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Dar a Luz: Shining Light on Maternity Care Mistreatment

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Executive Summary
Maternity care mistreatment is a pressing issue that affects approximately one in five women, underscoring a significant gap in the quality and equity of healthcare services during a crucial period.[1] Among these women, Latinas represent about 29 percent, raising serious concerns about the accessibility and quality of care they receive.[2] This situation is particularly alarming given that the United States, a developed, high-income nation, allocates substantial resources to healthcare yet fails to achieve the expected positive outcomes for all its citizens.

Racial disparities in maternity care are evident and continue to exacerbate existing inequities within the healthcare system. Black mothers experience maternal mortality[3] at a significantly higher rate than their white counterparts, highlighting the urgent need for systemic changes. Experiencing deaths at a rate significantly higher than their white counterparts highlights the urgency for systemic changes. The medicalization of childbirth has led to prioritizing clinical protocols over the individual needs and dignity of patients. Contributing to a healthcare environment where dismissal of their concerns and a lack of respect for their autonomy.

- Considering these challenges, there is a need for respectful, humane patient-centered maternity care. This approach should prioritize the dignity and individualized attention that every birthing person deserves. Addressing the roots of these issues—not only through policy changes but also through a fundamental re-evaluation of how maternity care delivery can help pave the way for improved outcomes and a more equitable healthcare system.

Background
The medicalization of childbirth in the United States has created a cultural shift in knowledge about birth practices. Between the 19th and 20th centuries, births transitioned from midwife-assisted home settings to hospitals in the United States and Europe.[4] Advancements in cesarean sections and pain relief, such as epidurals, have significantly improved the outcomes for individuals with high-risk pregnancies.

In recent years, midwifery and birth doula care have become popular among White populations. Dating back to the period of slavery, “Granny Midwives” were often the primary or sole providers of maternal care.[5] “Granny Midwives” were enslaved women who played a crucial role in assisting slave owners by ensuring the health of their labor force by practicing and training other slaves. In attending the births of the slave owners’ children, these midwives gained increased mobility and the opportunity to earn income for their services, a privilege not afforded to other enslaved individuals.[6]

The whitewashing of maternal health care has impacted communities of color who were once experts in the birth process and upheld a patient-centered approach, but are now far removed. In the 1970s, during the home birth movement among White women, doula, and midwifery care were presented as a luxury and lifestyle choice that concealed the traditions of people of color.[7]

The transition began when white male physicians colonized the field of obstetrics by opposing midwifery care, thereby shifting the practice of childbirth into hospital settings. This shift was influenced by the Flexner Report of 1910, which not only standardized medical education but resulted in the closure of predominantly Black medical institutions.[8] This development spurred by racism in the U.S. established a framework for disparities within the medical workforce. Subsequently, the

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Sheppard Towner Act of 1921 emerged as one of the first social welfare programs aimed at reducing infant and maternal mortality rates. However, it also led to a largely White workforce, thus diminishing the diversity within the field.[9]

The delegitimization of birth doulas and midwifery has significantly contributed to the current maternal health crisis. Black women are three times more likely to die from childbirth complications, Native American women are twice as likely, and women in rural areas face one-and-a-half times the risk.[10] This is particularly concerning as the U.S. is one of the few high-income countries with a high maternal mortality rate.[11]

Problem Analysis

Many Latinas have experienced dismissal in healthcare settings. One in five women report mistreatment during maternity care. Among the 20 percent of women who reported such experiences, 30 percent were Black, 29 percent were Hispanic, and 27 percent were multiracial.[12]

Picture this:

- *You enter an emergency room in labor, feeling scared about having your child after carrying them for 39 weeks. As someone who is not from the United States, you don't know the language and have traveled a long way in search of better opportunities. When you arrive at the emergency room to receive care, you find yourself navigating a system that feels completely unfamiliar.*
- *Afraid and in pain, you try to calm your concerns. In the triage room, you are placed on a fetal monitor to check your baby's heart rate. A nurse also begins the process of using the Maternal-Fetal Triage Index (MFTI), a five-level tool that nurses use to prioritize the urgency of care for pregnant women seeking assistance in an obstetrical triage unit.*
- *Without an advocate or someone to help translate and ease your fears, you feel isolated. You've worked multiple jobs to make ends meet, leaving you no time to take birthing classes. New to the United States, you are forced to go along with whatever the nurse and doctor tell you. Powerless and vulnerable, you have no choice but to trust the medical providers' knowledge.*
- *Feeling uncomfortable about asking questions as everything moves quickly around you, you muster the courage to seek a general understanding of the procedures being performed. However, each time you ask a question, you are quickly dismissed, made to feel as though you don't know what is best for you.*

Mistreatment can include: not receiving a response when asking for help, being shouted at or scolded, not having their physical privacy protected, and being threatened with the withholding of treatment or being forced to accept unwanted treatment.

Dignity is at the core of the issue. Women, like everyone else, deserve respectful medical care. The Centers for Disease Control and Prevention (CDC) defines respectful maternity care as care that maintains dignity, privacy, and confidentiality; ensures freedom from harm and mistreatment; and allows for shared decision-making and continuous support during labor and childbirth.[13]

In the U.S., childbirth has shifted from a natural process to a medical condition requiring hospital treatment. About 98.4 percent of births occur in hospitals, while 0.99 percent take place at home, and 0.52 percent occur at birth centers.[14] These shifts have significantly contributed to saving lives by reducing maternal and infant mortality rates, in comparison to the early 1900s, as illustrated in Figure 1.[15]

Agency to exercise preference in birthing positions is important when considering that lying back with legs bent and positioned in stirrups (lithotomy position) is not research-supported as an optimal birthing position, and in many cases, causes more pain.[16] However, if patients who may have

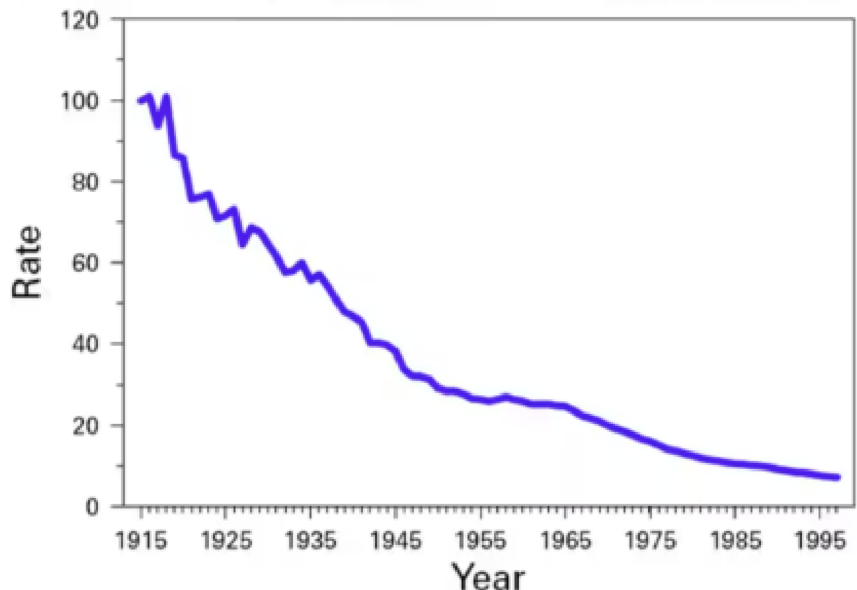


FIGURE 1. Infant mortality rate,* by year — United States, 1915–1997

*Per 1000 live births.

experienced maternity care mistreatment may feel reluctant to express discomfort or dissatisfaction.

Membrane sweeps involve inserting gloved fingers into the cervix to separate the amniotic sac from the uterus. This procedure can be one of the first options offered to induce labor if it isn't progressing.[17] However, patients often experience pain and bleeding as a result of the procedure. If patients are not aware that they can decline certain interventions, they may feel pressured to comply with their doctor's recommendations.

Women and patients should be the focus of care, as opposed to placing more value to hospital policies. It's essential to understand that procedures are designed to benefit patients and address their concerns, especially when they are unfamiliar with the cultural values and healthcare approaches in the U.S. Foreign-born patients, who may not be accustomed to the healthcare system, often do not have the opportunity to challenge unnecessary medical interventions.

Many women may face significant challenges due to a lack of awareness about their rights, and difficulty in advocating for their own needs. The power imbalance between medical providers—such as physicians—and patients can further complicate this situation, particularly for those in vulnerable circumstances.[18] The unequal patient-provider relationship gives a way for mistreatment to take place. A qualitative study examining the experiences of women from Asian and Pacific Islander, Black, Latina, and Middle Eastern backgrounds found that Black and Latina participants often experienced stress related to racism, both for themselves and their children.[19] Latinas reported fears about their immigration status and noted that they received better care when accompanied by white partners, expressing that the color of their skin influenced their experiences.

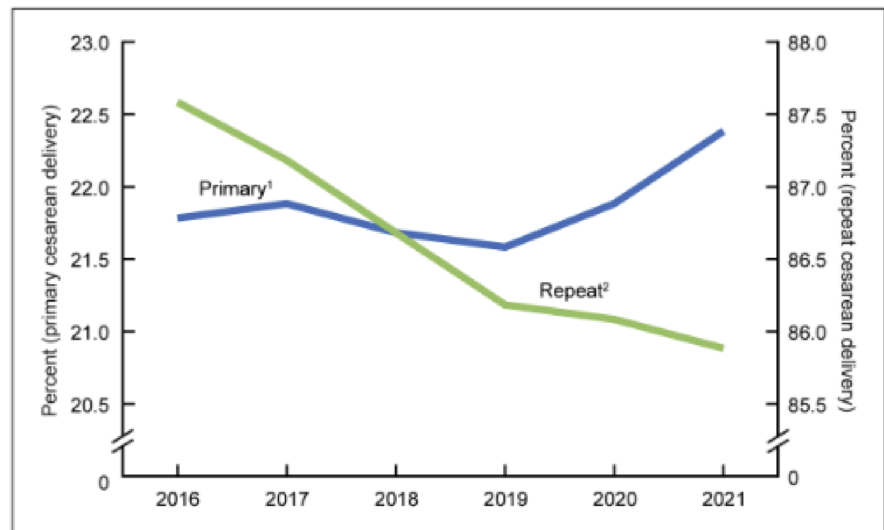
It's important to highlight that Afro-Latinas face systemic racism within the healthcare system due to the established Black maternal health crisis.[20] Nearly 50 percent of births in U.S. hospitals are financed through Medicaid, a joint federal and state program designed to provide health coverage to those living within the federal poverty level. Notably, Black mothers represent 64.0% of these deliveries, while Hispanic mothers account for 58.1%.[21] Understanding these statistics is crucial, they illuminate the challenges Afro-Latinas face, they fall into both the Black and Hispanic categories, facing dual discrimination, and often encountering the most difficult aspects of the medical system.

Cesarean deliveries have saved the lives of many with high-risk pregnancies. Cesarean deliveries are surgical procedures performed to facilitate the delivery of the baby through an incision made on the mother's abdomen. In recent years, there has been a rise in c-sections, as noted in Figure 2.[22] One of the objectives of the Maternal Health Working Group of Healthy People 2030, is to reduce cesarean births among low-risk women with no prior births.[23] Healthy People 2030 consists of national objectives set each decade by the U.S. Department of Human and Health Services in the Office of Disease Prevention and Health Promotion. In medically unnecessary cases, c-sections lead to an increased risk of infections and blood clots. If women are unaware of these risks or have the opportunity to express concern, they will likely face avoidable risks.

Language can pose significant challenges for patients who may not fully understand the medical procedures during birthing procedures. Advocating for themselves can be daunting for individuals who don't speak English fluently or feel uneasy with the language. Language that implies negativity can reinforce existing power imbalances and contribute

Figure 2:
Vital Statistics Surveillance Report

Figure 1. Primary and repeat cesarean delivery: United States, 2016–2020 final and 2021 provisional



¹Significant quadratic trend for 2016–2021; significant increasing trend for 2019–2021 at $p < 0.05$.
²Significant decreasing trend at $p < 0.05$.
NOTES: All rates are significantly different from the previous year at $p < 0.05$. Primary is cesarean delivery to women without a previous cesarean. Repeat is cesarean delivery to women with a previous cesarean delivery.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Natality.

to biases against particular groups of people, like Latinas.[24] It's important to focus on the person giving birth and to view all births as natural processes. This approach should be filled with care, teamwork, and support.

Conclusion

Legislation addressing maternal mistreatment needs to be comprehensive, incorporating the roles of culturally sensitive and competent birth doulas. Participants in a qualitative study expressed that merely having racial concordance, identifying the same race as your provider, is insufficient; it serves as a "band-aid" solution short of addressing deeper issues.[25] This can be done by advocating for community-based doulas who truly mirror the communities they serve in language and shared life experiences. Additionally, legislation should pave the way for community members to train as midwives and doulas, fostering a more inclusive and supportive environment for all.

The Health Resources and Services Administration has initiated the Healthy Start Supplement: Community-Based Doulas grant to help bridge the existing gaps in maternal care.[26] However, it is essential to go beyond this grant and pursue a broader expansion of support. The Biden-Harris administration laid out a comprehensive plan to tackle the maternal health crisis in the U.S., which included establishing birthing-friendly hospitals that adhere to specific guidelines for patient access.[27] This plan proposed expanding Medicaid coverage from 2 months to 12 months following a live birth, encouraging states to adopt doula care coverage, and allocating $16 million for maternal and early childhood initiatives.

Furthermore, Medicaid coverage for doulas should include fair reimbursement rates that incentivize delivering high-quality care. This approach is particularly important for families of color, promoting cultural concordance–people who share lived experiences encompassing racial and ethnic backgrounds.

The shift away from a patient-centered model of care highlights the urgent need to address the mistreatment that Latinas and Afro-Latinas encounter in maternity care. It's crucial to have midwives and doulas who can advocate effectively for their patients and deeply understand culturally relevant practices.

Endnotes

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