Using a novel approach to explore women's caesarean birth experience

Abstract

How a woman experiences birth is influenced by how she is treated, and who has power and control in the birthing environment. Focus on 'delivery' of an infant disregards the transformative event for the woman, with poorer physical and psychological outcomes. New evidence is needed to understand how to prevent trauma and improve maternal wellbeing. This paper presents a feminist methodology to view the lived experience of caesarean birth. Feminist birthing theories integrated with a phenomenological perspective provide insight for those working in maternity care and create a novel framework for researchers considering the position of women in a medicalised healthcare system. Feminist phenomenology with a theoretical feminist overlay refreshes the methodological framework for a new understanding of how this perinatal event impacts women.

Keywords

Birth experience | Caesarean section | Feminism | Midwifery | Phenomenology | Women

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Caring for women through childbearing has traditionally been carried out by other women trained through both lay and professional apprenticeships (Davison, 2020; Reed, 2021). The medical paradigm of hospital-based, male-controlled, obstetric care has increasingly dominated from the 19th century, moving away from female, midwifery-led, home-based care (Reed, 2021). The health and survival rates of women and babies have improved with medical advances and training; however, it has increasingly removed the woman as the person of greatest value in the birthing space. This is now associated with increasing levels of physical and psychological birthing trauma. In high-income countries, maternal morbidity and mortality is increasing, despite the plethora of scientific advances (Hoyert, 2023). Gender equality, political empowerment of women and maternal birthing outcomes are closely linked with midwifery-led, woman-centred care, rather than the obstetric-led model, and are known to improve results for women and their babies (Bhalotra et al, 2023).

The position of the midwife has increasingly diminished, to the point where these healthcare professionals are valued as a specialist nurse rather than a profession in their own right (Drife, 2023). This is in contrast to midwifery training models, which have continued to advocate for woman-centred care, physiological labour and birth targets, and autonomous continuity of midwifery care (Crepinsek et al, 2023). The definition of a midwife is one who is recognised as an accountable specialist who works across the perinatal spectrum in partnership with women, their family and the community (International Confederation of Midwives (ICM), 2017).

Evidence is mounting showing that midwifery care is safest for most women and babies as well as being more viable for the healthcare system (Gamble et al, 2021). The medicalisation of the normal progression of labour has led to poorer outcomes, particularly maternal (Reed, 2021). Interventions have resulted in externalising the fetus as a separate entity from the woman and undermined her embodied knowledge and

right to bodily autonomy (Melamed, 2023). Interfering unnecessarily in pregnancy, labour and birth leads to poorer outcomes and negative birth experiences (Dahlen et al, 2022). Birthing by caesarean section further reduces maternal control, exacerbated by separating women and their infants at birth, causing distress and trauma (Deys et al, 2021). Women are now demanding evidence-based maternity care led by midwives through consumer advocacy networks and parliamentary inquiries (Boecker, 2023).

According to the International Code of Ethics for Midwives (International Confederation of Midwives, 2014), midwives partner with, empower and support women to be active participants in deciding how they birth. The Australian Code of Conduct for Midwives (Nursing and Midwifery Board Ahpra, 2018) identifies the values and domains to which the midwife must abide, focusing on safe, woman-centred care that is respectful, honest, and compassionate. The Australian Government (2020) describes woman-centred care as focused on the uniqueness of each woman's needs, choices and right to bodily autonomy. Similarly, in the UK, the Royal College of Midwives (2014) has policies that promote woman-centred, respectful care. While these standards appear to guide the care of birthing women, the majority of maternity services in Australia are policy, not woman-focused. This highlights the obstetric hierarchical barriers that protect the system and its practitioners, an issue that other countries are attempting to address (Dahlen et al, 2023).

Research using a feminist, qualitative framework aligns with the midwifery content and context of working 'with woman' in all models of care and all birthing environments (Hawke, 2021). It is less about the gender identities of the health professionals and birthing people, and more about the history that set up the systems. It follows the central principle of woman-centredness that midwives learn, work and teach in. Qualitative midwifery research seeks to place value on the unique position of the midwife in academic exploration, moving away from the dominating and favoured quantitative, medical model that leads the health system (Newnham and Rothman, 2022). This article shows the development of phenomenology into a feminist approach, enriched by the novel perspective of two feminist birthing theories, to address knowledge gaps for women experiencing birth by caesarean section.

Phenomenology

Phenomenology can describe how an event, such as birth, is understood in the landscape of surrounding experiences and overall context (Dodgson, 2023). The subjective and contextual approach suits health research in providing the rich data of patient encounters in health services. Examining and understanding participant reflections of personal experience, such as in maternity care, can help inform policy and practice and improve outcomes well beyond morbidity and mortality.

Foundational work by the philosopher Husserl highlighted and distinguished between the physical and mental experience to show essence or true meaning (Dowling and Cooney, 2012). This required the researcher to set aside, or bracket, their own beliefs or assumptions to be able to fully understand and describe the experience of the participant. However, in the maternity care landscape of historical gender inequality and sexual difference, it could be argued that complete bracketing is ineffective, with the experience potentially influencing both researcher and participants alike (Mann, 2018a).

Heidegger further developed phenomenology to move beyond describing the experience to the interpretation of hidden meanings, which identified and included the beliefs of the researcher (Dowling and Cooney, 2012). This hermeneutic style clarified the context and is well-suited to midwifery-led research, where midwife and woman are entwined metaphorically, physically and contextually (Dowling and Cooney, 2012; Miles et al, 2013). The relationship between researcher and participant is seen as a fundamental concept of phenomenology (Dodgson, 2023) and is reflective of the midwife-woman connection.

Feminist phenomenology

Research in general, including phenomenological enquiry, tends to be grounded in a patriarchal world view, where the 'normal' human experience is often androcentric (Bailey and LaFrance, 2017; Mann, 2018b). Historically, studies and philosophies have used man as the standard (primary) and woman as 'other' (secondary), implying lesser value (Beauvoir, 2009; Bailey and LaFrance, 2017). Female experiences have been dismissed as subjective and personal, rather than philosophical and valuable (LaChance Adams and Lundquist, 2013). Feminist phenomenology enables recognition of subjective and social constructs, stripping it back to identify the uniquity of female experience (Zeiler and Käll, 2014). It supports an inquiry about women as both the primary subject and the frame of reference (Mann, 2018b). Birth experience as a phenomenon impacts women.

Feminists have explored the shared circumstances of women, pregnancy and motherhood, the contexts and experiences that are both connected and individual, and influenced by each woman's history, culture and background (LaChance Adams and Lundquist, 2013). Feminist phenomenology accounts for these distinctions in the broad landscape of women and birthing. This is in

contrast to the authoritative, patriarchal obstetric model, which has progressively focused on fetal wellbeing and selfhood over that of the woman (Melamed, 2023). Devaluing the female body to one of an organic, and often faulty, machine to create a child has reduced women's agency over their own bodies (Davison, 2020; Reed, 2021).

Traditional research offers a male-dominated view of the world, even when the subjects are female (Shabot and Landry, 2018). Research continues to under-represent women in human studies, particularly those who are pregnant or breastfeeding. Applying feminism to phenomenology informs the context of sexual difference in experiences such as pregnancy and birth, illness and pain, and what health means to individuals.

As an early feminist, Beauvoir (2009) argued that woman was more than a 'womb' and motherhood, seeing reproduction and fertility as the link to society's subjugation of the female sex. She described femininity, womanhood and becoming a mother as being connected to the ontological expectation of a female. Beauvoir (2009) gave no thought to any innate desire a woman may have to be a mother, perhaps because in her era, marriage was the only choice for a woman that was socially acceptable. Moving on to the 21st century, there continues a stereotypical tendency to bring up girls to nurture, help and behave, and expect 'boys to be boys', in other words masculine, aggressive and dominant (Ford, 2018a). This dominance is demonstrated in feminist sociocultural models of both rape (Walsh, 2015) and obstetric-led maternity care (Fahy et al, 2008). Women and midwives commonly describe birth experiences as 'rape', violent, non-consensual and dominating (Shabot, 2016).

Contemporary feminists have largely avoided the rights of the birthing woman and 'mother', focusing on women's rights in society and employment (Hill, 2019). While acknowledging the disparity of where women live and birth, questioning the need for disproportionate interventions and highlighting the powerlessness of the woman, pregnant and birthing women have been otherwise left out of the sense of urgency for feminist reform, except in the reproductive choice of termination (Ford, 2018b). Feminist research in the birthing space seeks to identify and rectify these gaps and inform policy and culture.

Connection: feminism, feminist phenomenology, mother and midwife

In a landscape of insignificance, birthing women are valued more for their ability to carry and birth a healthy child than make decisions about their own wellbeing. Around the world, religious and government regulations continue to control a woman's reproductive right to prevent, space or end pregnancy (LaChance Adams and Lundquist, 2013; Hill, 2019). Choosing to not become a mother can be ridiculed or denied, where the choice of marriage, sex and procreation may not be the woman's to make (Leach, 2020). However, many women continue to desire and strive to be mothers, as demonstrated by those who are unable to become one without medical intervention (Ulrich and Weatherall, 2000).

Conceiving, carrying and birthing a child is understood and experienced as a transformation of woman to mother, hormonally and culturally driven, and unique to those of female sex (Ulrich and Weatherall, 2000). Using a feminist approach to understand the experience of women identifying as women is not trivialising a gendered point of view to diminish others, but recognises the significance of a woman's experience (Mann, 2018b). Feminism does not seek to devalue those who choose not to use the terminology of 'woman' or 'mother', but continues to highlight the historical undervaluing of women and advocate for those who remain the majority of birthing persons (Gribble et al, 2022).

A midwife is educated in the holistic nature of birth, using a mind, body and spirit understanding of how each element impacts the experience and outcomes for women (Miles et al, 2013; Moloney and Gair, 2015). It is well understood through both cultural transmission of knowledge and research that the emotional and spiritual experience of the woman can and will impact normal labour progression, hormonal patterns and ongoing mothering, her embodied self (Fahy et al, 2008). This has the potential to affect the future of the woman's family, as well as the society in which they live, across many generations. Midwives have a unique role to guide and protect a pregnant and birthing woman to enhance positive experience and outcomes well beyond the birthing room. Feminist phenomenological research can examine the roles of both mother and midwife, through the intellectual, emotional, and ideological perinatal experience.

Linking feminist theory with methodology

The use of feminist theories aligned with a feminist phenomenological research enquiry provides a framework with which to better understand and analyse data collected. Two that are particularly suited to the experience of birth from a midwifery context are that of the 'Birth Territory Theory' by Fahy and Parratt (2006) and Reed et al's (2016a) 'Childbirth as a Rite of Passage'. Both focus on the importance of woman-centred care and the role of the midwife

in protecting women's physical, emotional and spiritual rights. This fits with both the Heideggerian understanding of lived experience and the holistic model of midwifery care, which seeks to understand mind, body and spirit of the individual woman (Miles et al, 2013; Moloney and Gair, 2015).

Key points

- Negative birth experiences are increasingly acknowledged as related to how women are treated during pregnancy and childbirth, and a feminist issue.
- Woman-centred care, led by midwives, can improve the experience for women.
- The patriarchal medical system negatively impacts both the birthing women and the midwives caring for them.
- This paper shows a new framework to understand birth experience using a unique feminist methodological and midwifery-based theoretical approach.

Birth territory

The theory of birth territory describes and predicts birth outcomes and the woman's experience through the relationship between the physical birthing environment and balance of power and control (Fahy and Parratt, 2006). It defines key concepts that can be used to guide the understanding of women's birth experiences for research and practice. Fahy and Parratt (2006) define the birth environment or 'terrain' of two extremes, 'sanctum' or 'surveillance room'.

In current hospital-based models of care, most birthing environments sit somewhere along this continuum, with midwives ideally working towards reducing a surveillance room atmosphere. The safe, private and optimal sanctum promotes normal labour and birth, where the woman feels in control and supported. The more the terrain deviates to that of the surveillance room, clinical and focused on the staff's needs, the greater the fear and poorer outcomes for the woman (Fahy and Parratt, 2006). The woman has limited choice, less bodily autonomy and is unable to rely on her own intrinsic knowledge and power in the surveillance room (Fahy et al, 2008). While it would be ideal for all women to birth in the sanctum, realistically, measures that improve medical safety can be necessary but often increase fear and reduce satisfaction for the woman, including the operating theatre.

The balance of this theory is the presence of power and control in the birthing environment, explained as 'jurisdiction' by Fahy and Parratt (2006), divided further into 'integrative power' and 'disintegrative power', 'midwifery guardianship' and 'midwifery domination'. Even in the more medicalised and obstetric-led model of birthing care, a midwife or other healthcare provider acting in the guardianship role can return power to the woman by enabling feelings of safety and sense of control. They can promote the woman's integrative power of mind, body and spirit to make decisions for herself and her birth (Fahy et al, 2008). This can impact a woman's overall experience irrespective of the labour or birth outcome.

The environment of an operating theatre for a caesarean section birth provides the extreme example of a surveillance room. This medical environment, set up to meet the needs of the clinicians performing the procedure, limits physical function and the emotional wellbeing of the woman, while increasing fear and emotional distress. The midwife does not attend as accoucheur, so is well placed to advocate and ensure care is centred on the woman by seeking consent and choice, promoting skin-to-skin contact, and not separating her from her baby. This has been shown to improve the birth experience of women who have a caesarean section (Deys et al, 2021).

Childbirth as a rite of passage

The role of the midwife as a woman-centred guide and protector is explored further in the theoretical framework of childbirth as a rite of passage (Reed et al, 2016a). The birth journey is described through three phases: separation, liminality and incorporation. This is understood as the woman minimising external and internal distractions, entering into an altered state of awareness, and finally, with the birth of the baby, reintegrating with the external world, adding her experience into her sense of self (Reed et al, 2016a). A positive experience is closely associated with the protection and care a woman receives during her labour and birth and feeling in control of her body and her baby (Reed, 2021).

Reed et al's (2016b) theory balances the rites of passage with the rites of protection in woman-centred care, maintaining the safety of the woman and assessing labour progress, without distracting her from her internal wisdom, framing the woman as the expert of herself. Even in a medicalised birth scenario, such as caesarean section, respectful and kind midwifery care that advocates and supports choice empowers the woman to be her embodied self and have a positive experience (Reed, 2021). Reed et al (2016a) connects the transformative passage of woman to 'mother' with the experience of birth, rather than the birth itself.

These theories provide the structure needed to understand the depth of perinatal experience. They highlight the importance of the metaphysical aspect of birthing and the influence of power and control. Pregnancy, birth and motherhood all intimately entwine to form the lived understanding for the woman, no stage separate or less significant for how she feels.

A feminist phenomenological framework to understand caesarean birth experience

A positive birthing experience should not depend on modality or environment. Women should expect safe and compassionate care at any birth, leaving them empowered and satisfied. The impact of birth extends well beyond the perinatal period, influencing the mother–child relationship, emotional wellbeing and if or when she will have future children (Deys et al, 2021). How a woman is made to feel during her birth impacts the overall experience. Positivity and empowerment are derived more from the way a woman is treated than how she births (Reed et al, 2017).

A caesarean section birth is known to increase the risk of a negative birth experience, limiting or removing power and control over a woman's own body, choices and baby (Deys et al, 2021). The woman is more likely to be separated from her baby, compounding the lack of control they have, to see, feed and hold their newborn (Deys et al, 2021). Midwives continue to be present for a caesarean birth, creating the opportunity to be 'with woman', guarding, respecting, protecting and supporting the woman and the environment. Creating a safe setting in an operating theatre is less about the equipment and architecture and more about the people in that space. It is about the social hierarchy, physical control and the perception of power and how the woman is ranked in priority in that birth setting. A feminist lens creates the opportunity to view a caesarean birth from the woman's unique perspective and positively influence her experience of birth and transition to motherhood.

Conclusions

Midwives are philosophically and ethically best placed to work in both a feminist and a woman-centred framework. Their professional and educational bodies, which define and demonstrate midwifery practice, direct midwives to provide safe, respectful and supportive maternity care. It is well within their domain to advocate and act for the change needed to improve birthing experiences for women in all birth scenarios.

The use of feminist phenomenology provides the structure for researchers to explore birth experience in a landscape of increasing birth trauma and obstetric neglect. It is grounded in feminist philosophy and can be developed further by the lens of these two feminist birthing theories. **BJM**

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CPD reflective questions

- What element of maternal care most influences a woman's birth experience?
- What are the challenges for midwives who strive for woman-centred care in the hospital setting, and what can you do to make change?
- Do midwives still have a primary woman-focused role in the operating theatre?
- Can a feminist viewpoint be reflected in clinical care?
- How does a feminist lens in midwifery research create change?

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