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"Where's my baby?"

What is the maternal experience of separating well mothers and babies at caesarean section birth?

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A thesis submitted in the fulfilment of the requirements for the degree of

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Faculty of Health Sciences

2024

Statement of Authorship and Sources

I, *Linda Deys*, declare that this thesis, submitted in fulfilment of the requirements for the conferral of the degree Doctor of Philosophy, from the Australian Catholic University, is wholly my own work unless otherwise referenced or acknowledged. This thesis contains no material that has been extracted in whole or in part from a thesis that I have submitted towards the award of any other degree or diploma in any other tertiary institution. No other person's work has been used without due acknowledgment in the main text of the thesis. All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required)

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Verification

This statement verifies that the greater part of the work in the named manuscripts is attributed to the candidate. *Linda Deys* conceived and designed the research project and undertook data collection and analysis. She prepared the first draft of each of the manuscripts for publication and responded to the editorial comments of co-authors. *Linda Deys* prepared articles for submission to the relevant journals and responded to reviewer and editor comments to finalise the manuscripts for publication.

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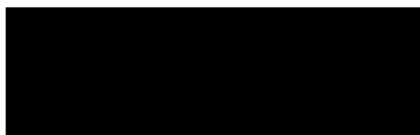

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Abstract

Problem: Separating women and babies in the first hours after birth reduces birth satisfaction and contributes to a poor birth experience and trauma.

Background: The experience of birth is as individual as the women who are birthing, a complex interaction of when, where and how, influenced by people both in and out of the room. This experience changes the woman in an instant, as she transforms to 'mother'. She is changed physically, emotionally and spiritually, and how she feels during each of her births will remain with her over a lifetime.

In a landscape of birth trauma recognition, simply becoming a mother and getting a 'healthy baby' is not enough. Negative experiences of birth affect maternal mental wellbeing, parenting, relationships and future pregnancy planning. The experience of fear, loss of control, grief and shame are influenced more by the people and environment the woman births in than how her baby is born.

Birthing by caesarean section increases the risk of separation and is known to reduce maternal satisfaction and negatively impact transition to motherhood. It is often not the woman's preferred mode of birth and commonly occurs in an emergency scenario. Operating theatres are cold, bright, sterile, and noisy, the opposite to the ideological environment for a baby to be born. This further limits bodily autonomy for the woman and increases fear. While alterations to the physical environment can be minimal, adjusting the clinical practice of care givers in the birthing space can improve the experience for women.

Keeping a woman in close physical contact with her baby after birth, ideally skin-to-skin, is known to create a positive experience. This facilitates a sense of control over her own body and baby which improves the overall experience alongside bonding, mothering and feeding outcomes. While this has been standard practice at vaginal births for many years, women birthing by caesarean section continue to be separated from the baby at birth even when both are well.

This study was conceived through an antenatal lactation clinic environment where I supported women with previous breastfeeding issues. While breastfeeding is well known to

be negatively impacted by the separation of the mother and baby, it was clear that their experiences were about more than poor breastfeeding outcomes. Women who had birthed by caesarean section stood out as they recounted the experience of being separated from their baby. No skin-to-skin, not knowing if the baby was safe, and the ongoing trauma associated with this separation. Evidence on the benefits of skin-to-skin and policies to support it were not enough to make this standard practice within my local health district. This anecdotal experience of women was not valued as sufficient proof to change practice and there was insufficient evidence to be found in the literature to support this important aspect of caesarean birthing.

Aim: The aim of this research was to understand the experience of women who were separated from their baby at caesarean section birth without a medical need.

Methods: Participants were purposively sought through a social media maternity advocacy group in one local health district. Inclusion criteria included women who had birthed by caesarean section in the previous ten years and had been separated from their newborn baby without medical indication. Fifteen women from across Australia were subsequently interviewed using an unstructured phenomenological interview style. Data was coded with NVIVO software then analysed using a Modified van Kaam approach. A novel feminist phenomenological framework embedded with two birthing theories was then used to explore the experience of the participants.

Findings: The results of this research exposed the significant trauma experienced by all study participants from both the separation event and overall perinatal care. Four major themes emerged from the data and characterised the experience of being separated from one's healthy baby at caesarean section – *Disconnection* (from their own body, baby and partner), *Emotional Turmoil* (intense and prolonged feelings that impacted their significant relationships), *Influence* (displaying the vulnerability and unequal balance of power for women) *and Insight* (the reflection and wisdom of women as they came to terms with their experience).

The importance of the birthing event and the transition to motherhood did not appear to be acknowledged by the health care providers caring for the participants. Provider and facility needs were valued above those of the woman, decision making and control were balanced

firmly in favour of the hospital, and the powerlessness and subsequent violation of human rights of women were not recognised. Woman-centred care is a notion that appears frequently in maternity services policy and education and linked to midwifery care through foundational and ethical documents. However, this did not translate to woman-centred practices as shown by the participants stories.

Conclusion: Separating mothers and babies at caesarean section birth causes and exacerbates significant trauma for women. Midwives are particularly well placed to advocate for, protect, and support women to have choices around their pregnancy and birthing care. Within the operating theatre environment, a midwifes purpose is similar to that of the birthing unit - to provide and relay information, encourage and emotionally support the woman, and observe for signs of wellbeing in mother and baby. Enabling the woman to have skin-to-skin with her baby and not be separated promotes essential physical and emotional health and should be recognised for its significance in perinatal care. Midwives are the key in keeping mothers and babies together and improving birth experience.

Key Words: women; skin-to-skin; feminist; caesarean section; birth; mother; midwife; phenomenology

Publications and Conference Presentations from this Research

Papers:

1. Deys L, Wilson V & Meedya S (2021) What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. *Midwifery*, 101, 103063. https://doi.org/10.1016/j.midw.2021.103063

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International Normal Labour and Birth Conference, India (Virtual). 2-4th December 2020. *What are women's experiences of immediate skin-to-skin contact at caesarean section when mother and baby are well?* Poster presentation.

UOW School of Nursing Research Conference. November 2021. *Through the eyes of a midwife: Using a feminist phenomenological approach to explore maternal birthing experience.* Virtual-oral presentation.

SESLHD & ISLHD Person-Centred Masterclass Presentation, July 2022. *Valuing women in maternity care – how a woman-centred approach improves birth experience.* Virtual-oral presentation. **Invited Speaker.**

Virtual International Day of the Midwife (VIDM) Conference. 5th May 2023. *"Where's my baby?" How do women experience separation from their baby at caesarean section birth.* (preliminary findings). Virtual-oral presentation.

Lactation Consultants of Australia and New Zealand (LCANZ) Conference. 20-21st October 2023. Melbourne, Australia. *Breastfeeding In Spite Of.* Oral presentation.

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Publications, Presentations and Achievements Concurrently with this Research

Papers:

Deys L (2022) We did it!! Our BFHI journey. Australian Midwifery News, 31(1), 56-57. https://search.informit.org/doi/10.3316/informit.819845067331456

Conferences:

International Confederation of Midwives Triennial Conference, Bali, Indonesia. 11-14th June 2023. *Supporting ability: using a woman-centred approach to care for a woman with significant disabilities through pregnancy, birth, and breastfeeding.* Oral presentation.

Webinar presentations - invited speaker:

Australian College of Midwives. 23rd November 2022. Working With Women Who…Series 4. Breastfeeding Challenges. *Nipple Trauma.* https://midwives.org.au/Web/Web/Shop/Item_Detail.aspx?iProductCode=20221123W4

HETI Education and Training, TSU Jumbunna Webcast Series. 29th February 2024*. Bub's Tucker in the First 2000 Days – supporting parents with informed feeding choices; newborn feeding expectations & feeding in emergencies*. https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/training-support-unit-for-amihs-and-bsf-program-staff/tsu-webcasts-and-webinars

HETI Education and Training, TSU Jumbunna Sessions. 6th August 2024 *It takes a community to Breastfeed: Promotion, Protection and Support.* https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/training-support-unit-for-amihs-and-bsf-program-staff/tsu-webcasts-and-webinars

Awards:

- ISLHD Quality & Innovation Awards 2022 –

Winner - Category 2: Excellence in Aboriginal Healthcare and ISLHD Nomination – NSW Premiers Awards Putting Citizens at the Centre, for *The Breastfeeding Project, Child and Family Services.*

- NSW Government Excellence in Nursing and Midwifery Awards 2023 -

ISLHD Nomination for *Midwife of the Year Award*

- Virtual International Day of the Midwife 2024 Conference – Certificate of Appreciation – Session Facilitator

Projects:

Rotary PNG Midwifery Leadership Buddy Project, 2024

- Successful application as project team member for Stage 1, Workshop Group 4
- Attended workshop in Port Moresby April 2024
- 12 month volunteer project position supporting two PNG Midwifery buddies with projects to reduce the maternal mortality and morbidity rate in PNG.

Parliamentary Submissions (related to research)

- 15/8/2023, Submission No. 1167 –Birth Trauma Senate Inquiry, NSW (Appendix C)

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Chapter 1: Introduction and thesis overview “The Why”

1.1 Chapter Foreword

The following thesis chapters will show the path taken as I sought to find answers to understanding the experience of women who had been separated from their babies at caesarean section birth without medical need. These women presented to my lactation clinic with histories of breastfeeding struggles closely linked to trauma and interventions. As they shared their birth story, each spoke of their babies being sent away, usually back to the post-natal ward with their partner. They shed tears as they told of the fear of not knowing their baby was safe or even alive, of not understanding why they were not ‘allowed’ to hold their baby, and of now being angry as they realised this was a big part of how they lost that early connection to their child. They talked of desiring skin-to-skin for bonding and feeding, but the separation event added so much more to their trauma. I needed to understand why being separated from their baby had such devastating consequences for them and why there was such little evidence available to make meaningful changes to our hospital practice.

1.2 Introduction

The inextricable connection of a woman and her infant reaches well beyond the gestation of a pregnancy. The terminology of ‘mother-baby dyad’ seeks to identify this important foundational relationship - one entity with two elements. Identifying and supporting this dyad promotes health and wellbeing for women, infants, families and communities. Keeping mother and baby together in the immediate period following birth, ideally in skin-to-skin contact, enables the process of attachment and nourishment to begin and its value is recognised with high level evidence. The establishment of the newborn microbiome, epigenetic modification, hormonal balance, physiological stability, nutrition, and emotional attachment all optimally require the physical connection between mother and

baby (Almgren, 2018; Campbell et al., 2019; Guala et al., 2017; Moore et al., 2016; Zapata-Martín Del Campo et al., 2018). It is well documented that separation impacts this important basal event for the infant (Almgren, 2018; Widström et al., 2019). Reciprocal benefits have also been established for the mother, hormonally preparing her body for post pregnancy and reducing the risk of illness and disease over her lifespan. Removing her baby increases the risk of haemorrhage, delays involution, increases the risk of depression and anxiety, and inhibits milk production and the ability to breastfeed (Campbell et al., 2019; Moore et al., 2016; Schwartz & Raines, 2018). Despite this evidence babies continue to be removed from their mothers immediately after birth.

Separation of mothers and babies began as a consequence of advancing medical practices in the early 1900's (Anderson et al., 2004; Stelfox & Nagle, 2011). Increasing hospital births under obstetric care, expectations that mothers needed rest, and that babies were more safely cared for by staff in a nursery created the accepted culture of separation (Anjur & Darmstadt, 2023).

In more recent literature, the benefits of maintaining the close contact of the dyad have focussed more on benefits to the baby and breastfeeding initiation and duration (Almgren, 2018; Guala et al., 2017; Stevens et al., 2014). International bodies developed evidence-based policy and guidelines to protect the rights of the child and their health through breastfeeding in the 1970 – 1990's including the Ten Steps to Successful Breastfeeding and the WHO Code for the Marketing of Breastmilk Substitutes (United Nations, 1989; World Health Organization, 1981, 2018b). As early as 1977 research identified the risk involved with separation of the mother and baby after birth identifying reduced breastfeeding and increased infant mortality (Anderson, 1977, 1989). Anderson proposed

that the interaction between a mother and her baby in the early post-partum period is one of mutual care-giving and benefit, promoting physiological development for the infant (1989). These historical research foundations have continued to inform best practice and ongoing studies of separation into the 2000’s, including limited association with maternal experience (Anderson et al., 2004; Guala et al., 2017; Stelfox & Nagle, 2011).

Research into dyad separation has predominantly considered maternal outcomes in relation to mortality and morbidity, particularly regarding breastfeeding success (Crenshaw, 2014). Breastfeeding initiation and duration is associated with reduced incidence of breast and ovarian cancer (Scoccianti et al., 2015; Stordal, 2023), cardiovascular disease (Nguyen et al., 2019; Tschiderer et al., 2022) and diabetes (Melov et al., 2022; Poudel & Shrestha, 2016). However, maternal emotional and mental wellbeing associated with mother-infant separation at birth has been less well studied.

Skin-to-skin is recommended irrespective of birth mode or feeding choice because of the known benefits to the maternal-infant relationship (Widström et al., 2019). Maternal oxytocin is released when in skin-to-skin contact with her baby, shown to calm the mother, reduce her pain, and promote bonding (Crenshaw, 2014). Emotional wellbeing and psychological health are closely linked for both the mother and baby, with separation and no skin-to-skin shown to increase risk of negative effects (Buil et al., 2016; Schwartz & Raines, 2018; Townsend et al., 2020). While the benefits of skin-to-skin practice are invaluable it is also one of the best ways to ensure mother and baby do not get separated from each other.

Understanding the mother’s experience of being separated from her baby at birth, particularly when the birth is operative has not been well researched, and less so with separation as the primary focus. Bayes et al. (2012) used a grounded theory approach to

identify the experience of women having a medically necessary caesarean section. Whilst not specifically looking at separation, this issue was identified and showed a negative impact on mother-baby attachment well beyond the initial post-partum period. When separated, women described feeling *“irrelevant, invisible, disconnected and surplus to requirements”* (Bayes et al., 2012)[p. e902], and while they initially had a strong desire to hold their baby this dissolved to feeling disengaged from their infant and indifferent to the baby’s needs following the separation period. Similar findings were shown in a study by Nyström and Axelsson (2002) using a phenomenological-hermeneutic approach with women separated from their unwell babies when transferred to neonatal care, who described loss of control, disempowerment and disappointment. Disempowerment of the woman is a common theme identified in research, with health professionals seen to be holding the power of ‘allowing’ women and babies to stay together (Bertrand & Adams, 2020; Fahy & Parratt, 2006; Patterson et al., 2019; Zwedberg et al., 2015).

Bystrova et al. (2009) found that no skin-to-skin or early breastfeeding and separating the dyad in the first two hours impacted the relationship a mother had with her baby twelve months after birth, even when they were reunited after the two-hour period. A similar result was found in another study which compared the outcomes of skin-to-skin contact and mother-child relationship nine years later, showing how the disruption of this critical early period can impact far beyond the post-partum phase (Bigelow et al., 2018).

While available research broadly describes the issue of separating mothers and babies and not supporting skin-to-skin, it lacks the specific focus on the area of concern - that of the experience of women who have a caesarean section birth and are separated from their newborn without a medical reason. Finding contrasting studies which demonstrated the

experience of women who had a caesarean and *were not* separated was more achievable, especially if skin-to-skin was the baseline.

In Chapter Two I present the integrative literature review of papers on the birth experience for women who had skin-to-skin contact at caesarean birth and were therefore not separated from their babies. This provides clear rationale for this original research study which I subsequently conducted. It establishes the positive birth experience women feel when they stay in close physical contact to hold and feed their babies at birth.

Separation of the dyad is about more than where or how a woman births. Birthing in hospitals led to the creation of environmental barriers such as independent maternity and neonatal care environments which promoted separation (Anjur & Darmstadt, 2023). Furthermore, it represents the systemic androcentric issues experienced by women seeking health care in general. This sex and gender-based gap changes the experience of care for women as compared to men. Female physical symptoms are often dismissed or labelled psychological, diagnosis delayed or misidentified, and treatment not sufficient or effective (Merone et al., 2022). I have further explored this as a feminist issue for perinatal women in Chapters Three and Four as the theoretical underpinnings and methodological choices are justified in detail.

Dismissive and disrespectful maternity care stems from a health service which already disadvantages women. This fragmented model has overlooked the evidence of midwifery-led, continuity of care which is strengthened by woman-centredness (Homer, 2016; Leap, 2009). Midwifery philosophy is underpinned by the feminist principles of woman-centred care, coined during the woman’s health movement of the 1960’s and 70’s (Davison, 2021; Leap, 2009). Even in the event of unexpected or planned medicalised births, woman-centred care

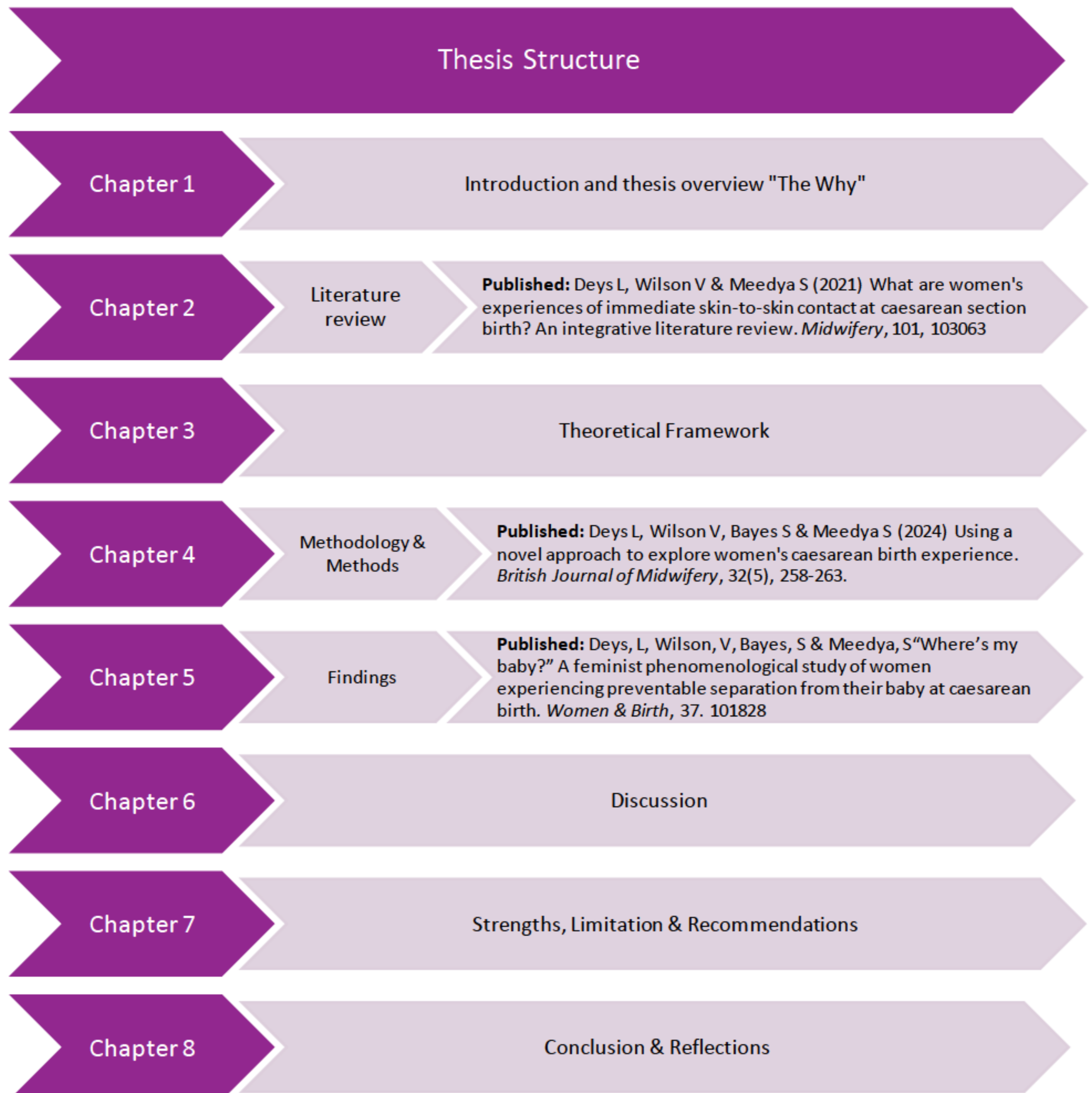
from all health care providers, but particularly midwives, ensures focus on the woman and her rights for choice, respect and self-determination. In general, health services have moved from patient-centred to person-centred frameworks in policy to better represent the individual person receiving care (Edgar et al., 2020), however in patriarchal facilities this language still exposes women to invisibility. Research and policy have also toyed with the concept of *women*-centred care which weakens the idea of individualised care to the woman (Leap, 2009). Woman-centred terminology is founded in the care midwives should be providing but this is difficult in a fragmented and medicalised health system where the connection between woman and midwife is often forgotten by the midwives themselves or unvalued by the institution (Davison, 2021). It is further challenged by the predominantly female midwifery workforce who are also subject to gender bias. The findings and ensuing discussion in Chapters Five and Six describes this lack of woman-centred care evidenced by the participant stories.

The findings which are explored through this research show how this loss of woman-centredness has created negative and traumatic birth experiences, with the fetus valued above the woman’s right to self-determination (Davison, 2020). While is it is unclear whether these participant caesarean section events were life-saving or essential, all mothers and babies were stable at birth and all showed that the personal autonomy of the woman was disregarded. The treatment of women in the perinatal period reflects their societal value and imbalance of power of men over women (Tsakmakis et al., 2023). Birth trauma stemming from interventions women agreed to through poor information and coercion is a systemic function of discipline within health care which needs to be exposed and confronted (Boecker, 2023; Chadwick, 2017; Dahlen et al., 2022). Despite valid definitions of birth trauma and

obstetric violence, psychological damage and distress has not been considered adequately. I have explored this further in Chapter Seven to consider the terminology of obstetric neglect as it relates to human rights and to this research. Recommendations from my research include addressing the workplace culture, policy and practice of maternity care providers and particularly of midwives who are best placed to improve outcomes and birth experiences for women.

The thesis will conclude with Chapter Eight, presenting the journey of this PhD candidate along with an overview of key findings. This novel approach to understanding the birth experience of women who were separated unnecessarily from their babies at caesarean section sets the stage for both further research and being instrumental in policy, practice and cultural change.

1.3 Overview of Thesis



Chapter 1 explains the background of maternal-infant separation and the reason this research was necessary, and an overview of thesis structure.

Chapter 2 reports the current evidence to support keeping mothers and their babies together immediately after birth in skin-to-skin contact. It describes the experience of women who have been supported to stay in this close physical contact with their babies with three main themes identified – *a positive birth experience, sense of control* and *natural*. The author accepted manuscript of this integrative review is included, having been published in *Midwifery* in 2021 (PDF of publication is displayed in Appendix D)

Chapter 3 exhibits the theoretical underpinnings of this feminist qualitative research project, and showing why two feminist birthing theories are of value to this study. Both theories focus on woman-centred care and the important role of the midwife.

Chapter 4 develops the feminist framework and demonstrates the methodology of Feminist Phenomenology and how this fits with the PhD candidates epistemological and ontological understandings. The methods used to conduct the research are then explained in this chapter. It includes the author accepted manuscript that was published in 2024 in the *British Journal of Midwifery* (PDF of publication can be seen in Appendix E)

Chapter 5 presents the findings of the research including the themes and subthemes, with a focus on the words of the participants within each section – *Disconnection (desire to hold baby; separation, no skin-to-skin, breastfeeding), Emotional turmoil (emotions at birth, emotions since birth, impact on relationship with baby, impact on relationship with partner), Influence (power & control, maternal choice and consent, coercion, staff actions), and Insight (mother's knowledge, interventions, the partner, next birth).* The author accepted manuscript

published in *Women & Birth* in 2024 is also presented. (PDF of publication can be seen in Appendix F)

Chapter 6 argues the relevance of the research and offers a discussion of the findings that show separating mothers and babies at caesarean section birth negatively impacts their experience and causes trauma. It also considers the importance of unexpected findings related to breastfeeding outcomes.

Chapter 7 firstly explores the strengths and limitations of the research. It then expands the concept of obstetric neglect and presents the recommendations of policy and workplace culture changes that are needed to improve the wellbeing of birthing women. It also highlights the important role of the midwife and the need for them to step back into the space of advocate, protector and supporter of the women in their care.

Chapter 8 shares an overview of the key findings and draws final conclusions. I reflect on my PhD journey and close with final recommendations.

Chapter 2: Literature Review

2.1 Chapter foreword

As discussed in the previous chapter, evidence was lacking to understand the experience of women who had been separated from their baby at caesarean section when mother and baby were well. Therefore, a review of the literature was completed on the contrasting experience for women who birthed by caesarean and were supported to remain in close physical contact with their baby soon after birth. Close physical contact was identified as skin-to-skin contact, based on best-practice evidence of skin-to-skin immediately after birth for at least one hour. This enabled an understanding of what was possible for women birthing by caesarean section and how this experience could impact their birth satisfaction and wellbeing.

The original review was published in *Midwifery*, 2021 and is presented next. The PDF can also be viewed in Appendix D. An abstract on the review was also accepted and delivered as a poster at the virtual International Normal Labour and Birth Conference, India held on the 2nd - 4th December 2020, titled *What are women’s experiences of immediate skin-to-skin contact at caesarean section when mother and baby are well?* (see Appendix G).

2.2 Author accepted manuscript for Original Literature Review

Deys, L, Wilson, V & Meedya, S (2021) What are women’s experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. *Midwifery,* 101, p103063. https://doi.org/10.1016/j.midw.2021.103063

Scientific Journal Ranking - Q1; Impact Factor 2.86

Abstract

Background: Skin-to-skin is a well-established practice at vaginal births promoting the health of women and babies. Facilitation of skin-to-skin at caesarean section birth is growing despite environmental and historical challenges. This is led by the expectancy of women and of health professionals increasingly understanding its importance.

Objective: To synthesise original research that explores the experience of women having immediate and uninterrupted skin-to-skin contact at caesarean section when woman and baby are well.

Design: Integrative literature review.

Data sources: The databases of SCOPUS, PubMed, CINAHL plus, Wiley Online, Cochrane Library, Web of Science and MIDIRS were used to identify studies from 2010-2020. Hand searching of library journals, reference and citation lists were also used.

Methods: The framework of Whittemore and Knafl (2005) was used to guide the literature search, thematic analysis, and synthesis of original research. Initial screening against inclusion criteria was utilised for English-published papers of full-term, well, woman and baby dyads who experienced skin-to-skin at caesarean section birth. Papers were not limited by methodology. The validated Mixed Methods Appraisal Tool (MMAT) was used for critical quality appraisal (Bartlett et al., 2018).

Findings: In total, 750 results were returned in the initial search and a final 13 papers were included in this review including quantitative (6), qualitative (5) and mixed method (2) designs. Immediate and uninterrupted skin-to-skin at caesarean section birth, when mother and baby are well, is safe, appropriate, and desired by women, improving birth experience and satisfaction. Three main themes were identified with sub-themes – Positive birth experience (satisfaction; breastfeeding goals); Sense of control (empowered; birth, not a procedure); Natural (wanting to hold their baby; becoming a mother).

Conclusions: The findings of this review show that skin-to-skin improves the experience for women, and particularly empowers women having a caesarean section giving them a sense of a more natural birth. Women see skin-to-skin as an opportunity to maintain control and not be separated from their baby. Many studies have focused on the benefits of skin-to-skin but less so on the wants and choices of women. Women want to see, hold and feed their babies but are unable to achieve this of their own volition during a surgical birth. Understanding how women value this close physical contact can seek to inform further research on the impact of separation. This can inform policy and practice development in maternity care services to ensure best outcomes for both women and infants.

Implications for practice: The practice of skin-to-skin and keeping mother and baby together is valued by women and justified by research as best-practice for health and wellbeing. The findings of this paper highlight the importance of maternity settings facilitating both skin-to-

skin and non-separation for all women and their newborns, even more so at caesarean section births.

Key Words: skin-to-skin – caesarean section – mother – experience

Introduction

Keeping well mothers and babies in close physical proximity, ideally in skin-to-skin contact, facilitates a biologically normative sequence of events. The standard and accepted definition of skin-to-skin contact is direct, skin on skin contact between a woman and newborn at the moment of birth, undisturbed for at least an hour or until the baby has breastfed (United Nations Children's Fund (UNICEF), 2019). Irrespective of birth mode the World Health Organization (WHO) recommends the practices of both immediate skin-to-skin and keeping mothers and babies together in their *Ten Steps to Successful Breastfeeding* (World Health Organization, 2018b).

The many benefits of skin-to-skin include calming, bonding and physical stabilisation of the dyad regardless of feeding choice (United Nations Children's Fund (UNICEF), 2019). The birth event, and period immediately following, exposes the immune-naïve newborn to a microbial cascade, triggering immunological and epigenetic changes which impacts the lifetime health of the infant and may have impacts well into the following generations (Császár-Nagy & Bókkon, 2018; Tow, 2014). Skin-to-skin establishes the mother-infant relationship, with shared and responsive communication initiated during the contact (Velandia et al., 2010). Immediate and continuous skin-to-skin contact for both term and pre-term infants has been shown to reduce the need to transfer babies to neonatal care units (Schneider et al., 2017), to reduce infant stress, and improve the relationship of the dyad (Mehler et al., 2020; Mörelius et al., 2015).

The promotion and initiation of breastfeeding during skin-to-skin is known to extend the duration and exclusivity of breast milk feeds, providing further short and long term health benefits to woman and child and the communities in which they live (Campbell et al., 2019; United Nations Children's Fund (UNICEF), 2016). Not having immediate skin-to-skin with the mother at caesarean section birth has been shown to impact exclusive breastfeeding for up to six months. This remains independent of being reunited within two hours or having skin-to-skin with the other parent (Crenshaw, 2014; Guala et al., 2017; Moore et al., 2016).

Caesarean section birth has commonly and historically increased the likelihood of mother-infant separation at birth, even when the woman and baby are well (Bayes et al., 2012; Chalmers et al., 2010; Niela-Vilen et al., 2020; Rowe-Murray & Fisher, 2001). Research has shown barriers to the practice stem from over-stretched resources (Koopman et al., 2016; Mbalinda et al., 2018; Stevens et al., 2016), inadequately trained or knowledgeable staff (Koopman et al., 2016; Zwedberg et al., 2015), hospital practice and policies (Niela-Vilen et al., 2020; Puia, 2018; Stevens et al., 2016) and workplace cultural challenges(Niela-Vilen et al., 2020). Lack of antenatal education on the benefits of skin-to-skin means parents may be unprepared and unexpectant of the importance of skin-to-skin at birth (Stevens et al., 2016; Zwedberg et al., 2015). Particularly at a caesarean birth where women are already physically and emotionally disempowered (Bayes et al., 2012; Coates et al., 2020; Puia, 2018) or feel they are expected to be compliant non-participants in their birth event (Niela-Vilen et al., 2020). Increasing caesarean rates, mean around a third of women in developed countries are at risk of separation and poorer birth experience (Australian Institute of Health and Welfare, 2018; Coates et al., 2020; Townsend et al., 2020; World Health Organization, 2018a).

Since the 1970s pioneer researchers including Kennell and Klaus (1979) and Anderson (Anderson, 1977, 1989) have highlighted the risks of separation in the critical post-birth period. Bonding, self-regulation, mutual-caregiving and breastfeeding are all negatively impacted by taking babies away from their mothers. Studies have shown both swaddling and separating mothers from their infants have similar results, women shown to be rougher and less responsive to their infants and experiencing painful breastfeeding when compared to those who have immediate skin-to-skin (Dumas et al., 2013). Separation and no skin-to-skin contact has also been shown to impact the mother-infant relationship longitudinally, up to nine years after the birth event, impacting sensitivity, reciprocity and engagement (Bigelow et al., 2018; Bystrova et al., 2009).

Separation impacts birthing experience and decreases satisfaction for women even when accepted it is accepted as necessary for medical reasons (Carquillat et al., 2016; Coates et al., 2020; Ghanbari-Homayi et al., 2020). Prolonged separation, when the woman or baby require additional specialist care, further limits physical contact, sense of control and ability to 'mother' (Baum et al., 2012; Schwartz & Raines, 2018). The birth experience remains with the woman well beyond the period of infancy (Bayes et al., 2012; Bossano et al., 2017; Puia,

2018). This can influence her future mother-child attachment, her psychological wellbeing and future childbirth planning (Bayes et al., 2012; Puia, 2018; Townsend et al., 2020).

This integrative literature review critically analyses and synthesises research over the last decade to seek understanding of the woman’s experience of skin-to-skin at caesarean section when both woman and baby are well.

Methods

Design

An integrative literature review design was chosen to encompass the broad range of experimental and non-experimental research to better understand the phenomenon (Booth et al., 2016). The methodological framework developed by Whittemore and Knafl was used to rigorously analyse and synthesise the diverse and complex perspectives and develop new understanding (2005). This included identifying the problem, carrying out the literature search, evaluating and analysing the data and presenting a synthesis of the findings.

Search strategy

Skin-to-skin at caesarean section birth is historically recent in both practice and research, first described in 2008 as a ‘natural caesarean’ (Smith et al., 2008) and present in findings mainly within the last decade. Consideration of a timeline for inclusion in this integrative review search was 2010-2020. To ensure rigour in this research decision, simple topic search terms (skin-to-skin, caesarean, English, full text) were additionally run through two data bases in earlier time periods (2000-2004 and 2005-2009) with only one result, confirming the date selection choice was appropriate.

A comprehensive search of seven databases was carried out, ensuring a wide casting for possible literature sources and minimising the risk of missing relevant research – SCOPUS, PubMed, CINAHL plus, Wiley Online, Cochrane Library, Web of Science and MIDIRS. Key word search terms using Boolean operators included spelling variations and interpretations for ‘skin-to-skin’ (early contact, golden hour, kangaroo mother care); caesarean section (cesarean, c-section); mother (maternal); and experience (perception, attitude, feeling). Inclusion criteria were well, full-term infants, healthy women, skin-to-skin contact, caesarean section and printed in English language (Ames et al., 2019; Booth et al., 2016; Whittemore &

Knafl, 2005). Full-text and peer-reviewed papers were identified with no limitation in methodology of the studies. Hand searching of journal titles, reference and citation lists also contributed to title selection. The Endnote program was used for screening and reference management.

Study selection and quality appraisal

An initial 750 results were retrieved, 58 records were screened after duplicates were removed, 32 full-text articles reviewed for eligibility, with 19 removed for not satisfying selection criteria. This was independently assessed by the first and third authors. The Mixed Methods Appraisal Tool (MMAT) version 2018 (shown in Supplementary Table) was used as an approach to critically appraise the quality of empirical mixed studies literature for inclusion (Bartlett et al., 2018). Whittemore and Knafl (2005) suggest a data evaluation stage of the integrative review process to ensure overall quality of the diverse methodologies included. MMAT has been validated for reliability and quality testing of studies and was therefore used to underpin the selection process (Bartlett et al., 2018; Pace et al., 2012). Scoring greater than 5 (highest possible = 7) was used as a baseline for inclusion, completed independently by the two authors and discussed for selection consensus. The overall quality was high and no papers were excluded as all scored ≥ 5. Twelve studies were included, with two findings papers from one of these, resulting in a final 13 papers for analysis and synthesis in the review.

The results of the search and final selection of articles is shown using an adapted style flow diagram (Figure 2.1).

Data analysis

The data was manually extracted, summarised and coded following the Whittemore and Knafl model (2005). This allowed for reduction and organisation of the data for thematic analysis and interpretation, identifying the three main themes. This is shown in Table 2.1.

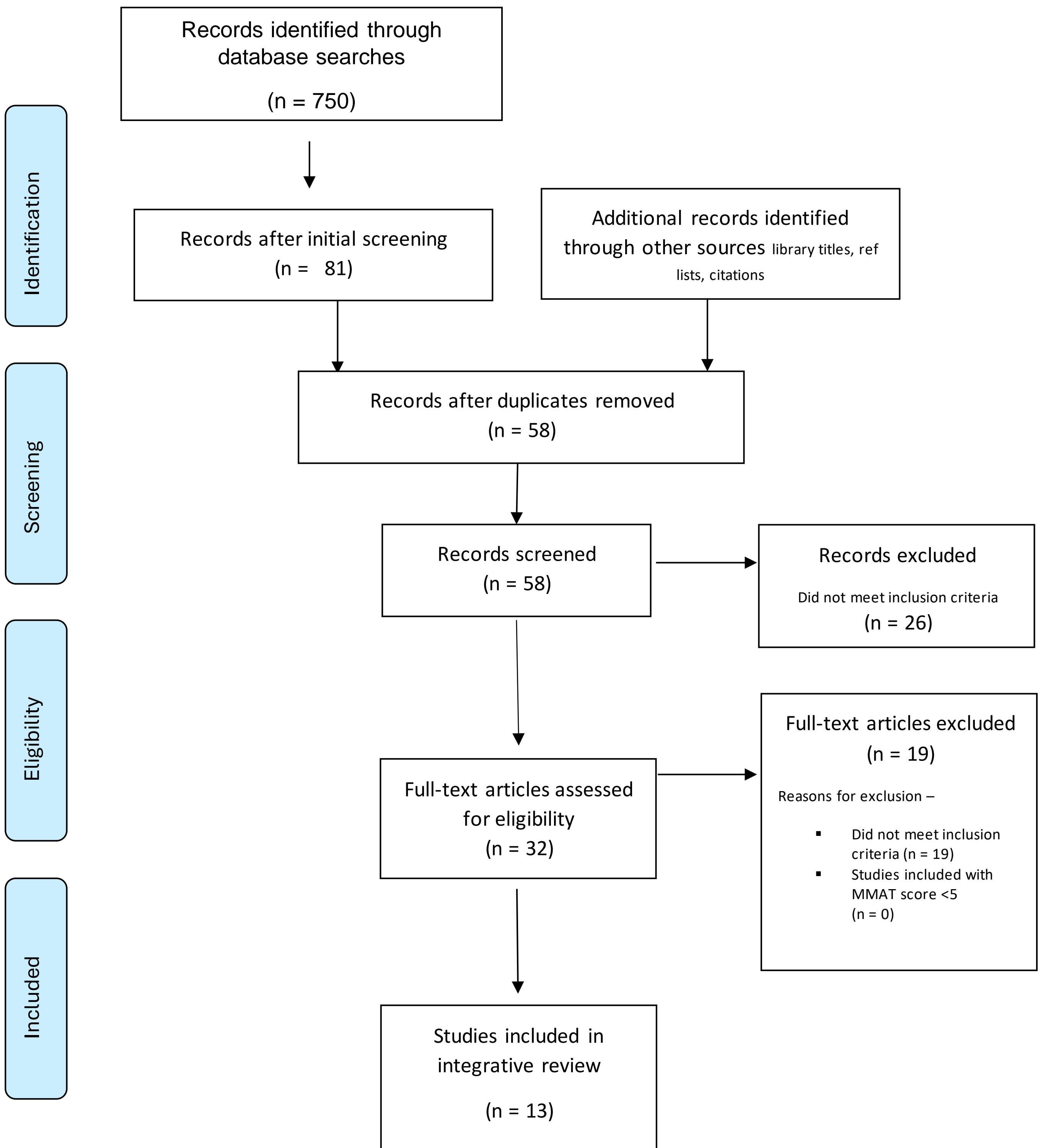


Figure 2. 1 Flow Diagram

Table 2. 1 Included Papers Findings Summary

Author/Year/Country	Study design	Participants	Aim/intervention	Key findings	MMAT score	Themes
Quantitative						
Armbrust et al /2016/Germany	Prospective RCT	205 women and their partners having a planned, term CS, term, low risk, spinal anaesthetic 1:1 simple randomisation – 102 intervention (CCB) and 103 control (CS)	**Aim:** To evaluate the safety, satisfaction and birth experience for patients using the “Charité Cesarean Birth” (CCB) procedure compared to standard caesarean (CS) **Data collection**: modified Likert-Scales and interview with questionnaire **Intervention:** ***CCB*** *= parents actively engaged in the birth by visualisation, cord cutting and early s2s.* ***CS*** *= baby taken immediately for assessment, no cord cutting, no s2s*	• **Primary outcome**: satisfaction and subjective birth experience - more positive birth experience (CCB vs CS) Mother: CI 1.7-2.1 (0.97) vs 2.1-2.4 (1.4), less breastfeeding problems: 2.1-2.5 (0.96) vs 1.4-2.0 (1.2) • **Secondary outcome**: safety - no significant difference in risk for mother or baby (length of procedure, EBL, vitals, Apgar)	7	• Positive birth experience • Sense of control • Natural
Brubaker et al/2018/USA	Prospective cohort	Total - 3006 women, English or Spanish speaking, 18-35yrs, singleton pregnancy, primiparas, infants 34-42 weeks gestation Of these - 155 elective CS, 708 unplanned CS (n=863 CS)	**Aim:** To see how soon after birth mothers got to see, hold and feed their newborns – association between mode of birth and maternal-newborn contact on maternal experience **Data collection**: secondary analysis of the data from First Baby Study (FBS) -1-month post-partum	• Women who had a CS birth (planned/emergency) reported less positive birth experience compared to normal vaginal birth (NVB) – significant association with being able to see their baby immediately (47.9-56.1% vs 87.6%, *p*= <0.001) or feed them <30mins after birth (12-19.7% vs 43.8%, *p*= <0.001), some association	7	• Positive birth experience • Sense of Control

			interviews using *FBS Birth Experience Scale*	found with being able to hold baby within 5 mins of birth (7.8-8.4% vs 76.5%, *p*= 0.074) • CS mothers had a positive birth experience if they could see, hold and feed their babies <30mins – more so that vaginal births with same time frames (*p*=0.010)		
Crenshaw et al/2019/USA	Quasiexperimental	40 women having elective CS at term, 20 in intervention group, 20 standard care (randomly assigned), 18-45yrs singleton pregnancy, English fluency, well at birth	**Aim:** To describe feasibility and outcomes of immediate and uninterrupted s2s at CS - maternal newborn physiologic stability and stress, maternal comfort, satisfaction and exclusive breastfeeding (is it feasible and safe to do s2s) **Intervention:** s2s that began during surgery/immediate **Data collection:** Feasibility/Pilot study – Interview using validated *Maternal Satisfaction with Cesarean* tool with one added open-ended question on their experience of s2s contact	• Women who had s2s were significantly more satisfied with both CS and s2s experience (*p*=0.015) • No difference in maternal or newborn stability • Mother’s cortisol was lower in s2s group (*p*=0.003), no difference in babies (*p*= 0.549) • No statistical difference in bf outcomes at hospital discharge (*p*=0.182) • NVIVO text analysis of open-ended question showed more positive sentiment in the s2s intervention group – ‘bonding’, ‘natural’ • **Overall:** immediate s2s is feasible and safe and women are more satisfied	7	• Positive birth experience • Natural

Jabraeili et al/2017/Iran	RCT double blinded	105 women who had a CS, spinal, term infants, Apgar >7 at 5min (low risk)	**Aim:** To assess the impact of s2s on maternal satisfaction **Intervention:** immediate and for 1hr at birth – plus 30m in recovery then 30min 3x/day for 3 days **Standard care:** no s2s **Data collection: Interview** Validated questionnaire used to measure satisfaction. No standardised tool was used to measure satisfaction.	Maternal satisfaction: • Significantly higher overall satisfaction of mothers who had s2s CI: -2.29 (-2.83 - -1.75), *p*=0.001 • Mothers who had s2s liked it	5	• Positive birth experience • Natural
Onsea et al/2018/Canada	Prospective observational cohort	Low risk, term pregnancies with elective CS – 15 couples had standard care and 6 couples 'gentle' CS (total 21) ***Definition of 'gentle' CS*** *– music/lowlights and warmer OT, drapes dropped so parents can watch baby born, mother can 'push', doctor massages baby's chest to mimic vaginal birth canal, immediate s2s*	**Aim:** To investigate the need for a 'gentle' caesarean section approach to improve satisfaction of parents. **Data collection:** questionnaires (adapted/validated, based on *Wijma Delivery and Expectancy Questionnaires A and B* and *Maternal Satisfaction Scale for Cesarean Section*) measured maternal satisfaction and birth experience pre-birth, 2-5 days post-partum and 6 weeks post-partum. Structured interviews pre-birth and at 6 weeks post-	• There was no difference in maternal satisfaction and birth experiences between the groups • The qualitative content analysis demonstrated that women reported more positive birth experience in the intervention group - 100% (gentle CS) vs 84.6% standard care • The 'gentle' CS group felt more involved in the birth (66.7% vs 46.2% in standard care) and less anxiety (50% vs 69.2%)	7	• Positive birth experience • Sense of control • Natural

			partum analysed using statistical qualitative content analysis. Recruitment continued until data saturation was achieved and no new findings at interview.			
Souza et al/2017/Brazil	Cross-sectional	200 recently birthed women	**Aim:** To analyse the mother/infant bond in association with type of, and experiences, during and after birth **Data collection:** Interviews using the validated *Mother-to-Infant Bonding Scale*	• Women who did not have s2s showed significantly more ‘sadness’ ($p=0.037$) • Pain and type of birth did not significantly influence bonding between mother/baby ($p>0.05$)	6	• Positive birth experience • Natural
Qualitative						
Bertrand&Adams/2020/USA	Phenomenology	13 women who had s2s at CS within the last 10 yrs, 18 yrs at time of consent	**Aim:** To explore the experience of women having s2s at CS birth **Data collection:** interviews via social media video chat, purposive sample – validity of method tested using a feasibility study to set standards of questions used	• Women felt they had a sense of control with their birth when they had s2s • S2s is a highly positive influence of the birth experience of women • Women want to hold their babies but were worried it wouldn’t be allowed	7	• Positive birth experience • Sense of control • Natural
Frederick et al/2016/USA	Ethnography	11 women, aged 23-38yrs, well, term infants, CS birth	**Aim:** To explore and describe the experience of a mother having immediate s2s with her baby at CS **Data collection:** observation of s2s at CS	• Primary theme – mutual caregiving – shared and reciprocal relationship and interaction between mother and baby	7	• Positive birth experience • Sense of control • Natural

			and in-depth interviews 24-48 hours post-partum	• Sense of empowerment and bonding for the mother • Presence and participation of the father was important for women doing s2s in OT • Caesarean/surgical environment described as difficult and impersonal but s2s helped to distract, relieve anxiety and engage with her baby		
Moran-Peters et al/2014/USA	Descriptive qualitative study	6 women >18yrs having their 2nd elective CS birth – English, well/term infants – purposive sample	**Aim:** To compare birth experience of mothers who had/did not have s2s at their second CS **Data collection:** semi-structured interviews	• S2s improved birth experience and mother-baby relationship • Women disliked separation from their baby • S2s felt 'natural' • Breastfeeding was easier/more successful with s2s – overall described as "good" or "wonderful", latching easier, baby calmer, better in comparison to previous birth experience	7	• Positive birth experience • Natural
Stevens et al/2018/Australia	Video ethnography	21 mother/baby dyads having an elective repeat CS with no other medical complications, 25-39yrs, singleton, planning to BF 26 support persons	**Aim:** To explore the impact health professionals have on s2s contact within 2hrs of CS birth **Data collection:** video recordings, observations, field notes, focus groups and interviews	• Mother/baby not seen as one, but separate beings • Obstetricians 'owning' the bottom half of the woman, anaesthetists the top half • Midwives 'owning' the baby and controlling what	7	• Sense of control • Natural

		210 health professionals, 125 involved in CS, 43 in focus groups/interviews		contact the woman had with her baby • Mothers wanted to hold their baby and have s2s but realised it was challenging in the theatre setting • S2s keeps women and babies together and provides a woman a sense of control/empowerment		
Stevens et al /2019/Australia (part of the above study – focus on previously unreported data)	Ethnography – interviews	21 mothers who had an elective repeat CS 6 weeks prior	**Aim:** To explore women’s experience of s2s and what they want in the 2hrs after CS **Data collection:** audio recorded interviews	• One overarching theme – “I want our baby” • Subthemes – ‘I felt disconnected when I was separated from my baby’, ‘I want to explore my naked baby’, ‘I want my partner involved’ and ‘it felt right’	7	• Positive birth experience • Sense of control • Natural
Mixed Methodology						
Lewis et al/2014/Australia	Mixed methods	Planned CS, English - 117 women (256 invited) did postal survey, 38 women interviewed (stopped this recruitment at saturation stage)	**Aim:** To increase knowledge around the perception women have for preparing and then experiencing a planned CS **Data collection:** At 2 weeks post-partum a survey tool for satisfaction using Likert scale – frequency distributions for responses with univariate comparisons for repeat CS, statistical software used. Semi-structured telephone interviews – thematic	• Quantitative findings showed most women were satisfied with the birth (78%) • Giving women choices and answering their questions empowers them (83%) • Skin-to-skin and being with their partner improved satisfaction and women wanted it – only 59% of women had s2s in OT and	7	• Positive birth experience • Sense of control • Natural

			analysis of interview transcripts.	38% continued into recovery.		
Sundin&Mazac/2015/USA	Quality Improvement Project	46 out of 205 women chose to have s2s in OT for a *repeat elective CS* (to assess satisfaction/compare with previous) Total of 583 CS, 60 s2s (to assess pain perception)	**Aim:** To evaluate satisfaction and the perception of pain of women when having a CS with immediate s2s. **Data collection:** Interview early post-partum with 2 questions using a Likert scale comparing previous CS no s2s with current CS with s2s (quantitative). Also then asked for 'additional comments', results sorted in broad categories (qualitative). Medical record review_of anaesthetic record – additional and administration of analgesia (quantitative).	• S2s at CS increased maternal satisfaction and lowered perceived pain compared to no s2s • Using s2s 96% reported being 'very satisfied' and 4% 'satisfied', previous birth (no s2s) 10% 'very satisfied', 84% 'satisfied' and 6% 'dissatisfied' • Additional analgesia was required for 53% of women without s2s and 43% if they had s2s	6	• Positive birth experience • Sense of control • Natural

Key: Skin-to-skin (s2s), Normal Vaginal Birth (NVB), Caesarean Section (CS), Operating Theatre (OT)

Results

The integrative literature review allowed for a broad inclusion of design and methodologies. The included papers were geographically diverse but predominantly from developed countries – United States of America (6), Australia (3), Canada (1), and Germany (1), with two developing nations Brazil (1) and Iran (1) (United Nations, 2014).

All met the criteria for well women and babies birthed by caesarean section at term, and reviewed outcomes of non-separation and skin-to-skin experience. The parity of the women and primary reason for caesarean section varied across the selected studies and included planned, unplanned and repeat procedures, the latter allowing for direct personal comparisons of skin-to-skin outcomes.

Some articles included partners and health professionals in their results, but the focus of the review was the experience of women. It is however acknowledged that both these groups play a significant role in the facilitation and support of women having skin-to-skin.

All thirteen papers reviewed highlighted the fact that skin-to-skin is not standard practice at a caesarean section. Safety for the practice was not seen as an issue, some papers specifically including and reporting on these outcomes positively (Armbrust et al., 2016; Crenshaw et al., 2019).

Skin-to-skin was identified as a specific intervention or as part of a new style of caesarean procedure to evaluate safety alongside maternal satisfaction and the establishment of breastfeeding (Armbrust et al., 2016; Jabraeili et al., 2017; Sundin & Mazac, 2015). It was used comparatively with multiparous women without previous skin-to-skin at a caesarean birth, emphasising their contrary outcomes and experience (Armbrust et al., 2016; Moran-Peters et al., 2014; Stevens et al., 2019; Sundin & Mazac, 2015). Women hoped for but did not expect skin-to-skin, most papers describing the fear of separation. The skin-to-skin experience was positive and emotional. Women viewed a caesarean section as a significant event and more than a surgical procedure, the overall experience improved when skin-to-skin was supported (Bertrand & Adams, 2020; Frederick et al., 2016; Lewis, 2014; Souza et al., 2017; Stevens et al., 2018). Noted was the unequal influence of power the woman had during a surgical birth, requiring other people to advocate for her to enable skin-

to-skin (Bertrand & Adams, 2020; Brubaker et al., 2019; Frederick et al., 2016; Stevens et al., 2019).

Three main themes, with sub-themes, were identified consistently in the papers reviewed. A *positive birth experience*, a *sense of control* and a perception it was *natural* (Table 2.2).

Table 2. 2 Themes and subthemes analysis

Themes	**Positive birth experience**		**Sense of control**		**Natural**	
Authors/sub-themes	**Satisfaction**	**Breastfeeding goals**	**Empowered**	**Birth not a ‘procedure’**	**Wanting to hold their baby**	**Becoming a mother**
Armbrust et al, 2016	✓	✓	✓	✓	✓	
Bertrand&Adams, 2020	✓		✓	✓	✓	✓
Brubaker et al, 2018	✓		✓			
Crenshaw et al, 2019	✓			✓		✓
Frederick et al, 2016	✓	✓	✓	✓	✓	✓
Jabraeli et al, 2017	✓	✓				✓
Lewis et al, 2014	✓		✓	✓		✓
Moran-Peters et al, 2014	✓	✓	✓		✓	✓
Onsea et al, 2018	✓		✓	✓	✓	✓
Souza et al, 2017	✓					✓
Stevens et al, 2018			✓	✓	✓	✓
Stevens et al, 2019	✓	✓	✓	✓	✓	✓
Sundin&Mazac, 2015	✓	✓		✓	✓	
Representation (*n*, %)	**12/13**	**6/13**	**9/13**	**9/13**	**8/13**	**10/13**
	92%	**46%**	**69%**	**69%**	**62%**	**77%**

Positive Birth Experience (sub-themes ‘satisfaction’ and ‘breastfeeding goals’)

Supporting a positive birth experience was aligned closely with keeping the woman in close physical contact with her newborn infant in the immediate newborn period in 12 of the

papers. Women highly rated being able to see, hold and feed their baby in the first hour after birth (Armbrust et al., 2016; Bertrand & Adams, 2020; Brubaker et al., 2019; Crenshaw et al., 2019; Moran-Peters et al., 2014; Onsea et al., 2018). Two studies trialled procedures which included modifying and integrating a number of less medicalised measures, including skin-to-skin, to improve maternal satisfaction (Armbrust et al., 2016; Onsea et al., 2018). The total numbers were small (205 in Armbrust et al, 21 in Onsea et al) but had similar results with the intervention groups (102 and 6) showing improved satisfaction through women feeling more involved, less fearful, increasing infant bonding and the perception of being better cared for. Crenshaw et al (2019) suggested a dose-responsive skin-to-skin duration to improve maternal satisfaction. Their intervention group of 20 women continued this contact for five hours and showed significantly higher satisfaction (p = 0.015) and more positive text analysis responses focusing on the opportunity to touch, bond, hold and breastfeed their baby.

The prospective cohort study of Brubaker et al (2019) did not specifically ask about skin-to-skin but compared results for around 3000 women from the ‘First Baby Study’ (around 30% caesarean) on the time until they saw, cuddled and breastfed their newborn. Early dyad contact was noted to improve women’s experience at caesarean section, more so than at vaginal birth (p = 0.010), particularly if the caesarean was unplanned. The births studied are noted to have occurred between 2009-2011 when skin-to-skin at caesarean section was novel, however the results of keeping the dyad in close physical contact reflected similar outcomes of the other studies – women wanting to hold their babies. It was more likely to occur with midwife or doula involvement, emphasising the role woman-focused staff have in facilitating positive birthing experiences. The phenomenological results of Bertrand and Adams’ research (2020) showed the similar association women had with skin-to-skin and being able to remain with their babies to meet and bond, the interaction itself being most important. The women in this study valued the experience, noting it alleviated feelings of disappointment at not birthing vaginally and reduced the clinical aspect of the surgical birth. The cross-sectional analysis of 200 women by Souza et al (2017) also did not focus on type of birth but with how bonding was related to experiences including skin-to-skin, and showed a significant increase (p = 0.037) in women’s ‘sadness’ when it did not occur. While this study included vaginal births, the rate of caesarean sections in this Brazilian study was unusually high (80%) with only around half of all births receiving skin-to-skin.

Twelve papers identified satisfaction as a measure of positive birthing experiences. Questions centred on time periods from birth to starting skin-to-skin and assessed women’s fears and expectations. Psychometric scale enquiry specifically asked questions about the immediate post birth criteria which are generally taken for granted at a vaginal birth such as skin-to-skin, bonding and birth experience (Armbrust et al., 2016; Brubaker et al., 2019; Crenshaw et al., 2019; Jabraeili et al., 2017; Lewis, 2014; Onsea et al., 2018; Souza et al., 2017). Open-ended questions and observation measured satisfaction with the experience of the woman’s involvement in the birth (Bertrand & Adams, 2020; Crenshaw et al., 2019; Frederick et al., 2016; Moran-Peters et al., 2014; Stevens et al., 2019; Sundin & Mazac, 2015). Results from these studies showed that including skin-to-skin at caesarean section increased positivity and emotional satisfaction. Women who had less fear, anxiety and pain would also be expected to be more satisfied. Three studies showed skin-to-skin eased these negative emotions (Crenshaw et al., 2019; Onsea et al., 2018; Sundin & Mazac, 2015).

Meeting breastfeeding goals as a positive birthing experience was also shown in some studies as being related to skin-to-skin contact, particularly noted by women having repeat caesarean sections (Armbrust et al., 2016; Frederick et al., 2016; Moran-Peters et al., 2014; Sundin & Mazac, 2015). This was associated with overall breastfeeding rates, earlier initiation and fewer problems encountered (Armbrust et al., 2016; Frederick et al., 2016; Jabraeili et al., 2017; Moran-Peters et al., 2014; Stevens et al., 2019). Two studies could not account for any statistical difference in breastfeeding rates for women who had skin-to-skin compared to those who did not. Crenshaw (2019) only measured exclusive breastfeeding at hospital discharge, and both intervention and control groups had early, if not immediate, skin-to-skin which may account for the limited lack of difference. Onsea et al (2018) also found no association for breastfeeding with their ‘gentle’ surgical approach which included skin-to-skin which they considered may be due to small study size and no randomisation.

Sense of control (sub-themes ‘empowered’ and ‘birth, not a procedure’)

Women’s lack of choice and control over their birth experience was a common theme across many of the papers. Lewis et al (2014) mixed methods study examined the preparatory period of a planned caesarean section, including birth plans, and compared this with the actual experience of the birth. Two-thirds of the 117 women surveyed had prepared a birth

plan which included skin-to-skin, but only a little over half of these felt it had directed their caesarean care. Most (83%) still saw it as a positive step to being included. Women who had immediate contact with their baby perceived improved overall birth experience and sense of control. Women felt empowered when planning their birth, describing being listened to, supported, informed and involved. There was a negative impact of not being heard despite indicating birthing preferences, or of not having the option to make a birth plan. As with other research, not having choice created a more clinical, surgical experience rather than ‘birth’ (Stevens et al., 2018). A sense of control through skin-to-skin was highlighted in the study by Bertrand and Adams (2020). Women feared separation and saw skin-to-skin as a way to regain control of where their baby was, also improving satisfaction and birthing involvement. Stevens et al (2018) noted that the physical possession of the baby being handed to the mother returned the sense of control that the woman experienced. This was identified as ‘ownership’ of the baby. Other studies also reflected this sentiment of ownership and belonging that women reclaimed with skin-to-skin, increasing a sense of control (Bertrand & Adams, 2020; Moran-Peters et al., 2014).

The importance of being able to play a central role in the birth was emphasised by Onsea et al (2018) and Armbrust et al (2016) evaluating their ‘natural birthing’ interventions, including skin-to-skin at caesarean section. Women identified less disappointment in not birthing vaginally, felt safer, and perceived they were active participants. In a number of studies, feelings of involvement were shown to be improved with the inclusion of skin-to-skin care when compared to the woman’s previous caesarean births with no skin-to-skin contact or to control groups (Bertrand & Adams, 2020; Frederick et al., 2016; Lewis, 2014; Onsea et al., 2018; Stevens et al., 2019). Women also associated skin-to-skin with feelings of empowerment, despite an environment which removes much of their physical control (Bertrand & Adams, 2020; Frederick et al., 2016; Stevens et al., 2018). Focusing on their baby provided a distraction from the surgical procedure and discomforts and reduced anxiety (Bertrand & Adams, 2020; Crenshaw et al., 2019; Frederick et al., 2016; Onsea et al., 2018). Stevens et al (2019) noted that immediate and undisturbed contact between mother and baby caused women to feel more connected and bonded with their baby, emphasised in descriptive and distressed quotes comparing their previous caesarean birth experiences without skin-to-skin (*“…most traumatic thing…”, “…felt like I was being cheated…”, “…hard*

time bonding…baby doesn't love me…shouldn't have been a mum…" p. 142). The study also identified that interruption of skin-to-skin negatively impacted the birth experience, women describing anger, sadness and loss.

Including skin-to-skin during a caesarean section made women feel they experienced a birth rather than a surgical procedure (Armbrust et al., 2016; Crenshaw et al., 2019; Frederick et al., 2016; Lewis, 2014; Onsea et al., 2018; Stevens et al., 2019; Sundin & Mazac, 2015). Women connected with their baby and disengaged with the clinical operating theatre environment. This placed the woman and her birth experience at the centre of the care and supported her right to be involved (Bertrand & Adams, 2020). When health professionals proactively enabled skin-to-skin, this was specifically noted in the results as an important consideration, with women reporting they did not feel they should have to advocate for themselves while in a vulnerable position (Bertrand & Adams, 2020; Brubaker et al., 2019; Lewis, 2014; Stevens et al., 2019).

Natural (sub-themes 'wanting to hold their baby' and 'becoming a mother')

Twelve of the thirteen reviewed papers portrayed the inclusion of skin-to-skin at a caesarean section birth as a more 'natural' approach. It enabled women to bond, discover and breastfeed their babies as they would at a vaginal birth. Natural intervention approaches, including skin-to-skin contact, when compared with standard caesarean care, showed improved birth experience and participation, the perception of receiving better care, more involvement and bonding, and less anxiety (Armbrust et al., 2016; Onsea et al., 2018). Mothers felt calmer and were able to respond, observe and communicate with their newborns (Bertrand & Adams, 2020; Crenshaw et al., 2019; Frederick et al., 2016; Jabraeili et al., 2017; Moran-Peters et al., 2014).

Results from all the qualitatively designed studies and the subjective findings from Sundin and Mazac's Quality Improvement project (2015) showed women wanted to hold their babies. Stevens et al (2018) describe this as an "urgency" (p. 461) and "intense maternal desire" (p. 460), with women traumatised by separation. This was further explained in their next paper (Stevens et al., 2019), women needing to be reassured their baby was safe and well by holding and exploring the naked baby during skin-to-skin. Bertrand and Adams (2020) identified the value women felt with skin-to-skin as a sense of contentment and belonging,

where they could know their baby was safe. A significant theme of Frederick et al (2016) was the desire women had to intimately hold, see and interact with their baby to be reassured the baby was well. Confirming the safety and wellbeing of the baby was also shown as important to women in the study by Moran-Peters et al (2014), the natural feel and smell of a newborn baby placed immediately in skin-to-skin contact was strongly associated with connection and calm.

Many women in these studies saw skin-to-skin at caesarean birth as the step associated with establishing a bond and assuming the role of mother (Bertrand & Adams, 2020; Frederick et al., 2016; Jabraeili et al., 2017; Lewis, 2014; Moran-Peters et al., 2014; Onsea et al., 2018; Souza et al., 2017; Stevens et al., 2019). They described themselves as becoming mothers. Birth is the first moment of physical separation of the woman and baby and within the environment of an operating theatre this often becomes spatial, with babies taken away from the woman and often the room. At a vaginal birth a woman typically remains responsible for maintaining a safe physical environment of warmth and security for the newborn, and there is opportunity for the dyad to communicate to meet each other’s needs through mutual caregiving. Stevens et al (2018) described the division of the mothers’ body during the operative procedure, with the anaesthetist ‘owning’ the top half of the woman’s body, the obstetrician the bottom half, and the baby owned by the midwife once it was born. Skin-to-skin meets the need of the woman to own and ‘mother’ the baby by enabling her to comfort and feed her newborn (Jabraeili et al., 2017; Stevens et al., 2018). Bertrand and Adams (2020) identified skin-to-skin as a transitioning step as women moved into the role of mother, responsible for keeping their baby safe and well rather than worried about what the staff were doing to them.

Discussion

This integrative review synthesises new knowledge from the combined and analysed results of 13 original research papers. Three main themes were identified for the experience of women having skin-to-skin at a caesarean section birth - *positive birth experience*, *sense of control* and *natural.* The findings from this review indicate evidence of the importance of early skin-to-skin contact at caesarean section to improve a woman’s overall birth experience. Women have a strong desire to stay close to their babies to see, hold and feed them. Skin-to-

skin delivers them the opportunity to inspect and connect with their newborns, which reduces their own fear and anxiety.

Skin-to-skin provides the option for women to not be separated from their baby. However, the studies are not clear whether it is the actual skin contact or the non-separation which improves the woman’s experience. This close physical proximity to the baby has been shown in earlier research to enhance dyad attachment, bonding and maternal emotional wellbeing, well before skin-to-skin was standard care at modern births (Anderson, 1989; Feldman et al., 1999).

Women remember how they feel at their birth, with experiences vividly recalled well into the future (Bossano et al., 2017; Brubaker et al., 2019; Puia, 2018). The care a woman receives at her birth has the potential to impact her psychological health and the relationship with the baby across her lifetime. All papers showed the value of skin-to-skin in improving the experience of women at caesarean section birth. Both quantitative and qualitative results demonstrated similar results and themes. A large selection of the data analysed was for planned caesarean cases, results could be potentially less clear for emergency procedures. However, the selection criteria for the review specified well women and babies, to establish there was no medical indication for separation, counteracting this ambiguity.

An operative birth places a woman in a vulnerable position where there is limited physical option to control her circumstances and surroundings. The woman cannot feel or move the lower half of her body, her safety and that of the baby is in the hands of others, and she often feels unwell as a result of medication and positioning. Without staff acknowledgement of the maternal significance of this event, the woman can be left feeling irrelevant and disconnected from her birth (Bayes et al., 2012). The balance of power against her is understood by women who desire skin-to-skin but experience fear as they expect interventions and separation (Bertrand & Adams, 2020). Returning ownership of the baby through skin-to-skin resonates with the meta-synthesis by O’Connell, Khashan and Leahy-Warren (2020) where women experiencing fear of childbirth can regain ownership of their birth through fear acknowledgement, empowerment and a sense of security. While all birth modes are experienced more positively with skin-to-skin, the findings of this review show the

themes of having a sense of control and feeling natural are particularly distinctive for women having a caesarean section birth. This new knowledge should direct the care women receive.

It is clear from this review that women want to be close to and hold their baby and that it is an important step in assuming the role of mother to the new baby. Mercer's *Becoming a Mother* theory identifies the importance of transitioning to the maternal role for the woman's own psychosocial development and the association of external factors, such as skin-to-skin and separation (Husmillo, 2013; Mercer, 2004). Sense of control, satisfaction and confidence in herself all have the potential to be impacted by an experience such as separation at caesarean section which risks poor self-esteem and role failure (Mercer, 2004). Ghanbari-Homayi et al (2021) in a systematic review of 19 studies with over 10, 000 women also identified that the woman feeling safe and taking control over childbirth was important for improving birth experience.

Limitations of this review

The main limitation identified by this integrative review was the lack of a consistent and standardised definition of skin-to-skin for caesarean section births. Researchers used varying standards for initiation and duration which were not clearly comparable. The general postulation was in comparing skin-to-skin versus none.

The UNICEF definition (2019) is challenged by the surgical setting where skin-to-skin practice is inconsistent. Some studies met this standard while others exceeded or fell short. The time frame of the last decade also meant that some of the research was being done when skin-to-skin at caesarean section was innovative and unexpected which may have influenced the lack of uniform definition.

While the majority of papers reviewed were of small sample sizes, making some results less conclusive at an individual level, this analysis has correlated the data to inform new understanding. The study populations were similar across all papers with results from both developed and developing countries showing universal outcomes and experiences for the women.

Implications for practice, policy and research

It is evident from this integrative review that women want and benefit from staying in close physical contact with their babies immediately after birth. Health professionals need to

recognise their role in accommodating and advocating for this practice in an environment where the balance of power lies with them. Having policies which support skin-to-skin at caesarean section, planning consistent implementation with education, staffing and resources, and promoting the practice as standard care unless there is a medical indication to separate is imperative to improving women’s birth experience.

The phenomenon of skin-to-skin and non-separation at caesarean section is demonstrated to positively improve the birth by giving a sense of control and more natural experience. Medicalisation of the birthing event to a surgical procedure has led to a general acceptance of separation and the expectation of medical need even when woman and baby are well. Further research for how women experience this separation is needed in order to change policy and practice and improve outcomes for women having caesarean births.

Conclusion

Skin-to-skin contact between a well woman and her newborn at caesarean section birth is a simple and safe way to ensure future physical and emotional wellbeing of both. The establishment of the mother-child relationship through bonding and mutual-caregiving, promotes ongoing security of care and nutrition for the infant and psychosocial wellbeing for the woman. The findings of this review have shown the urgent desire women have to see, hold and feed their babies in the moments after birth. The vulnerability of the woman during a surgical birth dictates the response woman-centred health professionals should guarantee – keeping the dyad together.

2.3 Revisiting the Literature in 2024

Figure 2.2 shows the preliminary analysis mapping of the original literature review process on a whiteboard. This was used along with multi-coloured sticky notes and highlighters in the printed papers. It helped with grouping, organising and comparing thoughts in the early stages. I found the visual and tactile style of putting my thoughts out in colour and being able to easily move and change ideas improved the outcome. I took photos along the way to share with my supervisors over Teams while we discussed both my process and the results. When reviewing the literature for the final time I used highlighters and sticky notes along with the theme table that was part of the final product of this original work as I was more familiar with the activity.

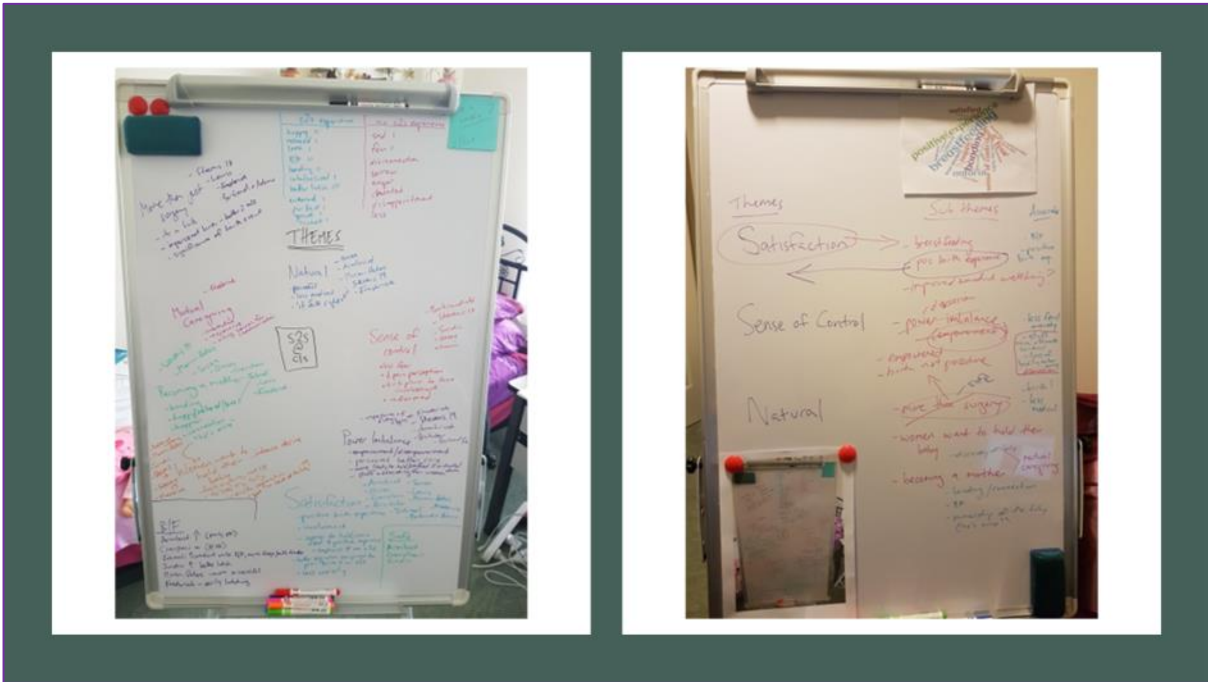


Figure 2. 2 Preliminary Analysis of Literature Review

Methods

As presented in the previous section, the original search returned 750 articles of which thirteen were selected for inclusion in the review. A Whittemore and Knafl framework was used as to guide the search and analysis (2005) and to ensure a critical quality appraisal, the validated Mixed Methods Appraisal Tool (MMAT) was employed (Bartlett et al., 2018). In March 2024 the search terms were rerun through the Australian Catholic University (ACU) library database myself, and the librarians at the Illawarra Shoalhaven Local Health District (ISLHD) also repeated a search they had done in mid-2020 using the same key words as the original search were used, Boolean operators, and including variations in spelling and meaning of terms, for skin-to-skin, caesarean section, mother and experience The search was completed in the same data bases of SCOPUS, PubMed, CINAHL plus, Wiley Online, Cochrane Library, Web of Science and MDIRS (Deys et al., 2021). The new timeframe was from 2020 (to ensure articles published in the second half of 2020 were not missed) to 2024.

Only papers that studied the experience of healthy women with well, term infants were again included. The ACU library search gave a broad 1368 results, with only one repeated article from 2020 which was used in the original integrative review. These were considered for relevance with a further eight, original research articles selected that met the search criteria. Two papers were by the same authors and from the same study, published in

separate years (Kahalon et al., 2021, 2022). Literature review papers, including my original review paper (Deys et al., 2021), were not included. The ISLHD library search produced 75 articles, after initial title screening 28 abstracts were reviewed, and only one additional paper was included in this update that did not appear in the ACU search. A total of nine papers were then reviewed, quality for inclusion verified using MMAT, with all scoring 5 or higher (see Table 2.3).

Table 2. 3 Review of Literature 2024

Author/Year/Country	Study design	Participants	Aim/intervention	Key findings	MMAT score	Themes
Junk-Wilson et al, 2024, USA	Cross-sectional, retrospective	2327 women who had a CS in the 10 yrs prior to 2022; 29.7% experienced s2s	**Aim:** To assess incidence and maternal characteristics of those who had s2s **Data collection:** survey	• Emergency and primary CS, being young, lower education and place of birth (state) increased risk of no s2s • Planned CS births showed more women knew about, requested, were offered and experienced s2s • Women wanted s2s more often than it happened • 2/3 of participants knew of s2s, 1/3 requested it and less than 1/3 experienced it • 90% of women who didn’t get s2s said they would have liked to	7	Positive birth experience
Machold et al, 2021, Canada	Hermeneutic phenomenology	10 women with a previous CS and no s2s who then had a CS with s2s. Interviewed 1-19 months post partum; all planned CS, well/term mother and baby at birth	**Aim:** To describe birth experience with and without s2s **Data Collection:** semi-structured telephone interviews	• 4 themes – • 1. Support for s2s – families and medical team • 2. Control – greater sense of control, empowerment and identifying as a mother with s2s • 3. Connection with infant – greater with babies that had been in s2s, more like a NVB; disappointment they lost this with previous birth/no s2s • 4. Logistical considerations – staffing and standard practice in OT had to be altered for s2s	7	• Positive birth experience • Sense of control • Natural
Radtke et al, 2022, Germany	Prospective cohort	110 birthing women, 29% of whom had	**Aim:** To assess safety of a “Charite” (natural) CS which	• Charite vs usual CS improved wellbeing and	7	• Positive birth experience

		Charite CS, 7% usual CS, 15% vacuum and 49% NVB	included s2s, along with parental birth experience and long term effects compared to other birth modes **Data collection:** standardised questionnaire at birth and again at 8 months	satisfaction without increasing maternal or neonatal morbidity and similar results to NVB		
Kahalon et al, 2021, Israel Kahalon et al, 2022, Israel (2 papers describing findings from same research)	Prospective cohort	1833 baseline with 1371 women completing both surveys (birth & 2 months) – 16% CS	**Aim:** to see if s2s improved birth satisfaction for CS births more than other birth modes **Data collection:** questionnaires in pregnancy and at 2 months post-partum, using the Childbirth Satisfaction Scale	• S2s improved birth satisfaction for all birth modes • While less s2s at CS, s2s associated with improved satisfaction, reduced feelings of fear and guilt	7	• Positive birth experience
Igarashi et al, 2023, Tanzania	Quasi-experimental	172 women -86 in control, 86 in intervention group	**Aim:** to understand the effectiveness of early s2s at CS (breastfeeding, Birth Satisfaction Scale, infant morbidity **Data Collection:** questionnaire and follow up 4 month survey	• Improved birth satisfaction with s2s, no significant difference in breastfeeding at 4 months less infections requiring hospitalisation for those who had s2s	7	• Positive birth experience
Kram et al, 2021, USA	RCT	129 women having CS – 68 contro1, 68 intervention group	**Aim:** To compare birth satisfaction between a traditional or 'family-centred' CS (intervention – view birth of baby, have immediate s2s) **Data collection:** randomised 1:1, not blinded; self-administered questionnaire in hospital plus baseline variable and characteristics taken from medical records	• No statistical difference with general satisfaction found other than s2s occurred sooner with family-centred approach (immediate s2s) • Women in traditional group still had control of when baby was given to them after initial check by medical team	7	• Sense of control
Campbell & O'Connell, 2021, Ireland	Participatory Action Research	84 women, elective CS	**Aim:** To understand the birth experience of women **Data collection for women:** questionnaire (The rest of the study focused on staff practice and attitudes)	• Elective CS only but this was a new practice of s2s introduced • Women felt happy, connected to their baby, bonding was promoted and women felt empowered • Facility s2s increase of 60% with this study	7	• Positive birth experience • Sense of control

Kjelland et al, 2020, USA	Mixed method	44 women having an elective CS	**Aim:** to examine the effect of a designated s2s nurse at elective CS on breastfeeding, patient satisfaction, and cost involved **Data collection:** bedside interviews to evaluate birth experience; feeding outcomes were recorded from patient records; cost was valued on the provision of a dedicated nurse for s2s care annually	• Strong satisfaction experienced by most women – increased bonding, infant safety, more natural birth • Having a dedicated nurse to help increased early initiation and discharging from hospital breastfeeding • Cost estimated at US$263 per patient	5	• Positive birth experience • Natural

Key: skin-to-skin (s2s); normal vaginal birth (NVB), caesarean section (CS), operating theatre (OT)

Results

Similarly to the initial integrative review in 2021, the nine included papers encompassed a broad range of methodology and design from predominantly high-income countries – United States of America (3), Canada (1), Ireland (1), Germany (1), Israel (2) and Tanzania (1). The use of MMAT was appropriately used again to appraise the quality of the mixed method studies with all papers bar one scoring 7, this other scored 5, demonstrating good quality.

The themes identified were consistent with the original review – *Positive Birth Experience, Sense of Control and Natural.* What was evident in more recent research was that the expectations of women appear to have changed, with more being aware of, and requesting, the practice of skin-to-skin at caesarean section. Unfortunately, it also demonstrated that it continues to not be standard practice and results in mothers and babies being separated unnecessarily (Junk-Wilson et al., 2024). As with the original review, lack of a consistent and standard skin-to-skin definition was a limitation in the literature, which had not improved with time.

The original sub-themes of Positive Birth Experience were *satisfaction* and *breastfeeding*. Skin-to-skin was, as expected, associated with improved confidence and success in breastfeeding (Igarashi et al., 2023; Kjelland et al., 2020; Machold et al., 2021). Satisfaction with birth continued to be seen as improved when women were given the opportunity to have skin-to-skin contact with their babies (Campbell & O'Connell, 2021; Igarashi et al., 2023; Kahalon et al., 2021, 2022; Kjelland et al., 2020; Radtke et al., 2022). Interestingly, the study by Kram et al (2021) found no statistical difference with satisfaction between their two randomised groups, one a ‘family-centred’ approach which included immediate skin-to-skin and the other a traditional approach. However, both groups still included skin-to-skin with only a small difference in time to it first occurring (sooner with ‘family-centred’). This shows in the time since the first literature review was done that at least some facilities have prioritised including skin-to-skin contact as standard care.

Having a Sense of Control, and sub-themes *empowered* and *birth, not a procedure* was highlighted in three papers (Campbell & O'Connell, 2021; Kram et al., 2021; Machold et al., 2021). Giving women choice over what happens to their babies at caesarean birth, including

the choice to hold their baby in skin-to-skin contact, left feelings of empowerment, happiness and connection to their infant. This was evident again in the papers demonstrating the theme of Natural, with sub-themes of women *becoming a mother* and *wanting to hold their baby*. Skin-to-skin helped women to identify as a mother (Machold et al., 2021) and improved the experience of bonding with their baby while knowing they were safe (Kjelland et al., 2020; Machold et al., 2021).

Conclusion

Revisiting the literature highlighted again that women strongly want to be in control of what happens to their baby after a caesarean section birth, to see, hold and feed them. Providing the opportunity for women to remain in close physical contact with their baby is a critical step in establishing the mother-child relationship that will improve the wellbeing of both, far beyond the day of birth.

This second review reaffirmed the value of this research for women who did not get to experience the close physical contact with their baby at birth. Their experiences should be shaping the changes in maternity care that seem to have commenced in some facilities, ensuring women birthing by any mode have control over what happens to their own and their baby’s bodies and are not separated from each other.

Chapter 3: Theoretical Framework

3.1 Chapter Foreword

The use of feminist theories aligned with a feminist phenomenological research enquiry provided a framework with which to better understand and analyse data collected. Two that are particularly related to the experience of birth from a midwifery context are that of the *Birth Territory Theory* by Fahy and Parratt (2006) and Reed, Barnes and Rowe *Childbirth as a Rite of Passage* (2016). Both focus on the importance of woman-centred care for the pregnant and birthing woman and the role of the midwife in protecting their rights physically, emotionally and spiritually. 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 & Gair, 2015).

3.2 Birth Territory

The theory of Birth Territory was developed to describe and predict birth outcomes and the woman’s experience through the relationship between the physical birthing environment and balance of power and control (Fahy & Parratt, 2006). It defines key concepts which can be used to guide the understanding of women’s birth experiences for research and practice. Fahy and Parratt define the birth environment or ‘terrain’ as two extremes, ‘sanctum’ or ‘surveillance room’(2006). Within current hospital-based models of care most birthing environments would 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. It enhances her sense of comfort and self-embodiment, offering the optimal woman-controlled territory which improves physical function and emotional security. The more the terrain deviates to that of the surveillance room (a clinical terrain, focused on staff needs and comfort) the greater the fear and poorer outcomes for the woman (Fahy & Parratt, 2006). The woman in this situation has limited choice, less bodily autonomy and is unable to rely on her own intrinsic knowledge and power in the landscape of surveillance (Fahy et al., 2008). It leads to increasing emotional distress, decreased wellbeing and poorer physical performance. Whilst it would be ideal for all women to birth within 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 within the birthing environment, explained as 'jurisdiction' by Fahy and Parratt, divided further into 'integrative power' and 'disintegrative power', 'midwifery guardianship' and 'midwifery domination' (2006). Midwifery guardianship, as a form of integrative power, is at its core woman-centred care. Irrespective of birth outcomes, the woman is respected and supported and ensured of a sense of safety. Disintegrative power and midwifery domination is wielded as disciplinary power - coercive, manipulative and undermining the woman's ability to make decisions for herself. In this space, women will often become docile and hand over their decision making and power to others in the room increasing the experience of birth trauma and decreasing satisfaction.

Even within the more medicalised and obstetric-led model of birthing care, a midwife or other care provider acting in the guardianship role can return power to the woman by enabling feelings of safety and sense of control. They can harness the use of enhancing the woman's mind, body and spirit by restoring her integrative power to make choices about 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 medicalised environment, set up to meet the needs of the clinicians performing the procedure, limits physical function and emotional wellbeing of the woman while increasing fear and emotional distress. The midwife is ideally placed to adopt the guardianship role in this terrain. They do not attend as accoucheur and are well placed to advocate for respectful and supportive care, centred on the woman. By seeking consent and choice, promoting skin-to-skin and not separating her from her baby this has been shown to improve the birth experience of women at caesarean section (Deys et al., 2021).

3.3 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, Barnes, et al., 2016). 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, Barnes, et al., 2016). A positive experience is closely associated with the protection and care a woman receives during her labour and birth and of feeling in control of her body and her baby (Reed, 2021).

The theory balances the *rites of passage* with the *rites of protection* in woman-centred care, maintaining safety of the woman and assessing labour progress, without distracting her from her internal wisdom – the woman as the expert of herself (Reed, Rowe, et al. (2016). Even within a medicalised birth scenario such as caesarean section, respectful and kind midwifery care which advocates and supports maternal choice, empowers the woman to be her embodied self and have a positive experience (Reed, 2021). In her research, Reed identifies that the transformation to ‘mother’ comes from the experience of birth rather than the birth itself (Reed, Barnes, et al. (2016).

Rites of passage focus on the holistic essence of the birth experience, safeguarding the preferences of the woman, ensuring her sense of control, and not putting her in a position of needing to defend her choices (Reed, 2021). The initial intent of this framework was to understand the experience of physiological birth (Reed, Barnes, et al., 2016) however Reed further developed this to include the medical rites of protection for births involving interventions, including caesarean sections. These rites of protection ensure a positive birth experience is possible for women having a medicalised or unplanned birth by protecting and supporting their rites of passage as they transition to ‘mother’, promoting ‘self-trust’ and empowerment in the woman.

These theories each provide the structure to understanding the perinatal experience as an entire perspective, a summary is provided in Table 3.1. They highlight the importance of the metaphysical aspect of birthing women and the influence of power and control. Pregnancy, birth and motherhood all intimately entwined to form the lifeworld understanding for the woman, no stage separate or less significant in how she feels. Both theories compliment the feminist and midwifery context of this research. The important elements of the birthing environment and the people within it, supporting the rights of safe, respectful and consensual birthing care to promote the wellbeing of women transitioning to

motherhood. This gave a structure to the data analysis process to understand the lived experience for the participants in the study.

Table 3. 1 Theory Summary

Birth Territory Describes, explains and predicts how a woman’s wellbeing as her embodied self is impacted by the birth environment (terrain) and use of power (jurisdiction).	**Terrain (birth environment)**	**Sanctum**	**Private, comfortable, enhancing woman’s sense of self, optimal physical & emotional wellbeing, safety**
		Surveillance	**Clinical, observed, staff comfort, reduced physical & emotional wellbeing, fear**
	Jurisdiction (power & control)	**Integrative power**	**Woman-centred, shared goals, enhanced maternal mind-body-spirit, self-expression & confidence**
		Disintegrative power	**Ego-centred and self-serving, undermining of woman’s decision making**
		Midwifery (HCP) guardianship	**Integrative power, respectful care, protecting woman & environment, sense of safety**
		Midwifery (HCP) domination	**Disintegrative and disciplinary power, subtle, manipulative with woman conceding power**
Childbirth as a Rite of Passage Describes how the childbirth experience Is shaped by maternity ‘rituals’ – what is said and done to support (rites of passage) and to protect mother & baby (rites of protection)	**Rites of Passage**	**Preparation and planning for birth, including intervention, minimising distractions, woman-centred, intuitive knowing, respectful and consensual, integration of mother and baby, connection, attending to the birth story**	
	Rites of Protection (non-physiological birth)	**Options & decisions, minimising distractions, advocating & supporting, meeting those providing care, woman’s choices, non-separation – mother in control of her body and baby, processing the birth experience – not staff interpretation**	

Chapter 4: Methodology and Methods “The How”

4.1 Chapter Foreword

My need to understand the lived experience of women giving birth in a patriarchal health system most closely aligned with a phenomenological framework viewed through the feminist theoretical underpinnings described in Chapter Three. Based on my clinical experience, I expected possible common themes as I reflected on the stories already told to me over many years. My focus was always on the value of the individual birth stories and points of view rather than generalising how women as a group experience something. As a midwife whose profession is underpinned by the philosophy of woman-centred care, each individual woman’s perinatal experience is fundamental to understand and inform clinical care, and therefore research (Rigg & Dahlen, 2021). This chapter will further describe why feminist phenomenology best suited this research, and how this was executed through methodology and methods. Section 4.2 will describe my personal ontological and epistemological assumptions and how these fit with the methodological choice for this research. The methodological framework is explored in Section 4.3, while the actual methods used to conduct the research are presented in Section 4.4. This includes ethical considerations, how rigour was ensured, and shows reflexivity.

In addition, a paper has been published in the *British Journal of Midwifery* (Deys et al., 2024a) to exhibit this novel approach to understanding caesarean birth experience. The author accepted manuscript is presented at the end of this chapter (Section 4.5).

4.2 Ontology, epistemology and methodology

Understanding one’s own personal paradigm is essential in developing the theory and methodology to be used in a research project as it reflects the personal belief of what counts as truth (Giddings & Grant, 2006). A researcher’s personal world view will likely align with certain ontological and epistemological assumptions for certain research paradigms and may colour how data is collected and understood. However, whilst a personal paradigm can shape the approach to be taken, the researcher may still choose a methodology which suits the purpose of the knowledge sought (Schneider, 2007). Giddings and Grant explain that a researchers ontological position will understandably control their epistemology, however the methodology chosen is more about how we gain the knowledge (2002). Kivunja and Kuyini

(2017) define ontology as the personal assumptions we make about reality and epistemology as what is counted as knowledge and how we know it.

My personal philosophy is one based on an ontology of a middle-aged, middle class, white Australian woman. I have been encouraged to achieve education and life experiences. I had an independent mother, an independence-supporting father, no brothers, and attended an all-female, selective school which promoted autonomous learning, feminist values and female autonomy. My career is one of a dominantly female workforce, with an early period of nursing but ultimately midwifery. The definition of the word ‘midwife’ has always sat very strongly with me – “with woman”. Although I have not always described myself as a feminist, I have recognised and valued women’s beliefs, experiences and ways of knowing as valid and authoritative, which aligns with this term (Jirojwang et al., 2011) and would now define myself this way.

My personal ontology assumes that women are of equal importance because my experience is one of fairness and being valued. I have grown up in a country and era where opportunities for women have been developing along a similar trajectory to my personal timeline, powered by women before me. I was born in a year that already gave me the right to vote, take contraception and work if I was married. I had just started my schooling when women started to see pay equality changes, financial support for single mothers and the first paid maternity leave. By the time I entered high school there were women in parliament, domestic violence was getting recognition and funding, and women could file for a divorce. My schooling was completed with me unconsciously knowing I had equal opportunities at work and education, and legal protection against discrimination for just being a woman (Victorian Women's Trust, 2024). I value these rights, recognise these are not global, and now continue the gender-equity fight for women in maternity care.

Kivunja and Kuyini (2017) describe the importance of philosophical assumptions such as these in understanding how the researcher makes meaning of the data. A feminist lens in qualitative research about women, by a woman, is an important facet in creating equality, equity and a non-judgemental position between the researcher and the participants (Holloway & Wheeler, 2010).

Knowledge generation, and seeking to interpret the information, was instilled in me by both parents and school. My personal epistemology assumes that both critical and creative thinking will generate knowledge, influenced by my ontology of female importance and equality in the world. My belief in what is true is based on experts in the field, be it a health professional or researcher with vast knowledge or the woman who is the expert in her experience of her own body and baby. Kivunja and Kuyini (2017) describe this as an 'authoritative epistemology', where knowledge is gathered from people who are authorities on the subject. I understand this from a clinical midwife perspective, where although there are rights and laws to protect women in Australia, the women experiencing our maternity care system give accounts where this is not the case. These health inequities for sex and gender are reflected across all health systems that provide care, research and education for and about women, based in androcentric history (Merone et al., 2022).

This gives rationale to how my own values and philosophy sit easily within a qualitative paradigm, in particular an interpretivist paradigm where the subjective reality is understood through human experience (Holloway & Wheeler, 2010; Kivunja & Kuyini, 2017). Phenomenology, specifically feminist phenomenology, appreciates the significance of the lived experience of the birthing woman, interpreted through the eyes of a female and feminist, midwifery researcher who recognises the historical gender-inequities in health research. This idea is explored and connected further in this chapter.

As a midwife still working clinically who has frequently heard similar birth stories to the ones shared by the participants it was important for me not to use this lens of past experience colour the way I collected and interpreted the data. I needed to remain curious about each narrative as a new experience, being careful to put assumptions aside, and to avoid commenting on clinical care decisions that had been made. All the participants knew I was a midwife, and a small number of the participants had birthed in my local health district. It would have been unethical for me to give opinions of particular practices or clinicians, so I was careful to maintain some neutrality, although I was able to clarify some of the details given using my midwifery and lactation knowledge without leading the participants to particular conclusions. In this context I saw my midwifery background as a benefit to being the interviewer. Impartiality was more challenging with later interviews as themes were starting to take shape, I maintained a research journal throughout the PhD and used this to

reflect on each interview in an effort to ensure I maintained this objectivity and openness to new concepts with each participant.

4.3 Methodology

Introduction

The choice of methodology was made clear through the recognition of my philosophical, ontological and epistemological understanding. The participant stories I expected from my clinical experience were grounded in gender-inequity and the hierarchal and patriarchal maternity health system. I wanted the expert knowledge of the participants’ lived experience.

This section will now show why a phenomenological approach was best suited to the aim of my research to understand the experience of women who have been separated from their baby at caesarean section birth without a medical reason. It will describe the evolution of phenomenology into a feminist approach with the novel perspective of two feminist birthing theories. The purpose of this theoretical framework was to support feminist research to improve understanding of women’s birthing experience.

Phenomenology

Qualitative midwifery research seeks to place value on the unique position of the midwife within academic exploration, moving away from the dominating and favoured quantitative, medical model which leads studies in the health system (Newnham & Rothman, 2022). To answer my research question, a naturalistic-interpretive paradigm aligned with the purposive and contextual sampling needed to understand the phenomena which was independently experienced by women who were separated unnecessarily from their baby at caesarean section birth (Holloway & Wheeler, 2010; Schneider, 2007). While I expected commonality, my focus was on the importance of the subjective, individual stories of participants to understand the experience. In considering methodology, the woman-centred nature of my personal and philosophical midwifery perspective did not fit with the hypothetical approach of Grounded Theory. My aim was to describe the essence of the phenomena rather than explain it with relationships of social processes and theory development (Polit & Beck, 2017; Urcia, 2021).

Phenomenology describes how an event, such as birth, is understood within 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 within clinical 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 general morbidity and mortality.

The foundation of phenomenology was based on the approach of the philosopher Husserl, highlighting and distinguishing between the physical and mental experience of phenomena to show the *essence* or true meaning (Dowling & Cooney, 2012). It 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. It is arguable that within the maternity care landscape of historical gender inequality and sexual difference, complete bracketing is ineffective as the experience influences both researcher and participants alike (Mann, 2018b) .

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

The need for a feminist approach

Care of the woman through the childbearing episode 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). Morbidity and mortality rates of women and babies improved with medical advances and training however it increasingly removed the woman as the person of greatest value in the birthing space. This in turn is now associated with increasing

levels of physical and psychological birthing trauma. In the developed world maternal morbidity and mortality is also now 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 known to improve results for women and their babies (Bhalotra et al., 2023). A midwife as the lead carer, maintains the critical support the woman needs, without compromising on appropriate referrals and escalations of care, and with no harmful outcomes when compared to other models (International Confederation of Midwives (ICM), 2017b).

The position of the midwife has increasingly diminished to one of handmaiden status, whereby these health care professionals are valued as a specialist nurse rather than a profession of their own right (Drife, 2023). This has been 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 of one who is a 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), 2017a). Evidence is mounting that midwifery care is safest for most women and babies and more viable for the health care system (Gamble et al., 2021). The medicalisation of the normal progression of labour has led to poorer outcomes, particularly maternal (Reed, 2021). Interventions such as external fetal monitoring have resulted in externalising the fetus as a separate entity from the woman and resulted in undermining her embodied knowledge and right to bodily autonomy (Melamed, 2023). Interfering unnecessarily in pregnancy, labour and birth leads to poorer outcomes and reduces the autonomy of women, leading to more 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). Birthing women themselves are now standing up to demand evidence-based maternity care led by midwives through consumer networks and parliamentary inquiries (Boecker, 2023).

Caesarean section births have a rightful place in maternity care provision, a viable and life-saving option in certain circumstances. Midwives continue to be ideally placed in this scenario, not as accoucheurs but to continue their role as advocate and support for the

woman. According to the International Code of Ethics for 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 (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 describes woman-centred care as focused on the uniqueness of each woman’s needs, choices and right to bodily autonomy (2020). While these standards appear to guide the care of women birthing in Australian health systems, the majority of maternity services are policy, not woman focused, demonstrating the obstetric hierarchical barriers that protect the system and its practitioners (Dahlen et al., 2023). This is exemplified when the term ‘woman-centred care’ does not appear once in the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) ‘*Maternity Care in Australia*’ framework (2017).

Research using a feminist, qualitative framework such as phenomenology has been demonstrated in other literature and 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 gender identity 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.

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 & LaFrance, 2016; Mann, 2018a). Historically, studies and philosophies have used man as the standard (primary) and woman as ‘other’ (secondary), implying lesser value (Bailey & LaFrance, 2016; Beauvoir, 2009). Female experiences have been dismissed as subjective and personal rather than philosophical and valuable (LaChance Adams & Lundquist, 2013). A feminist phenomenology style enables recognition of subjective and social constructs, stripping it back to identify the uniquity of female experience (Zeiler & Käll, 2014). It supports an inquiry about women as both the primary subject and the frame of reference (Mann, 2018a). Birth experience as a phenomenon impacts women - without the female-sexed body there would be no birth. Feminist Iris Young explored the shared circumstances of women, pregnancy and motherhood, the contexts and experiences that are both connected and

individual, influenced by each woman's history, culture and background (LaChance Adams & Lundquist, 2013). Feminist phenomenology accounts for these distinctions and understands the broad landscape of women and birthing. This is in contrast to the authoritative knowledge of the 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 simply create a child has reduced woman's agency over her own body (Davison, 2020; Reed, 2021). Feminist phenomenology research within maternity care offers the opportunity for emancipation, whereby women and midwives voices are heard, enabling a restoration of power and control.

Traditional research conducted with a phenomenological approach lacks diversity and offers a male-dominated view of the world, even when the subjects are female (Shabot & Landry, 2018). Research continues to underrepresent women in human studies, particularly those who are pregnant or breastfeeding. Applying feminism to phenomenology deepens and informs the phenomenological context of the sexual difference of experience in areas such as pregnancy and birth, illness and pain, and even what health means to individuals.

As an early feminist, Beauvoir 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 (2009). She described femininity, womanhood and becoming a mother as being connected to the ontological expectation of a female, being both accepted and expected that a woman marries, cares for her husband and has children. Beauvoir 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 onto the 21st century, there is still a stereotypical tendency to bring up girls to nurture, be helpful and behave, and expect 'boys to be boys' - 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 focused on women's rights in society and employment but have largely avoided the rights of the birthing woman and mother (Hill, 2019). They have acknowledged the disparity of where women live and birth, questioned the need for

disproportionate interventions, and highlighted the powerlessness of the perinatal woman. However, 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).

Connection: Feminism, Feminist Phenomenology, the Mother and the 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 (Hill, 2019; LaChance Adams & Lundquist, 2013). Choosing to not become a mother is ridiculed at the very least and forcefully denied at the other end of the spectrum 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, an innate yearning often shown most glaringly in those who are unable to become one without medical intervention (Ulrich & 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 & 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 specific nature of the phenomena that values the woman’s experience (Mann, 2018a). 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 & 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 immediate and wider 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.

Using the Feminist Phenomenological Framework to Understand Caesarean Birthing Experience

A positive birthing experience should not depend on modality or environment. Women should expect safe and compassionate care at a birth which leaves 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 her 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 own 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 within 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.

Summary

Midwives are philosophically and ethically best placed to work within 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.

This use of feminist phenomenology provides the structure for researchers to explore birth experience within a landscape of increasing birth trauma and obstetric neglect. It is grounded in feminist philosophy and can be developed further with the theoretical lens of the two feminist birthing theories, *Birth Territory* and *Rites of Passage* presented in Chapter Three.

4.4 Methods

This section will outline the methods used to recruit participants, conduct interviews and analyse data. It will present consideration of the ethical requirements of the study along with rigour and a reflexivity statement of myself and the research team.

Study Setting

The participants of this study were to be collected retrospectively to their birth experience. It was expected they would be mothers of young children and potentially had returned to work since the birth, so interviews which would meet their needs in terms of time and location were a priority.

Study Sample

Interest for inclusion in this study was collected through a single social media posting in 2021 (Figure 4.1). The original post was placed in an Australian maternity consumer advocacy group of my local health district. It is acknowledged that people who follow this group were targeted as those who were proactive in improving maternity care in Australia.

Inclusion criteria: female; previous caesarean section with separation from baby at birth (any parity); well mother with healthy term infant/s at the birth event; birthed in Australia between 2010 and 2021; over 18 years of age at time of consent for interview; English speaking.

Exclusion criteria: medical reason for separation at birth.

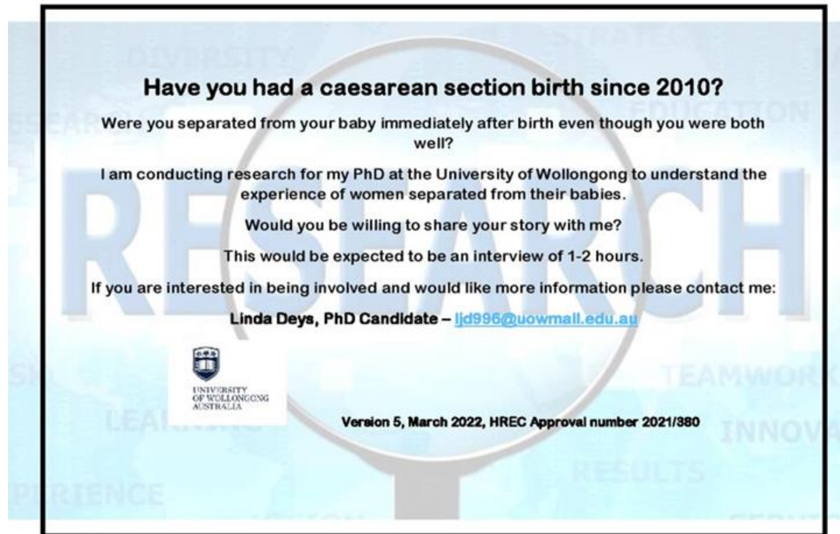


Figure 4. 1 Social Media Post

The initial research inclusion criteria included residence in the one local health district area to enable face-to-face interviews. However, the COVID-19 pandemic created the unexpected opportunity to use virtual technology, so this criterion was eliminated. Despite having some initial doubts about the effectiveness of the interview platform (Zoom), the benefits outweighed potential disadvantages (Oliffe et al., 2021) and suited the participants who had young children.

Participant Recruitment and Sampling

An unexpected response of 27 expressions of interest resulted in the first 24 hours, the post being spontaneously shared by group followers across other social media platforms, groups and private sharing. The use of social media as a recruitment strategy has been demonstrated by other researchers as an effective tool in purposive and snowball sampling (Kosinski et al., 2015; Leighton et al., 2021). This approach suited the methodology of this study, purposively seeking participants who have experienced the phenomenon of dyad separation to obtain rich data (Holloway & Wheeler, 2010). While the snowballing was unintentional on the part of myself, it clearly showed there was keen interest in the phenomenon. It also made participants who were outside of my local health district catchment accessible to me through the social media connections (Leighton et al., 2021).

Participant information and consent forms were sent to all of those who expressed interest via email. Recruitment was established by fulfilling inclusion criteria and returning the signed consent form via return email.

Data collection - Interviews

The decision to use interviews for data collection was made early in the protocol for this study. It allowed the opportunity to gain in-depth, individualised experiences of the event necessary for the phenomenological framework. Initial planning for in-person interviews included a venue of participant choice, the provision of morning tea as an opportunity to take a break if needed, and the prospect of suitable childcare arrangements if chosen or required. The transition to virtual interviewing and pandemic restrictions for all but one interview meant participants were all in their home environment and children were onsite. Most had made arrangements for their children to have supervision or alternate activities. Those with younger children chose times which fitted with sleep-time or easily managed their child’s needs, such as breastfeeding, while being interviewed. There was no predetermined length or structured format to the interview style, so the change in setting was immaterial.

Despite my reservations about the change in modality, online interviewing has been shown to be comparable to face-to-face styles for sharing personal and sensitive information (Guest et al., 2020). The unstructured, in-depth phenomenological interviews were conducted by myself and recorded, primarily via the Zoom platform, with one face-to-face interview done for participant preference, which was voice recorded.

It was clear from the first interview that the participants were not hesitant to share their experiences over Zoom. The phenomenological interview style allowed for the depth and detail needed for the rich data of each participant’s experience (Holloway & Wheeler, 2010). The unstructured approach enabled an informal and interactive conversation between myself and the participants to encourage a sharing of stories with little interruption, with prompting and redirecting questions to focus on the separation event used as needed (Polit & Beck, 2017).

The interview protocol was based on McGrath et al (2019), which included rapport building, listening and reflection and has been previously demonstrated in other health

related qualitative research interviews, (Huglin et al., 2021; Vafaei et al., 2023) and is shown in Table 4.1.

Table 4. 1 Interview Protocol

Interview Protocol (based on McGrath et al 2019)

1. Rapport building and comfort creation – general questions about things such as family, number of children – offer refreshments now and advise a further break can be added when the participant feels the need – ensure seating is of equal height
2. Remind the participant that the interview will be recorded and start recording
3. Thank participant for their involvement, remind them of their consent including their freedom to withdraw at any time up until data analysis, remind them again of the purpose of the research/interview (to understand their personal experience of being separated from their baby at caesarean section birth)
4. Ask participant verbal consent to proceed with the interview question
5. Question 1 – "Tell me about your birth experience"
6. Prompting/clarifying questions based on participant responses – eg: How did that make you feel? Can you explain that more?
7. Provide ample time for participant to respond, actively listening, respecting silences and maintaining interest
8. Pause the interview or take a short break if unanticipated emotions result
9. Conclude the interview with "Is there anything else you would like me to know?"
10. Stop recording, thank participant for her time and involvement

In preparation for the interviews and anticipation of potentially retriggering trauma for the participants as they shared their birth stories, I completed a Psychological First Aid Certificate through my local health district. I felt confident in my interviewing skills through my extensive clinical experience. Interviews were set up at mutually agreed times for each participant. I have discussed this further in the Ethical Considerations Summary to follow.

The one-to-two-hour interviews, with an average of 62 minutes duration, commenced with the opening question of "Tell me about your birth experience" followed by participant specific prompting and clarifying questions to focus on the phenomenon of separation. At the end of each interview, I did dot point handwritten notes in a notebook reflecting on how it went and my initial thoughts. These field notes included nonverbal cues and emotional behaviours to provide context to the next stage of data analysis (Sutton & Austin, 2015). These were identified in the notebook by date and time of interview only. The first two interview transcripts were completed verbatim by myself and reviewed by two of my supervisors, with remaining transcripts completed by a transcription service in verbatim style

soon after each interview. The verbatim text offered the opportunity to factor in significant emotions, pauses and other key points in the text (McGrath et al., 2019). A professional and secure research support transcription service was engaged, with video and audio files transferred under participant numbers for identification. These numbers were later transferred to pseudonyms for analysis and findings.

Data Analysis

Data analysis was manually conducted using a Modified van Kaam approach which included the grouping, reducing, thematizing, validating and describing of themes (Moustakas, 1994). This descriptive data analysis method seeks to understand the phenomenon by limiting researcher perceptions and beliefs from influencing participant responses (Galinha-de-Sá & Velez, 2022; Moustakas, 1994). It was well suited to this research as the participant voices and experiences are explored in depth and verbatim to fully understand their lived experience. A description of this process is shown in Table 4.2.

The interview recordings were initially replayed while reading the transcripts as they were returned to ensure accuracy, and handwritten notes taken on demographics and points of interest. I found this a good way to remember the emotion that was attached to what each participant was saying. The transcribed narrative data was then coded using the NVIVO program (Zamawe, 2015) – as I read through each transcript again, sections of the data were selected and placed under headings (nodes) that emerged. These nodes reflected experiences, emotions, and perceptions. Sixteen nodes, or by then sub-themes, were the result, which were further grouped into four overarching themes (incidence represented in Figure 4.2) with the frequency of data grouping into each sub-theme shown in Table 4.3 (node column).

Table 4. 2 Modified van Kaam Data Analysis

Data Analysis – 7 steps (Modified van Kaam)	**How I did this**
1.Listing & Preliminary Grouping	• Reviewing of each interview audio with transcriptions • Handwritten notes on demographics and points of interest, looking for the central common interest between participants • Re-reading each transcribed narrative through NVIVO software • Discussion of initial listing with 2 supervisors
2.Reducing & Eliminating	• Selecting text and putting into nodes of similar phrases and meaning from each participant • Using the common phrases to merge nodes into 16 more specific and descriptive sub-theme titles • Removing elements that were not relevant to the experience of dyad separation
3.Categorising & Theming	• Exploring the meanings behind the quotes in each node (sub-themes) • Themes constructed from the sub-themes
4.Applying & Validating the themes	• Rereading of the transcripts and nodes – checking the themes alongside the data • Reflecting on whether the themes describe the phenomenon of experiencing separation from one's baby • Discussion with 2 supervisors – changes made to define each theme more clearly
5.Construction of individual text description	• Verbatim quotes and passages of each participant collected under each sub-theme/theme
6.Construction of individual structural description	• Frequent and prominent themes from each participant collected showing common experiences of being separated from their baby
7.Construction of Structural-Textural Description	• A synthesis of experiences, quotes and themes combined together for an overall description and understanding of the phenomenon • Each theme related back to the lived experience of being separated from a well baby at caesarean section

Figure 4. 2 Frequency of data coding by theme

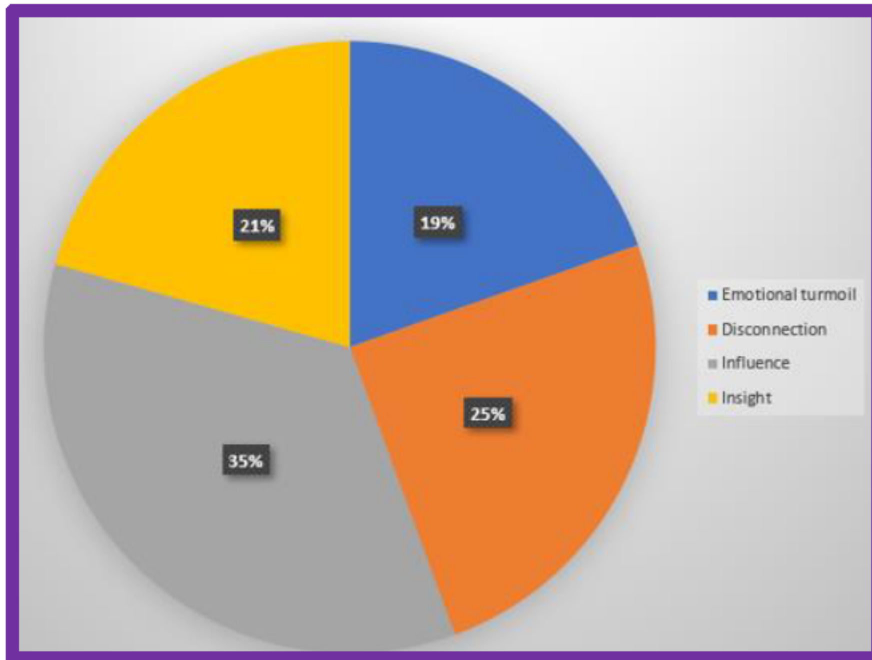


Figure 4. 3 Data Analysis "Sticky Notes"

Coding and themes were regularly reviewed and refined by the research team. The sticky notes featured again at this point, see Figure 4.3. These were then aligned with and viewed through the lens of the feminist birth experience theories - “Birth Territory” (Fahy & Parratt, 2006) and “Childbirth as a Rite of Passage” (Reed, Barnes, et al., 2016), see Table 4.3 for mapping. The birthing theories were reflective of the participant experiences, through the influence of terrain and jurisdiction and rites of passage and protection.

Table 4. 3 Data analysis mapped with birthing theories

Nodes (no. of references)	**Codes/Themes**	**Feminist Birthing Theory**		
		Birth Territory – (Terrain & Jurisdiction)	**Rites of Passage**	**Rites of Protection**
○ Desire to hold baby (19) ○ Separation (126) ○ No skin-to-skin (37) ○ Breastfeeding (60)	➢ Disconnection		●	●
○ Emotions at birth (60) ○ Emotions since birth (90) ○ Impact on relationship with baby (31) ○ Impact on relationship with partner (10)	➢ Emotional Turmoil	●		●
○ Power & control (104) ○ Maternal choice & consent (65) ○ Coercion (29) ○ Staff actions (143)	➢ Influence	●		●
○ Mother’s knowledge (35) ○ Interventions (35) ○ The partner (53) ○ Next birth (78)	➢ Insight		●	●

Ethical Considerations

Ethical conduct of medical research has been guided by the Declaration of Helsinki, developed by the World Medical Association, since 1964. It was most recently updated in 2013 and governs the ethical principles of medical research involving humans (World Medical Association, 2018). In short, these standards ensure research is carried out by suitable persons, risks are accounted for and should not outweigh potential benefits, confidentiality and dignity is maintained for the subjects, and there should be a benefit for the population being studied (World Medical Association, 2018). This is echoed by the National Health and Medical Research Council (NHMRC) National Statement of Ethical Conduct in Human Research. These guidelines direct research to have merit and integrity, justice, beneficence and respect for human participants (National Health and Medical Research Council, 2023).

Ethics approval

In demonstrating how this research met these principles, ethical approval was sought and granted. Initially this was granted by the University of Wollongong Human Research Ethics Committee (HREC), Australia (approval number 2021/380) and later transferred to the Australian Catholic University Human Research Ethics Committee (ethics register number 2021-3064T). For HREC approval letters see Appendix B.

Data Storage

Data protection was managed as per university guidelines. Participant names and contact details were removed from all transcripts and handwritten field notes taken were recorded under participant number and date of interview. These were later typed to include in electronic storage and originals destroyed. Consent forms were also stored electronically – all were sent via email so no hard copies were kept and any participant email files were permanently deleted once data analysis commenced. The deidentified electronic transcripts and audiovisual recordings were stored initially on a password protected personal laptop then transferred to password access required Australian Catholic University (ACU) OneDrive storage. Ongoing retention and disposal schedule is as per ACU Research Data Management Policy.

Research merit and integrity

The contribution of new knowledge and understanding from this research has the potential for improvement in the way women are treated in the perinatal period, in particular that women and their baby are not separated unnecessarily at caesarean section birth. This research was conducted by a suitably qualified and competent team including myself as the PhD candidate with extensive clinical knowledge and supported by senior academic supervisors with methodological, clinical and research expertise. The findings of the recent Birth Trauma Inquiry in NSW have highlighted the common but avoidable experience of birth trauma in both this state and further afield (New South Wales Parliament, 2024).

This integrity of this research has been demonstrated by the results which have increased knowledge and understanding, with these outcomes being already disseminated through publications and conference presentations. The papers and virtual conference presentation recordings have also been shared with maternity consumer networks through the social media group the participants were recruited from to maintain openness.

Justice

Participation in this research was voluntary with inclusion dependent on women responding to the social media post, being sent participant information, and then signing consent and returning that to me. The sharing of the post onto other social media platforms was done spontaneously by the original Facebook group members, not requested or expected. The women who participated were given clear information about what the study entailed, their rights to withdraw at any stage up until deidentification of data, and the prospective risk of reliving the trauma.

Beneficence

Interviews were conducted at times which were mutually suitable. I made sure I checked in with their wellbeing if they were becoming visible distressed during the conversation and offered pauses or halts. The risk of being retraumatised was included in the participant information sheets and revised on the day of interview, reminding the participants of the right to stop the interview or withdraw consent on the day. The altruistic motives of all participants were strongly felt and communicated during the interviews. They wanted to see

positive change come from sharing their stories. I saw the enormity of what they were giving me and this made me feel very responsible to ensure the quality of the research was high.

Respect

All participants were consenting adults who spoke and understood English and were therefore able to make decisions about their inclusion in this study. I was very mindful of the time, commitment and energy this took from them, particularly as mothers who had to leave the interview to go back to caring for their children. My respect for them has been demonstrated in my commitment to complete this research in a timely manner and to share the results widely, including sharing it back to the social media groups where they came from. All contact details were destroyed during the deidentification process, however all participants were told to expect publications to be shared on their consumer group social media pages.

Ethical considerations summary

Informed consent: Participant information sheets were provided to all interested responders to the social media post (Appendix A). This discussed the potential risks of reliving the trauma and included recommendations or contact details for organisations providing emotional wellbeing support, including their own General Practitioner. Study participants were reminded of this on the day of interview and their option to take a break, conclude or withdraw their consent, before commencing the interview. While most became emotional during their interviews, none elected to take a break, end early or withdraw their consent.

Consent forms were signed and emailed to me by all participants prior to interview and reconfirmed verbally prior to starting. This included the option to read their interview transcript before giving final consent to be included in analysis, only six participants chose to read their transcript, and all subsequently confirmed they were happy to continue to be included in the study. Transcripts were deidentified after agreement to continue, with participants given a final pseudonym to identify individual data and protect anonymity.

Right to withdraw: During the written/signed and verbal/confirmation consent process participants were informed of their right to withdraw at any stage up until deidentification for data analysis.

Confidentiality: All electronic and written documentation and data which could be linked with an individual participant was deidentified using participant number and date of interview initially, then pseudonyms. All data was stored electronically in my password protected personal laptop in my own home, and ongoing in accordance with ACU Data Management (password protected OneDrive).

Complaints: Interviews were done while I was a candidate at UOW, the participant information sheet provided both email and telephone contact details for the UOW Ethics Officer if participants had concerns or complaints about the conduct of the research (see Appendix A). No complaints were received by the participants or their personal associates.

Quality & Rigour

The relevance and trustworthiness of qualitative research hinges upon transparency of the research methods and methodology and a thorough depiction of the epistemological and theoretical underpinnings (Adler, 2022). The qualitative research style explores the essential details of human experience with credibility and reliability when trustworthiness, or rigour, is established through thorough and competent process (Holloway & Wheeler, 2010). This includes demonstrating the research process is credible, transferable, dependable and confirmable (Ahmed, 2024).

Credibility is demonstrated through the clear depiction of research method and methodology, transparency of the research team, including myself and the three supervisors, and reflexivity. The data collection protocol included rapport building to establish trust and promoted the collection of rich data from the open and honest birth stories which were shared. Interview transcripts were reviewed alongside the recordings to ensure tone and intent was clear, nodes and themes were reviewed in conjunction with my supervision team, and the two birthing theories were used to support the context of the data analysis.

Transferability The theoretical underpinnings and methodological framework described enables a deep understanding of the research and could be used in a variety of maternity settings and birth modalities. Publishing this framework enables replication for other researchers seeking to understand maternal experience from a feminist perspective (Deys et al., 2024a). In noting that the experience of these participants was similar for all 15 it is

significant that data saturation was complete by 13 participants however achieving and analysing the 15 reinforced there were no new themes being identified.

Dependability was also demonstrated with findings that were consistent for all 15 participants who had been separated from their babies at caesarean section birth unnecessarily. The data findings and themes were reviewed by the research team regularly. These methods, techniques and procedures for collecting and analysing data are clearly outlined in this chapter and would allow other researchers to replicate the process in their own context.

Confirmability ensures that the findings from the data reflect what the participants said, and this was verified through the liberal use of quotes from the data to support each sub-theme and theme. I kept a research journal during my PhD journey to reflect on my thoughts, processes and potential bias.

Reflexivity Statement

I conducted all interviews as the PhD candidate, with my background of being a Clinical Midwifery Consultant and International Board Certified Lactation Consultant (IBCLC). I conceptualised this research based on clinical experience and lack of evidence to promote meaningful change for women birthing by caesarean section who had experienced separation from their infant in my local health district, and this was supported and enhanced by the supervision team. I come from a background of having had two caesarean section births in a time before skin-to-skin contact was usual practice at any birth type and experienced no personal birth trauma. The supervision team all identify as female, with expertise in nursing, midwifery, and qualitative research. While it is acknowledged that not all birthing people identify as female, in line with the feminist underpinnings of this research and the importance of not erasing women from literature, the words woman, women and mother are used, along with the associated pronouns. All participants in this research identified as female.

4.5 Author accepted manuscript for Methodology Paper

Deys, L, Wilson, V, Bayes, S & Meedya, S (2024) Using a novel approach to explore women’s caesarean birth experience. ***British Journal of Midwifery, 32:5, p 258-263. DOI: 10.12968/bjom.2024.32.5.258*** (Published PDF version in Appendix E)

Scientific Journal Ranking – Q2; Impact Factor 0.49

Abstract

Background: 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.

Aim: To design a framework to view caesarean birth experience of women within an androcentric maternity system using a feminist, midwifery lens.

Discussion: 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 creates a novel framework for researchers considering the position of women within a medicalised health care system. Feminist phenomenology with a theoretical feminist overlay refreshes the methodological framework for a new understanding of how this perinatal event impacts women.

Key Words: birth experience; feminism; phenomenology; caesarean section; midwifery; women

Introduction

Care of the woman through the childbearing episode 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). Health and survival rates of women and babies improved with

medical advances and training however it 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 the developed world maternal morbidity and mortality is now 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 known to improve results for women and their babies (Bhalotra et al., 2023).

The position of the midwife has increasingly diminished to one of handmaiden status, whereby these health care professionals are valued as a specialist nurse rather than a profession of their own right (Drife, 2023). This has been 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 of 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), 2017a). Evidence is mounting that midwifery care is safest for most women and babies and more viable for the health care 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 resulted in undermining 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 (2014), midwives’ partner with, empower and support women to be active participants in deciding how they birth. The Australian Code of Conduct for Midwives (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 describes woman-centred care as focused on the uniqueness of each woman’s needs, choices and right to bodily autonomy (2020). While these

standards appear to guide the care of birthing women the majority of maternity services are policy, not woman, focused highlighting the obstetric hierarchical barriers that protect the system and its practitioners (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 gender identity 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 within academic exploration, moving away from the dominating and favoured quantitative, medical model which leads the health system (Newnham & Rothman, 2022). This paper 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 within 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 within 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 of philosopher Husserl, highlighted and distinguished between the physical and mental experience to show the *essence* or true meaning (Dowling & 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, within 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, 2018b) .

Heidegger further developed phenomenology to move beyond describing the experience to the interpretation of the hidden meanings, which identified and included the beliefs of the researcher (Dowling & 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 & 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 & LaFrance, 2016; Mann, 2018a). Historically, studies and philosophies have used man as the standard (primary) and woman as ‘other’ (secondary), implying lesser value (Bailey & LaFrance, 2016; Beauvoir, 2009). Female experiences have been dismissed as subjective and personal rather than philosophical and valuable (LaChance Adams & Lundquist, 2013). Feminist phenomenology enables recognition of subjective and social constructs, stripping it back to identify the uniquity of female experience (Zeiler & Käll, 2014). It supports an inquiry about women as both the primary subject and the frame of reference (Mann, 2018a). 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 & Lundquist, 2013). Feminist phenomenology accounts for these distinctions within 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 woman’s agency over her own body (Davison, 2020; Reed, 2021).

Traditional research offers a male-dominated view of the world, even when the subjects are female (Shabot & Landry, 2018). Research continues to underrepresent 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 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 (2009). She described femininity, womanhood and becoming a mother as being connected to the ontological expectation of a female. Beauvoir 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 onto the 21st century, there continues a stereotypical tendency to bring up girls to nurture, help and behave, and expect ‘boys to be boys’ - 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 informing policy and culture.

Connection: Feminism, Feminist Phenomenology, the Mother and the 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 (Hill, 2019; LaChance Adams & Lundquist, 2013). 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, often demonstrated with those who are unable to become one without medical intervention (Ulrich & 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 & 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, 2018a). 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 & 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 – *Birth Territory* and *Childbirth as a Rite of Passage* through a feminist phenomenological enquiry

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, Barnes and Rowe *Childbirth as a Rite of Passage* (2016). 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 & Gair, 2015).

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 & Parratt, 2006). It defines key concepts which can be used to guide the understanding of women's birth experiences for research and practice. Fahy and Parratt define the birth environment or 'terrain' of two extremes, 'sanctum' or 'surveillance room'(2006). Within current hospital-based models of care most birthing environments would 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 & 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). Whilst it would be ideal for all women to birth within 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 within the birthing environment, explained as 'jurisdiction' by Fahy and Parratt, divided further into 'integrative power' and 'disintegrative power', 'midwifery guardianship' and 'midwifery domination' (2006). Even within the more medicalised and obstetric-led model of birthing care, a midwife or other health care 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 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, and not separating her from her baby. This has

been shown to improve the birth experience of women at 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, Barnes, et al., 2016). 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, Barnes, et al., 2016). 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).

The Reed et al theory balances the *rites of passage* with the *rites of protection* in woman-centred care, maintaining safety of the woman and assessing labour progress, without distracting her from her internal wisdom – the woman as the expert of herself (2016). Even within 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 connects that the transformative passage of woman to 'mother' comes from the experience of birth rather than the birth itself (2016).

These theories both 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.

Using a Feminist Phenomenological Framework to Understand Caesarean Birthing 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 own 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 within 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 within 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 within 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.

Key Points

- Negative birth experiences are increasingly acknowledged as being 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.

Reflective Questions

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

4.6 Chapter Conclusion

This chapter has outlined the rationale and consideration of methodological choice, and the methods utilised to conduct this research. It has demonstrated the ethical principles which were adhered to, including the storage of data, and the data collection changes needed to continue the research during the Covid-19 restrictions. The chapter has concluded with the author accepted manuscript of the paper published in the British Journal of Midwifery (Deys et al., 2024a). The following chapter will present the findings of my research.

Chapter 5 – Findings

5.1 Chapter Foreword

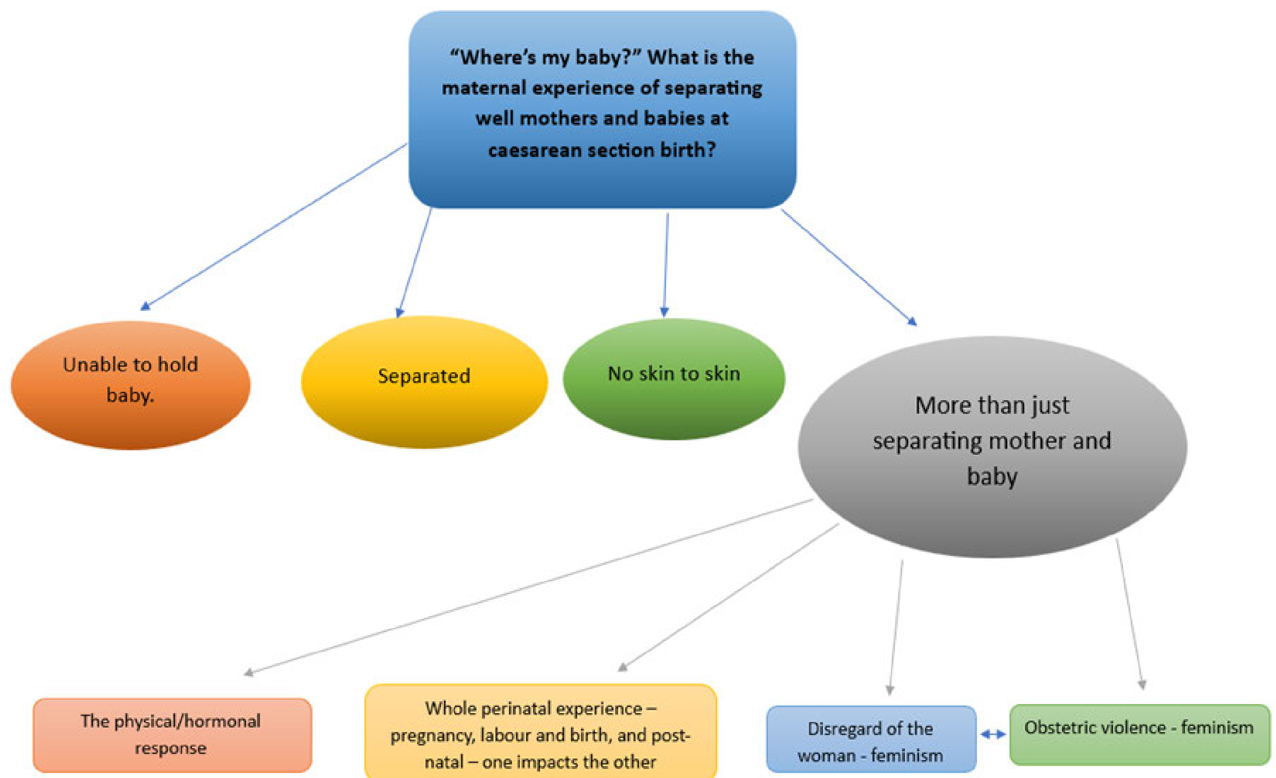
The previous chapters have explained that a negative birth experience has the potential to impact a woman’s transition to motherhood and emotional wellbeing far beyond the newborn period. It has established that separating woman from their baby at birth is known to reduce birth satisfaction and is more likely to happen at caesarean section births, and then outlined why and how this study was undertaken. This chapter now presents the findings of my research. The chapter will complete with the author accepted manuscript published in *Women and Birth* (Deys et al., 2024b). The PDF of this published paper plus supplementary file (themed participant quotes) and the Standards for Reporting Qualitative Research (SRQR) form submitted to the journal are in Appendix F. Pseudonyms are used for participants’ quotes.

5.2 Findings Part A

My initial reflections on the interviews and transcribed data were of the enormity of these birth stories as an overall picture. Separation itself meant no skin-to-skin and being able to hold and begin nurturing the baby, and to transition to ‘mother’. However, it was far more than just a physical construct of maternal-infant separation, with the participants describing the ripple effect of their perinatal journey along with physical and hormonal reactions. The merit of viewing this through a feminist lens was emphasised by their descriptions of obstetric violence and disregard. Figure 5.1 shows a mind map of my original thoughts when listening to the recordings the first time through and reflecting on the aim of the study.

The participants commented on their position of intensified vulnerability due simply to being a woman, and therefore a feminist problem. *“I have been like, this is, you know, this is a feminist issue”* (Erin while emphasising it wasn’t the caesarean birth that caused her trauma but the separation from her baby). It grounded me to listen to recent accounts from the last decade which continued to reflect the historical feminist mantra of the last century. Miranda said *“I feel like the system fails women, and I feel like if men gave birth…the hospital systems would be just, you know, A-class for them and no one would ever – they wouldn’t have any problems. The system would really, really support them. But because it’s women, um, you know, we’ve come from a position of women didn’t even have the right to vote, you’re man’s property.”*

Figure 5. 1 Initial Reflections



Identifying the maternal-infant separation phenomenon from the overall perinatal experience was initially challenging, with all fifteen participants revealing distressing and traumatic perinatal stories. The separation at birth was not shared as an isolated event but as part of their overall interpretation of what had happened to them. However, the whole experience set the scene for their general treatment and care management which ultimately led to them being separated from their baby. The four main themes which emerged from the data –*Disconnection, Emotional Turmoil, Influence, and Insight* - characterised the experience of separation without a medical indication. These themes consider how disciplinary power and a focus on facility priorities consequentially disempowers women as they transform to being 'mother', impacting relationships and emotional wellbeing well beyond the day of birth.

The language used by the women was powerful, the emotion was intense, and the purpose behind the participants choosing to be involved in this research was very clear – to

make changes for birthing women. I have underlined some of this powerful language in the quotes that follow to emphasise the significance of these women's contribution.

Theme 1: Disconnection

Disconnection was experienced for all participants, isolated from their own body, baby and partner, detached from the birth outcomes they expected to have. The four subthemes coded within this theme underline how the dyad separation was experienced by the participants – *Desire to hold baby, Separation, No skin-to-skin, and Breastfeeding.* This resonated particularly with Rites of Passage and Protection, centring on the needs and desires of the woman as she prepared to meet her baby, attend to her perspective of the birth story and become emotionally and physically connected with her child. The enormity of this process was not considered by the attending staff and lacked respect for the important role the woman had in her birth.

Desire to hold baby

The participants desire to hold their babies were not valued in any of these birth stories and some felt this physical separation was a deliberate act for not agreeing to treatment plans – *"…she was deliberately keeping me there to keep me separated from my baby. That's the punishment is – is being kept separate." (Louise, 5 hours separation)*. The duration of being apart, before being able to hold them, was sometimes unclear in their memories, but any amount of time felt too long – *"It was probably about an hour, but it felt like forever." (Naomi).*

"I don't even know how long I was in recovery for, to be honest, I don't know when – how long it was till we got to the room. Um, like she was born at, um, 1:40pm in the end and – yeah, I don't know – I'm not really sure. I feel like it was maybe around 5:00pm but then I could be completely wrong." (Maria).

Some were able to quantify the period of separation by external factors such as time-stamped photographs. But photographs also reminded them of the separation and being unable to hold the baby themselves – *"I don't have any memory of seeing him…he was kind of like, put around my shoulder area. I wasn't holding him…The anaesthetist took some photos for us…just stay on a file on my computer, and we never look at them." (Miranda).* Not holding

their baby prohibited them from checking their baby was safe and well, particularly for those pressured into a caesarean birth over concerns of fetal wellbeing.

“I just wanted to be with her. I remember going ‘Hurry up! Like, am I good yet? Can I get out?’ I think I was pretty much annoying the nurses going, ‘Okay, I’m good. Can I leave yet?’…I remember going, ‘But, I’ve got to get to my baby’, and they kept saying to me, ‘But you can’t’. I was just like, ‘Please, please let me see my baby.’” (Michelle, separated for 4 hours)

“And I kept on asking them, like, they were stitching me up. I was like, ‘Can you bring my baby back?’… I just didn’t feel like they really understood the urgency of it. I don’t think they understood, like, how important it was to me.” (Sally, separated for ‘at least an hour’ but unsure)

Separation

This sub-theme emerged from the emphasis the participants placed on the physical separation and the ongoing disassociation. Rather than empowering the woman to claim and bond with her baby it reinforced the dangers of her body, the baby more safely cared for by other people. Louise said *“They just took him. I didn’t hold him for two hours [crying].”* Maria said she could not see her baby initially but the baby was passed near her head so she could kiss her and was then taken for a brief stay in NICU despite the good condition, along with her partner *“And I think they were crowding her a lot, so I couldn’t really see her much, and I-I-I can’t really remember much of it, to be honest, other than she got passed to my head…I kissed her on the head, and then she was sent to the NICU even though she got nine out of nine Apgar scores.”.*

The reasons for separation were not communicated with the women, thereby not consented for. *“I had about three minutes. He was wrapped and given to me, and I kind of held him, looked at him, really. Then after a couple of minutes, it was, “Okay, he’s gotta go now,” but I didn’t know why.” (Alice, then separated for three hours)*

The concurrent removal of the partners who were sent with the babies added to the experience of separation, the loss of the only person in the room who was there for the woman herself: *“it really impacted me psychologically to be separated from the one person [husband], that I, you know, loved and was relying on” (Miranda).* The importance for the women was to see their baby was safe, to be a mother and be reunited with their partner:

"<u>I need, I want to go and see my baby</u>, and I wanted to be alone with her and my partner." (Louise, separated for 5 hours)

"<u>Where's my baby?</u> Where's my husband? Why-why am I still in the operating theatre?" (Jane, separated for two hours)

The further barriers and interruption to being able to connect with their baby, included the cleaning of all signs of the woman from her baby. Almost all participants brought this subject up, describing the rubbing, wiping and wrapping of their infants. Maternal senses which normally promote connection and relationship during transition to 'mother' were lost with this decontaminating and then removal of the baby – visual, aural, olfactory, and tactile:

"Like three metre's away. <u>They're cleaning every sign of me from her</u>. She came all wrapped up and clean to my arms. Well, what kind of skin-to-skin is it when the baby's completely wrapped up and clean?" (Rose) Rose went on to say the loss of the olfactory connection significantly impacted the relationship with her daughter *"I couldn't smell my [daughter] until she was about 8 months. I couldn't smell her. No sense of like this is how my daughter smells...It's still very dull. I think that's had a very big impact on me and I truly think that has to do with the separation, of like not being able to be the mammal of like licking your own baby once it comes out of you…It probably, yeah like the emotion that I could never put out of my body. <u>The numbness</u>." (16 months later).*

The participants saw mother-infant closeness at birth as a normal expectation, irrespective of birth mode: *"Caesarean or vaginal is not the issue, it's just that no matter which way you give birth, you should be going as close to the natural process as we can, and that is that the mother and the child stay together. So, I wouldn't care one iota, it would just be an-an assurance that she was with me, she came straight to me, um, my preference also would be that she wasn't cleaned off before she comes to me. Like, I would like her to just be given straight to me. Like, I don't care, it's all my fluids and stuff anyway." (Lauren)*

The physicality of connection was lost through the wrapping process, another barrier from each other *"It's a bit <u>heart breaking</u>, even just that, like, he was wrapped up before I got to cuddle him—like we never really did proper skin-to-skin." (Lily)* and an obstacle that impacted the visual connection also *"I didn't even really get to see her face cause they – the way they'd swaddled her up." (Louise).*

No skin-to-skin

Not being able to have close physical touch with their babies exacerbated the experience of separation and disconnection. Skin-to-skin contact with their newborn was expected by all participants and some had explicitly put this in their birth plans. It was not a priority of the hospital staff or facility, with only two participants supported briefly while in the operating theatre to attempt skin-to-skin. A further participant had attempted skin-to-skin contact, but the baby was half wrapped, seven held their wrapped baby briefly, four had a baby wrapped and held near their head and one had only a fleeting glimpse before her well baby was taken away. The women were taken to the recovery area within the operating department after the surgical procedure, however no babies remained, or returned to be, with the women, with some separations being many hours. The woman’s perceived low status in the birthing room was made clear through participant comments around skin-to-skin contact:

“She cut the cord before she even lifted her up…<u>she literally went against everything</u> that had been organised, …I was <u>denied</u> delayed cord clamping and the skin-to-skin. Skin-to-skin should be encouraged…you know, having mum and bub together and skin-to-skin costs the hospital nothing.” (Louise)

Others were more submissive and docile in their responses, dominated by the staff in the room and without any sense of power. Alice had requested skin-to-skin contact on her birth plan *“but I guess <u>they didn’t see it as being important</u>.”* Miranda described having a detailed birth plan which included the importance of skin-to-skin contact to her but felt unable to ask when it didn’t happen *“No [didn’t ask for skin-to-skin], I didn’t know when he came out and, just <u>the hostility in that room was, like, horrific</u>.”*

If women did ask for it to happen clinicians gave excuses for no skin-to-skin, ranging from staffing restrictions, infection risk, or room temperature: *“I was told that they <u>are not allowed</u> to do that because of infection control.” (Susannah); “But they told me beforehand, ‘Oh, sorry, it’s too cold down in the theatre, so once you go to recovery, you’ll be able to do skin-to-skin’.” (Michelle, the baby was not returned to recovery).* After filing a complaint, Jane was told *“Oh, whether or not the baby stays with you is really up to the flow in the birth suite and whether we've got enough staff."* But this was not explained on the day.

Some women didn't ask, and it didn't happen, and thought this was because it was seemingly not usual facility practice:

"And you know, they didn't talk about skin-to-skin or anything like that, so it was just slice, cut, over to the table, do all things, weigh, wrap her up, and then bring her to me all wrapped up." (Naomi)

"I didn't get to have him on me straight away. They put him back down, cut the cord, and then like rubbed him off, wrapped him up and then brought him over, which I was sort of more hoping that he would come to me, but we didn't really voice that very clearly in the theatre. I don't think anyone in the theatre sort of knew, 'cause it was a different midwife in the theatre with us than who was getting us prepped." (Lily)

Breastfeeding

The participants in this study had all planned to breastfeed and understood the importance of having skin-to-skin contact and an early feeding opportunity. They feared that separation had the potential to negatively impact breastfeeding success. Most of their breastfeeding journeys were challenging due to the early separation from their baby:

"I was very worried about the effect it could've had on our breastfeeding." (Louise)

"I was also nervous that I was gonna have trouble breastfeeding because it was like…how's the milk gonna start running when like, this is what's happening." (Erin)

All fifteen participants breastfed their infants with determination to succeed after their birthing experience and delays in commencing feeding due to being separated from their baby. Early challenges were expected and faced by most. Misinformation, absence of breastfeeding support and inconsistent advice from staff while in hospital exacerbated the early challenges:

"…they'd sort of plonked me there with the bed, and put the brakes on, and just sort of left me there, and then one of the ward midwives came in, and was like, unwrapped him and put him on, somehow got him on my boob, and…told my husband 'make sure she does this for 20 minutes'." (Susannah)

"I was just about to attach (baby) to the breast, and she just came over and was like 'you're doing it wrong! Hold the areola!'… Like, wow, <u>I just for a split second started to feel</u>

comfortable in my own ability, and no, no, no…it was like she just came in to tell me that I was doing breastfeeding wrong." (Erin)

Even so-called 'experts' created unnecessary barriers to successful breastfeeding *"one of the things that pissed me off the most, I guess, was the next day, having the lactation consultant from the nursery come down – 'Oh yeah, no, he doesn't seem to have a very good latch, you know we have this formula'. And I'm like, get out." (Maggie, exclusively breastfed without any need for formula).*

The physical, hands-on approach by midwives further disempowered and disembodied the women: *"…it was that sort of midwife-led, um, you know, jamming…" (Naomi, describing her first breastfeed attempt when reunited with baby).*

The participants surmounted the early, and for some ongoing, breastfeeding challenges in spite of their birth and separation experiences. They attributed breastfeeding to healing disconnection and create relationships with their babies:

"I still feel proud of 13 months…breastfeeding was the thing that really helped me to narrow that gap and form the bond with [son]." (Miranda)

"I think I was just very lucky, to be honest, that he fed well from the get-go, it's been actually really healing." (Alice)

These rites of passage to motherhood were interrupted through disconnection from their bodies, babies and partners. Rites of protection wielded to only further remove control over what happened to their body and baby increasing rather than protecting their vulnerability.

Theme 2: Emotional Turmoil

Emotional turmoil created conflicting and distressing responses through the separation event. The distress of the separation caused significant and conflicting emotions which impacted birth satisfaction, ongoing emotional wellbeing and relationships within the new family. The environment where birth took place, physically, characteristically and contextually impacted these emotional responses and connections. Four sub-themes were identified – E*motions at birth, Emotions since birth, Impact on relationship with baby, and Impact on relationship with partner.*

Emotions at birth

Describing the first moments after birth was very emotional for all participants. They used words that conveyed fear, failure, confusion and trauma. The participants had no sense of control over what was happening to them, most becoming docile and compliant with acceptance of having no choice. Although thirty percent of the births were planned caesarean sections, all participants similarly felt the reasons given for the caesarean, particularly the risk to their babies, were exacerbated to ensure compliance or were caused by previous medical interventions. In the clinical environment they experienced emotional distress, loss of safety for themselves and their baby, and manipulative control over the options given, including not being able to remain in close physical contact with their infant. These early emotions at separation were described as numbness, sadness and helplessness:

"…very surreal, like I know in my head I just had a baby but it doesn't feel like I just had a baby at all cause there's no baby." (Lily while in recovery)

"I was really worried about him [baby], it was something that I had put in my birth plan, about skin-to-skin, and that, especially in the first hour afterwards it is really important to me... I just felt anxious, but also really sad that I was missing out on that." (Sally)

"I didn't hold him for two hours [crying]. I didn't know what had happened to him and nobody knew what had happened to me. Like, it's just insane, and we were probably only a couple of corridors apart." (Clara)

The early signs of trauma were very clear in the way the participants described their experience, as Alice* waited for her baby to be born, lying on the operating table she said *"It was like being in a car accident.".* Miranda also said that moment of waiting for the baby to be born *"it was just shattering. It shatters you."* and after being coerced into the caesarean because of concerns for baby's safety:

"I was scared, but the whole time that I was [tearful] the caesarean was occurring, I thought he was dead. I thought he was – I thought he was dead. And I thought, um, I was just waiting. And he didn't come out crying…but then he came out, and he was – he was fine." (Miranda was then shown just his face as baby held, wrapped, near her shoulder before being taken to the postnatal ward).

The intensity of these relived emotions was raw and powerful. The interview recordings and the verbatim transcripts ensured the context and authenticity of these emotions were preserved.

Emotions since birth

In retelling their birth stories, the participants relived much of this emotional turmoil, however as they moved back to the present time and explained the outfall of the separation since the day of birth the description of their emotions changed. They felt disconnected from their own body through medication and equipment as well as separated from their baby which creating feelings of disembodiment and lack of control. Lauren felt self-conscious of her nakedness under the blanket, *"feeling strange and uncomfortable".* Having to remain in the recovery ward on her own: *"It just felt really weird. It was being under the sheet and <u>not being able to move and feeling out of control</u>."* Lauren went on to have a Vaginal Birth After Caesarean (VBAC) for her next birth and compared how she felt about her nakedness in each birth, she felt this was not an issue in the VBAC as she could move, was less vulnerable, and felt in control of her own body.

Being given the very brief time with their babies before they were removed was experienced as negatively as those who had no contact at all, Alice describing this as *"I got to hold him, but it was – it was sort of felt tokenistic in a way, <u>and it didn't feel like he was my child.</u>"*

The sadness and emotional turmoil continued in the longer term, many of the participants later diagnosed with depression, anxiety or Post Traumatic Stress Disorder (PTSD). Rose said *"I cry almost every day, if not every day, about this still."* She described her PTSD diagnosis, intrusive thoughts and suicidal ideation that had engulfed her since the birth, *"I'm afraid this thing is never going to leave me, it has been so long."* (16 months later) She continued to feel so alone and felt nobody in her family understood the enormity for her. Rose said that despite being willing to sacrifice everything for her daughter, *"<u>If I could buy magic, go back in time and not be pregnant, not to be true, all of the things that I did go through now of course I wouldn't have her</u>. I would swap today, I would go back in time, not be pregnant. And I tell you more, I would leave that hospital with empty hands but not as traumatised as I did. [crying…distressed]. I know this is very hard to understand, but I would."*

She further described her guilt at feeling this *"like a sin",* the *"suffocating anger"* and the trauma. This long-term anguish was resonated with by others, Naomi said *"I feel like I'll never get over it."*

All participants felt guilt for not being able to control what had happened to them and angry that the option of staying with their baby was not given to them. Erin summed it up concisely with *"This experience was fucked, I don't get to trade it in."* She did not get to see or hold her well baby but was shown a photograph and reunited after two and a half hours. This anger was a common description with the participants:

"What just still makes me angry a year on, is going, 'why did this happen to me', and then now knowing what I know, it's like, well, this seems to happen unfortunately to a lot of people unnecessarily. I just feel robbed of all the stuff that I should've done." (Clara)

"I should be more supported. And it just makes me so angry, and I have just felt angry ever since having children, about the inequalities that you face. And it just – it extends all through the birth system." (Miranda)

"I felt guilt about feeling numb. I felt guilt about being separated from her. I feel guilt about missing those, like, those first couple of hours of her life. I think I was just so disappointed in the system. I think the guilt's lessened. I think the frustration and anger still remain…I know that I wasn't in control, and I know I fought really hard. I was powerless in that, so I can't carry guilt over something I had no control over." (Lauren)

It was these immense, prolonged and devastating emotional feelings which led the participants to be involved in this research, Miranda saying *"My story is just one of, yeah, trauma and pain and all that kind of thing, and that's why I'm talking to you."* The visceral and palpable emotions in all fifteen interviews consistently demonstrated the turmoil created by the experience of being separated, the participants not given the consideration from carers of how this event would impact them.

Impact on relationship with baby

The separation experience negatively impacted bonding and establishing a relationship with their baby both immediately and in the longer term for all participants. Some of the women felt the connection with their baby had improved through breastfeeding

and over time, while for others they still felt the relationship with their child was permanently and negatively affected from not having the early hours with their babies after birth:

"I didn't feel that bond with him for a good couple of months...breastfeeding was the thing that really helped me to narrow that gap and form the bond with (baby)." (Miranda)

"…the feelings, the connection, the indescribable love, I think I even haven't got there yet. I have a good relationship with her. But a lot of it, it's out of duty. I know how I have to behave and I behave, but it's not this natural overjoyed burst of emotion." (Rose, describing the prolonged negative impact on bonding with her baby aged 16 months)

Some multiparous participants were able to compare the births with separation (index birth) to another birth, even when this was another caesarean section, where they were supported to have skin-to-skin and remain in close physical contact with their baby. Experiencing integrative power, feeling supported and having staff advocating for their choices to not be separated from their baby positively changed their parenting style. Birth order did not appear to make a difference to these experiences. Lily felt her emotional attachment and childrearing with her subsequent two children was very different to that of her first child (index), from the day of birth:

"I definitely think, looking at the differences, it was a very different connection and different feeling, um, even just from that very beginning" (Lily)

For Susannah who experienced two separation at caesarean events and then fought for a maternal assisted caesarean and no separation for her third, the connection was overwhelming different which she put down to not being separated from her baby. She described *"the connection I have with [baby] is, it feels horrible to say, completely different to the other two. From the get-go. Completely…amazing."*

The emotional response, or for some the lack of emotion and numbness, caused by the separation was clearly different when their baby stayed with them after birth, forming stronger bonds with the infant:

"I was so happy with that birth, I felt powerful, I felt in control, I felt comfortable, I felt strong, and I did connect with her, and so when I compare, it took a l-like a long while I think for me to feel—I don't know if I didn't feel connected to her, but I think it was just, it still felt

theoretical. You know, there was just something was off, and it just took time, and for both births, my-my whatever day blues they are, three or five days, were terrible, like I had a really bad hormone crash, and was just like ridiculously over the top emotional for both of them, and I do remember that I felt a bit or relief having that emotional day after [next baby] because I was-I think that's when I could start to pinpoint that I felt less numb, and I must care, and I must have some emotion." (Lauren, 10 years after this birth)

The participants talked of how the separation was felt by their babies, Erin felt rejected by her son in the first six weeks as she couldn't comfort him *"At first, I was jealous 'cause he* <u>*loved everyone but me*</u>*.";* Sally carried a lot of guilt that the separation made her son anxious about being separated again *"I can't help but think that the separation, like, actually had [sobbing] an impact on him a little bit and he seemed to be worried that we would get separated."*

Establishing a relationship with their babies was important for all participants, becoming 'mother' was impacted as they navigated the consequences of a birth dyad separation. Guilt about caring for one child differently to their others or being hypervigilant in providing quality care for the child they had been separated from was evident.

Impact on relationship with partner

All partners in this study were male, in committed relationships with the women and invested in the pregnancy and future child. Although not the focus of this research, the participants openly discussed how births and separations had significant impacts on the men as well as causing negative change and tension in their partner relationships. They recognised that their partners were as helpless as themselves and were limited in their ability to advocate and protect them, including at the separation of mother and baby. In discussing this Maggie said *"the damage it does first hand on, you know, not just the breastfeeding relationships but family, like entire family units can suffer because of this."* Connection and communication was changed for participants and their partners due to the separation experience.

Separating the woman from her main support person increased her vulnerability increasing fear and emotional distress. Partners own fear and distress was also increased by asking them to leave the woman in the operating theatre, not given information about her wellbeing, and then not being able to bond as a family and provide maternal support when

they were reunited. As predominantly first-time parents, the partners were not supported by staff but left alone with their new baby, often unsure what to do, including whether to do skin-to-skin contact. They continued to have negative effects on their mental health and relationships with their partners. The participants discussed the impact this has had on their sexual relationships and the planning of future pregnancy and birth plans. Rose was profoundly impacted by the trauma of her birth and separation and it continues to significantly affect her relationship with her husband:

"I left the hospital telling my husband that I wanted a divorce straight away because I couldn't believe that he wasn't there for me anyway. He has all the best intentions and I do see that he was also afraid and just didn't know any better. But that doesn't change the fact that he was the only one that could have said 'stop', put something out more than I was already screaming. But because he was silent and calm, it was one way of siding with the hospital, with the things that were done to me. He didn't advocate for me whatsoever."(Rose)

Erin also described the impact of the birth on her sexual relationship, saying *"But it was like, I started to just fear, I sort of have disconnected from that part of my body, and I don't know if that is the caeser, I don't know if it's a-uh, if it's the birth trauma, or you know, a physical thing mixed with the psychological, you know, but I've never really, like sexual function has never been the same."*

The data was very clear that separating the mother and baby had consequences which continued to echo into the ongoing relationship between the participants, their partners and their children. The transition to becoming a mother was interrupted, the disempowerment and loss of control impeded relationships, some of which were irrevocably changed.

The emotional turmoil experienced by the participants was influenced by the maternity health care providers across the whole perinatal journey but most significantly during the events that led to dyad separation. Figure 5.2 shows a word cloud of words used by the participants to describe their emotions over time, from immediate responses to then looking back and reflecting on how they felt after the birth up to time of interview.

Figure 5. 2 Emotions Over Time

Theme 3: Influence

This theme demonstrates the impact of the interactions and events that influenced the mother and baby separation. It is associated with the medicalised terrain that focused on staff needs over the that of the woman, with disciplinary privilege that coerces, manipulates and undermines the woman's ability to have choice in what is happening to her and her baby. The four subthemes demonstrate disintegrative power and removal of self-embodiment – *Power & control, Maternal choice & consent, Coercion* and *Staff actions.*

Power & Control

Prioritising provider and facility agendas over the women's choices and needs increased fear and decreased emotional wellbeing of the participants. The participants felt decisions to have a caesarean birth, who was present, and the power imbalanced against them, resulted in their submission to the birth management and procedures that followed. They had very limited recourse to make demands for options and this created an environment which necessitated or promoted the separation from their infant:

"At about 6/6.30 a.m I had an obstetrician storm into my room and demand – <u>he wasn't talking to me</u>, he was talking to my midwives, demanding that I had a C-section…No, like, introduction or anything to me…I was, like, very, very scared about one – I did not want a caesarean. There were a lot of people in the room – obstetricians are like the hierarchy, I guess." (Maria)

<u>"I know that it wasn't in my control</u>, and I know I fought really hard" (Lauren)

The loss of power, while not always consciously and purposefully removed, was detrimental to the woman both at the time of birth and in the months and years that

followed, Maggie said *"Maternity care doesn't realise how damaging it is when they, even though you know they, they probably don't mean to, but they very much <u>take woman's power away</u> and it has lifelong effects."*

It felt for some participants that the timing of their caesarean section was based on doctor preference rather than medical necessity, further removing control from the woman to delay or avoid further interventions:

"It's not lost on me that my C-section happened at 5pm…after you know, sort of trying to coerce me into it for a few hours before that." (Naomi)

"I was the last caesarean of the day because they didn't want to have to monitor or have a caesarean at three in the morning. Seven o'clock was just, ah, perfect for the end of the shift." (Rose)

The participants perceived their low value within the hospital system, Jane highlighted this with *"<u>basically I disappeared the moment I set foot in the hospital</u>."* The participants' felt power was not theirs and had been given away because of their vulnerability in the perinatal period:

"I think a lot of the time, women give their power to a doctor because they're a doctor. Like, we trust doctors inherently, don't we?" (Miranda)

"<u>I just feel like women are so vulnerable</u>, and it sometimes feels like we <u>get preyed upon</u> for a convenience, or for an opinion, at a particular time when you're even more vulnerable." (Lauren)

Their compliance had been groomed through much of their perinatal care, to put their trust in others rather than themselves. Retrospectively, the participants could see the unfairness in what had happened to them and that it was not in their power to control.

"<u>You know they [women] shouldn't have to fight for their respectful maternity care</u>." (Maggie)

Control was also a physical thing, being immobilised through drugs and the use of equipment such as blood pressure cuffs, restricted their ability to control what happened to themselves and their baby. Lily said *"I recall feeling very out of control, especially after the*

epidural went in for my, um, caesarean. Like not being able to move my legs or, you know, wriggle my bottom around or do like anything.” Michelle was unable to touch her baby when she was brought over to her *“So, they wrapped her up and brought her and sat her like here, so I was able to like, touch, my hands were down, so, ‘cause they had cannula in, so I couldn’t actually touch her.”*

Maternal choice and consent

The participants birthed in environments that created mistrust in their own bodies and intuition, disintegrative power used to serve the health professionals best interests rather than the woman’s. They did not realise they had the option to make a choice, or if they did the options were presented in a way that favoured the providers.

Overall, the participants described dismissive care that didn’t include them in the decision-making process for interventions or care options, told what would happen rather than seeking informed consent. Jane said *“I felt like I was being <u>managed as a misbehaving uterus, not a person</u>”.* Despite proactively choosing providers who would appear to support maternal choice, participants such as Michelle continued to be refused the option of their choice. She was refused the option to have a Vaginal Birth After Caesarean (VBAC) with her next pregnancy and denied skin-to-skin contact again with this second caesarean:

“I don’t even remember them asking for my opinion. It was just ‘You’re having a caesarean, <u>you’ve got no choice basically</u>’… I honestly don’t remember them really asking my opinion or anything. I just remember on the way down, the midwife saying ‘We’re short staffed. So if you wanted to have her [baby] in recovery [area] you probably won’t be able to’” (Michelle)

The participants described feeling they were not included in decision making during and immediately after the birth, or even that they were allowed to, such as Jane who explained, *“Unless someone tells you you’ve got a choice, you just do what people tell you to do.”*

Consent was not fully informed for care and procedures throughout the perinatal journey. And many of these procedures resulted ultimately in the separation from their baby. The participants agreed to things without always understanding the risks, benefits, or consequences:

"so <u>there was no informed consent</u>. I couldn't advocate for myself 'cause I didn't know" (Naomi)

"When I asked her [obstetrician] what the medical reason was she couldn't give me an answer." (Louise for repeat caesarean section)

"I was given a choice, but it felt like a very pressured choice." (Sally)

"It's not a question, it's like information, 'I'm gonna break your waters now'. She made me sit, I did sit, and I did consent, stupidly, and she broke my waters." (Rose, the midwife wanting to speed up labour at a planned home birth)

Naomi described two episodes of signing consent forms – for an induction of labour *"where it says the doctor had to fill it in to say that they had informed the patient and blah blah blah, and that's all blank, and I've just signed like a blank form."*. And then for a repeat caesarean section, she asked *"Are you going to tell me about the long-term effects, and the effects on my next pregnancies? He was like 'What do you mean?'"* Susannah echoed this lack of information given to gain consent for a second caesarean:

"He also didn't tell me when he was telling me these things that if I had a second Caesar, that they wouldn't allow me in [hometown hospital] to attempt a VBAC after having two caesars for a third baby. He didn't ask me how many children I wanted to have, he didn't tell me any of that information."

Rose likened aspects of her care to rape, having interventions performed explicitly against her wishes and clearly voicing she did not give consent:

"…she said that she was putting the thing on her scalp to have the continuous monitoring. And I was like I don't want that. I can't do that. <u>Don't do that. You don't have my consent</u> to do that. Don't do that. - Done."

This physically assaultive behaviour was also discussed by Clara who explained *"I'm just lying in the bed, and then another doctor comes in, and like, another doctors gonna do an internal, and <u>she literally shoves her hand up</u> and goes, 'We need to do an emergency caesarean right now.'" (no reason given to Clara, well baby, separated for 2 hours).* Louise felt badgered by an obstetrician who tried to enforce compliance by frequently booking caesarean procedures, phoning her at home and telling her when she came for appointments

that she couldn’t go home, despite being unable to give her a medical reason for the procedure. She eventually agreed with another doctor to have the caesarean as she felt worn down (*“I can’t take the harassment anymore”*), but only if the first doctor was not present. After her spinal block, lying on the operating table the first doctor came in and took over. *“I kept telling her that I don’t consent for her to touch me, um, it went ahead anyway. And there was nothing I could do ‘cause I was, you know, I had the spinal block in and couldn’t move.”* No other staff present advocated for her.

None of the participants felt they gave fully informed consent to either procedures or removal of their well-baby, *“They just took him.” (Clara).* There was no woman-centred care described and practitioners, in particular midwives who are there for the woman, did not advocate for and protect them. Health care providers were more likely to cajole and coerce the participants into compliance.

Coercion

The experience of coercion and control over decision making and interventions, timing of birth and separation from their baby was common with all participants, as described through the previous sub-themes. Health care provider domination subtly manipulated formal agreeance to procedures and actions, but in hindsight the women saw that the choice was not theirs. They used terms such as coercion and bullying being used:

“…they were so coercive – they still kind of called the shots even though we were the ones that made the decisions. It was because we were coerced to make those decisions.” (Maria)

“I was doing more research, I was finding out more information, I knew that I would have a fight based on what I was reading, but I just, I didn’t expect the extent that the obstetrician would go to, to bully me into a caesar.” (Susannah, when planning her second birth, separated again)

“I unfortunately had four weeks of intense coercion, and then it went to bullying to book a C-section.” (Louise)

Potential of elevated risk of harm to the baby was a frequently cited tool used to have the procedures which would eventually lead to dyad separation. Lily’s obstetrician wanted her to plan a scheduled caesarean due to her height – *“Some women really like to try, and*

you know, we can do an induction but more than likely you’ll end up in an emergency caesarean. The alternative is we book you in a scheduled caesarean, um, so your baby doesn’t have to go into distress.” There appeared to be choice, Lily didn’t want her baby to go into distress, so she agreed. She went on to have two subsequent VBAC births, her third over four kilos, with a doula as support.

Being able to make a decision for themselves was only acceptable if it met the clinician’s need. Susannah wanted to trial a VBAC but was told:

“He said, if you don’t book in a Caesar and you attempt a VBAC, I’m going to write down I don’t agree with it, and what will happen is you could potentially have a shoulder dystocia, um, you will become very ill, <u>and your baby could die.</u> So, I’m gonna write down that I don’t agree with that. You take all responsibility for anything that happens to you and your baby if you choose to go ahead with a VBAC.”

Health care providers of all disciplines had an impact on the experiences of the participants, taking ownership of the birth and the baby from the woman, physically and symbolically. Intimating the mother’s body was not safe, before or after birth, and the baby was better cared for by someone else.

Staff actions

All participants gave accounts of staff interactions that showed domination and control which extended from individual to facility level. Use of the ‘dead-baby card’ was common to gain consent for the caesarean sections birth. This exploitation of their vulnerability led to the increased and potentially unnecessary interventions which led to the maternal-infant separation despite all babies being well at birth:

“So, when you’re two first-time parents and you hear ‘If you don’t do this, <u>your baby’s gonna die’</u>, like, what do you do?... I wasn’t spoken to. I wasn’t told anything. I wasn’t asked anything.” (Clara)

“I got to 10cm dilation and, that’s when, you know, he just came in and said – told me I was <u>gonna have a dead baby</u>, and…he said ‘I don’t want to hear another word from you. You’re having a caesarean.’” (Miranda)

Some health care providers restricted knowledge or challenged opposing views. Susannah was told by her obstetrician to stop seeing midwives during her antenatal care as they were giving her *"misinformation"* about her options, she said *"he was 100 per cent abusing his position of power in that, in that moment."*

Despite many negative interactions, the participants did recall some positive exchanges and attempts by some providers to support them, and these were remembered with words that reflected respect, safety, and trust. Simple gestures such as introductions, a gentle manner, and kindness. Miranda felt the anaesthetist's warmth and kindness shown by holding her hand and explaining what was happening as her baby was born prevented further trauma *"he saved me from having a severe psychological injury."*. Sally also shared her interaction with two male staff in the recovery area as she desperately asked to be reunited with her baby *"And they were, like, very caring and lovely, but I just didn't feel like they really understood the urgency of it. Like, I think they were like, 'Oh, we'll check. Oh, sorry. No, they say no,' [maternity ward where baby was]. But I didn't feel like they were really advocating for me."* Maggie made positive mention of midwives caring for her in labour and postnatally, putting in *"an extra bit of work for us"*, as though this was not a standard expectation. The midwife at her caesarean section also attempted skin-to-skin through obstacles of people and equipment – *"my midwife kind of grabbed him off the paeds and kind of got him over to me and opened up my my gown and tried to rip the blankets off him and and get him onto my chest."*

The negative encounters with staff were disappointing for the participants, most of whom had sought maternity care providers and facilities that they thought aligned with their preferences. In preparation for the birth they had pursued knowledge for themselves and their partners and developed ideals and plans for labour and birth. In hindsight they reflected on a medicalised and patriarchal maternity care system:

"I really wanted to have a low intervention birth, so I tried to pick an obstetrician that was aligned to that...I'm someone who researches. I read everything…we probably did three birth courses…the system sets us up to fail – it's just not set up to support women…it's medicalised. And to find that person who will treat it as a natural event and support you through it, it's always gonna be a needle in a haystack" (Sally)

"…and that's partially the reason why I picked a female obstetrician, and yet, she is part of that patriarchal system…I think maybe I might have had a better go with a male obstetrician." (Naomi)

Despite their pregnancy preparation, none of the participants achieved the positive birth experiences they had hoped for, including skin-to-skin contact, and were not prepared for the disregard and disrespect they encountered. They had been realistic regarding the possibility of unexpected circumstances and outcomes, including caesarean birth, but some participants did note this could have been better covered during formal birth education classes:

"I did the hospital antenatal classes which are how to be a good patient at this hospital." (Naomi)

"…it didn't really help me prepare for the sort of politicky [sic] things that were going to happen…all this pressure to do these things that I didn't really want to do. I didn't know how to deal with that." (Jane)

To understand and resolve their conflicted feelings about their experiences, several of the participants sought informal or formal responses from the individual doctors, facilities, or governing bodies to explain and debrief the birth events. The general responses were indifferent, denied culpability, and were aimed at preventing litigation. One response from a health facility was shared with me by a participant. It acknowledged and apologised with how the woman felt but assumed no responsibility for what caused those feelings. It included a timeline and documentation and put the responsibility of what had transpired back on the woman. Alice interacted with an obstetrician while she remained an inpatient, *"His debrief was limited to, I guess, the CTG, and he basically came in, rolled it across the bed, and said, 'Look at that. That's massive. You're all good now though, right? Alright, see ya!'"*

The use of disintegrative power undermined and disenfranchised the birth experience for these participants. They recognise that the health service, policy, and personnel, create conditions which disadvantaged the consumer.

Theme 4: Insight

This theme reflected the longer-term impact of the birth separation, and how the women sought understanding of what had happened to prevent it occurring again. The four sub-themes were *Mother’s Knowledge, Interventions, The Partner,* and *Next Birth.* This theme shows how their experiences influenced their lives beyond the birth of separation. It showed them how their rites of passage to motherhood and the medical rites of protection were voided by the providers of maternity care.

Mother’s knowledge

Despite their antenatal preparation, the women understood that their knowledge was insufficient for the health systems they birthed in. They understood the conflict and inconsistency between evidence, policy, and individual practice. Trust had been lost and they didn’t feel safe, Clara said *“[crying]…I don’t know if I ever want to do this again…Like, we’ve been so mistreated, that <u>I don’t trust them</u>.”* This mistrust and fear was reflected in other participant comments:

“They’re supposed to have our best interests at heart. But actually they’ve all got their own agendas as well. Like, you’ve still got to advocate for yourself. You’ve still got to think for yourself, in my experience. And, you can’t trust. You cannot trust a doctor. No way. That is something I learnt from that process.” (Miranda)

“I was really quite nervous of my midwife, and the whole hospital. Like, <u>I just felt so unsafe</u>...At the time, I didn’t even know that labour could stall. Like, and now of course, looking back, I’m like, yeah, I friggin stalled because I was feeling completely unsafe, was scared of my midwife.” (Erin)

Since the birth and separation from their infant, all participants had sought further knowledge and ways they could protect themselves for the next birth. They recognised the vulnerability of themselves and their partners and the imbalance of power within the health system. If planning subsequent births, they again attempted to find maternity care providers which would support their choices, whether by caesarean or not, including private midwives and doulas. Five had a Vaginal Birth After Caesarean (VBAC), with a further one attempted but resulting in another caesarean and again being separated from her baby, this time for

medical reasons. Susannah and Michelle both described not being 'allowed' to have a VBAC, both had elective procedures and were separated from their well infants again.

Lily had a successful VBAC with the next birth. She increased her knowledge and discussed compromises she had been willing to make and of fighting for the things that were really important. She employed a doula, as did others, to support her and her partner.

"The more I thought about it [VBAC], the more I was like 'Well, we're gonna have to really focus and stand up more for what I really want if that's gonna happen'" (Lily)

The women increased their knowledge and the knowledge of others after having experienced being separated from their baby. They read resources by well-known researchers, authors and government documents and understood that their experience was not unique and readied themselves to have a better outcome if planning another baby:

"I kind of look at the Mothers and Babies reports when they come out, and I know that 2021 was published semi-recently, and that [her town] has the highest rate of inductions in New South Wales…I don't feel so bad about what happened during my birth because it's clearly a systemic problem." (Clara, who said she wished she had this knowledge before her birth)

"and we read, um, oh, I can't remember, but we read so many of those, you know, really empowering kind of, this, if you want a natural birth, you read these books… and as soon as I'd finish, [partner] would read them… And we almost did a mind map, like, if this happens, then do this, but if it doesn't happen, then—you know… Like, we walked into that ward with, like, boxing gloves on, basically, ready to have this birth." (Miranda, discussing her preparation for the next birth, a VBAC)

Sally took her increased knowledge further and set up a website for other women that gives reviews and statistics on birth providers and facilities to help women making choices about their pregnancy and birth care.

Knowledge and feeling empowered was what they needed to be in control of what was happening to them for the next birth, despite feeling they had prepared for the birth with separation they were disempowered by the system and health care providers. They understood the use of interventions and the medicalisation of the perinatal process led them to being separated from their baby.

Interventions

This specific aspect of the participants new knowledge was that medical interventions had the potential to negatively impact their birth experience and outcomes. In describing their birth stories and their lack of input into decisions being made about their care, interventions were commonly described as not being evidence-based or done without consideration of individual circumstances. This ultimately ended up with a caesarean and being separated from their baby.

“So, I was put on the CTG which I’m actually annoyed about it. That is something that does bother me because I now have found out from, I’m quite a big fan of Kirsten Small’s research around CTG use that even in high risk instances there’s no benefit to CTG, and in fact it can lead to you know, things such as caesarean.” (Maggie)

Some described the process of maternity care as factory like, everyone treated the same rather than woman-centred. Clara said *“We’re just a cog in the hospital machine, just getting churned out like a sausage.”* Naomi had a similar butcher type analogy saying *“I was just like a piece of meat on a slab.”*

The use of interventions and inconsistencies of advice given to the participants who had attempted labour was not conducive to physiological birth and felt by these participants to have contributed to the outcomes. Naomi said *“so they put me in a bed, and said I need to stay in the bed to keep the, um, trace”.* Clara was given a timeline of expected progress for her induction of labour, told *“If you’re active, that’ll cut four hours off. If you’ve got a positive mindset, that’ll cut another four hours off”* but then was attached to the machine to monitor contractions which immobilised her. Erin also described being attached to this machine which required straps around the abdomen: *“I think those belts are another thing that like, are just so spectacularly bad for labouring”.* Jane echoed these sentiments, *“So, yep, I’ve got this bloody wired CTG, uh, and can’t really go anywhere.”*

Equipment which would have helped the progress of labour was not offered or unavailable, Erin said *“I just like desperately wanted a bath, but there was no bath.”* Jane described finding a cupboard on her own in the birth room that contained the equipment she needed *“Uh, this is the cupboard with all the stuff in it, I'll just get something, and I was sort of sitting there bouncing.”*

Further interventions were offered to control the pain of labour rather than supporting the process, the power of suggestion intimating they weren't coping – Sally said *"essentially, the midwife said to me, 'Oh, um, you know, like, you're in a lotta pain. Like, do you want and epidural?' And I end up saying yes. I end up getting an epidural."* Rose also felt that her homebirth midwife was focused on the pain *"Instead of, I don't know, telling me to change positions, like not once my midwife offer me the grace of like would you try this position, or would you try this? It was just about contractions."*

The participants knew that having a caesarean section resulted in their separation from the baby and that a physiological birth would have kept them together. The interventions created the opportunity for cascading medicalisation of their births, disempowered them and voided their rites of passage.

The Partner

Partner support, or perceived lack of, had a deep impact on the birth experience for the participants. The partners vulnerability within the medical system was also recognised and the negative impacts for them acknowledged by the participants – *"those factors were extremely traumatic for him, um, thinking that, you know, he was never going to see me again…He thought I was gonna die." (Miranda)*. However, as men, they were also more likely to have their opinions respected or requested and could be asked to convince their partners to have certain procedures. Jane's obstetrician wanted to do a vaginal examination and membrane sweep at the 38-week antenatal appointment to initiate labour. When Jane was unsure about it the doctor said to her husband *"…'you should really do this'. She's like, 'Would you talk to her?'"* rather than answering Jane's questions.

Ultimately, the impact of mother-infant separation was exacerbated with separation of the participants from their significant other soon after birth:

"So the doula ended up spending those two and a half hours with [partner] and the baby, which I also was just so furious about, that another woman was there seeing [partner] becoming a dad and seeing my baby." (Erin)

Being reunited with the baby and partner was short-lived for many, with partners told to leave soon afterwards:

"So basically she was born, he went to NICU, came back to our room to get his stuff and get changed, and then got kicked out. Sent home." (Maria, after a brief visit)

"Basically in that same conversation when I was reunited, they told [partner] he was gonna have to go." (Erin)

In subsequent births, partners, like the participants, were better prepared and more likely to demand better care and be involved. After two caesarean births and separations Susannah said her partner did not want anymore. She persisted and at the final, maternal-assisted and emotionally healing caesarean he said *"Now I understand. Now I get it."* It was a healing birth for him as well.

Next birth

The decision to have another baby was complex, led by fear and trauma of the past, along with being hopeful for a better outcome. Eight had gone on to have a baby after the separation event and two were pregnant at the time of interview. All considered a repeat caesarean was either likely or possible and were attentive to details and birth plans for the next.

"I have future birth maps. So meticulously planned out in the case of, you know, future caesareans. Like if you dare take my baby away from me like sort of thing." (Maggie, had not yet had another pregnancy)

Some changed providers or models of care and some engaged a professional advocate such as a doula. Naomi said *"I wanted to have another one, but I knew I wanted a different experience, and so I went on an education spree basically, and I hired myself private midwives and that experience was much better." (despite birth complications)*

Susannah had experienced two caesarean births with separation from baby so, as previously discussed, sought an obstetrician who would do a maternal assisted caesarean section for the third. She said - *"The third one I found a doctor who was willing to support maternal-assisted caesarean. It was the most healing, amazing experience of my life, and I think will be forever, will be one of the best memories I ever have." (not separated at this birth).* Others, such as Clara also considered how the option of a maternal assisted caesarean would make a difference *"just from what I've seen is a possibility I've known, even the idea of*

a maternally assisted caesarean…being able to do skin-to-skin…and [baby] not just being wheeled away for no reason.”

The women recognised the importance of psychological wellbeing alongside the physical. Despite many hoping, planning or achieving a VBAC, the mode of birth was not the most significant objective. Lauren shared:

“I would just want it to be that I still got to have my baby with me all the time. Like, I don’t care. Caesarean or vaginal is not the issue, it’s just no matter which way you give birth, you should be as close to the natural process as we can, and that is that the mother and child stay together.”

The participants understood there are risks associated with giving birth, but felt these were often exaggerated to get compliance from women. Sally summed this up well, saying – *“And I think that that’s the problem, at the moment, is that all of the risk assessment that they do is based on physical, but they’ve not taken into account the psychological impacts of those decisions.”*

5.3 Findings Part B - Author accepted manuscript

Deys, Wilson, Bayes & Meedya (2024)“Where’s my baby?” A feminist phenomenological study of women experiencing preventable separation from their baby at caesarean birth. *Women and Birth*, 37, 101828. https://doi.org/10.1016/j.wombi.2024.101828

Scientific Journal Ranking - Q1; Impact Factor 4.15

Abstract

Problem: Separating women and babies immediately after birth contributes to poor birth experience and reduced satisfaction.

Background: A negative birth experience can impact a woman’s transition to motherhood and emotional wellbeing beyond the newborn period. Separating women from their baby at birth is known to reduce birth satisfaction and is more likely to happen at caesarean section births.

Question: What is the experience of women who are separated from their baby after caesarean section birth without medical necessity?

Methods: Unstructured, in-depth phenomenological interviews were conducted with fifteen women who had been separated from their well-baby at caesarean section birth. Data was analysed using a Modified van Kaam approach. A novel feminist phenomenological framework with two birthing theories was used to explore the experience of the participants.

Findings: Four major themes emerged – Disconnection, Emotional Turmoil, Influence, and Insight. These demonstrated significant trauma that both the separation and perinatal care created.

Discussion: The participants recognised their vulnerability and the lack of power and control they had over themselves and their baby, which was seemingly not acknowledged. Provider and hospital needs were valued above those of the women.

Conclusion: Woman-centred care was not evident in the treatment of these women despite the attendance of a midwife at each birth. This research challenges midwives and other health care providers to support and advocate for those birthing by caesarean section to return power and control and support them to remain in close physical contact with their baby immediately after birth.

Keywords: birth; caesarean section; feminism; women’s experience; phenomenology; skin-to-skin

Statement of Significance

Problem of Issue

Separation of mother and baby at caesarean section birth.

What is already known

Evidence shows the benefits of keeping mothers and babies together immediately after birth in skin-to-skin contact. Value is placed on physiological safety and institutional need, with birth experience and emotional wellbeing not always considered in settings such as operating theatres.

What this paper adds

This research presents a novel lens to understand how separation of mother and baby at birth impacts women. It highlights the unfair use of power and control by health care providers and facilities which benefits the system and traumatises women.

Introduction

The experience of birth is one individualised by the interplay of people and circumstances, including who, where and how the woman is cared for, and importantly, how she is made to feel (Downe et al., 2018; Reed, 2021). The idealised image of a powerful birthing woman, in control of her body and those around her (Furr, 2019) sits in stark contrast with the surging testimonies of obstetric violence and birth trauma inquiries (Boecker, 2023; Thomas, 2024).

Unfortunately for many women, birthing is no longer a traditional practice but a medically controlled and traumatic procedure (Reed et al., 2017). Commonly lip service is paid to 'woman-centred' care while the reality is one of facility focussed control. Women birthing by either an expectant or emergent caesarean section step further from the tradition of 'birth' to one of 'procedure', a surgical 'delivery', where the woman is far from the centre of care. The woman faces birth feeling powerless and fearful with the expectation she should just be grateful to have her baby (Tsakmakis et al., 2023).

Caesarean section has been shown to negatively impact a woman's overall birth experience, particularly for primiparous women and those for whom it is an emergency. (Kjerulff & Brubaker, 2018) Enabling skin-to-skin contact between the mother-baby dyad and non-separation of the woman from her baby are protective measures to improve birth experience, breastfeeding and long-term health (Brimdyr et al., 2023; Deys et al., 2021; Sheedy et al., 2022). Despite the evidence, women continue to be separated from their baby at caesarean birth, with healthcare process taking precedence over maternal choice. In Australia, rates continue to increase with 38% of women birthing by caesarean section in 2021, (Australian Institute of Health and Welfare, 2023) a figure similar to other high-income countries. This common medical event can lead to indifferent care for women who may be negatively impacted well into the future (Sega et al., 2021).

The phenomenon of maternal-infant separation from the woman's perspective has not been well studied. Previous research has focused on the impacts for maternal-child bonding and the physiological aspects of separation, but less is known about women's experience and outcomes.

Participants, ethics and methods

Study Design and Theoretical Framework

A feminist phenomenological framework was used to explore the experience of women separated from their baby at caesarean section birth in the previous ten years without medical necessity. This reflects the period in which skin-to-skin at caesarean section (and non-separation) was first recognised and documented in literature (Deys et al., 2021). It also accounts for evidence that show women remember and can recount their experience for many years after birth (Bayes et al., 2012; Bossano et al., 2017; Pereda-Goikoetxea et al., 2023; Puia, 2018).

Using a feminist approach to phenomenology sought to address the contextual and sexual difference of pregnancy and birth (Zeiler & Käll, 2014) .Human experience is not gender-neutral, and phenomenology typically portrays a male-dominated world view, even when participants are female (LaChance Adams & Lundquist, 2013; Shabot & Landry, 2018). The dominant modern maternity care paradigm devalues the female-sexed body as a faulty machine, with increasing interventions and pregnancy interruptions promoting the importance of the fetus over the woman and disregarding her right to self-determination (Davison, 2020). Birth trauma and obstetric violence occurs in maternity settings, with gender inequality reflecting the cultural and societal power imbalance of men over women (Tsakmakis et al., 2023). Feminist phenomenology provides opportunity to expose disparity in obstetric health care, policy and practice.

Adding the theoretical feminist lens of “Birth Territory” (Fahy & Parratt, 2006) and “Childbirth as a Rite of Passage” (Reed, Barnes, et al., 2016) facilitated focus for understanding woman-centred care in an androcentric obstetric system, encompassing physical, emotional and spiritual needs (Deys et al., 2024a). The theory of Birth Territory highlights the importance of maternity care providers, particularly midwives, in supporting and protecting the woman, applying her own intrinsic knowledge to foster a satisfying and empowering birthing experience. Environments and care providers that limit a woman’s power and control increase fear, poorer outcomes and reduce birth satisfaction (Fahy & Parratt, 2006; Reed, Barnes, et al., 2016). The theory of Childbirth as a Rite of Passage highlights the rights of women to bodily autonomy does not change with birth mode (Human Rights in Childbirth,

2019). Birth experience is associated with how a woman is treated and should reflect human rights. Recognising and challenging these intrapersonal and social factors that disempower women can be manifested with feminist research and theory (Harrison & Fahy, 2005) (see Table 5.1).

Table 5. 1 Birth Theories

<table>
<tr><td rowspan="6">Birth Territory
Describes, explains and predicts how a woman's wellbeing as her embodied self is impacted by the birth environment (terrain) and use of power (jurisdiction).</td><td rowspan="2">Terrain (birth environment)</td><td>Sanctum</td><td>Private, comfortable, enhancing woman's sense of self, optimal physical & emotional wellbeing, safety</td></tr>
<tr><td>Surveillance</td><td>Clinical, observed, staff comfort, reduced physical & emotional wellbeing, fear</td></tr>
<tr><td rowspan="4">Jurisdiction (power & control)</td><td>Integrative power</td><td>Woman-centred, shared goals, enhanced maternal mind-body-spirit, self-expression & confidence</td></tr>
<tr><td>Disintegrative power</td><td>Ego-centred and self-serving, undermining of woman's decision making</td></tr>
<tr><td>Midwifery (HCP) guardianship</td><td>Integrative power, respectful care, protecting woman & environment, sense of safety</td></tr>
<tr><td>Midwifery (HCP) domination</td><td>Disintegrative and disciplinary power, subtle, manipulative with woman conceding power</td></tr>
<tr><td rowspan="2">Childbirth as a Rite of Passage
Describes how the childbirth experience Is shaped by maternity 'rituals' – what is said and done to support (rites of passage) and to protect mother & baby (rites of protection)</td><td>Rites of Passage</td><td colspan="2">Preparation and planning for birth, including intervention, minimising distractions, woman-centred, intuitive knowing, respectful and consensual, integration of mother and baby, connection, attending to the birth story</td></tr>
<tr><td>Rites of Protection (non-physiological birth)</td><td colspan="2">Options & decisions, minimising distractions, advocating & supporting, meeting those providing care, woman's choices, non-separation – mother in control of her body and baby, processing the birth experience – not staff interpretation</td></tr>
</table>

Eligibility and Recruitment

Interest for inclusion in this study was collected through a single social media posting in 2021. The original post was purposively placed in an Australian maternity consumer advocacy group of the first authors local health district.

Table 5. 2 Methodology Summary Table

Ethics – ACU HREC	2021-3064T
Methodology	Feminist phenomenology
Inclusion criteria	Female, previous caesarean section with separation from baby at birth (any parity), well mother with healthy term infant/s at the birth event, birthed between 2010 and 2021, over 18 years of age at time of consent for interview, English speaking.
Exclusion criteria	Medical reason for separation of mother and baby at birth
Recruitment	Social media, snow balling.
Consent	Participants were sent an information sheet and if they agreed to participate, signed consent forms. Consent was verbally confirmed during interview.
Participants	Fifteen women aged between 23 and 38 years at time of birth separation who had birthed between 5 months and 10 years prior to interview. All participants were deidentified after data collection and provided with a pseudonym to protect confidentiality.
Data collection	Unstructured, in-depth phenomenological interviews based on the McGrath et al protocol.
Data analysis	Initial coding with NVIVO. Data analysed using a Modified van Kaam approach then viewed through the lens of two feminist birthing theories – *Birth Territory* (Fahy & Parratt, 2006) and *Childbirth as a Rite of Passage* (Reed et al, 2016).

Data collection & analysis

Unstructured, in-depth phenomenological interviews were conducted and recorded by the first author using a video conferencing platform for all but one which was in person and audio recorded. This interpretive approach allowed for the depth and detail needed for the rich data of each participant's experience (Holloway & Wheeler, 2010). The interview protocol was based on McGrath et al, (2019) including rapport building, listening and reflection and has been previously demonstrated in other health related qualitative research interviews (Huglin et al., 2021; Vafaei et al., 2023).

The one-to-two-hour long interviews commenced with the opening question of "Tell me about your birth experience" followed by participant specific prompting and clarifying questions focusing on the phenomenon of separation. The first two interview transcripts were completed by the first author and reviewed by the research team with remaining transcripts completed by a transcription service in verbatim style soon after each interview.

Transcript data was initially coded into 16 nodes using the NVIVO program (Zamawe, 2015) then manually analysed using a Modified van Kaam approach – grouping, reducing, thematizing, validating and describing (Moustakas, 1994). This was then viewed through the

lens of the feminist birth experience theories - "Birth Territory" (Fahy & Parratt, 2006) and "Childbirth as a Rite of Passage" (Reed, Barnes, et al., 2016). Coding and theming were regularly reviewed and revised by the research team, reducing the nodes to four overarching themes.

The Study Team and Reflexivity

The first author is a Clinical Midwife Consultant and PhD candidate and conducted all interviews. She conceptualised this research based on clinical experience and lack of evidence to promote meaningful change for women birthing by caesarean section who had experienced separation from their infant. She comes from a background of having had two caesarean section births in a time before skin-to-skin contact was usual practice at any birth and experienced no personal birth trauma. The author team includes three PhD supervisors, all who identify as female, with expertise in midwifery, nursing, and qualitative research.

Ethical Considerations

Initial ethical approval to conduct this study was given by the University of Wollongong Human Research Ethics Committee, Australia (approval number 2021/380) and later transferred to the Australian Catholic University Research Ethics Committee (ethics register number 2021-3064T).

Results

Participants

An unexpected response of 27 expressions of interest resulted in the first 24 hours, the post being spontaneously shared by group followers across other social media platforms, groups and private sharing. The use of social media as a recruitment strategy has been demonstrated previously as an effective tool in purposive and snowball sampling (Kosinski et al., 2015; Leighton et al., 2021).

Of the original 27 responses, two did not meet criteria, and 25 eligible women were sent participant information and consent forms via email. Fifteen women returned signed consent form and were subsequently interviewed over the next three months. All were included in data analysis and were anonymised with pseudonyms. Further recruitment was determined to not be necessary with data saturation reached.

The participants (Table 5.3) birthed in Australia, ranged in age from 23 to 38 years at the time of birth, all were in a permanent, heterosexual relationships and well educated. Their experience of separation had happened five months to ten years prior to the interview. Fourteen out of fifteen participants had been first time mothers and two experienced a subsequent caesarean section and separation event, providing a total of seventeen birth experiences included in the data. Twelve of these were emergent procedures.

Table 5. 3 Participant Demographics

Name (Pseudonym)	Age at birth/s	Parity at birth/s *	Time since birth/s separation
Maggie	34	primip	16 months
Rose	38	primip	16 months
Alice	33	primip	5 months
Louise	35	multip	5 years
Lauren	26	primip	10 years
Susannah	28, 30	primip, multip	3 ½ & 2 years
Jane	30	primip	3 years
Erin	35	primip	5 years
Sally	31	primip	2 ½ years
Lily	23	primip	10 years
Maria	30	primip	2 years
Michelle	27, 29	primip, multip	6 & 4 years
Naomi	34	primip	5 years
Clara	28	primip	1 year
Miranda	33	primip	2 ½ years

*Primiparous/Primip = first birth; Multiparous/Multip = subsequent births

Findings

Initially distinguishing the maternal-infant separation phenomenon from the overall perinatal experience was challenging with all participants sharing distressing and traumatic birth stories. Isolation of four main themes characterising the experience of being separated from one's healthy baby at birth emerged from the data –Disconnection, Emotional Turmoil, Influence, and Insight. The themes were then mapped with where they most aligned with the birthing theories, highlighting the significance of the separation event as a feminist issue. Rites of Passage was balanced with Rites of Protection based on the medicalisation of the birth experience (Table 5.4) (Reed, 2021).

Table 5. 4 Data analysis mapped with birthing theories

Nodes **(no. of references)**	**Codes/Themes**	**Feminist Birthing Theory**		
		Birth Territory – (Terrain & Jurisdiction)	**Rites of Passage**	**Rites of Protection**
○ **Desire to hold baby (19)** ○ **Separation (126)** ○ **No skin-to-skin (37)** ○ **Breastfeeding (60)**	➢ Disconnection		●	●
○ **Emotions at birth (60)** ○ **Emotions since birth (90)** ○ **Impact on relationship with baby (31)** ○ **Impact on relationship with partner (10)**	➢ Emotional Turmoil	●		●
○ **Power & control (104)**				

○ **Maternal choice & consent (65)** ○ **Coercion (29)** ○ **Staff actions (143)**	➢ Influence	●		●
○ **Mother’s knowledge (35)** ○ **Interventions (35)** ○ **The partner (53)** ○ **Next birth (78)**	➢ Insight		●	●

Theme 1: Disconnection

Four subthemes were coded within this theme – Desire to hold baby, Separation, No skin-to-skin, and Breastfeeding.

Desire to hold baby

Wanting to hold their baby at birth was strongly recalled by all participants. They described pleading and demanding for this to happen, and felt their urgency was at odds with hospital staff. The interval before they were able to hold their baby was sometimes unclear in their memories, but any amount of time was described as feeling too long, Naomi* saying *“It was probably about an hour, but it felt like forever”.*

Separation

In all cases, separation at birth did not reflect poor health of mother or baby. Initially the separation was within the room, babies taken out of view of the mother. Photos were offered as substitutes to seeing their baby, Jane* described how strange it was to see a photo of the student midwife holding her baby before seeing the baby herself. Some were shown the baby in what several women described as the ‘circle of life’ hold – baby held up high, under the armpits to show off genitalia over the drapes. This was distressing and confusing for Rose* as she didn’t realise female genitals may be swollen at birth so thought she had been shown a boy. The expectation of examining their baby at birth, counting fingers and

toes, and confirming gender was not realised due to separation. Erin* recounted she did not see her baby’s genitals for over 24 hours and how odd it was to see them after all that time. Babies were commonly taken to the neonatal unit, despite being in peak condition at birth, with fathers all going with the baby. This added to the experience of separation as their support person were also removed. All participants wanted to see their baby was safe, to be a mother and be reunited with their partner.

Separation impacted what the participants spoke of as tangible elements that connect mothers and babies, including smell, touch, and taste. The participants frequently described their babies being rubbed, wiped, cleaned, and wrapped. It was seen as a further barrier and interruption to being close to their baby, changing how they connected with their baby beyond the birth. Rose* shared she still had no sense of what her daughter smelled like 16 months later and likened it to stopping animals licking their babies to bond and connect. She felt this significantly impacted her relationship with her child.

No skin-to-skin

All study participants anticipated skin-to-skin contact with their newborn directly after birth, to hold, meet and feed their babies. Only two participants were supported with this briefly while in the operating theatre. The women were taken alone to the recovery area after the caesarean, with some separations being many hours. The woman’s perception of low status in the birthing room was explained through comments around skin-to-skin contact, and it not being ‘allowed’.

The participants felt that skin-to-skin was not valued in the operating theatre or recovery room environment. Alice* had requested skin-to-skin contact on her birth plan but stated she didn’t think the staff saw it as important. Miranda* described having a detailed birth plan which included the importance of skin-to-skin contact to her but felt unable to ask when it didn’t happen. If women did ask for it to happen clinicians gave excuses for no skin-to-skin, ranging from staffing restrictions, infection risk, or room temperature.

Breastfeeding

Despite traumatic birth experiences and being separated from their infants after the caesarean birth, the participants all knew skin-to-skin contact and breastfeeding was optimal

despite the immediate separation. They feared and came to realise that their relationship and feeding journeys may not be as expected.

All women in this study breastfed their infants through early challenges expected from a delay to first feeding through separation, many into toddlerhood. They described misinformation and lack of breastfeeding support soon after birth followed by poor and inconsistent advice from staff while in hospital. This exacerbated the experience of the initial separation from their infants with midwives latching babies to their breasts, further disempowering the women.

The inability to control what happened to their baby was devastating for the participants, their vulnerability increased with birthing in the operating theatre. They were disconnected from their body, their baby, and their partner with no right to self-agency.

Theme 2: Emotional Turmoil

Four sub-themes converged into this theme – Emotions at birth, Emotions since birth, Impact on relationship with baby, and Impact on relationship with partner.

Emotions at birth

The participants first moments after birth were filled with fear, confusion, and sadness. They used words which portrayed feelings of numbness and trauma, having to accept what was happening with no choice. While 30% of the births were planned caesarean sections, all felt pressured to accept the recommendation and were unsure about the true risk for their baby or necessity of the procedure. They had concern over their own and baby's safety, and then experienced the distress of being separated from their newborn.

Emotions since birth

These early feelings and emotions had turned to guilt and anger in the time since the birth separation experience. The participants recalled their lack of power and control and of disembodiment. The separation from the baby at birth had impacted how they mothered and their experience of motherhood. Clara* said she felt robbed of what should have been possible and had since realised this was not uncommon which increased her anger.

Impact on relationship with baby

All participants were negatively impacted by the experience of separation, affecting bonding, mothering and establishing a relationship with their baby in the hours, days and years since birth. Breastfeeding was commonly highlighted as a reconnecting feature of their mother-child relationships. For Miranda* this took months but was the thing she credited with narrowing the gap to form a bond with her baby.

Some multiparous participants compared the index birth to subsequent births where they remained in close physical contact with their infant and were clear about how it affected their parenting styles. Lily* felt the emotional attachment and childrearing with her following two children was very different to her first (index), from the day of birth, attributed to connection and positive feelings. Susannah* experienced two separation at caesarean events and fought for a maternal assisted caesarean and no separation for her third, she describes "the connection I have with [baby] is, it feels horrible to say, completely different to the other two. From the get-go. Completely…amazing."

Impact on relationship with partner

Although partners were not the focus of this research, the births and separations had significant negative impacts on them as well as the marital relationships. The participants recognised that their partners were also vulnerable and limited in their ability to advocate for and protect them, including during the separation of mother and baby. In discussing this Maggie* said *"the damage it does first hand on, you know, not just the breastfeeding relationships but family, like entire family units can suffer because of this."*

Partners were sent with the baby when taken away, not given information about the wellbeing of the women, and commonly asked to go home soon after mother and baby were reunited. Some did skin-to-skin with the babies but most were first-time parents and didn't know what to do. They continued to have negative effects on their mental health and relationships. The participants discussed the impact this had on their sexual relationships and planning of future pregnancy and birth plans. Rose* was profoundly impacted by the trauma of her birth and separation, had not had sex since, significantly affecting her relationship with her husband. Separating the mother and baby had consequences which were significant and enduring for the entire family.

Theme 3: Influence

The theme identified as ‘Influence’ demonstrated the impact of interactions and events that predisposed mother and baby separation. This included four subthemes – Power & control, Maternal choice & consent, Coercion and Staff actions.

Power & Control

Maternal care was not woman-centred and prioritised provider and facility agendas over the women’s choices and needs. The participants felt decisions to have a caesarean birth, who was present, and the power imbalance, created an environment which necessitated or promoted the separation, despite their wishes. Some felt that the timing of their caesarean section was based on doctor or facility inclination rather than medical necessity.

Vulnerability of the women and therefore the inability to speak up for themselves was evident in the data. They were not valued, Jane* highlighted this with *“basically I disappeared the moment I set foot in the hospital.”* The participants’ felt power was not theirs and it was given away because of their susceptibility.

Retrospectively, the participants could see the unfairness in what had happened to them and that it was not in their power to control. They felt that rather than having to be combative, women should be able to expect respectful maternity care as standard.

Maternal choice and consent

Overall, the participants described maternity health care providers who were generally dismissive. In some cases, they did not address women directly, did not introduce themselves, and participants were told what would happen rather than asked what they wanted, and were expected to comply. Michelle* chose the private health system twice, to have continuity of carer with an obstetrician. She was refused the option to have a Vaginal Birth After Caesarean (VBAC) with her next pregnancy and denied skin-to-skin contact again with her second caesarean:

“I don’t even remember them asking for my opinion. It was just ‘You’re having a caesarean, you’ve got no choice basically’… I honestly don’t remember them really asking my opinion or anything. I just remember on the way down, the midwife saying ‘We’re short staffed. So if you wanted to have her [baby] in recovery [area] you probably won’t be able to’” (Michelle)*

The participants identified that they didn't feel they were permitted to be included in decision making during and immediately after the birth. Consent was not 'fully informed' for care and procedures throughout the perinatal journey. The participants agreed to things without understanding the risks, benefits, or consequences, including separation.

Coercion

Across the perinatal period, including birth debriefing and provider feedback, the participants described the experience of coercion and control over decision making for interventions, timing of birth and separation from their baby. They felt that even though they formally agreed to procedures and actions, the choice was not theirs, describing the situation as both forced and bullying. One participant described the preparation and research she had done in preparation for her second caesarean section birth, having been separated from her baby at her first:

"I was doing more research, I was finding out more information, I knew that I would have a fight based on what I was reading, but I just, I didn't expect the extent that the obstetrician would go to to bully me into a caesar." (Susannah, separated again)*

Staff actions

The sub-theme of staff actions was developed from participant data about individual, multi-disciplinary staff members as well as the facility. Maternity care provider interactions included threats of harm or death for the baby if the participants didn't agree to the caesarean section. The participants realised retrospectively these risks were generally unfounded. Their vulnerability was exploited, leading to increased and potentially unnecessary interventions which led to maternal-infant separation.

While negative interactions were common, the participants acknowledged positive exchanges and attempts by some staff to support them, and these were remembered with words reflecting respect, safety, and trust. Simple gestures recalled such as introductions, a gentle manner, and kindness. Miranda* felt the anaesthetist's warmth and kindness shown by holding her hand and explaining what was happening as her baby was born prevented further trauma and psychological injury. Sally* shared her interaction with two male staff in the recovery area as she desperately asked to be reunited with her baby *"And they were, like, very caring and lovely, but I just didn't feel like they really understood the urgency of it. Like, I*

think they were like, 'Oh, we'll check. Oh, sorry. No, they say no,' [maternity ward where baby was]. But I didn't feel like they were really advocating for me."

The negative encounters with staff were further disappointing for the participants who sought maternity care providers and facilities they thought aligned with their preferences. They pursued knowledge for themselves and their partners and developed plans for labour and birth. In hindsight they reflected on a medicalised and patriarchal maternity care system:

"…and that's partially the reason why I picked a female obstetrician, and yet, she is part of that patriarchal system…I think maybe I might have had a better go with a male obstetrician." (Naomi)*

Despite pregnancy preparations, none of the participants achieved the positive birth experiences they had hoped for and were not prepared for the disregard and disrespect they encountered. They were realistic regarding the possibility of unexpected circumstances and outcomes, including caesarean birth, but some participants noted this could have been better covered during formal birth education classes. Antenatal classes were felt to have not met their needs but instructed how to behave within the system and do as they were told.

To understand and resolve their conflicted feelings about their experience, several of the participants sought informal or formal responses from the individual doctors, facilities, or governing bodies to explain and debrief the birth events. The responses were generally indifferent, denied culpability, and aimed at preventing litigation. Alice* interacted with an obstetrician as an inpatient, *"His debrief was limited to, I guess, the CTG, and he basically came in, rolled it across the bed, and said, 'Look at that. That's massive. You're all good now though, right? Alright, see ya!'"*

The use of disintegrative power undermined and disenfranchised the birth experience and promoted separation of the dyad. Health service, policy, and personnel was seen to create conditions which disadvantages the consumer.

Theme 4: Insight

This final theme reflected the longer-term impact of the birth separation, how the women sought understanding of what had happened, and how to prevent it occurring again

to either themselves or others. The four sub-themes were Mother’s Knowledge, Interventions, The Partner, and Next Birth.

Mother’s Knowledge

The women understood their pre-birth knowledge and preparation was insufficient for the health system they birthed in. They saw the conflict and inconsistency between evidence, policy, and individual practice.

Since the birth and separation from their infant, all participants had sought further knowledge. They recognised the vulnerability of themselves and their partners and the imbalance of power within the health system. If planning subsequent births, they again attempted to find maternity care providers which would support their choices, whether by caesarean or not, including private midwives and doulas. Five had a VBAC, with a further one attempted but resulting in another caesarean and separation from her baby, this time for medical reasons. Susannah* and Michelle* both described not being ‘allowed’ to have a VBAC, both had elective repeat procedures and were separated from healthy infants again.

Lily* had a successful VBAC with the next birth. She increased her knowledge and discussed the compromises she had been willing to make and of fighting for the things that were important. She employed a doula, as did others, to support her and her partner.

“The more I thought about it [VBAC], the more I was like ‘Well, we’re gonna have to really focus and stand up more for what I really want if that’s gonna happen’” (Lily)*

Interventions

One specific aspect of the participants new knowledge was that medical interventions had the potential to negatively impact their birth experience and outcomes. In describing their birth stories and their lack of input into decisions being made about their care, interventions were commonly described as not being evidence-based or done without consideration of individual circumstances. This ultimately ended up with a caesarean and being separated from their baby.

The Partner

Partner support, or perceived lack of, had a deep impact on the birth experience for the participants. As men, they were more likely to have their opinions respected or requested and were sometimes asked to convince their partners to have certain procedures.

Ultimately, the impact of mother-infant separation was exacerbated with separation of the participants from their partner soon after birth. Being finally reunited as a family was short-lived for many, with partners often told to leave soon afterwards.

Next birth

Eight of the fifteen participants had birthed further children after the separation event and two were pregnant. They were hypervigilant in their preparations for birth, considered a repeat caesarean was possible, and as noted earlier, used their knowledge and experience to prepare. Susannah* sought the obstetrician who would do a maternal assisted caesarean section for her third birth after two previous caesareans with baby separation. She was both overwhelmed at this transformative experience and regretful that she did not get this with her previous births. Her experience led her to widely share her personal birth video to encourage both women and health care providers to see what was possible.

The women in this study recognised the importance of psychological wellbeing alongside the physical. Sally* summed this up well, saying – *“And I think that that’s the problem, at the moment, is that all of the risk assessment that they do is based on physical, but they’ve not taken into account the psychological impacts of those decisions.”*

Discussion

This study highlights the significant impact for women separated from their baby at birth. Those who participated in this research collectively showed their experience was similar for all fifteen, including when it happened a second time, providing a valuable understanding of the phenomenon. While the overall perinatal experience for the participants was reflective of birth trauma and obstetric violence, the significance of the separation event escalated these profound psychological and emotional consequences. The desire to hold their baby was strong, and as has been demonstrated in other studies, was urgent, intense and affirming (Stevens et al., 2019) which can influence birth experiences (Ghanbari-Homayi et al., 2020). The women we interviewed were denied immediate skin-to-skin contact with their baby,

known to improve birth satisfaction, increase a sense of control, and seen by women as a way to ensure staying in close physical contact with their newborn to promote breastfeeding and connection (Deys et al., 2021). Despite separations lasting many hours in some cases, the breastfeeding outcomes in this study were largely in contrast with expectations, with separation and no skin-to-skin contact at birth usually associated with reduced duration and exclusivity (Crenshaw, 2014; Widström et al., 2019).

It could be argued that the stories recounted by participants up to ten years after birth were distorted by time, however this is not reflected in research showing women are able to recall birth experience and events for many years (Bigelow et al., 2018; Bossano et al., 2017; Brubaker et al., 2019; Puia, 2018). The feelings experienced by a woman at birth is directly related to how she perceives her safety. In viewing this through both “Birth Territory” (Fahy & Parratt, 2006) and “Childbirth as a Rite of Passage” (Reed, Barnes, et al., 2016) theories, safety is influenced by the people who are caring for a woman, and the environment in which she births. Reed and colleagues have also demonstrated, as we did, that when care provider agenda is prioritised over the birthing woman’s needs it is a factor in the woman’s experience of birth trauma (Reed et al., 2017).

Hospital birthing facilities are generally designed for staff benefit rather than women’s feelings of safety and sense of control (Fahy & Parratt, 2006). “Birth Territory” describes this ‘surveillance’ terrain where women feel fearful, resulting in poor physical functioning and emotional wellbeing (Fahy et al., 2008). This study highlights the importance of creating physically and psychologically safe birthing spaces, recognising the power imbalance and vulnerability of women.

The organisation and management of obstetric-led maternity services creates an environment prone to facility-controlled power to disadvantage and discipline women into submission. The participants explored both positive and negative accounts of midwives and health care providers who impacted their birth experience. Their descriptions included respectful and supportive care but recognised that this was often exceptional, not standard practice. The participants saw the potential of midwives, expected their support and guidance, and while being disappointed in what the midwives didn’t or couldn’t do, they saw this as a system failure. Hospital policy and androcentric power does not encourage care

provider guardianship for women and the hierarchical structure is a risk to women's safety (Kanaris, 2023). Patriarchy disempowers midwives and other care providers which in turn disembodies and traumatises women (Patterson et al., 2019).

Power and control were strong concerns for all participants, who recognised the little they had. Previous work, like our study, has shown that skilled and even kind caregivers who meet their own needs first take away the power, respect and confidence of woman, limit her participation, and cause negative birth experience and trauma (Goer, 2023). Empowering women to give birth, rather than being delivered-of their babies, improves birth satisfaction and wellbeing of the dyad (Fahy et al., 2008).

The strength of this research was using feminist theory to deeply explore the rich data sets. Both birthing theories illuminated the power imbalance created when women are surrounded by staff and environments that manipulate and discipline. The women who chose to be in this study were motivated to change this system, and perhaps not representative of all similarly birthing women who were separated from their baby. This limitation could be developed with further research to understand a broader selection of women and the providers who have cared for them.

Conclusion

This study sought to understand the experience of women who birthed by caesarean section and were unnecessarily separated from their baby. The findings demonstrate that separation caused deep emotional and psychological impacts for the participants. Their sense of control was diminished by facility power, disciplining women into submission using policy and fear. Australian maternity systems, like others around the world, focus on the physical risk of pregnancy, labour and birth, and particularly the risk to the infant. Consideration should be given to the woman's human right to self-embodiment, preventing psychological harm and the consequences of separation at birth for both mother and child.

5.3 Chapter Conclusion

The results of this research were raw, emotional and rich with the maternal lived experience of being separated from one's baby at caesarean section. It shows the labyrinth of the perinatal experience and the consequential cascade each interruption, opposition and

intervention had in leading to dyad separation. The next chapter will discuss these findings, argue their relevance to maternity care systems and providers and challenge health care providers, in particular midwives, to do better.

Chapter 6: Discussion

6.1 Chapter Foreword

Chapter 5 presented the findings into four overarching themes *Disconnection, Emotional turmoil, Influence and Insight*. In this chapter I will discuss the findings and demonstrate how these have answered the research question on how women experience separation from their baby at caesarean section birth when it is not medically necessary. The **emotional turbulence** will be described first, the psychological trauma of the removal of their baby having resounding and ongoing influence in the life of the participants. **Being prepared** for both the birth of separation and for subsequent births will then be explored further, followed by the theoretical underpinnings and methodological framework which were shown in Chapter’s 3 and 4. **Birth Territory and Rites of Passage** are brought together to understand the lived experience of the participants through a feminist lens. I will then reflect on the term **‘Obstetric Violence’** and how this corresponds with my findings, contemplating an extension to this terminology to better encompass the psychological trauma caused by health care providers and systems. The unexpected breastfeeding outcomes will also be further explored in this part of the thesis. While breastfeeding outcomes were not the aim of this study, these **ancillary findings** further describe the maternal experience of separation in reestablishing and connecting with their infant through breastfeeding.

Despite the overall traumatic perinatal experience, the separation of the participants from their newborn infants demonstrated profound psychological and emotional consequences. The desire to hold their baby was strong and this has been also described in other studies as urgent, intense and affirming (Stevens et al., 2019). My literature review in Chapter 2 developed these points in more detail, showing how women experience this close physical contact with their newborn at birth. The women I interviewed were denied immediate skin-to-skin contact with their baby, which is known to improve birth satisfaction and give women a sense of control, and is seen by women as a way to ensure non-separation and promote breastfeeding and connection (Deys et al., 2021).

6.2 Emotional Turbulence

In describing their emotions at the birth and time of separation, the participants used words known to be associated with a traumatic event – numb, frightened, scared, anxious. This detached and emotionally critical response was also evident in their descriptions of

physical reactions such as uncontrollable shaking, representing a dominance of the sympathetic nervous system (Walter et al., 2021). The participants in this study were all denied the opportunity to increase their endogenous, stress-relieving and soothing oxytocin with immediate skin-to-skin contact and early breastfeeding, known to alleviate these feelings and physical reactions (Walter et al., 2021). Whilst acknowledging that the majority of these caesarean births were not planned or wanted, and therefore inherently stressful, trauma was inflicted further by maternal-infant separation.

Over time, including for some up to ten years later, the emotions progressed to anger, sadness, frustration, shame and failure that were still fresh during the interviews (see Figure 5.2). The responses reflected normal reactions to trauma rather than signs of mental illness (Center for Substance Abuse Treatment (US), 2014) although some participants had been diagnosed with Post Traumatic Stress Disorder (PTSD) and Post Natal Depression since the birth of their child. Women with both a negative experience and caesarean section as independent factors are at increased risk of birth trauma and PTSD related to the birth (Horsch et al., 2024). Although some participants had been established to exhibit childbirth related mental health conditions, all displayed emotional responses linked to birth trauma which was exacerbated by being separated from their baby.

6.3 Being Prepared

All participants talked of the preparations for childbirth and the knowledge they had sought prior to the birth and separation event. They navigated their entire perinatal experience during the research interview to explain how the period of separation had impacted them, and it was clear that these women did not enter the process blindly. They chose providers, facilities and expertise that would ensure the best outcomes for themselves and their babies, whatever the mode of birth and most had written birth plans they discussed with the providers.

Women are expected to prepare for childbirth by health facilities, health care providers, families, friends and social media. It is a time of joy and excitement for many as well as some trepidation. Birth plans should offer the opportunity for women and health care providers to communicate and cooperate to improve informed decision making (Bell et al., 2023). Developing the plan and finding the right perinatal support provider is promoted, often

at high prices, as being a way to ensure a safe pregnancy and birth. However, perception of safety differs between maternity care disciplines and providers, and as already discussed, generally focuses on baby wellbeing (Davison, 2020). Women value psychosocial safety equally with the physical, and want a positive experience from their birth (Downe et al., 2018). They can feel empowered when supported and involved in planning their birth, even when the outcome is unanticipated (Lewis, 2014).

While only five of the birth stories in this research involved a planned caesarean birth, the women were given little informed choice prior to the event and most did not understand the exact reason for an elective caesarean. The value of a birth plan for women having planned caesarean sections reflects a right to respectful maternity care, however the majority of women can still be denied their preferences, including immediate skin-to-skin at birth, regardless of requests (Barnes et al., 2022). Developing a birth plan, even with contingency options for emergent or unanticipated events, requires ongoing respect and support from health care providers to be effective. This was not evident in the stories recounted in this study.

6.4 Birth Territory and Rites of Passage

Many of the participants described transiting through terrains which resembled surveillance rooms, from the monitoring in birthing units to the ultimate transfer to the operating theatre. Hospital birthing facilities are commonly designed to monitor women and provide ease for staff to do so rather than the homely and sacred places conducive to physiological birth (Goldkuhl et al., 2022). "Birth Territory" describes this terrain as places where women feel unsafe and fearful, with resulting poor physical functioning and emotional wellbeing (Fahy et al., 2008). Safety has been linked with the birth environment in other studies, influencing birth satisfaction and outcomes (Maxwell et al., 2024). Feeling unsafe and having no sense of control in the clinical environment was described by these participants and implicated in their overall birthing experience and subsequent separation from their babies. The operating theatres were portrayed to them as "too cold", insufficiently staffed, and an environment that would cause infections for babies left with their mothers.

The terrain of the mother's bodies was additionally deemed unsafe, both before and after birth, with actions and comments alluding to the baby being safer in the care of staff,

neonatal units or fathers. The design of the operating theatres created visual separation of the dyad, with equipment and people in the way for mothers to even be able to see if their baby was alive and well.

The rituals around birth, including the medicalised processes can either strengthen or delete the power a woman has at a time when she is most vulnerable and open to suggestion (Reed, 2021). Autonomy for the participants was thwarted by removing their right to make informed decisions about their own care (Brand & Gartland, 2024). This lack of autonomy was particularly emphasised when the rights of the fetus was elevated above the woman, coercing compliance rather than seeking consent. This health care provider focus of fetal rights over maternal human rights complicates any notion of woman-centred care (Newnham & Kirkham, 2019). The rituals demonstrated in the births of these participants emphasised their failure to safely carry and birth their child, let alone care for them with their bodies after they were born.

The jurisdiction of the operating theatre, in particular the people who were in the environment caused disintegrative power that undermined the participants self-embodiment. The medical Rites of Protection which could have supported the women having non-physiological birth, worked against the participants to favour the health care providers. This was highlighted with the lack of support given to them to stay in close physical contact with their newborns. Health care providers, in particular midwives, should be well placed to provide respectful, safe and supportive care to improve the psychological as well as physical birth outcomes by centring on and partnering with women (Shiindi-Mbidi et al., 2023).

The organisation and management of obstetric-led maternity services creates an environment prone to facility-controlled power that disadvantages and disciplines women into submission. Midwifery or health care provider guardianship versus domination was illustrated by all participants who explored both positive and negative accounts of midwives and other health care providers who impacted their birth experience. Their descriptions included respectful and supportive care but recognised that this was often exceptional, not standard practice. The potential of midwives to provide protective and respectful care was anticipated by the participants, particularly those who had established relationships with them in the antenatal period. While disappointed in what the midwives didn’t or couldn’t do

in the labour and birth period, they also understood this was an organisational failure. Hospital policy and androcentric power does not encourage care provider guardianship for women and the hierarchical structure is a risk to women’s safety (Kanaris, 2023). Patriarchy disempowers midwives and other care providers which in turn disembodies and traumatises women (Patterson et al., 2019).

Power and control, or jurisdiction, were strong concerns for all participants, who recognised the little they had. Previous work, like our study, has shown that skilled and even kind caregivers who meet their own needs first take away the power, respect and confidence of the birthing woman, limit her participation, and cause a negative birth experience and trauma (Goer, 2023). Empowering women to give birth, rather than being delivered-of, their babies improves birth satisfaction and wellbeing of the dyad (Fahy et al., 2008). And while medical interventions and caesarean births are more likely to disempower women and reduce birth satisfaction it is not the birth mode but instead how a woman is treated by health care providers that will impact her experience (Brand & Gartland, 2024; Lawal et al., 2024; Reed, 2021). It was also the production line, ‘butcher shop’ experience which was not woman-centred, individualised or respectful that impacted birth experience (Schobinger et al., 2024).

The impact of the birth separation event altered how the participants transitioned to ‘mother’ and continued to impact the relationships they had with their partners and infants beyond the perinatal period. Some felt that a lack of action from their partners to provide protection had made them complicit in the trauma and separation they experienced. For several this was short lived as they reflected on the shared distress and lack of control but for others it continued to affect their relationships. Similarly, while the majority felt little or no attachment to the infant immediately after birth, most developed positive relationships over days or months. The participants clearly associated this lack of early connection with the separation at birth, including being parted from partners. They also reflected that skin-to-skin and breastfeeding were healing and supportive factors in the establishment of a relationship with their baby. This is understandable with the well-known role of oxytocin for mother-infant bonding, the hormone being released during both skin contact and suckling on the nipple (Walter et al., 2021).

6.5 Obstetric Violence and Neglect

Obstetric violence, a gendered abuse within maternity care, is increasingly affecting women, and being recognised, globally (Keedle et al., 2024). It is a term which has been added to legislature in many countries in an attempt to protect women during the perinatal period, covering the physical, sexual, emotional and psychological harm caused by maternity health care (Chervenak et al., 2024; Perez D'Gregorio, 2010). Australia is not one of these countries, however the 2023 Birth Trauma Inquiry in New South Wales, has sought to report on and address this shortfall (New South Wales Parliament, 2024). I was impelled to make a submission to this inquiry in 2023 based on my clinical experience and the prominence of obstetric violence portrayed in this research (see Appendix C). The care the participants in this study received caused harm which was significant and enduring – physical trauma, non-consensual and painful sexual touch, emotional turmoil and psychological injury. This fits directly with the definition of obstetric violence. Separating a woman from her baby without medical reason and stopping her from holding and feeding her baby immediately after birth fits the definition of obstetric violence (Perez D'Gregorio, 2010).

Obstetric violence can be normalised by governments, institutions and providers with the belief that it improves safer outcomes for women and babies (Downe et al., 2023). It increases when the rights of a fetus are elevated over the rights of the woman, and does not account for the woman's authority to make choices that are right for her and her baby (Deys et al., 2024a). Declining or disagreeing with a proposed treatment increases the risk of abuse and disrespectful maternity care (Niles et al., 2021). This was evident in the stories the participants shared, with coercion and bullying being used alongside threats of harm for their babies if they didn't comply with recommended interventions. Obstetric violence has become a form of discipline, concealed within the context of maternity services, to ensure compliance from women (Chadwick, 2017).

In Australia around one third of women birth by caesarean section (Australian Institute of Health and Welfare, 2023) and the same number experience birth trauma (Keedle et al., 2022). The general perception of trauma requiring physical harm disregards the significance of psychological injury. This research has demonstrated the significance of maternal-infant separation for increasing psychological and emotional harm. In particular, it has highlighted

the influence of healthcare providers in propagating this harm through invalidating maternal choice, pressuring consent, and removing power and control from the woman. Vulnerability of the women was not considered, and facility and provider agendas were prioritised. Fear was used to limit and direct decisions made by the women who felt intimidated and defenceless. The use of threats and coercion is associated with the experience of psychological abuse (Keedle et al., 2024). The participants all complied with the caesarean section birth which resulted in being separated from their baby because of the escalated risks presented to them to gain ‘consent’. They had no choice about the subsequent removal of their newborn babies.

Any debriefing the participants experienced did not acknowledge the trauma they experienced but focused on reducing litigation and the obligation of gratitude to have their baby. This neglected the significance of the trauma and minimised the importance of the woman.

6.6 Ancillary Findings Related to Separation - Breastfeeding

Although separation from their babies lasting hours in most cases, the breastfeeding outcomes of the participants in Theme 1 were largely in contrast with expectations, with separation and no skin-to-skin contact at birth known to be a factor in lactation failure (Crenshaw, 2014; Widström et al., 2019). These unexpected outcomes were presented in 2023 at the Lactation Consultants of Australia and New Zealand (LCANZ) conference in Melbourne, abstract as follows and also presented in Appendix G.

Abstract: Lactation Consultants of Australia & New Zealand (LCANZ), Melbourne 2023 - *Breastfeeding In Spite Of* – unexpected findings

> Keeping mothers and babies together in the immediate period after birth, ideally in skin-to-skin contact, is well known to facilitate a biologically normal chain of events, including breastfeeding.
>
> In my PhD research I have sought to understand the experience of women who were separated from their baby after caesarean section birth without medical reason. I expected to hear stories of breastfeeding struggles and failure, but what I found was resilience and

determination in spite of their negative and often traumatic birth experiences. Breastfeeding was not without challenges but the women overwhelmingly took back the control they lost during their birth and sought to re-establish the relationship with their baby by feeding and nurturing them.

This presentation shares the stories of 15 women who participated in interviews of a feminist phenomenological research study. It will show the strength of women who despite a loss of centrality, power and connection with their baby during and soon after birth, still breastfed successfully and long-term.

Breastfeeding is a human right, closely associated with positive health and wellbeing of both mother and baby (Van et al., 2023). Initiation, exclusivity and duration all play a part in preventing short- and long-term illness, supporting healthy relationships and protecting emotional as well as physical health. Successful breastfeeding is closely related to pregnancy, birth and early post-natal experiences with medical interventions likely to have negative impacts (Andrew et al., 2022). Caesarean section births are associated with reduced initiation, duration and exclusivity, for multifaceted reasons, including interrupting how women and babies interact with each other in the first moments after birth (Guala et al., 2017; Walker, 2022). Women having caesarean sections are more likely to have underlying health conditions leading to more medicalised births, are given more medications, have more difficulty finding comfortable positions to feed their babies, but notably they are more likely to be separated from their baby in the first hours. Women who are traumatised by their birth event are less likely to enjoy and transition to becoming a mother which correlates with reduced breastfeeding over at least the next 12 months (Mitchell & Whittingham, 2023). No immediate skin-to-skin, delays to first feed and prolonged separations are all known to have poorer breastfeeding outcomes (Crenshaw, 2014; Parker et al., 2020; Smith et al., 2017).

In spite of this evidence, the participants in this study all achieved a breastfeeding relationship with their child, many long-term or still breastfeeding at interview. Being successful in breastfeeding enabled bodily autonomy, power and control lost at birth to be returned to them. This served to ameliorate some of the birth and separation trauma, promoting a physical and emotional connection between the dyad. Most had anticipated and experienced early struggles with establishing lactation but were triumphant in taking back the control that had been taken from them, independent of breastfeeding duration. Those who

did not achieve their full goals or the mother-child relationship they wanted blamed the separation from their baby at birth, unable to bond and experience the biological norm. The participants in this study frequently described cultural practices within the services they birthed in which negatively impacted satisfaction and demonstrated that skin-to-skin contact and keeping mothers and babies together was not either respected or standard practice.

Protecting women from birth trauma and negative birth experience should be the goal of all maternity care providers. Ensuring women have informed choice, supporting their decisions, keeping mothers and babies together, and ensuring safety and respect will improve both birthing and breastfeeding outcomes. Providing more intensive breastfeeding support and care to women who have experienced adverse birthing events such as caesarean section or unavoidable separation from their newborn enables them to bond and breastfeed more successfully with their infants (Tzitiridou-Chatzopoulou et al., 2023). This unexpected finding should inspire both women and health professionals to encourage the psychologically and mutually protective effect of breastfeeding for mothers as well as babies following birth trauma.

6.7 Chapter Summary

The participants in this study frequently described cultural practices within the services they birthed in which negatively impacted satisfaction and demonstrated that skin-to-skin contact and keeping mothers and babies together was not either respected or standard practice.

The theoretical relationship for Rites of Protection was significantly associated with all themes as seen in Table 4.3. Medical interventions have a rightful place in maternity care with the potential to save maternal and neonatal lives. However, informed consent is difficult when patriarchal medical systems expect compliance from women who are given misleading details, suggestion and exaggerated risk to comply with procedures (Reed, 2021). Rites of Protection need to be balanced with the Rites of Passage, with health care providers, in particular midwives, ensuring women remain at the centre of care and supported to be involved in decisions with options, not ultimatums.

Blending the terrain and jurisdiction of the Birth Territory theory (Fahy et al., 2008) with the conception of power and control with Rites of Passage and Protection (Reed, 2021) provided insight into the experience of the participants in the research. The influence of maternity care providers and facilities is the largest, modifiable factor where change can positively affect all other experiences for women.

Chapter 7: Strengths, Limitations & Recommendations

7.1 Chapter Foreword

This study sought to understand the experience of women who had a caesarean section birth and were separated from their baby unnecessarily. The findings demonstrate that separation caused deep emotional and psychological impacts for the participants. Their sense of control was diminished by facility power, disciplining women into submission using policy and fear. Australian maternity systems, like many other around the globe, focus predominantly on the physical risk of pregnancy, labour and birth, and especially the risk to the infant. My research stresses that consideration needs to be given to the woman’s human right to self-embodiment, the prevention of psychological harm and the consequences for the woman separated at birth from her baby. Keeping mothers and babies together at birth can mitigate the impact of birth trauma and protect ongoing maternal wellbeing. This chapter will present the strengths and limitations of this body of work and share recommendations to improve the maternity care experience for women through practice and policy change, along with suggested future inquiry.

7.2 Strengths & Limitations

Critically examining this research for limitations and strengths created the opportunity to discover flaws in the appropriateness of the study and the findings made. The greatest strength was in the use of a feminist phenomenological approach using feminist birthing theories to create the structure to understand the birth experience. The traumatic and negative experiences shared through this approach strengthened the quality of the findings due to the rich descriptions of the participant data.

While the findings may not represent the experience of all women birthing by caesarean section who are separated from their babies, they were consistent for these participants. Potential limitations were identified and considered – that of the purposive and snowball sampling technique, a smaller number of participants, participant demographics, and the trustworthiness of participant memory recall.

Strengths

Feminist birthing theories: The strength in using feminist birthing theories supported the methodological enquiry with previously developed tools on the experience of birth. These

have been used formerly to understand physiological labour and birth, however the premise of a woman 'giving birth' and transitioning to 'mother' through mind, body and spirit should be viewed the same regardless of birth mode. The feelings experienced by a woman at birth are directly related to how she perceives her safety which is influenced by the people who are caring for her, and the environment in which she births. This is the first research to use both "Birth Territory" (Fahy & Parratt, 2006) and "Childbirth as a Rite of Passage" (Reed, Barnes, et al., 2016) theories (see Chapter 3 for more details) to understand the maternal caesarean birth experience and the particular aspect of being separated from a baby without medical indication. The participants in this study all birthed in a similar environment – an operating theatre, in Australia, with similar health professional disciplines around them. The results were comparable for both planned and emergent procedures, showing that the agenda of the care providers were prioritised over the needs and wants of these women, something also demonstrated in other research, and a factor in the woman's experience of birth trauma (Reed et al., 2017). This continues to be relevant when no change is being seen over the last ten years, despite growing evidence to support keeping mothers and babies together in skin-to-skin contact.

Limitations

<u>Purposive Sampling</u>: As discussed in Section 4.4 *Participant Recruitment and Sampling*, purposive sampling in qualitative research provides the opportunity to explore rich data sets such as these and provide subjective knowledge of the phenomena rather than population generalisations (Bolderston, 2012; Polit & Beck, 2017). Seeking participant involvement from a proactive maternity consumer group known to be seeking better outcomes for women was a deliberate technique to find the unique set of vulnerable women who had been impacted by the phenomenon. As a qualitative study seeking to understand the experience of women separated from their baby at caesarean section this suited the objectives well. The phenomenological framework meant searching for the subjective and specific knowledge of the participants rather than a generalised assumption of all birthing women. As considered, not all women negatively experience separation from their baby, however this group of women were all deeply and comparably impacted, providing abundant data to be considered. Replicating this study across a broader population sample could identify different themes or reinforce the validity of this research.

The participants individually chose to be involved in this study by responding to the call out, along with the social media group members who chose to share the original recruitment post to other platforms, creating a snowball effect. This altruistic motivation for research participation has previously been demonstrated, with expected shared empathy and connection to a community, along with feelings of common good benefiting participants (Carrera et al., 2018). All participants in this study had altruistic reasons for their involvement, connecting and empathising with future birthing women and wanting to improve birthing experience for those having caesarean sections. Erin* had shared the Facebook recruitment post with her extended family, her mother responding straight back with *“this is what you’ve been waiting for”.* She felt relief that this research was being conducted and very keen to be involved:

“The fact that someone out there is identifying this as an issue, and it’s, you know, being looked into, and maybe this will change, is also just a healing thing to know”

Small participant numbers: Only fifteen women participated in this research, however they collectively showed that separating a mother from her baby at caesarean birth was experienced similarly. This included when it happened a second time. There were no differences seen in experiences of being separated from their baby for procedures which were either planned or unplanned. This provided a strong and valuable understanding of the gender-based phenomenon and hints at the breadth of the issue in our patriarchal health systems. A much larger sample may have added to the sub-themes or themes however data saturation was noted at participant 13 with no additional themes in the final two interviews.

Participant demographics: All participants in the study were well educated and predominantly white women who birthed in the Australian health care system. The findings may not be replicable with women of different cultural or national backgrounds experiencing the same birth and separation event around the world. However, respectful maternity care is globally recognised as a human right, acknowledging the importance of women’s preferences and maternal birth experience (World Health Organization, 2018c). Including more culturally and linguistically diverse women who birthed in Australia who experienced the same separation event at caesarean section birth may have provided a broader understanding. This research

could also inform investigators from other countries to replicate the study to gain an understanding of the lived experience of their birthing women.

Trustworthiness of participant recall: In considering the potential limitations it could be argued that the stories recounted by these participants up to ten years after birth could be distorted by time, however this has not been reflected in other literature, with women shown to be able to recall birth experience and events for many years (Bigelow et al., 2018; Bossano et al., 2017; Brubaker et al., 2019; Puia, 2018). The participants collectively reported consistent stories despite up to a decade since their births, reinforcing the validity of the time period used. I justified the study term through my original literature review to show that skin-to-skin as the ultimate method of not separating babies from their mothers was not routinely presented in literature or potentially occurring at caesarean sections prior to 2010 (see Chapter 2, Section 2.2).

7.3 Policies That Support Women

Respectful and safe maternity care should not be dependent on an individual practitioner but supported by policy and informed practice. International policy advocates for woman-centred, midwifery-led continuity of care that supports every woman's human right to safe and respectful perinatal care (World Health Organization, 2018c).

Woman-centred care in midwifery-led continuity of care (CoC) models have been demonstrated repeatedly as being safest for women and equally safe for babies and yet continue to have slow uptake in high-income countries including Australia (Homer, 2018; Renfrew et al., 2014). Lack of access to this option increases risk of obstetric violence and the experience of trauma (Keedle et al., 2024). Including midwifery-led CoC in policy facilitates the shift to a reducing hierarchical structure and improving power balanced decision making for women (Cummins et al., 2020).

Policy should be developed in consultation with both evidence and the women it aims to support. A national Australian guiding document on woman-centred care was released in 2019 (COAG) but neglected to fully address the evidence of midwifery CoC and to clearly value maternal choice and right to self-embodiment (Dahlen et al., 2023). This research provides evidence of the importance of woman-centred practice, psychologically safe and respectful

maternity care which can be used to inform practice documents at local, state and national level. It highlights the importance of the consumer experience and right to self-determination, both of which should be addressed by policy.

Respectful maternity care practice should be evidence-based, including supporting skin-to-skin care at all births unless medically contraindicated. Maternal choice and consent should include pathways for women who decline the treatment being recommended by the practitioner without retribution, and ensure the woman has ultimate rights to both her body and her baby. These policies and pathways must recognise the inherent gender-bias and patriarchal health system history to make meaningful change for future birthing women (Betron et al., 2018). Sharing the findings of this research through both conference presentations and publications ensures this new evidence can inform policy and procedure change.

7.4 Addressing Workplace Culture

Addressing the challenges of workplace cultures that remove power and control from women, increase fear and lead to poor birth satisfaction requires change at all levels. The historically androcentric and gender divisive norm of health services creates a culture of inequity and dismissive care towards women, both as givers and receivers of treatment (Betron et al., 2018; Dahlen et al., 2022; Merone et al., 2022).

Providers who deliver care to women, including maternity services, must be challenged and systems put in place that promote the bodily autonomy of women. Respectful care does not require women to acquiesce to care providers or be a ‘good girl’, or to give away their power to the authority of the provider (von Benzon et al., 2024). Changing cultural behaviours includes **shifting the language** that both midwives and doctors use, **recognising the reason change is important**, and **acknowledging the rights of women to disagree** with suggested treatment plans.

Hospitals currently function within hierarchical structures and a balance of risk and complexity, however women still need respectful, fair, kind and psychologically safe care (Lephard, 2023). Cultural norms which respect the human rights of childbearing women start with supporting the individual care providers, particularly those who are also challenged by

patriarchal constraint such as the predominantly female midwifery workforce (Dahlen et al., 2022).

Educating and empowering women is a small but important part of changing maternity care practice and culture. However, telling women they have a choice is not the same as giving them informed choice. The current system needs to change, returning power through truly woman-centred care, before women will be able to make autonomous decisions about their care. Informed choice and shared-decision making does not account for facility and provider power (Yuill et al., 2020). Education of maternity care providers to understand the balance of power, bodily autonomy and what increases risk for childbirth trauma and reduced maternal wellbeing has the potential to improve outcomes for women (Heys et al., 2022; Leinweber et al., 2023; Yuill et al., 2020).

7.5 Midwifery Care

It would be expected that not all women who have had a caesarean section and are separated from their baby have been traumatised, however this was the experience of the participants in this research. Lily* who was traumatised by her caesarean birth went on to have two successful VBAC births. She did not think it was the mode of birth but the care provider support she experienced, *“People who have beautiful caesarean experiences, they’re usually pretty happy to just have another one.”*

Health care providers, in particular midwives, are the key to supporting women to feel safe and have a sense of control for all births, including the choice to hold and stay with their baby (Avery, 2023; Dahlen et al., 2022). Midwifery-led care can reduce the incidence of caesarean section births however this birth mode will remain an important and safe option for many women and babies. Midwifery attendance at caesarean section births in Australia is standard and all participants talked of midwives’ presence. The midwife’s role is valuable in a supportive context, advocating for and supporting woman’s choices. This includes skin-to-skin contact, non-separation of the dyad, and early feeding, all known to be desired by women (Deys et al., 2021).

This was not the overall midwifery experience of the participants in this research who talked of mistrust, lack of protection and unsupportive care, Miranda* saying *“I don’t feel she*

was supportive at all. She was certainly not an advocate." Maria* also said that *"I felt like they didn't really protect me as well as they should have"* but acknowledged, along with other participants, that midwives may behave like this to protect themselves *"I know that that's because of the fact that they're still governed by the policies of that hospital, and they didn't want to get in trouble."* Naomi* saw this as them being institutionalised *"They were basically obstetric nurses…note-takers, and um, you know, IV checkers. That's all they were because it's the institution, and it's the culture."*

The International Definition of the Midwife recognises the importance of the midwifery scope of practice as a partnership role with the woman (International Confederation of Midwives (ICM), 2017a). Midwives responsibilities include being a supporter of women's rights to make decisions about their care and empower them to speak for themselves (International Confederation of Midwives, 2014). The findings of this study call out the challenge to midwives to work within their code of practice and ethics with all women, at all births. Improving perinatal satisfaction, providing respectful care and eliminating harmful practices sits soundly within midwifery responsibilities (Avery, 2023).

However, gender and power inequality extend to the staff caring for women in maternity services (Betron et al., 2018), with midwifery being a predominantly female workforce. The patriarchal hierarchy of maternity care systems dominates both midwives and mothers with science and risk modelling rather than supporting autonomy (Dahlen et al., 2022; Einion & Robertson, 2023). Future post-doctoral research should include the experience of midwives, particularly as these are the health care providers most likely to be able to improve outcomes for women.

7.6 Redefining Psychological Obstetric Trauma

The discrediting which occurs for psychological trauma leads me to consider the term 'obstetric neglect' as an additional but significant description for what these participants experienced. It does not seek to devalue or remove the terminology of 'obstetric violence' which includes psychological trauma in its overall definition. However, it highlights the important facet of disempowerment by voiding choice, influencing consent and coercing compliance. While this research showed examples of violent physical trauma it was the psychological distress and damage that remained with them well beyond the day of birth.

Women are consistently told that these experiences are not valuable by escalating the importance of the baby over themselves – *“you better be thankful because you have a healthy, beautiful baby” Rose** (Perrotte et al., 2020). The gendered interpretation of a woman prepared to sacrifice herself for her baby has been perpetuated through androcentric health systems and needs to be recognised as neglectful of the rights of women. Neglect indicates a failure of care or provision for the importance of the woman in her own right, not just as ‘mother’. As with obstetric violence, obstetric neglect can leave women feeling disrespected, powerless, dehumanised and violated (Keedle et al., 2024). Using the term ‘obstetric violence’ alone has led some health providers to call it a misleading term because it is a too strong and emotionally charged, likened to acts of terrorism (Chervenak et al., 2024). The watered-down version suggested by Chervenak et al (2024) to ‘mistreatment’ emphasises the patriarchal influence and the minimises the trauma experience of women. I propose the fully informed label of ‘obstetric violence and neglect’ to fully validate the experience of women.

7.7 Chapter Summary

The potential for meaningful change for perinatal women in the current maternity care system leans on current and future research. Acknowledging and redefining birth experience language to include the dissatisfaction and trauma women are facing is the first step towards transforming the service. Table 7.1 summarises the policy, practice and research recommendations I have made from this research.

Table 7. 1 Recommendations summary

Recommendation	Policy & Practice	Research
Policies that support women	CoC Models of Midwifery care increased Woman-centred care embedded in all policy and procedure documents Non-punitive pathways of care for women who decline recommended treatment option Skin-to-skin at all births as standard practice – set in policy and auditing processes	National monitoring of skin-to-skin and exclusive breastfeeding rates of individual facilities
Addressing workplace culture	Challenging hierarchical structures through HCP education and policies which acknowledge individual rights and autonomy	
Midwifery care	Support for midwives to work within their scope of practice as autonomous practitioners including through CoC	Understanding the gender and power experience for midwives working in health care facilities.
Redefining Psychological Obstetric Trauma	Valuing psychological trauma and violence through the additional term of 'obstetric neglect' HCP education on the impact of psychological birth trauma and confronting current practices which exacerbate and precipitate the experience of trauma for perinatal women	

Chapter 8: Conclusion and Reflections

8.1 Chapter Foreword

This chapter seeks to bring summation and conclusion to this thesis body of work. Each segment of the research purpose and process has been presented, with the final chapters showing the assumptions drawn and recommendations made. The following will present a conclusion to the thesis, reflect on the PhD journey which led to this culmination of work and make closing remarks.

8.2 Conclusions - "Where's my baby?"

This feminist phenomenological study provides new understanding on the lived experience of women separated unnecessarily from their baby at caesarean section birth. In examining the participant births within an androcentric obstetric system, a framework of two feminist birthing theories, Birth Territory (Fahy & Parratt, 2006) and Childbirth as a Rite of Passage (Reed et al, 2016) have been used. This has presented a deeper understanding of birth as more than a physical experience and the negative impact of removing power and control from the woman and placing it with the health care provider. This research explores birth trauma exacerbated by separation of mother and baby, through both obstetric violence and neglect.

Fifteen women were interviewed on this experience of separation immediately after birth and being denied the opportunity to have skin-to-skin contact, hold or breastfeed their baby, despite them both being medically stable. The disregard of woman's choice and a focus on 'delivering' a baby did not account for the transformative experience of birth and becoming a mother. The woman's vulnerability was extorted by the medical system, ignoring wants, requests and rights, with the balance of power sitting firmly with the medical system. The distress and trauma of the participants births continued to impact their relationships, wellbeing and lives to at least ten years after birth.

As described, four main themes were identified – *Disconnection, Emotional Turmoil, Influence* and *Insight*. While the entire perinatal experience for these women was traumatic, the separation from the baby at birth had profound emotional and psychological impacts. They saw their lack of power and control in the birthing environment as something that was removed or denied by the health care providers. Physical safety, predominantly of the baby,

was prioritised by health care providers as a rationale for denying or limiting mothers’ choice to stay with her baby even when they were medically stable. Psychological safety of the woman was disregarded without considering consequences beyond the birth room.

Returning power and self-advocacy to the woman is a basic human-right which maternity services should be striving for. The most modifiable factor to improve birth satisfaction and reduce trauma is the influence of health care providers, especially midwives. Recommended changes to policy, practice and culture based on this and future research has the potential to create positive change for birthing women (see Table 7.1). This includes changing language and terminology in the way we communicate with women and define their experience.

8.3 PhD Reflections – Trees

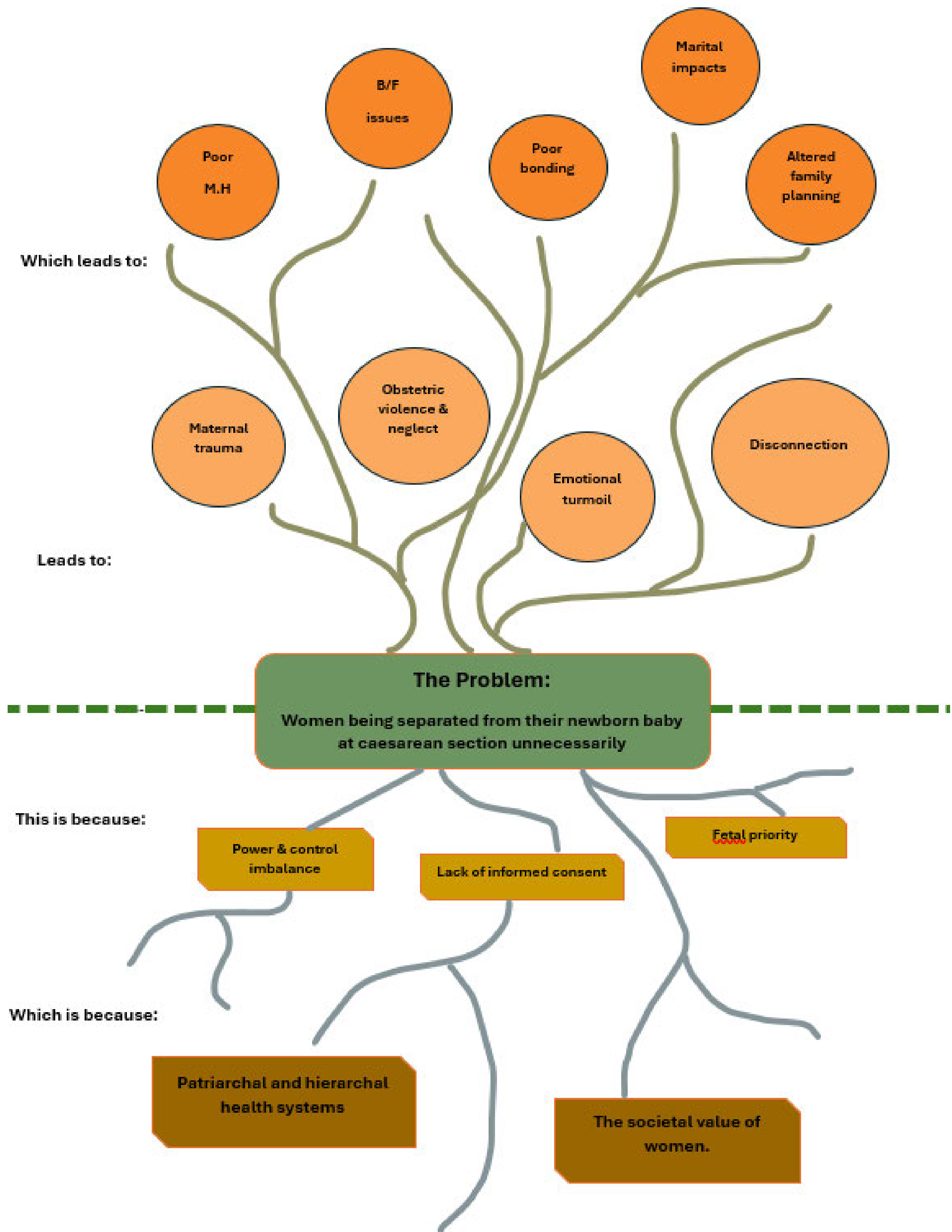
Looking back at my PhD diary leaves me wondering how I ever came to be here at the finish line, especially starting off in the year Covid-19 commenced and ‘unprecedented’ became a popular word. My passionate but naïve start in 2020 wanted meaningful change for women birthing by caesarean section in my health district and beyond. I was fortunate to have supervisors who also saw the value in what I wanted to achieve in finding the evidence needed to change culture, policy and practice. The research broadened my usual focus and anyone who asked me what my research topic was about was always surprised it wasn’t about breastfeeding alone. While this started out in a lactation clinic, I am reminded of the tree of life analogy, often used to symbolise both birth and breastfeeding - my feminist roots so deep in the ground I could only feel their strength, my strong midwifery trunk and my growing canopy of woman-centred care and lactation knowledge.

The Problem Tree is also another good analogy for this work, remembering that the problem we see is rooted in something much deeper and bears the fruit of what nourished the tree (Figure 8.1). Deep in the soil is the societal value of women and the patriarchal health systems which care for them during the perinatal period. This grows roots which prioritise the fetus over the woman, create dominion over the woman and not give her the information she needs to make decisions about her care. This control over the woman leads to outcomes which include the dyad separation at caesarean section birth, where the woman has lost autonomy and fears for the safety of her baby. The fruits born by this separation alter her

path to being ‘mother’, create trauma and emotional damage and redirect her relationships and psychological wellbeing. My hope is that this research fertilises the roots of maternity services to change outcomes for future birthing women.

The Problem Tree also helps describe the “What?” of Driscoll’s Model of Structured Reflection (What? So what? & Now what?) (Stonehouse, 2020). The visualisation of where my PhD started, at the problem of women being separated from their babies at caesarean section without a medical reason – well-mother and well-baby who in another context of birth would have been in close physical, skin-to-skin contact immediately.

Figure 8. 1 Problem Tree



The growth of my own tree was like any good life event, with challenges along the way. My Integrative PhD journey was planted at the University of Wollongong, I was excited to have face-to-face classes and be physically linked with a university campus. However, after just a few sessions the pandemic took hold and progressively everything in my study, work and social life became virtual. I was amazed at the support of UOW, lectures and courses continuing online, physical books were mailed out from the library, and my supervision with Val and Shahla went to Skype. It was still an isolating experience, confounded by the general restrictions of living during a pandemic, but my PhD seedling continued to grow. Despite movements forward such as publishing my literature review, I noted in my diary that I was *"feeling very unenthused and have lost my mojo"* (Diary reflection August 2021), as the restrictions meant no face-to-face interviewing and I had to consider using Zoom. So much of life was on a computer that it was disheartening to think my research interviews would be too, I couldn't imagine any benefits at that stage.

Working full-time added to the complexities of doing a PhD, especially with a large portion of this being from home, I used up all the nutrients in the soil which had to be replenished frequently by my supervisors, colleagues, friends and family. Working in a Clinical Midwifery Consultant role, I continued to provide breastfeeding support and education for patients and staff across the district. I have created content for our health district website development, prepared and presented education for local and state forums, participated in local and state working groups, and reviewed and developed policy documents. In 2023 I took ten months of reduced hours from work which gave me the time to propel data analysis and writing.

It was hard going back to full-time at the end, but I was now a strong sapling. I also had the "So what?" of my research (Stonehouse, 2020), my themes were identified and findings being developed, *"Feeling the responsibility of these birth stories, powerful, traumatic"* (Diary reflection April 2023). The responsibility of getting this done right was a little overwhelming at times. I started presenting some of these preliminary and unexpected findings in 2023. I found this cemented what was being analysed and developed into a thesis. But the 'so what' was more than the thesis, it was about getting it done well so that change was possible for the women.

As a midwife and IBCLC I have been passionate about woman-centred care and supporting women in the choices they make. I feel very strongly about the impact of commercial interests such as infant formula companies undermining women with suggestive marketing ploys. In early 2023 I had an abstract presenting some of my research findings accepted for the NSW Australian College of Midwives (ACM) conference, excited to share this at my professional association program. However, I soon noticed that a major sponsor of the conference was also the fifth largest formular manufacturer in the world. Despite claims and reassurances about company parentage for other products from ACM I chose to withdraw my abstract. This research journey has empowered me and given me a strength in knowing I am able to make change. The outcome of this was a change to the ACM National sponsorship policy and the company was removed from the conference. I didn’t get to speak but I am proud to have been able to make effective change.

*“Update on ACM – email received from CEO – they dropped **** as a sponsor for all future conferences (and the NSW one which was on the next weekend after receiving my email – such a relief and an amazing and unexpected result – will have to add that into my thesis!! A huge win!! Unfortunately, I wasn’t able to present at that conference and the abstracts for the national conference are closed but I have rejoined as a member (to keep an eye on them!) and will consider conferences in 2024.”* (Diary reflection April 2023)

I have continued to ‘keep an eye on them’ and have been on the NSW ACM conference organising committee for 2024 and now for 2025. This is a new side of me I have discovered during this PhD journey, that I can be bold and take a stand, very much like the women in my research. There have been tears and insecurities along with the cheers and triumphs.

The year 2023 also saw my tree roots dug up and replanted at the Australian Catholic University. Supervisor moves led the transfer, Shahla became my primary supervisor, Val continued her support and Sara joined the team. The move was challenging in many ways, but the transplant shock was minimal. My roots took strongly at ACU, and I grew taller and stronger under the cultivation of my team. Writing papers and chapters has at times been all-consuming and at others I have struggled to commit to the process. I was reminded of a HDR workshop I did at UOW in my first PhD year by Hugh Kearns, based on his book Defeating self-sabotage: getting your PhD finished (Kearns et al., 2009). He talked of managing procrastination (don’t wait for motivation, break it down, build in a reward) and perfectionism

(being selective with what needs to be perfect, setting deadlines, just finishing). I struggled with motivation at times and 'wasted' time that could have been better spent, but on reflection some of the wasted time was me recharging my batteries. I do recognise in myself the need to be 'perfect', my integrative year of course work in 2020 saw me with a GPA 6 average, I was very disappointed to get less than a high distinction. And this carried over to draft papers and chapters, I wrote and rewrote – nothing was ever 'rough' in draft form.

So, "What now?" (Stonehouse, 2020) As a tall, strong young tree I have completed the PhD cycle. I have born the fruits of publications and conference presentations, summarised again in Table 8.2. There are many small branches still growing which are supporting changes in the way women are treated when giving birth. I have shared, and will continue to share, publications and presentation recordings, when possible, with the social media group members where my original post went out. I want to ensure that the women who so bravely shared their stories and bared their emotions with me will get to see the results. And then there is policy change in both my local health district and across NSW. Despite occasional bouts of imposter syndrome, doing this PhD has encouraged my activity in state-wide groups and given me a voice to use the evidence from this research to change culture and practice and future projects. Ongoing propagation is needed so that perinatal care into the future is a place where women feel safe and powerful and in control, even when things have gone awry. The forest of change is growing around me and there is strength when we are all working towards the same outcomes.

Table 8. 1 Research Output "Where's My Baby?"

Presentation	Publication
International Normal Labour and Birth Conference, India (Virtual). 2-4th December 2020. *What are women's experiences of immediate skin-to-skin contact at caesarean section when mother and baby are well?* Poster presentation.	Deys L, Wilson V & Meedya S (2021) What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. *Midwifery,* 101, 103063. https://doi.org/10.1016/j.midw.2021.103063
UOW School of Nursing Research Conference. November 2021. *Through the eyes of a midwife: Using a feminist phenomenological approach to explore maternal birthing experience.* Virtual-oral presentation.	Deys L, Wilson V, Bayes S & Meedya S (2024) Using a novel approach to explore women's caesarean birth experience. *British Journal of Midwifery,* 32(5), 258-263. https://doi.org/10.12968/bjom.2024.32.5.258
SESLHD & ISLHD Person-Centred Masterclass Presentation, July 2022. *Valuing women in maternity care – how a woman-centred approach improves birth experience.* Virtual-oral presentation. (Invited Speaker)	Deys, L, Wilson, V, Bayes, S & Meedya, S (2024) "Where's my baby?" A feminist phenomenological study of women experiencing preventable separation from their baby at caesarean birth. *Women & Birth,* 37(6) 101828 https://doi.org/10.1016/j.wombi.2024.101828
Virtual International Day of the Midwife (VIDM) Conference. 5th May 2023. *"Where's my baby?" How do women experience separation from their baby at caesarean section birth.* (preliminary findings). Virtual-oral presentation.	
Lactation Consultants of Australia and New Zealand (LCANZ) Conference. 20-21st October 2023. Melbourne, Australia. *Breastfeeding In Spite Of.* Oral presentation.	
Virtual International Day of the Midwife (VIDM) Conference. 5th May 2024. *Understanding birth trauma from the perspective of obstetric neglect.* Virtual-oral presentation.	

8.4 Final Recommendations & Conclusion

Using a feminist phenomenological framework to understand the experience of women separated at caesarean birth from their well, term baby demonstrated a new understanding of the maternity care system. Birth trauma is being increasingly brought to the attention of governments and the public, no longer shrouded in the complexities of risk and biological expectations of women. This research has added evidence to the knowledge of maternal birth experience and highlights the value of the woman, not just as procreative vessels, but the main character of her birth event.

This study has shown that separating these participant mothers from their well-babies at caesarean section birth caused disconnection and emotional turmoil, influenced by an inequitable balance of power favouring health care providers. Their insight was part of the reason they chose to be involved in this research, to improve birthing for future women, including themselves. The fact that they all experienced this separation similarly should lead those who provide, develop, and educate on maternity care to consider the significance this has for many birthing women.

The results show that the environment a woman births in and the people who are supporting her have the potential to impact her psychological and emotional wellbeing across her lifetime. Removing power and control from the woman and leaving it in a patriarchal health system is leading to reduced satisfaction, poor birth and postnatal experiences, and increasing the disease burden of mental health in our communities. Women are experiencing obstetric violence and neglect, causing long lasting trauma and relationship crises. We need to do better.

Recognising that current practices are not working is just the beginning. The culture of maternity care needs to change, midwives need to remember their role in woman-centred care and birthing women need the support and confirmation of safety and respect which gives them the option to stay in close physical contact with their baby after a caesarean section birth.

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Research Portfolio Appendices

Appendix A: Participant Information & Consent Form

Research Participant Information Sheet

What is it?

You are invited to participate in research being conducted by Linda Deys, PhD candidate at the University of Wollongong. Linda is a Clinical Midwife Consultant and International Board Certified Lactation Consultant.

Linda is seeking to understand **the experience of women who are separated from their babies at caesarean section birth without medical reason**.

The research is being supervised by Professor Valerie Wilson, Professor of Nursing UOW & ISLHD and Dr Shahla Meedya, RM, IBCLC, Senior Lecturer, Faculty of Science, Medicine and Health, UOW.

What will it involve?

Participation in this research will involve a single interview with Linda. This will be voice recorded. The interview session is expected to take 1 to 2 hours. This can be done in your own home, via Zoom or in a safe and private venue of your choice. Child care can be provided free of charge if needed.

Participation is voluntary and open to women living in the Illawarra Shoalhaven district who have experienced separation from their well, term baby during a caesarean section birth in the last 10 years without medical reason. Women who live outside of the area can be included with interviews conducted via Zoom only. Participants must be over 18 years of age at the time of consent to be interviewed and be English-speaking.

Are there any risks to me?

The topic is an important one to many women. You may find it helpful to discuss your birth story but it may bring up emotions as you re-tell your experience. Debriefing and counselling can be provided through the Illawarra Shoalhaven Local Health District (ISLHD) if required. Alternatively, you can contact your GP or one of the services listed below. Breaks and refreshments will be provided as you need during the interview.

You can choose to stop the interview at any time without any negative consequences. You can decide to withdraw your consent to be involved in the research up until the point of data analysis where your details will no longer be identifiable.

You will have the opportunity to read a copy of the interview transcript before it is de-identified for analysis if you would like.

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AUSTRALIA

Privacy and confidentiality are assured. All data, audio and written, will be deidentified and stored securely in UOW cloud-based data management program for a minimum of five years in accordance with the University of Wollongong's Research Data Management and Privacy policies and guidelines.

Linda is responsible for the analysis of the data, assembling the results, and sharing the findings through publications and presentations under the supervision of Prof Val Wilson and Dr Shahla Meedya. Ethics approval has been sought and granted through the UOW Human Research Ethics Committee (ethics approval number 2021/380). If you have any concerns or complaints about the conduct of the research you can contact the **UOW Ethics Officer on 02 42213386 or email uow-humanethics@uow.edu.au**

Linda, her supervisors and the UOW have no conflicts of interest to declare. The information from the interviews will be used to understand how the separation from her baby affects mothers. The aim is to improve birthing outcomes for women who have a caesarean section. The results will be published in Linda's PhD thesis, publications in peer-reviewed and clinical journals, conference presentations and will include an open community forum presentation in the Illawarra.

Would you like to be involved or do you have any questions?

If you would like to participate, please complete and sign the attached consent form and return it to Linda via email at ljd996@uowmail.edu.au

You are free to choose to participate and to withdraw from the research at any time up to the point of data analysis.

If you have any further questions you can **contact Linda on 0418532997** or email address ljd996@uowmail.edu.au; Val Wilson -vwilson@uow.edu.au; or Shahla Meedya smeedya@uow.edu.au

Contacts for emotional well-being support:

Beyondblue - https://www.beyondblue.org.au/, ph. 1300 22 4636

PANDA (Perinatal Anxiety and Depression Australia) - https://www.panda.org.au/, ph. 1300 726 306

COPE (Centre of Perinatal Excellence) - https://www.cope.org.au/

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Consent to participate

Study Title - *What is the experience of women who are separated from their well babies at caesarean section birth?*

- I have read the participant information and understand the purpose of the study, what is involved, what data is being collected
- I understand what will be done with this data upon completion of the research
- I have been given the time and opportunity to ask questions and have been given clear answers
- I give consent to be interviewed and for this to be voice recorded
- I am aware I can choose where I want to have the interview conducted
- I understand that all information provided by me will be kept private and confidential and I cannot be identified in the analysis and results
- I understand that retelling my story may bring up strong feelings and that support will be provided during and after the interview if I need it
- I understand that I may withdraw from the study at any time up until data is being analysed and I do not need to answer questions I feel uncomfortable with
- I understand I will keep a copy of the participant information and signed consent form
- I am over 18 years of age currently
- I agree to participate in this research and give my consent voluntarily

____

(full name of participant)

____

(signature)

____

(date)

I would prefer a virtual interview ☐

I would like to read the transcript of my interview ☐

I would like the option of a baby sitter (face-to-face only) ☐

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Appendix B: University Ethics Approval

University of Wollongong - 2021

From: uow-humanethics@uow.edu.au <uow-humanethics@uow.edu.au>
Sent: Wednesday, December 8, 2021 7:58 AM
To: Val Wilson <vwilson@uow.edu.au>
Cc: Shahla Meedya <smeedya@uow.edu.au>; Linda Deys <ljd996@uowmail.edu.au>; UOW Human Ethics <uow-humanethics@uow.edu.au>
Subject: HREC Approval of Application 2021/380

Dear Professor Wilson,

I am pleased to advise that the application detailed below has been **approved**.

Currently face-to-face research is not permitted without an approved COVID safe plan.

When you resume face-to-face research, if it has not been approved in your original protocol, you must submit an amendment to the HREC for approval at that time.

Please be aware that for any future data collection that occurs face-to-face, the current UOW requirement is that all researchers must complete a COVID-19 Safe Work Plan and have the document signed off by an appropriate WHS signatory. The document is accessible from the Intranet here https://intranet.uow.edu.au/coronavirus/returning-to-campus/index.html, and should be submitted to whs-admin@uow.edu.au. The COVID-19 Safe Work Plan also requires Ethics approval prior to face-to-face research commencing/recommencing.

Ethics Number:	2021/380
Approval Date:	08/12/2021
Project Expiry Date:	07/12/2022
Project Title:	“Where’s my baby?” What is the maternal experience of separating well mothers and babies at caesarean section birth?
Researcher/s:	Meedya Shahla; Deys Linda; Wilson Valerie
Documents Approved:	Ethics Application 18092021 RDMP 16092021 Response to review 06122021 Interview Protocol 05102021 Interview Protocol Questions 30092021 Research Proposal updated Dec 2021 Participant Information Sheet and Consent Form V3 06122021 Ethics Training Certificates for: Meedya Shahla; Deys Linda; Wilson Valerie

Sites:

Site	Principal Investigator for Site
Participants choice of location/venue	Linda Deys

The HREC has reviewed the research proposal for compliance with the *National Statement on Ethical Conduct in Human Research* and approval of this project is conditional upon your continuing compliance with this document. Compliance is monitored through progress reports; the HREC may also undertake physical monitoring of research.

Approval is granted for a twelve month period; extension of this approval will be considered on receipt of a progress report **prior to the expiry date**. Extension of approval requires:

- The submission of an annual progress report and a final report on completion of your project.
- Approval by the HREC of any proposed changes to the protocol or investigators.
- Immediate report of serious or unexpected adverse effects on participants.
- Immediate report of unforeseen events that might affect the continued acceptability of the project.

If you have any queries regarding the HREC review process or your ongoing approval please contact the Ethics Unit on 4221 3386 or email uow-humanethics@uow.edu.au.

Yours sincerely,

Natascha Klocker

Associate Professor Natascha Klocker,
Chair, UOW & ISLHD Social Sciences Human Research Ethics Committee

The University of Wollongong and Illawarra and Shoalhaven Local Health District Social Sciences HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.

Australian Catholic University – 2023

From: Tanya Quesnel <Tanya.Quesnel@acu.edu.au> **On Behalf Of** Res Ethics
Sent: Tuesday, 21 March 2023 4:14 PM
To: Shahla Meedya <Shahla.Meedya@acu.edu.au>; Sara Bayes <Sara.Bayes@acu.edu.au>
Cc: Res Ethics <Res.Ethics@acu.edu.au>; 'valerie.wilson@health.nsw.gov.au' <valerie.wilson@health.nsw.gov.au>; Linda Deys <linda.deys@myacu.edu.au>
Subject: [2023-3064T] - Ethics application approved!

Dear Applicant,

Chief Investigator: Dr Shahla Meedya, Dr Sara Bayes, and Prof. Valerie Wilson
Student Researcher: Linda Jane Deys
Ethics Register Number: 2023-3064T
Project Title: “Where’s my baby?” What is the maternal experience of separating well mothers and babies at caesarean section birth?
Date Approved: 21/03/2023
End Date: 20/12/2024

The Australian Catholic University Human Research Ethics Committee has considered your application for ethics transfer 2023-3064T. As this application has already been ethically reviewed by **UOW & ISLHD Social Sciences Human Research Ethics Committee** (Ethics Reference: 2021/380), ACU HREC accepts the approval with no further conditions.

This project has now been recorded as an ACU project for which ACU is responsible. Continued approval of this research project is contingent upon the submission of an annual progress report which is due on/before each anniversary of the project approval. A final report is due upon completion of the project. A report proforma can be downloaded from the ACU Research Ethics website.

Researchers are responsible for ensuring that all conditions of approval are adhered to and that any modifications to the protocol, including changes to personnel, are approved prior to implementation. In addition, the ACU HREC must be notified of any reportable matters including, but not limited to, incidents, complaints and unexpected issues.

Researchers are also responsible for ensuring that they adhere to the requirements of the National Statement on Ethical Conduct in Human Research, the Australian Code for the Responsible Conduct of Research and the University's Research Code of Conduct.

Any queries relating to this application should be directed to the Ethics Secretariat (res.ethics@acu.edu.au). Please quote your ethics approval number in all communications with us.

We wish you well with your research project.

Kind regards,

Tanya Quesnel
on behalf of ACU HREC Chair, Assoc Prof. Michael Baker

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Appendix C: Submission to NSW Parliamentary Senate Inquiry into Birth Trauma, NSW

Submission
No 1167

INQUIRY INTO BIRTH TRAUMA

Name: Ms Linda Deys
Date Received: 15 August 2023

Partially
Confidential

Submission to the Birth Trauma Senate Inquiry, NSW

15/8/2023

Linda Deys

Clinical Midwife Consultant for the Local Health District

PhD Candidate at

I will be addressing all of the Terms of Reference in my submission

I would like to be given the opportunity to give evidence at the hearing and share my clinical and academic knowledge and experience

Dear Committee,

I have been a midwife for 32 years, I have worked across the whole scope of midwifery practice in this time, in the private and public health system and for an Aboriginal Maternal Infant Health Service. All of this has been in NSW, around 6 years in Sydney metropolitan, but predominantly in the regional and rural sector of the south coast. I make this submission as both a clinician with substantial experience and an academic researcher.

As a clinician I have witnessed and been an unwilling participant to obstetric violence perpetrated on women in labour and birth. The vast number of midwives are women, caring for an all-female clientele, in a hospital system which is ruled by patriarchal history, culture and policy. Midwives, as women, are subjected to similar power and control issues within the maternity space. Some of us fight against this as ‘midwives’, while others submit to becoming ‘obstetric nurses’, the latter being a passive group who do as they are told in an attempt at self-preservation. Neither is an easy path.

Vicarious trauma is rife within maternity care. Midwives work ‘with women’ as our title defines, and we are governed by registration standards to provide safe, respectful and quality care that is woman-centred (1). This means focusing on each individual woman and her unique needs, hopes and expectations, including physically, socially, emotionally, psychologically, spiritually and culturally. Her rights to bodily autonomy, informed choice and control, over both herself and her baby are paramount. Our standards acknowledge that the woman alone has the right to make decisions about both herself and her baby and that the baby is not an independent being, separate from the mother (2). However, we are unable to fulfill these standards in the current maternity system. Despite often knowing the women intimately, emotionally and physically, the care we provide is always trumped by obstetric input in even the most normal and physiological circumstances. Obstetric care is an essential role within maternity services when pregnancy, labour, birth or post-partum events step outside the normal range. It saves lives. However, it should have no part of the ‘normal’, as medical doctors are not trained in normal. Midwives are trained to support the typical and therefore recognise abnormal and refer on as per our clearly defined National Midwifery Guidelines for Consultation and Referral (3).

As a midwife I have held women’s hands and looked into their eyes while they are restrained to have their bodies cut and babies pulled from their bodies. Their partners, other midwives or health professionals also enlisted to help hold them down as they screamed for the doctor to stop, while the doctor has told them to ‘shut-up’. Hand holding is not enough.

As a midwife I have tried to explain why a doctor has decreed an induction of labour or a caesarean section is warranted, knowing there is often no medical indication and that the evidence they have cited to the woman is out of date, statistically biased or has been refuted. I have advised the woman she has the ‘right’ to say no, that it is her body, her baby, her choice but I know she does not have that power or right in the current system. I have often heard doctors tell women that if they don’t do what they say their ‘baby could die’ or that they would refuse care or send them to another facility.

As a midwife I have heard the stories of women who are so traumatised by their previous birth that they are choosing care outside the system for their next birth. They fear the health system and do not trust any of us working within it.

In my current leadership role I specialise in lactation support. This includes antenatal clinics for women who have experienced previous breastfeeding challenges or are expecting them with their current pregnancy/baby. I have sat with so many women who described birth trauma, obstetric violence, and loss of bodily autonomy with previous pregnancies which have then resulted in poor breastfeeding outcomes. Much of the traumatic birth experience centred around being separated from their baby soon after birth, particularly at caesarean section. This heightened the fear and trauma as they often did not know what had happened to their newborn. There is very little evidence to show how maternal separation impacts women emotionally which has led to me doing a PhD on the subject.

My research is titled *“Where’s my baby?” Understanding the maternal experience of unnecessary separation of women from their babies at caesarean section birth*. I commenced this is 2020 and am currently writing up my findings papers. I interviewed 15 women who had a caesarean section birth, well mothers and babies, elective and emergent procedures, whose babies were removed from their care, sight and proximity shortly after birth. Their support persons were sent with the baby. They were not reunited for many hours and there was no medical indication for the separation. This is despite many hospital policies which supported keeping mothers and babies together.

The birth experience for these women has been profound. I only looked at women who had birthed in the previous 10 years, but other research has shown that women remember their birth experience for much longer than this. Keeping mothers and babies in immediate and uninterrupted skin-to-skin contact after birth has the potential to improve the overall experience and is protective for both mothers and babies emotional and physical well-being. My published literature review on this topic explains the evidence further (4). And yet, in 2023, they are still being separated and traumatised further.

My background as a midwife, my experience of caring for women experiencing obstetric violence, and my clinical and academic knowledge of the long term impacts of separating mothers and babies at birth makes me feel very responsible for the 15 participant stories in my data collection. Fifteen one to two hour interviews of traumatised women who cried, swore and expressed anger and frustration at what had been done to them. This impacted their decisions to have further children, changed their relationships with partners and infants, and negatively impacted their mental health and well-being. They had no power and control and did not give informed consent for many of the procedures that were done to them during pregnancy, labour & birth, and post-natally. They were coerced and threatened with risk of harm to their babies and had interventions initiated which were mostly not necessary and caused a further cascade of emergent procedures. I attach below a word cloud of the emotional responses from those interviews to highlight how these women felt both at the time of birth and separation and in the days, months and years since (appendix 1). All of these

women identified their own vulnerability and lack of power and control. They knew it should not be up to themselves to fight for what they needed and wanted during their birth.

I have presented my preliminary findings at an international midwifery conference this year (Virtual International Day of the Midwife) which includes some quotes from the participants and this can be viewed here - https://www.youtube.com/watch?v=is7ho3NoP4w&ab_channel=VirtualMidwives. I have draft papers in progress which I hope to have published in the coming months as well as further conference presentations. This will add to the growing body of evidence of birth trauma and obstetric violence in our current maternity health system. It has to change, we cannot continue to so negatively impact the lives of women in our community as these women are the ones caring for our children and future. Trauma is generational, now is the time to make change and protect our future.

In summary, my recommendations for making a change are as follows:

- True woman-centred care with a known midwife caring for all women, independent of risk or cultural identity, in a continuity of care model
- Support currently publicly funded Aboriginal Maternity care services to expand to full continuity of care models
- Trust midwives to work within their scope of practice and professional standards
- Increase midwife numbers – recognise this is a profession distinct from nursing and acknowledge the unique skills they have to care for pregnant, birthing and post-natal women – continuity of care cannot happen without sufficient midwives
- Work within our medical systems to change the patriarchal and hierarchal culture – equality for women truly starts here
- Informed consent for all women throughout their perinatal journey, and a medical system which understands a woman has the right to decline recommended care
- Understanding that a woman is not a vessel to incubate a baby – her rights will always eclipse those of an embryo, foetus or baby – her choice, her body, her baby – if we support women they will make the choice that is right for them and their baby
- Provide birth debriefing for all women so they have the opportunity to understand what happened during their birth and why certain things happened – only women have the option to say if they have experienced birth trauma, there is no criteria or box ticking to define birth trauma
- Be mindful in language that excludes women in any decision or outcomes from this inquiry – the majority of people having babies are women/mothers, removing this language further impacts the rights of women
- Be aware that some people having babies do not identify as women and that some people who are breastfeeding may not be biologically female – all need respect and care which is centred around their specific needs, including the language that defines them

Kind regards

Linda Deys

References and suggested reading for the committee:

1. Midwife standards for Practice (AHPRA) - https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/midwife-standards-for-practice.aspx
2. Providing woman-centred care (Aust. Government) - https://www.health.gov.au/resources/pregnancy-care-guidelines/part-a-optimising-pregnancy-care/providing-woman-centred-care
3. National Midwifery Guidelines for Consultation and Referral (NSW MOH) - https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_008
4. Deys L, Wilson V, Meedya S. What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. *Midwifery* 2021; **101**: 103063.

Appendix 1

Appendix D: Publisher permission for sharing published literature review plus PDF

Deys, Wilson & Meedya (2021) What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review. *Midwifery*, 101.

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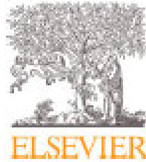

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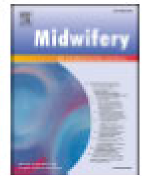

Review Article

What are women's experiences of immediate skin-to-skin contact at caesarean section birth? An integrative literature review

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A R T I C L E I N F O

Keywords:
Skin-to-skin
caesarean section
experience
mother

A B S T R A C T

Background: Skin-to-skin is a well-established practice at vaginal births promoting the health of women and babies. Facilitation of skin-to-skin at caesarean section birth is growing despite environmental and historical challenges. This is led by the expectancy of women and of health professionals increasingly understanding its importance.

Objective: To synthesise original research that explores the experience of women having immediate and uninterrupted skin-to-skin contact at caesarean section when woman and baby are well.

Design: Integrative literature review.

Data sources: The databases of SCOPUS, PubMed, CINAHL plus, Wiley Online, Cochrane Library, Web of Science and MIDIRS were used to identify studies from 2010-2020. Hand searching of library journals, reference and citation lists were also used.

Methods: The framework of Whittemore and Knafl (2005) was used to guide the literature search, thematic analysis, and synthesis of original research. Initial screening against inclusion criteria was utilised for English-published papers of full-term, well, woman and baby dyads who experienced skin-to-skin at caesarean section birth. Papers were not limited by methodology. The validated Mixed Methods Appraisal Tool (MMAT) was used for critical quality appraisal (Bartlett et al., 2018).

Findings: In total, 750 results were returned in the initial search and a final 13 papers were included in this review including quantitative (6), qualitative (5) and mixed method (2) designs. Immediate and uninterrupted skin-to-skin at caesarean section birth, when mother and baby are well, is safe, appropriate and desired by women, improving birth experience and satisfaction. Three main themes were identified with sub-themes – Positive birth experience (satisfaction; breastfeeding goals); Sense of control (empowered; birth, not a procedure); Natural (wanting to hold their baby; becoming a mother).

Conclusions: The findings of this review show that skin-to-skin improves the experience for women, and particularly empowers women having a caesarean section giving them a sense of a more natural birth. Women see skin-to-skin as an opportunity to maintain control and not be separated from their baby. Many studies have focused on the benefits of skin-to-skin but less so on the wants and choices of women. Women want to see, hold and feed their babies but are unable to achieve this of their own volition during a surgical birth. Understanding how women value this close physical contact can seek to inform further research on the impact of separation. This can inform policy and practice development in maternity care services to ensure best outcomes for both women and infants.

Implications for practice: The practice of skin-to-skin and keeping mother and baby together is valued by women and justified by research as best-practice for health and well-being. The findings of this paper highlight the importance of maternity settings facilitating both skin-to-skin and non-separation for all women and their newborns, even more so at caesarean section births.

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Introduction

Keeping well mothers and babies in close physical proximity, ideally in skin-to-skin contact, facilitates a biologically normative sequence of events. The standard and accepted definition of skin-to-skin contact is direct, skin on skin contact between a woman and newborn at the moment of birth, undisturbed for at least an hour or until the baby has breastfed (United Nations Children’s Fund (UNICEF), 2019). Irrespective of birth mode the World Health Organization (WHO) recommends the practices of both immediate skin-to-skin and keeping mothers and babies together in their *Ten Steps to Successful Breastfeeding* (World Health Organization, 2018b).

The many benefits of skin-to-skin include calming, bonding and physical stabilisation of the dyad regardless of feeding choice (United Nations Children’s Fund (UNICEF), 2019). The birth event, and period immediately following, exposes the immune-naïve newborn to a microbial cascade, triggering immunological and epigenetic changes which impacts the lifetime health of the infant and may have impacts well into the following generations (Császár-Nagy and Bókkon, 2018; Tow, 2014). Skin-to-skin establishes the mother-infant relationship, with shared and responsive communication initiated during the contact (Velandia et al., 2010). Immediate and continuous skin-to-skin contact for both term and pre-term infants has been shown to reduce the need to transfer babies to neonatal care units (Schneider et al., 2017), to reduce infant stress, and improve the relationship of the dyad (Mehler et al., 2020; Mörelius et al., 2015).

The promotion and initiation of breastfeeding during skin-to-skin is known to extend the duration and exclusivity of breast milk feeds, providing further short and long term health benefits to woman and child and the communities in which they live (Campbell et al., 2019; United Nations Children’s Fund (UNICEF), 2016). Not having immediate skin-to-skin with the mother at caesarean section birth has been shown to impact exclusive breastfeeding for up to six months. This remains independent of being reunited within two hours or having skin-to-skin with the other parent (Crenshaw, 2014; Guala et al., 2017; Moore et al., 2016).

Caesarean section birth has commonly and historically increased the likelihood of mother-infant separation at birth, even when the woman and baby are well (Bayes et al., 2012; Chalmers et al., 2010; Niela-Vilen et al., 2020; Rowe-Murray and Fisher, 2001). Research has shown barriers to the practice stem from over-stretched resources (Koopman et al., 2016; Mbalinda et al., 2018; Stevens et al., 2016), inadequately trained or knowledgeable staff (Koopman et al., 2016; Zwedberg et al., 2015), hospital practice and policies (Niela-Vilen et al., 2020; Puia, 2018; Stevens et al., 2016) and workplace cultural challenges (Niela-Vilen et al., 2020). Lack of antenatal education on the benefits of skin-to-skin means parents may be unprepared and unexpectant of the importance of skin-to-skin at birth (Stevens et al., 2016; Zwedberg et al., 2015). Particularly at a caesarean birth where women are already physically and emotionally disempowered (Bayes et al., 2012; Coates et al., 2020; Puia, 2018) or feel they are expected to be compliant non-participants in their birth event (Niela-Vilen et al., 2020). Increasing caesarean rates, mean around a third of women in developed countries are at risk of separation and poorer birth experience (Australian Institute of Health and Welfare, 2018; Coates et al., 2020; Townsend et al., 2020; World Health Organization, 2018a).

Since the 1970s pioneer researchers including Kennell and Klaus (1979) and Anderson (1977), (1989) have highlighted the risks of separation in the critical post-birth period. Bonding, self-regulation, mutual-caregiving and breastfeeding are all negatively impacted by taking babies away from their mothers. Studies have shown both swaddling and separating mothers from their infants have similar results, women rougher and less responsive to their infants and experiencing painful breastfeeding when compared to those who have immediate skin-to-skin (Dumas et al., 2013). Separation and no skin-to-skin contact has also been shown to impact the mother-infant relationship longitudinally, up to nine years after the birth event, impacting sensitivity, reciprocity and engagement (Bigelow et al., 2018; Bystrova et al., 2009).

Separation impacts birthing experience and decreases satisfaction for women even when accepted it is necessary for medical reasons (Carquillat et al., 2016; Coates et al., 2020; Ghanbari-Homayi et al., 2020). Prolonged separation, when the woman or baby require additional specialist care, further limits physical contact, sense of control and ability to ‘mother’ (Baum et al., 2012; Schwartz and Raines, 2018). The birth experience remains with the woman well beyond the period of infancy (Bayes et al., 2012; Bossano et al., 2017; Puia, 2018). This can influence her future mother-child attachment, her psychological well-being and future childbirth planning (Bayes et al., 2012; Puia, 2018; Townsend et al., 2020).

This integrative literature review critically analyses and synthesises research over the last decade to seek understanding of the woman’s experience of skin-to-skin at caesarean section when both woman and baby are well.

Methods

Design

An integrative literature review design was chosen to encompass the broad range of experimental and non-experimental research to better understand the phenomenon (Booth et al., 2016). The methodological framework developed by Whittemore and Knafl was used to rigorously analyse and synthesise the diverse and complex perspectives and develop new understanding (2005). This included identifying the problem, carrying out the literature search, evaluating and analysing the data and presenting a synthesis of the findings.

Search strategy

Skin-to-skin at caesarean section birth is historically recent in both practice and research, first described in 2008 as a ‘natural caesarean’ (Smith et al., 2008) and present in findings mainly within the last decade. Consideration of a timeline for inclusion in this integrative review search was 2010-2020. To ensure rigour in this research decision, simple topic search terms (skin-to-skin, caesarean, English, full text) were additionally run through two data bases in earlier time periods (2000-2004 and 2005-2009) with only one result, confirming the date selection choice was appropriate.

A comprehensive search of seven databases was carried out, ensuring a wide casting for possible literature sources and minimising the risk of missing relevant research-SCOPUS, PubMed, CINAHL plus, Wiley Online, Cochrane Library, Web of Science and MIDIRS. Key word search terms using Boolean operators included spelling variations and interpretations for ‘skin-to-skin’ (early contact, golden hour, kangaroo mother care); caesarean section (cesarean, c-section); mother (maternal); and experience (perception, attitude, feeling). Inclusion criteria were well, full-term infants, healthy women, skin-to-skin contact, caesarean section and printed in English language (Ames et al., 2019; Booth et al., 2016; Whittemore and Knafl, 2005). Full-text and peer-reviewed papers were identified with no limitation in methodology of the studies. Hand searching of journal titles, reference and citation lists also contributed to title selection. The Endnote program was used for screening and reference management.

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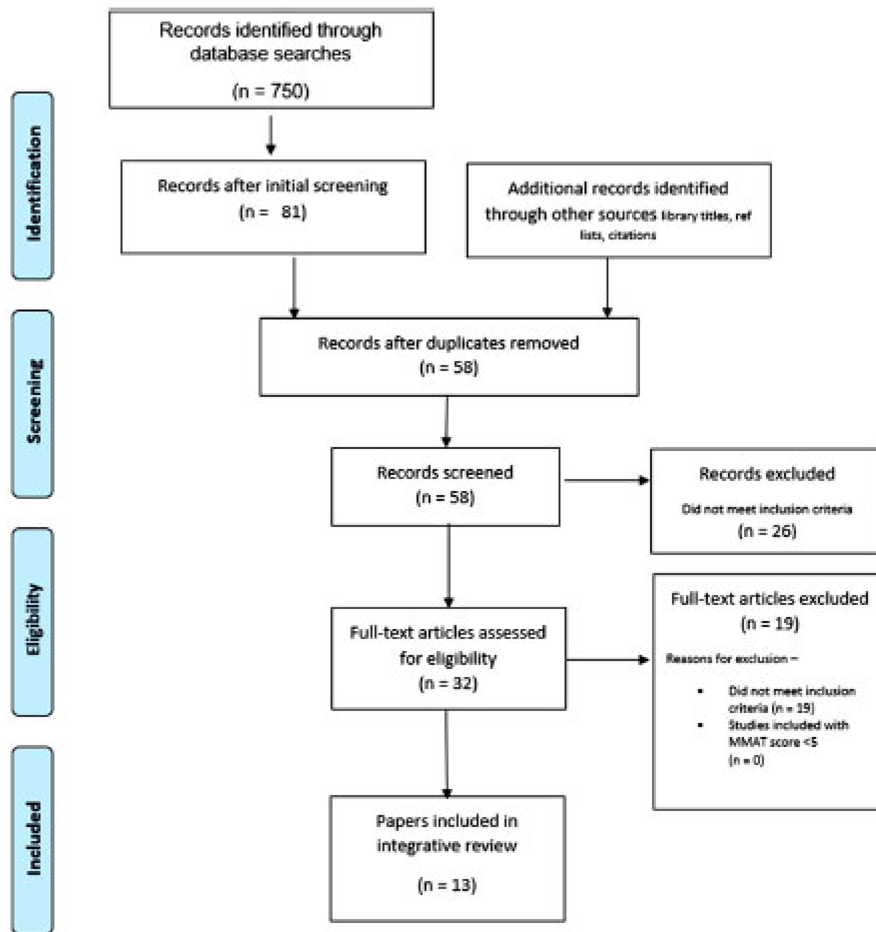

Fig. 1. Flow diagram

Study selection and quality appraisal

An initial 750 results were retrieved, 58 records were screened after duplicates were removed, 32 full-text articles reviewed for eligibility, with 19 removed for not satisfying selection criteria. This was independently assessed by the first and third authors. The Mixed Methods Appraisal Tool (MMAT) version 2018 (shown in Supplementary Table) was used as an approach to critically appraise the quality of empirical mixed studies literature for inclusion (Bartlett et al., 2018). Whittemore and Knafl (2005) suggest a data evaluation stage of the integrative review process to ensure overall quality of the diverse methodologies included. MMAT has been validated for reliability and quality testing of studies and was therefore used to underpin the selection process (Bartlett et al., 2018; Pace et al., 2012). Scoring greater than 5 (highest possible = 7) was used as a baseline for inclusion, completed independently by the two authors and discussed for selection consensus. The overall quality was high and no papers were excluded as all scored ≥ 5. Twelve studies were included, with two findings papers from one of these, resulting in a final 13 papers for analysis and synthesis in the review.

The results of the search and final selection of articles is shown using an adapted style flow diagram (Fig. 1).

Data analysis

The data was manually extracted, summarised and coded following the Whittemore and Knafl model (2005). This allowed for reduction and organisation of the data for thematic analysis and interpretation, identifying the three main themes. This is shown in Table 1.

Results

The integrative literature review allowed for a broad inclusion of design and methodologies. The included papers were geographically diverse but predominantly from developed countries – United States of America (6), Australia (3), Canada (1), and Germany (1), with two developing nations Brazil (1) and Iran (1) (United Nations, 2014).

All met the criteria for well women and babies birthed by caesarean section at term, and reviewed outcomes of non-separation and skin-to-skin experience. The parity of the women and primary reason for caesarean section varied across the selected studies and included planned, unplanned and repeat procedures, the latter allowing for direct personal comparisons of skin-to-skin outcomes.

Some articles included partners and health professionals in their results, but the focus of the review was the experience of women. It is however acknowledged that both these groups play a significant role in the facilitation and support of women having skin-to-skin.

All thirteen papers reviewed highlighted the fact that skin-to-skin is not standard practice at a caesarean section. Safety for the practice was not seen as an issue, some papers specifically including and reporting on these outcomes positively (Armbrust et al., 2016; Crenshaw et al., 2019).

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Table 1
Included papers findings summary

Author/Year/Country	Study design	Participants	Aim/intervention	Key findings	MMAT score	Themes
(Armbrust et al., 2016)/Germany	Prospective RCT	205 women and their partners having a planned, term CS, term, low risk, spinal anaesthetic 1:1 simple randomisation – 102 intervention (CCB) and 103 control (CS)	**Aim:** To evaluate the safety, satisfaction and birth experience for patients using the "Charité Cesarean Birth" (CCB) procedure compared to standard caesarean (CS) **Data collection:** modified Likert-Scales and interview with questionnaire **Intervention: CCB** = *parents actively engaged in the birth by visualisation, cord cutting and early s2s.* **CS** = *baby taken immediately for assessment, no cord cutting, no s2s*	**Primary outcome:** satisfaction and subjective birth experience – more positive birth experience (CCB vs CS) Mother: CI 1.7-2.1 (0.97) vs 2.1-2.4 (1.4), less breastfeeding problems: 2.1-2.5 (0.96) vs 1.4-2.0 (1.2) **Secondary outcome:** safety – no significant difference in risk for mother or baby (length of procedure, EBL, vitals, Apgar)	7	Positive birth experience Sense of control Natural
(Brubaker et al., 2019)/USA	Prospective cohort	Total - 3006 women, English or Spanish speaking, 18-35yrs, singleton pregnancy, primiparas, infants 34-42 weeks gestation Of these - 155 elective CS, 708 unplanned CS (n=863 CS)	**Aim:** To see how soon after birth mothers got to see, hold and feed their newborns – association between mode of birth and maternal-newborn contact on maternal experience **Data collection:** secondary analysis of the data from First Baby Study (FBS) -1-month post-partum interviews using *FBS Birth Experience Scale*	Women who had a CS birth (planned/emergency) reported less positive birth experience compared to normal vaginal birth (NVB) – significant association with being able to see their baby immediately (47.9-56.1% vs 87.6%, p= <0.001) or feed them <30mins after birth (12-19.7% vs 43.8%, p= <0.001), some association found with being able to hold baby within 5 mins of birth (7.8-8.4% vs 76.5%, p= 0.074) CS mothers had a positive birth experience if they could see, hold and feed their babies <30mins – more so that vaginal births with same time frames (p=0.010)	7	Positive birth experience Sense of Control
(Crenshaw et al., 2019)/USA	Quasiexperimental	40 women having elective CS at term, 20 in intervention group, 20 standard care (randomly assigned), 18-45yrs singleton pregnancy, English fluency, well at birth	**Aim:** To describe feasibility and outcomes of immediate and uninterrupted s2s at CS - maternal newborn physiologic stability and stress, maternal comfort, satisfaction and exclusive breastfeeding (is it feasible and safe to do s2s) **Intervention:** s2s that began during surgery/immediate **Data collection:** Feasibility/Pilot study –Interview using validated *Maternal Satisfaction with Cesarean* tool with one added open-ended question on their experience of s2s contact	Women who had s2s were significantly more satisfied with both CS and s2s experience (p=0.015) No difference in maternal or newborn stability Mother's cortisol was lower in s2s group (p=0.003), no difference in babies (p= 0.549) No statistical difference in bf outcomes at hospital discharge (p=0.182) NVIVO text analysis of open-ended question showed more positive sentiment in the s2s intervention group – 'bonding', 'natural' **Overall:** immediate s2s is feasible and safe and women are more satisfied	7	Positive birth experience Natural
(Jabraeili et al., 2017)/Iran	RCT double blinded	105 women who had a CS, spinal, term infants, Apgar >7 at 5min (low risk)	**Aim:** To assess the impact of s2s on maternal satisfaction **Intervention:** immediate and for 1hr at birth – plus 30m in recovery then 30min 3x/day for 3 days **Standard care:** no s2s **Data collection: Interview** Validated questionnaire used to measure satisfaction. No standardised tool was used to measure satisfaction.	Maternal satisfaction: Significantly higher overall satisfaction of mothers who had s2s CI: -2.29 (-2.83 - -1.75), p=0.001 Mothers who had s2s liked it	5	Positive birth experience Natural

(continued on next page)

Table 1 (*continued*)

Author/Year/Country	Study design	Participants	Aim/intervention	Key findings	MMAT score	Themes
(Onsea et al., 2018)/Canada	Prospective observational cohort	Low risk, term pregnancies with elective CS – 15 couples had standard care and 6 couples 'gentle' CS (total 21) ***Definition of 'gentle' CS*** *– music/lowlights and warmer OT, drapes dropped so parents can watch baby born, mother can 'push', doctor massages baby's chest to mimic vaginal birth canal, immediate s2s*	**Aim:** To investigate the need for a 'gentle' caesarean section approach to improve satisfaction of parents. **Data collection:** questionnaires (adapted/validated, based on *Wijma Delivery and Expectancy Questionnaires A and B* and *Maternal Satisfaction Scale for Cesarean Section*) measured maternal satisfaction and birth experience pre-birth, 2-5 days post-partum and 6 weeks post-partum. Structured interviews pre-birth and at 6 weeks post-partum analysed using statistical qualitative content analysis. Recruitment continued until data saturation was achieved and no new findings at interview.	There was no difference in maternal satisfaction and birth experiences between the groups • The qualitative content analysis demonstrated that women reported more positive birth experience in the intervention group - 100% (gentle CS) vs 84.6% standard care The 'gentle' CS group felt more involved in the birth (66.7% vs 46.2% in standard care) and less anxiety (50% vs 69.2%)	7	Positive birth experience Sense of control Natural
(Souza et al., 2017)/Brazil	Cross-sectional	200 recently birthed women	**Aim:** To analyse the mother/infant bond in association with type of, and experiences, during and after birth **Data collection:** Interviews using the validated *Mother-to-Infant Bonding Scale*	Women who did not have s2s showed significantly more 'sadness' (p=0.037) Pain and type of birth did not significantly influence bonding between mother/baby (p>0.05)	6	Positive birth experience Natural
(Bertrand&Adams, 2020)/USA	Phenomenology	13 women who had s2s at CS within the last 10 yrs, 18 yrs at time of consent	**Aim:** To explore the experience of women having s2s at CS birth **Data collection:** interviews via social media video chat, purposive sample – validity of method tested using a feasibility study to set standards of questions used	Women felt they had a sense of control with their birth when they had s2s S2s is a highly positive influence of the birth experience of women Women want to hold their babies but were worried it wouldn't be allowed	7	Positive birth experience Sense of control Natural
(Frederick et al., 2016)/USA	Ethnography	11 women, aged 23-38yrs, well, term infants, CS birth	**Aim:** To explore and describe the experience of a mother having immediate s2s with her baby at CS **Data collection:** observation of s2s at CS and in-depth interviews 24-48 hours post-partum	Primary theme – mutual caregiving – shared and reciprocal relationship and interaction between mother and baby Sense of empowerment and bonding for the mother Presence and participation of the father was important for women doing s2s in OT Caesarean/surgical environment described as difficult and impersonal but s2s helped to distract, relieve anxiety and engage with her baby	7	Positive birth experience Sense of control Natural
(Moran-Peters et al., 2014)/USA	Descriptive qualitative study	6 women >18yrs having their 2nd elective CS birth – English, well/term infants – purposive sample	**Aim:** To compare birth experience of mothers who had/did not have s2s at their second CS **Data collection:** semi-structured interviews	S2s improved birth experience and mother-baby relationship Women disliked separation from their baby S2s felt 'natural' Breastfeeding was easier/more successful with s2s – overall described as "good" or "wonderful", latching easier, baby calmer, better in comparison to previous birth experience	7	Positive birth experience Natural

(continued on next page)

Table 1 (*continued*)

Author/Year/Country	Study design	Participants	Aim/intervention	Key findings	MMAT score	Themes
(Stevens et al., 2018)/Australia	Video ethnography	21 mother/baby dyads having an elective repeat CS with no other medical complications, 25-39yrs, singleton, planning to BF 26 support persons 210 health professionals, 125 involved in CS, 43 in focus groups/interviews	**Aim:** To explore the impact health professionals have on s2s contact within 2hrs of CS birth **Data collection:** video recordings, observations, field notes, focus groups and interviews	Mother/baby not seen as one, but separate beings Obstetricians 'owning' the bottom half of the woman, anaesthetists the top half Midwives 'owning' the baby and controlling what contact the woman had with her baby Mothers wanted to hold their baby and have s2s but realised it was challenging in the theatre setting S2s keeps women and babies together and provides a woman a sense of control/empowerment	7	Sense of control Natural
(Stevens et al., 2019)/Australia (part of the above study – focus on previously unreported data)	Ethnography – interviews	21 mothers who had an elective repeat CS 6 weeks prior	**Aim:** To explore women's experience of s2s and what they want in the 2hrs after CS **Data collection:** audio recorded interviews	One overarching theme – "I want our baby" Subthemes – 'I felt disconnected when I was separated from my baby', 'I want to explore my naked baby', 'I want my partner involved' and 'it felt right'	7	Positive birth experience Sense of control Natural
(Lewis et al., 2014)/Australia	Mixed methods	Planned CS, English - 117 women (256 invited) did postal survey, 38 women interviewed (stopped this recruitment at saturation stage)	**Aim:** To increase knowledge around the perception women have for preparing and then experiencing a planned CS **Data collection:** At 2 weeks post-partum a survey tool for satisfaction using Likert scale – frequency distributions for responses with univariate comparisons for repeat CS, statistical software used. Semi-structured telephone interviews – thematic analysis of interview transcripts.	Quantitative findings showed most women were satisfied with the birth (78%) Giving women choices and answering their questions empowers them (83%) Skin-to-skin and being with their partner improved satisfaction and women wanted it – only 59% of women had s2s in OT and 38% continued into recovery.	7	Positive birth experience Sense of control Natural
(Sundin & Mazac, 2015)/USA	Quality Improvement Project	46 out of 205 women chose to have s2s in OT for a repeat elective CS (to assess satisfaction/compare with previous) Total of 583 CS, 60 s2s (to assess pain perception)	**Aim:** To evaluate satisfaction and the perception of pain of women when having a CS with immediate s2s. **Data collection:** Interview early post-partum with 2 questions using a Likert scale comparing previous CS no s2s with current CS with s2s (quantitative). Also then asked for 'additional comments', results sorted in broad categories (qualitative). Medical record review of anaesthetic record – additional and administration of analgesia (quantitative).	S2s at CS increased maternal satisfaction and lowered perceived pain compared to no s2s Using s2s 96% reported being 'very satisfied' and 4% 'satisfied', previous birth (no s2s) 10% 'very satisfied', 84% 'satisfied' and 6% 'dissatisfied' Additional analgesia was required for 53% of women without s2s and 43% if they had s2s	6	Positive birth experience Sense of control Natural

Key: Skin-to-skin (s2s), Normal Vaginal Birth (NVB), Caesarean Section (CS), Operating Theatre (OT)

Skin-to-skin was identified as a specific intervention or as part of a new style of caesarean procedure to evaluate safety alongside maternal satisfaction and the establishment of breastfeeding (Armbrust et al., 2016; Jabraeili et al., 2017; Sundin and Mazac, 2015). It was used comparatively with multiparous women without previous skin-to-skin at a caesarean birth, emphasising their contrary outcomes and experience (Armbrust et al., 2016; Moran-Peters et al., 2014; Stevens et al., 2019; Sundin and Mazac, 2015). Women hoped for but did not expect skin-to-skin, most papers describing the fear of separation. The skin-to-skin experience was positive and emotional. Women viewed a caesarean section as a significant event and more than a surgical procedure, the overall experience improved when skin-to-skin was supported (Bertrand and Adams, 2020; Frederick et al., 2016; Lewis, 2014; Souza et al., 2017; Stevens et al., 2018). Noted was the unequal influence

Table 2
Themes and subthemes analysis.

Themes Authors/sub-themes	Positive birth experience		Sense of control		Natural	
	Satisfaction	Breastfeeding goals	Empowered	Birth not a 'procedure'	Wanting to hold their baby	Becoming a mother
(Armbrust et al., 2016)	√	√	√	√	√	
(Bertrand&Adams, 2020)	√		√	√	√	√
(Brubaker et al., 2019)	√		√			
(Crenshaw et al., 2019)	√			√		√
(Frederick et al., 2016)	√	√	√	√	√	√
(Jabraeili et al., 2017)	√	√				√
(Lewis et al., 2014)	√		√	√		√
(Moran-Peters et al., 2014)	√	√	√		√	√
(Onsea et al., 2018)	√		√	√	√	√
(Souza et al., 2017)	√					√
(Stevens et al., 2018)			√	√	√	√
(Stevens et al., 2019)	√	√	√	√	√	√
(Sundin & Mazac, 2015)	√	√		√	√	
Representation (n, %)	**12/13** **92%**	**6/13** **46%**	**9/13** **69%**	**9/13** **69%**	**8/13** **62%**	**10/13** **77%**

of power the woman had during a surgical birth, requiring other people to advocate for her to enable skin-to-skin (Bertrand and Adams, 2020; Brubaker et al., 2019; Frederick et al., 2016; Stevens et al., 2019).

Three main themes, with sub-themes, were identified consistently in the papers reviewed. A *positive birth experience*, a *sense of control* and a perception it was *natural* (Table 2).

Positive birth experience (sub-themes 'satisfaction' and 'breastfeeding goals')

Supporting a positive birth experience was aligned closely with keeping the woman in close physical contact with her newborn infant in the immediate newborn period in 12 of the papers. Women highly rated being able to see, hold and feed their baby in the first hour after birth (Armbrust et al., 2016; Bertrand and Adams, 2020; Brubaker et al., 2019; Crenshaw et al., 2019; Moran-Peters et al., 2014; Onsea et al., 2018). Two studies trialled procedures which included modifying and integrating a number of less medicalised measures, including skin-to-skin, to improve maternal satisfaction (Armbrust et al., 2016; Onsea et al., 2018). The total numbers were small (205 in Armbrust et al, 21 in Onsea et al) but had similar results with the intervention groups (102 and 6) showing improved satisfaction through women feeling more involved, less fearful, increasing infant bonding and the perception of being better cared for. Crenshaw et al. (2019) suggested a dose-responsive skin-to-skin duration to improve maternal satisfaction. Their intervention group of 20 women continued this contact for five hours and showed significantly higher satisfaction ($p = 0.015$) and more positive text analysis responses focusing on the opportunity to touch, bond, hold and breastfeed their baby.

The prospective cohort study of Brubaker et al. (2019) did not specifically ask about skin-to-skin but compared results for around 3000 women from the 'First Baby Study' (around 30% caesarean) on the time until they saw, cuddled and breastfed their newborn. Early dyad contact was noted to improve women's experience at caesarean section, more so than at vaginal birth ($p = 0.010$), particularly if the caesarean was unplanned. The births studied are noted to have occurred between 2009-2011 when skin-to-skin at caesarean section was novel, however the results of keeping the dyad in close physical contact reflected similar outcomes of the other studies – women wanting to hold their babies. It was more likely to occur with midwife or doula involvement, emphasising the role woman-focused staff have in facilitating positive birthing experiences. The phenomenological results of research Bertrand and Adams (2020) showed the similar association women had with skin-to-skin and being able to remain with their babies to meet and bond, the interaction itself being most important. The women in this study valued the experience, noting it alleviated feelings of disappointment at not birthing vaginally and reduced the clinical aspect of the surgical birth.

The cross-sectional analysis of 200 women by Souza et al. (2017) also did not focus on type of birth but with how bonding was related to experiences including skin-to-skin, and showed a significant increase ($p = 0.037$) in women's 'sadness' when it did not occur. While this study included vaginal births, the rate of caesarean sections in this Brazilian study was unusually high (80%) with only around half of all births receiving skin-to-skin.

Twelve papers identified satisfaction as a measure of positive birthing experiences. Questions centred on time periods from birth to starting skin-to-skin and assessed women's fears and expectations. Psychometric scale enquiry specifically asked questions about the immediate post birth criteria which are generally taken for granted at a vaginal birth such as skin-to-skin, bonding and birth experience (Armbrust et al., 2016; Brubaker et al., 2019; Crenshaw et al., 2019; Jabraeili et al., 2017; Lewis, 2014; Onsea et al., 2018; Souza et al., 2017). Open-ended questions and observation measured satisfaction with the experience of the woman's involvement in the birth (Bertrand and Adams, 2020; Crenshaw et al., 2019; Frederick et al., 2016; Moran-Peters et al., 2014; Stevens et al., 2019; Sundin and Mazac, 2015). Results from these studies showed that including skin-to-skin at caesarean section increased positivity and emotional satisfaction. Women who had less fear, anxiety and pain would also be expected to be more satisfied. Three studies showed skin-to-skin eased these negative emotions (Crenshaw et al., 2019; Onsea et al., 2018; Sundin and Mazac, 2015).

Meeting breastfeeding goals as a positive birthing experience was also shown in some studies as being related to skin-to-skin contact, particularly noted by women having repeat caesarean sections (Armbrust et al., 2016; Frederick et al., 2016; Moran-Peters et al., 2014; Sundin and Mazac, 2015). This was associated with overall breastfeeding rates, earlier initiation and fewer problems encountered (Armbrust et al., 2016; Frederick et al., 2016; Jabraeili et al., 2017; Moran-Peters et al., 2014; Stevens et al., 2019). Two studies could not account for any statistical difference in breastfeeding rates for women who had skin-to-skin compared to those who did not. Crenshaw (2019) only measured exclusive breastfeeding at hospital discharge, and both intervention and control groups had early, if not immediate, skin-to-skin which may account for the limited lack of difference. Onsea et al. (2018) also found no association for breastfeeding with their 'gentle' surgical approach which included skin-to-skin which they considered may be due to small study size and no randomisation.

Sense of control (sub-themes 'empowered' and 'birth, not a procedure')

Women's lack of choice and control over their birth experience was a common theme across many of the papers. Lewis et al (2014) mixed methods study examined the preparatory period of a planned caesarean section, including birth plans, and compared this with the actual experi-

ence of the birth. Two-thirds of the 117 women surveyed had prepared a birth plan which included skin-to-skin, but only a little over half of these felt it had directed their caesarean care. Most (83%) still saw it as a positive step to being included. Women who had immediate contact with their baby perceived improved overall birth experience and sense of control. Women felt empowered when planning their birth, describing being listened to, supported, informed and involved. There was a negative impact of not being heard despite indicating birthing preferences, or of not having the option to make a birth plan. As with other research, not having choice created a more clinical, surgical experience rather than 'birth' (Stevens et al., 2018). A sense of control through skin-to-skin was highlighted in the study by Bertrand and Adams, (2020). Women feared separation and saw skin-to-skin as a way to regain control of where their baby was, also improving satisfaction and birthing involvement. Stevens et al. (2018) noted that the physical possession of the baby being handed to the mother returned the sense of control that the woman experienced. This was identified as 'ownership' of the baby. Other studies also reflected this sentiment of ownership and belonging that women reclaimed with skin-to-skin, increasing a sense of control (Bertrand and Adams, 2020; Moran-Peters et al., 2014).

The importance of being able to play a central role in the birth was emphasised by Onsea et al. (2018) and Armbrust et al. (2016) evaluating their 'natural birthing' interventions, including skin-to-skin at caesarean section. Women identified less disappointment in not birthing vaginally, felt safer, and perceived they were active participants. In a number of studies, feelings of involvement were shown to be improved with the inclusion of skin-to-skin care when compared to the woman's previous caesarean births with no skin-to-skin contact or to control groups (Bertrand and Adams, 2020; Frederick et al., 2016; Lewis, 2014; Onsea et al., 2018; Stevens et al., 2019). Women also associated skin-to-skin with feelings of empowerment, despite an environment which removes much of their physical control (Bertrand and Adams, 2020; Frederick et al., 2016; Stevens et al., 2018). Focusing on their baby provided a distraction from the surgical procedure and discomforts and reduced anxiety (Bertrand and Adams, 2020; Crenshaw et al., 2019; Frederick et al., 2016; Onsea et al., 2018). Stevens et al. (2019) noted that immediate and undisturbed contact between mother and baby caused women to feel more connected and bonded with their baby, emphasised in descriptive and distressed quotes comparing their previous caesarean birth experiences without skin-to-skin (*"…most traumatic thing…"*, *"…felt like I was being cheated…"*, *"…hard time bonding…baby doesn't love me…shouldn't have been a mum…"* p. 142). The study also identified that interruption of skin-to-skin negatively impacted the birth experience, women describing anger, sadness and loss.

Including skin-to-skin during a caesarean section made women feel they experienced a birth rather than a surgical procedure (Armbrust et al., 2016; Crenshaw et al., 2019; Frederick et al., 2016; Lewis, 2014; Onsea et al., 2018; Stevens et al., 2019; Sundin and Mazac, 2015). Women connected with their baby and disengaged with the clinical operating theatre environment. This placed the woman and her birth experience at the center of the care and supported her right to be involved (Bertrand and Adams, 2020). When health professionals proactively enabled skin-to-skin, this was specifically noted in the results as an important consideration, with women reporting they did not feel they should have to advocate for themselves while in a vulnerable position (Bertrand and Adams, 2020; Brubaker et al., 2019; Lewis, 2014; Stevens et al., 2019).

Natural (sub-themes 'wanting to hold their baby' and 'becoming a mother')

Twelve of the thirteen reviewed papers portrayed the inclusion of skin-to-skin at a caesarean section birth as a more 'natural' approach. It enabled women to bond, discover and breastfeed their babies as they would at a vaginal birth. Natural intervention approaches, including skin-to-skin contact, when compared with standard caesarean care, showed improved birth experience and participation, the perception of receiving better care, more involvement and bonding, and less anxiety (Armbrust et al., 2016; Onsea et al., 2018). Mothers felt calmer and were able to respond, observe and communicate with their newborns (Bertrand and Adams, 2020; Crenshaw et al., 2019; Frederick et al., 2016; Jabraeili et al., 2017; Moran-Peters et al., 2014).

Results from all the qualitatively designed studies and the subjective findings from Sundin and Mazac's (2015) Quality Improvement project showed women wanted to hold their babies. Stevens et al. (2018) describe this as an "urgency" (p. 461) and "intense maternal desire" (p. 460), with women traumatised by separation. This was further explained in their next paper (Stevens et al., 2019), women needing to be reassured their baby was safe and well by holding and exploring the naked baby during skin-to-skin. Bertrand and Adams (2020) identified the value women felt with skin-to-skin as a sense of contentment and belonging, where they could know their baby was safe. A significant theme of Frederick et al. (2016) was the desire women had to intimately hold, see and interact with their baby to be reassured the baby was well. Confirming the safety and well-being of the baby was also shown as important to women in the study by Moran-Peters et al. (2014), the natural feel and smell of a newborn baby placed immediately in skin-to-skin contact was strongly associated with connection and calm.

Many women in these studies saw skin-to-skin at caesarean birth as the step associated with establishing a bond and assuming the role of mother (Bertrand and Adams, 2020; Frederick et al., 2016; Jabraeili et al., 2017; Lewis, 2014; Moran-Peters et al., 2014; Onsea et al., 2018; Souza et al., 2017; Stevens et al., 2019). They described themselves as becoming mothers. Birth is the first moment of physical separation of the woman and baby and within the environment of an operating theatre this often becomes spatial, with babies taken away from the woman and often the room. At a vaginal birth a woman typically remains responsible for maintaining a safe physical environment of warmth and security for the newborn, and there is opportunity for the dyad to communicate to meet each other's needs through mutual caregiving. Stevens et al. (2018) described the division of the mothers' body during the operative procedure, with the anaesthetist 'owning' the top half of the woman's body, the obstetrician the bottom half, and the baby owned by the midwife once it was born. Skin-to-skin meets the need of the woman to own and 'mother' the baby by enabling her to comfort and feed her newborn (Jabraeili et al., 2017; Stevens et al., 2018). Bertrand and Adams (2020) identified skin-to-skin as a transitioning step as women moved into the role of mother, responsible for keeping their baby safe and well rather than worried about what the staff were doing to them.

Discussion

This integrative review synthesises new knowledge from the combined and analysed results of 13 original research papers. Three main themes were identified for the experience of women having skin-to-skin at a caesarean section birth - *positive birth experience, sense of control* and *natural*. The findings from this review indicate evidence of the importance of early skin-to-skin contact at caesarean section to improve a woman's overall birth experience. Women have a strong desire to stay close to their babies to see, hold and feed them. Skin-to-skin delivers them the opportunity to inspect and connect with their newborns, which reduces their own fear and anxiety.

Skin-to-skin provides the option for women to not be separated from their baby. However, the studies are not clear whether it is the actual skin contact or the non-separation which improves the woman's experience. This close physical proximity to the baby has been shown in earlier research to enhance dyad attachment, bonding and maternal emotional well-being, well before skin-to-skin was standard care at modern births (Anderson, 1989; Feldman et al., 1999).

Women remember how they feel at their birth, with experiences vividly recalled well into the future (Bossano et al., 2017; Brubaker et al., 2019; Puia, 2018). The care a woman receives at her

birth has the potential to impact her psychological health and the relationship with the baby across her lifetime. All papers showed the value of skin-to-skin in improving the experience of women at caesarean section birth. Both quantitative and qualitative results demonstrated similar results and themes. A large selection of the data analysed was for planned caesarean cases, results could be potentially less clear for emergency procedures. However, the selection criteria for the review specified well women and babies, to establish there was no medical indication for separation, counteracting this ambiguity.

An operative birth places a woman in a vulnerable position where there is limited physical option to control her circumstances and surroundings. The woman cannot feel or move the lower half of her body, her safety and that of the baby is in the hands of others, and she often feels unwell as a result of medication and positioning. Without staff acknowledgement of the maternal significance of this event, the woman can be left feeling irrelevant and disconnected from her birth (Bayes et al., 2012). The balance of power against her is understood by women who desire skin-to-skin but experience fear as they expect interventions and separation (Bertrand and Adams, 2020). Returning ownership of the baby through skin-to-skin resonates with the meta-synthesis by O'Connell, Khashan and Leahy-Warren (2020) where women experiencing fear of childbirth can regain ownership of their birth through fear acknowledgement, empowerment and a sense of security. While all birth modes are experienced more positively with skin-to-skin, the findings of this review show the themes of having a sense of control and feeling natural are particularly distinctive for women having a caesarean section birth. This new knowledge should direct the care women receive.

It is clear from this review that women want to be close to and hold their baby and that it is an important step in assuming the role of mother to the new baby. Mercer's *Becoming a Mother* theory identifies the importance of transitioning to the maternal role for the woman's own psychosocial development and the association of external factors, such as skin-to-skin and separation (Husmillo, 2013; Mercer, 2004). Sense of control, satisfaction and confidence in herself all have the potential to be impacted by an experience such as separation at caesarean section which risks poor self-esteem and role failure (Mercer, 2004). Ghanbari-Homayi et al. (2021) in a systematic review of 19 studies with over 10, 000 women also identified that the woman feeling safe and taking control over childbirth was important for improving birth experience.

Limitations of this review

The main limitation identified by this integrative review was the lack of a consistent and standardised definition of skin-to-skin for caesarean section births. Researchers used varying standards for initiation and duration which were not clearly comparable. The general postulation was in comparing skin-to-skin versus none.

The UNICEF (2019) definition is challenged by the surgical setting where skin-to-skin practice is inconsistent. Some studies met this standard while others exceeded or fell short. The time frame of the last decade also meant that some of the research was being done when skin-to-skin at caesarean section was innovative and unexpected which may have influenced the lack of uniform definition.

While the majority of papers reviewed were of small sample sizes, making some results less conclusive at an individual level, this analysis has correlated the data to inform new understanding. The study populations were similar across all papers with results from both developed and developing countries showing universal outcomes and experiences for the women.

Implications for practice, policy and research

It is evident from this integrative review that women want and benefit from staying in close physical contact with their babies immediately after birth. Health professionals need to recognise their role in accommodating and advocating for this practice in an environment where the balance of power lies with them. Having policies which support skin-to-skin at caesarean section, planning consistent implementation with education, staffing and resources, and promoting the practice as standard care unless there is a medical indication to separate is imperative to improving women's birth experience.

The phenomenon of skin-to-skin and non-separation at caesarean section is demonstrated to positively improve the birth by giving a sense of control and more natural experience. Medicalisation of the birthing event to a surgical procedure has led to a general acceptance of separation and the expectation of medical need even when woman and baby are well. Further research for how women experience this separation is needed in order to change policy and practice and improve outcomes for women having caesarean births.

Conclusion

Skin-to-skin contact between a well woman and her newborn at caesarean section birth is a simple and safe way to ensure future physical and emotional well-being of both. The establishment of the mother-child relationship through bonding and mutual-caregiving, promotes ongoing security of care and nutrition for the infant and psychosocial well-being for the woman. The findings of this review have shown the urgent desire women have to see, hold and feed their babies in the moments after birth. The vulnerability of the woman during a surgical birth dictates the response woman-centred health professionals should guarantee – keeping the dyad together.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2021.103063.

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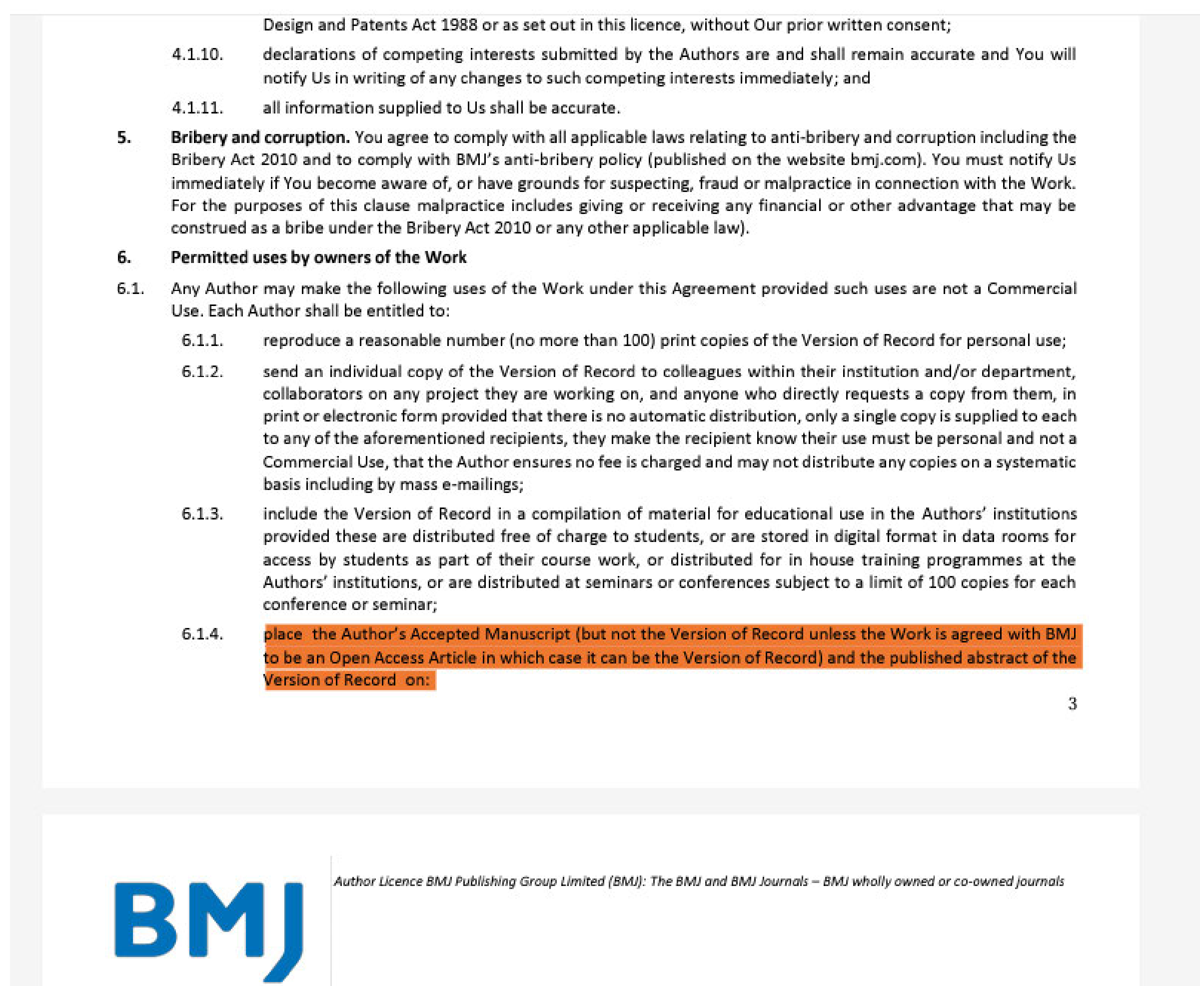
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Using a novel approach to explore women's caesarean birth experience

Linda J Deys, Valerie Wilson, Sara Bayes, Shahla Meedya

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).

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.

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.

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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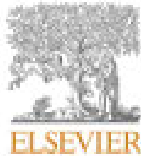

"Where's my baby?" A feminist phenomenological study of women experiencing preventable separation from their baby at caesarean birth

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A R T I C L E I N F O

Keywords:
Birth
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Women's experience
Phenomenology
Skin-to-skin

A B S T R A C T

Problem: Separating women and babies immediately after birth contributes to poor birth experience and reduced satisfaction.

Background: A negative birth experience can impact a woman's transition to motherhood and emotional well-being beyond the newborn period. Separating women from their baby at birth is known to reduce birth satisfaction and is more likely to happen at caesarean section births.

Question: What is the experience of women who are separated from their baby after caesarean section birth without medical necessity?

Methods: Unstructured, in-depth phenomenological interviews were conducted with fifteen women who had been separated from their well-baby at caesarean section birth. Data was analysed using a Modified van Kaam approach. A novel feminist phenomenological framework with two birthing theories was used to explore the experience of the participants.

Findings: Four major themes emerged – Disconnection, Emotional Turmoil, Influence, and Insight. These demonstrated significant trauma that both the separation and perinatal care created.

Discussion: The participants recognised their vulnerability and the lack of power and control they had over themselves and their baby, which was seemingly not acknowledged. Provider and hospital needs were valued above those of the women.

Conclusion: Woman-centred care was not evident in the treatment of these women despite the attendance of a midwife at each birth. This research challenges midwives and other health care providers to support and advocate for those birthing by caesarean section to return power and control and support them to remain in close physical contact with their baby immediately after birth.

Statement of Significance

Problem of Issue

Separation of mother and baby at caesarean section birth.

What is already known

Evidence shows the benefits of keeping mothers and babies together immediately after birth in skin-to-skin contact. Value is placed on physiological safety and institutional need, with birth experience and emotional well-being not always considered in settings such as operating theatres.

What this paper adds

This research presents a novel lens to understand how separation of mother and baby at birth impacts women. It highlights the unfair use of power and control by health care providers and facilities which benefits the system and traumatises women.

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Table 2
Methodology Summary Table.

Ethics – XX HREC	XXXX
Methodology	Feminist phenomenology
Inclusion criteria	Female, previous caesarean section with separation from baby at birth (any parity), well mother with healthy term infant/s at the birth event, birthed between 2010 and 2021, over 18 years of age at time of consent for interview, English speaking.
Exclusion criteria	Medical reason for separation of mother and baby at birth
Recruitment	Social media, snow balling.
Consent	Participants were sent an information sheet and if they agreed to participate, signed consent forms. Consent was verbally confirmed during interview.
Participants	Fifteen women aged between 23 and 38 years at time of birth separation who had birthed between 5 months and 10 years prior to interview. All participants were deidentified after data collection and provided with a pseudonym to protect confidentiality.
Data collection	Unstructured, in-depth phenomenological interviews based on the McGrath et al. protocol.
Data analysis	Initial coding with NVIVO. Data analysed using a Modified van Kaam approach then viewed through the lens of two feminist birthing theories – *Birth Territory* (Fahy & Parratt, 2006) and Childbirth as a *Rite of Passage* (Reed et al., 2016).

related qualitative research interviews [29,30].

The one-to-two-hour long interviews commenced with the opening question of "Tell me about your birth experience" followed by participant specific prompting and clarifying questions focusing on the phenomenon of separation. The first two interview transcripts were completed by the first author and reviewed by the research team with remaining transcripts completed by a transcription service in verbatim style soon after each interview.

Transcript data was initially coded into 16 nodes using the NVIVO program [31] then manually analysed using a Modified van Kaam approach – grouping, reducing, thematizing, validating and describing [32]. This was then viewed through the lens of the feminist birth experience theories - "Birth Territory" [22] and "Childbirth as a Rite of Passage" [23]. Coding and theming were regularly reviewed and revised by the research team, reducing the nodes to four overarching themes.

The study team and reflexivity

The first author is a Clinical Midwife Consultant and PhD candidate and conducted all interviews. She conceptualised this research based on clinical experience and lack of evidence to promote meaningful change for women birthing by caesarean section who had experienced separation from their infant. She comes from a background of having had two caesarean section births in a time before skin-to-skin contact was usual practice at any birth and experienced no personal birth trauma. The author team includes three PhD supervisors, all who identify as female, with expertise in midwifery, nursing, and qualitative research.

Ethical considerations

Initial ethical approval to conduct this study was given by the University of Wollongong Human Research Ethics Committee, Australia (approval number 2021/380) and later transferred to the Australian Catholic University Research Ethics Committee (ethics register number 2021-3064T).

Results

Participants

An unexpected response of 27 expressions of interest resulted in the first 24 hours, the post being spontaneously shared by group followers across other social media platforms, groups and private sharing. The use of social media as a recruitment strategy has been demonstrated previously as an effective tool in purposive and snowball sampling [33,34].

Of the original 27 responses, two did not meet criteria, and 25 eligible women were sent participant information and consent forms via email. Fifteen women returned signed consent form and were subsequently interviewed over the next three months. All were included in data analysis and were anonymised with pseudonyms. Further recruitment was determined to not be necessary with data saturation reached.

The participants (Table 3) birthed in Australia, ranged in age from 23 to 38 years at the time of birth, all were in a permanent, heterosexual relationships and well educated. Their experience of separation had happened five months to ten years prior to the interview. Fourteen out of fifteen participants had been first time mothers and two experienced a subsequent caesarean section and separation event, providing a total of seventeen birth experiences included in the data. Twelve of these were emergent procedures.

Findings

Initially distinguishing the maternal-infant separation phenomenon from the overall perinatal experience was challenging with all participants sharing distressing and traumatic birth stories. Isolation of four main themes characterising the experience of being separated from one's healthy baby at birth emerged from the data –*Disconnection, Emotional Turmoil, Influence, and Insight*. The themes were then mapped with where they most aligned with the birthing theories, highlighting the significance of the separation event as a feminist issue. Rites of Passage was balanced with Rites of Protection based on the medicalisation of the birth experience (Table 4) [1].

Theme 1: Disconnection

Four subthemes were coded within this theme – *Desire to hold baby, Separation, No skin-to-skin, and Breastfeeding.*

Desire to hold baby. Wanting to hold their baby at birth was strongly recalled by all participants. They described pleading and demanding for this to happen, and felt their urgency was at odds with hospital staff. The interval before they were able to hold their baby was sometimes unclear in their memories, but any amount of time was described as feeling too long, Naomi* saying *"It was probably about an hour, but it felt like forever"*.

Separation. In all cases, separation at birth did not reflect poor health of mother or baby. Initially the separation was within the room, babies taken out of view of the mother. Photos were offered as substitutes to

Table 3
Participant Demographics.

Name (Pseudonym)	Age at birth/s	Parity at birth/s[a]	Time since birth/s separation
Maggie	34	primip	16 months
Rose	38	primip	16 months
Alice	33	primip	5 months
Louise	35	multip	5 years
Lauren	26	primip	10 years
Susannah	28, 30	primip, multip	3 ½ & 2 years
Jane	30	primip	3 years
Erin	35	primip	5 years
Sally	31	primip	2 ½ years
Lily	23	primip	10 years
Maria	30	primip	2 years
Michelle	27, 29	primip, multip	6 & 4 years
Naomi	34	primip	5 years
Clara	28	primip	1 year
Miranda	33	primip	2 ½ years

[a] Primiparous/Primip = first birth; Multiparous/Multip = subsequent births

Introduction

The experience of birth is one individualised by the interplay of people and circumstances, including who, where and how the woman is cared for, and importantly, how she is made to feel [1,2]. The idealised image of a powerful birthing woman, in control of her body and those around her [3] sits in stark contrast with the surging testimonies of obstetric violence and birth trauma inquiries [4,5].

Unfortunately for many women, birthing is no longer a traditional practice but a medically controlled and traumatic procedure [6]. Commonly lip service is paid to 'woman-centred' care while the reality is one of facility focussed control. Women birthing by either an expectant or emergent caesarean section step further from the tradition of 'birth' to one of 'procedure', a surgical 'delivery', where the woman is far from the centre of care. The woman faces birth feeling powerless and fearful with the expectation she should just be grateful to have her baby [7].

Caesarean section has been shown to negatively impact a woman's overall birth experience, particularly for primiparous women and those for whom it is an emergency. [8] Enabling skin-to-skin contact between the mother-baby dyad and non-separation of the woman from her baby are protective measures to improve birth experience, breastfeeding and long-term health [9–11]. Despite the evidence, women continue to be separated from their baby at caesarean birth, with healthcare process taking precedence over maternal choice. In Australia, rates continue to increase with 38 % of women birthing by caesarean section in 2021, [12] a figure similar to other high-income countries. This common medical event can lead to indifferent care for women who may be negatively impacted well into the future [13].

The phenomenon of maternal-infant separation from the woman's perspective has not been well studied. Previous research has focused on the impacts for maternal-child bonding and the physiological aspects of separation, but less is known about women's experience and outcomes.

Participants, ethics and methods

Study design and theoretical framework

A feminist phenomenological framework was used to explore the experience of women separated from their baby at caesarean section birth in the previous ten years without medical necessity. This reflects the period in which skin-to-skin at caesarean section (and non-separation) was first recognised and documented in literature [9]. It also accounts for evidence that show women remember and can recount their experience for many years after birth [14–17].

Using a feminist approach to phenomenology sought to address the contextual and sexual difference of pregnancy and birth [18].Human experience is not gender-neutral, and phenomenology typically portrays a male-dominated world view, even when participants are female [19,20]. The dominant modern maternity care paradigm devalues the female-sexed body as a faulty machine, with increasing interventions and pregnancy interruptions promoting the importance of the fetus over the woman and disregarding her right to self-determination [21]. Birth trauma and obstetric violence occurs in maternity settings, with gender inequality reflecting the cultural and societal power imbalance of men over women [7]. Feminist phenomenology provides opportunity to expose disparity in obstetric health care, policy and practice.

Adding the theoretical feminist lens of "Birth Territory" [22] and "Childbirth as a Rite of Passage" [23] facilitated focus for understanding woman-centred care in an androcentric obstetric system, encompassing physical, emotional and spiritual needs [24]. The theory of Birth Territory highlights the importance of maternity care providers, particularly midwives, in supporting and protecting the woman, applying her own intrinsic knowledge to foster a satisfying and empowering birthing experience. Environments and care providers that limit a woman's power and control increase fear, poorer outcomes and reduce birth satisfaction [22,23]. The theory of Childbirth as a Rite of Passage highlights that the rights of women to bodily autonomy does not change with birth mode [25]. Birth experience is associated with how a woman is treated and should reflect human rights. Recognising and challenging these intrapersonal and social factors that disempower women can be manifested with feminist research and theory [26].

Eligibility and recruitment

Interest for inclusion in this study was collected through a single social media posting in 2021. The original post was purposively placed in an Australian maternity consumer advocacy group of the first authors local health district.

Data collection & analysis

Unstructured, in-depth phenomenological interviews were conducted and recorded by the first author using a video conferencing platform for all but one which was in person and audio recorded. This interpretive approach allowed for the depth and detail needed for the rich data of each participant's experience [27]. The interview protocol was based on McGrath et al., [28] including rapport building, listening and reflection and has been previously demonstrated in other health

Table 1
Birth Theories.

Birth Territory Describes, explains and predicts how a woman's wellbeing as her embodied self is impacted by the birth environment (terrain) and use of power (jurisdiction).	Terrain (birth environment)	Sanctum	Private, comfortable, enhancing woman's sense of self, optimal physical & emotional wellbeing, safety
		Surveillance	Clinical, observed, staff comfort, reduced physical & emotional wellbeing, fear
	Jurisdiction (power & control)	Integrative power	Woman-centred, shared goals, enhanced maternal mind-body-spirit, self-expression & confidence
		Disintegrative power	Ego-centred and self-serving, undermining of woman's decision making
		Midwifery (HCP) guardianship	Integrative power, respectful care, protecting woman & environment, sense of safety
		Midwifery (HCP) domination	Disintegrative and disciplinary power, subtle, manipulative with woman conceding power
Childbirth as a Rite of Passage Describes how the childbirth experience Is shaped by maternity 'rituals' – what is said and done to support (rites of passage) and to protect mother & baby (rites of protection)	Rites of Passage	Preparation and planning for birth, including intervention, minimising distractions, woman-centred, intuitive knowing, respectful and consensual, integration of mother and baby, connection, attending to the birth story	
	Rites of Protection (non-physiological birth)	Options & decisions, minimising distractions, advocating & supporting, meeting those providing care, woman's choices, non-separation – mother in control of her body and baby, processing the birth experience – not staff interpretation	

Table 4
Data Analysis mapped with birth theories.

Nodes (no. of references)	Codes/Themes	Feminist Birthing Theory		
		Birth Territory – (Terrain & Jurisdiction)	Rites of Passage	Rites of Protection
○ Desire to hold baby (19)	➢ Disconnection		●	●
○ Separation (126)				
○ No skin-to-skin (37)				
○ Breastfeeding (60)				
○ Emotions at birth (60)	➢ Emotional Turmoil	●		●
○ Emotions since birth (90)				
○ Impact on relationship with baby (31)				
○ Impact on relationship with partner (10)				
○ Power & control (104)	➢ Influence	●		●
○ Maternal choice & consent (65)				
○ Coercion (29)				
○ Staff actions (143)				
○ Mother's knowledge (35)	➢ Insight		●	●
○ Interventions (35)				
○ The partner (53)				
○ Next birth (78)				

seeing their baby, Jane* described how strange it was to see a photo of the student midwife holding her baby before seeing the baby herself. Some were shown the baby in what several women described as the 'circle of life' hold – baby held up high, under the armpits to show off genitalia over the drapes. This was distressing and confusing for Rose* as she didn't realise female genitals may be swollen at birth so thought she had been shown a boy. The expectation of examining their baby at birth, counting fingers and toes, and confirming gender was not realised due to separation. Erin* recounted she did not see her baby's genitals for over 24 hours and how odd it was to see them after all that time. Babies were commonly taken to the neonatal unit, despite being in peak condition at birth, with fathers all going with the baby. This added to the experience of separation as their support person were also removed. All participants wanted to see their baby was safe, to be a mother and be reunited with their partner.

Separation impacted what the participants spoke of as tangible elements that connect mothers and babies, including smell, touch, and taste. The participants frequently described their babies being rubbed, wiped, cleaned, and wrapped. It was seen as a further barrier and interruption to being close to their baby, changing how they connected with their baby beyond the birth. Rose* shared she still had no sense of what her daughter smelled like 16 months later and likened it to stopping animals licking their babies to bond and connect. She felt this significantly impacted her relationship with her child.

No skin-to-skin. All study participants anticipated skin-to-skin contact with their newborn directly after birth, to hold, meet and feed their babies. Only two participants were supported with this briefly while in the operating theatre. The women were taken alone to the recovery area after the caesarean, with some separations being many hours. The woman's perception of low status in the birthing room was explained through comments around skin-to-skin contact, and it not being 'allowed'.

The participants felt that skin-to-skin was not valued in the operating theatre or recovery room environment. Alice* had requested skin-to-skin contact on her birth plan but stated she didn't think the staff saw it as important. Miranda* described having a detailed birth plan which included the importance of skin-to-skin contact to her but felt unable to ask when it didn't happen. If women did ask for it to happen clinicians gave excuses for no skin-to-skin, ranging from staffing restrictions, infection risk, or room temperature.

Breastfeeding. Despite traumatic birth experiences and being separated from their infants after the caesarean birth, the participants all knew skin-to-skin contact and breastfeeding was optimal despite the immediate separation. They feared and came to realise that their relationship and feeding journeys may not be as expected.

All women in this study breastfed their infants through early challenges expected from a delay to first feeding through separation, many into toddlerhood. They described misinformation and lack of breastfeeding support soon after birth followed by poor and inconsistent advice from staff while in hospital. This exacerbated the experience of the initial separation from their infants with midwives latching babies to their breasts, further disempowering the women.

The inability to control what happened to their baby was devastating for the participants, their vulnerability increased with birthing in the operating theatre. They were disconnected from their body, their baby, and their partner with no right to self-agency.

Theme 2: Emotional turmoil

Four sub-themes converged into this theme – *Emotions at birth*, *Emotions since birth*, *Impact on relationship with baby*, and *Impact on relationship with partner*.

Emotions at birth. The participants first moments after birth were filled with fear, confusion, and sadness. They used words which portrayed feelings of numbness and trauma, having to accept what was happening with no choice. While 30 % of the births were planned caesarean sections, all felt pressured to accept the recommendation and were unsure about the true risk for their baby or necessity of the procedure. They had concern over their own and baby's safety, and then experienced the distress of being separated from their newborn.

Emotions since birth. These early feelings and emotions had turned to guilt and anger in the time since the birth separation experience. The participants recalled their lack of power and control and of disembodiment. The separation from the baby at birth had impacted how they mothered and their experience of motherhood. Clara* said she felt robbed of what should have been possible and had since realised this was not uncommon which increased her anger.

Impact on relationship with baby. All participants were negatively impacted by the experience of separation, affecting bonding, mothering and establishing a relationship with their baby in the hours, days and years since birth. Breastfeeding was commonly highlighted as a reconnecting feature of their mother-child relationships. For Miranda* this took months but was the thing she credited with narrowing the gap to form a bond with her baby.

Some multiparous participants compared the index birth to subsequent births where they remained in close physical contact with their infant and were clear about how it affected their parenting styles. Lily* felt the emotional attachment and childrearing with her following two

children was very different to her first (index), from the day of birth, attributed to connection and positive feelings. Susannah* experienced two separation at caesarean events and fought for a maternal assisted caesarean and no separation for her third, she describes *"the connection I have with [baby] is, it feels horrible to say, completely different to the other two. From the get-go. Completely…amazing."*

Impact on relationship with partner. Although partners were not the focus of this research, the births and separations had significant negative impacts on them as well as the marital relationships. The participants recognised that their partners were also vulnerable and limited in their ability to advocate for and protect them, including during the separation of mother and baby. In discussing this Maggie* said *"the damage it does first hand on, you know, not just the breastfeeding relationships but family, like entire family units can suffer because of this."*

Partners were sent with the baby when taken away, not given information about the wellbeing of the women, and commonly asked to go home soon after mother and baby were reunited. Some did skin-to-skin with the babies but most were first-time parents and didn't know what to do. They continued to have negative effects on their mental health and relationships. The participants discussed the impact this had on their sexual relationships and planning of future pregnancy and birth plans. Rose* was profoundly impacted by the trauma of her birth and separation, had not had sex since, significantly affecting her relationship with her husband. Separating the mother and baby had consequences which were significant and enduring for the entire family.

Theme 3: Influence

The theme identified as 'Influence' demonstrated the impact of interactions and events that predisposed mother and baby separation. This included four subthemes – *Power & control, Maternal choice & consent, Coercion* and *Staff actions*.

Power & Control. Maternal care was not woman-centred and prioritised provider and facility agendas over the women's choices and needs. The participants felt decisions to have a caesarean birth, who was present, and the power imbalance, created an environment which necessitated or promoted the separation, despite their wishes. Some felt that the timing of their caesarean section was based on doctor or facility inclination rather than medical necessity.

Vulnerability of the women and therefore the inability to speak up for themselves was evident in the data. They were not valued, Jane* highlighted this with *"basically I disappeared the moment I set foot in the hospital."* The participants' felt power was not theirs and it was given away because of their susceptibility.

Retrospectively, the participants could see the unfairness in what had happened to them and that it was not in their power to control. They felt that rather than having to be combative, women should be able to expect respectful maternity care as standard.

Maternal choice and consent. Overall, the participants described maternity health care providers who were generally dismissive. In some cases, they did not address women directly, did not introduce themselves, and participants were told what would happen rather than asked what they wanted, and were expected to comply. Michelle* chose the private health system twice, to have continuity of carer with an obstetrician. She was refused the option to have a Vaginal Birth After Caesarean (VBAC) with her next pregnancy and denied skin-to-skin contact again with her second caesarean:

> "I don't even remember them asking for my opinion. It was just 'You're having a caesarean, you've got no choice basically'… I honestly don't remember them really asking my opinion or anything. I just remember on the way down, the midwife saying 'We're short staffed. So if you wanted to have her [baby] in recovery [area] you probably won't be able to'" (Michelle*)

The participants identified that they didn't feel they were permitted to be included in decision making during and immediately after the birth. Consent was not 'fully informed' for care and procedures throughout the perinatal journey. The participants agreed to things without understanding the risks, benefits, or consequences, including separation.

Coercion. Across the perinatal period, including birth debriefing and provider feedback, the participants described the experience of coercion and control over decision making for interventions, timing of birth and separation from their baby. They felt that even though they formally agreed to procedures and actions, the choice was not theirs, describing the situation as both forced and bullying. One participant described the preparation and research she had done in preparation for her second caesarean section birth, having been separated from her baby at her first:

> "I was doing more research, I was finding out more information, I knew that I would have a fight based on what I was reading, but I just, I didn't expect the extent that the obstetrician would go to to bully me into a caesar." (Susannah*, separated again)

Staff actions. The sub-theme of *staff actions* was developed from participant data about individual, multi-disciplinary staff members as well as the facility. Maternity care provider interactions included threats of harm or death for the baby if the participants didn't agree to the caesarean section. The participants realised retrospectively these risks were generally unfounded. Their vulnerability was exploited, leading to increased and potentially unnecessary interventions which led to maternal-infant separation.

While negative interactions were common, the participants acknowledged positive exchanges and attempts by some staff to support them, and these were remembered with words reflecting respect, safety, and trust. Simple gestures recalled such as introductions, a gentle manner, and kindness. Miranda* felt the anaesthetist's warmth and kindness shown by holding her hand and explaining what was happening as her baby was born prevented further trauma and psychological injury. Sally* shared her interaction with two male staff in the recovery area as she desperately asked to be reunited with her baby *"And they were, like, very caring and lovely, but I just didn't feel like they really understood the urgency of it. Like, I think they were like, 'Oh, we'll check. Oh, sorry. No, they say no,' [maternity ward where baby was]. But I didn't feel like they were really advocating for me."*

The negative encounters with staff were further disappointing for the participants who sought maternity care providers and facilities they thought aligned with their preferences. They pursued knowledge for themselves and their partners and developed plans for labour and birth. In hindsight they reflected on a medicalised and patriarchal maternity care system:

> "…and that's partially the reason why I picked a female obstetrician, and yet, she is part of that patriarchal system…I think maybe I might have had a better go with a male obstetrician." (Naomi*)

Despite pregnancy preparations, none of the participants achieved the positive birth experiences they had hoped for and were not prepared for the disregard and disrespect they encountered. They were realistic regarding the possibility of unexpected circumstances and outcomes, including caesarean birth, but some participants noted this could have been better covered during formal birth education classes. Antenatal classes were felt to have not met their needs but instructed how to behave within the system and do as they were told.

To understand and resolve their conflicted feelings about their experience, several of the participants sought informal or formal responses from the individual doctors, facilities, or governing bodies to explain and debrief the birth events. The responses were generally indifferent, denied culpability, and aimed at preventing litigation.

Alice* interacted with an obstetrician as an inpatient, *"His debrief was limited to, I guess, the CTG, and he basically came in, rolled it across the bed, and said, 'Look at that. That's massive. You're all good now though, right? Alright, see ya!'"*

The use of disintegrative power undermined and disenfranchised the birth experience and promoted separation of the dyad. Health service, policy, and personnel was seen to create conditions which disadvantages the consumer.

Theme 4: Insight

This final theme reflected the longer-term impact of the birth separation, how the women sought understanding of what had happened, and how to prevent it occurring again to either themselves or others. The four sub-themes were *Mother's Knowledge, Interventions, The Partner,* and *Next Birth.*

Mother's knowledge. The women understood their pre-birth knowledge and preparation was insufficient for the health system they birthed in. They saw the conflict and inconsistency between evidence, policy, and individual practice.

Since the birth and separation from their infant, all participants had sought further knowledge. They recognised the vulnerability of themselves and their partners and the imbalance of power within the health system. If planning subsequent births, they again attempted to find maternity care providers which would support their choices, whether by caesarean or not, including private midwives and doulas. Five had a VBAC, with a further one attempted but resulting in another caesarean and separation from her baby, this time for medical reasons. Susannah* and Michelle* both described not being 'allowed' to have a VBAC, both had elective repeat procedures and were separated from healthy infants again.

Lily* had a successful VBAC with the next birth. She increased her knowledge and discussed the compromises she had been willing to make and of fighting for the things that were important. She employed a doula, as did others, to support her and her partner.

> "The more I thought about it [VBAC], the more I was like 'Well, we're gonna have to really focus and stand up more for what I really want if that's gonna happen'" (Lily*)

Interventions. One specific aspect of the participants new knowledge was that medical interventions had the potential to negatively impact their birth experience and outcomes. In describing their birth stories and their lack of input into decisions being made about their care, interventions were commonly described as not being evidence-based or done without consideration of individual circumstances. This ultimately ended up with a caesarean and being separated from their baby.

The partner. Partner support, or perceived lack of, had a deep impact on the birth experience for the participants. As men, they were more likely to have their opinions respected or requested and were sometimes asked to convince their partners to have certain procedures.

Ultimately, the impact of mother-infant separation was exacerbated with separation of the participants from their partner soon after birth. Being finally reunited as a family was short-lived for many, with partners often told to leave soon afterwards.

Next birth. Eight of the fifteen participants had birthed further children after the separation event and two were pregnant. They were hypervigilant in their preparations for birth, considered a repeat caesarean was possible, and as noted earlier, used their knowledge and experience to prepare. Susannah* sought the obstetrician who would do a maternal assisted caesarean section for her third birth after two previous caesareans with baby separation. She was both overwhelmed at this transformative experience and regretful that she did not get this with her previous births. Her experience led her to widely share her personal birth video to encourage both women and health care providers to see what was possible.

The women in this study recognised the importance of psychological well-being alongside the physical. Sally* summed this up well, saying – *"And I think that that's the problem, at the moment, is that all of the risk assessment that they do is based on physical, but they've not taken into account the psychological impacts of those decisions."*

*(*pseudonyms)*

Discussion

This study highlights the significant impact for women separated from their baby at birth. Those who participated in this research collectively showed their experience was similar for all fifteen, including when it happened a second time, providing a valuable understanding of the phenomenon. While the overall perinatal experience for the participants was reflective of birth trauma and obstetric violence, the significance of the separation event escalated these profound psychological and emotional consequences. The desire to hold their baby was strong, and as has been demonstrated in other studies, was urgent, intense and affirming [35] which can influence birth experiences [36]. The women we interviewed were denied immediate skin-to-skin contact with their baby, known to improve birth satisfaction, increase a sense of control, and seen by women as a way to ensure staying in close physical contact with their newborn to promote breastfeeding and connection [9]. Despite separations lasting many hours in some cases, the breastfeeding outcomes in this study were largely in contrast with expectations, with separation and no skin-to-skin contact at birth usually associated with reduced duration and exclusivity [37,38].

It could be argued that the stories recounted by participants up to ten years after birth were distorted by time, however this is not reflected in research showing women are able to recall birth experience and events for many years [15,16,39,40]. The feelings experienced by a woman at birth is directly related to how she perceives her safety. In viewing this through both "Birth Territory" [22] and "Childbirth as a Rite of Passage" [23] theories, safety is influenced by the people who are caring for a woman, and the environment in which she births. Reed and colleagues have also demonstrated, as we did, that when care provider agenda is prioritised over the birthing woman's needs it is a factor in the woman's experience of birth trauma [6].

Hospital birthing facilities are generally designed for staff benefit rather than women's feelings of safety and sense of control [22]. "Birth Territory" describes this 'surveillance' terrain where women feel fearful, resulting in poor physical functioning and emotional well-being [41]. This study highlights the importance of creating physically and psychologically safe birthing spaces, recognising the power imbalance and vulnerability of women.

The organisation and management of obstetric-led maternity services creates an environment prone to facility-controlled power to disadvantage and discipline women into submission. The participants explored both positive and negative accounts of midwives and health care providers who impacted their birth experience. Their descriptions included respectful and supportive care but recognised that this was often exceptional, not standard practice. The participants saw the potential of midwives, expected their support and guidance, and while being disappointed in what the midwives didn't or couldn't do, they saw this as a system failure. Hospital policy and androcentric power does not encourage care provider guardianship for women and the hierarchical structure is a risk to women's safety [42]. Patriarchy disempowers midwives and other care providers which in turn disembodies and traumatises women [43].

Power and control were strong concerns for all participants, who recognised the little they had. Previous work, like our study, has shown that skilled and even kind caregivers who meet their own needs first take away the power, respect and confidence of woman, limit her

participation, and cause negative birth experience and trauma [44]. Empowering women to give birth, rather than being delivered-of their babies, improves birth satisfaction and well-being of the dyad [41].

The strength of this research was using feminist theory to deeply explore the rich data sets. Both birthing theories illuminated the power imbalance created when women are surrounded by staff and environments that manipulate and discipline. The women who chose to be in this study were motivated to change this system, and perhaps not representative of all similarly birthing women who were separated from their baby. This limitation could be developed with further research to understand a broader selection of women and the providers who have cared for them.

Conclusion

This study sought to understand the experience of women who birthed by caesarean section and were unnecessarily separated from their baby. The findings demonstrate that separation caused deep emotional and psychological impacts for the participants. Their sense of control was diminished by facility power, disciplining women into submission using policy and fear. Australian maternity systems, like others around the world, focus on the physical risk of pregnancy, labour and birth, and particularly the risk to the infant. Consideration should be given to the woman's human right to self-embodiment, preventing psychological harm and the consequences of separation at birth for both mother and child.

Author agreement

This article is the authors original work and has not been previously published or currently under consideration for publication elsewhere.

All authors have seen and approved the submitted manuscript and agree to abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives

Ethical statement

Initial ethical approval was gained via the University of Wollongong Human Research Ethics Committee, Australia (approval number 2021/380) on the 8/12/2021 and later transferred to the Australian Catholic University Human Research Ethics Committee (ethics register number 2021–3064 T), approval date 21/3/2023. All participants provided informed written and verbal consent for inclusion in this study.

Declaration of Competing Interest

None.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2024.101828.

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“Where’s my baby?” A feminist phenomenological study of women experiencing preventable separation from their baby at caesarean birth. – Supplementary File, WOMBI

Themes/Supportive Quotes (additional)

Theme	Sub-theme	Supporting quote
Disconnection	Desire to hold baby	*“And I kept on asking them, like, they were stitching me up. I was like, ‘Can you bring my baby back?’… I just didn’t feel like they really understood the urgency of it. I don’t think they understood, like, how important it was to me.” (Sally*, separated for ‘at least an hour’ but unsure)*
	Separation	*“I need, I want to go and see my baby, and I wanted to be alone with her and my partner.” (Louise*, separated for 5 hours)* *“Where's my baby? Where's my husband? Why-why am I still in the operating theatre?” (Jane*, separated for two hours)*

	No skin-to-skin	*“And you know, they didn’t talk about skin-to-skin or anything like that, so it was just slice, cut, over to the table, do all things, weigh, wrap her up, and then bring her to me all wrapped up.” (Naomi*)*
	Breastfeeding	*“I was also nervous that I was gonna have trouble breastfeeding because it was like…how’s the milk gonna start running when like, this is what’s happening.” (Erin*)* *“…it was that sort of midwife-led, um, you know, jamming…” (Naomi*, describing her first breastfeed attempt when reunited with baby)*
Emotional Turmoil	Emotions at birth	*“…very surreal, like I know in my head I just had a baby but it doesn’t feel like I just had a baby*

		at all cause there’s no baby.” (Lily while in recovery)* *“I didn’t hold him for two hours [crying]. I didn’t know what had happened to him and nobody knew what had happened to me. Like, it’s just insane, and we were probably only a couple of corridors apart.” (Clara*)*
	Emotions since birth	*“I felt guilt about feeling numb. I felt guilt about being separated from her. I feel guilt about missing those, like, those first couple of hours of her life. I think I was just so disappointed in the system. I think the guilt’s lessened. I think the frustration and anger still remain…I know that I wasn’t in control, and I know I fought really hard. I was powerless in that, so I can’t carry guilt over something I had no control over.” (Lauren*)*

	Impact on relationship with baby	*“…the feelings, the connection, the indescribable love, I think I even haven’t got there yet. I have a good relationship with her. But a lot of it, it’s out of duty. I know how I have to behave and I behave, but it’s not this natural overjoyed burst of emotion.” (Rose*, describing the prolonged negative impact on bonding with her baby aged 15 months)*
	Impact on relationship with partner	*“I left the hospital telling my husband that I wanted a divorce straight away because I couldn’t believe that he wasn’t there for me anyway. He has all the best intentions and I do see that he was also afraid and just didn’t know any better. But that doesn’t change the fact that he was the only one that could have said ‘stop’, put something out more than I was already screaming. But because he was silent and calm, it*

		was one way of siding with the hospital, with the things that were done to me. He didn't advocate for me whatsoever."(Rose)*
Influence	Power & Control	*"At about 6/6.30 a.m I had an obstetrician storm into my room and demand – he wasn't talking to me, he was talking to my midwives, demanding that I had a C-section…No, like, introduction or anything to me…I was, like, very, very scared about one – I did not want a caesarean. There were a lot of people in the room – obstetricians are like the hierarchy, I guess." (Maria*)* *"I think a lot of the time, women give their power to a doctor because they're a doctor. Like, we trust doctors inherently, don't we?" (Miranda*)*

	Maternal choice & Consent	*“Unless someone tells you you’ve got a choice, you just do what people tell you to do.” (Jane*)* *“I was given a choice, but it felt like a very pressured choice.” (Sally*)*
	Coercion	*“…they were so coercive – they still kind of called the shots even though we were the ones that made the decisions. It was because we were coerced to make those decisions.” (Maria*)*
	Staff actions	*“So, when you’re two first-time parents and you hear ‘If you don’t do this, your baby’s gonna die’, like, what do you do?... I wasn’t spoken to. I wasn’t told anything. I wasn’t asked anything.” (Clara*)* *“I got to 10cm dilation and, that’s when, you know, he just came in and said – told me I was gonna*

		have a dead baby, and…he said ‘I don’t want to hear another word from you. You’re having a caesarean.’” (Miranda)* *“I really wanted to have a low intervention birth, so I tried to pick an obstetrician that was aligned to that...I’m someone who researches. I read everything…we probably did three birth courses…the system sets us up to fail – it’s just not set up to support women…it’s medicalised. And to find that person who will treat it as a natural event and support you through it, it’s always gonna be a needle in a haystack” (Sally*)*
Insight	Mother’s knowledge	*“They’re supposed to have our best interests at heart. But actually they’ve all got their own agendas as well. Like, you’ve still*

		got to advocate for yourself. You've still got to think for yourself, in my experience. And, you can't trust. You cannot trust a doctor. No way. That is something I learnt from that process." (Miranda)*
	Interventions	*"So, I was put on the CTG which I'm actually annoyed about it. That is something that does bother me because I now have found out from, I'm quite a big fan of Kirsten Small's research around CTG use that even in high risk instances there's no benefit to CTG, and in fact it can lead to you know, things such as caesarean." (Maggie*)*
	The Partner	*"So the doula ended up spending those two and a half hours with [partner] and the baby, which I also was just so furious about, that another woman was there*

		seeing [partner] becoming a dad and seeing my baby.” (Erin)*
	Next birth	*“The third one I found a doctor who was willing to support maternal-assisted caesarean. It was the most healing, amazing experience of my life, and I think will be forever, will be one of the best memories I ever have.” (Susannah*, not separated at this birth)*

*pseudonym

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Page/line no(s).

Title and abstract – “Where’s my baby” A feminist phenomenological study of women experiencing preventable separation from their baby at caesarean birth.

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	1 - 2

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	3 - 4
Purpose or research question - Purpose of the study and specific objectives or questions	4

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	4 - 6
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	6
Context - Setting/site and salient contextual factors; rationale**	5
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	5, 7
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	7
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	5 – 7 plus table 1
Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	5 - 6
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7, plus table 2
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	5 - 7
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	5 - 6
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	5 - 6

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	7 – 19 plus table 3
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	7 – 19 plus supplementary file

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	19 - 21
Limitations - Trustworthiness and limitations of findings	19

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	22
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	22

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014 DOI: 10.1097/ACM.0000000000000388

Appendix G: Accepted Conference Research Abstracts

15th Normal Labour and Birth Research Conference (NLBC) December 2020 (held virtually due to pandemic)

Presentation theme - "Positive Birth" abstract – literature review

Title: What are women's experiences of immediate skin-to-skin contact at caesarean section birth when mother and baby are well?

Background:

The benefits of keeping mother and baby in immediate and uninterrupted skin-to-skin contact after birth are well known. Skin-to-skin triggers the biological sequence of events which promotes physiological, psychological, microbial and epigenetic changes that impact the dyad across their lifetime. The promotion of early feeding during skin-to-skin increases the initiation, exclusivity and duration of breastfeeding, furthering health benefits for mother, baby and their community. Research additionally shows that skin-to-skin contact promotes bonding, mutual-caregiving and self-regulation that impacts the mother-infant relationship well beyond the perinatal period.

Caesarean section birth occurs in around a third of women and significantly impacts the facilitation of skin-to-skin, increasing separation, even when both are well.

Objectives:

To understand what is already known about the experience of skin-to-skin for women having caesarean section births at term when both are well.

Methods:

An integrative literature review, critically analysing and synthesising data from mixed designs and methodologies. A comprehensive search with keywords (truncations, spelling variations and Boolean operators) for 'skin-to-skin', 'caesarean section', 'experience' and 'woman or mother', 2010-2020, was undertaken in seven data bases. 32 articles were appraised for eligibility with 13 studies chosen to meet inclusion criteria – quantitative (6), qualitative (5) and mixed method (2).

Analysis included organising data into themes by describing, extracting and coding. These concepts have been interpreted and integrated to synthesise new understandings and identify knowledge gaps to inform further research.

Findings:

Skin-to-skin at caesarean section is as valuable to women as when having a vaginal birth. Women wanted to hold and meet their babies and experienced these yearnings physically and emotionally. Themes included “becoming a mother’, “sense of control”, “satisfaction” and “empowerment”. Women experienced immediate skin-to-skin as a normal and natural process, an establishment of their importance as ‘mother’, enabling bonding and alleviating fear. They felt satisfied and involved with their birth and experienced earlier and more successful breastfeeding outcomes. Women feared separation but felt they had limited influence on it being ‘allowed’.

Conclusions/implications:

Keeping mothers and babies together is well established as benefitting lifelong health. Women want to be with their baby. The reasons behind separation at caesarean section are often institutional and can be improved by education and change to policy and practice. This review has highlighted the gap in literature on the emotional impact for women separated from their well, term infants at surgical births. Further research in this space seeks to inform policy and change in practice.

Virtual International Day of the Midwife Conference (VIDM) 2023 –

"The Art and Science of Midwifery: Celebrating 15 Years of VIDM" Abstract (virtual presentation) - preliminary findings

Abstract topic: Skin-to-skin at caesarean section has been around for as long as VIDM but women continue to be separated from their babies unnecessarily. The art of empowering women is a midwifery skill – they are the key in supporting women in all births.

Abstract title: *"Where's my baby?" How do women experience separation from their baby at caesarean section birth?*

The problem: Midwives guide, create safety and share goals with women through labour and birth. When the birthing landscape is an operating theatre, women lose their autonomy and the midwives' role of being 'with-woman' is challenged. Midwives have the opportunity to create an environment where the woman has power and agency over her body and baby. Separating a mother from her baby can negatively impact her birth experience.

Design: Using a feminist phenomenological framework, fifteen women who experienced non-medically indicated separation from their infant at caesarean section were interviewed.

Results: Preliminary data analysis using a Modified van Kaam approach showed feelings of powerlessness, loneliness, sadness and frustration which lasted well beyond the perinatal period. This reflected a patriarchal, staff-focused environment where women were disregarded and did not feel safe.

Conclusion: Separating mothers and babies at caesarean section negatively impacts birth experience. Midwives have the opportunity to recognise power imbalance and create a sanctum within the surgical environment. Recognising that birth is more than the mode of delivery, midwives are often the only ones in a position to be the woman's advocate as she births and meets her baby.

Key words: midwife; caesarean section; separation; birth experience; feminism; phenomenology

Lactation Consultants of Australia & New Zealand (LCANZ), Melbourne 2023 - *Breastfeeding In Spite Of* – unexpected findings

Keeping mothers and babies together in the immediate period after birth, ideally in skin-to-skin contact, is well known to facilitate a biologically normal chain of events, including breastfeeding.

In my PhD research I have sought to understand the experience of women who were separated from their baby after caesarean section birth without medical reason. I expected to hear stories of breastfeeding struggles and failure, but what I found was resilience and determination in spite of their negative and often traumatic birth experiences. Breastfeeding was not without challenges but the women overwhelmingly took back the control they lost during their birth and sought to re-establish the relationship with their baby by feeding and nurturing them.

This presentation shares the stories of 15 women who participated in interviews of a feminist phenomenological research study. It will show the strength of women who despite a loss of centrality, power and connection with their baby during and soon after birth, still breastfed successfully and long-term.

Virtual International Day of the Midwife (VIDM) 2024 –

"Sustainable Midwifery: Caring for Tomorrow's World" Abstract (virtual presentation) Research Findings

Topic: Partnering with women.

Title: Understanding birth trauma from the perspective of obstetric neglect.

The problem: Obstetric violence creates visions of a brutal and purposeful assault, however more covert practices cause similar psychological harm, are less understood, and more likely to be disregarded. Separating women from their well-baby at a caesarean section birth can cause long-lasting trauma.

Method: A feminist phenomenological study, using birthing theories to understand the experience of women separated from their baby at caesarean section birth without a medical indication.

Results: We identified four main themes that were interlinked: *Disconnection, Emotional Turmoil, Insight and Influence.* This presentation expands on *Influence* and the sub-themes of power & control, maternal choice & consent, coercion and staff actions. While obstetric violence was perceived with the physically forceful actions that some of these women experienced, it also showed more insidious events which caused comparable traumatic responses. The term 'obstetric neglect' was coined to symbolise maternity care where maternal choice and consent was voided by health care providers using power, control and coercion that influenced participant birth outcomes and experience.

Conclusion: Birthing in an operating theatre environment limited the capacity of the participants to bodily autonomy and this vulnerability was not accounted for with woman-centred care. Midwifery training and values align with the need for the protection of, and advocacy for, women. These findings demonstrate the importance of a respectful, empowering and supportive midwifery contribution through every pregnancy and birth, in the development of policies and procedures, done in partnership with women.

Theme connection: The identity of midwifery has been increasingly tested both externally and internally. Holding on to the definition, scope and ethical integrity of a midwife is essential to sustain midwifery into the future or we risk stepping into the role of 'obstetric nurse'. It should

not matter where a woman chooses or needs to birth, from home, to birthing unit to the operating theatre - midwifery care must be the same. Woman-centred, protective, supportive, empowering to provide psychological and physiological safety and improve birth experience. Traumatised women impact family and societal wellbeing, changing how our communities will experience birth and mothering well into the future.

This research challenges midwives to hold onto their past to protect their future.