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THOUGHTS, EMOTIONS AND EXPERIENCES IN TWO DIFFERENT GENERATIONS OF WOMEN UNDERGOING CESAREAN SECTION

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Thoughts, Emotions and Experiences Among Women in Two Different Generations Undergoing Cesarean Section

LICENTIATE THESIS

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To my Dearest:

Frederik, Olivia, Molly & Elvira

ABSTRACT

Background: Giving birth is a major life event and the memories of the birth are often something that women carry with them for the rest of their lives. There can be a lot of emotions and fears tied to childbirth. Some women wish to avoid a vaginal delivery, while others are taken by surprise by how an emergency caesarean section affects them. Over the last two decades in Sweden, caesarean sections have has become a common maternal request. The overall aim of this thesis is to study the attitudes toward and the experiences of caesarean section among healthy first- time mothers.

Methods: Both paper I and II in this thesis conducted using a qualitative method with content analysis. In the first study, 12 healthy first-time mothers requesting a caesarean section were interviewed in gestational weeks 26-36. In the second paper, 22 women who underwent caesarean section during the 1970s and 1980s interviewed.

Results: The overarching theme that emerged from our first study was that the wish to have a planned caesarean section in healthy women with normal pregnancy is deeply rooted: a feeling that is described as going beyond the fear of childbirth. Four underlining themes - or categories of motivation - emerged through the analysis of the content found in the interviews. Those categories were as follows: Seeing no other option other than a caesarean section; Wishing for control and safety; Managing one's own opinions and reactions and those of others; Previous experience of health care. The overarching theme in study II formulated to describe the women´s experience of having undergone a caesarean section 30 and 40 years ago is described as "a surprising life event". Four categories were identified, including: vaginal birth; the norm, a total loss of control, acceptance, and contact with the child.

Conclusions: Attitudes and expectations related to caesarean section have changed over time. In modern medicine, women and their partners are more involved in the process leading up to caesarean section. Some women argue that it is their right to decide the way in which they will give birth. Conversely, women giving birth 30 to 40 years ago were not prepared for anything else other than a normal vaginal delivery.

Keywords: mode of delivery, caesarean section on request

LIST OF SCIENTIFIC PAPERS

This thesis is based on the following two papers, which are referred to in the text using Roman numerals:

I. Sahlin M, Carlander-Klint A-K, Hildingsson I, Wiklund I. First-time mothers wish for a planned caesarean section, a deep rooted feeling. *Midwifery*. 2013;29(5);447-52

II. Sahlin M, Wiklund I, Andolf E, Löfgren M, Carlander-Klint A-K."An Undesired Life Event". A retrospective interview study of Swedish women's experience of Caesarean Section in the 1970s and 1980 (submitted)

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Contents

LIST OF ABBREVIATIONS

CTG	CardioTocoGraphy
CS	Caesarean Section
DNA	Deoxyribonucleicacid
EDA	Epidural Anaesthesia
ICM	International Confederation of Midwives
SBF	Swedish Midwifery Association
SFOG	Swedish Federation of Obstetricians and Gynaecologists
SMER	Swedish National Council of Medical Ethics
VE	Vacuum Extraction
WHO	World Health Organisation
WMA	World Medical Association

1. INTRODUCTION

For most people, childbirth is a major life event and leaves no one untouched. The memory of the birth of a child (or children) is something that most people carry with them for the rest of their lives. Transition to motherhood can be a dramatic event: some women are strengthened by the experience; some are traumatized by it. In modern medicine, patients often have the opportunity to choose between different medical treatments. There appears to be a movement to promote the right for women to choose a caesarean section. The outcome of labour can be a spontaneous vaginal birth, an instrumental delivery with forceps, vacuum extraction, or an emergency caesarean section. The number of births by caesarean section in Sweden is 17%, which varies significantly between regions and clinics. In the beginning of the 1970s, Sweden's caesarean section rate was 5 %. In 2018, the proportion of caesarean sections ranged between 7 and 23 %. The proportion of births by caesarean section has not increased as much in Sweden as it has in many other high-income countries (Fig.1) (1).

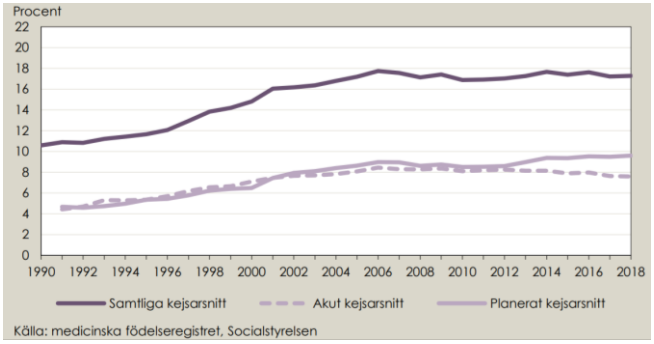

Fig. 1. *Caesarean section rate in Sweden from 1973-2018*

In Denmark and Norway, the figures are the same (2). The caesarean section proportions vary between 1 % and 50 % globally. The WHO withdrew its recommendation for an appropriate number of caesarean sections in a country in 2010 with the following statement: "There is no empirical evidence for an optimum percentage of caesarean section. What matters most is that all women who need Caesarean sections receive them" (2). A recently published WHO report states that a caesarean section national rate above 10 % does not reduce the maternal or neonatal mortality rates (3).

2. BACKGROUND

2.1 Birth From a Historical Perspective

The evolvement in modern obstetric care is believed to be the mainly reason to the decline in maternal mortality in western countries following the 1930s. Public health policy, poverty reduction, and the reduction of malnutrition seem to have less importance on the development of the obstetric care (4). The maternal mortality pattern prior to the evolvement of modern medical technology was not equal in all developt countries. Low maternal mortality rates in The Netherlands, Norway, and Sweden were reported in the early 20th century and were believed to be a result of an extensive collaboration between physicians and highly competent and locally available midwives. Between 1900 and 1904, Sweden had an annual maternal mortality rate of 230 per 100 000 live births, while the rate for England and Wales was substantially higher: 440 per 100 000. Sweden is today in top of the world regarding newborn and maternal mortality. Fewer than three out of 1,000 babies and fewer than four women out of 100,000 die during childbirth. Given its long history of different contributions to the development of the maternal care in Sweden, the country is often highlighted as a success story internationally (4).

From a historical point of view, childbirth has taken place in the home of the birthing woman. Most births in Europe today take place in hospitals, and the rates of planned home births differ between countries (5). Homebirth is uncommon in Sweden, accounting for less than one in every 1000 births; in fact, home birthing is not usually even offered as an option.

2.1.1 Caesarean Sections From a Historical Perspective

Back in the Roman Empire, the purpose of caesarean sections was to separate the foetus from the woman. This was performed either with a small hope of saving the life of the foetus when the birthing woman was dead or was dying. Otherwise, it was performed for religious reasons in order to allow the infant to be buried separately from the mother. Not until the nineteenth century did the possibility of saving life of the pregnant woman even come within the grasp of the medical profession (6). Seventy years ago, maternal mortality following caesarean section was still much higher than mortality after a vaginal delivery. With anaesthetic techniques and the introduction of antibiotics and blood transfusions, the improved safety of modern medicine has made having a caesarean section safer (7).

The world saw the first dramatic increase in caesarean sections in the early 1970s. The introduction of the foetal heart monitoring system - or CTG - was one of the reasons for this increase. The most common indication for caesarean sections was foetal distress. Notzon et al studied the rate of caesarean section by indication in four countries during the 1980s: Sweden, Norway, Scotland, and the United States. The rapid increase in having a caesarean section, which began in the early 1970s, dropped significantly during the 1980s in all four countries. The caesarean section rate declined in the mid1980s in Sweden. By 1990, the overall rate in the countries included in the study ranged from 24 % (in the United States) to 11% (in Sweden). All the investigated countries had similar caesarean section rates for breech presentation, foetal distress, and "other" indications. United States reported higher rate of Caesarean sections after a prior delivery by caesarean section (8).

2.2 Increasing Rate of Caesarean Section

Different aspects of caesarean sections have been the focus for research during the last three decades with an increasing amount of published scientific articles. Furthermore, the subject has also been a hotly debated topic in the media. The Swedish media, in particular, has attributed the increasing rate of caesarean section to women choosing for themselves: particularly, highly educated women with a desire to have a planned caesarean. This picture is not in line with the research, however, which shows that Swedish women who request a planned caesarean section are often lower educated, more vulnerable, living without a partner, born abroad, are more often smokers who often suffer from general anxiety (9), (10). Some reports suggest that women who undergo a planned caesarean section on their own request are significantly more often suffering from mental illness and stress-related disorders (11).

2.2.1 Indications for Caesarean Sections Have Changed

The indications for having a caesarean section have changed over the years. Thirty years ago, the vast majority of pregnant women gave birth vaginally, even if the baby was in a breech position. Today, more than 90 percent of women who are pregnant with babies in a breech position, tend to undergo a caesarean section. The proportion of twin pregnancies that are born via caesarean section has also increased significantly; more than half of all twins in the Sweden are born by caesarean section. One of the groups that has seen the biggest increases in planned caesarean section is healthy first-time mothers with a single pregnancy with a full-term foetus in crown position, in 1990, this group accounted for some

permille; in recent years, they accounted for 3-4 % of the planned caesarean sections with regional variations (1). The authors found that, according to a Swedish study conducted at a university hospital in Stockholm, the main reason for an elective caesarean section in 1992 was pathological foetal position or a uterine factor. At the same hospital in 2005, the main indication for an elective caesarean section was a psychosocial indication defined as maternal fear of birth or maternal request without any co-existing medical indication. The researchers found that the total caesarean section rate rose from 11 % to 20 % (12). According to a qualitative study in Australia, the wish for a controlled delivery and the security that follows a planned caesarean section were the main reasons for some first time-mothers to request a caesarean section (13). The wish to avoid the many unpredictable factors associated with a vaginal delivery has been described as the reason why some women request a caesarean section (14). The Swedish media has also reported that a women's need for control and security are behind the increased numbers of caesarean sections. The authors found that one particular Swedish study states that caesarean section upon maternal request is more common in the capital area (15).

2.3 The Short-Term Impact of Caesarean Section on Mother and Child

The short-term consequences of caesarean section for the mother is mainly an increased risk of infection in the surgical wound and thrombosis: particularly, deep venous thrombosis in the lower part of the body, legs and/or feet, due to immobilisation. Some studies indicate an increased risk for postpartum haemorrhaging following a caesarean section (16), (17). Some literature describes delayed onset of breastfeeding after caesarean section due to more severe pain (16) (17). One Swedish study found there is no significant difference in the mothers' rating of contact with their child between those who had undergone a caesarean section and those who had had a vaginal birth. However, the authors found that mothers who had a vaginal birth experienced less stressful breastfeeding compared to those who gave birth through a planned caesarean section (18).

The most common short-term consequences for the newborn child following caesarean section are different forms of breathing disorders (19). This complication is the most common one in children who have undergone a planned caesarean section. Going into labour is considered to have a positive effect on the child. The contractions of the uterus positively trigger the hormonal responses in the baby. The closer to the estimated date of

birth the planned caesarean section is performed, the smaller the risk is of the child developing a breathing disorder (19), (20). Other relatively common complications following caesarean sections are hypoglycaemia and difficulties in holding one's body temperature (21).

2.3.1 The Long-Term Impact of Caesarean Section on Mother and Child

Following a caesarean section or other surgery in the womb, the risk of uterine rupture increases during the next pregnancy and particularly during the next labour. A uterus rupture is life threatening for both mother and child. Following a caesarean section, various problems have been observed with the placenta in the next pregnancy (22). These complications increase the risk of illness; in the worst-case scenario, there is greater risk of mortality in mother and child. The risk of detachment of the placenta increases by 1.3-2.4 times (23).

The effects of the mode of delivery on the foetus are still only partially known. A Norwegian population-based cohort study found that children born by caesarean section have an increased incidence of asthma and allergies, among other things (24). A Swedish research group has reported similar findings regarding the increased incidence of asthma and/or gastroenteritis during childhood in those born by caesarean section (9). In a recently published study, data suggested that delivery by caesarean section may give epigenetic changes in the DNA. This could indicate that there may be an association between mode of delivery and increased morbidity later in life (25). A Swedish study reports that mode of delivery affects the epigenetics in the stem cells of a newborn. This discovery may have health implications later in life (26).

2.4 Healthcare System in Sweden

The values upon which the health care in Sweden is based on is called *the law of health and welfare*. The latest version is dated from 2017. It says:

"Care must be given with respect for the equal value of all people and for the dignity of the individual. Anyone with the greatest need for health care should be given priority over care."

Over the years, the law has been evaluated and updated.

The foundation of the law consists of the same values since 1982. The later version points out the patient's right to co-determine of their own care (27).The law is based upon some basic ethical principles: human dignity principle, the needs-solidarity principle, as well as cost-effectiveness principle. Cost-effectiveness principle should only come to effect after the needs-solidarity principle has been applied. These principles should guide those who have to make decisions within the health care system regarding priorities; these should be the basis for further consideration and discussion (28). Appendices include the following: "the patient's autonomy and integrity should be respected. Health services should be designed and implemented in consultation with the patient" (29). The Child Convention became new as a law in Sweden in 2020. This means that the best interests of the child should be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies. Sweden was one of the first countries to ratify the convention in 1990. Whether or not the Child Convention will have consequences in healthcare remains to be seen (Convention on the Rights of the Child, 1990).

2.4.1 Swedish Birth Context

Antenatal care in Sweden is organized within the public primary health care system with the midwife as the primary caregiver. Care during labour, birth, and the postnatal period usually occurs in hospitals with midwives as the independent caregiver in uncomplicated cases. When and if a complication occurs, the midwives work in collaboration with the obstetricians. A woman who prefers to have a planned caesarean section needs to go through some formal procedures. She must see an obstetrician who has to be convinced about the need to perform surgery without a medical indication. Prior to that meeting or then some days after, she will see a midwife once again to talk about the reasons behind her wish for a planned caesarean section (30) The majority of obstetric departments in hospitals have established qualified teams with midwives and obstetricians who provide support for women who suffer from childbirth related fear (31).

2.5 Women's Autonomy in Childbirth

The experience itself is an important outcome of birth. Studies of birth outcomes and women's perspectives of care are increasingly used to evaluate and develop maternity care services. Certain elements of care such as support, participation in decision-making,

attentiveness to psychological needs, and wishes for birth, information, and the woman's feelings of being listened to are said to be very important for pregnant women (32) (33). Providing individual and supportive care for all pregnant women in our country is a big challenge when different models of care during childbirth rarely exist (34). Policymakers and professionals must consider how counselling, support, and organisation of care should be designed in order to improve a woman's birth experience (35).

In recent years, some people have been speaking in favour of women's autonomy in childbirth by advocating for caesarean sections on maternal request. Among midwives and obstetricians, the discussion of whether or not healthy pregnant women should be able to choose a caesarean section has been related more to the fear of medicalization of childbirth rather than questions related to autonomy. According to SMER (The Swedish National Council on Medical Ethics), autonomy is "one of the basic principles of medical ethics. It is man himself (here: the woman giving birth) who has the right to decide over her life and her actions. She has the right to decide what she wants to know and not know. She has the right not to be influenced or forced to undergo medical treatments. Conversely, she has a right to know what the treatment involves: the risks of this treatment and how painful it can be, as well as the consequences such a treatment might have and how to avoid them. Subsequently, the pregnant woman has the right to say yes or no to a treatment" (36).

Being autonomous means that you, as a patient, are the one who governs your own life (38). In this case, the patient needs to understand the impact and the given information of having a vaginal birth versus a planned caesarean. According to Sjöstrand et al, there are three elements that have a major impact in discussions about autonomy:

1. Competence, meaning that the patient must be able to have decision making capacity, and to make the right decisions in relation to their plans and wishes.
2. Efficiency, meaning that the patients need to be able to fulfil their goals and plans.
3. Authenticity, meaning that the patient needs a base desire, which emerges through a critical review of information. These three elements are needed for the individual when arguing for one's autonomy (38). The birthing woman and her partner must possess these three skills. They are competent enough to make decisions about their own desires and their own body. They are often very well informed about their own desire of mode of delivery and their rights in relation to their own choice.

2.6 Attitude

Attitudes towards birth and the way in which to support a woman who requests a planned cesarean section have been greatly studied and discussed over the years (39)**.** Decisions are probably not always deliberate. People who are caught between different choices may use their instinct to process information about choice options in accordance with how they feel rather than what they think. Focusing upon feelings of choice causes people to see themselves reflected in those choices. This leads to enhanced attitude certainty and advocacy on behalf of that attitude (40)

As with all psychological constructs, attitudes are latent: i.e. we cannot directly observe them. A mental and emotional entity characterises a person. Social science research points out that attitude is a multi-dimensioned construction (37). Attitude can be formed from a person's past and present. Attention should probably be given to behaviour and subjective norms when attempting to understand attitudes.

3. AIMS

The overall aim of the thesis is to study attitudes regarding caesarean sections among healthy first-time mothers and among those who became mothers by caesarean sections during the 1970s and 1980s. What could be the current underlying reasons for a healthy woman's wish for a planned caesarean section? The aim of the second study in the thesis is to research and describe Swedish women's experience of having undergone a caesarean section during the 1970s and 1980s, and what this experience has meant to the individual woman's health and thoughts about childbirth later in life. The thesis consists of two papers. The specific purposes of the papers are the following:

- Study 1: To investigate the underlying reasons behind the desire to have a caesarean section in the absence of medical indication in healthy first-time mothers.
- Study 2:.To study women´s experiences of caesarean section during the 1970s and 1980s in Sweden.

3.1 MATERIAL AND METHODS

3.1.2 Overall Study Design

Study I & Study II are both based upon a qualitative descriptive study design with content analysis.

Table 1. Papers Included in This Thesis.

Title	Study Sample	Data Collection	Methods of Analysis
First-Time Mothers' Wish for a Planned Caesarean Section: Deeply Rooted Emotions (I)	12 primiparous women	Individual interviews in late pregnancy	Content analysis
"An Undesired Life Event", A retrospective interview study of Swedish Women's Experience of Caesarean Section in the 1970s and 1980s	22 women who underwent caesarean sections in the 1970s and 1980s.	Semi-structured interviews	Content analysis

Qualitative data is a descriptive form of research; it could consist of quotations, observations, focus groups and/or excerpts from documents. This kind of data tells a story. By asking open-ended questions about a critical incident, the investigator might understand experiences and attitudes through a purposeful sample. This captures the respondent's attitude and experience on the given topic. Qualitative research helps the researcher answer questions such as how patients experienced the care and the staff in their interaction with a healthcare provider. Moreover, qualitative research can describe the interaction and cooperation between healthcare providers and the societies in which they are operating (41).

3.2 Study Settings

The study in paper I was conducted at a hospital in the northern part of Stockholm: Sweden's capital. This hospital holds two labour wards with caesarean rates of 18,9% and 21%, respectively (2018). The two wards both account for approximately 10 715 births in 2019.

Paper II is based on a study carried out through snowball sampling using Facebook. The first and last article author of the study sent out a request through their Facebook accounts.

3.3 Data Collection

Data in study I was collected by face-to-face interviews. Two of the authors (MS & AK) interviewed the twelve women. The women included in the study received the invitation to participate during a scheduled antenatal care visit, which had been set up for them to discuss their request for a caesarean section with an obstetrician, as per normal practice in Sweden. The information about the study was given to the women after they were given a scheduled date for a caesarean section. All of the participants spoke Swedish, and all lived in the Stockholm area.

The data in Study II was also collected through interviews. Semi-structured questions were used to explore the experiences of 22 women of giving birth via caesarean section during the 1970s and 80s. The participants in the study were recruited via so called snowball sampling through Facebook (42). The first and last author of the study sent out a request through their respective Facebook accounts. The first snowball sampling was carried out in the fall of 2014 and the second took place during in fall of 2015. The message was shared 29 times via the authors' Facebook friends. This led to 16 women accepting to participate

in the study. Following the analysis of the second sampling, we realised that more data was needed in order to reach a rich description. Therefore, a third invitation to participate was sent out in the fall of 2017. Seven women volunteered to participate; thus, a total sample of 22 women participated in the study. All participants spoke Swedish and lived in different locations throughout Sweden.

3.4 Data Analysis

A content analysis by Graneheim and Lundman was used in both papers I and II. This analysis was done in different steps in order to maintain an objective and systematic process (43). Content analysis is an empirical science, which involves analysing and drawing conclusions from the given information, as per these case interviews. (43). The studies (I&II) focused upon the content in the text, highlighting the visible and obvious components. The interviews were transcribed, and the text was read several times after which the authors began to build meaningful units of text based on content and topics. These meaningful units were condensed in order to shorten the text, yet still maintain the entire contents. Coding and grouping of the condensed text were carried out to reflect the central messages of the interviews. The last step of the analysis was to determine from the codes the overall theme that emerged through the data, as well as a theme that illustrates the latent content of the text. The theme is an interpretation of the underlying meaning. Although the aforementioned procedures explain the process as being linear, the writers moved back and forth between stages throughout the process in order to establish trustworthiness. The two authors worked in parallel, as well as together, with the data in order to ensure reliable interpretation of the data. Reflection and discussion about the codes and categories was continuous throughout the data analysis. Lastly, all of the authors scrutinized and discussed the findings until consensus was reached.

4 ETHICAL CONSIDERATIONS

The Research Ethics Committee at the Karolinska Institute has approved all studies included in this thesis. Due to the extended interviews, a letter was sent to the committee explaining the changes in both Paper I with diary number2008/1686-31/3 and Paper II with diary number 2010/361-31/5. Approval to extend the number of informants in paper II was granted diary number 2017/1818-32.

In paper I, participants were asked to participate in the study around the time of their appointment when their physician approved their request for a planned caesarean. They then received information about the overall plan, purpose, and method of the study. They signed an informed consent. One of the paper's first two authors called the patient a few days after the visit in order to schedule a date for the interview.

In paper II, those who chose to participate responded to an invitation via Facebook. The first and last author of the study started a so-called snowball sampling in order to reach out to possible interviewees in different parts of the country. All interviews were recorded and transcribed with permission of the participants. None of the participants could be identified; thus, all were replaced with codes. The authors were all active clinicians and were, thus, protected by the Public Access to Information and Secrecy Act. The authors were aware that the interviews could provoke thoughts and feelings, for which the participants would be perhaps not prepared.

The studies were conducted in accordance with the Helsinki Declaration; all participants were thoroughly informed and had been given consent to participate before the studies were initiated. (44).

5 RESULTS

5.1. First Time Mothers' Wish for a Planned Caesarean Section: Deeply rooted emotions

Paper I highlighted first-time mothers' desire for a planned caesarean section without medical indication. The interviewed women were all well: both physically and psychologically. Their pregnancies were normal, and they expected to have a healthy child. They were between 25 and 39 years old: spoke Swedish, did not smoke, and all had a professional career: nurse, designer, CEO, etc.

The overarching theme that emerged was that having a planned caesarean is a deeply rooted desire. This feeling goes beyond the fear of childbirth. The emotions were described as deeper than the fear of giving birth.

Four categories emerged throughout the text to describe the content of the interviews: ***feeling there is no other option than to have a caesarean section; a wish for safety and control; managing one's own opinions and reaction, and those of others; and previous experience of health care***. In the category "*No other option than a caesarean*

section" the respondents described as their wish to have a caesarean section was about something deeper than simply the fear of giving birth. The women described the emotions around giving birth vaginally as thoughts and feelings they had since childhood. Several of the respondents had thoughts of avoiding a pregnancy due to these long-standing ideas. Factors, such as age and their partner's desire for children, were decisive factors for pregnancy.

A caesarean section was referred to as being a *safe and controlled way of giving birth*. The reasons the women provided for thinking in such a way included the avoidance of hypoxia for the foetus, controlling pain during the birth and postpartum, and decided on a set time and place to birth. Having a team of doctors, midwives, and other healthcare personnel in the operating room gave them a positive sense of being in control.

Several of the women interviewed reported that they felt secure and determined n their choice of mode of delivery. Several expressed that it felt like the surroundings thought they were cheating, that they chose the "easy way" furthermore, they expressed, that it felt like others viewed them as unfeminine, not good enough, choosing the easy way out, and that they were being provocative. They felt as though they were public property: that other people had the right to comment on their choice of delivery. These reactions deterred the women of talking about their choice with others. The respondents described having a planned caesarean section as a modern way of giving birth. Many stressed it was their right to decide over their own bodies. Many argued it is up to the single individual to decide their mode of delivery. They struggled with "managing their own opinions and reactions with those of others".

Previous experience of health care was the fourth category, in which the respondents described earlier experiences with healthcare: either those experienced for themselves or those by close relatives. Some of the respondents had close relatives with cancer diagnosis who had been ill for many years. Others had been ill or been through a big trauma themselves. regardless of their background, they all described not being seen during their earlier contacts with the healthcare system. They saw this as a feeling of loneliness, not being believed in, poor communication, and a feeling of being invisible. They had decided during these contacts not to expose themselves to anything like that ever again. And so thoughts of a planned caesarean emerged as the only possible option to give birth to any future children. The interviewed women described that the wish for a planned caesarean section was established during previous experiences of health care.

5.2. “An undesired Life Event”, a retrospective interview study of Swedish Women’s Experiences of Caesarean Section During the 1970s and 1980s

With the exception of one, all caesarean sections were conducted as emergency caesarean sections or as sub-acute caesarean sections. Emergency caesarean sections were performed both prior to, as well as following the start of delivery: e.g. the onset of contractions. Dysticoa was the major reason to perform a caesarean section. The sub-acute caesarean sections, which the interviewed women went through were sometimes scheduled from one day to the other, while some were ordered the same day as the dystocia was diagnosed.
The overall theme is formulated as *Caesarean Section: An Undesired Life Event*. This describes the interviewed women's experience of giving birth by caesarean section in the 1970s and 1980s. Four categories emerged from the data set: Vaginal Birth: The Norm; A Total Loss of Control; Acceptance; and Contact With the Child. These women who underwent a caesarean section 30-40 years ago have all mixed feelings toward the operative birth of their children. Most stated that they were intent on and preferred a vaginal birth. Therefore, the women were completely unprepared for a caesarean section which, in turn, had an impact upon the experience of birth. All interviewed women reported unblemished physical health in the long term. In the short term, many described that they had been psychologically affected.
The first category was *Vaginal Birth: The Norm*. A vaginal birth was seen as the only option and caesarean section was performed only for serious conditions. Even those who had heard dreadful birth stories of friends and relatives seemed not to imagine any mode of delivery other than a vaginal birth. They had a curiosity about giving birth vaginally and did not consider any other way of giving birth. The information they received during their pregnancy focused upon vaginal birth. The women received little information of what would happen in case of an emergency followed by caesarean section. Several of those interviewed still felt disappointed with their caesarean section after thirty to forty years. They reported that neither they nor society knew of any other way to give birth other than vaginally; it was the norm. Several of the women had an opinion that caesarean section has become more common, almost a normality, and that it is easier to perform a caesarean section nowadays. Many women talked about an approach where both healthcare workers and pregnant women have a more tolerant attitude toward caesarean section. This mainly

applies to caesarean section without medical indication. Many women described this approach to caesarean section as an attitude, which did not exist back then.

A Total Loss of Control was the second category in the study. The majority of the women who had undergone an emergency caesarean section were not prepared for the event. Those who were interviewed described the experience with such words as surreal, traumatic, and shocking. There were no differences between a planned caesarean section or an emergency caesarean section. They all were poorly prepared for the event, as they were not familiar with the procedure. Others described how they were psychologically affected by the caesarean section and its circumstances. Women who experienced being psychologically affected by the caesarean explained that they did not receive the support they wanted: for example, no one asked questions or paid attention to their psychological well-being. Many who experienced being psychologically affected by the caesarean section also stated that they did not receive the support they wanted. Several felt that no one asked questions or payed attention to their psychological well-being. The women described feeling that information was being withheld from them: before, during, and after the caesarean section. This applies to both the caesarean section, as well as individual events: for example, in the preparation room prior to surgery or in the recovery unit. Information about their post-operative physical condition varied. Some were well informed about what it physically meant to undergo a caesarean section; others knew nothing about what it implied. Furthermore, the women experienced a lack of follow-up and information about what they had been through. They were not given the pre-requisites for feedback or the opportunity to obtain answers to their questions. Some felt that they did not get enough information about their physical condition, while others were satisfied. While in hospital, the women experienced that they did not receive information about what they had been through. They lacked information about how their caesarean section could affect them psychologically and how the procedure affected their bodies during and after the procedure. Women who were eager to know more about their experience of having had a caesarean section, asked for more information when being discharged from the discharging doctor, midwife, or at the midwife in the primary care. Many said they were treated without empathy. They expressed that staff made negative comments directly to them and about them in a way that made it obvious that they would overhear what was being said about them. These experiences were described as having occurred in both the recovery ward and from the postpartum ward.

The third category is A*cceptance*. The women described the physical pain after their caesarean section in different ways. Some were taken by surprise by the pain after the operation, while others stated that they were well pain-relived postpartum. Other women

described that, despite the physical pain, they were mobilized soon after the caesarean section. Others stated the opposite and described the recovery as tough and as something that took a long time. Some women mentioned how the anaesthetic made them feel disconnected directly after the caesarean section.

Some of the women in the study were very ill during and after the operation. Not everyone, however, shared these negative experiences; some women were actually satisfied with the follow-up and the information given to them about their physical condition. Regardless of their physical or mental well-being after the caesarean section, all of those interviewed claimed that their physical health had not been affected in a long-term perspective. Some women talked about how the caesarean section had affected their appearance in different ways. They had also chosen not to allow this to affect them.

Some of the women who have daughters stated that they had not talked about their own caesarean section in a way that had made their daughters want a caesarean section. On the contrary, they had encouraged their daughters to give birth vaginally. Meanwhile, others spoke about caesarean section in a more positive way when talking to their daughters.

The fourth category Contact *with the Child* includes accounts from many of the interviewed women describing a difficulty to embrace the child after the caesarean section. Some of the women could not even understand that the new-born child was theirs. These women explained that, since they were anesthetized, it took long time before they got to meet their child. The time for mother and child to be reunited after the caesarean section varied from direct contact to several days. The time differences were due to the following circumstances: health problems for the woman or the child had to stay at the neonatal ward. When the women then met the child for the first time, it was difficult for her to accept that the child belonged to her since she had not been awake during the birth. The women who had partners that were allowed to be present during the caesarean section and the postpartum care of the baby explained having a sense of security with that; therefore, they explain that the contact with the child was smoother compared to when neither parent was involved in the baby's care. Furthermore, some of the interviewed women talked about the health care environment as being unfavourable for the early establishment of the mother-child contact. These women described that the healthcare environment or healthcare professionals did not support or encouraged early contact with their child. Almost none of the interviewed women talked about early skin-to-skin contact as even being a suggestion.

6 DISCUSSION

6.1 Methodological Considerations

One study in this thesis examined attitudes to caesarean section among a group of healthy first-time mothers. The second study examined mothers' experiences of undergoing a caesarean section during the 1970s and the 1980s. Data collection through qualitative research by semi-structured interviews could both provide a deeper understanding and knowledge of the attitude regarding the mode of delivery among first time mothers and experiences of caesarean section during 1970s and 1980s.

The two studies (Paper I & II) use a qualitative research method. The possibilities for generalisation are limited since qualitative research most often includes a smaller sample size, using questionnaires and/or group interviews to answer questions about attitudes or experiences. The advantage of this is that this methodology helps us to understand what individuals think about their own live experiences (45). Since qualitative research depends upon the formulation of questions and the interpretation of answers, credibility and trustworthiness of the researchers and the study is key. An understanding of preconceived notions and biases of the authors is essential in order to present and interpret the findings in the most truthful way possible (46).

6.1.1 Methodological Discussion

The research design is based upon the research question. Research starts with an interest in a phenomenon. As an example, we asked ourselves what could be the background to healthy first-time mothers requesting a planned caesarean section? In order to collect information about possible reasons for caesarean section on maternal request, we chose to conduct a qualitative interview study with content analysis. How women evaluate their childbirth experience following a caesarean section in a longer perspective is the focus in Study Two.

6.2 DISCUSSION OF RESULTS

The two studies included in the thesis have examined different aspects of attitudes and experiences of mode of delivery in two generations. The following two chapters present the findings study by study, as well in comparison with what is seen as different attitudes toward birth in these two groups.

6.2.1 First time Mother's Wish for a Planned Caesarean Section, deeply rooted emotions

The twelve women interviewed in paper I had all determined they would not undergo a vaginal delivery. They had different reasons for this. Four categories arose in the text:

No Option Other Than a Caesarean Section

A Safe and Controlled Way of Giving Birth

Management One's Own Opinions and Those of Others

Previous Negative Experience of Health Care

A Planned Caesarean is a Deep-Rooted Feeling was the joint theme of the study.

No other option than a planned caesarean section was a category that arose through the data. The respondents reported that they postponed pregnancy due to a deeply rooted and negative emotion toward the thoughts of giving birth. This is in line with Davis-Floyd who argues that there are three different ways to see the body in relation to childbearing: a technocratic, humanistic, and holistic approach (47)**.** Several of the women interviewed in the study were shown to have a technocratic approach to their body and childbearing. They saw themselves as "containers" to a foetus. Women who tend to objectify their bodies may be more attracted to caesarean section. This is in line with Andrist who hypothesises that women who objectify their body are more likely to be interested in a planned caesarean section (48). This approach contradicts the medical culture and their holistic approach to the body and childbirth. Several of the women in our study had built up various strategies in hopes of convincing the doctor to give her or his approval of a planned caesarean section. This meeting was something they all feared. They had different strategies to handle it. Some invented that they had medical problems, which they used as an argument; one even pretended that she was mentally unstable. The women had a preconceived idea of the doctor's attitude to their choice. After the medical meeting, they felt relieved and as thought they had been heard. They experienced this meeting as being much easier than they had imagined. They felt that, after the meeting, they could embrace the pregnancy in a deeper way. Our study shows that women expressed having been heard and listened to and treated respectfully by both midwives and obstetricians through the antenatal period. Gunnervik et al found that midwives working at the antenatal clinics were more willing to understand a woman's desire to have a planned caesarean section than those midwives who worked in the maternity ward (49). Guittier et al and Hellmark-Lindgren found the opposite: that women had been treated by staff lacking in understanding their patients' point of view (50).

Hellmark-Lindgren found that women needed to struggle and argue a lot in order to realise their wish for a planned caesarean section (14). Guittier et al found that there was a built-in hierarchy among the 24 women who were included in their qualitative analysis. Twelve of the women had undergone caesarean section: six had experienced emergency caesarean sections and six went through planned caesarean section. Twelve of the women had undergone vaginal delivery. The women said that, at the top of that hierarchy, were those women who had given birth in a natural way: e.g. no heavy anaesthesia. At the bottom of the hierarchy are those who delivered by caesarean section (50). This finding is in line with our finding in Paper I. The interviewed women had problems dealing with the management of their own opinions and reactions, as well as those of others, toward their choice of mode of delivery. By not giving birth vaginally, they felt unwomanly and thought that others would perceive them in that way too. Furthermore, terms such as cheating and not good enough were highlighted by the women in Paper I. This attitude is different from what the group giving birth between 1970 –1980 are telling us; they expressed that the only way to give birth in their mind was vaginally. They never considered a caesarean section as being an option. At this time in history, birth preparation classes very seldom mentioned.

The first-time mothers we interviewed who had requested a planned caesarean section believed a planned caesarean section to be a safer and more controlled way of giving birth: especially for the foetus. This is in line with other results (51), (52). A planned caesarean section comes with a given birthplace, day, and time; it removes the insecurity and uncertainty associated with a vaginal delivery. Furthermore, the woman will not be referred away from the selected hospital. This result is in line with other Swedish articles (14), (53). Women interviewed in Paper I stated they had been neglected, not seen, and not listened to during contact with healthcare at a young age. Some had suffered from illness and some had had close family members who had had close contact with the health care services. Regardless of how they had acquired the bad experience, they all shared the feeling of not been seen. This meant that, as young girls, they were determined not to expose themselves to the victimization they had experienced. According to them, a vaginal birth is an avoidable exposure. To our knowledge, there are no other studies showing this result.

6.2.2.2 An undesired Life Event: A Retrospective interview study of Swedish Women's Experiences of Caesarean Section During the 1970s and 1980s

The data presented in the second study was collected from a purposeful sample of women who delivered a child by caesarean section 30-40 years ago. It was clear from the interviews that the women in this study had little initial comprehension about operative childbirth. They all were shocked and surprised over the outcome of their birth following the caesarean section. *A Surprising Life Event: Women's Experience of Caesarean Section During the 1970s and 1980s* was the overall theme that emerged through the data, which applies to both the women who gave birth via an emergency caesarean section and those who had a planned caesarean section.

Four categories were identified:
Vaginal Birth as The Norm
Total Loss of Control
Acceptance
Contact With the Child

Vaginal Birth as The Norm was the first category; it describes that women in the study always believed they would give birth vaginally; there was no doubt about that. In our first study where women requiring a planned caesarean section without medical indication, we found that the women expressed there was no other option than a caesarean section (54). This contradiction could be explained by differences between these two generations related to changed norms, both in society and in healthcare. Also, indications have increased for when caesarean section is recommended (54).

Several of the women interviewed still felt disappointed with their caesarean section after thirty to forty years. They reported that neither they nor society knew of any other way to give birth other than by vaginal delivery; this was the norm. The women explain the experiences of a caesarean section as an event for which they were poorly prepared. During the 70s, midwife Signe Jansson introduced in Sweden, what is known as, prophylaxis courses: birthing preparation where the woman learns special breathing techniques. Many of the interviewed women attended these classes, which were located in most parts of the country. The focus of the program was that the woman would give birth vaginally and that, according to Jansson, every contraction would be met with breathing and relaxation (55).

Maternal healthcare did not seem to properly inform the women how a caesarean section was performed. The internet with its huge range of information did not exist. They suffered from a lack of information. According to Young, the births were medicalized during the late 1960s and 1970s, and giving birth was not seen as a natural part of life, as it had been before the medicalization in the 60s. This development of maternity care might have made the women more dependent upon healthcare staff and clinical routines. Midwives and Obstetricians were authoritarians (56).

Total loss of control was the second category in the study, in which the women explain their experiences with words such as "surreal", "traumatic", and a "shocking life event". As they were not familiar with the procedure, women who underwent a planned caesarean section, as well as those who had undergone one in an emergency, felt they were poorly prepared for the event. A study from Canada found that few women were prepared for a caesarean section. They had the goal of giving birth vaginally. Some had not read or informed themselves about anything other than a vaginal birth (57). That is in line with how the women in our study chose to prepare themselves. Others described how they were psychologically affected by the caesarean section and its circumstances. Women who experienced being psychologically affected by the caesarean section told us they did not receive the support they wanted: for example, that no one asked questions or paid attention to their psychological well-being. It seems that the women in the study where not treated differently compared to the women who had given birth vaginally. The women described feeling that information was being withheld from them: before, during, and after the caesarean section. This applies to both the caesarean section as a whole, as well as individual events: for example, in the preparation room prior to surgery or in the recovery unit. Furthermore, the women experienced a lack of follow-up and information about what they had been through. Some felt that they did not get enough information about their physical condition, while others were satisfied. Those affected by a complicated caesarean section, postpartum haemorrhage or high blood pressure after surgery, reported that they experienced a great lack of information. They did not know what had happened. This lack of information about their medical conditions where described by some of them as a painful experience. Furthermore, they lacked information about how their caesarean section could affect them psychologically and how the procedure affected their bodies during and after the procedure. According to Mc Donnell et al, the caring professions tends to treat the women undergoing caesarean section as those who have given birth vaginally; thus, they are not given the same care as other patients who have undergone surgery. If they were to

be treated as though they had just had surgery, one will find possible obstacles to mobilization at an early stage. According to Mc Donnell et al, pain relief is given in a different way in this approach, as opposed to the woman who has just delivered. When the woman is satisfied with the pain relief, mobilization is facilitated and the healing process accelerated, thereby, increasing the women's well-being (58). When being discharged, women who were eager to know more about their experience of having had a caesarean section, asked for more information from the discharging doctor or midwife, or from the midwife in the primary care. Providing information is difficult. In an article exploring women´s health issues, a lack of information between the pregnancy and the postpartum care was described. During pregnancy, information was provided by healthcare providers; information was found on the internet and in various applications. When it came to postpartum information, the women felt dissatisfied with receiving any information regarding, among other things, expected mental health (59). Also, concerns related to the child and the mother's physical health during postnatal care has been described recently (60). Since the sources are far greater in 2017 and 2018 than they were in the 1970s and 1980s, one can imagine the extent to which women felt dissatisfied with receiving information some 30-40 years ago.

Many said they were treated without empathy. They expressed that staff made negative comments directly to them, and about them, in a way that made it obvious they would overhear what was being said about them. These experiences were described from the recovery ward and the postpartum ward. Sally Macintyre found criticisms of the delivery care in Scotland and the UK in 1977; she reported the following issues:

"(a) Being left alone during first stage of labour;

(b) Insufficient explanation or unanswered questions regarding information about procedures;

(c) Husbands not allowed to be present, excluded at certain points, and not contacted;

(d) Not enough choice of analgesia/anaesthesia, too much or too little analgesia/anaesthesia;

(e) Rude or inconsiderate staff, staff treating women as inanimate objects, stupid, or like children;

(f) Neglect in puerperium, baby being removed with no explanations about the baby's whereabouts;

(f) Waiting too long to have episiotomies stitched (61)."

Some of this critique of maternity care is aligned with what women in our study reported. A state-of-the-art document on normal birth was published in Sweden in 2001. The starting point of the report was that the goal of care during childbirth should be to the minimize intervention in the course of achieving redemption: a healthy mother, a healthy baby, and a positive experience of childbirth (62). It is evident that health professions during the 70's and 80's did not know or realise the extent to which an emergency caesarean section influenced the experience of birth. If the baby was healthy, the childbirth experience must be good, and the professions did what was expected of them. Furthermore, it may be that health professionals involved in maternity care were satisfied with finally being able to prioritise the unborn child (which came first in the early 1960s). This was thought to be enough for the woman. For the individual woman, this might have been experienced as a personal failure because all the focus was on the vaginal birth at the time.

In the category A*cceptance*, the women explain that they came to accept the fact that they had been through a caesarean section. They were, indeed, shocked and not satisfied with the experience, but they coped with it; several stated that they came across their negative experiences rather quickly during the postpartum time in the hospital. Several talked about the right decision being made, given the circumstances. There had not been any alternatives. The degree of physical pain following the caesarean section varied between study participants.

The recovery could be tough and take a long time. Regardless of their physical well-being after the caesarean section, the women claimed that their physical health had not been affected in a long term. The experiences of the caesarean section did not affect the women´s intentions to give birth to more children. However, serious medical conditions during pregnancy and birth could be reasons to refrain from a new pregnancy and birth.

Antonovsky explained the origin of health through what is known as the salutogenic model: understanding, manageability, and meaningfulness. These three characteristics are the basis for the salutogenic thinking and are termed "sense of context" (KASAM in Swedish) or as "sense of coherence" (SOC) (63). The interviewed women in our second study have described occasions or situations during and after the caesarean section, which have given them a sense of loss of control, shock, trauma and/or delayed contact with the child. Despite this, they explained they were not physically or mentally affected in the short or long term. According to the salutogenic approach, these findings might be due to the fact that the women in the study occupy a high degree of understanding, manageability, and meaningfulness. Thus, the mode of delivery did not affect their long-term health.

A majority of the women in our study who had daughters reported that they had not talked about the caesarean section as a positive outcome of the pregnancy. They had supported their daughters to give birth vaginally in cases where there was no medical impediment. They did not believe that the indication for their caesarean section would be “inherited”. There were some women, however, that spoke in a more positive way of caesarean section with their daughters and daughters-in-law. Some research indicates a certain relationship to increased risk of dystocia of women who have a mother or sister who had suffered from dystocia when they gave birth. This means there might be a hereditary relationship (64) (65). Algovik et al found that there may be a genetic heredity for dystocia. In 34% of the surveyed families in Algoviks study, the mother had some form of obstetric problems during childbirth (66).

The fourth category, *Contact With the Child* describes their experiences from the first days as a new parent. Several describe the time after the caesarean section with a feeling of loneliness because they had to be by themselves without partner and child. One of the most difficult experience for them was not knowing how or where their baby was. The absence of the child was tremendous. Suspicions about whether the baby was theirs or not hampered their first days and made the initial contact problematic. In some cases, the lack of early contact with the new-born baby led to reduced wellbeing, suspicion of whether or not the baby was even theirs, and delayed contact between mother and child. In some cases, it took them several years to feel a deep mother-child relationship. Recent research has made present obstetrics more aware of the fact that the abrupt interruption of birth - such as emergency caesarean section - creates alienation from the child. The interviewed women´s experiences in this article are in line with a recently published systematic review where evidence on early skin-to-skin contact after birth provides several benefits to both the woman and the newborn. The benefits include providing maternal and newborn analgesia with decreased pain, increasing parental bonding and interaction, and decreasing maternal depression and anxiety (67). Zauderer found that the separation between mothers and new-borns is associated with decreased maternal satisfaction and decreased chance of neuro-behavioural and physiological benefits for mothers and their newborns, and delayed start to breastfeeding (68). Waldenström et al found that separation of mother and child increased the risk of not being satisfied with childbirth. An explanation of the finding might be that there is a lack of knowledge from the caregivers about the specific needs of mothers who are separated from their new-borns (69). At the time when the interviewed women

underwent caesarean section, knowledge about the importance of skin-to-skin contact between mother and baby was not yet known or published.

Birth Preparation

Birth preparation classes have been offered to pregnant women in Sweden since 1948 with the aim of preparing the prospective parents for their new roles in a family. Initially, the focus was only on preparation for the birth itself (70) (71)**.** Weather birth preparation classes effectively prepare mothers and their partners for birth has been discussed and studied and for many years. Birth preparation classes were held simply because health professionals thought that they helped mothers to manage labour and birth (72). Various models of preparation for childbirth have emerged. From the beginning, the classes were addressed to the woman alone; however, her partner became more and more involved. The content and focus of the education have also been broadened and the way the education is organized has changed (70)**.**

During the 1970s, the demands for better maternal and maternity care predominantly came from women's movements. This led to the focus since the 1980s on both preparation for the birth itself and preparation for the expected parenthood.

6.2.3 Autonomy Principles

There has been a lot of discussion about whether healthcare professionals (obstetrician) or the woman herself should have the right to make the final decision about the woman's mode of delivery. When it comes to a healthy woman's planned caesarean section versus a planned vaginal birth, one can argue that it is neither required nor recommended that physicians offer the less beneficial or riskier procedures when choices are no longer equal. If a patient requests a less than optimal option, should the physician respect the patients' wishes? One of the ethical imperatives of patient-centred care is the balanced, evidence-based presentation of risks and benefits of caesarean section by providers to patients. What limitations are there in the woman's right to decide over her own body? According to our beliefs, one has the right to make decisions about one's own health, body, sexuality, and reproductive life without fear, coercion, violence or discrimination. All over the world, however, people's freedom to make these decisions is controlled by the state, medical professionals, laws, and even their own families.

An antenatal consent process, which empowers pregnant women and supports their autonomy requires their consent of provided information to be elicited (73). There could be a difficult balance between a patient's wish and the professional knowledge. If consent is to remain the legal yardstick of autonomous choice-making, women's understanding needs to be more explicitly addressed (73).

6.2.5 Ethical Concerns Regarding Caesarean Section on Request

There are several ethical aspects to consider when a woman demands a caesarean section. ICM, International Confederation of Midwives, follows an ethical code that states: "The midwives are to respect a woman's right to informed choice and support a woman's acceptance of responsibility of her choice". Which treatment is based upon the cost-effectiveness principle and the marginal utility principle is another ethical consideration, meaning the cost of treatment should be reasonable from a medical, humanitarian, and socio-economic point of view. The medical professions need to take the pregnant woman's right to her own autonomy into account. This might be a difficult ethical decision to make when the vast majority who want a planned caesarean section are actually healthy women and the indication for surgery hardly exists.

The compensation for the actions made in maternity care varies slightly between the municipalities in Sweden; however, it is clear the cost involved in an uncomplicated caesarean section is generally double that of a normal vaginal delivery. With the tax-funded socialised healthcare system in Sweden, priorities among different groups of patients begs discussion, from both an economic and moral point of view. From a global perspective, increasing rates of caesarean section are debated since there is evidence that medically unnecessary caesarean sections are associated with worse outcomes for mothers and their children (74). Is it, therefore, viable to accept healthcare to perform caesarean section without a medical indication? Is it viable not to respect the autonomy of a pregnant woman who asks for one? What responsibility has the medical profession when a patient chooses a less beneficial choice for the birth of her child?

7 FINDINGS

The two papers involved in this thesis reveal different aspects of attitudes toward the mode of delivery. These attitudes and experiences among the two generations of women participating in this research could probably be explained by changes in healthcare. They may also reflect attitudes in society. We found some similarities among the women in the study despite many differences among the two study groups. The detected common areas are the following: a need for clarity of information, an empathetic approach of all healthcare personnel, and participation in decisions made regarding the care for the mother and baby. That being said, they have different reasons for their wishes about how care should be structured. The women in study I argued that it is their legal right to have a planned caesarean section. And they were well informed of their rights. The women in Study II did not want the caesarean section they had, nor did they choose their mood of delivery. The women in Study II seem to have a more hierarchical approach to physicians and healthcare professionals than those in the first study. A lot has happened in the area of technological development during the years between the study groups that gave birth. Nowadays, it is extremely common to own a smartphone. With new technology, access to information has dramatically increased. The fact the study groups differ in terms of knowledge before giving birth can be attributed to technological developments.

Paper I

The results from paper I show that a request for a planned caesarean section can be a deeply rooted feeling among first-time mothers wanting to avoid a vaginal delivery. The women who participated in the semi-structured interviews conducted in the study put words to their thoughts and feelings about the mode of delivery. They had carried with them the feeling of not wanting to go through a vaginal birth since childhood, through youth, and into their adult lives. Several had postponed pregnancy and childbirth because they could not imagine giving birth. There are several reasons why they eventually chose to become pregnant. These factors include age and the fact their partner wanted to have children.

There were several reasons why they did not want to undergo pregnancy and childbirth. They were attracted to the control and security that came with a planned caesarean. A given time and a given place were important factors for these first-time mothers. One of the reasons for their preference to have a planned caesarean came from feelings of loneliness and vulnerability in association with the treatment they received from healthcare providers during their childhood and/or adolescence. These negative experiences led them to decide

early in life not to submit to a vaginal birth. Their choice of the mode of delivery proved to be a complex social issue for them. They felt that friends and relatives, and even people they did not know took the liberty to voice their opinions aloud about their choice of giving birth in a way that disturbed them. This group of women insisted that the mode of delivery is their right to choose. In some cases, they refer to the healthcare law and, in some cases, to their right to autonomy. Paper I shows that in this group, the women's wish to avoid vaginal delivery goes far beyond fear of childbirth.

Paper II

The findings in Paper II reveal the overarching theme: that undergoing a caesarean section during the 1970s and 1980s was a surprising event for the women who participated in the study. Those interviewed put words to the experience of giving birth by surgery. They had no other option in mind throughout the pregnancy other than tom give birth vaginally. In one way or another, they all expressed having experienced feelings of loneliness, exposure, vulnerability, and being contested. The perception of pain was more difficult when the confirmation of pain was missing and the identity as a mother was less clear in those who experienced a low degree of confirmation.

The women in the study expressed being surprised that the birth ended with a caesarean section; it was something they had not had in mind. Some of the women who have daughters stated that they had not talked about their own caesarean section in a manner that influenced their daughters decision to have a caesarean birth. In fact, they had explicitly encouraged their daughters to give birth vaginally when the time came for them to deliver. Meanwhile, others spoke about caesarean section in a more positive way when talking to their daughters. The second study in the dissertation demonstrates that women carry with them their experience of having had an emergency caesarean for a long time, most probably for life. Healthcare could learn from their experience and work further to develop methods that ensure mother and child are not separated directly after birth.

Furthermore, the study is important for neighbouring areas with which obstetrics collaborate: anaesthesia and neonatology. It is important that all the related birth resources understand the importance of the woman's experience.

7.1 Conclusions and Clinical Implications

This research could be of clinical importance. In Papers I & II we found that previous negative contact with health services can leave deep wounds and have a lasting effect of not being seen or heard. Healthcare students and staff must be aware that patients often feel lonely and vulnerable during hospital stays. Furthermore, decision makers should understand that healthcare needs good staffing and peripheral resources in order to create an environment that has the appropriate time to devote to their patients. Also, healthcare leaders on the clinical level must support a culture where patients' voices are important and where there is time for communication.

Sweden is a world leader in terms of safe obstetric care. The rate of maternal and child mortality is very low. This research increases the knowledge of pregnant women's individual and personal arguments to have a planned caesarean section at their own request without a medical indication. Moreover, the second study highlights the importance of preparation for childbirth and the need of patient-centred holistic care. This raises the awareness that, at the time when these women gave birth, the health profession and the birthing women were not quite compatible. Pregnant women were not prepared for a complicated birth and maternity care was, at that time, an institution that focused mainly on saving lives and was not used to involving the women and her partner in discussions related to their birth. Healthcare providers should listen to the birthing woman and her partner. Furthermore, the study is important for neighbouring areas that work with obstetrics: anaesthesia and neonatology. It is important that all the related resources around the maternity care understand the importance of the woman's experience.

Attitudes and indications related to caesarean section have changed over time. In modern medicine, women and their partners are more involved in the process leading to giving birth by caesarean section. As established, some women argue that it is their right to decide mood of delivery. Women in this study who gave birth 30 to 40 years ago were not prepared for anything other than a normal vaginal delivery. Critiquing the prevailing paradigm and, instead, listening to the experience of pregnant women and their partners could prove to be a fruitful strategy in order to improve healthcare during birth.

7.1.2 Take Home Messages

- Attitudes and expectations in relation to birth have changed during a relatively short period in time.
- The woman's participation in the birth should be encouraged through good information, participating in decisions, and respectful treatment and individualized care.
- Early contact between parents and children in a calm and supportive atmosphere should be encouraged.

8 FUTURE RESEARCH

These two studies touch the surface of many questions that remain unanswered: for example, the right of the unborn child. If the child has a less ideal start after a planned caesarean section compared to those children born via vaginal delivery, is it correct to agree to a caesarean section without a medical indication? The pregnant woman can state her opinion; the unborn child cannot.

The women who were interviewed in Paper I where all children 25-30 years ago. A lot of time has passed since they were dependent children. The experience they had when they were children might not reflect the healthcare of today. Still, they refer to what they have experienced - whether it is being a patient or being a relative to a sick parent or sibling. How the experience of healthcare affects one’s future trust in healthcare is an interesting area for future research. When children are involved, it is important to investigate, ensure, and follow up on how and if healthcare performs safely and harmoniously on all levels.

Furthermore, it would be of great importance to invent a screening instrument, such as a tool, for the obstetricians and midwives to use in their daily activities, which would facilitate communicating with women who demand a caesarean section without medical indication. There are reasons to believe that some women should be offered a planned caesarean section without medical indication, while others should be guided through a vaginal delivery. These women might change their minds and opt for a vaginal birth if

maternity care could offer a better alternative based upon proper continuity and the informed support from a known midwife.

9 SUMMARY IN SWEDISH

9.1 Bakgrund

Barnafödande är en stor händelse i livet för de flesta människor och minnet av ett barns födelse är något som de flesta människor bär med sig under resten av sina liv. Att bli mamma kan vara en erfarenhet som stärker vissa kvinnor och traumatiserar andra. I modern sjukvård kan patienter ibland välja mellan olika medicinska behandlingar. När det gäller barnafödande har det också varit en trend mot ett ökat inflytande från den gravida kvinnan för rätten att välja en förlossning med kejsarsnitt. En förlossning kan sluta på många sätt, spontant och okomplicerat, med sugklocka/tång eller med ett akut kejsarsnitt.
I Sverige har andelen förlossningar med kejsarsnitt ökat från 5 procent år 1973 till 17,5 procent år 2017 (Socialstyrelsens data). Den grupp som i särklass bidragit mest till den observerade ökningen är gruppen fullgångna barn i huvudbjudning och enkelbörd.
Kejsarsnitt genomförs antingen som ett akut ingrepp under pågående förlossningsarbete eller som ett planerat ingrepp. Indikationerna vid planerade kejsarsnitt sker antingen av medicinska skäl eller på grund av att den gravida kvinnan inte kan tänka sig att genomgå en vanlig vaginal förlossning. Internationellt uppskattas kejsarsnitt *på kvinnans* begäran variera mellan 4-18 % av alla kejsarsnitt. Om en frisk kvinna i Sverige önskar föda barn med planerat kejsarsnitt utan att medicinsk indikation för detta föreligger, remitteras hon till en obstetrisk mottagning på närmaste sjukhus. Där kommer hon att samtala med en specialist (förlossningsläkare) som har till uppgift att fatta beslut om hennes önskemål ska tillmötesgås eller ej. Det har kliniskt visat sig vara svårt att neka dessa patienter ett planerat kejsarsnitt. Upplevelsen av att föda barn genom kejsarsnitt för 30-40 år sen är inte kartlagt tidigare. Hur upplevde de att föda med kejsarsnitt? Som kliniskt verksamma barnmorskor önskade vi genomlysa detta. Det är av stor vikt att granska och kunna sin historia för att driva arbetet framåt.
Det är känt att faktorer som bidrar till friska kvinnors efterfrågan av kejsarsnitt är relaterat till ålder över 35 år, tidigare erfarenhet av planerat eller akut kejsarsnitt, en tidigare negativ förlossningsupplevelse, en komplicerad graviditet och förlossningsrädsla. Det har även visat sig finnas en relation mellan socioekonomiska faktorer som arbetslöshet, rökning och etnicitet. I gruppen kvinnor med låg utbildning och låg inkomst har man också funnit att

önskan om kejsarsnitt är vanligare än hos andra. Denna grupp av kvinnor tenderar även att få mer prenatala depressiva symtom och skiljer sig i viss utsträckning i sin personlighet från kvinnor som planerar en vaginal förlossning. Djupare kunskap om hur friska kvinnor som önskar kejsarsnitt resonerar kring sitt barnafödande och om sina förväntningar saknas idag.

9.2 Syfte

Det övergripande syftet med avhandlingsarbetet är att öka kunskapen om faktorer som kan ha en betydelse för förändringar avseende attityder till barnafödande, med särskilt fokus på kejsarsnitt. Avhandlingen består av två delarbeten. Det specifika syftet för respektive delarbete är:

- Studie 1: att undersöka bakgrunden till önskan om att föda barn med planerat kejsarsnitt hos friska förstföderskor (intervjustudie med kvalitativ design).
- Studie 2: att undersöka hur kvinnor som genomgick kejsarsnitt på 1970 och 1980 talen upplevde sitt barnafödande och kontakt med det nyfödda barnet samt den egna hälsan i ett längre perspektiv (intervjustudie med kvalitativ design).

9.3 Metod

I den första studien användes en kvalitativ metod. Tolv friska kvinnor som väntade sitt första barn intervjuades. Samtliga av de intervjuade hade önskat samt fått beviljat ett planerat kejsarsnitt utan medicinsk indikation. Intervjuerna genomfördes under graviditetsvecka 26-36. Innehållsanalys användes analysmetod.
I studie två genomgick tjugotvå stycken kvinnor som fött barn med kejsarsnitt på 1970-talet och 1980 - talet intervjuer. Svaren analyserades med hjälp av innehållsanalys. Frågorna var semi-strukturerade. Rekrytering av deltagare till studien skedde med en så kallad ”snowballsampling” via Facebook. De 22 intervjuade kvinnorna födde barn i olika delar av Sverige på små och stora kliniker.

9.4 Sammanfattning av resultat

Förstföderskorna i den första studien beskriver sina tankar kring barnafödandet som en djupt rotad känsla av att *inte* vilja föda barn vaginalt. De har undvikit graviditet och barnafödande på grund av dessa negativa känslor. Avgörande faktorer som gjorde att de genomgick graviditeten var partners önskan om barn samt åldersfaktorn. Ett kejsarsnitt ansågs som ett mer kontrollerat och säkert sätt att föda barn. En given tid och plats för

födelsen tilltalade dem. Deras tankar har funnits med dem sedan barnsben. De har upplevt en avsaknad av förståelse och tillit vid tidigare kontakter med hälso- och sjukvården vilket har lett till att de undvikit en intim kontakt med sjukvården så som att föda vaginalt innebär, menar de. Deras önskan om ett planerat kejsarsnitt går bortom rädsla för att föda, det är djupare än så uppger de i studien.

I den andra studien beskriver kvinnorna sina erfarenheter av att genomgå kejsarsnitt på 1970 och 1980-talen. Det var på flera sätt en chockerande upplevelse. Att vara separerad från sitt barn uppger flera av kvinnorna som en jobbig upplevelse, det har både kortvariga och långvariga konsekvenser hos den nyblivna mamman. Vidare beskrev de att stödjande kommunikation är av stor betydelse när man tar hand om en ny mamma i en svår situation. Att få information om vad som har hänt är viktigt. De flesta kvinnorna accepterade vad de hade upplevt och påverkades således inte på långsikt fysiskt eller psykiskt av den turbulenta upplevelsen av att genomgå kejsarsnitt. Minnet av en förlossning är starkt och kvinnan bär det med sig under stora delar av sitt liv.

9.5 Metodologisk diskussion

I denna avhandling, ingår två studier vilka den i den första undersöktes attityder till kejsarsnitt bland en grupp friska förstföderskor samt i den andra studien undersöktes kvinnors erfarenhet av att genomgå kejsarsnitt på 1970-talet och 1980-talet. Datainsamling genom enkätundersökning och kvalitativ forskning med hjälp av semistrukturerade intervjuer kan både ge en djupare förståelse för och kunskap om vissa företeelser. I detta fall om barnaföderskor, barnmorskor och förlossningsläkares inställning till förlossningssätt.

Kvalitativ forskning är av värde då forskare önskar gå in på djupet i hur människor resonerar, tycker och tänker kring ett givet ämne. Metoder som används då kan vara intervjuer av enskilda individer, samtal i fokusgrupper eller genom observationsstudier. Begränsningen kan vara att det är små material vilket gör att det inte går att generalisera resultatet. Å andra sidan, har inte den kvalitativa forskningen för avsikt att svara på en generaliserande nivå, den svarar på vad vi som individer tycker om våra egna erfarenheter i ett givet ämne.

Generellt väljs forskningsdesign baserat på forskningsfrågan. Forskningsprocessen startar i ett intresse för ett fenomen. Som exempel frågade vi oss vad som kan tänkas vara bakgrunden till att friska förstföderskor vill genomgå ett planerat kejsarsnitt. För att få

information om tänkbara orsaker valde vi att genomföra en kvalitativ intervjustudie med innehållsanalys.
Vidare funderade forskargruppen på hur det var att föda med kejsarsnitt under tidigare generationer. Hur upplevde kvinnorna det då? Även denna studiedesign valde forskargruppen att använda innehållsanalys.

9.6 Slutsats och kliniska implikationer

Studie I påvisar fyra stycken kategorier som gör att dessa förstagångsmödrar önskar ett planerat kejsarsnitt utan medicinsk indikation. Dessa är:

- “Inget annat alternativ än kejsarsnitt”.
- “En önskan om kontroll och säkerhet”.
- “Hantering av egna och andras åsikter samt reaktioner “ .
- “Erfarenhet av sjukvården”.

Det övergripande temat - “ett planerat kejsarsnitt är en djupt rotad känsla”. Deras önskan om ett planerat kejsarsnitt är bortom förlossningsrädsla, det är djupare än så, ansåg deltagarna i studien.

Data som presenteras i studie II samlades in från ett urval av svenska kvinnor som har fött barn genom kejsarsnitt för 30-40 år sedan. Kvinnorna i studien hade överraskande lite kunskap om operativ förlossning och var inte förberedda för en komplicerad förlossning. Det övergripande temat som framkom var att kejsarsnitt under 1970-talet och 1980-talet var på många sätt en "överraskande livshändelse ". De var dåligt förberedda på att ett kejsarsnitt faktiskt kunde inträffa. De fyra kategorierna som forskargruppen fann var:

- ”Vaginal förlossning, en norm
- ” Kontrollförlust”.
- ”Accepterande”.
- ”Kontakt med barnet.”

Kvinnorna som intervjuades i studie II var oförberedda på ett kejsarsnitt. Detta beskrev de som hade genomgått ett planerat kejsarsnitt såväl som de som hade genomgått ett akut kejsarsnitt. Upplevelsen beskrevs i ord som traumatisk och chockerande.

Avhandlingen kan bidra till att öka kunskapen och förståelsen för hur vissa kvinnor resonerar kring sitt barnafödande. Avhandlingen bidrar vidare med kunskap om att upplevelser av sjukvård tidigare i livet kan påverka känslor inför barnafödande. Fler av de intervjuade kvinnorna talade om traumatiska upplevelser, egna och anhörigas, som de bär med sig under livet. När de senare i livet ska föda barn värjer de sig, så långt det går, för att utsätta sig för intima situationer. Mer forskning behövs för att undersöka detta fynd. Att vara kritisk mot rådande paradigm kan vara fruktbara strategier för att förbättra vården under förlossningen. En öppenhet och beredskap att lyssna på kvinnor och deras partners och omvärdera gamla idéer bör vara en naturlig del av svensk förlossningsvård. De intervjuer som genomförts i denna avhandling mellan två olika generationer tyder också på att attityder och förväntningar kring barnafödande har förändrats under en relativt kort period.

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References

1. The National Board of Health and Welfare. *Medicinska födelseregistret.* Stockholm : www.socialstyrelsen.se, 2018.
2. Luz Gibbons, José M. Belizán, Jeremy A Lauer, Ana P Betrán, Mario Merialdi and Fernando Althabe. *"The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage.".* u.o. : World Health Report, 2010.
3. Betran AP, Torloni MR, Zhang JJ, Gu¨lmezoglu AM for the WHO Working Group on Caesarean Section. WHO Statement on Caesarean Section Rates. . *BJOG.* 2016, ss. 667-670.
4. Högberg, U. *Maternal mortality in Sweden.* Umeå : Umeå University, 1985.
5. Lindgren, H, Kjaergaard, H, Olafsdottir, OA, Blixt, E. Praxis and guidelines fore planned homebirth in the Nordic countries – an overview. *Sex Repr Healthc.* 2014, ss. 3-8.
6. Medicine, US National Library of. www.nlm.nih.gov/exhibition/cesarean/. *www.nlm.nih.gov.* [Online] December 2015.
7. Francome C, Savage W. Caesarean section in Britain and the United States 12% or 24% is either right rate? *Soc.Sci.Med.* 1993, ss. 1199-1218.
8. Notzon C, Cnattingius S, Bergsjö P, Cole S, Taffel S, Irgens L, Daltveit A-K. Cesarean section delivery in the 1980s´: international comparison by indication . *Am J Obstet Gynecol.* 1994, ss. 170:504-8.
9. Källén K, Rydhström H, Otterblad Olausson P. *Kejsarsnitt i Sverige 1991-2001.* Stockholm : Socialstyrelsen, 2005.
10. Wiklund, I. *Caesarean section on maternal request. Personality, fear of childbirth and signs in depression in first-time mothers(PhD thesis).* Stockholm : Karolinska Institutet, 2007.
11. Sydsjö G, Möller L, Lilliecreutz C, Bladh M, Andolf E, Josefsson A. Psyciatric illness in women requesting caesarean section. *BJOG.* 2015, ss. 351-358.
12. Vladic Stjernholm, Y, Petersson, K, Eneroth, E. Changed indications for cesarean sections. . *Acta Obstetrica et Gynecologica.* 2010, ss. 89;49-53.
13. Fenwick J, Staff L, Gamble J, Creedy D.K, Bayes S. Why do women request caesarean section in a normal healty pregnancy. *Midwifery.* December 2010, ss. 394-400.
14. Hellmark-Lindgren, B. *Pregnoscape: Den gravida kroppen som arena för motstridiga perspektiv på risk, kön och medicinsk teknik (PhD thesis).* Uppsala : Uppsala University, 2006.
15. Karlström, A, o.a. Cesarean section without medical reason, 1997 to 2006: a Swedish register study. *Birth.* 2010, ss. 11-20.
16. Karlström A, Lindgren H, Hildingsson I. Maternal and infant outcome after caesarean section without recorded medical indication: findings from a Swedish case-control study. *BJOG.* Mars 2013, ss. 479-86.
17. Bodner K, Wierrani F, Grunberger W, Bodner-Adler B. Influence of the mode of delivery on maternal and neonatal outcomes: a comparison between elective caesarean section and planned vaginal delivery in a low-risk population. *Arch Gynecol Obstst* . 2011, ss. 1193–8.
18. Klint Carlander A-K, Edman G, Christensson K, Andolf E, Wiklund I. Contact between mother, child and partner and attitudes towards breastfeeding in relation to mode of delivery. *Sexual & Reproductive Healthcare.* 2010, ss. 27-34.
19. Tita AT, Landon MB, Spong CY, Lai Y, Leveno KJ, Varner MW. Timing of elective repeat cesarean delivery at term and neonatal outcomes. *N Engl J Med.* January 2009, ss. 111-20.

20. Hansen AK, Wisborg K, Uldbjerg N, Henriksen TB. Risk of respiratory morbidity in term infants delivered by elective caesarean section: a cohort study. *BMJ.* January 2008, ss. 85-7.
21. Hägnevik K, Faxelius G, Irestedt L, Lagercrantz H, Lundell B, Persson B. Catecholamine surge and metabolic adaptation in the newborn after vaginal delivery and caesarean section. *Acta Paediatr Scand.* September 1984, ss. 602-9.
22. Ecker, J. Elective cesarean Delivery on Maternal request. *JAMA.* 2013, ss. 1930-1936.
23. Lagercrantz, H, Hellström-Westas, L, Norman M. *Neonatologi.* Lund : Studentlitteratur, 2015.
24. Tollånes MC, Moster D, Daltveit, Lorentz M, Irgens MD. Cesarean Section and Risk of severe childhood asthma: A population-based cohort study. . *J Pediatr.* 2008, ss. 153:112-6.
25. Schlinzig T, et al. Epigenetic modulation at birth – altered DNA-methylation in white blood cells after caesarean birth. *Acta Paediatr.* 2009;98, ss. 1096-9.
26. Almgren M, Schlinzig T, Gomez-Cabrero D, et al. Cesarean delivery and hematopoietic stem cell epigenetics in the newborn infant: implications for future health? *Am J Obstet Gynecol.* 2014, ss. 1-8.
27. Parlament, The Swedish. Hälso- och sjukvårdslag (2017:30). Stockholm : u.n., 2017.
28. Hälso- och sjukvårdslag (1982:763).
29. Patientlag (2014:82).
30. Socialstyrelsen. *Rapport 2011:09 Indikation för kejsarsnitt på moderns begäran.* Stockholm : Socialstyrelsen, 2011.
31. Karlström A, Engström-Olofsson R, Nystedt A, Thomas J, Hildingsson I. Swedish caregivers´ attitudes towards caesarean section on maternal request. *Women and birth.* 2009, ss. 57-63.
32. Hodnett, E.D, o.a. Continuous support for women during childbirth. *Cochrane Pregnancy and Childbirth Group.* February 2011.
33. Thorstensson S, Ekström A, Lundgren I, Hertfelt Wahn, E. Exploring Professional Support Offered by Midwives during Labour: An Observation and Interview Study. *Nursing Research and Practice.* 2012, ss. 648405-658405.
34. Tingstig C, Gottvall K, Grunewald C, Waldenström U. Satisfaction with a modified form of in-hospital birth center care compared with standard maternity care. *Birth.* June 2012, ss. 106-14.
35. Bergeron, V. The ethics of cesarean section on maternal request:a feminist critique of the American College of Obstetricians and gynecologists' position on patient-choice surgery. *Bioethics.* 2007, ss. 478–487.
36. The Swedish National Council on Medical Ethics. *http://www.smer.se/.* [Online]
37. Tanya K, Altmann RN. Attitude: A concept Analysis. *Nursing forum.* 07 2008.
38. Sjöstrand M, Eriksson S, Juth N, Helgesson G. Paternalism in the Name of Autonomy. *The Journal of Medicine & Philosophy.* 2013, ss. 710-724.
39. Möller L, Josefsson A, Lilliecreutz C, Gunnervik C, Bladh M, Sydsjö G. Reproduction, fear of childbirth and obstetric outcomes in women treated for fear of childbirth in their first pregnancy: A historical cohort. *Acta Obstet Gynecol Scand.* Dec 2018.
40. Maglio, S. J. Reich, T. Feeling certain: Gut choice, the true self, and attitude certainty. *Emotion.* 2019, ss. 876-888.
41. Greenhalgh T, Annandale E, Ashcroft R, Barlow J, Black N, Bleakley A et al. An open letter to The BMJ editors on qualitative research. 2016 BMJ, s. 352;i562.
42. Atkinson R, Flint J. Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies. *Social Research Update.* 2001, s. Issue 33.
43. Graneheim U. H, Lundman, B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today.* 2004, ss. 24(2), 105-112.

44. *WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects.* [Online] www.wma.net.
45. Kvale S, Berinkmann S. *Den kvalitativa forskningsintervjun.* Lund : Studentlitteratur, 2009.
46. Quinn, Patton Michael. *Qualitative research & Evaluation methods.* u.o. : Sage Publications, 2002.
47. Davis-Floyd, R. The technocratic, humanistic and holistic paradigs of childbirth. *Int J Gynecol Obstet.* 2001, ss. 5-23.
48. Andrist, LC. The implications of objectification theory for women´s health: menstrual suppression and "maternal request" caesarean section delivery. *Health care Women Int.* 2009, ss. 551-65.
49. Gunnervik C, Josefsson A, Sydsjö A, Sydsjö G. Attitudes towards mode of birth among Swedish midwives. *Midwifery.* den 26 Feb 2010, ss. 38-44.
50. Guittier M-J, Cedraschi C, Jamei N, Boulvain M, Guillemin F. Impact of mode of delivery on the birth experience in first-time mothers: a qualitative study. *BMC Pregnancy and childbirth.* August 2014.
51. Akintayo AA, Ade-Ojo IP, Olagbuji BN, Akin-Akintay OO, Ogundare OR, Olofinbiyi BA. Cesarean section on maternal request: the viewpoint of expectant women. *Arch Gynecol Obstet.* den 31 October 2013.
52. Pakenham S, Chamberlain SM, Smith GN. Womens view on elective primary caesarean section. *J Obstet Gynaecol Can.* 2006, ss. 1089-94.
53. Wiklund I, Matthiesen AS, Klang B, Ransjö-Arvidsson AB. A comparative study in Stockholm of labour outcome and women´s perceptions of being referred in labour. *Midwifery.* 2002, ss. 193-9.
54. Sahlin M, Klint-Carlander A-K, Hildingsson i, Wiklund I. First-time mothers wish for a planned caesaren section-Deeply rooted emotion. *Midwifery.* den 27 Feb 2012.
55. Abascal, G. *Att möta förlossningssmärta.* Stockholm : Bonniers Fakta, 2013.
56. Young, IM. Pregnant embodiment: subjectivity and alienation. *J Med Philos.* den 9 Feb 1984, ss. 45-62.
57. Somera MJ, Feeley N, Ciofeni C. Women´s experience of an emergency caesaren section. *J Ckin nurs.* 2010.
58. McDonnell NJ, Keating ML, Muchatuta NA, Pavy TJ, Paech MJ. Analgesia after caesarean delivery. *Anaesth Intensive Care.* 2009 Jul, Vol. 37(4)539-51.
59. Guerra-Reyes L, Chrustie V.M, Prabhakar A, Siek K. Mind the Gap: Assessing the Disconnect Between Postpartum Health Information Desired and Health Information Received. *Women´s health issues.* 2017.
60. I Wiklund, J Wiklund, V Pettersson, A-M Boström. New parents' experience of information and sense of security related to T postnatal care: A systematic review. *Sexual & Reproductive Healthcare.* 2018.
61. MacIntyre, S. The Management of childbirth: a review of sociological research issue. *Soc. Sce & Med.* 1977, ss. 477-484.
62. Nordström L, Waldenström U. *Handläggning av normal förlossning, State of the art, normal birth.* Stockholm : Socialstyrelsen, 2001.
63. Antonovsky, A. *Health, stress and coping.* San Fransisco : Jossey-Bass, 1979.
64. Berg-Lekas ML, Hogberg U, Winkvist A. Familial occurrence of dystocia. *American journal of obstetrics and gynecology.* 1998, ss. 117-121.
65. Varner MW, Fraser AM, Hunter CY, Corneli PS, Ward RH. The intergenerational predisposition to operative delivery. . *Obstetrics and gynecology.* 1996, ss. 905-911.
66. Algovik M, Kivinen K, Peterson H, Westgren M, Kere J. Genetic evidence of multiple loci in dystocia-difficult labour. *BMC Med Genet.* den 30 June 2010.

67. Moore, E. R., Anderson, G. C., Bergman, N., & Dowswell, T. Early skin-to-skin contact for mothers and their healthy newborn infants. . *Cochrane Database of Systematic Reviews.* 2012.
68. Zauderer, C., Goldman, S. Cesarean mothers' perception of benefits associated with skin-to-skin contact. . *Journal of Obstetric, Gynecologic, & Neonatal Nurses.* 2012, ss. 150-151.
69. Waldenström U, Rudman A, HildingssonI. Intrapartum and postpartum care in Sweden: Women´s opinions and risk factors for not being satisfied. *ACTA Obstetricia et Gynecologica.* May 2006, ss. 551-560.
70. Hallgren A, Lundgren I. *Förlossningsförberedelser och metoder för att hantera.* Lund : Studentlitteratur, 2010.
71. Gleichmann, L. *Föräldrarskap mellan styrning och samhällsomvandling. En studie* av syn på föräldrar och relation mellan familj och samhälle under perioden 1957-1997. Stockholm : HSL förlag, 2004.
72. Bergström M, Kieler H, Walldenström U. Psychoprophylaxis during labor: associations with labor-related outcomes and experience of childbirth. *Birth.* Mars 2010.
73. Nicholls J, David AL Iskaros J, Lanceley A. Consent in pregnancy: A qualitative study of the views and experiences of women and their healthcare professionals. . *Eur J Obstet Gynecol Reprod Biol.* Jul 2019, ss. 132-137.
74. Wiklund I, Cheung Fen N, Cadée F. Appropriate use of caesarean section globally requires a different approach. *The Lancet.* Oct 2018.