Obstetric mistreatment in the United States:
A narrative review

Independent Study submitted to
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Abstract

Background: The widening maternal health disparities in the United States (U.S.) require a close introspection of possible clinical and social causes. Regarding the latter, the interwoven elements of racism and social marginalization in the U.S.' healthcare system may perpetuate experiences of discrimination that contribute to adverse maternal health outcomes. These experiences qualify as 'obstetric mistreatment,' or dehumanizing treatment by medical personnel during and after birthing experiences.[1] Given that mistreatment is difficult to identify without standardized measurements and that it has proven adverse impacts on birthing individuals, a review of existing studies that quantify mistreatment and offer patient-centered solutions is necessary to begin understanding and thus addressing it.

Methods: This narrative review included published peer-reviewed studies that reported quantitative findings on the rates and predictors of obstetric mistreatment and/or qualitative descriptions of experiences of mistreatment. Keywords for searching were pre-selected and used in online databases (PubMed, Columbia University Library, and Google Scholar). Only peer-reviewed articles published from 2000 to 2023 that studied mistreatment in a U.S. setting were included. 42 articles were initially identified, and ultimately 12 peer reviewed studies with a mix of study methodologies were selected. A systematic review was not possible given limited literature available and varied types of studies (mixed-methods, quantitative, and qualitative studies).

Results: Published research indicates that mistreatment occurs in approximately 1 of 6 birthing individuals in the U.S., with birthing individuals of color being 2 times as likely to report a healthcare provider had ignored them, refused requests for help, or failed to respond to requests for help.[2] Three themes emerged from the literature review that all attributed causes and trends in obstetric mistreatment to individual predictors and systemic faults. Obstetric mistreatment was common amongst birthing individuals of color; based on qualitative reports, those experiencing mistreatment felt this was largely due to institutional bias that affects care delivery especially for birthing individuals of color, and medicalization of the birthing process that disregards birthing individuals' autonomy.

Conclusions: By reviewing existing literature on the prevalence and underlying causes of mistreatment, the review uncovered patterns in mistreatment that may explain maternal health disparities and could be targets for interventions. *The literature indicated that obstetric mistreatment occurs because of fundamental shortcomings and systemic bias in the U.S. healthcare system that are rooted in racial disparities and social determinants of health. These instances of mistreatment may culminate into adverse birthing experiences that occur disproportionately among birthing individuals of color.*

Background

The United States has the highest rate of maternal mortality among high income countries.[3] Maternal mortality rates amongst Black and American Indian women are over 3 and 2 times higher, respectively, compared to the rate for White women.[4] These health disparities necessitate a deeper understanding of the causes contributing to this crisis. These causes may go beyond clinical shortcomings, but rather social factors that are more difficult to grasp and quantify. These social factors that affect healthcare may manifest as experiences of obstetric mistreatment amongst birthing individuals, that have pervasive effects on not only the physical, but mental well-being of birthing individuals throughout the birthing process. Obstetric mistreatment is defined as dehumanizing treatment of a birthing individual by any medical personnel that results in loss of autonomy and may contribute to traumatic and thus adverse birthing experiences.[1] Maternal health disparities are mirrored with those of mistreatment. Monica et. al states that these disparities in mistreatment have been attributed to social determinants of health (i.e.: unstable housing, food insecurity, chronic stress, lack of healthcare) that are exacerbated amongst women of color.[5] As a result of experiencing mistreatment, birthing individuals report delaying or stopping prenatal or primary care all together which may have negative ramifications for not only the individual's health but the resulting child's health.[5] Studies have shown that infants whose mothers do not receive prenatal care, are 3 times more likely to have low birth weight[6] and are more likely to be at risk for neonatal or preterm death.[7]

The objective of this narrative review is to summarize published peer-reviewed literature on the prevalence and predictors of obstetric mistreatment amongst birthing individuals in the United States (U.S.), as well as provide accounts of mistreatment and proposed recommendations by affected birthing individuals. Based on this literature, we present recommendations for (1) further research on obstetric mistreatment and (2) policy and program changes that could address the root causes of mistreatment.

Methods

This narrative review focused on studies investigating mistreatment in the U.S., given the high rates of maternal mortality, wide racial disparities in maternal health, as well as the number of systematic (i.e.: policy, insurance system, medical education system) and social factors (i.e.: systematic racism) that influences maternal health in the country. We limited inclusion to peer-reviewed articles published in English from 2000 to 2023. Search terms combined concepts of maternal health disparities, medicalization of the birthing process, disrespect, and obstetric mistreatment (*Figure 1*). We searched the databases: Google Scholar, Columbia University Libraries, and PubMed between December 13th, 2022 to March 17th, 2023. Back reference searching was also conducted to identify articles. Title and abstract reviews were conducted to finalize included studies. For each study, we collected information on the sample, methodology, analysis, the results, and key takeaways from the discussion. For quantitative studies, we recorded any statistical measures on rates or predictors of mistreatment, such as odds ratios that

report higher rates of mistreatment amongst birthing individuals of color or p-values that indicate statistical significance of mistreatment occurring, and thus indicate disparities in mistreatment. For qualitative studies, we compiled findings for all studies and used an inductive process to identify key themes across studies.

Results

Study Selection and Characteristics

From database and back reference searching, a total of 42 articles were identified that were relevant to social predictors of maternal health disparities. These 42 articles were narrowed to 26 articles that discussed obstetric mistreatment, and from these 26, abstracts were reviewed to identify studies that met the inclusion criteria resulting in a final selection of 12 studies. Figure 1 depicts the study selection process. The included studies had a mix of qualitative and quantitative methodologies. Quantitative studies used surveys to measure rates and predictors of mistreatment. Qualitative studies included interviews and focus group discussions to glean in-depth narratives and explanations for obstetric mistreatment. These included describing common patient characteristics that may contribute to experiencing mistreatment, describing experiences of mistreatment and resulting effects, and identifying solutions to mistreatment.

From the analyses, several themes emerged that connect systematic and fundamental patterns of mistreatment. The first theme explores individual predictors such as race and socioeconomic status that contribute to mistreatment, while the second and third themes uncover broader institutional factors, namely the over-medicalized nature of and systemic racial bias in the U.S. healthcare system.

Prevalence of mistreatment overall and by race-ethnicity

The mixed-methods and quantitative methodology studies documented rates of mistreatment and significant associations between mistreatment and social and racial patient characteristics. Vedam et. al inquired about mistreatment during the birthing process in the U.S. and confirmed that mistreatment is adversely occurring amongst women of color with lower socioeconomic status. The study utilized community based participatory research and administered a survey to any women who had experienced pregnancy between 2010 to 2016. Of the 2,138 women who completed the survey, ⅙ reported experiencing mistreatment with the most common form of mistreatment being scolded by health care providers. Hispanic and indigenous women were 2 times more likely to have healthcare providers scold them, or be ignored when requesting help.[2] Furthermore, Prater et. al reports similar statistics through a community based participatory study at a community health center based in St. Louis, Missouri, conducted between 2020 to 2021. Black birthing individuals were 3.9 times more likely to have experienced disrespect ($p<0.05$), and 0.1 times less likely to report having control over their health decisions ($p<0.05$).[8]

Theme 1: Predictors of Mistreatment

For birthing individuals of color, obstetric mistreatment presents as barriers to obtaining high quality health care (a human right as presented by the WHO[9]). 'Racialized stigma', or the disproportionate stigmatization by race based on false stereotypes, plague patient-provider interactions, leading to uncomfortable and disrespectful experiences for patients.[5] Monica et. al reports that these experiences are a form of mistreatment, and may contribute to worse health outcomes such as increasing stress amongst birthing individuals, and thus higher odds of preterm birth and depressive symptoms.[5]

A common reported cause of pervasive mistreatment as found from the qualitative studies, amongst birthing individuals of color, was the presence of both racial and gender biases in patient-provider interactions. Rosenthal et. al, through studies amongst birthing individuals in U.S. hospitals, argues that an intersectional approach must be taken to understand the complex merging of different identities that result in false stereotypes.[10] Intersectionality occurs as a result of an overlap of multiple social systems of race, class, and gender; women of color and lower socioeconomic status are thus at a higher risk of oppression due to 'gendered racism,' and thus experience poorer maternal health outcomes.[10] The overlap of gender and racial bias amplifies negative impacts on birthing individuals, leading to disproportionate adverse outcomes. Renee et. al conducted focus group discussions with Black birthing individuals, and found that participants reported experiencing gendered racism through all their interactions with healthcare personnel.[11] This included reports of being stereotyped (i.e.: assuming they were single mothers, were on welfare, or uneducated) while obtaining and receiving prenatal care, and overall feeling devalued as compared to White birthing individuals. Likewise, participants from the study who reported healthy relationships with providers, stated that what made these relationships positive was the "non judgemental" nature of it that was void of assumptions based on their gender or race. Similarity, Nefertiti et. al conducts focus groups amongst Black pregnant mothers and 2 essential themes emerged: obstetric racism and obstetric resistance. The study reports that causes of mistreatment must not be attributed solely to race, but also to gender and age, as rates of mistreatment are even more pervasive amongst Black birthing individuals who were younger and nulliparous. Women reported obstetric racism as a result of the intersection of their gender, race, and age through experiencing false perpetuated stereotypes by providers and staff (i.e.: ghetto references), and resulting stress from these judgmental experiences. These resulting experiences culminated into obstetric resistance, where patients reported feeling that they had little autonomy in healthcare decisions, often a result of the provider disregarding the patient's questions or failing to provide healthcare information.[12] Further themes will explore deeper causes of obstetric mistreatment as a result of fundamental frailties in the U.S. healthcare system.

Theme #2: Overmedicalization of the birthing process

Adverse maternal health outcomes in the U.S. are becoming increasingly attributed to the 'overmedicalization' of the birthing process. 'Overmedicalization' represents unnecessary and

invasive medical procedures that ultimately place the birthing individual at more risk.[13] Laura et. al examines patient-provider relationships' effects on the likelihood of having unnecessary medical procedures or experiencing discrimination. The study found that providers who view patients trying to exercise their autonomy in decision making as "problem patients." Such impressions can affect patient-provider interactions, leading to discrimination.[13] Furthermore, Tello et. al through oral interviews with patients, reported patients feeling objectified and having a loss of autonomy to decide their treatment plans. Patients reported coercion to accept unplanned medications and being denied requests such as changing positions or leaving their rooms, by all medical personnel. As a result, patients reported feeling emotionally crushed and associated distress with receiving healthcare.[1]

Pertaining to the birthing process, overmedicalization may include unnecessary C-Sections. Tello et. al reports that medical interventions that involve episiotomies (surgical cuts during delivery) as compared to non-invasive vaginal deliveries, had poorer health outcomes. Furthermore, participants in the study reported higher instances of mistreatment due to declining of medical procedures; the odds of reporting poor treatment was 5 times greater ($p<0.001$) amongst birthing individuals of color who had declined medical procedures recommended by providers, and 4.36 times greater ($p<0.001$) amongst women who reported a difference in opinion with their provider.[1] Logan et. al reports similar disparities, with 39.1% of birthing individuals of color feeling pressure to accept any medical procedures (i.e.: C-section, episiotomy, epidural, medication to start/speed labor) as opposed to 25.5% of white birthing individuals.[14] Furthermore, Monica et. al also reported that Black birthing individuals were less likely to receive clinical and social support services during their pregnancy, and more likely to give birth by C-Sections.[5] Monica et. al reports these suppositions are due to providers assuming birthing individuals of color are not aware enough to make informed medical decisions, when in reality, birthing individuals reported feeling competent and confident to decide their birthing plan and care for their babies.[5] Overall, these results indicate correlations between race, mistreatment and being forced to have unnecessary medical procedures.

Theme #3: Institutional shortcomings and systemic bias

Institutional shortcomings may also affect the quality of care delivered. Systemic bias in medical systems may affect the delivery and quality of maternal health services. Prater et. al, through collecting patient recounts, concluded that the U.S. healthcare system has evident bias that perpetuates discrimination against women of color.[8] Monica et. al reported that 'racial microaggressions,'[5] or disrespectful and incorrect stereotyping, present in healthcare settings such as those described in Renee et. al were associated with adverse health outcomes such as postpartum depression and potentially preterm birth.[11]

Furthermore, these biases may contribute to failure to meet professional standards of care. Tello et. al through oral interviews with patients, matches experiences of mistreatment

against ‘Bohren’s 7 domains of mistreatment’. These domains include: physical abuse, verbal abuse, sexual abuse, stigma and discrimination, professional care failures, poor rapport, and system conditions. Failure to meet professional standards of care was one of the most reported experiences (22.1%). This included ineffective communication, lack of care and autonomy, and most notably pertaining to a faulty healthcare system, a lack of formal or standardized protocol on obtaining informed consent on performing exams. Examples included invasive cervical exams with no prior briefing, and provider neglect in spite of patients reporting distress and pain to such exams. These constrained patient-provider relationships may lead to mistreatment.[1] Peahl et. al, through semi-structured interviews with 19-low income Black birthing individuals and 19 healthcare workers, reports impersonal patient-provider relations. Patients reported that appointments were lacking time and structure, and left appointments with unanswered questions and a resulting lack of trust in their provider. They also reported poor emotional and social support on part of healthcare workers, which made it difficult to trust and confide with medical or pertinent concerns. One patient reported that they felt no need to waste further resources and time at these appointments due to these concerns. Healthcare workers acknowledged these patient complaints, largely due to time and resource limitations on their part. As a result, healthcare workers expressed a desire for more meaningful relationships with patients and better support to manage the ‘nonmedical’ needs of patients.[15]

Differences in opinion between patients and providers and resulting discrimination may be prevented by increasing the capacity of holistic models of care that center patients. These models are characteristic of community centers such as federally qualified health centers (FQHC). Prater et. al administers its study through a community based participatory model at a FQHC. The FQHC embedded social determinants of health in their screening and treatments in an effort to provide trauma informed and culturally competent care to its dominantly underserved patient population. The study reported that community health centers were ideal sites to study mistreatment as they were ‘closer’ to affected individuals and honored patient decision making capabilities, and thus should be modeled in hospitals.[8] Logan et. al reports that individuals who had a planned hospital birth were 4 times more likely to report pressure to accept procedures, as opposed to individuals who had planned community births. Planned community births were correlated with fewer instances of mistreatment and overall better patient outcomes given that birthing individuals are able to exercise their decision making capabilities.[14]

Discussion

This narrative review summarizes qualitative and quantitative studies of the sociodemographic factors correlated with adverse birthing experiences and the underlying causes of obstetric mistreatment. By reviewing existing literature on programs and studies that investigate and ameliorate mistreatment, the review uncovered patterns in mistreatment by race-ethnicity and social determinants of health that may contribute to maternal health disparities.

All selected literature discussed social predictors of mistreatment, ranging from systematic factors to individual experiences. All literature studied mistreatment in relation to patient race, and found disproportionate rates of mistreatment amongst birthing individuals of color. Existing studies overwhelmingly support the claim that race is associated with adverse health outcomes, via institutional pathways and social determinants of health. Findings from the selected quantitative studies supported these claims through survey data that indicate disproportionately poor outcomes amongst birthing individuals of color. Qualitative studies provide deeper accounts of incidents of discrimination and poor outcomes, on the basis of gender and race.

Many of these accounts of mistreatment could be traced back to institutional faults in the U.S. medical system that perpetuate bias and poor relationships between providers and patients. The literature establishes, through qualitative experiences, that the U.S. healthcare system is affected by implicit biases that are disproportionately felt by patients of color. This bias affects patient-provider relationships, prescribed treatments, and patient health outcomes.[16] Furthermore, these biases affect how providers view patients, often as individuals with no knowledge or awareness of their wellbeing. As a result, birthing individuals of color are pressured to follow providers' medical plans with little regard for the individual's unique, clinical, or holistic needs. Our literature supported these claims; selected qualitative studies through discussions with birthing individuals of color reported the presence of false racial stereotypes and differential treatments compared to white birthing individuals. Representation was a key theme that arose through the study's interviews with patients, with patients reporting that they felt more understood, and thus taken better care of, by doctors who they ethnically identified with. Ngyuen et. al thus proposes advocating for more representation by having hospitals invest in and recruit individuals of color. While representation may not fundamentally address bias, it ensures a sense of belonging amongst patients and an empathy in understanding unique cultural considerations and racial challenges.[17]

Furthermore, institutional faults may contribute to medicalization. Laura et. al reports that in the US healthcare context, patients are viewed as consumers. While this consumerist behavior is expected to give birthing individuals autonomy, it assumes that higher quality and number of services are provided to those with the most means to afford them.[13] Instead, a more equitable, patient centered approach may be encouraged, where patients are equipped with full medical and clinical knowledge of options to select their treatments, and providers are with patients at every step to assist them in neutral and non-judgemental decision making. Peahl et. al reports that both healthcare workers and patients had a shared desire to reform this medical system to allow for more time with patients, integrated social support, and social determinants screening, that a patient center model could allow for. Healthcare workers acknowledged the system's faults, and

proposed having more cultural empathetic training to assist with tailoring patient needs during care delivery.[15]

Implications for Policy and Practice

A review of existing legislation found an increasing attention to the issue of mistreatment and racial disparities in pregnancy related deaths. A foremost one, the World Health Organization (WHO), published eight standards in 2017 that gave guidance as to how health care services may be provided to improve health outcomes amongst birthing individuals. These standards emphasize that birthing individuals deserve quality and respectful care that can be achieved with safe birthing environments and communicative providers.[9] These standards have not been universally enforced in US-based healthcare settings but have been acknowledged by international agencies (i.e.: International Federation of Gynecologists and Obstetrics, International Pediatric Association, and White Ribbon Alliance). To enforce respectful care delivery, similar standards may be developed and implemented in care settings across the country, with accountability measures set by governance or policies.

While causes of mistreatment are wide and fundamentally ingrained in the medical system making them hard to eradicate, published studies provide clear directions and implications for policy and programming. These interventions may fall under educational initiatives and/or a revamped model of care that centers patient needs and recommendations. Especially from the qualitative studies, there was a clear consensus across qualitative studies where birthing individuals of color reported clear shortcomings in their healthcare systems that contributed to mistreatment. To address these needs, potential interventions beginning in medical education systems may be implemented. These include cultural competency and anti-bias workshops beginning in medical school throughout providers' professions, inviting community health workers or patients to hospital advisory boards, implementing racialized pregnancy stigma screenings, integrating holistic care providers (i.e.: doulas), recruiting and retaining racial and ethnic minority staff, and above all providing consistent and interactive cultural awareness training.[18] These are a few examples that may be implemented at both the hospital level and foundationally at the medical education level to begin addressing racial and gender biases that have been continuously perpetuated in the US healthcare system.

On a broader level, policy that targets not only medical education but also medical facilities can emphasize quality respectful care delivery. These plans may be operationalized through health plans that reimburse providers based on performance; integrating measures that assess interactions between providers to birthing individuals throughout the process may encourage respectful care delivery. Furthermore health policies may reimburse holistic care providers that may facilitate patient-provider interactions by acting as advocates on part of birthing individuals.

Implications for Future Research

Finally, to inform policy and program planners, future literature can also include perspectives of healthcare workers and a broader patient population, and use a community based participatory process (CBPP) to design individual surveys. Studies such as Peahl et. al interviewed both healthcare workers and birthing individuals, and thus uncovered reasons for shortcomings and mistreatment on the healthcare side that can be directly addressed. Furthermore, Nguyen et. al interviewed not only Black birthing individuals, but also individuals who identified as Asian and Pacific islander, and Middle Eastern.[17] By interviewing multiple ethnic groups, the study uncovered other cultural or religious factors that contribute to mistreatment and also must be addressed. Finally, most selected studies used CBPP to generate both qualitative and quantitative survey questions. While no studies compared the utility of academically generated questions to questions generated by CBPP, given that mistreatment is a non-clinical risk factor that affects birthing individuals, having said individuals partake in related interventions is empowering and effective.

Limitations

Given that obstetric mistreatment in the US context has only recently become a topic of concern, there is little published literature. Our initial search only identified 42 relevant articles from which 12 articles met our inclusion criteria. This dearth of literature may be partly attributed to the lack of standardized measurements or surveys in the U.S. to assess mistreatment. Vedam et. al had administered a novel survey developed by community input that may be modeled in the future, and Tello et. al had utilized Bohren's 7 domains of obstetric mistreatment to identify mistreatment amongst study participants.[1] Furthermore, given that the literature search was conducted for only several months through a few databases, there may be more literature (published and unpublished) on mistreatment studies. There may be more reports on mistreatment that are not yet captured in peer reviewed literature. More advanced narrative reviews may require a preset, sophisticated search strategy including non peer-reviewed literature that may garner more content to review.

Conclusion

While the clinical causes of maternal mortality and morbidity are more tangible, there are wide ranging, fundamental social causes that also play an important role in driving adverse maternal health outcomes. These social causes often manifest in the relationships of patients and providers through obstetric mistreatment, and have numerous ways of physically and psychologically influencing health outcomes. Mistreatment is a result of racialized stigmas on part of providers that affect the quality of care and treatments delivered to birthing individuals. Mistreatment leads birthing individuals to feel devalued which not only affects their wellbeing, but also discourages them from pursuing healthcare. This latter consequence has detrimental effects.

While racialized stigmas are institutionally present throughout the US healthcare system, they especially affect birthing individuals due to the intersection of both gender and racial biases. These institutional faults led to perpetuation of systemic bias and increasingly medicalized modes of healthcare delivery. To right these faults, a greater emphasis must be placed on holistic and careful medicine that does not resort to seemingly safer and faster medical procedures. Furthermore, the integration of anti-bias programs and structural changes in healthcare delivery are steps toward fundamentally addressing rising rates of adverse maternal health outcomes in the U.S.. With the maternal mortality and morbidity rates rising in the U.S. despite advances in medical technology, inclusive and upstream actions must be taken that investigate existing societal factors and above all, center the needs and experiences of those most affected. These non-clinical predictors of maternal mortality and morbidity are encompassed by an increasingly recognized concept that requires swift action: obstetric mistreatment.

Figure 1: Flowchart for study selection

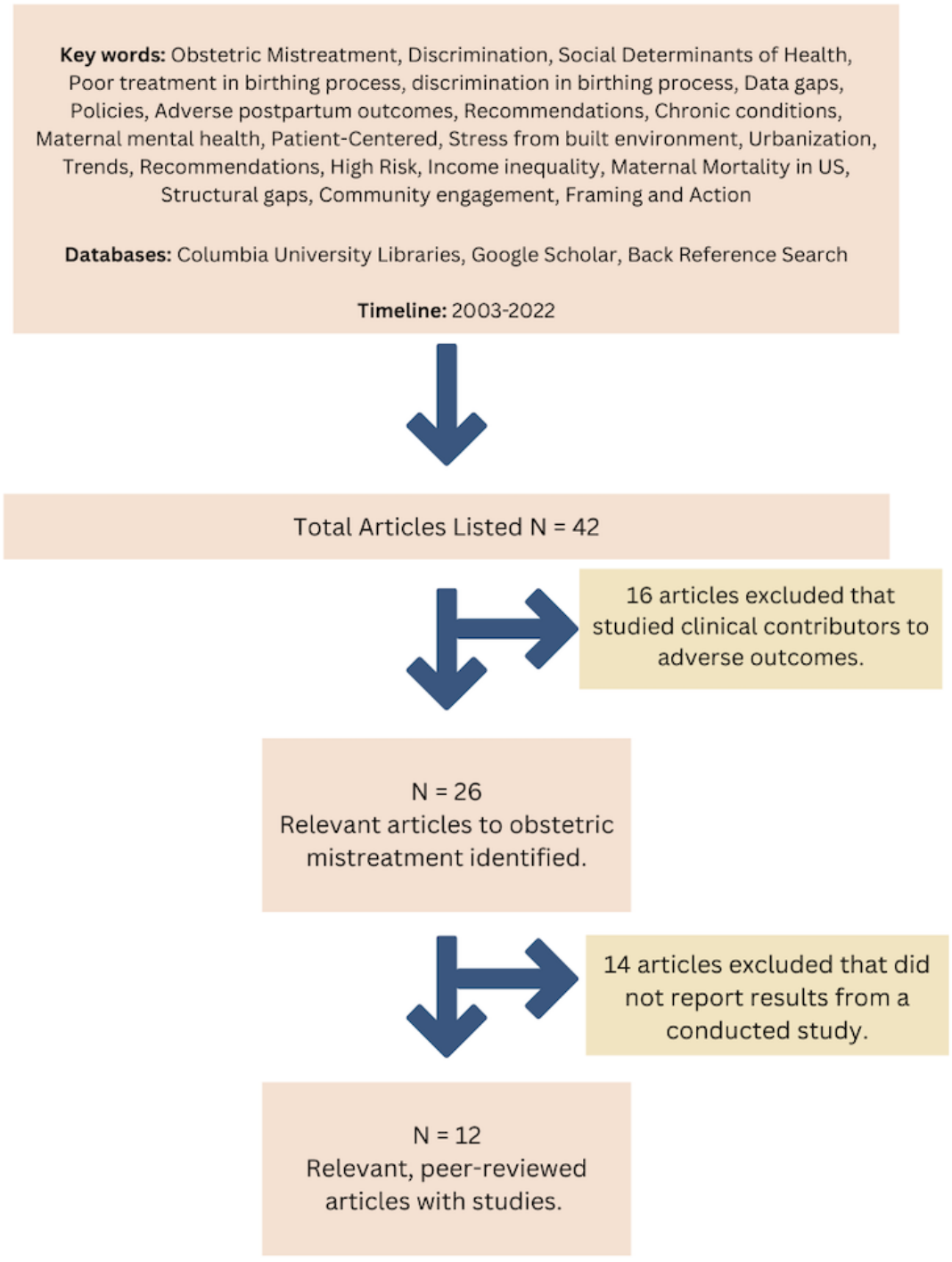

Table 1: Characteristics of Selected Studies

#	Paper	Method	Data collection	Setting	Population	Years Studied	Number of Participants
1	Vedam, S., Stoll, K., Taiwo, T.K. *et al.* The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health* 16, 77 (2019). https://doi.org/10.1186/s12978-019-0729-2	*Mixed Methods study*	*Cross-sectional survey (patient designed) administered*	*U.S. - national*	*Women who experienced at least 1 pregnancy between 2010-2016.*	*2010-2016*	*N= 2700*
2	Prater, C., Cohen, L., Chau, E., Carter, E. B., Kuebee, B., Tepe, M., & Keegan, M. (2022). Perceived discrimination during prenatal care at a community health center. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-022-01315-5	*Mixed Methods Study*	*Phone survey, which included questions from Discrimination in the Medical Setting survey*	*St. Louis, MO* *Women recruited from 5 FQHCs.*	*Women older than 18 years of age, recruited from 5 FQHCs where they were receiving prenatal care.*	*2020-2021*	*N = 97*
3	Logan, R. G., McLemore, M. R., Julian, Z., Stoll, K., Malhotra, N., & Vedam, S. (2022). Coercion and non‐consent during birth and newborn care in the United States. Birth, 49(4), 749–762. https://doi.org/10.1111/birt.12641	*Mixed Methods Study*	*Secondary analysis of "Giving Voice to Mothers" study*	*U.S. - national*	*Women who experienced at least 1 pregnancy between 2010-2016.*	*NA*	*N = 2700*
4	Monica R. McLemore, Molly R. Altman, Norlissa Cooper, Shanell Williams, Larry Rand, Linda Franck, Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth, Social Science & Medicine, Volume 201, 2018, Pages 127-135, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2018.02.013.	*Qualitative Study*	*Secondary analysis of focus group*	*Bay Area: Fresno, Oakland, and San Francisco CA*	*Women of color (Age 18 or greater) who had pregnancies recruited from community-based programs.*	*NA*	*N = 54*
5	Nguyen, T.T., Criss, S., Kim, M. *et al.* Racism	*Qualitative Study*	*11 Semi-structured*	*U.S. - national*	*Women recruited by social*	*NA*	*N = 52*

	During Pregnancy and Birthing: Experiences from Asian and Pacific Islander, Black, Latina, and Middle Eastern Women. *J. Racial and Ethnic Health Disparities* (2022). https://doi.org/10.1007/s40615-022-01475-4		*Focus group discussions*		*media (purposeful sampling), at least 18 years of age, and have had children or were open to having children. Participants must also self identify with being: Black, Latina, Middle Eastern, Asian, or Pacific Islander.*		
6	Peahl AF, Moniz MH, Heisler M, et al. Experiences With Prenatal Care Delivery Reported by Black Patients With Low Income and by Health Care Workers in the US: A Qualitative Study. JAMA Netw Open. 2022;5(10):e2238161. doi:10.1001/jamanetworkopen.2022.38161	*Qualitative Study*	*Human centered designed informed interviews*	*Detroit, Michigan*	*Women were recruited from prenatal care clinics.*	*2019-2020*	*19 Black Patients* *19 Health care workers (physicians, nurses, community health workers)*
7	Tello, Hannah J. PhD; Téllez, Dylan J. PhD; Gonzales, Joseph E. PhD. Identifying Obstetric Mistreatment Experiences in U.S. Birth Narratives: Application of Internationally Informed Mistreatment Typologies. MCN, The American Journal of Maternal/Child Nursing 47(3):p 138-146, May/June 2022. | DOI: 10.1097/NMC.0000000000000811	*Qualitative Study*	*Oral Interviews*	*U.S. - national*	*Participants over the age of 18 years, who had given birth or had been infant feeding, recruited via paper/digital flyers*	*NA*	*N = 131*
8	Renee Mehra, Lisa M. Boyd, Urania Magriples, Trace S. Kershaw, Jeannette R. Ickovics, Danya E. Keene, Black Pregnant Women "Get the Most Judgment": A Qualitative Study of the Experiences of Black Women at the Intersection of Race, Gender, and Pregnancy, Women's Health Issues, Volume 30, Issue 6, 2020, Pages 484-492, ISSN 1049-3867, https://doi.org/10.1016/j.whi.2020.08.001.	*Qualitative study*	*Semi-structured interviews*	*New Haven, Connecticut*	*Pregnant women who identified as pregnant, at least 18 years of age. Recruited via flyers in healthcare and public settings.*	*NA*	*N = 24*
9	Nefertiti Oji Njideka Hemphill, Natasha Crooks, Wenqiong Zhang, Fareeha Fitter, Katherine Erbe, Julienne N. Rutherford, Kylea L. Liese, Pamela Pearson, Karie Stewart, Nicollette Kessee, Luecendia Reed, Lisa Tussing-Humphreys, Mary Dawn Koenig,	*Qualitative Study*	*2 focus groups conducted*	*Chicago, Illinois*	*Pregnant women (aged 18-24) identifying as Black, recruited from the 'New Moms' or a non profit community organization.*	*NA*	*N = 11*

	Obstetric experiences of young black mothers: An intersectional perspective, Social Science & Medicine, Volume 317, 2023, 115604, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2022.115604.						
10	Attanasio, L., & Kozhimannil, K. B. (2015). Patient-reported communication quality and perceived discrimination in Maternity Care. *Medical Care*, *53*(10), 863–871. https://doi.org/10.1097/mlr.0000000000000411	*Quantitative Study*	*Secondary analysis of "Listening to Mothers" quantitative survey data*	*U.S. - national*	*Women who had given birth in a US Hospital between 2011 and 2012, and aged 18-45 years*	*2011-2012*	*N = 2400*
11	Laura B. Attanasio, Rachel R. Hardeman, Declined care and discrimination during the childbirth hospitalization, Social Science & Medicine, Volume 232, 2019, Pages 270-277, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2019.05.008.	*Quantitative Study*	*Secondary analysis of "Listening to Mothers" quantitative survey data*	*U.S. - national*	*Participants between the age of 18-45, who gave birth to a singleton baby*	*2011-2012*	*N = 2400*
12	Rosenthal L, Lobel M. Gendered racism and the sexual and reproductive health of Black and Latina Women. Ethn Health. 2020 Apr;25(3):367-392. doi: 10.1080/13557858.2018.1439896. Epub 2018 Feb 15. PMID: 29447448.	*Quantitative Study*	*2 survey studies 1.Community data collection 2. Online data collection*	*1st study in New York, and 2nd study in U.S.*	*Women who gave birth in U.S. hospitals in 2011 and 2012.*	*NA*	*Study 1 : N = 135, and Study 2: N = 343*

Table 2: Key Findings of Selected Studies

#	Article	Study Aim	Results	Key Interpretations
1	Vedam, S., Stoll, K., Taiwo, T.K. *et al.* The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health* 16, 77 (2019). https://doi.org/10.1186/s12978-019-0729-2	Study inquired on patient-designed indicators of mistreatment in a large national survey. Study aimed to examine correlations between race and mistreatment (intersectionality).	*1 in 6 women reported experiencing mistreatment, with most mistreatment occurring as healthcare providers shouting at or scolding patients (8.5%).* *Indigenous women (32.8%) most likely to experience mistreatment, followed by Hispanic women (25.0%), and Black women (22.5%). Women of color were 2X as likely as white women to report a healthcare provider had ignored them, refused requests for help, or failed to respond to requests for help.*	The indicators of mistreatment may be implemented in patient-reported outcomes research on a global scale to address respectful care in maternity practices.
2	Prater, C., Cohen, L., Chau, E., Carter, E. B., Kuebee, B., Tepe, M., & Keegan, M. (2022). Perceived discrimination during prenatal care at a community health center. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-022-01315-5	Study administered community based participatory model to measure perceived discrimination and healthcare quality during prenatal care and delivery at a community health center that serves historically marginalized populations.	*Black patients reported higher odds of disrespect (aOR = 3.9, $p < 0.05$), lower control over health choices (aOR = 0.1 $p<0.05$), and more likely to perceive a lack of respect (12% vs 2%, $p = 0.045$).* *21% of all participants reported perceived discrimination, with 31% of black participants reporting discrimination.*	Healthcare institutions should be cognizant of the influence of social structures that may affect implicit bias. The study recommends cultural competency training to reduce these bias, and that community health centers, like those where the study was administered, are ideal for investigating and thus reducing health inequities given that such centers cater to historically marginalized populations.
3	Logan, R. G., McLemore, M. R., Julian, Z., Stoll, K., Malhotra, N., & Vedam, S. (2022). Coercion and non‐consent during birth and newborn care in the United States. Birth, 49(4), 749–762. https://doi.org/10.1111/birt.12641	Study aims to understand structural and systemic factors that may influence the birthing process.	*Significant differences in pressure/non consented procedures by racial and ethnic identity. Birthing individuals who identified with Black identity experienced non consented procedures during prenatal care (aOR = 1.89, 95% CI: 1.35 - 2.64), and vaginal birth (aOR = 1.87, 95% CI: 1.23 - 2.83). Furthermore, birthing individuals who identify as minority racial or ethnic identities reported more pressure to accept perinatal procedures (aOR = 1.55), than white birthing individuals.*	Study reported that birthing individuals who had midwives and gave birth in community settings were less likely to experience pressure to accept procedures or non consented procedures. Strengthening professional standards and systems that honor patient autonomy can prevent coercion.
4	Monica R. McLemore, Molly R. Altman, Norlissa Cooper, Shanell Williams, Larry Rand, Linda Franck, Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth, Social Science & Medicine, Volume 201, 2018,	Given the complex factors that affect health care delivery amongst women of color, this study aimed to inquire about birthing and healthcare experiences of women of color who are at risk for preterm birth delivery.	*5 themes emerged from patients' recounts of pregnancy experiences:* *1. Disrespect by providers: Feeling dismissed/rude treatment because of a patient's race, marital status, knowledge, education, low-income, and public insurance.* *2. Stressful interactions: Lack of empathy, difficulty scheduling appointments,* *3. Inconsistent social support: With a lack of social support, reported stigmatization which increased stress,*	Health system factors (particularly weak patient-provider relations) can adversely affect women of colors' health care experiences. Service delivery should take into account patient recommendations to improve provider-patient communication so that providers understand individual factors affecting patient care.

	Pages 127-135, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2018.02.013.		*and reduced sustainable care (no one to help take to hospital)* *4. Unmet information needs: Lack of information from providers pertaining to administered clinical tests or medications.* *5. Perceived competence and confidence in parenting and newborn care: participants felt confident to raise their child, but reported gaps in knowledge.*	
5	Nguyen, T.T., Criss, S., Kim, M. *et al.* Racism During Pregnancy and Birthing: Experiences from Asian and Pacific Islander, Black, Latina, and Middle Eastern Women. *J. Racial and Ethnic Health Disparities* (2022). https://doi.org/10.1007/s40615-022-01475-4	Study aims to garner qualitative research on birthing and pregnancy experiences for not only Black birthing individuals, but also birthing individuals who identify with being Asian or Middle Eastern. Study takes health equity conceptual framework.	*Found 3 common themes amongst discussions* *1. vulnerability and voice in pregnancy and birthing experiences: unequal power dynamics in patient-provider relationships and discrimination as a result of political or social events.* *2. higher prevalences of mental and physical health: chronic stress as a result of racism and a lack of support systems compounded stress.* *3. lack of representation or advocacy for appropriate care: providers were not culturally aware which led to incorrect suppositions. Participants affirmed need for doulas and holistic resources (i.e.: pregnancy support groups).*	Across birthing individuals of color there are commonalities in experiences of discrimination that shed light on the need to integrate cultural competency in healthcare services.
6	Peahl AF, Moniz MH, Heisler M, et al. Experiences With Prenatal Care Delivery Reported by Black Patients With Low Income and by Health Care Workers in the US: A Qualitative Study. JAMA Netw Open. 2022;5(10):e2238161. doi:10.1001/jamanetworkopen.2022.38161	Study aimed to compare patient and healthcare worker's experiences in delivering prenatal care. Patients were largely low income black birthing individuals.	*Interviews affirmed the 5 aspects of prenatal care: medical care, anticipatory guidance, social support, practitioners, care infrastructure.* *Both patients and healthcare workers reported failures in prenatal care delivery, gaps in guidance during pregnancy, and strictures in patient-provider relationships.*	There were failures attributable to the system and material limitations that prevents healthcare workers from delivering high quality care to patients. The study recommends considering these limitations in designing ideal and quality prenatal care models that are catered for particularly low income and colored birthing individuals.
7	Tello, Hannah J. PhD; Téllez, Dylan J. PhD; Gonzales, Joseph E. PhD. Identifying Obstetric Mistreatment Experiences in U.S. Birth Narratives: Application of Internationally Informed Mistreatment Typologies. MCN, The American Journal of Maternal/Child Nursing 47(3):p 138-146, May/June 2022. | DOI: 10.1097/NMC.0000000000000811	Study collects oral narratives of US-based births and analyzes transcripts for evidence of mistreatment.	*A total of 42.7% of individuals reported obstetric mistreatment, which often included poor rapport or failure to meet professional standards. 68.7% of participants identified experiencing poor rapport, and 22.1% of participants reported failures to meet professional standards of care.* *Of the participants who reported mistreatment, the participants reported experiencing an average of 3.11 instances.*	Study contributes vital narratives to understanding mistreatment which validate that the US, despite being a high income country with advanced healthcare services, fundamentally struggles with sustaining basic and equitable care models. Narratives such as those collected by this study may inform best practices for developing programs that mitigate mistreatment and factors leading to it.
8	Renee Mehra, Lisa M. Boyd, Urania Magriples, Trace S. Kershaw, Jeannette	Study aims to understand Black birthing individuals' experiences of gendered racism during the birthing process by using an intersectionality	*Women reported experiencing racialized pregnancy stigma (sometimes regardless of SES) and that it was a source of stress during their pregnancy. These stigmas included assuming that black birthing individuals were*	The study produced reports of negative and false stereotypes that are perpetuated amongst healthcare workers, and affect the health of black birthing individuals. Acknowledging these false stereotypes and

	R. Ickovics, Danya E. Keene, Black Pregnant Women "Get the Most Judgment": A Qualitative Study of the Experiences of Black Women at the Intersection of Race, Gender, and Pregnancy, Women's Health Issues, Volume 30, Issue 6, 2020, Pages 484-492, ISSN 1049-3867, https://doi.org/10.1016/j.whi.2020.08.001.	and biopsychosocial framework.	*single, hyper-fertile and multiparous. These hostile experiences often precluded women from pursuing prenatal care regularly.*	their impact is vital to instituting cultural competent care.
9	Nefertiti OjiNjideka Hemphill, Natasha Crooks, Wenqiong Zhang, Fareeha Fitter, Katherine Erbe, Julienne N. Rutherford, Kylea L. Liese, Pamela Pearson, Karie Stewart, Nicollette Kessee, Luecendia Reed, Lisa Tussing-Humphreys, Mary Dawn Koenig, Obstetric experiences of young black mothers: An intersectional perspective, Social Science & Medicine, Volume 317, 2023, 115604, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2022.115604.	Study aims to understand pregnancy and birthing experiences of black birthing individuals residing in historically marginalized communities.	*Developed 2 overarching themes of obstetric racism and obstetric resistance, with women identifying as black reporting 54-78% experiencing racial discrimination. To understand the impact of obstetric racism, sub-themes are identified: intersectional identities and how patients protected themselves against obstetric racism.*	Study urged more community centered models that advocate for patient autonomy and holistic care providers (i.e.: midwives or doulas). Such models are considerate of patient needs and cultural competency.
10	Attanasio, L., & Kozhimannil, K. B. (2015). Patient-reported communication quality and perceived discrimination in Maternity Care. *Medical Care*, *53*(10), 863–871. https://doi.org/10.1097/mlr.0000000000000411	Study aims to assess racial and ethnic disparities in patient-reported communications with providers, and any perceived discrimination.	*65% of women reported barriers to open discrimination.* *20.9% of Black non-hispanic birthing individuals reported poor treatment in hospitals, compared to 8.4% white non-hispanic birthing individuals. Black (aOR = 2.99) and Hispanic (aOR = 2.25) birthing individuals reported higher odds of discrimination*	Study suggests providing social and educational support services to all birthing individuals, in addition to clinical care. Such programs can be implemented widely through policy changes.
11	Laura B. Attanasio, Rachel R. Hardeman, Declined care and discrimination during	Study aimed to investigate correlations between declining medical procedures (i.e.: C-sections)	*Declining care was significantly associated with C-sections (aOR = 1.5, p = 0.030). Furthermore, declining care was associated with higher odds of*	Although the US healthcare system prides itself in having the patient act as a consumer, the reality is often that patients are penalized for trying to make their own

	the childbirth hospitalization, Social Science & Medicine, Volume 232, 2019, Pages 270-277, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2019.05.008.	and instances of mistreatment during childbirth.	*reporting poor treatment due to race (aOR = 5.0, p < 0.001), insurance status (aOR = 4.18, p < 0.001), having a different opinion with a provider (aOR = 4.36, p< 0.001).*	decisions. This penalty is graver for women of color and of lower socioeconomic status. Given the increasing medicalization of the birthing process, birthing individuals must be given more autonomy and awareness to make informed decisions about their own health.
12	Rosenthal L, Lobel M. Gendered racism and the sexual and reproductive health of Black and Latina Women. Ethn Health. 2020 Apr;25(3):367-392. doi: 10.1080/13557858.2018.1439896. Epub 2018 Feb 15. PMID: 29447448.	Study aimed to take an intersectional approach to examine unique experiences of mistreatment through 2 tiers of survey - New York State, and United States.	*Black and Latina women reported greater frequency of and concern over stereotype related gendered racism in both New York State (17.90%, p<0.001), and United States (22.23%, p<0.001). Stereotype related gendered racism was positively associated with pregnancy-specific stress (New York State, p<0.001 and United States, p<0.001).* *Both surveys reported results that suggest that gender and racial discriminations can affect women's sexual and reproductive health outcomes.*	Study urged greater inclusion of Black and Latina women that take into account gendered racism experiences and coping mechanisms. Such experiences and an understanding of intersectionality are important for providers and practitioners to hear and consider in their practices.

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