AIMS For a better birth...

Research Review

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Hazel Keedle, Virginia Schmied, Elaine Burns and Hannah Grace Dahlen
A narrative analysis of women's experiences of planning a vaginal birth after caesarean (VBAC) in Australia using critical feminist theory
BMC Pregnancy and Childbirth (2019) 19:142
https://www.ncbi.nlm.nih.gov/pubmed/31035957

What is this study about?
This is a study about women's experiences of planning a vaginal birth after caesarean section (VBAC) in Australia. The paper reports on the second phase of a three-phase study. In this phase, the researchers explored women's experiences, thoughts and feelings after antenatal appointments and after the birth.

Who took part?
Pregnant women who had experienced a caesarean in their previous pregnancy were recruited via aflyer on social media. Eleven women completed the study.

How did the researchers explore women's experiences?
All of the participants downloaded an app onto their smartphone. They were encouraged to audio or video record their thoughts and feelings within 24 hours of an antenatal appointment. Women were not to record the specifics of their interactions with health care providers (HCPs), nor the details of HCP names or facilities (i.e. hospital or clinic names). Any mention of these were deleted by the researchers.

Six weeks after the birth, the participants were interviewed either over the phone or face-to-face. These interviews were semi-structured, which means that the interviewer had some very basic and broad questions (in this case just five). This provides the interviewee with the opportunity to discuss their experiences in reasonable depth. The interviews lasted between 45 and 90 minutes.

The researchers then analysed the women's narratives and noted the common themes that appeared within the stories.

What did the researchers discover?
Although all eleven women planned a VBAC, only six gave birth this way (one experiencing an instrumental birth) and the other five had repeat caesarean sections.

Four themes were identified that played a role in whether women felt resolved* or disappointed following the birth of their baby. These included, having:

1. Confidence in oneself;
2. Control;
3. Supportive relationships with HCPs;
4. An active labour.

The researchers discovered that although these factors were all independent, they had a cumulative effect. In other words, high levels of all four of these factors, resulted in women feeling resolved* after their birth regardless of whether they had a VBAC or not.

***The authors defined feeling 'resolved' as 'to settle or find a solution to a problem or contentious matter.'**

What were women's stories?
The paper provides some of the stories that women gave to researchers and describes them under the above themes.

1. Control
The authors demonstrate the fight that women have in planning a VBAC by using the example of Tonia. Tonia struggled to find the support she needed from HCPs. She wanted to decline vaginal examinations (VEs) due to being raped when younger as she knew they would be triggering and would stall her labour. However, when she showed her obstetrician her birth plan, he would not agree to this and Tonia felt that

she was being treated like a statistic and not an individual. When she went into labour, she was manipulated into a VE, but still managed to have a VBAC.

2. Confidence

The authors use Isabella's story to reflect the impact confidence had on her ability to have a VBAC despite strong opposition. Her obstetrician told her that if she did not agree to a repeat caesarean at 37 weeks that the hospital would not provide care for her. However, Isabella hired a doula and sought support from her midwifery team with whom she had developed a good relationship. She knew that they would support her regardless of whether they agreed with her choices.

Isabella endured negativity from the obstetrics team including one doctor asking, "how would I feel if I had a hysterectomy and dead baby as a result of my choices?" Nevertheless, she laboured at home, and when she arrived at hospital, she gave birth vaginally within twenty minutes. Isabella's doula later commented positively on how her midwife had actively buffered Isabella from any unnecessary interference from staff.

3. Relationship with HCP

Bianca's story was used as an example of the benefits of a good relationship with a HCP. Bianca had a private midwife who had experienced her own VBAC, which, Bianca felt, may have helped the midwife to be very supportive of her decisions. She trusted this midwife and experienced Continuity of Carer. Bianca had a VBAC in the hospital after five hours of labour.

4. Staying active and upright

Dehlia's story reflects the importance of staying active and upright during labour. She had a supportive obstetrician and midwife who were confident in her ability to have a VBAC. She laboured in the shower and managed to birth her 4.9kg (10.8lb) baby vaginally. Dehlia was convinced that she would not have been able to do that if she had opted for an epidural.

AIMS Discussion

This is a valuable study that explores VBAC from the perspective of women planning to birth in this way. The obstetric and midwifery literature tends to omit women's voices and to concentrate on numbers and statistics. This research is therefore a very welcome and useful contribution to the evidence base.

After outlining the participants' narratives, the authors then discussed some of the academic theories underpinning women's experiences. This included concepts such as power relations in the birthing room and the patriarchal nature of the maternity system. We agree with the authors' arguments on these points. Importantly, from a feminist perspective, the obstetric system is patriarchal in that it was created by men based on men's interpretations of women's bodies and how they should and should not labour and birth. The foundations for this system were laid before women were even allowed to become doctors. In contrast, while the midwifery profession's origins were based on woman to woman care, the dominant authority of men in society means that midwifery has come to be seen as the inferior profession. In addition, in more recent years, due to the pathologisation and medicalisation of pregnancy

and birth, midwifery is becoming ever closer to obstetrics as women's bodies are viewed as sites of risk that need to be managed and controlled.

This becomes evident in Keedle's study. Women are 'fighting' to give birth vaginally. Vaginal birth is the default outcome for all pregnancies, therefore serious ethical questions should be raised when women have to 'fight' to enable their bodies to carry out a normal bodily function. While AIMS fully supports repeat caesarean sections for those women who wish to make that birthing decision, vaginal birth should not be denied to women who want to attempt VBAC. In fact, we would question why any HCP believes they have a right - or the ability - to 'prohibit' or 'disallow' a woman to give birth vaginally. Equally, threatening to withdraw care from women who want to VBAC is bullying and nullifies any woman's informed consent to surgery as she would have been coerced into agreeing.

The final point we would argue is that Keedle's four themes reflect what*all* women need to ensure their best chance of a vaginal birth, and to be satisfied with the experience, regardless of the eventual mode of birth. It is frightening that in 2020, researchers are still trying to prove that a woman having control during labour and birth, staying upright, feeling confident and having good relationships with her HCPs are the most important factors for a good outcome. We can only hope that as more research exploring women's experiences of birth is produced, that a shift will take place that puts women at the centre of birth, ensuring that they receive the respectful care that they deserve.