Qualitative Health Research
1–16

DOI: 10.1177/1049732315612041
qhr.sagepub.com
SAGE

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

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Abstract

Despite the consequences for women's health, a repeat cesarean section (CS) birth after a previous CS is common in Western countries. Vaginal Birth After Cesarean (VBAC) is recommended for most women, yet VBAC rates are decreasing and vary across maternity organizations and countries. We investigated women's views on factors of importance for improving the rate of VBAC in countries where VBAC rates are high. We interviewed 22 women who had experienced VBAC in Finland, the Netherlands, and Sweden. We used content analysis, which revealed five categories: receiving information from supportive clinicians, receiving professional support from a calm and confident midwife/obstetrician during childbirth, knowing the advantages of VBAC, letting go of the previous childbirth in preparation for the new birth, and viewing VBAC as the first alternative for all involved when no complications are present. These findings reflect not only women's needs but also sociocultural factors influencing their views on VBAC.

Keywords

childbirth; content analysis; focus groups; health care, culture of; interviews; midwifery; nursing, maternity; relationships; qualitative; Europe; Vaginal Birth After Cesarean; VBAC

There is a widespread global concern over the continuing rise in cesarean section (CS) birth because of the higher risks for women's health (EURO-PERISTAT, 2013; Organisation for Economic Co-Operation and Development, 2013; Villar et al., 2007). Despite vaginal birth after a previous cesarean (VBAC) being the recommended option, and despite successful VBAC being associated with fewer major complications (McMahon, Luther, Bowes, & Olshan, 1996), a shorter recovery period, and high maternal satisfaction (Shorten & Shorten, 2012; Shorten, Shorten, Keogh, West, & Morris, 2005), repeat CS following previous CS is the largest determinant contributing to increased CS rates (EURO-PERISTAT, 2013; Guise et al., 2010). The U.K. National Sentinel study on CS showed that repeat CS contributed to 23% of the overall CS rate (Royal College of Obstetricians & Gynaecologists, 2001), and a study by Kazmi, Saiseema, and Khan (2012) showed that in Oman, 33% of the overall CS rate resulted from repeat CS. Although the reasons for repeat CS are still unclear, studies indicate such motivations as fear of uterine rupture in a subsequent birth, fear of health care providers who do not offer any choice other than a repeat CS, and convenience for women and clinicians (Bryant, Porter, Tracy, & Sullivan, 2007; Hopkins, 2000; Weaver, Statham, & Richards, 2007).

VBAC is associated with lower maternal mortality and less overall morbidity for mothers and babies (Guise et al., 2010). However, based on a limited number of randomized, controlled trials that compared outcomes for women planning a repeat elective CS birth with women planning a vaginal birth (Dodd, Crowther, Huertas, Guise, & Horey, 2013), the currently available evidence demonstrates that VBAC is a reasonable and safe option for most women with previous CS (Guise et al., 2010). In the European Union, VBAC rates are significantly lower in Germany, Ireland, and Italy, at 29% to 36%, than those in Finland, the Netherlands, and Sweden, at 45% to 55% (EURO-PERISTAT, 2008). The variability in VBAC and

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attempted VBAC rates between and within countries indicates the capacity to increase the proportion of women attempting VBAC and vaginal births (EURO-PERISTAT, 2013; Scott, 2011). Although women's views of vaginal birth have been explored in Finland (Callister, Vehvilainen-Julkunen, & Lauri, 2001) and of home birth in the Netherlands (Johnson, Callister, Freeborn, Beckstrand, & Huender, 2007), more insight is needed into women's views regarding how VBAC rates might be improved.

A systematic review and meta-synthesis (Lundgren, Begley, Gross, & Bondas, 2012) and a limited number of qualitative studies published since then (Dahlen & Homer, 2013; Godden, Hauck, Hardwick, & Bayes, 2012) have looked into different aspects of women's experiences of VBAC. All originated from Anglo-American countries, and the results showed that, despite the evidence underpinning VBAC as a safe option for women with previous CS birth, institutions and professionals are not supportive of VBAC. The communication with caregivers was described as highly risk-oriented and not supportive of women desiring VBAC, which can eliminate trust and generate fear in women seeking to make the right choice (Dahlen & Homer, 2013; Godden et al., 2012; Lundgren et al., 2012). As a result of this unsupportive environment, making VBAC happen demands strong motivation and a sense of responsibility on the part of women (Godden et al., 2012). In the three articles, women often reported they had to negotiate a system that was generally not in favor of VBAC and required them to seek information about VBAC themselves by, for example, searching the Internet and by meeting women who had experienced VBAC (Dahlen & Homer, 2013; Godden et al., 2012; Lundgren et al., 2012).

The results also demonstrated that women want to be involved in decision making (Dahlen & Homer, 2013; Godden et al., 2012; Lundgren et al., 2012). The women in these studies wanted to feel in control of their choice, mostly because they experienced a lack of control in the previous birth. They mentioned a strong desire to heal from the previous experience by choosing either VBAC or a planned repeat CS. Finally, women, in contrast with caregivers, see all kinds of positive aspects of giving birth vaginally. There are practical benefits such as faster recovery, and psychological aspects such as the meaningful experience of giving birth naturally and the mother–baby bonding. Some women mentioned giving birth vaginally as fundamental to motherhood (Godden et al., 2012; Lundgren et al., 2012).

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

This study is part of the ongoing 4-year OptiBIRTH project. The key aim of the project is to improve maternal health service delivery and optimize childbirth by increasing VBAC through enhanced woman-centered maternity care across Europe (www.optibirth.eu/optibirth/). The findings of this study, together with the findings from a similar study of clinicians' views on VBAC, as well as women's and clinicians' views from countries with low VBAC rates, were used to develop an antenatal educational intervention targeted toward women and clinicians. This intervention is being tested in a randomized trial within the OptiBIRTH project in three European countries with low VBAC rates. This study focused on interviews with women from countries with high VBAC rates: Finland (FI), the Netherlands (NL), and Sweden (SE).

Settings

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

In the Netherlands, maternity care is organized in a somewhat different way. Every Dutch adult is obliged to have insurance for standard care; midwifery care is included. The insurance is partly funded through taxes, but also includes an individual cost (± €1,100, US$1208), plus an income-related contribution. Low-risk women may choose whether to give birth at home or at an outpatient clinic. However, as an outpatient, a woman has to pay the hospital around €325, US$357 (Royal Dutch Organisation of Midwives, 2012). The rate of home birth is higher in the Netherlands, about 20%, but is decreasing. Normal pregnancy and childbirth are primarily led by independent midwives, but if risk factors arise or complications occur, the midwife refers the woman to secondary or tertiary obstetric care, where the obstetrician

takes over responsibility. Moreover, midwives work in a clinical setting and take care of most births (Cronie, Rijnders, & Buitendijk, 2012). Risk assessment in the Netherlands is based on the Obstetric Indication List (OIL), a national guideline specifying indications for referral based on evidence and/or consensus by professionals involved in maternity care.

The overall rate of CS is low in the three countries: For Finland, it is 16.8%, the Netherlands 17%, and Sweden 17.1% (EURO-PERISTAT, 2013). In contrast, the rate of VBAC is high in these countries, varying between 45% and 55% (EURO-PERISTAT, 2008).

Care for Pregnant Women With Previous CS Birth

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

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

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

Method

This is a qualitative descriptive study using conventional content analysis of the data (Hsieh & Shannon, 2005; Polit & Beck, 2012). Such an approach is useful when little is known about the topic of research (Estabrooks, Field, & Morse, 1994; Hsieh & Shannon, 2005), which in our study was factors of importance for improving the rate of VBAC among women in high VBAC countries. Content analysis is defined as "a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use" (Krippendorff, 2004, p. 18). Methods of systematic analyses of text have their origins from theology in the 17th century, were later developed into content analysis, and were used primarily in research on media, communication, and propaganda during the 20th century (Hsieh & Shannon, 2005; Krippendorff, 2004). Content analysis is used in research with both quantitative and qualitative approaches, and consequently has influences from logical positivism, as well as more recently from hermeneutics (Elo & Kyngäs, 2008; Krippendorff, 2004). For our study, we needed an analytic method that would reveal the women's views. The method of content analysis described by Elo and Kyngäs (2008) allows for some amount of interpretation when making decisions on the content of different categories, which was appropriate for the research question in this study: women's views on factors of importance for improving the rate of VBAC. We used a conventional content analysis approach because the research purpose was to gain a richer understanding. This approach implies creating categories from data during the data analysis, in contrast to directed and summative approaches where the researcher uses existing theory to develop initial codes for the analysis (Hsieh & Shannon, 2005).

The original study plan was to perform focus group interviews with women in countries with high and low rates of VBAC. Focus groups are a method developed by Robert Merton and Paul Lazarsfeld in the 1940s (Wibeck, 2010). From the beginning, focus groups were mostly used in marketing research, but the method has its basis in social science. It can be used to investigate values, attitudes, and the complex phenomena that originate from social interaction (Barbour, 2010; Wibeck, 2010). Besides the participants, a focus group implies researchers who stimulate the discussion and observe the participants' interaction (Barbour, 2010). As the interviews were part of the intervention development for the OptiBIRTH project, and timely results were of the essence, focus groups could not be performed in all settings, and therefore, this study used a combination of focus group and individual interviews. The individual interviews were semistructured (Polit & Beck, 2012), using an interview or topic guide with the same five questions posed in the same order as in the focus group interviews. Our choice of content analysis as the method of analysis was based on its appropriateness for the research question, and on its suitability for use with the data from both focus groups and individual interviews (Krippendorff, 2004).

Participants and Data Collection

Individual or focus group interviews with 22 women were conducted in three countries during 2012–2013. The

data were derived from eight individual interviews (FI), one group interview with 6 participants and three individual interviews (NL), and one group interview with 3 participants and two individual interviews (SE). In each country, the interviews were conducted with women on one single occasion in both urban and rural maternity unit settings. All women were of fertile age and had experienced VBAC.

In Finland, women with a previous CS who had given birth vaginally during 2010 and 2011 were identified via hospital registers in one birth setting located in a university hospital in a medium-size city. VBAC rates in the hospital were among the highest in the country, 56.8% in 2011. The women were contacted by mail, with a letter containing information about the study. Women interested in participating filled in and returned a response letter. Thereafter, they were contacted via telephone by the researcher and were provided with additional information. An appointment for an interview was arranged for women who gave their verbal agreement on the telephone. Before the actual interview, the women signed a consent form. All eight individual interviews were performed during February to April 2013 in a location chosen by the women. Each interview lasted approximately 15 to 20 minutes and was performed by a research assistant.

In the Netherlands, as all women who experience VBAC are cared for by primary care midwives during the prenatal period, we asked two midwifery practices, one rural and one urban, both having approximately 300 registered women per year, to identify those who had experienced VBAC during 2010–2012. These women gave birth in different hospitals, where the VBAC rates are about 54%. The women were contacted by telephone and informed about the study by their former midwife. Women interested in participating were provided with additional information by mail and gave verbal approval for participation to their midwife. Thereafter, an appointment for an interview was arranged, and the women signed a consent form beforehand. Both forms of interviews were held in November and December 2012. The focus group interview, which was held at the midwifery practice, was performed by two experienced interviewers (Evelien van Limbeek and one assistant) and lasted 75 minutes. The individual interviews, which took place at either the midwifery practice or another location preferred by the women, were performed by Evelien van Limbeek and lasted 20 to 30 minutes.

In Sweden, women with a previous CS who had given birth vaginally during 2010 and 2011 were identified via hospital records in two maternity settings. One maternity setting is placed at a university hospital in a large city. The other maternity setting is located at a hospital in a smaller city. VBAC rates in both settings were about 55% in 2013. The women were contacted by mail, with a letter containing information on the study. Women interested in participating filled in and returned a response letter. Thereafter, they were contacted via telephone by the researcher and were provided with additional information. An appointment for an interview was arranged for women who gave their verbal agreement on the telephone. Before the actual interview, the women signed a consent form. Both forms of interviews were held during 2012 and 2013. The focus group interview, which took place in a conference room at a university, was facilitated by Christina Nilsson and Ingela Lundgren and ran for 90 minutes. The individual interviews, which took place either in a private room normally used for meetings at a hospital or in an undisturbed meeting room at a university, were conducted by Christina Nilsson and lasted about 30 minutes.

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

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

Ethical Approval

Ethical approval was obtained for the OptiBIRTH project as a whole and from each country separately: Medical Ethical Examination Board, Atrium-Orbis-Zuyd, 12N101 (NL); Regional Ethical Review Board, Gothenburg, 739-12 (SE); Committee on Research Ethics, University of Eastern Finland, 20/2012 (FI).

Data Analysis

When analyzing the focus group and individual interviews, we used conventional inductive content analysis (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). The focus group and individual interviews were transcribed verbatim in the participants' native language. All data were regarded as a whole, analyzed in the same way, and organized through open coding, creation of categories, and abstraction (Elo & Kyngäs, 2008). We used the following steps during the analysis: selecting the units of analysis,

making sense of the data as a whole, doing open coding, using coding sheets, grouping, categorizing, and abstracting (Elo & Kyngäs, 2008). The units of analysis were parts of the interview texts answering the five questions. Each participating researcher in the three countries did the open coding and created subcategories through abstraction in their native language up to a certain point. First, the transcribed data were read in their entirety. Next, notes and headings that answered each question (units of analysis) were written in the margins. These notes were grouped together on coding sheets, ending up with the formation of 5 to 10 subcategories for each question, together with quotations. Creating a category implies the data were assessed as belonging to a certain group when comparing similarities to and differences with other groups of data (Elo & Kyngäs, 2008). After the formation of the subcategories, the text was translated into English and sent to Christina Nilsson.

Subsequently, Christina Nilsson and Ingela Lundgren analyzed all the subcategories from the three research groups. In this step, the subcategories emerging from each question were grouped together according to their similarities and differences, and further abstracted into overall subcategories and main categories. Abstraction means a more general description of data through creating categories and subcategories labeled with words expressing their characteristics (Elo & Kyngäs, 2008). Subcategories describe similar content under a main category (Elo & Kyngäs, 2008). During this process of the analysis, we held Skype meetings to discuss the findings. We also validated the data on several occasions in each country via email, using the Track Changes tool in MS Word. Finally, all researchers validated the final results.

Results

The views on factors of importance for improving the rate of VBAC among women in high VBAC countries are presented in five categories: receiving information from supportive clinicians, receiving professional support from a calm and confident midwife or obstetrician during childbirth, knowing the advantages of VBAC, letting go of the previous childbirth in preparation for the new birth, and viewing VBAC as the first alternative for all involved when no complications are present. These categories are presented below with their subcategories, and with illustrative quotations. At the end of each quote, the woman's country code is indicated: FI (Finland), NL (the Netherlands), and SE (Sweden).

Receiving Information From Supportive Clinicians

The first category that emerged was receiving information from supportive clinicians. The category addresses the women's need for tailored information, as well as an emphatic and supporting attitude from clinicians when giving them the information, which was characterized by the following subcategories: having realistic information tailored to women's needs; having a midwife or doctor during pregnancy who listens, encourages, and motivates; and receiving guidance and support for VBAC, as well as being listened to when asking for CS.

Having realistic information tailored to women's needs. The women considered that information from clinicians should be tailored to women's needs. They reported that it is easier for them to go through VBAC when they are well informed and know what is going to happen. It is important for her to be heard and to receive answers to her questions. They said that information should contain both facts and experiences. They described that the information they receive must be straightforward and realistic and should provide answers to their questions. The information should not be idealized—it must also contain what is painful and difficult. "You need very clear information, no glorification" (SE). However, the need for information differs among women; caregivers must therefore adjust their information and counseling to the needs of the specific woman.

Overall, women in this study wanted to hear that, from a professional point of view, VBAC is unquestionably the first choice. "After the CS, we talked in the health center [with the physician, who said] that there is no obstacle to vaginal birth" (FI). The information that a CS birth is not an obstacle for future vaginal births should be given at an early stage, preferably as soon as the woman comes back from the operation ward after her first CS. These women suggested that women should be given the opportunity to have a face-to-face meeting with a doctor and to ask questions, before leaving the hospital. The information from professionals should contain facts about complications, indicate what the CS signifies for subsequent vaginal births, and clarify that there are no urgent reasons for a second CS.

The women asked for general knowledge about how the scar would heal and how to deal with it in the next pregnancy. For example, one said, "That wasn't clear to me and then you make your own scenario in your head. Oh my God, what if this scar will tear? These things went through my head" (NL). Potential rupture of the uterine scar is something that the women from all three countries expressed fear about.

Having a midwife or doctor during pregnancy who listens, encourages, and motivates. The women described the midwife or physician at the antenatal clinic as the central person in supporting women to dare to give birth vaginally: "She really listened to me, which was of great importance to me, as I felt that I had confidence in her" (SE). Support

in this case primarily means listening to, encouraging, and motivating the woman to elect to have a VBAC. A flexible visit schedule, allowing for additional visits, is also helpful, and the midwife must be aware that, after a previous CS, a woman may feel unsure about vaginal birth as she has never experienced it before and needs extra attention. For example, one woman said, "You feel after CS that you are a primipara, but you are not treated like that although in a sense you are primiparous" (FI). The women described clinicians' and partners' support, encouragement, and understanding as crucial when their self-confidence is lacking. The women expressed that it is vital that they feel confident. As one said,

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

Confidence was something the women reported that a caregiver could contribute to by establishing a personal relationship in which the women felt safe and that enabled them to rely on the caregiver's expertise. Thorough information and good preparation are factors that enable women to feel confident and trust the caregiver. They want a caregiver who respects and takes them seriously, but sometimes the caregiver acts in a way that limits the woman's trust.

Receiving guidance and support for VBAC, as well as being listened to when asking for CS. The women stated that it is essential that doctors listen to women who ask for a CS birth, as some of them may have strong motives such as fear, or experiences of rape. The women considered that physicians must therefore listen carefully and decide what is best for the individual woman.

The women believed it was a good idea to guide a woman toward VBAC and at the same time have a date booked for a CS. One said, "We had a date for a CS, but I could change my mind and that was a relief. And I realized quite quickly that I didn't want a planned CS; I wanted to go for a vaginal birth" (SE). The women stated that this approach can help them feel more secure as they still have the chance to change their mind and give birth vaginally. In the case of doubt, gentle pressure from the professionals toward VBAC was considered positive.

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

The second category, receiving professional support from a calm and confident midwife or obstetrician during childbirth, addresses the women's need to feel safe during birth, in a peaceful environment where clinicians' attitudes, actions, and promises are vital. The category comprised the following subcategories: providing calm surroundings and continuous attentive guidance, making necessary interventions in time, and taking agreements seriously.

Providing calm surroundings and continuous attentive guidance. The women mentioned several factors of importance for them. Central is good support from a midwife or physician during childbirth. Women in this study prefer calm surroundings during birth and strongly appreciate continuity of care. They believed that a woman's previous CS birth should not make the midwife anxious; moreover, the midwife fully understanding it is the woman's first vaginal birth helps to keep the woman feeling safe. As one woman said, "The midwife's attitudes are key to how the birth succeeds" (FI).

The women appreciate continuous care by, preferably, the same professional. Some women described feeling left alone and being seized by panic when professionals left them. The Dutch women, in particular, commented on this, and sometimes they experienced the obstetrician as running in and out of the birthing room. One woman experienced this:

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

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

The women wanted to be directed through the birth process by a calm and confident professional. They appreciated midwives or obstetricians who told them what to do during labor. Clear instructions helped them reduce fear and gain confidence in their own efficacy. The women mentioned that, particularly for a woman fearing childbirth, it is important to receive support from a midwife who is calm and confident, motivates the woman, and tells her what to do during the birth. The women reported that good contact between the woman and the midwife is essential, and that the midwife needs to acknowledge the woman's pain and give her pain relief in time. According to the women, the midwife must be experienced: New midwives should not care for women who have a fear of childbirth. If a woman arrives at the maternity ward in early labor, she will feel safer if she knows that she will not be sent home again. The women

mentioned that when women feel afraid of giving birth vaginally, it is also helpful to explain thoroughly what is going to happen. They want to know how the baby moves through the birth canal and also want indications of how and when to push and what happens in utero.

Making necessary interventions in time. The women considered that it was acceptable if caregivers motivated them to hold on a little longer, but some thought that they were pushed beyond their limit. One woman explained:

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

In particular, women who had a negative experience during the first birth and many interventions (failed assisted vaginal birth) before CS was decided on emphasized that obstetricians must not hesitate to intervene in this type of situation. Some women considered that they were pushed to the limit. One said, "Why did I have to suffer for 26 hours before they took the baby out, just because the baby was in good condition? . . . I had been screaming for hours that I didn't want to do this" (SE). She also stated that she never received any explanation for why it took so long before the CS was performed, and viewed her suffering as something that could have been avoided, or at least stopped earlier.

Taking agreements seriously. The women mentioned that any prior agreements about the birth must be made known to the midwife or obstetrician who is assisting with the birth. The women did understand that in some circumstances, the birth plans they make will not always come true. However, some women experienced that the professionals did not always keep agreements. For example, one explained,

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

When agreements that could have been kept were not followed, the women believed they were not taken seriously. The failure to keep an agreement was also highly damaging to the relationship between the caregiver and the woman, and resulted in women feeling less confident during the birth.

Furthermore, some women thought that physicians had the tendency to stretch the agreements that had been made. Some of the Dutch women mentioned they sometimes perceived that the physician minimized their worries, and that made them feel they were not a partner in the childbearing process anymore. The women thought they have to feel heard by their midwife or obstetrician in order to play an active role.

Knowing the Advantages of VBAC

The third category, knowing the advantages of VBAC, addresses the women's desire to have a vaginal birth, as well as receive inspiring information about it. This category entailed the following subcategories: having a more emotional, positive, and empowering experience; wanting to experience a vaginal birth; and receiving information from experienced women.

Having a more emotional, positive, and empowering experience. Women in this study considered that knowing about the advantages of vaginal birth could motivate a woman to have a VBAC. They described how it felt good to experience childbirth, to sweat and struggle: "I want the drama, including sweating and struggling, and then a baby arrives. I think it feels odd just laying down, having the cut, and out comes a baby" (SE). The childbirth was an overwhelming experience; one woman described the feeling after her VBAC as "Yes! I did it!" (SE).

The women mentioned that they appreciated the difference between giving birth by CS and giving birth vaginally. The emotional aspects of giving birth vaginally were essential for them. They described the experience as unique and fulfilling despite the pain. One described a feeling of great pride when she gave birth vaginally:

> I think the whole emotional part of giving birth vaginally is an important factor. . . . The feeling that I worked for it, that was wonderful. You could call it pride: Yes, I did that. You see we can do it. (NL)

The women thought they worked hard and suffered during the birth, but it was their own accomplishment and they were extremely proud of themselves. As one described it,

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

If the first childbirth ended up with an emergency CS, some women regarded it as a disappointment. They experienced it more as if someone else was "delivering" the baby, and they did not play a big part in it. The women felt more aware of the whole birth experience compared with giving birth by CS and saw the more active role they play in birth as an important factor for VBAC.

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

Some women experienced the recovery after VBAC as more rapid and less difficult than the recovery after CS. One said,

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

These women described how, after VBAC, they started nurturing their child sooner and were not immobilized by prescribed bed rest. Furthermore, they could return home more quickly.

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

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

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

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

The fourth category, letting go of the previous childbirth in preparation for the new birth, addresses the women's need to process previous births before visualizing the next birth. This category includes the following subcategories: having information and guidance from clinicians, alleviating fear and processing negative birth experiences, and letting go of a previous positive experience of CS.

Having information and guidance from clinicians. The women considered that the midwife or doctor should help the woman to let go of the previous birth and put it aside so that she can focus on the approaching childbirth. One woman described this as follows: "The physician made me [feel] sure that the vaginal birth will be a success and it is going to be a very nice delivery" (FI). Information on what happened during the previous birth was particularly mentioned as understanding previous indications for CS could help women feel more confident about a successful VBAC. One woman explained how she believed the midwife is essential as she can help the woman separate the childbirth experiences and clarify that the next childbirth does not have to be similar to the previous one:

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

The women said the midwife can guide them to a new way of thinking; she should be supportive and strengthen them. If a woman has fears, the midwife should try to find out why, and if necessary refer her to a "fear clinic" and/or a psychologist, or schedule extra visits if the woman wants.

For some, being the only couple who had experienced a CS birth in a group of women and men who had recently become parents was difficult. One said, "I couldn't feel their happiness. I missed coming to a group with others who had the same experiences" (SE). Special parenthood classes at antenatal centers were suggested for women and their partners who have experienced CS. The women proposed that such classes should include education on vaginal childbirth.

Alleviating fear of childbirth and processing negative birth experiences. The women saw fear as one of the main factors that can hinder VBAC, and one woman explained this as, "I told other people [not professionals] all the time that I was afraid. I asked them, what could I expect, how does it start, what do contractions feel like, what do I have to do?" (NL). For Swedish and Finnish women with fear of childbirth, support from midwives at a "fear clinic" gave them the opportunity to talk through both the previous and the impending childbirth and write down a personal birth plan. For example, "After the first delivery, I had a lot of fears. I went to discuss the issue in the 'fear clinic,' as I wanted to experience vaginal birth" (FI). It was considered positive that the partner could also describe his experience of the previous birth. One woman described how the midwife ". . . asked both me and my husband what we wanted to happen. . . . We had to write it down and then go through what we had written, and then we went through the technical details" (SE). To be able to visit the maternity ward was seen as important, as was receiving advice on how to handle the situation in the event of an emergency CS during the next birth.

One woman described an extremely rapid VBAC, something that she was unprepared for and which resulted in a negative childbirth experience: "Even though I'd already given birth to a child, I needed them to understand that this was my first vaginal childbirth because this was a completely new situation" (SE). The contractions were intense and made it difficult for her to understand what was happening, and she was stressed and anxious. She felt exposed, and experienced the midwife as insecure and unaware of it being the woman's first vaginal birth. This woman said she also lacked a postpartum conversation with the midwife, which would have been helpful.

Letting go of a previous positive experience of CS. According to some of the women, a planned CS birth due to breech presentation can be an extraordinarily good experience, particularly if the CS does not lead to separation from the child. "They had a room at the maternity ward, which meant that I could stay there together with my son and husband. . . . I had a very positive experience of CS" (SE). Such positive experience can bring hopes that the next child also will be in a breech position. Moreover, the decision to perform a CS can be experienced as a salvation after being in labor for a long time. Some of the women were relieved that the ordeal finally ended and their baby was born. As a result, they did not say that they would regret it if the next birth ended up as a CS again. One woman said,

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

Some women stated that they had a faster recovery after VBAC than after CS, while others found it slower. For example, some Dutch women mentioned negative aspects such as physical discomfort (e.g., pain, problems holding onto urine, stool problems) that often accompanies vaginal tears or episiotomy. One woman had a number of problems:

> After my natural birth, I was constipated, my breasts were leaking for 4 months. I had all kinds of problems, and with the first [CS], nothing. . . . You hear all kinds of stories about CS being major abdominal surgery, but everything went fine in my case. I had absolutely no problems at all. (NL)

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

The final category, viewing VBAC as the first alternative for all involved when no complications are present, addresses the women's needs for support in decisions on the mode of birth, as well as in their desires to give birth vaginally. The category consists of three subcategories: recognizing that the decision about CS must be taken by professionals with special competence, participating in decision making but not making the final decision, and viewing vaginal birth as the normal thing to do.

Recognizing that the decision about CS must be taken by professionals with special competence. The women stated that decision making about CS birth is not for people in general and should be left to specialists in the field. One explained,

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

The women considered no matter how much a layperson reads, medical knowledge and experience are still required to make an adequate decision. As one woman put it, "It doesn't matter how much I read, I don't have the education, I don't have the experience. Okay, it's my body, but I want someone who really knows what they are doing when they make the decision" (SE). The women stated that they do not want to make the decision by themselves, and that they would rather not make their own choice. They trust that the professional's decision is right and accept it.

The women were clear that the safety and well-being of their baby have the highest priority. One statement exemplifying this was, "I'm just happy that it went well both times and that my children are fine; that's what's most important to me. My own experiences come second" (SE). Most women were willing to follow the advice of professionals that benefits their baby's health; for example,

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

The women stated that they do not want their baby to be exposed to any risk, and they want professionals to put their baby first.

Participating in decision making but not making the final decision. The women from Finland, the Netherlands, and Sweden were asked about their views on shared decision making. However, the women in these countries were not used to decision making together with professionals. On the contrary, some women considered that if women decide themselves, the CS rate would increase, and mentioned that having a CS birth should not be regarded as an easy option. Some women thought that CS is considered by many women as a way of not only avoiding childbirth pain but also avoiding what may be experienced as unpleasant and unknown. However, some women thought the possibility to choose can also increase women's fear.

The women thought that it was important to take part in a discussion with professionals, to receive guidance and support, as well as be listened to, and that "shared decision making" in general is essential, but the final decision must be taken by the specialists. As one woman explained, "I as the patient, together with the doctor, want to have influence on the decision making" (NL). They wanted to influence the decision making, and most of them considered that they were the one making the decision based on the advice of the professional.

Viewing vaginal birth as the normal thing to do. The Dutch women did not think that they made a choice whether or not to have a VBAC. It was simply the normal thing to do when there were no reasons not to give birth vaginally. One woman explained,

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

The women considered that vaginally is how women give birth in the Netherlands. This is the opinion of both the women and their caregivers, so there is little discussion about the mode of birth. Most women come to the professional with the idea of giving birth vaginally and do not think that there is any other option, unless medical complications arise. One woman's experience was as follows:

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

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

The Finnish women said that it felt good to be able to give birth vaginally after a previous CS, because they did not experience the same limitations this time. Health professionals during pregnancy (at the community maternity clinic) supported their decision, and the final decision was made with the midwife and the obstetrician during a birth plan meeting.

The Swedish women mentioned that it feels strange to be able to choose not to give birth vaginally. One woman said, "Vaginal birth must be the basic principle" (SE). The women mentioned that in Swedish society, vaginal childbirth and also breastfeeding are considered the best options. Giving birth vaginally is prestigious. For instance, vaginal birth is regarded as a female virtue, and it is particularly prestigious to give birth without pain relief. A wish to feel capable was mentioned as one of the reasons for choosing VBAC. Modern women want to make their own choices, at the same time believing that prestige affects the mode of birth. However, some of the

Swedish women were suspicious that recommendations of vaginal childbirth could be motivated by a desire to make cost savings in the maternity care system.

Discussion

The main findings from this study demonstrate that for these women in three countries with high VBAC rates, important factors in improving the VBAC rate are concentrated in five categories:

- Receiving information from supportive clinicians
- Receiving professional support from a calm and confident midwife or obstetrician during childbirth
- Knowing the advantages of VBAC
- Letting go of the previous childbirth in preparation for the new birth
- Viewing VBAC as the first alternative for all involved when no complications are present

One of the aims of the OptiBIRTH research project, which this study is part of, is to learn from the best, in this case by listening to the voices of childbearing women living in countries with high VBAC rates. What could professionals from countries with low VBAC rates learn from women in Finland, the Netherlands, and Sweden?

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

Previous research has indicated that support during childbirth is of utmost significance for birthing women in relation to the quality of their experience and the birth outcomes (Hodnett, Gates, Hofmeyr, & Sakala, 2013; Larkin, Begley, & Devane, 2009; Matthews & Callister, 2004). The women in our study highlighted clinicians' individual competence as essential, in particular, their ability to radiate calmness and confidence. The women prefer calm surroundings during birth and clinicians who are confident with VBAC. These findings indicate that women during VBAC seem to need particular forms of support, where clinicians' confidence in VBAC is one important factor, similar to the findings from Godden et al. (2012). These women's need for calm birth surroundings is in line with the concepts of an "environment of care" (Kennedy, Shannon, Chuahorm, & Kravetz, 2004) and a "sanctum" or protective birthing room (Fahy, Parratt, Foureur, & Hastie, 2011). Such birth environments, focused on creating feelings of safety for the birthing woman, are also described as a "birthing atmosphere" (Berg, Olafsdottir, & Lundgren, 2012). This atmosphere includes obstetrical nurses' and midwives' ability to support normality, creating a calm and safe atmosphere that supports women to follow the process of birth (Berg et al., 2012). A calm atmosphere can be difficult to achieve because of institutions' demands for a more medicalized approach when caring for women during a VBAC, compared with a more "normal birth" (B. Hunter, 2004; L. Hunter, 2002). Midwives' and other clinicians' support during birth might involve different approaches to care that are described as being "with woman" or being "with institution" (B. Hunter, 2004; Thorstensson, Ekström, Lundgren, & Hertfelt Wahn, 2012). The "with institution" attitude implies an attention to efficiency, with a focus on physical safety and risk management rather than on the woman's needs (Kennedy et al., 2004; Thorstensson et al., 2012).

The women in our study expressed a need for continuous attentive care. A subgroup analysis suggests that continuous support during childbirth is most effective when the provider is neither part of the hospital staff nor in the woman's social network (Hodnett et al., 2013). Doulas are paraprofessionals who are often employed by the women (C. Hunter, 2012) and whose role lies between natural and professional care (Lundgren, 2010). Doulas are trained and experienced in childbirth to provide women and their partners with physical, emotional, and informational support during labor and birth (International Doulas of North America, 2005). The doula is a coach who mediates a belief in the woman's capacity to give birth (Lundgren, 2010), "holding the space" in terms of creating and maintaining intimacy; doulas and women maintain this intimate space even within the institutionalized medical clinical birth experience (C. Hunter, 2012). More research is needed to understand different caregivers' and support persons' roles in VBAC.

The findings from our study demonstrate the positive aspects for women in giving birth vaginally, where they stated a strong desire to give birth vaginally after a previous

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

The women viewed fear, particularly when related to experiences from the previous CS, to be one of the main factors that could hinder VBAC, and they reported the need to let go of the previous childbirth experience to be able to prepare for the next birth. Giving women the opportunity to tell their story of a distressing, or even traumatic, birth experience (Crowther, Smythe, & Spence, 2014; Thomson, 2011) allows them to share the experience, as well as to discuss fears, missing pieces of information, or feelings of inadequacy or disappointment (Callister, 2004, 2006). This opportunity can be offered both during pregnancy and after the birth, depending on the maternity ward's organization and actual context. Gamble and Creedy (2009) suggested a counseling model for women after a previous distressing or traumatic birth experience, with midwives and nurses providing the counseling. A previous negative childbirth experience is associated with subsequent fear of childbirth to a greater extent than in the previous mode of birth and accompanying obstetric complications (Beck, 2004; Storksen, Garthus-Niegel, Vangen, & Eberhard-Gran, 2013; Nilsson, Lundgren, Karlström, & Hildingsson, 2012). At the so-called "fear clinics" in Finland and Sweden, women can discuss their previous distressing birth experiences and any birth trauma. However, there is a notable lack of studies on how to support women in letting go of a previous negative birth experience, and the actual effects on women's possible fear are as yet unclear. Still, the subsequent childbirth has the potential to either heal or retraumatize women after a previous distressing birth (Beck & Watson, 2010).

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

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

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

present) reflects a cultural fit of VBAC and the conception of birth. This way of thinking is true also in Finland, a country where 99.9% of deliveries are in hospitals. More research is needed to study the cultural aspects of VBAC in countries with high VBAC rates.

In addition to the culture are other influences such as economic or legal differences between countries (Habiba et al., 2006). In Finland, the Netherlands, and Sweden, women are not entitled to have an elective CS birth if there is no medical reason for it. The obstetrician makes the final decision for CS, and the women seem to be content with this situation. The women in our study stated that it was necessary for them to take part in discussions around the mode of birth, and they wanted clinicians to listen carefully to them, but the final decision needed to be made by a professional with knowledge and experience. It was shown previously that giving control to others resolved difficult personal emotions that women experienced in attempting to make an individual choice about the mode of birth (Goodall, McVittie, & Magill, 2009). However, women having less autonomy in decision making can be one explanation for the high VBAC rates and the low CS rates in these countries. In other European countries, as well as non-European countries, women have the opportunity to decide for themselves. Nevertheless, Goodall et al. (2009) found that even women who were able to decide on the mode of birth after CS easily relinquished control to the caregiver involved. Still, the evidence is limited on the effectiveness of interventions to support decision making about VBAC, and more research is needed, particularly on what support women require in sharing the decision making with their care providers (Horey, Kealy, Davey, Small, & Crowther, 2013).

Methodological Considerations

The aim of the study was to investigate women's views on factors of importance for improving the rate of VBAC among women in countries with high VBAC rates. To our knowledge, this is the first study of women's views on VBAC in countries where VBAC rates are high. As the question of VBAC is complex, it needs to be answered qualitatively. We combined individual interviews and focus groups in the data collection, which made it easier to recruit women working full time and living in different parts of the country. Irrespective of individual interviews or focus groups, we asked women the same five questions and in the same order. The use of a combination of two methods can both be a study limitation and a strength. In a group discussion, the participants can inspire each other in describing the studied topic (Barbour, 2010); on the other hand, the individual perspective can be overlooked in focus groups, so the combination of both methods is useful.

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

To form 5 to 10 subcategories for each question and select example comments from the women, we analyzed the data in the women's native language. After this analysis, the data were translated into English by each country team. As the translations were from Finnish, Swedish, and Dutch, into English, there might be misunderstandings on some concepts. We aimed to minimize the risk of such misunderstandings by ensuring careful translations of the data. Furthermore, in reporting on the results, we included a large number of comments from the women to reduce the risk of misconceptions. Nevertheless, the findings represent the views of women from three countries with high VBAC rates, and variations in the data may have resulted.

Qualitative studies cannot claim generalization. Instead, we use the word transferability in discussing the relevance of the results for contexts other than the one studied (Whittemore, Chase, & Mandle, 2001). This study concerned three European countries, and their maternity organizations are different in some aspects. To facilitate transferability, we described the studied contexts carefully (Elo & Kyngäs, 2008; Whittemore et al., 2001). Although the data gathering was conducted in the three countries, we had the common goal of reaching good data saturation. According to Polit and Beck (2012), several factors affect data saturation: the data quality, the research topic's scope and sensitivity, and the researcher's competence. We believe the sample size was sufficient for data saturation on the basis of the interviews (focus groups and individual) being performed with women with a recent experience of VBAC who willingly reflected on and communicated their experiences and views, thereby yielding rich data quality. In addition, we drew on our experience in qualitative research when we gathered and analyzed the data in this study.

Recommendations for Future Research

There is a need for more studies on both women's and clinicians' perspectives on VBAC in countries with both high and low VBAC rates. In particular, research on clinicians' competence and attitudes toward VBAC is lacking, as well as studies on the roles of different caregivers and support persons in VBAC. There is limited evidence on when, how, and by whom information should be given to women after a CS to improve VBAC rates and decision making on VBAC. There is a need for studies evaluating different kinds of support to women after negative birth experiences and birth trauma. In addition, evidence is lacking on optimal care for women during VBAC. Finally, more studies on the cultural aspects of VBAC in countries with high and low VBAC rates are required.

Conclusion

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

Acknowledgment

We are grateful to the European Commission for funding the OptiBIRTH study.

Authors' Note

The opinions expressed here are those of the study team and are not necessarily those of the European Commission. Portions of this study were presented at Optimising Childbirth Across Europe—An Interdisciplinary Maternity Care Conference, April 9–10, 2014, in Brussels, Belgium.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The OptiBIRTH study was funded by the European Commission under the European Union's Seventh Framework Programme (FP7/2007-2013) through grant agreement number 305208.

References

Barbour, R. (2010). Focus groups. In I. Bourgeault, R. Dingwall, & R. de Vries (Eds.), *The SAGE handbook of qualitative methods in health research* (pp. 327–352). London: SAGE.

Beck, C. (2004). Birth trauma: In the eye of the beholder. *Nursing Research*, *53*, 28–35.

Beck, C., & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing Research*, *59*, 241–249.

Berg, M., Olafsdottir, O.-A., & Lundgren, I. (2012). A midwifery model of woman-centred childbirth care—In Swedish and Icelandic settings. *Sexual & Reproductive Healthcare*, *3*, 79–87. doi:10.1016/j.srhc.2012.03.001

Bryant, J., Porter, M., Tracy, S., & Sullivan, E. (2007). Caesarean birth: Consumption, safety, order, and good mothering. *Social Science & Medicine*, *65*, 1192–1201.

Callister, L. C. (2004). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *33*, 508–518.

Callister, L. C. (2006). The meaning of giving birth and mastery of the experience. *International Journal of Childbirth Education*, *21*(3), 7–8.

Callister, L. C., Vehvilainen-Julkunen, K., & Lauri, S. (2001). Giving birth: Perceptions of Finnish childbearing women. *MCN: The American Journal of Maternal/Child Nursing*, *26*, 28–32.

Catling-Paull, C., Johnston, R., Ryan, C., Foureur, M. J., & Homer, C. S. E. (2011). Non-clinical interventions that increase the uptake and success of vaginal birth after caesarean section: A systematic review. *Journal of Advanced Nursing*, *67*, 1662–1676. doi:10.1111/j.1365-2648.2011.05662.x

Centraal Bureau voor de Statistiek. (2014). *Place of birth, length and weight*. Retrieved from http://www.cbs.nl/en-GB/menu/home/default.htm

Christiaens, W., Nieuwenhuijze, M., & de Vries, R. (2013). Trends in the medicalisation of childbirth in Flanders and the Netherlands. *Midwifery*, *29*(1), e1–e8. doi:10.1016/j.midw.2012.08.010

Cronie, D., Rijnders, M., & Buitendijk, S. (2012). Diversity in the scope and practice of hospital-based midwives in the Netherlands. *Journal of Midwifery & Women's Health*, *57*, 469–475. doi:10.1111/j.1542-2011.2012.00164.x

Crowther, S., Smythe, L., & Spence, D. (2014). Mood and birth experience. *Women and Birth*, *27*, 21–25. doi:10.1016/j.wombi.2013.02.004

Dahlen, H. G., & Homer, C. S. E. (2013). "Motherbirth or childbirth"? A prospective analysis of vaginal birth after caesarean blogs. *Midwifery*, *29*, 167–173. doi:10.1016/j.midw.2011.11.007

Davis-Floyd, R. (1992). *Birth as an American rite of passage*. Berkeley: University of California Press.

de Vries, R. (2005). *A pleasing birth: Midwives and maternity care in the Netherlands*. Amsterdam, The Netherlands: Amsterdam University Press.

Dodd, J. M., Crowther, C. A., Huertas, E., Guise, J. M., & Horey, D. (2013). Planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean birth. *Cochrane Database of Systematic Reviews*, *12*, CD004224. doi:10.1002/14651858.CD004224.pub3

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*, 107–115. doi:10.1111/j.1365-2648.2007.04569.x

Estabrooks, C., Field, P., & Morse, J. (1994). Aggregating qualitative findings: An approach to theory development. *Qualitative Health Research*, *4*, 503–511.

EURO-PERISTAT. (2008). *European perinatal health report 2004*. Available from http://www.europeristat.com

EURO-PERISTAT. (2013). *European perinatal health report 2010*. Available from http://www.europeristat.com

Fahy, K., Parratt, J., Foureur, M., & Hastie, C. (2011). Birth territory: A theory for midwifery practice. In R. Bryar & M. Sinclair (Eds.), *Theory for midwifery practice* (pp. 215–240). Houndmills, UK: Palgrave Macmillan.

Frith, L., Sinclair, M., Vehviläinen-Julkunen, K., Beeckman, K., Loytved, C., & Luyben, A. (2014). Organisational culture in maternity care: A scoping review. *Evidence Based Midwifery*, *12*, 16–22.

Gamble, J., & Creedy, D. K. (2009). A counselling model for postpartum women after distressing birth experiences. *Midwifery*, *25*(2), e21–e30. doi:10.1016/j.midw.2007.04.004

Gibbins, J., & Thomson, A. M. (2001). Women's expectations and experiences of childbirth. *Midwifery*, *17*, 302–313. doi:10.1054/midw.2001.0263

Godden, B., Hauck, Y., Hardwick, T., & Bayes, S. (2012). Women's perceptions of contributory factors for successful vaginal birth after cesarean. *International Journal of Childbirth*, *2*, 96–106.

Goodall, K., McVittie, C., & Magill, M. (2009). Birth choice following primary caesarean section: Mothers' perceptions of the influence of health professionals on decision-making. *Journal of Reproductive and Infant Psychology*, *27*, 4–14.

Guise, J. M., Eden, K., Emeis, C., Denman, M. A., Marshall, N., Fu, R. R., . . .McDonagh, M. (2010). Vaginal birth after cesarean: New insights. *Evidence Report/Technology Assessment (Full Report)*, *191*, 1–397.

Habiba, M., Kaminski, M., Da Frè, M., Marsal, K., Bleker, O., Librero, J., . . . Cuttini, M. (2006). Caesarean section on request: A comparison of obstetricians' attitudes in eight European countries. *An International Journal of Obstetrics & Gynaecology*, *113*, 647–656. doi:10.1111/j.1471-0528.2006.00933.x

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, P. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, *7*, CD003766. doi:10.1002/14651858.CD003766.pub5

Hopkins, K. (2000). Are Brazilian women really choosing caesarean section? *Social Science & Medicine*, *51*, 725–740.

Horey, D., Kealy, M., Davey, M. A., Small, R., & Crowther, C. A. (2013). Interventions for supporting pregnant women's decision-making about mode of birth after a caesarean. *Cochrane Database of Systematic Reviews*, *7*, CD010041. doi:10.1002/14651858.CD010041.pub2

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*, 1277–1288.

Hunter, B. (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery*, *20*, 261–272. doi:10.1016/j.midw.2003.12.004

Hunter, C. (2012). Intimate space within institutionalized birth: Women's experiences birthing with doulas. *Anthropology & Medicine*, *19*, 315–326. doi:10.1080/13648470.2012.692358

Hunter, L. (2002). Being with woman: A guiding concept for the care of laboring women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *31*, 650–657.

International Doulas of North America. (2005). *DONA: The birth doula's contribution to modern maternity care*. Author. Retrieved from http://www.dona.org/publications/position_paper_birth.php

Johnson, T. R., Callister, L. C., Freeborn, D. S., Beckstrand, R. L., & Huender, K. (2007). Dutch women's perceptions of childbirth in the Netherlands. *MCN: The American Journal of Maternal/Child Nursing*, *32*, 170–177. doi:10.1097/01.NMC.0000269567.09809.b5

Kazmi, T., Saiseema, S., & Khan, S. (2012). Analysis of cesarean section rate—According to Robson's 10-group classification. *Oman Medical Journal*, *27*, 415–417. doi:10.500/omj.2012.102

Kennedy, H. P., Shannon, M. T., Chuahorm, U., & Kravetz, M. K. (2004). The landscape of caring for women: A narrative study of midwifery practice. *Journal of Midwifery & Women's Health*, *49*, 14–23.

Krippendorff, K. (2004). *Content analysis: An introduction to its methodology* (2nd ed.). Thousand Oaks, CA: SAGE.

Larkin, P., Begley, C., & Devane, D. (2009). Women's experiences of labour and birth: An evolutionary concept analysis. *Midwifery*, *25*, e49–e59.

Lundgren, I. (2010). Swedish women's experiences of doula support during childbirth. *Midwifery*, *26*, 173–180. doi:10.1016/j.midw.2008.05.002

Lundgren, I., Begley, C., Gross, M., & Bondas, T. (2012). "Groping through the fog": A metasynthesis of women's experiences on VBAC (vaginal birth after caesarean section). *BMC Pregnancy & Childbirth*, *12*, Article 85.

Matthews, R., & Callister, L. C. (2004). Childbearing women's perceptions of nursing care that promotes dignity. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *33*, 498–507. doi:10.1177/0884217504266896

McMahon, M. J., Luther, E. R., Bowes, W. A., Jr., & Olshan, A. F. (1996). Comparison of a trial of labor with an elective second cesarean section. *New England Journal of Medicine*, *335*, 689–695.

Nilsson, C., Lundgren, I., Karlström, A., & Hildingsson, I. (2012). Self reported fear of childbirth and its association with women's birth experience and mode of delivery: A longitudinal population-based study. *Women and Birth*, *25*, 114–121.

Organisation for Economic Co-Operation and Development. (2013). *Health at a glance 2013: OECD indicators*. Retrieved from http://www.oecd.org/health/health-systems/health-at-a-glance.htm

Polit, D., & Beck, C. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). New York: Lippincott Williams & Wilkins.

Royal College of Obstetricians & Gynaecologists. (2001). *The National Sentinel Caesarean Section Audit Report: Clinical effectiveness support unit*. London: Author. Retrieved from https://www.rcog.org.uk/globalassets/documents/guidelines/research–audit/nscs_audit.pdf

Royal Dutch Organisation of Midwives. (2012). *Midwifery in the Netherlands*. Retrieved from http://www.knov.nl/samenwerken/tekstpagina/489/midwifery-in-the-netherlands/

Ryding, E. L., Persson, A., Onell, C., & Kvist, L. (2003). An evaluation of midwives' counseling of pregnant women in fear of childbirth. *Acta Obstetricia et Gynecologica Scandinavica*, *82*(1), 10–17.

Scott, J. R. (2011). Vaginal birth after cesarean delivery: A common-sense approach. *Obstetrics & Gynecology*, *118*(2, Pt. 1), 342–350. doi:10.1097/AOG.0b013e3182245b39

Shorten, A., & Shorten, B. (2012). The importance of mode of birth after previous cesarean: Success, satisfaction, and postnatal health. *Journal of Midwifery & Women's Health*, *57*, 126–132.

Shorten, A., Shorten, B., Keogh, J., West, S., & Morris, J. (2005). Making choices for childbirth: A randomized controlled trial of a decision-aid for informed birth after cesarean. *Birth*, *32*, 252–261.

Storksen, H. T., Garthus-Niegel, S., Vangen, S., & Eberhard-Gran, M. (2013). The impact of previous birth experiences on maternal fear of childbirth. *Acta Obstetricia et Gynecologica Scandinavica*, *92*, 318–324. doi:10.1111/aogs.12072

Thomson, G. (2011). Abandonment of being in childbirth. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative research in midwifery and childbirth: Phenomenological approaches* (pp. 133–152). London: Routledge.

Thorstensson, S., Ekström, A., Lundgren, I., & Hertfelt Wahn, E. (2012). Exploring professional support offered by midwives during labour: An observation and interview study. *Nursing Research and Practice*, *2012*, 1-10. doi:10.1155/2012/648405

Villar, J., Carroli, G., Zavaleta, N., Donner, A., Wojdyla, D., Faundes, A., . . . Acosta, A. (2007). Maternal and neonatal individual risks and benefits associated with caesarean delivery: Multicentre prospective study. *British Medical Journal*, *335*(7628), 1025–1029.

Weaver, J., Statham, H., & Richards, M. (2007). Are there "unnecessary" cesarean sections? Perceptions of women and obstetricians about cesarean sections for non-clinical indications. *Birth*, *34*, 32–41.

Whittemore, R., Chase, S., & Mandle, C. (2001). Validity in qualitative research. *Qualitative Health Research*, *11*, 522–537. doi:10.1177/104973201129119299

Wibeck, V. (2010). *Fokusgrupper [Focus groups]* (2nd ed.). Lund, Sweden: Studentlitteratur.

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