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"It Wasn't Like I Was Trying to Run to Weed Right Away, I Wanted Other Options": A Qualitative Study of Prenatal Healthcare Experiences Among Latina Birthing People Using Cannabis in California

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ABSTRACT

Objective: Cannabis is the most commonly used illicit substance during pregnancy. Negative health and social outcomes associated with cannabis use disproportionately affect birthing people of color, particularly Latinas. Latina birthing people face compounding barriers to prenatal care, including discrimination, immigration-related fears, and distrust of healthcare systems rooted in histories of obstetric racism. This study examines the perspectives and experiences of Latina birthing people in California as they navigate prenatal care while using cannabis. **Method:** We conducted qualitative, semi-structured interviews with 20 Latina birthing people. Eligible participants reported current or previous pregnancy within the last year concurrent with cannabis use, identified as Latina, lived in California, were 21 years or older, and spoke English and/or Spanish. We used constructivist grounded theory methods to analyze the data. **Results:** We found that Latina birthing people who use cannabis: 1) Perceived their intersectional identities (race/ethnicity, age, partnership status) as potential vulnerabilities to poor prenatal care, particularly around cannabis use disclosure; 2) Sought more supportive clinicians based on these intersectional identities, though financial and insurance barriers prevented them from accessing preferred clinicians; and 3) Proposed solutions to improve their care, such as identifying clinicians who looked like them or adopting a whole-person approach that contextualized their cannabis use within their lived experiences. **Conclusions:** Discrimination, stigma, and racial profiling of Latina birthing people who use cannabis contribute to unsafe prenatal care environments. Open communication about the motivations and implications of cannabis use is needed to improve prenatal experiences and outcomes for Latinas, who may be using cannabis as a form of self-medication in the context of inadequate care access. Given that Latina birthing people who use cannabis experience discrimination, stigma, and racial profiling in prenatal care settings, it is critical to build structurally competent clinical environments that foster open, nonjudgmental counseling where discussions around cannabis use can occur safely. Systems-level interventions are needed, including clinician training on cannabis use counseling and bias, expanded and diversified clinical workforces, and community-based care options, such as doula integration.

Key words: = cannabis; intersectionality; risk; pregnancy; health care providers; hospital; stigma; discrimination; racism

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Cannabis, the most illicit used substance in pregnancy, is federally illegal in the United States but legal recreationally in California for adults 21 and over, with medicinal use allowed for those 18 and older. Rates of self-medicating with cannabis are disproportionately higher among Black, Indigenous, and People of Color (BIPOC) pregnant people. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics recommend that birthing people refrain from cannabis use to minimize infant exposure and the risk of adverse fetal neurodevelopment outcomes (e.g., small for gestational age, low birth weight; ACOGa, 2025; Ryan et al., 2018). Despite these risks and recommendations, between one quarter and nearly half of people who use cannabis in preconception report continuing to use during pregnancy (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024; Mark & Terplan, 2017; Young-Wolff et al., 2025).

Qualitative studies show that birthing people use cannabis for its perceived health benefits during pregnancy and postpartum, such as a substitute for prescribed medications used to treat mental health concerns, as well as to manage stress and nausea associated with pregnancy (First et al., 2022; Gould, Ganesh, & Ceasar, 2024; Gould, Ganesh, Nguyen, et al., 2024; McCoy et al., 2023; Solmi et al., 2023; Vanstone et al., 2021; Young-Wolff et al., 2023). These patterns of self-medicating with cannabis during pregnancy are further pronounced among BIPOC birthing people. For example, our prior research showed that Latinas are more likely than White birthing people to use cannabis to alleviate severe nausea and vomiting during pregnancy as a form of self-medication (Becerra et al., 2024). Latinas may also underreport prenatal cannabis use or avoid prenatal care altogether due to concerns about criminal-legal consequences, such as family separation, deportation, and loss of legal status (Stone, 2015; Young-Wolff et al., 2021). In contrast, other studies have reported that relative to other racial/ethnic groups, Latinas approach perinatal cannabis use with more health-cautious beliefs, including less endorsement of using cannabis to manage pregnancy-related symptoms and greater concern about potential negative health effects (i.e., lowering infant IQ; Cameron et al., 2022). Given these perspectives and the disparities facing Latinas, understanding and eliminating inequities in maternal health among Latina birthing people who use substances, including cannabis, remains a national public health priority (The White House, 2023).

In addition to racial/ethnic disparities in prenatal care initiation among Latinas, socioeconomic factors also play a critical role. Latinas reported that discrimination from clinicians was heightened by additional factors such as their socioeconomic or insurance status (Bellerose et al., 2022). Low socioeconomic status is found to be a deterrent to timely prenatal care initiation related to insurance status, such as barriers in the public insurance enrollment process (Green, 2018), and challenges in finding clinicians willing to accept new Medicaid patients (Bellerose et al., 2022). Similarly, research shows that immigrant birthing people, including Latinas, have lower rates of first trimester prenatal care initiation than U.S.-born birthing people (Choi et al., 2025), with recent immigrants to the U.S. reporting fear that utilization of prenatal care could lead to deportation or denial of future citizenship (Bellerose et al., 2022). These overlapping barriers of race, class, and immigration status contribute to unmet social needs and psychosocial stressors that have implications for adverse pregnancy outcomes for Latinas, such as preterm birth or low birth weight (Belak et al., 2025; Girardi et al., 2023; Young-Wolff et al., 2024). Given the intersection of race/ethnicity, socioeconomic status, and prenatal cannabis use and its impact on health equity, it is critical to examine the perspectives and prenatal care experiences of Latinas who use cannabis in California, where cannabis has been recreationally legal since 2018.

Racial/ethnic disparities during pregnancy and childbirth have a significant history in the United States and California (Davis et al., 2012; Stern, 2005). For example, in the 1960s-1970s, Mexican-American Latinas of working-class status were often coerced to undergo surgical sterilization at Los Angeles County General Hospital, where physicians lied about the procedure, failed to provide informed consent in patients' preferred language, or simply performed the procedure without consent. A witness testified that supervising physicians pressured residents into coercing patients to consent, justifying these practices with stereotypical rhetoric and framing Mexican women as hyper-fertile and large

immigrant families as straining California's welfare programs (Stern, 2005). Sterilizations of Latinas occurred again from 2005-2012, when hundreds of women from California state prisons stated they were coerced into sterilizing procedures (Avila & James, 2024). The term *obstetric racism* has been used to describe the heightened vulnerability of birthing people who are also racial/ethnic minorities, notably BIPOC birthing people, and how such identities increase health risks for both mother and baby (Davis et al., 2012). For patients who may already experience identity-based judgment, the addition of being labeled a "cannabis user" may exacerbate perceptions of scrutiny and paternalization that discourage open dialogue about cannabis use with health professionals. Findings from qualitative work, including our own team's prior research, show that birthing people who use cannabis are attempting to address their own physical and mental health symptoms (Becerra et al., 2024) and mitigate harm to the fetus by reducing the amount or type of cannabis used and attempting to obtain cannabis from sources deemed to be safe (Gould et al., 2025; Gould, Ganesh, & Ceasar, 2024). Additional qualitative studies indicate that many patients obtain information about cannabis use from sources outside the healthcare system, because punitive messaging and distrust in clinicians discourage open communication in healthcare settings (Ceasar et al., 2023; Denson et al., 2025; Gould, Ganesh, Nguyen, et al., 2024). Our work among Californian birthing people who use cannabis showed that race/ethnicity, gender, and socioeconomic status can negatively impact patient care, including clinician judgment or removal of patients from care (Gould et al., 2025). However, data are limited on the unique risks Latinas who use cannabis face when interacting with prenatal care clinicians. Where other studies (Cameron et al., 2022; Denson et al., 2025), including our own prior research (Ceasar et al., 2023; Gould, Ganesh, Nguyen, et al., 2024), have described the motivations reported by patients for cannabis use during pregnancy and the perspectives of clinicians seeing these patients, the current study aims to elucidate how Latina birthing people who use cannabis navigate the healthcare system and interact with clinicians in California during the obstetric period.

METHODS

Data Collection – Participant Recruitment

We conducted qualitative, semi-structured interviews with 20 Latinas ($N = 20$). We recruited via an online research platform (User Interviews) and social media advertisements. These recruitment efforts directed potential participants to a HIPAA-compliant REDCap survey to confirm eligibility and schedule an orientation session, which included signing an informed consent form and participating in a qualitative interview. To be eligible, participants had to report current or previous pregnancy within the last year concurrent with cannabis use, identify as Latina, live in California, be 21 years of age or older, and report English or Spanish fluency.

Data Collection – Semi-Structured Interviews

We conducted and recorded 60-minute interviews remotely via HIPAA-compliant Zoom video calls between September 2023 and March 2024. We used a semi-structured interview guide which drew upon existing qualitative and quantitative literature outlined in the introduction (see Appendix 1: Interview Guide). We developed the guide using the National Institute on Minority Health and Health Disparities framework and insights from past studies conducted by our team (Becerra et al., 2024; Ceasar et al., 2023; Gould et al., 2025; Gould, Ganesh, & Ceasar, 2024; Gould, Ganesh, Nguyen, et al., 2024; O'Brien et al., 2014). All study procedures were approved by the Institutional Review Board (IRB UP-21-00282). We tested and refined the interview guide questions within the research team. We met weekly to discuss participant recruitment and data collection, iteratively revising the interview guide to elicit richer responses from participants.

Each interview was conducted by two team members, with one person leading the discussion and the other taking analytical notes and following up with corresponding questions. Using probes, we delved deeper into new topics introduced by the participants. This was done to expand upon the original scope of the interview guide (Charmaz, 2014). An external HIPAA-compliant transcriptionist de-identified and transcribed the interviews for analysis.

Data Analysis – Constructivist Grounded Theory

We used constructivist grounded theory methods to develop the results (Charmaz, 2006). Two team members (JL and RS) wrote initial memos within the interview transcripts based on emerging thematic subject areas, then compiled and discussed the initial themes together with RCC, EEG, and SSG to develop an initial codebook. The team revised and discussed the initial codebook during weekly meetings to further develop it. The codebook included definitions and examples for each emergent theme (i.e., *Fearing or receiving differential pregnancy care, treatment because of who I am*). We used ATLAS.ti (version 22.1.0) and after testing the codebook against a few transcripts as a team, we revised the codebook to a set of 22 thematic codes (Appendix 2: Codebook). Two team members (LM, ES) coded the data with the support of senior lab members (EEG and SSG). Throughout the analysis process, the analytical team met weekly to synthesize findings and develop final memos. We used insights from our research team discussions to develop three results related to prenatal care experiences among Latina birthing people who use cannabis. Throughout the research process, we used the Standards for Reporting for Qualitative Research (SRQR) framework (O'Brien et al., 2014), see Appendix 3.

RESULTS

Latinas who used cannabis during pregnancy described how: 1) their intersectional identities (e.g., race/ethnicity, age, partnership status) were perceived as potential sources of vulnerability to poor prenatal care, particularly in the context of disclosing cannabis use; 2) awareness of their intersectional identities shaped their prenatal care experiences to identify and seek care from clinicians they perceived as more supportive, although financial- and insurance-related barriers limited their access to preferred clinicians; and 3) they proposed strategies to improve their care, such as seeking younger clinicians who shared their intersectional identities, or clinicians who adopted a whole-person approach that contextualized cannabis use within patients' lived experiences. Demographic data can be found in Appendix 4, Table 1. Authors assigned pseudonyms to all participants.

Intersectional Identities as Potential Vulnerabilities in Prenatal Care as Related to Cannabis Use Disclosure

Birthing people who used cannabis in our study determined that identity factors such as age and race/ethnicity affected the quality of care they received. They viewed their intersectional identities as vulnerabilities that were shaped by their experiences of racialization and stigmatization in clinical settings, which affected how they navigated their cannabis use disclosure in prenatal care.

Gabriela, for example, felt judged at her prenatal visits by her clinician due to her age and race/ethnicity:

> "My mom is Hispanic and ... has dark skin but my dad's Caucasian, so I have very fair skin... I would go with my mom to a lot of my appointments. ... [The OB-GYN] gave me a weird vibe like he was kind of judgmental [toward us]. I was also young too, so I was a young Hispanic person [without the father of the baby present]. Obviously, my mom's in there with me and my mom is visibly Hispanic...
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> It was demeaning when you're younger and then combined with [being Latina] ...You're already starting off in the negative is how I felt. I felt like I had to present myself very proper as if I knew what I was doing so you don't...give anybody the wrong impression that you don't have yourself together and you're not capable of doing the job...[of] taking care of a baby....[P]eople also look at you differently when you are married and as a united front, they see you in a better light, I guess." (Gabriela)

Gabriela described experiencing discrimination toward herself and her mom, a dark-skinned Hispanic woman, during her appointments with her clinician, an older non-Hispanic White male obstetrician-gynecologist. As a young, single, Hispanic woman, Gabriela was cognizant of the multiple, overlapping sources of judgment toward her, even before cannabis entered her care discussions. She noted having to police her behavior, demeanor, and appearance to counter the OB-GYN's inherent negative assumptions about her capabilities as a mother.

After experiencing the OB-GYN as being dismissive and making her feel like she "wasn't worth his time," she switched to a female, Latina OB-GYN, whom she felt provided better care.

> "[M]y OB-GYN was Latina…I don't know if that's what it is [that I felt the care was better than the other OB-GYN] because she reminded me of my mom and looked like my mom. I don't know if it was just a comfort thing, especially...when you're in a scary situation and you're having worries early on and I was bleeding and spotting and stuff like that...[I]t was very comforting." (Gabriela)

Gabriela also shared that her age, skin color, ethnicity/race, and partnership status were of importance because it influenced how openly she could discuss her prenatal cannabis use with her clinicians:

> "I wish I could openly and freely talk to my doctor without feeling like there's judgment [about using cannabis during pregnancy]... There's been experiences with family friends where... [clinicians] don't want you to go home [with the baby after birth] or they were even making comments about CPS [Child Protective Services] where they [became] concerned she's a drug addict, you know what I mean?...
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> I don't care about judgment as much as I would say. I'm concerned there would be a step further than that and somebody would be feeling incompetency as a mother in me being able to take care of my child in a safe way." (Gabriela)

While Gabriela had not personally been threatened by her clinician with Child Protective Services (CPS) involvement, she was acutely aware of such experiences occurring among her social network, which shaped her fear of disclosing her cannabis use. Her awareness that clinicians would question the parenting abilities of mothers who used cannabis and threaten removal of their newborns made Gabriela concerned about the stakes of disclosure. She worried that disclosing cannabis use would lead her clinician to doubt her competency as a mother, a fear compounded by her age, race/ethnicity, and partnership status. She described how these numerous factors made her especially vulnerable to being labeled, like her family friends, as a "drug addict" rather than being recognized as a capable parent.

In addition to being Latina, Melanie also reported that she felt judged for her age and partnership status even before she disclosed her cannabis use. Once cannabis entered the equation, this judgment felt amplified:

> "I felt that I was being misunderstood and judged [by my prenatal care clinician] without getting to be known [by them]. And I felt like it didn't matter. What mattered was what she could make happen [to] me if I didn't listen to her. ... Cause all she really saw was 'There's a positive drug test [for cannabis use], she's going to be a single mom and she's young.'" (Melanie)

Melanie felt that her age and partnership status, coupled with her cannabis use, created conditions that rendered her vulnerable to stigmatization, such as potential CPS involvement, by her clinician. In this way, she came to understand these identities as vulnerabilities themselves, given how clinicians responded to her.

Navigating Structural Barriers in the Search for Supportive Prenatal Care

Participants in our study felt restricted by their insurance coverage in their ability to seek out clinicians they perceived as open to discussing cannabis use in informative and non-judgmental ways. They felt that their insurance limited them to clinicians who were less holistic and more likely to view their cannabis use as grounds for punitive actions, such as urine testing and CPS involvement. For example, Manuela described difficulties accessing medication that alleviated her symptoms and reduced her need for cannabis:

> "[I said to my clinician] 'The medicine you prescribed for me… was $90 for every two weeks, and its good medicine. It really helps [with pregnancy symptoms, so I don't need to use cannabis] but it's really expensive so how long am I going to need this for? The end of the pregnancy? Am I going to be paying this every two weeks?'…I have private insurance with a

> prescription plan...[but] the pharmacy closest to me wasn't available so I would have to [drive] twenty minutes to the next pharmacy... [that] sounds like a lot of work when you're already nauseous... and I had to take my son in the car… it's just easier to just go to my garage [and smoke cannabis]… everyone lives life better that way." (Manuela)

Manuela's challenges with accessing her prescribed medication included hidden costs that she felt her clinician was unaware of, such as out-of-pocket expenses beyond her private insurance coverage, as well as the time and resources required to regularly travel to pick up the medication. Compared to the burden of obtaining her prescription, Manuela found cannabis to be the more accessible option for managing her pregnancy symptoms.

Desiree was also seeking alternative options for symptom management, but did not feel that she received adequate support from her clinician:

> "I have to see whoever my insurance covers ... if [my care team] would tell me that they support my decision [to use cannabis] it would be great... [or] give me more options of other natural remedies I can use for any bad symptoms that I'm having during pregnancy... It wasn't like I was trying to run to weed right away, I wanted other options... It would just be more natural herbs, you know, from all around the world like things that our ancestors used. " (Desiree)

Because of the cost of her healthcare, Desiree felt that she was unable to seek care beyond what her insurance covered. As a result, she felt limited to a clinician who did not support her desire for alternative symptom management options outside of both cannabis and pharmaceuticals.

Melanie had previously established care with a clinician who was aware of her cannabis use, but due to an insurance-related change in clinicians, she experienced judgment and threats from her new clinician:

> "I was in the middle of my pregnancy. I switched providers from the one that I had been with since high school because my insurance company ended up changing ... to a different group...When I went over to her [the new OB-GYN for my visit] you know, same old routine. Come in, check in, pee in the cup ... I come into my next appointment...and she brings me into a room ... and says basically I have a drug problem. And I go, 'what do you mean?' She's like, 'Marijuana came out in your system. Would you like to explain this?' And then basically threatened me with losing my child if the next time I came in, I wasn't clean [provided a urine toxicology without any indication of cannabis use].
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> I felt really unheard by this new doctor compared to my old doctor that understood [my use of cannabis for chronic pain and cysts related to PCOS] because she had been with me for forever ... [The new OB-GYN] saw the [medical] file ... and disregarded me and wanted to assume [about my substance use]. And then use her power as a doctor to say, 'Hey, if you don't do this right because this is my view. This is how I see it. Then you can lose your child.'" (Melanie)

Melanie shared how being forced to change OB-GYNs exposed her to a new set of risks during her pregnancy. Rather than engage with her medical history or understand the context of her cannabis use, Melanie felt the new OB-GYN reduced her to a positive drug test and used her clinical authority to threaten her into being compliant as a condition for keeping her child. In contrast to her previous OB-GYN, Melanie felt the new OB-GYN was not curious about her motivations for cannabis use to reduce pain and instead assumed she had substance use issues.

Gabriela also experienced insurance barriers that prevented her from accessing a clinician with whom she felt safe discussing her cannabis use. When asked what she would look for in a clinician who might make her feel safe and without threat of CPS intervention, she responded:

> "[I'd feel more comfortable with] a holistic doctor or having a doula ... that's the experience that I looked for initially ... I prefer holistic things rather than turning to pills ... but it's hard to find affordable holistic doctors. They're not covered under your insurance ... you're paying out of pocket to feel more comfortable, to feel like you're having somebody that you would feel safe with, [to] feel like you could talk to them openly about

> your different methods of pain relief. And using cannabis, obviously ... You end up going the traditional route anyway because [of] insurance." (Gabriela)

Gabriela sought care where she could openly discuss her pregnancy-related symptoms and pain relief strategies. She described feeling more comfortable with clinicians whose beliefs around holistic care aligned with her own, although she felt this option was inaccessible with her current insurance plan. Gabriela believed that being able to "feel more comfortable" and "safe" through holistic prenatal care, such as having a doula, would require paying out-of-pocket costs beyond her insurance coverage.

Participants Desired Clinical Relationships Based on Shared Identity and Whole-Person Care That Could Foster More Supportive Discussions About Their Cannabis Use

Participants described receiving and anticipating better care from clinicians who were closer to their age or shared similar backgrounds, which they felt would facilitate more open discussions about their cannabis use. They believed that clinicians with shared backgrounds would be better positioned to engage meaningfully with the context and motivations surrounding their cannabis use. For example, Nicole attributed differential care related to her cannabis use solely to the age of the clinician she was receiving care from:

> "Whatever doctor you go to, they keep track [of your cannabis use]. When it's a new doctor, I feel like I have to almost start over [again with them.] So, I definitely don't want to have to talk about [my cannabis use] again. And to be honest, you can tell ... which ones are judging me, their tone changes a little bit. Just a little bit ... [T]he ones that are encouraging [you to talk about it] and ... brings it up, they want to talk about it and then we start talking about it. I like that ...
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> [T]here has been one doctor that said that it would probably be better if I choose to eat it or have it in a drink instead of smoking ... So, I said, 'Oh, okay.' But I don't really do the teas or anything ... honestly, I feel like it's more [with] older doctors ... I don't see a lot of old[er] doctors anymore ... They're definitely younger [the doctors who are more accepting of cannabis use]." (Nicole)

Nicole noted that each clinician transition required her to restart the conversation about cannabis, making her reluctant to disclose at all. She valued clinicians who actively invited discussion about her cannabis use, including notably one clinician who offered harm reduction guidance by suggesting she consume cannabis in edible or beverage form, rather than smoking. She attributed these more accepting approaches to her cannabis use to younger clinicians and felt that older clinicians were more likely to respond with judgment.

Alejandra also felt she had a more positive prenatal care relationship after she switched to a younger nurse practitioner, by whom she felt more cared for, regardless of her cannabis use:

> "[For my second pregnancy,] I didn't feel comfortable speaking to [the OB-GYN] and asking her an opinion about [my cannabis use] ... I saw my nurse practitioner a lot [more]. The relationship that we had made me feel more comfortable to ask her these questions [about cannabis]. She almost felt as if she was a friend ... she was very open about [cannabis].
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> She didn't seem judgmental at all. I could ask her any question, and she would easily come with an answer to me in a way to where I wouldn't feel ... that stigma [towards my cannabis use] ... The older they are, the more stuck in their ways they are. My ... OB, was a lot older than my nurse practitioner. She's young, close in age to me." (Alejandra)

When she saw a clinician closer to her own age, Alejandra noted a marked difference in the quality of care she received, reinforcing her understanding of generational differences in care. Her nurse practitioner fostered a prenatal care environment in which she felt safe disclosing her cannabis use and asking questions about it. This contrasted with the relationship with her former obstetrician, an older woman with whom she felt uncomfortable and at risk of judgment.

Aria also suggested that clinicians who could relate to her life experiences and community would be less likely to engage in the kind of swift

judgment she had encountered with other clinicians when discussing her cannabis use:

> "[If I saw a Latina clinician] maybe they'd be more understanding or not so heavy on the judgment [towards my cannabis use] ... [W]hen you see someone [like that] there's a part of me that's like, 'They're going to get it,' or that they're going to understand you ...
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> [W]hen you have people that look like you and that are from the same community as you, they've grown up in the same [circumstances] ... they're not so uptight about things. They're more understanding instead of being so closed off." (Aria)

Aria felt that having a clinician who shared her background would reduce the cognitive burden of navigating her care by relieving her of making a choice between finding a more understanding clinician or withholding information about her cannabis use to avoid punitive consequences. For Aria, a clinician who shared her lived experiences would be more likely to possess an innate understanding of the circumstances surrounding her cannabis use, thus eliminating the need for her to continuously justify or contextualize her use.

Adelia described feeling that her financial constraints were unrecognized by her clinician. She felt that her clinician lacked the shared lived experiences to empathize with the challenges she faced in caring for herself as a Latina birthing person:

> "If I wasn't a woman of color, my care would be different. I don't feel like [my clinician is] racist, but I also don't think that she has some of the same concerns that women of color do ... I was trying to explain to her … [I needed] allergy medicine … so I sent her a message and [asked for] a refill ... and she's like, 'It's over the counter.'
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> 'I don't know if you have a history of dealing with patients who are low income,' I said, 'but sometimes over-the-counter medication is covered by insurance if you write me a prescription.' She goes, 'Okay, but no prescription.' And she tells me how much it is, and I don't have an extra forty dollars to pay for allergy medication ... It's things like that that she didn't understand. Forty dollars can make a big difference, especially when it's unexpected ... I had to explain to her that … Eighty dollars is a meal for my family, that makes a big difference ... That one incident that made me realize we come from two different worlds." (Adelia)

Disparities in their financial lived experiences left Adelia feeling unable to have conversations with her clinician. While Adelia did not perceive her clinician as overtly racist, she nonetheless felt her care needs were unmet. She identified that a clinician who was also a woman of color, Latina or otherwise, would be better positioned to relate to her racial/ethnic identity and her socioeconomic circumstances, and thus would be able to adapt care accordingly. In her current care dynamic, she was required to explain the realities of her financial situation rather than have them implicitly understood. Adelia identified some ways in which her clinician could leverage her position within the medical system to alleviate her financial stress, such as writing a prescription. Adelia felt that her clinician was unable to see such pathways due to the chasm between their lived experiences:

> "I told her yes, I used edibles occasionally but like it wasn't an everyday thing. And so she said, 'well, okay, you're kind of gonna have to stop.' And I was like, 'well, it's not like it's every day, that shouldn't be a problem.' And then when the morning sickness kicked in [and I was losing 12 pounds in the first four months of my pregnancy] I was like, 'oh no, I think this is necessary.'
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> And so she said she would schedule a meeting for me with like … she called it a case manager and the case manager essentially was asking me about like my habits, if I have any drug problems, did I have a history of drug, of family drug problems or mental illness and things like that, and I was like, 'yeah, well, that has no bearing upon me.'" (Adelia)

While she had previously disclosed her cannabis use, the absence of a clinician with an innate understanding of her lived experiences posed ongoing challenges for continued discussions about her cannabis use. Her clinician's referral to a case manager to address

her cannabis use further compounded her sense of being unheard and unsupported. These repeated experiences of feeling dismissed and not having her needs met led Adelia to feel isolated and unable to trust her clinician with further conversations about her cannabis use.

DISCUSSION

The core contribution of this study is a qualitative exploration of Latinas' lived experiences navigating prenatal care while using cannabis. We found that Latinas who used cannabis during pregnancy viewed their intersectional identities (race/ethnicity, age, partnership status) as potential vulnerabilities for poor prenatal care, shaped by broader patterns of discrimination, racialization, and stigmatization in medicine. To address these challenges, Latinas in our study proposed solutions, such as seeking younger clinicians or those who shared their intersectional identities, as well as clinicians who adopted a whole-person approach to understanding their motivations for using cannabis during pregnancy.

Upon disclosing their cannabis use, birthing people in our study became acutely aware of their overlapping identities (i.e., being young, Latina, unpartnered) as vulnerabilities that heightened their risk for stigma and punitive intervention. These intersecting identities, intensified by pregnancy, often placed them in hostile care environments that preceded any disclosure of cannabis use to their clinicians. This led participants to expect inequitable consequences at the initial point of care, such as CPS involvement, and further discouraged them from disclosing use. When disclosure did occur, feelings of being misunderstood by their clinicians further complicated the care relationship.

Having experienced racialization, stigmatization, and dismissal in healthcare stemming from the vulnerabilities associated with their intersectional identities, participants identified preferred clinicians and care models but were unable to access them due to structural barriers. These barriers included insurance-mandated clinician changes, difficulties switching clinicians within network, and the high costs of non-standard care. Some participants expressed interest in integrating doulas alongside their primary perinatal clinician to improve communication about cannabis use and better manage associated risks, while others indicated interest in alternative medicine approaches, such as natural remedies or herbs traditionally used during pregnancy. In summary, Latinas who used cannabis during pregnancy reported more positive care experiences with younger clinicians, whom they perceived as more receptive to their pregnancy-related symptoms and less stigmatizing of their cannabis use. This led Latinas in our study to seek out clinicians capable of engaging openly with their motivations for cannabis use and non-stigmatizing care environments that facilitated disclosure as well as deeper discussions about self-medicating their pregnancy-related symptoms with cannabis.

Intersectionality and the Importance of Shared Identities in Navigating Prenatal Care as A Latina Patient

While increases in cannabis use during pregnancy have been documented across all racial/ethnic groups, including disadvantaged and racially minoritized communities (Cameron et al., 2022), unpacking these trends with an intersectional lens is critical for understanding how multiple identities shape the lived experiences of Latina birthing people who use cannabis. In our study, we applied an intersectional framework to unpack the narratives of Latinas who used cannabis during pregnancy to illuminate how the convergence of race, gender, age, class, and substance use shaped their interactions with the healthcare system. The framework of intersectionality is valuable in maternal health research (Hankivsky et al., 2010) as analyses rooted in a single identity may obscure the compounding effects of additional, overlapping identities, such as race, class, and gender (Hankivsky et al., 2010). For example, a 2020 review identified that Latinas were more significantly impacted than Latinos by discrimination-related poor mental health, reflecting the burden of multiple intersecting identities (Lebron & Viruell-Fuentes, 2020). Additionally, in a multiracial sample of birthing people, experiences of discrimination were associated with a lower quality of life (Lebron & Viruell-Fuentes, 2020).

Latinas in our study navigated their intersectionality throughout the care process,

even before disclosing cannabis use with their clinicians. This hesitation to disclose substance use is consistent with literature showing high levels of gender- and ethnicity-based discrimination in healthcare and inadequate perinatal support for Latinas (Sakala et al., 2018; Sheppard et al., 2014). Latinas in our study described taking on the role of the "good patient" to prevent poor care by managing perceived judgments around ethnicity, age, gender, and partnership status (Jønsson & Spalletta, 2023). The expectation to be a "good patient" is further complicated by cannabis disclosure, as Latinas in our study also felt pressured to be a "good woman" and "good mother" for clinicians who were quick to drug test them, label them as "drug addicts," and threaten them with CPS involvement (Stone, 2015). Although Latinas in our study expressed a desire to disclose cannabis use and maintain clinical support during pregnancy, fear of punitive consequences such as termination of care and family separation deterred them from doing so. These findings are further supported by related work from our team showing that Latinas experience higher rates of nausea and vomiting during pregnancy than non-Latina White women and are more likely to use cannabis to self-medicate these symptoms (Becerra et al., 2024).

Latinas in our study felt safer disclosing their cannabis use to clinicians who looked like them and shared their lived experiences, including those closer in age to them. Yet in California, where Latinas/os make up 38.9% of the state population, only 2.7% of physicians identify as Latina, underscoring the challenges Latina patients face in finding racially/ethnically concordant care (Anaya et al., 2023). This lack of representation, including among OB-GYNs (Polan et al., 2024), has been associated with poorer patient-clinician communication and lower quality of care (Martínez et al., 2022). In terms of age concordance, participants felt more comfortable discussing cannabis use with clinicians who were around the same reproductive age as the patient. These findings are consistent with prior research indicating that clinicians who are younger (aged 40 years and under) and those who identify as female are more likely to initiate conversations about cannabis use with patients (Holland et al., 2016; Schauer et al., 2022). Together, this research suggests that clinician characteristics—such as age and gender—may influence both the likelihood and tone of cannabis-related discussions in prenatal care. Patients may feel more comfortable disclosing cannabis use to clinicians who share similar demographic characteristics, as these clinicians may demonstrate greater openness and rely less on punitive approaches to counseling (Holland et al., 2016). While a systematic review suggests that less experienced clinicians may face greater challenges addressing cannabis use during pregnancy (Panday et al., 2022), our findings point to a generational shift in clinician comfort with cannabis. These changes may reflect improvements in formal cannabis education among newer medical trainees compared to established clinicians who received minimal training and may rely on anecdotal evidence (Jacobs et al., 2022). Our findings underscore the need for evidence-based and equitable cannabis education across all training levels to reduce bias related to cannabis use and ensure consistent, high-quality prenatal care for Latina birthing people who use cannabis.

In addition to racial/ethnic and age concordance, participants described a significant socioeconomic gap between themselves and their clinicians. This feeling of being "from two different worlds" (i.e., patients accessing low-income care from much higher-income clinicians) contributed to participants feeling misunderstood with respect to the barriers they faced in accessing care and their reasons for self-medicating with cannabis. When feasible, this led some participants to "shop around" for clinicians who would counsel rather than judge them. This finding is consistent with research showing that women who feel stigmatized and discriminated against after disclosing substance use during pregnancy are less likely to seek comprehensive care (Stone, 2015). The need "to shop around" for adequate prenatal care is concerning, given that continuity of care from pregnancy through the postnatal period is shown to have beneficial maternal health outcomes (Hodnett, 2000).

Unsafe Health Care Environments

Our findings underscore the need for clinicians to adopt counseling rather than punitive approaches to cannabis use, given that clinician mistrust and lack of support during pregnancy can have negative implications for

maternal and child outcomes. These negative effects are even more pronounced for Latinas, who more often report higher rates of perceived discrimination and medical mistrust than non-Hispanic Whites (Davis et al., 2012; Weech-Maldonado et al., 2012). Given that Latinas are less likely than non-Hispanic White women to initiate prenatal care in the first trimester or attend the recommended number of prenatal visits (ACOGb, 2025), our findings highlight the importance of building clinical trust and improving access to prenatal care services as key strategies for reducing maternal health disparities (Camargo et al., 2023; Docherty & Johnston, 2015; Selchau et al., 2017).

Women often use cannabis for its perceived "natural" health benefits during pregnancy (Chang et al., 2019), such as a substitute for prescribed medications to manage mental health concerns, stress, and nausea associated with pregnancy (First et al., 2022; Gould, Ganesh, & Ceasar, 2024; Gould, Ganesh, Nguyen, et al., 2024; McCoy et al., 2023; Solmi et al., 2023; Vanstone et al., 2021; Young-Wolff et al., 2023). Research among Latinas shows that complementary and alternative medicine usage in pregnancy does not replace conventional medicine (Bercaw et al., 2010), suggesting that participants in our study may view cannabis as an accessible supplement to traditional medicine. Participants in our study expressed interest in complementary and alternative medicine, which is widely used in pregnancy despite limited evidence to support this (Bowman et al., 2018). While medical associations and governmental bodies recommend abstaining from cannabis during pregnancy, given that no safe level of use has been established (ACOGa, 2025; Ko et al., 2020; SAMHSA, 2024), our data highlight how limited access to standard and adequate care may drive continued use. To retain patients in care, clinicians must recognize the range of motivations underlying Latinas' cannabis use decisions during pregnancy (e.g., distrust of conventional medicine, desire for holistic options) and respond with non-judgmental, evidence-based guidance (Cernat et al., 2024; Mitchell-Foster et al., 2021).

Several participants shared how changes in insurance coverage placed them in an unsafe environment, forcing them to transition to new clinicians who lacked compassion, training, or time to understand their motivations for cannabis use during pregnancy. This disruption in care consistency is particularly concerning given that women who use substances during pregnancy are already at higher risk of discontinuing prenatal care (Stone, 2015), inviting downstream consequences for maternal and child health. For example, women who do not receive prenatal care are three times more likely to give birth to low birth weight infants, and their babies are five times more likely to die in infancy (U.S. Department of Health and Human Services [HHS], 2020; World Health Organization [WHO], 2014). As reflected in our findings, supplementary care models may support improved communication around cannabis use and its associated risks between Latina patients and their clinicians. For example, doula integration into perinatal care has been found to lower the risk of cesarean delivery and postpartum depression (Falconi et al., 2022; Mabiala-Maye et al., 2025).

This study also showed that Latinas feared being drug tested by their clinicians and, in some cases, were threatened with newborn separation by CPS if they did not produce a "clean" drug test. These findings align with research showing that women with public or no insurance or single partnership status have a higher likelihood of being subjected to drug testing (Malekmadani et al., 2024). The compounding burdens of insurance status, race/ethnicity, and socioeconomic factors on Latinas' prenatal care experiences suggest that cannabis use may represent a form of self-medication in the face of inadequate care. This is consistent with research showing that rates of self-medicating with cannabis during pregnancy are more pronounced among women of color (First et al., 2022) who are disproportionately subjected to drug testing policies and practices.

The Role of Structural Competency in Bridging Intersectional Maternal Health Disparities

Structural competency prioritizes implementing systematic interventions (Metzl & Hansen, 2014), such as non-punitive institutional responses to substance use, clinician training on cannabis disclosure, and clinical workforce diversification. We apply structural competency as a critical framework for addressing barriers identified in our study. In doing so, we call for structural competency training across all levels of

clinical education and a commitment to a more diverse clinician workforce reflective of patients' intersectional identities and lived experiences. This means building and supporting the existing workforce of clinicians of color so they can contribute to meaningful change and leadership within healthcare institutions. While expanding training on structural competency is imperative, it is equally important to expand the clinician workforce to be more representative of multiple patient identities, a call echoed by previous data. Our findings showed that Latinas felt most supported by clinicians who looked like them (i.e., younger Latina women and/or clinicians of color), and research confirms that racial/ethnic representation in the workforce improves healthcare access for racially minoritized populations (Lett et al., 2019; Salsberg et al., 2021). Despite decades of efforts, Black and Latine physicians remain underrepresented in medicine (Lett et al., 2019). While trainee diversity is slowly growing, its impact on patient care has yet to be fully realized (Lett et al., 2019).

Structurally competent care that identifies and addresses the social, political, and economic drivers of health inequity, alongside supportive patient-clinician relationships, has the potential to improve care experiences for Latina birthing people who use cannabis. Applied to maternal health, structural factors such as entrenched discrimination within healthcare institutions and inequitable economic policies drive inequities across race/ethnicity, class, age, and gender. A structural competency framework can guide clinicians and health systems to identify prenatal policies and practices that reduce these structural determinants and strengthen pathways toward maternal health equity among Latina birthing people who use cannabis (Crear-Perry et al., 2021). Under this framework, the focus of our inquiry expands beyond cannabis use itself to the broader gendered, racialized, and socioeconomic conditions shaping prenatal care for the Latina birthing people we interviewed.

Our findings highlight how improving patient-clinician interactions is paramount to ensuring equitable health outcomes for birthing people. Although participants described interpersonal experiences of judgment, stigma, and symptom dismissal, amplified by their race/ethnicity, age, and partnership status, these challenges stem from structural rather than individual failures and must be addressed accordingly. Structural competency draws from concepts such as cultural competency, social determinants of health, and structural vulnerability, and is a lens to understand and address structural drivers of health inequity (Bourgois et al., 2017). While shared patient-clinician backgrounds may facilitate greater understanding of patients' lived experiences and their motivations for cannabis use, structural competency offers a lens through which all clinicians, regardless of their background, can learn to recognize health inequities. By deepening clinicians' understandings of the structural drivers of health and providing a framework for applying this knowledge in practice (Metzl & Hansen, 2014), structural competency enables clinicians to shift stigma, judgment, and blame away from patients and towards systemic conditions that shape individual health.

Conclusion

Further interventions are needed to address systemic barriers for Latina birthing people who use cannabis, including insurance coverage gaps and limitations in clinician training, to reduce punitive measures, such as CPS involvement and parent-child separation, and to improve access to trusted, nonjudgmental care. We identified three key intervention points: 1) develop institutional interventions to train clinicians in structural competency, 2) expand and diversify the clinician workforce to better reflect the multiple identities of the patients they serve, and 3) improve healthcare coverage (including interventions such as doula integration into prenatal care) to reduce financial barriers and retain patients in care. Structurally competent care and supportive patient-clinician relationships are imperative for birthing people who use cannabis. Applying this framework to create safer clinical environments may help to foster open communication about cannabis use motivations and improve perinatal outcomes for Latina birthing people.

Limitations

This study has limitations. First, we did not explicitly examine distinctions across clinician types, as participants' care experiences varied notably between physicians and nurse

practitioners. This points to potential differences in comfort related to differing levels of social distance, a concept warranting further research. Second, we conducted this study in California, where public health insurance is available through Medi-Cal, which may not be generalizable to insurance systems in other states. Our findings in Result 3 may be specific to this limitation. While the specific ways in which insurance limited participants' ability to seek care may not be generalizable, the broader vulnerabilities we documented in prenatal care environments have wider application. Future studies should continue to identify additional structural factors that shape healthcare experiences among birthing people who use cannabis.

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