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OPEN PEER COMMENTARIES

The Birth of Injustice: COVID-19 Hospital Infection Control Policy on Latinx Birth Experience

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Disparities in maternal morbidity and mortality for Latinx populations are a paradigmatic example of the now widely acknowledged structural racism in U.S. health care that predisposed minorities to disproportionate harms from COVID-19 (CDC 2020a). Latinx pregnancies are associated with higher rates of severe maternal morbidity than White counterparts, and while overall maternal mortality is lower, they experience higher mortality due to common preventable causes like hypertension and hemorrhage (Howell 2018). Pregnancy also increases risk of severe COVID-19 illness, yet near-universal exclusion from drug and vaccine trials significantly impairs access to evidence-based treatment and prevention (CDC 2020b). Meanwhile, 23% of U.S. pregnancies are among Latinx individuals, compared to 35% of COVID-19 cases in pregnancy. Latinx individuals facing the greatest language and legal barriers to care disproportionately reside in current COVID-19 hotspots in the southwestern United States (CDC 2020a; Martin et al. 2019; "COVID-19 United States Cases by County" n.d.).

Our response to Sabatello and colleagues (2021) examines the impact of COVID-19 testing, tracing, and surveillance vis-à-vis hospital infection prevention and control (IPC) policies at this intersection of vulnerabilities. We illustrate how IPC policies impose greater burdens on Latinx populations and ultimately challenge the viability of community engagement and truth and reconciliation commissions (TRCs) as the primary mechanism of redress.

COVID-19 POLICIES IN INPATIENT OBSTETRIC SETTINGS AND IMPLICATIONS FOR LATINX PARTURIENTS

Acuteness of the pandemic resulted in rapid implementation of many IPC policies intended to minimize necessary COVID-19 exposures and preserve scarce resources in hospital settings. Much like broader public health policies, the spectrum of practices described in the following fluctuates with local COVID-19 prevalence and risk tolerance.

COVID-Positive Isolation

As testing capacity has increased throughout the United States and in recognition of the prevalence of asymptomatic infection, many hospitals mandate universal SARS-CoV-2 testing upon admission to the obstetrics unit. When a test returns positive, implications may include prohibition of any visitors, mandatory masking throughout labor and delivery, and possible separation of newborn and mother upon birth.

Latinx individuals are disproportionately likely to test positive for SARS-CoV-2 and thus be forced to labor

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alone. It is also disproportionately likely that their support person of choice will test positive and be excluded from staying. Laboring alone is made worse for women with limited English proficiency or limited access to technology, which, combined with mask wearing, further compromises the ability to communicate effectively during labor. Additionally, the medical team is more likely to limit time at the bedside, compounding communication barriers and reducing access to health advocacy. For some Latinx women, the recent context of separating children and parents by the Department of Homeland Security may increase trauma surrounding potential infant separation (Simha 2019).

Compromising Access to Essential Advocates

Building on principles of contact tracing and physical distancing, visitor restrictions in hospitals have been commonplace throughout the pandemic, with laboring women typically limited to one visitor. The critical roles of support persons, students, midwives, doulas, and in-person interpreters are lost when they are considered nonessential and excluded from labor rooms. These policies may force laboring women to choose between the other parent and their doula, mother, or sister—potentially sacrificing those best suited to support them through labor and delivery.

Though the intention is a universal rule to equally limit hospital traffic, a policy limiting laboring individuals to one support person tacitly assumes the cultural norms and familial patterns most common in White households: the archetypal married couple wherein the male partner is the father and designated support person. By contrast, more than half of Latinx parturients are single—double the rate of their White counterparts—and therefore more likely to rely on a network of support persons to fill different critical roles during childbirth (Martin et al. 2019). Additionally, in-person support is especially critical for those laboring without pharmacologic interventions, and only 48% of Latinx vaginal births receive spinal/epidural anesthesia in labor, compared to 69% for White births (Osterman and Martin 2011).

Restricting the support team, beyond psychosocial harms, heightens the risk of testimonial injustice and potential downstream adverse health effects. Women of color face greater skepticism from their providers and their reported symptoms are more likely to be overlooked (Norton et al. 2020). Language barriers further compromise communication, and elimination of in-person interpreters—particularly in the setting of masking—further compounds these risks by detracting from forces that can strengthen the voices of Latinx parturients (Le Neveu, Berger, and Gross 2020).

Exacerbating Structural Inequities

In addition to restricting the number of visitors, many hospitals impose additional surveillance upon visitors. This can include requirements to present personal identification prior to entry and to remain in the patient's room for the duration of the hospitalization, with ingress and egress prohibited. Identification (ID) requirements disproportionately affect Latinx populations, particularly for individuals with fears related to immigration status, and may deter the support person from being present during labor and delivery. Visitors for Latinx parturients may be more likely to have responsibilities, including employment, that would require them to leave and return to the hospital or to switch off with other support persons. Eliminating these possibilities may make Latinx individuals more likely to be alone for all or part of their birth hospitalization.

CONCLUSIONS AND NEXT STEPS

This case study demonstrates how apparently egalitarian hospital IPC may inadvertently exacerbate inequities for Latinx parturients. The proposed measures of community engagement and TRCs will enable us to build trust over time and to guard against such injustices during future pandemics, but they may not offer substantial redress for the current pandemic.

Deliberative democracy is ideal for evolving cultural competency but is not optimized for rapidly evolving health crises demanding immediate action and conscientious leadership. TRCs elevate community advocates in the realm of institutional policy and help balance power asymmetries over time, but also require intensive reflection, engagement, and iteration over months to years. Realistically, neither is swift enough to prevent necessarily top-down crisis standard-of-care policies from deepening disparities.

During acute phases of pandemic response, we must rely on the authority of health care leaders and public health professionals. Efforts to diversify the voices directing policy during active crises, while perhaps symbolically valuable, may effectively offload the responsibility for ensuring just institutions to those who have been systematically marginalized by them. These recommendations assume that vulnerable communities have the capacity to assume such a role and that doing so will not further burden them. Communities must do what they can to keep

institutions in check, but it is our institutional leadership that holds the foremost duty to wield its power judiciously in the first place.

Harm reduction is critical during a pandemic. However, the combination of fear, duress, and moral panic produced policies focused exclusively on preventing harms from COVID-19 itself, while forgetting that COVID-19 is not the greatest threat for our most vulnerable populations. While the virus may be colorblind, our institutional responses are not. The pandemic's propensity to deepen disparities in health and well-being were foreseen—immediate action is needed to address the now evident excess harms Latinx individuals face during pandemic-era U.S. childbirth. We propose that national professional organizations recommend the following:

1. Clarify that all birthing persons have a right to have a support person of choice regardless of COVID-19 status of the patient or their designated visitor.
2. Ensure adequate bedside support:
   - Recognize in-person interpreters and doulas as essential health care team members.
   - Permit both labor support person and other parent to be present or swap as needed.
   - Allow more than one visitor when patient or support person has limited English proficiency.
   - When bedside support is limited, ensure access to technology that permits remote connectivity with support persons who cannot be present.
   - Permit both parents to be present once birth is imminent.
   - Encourage early discharge when appropriate if close outpatient follow-up is feasible.
3. Employ multimodal approach to minimize language barriers:
   - Prioritize matching health care workers with corresponding language proficiency.
   - Use clear masks to maximize nonverbal communication.
   - Ensure that electronic interpretation devices are optimized for mask wearing.
   - Increase use of multilingual signage, recordings, and closed-circuit videos.
4. Sensitivity to the potential for policies of separation and surveillance (e.g., separating mother/infant, ID requirements) to impose undue risks and retraumatize the most vulnerable individuals.
5. Further action on state and national levels to support wider access to safe alternatives to hospital birth for low-risk individuals:
   - Mandate universal Medicaid and insurance coverage for midwifery-supported community birth.
   - Eliminate laws restricting full scope midwifery practice.
   - Promote collaborative agreements between birth-center practices and nearby hospitals.

Sabatello and colleagues note that "Both the design of our health care system and the nature of medicine may entangle clinicians (wittingly or not) with structural racism" (Sabatello et al. 2021). The potential for well-intended policies to unwittingly drive deeper disparities into the seemingly universal experience of childbirth highlights our need not only to plan more carefully for the future, but to apply increased scrutiny to even the most egalitarian policies as potential sources for injustice.

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