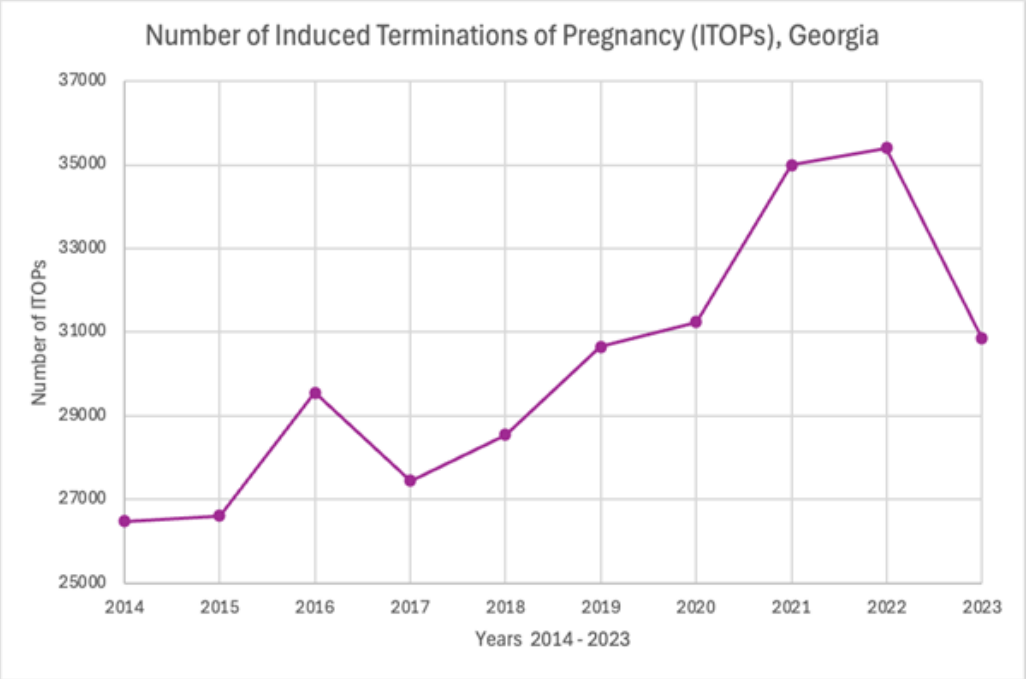

Figure 1. Number of Induced Terminations of Pregnancy, Georgia, 2014 - 2023

(Georgia Department of Public Health, Office of Health Indicators for Planning) [19].

This is a result of people traveling across state lines to receive abortion care, indicating that the restrictions on abortions are not effective at decreasing the number of abortions, but it results in people seeking other measures to receive care. This leads to people seeking unsafe abortions, ultimately leading to an increase in maternal mortality. Researchers found that if none of the abortions in 2020 were allowed to occur, there would have been a 24% increase in maternal mortality that year because it is a lifesaving procedure [23]. Additionally, the GA Department of Public Health's maternal mortality committee reported that 110 out of 113 pregnancy related deaths from 2018-2020 could have been prevented [24]. After reporting that the deaths of two women in Georgia were a direct result of restrictive abortion laws which prevented them from obtaining life-saving care, the maternal mortality committee was disbanded [24]. In one of these cases, the committee was able to provide valuable information about the cause of a death beyond what the medical examiner provided because one of the goals of the committee was to research the cause of maternal deaths holistically [24].

Therefore, due to the disbandment of this committee, much of the data and research surrounding maternal mortality will not be as thorough, leading to a lack of information and potentially dangerous consequences. This is an indication of the life-threatening impacts of the reversal of Roe v. Wade. The restrictive laws prevent women from seeking care from professionals and instead force them to find other methods of abortion which can lead to incomplete abortions or other severe complications that if untreated can be fatal [24].

Healthcare Impacts on Various Races

According to the GA Department of Public Health, from 2019-2021 the pregnancy maternal mortality ratio is 35.69 per 100,000 live births, which is one of the highest in the country when compared to the CDC data comparing maternal mortality by state from 2018-2022 [19]. Although in 2022 the amount of pregnancy related deaths fell to 25.1 per 100,000 births, 87% of those were preventable [19]. Comparing the amount of induced terminations by race using the OASIS data, it was proven that this decrease was much more significant for Black (or African American) women, both of which showed a decrease of 2215 abortions from 2022 to 2023 [19].

Figure 2 also shows that Black women received more abortions than other racial groups during any year, proving that any law restricting abortion care would have a greater impact on these individuals. It was also reported by the Georgia Department of Public Health that Black women were 2.3 times more likely to die from a pregnancy-related cause than White women, highlighting the care disparity [19]. This is indicative of a decrease in abortion care and reported abortions for all women, but specifically black women.

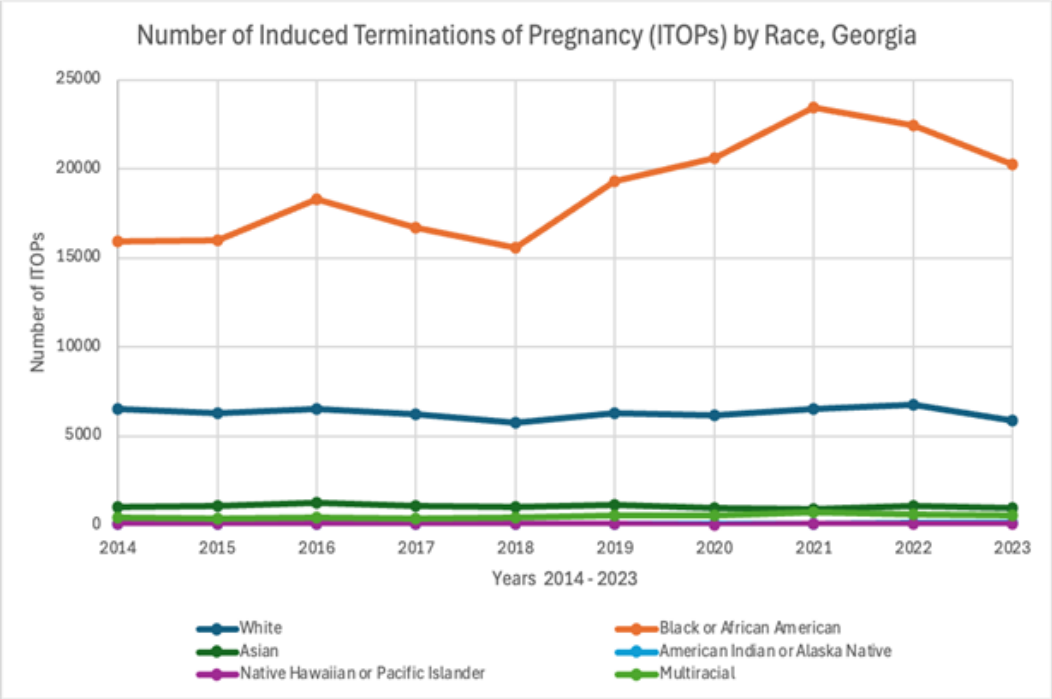

Figure 2. Number of Induced Terminations of Pregnancy by Race (White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and Mulitracial), Georgia, 2014 – 2023.

(Georgia Department of Public Health, Office of Health Indicators for Planning) [19].

Already disproportionately disadvantaged in the healthcare system, state abortion bans threaten millions across the nation. This decision is especially harmful for women of color who have less access to quality care and face economic and financial barriers. The decision of Dobbs affects more than 6.7 million Black women who either live in states that have banned abortion or are likely to place restrictions/ban it [25]. Black women are also more likely to be the sole breadwinners of their families and when unable to access abortion care, the development of their existing children is negatively impacted. Of the 6.7 million in these states, almost half are economically insecure. This means that they are more likely to be impacted by state bans as they are unable to travel out-of-state or pay for abortion care, pushing them deeper into the never-ending poverty cycle. With the decision of Dobbs, abortion has not become less likely to occur; instead, it has simply raised the costs of abortion treatment and care, and increased the risks of the women that are seeking this treatment. Indigenous Americans are twice as likely to die from pregnancy-related causes than their white-counterparts. Paired alongside the maternal health crisis in the United States with the number of pregnant and birthing people dying doubling between 1987 and 2018, racial disparities are becoming key players in this crisis [26].

The lack of racial and ethnic diversity in the medical field, let alone the perinatal workforce, contributes to the mistreatments and abuse that many mothers face. Only 11% of all OBGYNS are Black, with only 6.3% of all nurse midwives being Black as well [26]. With African American infants also dying at higher rates and being at greater risk, health outcomes could be possibly linked to systemic racism. Transcripts from interviews allowed researchers to deduce that the majority of women described experiences that fit the definition of institutionalized racism where the system is simply designed in a way that works against diverse communities in terms of quality prenatal care [27].

An experiment in the National Library of Medicine, white perinatal care clinicians who served racially diverse women were interviewed many of whom were obstetrician/gynecologists or certified nurse midwives [28]. Results indicated that there were three themes prevalent in their answers: inequitable care, surveillance of Black women and families, and structural healthcare issues, seen across the entire United States healthcare system. With both of these experiments, it becomes clear that racism and stereotypes continue to openly and negatively impact Black women's perinatal care experiences and health outcomes, along with other minority and underrepresented groups.

National Impact of Roe v. Wade

The effect of Roe vs. Wade is substantial. The decision previously made state abortion bans unconstitutional, legalizing abortion care and making it more accessible and affordable for women across the nation. On June 24, 2022, however, this decision was overturned, and states were once again left to their discretion on what restrictions they wanted to be implemented [29]. This decision disproportionately affects the lives of many throughout the nation, especially women of color and those who are economically unstable. According to KFF, thirteen states have completely banned abortion with eleven states currently having some gestational limit, with six states restricting from

6-12 weeks from the last menstrual period [30].

This has numerous negative implications, impacting from women's education to racial and gender equity. The use of political power can be seen in this decision with influences on certain communities in society to make choices about reproductive health reinforced by systemic racism [29]. Millions of underrepresented communities will have to travel out-of-state to access non-affordable abortion care. Women of color is one of the main targets of this power move; while there is more governmentality over women's bodies, there are nuances of this policy that have completely eliminated the care for women physical and psychological wellbeing with the extend of abortion restrictions making it illegal even in cases of rape and incest [31].

Beyond this, however, the "north-south" divide expands in terms of restrictions to abortion and the worsening of healthcare inequalities [32]. It also raises concern for the next steps states may take and if women will be able to access medical services such as contraception or IVF, affecting autonomy and healthcare services in every sector. This decision essentially left those with health-related needs with no power to be able to receive adequate care without being under risk of poverty, legal incrimination, etc. These choices affect reproductive justice and especially impact Black, Indigenous, and racialized women who already face health disparity and prenatal care, increasing their struggle to access medical services. Essentially, it feeds into the systemic racism and stigmatization and makes abortion more deadly for women. It not only impacts their literal physical health but can and will contribute heavily to economic instability as there are no plans for the government to provide support for families that may already be below the salary required to live day-to-day, let alone comfortably. The nation does not guarantee (more) funds for nursery care or disability services: both aspects of life that need to be considered as they not only contribute severely to the life of parents but also to the growth and development of the child.

Policy Recommendations

Numerous lawsuits have ensued since the establishment of these decisions; challenging abortion bans on the grounds of state constitutional protections. This ongoing litigation adds uncertainty to the availability of care. Healthcare providers face legal and ethical dilemmas, especially in states with ambiguous laws regarding abortion to save the life of the pregnant person. Fear of prosecution has led to delays in providing necessary care, even in emergencies. Telemedicine and medication abortion services have emerged as critical tools for expanding access, though they face legal challenges in restrictive states [33].

A policy permitting healthcare providers to perform abortions when medically necessary can ensure patient safety while addressing ambiguity in restrictive abortion laws. Such policies often allow abortions in cases where the pregnant person's life is at risk, when continuing the pregnancy poses a severe threat to their physical health, or in situations involving fatal fetal anomalies [28]. Clear guidelines should be outlined for "necessary circumstances," including life-threatening conditions (such as ectopic pregnancies or preeclampsia), severe infections (such as sepsis), or non-viable pregnancies incompatible with life. Explicit legal protections for healthcare providers who act in good faith to safeguard the patient's health should be in place for shielding them from criminal or civil liability and to prioritize provider discretion to minimize delays in care caused by fear of legal repercussions. Provisions to maintain confidentiality and respect for patient autonomy ensures informed consent without having additional bureaucratic barriers to care [34,35].

In varying degrees, policies allowing abortions in necessary circumstances exist in many states, but their scope and clarity differ significantly. States like California, New York, and Illinois protect providers who perform medically necessary abortions, defining such circumstances in their laws and allowing provider discretion without fear of prosecution. In states with strict abortion bans, exceptions for "life-threatening" circumstances are often included; however, the criteria is vague, leaving providers uncertain about when they can act [33].

Examples include states like Texas and Florida, where exceptions exist for medical emergencies but lack detailed definitions. Some states, like Colorado, have adopted comprehensive reproductive health acts that ensure access to medically necessary abortion while explicitly protecting both patients and providers. These models are often cited as best practices for balancing regulation with healthcare needs [30].

Sustainable Reproductive Care in Maternal Healthcare Deserts

Enabling virtual consultations for prenatal and abortion care to mitigate geographical barriers in underserved areas can be meaningful measures for increasing care access in these areas. Funding and regulatory support for telemedicine are needed, particularly for maternal health specialists and OB/GYNs. Financial incentives such as Medicaid Reimbursement for healthcare professionals who practice in maternal health shortage areas can attract more providers to participate in state programs aimed at sustainable reproductive and abortion care [34,36].

Increased Funding for Doula Programs

States like Minnesota and Oregon have implemented Medicaid reimbursement for doula services. Expanding this nationwide can significantly improve maternal outcomes by reducing disparities in maternal morbidity and mortality rates that may stem from inadequate abortion care. Providing grants to community-based organizations to train doulas and fund doula certification programs from underrepresented communities ensures cultural competence and trust in prenatal and abortion care delivery [34].

Persuading Policymakers

Building coalitions with influential healthcare organizations, advocacy groups, and community leaders can amplify the message and demonstrate widespread support. Presenting concrete data and evidence that highlights the positive impact of doula programs on maternal and infant health outcomes, as well as the cost-effectiveness of such initiatives, can appeal to fiscal conservatives concerned about budget allocations. Emphasizing the role of doulas in reducing maternal mortality rates, which are notably high in Georgia, can also create a compelling narrative that aligns with public health priorities [37].

Framing the need for permitting healthcare providers to perform medically necessary abortions within the context of safeguarding women's health and upholding medical ethics is an additional approach. Testimonials from healthcare professionals, patient stories, and case studies can humanize the issue and highlight real-world implications of restrictive policies [38]. Addressing potential concerns about the misuse of such permissions by clearly defining medical necessity and establishing oversight mechanisms can help mitigate opposition [39].

For virtual consultations, emphasizing the challenges faced by individuals in rural or underserved areas due to geographical barriers can be persuasive. Demonstrating how telehealth solutions can enhance access to essential prenatal and abortion care, reduce health disparities, and improve outcomes resonates with policymakers focused on equity and efficiency [37]. Leveraging pilot program results or case studies from other states with successful telehealth implementations can provide concrete examples of efficacy and scalability [39].

Engaging with policymakers through personalized meetings, providing concise and well-researched policy briefs, and organizing public forums or town halls to showcase community support can further strengthen advocacy efforts. Building relationships with key legislators, understanding their priorities, and framing the policy changes in ways that align with their values and constituents' needs can ultimately lead to more effective persuasion and policy adoption [37].

Conclusions

The implications of abortion bans have already resulted in adverse impacts on communities across the country, particularly in marginalized groups based on socioeconomic status and race. There is evidence that abortion restrictions and bans only deepen existing health inequities and disparities, disproportionately impacting communities of color and those in lower socioeconomic classes. The effects of the abortion bans are exacerbated by the difficulty with interpreting the regulations around abortion restrictions and a shrinking obstetric-gynecological medical force that cannot meet the demands of patients. In order to ensure the health of patients, we recommend a series of policy recommendations that address maternal healthcare deserts, the expansion of doula-support programs and provider protections, and the ambiguity around current abortion restrictions and laws. As abortion restrictions and bans have recently gone into effect, it is vital to continue monitoring the changes in healthcare outcomes and patient experience in seeking medical care in the coming years in order to have a more comprehensive understanding of the impacts of this legislation. Additionally, a longitudinal comparison of health outcomes in states with and without abortion restrictions may be useful in providing further insight to the intersection of policy and medicine.

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