

REVIEW ARTICLE

Factors that Influence Women's Decision on the Mode of Birth After a Previous Caesarean Section: A Meta-ethnography

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ABSTRACT

Background: Caesarean section (CS) rates are continuing to rise worldwide. Elective repeat CS (ERCS) greatly contribute to the rising rate which increases unnecessary risks of maternal and neonatal morbidity and mortality. Vaginal birth after caesarean (VBAC) is a safe mode of birth for most women; however, uptake remains low. Our objective is to find the factors that influence women's decision-making to support informed choices for the mode of next birth after caesarean section (NBAC).

Methods: A literature search was conducted in CINAHL, Maternity and Infant Care, Embase, EmCare, Cochrane Library and Medline databases. Primary, qualitative, peer reviewed, English language research articles were assessed according to inclusion/exclusion criteria. Articles were systematically assessed for inclusion or exclusion. Included studies were assessed using the Critical Appraisal Skills Programme qualitative studies checklist, Noblit and Hare's seven-step meta-ethnography approach synthesised themes.

Results: Fourteen primary research articles were included. Six studies on 287 women focused on VBAC, and eight studies examined both VBAC and ERCS with 1861 women and 311 blogs. Thematic analysis yielded four primary themes: Influence of health professionals, impact of previous birth experience, optimal experience, and being in control.

Conclusion: This meta-ethnography highlights health professionals' influence on women's decision making. To assist in decision-making, women need supportive health professionals who provide the current evidence-informed information about risks and benefits of each mode of birth. Health professionals need skills to provide supportive shared decision-making, debrief women regarding indications for their primary caesarean, and address issues of safety, fear, and expectations of childbirth.

Keywords: Obstetric labour complications, Health personnel, Midwifery, Qualitative research

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INTRODUCTION

The caesarean section (CS) rate, in most developed countries, is steadily rising. The high CS rate is of concern because CS rates above 15% are not associated with reduced maternal or infant mortality.¹ CS operations involve short- and long-term risks to the woman such as postoperative infection and haemorrhage.² The immediate risks to the baby include an increase in preterm birth, transient tachypnoea, and primary pulmonary hypertension.³ Long-term risks to the baby include increased rates of asthma and obesity.²

A large percentage of the overall CS rate is due to elective repeat CSs (ERCS) and many of these are not medically indicated.⁴ Repeat CS come with added risks for women. Between 12-46% of pregnancies after one CS and 26-75% of pregnancies after two CSs have an increased risk of developing a placental abnormality such as placenta praevia or placenta accreta.⁵ These placental insertion complications increase the difficulty of CS surgery and can lead to devastating complications such as major obstetric haemorrhage, disseminated intravascular coagulation, blood transfusion, visceral damage, and critical care admission.⁵

A vaginal birth after CS (VBAC) is considered as the best practice and the most cost-effective birthing option for eligible women to reduce repeat CSs and their associated risks.⁶ Women having a successful VBAC report fewer major complications, a shorter recovery, increased bonding and breastfeeding success, and high maternal satisfaction.⁷ Increasing the rate of successful VBAC will help reduce the overall CS rate with associated morbidities and increase women's birth experience satisfaction.^{6,7}

There is a paucity of literature reviews exploring the factors that influence a woman's choice for her next birth after caesarean section (NBAC). A literature review is needed to understand what influences a woman's decision-making for a VBAC or ERCS, so health professionals will be able to provide

guidance and appropriate information to assist women in their choice.

METHODS

Meta-ethnography is the most commonly used qualitative synthesis approach in healthcare research. It is an inductive, interpretative approach, upon which most interpretative qualitative synthesis methods are based.⁸ This meta-ethnography followed Noblit and Hare's seven-step approach, which involves using the nature of interpretive explanation to guide the synthesis of ethnographies or other qualitative studies.⁹ The seven-steps are: 1) getting started; 2) deciding what is relevant to the initial interest; 3) reading the studies; 4) determining how the studies are related; 5) translating the studies into one another; 6) synthesising translations; and 7) expressing the synthesis.⁹ The authors define 'translating' as the process of describing the concepts in studies and comparing and contrasting them with one another.⁹

Step 1 – Getting Started

Currently, there is no literature review exploring the factors that influence women's decision on the mode of birth after a previous caesarean section to guide health professionals in supporting women in subsequent pregnancies. Therefore, the research question of this meta-ethnography is "What are the factors that influence women's decision on the mode of birth after a previous caesarean section?"

Step 2 – Deciding What is Relevant to the Initial Interest

Relevant studies were identified by searching CINAHL, Maternity and Infant Care, Embase, EmCare, Cochrane Library, and Medline databases on 30 June 2021. Search terms included 'caesarean' OR 'cesarean' OR 'mode of birth' OR 'birth mode' AND 'preferences' OR 'factors' OR 'decision-making' OR 'birth choices'. A time period of 2010-2021 was used to ensure most current research (no more than 10 years old).

Articles published in non-English languages were excluded as there was no funding for translation.

References were imported into EndNote and Covidence to systematically assess research articles for inclusion or exclusion. All articles were reviewed by reading the title, abstract and, if necessary, full text. Primary qualitative research articles were included when relevant to women’s decision-making process for NBAC or ERCS with self-reported reasons for their preferences. Articles on women’s birth experience or satisfaction and health care professional’s opinions were excluded.

The database searches yielded 1379 articles; 142 duplicates were excluded. Title search alone excluded 1115 articles, following the inclusion and exclusion criteria, leaving 122 articles to be screened by abstract. References were imported into Endnote for abstract review, and a further 71 records were excluded leading to 51 eligible articles for full text assessment. Covidence screening of the 51 full text records led to exclusion of 37.

Therefore, 14 qualitative, primary research articles met the inclusion criteria and were included in the meta-ethnography (Figure 1).

Step 3 – Reading the Studies

The Critical Appraisal Skills Programme (CASP) qualitative studies checklist was used to assess the quality of the included studies.¹⁰ The CASP checklist has been used by health care professionals for over 25 years to assess published literature and provides a suitable checklist to assess the validity, reliability, and generalizability of the included studies.¹⁰ No articles were excluded on the quality assessment as all studies were of high quality and met ethical and methodological standards.

Step 4 and 5 – Data Abstraction and Translation

Articles were entered into NVivo 12, and the results and discussion data were thematically analysed. First-order constructs were obtained from direct quotations in the ‘results’ section. Second-order constructs were obtained from the authors’ account and interpretation of findings in the ‘results’ and

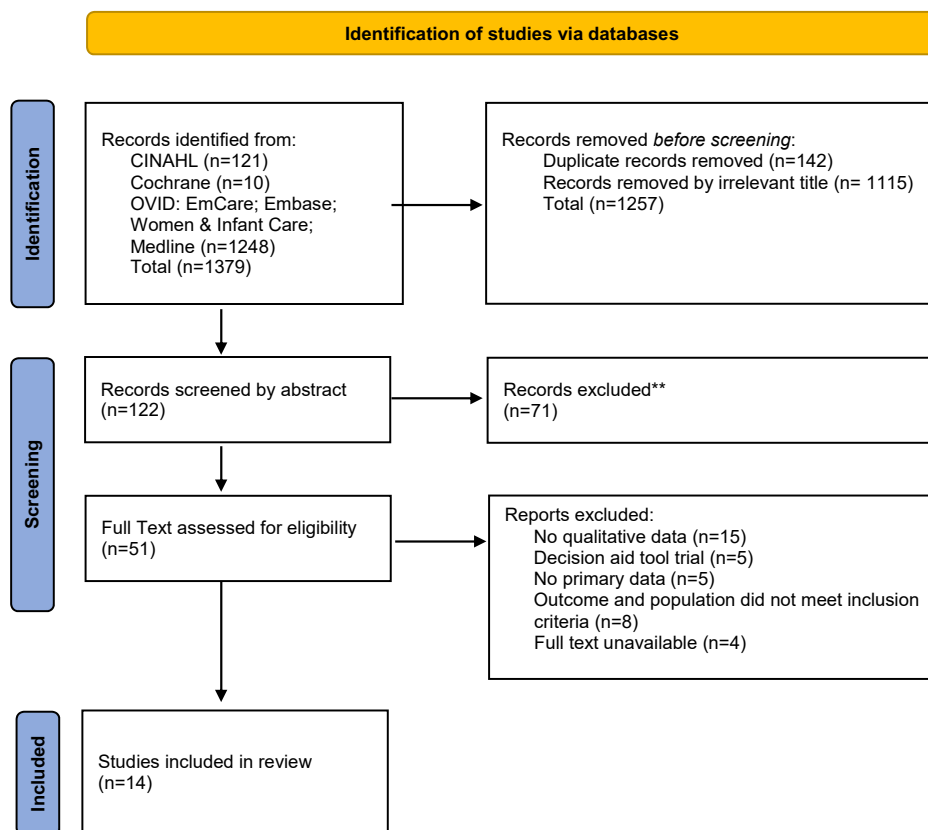


Figure 1 PRISMA flow diagram.

‘discussion’ sections of each study. Step five involved the author translating or comparing and contrasting the themes of each study in an iterative manner.⁹ During this process, third-order constructs were further developed and confirmed, and a line-of-argument formed culminating in step six synthesising translations.

RESULTS

Across the 14 studies in this meta-ethnography, a total of 2,148 participants and 311 blogs were incorporated. Specifically, the studies included: one on thematic analysis of blogs, eight qualitative descriptive studies, three mixed methods, and two grounded theory studies (Table 1). All included studies met high quality criteria as per CASP checklist. Only the qualitative aspects of the mixed method studies met the criteria for the meta-ethnography and were included. From the 14 studies, the countries where the research was done included Australia (n=3), USA (n=4), Taiwan (n=2), Canada (n=1), Germany (n=1), Ireland (n=1), Italy (n=2), Finland (n=1), Netherlands (n=1), Sweden (n=1), and Turkey (n=1). The study participants varied greatly across the studies, as detailed in Table 1.

Step 6 and 7 – Synthesising and Expressing Translations

Despite the variations in participant characteristics, most of the studies included similar themes. Initial grouping of the first and second-order constructs resulted in 15 subthemes within four main themes, as shown in Table 2.

1. Influence of Health Professionals

The most common theme among all studies was the influence of health professionals on women’s chosen mode of birth after CS. Health professionals were regarded as experts creating a power and knowledge imbalance, especially during labour when women are most vulnerable.^{16, 20} The opinions and knowledge of health professionals impact women’s decision on VBAC or ERCS. Most of the studies focused on the negative views of health professionals on VBAC, especially obstetricians. Many women felt directed towards an ERCS by their obstetrician without sufficient education or choice.^{11, 14-17, 24} The doctors with negative views of VBAC focused on risks, either for the women or for the doctors themselves.^{13, 20, 22}

Table 1: Data extraction from included studies in the meta-ethnography

Author/ Year/ Country	Aims of study	Methodology/ sample	Main Findings/Conclusions	Strengths and weaknesses
1. Akgun & Boz/ 2019 /Turkey ¹¹	To discover, identify, and interpret the decision-making processes and experiences of women on VBAC ^a	Descriptive phenomenology/ 12 women who had VBAC<2 years ago	The women had to find a way to have a VBAC as there were many obstacles especially unsupportive medical professionals. They believed their body was designed to birth vaginally and the baby’s movements signaled his/her assistance. The women conducted their own research weighing up the risks and accepting them. The women became active participants in decision-making. The women found strength through sharing stories and being physically and psychologically prepared.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims with an interview guide provided. Relationship between participants and researcher not considered. To ensure trustworthiness the author and a second coder analysed the narratives using an iterative process to reflect on themes. Ethics discussed. Clear statement of the findings.

Author/ Year/ Country	Aims of study	Methodology/ sample	Main Findings/Conclusions	Strengths and weaknesses
2. Attanasio, Kozhmannil & Kjerulff/ 2019/ USA ¹²	(a) To determine pre-existing preferences; experiences of first birth; postpartum recovery experiences; and perceived risks and benefits of VBAC in shaping women's VBAC preferences; and (b) To thematically categorize women's open-ended reasons for preferring vaginal or cesarean birth in the future	Mixed methods: Open-ended survey with qualitative and quantitative analysis/ 616 women who had CS ^b for first birth and not pregnant 12months postpartum	Women's previous birth experiences influenced their subsequent birth mode. A positive or negative experience led to repeating or avoiding previous experience. Women who wanted a VBAC wanted to avoid surgery, have an easier recovery, and wanted a larger family. Many women found it difficult to access VBAC support but the most frequent reason for a VBAC was wanting the experience of a natural or vaginal birth. Nearly half of respondents preferred VBAC in future births, but national estimates indicate that only about 12% of women with prior cesareans have a VBAC. This suggests a need to ensure greater access to VBAC for women who want it.	Aims clear. Methodology and design were appropriate with the qualitative portion explained. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims, however brief responses and no clarification obtained. Relationship between participants and researcher not considered. To ensure trustworthiness the author and a second coder analysed the narratives using an iterative process to reflect on themes. Ethical considerations or approvals absent. Clear statement of major findings. Themes with few responses ignored.
3. Basile et al/ 2021/ USA ¹³	To investigate how US women who desired a VBAC navigated a subsequent pregnancy and childbirth	Convergent parallel mixed methods /1711 women with previous CS and subsequent birth in past 5yrs	Many participants who planned a VBAC had to work extremely hard to obtain a VBAC, actively seeking out caregivers who would form a partnership that gave them more autonomy and made them feel respected. Self-education was a key factor as well as surrounding themselves with supportive peers, doulas and providers.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims. Relationship between participants and researcher not considered. To ensure trustworthiness a second coder confirmed coding for 25% of data with consensus. Ethics discussed. Clear statement of the findings with detailed implications for research practice and policy.
4. Chan et al/ 2020/ Australia ¹⁴	To explore women's experiences of their involvement in decision-making during a subsequent pregnancy after a previous caesarean birth, irrespective of their preferred birth mode and birth outcomes	Descriptive qualitative/17 women in third trimester >18yrs with 1 or more CS and low to moderate self-reported anxiety	Past experiences influenced the decision-making process. Women desired to claim ownership in decisions by challenging professional judgement and prioritising her needs, wishes and preferences. Women's experiences around decision-making in a subsequent pregnancy can vary according to whether their fears and anxieties are acknowledged and addressed. Women who are informed, and receive support and respect are empowered to move forward.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Reasons given for non-participation. Data collected in a way that addressed the research aims with saturation reached. Relationship between participants and researcher clearly noted. Ethics discussed. A cross-section of transcripts were analysed by three members of the research team ensuring each data source was reviewed by the first author and another researcher. Unique subset of women interviewed and therefore not generalisable results. Further research topics recommended.

Author/ Year/ Country	Aims of study	Methodology/ sample	Main Findings/Conclusions	Strengths and weaknesses
5. Chen et al/ 2017/ Taiwan ¹⁵	To determine factors affecting Taiwanese women's decision making regarding VBAC	Interpretive descriptive qualitative study/ 29 women at 34-38wks gestation with 1 previous CS and eligible for VBAC 14 VBAC, 10 ERCS ^c & 5 undecided	Women who had a negative experience of CS anticipated a VBAC comparing the negatives of a CS with the positives of a VBAC. Cultural factors influenced decisions but fear of VBAC complications and influence of professionals towards ERCS took priority for some women. Women who have had a previous CS are prepared to have a vaginal birth but are not always supported to carry out this decision.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims. Relationship between participants and researcher considered. Credibility, confirmability, dependability and transferability discussed. Triangulation strategies used. Ethics discussed. Clear statement of the findings with implications for future care.
6. Chen et al/ 2018/ Taiwan ¹⁶	To explore women's decision-making processes and the influences on their MOB ^d following a previous CS	Grounded theory/21 women with a previous CS and Low risk pregnancy at 30-32wks and again postpartum	The health and wellbeing of mother and baby were the major concerns for women. Previous birth experiences influenced decisions. Women sought information to evaluate pros and cons of each birth mode. Routine provision of explanations by obstetricians regarding risks associated with alternative birth options, in addition to financial coverage for ERCS from National Health Insurance, assists women's decision-making.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate with variations to protocol explained. Data collected in a way that addressed the research aims with an interview guide pretested. Relationship between participants and researcher considered with bracketing. To ensure credibility codes and themes which were refined, discussed, and agreed by the three authors. Member checking conducted. Ethics discussed. Clear statement of the findings with implications for practice.
7. Dahlen & Homer/ 2013/ World-wide (majority USA) ¹⁷	To examine how women use English language internet blog sites to discuss the option of VBAC and what factors influence these women's decision to have a VBAC or ERCS.	Thematic analysis/ 311 blogs	Women filtered their decision making regarding VBAC through a belief system that prioritises according to their personal approaches of motherbirth or childbirth. Several themes were identified including surviving the damage; inadequate bodies; choice and control; fearing and trusting birth; negotiating the system; and minimising or overestimating risk.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims. Relationship between participants and researcher considered with bracketing. To ensure credibility codes and themes which were refined, discussed, and agreed by two authors. Ethics discussed but not required due to public nature of blogs. Clear statement of the findings and limitations.

Author/ Year/ Country	Aims of study	Methodology/ sample	Main Findings/Conclusions	Strengths and weaknesses
8. Davis et al/ 2020/ Australia ¹⁸	To examine the factors that motivate women who have had a previous CS to consider planning a vaginal birth.	Qualitative descriptive study/18 women with a previous CS and eligible for VBAC	These women were committed to natural birth and drew on their previous experience of CS to highlight the downside of recovery post CS. Decision making for these women was complex. During the decision-making process, women individualised the information provided to balance risk and chance within the context of their own circumstance. Supportive healthcare providers were important in motivating women towards vaginal birth and midwives were identified as being more supportive than obstetricians.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims and saturation reached. Relationship between participants and researcher not considered. To ensure credibility codes and themes were discussed and agreed by four authors. Ethics considered. Clear statement of the findings and implications for future practice.
9. Konheim-Kalkstein et al/ 2017/ USA ¹⁹	To determine factors that influence pregnant women to choose VBAC	Mixed methods/173 pregnant women with 1 previous CS currently pregnant less than 35wks eligible for VBAC	Women who want a VBAC are wanting to experience vaginal birth and feel it is natural. They have a desire to control their own body and felt it was safer for baby. Women wanting an ERCS wanted a controlled environment and a planned birth. Women may be more likely to choose VBAC if they are encouraged to believe that they can help control the outcome, especially if their desire for a vaginal birth experience is high.	Aims clear. Methodology and design were appropriate for quantitative portion. The qualitative methodology not explained. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims. Relationship between participants and researcher not considered. Questionnaire not piloted and reliability and validity not discussed. Ethics considered. Clear statement of the findings and some limitations discussed.
10. McGrath et al/2010/ Australia ²⁰	To explore, from the mothers' perspective, the decision-making experience about subsequent birth choice for women who had previously delivered by CS	Descriptive phenomenology/ 4 women with 1 previous CS and a subsequent birth	A range of disciplines, especially obstetrics, midwifery and general physician, impact on the birth decision. Women need to make informed choices in partnership with their healthcare providers and feel supported in their birth choice. However, from the mothers' perspective, the extent of prenatal information provision was biased towards ERCS and heavily risk based.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate although a very small number of participants. Data collected in a way that addressed the research aims. Relationship between participants and researcher considered. To ensure credibility codes and themes were refined, discussed, and agreed by multiple authors. Ethics considered. Clear statement of the findings. Some links made to professional practice. No further research recommendations.

Author/ Year/ Country	Aims of study	Methodology/ sample	Main Findings/Conclusions	Strengths and weaknesses
11. Munro et al/ 2017/ Canada ²¹	To explore attitudes towards and experiences with decision-making for mode of delivery after caesarean from the perspectives of Canadian women	Constructivist grounded theory/23 women eligible for VBAC	Women reflected on prior birth experience and balanced pros and cons of each MOB to decide what was important in the next birth. Seeking control and becoming an active participant in decision-making was a common theme. Other factors included what the local hospital offered, or did not offer, for VBAC and the feelings of unbalanced and impersonal appointments with unsupportive health professionals. Women begin decision-making for NBAC ^e earlier than previously reported and their choices are influenced by personal experience and psychosocial concerns.	Aims clear. Methodology and design were appropriate. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims and triangulation occurred. Relationship between participants and researcher was considered. To ensure trustworthiness two researchers involved in coding and a form of member checking used. Rigour had own subheading and discussed thoroughly. Ethics discussed. Clear statement of the findings with links to future practice and limitations explained.
12. Nilsson et al/ 2017/ Germany, Ireland, Italy ²²	To investigate women's views on important factors to improve the rate of VBAC in countries where vaginal birth rates after previous caesarean are low	Qualitative study/ 51 women with 1 previous CS and pregnant	Women's decision-making about VBAC in these countries involves a complex, multidimensional interplay of medical, psychosocial, cultural, personal and practical considerations. Stated pressure to have ERCS through scare tactics, poor information and cultural negativity towards VBAC. Want to be involved in decision-making and feel in control. Seek out own education, balancing pros and cons and desiring for continuity of care with supportive professional.	Aims clear. Methodology and design were appropriate with interview questions supplied. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims. Relationship between participants and researcher was not considered. To ensure trustworthiness multiple researchers involved in coding. Ethics discussed. Clear statement of the findings with recommendations for future research.
13. Nilsson et al/ 2017/ Finland, Netherlands, Sweden ²³	To determine women's views on factors of importance for improving the rate of VBAC in countries where VBAC rates are high	Qualitative descriptive study/ 22 women who experienced a VBAC	Women want to receive information from supportive clinicians and professional support from a calm and confident midwife or obstetrician during childbirth. According to these findings, VBAC is facilitated when it is the first alternative for all involved and no complications are present. Women feel they need to let go of their previous birth to prepare for next birth and know advantages of VBAC.	Aims clear. Methodology and design were appropriate with interview questions supplied. Recruitment explained and was appropriate. Data collected in a way that addressed the research aims. Relationship between participants and researcher was not considered. To ensure trustworthiness multiple researchers involved in coding. Ethics discussed. Clear statement of the findings with recommendations for future research.

Author/ Year/ Country	Aims of study	Methodology/ sample	Main Findings/Conclusions	Strengths and weaknesses
14. Simeone et al/ 2019/ Italy ²⁴	(a) To understand the process that women use to select a VBAC rather than a repeat cesarean, (b) To understand the mothers' lived experience of that VBAC, and (c) to use the aforementioned data to inform the development of new educational programs for mothers considering VBAC	Phenomenology/11 women with successful VBAC in previous 6wks	The choice of VBAC is the result of the sum of many factors, including previous experiences, personal expectations of a natural birth process, medical advice, and familial or social expectations. Women sought information online and from other VBAC experience stories. They lacked support for VBAC by health system/providers and family members.	Aims clear. Methodology and design were appropriate with interview technique tested prior to study. Recruitment explained and was appropriate with one unexplained refusal to participate. Data collected in a way that addressed the research aims and triangulation used. Member checking conducted. Data saturation reached. Relationship between participants and researcher considered with bracketing. To ensure trustworthiness two researchers involved in coding and a form of member checking used. Ethics discussed. Clear statement of the findings with links to future practice. Limitations considered.

^aVaginal birth after caesarean; ^bCaesarean section; ^cElective repeat caesarean section; ^dMode of birth; ^eNext birth after caesarean

Table 2: Subthemes and themes in the study

Subthemes	Themes
Negative versus positive views Insufficient knowledge Quality of individualized care Communication styles and scare tactics	Influence of health professionals
Fear and trauma Motherhood and bonding The known versus the unknown	Impact of previous birth experience
Recovery It's natural, a rite of passage Cultural considerations Safety	Optimal experience
Self-educating Online peer support Balancing risks Active participant in decision-making	Being in control

In studies that reported positive support for women's decision-making, nurses, midwives, and doulas were more frequently positive towards VBAC than obstetricians.^{11, 13, 17, 18} Women in the Netherlands were presented with scientific evidence and persuaded by health professionals that VBAC is the safest option for birth.²³ Nilsson et al. was the only study in this meta-ethnography to specifically

mention an overwhelming support from health professionals for VBAC.²³ A positive and optimistic approach from health professionals inspired and encouraged VBAC eligible women to give birth vaginally.^{22, 18, 24} In some studies, participants perceived that health care professionals had insufficient knowledge about VBAC.^{16, 17, 20, 21, 24} Health professionals in countries where VBAC was accepted and

promoted, such as Netherlands and Norway, provided information that was weighted towards VBAC,²³ whereas in all other studies the information weighted towards ERCS. Attanasio et al. reported that women in their study had overall low knowledge of the risks and benefits of both options, but women who chose a trial of labour and VBAC were more knowledgeable than those who chose an ERCS.¹² Two studies reported that women stated that practical information on health risks and benefits were lacking from health professionals and felt statistical information was less understood.^{16, 24}

Maternity health professionals who provided quality of individualized care were specifically mentioned as important to most women in the studies. Compassion, empathy, patience, fear acknowledgement, and respectful listening were the traits expected of health professionals.^{14, 18, 22, 23} Listening was identified as an important thread in several studies for: decision-making, trust, and de-briefing previous birth experiences.^{18, 21, 23} Women want to receive psychosocial and spiritual care beyond routine care and need information provided with time to process and make decisions.^{11, 14, 21} Chan et al. and Munro et al. documented the rushed antenatal appointments and one-way discussions that led to women being told what to do instead of shared decision-making.^{14, 21} Women preferred continuity of care with a trusted health professional who gave them time for education and questions.^{13, 14, 18, 22, 23}

Some of the studies highlighted the communication styles, timing, and content of discussions between health care providers and women. Two studies explained that women needed a clearer understanding of the factors leading to their previous CS and the likelihood of a repeat indication.^{18, 23} Munro et al. and Nilsson et al. added that this understanding should be given in the early postnatal period of the primary caesarean.^{21, 23} Davis et al. highlighted that women desire to hear the positives rather than focusing on the risks of either mode of birth.¹⁸

However, women in the study by Nilsson et al. wanted unglorified information from their healthcare provider that was straightforward and realistic.²³ When communication styles involved ongoing discussions with alternative, realistic plans and choices, women developed a trusting relationship with their healthcare professionals.¹⁴ Most authors reported that not all health professionals were meeting these communication needs and the studies show that often women feel unsupported, ill-educated, and unprepared to make an informed decision about their NBAC.^{14, 18, 20-22}

Many women in these studies experienced 'scare tactics' from their health professionals. The scare tactics included threats of death to themselves or their baby from uterine rupture and haemorrhage, or hysterectomy and no further children.^{13, 14, 20-22} In these cases, the risks were unbalanced in favour of ERCS, and women felt VBAC was the most risky option.^{16, 22} Some health professionals explained care would be withdrawn if women refused to comply with policies, even if birth was imminent.^{13, 17} It was reported that experienced health professionals informed the women that their bodies were not capable of vaginal birth due to a small or misshapen pelvis despite no confirmed evidence.^{12, 13, 17} The influence of these scare tactics by health professionals, combined with the impact of their previous labour and birth experience, led to women fearing labour and vaginal birth.

2. Impact of Previous Labour and Birth Experience

All but two studies showed how past experiences were strong predictors for future decision-making. Despite all women having experienced a CS birth, the effect of their birth impacted their current decision-making in various ways. Akgun and Boz¹¹ described some women's CS as a multifaceted 'traumatic' experience involving depression, fear of surgery and death, and pangs of remorse. Chen et al.¹⁵ and Simeone et al.²⁴ also described the negative memories of CS births impacted on the women's physical,

psychological, and social aspects of life. Specific negative experiences women wished to avoid included a long and traumatic labour, especially inductions of labour and/or failed instrumental birth resulting in an emergency CS.^{11, 14, 15, 18, 22, 23} Some women were 'traumatised' by a lack of privacy and informed consent for maternal positioning, vaginal touch or emergency procedures.^{11, 14, 17} Other women focused on the extended recovery time and long-lasting pain of the CS operation.^{15, 24} The combination of a long labour and then an emergency CS caused some women to feel they suffered twice or unnecessarily.^{16, 17, 22, 23}

Psychological sequelae in being unable to achieve a vaginal birth and/or concern of an inability to give birth vaginally in the future exacerbated feelings of fear, failure, and disappointment.^{15, 18, 21, 23, 24} Attanasio et al. reported the women's disappointment extended to a feeling of missing out on a positive experience in their first birth.¹² Fears developed from a previous birth experience created varied responses in the women. Some women were compelled to experience a vaginal birth at home and avoid hospitals, while others wished to avoid the labour and vaginal birth experience entirely and opted for an ERCS.^{14, 16, 18, 21-23} Some women feared the unknown as they did not experience labour with their previous birth and felt as though they were primiparous and required education and support from health professionals acknowledging this status.²³

Family, friends, and cultural fears also influenced women's decision making. Women were strongly influenced by their partner's fears. Partners were traumatised by previous experiences and encouraged an ERCS to avoid feelings of helplessness and fear again.²² Women felt their partners would be reassured by a known outcome by choosing an ERCS.²² Family members, especially in a culture of "once a CS, always a CS" pressured women into an ERCS.^{22, 24} Alternatively, cultural expectations of vaginal birth led to shame of their initial CS and encouraged women to

attempt a VBAC.^{21, 23}

The previous birth experience negatively impacted the feelings of motherhood and bonding as identified by some women who were unable to care for their newborn due to immobility and pain of CS surgery and occasionally failed instrumental birth.^{11, 15, 24} Anxiety increased for women who were separated from their newborn immediately after CS due to hospital policy preventing skin-to-skin contact (in the operating theatre and recovery) or the need for the newborn to attend the nursery.^{11, 15, 21} Separation created difficulties with bonding and breastfeeding, which some women described as a deficiency in their maternal nature, increasing their perception of failure and often resulting in post-partum depression and anxiety.^{11, 15, 21}

A positive CS experience influenced some women to decide for ERCS and perceived the CS as a known experience that was safe. Women felt that they knew what to expect, the outcome was certain, and they were allowed to plan.¹⁵ Most of the women with a calm, positive, and previous elective CS birth did not experience labour due to breech presentation or placenta praevia.^{21, 23} Most of these women feared the uncertainty and pain of labour and vaginal birth and lacked confidence in their ability to give birth vaginally.²¹⁻²³ The women's previous birth experience, whether positive or negative, influenced their perception of the optimal birth experience for their next pregnancy.

3. *Optimal Experience*

Women chose to approach the NBAC in different ways. A shorter recovery period was considered important to most women in the included studies with women who preferred a VBAC, describing the less painful and shorter recovery as a reason for their preference.^{12, 15, 16, 18, 21-24} A shorter stay in hospital and less time away from a toddler was also mentioned as an advantage of vaginal birth.²² Women, especially those with little social support, wished a faster recovery to independently drive a car; care for an older child, a newborn,

their husband; and to return to full time work.^{15, 18, 21, 24} Other reasons for preferring a VBAC included the inconvenience of CS birth such as catheterization, intravenous equipment and immobility which added to women's physical discomfort and impacted their interaction with their newborn.^{15, 24} Immediate skin-to-skin and uninterrupted bonding with their baby which led to better breastfeeding outcomes was a consideration for many women considering a VBAC.²¹⁻²⁴ However, other women had concerns about perineal muscle strength, incontinence, and episiotomies feeling a CS birth prevented these complications.^{16, 21, 23} Alternatively, Attanasio et al. mentioned a few women who had a positive recovery experience after their CS and stated a better recovery post-caesarean as the reason for their choice of an ERCS over a VBAC.¹² Also, Munro et al. emphasized a lack of social support as a reason for women to decide for an ERCS to ensure scheduled help from family and friends.²¹

A thread that ran through many narratives was that vaginal birth was natural, a rite of passage and integral to becoming a mother.^{12, 17, 19, 22, 24} Women who believed birth was a natural process felt confident to achieve a vaginal birth by listening to their bodies.^{11-13, 17-19, 22, 24} There was a feeling of vaginal birth being fulfilling and an achievement through sweat and pain.²²⁻²⁴ A desire to experience the moment of spontaneous birth, discover the sex of the baby, and share this intimate moment with their partner was considered important to many women.^{21, 22, 24} Women simply stated they wanted to experience labor and vaginal birth often to feel included by other women; be able to share their birth stories; and feel the happiness of other parents.^{12, 15, 18, 19, 22-24} A goal of natural birth stemmed from a desire to gain social acceptance among other women.^{23, 24}

Cultural considerations also impacted the idea of the optimal birth experience. In Taiwan, CS birth is considered harmful and compromises ongoing health, whereas vaginal birth is considered to keep the Qi balance of Yin and Yang.¹⁵ In the Netherlands, women

and care-givers consider vaginal birth as normal.²³ In Sweden, vaginal birth and breastfeeding are prestigious and a female virtue, especially to give birth without pain relief.²³ Minimizing drug intervention was culturally important to some women in Italy and USA for the health of the mother and newborn.^{19, 24} In Sweden and Taiwan, women felt labor and birth was the best option for the baby and the responsibility of a good mother.^{15, 23} Contradicting views were found by Simeone et al. as women in Italy felt CS was the safest mode following a previous CS and felt intense pressure from family not to attempt a VBAC.²⁴

Each woman acts in what she perceives as the best interests of her child, though for opposing reasons and this thread of safety, both physical and emotional reasons were explored in most studies. The most common physical reason for women who had chosen an ERCS was the belief that a CS operation was safer for the baby.^{15, 12, 21} However, women who had chose VBAC stated vaginal birth was safer.^{12, 23} Some women in the Chen et al.'s study explained the positive effects on the baby's respiratory system in vaginal birth, while others feared injury in the birth canal and requested a CS.¹⁵ Dahlen and Homer's global study of 311 blogs found out that women who believed CS was the safest mode of birth for their baby felt sacrificing their bodies and desires for vaginal birth was unselfish, motherly behavior.¹⁷ Nilsson et al. indicated that the safety and well-being of the baby is the highest priority; however, Chan et al. argues that a baby born healthy and alive is poor compensation for neglecting woman-centered care.^{14, 23} Emotional safety revolved around a planned birth experience and a sense of control, often stated by women as a reason for an ERCS.^{13, 15, 21} Specifically, women felt the risk of uterine rupture during VBAC meant CS was a controlled and safe mode of birth.^{16, 24} However, Chen et al. illustrated that assumptions of safety were often based on misunderstandings of the risks and benefits of both modes of birth.¹⁶ As the conflicting view

above shows, safety concerns do not predict women's choice on their next mode of birth.¹⁹

4. *Being in Control*

Control was expressed in various ways, by both authors and women across the studies, such as self-educating, supporting emotionally, balancing the risks; and participating actively in decision-making. These sub-themes are intertwined. Women were able to gain the confidence and knowledge to take control of their birth experience as they sought further education, emotional support from peers, and balance in the risks of each mode of birth. Many studies found that women felt they did not receive enough information from health professionals and undertook their own research to self-educate about VBAC.^{11, 13, 14, 20, 22, 24} On-line sources used for self-education included broad Internet searches, blogs, and social media sites.^{11, 16, 17, 21-24} Chen et al. highlighted that some women obtained evidence-informed knowledge, while others did not.¹⁵ The Internet holds both accurate and inaccurate information with inaccurate information skewing some women's opinions.¹⁶ These skewed opinions are corroborated by celebrities and media representing CS birth as easy and neglect to state the risks and potential complications.²² The reliability of information from the media and Internet sources prompted many women who would prefer to receive high quality information from health professionals on the benefits and risks of both VBAC and ERCS.^{16, 22} Many women who could not decide on their mode of birth also practiced self-education; however, an understanding of the self-education of women choosing an ERCS was not thoroughly explored in the included studies.^{14, 21-23}

Another thread in the theme of being in control was online peer support through social media and blogs, which have a large number of followers, especially for women who wanted or had attempted a VBAC.^{11, 16, 17} The information derived from these online communities were both factual and experiential.¹³ Women found

like-minded peers who gave encouragement and motivation to choose a VBAC.^{11, 21} Strong bonds formed as women supported each other by sharing common experiences and providing a platform for birth debrief.^{17, 22, 23} Simeone et al. expounded that blogs allowed women to gather information given freely and without taboos while maintaining anonymity.²⁴

Balancing risks, or pros and cons, was identified as a common decision-making process in the studies.^{11, 13, 16, 20} The women decided on which risks were acceptable and what was most important to their individual beliefs and situation.^{11, 18, 21} The decision was often described as extremely difficult and stressful with their preferred mode of birth often contrasting their actual choice once tradeoffs were made between clinical and social outcomes.^{17, 21, 23} The 'risk' of uterine rupture was the greatest risk expressed by health professionals and women.^{17, 18, 20, 22} To mitigate this risk, some women deliberately increased their pregnancy spacing to strengthen their uterus.^{15, 16, 18} Women also felt reassured by birthing in a hospital with close monitoring to intervene, if necessary.^{16, 18} Whilst some women felt forced to take additional risks such as home-birthing, free-birthing or labouring at home until fully dilated due to hospital policies rejecting VBACs as a birthing option.^{13, 17, 21}

Knowledge and peer support enabled women to gain confidence to be active participants in decision-making and gained more control in their birth experience.¹³ In some cases, women were supported by health professionals in their decision-making, while others had to convince their caregivers of their views through evidence-informed knowledge.^{11, 14, 15} Other women actively changed care providers to ensure support or enlisted partners and doulas as advocates.^{11, 14, 21} Fragmented care with multiple opinions of various health professionals inhibited shared decision-making.²² Women also found a difference in risk threshold between themselves and their care providers which resulted in disunity and caused women to be

guided by friends, family, and like-minded peers.²² In contrast, women who participated in collaborative decision-making reported greater autonomy and more respectful care.¹⁴ Women also wanted the ability to change their mind or have options available such as a booked caesarean with the option to VBAC if spontaneous labor ensued.^{14, 18} Munro et al. and Nilsson et al. found that being an active and empowered participant in the decision-making process led to greater birth experience satisfaction regardless of the mode of birth.^{21, 22} However, failure of health professionals to keep agreements was highly damaging to a trusting relationship leading to reduced confidence and empowerment.²³ In general, women felt that in their first pregnancy they were unaware of their choices and role in decision-making and wished for more involvement in their next pregnancy and birth.¹⁴

From step 7, expressing the synthesis, and identification of the four themes and 15 subthemes, the authors reached consensus on three important factors that influenced women's decision-making; they included the perspective of women who choose an ERCS, health professionals' influence and model of care, and the role of partners in NBAC decision-making.

DISCUSSION

The findings of this meta-ethnography present qualitative evidence from the perspective of women who have had a CS and must decide on a mode of birth for the next birth. Women's decision-making regarding NBAC is complex and varied with three important factors identified: the perspective of women who choose an ERCS, health professionals' influence and model of care, and the role of partners in NBAC decision-making.

The factors that influence women who choose an ERCS is not well understood as there are no studies focusing specifically on this group of women. However, within the themes of the studies reviewed, women identified that the main reasons for an ERCS were a desire

for a controlled and known experience due to the trauma of the previous birth notably a difficult labour leading to an emergency CS.^{15, 16, 21} Birth trauma is associated with many unplanned interventions during childbirth, including emergency CS.²⁵ Benton et al.'s literature review also found that emergency CS negatively impacted infant feeding, birth satisfaction and self-esteem.²⁵ Women who report a negative birth experience also have an increased fear of childbirth in a subsequent pregnancy.²⁶ Women who fear childbirth are more likely to choose an elective CS than women who do not.²⁵ Interventions to address fear of childbirth, especially after a previous traumatic experience, could reduce women's fear in a subsequent pregnancy.²⁷ However, more research is required to identify effective interventions to prevent fear of childbirth and address birth trauma.^{25, 27}

It could be argued that understanding these and other factors influencing women to choose an ERCS is paramount to reduce the overall CS rate as these are the women who could potentially reduce the CS rate.

Health professionals' opinions have an influential impact on women's decision on VBAC or ERCS. Encouragement, empowerment, and continuity of carer from maternity health professionals are essential practices that can increase women's confidence to give birth vaginally.^{14, 22} Women's opinions and fears on NBAC were frequently determined in the early postnatal period after a CS or in the pregnancy interval.^{21, 23} Furthermore, the mode of birth decision is often made by women before a subsequent pregnancy.²¹

Current, evidence-informed education provided in the first trimester of a subsequent pregnancy is a strategy that may assist women in making an objective decision. However, Kelly and Barker suggest women may be less likely to listen and change their predetermined NBAC decision.²⁸ Munro et al. and Nilsson et al. recommended that women should receive debriefing by relevant health professionals in the early postnatal period.^{21, 23} The debriefing

should involve an opportunity to ask questions and an explanation of the indications of the CS with balanced evidence-informed information on the pros and cons of both modes of birth in a subsequent pregnancy based on the woman's individual risk factor.^{21, 23} A recent scoping review by Watson et al. clearly identifies the lack of communication, compassion, and understanding from health care professionals that exacerbated traumatic experiences.²⁹ The pillars of shared decision-making include early debriefing and education providing the woman with time to reflect on her birth and her personal values, and weigh her options before conception of the next pregnancy.^{14, 21, 30}

The role of an intimate partner in health-related decision-making is an acknowledged, yet under-researched, topic and as such the role of the partner in decision-making was under-represented in the studies included in this meta-ethnography. The research that has been conducted on the influence of partners on pregnancy and childbirth focuses on contraception and breastfeeding outcomes.^{31, 32} In these studies, the partner was found to have a strong influence on decision-making, either as a supporter or a deterrent, with some women changing their behavior or preferences to align with a partner's preference.^{31, 32} It would be reasonable to assume that partners would have influence on other important decisions such as mode of birth after CS. Munro et al. specifically mentions women's desire to have their partner involved in the NBAC decision-making.²¹ Two other studies explored the influence of partners on requesting an ERCS due to previous birth trauma or cultural expectations of "once a CS, always a CS".^{22, 23} Finally, women who participated in the study carried out by Simeone et al. desired to share a vaginal birth experience with their partners, encouraging a VBAC.²⁴ All four studies that mentioned the partner's roles described different roles in influencing a woman's decision-making process. There is an identified need to explore more fully the influence of intimate partner's beliefs on women who are deciding on an NBAC mode of birth.

The findings of this meta-ethnography highlight the need for all women to receive thorough debriefing practices in the early postnatal period after a CS with a relevant health professional who has the skills and knowledge to provide balanced information on VBAC and ERCS. Women would also benefit from a health policy that increased access to continuity of care midwifery models for all women, including pregnancies deemed as high risk and those undergoing VBAC. To address the limitations of this meta-ethnography and its knowledge gaps, we recommend that further research is required to investigate why health care professionals may have negative views of VBAC; and how health professionals can increase women's confidence to choose VBAC. An identified gap in the literature that requires further exploration are the factors that influence eligible women to choose an ERCS over a VBAC and partner's influence in the decision-making process. Furthermore, the opinions of women who experienced an emergency CS need to be explored separately from women who underwent an elective CS.

The limitations of this meta-ethnography are that whilst the literature search was comprehensive, the inclusion of only published qualitative literature in the English language might have missed some studies. Although the database search was extensive, it did not include the Web of science or Scopus. A strength of this meta-ethnography is incorporating women from a range of countries and cultural backgrounds and exploring their views on VBAC.

CONCLUSION

The factors that influence a woman's decision on her chosen mode of birth after CS are multifaceted and complicated. These decisions are influenced by the opinions of health professionals, cultural beliefs, and personal beliefs that at times contradict evidence-informed practice. This meta-ethnography review of the literature highlights the influence of health professionals on women's decision-making both negatively

and positively. To assist in decision-making, women need respectful and supportive health professionals who provide evidence-informed information about the risks and benefits of each mode of birth. To do this, health professionals need current evidence-informed knowledge to provide supportive shared decision-making; the means to debrief women regarding the indication for their previous CS; and address issues of safety, fear, and expectations of childbirth to meet individual needs. With evidence supporting VBAC, as the safest option for most women, health professional support and balanced evidence-informed information can make a significant difference in the rising rates of clinically unnecessary ERCS.

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