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Adeola Adelekan April 9, 2024

From Paper to Practice – U.S. Maternal Health Legislation and Racial Health Disparities 2013-2023

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Abstract

From Paper to Practice: U.S. Maternal Health Legislation and Racial Health Disparities 2013-2023

By Adeola Adelekan

This thesis delves into the nexus of U.S. maternal health legislation and its impact on Black maternal health outcomes, with a focus on race-consciousness in policy formulation and implementation. Drawing on historical contexts and contemporary legislative trends, the research explores how policy initiatives have addressed racial disparities in maternal health outcomes over the past decade. Through a comprehensive analysis of 33 pieces of federal legislation introduced or passed between 2013 and 2023, the study identifies patterns, trends, and outcomes concerning the intersection of policy and Black maternal health.

The findings reveal a significant increase in the introduction of maternal health-related bills in Congress over the study period, with 76% of these bills addressing racism in various forms. However, despite the prevalence of race-conscious legislation, the success rate of race-conscious bills remains disproportionately low, with only 9% becoming national law. Contrastingly, bills that did not address racism showed a 50% success rate, indicating a systemic barrier to the enactment of race-conscious policies.

Through case studies of specific legislative proposals, such as the Kira Johnson Act and the Black Maternal Health Momnibus Act, the research illustrates the nuanced dynamics of policy development and implementation. While some bills, like the Preventing Maternal Deaths Act, focus solely on maternal health without addressing racial disparities, they have shown higher success rates in legislative processes. Conversely, bills like the Black Maternal Health Momnibus Act, which comprehensively address institutional and interpersonal racism in maternal healthcare, face significant hurdles despite their evidence-based approach.

The study highlights the urgent need for effective policy interventions that not only acknowledge but actively work to dismantle structural racism in maternal healthcare. It proposes strategies to combat legislative apathy, increase investment in anti-racist healthcare initiatives, and promote community advocacy and engagement. Ultimately, the research underscores the critical role of legislation in shaping maternal health outcomes and advocates for comprehensive, race-conscious policies that prioritize the well-being of Black mothers and address historical injustices embedded in the healthcare system.

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This thesis is for my community and those impacted by bias in the healthcare system. I hope people learn from this work and are inspired to create change for a better future in healthcare.

Thank you.

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An analysis of race-consciousness in US maternal health policy and its impact on Black maternal health outcomes

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Introduction

In the United States, healthcare policy allows us to understand, plan, and implement health initiatives that directly reform the healthcare industry. These reforms impact the real-world health outcomes of its citizens. However, not all policies address the nuanced nature of public health issues such as the social factors that contribute to health outcomes. Policymakers do not always consider topics such as race, gender, socioeconomic status, sexuality and disability when writing, proposing or implementing new legislation. Maternal health is a great example of how these identities can be overlooked which leads to drastic disparities in health outcomes. Social issues have been increasingly embedded into American laws over the past 200 years as discussions about social justice have risen in prevalence and number in US society. Policies that directly address the aforementioned categories (race, gender, etc.) which have led to tangible changes for marginalized communities. For example, the Civil Rights Act of 1964 was intentional in its prohibition of segregation and discrimination on the bases of age, gender, sex, etc. Its implementation during the Civil Rights Movement has created pathways to social equity for Black people and other marginalized groups. The Civil Rights Act delegitimized segregation reducing the impact of structural racism on American Society. This bill is a prime example of race-conscious policy meaning that was intended to improve the conditions of a certain racial group, in this case, Black Americans. So how has maternal health policy impacted the inequities in health outcomes over the past decade? In what ways does health policy help or hinder maternal health outcomes for Black women? How has the legislative landscape impacted Black maternal health landscape? In this thesis, I will examine how health policy affects maternal health in the US, for example, in terms of topics like mortality rates, maternal health disparities, as well as maternal health outcomes. I will specifically analyze maternal health policy and its

effectiveness on reducing the impact of structural racism on Black maternal health. First, I will examine the historical significance of race-conscious and social policy, highlighting the relationship between US policy and Black women's reproductive experiences. Secondly, I will examine the state of maternal health in this country over the past decade highlighting trends and disparities. Third, I will analyze maternal health policy introduced in the House or Senate within the last decade. I also plan to note which policies make it through either the House and/or Senate and eventually become law. I hypothesize that the lack of "race consciousness" in maternal health policy (intentionally or unintentionally) contributes to the racial disparities we see in maternal health outcomes today. Finally, I will further explain a gap in literature regarding maternal health policy implementation as well as barriers to policy success. This framework will provide an understanding of the relationship between national policy and maternal health outcomes, highlighting the significance of race-conscious health policy that does not merely address disparities but seeks to mitigate them.

Background

In 1619, the first African women were taken captive and brought to the shores of the Colonies with a primary objective to exploit their reproductive capabilities. This issue was only exacerbated in 1808 when the transatlantic slave trade was abolished, and breeding plantations grew in both size and number *(LDHI, 2024).* This was done to establish a strong slave labor force for plantations cultivating across the southern United States without the need to travel to Africa. In order to keep the labor force growing, the legal principle known as "partus sequitur

ventrem,"[1] dictated that a child inherited the condition of their mother (regardless of the father) in terms of freedom from bondage. Therefore, if a mother was enslaved, so was her child, thereby denying them any social or legal autonomy over their bodies. This was especially tactical in insuring that biracial children that were conceived through rape would stay enslaved despite the free status of the white father. This phenomenon over 400 years ago, was the start to a long and complicated history between Black women and reproduction in the United States. Enslaved women were treated as racially objectified property, devoid of any rights over their bodies or even the children they bore. The laws that sanctioned slavery and ownership permitted practices akin to animal husbandry and various breeding techniques. These methods were used to exploit, manage, and control Black female reproduction in order to maximize profits. In the American colonies, the enslaved population was categorized under the Chattel Property System. This system allowed enslaved individuals to be considered legal property and not people. Because of this, they were able to be bought, sold, and owned indefinitely, subject to the complete discretion of their owners. These are early examples of laws and policies that directly impacted the experiences of Black mothers – early legal influences on Black maternal experiences.

These laws not only controlled Black reproduction, they also influenced how Black women were treated by medical professionals. J. Marion Sims who is understood to be the "Father of Gynecology" was known for performing surgeries and other gynecological experiments on Black women between 1845 and 1850. He focused primarily those with vesicovaginal fistula, a condition that often results from "prolonged obstructed labor"[2] *(L. Lewis Wall, 2006)*. Main critics of Sims make the assertion that under the social and legal climate of his experiments, enslaved women could not have provided voluntary, informed consent. This is

[1] Partus sequitur ventrem - "that which is born follows the womb"
[2] Prolonged obstructed labor – difficulty in labor that causes it to be more than 12 hours

because they were seen as property and not autonomous people under the Three Fifths Compromise which was not repealed until 1868*(L. Lewis Wall, 2006).* Considering that, by law, enslaved women were not classified as people, (nor did laws exist addressing slave experiments or consent) Sims experimental subjects were overlooked by the American legal system. While his actions are definitively questionable by today's standards, the political and legal climate at the time legitimized them. This speaks to the power of legal and political action when addressing health outcomes of minoritized groups.

Another example of health policy that has had tangible effects on health outcomes is the Hill-Burton Act passed in 1946. The act provided healthcare facilities such as hospitals and nursing homes with federal grants, loans and other funding for modernization and construction *(HRSA "Hill-Burton Free and Reduced-Cost Health Care", 2023)*. This was meant to improve health facilities across America; however, it included this clause:

> "such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, **but an exception shall be made in cases where separate hospital facilities are provided for separate population groups**, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group"

This statement, although seemingly inclusive, created a loophole allowing healthcare systems that utilized federal funding to continue to operate in segregated hospitals on the basis of "separate but equal". According to the Appellate Court decision in *Simkins vs Moses H. Cone Memorial Hospital* in 1963, this clause is unconstitutional and in violation of the 14th and 15th amendments *(Largent, 2018)*. In this case, Moses H. Cone Memorial Hospital and Wesley Long Community Hospital had been receiving federal funding through the Hill-Burton Act while simultaneously refusing to accept Black patients. This policy allowed the continuation of segregated hospital systems which were shown to provide higher quality care to white patients in

predominantly white facilities. This is a prime example of how health policy can have intended or unintended effects on racial health disparities.

Presently, the decision on the Supreme Court case Dobbs vs. Jackson Women's Health Organization which overturned Roe V. Wade[3] had direct effects on maternal health outcomes as well as the industry as a whole. The supreme court decision in this case which overturned the legalization of abortion care, has had negative impacts on the maternal health workforce. Based on a survey of OBGYNs analyzed by the Kaiser Family Foundation, the Dobbs decision prevented 68% of OBGYNs from being able to handle pregnancy-related emergencies such as miscarriages and 64% of them believe that the decision has worsened maternal mortality for this reason. Furthermore, 70% saw that the decision exacerbated racial and ethnic inequities in maternal health and over 50% felt that this ruling worsened the ability to attract and retain new diverse specialists to the field. *(KFF, 2023).* This is a real-world example of how policies and laws can impact the reproductive landscape and those who work in the field.

In summary, the relationship between policy, laws and health outcomes has always persisted especially in terms of Black maternal health experiences. Legislation has had a clear impact on personhood, autonomy, racial equity and the maternal health workforce. All in all, U.S. legislation remains effective in improving or worsening health outcomes for its citizens.

[3] Roe v. Wade – 1973 Supreme Court case where the court ruled that the Constitution of the United States generally protected a right to have an abortion.

US Maternal Health Overview

In order to understand an overview of maternal health policy in the United States, we must first define what maternal health is. The World Health Organization defines maternal health as "the health of women during pregnancy, childbirth and the postnatal period" *(WHO, 2020)*. Next, we will look to understand the definition of maternal death, maternal mortality as well as maternal morbidity. The CDC defines a maternal death as "occurring during pregnancy or up to 1 year after the pregnancy has ended." *(Center for Disease Control, 2022)*. Maternal mortality (also known as pregnancy-related death) is defined as "the death of a woman while pregnant or within 42 days of the termination of the pregnancy,"; this excludes accidental or incidental causes. *(NVSS, 2019)*. Maternal mortality and maternal death are not to be confused with maternal morbidity which is "any health condition attributed to and/or complicating pregnancy, and childbirth that has a negative impact on the woman's well-being and/or functioning" *(WHO, Maternal Morbidity and Well-Being")*. Maternal healthcare is a complex topic as each stage of reproduction presents its own challenges and dangers.

Between 2013 and 2017, the overall average US Maternal Mortality rate sat at 21.5 deaths per 100,000 live births *(Singh, 2020)*. For Black women, this number was over double that average at 48.2 deaths/100k while the rates for white women were 19.0 deaths/100k *(Singh, 2020)*. In the United States, the Total US Maternal Mortality rate per 100 thousand live births has increased from 17.4 in 2018 to 32.9 in 2021 *(CDC, 2021)*. For Black Americans, this rate has gone from 37.3 to 69.9 per 100,000 live births. Compared to white Americans, whose maternal mortality rate has increased from 14.9 to 26.6 in the same 3-year span, this is a drastic inequity. (See Figure 1) Maternal mortality has been on the rise over the past decade despite advancements in technology such as maternal telehealth services. These rates also increase with

maternal age as the rates 2021 for women ages 25-39 and 40+ are 31.3 and 138.5/100k respectively *(CDC, 2021)*.

Below is a list of the most prevalent causes for maternal health issues and maternal mortality including but not limited to:

- Mental health conditions (including deaths to suicide and overdose/poisoning related to substance use disorder) (23%)
- Excessive bleeding (hemorrhage) (14%)
- Cardiac and coronary conditions (relating to the heart) (13%)
- Infection (9%)
- Thrombotic embolism (a type of blood clot) (9%)
- Cardiomyopathy (a disease of the heart muscle) (9%)
- Hypertensive disorders of pregnancy (relating to high blood pressure) (7%) *(CDC, 2022)*[4]

Despite this list, roughly 84% of maternal deaths are considered preventable meaning that there was some way to avoid such a dire outcome. This could be through increased healthcare access, reduced stress and other factors*).* More than half of pregnancy-related deaths (~53%) occur up to 1 full year post-partum showing how pregnancy presents dangers for a woman's health long after giving birth *(CDC, 2022)*.

Even though over 50,000 women suffer from pregnancy complications annually, Black women in the US are three times more likely to die due to a pregnancy-related cause than their white counterparts *(CDC, 2021).* Between 2012 and 2014, Black women made up of 60% of maternal deaths despite being only 13% of the population *(Georgia Maternal Mortality Review*

[4] CDC – "Four in 5 Pregnancy-Related Deaths in the U.S. Are Preventable" 2022

Committee, 2020). Further, 40% of Black women experience maternal mental health symptoms and conditions like postpartum depression *(Hoyert, 2022).* Mental health challenges can further exacerbate conditions of stress and inflammation, two main causes of maternal health conditions. In fact, Black women face the highest prevalence of hypertensive disorders at 20.9% overall with 15.6% experiencing pregnancy-related hypertension. The rates of hypertensive/stress-related disorders for Black women average 7 percentage points higher than any other racial group *(Hoyert, 2022)*. These are alarming statistics that should not be ignored; however, Black women are statistically less likely to seek and receive treatment due to stigma, discrimination or financial barriers *(Hoyert, 2022).*

Overall, over the past decade, average maternal mortality rates have been on the rise for all racial groups, however they have been disproportionately increasing for Black women. Between 2018 and 2021 there was a significant rise in maternal mortality rates which can be attributed to health issues exacerbated by the COVID-19 pandemic. Further, instances like the death of Ahmaud Arbery and George Floyd as well as other events contributing to the Black Lives Matter Movement led to an increase in racial tension starting in 2020. This phenomenon held negative impacts on overall well-being for Black Americans resulting in both mental and physical challenges *(Eboigbe, 2023).* With this rise in maternal mortality, we also see a rise in maternal health legislation being introduced in Congress post 2020 (See Figure 2). This is likely a direct response to the dire health situations we saw arise after COVID-19.

To better understand the relationship between maternal health legislation and maternal mortality rates in the United States, I will be exploring maternal health policy and its impact on Black maternal health statistics. This thesis will examine health policy proposed and passed on a

national level in the past decade (between 2013 and 2023) seeing which policies addressed or sought to alleviate the racial disparities in maternal mortality in the US.

Literature Review

Policymaking in the United States ought to follow a few basic steps and guidelines in order to be effective *(NIH, 2016)*[5]. These include impartial decision making, accountability, collecting full and objective information, applying well-considered criteria, and following a rigorous and fair process *(NIH, 2016).* The legislative branch is the most suited to create health policy out of the three branches of government because it has the ability to draw from a more diverse body (635 members in total) and has the resources to access data and expertise of professionals while having the primary responsibility of creating policies and laws *(NIH, 2016).* Health policy can improve or damage health outcomes through education programs, prevention initiatives, regulations in healthcare services, funding for health programs, and access to health insurance *(Osypuk et al., 2014).* This impact highlights the importance of data driven health policy in any government system. Additionally, social policy has the ability to influence health outcomes through improving social determinants of health such as socioeconomic status, employment, or dismantling systems of gender bias, age discrimination or racism. (*Osypuk et al., 2014).* In summary the effectiveness of policy depends on its impact on individuals lived experiences through the programs and initiatives a bill supports.

For bills to become law in the U.S., they must undergo an extensive legislative process outlined below *(House.gov, 2024):*

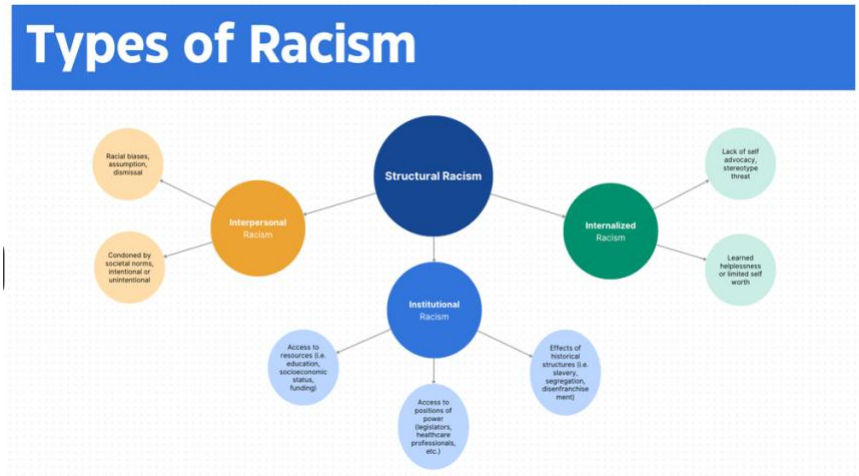
[5] NIH.gov, Biomedicine et al., 2016

1. The bill is proposed then introduced in the House of Representatives (House) or Senate
2. The bill goes to a specific committee, is reported, then debated on
3. The bill is voted on in the House or Senate
    a. A simple majority vote is required to pass (218 in the House and 51 in the Senate)
4. The bill is referred to the Senate (if proposed in the House) or referred to the House (if proposed in the Senate)
5. The bill is sent to the President's desk to be signed into law

To gain a better understanding of the overall political climate during the scope of this study (2013-2023), it is important to note that in the United States, the Democratic party controlled the Senate from 2013 to 2015 and again between 2021 and 2023. In this same decade, the Republican party maintained the majority between 2015 and 2021 *(Senate.gov, 2023)*[6]. In the House of Representatives, the Republican party held the majority from 2013 to 2019 until the Democrats took control of the House from 2019 to 2023 *(House.gov, 2024)*[7]. During this same decade, the role of President of the United States was occupied by Barack Obama (Democrat) from 2013 to 2017 until Donald Trump (Republican) took office until 2021 and was then replaced by Joe Biden (Democrat) *(whitehouse.gov, 2022)*[8]. Further, out of 435, 310 members of the US House are white and 59 (13%) identify as Black. In the Senate, out of 100, 88 members are white and only 4 identify as Black[9]. This is useful in understanding who is writing, supporting and enacting laws throughout the decade analyzed in this study.

[6] Senate.gov, U.S. Senate: Party Division, 2023
[7] House.gov, Party Divisions of the House of Representatives, 1789 to Present | US House of Representatives: History, Art & Archives, 2024
[8] whitehouse.gov, Presidents | the White House, 2022
[9] https://www.statista.com/chart/18905/us-congress-by-race-ethnicity/

In discussing “race-conscious” policy, we must look to understand what racism is and how it manifests in American society. The four forms of racism – structural, internalized, institutional, and interpersonal all contribute to the issue of maternal health disparities *(Francis et al. 2023).* Race-conscious policy “is policy that aims to improve the conditions of racial minorities. The main purpose is twofold: to compensate for past discrimination against the target race, and to increase equality of opportunity” *(Brown, 1931).* Institutional Racism is defined as differential access to goods, services, resources and opportunities of society based on race *(Camara Phyllis Jones, 2000)*. It can affect both material access (wealth, housing, food) as well as the ability to gain power within a society or system *(Camara Phyllis Jones, 2000)*. Interpersonal Racism is characterized by prejudice or discrimination from one person or group to another. It can be conscious or subconscious and can manifest as lack of respect, dismissal, and overall dehumanization *(Camara Phyllis Jones, 2000).* Internalized racism represents the intentional or unintentional acceptance of stereotypes and negative messages regarding someone’s own humanity and worth because of their race. This can result in helplessness and lack of self-advocacy *(Camara Phyllis Jones, 2000)*. Structural Racism is defined as the umbrella term encompassing the other three forms; the laws, policies, traditions, culture and other factors that uphold the other three. It bolsters the interconnected and intertwined nature of institutional, interpersonal and internalized racism highlighting how they work in tandem to contribute to the oppression of minoritized groups, especially Black people *(Camara Phyllis Jones, 2000)*.



Structural racism in healthcare, refers to the pervasive influence of historical, cultural, and current racist systems and institutions that intersect to create a web of inequity affecting communities of color *(Yearby, 2022).* Operating through laws and policies, structural racism allocates resources in ways that disempower and devalue racial and ethnic minority groups, leading to inequitable access to high-quality care. An illustrative example of this is the unequal distribution of health insurance coverage, with racial minorities experiencing disproportionately higher uninsured rates compared to their white counterparts *(Yearby, 2022).* This disparity leads to unequal access to healthcare services, further marginalizing minority populations and contributing to health disparities. This phenomenon is exacerbated by income inequality, another symptom of structural racism. Structural racism perpetuates inequities in maternal health outcomes by reinforcing systemic health inequality as a whole.

Institutional racism in healthcare, manifests as differential access to goods, services, resources, and opportunities based on race within healthcare institutions and systems. This systemic phenomenon, as defined by Camara Phyllis Jones, encompasses both material access to healthcare services and the ability to gain power within the healthcare system. Historically, the

U.S. health care delivery system has perpetuated institutional racism through systematic segregation and discrimination against patients of color. This phenomenon is also evident in cases like the Hill-Burton Act and Moses H. Cone Memorial Hospital which allowed hospitals to segregate facilities. This inequality has led to the creation of hospitals and clinics exclusively designated for racial and ethnic minorities *(AAFP, 2019).* Despite legal advancements against institutional racism, the lingering effects of discrimination persist, with these facilities often experiencing financial constraints and inadequate staffing. This unequal distribution of resources can result in disparities in access to and quality of care *(Williams, Rucker, 2000).* Additionally, while overt segregation may have ceased, discrimination based on insurance status remains prevalent, disproportionately affecting non-white populations and perpetuating racial and ethnic health disparities *(Williams, Rucker, 2000).* This is another example of how institutional racism effects health.

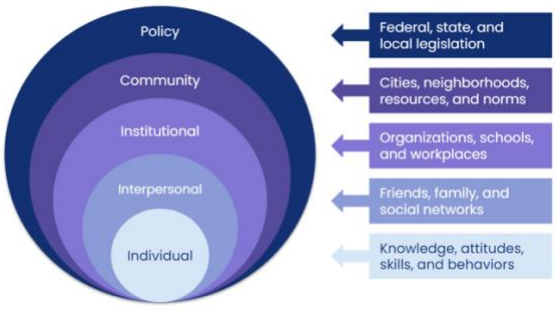
Interpersonal racism in healthcare, entails instances of prejudice or discrimination directed from one party to another. This can manifest consciously or subconsciously and often results in the lack of respect, dismissal, or overall dehumanization of patients based on their race or ethnicity *(Hamed, 2022).* For example, a healthcare provider may exhibit interpersonal racism by disregarding a Black woman's concerns or complaints during childbirth, attributing them to exaggerated pain or hysteria. Additionally, a patient of color may experience interpersonal racism when the healthcare staff fails to adequately communicate treatment options or involve them in decision-making processes, leading to feelings of disempowerment and marginalization. Such instances of interpersonal racism not only erode patient-provider trust but also contribute to disparities in maternal health outcomes by perpetuating unequal treatment based on race or ethnicity *(Hamed, 2022).*

The impact of structural, institutional and interpersonal racism is reflected in internalized racism. Internalized racism can lead to helplessness and devaluing one's worth *(Camara Phyllis Jones, 2000),* which can prevent Black women from questioning their medical treatment, keeping them from speaking up to doctors and overall decreasing their capacity for self-advocacy *(Peek et al. 2010).* This presents additional dangers during pregnancy as childbearing is a very personal and individualized experience that requires the input of both the mom and healthcare provider. For example, if a mother is in pain and experiencing symptoms of preeclampsia, she will explain these symptoms to her healthcare provider. If the healthcare professional holds biases that Black people experience less pain or exaggerate their pain levels, she may misdiagnose her patient. If the mother is not persistent in being heard or assumes the healthcare professional "knows best" this could have dire impacts on the health and well-being of the mother and baby.

Examples in Healthcare		
Institutional	**Interpersonal**	**Internalized**
1	2	3
Lack of Black OBGYNs and other culturally congruent professionals	Medical racism or bias	Lack of self advocacy
Lack of race concious health policy	Decreased pain management due to stereotypes that Black people experience less pain	Listening to Doctors instead of your own body
Lack of SDOH efforts	Lack of implicit bias training or DEI hiring initiatives	Not wanting to feed into aggressive or angry stereotypes (stereotype threat)
Lack of financial investment in race concious maternal health initiatives (ex. implicit bias training)	Dismissal of complaints (i.e. discomfort, symptoms) due to subconcious bias	Lack of education on maternal health topics
Lack of initiatives targetting minority communities and their unique needs	Negligence (intentional or unintentional) due to bias	Distrusting qualifications/expertise of healthcare workers of color

The multifaceted nature of racism operates across different levels of the Social-Ecological Model of Health, impacting individuals, relationships, and institutions in complex

ways (CDC, 2022)[10]. Internalized racism affects individuals at the intrapersonal or individual level of the social-ecological model by shaping their beliefs, attitudes, and perceptions about themselves based on racial stereotypes. Interpersonal racism operates at the interpersonal/relationship level, influencing interactions between individuals through discriminatory behavior, prejudice, and bias, leading to interpersonal conflicts and unequal treatment. Institutional racism operates at the institutional and community levels, perpetuating systemic discrimination through policies, practices, and norms within organizations and institutions, resulting in disparities in access to resources, opportunities, and services among different racial groups. These forms of racism intersect and reinforce each other, contributing to the maintenance of racial inequalities across various societal structures and systems. Collectively, they shape the social environment and impact the well-being of individuals and communities within the broader social-ecological framework.



[11]

The stress of racism has had a lasting impact on the health of Black Americans including, but not limited to, women of childbearing age. It impacts physical health in a number of ways as

[10] CDC – The Social Ecological Model
[11] Social Ecological Model for Health – Kasley Killam - https://kasleykillam.medium.com/the-inspiration-behind-community-microgrants-5bdedff5e48a

a chronic stressor contributing to adverse physiological outcomes (maternal mortality, low birth weight babies, etc.) and to the body's inability to reach a normal state of balance across various organ systems *(Lui, Glynn, 2021).* The impact of racism can start during ones youth as "high levels of inflammation, found in children from disadvantaged racial and ethnic minority populations, can be a precursor to chronic disease later in life" *(Slopen, 2021).* Being the target of racially motivated discrimination can often result in stress that can adversely affect both physical and mental health. Because of this, examples of racism are used to assess both acute and chronic instances of stress for ethnic minorities *(Williams, 2018).* For example, being passed over for a promotion unjustly or having a family member targeted by police are just a few examples of race-related stressors that can cause physical symptoms and negatively affect health outcomes. Examples of discrimination in the healthcare setting can exacerbate these issues when vulnerable populations go to seek medical attention (due to the impact of racial stress) and are faced with further bias: "Research reveals that high levels of negative stereotypes, through normal, subtle and often subconscious processes, can guide expectations and interactions with others in ways that reduce the quality of service provided by mental health professionals to persons who belong to stigmatized social groups" *(Williams, 2018).* In essence, racism causes stress from a young age that can lead to chronic health conditions later in life. These conditions can be made worse when faced with discrimination in a healthcare setting.

The most prevalent causes of maternal health problems include mental health issues, hypertensive disorders such as preeclampsia or eclampsia as well as cardiomyopathy and other heart problems *(CDC, 2022).* These disorders are most closely related to stress and inflammation. As outlined above, the three forms of racism play a large role in the stress and health of Black populations. Considering that pregnant women are already at-risk of high blood

pressure and other types of inflammation; a clear connection can be drawn between racism and Black maternal health outcomes.

The three forms of racism when it comes to healthcare, specifically Black maternal health, do not operate in singularity but rather in tandem with one another *(Francis et al., 2023)*. This interconnected nature is not often understood as it is assumed that these levels or racism work simultaneously rather than jointly. According to a study conducted by Dr. Brittney Francis in 2023, these three forms of racism have contributed to increased rates of Black maternal hypertension, a leading cause of Black maternal mortality *(Francis et al., 2023)*. In this study, **all** participants reported experiencing medical discrimination due to factors such as perceived insurance status, assumption of non-compliance or "not caring", and aggressiveness *(Francis et al., 2023)*. These are prime examples of the harms of interpersonal racism manifesting through the lack of respect or dismissal mentioned by Jones. Examples of medical racism such as this, coupled with the few Black professionals in maternal care, highlight how the three forms of racism are not mutually exclusive. One aspect has to do with personally mediated racism while the other is institutional through a lack of Black people in positions of power in the healthcare industry. These phenomena operate together and have a direct impact on various biomarkers such as inflammation, stress and hormone imbalance which can negatively affect maternal health *(Williams, Mohammed, 2013), (Paradies et al. 2015).*

One way to combat the drastic disparities in maternal health is through culturally congruent care and diversifying the maternal health workforce. Culturally congruent care refers to healthcare practices that are tailored to align with the cultural beliefs, values, traditions, and preferences of individual patients or specific cultural groups *(Stubbe, 2020).* This approach recognizes that culture significantly influences how individuals perceive health, illness, and

healthcare *(Stubbe 2020).* Culturally congruent care seeks to bridge the gap between healthcare providers and patients by integrating cultural understanding into the delivery of health services *(Stubbe, 2020).* This can be exemplified through language translators, understanding religious practices, or simply having a healthcare provider of the same race or ethnic background. However, Black women, regardless of what stage they are at in their reproductive lifespan (preconception, pregnancy, postpartum), have reported a lack of culturally congruent providers equipped to treat their unique needs *(Chambers et al., 2021).* Instances where culturally congruent care is lacking have had overall negative effects on the health and wellbeing of the mother and child *(Chambers et al., 2021).* This is a prime example of institutional racism, outlined by Jones, as Black women are often not able to acquire the societal positioning to become healthcare professionals like OBGYNs; nor can they often afford to select professionals that share the same cultural understanding as patients. This is due to the fact that many Black women also face discrimination in hiring and promotion, preventing them from becoming the doctors and maternal health professionals that their community needs *(Chambers et al., 2021).* However, these issues can be mitigated through things like Diversity, Equity and Inclusion (DEI) efforts that promote culturally congruent care and a diverse maternal health workforce. This is crucial as studies have shown that many Black women report feeling safer with Black midwives and doctors while there remains lack of sufficient Black healthcare providers for the Black female population *(Chambers et al., 2021).*

Government policies impact the daily lives of those living within the governed state. According to a 2018 study, when examining the effects of health policy "a tentative pattern emerges and it is possible to identify (1) public health policy interventions that are effective in

reducing health inequalities; (2) those that do not have any effect on health inequalities or where the evidence is unclear; and (3) those interventions that appear to increase health inequalities" *(Thomson, et al.).* For example, under the Affordable Care Act, the requirement to be Medicaid eligible during pregnancy is that you must have an income that is 200% of the Federal Poverty Level[12] (FPL). This allowed women who normally wouldn't qualify for Medicaid at 138% FPL to receive free medical care while pregnant. However, even to this day, nearly half of women in Medicaid non-expansion states experienced insurance churn [13] from pre-pregnancy to their postpartum period. This means that in states where Medicaid was not expanded, women were more likely to lose insurance coverage after giving birth compared to only 1/3 of women in Medicaid expansion states. This policy is effective in reducing health inequalities but only after it has been implemented in the state government. An additional example of healthcare legislation that seek to reduce maternal health problems include the Preventing Maternal Deaths Act which was signed into law in 2018. This bill mandated reporting on pregnancy-related deaths and provided financial support for state-based Maternal Mortality Review Committees (MMRCs). These MMRCs offer standardized reports of pregnancy-related deaths and utilize clinical and non-clinical data to identify population-based risk factors of maternal health problems. The reports are also required to include data on any maternal health disparities that persist. This helps policymakers make informed decisions and write effective policy based on trusted data however it does not have any effect on reducing racial health inequalities besides simple data collection.

Before the American Rescue Plan Act of 2021 (ARPA), a mother who was not previously on Medicaid and was enrolled during pregnancy could remain covered for 60 days post-partum

[12] A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.
[13] Insurance Churn – n. Transferring from different methods of coverage and/or becoming uninsured

before she was removed from her Medicaid plan. This was extended to one full year through the passing of ARPA. This policy allowed women who had recently given birth in the past year to stay insured even if they did not meet the Medicaid eligibility income requirement as a non-pregnant individual which is set 138% FPL (*Health Affairs, 2021)*. The stability of postpartum coverage for 12 months increased the use of postpartum and outpatient care which has been proven to improve the health outcomes of both the mother and baby *(Elevance Health PPI, 2022)*. 46 states have pursued Section 1115 Waivers from CMS in order to allow the states to implement and fund postpartum extension by statistically demonstrating improved outcomes. However, the Helping MOMS Act of 2019 would allow states to bypass this waiver in order to extend Medicaid coverage to one year without having to prove its impact. *(Kaiser Family Foundation, 2023)*.

Legal policies and bills have tangible impacts on health outcomes. So how have maternal health policies impacted maternal health disparities? How does the presence or lack of race-conscious policy impact Black maternal health? What have been the effects of maternal health policy changes on the experiences of Black mothers? These are the central questions driving the scientific research conducted in this study.

Rationale

Studies such as *(Francis (et al.), 2023)* and *(Williams, 2018)* have documented how structural racism is the underlying factor behind the health disparities that we see today. The lack of inclusive policy that considers race and racism as a contributing factor to this problem provides no relief to the issue. As clearly shown in the background and literature review, national policies and programs have a direct impact on the medical field and can alleviate or contribute to

health inequalities. However, so much policy we see today does not directly address the racial factors concerning maternal health outcomes and disparities. To address this gap in literature, this study explores maternal health policy proposed and passed within the last decade, analyzing which policies address institutional, interpersonal, or internalized racism. Further, it will illuminate any barriers to success that race-conscious policy may face in US Congress.

Hypothesis

The absence of written health policies aimed to mitigate racial disparities in maternal health serves as a significant contributing factor to the widening gap observed between Black and white maternal mortality rates in the United States.

Search Strategy

To gain a better understanding of the answer to my research questions, I conducted a systematic qualitative analysis of national U.S. policy introduced between 2013 and 2023 addressing maternal health. I searched for bills that directly seek to improve maternal health issues analyzing for race-conscious programs or initiatives concerning maternal health. This was done using an official government database Congress.gov/bill.

Key search terms included: Black maternal health, maternal health, maternal mortality, maternal morbidity, pregnancy-related, prenatal, perinatal, postpartum, implicit bias, and racism.

Each term was searched independently on the database, and duplicate results were removed from analysis. Further, I interviewed a maternal health legislator to gain insight into the context and reasoning behind these policies. Our conversation shed light on congressional

priorities regarding maternal health within the legislative workforce as well as barriers to policy implementation.

Methods

I searched the US Congress legislative databases using Congress.gov for maternal health policies introduced from 2013 to 2023. I screened 261 national bills from the US House of Representatives and Senate (See Figure 3). Data collection included bill characteristics an assessment of purpose and goals as well as any mention of Black maternal health or healthcare disparities. Additionally, the data analysis identified the level of racism (internalized, interpersonal or institutional) that each policy addressed, if any.

For policies to be eligible for this study, they had to be:

1. Introduced, enacted, or proposed by US Congress – either the House of Representatives or the Senate
2. Introduced between 2013 and 2023
3. Written to address maternal health and/or mortality issues
    a. Either through the bills defined "Purpose" or
    b. Through and assessment of the bill's characteristics

Data captured for each bill included:

- Date of introduction
- Assessment of the overall purpose of the bill

- Bill characteristics such as program implementation, policy changes, financial investment (i.e. grants) or committee formulation
- Status of bill
- Political party affiliation of the bill's main sponsor
- Level of racism addressed (internalized, interpersonal or institutional)

The date of introduction gave insight into the political climate of the congressional body in which the bill was introduced. Since elections happen on a cycle, it is important to understand when a bill was proposed to see which party had the majority as well as the political state of the country at that time. The date of a bill explains the context in which the policy was proposed, helping us gain an understanding of the legal, political and social dynamics surrounding the bill as well as its relationship to bills before it. The overall purpose of the bill is stated at the beginning and outlines the main objective of the legislation, this provides an idea of what the overarching theme of the bill would be as well as its ultimate goal. Bill characteristics were found in the main body of the bill that was analyzed to see what specific actions the legislation called for. For example, what programs or specific policies would be enacted under the bill and the level of financial investment required (i.e. implicit bias training programs or grants for healthcare accessibility). The status of the bill explained how far the bill got in Congress, "Introduced" being the least successful and "Became Law" being the most successful. The sponsor is the bill's main proponent and gives insight into which congress members from across the country designed these policies as well as their political affiliation.

Bills with the same title that were introduced in different years were refined to the most recent bill as newer versions contained more up to date information and had more relevant

solutions for the time period. Considering that the scope of the study is only 10 years, using the most recent version of a piece of legislation allows for collection of the most comprehensive and amended version of policy. Bills introduced in the House and Senate within the same year were refined to the first/original bill. This is due to the fact that bills introduced in both the House and Senate are often identical. Once passed in both chambers of congress they become law. Therefore, I chose to include the original bill to acknowledge the original writers and sponsors.

The overall framework used in this study is sourced from Belinda Needham et. al. (2022). Their conceptual framework (See Figure 4) outlines six key considerations, four of which are used in this study:

1. Policy identification
2. Population of interest
3. Outcome measurement
4. Analytic approach.

I used inductive qualitative analysis to determine the themes and content of the bills. They were then analyzed to discern if they explicitly addressed race, ethnicity, racism, racial/ethnic disparities, health equity, minority communities, Black women, or underserved communities. Policies were separated by those that (1) did not mention these terms, (2) simply included or the aforementioned terms, or (3) those that directly address Black maternal health and racial disparities. From this, percentages were calculated based on how many policies that address these issues are passed and implemented vs not passed. For example:

- Percentage of bills that addressed internalized, interpersonal, institutional racism or a combination of the three

- Percentage of bills that passed the House or Senate and addressed any form of racism
- Percentage of bills that passed that did not address any form of racism
- Percentage of bills that did not pass (were unsuccessful) and addressed racism
- Percentage of bills that did not pass and did not address racism

To conduct the qualitative appraisal, I evaluated three aspects to gauge the impact and purpose of a policy and its initiatives. In my analysis, I tailored the framework to concentrate on the intention of the bill in regard to addressing any forms of racism by examining (1) its stated objectives, (2) any intended or unintended consequences, both positive and negative, that may arise independently of the objective, and (3) its impact on health equity and discrimination reduction for Black mothers. This includes whether it produces disparate outcomes for different populations and whether it contributes to the maintenance, exacerbation, or reduction of health inequities.

Examples of intentional or explicit efforts to address interpersonal, internalized and institutional racism go beyond merely acknowledging racial disparities in maternal health and work to create tangible positive impact. For example:

- Interpersonal
    - Implicit bias training programs for healthcare professionals (interpersonal)
    - Education programs on topics like culturally congruent and culturally competent care
- Institutional
    - Funding for programs targeting Black or minority populations concerning maternal health

    - Systems implemented that track or monitor maternal issues by race AND seek to mitigate those disparities (not just data collection)
    - Establishing and or funding programs that address social determinants of health AND seek to mitigate them by reducing costs, accessibility barriers, etc.
    - Creating committees or task forces that include representation of minority communities
- Internalized
    - Encouraging self-advocacy and raising awareness regarding how to handle situations of bias

Examples in legislation and which form of racism they work to address

EXAMPLE	FORM OF RACISM
Standardized anti-racism and implicit bias training for maternal health workforce	Interpersonal
Diversity-focused recruitment	Institutional
Maternal health education in minority communities	Institutional, Internalized
Funding and technical assistance for Black maternal health initiatives	Institutional

Based on this data, a regression was run to find the correlation between whether a bill addressed a level of racism and the risk of being unsuccessful (See Figure 5).

- Bills that addressed racism were given a value of 1, bills that did not address racism were given a value of 0

- Bills that were successful (meaning they passed the introductory level) were given a value of 1 while unsuccessful bills were given a value of 0
- The 2 variables were then analyzed to see how correlated unsuccess and race-consciousness are in maternal health legislation from 2013-2023

Results

The screening produced 261 bills, or laws introduced in the house or senate between 2013 and 2023 that addressed healthcare on a national scale. After removing those that did not address maternal health issues 54 bills remained. Removing the earlier versions of bills reintroduced in a later year and identifying bills introduced in both the house and senate, where each pair/group counted as one, the number of bills resulted in 33 individual or grouped pieces of federal legislation related to maternal health and mortality introduced or passed in the House of Representatives and/or Senate between June 6th 2013 and May 18th 2023. (See Figure 6)

Between 2013 and 2023 there was an overall increase of maternal health policy being introduced in Congress each year with the majority being proposed in 2021.

The total aforementioned list of legislations (n=33) consisted of 29 bills (87%) that had been introduced in the House or Senate but not passed. In addition to this, 1 bill (3%) had passed in the House while 3 bills (9%) became law. (See Figure 7)

Of this total (n=33), 13 bills (39%) addressed institutional racism, 1 bill (3%) addressed interpersonal racism, 0 bills (0%) addressed internalized racism, and 11 bills (33%) addressed

both institutional AND internalized racism. 8 bills (24%) did not address any form of racism at all. (See Figure 8)

Of those that were introduced and not passed (n=29), 13 bills (45%) addressed institutional racism, 1 bill (3%) addressed interpersonal racism, 0 bills (0%) addressed internalized racism, 11 bills (38%) addressed institutional AND interpersonal racism. 4 bills (13%) did not address any form of racism at all. (See Figure 9)

Of those that made it beyond the introduction phase (n=4), 1 bill passed in the House while 3 bills became law. These bills are H.R. 3226 (passed the House), H.R.958/ S. 796/ L. 117-69, S. 1112/ H.R. 1318/ L. 115-344 and S. 198/ H.R. 1218/ L.117-247. Out of these 0 bills (0%) addressed institutional racism, 0 bills (0.00 or 0%) addressed interpersonal racism, 0 bills (0%) addressed internalized racism, 0 bills (0.00 or 0%) addressed institutional AND interpersonal racism, and 4 bills (100%) did not address any form of racism at all. (See Figure 10)

This data adds additional understanding to my hypothesis: it is not the mere lack of race-conscious policy that contributes to these disparities but the lack of successful race-conscious policy. Successful policy would mean that the bill makes it through the 5 stages of implementation to be signed by the President and become law. Bills that address racism have been written and introduced in their respective chambers of Congress, however they are not being implemented into our national health systems.

Name	Code	Date Introduced	Status	Addresses Institutional Racism	Addresses Interpersonal Racism	Addresses Internalized Racism
MOMS for the 21st Century Act	H.R. 2286	6/6/13	Introduced in the House	x	x	
21st Century Women's Health Act	H.R. 3652	9/30/15	Introduced in the House	x		
Preventing Maternal Deaths Act	S. 1112/ H.R. 1318/ L. 115-344	3/2/17	Became Law (12/21/2018)			
Save Women's Preventive Care Act	S. 1045	5/4/17	Introduced in the Senate (parts were included in another bill)	x		
Ending Maternal Mortality Act	H.R. 7561	5/10/18	Introduced in the House	x		
MOMMA'S Act	H.R. 1897	3/27/19	Introduced in the House	x		
Excellence in Maternal Health Act	H.R. 4215	8/30/19	Introduced in the House	x	x	
Anti-Racism in Public Health Act	S. 162	2/2/21	Introduced in the Senate	x		
Data Mapping to Save Mom's Lives Act	S. 198/ H.R. 1218/ L.117-247	2/3/21	Became Law (12/20/2022)			
Rural MOMs Act	H.R. 769	2/3/21	Introduced in the House			
Mom's MATTER Act	H.R. 909	2/8/21	Introduced in the House	x		
Social Determinants for Moms Act	H.R. 943	2/8/21	Introduced in the House	x		

Justice for Incarcerated Moms Act	H.R. 948/ S.341	2/22/21	Introduced in the Senate		
Kira Johnson Act	H.R. 1212	2/23/21	Introduced in the House	x	x
Protecting Moms and Babies Against Climate Change Act	S.423	2/24/21	Introduced in the Senate	x	x
Supporting Best Practices for Healthy Moms Act	H.R.1350/ S. 408	2/25/21	Introduced in the House	x	
Protecting Moms Who Served Act	H.R.958/ S. 796/ L. 117-69	3/17/21	Became Law (11/30/2021)		
Maternal CARE Act	S. 1234	4/20/21	Introduced in the House		x
MOMMIES Act	S. 1542	5/10/21	Introduced in the Senate	x	x
Healthy MOM Act	H.R. 3126	5/11/21	Introduced in the House		
Maternal Health Quality Improvement Act	S. 1675	5/18/21	Introduced in the Senate	x	
Helping MOMS Act	H.R. 3345	5/19/21	Introduced in the House	x	
TRIUMPH for New Moms Act	H.R. 4217	6/29/21	Introduced in the House	x	
Protect Black Women and Girls Act	H.R. 6268	12/14/21	Introduced in the House	x	x

Mamas First Act	H.R. 7475	4/7/22	Introduced in the House		
Health Equity and Accountability Act of 2022	H.R.7585	4/26/22	Introduced in the House	x	x
Maternal Health Pandemic Response Act of 2022	S. 5284	12/15/22	Introduced in the Senate	x	x
Mothers and Newborns Success Act	S. 964	3/23/23	Introduced in the Senate	x	
PREEMIE Reauthorization Act	H.R. 3226	5/11/23	Passed in the House		
Social Determinants for Moms Act	H.R. 3322	5/15/23	Introduced in the House	x	
IMPACT to Save Moms Act	H.R. 3346	5/15/23	Introduced in the House	x	x
Black Maternal Health Momnibus Act	S. 1606	5/15/23	Introduced in the Senate	x	x
Perinatal Workforce Act	H.R. 3523	5/18/23	Introduced in the Senate	x	x

Data Analysis

Based on the aforementioned data, it is clear that the issue lies in the passing and legislative success of race-conscious legislation. Many legislators such as Lauren Underwood, Robin Kelly, Cory Booker, Joi Moore, and other elected officials have done the work creating

bills that directly address the issue of racism in maternal health disparities. Considering that the vast majority (76%) of legislation used in this study address racism on at least one level, there is clearly no lack of race-conscious legislation being proposed. However, the success rate of these bills over the past ten years is close to zero. Meanwhile bills that did experience success in the House, Senate or beyond did not seek to work against institutional, interpersonal or internalized racism. Further, bills that did not address racism at any level held a 50% success rate in this study showing that legislation is more likely to be successful if they avoid addressing topics of racism. After running a linear regression, the "Multiple R" value of this data set is close to 1 meaning there is a strong correlation between bills that address racism and bills that are not passed.

For example, the Kira Johnson Act (H.R. 1212), proposed by Representative Alma Adams (D-NC) in 2021, is focused on improving maternal health outcomes for racial and ethnic minority groups, particularly Black pregnant and postpartum individuals. This bill was written in direct response to the unfortunate tragedy of Kira Johnson's death which resulted from excess bleeding due to lack of medical attention from hospital staff during labor. Under this bill, the Department of Health and Human Services is mandated to award grants for community-based programs targeting Black pregnant and postpartum individuals, emphasizing outreach led by Black women and culturally congruent programs. The grants also support maternal mental health and substance use disorder treatments aligned with evidence-based practices. The Kira Johnson Act asserts that healthcare providers and maternity care workers will receive training to reduce and prevent racism, implicit bias, and discrimination in their practice. These training programs will specifically focus on "respectful" maternity care and cultural congruence. Further, the National Academies of Sciences, Engineering, and Medicine will conduct a study on issues

related to these training programs and conduct reports on ways to improve them. Additionally, the Government Accountability Office will study compliance programs focusing on advancing respectful, culturally congruent, trauma-informed care in maternal healthcare facilities. The bill emphasizes that these programs and investments will be geared towards improving community-based organizations in underserved communities with high maternal mortality rates and diverse leadership. Congress would also conduct a study on the design and implementation of these programs and their effectiveness at reducing bias, racism, and discrimination in maternity care settings. The bill also introduces a Respectful Maternity Care Compliance Program to institutionalize mechanisms for reporting instances of racism or bias based on race, ethnicity, or other protected classes, ensuring a comprehensive approach to ending preventable maternal mortality and severe maternal morbidity. Due to its focus on sytemic and personal inequality/bias, this bill was classified as addressing both institutional and interpersonal racism. Unfortunately, this bill did not make it past the introduction phase.

Conversely, the Preventing Maternal Deaths Act (H.R. 1318) proposed by Representative Jaime Herrera Beutler (R-WA) in 2018 focuses on supporting the Department of Health and Human Services (HHS) in instituting a program offering grants for states to address maternal mortality by reviewing and analyzing pregnancy-related and pregnancy-associated deaths. This initiative involves the establishment and maintenance of maternal mortality review committees aimed at evaluating relevant information. For example, the bill allows the CDC to analyze data collected from these maternal mortality review committees as the finding must be reported to them after each fiscal year. Under this bill, states are mandated to develop ongoing healthcare provider education plans, disseminate findings, implement recommendations, and ensure uniformity in information collection through case abstraction forms for HHS review. They must

also establish mandatory reporting procedures for health facilities and professionals concerning maternal deaths, with optional family member reporting. Each case undergoes investigation and case summary preparation for committee review and inclusion in relevant reports. To offset some of these data collection and program costs, states may partner with neighboring states under this bill as well. Furthermore, H.R. 1318 amends the Public Health Service Act to guide HHS in collected data in order to discover areas where there may be maternal health disparities as well as promoting mental and behavioral health activities. However, the bill does not address any level of racism that could contribute to the aforementioned disparities. The overarching objective is to support states in preserving and enhancing maternal health throughout pregnancy, childbirth, and the postpartum period through enhance data collection and analysis programs. This bill was signed into law in 2018.

The Protecting Moms who Served Act (S.796), proposed by Senator Tammy Duckworth (D-IL) in 2021 mandates the implementation of the maternity care coordination program by the Department of Veterans Affairs (VA). Under this bill, community maternity care providers, who are non-VA providers, will receive training and support from the Department of Veterans Affairs to address the unique needs of pregnant and postpartum veterans, with a specific focus on mental and behavioral health conditions related to their service in the Armed Forces. A financial allocation of $15,000,000 was designated for fiscal year 2022 to facilitate this training initiative. Additionally, under this bill, the Comptroller General is required to conduct a study on maternal mortality among veterans, including information on racial and ethnic disparities in maternal health outcomes. The study aims to identify causes of maternal mortality, such as post-traumatic stress disorder (PTSD) and military sexual trauma, shedding light on disparities in health outcomes for veterans based on these psychological issues. The bill mandates a report on

maternal mortality and severe maternal morbidity among pregnant and postpartum veterans, including data on infertility diagnoses, disaggregated by various demographic factors such as location, where they served, etc. Notably, the report will offer recommendations for legislative actions to address issues such as poverty, food insecurity, and education for veterans. While the bill doesn't directly address racism, it acknowledges the existence of racial and ethnic disparities and seeks to understand these disparities in maternal health outcomes for pregnant and postpartum veterans. This bill was signed into law on November 11th 2023.

Notably, the Black Maternal Health Momnibus Act (H.R. 3305), proposed by Representative Lauren Underwood (D-IL) in 2023, aims to address and end preventable maternal mortality, severe maternal morbidity, as well as Black maternal health disparities in the United States. The bill has also been proposed by Senator Cory Booker (D-NJ) in 2023. It recognizes the presence of maternal health disparities, which have a disproportionate impact on minority communities due to bias and discrimination in healthcare. The bill focuses on several key areas, including training for respectful maternity care, reducing racial bias in maternity care settings, improving maternal health for veterans, growing a diverse perinatal workforce, and funding diverse maternal mortality review committees. Although this bill aims to promote better maternal health across the country, it has a primary emphasis on racially underserved communities. It emphasizes the importance of collecting better data, providing grants to minority serving institutions for the study and practice of maternal health, and supporting justice for incarcerated mothers through model programs and grants. The Momnibus Act states that the Department of Health and Human Services must address social determinants of health such as childcare, housing and other social issues faced in Black and other minority communities. Furthermore, the bill introduces an alternative payment model demonstration project to test new payment models

for maternal care in economically disadvantaged communities and improve maternal health outcomes. The bill addresses the impacts of climate change on maternal and infant health, funding for maternal vaccinations, and research on climate change risk zones for mothers and babies. It provided funding and other resources to diversify the maternal health workforce and discusses telehealth solutions to maternal issues. The racism addressed in the bill is both institutional and interpersonal. It not only acknowledges the systemic disparities and biases that affect minority communities in maternal healthcare but provides funding and programs to combat them. This comprehensive legislation aims to enhance maternal health outcomes and ensure equity in care for all mothers, particularly those who identify as Black or coming from other marginalized backgrounds. This bill is reintroduced in the House every year and does not pass, it has also been introduced in the Senate where it was unsuccessful as well.

Overall, there is a lack of successful policy that goes beyond merely mentioning racial disparities in the text. Bills that address and seek to mitigate one or more forms of racism tend to be less successful despite their comprehensive and evidence-based approach to reducing the racial disparities in maternal health outcomes. Further, it is important to note that the Kira Johnson Act (H.R. 1212) and the Black Maternal Health Momnibus Act (S. 1606) did not pass even though they were proposed by Democrats in a Democratic majority House and Senate respectively, with a Democrat President in office. Meanwhile the Preventing Maternal Deaths Act (H.R. 1318) passed and became law after being proposed by a Republican in a Republican majority House and Senate and then was signed into law by a Republican President. Further, the Protecting Moms who Served Act (S.796) became law after being proposed by a Democrat in a Democrat majority House and Senate and was signed by a Democrat President (Biden). Therefore, party majority cannot be claimed as a deciding factor for a bill's success. The main

difference is their discussions about racism, the purpose of its programs and initiatives as well as their intended impact on maternal health disparities. (See Figure 11)

Additional Contextualization

In an effort to gain a better understanding of the barriers behind the lack of successful race-conscious policy, I interviewed a legislative assistant who specializes in maternal health legislation. She serves as part of Representative Nikema Williams' policy team and for the purpose of confidentiality, she will remain anonymous. Our conversation is outlined below:

Question	Response Notes
What are the main priorities in maternal health legislation today?	- The Black Maternal Health Caucus has been working to get the Momnibus Act passed - The Test to Save Moms bill is a telehealth-focused bill that has become a priority as extending telehealth resources to underserved and rural communities has become increasingly important - Expanding opportunities for Black women in the healthcare space creating a more diverse maternal health workforce

In what ways do policy and legislation look to improve racial health disparities in maternal health outcomes?	- Increased focus on dedicating resources to underserved communities - Increased access to education and information in marginalized areas
In what ways has maternal health legislation changed over the past decade? What trends or keywords have you noticed evolve?	- In even just the past few years (post-COVID) there has been a major push in telehealth services in order to increase healthcare providers' scope of practice
When it comes to gaining an understanding of topics in order to inform legislation, where do you get your information from?	- Legislators will often take meetings with advocacy groups, university researchers, non-profits, and healthcare professionals to gain insight into maternal health issues
In your opinion, how effective is maternal health legislation that has been passed over the past decade? What improvements have been made and what can still be done?	- The passing of the American Rescue Plan Act expanded postpartum coverage under Medicaid from 60 days to 12 months is an improvement that has already been implemented - Improvements include passing bills like the Momnibus Act - Increase funding for projects that address and mitigate racial disparities in maternal health

What are some of the main reasons maternal health legislation does not get passed? (Ex. cost, political opposition, etc.)	- Overall apathy, it doesn't affect certain legislators and they can't relate to these issues based on their lived experience - Healthcare policy is hard to implement due to cost and resources - It is easier to pass a bill if there are less requirements (ex. research or a study/data collection is easier and faster compared to creating, funding, and hiring for a healthcare committee or program)
What can be done on the policy side to improve health equity and reduce racial disparities in maternal health?	- Emphasizing the need for and importance of comprehensive policy implementation - Utilizing data and statistics, stories and testimony are not enough
What about your job gives you hope?	- A passion for reproductive rights and justice - Working with someone with the same values and priorities (Black women in advocacy)

My conversation with this legislator as a supplemental component of my research shed valuable insight into the context and underlying factors that contribute to legislative success or lack thereof. She also provided additional information on the process, priorities and challenges

associated with race-conscious maternal health policy. She outlined a few key points that I want to expand on in further detail:

Her team, as well as many other legislators in both the House and Senate, do see Black maternal health as a main priority, especially considering the alarming statistics outlined in the literature review. In fact, within Congress, the main focus of the Black Maternal Health Caucus is the Momnibus Act that is reintroduced every year. The overall bill has a variety of other policies that are included within its text. Examples of this include the Test to Save Moms bill which is meant to extend telehealth services for expectant mothers, as well as the Kira Johnson Act which focuses on reducing healthcare bias that contributes to Black maternal health disparities. The Momnibus Act is one of the bills included in this study that has not passed the introductory phase despite being proposed year after year by Congresswoman Underwood and Senator Cory Booker's offices.

A prime example of successful maternal health policy that we discussed is found in American Rescue Plan Act. Sections 9812a and 9822a[14] permanently grant states the option to provide 12 months of Medicaid coverage to postpartum women and children – an improvement on the original 60-day policy. This is an example of implemented health legislation can guarantee continuity of care for postpartum women which ultimately improves health outcomes and mitigates health risk.

After inquiring about some barriers to success for maternal health policy, the legislator explained that "For some people, it doesn't affect them, so they don't have the lived experience to be able to relate to that. In terms of healthcare policy, some of it at its core is hard to implement because it takes an agency, sometimes the implementation can be harder. It is easier

[14] American Rescue Plan Act - https://www.congress.gov/bill/117th-congress/house-bill/1319/text

to pass a bill if there is less department requirement on an agency like research. If you are asking someone to create a program that is dedicated to a specific issue, that takes departmental resources, allocated funding, hiring and additional time." Based on this quote, our elected officials may not have the tools or ability to understand a topic that does not affect them. Their limited understanding then inhibits their willingness to invest money, personnel and other resources to solve the issues of maternal health disparities.

In summary, the main obstacles for race-conscious legislation, according to this expert, are congressional apathy and limited resources. To combat this apathy, she stated that the goal moving forward should be, "Emphasizing the need and the importance for [effective legislation]. A lot of really good healthcare advocates have done a great job highlighting these issues using data. 60% of [maternal] deaths being Black women is an alarming rate. We are one of the world's leading nations and we should not have maternal mortality rates that are alarming to this degree. People want to see hard tangible facts and evidence. It is good to have stories but better to have facts and break it down by state and county." This legislator encourages us place emphasis on the data and facts that illuminate the issue. If an elected official is not moved by stories and anecdotes, statistics and research results should be utilized instead.

Overall, my conversation with this individual outlined that Black maternal health is a priority for many members of Congress and their teams. However, it has not garnered enough interest in lawmakers whose communities are not directly impacted. This creates challenges to policy implementation as legislators are not willing to allocate resources towards a phenomenon they do not fully understand the gravity of. Despite this, there are examples of successful health policy that have had real-world positive effects such as the American Rescue Plan Act. In

conclusion, my interview with the legislator provided valuable insights into the complexities surrounding legislative efforts to address Black maternal health disparities.

Addressing Counter Claims

Some argue that healthcare legislation does not have tangible impacts on health outcomes, claiming that policy may look effective on paper but fails to have real world applications. The American Rescue Plan Act is tangible evidence of the falsity of this claim. Sections 9812a and 9822a[15] specifically extend postpartum Medicaid coverage for pregnant women up to 12 months after delivery. The Federal Poverty Level to qualify for Medicaid is higher for pregnant women than mothers. This means that after a woman gives birth, depending on her income she may be kicked off Medicaid coverage after 60 days before this provision in ARPA was made. By allowing new mothers to remain insured for up to a year after they give birth, they are able to access healthcare services as a non-pregnant individual that they otherwise may not be able to afford. This allows for continuity of care[16] and increased outpatient care utilization (i.e. follow-up appointments, check ins with a PCP, etc.)

> "The effects of Medicaid expansion on postpartum Medicaid enrollment and outpatient utilization were largest among women who experienced significant maternal morbidity at delivery. These findings provide evidence that expansion may promote the stability of postpartum coverage and increase the use of postpartum outpatient care in the Medicaid program." (S. Gordon, 2020)

This policy has had proven positive impact on the health outcomes of both the mother and baby especially in low-income populations where the risk of maternal mortality is high. Overall, the

[15] American Rescue Plan Act - https://www.congress.gov/bill/117th-congress/house-bill/1319/text
[16] Continuity of care - the process by which the patient their healthcare provider care team are involved in ongoing health care management over time (Gulliford et al. 2006)

American Rescue Plan Act serves as a prime example of successful healthcare policy meant to improve outcomes for underserved communities, in this case low-income mothers.

Discussion

In recent years, there has been a growing recognition of the significant racial disparities in maternal health outcomes in the United States. This is reflected in the amount of race-conscious maternal health policy that has been introduced since 2013 and especially after the start of the COVID-19 pandemic. While there has been substantial legislative effort to address these disparities, the success rate of race-conscious bills has been disappointingly low. This discussion explores the complexities surrounding the implementation of race-conscious policy in maternal health. I will identify external factors contributing to these challenges and emphasize the importance of comprehensive policy approaches. Finally, I will examine further implications and considerations for next steps based on the data from this study.

One of the key findings of this research raises an additional point that my original hypothesis[17] did not consider: the issue of maternal health legislation lies not in the lack of race-conscious policy but in the inadequate implementation and low success rate of these bills. Despite the introduction of numerous bills in Congress that address racial disparities in maternal health on the institutional and/or interpersonal level, none have successfully navigated through the legislative process to become law. This raises questions about the barriers to success in passing race-conscious legislation.

[17] Hypothesis: The lack of intentional health policy looking to specifically address racial maternal health disparities has become a contributing factor for the increasing difference between Black and white maternal death rates in the United States.

In the United States, thousands of bills are introduced to Congress each year. Of these, about 6-7% become law on average. In the past decade, 9% of maternal health legislation has become law meaning that maternal health legislation has an overall above average success rate. However, policies that are not race-conscious are disproportionately represented in the "Success" category as no race-conscious bills made it past the introduction phase.

It is evident through results and research analysis that political party majority is not a deciding factor. Instead, as outlined in my conversation with a Georgia legislator, issues of resources and attitudes towards the subject of racism play a large role. This study has shown that regardless of party majority, bills that address and seek solutions for the effects of racism on maternal health are not successful. In fact, democrat-proposed bills that address racism are not successful even when Democrat legislators are in the majority. In contrast to this, bills that do not address racism are more likely to pass regardless of which party is in the governmental majority showing how the race-consciousness of these bills are the main differentiating factor. This is largely due to the fact that many legislators are not moved by this issue as it does not impact to them or members of their community. Considering that white people, and men, are disproportionately overrepresented in high government roles, Congress may not be sympathetic to Black maternal health challenges. Because of this, it is crucial that evidence-based educational tools about maternal health disparities are disseminated to not just underserved communities, but policymakers as well. This will outline the importance of a more race-conscious healthcare system that is supported and guided by intentional health policy and call more policymakers to action.

My interviewed with the legislative expert provided valuable insights into the complexities surrounding congressional efforts to address Black maternal health disparities. It

became evident that while Black maternal health is recognized as a critical priority among many legislators and their teams, persistent challenges hinder comprehensive action. The repeated proposal of the Black Maternal Health Momnibus Act each year underscores the ongoing struggle to enact meaningful change despite dedicated advocacy. Formidable barriers persist for dozens of other bills like the Momnibus Act. This includes congressional apathy and resource constraints which impede the progression of race-conscious policy in maternal health. Structural barriers within the legislative process, such as partisan politics and competing policy priorities are just half the battle; allocation of resources and overall disinterest towards the issue also hinder the progress of bills aimed at addressing racial disparities. Because healthcare is so expensive in America, the problem is simple: if law makers are not emotionally invested in the issue, they will not be financially invested in solving it. Additionally, systemic racism embedded within institutions and societal norms may perpetuate these inequities and undermine efforts to enact meaningful change. Many policy makers may be turned off by topics of race in legislation explaining why bills that do not mention race or racism regarding maternal health are significantly more successful. However, this should not be enough to keep legislators from working towards improving health outcomes for Black women.

To overcome these challenges, concerted efforts to emphasize the urgency and importance of addressing Black maternal health disparities, backed by robust data and evidence, are essential. Data and statistics are much harder to ignore than individual anecdotes. While significant hurdles remain, there exists a pathway forward through continued advocacy, strategic policymaking, and unwavering commitment to equity in maternal healthcare. For example, The American Rescue Plan Act's tangible impact on postpartum healthcare coverage serves as a beacon of successful policy implementation. This passed due to dedicated efforts from legislators

and other elected officials. Another way to combat legislator apathy is through interest convergence[18]. This phenomenon is evident in successful policy like the Protecting Moms Who Served Act. Although this bill was focused on maternal health, congressional leaders who may not know much about healthcare but are invested in the veteran community were moved to support it. This method can be used to help Black expectant mothers by proposing reduced cost of care legislation or including provisions that help the uninsured. If topics of race turn policymakers away, ideas around cost-reduction may provide a middle ground. These examples highlight the creativity and persistence necessary to get important and effective legislation implemented into the US healthcare system. Despite the obstacles, the interview instilled hope for the future by showcasing instances of successful policy initiatives that have positively influenced health outcomes.

While addressing racial disparities in maternal health requires race-conscious policy that addressed the three levels of racism, the interconnected nature of racism further compounds the issue. Comprehensive policy approaches should not only focus on addressing institutional, interpersonal or internalized racism but also consider the impact of racism on maternal health outcomes when these forms work in tandem. This study discusses the basics of addressing any of the three forms of racism, however, it is important to consider that structural racism (the overall umbrella term under which the three forms interact) is the true all-encompassing issue.

Interpersonal and institutional racism have profound and intersecting impacts on Black maternal health, contributing to disproportionately high rates of maternal mortality and morbidity among Black women. Interpersonal racism manifests in biased attitudes and behaviors from

[18] Interest convergence - a principle that suggests that social change for minority groups occurs when their interests align with those of the majority

healthcare providers, leading to dismissive treatment, neglect of symptoms, and inadequate care during pregnancy, childbirth, and postpartum periods. This bias can result in delays in necessary care/procedures, misdiagnoses, and other complications that exacerbate maternal health disparities. A prime example of this is in the case of Kira Johnson. Kira Johnson, a Black woman, unfortunately passed away due to complications following a scheduled cesarean section at Cedars-Sinai Medical Center in Los Angeles. She experienced severe hemorrhaging and did not receive adequate medical attention in time, despite her requests. This ultimately led to her tragic death. Her story shows the dire impact that interpersonal racism can have on an individual and their loved ones.

A crucial solution to combatting instances of interpersonal racism is the provision of culturally congruent care. Many bills in this study such as the Protecting Black Women and Girls Act as well as the Health Equity and Accountability Act include this topic as ways to combat interpersonal racism but were never passed. Culturally congruent care involves not only acknowledging diversity but also actively incorporating cultural competence into every aspect of healthcare delivery, including communication, decision-making, treatment plans, and healthcare settings. It emphasizes the importance of respecting and valuing the patient despite cultural differences. Culturally congruent care promotes cultural humility among healthcare providers, and fosters trust and collaboration between providers and patients from diverse cultural backgrounds. Ultimately, culturally congruent care aims to improve health outcomes by ensuring that healthcare practices are respectful, relevant, and effective within the cultural context of each patient. This can be achieved through diversifying the maternal health workforce or investing in trainings that teach healthcare providers how to be more culturally competent. Overall, to address these forms of bias and improve Black maternal health outcomes, proactive measures are

essential. Healthcare providers must undergo comprehensive training on implicit bias recognition and mitigation to ensure culturally competent and respectful care for Black mothers.

Institutional racism is embedded within healthcare systems, perpetuating inequities through policies, practices, and structures that disadvantage Black women in healthcare institutions. This includes limited access to healthcare positions for Black women. The Perinatal Workforce Act include sections devoted to diversifying the maternal health workforce but did not get past the introduction phase. Investing in maternal health programs in underserved communities would help Black women gain more positions of power within the healthcare system allowing more Black patients to get the support they need. Further, institutional racism manifest as systemic barriers to quality healthcare access and affordability, for example, decreased quality and inadequate resources in prenatal care centers within underserved communities. These issues can only be solved through financial investment in programs and initiatives that work to combat these institutional barriers. Implementing community-based doula programs and midwifery care models can provide culturally sensitive support and advocacy throughout the perinatal period while allowing more women of color to enter the maternal health field. These tactics not only address the immediate effects of racism on Black maternal health but also contribute to dismantling systemic barriers and promoting health equity for all mothers. However, solutions such as these cannot effectively exist on a national level without U.S. legislative support. It is crucial that Congress puts these initiatives, investments and programs, into writing and provides the necessary resources for implementation.

When people research and discuss the effects of racism on health, they often focus solely on interpersonal and institutional racism. This is evident through the fact that no bills in this

study addressed interpersonal racism at all. However, internalized racism – wherein individuals internalize negative stereotypes and beliefs about their own race – can have profound effects on health-seeking behaviors and healthcare experiences. Internalized racism can often lead to perceptions of unworthiness or the reluctance to ask medical professionals for more. Many Black women may, subconsciously, not see themselves as deserving of better care causing them to refrain from complaining or speaking up. Additionally, healthcare providers can reinforce internalized racism through examples of interpersonal racism such as dismissal or disrespect. Prejudice from maternal health professionals can cause Black women to shy away from advocating their needs due to fear of being misunderstood, stereotyped, ignored or, in some cases, mistreated further. However, no bills addressed this form of racism directly. Moving forward, it is crucial to incorporate provisions in legislation aimed at combating internalized racism and stereotype threat in maternal care. This means investing in educational initiatives that empower Black women and other people of color to advocate for their own health and well-being. If a woman has a better understanding of maternal health and the pregnancy process, she is more inclined to speak up when things don't seem right. When Black women are equipped with the maternal health knowledge and language necessary to advocate for themselves, internalized racism has a lower impact on maternal health outcomes. National policies supporting these educational programs can play a pivotal role in addressing internalized racism. In summary, policymakers can help mitigate the impact of stereotype threat and low self-advocacy on maternal health disparities by promoting health education and self-advocacy programs. These initiatives will equip women with the tools to navigate the healthcare system and seek holistic care that honors their unique needs and experiences.

In conclusion, the examination of race-conscious maternal health policy and its implementation challenges underscores a pressing need for comprehensive approaches to address racial disparities in maternal health outcomes. Addressing racial inequity in maternal health requires a multifaceted approach that goes beyond the mere introduction of race-conscious policy and focuses on paths to effective policy implementation. Despite legislative efforts, the low success rate of race-conscious bills highlights systemic barriers within the legislative process, including resource constraints and congressional apathy. Moreover, while significant strides have been made in recognizing Black maternal health as a priority, persistent challenges hinder comprehensive action. Structural racism, intertwined with interpersonal, institutional, and internalized forms, exacerbates maternal health inequities among Black women. To overcome these challenges, concerted efforts must emphasize the urgency of addressing racial disparities backed by robust data and evidence. Strategies such as culturally congruent care, diversifying the maternal health workforce, and empowering individuals to advocate for their own health are vital in dismantling systemic barriers and promoting health equity. Through continued advocacy, strategic policymaking, and an unwavering commitment to equity in maternal healthcare, there is hope for meaningful progress in improving outcomes for Black mothers and advancing health equity for all.

Conclusion

The evidence presented in this thesis shows the success, prevalence and efficacy of race-conscious maternal health policy between 2013 and 2023. The original hypothesis opined that there was a lack of policy that addresses racism’s effect on maternal health; this lack contributes to the racial disparities we see today. Instead, the data supports that race-conscious policy is not

lacking but faces significant barriers to success and implementation. These barriers are a main component of why such drastic racial disparities not only persist but are growing in this country. All of health-conscious policy (policy that addresses one of the three forms of racism) in this study did not get passed the introductory stage in both the House and Senate. In a striking contrast, all bills that were passed in this decade did not seek to mitigate any forms of racism in maternal healthcare. Congressional apathy exacerbates this phenomenon through an unwillingness to direct resources towards initiatives that seek to mitigate racism in healthcare and Black maternal health issues. For example, the Maternal Care Act planned to allocate $5,000,000 towards implicit bias training for maternal health workers from fiscal year 2022 to 2026 but did not make it past the introductory phase. Limited resources and personnel make it difficult to successfully integrate plans such as this into our national health system without unified support from policymakers.

Further, it is imperative for policy initiatives to address the root physical causes of maternal mortality, including conditions such as preeclampsia and other inflammation and stress-related maternal health issues that disproportionately affect women of color. As outlined in the literature review, racism does not simply worsen these inflammatory conditions but is some cases causes them. The impact of structural racism and racial stressors contributes to real health conditions and outcomes. Although it is important to address social determinants of health, racism and other social factors, it is crucial to draw a direct line between these social issues and how they manifest physically and mentally. By acknowledging and addressing these root causes, policymakers can develop more effective strategies for improving maternal health outcomes.

Because these comprehensive and evidence-based bills remain vastly unsupported, it is important to direct educational resources both Black and underserved communities about the

prevalence of Black maternal health disparities. An example of this, highlighted in my interview with the legislative expert, would be involving churches and other community-based organizations like sororities and fraternities to develop innovative engagement strategies with Black communities. This will, in turn, promote advocacy from within the Black community to encourage policymakers to take action against maternal health disparities.

Overall next steps outlined in this study include:

- Combatting legislator apathy through data and evidence-based approaches
    - Utilizing interest convergence to reach unlikely audiences
- Increased investment in healthcare initiatives that combat racism
    - Training programs on implicit bias and culturally congruent care
    - Educational workshops specifically educating Black women on Black maternal health and maternal health disparities
    - Advocacy programs for healthcare workers and Black people on the topic of maternal health
- Combatting racial and social issues that cause stress and inflammation
- Encouraging policymakers to pass race-conscious health legislation like the Maternal Health Momnibus Act and many others

The purpose of this study is not just to provide tangible evidence explaining the impact of legislation on health disparities. I chose this topic specifically to recognize and highlight the struggles experienced by the Black women that came before me; hoping to begin a path towards rectifying an issue that has impacted those in my community for centuries. The findings in this

research are truly just the beginning. Other forms of bias such as sexism, homophobia, ableism, xenophobia and religious bias contribute to the maternal health challenges faced by other marginalized groups. Research studies such as this should not stop here as legislation plays a pivotal role in our healthcare system and ultimately impacts real-world health outcomes. This ideology dates back to 1619 as laws and policies dictated Black women's personhood, reproductive control and maternal health experiences. Issues surrounding reproductive care are especially pressing for the Black community as a threat on Black women presents dangers for the health and continuity of Black people in America as a whole. In order to protect the Black community, we must first protect and value the Black mother. This starts with comprehensive legislation that seeks to correct past injustices and create positive change in the healthcare landscape.

Figures

Figure 1

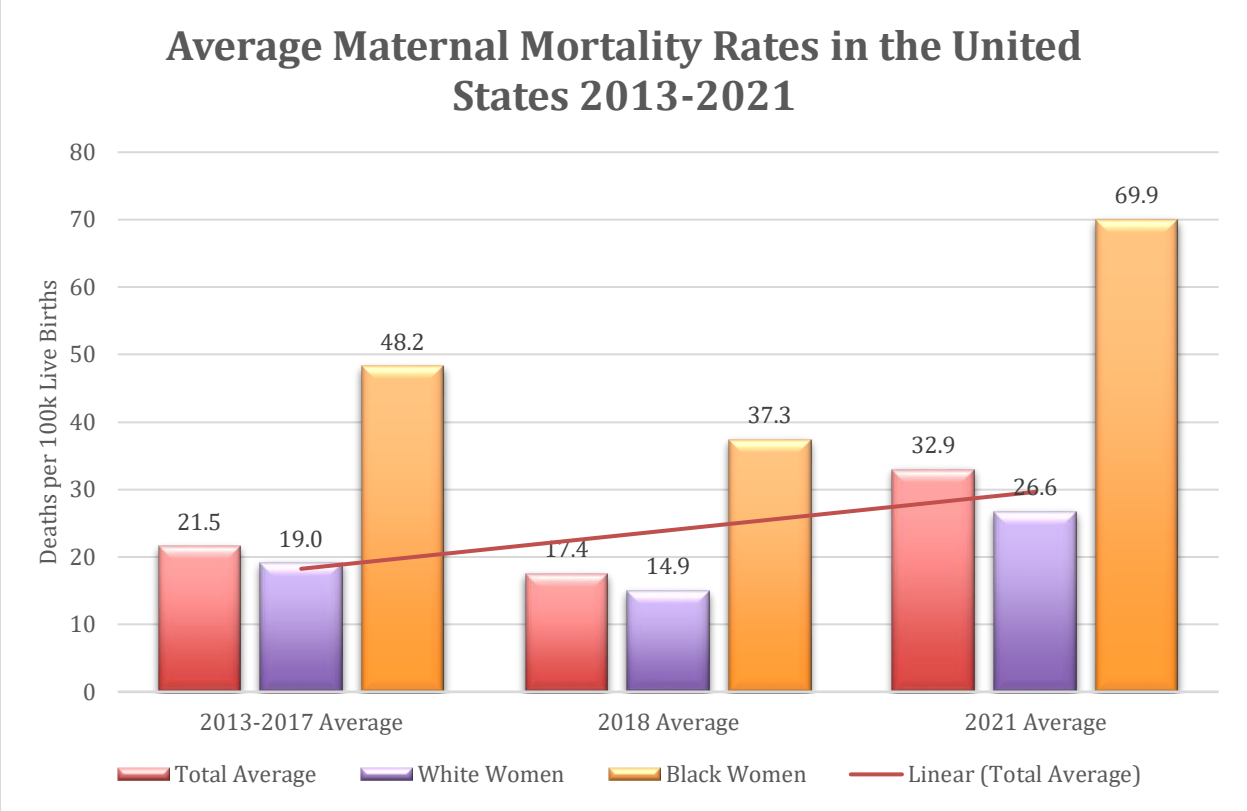


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Figure 2

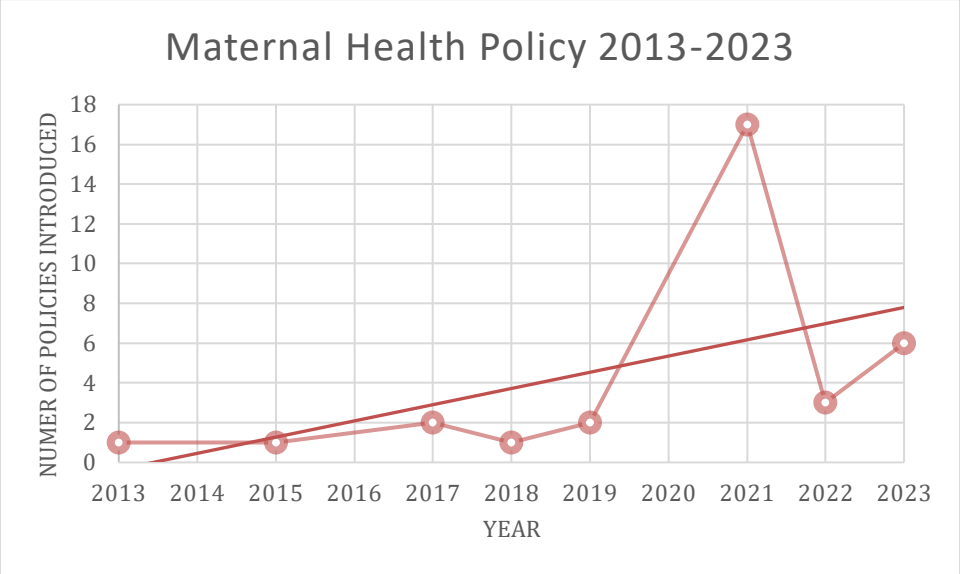

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Figure 3

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Figure 4

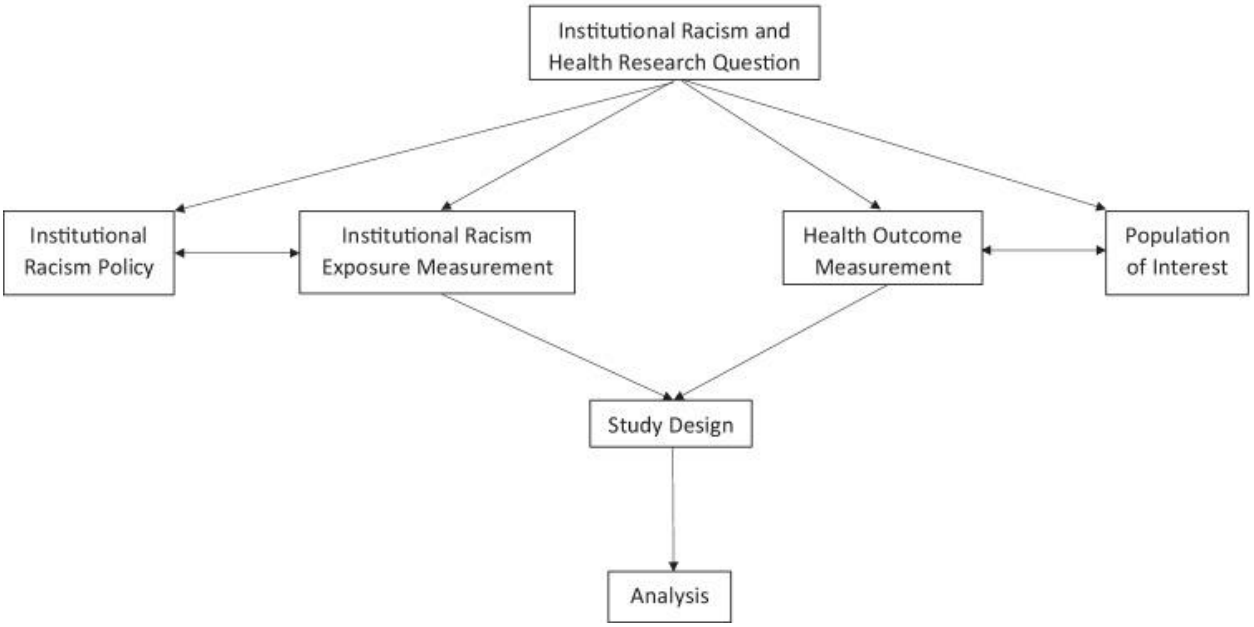

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Figure 5

Name	Status	Addressed Racism.
MOMS for the 21st Century Act	0	1
21st Century Women's Health Act	0	1
Preventing Maternal Deaths Act	1	0
Save Women's Preventive Care Act	0	1
Ending Maternal Mortality Act	0	1
MOMMA'S Act	0	1
Excellence in Maternal Health Act	0	1
Anti-Racism in Public Health Act	0	1
Data Mapping to Save Mom's Lives Act	1	0
Rural MOMs Act	0	0
Mom's MATTER Act	0	1
Social Determinants for Moms Act	0	1

Justice for Incarcerated Moms Act	0	0
Kira Johnson Act	0	1
Protecting Moms and Babies Against Climate Change Act	0	1
Supporting Best Practices for Healthy Moms Act	0	1
Protecting Moms Who Served Act	1	0
Maternal CARE Act	0	1
MOMMIES Act	0	1
Healthy MOM Act	0	0
Maternal Health Quality Improvement Act	0	1
Helping MOMS Act	0	1
TRIUMPH for New Moms Act	0	1
Protect Black Women and Girls Act	0	1
Mamas First Act	0	0
Health Equity and Accountability Act of 2022	0	1
Maternal Health Pandemic Response Act of 2022	0	1

Mothers and Newborns Success Act	0	1
PREEMIE Reauthorization Act	1	0
Social Determinants for Moms Act	0	1
IMPACT to Save Moms Act	0	1
Black Maternal Health Momnibus Act	0	1
Perinatal Workforce Act	0	1

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Figure 6

Name	Code	Sponsor	Date Introduced	Status	Level of Racism Addressed
MOMS for the 21st Century Act	H.R. 2286	Lucille Roybal-Allard (D-CA)	6/6/13	Introduced in the House	Institutional, Interpersonal
21st Century Women's Health Act	H.R. 3652	Suzanne Bonamici (D-OR)	9/30/15	Introduced in the House	Institutional
Preventing Maternal Deaths Act	S. 1112/ H.R. 1318/ L. 115-344	Jaime Herrera Beutler (R-WA)	3/2/17	Became Law (12/21/18)	None
Save Women's Preventive Care Act	S. 1045	Patty Murray (D-WA)	5/4/17	Introduced in the Senate (parts were included in another bill)	Institutional
Ending Maternal Mortality Act	H.R. 7561	Raja Krishnamoorthi (D-IL)	5/10/18	Introduced in the House	Institutional
MOMMA'S Act	H.R. 1897	Robin Kelly (D-IL)	3/27/19	Introduced in the House	Institutional
Excellence in Maternal Health Act	H.R. 4215	Robin Kelly (D-IL)	8/30/19	Introduced in the House	Institutional, Interpersonal
Anti-Racism in Public Health Act	S. 162	Larry Buschon (R-IN)	2/2/21	Introduced in the Senate	Institutional

Data Mapping to Save Mom's Lives Act	S. 198/ H.R. 1218/ L.117-247	Jacky Rosen (D-NV)	2/3/21	Became Law (12/20/2022)	None
Rural MOMs Act	H.R. 769	Dan Newhouse (R-WA)	2/3/21	Introduced in the House	None
Mom's MATTER Act	H.R. 909	Lisa Blunt Rochester (D-DE)	2/8/21	Introduced in the House	Institutional
Social Determinants for Moms Act	H.R. 943	Lucy McBath (D-GA)	2/8/21	Introduced in the House	Institutional
Justice for Incarcerated Moms Act	H.R. 948/ S.341	Cory Booker (D-NJ)	2/22/21	Introduced in the Senate	N/A. Does not address any forms of racism but acknowledges racial disparities.
Kira Johnson Act	H.R. 1212	Alma Adams (D-NC)	2/23/21	Introduced in the House	Institutional, Interpersonal
Protecting Moms and Babies Against Climate Change Act	S.423	Edward Markey (D-MA)	2/24/21	Introduced in the Senate	Institutional, Interpersonal
Supporting Best Practices for Healthy Moms Act	H.R.1350/ S. 408	Robin Kelly (D-IL)	2/25/21	Introduced in the House	Institutional
Protecting Moms Who Served Act	H.R.958/ S. 796/ L. 117-69	Tammy Duckworth (D-IL)	3/17/21	Became Law (11/30/2021)	N/A. Does not address any forms of racism but acknowledges racial disparities.

Maternal CARE Act	S. 1234	Kirsten Gillibrand (D-NY)	4/20/21	Introduced in the House	Interpersonal
MOMMIES Act	S. 1542	Cory Booker (D-NJ)	5/10/21	Introduced in the Senate	Institutional, Interpersonal
Healthy MOM Act	H.R. 3126	Bonnie Watson-Coleman (D-NJ)	5/11/21	Introduced in the House	None
Maternal Health Quality Improvement Act	S. 1675	Raphael Warnock (D-GA)	5/18/21	Introduced in the Senate	Institutional
Helping MOMS Act	H.R. 3345	Robin Kelly (D-IL)	5/19/21	Introduced in the House	Institutional
TRIUMPH for New Moms Act	H.R. 4217	Nanette Barragan (D- CA)	6/29/21	Introduced in the House	Institutional
Protect Black Women and Girls Act	H.R. 6268	Robin Kelly (D-IL)	12/14/21	Introduced in the House	Institutional, Interpersonal
Mamas First Act	H.R. 7475	Gwen Moore (D-WI)	4/7/22	Introduced in the House	None
Health Equity and Accountability Act of 2022	H.R.7585	Robin Kelly (D-IL)	4/26/22	Introduced in the House	Institutional, Interpersonal
Maternal Health Pandemic Response Act of 2022	S. 5284	Elizabeth Warren (D-MA)	12/15/22	Introduced in the Senate	Institutional, Interpersonal
Mothers and Newborns Success Act	S. 964	Tim Kaine (D-VA)	3/23/23	Introduced in the Senate	Institutional

PREEMIE Reauthorization Act	H.R. 3226	Anna Eshoo (D-CA)	5/11/23	Passed in the House	None
Social Determinants for Moms Act	H.R. 3322	Jahana Hayes (D-CT)	5/15/23	Introduced in the House	Institutional
IMPACT to Save Moms Act	H.R. 3346	Janice Shackowsky (D-IL)	5/15/23	Introduced in the House	Institutional, Interpersonal
Black Maternal Health Momnibus Act	H.R. 3305, S. 1606	Cory Booker (D-NJ)	5/15/23	Introduced in the House, Introduced in the Senate	Institutional, Interpersonal
Perinatal Workforce Act	H.R. 3523	Gwen Moore (D-WI)	5/18/23	Introduced in the Senate	Institutional, Interpersonal

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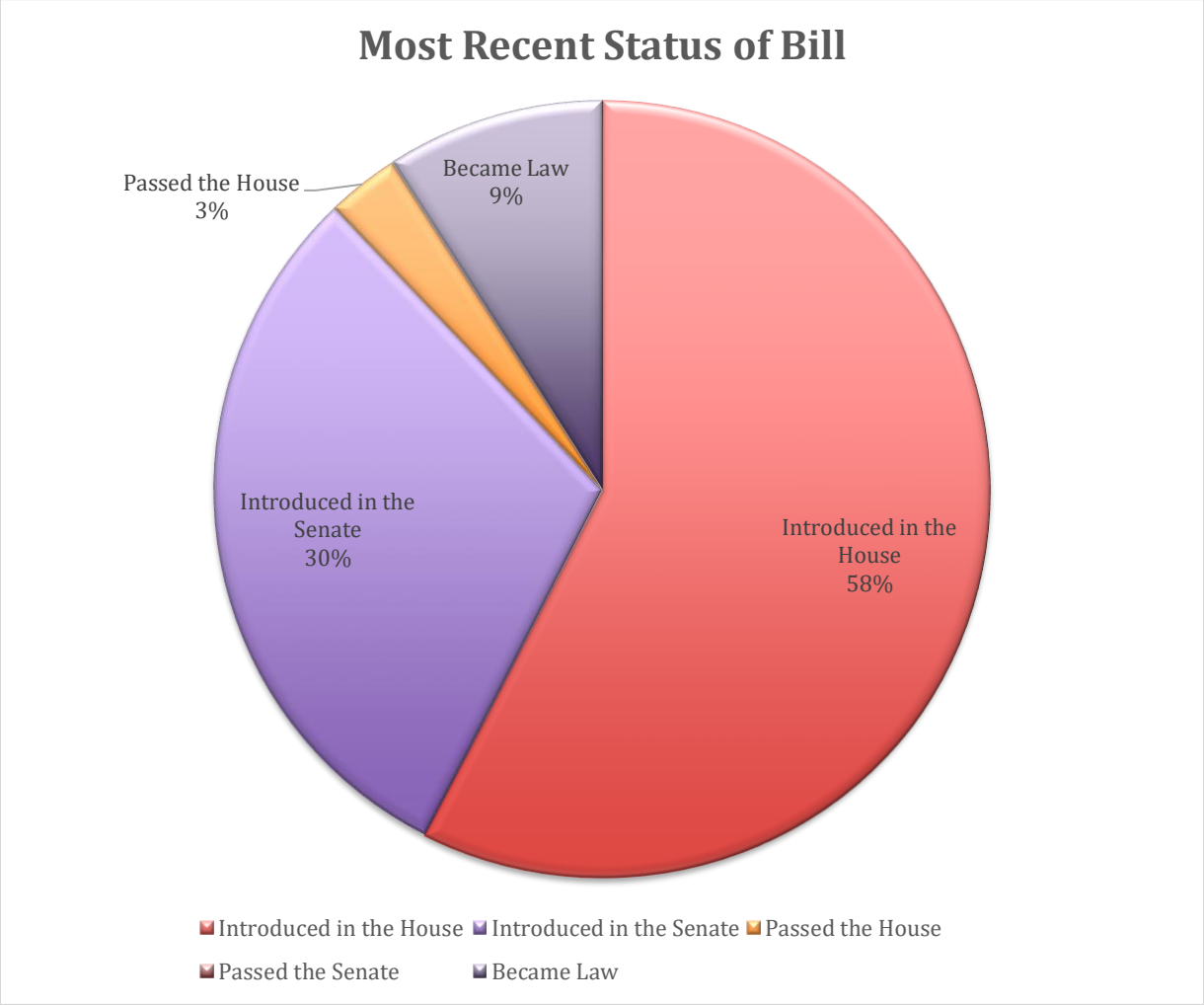
Figure 7



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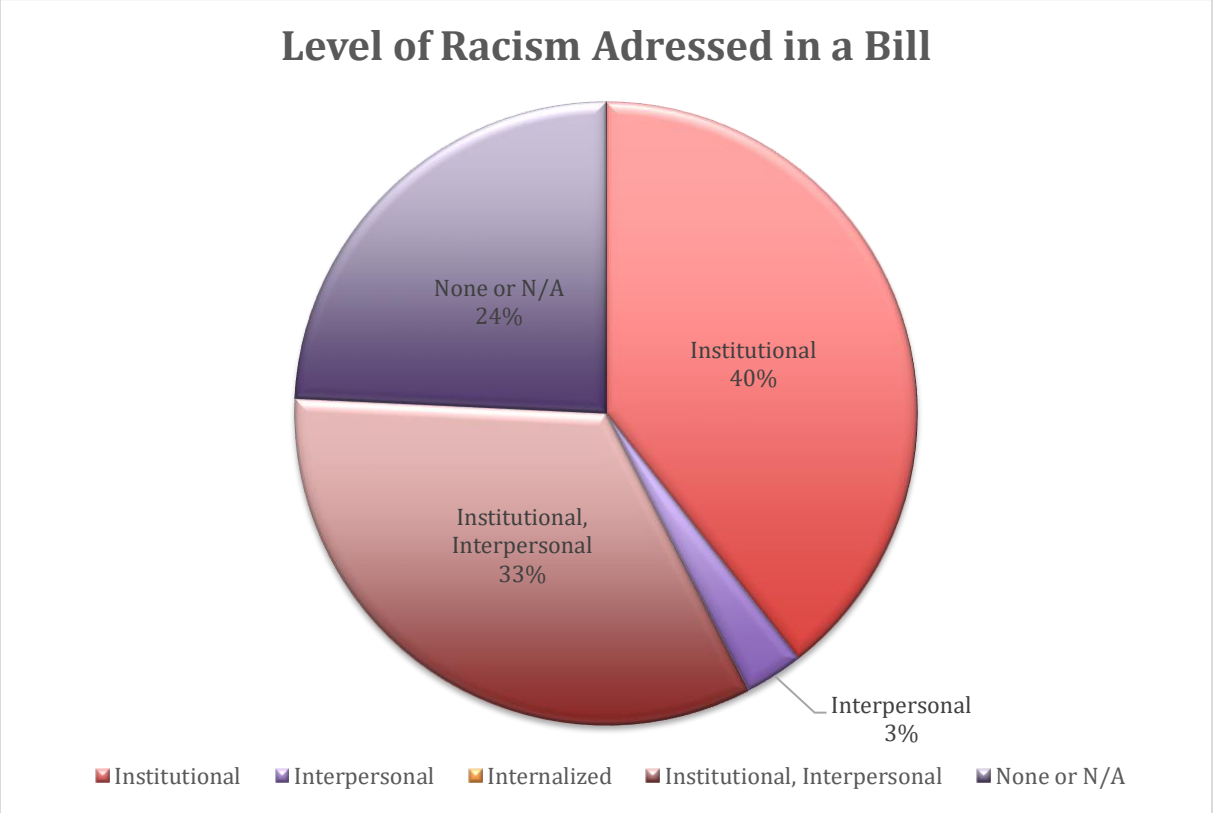

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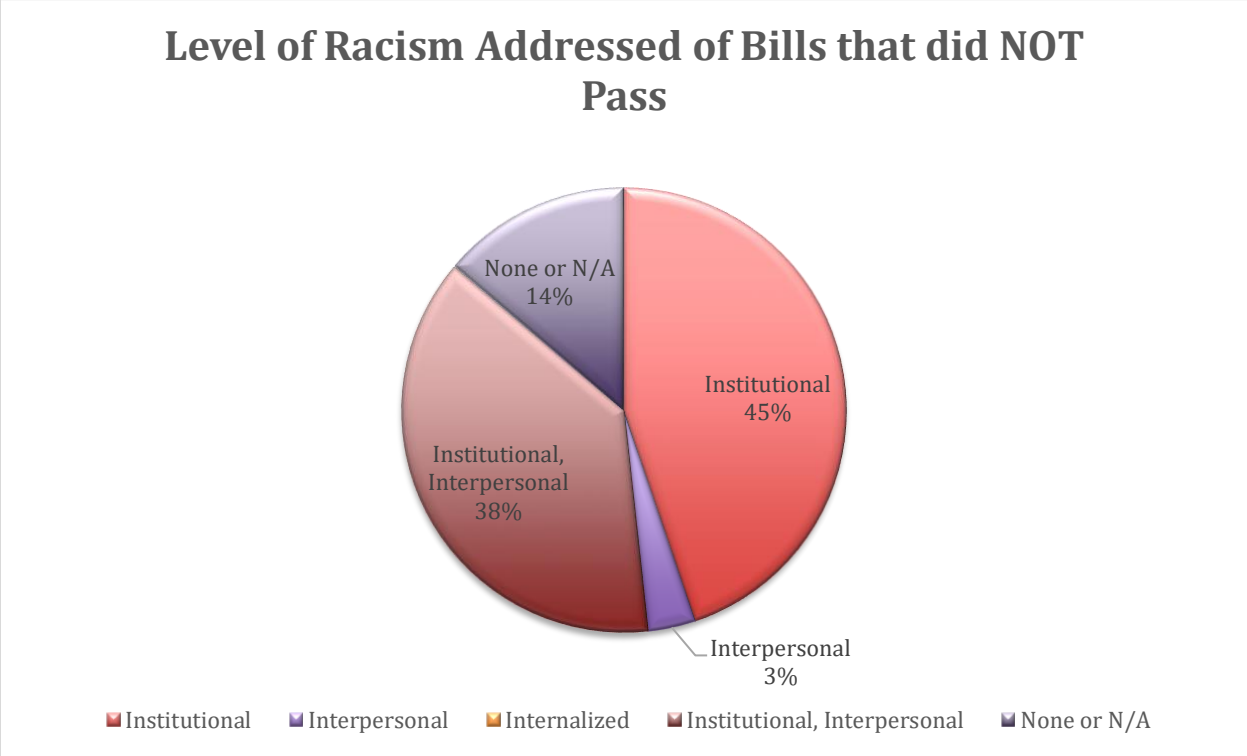

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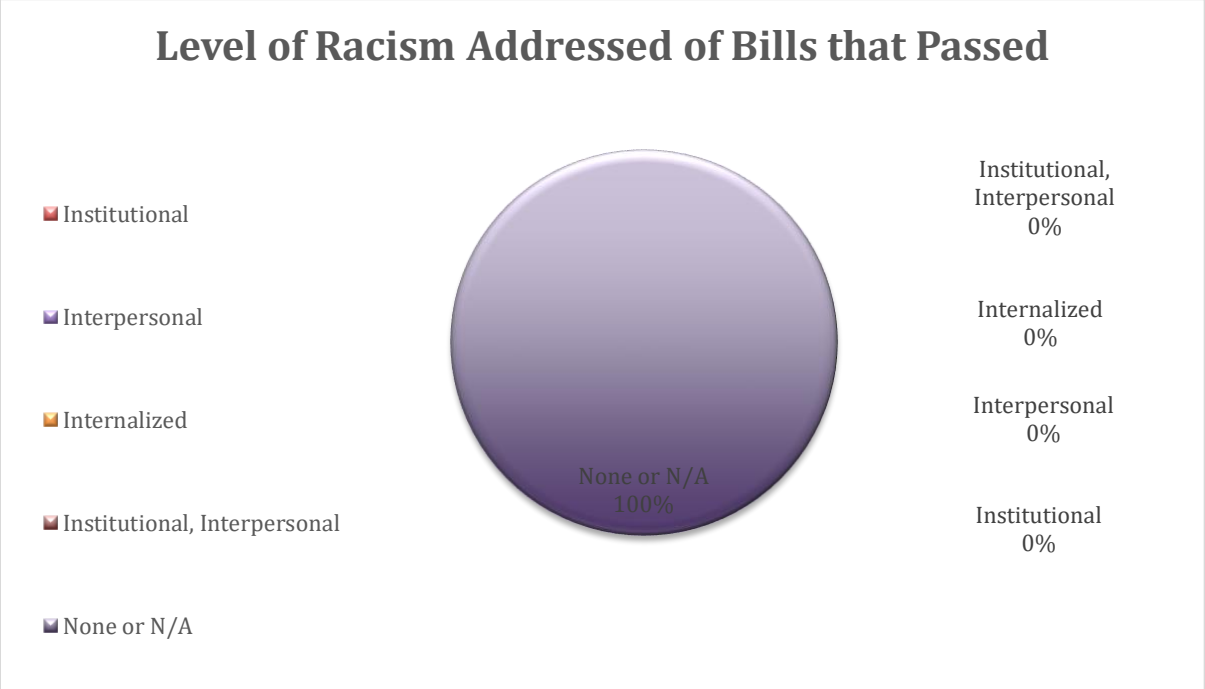

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Figure 11

Name	Code	Date Introduced	Status	Addresses Institutional Racism	Addresses Interpersonal Racism	Addresses Internalized Racism	Party Majority House	Party Majority Senate	Bill Sponsor
Preventing Maternal Deaths Act	S. 1112/ H.R. 1318/ L. 115-344	3/2/17	Became Law (12/21/2018)				R	R	Jaime Herrera Beutler (R-WA)
Data Mapping to Save Mom's Lives Act	S. 198/ H.R. 1218/ L.117-247	2/3/21	Became Law (12/20/2022)				D	D	Jacky Rosen (D-NV)
Kira Johnson Act	H.R. 1212	2/23/21	Introduced in the House	x	x		D	D	Alma Adams (D-NC)
Protecting Moms Who Served Act	H.R.958/ S. 796/ L. 117-69	3/17/21	Became Law (11/30/2021)				D	D	Tammy Duckworth (D-IL)
PREEMIE Reauthorization Act	H.R. 3226	5/11/23	Passed in the House				D	D	Anna Eshoo (D-CA)
Black Maternal Health Momnibus Act	S. 1606	5/15/23	Introduced in the Senate	x	x		D	D	Cory Booker (D-NJ)

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