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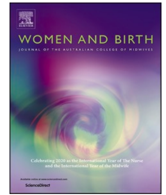

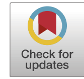

"Where's my baby?" A feminist phenomenological study of women experiencing preventable separation from their baby at caesarean birth

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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 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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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 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*	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

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 – E*motions 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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