Lauren Underwood: Balancing Maternal Equity and Political Compromise

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Abstract: Lauren Underwood introduced the Momnibus Act in 2020 as a piece of proposed legislation encompassing various frameworks to improve maternal health outcomes in the United States and eliminate the rampant racial disparities found in the medicalized birthing process. Underwood created this legislation to advocate for equality within the maternal health field and ensure that no woman falls victim to preventable complications from birth. A large part of the bill is the expansion of federal support for paraprofessionals like doulas, whose presence in the birthing process has shown to reduce the risk of birthing complications. However, the difficulties of the Covid-19 pandemic stalled Underwood's original bill. After reintroduction into the House, the only way to ensure this bill was considered was to combine it with President Joe Biden's Build Back Better Framework. Although Build Back Better passed through the House with relative ease, one Democratic Senator named Joe Manchin withheld his support, which halted the bill in the Senate. Now, the fate of Momnibus legislation rests upon the ability of Underwood and her fellow Democrats to compromise with their colleague, which may in turn compromise the efficacy of Build Back Better and Momnibus. Is getting something passed better than nothing at all?

Introduction

After another day of advocacy in the 116th session of Congress, Underwood descended the steps of the House of Representatives feeling optimistic about the future. Her bill, the Momnibus Act, now incorporated into the larger Build Back Better Act, finally passed in the House after more than a year of constant obstacles. Despite the hardships and roadblocks, Underwood felt that the bill's benefits to the community were well worth it. Underwood crafted this bill to lessen maternal health inequities that Black women currently face in the United States. To achieve these protections, she first found Senate members to introduce and advocate for the bill. Then, just as negotiations had begun in the spring of 2020, the Covid-19 pandemic halted the talks and seemingly ended the future of Momnibus (El-Sayed 2022). Even in the face of a global pandemic, Underwood and her colleagues remained determined and reintroduced the bill in the 2021 session of Congress. Although Underwood and her colleagues held onto hope about the passage of the bill, in a few short months, one fellow Democrat who failed to see the benefits of the bill or justify the price tag of this sweeping social policy would stall the Build Back Better Act.

Entry Into the House

At 32 years old, Lauren Underwood entered Congress as the youngest Black woman to be sworn into the House of Representatives (Lauren Underwood Campaign [LUC] 2021). Almost

immediately, Underwood began working towards the creation of the Black Maternal Health Caucus and the drafting of the Momnibus Act, both of which were made to rectify the blatant inequalities Black women face in maternal health (LUC 2021). Underwood did not take her responsibility to the Black women in her community and across the nation lightly, seeing the urgency of political action on this issue. American women, especially Black women, are at considerably higher risk for pregnancy complications and postpartum maternal death than women in comparable nations, such as France, Canada, and the United Kingdom (Tikkanen, Gunja, FitzGerald, and Zephyrin 2020). As a former nurse, Underwood recognized this disparity, understanding the true cost of maternal health inequalities on women's lives (El-Sayed 2022).

Underwood witnessed the fatal consequences of maternal health inequities firsthand in 2017, when she had to grapple with the devastating loss of her close friend, Dr. Shalon Irving (El-Sayed 2022). Underwood met Irving during her master's program at Johns Hopkins (Brooks 2021). The two were quick friends and stayed close as they each began government jobs in public health. Irving worked as an epidemiologist for the Center for Disease Control in the violence prevention division (Brooks 2021). In 2016, Irving gleefully shared the news with Underwood that she was pregnant, so the two friends excitedly talked about the future and the baby. Irving's natural pregnancy was a happy surprise for a woman whose fertility treatments had continually failed (Roeder 2020). In the weeks after giving birth, Irving began experiencing a multitude of concerning symptoms related to preeclampsia, a preventable condition linked to high blood pressure during pregnancy (El-Sayed 2022). Unfortunately, in a matter of weeks following the birth of her daughter, preeclampsia claimed Irving's life, leaving her child without a mother (Brooks 2021).

In the aftermath of this tragedy, Underwood realized that her friend was the victim of a healthcare system plagued with racial disparities and discrimination. Irving was an educated woman who had been under the care of quality physicians in a good hospital, and as an employee of the CDC, she had an intimate knowledge of the enhanced birthing risks Black mothers face in the United States (Brooks 2021). Moreover, as a woman who struggled with high blood pressure for years, Irving understood her increased risk for preeclampsia (Brooks 2021). Irving's background should have greatly mitigated her health risks, but the doctors dismissed her continual concerns of worsening preeclampsia (Brooks 2021). Instead of initiating the standard life-saving treatment for this disorder, which includes antihypertensive and antiseizure medications, her health providers negligently ignored her complaints and told Irving that her symptoms were normal after birth (Cleveland Clinic [CC] n.d.). Clearly, Irving's collapse and subsequent death only three weeks after giving birth exemplify that the severity of her condition could not justifiably be mistaken as normal (Brooks 2021). Losing a friend to racial inequity in maternal health solidified Underwood's determination to prevent any other women from experiencing these disparities. Given her experience with personal loss and medical background as a nurse, Underwood entered the House ready to tackle the blatant inequalities that women of color face in medical care (El-Sayed 2022).

Underwood's Politics

Underwood's time in the House has been marked with challenges in navigating a system created and dominated by cis-gender white men. Like any other woman in politics, Underwood has also combated the presumptions surrounding women's roles in the political world, a problem

reflected in the difference between descriptive and substantive representation.[1]Some believe that sharing a critical identity with a represented group, such as being a woman, means that representatives must have the same ideology as everyone in that group. The danger with relying on the descriptive representation model is that just because two people share a similar background or experience, the representative may not have the same political goals as his or her constituents (Wineinger 2022). For instance, a female politician may share some similar life experiences with other women, yet this representative may vote against pro-abortion legislation. In contrast, substantive representation acknowledges that just because two people may share certain identities, they do not necessarily share the same views on different issues (Wineinger 2022). Substantive representation shifts focus onto the issues a specific group faces regardless of if they share a background or not (Wineinger 2022). In many instances, fellow politicians and constituents alike may automatically assume female politicians support "women's issues" solely based on their sex (Wineinger 2022). However, every person is different. Not all female representatives support the ideas and legislation that Underwood does, and her commitment to furthering women of color's equality and protections is what makes her both a descriptive and substantive representative of women's rights.

Emphasizing a substantive approach to representation, Underwood entered the House intent on protecting the rights and expanding equality for both her constituency and women of color across the country. Underwood's history of her bills and support paints a picture of a representative dedicated to improving women's lives in the United States. For instance, in the 117th session of Congress alone, Underwood has not only sponsored the Momnibus Act but also bills like SALT Fairness for Working Families Act (Library of Congress [LOC] n.d.b). This bill focuses on providing financial relief to working families, which includes working mothers (LOC n.d.b). In the same session, Underwood also sponsored Women's Retirement Protection Act, which seeks to increase benefits for part-time workers and improving spousal rights surrounding divorce (LOC n.d.b). Underwood's creation and support of the Momnibus Act, then, aligns with her past actions and emphasize her sincere desire to serve women of color.

Underwood's shared history with her constituents also shapes her style of representation. A white, male representative lacks the personal background to understand the nuanced experiences of women of color, such as the feeling of having pregnancy complications. As one study points out, constituents are more likely to support representatives who have similar backgrounds as them, especially a shared racial background (Gay 2002). While Underwood does not personally share the experiences of every woman, her legislative actions reflect her areas of experience and expertise. For example, before Underwood entered the political sphere, she was a nurse (El-Sayed 2022). As a nurse, Underwood directly engaged with the communities that she now serves as a congresswoman, witnessing firsthand their needs and hardships. Besides her time working in a hospital environment, Underwood was also employed at the Department of Health and Human Resources to help advise and guide communities in need, including Flint, Michigan, during its drinking-water crisis (Webb 2020).

Additionally, Underwood's experience in the workforce granted her insight into the challenges working women face today. As a nurse, Underwood saw how her patients of color, especially when pregnant, face more disparities, such as limited access to quality care and more issues with physician biases, than their white counterparts. This background, in combination with

[1] Descriptive representation describes representatives that share similar backgrounds or identities to the people they represent as effective representation, while substantive representation views effective representatives as those who share similar views as the people they represent (Childs and Krook 2006).

the lived experience of losing a dear friend to the medical system's failure to properly care for women of color, equips Underwood to draft effective legislation on this prominent issue. Underwood's dual role as a substantive and descriptive representative for women and women of color empowers her constituents by serving them with both empathy and tangible action.

Current Status of Childbirth in the United States

As Underwood experienced, one moment is all that it takes to change someone's life forever. Whether that moment is a mother joyfully holding her healthy baby after giving birth or a family receiving news of their loved one's death after childbirth, these moments impact someone forever. Sadly, for Underwood and her friend's family, this life-changing moment was when Irving collapsed at home from preeclampsia (Brooks 2021). Unfortunately, for many families in the United States, the loss of a mother, wife, friend, or daughter due to complications from childbirth is all too common. While the United States may be considered the world's wealthiest nation, the maternal mortality rate in this country is woefully higher than in any other developed nation (See Appendix B) (Tikkanen, Gunja, FitzGerald, and Zephyrin 2020). In fact, the US is the only developed nation where maternal mortality rates have increased rather than decreased in recent years (See Appendix B) (Tikkanen, Gunja, FitzGerald, and Zephyrin 2020). Looking closer at who is predominantly affected within the country paints an even more disheartening picture. Non-Hispanic Black women are two times more likely to die from a pregnancy than their non-Black peers (Hoyert 2022). Even more concerningly, the maternal mortality rates for every demographic group have steadily increased between 2018 and 2020 (See Appendix A) (Hoyert 2022). As medicine advances, health outcomes should improve. Thus, the question becomes whether increased medicalization of childbirth is an effective healthcare solution, or if this medical trend coupled with socioeconomic disparities is contributing to the growing maternal mortality rate in the country.

In the US, physicians tend to rely on the process of medicalization[2] and the belief that this process creates interventions that are superior to any other form of treatment. When a doctor assesses a patient's bodily health, any problem "is defined in medical terms…using medical language…or 'treated' with medical intervention" (Brubaker and Dillaway 2009, n.p.). For Irving, her doctors focused more on how the birth was a medical success and ignored Irving, a woman of color, telling them that she felt unwell in the aftermath of childbirth (Martin and Montagne 2017). Thus, medicalization approaches may often fail to encompass the larger picture of a mother and child's health.

Even though the medical field has made crucial advancements that improve overall patient care, the medicalization of childbirth has a critical blind spot. This blind spot involves lack of attention to the mother's bodily sensations and her preferences for potential treatment. As the use of medicalized practices, such as the administration of pain medications and Cesarean sections, continues to rise during childbirth care, women continue to experience feelings of less and less control over their bodies and their births (Kauffman 2015). Multiple researchers have begun to suspect that reliance on these interventions are silencing mothers during the childbirth process, which results in unnecessary medical interventions in place of more natural births, which use the minimal number of medical interventions (Kauffman 2015). These mothers are being silenced by these interventions because a greater emphasis is being placed on using interventions for every

[2] Medicalization refers to the belief that scientific knowledge and medical interventions are considered the best and most efficient solutions to health-related problems (Brubaker and Dillaway 2009).

birth rather than promoting the idea that these mothers can choose how they would like to give birth.

While the dismissal of women's needs and experiences during childbirth affects all women, this phenomenon is particularly dangerous for women of color. Research suggests that implicit biases push physicians to disregard what Black mothers tell them they feel during birth, and this dismissal can lead to life-threatening conditions like preeclampsia going undiagnosed and untreated (Glover 2021). Listening to a mother during and after birth becomes especially important when considering that 52% of maternal deaths occur after birth (See Appendix C) (Tikkanen, Gunja, FitzGerald, and Zephyrin 2020). Lethal conditions that occur postpartum may go undiagnosed or untreated for a variety of reasons, including women feeling unempowered in their birthing journey to speak up or fearing dismissal by their providers (Kauffman 2015). Another reason behind the unsettling number of postpartum deaths stems from the lack of postpartum care provided in the US (Melillo 2020). Other countries like the United Kingdom offer postpartum checkups for new mothers after one week, which ensures that the mother is receiving the attention she needs to identify any possible health issues (Melillo 2020). Without this continual spectrum of care, women in the US may go undiagnosed.

Despite seeking out postpartum care, Shalon Irving was tragically one of the many women who was silenced by her providers. In the weeks after her successful Cesarean section, Irving made repeated visits to her doctors to seek treatment for a series of worrying symptoms (Roeder 2020). First, Irving told her doctors about a hematoma at her incision site (Roeder 2020). Then, she raised concerns about high blood pressure, swollen legs, and blurred vision. (Roeder 2020). With each visit, her doctors insisted that these symptoms were normal. In reality, these symptoms were key clues that Irving was suffering from preeclampsia, which can lead to a fatal eclampsia seizure if not treated promptly (CC n.d.). Even with her education, support system, and knowledge of birthing inequalities, medical professionals still invalidated Irving's concerns, which led directly to her death.

Despite the clear faults of maternal care under the American medical system, mothers see little other choice beyond trusting these over-medicalized processes (Throsby 2004). Mainstream media and the popular opinion that hospital births are higher quality than home births have both contributed to reliance on a flawed medical system. Most individuals believe that giving birth in a hospital setting with a physician is the only way to safely give birth, since medical settings are lauded as the modern place to give birth compared to home births (Dickert 1993). In fact, only 1.5% of all births in the United States take place in an out-of-hospital setting (Melillo 2020). While these medical settings are crucial in some cases to protecting mothers' safety, especially if they have health factors that put them at high-risk for birthing complications, hospitals have become places of inequity, where both conscious and subconscious discrimination thrive. For example, doctors and nurses are more likely to presume the needs of Black female patients without input than for white female patients (Kauffman 2015). Another reason for discrimination in the healthcare field revolves around stereotypes connected to Black women and Black mothers. The "sapphire" stereotype depicts Black women as overemotional and aggressive, which makes some health professionals unwilling to have discussions with their patients (Rosenthal and Lobel 2016). Similarly, the "welfare queen" depicts Black women as uneducated and greedy, and this stereotype is used by some professionals to justify their ignoring patient requests and concerns (Rosenthal and Lobel 2016). These stereotypes, which are inherently present in the predominantly-white medical school system, may explain why physicians are more likely to silence Black women rather than white women. Beyond the problem of stereotypes, medical professionals may justify ignoring

patient input by referring to their educations (Kauffman 2015). Education notwithstanding, every patient has a right to take an active part in the decision-making process surrounding their care. These problems must be rectified to protect mothers who choose to use these services regardless of their race.

Creation of the Momnibus Act

As these risks continued to threaten the lives of Black mothers, Underwood, along with Black Maternal Health Caucus members like co-founder Alma Adams, introduced the Momnibus Act into the House in March of 2020. Underwood found strong support in the Senate from Senator Kamala Harris, who enthusiastically advocated for the passage of Momnibus because she saw this bill as an opportunity to help women across the country (El-Sayed 2022). Having advocates of the bill in both chambers of Congress is integral for the bill's success because it gives the proposed legislation someone who will defend it against any opposition. Thus, while Adams and Underwood were positioned to push for discussion of Momnibus on the House floor, Harris was positioned in the Senate to tackle any opposition and promote the bill's passage.

Momnibus contains multiple strategies for mitigating racial inequalities in maternal health. The Act first began in 2020 with nine bills, including essential provisions to expand Women, Infants, and Children (WIC) food benefits and coverage to 24 months as well as address the environmental factors that contribute to disparities in birthing, which includes factors like water and air pollution in lower-income areas that can have negative impacts on child health (LOC n.d.c). Three more bills were also added to Momnibus during its reintroduction during the Covid-19 pandemic that aimed to help mothers deal with pandemic hardships, such as getting the Covid-19 vaccine (LOC n.d.c). Moreover, one bill aims to expand the perinatal workforce (LOC n.d.c). The perinatal workforce would receive greater funding and training opportunities for midwives and doulas. This bill is of particular interest because midwives and doulas, who are seen as less legitimate birthing option compared to hospitals, are commonly left out of the discussion of how to eliminate birthing disparities and decrease overall maternal mortality rates in the United States.

How Paraprofessionals Reduce Disparities

Paraprofessionals in the maternal health field are primarily comprised of midwives and doulas. Both professions provide an alternative to childbirth in a hospital setting, but the history and status of the two fields differ from one another. Midwives, unlike doulas, are more closely tied to the modern birthing process. In the early twentieth century, professionals in the medical field incorporated midwives into the nursing community to form "nurse-midwives" in an attempt to professionalize and standardize the practice (Davis-Floyd 2009). These nurse-midwives underwent training programs and began entering hospital settings (Davis-Floyd 2009). This integration allowed nurse-midwives more respect and acceptance into the medical community (Davis-Floyd 2009). Of course, some midwives still exist independently from medical establishments, though popular perception of non-hospital care as dangerous is a potential obstacle to their success.

As the midwife practice became intertwined with medical practice, the regulation and oversight involved in mainstream medicine began affecting midwife care (Horwitz and Hall 2021). The medical field is highly regulated by governmental and medical standards, as is needed to ensure quality care and a safe environment for all individuals. However, this regulation, which includes schooling requirements and stringent insurance policies for independent midwives, enables gender and racial inequalities, which leads to more expensive medical bills for mothers

and inaccessibility for groups like women of color (Horwitz and Hall 2021). The decentralized nature of US regulations also makes it more difficult for women to achieve legal certification as midwives, which severely limits where women can find midwife care (Horwitz and Hall 2021). Moreover, shortages of midwives are concentrated in rural and inner-city areas, which exacerbates economic and racial disparities between who can and cannot receive midwife care (Horwitz and Hall 2021).

Moreover, while nurse-midwives have lost the more human and personal aspects of birth, independent midwives who practice more holistic birthing methods contradict popular American conceptions about how a birth should occur (Merelli 2017). The show *The Mindy Project*, for example, comments that midwives are "charlatans," which exemplifies how even popular culture has negative views of midwifery (Merelli 2017, n.p.). American trends towards a more formal and professional birthing atmosphere began in the early twentieth century. Multiple academic journals, both domestic and abroad, began criticizing US medical schools for producing poorly taught and unprofessional doctors (Merelli 2017). In response, American medical schools began emphasizing the use of modern technology, crafting the medical field into a more regulated, impersonal, and professional setting (Merelli 2017). While this shift was no doubt crucial to creating a safer space for diagnosis and treatment, this trend also pushed the medical field to consider other forms of care, such as midwifery, to be a lesser and more dangerous form of care (Merelli 2017). The shift towards the regulated medical system we know today most likely contributes to the popular belief in the US that births must occur under the watchful eye of a physician rather than an independent midwife. Negative stigma around the independent midwife in conjunction with the medicalization of nurse-midwives results in the continuation of birthing as a medical procedure rather than a natural process. Midwives must constantly confront the medicalization of childbirth, which creates tension and sometimes results in a detachment between mother and caregiver that can be detrimental to the emotional and physical health of the mother (Davis-Floyd 2009).

Doula care, on the other hand, has not undergone widespread integration into mainstream birthing. Instead, doulas "are focused on both the medical and psychological needs of women during the birth process" (Lantz et al. 2005, n.p.). Doulas provide emotional support and act as the mother's advocate before, during, and after birth. This type of care may be crucial in reducing maternal mortality and closing the disparity between white birth outcomes and Black birth outcomes (Lantz et al. 2005). These providers actively reduce disparities in medical outcomes by voicing their patients' needs to medical staff and providing services in underserved areas (Strauss, Giessler, and McAllister 2015). Doula care also contributes to a lesser use of medical interventions in low-risk births by ensuring that patients have advocates who empower them to speak up to medical staff and say no to interventions while also providing emotional support to reduce stress during birth (Strauss, Giessler, and McAllister 2015). Doulas, then, can be an integral presence in hospital settings because they are solely focused on the mother's wellbeing while the doctors focus on the actual birth. Having the reassuring presence of a doula can in itself lead to a more relaxed atmosphere conducive to giving birth (Dekker 2013). In addition, a doula's patient advocacy is more likely to reduce medical interventions like Cesarean sections and pain medications, increasing the rate of natural, vaginal births (Dekker 2013). Avoiding these interventions when unnecessary is essential for limiting potential medical complications, such as adverse reactions to the medications and extended recovery times (Dekker 2013). This reduction of unneeded interventions and the creation of a personal connection to the mothers reflect the three pillars of doula care—physical support, emotional support, and advocacy (Dekker 2013). The physical and emotional support ensure that the mother feels like she has a support system, while advocacy

protects mothers from doctors initiating any interventions that the mother may not want (Dekker 2013). In a similar vein, doula advocacy gives women another voice to ask questions and voice concerns, such as the concerns Irving faced. Thus, not only to doulas provide a way of decreasing the use of unnecessary interventions, but they also act as a resource to ask for additional medical care when needed.

Reducing medical interventions is an important step in minimizing both complications during the birthing process and postpartum complications like the preeclampsia that Underwood's close friend experienced. Between 1998 and 2009, there was a 114% increase in postpartum hospitalizations, which coincided with a marked rise in the rate of Cesarean sections (Strauss, Giessler, and McAllister 2015). Cesarean sections likely contributed to this rise in postpartum hospitalizations because scientific evidence suggests the procedure comes with "an increased risk of serious short- and long-term complications and hospital readmission" (Strauss, Giessler, and McAllister 2015, n.p.). Doula care can help mothers in this after-birth period where the current United States medical field fails. When using a doula, mothers do not stop seeing this provider after the birth. On the contrary, doulas are quite active during the postpartum period visiting mothers, coaching breastfeeding, and ensuring that both mother and baby are thriving (Strauss, Giessler, and McAllister 2015).

However, like any service, there is a cost to doula care. Depending on where an individual lives, the average cost can be between $800 and $2500 (Weiss 2021). Unfortunately, not all insurances will cover this cost or even part of this cost (Cigna, n.d.) Thus, affordability is a major factor that has limited the ability of doulas to alleviate racial and economic disparities in the birthing process (Strauss, Giessler, and McAllister 2015). The communities that need these services the most are, unfortunately, unable to pay out-of-pocket for these types of services. Underwood's Momnibus Act seeks to resolve the financial limitations that hinder the reach of doulas. Momnibus would diversify the doula workforce, provide more training for paraprofessionals, extend postpartum insurance coverage to one year after birth, and provide funding to prenatal organizations and community-based organizations (LOC n.d.c). Underwood and her colleagues have witnessed the medical disparities ingrained into medicalized childbirth, and the Momnibus Act provides a clear path that could lessen disparity and reduce maternal mortality rates in the United States.

While most doulas and other paraprofessionals praise Momnibus for its integration of these personalized services into mainstream birthing, some doulas have expressed a few concerns. For instance, some doulas worry that third-party reimbursement from governmental agencies, which is part of Momnibus, could lead to increased oversight, limitations, and restrictions to the care they provide (Lantz et al. 2005). In essence, some doulas worry that in making doula care more accessible through government action, the care itself will lose the personal connections that are what make these services so crucial. As midwives know all too well, this fear may be warranted. When oversight becomes excessive, doulas must focus more on following regulations and less on spending time with mothers to form an emotional bond. Emotional bonds are the foundation of doula work because supporting someone through birth requires trust.

Furthermore, in many states, the integration of midwives into more mainstream birthing has resulted in excessive regulations, which prevent many midwives from providing the care mothers need (DiFilippo 2021). For instance, New Jersey requires midwives to have a consulting agreement with a physician to practice (DiFilippo 2021). More physicians are leaving private practice and more insurance companies refuse to support these partnerships due to liability concerns, and these factors make practicing hard for midwives (DiFilippo 2021). These insurance

companies fear that doulas may be accused of negligence for actions such as making medical decisions that harm the mother, breaching medical records, or failing to contact medical assistance when the mother needs it (Cochran 2020). The unease these companies feel is only magnified by the fact that most states and the federal government are not requiring any official certification to be a doula since doulas are not considered a formal profession (Cochran 2020). This lack of professional status may stem from doula care's reputation as a more informal emotional support network rather than a crucial piece in the maternal continuum of care (Cochran 2020). Dismissing doulas from the professional community only increases insurance company fears of malpractice lawsuits against doulas (Cochran 2020). These fears about paraprofessionals like doulas make it harder for them to find willing insurance companies. While mothers no doubt are in desperate need of paraprofessionals, these paraprofessionals must find a way to navigate red tape without compromising the integrity of their services.

While doula and midwife services each provide a way to evade the usual medicalization of birth and reduce maternal mortality disparities, these services on their own cannot resolve inequity in women's care. Instead, only a concerted effort between professionals and paraprofessionals alike in a community-focused practice can properly address flaws of the maternal healthcare. Underwood's belief in this combination of care is what drew her to create Momnibus. In one article, Underwood emphasizes that:

> By scaling these programs and investing in the organizations doing the hard and necessary work to promote birth equity, we can end our nation's maternal health crisis and ensure every American has access to the high-quality care and robust support they need during and after pregnancy (Underwood 2021, n.p.).

Underwood's belief in collaboration is not just based on a hope that care will improve when professionals and paraprofessionals work together. Widespread evidence suggests that collaboration between medical and non-medical professionals improve overall quality of care. A practice in Brazil provides a prime example of this quality of care. Historically, Brazil's high percentage of elective Cesarean sections has earned it the title of "World Champion of Cesarean Sections," though an increase in Cesarean sections does not necessarily indicate improved quality of care for women (Davis-Floyd 2009, 274). Women in Brazil were facing a similar overuse of medical interventions that women here in the United States continue to grapple with. Dr. Ricardo Jones, a doctor in Porto Alegre, Brazil, made the decision in the 1980s to stray from the hyper-medicalized approach to childbirth and create a practice centered on the patient (Davis-Floyd 2009). In this practice, he worked with a doula and a nurse-midwife. This trio provided birthing care both in the hospital and at the patients' homes to maximize the comfort of the patient (Davis-Floyd 2009). With a doula, the patients had an advocate and an empathetic shoulder to lean on during birth. With a midwife, mothers had a paraprofessional trained in natural birthing practices. With Dr. Jones present, patients had a physician to provide medical interventions if mothers needed them. Together, this team could put the women at the center of the birthing process rather than medical protocols.

Another physician in the United States also found this team-centered model of care to be a valuable way of improving birthing outcomes in underserved areas. Dr. Barbara Levin created a birthing center in rural Monroe County, Tennessee, with the explicit purpose of minimizing medical interventions and maximizing patient comfort throughout the birthing process (Dickert 1993). To accomplish this, Levin established a practice with both physicians and midwives in a

building that created a sense of homely comforts, so women would not have to give birth in the sterile, unwelcoming environment of a hospital (Dickert 1993). This center was quite successful in improving the birthing outcomes and reducing medical interventions of women in this area (Dickert 2013). These community-oriented centers that employ both professionals and paraprofessionals emphasize the mother, an approach that will improve birthing outcomes in the United States.

Covid-19 Halts Momnibus

Unfortunately, just as discussions on the Momnibus Act began on the House floor, the Covid-19 pandemic spread across the country and halted any discourse on new bills (El-Sayed 2022). This setback did not deter Underwood and her colleagues, however. During the height of the pandemic, Underwood set to work creating additional sections of Momnibus that would support women under the weight of the extra hardships that arise when giving birth during a global pandemic.

While the Covid-19 pandemic has had an immensely profound effect on all populations around the world, expectant mothers have faced another layer of hardships in the maternal care field. During the height of the pandemic, hospitals across the country shut their doors to patient visitors and what they deemed non-essential personnel (Schell 2021). Thus, when a woman entered a hospital to experience the joys and trials of childbirth, they had to do so without any support of either family or doulas. Multiple studies find that the presence of even one person as a supporter or advocate in the hospital room can lessen the chance of needing a medical intervention and even make birthing less painful (Schell 2021). In this case, these doulas are providing what the current medical system cannot, a reassuring presence whose single concern is being personally connected to the mother.

Moreover, some hospitals created protocols requiring all women to either be induced into labor or have Cesarean sections to hasten the birthing process and thus limit the spread of Covid-19 (Schell 2021). Similarly, other hospitals separated mother from child if the mother was suspected of having Covid-19 (Schell 2021). Requiring interventions as well as separating mother and child during the crucial moments after birth can have major psychological and physical effects of both mother and child (Schell 2021). Doulas across the world worried for the wellbeing of the mothers under their care as hospitals became increasingly high-risk and unwelcoming environments for mothers. Usually, doulas are right beside their clients during birth, whether that birth is at home or at a hospital. In a study, one US doula explained her concerns for her clients in hospitals because of the unique racial disparities in the US. This doula explained:

> My clients are young, single, clinic patients who are typically women of color. Their care within the hospital is not given with dignity and respect. I have seen it with my own eyes. Without having a doula there for support, these girls are at the mercy of the doctors and nurses, as they don't feel empowered enough to speak up or question anything. It saddens me greatly, as this was why I got into doula-work (Searcy and Castañeda 2021, n.p.).

To protect these vulnerable mothers, many doulas attempted to utilize the tools of telemedicine and provide their services via Skype, Zoom, or phone (Nguyen, Donovan, and Wright 2021). While these virtual sessions may have been the best support that could be given in a pandemic, this online method of care is a poor substitute for in-person support. Multiple doulas

pointed out that communicating with clients virtually made it more difficult to establish trust and a personal relationship, which is integral for a doula to successfully advocate for their client (Nguyen, Donovan, and Wright 2021). Thus, while telemedicine seems to remain popular for physicians even as hospitals lift pandemic protocols, doula care must return to its original form to sufficiently help mothers during birth (Nguyen, Donovan, and Wright 2021).

Moreover, as the restrictions on visitors increased in hospitals, many mothers turned toward home birth and birthing centers as viable alternatives. While this trend toward alternative birthing environments may seem to be a victory for both mothers and paraprofessionals alike, birthing centers were not ready for such a large spike in mothers requesting their services. The limited number of midwives, doulas, and birthing center staff had to attempt to care for an increasing population of mothers without enough providers or financial support (Schell 2021).

To make matters worse, many insurances still would not cover the cost of a home birth or birth at a birthing center, which barred the women most in need of humanized birthing services from accessing these services (Schell 2021). Thus, the pandemic became the worst possible scenario for exacerbating financial and racial inequality in birth outcomes for mothers. Despite increased interest in these services, the healthcare system lacks meaningful pathways for enabling greater access to non-hospital care. Legislation like Momnibus, then, seems like the only way to organize birthing services across the country and dismantle the financial barriers that became exacerbated during the global pandemic.

The new sections of Momnibus addressing the challenges of the pandemic expanded this crucial piece of legislation from the original nine to twelve bills. These bills include the Maternal Vaccination Act, which attempts to protect expectant mothers from vaccine misinformation and create a safe birthing environment during the time of Covid-19 (El-Sayed 2022). With these additional parameters, Momnibus could protect women's health and wellbeing in a post-pandemic era.

The Reintroduction of Momnibus

The delays of the pandemic also forced Underwood to seek a new supporter of Momnibus in the Senate, after her colleague Kamala Harris became Vice President. Underwood found this support in Senator Cory Booker. Senator Booker is a representative of New Jersey and shares a similar conviction with Underwood that the government has a duty to help decrease disparities among Americans (Cory Booker Campaign [CBC] n.d.). As a staunch supporter of the Affordable Care Act, Booker seemed like a prime candidate to pick up the mantle of the Momnibus Act in the Senate, since both bills focus on limiting inequities through healthcare (CBC n.d.). With new and old supporters alike, Underwood reintroduced the Momnibus Act into the next Congressional session in 2021.

In the House, Momnibus received widespread support, and it was soon combined with the larger Build Back Better Act in an attempt to speed its passage along in the Senate. Build Back Better is the legislative plan proposed by President Joe Biden as a framework to promote economic growth and security among the American middle class (The White House [WH] 2021). Aspects of the framework include legislation to combat climate change, improve educational programs, expand affordable healthcare, and other pieces of legislation to assist families economically (WH 2021). Integrating Momnibus into another bill proved to be a strategic move on Underwood's part. As a major policy goal of the presidency, the Build Back Better Act presented the perfect opportunity to ensure that Momnibus would be higher on the Congressional agenda in this session of Congress (El-Sayed 2022). Underwood and her supporters quickly rallied agreement from

fellow Democrats that Momnibus should be incorporated into Build Back Better, since the heart of both acts is to help the American people.

Despite the apparent benefits of expanding the equity and accessibility to maternal health, Underwood and her supporters still faced challenges in passing this legislation. Creating the bill's framework was the first struggle, but getting the bill heard on the House floor posed another challenge entirely. Having a bill heard in Congress poses a challenge to lawmakers because legislators introduce hundreds of bills each year, only two percent of which are passed (GovTrack n.d.). Thus, legislators face a daunting race against time to ensure that their bills can be considered and voted on, which is usually easier to do when the president backs their legislation. Thus, when Build Back Better, a plan that was such a large part of the president's campaign, entered the House, supporters of Momnibus quickly utilized this opportunity to ensure that Momnibus was heard in this session of Congress. After a successful integration of Momnibus into Build Back Better, this act quickly passed in the House, and then the real challenge began in the Senate. Underwood and other Democrats elected to use budget reconciliation voting (Zhou 2021). Budget reconciliation voting only requires a simple majority for the bill to pass, which may seem simple when considering that exactly half of the Senate is composed of Democrats (Zhou 2021). Any hope for this bill moving swiftly through the Senate, however, was quickly diminished by Democrat Joe Manchin of West Virginia.

Joe Manchin

Joe Manchin has been serving as a West Virginia Senator since 2010 (Joe Manchin Campaign [JMC] n.d.). During his time in politics, Senator Manchin has made it his goal to help get the government's "fiscal house" in order (JMC n.d., n.p.). Manchin's attempts at limiting government spending are apparent through his support of fiscally conservative legislation, such as the CAPS Act, which aims to reduce government spending (LOC n.d.a). Manchin also supported a balanced budget amendment to the Constitution, which would prevent total spending from exceeding total receipts for the year (LOC n.d.a). His stance on fiscal conservatism suggests that he is one of the last so-called Blue Dog Democrats, a group of fiscally conservative legislators in 1995 who saw themselves as in between extreme left and right, answering a common call for a balanced budget (Political Dictionary 2022). As a Blue Dog Democrat, Manchin thus views social policy through a fiscal lens. While Manchin appears to support more liberal policies, such as universal healthcare, he differs from his Democrat colleagues on the acceptable size and cost of these programs (Office of Joe Manchin [OJM] n.d.).

Concern over fiscal imbalance is what first made Machin skeptical of Build Back Better. As a wide-sweeping social policy bill, Build Back Better initially sported a $1.75 trillion price tag (Lanier 2021). Clearly, Build Back Better's cost was not in alignment with Manchin's political stance on fiscal spending (OJM n.d.). Manchin was also quick to criticize the decision by his fellow Democrats to make many of the social programs within Build Back Better temporary. For instance, Build Back Better has an article that expands funding for state pre-kindergarten programs (WH 2021). While this program is no doubt important, Build Back Better advocates were forced to compromise with more conservative opinions by only funding this program for seven years (Prokop 2021). Temporary programs equate a lower price tag, which in turn makes this large bill less overwhelming for fiscally conservative politicians to support. While this compromise ensures that states will receive the help needed to support education, at least briefly, it also raises the question of what will happen to this program and the other temporary programs of Build Back

Better once they expire. While Congress could vote on bills that would extend funding for these programs, the same issue of fiscally conservative representatives opposing the spending of more money remains. Manchin was a strong critic of the brief lifespan of the programs because of his concern for what would happen after these programs end (Prokop 2021). Manchin also voiced his worry that short-lived programming was a Democrat reliance on "budget gimmicks" to hide the true cost of the bill (Prokop 2021, n.p.). Thus, every bill encompassed in Build Back Better faces the very real possibility of being cut down financially, including Underwood's bill.

While Manchin's opposition to the programs in Build Back Better does not directly critique Momnibus programming, his opposition to Build Back Better as whole still prevents Underwood's bill from becoming law. This opposition exemplifies the risk that Underwood and her colleagues took when integrating Momnibus into Build Back Better. While their choice ensured that their bill would be considered in this session of Congress, they also faced the risk of Momnibus losing critical funding because of compromises with conservatives. Manchin's stance against Build Back Better also reveals that just because politicians share the same political party does not mean that they will agree on the same policies. In essence, Manchin's stance exemplifies the dangers of relying on descriptive representation. While he is a self-proclaimed Democrat, Underwood and her colleagues have learned firsthand that they cannot rely on party lines alone to secure votes.

Manchin also has a more strategic political reason for opposing Build Back Better. As part of the bill's social policy, Democrats incorporated a massive amount of clean energy legislation that totals almost $500 billion (Prokop 2021). One of these pieces of legislation calls for a clean electricity repayment program that rewards companies that use clean energy while fining those still using fossil fuels (Prokop 2021). Manchin, as an advocate for his constituents, understood that renewable energy programming would negatively impact the largest industry and economic backbone of his state: coal mining (Atitwa 2020). As Manchin himself makes clear in his platform, he believes in creating a "balanced national energy plan that utilizes all of our resources and recognizes that fossil fuels will be a vital part of our energy mix for decades to come" (JMC n.d., n.p.).

Thus, while Manchin's opposition to this social policy may seem surprising for a Democratic Senator, he is prioritizing the economy of his state. Manchin's opposition to the clean energy legislation in Build Back Better also emphasizes the drawbacks that Underwood and her colleagues must now navigate after deciding to place Momnibus with a larger social policy legislation.

Attempts at Compromise

In a first attempt to compromise with Manchin, lawmakers focused on cutting Build Back Better programming down to reduce the cost, which in turn drew money away from important bills like Momnibus (Zhou 2021). As compromising continued, Underwood and "The Squad" began to formulate ways to protect key legislation in Build Back Better (Zhou 2021). The Squad refers to a group of progressive Democrats in the House of Representatives whose goal is to support progressive legislation (Zhou 2021). To avoid gutting the programs further, The Squad had another proposal to convince Manchin to support Build Back Better. They suggested coupling Build Back Better with the Bipartisan Infrastructure Bill (Zhou 2021). This bill would provide millions of dollars to broadband infrastructure to ensure that every American has access to high-speed internet (WH n.d.). Manchin staunchly supported this infrastructure bill because it would help his constituents who live in areas with poor internet service. Thus, The Squad thought that coupling

Build Back Better and the Bipartisan Infrastructure Bill would incentivize Manchin to put his previous hesitations aside and support Build Back Better.

Weeks after combining the infrastructure bill and Build Back Better, moderates and President Biden decided that the bills should be separated again because getting both passed was taking longer than expected (Zhou 2021). Biden began telling fellow Democrats that he could guarantee Manchin's vote if the decision was made to separate the bills (Zhou 2021). A vote was called. The votes were counted. All but six House members, consisting of Underwood and the fellow Squad members, voted for the separation (Zhou 2021). With their leverage gone, Build Back Better reached a stalemate in the Senate. As the stalemate began, President Biden reassured Squad members that he would personally sway Manchin (Ahlman 2022). Biden's determination to help this bill pass stemmed from his interest in incorporating improvements of hard infrastructure with "soft" infrastructure, which includes sectors like healthcare" (Ahlman 2022, n.p.). Biden's administration also wants this package passed because failing to pass such a large part of Biden's platform would reflect negatively on the administration.

However, after Biden's personal attempts at convincing Manchin failed, Democrats realized that they would have to acquiesce to Manchin's call for a lower price tag by cutting their legislation further. The continual cuts to Build Back Better were an especially hard blow to Underwood and other Democrats with legislation accompanying Build Back Better, especially because legislators negotiating budget cuts insisted on leaving the $500 billion energy component of the bill untouched (Prokop 2021). Lawmakers safeguarded energy aspects of the bill since they are a large part of the president's legislative plan and deemed crucial to have passed (Prokop 2021). Thus, other legislation like Momnibus laid under the fiscal knife, threatening to compromise the benefits that this legislation would provide. Meanwhile, as these cuts continued, Manchin even began telling the press that Build Back Better is "dead," asking reporters "What Build Back Better bill? There is no, I mean, I don't know what you all are talking about" (Foran, Raju, and Barrett 2022, n.p.).

Now, Underwood and her colleagues must decide how to move forward. They could attempt to separate the bills again and get it passed through Congress on its own. However, this move harbors the risk of Momnibus never being heard on the Congress floor and joining hundreds of other unknown bills swept under the rug. Do they make further cuts from the bill and hope that Manchin will support it? Or do they resign to the defeat that Manchin believes has already occurred?

Where Do They Go From There?

For Manchin, Build Back Better represents an increase in the government's spending. For Underwood, Build Back Better's Momnibus Act represents an opportunity to prevent families from experiencing the loss she once experienced. Underwood believes that investments in equitable maternal care "uphold a fundamental principle: in America, every family has a right to thrive. That principle begins with a safe and healthy pregnancy and birth" (Underwood 2021, n.p.).

There is hope for Momnibus. Hope can be found in the one piece of Momnibus legislation that was able to pass through the Senate independently: the Protecting Moms Who Served Act. This piece of legislation intends to divert more resources to the federally run Veterans Affairs (VA) hospitals to improve birthing outcomes for mothers who served in the military (El-Sayed 2022). Thus, the rest of Momnibus and what it stands for may still one day become law. Whether this passage is with Build Back Better this Congressional session or in a future session remains to be seen.

The struggle for the passage of Momnibus, in essence, mirrors the struggles that women of color face every day. Just as uncertainty clouds the future of Underwood's bill, women of color face a wall of uncertainty as they attempt to navigate the maternal health system. Racial disparities plague maternal care, ranging from outright discrimination to more subtle silencing that places women in harm's way. Until the medical system can respect the autonomy and power of a woman over her own birth, the United States will continue to have a staggering maternal mortality rate compared to other countries. Doulas and midwives, moreover, face their own struggle of balancing patient-centric birthing with the barriers of overregulation. While Momnibus provides paraprofessionals with the promise of federal assistance to expand their practices and reach more communities, these caregivers must wonder if the assistance given will promote the medicalization of their fields, just like the medicalization of mainstream maternal health.

Women cannot face issues like birthing inequities and medicalization alone. Affected mothers need strong advocates in government that will defend their rights with earnest, compassionate representation. These advocates, such as Lauren Underwood, should draw on both shared experiences and a desire to uplift marginalized groups. With growing support and awareness among politicians and ordinary people, the US may finally overcome issues of racial disparities in birthing.

A New Day For Build Back Better: How Did Momnibus Fare?

On August 16, 2022, Build Back Better was signed into law (Foster 2022). However, this bill was passed under the name Inflation Reduction Act, and the name was not the only thing that changed (Foster 2022). Build Back Better began with an estimated cost of over $3.5 trillion, but the Inflation Reduction Act has a budget of only $2 trillion (Krawzack 2022). The question then is: What programs were cut out of the bill to facilitate this staggering cost reduction? The answer to this question does not bode well for black mothers. In the new legislation, there are no traces of the Momnibus and its wide sweeping attempts to lessen maternal inequalities in this country (LOC n.d.d). Granted, the Inflation Reduction Act does contain measures that will help mothers, such as sections promoting the expansion of affordable housing and reduction of pollution (Foster 2022). These pieces help ensure that black mothers have basic necessities like shelter and healthy air. However, sections like the extended support of the perinatal workforce that is crucial to helping mitigate disparities in birthing are missing from the new law (LOC n.d.d).

With these updates to Build Back Better, the risks of incorporating Momnibus into this bill can be better assessed. Clearly, the environmental legislation passed in the Inflation Reduction Act are essential to combat climate change and promote a healthy planet. While these pieces of the legislation were successfully passed, however, Momnibus was left behind, reminiscent of how this country continues to leave its most vulnerable populations behind. Mothers, especially Black mothers, need the support that Momnibus could have provided. In the end, combining Momnibus with Build Back Better was meant to help Momnibus pass by pushing it through with other legislation. This method seems to have resulted in Momnibus being lost under the weight of other larger pieces of legislation, and when cuts had to be made, Momnibus and other smaller articles were the first to go.

Even with this setback, legislation that was part of Momnibus still could have a future. In later Congressional sessions, Underwood and her allies will have more opportunities to propose bills that focus on supporting women of color. As for right now, these representatives and their constituents must appreciate what has been accomplished through the Inflation Reduction Act while also looking to the future at new ways of mitigating birthing disparities.

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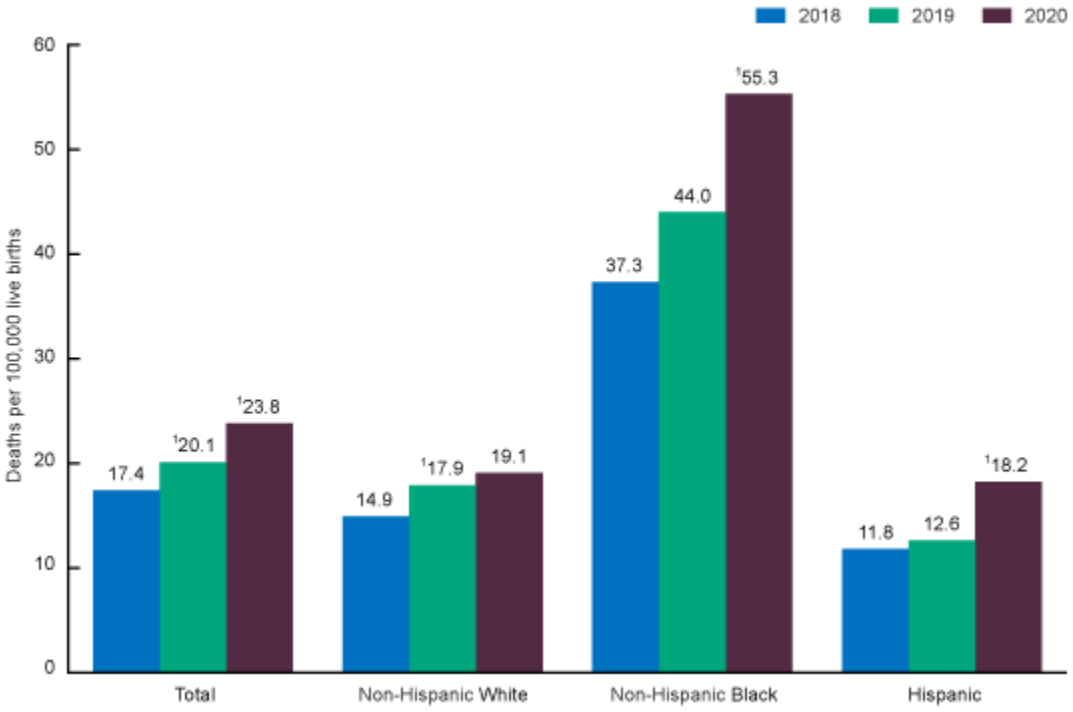
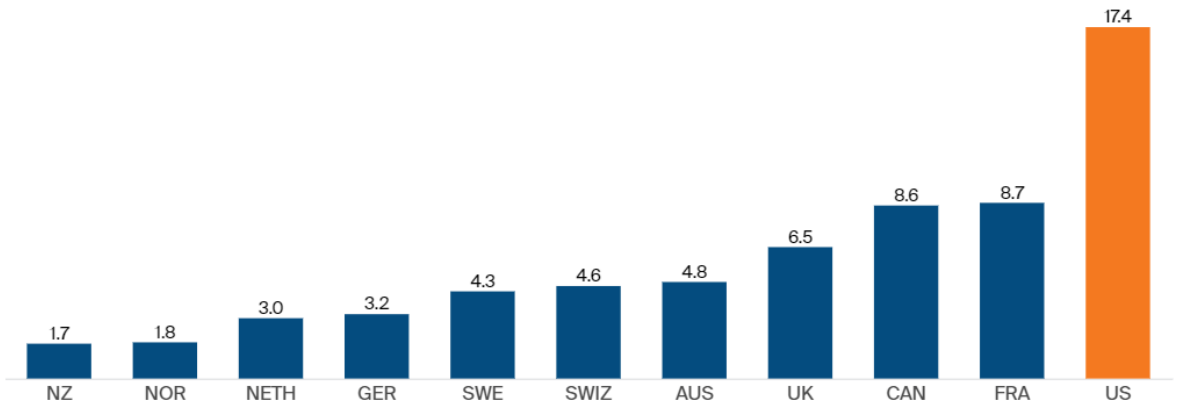
Appendix A: Maternal mortality rates, by race and Hispanic origin: United States, 2018–2020 (Hoyert 2022)



Appendix B: Maternal Mortality Ratios in Selected Countries, 2018 or Latest Year (Tikkanen, Gunja, FitzGerald, and Zephyrin 2020)

Deaths per 100,000 live births



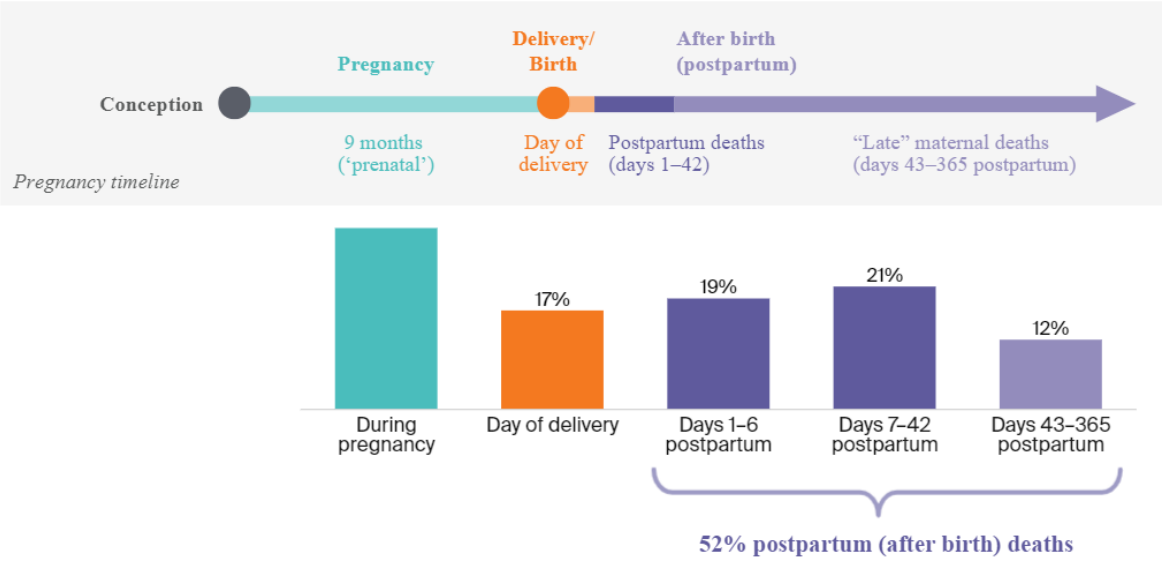
Download data

Notes: The maternal mortality ratio is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Data: OECD Health Data 2020, showing data for 2018 except 2017 for Switzerland and the UK; 2016 for New Zealand; 2012 for France.

Source: Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/411v-9255

Appendix C: Timing of U.S. Maternal and Pregnancy-Related Deaths, 2011–2015 (Tikkanen, Gunja, FitzGerald, and Zephyrin 2020)



Data: Centers for Disease Control and Prevention Pregnancy-Related Mortality Surveillance data from: Emily E. Petersen et al., "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017," *Morbidity and Mortality Weekly Report* 68, no. 18 (May 10, 2019): 423–29.

Source: Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/411v-9255