

Pregnancy and birth in the United States during the COVID-19 pandemic: The views of doulas

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Abstract

Background: Much of the emerging research on the effects of SARS-CoV-2 disease (COVID-19) on pregnant people and their infants has been clinical, devoting little attention to how the pandemic has affected families navigating pregnancy and birth. This study examined the perspectives of doulas, or nonclinical labor support professionals, on how pregnancy and birth experiences and maternal health care delivery systems changed in the early weeks of the COVID-19 pandemic.

Methods: Semi-structured interviews using open-ended questions were conducted over the phone with 15 birth doulas. Doulas were invited to participate because of their close relationships with pregnant and birthing people and the comprehensive support they offer. The interview transcripts were analyzed inductively.

Results: Doulas' clients faced three predominant COVID-19-related pregnancy and birth challenges: (a) fear of exposure; (b) limited access to their expected support systems; and (c) uncertainties surrounding hospital restrictions on labor and birth. Doulas responded creatively to help their clients confront these challenges. Participants expressed various criticisms of how maternal health care systems handled the emerging crisis, argued that COVID-19 exposed preexisting weaknesses in US maternity care, and called for a coordinated care model involving doulas.

Discussion: Doulas' close relationships with pregnant people enabled them to be an important source of support during the COVID-19 pandemic. Added to the larger body of work on the impacts of doula care, this study supports widespread calls for universally integrating doulas into maternity care systems as a targeted strategy to better support pregnant and birthing people in both crisis and noncrisis situations.

KEYWORDS

COVID-19, pandemics, pregnancy experiences

1 | INTRODUCTION

The SARS-CoV-2 disease (COVID-19) crisis has transformed pregnancy and birth care for people all over the world. One recent survey of birth practitioners¹ found that COVID-19-related changes in maternal health care included greater reliance on virtual prenatal and postnatal visits, more mask- and glove-wearing in hospitals, limits on the number of support persons in labor and birth rooms, and patient uptake of duties normally

provided by health professionals (such as checking vitals). In the early days of the pandemic, very little research investigated the impacts of these changes, or the pandemic more broadly, on the experiences of pregnancy and birth; instead, most COVID-19 maternal health research was clinical in scope. A rapid evidence review² published in April of 2020 of the psychological and clinical effects of COVID-19 on birthing people and their infants found no studies examining the psychological effects of COVID-19 in pregnancy. However, one study³ compared the

experiences and feeding practices of people who gave birth before or during the lockdown in the United Kingdom (UK) and found that a greater percentage of the latter reported that their mental health was negatively affected by the lockdown. In addition, two studies^{1,4} found that as a result of the pandemic, pregnant people in the United States were considering community birth⁵ (home and birth center birth) out of fear of possible exposure to COVID-19.

Given the unprecedented nature of this pandemic, as well as reports⁶ that coronaviruses may become more common in future, understanding its effects on pregnancy and birth is vital. This study's primary purpose was to begin to examine how the pandemic altered the experiences of pregnancy and delivery, with a focus on the early days and weeks of the pandemic. I aimed to identify preliminary strategies for supporting pregnant and birthing people in a time of crisis, which could be more deeply examined in future research. In doing so, I drew on the perspectives of doulas—birth professionals whose primary role is supporting birthing people. Birth doulas, or nonclinical labor support professionals, offer multiple forms of support, including continuous, hands-on, physical support in labor; educational information about pregnancy and birth; emotional support before, during, and after birth; guidance in the development of birth plans and informed decision-making; and referral to various types of community support.⁷⁻⁹ A wealth of research has shown that although doulas offer clear benefits for pregnant and birthing people,¹⁰⁻¹² they are often marginalized in the maternal health community and seen as nonessential workers.¹³ This positionality—as often the only practitioners offering continuity of care, yet on the margins of the accepted maternity care team—makes doulas a critical source of insight for assessing the effectiveness of maternity care practices in meeting the needs of birthing people. Because doulas most often work in the hospital setting in the United States, they must abide by hospital policies and defer to physician authority to secure and maintain access to clients. Yet, their allegiance is to their clients rather than health care institutions.^{14,15}

In interviewing doulas about their clients' pandemic experiences, I sought to answer the following questions: (a) What were the major challenges and concerns that pregnant and birthing people faced in the early weeks of the COVID-19 pandemic? (b) How did doulas help their clients to respond to these pandemic-related challenges? (c) How do doulas view maternal health care systems' responses to the coronavirus crisis? and (d) What changes do they believe should be made to better support pregnant and birthing people going forward?

2 | METHODS

This paper draws on data collected between late March and mid-April 2020 from open-ended, semi-structured, in-depth

interviews with 15 birth doulas from throughout the United States. I began recruitment using my existing connections with doulas in the Washington metropolitan area. Additional recruitment of doulas from outside of this region was facilitated from these initial contacts. Concept saturation is reached when “no new information or themes are observed in the data,”^{16(p59)} and in this project, this occurred during the last three interviews.

Phone interviews, which averaged around one hour and were audio-recorded, were conducted at times convenient to the participants. The interviews were structured as a conversation focused on the topic at hand, but flexible enough to allow respondents to offer relevant data not anticipated by the interview guide.¹⁷ I sought to gather information about the challenges doulas' clients faced as a result of COVID-19, their clients' responses to the crisis, how hospitals and birth centers adjusted their policies and standard procedures, any perceived impacts on the quality of care provided, and how they and the larger community of doulas where they live modified their model of care to better meet the needs of clients.

I analyzed the data inductively¹⁸ using the constant comparison method¹⁹ and followed qualitative content analysis procedures outlined by Zhang and Wildemuth.²⁰ In the first stage of analysis, I identified the conceptual categories of the coding schema through an initial review of the transcripts. The coding schema was targeted at the study's research questions, designed to be comprehensive, and took into account the variety of responses from doulas regarding their and their clients' COVID-19-related experiences. I then used this schema to code all of the transcripts. For example, in the initial review of the transcripts, I found that doulas reported that their clients expressed immense fear and anxiety over being exposed to COVID-19. This led to the creation of a code “fear of exposure,” and in the structured phase of analysis, I coded for any references made by doulas to worries about contracting the coronavirus. The codes represented themes, and in the final phase of analysis, I drew conclusions based on the themes that arose in the coded data. In the analysis that follows, pseudonyms are used for all participants, as well as for all organizations and communities mentioned by interviewees.

3 | RESULTS

All doulas identified as female, with a mean age of approximately 39 years. The majority of participants were White (86.7%), had at least some college education (86.7%), and were from the Washington metropolitan area (66.7%) (see Table 1 for the full characteristics of the sample). Findings indicate that whereas doulas' clients were significantly affected by the emerging crisis, doulas found ways to respond creatively to ensure that their clients were supported during

this difficult time. Doulas identified a number of shortcomings within health care systems that prevented institutions from meeting the core needs of pregnant and birthing people

and provided recommendations for changes in how to more effectively deliver care during both pandemic and nonpandemic times.

TABLE 1 Characteristics of respondents (n = 15)

Characteristic	%	n = 15
Location		
Maryland	26.7	4
Florida	13.3	2
California	6.7	1
Texas	13.3	2
D.C	33.3	5
Virginia	6.7	1
Age, years		39.1 (mean)
Gender (self-identified)		
Female	100.0	15
Race/ethnicity (self-identified)		
White/Caucasian	86.7	13
Black/African American	13.3	2
Certification status		
Yes, certified	80	12
No, not certified	6.7	1
Did not specify	13.3	2
Education level (highest degree attained)		
High school graduate, diploma or the equivalent	13.3	2
Associates degree	13.3	2
Bachelor's degree	60.0	9
Postgraduate degree	13.3	2
Clients that gave birth by the time of interview and after regional lockdown		
0-1 births	53.3	8
2-4 births	33.3	5
5-7 births	6.7	1
Unsure/did not specify	6.7	1
Length of time practicing as a doula		
0-3 years	26.7	4
4-6 years	20.0	3
7-9 years	20.0	3
10-12 years	20.0	3
13-15 years	6.7	1
16-19 years	6.7	1
Type of practice		
Member of group practice	6.7	1
Owner of group practice	20.0	3
Partnership with 1 other doula	13.3	2
Solo practice	60.0	9

3.1 | COVID-19-related pregnancy and birth challenges

Doulas' narratives highlighted three predominant challenges experienced by clients as a result of the pandemic. The first was the possibility that they, their family members, or their neonatal babies might contract COVID-19. This worry was an ever-present aspect of pandemic pregnancy, and particularly acute during the intrapartum stage, as clients worried about the effects of a COVID-19 diagnosis on their neonatal child.

A second challenge doula identified was clients' limited access to their expected support systems during pregnancy and birth. Most hospitals began permitting only one support person, meaning that clients were forced to choose between a partner or a trusted doula. This created enormous anxiety for clients who felt entitled to, and indeed, in greater need of, support in the labor room. One doula expressed her and her clients' frustration with limitations in the number of support persons allowed in hospitals, saying: "They're expecting to have me at their birth and then they can't. And it's definitely difficult as a doula because I just have to sit back and be like, 'well, I can't do my job, you know?'" (Mona, a 29-year-old doula who identified as Black).

Although clients had extra burdens owing to less direct aid in the form of pregnancy care, labor support, or help with domestic duties and childcare, isolation from their support teams made pregnancy and birth emotionally difficult. When asked about the struggles her clients were facing, Janice (a 51-year-old White doula) identified isolation as a major problem:

I think [it's] the isolation. You know, they're not being able to see any family members, any friends. They're completely isolated. I know some of my moms that are having their second babies remember what it was like with the first, where you had friends and visitors and all of that. And now with the second one, you know, they're out there alone, and no one has seen them.

A third challenge involved the uncertainties surrounding changes in hospital policies related to labor and delivery. These were in flux in the first few weeks of lockdown. For clients giving birth during this time, they and their doulas experienced significant uncertainty and anxiety regarding how birth choices would be curtailed in the hospital. Clients were particularly

worried that hospitals might separate babies from parents if either were suspected to be infected. Since testing could take days to come back, the unknown duration of this separation also produced anxiety.

In addition to concerns about formal policies, pregnant people were concerned with unnecessary reliance on technological interventions to speed up labor. Clients often turn to doulas because they desire an unmedicated birth involving minimal interventions, and they felt that the ways hospitals were responding to the pandemic would limit the chance of their preferred birth. Doulas felt that if they were not allowed in the hospital, their clients were less likely to give birth as planned. Hospital restrictions were viewed by clients as encroaching on their autonomy and right to give birth according to their own preferences. Despite the pandemic, they felt entitled to birth choices and were upset that their voices were not considered in the formulation of new policies. As Margaret (a 34-year-old White doula) explained:

But yeah, I think the biggest thing is these moms just want to make sure that they feel like their rights...they're being heard. And their rights are being...they're safe, you know. And that their rights are not being trampled on when it comes to being able to be out of the bed and moving.

3.2 | Doula support during the COVID-19 pandemic

Doulas quickly identified the challenges their clients faced after lockdown and took steps to adjust their care to minimize the stress their clients experienced. Notably, all participants supported clients' rights to birth in the way they chose. In addition, they all acknowledged that every birth is different, with some pregnancies and deliveries being more or less stressful and challenging. As such, doulas recognized and discussed at length the need for highly adaptable care in difficult circumstances. Participants' philosophy of care and high stress tolerance positioned them to be able to quickly modify their care plans and approaches to the uncertainties of the pandemic.

Doulas used three primary strategies to help their clients manage their pregnancies and births during the pandemic. First, they devoted extra time during the prenatal period to preparing their clients for pregnancy. Doulas in this study described normally holding one or two prenatal appointments and being available via text or phone throughout pregnancy to answer clients' questions. In response to the coronavirus, doulas spent significantly more time helping clients prepare for labor and developing contingency plans in case hospital policies changed. Some of this preparation involved gathering

information about hospital policies and clinical data and recommendations about COVID-19.

When it became increasingly likely that they would not be able to attend the birth, doulas began to teach their clients the hands-on techniques and comfort measures that doulas typically employ during labor and delivery. Although doulas described educating their clients on various aspects of labor and delivery support prepandemic, in response to the pandemic they increased or modified the skill set they thought their clients might need. Doing so involved increased interaction with the clients' main support person attending the birth:

So, I have found some diagrams now of positions for pushing, so that [the] partner can actually bring those. So I go over that with them. [I say], "Okay, you need to try all of these. I know the hospital has a go-to for how they like women to push, but that's not necessarily in your best interest." So if I was there physically, [I] would be doing all of [this]. Let's get into this position, that position (Jennifer, a 55-year-old White doula).

The second way doulas helped clients confront the challenges of birth during COVID-19 was with additional emotional support before labor and delivery. Doulas drew on their stress-management skills to help their clients deal with their fears. This involved many conversations, through texts or phone calls, reassuring their clients that they and their families were safe and that their labor and delivery would proceed normally. Clients relied on their doulas more than usual because of the unprecedented situation and because they were deprived of regular access to their familial and provider support teams.

A third way doulas adjusted their care approach was by being available virtually. Although doulas varied in terms of their willingness to provide in-person care, all were forced to provide virtual care, either because they were not allowed in hospitals or because clients preferred to minimize personal interaction. All doulas were comfortable offering virtual support during pregnancy because they often communicated with clients by phone or video chat. However, most participants did not have experience offering virtual support during labor and birth and had to very quickly learn the procedures for engaging virtually with clients.

3.3 | Doulas' views of pandemic-induced changes in maternity care delivery

Participants had many criticisms of how the maternal health care systems in their regions had been handling the pandemic, including failure to implement early discharge programs for healthy mothers and babies, as well as failure to

open a separate, non-emergency room entrance to reduce potential exposure. However, the major areas of concern involved policies limiting doulas or support persons in the hospital. In considering the ways doulas' access to intrapartum clients changed with the pandemic, it is first helpful to contextualize prepandemic relationships between doulas and the US health care system. Participants reported that although they had collegial relationships with hospital staff before the crisis, they regard these relatively positive relationships as a result of efforts made almost exclusively by doulas. Doula argued that this is because hospital staff in general, and obstetricians most particularly, do not value their role as a source of support to birthing people, nor do they regard doulas as valuable members of the maternity care team. This is a source of great frustration for doulas, who feel that they should be regarded as vital and respected members of the care team.

In limiting or banning doula access to hospitals, the pandemic exposed what doulas feared—that they are low in the maternity care team hierarchy and not valued for the expertise they offer. It is important to note that not all doulas interviewed agreed that they *should* be allowed in hospitals during the pandemic. Participants described a doula community divided over whether they should be seen as essential personnel given how little was known at that time about the impact of SARS-CoV-2 on birthing people and newborns. Some doulas advocated for the opportunity to support clients in person, whereas others supported doula bans as protective for both the care team and the birthing family. Doula such as the one quoted below claimed that birthing people have the right to professional labor support:

But I do believe that we need to be seen as essential. We're not visitors. You know, we're not aunts and sisters and grandmas that are there to hang out. We are there because we're hired and we... you know, statistically, outcomes are better with doula support. There are statistics to support that. So, we need to be seen as essential and part of the team. (Jennifer, a 55-year-old White doula).

Several participants also raised equity concerns in this context and emphasized how well-documented inequities in birth outcomes resulting from structural racism have been exacerbated by the pandemic. Although most of the doulas served predominantly White, middle-class women, a smaller percentage of the doulas interviewed served minoritized populations, including socioeconomically disadvantaged, racial and ethnic minority, and queer/nonbinary populations.

Participants described the intersectional barriers to doula care that minoritized communities face, emphasizing the particular forms of discrimination and mistreatment Black

women all too often face at the hands of White doctors. These doulas were acutely aware that Black clients, like Black, Indigenous and People of Color (BIPOC) communities in the United States more generally, had lower access to COVID-19 tests, and greater concerns about being the targets of both disrespectful care and unnecessary interventions such as inductions or scheduled cesareans. They were also more likely to be affected negatively by policies limiting the number of support people in the labor room. As Lisa (a 33-year-old Black doula) described:

And traditionally most of my Black clients have wanted as much family as they could [to] come, you know, as they have available. I've been at births with five and six people in the birthing room with my Black clients. So I think that it's already being seen, the impact of not having that supportive family around, [which] is already impacting people of color's birth.

Not all doulas referenced inequities in maternal health care. However, all agreed that COVID-19 was exposing preexisting weaknesses in the maternal health care system that compromise the health of pregnant people and their babies. Problems they identified as being exacerbated in the crisis included: a lack of coordinated care, health professionals' lack of experience with unmedicated birth, pressure to adopt medical interventions, and disrespect of pregnant people's right to make informed decisions. Doula advocated for a system of coordinated care where they could be recognized as important parts of the care team and where hospitals employed diverse doulas on their staff members. They also called for better integration across birth settings that might have enabled healthy individuals with low-risk pregnancies to give birth at home or in birth centers with midwives during the pandemic. Such strategies would not only help reduce the spread of the virus during the pandemic, but might also improve maternal health in nonpandemic circumstances.

4 | DISCUSSION

An analysis of doulas' narratives provides insight into the struggles faced by pregnant and birthing people in the United States during the early period of the SARS-CoV-2 pandemic and reveals the strategies doulas employed for supporting their clients during this time of crisis. Doula also commented on pandemic-related adjustments in care and the ways these further disadvantaged patients who were already negotiating high levels of fear and anxiety to the unknowns of the virus. Overall, doulas perceived that their clients' challenges were a product of not just the threat of contracting the coronavirus, but also of the ways the health system managed the early days of the crisis.

Crises often reveal and compound society's systemic fractures and flaws,^{21,22} and the havoc wreaked by COVID-19 has been in no small part because of the preexisting shortcomings and failures of the US health care system prepandemic. That some pregnant people feel they need doula support in the labor room speaks volumes about the limited control and support they worry they will have in hospitals. The lack of input from patients and doulas on what level of support was needed reveals the single-minded focus of US obstetrics on technologies and disease management over and above—and sometimes completely to the exclusion of—any emphasis on birthing people's psychosocial needs. This “technocratic form of care”²³ has been described as hyper-valuing the clinical side of pregnancy and birth at the expense of more holistic perspectives on maternal and familial wellbeing, and scholars have associated such approaches with the subpar maternal and infant health outcomes in the United States.^{24,25}

Doulas in this study did not reject the value of biomedical approaches outright, but instead took a more humanistic approach,²⁶ which Davis-Floyd and Sargent^{27(pp81-82)} describe as aiming for “reform rather than revolution,” seeking to “soften the hard edges of techno-medicine.” Findings from this study correspond with research¹⁴ showing that most doulas desire a team-based approach to maternity care, as well as research^{26,28,29,30} showing that doulas are potential change agents. Emerging work¹⁴ shows that when confronted with physician resistance to client preferences, doulas engage in subtle maneuvers to resist the prevailing authority of physicians in a way that does not overtly oppose their authority, but that supports power sharing.

This work allows us some sense of how early policies were experienced by doulas and their clients and entails an explicit critique of the ways many hospitals were quick to remove access to critical support people. However, it is important to acknowledge that the doula community is not monolithic. Doulas were split as to whether they should have been allowed to work in hospitals in the early days of the pandemic. In addition, only a handful raised equity concerns explicitly. The latter finding is particularly concerning given the degree of inequity in health outcomes in the United States,^{33,35} as well as research showing that culturally matched, community-based doula and midwifery care can make a critical difference in underserved and minoritized communities.³³⁻³⁵ The voices of Black doulas in the study, in line with a growing body of research,^{36,37} elevate a clear call for birth advocates who serve minoritized clients.

4.1 | Limitations

The primary limitation of this research is that the results cannot be generalized to all doulas, as this work was qualitative, and therefore, intended to provide a deeper understanding of what

it was like to be a doula or doula's client in a few areas of the United States at the beginning of the SARS-CoV-2 pandemic. An additional limitation is that because of the few BIPOC participants in the sample, this study does not center the voices of racially marginalized groups. Future research should target doulas from BIPOC communities to understand the pregnancy and birth experiences of BIPOC individuals and the unique ways in which BIPOC doulas deliver support to their clients.

4.2 | Conclusion

Standing at the intersections of service users' and clinicians' worlds, doulas' unique position gives them a vantage point that can inform strategies and policies to better support pregnant people and optimize care in health systems disrupted by widespread infectious disease. Findings show that doulas' close relationships with pregnant and birthing people allowed them intimate knowledge of their clients' support needs. In addition, they were well situated to adapt to these needs when confronted with the emerging pandemic. If doulas were integrated as vital and valued members of the maternity care team, obstetricians and nurses would have ready access to important information about clients' needs and could collaborate to deliver information and nonclinical care to patients at a time of elevated need. Integrating doulas into maternal health care will take effort at the systems level; future doula research should investigate how doulas can be formally integrated into US maternity care.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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