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Vaginal Birth After Cesarean: Views of Women From Countries With High VBAC Rates.

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Abstract
Despite the consequences for women's long-term health, a repeated cesarean section (CS) after a previous CS is common in Western countries. Vaginal childbirth after cesarean (VBAC) is the recommended option for most women, yet VBAC rates are decreasing and vary across maternity organizations and countries. We investigated women's views on factors of importance for VBAC in countries where VBAC is relatively frequent. We interviewed 22 women who had experienced VBAC in Finland, the Netherlands, and Sweden. We used content analysis, which revealed five categories in the data: To receive information from supportive clinicians, Professional support from a calm and confident midwife or obstetrician during childbirth, To know the advantages of VBAC, Letting go of the previous childbirth in preparation for the new birth, and VBAC is the first alternative for all involved when no complications are present. These findings reflect not only women's needs, but also sociocultural factors influencing their views on VBAC.

Keywords
childbirth; content analysis; focus groups; health care, culture of; interviews; midwifery; nursing, maternity; relationships

There is a widespread global concern over the continuing rise in cesarean section (CS) because of the higher risks for women's health (EURO-PERISTAT, 2013; OECD, 2013; Villar et al., 2007). Despite vaginal birth after a previous cesarean (VBAC) being the recommended option, repeated CS following previous CS is a significant factor contributing to overall increased CS rates (EURO-PERISTAT, 2013; Guise et al., 2010).
VBAC is associated with lower maternity mortality and less overall morbidity for mothers and babies (Guise et al., 2010). However, based on a limited number of randomized, controlled trials that compared outcomes for women planning a repeat elective cesarean with women planning a vaginal birth (Dodd, Crowther, Huertas, Guise, & Horey, 2013), the currently available evidence demonstrates that VBAC is a reasonable and safe option for most women with previous CS (Guise et al., 2010). In the European Union, VBAC rates are significantly lower in Germany,

Ireland, and Italy, at 29%-36%, than those in Finland, the Netherlands, and Finland, at 45%-55% (EURO-PERISTAT, 2008). The variability in VBAC and attempted VBAC rates between and within countries indicates the capacity to increase the proportion of women attempting VBAC and vaginal births (EURO-PERISTAT, 2013; Scott, 2011). Therefore, more insight is needed into women's views regarding the improvement of VBAC rates.

A limited number of qualitative studies, all originated from Anglo-American countries, have looked into different aspects of women's experiences of VBAC (Dahlen & Homer, 2013; Godden, Hauck, Hardwick, & Bayes, 2012; Lundgren, Begley, Gross, & Bondas, 2012). Results from these three studies showed that despite the evidence underpinning VBAC as a safe option for women with previous CS, institutions and professionals are not supportive of VBAC. The communication with caregivers was described as highly risk-oriented and was not supportive of women desiring VBAC, which can eliminate trust and generate fear in women seeking to do the right thing (Dahlen & Homer, 2013; Godden et al., 2012; Lundgren et al., 2012). As a result of this unsupportive environment, making VBAC happen demands strong motivation and sense of responsibility on the part of women (Godden et al., 2012). In the three studies, the women often reported they had to negotiate a system that was generally not in favor of VBAC, and required them to seek information about VBAC themselves by, for example, searching the Internet and by meeting women who had experienced VBAC (Dahlen & Homer, 2013; Godden et al., 2012; Lundgren et al., 2012). The results also demonstrated that women want to be involved in decision making. The women in these studies wanted to feel in control of their choice, mostly because they experienced a lack of control in the previous birth. They mentioned a strong desire to heal from the previous experience by choosing either VBAC or a planned repeated CS (Dahlen & Homer, 2013; Godden et al., 2012; Lundgren et al., 2012). Finally women, in contrast with caregivers, see all kinds of positive aspects of giving birth vaginally. There are practical benefits such as faster recovery, and psychological aspects, such as the meaningful experience of giving birth naturally and the mother-baby bonding. Women mentioned giving birth vaginally as fundamental to motherhood (Godden et al., 2012; Lundgren et al., 2012).

In summary, more research about women's views on and barriers to VBAC and their respective participation in decision making is needed—especially since previous research was only conducted in an Anglo-American context, and studies of women in countries with relatively high VBAC rates are lacking completely. The aim with this study was to investigate women's views on factors of importance for improving the rate of VBAC among women in high VBAC countries.

Methods

This study is a part of the ongoing 4-year OptiBIRTH project, which is funded by the European Union and involves eight European countries. The key aim of the project is to improve maternal health service delivery, and optimize childbirth, by increasing VBAC through enhanced patient-centered maternity care across Europe (www.optibirth.eu). The findings of this study together with the findings from a similar study of clinician's views on VBAC, as well as women's and clinicians' views from countries with low VBAC rates, are part of an antenatal educational intervention targeted toward both women and clinicians. These interventions are being tested in

a randomized trial within the OptiBIRTH project in three European countries with low VBAC rates. This study focused on interviews with women from countries with high VBAC rates: Finland (FI), the Netherlands (NL), and Sweden (SE).

We used a descriptive qualitative method with conventional content analysis of the data (Hsieh & Shannon, 2005; Polit & Beck, 2012). Such an approach is useful when little is known about the phenomenon under study (Estabrooks, Field, & Morse, 1994; Hsieh & Shannon, 2005): women's views of important factors for improving the rate of VBAC. Content analysis is defined as "a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use" (Krippendorff, 2004, p. 18). Systematic analyses of text have origins from theology in the 17th century, were later developed to content analysis, and foremost were used in research on media, communication, and propaganda during the 20th century (Hsieh & Shannon, 2005; Krippendorff, 2004). Content analysis is used in research with both quantitative and qualitative approaches, and consequently has influences from logical positivism, as well as during later years, from hermeneutics (Elo & Kyngäs, 2008; Krippendorff, 2004).

The original study plan was to perform focus group interviews with women in countries with high and low rates of VBAC. Focus groups are a method developed by Robert Merton and Paul Lazarsfeld in the 1940s (Wibeck, 2010). From the beginning, focus groups were mostly used in marketing research, but the method has its basis in social science. It can be used to investigate values, attitudes, and the complex phenomena that originate from social interaction (Barbour, 2010; Wibeck, 2010). Besides the participants, a focus group implies researchers who stimulate the discussion and observe the participants' interaction (Barbour, 2010). Since the focus groups were part of interventions development for the OptiBIRTH project and timely results were of the essence, focus groups could not be performed in all settings, and therefor this study used focus groups and individual interviews combined. The individual interviews were semistructured (Polit & Beck, 2012), using an interview guide with the same five questions as in the focus groups interviews. The questions were used as a topic guide and posed in the same order as in the focus groups (Polit & Beck, 2012).

Settings

The interviews took place in Finland, the Netherlands, and Sweden. In all three countries, as a general rule women are not entitled to have a planned CS if there is no medical reason for it. However, the countries' maternity care systems show both similarities and differences. Maternity care in Sweden and Finland is free of charge and funded by taxes, and almost all births occur in hospital. Midwives in Sweden and Finland have an independent role and responsibility during normal pregnancy and labor. When complications occur, a physician takes over the responsibility, but the midwives remain involved in the woman's care. Women in Sweden and Finland can seek help for fear of childbirth in special "fear clinics" (Ryding, Persson, Onell, & Kvist, 2003). At these clinics, women can discuss their fears during face-to- face meetings with specially educated midwives.

In the Netherlands, the maternity care is organized in a somewhat different way. The rate of home birth is higher in the Netherlands, about 20%, but is decreasing. Normal pregnancy

and childbirth are primarily led by independent midwives, but if risk factors arise or complications occur, the midwife refers the woman to secondary or tertiary obstetric care, where the obstetrician takes over responsibility. Also, midwives are working in the clinical setting and take care of most births (Cronie, Rijnders, & Buitendijk, 2012). An ongoing risk assessment is based upon the Obstetric Indication List (OIL), a national guideline specifying indications for referral based on evidence and/or consensus by professionals involved in maternity care. The overall rate of CS for Finland is 16.8%, the Netherlands 17%, and Sweden 17.1% (EURO-PERISTAT, 2013). The rate for VBAC varies between 45% and 55% in these countries (EURO-PERISTAT, 2008).

Care for pregnant women with previous CS.

In Finland, pregnant women have regular visits to maternity health care centers during pregnancy. In these centers, public health nurses or midwives, as well as general practitioners (GPs), meet the women regularly. In gestational week 36-37, women visit the hospital clinic for a birth plan. At this visit, she can discuss issues around the mode of birth with an obstetrician.

In Sweden, there are no national guidelines for VBAC, only local. If a woman had a CS previously and this circumstance has no implication for her next birth, she will be recommended a VBAC and visit a midwife during pregnancy on a regular basis. Only if problems or special issues occur does the midwife consult an obstetrician. However, a woman expressing an intense fear of and/or strong preference for CS will be referred by her midwife to the fear clinic, and/or to an obstetrician (Ryding et al., 2003).

In the Netherlands, women with a previous CS are prenatally cared for by the midwife in primary care until 36 weeks. In this period, the midwife prepares the women for VBAC. The midwife recommends to women with a previous CS that they make an appointment with the obstetrician to talk about the upcoming birth, so they can discuss matters they are uncertain of or scared about and discuss a birth plan. In cases of planned CS, the support should also include preparation for this intervention. Around 36 weeks, all women with a previous CS are referred to the obstetrician for further care and for the birth.

Participants and Data Collection

Individual interviews and focus groups interviews with women were conducted in three countries during 2012-2013. The data were derived from eight individual interviews (FI), one group interview with 6 participants and three individual interviews (NL), and one group interview with 3 participants and two individual interviews (SE). In each country, the interviews were conducted with women in both urban and rural maternity unit settings. All women were of fertile age and had experienced VBAC.

Whether they took part in a focus group interview or an individual interview, all participants were asked five questions. These were based on actual research described in the approved proposal for the European Union on the OptiBIRTH project. Moreover, the questions were formed with consensus between all participating researchers during a project meeting, where each question was discussed extensively to prevent key elements from becoming lost in translation. The questions were

1. In your opinion, what are the important factors for VBAC?
2. What are the barriers to VBAC?
3. What is important to you as a woman?
4. What is your view on shared decision making?
5. How can women be supported to be confident with VBAC?

Ethical Approval

Ethical approval was obtained for the OptiBIRTH project as a whole, and from each country separately: (METC-NL 12N101 (NL), EPN (Ethical Review Board) Göteborg 739-12 (SE), and Committee on Research Ethics 20/2012 (FI).

Data Analysis

When analyzing the focus groups and individual interviews, we used inductive content analyses as described by Elo and Kyngäs (2008). The rationale for this choice was the lack of earlier studies in the area, requiring an inductive approach that implies a movement from the particular to the more general, in contrast to a deductive approach based on previous knowledge (Elo & Kyngäs, 2008). Furthermore, three approaches to content analysis have been identified: conventional, directed, and summative (Hsieh & Shannon, 2005). It is important to define which approach to content analysis is to be used before the analysis starts (Hsieh & Shannon, 2005). We used a conventional content analysis approach, because the research purpose was to gain a richer understanding of the phenomenon. This approach implies creating categories from data during the data analysis, in contrast to directed and summative approaches where the researcher uses already existing theory to develop initial codes for the analysis (Hsieh & Shannon, 2005).

The focus groups and individual interviews were transcribed verbatim in the participants' native language. All data were regarded as a whole and analyzed in the same way, organized through open coding, creating categories and abstraction (Elo & Kyngäs, 2008). The following steps were used during the analysis: selecting the units of analysis, making sense of the data as a whole, doing open coding, using coding sheets, grouping, categorizing, and abstracting (Elo & Kyngäs, 2008). The units of analysis were parts of the interview texts answering the five questions. Each participating researcher (CN, EvL, KVJ, IL) in the three countries did the open coding and created subcategories through abstraction in their native language up to a certain point. First, the transcribed data were read in their entirety. Next, notes and headings that answered each question (units of analysis) were written in the margins. These notes were grouped together on coding sheets, ending up with the formation of 5-10 subcategories for each question together with quotations. Creating a category implies the data were assessed as belonging to a certain group when comparing similarities to and differences with other groups of data (Elo & Kyngäs, 2008). The subcategories were translated to English and sent to the first author (CN).

Subsequently, all the subcategories from the three research groups were analyzed together by CN and IL. In this stage, all subcategories emerging from each question were

grouped together according to their similarities and differences, and further abstracted into overall subcategories and main categories. Abstraction means a more general description of data through creating categories and subcategories labeled with words expressing their characteristics (Elo & Kyngäs, 2008). Subcategories describe similar content under a main category (Elo & Kyngäs, 2008). During this process of the analysis, Skype meetings were held for discussion of the findings. The data were also validated on several occasions in each country via email, using the Track Changes tool in MS Word. Finally all researchers validated the final results.

Results

The results showed that the views on factors of importance for improving the rate of VBAC among women in high VBAC countries can be divided into five subjects: (1) to receive information from supportive clinicians, (2) professional support from a calm and confident midwife or obstetrician during childbirth, (3) to know the advantages of VBAC, (4) letting go of the previous childbirth experience in preparation for the new birth, and (5) considering VBAC as the first alternative when no complications are present. These subjects are presented below with their subcategories, and with illustrative quotations. At the end of each quote, the woman's country code is indicated; FI (Finland), NL (the Netherlands), and SE (Sweden).

Receiving Information From Supportive Clinicians

The first category that emerged was related to receiving information from supportive clinicians, which was characterized as follows: realistic information tailored to women's needs, to have a midwife or doctor during pregnancy who listens, encourages, and motivates, to receive guidance and support for VBAC, as well as being listened to when asking for CS.

Realistic information tailored to women's needs. The women considered that information from clinicians should be tailored to women´s needs. It is easier for a woman to go through VBAC when she is well informed and knows what is going to happen. It is important for her to be heard and to receive answers to her questions. The women in this study said that information should contain both facts and experiences. They described that the information they receive must be straightforward and realistic, and that it provides answers to their questions. The information should not be idealizing; it must also contain what's painful and difficult. "You need very clear information, no glorification" (SE). However, the need for information differs among women. So caregivers must adjust their information and counseling to the need of the specific woman.

Overall, the women wanted to hear that, from a professional point of view, VBAC is unquestionably the first choice. The information that a CS is not an obstacle for future vaginal births should be given at an early stage, preferably as soon as the woman comes back from the operation ward, after the CS. All women should be given the opportunity to have a face-to- face meeting with a doctor and to pose questions before leaving the hospital. He [the doctor] sat down with me for an hour explaining everything, from the time I arrived at the hospital to how to take care of myself and the scar. . . . If he hadn't been there, I wouldn´t have had any idea

what to do afterward. (SE) The information from professionals should contain facts about complications, indicate what the CS signifies for subsequent vaginal births, and clarify that there are no urgent reasons for a second CS. “After the CS, we talked in the health center [with the physician, who said] that there is no obstacle to vaginal birth” (FI).The women asked for general knowledge about how the scar would heal, and how to deal with it in the next pregnancy. Potential rupture of the uterine scar is something that the women from all countries expressed fear about. “That wasn’t clear to me and then you make your own scenario in your head. Oh my God, what if this scar will tear? These things went through my head” (NL).

To have a midwife or doctor during pregnancy who listens, encourages, and motivates. The midwife or physician at the antenatal clinic is described as the central person in supporting the woman to dare to give birth vaginally. Support in this case primarily means listening to, encouraging, and motivating the woman to elect VBAC. A flexible visit schedule, allowing for additional visits, is also helpful. The midwife must be aware that after a previous CS, a woman may feel unsure about vaginal birth and need extra attention. Clinicians’ and partners’ support, encouragement, and understanding are described as empowering when self- confidence is lacking. “You feel after CS that you are a primipara, but you are not treated like that although in a sense you are primiparous” (FI).

Women expressed that it is vital that they feel confident. This was something that the caregiver could improve by establishing a personal relationship in which the women felt safe and which enabled them to rely on the caregiver’s expertise. Thorough information and good preparation are factors that enable women to feel confident and trust the caregiver. They want a caregiver who respects and takes them seriously, but sometimes the caregiver acts in a way that limits the woman’s trust. “She really listened to me, which was of great importance to me, as I felt that I had confidence in her” (SE).

> That it would take that long again, that was my fear. She [the obstetrician] said, “I guarantee you that it will not happen again. We will intervene in time; if necessary, we will do a CS if it’s really taking too long.” (NL)

To receive guidance and support for VBAC, as well as being listened to when asking for CS. Doctors should/must listen to women who ask for a CS, as some of them may have strong motives such as fear or experiences of rape. The physician must therefore listen carefully and decide what is best for the individual woman. However, some women mentioned that having a CS should not be regarded as an easy option.

The women believed it is a good idea to guide a woman toward VBAC, and at the same time have a date booked for a CS. This will make the woman feel secure, since she still has the chance to change her mind and give birth vaginally. In the case of doubt, gentle pressure from the professionals toward VBAC was considered positive. “We had a date for a CS, but I could change my mind and that was a relief. And I realized quite quickly that I didn’t want a planned CS; I wanted to go for a vaginal birth” (SE). “The MD said that no one is forced to deliver vaginally—this made me feel highly safe to have a VBAC” (FI).

Receiving Professional Support From a Calm and Confident Midwife or Obstetrician During Childbirth.

The second category, receiving professional support from a calm and confident midwife or obstetrician during childbirth, comprised the following: calm surroundings and continuity of care, clear instructions and attentive guidance, necessary interventions must be made in time, and agreements must be taken seriously.

Calm surroundings and continuity of care. The women mentioned several factors of importance for them. Central is good support from a midwife or physician during childbirth. They prefer calm surroundings during birth, and strongly appreciate continuity of care. Epidural and other forms of pain relief helped. The woman's previous CS should not make the midwife anxious; moreover, the midwife fully understanding it is the woman's first vaginal birth helps her to feel safe. "The midwife's attitudes are key to how the birth succeeds" (FI).

Continuous care by preferably the same professional is appreciated by childbearing women. Some women described feeling left alone and being seized by panic when professionals left them. "I would have needed a midwife who told me what was happening and what would happen next, so I could have followed" (SE). Feeling left alone was also expressed by Dutch women, who sometimes thought that the obstetrician was running in and out of the delivery room.

> The only bad thing was that X [the obstetrician] was taking care of four or five laboring women at the same time. She went from them to me and from me to them again . . . so then I told her that someone had to stay with me. She asked the midwife and she sat with me the whole time. (NL)

Furthermore, women do not like giving birth in a hectic environment, so the number of professionals in the room must be limited to the woman's partner and one or two professionals, who remain calm and promote trust. "I don't need so many people there. Just my husband and the obstetrician, that's fine. . . . The ambience just has to be calm, I mean"(NL).

Clear instructions and attentive guidance. Women want to be directed through the birth process by a calm and confident professional. They appreciated midwives or obstetricians who told them what to do during labor. Clear instructions helped them reduce fear and gain confidence in their own efficacy. "There were moments that I thought, 'I need contact.' So that's what I said: 'I need contact! Look me in the eyes when I have to push.'. . . That person just had to be there for me" (NL).

The Dutch women stated they appreciate that they know the professionals who are attending the birth. They expressed that seeing a familiar face helps in gaining trust in a good outcome, as does being attended by a more experienced and older professional, because that person being there encourages the women's trust and confidence. "I had an experienced obstetrician present, and I believe that gave me peace of mind. He was slightly older, somewhat more experienced; I liked the idea of that" (NL).

The women mentioned that particularly a woman fearing childbirth, should receive support from a midwife who is calm and confident, motivates the woman, and tells her what to

do during the birth. It is essential that there is good contact between the woman and the midwife, and that the midwife confirms the woman's pain and gives her pain relief in time. The midwife must be experienced; new midwives should not care for women who have a fear of childbirth. If the woman arrives at the maternity ward in early labor, she will feel safer if she knows that she will not be sent home again. The women mentioned that when women feel afraid of giving birth vaginally, it is also helpful to explain thoroughly what is going to happen. They want to know how the baby moves through the birth canal, but also want indications of how and when to push and what happens in utero.

Necessary interventions must be made in time. The women considered that it was acceptable if caregivers motivated them to hold on a little longer, but some thought that they were pushed beyond their limit. In particular, women who had a negative experience during the first birth and many interventions (failed assisted vaginal delivery) before CS was decided on emphasized that obstetricians must not hesitate to intervene in this type of situation. Similarly, for women who fear childbirth, interventions must not be postponed for too long.

> I understand that if a woman says she cannot go on any longer, her obstetrician motivates her by saying, "You have to try longer; you can do it!" But he has to do it in the beginning. Not toward the end, when she has been in labor for a very, very long time. (NL)

Some women experienced that the decision about emergency CS during their previous birth came too late, which led to protracted suffering that felt unworthy of a human being. This type of suffering must be stopped earlier. One woman stated that she never had any explanation why it took so long before the CS was performed: "Why did I have to suffer for 26 hours before they took the baby out, just because the baby was in good condition? . . . I had been screaming for hours that I didn't want to do this" (SE).

Agreements must be taken seriously. The women mentioned that any prior agreements about the birth must be known to the midwife or obstetrician who is assisting with the birth. They do understand that in some circumstances, the birth plans they made will not always come true. Moreover, the women experienced that the professionals did not always keep agreements. When agreements that could have been kept are not followed, the women believed they were not taken seriously. The failure to keep an agreement was also highly damaging to the relationship between the caregiver and the woman, and resulted in the woman feeling less confident during the birth.

> They just have to listen to you and keep the agreements! They of course can promise you anything . . . we will do this and that, but if in the end it didn't happen, because it was a little hectic on the ward, then you think, why did I have this appointment [at 30 weeks]? (NL)

Furthermore, some women thought that physicians had the tendency to stretch the agreements that had been made. Especially regarding the moment of intervention (e.g., epidural or instrumental delivery), some women considered that they were pushed to the limit. Some women mentioned they wanted to feel that they are taken seriously. Dutch women sometimes perceived that the physician minimized their worries, and that made them feel they were not a

partner in the childbearing process anymore. Women have to feel heard by their midwife or obstetrician in order to play an active role.

Knowing the Advantages of VBAC

The third category, knowing the advantages of VBAC, entailed the following: a more emotional, positive, and empowering experience, wanting to experience a vaginal birth, and information from experienced women.

A more emotional, positive, and empowering experience. Knowing about the advantages of vaginal birth could motivate a woman to have a VBAC. Women described how it felt good to experience childbirth, to sweat and struggle. The childbirth was an overwhelming experience; one woman described the feeling after her VBAC as "Yes! I did it!" (SE).

Compared with CS, everything was experienced as easier afterward. One woman experienced a special feeling of calmness, all the pain disappeared, and the woman, child, and partner were together: "I want the drama, including sweating and struggling, and then a baby arrives. I think it feels odd just laying down, having the cut, and out comes a baby" (SE).

The women mentioned that they appreciated the difference between giving birth by CS and giving birth vaginally. For the women, the emotional aspects of giving birth vaginally were of considerable importance for them. They described the experience as unique and fulfilling despite the pain. The women also described a feeling of great pride when they delivered vaginally. They worked hard and suffered during the birth, but it was their own accomplishment and they were extremely proud of themselves. If the first childbirth ended up with an emergency CS, some women regarded it as a disappointment. They experienced it more as if someone else was "delivering" the baby and they did not play a big part in it.

I think the whole emotional part of giving birth vaginally is an important factor. . . . The feeling that I worked for it, that was wonderful. You could call it pride; yes, I did that. You see we can do it. (NL) Furthermore, the women felt more aware of the whole birth experience compared with giving birth by CS. One woman mentioned that when a woman has an epidural, she hands over the birth to the caregiver. Women see the more active role they play in birth as an important factor for VBAC.

> When you have a CS, you get an epidural and someone else is grubbing around in your abdomen and gets the baby out. I mean, when you deliver naturally, you're doing it yourself, and you experience it much more intensely compared with CS. (NL)

The women reported that the body is made for vaginal birth and it is preferable to CS. They said that it feels more natural and safe, and recovery is more rapid. They saw vaginal birth as the best option for the child and commented that it is also good for the baby that the mother sees it coming out, since it facilitates bonding between mother and child. The women described that compared with CS, vaginal births are a way for them to reach the same level of happiness as other parents. One woman explained that the body needs the process of giving birth, and it is good for the soul to give birth vaginally. She described undergoing a CS, planned or not, as not having experienced a real childbirth. To give birth vaginally is childbirth "like it should be" (SE). She reported how her love for the child washed over her like a waterfall: "I think the experience

afterward is so much more fantastic. It's worth it, so to speak. You feel much calmer and it feels more relieving" (SE).

Some women experienced the recovery after VBAC as more rapid and less heavy than the recovery after CS. After VBAC, they started nurturing their child sooner and were not immobilized by prescribed bed rest. Furthermore, they could return home more quickly.

> When she was born [after CS], I was lying there with my zipped belly. I could hardly move, let alone come out of bed to change her diaper. . . . Well, when I had my VBAC I also had some sutures, but I can tell you that's a totally different feeling, (NL)

Wanting to experience a vaginal birth. The women described their desire and willingness to experience giving birth vaginally, as it was an experience and a challenge they did not want to miss. "The experience is so important—how to give birth normally; it is the most important reason" (FI). Some women thought there is prestige in giving birth vaginally. If a woman has had a CS, it may be difficult to share the birth narrative with women who have given birth vaginally. The women wanted to be a part of the club and be able to share their birth narratives with other women. They believed they would miss out on an extraordinary experience if they never felt contractions or gave birth naturally. "I jumped for joy when the doctor said I could have a vaginal birth after CS, as I thought that it should always be CS" (FI).

Some women discussed that pregnancy is a process that prepares women for childbirth; likewise, giving birth prepares women and makes it easier to take care of the baby. One woman said that giving birth vaginally is how the body works, and that childbirth happens naturally in the body, in the same way as menstruation. It is natural to give birth vaginally, she commented, and it is best if the process can have its course: "It's very strange when you choose not partake in the whole process [of childbearing], because it's like you decide not to take care of the child like you should" (SE).

Information from experienced women. The women reported that they search for and retrieve information from a range of sources. They mentioned the Internet and friends as significant sources of information. Moreover, the women suggested that it would be extremely valuable to meet other women who have experienced VBAC and listen to their experiences. They considered that meeting other women is more productive than only reading about VBAC, or listening to doctors. In such support groups, women could receive support and prepare themselves by listening to women's narratives, and also describe their own experiences. The groups entail working through the previous childbirth together—i.e., talking about the experience and sharing feelings such as anger. For example, Dutch women mentioned that it would have been helpful for them if they had the possibility to contact women who had experienced VBAC. They suggested that information and support meetings be organized and indicated that they would be prepared and motivated to share their experiences with women who are planning to have a VBAC. "Your midwife did not experience VBAC herself, and I believe it would be very helpful to hear from women who experienced it and recognize your fears. I believe that would be the most effective way to reassure women" (NL).

Letting Go of the Previous Childbirth in Preparation for the New Birth

The fourth category, letting go of the previous childbirth in preparation for the new birth, includes the following activities: information and guidance from clinicians, alleviate fear and process negative birth experiences, letting go of a previous positive experience of CS, and antenatal classes.

Information and guidance from clinicians. The women considered that the midwife or doctor should help the woman to let go of the previous birth and put it aside so that she can focus on the approaching childbirth. "The physician made me [feel] sure that the vaginal birth will be a success and it is going to be a very nice delivery" (FI). Information on what happened during the previous birth was particularly mentioned, since understanding previous indications for CS could help women feel more confident about a successful VBAC. The midwife is essential, as she can help the woman separate the childbirth experiences and can clarify that the next childbirth does not have to be similar to the previous one. The midwife can guide the woman to a new way of thinking; she should be supportive and strengthen her. If the woman has fears, the midwife should try to find out why, and if necessary refer the woman to a "fear clinic" and/or a psychologist. It is important that the midwife schedules extra visits if the woman wants them.

> She encouraged me to believe that the second childbirth had nothing to do with the first one. . . . To let go [of the first birth] was difficult, because I had a hard time imagining that things could be different. (SE)

Alleviate fear of childbirth and process negative birth experiences. The women saw fear as one of the main factors that can hinder VBAC. They did not consider that this fear is related to their previous experience, but is similar to that of women who are going to give birth for the first time. "I told other people [not professionals] all the time that I was afraid. I asked them what I could expect, how does it start, what do contractions feel like, what do I have to do?" (NL).

One woman described an extremely rapid VBAC, something that she was unprepared for and which resulted in a negative childbirth experience. The contractions were intense and made it difficult for her to understand what was happening, and she was stressed and anxious. She felt exposed, and experienced the midwife as unsecure and unaware of it being her first vaginal birth. This woman also did not have a postpartum conversation with the midwife.
"Even though I'd already given birth to a child, I needed them to understand that this was my first vaginal childbirth, because this was a completely new situation" (SE).

Some women considered vaginal birth more painful than CS. They thought that this factor could prevent other women considering VBAC from choosing this option. However, they themselves believed that the pain is forgotten easily. "Anyhow, the moment you give birth naturally, it hurts and a CS does not, at least not in my case. However, you can easily cope with that and forget about it immediately" (NL).

For Swedish and Finnish women with fear of childbirth, support from midwives at a "fear clinic" gave them the opportunity to talk through both the previous and the impending childbirth and write down a personal birth plan. "After the first delivery, I had a lot of fears. I went to discuss the issue in the 'fear polyclinic,' as I wanted to experience vaginal birth" (FI). It

was considered positive that the partner could also describe his experience of the previous birth. To be able to visit the maternity ward was important, as was receiving advice on how to handle the situation in the event of an emergency CS during the next birth.

> She asked both me and my husband what we wanted to happen. And she reminded us that we should be realistic when picturing our dream birth. We had to write it down and then go through what we had written, and then we went through the technical details. (SE)

Letting go of a previous positive experience of CS. According to some of the women, a planned CS due to breech presentation can be an extraordinarily good experience, primarily if the CS does not lead to separation from the child. Such positive experience can bring hopes that the next child also will be in a breech position. "They had a room at the maternity ward, which meant that I could stay there together with my son and husband. . . . I had a very positive experience of CS" (SE).

Moreover, the decision to perform a CS can be experienced as a salvation after being in labor for a long time. Women were relieved that the ordeal finally ended and their baby was born. As a result, they did not say that they would regret it if the next birth ended up as a CS again.

> I was very glad that it finally became a CS, because when you have contractions from 8 in the morning until midnight the next day, and you're not progressing at all, then you feel relieved if someone says we're going to perform a CS. . . . So the second time, I told the obstetrician several times, just cut me open and get her out, because I am finished with it. (NL)

In contrast to that experience, some women stated that they had a faster recovery after VBAC than after CS, while other women stated they had a slower recovery after VBAC. For example, some Dutch women mentioned negative aspects, such as physical discomfort (e.g., pain, problems holding urine, stool problems), that often accompany vaginal tears or episiotomy. However, they also reported that they experienced the recovery from VBAC more negatively because of a need to recover more quickly, since they had at least two children to take care of during their recovery.

> After my natural birth, I was constipated, my breasts were leaking for four months. I had all kinds of problems, and with the first [CS], nothing. . . . You hear all kinds of stories about CS being major abdominal surgery, but everything went fine in my case. I had absolutely no problems at all. (NL)

Antenatal classes. Special parenthood classes at antenatal centers could be supportive for women and their partners who have experienced CS. Such classes should include an explanation of vaginal childbirth. For some women, being the only couple who had experienced a CS in a group of women and men who had recently become parents was difficult. "I couldn't feel their happiness. I missed coming to a group with others who had the same experiences" (SE).

Considering VBAC the First Alternative for All Involved When No Complications Are Present

The last category, VBAC is/being the first alternative for all involved when no complications are present, comprised the following: the decision about CS must be taken by professionals with special competence, participate in decision making but not take the final decision, and vaginal birth is the normal thing to do.

The decision about CS must be taken by professionals with special competence. The women stated that decision making about CS is not for people in general, and should be left to specialists in the field. No matter how much a lay person reads, medical knowledge and experience are still required to make an adequate decision. The women stated that they do not want to make the decision by themselves, and that they would rather not make their own choice. The women trust that the professional's decision is right and accept it. "It doesn't matter how much I read, I don't have the education, I don't have the experience. Okay, it's my body, but I want someone who really knows what they are doing when they make the decision" (SE).

> To make the decision, it was stressing and complicated. I was in a way somewhat depressed before delivery, because I had to make such decisions and thinking if the decision was right, and as a layperson, I searched for materials and information from the Net. (FI)

The women were clear that the safety and wellbeing of their baby are the most important aspects. "I'm just happy that it went well both times and that my children are fine; that's what's most important to me. My own experiences come second" (SE). So they are willing to follow the advice of professionals that benefits their baby's health. They do not want their baby to be exposed to any risk, and they also want professionals to put their baby first.

> I just really wanted to give birth naturally, even though it was a breech. But when the obstetrician tells you, I don't think it is responsible to try any further, who am I to say that I want to proceed? (NL)

Participate in decision making but not take the final decision. The women from Finland, the Netherlands, and Sweden were asked about their views on shared decision making. However, the women in these countries were not used to decision making together with professionals. On the contrary, some women considered that if women decide themselves, the CS rate would increase. Moreover, Dutch women believed they do not have a choice; giving birth vaginally is just the normal thing to do. The women thought that it was vital to take part in a discussion with professionals and to receive guidance and support, as well as be listened to, but the final decision must be taken by the specialists.

Some women thought that CS is considered by many women as a way of not only avoiding childbirth pain, but also avoiding what may be experienced as unpleasant and unknown. However, the possibility to choose can also increase women's fear.

The women believed that "shared decision making" in general is essential. Women must participate in the decision-making process, but they should not take the final decision. They wanted to influence the decision making, and most of them considered that they were the one

making the decisions based on the advice of the professional. "[It was] my own decision totally to experience vaginal birth, and thus there was no need for shared decision making. I made the decision!" (FI). This was the case for all types of decisions—for example, the decision to have pain relief or to have people present at the birth—but not for the decision of having a VBAC or not. "I as the patient, together with the doctor, want to have influence on the decision making. I would like to have influence. I believe I also did" (NL).

Vaginal birth is the normal thing to do. Dutch women did not think that they made a choice whether to have a VBAC. It was simply the normal thing to do when there were no reasons not to give birth vaginally. If there are no reasons not to, they go along with the advice that they have been given, and that advice is VBAC. Other options are only discussed when medical reasons prohibit giving birth naturally.

> I don't think that she [the midwife] was thinking: "Well, let's discuss whether this lady wants to give birth by CS or vaginally." No, I don't believe it ever crossed her mind. We just both thought the position of the baby is right, so I am going to give birth naturally. (NL)

Cultural factors influence women's choices relating to birth. Vaginally is how women give birth in the Netherlands. This is the opinion of both the women and their caregivers, so there is little discussion about the mode of delivery. Most women come to the professional with the idea of giving birth vaginally and do not think that there is any other option, unless medical complications arise. "The first time, I had a planned CS due to breech presentation, but the second time, I just could try [to give birth vaginally]" (NL).

The Swedish women mentioned that it feels strange to be able to choose not to give birth vaginally. If a woman has the ability to give birth vaginally, it should not be possible to avoid it. Vaginal birth must be the basic principle. The Finnish women reported that it felt good to be able to give birth vaginally after a previous CS, because they did not experience the same limitations this time.

Women who ask for a CS are mostly advised to reconsider their choice in the Netherlands. Clinicians persuade women with scientific evidence indicating that VBAC is the safest option for giving birth.

> So at 30 weeks I went to the hospital and I told them I want a CS! They told me: "Well, madam, that's just not how it works around here." And I asked them why not, and they told me that having a VBAC was safer and that they would monitor me closely. . . . Looking back, I am glad they talked me out of it. (NL)

The Finnish women emphasized that the discussions with health professionals during pregnancy (at the community maternity clinic) supported their decision, and the final decision was made with the midwife and the obstetrician during a birth plan meeting. The Swedish women mentioned that in Swedish society, vaginal childbirth and also breastfeeding are considered the best options. Giving birth vaginally is prestigious. For instance, vaginal birth is regarded as a female virtue, and it is particularly prestigious to give birth without pain relief. A wish to feel capable was mentioned as one of the reasons for choosing VBAC. Modern women

want to make their own choices, while at the same time believing that prestige affects the mode of birth. However, some of the Swedish women were suspicious that recommendations of vaginal childbirth could be motivated by savings in the maternity care system.

Discussion

The main findings from this study demonstrate that for women, important factors in improving the VBAC rate concentrated on five themes:

1. Wanting to receive information from supportive clinicians.
2. Receiving professional support from a calm and confident midwife or obstetrician during childbirth.
3. Wanting to know the advantages of VBAC.
4. Needing to let go of the previous childbirth in preparation for the new birth.
5. Considering VBAC as the first alternative when no complications are present

One of the aims of the OptiBIRTH research project, which this study is part of, is to learn from the best. What could professionals from countries with low VBAC rates learn from Sweden, Finland, and the Netherlands?

The women stated that they need information about VBAC from supportive clinicians, but they also asked for information from other women with experiences of VBAC, a finding also demonstrated in other studies (Dahlen & Homer, 2013; Godden et al., 2012). Besides receiving information through listening and reading, the women considered meeting other women as an contribution to their knowledge. They suggested specific antenatal groups where they could receive support and prepare themselves by listening to women's narratives while also being able to describe their own experiences. Furthermore, our study gives more details about the content of the information, and how and by whom it should be delivered. The women asked for straightforward and realistic information that provides answers to their questions. The information should not be idealizing; it must also contain what is painful and difficult. In addition, the information should be tailored to women's needs, in line with the results from a previous study demonstrating that individualized information increases the VBAC rate (Catling-Paull, Johnston, Ryan, Foureur, & Homer, 2011).

Previous research has indicated that support during childbirth is of utmost importance for birthing women in relation to the quality of their experience and the birth outcomes (Hodnett, Gates, Hofmeyr, & Sakala, 2013; Larkin, Begley, & Devane, 2009). The women in our study pointed out clinicians' individual competence as important, in particular their ability to radiate calmness and confidence. The women prefer calm surroundings during birth, and clinicians who are confident with VBAC. These findings indicate that women during VBAC seem to need particular forms of support, where clinicians' confidence in VBAC is one important factor, similar to the findings from Godden et al. (2012). The women's need for calm birth surroundings is in line with the concepts of an "environment of care" (Kennedy, Shannon,

Chuahorm, & Kravetz, 2004) and a "sanctum" or protective birthing room (Fahy, Parratt, Foureur, & Hastie, 2011). Such birth environments, focused on creating feelings of safety for the birthing woman, are also described as a "birthing atmosphere" (Berg, Ólafsdóttir, & Lundgren, 2012). This atmosphere includes obstetrical nurses' and midwives' ability to support normality, creating a calm and safe atmosphere that supports women to follow the process of birth (Berg et al., 2012). A calm atmosphere can be difficult to achieve because of institutions' demands for a more medicalized approach when caring for women during a VBAC, compared with a more "normal birth" (B. Hunter, 2004; L. Hunter, 2002). Midwives' and other clinicians' support during birth might involve different approaches to care that are described as being "with woman" or being "with institution" (B. Hunter, 2004; Thorstensson et al., 2012). The "with institution" attitude implies an attention to efficiency, with a focus on physical safety and risk management rather than on the woman's needs (Kennedy et al., 2004; Thorstensson et al., 2012).

The findings from our study demonstrate the positive aspects for women giving birth vaginally, where they stated a strong desire to give birth vaginally after a previous CS. The women described VBAC as a more emotional, positive, and empowering experience than CS. This finding is in line with research demonstrating that vaginal birth has a personal meaning for women, which contributes to their determination to achieve VBAC (Godden et al., 2012; Lundgren et al., 2012). Furthermore, the women thought they were more aware of the whole birth experience compared with the CS. Research has demonstrated that women want to be active and experience control during vaginal childbirth (Gibbins & Thomson, 2001; Larkin et al., 2009), the opposite to how some of the women in our study experienced the previous CS. They experienced their own role as smaller and more passive, as if they had handed over the birth to the caregiver. Moreover, the women pointed out that the positive aspects of VBAC influenced them when they collected information and made decisions about the mode of birth.

The women saw fear as one of the most main factors that could hinder VBAC, and they stated a need to let go of the previous childbirth experience to be able to prepare for the next birth. Giving women possibilities to tell their narrative of a distressing birth experience permits them to share the experience, as well as to discuss fears, missing pieces of information, or feelings of inadequacy or disappointment (Callister, 2004). These possibilities can be offered both during pregnancy and after the birth, depending on the maternity ward's organization and actual context. Gamble and Creedy (2009) suggested a counseling model for women after a previous distressing or traumatic birth experience, with midwives and nurses providing the counseling. A previous negative childbirth experience is associated with subsequent fear of childbirth to a greater extent than in the previous mode of birth and accompanying obstetric complications (Beck, 2004; Nilsson, Lundgren, Karlström, & Hildingsson, 2012; Storksen, Garthus-Niegel, Vangen, & Eberhard-Gran, 2013). There is a notable lack of studies on how to support women in letting go of a previous negative birth experience, and the actual effects on women's possible fear are, as yet, unclear. Still, the subsequent childbirth has the potential to either heal or retraumatize women after a previous distressing birth (Beck & Watson, 2010).

In our study, the experiences of previous CS varied among the women. The women described very different experiences of, for instance, a planned CS due to breech presentation, or an emergency CS after a prolonged labor. Accordingly, their need to process their previous CS

birth varied. Some women whose planned CS had been a positive experience still felt anxious about the unknown, a feeling that had to be considered before they could start their preparation for the next childbirth. Women who had experienced an emergency CS as a salvation from their suffering during birth had other needs. The women mentioned midwives and physicians supporting role in the process of letting go of a previous birth experience. Together, these findings indicate that clinicians at antenatal clinics should ask women about their experience of the previous CS first, before they go into their possible preferences for the next birth. Consequently, women with previous CS have to be met individually by clinicians, and be given individual information (Catling-Paull et al., 2011).

Moreover, the women stated that VBAC is the first alternative for all involved when no complications are present. For instance, women in all the three countries considered vaginal birth as the way to give birth; it seems to be a part of the culture. It is interesting that the three countries with high VBAC rates differ in how the maternity care is organized. Sweden and Finland have no option for home birth in the public health care system, unlike Holland, where the home birth rate is 20% (CBS, 2014). In his book, DeVries (2005) described how cultural ideas have shaped the delivery of maternity care in the Netherlands. For centuries, the Dutch people held values such as domesticity, soberness, avoidance of showiness, fearlessness of pain and discomfort, and thrift, all aspects that support the option of home birth. In the Netherlands, birth is understood as a low-tech social event that should whenever possible take place at the center of family life, the comfortable home (Christiaens, Nieuwenhuijze, & de Vries, 2013; De Vries, 2005).

However, the similarity in the three countries is that midwives have their own responsibility for normal pregnancy and childbirth. Davis-Floyd (1992) pointed out that the Americans value technology, a controlling nature, and patriarchy, and therefore, birthing rooms in the United States are characterized by men and by technological devices that aim to control the natural process of birth. A recent review highlighted professional conflicts within the organizational culture, as well as procedural imperatives and time pressures, as important barriers to improving maternity care (Frith et al., 2014). The conception of birth is deeply rooted in systems, and the role of culture is often underappreciated (De Vries, 2005). In all the countries with high VBAC rates, the technology and the controlling nature are present, as in the United States. However, it seems as if an aspect of birth as normal exist at the same time, since the women in our study live in countries with high VBAC rates and lower overall CS rates. It appears that in these countries, the way of thinking about birth is toward the value that birth is normal, and seeing VBAC as the first alternative (as long as no contraindications are present) reflects a cultural fit of VBAC and the conception of birth. This way of thinking is true also in Finland, a country where 99.9% of deliveries are in hospitals.

In addition to the influence of the culture, there are other influences such as economic or legal differences between countries (Habiba et al., 2006). In Finland, the Netherlands, and Sweden, women are not entitled to have an elective CS if there is no medical reason for it. The obstetrician makes the final decision for CS, and the women seem to be content with this situation. The women stated that they needed to take part in discussions around the mode of birth, and they wanted the clinicians to listen carefully to them, but the final decision needed to

be made by a professional with the knowledge and experience. It was shown previously that giving control to others resolved difficult personal emotions that women experienced in attempting to make an individual choice about the mode of delivery (Goodall, McVittie, & Magill, 2009). However, that women have less autonomy in decision making can be one explanation for the high VBAC rates and the low CS rates in these countries. In other European countries, as well as non-European countries, women have the possibility to decide themselves. Nevertheless, Goodall et al. (2009) found that even women who were able to decide on their mode of birth after CS easily relinquished control to the caregiver involved. Still, the evidence is limited on the effectiveness of interventions to support decision making about VBAC, and more research is needed, particularly on what support women need in sharing the decision making with their care providers (Horey, Kealy, Davey, Small, & Crowther, 2013).

Methodological Considerations

The aim of the study was to investigate women's views on factors of importance for improving the rate of VBAC. To our knowledge, this is the first study on women's views on VBAC from countries where VBAC rates are relatively high. Since the question of VBAC is complex, it needs to be answered qualitatively. We combined individual interviews and focus groups in the data collection as a way to save time, seeing that the study was a part of interventions development for the OptiBIRTH project. Additionally, the combination made it easier to recruit women working full time and living in different parts of the country. Irrespective of individual interviews or focus groups, we asked the women the same five questions and in the same order. The use of two methods combined can be a study limitation, because in a group discussion, the participants can inspire each other in their description of the studied phenomena (Barbour, 2010). Nevertheless, the individual perspective can be overlooked in focus groups.

As for the data analysis, the study group made joint decisions on how to analyze the data and combine the results from the different countries. We decided to analyze the data in the same way by using open coding, employing abstraction, and creating categories (Elo & Kyngäs, 2008), whether the data were gathered through the focus groups or the individual interviews. Moreover, the data were structured as one unit of analysis for each question (Elo & Kyngäs, 2008). There is a risk of having analyzed two different phenomena—in the focus groups, the views of the group; and in the individual interviews, the individual perspective. But we see these different views as a variation, and in that way, a strength. For the study's trustworthiness, we sought to describe the data gathering and data analysis as clearly as possible (Elo & Kyngäs, 2008).

To form 5-10 subcategories for each question and select example comments by the women, we analyzed the data in the women's native languages. After this analysis, the data were translated into English by each country team. Due to translations from Finnish, Swedish, and Dutch to English, there might be misunderstandings on some concepts. We tried to minimize the risk of such misunderstandings through a careful translation of the data. Furthermore, in reporting on the results, we included numerous quotations to reduce the risk of misconceptions. Nevertheless, the findings represent the views of women from three countries with high VBAC rates, and thereby contribute to variations in data.

Qualitative studies cannot claim generalization. Instead, the word transferability is used to discuss the results' relevance for contexts other than the one studied (Whittemore, Chase, & Mandle, 2001). This study included three European countries, and their maternity organizations are different in some aspects. To facilitate transferability, we sought to describe the studied contexts carefully (Elo & Kyngäs, 2008; Whittemore et al., 2001).

Conclusions

If health professionals aim to improve VBAC rates, several factors from the women's perspective have to be taken into account. In caring for women who are pregnant after previous CS, professionals should be observant of their needs at the individual level. Women want to receive information from supportive clinicians and professional support from a calm and confident midwife or obstetrician during childbirth. The women in our study wanted to know the advantages of VBAC, and professionals need to guide women so they can let go of the previous childbirth in preparation for the new one. Furthermore, clinicians must be aware that VBAC rates are also related to sociocultural factors. According to these findings, VBAC is facilitated when it is the first alternative for all involved and no complications are present. Consequently, these findings reflect not only women's needs, but also sociocultural factors influencing their views on VBAC.

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