Midwifery 62 (2018) 6–13

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

A qualitative study of nulliparous women's decision making on mode of delivery under China's two-child policy

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ARTICLE INFO

Keywords:
Decision making
Mode of delivery
Nulliparous women
Two-child policy

ABSTRACT

Objective: To explore nulliparous women's perceptions of decision making regarding mode of delivery under China's two-child policy.
Design: Qualitative descriptive design with in-depth semi-structured interviews.
Setting: Postnatal wards at a tertiary specialized women's hospital in Shanghai, China.
Participants: 21 nulliparous women 2–3 days postpartum were purposively sampled until data saturation.
Methods: In-depth semi-structured interviews were conducted between October 8th, 2015 and January 31st, 2016.
Results: Two overarching descriptive categories were identified: (1) women's decision-making process: stability versus variability, and (2) factors affecting decision making: variety versus interactivity. Four key themes emerged from each category: (1) initial decision making with certainty: anticipated trial of labour, failed trial of labour, 'shy away' and compromise, anticipated caesarean delivery; (2) initial decision making with uncertainty: anticipated trial of labour, failed trial of labour, 'shy away' and compromise; (3) internal factors affecting decision making: knowledge and attitude, and childbirth self-efficacy; and (4) external factors affecting decision making: social support, and the situational environment.
Conclusion and implications for practice: At the initial period of China's two-child policy, nulliparous women have perceived their decision-making process regarding mode of delivery as one with complexity and uncertainty, influenced by both internal and external factors. This may have implications for the obstetric setting to develop a well-designed decision support system for pregnant women during the entire pregnancy periods. And it is recommended that care providers should assess women's preferences for mode of delivery from early pregnancy and provide adequate perinatal support and continuity of care for them.

Introduction

Decision making on mode of delivery is a process involved by both clients and health care providers, based on specific clinical assessment and women's preferences (Kaimal and Kuppermann, 2012). Determining the optimal delivery approach for each pregnant woman is critical to providing high quality, woman-centred care in both midwifery and obstetrics (Yee et al., 2015). However, although the natural process of vaginal birth has been viewed as the unquestioned mode of birth, the caesarean section rates in recent years have risen beyond the WHO recommended maximum level of 15% in many countries worldwide (Khan et al., 2017; Chung et al., 2017). According to a WHO survey, the caesarean delivery rate in China reached 46.2% (Lumbiganon et al., 2010). In addition to medical indications, non-medical factors such as improved surgical technologies, overused monitoring methods, older age of first-time mothers, high birth weight, doctor recommendations, and maternal request have contributed to the increase in caesarean section rate (Hsu et al., 2008; Deng et al., 2014; Wang, 2017).

Under China's one-child policy, women had considered caesarean section as the optimal delivery mode to assure fetal safety. The majority of women chose an elective caesarean section to deliver their first child in the belief that they would have no further pregnancies. Therefore the one-child policy was seen as a potential factor for causing China's high caesarean section rate (Wang et al., 2012). However, with the emergence of population aging problems this widely criticised policy came

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https://doi.org/10.1016/j.midw.2018.03.007
Received 31 October 2017; Received in revised form 14 February 2018; Accepted 11 March 2018

to an end in 2014. Then a two-child new birth policy, which allowed families to have a second child if either parent is an only child, was officially announced by the Chinese government. In December 2015 the Chinese government announced again that all couples were allowed to have two children, marking the new beginning of the universal two-child policy (Zeng and Hesketh, 2016; Kim, 2015). The launching of this two-child policy has raised new concerns that there will be an immediate shortage of midwives, obstetricians and neonatologists required to meet additional demand for maternity care services. In addition, there will be an increasing trend towards the anticipated higher proportions of women with advanced age and potential complications. These high-risk pregnant women and women who have had a previous caesarean delivery will entail challenges for China's health care system (Cheng and Duan, 2016). Therefore, the Chinese government has endeavoured to increase social awareness of the advantages and disadvantages of different modes of birth, to develop more midwifery resources, and to improve antenatal counselling in maternity care settings.

Currently, the implementation of China's two-child policy has made numerous families reshape their birth intentions and decision making on mode of delivery (Zhu et al., 2016). A decision-making process regarding mode of delivery has a dynamic nature during the course of pregnancy and labour (Kaimal and Kuppermann, 2012; Deng et al., 2014). Women's preferences for delivery mode differ widely within diverse cultural backgrounds. Deng et al. (2014) found that 25% and 28% of pregnant women without medical indications had preferences for caesarean deliveries during the early and late trimesters, respectively, while their actual caesarean section rates accounted for 48%, much higher than the expectations (Deng et al., 2014). Yet correlations have also been found between women's preferences and actual mode of delivery. Studies have demonstrated that among women who attempt a vaginal delivery, the strength of this preference has been associated with increased likelihood of achieving this goal (Wu et al., 2014; Yee et al., 2015). The cause of high caesarean section rates is multifactorial, among which, caesarean section for maternal request accounts for a large proportion of China's high caesarean section rate. A cross-sectional study conducted in China reported that the rate of caesarean delivery for maternal request was 16.6% in secondary hospitals and 10% in tertiary hospitals (Wang et al., 2017). The major reasons that Chinese women request caesareans include fear of pain, anxiety about the ability to give birth, worry about fetal safety, and the ability to choose an auspicious date for the birth (Sharpe et al., 2015; Wang, 2017). Furthermore, Lowe (2000) pointed out that childbirth self-efficacy is considered to be a key determinant prompting women to have preference for normal vaginal delivery. Beyond that, social relationships and support during pregnancy and childbirth provide a critical role in affecting women's decision making on mode of delivery and ensuring their well-being both physically and mentally (Mlotshwa et al., 2017; Stutzer et al., 2017).

Kaimal and Kuppermann (2012) stated that primary caesarean delivery requires both the clinical assessment and judgment of the provider performing the procedure and the consent of the patient. Maternal request may have a significant influence on mode of delivery as a result of a greater emphasis on consumer choice. Women are encouraged to have the right to be involved in decisions related to their delivery mode (Dunn and O'Herlihy, 2005). Meanwhile, for obstetric care providers, providing the optimal delivery mode is a key factor to ensure maternal and fetal health and safety. Therefore, shared decision making between women and healthcare providers is recommended to establish a co-operative process facilitating a reciprocal knowledge flow (Noseworthy et al., 2013). The shared decision-making model has become popular in some clinical contexts in obstetrics, including for decision making regarding mode of delivery (Kaimal and Kuppermann, 2012).

However, in China maternity health care is an obstetrician-led model. In China pregnant women receive routine antenatal care from obstetricians at the clinics. Almost all midwives employed in hospitals work in labour and delivery units, providing intrapartum care for labouring women. During each antenatal visit, women can only spend a few minutes with their obstetrician due to the large number of women requiring assessment and time constraints (Gu et al., 2013). Therefore, they do not usually gain sufficient information from obstetricians. No adequate time is routinely arranged for making shared decision makings between women and the care providers. Although women can seek information from other sources including their family members, friends, media of various types, etc., such information obtained might be informal and misleading. Therefore, Chinese pregnant women lack adequate support in decision making about childbirth-related issues including mode of delivery. This gives rise to questions about how Chinese nulliparous women shape their specific expectations or preferences for mode of delivery and fulfil this decision-making process. Therefore, we consider it essential to understand and describe women's perceptions of decision making on mode of delivery in the context of China's two-child policy.

Methods

Aim

The aim of this study was to explore and describe Chinese nulliparous women's perceptions of decision making regarding mode of delivery under China's two-child policy.

Design

To obtain a full understanding of nulliparous women's perceptions of decision making regarding mode of delivery, a qualitative descriptive design with semi-structured interviews and interpretive dimension (Richard, 2011) was chosen. The qualitative research was developed to explore the everyday world of human beings, such as their experiences, perceptions, attitudes and beliefs (Jirojwong et al., 2014). Such an approach enabled us to unfold the hidden meanings behind the women's decision making on delivery mode. The research team was comprised of three graduate student investigators trained in qualitative research methods (GCY, SS, TH), three clinical midwifery supervisors (ZXL, WXJ, ZY) with qualitative research experience, and one nursing professor (DY) with expertise in qualitative research methodology.

There is a dearth of research using qualitative method to explore women's decision making in terms of mode of delivery, especially in the context of China's two-child policy. As such, our study adopted the descriptive qualitative approach to describe and understand nulliparous women's perceptions of decision making regarding delivery mode in the context of new child policy.

Participants

Women were eligible to participate if they met the following criteria: (1) singleton pregnancy; (2) nulliparous women 2–3 days postpartum (including spontaneous and forceps vaginal delivery, selective planned caesarean section, and emergency caesarean delivery in labour); (3) Shanghai local residency; (4) Mandarin speaking; and (5) aged 18–49 years. A total of 35 nulliparous women were eligible to participate in this study. Purposive sampling was undertaken to ensure the recruitment of a wide range of first-time mothers of diverse ages, and with different modes of delivery in the study setting. This sampling method is the process of identifying and deliberately selecting the cases that the researcher believes will provide 'information-rich' data (Collingridge and Gantt, 2008). Thus, we recruited 35 participants and the final sample size was 21. As data redundancy was occurring and no new information emerged after the 21th interview, data saturation was reached and there was no necessity to recruit more women.

Data collection

This study was carried out in the postnatal wards of the Obstetrics and Gynecology Hospital of Fudan University, Shanghai, China. The hospital is a specialised tertiary teaching hospital in China. There are 29