

Women's Perceptions of Contributory Factors for Not Achieving a Vaginal Birth After Cesarean (VBAC)

Georgina Kelly, Yvonne L. Hauck, Sara Bayes, and Tasmin Hardwick

BACKGROUND: With cesarean rates around the world escalating, concern is growing around why women wanting a vaginal birth after cesarean (VBAC) are not achieving their goal.

AIM: To gain an understanding of women's perceptions of factors they felt contributed to not achieving a VBAC.

SETTING AND PARTICIPANTS: Fifteen women were interviewed following a nonelective repeat cesarean section (NERCS). They had attended a Western Australian midwifery-led service, next birth after cesarean (NBAC), and labored but were not successful in achieving a VBAC because of reasons around delayed progress. Interview transcripts were analyzed using Colaizzi's method of thematic analysis.

FINDINGS: Five themes emerged: "Tentative commitment with lingering doubts," "My body failed me," "Compromised by a longer than tolerable labor," "Unable to effectively self-advocate in a climate of power struggling and poor support," and "The inflexibility of hospital processes." The final theme included two subthemes: "Restrictive policies" on labor and use of the cardiotocography, "The CTG."

CONCLUSIONS: When labor did not progress as envisaged and hospital processes adversely affected how women were supported, women's doubts around being able to achieve a VBAC were reinforced with a NERCS. Maternity services need to ensure clinical practice reflects best evidence while assuring staff are supportive of women's choice.

KEYWORDS: VBAC; qualitative evaluation; childbirth; perception

BACKGROUND

From the introduction of oral contraceptive to the use of in vitro fertilization and genetic technologies, the past century has seen exponential advances in fertility and associated childbearing choices. In stark contrast over the same period is the decline in spontaneous vaginal births. According to the Australian Bureau of Statistics spontaneous vaginal births, excluding assisted vaginal births, in Australia have dropped from 68% in 1991 to 59% in 2004, whereas cesarean section (CS) has grown from 18% to 29% (Linacre, 2007). The story is similar in other developed countries. In the United States in 1965, the rate of CS was less than 5%, however, this birth

mode now accounts for more than 30% of U.S. births (Guise et al., 2010). Similarly, the United Kingdom's CS rate is at an all-time high of 24.8% (The Information Centre for Health and Social Care, 2012).

The increase in CS is further compounded by the fact that one CS predisposes women to a further operative birth in subsequent pregnancies. Despite the World Health Organization (1985) and many medical professional bodies endorsing vaginal birth after cesarean (VBAC) for most women with one previous CS (American College of Obstetricians and Gynecologists, 2010; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2010; Royal College of Obstetricians and Gynaecologists, 2007), birth



statistics across the developed world indicate that for most women with a previous CS, elective repeat cesarean section (ERCS) remains the dominant mode for subsequent births (The Information Centre for Health and Social Care, 2012; Li, McNally, Hilder, & Sullivan, 2011). Even though VBAC has been calculated as a feasible birth mode for 60%–80% of women, VBAC rates remain low (Guise et al., 2010). Australian birth statistics suggest that numbers of maternity health professionals who are supportive of women who prefer VBAC are relatively low (Li et al., 2011), although measures are being taken to improve availability of this choice. In New South Wales [NSW], the Health Department has directed its services to reduce their CS rates (NSW Government, 2010), whereas the tertiary maternity service for the state of Western Australia introduced a “Next Birth after Cesarean” clinic in 2008 with a similar aim (Government of Western Australia: Department of Health, 2009).

Reluctance among health professionals to support VBAC has been related to the risk of uterine rupture (Wells, 2010). This is despite a comprehensive body of work supporting the overall increased safety of VBAC relative to uterine rupture and other risks of ERCS for women and babies (Guise et al., 2010; Hruban et al., 2012; Lydon-Rochelle, Cahill, & Spong, 2010; Macones et al., 2005; Wen et al., 2004). Risks associated with VBAC are reportedly similar to those associated with vaginal birth in a first labor (Rozen, Ugoni, & Sheehan, 2011), and maternal morbidity rates in VBAC are comparable to those associated with elective CS (Grobman et al., 2009). Nonetheless, in 2009, 87.0% of Western Australian women with a previous CS were recorded as having a repeat CS with similar rates of 86.3% in 2010 (Joyce & Hutchinson, 2012; Joyce & Tran, 2011).

Being supported during pregnancy to pursue a VBAC is one contributor to the likelihood of achieving a successful VBAC. Even so, studies have highlighted other factors such as previous VBAC and spontaneous labor may increase the likelihood of a successful VBAC (Madaan, Agrawal, Nigam, Aggarwal, & Trivedi, 2011). The risk for an unsuccessful VBAC is associated with labor induction, dystocia, and maternal obesity (Landon et al., 2005). Although useful in terms of outcome prediction (Grobman et al., 2009; Guise et al., 2010), these quantitative studies have had limited impact on decreasing CS rates, confirming the need for further investigation. A recent collaborative review of the body of evidence concerning VBAC by the U.S. National Institutes of Health (Cunningham et al., 2010) highlighted how intrapartum factors may be affecting VBAC

rates and recommended further investigation into this aspect of care. A Cochrane systematic review on the subject similarly suggests that contributory factors influencing CS warrant additional research (Khunpradit et al., 2011).

Qualitative studies reporting women’s perceptions in relation to VBAC have concentrated on their decision making (Meddings, Phipps, Haith-Cooper, & Haigh, 2007; Penso, 1994) and postnatal reflections of their birth experience (Fawcett, Tulman, & Spedden, 1994; Fenwick, Gamble, & Mawson, 2003). Women’s dissatisfaction with their childbirth experience implicating CS has also been described (Chigbu, Enwereji, & Ikeme, 2007; Dahlen & Homer, 2011). Nevertheless, we have limited understanding of women’s perceptions of what they feel influenced their desired VBAC becoming a nonelective CS.

METHOD

Research Design

The aim of this study was to gain an understanding of women’s perceptions of factors they felt contributed to not achieving their desired VBAC. To capture women’s perspectives of their birth experiences, a descriptive qualitative design was chosen (Polit & Beck, 2010). Qualitative research focuses on the subjective description and interpretation from participants’ words to gain rich data and insight into an understanding of human experiences (Liamputtong, 2010; Taylor, Kermode, & Roberts, 2007).

Participants and Setting

The participants were drawn from the next birth after cesarean (NBAC) service, which was set up at King Edward Memorial Hospital (KEMH) in 2008. As the only public tertiary maternity hospital in Western Australia, KEMH accommodates around 6,000 births annually, and cares for most high-risk pregnancies within its obstetric-led model of maternity care. The NBAC clinic offers a midwifery-led antenatal service as an alternative for women who have had a previous cesarean birth. To facilitate continuity, a core group of three midwives see the women at all visits, excluding 24 and 36 weeks’ gestation where they are examined by a medical officer in the mainstream antenatal clinic. NBAC midwives provide continuity within the antena-

tal period only and at this stage are not able to follow women through the intrapartum or postpartum period. The clinic promotes informed choice; women who want to pursue either a VBAC or an ERCS are accepted. From January 2009 to December 2011, 621 women attended the NBAC clinic during their pregnancy. Of these women, 198 (31.9%) achieved a VBAC, 237 (38.2%) chose an ERCS, and 186 (29.9%) experienced a nonelective repeat cesarean section (NERCS).

Inclusion criteria included women attending the NBAC service who were English speaking, chose to pursue a VBAC in their most recent pregnancy, and commenced labor but experienced a nonelective CS primarily because of a delay in labor progress. All women had their NERCS between the months of October 2010 and September 2011. During this 12-month study period, 53 NBAC women had a NERCS, of whom 31 met our inclusion criterion of primary delayed progress. Details of women who met the inclusion criteria were obtained from the NBAC service records who were then invited to participate in our study.

Recruitment and Data Collection

Women were recruited by telephone, and informed about the study and the approximate time commitment to participate in a telephone interview. Eighteen of the potential 31 women were contacted; 3 declined. Because data saturation was obtained with 15 interviews, the remaining 13 potential participants were not contacted. Semistructured individual in-depth telephone interviews (between September and December 2011) allowed for flexibility in sharing of birth experiences and elaboration of women's responses (Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007). Open-ended questions were used to explore the participant's perspective surrounding what they felt contributed to not achieving a VBAC. During the interview, participants were asked prompting questions around a focal question: "What do you feel influenced your recent birth becoming another cesarean"?

Data Analysis and Trustworthiness

Data analysis of the verbatim transcripts was undertaken by a team of four midwives using Colaizzi's method to capture and describe the women's experiences. The descriptive, qualitative design following Colaizzi's procedures was well suited to gain an understanding of these women's perceptions (Schneider et al., 2007). This method

included reviewing all data, extracting key statements and concepts, then further refining and organizing data into similar groupings (Polit & Beck, 2010). From this process, a list of preliminary categories and potential themes emerged, which were refined through collaboration between the research team members to confirm the final themes and subthemes. All team members analyzed the transcripts independently prior to coming together to debate and finalize themes. The team comprises two research midwives and two clinical midwives. The participants' perception of the factors around their not achieving a VBAC was summarized within emergent themes with supportive quotes. Recruitment ceased when data saturation was reached (Schneider et al., 2007); preliminary saturation occurred after 13 interviews, with 2 further interviews conducted to confirm saturation.

Ethical Considerations

Ethical approval was obtained from the WA Women and Newborn Health Service Human Research Ethics Committee (Number 2582). All women were informed of the study aim when invited to participate and confirmed their willingness to having the interviews digitally recorded. Verbal consent was obtained over the telephone. The midwife who conducted the interviews was not involved in any midwifery care or contact with the participants prior to the interview. All data is recorded on a password-protected computer in accordance with the National Health and Medical Research Council guidelines (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors' Committee, 2007) and will be retained for 5 years.

Because of the topic sensitivity, some women during their interviews demonstrated distress as their voices broke or trembled. Others expressed anger. At the completion of the interviews, all participants were informed of support services available to them within the health service and the wider community such as the KEMH Department of Psychological Medicine, the NBAC service telephone debriefing, and the peer support group "Birthrites: Healing After Cesarean."

FINDINGS

Fifteen NBAC women who expressed a desire for a VBAC but experienced a NERCS in their recent pregnancy were interviewed. Participants' age ranged from

25 to 39 years (mean 31 years) and were married or in a de facto relationship. All women experienced labor either of spontaneous onset ($n = 13$) or as a result of induction ($n = 2$), but because of a primary delay in progress of their labor had a NERCS. In addition to this delay in labor progress, fetal distress was also noted for three participants. Documented labor ranged from 3 hr 14 min to 25 hr 12 min with an average just more than 12 hr. The average infant birth weight was 3.82 kg, with all but one infant's birth weight being greater than the Australian average of 3.37 kg (Linacre, 2007). Further labor and birth information as well as a summary of recognized risk factors for unsuccessful

TABLE 1 Recent Labor and Birth Information

VARIABLE	NUMBER OF PARTICIPANTS
Labor onset	
Spontaneous	7
Spontaneous + augmented	6
Induced	2
Total	15
Length of labor (hr)	
<6	1
6–15	9
>15	5
Total	15
Cervical dilation at time of cesarean (cm)	
First stage	
0–3 (Latent stage)	3
4–7 (Active stage)	10
8–10 (Transition)	0
Second stage (full dilatation)	2
Total	15
Pain relief (combinations used)	
Water (bath or shower)	1/15
Nitrous gas	6/15
Intramuscular narcotic (morphine)	5/15
Epidural	15/15
Birth weight (kg)	
<3.37 (Australian average)	1
3.37–4.00	8
>4.00	6
Total	15
Apgar scores at 1 min after birth	
<7	4
8–10	11
Total	15
Apgar scores at 5 min >8	15/15
Other:	
History of previous miscarriage or termination	7/15
Employed a doula for current labor support	4/15
Previous pregnancy under private obstetric care	5/15

TABLE 2 Risk Factors for Unsuccessful VBAC

VARIABLE	NUMBER OF PARTICIPANTS N = 15
No previous VBAC	15
No previous vaginal birth	14
Cervical dilatation at admission less than 4 cm	13
Previous CS for dystocia	10
Male infant	7
Body mass index greater than 30	6
Neonatal birth weight greater than 4,000 g	6
41+ weeks' gestation	4
Less than 2 years from previous CS	4
Short stature (<156 cm) (Kappel et al., 1987)	3
Advanced maternal age	
35–39 years	3
40+ years	0
Induced labor	2
Previous preterm CS	2
Non-White ethnicity	1
No epidural anesthesia	0
(Note: All participants had an epidural during labor)	

Note. VBAC = vaginal birth after cesarean; CS = cesarean section. Adapted from Kappel, B., Eriksen, G., Hansen, K. B., Hvidman, L., Krag-Olsen, B., Nielsen, J., . . . Wohlert, M. (1987). Short stature in Scandinavian women: An obstetrical risk factor. *Acta Obstetrica et Gynecologica Scandinavica*, 66(2), 153–158; and Royal College of Obstetricians and Gynaecologists. (2007). *Green-top guideline no. 45: Birth after previous caesarean birth*. Retrieved from <http://www.rcog.org.uk/womens-health/clinical-guidance/birth-after-previous-caesarean-birth-green-top-45>

VBAC by our participants (Royal College of Obstetricians and Gynaecologists, 2007) are provided in Tables 1 and 2. Of the 15 risk factors associated with not achieving a VBAC, only 4 were related to most of our participants: 15 had not experienced a previous VBAC; 14 had never experienced a vaginal birth; 13 presented with a cervical dilatation of less than 4 cm at admission; and for 10 women, their previous CS was related to dystocia.

Five themes emerged during data analysis: “Tentative commitment with lingering doubts,” “My body failed me,” “Compromised by a longer than tolerable labor,” “Unable to effectively self-advocate in a climate of power-struggling and poor support,” and “The inflexibility of hospital processes” (Table 3). Direct quotes have been used to illustrate women's stories and participant numbers (P1–P15) have been used to protect their privacy.

TABLE 3 Factors Perceived by Women for Not Achieving VBAC

THEMES AND SUBTHEMES
Tentative commitment with lingering doubts
My body failed me
Compromised by a longer than tolerable labor
Unable to effectively self-advocate in a climate of power struggling and poor support
The inflexibility of hospital processes
Restrictive policies
The CTG

Note. VBAC = vaginal birth after cesarean; CTG = cardiotocography.

Tentative Commitment With Lingering Doubts

This theme depicts the residual degree of uncertainty about the likelihood of achieving a VBAC that persisted for many of our participants regardless of anything else that happened to influence their eventual mode of birth. For many, uncertainty and doubts were always there: *I mean I went in with the expectation that I would not be successful . . . Just the statistics . . . knew that I probably would not be successful if I tried* (P5). In some cases, these seeds of doubt were planted during women's antenatal clinic visits by medical staff: P4's experience was that, *She [doctor] said a couple of comments that sort of depleted my confidence about having a natural birth*. P9 was advised by the doctor she saw that, "[vaginal birth] *ain't gonna happen and, if it . . . it's up to basically us to make it happen for you,*" which she went on to describe as, *very disempowering and I didn't like that very much, though probably realistic*.

For those whose labor did not get underway spontaneously and for those in whom labor was slow to progress, this reinforced their conviction that they wouldn't be able to do it: *I probably completely lost hope when . . . after they ruptured my membranes I didn't go into labour . . . I felt like it was all going downhill from that point on 'coz I knew that it was just intervention after intervention was going to happen* (P1).

For some participants, doubt about the likelihood of giving birth naturally was related to their own ambivalence. For these women, having the opportunity to attempt labor and being enabled to pursue a vaginal birth this time was reported to be important. In addition, actually giving birth vaginally came with several caveats and so consequently, when labor did not progress as envisaged, the decision for a repeat cesarean was made fairly easily, especially when multiple personal conditions were met. P2 provided an example when she

said, *I thought "ok, because there's a few factors, it's not just, oh the baby's stuck"* (P2). Although they had consistently verbally expressed a desire to have a vaginal birth, some participants subsequently confessed relief when it was decided that a CS would be necessary. P8, for instance, said, *The fact that it ended up in a caesar[ean] didn't really bother me because I was quite scared of having a natural birth anyway*.

Motivation for a VBAC among these women varied; some shared how they attempted it to please themselves and/or others and that for them, attempting a labor that was not successful with a VBAC was enough to satisfy societal and personal expectations. Others said that as a VBAC had been medically approved, they felt obliged to attempt it. Some said they wanted to experience labor to say that they'd done it, and others said it was about being given a choice that they did not have with their previous CS. Many commented on being underprepared for labor and on their subsequent reliance on medical opinion when deviations from accepted norms occurred during their birthing episode.

My Body Failed Me

The narratives of most of our participants contained references to their body's lack of capacity to labor and give birth naturally. For example, two women were discouraged when they did not commence labor spontaneously and were induced for being more than 40 weeks' gestation. Many women took ownership of this perceived failure with statements such as: *I don't dilate* (P1), *my cervix is really slow and . . . won't open* (P4), and that there was *not a great fit . . . through my pelvic canal* (P2). If they could have influenced any change in their birthing experience, they suggested that they would *get a new cervix* (P4) or *alter the shape of my pelvis* (P3) because the fault was *what my body did and not what anyone else there did* (P8). From pelvic shape, cervical behavior, genetics (P10), and physiology (P4), the conviction that their body failed them was a common feature in women's perception of why they did not achieve a VBAC. For four women, the interplay between the baby and their own body was the issue: these women described being unable to physically facilitate the passage of a 'posterior' baby: *The baby being posterior was probably the main thing. I mean now there's no denying after 30 hrs of labour if you've only dilated 2 cms and or 3 cms or whatever it was . . .* (P9).

Some women also shared how their labor went on longer than expected: *28 hours . . . and still hadn't dilated much* (P4). On arrival to hospital, most participants were

assessed as not in established labor as per hospital guidelines. Some expressed their disappointment when minimal progress was being made despite painful contractions.

Interestingly, for some women this realization was healing. Some participants suggested that being able to isolate their body as a main causative factor for not achieving a VBAC, this time enabled them to resolve feelings of failure and blame they had harbored about their first CS: *It healed a lot that we had hanging over us from the first birth* (P3).

Compromised by a Longer Than Tolerable Labor

Data analysis confirmed that participants experienced unmet expectations around their ability to tolerate a natural labor that progressed beyond the limits deemed acceptable to the hospital. Regardless of whether labor was considered established or not, the enormous challenge of enduring painful contractions for a prolonged time was a common feature of the stories. Participants expressed how *experiencing that much pain just affects your decision making and your resilience* (P4). As P10 stated, *when you're in that situation where you're in pain and stuff like that you just go with the flow*. Exhaustion and tiredness affected women's decision making and ability to advocate for what they wanted: *I think even if I had suddenly dilated and continued with things I don't think I would've had the energy to actually kind of get right through labor* (P2). Some women described how interventions were introduced to accelerate the labor with the goal of meeting partogram guidelines. These interventions limited access to labor care options such as showers and baths resulting in women submitting to more medical options: *tends to lean you toward more like medical interventions like drugs and the epidural* (P1). Because labor did not progress as anticipated and time slowly passed by, women's doubts in their own physical ability became more evident:

I was still only 2–3 cms despite having laboured all morning in great pain and I tried showers, walking around, everything, but you know nothing really worked, so I opted to have an epidural and I'd even said to them "look um I'll have the epidural but can you schedule me in for a C-section as well" because I just thought this labours never going to happen by itself, you know I'd already been in labour for well over 24 hrs and I was exhausted (P4).

Unable to Effectively Self-Advocate in a Climate of Power Struggling and Poor Support

Comments made by women concerning their inability to advocate for themselves during labor, and the part that caregivers' support, or lack thereof, played are captured in this theme. As noted previously, midwives from the NBAC service did not care for these women during the intrapartum period. In the main, participants felt their self-advocacy was limited, and that this resulted in their being readily influenced by and accepting of the opinion of others: The example P11 gave is as follows:

At 22 hours they said "look, I think you've pretty much had enough"; I'd dilated to 6 cms and wasn't really going anywhere fast and they said for my safety and the baby's safety it would probably be best for a Caesar[ean] . . . And . . . I was thinking that's the right thing to do.

For some women, their previous childbirth experience(s) left them fearing being alone in labor, and so they paid for a personal support person to stay with them. Doulas were employed by 4 of the 15 participants who described feeling unable to "manage" a VBAC on their own: *I hired a doula as well, sort of to talk over what had happened last time so I feel like I'd already come to terms with the fact that I might have a caesarean again* (P14). The presence of a doula did seem to the women to influence labor and birth suite midwives' behavior; these participants reflected on how the midwives did not remain in the room and that they were often left alone with the doula.

Some participants experienced caregivers they perceived as not ideal in that they would not "work with" women's intrapartum needs and wants. One participant recalled *I remember fighting with the midwife because I really wanted to have a shower and she wouldn't let me off the monitor* (P9). Some women lamented staff not respecting their desire for nonpharmacological pain management: *no natural pain relief was ever offered like in terms of heat packs or anything. It was, yeah, that was a bit disappointing really* (P1). The intrapartum experience for women was heavily dependent on the personality and approach of the midwife allocated to them on the day; *The midwives, you don't know them, so you have no emotional support and I found them quite off-standish* (P1). Not having any "connection" to or being known by the midwife influenced the women's determination in pursuing their desired VBAC. Some participants found their

experience disappointing but were reluctant to implicate their caregivers: *It's not to say they were bad midwives, it's just for what I needed I didn't get the support I would've liked* (P9). It was felt that some midwives demonstrated their not being receptive to women's needs by returning to the labor room to yell (P9) at them for changing positions or leaving participants alone who were afraid: *I didn't really know what I was doing and I was scared that something would happen while she [midwife] wasn't there* (P5).

The Inflexibility of Hospital Processes

The final theme that emerged from the analysis of our data also included two subthemes, namely "restrictive policies" and "The CTG."

Restrictive Policies

Women perceived that VBAC clinical guidelines could negatively influence their chance of achieving a VBAC depending on how strictly they were enforced: *I found them [midwives] to be very much interested in the protocols of the hospital and doing what was right by the hospital but not doing much to help facilitate a natural birth* (P9). Some participants expressed frustration with restrictions placed on them resulting in few options to "naturally" manage pain and limited movement. For example, having an intravenous infusion limited opportunities to use water for pain management or be freely able to walk around. Time limits around labor progress were affected by how busy the labor suite was in being able to promptly offer augmentation which then extended the length of labor: *no rooms available on the labour ward* (P2). Participants shared how they were told *to come straight in as soon as you're having contractions* (P8) rather than waiting until the contractions were regular. They did not agree with strict time constraints around their progress that suggested they were treated *differently* (P9); *I was taking the time of a first labour, first birth but I had the time constraints of a second birth and a VBAC* (P2).

The CTG

Staff enforcement of continuous cardiotocography (CTG) and the subsequent restriction of participants' movement was the focus of this subtheme. P9 said, *I wasn't able to change positions, I wasn't able to have a shower, going to the toilet I felt like hurried because you know the time pressures of taking the monitor off*. In P5's case, the fetal monitor meant *I couldn't leave the bed*. Many participants observed the CTG to mean the midwives' role changed

from that "being with woman" to "being with machine." *The midwife, every time the stupid monitor would beep or blip or something they'd come in and yell at me for rolling over but I was, it wasn't about facilitating the birth, it was all about the monitor* (P9). Women indicated how they were not able to negotiate any flexibility around these restrictions as P9 continues her story: *it became exhausting to fight every time I wanted to take the fetal monitor off . . . it was all about the baby's heart beat and nothing about me as a labouring mother*.

Consequences

Although it doesn't contribute to answering our specific research question, women provided a substantial amount of information on how their unsuccessful pursuit of a VBAC left them feeling, which we feel is important and relevant to include. All women expressed how they were grateful to have a healthy live baby but feelings of disappointment and sadness prevailed. With the reality of a vaginal birth lost, participants expressed emotions such as *you feel like a bit of a failure* (P15). Most women also expressed a degree of relief when the decision for a CS was made. Although disappointed, they resolved the experience by focusing on acknowledging their effort and confirming there was nothing more that could have been done. Most participants appreciated that their CS was necessary to facilitate the baby's safe birth, and as such felt *there was nothing really that I could change* (P8) or *everything went great and the baby was healthy . . . so that's all you can ask for really* (P7). Factors contributing to their not achieving a VBAC were regarded as being beyond their control: *I think I've given this a good crack and I feel like I've done everything I can* (P2). To move forward, participants focused on the outcomes rather than process: *I think it's a horrible way to have a baby. So that part of it, not very nice but obviously when you're left with a beautiful baby boy or baby girl then it becomes a happy moment. You've just got to try and forget the rest* (P13). The process of labor and birth was also rationalized by some as being not as important as they had anticipated: *the birth isn't everything you know, you've got the whole everything afterwards to deal with* (P14).

DISCUSSION

The findings of this investigation are limited by the fact that they only represent the views of women attending one Australian maternity service. Nonetheless, they

provide a valuable addition to the knowledge that already exists about women's perceptions of the inevitable and modifiable factors that led to them birthing as they did.

For our participants, three elements were perceived to have played a part in their planned VBAC not eventuating. These included their own lack of belief in the likelihood of achieving a VBAC, their own body's apparent physical incapacity, and a context that was predominantly unsupportive of VBAC.

Uncertainty About the Likelihood of Achieving a Vaginal Birth After Cesarean

Many of the women in our study attributed their non-elective CS in part to a lack of confidence that a vaginal birth would actually eventuate for them. For some women, it was the fact of their inability to birth vaginally previously that underpinned this state of mind. For others, their belief was undermined by health professionals they encountered during pregnancy and/or labor who expressed doubt about their ability to achieve a VBAC. For some, both factors were present. Regardless of the etiology, what seemed to have been happening for some women was a form of self-fulfilling prophesying, wherein they had come to form a belief about how their birth would turn out and then unwittingly affected behaviors antenatally and intrapartum, such as imposing conditions that they were unlikely to fulfill upon themselves, that made their prediction come true (Merton, 1968; Sternberg, 2011). In contrast, women whose attempt at VBAC was successful are reported to attribute the outcome in part to having a firm belief that they could give birth vaginally, and an unwavering determination to do so even in the face of others' doubt (Godden, Hauck, Hardwick, & Bayes, 2012).

The Body's Capacity

Some of the informants in this study described feeling very uncertain that their body would be able to facilitate the natural birth of their baby, and the fact that a CS resulted was, for them, clear proof that it was not physically possible. Our study did not seek to make any judgment about the necessity of participants' CSs or about caregivers' decision making in that regard. Perinatal statistics from comparative populations and maternity care systems, suggest that true physiological incapacity is unlikely to be the sole cause of women's inability to achieve a VBAC; a survey of 38 maternity units in the Netherlands, for example, reported a 76% VBAC

attempt rate and a 54% success rate across the included providers (Kwee, Bots, Visser, & Bruinse, 2007).

Women who are placed with the NBAC service and wish to attempt a VBAC are carefully selected based on their being no preexisting reason why they shouldn't birth naturally. Their failure to do so in proportions greater than the subpopulation who have not had a CS previously, therefore, indicates that there must be something in these women's environment or psyche that is to blame. In healthy women with a well fetus and a "low-risk" profile, that "something" is possibly that recourse to CS for labor dystocia, or "failure to progress," is possibly more often a case of "failure to wait" on the part of maternity caregivers (Cheng, Shaffer, Bryant, & Caughey, 2008; Zhang et al., 2010).

In addition, women's lack of body confidence in relation to childbearing is known to extend to their perceived ability to perform other natural functions of mothering. Poor self-image and lack of confidence can be detrimental factors in women's attempts to breastfeed successfully (Hall & Hauck, 2007; Hauck, 2004). When added to what we know about the detrimental effect that CS has on breastfeeding per se (Zanardo et al., 2010), the consequences for mothers and babies of an unsuccessful VBAC attempt, which women attribute to their body failing them, are concerning.

Health Care Professionals and Protocols

The final factor that several of our informants attributed to their unsuccessful VBAC was what they perceived as disobliging attitudes and behaviors displayed by those allotted to care for them in the intrapartum period. Compounding the unhelpfulness women experienced was what they described as caregivers' unquestioning "buy in" to clinical practice guidelines which, women found, were disregarding of and inhibitory to their natural mammalian instincts in labor.

Lack of caregiver support for women's hopes, plans, and needs for labor and birth is well known to feature as a stressor in women's accounts of their birth experiences. In their study investigating the experiences of women in Nigeria who failed in their attempt to achieve a VBAC, Chigbu and colleagues (2007) found, as we did, that having limits placed on options available during labor was a particularly dissatisfying aspect of the intrapartum episode for women. What is also apparent is that when women do experience stress and fear in labor, such as would occur as a result of uncertainty, derision, abandonment, inhibition, and constraint, there is a detrimental effect on the progression of labor

(Adams, Eberhard-Gran, & Eskild, 2012). Conversely, where women attempting and achieving a VBAC did feel as if the health professionals around them during labor were supportive and “on side,” they have been reported to identify this as a key attribute in their success (Godden et al., 2012).

Our findings highlight the need for further research to illuminate aspects of providing care for women wanting a VBAC. Greater insight into the perceptions, challenges, and barriers midwives face when caring for women who express a desire for a VBAC warrants further exploration. This relatively homogenous group of women all experienced an emergency CS because of a primary delay in the progress of their labor. Likewise, women planning a VBAC but who experienced an emergency CS for other reasons should also have their experience explored.

CONCLUSION AND RECOMMENDATIONS

The findings of this small study add a previously unexplored dimension, that of women who pursued but did not have a VBAC, to the existing body of work on women's views of why their childbearing episode unfolded as it did. Undoubtedly, some of the women in our study were truly unable to give birth vaginally. It is also possible that some were physiologically capable of giving birth vaginally but were unable to attain their goal of a VBAC because of an interrelated set of intrinsic and exogenous factors that conspired, albeit unintentionally and unwittingly on anyone's part, against this outcome.

It is imperative that, if the unacceptably high CS rates across the world are to be stemmed, maternity services need to reexamine their VBAC policies, procedures, and guidelines to ensure that they reflect best evidence and require staff to be supportive of women's choice for this birth mode. Given that the risk of uterine rupture in gravid and laboring women who have had a previous CS is known to be negligible, it is incumbent on services to demonstrate a positive organizational stance to supporting eligible women to pursue and achieve a VBAC.

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Correspondence regarding this article should be directed to Yvonne L. Hauck, RN, RM, BScN, MSc, PhD, Professor of Midwifery, Curtin University and King Edward Memorial Hospital, Curtin Health Innovation Research Institute, Perth, Western Australia. E-mail: y.hauck@curtin.edu.au

Georgina Kelly, BN, PG, Dip Mid, Graduate Registered Midwife, Department of Nursing and Midwifery Education and Research, King Edward Memorial Hospital, Subiaco, Western Australia.

Yvonne L. Hauck, RN, RM, BScN, MSc, PhD, Professor of Midwifery, Curtin University and King Edward Memorial Hospital, Curtin Health Innovation Research Institute, Perth, Western Australia.

Sara Bayes, RN, RM, Dip Nurs, PG Dip Mid, M Mid, PhD, Research Implementation Fellow, Collaboration for Leadership in Applied Health Research and Care—Nottinghamshire, Derbyshire, and Lincolnshire—University of Nottingham, England, United Kingdom and Adjunct Midwifery Research Fellow, Curtin University, Curtin Health Innovation Research Institute, Perth, Western Australia.

Tasmin Hardwick, BN, PG Dip Mid, Clinic Midwife, Next Birth After Caesarean Clinic, King Edward Memorial Hospital, Subiaco, Western Australia.