‘Pop-up’ birth centers? Considering COVID-19 responses and place of birth in England

Cassandra Yuill, Christine McCourt and Lucia Rocca-Ihenacho

In Britain, antenatal and birth care in community settings is managed by midwives, and transfers to hospitals occur in the event of complications. Increasingly, research shows that for low-risk women, birth centers (midwifery units) are safer, beneficial for women, and cost-effective. Based on this evidence, UK maternity policy has promoted the wide-scale implementation of midwifery-led care and units, reorienting the locus of maternity away from the hospital and back into the community, where midwifery services historically operated until the mid-20th century.

In the wake of the COVID-19 pandemic, many services swiftly closed birth centers and centralized care into hospital units with on-site obstetric care, or Obstetric Units (‘OUs’), despite the risk of nosocomial infection. Closures generated pushback from parents, activists and researchers, some of whom have been championing ‘pop-up’ community birth centers in order to keep healthy women out of hospitals. In this brief, we critically examine the centralization of care during the pandemic and report on efforts to establish ‘pop-up’ birth centers in England.

Centralization of care in past and present

British domiciliary midwifery was a precursor to and model for the National Health Service (NHS). In the late 19th century, maternal and infant health came to be viewed as an important public health matter, leading to the creation of a free maternity service run by community-based midwives, in collaboration with general practitioners (GPs) who attended complications in birth. Homebirth remained the norm for many British women until the mid-20th century, as interest in hospital birth grew and obstetricians contended with midwives and GPs for control of birth care. The 1960s brought major shifts towards universal hospital birth, which were backed by government policy in 1970. This initial centralization process was consolidated further by the early 21st century under neoliberal health reforms, and there was a general push to merge smaller services into large administrative and service-provision units called ‘NHS Trusts’.

Mergers of OUs were predicated on clinical propositions that larger and more specialized units with constant senior medical presence would be safer and more 'efficient', drawing on evidence from elective operations and acute stroke care, yet evidence-based guidelines continue to advocate community-based birth care. A majority of NHS Trusts now have birth centers, though implementation and support of these facilities in practice is patchy. Before the COVID-19 pandemic, mapping of English maternity services demonstrated that birth centers have the potential to support about 36% of births but in actuality only support 14%. Moreover, birth centers located outside of hospitals ('freestanding midwifery units') can face closure, and they are perceived by the media to be "unaffordable luxuries" compared to centralized care, particularly if birth rates are low, although this does not reflect the evidence base.

In mid-March, as lockdown measures were stepped up, reports, mainly through social media and professional networks, emerged that birth centers and homebirth services in England were being suspended. Reasons given included midwifery shortages staff reassignments to labor wards, and gaps in ambulance availability. The suspensions were rapid, and there was little transparency from NHS Trusts about how and why such decisions were made. As a result, women became vocal about planning unattended births at home out of fears of exposure to infection, and giving birth without companions in hospitals. The Royal College of Midwives issued guidelines about 'Freebirth', advising midwives to respect women's choices, but the term seemed curiously incongruous at a time when many women contemplated this out of fear, in the face of rapid withdrawal of midwives from community to hospitals.

What followed was a flurry of activity, first online and then in newspapers, among pregnant women, healthcare professionals, maternity activists, and researchers attempting to make sense of sudden centralization and untangling what needed to be done to re-open, and even expand, community-based midwifery-led care at a time when hospitals were increasingly perceived by the public as risky. This was a chance to show the efficacy and safety of birth centers, both in crisis and beyond, and an opportunity to translate evidence into practice in pivotal ways. How could we respond and build momentum? For us, this meant generating statements, analyzing professional guidelines, updating social and professional networks, writing articles and applications, and rapidly convening meetings with stakeholders.

‘Pop-up’ birth centers

While hotels were rapidly being closed as part of lockdown measures, we mused on the possibility of finding creative temporary uses for them, reminded of the conversion of country houses during World War II to provide maternity care away from the risk of the ‘blitz’ in British cities. Near the end of March, a Dutch midwife shared a video on a professional network’s Facebook group that described how a hotel near a hospital in Bernhoven converted three rooms into a birth center. Encouraged by this, working groups, proposals and digital workshops were quickly conceived by key researchers and stakeholders, to identify possible locations and receptive NHS Trusts. For stakeholders, there was a sense that we could create ‘pop-up’ birth centers like the Netherlands, that they could be set up in a few days with the same equipment used by homebirth teams, and that this would be a proactive way to adapt, rather than centralizing births in hospitals.

There were growing concerns of heightened risk of infection in hospitals, and how this would intersect with the higher risks of interventions that come with hospital births, potentially generating additional risks through longer stays, and greater demands on health personnel and acute medical resources like operating theatres. Uncertainty about COVID-19 infection and its effects permeated – and continues to govern – every part of life and decision-making. However, we did know that settings located outside of areas where infected people were being cared for conferred additional safety. London, one of the hardest hit areas, has few freestanding midwifery units but many hotels, so the city would have benefited from ‘pop-up’ birth centers, particularly in Northeast London, where there is high population density and infection rates were worse.

The momentum among midwifery-led care advocates was there; the desire among women to avoid hospitals was increasingly prevalent. A hotel broker, who was also an active member of her local maternity group, was on board to begin identifying eligible buildings. All that remained was finding a service willing to pilot a ‘pop-up’ birth center and the support of NHS England and professional bodies (the Royal Colleges of Midwives and of Obstetricians and Gynaecologists). This support never materialized, and without it, no services stepped forward. To date, there are still no statistics on which trusts suspended their community-based maternity services and which kept them in operation.

Closing thoughts

Why has a creative solution based on evidence and rooted in alleviating hospital strains and promoting families' wellbeing been ignored? To date, there has been no recognition from NHS England or the Royal Colleges of the idea of 'pop-up' birth centers. Despite authoritative evidence and guidelines and efforts to shape more distributed services, English maternity care is still concentrated around obstetrics and centralized in terms of place and power, and the silences around community-based birth settings and solutions insure this remains so. Silence, as anthropological research has shown, can demarcate presence rather than absence in social life, taking on a tangible potency through unspoken actions that communicate and transmit the past. In our experiences of working to promote community-based care and 'pop-up' birth centres during the ongoing pandemic, silences were not only 'normative co-presences' but also strategic, carrying traces of the history of English maternity care and defining how decisions are made and maintained in the present.

What we have mainly noted is that centralization imperatives are a confluence of powerful precedents about where birth *should* take place, and distributions of power between community and hospital. Centralization also highlights how the notion of essential is consituted in maternal health is constructed and reified in services. Birth centers are still considered to be outside, alternative and optional, even if the policy rhetoric says otherwise. The very boundary or otherness that led increasing interest in birth centers, once hospitals were no longer assumed to be the safest place for birth, also led their potential value in the crisis to be disregarded. Instead, resources were retrenched into what is seen as essential and normal – the OU – and many women were left feeling powerless, afraid to go to hospital in labor, faced with the possibility of limited social support and contemplating 'freebirth' at home.

What can we, as anthropologists and advocates, do to make the most of our knowledge and support stakeholders and our interlocutors? The British health and care system, despite its many strengths, is deeply and affectively entrenched in conceptualizations of risk and safety mediated by historic hierarchies and power imbalances. NHS responses to COVID-19 throw a clearer light on how these underlying issues have remained unspoken in attempts at maternity reform. Anthropologists have a responsibility then to be outspoken in our critique of the gaps and contradictions between health-policy and healthcare, particularly when it concerns reproductive rights and the safety and wellbeing of families. We also have a responsibility to assist our interlocutors in their actions to improve healthcare, especially in

times of crisis, to practice public anthropology and use our expertise to enhance creative solutions.

Dr Cassandra Yuill, PhD is a medical anthropologist, specializing in maternal health. Her research focuses on health decision-making, particularly about maternity care, in the United Kingdom. Her key interests include place of birth, interaction of policy and maternity services, and midwifery-led care. She is a Research Fellow in the Centre for Maternal and Child Health Research at City, University of London.

Prof Christine McCourt, PhD is Professor of Maternal and Child Health, School of Health Sciences, at City, University of London. Her main area of work has been on maternity and women's health, with particular interests in institutions and service change and reform, on women's experiences of childbirth and maternity care and in the culture and organization of maternity care.

Dr Lucia Rocca-Ihenacho, RM, PhD is an academic midwife and social scientist who is passionate about empowerment and facilitating change. Her academic work focuses on supporting the development of positive team culture and the scaling up and implementation of midwifery units, especially in countries where they are not a reality. She is a lecturer in the School of Health Sciences at City, University of London and CEO of the Midwifery Unit Network.