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“We did not share our sob stories, we brought doctors to speak to the measure instead”: A narrative analysis of pro-choice testimony and legislative debate related to Georgia’s fetal “heartbeat” abortion ban

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Abstract

"We did not share our sob stories, we brought doctors to speak to the measure instead": A narrative analysis of pro-choice testimony and legislative debate related to Georgia's fetal "heartbeat" abortion ban

By: Bethany Burns-Lynch

In May 2019, Governor Brian Kemp signed HB 481 into law, banning abortion in Georgia upon detection of a "heartbeat." Almost 100 early abortion bans have been introduced in 25 states since 2011. With the number of bills targeting women's access to abortion increasing, it is more important than ever to understand the rhetoric and narratives employed by both the abortion rights and anti-abortion sides of the argument. The purpose of this study was to distinguish and characterize the arguments, tactics, and evidence used by legislators and community members in opposition to HB 481 and in support of reproductive rights. Verbatim legislative debate and community testimony from March 2019 was coded using a constant comparative method and analyzed using thick descriptions of frequently used codes to identify themes. Inductive codes included women's rights, maternal mortality, and feasibility of enforcement. Three major themes emerged: the "negative hits" HB481 will have on the health outcomes of Georgia women; infringements of fetal "personhood" on the "fundamental rights of women"; concerns over feasibility and "flawed" implementation; and prioritization of narratives from doctors and other medical professionals. Testimony emphasized how HB481 would "worsen Georgia's dismal" maternal mortality and exacerbate the "shortage of OBGYNs" in the state. Legislators discussed HB481's "vague" enforcement and cost, as well as restricting women's "freedom of choice" and its "disproportionate" effect on Georgia's "most vulnerable women." Opponents of HB481 relied heavily on testimony from medical professionals (74% of committee speakers) and described "listening" to physicians; finally, legislators frequently referenced professional organizations. Pro-choice argumentation included a strong focus on health and women's rights with inattention to specific legal arguments. Supporters of abortion bans weave together legal and health arguments, therefore, new legal strategies to combat further gutting of abortion rights must do the same.

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I would also like to thank all the people who fought to stop HB 481 from passing into Georgian law. Thank you for all the organizing, lobbying, and time spent working to protect the health and rights of women here in Georgia. Your efforts do not go unnoticed or unappreciated.

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1. Introduction

On May 7th, 2019 Governor Brian Kemp signed House Bill 481: The Living Infants and Equality (LIFE) act into law, making Georgia the state with the most restrictive abortion legislation in the United States at the time. Not only does HB 481 ban abortion after 6 weeks gestation, it also gives full legal rights and protections to unborn children.[1] HB 481 in its assertion of fetal personhood, argues that modern medical science, "demonstrates that unborn children are a class of living, distinct persons and more expansive state recognition of unborn children as persons did not exist when *Planned Parenthood v. Casey* (1992) and *Roe v. Wade* (1973) established abortion related precedents."[2] It also codifies that, "[i]t shall be the policy of the State of Georgia to recognize unborn children as natural persons."[2] The 6-week benchmark for abortion comes from the definition of 'unborn child', which HB 481 marks as when the fetus, "[has] a detectable human heartbeat,"[2] directly contradicting the standard definition of 'childhood' used by the American Academy of Pediatrics of between the ages of 2 and 12 years.[3]

Despite the fact that 71% of Americans and 70% of Georgia voters oppose overturning *Roe v Wade*,[4,5] 'heartbeat' bills such as HB 481 are designed to challenge and overturn the Supreme Court's decision. Almost 100 fetal heartbeat bills have been introduced in 25 states since 2011. In 2019, 14 states all introduced bills that would ban abortion as early as 6 weeks.[6] There has been an extreme acceleration in the passage of 'heartbeat bans' since 2018. North Dakota was the first state to pass one in 2013, followed by Arkansas that same year. The next to pass was from Iowa in 2018, with 7 more all following in 2019. None of these laws have gone into effect, as state and federal courts have struck them down and the Supreme Court has so far refused to hear the cases.[7,8]

With the number of bills targeting women's access to abortion increasing, it is more important than ever to understand the rhetoric and narratives employed by both the abortion rights and anti-abortion sides of the argument. Rhetorical analysis combined with narrative principles of incorporating context to see how stories are developed and employed as political strategy has helped improve our understanding of the types of narratives that will resonate with both legislators and the general public. Analysis of the rhetoric around fetal personhood reveals the uneasy fault line of the American political tolerance of 'necessary' abortion, but discomfort around abortion access being too easy.[9] Understanding these nuances can help abortion advocates and researchers understand how best to build evidence-based cases against them.

Analysis of rhetoric around abortion is often conducted with mass media sources, as they are easy to access and reveal important details about public conceptions around abortion.[10-13] These types of sources and analysis are important, particularly for understanding abortion rights argumentation and public perception. Exposure to personal narratives about abortions can reduce stigma felt both by women who have had abortions and women who have not.[14] Women who have shared personal abortion stories report that the experience was generally positive and empowering, even when they received backlash and harassment as a result.[15] First person narratives have been rejected as traditional sources of evidence, but scholars in disciplines like feminist theory have pushed back on the devaluation of first-person narratives.[16] Research has also suggested that legislators in particular are swayed by first person narrative evidence.[17-18] This presents a unique problem in abortion rights rhetoric. The most commonly used narratives by abortion rights advocates present abortions as unwanted but necessary procedures. The focus on unfortunate circumstance and abortion as a last resort create narratives which leave little room for advocates of abortion rights who believe that abortion should be widely available without

moral judgement. Rhetorical analysis of these trends shows that they might be doing more harm than good in creating conceptions of abortion in the public policy sphere.[12]

Rhetorical analysis of legislative debate is a particularly useful tool in public policy analysis. Close textual analysis of political debate and speeches can illuminate the private machinations behind public policy decisions[19] as well as help us understand the types of evidence and argumentation that appeals most to legislators.[18] Systematic analysis of abortion debate has provided valuable insight into the types of narratives used in abortion debates, where they are employed, and how effective they are.[20,21] Patterns in argumentation have been shown to be primarily strategic in nature, with wide ranges of narratives identified and deployed differently depending on the type of restriction or type of arguments made by the other side, and the perceived 'strength' of the political base according to legislative make-up.[20] What this demonstrates is that it is critically important to have a nuanced understanding of each different type of abortion restriction and narrative framing individually in order to develop politically effective messaging against these restrictions.

As the numbers of early abortion bans like HB 481 continues to rise exponentially, it is critically important to understand the current arguments and strategies used by both anti-abortion and abortion rights advocates. The purpose of this study was to distinguish and characterize the arguments and tactics used by legislators and community members in opposition to HB 481, Georgia's early abortion ban.

2. Literature Review

2.1 Abortion in the United States

Abortion rates in the United States has been in decline since 1981; in 2017 the abortion rate was 13.5 per 1,000 women aged 15-44, the lowest rate since the legalization of abortion in 1973. The decline has been attributed to falling rates of pregnancy and births overall, not due to abortion restrictions.[86] Even considering the decline in abortion rates, abortion remains a common medical procedure in the US. An estimated 24% of American women will have an abortion before the age of 44, and in 2017 18% of all pregnancies ended in abortion.[22] Research on characteristics of women seeking abortions in the United States has found that 59% had already given birth at least once, and 75% were low-income. Racial demographics show that of patients obtaining abortion services, 39% were White, 28% were Black, 28% were Hispanic, and 9% other ethnicities.[22] Abortion is more common in urban states than in rural states, with many women forced to travel from rural to urban areas to obtain access to abortion services.[23] Accessibility of abortion varies widely between states; in 2019, "29 states were considered hostile toward abortion rights, 14 states were considered supportive and seven states were somewhere in between".[22]

Though abortion trends in the United States are decreasing overall, that is not the case in the state of Georgia. Georgia is generally considered to be hostile to abortion rights, though less so than other states in the South. Over 35,000 abortions were performed in Georgia in 2017, an 8% increase from 2014 numbers. Access to abortion is a significant problem, with only 5% of counties containing an abortion clinic; 55% of Georgia women live in a county with no abortion clinic.[24] Over half (59%) of patients who received an abortion between 2012-2016 in Georgia were Black, and 30% White.[25] Georgia is an important hub for abortion access in the Southeast,

and many women from surrounding states travel to Georgia to obtain an abortion. One in ten (10.1%) abortions performed in Georgia overall between 1994-2016 were for out of state patients, and out of state patients saw an increase of 35.3% between 1994 and 2016. Out of state residents obtaining abortions during this period also had a higher average gestational age, suggesting that they did not have access to abortion care in their home state and had to wait to receive care in Georgia.[25]

2.2 Constitutional Context

American women's right to have an abortion was codified in law through two landmark Supreme Court decisions made on January 22nd, 1973: *Doe v Bolton* and *Roe v Wade*. These two decisions cemented women's rights to abortion in the United States as part of their right to privacy under the 4th and 14th amendments. *Roe v Wade* established women's right to an abortion from the first trimester of pregnancy until fetal viability, defined as "the capability of meaningful life outside the mother's womb".[26] It further established the rights of states to regulate abortion after the first trimester,[27] except where necessary, "for the preservation of the life or health of the mother".[26] The decision made in *Roe v Wad*e, particularly the Court's statement on viability, set a precedent that the Court would consider biological arguments as well as legal arguments in cases set before it.[28] The Supreme Court based their decision on the ill-defined Constitutional right to privacy, a controversial position that abortion rights and anti-abortion advocates alike have criticized.[29]

The right to privacy that formed the basis of the Court's decision in *Roe v Wade* is considered tenuous because such a right is not explicitly defined in the constitution, and so the decision was based on an amalgamation of several amendments. The right to privacy as it concerns sexual and reproductive health was primarily developed over two Supreme Court cases

concerning contraceptive legality. The first articulation of the privacy argument came from Justice William O. Douglas' majority decision in Griswold v Connecticut in 1965.[30] This case addressed a Connecticut law that forbid the use of contraceptives entirely and while the majority opinion was focused on the 14th amendment "due process" protection, Justice Douglas also identified the existence of privacy rights as "implied" in other amendments, particularly the 1st, 4th, 5th, and 9th.[29-31] The decision was based primarily on the statute's effect on married couples concerning their "right of marital privacy."[30-31] The right to privacy based on the 14th amendment was expanded in the case of Eisenstadt v Baird in 1972, which challenged a Massachusetts law preventing unmarried patients from accessing birth control. The equal protection clause was used to argue that unmarried individuals should not have their access to contraception restricted, as well as explicitly establishing that the "constitutionally protected right of privacy inheres in the individual, not the marital couple."[30,32]

Abortion rights advocates and anti-abortion advocates were both unhappy with the privacy argument used as the basis for *Roe v Wade*. Legal scholars argue that the Roe decision is based on an extremely liberal constructionist reading of the Constitution, as not only is the right to privacy a liberal take on the Amendments, but the application of the right to privacy to abortion at all is a misapplication of the legal principle. Abortion, unlike contraception used by married couples, is not an act that takes place in private. Legal scholars have criticized Justice Blackburn's majority opinion on the case as, "not constitutional law and gives almost no sense of an obligation to try to be".[30] Other scholars, particularly feminist legal scholars, argue that a decision based on equality rather than privacy arguments would have created a more solid foundation for abortion rights than *Roe v Wade* was able to establish.[29]

One of the most critical findings of the Court's decision in *Roe v Wade* was its rejection of 'fetal personhood,' the legal recognition giving full protection and standing from the moment of conception. The majority decision explicitly stated, "the word 'person' as used in the 14th Amendment, does not include the unborn".[26] However, the Court acknowledged that personhood is a central element in abortion rights. The recognition of fetal personhood as a valid legal principal would have a devastating effect on abortion rights, as, "if this suggestion of personhood is established, the appellant's case, of course, collapses, for the fetus' right to life is then guaranteed specifically by the Amendment".[26]

While *Roe v Wade* established abortion rights for American women, the *Doe v Bolton* decision created limits on the barriers states could put on women's ability to access that right. The Georgia law challenged in *Doe v Bolton* allowed abortion under circumstances where the health of the mother was at risk, where serious fetal disability was detected, and in the case of rape or incest. However, the Georgia law included strict procedural requirements, such as requiring all abortions to be conducted in licensed hospitals, and written certifications from both physicians and administrative staff approving the abortion as necessary.[27] The 1973 Supreme Court ruling struck down all these provisions as well as Georgia's requirement that women seeking abortions be residents of the state. *Doe v Bolton* also took a broad position on health, with Justice William O. Douglas noting in his concurring opinion that health may include situations that, "may imperil the life of the mother, or which, in the full setting of the case, may create such suffering, dislocations, misery, or tragedy as to make an early abortion the only civilized step to take".[33] Together, *Roe v Wade* and *Doe v Bolton* constituted a major shift in American abortion law, invalidating abortion laws in all 50 states.[34]

2.3 The Rise of Early Abortion Bans

"Heartbeat bills", also known as early abortion bans, refer to bills that restrict abortion access after fetal cardiac activity is detectable. The benchmark used by these bills is the earliest point when a fetal heartbeat is medically detectable, commonly understood to be at 6 weeks. "Heartbeat bills" constitute a particularly dangerous attack on abortion access because most women are not aware they are pregnant at the 6 week mark, functionally transforming these bills into total abortion bans.[35-36] Abortion rights advocates have been extremely resistant to referring to this type of legislation as 'heartbeat bills' in response, with Planned Parenthood promoting the use of '6-week abortion bans' instead.[37-38] Ceding to the terminology of 'heartbeat bills' lends legitimacy to the idea that there is a fetal heartbeat at 6 weeks, despite professional organizations such as the American College of Obstetrics and Gynecology challenging the medical accuracy of the term 'heartbeat' at 6 weeks (ACOG, 2017).[39]

The first early abortion ban legislation appeared in Ohio in 2011, and almost 100 more of these bills have been introduced in 25 states since. All such legislation has either failed to pass or been blocked by the courts. In 2013, North Dakota and Arkansas passed their own versions of this type of legislation building a slow momentum; no states followed their lead until Iowa in 2018. However, 2019 brought an extreme acceleration in heartbeat bans, with Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, New York, Ohio, South Carolina, Tennessee, Texas and West Virginia all introducing bills and Kentucky, Mississippi, Ohio, Georgia, Louisiana, Missouri, and Alabama all passing heartbeat bans. All 9 passed heartbeat bans have been blocked in court as unconstitutional.[6-8]

These bills exploit a weakness in the Roe v Wade decision concerning the definition of fetal viability as the benchmark determining the states' ability to restrict abortion rights. While

the Court did establish a framework based on pregnancy trimesters to indicate whether abortion restrictions would comply with their decision, maintaining that all first trimester abortions were protected and all third trimester abortions prohibited to balance maternal and fetal rights, this was based on the Court's definition of viability.[26] Justice Blackburn reportedly conducted thorough research on fetal development when deliberating *Roe v Wade* and settled on fetal viability at the point where fetal rights became "compelling" rather than quickening or conception, two other benchmarks up for consideration.[40]

The Court established 28 weeks as the point where a fetus becomes viable, however it also acknowledged that viability might come earlier.[40] Improvements in medical technology since 1973 have changed the way viability and "meaningful life" is understood in the context of fetal development. While the survival rate for premature births (>30 weeks) increases exponentially the later the birth,[41] trends in premature birth (22 weeks-25 weeks) survival rates have been steadily increasing since the 1990s.[42] As medical technology's ability to successfully support premature births improves, so does the cultural understanding of viability (Bronstein, 2019).[43] Legal scholarship has identified this manner of pushing back the definition of 'viability' as a critical weakness of *Roe v Wade*. Technological advancements allow earlier survival for preterm births, undermining the medical basis of the trimester system established by *Roe v Wade* and opening an avenue for new anti-abortion legislation designed to challenge the precedent.[28, 40, 44-45]

The question of 'fetal personhood' in abortion discourse has been central since the Supreme Court rejected the assertion that a fetus was considered a legal person under the 14th amendment.[26] While fetal personhood laws usually come in the form of full abortion bans without exception, personhood language is sometimes included in early abortion bans such as

Georgia's HB 481.[2,46] The goal of fetal personhood legislation is to establish full legal rights and protections under the law for fetuses.[21] Medical advancements have introduced successful intervention to infants born as early as 22 weeks, supporting shifting cultural understandings of viability and personhood.[43] Americans have historically been wary of committing firmly on the side of either fetal personhood or unrestricted abortion access, preferring an uneasy balance between the two.[9] Personhood rhetoric is common even in media depiction of abortion; analysis of media coverage of abortion between 2013-2016 found that while personal abortion narratives were included in only 11% of pieces, fetal personhood language was present in almost 33%.[47]

Model legislation has played a significant role in the proliferation of heartbeat bills since 2011. Model legislation is a common tactic used by anti-abortion advocacy groups, where 'model text' of bills are drafted and then made available to anti-abortion legislators across the country who can then introduce the legislation into their own states.[48-49] The 2011 Ohio bill was drafted by Faith2Action, an anti-abortion advocacy organization that offers the text of that bill on their website.[50] Model legislation has been an extremely successful strategy primarily employed by anti-abortion advocacy groups; in 2019, 29 of 30 abortion restriction bills passed by state legislatures were based on model legislation.[51]

2.4 Living Infants Fairness and Equality (LIFE) Act – HB 481

Georgia House Bill 481, also known as the Living Infants Fairness and Equality (LIFE) Act, was introduced into the House on February 25th, 2019. HB 481 establishes two new restrictions on abortion in Georgia: it bans access to abortion after a fetal "heartbeat" is medically detectable, and it establishes fetal personhood and grants full legal protection.[2] HB 481 was designed to fulfil Governor Brian Kemp's campaign promise to pass a 6-week abortion restriction "heartbeat bill" when elected in 2018.[52] It was sponsored by 6 Republican

representatives in the House: Representatives Ed Setzler, Jodi Lott, Darlene Taylor, Josh Bonner, Ginny Ehrhart, and Micah Gravley. It successfully passed through the House Health and Human Services committee on March 6th and was successfully passed by the House on March 7th. The vote was almost entirely along party lines, with 91 of 92 yea votes from Republicans, and 70 of 73 nay votes from Democrats. The bill was introduced into the Senate on March 8th by Senate sponsor Senator Renee Unterman, passed through the Senate committee on Science and Technology on March 18th, and passed by the Senate with amendments on March 22nd. The Senate vote was even more clearly delineated on party lines, with all 34 yea votes from Republicans and all 18 nay votes from Democrats. The amended version of HB 481 was passed by the House on March 29th and signed into law by Governor Brian Kemp on May 7th, 2019.[53-54]

HB 481 introduced several new provisions into Georgia law, the two most important being establishment of a detectable heartbeat as the marker for fetal viability, and, "amend[ing] state law to define 'natural person' to mean 'any human being including an unborn child.'".[55] The establishment of a fetal heartbeat as the benchmark for viability means that before an abortion can be performed, providers must confirm that there is no detectable heartbeat present. HB 481 also include exceptions for cases where the life of the mother is at risk, fetal health is at risk, or the pregnancy is a result of rape or incest and a police report has been filed. HB 481 uses the establishment of personhood to include fetuses in state census calculations, as well as expands the definition of dependents to include fetuses in the Georgia tax code. HB 481 also includes some traditionally targeted restrictions on abortion providers (TRAP) provisions, including requiring facilities providing abortion services to be licensed by the State Department of Community Health and restricting those who can perform abortion procedures to licensed physicians.[55]

Though HB 481 was signed into law by Governor Kemp, abortion rights advocates in Georgia responded swiftly to protect access to abortion for Georgian women. On June 6th, 2019, the American Civil Liberties Union (ACLU) filed *Sistersong v Kemp* as a constitutional challenge to HB 481. *Sistersong v Kemp* argues that HB 481 violates *Roe v Wade* and many other cases establishing precedent on fetal viability. The complaint also highlights how already disadvantaged Georgians will be the most greatly affected, and that HB 481 will create a dangerous situation where the health of Georgian women is not prioritized.[56] The ACLU also filed a request for an injunction blocking HB 481 from going into effect on January 1st, 2020 until the legal challenge has been settled.[57] This injunction was granted on October 1st, 2019 by a federal judge; HB 481 will not go into effect until after the constitutional challenge has been settled.[58]

2.5 Sexual and Reproductive Health in Georgia

While HB 481 creates one of the most restrictive environments for abortion rights in the country, this bill joins an expansive number of abortion restrictions already in place in Georgia. Georgia's current abortion law in place until HB 481 goes into effect bans abortions after 20 weeks, again cutting *Roe v Wade's* standard of viability short. Georgia has a 24-hour waiting period, and mandatory counseling that contains information on fetal development and fetal pain, as well as resources for women who decide to keep the pregnancy. Georgia severely limits insurance coverage of abortion, restricting any plans offered on the state marketplace from offering coverage, not offering coverage to state employees, and not offering Medicaid coverage for abortion. Georgia also requires parental notification of all minors seeking an abortion, with no exceptions for victims of rape, incest, or child abuse. While the legal landscape surrounding abortion in Georgia is bleak, legal protection of contraceptives access is more encouraging.

Georgia requires all insurance policies with prescription drug coverage to cover contraceptives as well and has offered contraceptives coverage for low-income women.[59]

Besides experiencing extremely restricted access to abortion, Georgian women are experiencing several other sexual and reproductive health crises as well. Georgia ranked 48th in the nation in maternal mortality in 2016, with 40.8 maternal deaths per 100,000 live births. Within that already chilling statistic, racial disparities are significant, with black women experiencing rates of maternal mortality more than three times than that of white women in Georgia 2010-2012.[60] This is partially a result of Georgian women's dismal access to healthcare. Georgia ranks 48th in the nation in women's healthcare coverage, and half of Georgia counties do not have a practicing OBGYN.[61] Racial disparities also significantly affect access to healthcare; 80% of black mothers have to leave the county they live in for OBGYN care.[60] Georgia is also currently experiencing a sexually transmitted infection crisis; according to Centers of Disease Control data, Georgia ranked in the top 10 states for chlamydia, gonorrhea, and syphilis cases in 2017.[62]

2.6 Health Effects of Abortion Restriction

Evidence shows that restrictive legal environments have a detrimental effect on women's health without substantially decreasing the number of abortions being performed. Before the establishment of *Roe v Wade* and *Doe v Bolton*, maternal mortality due to all causes including abortion was decreasing in the United States due to increased skill from providers and critical discoveries such as penicillin to treat sepsis. It is difficult to quantify exactly how many unsafe abortions were happening in the United States before 1969, when the CDC first started collecting surveillance data on the topic.[63-64] However, analysis of maternal mortality due to abortion shows that there was a significant decline after 1973 and the establishment of the right to abortion

access that can be attributed to the shift from illegal to legal abortion.[64] As a result of Roe v Wade and Doe v Bolton, maternal mortality resulting from unsafe abortion declined, "from greater than 100 deaths annually (likely an underestimate as a result of underreporting) to four deaths in 2013".[65] While not all of this decline can be attributed to legalization, as new techniques and provider knowledge have made the procedure safer, the shift to legal abortion was a significant driver of this decrease.[64, 66]

In contrast, trends in abortion incidence worldwide show that abortion restrictions do not have a significant impact on the incidence of abortion but instead effect mortality due to abortion.[67] Maternal mortality due to unsafe abortion is directly affected by the abortion legislation, as the highest rates of unsafe abortions are seen in countries with restrictive policies, as much as 10 times as high as countries with abortion on request policies.[68] Unsafe abortion constitutes a significant health burden, as 13% of maternal deaths worldwide can be attributed to unsafe abortion.[68] Legal abortion has also proved to be significantly safer than childbirth, with maternal mortality associated with childbirth accounting for 14 times more maternal death than that due to legal abortion in the United States.[69] Policies that establish restrictive environments, such as the global gag rule, have been shown to adversely affect the functioning of health systems while failing to decrease abortion incidence.[70]

Preliminary data suggesting that the modern increase in abortion restrictions in the United States and the subsequent reduction of access for American women will increase incidence of illegal abortion have already started to emerge.[65] Researchers analyzing Google search terms found searches for methods of self-inducing abortions jumped 40% in 2011, a year in which 92 abortion restriction laws were passed, and the same year the Ohio early abortion ban legislation became law. This jump in Google searches was unique to the United States; the number of

Google searches for self-induced abortion methods remained level in Canada. Analysis of individual states' search terms found that states that had strict limitations on abortion access had higher rates of Google searches for self-inducement methods.[71] Searches in the United States have increased more than 100% since the early 2000s; while a clear causal link has yet to be determined, evidence from Texas shows a rapid increase in maternal mortality since the enactment of abortion restrictions in 2011.[65] Currently, Georgia is ranked worst in the nation for maternal mortality creating a dangerous environment for the introduction of early abortion ban legislation.

2.7 Abortion Storytelling in Abortion Rights Advocacy

The use of personal narratives has emerged as a critical part of abortion rights advocacy strategy.[12, 16, 72-74] Abortion narratives have the power to influence both stigma experienced at the individual level[14], as well as serve as a call to action. The story of Savita Halappanavar's preventable death in Ireland was a major motivating influence that led to the repeal of Ireland's abortion restrictions.[74] In the field of public health, first person narratives are generally considered to be lower quality than quantitative evidence. However, other disciplines like feminist theory have embraced the evidentiary strength of these narratives.[16]

Abortion narratives preferred by the abortion rights movement have focused on 'necessary' abortions, either for medical reasons or because of other mitigating circumstances such as rape or incest.[12, 47, 72-73] Analysis of common abortion narratives suggest that the narratives most appealing to abortion rights advocates are ones that frame the woman seeking an abortion as a sympathetic figure. Common themes in these narratives included dealing with accidental pregnancy despite taking precautions and framing the decision to have an abortion as empowering.[72] Prioritizing these types of narratives may have the unintended effect of further

stigmatizing women who have “undesirable” abortion stories, those who were not careful, have had multiple abortions, or choose abortion under less morally acceptable circumstances. This should be considered a significant problem as the many American women who have chosen to have an abortion do not perfectly fit a sympathetic narrative.[12, 72]

Various rhetorical strategies have been shown to effectively influence legislators, particularly on the subject of abortion. First person narratives and the use of emotive language have been demonstrated to be extremely effective as used by advocates of banning ‘partial birth’ abortion.[17, 75] Research has shown that lawmakers are not overly affected by the presentation of evidence and are more likely to continue to believe trusted sources and draw broad conclusions from anecdotes than be influenced by new evidence.[18] This poses a particular challenge for public health practitioners in the types of evidence prioritized by the discipline. Recent research on abortion rhetoric has shifted to focus on legislative debate and testimony in order to better understand the legislative process and forge stronger arguments in support of abortion rights.[20-21]

3. Methods

3.1 Population and Sample

The study population for this project included testimony from 44 legislators from both the Georgia House of Representatives and Senate, as well as 29 community members who spoke against HB 481. HB was identified for analysis on the basis of the severity of the bill at its introduction, the public availability of debate footage, and the geographic location of the research team in Georgia. The data were collected by identifying when in the legislative calendar HB 481 was discussed. The transcripts used in this analysis come from the March 6th House Health and Human Services committee hearing, the March 7th House floor debate, the March 14th and March 18th Senate Science and Technology hearings, the March 22nd Senate chamber debate,

and the March 29th House floor debate and second vote. In all, 14 hours of debate on HB 481 were transcribed and coded for this analysis.

The publicly available footage from these sessions was procured from the Georgia Legislature website. Videos were downloaded, converted into audio files and transcribed using the automated transcription service, Happy Scribe. A research assistant checked the transcriptions for fidelity.

3.2 Research Design

Data analysis was done using a qualitative narrative analysis technique. Narrative analysis, or narrative inquiry, is a qualitative research process that focuses on the analysis of data as 'stories' that emerge from intentionally collected research data or from other secondary data sources, such as newspaper articles or legislative debate.[76-77] Understanding and analyzing qualitative data as stories is useful not only to identify themes and patterns in the types of stories being told, but also allows researchers to examine why and how particular stories are used in various contexts.[76-77] This technique was selected because persuasive testimony is often dependent on persuasive story building. Forging personal connections through sharing narratives has been shown to be one of the most effective persuasive techniques in abortion debate,[18] and to understand the testimonies given about HB481 it is critical to understand them as narratives.

3.3 Procedures

The preliminary codebook was derived from previous analysis focused on arguments used by supporters of HB 481.[21] The codebook was adapted for this work using descriptive memoing to identify inductive codes and argumentation unique to opponents of HB 481. New codes focused in particular on women's health and provider experiences, such as workforce issues, maternal mortality, medical ethics, and women's rights and related sub codes. The

legislative session transcripts were coded using MAXQDA 18 software. Demographic and professional information on participants was gathered by reviewing the taped legislative sessions and visually determining the race and gender of each speaker.

3.4 Data Analysis

Analysis was conducted by identifying the codes used with the most frequency. This was done by first creating a word cloud for the authors to get a visual sense of what codes were being used most frequently. Different word clouds were created for committee hearings where community testimony was given and for legislative debate to identify different patterns in code frequency. Further examination of the codebook was used to finalize the list of codes on which we focused our analysis. Thick descriptions were written for all parent codes containing more than 30 coded segments and sub codes containing more than 25 segments, allowing deep analysis of patterns within codes. Thick descriptions are a qualitative analysis technique that focuses on description of a single code or part of the data in order to develop a comprehensive understanding of not only the content of the codes but the context in which they are used. Thick descriptions are created inductively through examining all segments of a code to understand the full nuance of the arguments; they are also particularly useful for identifying patterns and connections between codes and themes.[78] Thick descriptions are particularly useful when conducting narrative analysis as they allow for deep exploration of 'why and how' particular codes are used within narratives. The codes identified for thick descriptions were health/medical (56 segments), enforcement (49 segments), appropriation (41 segments), medical practice (39 segments), personal narrative (38 segments), statistics (33 segments), maternal mortality (31 segments), heartbeat (30 segments), workforce issues (29 segments), gender (27 segments), and constitutional/federal (25 segments).

3.5 Ethical Considerations

The Emory University's Institutional Review Board (IRB) found that this study was exempt since it did not meet the definition of human subjects research. While the research team recognizes that abortion rights advocates and legislators are exposed to risk by being publicly identified with the pro-choice position, we do not believe that we have exposed any of the research subjects to increased risk of harm as the data used are all publicly available. Research also suggests that women publicly sharing abortion narratives describe the experience as positive even when they have received negative feedback or harassment as a result.[15]

4. Results

4.1 Demographics

Demographic analysis of the legislative debate on HB 481 identified 44 legislators and 30 community members who spoke against the bill. Though the majority of the Georgia legislature is White and male (69.49% and 69.07% respectively), Black and female legislators were disproportionately represented among those speaking in opposition to HB 481 (54.55% and 77.27% respectively (Table 1). Demographic analysis of community testimony showed this to be a continued pattern in regard to sex, but not to race. Women (83.33%) were vastly overrepresented among community members giving testimony. However, where Black members of the legislature played a prominent role in opposing HB 481, Black Georgians made up only 23.33% of community members giving testimony. This is notable considering the United States Census Bureau estimates that 32.4% of Georgia residents identify themselves as Black or African American.[79] Most community members identified themselves as Atlanta residents, where the Census Bureau estimates 51.8%[80] of the population identifies as Black or African American.

Table 1
Demographic Characteristics of Legislators and Community Members Who Spoke in Opposition to HB 481

	Georgia Legislature[81]	Anti-HB481 Legislators	Anti-HB481 Community Members	Georgia Population[79]
Sex				
Female	72 (30.50%)	34 (77.27%)	25 (83.33%)	51.4%
Male	163 (69.07%)	10 (22.73%)	5 (16.67%)	48.6%
Race				
White	164 (69.49%)	18 (40.91%)	18 (60.00%)	52.4%
Black	60 (25.42%)	24 (54.55%)	7 (23.33%)	32.4%
Hispanic	3 (1.27%)	1 (2.27%)	1 (3.33%)	9.8%
Asian	2 (0.85%)	1 (2.27%)	4 (13.33%)	4.3%
Other	4 (1.69%)	0 (0%)	0 (0%)	1.1%
Total	236	44	30	10,617,423

Note: Sex composition data collected in 2019, and race composition data collected in 2018. There is some variation in the sex and race composition statistics and the total number of legislative seats due to seat vacancies and other non-election related turnover.

Medical professionals were heavily overrepresented in comparison to other professionals in community testimony. Medical professionals made up 73.33% of community members who testified in both House and Senate committee meetings, including OBGYNs, RNs, medical students, and other professionals. 16.67% of community members did not identify their professions while they were giving testimony.

Table 2
Occupation of Community Members Who Spoke in Opposition to HB481

	Anti-HB481 Community Members
Medical Professional	22 (73.33%)
Legal Professional	3 (10.00%)
Other/Unknown	5 (16.67%)
Total	30 (100%)

4.2 Testimony Analysis

Opponents of HB 481 deployed three foundational arguments, supported by a wider variety of rhetorical tactics. The foundational arguments include that implementation of HB 481: negatively affects women's health; threatens women's rights; is unable to be operationalized; and that narratives from healthcare providers were privileged over other narratives. While overall all arguments were used by both legislators and community members giving testimony, legislator speeches featured rights-based and operationalization arguments more prominently, while community testimony heavily featured narrative and health-based arguments; women's health arguments featured prominently in both types of testimony.

Figure 1: Tactics used by HB 481 Opponents

Tactics	How they were used	Example
Financial Cost	Used most frequently by legislators when discussing the theme of operationalization	*"We have no idea how much this tax deduction is going to cost. There will also be criminal enforcement costs that are going to go with that. We have no idea how much that's going to cost. And there'll be two tiers of constitutional challenges with this. First, the challenge under the current U.S. Supreme Court law. But secondly, this bill provides standing for individuals to continually sue the state of Georgia over the provisions in this bill. So we're going to have massive cost. We have no idea where they are and in my mind that would on its own justify tabling so that these uncertainties could be arrived at"*
Legal Precedent	Used most frequently by legislators when discussing the theme of women's rights; also discussed by community members in particular those who identified themselves as legal professionals	*"The ACLU of Georgia opposes HB 481 because the government should never criminalize the most intimate decision women and couples can make, and flies in the face of nearly 50 years of Supreme Court precedent"*
Medical Authority	Used most frequently by community members using medical authority to support their claims in regards to the theme of women's health	*"This bill plans to redefine viability, conveniently the American College of Obstetricians and Gynecologists with its membership of over 55,000 OBGYNs across the U.S. already has a definition of viability. So not only is this shocking and inappropriate for lawmakers to suggest but it's also completely unnecessary as medical experts have already done this."*
Scientific Evidence	Used most frequently by community members using medical authority to support their claims in regards to the theme of women's health	*"At six weeks if you look at the side, the thickness of your fingernail that is the size of the fetus. It is 2 to 3 millimeters thick not centimeters. It proposes that there is a heartbeat, at that point in time sometimes on ultrasound with very enhanced technology you can see motion in the heart but those are the Purkinje fibers that are developing that will eventually intervene the heart. But that*

		does not mean there's a formed heart nor that there is a heartbeat so it is misleading."
Statistical Evidence	Used most frequently by legislators, often discussing maternal mortality and provider shortage statistics in relation to the theme of women's health	*"My research demonstrates that 55% of the areas outside of metro Atlanta have a shortage of providers that care that care for pregnant women and deliver babies. 80% of these areas have no obstetricians whatsoever, and those care deserts have grown more than 20% in the past eight years. Furthermore in the past 25 years more than 30 labor and delivery units in Georgia have closed leading to a nearly 50% decline in rural birthing facility access."*
Storytelling	Used by community members to share personal abortion stories, abortion stories from patients, and personal experiences from medical professionals. Used by legislators often to discuss their own fertility history, rarely sharing personal abortion stories. Also used by legislators to share constituent experiences with abortion.	*"Let me tell you how it feels to be a woman and a mother of a daughter, whose reproductive health this body now claims as its own. My husband and I were talking about this bill the other night and he told me that he didn't want me to share anything personal because no one was entitled to that information and I have always fiercely guarded my privacy, but let me be clear the deepest darkest times of my life have occurred in the presence of and with my physician."*

4.2.1 HB 481 would negatively affect women's health

The most common foundational argument used by opponents of HB 481 addressed the negative health effects the bill would have on Georgian women. This argument was used by legislators and community members alike, and elements of or relating to this argument were seen in almost every speaker's remarks. The three most prominently used elements of this argument were: that HB 481 would cause providers to hesitate to give lifesaving care to pregnant women that may harm the fetus; that HB 481 would increase Georgia's provider shortage and drive OBGYNs out of the state; and that HB 481 would therefore result in a significant increase in Georgia's already "*dismal*" maternal mortality rate. Opponents of HB 481 emphasized how the bill would result in further deterioration of the already weak health system and limit women's access to healthcare; by including fetal personhood language, HB 481 creates a medical environment where healthcare providers must compromise the quality of care they give women in order to ensure fetal health and safety. One practicing OBGYN noted her fears that,

> *"Medical providers may not complete radiologic imaging for fear of harming the unborn. They may not give chemotherapy; they may defer surgery for the mother and fear of being charged with homicide. OBGYNs caring for common conditions in pregnancy may feel the need to wait for a higher blood pressure, a higher fever, or even more blood loss."*

Community members identified this as particularly dangerous for women with medical conditions whose treatments had adverse health effects on fetal development. There is no clear language in the bill of when the life of the mother exception is in effect under such circumstances, despite targeted questioning from a legislator to the bill's sponsor on the issue.

Women with cancer or living with mental illness who require medication "*critical to [their] daily activity*" that is incompatible with pregnancy were identified as particularly vulnerable.

Providers giving testimony made it clear that HB 481 would cause "*brain drain*" of OBGYNs out of Georgia and prevent new medical students from choosing to study in the state. The statistic most commonly cited by community testimony and legislators alike was that, "*50% [of] Georgia counties*" do not have a practicing OBGYN. Personal stories about struggles to access reproductive health care in rural parts of the state appeared in all types of testimony as well. In community testimony given by an OBGYN, she cited statistics that 88% of Georgian OBGYN residents responded "no" to the statement, "*Georgia will become a more attractive state in which to practice obstetrics*" if HB 481 was passed. One OBGYN who previously worked in a rural part of the state shared her experience working in a hospital that denied patients access to abortion,

> *"I left for these restrictive policies and I left because of the lack of supportive policies for maternal health that kept me from completely doing my job and that kept me from providing the quality of OBGYN care that I'd pledged to provide. I loved that job and I left."*

Opponents of HB 481 emphasized the "*obligations*" of providers to their patients, particularly their duty to provide "*evidence-based care*." This was framed as a critical failing of the bill; by interfering with decisions that should be "*between a woman, partner, and medical staff*", supporters of HB 481 are undermining the relationship between patients and their doctors and threatening women's ability to receive "*high quality medical care*."

Opponents of HB 481 argued that provider hesitance to provide lifesaving care and women's decreased access to medical care caused by a worsened provider shortage would have a

devastating effect on Georgia's maternal mortality rates. The second most commonly cited statistic by opponents of HB 481 referenced how, "*more women die from pregnancy in this state than any other*," Georgia's 50th ranking for maternal mortality. Legislators and community members alike presented another inevitable consequence of the bill: illegal abortion. They offered stories of women who resorted to illegal abortions under restrictions like HB 481, with one community member sharing the story of her own abortion, noting that if HB 481 had been in place at the time,

> *This limitation of my options would not change my confusion, nor would it change my feelings of fear, and nor would it erase my sense of desperation and I truly believe that this conversation is about safe and legal abortions. It's not about if- whether or not I would have had an abortion is not on the table- it is how.*

One community member testified that we know that, "*maternal mortality and infant mortality are higher in places where abortion is illegal or highly restricted*" not only as a result of illegal abortion. Opponents of HB 481 used this frame as the most important argument of the dangers of HB 481 to Georgian women's health.

4.2.2 HB 481 threatens women's rights

Opponents of HB 481 framed their legal arguments against the bill as protecting women's rights that were under attack. One of the most important if not nuanced arguments was the unconstitutional nature of the bill. The constitutionality of the bill was addressed primarily by legislators and community testimony given by legal professionals; it was rarely seen in community testimony from medical professionals. While community testimony engaged in more depth about the constitutional issues at play, most legislators noted the unconstitutional nature of

the bill in order to highlight its vulnerability to being struck down. Viability emerged as an important point of contention, with one legislator noting,

> *"…the United States Supreme Court has affirmed that women have a constitutional right to abortion. The bill bans abortions long before the point of viability regardless- regardless, of what the state of Georgia prints in the law, whether a fetus is viable because a medical determination occurs much later in pregnancy."*

HB 481 intended to replace the current constitutional standard of fetal viability as the threshold for abortion restriction with the 6-week detection of the heartbeat. Medical professionals and legislators alike rejected this new benchmark as not "*medically sound*", arguing that a heartbeat can still be present in a case "*not sustainable with life*." Testimony from community members who had chosen to abort wanted pregnancies that had heartbeats but were not compatible with life were particularly strong support for this point, such as testimony from one community member that, "*Our daughter had no brain or skull but she did have a heartbeat. Once again we had options: plan a funeral or end the pregnancy*."

Legislators in particular emphasized "*choice*" as a fundamental right that would be stripped by HB 481, whereas medical professionals giving community testimony referred to 'decision making' and the right for women to make decisions with their doctors rather than grander scale 'choice' arguments. Opponents of HB 481 also highlighted how restrictive abortion policies like heartbeat bills make it more difficult to make choices about abortion. One legislator argued, "*Asking a woman to make a decision in a day's time from finding out she is even pregnant to making a lifelong choice is unfair and dangerous.*" Opponents argued the damage done to women forced to carry unwanted or nonviable pregnancies to term; one

community member who was denied an abortion when she needed it described her experience as, "*forced motherhood, forced slavery*."

The perception of the bill's language as vague and poorly defined also opened up new threats to women's rights in Georgia. One legislator highlighted these concerns for pregnant women who had experienced miscarriage,

> *"She would risk be at risk of criminal indictment for virtually any perceived self-destructive behavior during pregnancy which could cause miscarriage to which smoking, drinking, using drugs, using legal medications, driving while under the influence, or any other dangerous or reckless conduct."*

Another legislator addressed the possibility of even more draconian restrictions on women's freedom as a result of this bill, such as,

> *"…the state will need to investigate or surveil women who engage in behavior that could be detrimental to their fetus. … What if the person claiming to be the father thinks that the mother is an unsafe mother, could he be granted custody by a court? Could the pregnant woman be prevented from travelling across state lines if the putative father believes that the mother is attempting to kidnap the fetus?"*

The implications of enforcement and balancing the newly minted legal status of fetal personhood against the legal status of their adult mothers was not well defined in the bill's text.

Legislators and community members alike discussed the way HB 481 would disproportionately affect the lives of Georgians who are already disadvantaged. One provider noted that, "*States that have more strict abortion restrictions have worse maternal and child health indicators, and this disproportionately affects people who are poor and women of color.*" Testimony given by experts highlighted how black women had been unable to access safe

abortions under Georgia law before Roe v Wade, but that "*white Atlanta women*" were able to access safe abortions. Multiple speakers argued that this continues today, as maternal mortality for black mothers is "*four to five times higher*" than for white mothers. This issue of equity was also identified as a significant factor affecting the provider shortage, as women in low-income and rural counties were less likely to have access to OBGYN care and turns HB 481 into, "*an outright ban on abortion for women who don't have the ability to travel out of state,[or] take time off work find child care*."

4.2.3 HB 481 is unable to be operationalized

The foundational argument favored most heavily by legislators focused on the unfinished nature of HB 481. Opponents identified several significant changes to current Georgia law that will require new systems of enforcement and funding to implement, the specifics of which were absent from HB 481's text. Opponents of the bill focused on the lack of fiscal note and the unclear liability established by fetal personhood as the most significant barriers to operationalization.

The most significant operationalization issue identified by opponents of HB 481 is the lack of fiscal data presented in debate on the bill. Under Georgia law, fiscal notes are required for, "any bill significantly impacting the state revenues or expenditures" and gives an estimate for the overall cost of said legislation.[82] Legislators questioned the various ways HB 481 would drastically increase state expenditures on things like the census and "*tax deductions*" with no fiscal note attached to the bill, meaning that no one could say exactly how much it would cost. In particular, opponents of the bill were concerned about the language that expands eligibility for the child tax credit back to conception, including establishing women who have had miscarriages as eligible. One legislator expressed her concern about,

"*How would the state have a way of verifying about a pregnancy that early, I'm just asking how you think we would verify this or this part of the law is enforceable.*"

When the bill sponsor replied that a medically verified pregnancy test would be the accepted proof, the legislator continued, "*that makes me even more concerned about it now because somebody has to pay for that*." The issue of payment for new requirements under the bill is also identified in paternity tests to establish child support before delivery. Opponents of HB 481identified the lack of operationalization details as a significant barrier to determining how much implementation of the bill will cost and prevented the opposition from questioning where that money would come from.

This theme was often connected to the issue of constitutionality and women's rights, as opponents pointed out that the unconstitutional nature would require the bill to be defended in court. One legislator expressed concern that, "*based on what we know about other states experiences in defending blatantly unconstitutional laws such as this, Georgia taxpayers will be paying millions of dollars to defend this law*." Legislators were very concerned that the fiscal note did not address the cost of these challenges, describing them as "*fiscally irresponsible*." A serious concern from one legislator was that, "*not a single state in this country has managed to put similar legislation into lasting practice as courts have continuously deemed them unconstitutional*."

Opponents of HB 481 also identified its "*constitutionally vague*" language around provider obligations and liabilities as a result of the new legal status established by fetal personhood as a critical flaw. In her testimony, one practicing OBGYN cited statistics noting that 76% of Georgia OBGYN residents surveyed said they were "*more concerned about being sued as a physician*" as a result of HB 481. Opponents of HB 481 characterized these new legal

obligations as "*broad overreach*" from the state, "*putting a wide array of medical professionals in the untenable position of denying medical care to pregnant people for fears of persecution*." When questioned directly by a legislator, the bill sponsor refused to definitively create guidelines on how a heartbeat should be measured, leaving health care providers open to prosecution if their interpretation of the statute differed from the state's. The bill's sponsor continued to emphasize the flexibility of the law in response to one opponent of HB 481 who asked,

> *"…if a woman knowingly has cancer or any other type of condition that requires some type of medical treatment that it's already proven to be adversely impact their embryo does the mother have to continue on until they find out that that has impacted or created an issue or problem with the infant or a fetus?"*

Health care providers who spoke against HB 481 did not find this flexibility reassuring, but rather a major cause for concern.

4.2.4 Opponents of HB 481 focused on narratives from health care providers

Opponents of HB 481 used personal narrative as an important type of evidence in testimony against the bill, however narratives from providers rather than women sharing their own abortion experiences were prioritized. Of the 22 health care professionals that gave testimony during committee hearings, only 7 of them shared stories from their patients dealing with abortion (Table 3). Most of the provider testimony was focused on how the bill would affect the way they practice in Georgia.

Table 3
Category of Abortion Narrative Shared in Anti-HB 481 Testimony

	Anti-HB481 Speakers
Legislator Sharing Constituent Stories	6 (31.58%)
Legislator Sharing Personal Story	2 (10.53%)
Medical Professional Sharing Patient Stories	7 (36.84%)
Community Member Sharing Personal Story	4 (21.05%)
Total	19 (100%)

There was a wide variety of personal abortion narratives shared by opponents of HB 481. Each of the 6 women who shared personal narratives had different experiences which highlighted the diversity of abortion experiences and ways that women would be hurt by the passage of the bill and humanized women seeking abortions. Two of the community members who gave testimony in committee meetings shared stories of terminating pregnancies with heartbeats because of medical circumstances out of their control. One woman testified that,

> *"There was nothing wrong with the baby but it was killing me. Under this bill the baby is viable. There's nothing wrong with the baby but there was something wrong with me. So under this bill I wouldn't be here. I would be dead. I wouldn't be here to enjoy my children. They would have no mother. So that's a variable we don't think about. And that's what's important, a name to a face. I wouldn't be here, I would be dead."*

Another community member spoke of her experience after being denied an abortion,

> *"I wanted to go to college and be a medical student but that was dictated by other people. I had a right to make my own decisions but today I see here that women aren't allowed to make their decisions. The decision making is in the hands of the government,*

> *but the government is not there with the woman feeling her pain, feeling her life, feeling her challenges, feeling her hopes and her dreams."*

One of the legislators shared her experience, "*I stand here today confident in my decision to terminate my pregnancy when I was sexually assaulted*." The other two women who shared their abortion stories focused on how the pregnancies were not wanted regardless of the circumstances of conception, and that abortion was the right choice for them. The second legislator described her experience,

> *"Now my pregnancy was not the result of rape or incest but abortion was the right decision for me. I do not regret my decision. I didn't regret it at the time and almost 20 years later today, I do not regret my decision, and I am not scarred. I still do not regret my decision. It is time for government to simply do one thing: trust women."*

Opponents of HB 481 shared a wide range of abortion narratives to highlight the ways the bill would hurt Georgian women.

5. Discussion

In their attempt to stop HB 481 from becoming Georgia law, four major themes emerged from opponents' arguments: that HB 481 was dangerous to Georgian women's health; that HB 481 represented a threat to Georgian women's rights; that HB 481 could not be operationalized effectively; and that opponents of HB 481 focused on the experiences of healthcare providers. Though these arguments underpinned most of the testimony given on the bill, the specific ways they were deployed by community members and legislators varied widely, a finding consistent with other research on legislative abortion debate.[20] As early abortion bans continue to be debated in state legislatures it is important for abortion rights advocates to critically examine the ways they structure their own arguments in opposition to these bills.

The most prominent theme that emerged was that HB 481 would negatively harm women's health. This theme is important because the state of maternal health in Georgia has already been identified as a crisis.[60-61] Abortion rights advocates commonly use medical or scientific framing in arguments against abortion restrictions,[20] but these frames are used less frequently by proponents of these restrictions.[17, 21-22] Georgia legislators, even some of the most vocal proponents of HB 481, have professed a commitment to protecting the health and lives of Georgian mothers -- something which ought to be a concern of all state legislators. Identifying the contents of HB 481 as directly in opposition to that goal is an important foundation to rest the arguments against the bill.

This theme demonstrates the clear priority of opponents of HB 481: pregnant people. Georgia's early abortion ban was written to create a new and legally distinct class of protected persons based on a distinctly non-medical understanding of fetal cardiac activity. [21] Emphasizing the medical inaccuracies and contradictions inherent in this undertaking was a key strategy used by opponents of the bill. Abortion rights advocates focused on the damage HB 481 will do to health care provider's ability to provide comprehensive and high-quality care to women. Early abortion bans create a 'balance test' between fetal and maternal rights, however proponents of HB 481 rarely engaged in discussion of women's health unless prompted by opposing legislators.[21] Centering women's health and wellness in response to these bills establishes abortion advocates' fundamental argument that the lives of women are important and that their decisions about their own reproductive health care decisions should be trusted; such decisions were not viewed as being a role the state should subsume.

The second significant theme was that HB 481 threatens Georgian women's rights. Early abortion bans are specifically intended to challenge the current constitutional standards of

abortion restriction.[83] Reference to the 'right to choose' or other references to rights without specifically referencing *Roe v Wade* or other constitutional justification for said rights is common in rhetoric used in opposition to abortion restrictions, but these arguments are still fundamentally based on the *Roe* decision.[20, 29] Legal arguments focused on the unconstitutionality of early abortion bans, like those used by opponents of HB 481, are not likely to be effective when the primary intent of the legislation being debated is to challenge that constitutionality. While campaigning in 2018 now Governor Brian Kemp's pledged support for a 6-week ban, "six weeks is certainly worth the inevitable courtroom battle."[52] He kept that pledge by singing HB 481 into law in March 2019.

Another significant theme was that HB 481 is impossible to operationalize. This theme highlighted the inconsistencies in and rushed nature of the bill. Despite the fact that much of the legislative strategy used for HB 481 came from model legislation, fiscal implications were one of the most significant concerns even for proponents of the bill.[21] Opponents of HB 481 recognized this weakness and made it a focus of their argumentation against the bill; they did this through questioning the bill sponsor on specifics of cost and implementation as well as in their speeches.

A critical tactic used by opponents of HB 481 was to prioritize narratives from health care professionals. As a result, narratives from women sharing their own abortion stories were deprioritized. Sharing of abortion narratives is considered an important element of feminist argumentation and abortion rights strategy.[12, 16, 84] While opponents of HB 481 did bring women who have chosen to have abortions to speak on the bill, heavy priority was given to health care providers and their testimony both concerning the effect on their patients and their own practice. Anecdotally, this was a strategy decision to deprioritize abortion stories relative to health care

professionals within community testimony; in fact, “many organizations expressed dismay” that personal abortion narratives were not being centered and solicited by the opposition strategy.[85]

This decision represents a possible error in opposition strategy. Evidence suggests that legislators are not particularly swayed by expert testimony given on abortion restrictions, they are much more reactive to personal stories and connections.[17-18] Sharing personal abortion narratives has been demonstrated not only to have a positive impact on outsider perspectives of abortion, but to be a positive and empowering experience for those sharing their abortion stories as well.[14-15] Some of the most powerful testimony in the HB 481 debate came from opponents to the bill sharing their fertility experiences, both directly related to abortion and not. Provider and personal abortion narratives are both effective tools that can be used by abortion advocates, but a more careful balance might have allowed both types of narratives to be used more effectively.

5.1 Study Limitations

The most significant limitation to this study is the data used are from publicly available sources and were not collected deliberately for use in this analysis. This means that researchers were unable to probe for more information or clarity, as well as looking deeper into the motivations or intended strategies that participants used in debate. However, the research team’s knowledge and familiarity with the debate and public response as Georgia residents worked to balance this limitation.

While this analysis does include demographic data on the participants, these data were collected through observation of the recorded footage and not systematically collected data. This resulted in a reliance on both perceived race and gender for the analysis, as well as preventing the inclusion of age and other non-observable demographic data from being included in the analysis. Additionally, legislators and community members giving testimony were coded as

either in favor of HB 481 or opposed to it for the purpose of this analysis. This designation was made through observation of arguments made, identification of testimony as either for the opposition or in support, through party affiliation of speakers, or through identification of their final vote on HB 481. Effort was made during coding to categorize speakers using at least two of these determinants of position to ensure accuracy, however since these data were collected secondarily it is possible that some of their positions have been mischaracterized in this analysis.

Another potential limitation is the authors' strongly held opposition to HB 481. All of the authors believe themselves to have a personal stake in the bill's passage and were actively involved in the efforts to stop it. While we acknowledge this potential bias, great effort was taken to ensure impartiality throughout the coding and analysis process by engaging in reflexive journaling and discussion of the research topic with others not as directly involved.

5.2 Conclusion

American women are currently facing an unprecedented attack on their right to safe and legal abortion. Early abortion bans like HB 481 using fetal "heartbeats" as viability standards appropriate medical language and concepts to push a fundamentally anti-science agenda. This research continues with the narrative analysis of legislative testimony methodology pioneered in Evans and Narasimhan's 2020 analysis of pro-HB 481 legislative testimony and debate to distinguish and characterize the arguments used by abortion rights advocates in opposition to HB 481. As anti-abortion legislators continue to introduce early abortion bans to legislatures across the country, it is critical to understand the ways abortion rights advocates can build arguments to stop them.

6. Public Health Implications

6.1 Public Health Researchers

- This research demonstrates the importance for public health researchers to expand the methodologies and data sources used to have a greater effect on public policy.
- It is critical to understand how legislators use our work in building their political strategies and arguments in the fight to protect access to safe and legal abortion.
- By developing more thorough understandings of what evidence and political strategies are most persuasive and compelling for legislators, public health researchers can produce more relevant and persuasive work for abortion rights advocates to use; similarly counter arguments against policies designed to undermine abortion rights may be gleaned.
- Analysis of the types of argumentation favored by legislators as conducted in this research shows what legislators in favor of abortion access consider important.

6.2 Abortion Rights Activists

- Abortion rights activists must use more reflexivity when creating strategy to block the adoption of further abortion restriction. It is easy to rely on professional testimony and ‘sympathetic’ abortion narratives, but this does a disservice to those who do not fit into the idealized abortion story.
- This research can be used to better understand how arguments are interpreted by observers. This type of deep analysis of argumentation is important to understand when building strategies to prevent the passage of new bills looking to restrict access to abortion, whether they be early abortion bans currently favored by anti-abortion legislators or new restrictions developed in the future.

6.3 Abortion Providers

- Abortion providers have a responsibility to speak in opposition of bills that would harm their patients or negatively affect access to necessary health services. However, this should not come at the expense of centering those most affected by abortion restriction. Abortion providers must find this balance in order to improve the strength of their testimony.

6.4 Legislators

- Legislators looking to stop the passage of similar bills in their own states can use this research to determine how abortion advocates structured their arguments in Georgia. This can serve as a starting point for tailoring in response to the specific conditions of the bills in their own legislatures.
- Female pro-choice legislators may choose to share their own personal abortion stories as a tactic to raise accountability among their peers; likewise, male legislators may amplify the voices and stories of their female colleagues, family, members and friends.

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