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Influences on vaginal birth after caesarean section: A qualitative study of Taiwanese women

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ABSTRACT

Background: Vaginal birth is a safe mode of birth for most women who have had a prior caesarean with a transverse incision. Despite the evidence, most Taiwanese women who have had a previous caesarean are rarely offered the opportunity to consider any possibility other than a repeat caesarean.
Aim: This study explored factors affecting Taiwanese women's decisionmaking regarding vaginal birth after cesarean.
Methods: Ajzen's Theory of Planned Behaviour provided the theoretical framework to underpin the study, which adopted an interpretive descriptive methodology. Sequential semi-structured interviews were conducted with 29 women who had a previous caesarean and were pregnant between 34 and 38 weeks gestation, ten women who attempted vaginal birth in the third to fifth day postpartum, and 25 women in the fourth week postpartum. Boyatzis' method of thematic analysis was used to identify themes and codes.
Findings: This paper reports the findings of the prenatal interviews with 29 participants. The major factor influencing women's decision-making was to avoid negative outcomes for themselves and their babies. Three thematic codes describe influences on the women's decisions: 'past experience of childbirth', 'anticipating the next experience of normal birth' and 'contemplation on the process of childbirth'.
Conclusions: Women who have had a previous caesarean section are prepared to have a vaginal birth but are not always supported to carry out this decision. Changing the models of antenatal care is recommended as a strategy to overcome this difficulty therefore empowering women to make a meaningful choice about VBAC after a CS.
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Statement of significance

Problem

Despite evidence that supports Vaginal Birth After Caesarean (VBAC) as a safe mode of birth for most women who have had previous caesarean section (CS), VBAC uptake remains low in Taiwan and many developed countries.

What is already known

Women's decision-making regarding a VBAC is influenced by women's concern for their infants' safety.

What this paper adds

This paper adds a cultural understanding of the effects of CS on Taiwanese women's bodies and health and thus influences their decision-making regarding a VBAC.

1. Introduction

Caesarean section (CS) rates in many developed countries, including Taiwan, have exceeded 30% over the past decades.[1,2] This

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rate exceeds the 15% as recommended by the World Health Organization (WHO).[3] While CS is a life-saving procedure, it is not risk free. Of concern is the recognition that a prior CS has become a leading cause for a repeat CS, yet a repeat CS is associated with serious adverse effects on women's health. Despite evidence which supports vaginal birth after caesarean (VBAC) as a safe mode of birth,[4] most Taiwanese women who had a previous caesarean section had a repeat CS (n = 30,646) in 2014 compared to small number of women who had VBAC (n = 740).[5] The aim of this study was to explore factors affecting Taiwanese women's decision-making regarding a VBAC.

1.1. Taiwan maternity care system

In Taiwan, the health care system is considered well established and advanced.[6] A mandatory National Health Insurance (NHI) scheme was introduced in 1995 and provides universal coverage for 23 million Taiwanese citizens.[7] The universal coverage provides free access to varying levels of medical care. The medical care in Taiwan is classified into four categories based on patient bed capacity. These categories include medical centres with 500 patient beds and over, followed by regional hospitals with 300 beds and over, district hospitals with 100 beds and clinics with nine beds. Under the NHI program all childbearing women have equal access to maternity care within these various health care providers during pregnancy, labour and post-natally, including ten free antenatal visits.[6] Most common maternity services, including vaginal birth and CS are covered by the NHI.

1.2. Caregivers of childbirth in Taiwan

Global perspectives indicate that a midwifery model of care, which supports a woman-centred philosophy, is good for the promotion of normal birth. The midwife has been advocated as an expert to care for women in normal birth. The important role of the midwife in normal birth is supported by established midwifery education and practice in most developed countries.[8,9] In Taiwan, due to reforms of the health care system, the shift of the place of birth from home to hospital, and maternity caregiver from midwife to obstetrician, took place in the 1970s. These shifts changed a physiological approach to birth to a medicalised approach.[10] Since the 1970s, hospitals in Taiwan have become the primary place of birth in order to improve safety, and as a result childbirth is regarded as a medical event.[11] Obstetricians provide several obstetric interventions for childbirth and they have become the primary caregivers during pregnancy, labour and birth.[5,10] To date, compared to the majority of 214,234 annual births managed by obstetricians there were less than 200 births facilitated by practicing midwives.[5]

2. Literature review

A medically indicated CS may prevent adverse outcomes for women and their babies.[3] However a CS is also associated with maternal complications including bleeding, hysterectomy, maternal admission to an intensive care unit, maternal hospitalisation over seven days, maternal death, antibiotic treatment after caesarean[12,13] and wound infection.[14] Having a history of a CS becomes a leading cause for a repeat caesarean in future pregnancies. Women with multiple caesareans are at increased risk of placenta accreta, cystotomy, bowel injury, urethral injury, ileus, need for ventilation, Intensive Care Unit (ICU) admission, hysterectomy, blood transfusion and duration of hospital stay and duration of operation time.[15,16] A prospective study and a systematic review[15,16] reported that the risk of accreta placenta and hysterectomy increases when the number of repeated caesarean increases. The odds ratio for hysterectomy was 1.4, 3.8 and 5.6 for second, third and fourth caesarean respectively.[15] This is a significant health outcome and impacts on the women's ongoing fertility.

From a child health perspective, infants who are delivered by caesarean are at increased risk of respiratory illness immediately after caesarean.[4,17,18] They are also more likely to not experience the benefits of immediate interaction with their mothers including skin to skin contact, positive breastfeeding outcomes, early mother–infant attachment, and infant's adjustments to the environment outside the uterus.[19–21] VBAC is a reasonable and safe choice for the majority of women who have had a prior caesarean with a transverse incision.[4] Successful VBAC is associated with positive health outcomes for 80% of these women, including low mortality rate, no increase of the risk of hysterectomy and blood transfusion and lower likelihood of uterine rupture when VBAC was achieved.[4,22] It is important to note however, that studies of VBAC which attempted to measure child health outcomes were slightly in favour infants who were delivered by CS.[4,23] To date, the best evidence derived from Cochrane review of 15 non-RCT studies with 47,682 women in developed countries concluded that the absolute risk of neonatal death and risk of admission to NICU in VBAC cohort is negligible.[4] Based on the best evidence, VBAC is recommended as a safe option for the majority of women with a previous CS.[4] Despite evidence support that VBAC is a safe option for birth after a CS, the health information women are given may not always reflect what evidence supports.

A number of studies identify the influences affecting women's decision-making processes. These influences include information and advice women receive from their care providers, particularly doctors and information provided by hospitals. Doctors' approval or disapproval has been found to be the most influential factor for women's choice of birth method. Support for women's decisions about a birth method by obstetricians is cited in other studies as one of the factors for a successful VBAC.[24–29] In Ridley et al.'s study,[24] four women stated that their obstetricians' encouragement and assurance were influential in their decision for this birth method. In Taiwan, Liu et al.[25] interviewed ten Taiwanese women who had achieved a VBAC. These women reported that their decision for a VBAC was also approved by obstetricians. Two additional unpublished Taiwanese qualitative studies consistently revealed that obstetricians' final approval for a VBAC was significant in the women's decisions for a VBAC.[26,27] However, in an early survey, Murphy and Harvey[28] found that more commonly, obstetricians influence American women's decisions to choose CS rather than VBAC. Additionally, a survey was undertaken in Taiwan regarding obstetricians' influence on women's (n = 71) decisions of birth method.[29] This survey found that 41% (n = 29) of women did not consider a VBAC because their obstetricians did not suggest it. Despite obstetricians' positive influence on some women's choice to have a VBAC, in general Taiwanese obstetricians' attitudes towards VBAC are conservative.

Evidence affirms that the continuity of midwifery care models increased the likelihood of vaginal birth including VBAC.[9,30–32] In continuity of midwifery care models, women were satisfied with information provision, involved in decision-making and felt more in control.[9,32,33] A qualitative study reported that a total of thirteen Western Australian women who achieved a VBAC accredited their success to using a midwife-led Next Birth After Caesarean (NBAC) services.[32] A strong feature of these NBAC services is promoting informed choice by providing women with unbiased information about birth choice. This finding reaffirms that a supportive environment essentially impacts on women's decision-making for a VBAC. Global perspectives support that midwifery-led care is an essential form of care in childbirth and is available in most

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