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The Exploration of Elective Caesarean Sections as a Choice Around Childbirth

Maura Lappeman

AGRMAU001

A minor dissertation submitted in partial fulfilment of the requirements for the award of the degree of MA Clinical Psychology

Supervisor: Sally Swartz

Faculty of the Humanities

University of Cape Town

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: _____

Date: _____

University of Cape Town

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Dedication

This dissertation is dedicated to my mother, Isabel Aguirre. My desire is that I can be a mother to my children as she was a mother to me.

Abstract

A growing number of women in the private health sector are choosing to have elective caesareans in South Africa. This dissertation explores the motivations influencing women who choose an elective caesarean section (CS) for non-health reasons. Qualitative research describing factors influencing pregnant women's decisions in South Africa is limited and inconclusive (Chadwick, 2007). Thus, most of the literature that was examined was internationally based. The literature review highlights how technology has given us more options and better care when it comes to pregnancy and childbirth. With the medicalisation of childbirth, however, obstetricians have more power and control in a woman's life and therefore might directly influence the choices she makes.

This study considered 10 South African women's narratives of their decision-making process in deciding to have an elective CS. On average, it had been approximately 2 years from the time when the women had the elective caesarean section. As the aim of the study was to hear how the women positioned themselves in their stories, the researcher's interventions were limited to a minimum through semi-structured interviews. The data was transcribed and the use of narrative analysis was employed to evaluate the data.

This dissertation interrogated the word 'elective' in the context of a medicalised childbirth. The narrative structure highlighted how the obstetrician was a crucial decision maker for the women by either the language they used which conjured up images of fear or by simply portraying the elective CS as a rescuer for the pregnant women from her own 'unruly' body. All the women had chosen to place their trust in their obstetrician and the medical technology involved in

childbirth. The choice of how they would deliver was handed over to the doctor from their first appointment.

Elective CS are becoming an accepted cultural norm within the private health sector in South Africa. Women ultimately choosing CS see their bodies as a vessel for a healthy baby and that how the baby enters the world is less significant. Through the exploration, these 10 women's doctors emphasized vaginal birth's complications and underplayed its benefits. On the other hand, the best elements of CS are communicated and advocated and the worst underemphasised. Elective CS rate will continue to increase as long as women see it as their obstetrician's choice in having a healthy baby.

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND

Women want equal rights, equal pay and equal opportunity. Although we have witnessed increasing gender equality a woman's physiology reminds her every month how different she is to men. The male and female bodies morph very differently from puberty with the male becoming more lean, muscular and stronger and the female body getting itself ready to sustain another life.

“The experience of childbirth is a complex series of events which take place over an extended period of time. It rarely simply spans the nine months of gestation, but is the product of a lifetime of learning, planning and social influence. The nine months may be experienced as an eternity or an instant. The culmination of pregnancy- the birth of a baby- has consequences for the individual for the rest of an individual's life.” (Sherr, 1995, p.1).

Women have been delivering babies since the beginning of human existence but in the beginning of the 20th century birth was medicalised and physicians started to deliver babies (Williams, 1997). Women no longer needed to stay at home to deliver but could go to a hospital and be surrounded by medical professionals ‘just in case something went wrong’. Women were given more choice about how to deliver their child with the development of different medical interventions, including induction and pain relief such as an epidural or a caesarean section delivery (CS).

Choice does not necessarily make life less complicated. With more options comes an increased realization that you could make the wrong choice, and this awareness can produce anxiety: “What

we think and the connections made between ideas, everything we anticipate, what we hope for and fear- these are part of our birth culture.” (Kitzinger, 2005, p.1).

1.2 RATIONALE FOR CURRENT STUDY

Each year increasing numbers of women around the world have a CS. In April 1985, the World Health Organisation (WHO) stated that no region in the world should have a caesarean rate greater than 10 to 15% (WHO, 1985). According to our national health statistics most up-to-date statistics (Rothberg & McLeod, 2005), South Africa has very high caesarean section rates in the private sector (61.9%). Some private hospitals have a 90% CS rate. In a popular South African pregnancy magazine (Dumbrill, 2008), they state that figures show one in three women have a CS. (The source of this data is unclear.) The Western Cape is the province with the highest rate of CS (23%), which includes both private and public sectors. Although these figures are not divided into emergency versus elective CS, one of the main reasons for such high figures of CS is that women are given a choice by both their doctors and medical aid schemes to deliver how they wish. Any study done in South Africa must however take into account the socio-economic legacy of Apartheid and that choice of an elective CS is only given to those who can afford it with private medical aid and where resources are available.

This dissertation will explore the motivations influencing women who choose an elective CS. For the purpose of this dissertation, an elective CS is when a caesarean delivery is performed for non-health reasons.

This study will hopefully contribute to furthering the understanding of women's choices in childbirth and to assist South African women in receiving accurate and unbiased information about the planned mode of delivery for the baby so that they can make an informed

choice. Several international studies have found that increased anxiety strongly influences women's birth choices –especially the choice of having an elective CS (McCourt et al., 2007). This finding is particularly relevant for research within the field of psychology. The aim of this study is to give counsellors, nurses, health professionals and psychologists in South Africa a deeper insight into why women have made the choice to have an elective CS and to suggest how to support them in bonding with their new child.

Chapter 1 outlines the significance of this study, which includes a rationale for studying why women are choosing to have elective CS. Chapter 2 reviews the literature currently available on this topic. Chapter 3 describes the methodology employed in the research process. The analysis of the data is outlined in chapter 4. Chapter 5 is a discussion of the results. The final chapter provides a summary of the results as well as recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The following review of literature seeks to inform the current study by first exploring briefly the history of medicalised childbirth over the centuries as a background to the current South African hospital interventions in childbirth. The literature review also looks at elective CS as a birthing option. A feminist viewpoint is taken into account as well as several popular literature articles that focus on why women are choosing elective CS.

2.2 DEFINING TERMS AND PARAMETERS

The term Caesarean Section (CS) means the delivery of the foetus, placenta and membranes through a surgical incision in the abdominal and uterine wall (Ainbinder, 2003). It is a major surgical operation and is usually performed awake under regional anaesthesia (Keogh, 2005). An elective CS is a CS that is performed before the onset of labour or before any complications which would make it necessary to have an emergency CS. Previously a CS would be performed in cases where a vaginal delivery was either not viable or would cause more injury or harm to the mother or baby than vaginal delivery. There are times when a CS must be performed such as cephalopelvic disproportion, which is when the head of the foetus is too large to come through the vagina, or placenta previa, where the birth canal is blocked by the placenta (Ainbinder, 2003). An elective CS is when a caesarean delivery is performed for non-health reasons.

2.3 A BRIEF HISTORY OF MEDICALISED CHILDBIRTH

Historically birth happened at home with female relatives or neighbours assisting with the delivery. The skills to perform such a delivery were passed down from generation to generation

(Williams, 1997). Men stood on the side lines as the women instinctively did what they needed to do for a safe delivery (Kitzinger, 2005). In ancient mythology, the goddesses were said to stand by at the delivery of a child. As early as 3000 BC, Egyptian drawings show women helping women deliver (Cronjé, 2000). Female midwives are also mentioned in the Old Testament of the bible. During these times many women and babies died for various reasons including poor nutrition and living conditions weakened the female body making it susceptible to disease in childbirth. Without a very experienced midwife, a natural occurrence in childbirth, such as an umbilical cord wrapped around a baby's neck, might suffocate a baby in labour. Fatal circumstances for mother and child such as when the placenta formed over the cervix (Placenta Previa) meant almost certain death for both (Nelson, 1996).

Without the benefit of what we know through technology and medicine today, childbirth carried inevitable risks.

Male midwives emerged in the 16th century and with them came surgical intervention (Williams, 1997). They were called in for difficult deliveries as a last resort (Wilson, 1995). In the 18th century formal instruction for the delivery of babies was given to both men and women, however men, purely because of their gender, were placed in a position of power over the women and the profession of obstetrics was born (Williams, 1997).

The development of anaesthesia in the 19th century led the way for women to have surgical births (Drife, 2002). The term "Caesarean" is often said to be because Julius Caesar was delivered by a CS (which is unlikely)(Wilson, 1995). The term caesarean probably comes from the Latin word of *caedere* which means to cut. The Roman Law of Lex Caesare stated that if a woman died late in her pregnancy that her baby should be cut out of her and, if dead, buried

separately (Drife, 2002). The first CS of modern times when the woman survived was done by Mary Donally, a female midwife, in 1738. It was performed without anaesthesia (Drife, 2002). Before the 1800 CS were merely actions of desperation to save the infant of a dying mother (Shorter, 1982). The first CS performed in South Africa was on the 25 July 1826 in Cape Town by Dr James Barry. The baby delivered, James Barry Munnik, later became the grandfather of the late Prime Minister James Barry Munnik Hertzog (Cronjé, 2000).

Before 1900 only the poor and unwed mothers gave birth in hospitals (Shorter, 1982). But by 1920 hospital births were the norm in every Western country except the Netherlands and then, by 1976, even in the Netherlands two out of three women were giving birth in hospitals (Shorter, 1982). The main factor why hospital births became popular was that it was perceived as an environment for a safer delivery (Shorter, 1982). Even by the 1920s the most effective way to avoid death of either the mother or child was caesarean section which could only occur in a hospital.

The 20th Century brought with it the monitoring of mother and foetus throughout the pregnancy in order to improve the well-being of the new born (Williams, 1997). This monitoring allowed obstetricians more power and control in a woman's life and therefore directly influenced the choices she would make.

Pregnancy then became a science. Pregnancies are compared to other pregnancies in order to ensure that they fall into the 'normal standards' of what a pregnancy should be like. Every woman is no longer unique, but needs to conform to standardised charts (Williams, 1997). Doctors rely heavily on machines to read, diagnose and regulate the pregnancy (Kitzinger, 2005). All this monitoring meant that childbirth needed to move into hospitals (Walsh, 2004).

Instrumental delivery, such as the forceps and the vacuum extractor, also was ushered in with the 20th Century (Drife, 2002). These instruments were used to make delivery for the mother easier by giving the doctor the ability to grip the baby's head to help the mother in the delivery. A number of injuries to both mother and child can result with the use of these instruments and so today the trend is to steer away from using forceps (Ainbinder, 2003).

Being able to observe the foetus in the uterus has revolutionised modern pregnancy. Ultrasound has become a routine part of care for pregnant women in most countries with developed health services. It is one of a range of techniques used in screening and diagnosis (Garcia et al, 2002). For more than 30 years ultrasound has been applied for the evaluation of pregnancies. The main foci have been foetal well-being and the development and screening of foetal abnormalities. As equipment is improving, and as experience is growing, increasingly precise diagnoses are obtained (Avni et al, 2007).

In recent years, technology has allowed the mystery of what happens in a woman's uterus to be observed in a very detailed manner. For example, 2D and 4D ultrasound scans are used to provide accurate measurements of the foetus.

Ultrasound was initially developed as a submarine detection method in World War I. In the mid-1950s, Ian Donald adapted the sonar device to scan for abdominal tumours, many of which turned out to be pregnancies. By 1965 foetal biparietal diameter and blighted ova were being detected by the technique. By 1968 this had become a routine method for estimating foetal growth and maturity in many hospitals (Oakley, 1986).

Since then the technology has rapidly improved. This has many advantages in early problem detection but has also continued to provide power to medical practitioners by increasing how

dependent the woman is on the interpretation of the person doing the scan (Oakley, 1986). It is a further way of reducing the importance of women's own knowledge about their bodies in favour of “objective” measurements (Oakley, 1986).

The improvements in these observations and others like amniocentesis, which is the removal and testing of amniotic fluid, have greatly benefitted the medicine of pregnancy and childbirth but has also, had social side effects relating to choice, as will be discussed in this thesis.

2.4 THE BENEFITS OF MEDICALISING CHILDBIRTH

More can be known about pregnancy and childbirth with technology. With knowledge about childbirth, the maternal death rate has dropped considerably. At the start of the 19th Century, 1 in 200 pregnancies led to the death of the mother whereas now in the Western world where childbirth has been medicalised, the maternal mortality rate is 1 in 10000 (Drife, 2002). The three main reasons for maternal mortality previously were puerperal fever, toxæmia and obstetric haemorrhage (Loudon, 1992). All these have almost been eradicated through antiseptics, antibiotics and blood transfusions. Antenatal care and blood pressure monitoring have also helped significantly to preserve both the mother and baby's life. All these interventions were due to the progression of the medical field. From historical documents, it is noted that people feared childbirth as there was an anticipation of the labouring woman dying or being permanently injured through the labour (Leavitt, 1986). Both men and women embraced a medicalised model that would mean safer births.

“Antenatal care is total, comprehensive surveillance of mother and fetus, with the main-if not only- objective, a pregnancy that will culminate in the birth of a normal infant and a happy, healthy mother.” (Nel, 2000, p.78). The medicalisation of childbirth was created to assist in the

delivery of a healthy baby. Due to an improvement in technology especially in the last 20 years, any abnormalities of the foetus can now be seen or complications in a pregnancy can be noted very early on (Sherr, 1995).

Hearing the foetal heartbeat and receiving numerous ultrasound photos are effective in helping the parents(both mother and father) bond with their unborn child (Kukla, 2005).

2.5 TRUST IN MEDICAL PRACTITIONERS AS THE EXPERTS

Medical doctors are highly regarded by their communities (Sherr, 1995). Most women who are advised by their obstetrician that a CS is best, will follow the medical advice (Kitzinger, 2005). This is due to the fact that in viewing the doctor as the expert, adhering to their advice or recommendation is seen as logical; and the only logical explanation for 'medical disobedience' is that the patient is irrational (Jackson, 2006). If not irrational, the only reason someone would go against doctors' recommendations is that it is unintentional and because of a lack of patient knowledge and understanding (Playle & Keely, 1998).

According to Foucault (1978), power manifests in "the instruments, techniques and procedures employed in the attempt to influence the actions of others" (Hindess, 1996, p. 141). Foucault notes that the more knowledge one has the greater the increase in power one has to shape other people's lives (Foucault, 1980). The power of the medical doctor in the medical setting is established because their knowledge is seen as credible and legitimate (Playle & Keely, 1998) and therefore it is difficult to question or challenge. "Medical language affects not only the care we receive but also how we think about and experience our bodies" (Kitzinger, 2005, p. 57).

Many women would surrender all their power and/or choice in order to have a 'live birth' (Sherr, 1995). It has been found that obstetricians increasingly advise surgical interventions to circumvent potential problems (Kitzinger, 2005) and women seem to go along with their recommendations. This deference to the doctor without questioning reinforces the doctor's power (Sherr, 1995). Increasing numbers of women having CS believe that medical discourses support and reinforce their decision as a 'safe' and 'responsible' choice (Fenwick et al, 2010).

2.6 CURRENT SOUTH AFRICAN HOSPITAL INTERVENTION IN CHILDBIRTH

In the South Africa context, it is understood that most women with or without medical aid will give birth in a hospital. Of course, as stated earlier, those with medical aid will be given far more choice in what their birthing plan will be. Having a hospital birth comes with certain standardised hospital procedures. Some of these may benefit some women while others may not. Every intervention comes with benefits, but also potential risks (Archie & Biswas, 2003). Although all these procedures are distinctive and possibly avoided, they are also interlinked as one acts as a precursor for another.

2.6.1 The preparation procedures

A preliminary patient history is taken after a pregnant woman arrives in the maternity ward, followed by an abdominal examination, and then a vaginal examination to see how far along in the birthing process she is (Schoon, 2000). Labour has been divided into three stages: The first stage is the interval between the onsets of contractions until the cervix is dilated (usually between 6-18 hours). The second stage is the interval between when the cervix is dilated and the delivery of the baby (usually between 30 minutes to 3 hours). The third stage is the delivery of the placenta (0 to 30 minutes) (Archie & Biswas, 2003). Blood pressure is recorded and urine

examined. Until recently, enemas were also given to clear the mother's bowel, which was thought to help in giving more room for the baby's head to descend into the birth canal (Nelson, 1996). A routine shaving of a woman's pubic hair is usually done for women undergoing a surgical birth.

2.6.2 Monitoring the baby's heart beat

Foetal heart rate monitoring is routine in hospitals. External electronic monitors are strapped around the mothers' body to monitor the strength of the mother's contractions and the baby's heart beat especially during the contractions (Nelson, 1996). This intensive monitoring gives a continuous flow of information to the doctors; however, the straps are uncomfortable for the mother and constantly need to be adjusted when mother or baby moves. This procedure then leads to confining the labouring woman to a bed as a woman cannot walk around with a monitor strapped to her.

2.6.3 Induction of labour

Induction is the initiation of labour prior to the natural onset of labour by medical and/or surgical means for the purpose of delivering the baby through the vagina (Grobler, 2000). It is associated with an increased likelihood of forceps delivery and caesarean section.

Medical induction is when two prostaglandins are given to the mother to prepare the cervix for dilation. Afterwards the mother is given oxytocin to increase uterine contractions (Grobler, 2000). Surgical induction is the stripping or rupturing of the membranes which can help trigger the hormones which initiate labour (Grobler, 2000). This procedure can cause a mother distress and discomfort which can turn a normal delivery into a surgical one (Archie & Biswas, 2003).

An induced labour can also cause stress to a foetus that is not fully matured possibly leading to array of health risks like underdeveloped lungs (Archie & Biswas, 2003).

2.6.4 Medication for pain

There are two main options for pain relief: analgesic medicines which relieve pain without total loss of sensation, and anaesthesia which involves the total loss of sensation such as an epidural or spinal block. Many women are anxious and apprehensive at the onset of labour so ask for pain relief. Pain relief can relax the mother but also slow down labour and produce a drowsy newborn (Yarnell & McDonald, 2003).

2.6.5 The episiotomy

During labour, it is common that the mother will tear her perineal body as the baby passes through. An episiotomy is a surgical incision in the vaginal wall prior to the delivery in order to enlarge the soft tissue outlet of the birth canal which reduces foetal and maternal injuries and shortens labour (Wessels, 2000).

2.6.6 Instrumental vaginal delivery

Forceps and vacuum extraction deliveries are usually the most common obstetric interventions (Cronje, 2000). These instruments were used to make delivery for the mother easier by giving the doctor the ability to grip the baby's head to help the mother in the delivery. A number of injuries to both mother and child can result with the use of these instruments and so today the trend is to steer away from using forceps (Ainbinder, 2003).

2.7 ELECTIVE CS AS A BIRTHING OPTION

It is reasonable to assume that every woman hopes to have a positive childbirth experience. The main factor that concerns most prospective mothers is the thought of the pain associated with the delivery of the foetus (Saisto & Halmesmaki, 2003). Public opinion is that the elective CS is an 'easier option' with respect to the overall pain experience (Keogh et al, 2005). This reason alone has contributed significantly to the rise in elective CS (Saisto & Halmesmaki, 2003). It has also been established that elective CS offer no health benefits to either mother or child, but instead elective CS has higher risks, both physically and emotionally, compared to a normal vaginal delivery (McFarlin, 2004).

Elective CS is a new phenomenon and little research has been done on the subject as in many first world countries, including America, England and New Zealand, women are not given the choice of delivery for their first child and a CS is only given in an emergency. Research into why women are electing CS is limited.

In March 2007 a team of researchers (McCourt et al, 2007) published a critical review of the literature on elective CS and decision-making. What these researchers found is that "few studies directly addressed women's own perception of their role in decision making" (McCourt et al, 2007). Since their critical review of the literature from 2005, numerous opinion articles on elective CS have appeared, especially on the internet and in women's magazines. In spite of this, very few research articles on what motivates a woman to request an elective CS have been published. An Australian study reported that women electing CS view themselves solely as a vessel to carry the baby; for them birth becomes about the baby and not the woman. This results in a disconnection between the self and body and therefore places control outside the self

(Fenwick et al, 2010). Currently the only South African research on this topic was published in 2007 by Rachele Chadwick in which she explores and compares birth stories of women who had homebirths versus women who had elective CS.

2.8 ADVANTAGES AND DISADVANTAGES OF A CS

The main advantage of a CS is a decrease in complications of delivery, such as birth injuries to mother and baby. The significant benefits to the mother are that it may reduce urinary and fecal incontinence, which are common postpartum problems (Hannah, 2004). Other psychological advantages for the mother are avoidance of labour pains, alleviation of fear and anxieties of an unknown labour that could occur at any time, and reduced worry about the health of the baby (Hannah, 2004). Advantages for the baby are reduced unexplained stillborns or complications of labour such as clinical chorioamnionitis, fetal heart rate abnormalities, and cord prolapse (Hannah, 2004).

The main disadvantage is that maternal morbidity and mortality is four times higher than with a vaginal delivery. Other risks for the mother are pelvic infections, side effects of the anaesthesia, surgical complications, haemorrhage and uterine rupture (Cronjé, 2000). The psychological impact of surgery may also be seen as a risk (Kitzinger, 2005). There are few, if any, disadvantages for the foetus (Cronjé, 2000).

Another issue to consider is that a vaginal birth that results in an emergency CS carries higher risks for the mother than if the mother opted for an elective CS (Hannah, 2004).

In the few studies published on mother to child bonding after a CS, there seems to be evidence that a CS affects breastfeeding negatively initially (Cakmak & Kuguoglu, 2007) and infant care/

bonding initially (Karlstrom et al, 2007). The reasoning behind this that both these studies found is the pain factor after a major abdominal surgery. In the study by Karlstrom et al (2007), the researchers note that bonding with the infant is harder after a negative birth experience such as an emergency CS although there is relief that the baby is healthy. In an elective CS, the women are more mentally prepared and thus their birth experience maybe be seen in a positive light. This area of research needs more exploration.

2.9 A FEMINIST'S RESPONSE TO MEDICALISED CHILDBIRTH

Some feminists believe that the male led medicalisation of childbirth has had detrimental effects (Walsh, 2004). Almost every pioneer in the medicalisation history of childbirth has been male (Drife, 2002). Pregnant women have been seen as ill and in need of medical attention, instead of healthy women bringing forth new life. They argue that this medicalised way of viewing pregnant women has taught women that their natural instincts and inherited wisdom in delivering babies are flawed (Stewart, 2004). They want childbirth to be given back to the women. Some feminists look at how women are disadvantaged in society and they believe the medicalisation of childbirth is yet another way that women are disadvantaged as the power has been taken away from them (Stewart, 2004). Feminists claim that a medical choice cannot be meaningfully exercised unless women are made aware of the sexist underpinnings of the medical model of childbirth. Feminists also express concern about the effects of normalizing elective CS and making it a reasonable option available to pregnant women (Bergeron, 2007).

Starting in the 1960's, the natural childbirth movement began in response to the medicalisation of childbirth, with the aim of trying to give birth back to the woman (Kayne et al., 2001). Feminists support the philosophy of midwifery, which is based on acknowledging and

supporting natural processes, intervening only when necessary, and advocating for women and their families (Kitzinger, 2005).

Through being very vocal, the feminist movement has made significant contributions in ensuring more humane birthing practices in hospitals and serve as a monitor for increasing rates of intervention and CS in “First World” countries (Chadwick, 2007).

2.10 POPULAR LITERATURE

From the numerous opinion-based articles, the possible reasons why more women are electing a surgical birth are:

2.10.1 Fear of labour and delivery

Tocophobia is the unreasonable fear of natural childbirth. (Keogh et al, 2005). A woman’s psychological state is important in labour (Cronjé, 2000). A negative depressed or fearful attitude can lead to a slow progression of labour, which leads to a longer labour and more need for pain relief (Cronjé, 2000). This then leads to more anxiety, which hinders the progression of labour, which in turns gives more reason for an emergency CS. Most doctors would rather intervene before this downward spiral by suggesting a CS to an anxious and/or fearful patient (Cronjé, 2000).

2.10.2 Convenience and control

The elective CS has many advantages in the case of working women with limited time off for maternity leave. It allows the best utilization of maternity leave and finding adequate help from family and friends. Many women have the perception that it is the “easier choice with respect to the overall pain experience” (Keogh et al, 2005, p. 167).

2.10.3 The baby's safety

The baby's safety is a primary concern (Kitzinger, 2005). Advantages for the baby are reduced unexplained stillborns or complications of labour such as clinical chorioamnionitis, fetal heart rate abnormalities and cord prolapsed (Hannah, 2004).

2.10.4 To avoid the risk of urinary incontinence

Urinary incontinence is defined as the involuntary loss of urine (Hannah, 2004; Tarnay & Bhatia, 2003). After a natural birth the female body experiences excessive trauma that will heal within six weeks of the birth, however, the pelvic floor muscles almost recover to their former self but not entirely (Cooreman, 2000). With this trauma, subsequent pregnancies and age, many women will experience urinary incontinence (Jong, 2008).

2.11 CHAPTER SUMMARY

The literature review served to inform the current study on elective CS by first providing some history on childbirth and how childbirth started out being a woman-dominated speciality but has now become a very much medicalised institution in need of doctors as gatekeepers. The review looked at the benefits of this progress in medicine and how society has benefitted, as well as exploring the trust that has subsequently been placed in the hands of medical practitioners.

It then looked at the birthing procedure in a South African context followed by a more focused exploration on elective CS as a birthing option, including its advantages and disadvantages. The review ended off with a look at the feminist response to the medicalisation of childbirth, which

has often been negative. Finally, some insights from popular literature were included to give more reasons why women elect to have CS.

University of Cape Town

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter first looks at the research aims and rationale for the research design. The sample, data collection and procedures are then explained. Following this, will be an explanation of how the research question is answered through employing narrative analysis. Ethical considerations are outlined. It is important to note my own feelings and experiences of doing the interviews with the woman. The chapter ends with a discussion that reflects on my experiences.

3.2 Research aims

This study will hopefully be contributing to further understanding women's choice in childbirth. The literature review highlighted the need for local South African based studies that address why women are choosing to have elective CS. As the current trend of increasing elective CS continues, the aim of this study is to arrive at a deeper insight into why women have made the choice.

3.3 Research design

In the pursuit of hearing each mother's story without too much prompting, the research design for this dissertation is a qualitative, exploratory, descriptive and contextual design. This research has adopted a narrative approach to understanding the participants' accounts. Narrative analysis looks at the ways people make sense of their lives by representing them in a story form (Henning, 2004). Narratives fall in the broader realm of social constructivism, which emphasizes the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding.

The research was contextualized to middle class women residing in the Cape Town area in the Western Cape. They were accessed through the private health care system.

3.4 Sample

The participants comprised of ten women who chose to have an Elective Caesarean section. Women were contacted who were apart of the Parenting Centre that holds support groups on Thursday morning for new mothers. Although the group advertises that pregnant women and any mother of a young child is welcome, the group generally consists of first time mothers aged anywhere between 20 years and 40 years old. It is held in the maternity waiting room of a private hospital in Claremont. The mothers are from middle to upper class families and the majority live in the Southern suburbs. Entry was gained as the researcher has been apart of this group as a first time mother. The mothers in the group were asked directly to participate in the study. This also included a snowballing technique where the young mothers were also asked to refer others they know for the study. Table 1.1 below gives a brief summary of each of the participants.

Table 1.1: Overview of the participants

*Name	DOB	*child	DOB	occupation	hospital	Place of residence	Race/Culture
Gail	17 August 1978 (31 years)	Thamaga	5 November 2007 (2 years 5 months)	Embryologist	Kingsbury	Claremont	<i>Black (Venda/Sotho)</i>
Amy	1 May 1980 (30 Years)	Adam	26 Jan 2009 (1 year 4 months)	Self employed	Kingsbury	Claremont	<i>English White</i>
Belinda	12 May 1981 (29 Years)	Gabrielle	31 July 2008 (1 year 10 months)	Teacher	Overseas	Edgemead	<i>South African Asian</i>
Shirley	25 July 1975 (34 years)	Imaan	5 Sept 2008 (1 year 9 months)	Student	Constantiaberg	Tokai	<i>Coloured (Muslim/Indian community)</i>
Nina	10 april 1971 (39 years)	Luke	19 June 2008 (Almost 2 years)	Homemaker	Constantiaberg	Constantia	<i>English White</i>
Lily	3 May 1974 (36 years)	Daniel	23 April 2007 (3 years)	Self employed	Vincent Pallotti	Plumstead	<i>English white</i>
Jessica	6 April 1970 (40 years)	Ruan	26 Sept 2008 (1 year 8 months)	Debtors Credit Controller	Constantiaberg	Plumstead	<i>English white</i>
Nadia	1 March 1976 (34 years)	Daniel	19 Feb 2008 (2 years 3 months)	Registered Nurse	Panarama	Stellenberg	<i>Afrikaans white</i>
Candice	14 August 1973 (36 years)	Jessica	5 March 2007 (3 years 2 months)	Office Administrator	Vincent Pallotti	Plumstead	<i>Coloured</i>
Camille	20 Jan 1972 (38 years)	Michael	18 Feb 2008 (2 years 3 months)	Pharmacist	Cape Town Medi-clinic	Claremont	<i>EnglishWhite</i>

*Pseudonyms are used to protect the confidentiality of the participants.

For the purpose of this dissertation, an elective Caesarean section is a caesarean delivery performed for non-health indications. On average, it had been 2 years and one month from when the women had the elective caesarean section.

Excluding women who previously had a caesarean section was considered as concerns about uterine rupture remain and many obstetricians are questioning whether or not a natural birth after a CS is safe (Flamm, 2001; Cahill et al, 2006; Socol, 2003). However, since it is still a contentious topic, a decision was made not to eliminate women who had a previous CS.

3.5 Data collection

The data collection took place over a period of two months. As the aim of the study was to hear how the women positioned themselves in their stories, the researcher's interventions were limited to a bare minimum. Through semi-structured interviews (see Appendix B for the interview schedule), flexibility was given to explore different topics that arose in the interview (Smith, Harre & Van Langenhove, 1995). The researcher was also able to clarify certain points about the participants' stories when necessary.

Some time was spent with each of the women before the interview, to obtain additional background information about them such as gender, age, race, profession, where they live and age of their child.

3.6 Procedures

An initial proposal was presented to the Ethics Committee of the Department of Psychology of the University of Cape Town before undertaking any interviews. Ethical approval was received.

One pilot study was conducted in order to test the relevance and quality of the interview schedule. The initial interview schedule was slightly adjusted and an additional question or two was added on.

Written informed consent was obtained from all ten participants (See Appendix A and ethical considerations).

Each interview was conducted in a place and at a time convenient for each of the women. As all had young children, the women were interviewed in the privacy of the mother's own home or in a child-friendly location of their choice.

3.7 Data analysis

3.7.1 Narrative analysis

People make meaning of their life through interactions with others and the environment in which they live (Squire, 2009). There is no meaning in the world until people construct it; therefore narratives are rarely straightforward as they are filled with conscious cognitions and feelings spiced with unconscious emotions (Squire, Andrews & Tamboukou, 2009). People do not find meaning, they make it through language whether spoken or written. The meaning people make is affected by their social interpretation of the situation.

Narrative analysis looks at the ways people make sense of their lives by representing them in a story form (Henning, 2004). Through language we express our thoughts but also language shapes our thoughts (Kitzinger, 2005). Narratives are neither true nor false but are an individual's view of the world they live in (Riessman, 1993). They help an individual to make sense of their social, historical and cultural locations. Narratives fall in the broader realm of social constructivism, which emphasizes the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding.

Individuals tell their story, linking the past to the present, and in doing so choose their subjective identity (Beck, 1992). Each time a story is told, the meaning attached to the story may change according to the way in which the lived experience is processed over time (Day Sclater, 2003). This gives each narrative a temporal dimension and this is important to note when analysing stories.

The way a story is told is limited to the language and discursive tools available to the storyteller at the time of the telling of the story (Terre Blanche & Durrheim, 1999). In understanding a person's story and how a person makes meaning of a story, it is important to not only pay attention to the language used but also how the story is delivered.

3.7.2 Rationale for using narrative analysis

Research that uses narrative analysis involves life story research or oral history. It adopts a qualitative approach using semi-structured interviews where the researcher allows the participants to talk with as little interference as possible.

To understand choice and how choices are made, one must first understand the woman making the choice. Each woman needs to be listened to. How does this woman position herself in her story? In order to organize the data to present the participants' stories in a way that provides a description of "the norms and values that underlie this cultural behaviour" (Rubin & Rubin, 1995, p. 229) of elective CS, narrative analysis was used to analyse the data.

For further analysis of the data, I have used a thematic approach for the narrative analysis as outlined by Riesman (2008). Thematic analysis is associated with searching for common themes which arise through the data to find repeated patterns of meaning. Related themes through the data help "build toward a boarder description or an overall theory" (Rubin & Rubin, 1995, p. 234). This process involves thoroughly engaging oneself in the data by reading and re-reading the interview transcripts (De Vos, Strydom, Fouché & Delpont, 2005). To make sense of the data, I first analyzed each woman's story separately before clustering the story into main themes. As common concepts began emerging, they were clustered into similar groups. The themes I identify pertain specifically to discovering how the participants came to choose an elective CS.

In the discussion section, I look at these themes and make sense of their relevance to answer the question of this study.

3.7.3 Analysis procedure

In order to analyse the data, I organised the data according to:

1. General experience of an elective CS
2. Making the decision
3. Key themes in making the decision
4. Narrative structure in the decision making process
5. Narrative tones (whether pessimistic or optimistic about the woman's birthing experience).

I start the analysis of the women's stories by creating a general experience of all the women in terms of having their child through CS delivery. Although there was variation, there are common elements that run through their stories. These common elements constructs a general elective caesarean birth experience for this group of women.

Through interweaving all the women's stories, I go on to look at how their decisions to elect a CS were made. The nature of how these decisions were made is looked at through the women's eyes and what they perceived the influences on their choice to be. To further understand the women's choices, I investigated key themes in their collective narratives. The themes I identify pertain specifically to discovering how the participants came to choose an elective CS.

I was able to cluster the women within the ten interviews into three narrative structures by tracking how each woman placed themselves in their narrative.

The narrative tone is conveyed in the details of the narrative and in how the story is told (Crossley, 2000). An optimistic story can be filled with good experiences or one that, despite negative experiences, remains hopeful. Similarly, a pessimistic story can arise from unpleasant experiences or from the good experiences being perceived in a negative light (Crossley, 2000).

3.8 Ethical considerations

Informed consent from each of the participants was obtained (See Appendix A). In this particular research project, only mothers that were eighteen years or older and that had the capacity to give independent consent were interviewed.

The nature and the purpose of this study were thoroughly explained thus allowing each mother to decide whether or not to participate. The participants were informed that they may at any time during the course of the research interviews decide that they no longer wanted to participate in the research project. Referrals for counselling would be made if deemed necessary.

Each participant was aware that they would remain anonymous in the research project and in any subsequent findings and recommendations. Confidentiality would be maintained throughout the process.

Written consent was also specifically obtained for recording the interviews. A small digital recorder was obtained from the university and was used to record each woman's story. The interviews, including obtaining the woman's demographic information, took between half an hour to an hour. The interviews were subsequently transcribed verbatim.

3.9 Reflexivity

“The narrative psychological researcher, as in other qualitative and discursively orientated approaches, believes that the material used in any kind of analysis is deeply influenced by the researcher.” (Crossley, 2000, p. 527).

It is important to note my own feelings and experiences of doing the interviews with the women. In 2008 I had an opportunity to experience carrying a fetus full term. I was continually asked how I was going to deliver the child. At that stage I was under the impression that I would have a vaginal or normal delivery as it is called today. Even my gynecologist kept saying “*let us wait and see*”. Many of my peers expected me to go for the “*safer delivery*” of an elective CS.

I unfortunately had an emergency CS and experienced the post-operative pain. This experience led me to question why so many women in the private health sector are electing to have CS. Thus my thesis topic was born.

My own birthing experience could be viewed as a limitation to the research. That I already was negative towards elective caesarean sections could leak into the interview and into the dissertation. In any qualitative research there will be biases present and thus the importance of having a supervisor who will critically question my analyses (Marshall & Rossman, 1999).

In light of my own experience of a CS, I have tried to pay close attention to my own partiality. I did express to all the women that I have had a CS but divulged a little about my own experience as I felt that they could have felt judged by me as the researcher.

CHAPTER 4: ANALYSIS

4.1 Introduction

I start the analysis process by constructing a general CS delivery experience for all the women interviewed. Although the experience varied across the sample, there are common elements that run through their stories. These common elements construct a general elective caesarean birth experience. Then I look at how they came to make the decision to have an elective CS and explore the themes that they highlight in making their decisions. I close off the analysis of the interviews with a look at each woman's narrative tone, whether pessimistic or optimistic, about their birthing experience.

4.2 Constructing an elective caesarean birth experience

In order to orientate the audience, a general elective CS experience is constructed. This section provides details of the events associated with an elective CS and the characters involved. The women used restitution narratives, which are narratives used to describe the process of going from health to sickness to health (Frank, 1995) usually through medical intervention. The basic plot of the restitution story is that yesterday I was healthy, today I am sick but tomorrow I will be better (Frank, 1995). This narrative type is about movement away from and back towards health, exploring the experiences and meaning of investigations and treatments. Most of the narratives proceeded as follows:

The experience starts with the woman knowing the time that she arrived at the hospital; what day of the week it was; and when she entered theatre.

Gail said: *“I remember it was a Monday because I’d been working the Friday.”* She also said: *“I was due for the CS at 9 o’clock. I just went in. I was okay”*. Shirley said: *“She was born on the 5th. I think it was a Friday... No, no... it was on a Tuesday because my gynae does Caesars on a Tuesday and a Friday/.../We did it first thing in the morning. Well, it was about... seven, I was prepped; eight o’clock I was actually into the theatre”*. Camille as well remembered that: *“he scheduled an elective cesarean on Monday afternoon.”*

The women felt that it was a surreal experience as they entered the hospital. They were feeling well and knew exactly what was going to happen. Most, if not all, said it was a strange experience walking in the hospital knowing that in a short while they would have a baby in their arms.

Camille said: *“It’s kind of different to what you’re expecting walking into the hospital. Normally you feel fine, checking in before they take you for the Caesar”*. Lily felt strange about it saying: *“Actually it was awful because it seemed severe because you would have no preparation it is like you just wake up when you are normal and then you go to the hospital and they give an injection and then they start to cut so it’s like very odd experience, so I personally didn’t enjoy it, I know other women say it was wonderful but I didn’t enjoy it.”*. Candice said: *“We just had to be there, knowing it was going to happen now”*

Most of the women were informed through the process what was happening.

Gail said that: *“My doctor was there/.../ Everyone explained what was going to happen and I sat there...they were going to do an epidural thing. I think it was the only painful part of the whole thing /.../. And then I felt nothing.”*

Camille said: *“I think it was pretty much as I’d expected. /../ Everything was much quicker.”* Amy said: *“From the time I was admitted into the theatre, to arriving back into my hospital bed, it actually went really well. The nursing staff was amazing, really really friendly and fantastic. My gynae was very informative, very, very good and attentive...”*

Nadia said for her she: *“felt very relaxed. /.../ I feel it was good overall. Really. I knew what I was in for; it was a good experience.”* Gail said that during the procedure: *“he was telling me what he was doing. Then suddenly I heard a baby cry. /.../ There was nothing to feel. I felt absolutely nothing. There was just this baby there.”*

Jessica said: *“Actually I had a very pleasant experience, I knew I was going to have a cesarean so was prepared for that, we waited quite a while to go into the theater which was nerve racking.... because you obviously want to see what your baby’s going to look like, I had epidural anesthetic, so when he came out obviously I had no pain nothing, but everything was fine it was very quick, they obviously took him out, Peter was in the theatre with us and everything went very well, I had no problems with his APGAR., everything was fine, they put him in my chest immediately after birth which I loved and he recognized our voices immediately which was very special, he turned to us immediately and I breastfed him immediately as well, so I had a very good experience.”*

The after pain was not a pleasant experience as it caused them to want drugs that left them groggy and wanting to sleep, instead of wanting them to see their baby.

Shirley said: *“But the after-feeling is not a nice feeling; the groggy feeling and the fact that you want to sleep all day, you don’t want to see your baby. That’s not a nice thing.”* And similarly

from Gail: *“Then I was whisked off to the ward and then I slept. I just slept...That’s all I remember is sleeping and sleeping and sleeping.”*

4.3 Decision making process

The main goal of this study aims at furthering the understanding of women’s choice in childbirth.

4.3.1 Making the decision

Belinda was living in Japan teaching English when she fell pregnant with her son. She had planned to have a natural birth but after a discussion with the doctor in the 38th week of her pregnancy, she decided to have an elective CS. According to Belinda, it wasn’t that the doctor suggested it overtly but as they conversed, she was convinced that an elective CS was the best option. Another contribution to her decision was her mother who *“promised”* her that *“it will ruin your life if you have natural.”* These are very strong words from her mother to whom she is very close. She also had some scarring from a previous operation and the doctor agreed with her that it was a nice opportunity to try and clean the scarring up a bit during the operation.

Candice chose to have an elective CS as she had had an emergency CS with her first child. Because her emergency CS had been very traumatic, when she heard that an elective CS was a better option she decided to go for it. Reasons given were that it is controlled and that you are mentally able to prepare for the surgery.

Camille was one of the interviewees who was the most keen to have a natural childbirth even though she had had a prior CS. Her doctor allowed her to go one week past her due date and then she said he thought: *“it was too risky to carry on waiting any longer so he scheduled an elective cesarean”*. Camille felt that she did not have a choice and was: *“definitely pushed into it but*

more gently persuaded the second time around that that was the way to go.” She had strong feelings about this and said: “I wasn’t happy, right until as they wheeled me into theatre, I wasn’t really happy about it”.

Gail initially said that she wanted to have a natural birth. A number of her colleagues, who are doctors, told her that she was going to have a CS and were even more convinced when she told them who her gynecologist was (they obviously knew him and his reputation). She subsequently told her gynecologist that she wanted natural birth but he told her that it “*wasn’t a good idea*” because the baby was big and growing quite fast. She then submitted and, according to her, there was not much of a debate after that. Another factor that she said did influence her is that her sister had given birth two years prior by natural birth and had felt that she would rather have had a CS even though in her culture: “everyone believes that you are more of a woman if you give birth naturally”. There was a lot of pain in her sister’s natural birth which she felt was not recognized by others.

Jessica’s history made her extremely sensitive to safety concerns. She had a previous CS 10 years prior, but unfortunately her first son was killed in a car accident at age 3. At 39 years old, she got pregnant but miscarried. A few months later, she again got pregnant and carried the baby successfully to term. Given her age and the emotional trauma of her earlier losses, Jessica was very concerned about minimising the perceived risks.

Lily had two children eighteen months apart. Her first was an emergency CS and so her doctor suggested that her second be an elective. Lily said: “*She recommended it. Just because it’s dangerous, (my children) were 18 months apart so it was recommended because it could be*

dangerous and I would have my old scar ruptured and because since I had difficult pregnancy with the first one she was afraid that I might have the same type of birth.”

Amy is familiar with hospitals and doctors. She was diagnosed with type 1 diabetes at sixteen years old. Her decision was based on what she perceived would be safer for her and her son “...and because of the danger to me if the labor is prolonged and that they have to monitor my sugar levels, they always said to me that if Adam was of a certain size, which might mean a difficult birth.”

20 years ago Nina gave birth naturally to her first son. Being 39 years old this time around, she thought that there could be more complications. Later she found out that her age would not necessarily mean more complications but she decided to still have an elective CS. Another influence in her decision was that her husband is a pilot and so being able to schedule the birth around his flight schedule was very convenient.

Nadia was very straightforward about her decision. She had a CS previously so when her doctor said he would do another CS, she agreed. Being a registered nurse, she had also assisted in the delivery of seventeen babies and expressed her awareness of the associated risks of having vaginal birth.

Several factors influenced Shirley's decision. This was her third child. The previous two had been natural birth so a CS would be a new experience for her. She also felt it was convenient as she had a psychology exam in the following three weeks that she wanted to write so having a CS would allow her to know exactly when she was giving birth.

4.4 Key themes in the decision making process

People rarely make decisions based on an examination of all the options available to them. Many factors influence a decision. Sherr (1995) notes that: *“decisions are usually based on heuristics and simplified processes, limited by available information and mediated by situational factors, biases, stresses and social norms/pressures”* (p. 24) . In this section, I will explore the three main themes that emerged in the interviews that influenced the women to elect a CS. The first theme is how the women saw childbirth as something dangerous and something to fear. The second theme is how the participants believed that their doctor knew best and so subsequently followed their advice. Finally, I end with the theme of an elective CS being a convenient option.

4.4.1 Fear and Danger associated with childbirth

Firstly, I will explore fear and danger of childbirth as this is the most predominant theme in the interviews.

The reason for Belinda’s decision was that the doctor had said that the baby’s head had not engaged into the pelvis and he said: *“by the look of it, you are welcome to wait but probably it’s going to be an emergency Caesar”*. Already she admitted at that point that she: *“really didn’t like the idea of emergency anything so I thought just operate”*.

Already the images conjured up in an ‘emergency’ operation are ones of haste and danger. The doctor also mentioned that: *“in Japan they always cut you in your vagina.”* This *“freaked”* Belinda as she said: *“in my birth plan I was like please don’t cut and he said he’s sorry but they always cut cause they rather prevent tearing and that’s their philosophy”*. Episiotomy is a well-known procedure, which doctors use in order to avoid tearing of the perineum. We don’t know

why the doctor did not use the medical term and instead expressed it as cutting of the vagina. However one chooses to interpret it, her personal understanding of the process she expected for natural childbirth was altered. The word “*freaked*” is a strong word showing anxiety. Cutting the vagina presented itself as dismaying. After hearing that she would likely be cut, she said: “*it wasn’t what I thought it’s going to be*”. The choices presented themselves to her as an emergency operation and/or cut vagina versus an elective CS.

The pain from Candice’s first CS was so severe that she reported she could hardly walk for six months. She chose an elective CS even though she was very fearful of the pain and the potentially same consequences of her previous CS. Her first doctor had committed suicide and so when she had found a new doctor who suggested that she have an elective CS.

Candice used phrases related to fear a number of times in her interview. Words like ‘*fear*’, ‘*scary*’, ‘*fearful*’ and ‘*scared*’ came up regularly when describing the process of childbirth. She would say things like: “*I know that you could elect for natural but no, I wasn’t going to take that chance. I think it was too scary for me.*” It is also interesting that at the beginning of the interview she said that she “*couldn’t try the natural way*” but later she said that she knew she could try for natural but decided not to do so. By saying that she did not want to take a “*chance*” it implies that her feelings towards the safety of natural childbirth had been influenced to the negative. The tension lies in whether she actually had a choice or whether her fears (wherever they stem from) take that away. In the end Candice chose to go with the post-operative pain of a CS versus the uncertainty of a natural birth.

Gail said that she wanted a natural delivery and had a deep-rooted cultural perception of the relationship between natural childbirth and being a good mother. This was reinforced by the

comment of the same nature that came from a colleague. Her husband too had made a hurtful comment on the same subject matter of her delivery choice. Despite all this, her real motivation came out when she said: *“I just wanted something straightforward that’s not going to make me think of what could go wrong”*. Jessica similarly spoke of not wanting to lose her child so she spoke of having an elective CS with fewer risks than a natural birth.

Shirley had a form of vaginal thrush or a similar infection in the period that she was due to give birth but the doctor was unsure about exactly what it was. Shirley spoke of a type of infection that can cause your child to lose their sight. When discussing it with her doctor, Shirley said that the words she used were: *“we can circumvent that by not going through birth canal and having a Caesar, so there is that option.”*

Natural childbirth experiences of family, friends and even strangers contributed to making an elective CS a better option. Candice felt like she could not try the natural way as she had read stories of bad natural births. Nadia’s second statement to me of the interview was: *“I would never go for natural.”* Nadia found it necessary to emphasize how horrific natural childbirth was. *“I saw what happens. I have delivered seventeen babies and I saw it’s much more difficult. The child does not come out quick enough. Sometimes you have to cut through the perineum. Umm... thank you but never”*.

4.4.2 The doctor knows best

When I asked Belinda whether the doctor actually suggested the CS to her, she responded in a way that was sympathetic to the doctor: *“No shame, I wouldn’t say he suggested it because he just said that probably it would be an emergency. He didn’t say that I should do anything”*.

Judging from Belinda’s sympathetic response to whether the option was hers or his, the doctor

did not seem to her to have any negative intentions. Belinda ended up saying that she might as well get the baby out and with the doctor being happy about the opportunity to experiment by working on a previous scar – the decision was made.

In Candice's case the doctor said: *"Let's see, we'll see closer to the time what happens"* but the doctor did advise then that she have a CS since she did have a prior CS. There was no further discussion.

Gail was certainly caught between two opposing schools of thought, her culture and those around her in the medical field in which she works. Despite all her comments about the influences that she had in her decision, it was evident that she was leaning towards a CS and the doctor was the final confirmation that she needed. She ended by saying that: *"I do think it's a bit primitive to give birth naturally."*

Camille wanted natural birth and much of this sentiment seems to be attributed to the fact that she felt: *"I think we rushed Stuart (her first child) to the Caesar, I could've given birth natural to Stuart"*. This experience continued to bother her and she said: *"I knew at back of my mind that once you've had one Caesar, the chances of having a natural child birth are less than before"*. It was evident during the whole interview that she felt like her choice was removed in both births. Her sentiments are summed up in her closing statement: *"I'm not completely anti-Caesar, and I think they've definitely got a place and medically, they are often indications that that is definitely the way to go and that is the right choice to make. I think the vast majority of gynecologists do nudge you or push you a little bit into it and I think it is more convenient for them and I think that is often why we end up having these Caesars because it fits into their schedule a little bit better. On the whole, I think certainly in South Africa, we do far too many Caesars... in the*

private sector, not public. In the private sector, they do too many just for convenience. In fact I've heard of gyns who won't deliver normally and gyns who definitely lead you into it."

Jessica's doctor said she *"wasn't prepared to risk me trying for normal and may be risking losing Ruan, so I think on that base we decided to rather do a cesarean."* Then the doctor said she: *"is not prepared to risk me losing Ruan cause she knew how much he means to me, and also my age as well, being a bit older."* In Jessica's own words: *"I didn't really have much of a choice."*

There are risks with any birth option so for the doctor to say she was not willing to risk the baby's life as a motivation to have a CS suggests that she was stating her own preference, as there are risks in both natural and CS births. Jessica says she would not have gone against her doctor and even stated that her doctor *"was quite strong in the point"* that going the natural route could lead to something going wrong.

Lily did not consider researching other options because she said of her doctor: *"I just thought that she knows best"*. It is notable how much faith Lily put in the decision of the doctor. This is an understandable stance and she did say: *"if you have a doctor that you trust and is good, go with what they think"*. It, however, assumes that the doctor is impartial. In all the interviews with mothers who had prior CS, the doctors had expressed that it was not a good idea to try for natural birth. They did not seem to make any attempt to explain how natural birth is possible post CS. It was presented as an unsafe option as opposed to one with a different set of risks.

Amy realised that being diabetic did not necessarily mean she had to have a CS but said that the doctors *"would prefer if I went with a cesarean."* The doctor suggested it to her and she researched her options because she wanted what was best. Options included being *"induced at thirty eight weeks or cesarean at thirty nine weeks, depending on the size of the baby and how*

the pregnancy has gone.” As her pregnancy progressed, *“They were worried about my diabetes and his size and so the safer option going forth was a C-section when he hit the four kilogram mark”*. Amy also said: *“I don’t know what would have gone wrong in the birth process if I hadn’t taken my doctor’s advice and I wouldn’t want to live with the consequences if something had gone wrong.”* For most of the women I interviewed, this came across as a real fear of going against the doctor and having to live with the consequences.

For Nina, the doctor did encourage the CS as a better option as she had had some problems during her natural birth 20 years previously. It is notable to look at the wording Nina used to express what the doctor said: *“she said based on my history it might be a better idea because at least we know there won’t be or there will be less complications compared to the first one.”* What I have found in this and other interviews is that when there is talk of natural child birth, what could go wrong is often spoken of yet very little is spoken of the complications associated with a surgical birth.

4.4.3 Convenience

Convenience was another theme that came through in the interviews. It was evident in some of the interviews but not all.

Nina’s husband is a pilot so a scheduled date was important so that her husband could be at the birth.

Shirley admitted that she was happy that she would be able to have a: *“way out”* of having a natural delivery although she was expecting to have her child naturally like her previous delivery. She had an exam three weeks after giving birth so she was pleased to have a set date for the CS. For Shirley, who had two other children at home, a planned experience was the better

option. *“I didn’t miss the pain and the not knowing because my kids were sorted out, they went to school, everybody was sorted out, we knew what was going to happen when, how, how long I was going to stay and I was going back home at the weekend, and the kids are going to be around me again.”*

Belinda had a scar from a previous operation and thought to: *“kill two birds with one stone do a little bit of reconstructive surgery”*. This is not a CS convenience story but it is related to the theme.

4.5 Narrative structure in the decision making process

The narratives of all the women followed a similar chronological narrative plot: The pregnancy and their initial thoughts on childbirth – the interaction with their doctor which either complicated or confirmed their decision on the birth of their child – the CS – the healthy baby. From the onset, all the women chose the medical model of childbirth meaning that they selected specialist doctors (gynecologists) to deliver their babies. All planned private hospital births.

The main characters in their narratives were themselves, the doctor and their baby. None of the ten interviewees mentioned their husband’s involvement in the decision making process. Nine of the husbands attended the births yet played a silent role in the narrative with regard to the decision of having a CS.

Within the ten interviews, I was able to cluster the women into three narrative structures by tracking how each woman placed themselves in their narrative.

4.5.1 Group A(Nina, Candice and Nadia)

Group A's narrative structure went as follows:

These participants had already decided to have an elective CS. They did not want a vaginal birth from the onset of their pregnancies. Their interaction with their doctors was simply an affirmation of their decision. There was no conflict of interest or debate. They saw themselves as the active protagonist or the central agent making the decision.

Candice said: *"I knew in my mind that I wanted to ask for the cesarean and she [The doctor] was fine with it. She said we can go with what you want"* and again a little later in the interview: *"I knew this is what I wanted."* When asked how others responded to her decision, she again reiterated: *"I knew in my mind that this was what I decided and this was how I was going to go."*

Nina similarly said: *"I mentioned [the CS] as that was my choice and the doctor said based on my history it might be a better idea because at least we know there won't be or there will be less complications compared to the first one."*

Nadia was more adamant that she *"would never go for natural."* So when the doctor suggested a CS, she agreed.

4.5.2 Group B(Jessica, Shirley, Belinda, Amy, Gail and Lily)

Group B's narrative structure went as follows:

These participants were not set on having a vaginal birth. Most expressed that during their pregnancy, they thought that they would have liked to try having a vaginal birth. The interaction with their doctor shifted their viewpoint. They then decided they wanted what was best for the delivery of their baby and put their trust in the hands of the doctor. These participants see

themselves as witnesses who were subjected to the doctors' authority. It is the medical doctor that clearly emerges as the central actor or hero in their narrative (Chadwick, 2007).

Belinda said: *"No shame, I wouldn't say he suggested it because he just said that probably it would be an emergency. He didn't say that I should do anything.....I don't think he coerced me or anything like that."* She also mentioned that the conversation about having a CS occurred when she was *"heavily pregnant"* and felt *"just get him out whichever which way. At that point it doesn't matter anymore."*

Jessica similarly said: *"I know she [the doctor] was quite strong on the point of that she doesn't want to risk me trying for normal if something goes wrong because of my past history."* Jessica saw her doctor as looking out for her best interest. *"My gynae wasn't prepared to risk me trying for normal and maybe risking losing Ruan, so I think on that base we decided to rather do a cesarean."*

Shirley having had two previous vaginal births was not expecting her doctor to give her an option of a CS. Shirley had thrush so her doctor said that: *"we can circumvent that by not going through the birth canal and having a Caesar."* Shirley agreed although there was another option of having a pap smear to see if the thrush was a normal yeast infection. The doctor said that there is a type of thrush could affect the baby's eyes so when Shirley heard that she responded with *"Right, so when do we do the Caesar?"*

Amy, having had type one diabetes since she was sixteen years old, was more the willing to follow the advice of the doctors. The CS was recommended to her when she asked *"what would be the safest and best."* She also stated that *"If I hadn't taken my doctor's advice, I wouldn't want to live with the consequences if something had gone wrong."*

Lily stated that *“I didn’t actually research [CS]. I just thought that she [the doctor] knows best.”*

The doctor knowing best uncomplicated the woman’s decision. There was no contradiction or tension; just an acceptance of what was inevitable.

Gail wanted a natural birth until her doctor said *“he doesn’t think that’s a good idea.”* When Gail asked why, the doctor said *“the baby is growing quite fast and he is big.”* Gail responded by saying: *“Okay, I’ll have a Caesar.”* There was no debate.

4.5.3 Group C(Camille)

Group C’s narrative structure went as follows: Camille really wanted to try a vaginal birth but her interaction with her doctor caused a point of conflict. When asked if she suggested a CS to the doctor, she adamantly replied: *“I didn’t suggest it. I would never have suggested it, definitely not.”* There are more tensions and contradictions in her narrative as she tries to make meaning of her narrative. She sees herself as a victim of her doctors’ authority. *“I was definitely pushed into it”* and later she said: *“I was definitely persuaded from him from a medical point of view”*.

4.5.4 Perspective

Perspective in narratives refers to the fact that a narrative contains a point of view toward what happened which tells the listener what is significant (Gee, 1991). At the end of all ten interviewee’s narratives, all the women’s perspectives were that having a healthy baby is what really is significant. The actual experience of the CS was seen as a procedure and not a life-changing event. The life-changing event was the baby.

4.6 Narrative tones

Belinda's narrative illustrates her struggle in not wanting to hold the doctor directly accountable for her choice of having a CS. She remained positive throughout the interview and laughed freely when telling her story. Yet when asked about her decision in hindsight, her response of: *"if I could do again I probably would do natural like I would try. In hindsight I would have not gone for caesarean section I would have tried natural"* indicates some level of disappointment at her decision. She then followed the thought up with: *"but it worked out fine and he is healthy and I am healthy so it's fine. I would like to try natural next time and if I can't do it then I don't mind having a caesarean section again but I would like to try."* The narrative tone had some elements of disappointment and of real anxiety but is generally optimistic especially in regards to the future of trying a natural birth.

Candice's tone was optimistic. She experienced a lot of pain and criticism but she shrugged it off. She laughed most of the interview as she reminisced on her birth. Despite the jovial nature of the interview, her narrative was filled with words expressing the pain and fear that she experienced. She saw herself as the agent of her decision. *"I knew in my mind that this was what I decided and this was how I was going to go."*

Camille's story was one of a woman struggling to come to terms with her decision to have a CS. She spoke of how she would have made different decisions in hindsight although she said she probably would have still landed up having a CS. Her tone was pessimistic and sad as her last statement of the interview highlights. There was helplessness in her narrative where she spoke of being *"pushed"* or *"persuaded"* into the decision of having a CS. She constructed herself as a witness throughout the interview. *"I didn't choose. I would have carried on waiting for a natural"*

birth. I was definitely pushed into it but more gently persuaded the second time around that that was the way to go. So I was definitely persuaded from him from a medical point of view it was the way to go, with my weight and we had tried. It wasn't going to happen. It wasn't going to happen imminently; the baby was getting big; this was the sensible thing to do. I wasn't happy, right until as they wheeled me into theatre, I wasn't really happy about it."

Gail's tone could be described as one of uncertainty. Much of her decision was made up from those around her (her sister, colleagues and her doctor). Although she does say she would not have made a different choice, she still looked for reassurance from me during the interview. *"I just feel in my opinion that people need to change their opinion about giving birth that way. It's a choice. It's a medical choice that you make. It's up to you. It's really up to you."* Although she emphasized that the decision is up to the individual, it was evident through her story that ultimately others influenced the choice for her.

Jessica was optimistic in her narrative. All the way through the interview, she expressed how she felt her doctor had done the right thing and despite her nervousness initially, she thought the experience was pleasant. I think being older, and knowing this was to be her only child, she treasured the memories of the whole birth. *"Actually I had a very pleasant experience, I knew I was going to have a cesarean so was prepared for that. We waited quite a while to go into the theater which was nerve racking.... because you obviously want to see what your baby's going to look like. I had epidural anesthetic, so when he came out obviously I had no pain nothing, but everything was fine. It was very quick/.../ everything went very well/.../everything was fine. They put him in my chest immediately after birth which I loved and he recognizes our voices immediately which was very special.He turned to us immediately and I breastfed him immediately as well, so I had a very good experience."*

I would describe Lily's tone as one of sadness as she reflected back on her birth of Daniel. She remembers it as one of a lot of pain afterwards. She spoke of being a good mother after the birth almost appearing to reassure herself that she was a good mother. *"Once you have your baby then that's when you can judge if you are a good mom or not like how you behave afterwards when you have a baby, but the process to get the baby out I actually don't think it matters."*

Amy's tone was almost one of resolve with her situation in life. She is diabetic and although this condition does not necessarily mean a CS is required, Amy seemed willing to comply with the doctor's advice. She was also resistant at first to being interviewed as she felt her CS was not an elective CS. *"If I didn't have the medical problems and I'd had a normal pregnancy, progressing as it was expected to; I'd have gone for a natural birth. So in another life... (laughs)...I would've had a different option."*

Nina's tone was very non-committal. After having given birth both naturally and by CS she did not favour either even though her choice to have a CS was largely based on the unpleasantness of the first delivery. She generally seemed to be negative in her interview and it came across that this was not a very desirable topic of conversation for her. *"I must say I went to antenatal classes and they weren't very supportive at all. They kept asking me more reasons for having a C-section. In fact, I was told things have changed and that's the way to go and natural is the best way. You are not a mother until you have pushed and all that kind of thing. I was just like... you know... whatever. I am the one that has to go through it and it's easy for everyone to stand aside and shout but it's a personal choice and that's exactly what it was so I didn't take it to heart real and that was it."* Nonetheless, she chose not to say unequivocally that in her opinion that the CS was better. *"I think if you have a choice and you want to do it the natural way, it's an awesome*

experience. I mean don't rule it out. It was just for me it wasn't the way to go for the second time. I am not saying don't go with the elective Caesar, it's definitely a personal choice."

There were many contradictions in Nadia's story; she was the most in favour of having a CS but still felt the need to justify her decision. Her tone came across as angry and upset especially when she described the horrors of childbirth. "*I would never go for natural/.../I have delivered seventeen babies and I saw it's much more difficult. The child does not come out quick enough. Sometimes you have to cut through the perineum. Umm... thank you but never.*" Even since the interview, she contacted me to let me know of another horrific natural birth experience she had just heard about.

Shirley was very optimistic throughout her story emphasizing that she had done both the natural birthing and the caesarean birth and she would never go back to natural. Her narrative was full of comparisons between the two experiences. Having had natural before seemed to give her confidence in justifying having a CS.

CHAPTER 5: DISCUSSION

“All interpretations are provisional; they are made by positioned subjects who are prepared to know certain things and not others...analyses are always incomplete.” (Rosaldo, 1989)

5.1 Introduction

Although today women seem to have more choice when it comes to childbirth when compared to their predecessors, their options in childbirth fall within a tightly controlled environment of doctors and other medical professionals (Williams, 1997). The word ‘elective’ denotes there is a choice. This dissertation interrogates the word ‘elective’ in the context of a medicalised childbirth.

5.2 Fear of childbirth

Fear of giving birth vaginally emerged as a primary reason for an elective CS. Results from this study have similar results to other international studies with regard to childbirth fears (Cronjé, 2000; Keogh et al, 2005; Fenwick et al, 2010). In the interviews, words like ‘*fear*’, ‘*scary*’, ‘*fearful*’ and ‘*scared*’ came up regularly when describing the process of childbirth. The choice to have an elective CS was seen as a ‘safer choice’ with perceived less risk than a vaginal childbirth. Results from this study correlated with the findings from Chadwick’s (2007) study that dangers and risks always were associated with “the birthing body itself and were never attributed to medical intervention and technology.”

It is evident that women in South Africa who are able to afford private hospitalisation are a part of a technocratic society that highly values science and technology often at the expense of nature (Davis-floyd, 1994). Women believe that by altering natural processes with technology, a chaotic

and unpredictable birth becomes better and safer through an elective CS (Fenwick et al, 2010). A labour and vaginal birth that includes several ultrasound scans and monthly doctor's visits, then a hospital stay, continuous fetal heart rate monitoring, induction of labour, epidural analgesia, forceps delivery, episiotomy and multiple caregivers is as natural as an elective CS (Hannah, 2004). The reality is that the true opposite of an elective CS is a birth that would need to fall outside the medicalised system like a homebirth. Most South African women with private medical aid are fearful of homebirths as they associate birth as a medical event (Chadwick, 2007). Homebirths are thought of exclusively in terms of risks (Kitzinger, 2005) and are deemed as "too risky". Even women who decide on a homebirth are required not only to have a midwife but also an obstetrician on call just in case something goes wrong. These women also are required to visit this obstetrician a few times during their pregnancies. Many obstetricians are reluctant to be on call for home births as there is risk involved (Chadwick, 2007). Our society expects women to adhere to medical advice or recommendations as if it is the logical choice; and the only logical explanation against medical recommendation and for having a homebirth is that the woman is irrational (Jackson, 2006). For women choosing an elective CS, dangers and risks are always associated with the birth itself and not with the medical intervention. Technology is seen as the solution and never the problem (Chadwick, 2007).

5.3 Healthy baby is what is most important

This research has indicated that these particular women were not as much concerned with how the baby entered the world as the safety of the baby. The value of a natural childbirth was not central enough to pursue past the discussion with their doctors. Most distrusted their own body's ability to have a safe delivery of their babies and therefore feared what could go wrong.

By viewing themselves solely as a vessel to carry the baby, for them birth becomes about the baby and not the woman. Similar results were found in an Australian study that found women who have elective CS had a disconnection between the self and body and therefore placed control outside the self (Fenwick et al, 2010).

Ultimately, for the participants, the birth was not about the experience but about having a healthy baby. For women in this study, through the narrative structure it was made clear that they believed a CS was for them truly the only guarantee of having a healthy baby. At the end of all ten interviewee's narratives, all the women's perspectives were that having a healthy baby is what really is significant. Like a fairy tale, they all had received their happy ending.

All felt like they bonded well with their children in the early weeks. Most did not experience as much pain as they thought they would which helped in bonding.

Research has also shown that due to CS being performed under general anesthesia, mothers take longer to recover from the effects of anesthesia and the operation which affect them holding and breastfeeding their babies (Cakmak & Kuguoglu, 2007). This research does not support these findings as all the women chose to breastfeed their babies within the first few hours of having the baby.

5.4 Doctors as the experts

All the women I interviewed said their doctors were supportive of their decision to have a CS. According to the participants in this study, the doctors did not speak about the benefits of a natural birth or the risks of a CS. None of the doctors tried persuading the women to try having a natural birth. What was fascinating is that every woman gave a detailed reason for their decision,

which usually included the doctor's recommendation. No doctors tried to persuade the women to have a natural birth. In the narrative structure, the data shows how each doctor argued in favour of the elective CS. This finding was similarly supported by another international study, which noted that women choosing elective CS perceived that medical discourses supported and reinforced their decision as a 'safe' and reasonable choice (Fenwick et al, 2010). No one got a second opinion nor questioned their doctor. (Even Camille expressed her absolute desire to have a vaginal birth eventually submitted to the authority and expertise of her doctor). What was important to them was a healthy baby in their arms. All knew that there were other options but decided to go with doctor's suggestion. Other research has found that this is result of a technocratic hierarchal medicalised system where death is feared so standardization or routine is created in order to control the unruly body and 'authority' is invested in the doctor (Davis – Floyd, 2001; Fenwick et al, 2010). Elective CS is just another step in the progress of medicalised childbirth.

In conclusion, the results of this study can be summarized by Sheila Kitzinger (2005):

“Statements about caesareans being a 'woman's choice' ignore the power differential between woman and obstetricians. By reinforcing the idea that caesareans are completely safe, easy, efficient and desirable for the baby's wellbeing-and even its life-and claiming that with a caesarean a woman avoids pain and injury, an emergency procedure has become routine practice.

The medical system has co-opted the notion of choice” (p. 82).

CHAPTER 6: CONCLUSION

6.1 Introduction

This chapter presents a recap of the main findings that are previously illustrated in Chapters 4 and 5. It also discusses some of the limitations of the study and possible recommendations for future research.

6.2 Conclusion

The aim of this study was to provide insight into why women in South African private hospitals are choosing to have surgical births in the absence of a medical reason. The findings indicated that the participants' viewed giving birth as a fear-inducing event and that in their focus to deliver a healthy baby, they submitted to the doctor's authority whilst accepting that their doctors knew best. This was explored through 10 women's narratives of their decision making process in deciding to have an elective CS. Current South African research into this topic is limited and inconclusive (Chadwick, 2007). Only one study focussing on women's subjective experiences of childbirth in South Africa was found. Thus, most of the literature that was examined was internationally based and this called for caution in the interpretation of the results.

The literature review highlighted how technology has given us more options and better care when it comes to pregnancy and childbirth. With the medicalisation of childbirth, however, obstetricians have more power and control in a woman's life and therefore directly influence the choices she would make.

The word 'elective' suggests there is a choice. This dissertation interrogated the word 'elective' in the context of a medicalised childbirth. The narrative structure highlighted how the obstetrician

was a crucial decision maker in their story. The medicalisation of childbirth was often created to assist in the delivery of a healthy baby. The doctor shaped the decision for the women by either the language they used which elicited fear or by simply portraying the elective CS as rescuing the pregnant women from her own 'unruly' body. It is hard to deviate from the advice of medical practitioners once you have chosen the medical model of childbirth from the onset which each of the participants had. They had chosen to place their trust in their obstetrician and the medical technology. The choice of how they would deliver was handed over to the doctor on their first appointment.

Elective CS are becoming an accepted cultural norm within the private health sector in South Africa. It was clear that the women choosing CS see their bodies as a necessary vessel for a healthy baby. Exactly how the baby enters the world is less relevant to them.

Vaginal birth is not portrayed by doctors as a potentially momentous, life changing and profound experience (Chadwick, 2007). Its related complications are explained and benefits underplayed. On the other hand, the best elements of CS are communicated and advocated and the worst underemphasised. This bias certainly came through in the interviews. With this in mind, the elective CS rate will continue to increase as long as women see it as their obstetrician's choice in having a healthy baby.

6.3 Limitations

Due to the scope of the research as well as limited time available, the size and spread of the interviews was constrained to only ten women. The results, therefore, are not statistically meaningful and cannot be generalised. Nevertheless, this is a preliminary study in South Africa which has generated results that could be used to explore this and related topics in greater detail.

Using volunteers could also be a limitation for two reasons. Either women will volunteer who had a wonderful experience and strongly believe others should also elect this type of delivery; or women will volunteer who had a traumatic experience and want to discourage other women. These are natural limitations in narrative analyses and while they are noted as potential limitations, they are also part on research of this nature.

6.4 Recommendations for future research

The findings of this dissertation may lend itself to further empirical research into how obstetricians view their role in the rising elective CS rate in private hospitals. Currently their viewpoint has not been captured in existing South African research literature.

Another research topic could be a comparative study between women choosing home births and women choosing a medicalised childbirth, looking at reasons for both choices. No obstetricians or women who delivered vaginally were interviewed in order to make comparisons to the current data.

Research into the economics of elective CS, in terms of cost and reimbursement, would also be of value. The health insurers put pressure on both doctors and patients by what they are willing to reimburse. If they refused to cover elective CS, and only covered emergency CS, the practice could greatly diminished.

An intervention that could be researched is the benefit of having antenatal group counseling where women talk about their fears of childbirth.

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Appendices

Appendix A - Consent Form

The Exploration of Elective Caesarean Sections as a choice around childbirth

1. Purpose of the Study

I want to explore the motivations influencing women who choose an elective caesarean section.

2. Procedures

You will be interviewed at a time and place convenient to you; and will last for a maximum of 1 hour. The interviews will be recorded.

3. Risks

I anticipate limited risk to you from partaking in this study. You may feel uncomfortable talking about the experience or it may bring up different emotions reminiscing about your child's birth. You are free to withdraw at any point. I will also make referrals for counselling if necessary.

4. Confidentiality

In order to maintain confidentiality I will not include your names or any identifiable detail in the research.

5. Benefits

This study will be contributing to further understanding the women's choice in childbirth and to make sure South African women receive accurate and unbiased information about

childbirth about the planned mode of delivery for the baby to help them make an informed choice. If the current trend of the increase in elective caesarean sections continues, the aim of this study to give counsellors, nurses, health professionals and psychologists in South Africa a deeper insight into why women have made the choice.

1. I agree to participate in this research project.
2. I may cease to take part in this study at any time during or after the interview.
3. My anonymity will be protected by ensuring that my name does not appear anywhere in the study.
4. I am aware of what my participation involves.
5. My questions about the study have been satisfactorily answered.
6. I give consent for this interview to be recorded.

I have read the above information and agree to the terms of study and give my consent to participate.

Participant's signature: _____ Date: _____

I have explained the above and answered all questions asked by the participant:

Researcher's signature: _____ Date: _____

Appendix B - Interview Schedule

- 1) “Tell me your story about your experience of your child’s birth.”
- 2) “How you came to choose to have an elective CS?”
- 3) “Did you suggest the elective CS to your doctor or did your doctor suggest it to you?”
- 4) “Tell me about the early weeks of your relationship with your child.”

University of Cape Town