Women's experiences of intrapartum care and recovery in relation to planned Caesarean Sections: An interview study

Abstract

Problem and Background: Approximately one third of women in high-income countries give birth by caesarean section (CS). Better understanding of women's CS experiences is vital in identifying opportunities to improve women's experience of care.

Aim: To identify opportunities for service improvement by investigating Australian women's experiences of care and recovery when undergoing a planned CS.

Methods: Qualitative telephone interview study with 33 women who had a planned CS at one of eight Australian hospitals. Semi-structured interviews were conducted to elicit women's perspectives, experiences and beliefs surrounding their planned CS. Interviews were transcribed verbatim and analysed inductively using NVivo-12.

Results: Women's experiences of CS care were mixed. Regarding intrapartum care, many women stated their planned CS was a positive experience compared to a previous emergency CS, but was scarier and more medicalised compared to vaginal birth. CS recovery was viewed more negatively, with women feeling unprepared. They reported disliking how CS recovery restricted their role as a mother, wanting more time in hospital, and greater support and continuity of care.

Discussion: Women reported largely positive intrapartum experiences of planned CS but relatively negative experiences of CS recovery. They wished for time in hospital and support from staff during recovery, and continuity of care.

Conclusion: By incorporating shared decision-making antenatally, clinicians can discuss women's birth expectations with them and better prepare them for their planned CS and recovery.

Keywords: Women; Cesarean Section; Experiences; Intrapartum; Recovery

Statement of Significance

Problem

Around one third of women in high-income countries give birth by CS, however women's voices regarding CS experience and recovery are under-represented.

What is Already Known

A substantial proportion of women, ranging from 20% to 100%, report negative CS experiences however most studies regard the experiences of women who have had an emergency CS, with fewer studies specific to planned CS.

What this Paper Adds

Women who had planned CS reported mixed experiences: often positive intrapartum (particularly if the woman previously had emergency CS), however negative recovery experiences. They articulated specific areas of improvement that can be targeted using antenatal shared decision-making.

Introduction

Global rates of caesarean section (CS) have almost doubled from 12.1% in 2000 to 21.1.% in 2015 (1). Australia's CS rates rose from 30% to 33% between 2005-2015, with elective CS rates accounting for the majority of the rise (2, 3).

CS are potentially life-saving procedures, whilst also hosting the added benefits of moderately reducing urinary continence and pelvic organ prolapse rates (4). Its benefits may play a part in the rising CS rates, resulting in the CS becoming one of the most commonly performed surgical procedures worldwide(5). Nevertheless, CS still carry risks; in the short-term, these include increased infection and transfusion rates for mothers and increased respiratory distress syndrome rates for babies (4, 6, 7). Longer-term risks include abnormal placentation, catastrophic haemorrhage and uterine rupture in subsequent pregnancies (8-10). To ascertain at which point the benefits outweigh the risks, a WHO ecological study (2016) found that a significantly negative association between CS rates and mortality only when rates were below 5-10% (9-11). However, with the literature dominated by debate surrounding CS risks, benefits and optimal rates, comparatively limited focus is made on the crucial area of women's experiences of care and recovery.

Currently, studies in relation to women's experiences of CS care present mixed results. Although the majority of women report being satisfied with their CS birth, substantial proportions of women, ranging from 20% to 100% in prior studies (approximately one-third on average), report negative experiences (12-19). Particularly, women report feeling ignored and dismissed by medical staff (13, 20-23), experience a loss of control over their birthing experience (13, 14, 20-26) and feel they were not informed about events and decisions made during birth (20, 23, 27). In regard to post-CS recovery, existing literature suggests that many women did not receive an adequate debriefing about birth events and were dissatisfied with the information provided and thus felt inadequately prepared for the post-birth time period (23, 26, 27).

Negative experiences of CS are particularly common amongst women who underwent an emergency CS in comparison to a planned CS (12, 20, 23, 28-30). In particular, women undergoing an emergency CS were likely to feel they lacked control over the birthing experience, due to them not being informed about CS antenatally or the lack of time they had to absorb intrapartum events (25).

The majority of studies focus on the experiences of women who had an emergency CS (14, 25-27) or on CS reported as a group (without separating the experiences of planned versus emergency) (12, 13, 15-18, 20, 23, 28-34) providing limited insight into the experiences of women who had a planned CS. However, studies comparing the experience of women who had a planned versus emergency CS suggest that the experiences of these women are different (12, 20, 23, 28-30). Therefore, to ensure women receive the care they need, enhancing our understanding of the experiences of care in women who underwent a planned CS is important. The aim of this study is to investigate Australian women's experiences of care and recovery when undergoing a planned CS.

Methods

A qualitative interview study was conducted between May and August 2019 across eight Australian public hospitals (seven in metropolitan Sydney, one in regional New South Wales). Ethics approval for this study was granted (details withheld for purposes of peer review).

Participants and Recruitment

Thirty-three telephone interviews were conducted with purposively sampled women who had undergone a planned CS**.** All women had undergone a planned CS between two weeks and five months previously and were proficient in English.

Recruitment occurred in two stages. Firstly, in a separate survey study conducted by the authors between October 2018 and July 2019, women scheduled for planned CS were given the option to indicate their willingness to participate in post-natal interviews in a survey administered during their antenatal booking appointment. Within three weeks of survey submission, interested women were contacted to confirm participation and sent information statements and consent forms to return. The second stage involved posting information statements and consent forms to 25 randomly-selected post-partum women, who underwent planned CS between March and June 2019 at each of seven study hospitals, using hospital database records for identification. This stage was not applied to one hospital, as sufficient women had already been recruited from this site.

Data Collection

Women were offered either a telephone or face-to-face interviews during their initial phone call, however all women preferred the telephone interview. Each interview lasted between 15-35 minutes. Prior to the interview's commencement, understanding of study information and the submission of written consent was confirmed, or an audio-recording of consent was undertaken. All women consented to having the interview audio recorded apart from one, for whom the interviewer manually noted down the responses. Women were also given the opportunity to have information statements re-sent or ask questions to clarify their understanding.

An interview guide was developed to facilitate the semi-structured nature of the interviews and broad areas of questioning surrounding women's mode of birth (MOB) preferences, their intrapartum CS experiences, their experiences of recovery and any opportunities for improvement. Broad open-ended questions elicited women's perspectives, their experiences of the CS and the information provided, and identified issues important to them regarding their CS experience. Focused questions prompted women to clarify issues previously raised. Member-checking was used

to clarify that the interviewee's intended meaning was accurately understood by the researcher. Interviews were conducted by a student researcher who had received training from and was supervised closely by a trained qualitative researcher.

Data Analysis

Interview recordings were de-identified, transcribed verbatim and coded into the NVIVO-12 qualitative analysis software in two rounds (35). Inductive analysis was employed, with codes categorized based on similar characteristics (36, 37). Information that did not align with the study's research questions were removed, and categories were compared and contrasted to identify major themes (37, 38). Pseudonyms have been used.

Findings

The reasons for CS of the 33 women who participated in this study included single (n=13) or multiple previous CS (n=8), breech presentation (n=6), placenta praevia (n=1), amniotic band obstruction (n=1), previous birth complications (n=3), and maternal request due to birth anxiety (n=1). Amongst women who had a previous CS, a past negative birthing experience was frequently cited as a reason for why they chose planned CS, rather than attempted vaginal birth (VB), in their most recent pregnancy (n=7). Four main themes, with associated subthemes, (Table-1) were identified: women's overall experiences of CS care, women's experiences of intrapartum CS care, women's experiences with post-operative and post-discharge recovery, and women's suggestions for improvement.

Women's Overall Experiences of CS Care

Overall, while women reported mixed to positive experiences of care, some women reported "managing their expectations" given "it's the public system". Several women commented that the public hospital system's service quality was sub-par to the private system (n=6), but they had come to accept this. As was voiced by one woman:

> *"Look it's the public system, it's very in and out do you know what I mean? So, all the nurses are very nice, it's not the five star treatment but that's a public hospital thing and you expect that so..."* (Leslie, Repeat CS)

Women related this to factors such as the inadequate resources and staffing (n=3) and lack of continuity of care. With the former, women felt that maternity wards did not have enough midwives to care for women, and recalled having to wait long periods of time to undergo their CS due to the lack of operating staff or available theatres:

> *"It was so frustrating, and they kept saying "Oh we can't do that because the theatre has people in it"* (Joanne, Requested Repeat CS)

Specific continuity of care concerns related to women not being able to consult with or even know the doctor performing the CS beforehand (n=4). Women who by chance had met the doctor prior to their caesarean (n=4) said that it translated into a more positive birthing experience:

> *"One thing that was really good was that the doctor that I consulted with the week before was the obstetrician that did the caesarean section and I quite liked, I was quite happy with that, I was glad that I got to have a conversation with her before the actual day."* (Charlotte, Requested Repeat CS)

Women's Experiences with Intrapartum CS Care

In terms of intrapartum care, experiences were mixed, although more often positive than negative.

Positive Experiences

Women who had positive experiences appreciated how relaxed (n=4) and prepared (n=6) they felt, how the experience was quick (n=6) and how they were able to be an active participant in the birth (n=2) by regularly engaging with the medical staff in the room (n=26):

> *"They were keeping me informed, they were telling [husband's name] what was happening, they were just so attentive and distracting me from the pain they were amazing. […] so it was a lot smoother and we were a little bit more involved I think this time rather than last time, which was a lot tougher" (*Nadine, Repeat CS)

> *"I think being reassured the whole time that everything is okay […] sometimes you're just wondering "is everything okay?" and I asked them "is everything okay?" and they said "yeah, yeah of course everything's perfectly fine" so for me it was important to be talked through and telling me that I was fine and my baby was fine.* (Rose, Requested Repeat CS)

Women frequently compared their recent planned CS to the rushed, unpredictable nature of their previous emergency CS (n=12), and how the planned CS felt much more controlled (n=7), and thus more positive:

> *"I had a really bad experience with the first one, because it was rushed and everything and this second Caesar kind of removed all the bad memories that I had so yeah everything was more controlled so I felt much better."* (Charlotte, Requested Repeat CS)

"Oh my god it was heaven! (laughs). I expected my baby to come that day and I got my baby that day. It was wonderful! There was no complications, there was no "oh my god is my baby going to be okay" […] Going into the surgery itself, it was at a slow relaxed pace, whereas emergency they couldn't get me in there quick enough, […] it was very rushed and very scary" (Nadine, Repeat CS)

Negative Experiences

Women who had negative experiences described their CS as scary. Women voiced how it was scary to have a major surgical experience (n=4), and since it was planned, they were hyper-aware of what was going on. Several women compared the planned CS to a previous VB experience, and voiced that it felt more like a medical procedure (n=5), rather than giving birth:

*"It was definitely different from the vaginal delivery, far more clinical and precise and orderly" (*Andrea, Requested CS + Previous Traumatic birth)

"It's just like you're going in for the operation and you're waiting for your name to be called in, you get into your dressing gown and off you go. It's actually really strange compared to actually experiencing the contractions and waiting for the baby to come and when are my waters going to break" (Hannah, Previous CS)

Women also felt scared when their baby had to be taken away soon after giving birth to be checked (n=2) and appreciated when their partner could accompany the baby (n=2), and when the baby was brought back quickly (n=1).

Some women experienced complications during the birth (n=5). These women reported feeling distressed when unexpected events occurred during the birth in relation to pain (n=3) and

anaesthetic reactions (n=6). The likelihood of these were not communicated beforehand and left a negative impression on the CS experience:

> *"The one thing that did shock me was the amount of pain that I had […] I was in so much pain and discomfort" (*Natalie, Repeat CS)

> *"I'd say the worst thing about it actually was the anaesthesia […] it made me feel sick and nauseous, and they had to keep doing corrections and stuff"* (Alice, Medically-Indicated Breech)

Women's Experiences with Post-operative and Post-discharge Recovery

Women's experiences of recovery were also mixed, although more often negative than positive.

Positive Experiences

Some women valued being able to bond with their baby in the recovery room (n=3) and voiced that the recovery was actually easier than expected (n=2). One woman was particularly appreciative of the support she received from the hospital after she went home:

> *"I get frequent calls to ask how I am doing, how is my breastfeeding going on, how is my baby. […] I felt supported by the midwives and doctors and everyone. Even yesterday I got a call that I haven't gone for my 6 weeks diabetes check-up and I got a call asking why I haven't come. […] somebody's actually looking after you and you know you have people who care for you"* (Gayathri, Requested Repeat CS)

Negative Experiences

In terms of negative experiences, several women found that the recovery period to be longer and more painful (n=6) than they were told it would be:

> *"Everybody talks about, all the doctors, midwives, online other mothers, talk about the magic six weeks of recovery. "Once you get to six weeks you're fine!". And I definitely did not find that to be the case […]"* (Jenny, Multiple Previous CS + Trauma)

Women particularly disliked how the recovery period restricted them from assuming their role as a mother (n=3). They disliked being constantly dependant on the nursing staff, and for one woman this was particularly distressing:

> *"I found it really frustrating that when I couldn't get up to my baby I was forced to constantly press the nurses button for simple things like changing her nappy or if she was crying […] it puts a lot of emotional strain of the mother when you can hear your baby cry and you haven't prepared yourself for […] not being able to look after your baby"* (Susan, Repeat CS)

Women also felt they needed significantly more time (n=4) and support (n=4) during recovery. Women reported feeling "shuffled" out of hospital, and one women emphasised how one extra day in hospital during her most recent birth made a huge difference to her. Women attributed the lack of support to inadequate staffing, and additionally felt hospital staff were rude and unwilling to provide support to recovering mothers. One mother was really frustrated by this, because she would rather care for her baby herself but was only asking for help because she truly needed it:

> *"They have very limited staff and they tell us whenever I need them, […] they say "look you are not the only patient, there are other patients […] if a mother is like me, she would never ever like to give her baby to anyone else unless it is pretty much needed…so I needed help and I wasn't provided."* (Zobia, Previous Traumatic Vaginal Birth)

Women also felt that there was miscommunication during shift changes, leading to incorrect care (n=1), and inadequate breastfeeding support (n=2), with one women stating that the staff constantly promoted bottle-feeding instead of teaching her to breastfeed:

> *"it didn't seem like they had any support in the breastfeeding? It was more like forced with the bottle, bottle, bottle? […] he's not latching but I'm trying to and they just seemed like they didn't want to help at all"* (Monica, Multiple Previous CS)

Impact of Women's CS Experience on Future Decision-Making

Overall, women who had negative experiences felt that when comparing it to women with VB who had easier recoveries, they would still prefer to have a VB in the future (n=5):

> *"I've never had a natural so I don't know what that feels like…but um…my sisters had one and….to see her to be able to get up straight away, whereas I couldn't get up the next day and it felt all funny and weird getting up […] yeah no I definitely wouldn't recommend them."* (Halima, Multiple Previous CS)

In contrast, women who had positive experiences felt that, upon reflection, it changed their pre-CS perceptions of this MOB for the better, and inclined them towards wanting a CS again in the future (n=11):

> *"I had a very positive experience with the caesarean section. And although it was painful after I think I would probably just go again with the c-section if I had an option with the next child."* (Corrine, Breech presentation)

> *"Looking back I don't know why I was so scared. Because actually it made giving birth the easiest thing in the world" (*Rachel, Placenta Praevia)

Women's Suggestions for Improvement

Overall, women voiced multiple areas of improvement based on their own care and recovery experiences during their CS. The three major suggestions surrounded women's need for continuity of care (n=9), antenatal information about the intrapartum and recovery experiences (n=24), and more support during recovery (n=6).

Firstly, women appreciated the ability to have a sense of continuity and familiarity with their healthcare team during the CS. Although women recognised that having the same clinician follow them throughout pregnancy and being present during birth may be unfeasible in the public system (n=4), they communicated the need for at least meeting the operating clinician prior to their CS (n=4), in order to make them feel more comfortable and engaged with staff during the birth.

Secondly, women believed that they could be provided with more information antenatally to better prepare themselves for the CS and its recovery. Some women noted that they experienced complications or pain during their CS, the likelihood and severity of which was not sufficiently explained antenatally (n=10). This concerned women because the lack of preparation resulted in women being frightened when such events unexpectedly occurred during their CS. Women similarly felt that the reality of the recovery period, in terms of its length and the associated pain, was not adequately explained antenatally, and would have appreciated more information surrounding these topics to prepare them (n=10).

Finally, women voiced that their need for more support from midwives and other healthcare staff during recovery (n=6). They ideally wanted more staff to care for recovering women, as many struggled to assume the role of a mother postnatally, especially since they were simultaneously

recovering from major surgery. Women believed that incorporating these suggestions into future practice may help improve the planned CS experience for expectant mothers.

Discussion

This study provides insight into women's experiences with planned CS in eight Sydney public hospitals, including their overall care, intrapartum care experiences, and recovery. Experiences with CS care were mixed: women reported mostly positive experiences of the intrapartum component of care, however many were not satisfied with their post-operative and post-discharge recovery care.

Overall, women more often had positive experiences of the intrapartum care during their planned CS. Several women in this study compared their planned experience to their previous rushed and scary emergency CS if they had had one, stating that the former felt more controlled, which they appreciated. This finding is consistent with worldwide studies in which women expressed a greater satisfaction with their planned CS compared to previous emergency CS experiences (12, 20, 23, 28-30). Specifically, women in an Irish study appreciated the information they received in preparation for their CS experience and the debriefing they received post-partum (39). Such preparation could contribute to the appreciation that women appeared to have towards the sense of control they experienced during a planned CS compared to an emergency CS.

Many women raised concerns regarding the lack of continuity of care that they experienced both in the lead-up to and during their CS. Women disliked the fact that often they did not know or had not even spoken to the clinician conducting their CS. Women who coincidentally had the same clinician they had met previously voiced their appreciation for this. Few studies have discussed continuity of care in the context of planned CS, however a Swedish survey study (40), that included women who underwent planned CS amongst other MOBs, found that having a known midwife during birth positively impacted birth experiences, particularly surrounding fear and labour pain. New South

Wales Health "Towards Normal Birth" guideline recognises the importance of implementing continuity of care programs (41), with a Dutch survey study even finding a moderate, yet non-significant, correlation between experienced continuity and experienced quality of care (42). Ensuring women meet with the clinician performing their CS prior to going up to the operating theatre, or have a known member of staff present, may help alleviate feelings of detachment that women feel towards staff during the CS, and thus improve women's experiences with CS.

Several women voiced negative experiences of recovery, particularly regarding the lack of support received during this period and its unexpected length. Women elaborated that recovery's expected difficult aspects, such as pain, were aggravated by what they perceived as the rudeness and unwillingness of midwives to provide support. Similar concerns have been voiced by women in other studies (14, 20, 23). In this study, this extended to the lack of breastfeeding support. Several studies have documented reduced rates of post-CS breastfeeding initiation compared to other MOBs (43-45). This worried women during decision-making and their negative support-related experiences confirmed these concerns.

Women in this study were frustrated by their dependence on clinicians during recovery, and how they were limited in their maternal role even once they returned home. These concerns were similarly voiced by post-partum women in Australian and English, who commented on how the recovery period involved pain and mobility issues that restricted their ability to assume caregiving responsibilities (46-48). Furthermore, women studied by Weckesser et al (2019) specified that they often sought reassurance and support from staff regarding post-operative complications, as they felt insufficiently informed prior (46). For women requesting extended hospital stays to utilise the available support, effective promotion of midwifery discharge support programs may help provide continued guidance for postpartum women during the transition from hospital to home (49). Improving recovery-related support and educating women on caring for and breastfeeding their baby may also help alleviate the specific anxiety that women have towards CS recovery.

In order to address women's need for more information to better prepare them for the intrapartum events of a CS and its recovery, a process of shared decision-making should be implemented during pregnancy. Shared Decision-Making (SDM) is a process in which women are provided with the best available evidence-based information in order to make an informed decision that is line with their own beliefs and preferences (50), and has been shown to improve patient satisfaction, health literacy engagement and decision self-efficacy (51). SDM is in line with best-practice guidelines that emphasise the importance of acknowledging women's preferences and providing sufficient evidence-based information when providing woman centred-care (52). By ensuring women are engaged in SDM antenatally, clinicians can address both the concerns women may have in regard to their CS experiences, and also their knowledge gaps in relation to issues such as postnatal recovery. By preparing women through ensuring they are informed about their upcoming CS, women may feel more aware of surrounding events and thus feel more in control during birth, which may leader to greater satisfaction and more positive experiences with their CS.

Strengths and Limitations

This study's main limitation is the disproportionate participant numbers across hospitals. The majority of interviewed women were seen at a single hospital, meaning applicability across all eight hospitals is limited. Recruitment was restricted by the fact that some hospitals did not have dedicated CS booking clinics and clinicians had to remember to give women surveys at the time of CS booking, with women then having to remember to return surveys personally or through the post. However, our findings have common themes with the limited other studies in this area, suggesting many findings, particularly those around post-CS support and recovery, can be applied more broadly. This study's strengths include the interview's adaptive semi-structured nature. This allowed adoption of an explorative approach to identify the various reasons behind women's beliefs, how their experiences shaped their perceptions, and any broad opportunities for improvement based what

was important to them, which collectively may be communicated to hospitals to increase standard of care.

Conclusion

Women largely had positive intrapartum experiences of planned CS, in which they felt engaged with their medical staff and thus the birth events. Conversely, women reported relatively negative experiences of recovery, for which they felt they received limited support and were not adequately prepared. Women attributed negative experiences to the lack of information provided antenatally, that could have better prepared them to care for themselves and their baby postnatally. By incorporating a process of shared decision-making antenatally, clinicians can ensure that women are provided with sufficient information to prepare them for their planned CS and its recovery, thus improving planned CS experiences.

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Table 1: Table of Themes and Subthemes

Themes	Subthemes
Women's overall experiences of CS care	Impact of women's CS experience on future decision-making
Women's experiences of intrapartum CS Care	Positive Experiences a. Felt relaxed b. Felt prepared c. A quick experience d. Was an active participant during birth e. Felt engaged with staff f. Better than their previous emergency CS Negative Experiences a. Scary as a surgical procedure b. Felt more like a medical procedure than a birthing experience c. Scary that their baby was taken away quickly post-birth d. Experienced complications e. Experienced pain f. Experienced anaesthetic reactions

Women's experiences with post-operative and post-discharge recovery	Positive Experiences a. Able to bond with baby b. Recovery was easier than expected c. Received support during the home-to-hospital transition Negative Experiences a. Recovery was longer and more painful than expected b. Recovery restricted women from assuming an independent maternal role c. Needed more time and support d. Need more breastfeeding support e. Recognised a lack of communication between staff
Women's suggestions for improvement	a. Need for care continuity b. Need for more antenatal information c. Need for more support during recovery