

**“Trying for a VBAC”:  
An Ethnography of cultural change within a randomised trial  
aimed at increasing vaginal birth after caesarean section: The  
OptiBIRTH study.**

A thesis presented to the University of Dublin, Trinity College for the  
degree of Doctor of Philosophy

By

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## **Declaration**

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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## Summary

### **Background:**

There is a real and valid concern worldwide around increased caesarean section (CS) rates. The OptiBIRTH Study was designed to address these concerns through the implementation of a complex intervention in a cluster randomised trial aimed at increasing vaginal birth after caesarean section (VBAC). The overall aim of the OptiBIRTH Study was to improve maternal health service delivery and optimise childbirth, by increasing VBAC through enhanced patient-centred maternity care across Europe. However, birth is not only influenced by medicine, but it is also influenced by culture and this requires consideration.

### **Aim:**

The aim of the thesis is to detail the implementation of the OptiBIRTH intervention in one trial site, to determine if the intervention affects cultural change around VBAC as a viable mode of birth. Engaging with all of the stakeholders and exploring their perspectives, allows for a more complete view of the organisational culture surrounding the intervention, and also for an evaluation as to whether cultural change has taken place in making decisions around mode of birth after a previous CS. This ethnography aims to contribute more to the understanding of the implementation of the OptiBIRTH study so that, in moving forward, if the OptiBIRTH intervention is deemed to be effective, it will have the appropriate knowledge and understanding regarding perspectives of the participants and how the intervention could potentially be modified so as to be implemented more effectively.

### **Method:**

Ethnography was the chosen method for this thesis. The ethnography was conducted over a period of 16 months, with interviews conducted with the key stakeholders of the intervention; that is the women, clinicians, and Opinion Leaders (OLs) who are part of the intervention. Ethical approval was granted by Trinity College Dublin and the Health Service Executive (trial site). Data collection consisted of detailed observation in the field-site, field-notes generated from the observation and interviews with the participants. The outcome of the data analysis is presented in the findings chapters as

the analysis process was integral to the findings of the thesis. I have presented them in this way as both the data analysis and the development of the findings was a concurrent process.

### **Findings:**

The findings indicated that the process of ritualization of the intervention, the changing of women's identities, the transference of authoritative knowledge, and the effect of various power positions affected the intervention and its status in the field-site. This ethnography determined that, while the overall culture in the field-site did not change, smaller, more individual cultural changes were observed, from both the women and clinicians' taking part. However, the absence of participation by senior consultants and doctors was found to hinder the implementation of the intervention and it was the women who were driving change around mode of birth after CS; suggesting that the women who participated did not hamper VBAC uptake, rather the clinicians who did not engage with the intervention. This suggests, moving forward, that the clinician component of the intervention should be more focused in targeting the clinicians than the women. The findings from this research provide insights into the factors that are associated with cultural change during the implementation of the OptiBIRTH study.

### **Implications:**

This ethnography revealed the interrelationships between power, knowledge, ritual, and identity that developed during the course of the intervention. It is these factors that relate to cultural change around VBAC and for the future implementation of the OptiBIRTH study in other maternity services. Through the active incorporation of the OptiBIRTH intervention into the field-site, thought around the subject of VBAC and repeat CS has slowly changed but needs further time to change the culture completely. Yet, commitment from consultants and other doctors could further change in the field-site and give coherent support to women trying for a VBAC. The conclusions from this ethnography may contribute in some way to the broader OptiBIRTH Study, if the intervention is deemed to be effective, and if it is to be instated in maternity units in Ireland, in the future.

## **Dedication**

My thanks go to all the participants who were kind enough to share their time with me during this special phase of their lives. Without their openness and generosity this ethnography could not have been possible. A special thanks to the Opinion Leaders who gave their time and kindness to me in the field-site.

I would also like to thank my supervisors, Dr Valerie Smith, Professor Cecily Begley, and Adjunct Professor David Prendergast, for their support and guidance throughout the whole research process. They encouraged me throughout to produce this thesis and I am truly grateful for their insight and for encouraging me to always do better. I would also like to acknowledge the OptiBIRTH study research team and EU FP-7 Grant.

I would like to acknowledge the support of my family and friends. Thanks for listening to me and putting up with me even though you had no idea what I was doing.

Finally, a special mention to Eamon, my rock. I couldn't have done it without you.

This thesis is dedicated to my mother. Thank you for getting me to where I am today.

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## **List of Abbreviations**

ACOG	American Congress of Obstetricians and Gynecologists
BMI	Body Mass Index
CMM	Clinical Midwife Manager
CoP	Community of Practice
CS	Caesarean section
ERCS	Elective repeat caesarean section
GP	General Practitioner
HSE	Health Services Executive
IOL	Induction of Labour
MOL	Midwifery Opinion Leader
OL	Opinion Leader
OOL	Obstetric Opinion Leader
REC	Research Ethics Committee
RCT	Randomised controlled trial
TCD	Trinity College Dublin
TOL	Trial of labour
TOLAC	Trial of labour after caesarean section
UK	United Kingdom
UR	Uterine rupture
US	United States of America
VBAC	Vaginal birth after caesarean section
WP	Work Packages



# **Chapter One: Overview of Thesis**

## **1.1 Introduction**

Birth is a complex, natural, and culturally diverse domain that is biologically stamped in our genetic structure. The need to reproduce is seen as necessary in all species to ensure survival. Yet with humans and the evolution of science and technology, the way that we birth has become a more complex social and cultural issue requiring much thought and attention.

In this thesis, using the method of ethnography, I detail a journey that focuses on the implementation of a complex intervention in a cluster randomised trial (the OptiBIRTH Study) aimed at increasing vaginal birth after caesarean section (VBAC) in one trial site. I explore how the introduction of this intervention into a maternity environment affects cultural change surrounding VBAC as a viable mode of birth after caesarean section (CS). I further explore how the intervention gives legitimate meaning to VBAC from the perspectives of women and clinicians who participated in OptiBIRTH in one field-site.

## **1.2 The Evolution of Birth in the Western World**

From the beginning of the 18<sup>th</sup> century, there was a shift from a traditional midwifery model of care to a more medicalised model of childbirth. During the 18<sup>th</sup> and 19<sup>th</sup> century the role of the midwife was challenged by men and medicine and there was a

significant move from birth in the home to birth in lying-in hospitals throughout Europe (King, 2012). This gave male accoucheurs and their intervention instruments for childbirth, most notably the obstetrics forceps, access to birthing women on a large scale (Fahy, 2006). With the creation of various instruments for assisting with problematic births, the medical profession could claim their superiority over midwives in their skills at managing birth (Donnison, 1999). Subsequently, the medical and male dominance over birth came into effect with various medical organisations, such as surgeons and accoucheurs, claiming that it would be preferable for male professionals to be present for all types of birth rather than the female midwife (Lowis & McCaffrey, 2004). The increased use of lying-in hospitals as well as the introduction of the United Kingdom (UK) Medical Act 1858, which gave male medical practitioners the right to control medical practice and limit others from practising medicine, resulted in an increased routine use of interventions during childbirth in a male, medically controlled hospital environment (Arnold, 2006). This meant that the medical, male professionals began to control birth and how women birthed, diminishing the role of the midwife and normal childbirth. From the 18<sup>th</sup> century to our modern times, medicine has consisted of men and a medical model of care. This relates to the technocratic model of birth, described by Davis-Floyd (2001) in the Western World where the female body is seen as a machine that produces babies but needs help to achieve this; a notion made evident in the increased rates of CS that we see today (EURO PERISTAT, 2010). The technocratic model of birth can be seen as the value system that is employed in the Western World that is “strongly oriented toward science, high technology, economic profit, and patriarchal governed institutions that gives value to routine obstetrical procedures that have little or no scientific evidence to justify” (Davis-Floyd, 2001,

p.S5/S6). The dominance of patriarchy and male medical professionals was given credence in Ireland when, in 2012, there was nationwide media coverage of the appointment of Dr Rhona Mahony as the first female Master of the National Maternity Hospital since the hospital's inception in 1894 (Houston, 2011). The technocratic model that has been employed in the Western World shows how culture can heavily influence childbirth and that, when exploring pregnancy and birth, the socio-cultural context should be considered.

### **1.3 Anthropology and Birth**

The relationship between anthropology and the arena of pregnancy and birth has grown in recent decades. Works in this area of study include the use of CS in North America (Wendland, 2007), ultrasound technology in Australia (Harris *et al*, 2004), midwifery programmes in Guatemala (Maupin, 2008) and, closer to home, home birth midwifery in Ireland (OBoyle, 2016). These types of anthropological studies fall under the area of medical anthropology, which explores how “all knowledge relating to the body, health and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space” (Lock & Scheper-Hughes, 1990, p.49).

In anthropological terms, pregnancy and birth have been described as rites of passage for women in many societies (Davis-Floyd, 2003; Machin & Scamell, 1997; Balin, 1988). Rituals exist for what is perceived as being right to do in pregnancy and birth and can be related to the culture that people live in and are influenced by (Kaphle *et al*, 2013; Higginbottom *et al*, 2013). As Western societies become increasingly reliant on

new technologies to manage pregnancy and birth, a woman and her body's place in this natural process are being largely overshadowed, including the decision-making process of how she will birth her child. Women and the intimate knowledge that they have about their bodies are being swept to the side in favour of medical and male dominated knowledge (Barker, 1998). All the trust is placed with clinicians, whose knowledge is seen to supersede other relevant information and knowledge, such as the woman's prior birth experience and the knowledge that she has about her body (Cahill, 2001). The clinician is seen as the ultimate authority and is considered to possess superior knowledge to that of the woman because they have trained extensively to bring new life into the world; thus they are viewed as the only qualified persons to make decisions about birth (Zadoroznyj 1999; Lazarus, 1994). Obstetric technology and technical procedures are central in this environment and ownership of the artefacts necessary to manage labour simultaneously defines and displays who possesses authoritative knowledge and legitimate decision-making power (Klein *et al*, 2006). This becomes even more evident when considering CS and the myth of "once a caesarean, always a caesarean". A CS is a high-level technological procedure that is used to facilitate childbirth with the woman in the majority of cases having little or no control over the decision being made about mode of birth. What the woman's body tells her and what she knows by virtue of her bodily experience has no status in this setting; rather, what counts is the technological and procedural-based knowledge of the clinician (Davis-Floyd, 2003). This procedural-based knowledge about labour and birth is inaccessible to the woman and without the presence of a clinician and their knowledge, the birth may not be allowed to proceed. It is this role of technology and how it interacts with the "social" that constitutes authoritative knowledge (Malacrida, 2015). Authoritative

knowledge in childbirth is owned solely by the clinicians, who make the final decisions about how the labour is proceeding and how the woman will give birth (Hays, 1996).

The use of technology and interventions in pregnancy and birth has long generated much thought and debate. Robbie E Davis Floyd, in her book 'Birth as an American Rite of Passage' (2003) shows us how ideologies of birth are constructed, that the use of obstetric procedures in birth in American society are now a cultural norm and that the technocratic model,

“based as it is on this assumption of her inherent physiological inferiority to men, and for as long as it holds conceptual hegemony over this nation, that model will guarantee her continued psychological disempowerment by the everyday constructs of the culture at large, and her alienation both from political power and from the physiological attributes of womanhood”(Davis-Floyd, 2003, p.291).

The use of intervention in the pregnancy and birth process can now be seen as overshadowing the natural processes of pregnancy and birth. Martin (1987), in her cultural analysis of reproduction suggests that the woman is seen as imperfect and that she needs help during the childbirth process. With the increasing use of technology in labour, the woman is now an afterthought in the process, with machines monitoring her, rather than health care professionals attending the woman (Martin, 1987). This could be due to how most societies, especially in the Western World, have become so reliant on technology. Examples of technology reliance can range from people using mobile phones every day to stay in touch with various social media outlets or world news, to birth and the use of foetal monitoring and drugs to cope with labour. Yet, there are some who have frequently advocated for birth to be treated as a natural, physiological process

that women have undertaken for centuries (Zielinski *et al*, 2016; Kennedy & Shannon, 2004;Kitzinger, 1986;Rothman, 1982), rather than a medical event requiring technological management.

The idea for the OptiBIRTH study emerged during collaborative group discussions at a normal birth<sup>1</sup> workshop in Dublin in 2010 and within a COST Action ISO907: Creating a Dynamic EU framework for Optimal Maternity Care where concern over rising global CS rates was heavily expressed. The OptiBIRTH study aimed to increase VBAC through enhanced maternity care service delivery and optimise the childbirth experience throughout Europe (further information on the study is provided in section 1.4 below and in Chapter Two; see also [www.optibirth.eu](http://www.optibirth.eu)). In order to evaluate the intervention beyond pregnancy, birth and postpartum objective outcome measures, and to understand and gain insight into the intervention and its effectiveness from the perspective of trial participants, an ethnography of the implementation of the OptiBIRTH intervention was deemed important in investigating any potential cultural change around the subject of VBAC in one field-site.

The OptiBIRTH Study is unique in its own right, and needs to be understood not only from an obstetric or healthcare perspective, but also from a social and cultural point of view. Knowing about the cultural issues surrounding the implementation of OptiBIRTH will provide a benefit if the intervention is shown to be effective and is implemented on a larger scale.

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<sup>1</sup>For the purposes of this ethnography, “normal birth” refers to vaginal birth after caesarean section (VBAC). This is due to the fact that VBAC was referred to as normal birth at the field-site and this is the language that the participants used for VBAC.

## 1.4 Overview of the OptiBIRTH Study

The OptiBIRTH study, using a complex intervention that combines educating women and clinicians, use of clinician Opinion Leaders (OLs) to deliver and drive the intervention, and information technology (informative website and mobile phone applications), aimed to increase VBAC rates from 25% to 40% in the study intervention sites. This aim was met through the collaboration of both women and clinicians to create coherent women-centred care for women<sup>2</sup> with one previous CS to achieve increased VBAC rates. Broadly, the complex intervention sought to empower women through participation in specialised antenatal education classes on VBAC and to educate clinicians through educational sessions on the risks and benefits of VBAC. The OptiBIRTH study was conducted in three countries in Europe (Ireland, Italy, and Germany). Sixteen maternity units (15 trial sites where 2 units in Germany were combined as one trial site resulting in five trial sites in each of the three participating countries) that met the inclusion criteria for the study; that was, VBAC rates of less than 35% and an annual birth rate of greater than 2,000 births, took part in the study. Each trial site was randomly allocated to either intervention or control on a 3:2 ratio (three intervention and two control sites per country) and each site needed to recruit a sample size of 120 women. The OptiBIRTH study was funded by an EU FP-7 Grant (FP7-HEALTH-2012-INNOVATION-1, grant agreement no. 305208).

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<sup>2</sup>“Women-centred care” is care that “focuses on the woman’s individual needs, aspirations, and expectations, rather than the needs of the institution or professional. It recognises the need for women to have choice, control and continuity from a known caregiver or caregivers. This care encompasses the needs of the baby, the woman’s family and other people important to the woman, as defined and negotiated by the woman herself. “Women -centred care” addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations and recognizes the woman’s expertise in decision making” (Leap, 2000, p.20).

The primary outcome measures for OptiBIRTH were the VBAC rates in each trial site compared to the previous year and the VBAC rate for women included in the trial during the study period. Secondary outcome measures included various maternal morbidities, such as incidence of uterine rupture and haemorrhage, and other labour and birth outcomes; for example, length of labour, mode of birth, women's satisfaction and quality of life (using the SF36 at 3 months postpartum). Data on neonatal outcomes were also collected as part of the trial. These included admissions to the neonatal intensive care unit, length of stay and neonatal resuscitation. While the results of the trial are not yet available, the protocol for the trial has been published (Clarke *et al*, 2015) and the trial is registered with [www.controlled-trials.com](http://www.controlled-trials.com) (ISRCTN10612254).<sup>3</sup>

## **1.5 Overview of this Study**

Exploring cultural change surrounding the implementation of an intervention is complex and requires focusing on all stakeholder's views; that is women participating in the OptiBIRTH intervention, clinicians (midwives and obstetricians) practising at the intervention site and clinician Opinion Leaders (OLs) who form a component of the intervention specifically to facilitate and implement the intervention in their particular field-site. Engaging with all of these stakeholders and exploring their perspectives allows for a more complete view of the organisational culture surrounding the intervention and evaluating as to whether cultural change has taken place in making decisions around mode of birth after a previous CS. The inclusion of both women and

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<sup>3</sup> Please refer to Appendix 1 for the full article published regarding the OptiBIRTH study protocol



clinicians in my study was paramount so as to provide a comprehensive exploration and understanding of OptiBIRTH's place within the hospital setting and whether the intervention was successful in achieving increased VBAC in women who had one previous CS.

The OptiBIRTH study aimed to change practice. However, the setting for the intervention and this study is culturally mediated. This means that people experience their world, in this case the hospital and the field-site for this ethnography, as a cultural system and people respond differently to this system and how/what they think of it. Cultural change within this system means, in the context of this study, change regarding practice surrounding decision making for birth after CS. This would mean the language and communication between women and clinicians and how they make the decision about VBAC, as well as how these groups interact with the different components of the intervention. Rather than looking at this from a social point of view, taking the stance of changing culture around VBAC and CS gives a deeper understanding of how these modes of birth are understood and whether the OptiBIRTH study has an influence on women and clinicians views on mode of birth after CS. Exploring cultural change in relation to the implementation of the intervention can allow for understanding as to how OptiBIRTH impacted the field-site and whether or not there was change in how VBAC was communicated and discussed, rather than looking at the barriers and opportunities to the intervention.

Exploring cultural change in relation to the implementation of the intervention can allow for understanding as to how OptiBIRTH impacted the field-site and whether or

not there was change in how VBAC was communicated and discussed, rather than looking at the barriers and opportunities to the intervention.

The overall aim of the OptiBIRTH Study was to improve maternal health service delivery, and optimise childbirth, by increasing vaginal birth after caesarean section (VBAC) through enhanced patient-centred maternity care across Europe. Cultural change was not an explicit objective of the trial. This ethnography was described as a study of women's and clinicians' views of the acceptability of the intervention as part of Work Package 4. A more detailed discussion on the embeddedness of this ethnography is provided in Chapter 10 (see section 10.8.1).

## **1.6 Aim and Structure of the Thesis**

This ethnography explored the culture surrounding the implementation of the OptiBIRTH complex intervention in order to understand potential cultural change around decision making for VBAC as a viable mode of birth in women who have had one previous CS.

The aim of my thesis is to bring you through OptiBIRTH's journey in one field-site, from its early days of inception in the antenatal clinic where women were first provided with the study information and recruited to the trial and where clinicians were first exposed to the study, through the antenatal and intrapartum phases of the study, and finally, to a time of post-intervention where women participants have given birth and have exited the OptiBIRTH study. This journey is captured through observation, field-

notes, reflexive diaries and interviews with women and clinicians that participated in the study. To give structure to this story, my thesis is organised into the following chapters:

**Chapter Two** presents an in-depth literature review on global CS rates and considers VBAC and repeat CS in the context of these rates, including a brief overview of international guidelines on VBAC. A detailed exploration of qualitative studies that explore women's and clinicians' experiences and preferences with regard to CS and VBAC is provided, including a review of factors that might influence decisions around mode of birth after previous CS. The chapter concludes with further information on the OptiBIRTH study and details of the various components of the trial intervention.

**Chapter Three** presents the research methodology that informed my research methods and this study. This study was framed by an interpretative, constructionist, ethnographic methodology. Arguments for my chosen qualitative method are provided and the reasons for choosing this approach. I will also demonstrate the reasoning for choosing an interpretative paradigm for this study. The epistemological and ontological dimensions that informed this study will be discussed in detail regarding the stances that were taken. The epistemological stance will centre around a conversation on constructionism while the ontological stance will be related to realism. In this chapter I will also address the method of ethnography and why it was chosen as the research method for this study. The final section of this chapter will outline the method of reflexivity which is integral to conducting an ethnographic study and why it was an important part of the research process.

**Chapter Four** continues with the research design and details the methods that I utilised for data collection, including observation, interviews and field-notes. I also describe the field-site in this chapter and the journey I went through to gain access to the site. This chapter highlights the sampling and data analysis methods that I employed for this study, as well as addressing the ethical issues that arose with the use of ethnography. This chapter will also inform you of the rigor and trustworthiness methods that I incorporated into the study design so that this study would be reliable and valid.

**Chapter Five** presents the first of the findings sections of my thesis. In this chapter I examine the first-point of contact with OptiBIRTH in the antenatal clinic for participants. I will explore and discuss how OptiBIRTH completed a rite of passage to become incorporated fully into the antenatal clinic. I also explore how the intervention undertook a rite of passage in the clinic so that the recruitment process of the intervention would become a legitimate entity in the clinic and the conversation around VBAC could begin with the clinicians and women. This chapter will also detail the participants' first encounter with the OptiBIRTH intervention and the information that they received from the clinic staff.

**Chapter Six** explores the first of the two antenatal classes as a component of the OptiBIRTH intervention. In this chapter I discuss the construction of the “‘OptiBIRTH identity’” that occurred as a result of participating in this class. I begin by giving you a description of the setting for the antenatal class before looking at how the construction of the ‘OptiBIRTH identity’ occurred during the class through the use of positive

language and success stories given by the OLs. This chapter will also detail the notion of risk regarding VBAC and the presentation of risk to the women by the OLs.

**Chapter Seven** focuses on the second antenatal class and the concept of authoritative knowledge. In particular, the transfer of authoritative knowledge on labour and birth to the OptiBIRTH women as a result of taking part in this class is discussed, and the implications that has for decision-making on mode of birth. As well as this, I will address the concept of power that originated in the classes by the OLs regarding VBAC and the creation of a ‘VBAC’ clinic that was presented by the OLs in relation to power positions in the field-site.

**Chapter Eight** explores the clinician components of OptiBIRTH, which are the clinician information sessions that are facilitated by the OLs and the information provided on the website. In this chapter I will explore the effect of the OLs and their presence in the field-site. I will explore the effect also of the clinician’s information sessions and whether the information provided in them was used in practice or affected a cultural change. This chapter will also focus more on the OLs as part of the intervention and their experiences of OptiBIRTH.

**Chapter Nine** delves into the experiences and perceptions of participants after they have completed the intervention. This chapter will try to assess if the intervention had been successful in changing the perceptions of VBAC as a mode of birth and whether the intervention provided participants with a positive experience of birth and labour. It

will also explore as to whether the participants had any recommendations themselves on improving the intervention.

**Chapter Ten** concludes this thesis and presents the key findings of this ethnography and the issues that were raised in this study. It will provide a discussion on the findings with reference to theoretical insights drawn from the cultural themes of identity, power, and knowledge surrounding the OptiBIRTH intervention and this ethnography. This chapter will also present the recommendations that this ethnography has highlighted through an analysis of the data, as well as acknowledge the limitations of this study. I then conclude with a discussion on how this thesis contributes to knowledge in this field.

## **Chapter Two: Caesarean Section in Context**

### **2.1 Introduction**

To contextualise this ethnography within the OptiBIRTH study, an understanding of CS in the context of current maternity care is necessary. In this chapter I comprehensively explore and review the literature on CS and VBAC. Current obstetric trends, both nationally and internationally on CS and VBAC rates, and historical changes in these trends are identified. With CS and repeat CS rising globally, reasons as to why CS rates have risen and continue to rise at such accelerated rates, will be considered. The significance of exploring this literature is to gain a deeper understanding of the need for OptiBIRTH and the rationale for my embedded ethnographic study. In this chapter, to set the ethnography further in context, I also provide further details of the OptiBIRTH study including rationale, the study work-packages (WPs), a list of the components of the complex intervention developed specifically for participating women and clinicians, and why this trial is relevant in today's maternity world.

### **2.2 Search Strategy**

A search of the databases PubMed, JStor, EMBASE, CINAHL, Academic Search Complete, MIDIRS, and ProQuest Nursing and Allied Health Source using the keywords 'Vaginal Birth After Caesarean Section', 'VBAC', 'Caesarean Section', 'Decision Making', 'Experiences' and 'Views', combining the terms using the relevant Boolean terms of AND and OR, was conducted in September 2013. Additional search

strategies included reviewing reference lists and searching key sociological, anthropological and midwifery journals. Examples of these journals include BIRTH: Issues in Perinatal Care, Social Science and Medicine, Midwifery, and Medical Anthropology Quarterly. There were no restrictions in terms of country of article origin and both quantitative and qualitative research methods were included. From there, articles were identified and their reference lists were then searched to ensure that all literature pertaining to the review was included. The following sections that I present relate to the themes that were present in the literature and that pertain to this ethnography.

### **2.3 Once a caesarean, always a caesarean**

It is with “once a caesarean, always a caesarean” (Cragin, 1916) that the politics and perspectives surrounding CS in obstetrics changed for the remainder of the 20<sup>th</sup> century and continue to have a lasting effect into the 21<sup>st</sup> century. However, Cragin was predicting the near certainty of a CS in women who had failed to give birth vaginally after an active labour. This old adage bears significant relevance when exploring the complex arguments that surround the decision of whether to have a repeat CS or to give birth vaginally if appropriate (Ugwumadu, 2005).

The optimal way of providing the safest method of care and the optimum mode of birth for women who have had a previous CS has been hotly contested in the fields of obstetrics, gynaecology, and midwifery and in society in general. In recent decades there has been a trend in obstetric and maternity care towards a more interventionist and



technological oriented style of birth, culminating in the highest form of birth intervention; that is a CS (Davis-Floyd, 2003). An examination of the increase in CS rates over the past few decades, globally, shows evidence of this (EURO-PERISTAT Project, 2010; Brick & Layte, 2009). The United States of America (US) provides a prime example, highlighting the growing concerns for the declining rates of VBAC and the dramatic increase of repeat CS. Menacker (2005) found that there was a significant increase in CS between 1996 and 2003, based on the information reported in birth certificates collected by the National Center for Health Statistics. She also reported that the VBAC rate in the US decreased dramatically by 63% in the same timeframe, contrasting directly with an increase in repeat CS “from 69.8% to 88.7% per 100 births to low-risk women with a previous caesarean delivery” (Menacker, 2005, p.2). There has been criticism from some researchers, health care professionals and media outlets over these increasing rates, most notably the controversy of how to care for women who have had a previous CS and the influence clinicians can/might have on their choice (Jukelevics, 2009; Klein, 2005; Wagner, 2000; Flamm, 1997).

## **2.4 Rising CS rates**

Recent statistics have shown that the majority of developed and developing countries have CS rates that are continuously above the World Health Organization’s (WHO) recommended 15% (WHO, 2015; Cavallaro *et al*, 2013; Walker *et al*, 2002; Belizan *et al*, 1999). For example, in Europe, rates of CS range from 15% in the Netherlands to 52% in Cyprus (see Table 1 for variation in CS rates across Europe).

In recent years, the rate of CS in the United Kingdom (UK) has been relative to the increase that has been documented globally, with the total rate of CS reaching 24.8% in 2011 and with Scotland and Wales reaching a high of over 26%. More alarming, is the rise of elective CS, climbing swiftly from 4.9% in 1990 to 10.1% in 2011, and reaching up to 14.3% in Northern Ireland in 2009 (BirthChoice UK Professional, 2011).

**Table 1: Rates of CS across Europe (2010)**

<b>COUNTRY</b>	<b>CS RATE %</b>
<b>Austria</b>	28.8
<b>Bulgaria</b>	33.1
<b>Cyprus</b>	52.2
<b>Czech Republic</b>	23.1
<b>Denmark</b>	22.1
<b>England</b>	24.6
<b>Estonia</b>	21.2
<b>Finland</b>	16.8
<b>France</b>	21.0
<b>Germany</b>	31.3
<b>Ireland</b>	27.0
<b>Italy</b>	38.0
<b>Latvia</b>	24.4
<b>Lithuania</b>	25.2
<b>Luxembourg</b>	30.0
<b>Malta</b>	33.1
<b>Netherlands</b>	17.0
<b>Norway</b>	17.1
<b>Poland</b>	34.0
<b>Portugal</b>	36.3
<b>Romania</b>	36.9
<b>Slovenia</b>	19.1

<b>Slovakia</b>	29.4
<b>Spain</b>	22.2
<b>Sweden</b>	17.1
<b>Switzerland</b>	33.1

**Source: taken from European Perinatal Health Report, (2010)**

**([http://www.europeristat.com/images/doc/EPHR2010\\_w\\_disclaimer.pdf](http://www.europeristat.com/images/doc/EPHR2010_w_disclaimer.pdf))**

Walker *et al* (2004) examined the relationship CS had in society and the way it is perceived and considered to be a normal method of birth. Through their analysis of 92 questionnaires they found that all of the women in the study were in agreement that CS is seen as an easy and convenient way of giving birth. This finding was consistent across demographic variables including age, education and rural/urban location. This study highlights how socially acceptable CS and repeat CS have become. Following on from this study, Turner *et al* (2008) further explored the views of Australian women and clinicians for preference of mode of birth. This study, which involved 122 women attending an urban teaching hospital and 341 clinicians from across Australia, was interesting to note that preferences had changed since Walker *et al's* (2004) study, with women being more prepared to opt for a vaginal birth compared to that of clinicians;

“only 2% of pregnant women in the study were considering elective caesarean section with no obstetric indication whereas, by comparison, 10% of midwives and 21% of obstetricians would request an elective caesarean section were they to have a future delivery” (Turner *et al*, 2008, p.1499).

Even with this change in preferences, Law & Sullivan's (2009) analysis of 2007 perinatal statistics found that 31.8% of women who had given birth in Australian

hospitals had a CS. Further, they found that 83.3% of women who had a previous CS had a repeat CS.

In 12 of 19 Latin American countries, including Brazil, Mexico and Argentina, CS rates range from 16% to over 40% (Belizan *et al*, 1999), although there is a notable lack of national data in the countries that were analysed. Similarly, Betran *et al* (2007) estimated that the rates of CS in the developing Latin American countries were higher than in African countries, with the highest rate of CS in South Africa of 15.4% compared with Latin American countries having an average rate of 29.2%, ranging from a low of 1.7% in Haiti to a high CS rate of 39.1% in Mexico.

To contextualise and illuminate how CS has risen over time and the effects this increase can have on a society I use the specific example of Brazil to illustrate this further.

## **2.5 The case of Brazil**

Brazil presents an interesting example of one country with exceptionally high CS rates where in private care, CS accounts for “about one-fourth of all births, the caesarean delivery rate is close to 80%” (Potter *et al*, 2008, p.34). Brazil has become an interesting and provocative example of the rising rates of CS and repeat CS and the relationship women have with their clinicians (Behague *et al*, 2002). Raifman *et al* (2014) investigated the rising trend of CS in Brazil from 1991 – 2006 and indicated that CS increased from 33% in 1991 to 40% in 2006, with CS becoming more common with older, more educated women. Compared to the rates worldwide, Brazil is consistently in

a category of its own with the world's highest CS rates, averaging "30% in public hospitals and more than 70% in private hospitals and clinics" (Finger, 2003, p.628). Moreover, Potter *et al* (2001) highlighted in a previous study that many of the women interviewed about their preference for mode of birth had unwanted CS and this was especially prevalent in private sector participants. From their analysis of structured interviews using a standardised questionnaire with 1,612 women across Brazil, the authors surmised that this may be due to the relationship that clinicians have with women and their influence over women's decisions. Alternatively, it may be associated with the level of trust women place in their clinicians. Other studies have concurred with this possible reason for high CS rates in Brazil. Ribeiro *et al* (2007) investigated factors that led to increased CS rates in two different urban locations in Brazil and suggested that the increase was linked more to clinician preference than woman preference, with clinicians reasoning that a CS is safer for the baby and convenient as the CS birth process requires less of their time. Similarly, McCallum (2005) explored clinician's influence in the decision to have a CS and suggested that it is the social encounters women have with an obstetrician that influence them to accept CS and perceive that it is the best way to give birth. This suggests that there is possibly an underlying social process to the decision to have a CS. Women in Brazil may be influenced in this situation by the opinions of their clinicians, which may result in unnecessary CS. Potter *et al* (2008), in their exploratory study on whether women in Brazil are convinced to accept this radical procedure by their physicians, highlighted the fact that most of the CSs that occurred were among women who stated that they would have preferred a vaginal birth (79/117). Overall, medical professionals seem to agree/believe that a CS is better for a woman's health with claims that benefits of a CS can "range from the

prevention of perineal lacerations and later urinary or faecal incontinence to protecting sexual function” (Potter *et al*, 2008, p.39). This is just one of the many examples worldwide of the use of intervention and technology which has been so popularised that many are now convinced that a CS is the only safe option for giving birth.

## 2.6 CS and repeat CS

One of the contributing factors to the rise in CS rates globally is repeat CS. The risks of various morbidities for mothers that are involved with the repeated use of CS are greatly increased and can include placenta previa<sup>4</sup>, placenta accreta<sup>5</sup>, and bowel and bladder injury (Clark & Silver, 2011; Silver *et al*, 2006). Van Bogaert (2004) explored mode of birth after a previous CS in South Africa and found that, of the 584 hospital records that were reviewed, 382 (65.4%) women had a repeat CS. This high repeat CS trend was also found by Mone *et al* (2014) in Northern Ireland and Barber *et al* (2011) in a hospital in the US. With growing interest in how elective repeat CS (ERCS) affects the health of mothers, there are currently recommendations for VBAC to be an option for women with a previous CS where there are no medical indications to perform an ERCS (Kaplanoglu *et al*, 2015; Knight *et al*, 2014; Tessmer-Tuck *et al*, 2014; Fagerberg *et al*, 2013).

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<sup>4</sup> Normally, the placenta implants in the upper uterine segment. Placenta previa refers to “a placenta that either partially or totally lies within the lower uterine segment. This can lead to morbidities such as antepartum bleeding, blood transfusion, and hysterectomy” (Oyelese & Smulian, 2006, p.928).

<sup>5</sup> Placenta accreta refers to “a placenta that is abnormally adherent to the uterus. This condition can lead to massive obstetric haemorrhage and can result in complications such as hysterectomy, renal failure, and surgical injury to the bladder” (Oyelese & Smulian, 2006, p.933).

Bernstein *et al* (2012) explored whether women are being adequately informed when it comes to deciding on mode of birth after a CS. In their study of 155 women choosing between a VBAC and an ERCS they highlighted that both groups demonstrated a lack of knowledge on the risks and benefits of different modes of birth, particularly the risks associated with an ERCS. They concluded that women would agree with their clinician's preference for birth as, when the clinician believed a CS was best, "19 of 22 (86%) chose ERCS, whereas when patients felt their doctor preferred a TOLAC [trial of labour after caesarean<sup>6</sup>], 36 of 46 (78%) chose TOLAC" (Bernstein *et al*, 2012, p.204.e4). McGrath *et al* (2010) indicated similar results in their study on women's perspectives of VBAC. The authors concluded that it was the influence of health professionals and their preference to have another CS that influenced women. This plausibly suggests that health professionals, rather than women, are seen to be best situated to make decisions on mode of birth for women with previous CS. This may then lead to differences between patient preference and provider preference, an idea purported by Meddings *et al* (2007) and supported by the findings from research by Appleton *et al* (2000).

## **2.7 The Viable Option of VBAC**

VBAC is a real and significant option for women who have had one or more CSs. Until recent years, repeat CS after CS had dominated in clinical care, with VBAC being

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<sup>6</sup>Trial of labour after caesarean (TOLAC) is described as a "planned labour with a view to safe vaginal birth in a woman who has had a prior Caesarean section delivery" (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2010, p.3). A TOLAC is often alternatively referred to in the literature and in practice as simply a Trial of Labour (TOL) or as a Planned VBAC (PVBAC). The OptiBIRTH study team had a firm policy in place from the start of the study that this terminology, which appears to place the woman and her body "on trial" was not to be used. The preferred terminology was "planned VBAC."

viewed in the medical sphere as dangerous. Kotaska (2012) found that, due to various prominent reports that were released on the dangers of uterine rupture (UR), especially with regards to induction of labour, the rate of VBAC in the US fell to an extreme low of 10.6% in 2003. Similarly, in the UK, Black *et al* (2005) estimated recent trends in birth by CS during the years 1990-1999 and the percentage of VBACs that have occurred in this timeframe. Using information that was longitudinally gathered on the UK General Practice Research Database, they found that CS rates were “increasing since 1990, reaching 18.3% in 1999. During this same time period VBAC fell from 45% in 1991 to approximately 37% in 1999” (Black *et al*, 2005, p.154).

There are a growing number of clinicians however (Feldman *et al*, 2010), who disagree with the idea of repeat CS being the only option and view VBAC as safe and viable and are advocating this mode of birth to women. Landon *et al* (2005) investigated maternal outcomes for a VBAC and found that one of the main factors for the decline of VBAC is the notion of risk and suggested counselling for women who need to make a choice about mode of birth. This situation changed in 2004 with the publication of a systematic review by Guise *et al* (2004) of the benefits and harms of VBAC compared with repeat CS. The results of their review demonstrated that there was no significant difference between the two modes of birth with regards to maternal death or hysterectomy, and found that “more than 3 of 5 women who attempt trial of labour will have a vaginal delivery” (Guise *et al*, 2004, p.426). To add to this, recent literature further highlights that



“CS is associated with a higher rate of surgical, infectious, and thromboembolic complications than vaginal birth, as well as subsequent perinatal complications such as placenta praevia and placenta accrete” (Rozen *et al*, 2011, p.4).

However, after an extensive review of the literature, Dodd *et al* (2004) suggested that, as there are no randomised controlled trials that compare the two methods of birth, information should be given with caution about VBAC and ERCS and that all studies on the topic should be treated and interpreted in the same way. This would mean that for both methods of birth (CS and VBAC), caution about the risks and benefits of each and women’s feelings towards VBAC and ERCS should be taken into consideration for every individual woman.

To further the legitimisation of VBAC, the Agency of Healthcare Research and Quality (2010) in the US published an extensive literature review on the risks and benefits of VBAC and revealed that VBAC was a viable and, more importantly, a safe option for women with a prior CS. To add to this recommendation, they also warned of the dangers of repeat CS for mothers, for example, maternal haemorrhage which results in increased rates of blood transfusion, infection and fever, and hysterectomy. Further studies have documented the option of VBAC as safe. Macones *et al* (2005) investigated the incidence of and risk factors associated with UR in women attempting VBAC in various hospital settings. Through their analysis of data from a multi-centre cohort study involving a review of records of 25,005 women with a previous CS, they found the incidence of UR in women with a previous CS who were attempting VBAC was less than 1%. They concluded from this that women with a previous CS should be offered VBAC (Macones *et al*, 2005). Durnwald & Mercer (2004) purported the

viability of VBAC as safe for women when they investigated the predictors of successful trial of labour (TOL) after a previous CS. Their findings demonstrated that the rate of UR for women undergoing VBAC was 0.8% and that “the overall risk of this potentially catastrophic event is still rare and should not be used as a deterrent for a VBAC attempt” (2004, p.392). Studsgaard *et al* (2013) investigated the outcome difference between a TOL versus having a repeat CS and indicated that a TOL was a reasonable consideration for women with a previous CS and that in their participant population of 1,783 women, 1,161 chose a TOL and 783 (67%) of these women had a successful vaginal birth.

For many of the countries and studies above, maternal request for a CS was at the centre of the study. Weaver *et al* (2007) explored both women’s and obstetricians’ perceptions of CS in the absence of clinical indicators. Their findings from women and obstetricians appear conflicted. Obstetricians on the one hand, stated that maternal request was rare, but fear of childbirth was driving the CS rate upwards. In contrast, none of the women reported requesting a CS, yet thought it was the safest option for themselves and their baby. They recommend that, although the information about maternal request for CS is weak, if there is a fear about impending childbirth this must be “acknowledged by both women and health care professionals and time and resources allocated to deal with it” (2007, p.40).

## **2.8 Delving deeper: The reasons behind VBAC**

During the latter decades of the 20<sup>th</sup> century and continuing into the beginning of the 21<sup>st</sup> century, many medical and sociological researchers began studying this phenomenon, and advocated for health care professionals to begin to understand and carefully tackle the problem of rising CS and repeat CS rates. Studies are now beginning to analyse and investigate the ‘why’ behind the statistics. By looking at this, interventions and policy recommendations can allow for nations and societies to address the issue of rising CS rates.

### ***2.8.1 VBAC Policies In-Depth***

Resulting from the increased promotion of and positive knowledge around VBAC, there has been much discussion of the policies and recommendations that have been introduced as best practice guidelines for VBAC in various countries, for example the US, the UK and Australia. However, even with best practice guidelines for VBAC being produced worldwide, there still appears to be a missing element to this equation. Many of the institutes that have created guidelines for VBAC in their region have noted that there have been no randomised controlled trials (RCT’s) that have investigated VBAC and compared the results with ERCS (Royal College of Obstetricians and Gynaecologists, 2015; Royal College of Physicians of Ireland and the Health Service Executive, 2013; The American College of Obstetricians and Gynecologists, 2010). However, even in the absence of a RCT, the VBAC policies that are being implemented globally portray this method of birth positively and as a real and viable option for women with a previous CS. Nonetheless, this is often overshadowed by the notion of

risk in what undertaking a VBAC entails, compared to the relative perceived straightforwardness of CS.

This can be related back the notion of RCTs as being the gold standard of research and the privileging of knowledge that pertains to RCTs. The use of evidence-based medicine can become exclusionary and medical science is now only seen as valid “by an all-encompassing scientific research paradigm – that of post-positivism – but also and foremost in showing the process by which a dominant ideology comes to exclude alternative forms of knowledge” (Holmes *et al*, 2006, p.181).

As well as this, it can be easy for clinicians to assume that the outcomes of a RCT are related to best practice for the patient (Walker, 2003). While this may be true with RCT outcomes, this method can omit the fact that healthcare professionals may have their own personal knowledge of their patient. Due to the rigid approach of an RCT, this type of knowledge may not be seen as valid or appropriate when considering patient and hospital outcomes (Winch *et al*, 2002; Bonell, 1999). Therefore, while RCTs can prove very influential in guiding clinical decision-making and practice with regards to medical/healthcare outcomes and policy formation, the lack of alternative designs can also have a negative effect on these outcomes. This can be seen in relation to risk perceived with VBAC and CS, where there are few RCTs conducted in this area. However, the alternative knowledge that is provided by healthcare professionals and their intimate experience with VBAC has allowed for the formation of policy globally as well as carefully designed experiments and the use of qualitative inquiry. This alternative knowledge can also encompass the women that partake in the trial and

highlight their experiences of looking for information around VBAC and trying to access this mode of birth (Lundgren *et al*, 2012). It is this form of knowledge that can lend itself to the formation of an RCT and help to design an intervention that is suitable for the prospective research population.

Many countries globally provide guidelines for recommended practices in supporting a woman to attempt a VBAC, including Canada (Society of Obstetricians and Gynaecologists Canada, 2005), Australia and New Zealand (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2010), the UK (Royal College of Obstetricians and Gynaecologists, 2015), and Ireland (Royal College of Physicians of Ireland and the Health Service Executive, 2013).

The Canadian Society of Obstetricians and Gynaecologists published their guidelines in 2005 and stated that a woman who has had a previous CS should be offered a TOL, provided that she has no further complications during her pregnancy. The guideline also recommends that a woman should only be offered a TOL if the hospital can provide a CS if it is needed as well as continuous electronic foetal monitoring for women who are attempting a TOL. Australia and New Zealand guidelines were similar to those of Canada, with a focus on the risks of UR and the morbidities related to TOL and labour management. These guidelines, while stating that VBAC is an option, also warn that it carries multiple risks such as need for blood transfusion, fever, and thromboembolic disease. In all of the guidelines that were examined, VBAC was compared to ERCS and it was stated in the UK guideline that “there is virtually no risk of uterine rupture in women undergoing ERCS” (Royal College of Obstetricians and Gynaecologists, 2015,

p.8). However, when looking at the guidelines for best practice for VBAC, it was interesting to note that all of the guidelines focused mainly on UR and the risks with allowing women to attempt a TOL. An example of a guideline focusing on UR is the one from Ireland, wherein UR appears repeatedly in the guideline as an adverse outcome or risk of TOLAC. The guideline does not highlight the risks and benefits of VBAC, but rather how to monitor, prepare, and handle UR when attempting VBAC, despite the guideline stating that in one Irish maternity hospital, the “UR rate was 2 per 1000 overall” (Royal College of Physicians of Ireland and the Health Service Executive, 2013, p.6).

Even though the majority of these guidelines present similar recommendations for VBAC, Bujold (2010), found that, through a comparison of three of the countries mentioned (US, Canada and the UK), evidence about the risks and benefits of VBAC were limited and that potential bias could have occurred in these guidelines. This may be due to the fact that there are no RCT’s of VBAC and that the main adverse outcomes that are associated with VBAC are rare. The debate surrounding VBAC is furthered by Foureur *et al* (2010) who investigated the similarities and differences between six national guidelines concerning birth after CS, and explored the evidence each guideline used in its informed creation. Similarly, they found differences in UR rates in each guideline and overall indicated that “the guidelines create difficulties for clinicians and women” (2010, p.9). This evidence, or the lack thereof of high-quality evidence on VBAC and the variability among VBAC guidelines, may lead to confusion and a lack of understanding on the part of women and clinicians when considering the decision to

undertake a VBAC and ensuring that they are knowledgeable of both the risks and benefits of VBAC.

### 2.8.2 VBAC – *Behind the Statistics*

The European Perinatal Health Report (2010) illustrates significant changes in the rate of CS in many countries between 2004 and 2010 with many increases, for example, 10% in Slovakia and 2% in Ireland during this time period. However, there are few qualitative studies that examine the perspective of the women when it comes to their preferred mode of birth after a previous CS. Lundgren *et al* (2012) conducted a metasynthesis of women's experiences on VBAC and found that women experienced VBAC like "groping through a fog", whereby there were no clear answers or consensus on the subject of VBAC from healthcare professionals. Healthcare professionals' influence with regards to the decision on birth methods appeared prominent as 47% of women felt that VBAC should only be presented as an option. VBAC is seen as the riskier option, both from the health professionals giving the information and the women receiving the information (Appleton *et al*, 2000). This could possibly breed a culture of risk that surrounds the option of VBAC. Even though the option of VBAC is not without risks, there are also benefits over ERCS and these should be considered by women when deciding how to birth (Agency for Healthcare Research and Quality, 2010).

Yet, with the information available that VBAC is a viable option for women, Wendland (2007) supports the thinking that the mother has now become defunct when it comes to

the decision on mode of birth. Increasingly, evidence-based medicine is now being referred to when clinicians make the decision about birth, with the mother being excluded from a vital part of the birthing process. Ridley *et al* (2002) explored qualitatively what influences a woman's decision in choosing VBAC. Through in-depth interviewing of five women who achieved a VBAC, the authors recommend that physician encouragement, being properly informed and having a sense of control in the decision making process may lead the way in understanding the process of deciding what kind of birth a woman would like to have.

Another aspect of VBAC is the relationship clinicians have with VBAC and their fears about the process of decision-making with women about their mode of birth. There have been relatively few studies that specifically look at the perspective of clinicians and their thoughts around VBAC. Habiba *et al* (2006) began to explore this aspect when they examined the attitudes of obstetricians in performing a CS on maternal request in the absence of medical indication in eight European countries. They found that fear of litigation became a strong motivator for obstetricians in performing CS for maternal request, so much so that, in the majority of the countries where the survey was conducted (five out of eight countries), obstetricians did not want to deal with the legal consequences that are associated with a vaginal birth, "from 30% in the Netherlands and Sweden, to more than 80% in Spain, Luxembourg and France" (2006, p.652). Ghetti *et al* (2004) also analysed physicians' responses to CS by request in the US. In their survey of 170 obstetricians, 67% of the sample would agree to a CS if there was a previous low transverse CS, "despite primary obstetrician's recommendation of a trial of labour" (2004, p.282). Klein *et al* (2011) explored clinicians' opinions on VBAC by



examining the attitudes of new generation Canadian obstetricians and determining if they differed from their predecessors. Overall, this study highlighted that new generation obstetricians were less comfortable with VBAC, preferring a more medical model to birth. In addition, they did not favour suggested approaches to reducing the CS rate and even appeared fearful of the idea of vaginal birth. The obstetricians that were over the age of 40 in the sample seemed more positive about vaginal birth and a woman-centred model of care. This is in stark contrast to a Swedish study conducted by Gunnervik *et al* (2008) where they found that

“older and longer work experience obstetricians and gynaecologists were more positive towards CS on maternal request and elective CS for women who fear delivery, yet did not agree on the statements that vaginal deliveries increase the risk for incontinence, prolapse and pelvic floor dysfunction” (2008, p.440).

Differences in opinion about CS are also evident between professionals. Monari *et al* (2008), in their analysis of attitudes of 148 midwives and 100 obstetricians in Italy, concluded that midwives and obstetricians differed significantly on this issue. They found that midwives were more supportive of women who wanted a VBAC compared with obstetricians. It was the midwifery participants who were more concerned with the risks involved with ERCS. Of interest, midwives were more concerned about the rate of CS than obstetricians, indicating, perhaps, contrasting philosophical stances that midwives and obstetricians have when it comes to pregnancy and birth.

### **2.8.3 *Contrasting Models of Care***

The midwifery model of care advocates for the natural ability of women to give birth and views birth as a normal event in the life of a woman. The midwifery model aims to

support continuity of care for the women through the whole pregnancy and birthing experience and to minimise technological interventions during labour and birth unless there is evidence that interventions are required (Sandall *et al*, 2013). The midwifery model of care is situated around the woman, ensuring that she is involved in the pregnancy and birth process. Midwifery views pregnancy and birth as an experience for the woman and supports a philosophy whereby women should be supported and encouraged throughout, as well as giving women information and comfort during the birthing process (Rooks, 1999).

This model contrasts with models of care that obstetricians and other healthcare professionals have employed in the maternity services. From the beginning of the 17<sup>th</sup> century and the Enlightenment of the 18<sup>th</sup> century, with the advancements of science and technology, labour and birth was increasingly seen as a medical event. This medicalisation of birth led to birthing being controlled by technology and clinicians who were deemed to have more knowledge of the process than the women who were giving birth. The woman was left out of the experience and the decision on the mode of birth. They were expected not to participate in birth, but rather conform to the medical model of care that was employed (Parker & Gibbs, 1998). The medical model of care does not see birth as a normal event, but rather an event that is abnormal and that birth needs supervision and intervention from medical professionals (Merchant, 1983). These contrasting philosophies can lead to a conflict between the two groups in terms of the care and service provided to women, as well as conversing with women about how they would like to birth after a CS.

From a review of the available literature, there is a lack of understanding with regards to how clinicians feel overall about VBAC and their perspectives on the benefits and risks related to this mode of birth. Decision-making on mode of birth after a previous CS is highly complex and needs an in-depth exploration. Exploring the relationship between women and clinicians and the influences on the decision for a woman to have a repeat CS or VBAC may help understand the reasons for the rising CS rate in this group of women, both in Ireland and elsewhere. My ethnographic study, embedded within the OptiBIRTH randomised trial, will assist in addressing this relationship, in part, by examining the institutional cultural changes surrounding VBAC and associated care in women who have had one previous CS.

## **2.9 The OptiBIRTH Study**

As outlined in Chapter One, the OptiBIRTH study is an EU-FP7 funded cluster randomised trial testing a complex intervention, versus usual care (control), aimed at increasing VBAC rates in women who have had one previous CS. Eleven partners, across eight European countries are involved in the study, with the trial taking place in three of these countries; Italy, Germany and Ireland. The Principal Investigator and study co-coordinator who has overall responsibility for the study is based in Trinity College Dublin (TCD), Ireland. The overall project commenced in September 2012 and is due for completion in September 2016. The project is divided into six discrete work packages, for which individual partners, and their team, are responsible (see Table 2 for details). As the project remains ongoing and the trial findings have yet to be made

public, full details of the intervention cannot yet be disclosed; however, as an overview of the publically available information, the intervention broadly consists of:

1. Evidence-based education of women on VBAC and ERCS through two purposively developed antenatal classes delivered at 24-31 and 31-35 weeks' gestation
2. Evidence-based education of clinicians on risks and benefits of VBAC
3. Introduction of communities of practice (women and clinicians sharing knowledge)
4. Clinician Opinion Leaders (OLs) (one midwife and one obstetrician at each intervention site) as drivers of the intervention
5. Audit and clinician peer review of CSs in each site
6. Interactive website and mobile phone applications to assist decision-making on mode of birth after previous CS

The published trial protocol (Clarke *et al*, 2015) is provided in Appendix 1.

The OptiBIRTH project received ethical approval (see Appendix 2) from the Faculty of Health Sciences, TCD and from each country's trial participating hospital sites.

**Table 2: Overview of the OptiBIRTH study**

Work Package (WP)	Description
WP 1: Project Management and Co-ordination	<ul style="list-style-type: none"> <li>• Managed by TCD</li> <li>• Ensuring that the OptiBIRTH project is successfully completed and is fully compliant with the EC Grant Agreement and Consortium Agreement.</li> <li>• Engaged in the financial and administrative tasks of the project (financial and progress reports)</li> </ul>
WP2: Development and Refinement of the Women-Centred Intervention	<ul style="list-style-type: none"> <li>• Explaining the factors that are important for improving VBAC rates as well as reducing fear of childbirth in various maternity settings across Europe.</li> <li>• Conducting systematic reviews on other women-centred interventions and on clinician-centred interventions to increase VBAC rates and to inform development of OptiBIRTH's complex intervention.<sup>78</sup></li> <li>• Focus-group interviews with women and clinicians in countries with high VBAC rates were conducted to explore cultural views on VBAC and investigate what works or does not work in these countries.</li> </ul>
WP3: On-line translation of "OptiBIRTH" Intervention, design into ICT tools	<ul style="list-style-type: none"> <li>• Development of an interactive "OptiBIRTH" website.</li> <li>• Responsible for the creation of mobile applications that allowed women to further their decision making and goal setting with regards to VBAC.</li> </ul>
WP4: Methodology and conduct of the cluster randomised trial	<ul style="list-style-type: none"> <li>• The implementation of the trial</li> <li>• The introduction of the intervention to the different maternity care settings in low VBAC countries in Europe as well as the assessment of the effectiveness,</li> </ul>

<sup>7</sup>Lundgren, I., Smith, V., Nilsson, C., Vehvilinen-Julkunen, K., Nicoletti, J., Devane, D., Bernloehr, A., van Limbeek, E., Lalor, J., Begley, C., (2015), "Clinician-centred interventions to increase vaginal birth after caesarean section (VBAC): a systematic review", *BMC Pregnancy and Childbirth*, **15**(1), pp.1-9. Please see Appendix 3 for the full article

<sup>8</sup>Nilsson, C., Lundgren, I., Smith, V., Vehvilinen-Julkunen, K., Nicoletti, J., Devane, D., Bernloehr, A., van Limbeek, E., Lalor, J., Begley, C., (2015), "Women-centred interventions to increase vaginal birth after caesarean section (VBAC): A systematic review", *Midwifery*, **31**(7), pp. 657–663. Please see Appendix 4 for the full article

	<p>both clinical and cost, in the maternity settings.</p> <ul style="list-style-type: none"> <li>• The collection of morbidity data from women through antenatal and postnatal surveys, neonatal morbidities, and intrapartum interventions, which included the use of epidural or induction of labour.</li> </ul>
WP5: Economic Analysis	<ul style="list-style-type: none"> <li>• Economic evaluation of direct and non-direct medical costs and determined variation of costs across Europe.</li> <li>• To determine if the OptiBIRTH intervention was cost-effective.</li> </ul>
WP6: Evaluation, dissemination, implementation and exploitation	<ul style="list-style-type: none"> <li>• Measure the success of OptiBIRTH and to make sure that the results of the study are disseminated across Europe</li> <li>• Report the results of the study to key-stakeholders and to disseminate the results to the wider public, clinicians and policy makers.</li> </ul>

This project, if successful, will not only change the perception of VBAC being a viable option after CS, but will also give women and clinicians the opportunity to make the decision together and allow women increasingly informed choice in their preference for birth after a CS.

## 2.10 Conclusion

The body of evidence discussed in this chapter suggests that CS and VBAC are complex issues and whether to undergo VBAC or not is equally complex from the perspectives of women and clinicians. This chapter has provided a comprehensive scope of CS rates and some of the potential reasons behind the increased use of CS in maternity care. This has implications for this study as it is due to the concern for CS rates that the OptiBIRTH study was developed. Understanding the implementation of

OptiBIRTH, from the perspective of those involved in the trial (women and clinicians), is important for determining whether the trial intervention had a positive impact. This is the rationale for my embedded ethnographic study whereby I aim to achieve understanding and insight as to whether OptiBIRTH had an effect on influencing decision-making for VBAC and the culture/cultural change surrounding this process.

In the next chapter, I detail the methodology that informed my ethnography. I will explore and present also my epistemological and ontological positions and how these are central to informing my embedded ethnographic study.

## **Chapter Three: Research Design - Methodology**

### **3.1 Introduction**

To explore if the OptiBIRTH package of care impacted on the culture of decision-making surrounding mode of birth after CS, an ethnographic methodology was chosen. This methodology was selected as it was seen as the most appropriate way to answer the research question. This methodology was framed by an interpretative, constructionist approach that guided the framework of this ethnography. This chapter presents the aims and objectives of this study and provides a thorough description of the methodological approaches to the various stages of data collection and analysis. The research design is described, with justification for choosing ethnography provided. Both the philosophical and theoretical underpinnings, which are crucial in understanding the viewpoint of the ethnography, and the theoretical framework that guided the conduct of this ethnography, will be discussed. The epistemological and ontological stances of this ethnography will be explored in depth as well as the subject of researcher influence and reflexivity, which are of major importance when conducting an ethnographic study.

### **3.2 Research Aims and Objectives**

The aim of this ethnography was to explore how the OptiBIRTH intervention affected cultural change surrounding the decision-making process regarding mode of birth after one previous CS from the perspectives of those involved in making these decisions (that



is; women taking part in the study, hospital clinicians, and clinician (midwife and obstetrician) OLs as drivers of the intervention.

The objectives of the ethnography were:

1. To understand the experiences and perspectives of women participating in the OptiBIRTH trial, at one trial intervention site, and how these experiences and perceptions may change over the course of the study as women consider their options for subsequent mode of birth after one previous CS.
2. To understand the meanings (what participants hold in the highest value) behind the decision-making process around mode of birth after previous CS and any influence the OptiBIRTH intervention might have on these decisions at different time points during the trial (e.g., on admission to the trial, during the trial and at the end of their participation in the trial) from the perspective of women.
3. To explore the traditions, beliefs and notions on VBAC, at the launch of the trial intervention, and the decision-making processes for subsequent mode of birth after one previous CS from the perspective of clinicians caring for women who have had one previous CS, and how these might change as the trial progresses.

4. To gain an in-depth understanding of the views of the obstetrician and midwife OLS employed at the study site to deliver the intervention, and to explore if their views change as the trial progresses.
5. To explore the interactions, and how these may change as the trial progresses, between women, clinicians and the opinion leaders on decision-making regarding mode of birth following previous CS.

To answer these aims and objectives, an appropriate research design and framework was developed, in order to provide context and inform the philosophical underpinnings of the study.

### **3.3 Choosing the Research Paradigm**

For decades, there has been a constant preoccupation with the epistemological and ontological concerns that are associated with ethnographic practice. Ethnography is an inductive process; it works from evidence gathered over a long period of time towards a theory and, thus, has a close relationship with epistemology. In ethnography, epistemology is the study of cultural knowledge as the goal of an ethnographer is to learn from people what counts as cultural knowledge for them, within the context of their specific environments. Epistemology is also concerned with the meaning of knowledge and “what it means to know. It is a background for deciding what kinds of knowledge are legitimate and adequate” (Gray, 2004, p.19).

Ethnography is an interpretive, constructivist, and reflexive process. To ensure that this methodology is developed, I will first describe the qualitative research approach that has been applied to this study.

### *3.3.1 The Qualitative Approach*

Cresswell (1994) suggests that qualitative enquiry involves understanding human and social processes, reporting detailed views of individuals and conducting studies in a natural setting. The goal of qualitative research is to discover patterns that emerge after close observation, careful documentation, and thoughtful analysis of the research topic. What can be discovered by qualitative research are not sweeping generalisations but contextual findings. The purpose of qualitative research is to understand and explain participant meaning (Morrow & Smith, 2000). Creswell (1994) defines qualitative research as:

“an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting” (p.15).

An inductive approach was taken to the generation and interpretation of data. The inductive view believes that the data collected can be used to develop concepts and theories that help us to understand the social world. This is in line with qualitative approaches, which are exploratory and focus on discovery and investigation. The qualitative research approach is concerned with the understanding of phenomena and meanings that people give actions, beliefs, or values in their social world. Because of this, I could see that the qualitative research approach would be the most useful for my

study, as I am looking at the social world of childbirth in the context of the OptiBIRTH study and the effect that the intervention may have had on an individual's beliefs, or the meanings they attach to trying for a VBAC. By choosing the qualitative research approach for this study, it allowed me to collect information to understand the culture of the hospital with respect to VBAC and decisions around mode of birth while OptiBIRTH was in place and to observe if any change in this culture occurred, following the implementation of the intervention. Choosing a qualitative approach for my study gave me greater access to deeper and more sensitive information, and facilitated me to observe the social and political world ingrained in the hospital more-so than a quantitative research paradigm would have. Thus a qualitative research approach was deemed best to achieve my study's aims and objectives.

That being said, I am also aware that there are some weaknesses associated with the qualitative research approach. Rubin & Babbie (2009), for example, argue that qualitative data are extremely limited in their extent to generalise findings to the overall population, which contrasts sharply to quantitative studies which are based on "rigorous sampling and standardised measurements" (p.230). This limited ability to generalise findings is due to smaller sample sizes in qualitative studies and the subjective nature of the topic being investigated. Yet, because of the nature of my embedded ethnography, a qualitative approach is appropriate as OptiBIRTH involves a specific intervention, aimed at a specific population and sample size (women with a previous CS and healthcare professionals in one study site). Therefore, some of the findings of this ethnography may only be related to the field-site in which this study was conducted. However, it could be suggested that the findings could be transferable to other units if

the intervention is seen to be effective. This ethnography explored the experiences and perspectives of women and clinicians that were participating in OptiBIRTH in one field-site at a specific point in time but the findings may be transferable to other maternity units.

Additionally, there is a possible risk in qualitative research that, due to the personal and subjective nature of qualitative research, analysis and interpretation of data may be influenced by the researcher's prior knowledge and personal perspectives on the topic under investigation (Rubin & Babbie, 2009). As I am not a healthcare professional, it is unlikely that I would have many pre-conceived ideas about decisions that need to be made around mode of birth following a first CS. However, I am a woman of childbearing age, and had some prior knowledge and views about normal birth versus CS. I was acutely aware of the danger of influencing data collected and every effort was made to conduct the ethnography in a reflexive and unbiased way. These potential limitations were taken into account when discussing the validity of the current study's findings and the reflexive process is discussed in greater detail in section 3.7.

### ***3.3.2 The Interpretive Paradigm***

A paradigm is a framework of beliefs, values and methods that the researcher utilises in order to design his/her study. Interpretivism is the set of beliefs that are associated with the qualitative approach. Interpretivists believe that there are many truths and multiple realities and that different people have different perceptions, values, and experiences. This way of thinking began in the late 18<sup>th</sup> century with the publication of the "Critique

of Pure Reason” by Immanuel Kant (1724-1804). Kant proposed that it is individuals that interpret their sensations rather than experiencing the “out there” world as it is. He was more interested in perception rather than objective reality and believed that reality and the world was a product of human perception and that these perceptions can change when the world that humans perceived is changed (Scott, 2002). This way of thinking was expanded on by Wilhelm Dilthey (1833-1911) and Max Weber (1864-1920), who introduced the concept of *verstehen*.

*Verstehen* means to understand in German. It is a concept that refers to entering into the shoes of the other in order to understand their point of view. The advocates of *verstehen* define it “as a singular form of operation which we perform whenever we attempt to explain human behaviour” (Abel, 1948, p.211). In achieving *verstehen* Weber emphasised that the researcher must understand the meanings of actions in the social world and humans must be seen to create that world by the organisation of their social world. Researchers should not treat the individual and the lived experiences like objects. This philosophical thinking was in a contrast to the more positivist position of the world which believes that “the nature of the world can be revealed by observation and that what exists is what we perceive to exist” (Burr, 2015, p.3).

The aim of interpretivism is to understand the experiences of those being studied in a subjective manner and, at the core of this paradigm, assumes that social actors generate meaningful constructs of the social world in which they inhabit and operate.

Additionally, the interpretive paradigm is associated more with the methodological approaches that provide an opportunity for the voice, concerns, and practices of

research participants to be heard (Weaver & Olson, 2006). Interpretive researchers believe that reality consists of people's subjective experiences of the external world; thus, they may adopt an inter-subjective epistemology and the ontological belief that reality is socially constructed. Walsham (1993) argues that, in the interpretive tradition, there are no 'correct' or 'incorrect' theories. Instead, they should be judged according to how 'interesting' they are to the researcher as well as those involved in the same areas. This is the interpretive approach, which aims to explain the subjective reasons and meanings that lie behind social action.

This research paradigm has been chosen due to its relationship with qualitative methodologies. It allowed for an in-depth exploration and greater insight into the subjective experience of participants in the OptiBIRTH trial. Furthermore, I believed that it was suitable for the embedded ethnography as the study is being conducted in a natural setting, which allowed me to collect substantial situational information through unstructured observation and open interviews. This research paradigm recognised the potential impact that I, as the research instrument, can have on participants and data. This was extremely important in this ethnography, as I was a new entity in the field-site, and new behaviours might be exhibited due to my presence, which must be acknowledged.

### **3.4 Epistemology and Social Constructionism**

Epistemology is the branch of metaphysics that deals "with ways of knowing and learning about the social world by asking questions such as how can we know about

reality and what is the basis of our knowledge?” (Snape & Spencer, 2003, p.13). As a researcher, I believe that the knowledge that we create is influenced by the culture and society that we come to know. It is the social processes that individuals participate in through a form of society, be that a hospital or in a home, that influences the creation of knowledge and culture. In Chapter Two, I discussed CS and VBAC and the perceptions around these forms of birth in the maternity world. Arguably, understandings of these forms of birth are influenced in some way by society and the interactions that women have with clinicians and therefore, the experiences that these women have with clinicians are being influenced by a certain type of knowledge creation that, in part, is both a societal and cultural issue.

In keeping with the epistemological stance that informed the research paradigm for this study, it is the theory of social constructionism that underpins my methodology. Social constructionism is a branch of philosophy that focuses on meaning and power.

Constructionism believes that meaning is not a property of objects and events themselves, but a construction of them. As Berger & Luckmann (1966) demonstrate, constructionism and knowledge pertains to the concepts that all individuals in society engage in knowledge production and the analysis of the social construction of reality.

Constructionism can be defined as

“knowledge and truth as created not discovered by the mind (Schwandt 2003) and supports the view that being a realist is not inconsistent with being a constructionist. One can believe that concepts are constructed rather than discovered yet maintain that they correspond to something real in the world” (Andrews, 2012, p.40).



Meaning is a product of the prevailing cultural frame of social, linguistic and symbolic practices that occur in a society; “The goings-on between people in the course of their everyday lives are seen as the practices during which our shared versions of knowledge are constructed” (Burr, 2015, p.3). These social processes and interactions in which people are constantly engaged are the product of different types of knowledge, which are constructed through subjective observations of our world. Social constructionism places the emphasis and construction of knowledge on the everyday interactions between people and the language that people use as a form of social action. This type of theorising is largely related to G. H. Mead (1863-1931) and his theory of social interactionism.

Mead believed that we are not born with the ability to engage in symbolic communication and self-reflexivity but rather we learn and develop these capacities as children. He uses the term “socialisation” to refer to the process by which we learn what it means to be an adult human being in society. It is in these interactions with others, through the sharing of language, that we can anticipate the meanings other selves will attribute to our attempts at communicative actions. Through this, he sees every person as a social construction. As Crotty (1998) demonstrates: “Mead’s social behaviourism embodies a thoroughly social point of view. In the Meadian analysis, human behaviour is social in origin, shaped by social forces, and permeated by the social even in its biological and physical aspects” (Crotty, 1998, p.62). Therefore, situations are not pre-defined, rather we creatively define reality and knowledge through interactions in particular situations.

Social constructionism is thus suited to my ethnography as it allowed me to explore the generation of knowledge and the socialisation of the actors in the study (women and clinicians) through the interactions they have with each other and with the OptiBIRTH intervention. It allowed for greater insight into the reasons for their actions and interactions through the examination of the language they use and how their knowledge of VBAC and CS is shaped during the trial. It also let me explore the social dependence of actors in the field-site and to see if they influenced each other's decisions and the knowledge informing those decisions. Social constructionism helped me to explore the acts of social practice that I observed as the main focus of enquiry for this ethnography. It also helped me investigate the knowledge construction behind these practices to explore if they changed over the course of the intervention when it came to making a decision about subsequent mode of birth after a previous CS.

With the social constructionist view, I can attempt to understand the experiences, values, beliefs, and perceptions that the women and clinicians have on mode of birth after CS and if their interactions with the OptiBIRTH intervention aided them in constructing a new belief or perception of birth after CS. This meant that I could look at the meanings the participants constructed around information that they received through OptiBIRTH and knowledge integration in their interactions with each other. The social constructionist viewpoint allowed me, as the researcher, to emphasise the development of shared meanings of the OptiBIRTH intervention through the social processes involving language and how the participants interacted with each other when it came to decision-making for mode of birth after CS.

### 3.5 Ontology and Realism

Ontology is the branch of philosophy that concerns itself with the nature of being and reality. This philosophical stance deals with “the study of being. It is concerned with what kind of world we are investigating, the nature of existence, with the structure of reality as such” (Crotty, 1998, p.10). With these ontological assumptions we try to respond to the questions “‘what is there that can be known?’ or ‘what is the nature of reality?’” (Guba & Lincoln, 1989, p.83).

With regards to the relationship that these ontological assumptions have with social constructionism, Guba & Lincoln (1994), believe that they have a relativist amalgamation. This suggests that there are multiple realities that are socially based and shared amongst individuals and cultures. The constructions that are produced by individuals are alterable with the realities that they are associated with. This constructionist relativism suggests that there are multiple yet conflicting social realities that are produced by humans that are changeable as humans become more informed and intelligent (Guba & Lincoln, 1994). Even with this, there are many forms that the ontological position could take, from critical realism associated with post-positivism to relativism that has been described above. Frazer & Lacey argue that

“even if one is a realist at the ontological level, one could be an epistemological interpretivist . . . our knowledge of the real world is inevitably interpretive and provisional rather than straightforwardly representational” (1993, p. 182).

Though epistemology and ontology give two contrasting philosophies of the social world, there can be an integration of both assumptions with Campbell (2002) suggesting

that researchers can believe that the ideologies of ontology can play a valuable role in the construction of knowledge (Maxwell, 2012). Crotty (1998) believes that epistemology and ontology are mutually dependent on each other and “to talk about the construction of meaning (epistemology) is to talk about the construction of a meaningful reality (ontology)” (p.10).

Hammersley (1992) proposed that ‘subtle realism’ can bridge the gap between epistemology and ontology. He suggested that subtle realism can help us to accept that the social world can be independent of an individual’s understanding but that this subjective understanding is only accessible through interpretation, from both the individual and the researcher. He brings to light questions of validity and relevance that the ethnographer must consider. In terms of the validity question, Hammersley (1992) contests that instead of having to choose between naïve realism and relativism, subtle realism allows the ethnographer’s representation and point of view to explore features of phenomena that can be seen as both valid and irrelevant. If we, as researchers, took the concept of realism at a first glance, we would be at odds with the theory surrounding the ethnographic approach: understanding the perspectives of culture and society. Realism sees beliefs and values as a product of reality and does not take into account interpretation or representation. ‘Subtle’ realism alleviates this situation. It lets us realise that while we are allowed to investigate independent phenomena, we must “rely on cultural assumptions and reject(s) the idea that knowledge must be defined as beliefs whose validity is known with certainty” (Hammersley, 1992, p.52).

A constructionist epistemology and ontology places “priority on the phenomena of study and seeing both data and analysis as created from shared experiences and relationships with participants and other sources” (Charmaz, 2006, p.330). With this in mind and using the ethnographic approach, this study is capable of understanding women’s and clinicians’ beliefs on different methods of birth after a CS, instead of judging their actions, and also documenting different positions and perspectives when exploring the culture surrounding the OptiBIRTH intervention within the setting of the field-site. The participant experience and their interpretation of the knowledge that they are provided with are crucial for understanding the significance the OptiBIRTH study could have not only for the individual participants, but also for the field-site society.

### **3.6 Ethnography**

Chapter 2 explored the current issues surrounding CS and VBAC in the obstetric world and the rationale for the OptiBIRTH Study. To illuminate the influence of the OptiBIRTH study, I needed to explore the relationship between women and clinicians during the intervention and to ascertain as to whether this relationship develops in line with the aims of the intervention. Ethnography, which has a focus on exploring culture and how culture affects society from a personal, professional and historical viewpoint, allowed me to investigate how the intervention progressed from the perspective of the involved individuals. It also facilitated me to explore the intervention from an overall field-site point-of-view and how the intervention can influence and shape the institutional cultural norms that have been rooted in the field-site society when it comes to decision-making around VBAC.

### 3.6.1 What is Ethnography?

Ethnography has been described as

“the researcher participating, either overtly or covertly, in people’s daily lives for an extended period of time, watching what happened, listening to what is said, and/or asking questions through informal and formal interviews – gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry” (Hammersley & Atkinson, 2007, p.3).

The main aim of ethnography is to provide holistic insights into people’s lives, including their views and actions in locations that they inhabit through the medium of observations and interviews (Reeves *et al*, 2008). It involves describing a culture and gaining an understanding, from the native’s point of view, of their way of living in their natural setting. The main features of ethnography as a method are rich and thick descriptions of patterns of social interactions and interpretation of those patterns that show meanings for the culture that is being studied. The emphasis of ethnography is the description and understanding of the complexities and regularities of human behaviour that may implicate social and cultural processes (Lambert *et al*, 2011). The process of ethnography is not pre-determined; rather it is flexible in nature, allowing the researcher to capture the invariable nature of social phenomena in that particular setting, which are constantly interchangeable (Silverman, 2006; Freebody, 2003; Argyris, 1985; Spradley, 1980).

In contemporary terms, moving away from the imperialistic and colonial foundations of anthropology and ethnography, notably from describing ‘the Savage’ from the times of

Bronislaw Malinowski (1884-1942) and 'Argonauts of the Western Pacific' (1922) to Clifford Geertz (1926-2006) and his work on the meaning of cockfighting in Balinese culture in the 1950s, it is now considered useful to apply the ethnographic method to the study of particular social problems or understanding organisations and their culture (Silverman, 2006; Patton, 2002). Instead of learning about strange and different cultures, the emphasis is now on understanding our own society and cultures that are attached to it. Ethnography can be applied to a myriad of situations and settings, from organisational studies to programme evaluations, as these each develop their own cultures and this culture can have an effect on the processes and outcomes. Patton (2002, p.83) states that "improving a program, then, may include changing the program's culture. An ethnographic evaluation would both facilitate and assess such change." This can also be applied to intervention based research. Larsen (2007) argues that although randomised controlled trials (RCTs) are seen as the "gold standard" in medical research, an ethnography that focuses on the person has much to offer in terms of understanding complex therapeutic processes. Furthermore, a qualitative perspective can allow for an in-depth exploration of the sociocultural reality of services and "offer an interpretive methodology that draws on theoretical models of interpersonal and cultural dynamics to provide a critical analytic exploration and understanding of how these services work" (Larsen, 2007, p.334). This use of ethnography to enhance RCTs is supported by Hong *et al* (2005) when they conducted an ethnographically informed evaluation research during the implementation of an intervention programme that addressed HIV prevention.

The aim of using ethnography as a method is to understand the complexity of human behaviour. This includes their beliefs, values, practices and perceptions. Boyle (1994) suggests that “a central tenet of ethnography is that people’s behavior can only be understood in context” (p.159). As ethnography aims to provide a holistic insight into people’s behaviour, this can include both the environment in which they are situated and the historical context, which can give the ethnographer a more complete picture of how the society is structured and how it operates. To explore the complexity of human reality, ethnography can be used to seek to understand the interrelationships between the social processes, the socio-cultural context that contribute to how people’s reality is constructed.

To achieve this understanding, an ‘emic’ and ‘etic’ approach to studying the culture should be maintained by the ethnographer, or an insider/outsider approach.

The ‘emic’ approach relates to understanding the culture from the perspective of the people being studied while the ‘etic’ approach pertains to understanding the culture from the perspective of the researcher and the research paradigms that they have brought with them (Pelto & Pelto, 1978).

The methods that ethnographers use to gather data is predominately qualitative based, with means

“carrying out fieldwork and living in the communities of their hosts, observing activities of interest, recording fieldnotes and observations, participating in activities during observations (participant and non-participant observation), and carrying out various forms of ethnographic interviewing” (Whitehead, 2004, p.7).



Employing ethnography is to “to uncover the meanings which underpin social interactions through the researcher’s direct involvement with the interactions which constitute social reality for the group being studied” (Giddens, 2001, p.646). It involves immersion in the setting which is being observed and gaining the perspective of the participants in their culture. It is the study of individuals and groups and gaining a first-hand experience of their setting and culture over a period of time, using the methods of interviews and participant observation to actively learn about social behaviour (Giddens, 2001). A more comprehensive description of the data collections methods employed for this ethnography, namely observation and interviews, is provided in the next chapter (section 4.6).

Ethnography was chosen as the main method of inquiry due to its emphasis on exploring the nature of a particular phenomenon that occurs in society and understanding the social settings and social processes, rather than setting out to test a set of hypotheses (Atkinson & Pugsley, 2005). In applying an ethnographic approach to the health care setting, Savage (2000) believes that ethnography is useful here as it can identify how an organisation’s structure for decision-making can be influenced by an informal structure created by groups and individuals within the organisation that informs local knowledge in particular settings. Van der Geest & Finkler (2004) rationalise the use of ethnography in the hospital setting as hospitals have their own distinct culture with individual hospital care influenced by the different cultural norms, medical views and traditions that are found in that particular society. Therefore, the care provided and the decision-making processes can vary widely. Goodson & Vassar (2011) also believe that ethnography is amenable to the health care setting as it allows the

researcher to investigate not only differences among cultures, genders and professions, but also an in-depth exploration of decision-making in the hospital setting that leads to a better understanding of the relationship between the client and healthcare provider's team.

The culture under investigation is the culture around decision-making around mode of birth after a previous CS in one field-site of the OptiBIRTH intervention. I agree with Lynam *et al's* (2007) belief that culture is a dynamic social construction, rather than a firm set of beliefs and practices. Therefore, to understand the practices around decision-making for mode of birth after a CS, the broader cultural and societal discourses around decision-making for birth were explored. Further to this, I aimed to investigate as to whether the presence of the OptiBIRTH intervention had an impact on this decision-making process and if it had an overall effect on the cultural and societal discourse on birth after a CS.

Healthcare settings do not exist as a separate entity, but rather can be influenced by the society and culture in which they are situated. They are part of the cultural system and these systems are dominated by broader societal and cultural ideals of the roles that women and clinicians have (Helman, 2000). Furthermore, there are various social determinants regarding CS and mode of birth after CS, such as demographics, socio-economic status, but what this ethnography hopes to achieve is a deeper cultural understanding of how birth after CS is constructed and whether the presence of the OptiBIRTH intervention influences how birth after CS is constructed after participation. This ethnography aimed to look at the wider cultural impact of the OptiBIRTH

intervention in one field-site to explore whether or not the intervention had an influence on the overall field-site culture in which I participated. The role that ethnography can play in understanding hospital or clinical practices is now considered important in improving outcomes and informing policy for best practice (Renado & Marston, 2015; Dixon-Wood *et al*, 2013; Cook, 2005)

### **3.6.2 Hospital Ethnography**

There is an increasing body of ethnographic literature that centres on hospital or clinical settings in understanding culture and its effects on patient experience and service delivery. Long *et al* (2008) provide a description of hospital ethnography, in which they provide an insight into the uses of ethnography in the hospital and healthcare setting. The use of ethnography in the hospital setting can allow for a reflection on a multitude of issues that affects not only the patient, but also the doctors, nurses, and managers that operate in this sphere. The use of ethnography in the hospital setting can bring about a new insight into this complex institution and the people that inhabit it. Goodson & Vassar (2011) detail the uses of ethnography in healthcare and medical education research. They suggest that ethnography can, in the hospital setting, help to understand the nurse/patient relationship better and allow for decision-makers to obtain reliable information to deliver and implement healthcare initiatives that benefit both parties more successfully. Shand (2005) believes that there has been a surge of interest in the use of anthropology in the hospital setting, with “anthropologists working alongside medical practitioners and whose work should have practical implications and therefore be shown to be of direct clinical importance” (Shand, 2005, p.106). Recent

ethnographic research conducted in the hospital or clinical setting includes the relationship the hospital setting has with religious beliefs (van der Geest, 2005), the structural and cultural influence family members can have in a hospital (Zaman, 2013), how support is perceived by women in Ghana attending an obstetric fistula clinic (Sullivan *et al*, 2016), and narratives around symptoms in the diagnoses of angina in the UK (Somerville *et al*, 2008). Ethnography has also been used recently in the midwifery and nursing arenas on a variety of topics. Examples include nurses' experience of breastfeeding while on night shifts (Grassley *et al*, 2015), the conceptualisation of risk in childbirth within a continuity of care midwifery programme (Dove & Muir-Cochrane, 2014), and cultural perceptions of safe health behaviours in Sudan (Serizawa *et al*, 2014). By using ethnography in the hospital or clinical setting, a deeper understanding of the informal structures of the organisation can be understood and the delivery of healthcare can then be informed to include these structures.

Anthropology allows for the study of human interaction and action, as these areas can discern the patterns of human behaviour that is reflective of values, norms, and beliefs found in their particular culture or society. By studying maternity care and the implementation of an intervention to improve maternity care in the context of anthropology can allow for a better understanding of how culture can influence the development of improving care in the maternity sphere. By exploring the connection between this area of care and culture, it can make a meaningful contribution to knowledge and our understanding of the potential changing of care models and the views of the women and clinicians involved.

To study as to whether the OptiBIRTH intervention had an impact on the structure of the hospital and whether it could impact the societal and cultural views of VBAC, this ethnography was proposed to determine if the intervention could be deemed as effective in affecting change. By placing this ethnography in the growing body of hospital ethnography, it can be said that this study could allow for a better understanding of the workings of the intervention and how the intervention is construed in the field-site. This could then have an impact on the interventions uptake and its potential for a cultural shift toward seeing VBAC as a positive and viable option for women with a previous CS.

### **3.7 Reflexivity**

Reflexivity is of the utmost importance in ethnographic research. Reflexivity refers to the researcher reflecting on the social processes that might influence how the data are interpreted and conveyed, and the researcher must be critical of these influences (Brewer, 2000). Reflexivity encourages the researcher to be honest about their role in the research study, which can help to improve the design of the study and the way they conduct themselves in the study over a period of time. Hansen (2006) views reflexivity as a way to assist researchers constantly to question their pre-fieldwork assumptions and interpretations, and that these interpretations should be portrayed to people reading the research. In this sense, a certain degree of self-reflexivity will be shown to the readers so that they will understand the meaning of the research (Potter, 1996).

Therefore, the process of reflexivity gives way to a constant examination of the researcher's interpretations of what is being observed and an examination for the potential of bias in the representation of those interpretations and representations. It is extremely important to consider when writing up, how people who have participated in the ethnography are represented and how I have interpreted the knowledge that they have shared with me. John Brewer (1994, p.235-236) suggests principles which help "qualitative researchers who seek to be reflexive in both descriptive and analytic senses". In using these principles, I established the wider relevance of the topic and identified the grounds on which empirical generalisations are made, discussed the research problems that arose during all stages of the research process and established the integrity of myself as the researcher by acknowledging the strengths and weaknesses of the research design as well as the grounds on which knowledge claims are being justified. By being reflexive in all aspects of the research process, the readers can assess the credibility of the research by determining the influence that factors, such as power relations and the interactions I have with participants, have had on the data.

### **3.8 Conclusion**

The research methodology described in this chapter, that being a constructionist view to the development of knowledge and culture, was intrinsic to the ethnographic exploration of the OptiBIRTH study. Examining these methodological assumptions gave rise to an ethnographic framework that is reflexive and gives a comprehensive view of the study in all facets.

The next chapter describes how the research paradigm and philosophical choices that were made to inform this ethnography assisted with the development of the study research methods.

## **Chapter Four: Research Design – Methods**

### **4.1 Introduction**

In this chapter, I present the methods of data collection that were employed to conduct this ethnography. Included in this chapter is a description of the research settings, the process of gaining access to the research site, the sampling methods, the data collection methods and the method of data analysis. I will present the ethical approval procedures that I undertook for this ethnography, including a consideration of the ethical principles which influenced all stages of my study, including fieldwork, analysis of data and rigour in study conduct.

### **4.2 Choosing the Research Site**

As mentioned previously (section 1.4), the OptiBIRTH study occurred in five hospitals in Ireland with three of these allocated to receive the study intervention. The three intervention hospitals are dispersed across the country and have different annual birth rates (approximately 5000 births in one unit and 2000 in each of the other two units). Their rates of VBAC, which were analysed during a preliminary audit conducted for the OptiBIRTH study, also differed, ranging from 24% to 35% for all women with any number of previous CS (rates for women with one previous CS only were not available from all study sites at the time of audit). Two of the sites are situated in large urban areas, while the third site has a more rural location. Only one site is a standalone



maternity hospital. The other two sites are maternity units within general hospitals that additionally provide general medical and surgical adult health services to the surrounding regions.

As it was logistically (travelling to geographically diverse locations) and practically (time required to be in the field) impossible for me as a lone researcher to conduct the ethnography in all three intervention sites, the first decision I made was choosing the most suitable of the three sites for this ethnography. Very quickly, I opted for the largest of the three sites as I felt it would provide me with the greatest number of potential participants in the time frame that was available for me to carry out my field-work. The site was also chosen because of its large urban location and thus the potential to provide a more demographically and social-economically diverse cohort of participants.

To maintain site anonymity, I shall refer to the chosen study site from here on, using the pseudonym of the Large Maternity Hospital (LMH). The LMH, with an annual birth rate of approximately 5000 births, provides antenatal, labour and postnatal care to the surrounding areas and counties. It also facilitates training and education, including hospital placement opportunities, for healthcare students attending the local university. Staff members within the maternity department include consultant obstetricians, midwives, obstetric registrars, physiotherapists, social workers, and other support staff, such as maternity care assistants, domestic, catering and porter staff. Antenatal clinics are held in the LMH five days per week, excluding bank holidays. On average, around 80-100 women are seen at each clinic and there are, on average, 10-15 new maternity bookings per day.

The antenatal clinic is situated on the lower level of the LMH at the far end of a corridor. To arrive at the antenatal clinic, individuals must pass through a long corridor that houses the physiotherapy department, the ultrasound room and the colposcopy clinic. At the main entrance, there are double doors that allow entry into the clinic, which includes the booking rooms, midwives' clinic and reception. A more detailed description of the field-site will be provided to you in the following chapter (see section 5.2)

### **4.3 The Field-work Period**

The field-work phase of this ethnography lasted 16 months, from the pilot phase of the intervention in February 2014 until June 2015. This prolonged exposure in the field meant that I could follow the natural progression of the intervention, from its immediate inception in the field-site, to the last group of women that participated in the purposively developed trial antenatal classes. This lengthy field-work gave me the resources, through observation, field-notes, diaries and interviews, to ascertain whether there was a cultural change surrounding VBAC as a mode of birth after one previous CS in the hospital following implementation of the intervention. In a following section, I describe my experiences of preparing to enter, entering and then leaving the field-site. Prior to this, however, I should like to give you some context surrounding myself as the researcher.

#### *4.3.1 The Researcher*

The researcher in ethnography is an integral part of the research study, becoming deeply immersed in the data collection and analytical process. For this reason, I believed it important to provide some background information on myself and as a research instrument within this study. I am in my mid-twenties, and I am the eldest of three children. After completing a Bachelor of Social Science in University College Dublin, I applied for a Masters in Social Research in TCD, as I am interested in how society works and how research represents people. During my undergraduate studies, the research components were my favourite parts of the course and I decided that this was a path that I wished to pursue. After being accepted onto the Masters programme, I focused specifically on the lives and experiences of pregnant women, through a group project that explored the perceptions of women to ascertain when the “optimal time” to become pregnant was. This led to my work placement for the course, where I became involved with a large longitudinal research study examining maternal morbidity in first time mothers in Ireland (the MAMMI study; for further information, please see [www.mammi.ie](http://www.mammi.ie)). It was during this involvement that I conducted my own research study for my dissertation which explored why first-time mothers decide to participate in longitudinal research. Participants in my study were a small cohort of those participating in the MAMMI study. The experience of openness and listening to these women talking about such an emotional time in their lives was incredible. I thoroughly enjoyed the whole process of talking to these women and their experiences of research. It was then that I knew that this was the path that I wanted to take in research; the lived experience of pregnant women and how their voices are heard, both in society and in

research. It was soon after this that the position of doctoral candidate within the OptiBIRTH study arose, and I immediately applied for the position, which I was fortunate to be offered. It is through these processes and experiences that I have developed as the research tool for this ethnography.

#### *4.3.2 Preparing to Enter the Field and Ethical Approval*

Preparation for entering the field coincided with the actions of WP2 as detailed in Table 2 (section 2.8) I had the opportunity to attend and observe focus group interviews, in May 2013, that were conducted to ascertain possible barriers that prevent the promotion of VBAC, as well as the views of women and clinicians on VBAC.

This gave me the opportunity to visit my study's field-site, as a member of the OptiBIRTH research team rather than as an ethnographer at this time (my study was introduced at a later time when the intervention was developed), and make first contact with the hospital clinicians. By observing the focus groups, I got an initial sense of staff feelings toward VBAC, the opinions that clinical staff currently held and their thoughts on how and what OptiBIRTH should incorporate as a legitimate package of care.

Although I had yet to achieve specific ethical approval for the ethnography (I was covered to attend the focus groups as a member of the OptiBIRTH team under Trinity College ethical approval), and locate a gatekeeper for my study, attending the focus groups gave me a real flavour of the clinical atmosphere and where VBAC was situated in it.

Around the same time as the focus groups, I was applying for ethical approval for my ethnography from TCD. The Committee, with my first application, raised some concerns related to observations in the antenatal clinic and informed consent in the field-site and the fact that I was not a healthcare professional. After discussing the concerns with my supervisors, I made an amendment to my study design whereby women would now be informed of my presence and the ethnography in the overall main trial OptiBIRTH information leaflet that they received when they first booked for maternity care at the field-site and prior to consenting to participate in the OptiBIRTH study. Following this, I would only observe interactions between women who had consented to and were participating in OptiBIRTH, and their clinicians. Information pertaining to myself, including that I am not a healthcare professional and the reason for and design of the embedded ethnography were detailed in booklets that I had created specifically for the ethnography. Furthermore, details of observing (as part of the ethnography) were added to the consent form (tick-box format) and highlighted in red writing. This ensured that women who were consenting to OptiBIRTH in this site would also be aware that a researcher would be present in the field-site observing as part of the study (see Appendix 5 for consent form). Separate information and consent forms for interviews, etc, were developed and distributed at a later time (see section 4.5.1 and 4.5.2 for details). These amendments were taken back to the Faculty of Health Sciences Research Ethics Committee (REC) in TCD and formal ethical approval was granted on 8<sup>th</sup> July 2013 (see Appendix 6).

A separate ethical application was submitted to the Health Services Executive (HSE) REC for site specific ethical approval. The process for this application included visiting

the field-site with my supervisor to meet the obstetric OL (OOL) for the intervention, who was also the obstetric clinical lead in the hospital, in July 2013. We provided him with the information on the embedded ethnography and requested that he might act as the clinical sponsor for the study as was required on the ethics application. The OOL was, at this time, already aware, in brief, of the ethnography through information provided by the post-doctoral researcher for OptiBIRTH. Following my supervisor and myself providing further information on my study, the OOL was happy to support my study and signed the form for submitting to the Ethics Committee indicating his support.

After this meeting, I submitted the application to the HSE REC on the 27<sup>th</sup> August 2013. I was invited to attend a meeting with the REC to discuss my ethnography on the 11<sup>th</sup> September 2013. The REC, to my relief, had absolutely no concerns about the ethnography and I was granted ethical approval, without a need for amendments, on the 12<sup>th</sup> October 2013 (see Appendix 7 for letter of approval).

During the time I was preparing and submitting my ethics applications, I also embarked on a period of training and knowledge gain to prepare myself for data collection, as this was my first foray into the world of ethnography and my first experience of conducting research in a hospital. In July 2013, I participated in a workshop in Queen Mary, University of London, which focused on anthropological methods in clinical practice. This gave me the opportunity to examine the field of medical anthropology and the use and practice of ethnography in this field. It also provided networking opportunities with other students similar to myself who were embarking on their studies and an

opportunity to ask questions from people who have conducted ethnographic research in a variety of cultures and places.

In January 2014 I attended an ethnography winter school held in the University of Maynooth, which is the only Department of Anthropology in Ireland. This was also a very insightful workshop that gave me an understanding of what field-work was actually like and to listen to other people who were at the same stage as I in their research studies. The workshop further prepared me with the tools to enter the field and to generate field-notes that were both descriptive and reflexive.

#### ***4.3.3 Researcher Access***

On the 13<sup>th</sup> January 2014 a meeting of the OOLs and the midwife OLs (MOLs) for each OptiBIRTH intervention site was held in TCD. I attended this meeting and introduced myself to the MOL and the OOL from the site in which the ethnography would take place. For anonymity purposes for the OOL, I will be referring to the OOL as a male for the remainder of this thesis. In the interest of this study I am not suggesting that the OOL is male but for this ethnography the OOL will be represented as male. With regards to the MOL, as the majority of midwives in Ireland are female, the midwife will be referred to in this study as female.

This was my first encounter with the MOL for the field-site. At the lunch break I was introduced to her by OptiBIRTH's post-doctoral researcher and described and discussed

the ethnography with her. She was very welcoming to the ethnography and was supportive of my coming to the field-site with her to be introduced to the clinical staff.

This was followed by a planned meeting with the MOL which took place on the 22<sup>nd</sup> January 2014. At this meeting, the MOL and I discussed the details of the embedded ethnography and how to access the antenatal clinic for the observation component of the study. At this meeting, I also provided the MOL with an information leaflet, designed for clinicians, outlining the aims of the study and informing staff in the hospital why I would be present during the OptiBIRTH trial (see Appendix 8). I made contact with the MOL again in February 2014 where we arranged a date for a meeting with clinic staff so I could introduce myself and my study in person. This meeting occurred on the 10<sup>th</sup> March 2014 and coincided with a clinician information session being held as part of the OptiBIRTH intervention in the antenatal clinic (see section 2.8). At the end of this meeting, I had an opportunity to present information on the ethnography to clinic staff collectively, provide them with the study information leaflet (see Appendix 8) and answer any questions that they had on the study at that time. This meeting additionally provided me with the opportunity to discuss with the Clinical Midwife Manager (CMM) my presence in the clinic and to ensure that she was agreeable to my presence in the clinic observing for the purposes of this ethnography.

Access to and my being present in the clinic for the ethnography was granted without any concerns and was met with support from both the CMM and the staff in the clinic. However, as I was a 'stranger' to the field site, it was difficult for me to place myself in the clinic so as to have the best possible location to observe while simultaneously



ensuring that I was not in the way of the running of the clinic. I decided then to situate myself at the entrance of the clinic, as only one of the doors is normally open so there is space to observe as well as not being in the midwives' way as they went about their clinical duties. If the clinic became extremely busy or if a midwife was dealing with a sensitive issue with a woman and I felt that I should remove myself, the CMM's office was open for me to place myself there with the door open. Overall, it took approximately four months for myself and the midwives in the clinic to reach a comfort level where my presence was not seen as intrusive to their environment.

#### **4.4 Sampling**

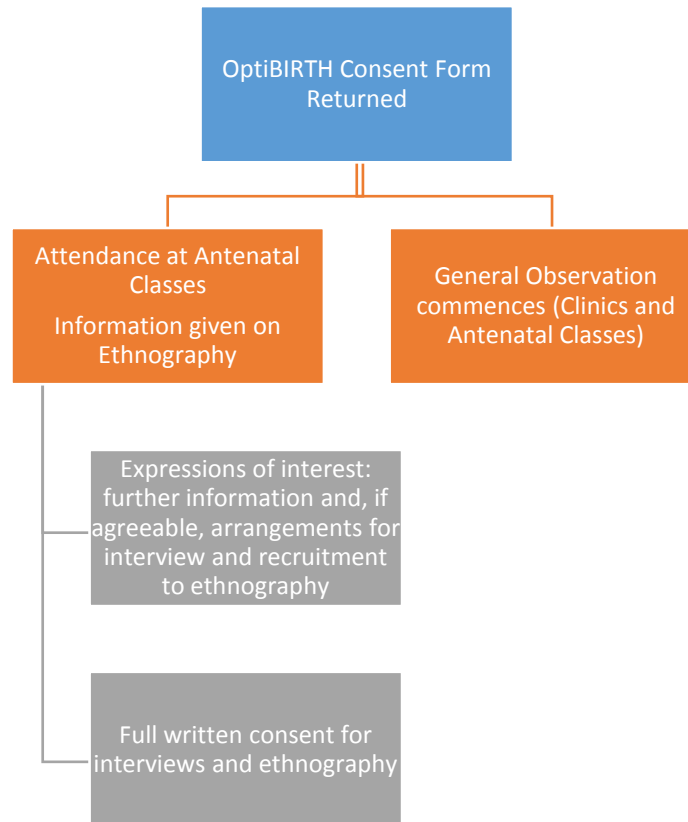
The sample size for the OptiBIRTH trial is 120 women at each study site with recruitment to this ethnography dependent on this sample. At the first booking visit to the field-site (at around 12 weeks' gestation), women who were eligible to take part in OptiBIRTH were provided with the main OptiBIRTH study information pack by the antenatal clinic staff member who was completing the booking. Women who returned a written consent form to the MOL agreeing to participate in OptiBIRTH provided the sample population for the ethnography (see Appendix 5). Purposive sampling was employed as it was deemed the most appropriate sampling strategy for recruiting women to the ethnography (interviews) from the sample population. Purposive sampling relates to "the sample units are chosen because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study" (Ritchie *et al*, 2003, p.78). It is often used in qualitative research to facilitate the researcher to obtain rich data and to

investigate the issues in question in a full and meaningful way (Patton, 2002). In this study, purposive sampling was used to gain a broad range of perspectives from women who were attending the antenatal classes or who solely used the website, and from clinicians from specific areas of the hospital such as the antenatal clinic and the labour ward.

#### ***4.4.1 Recruitment of Women***

Recruitment of women for interviews occurred via the OptiBIRTH trial antenatal classes and via the trial website, which participating women had access to. At the end of each antenatal class (see section 6.2 for schedule), the MOL facilitating the class provided an information pack detailing further the ethnography to women attending the class. Following this, I introduced myself, provided women with further information and the opportunity to ask any questions that they might have had about the ethnography. This information pack included a letter of introduction (Appendix 11) and a booklet containing information on the purpose of the study, the method of data collection, information on voluntary participation and assurances of confidentiality (Appendix 12). Women who expressed an interest in participating in interviews and/or taking part in interviews were asked to contact me directly or to talk to me at the end of the class or in the clinic. This information was replicated on the OptiBIRTH trial website and the pathway for contacting me was similar (that is by telephone, email or in person during a visit to the hospital/at their 2<sup>nd</sup> antenatal class). During the course of the ethnography, a poster was also created to increase women's, who were not attending the antenatal classes, awareness of my study (Appendix 23). The posters were placed in the

waiting area of the antenatal clinic, the main clinic and, with agreement from the MOL, added to the antenatal and postnatal packs that were posted out to women who were taking part in OptiBIRTH. A flow-diagram outlining the recruitment and consent processes to this study is detailed in Figure 1.



**Figure 1: Recruitment and Consent Process for Study (Women)**

#### **4.4.2 Recruitment of Clinicians**

An information letter was distributed to all staff in the field-site and presentations were conducted periodically to raise awareness of this embedded study (see Appendix 13). These presentations were provided in conjunction with the clinician educational information sessions that are a component of the OptiBIRTH intervention. Once the MOL had completed the OptiBIRTH information session, I provided a short three-

minute oral presentation describing the embedded ethnography and inviting them to take part in an interview with me to talk about their opinions of OptiBIRTH and their overall experience of participating in the intervention. The clinician information sessions were held monthly and facilitated by the OLs at the field-site. In this way, the majority of the maternity healthcare professional population in the field-site were informed of the ethnography and were given the opportunity to be interviewed about VBAC, the trial and their perspectives on both. For staff that expressed an interest in being interviewed, an information pack, similar to the information pack provided to women, was provided and I was available on site to provide more information or to answer any questions that clinicians might have had (see Appendix 8). Interviews with clinicians were conducted at the field-site.

#### ***4.4.3 Recruitment of Opinion Leaders***

The OLs, a component of the OptiBIRTH intervention, were also periodically interviewed throughout the intervention. This was necessary within this ethnography to determine their experiences of being involved in the research project as they are the main point of contact for information for study participants (both women and clinicians).

As the OLs are employed to facilitate the trial and advocate for VBAC, it is important to explore their perspectives as they may have a significant effect on influencing cultural change. For this reason, they were interviewed to explore further their thoughts on the

application of the intervention and on whether they believed they may have had a positive or negative influence on the aim of the OptiBIRTH trial.

Table 3 provides a breakdown of the study sample and the recruitment methods for each sample group.

**Table 3: Proposed Sample for the Study**

	<b>Women (Participating in OptiBIRTH)</b>	<b>Clinicians (staff in hospital)</b>	<b>Opinion Leaders (OptiBIRTH research team)</b>
<b>Method of data collection</b>	Interviews (1-2 over the course of the intervention)  Observation	Interviews (1-3 over the course of the intervention)  Observation	Interviews  Observation
<b>Recruitment of participants</b>	The OptiBIRTH trial antenatal classes	OptiBIRTH clinician information session  Antenatal clinic  Labour Ward	OptiBIRTH clinician information session  Antenatal Clinic  Contact them directly
<b>Number of participants (approximate number)</b>	20 depending on the interest for being interviewed and the amount of times they would like to be interviewed	15 depending on the interest for being interviewed and the amount of times they would like to be interviewed	2 (Opinion Lead midwife and Opinion Lead Obstetrician) interviewed several times over the course of the intervention

As this was an approximate number of participants that were estimated before the data collection phase, I have provided the actual number of participants that data collection was conducted for this ethnography in Table 4 below and the recruitment methods for each group.

**Table 4: Actual Sample for the Study**

	<b>Women (Participating in OptiBIRTH)</b>	<b>Clinicians (staff in hospital)</b>	<b>Opinion Leaders (OptiBIRTH research team)</b>
<b>Method of data collection</b>	Interviews (1-2 over the course of the intervention)  Observation	Interviews (1-3 over the course of the intervention  Observation	Interviews  Observation
<b>Recruitment of participants</b>	The OptiBIRTH trial antenatal classes	Antenatal clinic  Labour Ward	Contact them directly
<b>Number of participants</b>	15  4 women interviewed after giving birth	12	3 Interviews MOL 1 Interview OOL

## **4.5 The Participants**

The participants in this ethnography were women with similar demographic information. All of the women in the sample were married. Their ages ranged from 30-37 years old and were working outside of the home, apart from two. All of the participants had one child with their last birth ranging from six months to three years with the average being two years. Three of the women in the sample group had a previous vaginal birth before their CS. All of the women that made up the sample were

recruited at the antenatal classes and were interviewed in the field-site during their next antenatal clinic appointment.

With regards to the clinician sample for this ethnography, all of the participants were midwives that worked in various departments in the field-site, including the antenatal clinic, the labour ward, and the theatre department. Two of the participants were students that were conducting their final year internship in the field-site. The rest of the sample were qualified midwives. Their years as a midwife ranged from 3-30 years. Two of the midwives that I interviewed had worked at different hospitals in Ireland and had been in the field-site for at least the past five years.

Doctors (junior doctors, registrars and consultants) were approached and asked to participate in an interview for this ethnography but all declined. This may have implications for the findings of this study as doctors were not represented in the sample. However, during my time in the field-site I was able to observe doctors and consultants in their interactions with OptiBIRTH participants as well as with each other. Furthermore, I was allowed to have unrecorded conversations with doctors and consultants regarding OptiBIRTH and took field-notes after these conversations. This meant that I was able to record some data from doctors and consultants which did inform my findings. The use of observation over a significant period of time gave me the opportunity to observe the consultants and doctors and explore their interactions and determine if they did change over time during the intervention.

Fathers and partners of the participants of the intervention were not included in this ethnography as many of the partners did not attend the antenatal clinic during the recruitment phase or the OptiBIRTH antenatal classes. As well as this, the intervention was aimed at women rather than women and their partners, although partners were invited to attend the antenatal classes. To ensure that I had not missed any evidence of fathers or partners influencing the woman's decision making on mode of birth, I did ask women during our interviews how their partners felt about their decision and if they had an influence on their decision regarding mode of birth. For the majority of women their partner did not influence their decision around the mode of birth and were supportive of the decision to try for a VBAC, providing it was safe.

#### **4.6 Data Collection Methods**

In my study, I used two methods for collecting data (see Table 5 for summary details). These were participant observation and the use of semi-structured interviewing with a small cohort of women ( $n = 15$ ) from the full cohort that were participating in the intervention and 12 clinicians from various parts of the field-site. I also conducted interviews with the OLs at different time-points of the intervention. Over the course of the fieldwork period, I attended the field-site four days a week continuously for 11 months, gradually decreasing to between 2-3 days for the remaining five months. This fieldwork period generated approximately 655 minutes of interview data and 16 months of field-notes, including my reflexive diary. The OptiBIRTH trial pilot study commenced on 9<sup>th</sup> February 2014 and the main study commenced on April 1<sup>st</sup> 2014.



The data collection phase for this ethnography commenced with observation on the 9<sup>th</sup> February 2014 with the pilot study and continued for 16 months (to June 2015).

#### ***4.6.1 Observation***

Participant observation was the main method of data collection in this ethnography, as I spent the majority of my time in the field observing in a variety of settings (antenatal clinics, antenatal classes, clinician information sessions, consultant rooms, canteen) and it provided a large amount of data. Extensive observation as the researcher and ‘stranger’ to the field-site is paramount in order to note any interesting patterns that may have been a unique feature to the field-site, and also help to discern any patterns of interaction that may arise, and their significance, as well as ascertain whether there was a recurrence of certain phenomena or whether it was a once-off anomaly. Lengthy observation allows for valuable data to be gathered on the field-site and document any significant events or cultural changes that may have occurred during the data collection phase of this study. Observation involves engagement in the daily lives of individuals in their natural setting; “watching, observing and talking to them in order to discover their interpretations, social meanings and activities” (Brewer, 2000, p.59). It allows for rich, detailed description and provides opportunities for either participating in or viewing unscheduled events, which can help to describe and interpret people’s “behaviours, intentions, situations and events as understood by one’s informants” (DeMunck & Sobo, 1998, p.43). Participant observation can also allow for the researcher to experience native activities directly, to get the feel for the events that are occurring and to record his/her experiences and perceptions (DeWalt & DeWalt, 2002; Spradley, 1980).

Observation data collected throughout the study helped to inform questions and topics to explore further over the course of the ethnography. For example, through the process of cross-checking between observations and interviews, questions were added to interview guides for use in later interviews, and observation also became more focused on certain areas that were arising. For example, observing and listening to the language used by consultants when they were discussing the OptiBIRTH intervention helped me to realise that many of the clinicians were not familiar with or knowledgeable of the various components of the intervention that were available to the women, and, as a result of this, perhaps, they did not discuss OptiBIRTH with the women, rather simply informed them that VBAC was an option.

The observation was conducted using specific guiding principles for how observations should be, and were subsequently, performed. These were:

- the definition of what was to be documented in the observation and in every case;
- descriptive observations that provided an initial, general presentation of the field;
- focused observations that concentrated on aspects that were relevant to the research question;
- selective observations that were intended to purposively grasp central aspects;
- the end of the observation, when theoretical saturation had been reached, which meant that further observations would not provide any further knowledge (Flick, 2009).

General observations were conducted in the clinical environment in two main settings; i) the antenatal clinic and ii) a room where the OptiBIRTH antenatal classes and clinician information sessions, as part of the OptiBIRTH intervention, were held (sections 5.2 and 6.2 provide full descriptions of these areas). General observation involved observing the interactions that occurred between women that were participating in the trial, health care providers caring for these women, midwives in the antenatal clinic who provided eligible women with the study information and the OLs, as a component of the study intervention. Observation began when a midwife found the OptiBIRTH screening form in the woman's chart if it was her first booking visit, or if the midwife found 'OptiBIRTH' written on her chart. The screening form or note was placed in women's charts who were booking into the clinic by midwives each morning before the clinic began. The midwife would then tell me when a woman was eligible for OptiBIRTH and I would observe from my position, how the midwife and woman interacted. This included observing the language used by midwives to describe the intervention, the woman's response to this information and whether the woman had any questions for the midwife about the intervention, including the nature of these questions and the midwife's response. Although the midwives, for the majority of the observation period answered women's questions, at the time if a woman wanted further detailed information on the intervention, the midwife would direct her over to me. I would discuss the trial further and answer her questions as best as I could, either in the main clinic area or obtain the use of the CMM's office. On many occasions throughout the recruitment phase, the MOL was present in the clinic and would manage the recruitment of women to the study, which I also observed. I recorded observations through field-

notes, including noting what clinic staff said and did between themselves and between them and myself, and the non-verbal interactions that occurred with each other. Prior to commencing the study, staff in the clinical setting were fully informed (written and verbal information) of my embedded ethnography and that this required general observations of them in their work environment; that said, all staff had the option of excluding themselves from direct observations. None of the staff voiced any objection to the observation and all were agreeable in taking part. Furthermore, all staff, from the outset of the study, were informed that I am not a healthcare professional and that I was only present and observing in the capacity of researcher and doctoral student. I wore university identification and introduced myself as a researcher who was exploring views, experiences and thoughts on, in addition to any cultural change surrounding, the OptiBIRTH package of care. I was in the field for approximately four alternating days per week, and present in the antenatal clinics for 3 to 3 ½ hours per day for the observation period. Any greater length of time would have been detrimental and challenging to my memory and recording process ability (Patton, 2002).

The site MOL or OOL, or other midwife/obstetric staff member who were aware that a woman who was attending the clinic was participating in OptiBIRTH, acted as gatekeepers and introduced me to these women. Women were aware, having been previously informed in the OptiBIRTH trial 'Study Information Leaflet' (Appendix 9), that observations were taking place as part of the OptiBIRTH study. Women who wished to take part in OptiBIRTH, but did not want to be observed could opt-out of these observations by informing either the staff midwives, the MOL or myself. Where this occurred, observational data were not collected on these women. Observation data

were recorded through field-notes, which consist of “fairly concrete descriptions of social processes and their contexts and which set out to capture their various properties and features”(Walsh, 2012, p.255).

Clinicians and OLs were also generally observed as part of the ethnography. These observations were conducted in the antenatal clinic, the antenatal classes and during the clinician educational information sessions, which are facilitated by the OLs, as part of the OptiBIRTH trial. Observing these components was deemed important as they were designed to inform clinicians on the risks and benefits associated with VBAC and on the intervention. As such they had the potential to influence a change in clinicians’ thoughts on VBAC in general. In addition, attending these sessions facilitated observing how the OLs interacted with their colleagues. These interactions and the portrayed views of the OLs had the potential to impact on how clinicians view this information and, subsequently, how they relate this information to women participating in the trial; an important aspect of exploring cultural change.

Participant and non-participant observation was used interchangeably in the field-site depending on the situation. For the majority of my time in the antenatal clinic, non-participant observation was the method employed unless I was specifically asked to help in the clinic. This was the same for the antenatal classes and the clinician information sessions.

Following observation in antenatal clinic, antenatal classes, and clinician information sessions for a significant period of time and in conjunction with interviews, my

observation then changed to a more focused observation of interactions that were relevant to my research question. This meant observing how OptiBIRTH was portrayed to participants in the field-site, how OptiBIRTH was discussed between participants and observing as to whether the conversation around VBAC changed through language and interaction between women and clinicians.

#### **4.6.2 *Field-notes***

Field-notes are commonly associated with ethnography and are the description of what has been observed. They are the focus of the observation (Silverman, 2006; Bernard, 2006; Patton, 2002). Field-notes should contain recordings of where the observation took place, who was involved, what was happening, the sequence of occurring events and what feelings were evoked (Spradley, 1980). Short field-notes, or jottings, were handwritten in a small notebook during the observation period, where appropriate, and were subsequently expanded on and typed in a password protected word processing file. These notes contain descriptive information of what I saw, where I was, my feelings and reactions to occurring events, direct quotations of what was said during verbal interactions, my own interpretations of events and occurrences. From these notes, the process of analysis, by identifying emerging themes from these observations in the field setting, was commenced (Patton, 2002). Personal interpretations of, and feelings experienced, during observation were documented in a personal journal, as recommended by Bernard (2006), so that all of the emotional highs and lows that I encountered during the field-work period were documented. This documentation could later assist with my interpretation of my field-notes as it may highlight personal biases

that may have occurred during a particular observation period. An example of these kind of field-notes is presented below, where I was recording my frustration of finding my place in the intervention early in the study period, and using observation as a research method;

“It has been a rough week! It has been slow, boring, and frustrating! At the minute I am not seeing any benefit to being in the clinic since I have nothing to observe and nothing to do whatsoever when it comes to the intervention. I only hope that this funk that I am in will fade and that things in the clinic will pick up for the study because I don’t know if I can do this on a full time basis. It has been a bad week but I am sure that all ethnographers go through this at the start of any type of observation. This is the settling in period and I can only keep a positive head and hope that it doesn’t last too much longer!” (Field-note, May 2014)

By my recording how I am feeling during a particular observation period, like above, it allowed me to take this into account and will helped meto be more objective during the analysis phase of the study.

#### **4.6.3 Interviews**

Interviews are integral to ethnography. As Fetterman (2010, p.40) states “interviews explain and put into a larger context what the ethnographer sees and experiences”. The main aim of conducting interviews was to gain the perspectives and in-depth accounts of participants’ experiences and opinions on the OptiBIRTH package of care.

Interviews were performed with women participating in the trial, clinicians who were caring for these women and the OOL and MOL employed to advocate for VBAC and to implement and deliver the OptiBIRTH intervention. The interviews were semi-

structured in nature, which ensured that throughout the ethnography the areas that I believed were important were being captured while simultaneously allowing participants to forward their own ideas and thoughts (see Appendix 14 and Appendix 15 for interview guides for women and clinicians). An example of this would be the relationship between doctors and midwives and the unfolding power struggle over the aims of the OptiBIRTH intervention (see section 8.4.1). Bryman (2008) claims that semi-structured interviewing allows the participants freedom to reply in their own way and also allows questions that may or may not be on the interview schedule to be asked if needed to probe an issue further. The advantage of using this type of interviewing was that the participants can select what they perceive as personally important. For example, during the interview process, the subject of clinicians not discussing birth options with the women was a frequent theme that arose. Subsequently this area was then investigated through interviews with clinicians to ascertain their viewpoint on the subject of discussing birth options with OptiBIRTH participants (see Appendix 16 for modified interview guide). Semi-structured interviews also allowed for a great deal of flexibility (Kvale, 1996). This was important as the ethnography progressed with the intervention, whereby different social processes and phenomena might have emerged as the trial progressed. In this sense, it was important that the interviews were semi-structured to facilitate gathering of these changes in views and understandings over time. These interviews were also held at different time points during the intervention, for example, after the first and second OptiBIRTH antenatal classes, before giving birth and soon after finishing the intervention. This meant that if any changes occurred during the intervention, these could be captured at each time point for each participant. Interviews were held at the convenience of the participants and lasted, on average,



between 20-25 minutes. Written informed consent was obtained before each interview and a duplicate copy of the consent form was given to the participants for their records (Appendix 10). All of the participants who were interviewed for this ethnography were given the opportunity to read their interview transcripts, which were transcribed verbatim. This aided in making sure that the representations of their views and experiences are true representations, and, limited the risk of researcher bias and subjectivity. I also made notes after the interview had ended, to record non-verbal response and body language (Brewer, 2000). All interviews were recorded and participants were informed of this on the consent form provided.

**Table 5: Data Collection Methods**

<b>Sample</b>	<b>Women</b>	<b>Clinicians (staff participating in OptiBIRTH)</b>	<b>Clinicians (OLs as part of OptiBIRTH)</b>
<b>Observation</b>	<p>Antenatal Clinic</p> <p>OptiBIRTH antenatal classes</p> <p>General observation</p> <p>Interactions between women and health care providers</p>	<p>Antenatal Clinic and labour ward</p> <p>OptiBIRTH Clinician Information Session</p> <p>General Observation</p> <p>Interaction between staff and OptiBIRTH women</p>	<p>Antenatal Clinic and labour ward</p> <p>OptiBIRTH Clinician Information Session</p> <p>General Observation</p> <p>Interaction between OLs and staff as well as OptiBIRTH women</p>
<b>Interviewing</b>	<p>Women participating in OptiBIRTH</p> <p>1-3 interviews depending on uptake and interest</p>	<p>Staff participating in OptiBIRTH</p> <p>Intervention – clinic and labour ward</p> <p>1-3 interviews depending on uptake and interest</p>	<p>MOL and OOL</p> <p>2-3 interviews throughout intervention</p>

## 4.7 Data Analysis

“The important thing to recognise is that, order to produce an ethnographic study that is equally rich in data and concepts, it is not merely enough to manage and manipulate the data. Data are materials to think with”  
(Hammersley & Atkinson, 2007, p.158)

Ethnography involves deep immersion in the research process. This is emphasised even further during the process of analysing collected data whereby the researcher must immerse him/herself in the data to discover, understand, and interpret the gathered information so as to gain a sense of the culture and ensure accurate representation of that culture. Bernard (2013) suggests that, during the process of data analysis in ethnography “you tell a story, as you see it, of how the themes are related to one another and how characteristics of the speakers account for the existence of certain themes and the absence of others” (p.393).

There are various different types of data analysis that can be applied to the ethnographic context, such as discourse analysis, grounded theory and hermeneutics. When choosing the method of data analysis, a number of factors must be considered. These include the theoretical perspective taken, the methodology employed and the research aims and objectives of the study. As the researcher and the person conducting the data analysis, I believed that the use of a thematic analytical approach was best suited to this ethnography. Thematic analysis is deemed appropriate in the ethnographic method as it supports an interpretive view whereby data are organised into categories, sub-categories and patterns (Lindlof & Taylor, 2011) and therefore, the social context of the

participants in a study can be understood in a meaningful way (Lacey & Luff, 2001).

Thematic analysis allowed me to systematically work through the data to represent a view of reality by identifying recurring patterns through the linking of categories that have similar meanings.

I aimed to collect and analyse the data concurrently, as Hammersley & Atkinson, (2007) have stated that, through familiarisation with the data, emergent issues will guide later data collection. The process of analysis is not a distinct stage in ethnography, but rather a part of the data collection stage. This process was difficult to maintain, as Kleinman & Coop (1993) note that due to the time constraints of data collection, much of the in-depth data analysis is delayed until data collection has been completed. To compensate for this, I maintained on-going analytic memos and a journal that recorded emerging insights and themes of particular interest through re-reading and familiarising myself with the data already collected.

This process of coding and sorting data developed into three major periods of analysis. From the beginning, the period of becoming extremely familiar with the raw data that have been collected was undertaken. This included first impressions that were noted, categories that were identified as well as key concepts emerging (Patton, 2002). Themes and categories were then identified in the interviews and field-notes that helped to generate codebooks (See Appendix 17). This stage of data analysis allowed me to interact with the data that I had collected and dissect it from a more analytical perspective.

This study's raw data took the form of interview transcripts and field-notes (see Appendix 18 and 19 for interview transcripts). The interviews allowed me to hear from the participants and gain their understanding and interpretation of their participation in the intervention. The field-notes that I had accumulated then allowed me to give context to the interviews that had been conducted and to understand the setting and its relationship with the intervention. All field-notes were kept in a chronological order, with separate folders detailing the month and day and times in which they were taken. In this way, I had a clear idea of what was occurring throughout my time in the field so that I could keep a detailed record of the field-notes. Individual components pertaining to the intervention, such as the antenatal classes and clinician information sessions, were also kept separately.

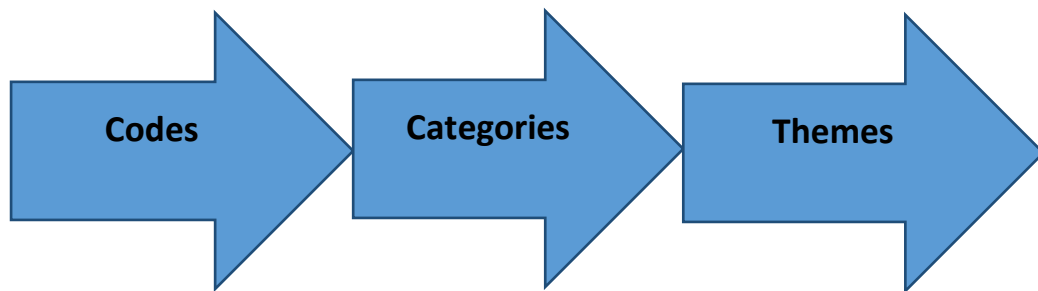
Coding data is a form of qualitative analysis, which Patton (1990, p.381) suggests as the "process of identifying, coding, and categorizing the primary patterns of data". The procedure for coding involved reading through the transcripts and field-notes generated over a period of 16 months. As I encountered data that illustrated a particular code, specific words or sentences would be highlighted and assigned a code. This process was very basic in looking for indicators of categories in both events and behaviours; for example, 'power plays' or 'socialisation' in certain situations. These are general codes to mark that an event has occurred that is of interest. I moved through the interviews and field-notes, assigning all codes that applied to the data. Material quotes corresponding to all issues that had been raised in the literature were extracted using the participant's words. In addition, new ideas and issues that had arisen directly from the participants' narratives were explored and analysed. I then reviewed all codes to assess the

commonality and differences between the interviews and notes. This open coding process then moved to the more analytic stage of selective coding. Selective coding is more focused and categorises the data more precisely (See Appendix 20 for example). “Selective coding provides a more abstract and comprehensive conceptual handle in the data than open coding. These focused codes not only serve to synthesise large amounts of data, but also to organise earlier codes into a coherent framework” (Charmaz & Mitchell, 2001, p.167). This coding involved exploring the consistencies between open codes that were generated in the first analytic stage, and refining them down to specific events and developing sub-categories. This process helped to generate understanding of the nature of the issues raised by the study participants. The codebooks allowed for critical data to be extracted and analysed, thus allowing for meaningful findings (See Appendix 17).

Once the data had been analysed literally and coded, interpretive analysis to understand the data and what was common across all data was reconstructed into categories and subcategories to create patterns, emerging themes. This was achieved through memo-making. Memo-making brought the ideas emerging from the data analysis together and where I recorded any ideas I had about the data. It helped me to make explicit comparisons between the categories that I coded which then aided me in discerning any patterns. These became central textual codes that facilitated links for the development of broader concepts and theoretical frameworks. These patterns in the data were able to describe any actions that played out in a social situation and how these actions affected the actors that were involved. This analysis of the patterns then developed into themes

that can be described by the categories that have been created from the analysis of the data.

I have provided a diagram to illustrate the process of data analysis for this ethnography:



**Figure 2: The process of data analysis and the relationship between each stage**

Through this process, a clearer framework of the data began to emerge and refining of the categories gave way to an interpretive analysis and the themes in this ethnography. This was achieved through an integration of the sub-categories with similarities into one main category that provide an explanation for the phenomena that were observed. An example of this can be seen in Chapter Six with the theme of Identity. Through the sub-categories generated from the data (the de-brief, language, and success stories) I was able to link the sub-categories as a pattern and interpret them under the main category of Identity. To further illustrate this process, I have provided a sample table of the codes and categories and how they refined to the themes of this ethnography:

**Table 6: Example of how the analysis progressed through codes, categories, to themes.**

<b>Code</b>	<b>Categories</b>	<b>Theme</b>
<b>Talking about previous birth</b>	<ol style="list-style-type: none"> <li>1. Language</li> <li>2. Success Stories</li> </ol>	Changing Identity
<b>Encouraging VBAC</b>		
<b>Interaction between women</b>		
<b>OOL anecdotes</b>		
<b>Language used</b>		
<b>Other doctors' practice</b>		
<b>OOL Influence</b>	<ol style="list-style-type: none"> <li>1. Power Position</li> <li>2. Levels of Risk</li> </ol>	Power Plays in the field
<b>Differing Opinions' of doctors</b>		
<b>Uterine Rupture</b>		
<b>Risk of VBAC/CS</b>		

The outcome of the analysis process described above is presented in the findings chapters of this thesis. The analysis process was integral to the findings of the thesis and I have presented them in this way as the data analysis and development of the findings occurred as a concurrent process. I believe that the presentation of the findings in this way shows the shape of the ethnography and the data collection process. By presenting my findings as part of the data analysis process it will give the reader a clearer image of the ethnography and how the data shaped the story of the intervention. The process of data analysis is an interpretive process and, using pattern recognition from field-notes and interviews as well as my reflexive diaries, I reconstruct the data to a more abstract



level of thought that provides a discursive order of the categories that were identified during the coding phase.

As well as this, ethnography is an interpretive process by the researcher of the data that have been collected. Due to my experience of data collection and the data analysis process, I felt that by presenting the findings in this way, this would be representational of the process that I experienced as the researcher and would have provided a rationale for the relationship between the data and the concepts developed. Ethnography is the telling of a story and the experiences within that story and I feel that the presentation of findings of cultural change when implementing the intervention in the field-site gives the reader a sense of this story and the sense of change that occurred in the field-site.

This ethnography can be seen as a consideration of the themes of ritualization, identity, authoritative knowledge, and power that affected the cultural dimensions of the field-site when it came to mode of birth after CS and its relationship with the OptiBIRTH intervention. These themes will be presented in the subsequent findings chapters and as part of the intervention with which they are associated.

#### **4.8 Ethical Considerations**

Ethical considerations are paramount to a study that involves humans and their behaviours, to both protect them and the researcher. Pregnant women, from an ethical context, are deemed a vulnerable population (Ruof, 2004), due to the fear of potential

harm to the foetus (from drugs, or effects of different types of care) on the part of both the researcher and the participant. The regulatory framework that surrounds the conduct of research involving pregnant women is based on sound ethical and legal reasoning that demonstrates when inclusion is appropriate and, more importantly, when clear and compelling reasons for exclusion are presented (Allesee & Gallagher, 2011). It is for these reasons that ethical considerations are vital to the success of the current study. “Ignoring the need for responsible research with pregnant women has brought profound costs, to women and foetuses” (Little *et al*, 2009, p.60).

A number of regulatory bodies have developed and implemented protocols around ethical conduct in research. The WHO, for example, in conjunction with the Council for International Organizations of Medical Sciences (CIOMS) has published Bioethical Guidelines that enforce the protection of pregnant women when they are participating in research. At the centre of this protection is informed consent and the acceptability of risk. This means that in research involving pregnant women, the informed consent process may (depending on each woman’s wishes) involve consultation with other parties, including partners and husbands, so an adequate time frame for consideration should be developed. This is to ensure that the woman fully understands the research and can make a rational decision about participation. This includes noting any potential risks to the foetus and accepting these risks on its behalf. Notably, these guidelines state that “all pregnant women should be presumed eligible for research” (CIOMS, 2002, p.49) (See Appendix 21).

At the European level, the Council of Europe created the Convention on Human Rights and Biomedicine (1997), which added to the dimensions of the Declaration of Helsinki and aimed to give human beings the best protection possible in terms of participating in research. Specifically, in relation to pregnant women, in 2005, the Council of Europe detailed additional protocols on research involving women during pregnancy so that they are protected and properly informed of what they are consenting to (Council of Europe, 2005). This clearly stated that any research involving pregnant women should only be conducted if there is minimal risk and burden to both the mother and foetus. Furthermore, the acceptable level of risk can only be decided by the woman and she has the final decision as to whether or not she will consent to take part in the research. Overall, the aim of the Council of Europe is to ensure that research involving human subjects is conducted to the highest ethical standards and that the participants of research are fully protected both legally and ethically.

At a national level, protocols for biomedical research were overseen by the Irish Council for Bioethics until December 2010. However, this organisation has since ceased its work due to government funding cuts which means that Ireland does not have an institutional body to regulate bioethics. This leaves a significant gap for ethics and research in Ireland, including the review and regulation of RECs throughout the country. Due to this, it is necessary to follow EU regulations on research involving pregnant women as they are the most comprehensive and up-to-date in terms of ethics and the protection of participants.

Several ethical considerations arose during the design and conduct of this study. These were informed consent, the protection of participants, and confidentiality and anonymity. Throughout all stages of this study I was cognisant of these issues and ensured they were consistently implemented through best research practice and good research design.

#### ***4.8.1 The Issue of Informed Consent***

One of the challenges in all research is ensuring that participants fully understand the research study, including any associated or potential benefits and harms, prior to entering the study (Horng & O'Grady, 2003). This can inextricably influence the concept of informed consent whereby individuals who are not informed in an adequate way, may consent to a study and potentially subject themselves to identifiable, or unidentifiable, risks that they may not fully understand.

For the embedded ethnography in the overall OptiBIRTH project, women, clinicians and the OLs consented to participate. Consent for general observation was obtained when a woman agreed to take part in OptiBIRTH (Appendix 5). For any woman or clinician who explicitly voiced that they did not wish to be observed, data on these individuals was not collected and reassurances of this were provided. However, throughout the ethnography neither clinicians nor the women participating in OptiBIRTH opted out of the observation component and process. No data was recorded on incidental observations of women in the antenatal clinic setting who were not participating in the OptiBIRTH study, as they were not part of my study objective.

#### ***4.8.2 Anonymity and Confidentiality of Participant Data***

All handwritten field-notes were stored together and on my person when I was in the field. This was done to ensure that field-notes would not be misplaced or any confidential information seen by participants. Field-notes were written onto a password protected computer and stored on an encrypted hard drive, to which only I have the password. Any identifying features that could be linked back to the participants in the ethnography, which included features that were connected to the clinic setting and the ward, were anonymised using a coding system. This was also done during the transcription process of interviews, whereby all identifying features were omitted for confidentiality purposes. All of the hard copies of interviews and field-notes, as well as the hard drive were stored in a locked filing cabinet in the School of Nursing and Midwifery in TCD. Data will be stored in this facility for 5 years from the date of interview as per accepted best practice and will be destroyed under the supervision of my supervisors in 2019.

#### ***4.8.3 Safety of Participants***

Before the commencement of the interviews, a safety strategy was developed with the permission and guidance of my supervisors, so that it might be implemented if necessary to do so. This strategy included stopping an interview if a participant became upset or distressed, which could range from upset over previous birth experience, to fear for the current pregnancy and labour, or general anxiety. As I am not a healthcare professional, the safety of participants and making sure that they were supported by

qualified clinicians was of the utmost importance. Following discussions with both my supervisors and midwives at the field-site it was decided that, if the need arose during the interview process, or at any point during the ethnography, I would inform the MOL of the participant's distress, as they have already had contact with them, and she would give them support as a health care professional or direct them to services that they could access. If it was the case that I could not get in contact with the MOL before an interview took place, I would inform either the CMM or a midwife in the clinic that I was conducting an interview with an OptiBIRTH participant and confirm that I could refer the woman to the clinic for support or information should she become distressed during the interview process; to which, on each occasion, they agreed.

If participants had other issues, for example issues with her partner or domestic issues, with their permission, a list of resources could be texted or posted to them, including a list of support services that were provided at the field-site.

Women who were participating in the ethnography were adequately informed that there were no risks to the foetus and that the research strictly focused on issues regarding the process of their decision-making on mode of birth after a previous CS and their experiences of the OptiBIRTH package of care. Minimal risk was paramount. Strong (2011, p.535) defines minimal risk in pregnant women as “risk that is not greater than the risks healthy adults have in common in daily life or encounter in common during the performance of routine physical or psychological examinations or tests”. I adhered to Guideline 17 of the 2002 CIOMS International Ethical Guidelines to BioMedical Research Involving Human Subjects, which was produced by the WHO. This guideline

is specifically tailored to research with pregnant women and was the most succinct regulation that could be found (See Appendix 21).

To ensure my safety during the study, I adhered to Lone Researcher Guidelines that were provided by TCD (Appendix 22). Doing this ensured that, in addition to participants' safety, I had a safety strategy for myself as the researcher. This included wearing university identification at all times, informing staff at the field-site that I was conducting an interview and the location in the field-site where it was taking place, and informing my supervisors of any interviews that I conducted outside of the field-site.

#### **4.9 The Researcher Influence**

Due to the nature of the ethnographic method and the researcher being the main instrument in data collection, there has been some debate on the influence of the researcher when they are observing their participants in particular situations. Many critics believe that the presence of a researcher will influence the behaviour of those being studied and not allow the ethnographer to document or represent social phenomena in an objective or accurate way (Spano, 2005; LeCompte & Goetz, 1982). Contrastingly, many ethnographers believe this to be beneficial to the method, as the participants, in altering their behaviour, often reveal profound truths about the phenomena being studied and it is these performances that are important; they reveal how the individuals perceive themselves and how they want to be perceived by “outsiders”. As Monahan & Fisher, (2010) highlight “..... observations are data to be interpreted, not the “results” themselves of the study, and as such, data need to be

analyzed by the ethnographer in light of the context in which they were generated” (p. 362). Staged performances are valuable data in themselves and should be treated as such. Therefore, it was necessary for me to maintain close proximity and interactions with my study participants, rather than distance and separation, to facilitate the transformation of observer and researcher effects from bias to meaningful data. Taking this stance helped me view interactions between women and clinicians positively. It also helped me to explore phenomena further during the interviews where I considered an observation to be of significant value to the data. The researcher effect on the study could potentially allow for data to become valuable in a way that it could not have been if the researcher was not present.

#### **4.10 Rigour and Trustworthiness**

Rigour and trustworthiness in qualitative research are often called into account. Many question how the concepts of validity and reliability can be addressed to ensure that the findings in qualitative research are just and true. However, several researchers have made attempts to address these concerns in their qualitative studies, most notably Guba (1981), who suggests four main criteria that should always be considered in a qualitative research study to achieve trustworthiness; credibility, transferability, dependability and conformability which together can address the evaluation of trustworthiness, or research rigour in a qualitative research study (Shenton, 2004).



#### *4.10.1 Credibility*

Research rigour in qualitative research is closely associated with the notion of credibility, which relates to internal validity. This seeks to ensure that the study measures what it set out to measure. To apply this credibility in a qualitative study, the researcher must ask themselves how confident they are with the truth of their findings based on the context, their informants and the research design employed. A qualitative study can be seen as being credible when it can present accurate descriptions and interpretations of human experience that people can recognise (Krefting, 1991). The credibility of this ethnography was addressed by my consistently referring back to the research aims of the study throughout the research process. I maintained credibility throughout by making sure that the research aims have stayed true to the purpose of the study, and by having open communication with my supervisors and my university peers. Lincoln & Guba (1985) suggest methods to ensure the credibility of a qualitative research study. These include prolonged engagement in the field and with informants, through intense participation and familiarity and member checking which involves constantly testing with the informants the researcher's interpretations and conclusions to ensure accurate representation. To ensure that credibility of the ethnography was not an issue, these methods for credibility were also implemented in this ethnography. To begin with, I spent 16 months in the fieldwork site, attending different clinics at different times during the week as well as clinician information sessions and antenatal classes for the women as part of OptiBIRTH. Furthermore, I had monthly meetings with my supervisors as well as regular open email communication as I was based in a location some distance from the TCD. I also attended monthly peer support sessions in

TCD with other students that were conducting research, which provided further support and advice on issues that I was unsure of. In terms of the member-checking to ensure credibility, the participants in the ethnography were given the option to review their interview transcripts for clarity and accuracy.

#### ***4.10.2 Transferability***

Transferability relates to the concept of external validity and how generalizable the findings of the study are and whether they can be applied to other situations and larger populations. The challenge here is that qualitative research is designed to be particular to specific environments and populations and therefore it is impossible to “demonstrate that the findings and conclusions are applicable to other situations and populations” (Shenton, 2004, p.69). Guba (1981) suggests that the collection and development of thick description, as explored and described by Geertz (1973) will allow for comparison of the context of the study to other possible contexts which will permit the researcher to make the rational judgement as to whether transfer of context is possible. This process of transferability is the responsibility of the researcher and will be discussed in the final chapter where the relevance of the findings of this ethnography for other settings and future studies will be discussed.

#### ***4.10.3 Dependability***

Dependability in qualitative research is akin to reliability in quantitative research and is concerned with the consistency of findings. This can prove problematic in qualitative research, in particular ethnography, as it is the nature of phenomena that is under

investigation to change, even during the research process. To address this concern in this study, and to ensure trustworthiness in the findings, each part of the research process was reported in detail, including the limitations and the decision-making processes that occurred throughout the study. The concept of dependability can also be enhanced through the method of triangulation to “ensure that the weaknesses of one method of data collection are compensated by the use of alternative data-gathering methods” (Krefting, 1991, p.221). Due to the complexity of the intervention and the ethnography looking at the relationships between clinicians and women, a method of interviews, participant and non-participant observation and field-notes was implemented, to ensure that a complete picture was recorded. These different sources of data can maximise the range of the data that is collected that will help to understand the concept as a whole. As Reeves *et al* (2008) conclude, the use of a triangulation method can become very useful, as what people say can contrast with the behaviours that they exhibit.

#### ***4.10.4 Confirmability***

The final construct in ensuring trustworthiness in qualitative research is confirmability (Guba, 1981). Confirmability is associated with the objectivity of the research. This means that there are certain steps that should be taken in order to ensure that the neutrality of the data is considered carefully and fully. This is done through careful documentation for all claims and interpretations from their sources to confirm that the data are supportive of the researcher’s analysis of findings. Another way of ensuring confirmability is using reflexive analysis so that the researcher is aware of their

influence on the data (Krefting, 1991). To encourage trustworthiness in the study, I maintained a reflexive journal which enabled me to record all of my insights and the ways in which I could have potentially influenced the research process. It provided an outlet for my thoughts and captured many ideas and insights that proved invaluable when it came to the in-depth analysis of the data. This is recommended by Liamputtong & Ezzy (2005) and, by storing my thoughts in this way, it helped with the final writing process.

## **4.11 Conclusion**

This chapter details the methods used in conducting the ethnography. Data collection and analysis for this study took place over a period of 16 months, working on a full-time basis.

The process of sampling and data collection methods were discussed extensively throughout this chapter. Ethical considerations were also addressed. The process of how datum were analysed has been explained in detail and how the rigour of the research was assured has been explored. The following section of this thesis will present the study's findings. This will be presented to you as the journey of the OptiBIRTH intervention through the field-site, from the recruitment phase to the antenatal classes and clinician information sessions and finally, the experiences of participants after they have completed the intervention. The following chapter will now begin this journey, with OptiBIRTH and its recruitment phase in the antenatal clinic.

# **Chapter Five: ‘First Contact’: OptiBIRTH and the Antenatal Clinic**

## **5.1 Introduction**

This chapter introduces OptiBIRTH’s journey through the field-site and the study’s findings which emerged from my experiences in the field, and the collective analysis of observations, fieldnotes, reflexive diaries, and interviews that were accumulated over a period of 16 months. I have arranged the findings in this, and the subsequent chapters, in following the trajectory of the OptiBIRTH intervention from the first meeting of eligible women in the antenatal clinic, to the antenatal classes and clinician information sessions that were part of the intervention. In presenting the findings in this way I hope to give a sense of the journey that this intervention had to take in the hospital.

Additionally, I hope to give a sense of the journey that I myself had to take as the ethnographer, from the first months following inception of the intervention, as it became established in the hospital, to the final group of women availing of the intervention and the changes that may have occurred in between. As this ethnography is exploring cultural change it seemed appropriate to present the findings of my study in this way.

Firstly, I will describe for you the research setting, in this case the antenatal clinic, in which much of the data collection took place. Following this I explore the effect of the intervention on the culture in the clinic setting. I will then move on to explore how

OptiBIRTH became incorporated in the clinic routine with the creation and implementation of a new clinic ritual; screening, recruiting, and giving information about OptiBIRTH to eligible women.

Throughout this chapter and in the remainder of this thesis I will also discuss my experiences in the field site during the implementation of the intervention that corresponded with the stages of the intervention.

As an ethnographer, I felt it was important to examine my influence in the clinic. I also present to you the difficulties I faced in trying to become included in the clinic setting and how I had to construct a representation for myself so that I would be seen as a legitimate entity in the clinic. I feel that this is an important point to address because even though I am part of OptiBIRTH, I am also outside of the trial intervention, and was not present to facilitate the trial. Rather, I was present as an independent researcher with a separate, albeit embedded, study. Therefore, throughout the period of data collection, this was an important point that I had to make in the clinic and this will be explored throughout this chapter.

## **5.2 The Setting**

As described in the previous chapter (see section 4.2), the setting for this ethnography is a large maternity hospital in an urban environment in Ireland. It provides many services to a large area, with the antenatal clinic being the first point of contact for the majority of women entering the service for maternity care.

### *5.2.1 The Waiting Area*

As you enter the antenatal clinic, the reception is situated to the left. This is where women check in for their appointments and where they are also given future appointments. The majority of the clinic floor space is taken up by a waiting area, which has rows of seating for the women and their partners. The seating is predominantly grey and the seats are back-to-back in rows in the middle of the waiting area. Other wooden seating is also available along the walls of the waiting area. During normal clinics, however, there is usually not enough seating for all of the women and partners attending and many have to wait standing up. As well as this there are various boards around the area that hold advertisements for private antenatal classes, breastfeeding techniques, domestic violence helplines and flu and sickness information. The average wait for a woman to be seen by the doctor (this includes having a blood test depending on their gestation, seeing a midwife and then a doctor) is two hours. For a woman attending her first booking visit this extends to three hours, which includes the booking consultation, having blood tests, having an ultrasound examination and then seeing a midwife and doctor. There are no coffee facilities in the waiting area, but there is a water vending machine. Overall, the waiting area is uncomfortable. The rows of grey seating are ragged and hard and it is difficult to sit in the waiting area for two to three hours. There is one large window that is patterned, so the majority of the light in this area is artificial. The window is single-paned and the waiting area can become cold at times.

### **5.2.2 The Main Clinic**

The main antenatal clinic is where the women see firstly the midwife, and then the doctor. There are five consulting rooms in the clinic, as well as a monitoring room where women, who may have reported reduced foetal movements or other such concerns, will have an electronic tracing of their baby's heart rate, an additional booking room and a clinical midwife manager's (CMM) office. The consulting rooms are divided by a long and narrow island in the middle of the clinic. On the right hand side of the island the rooms are taken by the Senior House Officers (SHOs) and the left hand side is taken by the registrars and the consultant on duty. SHOs are the junior members of the team, usually doctors with one or more years' experience in adult hospital care, who are undertaking a six-month period of experience in obstetric care. Registrars are more senior doctors who have undertaken at least a six-month period of obstetric experience and six months in neonatal care. There are normally two SHOs and two registrars on duty at each clinic with one consultant leading a clinic each day.

The island in the middle of the clinic is used primarily by midwives when they are talking to women. It holds a variety of forms for bloods, urine and appointment cards, as well as leaflets about support groups, birth plans and information about vaccinations. The forms are held on the island, stacked together, whereas the diaries, sample bottles and booking packs for first time mothers (they include diet and exercise advice, combined care information and advice on general pregnancy and health) are held in 'cubbies' in the island. The OptiBIRTH information packs are held also on this island. Before a clinic begins, the OptiBIRTH screening forms are put into relevant women's

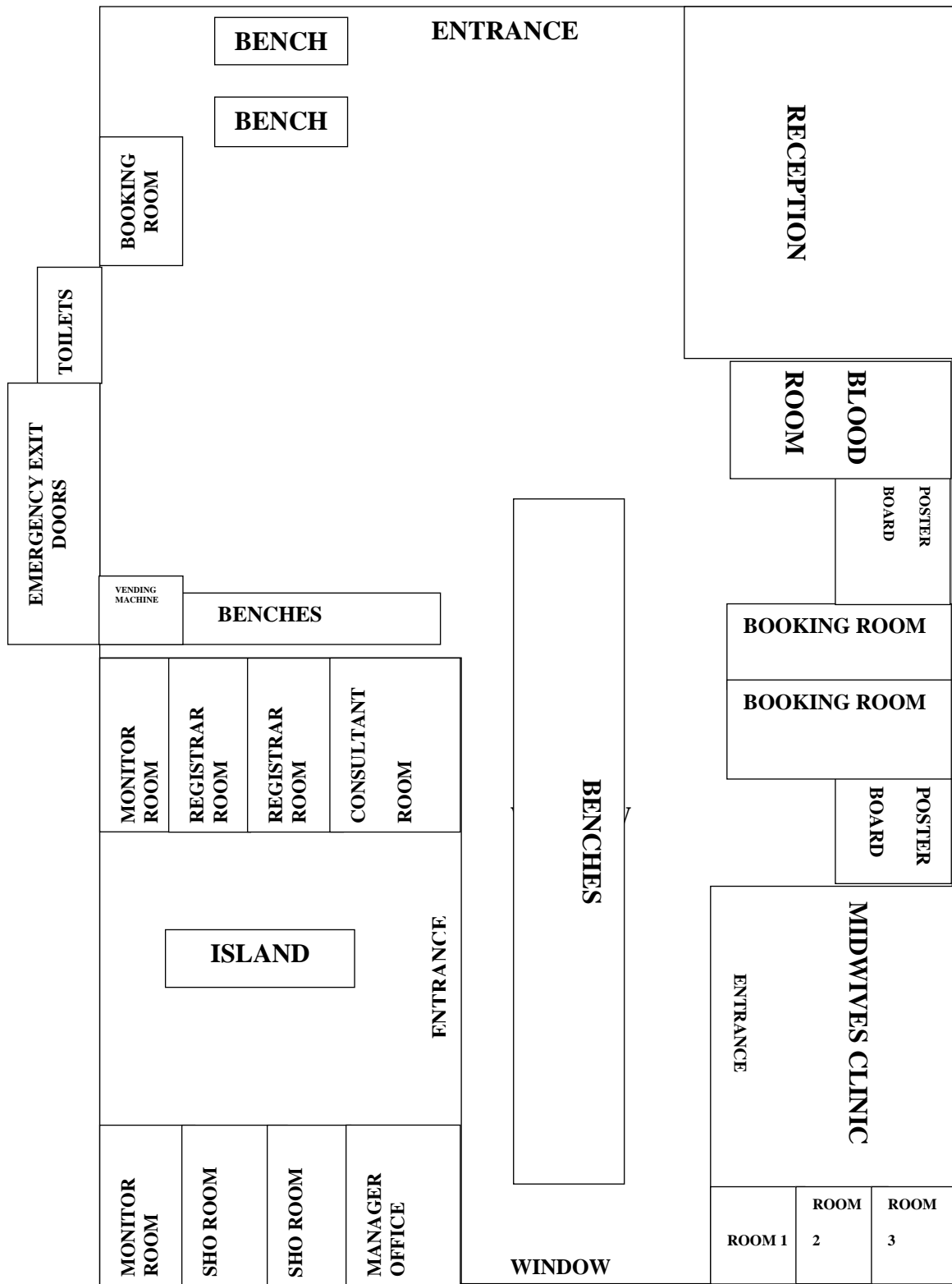


charts before they attend the clinic that morning and are filled out by a midwife who is attending to the woman's first booking visit. At the back of the clinic there are storage cupboards and a sink for washing hands. It is here that a woman's chart is placed after she is seen by the midwife and the chart is then taken by the doctor shortly after. The women are seen by the midwives at this island and normally there are three to four women being seen at the same time. Women are called in by the midwife and taken to a spot on the island. They are seen standing and are asked a variety of questions (foetal movement, vitamin intake, swelling of joints) and their urine is tested at the bottom of the island, closest to the sink. If the clinic is not busy and there are rooms available, midwives will use these rooms to talk to the women as the island is an open space and it is difficult to have a private conversation about any anxieties or worries. If it is a first time visit for a woman, she will be given a booking pack, as described above and the contents of the pack will be talked through. If there is a screening form in her chart, the midwife will fill out the form and then get an OptiBIRTH pack from the cubby in the island. She will then describe the OptiBIRTH intervention and give the information pack to the woman and ask her to wait outside and she will be called by a doctor. The chart is then placed at the lower-end of the clinic, beside the sink, for the doctors. These conversations with the midwives are short and women are normally finished within five minutes of being called, unless there is a problem the woman would like to talk about.

If it is a busy clinic, all five rooms will be used by the doctors. These rooms in the clinic consist of yellow walls, a bed with a disposable white sheet covering, a pillow, a stack of disposable white sheets to change after every woman and blue curtains for privacy. There are no chairs in the rooms, only a locker that charts are placed on, which holds

various medical supplies, such as gloves, tissues and gel for the scanning machine. In the registrar's consultation rooms, there is a scanning machine in each room. All of the rooms that the doctors see the women in are small and dark. They only comfortably fit two people at a maximum but there are normally three to four people, including a partner and a medical student. The registrar's side of the clinic does not have any windows and cubicles are dark and stuffy. There are some posters in the rooms, for example, recommended appointment dates, Body Mass Index (BMI) charts, information on washing hands and gestational diabetes figures. In three of the rooms, there are OptiBIRTH posters. On the SHO's side, it is much brighter but, in contrast, cold, as the rooms have single-paned windows. The feeling of the clinic and waiting area is that of being old and lacking in space. Figure 3 provides a diagram of the antenatal clinic on the following page that I had taken in my field-notes to give a visual sense of the space and logistics of the room.

During my time in the field, some improvements and upgrading of the clinic were made. These included installing a television screen in the reception area, which provided information on clinic visits, labour and protocols for leaving the hospital after birth. As well as this, in March 2014, the island that was described above where the women were being seen by the midwives was removed from the main clinic as it was deemed a "safety hazard". Instead of this island, stations were placed beside each door of the rooms used by the doctors, to give women more privacy. These stations had cupboards underneath the top of the station that held all of the information leaflets and urine bottles that the midwives used on an everyday basis.



**Figure 3: Diagram of the Antenatal Clinic**

### **5.3 Incorporating OptiBIRTH into the clinic – Establishing the Ritual**

This section gives a descriptive account of the experiences that emerged from the data that I collected during the implementation of the OptiBIRTH intervention and which are seen as influential in the antenatal clinic of the field-site. This begins from the early months of the intervention being placed in the antenatal clinic during the recruitment phase as well as clinic staff and attending clinician information sessions that are the main components that effect the antenatal clinic. The clinician information sessions will be discussed in greater depth in Chapter Eight. The implementation of OptiBIRTH in the antenatal clinic can be seen as the implementation of a ritual of information giving to women who were eligible, with the clinic staff, myself and the OLs being present to give legitimacy to the OptiBIRTH intervention.

#### ***5.3.1 Ritual***

Ritual is a part of everyday life in society. A ritual aims to assure you that you have control over your life. In living your life, this produces symbols and these are rituals, for example, having coffee before you make your breakfast or eating vegetables before the rest of your meal. These kind of everyday rituals have a meaning for you and has a function to your social order. A ritual can be seen as “a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is transformation” (Davis-Floyd, 2003, p.8). Rituals can be seen as constructions, in the way that they are experiments of human design that encourages “thinking more directly on the relationship between design and outcome” (Handelman, 2005, p.6).

Ritual has been a prominent subject for study in anthropology since its beginnings as a way of understanding and exploring different cultures. This can be seen specifically in the subject of religion and the rituals that pertain to the construction and implementation of different religious beliefs and practices. For example, Emile Durkheim (1858-1917) and his functionalist theory of religion maintained that rituals were used as a social order that prescribed how people should behave when in the presence of sacred objects, and people then reinforced the social behaviours to solidify their community. The symbolic anthropologist Clifford Geertz (1926-2006) saw religion as a symbolic system that is socially constructed through interaction that provides a social order of how people should live and therefore creates their reality. This belief in religion and its explanation of reality is fortified in people through the use of ritual, and these rituals and beliefs are then transformed so that they can conform to the outside world. From his perspective, religion is a cultural system that is strengthened with the use of ritual. Ritual can be seen as a way of communication, through acts, gestures or symbols of those who perform the particular ritual to those who then receive or observe the ritual. For instance, the ritual of the taking bread and wine in some Christian religions to denote the body and blood of Christ and his symbol of salvation, or blowing candles out on a birthday cake symbolising each year you have lived.

This exploration of ritual can also be applied to many settings and cultures, including healthcare, from an understanding of the ritual of infection control (Whitby *et al*, 2006; Friedman & Rhinehart, 2000) to understanding health care issues from a local point of view (Thomson & Hassenkamp, 2008; Cicourel, 2005; Brooks & Brown, 2002).

Looking more specifically in the midwifery and obstetric domain, Davis-Floyd (2003)

explores the role of ritual and rites of passage in her influential book 'Birth as an American Rite of Passage'. Her work explored the use of ritual in American obstetrics, which she maintains has now been transformed into a technological-minded procedure for women during pregnancy and birth, rather than a physiological event that is seen as a natural process for women. She suggests that "obstetrical procedures are in fact rational ritual responses to our technocratic society's extreme fears of the natural processes on which it still depends for its continued existence" (p.2).

The understanding of rituals in certain settings and organisational cultures can ensure that stakeholders understand the processes and beliefs of people who use and also provide services. The same can be applied to OptiBIRTH in the antenatal clinic. The screening process that is an integral process to the recruitment of women to the trial is a type of ritual as midwives are performing an act of communication to a woman that has had a previous CS. She is screening the women and giving information packs and the woman is receiving this information, therefore receiving the ritual of screening and eligibility for OptiBIRTH. This can be seen below with W8 when she was asked about how she found out about OptiBIRTH:

"They asked me actually, the nurse asked me when I was brought in em, what I would like, just first of all had I thought about it, and I said yeah actually I have and I think I'd like a normal delivery, and then they went into the OptiBIRTH. And asked if I would like to take part and I said 'oh yeah, I've read it [OptiBIRTH poster] outside', and then they gave me the leaflet then to take home and read". (Interview March 2015)

The same interaction can be seen from the clinician point of view when they were asked about how they tell the women about the intervention, as is demonstrated by C2:

“you’d say to them ‘Oh you’ve only had one previous section, this time it could be possible that you’d be after the trial of labour?’ and then you’d say ‘at the moment there is currently a study being held in the hospital as well as outside of Ireland as well, that’s looking at the success rate of Vaginal delivery after caesarean section, and then they’d be like, ‘Oh, yeah?’ and then you’d just say like ‘for your information and it’s totally optional to take part, so it’s completely up to yourself, today we just use screening process and after that you’ll get a pack that you will have to return to the hospital, em, then you’ll have a read up and decide whether you want to take part, and then, it’s just be em, attending two antenatal classes regarding VBAC that are specific to you after having a caesarean section’.” (Interview December 2014)

It is the midwife in the antenatal clinic that is the first point of contact when it comes to being informed about the intervention and therefore, as well as exploring the implementation of a new ritual in the clinic, it is important to look at how the participants in the OptiBIRTH intervention respond to the enactment of the ritual by the midwives in the clinic. To examine this, it was important to ask them their experiences of their first contact with OptiBIRTH, that is the screening process, and the information the midwives provided about the intervention before handing the OptiBIRTH information packs for them to read further. This was important to delve into because it was these individuals that were the outcome of the ritual; the participants of OptiBIRTH.

In discussing ritual in the context of OptiBIRTH, and to avoid confusion in meaning, it is important that I address the difference between ritual and habit so as to ensure clarity in my findings. A habit, while sharing some of the characteristics that are associated with ritual acts, tends to be a more singular behaviour that does not contain a significant meaning to the participant. A ritual however, “is a larger, plural experience that are

acted out by participants who assume particular, dramatic identities” (Rook, 1985, p.252). A ritual is involved in a certain kind of symbolism that is important to the participants whereas habit is a creation of routine behaviour that the participant may not have the full awareness of the behaviour that they are conducting. Therefore, “one’s level of involvement distinguishes habit from ritual” (Tetreault & Kleine, 1990, p.32)

### ***5.3.2 The Construction of Ritual***

The process of constructing ritual as well as the construction of a ritual that has meaning has been explored in the influential work of Catherine Bell (1953-2008) and her book ‘Ritual Theory, Ritual Practice’ (1992). Bell had a particular interest in Chinese religions and ritual studies and her experiences studying the ritual practices in Chinese religion led to her ground-breaking book mentioned above. She was inspired by the work of Victor Turner (1920-1983) and his work on ritual by attempting to change how we see ritual from a function that is part of our social and cultural life to an active process whereby ritual is “a stereotyped sequence of activities involving gestures, words, and objects, performed in a sequestered place, and designed to influence preternatural entities or forces on behalf of the actors’ goals and interests” (Turner, 1977a, p.183). In ‘Ritual Theory, Ritual Practice’, Bell created a framework for understanding both the nature of ritual as well as the functions of a ritual. She believed that ritual is a social process and activity, rather than being an action that can be taken from its context. She suggested that there should be a focus on ritualization and how it can develop significance from other practices and strategies that differentiate a



ritualized practice from its “conventional counterparts” (Bell, 1992, p.90). She believes that

“ritualization is a matter of various culturally specific strategies for setting some activities off from others, for creating and privileging a qualitative distinction between the ‘sacred’ and the ‘profane’, and for ascribing such distinctions to realities through to transcend the powers of human actors” (Bell, 1992, p.74)

This means that, rather than ascribing certain categories or definitions about what it means to be a ritual or to be ritualistic, it is more significant to understand how a ritual is given a meaning through human activities.

This way of thinking can be applied to the situation of OptiBIRTH and its relationship with the antenatal clinic. As explained above, ritual is related to social and cultural context and therefore is influenced by that. OptiBIRTH, the intervention itself with its components of recruitment and information giving to women and clinicians on the benefits and risks of VBAC, has to undergo a rite of passage in the antenatal clinic so that it can the intervention can become a legitimised figure and become part of the clinic. It is my belief that the creation of a ritual that involves OptiBIRTH allows for the intervention, from both the women and clinician perspectives, to become part of the antenatal clinic setting and therefore, make its way into the culture of the clinic. This would mean that, as well as the clinic giving information about pregnancy and related subjects, information about VBAC would be given to eligible women.

## 5.4 Constructing the OptiBIRTH rite of passage

A rite of passage can be seen as

“a series of rituals designed to conduct an individual (or group) from one social state or status to another, thereby effecting transformations both in society’s perceptions of the individual and in the individual’s perceptions of her/himself” (Davis-Floyd, 2003, p.17).

To look in-depth into a rite of passage, we must first look at the three phases that construct it. I will explain these phases in relation to OptiBIRTH in the antenatal clinic.

### 5.4.1 *Separation*

The separation phase of a rite of passage begins with a symbolic behaviour that breaks with the previous practices and rituals. For a pregnant woman, her rite of passage into hospital based maternity care begins at the antenatal clinic. It is in this domain that she gets the information about pregnancy, her first ultrasound confirming the pregnancy and the estimated due date for her baby, and is introduced to the midwives and doctors that she will be meeting over the course of her pregnancy. The same can be said of the OptiBIRTH intervention. The intervention is aiming to alter the behaviour in the field site of mainly ERCS and encourage a change in behaviour, including increased discussions on VBAC as a viable mode of birth after a previous CS.

Women who have had a previous CS attend the clinic and are introduced to the intervention with the ultimate goal of them achieving a VBAC. This is done through the rituals of the midwives screening the women to see if they are eligible for the intervention and, if they are, giving them the information about the intervention and

what it wants the women to achieve in this pregnancy and birth. If the woman is interested in being a part of the intervention, she has now gone through the first step of the rite of passage. She has broken away from the thought of having another CS and is given information about VBAC. The midwives help with this separation by giving the women the OptiBIRTH information and the perception that they can try for a VBAC and have clinical support behind them and their decision on how they would like to birth. As well as this, the staff in the clinic are involved in this separation phase. Due to the need to recruit women to the OptiBIRTH intervention and the attendance at clinician information sessions, they are now breaking away from assuming that the woman will go for a CS. Staff are now engaging with OptiBIRTH and VBAC by screening women for the intervention and if they are eligible, talking them through their option of having a VBAC and the benefits and risks of trying to have a VBAC. Through the screening process and giving information about OptiBIRTH, the staff in the clinic are breaking previous behaviour in terms of VBAC. The staff are actively engaging in a conversation about VBAC and the options women with a previous CS has with their current pregnancy. They are the gatekeepers of information that allow women to explore their options, rather than assume that a repeat CS is only way.

The first phase of the rite of passage of the OptiBIRTH intervention becoming part of the clinic was slow. This was explained by the CMM on my first week in the clinic when she emphasised that midwives in the clinic are always “very busy and they just forget” (Field-note, 6th March 2014). At this interaction, the screening forms for the intervention were placed on the island in the middle of the clinic so that the midwives would see

them and that they would remember to screen women. This initial worry regarding the recruitment of women in the clinic was shared also by C1:

**C1:** the staff in the antenatal clinic are excellent, they're fantastic, they're very, very busy and it's hard for them to remember everything. So it's hard for them to. . . I understand that. I worked there, I know what it's like trying to remember people who've had a previous section, that they are for. . . to encourage them or to screen them even for the OptiBIRTH. So once their screened then it's a matter of. . . hopefully they'll send back their consent forms. (Interview. July 2014)

The OptiBIRTH MOL was a frequent entity in the antenatal clinic and assisted as much as possible in the recruitment process. For many of the women that I talked to, it was the MOL that talked to them about OptiBIRTH and what the intervention entailed. Yet, whenever she was not there, I became the point of contact for many of the midwives in the clinic, whether a woman coming into the clinic would be suitable for the intervention, or even questions on the intervention itself. An example of this comes from my fieldnotes:

However, one of the problems that I am having in the clinic is that the midwives are relying on me quite a lot to do the actual screening for the intervention and then giving the women all the information about the intervention. This is not a good thing because I have the fear that they will simply not think of the intervention when I am not there and then women are slipping through the net that could really want to participate and could benefit from the intervention, but are not being given the information because of staff and their over-reliance on my presence in the clinic as a reminder for them about OptiBIRTH. I don't feel that this is my role in the clinic. (Diary Entry. July 2014)

The separation phase of the rite of passage of the intervention was difficult. Taking on the additional act of checking charts to see if a woman who had come into the clinic for a first visit had a previous CS, and screening them for the intervention, turned out to be slow and without the incentive or reminder of myself or the MOL in the clinic to either

tell the staff to screen women or to check the charts personally to see if there are any eligible women in the clinic made the process that much more difficult.

This period, which lasted from the pilot until a couple of months (July 2014) into the main study also posed many questions of me as an ethnographer and representation of myself. As I was new to being in the field of maternity care and the field of ethnography, there was a difficulty in how I represented myself. Conducting the ethnography, I was a participant observer and I relished the opportunity to see interactions between women and staff regarding the intervention. Yet, on the other hand, at the start it was hard for me to represent myself as part of OptiBIRTH, but yet not part of OptiBIRTH.

What I mean to say is that yes, I was part of OptiBIRTH, only in so much as I was there to see the intervention created any change. I was not in a position of power and was not an active member of the OptiBIRTH team. This boundary was hard to portray as I feel that many of the staff in the clinic saw me as a person of authority with regards to the intervention, similar to the role of an OL. (Diary Entry, May 2014)

In the first months of the intervention, there was an apparent reliance from the staff in the clinic on me when it came to both the criteria for screening women and information on the intervention. This type of influence was discussed in the previous chapter and therefore it must be acknowledged that I was an influence on the clinic staff to instil the approach of screening women for the intervention. However, even with me being there and the 'go-to' person on the intervention if the MOL was not in the clinic, I was still seen as the 'stranger' in the field and was only really approached when it pertained to

answering a question related to the intervention or if the staff did not have time to explain the intervention to women.

#### *5.4.2 Liminal Phase*

The liminal phase is the transitioning phase in the rite of passage, whereby people do not ascribe themselves to their old identities and behaviours but have not yet been completely incorporated into their community and their new identity. Pregnancy in general is seen as being in a liminal state (Davis-Floyd, 2003), whereby women are in-between being a woman and being a mother. Or in the case of the women in this ethnography they are already a mother and are pregnant again. The women participating in the intervention are in a liminal state, in that they have a decision to make as to whether they want to try for a VBAC or have a repeat CS.

Added to this, the OptiBIRTH intervention can also be seen to be going through the liminal phase during its time in the antenatal clinic. This liminal phase occurred in the early months of the main intervention until September 2014. It is between the states of being introduced to the clinic staff and women but at the same time it has not yet been considered to be a part of the clinic and the acts that are conducted in the clinic, such as asking the women if they smoke or if they have noticed any changes in the foetal movements. At the start of the intervention (April 2014), healthcare professionals were slow to take on the study and the recruitment process being slow, with many of the midwives in the clinic relying on me or the MOL to remind them of OptiBIRTH. This might have been due to the business of the clinic setting and staff being under workload

pressure. It might also have been due to staff not knowing enough about the study at this time so as to comfortably talk to the women about the intervention, what it aimed to achieve and by what means it would do so. At this time, OptiBIRTH was in an in-between stage in the clinic; depending on the midwife recruiting, it was either forgotten about or the midwife was able to give the eligible woman a full description of the intervention and to talk to her about VBAC and fill in the screening chart. I give an example of this from my fieldnotes:

As [Midwife 1] is leaving the clinic she turns to me and tells me that she booked a woman in today that had a previous CS. She then goes to the trolley and shows me the woman's chart so that I know she is eligible for the intervention when she comes into the clinic. [Midwife 1] did not mention whether she talked to the woman about OptiBIRTH or not so I have no idea what she knows. I have not really seen [Midwife 1] screen women in the clinic and she never really talks to me so I don't know how much she knows or thinks about the intervention. [Midwife 2] then comments that 'everything is flying today!' in terms of the charts being handled and it certainly is! [Midwife 2] then turns to [Midwife 1] and tells her that the trial has had its first birth. She is really excited and happy about it and I smile because the woman had a VBAC. It's good news. [Midwife 1] says "oh great!" and seems to be happy about it although she is always one of those people that always looks happy. But throughout this whole morning and recruiting without [Midwife 2] or myself being there as the reminder, which I don't think is a good thing, I believe that the intervention would be forgotten about. It is only with the midwives that really believe in the intervention that are trying to screen the women and I think they are the ones to truly let the intervention into the clinic and pave the way for other midwives in the clinic when myself and [MOL] are not there. <sup>(Field-notes, July 2014)</sup>

This field-note shows the 'in-between' stage of the intervention in the clinic. While some are actively involved with the intervention, there are others who show interest but

are not ready prepared to take the screening process on as a new ritual in the clinic.

Another example I give you is from an earlier time during the intervention:

Today there were 3 eligible women for the trial but only one was screened because 2 said that they were having a CS no matter what. It is consistently reoccurring in the clinic and the midwives are placid enough when a woman comes in and says that she is having a CS and there is no other way to birth. I must keep an eye on this and see what is happening in these interactions, from both the midwife and the woman perspective. At least the women that are being screened are positive about what the trial aims to achieve and that the midwives perceive it in such a way that they feel good about the trial. But this is only with the 2 midwives that are constantly screening the women. I have yet to really see another midwife screen a woman for the trial. I can see that it is always the same midwives who are screening the women. They seem to be the older, more senior midwives in the clinic. This is interesting to note because it is becoming part of their routine to check for women but not the rest of the clinic staff. <sup>(Field-notes, April, 2014)</sup>

By June of 2014 the lack of recruitment of women to OptiBIRTH had reached a crisis point. The study was behind schedule and it became obvious that something was not working in the clinic, meaning that not all of the women who were eligible for the intervention, were being screened and recruited. This can be seen with the field-note below:

She asks with if I was the “one doing the VBAC study” and then begins to ask how it was going (rates of recruitment and interest from the women). This is a constant process that I go through with staff in the clinic. There is this interest that they have in seeing how the study is going and if recruitment for the intervention is going well but from what I can see this interest is not translating into action from some of the staff. I am not saying that this is the case for all staff but the ones that are screening are in the minority. The midwives that ask me how the intervention is going are normally the ones that are not screening which is interesting to note. <sup>(Field-notes, June 2014)</sup>



The liminal state of the rite of passage for the intervention in the antenatal clinic showed that with some members of staff, the recruiting and screening phase of the intervention was taken up in a positive way. However, these staff members were in the minority.

As I was waiting for more women to come in I checked the cabinet to see if any women were screened this week and 2 more women were screened since I was here last, by both a midwife and a registrar. In my opinion, these two members of staff are screening women because they believe in the ethos of the intervention and are motivated to check the charts and see if women are eligible. They are making this part of the intervention part of their clinic routine. They have successfully incorporated the checking of charts and screening of women into the rituals and routines that they apply in the clinical setting. It is also an interesting development to see that a registrar has become involved in the intervention process. Since I have been in the clinic I have found it difficult to access this side of the clinic and thought that they would not have any interest at all, instead leaving it for the midwives to do. But instead, this registrar is allowing the intervention to enter her routine in the clinic because she is motivated and really believes in VBAC. <sup>(Field-notes, June 2014)</sup>

It was a very frustrating and worrying time for the MOL and myself as I, thinking in a selfish way, was not getting any data that was relevant to this ethnography. Yet, on the other hand, the midwives and doctors were beginning to treat me not as a 'stranger' or a person who was there 'auditing' their practices, but rather they were beginning to welcome me more into the main clinic. I was also in a liminal phase at this point. In the clinic, I was being seen as 'OptiBIRTH', but at the same time after being in the clinic full-time for six months (July 2014), I was beginning to transition away from OptiBIRTH towards being seen in the clinic as someone who could help them and not judge their practice. An example of this is where I was invited to come up to the island when the clinic was not busy and chat to the midwives about the intervention or the clinic in general, and I was also allowed to gather charts from women bringing them

from ultrasound to the clinic at the main entrance. It was at this point I believe that I was able to make myself useful to the midwives and this helped greatly when it came to observing in the clinic and in discussing with midwives their thoughts and perceptions of VBAC and how the subject is treated in the hospital. Yet, even though this added participation in the clinic was good for myself as an ethnographer, it was not good for OptiBIRTH's screening and information process in the clinic. It was only with the influence of the MOL coming down to the clinic most days after being informed by OptiBIRTH of the recruitment being behind schedule and doing the screening herself that the midwives began to take notice of the intervention. They began to realise that this is what they were supposed to be doing regarding the screening of women, and the intervention began to become entrenched in the clinic. However, this may have been due to the MOL taking over the role of the screening form and talking to the women in far greater detail than the midwives in the clinic.

#### ***5.4.3 Reincorporation***

The third phase involved in the rite of passage is the reincorporation and that the passage is consummated. This means that the participants can move into their community with their 'new' identities. With regards to the OptiBIRTH intervention, this meant that the process of recruitment and screening was incorporated as a ritual into the clinic and women who were already recruited to the study were seen as being 'part of OptiBIRTH'. Throughout this phase of the rite of passage in the clinic, women were being singled out by the midwives consistently checking the charts and asking women, including women who were already part of the intervention, if they had heard of

OptiBIRTH. I could see this phase come to fruition towards the end of my field work (October 2014):

“Both of the doors to the clinic are open so I place myself in the office. I haven’t been here in a week so I will have to make sure that everyone still remembers me and get used to me again. But today there is a relaxed atmosphere in the clinic, for it being busy! I check to see if there any screening forms in the cabinet in the office and I am happy to see that the staff are still screening women. I then ask myself the question; do they still need me as a reminder anymore? Of course this remains to be seen but it will be interesting as I will not be in the clinic anymore. But even with this, it is a good sign that, with no reminders or people taking over the screening process [myself or the MOL] they still have the intervention in mind and are checking charts and screening. They are actively partaking in the intervention and it seems to be working out ok from the amount of forms in the cabinet.” (Field-notes, January 2015)

After September/October 2014, one midwife and the MOL led the way in changing the way the intervention was incorporated into the clinic. They did this by moving the screening forms from the main clinic into the booking rooms. This meant that the midwives had the time to ensure that the woman would be eligible for the intervention and all of the information was given to them before they even met a midwife in the main clinic. This was done because the initial screening process was not working and, without the presence of myself or the MOL doing the recruitment herself, many women that were eligible for participating in the intervention were being missed. The intervention seemed to grasp ground and become more incorporated into the clinic when a midwife from another area was transferred to the antenatal clinic. This midwife was very interested in the intervention and began to create a ritual whereby, in the clinic or in the booking room, if a woman who had a previous CS came in, the word ‘OptiBIRTH’ was written in her chart, signifying that she was screened and was given

the study information pack. This word then signified throughout this woman's pregnancy and interactions with the antenatal class that she was part of the intervention and that she was trying to achieve a VBAC. It was then detailed by many of the clinicians working in the hospital that VBAC was discussed with the woman at many of her appointments and that she was still eligible to achieve it, barring any medical problems arising during the pregnancy. The women that were participating in the intervention were now being openly referred to as 'OptiBIRTH women' in the clinic.

This reincorporation phase of the rite of passage for the intervention becoming ritualised into the antenatal clinic was also aided by the increased presence of the MOL in the clinic and taking pressure off the clinic staff by taking the potential women for the intervention aside and giving them the detailed information about the intervention. By this time, I was, like the intervention, incorporated into the clinic setting, with the midwives allowing me to help out in the clinic (giving urine bottles to women or taking scan charts from the women to be put in the chart trolley) and I was allowed to move freely in the clinic and approach the midwives during quiet periods to talk to them, where they would tell me that "We'll give you a uniform." (Field-note October 2014). It was also during the latter stages of 2014, nine months into the implementation of the intervention, that many of the midwives became more interested in OptiBIRTH and I was their point of information about the intervention in the clinic, such as them asking how the women in the intervention were getting on. The staff in the clinic were now taking on their role as gatekeepers of information, rather than relying on myself to give information on the intervention:

The office was empty so I set myself up in there. While I was waiting I looked in the cabinet to see if there were any screening forms. There was one from today and two from last week. After a couple of minutes 2 more midwives came into the clinic and began to take charts and call women in. [Midwife] spots me in the office before she goes to call in a woman and tells me that “I got one today”. I tell her that “that’s great” and ask her “do you want me to speak to her”. She stops and looks at me and shakes her head, telling me that “no I already spoke with her, unless you want to?” to which I reply “no that’s grand thank you”. She nods at me and then calls a woman in. (Field-notes, October, 2015)

The women in the intervention were also aiding the ritualization of the intervention in the clinic at this time. As the intervention progressed, more women were attending the clinic that had already been recruited to the intervention and they were highlighted as wanting a VBAC in their charts and by telling the midwives in the clinic that they were still aiming for a VBAC.

## **5.5 The Beginnings of the OptiBIRTH Journey**

While this chapter has examined and described how the OptiBIRTH intervention established itself in the antenatal clinic, it is also important for the evaluation of the intervention to explore how the participants, namely the women who participated in the intervention, felt about their experience of OptiBIRTH in the clinic.

The majority of the women participating in the intervention found out about OptiBIRTH and were given the information packs that were related to OptiBIRTH by the midwives working in the clinic as well as myself and the MOL. It is with these interactions that the woman becomes aware of OptiBIRTH, its aims and objectives and

what the intervention can offer them as women who have had one previous CS, as has been described in section 1.4. It is this first contact and an initial conversation about trying to achieve a VBAC that will be a major focus for these women during their current pregnancy; a focus that is further facilitated for the majority of their pregnancy by the midwives and the MOL. Indeed, for many of the women that I interviewed, the decision on whether to try for a VBAC had not been discussed with them by the doctors in the clinic, as illustrated by an interaction I had with W9 when I asked her whether she has had a conversation about VBAC with their doctor:

**W9:** And then my last appointment here, I spoke to the doctor for... two, three minutes? That was it, so.

**Int:** Right, have they given you any information?

**W9:** No.

**Int:** No?

**W9:** No. (Interview, May 2015)

This type of interaction occurred similarly with W11:

**Int:** Has your doctor discussed yet your birthing options for this pregnancy?

**W11:** No. Em, well I just after the class last week I just changed over to [the OOL] now but before that, em, the doctor I'm actually under, I discovered at the class has left two years ago [Laughs] and em, so her clinics go on here but under local doctors. Nobody ever spoke to me about VBAC or even my birthing plan or options yet. (Interview, August 2015)

W12 found that it was only by her asking about her birthing options that only some of the clinicians addressed this question:

So, em... so if someone has talked to me about natural birth and that it was [doctor] because I approached him to talk about it. Apart from that, no, when I would meet his consultants, they weren't overly confident about it. They only take the scan, they take my current state, but no they wouldn't really talk about birthing options, no. (Interview, August, 2015)

This example of the interactions between the women participating in OptiBIRTH and the clinicians was constantly repeated throughout the antenatal clinic stage of the intervention. However, there were exceptions to this, with W8 telling me that

“they’re [the doctors] kind of saying there should be no reason. Like a couple of weeks ago it was like, ‘yeah, you’ve a ninety percent chance of having a VBAC, there’s no reason’”.

But for the majority of the women participating in OptiBIRTH, the main source of information about the intervention and VBAC in general was the midwives in the clinic and the MOL when she was present. This highlights the importance of the initial information that women get about the intervention through the midwives and the MOL. It sets them on their OptiBIRTH journey and their plans to try achieve a VBAC. This can be linked to the concept of the “OptiBIRTH identity” which I explore and detail further in the next chapter.

## **5.6 Conclusion**

This chapter has given an in-depth exploration of the creation of a ritual surrounding the OptiBIRTH intervention in the antenatal clinic, in terms of the recruitment and screening process as well as information giving to potential participants and clinicians who are giving the OptiBIRTH information. It has explored the ritualization process of the intervention in the antenatal clinic, combining this exploration with suggesting that OptiBIRTH undertook a rite of passage in the clinic in order to become a full working member of the clinic routine. This chapter has tried to convey the OptiBIRTH journey

in the antenatal clinic as a rite of passage that both the intervention, women and clinicians go through in order for the intervention to become an established and legitimate presence in the clinic, from both a healthcare user and provider point of view.

The next chapters describe and explore one of the main OptiBIRTH intervention components; the antenatal classes. Chapter Six examines the first of the two OptiBIRTH antenatal classes exploring specifically the experiences of the women and OLS attending the class and the construction of the OptiBIRTH identity.



## **Chapter Six: ‘Constructing Identity’ – OptiBIRTH’s First Antenatal Class**

### **6.1 Introduction**

This chapter presents the experiences of women and OLs during the first OptiBIRTH antenatal class<sup>9</sup>. The chapter is sub-divided into several discrete, yet complementary sections that reflect the process of the antenatal class and the underlying effects it has on those attending. The first section of this chapter will set the scene for the location of the antenatal class, including how the room is set-up for the class, and how the class is usually structured in terms of presenting the OptiBIRTH intervention information. The second section then considers the women that are participating in the class. It describes the identity that is constructed during participation in this class. This identity includes both the collective identity that is created by class participants sharing their stories of their previous birth experience, and their personal identity, which involves becoming a woman who is trying to have a natural birth. In the next section of the chapter, fear of childbirth for women attending the class, and information on the risk of a natural birth, including uterine rupture and the safety of natural birth, are explored. This chapter will then delve into the role of the OLs in the antenatal class, from their influence on the women to their own feelings on the overall approach and content of the class with regard to encouraging women to have a natural birth after a CS.

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<sup>9</sup> This Chapter was presented at the 16<sup>th</sup> Annual Healthcare Interdisciplinary Research Conference, TCD, November 2015

## 6.2 The Setting

The OptiBIRTH antenatal classes are held in the field-site in a room that is located on the ground floor near the main entrance and reception. The room is used, in the main, for educational purposes, with lectures and meetings held here as well as the room providing a study area for medical students from the local university. Compared to the antenatal clinic the room is modern, with double-glazed windows, and individual study areas fitted into the walls with lights above each one. Wi-Fi and facilities for conference calls are available and modern appliances are supplied, including a flat screen television, and a laptop on a stand for presentations. The room also provides additional tables, chairs and sockets for laptops across the room, for different functions that the education room provides. The layout of the room can vary depending on the purpose of its use. For example, as the numbers attending the antenatal classes are smaller than the clinician information sessions, less of the room is used. Tables are placed in a square towards the front of the room and chairs are placed facing the screen for the presentation element. Both the OOL and MOL are normally seated together at the top of the room. I normally positioned myself to the middle of the room, close behind the participants. The following picture (Figure 4) illustrates the usual layout of the room for the antenatal class.



**Figure 4: Layout of room for OptiBIRTH Antenatal Class**

For each class, the MOL and I arrived at the room one hour before the class was due to commence and set-up the room as Figure 4 illustrates. Setting-up the room included clearing any extra tables to the back of the room to give the room an open feeling, and to tidy the room of any rubbish that might have been left there from previous users. Bottled water (still and sparkling) with paper cups that were provided by the canteen were set close to the table and in view of the attendees as the room itself could get extremely warm and stuffy. After this was done, either the MOL or I set up the laptop for the presentations, and placed on the table, information leaflets about VBAC, labour and birth that were specifically created for the intervention. These leaflets were made available to the participants to take away with them after the class and for reading in their own time. The MOL and I also put up signs at reception and in the main entrance hallway of the field-site, indicating with arrows, directions to the education room where

the class was being held. The hospital receptionist and security personnel were also informed that the OptiBIRTH class were being held in the education room should any women enquire as to the location of the class.

For the most part of the field-work period, the OptiBIRTH antenatal classes were held in the evenings of the day that the OOL was present in the hospital, which was midweek. Towards the end of my time in the field, the classes were switched to early afternoon on the same day as previous, to see if the numbers of women attending the classes increased in any way; however, it did not. The length of the classes were between an hour and a half and two hours. For most of the duration of the study, there were one to two classes per month, depending on the volume of women who wanted to attend the class.

On average, between three and seven women attend any one antenatal class. Some women attend with their partners, although this was rare. There was an instance when a woman, her partner and their child attended the class; however, the child began to fidget soon after the class began and was taken out of the room by the woman's partner and did not return. There have also been some cases where partners have asked the MOL if the class is relevant to them. The MOL explained the class and some partners decided to leave. Women attending were all around the same gestational age, that is, between 24-31 weeks' gestation, as per OptiBIRTH criteria. Most of the women who attended had one child, but some women had a normal birth before having a CS with their previous birth.

At the first class, the women usually began to arrive sporadically ten minutes before the class was due to start. As the women arrived, both the MOL and I greeted them at the door, introducing ourselves and asking how they were. The MOL then invited the woman to have a seat at the table and offered her, and her partner if he was attending, water that had been provided for the class. While waiting for other women to arrive to the class, the MOL and I would strike up general conversations with those already present asking how they are feeling, how many weeks pregnant they are and whether they have accessed the OptiBIRTH website. These general conversations were initiated to assist women to feel more comfortable, to encourage them to talk amongst themselves, and to encourage women to become part of the conversation and the class.

Once all of the women in attendance were seated and comfortable, the MOL began the class by giving a brief overview of the OptiBIRTH study. She positioned herself at the table beside the women to create a comfortable atmosphere, more like a conversation than a lecture providing information, and to help put the women at ease. The MOL explained why OptiBIRTH is occurring in the field-site and the history behind the development of the intervention. This explanation included information on rising CS rates around Europe and worldwide, what OptiBIRTH aims to achieve, how it is structured for both participating women and clinicians, and what will happen once the intervention ends. It is after this that the MOL began the formal part of the class, beginning with OptiBIRTH presentations that had been created specifically for the intervention. She talked with the women about their previous birth experience, what they would like out of this birth, and then the presentations that are part of the

OptiBIRTH intervention were shown. The OOL generally attended the class mid-way through.

The aim of the first OptiBIRTH antenatal class was to provide factual information about OptiBIRTH and VBAC. This information included; the origins of the OptiBIRTH study and how the intervention was developed, and evidence-based information on risks and benefits of VBAC and repeat CS. In addition, women were informed where to find information about VBAC, and were told about the OptiBIRTH website and the apps that were developed as part of the intervention. Women then engaged in a community of practice (CoP)<sup>10</sup> meeting with the OOL and MOL, to share their personal experiences of their last birth with the group and their hopes for this current pregnancy. It gave women an opportunity to put questions to a medical professional about their previous birth and an opportunity to meet other women who were similarly positioned, that is, have had one previous CS birth. At the end of the antenatal class, I would walk to the front of the class and sit down beside the MOL and tell the class a little about myself (my background and why I was attending the class), and provide women with extra information on the embedded ethnography. This gave women an opportunity to talk to me about their experiences of the intervention and allowed those who were interested to organise a meeting with me at their next antenatal clinic appointment to chat informally or, if consenting, undertake a tape-recorded interview.

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<sup>10</sup> A Community of Practice (CoP) can be defined as groups “formed by people who engage in a process of collective learning in a shared domain of human endeavour. Communities of Practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly” (Wenger, E., (2011), *Communities of Practice: A Brief Introduction*)

The above passages are presented to give the reader a sense of the class structure and set-up/layout. In the next section, I present, through in-depth exploration and analysis, the ethnography of women's participation in the OptiBIRTH first antenatal class.

### **6.3 The First Antenatal Class – Creating the OptiBIRTH Identity**

This section describes, in-depth, the first antenatal class that the women attend. It attempts to give a value to their participation in the OptiBIRTH antenatal class. The class provides for the development of a 'sub-group' that the women identify with, of women who have had a previous CS who are now looking at an alternative mode of birth for their present pregnancy, specifically to have a natural birth. It will show how, during participation in the classes, the women see themselves differently to others who have not experienced a CS. It will also reveal how the bonding process for the women occurs when they begin to talk to each other about their previous birth experience and listen to other birth stories. This section will then explore different elements of the class, including the OL, their language, and the delivery of information during the class as a whole. It will then explore how both groups felt about the class, and their opinions on attending. The attending of the class as well as their participation can then be linked to the concept of identity, both collective and personal. I will show how, by participating in OptiBIRTH, women are re-moulding the way they view this birth experience and how they view themselves personally as a woman who is informed and educated and can try to have a natural birth after a CS.

Identity, specifically self-identity, has been largely untouched in anthropology, rather remaining in the domains of psychology and ethnic studies (Hammack, 2008; Eriksen, 2002; Stets & Burke 2000; Cohen, 1978). However, in exploring the culture of a specific group, the identities of individuals in that group must be examined so that the culture of the group and how they relate to society can be understood fully. As Jenkins (2008) informs us:

“Identity is our understanding of who we are and who other people are, and, reciprocally, other people’s understanding of themselves and of others (which includes us). It is a very practical matter, synthesising relationships of similarity and difference. The outcome of agreement and disagreement, and at least in principle always negotiable, identification is not fixed.” (p.18).

Identity and identification with a particular group is a core feature when examining the culture of different settings and different groups. This is especially linked to how people create their identities when it comes to race, religion and sexual orientation (Ysseldyk *et al*, 2010; Greenfield & Marks, 2007; Warnke, 2007; Rosario *et al*, 2006; Smedley, 1998; Rust, 1993). From when we first begin to recognise identity as a child, we have been creating an identity for ourselves. This identity could be as broad as creating a national identity, like being English, Irish or American, or it could involve a more specific collective identity, such as that of being part of a certain group. For example, I am an alumna of social science in University College Dublin (UCD), I am a part of a creative writing group and I am a vegan, representing three separate, personal collective identities. How we see ourselves and identify ourselves in society is constructed by how we allocate ourselves into groups and societies. The same can be said for women who are pregnant or who are mothers, or in the case of this ethnography, women who have



had a previous CS birth. These different roles that we have in our lives and labels that we can affiliate with allow us to create our individual identity in society. This construction of our identities is influenced by the social categories and groups with which we brand ourselves, through the similarity and differences that, culturally, we understand. Sokefeld (1999) explored the issue of investigating identity in anthropology, looking specifically at the relationship between the individual and the social and how they influence each other. While identity for many years focused on the 'sameness' of people in terms of social and individual identity, there has been a shift in this paradigm to a deeper exploration of plurality with reference to identity. This plurality of identity means that while we can be associated with different groups because of similar interests and experiences that have occurred in our lives, plurality of identity allows us to acknowledge that we also have differences in these groups when it comes to our identity. A perfect example of this is the women who are participating in OptiBIRTH. They are similar to the group that they ascribe themselves to, which is pregnant women, but they also have this plurality of identity in this group, as they are different to many others in the 'pregnant' identity; they are pregnant but they are trying to achieve a VBAC.

Bailey (1999), in exploring the changes that can occur in identity when women are making the transition to motherhood, found that women experienced a period of re-adjusting their identity. This readjustment occurred from both a societal and a personal point of view, changing from an individual sense of self in their work and space, to a pregnant sense of self, encompassing "a sense of entering a new community of women who had all been through this experience" (Bailey, 1999, p.344). Earle (2000) furthered

this conversation between first-time pregnancies and identity of self by including the influence of health care professionals and their effect on creating and maintaining a sense of identity during this time in a woman's life. Through her analysis, Earle found that many women need re-assurances that their feelings during their first pregnancy are similar to other women in similar circumstances. In Earle's (2000) study, the community midwife, in her authority role, was found to provide women with this re-assurance. Earle presents a further interesting concept related to self-identity and pregnancy when she describes that women also wanted to feel a sense of uniqueness during pregnancy and it was the midwife and the development of the personal and professional relationship between the women and midwife that fostered this feeling of uniqueness. Although these constructions of self-identity (feeling similar and feeling unique to others) were applied to first time pregnancies, their applications can be used to the women attending the antenatal class, which was evident during the course of this ethnography. In the OptiBIRTH intervention, these applications of self-identity, that is feeling similar to other women attending, but also feeling unique with their own birth story, are introduced to women who have had a previous CS but, through the CoP and listening to other birth stories, they are also unique. As the MOL tells them in the class "everyone has a different story" and "every labour is very different" (Field-note, 29th April 2015)

The transition to motherhood for many of the women allowed them to reposition themselves and adjust their identities to achieve their complete sense of self in both their pregnancy and personal life (Earle, 2000). In OptiBIRTH, many women attending the first antenatal class did not initially know that they could have a normal birth after a CS. For the majority, <sup>(n = 12/13 approximately)</sup> when interviewed or asked in the class, they

took a long time thinking of and going through all of the different groups they identified themselves with (e.g. family, friends, work colleagues or mother-baby groups), but could not think of a person they knew that had had a VBAC. It did not occur to them that they could have a VBAC. As one woman in the class stated “people presume that you will have another section” (Field-note, 6th May 2015). This is one of the many ways that society can largely influence the processes and thoughts of pregnant women who are interested in VBAC. Therefore, it is in the antenatal class that women develop a new identity and become immersed in a new group, collectively, through their participation as women who are trying to achieve a VBAC. As W1 illustrates

“when I originally found out I was pregnant this time, em, my GP said to me, you know ‘you’re most likely to have another section because they’re so close together,’ and you know I kind of thought that it wasn’t an option, originally to have a VBAC, but now I do and I kinda think, ‘ok they’re gonna try and help me have one’, you know? Help me as far as possible and sure if it doesn’t work out it doesn’t work out, but at least I can go and give it my best shot.” (Interview, W1 November 2014)

This demonstrates that, through participation in the class, women are now re-framing their identity through OptiBIRTH. They now are able to classify themselves under multiple identities; a pregnant woman, a mother, a woman who has had a CS and now a woman who is informed and knowledgeable about planning for a VBAC.

This leads me to think on constructionism and symbolic interactions, which are the basis on which this ethnography builds its interpretation. Constructionism is a branch of philosophy that focuses on meaning and power. It believes that meaning is not a property of objects and events themselves, but a construction. Every person can be seen

as a social construction of the reality in which they inhabit. Reality is therefore created through interaction in particular situations. These situations are not pre-defined, rather, we creatively define reality and knowledge through interactions. This creation then allows us to pursue our identities in society, through interaction and the classification of ourselves into groups that we believe are closely linked to our feelings of identifying in society. Relating this back to my ethnography, the women who participate in the classes are interacting with women who all have a shared history; they have experienced a CS. At the same time, they are collectively attending the class to inform themselves on how they can experience birth in this pregnancy, that is, they are becoming ‘socialised’ to the idea that they can experience a normal birth.

This is influenced by the information provided through the OptiBIRTH intervention and also through listening to other women’s stories. In this way, women attending the classes are creating a collective ‘OptiBIRTH’ identity. This is highlighted by W3 who stated that:

“it’s just great hearing other women’s experiences as well and what they’ve gone through and what they’re hoping to do this time as well”. (Interview, December 2014)

This theorising is further demonstrated perfectly by W6, who at the end of her first antenatal class said:

“I’m not the only one. We’re all in the same boat”. (Field-note, 11th May 2015)

## 6.4 The de-brief

“I think, kind of, really calmed me into thinking ‘yeah, you actually can do this, you’re able to’, you know? And em, it was because the focus group was so small as well, you really got a chance to ask anything that was on your mind.” (Interview, W1 November 2014)

The above quote illustrates that participating in OptiBIRTH, for many women, has provided them with the opportunity to let go of their previous birth experience and develop a positive focus to their current pregnancy and subsequent birth. This is achieved in the antenatal class by facilitating an open space in which women can share their previous birth stories with each other and as women who have been in a similar situation to each other; that is, having undergone CS previously. In this situation of ‘de-briefing’, while women assist each other in developing an ‘OptiBIRTH’ identity, the OLs, as facilitators of the antenatal class, can also significantly influence the creation of the OptiBIRTH identity for women.

During the ‘de-brief’, women are enabled to ‘let go’, to some extent, of their previous birth experience. Through discussions and information provision they are encouraged and empowered to embrace a positive and knowledgeable approach to their labour and birth in their current pregnancy. This approach is achieved through the construction of the ‘de-brief’ in the antenatal class, by both women and OL participation, which, in turn, aids further the construction of the ‘OptiBIRTH’ identity. Two prominent categories related to the way in which this ‘de-brief’ is conducted have emerged in this ethnography. These are Language and Success Stories.

### 6.4.1 *Language*

Language is the way in which humans communicate with each other. Communication is vital to the construction of cultures and societies and can be demonstrated in a variety of ways, from speech and body, to written or visual communication. Language is how we communicate our feelings, ideas and stories and therefore is paramount to the development of culture as well as the preservation of beliefs and social structures that create our individual ideas and identities and the collective identities that we classify ourselves by. In this ethnography, language and communication of new ideas surrounding VBAC emerged as being of utmost importance. By changing how new ideas are communicated to participants, including new ideas on birthing and new knowledge acquired during the class, it can instil the belief that a VBAC is achievable and that;

“where this time round I do have the option of having a natural birth, which is what I want and they’re all, you know, ‘go, go again or go with it and whatever and if there is a problem we’ll revise it down the line” (Interview, W3 December 2014)

Language used by the MOL and OOL facilitators in the class come into play here. Throughout all of the classes that I attended during the intervention <sup>(n=16)</sup>, I witnessed a shift in language used from a more uncertain opinion on natural birth to a more positive framework of communication. This turn towards a positive framework for communicating that natural birth is a viable option for women can be seen in a light similar to positive affirmations related to mindfulness and mental health. Throughout the class, the OLs kept the idea of the participants achieving a natural birth to the fore,

through the language that they used. An example of this is highlighted in the OOL telling the women that “90% of women prefer the experience of a vaginal birth” and that “if you get the normal, you’ll be pleased”. The MOL then encourages this type of thinking by telling the women about “positive thinking”. (Field-note, 11th February 2015)

The change in language over the course of the classes is also very evident in the CoP in the class. While the OOL listens to every woman’s previous birth experience, he goes on to explain why they may have had the CS and ends the conversation by telling them that they are “a suitable candidate” or “you’re right up our street”. An excerpt from my field-notes exemplifies this use of language:

“The room then goes quiet again and another woman is asked about her previous labour and birth experience. This woman had an elective CS for twins as one of the babies was in a breech position but before finding out about that she was very pro natural birth and planned a vaginal birth for the twins. [The OOL] says to her that it was a “pity in a way you didn’t get your chance” and “if you don’t try you don’t get there but most do get there”. Here he is trying to bolster the women by saying that they should at least try to have a natural birth because this is their last chance to even be given the option of having a natural birth. He tries to reassure them that how a “nice, smooth, straightforward” labour will help and that if labour commences and is going, then they will not stop it and they will “give them a bit of chance, give them another hour” to see if they progress and that they can achieve a natural birth. He emphasises the naturalness of the birth process and this is what they should try to achieve with this birth.” (Field-note, July 9th 2014)

The emphasis on the language used appears to have had an effect on participating women during the interview process. The influence of the interaction is visible in the women after the class through a new confidence that they appear to have and their positive outlook on having a VBAC, as a result of the CoP and their interactions with

the OLS. W1 described talking to the OOL about her hope for her current pregnancy as “it’s kind of an ease” and “It kind of gives you more of a sense of relief as well” (Interview, November 2014). W1 went on to have a natural birth.

#### **6.4.2 Success Stories**

Stories of personal experiences are very powerful tools in shaping a person’s attitude toward you as well as their feelings towards the subject matter. As Brown *et al* (2009) informs us

“Stories are, often concomitantly, aids to memory and ways of forgetting, diagnostic tools and distractions, means for social control and expressions of liberation, hegemonic and subversive. In all these ways, and others, stories are key to our conceptions, theories and research on change” (2009, p.325)

By using storytelling of our experiences, the thoughts and ideas that people have on a subject can be changed or influenced. From my experience of undertaking this ethnography, many of the stories that have been told to me about VBAC have changed my perception of it. These stories are recounted from different sources, and include women telling me about their positive experience of VBAC, and health care professionals in the hospital who show enthusiasm and a sense of pride when they tell me of a woman who achieved a VBAC. I myself do not have children nor have I gone through labour, so for me personally, before I began researching the topic I had no ‘real’ feelings or strong thoughts towards VBAC. I, like the majority of society, fell into the grasp of the old adage ‘once a caesarean, always a caesarean’ and was not, admittedly, aware that VBAC was a viable option. Prior to commencing this ethnography, I had no idea how having a VBAC would influence both women and clinicians and their



opinions on it and how much it means to them on a personal and professional (clinicians) level. This open storytelling and sharing of anecdotes has had a surprise impact on me and my feelings towards VBAC that I did not think would occur; in particular, it has influenced my thoughts and ideas on normal birth as a person and not simply as a researcher. By seeing the OLs genuine passion and pride with women having a VBAC has made me think twice on the subject and how important it is to everyone involved.

The use of success stories regarding VBAC and anecdotes from the OLs is a component of the class that generates intrigue and sometimes awe for the participating women. It leaves them with the idea that a VBAC has been achieved before in the hospital and, through the OLs telling them their personal accounts of the women having a VBAC, makes it a more real and tangible concept. A question that is always asked in every first antenatal class is how other women in OptiBIRTH got on in terms of having a VBAC. When the MOL re-iterates the percentages of women who have achieved a natural birth, there is always a look of disbelief around the class and an indrawn breath, with some women saying 'oh' in a way that indicates they either cannot believe that women are achieving a VBAC, or cannot believe that women are having the option to try for a VBAC. Another time that this occurred was when the MOL was telling the women that, during the time of this particular class,

“there were four women attempting a VBAC in the labour ward. The women could not believe it and looked at each other in surprise” (Field-note 6th May 2015).

These types of stories make achieving a VBAC a reality for the women. The OOL also provides many anecdotes regarding his experience of VBAC and in women achieving it. His stories, which he tells in all of the antenatal classes he attends, originate from his experience of working in different hospitals and from his private patients. The OOL tells the class that VBAC is “worthwhile” and his patients have been “pleased with themselves” after a VBAC. It is these stories and anecdotes that enable women to grasp the reality that a natural birth after a CS does occur and facilitates a positive framework of thinking about VBAC to take centre-stage in the class. It should be remembered, however, that the majority of women participating in OptiBIRTH had never heard or known someone who has had a VBAC. This is completely new territory in terms of thought and information for women. They only hear about the success stories through the OLs, and hearing these stories are important to them.

## **6.5 Risk**

One of the aims of the first antenatal class is to introduce women to the risks and benefits associated with both VBAC and repeat CS. This is achieved through a series of power-point presentations, delivered by the OLs facilitating the class and developed as part of the OptiBIRTH intervention package. At almost all of the classes, uterine rupture (UR), as a risk associated with VBAC, arises for discussion, and is generally initiated by the OLs. While some women in the classes had not heard of a UR, there were quite a few that had, with UR surrounded by a sense of fear.

To explain UR for the non-medical or unfamiliar reader: UR is a rare complication in pregnancy and labour. It occurs when there is

“a disruption or tear of the uterine muscle and visceral peritoneum (a membrane that provides support to the organs in the abdominal cavity) or a separation of the uterine muscle with extension to the bladder or broad ligament” (Landon *et al*, 2004, p.2583).

The occurrence of this is most obvious when there is a scar on the uterus from surgery, such as a CS. For this reason, there have been some concerns about the safety of VBAC, associated mainly with the pressure of labour contractions on the previous uterine scar. The occurrence of UR is, however, rare. Guise *et al* (2004), in a systematic review found that “it would take 263 elective repeat caesareans to prevent one uterine rupture due to trial of labour. However, elective repeat caesarean delivery is not guaranteed to prevent uterine rupture” (Guise *et al*, 2004, p 6). In the Irish context, there have been very few studies indicating the incidence of UR. Turner *et al* (2006) conducted a review of cases of UR in an Irish maternity hospital over the years 1993-2002. They found that, of 4,021 women with a previous CS, there were nine cases of UR none of which resulted in a maternal or foetal death. Therefore, while there is a risk in attempting VBAC, the incidence of UR is very low.

UR is usually introduced into the class at the ‘assessing risk for VBAC and repeat CS’ slide as part of the power-point presentation. It is here that the OLs try to allay the fears of women by engaging in a positive framework of thinking. They do this through communicating their personal experiences of UR and also providing confidence to women about the protocols involved in the hospital for the signs and symptoms of UR.

The OptiBIRTH package also plays its part in this discussion by informing women in the presentation of how low the incidence of UR is in women trying for a VBAC.

When UR is brought up, the OLs tell women that it is “the biggest risk for mothers when you have a contraction you are putting pressure on the scar” (Field-note, 21st January 2015)

but the “risk of it happening is quite low”. The MOL is constant in informing the women in each class that “I’ve only seen one [UR] in seven years” (Field-note, 21st January 2015). The MOL in this instance is making sure that the women know that this is a risk with VBAC but that it is a low risk and that, in her professional experience, she has only personally encountered one at the hospital. This is important to women in alleviating fear surrounding UR. By the OLs discussing their personal experience in a professional capacity, they are alleviating some of that fear.

The OLs also employ the tactic of informing the women of protocols in the hospital for the detection of UR. The MOL, when asked by women how they would know if UR was happening, reassures them by describing possible UR as having a “different pain” to that of a contraction and that the pain will be there between contractions. To monitor for UR, a monitor that assesses foetal heart rate and the uterine contraction rate will be worn at all times around the scar that may give an indication of the beginnings of scar dehiscence, and a midwife will be feeling the stomach periodically. The OLs are there to make sure that the women know the risk of a VBAC, but at the same time are relaying to them that “it is a risk but it is a very low risk”. (Field-note, 25th February 2015) They then put the women’s mind at rest by stating that if UR does happen, they have a 20-minute space in which to get to the theatre and get the baby out. Again, it is here that they are making sure that the women know that they are in safe hands and they will be

“watched like a laser” (Field-note, 6th May 2015). Although it may seem, from observing at the classes, that the women ask questions and are informed of the risks of trying for a VBAC, when interviewed they do not mention these risks at all. They leave it up to the doctors to assess the situation and make the decision. It may seem that the women know of the risk with having a VBAC but focus more on the benefits. This could be due to the OLs framing the risk in a positive way and downplaying the risk that is involved. For example, the MOL,

“...while practising the presentations with me, [the MOL] did not want to use the word ‘dying’ in the presentation and wanted to take the slide out. If the OLs are uncomfortable with presenting the risks of trying this type of birth, how are they able to accurately describe and objectively give the information to the women” (Diary Entry, 7th May 2014).

By downplaying risk, the OLs may be influencing women to have a lesser appreciation for risk in its fullest extent. The OLs are the major force in the antenatal class, in terms of professional experience, knowledge and authority on VBAC and CS. Therefore, if they downplay risk, even if the risk is a low risk, the women when making the decision to try for a natural birth, may not take all of the risks into account. However, to just mention to you that, as I was writing this chapter and submitting it to my supervisors, I was informed that

“women are more at risk of dying with repeat CS than with planned VBAC. With maternal mortality rates of around 6 in 100,000 (only one to two of which, usually, are due to birth, the rest are traffic accidents, cancer, suicide, murder, etc), everyone plays down the risk of dying because it is so slight. If you think of it, 1 in 100,000 – you’re probably safer in labour than crossing the road. So it may just be the usual uncomfortableness of discussing death in relation to birth, rather than anything to do with VBAC”. (Comment from Supervisor, July 17th 2015)

This comment shows to me that, when looking at what I have previously written about the downplaying of risk by the OLS, that this may be my naivety coming through in my reflection. As I am not a healthcare professional, I needed the knowledge from my supervisors to ensure that I am not taking any medical knowledge for granted and that what I say in my diaries I could go back and question its legitimacy. This overall experience that I had as an ethnographer and how it affected me will also be discussed in a later chapter.

## **6.6 Conclusion**

This chapter has explored and described the first of the OptiBIRTH antenatal classes. It reveals how, through the active participation of women with the intervention, women are collectively creating a new identity for themselves in the class, that is, an identity of women who are trying to achieve a VBAC. By talking to the OLS and being provided with information on VBAC and encouragement and confidence in having a VBAC, women can actively create an identity for themselves, both as a collective (participating in OptiBIRTH) and personal (trying for a natural birth after CS). This construction of a new identity is largely influenced by the OLS facilitating the class through their use of language and positive communication on VBAC, and by positively framing VBAC through personal success stories of women that have achieved the birth that they wanted.

The chapter also described the notion of fear, in particular, fear surrounding possible UR. Although women are being informed of the risks of UR, the OLs allayed their fears by downplaying the occurrence of UR and, sometimes, diluting the seriousness of its situation. When attending the classes and talking to the OLs, this was my feeling at the time but, stepping away from the field and talking with my supervisors about this situation, I now know that it may not be so much as downplaying the risks, but rather their views and based on their professional experiences. After all, they are the professionals and I have no background knowledge or education on UR. They achieved this by imparting information on their professional experiences of it, by informing women that few women or babies are harmed by UR, and by describing that hospital protocols are to hand if UR occurs.

The following chapter will now move on to explore the second OptiBIRTH antenatal class and the use of authoritative knowledge and power that occurred in this class.

# **Chapter Seven: Authoritative Knowledge and Power: The Second OptiBIRTH Antenatal Class**

## **7.1 Introduction**

This thesis now moves on to examine and discuss the second antenatal class that was developed as part of the OptiBIRTH intervention. This chapter will explore the experiences of the women and the OLS facilitating the class and it will try to convey the processes and effects of these processes that occur during this class on the women attending. The first section of the chapter provides a brief overview of the setting of the class in the field-site as well as describing the aims and objectives of the class. The chapter continues by illuminating the relationship between the women and their participation in this class, forwarding the idea that the class facilitates the construction of authoritative knowledge for them during this pregnancy. Furthering this conversation, the chapter progresses then to discuss induction of labour (artificially starting labour with drugs) which was a consistent subject brought up in the class by the OLS. The concept of a 'VBAC Clinic' was also to the fore in this second class and this will be discussed in relation to the concept of power and communication. The chapter will conclude with a summary of the second antenatal class component of the OptiBIRTH intervention before moving on to the next component of OptiBIRTH, the clinician information sessions, in Chapter Eight.



## 7.2 The Setting

As described in the previous chapter (section 6.2), both of OptiBIRTH's antenatal classes took place in the education room of the field-site. The second antenatal class was normally held the week after the first class, on the same day and at the same time. The setup for the class was the same as that illustrated by Figure 4 and the MOL and I set up the class together. The main aim of the second antenatal class was to prepare the women for labour and birth and what to expect if they had to have another CS. This session focused more-so on medical information than the first antenatal class and concentrated on the stages of labour and how to manage labour and birth. This class focused on women achieving the birth that they would want. The class, through its content, tried to empower the women to feel more confident about achieving a VBAC as well as ensuring that they knew that they would be supported throughout their labour and birth by the hospital. The class, similar to the first class, also included a CoP with the OOL, albeit to a shorter extent than first class, where the OOL gave a short talk about the benefits of VBAC and tried to instil confidence in the women about their pending labour and birth.

The attendance for the second antenatal class did not drop off and there were usually between three and seven women in this class with some partners attending both of the classes. After all of the participants had arrived and seated themselves, the MOL then began to describe the aims of this class and what the participants would learn about labour and birth in this class. Again, the MOL either sat in a chair or on a table to create a relaxed atmosphere. The second antenatal class gave more detailed presentations and

factual information on the process of labour and birth than the first antenatal class. The presentations ranged from showing women how they would know when their labour began at home to what happened during the different stages of labour and how to plan for a repeat CS if a VBAC is not recommended at the late stages of their pregnancy or during the labour. The CoP with the OOL, held towards the end of the class, allowed the participants to ask the OOL and MOL any questions about the field-site and VBAC. The OOLs also reassured the women again during the CoP about trying for a VBAC and reiterated the benefits and risks of VBAC to the women. The OOLs also discussed a repeat CS if it came to be the only option for giving birth.

This section has given you a taste of the second antenatal class and its differences to the first class. It is intended to show you what kind of information the women are presented with and the aim of giving women the appropriate preparation, support, and confidence in both the OptiBIRTH intervention and in VBAC as a method of giving birth. I now move on to explore the second class in more depth and, through deep immersion and analysis of the data collected, present the findings of this ethnography associated with the OptiBIRTH second antenatal class.

### **7.3 The Second Antenatal Class and Authoritative Knowledge**

The second antenatal class is based around ensuring women receive accurate information on labour and birth. The women are given both medical and non-medical tools to ensure that they are comfortable and able to employ various methods to cope with labour and birth. Many of the women attending the intervention antenatal classes

had not experienced labour before due to various circumstances in their previous pregnancy, such as a breech<sup>11</sup> birth or a preterm birth<sup>12</sup>, so this information was extremely important for them. For the majority of the women that attended these classes, their previous pregnancy occurred between 18 months and 2 years prior to their OptiBIRTH pregnancy. This length of time between pregnancies meant that a lot of the information that they had been given at antenatal classes during their first pregnancy was either forgotten or not relevant to this pregnancy. This class gave the women a chance to understand the process of labour and birth and obtain information about labour from a qualified health care professional. As well as this the participants were able to ask questions that could allay their fears about birth. This way of giving information to the participants in the class can be understood as the participants gaining authoritative knowledge about labour and birth, a concept related to Brigitte Jordan in her book 'Birth in Four Cultures: A Cross-cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States' (1978), which led the way for ethnography to incorporate itself into the obstetric field and, more importantly, the field of the anthropology of birth. As Robbie Davis-Floyd states in the foreword to the fourth edition (1993):

“This book was instrumental in defining the field of the Anthropology of Birth, as well as in establishing some of its primary methods for cross-cultural comparison, analysis, and strategies for planning change. In the fifteen years since its original publication, it has served field researchers, students, theorists, birth practitioners, and development planners, becoming a “classic in the field” and a “must read” for all those interested in birth.” (Jordan, 1993, p.ix)

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<sup>11</sup> A breech presentation means that the baby is lying bottom or feet first in the womb instead of the head first position (RCOG, 2008)

<sup>12</sup> Preterm birth is a birth that occurs before the beginning of the 37<sup>th</sup> week of pregnancy (Fraser & Cooper, 2009)

I first came across this book at the beginning of this ethnography, before I entered the field to collect data. For me, as a first-time ethnographer entering the field of pregnancy and birth, I was hugely influenced by this book. As the Anthropology of Birth is a niche and relatively new area, 'Birth in Four Cultures' was a book that I constantly referred back to throughout this ethnography. It helped me to develop my thoughts around birth. This came to fruition during my analysis of the second antenatal class, when I began to think about the concept of authoritative knowledge.

Jordan (1993) explains authoritative knowledge as

“an ongoing social process that both builds and reflects power relationships within a community of practice. It does this in such a way that all participants come to see the current social order as a natural order, i.e, as the way things (obviously) are.” (p.152).

Through her fieldwork in various countries (Mexico, Holland, Sweden and the US) Jordan came to the realisation that in a society or culture there is the existence of different knowledge systems, with some being given priority over others by the population related to these knowledge systems. In this sense, one knowledge system gains domination and legitimacy, therefore becoming authoritative. This is done by devaluing the other knowledge systems that are in society (Jordan, 1993). This structural superiority can be applied to the hospital setting where the knowledge and power of clinicians can devalue the knowledge of the woman and her experience with childbirth and the knowledge that she has about her body. Yet, authoritative knowledge systems operate so that the social order that is instilled in the setting is seen as the natural order and how things should be. In a hospital setting, considering birth, it is the

clinician structure that has superiority and absolute knowledge, with other participants (namely women) believing that this is the only legitimate kind of knowledge that exists. Starr (1982) demonstrates this when observing cultural authority in a medical setting, Cultural authority refers to “the probability that particular definitions of reality and judgements of meaning and value will prevail as valid and true” (Starr, 1982, p.13) and argues that the acquisition and cultural authority by doctors “had the consequence that they came to be in charge of ‘the facts’, that is to say, they acquired the authority to define when somebody is dead or alive, sick or well, competent or not” (Starr, 1982, p.15). As Jordan states “The power of authoritative knowledge is not that it is correct but that it counts” (Jordan, 1997, p.57). It is persuasive because it seems natural, reasonable and consensually constructed. Participants not only accept authoritative knowledge, but are actively and unselfconsciously engaged in its routine production and reproduction (Jordan, 1997). Throughout the observation period, I could see this when women were asked why they had a CS the first time and their decision about birthing this time. For a number of women, they relied on the information that was given to them by the doctors and this then influenced the decision they had to make about this pregnancy. Before participating in OptiBIRTH, they did not know that they could have a normal birth and they did not know if they could try for a normal birth, but would “discuss it with the doctor when I am in with her” (Field-note, May 2014). For other women, when they approached the subject of having a VBAC, their doctor simply said “No you can’t do that, you have to have a section” (The MOL told me this when I was talking to her about recruitment This was stated by a GP (General Practitioner<sup>13</sup>). The MOL

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<sup>13</sup> Under the Maternity and Infant Care Scheme in Ireland, a programme of care for expectant mothers is provided by both their family doctor and maternity hospital. Visits to the family doctor are alternated

related to me that this was the case with a woman when she was calling the woman back about participation. The woman chose the advice of her GP and decided not to participate in the study. <sup>(Field-note, May 2014)</sup> From this, it can be seen that medical knowledge is not only privileged, but also super cedes and delegitimises other potentially relevant information sources (OptiBIRTH).

The concept of authoritative knowledge is explored in a number of studies within the maternity sphere. The last couple of decades have seen a surge in interest regarding how authoritative knowledge is constituted in various cultural settings and the differing aspects of the maternity care domain (McCoyd, 2010; Cheyney, 2008; Browner & Press, 1997; Davis-Floyd & Sargent, 1996). So much interest has been generated in the domain of maternity care and authoritative knowledge that in 1997, a rich array of essays was brought together on this subject by Robbie Davis-Floyd and Carolyn Sargent entitled 'Childbirth and Authoritative Knowledge; Cross-Cultural Perspectives'. These essays ranged from foetal ultrasound imaging and authoritative knowledge in Greece to maternal health and tradition as authoritative knowledge in Sierra Leone. This emphasises how the topic of authoritative knowledge can be translated across different cultures and maternity systems, and shows that the anthropology of birth is a fascinating and diverse domain.

Returning to the OptiBIRTH package of care, it could be suggested that a transference of authoritative knowledge may occur, with women becoming more empowered to

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between hospital visits during the pregnancy and care for both mother and child after the birth is provided solely by the family doctor. (<http://www.hse.ie/eng/services/list/3/maternity/combinedcare.html>)

involve themselves in the decision-making process, giving them power and becoming legitimised in how the decision to birth is made. Authoritative knowledge will give them status in the social structure surrounding pregnancy and birth. This occurred with the introduction of special antenatal classes and a website that provided relevant information to women regarding birth after a previous CS. With this, a conversation and support structure was developed with clinicians that allowed women to access clinicians' authoritative knowledge so that they can make an informed decision based on knowledge that was deemed important and carried weight in the hospital.

OptiBIRTH allowed women the opportunity to become embedded into the hospital hierarchy of power and into the social structure in the maternity unit. This could be seen in the OptiBIRTH antenatal classes, when women are told that they have a choice and a say in how they will birth this child and prepared them for a natural birth or a repeat CS. Women participating in OptiBIRTH are given a vast amount of information about labour and what occurs during labour, drugs they can request (epidural for example) and strategies that they can implement to achieve the birth that they want (music, birthing ball). They were also informed that all staff in the hospital are involved in OptiBIRTH and that they will know that 'you are trying for a natural birth and will give you the chance to try if all goes to plan (Stated by MOL in all classes)'. With the information provided and the encouragement of a midwife and a high-ranking obstetrician, the knowledge that they acquired from OptiBIRTH could have potentially given them the confidence to know that they have the correct knowledge to become part of the decision making process of birth. It also became evident that having an obstetrician involved and giving information to women was very important in the classes. During this class, some women asked him if they could "refer back to what you have just told us" and "tell the

doctors what you just said to us”, to which the OL agreed. To have this support became important and, coupled with them being given the knowledge to ensure status in the maternity unit, gave women a clear standing in the social and knowledge system in the hospital:

“No but I’m glad that I have been involved in the OptiBIRTH, it has informed me. Now I haven’t done any of the paper work around it but that’s a task that I must get onto. But no I found the classes very beneficial and I found that the personnel doing it were very approachable and very informative.” (Interview, W12, August 2015)

### **7.3.1 *Gaining Knowledge and Confidence***

“Yes, and they’ve made me kind of confident in that like you know ‘you can do this’ because when I originally found out I was pregnant this time, em, my GP said to me, you know your most likely to have another section because they’re so close together, and you know I kind of thought that it wasn’t an option, originally to have a VBAC, but now I do and I kinda think, ‘ok they’re gonna try and help me have one’, you know? Help me as far as possible and sure if it doesn’t work out it doesn’t work out, but at least I can go and give it my best shot.” (W3, Interview December 2014)

Throughout my attendance at the second antenatal classes (n=16) I could see that by participating in the class and asking the OLs questions, women’s knowledge attainment grew leading to increased confidence in VBAC as a method of giving birth and their preparedness for having a repeat CS, if needed, without fear.

“no the second one I actually, I’ve been telling everyone about it since I came out that I found it really, very, em, beneficial and very interesting. Just to know the facts” (W11, Interview August 2015)



By attending this class, women were being prepared for labour, were given the education to both cope with labour pains and to know what the clinicians are giving them medically to cope with contractions. The class also provided the women with information and understanding as to why they might have a repeat CS so that they can fully understand this and the process surrounding it. A perfect example of this gain in knowledge is that many of the women thought that because they had a CS that, for their current pregnancy, they could not have an epidural<sup>14</sup>:

“[The MOL] tells the woman that “you’re like a first time mum in labour”. The woman then asks “so there is no problem having an epidural?” to which [the MOL] shakes her head and tells the women “no, none at all”. The woman looks confused and tells the class she “thought that the muscles would be weaker”. [The MOL] again shakes her head at this and repeats that “no, you’re like a first time mum”. The woman looks relieved then at the fact that she was wrong about the epidural and that she can have it.”

(Field-note, April 2015)

For many of the women who attended the class, it was the practical knowledge that they gained that was extremely important to them and gave them the confidence about having a VBAC and knowing what was going on during labour and birth. This can be seen with the conversation I had with W9 below when I asked about the second antenatal class and her thoughts on it:

**W9:** Really good, yeah, I think everything that was given was just practical and to the point, there was no ‘airy fairy’, you know? (Laughs). You know, ‘this is what’ll happen’ and you know ‘we’ll check in on your date’ and ‘we may give you an inducement’ and if not...

**Int:** Yeah.

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<sup>14</sup> Epidural is a form of pain relief whereby pain relief is “obtained by blocking the conduction of impulses along sensory nerves as they enter the spinal cord” (Fraser & Cooper, 2009, p. 503). The epidural is administered to the lumbar region of the back by an anaesthetist under strict conditions.

**W9:** Do you know? I think it was practical.

**Int:** Great.

**W9:** You know that's what you want really, you don't want someone saying, you know that everything is going to be roses either, you know? Yeah. (Interview, May 2015)

It was having the healthcare professionals facilitate the class that helped women to be sure about VBAC and have the confidence to give VBAC a try as is demonstrated with

W8:

**Int:** And then just with the then with the OptiBIRTH classes, what did you find most beneficial about attending them?

**W8:** Em I think it was such em... any question you had was answered.

**Int:** Mm hmm.

**W8:** Any question now, and I thought [the MOL] was very em, she would give you all the information she had, everything, all the knowledge she was able to tell you, she'd tell your there and then or she'd say; 'I'd have to come back to you on that' it was straight to you, I like that. (Interview, April 2015)

W11 also had similar sentiments about the second antenatal class:

**W11:** No I found that they covered, em, everything I wanted to know anyway. . . I was really delighted when I came out and it was really about what I wanted to know about which is the comparison of caesarean section and all the things you'd be worried about. The risks that are associated with and what may happen and if this does happen, you know like. . . for me it was the fear if my scar if, you know. . .

**Int:** The breakdown?

**W11:** Yes, what would happen there and it was all very well explained by [the MOL] and [the OOL] so I was yeah, I was delighted with the class. . .

**Int:** Great.

**W11:** No it was excellent. (Interview, August 2015)

Throughout the classes, the women felt comfortable to ask the OLS about different aspects of labour and birth that they were unsure of or were even fearful of.

Asking questions and listening to the information that OptiBIRTH provided them about labour and birth gave them the opportunity to achieve authoritative knowledge on both VBAC and repeat CS. After the women had left the class and during my interviews with them, it was clear that they felt knowledgeable about VBAC and having both OptiBIRTH and access to the OLS gave them the confidence and support that they needed when it came to making the decision about birthing:

**W12:**Very informative. Em, I found the personnel who did it were great at answering questions if you did have any to ask. They were informative and interesting. My husband was unable to attend with me, he would have attended the antenatal classes with me, so I can come away with me now with a few interesting facts and figures, you know a few interesting things to talk about. What it really did do though was raise my awareness around, you know that, I assumed that a C-section, you were almost destined to have another C-section. What it really raised my awareness around is that every birth is different and that you kind of have to go with the experience. I think that has prepared me for the next delivery. (Interview, August, 2015)

W14 was in the position of attending with her husband:

“Yeah he thought the information was so kind of unique to our situations, rather than the antenatal classes, where a lot of it is common sense that you already know, whereas we thought that this that we learned a lot. Yeah he’s asked a lot and one of my friends, she had a section the last time and she wants to have another baby so she’s like ‘what?’ So when the time comes, I know she’ll be coming asking questions, so...” (Interview, August 2015)

With her partner attending the class with her, it could be seen that they both benefitted from receiving the intervention and the class enabled them to support each other when planning a VBAC as well as others around them.

As the OOL stated when he was asked about his outlook on the women achieving a VBAC “You have education and can make the decision about your care” (Field-note, July 2014). Combining the women’s achievement in gaining authoritative knowledge, in the second class a demonstration of power by the OOL occurs which I now discuss.

#### **7.4 Induction and Power**

While the main aim of the second antenatal class was to give information and confidence to women about labour management and birth, other issues arose in the class regarding the management of labour by the OOL. This was in relation to the induction of labour (IOL).

IOL is the process whereby labour is started artificially involving the administration of certain drugs so that this will encourage the cervix to soften and dilate. IOL is “an intervention to initiate the process of labour by artificial means and is the term used when initiating this process in pregnancies from 24 weeks’ gestation” (Fraser & Cooper, 2009, p.558). The use of IOL occurs if the woman has a prolonged pregnancy (exceeds 42 weeks), intrauterine growth restriction (the foetus is compromised if the pregnancy continues) and maternal request among several reasons.

With regards to inducing a woman that has had a previous CS, the literature is ongoing with many countries examining the risks of inducing after a CS. The HSE guidelines (2013) on delivery after a previous CS state that, with an induction of labour there is an

increased with UR and that caution should be used. Similar thoughts exist in the ACOG (2010) guideline whereby the risk of IOL is associated with UR and these sentiments are echoed by the RCOG (2015). As well as these guidelines, there has been research into the use of IOL and VBAC (Kwee *et al*, 2007; Landon *et al*, 2005; Guise *et al*, 2003). Srinivas *et al* (2007), in their retrospective cohort study of 13,706 women who attempted VBAC, found that IOL was one of the largest factors concerning VBAC with 3,988 of the cohort being induced and, of these, 1,349 had a failed VBAC. Similarly, Sims *et al* (2001), in their analysis of 505 women attempting a VBAC, the success rate for VBAC was significantly lower in women who had their labour induced than women with spontaneous labour (57.9% and 77.1% respectively). On the other hand, Agnew & Turner (2009), investigating the use of induction after a previous CS found that, of the 1,818 women who achieved a VBAC, 421 had an induced labour. Of these, 421 however, 331 (76%) achieved a VBAC. The authors thus recommended that induction can be used and that it “is important to know not only the risk of uterine rupture but also, the likelihood of a successful vaginal delivery” (Agnew & Turner, 2009, p.210). The evidence suggests, however, that the subject of inducing a woman that has a previous CS and would like to try for a VBAC is a complicated issue.

Yet, I must state that it is not my place to deem whether IOL for VBAC is considered a right or wrong thing to do, even more-so because I am not a healthcare professional. As an ethnographer looking at the OptiBIRTH intervention, I am simply trying to understand the elements of the intervention and whether introducing this intervention effected cultural change in the field site. The literature and clinical guidelines on IOL

that I have described are presented to give you some context on the medical aspect of induction, rather than presenting an opinion on VBAC and IOL. I am simply conveying what occurred and the implications of giving the women this information to use when they are considering how they would like to birth in their current pregnancy.

From the very beginnings of the second class, induction came up in conversation with the OOL, with him bringing up the case and his reasoning for induction after a previous CS. Many of these conversations centred on his practice around induction (e.g. giving the women “1/2 a gel<sup>15</sup>”) and that his colleagues in the hospital did not believe in induction in women who had a previous CS. In fact, at one of the classes that he attended, he told women when the subject of induction arose “I always get into a bit of trouble for saying this at this talk” (Field-note, 8th October 2014). This type of thinking and telling women this information, I suggest, is related to the concept of authoritative knowledge and power. The women are hearing about induction after a previous CS from a highly qualified consultant in the field-site who believes whole-heartedly in VBAC and, with this knowledge and confidence in the OOL, they are given the information for them to use in the clinic and labour ward.

This culminated in two of the OptiBIRTH women asking their doctor in the antenatal clinic to be induced so that they could be given the fullest chance in achieving a VBAC (One of the women did go on to have a VBAC while the other women had a repeat CS).

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<sup>15</sup>What the OOL is referring to is Prostaglandin, a drug that is used to induce labour. Prostaglandin is hormone that is produced in the body to induce labour naturally. However, if spontaneous labour does not occur, synthetic Prostaglandin is “generally given by the vaginal route because of the relative lack of side-effects from this route. It is used for the induction of labour and acts on the cervix and myometrium (middle layer of the uterine wall)” (Fraser & Cooper, 2009, p.913).

Throughout my time observing the classes, it was constantly stated to the women by the OOLs that “the best scenario for you is to go into spontaneous labour” (Field-note, August 2014) and the conversation then moved towards induction and why it happens.

The issue of talking about induction and the OOLs telling the women that the OOL for this field-site is the only clinician in the field-site that will induce a woman that has had a previous CS can be linked to a control and power issue; control in that the OOL has control over the woman attempting the VBAC rather than leaving it to his colleagues, and power in that he is exhibiting power over his colleagues and showing the women in the class that he may be their best chance of having a VBAC because he induces labour.

By the OOL telling women of his use of IOL brings about the conversation of power and the use of power in the second antenatal class. He states to the class that the subject of inducing a woman that has had a previous CS is “quite controversial” and saying that he is a “control freak so I know what is happening” (Field-note, 8th October 2014). In another class, when induction came up, the women were told that the OOL was in favour of induction but not the rest of the doctors in the hospital and that the induction would be in a “controlled environment” and that potentially, by the woman not being given the chance to attempt the VBAC, “someone else will section her” (Field-note, 12th November 2014). By stating this to the women in the intervention, he is demonstrating power over his fellow clinicians in the field-site and creating the idea that he is the only person that, if left to the later stages of pregnancy, will allow them the chance to attempt a VBAC through controlled induction. It is this presence of power in the second antenatal class that is presented by the OOLs that I will now move on to discuss.

#### *7.4.1 Power and Control*

The concept of power has been explored for decades in anthropological works of various settings, from gender studies to governance and political power. When looking at power in anthropological and sociological terms we can refer back to the theoretical writings of Michel Foucault (1926-1984) and Pierre Bourdieu (1930-2002). Power in sociological writings as also been described as ‘authority’ which perceives power be a legitimate entity by the social structure.

Applying the concept of power and authority to this second antenatal class, the OOL constantly referred back to the practices of his colleagues, stating that “not all colleagues are open-minded”<sup>1</sup> (Field-note, June 20th 2014) and mentioned educating his colleagues around the subject of giving women the chance to try for a VBAC by making the decision with them. From this, the women see the OOL as the main clinician in power when it came to the decision around them trying to achieve a VBAC and would ask in the class if they could refer back to his opinion when discussing their option for VBAC with their doctors at their clinic appointments if they feel the need to. They could rely on him to ensure their best interests in achieving a VBAC were at the forefront. By using induction with a woman who has had previous CS, he is telling them he will give them a chance and how he does it for “[the OOLs] women. I give the gel the night before they are booked in for a section. We give a run for it and if they are not ripe then we can go for the section”<sup>2</sup> (Field-note, January, 2015).



Control on the part of the OOL could be seen when it came to the conversation around induction, from both his control over the way the woman would birth and control over his colleagues. When discussing induction in the class, he would tell them that he uses induction as a means of “controlling it [labour] and watching it like a hawk” (Field-note, January 2015) and that “personally I’ll give my ones a chance” (Field-note, February, 2015).

#### **7.4.2 *Contrasting Opinions***

The subject of induction appears to portray contrasting opinions between the OLs. An example of this is when the OOL had not arrived to the class and the MOL was discussing induction:

“[The MOL] constantly throughout the class emphasised the benefits of VBAC, especially the recovery aspect, telling the women that ‘you can go home after 24 hours’. [The MOL] then moves on the best scenario for the women and that is coming into the hospital in spontaneous labour. Then one of the women asks [the MOL] about drugs and induction. She tells the class that ‘we don’t do that routinely’ and if they did, she reassured them that it would be done in a safe environment and they would have on-to-one care. [The MOL] then emphasised to the class that it is ‘the last step on the ladder getting the gel’ and that ‘not everyone would be suitable for it’. The women are nodding along when they are listening to [the MOL]” (Field-note, 17th August 2014).

I then supplemented this in my diary when I observed this contrasting opinion on induction and giving this information to the women in the class:

“[The MOL] does not seem to share the same opinion about induction as [the OOL]. She seems to play down the availability of being induced when the woman comes in not in labour but wants to try for a VBAC. [The OOL] proposes to the women in every class that induction is available to them and that he would even seem to advocate using induction as a regular method for this group of women. It was interesting to see that [the MOL] does not show her feelings about induction (that it would essentially be a last

resort) to [the OOL] and looks to be quietly trying to push the play the idea of induction down when [the OOL] cannot be a greater influence than herself, like this class when she had full control of the information that was being given to the women” (Diary Entry, 17th August, 2014).

Throughout the intervention, the opinions around the use of induction between the OLs did not change and the interactions that I describe above were present in the majority of the antenatal classes.

As discussed in Chapter Two (see section 2.7.2), this contrasting opinion may be due to the contrasting philosophies between midwifery and obstetrics. In the class, when induction comes up in the conversation, the MOL stresses to them that if they are induced “it will not be the case of having multiple gels” and consistently tells the women that it is only the OOL that will induce a woman: “[The OOL] is the only one, for the last chance to try and have it” (Field-note, April 2015). However, if the OOL does not attend the class, the MOL will tell the participants that the OOL does induce but “you would want to be quite favourable” (Field-note, May 2015).

As well as showing power through the use of IOL after a previous CS, the OOL with the support of the MOL created the notion of a ‘VBAC clinic’ in the field site.

## **7.5 The ‘VBAC Clinic’**

From the inception of the intervention and commencement of the antenatal class component (July 2014), the notion of a ‘VBAC Clinic’ arose both in the class and during my conversations with the OLs. This ‘VBAC Clinic’ is linked in to the concept

of power that I have previously discussed, with the OLs, in particular the OOL, embracing the idea of a 'VBAC Clinic' from the very beginning of OptiBIRTH. In the second antenatal class, the OLs and women participating in OptiBIRTH engage in a CoP and the concept of a 'VBAC Clinic' is brought up and instilled in the minds of the women. This concept begins with the OOL asking the women in every class if they are already going to his clinic. If a woman tells him that they are, he suggests to them towards the later stages of their pregnancy to ask to see him personally so that he can examine them in his clinic. If there are women in the class that do not attend his clinic, he mentions to the women about potentially changing to his clinic "because of the study"<sup>(Field-note, July 2014)</sup>. If a woman does not want to move to his clinic for antenatal care, he is supportive of their decision and lets them know that they can achieve a VBAC even if they are not being taken care of in his clinic:

"[The OOL] then moves on to the hospital and the way that his colleagues operate when it comes to VBAC. A woman then speaks up and tells him that she is seeing [different doctor in the hospital]. She tells him that she is nervous about what [her doctor] will say about the birth and about trying to have a VBAC. [The OOL] is very reassuring to her and tells her that "I will tell [the doctor] about you and that you are attending [the MOL] to which she seems to be very relieved about."<sup>(Field-note, August 2014)</sup>

After the class, some of the participants asked the MOL about moving to the OOLs clinic and the MOL said that she would organise the change for the women to move to the OOLs clinic. It was interesting to note that, at one of the classes, three of the women changed to the OOLs clinic. I saw them all there subsequently on the same day and they sat beside each other chatting about the pregnancy and OptiBIRTH. After the antenatal classes, the OOL and the MOL sometimes discussed moving the women to his clinic. Again, this can be seen as the OLs engaging in a power play through telling the women

about his stance on VBAC and how they could have a better chance attending his clinic compared to other clinicians in the hospital. The MOL told women on multiple occasions, if they already attend the OOL's clinic that they can "ask to see [the OOL] because you are part of the study" (Field-note, February, 2015). When I discussed women moving to the OOLs clinic, the MOL told me that she agreed with the idea of a 'VBAC Clinic' for the women as it could bring them continuity of care in terms of trying to achieving a VBAC and that it would be easier overall to group the women together, like a diabetes clinic, so they could be supported throughout the pregnancy.

## **7.6 Conclusion**

This chapter has discussed and explored the second antenatal class that is part of the OptiBIRTH intervention. It has shown that women are being given authoritative knowledge on their labour and birth through participation in the classes so that they are informed and confident in making the right choice for their labour and birth. The class provided women with appropriate preparation for labour and birth showing that they have control and the knowledge to know what is happening, why it is happening and how they can become involved in the management of labour.

This chapter also discussed the role of power in the field site between clinicians, culminating in the forms of proposing the idea of inducing a woman after a previous CS and the concept of a 'VBAC Clinic'.

The following chapter leaves the women's component of the OptiBIRTH intervention and focuses on the clinician aspect of the intervention.

## **Chapter Eight: The Clinician Components of OptiBIRTH: Challenging the Culture**

### **8.1 Introduction**

“...in another way it’s about trying to change the culture in the hospital, which I think the main aim of OptiBIRTH is. I’m trying to change it into a more pro-VBAC, or pro-choice, I suppose, clinical environment. Really, that’s probably been the hardest part of it.” (Interview, C7, June 2015)

The clinician components of OptiBIRTH are comprised of the clinician information sessions that are given face-to-face and are available on a website where they can access evidence-based and up-to-date information on VBAC and OptiBIRTH, and the OLS who are an integral part of the intervention. In this chapter, I will explore the clinician information sessions and how the staff in the field-site responded to the information that was provided in these sessions. In particular, this chapter will explore the effectiveness of these sessions in relation to the topic of VBAC and whether the sessions are sufficient to bring about cultural change in the field-site. I will also present a discussion around CS and its influence on the intervention, with reference to trying to achieve cultural change in the site. I will also investigate the influence that the OptiBIRTH women had on the clinicians and their importance from the experiences of the clinicians caring for these women. A further discussion will then be presented regarding the OLS and their leadership in the field-site when it came to OptiBIRTH. This chapter will conclude with a discussion on the clinicians’ views as to whether or not the OptiBIRTH intervention was seen to be effective in the field-site. Firstly, I will give you a description of the research setting in which the clinician information sessions took place.

## 8.2 The Research Setting

As stated previously (section 6.2), the majority of the antenatal classes and the clinician information sessions are conducted in an education room that is situated on the ground floor of the field-site, close to the reception area. However, because the information sessions are presented to a much larger group than the antenatal classes, the setup of the room is quite different. Figure 5 provides an image so that you can get a sense of the difference between the set-up of the antenatal class and the clinician information session.



**Figure 5: Set-up for Clinician Information Session**

The times of these information sessions varied but for the majority of sessions, they were held on a mid-week morning, before the consultants had their weekly meeting. The sessions therefore occurred early in the mornings, before the first appointments in the antenatal clinic. Among the attendees were consultants, SHOs, registrars, the

management of the various hospital departments and midwives. The MOL normally gave the presentations to the attendees and answered their questions after the presentation along with support from the OOL. As well as this, the MOL conducted information sessions at various points of the intervention with different departments of the hospital that could not fully attend the larger sessions. These included the antenatal clinic and the labour ward. These smaller information sessions were important especially at the start of the trial in the antenatal clinic as this was the main place where women were recruited.

### **8.3 The Clinician Information Sessions**

The clinicians' information session of the OptiBIRTH intervention was designed to provide evidence-based information about VBAC, including its benefits and risks, to clinicians in the field-site so that they could be made more aware of what VBAC encompasses and what the intervention was trying to achieve. Information included in these presentations, delivered by the OOLs, centred on increasing awareness around the monthly CS rates in the field-site, the risks and benefits of VBAC and repeat CS and information that was collected during the OptiBIRTH focus groups in both high and low VBAC countries which informed the development of the OptiBIRTH trial intervention. Clinicians also had the opportunity to ask questions on the intervention. Two main features inherent to the sessions for those attending the sessions were obtaining information about VBAC and creating awareness around VBAC as being a viable option for women with a previous CS.



### *8.3.1 Obtaining Information*

One of the main goals of the clinician information session is to give the clinicians in the field-site evidence-based information on the risks and benefits of VBAC so that when they are interacting with the OptiBIRTH women, they have the appropriate knowledge to help them come to an informed decision on how they could birth. In addition to assisting clinicians create an open conversation with women about VBAC, the information sessions also seemed to generate a positive framework of thought regarding VBAC as C5 demonstrates:

“Well it’s something positive, like em, I suppose in a time where things have been cut back and, like, it’s very positive for the women and it’s positive for us as staff like. It’s showing that we can actually help people to achieve what they want to achieve and. . . no I find it’s good yeah.” (Interview, November 2015)

Considering this, it becomes clearer that the clinician information sessions are a central part of the intervention’s aim to equip participants with the appropriate knowledge to make an informed decision on whether a woman could try for a VBAC if the woman had no health-related issues that could prevent a VBAC. This could be related to the concept of authoritative knowledge that I previously discussed (section 7.3) but, rather than women this time, it is clinicians obtaining authoritative knowledge on the risks and benefits of VBAC, through these sessions, for use in their everyday practice. With this knowledge, their interactions with the women participating in the intervention can then be turned into a conversation in which both parties have the appropriate knowledge about VBAC. The benefits of participating in the clinician information sessions can be seen below in an interaction that occurred during an interview:

**C1:** Oh definitely. I mean some midwives will say to me they didn't realise the chance of, em, having a normal delivery for a woman going into spontaneous labour could be as high as 75%. They thought it was something around 30%.

**Int:** Really?

**C1:** Yeah. And they didn't realise that for women who's had a previous normal delivery and a caesarean section her chance could be up as high as 90% or 9 in 10. You know this, I think. . so definitely I can see stuff that I've, information that I've been giving to them in classes or in the clinician sessions I've heard them repeating to the women which is actually great! It's really good to see that and it's a bit of satisfaction I suppose for myself but. . so I do see, I do see the benefits of the study coming through yeah. The benefits of the education sessions. (Interview, July 2014)

This example shows the importance of information that is given during the information sessions as it not only affects the clinicians in the field-site, but also the women that would have been considering participating in the intervention. It is this trickle-down effect of information that provides a backdrop for the beginnings of a positive and informed conversation around VBAC and for changing the culture whereby women with one previous CS have an informed choice on what way they might birth. C3 provides an example of this when she was asked if she had seen any change toward VBAC since the implementation of the intervention:

“Yeah. I do yeah I think it really kind of it does. . . it really encourages us to kind of have a discussion with the ladies about it and I think then the more kind of discussion they have with us they're more... like they'd be kinda want to have a VBAC then?? because they have the discussion about it. And I think it kinda gives them the opportunity to ask us any questions they might have about it so. . . I do think it really does promote discussion about it and then everyone here is going to encourage VBACs

so, em, I think it does kind of. . . it would kind of make us all more kind of pro-VBAC then.” (Interview, October 2014)

This can be seen further when the participants of the information sessions were told that the “sessions were about giving factual information so that they can be part of the decision-making process” (Field-note, February 2015) and the intervention was “emphasising the woman feeling that she is part of the decision making and that we are not trying to make the woman have a VBAC” (Field-note, February 2015). It was the importance of promoting the idea of having a conversation or discussion with the woman during the sessions that allowed for the positive promotion of VBAC in both groups of women and clinicians to change the way VBAC is talked about and seen from the clinical viewpoint. As C3 said:

“Before OptiBIRTH came in, you’d, if someone has had a section in the past you would kinda mention VBAC but it might really have, kind of, it wouldn’t really prompt a conversation about as such whereas I think OptiBIRTH, you really kinda do, you’re explaining what the study is, you’re explaining what goes on and I think it really, it kinda does make it. . . you are really trying to promote it then. You’re trying to promote people to get involved in the study and stuff so I think it really is good then because, it’s kinda positive for all of us because, like that, we’d like to see everyone have a VBAC if they can so I think it is good!” (Interview, October 2014)

### **8.3.2 *The Importance of Feedback***

Gaining feedback in the sessions on how the intervention was progressing and the VBAC rates in the field-site was also important to the clinicians. It could be seen that, by informing the clinicians on the VBAC rates in the field-site, it could encourage them to participate actively in the intervention and, if the VBAC rates were not adequate, to

promote the intervention further. As C5 stated when she was asked about the information sessions:

“Very informative and, do you know, it’s good to hear success rates. . . yeah very good yeah. . .” (Interview, C5, November, 2015)

As well as informing the field-site on the VBAC rates, during the recruitment phase, gaining feedback on the screening process and the overall recruitment of women to the intervention was important. By informing the clinicians of the difficulties in recruitment, and slow/low recruitment, it allowed for an improvement in the awareness of the intervention and in the recruitment of women. This was seen in an information session conducted in February 2015 when the session concentrated on the overall VBAC activity in the field-site. The participants of the session were informed that

“at the beginning it was ‘slow enough’ but had ‘improved substantially’ and the staff were given praise for their commitment and improvement to the screening process and were thanked and praised on the improvement.” (Field-note, February 2015)

The constant presence of the VBAC rates and informing the clinicians about them could be viewed as an important element of the information sessions. This in turn, alongside the women progressing through the intervention, generated greater awareness of the intervention, in particular awareness of VBAC.

### **8.3.3 *Creating VBAC Awareness***

Creating awareness about VBAC as being a viable option for women after a previous CS was a feature that emerged from participating in the clinician information sessions. C2, a staff member from the antenatal clinic, gives an example below of attending the

information sessions and the impact that the sessions had on creating awareness of

VBAC:

“Oh, yeah, we had one of those with [the OOL], yeah they’re good, like he only came down, he was only starting when I was at the clinic, he came down, and just basically did, you know what [the MOL] does... with the... he goes through the slides and everything like that, he basically did that too. And it was fine, like you know it really just gives you the background knowledge that you need to explain it to the women, besides them meeting the doctors, you know it’s better for us, ‘cos we’re the people they meet first and if we turn them off it [laughs] you know? Yeah, no it’s fine, it’s good.” (Interview, C2, September 2014)

As C7 related to me:

“there is definitely more of a buzz, particularly since the end of last year, the numbers attempting VBACs were steadily rising in the latter part of last year and in the last quarter of last year, and then we had our highest rate, a VBAC rate of 40% in the last month of the year, which was the highest rate for last year. So yeah, hopefully now it will continue into the new year, it will stay that way. . . .” (Interview, June, 2015)

By creating an awareness of increases or decreases in the rates of VBAC, this can affect whether clinicians invest interest in and support for the intervention. As C7, continuing from the quote above states:

“I suppose doctors change over again every 6 months and we’re trying to keep them on board right now, you know?”

Creating VBAC awareness throughout the intervention was important due to the rotation of junior doctors in and out of the field-site which would have an effect on the support for intervention and the cultural change due to the intervention.

It appeared that the women participating in OptiBIRTH had an effect on the clinicians in the field-site, by generating awareness around the intervention and by encouraging the clinicians to partake actively in the intervention. This could be seen in the various departments of the field-site but particularly in the antenatal clinic and the labour ward, through the adoption of the ‘OptiBIRTH identity’ by the women.

“[The women] were good. They had the information behind them. Em, they were very supportive and, do you know, very good and they listened and it was very empowering.  
..” (Interview, C5, November, 2015)

For C3, she found that it was encouraging the women to become more aware of VBAC and have the appropriate information and knowledge that could lend itself to the women addressing their fears of vaginal birth:

“So I think that is really good because it might kinda help alleviate any fears that they have about a vaginal delivery cos it is kind of a scary thought after a section so I think the classes are a really good idea and the online stuff as well because at least it’s kind of a place where there’s kind of facts and they can chat about it and they’ll know it’s facts whereas, do you know, nowadays you can Google anything, can come upon it, whereas at least if they have the site then they have like the facts and they know where to go for that information then if they want it. . .” (Interview, October 2014)

By women participating in the intervention and acquiring the knowledge about VBAC and what occurs during labour and birth, the working relationship between the women and clinicians was supportive of and helpful to the women achieving the birth that they wanted; a constant feature of conversations and interviews that I had with clinicians. This support for the OptiBIRTH women was found to be a positive experience for the clinicians and they found the women to be more involved in the process of labour and birth, which in turn created a positive atmosphere of motivation and empowerment:

“Those women to be honest by the time they come to us they are well informed. They are, em, they know the risks. I find those women are very motivated for a vaginal delivery. They want it, which is great and our job then is to be there to support them and hopefully achieve that, yeah” (Interview C4, November 2015)

C10 reflected that, for many of the women that came in with a previous CS, it was the women themselves striving for a VBAC and pushing this discussion with their doctors:

“It’s perhaps, you know, they’re a little bit more open to it in the clinic if somebody is very keen, if there’s a patient who’s very keen to have a VBAC they perhaps tolerate it a little bit better but I don’t think they go pushing for it themselves or it nearly needs to seem to come from the patient, that the patient is very keen to get the VBAC rather than the doctor is very keen to do the VBAC and I think that’s still the way it is.” (Interview, December 2015)

The MOL also agreed with the women being more informed about VBAC and therefore becoming more aware of the procedures that occur with trying for a VBAC. This awareness could then foster a positive and open relationship with clinicians around VBAC and allowing the participants to encourage and support each other when the time came to make the decision on birthing.

## **8.4 The Shadow of Caesarean Section**

Although the clinician information sessions did bring about an increased awareness and a more positive view of VBAC, my observations and interviews indicated that CS still had an overbearing presence in the field-site. At the start of the intervention, the attendance at the information sessions included mainly managers and the midwives of the various departments in the field-site. The reaction to the information sessions was positive, with many of the participants (on average 14-15 participants) engaging with

the presentation and asking the MOL questions about VBAC and the intervention. The participants began to engage in a conversation about VBAC and how to talk to the woman with a previous CS and what to take into account when discussing VBAC with her, like previous birth experience. However, even with the positive engagement of midwifery staff with OptiBIRTH, concern over the non-attendance of obstetric consultants and registrars at the sessions could be felt with midwifery participants asking if the consultants were on board with the intervention being in the field-site. This was an issue at the beginning of the intervention as the choice of VBAC and repeat CS was a personal preference for each consultant, with the latter being the more popular choice. An example of the presence and influence of CS as being the de-facto choice for a woman with a previous CS can be seen below in fieldnotes that were taken after a clinician information session at the beginning of the intervention:

“After the session, [the MOL] and I went down to the clinic. [The MOL] checked the charts to see if there were any eligible women for the study. . . while waiting around in the office for more women to come in we began to talk about the session and the VBAC rates in the hospital. She began to tell me how political it is within with hospital with both the doctors and registrars. She told me that a huge argument had happened between the registrars about having VBAC as a choice and having unnecessary sections in the hospital. I couldn’t believe it! [The MOL] told me that this all came about because she did the CS rates for the hospital and the individual rates for each consultant. It turned out that some of the consultants had a far higher section rate than others and that when she told [Consultant], they flatly refused to believe that was his CS rate. Overall it would seem that the intervention is generating both conversation and tension between doctors who are pro-VBAC and those who value the repeat section. It will be interesting to see if the VBAC conversation develops and the CS rates may have been a wake-up call for the consultants. But at the same time, none of the consultants have come to the information sessions so maybe a bridge needs to be established by [the OOL] to ensure that the consultants know what OptiBIRTH wants to do.” (Field-note, April 2014)



This leads into the issue of differing opinions between consultants on VBAC and how they can affect the intervention. This differing opinion could be seen when a consultant talked to the MOL about VBAC and told the MOL about the

“conflicting guidelines when it comes to VBAC and scar healing, to which [the Consultant] told [the MOL] that “you’re very positive about it” and then booked a section for [an OptiBIRTH woman]” (Field-note, August 2014).

Regarding this interaction about this OptiBIRTH woman, who ended up having the repeat CS, the MOL related to me that in this particular situation, the woman was upset about not getting the chance to try for a VBAC and that the consultant “would be a problem” (Field-note, August 2014). This attitude toward VBAC from differing consultants and the women being given a chance for a VBAC could be due to the absence of a hospital-wide protocol on VBAC. It is the consultant opinion on VBAC and their feelings toward repeat CS that can cast a shadow on the intervention and its ability to change culture as C10 demonstrates:

“Em, the consultants, they’re just hard to change there’s no doubt about it. They’re a lost cause nearly, em, and in a way I feel the more you sort of say ‘well look I’m able to get good results’, the more they nearly go against you. They say ‘that’s very hard to be as good as that so we just carry on’ so they don’t want to sort of start to make a . . . they just sort of. . . and as I say they always make the case for this particular patient isn’t suitable for the thing so. . . em, which is, kind of, I think a bit poppycock but they’re able to stand over it in their own minds. . .” (Interview, December 2015)

#### **8.4.1 Consultant Opinion on VBAC**

One of the overarching features of the clinician component of the intervention and its success was the views of the different consultants in the field-site. Many of the

clinicians believed that the influence and opinion of the consultant would determine if a woman would have the chance to try for a VBAC. As one of the clinicians commented:

“Em... yeah, I think so, but a lot of the time I think if people really want a VBAC, we kind of have to recommend that [the OOL]. . it’s kinda like, I don’t know, that’s just... he’s always kind of done them, whereas the rest of the consultants are kind of new to it I think.” (Interview, C2, September 2014)

This way of thinking about VBAC and which clinicians would give the woman a chance to try for a VBAC could be seen in the antenatal clinic also, with many of the women in the intervention switching clinics to the OOL clinic as they thought that they would have a better chance of achieving a VBAC under his care. As C6 demonstrates:

“I think it probably depends a bit from consultant to consultant. Some are more positive than others. . . em, from the hospital point of view it depends on midwives to an extent.” (Interview, November, 2015)

For many of the clinicians that I talked to in this ethnography, they believed that the chance of having a VBAC or going for a repeat CS was based on the consultant preference on which mode of birth that the woman could try, as C6 informed me when she was asked about the consultants and their views on VBAC:

“Em, I suppose it is a small bias but, em, it just... everyone has their own thoughts; it’s the same with anything, like some people will induce early and some people will leave people go overdue, I don’t know, it’s just personal preference, you know?” (Interview, September 2014)

Therefore, while the intervention in the field-site gave a positive view on VBAC and raised awareness of VBAC as an option for women, there was no central ethos or protocol regarding VBAC incorporated by the consultants. The choice of having a

VBAC was down to the consultant that the woman attended. If the consultant did not agree with the idea that VBAC was a choice or an option for the woman, then her odds of trying to deliver vaginally could be hindered. As C6 told me when she was asked about the women who came in for a VBAC “It’s actually. . . it’s actually women that are going to [the OOL] more than anything.” (Interview, November 2015). Here she is referring to the women who are coming in and trying to achieve a VBAC in the labour ward and that, from her experience, this group of women would more often attend the OOL for antenatal care.

However, as the intervention progressed in the field-site, a change in attitude towards VBAC became visible whereby clinicians became more open-minded with regards VBAC and in supporting women try achieve VBAC. This occurred in the latter stages of this ethnography (March/April 2015). Many of the clinicians that I talked to stated that they could see a change in some consultants when it came to supporting a woman to try for a VBAC.

“Yeah they’re more better inclined and the women are given a chance and, like, we’ve had a good success rate here so, like, do you know, it’s good.” (Interview, C5, November 2015)

C4 showed the change seen in one of the consultants in the field-site and the effect that it had on changing the culture around VBAC:

**C4:** Definitely. . . Yeah Yeah. . . I don’t want to mention any names or anything but I can definitely see a change in one particular consultant. . .

**Int:** That’s perfect. And how does that make the [Location] feel?

**C4:** Oh it’s good that we’re all thinking the same, you know, because if one pushes in the opposite direction that just doesn’t, you know. . . work for the woman’s

benefit you know? Cos at the end of the day you're there for the woman. . .  
yeah. . . (Interview, November 2015)

By clinicians thinking similarly about VBAC and by having the appropriate information and support, clinicians can work together with each other and with women to give the woman a chance to try to achieve the birth that she wants.

Although this change in attitude was not seen in all of the consultants, I could sense the beginnings of a change toward VBAC overall. In time, this could then change the culture around VBAC in the field-site, but in my observations and interviews with participants, a small cultural shift around VBAC and CS emerged because of the intervention. A part of this change in the consultants' opinion on VBAC could be attributed to the OLs and their promotion of OptiBIRTH and the OptiBIRTH women themselves, which I discuss later in this chapter. This change and support for VBAC and OptiBIRTH could be seen toward the end stages of the trial (March 2015), with more consultants and doctors attending the clinician information sessions to learn about VBAC and the intervention. When I asked C7 about the doctors and their attendance at the information sessions, she told me that:

“5 consultants have attended and then 2 more, they haven't attended but they have, they're always asking me questions about the study.” (Interview, June 2015)

This attendance by consultants, albeit in the latter stages of the trial, and the doctors asking questions such as the hospital rates for VBAC and if the women are enjoying the study, shows a growing interest and awareness of VBAC and the intervention that could potentially lead to a larger shift in the hospital culture.

#### 8.4.2 *Consultant Fear and VBAC*

Earlier in this thesis, (section 2.7.2) I briefly discussed the differing philosophies of care between midwifery and obstetrics. This difference was during the implementation of the intervention when discussing the plan of care for a woman who would like a normal birth. An example of this is seen below, as detailed by C8:

“I get annoyed nearly at some women being sectioned and I think ‘oh my god will you not just give her a chance?’ and, you know, ‘why? This is ridiculous rushing in and sectioning this woman’ and some things you can stop. Last night we stopped a section, a lady with two previous normal deliveries and we definitely changed the course of her. She was signing for a caesarean section but as the manager, I rang the consultant. I wasn’t happy with the plan of care. You know, this isn’t the first time that I’ve done this. As the manager, as the person in charge I suppose having the knowledge makes you comfortable to talk to consultants and I suppose it makes you comfortable that you know that it’s not the right plan for this woman. She’s not happy with it. You can change this.” (Interview, December 2015)

As OptiBIRTH aims promote normal birth after CS which is more aligned with the midwifery philosophy of care (i.e. birth as a normal life event), a battle between midwifery and obstetric models of care began to emerge during the intervention’s presence in the field-site. Many of the midwives that I talked to could see an overall increase in the use of interventions during labour and birth, most notably inductions and CS, and this was a huge frustration for them, with many pondering with me the reasons behind the increase.

A prominent feature of these conversations was fear of litigation, which appears to be a significant worry for many in the obstetric arenas. Research supports this notion and has

shown that the fear of a litigation malpractice suit can have a serious effect on the rates of CS resulting in physician's practicing what is termed 'defensive medicine' (Minkoff, 2012). Yang *et al* (2009), in their investigation of the effects of malpractice pressure on the rate of VBAC and CS in the USA, found that the pressure of malpractice lowered VBAC rates, especially with regards to higher malpractice insurance. The fear of a malpractice lawsuit at

“complicated deliveries are considered to be a clinical area where defensive practices are widespread, only much larger effects would lead us to believe that the increased use of cesarean section due to defensive medicine considerations has been the driving force behind increases in either cesarean section rates or obstetrical care costs” (Dubay *et al*, 1999, p. 519)

This in turn leads to a fear of normality in childbirth with obstetricians:

“There's been a lot of high profile cases, high profile obstetric cases I think that's had an impact. I hear obstetricians talking about it and I think it influences their practice. . . . And I know this is the way but I know other hospitals are really trying as a result of this, they're really trying to focus on normality and I feel this is where this hospital needs to go next. It's trying a drive towards normality before. . . you know I feel there needs to be a focus on normality in a way before and then VBAC as part of that. I feel there needs to be more of a culture change but I think this year has been particularly hard because of what's happened. I think, again this is only my opinion but I know, I hear obstetricians talking about it.” (Interview, C8, December 2015)

The intense fear of litigation can be seen to be at odds with the concept and meaning of the OptiBIRTH study, with its aim to promote normal childbirth. The fear of litigation could be one of the forces that could prevent the cultural change toward a more open conversation around VBAC. C6 stated that:

“[the OOL] is unusual in that. There's much more. . . it's litigation, it's the barrister on your shoulder all the time that has them so. . . and actually [Laughs] I don't know if this

is going to you're probably not involved in any research into this area but I can never understand why the barristers are saying. . . they're really driving obstetrics and what happens and what doesn't happen. They've way too much influence in it. They need to be told 'actually that's not reasonable', you know, it's. . . I find that very disappointing.” (Interview, November 2015)

It would seem that the changing the culture around VBAC is linked to the larger concept on an ethos of normality in birth, which includes VBAC as the C8 demonstrates:

“So it's not just about VBACs it's a general focus towards normality. VBAC has to be about normality if you're aiming towards it so it's not just, I don't mean just the necessary VBAC. . . probably the whole ethos” (Interview, December 2015)

The lack of a major focus towards normality during the birth process was thus a major concern for many of the clinicians.

## **8.5 The Opinion Leaders**

The presence of OLs at each intervention site were a major component of the OptiBIRTH intervention. OLs (one clinical midwife and one obstetrician) were employed to become the point of contact for study participants, to drive the intervention, to facilitate the educational sessions and antenatal classes, and to advocate for VBAC as the first choice for women unless otherwise medically indicated. The OLs were individuals whose positive attitudes and behaviours towards VBAC would serve as a model for others. Therefore, because of their responsibilities, it was important for this ethnography to discover what effect, if any, the OLs had on the clinicians in the

field-site. I will discuss the OLs and their relationship with the women in OptiBIRTH in the next chapter.

### ***8.5.1 The Faces of OptiBIRTH***

“It’s good to have an identifiable person definitely. Definitely. Em, cos then if you have any queries or even just to say to her ‘oh I had a lady the other day and she was part of the study’ cos she will know, she’ll remember, [the MOL] is great for remembering the women. Em, it’s just lovely, you know, and it’s lovely for her then to see this is working do you know.” (Interview C4, November 2015)

The quote above supports having an identifiable figure related to the OptiBIRTH intervention as being important to the clinicians in the field-site. The presence of the resulted in the clinicians being more comfortable with the intervention by knowing that the intervention was being promoted in the site. The presence of OLs in the field-site also provided the clinicians with a go-to person to ask questions pertaining to individual women. As C5 demonstrates when asked about having the OptiBIRTH OLs in the field-site:

“Yeah. Good, they’re a good asset. They’re extremely good assets. No but they are like, em, they’re kind of. . . they give a feel-good factor like, they have a belief that this woman can do this and they have a belief in us as staff here in the hospital to support the women through labour.” (Interview, November 2015)

As well as being an identifiable person when it came to the intervention, the OLs also acted as a reminder for the clinicians of the study during its implementation. This was especially important during the recruitment phase in the antenatal clinic. As eligible women for the intervention could come in at any time during any day of the week, by



having an identifiable person promoting the intervention ensured that there was a constant presence and reminder to the staff to screen potential women. Because of the OLs being the ‘face’ of OptiBIRTH and having a presence in the clinic, through time, the intervention could settle in the clinic without requiring a reminder. This appeared evident towards the end of the intervention, with many of the antenatal staff continuing to screen if I or the OLs were not present:

“... at the minute I suppose it’s all down here that’s in my head but I think down here we are very good because we know ye are always around, I think if, do you know, when you’re here it’s probably always ‘no, ok, right we have to, we’ll get them to talk about OptiBIRTH now’ so I think down here we are good because we’ve started putting the forms in all of the charts for the bookings and then if when we’re doing the bookings if the girls aren’t suitable we’ll just take the form out of the chart again and put it to the side but it kinda makes you think then, it really brings it into your head ‘ok if she’s suitable for an OptiBIRTH I’ll have the form here’”. (Interview, C3, October 2014)

### **8.5.2 Sources of Information**

The OLs, in addition to being the ‘face’ of the intervention, were also a source of information on VBAC and on the OptiBIRTH intervention. While many of the clinicians did attend the information sessions, it was having the OLs present beyond these sessions that became their main sources of information. A website for the clinicians was included as part of the intervention and participants were told during the clinician information sessions that the website included the presentations that the OLs had shown them and up-to-date current literature on VBAC and its risks and benefits. At the end of the information sessions the username and password would be presented to them on the screen and they would be encouraged to go to the website to educate themselves further on OptiBIRTH and VBAC. However, through my conversations

with clinicians and the MOL, it would seem that the movement on the website was minimal and that many of the clinicians had chosen not to use the website as a source of information. It would appear that the clinicians preferred the OLs as their source of information as they were a consistent presence in the field-site and that they would be able to answer any questions that they may have regarding the OptiBIRTH women and the intervention itself. When C4 was asked if she had heard of the OptiBIRTH website she told me that “No I wouldn’t be familiar with that.” (Interview, November 2015). She found having the OLs and being able to ask any questions about women that have come through the labour ward that were part of the intervention, was preferable.

However, that is not to say that the website was not an important source of information for the clinicians in the hospital. The MOL stated in an interview that:

“I know a couple of the regs did. Midwives I know some of them definitely came up. . . a few midwives came up to me, even though I gave the, em, username and password at the sessions, they would come up afterwards maybe or at another time looking for it. And students would. . . em, definitely midwifery students would. Definitely some of the regs did. Whether they logged on I have no idea but. . . yeah. . .” (Interview, December 2015)

Therefore, the OLs could see that there was interest in the website, but a measurement of use was not taken and ultimately access to the OLs was more important as C2 illustrates:

“Yeah, yeah you need to have someone who is approachable for it I think, because if you were in any way nervous about it yourself or if you didn’t think it was good, you need someone you can go to and say ‘look this is what I think about it’, but to be honest I haven’t met anyone who has any problem with it.” (Interview, September 2014)

## 8.6 Conclusion

The clinician component, although effective in some way by increasing awareness of VBAC, has some way to go before it will result in lifting the shadow of the modern view of CS and obstetric interventions. The clinician information sessions, through the participants obtaining evidence-based information on VBAC and generating awareness on VBAC and the intervention, can open the way for clinicians to have a conversation with women about the birth they would like to have. In gaining authoritative knowledge on VBAC through the information sessions clinicians could lead the way in changing the culture around VBAC as a viable method for women with a previous CS.

While many of the clinicians were positive regarding the effect that the intervention had on the women who participated in OptiBIRTH, it would seem that cultural change was slow with the clinicians in the field-site, which they acknowledged. However, with this acknowledgement, cultural change was still seen by clinicians, albeit in a small way.

With continued support and education of clinicians surrounding VBAC, gradual cultural change could occur.

It would also appear that the OLS, as part of the OptiBIRTH intervention, are crucial in generating awareness and maintaining the position of VBAC in the field-site. Rather than access the website, it is the OLS and the information sessions where the clinicians go for information on OptiBIRTH or to ask questions on VBAC. It would seem that having a person as the 'face' of OptiBIRTH in the field-site is more effective than the online tool. The OLS, by being a source of information and a constant presence in the

field-site for the intervention, did seem to generate a more positive culture around VBAC for the clinicians.

The next chapter explores the perspectives of the women participants and the experiences of the OLs after they have completed the OptiBIRTH intervention as well as the reflections from the OLs around their experience of participating in OptiBIRTH and their feelings on cultural change and the intervention.

## **Chapter Nine: After OptiBIRTH**

### **9.1 Introduction**

The chapter explores the feelings and perspectives of the participants after they have completed the OptiBIRTH intervention. It will explore and attempt to understand how the participants felt after completing the intervention. In this chapter, I will explore what participants took away from their involvement in the intervention, in particular their feelings around their labour and birth. A discussion will also take place in the chapter on the participants' overall feelings of OptiBIRTH and what they found beneficial to them as well as recommendations on what could have been more effective. Overarching themes that emerged from the data included: Encouragement, being given a chance, and having the appropriate information was of importance to the OptiBIRTH women. For the women that had a repeat CS, their participation in OptiBIRTH was still of significant importance to them. The specialised website that was available to the OptiBIRTH women will be explored, similar to discussions in the previous chapter on the clinicians' website, and I will look at the participants' feelings and opinions towards the website.

In addition to examining the experiences of the OptiBIRTH women after they have completed the intervention, it was also important to investigate the OLs and their experiences of being part of the intervention. It is important to understand the

relationship the OLs had with the intervention and the participants so we can ascertain if they were valuable in the field-site.

## **9.2 Feelings after OptiBIRTH**

The women that I contacted after they gave birth were a mix of women who had a VBAC or had a repeat CS for various medical reasons. This was interesting for this ethnography because I could also explore the feelings of the women who had a repeat CS with regards to participating in the intervention. I interviewed the women after they had completed the intervention at 10 to 14 weeks postnatal. The interviews were conducted in this time-frame to allow a sufficient time to pass for women to recover from the birth, especially if a woman had a repeat CS, and time to reflect on her birth experience, while simultaneously not allowing too much time to pass that recall might be an issue.

### ***9.2.1 Gaining Information***

The women that participated in OptiBIRTH found that, after their birth experience, the intervention had been very informative for their birth and that, linked in with becoming informed on VBAC, the information gave them the encouragement to pursue planning for a VBAC.

“Ah it was very informative in fairness like, but as you say, like they gave me great kind of encouragement that there was a good chance that I would have a natural birth like. In fairness, they can see from my previous experience where, say, it was all running smoothly but then things didn’t go to plan for me. There was nothing OptiBIRTH could do about that but the classes were very informative. They were very helpful.” (Interview W3, August 2015)

For the women that went on to have a repeat CS, the intervention was a positive experience for them and they enjoyed becoming informed about VBAC and being given the chance to have a natural birth after a CS. The information that was given to them in the antenatal class was encouraging and they felt better equipped with labour and birth due to their participation in the intervention, as can be seen with W10:

“so I got to the second class and I did find that very informative and, you know, I came out feeling positive about the whole thing and really hoping I could have the natural delivery and it was very good like. . . I’d pass on tips now that I got. . . em, my younger sister is now expecting her first baby and she’s actually hasn’t had her first appointment yet she has it in a few weeks but she, em, I think she’s under [the OOL] clinics, you know, even though it is her first I’d still pass on any good info I got from it. So, no I was happy with the whole experience overall.” (Interview, W10)

This indicates that the information that the women received in the antenatal classes and throughout the intervention was of benefit to them, even if they had a repeat CS. The women felt more confident about labour and birth, both repeat CS and VBAC, and could now pass the information along to other family members or friends that would also benefit from their maternity experience. The perception of the women regarding the intervention was positive, and from the women that I talked to after they have given birth, it was a happy experience and they did not regret participating in the intervention, irrespective of their mode of birth outcome.

“yeah I was glad that OptiBIRTH gave me the option of thinking about it a little bit more and you’re a bit more informed, so yeah, that’s been my experience”. (Interview, W12)

### **9.2.2 *OptiBIRTH Encouragement and Support***

OptiBIRTH gave the women encouragement and support through their pregnancy and the decision that they made about planning for a VBAC. Even if it was the case that they did not have a VBAC, the women reflected on their OptiBIRTH experience in a positive light, with W3 saying that

“I definitely had more positives this time than the last time like so” (Interview, August 2015)

W3 looked at the whole experience in a positive way and did not feel that she had been robbed of having a VBAC. It was the attendance and participation in the classes that allowed her to have the knowledge about having a VBAC that allowed her to come to terms with having a repeat CS:

“Like in fairness after having a section, what they tried to explain in the classes was, you know, what would happen if you were to have a natural birth. So they really couldn’t have explained anything clearer for anyone who had a previous section like. They had all of these explanations off perfectly. It was just nature taking its own course then whether it would work or not like.” (Interview, August 2015)

W10 also felt the same way in the encouragement and support that she was given through her pregnancy and birth:

“so yeah, I found OptiBIRTH good that I got the support throughout and that, you know, like [the OOL] was absolutely excellent and right up to the end he was a great support and he tried everything, you know, in his power to give me what I wanted, like the natural delivery but obviously things don’t always work out the way you plan and look in the end, even though I had little complications afterwards when I go home I was still happy that it was a section in the end just because I could have been a lot worse off maybe if it was an emergency section or if, you know, if I had gone ahead with the natural and I could’ve been really in a bad way afterwards so, you know, it was probably a good thing in the end” (Interview, December 2015)



By being encouraged and supported by the intervention and the OLs, it allowed them to come to terms with having the repeat CS and to accept the CS by knowing that they were being given the opportunity to plan for a VBAC. The repeat CS was not the first option but rather a plan B that was in place and that the women understood and accepted:

“Yeah so that was it. So I tried everything. I tried everything under the sun to go naturally but they said that it wasn’t safe for me to continue and, you know, when his head was too high so that was it basically yeah. I had him by section then in the end so. . . when I found out that he was that big, you know, even the midwife that to me in the . . . theatre they said like, you know, it was probably going to be an emergency section even if I had gone myself.” (Interview, W10)

The quote above illustrates that the woman was informed of why she was having the section and there was an open conversation between her and her health care professional about her chances of having a VBAC. W10 was given the chance to go into labour to achieve a VBAC but this did not work out for her. She knew why she was having the section but also knew that she did her best and was supported and encouraged beforehand to try and have a VBAC.

By participating in the intervention, the women were given the information to allow them to feel safe and comfortable with the choice of planning for a VBAC, but also knew the process of a repeat CS and the reasons why a VBAC could not be a choice for them. For many of the women that attended the classes, their first section was an emergency CS and a traumatic experience for them. They did not know the process of having a scheduled CS. The involvement in the intervention allayed their fears about having another traumatic experience and, if it came that they could not have a VBAC,

helped them come to terms with having a repeat CS. Participating in OptiBIRTH

allowed the women to feel more comfortable with their decision to try for a VBAC:

**Int:** And ... participating in OptiBIRTH, has it affected how you've planned the, for the birth for this baby?

**W6:** No, but it, it has reassured me that it's, it's, that I'm doing the right thing.

**Int:** Yeah.

**W6:** That I've chosen the right path as opposed to just going for another c section. I really, I want to experience, as painful as it's going to be, (laughs) I want to be able to experience labour. (Interview, May 2015)

W12 found that, through participating in OptiBIRTH, the awareness that she was given on having a VBAC was encouraging for her to plan and have a VBAC and that it was because of the intervention that she believed that VBAC was an option for her.

OptiBIRTH gave her the information and support to plan and achieve a VBAC and her realisation of how much she wanted a natural birth.

“So what did OptiBIRTH give me? It definitely heightened my awareness around the possibility that I would be able to have it and it kind of whetted my appetite to be honest to have a vaginal birth because to be honest I hadn't really given it any thought the time before because it just happened so fast and it did kind of show me the benefits of going naturally and so on so it was more heightened awareness at that stage.” (Interview, December 2015)

Overall, the OptiBIRTH study allowed the women to realise that they could have a natural birth after a CS and, through information given through OptiBIRTH and by having the support of the intervention behind them, it gave the women a positive experience of the intervention and of trying to achieve a VBAC. The women did not have regrets in participating in the intervention. This was true for both the women that had a VBAC and the women that had a repeat CS for various reasons. In this sense,

women who participated in the intervention found real benefits from what OptiBIRTH provided them and they came away from experiencing the intervention more informed and encouraged to plan for a VBAC.

“I was glad that I took part in OptiBIRTH. Of course I won’t have the option again because I had the two sections, that’s your decision made for you. But it didn’t work out for me but I don’t have any regrets.” (Interview, W12, December 2015)

Therefore, the antenatal classes were seen as a positive aspect of the OptiBIRTH intervention and had a great influence on the women.

It could be said that women’s participation gave them personal benefits as a pregnant woman. This perceived personal benefit appears to centre primarily on learning about their pregnancy and their decision around mode of birth after CS. Research conducted by Ferguson (2000) also confirmed the importance pregnant women place on the personal benefits that could be achieved when deciding to participate in a clinical research trial. This study demonstrated that a large percentage of samples (52-87%) in his study decided to take part in the clinical trial because they believed they would receive better treatment during their pregnancy and labour. Founds (2007) was confident with this theme in her research on breech pregnancy. The women who participated in this study, which qualitatively examined women’s and health care providers’ experiences of breech during labour, wanted to make sure that they were informed to the best possible standard in relation to breech birth so that this health information could benefit them in the best possible way if a breech situation occurred. When Lamvu *et al* (2005) examined racial differences among pregnant women participating in research, they found that personal benefits, which included access to

free ultrasounds and pregnancy tests, as well as learning about pregnancy health, featured particularly strongly among the black population in relation to their decision/willingness to participate. According to Lamvu *et al* (2005, p.169), “a total of 30.7% of black women stated that they entered the study primarily to learn about pregnancy health in contrast to only 6.0% of white women who participated”. The concept of having personal benefit through participation in a trial has been noted by Barnett *et al* (2016) in which they found access to perceived better healthcare for themselves and their child was the reason for participating in a trial, with the opportunity to learn as one of the main reasons for staying in a study. This was also seen by Kost *et al* (2011) and Stunkel & Grady (2011) in their review of the literature of healthy volunteers’ motivations for participation in research.

This personal benefit of participating in the OptiBIRTH intervention can be seen with the women that I interviewed after they had completed the intervention. Participation in the intervention was a great influence on their knowledge of birth after CS and their participation could be seen as a personal benefit to them as they had options for birth after CS. It could be seen with the OptiBIRTH women that, even if they did not achieve the birth that they wanted, they had a positive experience with the intervention and gained something from participating, from information to confidence in their decision to the knowledge that they were not alone in making that decision as they had the support of other OptiBIRTH women and the support of the OLs.

### 9.2.3 *The Opinion Leaders*

While looking at the journey of the intervention in the field-site and the experiences of the participants of OptiBIRTH, it is also important to explore the relationship the women experienced with the OLs and the OLs' role in OptiBIRTH.

**W6:** I thought she was very, em, eh... she just presented everything very well, she was very calm, em, and I like the way that she didn't automatically, I don't know, you have this thing, when you, when you want to have the epidural, you have this thing where you think 'Oh I'm, failing, I'm not doing it right'.

**Int:** Ok

**W6:** But she was very much positive about, if you need it you take it, you take whatever you want and you ask for it, whatever you wanted. Which is, em, reassuring.

**Int:** Yeah.

**W6:** Em, 'cos you know, you're just, you have that fear you'd ask for it and they'd go, 'Oh no, no you're fine! you don't need it!' (Interview, March 2015)

The OLs brought comfort and support to the women along their journey toward trying for a VBAC. Even if it became the case that the woman could not have a VBAC, their feelings towards the OLs, in particular the MOL to which they had the most contact, were ones of encouragement and support as W3 demonstrates:

“At the appointments I used to meet [the MOL] when the appointments were due and she'd always be asking me how I was getting on and she was lovely now in fairness to her. She was always 'if you have any questions, give me a buzz, give me a call' and she was really nice now in fairness. They couldn't have done any more than they did for me anyway, do you know?” (Interview, August 2015)

W14 had similar sentiments about the MOL:

“Excellent. The [MOL] was so good at explaining stuff and I found out way more about, even about the last pregnancy and why I had the caesarean section and what went wrong. She just puts your mind at ease about everything so...” (Interview, August 2015)

It was clear that having the MOL present in the antenatal clinic and being available to the OptiBIRTH women was a great comfort and support to most of the women. Yet, for many, this idea of support went further. For a number of the women, the support offered by the MOL was of great importance and being able to discuss any problems with the midwife was perceived as a great benefit. Barnett *et al* (2016), in the study that has been mentioned above, found that the research staff was a very important contributor to women participating in the study and the development of a relationship with the research staff also yielding a positive impact on retention. The relationship that participants have with the research team was of great importance (Kost *et al*, 2011). Morris & Schneider (2010), in their study of research participants experience participation in diagnostic technology for breast cancer found that the social relationship between the participant and the researcher was an extremely important aspect of the study and that it should be given consideration when putting research into practice. Placing this in relation to the OptiBIRTH intervention, it could be seen that the OLs and the relationship that the participants had with the OLs, in particularly the MOL, was of importance to the women and a relationship that great value was placed on.

By having the presence of the OLs throughout their pregnancy, who are healthcare professionals that work in the field-site, gave them the encouragement and support that the women needed when they concluded the antenatal classes. This was even true during the labour and birth as W10 showed. She had been given the opportunity to try and go into labour under the care of the OOL but it was deemed that it was safer for the

baby to have a section. Even with this decision, there was support from the OOL that made her feel supported in the decision to have a CS:

I think they made the right call and, you know, they put him under and no distress and it could've turned out a different situation if they had chosen 'maybe we'll see can you go yourself' and, you know, it could've been putting him in danger and I felt like that they didn't want to do that, that they were very careful not to do that. So I was very happy yeah with my experience and [the OOL], I actually met him in the corridor before I went down for my section and he obviously had heard, you know, because he wasn't in that morning when they tried to break my waters twice so I think he came in later on that morning so he obviously heard from somebody, em, that I was, you know, down for the section so he came over to me and I met him in the corridor and he just, em, wished me the best of luck and, you know, just said that he was sorry it didn't go kinda the way I wanted it to go so. . . no I was very happy now. (Interview, December 2015)

### **9.3 The OptiBIRTH website**

A component of the OptiBIRTH intervention that I have not yet detailed in this thesis is the experience participants had of the OptiBIRTH website that was designed for the intervention. The website was available to all of the women that participated in the intervention and included information that was presented at the antenatal classes. The women had access to the OptiBIRTH presentations if they did not attend the antenatal classes, information on VBAC and repeat CS and testimonials from women who had a VBAC or repeat CS. The website also provided women with access to three apps that were released at specific stages during their pregnancy. The aim of the apps was to help women to design a birth plan for themselves that they could share with their clinicians. Once the woman had filled out the consent form and returned the form to the MOL, she would then be provided with a unique username and password to access the website.

While many of the women that I interviewed had, at least once during their time in the intervention, logged on to the website, many of the women did not rely on it for their information for VBAC:

- Int:** Em, can I then just ask, have you used the website?
- W9:** I did early on; I haven't used it in a good few weeks.
- Int:** Mm hmm.
- W9:** But I used it, when say I first got the information, I went on and logged on and had a look but... I find I'd be using the leaflets from the class,
- Int:** Ok.
- W9:** . . .more so than,
- Int:** Yeah.
- W9:** Actually logging on. Well because, I think the website, although it was good, I think... the videos are a bit too long. (Interview, June 2015)

Many of the women who attended the classes relied more on the leaflets, the OLS and the presentations in the classes for their information on VBAC. With the nature of family life, some did not get the time to use the website but attended the classes for their information on VBAC. W10 told me this when I asked her had she accessed the intervention website:

“I didn't no. I didn't use the website because to be honest I didn't get a chance to. . . a few times close to the end, you know, I went to try, get my bits together and log in and I'd been given a password and everything but just with [NUMBER] young kids at home I just didn't get the time” (Interview, December 2015)

The website was not seen as an important part of the intervention for some. But for others, it was a place that they could rely on for information:

**Int:** And how did you find it?



**W8:** Eh, it's ok, it's ok, it's a bit hard to navigate, loads of information, em, it was good, you know?

**Int:** That's great.

**W8:** It's good to go someplace that has all the information that you want, do you know what I mean? With experiences about having a section or not having a section you know? (Interview, June 2015)

### **9.3.1 Access and Opinion**

One of the main concerns regarding the intervention website was the access to the website itself and the apps. Some of the women had difficulties with the website and found the classes, where they could interact with other women and the OLs, more beneficial:

**W3:** Em, I thought it was excellent, I really did, I... I didn't really look at the website, I tried to download the app once, em, it didn't, I wasn't successful so, kind of actually forgot about it then, em, I kept the diary, and, eh I went to the two antenatal classes which I found brilliant. (Interview, February 2015)

W5 had some issues with accessing the website but found that, while the information was good, the presentations were long:

**Int:** Ok, and have you used the website?

**W5:** Just last night actually I had a little bit of problems getting on to it, but I had a look at it last night

**Int:** And what were your feelings on the website?

**W5:** Em, yeah, it was good, I thought it was good, there was a lot of information on it, em, just on the videos I thought they were a little bit bland, as in just eh, you know, just for yourselves to know, in, eh, it was just kind of like slides and someone just talking over the slides. (Interview, March 2015)

However, even with the difficulties with access, the women did use the website during their time in the intervention and found the information and specialised apps to be helpful to them when deciding to try for a VBAC. However, as I interviewed only women that attended the antenatal class I acknowledge that these women may have preferred the antenatal classes as they made an effort to attend them. Yet, it could be seen that, for the women that used both the antenatal classes and the website, it was the personal contact with other women and health-care professionals that was valued more and perceived to be more beneficial to them:

**Int:** So then, just then in terms of all about the website and the classes, what aspects of Optibirth do you find most beneficial to you?

**W6:** To me I found the classes much more beneficial,

**Int:** The classes?

**W6:** Yeah I need hearing the other, eh, women's stories, em, and just the whole, eh, learning about the whole process of ... that, that it is slightly different. (Interview, May 2015)

This relates back to my earlier chapter (Chapter Six) and the concept of identity that the women created by attending the antenatal classes. While they gained knowledge and information about trying for a VBAC and what occurs during labour and birth, the women were comforted by the fact that other women were trying to achieve the same thing they were and these women were not alone in what they wanted from planning a VBAC. As well as meeting other women in a similar situation to them, the classes were preferable to the website due to the presence of the OLs and the ability to ask health-care professionals questions pertaining to their previous birth and questions on having a VBAC:

**Int:** OK, yeah yeah. And can I just ask you, did you use the OptiBIRTH website?

**W12:** I did once. I did once, I attended 2 classes and I did it once at the beginning but I didn't go back to it, no.

**Int:** OK, can I just ask, did you just prefer the classes over the website?

**W12:** Yeah, I liked the face to face and the way you can ask questions, you know it's much I suppose, I did I preferred the classes. Not that there was anything wrong with the website it's just that I didn't revert back to it. I felt that the classes were giving me the information that I needed. (Interview, W12, December 2015)

For the women that attended the antenatal class and accessed the website, the antenatal classes and the presence of a health care professional was deemed to be of higher value to them. W14 illustrates this when I asked her about her thoughts of the information that she received through OptiBIRTH:

“Yeah, well.. I had known a lot of it because I had researched kind of bits already but the bits she said about what will happen this time and how long you will be left and the different statistics there were really good. I suppose knowing all the different facts and figures for the different rates of VBAC and repeat sections and the risks and the. It was very good knowing everything like. She explained it a lot more than the website does. I suppose the website is good but hearing it from a midwife and me being able to ask the questions back made the classes a lot better for me personally than the website” (Interview, August 2015)

In the majority of the antenatal classes, the MOL brought up the topic of the website and asked the women whether they had logged on to the website and their opinions on the website. Many of the women that attended had not yet looked at the website but for the women who did, they had many opinions on the website:

“While we were waiting for [the OOL] to come down to the class from the labour ward, [the MOL] took the opportunity to ask the women about the website and if they had used it. Two of the women in the class said that they had used the website. [the MOL] then asked the women what their thoughts were on the website. Both of the women had issues with accessing the website with their username and passwords. But after this

issue was resolved the women did not really think too much about the website. They thought that the website was a bit hard to get through, especially when it came to looking at the apps that were provided. Also, one of the women that had used the website said that ‘it’s not very appealing to look at’ and overall the feelings towards the website weren’t that good. Throughout all of this [the MOL] nodded her head, maybe in understanding or agreeing with them I don’t know which” (Field-note, May 2015)

The MOL also reiterated some of these sentiments to me when I interviewed her at the end of the intervention:

“Em, it’s fantastic. I think probably a couple of things could have been. . . and I know things were tweaked along the way and, you know, try and improve the, em, the user-friendliness of, eh, say the website. Probably not the most user-friendly of websites. A lot of women would report to me whether it was in the classes, I got a lot of emails from women, em ‘this isn’t working, unable to log in’ . . . problems.” (Interview, December 2015)

She also pointed out that the women would have liked it on their phones, but was positive in her talking about the website to the women:

“. . . a lot of women looked for it to be available on their phones cos, to be honest, not a lot people really turn on their laptop these days unless they’re doing work, it’s really just the phone. Em, but I understand the reason why you couldn’t have it on the market it was a study and once you explain it to them it’s fine. But if there was a way around that it would have been. . . better and we would have seen higher numbers using it.”  
(Interview, MOL)

During the implementation of the intervention, OptiBIRTH and its various components could not be available in the way the women wanted but this information could be useful if the intervention is deemed to be effective and is placed in other units.

However, it could be seen that the website was not an important component of the intervention. The women that I interviewed found that the face-to-face communication with the OLs in the antenatal classes to be of much more benefit to them and that the website was a consistent secondary thought to the class. This could be due to the fact that the website was not available on their phones or that there was not much emphasis placed on the website by the clinicians. While the website is part of the intervention, the antenatal classes seemed to foster a more positive image of OptiBIRTH in the field-site and the antenatal classes were viewed as the main component of the intervention.

Therefore, it could be suggested that, if the intervention is deemed to be effective and is placed in other units, a focus on access and improvement of the website component of OptiBIRTH would be valuable to the participants. This could include access to the website on their phones so they could access information at any place and time, such as waiting to see their doctor at the hospital, and improvement to the log-in of the website and making the presentations and voice-overs more positive and exciting to the viewers. This may have the effect of increasing the use of the website and women becoming more informed about their choice of trying to have a VBAC and discussing this option with their health-care professional.

#### **9.4 Reflections from the Opinion Leaders**

The OLs were an important aspect of the intervention in the field-site for both the women and the clinicians. It is therefore important to understand their experiences of undertaking the role of OL and how they themselves felt the intervention operated in the

field-site. For the most part, the OLS seemed to grow into the role as the intervention progressed and this allowed them to enjoy the role more in the field-site. While they had some opinions on what could have potentially been changed in the intervention to better suit the participants and the field-site, they found the intervention to be extremely beneficial to the participants and enjoyed their experience.

“I’d change a few things I suppose. . . I didn’t see OptiBIRTH as anything that could be harmful to a woman . . . . I think the information sessions are really good, they’re really, really good. Em, I think the information regarding having another vaginal delivery or having a caesarean section, women love getting that. They really pay attention. Partners really pay attention to that. They enjoy hearing about the labour again because for some of them it’s been a few years they’ve forgotten things. They want to know what’s changed in the hospital, what pain relief they can have and what’s safe to have when they’ve had a previous caesarean section. So definitely that. . . well they don’t particularly want to go to a whole set of antenatal classes again so really what I would love to see coming from OptiBIRTH is, em, those classes, those sessions built into their antenatal care whether it would be in the form of a VBAC clinic or just go to the normal clinic and have two extra appointments in their antenatal care. I don’t see what’s wrong. . . I don’t see, to be honest, how that could be difficult but I think that would be fantastic to do.” (Interview, MOL, December 2015)

The OOL had similar sentiments about his experience and it broadened his views on other aspects that could be changed in the field-site:

“Yeah. I like the classes. I don’t know whether they’re worthwhile because of the take-up. It’s tricky but maybe we should look for patients to ask to be informed and every so often have a meeting if they wanted to have the meeting on it. It just makes you think should you be doing that for things like twins, teenage pregnancy etc. Should you get groups and just talk to them as a group. These are the sort of things you can look out for which we don’t particularly do and maybe we should break patients into some sub-sets and bring them through together and give them a bit of. . . I quite liked the comraderie of them, seeing each other and certainly we got quite good results of the patients that came to the study, I think that was good.” (Interview, December 2015)

On the clinician part of the OptiBIRTH intervention, the OOL reflected that the components of the clinician information sessions and the audit practice could bring about consistent awareness on VBAC and slowly change the culture of allowing women to try for a VBAC:

“I suppose we should just bring it in to the induction of the new doctors every time they come, just say ‘look this is a hospital we do look for vaginal birth after a caesarean’ and that it is safe. We should really as part of their induction process where we’re telling them how we. . . what the hospital generalities are when we induce patients and what sort of vacuums we tend to use, how we repair and so on. We should perhaps have a class about VBACs at least every six months so that you inform the new doctors and, em, it probably would be a good idea alright. . .” (Interview, December 2015)

With regards to the audits, the OOL suggested that:

“I think we should really produce at our morning meetings at least once a month, once every two months, once every three months, our section rate versus our VBAC rate and I think if you get an extra five VBACs in the month you’ll probably find that your section rate does fall by one or two percent. So it does give a bit of a carrot and a stick and say ‘look if we could try and just up the VBACs we will be able to keep in the posse of people. We don’t want to be outside the posse. We don’t want to be the hospital leading the charge in the whole country for caesareans’. So maybe that would be a sort of, at least a bit of a carrot to everyone to try and improve because as I say, it’s too easy each week, each patient to say ‘oh this particular patient isn’t a very good candidate. I think I’ll do a caesarean’.” (Interview, December 2015)

It could be seen that both of the OOLs reflected that there were parts of the OptiBIRTH intervention that could be beneficial to the field-site and that these components could become part of the hospital culture after the intervention had ended.

At the end of the intervention, the OLs reflected on their experience of OptiBIRTH and what they enjoyed about their experience. While some aspects of the intervention were challenging for them, they did not have any regrets about participating in the intervention. The OLs, like the women and clinicians, took something from the intervention. For them, it was a rewarding experience helping women to try to achieve the birth that they would like and to try to change the perception of VBAC in the field-site. While some of the processes of the intervention were difficult as well as trying to change the culture in the field-site, they valued their experience of being an OL and had no regrets about taking on that role.

Em, I find it very challenging, it's very busy and it's very frustrating, but then it's very rewarding in another sense. What I particularly like and enjoy about it is the continuity factor. It's meeting the women in the antenatal classes and then in the labour ward, because I work in the labour ward as well. That's very, very rewarding, particularly when it's a good outcome of course. But it's lovely to hear it back from them when they say they enjoyed the classes and to know what I'm doing is worthwhile and it's making a difference. I know some of the women in the study have said to me, we wouldn't have had VBACs only for the study, so that's really worthwhile and with all of the women, I'm so glad I did it. (Interview, MOL)

Overall, the role of the OLs was seen in a positive light. The relationships that they built with OptiBIRTH women and encouraging change around VBAC culture was a rewarding experience for them. As can be seen in this section, the role of OL was a challenge, but during the course of the intervention the OLs grew into their role and had a positive experience, like the OptiBIRTH women.

“Oh absolutely, positives and negatives. Certainly, the positives outweigh the negatives. I mean when the women tell me they enjoyed the classes, they found them very beneficial. Even the women who go on to have elective caesarean sections said they found my classes very beneficial and they enjoyed them and they got more information



this time than in their previous pregnancies and they are able to go out and tell their friends stuff that they learned in the class. That's so rewarding and it's lovely to hear. It's lovely to know that I made a difference in somebody's life. That's really, really lovely. That is lovely. As I said, the positives for me definitely outweigh the negatives.”

(Interview, MOL, November 2015)

Yet there were challenges that the OLs pointed on during the intervention. One of the main negative challenges that the OLs found were that some of the consultants were indifferent to the intervention and VBAC and thus indifferent around the changing of field-site culture to a more open arena to discuss and promote normality after a CS.

“Yes. . . I don't know. I'm able to lead some things but I found this quite difficult. To my own colleagues it was hard. Fine to be an Opinion Leader for staff on a more junior level. They will listen a bit but people on your own level are set in their ways and I just found it very hard to get them to come to the lectures, get them to listen, get them to change. It was very difficult. Very difficult. They're not really on for change. It's funny yet they sort of do admire the Swedish system and all that sort of thing but as I say each individual week, each individual time, everything comes into the equation yeah. . . so I enjoyed the classes, I enjoyed doing the OptiBIRTH I must say but. . .” (Interview, December 2015)

A negative that was mentioned by the OLs was the uptake of the women attending the classes:

“So overall, I thought it was very well organised, em... it was disappointing in a way, the take up and so on with the patients and with the couples. They so often said they'd come and we thought we would have 7 couples and we would very often just have 3 or 4 couples, it was disappointing at times. It's surprising how low the drive is to get help and help is offered alright.” (Interview, OOL, December 2015)

The attendance at the class was sometimes seen in a negative light, even though both of the OLs enjoyed facilitating the class and the women themselves found the classes

helpful and informative for their pregnancy and birth. It could be suggested that, from the experiences of both groups of women and OLs, the classes could be incorporated into the antenatal schedule for women who have had a previous CS. This would mean that the women with a previous CS could manage their schedule and attend the classes, similar to attending routine antenatal appointments and would be given specific information on VBAC and the time to ask questions of healthcare professionals.

While the OLs enjoyed the experience of participating and facilitating OptiBIRTH in the field-site, with regards to changing of culture around VBAC and women with a previous CS, the OLs were cautious as to whether cultural change had occurred. They believed that some small change was visible in the field-site because of the intervention but overall, change was slow and that, while OptiBIRTH had started the conversation around VBAC, the change had only begun towards the end of the study and that the field-site would still have to examine itself carefully and implement further the change that OptiBIRTH had created once the intervention had finished:

“I think it probably will gradually increase a bit and I think our section rate has gone up too high. We have to start. . . it’s one of those real areas that you can make a dent in your section rate. So if our section rate is going high we’re really going to have to look at it. Well it depends what you think is too high. Is there really too high of a section rate? But it’s not good to be doing too many sections so we should definitely look at it, reducing the numbers. I think it will slowly increase the numbers of VBACs. I think it will but it will be slow.” (Interview, OOL, December 2015)

## 9.5 Conclusion

In conclusion, the participation of women in the OptiBIRTH intervention was seen to be a positive experience, even for women whose birth ended in having a repeat CS.

Through the attending of the antenatal classes and support from the OLs, the intervention gave the women the information and encouragement that was important for them to believe that they could achieve the birth that they wanted. On the other side of the story is the experiences of the OLs, which they described as a challenging role, but nonetheless, a gratifying role in the field-site. By helping the women to obtain knowledge and encouragement to birth the way that they would like to, gave the OLs satisfaction and enthusiasm to become invested in their roles as OptiBIRTH OLs in the field-site.

The final chapter of this thesis will bring together the findings of my study through an in-depth discussion of the knowledge that has been generated in this ethnography in the context of literature as well as providing recommendations that have emerged during the course of this study.

## Chapter Ten: Discussion and Recommendations

### 10.1 Introduction

“Birth is everywhere socially marked and shaped” (Jordan, 1993, p.1)

This quote provides a suitable backdrop to moving this thesis into the discussion chapter. As has been discussed in Chapter Two, the rise of CS is both a cultural and social change in the use of technology in birth practice and change in the way that birth is viewed. The use of technological interventions in birth has developed into a normal form of obstetric practice, with women and birth being seen as needing assistance from health care professionals. This can then give rise to increased use of interventions, such as repeat CS, in subsequent pregnancies. However, the OptiBIRTH study aimed to combat this use of repeat CS by giving both women and clinicians evidence-based information regarding VBAC and its efficacy from a social, medical, and economic point of view. In order to investigate whether or not OptiBIRTH instilled any form of cultural change around the subject of VBAC, this ethnography was proposed to explore how the OptiBIRTH intervention effected cultural change surrounding the decision-making process regarding mode of birth after one previous CS from the perspectives of those involved in making these decisions (that is; women taking part in the study, hospital clinicians, and OLs who are employed as part of the study to support women and clinicians’ decision-making in relation to VBAC). From this ethnography, different factors were identified under the multiple components of the intervention that affected the experiences of the participants as well as their experiences of the intervention in the field site.

This chapter will discuss the key findings that emerged from this study, referencing the findings, where relevant, to the published literature. The chapter will then move forward to discuss the findings in more detail with reference to the aims and objectives of this study and the contribution to knowledge that this thesis makes. My final discussion will focus on acknowledging the limitations of this study and highlight the recommendations that this thesis makes in order to improve the OptiBIRTH intervention if it is deemed to be effective and is placed in the maternity services programme for women who have had a previous CS.

## **10.2 Placing the Findings in the Literature**

While this ethnography was taking place, a number of articles relating to the OptiBIRTH study were published, which I will now discuss in relation to this ethnography. As this study continued and findings began to emerge from the data, I believe it was imperative to place what this ethnography has observed in the context of current available literature. This in turn will aid an understanding of how the findings fit into the current literature as well as understanding some of the gaps in knowledge that this ethnography hopes to fill.

During the course of the data collection and the writing up of the findings, I did not explore any of the literature available as I did not want my findings to be influenced by studies that had a similar outlook. I wanted to ensure that this ethnography was based on the perspectives of the participants involved and that I would not be influenced by

literature that had recently become available. When it came to writing this chapter, I noticed that many of the studies that had been recently published had similar findings to this ethnography; specifically exploring fear that surrounds VBAC and the differing philosophies in maternity care.

### **10.3 Revisiting the Findings, with reference to the Literature**

Nilsson *et al* (2015) conducted a systematic review to evaluate the effectiveness of women-centred interventions to increase VBAC. Through their systematic review, three studies met the inclusion criteria. Overall, even though there are very few studies conducted in this area, the findings of the review demonstrated that the use of decision aids and an antenatal programme for women helped them to gain knowledge about different modes of birth after a CS. Yet, there is a need for more research in this area and a need to evaluate an intervention to increase VBAC rates. Similarly, Lundgren *et al* (2015) conducted a systematic review evaluating clinician-centred interventions to improve VBAC rates. The result from three studies that met the inclusion criteria showed that there is a dearth of knowledge and literature regarding evaluating the effectiveness of interventions from both the woman and the clinician sides. However, they did note that the use of OLs as an intervention tool made a difference. This is interesting to note as this ethnography has detailed the journey of the OptiBIRTH participants and explored whether or not the intervention has been effective in changing the conversation and thinking regarding VBAC as a viable mode of birth. Therefore, this ethnography could become the impetus for increasing knowledge around the effectiveness of interventions aiming to improve VBAC rates.

Additional to these two reviews, a number of articles were published referring to CS and VBAC. Litorp *et al* (2015) explored both women's and caregiver's perspectives on CS with regards to the rising CS rate in Tanzania. They concluded that while both groups preferred having a natural birth, the caregivers had a more positive attitude to CS. In their study, they found that the women also felt that it was the decision of the caregiver whether or not the CS would take place, and that they had no control over the decision. Similarly, Marshall *et al* (2015) evaluated a mixed-methods study aimed at focusing on normal birth and reducing CS in England. In their evaluation of the 20 hospitals that participated in this programme, they concluded that, while there was only a marginal drop in the CS rate, the programme was beneficial to the care of the women. They found that the programme, through a change in the organisational culture of the hospital through prioritising normal birth and providing clear communication between multi-disciplinary teams, could help to decrease CS rates and promote the woman and normal birth. This could be seen in a similar light to the OptiBIRTH study, which aimed to increase VBAC rates through women-centred care and informing clinicians with evidence-based information. Konheim-Kalkstein *et al* (2015) focused on a content analysis of 300 posts on online discussion boards created for women who were deciding on whether to have a VBAC in the US. They found the majority of comments from these women related to health care professionals (20.7%) and choosing a health professional that would allow the women to try for a VBAC (10%). Their analysis showed the support the VBAC discussion board gave to women when they were deciding on a mode of birth after a CS. The discussion boards gave personal birth stories and narratives on trying for a VBAC and showing experiences of a successful

VBAC as well as medical information. This can be seen in a similar light to the antenatal classes provided by OptiBIRTH, in which women were supported by their similar goals of planning a VBAC and the medical information that OptiBIRTH provided to them for labour and birth.

### *10.3.1 Revisiting the Literature*

When this ethnography began in 2013, there was limited qualitative data available on the topic of VBAC. As discussed previously in Chapter Two, VBAC is seen as the riskier option for women. Health-care professionals are not comfortable with allowing women to try to have a VBAC due to the perceived medical risks for the woman and baby, but also the risks for the professionals themselves, including litigation and insurance costs. Women may not be given the chance to discuss trying for a VBAC as health-care professionals, namely obstetricians, would not present VBAC as a viable option for the woman. Since this ethnography was conducted, a number of articles have been published relating to VBAC and methods to improve VBAC rates (Martin *et al*, 2014; Obeidat *et al*, 2013). Gardner *et al* (2014) explored the use of management strategies to improve VBAC rates in Australia. These two strategies included consultants that were on call for the management of high risk pregnancies during labour, including women that were attempting a VBAC, and a specialised clinic for women who had a previous CS. Of the 396 women who participated in this study, 107 (27%) had a VBAC which was a significant increase from the year before (17.2%). By combining a specialised clinic for women with a previous CS and the standardised management of labour from consultants could improve VBAC rates. As well as this, the



differing philosophies of midwifery and obstetrics have been explored in relation to VBAC (Darling, 2011). Both of these subjects have been seen as key findings in this ethnography. I will now discuss these topics in more depth in order to place the findings of this ethnography in context with other relevant literature.

Furedi (2006, p.17) suggests that “people’s perception of health and illness is shaped by the particular account that their culture offers about how they are expected to cope with life and about the nature of human potential”. The system of health should be looked not only as a political organisation, but also a cultural organisation (Beckfield *et al*, 2013). Bero *et al* (1998) conducted a review of systematic reviews of interventions to promote the implementation of research findings. In their analysis of 18 reviews, they found that there is little information around the effectiveness of interventions that aim to change health service delivery. But culture is an important variable to consider when understanding health service delivery and behavioural change. Asad & Kay (2015) explored scholars and practitioners’ understandings of culture when looking at health interventions. In their analysis of 140 interviews conducted with non-governmental organisations (NGOs) working globally on health issues, they maintained that culture is important for understanding health interventions. Cultural knowledge in relation to health interventions can help to understand a project’s success or failure. As well as knowledge, cultural practice can influence health interventions. How groups select cultural knowledge they need can then facilitate both structural and cultural changes. Their findings on cultural change and health intervention evaluation suggest that culture evolves through the relationship between cultural knowledge and cultural practice. They propose that

“as groups of individuals accumulate new knowledge about effective health practices and effectively translate this knowledge into everyday behaviour, cultural changes that accommodate these new beliefs and practices can occur” (Asad & Kay, 2015, p.85).

By addressing cultural knowledge and cultural practice, improvements in healthcare delivery may occur for the long-term. Through understanding multi-dimensional aspects of culture for health interventions, this can lead to a distinct understanding of how to achieve cultural change and improve the institutionalisation of a health intervention (Ginsburg *et al*, 2005). In the health care setting, there has been literature forthcoming on examining culture as part of interventions to assess if change has occurred in the organisation. Larson *et al* (2000) conducted a study in which an intervention was implemented to change the culture around handwashing for health care professionals. They found that involving top management in the handwashing intervention, there was some change in the culture of handwashing, built over time. Parmelli *et al* (2011) conducted a systematic review exploring the effectiveness of certain strategies to change organisational culture in the healthcare environment. Their search of various databases, however, yielded small results (2 studies) and they concluded that, while the studies had positive results on changing organisational culture through the use of interventions, there was not sufficient evidence to identify effective measures for organisational culture change. It is acknowledged that culture is important to an organisation and that organisational culture is an aspect that must be considered when exploring healthcare performance and change in that performance (Davies *et al*, 2000; Scott *et al*, 2003; Mannion *et al*, 2009). It can therefore be suggested that this ethnography will contribute in some way to the understanding of the implementation of

the OptiBIRTH study and allow it to take the findings of this study when implementing it further if it is deemed to be effective.

### ***10.3.2 The Fear Generation***

As I discussed in Chapter Eight, there appears to be a fear amongst clinicians in relation to having VBAC as an option for women with a previous CS. This notion of fear has been addressed somewhat in the literature, with concern mainly on malpractice claims, which can be seen to influence care in obstetrics. Schifrin *et al* (2013) suggests that obstetricians are now employing ‘avoidance practices’ when it comes to VBAC, for fear of litigation. This could then substantially increase CS rates and the use of defensive medicine. Defensive medicine can be defined as “the use of diagnostic procedures/testing for treatments undertaken explicitly for the purpose of averting malpractice suits” (Tancredi & Barondess, 1978, p.879). Due to the fear of malpractice suits, it could be suggested that this fear is a factor that could be associated with the obstetrician not offering VBAC as an option for the woman and pushing the benefits of a repeat CS. A more defensive approach in relation to a woman with a previous CS is employed for the protection of the obstetrician. Schifrin & Cohen(2013) suggest that

“with the looming spectre of the allegation of malpractice, doctors, hospitals, and sometimes insurers tend to focus not on what is likely to happen, but on what might happen. They focus not on the probably normal result from implementation of a thoughtful, properly annotated plan of care carried out on an informed patient, but on the inherently small risk of maternal or fetal catastrophe, and on the understandable, but unsubstantiated, assumption that an allegation of negligence will follow any adverse outcome” (p.277).

In terms of fear and litigation in obstetric practice in Ireland, the rate of malpractice claims has been increasing and in general, “in 2012 the number of claims had increased 2.5 times compared with 2007” (Murphy, 2015, p.36). With more and more high profile cases involving obstetrics in the media, including Savita Halappanavar in 2012, Sally Rowlette in 2013, and the release of the Portlaoise Hospital Inquiry in 2015, this could then lead to higher insurance costs for obstetricians. These higher insurance costs coupled with the fear of malpractice suits leads the way for defensive medicine, higher CS rates and a fearful stance on allowing a woman to try for a VBAC. Draycott *et al* (2015) explored the role of insurers when it came to maternity care and suggested that insurers could lead the way in preventative medicine for both women and clinicians, through a multi-stakeholder approach to maternity care, which could then decrease litigation costs as well as insurance costs. Insurers have the potential to play a larger role in maternity care by working with the various clinicians to prevent avoidable harm in the maternity services. With this collaboration between insurer and clinician, the fear of litigation could potentially decrease, allowing for a more open opinion on various modes of birth and the promotion of effective protocols for VBAC.

### ***10.3.3 Midwifery Model Versus Medical Model***

I touched on the subject of the differing maternity philosophies in Chapter Two and Chapter Eight but I would like to explore this matter in more depth in relation to the key findings of this ethnography. The findings of this ethnography demonstrate that there is a differing opinion between midwives and obstetricians when it came to how a woman

was treated in labour and the mode of birth that she could potentially have. This is a conversation that has been carried out in the literature for many years.

Healy *et al* (2015) looked at midwives and obstetricians' perceptions of risk and its impact on practice and decision-making in labour. They found that midwives are in a difficult position due to the increased usage of technological and medical interventions in births that may be deemed low-risk. These low-risk births could continue without the use of interventions but obstetricians deem it necessary and safer for the woman and baby. It is the culture of increased use of interventions by obstetricians on women that "results in diminished responsibility for decision-making for both midwives and women while venerating obstetric input" (Healy *et al*, 2015, p.206). It is now assumed that birth is an abnormal process for women that requires intervention, which then breeds a culture of risk and fear instead of focusing on the normal process of birth and the well-being of the woman. It could be suggested that the focus on risk and the prevention of adverse outcomes in birth have become the main focus in maternity care, with the increased use of technology and intervention-based methods becoming the new 'normal'. This links back to the idea of defensive medicine that I have described in the previous section. Defensive medicine is now the main method of reducing risk and adverse outcomes by health-care professionals, instead of promoting birth as a natural process. Bryers & van Teijlingen(2010) contend that we now live in a society that embraces the technocratic model in maternity care and that the social model, which advocates the natural process of birth, has been put to the side. These models have been presented by Davis-Floyd (1993) and she suggests that with the technocratic model of birth the needs of the mother and the needs of the baby are separated and the body is

seen as a machine in a 'manufacturing process'. Medicine and the training of obstetricians is now concentrated on a technocratic model of birth, with obstetricians becoming socialised into a technological mode of birth from the beginnings of their medical training. The culture around obstetrical training revolves around the view that the woman is seen as a machine that needs guidance and intervention to deliver the child and that obstetricians are the technicians that maintain the woman's body during birth (Davis-Floyd, 1987). This way of thinking around the body and the birth process can then permeate into a hospital culture and influence its thoughts on birth and normalise the need for intervention in the birthing process. This then leaves the needs of the woman and the more holistic paradigm of birth to the side.

Kennedy (2010) explored health care reform in Ireland regarding maternity services. Through her analysis of maternity service provision, she states that Irish maternity care services are, for the most part, obstetric-led and continue to follow a highly medical model of care, including the active management of labour. Due to the dominance of the medical model, midwife-led care has been confined to a small number of units in Ireland. However, some strategies have now been published to maintain the needs of the woman at the forefront of maternity care. Towards the end of this ethnography, the Department of Health published a new maternity care strategy for Ireland. The National Maternity Strategy 2016-2026 (Department of Health 2016) aims to ensure that the mother is at the centre of care and is given the choice of care that she would like to receive that is in line with her medical needs and ensuring best practice in maternity care from both midwifery and obstetric fields.

#### *10.3.4 The Medicalisation of Childbirth*

With the differing caring philosophies that have been discussed in the previous section and briefly in Chapter One, the medicalisation of childbirth needs to be addressed. As the OptiBIRTH intervention was developed to increase VBAC as a viable option after a CS, the medicalisation of childbirth has been an implicit theme throughout this ethnography.

Over the past century, the medicalisation of childbirth has continued to dominate maternity care through the conceptualisation of risk and the generation of statistical data that is applied to whole populations (Lupton, 1999). Edwards and Murphy-Lawless (2006) contend that childbirth became medically controlled when doctors endeavoured to guarantee the safety of childbirth under their control and this began the dominance of medically controlled care in childbirth. The assurance of safety and lessening of risk in childbirth became the foundation by which doctors could assume their overall structural control over birth. Childbirth is now seen as a domain in which medical assurance counters the ‘inevitability of risk’ and by which directs women for a more intervention based approach (Tracy, 2006). This image of intervention can then lead to effects on women’s outcomes and the way childbirth is seen culturally. This also has the effect of doctors taking control of the childbirth process and, in a way, takes the woman away from the decision-making and overall control of her body.

Increasing interventions can bring risks to both mother and infant (Marshall et al, 2011; Albers, 2005) and can result in having an effect on women and their fear of childbirth.

Nilsson and Lundgren (2009) have shown that a negative birth experience can generate a level of fear that could be carried over to following pregnancies. So while there is a fear of risk by clinicians, there is also a fear of childbirth by women. This can be influenced by the families, friends, and by their culture (Fenwick et al, 2005). This fear may be due to the rise of interventions in childbirth and how birth is portrayed in Western countries (Saisto & Halmesmaki, 2007), including the language used around childbirth, such as ‘trial of labour’, ‘foetal monitoring’ and ‘emergency caesarean section’.

While this medicalisation of childbirth has been suggested to be linked to a fear of litigation that has been described in section 10.3.2 and have effects on the increased use of intervention, it could be proposed that a new way of approaching childbirth needs to be giving back control to the woman giving birth.

The OptiBIRTH intervention aimed to do this through educating women about their options for birth after a CS so that they could have some control and a degree of knowledge that they could choose the birth that they wanted and interact with their clinician. By trying for a VBAC, the women in the intervention were stepping away from a medicalised form of childbirth to a more women-centred approach to childbirth.

Throughout writing this ethnography, I wanted to ensure that the voices of the participants and the journey of OptiBIRTH in the field-site was focused on implementing cultural change when it came to allowing women to try for a VBAC.

From the findings, four themes that surrounded the implementation of the OptiBIRTH



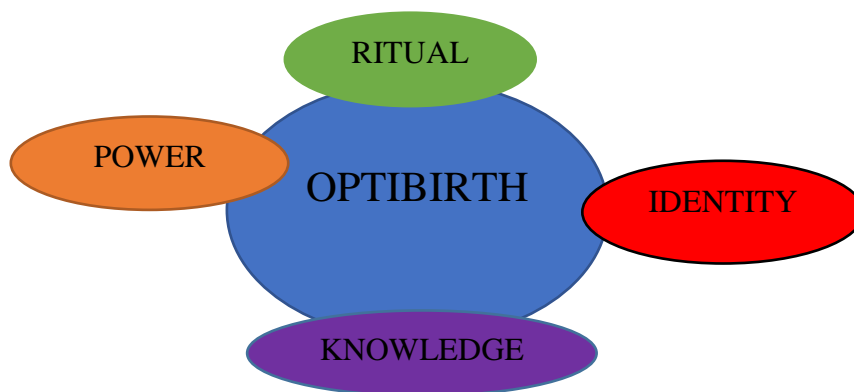
study and the view of changing culture when it came to women planning for a VBAC will be the focus of this discussion. These themes are:

1. Ritualization of the OptiBIRTH intervention
2. Changing identities of pregnant women
3. Transference of authoritative knowledge
4. Power Positions

These themes are demonstrated in Figure 6. I will now explore each of these themes that relate to OptiBIRTH alongside the relevant literature. From there, I will move on to the implications of these themes in relation to OptiBIRTH and explore their significance in effecting cultural change in the field-site as well as potential significance in the wider socio-cultural context of birth in other maternity units. From this discussion I will provide recommendations that have come to light from conducting this ethnography that could be of interest if moving forward with the OptiBIRTH study.

## **10.4 Interpretation of Findings**

Most of the participants in the OptiBIRTH intervention, specifically the women and the OLs, were motivated to have a VBAC. After obtaining information about the OptiBIRTH study, this was the plan for their pregnancy. During the course of the intervention, several themes emerged that relate to cultural change in the field-site and reflected the journey of OptiBIRTH and its participants.



**Figure 6: Themes surrounding OptiBIRTH**

#### *10.4.1 Ritualization of the intervention*

The belief system of a cultural milieu is enacted through ritual (McManus, 1979; Wallace, 1966) and analysing the rituals in the cultural setting can lead to a better understanding of their particular belief systems. From this, it can be seen that there has been a re-ritualization of birth under a technocratic model of birth, centred on a more social model of birth, aimed at introducing women into the decision-making process and making VBAC a viable option for women with a previous CS. Changing from a medical model of birth to a model of birth that focuses on normality requires a re-ritualization of the cultural system. This entails changing the belief system that is present in the field-site to incorporate new rituals and beliefs centred around the intervention and culture change around VBAC as a mode of birth. Davis-Floyd analysed the birthing system in the US through a ritual analysis and understood it as a socially constructed rite of

passage (2004). In this system, women's bodies are seen to be in need of medical management and technologically aided. Health care professionals and providers can transmit the core values to individuals so that they become socialised to the technocratic model and conforming to its values.

While the use of interventions is important to improve health outcomes and health service delivery, the social and cultural processes that underpin the success or failure of these interventions must be taken into consideration and explored thoroughly. As important as outcomes are, if the social and cultural structures are not properly understood, the long-term uptake of an intervention may be ineffectual. By understanding the cultural system that is in place, we can conceptualise the transformative actions that may occur to change the organisational structure of the setting and improve the uptake and significance of the intervention. The ritualization of interventions and their place in society has been examined in different arenas of care and health such as cancer rehabilitation (Tjornhoj-Thomson & Hansen, 2013). Using the concept of ritualization, they suggested that by applying ritual theory to the intervention programme, in their case a programme for cancer patients, it can “provide a conceptual framework for identifying, describing, and analyzing how rehabilitation intervention works, thereby calling attention to some of its transformative potentialities” (Tjornhoj-Thomson & Hansen, 2013, p.280). This analysis of the rehabilitation intervention and addressing the gap in knowledge surrounding the social processes and cultural complexities of intervention can also be applied to the OptiBIRTH intervention. By contemplating the social interactions, cultural considerations and social dynamics of OptiBIRTH and its implementation in the field-site, a clearer picture can be

distinguished as to how participants connect with the aims and objectives of OptiBIRTH and how OptiBIRTH relates to the social and cultural systems in place.

When recognising the use of ritualization Bell (1992) describes this concept as a way to “draw attention to the way in which certain social actions strategically distinguish themselves in relation to other actions” (p.74). This can be applied to the OptiBIRTH intervention in relation to what the participants in the field-site do and say with regards to the OptiBIRTH intervention and how this changes over the duration of the implementation of OptiBIRTH. As well as this, Bell believed that there is a relationship between ritualization and power relations in which “ritualization is a strategic play of power, of domination, and resistance within the arena of the social body” (Bell, 1992, p.202). This is interesting to apply to the OptiBIRTH intervention. The ritualization of the intervention in the field-site developed a power position; it gave power to the people who actively participated in the intervention and showed how the ritualization of the intervention generated both resistance and empowerment. The concept of power positions will be discussed in more detail in section 10.4.4. 4.

The OptiBIRTH study, through a period of re-ritualization in the clinic, allowed for a symbolic intervention in the technocratic model, emphasising the viable option of VBAC for women and for clinicians in the antenatal clinic that women could have the choice of a VBAC. As I discussed in Chapter Five, the OptiBIRTH study went through a rite of passage in the antenatal clinic in order to become part of the clinic routine and to become a legitimised entity in the clinic and in the field-site. As well as undertaking a rite of passage in the clinic, the intervention also came to represent a transformation in

the beliefs held around VBAC. As the intervention became a legitimised figure in the antenatal clinic, the belief system changed so that VBAC was now a subject that was discussed with women who had a previous CS.

Rituals are social constructions. Ritual is related to the socio-cultural context. They can be used to strengthen the cultural system that is in place and fortify one's understanding on a subject. Ritual is also a means of communication when it comes to one's activities that are of significance in the cultural system. Catherine Bell (1992) sees ritual as an active process in our social and everyday lives. Therefore, the focus on the ritualization of an activity or belief in a society is important to examine the significance of said beliefs so that we can understand what beliefs or activities a person holds in the highest regard. When it comes to the ritualization of the OptiBIRTH study in the antenatal clinic, specifically the recruitment process and giving women OptiBIRTH information, the intervention is given meaning through the human activities that surround it. The social construction around the activities related to the intervention allowed the process of ritualization to occur in the antenatal clinic, and thus undergo a rite of passage to become a legitimate entity in the field-site. Van Gennep (1960) and Turner (1979) believe that major life progressions are ritualised. This ritualization comes from a belief system that is so ingrained in our society that only through de-familiarising ourselves from these rituals that we can come to understand and believe the messages behind the rituals that we perform. A rite of passage occurs in three stages outlined by van Gennep (1960). The first, separation, relates to an individual separating themselves from their social state. There is then a liminal state in which the individual is not one thing or the other. An example of this would be a pregnant woman. The final stage is incorporation

whereby individuals are integrated back into their social with a new social status, for example, a mother. During the implementation of the intervention, as described by Van Genep (1960), the OptiBIRTH study underwent all three of the phases experienced during a rite of passage: separation of one's social status, a liminal period where a new status has not been acquired, and a reincorporation stage that re-integrates OptiBIRTH into the field-site society with a new status. The rite of passage helped to understand the transformation process of the intervention in the field-site following its implementation in the antenatal clinic and its journey to become a ritualised process during the recruitment phase by the participants. Recent explorations into ritual look in-depth at how symbolic activities that are intrinsic to rituals that societies employ enable individuals to reshape the values and ideals in a culture (Wirtz, 2007). McCallum & dos Reis (2005) explored how childbirth relates to a ritual in Brazil. They suggest that young women take childbirth as a ritual seriously and it is the social processes that relate to childbirth that define their transition to motherhood as well as influence class differences. Childbirth is a process that is laden with meanings and values to women and the rite of passage that is defined by childbirth is constructed through the meanings and values that women have. To look at ritual as a performance means that people are actively creating rituals and changing them to integrate them into their social world (Kang, 2006).

Cheyney (2011) in her ethnography of homebirth midwives and their clients in the US explored the way ritual proposes the construction, performance and maintenance of homebirth as a rite of passage. When looking at the rituals that are performed in homebirth, Cheyney suggests that "they provide a critical platform for resisting the

cultural normativity of medically managed hospital deliveries. Homebirths are constructed in opposition to dominant ways of giving birth” (2011, p.522). From conducting her ethnography, she came to the suggestion that homebirth can promote social change through the performance of rituals. Homebirth can be viewed as a ritual practice that is in a strategic position to remodel cultural categories around pregnancy and birth. Birthing at home allows women and midwives to nullify the view that women cannot give birth without being aided by technology and that

“homebirth practices are not simply evidence-based care strategies. They are intentionally manipulated rituals of technocratic subversion designed to reinscribe pregnant bodies and to reterritorialize childbirth spaces and authorities” (Cheyney, 2011, p.537).

This discussion can be seen in a similar fashion with the OptiBIRTH study. One of the aims of the intervention was to give evidence-based information regarding VBAC and its viability as a method of birth. This process of giving information to women and clinicians on VBAC generated manipulated ritual that disrupted the previously held ritual of giving a woman a repeat CS. The intervention challenged the model of care in the field-site so that a change in the ritual practice of information giving to a woman after a previous CS and gave authority to VBAC as an option for birth.

#### ***10.4.2 Changing Identities of pregnant women***

The findings of the ethnography demonstrated that identity as a woman that was trying for a VBAC, or an ‘OptiBIRTH’ woman was important to the participants in the intervention. With the women framing their identity around OptiBIRTH and their

association with the intervention throughout their pregnancy and birth, it gives them the encouragement and support to try and achieve a VBAC. The OptiBIRTH intervention allows the women to accept the new identity of a woman that is trying for a natural birth rather than a woman that has had a previous CS. The OptiBIRTH antenatal classes help the women in the intervention to process the experience of their previous birth and move forward to concentrate on the birth that they would like for their current pregnancy. Through this de-brief they can develop a new identity for this pregnancy and birth; a woman trying to achieve a VBAC. Throughout the implementation of the intervention, these women were referred to as 'OptiBIRTH women', suggesting their status in the field-site had changed because of the intervention. Rapp (1999) relates this to biosociality which can be seen as "the forging of a collective identity under the emergent categories of biomedicine and allied sciences" (p.10). Rapp here is talking about support groups for parents of children with Down Syndrome. Biosociality allows for the sharing of experience and friendship, but also difference. By actively examining the history and politics surrounding identity in health, it can allow us to explore the aspects in which biopower comes into focus. This can then lead to a comparative analysis of identity over time and in different socio-cultural contexts (Whyte, 2009). By exploring identity and health, the biosociality that individuals ascribe themselves with can aid in changing their identity and creating a collective identity. This can be related back to the intervention and the women that participated in the OptiBIRTH study.

Laney *et al* (2015) explored the influence of motherhood on the development of a woman's identity. Through their interviews with thirty women, they found that there was a transition for the women when reflecting on motherhood. Many felt that they had lost their identities when they became a mother, eventually finding their individual



identity again. Through regaining their identity after becoming a mother, their individual identity was redefined in a way that motherhood changed how they saw themselves. They developed a motherhood identity but still maintained

“a core sense of self as achieved prior to motherhood. The process of incorporating motherhood into women’s identities can be conceptualised as a fracturing of identity wherein women lose or have compressed selves for a time” (Laney *et al*, 2015, p.138).

The politics of identity relating to health has been explored by Whyte (2009). She discusses the formation of identity and subjectivity in relation to health as a paramount issue in the social sciences. “Identity politics focuses on social movements and organisations that reject neglect and discrimination and look to gain recognition and change social conditions” (Whyte, 2009, p.13). This issue of identity politics in health can be seen clearly in the array of research conducted on disability studies (Whyte & Muyinda, 2007; Priestley, 1995; Anspach, 1979). Rabinow (1996) tells us that rather than focusing on health and identities like race and gender, we should now explore the ways in which diagnostic technologies create social groupings as well as difference. Yet, it there is a dearth of knowledge with regards to pregnant women and the changing identities that pertain to them as women and mothers.

Kroger (2003a) declares that changes in an identity status is reflective in the structure of one’s identity. She states that this identity structure is the “filter through which one receives, retains, manipulates and evaluates one’s life experiences” (Kroger, 2003a, p.209). Lile (2013) explored the relationship of identity boundaries to identity statuses through an examination of the model of identity formation. In the model that is

proposed, she determines two parts to the development of an identity model: the role of boundaries and transitions during exploration. The first part of this identity model, the role of boundaries, articulates identity-related boundaries “perform the filtering or regulatory functions of an identity structure than frame the identity as a whole” (Lile, 2013, p.324/325). This relates to three areas: preserving the fundamentals of identity, distinguishing the self from the other, and regulating external social-cultural factors that impact identity (Lile, 2013). This is a more global perspective on identity formation, rather than the individual level which focuses more on identity fluctuation through modification and exploration of identity.

The second part of the model, transitions during exploration, reflects changes in an identity-related boundary but not the content of the identity. This process involves identity modification and identity synthesis. This process “refers to the boundary structure becoming more diffuse to integrate new potential commitments and discard previous commitments that no longer fit the individual” (Lile, 2013, p.330). This then allows the individual to discard previous identity commitments so that identity synthesis can occur.

Relating this model of identity formation to the OptiBIRTH study and its participants, the intervention gave the women in the study the opportunity to transition their identity through participation in the classes and modify their identity so that they could see themselves as an OptiBIRTH woman and a woman that is planning to achieve a VBAC. The first part of the model suggested by Lile can be applied to their identity that they formed before they entered the study and availed of the intervention. They gave

themselves the identity of a woman who has had a CS and that they would most likely have another CS due to their socio-cultural context. They were different to other women because they had a CS, so this was their fundamental identity. Through their participation in the intervention however, the process of modifying their identity occurred so that external factors (namely, the OptiBIRTH study) allowed them to integrate the identity of a woman trying to achieve a VBAC and discard the identity that they were going to have another CS. The OptiBIRTH study gave them a way to adapt a new individual identity that fit their identity structure.

#### *10.4.3 Transference of Authoritative Knowledge*

One of the main aims of the OptiBIRTH study was to ensure that both women and clinicians were provided with evidence-based knowledge on the risks and benefits of both VBAC and CS so that each group could engage in an informed conversation when it came to decide on how the woman would like to birth. Authoritative knowledge was a major factor that emerged from the findings of this thesis, and was relevant in both the women and the clinicians participating. In the interactions that occurred in the antenatal classes and the clinician information sessions, there was a transference of authoritative knowledge on VBAC and its viability as a method of birth after a CS. In the case of the OptiBIRTH women, they gained the knowledge that allowed them to make an informed decision on the birth they wanted and to have an informed conversation with their clinician about VBAC and its risks and benefits. With regards to the clinicians, they gained evidence-based knowledge on VBAC so that VBAC could become a legitimate option for women with a previous CS and make an informed decision with the woman

about trying for a VBAC. Women who attended the OptiBIRTH classes stated that they were more informed of the risks and benefits and became confident in their decision to try for a VBAC. Through their participation in OptiBIRTH, the women gained a position of power in the hospital culture to talk to their clinicians about what they wanted for this birth; they also gained information to give themselves legitimisation in the decision-making process. This is in line with the writings of Jordan (1993) that I discussed in Chapter Seven, whereby the knowledge system that is employed by obstetricians in the hospital is not based on evidence, but that the knowledge system that is employed by the women can become legitimate. This would mean that the women would become a component of the knowledge system in the hospital through their participation in the OptiBIRTH study. OptiBIRTH gives the women a legitimate standing in the hospital through information given in the antenatal classes and its credible presence in the hospital.

Knowledge around mode of birth after CS has been given some thought in the current literature. Chen and Hancock (2016) surveyed women on their knowledge of birth options after CS. From the sample of 33 women, they found that there were deficits in awareness when it came to the risks and benefits of CS and VBAC, which included seeing CS as not having any complications related to it for both mother and baby (48.5%). There are implications then for women and health professionals in not being informed about the various risks and benefits of CS and VBAC. Therefore, for informed choice around mode of birth, a dialogue between women and clinicians is important so that women are knowledgeable about the choices and that their clinicians has evidence-based information so they can support their choice as being safe and beneficial to them.

The decision-making process for mode of birth after CS has been seen to be influenced by their health care professionals and their approval or disapproval of the mode (Fenwick *et al*, 2003; Ridley *et al*, 2002) Accordingly, health care professionals need accurate, evidence-based information on risks and benefits on VBAC so that they can have authoritative knowledge and can provide unbiased support to women.

With regards to the link between power and a VBAC clinic that was described in Chapter 7, there are few articles exploring the use of a specialised clinic for women planning a VBAC. David *et al* (2010) provided feedback from women who attended a dedicated ‘Next Birth After Caesarean’ antenatal clinic in Western Australia. Through the use of a dedicated phone line, they found that the women found the service to be informative to their needs and helpful in their decision around mode of birth as their needs are different to other maternity service users. In the authoritative knowledge context, the women using this service had varying levels of knowledge about their choices for birth after CS. By using the telephone service, they were given legitimate knowledge about VBAC and their options by qualified individuals and by “helping women recognize and articulate their individual needs and values promotes a situation within which high quality decisions can be made” (David *et al*, 2010, p.170).

In a special issue of *Medical Anthropology Quarterly* (1996), authoritative knowledge was explored with regards to its social production in pregnancy and childbirth. This issue brought to light the relationship between pregnancy and childbirth and the importance of this relationship in understanding pregnancy and childbirth in different cultural arenas. Pentland *et al* (2011) conducted an integrative literature review looking

at knowledge transfer in healthcare to support evidence-based practice. Through their analysis of thirty-three papers, they found that the knowledge in this area was limited but that knowledge transfer is important for policy and practice. By identifying the needs and solutions to improve knowledge transfer, policy can then be created to facilitate and support knowledge transfer and exchange. This is important to note as knowledge transference was a major aspect of the findings in this study. By both clinicians and women gaining knowledge on VBAC and its risks and benefits, an informed dialogue between the two groups could be initiated so that the decision-making process involved both the woman and clinician. This gain in authoritative knowledge allows the woman to become a legitimate figure in the decision-making process of trying for a VBAC. It gives them information and confidence to begin the conversation with their clinicians about having a VBAC. Therefore, it is reasonable to assume that, with adequate supports and systems in place, accurate and authoritative knowledge transfer occurred through the OptiBIRTH study resulting in creating a practice of reliable support and information for both women and clinicians.

Ketler (2000) explored the creation of authoritative knowledge in Italy in relation to differently structured childbirth education courses. The main aim of these education courses, similar to antenatal classes, were to prepare women for their maternity journey by giving them basic medical knowledge of pregnancy and birth as well as hospital protocols. The education courses were the site in which information transmission occurred. She found that, in the course that was structured towards the women sharing their previous knowledge and experience, the interactions that women had between themselves around motherhood became the dominant form of knowledge, rather than

medical knowledge. Through her examination of the two differently structured classes, she found that

“some of the social processes that create the situations of structural equality enabling women to choose from several equally legitimate forms of knowledge, including those based in their own experience and to subsequently redefine that which is considered authoritative” (Ketler, 2000, p.149).

The knowledge of previous experiences held by the women in the course were seen to be valid, along with the medical knowledge given. Ketler suggested that the way in which education courses are structured, with women being encouraged to participate actively and share experiential knowledge, may have the consequence of de-medicalising maternity care. Experiential knowledge can become reassuring to women and they can relate to this type of knowledge in their daily lives. This is in contrast to medical knowledge which gives them the knowledge to prepare only for the institutional maternity experience. This could be related back to the antenatal classes of the OptiBIRTH study. In encouraging the women to discuss their previous birth experience, share and listen to the stories of other women in similar situations, and obtain evidence-based information on VBAC and repeat CS, authoritative knowledge was gained by the women and adequately prepared them for dealing with clinicians and their views on VBAC.

Obtaining authoritative knowledge by participation in the intervention was imperative to changing the culture in the field-site. Giving the women relevant and legitimate information on the risks and benefits on VBAC and repeat CS, as well as evidence-based information to clinicians, participants could feel confidence in themselves and in

trying to achieve a VBAC. By both groups obtaining authoritative knowledge, cultural change around VBAC could begin to occur and generate positive promotion of VBAC and a consensus between OptiBIRTH women and their clinicians on the birth that they would like to achieve.

#### *10.4.4 Power Positions*

The findings of this study indicate that there are certain dimensions of power in the field-site that relate to the OptiBIRTH study and the overall opinions on VBAC as a viable option for women with a previous CS. This was evident in the OptiBIRTH antenatal classes and the perceptions the OOL gave to the women regarding his colleagues and VBAC. This portrayal of power was also seen with the clinicians that I interviewed when they gave their impressions on the consultants in the field-site and VBAC when compared to the OOL. It could be seen that the OOL held a certain power position regarding VBAC and his standpoint in the field-site. The findings of this ethnography indicate that there are certain structures of power placed in the field-site when it came to VBAC and the dominance portrayed to the women by the OOL when it came to his colleagues and VBAC featured strongly.

Chapter Seven referred to the writings of Michel Foucault and his theory on power and knowledge. Foucault, in his thesis 'The Birth of the Clinic' (1963) which analysed the development of medicine and knowledge, proposed that there is a resolute association between power and knowledge. Foucault suggested that power and knowledge are created through accepted forms of knowledge and scientific understanding. It is a force in the use of social discipline and conformity that can be seen in the beginnings of the



18th century with the movement of birth from the home to institutions, with power now transcending politics and becoming an everyday phenomenon in social life. Foucault believed that power could be challenged however:

“To challenge power is not a matter of seeking some absolute truth (which is in any case a socially produced power), but of detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates at the present time” (Rabinow, 1991, p.75)

The findings from this ethnography indicate that the intervention challenges the power of the use of repeat CS and the viable option of VBAC. Through the participants engaging with the intervention, power could be detached from the use of repeat CS to obtain a new truth in VBAC and its use in the hospital. Foucault has been an enormous entity in anthropology with his writings on biopower. Biopower relates to discourses that influence both the individual and the general population. Obstetricians and midwives were at odds when it came to caring for a woman who wanted a natural birth and deciding that she would be more suited to having a CS. This was true not only for a woman who wanted a VBAC but for the general view in the field-site, with the midwives disagreeing with the obstetricians regarding the excessive use of intervention in labour and giving the woman what was, in their opinion, an unnecessary CS. While some of the midwives felt that the authoritative role of obstetricians in the field-site was hindering the way to an increased presence of normality in birth, the obstetricians maintained their power position by not interacting with the intervention despite being presented with evidence-based knowledge. Although this was the case until the final stages of the intervention, the power role that obstetricians play over birth could still be felt. When it came to the obstetricians interacting with the intervention, they

demonstrated the power position that they occupied in the field-site, with many not attending the information sessions until the end of the intervention or not at all. The OOL demonstrated his power position with regards to VBAC through telling the women about the views his colleagues had on VBAC and their chances of achieving a VBAC were better if they were under his care. Catling-Paul *et al* (2011) conducted a systematic review regarding non-clinical interventions that increase the uptake and success of VBAC. Through their analysis of 61 studies (27 reporting non-clinical interventions and 34 reporting clinical interventions), they found that non-clinical factors, such as the desire to reduce CS through hospital policy, did have an impact on the success of VBAC. It would seem that the attitude of clinicians to VBAC was a factor in the uptake and success of VBAC. The guidelines created by the hospital and perspectives obstetricians had regarding VBAC could be seen to impact on whether or not VBAC was an option for women and their impact on overall VBAC rates. Therefore, it could be suggested that the individual views of clinicians' is a factor that has to be of major consideration when implementing an intervention that is based around cultural change.

In the hierarchical structure of healthcare, the clinician can be seen to hold a position of authority (Price *et al*, 2014; Gardezi *et al*,2009; Goodyear-Smith & Buetow, 2001; Carter, 1994). This power is not held over their patients only, but also over other professions in the healthcare setting. Nugus *et al* (2010) suggest that

“the reason that doctors determine, and, in some circumstances, constrain, the input of clinicians in other roles into patient care is because doctors are socialized, in tertiary education and at work, through legal, organizational and cultural structures, to see

themselves as key decision-makers about patient care and the patient pathway through a health service” (p.909).

This is relevant to the findings of this ethnography as there was an exercise of power by doctors over women and also over midwives when it came to VBAC. As discussed earlier in this chapter (section 10.3.3) the contrasting models of care generate a hierarchal authority, with doctors exercising their power over midwives and making the decision as to whether a woman can try for a VBAC or not.

It could also be suggested that the women who participated did not block the uptake of VBAC, but rather the clinicians who did not engage with the intervention. One of the major elements that has been discussed in this ethnography and can be seen throughout this thesis is the prevalence of power positions during the implementation of the OptiBIRTH intervention. Power and representations of power began at the outset of the intervention, with the cases of certain clinicians disapproving of the aims and objectives of the intervention and their personal preference for repeat CS. This culminated, in my eyes, with the OLs and the OptiBIRTH women taking a power position for themselves and creating a collective group that supported OptiBIRTH and VBAC. This showed a small cultural change in the way that maternity services were restructured for the women participating in the intervention.

This ethnography has shown this to be true. For many in the field-site, the example of the senior clinicians not attending the clinician information sessions and fully participating in the intervention could be felt from other clinicians as well as the OLs,

with some commenting that the senior clinicians could not be changed and that they did not have the interest in changing their practice around VBAC and repeat CS. However, even though the attitude of senior clinicians were, for the most part, unchanged during the course of the intervention, small, slow changes in some clinicians could be seen with their use of VBAC. It is the observation of small changes around VBAC and the hospital culture around VBAC that could determine its success in changing culture in the future, once the intervention has been completed in the field-site.

## 10.5 Implications

As I discussed in Chapter Two, there is a lack of qualitative data when examining interventions or conducted alongside/within RCTs. This ethnography aims to contribute more to the understanding of the implementation of the OptiBIRTH study so that, moving forward, if the OptiBIRTH intervention is deemed to be effective, it will have the appropriate knowledge and understanding regarding perspectives of the participants and how the intervention could be modified to be more effectively carried out. The use of ethnography alongside or embedded within the RCT method can allow for a better understanding of the trial, from the perspectives of relevant key stakeholders, and what needs to be done to improve implementation, conduct and possible outcomes. Messac *et al* (2013) explored anthropological collaboration with evidence-based clinical research and suggested that

“the easiest way to bridge the disciplinary theoretical and methodological gulf between anthropologists and quantitative health researchers is to recognize the practical win/win benefits of augmenting the “validity and generalizability” of one another’s data” (p.184).

A collaborative approach between ethnography and quantitative sciences paves the way for a better understanding of the hard data that are collected as it can be placed in a socio-cultural context that data can be better understood and interpreted. An advantage of exploring the socio-cultural context of healthcare systems is that health policies can have a greater impact on society (Tesler, 2010; Janes & Corbett, 2009; Hahn & Inborn, 2009).

Taking this back to my study and OptiBIRTH, this means that the findings from this study will be of benefit to extending OptiBIRTH's intervention to other clinical sites if it is seen to be effective. This ethnography can help to understand the experiences of the participants and what changes could be made to implement OptiBIRTH in a more meaningful way for participants and in changing the culture in hospitals regarding VBAC.

Through the duration of this ethnography, certain aspects of the intervention have created change when it came to VBAC. This was especially true with the women that participated in the intervention and became informed about VBAC, repeat CS, and the risks and benefits of both options. The women could be seen, through their participation in OptiBIRTH, as the driving force of cultural change in the field-site and VBAC. The women came in to discuss with the clinicians their options, they were aware of the risks and benefits, as well as the procedures that were involved with both VBAC and repeat CS. The OptiBIRTH women created a positive image around VBAC, which resonated with the clinicians who assisted with their birthing options. While some of the clinicians

in the field-site did not involve themselves particularly with the intervention, the clinicians that did participate and attend the clinician information sessions and had a discourse with OptiBIRTH women also had a positive experience and embraced the aims of the intervention. Clinicians became more informed about VBAC and went on to promote VBAC in the field-site to women with a previous CS. Small cultural changes could be seen and, gradually, more clinicians in the field-site, through their interaction with the OLs and the OptiBIRTH women, created a small cultural change in the field-site that could become more wide-spread if certain policies are created with the promotion of VBAC, which I will discuss later in this chapter.

Throughout the findings of this ethnography, the intervention had a positive effect on the women that participated which seemed to be a key driver for the intervention in the field-site. However, it was also seen that the clinicians in the field-site during the time of the implementation did not fully engage in the intervention and the OptiBIRTH women were driving their care in the field-site. The implications of this lack of engagement could have had the effect whereby, while the majority of the midwives in the field-site were aware and engaged in the intervention, especially towards the end of my time in the field, the junior doctors, registrars and consultants did not actively involve themselves with the intervention and participate. The lack of participation by the doctors and consultants may then have hindered the care and opportunity of the OptiBIRTH women to interact with their health-care professional and discuss the modes of birth that were available to them. Some of the reasons for this lack of participation could be due to their unwillingness to change their practice or their personal belief in the VBAC. For me, it is hard to state explicitly why there was a lack of involvement

from the doctor side of the field-site as I was unable to obtain a recorded interview from any medical professional. However, through my observations, field-notes, and interviews with women and midwives, it could be seen that the overall authority was based solely on the beliefs and practices of the consultant or doctor. This relates back to the theme of power positions that I have discussed earlier in this chapter (section 10.4.4).

It could be suggested that the women who participated did not block the uptake of VBAC, but rather it was the clinicians who did not engage with the intervention. Therefore, it could be suggested that, moving forward, the clinician component of the intervention could be focused upon and target the clinicians more so than the women. This comment has been reflected in the recommendations in this ethnography (section 10.7) whereby I propose that, moving forward, the OptiBIRTH intervention if it is deemed to be effective, should focus more on the education and involvement of doctors and consultants in maternity units as they are in the position of authority in relation to birth options for women after a CS.

The findings that I have discussed in this chapter lend themselves to understanding the implementation of the OptiBIRTH intervention. Through the duration of the intervention being conducted in the field-site it was seen that there was a change in how VBAC was framed to participants and how the intervention influenced the relationship between the women and their clinicians. The intervention opened up a conversation around VBAC and, through time, this became more open between the participants and the decision process was then changed to include women and to include VBAC as a

viable option. The findings in this ethnography help to understand why this is the case and how the cultural change in the field-site developed to allow VBAC to become part of the culture and part of the conversation.

Changing the conversation involved the everyday discourse around VBAC for the women and the clinicians. Yet it must be said that this change in conversation lends itself to a more cultural change of openness and a positive attitude towards VBAC as being a viable mode of birth after CS. By opening the conversation during the implementation of the intervention, a deeper cultural change can then take place in which VBAC can become a legitimate entity in the field-site and affect positive change for both women and clinicians.

Throughout this ethnography the diversities and complexities that were embedded within the participants' narratives were uncovered. The findings from this research provide insights into the factors that are associated with cultural change during the implementation of the OptiBIRTH study. Insights and a thorough understanding of how these women interpret and perceive the research process in which they have placed themselves were explored throughout the current research. The knowledge gained from this study contributes to a greater understanding of women's and clinicians' experiences of participating in OptiBIRTH in this field-site.



## **10.6 Limitations to the Study**

Although this thesis explored the journey of OptiBIRTH, there were also limitations to the ethnography that need to be acknowledged. As I have previously described in Chapter 3 (see section 3.7), the ethnographic process for the researcher is full of self-reflection and is critical for understanding the findings. As with all research, limitations to this ethnography must be taken into account and acknowledged.

### ***10.6.1 The Sample***

As the field-sites for the intervention in Ireland were geographically placed in various parts of the country, as a lone researcher it was deemed that a one-field site would be the most suitable for conducting this ethnography. Accepting this, deciding on one field-site also resulted in a limited sample size from which to draw on and, potentially, limited diversity in the findings.

### ***10.6.2 Generalisations***

Ethnography explores a specific culture during a time-period. While this is extremely important in understanding a particular society, one of the limitations of ethnography is that it is not necessarily or easily generalisable. In the context of this ethnography, the findings from this study may not be applicable beyond the field-site. As an ethnography is normally set within a specific culture and is conducted during a set time-period, the findings may not be generalised to the wider socio-cultural context. This must be acknowledged as, if the intervention is deemed to be effective and is carried out in the wider maternity services, although it is hoped for the most part that they will be, it must

also be recognised that some of the findings presented in this thesis may not be applicable to other maternity units or hospitals.

### *10.6.3 Subjective Experience*

Conducting an ethnography is a subjective experience. The interpretation of culture will vary among different researchers and this must be acknowledged. The culture of a given society and its processes can be interpreted in a different way by a different researcher. Therefore, the interpretations of the data that I presented in the findings of this thesis may have been interpreted in another way by a different researcher. Huspek (1994) tells us that “the analyst is an experiential being whose past and ongoing experiences are inextricably bound up with dialogue” (p.46). The role of the ethnographer and their past experiences or opinions on the topic need to be acknowledged. It is imperative that the ethnographer actively takes part in reflexivity, both with the data and with themselves. In this way, the subjective experiences of the ethnographer can be assessed to ensure that the data were correctly collected and analysed and bias was kept to a minimum. This process of self-checking was also supported by my supervisors to make sure that I was not letting my previous experiences affect my interpretation of the data. This was important as time went on as I may have unconsciously created opinions about individuals that may not have been true but were based on my experience with them. While others may have interpreted the data differently I, along with my supervisors, acknowledged this and made every effort to ensure I was true to the data and undertook activities to ensure rigour and trustworthiness in my reporting of my findings.

## **10.7 Recommendations**

This ethnography has explored the implementation of OptiBIRTH in one field-site to determine if cultural change around the subject of VBAC occurred. It has looked at the cultural constructions that surround VBAC and CS in the field-site and how these constructions have changed through the implementation of OptiBIRTH over the course of 16 months. However, changing a culture cannot occur immediately and such an expectation is not realistic. To say that the implementation of OptiBIRTH has completely changed the culture in the field-site would not be true. Instead, I would acknowledge that, as discussed in this chapter, aspects of the hospital culture have shown an indication that cultural change is possible and has been initiated in some aspects of hospital views on VBAC. There are no instant solutions in changing a culture. These recommendations may not be of value in other units but are more specific to the field-site in which the ethnography was conducted. However, the recommendations that I make are to add to changing the culture that OptiBIRTH has begun, that could potentially be applied to other units in Ireland.

The recommendations from this study offers certain proposals that may already be in place in other units in Ireland but could be implemented to change the policies of VBAC and women with a previous section to a more coherent, nation-wide policy. These proposals address the changes in policies regarding VBAC through addressing hospital policies, maternity services and education of both women and health-care professionals.

### *10.7.1 Hospital Policy*

It is recommended that:

- A hospital-wide protocol be put in place in the field-site, with an evidence-based guideline that takes the fear out of trying for a VBAC for the clinicians, and a forum for clinicians to discuss individual cases and their needs, with the aim of changing the VBAC culture.
- The OptiBIRTH antenatal classes be incorporated into the antenatal care schedule for women with a previous CS, by adding two extra antenatal appointments.
- Consideration be given to developing a specialised VBAC clinic, which could benefit both women with a previous CS and the clinicians who care for them.
- Junior doctors receive educational input on VBAC and the hospital's policy on VBAC promotion, as part of their induction process every six months.
- An audit of VBAC and CS rates is presented to staff every 2-3 months, and an action plan documented if rates are not improving.

### *10.7.2 VBAC Promotion and Support*

It is recommended that:

- The role of the OLs be continued but with particular emphasis on having a full-time individual in the antenatal clinic, which would provide both women and health-care professionals with a point-of-contact in the clinic for information and promotion of VBAC.
- Women, at their first booking visit, should be referred to this individual to introduce the idea of having a VBAC from the beginning of their maternity care.
- More part-time MOLs should be appointed, who work in the labour ward, to support midwives caring for women planning a VBAC; this does not carry a salary cost, as the midwives will perform this function while on their rostered shift.
- The website, and its contents be improved to provide evidence-based information on VBAC and a safe area for women to discuss their fears and options with women in a similar position.

### ***10.7.3 Normality Promotion***

It is recommended that

- A hospital-wide guideline on the promotion of normality in birth be developed, with representations from stakeholders in midwifery and obstetric fields, women and hospital management. These guidelines could provide strategies for promoting normality in birth and additional protocols for supporting normality in birth for certain groups of women, such as those who have had a previous CS; this may contribute in small ways to the prevention of the primary CS, thus negating the need for a VBAC.

### ***10.7.4 Future Research***

Consideration should be given to undertaking research in the following areas:

- The implementation of an ethnography or similar research study in a different setting, for example, a smaller, rural hospital where OptiBIRTH is being implemented to assess the differences or similarities in changing the culture around VBAC and CS.
- An exploration of the field-site 1-2 years after the implementation of OptiBIRTH to assess if cultural change has occurred and, if not, why change did not materialise and what can be employed to appraise the reasons behind it.
- Modifying aspects of the intervention to preventing 1st time CS (e.g. information to women and clinicians). By informing women and clinicians of

risks and benefits of 1st time CS and the increased risk of repeat CS, the intervention could address the concerns of a rising CS rate from the beginning of a woman's obstetric career and this could then allow for the promotion of normal birth in these groups.

- Extension of the OptiBIRTH study to an online presence. This could include easier access to information online through the form of a mobile app and then evaluate women's experience of these online tools to understand if they are a viable option for use alongside the antenatal classes.

## **10.8 Reflections from the Ethnographer**

As well as discussing the findings of this ethnography, I would also like to give you, the reader, an insight into my reflections of this research study. As I am a first-time ethnographer I feel that, by reflecting on my experiences of conducting this ethnography, I can give you a better understanding of my position and the ethnographic process. This ethnography was an immense experience for me. Becoming part of OptiBIRTH and conducting this ethnography was a personal challenge but a rewarding professional experience. I developed many close relationships to participants in the intervention, and observing the progress of the intervention in the field-site was a valuable experience for me.

As well as being a gratifying experience for me, conducting this ethnography also had various challenges. I moved to an area of Ireland where I did not know anyone and, coming from a social science background, I can state that I had no maternity care knowledge. I do not have children so learning about the processes, language and politics in maternity care was difficult. Being a stranger to a new area as well as a stranger in the field-site was, to be honest, immensely intimidating and scary. This was my first experience of ethnography and for the first couple of months I didn't know how I was going to be able to do it for 16 months. As I was new to the field-site along with OptiBIRTH, people kept on believing that I was auditing their practice, and it took the presence of the MOL and the OOL talking to me about OptiBIRTH and VBAC to dissuade those thoughts. Doing fieldwork was a lonesome experience. It was not until the clinicians in the antenatal clinic began to really become involved with the intervention that they began to also accept me. I can distinctly remember being called one morning into reception with the other midwives and staff to have cake and I thought that this was one of the best days ever and that the clinic has accepted me. From then on fieldwork and trust between myself and clinicians got easier. I began to grow more confident as an ethnographer and in my study as time went on. Leaving the field was very hard and I still sometimes feel guilt for not being there, which I think most ethnographers go through. I feel so honoured to listen to the OptiBIRTH women's stories and share their OptiBIRTH experience. Before conducting this ethnography, in my naiveté, I didn't think that having a CS was a big deal and that it was completely normal to have another CS. Coming out of this ethnography has definitely changed my perspective on birth and the experience of birth. By listening to the participants, I can say that OptiBIRTH has had an effect on me. I believe now I am a more knowledgeable



woman that, one day, when I have children, will benefit me. I have more confidence in myself since conducting this ethnography and I believe now that this study has had a positive and lasting experience on my life that I will be forever grateful for, both as a researcher and as a woman. My experience of conducting this ethnography has been a positive one and I would hope to continue in my journey with ethnography as a researcher in the future and with maternity care. Conducting an ethnography is a once in a lifetime experience whereby one can delve into the unknown to catch a glimpse of a society that one may not normally have access to and then to tell their story so that their culture can be understood and recognised. This is a huge responsibility and I feel very privileged to be involved.

Challenging a mindset is where the change in culture and the change in behaviour lies. When practices that have been instilled in the health system and its organisational structure have remained passive, it can be difficult to assimilate new meanings and values to that system. To change culture is to challenge the values that are currently in place. Therefore, the interactions that people have are important in the drive for changing culture. As Taylor (2004) states:

“Culture is the result of messages that are received about what is really valued. People align their behaviour to these messages in order to fit in. Changing culture requires a systematic and planned change to these messages, whose sources are behaviour, symbols and systems” (p.3)

The OptiBIRTH intervention can be seen to be the systematic and planned change of behaviours surrounding VBAC. It is sending a message about VBAC as a valid birth option and changes the values that are placed on mode of birth after CS.

### *10.8.1 A Comment on Embeddedness*

As described in Chapter One, this ethnography and exploring cultural change was not an explicit objective of the OptiBIRTH trial. While I have discussed my experience of conducting this ethnography, I would like to reflect more on the barriers that I experienced during my time in the field-site.

Due to the fact that this ethnography and its aims and objectives were not explicitly stated as an objective for the OptiBIRTH study but were, rather, a small part of a work package, I as an ethnographer was granted partial authority in the field. The space in which I, as the ethnographer, and the ethnography itself was situated was a difficult space to define. This was due to the fact that the ethnography was part of the OptiBIRTH trial but my position as ethnographer did not give me power to conduct the intervention in the field-site. The barrier that this created was that I was viewed, especially at the beginning of my time in the field, as the person in charge of the intervention in the site, rather than the ethnographer that I wanted people to see me as. This produced the difficulty of participants, principally the doctors and consultants, viewing me as an ‘auditor’ of sorts, or, in the case of the midwives, that I could take on the responsibility of the recruitment of participants to the intervention. Because this

ethnography was to be seen as separate to the overall intervention but yet part of the overall OptiBIRTH study, it was difficult to position myself and the study.

If the ethnography had been embedded in the overall OptiBIRTH study design and reported as part of the intervention, rather than being an add-on, I believe that it would have been easier for the ethnography to have authority in the field-site and to also conduct the ethnography as part of the OptiBIRTH study. This may have given myself and this study legitimacy in the field-site and I may have been given access to doctors and consultants, because this study would have been seen as part of the research design.

However, it must be noted that, for the most part, this ethnography was afforded thought and consideration in the field-site, and it may have been the case that, because I was not seen as part of the OptiBIRTH intervention, I was then given access to people and experiences that may not have been granted to me if I was seen as an 'OptiBIRTH person'.

The question of embeddedness of this ethnography and the OptiBIRTH study is a difficult question to answer. I feel that if this study was seen as a bigger part of OptiBIRTH and part of the study objectives, I would have had a very different experience and had been treated more as a professional that was part of OptiBIRTH, instead of being treated as a PhD student. I may not have been given as much access to the field-site and I think that the trust between myself and the field-site would have been harder to create. But, on the other hand, if this ethnography had been part of the

OptiBIRTH research design, I may have been treated as a person of authority and power and had access to populations in the field-site, namely, the doctors and consultants and my experience would have been different and this ethnography may have produced different findings. But, it must be said that for the most part, I was allowed to embed myself into the field-site and gain access to the majority of the participants in the intervention. Full immersion was a challenge and I have to say that I achieved this in some part but, if this ethnography would have been embedded in the overall OptiBIRTH structure, I may have been able to achieve full immersion with all groups. My hopes for this ethnography is that I have been able to tell the story of OptiBIRTH and its participants clearly and succinctly, and that it shows the importance that planning for, and having, a VBAC holds for these women.

## **10.9 Summary**

This ethnography has detailed the journey of the OptiBIRTH study in one field-site to explore if cultural change around VBAC was advanced to allow for a more open conversation between maternity health care professionals and women about having the choice to try for a VBAC.

This ethnography is not only a story of OptiBIRTH and its participants but also my story and the experiences that I had as a researcher and becoming part of the culture as well as becoming part of OptiBIRTH. While the findings of this ethnography may not be generalised and are more specific to this study, the stories and experiences of the participants may contribute to changing the culture around VBAC in not only

midwifery and obstetric practice, but also in the broader social aspect of maternity care in Ireland. This thesis has detailed the implementation of the OptiBIRTH study and it is hoped that the findings of this ethnography can contribute to the understanding of the intervention alongside the quantitative data collected. It can provide a broader understanding of the OptiBIRTH study and help with its wider implementation if it is deemed to be effective in improved women-centred care and VBAC rates.

This study provided an in-depth qualitative exploration of the perspectives of women and clinicians in one field-site that was part of the OptiBIRTH study. It drew upon detailed observations and interviews to understand the implementation of this intervention and what occurred during its implementation in the field-site. This ethnography revealed the interrelationships between power, knowledge, ritual, and identity that developed during the course of the intervention. It is these factors that relate to cultural change around VBAC and for the future implementation of the OptiBIRTH study in other maternity services.

## **10.10 Conclusion**

This thesis has explored the OptiBIRTH intervention and its journey through the field-site, from the perspectives of the women, clinicians, and OLs that have participated. It has shown that, through the active incorporation of the OptiBIRTH intervention into the field-site, thought around the subject of VBAC and repeat CS has slowly changed but further time to change the culture completely is needed.

My hope for this thesis would be that people involved in the various strands of maternity care, including women themselves, as well as society in Ireland, realise that change is possible and that it takes both clinicians and women to begin the conversation on change. Culture is malleable; it just takes time and commitment but cultural change can be achieved. The OptiBIRTH study has opened up this conversation on normality and VBAC and this thesis has shown that, no matter how small, there have been tentative steps towards changing the culture surrounding VBAC and normality in this field-site.

This study goes some way towards broadening the understanding of cultural change in one field-site hosting the OptiBIRTH study, and how this influences the women and clinicians who participated. It is anticipated that the findings will contribute in some capacity, to development of the understanding of this intervention, both methodologically and theoretically, and its unique influence on its participants.

The findings showed that the OptiBIRTH intervention was acceptable and beneficial to both women and clinicians. They further showed that change is possible, but happens very slowly, and it takes both clinicians and women to begin the conversation on change. Further change and improvement of VBAC rates is now the challenge for the local clinicians.



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STUDY PROTOCOL

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## Improving the organisation of maternal health service delivery and optimising childbirth by increasing vaginal birth after caesarean section through enhanced women-centred care (OptiBIRTH trial): study protocol for a randomised controlled trial (ISRCTN10612254)

### Abstract

**Background:** The proportion of pregnant women who have a caesarean section shows a wide variation across Europe, and concern exists that these proportions are increasing. Much of the increase in caesarean sections in recent years is due to a cascade effect in which a woman who has had one caesarean section is much more likely to have one again if she has another baby. In some places, it has become common practice for a woman who has had a caesarean section to have this procedure again as a matter of routine. The alternative, vaginal birth after caesarean (VBAC), which has been widely recommended, results in fewer undesired results or complications and is the preferred option for most women. However, VBAC rates in some countries are much lower than in other countries.

**Methods/Design:** The OptiBIRTH trial uses a cluster randomised design to test a specially developed approach to try to improve the VBAC rate. It will attempt to increase VBAC rates from 25 % to 40 % through increased women-centred care and women's involvement in their care. Sixteen hospitals in Germany, Ireland and Italy agreed to join the study, and each hospital was randomly allocated to be either an intervention or a control site.

**Discussion:** If the OptiBIRTH intervention succeeds in increasing VBAC rates, its application across Europe might avoid the 160,000 unnecessary caesarean sections that occur every year at an extra direct annual cost of more than €150 million.

**Trial registration:** Current Controlled Trials [ISRCTN10612254](https://www.ccrtrials.com/ISRCTN10612254), registered 3 April 2013.

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## Background

Concern has been expressed globally at the rising caesarean section rate. For example, the World Health Organization (WHO) recently noted that 'caesarean section rates higher than 10 % are not associated with reductions in maternal and new-born mortality rates' [38]. In the United States in 2012, the caesarean section rate rose for the twelfth consecutive year to 32.8 %, a proportional increase of 56 % since 1996 [24]. In Europe, the caesarean section rate increased between 1999 and 2005 in all European Union member countries for which data were available [5]. In 2010, Italy had a caesarean section rate of 38 %, whereas the rate was 17 % in the Netherlands, indicating wide variations in maternity care practices within Europe [12, 23]. Some of the reasons that have been offered for the continuing increase in caesarean sections include medico-legal issues, the increasing use of electronic foetal heart rate monitoring, and reduced training in operative vaginal and vaginal breech births [1, 2, 19]. Maternal request for caesarean section, that is, a caesarean section in the absence of medically indicated reasons, is a further frequently cited reason for increasing caesarean section rates, ranging from 2.6 % to 26.8 % of all caesarean sections [20, 32]. The most common reason, however, is repeat caesarean section following previous caesarean section [27], and this is a significant factor contributing to the overall increased caesarean section rates. Repeat caesarean section accounts for more than one-third of all caesarean sections in the United States [7].

Vaginal birth after caesarean (VBAC) is a safe alternative to repeat caesarean section, is preferred by most women and is deemed to be a key way of reducing overall caesarean section rates (Cunningham 2010). However, VBAC rates, which rose steadily across the world in the early 1990s, have declined dramatically again. In 2006, for example, approximately 8 % of women in the US who had a previous caesarean section had a VBAC in their next pregnancy (Cunningham 2010). Other reports indicate VBAC rates of between 30 % and 56 % [4, 37]. In Europe, wide variations in VBAC rates exist between and within countries, reflecting variations in maternity care practices and maternity care provision. For example, VBAC rates in Germany, Ireland and Italy have been found to be significantly lower (29 to 36 %) than those in the Netherlands, Sweden and Finland (45 to 55 %) [11]. Combined with the high caesarean section rates in some countries, such as Italy, this means that many women in Europe are unlikely to have a vaginal birth unless they indicate that they would prefer that over a caesarean section [10].

A number of reasons are offered for the variations in VBAC rates. These include medico-legal factors and the

inaccessibility of tertiary care centres, but variations in caesarean section rates are more likely to reflect national and individual clinician's approaches to clinical decision-making [18]. Of the women who do choose and are supported to have a planned VBAC, VBAC success is considerably higher (70 % to 87 %) than the average rates (Cunningham 2010, [13]). This indicates that VBAC is a real and viable option for most women with previous caesarean section.

Increasing the caesarean section rates in conjunction with declining VBAC rates is a maternity care issue of particular concern. If caesarean section rates continue to rise at the rate of recent years, the projected overall caesarean section rate by 2020 will be 56 % [36]. Considering the increased adverse maternal and neonatal outcomes associated with caesarean section [9, 15–17, 21, 25, 28, 37], this trend and its potential effects on the health of women and babies into the future requires more attention. A dedicated and concerted effort by women and clinicians has the potential to halt increasing caesarean section rates [3], increase VBAC rates [33] and improve the overall maternal and neonatal health and wellbeing of women and their babies.

The OptiBIRTH trial, conducted across different European health settings, involves unique collaborative efforts of women and clinicians. It seeks to enhance women-centred maternity care and, through the development and testing of an innovative complex intervention aimed at increasing VBAC rates in high caesarean section and low VBAC countries, reduce the fragmentation and lack of coherence in health service delivery. The OptiBIRTH trial will provide evidence to inform the organisation and provision of maternity care for many hundreds of thousands of women with previous caesarean section in Europe. Two systematic reviews of existing evidence have been published as part of the wider OptiBIRTH project: one on women-centred interventions and one on clinician-centred interventions for increasing VBAC rates [22, 30]. These provide justification for this trial and assisted in the design of the OptiBIRTH intervention.

This protocol sets out the design of the OptiBIRTH trial and has been prepared in accordance with the SPIRIT guidelines for the protocol for a randomised trial [6]. Findings of the trial will be reported in accordance with the CONSORT recommendations [26].

## Aim

The aim of the OptiBIRTH project, of which this trial is one component, is to improve maternal health service delivery, and optimise childbirth by increasing vaginal birth after caesarean section through enhanced women-centred maternity care across Europe.

## Objectives

The objective of this trial is to compare the effects of an intervention that has been developed with the intention of maximising VBAC versus usual care. This will be done through a cluster randomised trial in maternity units in three European countries with relatively low VBAC rates. The intervention was developed within the OptiBIRTH project and includes an effort to develop communities of practice in the intervention sites through face-to-face and online activities.

## Registration

The OptiBIRTH trial was prospectively registered in the ISRCTN Registry before randomisation was done (ISRCTN applied for: 17 March 2013; ISRCTN assigned: 3 April 2013; and randomisation conducted: 7 April 2013). The trial was assigned the following number: ISRCTN10612254.

## Study setting

A total of 16 sites (maternity units) agreed to take part in the OptiBIRTH trial initially: five from Ireland, five from Italy and six from Germany. In order to be eligible for participation, each site had to have a VBAC rate of less than 35 % and to provide a letter from the lead obstetrician (and, when available, the lead midwife) stating that they were willing for their institution to join the study. However, one of the German sites was withdrawn from the trial because of failure to recruit any participants in the first 6 months.

## Methods/Design

### Design

This is a cluster randomised trial of maternity units in three countries with relatively low VBAC rates (Germany, Ireland and Italy). The units represent a variety of healthcare settings (small, medium and large units, with annual births of 2,000 to 8,500) in both urban and rural locations [14]. For the purposes of the randomisation, two maternity units in the same city in Germany were considered as a single cluster for the purposes of the trial.

### Pilot study

A pilot study was conducted from January 2014 in Germany and February 2014 in Ireland and Italy, with sites having been pre-randomised to the intervention or control (see below). This pilot was used to identify problems with the research design and trial processes, to refine data collection and to examine selection and enrolment processes. The pilot concluded in March 2014 in Ireland and in April 2014 in Germany and Italy. The main analysis for OptiBIRTH will exclude women recruited during the pilot trial. It will include data on

women who gave their consent on or after 1 April 2014 in Ireland and 1 May 2015 in Germany and Italy.

## Randomisation

The unit of randomisation in the trial is the maternity unit (the 'site'). Randomisation had to be done in advance of recruiting women to participate in the trial to allow appropriate preparations to be made in each site. Further, given the temporal nature of pregnancy, it is not possible to hold randomisation until all women in each participating site have been recruited, because some women would have given birth by the time the last woman would have been recruited. However, as with cluster trials in which the participants cannot be blinded to the intervention, once the sites had been randomised, it is possible that recruitment of women to the trial was influenced by the knowledge of whether or not they would receive the OptiBIRTH intervention at that site. Hence, the primary analyses for the trial (see below) will consider data at the level of each site as a whole, rather than at the level of the women who were approached and formally recruited.

Within each of the three countries, the maternity units were matched by their annual number of births and then by VBAC rate. They were matched in either pairs or triplets and then randomised 1:1 or 2:1 to intervention or control, respectively. The randomisation was done using the random number generator in Microsoft Excel [RAND], with the first site in each matched pair or triplet being assigned a random number between 0 and 1. If the number was below 0.500, the site was allocated 'OptiBIRTH intervention'. If it was above 0.500, the site was allocated 'control'. If the number had been exactly 0.500 the randomisation would have been done again, but this did not happen. Where a matched pair had been formed, the second site was automatically allocated the opposite of the first site. Where a matched triplet had been formed, if the first site was allocated to the control group, the other two sites were automatically allocated to the intervention group. If the first site was allocated to the intervention group, the randomisation was repeated for the second site, and the third site was automatically allocated to the opposite of the allocation for the second site.

The randomisations were done in the presence of a witness who was unaware of which site was associated with which code within the pairs and triplets until after the allocations were complete. Although we recognise that it is not possible to mask the allocation of the sites from people who are familiar with them, including pregnant women and practitioners, further information on the sites is not included in this published protocol, to reduce the possibility that this knowledge might influence the referral of pregnant women to

the participating sites during the recruitment phase for the trial or the follow-up period for the primary outcome analysis (see below).

#### Eligibility criteria for participants

To be eligible for inclusion, pregnant women at a participating site must meet the following criteria:

1. Be  $\geq 18$  years of age at the time of booking
2. Have had one previous caesarean section using a lower segment transverse incision (not a classical/high vertical incision)
3. Speak and understand a language for at least one of the trial countries (English, German or Italian)
4. Provide informed consent to participate in the study

If a woman is known to have a multiple pregnancy at the time of the booking, she is not eligible.

#### Training and support for trial sites

Staff members at all study sites are proficient in maternity care provision and in caring for women with one previous caesarean section. They are provided with information on the trial by members of the research team, including the national postdoctoral researchers and principal investigators.

#### Interventions

Participating sites were randomised to either intervention or control.

#### OptiBIRTH intervention

Sites randomised to the intervention group will receive a complex innovative programme of evidence-based antenatal strategies, incentives and activities to increase the empowerment, engagement and involvement of women with a history of one previous caesarean section. Full details of the OptiBIRTH intervention will be published in a separate paper but, in summary, it seeks to empower women and to develop a community of practice in the site, with the intention of increasing the VBAC rate. The package includes face-to-face educational sessions about VBAC for clinicians in each site, specially designed antenatal classes for the recruited women and an optional interactive website and applications, which will assist them in setting personal goals to achieve their optimal birth outcome. Building a community of practice at the site, which would be more favourable to VBAC, should impact all women at the site, not just those who attend the antenatal classes or access the online resources.

#### Control

Sites randomised to the control group will receive the current standard of care in that maternity unit.

#### Process evaluation

The OptiBIRTH research team has developed a process evaluation plan to explore and document the implementation of the OptiBIRTH intervention, and how it was received by key stakeholders and to identify factors that could explain variation in outcomes across intervention sites. This evaluation will include details of the attendance of clinicians at their face-to-face educational sessions, the attendance of women at the antenatal classes and their use of the online resources. It will also include the gathering of information from both clinicians and women on their experiences with the OptiBIRTH intervention and the various activities and resources made available to them. In addition, the sites in which the intervention was implemented will be described, and findings will be used to assist in interpretation of the trial results. Such process evaluations are particularly important in cluster randomised trials, where a 'standardised' intervention may, in fact, be implemented in different ways or be the subject of different reactions [31]. A resulting 'lack of effect' may thus merely indicate problems with implementation rather than true ineffectiveness [8].

#### Outcome measures

##### Primary

The primary outcome measure will be the VBAC rates for women with one previous caesarean section for each site comparing the years before and after the delivery of the intervention. This is calculated as the number of women who gave birth by spontaneous vaginal delivery or with the use of ventouse or forceps after a single previous caesarean section, divided by the total number of women who gave birth at the site after a single previous caesarean section.

##### Secondary

Secondary maternal outcomes collected at and shortly after birth are described below:

1. Use of health care and other resources
2. Labour onset (spontaneous, induced, etcetera)
3. Spontaneous rupture of membranes
4. Acceleration of labour (artificial rupture of membranes, oxytocin use)
5. Analgesia during labour
6. Length of labour
7. Mode of birth
8. Perineal trauma (1st, 2nd, 3rd, 4th degree tear; episiotomy)
9. Maternal morbidity (for example: post-partum haemorrhage, uterine rupture, wound breakdown, admission to intensive care unit, etcetera)
10. Maternal death
11. Length of postnatal hospital stay (days)



Secondary neonatal outcomes collected during pregnancy and at, and shortly after, birth are described below:

1. Fetal demise during pregnancy (miscarriage, stillbirth, intrauterine death)
2. Gestation at birth
3. Apgar scores at 1 and 5 minutes after birth
4. Umbilical arterial and venous cord pH and base excess
5. Neonatal resuscitation
6. Admission to neonatal intensive care unit
7. Neonatal mortality
8. Neonatal morbidity (for example: seizures, hypoxic-ischemic encephalopathy, intracranial haemorrhage, meconium aspiration syndrome, renal failure, etcetera)
9. Length of neonatal postnatal stay (days)

Secondary maternal outcomes collected at 3 months post-partum are described below:

1. Satisfaction (with the intervention, mode of birth and participation in trial)
2. Breastfeeding (initiation and over the first 3 months post-partum)
3. Quality of life (measured by SF-36)
4. Use of health care and other resources

#### Sample size assumptions and estimates

The sample size for this cluster randomised trial was derived by adjusting an estimate for the sample size for an individually randomised trial to allow for clustering. This was done by inflating the estimate by the design effect given by  $1 + (\bar{n}-1)\rho$ , where  $\bar{n}$  is the average cluster size and  $\rho$  is the estimated intra-class correlation coefficient (ICC) for this study. With a background proportion of successful VBAC of 25 % and an ICC of 0.05, 12 trial units would be required, each containing 120 participating women (840 women in the intervention group and 840 women in the control group), to detect a 15 percentage point difference in successful VBACs (that is, an increase from 25 % in the control group to 40 % in the intervention group), with power of at least 80 % and an alpha level of 0.05. If the true ICC values are less than 0.05, the power of the study will increase. To allow for a loss to follow-up of 20 % of women and the possibility that one site per country will drop out of the trial, 15 trial units (16 maternity sites) were randomised across three countries.

#### Recruitment and consent

In order to maintain the integrity of the cluster randomisation, each woman in each site will be screened for eligibility for OptiBIRTH, using a pre-designed Trial

Screening and Register Form. Although all those who are eligible could be considered to have been randomised, it will only be possible to use data for those who give their consent.

Following screening, women who are judged eligible for OptiBIRTH will be informed of the study verbally and will receive a 'study information pack', including a detailed information leaflet and a consent form. This will be done by the midwives who are providing their antenatal care and takes place at the earliest opportunity in the woman's interaction with the maternity unit. If a woman presents too late in her pregnancy to avail herself of the antenatal classes or the online resources, she will not be approached about OptiBIRTH. Women, having had time to consider the study information and agreeing to participate in the trial, will sign and return the consent form to the local research office. On receipt of the signed consent form, women will be contacted by the local postdoctoral researcher (or designated hospital midwife) and provided with further details on accessing the trial processes (intervention sites only).

When seeking their consent, women will be offered the opportunity to participate in the trial at one of two levels, which relate to both their use of the various elements in the intervention and the provision of data. If the OptiBIRTH intervention succeeds in building a community of practice at the site which is more favourable to VBAC, this should impact all women at the site, not just those who choose the 'full participation' option and attend the antenatal classes or access the online resources.

The two levels of participation are as follows:

1. Full participation: women in the intervention sites would choose this option if they wanted to be able to attend the OptiBIRTH antenatal classes and access the online resources. In both the intervention and the control sites, women who choose this option are agreeing to complete the health surveys and a diary of healthcare expenses and to allow the OptiBIRTH researcher to access their healthcare records and those of their babies.
2. Routine data only: women choose this option if they are willing to give permission for the OptiBIRTH researcher to access the healthcare records for themselves and their baby, but do not wish to attend the antenatal classes or access the online resources (in the intervention sites) or to complete the health surveys and diary of healthcare expenses (in both intervention and control sites).

#### Data collection

Pre-designed data extraction forms will be used to collect all study outcome data. These include forms for

participant self-report of antenatal and postnatal health and wellbeing and healthcare resource use, as well as expenditure surveys and clinician-report labour and birth outcome data collection forms. Where relevant, the forms will be provided to the participants and they will be asked to complete and return them to their hospital. Other data (such as routine data on birth events) will be collected at each participating site by each country's national postdoctoral researcher or a designated research assistant. Each national coordinating team will use specially created Microsoft Access forms to enter and store their data before submission of the data in encrypted form to the OptiBIRTH trial and data management centre. The relevant data are to be submitted for each woman at each stage in the OptiBIRTH trial (from screening through to the data gathered on the postnatal follow-up forms). Each country's national coordinating/ postdoctoral researcher will audit approximately 5 % of the records for each participating site during their visits to those sites.

#### Data management and validation

Data will be submitted by encrypted email to OptiBIRTH's trial and data management centre (Centre for Public Health, Queen's University Belfast) monthly and stored in the trial database (Microsoft Access 2007). Appropriate validation rules are in place for each field in the OptiBIRTH data. Cross-validation routines have been established, where the content of one field would determine the validity of data in another field. For example, if a woman has a spontaneous vaginal birth, the fields for capturing data following a caesarean section should not be completed. The OptiBIRTH trial database will contain identifiable information and, as such, conforms to legal requirements as defined in the UK Data Protection Act 1998. In response to this Act, Queen's University Belfast issued a Policy Statement and developed robust data protection recommendations that the Centre for Public Health at Queen's University Belfast adhere to. Given that the database contains identifiable data, the potential risk associated with this database relates to a potential breach of participant confidentiality, whereby a party not involved directly in the study gains access to identifiable data, and the aforementioned policies and practices are designed to prevent this.

#### Data analysis

Statistical analysis plans will be prepared for the analyses of both the clinical and the cost-effectiveness data, and made available separately to this protocol. Where possible, the main analysis will be by 'intention-to treat' but this is not always possible in a cluster randomised trial where, by the nature of the intervention, the recruiters and the potential participants are aware of

their allocated intervention before they are asked to provide their consent. Therefore, the principal analysis to test the effect of the intervention at the site level will compare differences in the primary outcome, namely the proportions of VBAC, between the intervention and control sites. The comparison of VBAC rates in each of the participating sites will compare the change in the VBAC rates in the intervention sites versus the change in the control sites between the calendar year 2012 (that is, before the OptiBIRTH intervention was available to any hospital) and, if possible, the 12-month period after the month that the last OptiBIRTH baby is born in each hospital. However, for some hospitals, it might be necessary to use the data for the calendar year (that is, January to December) that follow the birth of the last OptiBIRTH baby in that hospital because of the practical difficulties of accessing hospital level data for periods other than calendar years.

In addition to the primary analyses at the level of the hospital, we will analyse the data for the women who agree to take part in the trial and their babies, in order to assess the effects of the intervention on the secondary outcomes listed above. Where outcomes have been collected as continuous variables (for example, duration of labour) they will be analysed as continuous data to compare the intervention and control sites. Likewise, dichotomous data (for example, breast feeding at 3 months) will be used to compare the proportions in the intervention and control sites. The analyses will adjust for whether the woman had had any prior vaginal birth or prior VBAC, and her BMI and age. We will conduct subgroup analyses for these adjustment variables and the three countries. Our hypothesis is that the effects of the intervention will not be so heterogeneous across these subgroups to invalidate the calculation of an overall result for the trial as a whole.

#### Trial oversight

##### Trial management group

There will be monthly Skype or teleconferences of the Trial Management Group, comprising the principal investigators and postdoctoral researchers from each country, in addition to the principal investigator and data manager for the trial, the project coordinator for the OptiBIRTH project as a whole, and other members of the OptiBIRTH project as appropriate to the specific meeting.

##### Trial steering committee

The Trial Steering Committee (TSC) comprises the members of the overall Steering Committee for the OptiBIRTH project as a whole. This group meets quarterly, usually by Skype or teleconference but with one

face-to-face meeting per year. Summary reports for each site, each country and the trial as a whole will be prepared every 3 months for the OptiBIRTH TSC, showing the data for each 3-month period and for the full duration of the trial to date. These reports contain data relating to the management of the trial to show its progress without revealing interim results.

#### Data monitoring committee

To optimise participant safety and the scientific integrity and credibility of the results of the trial, an international Data Monitoring Committee (DMC) will conduct an interim analysis of data from approximately 400 to 700 women who have birthed and will provide an interim report. They will be provided with unblinded data on the VBAC rate at each site in the year before the OptiBIRTH trial began, the number of women recruited in each site and the proportion of those who are known to have birthed who did so by spontaneous vaginal delivery or with the use of ventouse or forceps. This initial assessment of the effects of the intervention on VBAC and safety will influence the decision on whether control sites should be offered the intervention on completion of the trial within the available funding timeframe. The DMC will assess participant safety and whether either intervention is showing a much stronger or weaker effect than expected. It will make recommendations concerning the future of the study to the TSC.

#### Ethical considerations

The ethical issues involved in this study are the key principles of ensuring the protection of human rights, the maintenance of scientific integrity, the minimising of harm and maximising of benefit and ensuring justice and equity, autonomy and informed consent, confidentiality, data protection and privacy. Ethical approval was granted by the Faculty of Health Sciences, Trinity College Dublin, Ireland and regional Research Ethics Committees for all participating study sites in each participating country. A list of the relevant committees was provided to the journal as part of the approval process for this manuscript, but, as noted above, identifying information for the sites is not included in this published protocol to reduce the possibility that this knowledge might influence referral of pregnant women to the participating sites during the recruitment or follow-up phases for the trial.

#### Ancillary studies

Should the opportunity arise to conduct a SWAT (Study within a Trial) in OptiBIRTH, this will be discussed with the TSC and implemented with their approval. The SWAT programme has been developed by the Northern

Ireland Network for Trials Methodology Research as a means to encourage the conduct of research within research, to reduce uncertainties about the most appropriate and effective methods to use in randomised trials and other evaluations of health and social care [34, 35].

#### Dissemination

The main findings of OptiBIRTH will be published under an Open Access model and will be presented at relevant national and international conferences. The current intention is that the analyses for the participating women will be published following collection of the final outcome data for all of those women.

#### Discussion

Recruitment to the OptiBIRTH trial is expected to close in all sites in 2015, with all participating women expected to birth by the end of the year. Recruitment has been slower than anticipated, in part because birth rates have fallen at several of the sites. As with cluster randomised trials in general, it has not been possible to recruit all potentially eligible women at each site. Among the reasons for this are that some of the women who were offered participation in the trial did not wish to join and because of challenges in fully initiating the study in each site. This may introduce differences between the participants in the intervention and control sites, which reinforces the importance of the primary analyses being a comparison of the VBAC rates for all women with one previous caesarean section at each site before and after the study period using routine data from each site. If the OptiBIRTH intervention succeeds in increasing VBAC rates, its application across Europe might avoid 160,000 unnecessary caesarean sections every year, which occur at an extra direct annual cost of more than €150 million.

#### Trial status

This protocol was submitted for publication in May 2015 when recruitment was ongoing. The last women are expected to join the trial by October 2015.

#### Abbreviations

DMC: Data Monitoring Committee; ICC: intra-class correlation coefficient; ISRCTN: International Standard Randomised Controlled Trial Number; SWAT: study within a trial; TSC: Trial Steering Committee; VBAC: vaginal birth after caesarean section; WHO: World Health Organization.

#### Competing interests

The authors declare that they have no competing interests.

#### Authors' contributions

MC helped to design the study and drafted, revised, finalised and approved the protocol. He is the leader of the Work Package for the OptiBIRTH trial within the OptiBIRTH project as a whole. GS drafted, revised and approved the protocol. VS drafted, revised and approved the protocol. DDa revised and approved the protocol. DDe helped to design the study and revised and approved the protocol. He is the Principal Investigator for the OptiBIRTH

trial in Ireland. MMG helped to design the study and revised and approved the protocol. She is the Principal Investigator for the OptiBIRTH trial in Germany. SGB revised and approved the protocol. PH revised and approved the protocol. SM helped to design the study and revised and approved the protocol. She is the Principal Investigator for the OptiBIRTH trial in Italy. JN revised and approved the protocol. CB helped to design the study and revised and approved the protocol. She is the Principal Investigator for the OptiBIRTH project as a whole. All authors have made substantial contributions to conception and design or acquisition of data for the OptiBIRTH trial. All authors read and approved the final manuscript.

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## Appendix 2: Ethical Approval for OptiBIRTH Study from TCD



COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH TRINITY COLLEGE DUBLIN  
Coláiste na Tríonóide The Trinity of Dublin

Dámh na nEolaíochtaí Sláinte,  
An Chéad Urlar, Foirgneamh na Ceimice (an sineadh)  
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T:- +353 (0)1 8964255

Prof. Cecily Begley, Prof. Joan Lalor,  
School of Nursing and Midwifery,  
24 D'Olier Street,  
Dublin 2

27 June 2012

**Study:** OptiBIRTH: Improving the organisation of maternal health service delivery, and optimising childbirth, by increasing vaginal birth after caesarean section (VBAC) through enhanced women-centred care.

FP7-HEALTH-2012-INNOVATION-1 HEALTH.2012.3.2-1

Dear Applicant(s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in May 2012, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely,

*PP O'Sheils*

Prof. Orla Sheils  
Chairperson  
Faculty Research Ethics Committee

## Appendix 3: Lundgren *et al.*, (2015)

Lundgren *et al.* BMC Pregnancy and Childbirth (2015) 15:16  
DOI 10.1186/s12884-015-0441-3



RESEARCH ARTICLE

Open Access

# Clinician-centred interventions to increase vaginal birth after caesarean section (VBAC): a systematic review

Ingela Lundgren<sup>1\*</sup>, Valerie Smith<sup>2</sup>, Christina Nilsson<sup>1</sup>, Katri Vehvilainen-Julkunen<sup>3</sup>, Jane Nicoletti<sup>4</sup>, Declan Devane<sup>5</sup>, Annette Bernloehr<sup>6</sup>, Evelien van Limbeek<sup>7</sup>, Joan Lalor<sup>2</sup> and Cecily Begley<sup>2</sup>

### Abstract

**Background:** The number of caesarean sections (CS) is increasing globally, and repeat CS after a previous CS is a significant contributor to the overall CS rate. Vaginal birth after caesarean (VBAC) can be seen as a real and viable option for most women with previous CS. To achieve success, however, women need the support of their clinicians (obstetricians and midwives). The aim of this study was to evaluate clinician-centred interventions designed to increase the rate of VBAC.

**Methods:** The bibliographic databases of The Cochrane Library, PubMed, PsychINFO and CINAHL were searched for randomised controlled trials, including cluster randomised trials that evaluated the effectiveness of any intervention targeted directly at clinicians aimed at increasing VBAC rates. Included studies were appraised independently by two reviewers. Data were extracted independently by three reviewers. The quality of the included studies was assessed using the quality assessment tool, 'Effective Public Health Practice Project'. The primary outcome measure was VBAC rates.

**Results:** 238 citations were screened, 255 were excluded by title and abstract. 11 full-text papers were reviewed; eight were excluded, resulting in three included papers. One study evaluated the effectiveness of antepartum x-ray pelvimetry (XRP) in 306 women with one previous CS. One study evaluated the effects of external peer review on CS birth in 45 hospitals, and the third evaluated opinion leader education and audit and feedback in 16 hospitals. The use of external peer review, audit and feedback had no significant effect on VBAC rates. An educational strategy delivered by an opinion leader significantly increased VBAC rates. The use of XRP significantly increased CS rates.

**Conclusions:** This systematic review indicates that few studies have evaluated the effects of clinician-centred interventions on VBAC rates, and interventions are of varying types which limited the ability to meta-analyse data. A further limitation is that the included studies were performed during the late 1980s-1990s. An opinion leader educational strategy confers benefit for increasing VBAC rates. This strategy should be further studied in different maternity care settings and with professionals other than physicians only.

**Keywords:** VBAC, Systematic review, Interventions, Clinicians

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## Background

Caesarean section (CS) rates have risen globally in the past decade, causing concern among clinicians. The lack of evidence of any decrease in morbidity associated with this rise 'raise questions about clinical effectiveness and the role of evidence' ([1], p. 78). Reasons suggested for the continuing increase in CSs include decreased training for clinicians in instrumental vaginal and vaginal breech births, medico-legal issues, the increased use of electronic fetal heart rate monitoring in labour [2-4], and maternal request [5,6]. Repeat CS after a previous CS birth is a significant contributor to overall increased CS rates and accounts for more than one-third of all CSs in the US [7].

Although a necessary and sometimes life-saving operation, CS is associated with more than double the rate of severe maternal morbidity and maternal mortality when compared with vaginal birth [8]. The challenge then is to reduce those CSs that are unnecessary, while retaining those that are needed to save lives and decrease morbidity. Planned vaginal birth after CS (VBAC) compares favourably with routine elective repeat CS. A systematic review and meta-analysis of 203 studies [9], demonstrated that maternal mortality was increased significantly with elective repeat CS (ERCS) compared with planned VBAC (1.34 versus 0.38 per 10,000). In contrast, perinatal mortality was significantly increased with planned VBAC (13 per 10,000) compared with ERCS (5 per 10,000) although absolute rates are low [9]. This complicates the decision-making process as clinicians and women attempt to balance the risks involved. However, as maternal morbidity is also greatly increased with ERCS when compared to planned VBAC [9], the evidence, on balance, suggests that VBAC is a reasonable and safe option for most women. In Europe, VBAC rates vary widely, and have declined considerably in recent years, with significantly lower rates in Spain and Portugal (20-30%) than in Sweden, the Netherlands and Finland (45-55%) [10]. Although difficulties accessing tertiary care and medico-legal reasons may influence VBAC rates, variations are more likely to arise from an individual clinician's approaches to decision-making around mode of birth [11]. Successful vaginal birth rates for women who plan a VBAC are high (70% to 87%) [10,12]; to achieve success, however, women need the support of their clinicians.

This systematic review was designed to identify, appraise and synthesise existing evidence that evaluated clinician-centred interventions designed to increase the rate of VBAC in women with a previous CS birth(s).

## Methods

Criteria for selection of studies

Reports of randomised controlled trials including cluster randomised trials that evaluated the effectiveness of any clinician-centred intervention (defined as any intervention

targeted directly at obstetricians and/or midwives or involving obstetricians and/or midwives as participants) designed to increase the rate of VBAC were considered eligible for inclusion in our review. Non-randomised studies and studies evaluating interventions to increase VBAC rates targeted at individuals other than clinicians were excluded. The primary outcome measure was VBAC, and the secondary outcomes were: compliance with intervention, modes of birth (instrumental birth, emergency CS, elective CS), maternal death, perinatal death and uterine rupture.

## Search strategy

We searched the electronic databases of The Cochrane Library (CENTRAL), PubMed, PsychINFO and CINAHL from their inception date to July 2014. The following search strategy was developed and adapted as appropriate to the various databases (Additional file 1).

The search string was reviewed for completeness and accuracy, using the peer review of electronic search strategies (PRESS) criteria [13], by a review team member not involved in the strategy development (CB). The PRESS criteria, developed through systematic review and expert opinion, facilitates independent review of the developed search strategy, prior to application, to enhance the quality of the search methodology in systematic reviews. Eleven criteria are listed which are used to guide the peer reviewer in assessing the developed search strategy; for example, assessment of whether the elements addressing the search question have been correctly combined with Boolean and/or proximity operators and assessment as to whether all relevant spelling variants are covered by the search terms. In addition, the selection of papers for inclusion in the review was performed independently by two teams of reviewers (IL and CN, and CB and JL). The web-based systematic review software DistillerSR (<http://systematic-review.net/>) was used to manage the search and citation screening process. DistillerSR is a 100% web-based package which allows reviewers download database identified citations. Independent screening by reviewers can then be performed from anywhere in real time using any web browser or type of computer. The system is designed to allow for identification of agreements by reviewers on inclusion and exclusion and movement of citations to next level screening (for example, where both reviewers agree on inclusion at abstract screening, the citation is forwarded for full text screening). In addition, any disagreements on inclusion at each level are highlighted for the reviewers. The package allows for rapid, easy and precise screening of papers for including in a systematic review.

## Quality assessment of included studies

The quality of the included studies was assessed using the quality assessment tool, 'Effective Public Health Practice



Project' [14], which assists in assessing randomised trials for potential sources of bias. This tool assesses components such as bias in selection, allocation, blinding, confounding, methods used for data collection, withdrawals from the study, analysis and intervention integrity. Following assessment, each study is assigned a rating of Strong quality (no weak ratings noted), Moderate (one weak rating noted) or Weak (two or more weak ratings noted). If an individual study received a 'Weak' global rating score, due to poor methodological quality, this study was subsequently excluded from analysis.

Two members of the review team (VS and JN) assessed the quality of included studies independently. Any disagreements were discussed and resolved by consensus. Where disagreements occurred that could not be resolved by consensus, we planned to consult a third reviewer; however, this was not necessary.

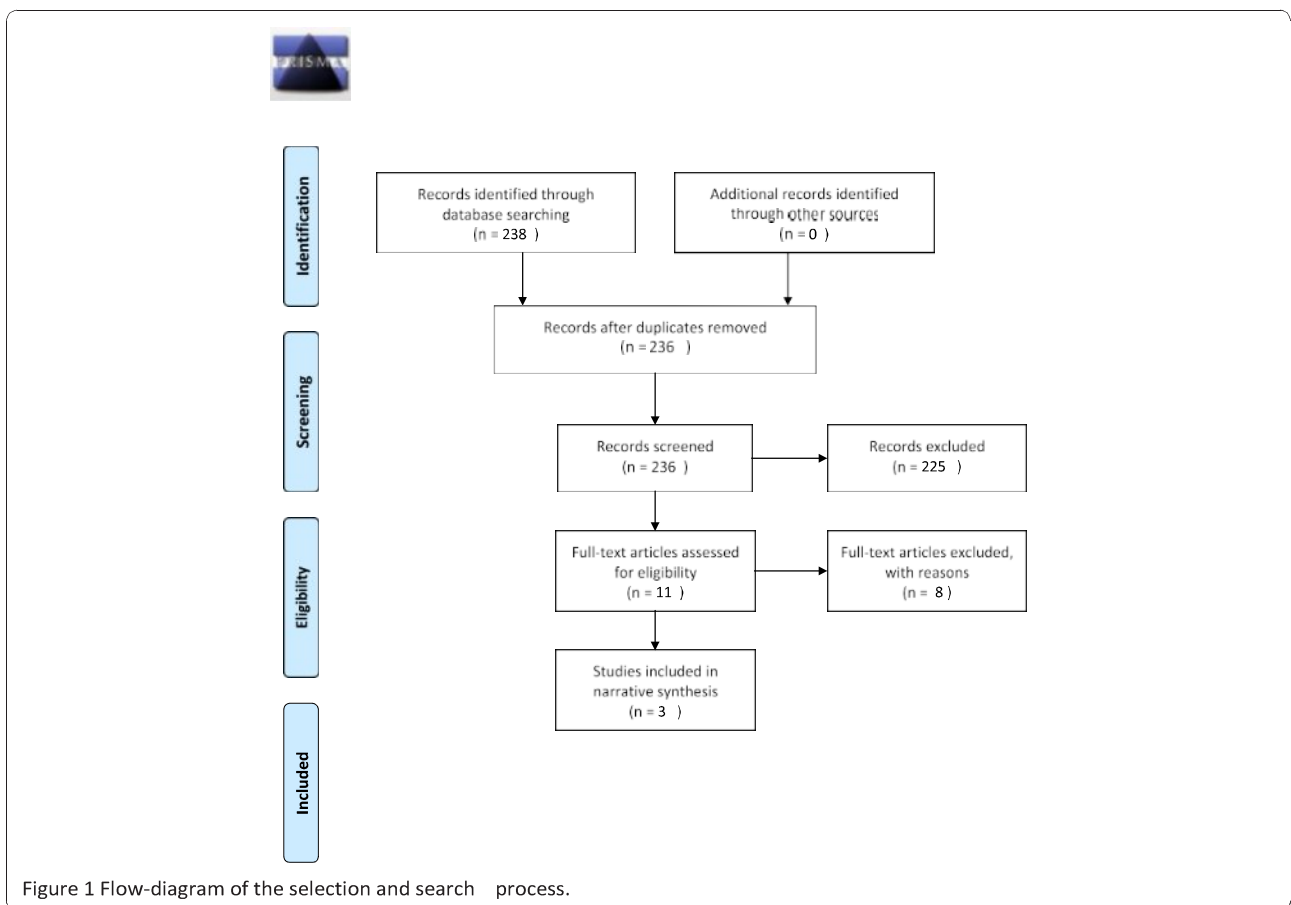
#### Data extraction and analysis

Three review team members (KVJ, AB and EvL) independently extracted data on outcomes of interest using a pre- designed data extraction form. The data were subsequently examined by a third reviewer (VS) for accuracy. We planned to perform meta-analyses of dichotomous data,

and to use a summary risk ratio with 95% confidence intervals to present the results and to pool continuous data using the mean, or standardised mean, difference with 95% confidence intervals. Due to the diverse nature of the interventions that were evaluated in the individual studies, statistical pooling of individual study results was not possible. Consequently, we have provided a narrative synthesis of the results.

#### Results

We identified 238 citations from the database search. After removing duplicates, 236 unique citations were screened by title and abstract and 225 of these were excluded. Full- text papers of the remaining eleven citations were obtained and reviewed. Eight of these were excluded: one did not focus on clinicians, two did not refer to a specific intervention, three did not focus on VBAC, one was a trial protocol and one was a review of trials of planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean section (See List of Saints). This resulted in three papers suitable for inclusion in this review (Figure 1). One study [15] evaluated the effectiveness of antepartum x-ray pelvimetry (XRP) in women with one previous CS. One study [16] evaluated the effects of



external peer review on CS birth and one study [17] evaluated opinion leader education and audit and feedback as methods for encouraging compliance with a guideline for the management of women with a previous CS.

#### Excluded studies

Mancuso A, De Vivo A, Fanara G, Albiero A, Priolo AM, Giacobbe A, Franchi M. Caesarean section on request: Are there loco-regional factors influencing maternal choice? An Italian experience. *Journal of Obstetrics and Gynaecology*, 2008 28(4), 382–385.

Caroline A. Crowther CA, Dodd JM, Hiller JE, Haslam RR, Robinson JS, on behalf of the Birth After Caesarean Study Group. Planned Vaginal Birth or Elective Repeat Caesarean: Patient Preference Restricted Cohort with Nested Randomised Trial *PLoS Medicine* 2013, 9(3), e1001192.

Bernitz S, Aas E, Øian P. Economic evaluation of birth care in low-risk women. A comparison between a midwife-led birth unit and a standard obstetric unit within the same hospital in Norway. A randomised controlled trial. *Midwifery* 2013, 28, 591–599.

Lavender T, Kingdon C, Hart A, Gyte G, Gabbay M, Neilson JP. Could a randomised trial answer the controversy relating to elective caesarean section? National survey of consultant obstetricians and heads of midwifery. *BMJ* 2005, 331, 490–91.

Montgomery AM, Emmett CL, trial coordinator, Fahey T, Jones C, Ricketts I, Patel RR, Peters TJ, Murphy DJ, professor of obstetrics, on behalf of the DiAMOND Study Group. Two decision aids for mode of delivery among women with previous caesarean section: randomised controlled trial. *BMJ* 2007 4 doi:10.1136/bmj.39217.67101955. Dodd JM, Crowther CA, Huertas E, Guise JM, Horey D. Planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean birth. *Cochrane Database of Systematic Reviews* 2013, 12, CD004224.

Giguère A, Légaré F, Grimshaw J, Turcotte S, Fiander M, Grudniewicz A, Makosso-Kallyth S, Wolf FM, Farmer AP, Gagnon MP. Printed educational materials: effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews* 2012, 10, CD004398.

Homer CSE, Besley K, Bell J, Davis D, Adams J, Porteous A, Foureur M. *BMC Pregnancy and Childbirth* 2013, 13:140. Does continuity of care impact decision making in the next birth after a caesarean section (VBAC)? A randomised controlled trial [<http://www.biomedcentral.com/1471-2393/13/140>].

#### Description of included studies

X-ray Pelvimetry as an assessment for suitability for VBAC Thubisi et al. [15] compared antepartum XRP with no antepartum XRP in women at 36 weeks gestation to

determine mode of birth. Participants were pregnant women (n = 306) with one previous transverse lower segment CS and no obvious medical or obstetric risk factor (e.g. abnormal fetal lie, intrauterine death, intrauterine growth restriction, multiple pregnancy and maternal medical disorders, such as cardiac disease, contraindicating a planned VBAC). One hundred and fifty-three women were initially randomised to each group, however, 18 women were subsequently excluded for the following reasons; four women withdrew (one and three in the intervention and control group, respectively) and 14 women were excluded due to pregnancy complications (eight in the intervention group and six in the control). Women in the intervention group received antenatal XRP at 36 weeks. If XRP measurements were above minimum values (i.e., sagittal inlet 11 cm, sagittal outlet 10 cm, transverse inlet 11.5 cm and transverse outlet 9 cm) women were permitted to attempt a planned VBAC (84 women). Women in the control group did not receive antenatal XRP but had a postpartum XRP (144 women). The main outcome measures of interest were mode of birth, including VBAC, maternal and perinatal morbidity and mortality and effect of antepartum XRP on the rate of repeat CS.

#### Opinion leaders and audit and feedback of CS

Lomas et al. [17] evaluated two interventions in their study; audit and feedback and use of opinion leaders. The unit of randomisation was a community hospital with at least 100 beds, of which 10 or more were obstetrical, that had no status as a teaching institution. Of 51 hospitals in 24 counties that satisfied the inclusion criteria, 16 hospitals were randomly selected to take part in one of the intervention groups or in the control group. Audit and feedback, which comprised of the following minimum activities; i) to establish departmentally agreed-on criteria for the use of CS in cases of women with previous CS, based on (but not identical to) the practice guideline, ii) to have medical audits of the charts of all women with a previous CS and to compare actual practice with the agreed-on criteria and iii) to hold meetings of the entire department every three months during 1988 for feedback and discussion of the audit results, especially discrepancies between actual criteria and agreed-on practice. Opinion leaders, which comprised of the following minimum activities: i) a mailing (early 1988) under the opinion leader's name with a covering letter of an information binder for each physician engaged in obstetrical care in the opinion leader's hospital (including the guideline in excerpt and in full version with a visual aid, a bibliography of relevant studies and letters of support for the guideline and the study); ii) a mailing (for later inclusion in the binder) of two further detailing sheets over the first months of 1988, addressing topics that the opinion leaders agreed were of concern to colleagues who might wish to consider

implementing the recommendations of the practice guideline; iii) the opinion leader was to host a meeting with an expert speaker who was both knowledgeable and credible in the area of VBAC; and iv) to maintain and enhance their regular formal and informal educational contacts with colleagues and to record these in logbooks for the first 12 months of the intervention. The control group included all physicians active in obstetrical care who received a single mailing (January 1988) of a copy of the practice guideline. A brief exhortatory letter drew attention to the portion of the guideline that addressed the use of CS for women with a previous CS. The letter emphasised that the guideline had been endorsed by the national obstetrical specialty society, and requested that physicians implemented the recommendations. The total number of participants eligible for planned VBAC was 2496 (n = 524 in audit and feedback intervention, 739 in opinion leader intervention and 1233 in control group). The primary outcomes were rates of trial of labour and VBAC over the 24-month study period.

#### Peer-review of CS

Bickell et al. [16] evaluated the effectiveness of peer review on CS rates. External peer review was performed by ACOG-trained teams of three or four physicians and nurse reviewers who visited intervention hospitals (n = 45), interviewed key staff members, and reviewed labour and birth records to assess the quality of care. Records were selected randomly using the New York State Department of Health hospital discharge data base. Review teams provided feedback to the hospital through an exit interview, written summary of findings and recommendations. Outcomes (rates of CS and VBAC) were compared to non-peer reviewed hospitals (n = 120) for the years before and after completion of the programme (1988–1993).

#### Methodological quality of included studies

Due to the nature of the intervention, blinding of either the clinician or the participating woman to her allocation was not feasible. Therefore, a lack of blinding did not negatively affect the quality assessment (Table 1).

#### Effects of interventions

We did not regard the three interventions studied to be sufficiently similar to ensure meaningful conclusions from a statistically pooled result. Therefore, a narrative synthesis of results is reported by presenting the major outcomes and results, organised by intervention categories. Forest plots illustrating point estimates (relative risks, (RR) and 95% confidence intervals (95% CIs) for each study for each of the main outcomes are presented. All of the studies reported the primary outcome of VBAC rates. Data on our pre-specified secondary

Table 1 Results of the methodological quality appraisal (Effective Public Health Practice Project) of the included studies

Component	Thubisi	Bickell	Lomas
Selection bias avoided	Strong	Strong	Strong
Allocation bias avoided	Moderate	Strong	Moderate
Confounders avoided	Strong	Strong	Strong
Blinding (but not considered when calculating global quality score)	Weak	Weak	Weak
Data collection methods	Weak	Strong	Strong
Withdrawals & Drop-outs	Strong	Strong	Strong
Analysis: Intention to treat	Strong	Strong	Weak
Intervention integrity: % of participants that received allocated intervention	Strong	Strong	Strong
Global quality score	Moderate	Strong	Moderate
Include study	Yes	Yes	Yes

outcomes were limited or reported variously in the included studies. Consequently, the primary outcome of interest only is reported in this review.

#### Antenatal XRP versus no antenatal XRP

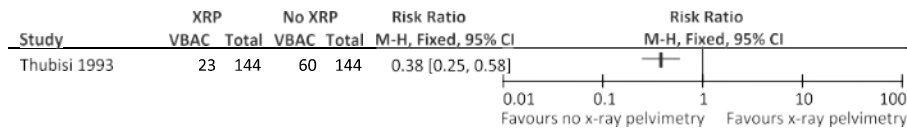
Thubisi et al. [15] evaluated antenatal XRP in women with one previous CS. Women receiving antenatal XRP were statistically significantly less likely to have a VBAC than women who did not undergo XRP in pregnancy (16% versus 42%) (Figure 2). When women in the intervention group, with an inadequate antenatal XRP (as per study protocol), were excluded from the analysis (60 women), the results remained statistically significant in favour of no antenatal XRP for increasing VBAC rates (27% versus 42%; RR 0.66, 95% CI 0.44-0.98).

#### Opinion leaders, audit and feedback of CS

In Lomas et al's [17] study, the analysis demonstrated no statistically significant difference in the incidence of VBAC between the audit and feedback (A/F) and control groups (12% versus 14%, respectively) (Figure 3). In contrast, an opinion leader education strategy (OLE) significantly increased the VBAC rate (25%) when compared to the control group (14%) (Figure 4).

#### Peer review of CS

Bickell et al. [16] reported the mean proportion of VBACs across all participating hospitals for the years 1988 (the year peer review was introduced) to 1993. The proportion of VBACs increased in both peer reviewed and non-peer reviewed hospitals during the study period (by 14.6% and 12.7%, respectively). The increase in mean VBAC proportions between peer-reviewed and non-peer-reviewed hospitals was not statistically significant (Figure 5).



## Discussion

### Main findings

This systematic review of clinician-centred interventions for increasing VBAC rates demonstrates that the use of opinion leaders significantly increases the rates of VBAC where the use of antenatal XRP significantly decreases VBAC rates. External peer review of CS did not demonstrate any statistically significant effect in either direction.

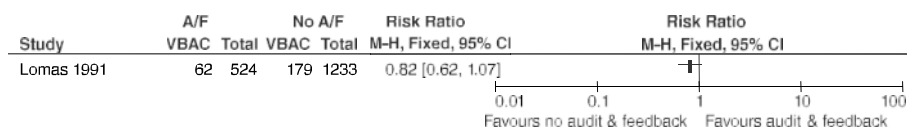
### Strengths and limitations

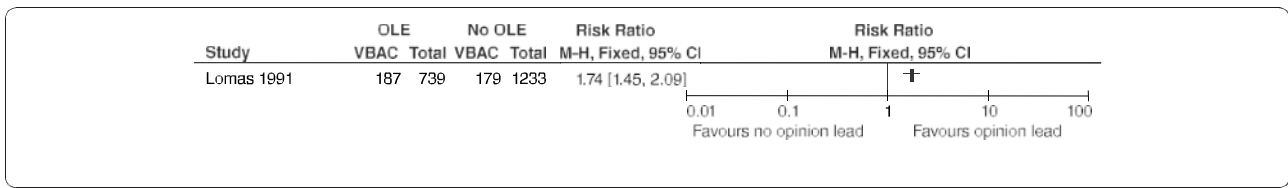
This was a comprehensive review, covering all key health-related databases from their inception. We found relatively few studies evaluating the effects of clinician-centred interventions on VBAC rates and, of those we did find, the interventions evaluated are of varying types. Of the three included studies, the methodological quality was judged to be either moderate or strong, adding strength to the findings of this review. All three included studies scored strongly on 'selection bias avoided' as the individuals selected to participate in the study were very likely to be representative of the target population. Thubisi received an overall 'moderate' score for allocation bias as alternative randomisation was used to ensure equal groups. A weak rating was allocated to the data collection component for this study as we were unable to determine from the paper whether the data collection tools/methods were reliable and valid. All three studies reported clearly their withdrawal/drop-out rates, receiving a component rating of strong on this methodological criterion. Finally, although a number of women (n = 60) in the Thubisi study did not receive the allocated XRP intervention due to strict protocol criteria, to receive a strong rating on this component the overall proportion of participants not receiving their allocated intervention must be greater than or equal to 80%. When the numbers in both intervention and control groups were considered, 79.7% overall received their assigned allocation. For this reason, we allocated a strong quality rating for this component in the Thubisi study. For the other two studies, greater than 80% of the participants received their assigned allocation and were thus deemed methodologically

strong on this component. One limitation of this review is that the included studies are rather old. Since the studies were performed the CS rate has increased in the included countries and the maternity care may also have changed. We had presumed to find more, and recently performed, studies.

### Interpretation

The study by Lomas et al. [17], with 76 physicians from 16 community hospitals in Canada, demonstrated that an educational opinion leader strategy significantly increases the VBAC rate when compared to a control (i.e. a single mailing of a copy of the practice guideline with a brief exhortatory letter drawing attention to the portion of the guideline that addressed the use of CS for women with a previous CS, and request for physicians to implement the recommendations). The educational opinion leaders supported their colleagues [17], which highlights the importance of learning from professional experts and following-up initial educational endeavors. According to this study, common guidelines are insufficient and should be combined with an educational strategy facilitated by an opinion-leader. These findings are supported by a review by Khunpradit et al. that examines non-clinical interventions, applied independently of patient care in a clinical encounter, for reducing unnecessary CS [18]. In this review, guidelines with support of local opinion leaders, internal peer review and mandatory second opinion were shown to be effective in reducing CS rates [19]. Although the study by Lomas et al. [17] was conducted in the late 1980s, we judge that the findings are of relevance today. The study assessed behavior change strategies and innovative education that improved the quality of care. These complex questions remain as important and relevant today as they did then. Further research, in the form of methodologically robust randomized trials, are needed to evaluate this strategy in different maternity care systems and countries. As concluded in a population-based cohort study about the rising CS rate in Australia, only 24% of the increase in primary CS rates could be explained by maternal factors and by increased private maternity





services, suggesting that changing attitudes towards CS birth are, in part, driving the increase [19].

The study by Thubisi et al. [15] does not support the hypothesis that routine antepartum XRP in women with a history of a previous CS effectively identifies those who can achieve a vaginal birth. Rather, the authors conclude that more women will succeed in giving birth vaginally without any additional harm to themselves and their babies if antepartum XRP is not performed. This conclusion is supported by recent guidelines recommending that the use of X-ray pelvimetry to decide about planned VBAC is associated with an increase in the repeat CS rate without any reduction in the rate of uterine rupture [20]. Sun and Wen [21] refer to the study by Thubisi et al. [15] as one of few randomised trials that studied the clinical usefulness of X-ray pelvimetry. Therefore, the study is relevant today even if it was performed more than 20 years ago. The authors [21] conclude that it would be better that x-ray pelvimetry is performed as a complementary treatment in women for whom a trial of labour after CS is planned, rather than performed as routine.

Since the rising CS rate over time is of international concern [1], we anticipated that we would have found more data on this phenomenon. Lomas et al. concluded that there were no adverse clinical outcomes attributed to the interventions, and the use of an opinion leader improved the quality of care. However, 74.2% of the women were offered VBAC and 38.2% experienced a successful VBAC which, according to the authors, may be due to women's expressed preferences, or 'patient factors'. Further advances may therefore have to rely on the education of women [17] on the advantages of planned VBAC when compared with repeat planned CS. We support that conclusion but would also suggest that other health professionals involved in VBAC-care, in addition to obstetricians, should be included. A study from Italy exploring professionals' (midwives and physicians) attitudes demonstrated differing attitudes towards CS according to professional roles [22]. Midwives appeared to be more aware of the risk of performing unnecessary CS, whereas

obstetricians were more likely to underestimate risk of CS and to overestimate the benefits of this procedure. The authors conclude that midwives discussing the risks and benefits of CS with women before birth could have a positive influence on VBAC rates. We suggest that further studies should include both midwifery and obstetric opinion leaders in order to validate this as an effective intervention to increase VBAC rates internationally.

Since the Lomas study [17] the CS rate has increased in Canada from 16.4% in 1995 to 23.3% in 2006, which occurred with no change in perinatal mortality [23]. The VBAC rate in Quebec has declined from nearly 40% in 1995 to 20% in 2009. Rossignol et al. [23] obtained statistical variations of CS rates over time, across Canadian regions, and within professional practices from 1969–2009. The results show that expectant management (as an alternative to labour induction) and planned vaginal birth after CS is the leading robust strategy to reduce rates of CS in women at low risk of obstetric complications. According to the authors, increasing the availability of VBAC would require appropriate identification of potential candidates (currently still a barrier), as well as specially trained professionals in centers that can ensure safety [23]. The authors conclude that the major argument against reducing the rate of CS remains the fear of legal action against clinicians for not intervening in the case of an adverse outcome. Fear of litigation is also supported by other authors as a major contributory factor to rising CS rates [17,23-25]. A study on obstetricians' attitudes to CS in eight European countries (Luxembourg, the Netherlands, Sweden, France, Germany, Italy, Spain and UK) found that fear of litigation was less relevant to physicians' decision-making in Sweden and the Netherlands, a finding consistent with the low medico-legal burden in these countries [24]. Sweden and the Netherlands have high VBAC rates of 45-55% [10], even higher than the peak rate in Canada in 1995 [24]. Therefore studies evaluating clinician-centred interventions for improving the VBAC rate must be related to a country's culture and maternity care settings. According to Chandrahan and Arulkumaran [25] medico-legal problems

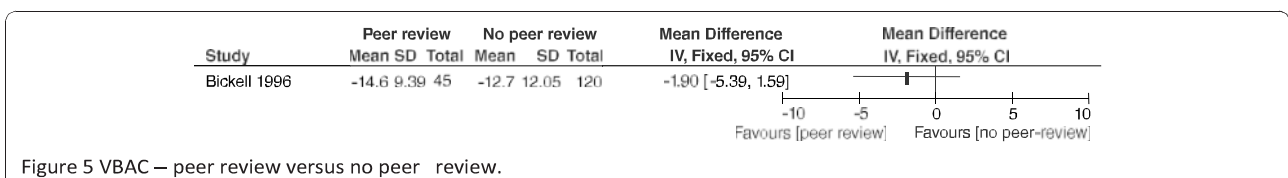


Figure 5 VBAC – peer review versus no peer review.

in obstetrics can be reduced by effective communication, team working, training and education, a finding that supports involving more professionals than physicians in interventions for increasing the VBAC rate.

## Conclusions

The findings from this systematic review of clinician-centred interventions to increase VBAC identified only three studies that met the inclusion criteria, highlighting limited research in this area. The findings show that the use of opinion-leaders in women with previous CS increases the VBAC rate, and the use of ante-partum XRP decreases the VBAC rate. There is a need for further research that evaluates interventions for increasing VBAC rates that target clinicians. In addition, an evaluation of the use of opinion-leaders in different maternity care settings and with professionals other than physicians is recommended.

## Additional file

[Additional file 1:](#) Search string.

### Competing interests

The authors declare that they have no competing interests.

### Authors' contributions

JL developed the search strategy, which was reviewed by CB, IL, CN and DD conducted the searches. IL and CN, and CB and JL independently selected papers for inclusion. JN and VS independently assessed the quality of the included studies. KVJ, EVL, and AB independently extracted data from the included studies, and VS checked these data for accuracy. DD did the data analysis and CB checked it. IL drafted the paper. All authors commented, and agreed on, the final version.

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## Midwifery



### Women-centred interventions to increase vaginal birth after caesarean section (VBAC): A systematic review



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#### abstract

**Objective:** to evaluate the effectiveness of women-centred interventions during pregnancy and birth to increase rates of vaginal birth after caesarean.

**Design:** we searched bibliographic databases for randomised trials or cluster randomised trials on women-centred interventions during pregnancy and birth designed to increase VBAC rates in women with at least one previous caesarean section. Comparator groups included standard or usual care or an alternative treatment aimed at increasing VBAC rates. The methodological quality of included studies was assessed independently by two authors using the Effective Public Health Practice Project quality assessment tool. Outcome data were extracted independently from each included study by two review authors.

**Findings:** in total, 821 citations were identified and screened by title and abstract; 806 were excluded and full text of 15 assessed. Of these, 12 were excluded leaving three papers included in the review. Two studies evaluated the effectiveness of decision aids for mode of birth and one evaluated the effectiveness of an antenatal education programme. The findings demonstrate that neither the use of decision aids nor information/education of women have a significant effect on VBAC rates. Nevertheless, decision-aids significantly decrease women's decisional conflict about mode of birth, and information programmes significantly increase their knowledge about the risks and benefits of possible modes of birth.

**Key conclusions:** few studies evaluated women-centred interventions designed to improve VBAC rates, and all interventions were applied in pregnancy only, none during the birth. There is an urgent need to develop and evaluate the effectiveness of all types of women-centred interventions during pregnancy and birth, designed to improve VBAC rates.

**Implications for practice:** decision-aids and information programmes during pregnancy 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.

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## Introduction

Rising rates of caesarean section (CS) is an issue of particular concern in the global maternity care field (EURO-PERISTAT, 2013), due to the increased adverse maternal and neonatal outcomes associated with CS (Morrison et al., 1995; Guise et al., 2010; Marshall et al., 2011). If rates continue to rise at the same pace as in recent years, the overall CS rate is projected to be 56% by 2020 (Solheim et al., 2011). A key factor contributing to increasing rates is the tendency for women who have had a previous CS to have a repeat CS rather than a subsequent vaginal birth (Cheng et al., 2011). Given the higher incidence of placenta praevia, placenta accreta, hysterectomy, and composite maternal morbidity in women who have increasing numbers of CS births (Marshall et al., 2011), the potential effects this trend will have on women's health in the future warrants immediate attention.

Vaginal birth after CS (VBAC) has favourable outcomes compared with planned elective repeat CS. Maternal mortality has been shown, through a systematic review and meta-analysis of 203 research reports (Guise et al., 2010), to be significantly increased with elective repeat CS (ERCS) compared with elective VBAC (1.34 versus 0.38 per 10,000). Planned VBAC, however, significantly increases perinatal mortality (13 per 10,000) compared with ERCS (5 per 10,000), though it should be noted that absolute rates of both mortalities are low (Guise et al., 2010).

CS performed without a medically indicated reason i.e., for maternal request, is a frequently cited reason for increasing CS rates, with current rates ranging from 2.6% to 26.8% of all CSs (Quinlivan et al., 1999; Jacquemyn et al., 2003). In particular, one Australian study found that the foremost primary indication for elective caesarean section was woman's choice, mostly due to women refusing to agree to a planned VBAC or to agree an attempt at vaginal breech birth (Quinlivan et al., 1999). In Sweden, the rate of CS without a medical indication increased threefold during the period 1997–2006; the most frequently stated reasons for an elective CS, in conjunction with no medical indication, were

previous caesarean sections (28%) and childbirth-related fear (13%) (Karlström et al., 2010). Maternal request for CS, both primary and repeat, is strongly associated with fear of childbirth and previous negative birth experience (Karlström et al., 2010; Stjernholm et al., 2010; Nilsson et al., 2012; Størksen et al., 2013).

One qualitative study (Emmett et al., 2006) explored women's views of decision-making around mode of birth following a previous CS. Women's experiences varied, with some making firm decisions and setting goals for themselves and others remaining uncertain about choosing between repeat CS and VBAC. Information given to women was most commonly provided by doctors and related mostly to procedural matters rather than focusing on the risks and benefits linked with VBAC. Women described that information was not provided routinely and they had to seek it actively, which is disappointing given the number of studies showing that education of all women in the antenatal period (including those with a previous CS) improves birth outcome (Maimburg et al., 2010) and is appreciated and requested by nulliparous and multiparous women alike (Mungrue et al., 2010). For example, relaxation and birth preparation classes, which have led to a reduction in CS rates in nulliparous women (Khunpradit et al., 2011), and psycho-educational group sessions for women experiencing an intense fear of childbirth (Salmela-Aro et al., 2012) could also be tried with women following previous CS.

Despite the knowledge that women respond to educational interventions, a recent metasynthesis of eight qualitative studies (Lundgren et al., 2012) found that women with previous CS felt they were 'groping through the fog' when it came to trying to access information on VBAC. The authors of this metasynthesis recommend that clinicians should provide women with evidence-based information on both the risks and benefits of VBAC, to assist in their decision-making. A recent Cochrane Review examined randomised trials of interventions designed to support decision-making about VBAC, the acceptability of any such interventions to women and their partners and how feasible their implementation would be (Horey et al., 2013). Their findings, based on three studies involving 2270 women, were

that the decision support interventions used had no effect on the women's mode of birth, or their preferences for mode of birth. However, the review was limited to interventions designed to support decision-making only and did not seek information on any other types of intervention designed to assist women to achieve VBAC, nor did it include interventions during birth. In addition, although women liked the decision support there was concern among health professionals about the impact on their time and workload.

Accordingly, a systematic review evaluating all types of women-centred interventions during birth as well as pregnancy, for increasing VBAC rates, was proposed. The aim of this paper is to report the conduct and findings of this systematic review.

## Methods

### Inclusion criteria

#### Types of participants

Participants were pregnant women who have had at least one previous CS.

#### Types of interventions

Any women-centred intervention, used during pregnancy or birth, that was designed to increase VBAC rates in women with at least one previous CS. Comparator groups included standard or usual care or an alternative intervention aimed at increasing VBAC rates.

#### Types of studies

Randomised trials, including cluster randomised trials, were eligible for inclusion.

#### Types of outcome measures

The primary outcome measure was incidence of VBAC. The secondary outcome measures were maternal satisfaction with mode of birth preference/decision and birth experience, knowledge about birth choices, maternal anxiety levels, compliance with the intervention, rate of decisional conflict, mode of birth (spontaneous vaginal birth, instrumental birth, and emergency CS), maternal mortality, perinatal mortality, length of labour, uterine rupture, baby birth weight, neonatal Apgar scores, and admission to a neonatal intensive care unit.

#### Search and selection strategy

We searched electronic bibliographic databases of The Cochrane Library, PubMed, PsychINFO and CINAHL from their inception dates, to 31 July 2014. The following search string was used: "Vaginal birth after cesarean" or "Trial of Labor" or normal birth or ventouse or forcep<sup>n</sup> or instrumental and Cesar<sup>n</sup> or Caesar<sup>n</sup> or VBAC or TOLAC AND "Randomized Controlled Trial"[Publication Type] OR "Controlled Clinical Trial"[Publication Type] OR "Randomized Controlled Trials as Topic"[Mesh Terms] OR "Placebos"[Mesh Terms] OR (random<sup>n</sup> AND trial<sup>n</sup>[tiab]) OR "randomized"[tiab] OR "randomly"[tiab] or placebo<sup>n</sup>.

Prior to applying the search strategy, the search string was reviewed for accuracy, by one member of the review team not involved in developing the search strategy (CB), using the Peer Review of Electronic Search Strategies (PRESS) criteria (Sampson et al., 2009). There was no restriction applied to years searched, but retrieval of papers was limited to English language publications only.

### Quality assessment of included studies

The Effective Public Health Practice Project (EPHPP) Quality Assessment Tool (2009) was used to assess the methodological quality of the included studies. This tool was chosen because it provides a thorough assessment of potential sources of bias in randomised trials. Methodological components assessed within this tool include selection bias, allocation bias, confounding, blinding, data collection methods, withdrawals and drop-outs and analysis and intervention integrity. A global quality rating of Strong (no weak ratings), Moderate (one weak rating) or Weak (two or more weak ratings) was assigned to each study following the quality assessment procedure. An *a priori* decision was made to exclude studies from the analysis that received a 'Weak' global rating score.

Two members of the review team (VS and JN) independently assessed the quality of included studies. Any disagreements were to be discussed and resolved by consensus. Where disagreements could not be resolved by consensus, recourse to a third member of the review team was planned; this was not required.

### Data extraction and analysis

Using a pre-designed data extraction form, data on the outcomes of interest were extracted independently by three members of the review team (KVJ, AB and EvL) and checked for accuracy by a fourth reviewer (VS). For dichotomous data, we planned to perform meta-analyses and present the results using a summary risk ratio with 95% confidence intervals. For continuous data we planned to present the mean difference with 95% confidence intervals. Due to the differing types of interventions evaluated in the individual studies, individual study results could not be pooled statistically in this review. A narrative synthesis of the results is provided instead.

## Findings

### Results of search and selection strategy

In total, 821 citations were identified using the designed search strategy. After removing duplicates, 799 unique citations were screened by title and abstract by two members of the team, and 784 were excluded. The reference lists of all remaining papers were checked for any additional relevant papers, but none were found. Full-text papers of the remaining 15 citations were read and 12 of these were subsequently excluded (7 had no intervention, 3 did not focus on VBAC, 1 was outside the topic, and 1 was excluded as it focused on clinician-centered interventions for increasing VBAC rates) (Table 1). This resulted in three papers meeting the inclusion criteria for this review (Fig. 1, Table 2). Final decisions on included papers were made by authors CN, IL, VS and CB.

Two studies (Shorten et al., 2005; Montgomery et al., 2007) evaluated the effectiveness of decision aids for mode of birth in women with a previous CS and one evaluated the effectiveness of an antenatal education programme (Fraser et al., 1997).

### Description of included studies

#### Decision aids for women

Montgomery et al. (2007) compared two computer-based decision-aids with usual care. Participants were pregnant women ( $n = 742$ ) with a caesarean section in their last pregnancy and expecting to birth their babies at or after 37 weeks gestation. The intervention groups received either an information programme or individualised decision analysis via a laptop. The information

Table 1  
Papers excluded from the systematic review.

Barakat, R., Pelaez, M., Lope, Z.C., Montejo, R., Coteron, J., 2012. Exercise during pregnancy reduces the rate of cesarean and instrumental deliveries: results of a randomized controlled trial. <i>J. Matern.–Fetal and Neon. Med.</i> 25, 2372–2376.
Bernitz, S., Aas, E., Øian, P., 2012. Economic evaluation of birth care in low-risk women. A comparison between a midwife-led birth unit and a standard obstetric unit within the same hospital in Norway. A randomised controlled trial. <i>Midwifery</i> 28, 591–599.
Cromi, A., Ghezzi, F., Uccella, S., Agosti, M., Serati, M., Marchitelli, G., Bolis, P., 2012. A randomized trial of preinduction cervical ripening: dinoprostone vaginal insert versus double-balloon catheter. <i>Am. J. Obstetr. Gynecol.</i> 207, 125–127.
Crowther, C.A., Dodd, J.M., Hiller, J.E., Haslam, R.R., Robinson, J.S., 2012. Planned vaginal birth or elective repeat caesarean: patient preference restricted cohort with nested randomised trial. <i>PLoS Med</i> 9, e1001192.
Eden, K.B., Dolan, J.G., Perrin, N.A., Kocaoglu, D., Anderson, N., Case, J., Guise, J.M., 2009. Patients were more consistent in randomized trial at prioritizing childbirth preferences using graphic-numeric than verbal formats. <i>J. Clin. Epidemiol.</i> 62, 415–424.
Emmett, C.L., Montgomery, A.A., Murphy, D.J., 2011. Preferences for mode of delivery after previous caesarean section: what do women want, what do they get and how do they value outcomes? <i>Health Expect.: Int. J. Pub. Particip. Healthc. Health Policy</i> 14, 397–404.
Flamm, B.L., Geiger, A.M., 1997. Vaginal birth after cesarean delivery: an admission scoring system. <i>Obstetr. Gynecol.</i> 90, 907–910.
Hashima, J.N., Guise, J., 2007. Vaginal birth after cesarean: a prenatal scoring tool. <i>Am. J. Obstetr. Gynecol.</i> 196, e22–23.
Hollinghurst, S., Emmett, C., Peters, T.J., Watson, H., Fahey, T., Murphy, D.J., Montgomery, A., 2010. Economic evaluation of the DiAMOND randomized trial: cost and outcomes of 2 decision aids for mode of delivery among women with a previous cesarean section. <i>Med. Decis. Mak.</i> 30, 453–463.
Law, L.W., Pang, M.W., Chung, T.K., Lao, T.T., Lee, D.T., Leung, T.Y., Sahota, D.S., Lau, T.K., 2010. Randomised trial of assigned mode of delivery after a previous cesarean section—impact on maternal psychological dynamics. <i>The J. Matern.–Fetal Neon. Med.: Off. J. Eur. Assoc. Perinat. Med., Fed. Asia Ocean. Perinat. Soc. Int. Soc. Perinat. Obstet.</i> 23, 1106–1113.
McLachlan, H.L., Forster, D.A., Davey, M.A., Farrell, T., Gold, L., Biro, M.A., Albers, L., Flood, M., Oats, J., Waldenström, U., 2012. Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. <i>BJOG: Int. J. Obstet. Gynaecol.</i> 119, 1483–1492.
Thubisi, M., Ebrahim, A., Moodley, J., Shweni, P.M., 1993. Vaginal delivery after previous caesarean section: is X-ray pelvimetry necessary? <i>Br. J. Obstetr. Gynaecol.</i> 100, 421–424.

programme provided women with evidence-based information on the probabilities of outcomes for the mother and baby associated with planned vaginal, and elective and emergency caesarean births. Women allocated to the individualised decision analysis also received information on the outcomes for mother and baby associated with the different modes of birth but probabilities were not explicit. The control group received usual care given by the obstetric and midwifery team and both intervention groups also continued to receive usual care. Women rated the value they attached to each outcome and these ratings were combined with the outcome probabilities to derive a preferred mode of birth. The primary outcomes were women's decisional conflict and mode of birth.

Shorten et al. (2005) evaluated the effectiveness of a decision-aid booklet for pregnant women with one previous caesarean section. Women allocated to the intervention group received a 'decision-aid booklet' at 28 weeks gestation containing evidence-based information. As in the information programme in Montgomery et al. (2007), the decision-aid included explicit probabilities and women's value ratings on the risks and benefits of possible modes of birth. The control group received usual care. Primary outcome measures were knowledge, decisional conflict, postnatal satisfaction and mode of birth.

#### Antenatal education programme for women

Fraser et al. (1997) compared written information with an antenatal education programme. Participants were pregnant women with one previous caesarean section who were at less than 28 weeks gestation ( $n = 1301$ ) on recruitment. Women in the written information group received information on the benefits of vaginal birth over elective repeat caesarean section. Women in the education programme received two individualised sessions focusing on predisposing, enabling, and reinforcing factors for VBAC. Enabling factors, for example, included informing women of recommendations favouring VBAC and of probability of planned VBAC at her local centre. The primary outcomes were VBAC and attempted VBAC.

#### Methodological quality of included studies

The nature of the intervention made it impossible, practically, to blind either the clinician or the participating woman to her

allocation. Therefore, a lack of blinding was not considered to undermine the quality of the included studies. Montgomery et al. (2007) had a high rate of recruitment and a low loss to follow-up, resulting in a relatively large sample of 742 (although data were only available on 713). Participants were slightly older and less deprived than women who did not consent to join the study, which affects the ability to generalise. Although the study was rated as methodologically strong, implementation issues meant that the decision aid could not be provided through the internet, but had to be accessed through a computer held by the researcher, which may have limited the participants' access and affected the results. The study by Shorten et al. (2005) had a smaller sample size ( $n = 227$ ) but a high response rate (90%), and overall received a 'strong' methodological quality rating. Fraser et al.'s study (1997) had the largest sample size ( $n = 1301$ ), but the withdrawal of 26 women's data for various reasons led to an increased risk of selection bias. Despite this, the study rated as 'moderate', as all other key methodological aspects were of a high standard. The overall category scores and global quality rating for each individual included study are provided in Table 3. Following the quality assessment procedure, all studies remained eligible for inclusion.

#### Effects of interventions

Interventions evaluated in the studies included decision-aids with information and explicit probabilities of outcomes with value exercises (Shorten et al., 2005), information and explicit probabilities of outcomes without value exercises (Montgomery et al., 2007), information and value exercises without explicit probabilities (Montgomery et al., 2007) and an antenatal education programme (Fraser et al., 1997). We did not therefore regard interventions to be sufficiently similar to ensure meaningful conclusions from a statistically pooled result. Therefore a narrative synthesis of results is reported by presenting the major outcomes and results, organised by intervention categories. All studies reported on VBAC rates as the primary outcome. In this review, we report on our primary outcome of interest (i.e. incidence of VBAC) and on our secondary outcomes of rate of decisional conflict and knowledge about birth choices only. For our remaining pre-specified secondary outcomes, data were reported variously, not measured in the included studies, or too limited to allow us to report in the review.

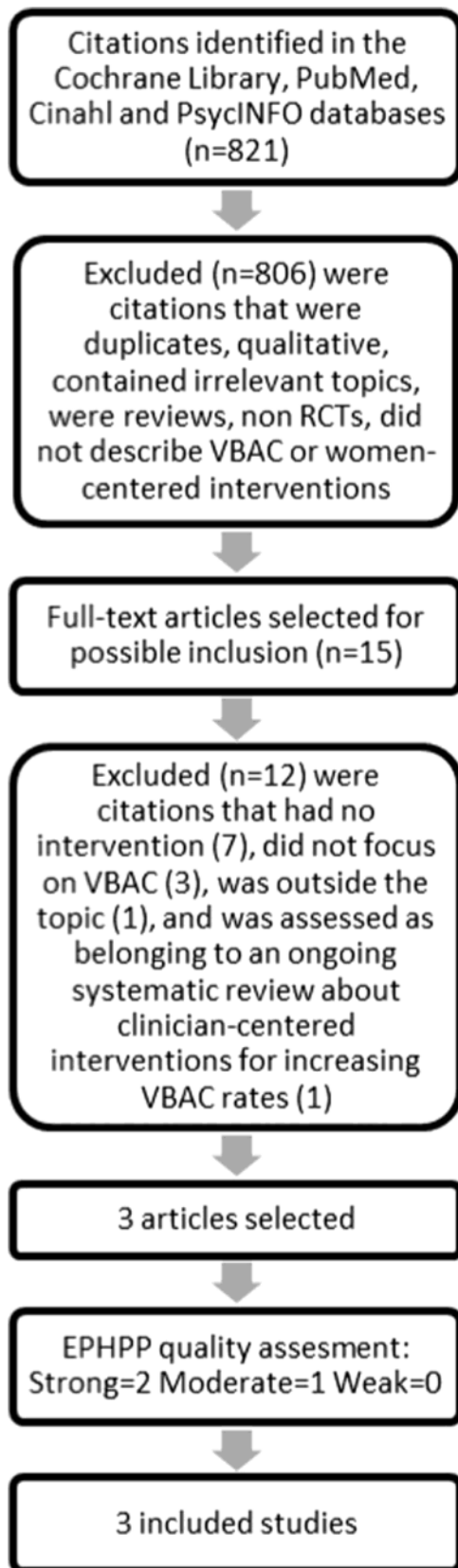


Fig. 1. Flow-diagram of the selection and search process.

#### Decision-aids versus usual care

Montgomery et al. (2007) compared an information programme and an individualised decision analysis with usual care. There was no statistically significant difference in the proportion

of women giving birth vaginally between women allocated to decision analysis (37%) and women allocated to usual care (30%) or between women allocated to the information programme (29%) and usual care (30%) (Fig. 2).

Compared with usual care, women in both intervention groups had significantly lower decisional conflict scores (information group — 6.2, 95% CI — 8.7 to — 3.7; decision analysis group — 4.0, 95% CI — 6.5 to — 1.5).

Shorten et al. (2005) evaluated the effectiveness of a decision-aid booklet with usual care. Women in the decision aid group had significantly higher mean changes in knowledge scores (1.73, 95% CI 1.08–2.37) and significantly lower decisional conflict scores (— 0.32, 95% CI — 0.50, — 0.14) than women in the control group.

The authors report that there were no significant differences between groups on ‘rate of uptake’ of trial of labour or elective repeat CS; however, data are not presented on these outcomes in a format that allows identification of effects between the groups to which women had been randomised.

#### Antenatal education programme versus written information

Fraser et al. (1997) compared written information with an antenatal education programme. There was no significant difference between the written information and antenatal education groups in the proportion of women having a VBAC (49% and 53% respectively, relative risk (RR) 1.08, 95% confidence interval (CI) 0.97–1.21) or attempting a VBAC (67% and 73% respectively, RR 1.05, 95% CI 0.97–1.12).

#### Discussion

The general strengths of the systematic review method are that it synthesises all the available research information in one area for the convenience of readers and for a greater understanding of the totality of the evidence on that topic. The main weaknesses are that reviewers are dependent on the quality of the data that exist, the way in which they were gathered, and on the study researchers’ interpretation. Our search strategy led to a large number of hits, indicating good sensitivity. However, only three studies were found that met our inclusion criteria, limiting the conclusions that could be drawn from the review. A further limitation of the review was that, because the interventions in the three studies were not sufficiently similar to ensure meaningful conclusions from a statistically pooled result, only a narrative synthesis could be reported.

There are few studies evaluating the effects of interventions focused on women to increase VBAC rates. The findings demonstrate that the use of decision aids and information programmes do not have a significant effect on VBAC rates. Nevertheless, decision-aids and information programmes significantly decrease women’s decisional conflict about mode of birth, and significantly increase their knowledge about the risks and benefits of possible modes of birth, and are thus of value.

Our findings are consistent with those of a recent systematic review on interventions to support women’s decision-making about VBAC (Horey et al., 2013), which includes the same three studies from UK, Canada and Australia. It is notable that we did not find any additional studies focusing on childbirth, rather than pregnancy, and none from outside those three English-speaking developed countries. In addition, we found no research looking at any method of increasing VBAC rates other than by supporting women’s decision-making. These findings highlight the need for a wider research agenda, that includes research on other women-centred methods aimed at improving VBAC rates. Horey et al. (2013) promote the need for more research focusing on interventions intended to help with shared decision making between pregnant women and their health professionals. We support this conclusion and would also

Table 2  
Papers included in the systematic review.

Fraser, W., Maunsell, E., Hodnett, E., Moutquin, J.M., 1997. Randomized controlled trial of a prenatal vaginal birth after cesarean section education and support program. <i>Childbirth Alternatives Post-Cesarean Study Group. Am. J. Obstet. Gynecol.</i> 176, 419–425.
Montgomery, A.A., Emmett, C.L., Fahey, T., Jones, C., Ricketts, I., Patel, R.R., Peters, T.J., Murphy, D.J., 2007. Two decision aids for mode of delivery among women with previous caesarean section: randomised controlled trial. <i>Br. Med. J. (Clin. Res. Ed.)</i> 334, 1305.
Shorten, A., Shorten, B., Keogh, J., West, S., Morris, J., 2005. Making choices for childbirth: a randomized controlled trial of a decision-aid for informed birth after cesarean. <i>Birth</i> 32, 252–261.

Table 3  
Results of the methodological quality appraisal of the included studies.

Component	Montgomery	Shorten	Fraser
Selection Bias	Strong	Strong	Weak
Allocation Bias	Strong	Strong	Strong
Confounders	Strong	Strong	Strong
Blinding	Weak	Strong	Weak
Data collection methods	Strong	Strong	Strong
Withdrawals and drop-outs	Strong	Strong	Strong
Analysis: intention to treat	Strong	Moderate	Strong
Intervention integrity: % of participants that received allocated intervention	Strong	Strong	Strong
Global quality score	Strong	Strong	Moderate
Include study	Yes	Yes	Yes

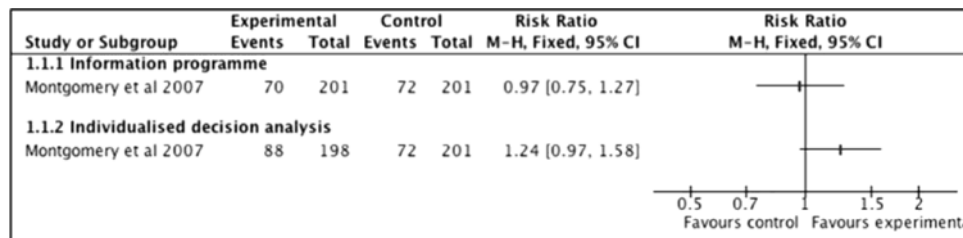


Fig. 2. Intervention effects for outcome 'vaginal birth after caesarean section (VBAC)' (comparison with usual care).

recommend studies from different countries with different decision-making processes.

Another Cochrane Review on interventions for reducing unnecessary caesarean sections (both primary and repeat) (Khunpradit et al., 2011), also demonstrated a lack of high-quality evidence on how to increase VBAC rates. In this review, Khunpradit et al. (2011) found that most studies were targeted at health personnel, with limited evidence of women-focused interventions for improving VBAC rates. Few studies on women's experiences of VBAC appear to have been performed. Of those that have been conducted, most are of Anglo-American origins where VBAC rates generally are low: 33% in England, Wales and Northern Ireland (Thomas and Paranjothy, 2001) and below 10% in the US (ACOG and SMFM, 2014), compared with countries such as Sweden, the Netherlands and Finland, with rates from 45% to 55% (EUROPERISTAT, 2008). Australia has a similarly low rate of 25%, based on a five-year review of statistics from 11 major obstetric units (Appleton et al., 2000).

Findings from a metasynthesis on studies from the UK, US and Australia (Lundgren et al., 2012), show that women felt uncertainty and anxiety in relation to their choice of VBAC, and experienced professionals as mostly non-supportive towards VBAC. The findings indicate that women tend to be alone in their expectations for a vaginal birth, and unsupported with their decisions around childbirth. This might, in part, explain the generally low VBAC rates in these countries. A qualitative study from Australia (Godden et al., 2012) that explored the experiences of women participating in a midwife-led service during pregnancy, with the purpose of promoting VBAC, demonstrated that women felt supported by midwives in the team. However, the women stated their need to have supportive midwives and doctors also during birth as an important factor for whether a

VBAC was actually accomplished and this was dependent on the admitting staff on a given day (Godden et al., 2012). Other contributory factors for achieving a VBAC were to offer special birth preparation classes for women with a history of CS, opportunities to meet other women with experience of VBAC, empower women's partaking in decision-making, stimulate women to write a birth plan, and make sure that all maternity caregivers promote VBAC (Godden et al., 2012). Moreover, other women-focused interventions shown to be effective in reducing CS rates (even though the randomised controlled trials were small in size), were nurse-led relaxation classes and birth preparation classes targeted towards women with fear of childbirth in their first pregnancies (Khunpradit et al., 2011). In some of the Nordic countries where the VBAC rates generally are high (e.g., Finland and Sweden), special 'fear clinics' have, for the past 20 years, been available to pregnant women with intense fear of childbirth (Ryding et al., 2003). At these clinics women can discuss their fears and mode of birth during face-to-face meetings with specially educated midwives. The clinics are known well to both women and care providers. For women requesting a repeat CS because of fear related to a previous negative birth experience that ended up in an emergency CS, individualised meetings can be of help and result in a withdrawal of CS requests (Ryding et al., 2003; Wiklund et al., 2012). The evidence demonstrates an obvious reduction of requests for CS in various kinds of support programmes for women with fear of birth (Sjögren and Thomassen, 1997; Nerum et al., 2006). However, the actual effects on women's fear are, as yet, unclear (Hildingsson et al., 2011). These studies demonstrate that successful women-centred interventions do exist, extend beyond just supporting women in their decision-making, and need to be researched. In

addition, an on-going study from Australia will show if continuity of

care during pregnancy and childbirth will impact decision making in the next birth after caesarean section (Homer et al., 2013); this will provide information on a women-centred intervention during birth, which at present is lacking.

## Conclusions

Few studies have evaluated the effectiveness of women-centred interventions designed to improve VBAC rates, and all interventions were applied in pregnancy only, none during the birth. 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. There is an urgent need to develop and evaluate the effectiveness of all types of women-centred interventions during pregnancy and birth designed to improve VBAC rates.

## Conflict of interests

The authors declare that they have no competing interests.

## Details of ethics approval

As this review was based on data from published literature, ethical approval was not required.

## Authors' contributions

All authors have made substantial contributions to all of the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, (3) final approval of the version submitted.

## Acknowledgements

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## Appendix 5: OptiBIRTH Consent Form



### The OptiBirth Study- Consent Form (intervention group)

Date:

□	□	/	□	□	/	□	□	□	□
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Woman's Details:

(Name, Address, DOB and record Number or affix addressograph)

Name of Researcher: Prof Cecily Begley (or local team member)

1. I confirm that I have read, or have had read to me, and understand the study information pack for the OptiBIRTH study and have had the opportunity to ask questions.
2. I understand that participation in this study is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my care or legal rights being affected.
3. I understand that sections of my care records and my baby's care records will be looked at by responsible individuals from the study organisers or from regulatory authorities where it is deemed relevant. I give permission for these individuals to have access to my records and use anonymised data in future studies.
4. I agree to take part in the OptiBIRTH study.

My name, printed

Date

Signature

--

□	□	□	□	□
---	---	---	---	---

--

day month year  
day month year

--

Midwife/Doctor name, printed

Date

--	--	--	--

Signature

Birth partner/translator, printed

Date

--	--	--	--

Signature

day month year

**OptiBIRTH study number:**



## Appendix 6: Ethical Approval Faculty of Health Sciences, TCD



COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH

TRINITY COLLEGE DUBLIN

Dámh na nEolaíochtaí Slaínte,  
Foirgneamh na Ceimice  
Colaiste na Tríonóide,  
Baile Átha Cliath 2, Éire.

Faculty of Health Sciences,  
Chemistry Building,  
Trinity College,  
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T:- +353 (0)1 8964255

Rebekah Maguire  
PhD Student  
School of Nursing and Midwifery  
Trinity College Dublin  
24 D'Olier Street  
Dublin 2

8 July 2013

Study: An Ethnography of cultural change within a randomised trial aimed at increasing vaginal birth after caesarean section: The OptiBIRTH study

Dear Applicant,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in April 2013, we are pleased to inform you that the above project (as amended) has been approved without further audit.

Could you please provide the committee with copies of the specific approvals (when available) from the various sites for the planned 'embedded ethnography' phase of the trial.

Yours sincerely,

*pp. Caroline Rooney*

---

Dr. Ruth Pilkington  
Chairperson  
Faculty Research Ethics Committee

Supervisors: Prof Cecily Begley and Dr Valerie Smith

**Appendix 7: Ethical approval HSE Mid-West Regional Research Ethics  
Committee**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

HSE West,  
Mid-Western Regional Hospital,  
Dooradoyle,  
Limerick, Ireland.

Tel: 00353 (0) 61 301111  
Fax: 00353 (0) 61 301165  
Website: www.hse.ie

12<sup>th</sup> September, 2013.

Ms. Rebekah Maguire,  
School of Nursing & Midwifery,  
Trinity College Dublin,  
24 D'Olier Street,  
Dublin 2.

**Re: Protocol Title**  
**An Ethnography of cultural change within a randomised controlled trial aimed**

Dear Ms. Maguire,

Thank you for attending the Research Ethics Committee meeting on the 11<sup>th</sup> September, 2013 in connection with your study.

I wish to advise that the Committee has now approved your study. However, you should note that your study cannot commence until you also receive Risk Management approval. This approval will be issued to you shortly.

You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success in your study.

Yours sincerely,

**Marie Hickey Dwyer,**  
**Consultant Ophthalmic Surgeon,**  
**Chairperson, Research Ethics Committee.**



## **Appendix 8: Study information leaflet for clinicians**



*Your Invitation to participate in*

### **An Ethnography of cultural change within a randomised trial aimed at increasing vaginal birth after caesarean section: The OptiBIRTH study**

*A study to explore the culture surrounding the OptiBIRTH intervention*

**Rebekah Maguire**

PhD Candidate, School of Nursing and Midwifery, Trinity College Dublin

**Dr Valerie Smith and Professor Cecily Begley**

Supervisors, School of Nursing and Midwifery, Trinity College Dublin



My name is Rebekah Maguire. I am originally from Co. Monaghan and I am 23 years old. I graduated from UCD in 2011 with a degree in Social Science. I then moved on and completed my Master's Degree in Applied Social Research in Trinity College Dublin in 2013. During the Master's I worked as a research assistant on the MAMMI Study (Maternal Health and Maternal Morbidity in Ireland). My dissertation involved studying the considerations pregnant women take into account when they decided to participate in the MAMMI study. From then I successfully applied for the position of PhD student with the OptiBIRTH study. My research interests include pregnant women and their experiences of research, birth rituals and decision making around pregnancy and birth.

*The OptiBIRTH study has been approved by the Research Ethics Committees of the HSE Mid-Western Regional Hospital, Limerick and the Faculty of Health Sciences, Trinity College Dublin.*

*This embedded study has been approved by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin and the Research Ethics Committee of the HSE Mid-Western Regional Hospital, Limerick.*

*The OptiBIRTH study is funded by the FP7-HEALTH-2012-INNOVATION-1 HEALTH.2012.3.*

### **Why have you been given this leaflet?**

You have been given this leaflet because you currently work in a maternity unit that is participating in the OptiBIRTH Study.

### **Why am I doing this study?**

I am a doctoral research student in the School of Nursing and Midwifery, Trinity College Dublin. I am doing this ethnography research, which is embedded within the OptiBIRTH study, as directed under the EU FP7 grant agreement.

The aim of this embedded study is to observe the OptiBIRTH intervention, to gain insight into clinicians' perspectives of the intervention and to observe any cultural changes associated with the intervention.

This ethnography will be important not only for the overall evaluation of the intervention, but also for transferring the intervention for use in other maternity care units once the trial is complete and if it is seen to be effective.

### **Who else is taking part?**

I will be asking midwives and obstetricians, engaged in practice at this hospital site, to take part in the study.

### **Within this study, I wish to find out:**

- What you think are the motivations for women to have a VBAC?
- Your thoughts regarding potential barriers for pregnant women to have a VBAC.

- Your thoughts on how women source and/or are provided with information about VBAC.
- Any influences that the OptiBIRTH intervention might have/is having on the decision making process for mode of birth.
- Your thoughts and perspective on the OptiBIRTH intervention.

### **What does taking part involve?**

I am asking you to allow me to observe, on some occasions, interactions you may have with the women who are participating in the OptiBIRTH trial. For example, with the consent of a woman participating in the trial, I may seek your consent also to attend a clinic visit with her. I may also ask you to take part in a brief interview with me designed to discuss your thoughts on the OptiBIRTH trial and VBAC in general. All information that will be gathered is confidential. Interviews and observations are voluntary and you do not have to take part if you do not wish to.

### **What types of questions might I ask you in an interview?**

If you are willing to take part in an interview, I will ask you about

- How women, in your opinion, source and/or are provided with information about mode of birth, and what type of information that might be?
- Any problems you experience with information on VBAC and how it is interpreted?
- What potential barriers you think exist for VBAC as an option for mode of birth after previous CS?
- What, in your opinion, motivates women to choose VBAC?
- How you feel about VBAC.
- Your thoughts and experiences of the OptiBIRTH intervention.

### **Are there any risks for you?**



There are no foreseeable risks with taking part in this study. However, if you feel there is any risk to you, or you are having any problems with the questions that are being asked, you can opt out and any time of the research process.

### **How will I protect your personal information?**

- All information will be kept strictly private and confidential. Information will be held for up to five years after the study for publication purposes.
- I will be using a unique study number throughout the study. All personal details will be removed from the interviews and your interview will not be linked to your personal details.
- All interviews will be anonymised and identifiers will be removed. This means that the interview will not be linked to you in any way.
- Paper copies of the information you give will be identified by your study number.
- I will be recording the interview. A paper copy will be made. The paper copy will be sent to you to confirm the accuracy of the interview. The recording will be destroyed after the interview is transcribed. The interview will be stored in a locked cabinet, in an area to which few people have access.

### **Can you leave the study at any time?**

Taking part is **completely** voluntary. You can withdraw at any time without any reason. If this occurs after the interview, your recording and paper copy of the interview will be destroyed.

### **How can you get in touch with me?**

Please feel free to contact me for additional information or for any queries that you may have about parts of the study.

My name is Rebekah Maguire and you can contact me by email at xxxxxxxx@tcd.ie or by phone on 086 XXX XXXX. I will be present in the hospital during the trial so if you have any questions I will be able to answer them in person.

Alternatively you can contact my supervisor Dr Valerie Smith by email at

xxxxxx@tcd.ie OR at 01 XXX XXXX.

## Appendix 9: OptiBIRTH Study Information Leaflet



### The OptiBIRTH Trial

#### Study Information for Women (intervention site)

##### ***Introduction***

We would like to tell you about an important research study that we are doing in this hospital and across other hospitals in (name of other two trial countries will be inserted here) within the European Union. This study may help to improve birth outcomes, by increasing vaginal birth after caesarean (VBAC) through more woman centred maternity care across Europe. The study is known as OptiBIRTH. This hospital is one of 15 hospitals taking part in the OptiBIRTH study. Although only women who are healthy and have had one previous caesarean section will be able to join the study, we want to let everyone know the study is taking place. Please read this information to see if you can and would like to join this study.

##### ***What is the OptiBIRTH study?***

The OptiBIRTH study is testing a new way of providing information, education and counselling for you and your partner to support you in making decisions around your next birth. The information aims to support you to make decisions and to work in partnership with your doctor or midwife in terms of the options open to you - labouring and giving birth vaginally or having a repeat caesarean section without going into labour.

##### ***What does taking part involve?***

This type of study is known as a randomised trial. The hospitals agreeing to take part are divided by chance into two different groups. Each hospital has an equal chance of being allocated to the new study information group (intervention), or to the usual care group (control). For the OptiBIRTH study, the hospital you are attending has been randomly allocated to the new study information group (intervention). This means that, by taking part in this study, you will test the effectiveness of the new information package which will involve the following:

- Accessing online information and support (if you wish, and have access to the internet)
- Receiving 3 to 5 free mobile phone applications (apps) to help with decision-making when meeting with your clinician to discuss your options for birth
- Attend specifically designed antenatal classes for women who have had a previous caesarean birth
- Completing a survey in pregnancy and two others that will be sent to you by post at 3 months and 6 months following the birth, that is designed to assess your emotional wellbeing, fatigue, your perception of how you are adjusting after the birth and any complications that you may be experiencing as well as any costs you have had to pay for treatment for any complications after birth (such as doctor's visits, medicines, taking time off work etc).
- Giving consent to the research team to access information from your case notes such as: type of birth, interventions in labour, analgesia used, any complicating factors such as pain, infection bleeding etc,
- Giving consent to the research team to access information from your baby's case notes such as: condition at birth, admission to the baby unit and any other complications associated with birth
- Giving consent that a researcher may be present at the clinic, and education sessions, observing interactions between you and your healthcare providers (excluding any intimate examinations, as the researcher is not a healthcare provider), and may have a conversation with you about your experiences.

Access to this extra educational information is in addition to normal care and is only available to women who are willing to take part in the information group.

### ***Why is this hospital taking part in the study?***

At the moment we know that vaginal birth rates after caesarean section vary widely across health care settings and countries. We understand that reducing caesarean section rates and increasing VBAC is not only better for women, their babies and their families but it is also more cost effective for the health service. This hospital is taking part in testing this new information package in order establish if offering standardised information to women and their partners regarding VBAC can improve care for women across Europe.

### ***Can I take part?***

If you can answer **YES** to each of the following questions you can take part:

- Are you 18 years of age or older?
- Have you had **ONE** previous caesarean section?
- Are you expecting one baby (not twins or triplets)?
- Is your pregnancy normal, without high blood pressure, diabetes or any other medical problems?

***What happens if I join this study?***

When you meet with your clinician, he or she will do a health check to make sure you can join the study. If your pregnancy is progressing normally, and you want to take part, the clinician will ask you to sign a consent form indicating that you agree to take part and that you understand what taking part involves. After this, you will be able to attend the special classes, and receive instructions on how to access the online support and mobile phone apps. You will also receive a survey to complete while still pregnant and again at 3 months and 6 months after your baby's birth. Information regarding the birth and your baby's wellbeing will also be accessed from your case notes.

***Do I have to take part in this study?***

**NO**, taking part is voluntary and will not affect your care if you choose not to participate.

***Are there risks or benefits to taking part?***

There are no known risks to taking part in this study. As your hospital has been allocated to the group to test the new information package, it is possible that you may find the information beneficial. However, the main benefit to taking part is that you will have helped us to answer whether this standardised information package is effective or not in improving VBAC rates.

***Can I leave the study after I have joined?***

**YES**, you can leave the study any time you wish. If you decide to leave the study you must tell the midwife on duty or contact the research team (the details are at the end of this booklet). If you leave the study your data will be removed from the database. This process is irreversible.

***Is my personal information kept private?***

**ALL** study information is kept private and secured in keeping with the law. Your information will be stored using a code so that any personal information will not be linked to your name. All study information will be kept for a minimum of five years, and all traces of your identity will be destroyed once the study is finished. Data which cannot be traced back to your identity will be stored for comparison with future studies. However, **IF** the findings of OptiBIRTH show further research is required we would like permission to contact you for continued participation. If you agree, then your data will continue be stored for the duration of the new study. The results of the study will be published. However, neither your name nor any personal details about you will appear in any publications. Your confidentiality will be maintained at all times.

***Who is leading this study?***

Professor Cecily Begley, a Professor of Midwifery from Trinity College Dublin in Ireland, has overall responsibility for this project. (Name to be inserted here) has responsibility for the study in (name of country to be inserted here)

This study is funded by *FP7 Health Innovation Programme 2012*.

***Compensation***

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

***Has this study received ethical approval?***

The study has received ethical approval from the following committees:

The Faculty of Health Sciences Ethics Committee, Trinity College Dublin, Ireland and  
xxxxxxxxx

***What do I do now if I wish to be in the study?***

You don't need to do anything else right now. It is only when you go into hospital to meet with your clinician that you can actually 'sign up' to join the study. This is when you will have the final health check to make sure that you are suitable to take part.

***Where can I get more information or ask questions about the study?***

The midwives and doctors in your hospital have information about the study. The OptiBIRTH study website (see [www.XXXXXXXXXXXXXXXXXX](http://www.XXXXXXXXXXXXXXXXXX) and then click on OptiBIRTH) also has information on the study and this will be updated regularly, including with eventual results. Finally, the researcher, XXX , will be happy to provide you with more information. You can contact XXX by emailing XXX or by telephoning XXXX.

THANK YOU FOR YOUR TIME AND FOR CONSIDERING TAKING PART IN THIS  
IMPORTANT RESEARCH STUDY.

## Appendix 10: Consent form for ethnography

### CONSENT FORM FOR INTERVIEW

#### **An Ethnography of cultural change within a randomised trial aimed at increasing vaginal birth after caesarean section: The OptiBIRTH study**

**RESEARCHER:** Rebekah Maguire

**SUPERVISORS:** 1. Professor Cecily Begley                      2. Dr Valerie Smith

#### **DECLARATION by participant: Please tick (X or ✓)**

1. I have read the information for this research study and I understand the contents.

Yes [ ]      No [ ]      initials [ ]

2. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

Yes [ ]      No [ ]      initials [ ]

3. I fully understand that my participation is completely voluntary and that I am free to withdraw from the study and this interview at any time (prior to publication) without giving a reason and that this will not affect my care or the care that my baby receives in any way.

Yes [ ]      No [ ]      initials [ ]

4. I understand that I will be provided with a copy of this interview transcript so that I can check it for accuracy.

Yes [ ]      No [ ]      initials [ ]

5. I am aware that the information I provide will be retained for *at least* 5 years and that this information is confidential and cannot be linked to me as an individual.

Yes [ ]      No [ ]      initials [ ]

6. I understand that the information from this study will be published.

Yes [ ]      No [ ]      initials [ ]

7. I understand that the transcript will not identify me by name but will use the study code and that the original digital recording will be erased once the accuracy of the transcript has been confirmed.

Yes [ ]      No [ ]      initials [ ]

8. I freely and voluntarily agree to be part of this interview process.

Yes [ ]      No [ ]      initials [ ]

**PARTICIPANT'S NAME: (printed)** .....

**NUMBER:** .....

**Email: (if appropriate)** .....

**PARTICIPANT'S SIGNATURE:** .....

**Date:** .....

**Name of researcher: printed.....**

**Signature.....Date:.....**

**One copy of this form will be given to the woman and one copy will be retained by the researcher**



## **Appendix 11: Letter of Introduction to Participants (Women)**

School of Nursing and Midwifery  
Trinity College Dublin  
24 D'Olier Street  
Dublin 2  
Dd/mm/2013

Dear Madam

My name is Rebekah Maguire and I am PhD student in the School of Nursing and Midwifery, Trinity College Dublin. I am currently working on a research study called the OptiBIRTH Project. The OptiBIRTH project is designed to increase vaginal birth after caesarean section (VBAC) rates through increased women-centred care and women's involvement in their care. The intervention to be tested involves evidence-based education of women and clinicians, introduction of communities of practice (women and clinicians sharing knowledge), opinion leaders, audit and peer review of CSs in each site, and joint decision-making by women and clinicians.

I am interested in looking at this intervention. Specifically, I wish to explore any cultural changes in how maternity care is provided before, during and after the OptiBIRTH intervention is implemented.

I have prepared an information booklet which tells you about the study and what it means to participate. I do hope you will take the time to read the information and to consider being part of the study. I am more than happy to provide you with more information or to answer any questions about your rights and what it means for you to take part.

I would like to ask you to consider taking part in the study. If you feel this is something that would interest you, I should be grateful if you would read the study information and the consent form, which are enclosed.

While the study is ongoing, I will be in the antenatal clinics of the (Hospital Name) to answer any questions you may have and to gain your consent if you are willing to take part.

Thank you for taking the time to consider participating. Please feel free to contact me on the study mobile number 08XXXXXXX or email xxxxxx@tcd.ie

I look forward to hearing from you  
Yours faithfully,  
Rebekah Maguire

Supervisor: Prof Cecily Begley Email: XXXX@TCD.IE Telephone: (0)XXXXXXX  
Supervisor: Dr Valerie Smith Email: XXXX@TCD.IE Telephone: (0)XXXXXXX

## Appendix 12: Study information leaflet for women



*Your Invitation to participate in*

### **An Ethnography of cultural change within a randomised trial aimed at increasing vaginal birth after caesarean section: The OptiBIRTH study**

*A study to explore the culture surrounding the OptiBIRTH intervention*

**Rebekah Maguire**

PhD Candidate, School of Nursing and Midwifery, Trinity College Dublin

**Dr Valerie Smith and Professor Cecily Begley**

Supervisors, School of Nursing and Midwifery, Trinity College Dublin



My name is Rebekah Maguire. I am originally from Co. Monaghan and I am 23 years old. I graduated from UCD in 2011 with a degree in Social Science. I then moved on and completed my Master's Degree in Applied Social Research in Trinity College Dublin in 2013. During the Master's I worked as a research assistant on the MAMMI Study (Maternal Health and Maternal Morbidity in Ireland). My dissertation involved studying the considerations pregnant women take into account when they decided to participate in the MAMMI study. From then I successfully applied for the position of PhD student with the OptiBIRTH study. My research interests include pregnant women and their experiences of research, birth rituals and decision making around pregnancy and birth.

*The OptiBIRTH study has been approved by the Research Ethics Committees of the HSE Mid-Western Regional Hospital, Limerick and the Faculty of Health Sciences, Trinity College Dublin.*

*This embedded study has been approved by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin and the Research Ethics Committee of the HSE Mid-Western Regional Hospital, Limerick.*

*The OptiBIRTH study is funded by the FP7-HEALTH-2012-INNOVATION-1*

*HEALTH.2012.3.*

### **Why have you been given this leaflet?**

You have been given this leaflet because you are taking part in the OptiBIRTH trial.

### **Why am I doing this study?**

I am a doctoral research student in the School of Nursing and Midwifery, Trinity College Dublin. I am doing this ethnography research, which is embedded within the OptiBIRTH study, as directed under the EU FP7 grant agreement.

The reason I am doing this embedded study is to gain an understanding, from your perspective, on the OptiBIRTH package of care, what worked well for you within the study and on any changes that might have occurred in relation to decision making around mode of birth after a previous CS as a result of the study.

### **Within this study, I wish to find out:**

- What are the motivations of women taking part in OptiBIRTH to have a vaginal birth after caesarean (VBAC) or a repeat caesarean section (CS).
- Are there any barriers for pregnant women to have a VBAC.
- How do women get information on VBAC.
- To observe interactions in the hospital before, during and after the OptiBIRTH trial, to see if there has been a change in how decisions are made for type of birth (that is VBAC or CS).

- Your thoughts on the OptiBIRTH study and the package of care you received by taking part in the study.

### **What types of questions might I ask you?**

I will ask you about:

- What influenced you to have a VBAC or a CS (or what made you decide to plan for a VBAC or CS).
- Any problems you experienced with getting information.
- How you feel about VBAC.
- How you feel about the overall process of making decisions around type of next birth after a previous CS.
- How you feel about taking part in OptiBIRTH and what it is/was like for you.

### **What does taking part involve?**

I am asking all women who are taking part in the OptiBIRTH trial to take part in this embedded study. I will be hoping that some of you will meet with me and take part in an interview (as short or as long as you would like it to be) to find out more about your experience of taking part in the study and about your thoughts on the study and VBAC in general. We can arrange for the interview at a time and place that suits you best. This will be voluntary and all information is private and confidential.

The interview will be tape-recorded but all information will be kept completely confidential. The interview will be transcribed (written out on paper) and you will have the opportunity to read this, if you like, to make sure you are happy with the information in it. Taking part in an interview is completely up to you and you do not have to take part.

### **Are there any risks for you and your baby?**

Taking part will pose no risks to you or your baby. **However**, if you feel there is

any risk to you or your baby, or you are having any problems with the questions that are being asked, you can stop the interview at any time you so wish and you can withdraw from this part of the study.

At this time it is also important to remind you that I am not a midwife or health care professional and cannot give you advice about your pregnancy or care. However, I am more than happy to facilitate you if you need help with a certain issue and direct your concerns to a suitable qualified individual.

### **How will I protect your personal information?**

- All information will be kept strictly private and confidential. Information will be held for up to five years after the study for publication purposes, but neither your name nor personal details will appear in any publications related to this study.
- I will be using a unique study number throughout the study. All personal details will be removed from the interviews and your interview will not be linked to your personal details.
- All interviews will be anonymised and identifiers will be removed. This means that information from the interview will not be personally linked to you in any way.
- Paper copies of the information you give will be identified by your study number.
- I will be recording the interview. A paper copy will be made. The paper copy will be sent to you to confirm the accuracy of the interview. The recording will be destroyed after the interview is transcribed. The interview will be stored in a locked cabinet, in an area to which few people have access.

### **Can you leave the study at any time?**

Taking part is **completely** voluntary. You can withdraw at any time without any reason. If this occurs after the interview, your recording and paper copy of the interview will be destroyed.

### **How can you get in touch with me?**

If you are interested in taking part in an interview with me, please contact me

using either my email or telephone as below.

If you wish to have more information or any questions answered before you decide if you would like to take part in an interview, please feel free to contact me using the details below

Alternatively you can contact my supervisor Dr Valerie Smith by email at xxxxxx@tcd.ie OR at 01 XXX XXXX.

My name is Rebekah Maguire and you can contact me by:

E-mail at xxxxxxxx@tcd.ie

Telephone: phone on 086 XXX XXXX

I will be present some of the OptiBIRTH at the antenatal classes so if you have any questions I will also be able to answer them in person.

## Appendix 13: Letter to Clinicians

To all Staff  
Maternity Hospital  
Location  
Location.

School of Nursing and Midwifery  
Trinity College  
24 D'Olier Street  
Dublin 2

[DATE TO BE INSERTED]

Dear [To be inserted]: (Midwives, Doctors, Midwifery students, Medical students, Maternity Care Assistants) (Doctor, Public Health Nurse, Practice Nurse, Women's groups)

My name is Rebekah Maguire and I am currently a PhD Candidate in the School of Nursing and Midwifery, Trinity College Dublin. I am working on the OptiBIRTH Project that will be conducted at your hospital/maternity unit.

I am interested in exploring and documenting possible cultural changes that might occur during the OptiBIRTH trial, from both the perspective of the women and the clinical staff that are involved. I wish to collect data for this study during the antenatal (clinics), intrapartum (where feasible and appropriate) and postpartum period in [NAME OF HOSPITAL].

The research method encompasses two parts: 1) an observation of the interactions that occur between staff and women in the maternity unit and 2) interviews that will be conducted at different time-points during the trial with both women and staff.

I have prepared an information leaflet about the study and I am more than happy to provide you with more information if you so wish. I welcome your interest in this study and hope you will create awareness of it amongst women who are eligible for the OptiBIRTH Study.

Yours faithfully

---

Rebekah Maguire BSocSc, MSc (Applied Social Research)

Tel: 08xxxxxxx

Email: remaguir@tcd.ie



## **Appendix 14: Interview Guide Women**

Thank you for agreeing to take part in this interview. If you do not understand any of the questions, please let me know and I will explain the question to you.

I also want to remind you that if any of the questions make you feel uncomfortable, you do not have to answer them and you are free to stop the interview at any time should you wish to do so. If you have any questions before we start the interview please feel free to ask.

### **Introduction**

First of all I would like to say congratulations on your pregnancy!

How are you feeling?

How has the pregnancy been so far?

That's great. I am just going to move on and ask you about your views on different modes of birth and where you got this information.

Could you tell me why you had a Caesarean Section?

Were you happy with this decision?

What did the doctors or midwives tell you?

Did you understand what they were saying to you?

What was your overall experience of having your child through Caesarean Section?

Now that you are having your [NUMBER] child, have you decided what mode of birth you would prefer?

What has the doctor or midwife told you about VBAC?

Are you happy with the way the staff give you information on different modes of birth?

Do you feel that it is your decision?

Who do you discuss different modes of birth with? What do they think?

Do you find it hard to get information about VBAC or Caesarean Section?

Where do you get your information?

Are you comfortable discussing this with staff?

Do you feel pressured to have a certain mode of birth?

Is there any part of having a VBAC that worries you? Why?

Is there any part of having a CS that worries you? Why?

Finally, I would like to move to the last section of the interview, is that OK with you?

Do you feel you understand what the staff tells you?

How did the staff explain the OptiBIRTH Study to you?

What is your opinion of the OptiBIRTH Study?

Why did you decide to involve yourself in the OptiBIRTH Study? Did you talk to anyone?

What do you think the benefits are for you and other women?

## **Appendix 15: Interview Guide Clinicians**

### **Introduction to Interview**

Good afternoon/Good evening. If you have any questions before we start, please feel free to ask.

### **PAUSE FOR QUESTIONS**

#### **Great now let's get started:**

So just to start off can you tell me a little about your views on VBAC?

Can you just tell me about how found out about the OptiBIRTH package of care?

Can you tell me how you talk to women about the OptiBIRTH package of care?

Can you tell me what you think of the OptiBIRTH package of care?

So the intervention has been in the hospital for the last 6 months: can you describe a little how the staff in the hospital are responding to the study?

Can you tell me if you think there has been any changes in how staff think about VBAC because of this study – what might these be?

How are you finding the intervention so far?

Is there anything that hasn't been mentioned here that you would like to share?

### **PAUSE FOR QUESTIONS**

**Ok we are at the end of the interview. I would just like to say thank you for participating and if you are unsure of anything or are uncomfortable, you can leave the project at any time. And again, everything that has been said is strictly confidential.**

## **Appendix 16: Modified Interview Guide Women**

### **Introduction to Interview**

Good afternoon/Good evening.

I just want to say thank you for agreeing to take part in this interview and to remind you of a couple of points before we start if that is ok:

Again thank you for agreeing to take part in this interview. The interview should not take longer than 30-40 minutes. If you do not understand any of the questions, please let me know and I will explain or repeat the question to you.

Also, if any of the questions make you feel uncomfortable, you do not have to answer them and you are free to stop the interview at any time should you wish to do so.

You will not be identifiable by name in any information related to the study; rather your study number will be used at all times.

Finally, this interview is being recorded and will be kept for five years from this date.

If you have any questions before we start, please feel free to ask.

### **PAUSE FOR QUESTIONS**

Great now let's get started:

First of all I would like to say congratulations on your pregnancy!

How are you feeling?

How has the pregnancy been so far? Has it been different from your previous pregnancy?

**Probe: Your overall experience of your previous pregnancy? What the doctors or midwives tell you? Happy with the decision? Understand why you had a CS?**

Can you tell me a little about how you find out about the OptiBIRTH Study?

- **Probe: How was it explained to you? What are your thoughts on the OptiBIRTH package of care? What did you like about it?**

- **Probe: Its influence? Changes? – (need something about effecting decisions/thinking around mode of birth)**

Overall do you feel any benefits participating in this research project?

- **Probe: Its structure for clinicians and women (Separate Questions)? Benefits for you? Information? Comfortable with decision?**

What has the doctor or midwife told you about VBAC?

- **Probe: happy with the way the staff give you information on different modes of birth? Who do you discuss different modes of birth with? What do they think? Do you feel that it is your decision?**

Can you tell me where do you normally get information about VBAC or caesarean section?

- **Probe: Where do you get your information? Are you comfortable discussing this with staff? Asked staff for information? What about the website and is it beneficial for you?**

How are you finding the OptiBIRTH package of care so far?

- **Probe: what aspects of the package of care are you findings most beneficial/what aspects are less beneficial for you? Is the package of care affecting your thinking/planning for your birth in this pregnancy?**

Is there anything that hasn't been mentioned here that you would like to share?

**Ok we are at the end of the interview. I would just like to say thank you for participating and if you are unsure of anything or are uncomfortable, you can leave the project at any time. And again, everything that has been said is strictly confidential.**

## Appendix 17: Coding example of fieldnotes

<p>[the MOL] begins the class by explaining the aims and objectives of OptiBIRTH and this first antenatal class and then asks if anyone would like to start. The room is completely quiet and everyone just looks at each other. There is an awkward atmosphere. [The MOL] tries to get them talking by asking "who is due first?" and again there is an awkward silence and no one begins to speak. She then changes tactics and singles out one woman by asking "what happened with you the last time?" The woman replies with one word "breech" and that is it. Silence. [The MOL] then tries again to get the women talking by talking her through what had happened with her previous birth but all is quiet in the room. [The OOL] then jumps into the one-sided conversation and all eyes are on him. He first goes on to explain breech birth and why it had to be a section, then moving on to his patient's experiences of vaginal birth versus a repeat CS, the whole process of a VBAC including time on the labour ward, saying</p>	<p>ANT_OPTI</p> <p>ANT_ENC</p> <p>ANT_SIL</p> <p>ANT_ENC/ANT_BRI</p> <p>ANT_SIL</p> <p>ANT_ENC</p> <p>ANT_SIL/ANT_OOL</p> <p>ANT_PRE/ANT_BRI</p> <p>ANT_EXP</p> <p>ANT_BRI</p> <p>ANT_VBAC</p> <p>ANT_ENC/ANT_EXP</p>
--	---

“the first birth for a lot of you” and what will happen this time round, finishing off this explanation by stating this “is not an individual event, but a career” referring to the fact that the women may want more children and the this will be there only chance to try and have a natural birth, as after 2 CS they cannot do anything but have another section. They will not have a choice. It has already been made for them. This is the only time that they will have a choice in the matter of how they would like to birth and how this will affect their next birth if they choose to have another child.

After this explanation ([The MOL] always stays very quiet when [The OOL] is talking. She just looks into space or at him. However [The OOL] has poor eye contact and is in the habit of looking at his hands when is talking to the women about labour and VBAC. This may be because he is uncomfortable being in the class and the situation or simply he is in his own world and that’s it. That is how he does things.), he then asks the room if anyone had

ANT\_VBAC

ANT\_ENC

ETH\_REAC

ANT\_MOL/ANT\_OOL/  
ANT\_OL

ANT\_MOL/ANT\_BODY  
ANT\_OOL/ANT\_BODY

ANT\_OOL/ANT\_BODY

ETH\_REAC

ANT\_ENC/ANT\_BRI  
ANT\_BODY

"laboured", to which he looks at every woman in the room, looking for an answer. One of the women looks at him and answers that she was "fully dilated and got a vacuum and was not prepared for a section at all". He listens to her and nods while commenting "yeah, yeah, yeah" which is something that he always does in the clinic when he is talking to anybody. He replies to her telling him her story by saying "anyone with a dab hand with a vacuum would have got it out". This is a strange comment to me and I am not sure what he means by this. Is this another dig at his colleagues saying that they are not as good at him? Is he trying to show his superiority and power, saying "I would have got the baby out without you having to go through a section"? Then, running with her story talks about the pelvis, its size and how this effects labour and birth and also getting the epidural, which could slow down the baby and your contractions. He states that he "would rather a birth without an epidural than a section" because the woman knows what her body wants her to do rather than the midwives telling her that

ANT\_ANS

ANT\_OOL/ANT\_EXP  
POW\_COLL/POW\_PLAY  
ANT\_OPIN

ETH\_REAC

ANT\_EXP/ANT\_OOL

ANT\_OOL/ANT\_OPIN  
ANT\_OOL

it is time to push.

The more he talks about certain things the more interest he shows in his craft and the more comfortable he gets although the eye contact with other people in the room is still quite bad and shows him to be a bit stand-offish, in my opinion. He then moves on to explain the medications to have in labour and his favourite topic- induction. It must be remembered that he is the only doctor in the hospital who will induce a previous CS and then goes on to explain his procedure for induction, specifically saying that he is "keen on it". I know that it is up to each individual doctor on the methods for a previous CS but saying things like this may get the hopes up for the women that they can be induced and then, when mentioning it to another doctor who does not believe in it, could shatter their hopes for a natural birth if things are not going their way and, for example, they are overdue. The topic of inducing a previous CS is not in the presentation slides for OptiBIRTH. Just something to note for myself in case it becomes

ETH\_REAC

ANT\_OOL/ANT BODY

ETH\_REAC/ANT\_OOL  
ANT\_OOL/ANT\_EXP

ANT\_IND

ANT\_OOL

ANT\_IND/POW\_PLAY/  
POW\_COLL

ANT\_OOL/ANT\_EXP/

ANT\_IND

ANT\_OOL/POW\_PLAY/  
ANT\_IND

ETH\_REAC

POW\_COLL

ANT\_IND

ANT\_OPTI/ ANT\_IND

ETH\_REAC/POW\_PLAY



an issue that plays into the power struggles in the hospital.

Method for induction

Coming in and checking the cervix to see if it is “ripe” and then over going to dates that the baby is due, both the woman’s dates and the dates from the scan. He states to the class that he is a “liberal inducer” but that he is “not recommending but it can be done”. While he is saying this (he does like to go off into his own world and can go into a tangent about things but he does show his passion when he is talking), the room is very quiet, except for him talking and the child in the room, who I think must be bored, the parents did not take anything in to keep the child occupied. He then goes back to his procedure for inducing again which would be coming in the day before, as you would if you were booked for a section and checking the cervix and the “watching her like a hawk” for any complications or if the baby is in distress. [The MOL] then interrupts this train of thought as he is not really supposed to be talking about induction. I don’t

ANT\_IND/ANT\_OOL/  
ANT\_EXP/ ANT\_OPIN  
ANT\_IND/ANT\_OOL/A  
NT\_EXP/  
  
ANT\_OPIN  
  
ETH\_REACT  
  
ANT\_PRE/ ANT\_SIL  
  
ANT\_IND/ANT\_OOL  
ANT\_EXP/ ANT\_OPIN  
  
ANT\_MOL/ANT\_OOL/  
ANT\_IND  
OPIN\_DIFF  
  
OPIN\_DIFF/ANT\_OL/  
ANT\_IND

think that the OptiBIRTH team agree with what he does and [the MOL] tries to reign him in from this giving of information that may be contradictory to OptiBIRTH and the hospital ethos but telling them about the other OptiBIRTH women and how they have gotten on with their birth. This generates an “oh” from all of the women. They are either surprised or encouraged that other women with similar previous birth experiences have gone through the intervention have come out the other side and have had a natural birth. [The OOL] then pipes in and says that having an elective section is “strange” and that it is “harder for yourself”. The room then goes quiet again and another woman is asked about her previous labour and birth experience. This woman had an elective CS for twins as one of the babies was in a breech position but before finding out about that she was very pro natural birth and planned a vaginal birth for the twins. [The OOL] tells says to her that it was a “pity in a way you didn’t get your chance” and “if you don’t try you don’t get there but most do there”. Here he is trying to bolster the women by

OPIN\_DIFF/ANT\_OPTI/  
 ANT\_IND  
 OPTI\_WOM  
 BIRTH\_OPTI  
 WOM\_REAC  
 ANT\_ENC  
 ANT\_PRES  
 ANT\_BODY  
 ANT\_OPTI/ ANT\_VBAC  
 ANT\_OOL  
 ANT\_OOL/ANT\_OPIN  
  
 ANT/SIL  
  
 ANT\_BRI  
  
 ANT\_OOL/ANT\_ANS/\_  
 ANT\_EXP  
 ANT\_ENC  
  
 ETH\_REAC

saying that they should at least try to have a natural birth because this is their last chance to even be given the option of having a natural birth. He tries to reassure them that how a “nice, smooth, straightforward” labour will help and that if labour commences and is going, then will not stop it and they will “give them a bit of chance, give them another hour” to see if they progress and that they can achieve a natural birth. He emphasises the naturalness of the birth process and this is what they should try to achieve with this birth.

The moves on to another woman to discuss her previous birth experience and why she had a CS. She also had twins and decided on a CS, which is completely understandable. She then asks him about the timing of each births in relation to the CS scar. This is the first question that has been asked in this class and the women are finally warming up to the structure of the class and listening to other women’s stories. They can see that all of their stories are different but they are there to achieve the same thing and that is a natural birth. I

ANT\_OOL/ANT\_VBAC  
/ANT\_ENC  
ANT\_OPIN/ ANT\_POS/  
OOL\_POS

ANT\_BRI

ANT\_OL/ ANT\_VBAC/  
BIRTH\_OPTI/ANT\_QUE

ANT\_BODY  
WOM\_BOND

ETH\_REAC/ANT\_BRI/A  
NT\_OPTI

suppose with the first class being like a de-brief of the previous birth experience and finding out information about having a VBAC, it also could be a bonding experience for women. They listen to each other stories and what they want out of this birth and can realise that they are not alone, that they can do it and are being given the chance to and that there are other women in similar situations that are going through the exact same thing. It's like a little club.

[The OOL] answers this questions "4 months" and everyone begins to laugh, probably in disbelief but that's why I'm laughing. That is a short span of time. I am learning so much from these classes!

He also then went on to talk about the baby's weight and its effect on having a natural birth but, again trying to be reassuring and give the women a boost of confidence, tells them that they (doctors) will "give you a try". At this time his phone rings and he answers it. He doesn't leave the rooms and just sits there and talks on the phone about a woman and doing a procedure and the class goes dead! It is really awkward and

WOM\_BOND

ANT\_OOL/ANT\_ANS

ANT\_BODY/ ANT\_PRE/  
OPTI\_WOM

ETH\_REAC

ANT\_OOL/ANT\_EXP

ANT\_OOL/ANT\_PRES/  
ANT\_ENC

ANT\_VBAC/ANT\_EXP

[The MOL] and I catch each other's eye and just smile like "what the hell is going on!" He ends his calls and then goes back to the same women, talking about the baby's weight. He refers to the fact that if you are married to a big man, you may have a predisposition to have a big baby and it would be worth considering "shaving half of a pound off it". This could make the labour and birth easier but I don't know I am only speculating.

The class then moves on to the next woman who also had a CS due to a breech baby. She is worried that this baby will also turn out to be in a breech position and adamantly does not want another CS. She asks [the OOL] if he, as a doctor, would turn the baby and if this could happen if the baby was in the breech position due to the scar from the CS. He answers her in a positive manner and says that he would try to turn the baby if that was to be the case and recommended that they would try to turn the baby as it would reduce the need for a CS. The woman listened carefully to all this and a sense of relief crossed her face, maybe due to the fact that they would try to turn the baby

ANT\_OOL/ANT\_EXP

ETH\_REAC

ANT\_BRI

ANT\_OOL/ANT\_QUE/A  
NT\_BRI

ANT\_OOL/ANT\_PRES/  
ANT\_ANS

ANT\_EXP/ ANT\_POS/  
ANT\_OPIN

OOL\_POS

ANT\_PRES/ANT\_BODY/  
\_ANT\_VBAC

ANT\_OPTI/ANT\_ENC/  
ANT\_POS

UR

if it was breech instead of immediately going for a section. She would still have a chance for a natural birth.

ANT\_EXP

UR\_EXP

The issue of uterine rupture comes up in the class and is brought up by [the OOL]. He explains what is (scar breakdown in the uterus) and how it works (feeling pain through the epidural and not feeling like a contraction) and then not labouring too long at home, saying "you better come in".

UR\_EXP

ANT\_EXP

OOL\_POS

Overall, his attitude is positive, bright and is making jokes in the class, putting the women at ease and tell them to "not be worried or fearful.

ANT\_ENC

ANT\_ENC

ANT\_POS

Just give it a try and be open-minded". This is kind of mantra in the class and these words are used throughout by both Opinion Leaders.

## Appendix 18: Example of Interview Woman

**Int:** Ok. So first of all I'd like to say congratulations on your pregnancy.

**W11:** Thank you.

**Int:** How have you been feeling?

**W11:** Good yeah.

**Int:** Yeah.

**W11:** Yeah. No complications or anything thank god. So all going well.

**Int:** And has it been different to your previous pregnancies?

**W11:** Maybe a bit sicker at the beginning, em, on my previous two pregnancies, em, I suffered from nausea at the start of the pregnancies up until about 14 weeks. Em, on this now it seemed to last about 16 and it seemed to be a lot worse but I don't know whether it was because I had two smallies at home that I had to mind as well that I felt like it was worse for that reason or. . . but yeah it did feel like the nausea was worse during this pregnancy so. . . but since then I'm flying it yeah, yeah. . .

**Int:** So can you just tell me how your section came about?

**W11:** Yes so that was my second, em, my second pregnancy so, em, basically on my last appointment which was I think the week before I was due, I came in and I seen a doctor here and he brought me in and gave me a little scan in one of these rooms and he said to me that, em, that I was having a very big baby first of all. He asked me did anyone ever tell me in this pregnancy that I was having a big baby and I said 'no' and I said 'how big?' and he said 'about [NUMBER] pounds' which I was in shock [Laughs]. And, em, then, em, I think he did a bit of an internal. He just wanted to see, he just felt around my tummy and couldn't feel the head and he said that the head was very high. So I think basically that was the main reason why. Well that's the main reason he gave me why they would do an, em, an elective section, he called it. Now I was due [DAY] so they gave me every

opportunity. They booked me in because it was around [DAY], em, the next available date for an elective section after all the holidays was the [DAY]. So he said I was booked in on that date for the section if nothing happened in-between. So they did give me every opportunity to go myself which I didn't and, em, so yeah he just said the head was too high. It wasn't going to drop at this stage and also he said the size of the baby compared to the size of me, he thought it might be a bit dangerous for me to try go myself. He said I could end up damaging my pelvis is what he said. So I really had no choice in the matter. I was booked in for it and that was it if I didn't go before that date which I didn't so. . .

**Int:** And how was your experience of the section?

**W11:** So the section itself, that experience fine, like, I came in to the maternity hospital the evening before and they did all the tracing of the baby and booked me in and explained to me what the process was going to be for the following morning. That was all fine and I was taken down, I was supposed to go down a bit earlier and they ended up. . . I went down anyway I think for about [TIME] and my little [GENDER] was born just after [TIME]. That was all fine, the operation itself was fine. I was the recovery that I just found very hard. I think the fact that I had another little [GENDER] at home, that I went home to that I wasn't probably resting up as much as I should've been or, you know, I just found it compared to my first pregnancy was, em, natural and I found that recovery much quicker, much easier than the section so. . .

**Int:** Yeah. That's great. So I'm just going to move on now to talk about OptiBIRTH if that's ok with you?

**W11:** Ok. Yeah.

**Int:** So can you just tell me how did you find out about the OptiBIRTH Study?

**W11:** So I found out on my first appointment here in the maternity. I met actually [the MOL] was covering down here that day. They were busy and she actually brought me in and,



em, she was just going through, em, this pregnancy and asked me what my history was and I told her I had one previous normal birth first and then section and she just asked me in conversation, you know, how did I find the section and I said 'really I didn't like the whole. . . I found the recovery very hard' and I just said to her if I had a choice I would love to go naturally this time. So then she told me she was leading this trial and what it was all about and if I'd be interested in taking part and I said absolutely because I'd love to. . . that was what I was hoping for and any help I could get with that I'd take it so. . .

**Int:** And before meeting [the MOL] did you know that you could have a natural or had you made up your mind?

**W11:** Well I had made up my mind that I. . . I was hoping I'd be able to go naturally but I didn't actually know. Em, I think that's where maybe some women don't know that. . . some women just think, now I'm sure some women it's by choice because maybe if they've had just one section then maybe it's the fear of going naturally that they don't know. It's the unknown maybe and maybe some women just aren't informed that, you know, after a section you still can go naturally again but I came in not knowing but hoping, em, that I'd be able to go naturally, that's the way I was thinking anyway so I was delighted to hear that there would be a chance that I could go naturally if everything went well and, you know so. . .

**Int:** Great. And I just want to move then to the classes that you participated in. how did you find the classes? Were they beneficial?

**W11:** OK. Yes. Well the first class I actually missed. Em, I was on holidays so I attended the second class last week. I actually, I didn't read the letter properly. I thought both classes were the same thing. I thought you could either attend one or the other. I didn't realise one was about something else but anyway, no the second one I actually, I've been telling everyone about it since I came out that I found it really, very, em, beneficial and very

interesting. Just to know the facts and, you know, cos I know a sister of mine is actually studying to be a nurse and is hoping to go into midwifery afterwards so I was raving about it to her and she said she would love, she would have loved to come into it if she knew that, you know, what I got out of the class. I told her, you know, about everything, the statistics and, you know, things you wouldn't really know. So I did find the class very, very beneficial and very helpful.

**Int:** Great.

**W11:** Yeah.

**Int:** And is anything you would have changed about the class?

**W11:** No I found that they covered, em, everything I wanted to know anyway. Em, because in the booklet that we got out, em, you know that we'd to fill out it was, you know, about expenses in your, you know, so I was kinda coming in here thinking that the class was going to be about that maybe, you know, about expenses in your pregnancy and how far you had to travel and things like that so I was really delighted when I came out and it was really about what I wanted to know about which is the comparison of caesarean section and all the things you'd be worried about. The risks that are associated with and what may happen and if this does happen, you know like. . . for me it was the fear if my scar if, you know. . .

**Int:** The breakdown?

**W11:** Yes, what would happen there and it was all very well explained by [the MOL] and [the OOL] so I was yeah, I was delighted with the class. . .

**Int:** Great.

**W11:** No it was excellent.

**Int:** And have you used the website?

**W11:** No unfortunately.

**Int:** That's no problem.

**W11:** I haven't yet but I will get on to it, em, I'm just very busy, two little [GENDER] at home so it's hard to get the time but. . .

**Int:** So would you prefer more face-to-face interaction?

**W11:** Well, yeah for me. Some people are probably. . . me now I'm not really a whiz kid on the computer so, em, yeah I prefer face-to-face and classes but for people that, you know, probably maybe don't have the time to come into a class or something like the online is very beneficial I'm sure to them. Em, it's just for me I think when you know you have to go to a class, you'll get out of the house and go to it but if you have to, em look at the internet at home it's to get time to sit down and do it, you know em, when you have smallies running around the place [Laughs].

**Int:** [Laughs] Ok. Can I just ask you has your doctor or any of the midwives asked you about VBAC or told you any information about VBAC?

**W11:** No.

**Int:** Has your doctor discussed yet your birthing options for this pregnancy?

**W11:** No. Em, well I just after the class last week I just changed over to [the OOL] now but before that, em, the doctor I'm actually under, I discovered at the class has left two years ago [Laughs] and em, so her clinics go on here but under local doctors. Nobody ever spoke to me about VBAC or even my birthing plan or options yet. Now on my appointment, about three weeks ago it was just for bloods but I did get to speak to a doctor at that and I did ask him, em, just about my scan which is [DAY], would they be able to tell me how big the baby is at the moment and if it was maybe a bit bigger than usual, would they bring me in maybe a bit early. So I did ask that doctor a few weeks ago about that and he said yeah that would be an option if. . . yeah. . .

**Int:** Great.

**W11:** But em, no besides that I had never heard of VBAC no. . .

**Int:** Do you know anyone who's had a VBAC?

**W11:** Em, I was trying to think. I'm sure I've heard of someone but I don't know personally, you know, someone. . .

**Int:** And can I just ask you have you look anywhere for more information about VBAC or repeat caesarean section?

**W11:** No, no, well not at the moment. I just took away those leaflets that you gave me last week and they were very interesting now to read yeah. . .

**Int:** Great. Ok so then just really finally how are you finding the OptiBIRTH package of care so far? The classes, the booklets?

**W11:** Yeah. Well I know I haven't availed of all, you know, I haven't gone on to the internet yet but, em, or the online, em, but no. . . what I've got so far I'm very happy with. It's just to be informed and to know what's available and, you know, and to be informed fully on both sides of it. What are the pros and cons of caesarean repeat or, you know, going naturally and yeah. . . no I was very happy so far anyway.

**Int:** Great. So is there anything that hasn't been mentioned here that you would like to share?

**W11:** No I don't think so.

**Int:** Great. So we're just at the end of the interview. I'd just like to say thank you for participating and if you're unsure of anything or you're uncomfortable you can leave the project at any time. And everything that's been said is strictly confidential.

**W11:** OK.

## Appendix 19: Example of Interview Clinician

**Int:** So just to start off can you just, em, tell me a little about your views on VBAC?

**C6:** I think it's very important because that we have that facility and that we encourage it because birth is a normal process and women should push out babies themselves  
[Laughs].

**Int:** [Laughs]. Yep!

**C6:** To sum it up!

**Int:** Yeah. And then can you just tell me maybe just a little about the hospital ethos with regards to VBAC?

**C6:** I think it probably depends a bit from consultant to consultant. Some are more positive than others. . . em, from the hospital point of view it depends on midwives to an extent. I'm a long time a midwife I started training in [Year] and where I trained there were very few caesarean sections. A caesarean section was a big deal. We didn't have epidurals and there was very little monitoring so women were up and mobile and we had a very low caesarean section rate. So, for me I just. . . I do feel that caesarean sections are definitely essential at times and that it's great to have the facility, you know, that we can section women as quickly as we can but I think sometimes they may be overused. . .

**Int:** Ok.

**C6:** And I do think the possibility of having a vaginal birth after that is very important. I think it's empowering for women to push out their babies and it's very important as a new mother to feel empowered and able to do things and know what you're at and look after your baby.

**Int:** Yeah. Em, you just mentioned [Year] was it?

**C6:** Yeah.

**Int:** Can you explain the changes, that you saw hardly any sections, like, it must be, like it's now a 40% section rate and everything, how does that make you feel as a midwife?

**C6:** Disappointed more than anything. Em, not always obviously, sometimes women definitely need to be sectioned there's always a . . . but I think it's a fallback position as well and then women, and you hear them saying 'well I'd prefer to have a section. I don't want to push. I don't want to labour'. That's dreadful. I think we've failed a bit as midwives or as health care professionals if we're not supporting women and the normal process. We are midwives you know? We should really. . . I just do find it disappointing.

**Int:** Ok. And can you tell me just then about the doctors and their views on VBAC?

**C6:** Eh, it depends some of them are very pro. [Doctor] particularly would be. He's great really, like he does his best to get them through and then others would probably feel it's more convenient just to section. It, you know, it just depends . . .

**Int:** Ok.

**C6:** And then of course it's, you know, mother choice and whether or not they're informed enough and educated enough to know. I think it, you know, why do a section in the first instance has a huge effect, if they're very traumatized by having an emergency section at the end of a labour they're maybe a bit more difficult but if they're having a section because they were breech the first time and they're now ok and is, you know, it's a planned section and so. . . yeah I think that makes a big difference and I do. . . and I think, you know, looking at that with mothers very soon after delivery, not within the very short post-natal period that they're here but maybe they really need to be sat down and have a long discussion with them, how they're really feeling and their partner because women don't come in on their own [Laughs]. Partners have a big effect. They need to be very much supported as well.

**Int:** Ok. So then just moving on to OptiBIRTH, can you just tell me how you found out about the OptiBIRTH study?

**C6:** I don't really know much about the OptiBIRTH study to tell you the truth.

**Int:** Ok so obviously it's just, em, designed to increase VBAC rates through women-centred care like specialized antenatal classes and specialized website and then through the education of doctors and midwives through evidence-based information through [the MOL] and [the OOL].

**C6:** Yeah I know, I knew [the MOL] was involved in the study. There was one talk one day which I got to half of. We don't always get to it here we're very busy [Laughs].

**Int:** Yeah.

**C6:** Yeah but I think it's a great idea [Laughs].

**Int:** [Laughs].

**C6:** I'm right behind you!

**Int:** And so OptiBIRTH, it's been here for two years, have you noticed any kind of change towards even talking about VBAC or, em, women coming in to have VBAC?

**C6:** Em, well there is more talk about it, yeah, that it. . . yeah, no, there is. . . certainly it's applauded, you know, it is generally applauded. . . but no not majorly.

**Int:** Ok.

**C6:** I suppose. . . well actually really what I suppose is that it would very often be women are privately cared for. It's actually. . . it's actually women that are going to [the OOL] more than anything. That's where all the information would be yeah. . .

**Int:** Ok. And how are you finding them coming in for the VBAC?

**C6:** Good. Well educated and well informed and enthusiastic and know what they're facing and. . .

**Int:** And how does that make you. . .

**C6:** Great! [Laughs] Let's do it!

**Int:** Yeah.

**C6:** Yeah, because, you know, fear is very counter-productive in labour. Fear increases adrenalin and adrenalin counteracts oxytocin and women that are frightened don't labour well and that's just it really.

**Int:** Ok.

**C6:** So if they're unsure whether this is a good idea or not or, more than that if their partner sitting beside them is a bit iffy about it and remembers the trauma from the first section, you know, that's very counter-productive in the labour room. So, you know, OptiBIRTH is a great idea [Laughs] from that point if we're educating for women to be properly prepared for it. I think it's essential.

**Int:** Yeah.

**C6:** Good luck! [Laughs]

**Int:** [Laughs] I know! It's a big ask!

**C6:** Yeah.

**Int:** Em, and then just overall have you seen any kind of positive change towards VBAC with doctors or midwives?

**C6:** Em, ah I think midwives yeah definitely. Doctors, as I said I think it varies. . . it depends on. . . some consultants are just more cautious than others. They've just different ways of practicing and. . . you know. . . I don't know why really. . . I don't know. . . like [the OOL], I had a, I looked after a breech lady of his recently and a lot of. . . and it was just, it was a singleton breech. . . like they'll do, they often won't do twins if the first baby's head comes head first and they don't mind trying to do the second one breech but it's very unusual to have a breech singleton and it was lovely. I was, you know, as I say I'm a midwife since [Year] and I've looked after breeches before but he's. . . [the OOL] is



unusual in that. There's much more. . . it's litigation, it's the barrister on your shoulder all the time that has them so. . . and actually [Laughs] I don't know if this is going to you're probably not involved in any research into this area but I can never understand why the barristers are saying. . . they're really driving obstetrics and what happens and what doesn't happen. They've way too much influence in it. They need to be told 'actually that's not reasonable', you know, it's. . . I find that very disappointing.

**Int:** Maybe it's due to the fear as well, you know, I suppose maybe it's a female dominated area and barrister are, for the most part, male? [Laughs] I don't know maybe!

**C6:** Yeah, maybe! [Laughs] That's interesting. . .

**Int:** I don't know but I know fear of litigation. . .

**C6:** It's huge! And even then you'd find students, like newly qualified students say, you know, 'it's not safe practice' and safe for who? Like is it going to effect the woman or the midwife or the obstetrician? Very often it's about fear of litigation for something that. . . oh I dunno I just wonder about it sometimes. . .

**Int:** Yeah. How have you found the new students with OptiBIRTH being in the hospital and their views around VBAC?

**C6:** Yeah good. Positive. I think the fact that they're midwives and not nurses primarily has its advantages and disadvantages that I do think they're. . . yeah I think that has a positive effect on wanting to have a normal delivery. Push the baby out yourself! [Laughs]

**Int:** [Laughs]. Yeah. So then just overall do you think that OptiBIRTH has had an effect in the hospital?

**C6:** Yes I do. I'd like more information though. It would be nice to have more feedback on how it's going and, you know, and it is because we are so busy, like, it's hard to get to your break here! [Laughs]

**Int:** Babies come whenever they want!

**C6:** Yeah, yeah. We just are too busy.

**Int:** But that's just. . . do you feel that OptiBIRTH will have a lasting effect once it's over around VBAC?

**C6:** Absolutely yeah. I think most women once they're well educated would choose not to have a caesarean section. And particularly that the more there are then that information will be out there that how much better a normal delivery is from a recovery. Actually we were just discussing last night that, em, insurance companies not insuring women to drive after a section for six weeks. Now I don't know why that is. I'm going to ring one of them because, like, I don't know. . .

**Int:** I've never heard of that.

**C6:** Yeah. Yeah! And, you know, if you're a mother with two kids and you've just had a caesarean section for your third and you're halfway up the mountain somewhere in [Location] that's very isolating, you know? So I think even from those practical things it's be. . . I mean I have, I've looked after loads of women who've had previous sections and they're having a vaginal birth and they really, really, really want it so. . . yeah. . . it's good! [Laughs]

**Int:** Yeah! That is. . . hopefully it will start to become the norm, normal birth. . .

**C6:** Yeah! Absolutely!

**Int:** Well that's really everything. Em, is there anything that hasn't been mentioned here that you would like to add?

**C6:** Em, no I don't think so. Well except I suppose just from the point of view of educating, I know [the MOL] involved but I think it's very important there's a good midwife input into educating the women and, you know, midwives from the labour ward because, you know, when you're here day in and day out for years I think you can probably give more

accurate information. A lot of the problems are fear. Women are afraid of labour. Isn't it a shame. [Laughs]

**Int:** Yeah.

**C6:** And then some aren't. Some women, you know, well educated women that have done hypno-birthing or whatever, coming in and enjoy it. It's a fantastic experience.

**Int:** And what about the doctor input to like, say the antenatal classes. Do you feel that's important?

**C6:** Em, no I don't really. I don't think it's the place for, em, obstet. . . no I don't really unless there's, em, issues. If it's a perfectly normal woman, healthy, well, uncomplicated, there's no need for the input of a doctor. And in fact that complicates it. Women need to know that this is a normal process. Now it's obviously different if you've got a scar on your uterus and you've got a previous section for, you know, VBAC but, yeah so they're. . . yeah you would need to have a doctor input there. . .

**Int:** Do you feel that women are more, would feel more comfortable with VBAC coming from a midwife, the information coming from a midwife?

**C6:** I think, em, there's two aspects of information there. One, she needs to know that it's safe for her with the scar that she has on her uterus to labour. But the information around labour and what's happened and the care and the options and the positions and the pain relief and, you know, what happens in labour should come a midwife because that's what we do. So I think it would be more accurate coming directly from us.

**Int:** Yeah.

**C6:** But the reassurance that, from a medical point of view that it is ok for her to labour on the scar, should come from an obstetrician.

**Int:** Ok.

**C6:** So mixed. You need input from both.

**Int:** Definitely yeah. Do you feel that women would, I suppose, do they listen more to the obstetrician than they would the midwife?

**C6:** It depends yeah. Women vary. It depends on where they're coming from with maybe their previous experience or experience of sisters or if they've had a good positive midwifery-led care then they'd listen to the midwife. It just depends. . .

**Int:** Yeah.

**C6:** Actually I think there's a big difference and this is. . . I don't know. . . I don't know why. . . I think there's a big difference in the way women, I'm from [Location] and, women in [Location] would be much more questioning and, em, all the obstetricians and why they're doing. . . like [Hospital] for example have a much lower caesarean section rate than we do and that's not just obstetric-led. That's also the women because I do find women don't always ask, like, they just will accept it.

**Int:** Ok.

**C6:** They're not even sure really sometimes why. . . oh well that's not true they are. . . they would definitely informed consent they give for a section but just, I don't think they. . .

**Int:** Ask the questions?

**C6:** Yeah. . . they just accept it. . .

**Int:** Do you feel they put too much trust maybe in. . .

**C6:** It's not so much trust they don't query. . .

**Int:** Do you feel maybe it's the influence of, maybe, of the internet or family members that they don't ask the right question?

**C6:** It's the family members. Well I definitely think female relatives have a big influence on how women feel. Em, yeah it does have a big influence. . . yeah. . . I sometimes just feel disappointed that they don't kind of know that they can do this.

**Int:** And how do you think that could change? What could be put in place?

**C6:** Education. Lots more of midwifery-led education antenatally including women with a previous section and obviously you do need an obstetric input but, you know, if they don't want to have a VBAC because they've a fear of labour, well we're the ones that do look after women in labour. So I think there needs to be a lot of input there.

**Int:** Do you feel that there's maybe, there's not enough antenatal education even for, leaving out the caesarean section, for your first baby? Do they get the right information?

**C6:** Em, I. . . you see. . . I think the midwives that give the antenatal education are very good on breastfeeding and very good on the aspects of it and a lot of them have worked here but some of them haven't worked here for a very long time and things change and, em, you know I think accurate information and what really happens is important. So, yeah, I think the. . . I do think actually the labour ward information could be improved.

**Int:** Ok.

**C6:** Just so they know exactly how long it's going to be and. . . and that the partner knows because sometimes I think they come in and they think it's all going to be over in a few hours and no, they get exhausted and anxious and. . .

**Int:** Like the movies!

**C6:** Yeah! Oh I dunno! [Laughs]

**Int:** That's great to know especially if it could improve rates or, em, section rates or decrease section rates like. . .

**C6:** Yeah. And also I, you know, if there was more, em, the labour ward's very noisy and there's a mix of all types of risk factors here. Like, if we had a low risk labour centre it would make a huge difference. There wouldn't be all these alarms and noises and machines and drips and. . . because it does. . . it makes people anxious and anxiety is not your friend in labour! [Laughs]

**Int:** Yeah. That's great to know! Em, I don't think I've any more questions.

**C6:** It was very interesting talking to you! [Laughs]

**Int:** Thank you for all the information and again if you're unsure of anything or are uncomfortable you can leave the project at any time. And everything that's been said here is confidential.

**C6:** Great!

**Int:** That's great! Thank you.

## Appendix 20: Codebook Sample

Code	Subject	Meaning
ANT_ANS	ANSWER	Answering questions in the class
ANT_BODY	BODY LANGUAGE	Notable body language that occurs in the class from all participants
ANT_BRI	DE-BRIEF	The aim of the class: De-briefing from the previous birth experience
ANT_ENC	ENCOURAGEMENT	Encouragement in the classes: talking, asking questions, participating in the class
ANT_EXP	EXPLAIN	Explanations that are given in the class
ANT_IND	ANTENATAL CLASS INDUCTION	Regarding conversations around induction
ANT_MOL	MIDWIFE OPINION LEAD	The MOL and her function in the class
ANT_OL	OPINION LEADERS	Pertaining to the OLs in the class and their interactions
ANT_OOL	OBSTETRIC OPINION LEAD	The OOL and his function in the class
ANT_OPIN	ANTENATAL CLASS OPINION	Individual opinions or comments that were noted

ANT_OPTI	OPTIBIRTH	Anything pertaining to the OptiBIRTH Study: Aims, components etc. Explanations or answering questions on the intervention
ANT_PRE	PRESENCE	Pertaining to anything that catches the participants and their reaction to it: questions, comments etc.
ANT_POS	ANTENATAL CLASS POSITIVE	Positive language and comments that occur in the antenatal class regarding VBAC and the women trying to achieve a VBAC
ANT_QUE	ANTENATAL CLASS QUESTIONS	Regarding any questions that were asked during the antenatal classes
ANT_SIL	SILENCE	Pertaining to silence in the room. Noting why it occurred
ANT_VBAC	VBAC	VBAC related comments or questions
BIRTH_OPT I	OPTIBIRTH WOMEN BIRTH	Comments or questions about OptiBIRTH women and their birth (VBAC or CS)
ETH_REAC	ETHNOGRAPHER REACTION	Noting the reaction of the ethnography in the field-notes
OOL_POS	POSITIVE OOL	Comments or conversations regarding the OOL with the women around VBAC and his opinion on VBAC
OPIN_DIFF	DIFFERING OPINIONS	Pertaining to any differences of opinion observed between participants or OOLs: interactions, body language



OPTI_WOM	OPTIBIRTH WOMEN	Regarding comments or questions about OptiBIRTH and the women participating
POW_COLL	POWER OVER COLLEAGUE S	Pertaining to the OLs and their representation of power over their colleagues to the women: observations, comments to women and opinions on VBAC and their fellow colleagues
POW_PLAY	POWER PLAY	Instances in which power is observed and how it is portrayed
UR	UTERINE RUPTURE	Conversations or interactions around uterine rupture
UR_EXP	EXPLAIN UTERINE RUPTURE	Occurrences in which uterine rupture is explained
WOM_BOND D	WOMEN BONDING	Relating to the women in OptiBIRTH and their interactions with each other and their relationships

## Appendix 21: Guideline 17 of the 2002 CIOMS International Ethical Guidelines to BioMedical Research Involving Human Subjects

### *Guideline 17*

#### Pregnant women as research subjects

Pregnant women should be presumed to be eligible for participation in biomedical research. Investigators and ethical review committees should ensure that prospective subjects who are pregnant are adequately informed about the risks and benefits to themselves, their pregnancies, the fetus and their subsequent offspring, and to their fertility.

Research in this population should be performed only if it is relevant to the particular health needs of a pregnant woman or her fetus, or to the health needs of pregnant women in general, and, when appropriate, if it is supported by reliable evidence from animal experiments, particularly as to risks of terato-genicity and mutagenicity.

#### *Commentary on Guideline 17*

The justification of research involving pregnant women is complicated by the fact that it may present risks and potential benefits to two beings — the woman and the fetus — as well as to the person the fetus is destined to become. Though the decision about acceptability of risk should be made by the mother as part of the informed consent process, it is desirable in research directed at the health of the fetus to obtain the father's opinion also, when possible. Even when evidence concerning risks is unknown or ambiguous, the decision about acceptability of risk to the fetus should be made by the woman as part of the informed consent process.

Especially in communities or societies in which cultural beliefs accord more importance to the fetus than to the woman's life or health, women may feel constrained to participate, or not to participate, in research. Special safeguards should be established to prevent undue inducement to pregnant women to participate in research in which interventions hold out the prospect of direct benefit to the fetus. Where fetal abnormality is not recognized as an indication for abortion, pregnant women should not be recruited for research in which there is a realistic basis for concern that fetal

abnormality may occur as a consequence of participation as a subject in research.

Investigators should include in protocols on research with pregnant women a plan for monitoring the outcome of the pregnancy with regard to both the health of the woman and the short-term and long-term health of the child.

### *Guideline 18*

#### Safeguarding confidentiality

The investigator must establish secure safeguards of the confidentiality of subjects' research data. Subjects should be told the limits, legal or other, to the investigators' ability to safeguard confidentiality and the possible consequences of breaches of confidentiality.

#### *Commentary on Guideline 18*

Confidentiality between investigator and subject. Research relating to individuals and groups may involve the collection and storage of information that, if disclosed to third parties, could cause harm or distress. Investigators should arrange to protect the confidentiality of such information by, for example, omitting information that might lead to the identification of individual subjects, limiting access to the information, anonymizing data, or other means. During the process of obtaining informed consent the investigator should inform the prospective subjects about the precautions that will be taken to protect confidentiality.

Prospective subjects should be informed of limits to the ability of investigators to ensure strict confidentiality and of the foreseeable adverse social consequences of breaches of confidentiality. Some jurisdictions require the reporting to appropriate agencies of, for instance, certain communicable diseases or evidence of child abuse or neglect. Drug regulatory authorities have the right to inspect clinical-trial records, and a sponsor's clinical-compliance audit staff may require and obtain access to confidential data. These and similar limits

## Appendix 22: Lone Researcher Guidelines provided by Trinity College



Dublin University of Dublin  
Trinity College



FACULTY of Health Sciences

# Lone Worker Guidelines

The following pages are guidance for researchers (staff and students) who are working alone or in small teams. They are intended to provide guidance to researchers in the field, irrespective of whether they are working on independent research projects or externally funded ones.

Who is this guidance for?

Members of staff or students who:

- work by themselves without close or direct supervision,
- or in small teams
- who may be vulnerable to the physical environment,
- lone travelling either by public transport or on foot and
- in particular for unaccompanied home visits.
- Researchers are expected to follow these guidelines and to use their professional judgement at all times.

### Safe working arrangements for staff who work alone

Lone working on campus should also be considered to have a reasonable element of risk, particularly when working in the evening, after dark and early in the morning.

You should have permission from your Head of Department or Supervisor and notify security to let them know when you are working late or any other time where you feel vulnerable.

Ensure that you have a telephone close to you at all times and the Campus security number to hand.

It is your responsibility to ensure that you alert a named co-ordinator/colleague, when your work involves you working alone, in vulnerable situations or undertaking home visits, so that an effective process is put in place to ensure your safety.

This includes:-

### Basics –

**Good common sense should prevail and all researchers should carry the following items each time they conduct research away from the University:**

- Carry an official **identity card** (with photograph).
- Carry a **comprehensive map** of the area.
- Carry a **torch** (and spare batteries).
- Carry a **mobile telephone** and **phone cards** (for areas with poor mobile reception).
- Carry a **personal alarm** (to be kept in an accessible place).

In addition, [each researcher](#) should:

- Maintain a **visit proforma** (Appendix 1) as well as their personal diary as a means of logging visits. The visit proforma must be easily accessible by colleagues who are monitoring your visit.
- Never carry large amounts of **money or valuables**.
- Always have familiarisation sessions on home visits with an experienced member of staff during their induction period and only complete a home visit on their own when they, and their more experienced colleague, agree that they are ready. A formal risk assessment should be undertaken prior to new staff undertaking lone working.
- Ask a colleague to accompany you if you feel at all uneasy about conducting a home visit on your own.
- Obtain information about where you are visiting before the visit. Ask how many people will be at the visit.

Risk assessment – ensure that there is opportunity to feedback relevant information from a lone visit – e.g. if you felt at risk or if there was an incident. This should be formally recorded and reviewed with your Supervisor/ Head of Department and other members of your team to ensure appropriate follow up action is taken and to minimise any risk in subsequent visits.

### Use of private cars

- Researchers or staff using their own cars for travel:
- Should where possible become a **member of a national breakdown service**.
- Ensure that car users have the appropriate level of insurance cover.
- Drivers should travel with **doors locked and windows closed**. If windows are open, handbags and briefcases should be kept out of sight.
- At night, the car should be **parked in a well-lit and busy place**. Multi-storey parks, or car parks where the car and the user will not be easily visible, should be avoided.
- If a driver thinks they are being followed, they should keep driving until they reach a busy area - Garda station or a garage, etc.

Staff should avoid taking research participants as passengers unless they know them.

### Pre visits

- Make and keep pre-arranged appointments, and notify the participant if you cannot

keep them.

- Try to arrange home visits during daylight hours whenever possible. During winter months, weekend visits may be more suitable than evening appointments.
- Consider the purpose of the visit. Does it pose a higher than usual potential of bringing about a violent response e.g. an interview in connection with emotional matters? If so, consider asking a colleague to accompany you or arrange to interview the person at the workplace.
- Ensure that an appropriate room is available and there is financial support to cover participants' travel expenses if necessary.

### **During a visit**

1. **Do not** enter someone's home, if you don't feel comfortable or safe.
2. **Do not** enter a house if the person you have arranged to see is not there. Be aware of, and maintain, personal safety at all times during visits.
3. Always explain your research role clearly and the conditions of confidentiality.
4. If the participant is anxious, consider encouraging them to have a carer/friend within sight/hearing.
5. Never meet aggression with aggression.

Your safety is the primary concern, which should be placed above completion of research tasks

### **Home visits**

- If you are late arriving for your appointment, advise your nominated colleague who will record the revised time on the visit proforma.
- When visiting people's homes, try to let the tenant lead the way. Avoid being the first to go into any room. Be extra careful when alone with participants e.g. fetching something from a handbag, comforting participants. You should always make sure that the exit from the room is clear.
- Animals in the home: if you are in any doubt about the behaviour of animals in the home, ask for it/them to be locked away while you are visiting.
- Never undertake an interview or assessment in the bedroom.
- Do not give your personal telephone number or address to clients.
- You should not interview anyone who is under the influence of alcohol or drugs.
- If you feel uncomfortable while in a person's home, you should take steps to leave immediately.
- A professional and friendly attitude should be adopted but over familiarity must be avoided.
- Remember that the interviewee may also feel anxious about the interview and your visit.

You should bear this in mind whilst also ensuring your own safety.

### **Be alert for signs of DANGER**

- Raised voice, rapid speech and babbling indicate rising tension.
- Changes in tone and pitch as the conversation progresses may suggest anger,

frustration or impending violent behaviour.

- Keep your distance. Each of us has a personal space, which we defend when we feel it is being invaded.
- Be alert for body language that may indicate developing anger – e.g. flushed face, fidgeting, pointing, folded arms.

### **Awkward or potentially threatening situations**

If an awkward or potentially threatening situation arises, this should be reported to a colleague as soon as possible. The facts should also be recorded in a specific “untoward incident” file.

Formal arrangements should be in place for staff to be accompanied by a colleague for subsequent visits if there have been any incidents giving cause for concern on the first occasion. If, for any reason, you are concerned for your personal safety once you arrive at your appointment venue, then do feel able to cancel your appointment. On return to the office, make alternative arrangements when another member of staff experienced in working on their own undertaking home visits can accompany you.

### **Process for monitoring researcher visits**

When visiting the home of a participant, you should leave the following details with a nominated colleague (complete a visit proforma) who **has formally agreed to monitor the duration of your visit**. The onus is on you, the researcher, to ensure that a colleague is aware of the details of your visit and has agreed to monitor during the visit and when the visit is completed. Ensure that your nominated colleague is available on the phone and contactable by you for the duration of your visit. Keep your nominated colleague adequately informed by leaving the following details:-

- Sign/make colleagues aware that you are leaving the office and make sure that a named colleague is aware of your visit and details provided on your visit proforma sheet.
- State clearly the name and address and telephone contact for where the interview will take place (and where the interviewee lives, if different) – take care about interviewee confidentiality.
- State the time of the appointment, when you expect the visit to be completed and when to expect you back in the office or the time you expect to contact your nominated colleague to let them know that your visit is safely completed.
- State the make, model, colour and registration of the car you will be driving and the route you will be taking.
- Contact your nominated colleague if you are late for your appointment who will note this on the visit proforma.
- If an appointment or the deadline for contact is after 5pm, the researcher must make other arrangements for someone (colleague/partner/friend/family) to undertake the departmental role in monitoring the researcher’s whereabouts. These details should be noted on the pro forma. Your nominated person should also be briefed on these procedures and given details of who to contact in the unit (Head of Department or nominated Deputy), in the case of your failure to return on time.
- Leave your mobile telephone switched on during the interview.
- It is the responsibility of the researcher to ensure that he/she has stated clearly the details about the visit. Where appropriate, a nominated colleague will monitor who is out of the office and when they can be expected to return. It is important that the office

are aware of the whereabouts of the researchers, including, wherever it may be practicably possible, the travelling time between the visited site and the office.

- Prepare yourself for difficult meetings by finding out everything you need to know before arriving and planning in your mind how you are going to deal with the situation.
- It is the responsibility of the nominated colleague to ensure s/he is available to receive a call and monitor the time when the visit should be over. If circumstances change, s/he should arrange for another colleague to monitor the visit.
- If the interview is still in progress as the deadline for contacting the department approaches, the researcher should excuse him/herself and call their nominated colleague to inform them.
- If the deadline passes and the researcher has not contacted the nominated colleague, the nominated colleague should ring the mobile telephone number of the researcher.
- If there is no answer, the nominated colleague should inform the Head of Department (or Deputy) immediately and ensure the police are informed immediately.
- If researchers decide that they are not going to return to the office after their last visit, they should ensure that the appropriate person in the office knows about that by telephoning in. The visit pro-forma can then be completed accordingly.

### **Additional useful guidance**

DCU Health and Safety – Out of Hours [http://www.dcu.ie/safety/out\\_of\\_hours.shtml](http://www.dcu.ie/safety/out_of_hours.shtml)

Risk Assessment for lone/ out of hours work:

<http://www.dit.ie/media/documents/healthsafety/policiesprocedures/Risk%20Assessment%20for%20Lone%20Out%20of%20Hours%20Work%202009.pdf>

Health and Safety Executive. Working Alone in Safety. Controlling the risks of solitary work. <http://www.hse.gov.uk/pubns/indg73.pdf>

Health and Safety Executive. Violence at Work. A guide for employers. <http://www.hse.gov.uk/pubns/indg69.pdf>

Paterson BL, Gregory D and Thorne S (1999). A protocol for researcher safety. Qualitative Health Research, 9(2): 259-269

The Suzy Lamplugh Trust. <http://www.suzylamplugh.org/home/index.shtml>



## Appendix 23: Ethnography Poster

# OptiBIRTH

- ARE YOU TAKING PART IN THE OPTIBIRTH RESEARCH STUDY?
- WOULD YOU BE WILLING TO TALK TO A MEMBER OF THE RESEARCH TEAM AT YOUR NEXT CLINIC VISIT?

We would love to hear about your experiences of being in the study!

Contact Rebekah on [xxxxxxx@tcd.ie](mailto:xxxxxxx@tcd.ie)

OR

Text YES and your name to 086 XXXXXXX and further information will be provided

Tell us what you think of OptiBIRTH!

This study has been approved by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin and the Research Ethics Committee of the (FIELD-SITE)



