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Australian women's perception of their preparation for and actual experience of a recent scheduled caesarean birth

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ABSTRACT

Objective: to add to knowledge around women's perceptions of their preparation for and actual experience of a recent scheduled caesarean birth.

Design, participants and setting: a mixed method study incorporating a postal survey and one-on-one interviews was used. The survey provided feedback on resources to prepare women for their caesarean birth such as a positive birth class, DVD and birth plan. Women were also invited to participate in an interview to share perceptions of their preparation and actual birth experience.

Participants attended the only public obstetric tertiary hospital in Western Australia and experienced their caesarean birth between August and December 2012 ($n=256$). Frequency distributions and univariate comparisons were employed for categorical data, whereas thematic analysis was undertaken with transcripts to extract common themes.

Findings: data reflect 46% (117 out of 256) of women returned a postal survey. The interview option was removed after three months of data collection, when 38 women were interviewed and data saturation was reached. Of the 61% (71 of 117) who completed a birth plan, 59% (42 of 71) felt it was used to guide their care. Only 38% (44 of 117) were able to stay together with their (baby and partner) in recovery. Thematic analysis revealed a positive theme suggesting their experience 'couldn't have been 'better' with sub-themes: 'involved in care'; 'informed the whole way through'; 'magical for him to be near me' and 'everything was done brilliantly'. Negative reflections centred around 'we were just a number' and included four sub-themes: 'no option'; 'still had questions'; 'separated from him and her' and 'none of it happened'.

Conclusion: acknowledgement that a scheduled caesarean section is more than a surgical procedure, but a birth is paramount. For women to have a positive birth experience we must respect their wishes within their birth plan and embrace a family friendly model, where mothers, partners and babies can stay together.

Introduction

Caesarean sections were traditionally categorised as elective or non-elective. However, the term elective caesarean section (CS) is being replaced with terms like prelabour CS, scheduled CS (SCS) or maternal requested CS without medical indications to reflect the context around the decision to perform a CS (Gallagher et al., 2012; Hutton and Kornelsen, 2012; Li et al., 2012). A prelabour or scheduled CS may occur due to medical indications or maternal request without medical indications (Arthur and Payne, 2005), however, evidence suggests the latter represents a minority (Weaver et al., 2007; Hutton and Kornelsen, 2012). Psychological issues such as fear and maternal perceptions of risk are recognised as major factors for maternal requested CS (McCourt et al., 2007; Weaver et al., 2007; Gallagher et al., 2012). A maternal requested CS influenced by fear and perceptions of risk may be based upon assumptions that CS will be safer than a vaginal birth (Fenwick et al., 2009; Sahlin et al., 2013). There is ongoing debate whether maternal requested CS is gaining cultural acceptance,

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especially amongst first time mothers (Sahlin et al., 2013) as childbirth trends may be a reflection of our technocratic society (Davis-Floyd, 2001).

Due to evidence confirming the risk of CS for both the woman and baby (Menacker and Hamilton, 2010), health institutes in England and America have issued statements that CS should not be offered where the woman and her baby are well (National Institutes of Health, 2006; National Institute for Health and Care Excellence, 2013). However, data from the United States suggest that targets to reduce the overall rates of CS for low risk women are not being met (National Institutes of Health, 2006). The rates of SCS have increased slightly over the last decade. However, in 2011, a SCS represented 40% of all women having a caesarean in England (National Health Service Maternity Statistics, 2012) and 59% of all Australian women (Li et al., 2012) having a caesarean for any reason. In England, the rates of SCS have changed little from 9% in 2001 (National Health Service Maternity Statistics, 2002) to 10% in 2011 (National Health Service Maternity Statistics, 2012). In Australia, the proportion of women having a SCS increased from 14% in 2001 to 19% in 2010 (Li et al., 2012), with Western Australia's (WA) SCS rate being 17% (Hutchinson, 2012). Research suggests this increase may be the result of more WA nulliparous women being delivered in the private sector (Einarsdóttir et al., 2013). The rates of SCS are difficult to quantify in America as there is insufficient evidence to evaluate this mode of birth (National Institutes of Health, 2006).

Although overall caesarean birth experiences have been studied extensively, less is known about women's perceptions of their scheduled caesarean birth. A different birth experience unfolds for women who request a caesarean, compared to those who perceive they have no autonomous choice even though both may view caesarean as a controlled mode of birth (Kingdon et al., 2009). The woman who has no autonomous choice in her caesarean, may experience grief at the lost opportunity for vaginal birth, thereby decreasing the likelihood of perceiving her birth experience as positive (Lobel and DeLuca, 2007; Bayes et al., 2012a).

Women experiencing a SCS have reported feeling insufficiently informed about the processes involved with their birth (Horey et al., 2011; Blüml et al., 2012). Lack of information and involvement in decision making around a woman's caesarean can reduce her sense of control (Lobel and DeLuca, 2007). Information can be perceived as too clinical (Bayes et al., 2012b), encouraging some to turn to non-clinical sources such as advice books (Kennedy et al., 2009) and the media (York et al., 2005). Imparting information in a clear, precise, easy to understand, consistent manner can assist women to quantify their risks and negotiate the rules around their birth (Kennedy et al., 2013), which in turn may reduce fear, anxiety and stress (Mansfield, 2008).

Scheduled caesarean section limits control over one's body which can trigger anxiety (Malacrida and Boulton, 2014). An important aspect of control around SCS relates to empowering women to translate their informed wishes into practice (Shorten et al., 2005). Positive birth experiences have been found to be contingent upon achieving most, or at least the priority childbirth expectations (Hauck et al., 2007). However, translating women's plans into lived experiences is often not achieved, despite extensive planning and preparation to execute their preferences through tools such as birth plans (Malacrida and Boulton, 2014). To address the gap in knowledge around perceptions of a scheduled caesarean birth and illuminate what may constitute a 'positive' experience, we set out to add to the body of knowledge by exploring women's perceptions of their preparation for and actual experience of a recent scheduled caesarean birth.

Methods

Design, participants and setting

A mixed methods design was used to explore women's perceptions of their preparation for and actual experience with a recent SCS. Mixed methods are ideally suited to provide insight into complex issues where further in-depth knowledge is required (Polit and Beck, 2010; Creswell and Plano Clark, 2011). This manuscript focuses on qualitative findings and briefly presents quantitative results. This study was performed at King Edward Memorial Hospital (KEMH), the only public obstetric tertiary hospital in WA, which has approximately 6600 births annually. Women scheduled for caesarean at KEMH are invited to complete a semi-structured SCS birth plan. They have the opportunity to attend a pre-admission clinic where they meet with an anaesthetist; talk to a midwife; and view a DVD (providing information on what women can do in preparation for their SCS and what to expect on the day and within the early postnatal days). Some choose to attend a monthly caesarean birth class offered to all women having a SCS which incorporates an operating theatre tour. Our sample included English speaking women, who had attended KEMH and delivered their baby through SCS between August and December 2012.

Recruitment and data collection

This study was performed in two stages. In stage one 256 women were invited to participate in an in-house designed two page postal survey with a reply paid envelope sent to their home address two weeks following their SCS. The survey was accompanied by an information letter used to gain implied consent informing women their responses would be confidential. It explained the study aim and why they were being invited to participate. The survey was not piloted as a previous version had been successfully used for women having a next birth after CS (Hall et al., 2012).

The survey determined if women had attended a caesarean birth class, viewed the DVD and completed a birth plan. Women ranked the usefulness of these resources and confirmed whether they felt involved and included in planning for and during their actual caesarean birth. Feedback on how these resources could be improved was sought. Overall satisfaction with their recent SCS was obtained using a Likert scale of very dissatisfied to very satisfied.

In stage two, interested women participated in a semi-structured audio-recorded telephone interview. Women were given the option to leave their contact details at the end of the survey if they wished to share further details about their preparation and actual SCS with a research midwife. This option was removed after three months of data collection, when 42% of women (38 of 90 respondents) had been interviewed and data saturation achieved. Prior to the interview active consent was sought confirming the woman was still willing to share the details about her preparation and actual SCS; that her confidentiality would be maintained; and she was willing to have her interview tape recorded. Interviews lasted between 5 and 25 minutes. At this time 77% (90 of 117) of women had completed the survey. Verbatim transcripts of the interviews and field notes were stored on a password protected computer in accordance with national guidelines (National Health and Medical Research Council, 2007). Ethical approval was obtained from the Women and Newborn Health Service Human Research Ethics Committee (4320/EW).