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Vaginal Birth After Caesarean:

Views of women from countries with low VBAC rates

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Conflict of Interest

All authors assure that there are no actual or potential conflicts of interest, including financial and personal relationships with people or organizations within three years of beginning the submitted manuscript that could inappropriately influence (bias) this work.

Abstract

Problem and background: Vaginal birth after caesarean section is a safe option for the majority of women. Seeking women's views can be of help in understanding factors of importance for achieving vaginal birth in countries where the vaginal birth rates after caesarean is low.

Aim: To investigate women's views on important factors to improve the rate of vaginal birth after caesarean in countries where vaginal birth rates after previous caesarean are low.

Methods: A qualitative study using content analysis. Data were gathered through focus groups and individual interviews with 51 women, in their native languages, in Germany, Ireland and Italy. The women were asked five questions about vaginal birth after caesarean. Data were translated to English, analysed together and finally validated in each country.

Findings: Important factors for the women were that all involved in caring for them were of the same opinion about vaginal birth after caesarean, that they experience shared decision-making with clinicians supportive of vaginal birth, receive correct information, are sufficiently prepared for a vaginal birth, and experience a culture that supports vaginal birth after caesarean.

Discussion and conclusion: Women's decision-making about vaginal birth after caesarean in these countries involves a complex, multidimensional interplay of medical, psychosocial, cultural, personal and practical considerations. Further research is needed to explore if the information deficit women report negatively affects their ability to make informed choices, and to understand what matters most to women when making decisions about vaginal birth after a previous caesarean as a mode of birth.

Keywords:

Content analysis; focus groups; Vaginal Birth After Caesarean; Caesarean Section; women's views

Statement of significance

Problem	Knowledge is lacking on women's views on factors of importance for improving VBAC rates in countries where the VBAC rate is low.
What is already known	In an international context of decreasing vaginal births and increasing CS rates, VBAC may have an important role to play in offering women opportunity to give birth vaginally. Some women who wish for VBAC have difficulties in obtaining relevant information in maternity organisations/cultures having risk-oriented views on VBAC.
What this paper adds	Increased evidence of what factors women in countries with low VBAC rates consider important for achieving VBAC.

Background

Continued increases in caesarean section (CS) rates are of global concern¹ due to the serious health risks for women and children²⁻⁴. In some countries the rate of CS has now reached 50%^{1,5}. An important factor contributing to the rising rates is repeat CS following a previous CS⁶.

For most women with a history of CS, vaginal birth after caesarean (VBAC) is considered a reasonable and a safe option^{3,7}. The rates of VBAC vary globally, with rates of 32% in United States of America (US), 32% in Australia, and 26% in the United Kingdom (UK)^{8,9}. In European member states VBAC rates are significantly higher in Finland, the Netherlands and Sweden (45-55%) than in Germany, Ireland and Italy (29-36%), even though VBAC success rates are known to range between 70 to 87%¹⁰. Despite this, the declining rates of VBAC indicate that many women with a previous CS undergo a routine repeat CS in the subsequent pregnancy¹⁰⁻¹².

Knowledge about women's views and experiences on VBAC is limited¹³. One recent study from countries with high VBAC rates demonstrated that VBAC seemed to be facilitated when it was the first alternative for both clinicians and women; however the women did ask for more individualised

support and information¹⁴. There are only a few qualitative studies describing women's perspective on VBAC in countries with low VBAC rates. These studies, originating from Australia, US and UK, demonstrated that women request balanced information, particularly on the advantages of VBAC, and seek a more supportive attitude from clinicians in relation to their questions^{13,15}. In the absence of such support, some women search additional information themselves from other sources such as the Internet¹⁶.

In summary, the question on VBAC is important in regard to women's needs, and the decreasing VBAC rates as well as increasing CS rates internationally. However, knowledge is lacking on women's views on how VBAC rates may be improved. The aim of this paper is to report women's views on important factors to improve the rate of VBAC in countries where VBAC rates are low.

Methods

This study of women's views of VBAC who have experienced one previous caesarean section is a part of the OptiBIRTH project, funded by the European Commission under the Seventh Framework Programme for Research and Technological Development (FP7). The OptiBIRTH study is a cluster randomised trial designed to increase VBAC rates in three European countries, Germany, Ireland, and Italy, through woman-centred care¹⁷. In order to do so a complex intervention was developed by the research team. The intervention contained an evidence-based education component¹⁷ for women and clinicians grounded on data from two systematic reviews^{18,19} and the findings from interviews (focus groups and individual) with women and clinicians in Finland, Sweden and the Netherlands (countries with high VBAC rates)^{14,20} and Germany, Ireland, and Italy (considered as countries with low VBAC rates). This paper presents findings from focus group interviews with women in Germany, Ireland, and Italy.

As little was known about women's views on the factors that might improve VBAC rates a qualitative approach was chosen, which would allow the research team to explore the research topic²¹. Focus group interviews were selected as the primary method of data collection as they are an effective way of gathering data on values and attitudes from groups of people, through social interaction²². However, we used individual or telephone interviews as well, since not all women could attend the focus groups. The focus group questions were generated through discussion and consensus amongst the research team. The voice of women and maternity care consumers were represented on the research team by a member of the Association for Improvements in the Maternity Services (AIMS) (<http://www.aims.org.uk/>). Five questions were asked at each interview (focus group or individual), in each country: 1. 'In your opinion, what are the important factors for VBAC?'; 2. 'What are the barriers to VBAC?'; 3. 'What is important to you as a woman (in relation to VBAC)?'; 4. 'What is your view on shared decision-making?'; 5. 'How can women be supported to be confident with VBAC?'

The interview data were analysed through conventional inductive content analysis according to Elo and Kyngäs²³, and Hsie and Shannon²⁴. The aim of qualitative content analysis is to use the data to build a model to describe the study topic in a conceptual framework, which is useful when there are no previous studies in that area²³.

Settings

In all three countries, publicly-funded maternity care is provided free of charge but there is also a private healthcare model existing in parallel. There are also some variations between countries in the way services are delivered, depending on local policy, clinical guidelines and legal frameworks.

In Germany, maternity services are mainly funded by the state, and some women choose to access care privately. Most women have antenatal care in a private practice (consulting rooms) mostly provided

by an obstetrician and further equipped with a midwifery service. Booking at the hospital is usually not required before 36 weeks of gestation. Women can also choose to contract a self-employed midwife, who will undertake part of the antenatal care and will be the main care provider during birth. The caesarean section rate in Germany is 31%⁵ but rates vary widely between regions and institutions^{11,25}.

In Ireland, the main publicly-funded model of maternity care is hospital-based, even for women without identified risks, and is consultant-led and midwife-managed²⁶. It can include shared antenatal care between the general practitioner (family physician) and hospital consultant, with birth occurring in hospital. Other models of care exist, such as DOMINO schemes, care in midwife-led units or homebirth provided by self-employed community midwives, but these were not offered by the particular sites taking part in the study. The CS rate in Ireland is 27%⁵, but rates vary widely across the 19 maternity units. The rate also varies within units, depending on whether women are attending as public, semi-private or private 'patients'²⁷. The Health Service Executive's clinical practice guideline on mode of birth following one previous caesarean section²⁸ recommends that all women should have a formal review with a senior obstetrician in early pregnancy, to discuss care in pregnancy and planned mode of birth.

In Italy, maternity care is also funded by the NHS, but antenatal care is mainly provided by private obstetricians. There are few midwife-led units, four of which, in Genoa, Florence, Modena and Turin, are built alongside the obstetric unit. Women deemed to be at 'low-risk' in pregnancy may choose to give birth at home, but this option is not funded by the public system and the home birth rate is low. Midwives are usually employed in the healthcare system and report to obstetricians, but they are still responsible for caring for women in normal pregnancy and labour. In some regions, community midwives provide maternity care to healthy women with low risk pregnancies, in health centres, referring them to hospitals near their expected delivery date, or when the risk of a complication arises

as set out in national guidelines. The overall CS rate in Italy is 38%⁵, but rates vary widely across the maternity units in the country, reaching 40 to 90% in southern regions. A national guideline on caesarean section²⁹, states that if there are no complications, all women should be offered a VBAC, and recommends counselling to support decision-making on the mode of birth.

Participants and data collection

Focus groups with women were conducted, in both urban and rural maternity unit settings, in 2012–2013. In order to be eligible women had to have experienced one previous caesarean section and be attending an intervention site for their maternity care. In each country, women who met the eligibility criteria were approached during their attendance at their antenatal clinic visits by a researcher and, or on the post-natal ward by a midwife and, if they expressed interest, were given an information leaflet and consent form. Interviews were held within the following two weeks at the respective maternity units at a time convenient for the participants. Five standardised questions were put to participants in each site in the same order to minimise variation in the data collected. The interviews were audio-taped. Near the end of the interviews issues important to the participants were confirmed with them. Moreover, the participants were given a final opportunity to add supplementary data. There was little variation in the data in terms of women's responses to the questions posed with the exception of how women might be supported to achieve a VBAC within the local setting and organisation of care.

In total 51 women participated across three countries. At this point enough information was retrieved to inform the design of the intervention³⁰. In Ireland (IR), data were derived from three focus group interviews (FGI) with in total 10 women, and individual telephone interviews with two women. Two of the women planned for VBAC, two women planned to have repeat CS, and the others were undecided. In Italy (IT), four focus groups were held with 20 women and in Germany (G) data were derived from three focus groups with 19 women. Seven women in Germany and one in Italy had experienced VBAC.

Data analysis

All interviews were transcribed verbatim in the language of the country and translated into English. Different analysis steps were then used: selecting the units of analysis, making sense of the data as whole, open coding, using coding sheets, grouping, categorising and abstracting²³. Sections of the interview text that answered the five questions were chosen as the units of analysis. Members of the research team in each of the three countries open-coded in their own language, which resulted in 5-10 subcategories per question. Country teams then translated the data into English and forwarded their initial analysis to CN, who together with IL synthesised the datasets. Similarities between countries could thus be identified and context-specific findings noted for discussion at the implementation phase of the educational intervention. The team met by SKYPE to discuss coding, interpretation, and emerging findings; this was critical to ensure consistency and accuracy of interpretation, especially when text was being translated. The data were also validated via email, using the Track Changes tool in MS Word. Repeated validation of the findings by all team members was crucial for maintaining rigour as data analysis proceeded and the findings were confirmed.

Ethical considerations and approval

The Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin, gave ethical approval for the OptiBIRTH trial and each of its constituent parts (Ireland). Permission to access women attending their unit was granted by the relevant local ethics committees Hannover Medical School, Nr. 1541-2012, date 04.09.2012 (Germany) and Comitato Etico dell'azienda Ospedaliera Universitaria San Marino, Genoa Nr. 18/12, date 24.08.2012 (Italy). The researchers in the participating countries gave written informed consent.

Findings

The factors women in Germany, Ireland and Italy identified as important for improving VBAC rates are presented in five categories, each with several subcategories (Table 1).

Table 1. Women’s views on important factors to improve the rate of VBAC: Categories and subcategories

Category	Subcategory
All involved having the same opinion about VBAC*	Different caregivers having a positive view on VBAC
	Reaching and keeping a mutually agreed plan for VBAC
Shared decision-making with clinicians supportive of VBAC	Understanding women’s different needs for participation in decision-making
	Women are exposed to different opinions from clinicians
Receiving correct information	Getting information as early as possible about the option of VBAC
	Balancing positive and negative factors
Being prepared for a VBAC	Antenatal classes and meeting other women with experience of VBAC
	Making a birth plan
	Process negative birth experiences and alleviate fear
A culture that supports VBAC	Confident clinicians who inspire women and respect their needs
	Questioning beliefs such as ‘once a CS always a CS’

*VBAC – Vaginal Birth After Caesarean

The categories and their subcategories are presented below using illustrative quotations, each identified by the woman’s country code: D (Germany), IRL (Ireland), and I (Italy).

All involved having the same opinion about VBAC

Different caregivers having a positive view on VBAC

In general women mentioned that it is very important that all professionals, who care for pregnant women with a previous CS are consistent in terms of their approach to VBAC. This consistency needs

to be present irrespective of professional background (obstetrician or midwife) or location and employment status (self-employed obstetricians and obstetricians in the clinic).

“For me it was very important that both obstetricians and midwives have the same attitude. I didn’t have this feeling in a clinic while attending antenatal classes”. (D)

“I think if the woman knows that the consultant, registrar and midwife are in agreement with each other, because they have conversed over it, that also improves their decision to continue with a VBAC. We are all singing from the same sheet”. (IRL)

However, opinions on VBAC vary between obstetricians, and the women in Italy said they were guided by recommendations of their obstetrician.

“Often the safest option depends on the obstetrician. The safest for him”. (I)

They asked for improved collaboration between midwives and obstetricians and this might be achieved through the formation of a ‘pro vaginal birth’ clinical group. Likewise, women from Ireland told of how their perceptions varied in terms of whether clinicians were supportive of VBAC or not. Clinician’s confidence and positive attitude towards VBAC was also mentioned as important by women in Germany.

“I was shocked that one third of women in Ireland were having CSs- this can’t be right? I was told if I have a CS first time I will always have one- it was the doctor in the antenatal clinic that said it to me.” (IRL)

“The combination of facts and a positive attitude towards VBAC, that it is feasible, it was the best for me” (D).

Women in Italy mentioned the importance of knowing their clinicians, and speaking about their feeling together with the clinicians.

“Once you are in labour, you really don't need that much the 6 meetings of the antenatal classes, perhaps you use what you've been taught, but I wanted to know where I was going to go, the midwives and the obstetricians” (I).

Women in Germany stated that it is important for women to feel well cared for during VBAC, and that a midwife is present. They want to be in control and hope that they will be offered different options such as a choice of positions in labour. Women in Italy mentioned the feeling of being a protagonist during birth as important. The partner's support and presence was revealed as important to women.

“I want to have self-control and self-determination in this situation.” (D).

“Being awake was important, I felt that not giving birth vaginally was a defeat, I didn't want to lose the moment of the birth” (I).

Reaching and keeping a mutually agreed plan for VBAC

Women mentioned the relationship with clinicians during pregnancy and birth as vital in maintaining their goal of VBAC. Women wish to be empowered, and they look for clinician's that have a positive attitude towards VBAC.

“The doctors in the clinic ‘Y’ were very kind and didn't make any fear, I felt empowered, it was very good” (D).

However, women's building of confidence in VBAC could depend on whether they had the same caregiver or had to see new clinicians at each appointment.

“When you go to your GP and then you come to clinic and you have a different midwife and then you could see someone different on the team every time as well so for you to get, to build up some sort of confidence, to be talking to someone different every time and you are just repeating yourself. And you get to the stage where you are like what is the point in me telling you because you won't see me the next time” (IRE).

Women in Italy stated that it was difficult to reach agreement with the obstetrician about VBAC, and then to maintain that agreement during labour. Women raised concern that even when a decision is made with the lead obstetrician to attempt a VBAC, if a different obstetrician is on duty when they are admitted in labour, pressure to deviate from the agreed plan and to acquiesce to a repeat CS may be applied. Some women had such a strong objection to a CS that they decided to give birth at home because they were frightened to end up in an operating theatre if they went to the hospital.

“When you get to the hospital, which is a very sensitive time, if you find an obstetrician who talks about enormous risks [associated with VBAC] and says that a CS would be better, you won't be a heroine and put your child's life at risk”. (I)

In one of the focus groups a woman gave an example of how, with the support of a midwife, she stood up against an obstetrician's decision to repeat a CS.

“Perhaps we shouldn't be led by fears, even the obstetrician's fear. We should have confidence in our rights and our willpower”. (I)

Shared decision-making with clinicians supportive of VBAC

Understanding women's different needs for participation in decision-making

The extent to which women wish to be involved in the decision-making process varies. Although some women are keen to be involved in the discussion that includes weighing up the evidence for and against VBAC, not all women are seeking this level of involvement in the decision-making process. Some women in Germany indicated that they would prefer to follow advice given by the obstetrician, some Italian women mentioned public midwives, while others in Ireland spoke of the importance of education in order to feel empowered to make an informed decision. Some women may even consult a number of professionals before reaching a decision.

I talked to my consultant; she said that she would prefer a CS if the anatomical functions of the maternal pelvis are not good. But I also consulted two other consultant obstetricians. In principle, that was the decision-making". (D)

The women in Ireland and Germany frequently referred to what they perceived to be an absence of shared decision-making, and lack of support, particularly in state funded maternity care settings.

"There is no process of shared clinical decision making with public patients as there isn't as much frequency and consistency in terms of appointments". (IRL)

"According to my experience I consulted several doctors, everyone says something different, but in the end the same conclusion: 'You have to decide yourself'. (D)

Given the perceived lack of support from clinicians in making a decision to undergo a VBAC, some women spoke about the importance of their partner's opinion when making a choice between a VBAC or a repeat elective CS.

"[My partner] was affected after the birth of my daughter so he wanted me to go for a section as well because there is no guess work, there is more structure with an elective

section than waiting to go into labour and then you don't know what is going to happen. I asked him what did he think I should do and he can't even talk about her birth still". (IRL)

"Getting our partners involved in this choice is fundamental. I told my partner 'if there isn't fetal distress, even if I am unable to make a decision, don't you dare give them consent to perform a C section!'" (I)

Women in Germany suggested that midwives could be good partners in the decision-making process as they are the most important professionals during normal birth, and they would like to have this in the future.

"It's not really necessary that it must be a doctor. I would prefer to confide in my midwife. I experienced my births more midwife-led, the doctors just came at the end". (D)

Women are exposed to different opinions from clinicians

Women raised concerns about differing opinions as to whether a VBAC is recommended or not.

"I had several talks to three different doctors. At the end three different opinions: 'we can take things as they came; 'it will be the same bad birth process as the last time'; 'it will be very easy'" (D)

One barrier described by the women is the general feeling of hostility against VBAC in some hospitals. One woman indicated that the objection to VBAC is more for the convenience of the hospital than an assessment of the woman's suitability, based on her obstetric history.

“Obstetricians gave me the impression that a CS would be the ideal solution, better planning, also comfortable for doctors. I think it is often a little propagated from doctors that one should not take a risk”. (D)

Data from each country indicated that clinicians opposed to VBAC will only present the negative aspects, whilst others are more open-minded. Women in Ireland and Italy mentioned hospitals commonly known among women as more ‘pro VBAC’.

“[Planned VBAC] is possible in only two hospitals in XX [city]. In the other hospitals it isn't even mentioned”. (I)

“When I asked for a VBAC at my first visit the doctor told me all about the risk of uterine rupture etc., it was like a horror story to be honest. If I hadn't been so convinced a VBAC was what I wanted I would have given up. I had images of an alien bursting out of me- the way it was presented was very frightening. ... I was presented with all the inconvenience of VBAC and all the positives of CS. (IRL)

Receiving correct information

Getting information as early as possible about the option of VBAC

Data from the women indicated that clinicians frequently failed to offer information on VBAC and some women did not know it was an option after a CS. Women commented on the fact that even when they did receive information it was too late in the pregnancy to consider VBAC as a viable alternative.

“Information must be given because it must be clear that there is an alternative to caesarean after a caesarean. Often the fact that you can give birth vaginally after a C-section isn't even taken into consideration”. (I)

“I didn’t get any information, just asked if I wanted to go for it [VBAC]”. (IRL)

Women also felt that VBAC should be advertised more widely on TV, as well as within the hospital, in clinics and waiting rooms, so that women can begin to start thinking of it as a normal outcome after one CS.

“There should be a media advertising, to make it a natural choice. If we heard about it on TV it wouldn't sound so strange. It would become automatic”. (I)

Women emphasised the importance of addressing the issue of the next birth immediately after the primary CS. Information on the potential for VBAC should be given soon after the caesarean birth, including debriefing as to why the CS was required. Verbal information was preferred, but leaflets were also important.

“I don’t know if it is possible to be informed earlier about VBAC that would be great. But, in general, as soon as possible”. (D)

However, if information about VBAC soon after the CS birth did not happen, women suggested the subject should be addressed at the booking visit on the subsequent pregnancy. Moreover, women expressed their need for frequent consultations. As complications had arisen previously, women wanted reassurance from the obstetrician on this pregnancy.

The last time I was in an out-patients clinic and I saw a midwife most of the time but this time they say I am high risk so I see the doctor. This time I have had a lot more scans, time and care. Even though the last time the midwife was lovely, and that, I would prefer meeting the doctor this time. (IRL)

Balancing positive and negative factors

In addition to receiving information regarding the pros and cons of a VBAC, women also indicated that information regarding the risks and consequences of a repeat CS is also necessary, and in particular an explanation as to why a repeat CS might be required.

“Are there any risks in a VBAC? Yes like everything in life. If we list all risks of a CS and we compare them to the risk of uterine rupture, probably we've got to put things in perspective”. (I)

Women felt that having accurate information about both VBAC and repeat CS enabled them to prepare for different circumstances during birth.

“It is true, it is painful, but if you are accompanied and prepared, trained for the pain, you can make it. It is something natural. There is pain but if it is managed, accepted, then it gets more bearable, especially if somebody is informed”.(I)

“I think that evident data is good information; they told me 1%” [risk of uterine rupture].” (D)

Moreover, the women were concerned about the delayed recovery time following CS, and wanted to avoid a prolonged recovery if possible.

“Once 37 weeks comes I am going to be trying to go into labour myself because who would want to spend five days in hospital after having an operation with a baby and a child at home”. (IRL)

Some women searched the internet as they were concerned that there simply wasn't time afforded in the clinics to discuss the options to their satisfaction, and they wanted to be prepared. They commented on how it can carry worrying information on VBAC. Although women were concerned

about the reliability of the information they sourced on the internet, which was often related to women's experiences rather than robust evidence, some did find it useful.

“Internet is extremely important for VBAC. I read a lot of studies. There are a lot of mothers who already experienced VBAC. There also are a lot of groups talking about VBAC on Facebook”. (I)

Being prepared for a VBAC

Antenatal classes and meeting other women with experience of VBAC

Antenatal classes specifically targeted at VBAC to inform and support women were suggested by the women. However, it was also felt that this class should cover both outcomes- VBAC and the possibility that some women will inevitably have a repeat CS (planned/emergency/ or in labour). It could be a chance for pregnant women after previous CS to talk about their experiences and perceptions concerning the following birth. In conventional antenatal classes these themes have no or little place or time.

“If there would be a group of women who did have a CS and who want to have a natural birth, communication would be better than in a mixed group of women (CS and natural birth)” (D).

The women suggested that meeting other women who have had a VBAC can inspire women to give birth. In addition to the educator/professionals giving women the confidence that they were capable of giving birth vaginally, speaking to women who had a VBAC might also be beneficial and they would like to hear their experiences of women who have had a VBAC, either during meetings or on the web.

“Talking to other women who have had a VBAC... That would be very important” (IRL).

Being able to talk to women with this experience might alleviate feelings of loneliness, and convince women to consider VBAC.

“I must say I was very lonely during this experience , not finding other women who had this experience, not knowing what options I have in this second pregnancy” (I).

In addition to antenatal classes, the women also described different kinds of training as ways to prepare themselves for VBAC. They mentioned autogenic training, breathing techniques, acupuncture, steam baths and perineal massages and mental training.

“I think that a mental training is necessary to be prepared to childbirth. If you want to succeed in having a vaginal birth, you have to mature consciousness in time” (I).

Making a birth plan

Women suggested that it might be helpful to have a personal plan for birth. They stated that women want to be sure, that all relevant factors are known to all professionals, so that they do not have to tell everyone the same story repeatedly. They want to know specific information on whether labour can be augmented following a CS and under what circumstances a repeat CS is indicated. Most importantly they want staff to know their preferences so that they can be supported during the birth.

“It would be good and very helpful for doctors and midwives during birth to be informed about the personal history, wishes, problems and other relevant concerns. What are this woman’s preferences? How can they support her?” (D).

“I want to get more information this time and I have written that up in the birth plan so that they tell me more about what is going on [during labor and birth]” (IRL).

Some of the women take into account that the second birth becomes a repeat CS too. To avoid a general anaesthetic in this case they consider getting an epidural during birth. As a support to women's choice a written eligibility for VBAC was suggested by women in Italy.

“I was screened yesterday in the C-section clinic, they gave me the application form [for an epidural], and they told me to hang on to it very carefully!! (I)”

Women wished for a familiar environment, where they know the professionals, and where the staff know their history. Perceived safety plays a role, and for some of the women it is important that a children’s hospital is affiliated. From others, they see a better chance to give birth vaginally if they have the possibility to give birth at home or at a birth centre.

“Now, I think that I would prefer a birth centre to a clinic, because there are more interventions during labour in the clinic” (D).

Process negative birth experiences and alleviate fear

A negative experience of previous labour was seen as a barrier for VBAC for many women, and they mentioned fear of birth pain. Some described a suboptimal relationship with the midwife caring for them, separation of mother and child after the caesarean section, a delay in development of a deep mother-child-relationship and ‘baby-blues’ in relation to the birth.

“If you’ve experienced an emergency CS and you’ve been through all labour not ending with a vaginal delivery, you’ll be wondering if it is worth to go through all that again or have a CS without waiting” (I).

Possible advantages of CS were described by some women as another barrier to VBAC.

“This was the first time I had some doubts, because I thought that I would know when it (the baby) comes, nothing goes wrong because nothing can happen to the baby with the umbilical cord.” (D).

The most striking barrier to VBAC in the data from Ireland was an absolute refusal to consider a prolonged induction of labour based on the women’s previous experience. Participating women did not comment on having a fear of childbirth *per se* but rather expressed their outright refusal to consider a long induction of labour that might ultimately result in an instrumental birth. Some women were adamant that they did not wish to experience an induction of labour again.

“What was important to me this time was I knew I couldn’t be induced now that I have had a section. So relieved. If I know I had to be induced again I would go for a section. It was the pain and the lack of information about the induction.” (IRL)

A culture that supports VBAC

Confident clinicians who inspire women and respect their needs

In addition to being a source of information and support for women considering VBAC women also indicated that the clinician caring for them needed to be optimistic about birth, a person who could support and inspire women to have confidence in their own ability to give birth. Some of the women suggested that they might request a repeat caesarean section purely because it is the only birth they know and they lack confidence in their ability to give birth.

Women might a little bit feel less of a woman because they didn’t deliver vaginally first time around and I sometimes wonder about the confidence to manage that (IRL).

For example, women in Germany felt empowered when they were supported by their care providers in their decision to have a VBAC. They highlighted that women want to be supported in their decision to

try VBAC and not to be undermined by negative attitudes from clinicians. The women wished for a good relationship with caring professionals, who respect their needs. They valued emotional support, as one woman from Italy described:

“You need to be accompanied: if the first delivery was lived with fear, because of the emergency that occurred, the second delivery will bring back all those emotions” (I).

Women suggested that they would be more likely to get such support from clinicians who were competent and experienced around providing care to women having VBAC.

“Knowing that in the hospitals where VBAC is offered, there is obstetrical staff ready to handle this sort of complications would be reassuring. Even midwives must be prepared to handle this kind of birth in a different way compared to a normal vaginal birth” (I).

The potential of having a ‘champion midwife’ for VBAC in the maternity services was raised by the women in Ireland. They would value meeting with a specific midwife who was well informed about VBAC, and who could spend time with them discussing their concerns in a balanced way. It was felt that this was especially critical for women in the public system that does not offer continuity of carer. The women in Germany stated they would be in favour of a centre specialised in VBAC. This could be clinics as well as midwife-led birth units or midwifery practices. The birth centre should be directly affiliated to a facility capable of providing a maximum level of care if an emergency arose. Women suggested special midwifery consultation hours with one or two solid contact persons, who are always approachable.

...” and you look for a clinic with experiences. But if you know that you can have a midwife consultation specialised in VBAC, it would be very good” (D).

Questioning beliefs such as ‘once a CS always a CS’

One of the barriers to VBAC mentioned by the women are the cultural beliefs about ‘once a CS always a CS’. This belief creates negative attitudes about VBAC among all persons involved; obstetricians, midwives, partners, family members and also the women herself. For instance, one woman in Italy described not having a single close female relative who had birthed vaginally to act as a role model for her in her desire for a VBAC.

“My parents are terrified, they’ve tried everything to convince me, saying that I’m crazy. This also happens because I come from a family where all women have had a CS, even my mother-in-law; up to now, nobody has succeeded in giving birth naturally, also because of this culture of after a CS, always a CS” (I).

Women in Germany also spoke about how media present the picture of CS. They think that the media portray an overly positive image of CS which trivialise the risks. Women would prefer a more balanced portrayal of CS in the media with a more accurate presentation of both the benefits and risks. They feel influenced by reports of more and more celebrities, who have CS.

“I think to establish the VBAC you also have to find arguments towards the media, that caesarean is an easy birth and celebrities also choose it. It is not talked about the risks and potential complications”. (D)

In contrast to such attitudes, the women instead spoke about how they would like to experience a normal birth. They wanted to experience what a birth was like and felt it was important for them to give birth naturally. They mentioned women’s own determination as an important factor for VBAC, and described different strategies to reach their goal. Some of the women were very determined about their decision for VBAC.

“I want to have the baby myself. I am a woman. I want to feel that pain for myself. I want to feel, I want to deliver my baby myself. I don't want caesarean” (IRL).

Discussion

The main findings demonstrate that for these women the important factors in improving the VBAC rate are that all involved have the same opinion, a shared decision-making with clinicians supportive of VBAC, receiving correct information, being prepared for a VBAC, and a culture that supports VBAC.

Women in this study spoke of the importance of encountering a culture that supports VBAC when they attend for care in their pregnancy. They want to be cared for by clinicians who view VBAC as the first birth choice when no complications are present. They believe that the clinicians' confidence in VBAC is a very important factor in motivating them towards VBAC as a choice. This is similar to the findings from other studies where clinician's attitudes and preferences have been shown to influence women strongly in their choice of mode of birth after a previous CS³¹⁻³⁴. Catling-Paull³⁵ suggests that local ownership of the desire to reduce CS rates or increase VBAC rates may be the most influential non-clinical factor in improving uptake and success rates of VBAC. Chen and Hancock³⁶ advise that it is imperative for clinicians to be aware of their own practice philosophy and personal preferences for birth options when counselling women. Women in the focus groups found that despite hospitals asserting that their organisational culture was pro-VBAC they did not always encounter clinicians who supported their choice for VBAC. Women found that clinicians gave selected information based on their own attitude to VBAC and that the information was not consistent among all clinicians. Women encountered a wide range of inconsistent attitudes and information from a variety of different clinicians on each visit for care. Opinions varied among the women regarding whether they encountered a clinician bias towards caesarean or advice that was weighted more towards VBAC.

However, the majority of women reported that the information clinicians gave tended to be about the benefits of CS and the risks of VBAC. Information about the benefits of VBAC was not commonly volunteered and some women felt that they themselves had to take responsibility for finding the information they needed, findings similar to those of other studies^{13,15,16}. Reports on clinicians' and women's views on VBAC in countries with high VBAC rates demonstrated a clearer consensus regarding VBAC^{14,20} than was indicated by the women in our study. Women described the conversations with clinicians as being very risk-orientated and focusing on the risks associated with VBAC rather than CS. The risks that the women were informed about were uterine rupture, death of the baby and the risk of ending up having another CS. The issues that women were predominantly concerned about were length of recovery, getting home quickly to their other children, breastfeeding and bonding with their baby. A number of previous studies have found similar differences in risk perception and interpretation between clinicians and women^{34,37-39} in addition to the failure of clinicians to consider the significance of practical considerations such as family obligations for women when decision-making⁴⁰⁻⁴². Turner et al⁴³ report that compared with clinicians, pregnant women tend to have a much higher threshold for the potential complications of vaginal birth. These disparities between the issues clinicians want to discuss with women and the issues women want to discuss create significant challenges around collaborative decision-making.

One of the key tenants of modern woman-centred maternity care is choice^{40,44}. For women to be able to make an informed choice about their birth options they need high quality information and a collaborative conversation with their clinician. In the absence of these collaborative conversations with clinicians, women will also be influenced by the relationships they have with friends, family and other sources of maternity information and the impact of these on the decision-making process can be quite significant. Women in the focus groups talked about their need to be involved in the decision about their mode of birth and they valued the opportunity to discuss the options available with both their obstetricians and midwives. Care providers have consistently been cited by women as having a significant external influence on the decisions they make during pregnancy^{32,33,42}. The women in this study described the midwife and the obstetricians at the antenatal clinic as a very significant influence

in supporting them to birth vaginally. They believed that having good quality information about the benefits and risks of all options empowered them to engage in a process of shared decision-making with their clinicians. Meddings⁴⁰ suggest that choice relates to more than just mode of birth and should include informed choice in relation to interventions such as induction of labour or pain relief choices in labour. However, the extent to which women want to be involved varies from considering the available evidence to following the advice given by clinicians. This is described in the literature as varying levels of involvement from shared decision-making to guided decision-making⁴⁵. While some women want to be involved in the decision making process others feel uncomfortable and overburdened by having responsibility for the decision and its potential consequences^{33,41,42}. This variation in women's preferences needs to be considered during the collaborative decision-making process. According to Graham et al⁴⁶ health professionals need to gauge varying levels of involvement required by individual women and to respond accordingly. Continuity of care is very important for building the types of relationships between women and clinicians that facilitate such individualised encounters. Women in this study endorsed the concept of incorporating individual patient preferences and values into the collaborative decision-making about mode of birth but they also described specific things that they themselves as individuals needed when preparing for VBAC.

The women in the study believed that information empowered them to both attempt and succeed at VBAC. Eden et al³² suggest that the confidence a woman has to succeed at a planned VBAC might also be related to how knowledgeable she is about VBAC. The literature is equivocal on whether being informed actually affects the rates of VBAC, but it is acknowledged that information decreases decisional conflict for women. A systematic review by Nilsson et al¹⁹ advocate that decision aids and information programmes should be provided for women as, even though they do not affect the rate of VBAC, they decrease women's decisional conflict and increase their knowledge about possible modes of birth. Women in the focus groups described being very poorly informed about VBAC and even being unaware that VBAC is a possibility after a previous CS. They felt that if VBAC rates are to improve there is an urgent need to raise awareness about VBAC and to make information more easily accessible. They described difficulties with finding reliable information. This is similar to findings in

the metasynthesis by Lundgren et al¹³, which showed that women with previous CS felt they were ‘groping through the fog’ when it came to trying to access information on VBAC.

Women had varying opinions about the reliability and quality of the information they found on the internet. Their concerns are justified. Bantan and Abenheim⁴⁷ caution about the lack of consistent evaluation and oversight of information on the internet and the difficulty for consumers in judging whether the information is safe, correct or current. Therefore, while women appreciate the internet and written information leaflets as a source of information, they prefer one-to-one consultations with their care providers to talk through their issues, concerns and decisions around VBAC. The women in this study talked about their need for reliable, straightforward, understandable, unbiased and realistic information to help them decide how to birth after a previous CS. They wanted information about both the benefits and risks of both VBAC and CS and they wanted that information from the clinicians looking after them in pregnancy. These findings are similar to those in the study on women’s views in countries with high VBAC rates¹⁴. However, important differences in our data were that women from low VBAC countries emphasised the importance of accurate, unbiased information. In contrast, data from women from high VBAC countries indicated that information should be given from clinicians who were supportive; gave extra attention, listened to them, encouraged them and guided them towards VBAC while also listening to their desires for CS¹⁴. These findings were confirmed by clinicians who recommended that women’s trust in VBAC needs to be strengthened²⁰ if VBAC rates are to increase appreciably. The metasynthesis by Lundgren et al¹³ about women’s experiences of VBAC recommend that clinicians should provide women with evidence-based information on both the risks and benefits of VBAC, to assist in their decision making. Women want that information from their clinicians to be tailored to their own, unique individual needs. Information needs differ among women and it is important that clinicians adjust their information-giving to the needs of each specific woman. Previous studies have demonstrated that individualised information increases the VBAC rate³⁵. The information given to women during their antenatal care was most commonly provided by doctors and midwives but women in the focus groups reported that information about VBAC was not necessarily provided routinely and they had to seek it actively if they were aware of the possibility for

and motivated towards a VBAC. The information given to women and how it was articulated was significantly related to the organisational attitude and culture towards VBAC.

Women in this study felt that the generic antenatal classes offered by the maternity services to multigravida women did not meet their unique needs and felt that they would benefit from specific antenatal classes targeted at VBAC. They wanted these classes delivered by a clinician who was a champion for VBAC and who would encourage and support them in achieving their VBAC. The women acknowledged that while they need information about VBAC from supportive clinicians, they also asked for information from other women with experiences of VBAC, a finding also demonstrated in other studies^{15,16}. Women felt that being able to talk to other women who had experienced VBAC would give them an opportunity to deal with previous negative birth experiences and any fears they had for this birth. This is in keeping with the women's need for practical information during their decision-making. For women in countries with high VBAC rates opportunities for alleviating possible fear of childbirth and processing negative birth experiences were important factors for VBAC¹⁴. In Finland and Sweden special 'fear clinics' were offering pregnant women face-to-face meetings with midwives specialised in meeting women with fears and previous negative birth experiences^{48,49}. The women talked about wanting to have a birth plan so that they could have some control over issues during labour such as induction and length of labour but also to ensure that clinicians were fully aware of their obstetric history, relevant risk factors and personal choices when looking after them in labour.

Women in this study were very articulate about their strong determination to birth vaginally and how much they wanted to experience a normal birth. They wanted to experience both the physical and emotional aspects of giving birth vaginally and recognised it as a significant life event. These findings concur with previous research demonstrating that vaginal birth has a personal meaning for women, which contributes to their determination to achieve VBAC^{13,14,32,40,50,51}. Dahlen and Homer¹⁶ explored in a study how women use English language blog sites to discuss VBAC, and called this the 'motherbirth–childbirth dichotomy', and found that the over-arching concept influencing women to

opt for a VBAC was their own personal internal 'birth framework'. Clinicians should be sensitive to this very influential personal value for women when they are collaborating with them during decision-making around mode of birth after a previous CS.

Limitations

All interviews were performed in the women's mother tongue. Initial analysis was conducted in the women's native language. Later during the analysis, the data were translated into English by each country team. As the translations were from German and Italian into English, multiple team meetings were conducted via SKYPE to ensure the accuracy of interpretation during the translation of the data. A large number of quotations from the women were inserted in the results to reduce the risk of misunderstandings of the data.

The women were asked the same five questions irrespective of whether the interviews were performed in focus groups or individually. Using a combination of two methods for gathering data could be a limitation since two perspectives have been analysed; the individual perspective and the views of a group. However, gathering and analysing these two perspectives may also reveal important variations of the data.

A qualitative research method is necessary when there is limited knowledge on the subject for investigation. When interpreting findings of qualitative research, the studied context should always be considered in relation to transferability. In this study, data originated from three European countries that in some respects have different maternity organisations and procedures. Therefore, to facilitate transferability, the studied contexts have been carefully described^{23,52}.

Conclusion

For these women the important factors in improving the VBAC rate were that all involved in caring for them have the same opinion about VBAC, that they experience shared decision-making with clinicians supportive of VBAC, they receive correct information, are sufficiently prepared for a

VBAC, and experience a culture that supports VBAC. The findings demonstrate that women's decision-making about vaginal birth after a previous CS often involves a complex, multidimensional interplay of medical, psychological, social, cultural, personal and practical considerations.

Recommendations for Future Research

Further research is needed to explore if the information deficit women report is affecting their ability to make informed choices. Additional exploration is also needed of clinicians' understanding of what matters most to women when making decisions about VBAC as a mode of birth. As this study was conducted within the OptiBIRTH study, which concerned European countries, further comparative exploration is needed of the influence of the local and national childbirth culture of other jurisdictions such as the USA and Australia on women's views of VBAC.

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