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The impact of COVID-19 visitor policy restrictions on birthing communities of colour

Molly R. Altman[1] [ORCID] | Meghan K. Eagen-Torkko[2] | Selina A. Mohammed[2] |
Ira Kantrowitz-Gordon[1] | Rue M. Khosa[3] | Amelia R. Gavin[4]

[1]Department of Child, Family, and Population Health Nursing, University of Washington School of Nursing, Seattle, Washington, USA

[2]University of Washington School of Nursing and Health Studies, Bothell, Washington, USA

[3]The Perfect Push, LLC, Redmond, Washington, USA

[4]School of Social Work, University of Washington, Seattle, Washington, USA

Correspondence
Molly R. Altman, University of Washington School of Nursing, Department of Child, Family, and Population Health Nursing, 1959 NE Pacific St., Box 357262, Seattle, Washington 98195.
Email: mraltman@uw.edu

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Abstract

Aims: To explore the experiences of care for pregnant and birthing people, and the nurses who cared for them, during the COVID-19 pandemic, with special emphasis on the impact of visitor restrictions policies.

Design: Qualitative study using critical thematic analysis.

Methods: We conducted semi-structured interviews with 15 community members who were pregnant and/or gave birth and 14 nurses who worked in the perinatal setting between April and August 2020. Participants were recruited via purposive and snowball sampling, and interviews were conducted virtually via the Zoom platform. The research team used critical thematic analysis methods informed by other interpretive methodologies to arrive at resultant themes.

Results: Participants described experiences pertaining to how visitor restriction policies are not equitable and disproportionately impact Black, Indigenous, and People of Color (BIPOC) families, and the direct impacts of not having support people, and also provided recommendations for how to adapt current policies to be more equitable.

Conclusions: Visitor restriction policies have had a disproportionately harmful effect on BIPOC patients and families, leading some patients to make decisions that increase their physical risks to alleviate their risk of labouring and birthing without desired support.

Impact: While this pandemic is nearing the end, these results can guide structuring of policy not only for the next pandemic, but also for universal policy development. Mitigating the effects of racism in policies, by including diverse stakeholders in decision-making, should be an inherent part of hospital administration procedures.

KEYWORDS
birth, COVID-19, health disparities, nurses, pregnancy, qualitative, racism, visitor policy restrictions

1 | INTRODUCTION

Prior to the novel coronavirus SARS-CoV-2 (COVID-19) pandemic, hospital labour and delivery units had encouraged families and friends to spend time with patients, based in part on research showing such policies were beneficial for patients, and associated with shorter hospital stays and better patient outcomes (Bohren et al., 2017). Indeed, there is a body of research supporting the presence of support people in labour and at births (World Health Organization, 2016), and it had become not only considered best practice, but also

a widespread cultural norm. The perceived need for hospitals to reduce visitors to prevent spread of COVID-19 brought an abrupt end to this support system. The visitor policies varied from place to place and setting to setting—and sometimes even day to day—from no visitors at all in New York City at the height of the outbreak (Caron & Van Syckle, 2020), to few or no restrictions on visitors in states with limited responses to the pandemic. However, a common model was to limit the birthing person to one visitor, generally the other parent, and perhaps a doula (trained labour support person) (Arora et al., 2020; Saiman et al., 2020).

1.1 | Background

Although visitor policy restrictions may be an effective way to reduce COVID-19 exposure potential from 'non-essential' persons in the hospital, the restrictions failed to take into account the role that visitors and support people played in the safety and well-being of birthing people, particularly Black, Indigenous, and People of Color (BIPOC). All of these communities already report experiencing significant bias and discrimination in accessing healthcare (Alhusen et al., 2016; Altman et al., 2019; Davis, 2018; McLemore et al., 2018). Indigenous, Hispanic, and Black women are twice as probably as White women to report mistreatment by maternity care providers (Vedam et al., 2019). Mistreatment includes being shouted at, ignored, or refused or delayed response to a request for help. Doulas and other support people can help recognize and counteract bias and mistreatment of birthing people (Wint et al., 2019). Given the disparate impact of COVID-19 on marginalized communities, the intersectionality of existing racism with responses to the COVID-19 pandemic needs to be assessed (Lemke & Brown, 2020; Niles et al., 2020).

2 | THE STUDY

2.1 | Aims

The purpose of this multidisciplinary, qualitative study was to explore the experiences of care for pregnant and birthing people, as well as for the nurses caring for them, during the COVID-19 pandemic. The main results from this study examined how the changes in the healthcare system due to COVID-19 pandemic impacted both patients and nurses in the perinatal setting (Altman et al., 2021). In this analysis, we sought to specifically examine the role of visitor policy restrictions on the experiences of perinatal care for the birthing person using both patient and nurse perspectives.

2.2 | Design

This in-depth qualitative study used thematic analysis approaches (Braun et al., 2014) for its ability to exemplify the patterns of experience while keeping the focus of analysis closer to the shared participant experience rather than the researcher interpretation. Braun and Clarke also provide space for data to be viewed in context (i.e. power, privilege), making it a well-fitting methodological structure for this study. As a way to further strengthen the contextual understanding of data in power structures, we also used Lawless and Chen's (2019) guidance on critical thematic analysis as well as author expertise from a broad range of qualitative backgrounds including discourse analysis, ethnography and grounded theory.

2.3 | Sample/participants

The two participant groups (patients and nurses) were recruited between April and August 2020 using targeted and snowball recruitment strategies via a state-wide social media group dedicated to birth professionals. Specifically, two recruitment requests were placed via this social media page: for birth professionals to share study recruitment information with patients and community, and for nurses practicing in the perinatal setting. Interested individuals were screened on expressing interest, with recruitment flyers explicitly prioritizing BIPOC patients and nurses to assure a diverse representation of participants. Inclusion criteria for patient participants included either being pregnant during or had given birth in Washington State since March 2020; criteria for nurse participants included actively working in a perinatal setting (inpatient or outpatient) since March 2020. Recruitment continued until emerging concepts were deemed complete and described fully by the research team.

2.4 | Data collection

Virtual, semi-structured interviews were conducted between April and August 2020 via the Zoom platform by three members of the research team, with audio and video recordings captured after verbal consent was obtained. Audio recordings were professionally transcribed and transcripts were reviewed for accuracy and de-identified by the lead researcher. Interviews were open-ended, approximately 1 hour in duration, and guided by prompts when necessary, with the initial prompt directed to elicit the participant's experiences of care (or providing care) during the pandemic (interview guides included in Tables 1 and 2). Demographic variables such as racial/ethnic, sexual and gender identities were all self-described by participants prior to starting the interview.

2.5 | Ethical considerations

Participants were provided $50 as remuneration, and human subjects research approval was obtained through the University of Washington Institutional Review Board. Participants were provided a consent information sheet prior to their interview, which was then reviewed with the participant with opportunity to ask questions

TABLE 1 Interview guide for patient participants (to serve as prompts if needed to elicit conversation)

1	I'd love to hear about your experience with health care providers through your pregnancy and birth in the context of the COVID–19 pandemic. Can you share a little about your experiences? Let's start with your pregnancy. And what about your labor and birth? Can you share about experiences after you went home after your birth? Postpartum and breast/chestfeeding?
2	Were there good aspects that you appreciated in the care you received?
3	Were there bad experiences that you want to share?
4	Are there any aspects of care that you would have liked to be different?
5	Are there elements of care that either were useful or are barriers for you?
6	Did you have any moments where you changed your plan or your decisions around pregnancy or birth? Can you tell me more about them?
7	Do you think issues like racism, prejudice, or discrimination fit into your experiences at all? - Or related to any other aspect such as your insurance or your income?
8	Do you have ideas about how health care providers or the health care system could change to improve care during a pandemic like this?
9	Is there anything that I missed or anything you'd like to add that we haven't talked about?

TABLE 2 Interview guide for nurse participants (to serve as prompts if needed to elicit conversation)

1	I'd love to hear about your experience working with pregnant and birthing people in the context of the COVID–19 pandemic. Can you share a little about your experiences?
2	Were there good aspects that you appreciated in how hospitals changed to accommodate the pandemic?
3	Were there bad experiences that you want to share?
4	Are there any aspects of the care you could provide that you would have liked to be different?
5	Are there elements of care (policy or practice) that either were useful or are barriers for you?
6	Do you think issues like racism, prejudice, or discrimination fit into your experiences caring for patients at all?
7	Do you have ideas about how the health care system could change to improve care during a pandemic like this?
8	Is there anything that I missed or anything you'd like to add that we haven't talked about?

before initiating recording. As part of this information sheet, participants were offered mental health and emotional support resources if needed, and reminded that they can stop the interview at any time. After each interview, the interviewer offered an opportunity to debrief without recording to address anything that may have surfaced for the participant during the interview process.

2.6 | Data analysis

The research team used critical thematic analysis as the main methodology for this study (Braun et al., 2014; Lawless & Chen, 2019), with additional methodological techniques from critical discourse analysis and situational analysis (Clarke, 2003; Powers, 1996) overlayed as part of the group analysis process to ensure rigor and reflexivity. The lead researcher performed inductive coding on all transcripts, with additional members of the team also reviewing transcripts using individually oriented interpretive qualitative methods to add context and deeper understanding to resultant codes and constructs. Each transcript was then reviewed as a team, resulting in a group analysis memo. Themes were constructed from triangulating the initial coding and group analysis memos, with exemplar quotes identified through this process.

2.7 | Rigor

The COREQ guidelines were followed in the development and conduct of this qualitative study (Tong et al., 2007). The research team was comprised of researchers with expertise in qualitative methods, health disparities, racism and discrimination and intersectionality, with three of six researchers identifying as BIPOC, all of which contributed to the context and positionality held for this study. Rigor was maintained via frequent team meetings, group memos with a process for reaching consensus on themes and constructs, triangulation between the participant and nurse themes, and the use of processes from several qualitative methods to capture multiple

perspectives and understandings (Braun et al., 2014; Clarke, 2003; Powers, 1996). The inclusion of a BIPOC community member with lived experience both personally and professionally as an advanced practice nurse as part of the research team also strengthened the methodological approach, providing avenues for input from those in and caring for the affected communities.

3 | FINDINGS

Overall, we obtained a diverse sample of both patients and nurses, with 60% of the patient sample (9 of 15 total participants) and 43% of the nurse sample (6 of 14 total participants) identifying as people of colour, with diverse gender identities and sexual orientations included. Of the patient participants, the majority (60%) were experiencing their first pregnancy and birth and 40% were pregnant at the time of the interview. Nurse participants had on average 7 years of registered nursing work experience and 6 years of experience in perinatal care (Table 3).

The following themes were identified as related to the policy restrictions enacted in hospital settings due to the COVID-19 pandemic: Policies are not equitable and disproportionately impact BIPOC families, restricting visitors has a profound impact on the experience of pregnancy and birth, and recommendations for centering community in policies.

3.1 | Policies are not equitable and disproportionately impact BIPOC families

Both patient and nurse participants clearly described a disparate impact from visitor restrictions on BIPOC patients and families. A Black nurse participant shared how the fact that many BIPOC families use a large family structure for support creates inequity:

> I feel like culturally a lot of communities of color typically have a strong extended family and larger families and that has been really challenging because they're not allowed to and oftentimes their support person might not be their partner and so you have women having to make decisions, "I want the father of the baby present" typically it's the father of the baby present, "But I also want my mother or my aunt because they are actually going to support me through this labor". (N14)

An Asian pregnant participant also acknowledged how visitor restrictions impacted how they determined what their support would look like:

> My husband and I come from big families so we were ready to have that whole birthing center filled with our family members waiting in the lobby but when they said we could only pick one designated person to be there I was like,

TABLE 3 Participant characteristics

	Patient Group N (%)	Nurse Group N (%)
Total participants	15 (100)	14 (100)
Median age [range]	31 [20–38]	34 [25–40]
Self-identified race/ethnicity[a]		
Black/African American	6 (40)	2 (14)
White/Caucasian	6 (40)	8 (57)
Asian[b]	3 (20)	2 (14)
Latinx	1 (7)	3 (21)
Indigenous	1 (7)	1 (7)
Gender		
Man (transgender)	1 (7)	0 (0)
Woman	14 (93)	14 (93)
Non-binary/genderqueer	0 (0)	1 (7)
Sexual orientation		
Straight/heterosexual	13 (86)	12 (86)
Queer	1 (7)	1 (7)
Bisexual/pansexual	1 (7)	1 (7)
Geographic location		
Washington State	15 (100)	11 (79)
Other states[c]	0 (0)	3 (21)
Parity		
First pregnancy/birth	9 (60)	
Pregnancy status		
Pregnant at time of interview	6 (40)	
Median gestational age in weeks [range]	30 [26–37]	
Postpartum at time of interview	9 (60)	
Median time since birth in weeks [range]	4 [2.5–7]	
Median length of time as RN in years [range]		7 [1.5–15]
Median length of time in OB setting in years [range]		6 [1.5–15]

[a]Totals do not equal 100% due to ability to choose multiple racial identities.
[b]Asian identities included: Chinese, Filipino, Hong Kong, Indian.
[c]Other states included: New York, Georgia, Michigan.

> "Okay, well my sister". So we chose her but then she's an ER nurse at [Hospital] so then they were exposed to Covid so that was thrown out the window. So just my husband and I. (C11)

Community participants acknowledged that support people are often considered advocates who protect patients against racist and discriminatory behaviours from health professionals. By losing the ability to have support people present at health care visits and at the hospital for labour and birth, patients were then

put at higher risk for mistreatment and exposure to racism. One Black participant shared:

> But my mom was really advocating [for me]. She was thinking about things I wasn't really thinking about. Same with my doula. [S]he kind of just gives me a lot of comfort and gives me the space and room to advocate for different alternatives. Then my boyfriend, he will help me do things I might not want to do (laughs). [...]So all three of these people help advocate for me or push me in different ways that I feel like are necessary and add extra protection and support in these care systems. [...]I hear so much about how like Black women are disregarded in labor, either the labor pains or they are pushed to get a C-section where it might not be necessary and things, and I feel like I just need them there to either push me, advocate for me or make sure things are okay. (C10)

Nurse participants noted that visitor policies were modified for White families, while BIPOC families' requests were often ignored or resulted in poor treatment. One Black nurse participant described how this phenomenon occurred in their hospital:

> You have your Caucasian couple who work for Microsoft or Amazon and, you know, they're the "cute couple" and if they complain enough, the manager is like, "Oh, well maybe", you know, and, "We can bend the rule". But then you have your patients who don't speak English very well or their family lives far away and they're low income and first of all they would never even, you know, try to go against the policy but secondly, it still affects them, not being able to have people. So I feel like people are affected disproportionately by the rules and I feel like some of the rules are unjust. (N11)

A White nurse participant described how the visitor restrictions were disproportionately applied to patients experiencing high risk pregnancies who had long-term hospital stays:

> We have people who don't speak English as a first language and they're here for weeks, months sometimes and they just sit in their room by themselves, without their kids, without their family because of distance but also because they know they can only have one visitor a day and they follow the rules and now, you know, the squeaky, the person who already has a visitor and is now asking for more, you're going to give it to that person and of course it just feels like it's a white woman who is getting this. (N8)

One Black patient participant described a situation in which she did everything required to facilitate changing support people through a long labour and birth hospitalization, yet still received poor treatment from a nurse when her husband needed to leave:

> So we had got it approved that my god-mom would come, she would be with me for the first day, for the first 14 hours, then she would leave. Then the doula would come, which she did. She came twice. She was able to come, leave, come back and then leave. Then my husband, he was able to come but not leave. They said to him, "You can't leave here. If you leave here you're not going to be able to get back". And I had already called somebody else to come and relieve him and we had already got that approved. Well there was a mean lady and she said that he couldn't do it. "Well, if you leave here, you're not coming back". (C15)

3.2 | Restricting visitors has a profound impact on the experience of pregnancy and birth

Both patient and nurse participants described multiple impacts from not having the desired support systems available for labour and birth. One impact described repeatedly was a loss of agency and support needed during a transformational family event like childbirth. One Black pregnant participant shared her feelings about her upcoming birth, particularly how her loss of support created a need to rely on her provider's judgment, which was not trusted to be in her best interest:

> "I am not even going to have a birth where I am in control, like I'm not going to have one like that". Even though, let me say this, my provider has been saying she will support me but I know where she is leading me. I can tell what she feels more comfortable with and I definitely don't want to be in labor with a provider who's uncomfortable with the way things are going because that makes me scared (laughs). So, you know, that's pretty much, yeah, that's pretty much it. I have lost the motivation and the drive to advocate. (C7)

Nurse participants also describe the impacts of having fewer support people for their patients, particularly in adding to their responsibilities for labour support and seeing the impact on the lone support person. A White nurse participant shared:

> I feel like it's been exhausting for them to not have an additional set of hands in there and a lot of our patients, you know, their plan was to have their mom there to support or their aunt or somebody and so just having the partner there has been, I just feel like they're all exhausted. [...] Yeah, I think it's hard for them not having the support system that they planned for. (N3)

An Indigenous Latina nurse shared her concern that patient outcomes may suffer due to lack of support, particularly in cases where patients do not have enough support to manage a difficult labour:

Sometimes I wonder like, I had a mom that had to go to C-section because she just didn't feel good and couldn't get the rhythm of the pushing and before she started pushing we talked about how she wished her mom could have been there and everything like that and I wonder, you know, if her mom could have been there, could we have avoided a C-section? Would your mom have had the eye-to-eye contact and been like, "Push girl," you know? I don't know. (N10)

Both patients and nurses noted the mental health effects that patients were experiencing as a result of visitor restrictions and fear of being separated from family during pregnancy and birth. One White patient participant shared:

My biggest fear, I hope this thing doesn't get so bad, which I'm hoping it calms down by then, where I have to be like one of those women that you've seen across the country who have to deliver alone. That would kill me. That would just -- I would not want to go. (C4)

In response to fear of separation from family and support people, several participants noted that they considered changing their birth plans to assure a higher likelihood of having their support people present during their labour and birth, predominantly in choosing a community-based or out-of-hospital birth setting. A White patient participant described her thought process:

Would I have been presented with the choice to like either have support and be out of the hospital and potentially have another huge hemorrhage and then have to transfer to the hospital or do I have to forego the support in order to have adequate medical care? I think for me that just felt like so incredibly unethical, and still does. (C5)

3.3 | Recommendations for centering community in policies

The majority of participants, both nurses and community members, advocated for visitor restriction policies to be flexible and able to be altered to fit particular patient needs. A Southeast Asian nurse participant shared support for the rationale behind visitor policies, but a need to change the policy to support patients on an individual basis:

So visitor policies did change and they worked, I think not to 100%. But they worked because sometimes we had to be flexible and sometimes we had to advocate for our patient to tweak the policy for that particular patient. (N13)

In addition, nurse participants noted that visitor restrictions should be loosened to allow more people, particularly since universal testing of hospital staff was not common and nurses could carry the same risk as visitors of exposure. As one White nurse participant stated:

If people are wearing masks and aren't showing signs and symptoms that we should allow more people. Or, I mean,

I don't know. It's hard. You don't want all your visitors just getting tests to come in but it's just... I mean, at the point if we're not being tested and they're coming, yeah, I feel like they can loosen it up. It's not like I'm going to work every day and nobody knows my status. I mean, I could be shedding COVID all over (laughs), you know what I mean? Yeah, I don't know. I don't know. The only thing I can think of is just, I guess the question is "What's a good number, three, four, five?" (N9)

Another recommendation was to increase the representation of both diverse communities and diverse provider roles in decision-making around hospital policies, to ensure that multiple perspectives and disparate impacts are being considered. A Black nurse participant shared how centring the patient community in policy decision-making would be a step towards more equitable policy:

I think having multiple people from different backgrounds involved reviewing these policies would be very helpful. It has to be the people who are affected, right? So we have to look at our patient population and what that looks like and we need to like understand what they're going through and their needs and kind of base our policies off of that. (N11)

Using policy to assure an environment of support for people during pregnancy and birth not only can help reduce disparate experiences, but also can be impactful throughout a person's life. As one White patient participant noted:

How you birth stays with you for the rest of your life. [...] You remember if you were supported, if it was traumatic, if it was positive and I just think if you have that support person there it changes everything. You're going to remember if you had to labor alone for the rest of your life." (C1)

4 | DISCUSSION

Our study highlighted multiple impacts from visitor policy restrictions due to the COVID-19 pandemic on patients, particularly those from marginalized communities. By restricting visitors, many BIPOC patients had their support networks disrupted, reducing sources of advocacy and protection from racism and mistreatment in the hospital setting. In addition, nurse participants highlighted how these policies were biased in nature and likely contributed to furthering health disparities in BIPOC communities. Visitor restriction policies were one vital concern among other failings seen in the health care system's response during the COVID-19 pandemic, such as adaptations to care delivery that did not meet patients' needs, an unmet need for additional support and mental health resources, and inconsistencies in policies and procedures that frayed trust between nurses and institutions (Altman et al., 2021).

Recognizing the important role of advocacy that support people provide for BIPOC communities is present and confirmed in the existing literature. Racism and discrimination are widely recognized as barriers to pregnancy and birth care in the hospital setting (Alhusen et al., 2016; Altman et al., 2019; Davis, 2018; McLemore et al., 2018). Forcing patients to choose one person, who often is a partner and not always the primary source for support and advocacy, limits their ability to get what they need from their providers in their care (Simon et al., 2016). The role of support people is often seen as an essential safety measure, not just a comforting presence, in which the presence of another person may make a significant difference in how the patient experiences their care (Davis, 2018; Wint et al., 2019). The restriction of visitors likely plays a role in exacerbating disparities in experience of care for BIPOC patients, both through the actual policy itself and through biased enforcement of the policies by nurses and other health care personnel (Niles et al., 2020). While the perceived benefit from visitor restrictions includes a reduced potential for exposure to the COVID-19 virus, providers and health care systems need to balance the ethical quandary of then increasing risk for perpetuating health disparities, particularly exposure to racism and mistreatment by providers for BIPOC communities (Bruno et al., 2020).

4.1 | Limitations

The parallel structure of exploring experiences of patients and nurses simultaneously was a considerable strength in this study, with the benefit of exploring the relational impacts of visitor policies from multiple perspectives in the hospital setting. Taking into account the mutuality of the shared experience, both nurse and patient experiences bring depth of understanding to the impact on the birthing person and family. We also intentionally interviewed large proportions of BIPOC participants in both groups to assure that our data captured diverse experiences, knowing the impacts of racism on experiences of care, and had a racially diverse research team including community members to support appropriate interpretation of the results. However, several limitations to our study include inability to have in-person interviews due to the pandemic, and the use of Zoom for interviews may have limited the ability for interaction and non-verbal cues. Given the nature of the study, we also do not intend to generalize these results to other settings, but instead hope that these results can be transferrable and may lend meaning and direction for adapting and implementing visitor policies in a culturally appropriate way.

5 | CONCLUSIONS

These results from our study examining experiences of pregnancy and birth care during the COVID-19 pandemic highlight the importance of considering impacts from policies and of involving those with lived experience in policy making decisions. Recommendations by participants include recognizing that visitor restrictions enacted for other areas of the hospital do not pertain to perinatal care, and as such should be amended to include the recognition of how critical support is for labouring and birthing people and their birth outcomes (Bohren et al., 2017). In addition, including BIPOC in policy decisions is required to reduce risk of perpetuating harm through biased policies. While this pandemic is nearing the end, these results can hopefully be used to guide structuring of policy not only for the next pandemic, but also for universal policy development. Mitigating the effects of racism in policies, by including diverse stakeholders in decision-making, should be an inherent part of hospital administration procedures.

In response to the COVID-19 pandemic, hospitals utilized visitor restriction policies to reduce the potential risk for spreading infection for patients under their care. However, as our study depicts, these visitor policies have had a disproportionately harmful effect on BIPOC patients and families, leading to some patients opting to make decisions that increase their physical risks to alleviate their risk of labouring and birthing without desired support. Given the importance of support people for BIPOC patients in mitigating risk of racism and bias in hospital encounters, these policies have had the unintended effect of exacerbating racism in the hospital setting.

CONFLICT OF INTEREST
The authors have no conflicts of interest to disclose.

AUTHOR CONTRIBUTIONS
All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*):

1. substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
2. drafting the article or revising it critically for important intellectual content.

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ORCID
Molly R. Altman https://orcid.org/0000-0002-0453-0469

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