WOMEN’S REASONS FOR AND EXPERIENCES
OF HAVING A HOMEBIRTH FOLLOWING A
PREVIOUS CAESAREAN EXPERIENCE

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This thesis is submitted for the degree of Master of Nursing (Honours)

July 2015
I dedicate this thesis to three important people in my life that passed away during my thesis journey.

Neddy McDonald – my ‘mountain mum’, a woman who demonstrated true compassion and love to everyone she met

Anne Lee – my Granny and my inspiration, she saw the midwife in me and with her I share my love for midwifery and our determined spirit

David Lee – my Dad, with whom I share my love for learning and belief in being true to yourself

I know you would be so proud of me, Dad
In any society, the way a woman gives birth and the kind of care given to her and the baby points as sharply as an arrowhead to the key values of the culture

Sheila Kitzinger
STATEMENT OF AUTHENTICATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Signed:

Date: 10/08/2015

Hazel Sarah Keedle
ABSTRACT

Background – The rates of caesarean section are rising across the developed world yet the vaginal birth after caesarean (VBAC) rate remains low. Caesarean section is related to increased morbidity for both women and babies, including higher rates of infection, increased need for blood products, operative trauma and neonatal intensive care admissions. Qualitative research suggests that there are women who prefer vaginal births after caesarean if this is supported and dislike unnecessary interventions. VBAC success rates are higher out of hospital than in hospital. A small number of women in Australia choose to have a homebirth after caesarean (HBAC). The reasons women choose to have a HBAC and their experiences have not been explored in research.

Aims and methods – This study aimed to explore women's reasons for and experiences of choosing a homebirth following a caesarean section, by undertaking qualitative semi-structured interviews with 12 women who had a HBAC in the previous five years in Australia. A feminist theoretical framework was used to underpin the research and understand the power relations influencing the emerging themes. Eight privately practising midwives (PPMs) participated in a focus group to enhance and provide extra depth and meaning to the study. Thematic analysis was used to analyse the data.

Results – The overarching theme was ‘It’s never happening again’ with two associated themes of ‘why it’s never happening again’ and ‘how it’s never happening again’. In the theme ‘why it’s never happening again’ the women described their previous caesarean experience and identified episodes of
bullying, intimidation and unnecessary interventions, resulting in what many of the women described as a traumatic birthing experience. With their next pregnancy the majority of women approached the hospital with the wish to have a VBAC but often found bullying and intimidation was repeated with no apparent room for negotiation. In this context, women sought other options and homebirth emerged as a valid one. In the theme ‘How it’s never happening again’, the importance of support from a variety of sources, gaining knowledge about natural birth and employing the services of a PPM emerged as important factors. In this theme women also reported on the positive effect of a HBAC.

Discussion – A previous experience of birth trauma, the over-medicalisation of childbirth and disrespectful and abusive attitudes of health care providers were the major influences for women pursuing a more positive birth option and choosing to have a HBAC. Gathering support and the close and continuous relationship with a PPM were factors that helped the women achieve their HBAC.

Conclusion – Maternity care services often contribute to women having disempowering and traumatic birthing experiences and some appear to provide little support for women who wish to avoid over-medicalisation. Research is needed to explore ways for maternity providers working in the mainstream maternity care system to become more flexible in their guidelines and approach so they can meet the needs of these women within the hospital environment rather than turning them away. Homebirth can be a healing and empowering experience for women and is a valid option for women seeking a VBAC.
This thesis would not be possible without the contribution of women and midwives who gave up their time to be interviewed and to attend the focus group. Thank you for your honest sharing of your stories. I would like to acknowledge my amazing team of supervisors, Professor Hannah Dahlen, Professor Virginia Schmied and Dr Elaine Burns. You have been an inspiration to me with your knowledge and passion and have gently guided and encouraged me when I have needed it most. Thank you. To my children who have been as patient as they can be whilst I have typed away, thank you for keeping me grounded! My Mum for her strength and encouragement, thank you. To my forever biggest fan and best friend, my husband Warren: Thank you for never doubting my ability and for making the space in our lives for me to work so hard.
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LIST OF ABBREVIATIONS AND ACRONYMS

VBAC – Vaginal Birth after Caesarean

HBAC – Homebirth after Caesarean

PPM – Privately Practising Midwife
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1 INTRODUCTION

1.1 Introduction

This study explores women’s reasons for and experiences of having a homebirth after a previous caesarean (HBAC). The majority of women who have a caesarean in Australia elect to have a repeat caesarean for subsequent births. Less than a quarter of subsequent births are a vaginal birth after caesarean (VBAC) (Z. Li, Zeki, R., Hilder, L., Sullivan, EA., 2013). The number of women who attempt a VBAC, but end up with a repeat caesarean during labour, is not identified in national data. Less than 1% of women choose to have a homebirth in Australia and some of these women will choose this option to facilitate a HBAC.

The available research identifies that the chance of having a VBAC are greater at home than in hospital (Beckmann, Barger, Dorin, Metzing, & Hellmers, 2014; Cheyney et al., 2014; Janssen, 2009) and many women prefer to have a VBAC
rather than a repeat caesarean (J. Fenwick, Gamble, J., Hauck, Y., 2006; Meddings, Phipps, Haith-Cooper, & Haigh, 2007). The supporting research is explored in depth in chapter two. Little research has been undertaken to explore why women choose to have a HBAC or what was the experience from the women’s perspective. This study explores both of those aspects.

This chapter outlines the purpose and justification for undertaking the research study, "Women’s reasons for and experiences of choosing a homebirth following a caesarean section". This introductory chapter provides an overview of the current literature and political and historical factors in Australia impacting on women’s choices following caesarean section. The aims and objectives of the study are outlined and the methodological approach and ethical issues are described.

1.2 Aims and Objectives

This study aims to explore women's reasons for and experiences of choosing a homebirth following a caesarean section.

1.3 The study objectives are:

- To determine the information and resources women seek to support their decision to have a HBAC
- To explore how women prepare for a HBAC
• To identify how women perceive safety and risk when contemplating a HBAC
• To identify reactions women experience when discussing their choice with family, friends and health professionals
• To explore the decisions women would make if midwife-attended HBAC was no longer an option
• To explore PPMs’ perspectives on HBAC

1.4 Background

In this section, the benefits of VBAC and VBAC rates, both internationally and nationally, will be explored. The role of the midwife, and specifically the issues that surround being a PPM, will be discussed before describing the current state of homebirth in Australia.

1.4.1 VBAC benefits

“Vaginal birth after caesarean (VBAC) is defined as a vaginal delivery by a woman who has had a previous caesarean delivery” (Cunnigham, 2010, p. 4). There are many benefits for women, their families and society when women are supported to have a VBAC. Vaginal birth can lead to quicker post birth recovery,
less operative trauma, shorter length of hospital stay and improved feelings of wellness both physically and psychologically for women (Clark, 2011; J. Fenwick, Gamble, J., Hauck, Y., 2006; Lyell, 2011; Silver, 2006). The risks involved in repeat operative deliveries for subsequent pregnancies include an increase in operative trauma, placenta praevia and accreta, surgical injury, adhesions, postpartum haemorrhage, endometritis and hysterectomy. These are increased if the VBAC results in a repeat caesarean during labour compared to an elective caesarean (Crowther, 2012; Gilbert, 2012; Landon, 2004; Nigam & Anand, 2015; Silver, 2006).

Women who plan for a VBAC have an increased risk of uterine rupture. Uterine rupture rates are associated with factors such as length of time between previous caesarean and subsequent VBAC and the use of pharmacological induction methods during the VBAC (Buhimschi, Buhimschi, Patel, Malinow, & Weiner, 2005; Fitzpatrick, 2012; Palatnik & Grobman, 2015; G. Smith, Pell, JP., Pasupathy, D., Dobbie, R., 2004; Stamilio, 2007; Stock et al., 2013). For women giving birth the benefits can also include feelings of pride and achievement which can lead to a period of psychological healing following previous birth trauma (Thomson, 2010).

### 1.4.2 VBAC rates

The number of women having a VBAC has declined in recent years in countries such as the USA (United States of America) and Australia (Gochnour G, 2005)
although it is unclear how many women would have chosen a VBAC instead of an elective caesarean if they were supported to do so. International and national data indicates the rate of uterine rupture varies from 0.1–2.7%, with VBAC success rates between 14-90% (Gilbert, 2012; Landon, 2004; Latendresse, 2005; Stamilio, 2007). It has been suggested the fall in VBAC rate is due in part to the practice guidelines for VBAC published by the American College of Obstetricians and Gynaecologists in 1999, which recommend close proximity to operating theatre for any woman ‘attempting’ a VBAC (Cunnigham, 2010).

Prior to these guidelines, the VBAC rate in the USA was up to 28.3% in 1996 but by 2002 had declined to 12.6%. The changes made to the recommendations were that if a woman was to opt for a VBAC she had to be in close proximity to an operating theatre. The wording in the guideline was changed from ‘within a reasonable time frame’ to being ‘immediately available’ (R. G. Roberts, Deutchman, M., King, V.J., Fryer, G.E., Miyoshi, T.J., 2007). Understandably, this impacted greatly upon women living in rural and remote areas where operative birth options required significant travel (Gochnour G, 2005; R. G. Roberts, Deutchman, M., King, V.J., Fryer, G.E., Miyoshi, T.J., 2007). In 2010, the National Institute of Health (NIH) held a Consensus Development Conference in the USA on VBAC and found the recommendation for immediate access to operating theatre was based on poor levels of evidence (Agarwal, 2007). It also found this recommendation, along with increased litigation of health professionals, had led to a decline in VBAC (Cunnigham, 2010; King, 2010).
The caesarean section rate has increased in Australia from 27% in 2002 to 32.3% in 2011 (Z. Li, Zeki, R., Hilder, L., Sullivan, EA., 2013). Australian national data indicates the rate of vaginal birth after caesarean (VBAC) is 12.3% (Z. Li, Zeki, R., Hilder, L., Sullivan, EA., 2013). The rate is highest in the public sector and lowest in the private sector (NSW Health, 2014).

The rate of successful VBAC in NSW in 2012 ranged from 1.8% to 10.9% for private hospitals; for public hospitals, the rate ranged from 1.2% to 28.6%, with some hospitals not offering VBAC as an option (NSW Health, 2014). Significant differences in VBAC rates exist amongst hospitals in NSW. Since 2000, the rate of VBAC has declined from 21.8%, to 11% in 2012 (Figure 1.) (NSW Health, 2014).

Figure 1-1: Rates of VBAC for NSW between 2000 and 2012

In a population-based study undertaken in NSW (Homer, 2011) the VBAC rate was found to have decreased significantly from 31% in 1998 to 19% in 2006. The VBAC success rates differed slightly between women who laboured
spontaneously (59%) and for women who were induced (62%). NSW Health (2010) released the *Towards Normal Birth in NSW* policy that aimed to:

Provide or facilitate access to vaginal birth after caesarean section operation (VBAC) that is supported by a written vaginal birth after caesarean section operation policy/guideline and health care staff with the skills necessary to implement this policy/guideline. (p. 8).

Despite this policy initiative, women still face restrictive policies and variable attitudes from health professionals.

1.4.3 Midwives and Midwifery Practice in Australia

Alongside the exploration of women’s experiences of HBAC and the review of current research about VBAC, this study also explores why PPMs support women to have a HBAC. Midwifery has recently been defined by Renfrew et al. (2014) in the Lancet Series on Midwifery as the:

“Skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, post partum, and the early weeks of life. Core characteristics include optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women’s individual circumstances and views; and working in partnership with
women to strengthen women’s own capabilities to care for themselves and their families” (p. 1130).

When midwives are able to work within this scope of practice, there are benefits across the spectrum including reductions in maternal and neonatal morbidity and mortality, better maternal satisfaction, reduced intervention rates and better public health outcomes (Renfrew et al., 2014; Sandall, 2013). In Australia, midwives are governed by the National Competency Standards for Midwives and the Code of Ethics for Midwives in Australia (Nursing and Midwifery Board of Australia, 2008a, 2008b). PPMs along with other midwives also adhere to the National Midwifery Consultation and Referral Guidelines (Australian College of Midwives, 2014).

The majority of midwives in Australia work for hospitals that operate under state or territory governance. There are currently 32,956 registered practising midwives in Australia; although this number does not reflect their location of work, it does identify currently practising midwives who have fulfilled the minimum continuing practice development (CPD) points required for registration (Nursing and Midwifery Board of Australia, 2015). Up to 2014, midwifery registration contained no questions to identify whether a midwife is providing intrapartum care in the home. Although this has recently been added to the 2015 registration, it is difficult to obtain accurate figures on the numbers of midwives in Australia who provide homebirth services.
In 2010, the Federal Government's maternity changes gave midwives access to Medicare rebates for antenatal and postnatal services. The NMBA implemented a criteria for ‘eligible midwives’ for access to the Medicare rebates (Nursing and Midwifery Board of Australia, 2013). The criteria for an eligible midwife includes the completion of a pharmacology and diagnostics course, three years full time midwifery experience across the continuum of midwifery care and the successful completion of a professional practice review program (Nursing and Midwifery Board of Australia, 2013). This is currently under review and may change. Applicants submit proof of eligibility to the Australian Health Practitioners Regulation Agency (AHPRA) and, once approved, a notation is placed on the midwife’s registration stating: “Eligible midwife competent to provide pregnancy, labour, birth and post natal care and qualified to provide the associated services and order diagnostic investigations required for midwifery practice, in accordance with relevant State and Territory legislation” (Nursing and Midwifery Board of Australia, 2015, p. 7).

As well, an eligible midwife may be endorsed by AHPRA, on successful completion of an approved pharmacology course, to supply scheduled medications, which is recorded on the midwife’s registration as: “Endorsed as qualified to prescribe schedule 2, 3, 4 and 8 medicines required for midwifery practice across pregnancy, labour, birth and post natal care, in accordance with relevant State and Territory legislation” (Nursing and Midwifery Board of Australia, 2010, p. 2).
In Australia, there are currently 282 practising eligible midwives, with 157 also endorsed to prescribe (Nursing and Midwifery Board of Australia, 2015). To practice as a homebirth midwife in Australia, the PPM is required to hold professional indemnity insurance (PII) for antenatal and postnatal care, with an exemption for intrapartum care (discussed below); this has been made available for both eligible and non-eligible PPMs through two insurance companies, MIGA and VERO. The VERO insurance product has recently been withdrawn, creating an environment where non-eligible PPMs will no longer be able to obtain insurance and therefore no longer legally practice as a PPM unless they are able to apply for eligibility (Australian College of Midwives, 2015). In coming years, the environment affecting PPMs in Australia is set to continually shift and thereby change the landscape of private midwifery and homebirth.

1.4.4 Current homebirth issues

This study explores issues around women having a HBAC. The majority of women have a VBAC in hospital but some women choose to have a HBAC. The latest Australian statistics indicate that 0.4% of births are planned home births, although it is argued some may go unreported (Laws, 2010; Z. Li, Zeki, R., Hilder, L., Sullivan, EA., 2013).

Currently women who choose to have a HBAC can only do so with a PPM, otherwise the procedure is not supported in most publicly-funded homebirth
programs in Australia. VBAC is considered to add risk to birth and there are strong moves to regulate midwives providing this care in line with the current changes to private practice (H. G. Dahlen, 2012). These changes suggest limiting the practice of PPMs to low risk women only, as identified by the National Consultation and Referral Guidelines (Australian College of Midwives, 2014). There have also been some high profile coroners cases involving poor outcomes from VBAC at home (Olding, 2012). The Western Australian home birth policy states clearly that a previous caesarean section excludes women from being eligible for a publicly funded homebirth (W A Department of Health, 2012).

Australia’s State and Territory health ministers were presented with an options paper in June 2012 at the Australian Health Workforce Ministerial Council (AHWMC) which proposed insurance for midwives caring for low-risk women at home but it deliberately excludes VBAC. The requirement for insurance has become a problem for PPMs since the implementation of the National Registration and Accreditation Scheme which requires health professionals to have insurance for all areas of practice; however, no insurance products are available to cover intrapartum care (H. G. Dahlen, 2012; Teakle, 2014). The Health Practitioner Regulation National Law Act recognises that PPMs can be exempt from requiring PII when attending a homebirth if no PII available. This was put in place for two years and later extended several times, with a current expiry date of 31 December 2016 (Teakle, 2014).
As already identified, the risk associated with VBAC is uterine rupture and is therefore considered a high-risk birth in obstetric literature (Kamath, Todd, Glazner, Lezotte, & Lynch, 2009; Landon, 2004; Silver, 2006). Debate continues in the scientific literature about the benefits and harms associated with VBAC or elective repeat caesarean section (ERCS) (Crowther, 2012; Gilbert, 2012). While most health providers recognise VBAC as a valid birth choice, it is often discouraged in both overt and covert ways. Health providers express concerns about safety, backup for emergencies and medico legal risk (Macones et al., 2005; Yang YT, 2009).

The reasons women choose to have a HBAC are not clear and limited research is available on this topic. Researching this experience is important and women who have chosen to have a HBAC can offer invaluable insights into the decision-making and experiences of this choice. This may in turn help health professionals understand what factors are important to women when they are attempting to increase the VBAC rate in hospital and provide services which cater to a range of women’s needs.

1.4.5 The story behind the HBAC study

The interest in this topic came from my own personal journey of a planned homebirth and then transfer for a caesarean section with my first child. With my second pregnancy I had a hospital transfer following an attempted HBAC. As a
PPM, I also have professional experience assisting women to achieve HBAC in the current tumultuous homebirth climate. These dual insights help inform my belief in the importance of HBAC as an option for women. This will be further explored in the reflexivity section in the methodology chapter.

A feminist methodology has been used to guide the data collection, analysis and interpretation in this study. This was considered the most appropriate approach because as the researcher, I was particularly interested in how the dominant biomedical maternity care system impacted on women’s experiences and the decisions they made. Using the foundations of reproductive choice and authoritative knowledge, the experiences of women in this study are explored and discussed using a feminist lens.

1.5 Outline of thesis

1.5.1 Chapter 1 - Introduction

This first chapter has reported VBAC and caesarean rates both nationally and internationally and discussed some of the different factors that have contributed to these rates. The current climate around homebirth and PPMs in Australia has been discussed to provide a background to this study. The aims and objectives of this study have also been identified.
1.5.2 Chapter 2 – Literature Review

This chapter provides a comprehensive review of the research around VBAC and examines the qualitative and quantitative research available. The chapter begins by exploring the research around women’s attitudes and views around VBAC and research about VBAC education and how women decide on their mode of birth. The factors that increase VBAC rates are discussed as well as the morbidity and mortality comparisons between VBAC and caesarean. Research around VBAC in various locations, such as hospital, birth centres and homebirth are explored. Finally the research around birth trauma is discussed.

1.5.3 Chapter 3 - Methodology

The third chapter identifies the theoretical background and methodologies used. This study is a qualitative interpretive study that explores women’s reasons for and experiences of choosing a homebirth following a caesarean section. Feminist methodology is the theoretical framework used in this study and this is introduced and discussed in this chapter.

The study involved individual interviews with women who have had a previous caesarean section and chose to have a HBAC. A focus group with PPMs was conducted to ascertain their perceptions about this issue, why they think
women seek this choice and their support and what they think are the potential implications for women under proposed legislative changes.

1.5.4 Chapters 4 & 5 – Why it’s never happening again & How it’s never happening again

Chapters four and five present the study findings and describe the themes, subthemes and concepts that emerged from the analysis. An overarching theme of ‘It’s never happening again’ is divided into two themes of ‘Why it’s never happening again’ and ‘How it’s never happening again’. These two themes follow a logical and chronological order towards achieving a HBAC. In chapter four women’s experience of their previous caesarean is explored as well as any subsequent births before their HBAC. The themes, subthemes and concepts in this chapter identify the traumatic experiences and feelings that resulted in women's resolve to prevent the same experience repeating in their subsequent pregnancy.

In chapter five the themes, subthemes and concepts demonstrate the actions and support that the women undertook and sought out in preparation for their HBAC. The importance of becoming knowledgeable and surrounding themselves with positive support become evident in their pursuit of their goal. The relationship with their PPM is also explored. The triumphant feelings surrounding the actual HBAC experience and how this has influenced their
beliefs and practices around birth and mothering are exhibited within the subthemes and concepts in this chapter. Throughout both results chapters, the findings from the focus group of PPMs are interwoven to add greater depth to the women’s experiences and voices.

1.5.5 Chapter 6 – Discussion

This chapter examines the issues found in this study in relation to current research. The chapter begins by discussing the experience of birth trauma reported by the women in this study and also identifies, in related research, the prevalence of disrespect and abuse of women during pregnancy and childbirth, and the overmedicalisation of childbirth. The benefits of support for women through support groups is established in the research and also discovered in this study. The role of the PPM in a partnership model is viewed through the feminist lens and the differences between different models of care discussed. Finally, the current climate around HBAC is discussed, including the issue of freebirth.

1.5.6 Chapter 7 – Conclusion

This chapter explores the rationale for the study and discusses the value of using feminist methodology as well as the significance of the overarching theme of ‘It’s never happening again’. The limitations and implications of this study are also presented in this chapter. Possible future research is also discussed.
1.6 Conclusion

This introductory chapter has presented the background and setting of this study including rates of VBAC and the current homebirth climate in Australia. The issues surrounding PPMs’ practice of HBAC and the role and scope of practice as highlighted in research is examined. The aims and objectives of this study are demonstrated and an outline of this thesis given. The following chapter will explore the research available around the issue of VBAC and HBAC.
2 LITERATURE REVIEW

2.1 Introduction

This chapter aims to explore the existing research on VBAC and HBAC to provide a background and purpose to this research project. A systematic approach was used to identify relevant research and critically review the relevance to the research question and quality of the research. The aim of this study is to explore the experiences and reasons why women choose to have a VBAC at home. The different issues around having a VBAC in hospital compared to having a HBAC are investigated.

This chapter begins with identifying the systematic search method for relevant literature and presents the studies in two tables, one of quantitative studies and one of qualitative studies. Eleven themes or key issues emerged from this
review of both qualitative and quantitative research. The literature review commences with the exploration of women's attitudes and views around VBAC and research about VBAC education and how women decide on their mode of birth. Factors contributing towards achieving a VBAC were a common theme and these factors have been broken into sub themes. The morbidity and mortality risks of caesarean are discussed and comparative studies into the risks and outcomes of VBAC versus caesarean are explored. The review focuses on the outcomes of VBAC out of hospitals, the management of VBAC in hospitals and the research around birth trauma. Within birth trauma, the issues around how women felt about their previous traumatic birth (some of which were caesareans) are discussed and also how a positive subsequent birth can have a healing effect.

2.2 Literature Review Method

A search of the following databases was undertaken: CINAHL, Medline, Scopus, PubMed and Cochrane. Papers published between 1990-2015 were included to ensure key papers were identified. Keywords used were: caesarean, VBAC, vaginal birth after caesarean, homebirth, childbirth. Opinion pieces and anecdotal articles were removed. Further papers were found by searching reference lists of the included studies, resulting in a snowball effect. In total, 47 studies have been included in the literature review. A quantitative and a qualitative table were created to identify key features of each study. One mixed
methods study was included in the quantitative studies table. There were thirty six studies included in the quantitative table (table 2-1) with the majority (25) identified as retrospective cohort studies. Five studies were Randomised Controlled Trials (RCT). The qualitative table has eleven studies (table 2-2) and 8 of these studies utilising qualitative interview techniques.
Table 2-1: Quantitative research

<table>
<thead>
<tr>
<th>Author/Date/Country</th>
<th>Aim of Study</th>
<th>Sample/Inclusion Criteria</th>
<th>Study Design/Methodology/Methods</th>
<th>Main Outcomes</th>
<th>Secondary Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agarwal et al (2007) India</td>
<td>To evaluate the outcome of women with previous caesareans in a resource-constrained setting so that an appropriate management protocol can be decided</td>
<td>$n = 447$ women All women with previous caesarean section to a large referral hospital</td>
<td>Observational study</td>
<td>27.7% VBAC</td>
<td>• No availability of continuous monitoring seen as increased decision to repeat caesarean • 39.1% women had no antenatal care • Four maternal deaths, two due to maternal collapse for uterine rupture</td>
</tr>
<tr>
<td>Algert et al (2008) NSW Australia</td>
<td>To estimate the effect of the onset of labour before a primary caesarean delivery on the risk of uterine rupture if VBAC is attempted in the next pregnancy</td>
<td>$n = 10,160$ women Women with a primary caesarean from the recorded births between 1994-2004 that could be linked to a subsequent birth in the period 1998-2004</td>
<td>Retrospective descriptive population data records</td>
<td>0.38% uterine rupture rate 65.3% successful VBAC rate overall Women who had a vaginal birth prior to their caesarean had a VBAC successful rate of 84.8%</td>
<td>• For women with a history of spontaneous labour or vaginal birth, the uterine rupture rate was 0.2% • Women without this previous history but who required induction or augmentation for the VBAC had a uterine rupture rate of 1.1% • 21.5% women</td>
</tr>
</tbody>
</table>

- VBAC: Vaginal Birth After Caesarean
- LSCS: Low Segment Caesarean Section
- VBAC: Vaginal Birth After Caesarean
- IV: Intravenous
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Objective</th>
<th>Sample Size</th>
<th>Design</th>
<th>Outcomes</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Beckman et al (2014)          | Germany     | To describe neonatal and maternal outcomes in mothers who started labour in German out-of-hospital settings | n = 24,545 women with 2nd pregnancy at term, 1927 with prior caesarean, 22,618 with prior vaginal birth | Retrospective data analysis of German out-of-hospital data 2005-2011 | 77.8% VBAC success rate 38.3% transfer rate for VBAC 4.6% transfer rate for non-VBAC | • 3.1% neonatal transfer for VBAC vs. 1.4% for non-VBAC  
• Prolonged first stage highest reason for transfer |
| Buhimschi et al (2005)        | USA         | To identify whether the use of prostaglandin in induction of labour related to increased uterine rupture rate through dissolution | n = 26 women Women with a prior caesarean birth who experienced a uterine rupture during active labour | Retrospective review of clinical records over a 10 year period | 90% of rupture at site of scar when using prostaglandin/oxytocin 47% of rupture at site of scar when using oxytocin | • Women using prostaglandin starting labour with an unfavourable cervix |
| Cheyney et al (2014)          | USA         | To examine the outcomes of planned homebirths between 2004-2009           | n = 16924 women (1054 women had previous caesarean) Statistics from Midwives Alliance of North American Statistics Project (MANA Stats) | Retrospective review of planned homebirth statistics 2004-2009 | 89.1% homebirth rate 87% HBAC rate 5.2% Caesarean rate | • 2.85/1000 intrapartum fetal death rate for planned HBAC  
• 1.3/1000 intrapartum fetal death rate overall  
• 0.85/1000 intrapartum fetal death rate for low risk women |
<p>| Constantine et al (2009)      |             | To validate a VBAC prediction model on a                                  | n = 502 women Women with a vertex | Cohort study | 52.2% VBAC success rate | • Uses maternal age / body mass index (BMI) / ethnicity / |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Study Details</th>
<th>Participants</th>
<th>Study Design</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>different cohort</td>
<td>singleton at term who had one previous caesarean and attempted a VBAC between 01/2002 and 08/2007</td>
<td>When the predicted chance of VBAC success was less than 50%, the actual and predicted VBAC rates did not differ. When the predicted VBAC rate was higher than 50%, the actual VBAC rate was around 10% less.</td>
<td>prior vaginal birth / prior VBAC / indication of previous c/s • Based on North American population</td>
</tr>
<tr>
<td>Crowther et al (2012) 14 Australian hospitals</td>
<td>To compare the benefits and risks of a planned caesarean with a planned VBAC</td>
<td>n = 2345 women Women with one prior caesarean and a single cephalic term pregnancy and 'suitable' from an obstetrician</td>
<td>Multicenter prospective restricted cohort study</td>
<td>0.2% uterine rupture rate 43.2% VBAC success rate in planned VBAC cohort More fetal / infant mortality and morbidity in planned VBAC group vs. elective caesarean group (2.4% vs. 0.9%) • Outcomes based on planned VBAC not actual VBAC so both emergency and elective caesareans within this cohort</td>
</tr>
<tr>
<td>Dahlen et al (2014) NSW Australia</td>
<td>To examine the rates of obstetric intervention and perinatal morbidity and mortality in low risk women in both private and public hospitals</td>
<td>n = 691,738 women Linked data population based retrospective cohort study during 2000-2008</td>
<td>Low risk women – 20-34yrs, no hypertension or diabetes, non-smoker, with a single cephalic term pregnancy Private hospitals had higher rates of obstetric intervention vs. public hospitals Babies more likely to be born before 41 weeks and less likely to have an APGAR over 7 at 5 minutes and have an admission to SCN/NICCU</td>
<td>• 45% NVB rate in private hospital vs. 65% in public hospital for first pregnancies • 70.8% Epidural rate in private hospital vs. 35.4% in public hospital for first pregnancies</td>
</tr>
<tr>
<td>David et al (2008)</td>
<td>To evaluate the safety</td>
<td>n = 364 women</td>
<td>Retrospective</td>
<td>0% uterine rupture</td>
</tr>
</tbody>
</table>
| German birth centres | of VBAC in birth centres and to identify any difference with maternal and neonatal outcomes | prior caesarean $n = 6448$ women with no prior caesarean in control group
Target group – all second births to mothers with a previous caesarean
Control group – all second birth mothers with no previous caesarean | evaluation of prospectively collected data | rate 73.5% VBAC success rate 97.9% NVB rate in control group | maternal or neonatal mortality or morbidity between target and control group |
| Dekker et al (2010) | Four Australian States | To quantify the risk of uterine rupture in women with a previous caesarean in different modes of birth and with or without the use of pharmacological induction methods | $n = 29,008$ women
All women with a previous caesarean having their second singleton birth between 1998-2000 | Population based retrospective cohort study | 0.15% uterine rupture rate in spontaneous VBAC 1.91% uterine rupture rate with use of oxytocin |
| Fitzpatrick et al (2012) | UK | To estimate the uterine rupture rate and the risk factors and outcomes of VBAC vs. elective caesarean | $n = 159$ women with uterine rupture $n = 448$ women with previous caesarean and no uterine rupture (control group)
Case notes of women having had a uterine rupture during the 13 month study period
Control group included women who had a previous caesarean and had a subsequent birth | Case control study | 0.2% overall uterine rupture rate
Rupture rate increased with >2 previous caesareans / <12 months since last caesarean / use of oxytocin for labour induction |
<p>| | | | | | Two maternal deaths (1.3% of uterine rupture cases) 18 perinatal deaths |</p>
<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Country</th>
<th>Objective</th>
<th>Sample Size</th>
<th>Methodology</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foureur et al (2010)</td>
<td>Australia</td>
<td>To assess the quality of national guidelines for management of VBAC</td>
<td>6 guidelines</td>
<td>Purposive sampling of six countries' national guidelines from national organisations</td>
<td>Analysis of guidelines with use of Appraisal of Guidelines for Research and Evaluation (AGREE) instrument</td>
<td>1/3 guidelines scored well under the AGREE instrument. Uterine rupture rates varied from 0%-2.8%. VBAC success rates varied from 30%-85%.</td>
</tr>
<tr>
<td>Fraser et al (1997)</td>
<td>North America and Canada</td>
<td>To explore whether providing prenatal education increases VBAC success rates</td>
<td>1275 women</td>
<td>Women with a previous caesarean and a current pregnancy &lt;28 weeks gestation</td>
<td>RCT two groups; document group and verbal group</td>
<td>Similar VBAC success rates between document and verbal group (49% vs. 53%).</td>
</tr>
<tr>
<td>Janssen et al (2009)</td>
<td>Canada</td>
<td>To compare the outcomes of planned homebirth/planned hospital birth with a midwife and planned hospital birth with an obstetrician</td>
<td>2889 planned homebirth with midwife</td>
<td>n = 4752 planned hospital birth with midwife</td>
<td>Comparison data analysis study</td>
<td>Perinatal death rate 0.35%, planned homebirth 0.57%, planned hospital midwife 0.65% planned hospital obstetrician. 89.9% NVB rate at home vs. 82.3% hospital midwife and 75.2% hospital obstetrician.</td>
</tr>
<tr>
<td>Kamath et al (2009)</td>
<td>USA</td>
<td>To examine the neonatal outcomes of elective caesarean and women with one prior caesarean and a</td>
<td>672 women</td>
<td></td>
<td>Retrospective cohort study</td>
<td>Caesarean related to higher NICU admission, higher rates of</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Objective</td>
<td>Population</td>
<td>Methods</td>
<td>Outcomes</td>
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</tbody>
</table>
| Landon et al (2004)            | USA         | To assess risks of uterine rupture and associated maternal and neonatal morbidity and mortality | n = 17,898 attempted VBAC  
n = 15,808 repeat caesarean  
All women with a history of previous caesarean and a singleton pregnancy | Prospective multicentre observational 4 year study | 73.4% VBAC success rate  
0.7% uterine rupture rate  
1.8% neonatal death rate in uterine rupture cases  
Endometritis and transfusion rates highest in emergency caesarean |
| Knight et al (2014)            | UK          | To examine the demographic and obstetric factors that may affect the uptake and success rates of VBAC | n = 143,970 women  
Women who attempted a VBAC for their second birth | Cohort study | 63.4% VBAC success rate  
Women who were younger, white and had an elective caesarean for their first birth had higher VBAC success rates  
* Failed labour of induction had lowest VBAC success rate |
| Kennare et al (2009)           | South Australia | To examine outcomes for planned homebirths and planned hospital births | n = 1141 women planned homebirth  
n = 292,467 women planned hospital birth  
Planned homebirths during 1991-2006 | Population based study | Excluding congenital anomalies, no statistical difference was found in perinatal mortality between planned homebirth and planned hospital birth  
* 8.8% women planned a VBAC at home  
* Includes births planned at home at time of antenatal booking  
* 9.2% caesarean rate for planned homebirth vs. 27.1% planned hospital birth |

VBAC = vaginal birth after caesarean

Subsequent term pregnancy

Resuscitation at birth

Emergency caesarean after attempted VBAC had highest requirement for resuscitation
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Objective</th>
<th>Study Design</th>
<th>Outcomes</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latendresse et al (2005)</td>
<td>USA</td>
<td>To describe the outcomes of women who intended to homebirth with a previous caesarean</td>
<td>Data from a previous prospective study</td>
<td>0% uterine rupture rate 93% VBAC success rate 5.3% repeat caesarean rate 87.7% VBAC at home</td>
<td>* 91.8% used intermittent auscultation for fetal monitoring</td>
</tr>
</tbody>
</table>
| Leiberman et al (2004)        | USA           | To obtain the relevant data to formulate national guidelines on VBAC in birth centres | Prospective multicentre observational cohort                                  | 0.4% uterine rupture rate 87% VBAC rate 0.5% neonatal morbidity                             | * Women more than 42 weeks or more than one previous caesarean included in study  
* Advises that VBAC's be undertaken in hospitals |
| Li et al (2015)                | UK            | To explore the risks and outcomes of ‘higher risk’ women planning to homebirth vs. obstetric unit | Prospective cohort study                                                      | Adverse perinatal outcome lower in homebirth group                                           | * Maternal interventions lower in homebirths  
* 18.21% had previous caesarean |
<p>| Macones et al (2005)          | USA           | To assess risks of uterine rupture and associated maternal and neonatal morbidity and mortality | Multicenter case-control cohort study                                         | 75.5% VBAC success rate 0.9% uterine rupture rate                                           | * Prior vaginal birth decreased uterine rupture rate |
| Mercer et al (2008)           | USA           | To estimate the risks and success rates to women who have a               | Secondary analysis of a 4 year observational study (see Landon et              | VBAC success increased with the more VBAC's a woman                                        |                                                                                               |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Objective</th>
<th>Participants</th>
<th>Study Design</th>
<th>Comparison</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery et al (2007)</td>
<td>UK</td>
<td>To determine effects of two computer based decision aids on women deciding on mode of birth for their next birth after caesarean</td>
<td>n = 742 women</td>
<td>RCT usual antenatal care, information program, decision analysis tool</td>
<td>Decision conflict reduced in all three cohort later in pregnancy but reduced more in both intervention groups</td>
<td>Slightly higher VBAC rate in decision analysis tool cohort than other cohorts (37% vs. 30% and 29%)</td>
</tr>
<tr>
<td>Naji et al (2007)</td>
<td>UK</td>
<td>To use scar thickness by ultrasound, demographic data and obstetric history to develop a model to predict success of VBAC</td>
<td>n = 121 women</td>
<td>Selected cohort for ultrasound scar thickness measurement</td>
<td>61% VBAC success rate</td>
<td>The residual myometrial thickness (RMT) was higher in the second trimester in successful VBAC’s</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Objective</td>
<td>Population Details</td>
<td>Methodology</td>
<td>Outcome/Result</td>
<td></td>
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</tr>
<tr>
<td>Smith et al (2004)</td>
<td>Scotland</td>
<td>To investigate the factors associated with increased neonatal death due to uterine rupture in attempted VBAC</td>
<td>$n = 35,854$ women Women with one previous caesarean who did not have an elective caesarean for their subsequent birth</td>
<td>Population based retrospective cohort study</td>
<td>0.35% uterine rupture rate 74.2% VBAC rate  • Uterine rupture rate increased in woman without a previous vaginal birth history and when labour induced with prostaglandin</td>
<td></td>
</tr>
<tr>
<td>Srinivas et al (2007)</td>
<td>USA</td>
<td>To identify clinical factors to accurately predict failure in women attempting VBAC</td>
<td>$n = 13,706$ women Women offered a VBAC</td>
<td>Secondary analysis of a retrospective cohort study see Macones et al (2005)</td>
<td>24.5% emergency caesarean rate  • Authors unable to determine significant clinical factors to predict failure in VBAC</td>
<td></td>
</tr>
<tr>
<td>Stamilio et al (2007)</td>
<td>USA</td>
<td>To investigate the uterine rupture rate in short interpregnancy interval</td>
<td>$n = 13,331$ women Women who attempted a VBAC</td>
<td>Secondary analysis of a retrospective cohort study see Macones et al (2005)</td>
<td>Highest uterine rate of 2.7% associated with short interpregnancy interval of &lt;6 months  • 0.9% uterine rupture rate</td>
<td></td>
</tr>
<tr>
<td>Stock et al (2013)</td>
<td>Scotland</td>
<td>To investigate the outcomes of women having a induction of labour (IOL) for VBAC compared to elective caesarean</td>
<td>$n = 46,176$ women Women with one previous caesarean, pregnant and suitable for a VBAC</td>
<td>Population based retrospective cohort study</td>
<td>59.4% VBAC rate in IOL cohort  • 0.66% uterine rupture rate in IOL cohort  • 0.88% uterine rupture rate when prostaglandin used in IOL</td>
<td></td>
</tr>
<tr>
<td>Wang et al (2006)</td>
<td>Taiwan</td>
<td>To develop a web based VBAC education program for women</td>
<td>$n = 10$ women Pregnant women with a previous caesarean and $&gt;32$ weeks gestation without pregnancy complications</td>
<td>Mixed methods; quantitative survey analysis and phenomenological qualitative interviews</td>
<td>88.89% VBAC success rate  • Women undertook in total 90 minutes of VBAC education</td>
<td></td>
</tr>
</tbody>
</table>


Table 2-2: Qualitative research

<table>
<thead>
<tr>
<th>Author / Date / Country</th>
<th>Aim of study</th>
<th>Sample / Inclusion Criteria</th>
<th>Study design/methodology/methods</th>
<th>Key findings / themes</th>
<th>Additional findings / subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dahlen &amp; Homer (2011)</td>
<td>How women discuss the option of VBAC and the factors that influence their decision on mode of birth on the blog sites</td>
<td>n = 311 blogs Qualitative study using internet blog sites over a one year period Blog sites that were identified via a search engine with the variety of different terms used for VBAC</td>
<td>Qualitative study using internet blog sites over a one year period</td>
<td>There were two viewpoints found: 'motherbirth' or 'childbirth'</td>
<td>• 'motherbirth' put benefits of birthing to both the mother and baby • 'childbirth' put priority to the baby</td>
</tr>
<tr>
<td>Emmett et al (2006)</td>
<td>To explore how women chose their mode of birth for their subsequent birth following a previous caesarean</td>
<td>n = 21 women Women with a previous caesarean and had a recent birth 2-8 months prior to recruiting</td>
<td>Qualitative interview study</td>
<td>Mixed reaction to deciding on mode of birth but overall women felt they made their own decision</td>
<td>• Women felt anxiety deciding on mode of birth • Women had to find own information and resources</td>
</tr>
<tr>
<td>Fenwick et al (2003)</td>
<td>To explore women's experiences of achieving a VBAC and their perceptions of their caesarean</td>
<td>n = 59 women Women with a previous caesarean who planned for a VBAC in the subsequent pregnancy</td>
<td>Descriptive qualitative survey</td>
<td>78% women stated caesarean experience was traumatic</td>
<td>• Themes include loss of control, negative comments from health professionals, positive effect of VBAC</td>
</tr>
<tr>
<td>Fenwick et al (2007)</td>
<td>To explore the</td>
<td>n = 35 women Qualitative interviews</td>
<td></td>
<td>The caesarean</td>
<td>• Themes include reflections on</td>
</tr>
<tr>
<td>Location</td>
<td>Topic</td>
<td>N</td>
<td>Methodology</td>
<td>Themes</td>
<td>Findings/Implications</td>
</tr>
<tr>
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<td>Western Australia</td>
<td>Knowledge and expectations of women planning a VBAC</td>
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<td>Women who had a previous caesarean and are planning a VBAC for a subsequent birth</td>
<td>Reinforced to the women the importance of a vaginal birth. Caesarean, attitudes of family and friends and women's belief in birth</td>
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<td>Forssen (2008) Sweden</td>
<td>To explore the lifelong affects of negative experiences of pregnancy and birth</td>
<td>n = 20 women</td>
<td>Qualitative interviews</td>
<td>Themes around loss of control, condescension and blame, dismissal of knowledge and pain, shocking experience and lifelong shame</td>
<td>Authors surprised at how vivid and accurate the memories of childbirth.</td>
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<td>Frost et al (2009) UK</td>
<td>To explore women's views and experiences around decision making for mode of birth and their experiences of using the decision making tool</td>
<td>n = 30 women</td>
<td>Qualitative interviews within an RCT</td>
<td>Themes around the role of decision aids, the impact of decision aids on knowledge and anxiety, prior preferences and outcome</td>
<td>The cohort of women who received the information program felt more knowledgeable and able to make a decision.</td>
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<td>McGrath et al (2010) Queensland, Australia</td>
<td>To explore the decision making process for subsequent birth following a caesarean from a woman's perspective</td>
<td>n = 20 women</td>
<td>Phenomenological qualitative interviews</td>
<td>Themes around VBAC perceived as riskier that repeat caesarean, inconsistent support from medical staff, bias towards caesarean</td>
<td>Women concerned that they can not stand by their wishes when being pressurised by obstetric staff.</td>
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<td>Meddings et al (2007) UK</td>
<td>To explore the level of informed choice and decision making women had when planning their next birth after a caesarean</td>
<td>n = 8 women</td>
<td>Phenomenological qualitative interviews</td>
<td>Themes around informed choice, better recovery after birth and influences on bonding</td>
<td>Women felt that obstetric and midwifery bias was towards VBAC. Two women had a repeat caesarean.</td>
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<td>Study</td>
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<td>Research Question</td>
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<td>Methodology</td>
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<td>Moffat et al (2006)</td>
<td>Scotland</td>
<td>To explore women's decision making during current pregnancy regarding next birth after caesarean</td>
<td>n = 26 women, Women local to participating hospital, &gt;16yrs, first birth caesarean for non-recurring reason</td>
<td>Qualitative study using observation, diaries and interviews</td>
<td>Themes around difficulty in making decision re mode of birth and factors affecting decision making</td>
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<td>• Some women wished to experience vaginal birthing</td>
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<td>• Variety of levels of information given to women</td>
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<td>Thompson &amp; Downe (2010)</td>
<td>UK</td>
<td>To explore women's experiences of having a positive birth following a traumatic birth</td>
<td>n = 14 women, Women who had a self-defined traumatic birth and either had or were planning a following positive birth experience</td>
<td>Interpretive phenomenological interviews</td>
<td>Main theme of 'changing the future to change the past' with themes including resolving the past and preparing for unknown, being connected, being redeemed and being connected</td>
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<td></td>
<td>• All women received continuity of care and described trust, mutuality and respect with their healthcare provider</td>
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<td>• Five women had a 'traumatic' caesarean</td>
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2.3 Women’s attitudes and views of VBAC

The literature review commences with identifying and discussing the research available on women’s attitudes and views of VBAC, as this is one of the focus areas of this thesis. Although the thesis is focusing on the experiences of women having a HBAC, no research is available that specifically looks at the experiences of this group of women. However, research papers are available exploring the attitudes and views of women having a VBAC in hospital.

Five qualitative studies are identified that explore women's attitudes and experiences of VBAC. Three of the studies explored the perceptions and experiences of women planning to have a VBAC in the hospital environment and one explored the experiences of women having a water VBAC in a midwife led unit (McKenna & Symon, 2014). Common throughout the studies were: informed choice, differences in recovery from childbirth and influences on bonding (J. Fenwick, Gamble, J., Hauck, Y., 2006; McGrath, 2010; Meddings et al., 2007). Actively avoiding medical intervention was a reason to pursue a water VBAC (McKenna & Symon, 2014). Women chose to have a VBAC to be able to drive a motor vehicle postnatally and have a faster recovery compared to a caesarean. This is predictable as it is a practical area of concern for women with small children and busy family lives. Fenwick et al (2006) also reported the positive effect of family and friends attitudes towards VBAC, the effect of
reflection on the previous caesarean as well as the benefit of VBAC to the health of the baby.

Women found differences in the way health care providers either positively supported or negatively influenced their decision to pursue a VBAC. Some women found if the health care provider offered choice and involved the women in all of the decision-making, they could trust the health care provider (Meddings et al., 2007). Other women found that the health care provider did not give sufficient information (McKenna & Symon, 2014), and implied VBAC was very risky which resulted in the woman feeling bullied into following the staff recommendations and later made to feel guilty if anything was to go wrong (McGrath, 2010).

A recent study by Dahlen and colleagues (2011) explored discussions about VBAC on international blog sites. The major theme was termed ‘motherbirth / childbirth’. The ‘Motherbirth’ framework described women who expressed the opinion that a mother’s health and wellbeing were important for a healthy baby and that the experience of giving birth was important for this. These views were held in a balance with the needs of the baby. These women were more likely to choose a VBAC (H. Dahlen, Homer, C., 2011). The ‘Childbirth’ framework was described as one where women put the needs of the baby above their needs, and chose what they believed to be the less risky birth option, an elective caesarean. Other themes that arose were similar to previous research, such as
the importance of choice, fear of giving birth and perceptions of body failure (H. Dahlen, Homer, C., 2011).

2.4 VBAC education and decision making programs

Nine studies look at the way women make their decision to aim for a VBAC or choose to have a repeat elective caesarean. Five of these studies included educational program component and investigated how that might influence decision-making and outcome (Emmett, 2006; Fraser, 1997; Frost, 2009; Montgomery, 2007; Wang, Chung, Sung, & Wu, 2006).

Three studies explored the effect of a variety of educational programs on women's decision making and VBAC outcomes. These included a face to face education program versus a pamphlet (Fraser, 1997), a 90 minute computer based information resource (Wang et al., 2006) and an information program covering issues such as complications for the mother and baby compared with a decision analysis program (Montgomery, 2007).

The success of the above programs was mixed and may have been related to a bias in content, for example Wang et al (2006) found, despite being a small study, a positive attitude and increased knowledge was apparent following the intervention and led to an increase in the number of women planning to have a
VBAC from six women to nine, with eight proceeding to have a successful VBAC. The program was positively focused towards VBAC and included other women’s experiences of VBAC. However, the study by Frost et al (2009) that included interviews with 30 of the women from the DiAMOND trial (Montgomery, 2007). Women were either given standard obstetric care, given a decision analysis tool or undertook an information program. It was found that some of the women’s concerns about both the decision analysis tool and the information program were that they were scare-mongering and not promoting vaginal birth (Frost, 2009). One study found that women who scored high on motivation for vaginal birth were more likely to have a VBAC, regardless of education style (Fraser, 1997).

### 2.5 Factors contributing to VBAC

Several factors are reported in the literature that contribute to women having a VBAC, including: spontaneous onset of labour, a previous vaginal birth, a previous VBAC, demographic factors and the indication for the prior caesarean (Costantine M, 2009; Grobman W, 2007; Harper, 2008; Knight et al., 2014; Srinivas et al., 2007).

#### 2.5.1 Previous vaginal birth
History of a previous vaginal birth was significantly associated with a VBAC in two studies (Algert, Morris, Simpson, Ford, & Roberts, 2008; Srinivas et al., 2007). There was a significant increase in the rate to 84.8% if the woman had a previous vaginal birth and a decrease to 60% if the woman required induction or augmentation (Algert et al., 2008).

2.5.2 Previous VBAC

Mercer et al (2008) found women who had a previous VBAC were more likely to have a vaginal birth for subsequent pregnancies. For women with no previous VBAC, the rate of VBAC was 63.3% compared to 87.6% if they had one previous VBAC and 90.9% if they had two or more VBACs (Mercer et al., 2008). Interestingly, women who had a history of two or more VBACs also tended to have a history of more than one caesarean.

2.5.3 Indication for previous caesarean

Two studies found previous caesareans due to ‘failed inductions’ or due to cephalopelvic disproportion (CPD) were found more commonly in the repeat caesarean group compared to the VBAC group (Mercer et al., 2008). Women who had a failed induction for the previous emergency caesarean were least likely to attempt or achieve a VBAC (Knight et al., 2014).
2.5.4 Demographic and obstetric details

Three studies (Costantine M, 2009; Grobman W, 2007; Knight et al., 2014) have reported VBAC was higher in younger women, women with lower BMI and white ethnicity. Knight et al (2014) defined different ethnicity as white, Asian, black, other and unknown, Constantine (2009) identified African American, Hispanic and white and Grobman (2007) identified white, African American, Latina and other. Obstetric reasons with higher VBAC rates are previous vaginal birth, a non-recurring reason for caesarean or a previous elective caesarean.

2.5.5 Thickness of scar

The use of a routine ultrasound to measure scar thickness as a way of predicting if a successful VBAC will result, has not been recommended, but a small study done in the UK of 121 women found a high prediction accuracy when measuring the residual myometrial thickness (RMT) in ultrasounds in each trimester (Naji et al., 2013). It was suggested that women who had minimal changes in RMT measurements during the pregnancy were more likely to have a vaginal birth. Other factors included an increase in repeat emergency caesareans following induction of labour (Naji et al., 2013).
2.6 Risks related to repeat caesarean

A large prospective multicentre study investigating maternal morbidity related to repeat caesareans found an increase in placenta previa and accretia, hysterectomy and length of stay in hospital (Silver, 2006). Further maternal morbidity associated with repeat caesareans include chronic pain, pelvic adhesions, operative trauma and an increase in blood transfusion rates (Clark, 2011; Lyell, 2011). The relationship of caesarean birth to reduced fertility is uncertain (Oral, 2007). It is possible psychosocial issues influence the decision to get pregnant again (Oral, 2007).

2.7 Maternal morbidity & mortality in caesarean versus planned VBAC

In this section the literature review will focus on the large multicentre studies that have identified the differences in maternal morbidity and mortality of women with a previous caesarean section and the different modes of birth for their subsequent birth. The outcomes from these studies include maternal morbidities such as endometritis, increased bleeding requiring a blood transfusion and operative injury following planned VBAC compared to elective caesareans (Crowther, 2012; Gilbert, 2012; Landon, 2004; Nigam & Anand, 2015). However, when the data is available to identify the mode of birth in the planned VBAC group, it is apparent the increased morbidities are attributable to emergency caesareans. For example, in the Landon et al (2004) study of
planned VBACs resulting in a caesarean section, the rates of endometritis was 7.7% compared with 1.2% if a vaginal birth resulted and 1.8% when the woman had an elective caesarean section. Similarly, the need for a transfusion when a VBAC was unsuccessful was 3.2%, 1.2% if successful and 1.0% if an elective caesarean was performed (Landon, 2004).

2.7.1 Factors that increase uterine rupture rate

Fear of uterine rupture is one of the key deterrents for VBAC (Guiliano et al., 2014). The uterine rupture rate varies in different studies, from 0.1%-2.7% (Gilbert, 2012; Landon, 2004; Latendresse, 2005; Stamilio, 2007). A recent Australian study found the uterine rupture rate was 0.2% (Crowther, 2012).

Studies have also looked at the factors that increase uterine rupture rates in woman who have a history of a previous caesarean. Two factors have been identified, the interval between the caesarean and following pregnancy (the inter-pregnancy interval) and the use of pharmacological agents for induction of labour (Buhimschi et al., 2005; Fitzpatrick, 2012; Palatnik & Grobman, 2015; G. Smith, Pell, JP., Pasupathy, D., Dobbie, R., 2004; Stamilio, 2007; Stock et al., 2013).

2.7.2 Short inter-pregnancy interval
Stamilio et al (2007) specifically looked at the impact of short pregnancy interval. The results suggest that women who have a short inter-pregnancy period (from date of birth to date of conception of next pregnancy) have an increased uterine rupture rate of 2.7% compared to the rate for women who have more than six months interval of 0.9%, although the rate of successful VBAC did not differ at 77% (Stamilio, 2007). One study that focused on the reported cases of women who had experienced a uterine rupture found rupture rates increased with a short inter-pregnancy interval of less than 12 months and where induction/augmentation occurred (Fitzpatrick, 2012). RANZGOG state a period of less than 18 months since the previous caesarean is a contraindication to VBAC (RANZCOG, 2010).

2.7.3 Induction of labour

Studies have examined the use of pharmacological methods of induction or augmentation of labour (IOL) and the effect on the incident rate of uterine rupture in women attempting a VBAC. The highest rate of uterine rupture tends to occur following a multi-pharmacological use of prostaglandin gel and oxytocin (Buhimschi et al., 2005; Dekker, 2010; Palatnik & Grobman, 2015; G. Smith, Pell, JP., Pasupathy, D., Dobbie, R., 2004; Stock et al., 2013). Alternatives to pharmacological IOL have been explored in a study on serial membrane sweeping (Hamdan, Sidhu, Sabir, Omar, & Tan, 2009). The sample size was relatively small at 108 in the sweeping group and 105 in the control group. The treatment involved either weekly membrane sweeping or weekly vaginal
examinations and no difference was found in primary outcomes of onset of labour or repeat caesarean delivery rate and there were no uterine ruptures (Hamdan et al., 2009). A recent study found no difference in success rates of VBAC or neonatal and maternal outcomes for women with a history of one or two prior caesareans and pharmacological induction of labour methods (E. S. Miller & Grobman, 2015).

2.8 Neonatal Morbidity and Mortality

The large studies that compared the outcomes of VBAC verses elective caesarean also included neonatal morbidity and mortality (Crowther, 2012; Landon, 2004). One study found an increase in the rate of antepartum stillbirth in the planned VBAC cohort (0.6%) compared with the elective caesarean group (0.2%) (Crowther, 2012). The authors did identify that these numbers included babies with known congenital malformations and women experiencing fetal death in utero who were encouraged to have a VBAC rather than a caesarean.

Gilbert (2012) and Kamath et al (2009) have found that neonates born by VBAC have less need for resuscitation with oxygen and fewer admissions to Neonatal Intensive Care Units (NICU) when compared to babies born by caesarean section. These infants displayed a slight increase in transient tachypnoea and an increase in newborn infection (Gilbert, 2012; Kamath et al., 2009).

The size of the hospital has been found to be a contributing factor to the risk of neonatal death resulting from uterine rupture (G. Smith, Pell, JP., Pasupathy, D.,
Dobbie, R., 2004). Of 107 uterine ruptures in the study by Smith (2004), 17 neonatal deaths of which 13 occurred in hospitals that have <3000 births per annum, 15 in women with no previous vaginal birth and five associated with the use of prostaglandin as an induction method (G. Smith, Pell, JP., Pasupathy, D., Dobbie, R., 2004). A study that explored the outcome following partial uterine ruptures or complete uterine ruptures found no neonatal deaths in the partial uterine rupture and a 13.6% neonatal mortality rate in the complete uterine ruptures (Guiliano et al., 2014).

2.9 Place of Birth

VBAC undertaken at home is discussed in the literature but no studies have specifically looked at its safety. There are studies that look at the safety and outcomes of births undertaken at home or in birth centres compared with hospital births and some of these include VBAC’s. This will be explored in the next section.

2.9.1 Birth Centres

Two studies have been undertaken which identified the safety and outcomes associated with planning a VBAC in a birth centre. The uterine rupture rates were 0% and 0.4% (David, 2008; Lieberman, 2004). There were also high VBAC
rates of 73.5% and 87% in these two studies yet the recommendations from Lieberman et al (2004) were to advise women planning a VBAC should undertake this in a hospital environment, which subsequently led to the decline in VBACs throughout US birth centres.

Birthing centres can provide an alternative for women who do not want to give birth in hospital and are reluctant to give birth at home. One such birthing centre provided services for women who were wishing to VBAC after 1-2 caesareans, or vaginal breech birth, or for vaginal multiple births, and conducted a review of their services and statistics (Deline et al., 2012). They reported a caesarean rate of 4%; of 92 women planning a VBAC, 96% achieved a vaginal birth with no cases of uterine rupture (Deline et al., 2012). The women giving birth at the centre were offered continuous support from a clinician, hot packs and massage for pain relief, were able to mobilise and were monitored with intermittent fetal monitoring.

2.9.2 Homebirth

The safety and outcomes of having a HBAC can be extrapolated from studies that have looked at the safety of homebirth when women planning a HBAC have been included in the data. Seven studies have included women that had a HBAC with some including the HBAC rates. Beckman et al (2014) found that the HBAC rate was 77.8% compared to a hospital VBAC rate of 32%. The rate of transfer to hospital for women planning to HBAC was larger with 38.3% of women
transferring compared to a transfer rate of 4.6% for women with no history of a previous caesarean. Similar HBAC rates exist within other research: 72% (Avery, 2004), 87% (Cheyney et al., 2014) and 87.7% (Latendresse, 2005). Uterine rupture rates in these studies have not been reported (Kennare, 2009) or have been reported as zero (Avery, 2004; Beckmann et al., 2014; Cheyney et al., 2014; Janssen, 2009; Latendresse, 2005). In a review of midwives’ data, Midwives Alliance of North American Statistics Project (MANA Stats), women planning a HBAC had a higher intrapartum fetal death rate of 2.85/1000 compared to the rate of 0.85/1000 for low risk women (Cheyney et al., 2014).

A comparison of ‘high risk’ women giving birth at home or in an obstetric led hospital and ‘low risk’ women found that intervention rates were lower at home and intrapartum morbidity and mortality and NICU admission were higher in hospital amongst the ‘high risk’ women (Y. Li et al., 2015). When the ‘high risk’ and ‘low risk’ women giving birth at home were compared, there was a higher occurrence of an adverse perinatal outcome in the ‘high risk’ women. Of the ‘high risk’ women giving birth at home, 18.21% had a history of a previous caesarean; there was no information on VBAC rates (Y. Li et al., 2015).

Some women choose to give birth ‘outside the system’ in response to these perceived difficulties. These women choose to either free birth, which is an intended birth at home with no health professional, or they have a high risk homebirth, which is a birth at home with a midwife in attendance but with a risk factor that would exclude them from a publicly funded homebirth (M. Jackson, Dahlen, & Schmied, 2012).
Guidelines for how VBAC is managed in a hospital are largely written by national organisations and professional bodies and these can vary widely (Foureur, 2010). Foureur (2010) examined national guidelines from six different countries. The critique to search for clarity, applicability, independence and rigor yielded interesting results (Foureur, 2010). There was disparity between VBAC success and rupture rates with the rates not always referenced. Four of the guidelines recommended continuous fetal monitoring; one guideline stated that there was limited evidence to support continuous fetal monitoring. Continuous fetal monitoring during labour is recommended in Australian national guidelines yet there is little research evidence to support this recommendation (Foureur, 2010; RANZCOG, 2010).

For Australian hospitals the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) guidelines are used to guide practice. At the time of the Foureur et. al. (2010) review, no guidelines were available from RANZCOG about VBAC, but they have subsequently become available. Like the other national guidelines these indicate that women should have continuous cardiotocography (CTG) monitoring, epidurals are of no harm, women should be restricted to clear fluids, and that induction and augmentation can be offered with caution (RANZCOG, 2010). Other authors have suggested it
is time to reassess these guidelines to make them more evidence-based and woman-centred (Cunnigham, 2010; Shorten, 2010).

Women have identified that routine practices such as continuous fetal monitoring have negatively influenced the ability for them to have a VBAC due to mobility restrictions (J. Fenwick, Gamble, J., Mawson, J., 2003). Women reportedly prefer intermittent fetal auscultation which allows for intermittent ambulation and deem other routine practices as unnecessary (J. Fenwick, Gamble, J., Mawson, J., 2003).

Fruscalzo et al (2012) found that implementing a VBAC policy that routinely offered VBAC over an elective caesarean led to increases in VBAC (Fruscalzo, Salmeri, Cendron, Londero, & Zanni, 2012). The VBAC policy also stated that the only induction methods to be used were castor oil and amniotomy and epidurals would not be offered or used during labour (Fruscalzo et al., 2012). The study sample was small (170 women) but the vaginal birth rate was 63.5% and the overall caesarean rate for the hospital decreased from 19.6% to 14.9% (Fruscalzo et al., 2012).

2.11 Birth Trauma
Much of the research on VBAC looks at physical outcomes such as a ruptured uterus or operative trauma with little consideration of the psychological issues these different types of birth induce. Birth trauma is not necessarily caused by the actual mode of birth but instead can be caused by the feelings women experience during and after giving birth (Bruijn, 2008). Feelings that seem to be attributed to birth trauma include being vulnerable, frightened, out of control, ignored and abandoned, and anxious (Bruijn, 2008; R. Elmir, Schmied, V., Wilkes, L., Jackson, D, 2010). Traumatic birth has been found to impact on women for many years and can have an impact on lifelong self-esteem and willingness to seek healthcare (Forssen, 2012).

A review of the literature around birth trauma conducted by Elmir (2010) revealed that a traumatic birth could have an effect on maternal – infant relationships and also on relationships with partners. Elmir (2010) discusses the importance of counselling and debriefing and suggests women should be given this opportunity, although more research is required on the value of these interventions. Women who have a primary caesarean may experience some or all of these feelings during their birth experience and they may or may not have explored these issues before becoming pregnant again.

A survey of 59 women who had a previous caesarean found that the previous birth experience was often described as traumatic and on average rated 3/10 on a Likert scale with one as severe trauma and 10 as no trauma (J. Fenwick, Gamble, J., Mawson, J., 2003). The researchers found five themes arose out of the open-ended questions about previous birth experience; these included the women's perceived feelings of failure, their sense of a loss of control, the
treatment from their health care providers, their experience of labour and caesarean, and the distress of being separated from their baby at birth (J. Fenwick, Gamble, J., Mawson, J., 2003). Twenty-nine of the 59 women in this study went on to have a VBAC and the responses following these births were markedly more positive with an average rating of 9/10 on the Likert scale. The two themes that emerged from these experiences related to how women felt that they were being supported and whether they felt that they were in control (J. Fenwick, Gamble, J., Mawson, J., 2003). Participants were accessed from a consumer group called Birthrites who, via their website, aim to educate and inform women about their choices around caesarean and supporting women who wish to have a VBAC, both nationally and internationally. The authors recognise this cohort of women is not a representative sample of women who have experienced caesareans or VBACs as these women have accessed the website with intention (J. Fenwick, Gamble, J., Mawson, J., 2003). It would be interesting to replicate this study now 11 years later, as forums and support groups via the internet have increased in popularity and usage with Birthrites website registering over one million hits (Birthrites, 2012).

A small UK qualitative study that looked at women’s’ experiences of a positive birth following a traumatic birth highlighted the benefits of an after birth service where women were able to meet with a midwife consultant on a needs basis to explore the woman’s traumatic birth narrative and to be able to make plans for the next birth (Thomson, 2010). Five of the women in the study (5/14) had a caesarean for their first birth. A large proportion of these women were not accessing the service until their next pregnancy (Thomson, 2010). Women who
went on to have a positive birth expressed feelings of pride and achievement and described it as a healing experience, termed ‘redemptive birth’ by the authors. This study included two women choosing to have an elective caesarean (Thomson, 2010).

2.12 Future VBAC research

Looking towards the future, research is emerging into the importance of exposure of the microbiome for the neonate and the potential issues that could occur from the lack of exposure to the *Lactobacillus* rich environment of the vagina compared to birth via caesarean (Gregory, 2011) and the importance of the early breastfeeding experience (Hyde, Mostyn, Modi, & Kemp, 2012).

The longer-term health ramifications of caesareans for the baby as well are not minor. A review of the literature found there is increasing evidence of a link between caesarean birth and future diseases in the child, such as Type 1 diabetes, asthma, allergies, gastroenteritis, obesity and some cancers (Hyde et al., 2012). The authors conclude that “normal vaginal delivery is an important programming event with life long-health consequences.” (Hyde et al., 2012, p. 239).

2.13 Gaps in literature
This literature review has looked at the quantitative and qualitative research surrounding the various aspects of VBAC. Within the qualitative studies there was a focus on why and how women chose their birth options as well on the experience of having a VBAC in a hospital or MLU. Women choosing to have a HBAC are a specific group that have not been researched before. This review has found VBAC rates are higher out of hospital and the risks are favourable at home compared to having a VBAC in hospital. Knowledge is lacking about why women choose to have a HBAC, the experiences that led to this decision and how the women felt about their HBAC. This study aims to explore the reasons for, and experiences of, women who had a HBAC.

2.14 Conclusion

This literature review has explored the current issues surrounding VBAC, from the risks of uterine rupture and maternal and neonatal morbidity and mortality, to the women’s attitudes, views and experiences. The safety of HBAC has also been explored. It has been shown through this literature review there is a lack of understanding and knowledge surrounding the reasons why women would choose to have a HBAC and also what the opinions are of the midwives that support women having a HBAC. This research study will explore these areas.
3 METHODOLOGY AND RESEARCH METHODS

3.1 Introduction

The purpose of this chapter is to describe the theoretical framework, methodology and research methods used for this study. The aim of this study was to explore women’s reasons for, and experiences of, choosing a homebirth following a caesarean section. This chapter begins with a discussion of the qualitative approach used. A feminist theoretical approach was the framework deemed most suitable to guide data collection, analysis and interpretation and is discussed prior to presenting the methods used to undertake the study. Information on the recruitment, data collection, research setting and data analysis is provided for both the in-depth interviews and the focus group with PPMs and these methods are related back to a feminist framework. The importance of reflexivity in qualitative feminist research is discussed and a
reflexive account of the author's position in this research is included. Finally, the ethical considerations for this study are explored and the steps taken to ensure they are met are discussed.

### 3.2 Study methodology

This is a qualitative study exploring factors surrounding a woman’s decision and experience of having a HBAC. Qualitative research seeks to understand human behaviour from the perspective of the individual (Melia, 2010). This is achieved through exploration of participant’s views and perspectives in order to understand their experiences (N. L. Denzin, Y., 2000; Yin, 2010). In contrast, quantitative research starts from a hypothesis that can be proven or disproven with the analysis of numerical data; however, qualitative studies aim to gain an in-depth understanding of the experiences of the participants (Holloway, 2013; Tong, 2007; Yin, 2010). Qualitative approaches therefore are inductive rather than deductive and contribute to theory generation rather than theory testing (Giacomini, 2010).

A qualitative research methodology was chosen for this study because the aim was to explore women's reasons for, and experiences of, choosing a homebirth following a caesarean section. Taking a qualitative approach allows the participants’ experience to be explored and for commonalities and key concepts around their reasons for their decision to have a HBAC to be identified. Different
theoretical frameworks exist to inform a qualitative approach and can influence the way the research is conducted and analysed. These frameworks become the lens through which the researcher explores the data. It became apparent a feminist theoretical framework would be a relevant theoretical perspective for this qualitative study. Aspects of feminist theoretical approaches to research and the relevance to this study are therefore explored.

3.3 Feminist Epistemology

Qualitative feminist research grew from the recognition of a male biased preference for scientific enquiry and quantitative knowledge (Bortin, 1994; Dixon, 2011; Hesse-Biber, 2007; Wickham, 2004). The quantitative approach to research was viewed as failing to capture the lives and experiences of women. Feminist authors criticised the lack of research into women or women’s experiences, let alone research undertaken by women with women and most importantly for the benefit of women (Grosz, 2010; Webb, 1993). Feminist research has a desire to bring about positive changes for female research participants (Eriksson., 2008; Kaufmann, 2004; Letherby, 2003).

Different feminist epistemologies emerged from the foundations of feminist research and from the different waves of feminism and each of these has contributed to a better understanding of women’s position and situation. The origins of feminism vary across cultures and the extent of the equality of men
and women are vastly different around the world (Calvini-Lefebvre et al., 2010; J. Evans, 1998; Kaufmann, 2004). A brief synopsis of the history of feminism will be described with the aim of gaining an understanding of how feminist epistemology developed and the different schools of thought that grew from this. There has been criticism of using the term ‘waves’ of feminism as this can imply a linear chronology of the development of feminism; this can be misleading by suggesting women’s concerns and related concepts are sequential rather than concomitant, which is especially relevant for the second, third and fourth waves of feminism (E. Evans & Chamberlain, 2014; Phillips & Cree, 2014).

The first wave of feminism is traditionally related to the suffragette movement fighting for equality in voting rights throughout the western world. Australia’s suffragette history is principally an issue for white middle and upper class women, with women receiving the right to vote in 1902. The racial disparities are notable in the writings of the time and of the deliberate amorphousness of Aboriginal people, preventing distinction between Aboriginal men and women and therefore Aboriginal women had to wait until 1962 to have the right to vote (Big Black Dog Communications, 2010; Crowley, 2001).

The second wave of feminism came from the activist-laden culture beginning in the 1960’s and the realisation for women that sexism was rife not only in the public domain but within the domestic sphere of their lives (Kaufmann, 2004). This wave raised issues such as equality at work, the role of housework and
childcare in restricting women's lives, appearance, and women's health care alongside negative connotations about radical, man-hating feminists that persist today (Kaufmann, 2004; Munro, 2013). Dissonance within the second wave feminist movement came from marginal groups, such as women of colour and lesbians and the transgender/transsexual community in the late 1980s, that led to a third wave of feminism (E. Evans & Chamberlain, 2014; Phillips & Cree, 2014). Acknowledgement that racism and homophobia existed within feminism prompted these marginal groups to develop a strong voice and show that feminism was multifaceted and could benefit all (Munro, 2013). The focus shifted from the radical (predominantly white) cohesive group to individualism, in line with the societal shift in the same era (Munro, 2013). Feminism has also embraced a fourth wave with the technological advances of social media, allowing for feminists to gain a wider audience. Successful online campaigns advocating equality and against gender-based hate speech have also created debate around ‘feel good’ campaigns that generate support with little effect for change (Baumgardner, 2011; Munro, 2013; Phillips & Cree, 2014).

The differing perspectives of feminist empiricism, standpoint theory and postmodernism have stimulated debate and some division, due to the differing perspectives of the benefits and disadvantages each viewpoint brings to feminist theory (Nash, 2012; M. Stewart, 2004b; Stone, 2007). Feminist theory today can be best described as ‘a river fed by different feminisms and different feminists’ (Humm, 1997, p. 7).
Drawing on feminist understandings, the concept of authoritative knowledge and its application to reproductive choices has most relevance to this study. This will be explored next.

3.3.1 Feminist theory and reproductive choice

Central to feminist ideology and activism has been the issue of reproductive choice (Lazarus, 1997). Throughout successive feminist waves, different views have existed on reproductive rights (Behruzi, 2013). Amongst the first wave feminist struggle for votes and jobs, was the fight to allow the use of pharmacological analgesia during childbirth and for the belief that the withholding of such was limiting choice in childbirth (Beckett, 2005). The backlash from the introduction of pharmacological analgesia in childbirth was the often harming effects to the woman and baby. Women who were sedated often had no recollection of the giving birth process and, as well, women were separated from their family by being in institutions (Beckett, 2005).

Alongside the rise of the second wave of feminism was a recognition of the over-medicalisation and abuse that occurred in childbirth and a move towards a more natural approach to childbirth (Behruzi, 2013). In the 1970’s and 1980’s, feminist anthropologists and sociologists such as Robbie Davis-Floyd, Sheila Kitzinger, Brigitte Jordan and Anne Oakley further theorised around childbirth (R. Davis-Floyd, Sargent, C., 1997; Jordan, 1997; Kitzinger, 1997; Oakley, 1993).
It is well identified through the work of Oakley (1993) that the increasing medicalisation of birth in the 20th Century and the dominant position of obstetricians has resulted in a paternalistic view that childbirth is a pathological process, with women as passive hosts of the end product, the baby. The idea that women were the experts about their body, with choice and control over their pregnancy and birth, became overridden by the pervasive view that medical advancement was the reason for better maternal and neonatal outcomes. This was further supported by the self-fulfilling prophecy that obstetricians are the experts who can dictate the uptake and management of antenatal, intrapartum and postnatal care. The practices of hospitals writing and enforcing generalised policies and procedures resulted in the staff being expected to manage and manipulate the women accessing this care (Oakley, 1993).

3.3.2 Authoritative Knowledge

Brigitte Jordan named the medical philosophy and paternalistic power of medical professionals - in this case obstetricians - as 'Authoritative Knowledge,' which she described as “the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand” (Jordan, 1997, p. 58).
Anthropological studies into birth found that different cultures displayed a similar ethos of horizontal distribution of knowledge between the woman, her support people and the midwife but since the 19th and early 20th century, these well-working models were threatened by the rise of the technocratic medical model of birth (R. Davis-Floyd, Sargent, C., 1997). In the technocratic model of birth, the ownership of authoritative knowledge was held by the obstetrician and delineated dependent on hierarchy. The woman did not hold any useful knowledge; her feelings, previous experience or how her body is innately acting were of no consequence (Jordan, 1997). This theory is based on observational data over 20 years ago in an American hospital but still has relevance today.

Major concepts in midwifery research influenced by feminist theory include issues around informed choice (McAra-Couper, Jones, & Smythe, 2011), the dominant medical establishment and reduced midwifery autonomy (Adams & Bourgeault, 2004; Brodie, 2002; Green, 2008; Keating & Fleming, 2009) and the critique of transition to motherhood theories (Parratt & Fahy, 2011). McAra-Coupler and colleagues explored the issues around informed choice and control at birth using a feminist lens, and found that choice was predetermined by societal expectations and current trends which favoured a clean, controlled and hi-tech surgical birth (McAra-Couper et al., 2011).

Belief and trust in the hegemonic obstetric model of care was found to be an influence on why women chose to hire a private obstetrician for their pregnancy
and birth experience (Campo, 2010). The women in the study by Campo (2010) found their initial wishes around choice became overtaken by the dependent relationship encouraged by the patriarchal stance of obstetric care. The women's fears around birth were often reinforced by the obstetrician’s discourses around the dangers and risks of vaginal birth which then influenced and had implications for the women's birth experiences (Campo, 2010). In this study the women directed their disappointment to the natural birth movement rather than on obstetric practices, identifying the perceived notion of failure and guilt above the notion of blame.

3.3.3 Opposing Authoritative Knowledge

Midwives who act against the hegemonic authoritative knowledge may face certain challenges. Davis-Floyd and Davis (1997) explained that PPMs who provide home birth services work on the ‘normalisation of uniqueness’ and that the technocratic model defines normal birth only if it fits within very rigid parameters. PPMs have to continually balance their trust and acceptance of a woman’s uniqueness with the consequences of straying too far outside medical protocols. This study explores the role of the PPM through the women’s account of their HBAC experiences and through the focus group of PPMs.

This study uses a feminist lens to explore what happens when a group of women choose to go against the policies and procedures and turn away from
the commonly accepted medicalised constructs by having a HBAC rather than attempt, even if permitted, a VBAC in hospital. The women in this study are a unique cohort. They women have chosen, firstly, to have a VBAC rather than the more common practice of a repeat elective caesarean and, subsequently, have chosen to have their VBAC at home rather than in a hospital environment. Both choices are in contrast to the recommendations of the dominant medical model. The reasons women came to these alternative decisions and how they were treated when making these choices will be explored in this study. Exploration of this through a feminist lens offers an opportunity to situate this work within the larger feminist dialogue, including concepts of power and resistance and authoritative knowledge (Gill, Mariko Matthews, Zannettino, & Carroll, 2008; Swigonski, 1994; Wickham, 2004).

3.4 Study design and methods

This study is a qualitative interpretive study informed by feminist theory and using feminist approaches to inform data collection, analysis and interpretation. The design of this study has been informed by the COREQ guide and includes the assessment of rigour, credibility and relevance (Kitto, 2008; Tong, 2007; Tuckett, 2005). This design was developed specifically for qualitative research including interview and focus group methods of data collection and is set up in three domains (Tong, 2007). These domains are ‘research team and reflexivity’,
‘study design’ and ‘analysis and findings’ and will be discussed in this chapter (Tong, 2007).

Qualitative methodologies can include a variety of data collection, analysis and reporting methods. This study includes in-depth interviews by phone, Skype or in person, with women who had experience of HBAC, plus a focus group of PPMs who cared for women experiencing a HBAC. Thematic analysis was used to analyse the data.

In the following section, the approach to recruitment and data collection is discussed. This is divided into two sections – firstly, outlining the recruitment and data collection with women who had a HBAC and, secondly, outlining the methods used to collect data from the PPMs.

3.4.1 Study participants – women having a HBAC

3.4.1.1 Inclusion criteria

English speaking women who had experienced a HBAC within the last five years were included in the study. The time frame of five years was used to reflect the current climate of homebirth in Australia. The women needed to be able to speak English fluently to avoid misinterpretation due to language difficulties, and the women had to be willing to be interviewed. The number of previous caesareans or previous vaginal births was not identified within the inclusion or
exclusion criteria and as such, women with more than one caesarean or vaginal birth were included.

3.4.1.2 Recruitment

An information flyer was developed with basic statements such as ‘Have you had a VBAC at home’ and ‘I am looking for women to interview who are willing to share their story around VBAC at home’ including relevant contact details (see Appendix 1). This was placed on a range of home birth specific web pages and social network sites, for example, Homebirth Australia and International Caesarean Awareness website, and through informal snowballing techniques (Ribbens, 1998). Homebirth specific groups advertised the study on their Facebook pages and this resulted in the biggest response, with the majority of women making contact over a three-day period following the Facebook posts. Two women were forwarded the information from friends. In total, 36 women made contact to indicate their interest in taking part. These women were sent information and consent forms to be returned by post or email if they were happy to participate in the study. The participant information sheet (included in Appendix 2) detailed how the study data would be used and outlined the expectations about the length of the interview and how privacy and confidentiality would be maintained.
Four women were excluded as they did not fulfil the inclusion criteria; either the length of time since their HBAC was more than five years or they were planning to HBAC with a current pregnancy. Sixteen women did not return consent forms and two women were unable to commit to interview due to time or family commitments. One explanation for the low number of returned consent forms is that women may not have had access to printing facilities. The forms required printing and signing, and both scanning and emailing or posting to the researcher. This may have been a deterrent for those without the necessary equipment or time. In total, 12 women across Australia returned consent forms and were scheduled for interviews. A decision was made to interview only women who had returned a signed consent form in order to comply with ethics requirements.

3.4.1.3 Participants’ Demographics

The age of the women ranged from 26-40+yrs with the majority being within 31-35yrs. All were either married or partnered. No women identified as Aboriginal or Torres Strait Islander. One woman was born in the UK and the remaining women were born in Australia. The women who participated came from the five states across Australia and were primarily from metropolitan areas. Participants predominantly had tertiary level education, with one woman completing her high school education and the remaining women identifying as having qualifications at certificate/diploma level, degree and postgraduate levels (Table 3-1).
Two women had more than one previous caesarean, one woman had two previous caesareans and one woman had four previous caesareans. Four women had a VBAC in hospital prior to their HBAC. The majority of the women (10/12) employed a PPM for their HBAC but one woman had a freebirth with an unregistered birth worker and another had a freebirth with only family support. The participant demographics are presented in Table 3-1.
<table>
<thead>
<tr>
<th>Women</th>
<th>State</th>
<th>Age</th>
<th>Marital status</th>
<th>Qualifications</th>
<th>Employment</th>
<th>Antenatal model of care</th>
<th>Previous births</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NSW</td>
<td>39</td>
<td>Married</td>
<td>Certificate/Diploma</td>
<td>Part time</td>
<td>PPM</td>
<td>3XNVB</td>
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<td>4XC/S</td>
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<td>1XVBAC</td>
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<td>1XHBAC</td>
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<td>2</td>
<td>NSW</td>
<td>30</td>
<td>Married</td>
<td>University Degree</td>
<td>Part time</td>
<td>PPM</td>
<td>2XC/S</td>
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<td>1XHBAC</td>
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<tr>
<td>3</td>
<td>NSW</td>
<td>33</td>
<td>Married</td>
<td>University Degree</td>
<td>At home</td>
<td>PPM</td>
<td>1XC/S</td>
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<td>1XHBAC</td>
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<tr>
<td>4</td>
<td>NSW</td>
<td>35</td>
<td>Partner</td>
<td>Postgraduate Degree</td>
<td>Part time</td>
<td>PPM</td>
<td>1XC/S</td>
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<td>5</td>
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<td>40</td>
<td>Married</td>
<td>Certificate/Diploma</td>
<td>Full time</td>
<td>PPM</td>
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<td>1XHBAC</td>
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<tr>
<td>6</td>
<td>NSW</td>
<td>35</td>
<td>Married</td>
<td>Certificate/Diploma</td>
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<td>PPM</td>
<td>1XC/S</td>
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<td>1XHBAC</td>
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<tr>
<td>7</td>
<td>NSW</td>
<td>38</td>
<td>Partner</td>
<td>High School Certificate</td>
<td>At home</td>
<td>PPM</td>
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<td>8</td>
<td>NSW</td>
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<td>Married</td>
<td>Certificate/Diploma</td>
<td>At home</td>
<td>PPM</td>
<td>1XC/S</td>
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<tr>
<td>9</td>
<td>VIC</td>
<td>33</td>
<td>Married</td>
<td>Certificate/Diploma</td>
<td>At home</td>
<td>PPM Midwives clinic</td>
<td>1XC/S</td>
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<td>1xHBAC</td>
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<td>10</td>
<td>SA</td>
<td>34</td>
<td>Married</td>
<td>Certificate/Diploma</td>
<td>At home</td>
<td>Unregistered birth worker</td>
<td>1XC/S</td>
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<td>1xHBAC</td>
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<tr>
<td>11</td>
<td>QLD</td>
<td>29</td>
<td>Partner</td>
<td>Certificate/Diploma</td>
<td>Self-employed</td>
<td>Freebirth</td>
<td>1XC/S</td>
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<td>1XHBAC</td>
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<tr>
<td>12</td>
<td>WA</td>
<td>30</td>
<td>Married</td>
<td>University Degree</td>
<td>At home</td>
<td>PPM</td>
<td>1XC/S</td>
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<td>1xHBAC</td>
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</tbody>
</table>
3.4.2 Data collection

Twelve women were interviewed. Eight interviews were face to face in the woman's home. Three interviews were by telephone and one by Skype. The eight face-to-face interviews were in NSW. Women from Western Australia, South Australia, Victoria and Queensland took part in the telephone/Skype interviews.

Telephone and Skype interviews were arranged for women in states other than NSW. The women in NSW were all living in a large metropolitan city four hours from the author’s location in regional NSW. The women were contacted and potential dates and times for interview were discussed and arranged.

At the beginning of the interview, all relevant information about the study was provided and women were given the opportunity to review the information sheet, ask questions and sign the consent form. The telephone and Skype interviews were conducted at suitable times for the women after being arranged by email. Each woman was in her home when interviewed. Before commencing the interviews by Skype or phone, confirmation was obtained with the woman to ascertain if they were still happy to participate and the signed consent form was checked for completion. The demographic form was emailed to participants and requested to be returned by email. These were all returned within the week.
3.4.3 Conducting the interviews

Semi-structured interviews were undertaken with women who had a VBAC at home. Feminist researchers often use interviews and focus groups as they are seen as a way for participants to voice their experiences (Eriksson, 2008). Feminist research identifies important issues around the role of the researcher when using interviews as a data collection method. These issues include ensuring a non-hierarchical relationship and rapport, as well as reciprocity and empathy with participants (Alasuutari, 2008). The use of non-hierarchical relationships between the interviewer and interviewee originates from early work by feminist authors such as Anne Oakley (1981) and Helen Roberts (H. Roberts, 1981) in the pursuit of an enabling way to explore views without the complexity of unequal power relationships (Alasuutari, 2008). More recently, some consensus emerged that a degree of inequality is inevitable in the interviewer-interviewee relationship (R. Elmir, Schmied, V., Jackson, D., Wilkes, L., , 2011; Tang, 2002). However, unequal power relationships can manifest in the actions and interactions of both the interviewer and the interviewee and are likely to be more fluid in nature or change over the course of the interview or study period (Alasuutari, 2008; Webb, 1993).

Feminist researchers also discuss the importance of building rapport with the participant as a way to enhance their story telling (R. Elmir, Schmied, V., Jackson, D., Wilkes, L., , 2011; Karnieli-Miller, 2009). Reciprocity can facilitate
this, although the depth and areas of sharing can be a challenge for feminist researchers and can have both positive and negative effects on the relationship and eventual data collection (Alasuutari, 2008; Webb, 1993).

Rapport building was initiated through participant recruitment via email communication or telephone conversations that were required to secure recruitment and organise the interviews. Reciprocity commenced in these early conversations regarding the reasons for researching the topic of HBAC. This demonstrated a two-way process of information sharing, developing trust and rapport at an early stage (Alasuutari, 2008; R. Elmir, Schmied, V., Jackson, D., Wilkes, L.,, 2011; A. Trainor & Bouchard, 2013).

The first four face-to-face interviews were undertaken with a supervisor present. The supervisor took on a mentoring role during the interview and then reflected on the interview techniques post interview. The interviews were conducted in the women’s own homes and audio was recorded. Women were aware of the recording and were given the option to stop the interview at any time if they needed to, for interruptions such as telephone calls or to attend to children or if they needed a break due to being distressed. All women were able to complete the interviews.

The remaining interviews were conducted via Skype or telephone. Following the initial Skype interview, it was decided to use the telephone as the internet
connection was poor and did not allow for clear and consistent interview techniques and recording. There has been discussion around the validity and quality of online interviewing and its benefits (Deakin & Wakefield, 2013) but at the time, the restrictions of inconsistent internet connection prevented this being a valid option for this study. The telephone interviews were conducted at a time suitable for the women and recorded with the telephone on speaker. A disadvantage with telephone interviews can be the lack of non-verbal cues and also the lack of pre-interview rapport-building discussions (Deakin & Wakefield, 2013).

Rapport was built with the Skype/telephone interviewees through emails and telephone conversations prior to the interview. The Skype/telephone interviews were shorter in length than the face-to-face interviews. Face-to-face interviews ranged from 25 to 90 minutes while telephone/Skype interviews ranged from 20 to 45 minutes. During the face-to-face interviews, some breaks occurred when the recording was not paused and others when the woman needed time for a break after becoming upset, which helps to explain the range of interview duration. Interview questions are presented in Table 2. These questions were used in every interview as well as specific questions for clarification of information or experiences.

The interviews were subsequently transcribed. Due to time constraints, an external transcriber was used for the majority of interviews. Once the transcription was received, they were audited by checking against the
recording. After checking, the transcription was ready for the coding analysis that will be described in the section on data analysis.

Table 3-2: Interview questions with women

<table>
<thead>
<tr>
<th>Questions for the interviews with women</th>
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</thead>
<tbody>
<tr>
<td>What led you to have a VBAC at home?</td>
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<td>How did you prepare for your VBAC at home?</td>
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<tr>
<td>Can you explain to me your thoughts on risks associated with VBAC at home?</td>
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<tr>
<td>What were the reactions of your friends and family on your decision to have a VBAC at home?</td>
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<tr>
<td>What would you do if a midwife-attended VBAC at home was no longer an option?</td>
</tr>
</tbody>
</table>

3.4.4 Focus group with PPMs

It was decided a focus group with PPMs would generate extra depth and understanding in the data collected from the women who were interviewed. To access a number of PPMs, it was decided to contact the Australian Society of Independent Midwives (ASIM) as this organisation holds regular meetings for PPMs in the Sydney region. An ASIM representative was contacted by email to ask whether members would consent to be part of a focus group discussion about why women choose to have a HBAC. After gaining agreement, a flyer was sent via ASIM to members with details of a date, location, contact details and the wording, ‘Do you support women to have a VBAC at home? Please come along to
a focus group with privately practising midwives who support women who choose to VBAC at home’ (see Appendix 3). Participant criteria were outlined in the flyer indicating the midwife needed to be currently supporting women in practice to have a HBAC and be willing to attend a focus group.

A week before the meeting another email was sent via ASIM to members to remind them of the focus group and encourage participation, along with an information sheet detailing how the study findings would be used, the expectations on the duration of the focus group and issues around privacy and confidentiality. On the day of the focus group, each midwife was given a copy of the information sheet. They signed the consent form and provided demographic data on a separate form. Eight PPMs took part in the focus group. All came from within an hour of metropolitan area. The youngest PPM was 26 years old while the majority were in their 40s. Four participants had between 5-10 years of midwifery experience, one had 3-4 years, one had 11-15 years, one had 16-20 years and one had more than 20 years experience.

Focus groups are considered beneficial for creating a forum where issues and ideas can be discussed and negotiated, allowing the researcher further insight into the topic (Alasuutari, 2008). Focus groups facilitate the gathering of qualitative data from individuals who have shared a common experience and gaining an understanding of the dynamics that influence the group (Morgan, 1997; D. W. Stewart, Shamdasani, P.N., Rook, D.W., 2007). Interaction between the participants of the focus group can be observed and the amount of
participation in the group noted (Morgan, 1997). Focus groups have been described in feminist research as a way of reducing hierarchal relationships (Alasuutari, 2008).

The focus group took place approximately eight months after the interviews were undertaken and analysed. The focus group was conducted during one of the Australian Society of Independent Midwives regular meetings. The location was a café in a park setting. The midwives all knew each other and appeared relaxed and chatty in each other's company. Background noise was audible in the recording of the focus group but did not compromise hearing and identifying each midwife's voice. Before commencement of the recording, it was confirmed that all consent and demographic forms had been signed and collected and everyone who was expected was present.

The focus group began with introductions and a brief overview of the research project. At the start of the group, participants were informed the facilitator would ask a series of questions and allow adequate time for participants to address each question. It was also important to inform participants that discussion would be directed if required. Privacy and confidentiality were discussed in relation to each other and to what could be disclosed within the group, especially due to the public location. Six questions were developed in advance to ensure the data collected was pertinent to the study and to gain a deeper insight to the information gathered from the women’s interviews. These questions can be found in Table 3-3. During the focus group, the questions were
used as a method of starting a discussion or clarifying an issue. Following the focus group, the recording was transcribed and the data evaluated using thematic analysis.

**Table 3-3: Focus group questions**

<table>
<thead>
<tr>
<th>Questions for the focus group with midwives</th>
</tr>
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<tbody>
<tr>
<td>What is your understanding about why women choose to have a VBAC at home?</td>
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<tr>
<td>Why do you support women to have a VBAC at home?</td>
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<tr>
<td>What are the advantages/disadvantages to having a VBAC at home?</td>
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<tr>
<td>What are your thoughts on the risks associated with VBAC at home?</td>
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<tr>
<td>What do you think women who choose a VBAC at home think about the risks?</td>
</tr>
<tr>
<td>What would you do if legislation made attending a woman having a VBAC at home no longer an option?</td>
</tr>
</tbody>
</table>

### 3.5 Data Analysis – Thematic Analysis

Thematic analysis was used to analyse both data sets (interviews with women and focus groups with PPMs) (Attride-Stirling, 2001). Thematic analysis was chosen as it aligns with a qualitative interpretive method that could be underpinned by a feminist theoretical framework. It was not my intention to generate a theory which would occur using a grounded theory approach or analyse discourse that would occur with a discourse analysis approach. Being new to qualitative research thematic analysis was more accessible and less complex to undertake than grounded theory.
“Thematic analysis involves the searching across a data set – be that a number of interviews or focus groups, or a range of texts – to find repeated patterns of meaning” (Braun & Clarke, 2006, p. 15). The process commences with the transcribing of interviews and reading and re-reading the transcripts. The fluid nature of thematic analysis involves coding data items, developing lists of codes, identifying themes across the data set and then returning to the data items and deciding on their relevance and fit to the themes. Themes develop out of the codes and the research story determines the overarching theme from the themes and subthemes (Braun & Clarke, 2006).

Data were managed using the qualitative coding software, NVIVO. Transcripts were uploaded into NVIVO, which allows for a document to be read and edited. The documents were edited to de-identify the women. A pseudonym was allocated to each woman and any family member, health practitioner and hospital name was changed. This also allowed for another read of each interview before starting coding. Coding can be described as reading a portion of text, identifying the content of the text and then grouping texts with similar content. In NVIVO, the groupings of text are called nodes which can be grouped under parent nodes.

After the transcripts were coded, each of the sections of text within each code were examined to identify similarities between the texts. The name of the code at that preliminary stage was derived from the initial entries, and then at a later stage a piece of text that surmised the code would become the title. The codes
were grouped under parent codes from which emerged the development of themes and subthemes and concepts.

At this stage, a document containing the codes and examples of text from the codes were sent to the supervisors to be checked for consistency and were subsequently renamed as provisional themes, subthemes and concepts and the research story emerged. An overarching theme became evident, consisting of subthemes and, within them, a number of concepts. An example is shown below.

**Figure 3-1: Themes and concepts**

- **Overarching theme**
  - It's never happening again
  - Why it's never happening again
  - I was traumatised for years
  - I was gutted

These will be presented and discussed in detail in the following chapters. The data samples within these new themes, subthemes and concepts were continually evaluated for relevance and the transcripts re-read to ensure
validity of allocation and to check no pieces of text were missing from the themes.

The focus group transcript was coded in NVIVO on a separate file, although the same theme names were applicable, and served to add greater depth to the women's themes. Preliminary analysis was undertaken, after which supervisors reviewed some of the transcribed data and discussed and checked interpretations made during data analysis.

3.5.1 Study Rigour

Trustworthiness of qualitative data and analysis comprises credibility, transferability, dependability and conformability (Bryman, 2001; N. L. Denzin, Y., 2000). In this study trustworthiness was demonstrated by the use of reflexivity, describing the audit trail and field notes, the involvement of supervisors during data collection and analysis and the identification of similar themes in comparable studies. Conformability was achieved by revealing details of the research, including participant quotations, to demonstrate how the process of data analysis and synthesis has taken place (N. K. Denzin, 2009). Transferability describes the ability of the research to be undertaken again by different researchers, with the findings being similar (N. K. Denzin, 2009). The findings were shared post analysis with the women. Conference presentations
and the published paper were sent by email to the women. The response was that the findings resonated with their experiences.

The transparency of the step-by-step procedures of the study provided a thorough description of the relevance of the research question to the chosen methodology, thereby enhancing the ability of the study to be replicated and to demonstrate its dependability (N. K. Denzin, 2009; A. A. Trainor & Graue, 2014). In this study, transparency is demonstrated through the explanation of the research question and its aims and objectives, and by relating this to the choice of qualitative research through a feminist lens. The credibility of the study will be demonstrated in the results chapters and the discussion chapter where the data has been analysed, coded and discussed (Tong, 2007).

3.6 Reflexivity

Feminist researchers attempt to eliminate hierarchal relationships between the researcher and the researched, although there is recognition that to an extent this is unavoidable (Alasuutari, 2008). Reflexivity is seen in both qualitative research and feminist theory as a method of reducing the hierarchal effect between researcher and participant and a way of demonstrating evaluative rigour (Hesse-Biber, 2007; Kitto, 2008).
Reflexivity can be seen as “the process through which a researcher recognizes, examines, and understands how his or her own social background and assumptions can intervene in the research process” (Hesse-Biber, 2007, p. 21). Reflexivity increases validity and transparency in research (Pezalla, 2012), provides opportunity for a deeper insight into researcher-participant relationships (Burns, 2012) and is necessary through all stages of the research process (Eriksson., 2008).

My interest in the research topic of VBAC came from personal experience. I became a midwife before I became a mother. I am also a granddaughter of a district midwife from the UK who was vocal about her passion for homebirth. When I became pregnant with my first child, I was keen for a homebirth and hired a PPM. This pregnancy resulted in an emergency caesarean for breech presentation. My next pregnancy came quickly, discovering I was pregnant when my first baby was only six months old. I was committed to having a VBAC at home and avoided antenatal care. My labour was spontaneous but long and my birth support not available so I transferred to hospital but had a VBAC. I found many obstacles during my labour in hospital, one being health professionals’ views. An example of this was a midwife encouraging me to have an epidural “just in case you have to go to theatre, you do know we had a rupture here recently and the baby died”. I declined. Another obstacle was restrictive practices; I was expected to have a CTG on and be given intravenous
fluids (another ‘just in case’ intervention). Following my births, I have practiced as a PPM assisting women to birth at home.

Several issues have arisen from my experience: I believe my caesarean was traumatic and out of my control; I believe that I lost faith in my health care provider; I experienced negative attitudes regarding my decision to VBAC; I had a VBAC; I found my VBAC healing and triumphant.

Having this experience puts me in the position of an “insider” researcher. There are discussions in the literature around the role of the insider or outsider researcher in qualitative research (Corbin Dwyer, 2009). An insider is a researcher who is researching an area where they share “the characteristic, role of experience under study with the participants or an outsider to the commonality shared by participants” (Corbin Dwyer, 2009, p. 55). An important consideration for the insider researcher is to recognise there may be subcultures, similarities and differences between the participants and between the participants and the researcher (Corbin Dwyer, 2009).

I was aware that although there may be some similarities between my own and the participants’ stories, there are also many differences and the women may not feel as positive as I do about their birth experience. I was also aware of the potential influence my experience might have in the analysis and interpretation of the data. This was explored through feedback between researcher and supervisors.

3.7 Ethical Considerations
Ethical considerations are an important part of a research study, therefore addressing potential ethical issues prior to commencement of data collection safeguards the participants and the data. An online course from the Research Services office at University of Western Sydney (UWS) that included information on ethical considerations for research projects was completed and a seminar on ‘Introduction to Ethics’ attended. The University of Western Sydney’s Human Research Ethics Committee (HREC) gave approval for the study with the registration number H9853.

Ethical considerations relevant to this study included the potential trauma for participants by telling their story, ensuring privacy and confidentiality, privacy of health professionals in the focus group, and privacy of health professionals and hospitals potentially named during data collection. During the process of sharing her experience, a woman may feel she has disclosed information that is personal and may be traumatic to recall. A researcher has an ethical responsibility to provide access to external counselling services to the woman if the woman chose. Contact details of external counselling services were made available to the women if requested. The women had the opportunity to withdraw from the study at any time. All of the women interviewed were given pseudonyms to protect their privacy, as were health professionals or hospitals named in the transcripts. The midwives in the focus group were given numbers and de-identified to ensure privacy.
Permission to create a sound bite of the women’s verbal responses to the question “how did you feel after your HBAC” was sought from the HREC and approved. The women were contacted and told the sound bite would be used for presentation at conferences, and all the women gave consent. Yearly progress reports were submitted to the HREC detailing the progress of the study and its estimated completion date.

3.8 Conclusion

This chapter has described the methodological approach to the research, outlining the theoretical framework and design of this study. A qualitative research approach was found to be the most appropriate as it allowed for the exploration of an individuals’ experiences, in this study of women who had a HBAC. Feminist theoretical underpinnings guided the research and informed the data collection methods.

To ensure clarity and trustworthiness, the research design and specific methods of data collection and analysis have been outlined. The role of reflexivity and ‘insider’ status was defined and established.

The chapter concluded with an explanation of the pertinent ethical considerations and how these were approached. The following two chapters
present the findings under the two themes, ‘Why it’s never happening again’ and ‘How it’s never happening again’.
4 WHY IT’S NEVER HAPPENING AGAIN

4.1 Introduction

This chapter presents the findings from the analysis of 12 interviews with women who chose to have a HBAC. The aim of the research was to explore women's reasons for and experiences of choosing a homebirth following a caesarean section. The overarching theme that emerged from the data was “It’s never happening again”. The experiences of women are supplemented with the data reporting the experience of PPMs who support women to have a HBAC.

4.2 It’s never happening again

The overarching theme that emerged from the data is “It’s never happening again”. It captured the strong intentions of women, following a previous, often traumatic birth or births.
As I started to heal, as I started to feel less guilty about it and less like I’d done something wrong, I started to get angry and that’s what made me determined and I said, you know, “It’s never happening again, that’s it.”

It’s happened to us twice now … next time we’re going to do it right. (Anne)

The theme has been separated into two parts. "Why it’s never happening again" describes women’s thoughts and reflections on their previous birth experience, the distress they experienced and their determination that “It’s never happening again”. "How it’s never happening again" captures the women’s journeys from their decision to have a HBAC to achieving their HBAC. This is discussed in the following chapter examining how women sought other options and then prepared for and ultimately achieved their goal of a HBAC. The themes, subthemes and concepts identified in Table 4-1 are further explored in this chapter.
Table 4-1: 'Why it’s never happening again’ subthemes and concepts

<table>
<thead>
<tr>
<th>Subtheme:</th>
<th>Concept</th>
</tr>
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<tbody>
<tr>
<td>I was traumatised for years</td>
<td><em>I was gutted</em></td>
</tr>
<tr>
<td></td>
<td><em>Feeling like a failure</em></td>
</tr>
<tr>
<td>A piece of meat on a cold slab</td>
<td><em>Loss of control</em></td>
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<tr>
<td></td>
<td><em>Caught in the system</em></td>
</tr>
<tr>
<td>You can smell the fear in the room</td>
<td><em>Obstetricians don’t believe in birth</em></td>
</tr>
<tr>
<td></td>
<td><em>Vulnerable to fear as you just don’t know</em></td>
</tr>
<tr>
<td>The inflexible system</td>
<td><em>Realising the system is inflexible</em></td>
</tr>
<tr>
<td></td>
<td><em>Bullied again, hospital as trauma</em></td>
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</table>

4.3 I was traumatised by it for years

In this subtheme women described the process of identifying and working through the trauma surrounding the initial (and any additional) labour/caesarean birth experiences. The women often identified that the stress and trauma of the birth experience did not become evident for several weeks after the birth and often remained with them for ‘years’.

*I was traumatised by it for, you know, years, really. Someone came and saw me … in hospital, from the, you know, post natal depression sort of, clinic thing. (Natalie)*
The stress and trauma sometimes resulted in postnatal depression and physical symptoms that prevented the women being able to see how distressed they were. It was often a health professional who identified that the woman needed extra help.

At about four weeks my primary midwife was talking to me about how I wasn’t really sleeping, and she ... helped me realise that it was me that was awake and not the baby, and that I was actually like replaying this surgery ... that was what I was calling it, not the birth, but surgery, over and over in my mind and it made me sort of realise that I needed to speak to someone about it. (Mary)

During the interview some women explained how they had been referred for counselling through community health or by their general practitioner, ranging from a one-off session to a series of sessions. Counselling included a range of supportive approaches for example, going through medical notes, debriefing and validating the woman’s feelings of distress.

I had a couple of hour interview with a lady who discussed ... the traumatic birth and sort of just validated my feelings. And then it was my child health nurse who ... it must’ve been at my six week appointment ... and I was still teary about the ... birth, who put me in contact with a lady who ... came to
my house, a couple of times, for a counselling session ... I think she kept in contact with me a couple of times. (Natalie)

This subtheme gives some understanding of the depth of distress and trauma the women experienced and how this manifested after the experience. The following subthemes explore different aspects of this traumatic experience. An understanding of these emotions is essential to understanding why the women decided they would never go through an operative birth again.

4.3.1 I was gutted (disappointment, distress)

This concept deals with the grieving the women experienced over the loss of the normal birth they were looking forward to. The women planned for a normal birth and often had no doubt they could and would achieve this. Women described feelings of regret, self-blame, isolation and feeling robbed.

It was really out of the blue, and I really did grieve for ... the loss of my natural delivery, I had been so looking forward to it, and I had always said up to that point, “If I end up having a caesarean I will feel really robbed.” And I did, and for a couple of weeks after my birth ... I would just cry, spontaneously, just cry, because I would be so upset about it. (Carol)
Focus group data gathered from PPMs revealed the lack of trust women developed in their own bodies following a caesarean section, how this impacted on the next birth and the work they needed to do with women seeking a HBAC.

*You’re often working with women that don’t believe that they can do it and that’s the difference, if you are working with someone having their first baby or subsequent babies, they’re usually coming with the attitude that they can do it and these women often come with not thinking that they can, it’s often a case of having to change that mind-set. (PPM focus group)*

4.3.2 Feeling like a failure

This concept deals with the complex array of emotions that arose for the women surrounding the previous caesarean. The emotions varied from guilty and stupid to being annoyed and angry with themselves or the system.

*I felt like ... I was a failure, like ... it was stupid to have thought that I could have a home birth. (Mary)*[Mary’s first birth was a planned homebirth and she was transferred for an emergency caesarean]

Some women expressed guilt at trying for a normal birth after a caesarean section, feeling that it was a selfish pursuit.
In the heat of the moment, I felt guilty ... I felt like it was a selfish pursuit of me to try and have a VBAC. (Anne)

During the focus group, PPMs identified the feelings of failure articulated by women. The midwives were able to recall experiences of women feeling let down or failed by the hospital system and let down or failed by their own body and baby.

She said with the first one she went into it totally believing that she could give birth and came out blaming the system and with the second one she didn’t have anyone to blame because it wasn’t the system that had failed her and she went into this whole thing with that her body failed her and her babies were stupid because they don’t know how to get out. (PPM focus group)

This subtheme and concepts reflect the complex emotions and resulting trauma that women identified when reflecting on their previous caesarean or caesareans. The next subtheme discusses how they felt during the caesarean experience.

4.4 A piece of meat on a cold slab
Women were able to recall in detail the experience of having a caesarean section. They remembered how the health professionals acted and what they said and how the casual impersonal nature had lasting effects on them. Women seemed to find the fact that the doctors were able to have casual conversations with each other about weekend pursuits or sporting interests as almost irreverent considering they were having a baby. Women reflected on these actions and conversations years after the event.

*God, even now it brings up emotions [silence, quiet crying]... I was gutted that I was having a caesarean and because it was breech it was still deemed as a choice, not an emergency ... the experience of having a caesarean ... you are cut open and then they take the baby and I’m deliriously happy that he’s, that he’s been born [crying], sorry, but the doctors, but they’re talking about their weekend while they are stitching me up ... you just feel like a piece of cold meat on the slab, and I remember saying, excuse me, and asking them a question and it was like it was a big thing. (Jeanne)*

Some women were able to articulate about the feeling of dissociation from their own body and the body the health professionals were working on behind the surgical screen.

*No one in the operating theatre spoke to us, it was 2:20am ... it felt very production line, we were just another caesarian that day ... they were*
talking about the tennis while my son was being born ... you know, we were one side of the curtain and I felt like everyone else was on the other side.

And then he was born ... the pediatrician kind of put him up next to me, like, pretending like the baby was talking to me, “Oh, hello mummy.” (Natalie)

The women identified feelings of disempowerment, perhaps due to the loss of control of the situation, which will be discussed under the following concept.

4.4.1 Loss of control

Women described a feeling of loss of control throughout the pregnancy and birth continuum, not only at the caesarean. Having decisions made for them, and about them, typified these feelings. Women reported they were often not given enough information and lacked control in the birth process. Recalling their first labour, women gave examples of medications that were given without informed consent, through to the refusal to provide adequate birthing props to help the woman gain comfort. Often these were not singular actions but could be identified as one of many actions that contributed to the woman feeling she had no control during her labour and eventual emergency caesarean.

I ended up caving, even though I wanted a natural birth ... I couldn’t get comfortable. Even though I’d realised I was having a back labour, no one
could get me a mat for my knees, the bung [cannula] was really hurting my hand, I couldn’t get down on all fours ... I ended up asking for an epidural ...

I was told to sit back, have a cup of tea. I kept wanting certain things, wanting to lean forward but I just got told to sit back in the bed. After a period of time my obstetrician phoned and said that I’d better get my head around the fact that baby wasn’t going to be born vaginally, so all that was done via phone call ... and that I should suddenly consent and have a caesarean, and so I did. (Natalie)

The sense of loss of control was often felt by women when trying to gain support for achieving a VBAC. Women described the patriarchal stance that health professionals took in their language of ‘allowing’ the woman to behave in certain ways that fitted the protocol that they followed.

And he said, “So here’s what I’m going to do ... ” [laughs] And, when he spoke to me he sat back in his chair and he put his hands up on his head, and ... I don’t know, it was all about the body language, and it just, it just made me annoyed, and he said, “I will allow you a trial of scar and here’s the conditions: You have to go into labour by 41 weeks, you have to progress at a centimetre an hour, you have to come in as soon as labour starts, you have to be under continual monitoring, you’re not allowed in water ... ” And he just went on and on and on. Anyway, so he said, “This is your best bet, and you know, this is my offer to you, this is your best bet.” And he said, “But if another doctor’s on it won’t be supported.” (Anne)
4.4.2 Caught in the system

Women described the impersonal nature of the hospital system and how they felt like just a number in the process. This included the health professionals not knowing the woman’s name and not introducing themselves.

*I went back to the high risk clinic, and then I just saw doctors, I don’t know their names, they didn’t introduce themselves, I didn’t know who they were, one was an endocrinologist and one was, either an obstetrician or paediatrician ... it’s almost like they had a book and they just read out of the book to me exactly what they had to say and then got up and opened the door for me to leave.* (Louise)

Some women found the hospital staff was very matter of fact in the way they treated the woman needing to have a caesarean and other women felt they were aware the labour ward was busy and felt they were inconveniencing the hospital staff.

4.5 You can smell the fear in the room
The women who experienced a VBAC (or attempted a VBAC) in the hospital system were able to reflect on the differences between their VBAC and a HBAC. Although the hospital environment was identified as having a negative impact, the attitude and behaviours of the health professionals they dealt with had a greater negative impact on their experiences. Women found that health professionals often appeared uncomfortable with looking after women wishing to achieve a VBAC.

_They were lovely when I got there. As soon as they read my notes ... they went away, read my notes, came back and went, “Oh! Out of the shower, up on the bed here, we just need to do this and this and this.” And I went, “Oh, bugger ... ” And the registrar really ... was very uncomfortable with me. She asked me literally every hour, on the dot, “Is it ok if we ring theatre? Can we ring theatre now, and book you in?” And I kept saying, “No. No. No, we’re not.”_ (Leslie)

The women also found their labour was restricted due to the time limits they were put under, especially if they were attempting a VBAC in the hospital.

_I know now that as soon as I... they did that first internal, I was put on the clock._ (Carol)
Women perceived that staff did not believe they would be able to achieve a VBAC, in contrast to the strong sense of self-belief by the women.

Midwives in the focus group discussed the fear that surrounds VBAC and the negative impact fear has in the labour and giving birth environment. PPMs identified that midwives have a responsibility not to allow fear to enter the birth space due to the detrimental effects on the woman.

“I always sometimes feel that if I bring fear in then that will emanate and women pick up on everything so porously in whatever environment they’re in, and if you bring it in.” Interviewer 2: “So do you think they recognise fear?” “Absolutely, so there’s not a lot of room for it!” (PPM focus group)

The extent of fear in the society about birth and the effects this causes was also explored in the focus group.

I guess too we can’t blame them when we live in such a society that even the media is constantly projecting a negative framework around these choices that women are making and the fear just produces more fear and fear and fear and until you go through it and see it, you know. (PPM focus group)
The following concepts explore the experiences of women in relation to obstetricians’ opinions around VBAC and how women’s ignorance in the giving birth process makes them vulnerable.

4.5.1 Obstetricians don’t believe in birth

When women were reflecting on the interactions they had with health professionals in previous births or in the preparation for the VBAC, a theme around obstetricians emerged. Women were surprised by the negative attitudes directed at them around natural birth and VBAC.

I keep thinking back to one appointment, where the obstetrician said to me, "But ... why would you want to give birth vaginally?" And ... I think the question alone made me go, "This isn’t going to work." Obviously, because he’s not ... of the right frame of mind. And he said, "But I just don’t understand why you’d want to have a vaginal birth." And I said, "Well, it’s not very nice to have your stomach cut open and a baby ripped out of it." And he said, "Well I can’t imagine it’d be very nice to push it out of your vagina either." And [laughs] and I was just ... I, I ... my jaw hit the floor, because I thought you’re an obstetrician! You’re ... this is your job, and you’re telling me ... like, I just couldn’t understand it. Because I find obstetricians don’t, they don’t believe in birth. They’re ... they’re surgically trained, you know? Not naturally trained. (Anne)
Women had the view that health professionals just presumed they would opt for a repeat caesarean section, quickly followed by disbelief she would be able to achieve a VBAC.

*Originally when I was planning the hospital birth, I thought, yeah, she’ll be really supportive of me having a natural delivery, and I went in there when I found out I was pregnant ... the first thing she said to me is, “Oh, I assume you’ll just have another caesarean?” And I was like, “Aah ... no. That’s not my plan.” And ... she basically said to me, “I bet you end up having another caesarean.”* (Carol)

The women described how they might have initially believed everything the obstetrician told them about the reasons for the caesarean experience but often they transitioned to disbelief of those reasons during a period of debriefing and reviewing medical notes.

*From all the paperwork that I have read and gone through with my counsellor and also with some independent midwives, he just ripped out my placenta, he didn’t let it detach itself or didn’t give me the drug to allow it to detach so when he ripped out the placenta, it made me haemorrhage, so that was the cause of the haemorrhage and the C-Section probably should have been avoided, so that whole process I nearly lost my womb and to me,
I nearly lost my life where he's coming to me and saying, we saved you, we saved your baby, there's nothing I could have done and all this stuff, so and at that time I actually believed him, I thought he had saved my baby's life. (Josephine)

4.5.2 Vulnerable to fear as you just don't know

This concept looks at how the women reflect on the knowledge they had at the beginning of their giving birth journey, to the knowledge they have after their HBAC. Some women identified that they had very little knowledge beforehand and had done little research, whereas other women felt they had some knowledge but not enough to prevent the caesarean.

I hadn’t done any of the research that I have now done into all the benefits of natural birth but no-one had told me that. (Amy)

Some women reflected on the sources of their knowledge during their first pregnancy and found they were not adequate, including antenatal classes presented by the hospital.
They pass that off to an antenatal class up at the hospital which is not a great place to get your information from ... from what I remember it was just a menu of what drug options are available to you and a time line that fits along with the drug menu. (Jodie)

Following the previous caesarean experience and their journey into motherhood, the women were able to identify the areas they now felt they were more knowledgeable about. The women described the lack of information given by health professionals during their first pregnancy as a disappointment.

Since then I’ve learnt that there are lots of things you can ask for, you can ask for the baby to be brought straight to your chest, you can start breastfeeding straight away, you can have your baby in recovery with you, and I felt really, I guess I felt really ripped off that no one told me that, that they just assumed they could go on about their job that was such a way that was easiest for them but not necessarily best for us. (Louise)

This subtheme reflected the experiences of women who attempted (and in some cases achieved) a VBAC in the system. Issues that have been discussed include how the women were subject to the attitudes and behaviours of the health professionals they were in contact with. The obstetricians mostly displayed a lack of support for women wishing to have a VBAC and expected women to elect for a repeat caesarean. Whilst the women identified that a lack of knowledge
and increased vulnerability was natural due to the lack of experience in giving birth, it was also discussed that the health professionals compounded this situation due to their lack of willingness to educate women.

4.6 The inflexible system

The majority of women did not plan to have a HBAC at the onset of the pregnancy and this theme explores how women approached the hospital system and the trauma and inflexibility they experienced. The concepts arising from this theme are ‘Bullied again’ and ‘Realising the system is inflexible’. In ‘Realising the system is inflexible’, the women approach the hospital with their wishes for a VBAC. ‘Bullied again’ demonstrates the attitudes and behaviours the women experience when the hospital care providers do not agree with their wishes.

4.6.1 Realising the system is inflexible

Women approaching a VBAC have the knowledge and experience of their previous caesarean births as a point of reference. Women may well have experienced a range of interventions during their last pregnancy and labour prior to the eventual caesarean and are hoping to avoid the same cascade of interventions happening again. With those previous experiences, many of the
women approached the VBAC in hospital with the attitude that they can negotiate the interventions they would agree to and those they would wish to avoid. Women described experiences of trying to persuade the hospital to compromise and realising how difficult that can be and how different it would be if they had decided to have a HBAC from the onset.

I have never tried harder in my life to compromise, and that was the thing that just blows my mind ... I was ... trying to make the system actually fit this compromise that isn’t there ... I don’t know what sense I would have had of that if I’d just planned it at home from the beginning, it’d probably just sort of all be very pleasant. (Laura)

Women also described the frustration around attitudes to VBAC and the resistance of staff to listen to the individual experiences of women and consider each case as unique.

I kept saying to them, “It’s there, it’s in front of you, it’s in my history! You know that I’m going to go into labour close to 42 weeks! You know I’m going to have a posterior baby! You know my labour’s going to stall at seven centimetres! This is what’s going to happen! By laying on my back and not being allowed to be in the water and help me cope with those contraction, you’re not enabling me to have a VBAC, you don’t ... you’re not supportive of it. As much as you say, ‘Yes, we support VBAC.’ You’re not
showing me that you are, because you’re not prepared to do the things that I need to help it happen.” And that’s what I found very frustrating.

(Leslie)

The women were able to identify that the hospital care providers were often basing their opinions and actions on policies and protocols that are in place for the management of women planning a VBAC.

During the focus group the PPMs discussed interventions and protocols that are used by hospitals and the effect these may have on the women wishing to achieve a VBAC.

Often in the hospital people might make suggestions of pain relief where the woman’s body is then numbed and she can’t feel what’s going on in her own body and that’s often where women do have rupture, where they can’t tell you and feedback what’s going on in their body. (PPM focus group)

The women have identified the system is not flexible for individualised care but some women found the reactions they received were so negative that they could be described as bullying.
4.6.2 Bullied again, hospital as trauma

The women found they were subject to varying degrees of intimidation and bullying by hospital staff, from repeated lecturing to disrespectful scaremongering. Some women found that at each antenatal appointment, they were told about the same restrictions that would occur during labour such as continuous monitoring, IV therapy and no water births and there was no willingness by the hospital staff to compromise on these issues.

*And basically the further my pregnancy got along they just, they just kind of said, “Well, no.” And even to the point where I said, “I’m actually saying ... like, I put it in my birth plan that we’re going to say no to continuous monitoring and things like that.” And they were just saying, “Well, you can’t”. (Laura)*

When women did attempt to find alternatives to the restrictive hospital policies, they found that the health professionals turned to scaremongering and bullying to persuade women to change their minds. The health professionals would use language such as ‘catastrophic’ and ‘dead baby’ to coerce the women into agreeing to their policies. Some women found they were threatened with being reported to social services.
When I was pregnant with Jo, I was told by a doctor that I was most likely going to die and that my son Jack wouldn’t have a mother to go home to, and to embark on a VBAC was stupidity so, I knew that was ridiculous but, and it still effects you. (Jeanne)

The subtheme of the inflexible system captures the reactions from hospital care providers towards women planning to achieve a VBAC, either in the hospital environment or in the home. Women reported often approaching the hospital with intent to birth there but asking for compromises on procedures and interventions. The lack of respect shown towards these wishes and the strong bullying behaviour impacted greatly on women. In many of these situations, the reactions acted as a catalyst for women to seek further information and alternative models of care.

4.7 Conclusion

This chapter has explored the women's feelings around their caesarean experience and the ongoing feelings of regret and disappointment. The feelings are so strong that this motivated women to ensure they did not repeat this experience with their next pregnancy. With their second or subsequent pregnancy, the women often attempted to negotiate with a hospital regarding their giving birth wishes and were treated with bullying behaviour to encourage them to follow hospital policies. In the next chapter, the actions that women
took to become informed of their choices and how they were able to achieve their HBAC are explored.
5 HOW IT’S NEVER HAPPENING AGAIN

5.1 Introduction

In this chapter the subthemes around “How it’s never happening again” are explored. In Chapter four the reflections of the women about their previous caesareans and the prejudiced behaviour the hospitals demonstrated to them when pursuing a VBAC was explored. In this chapter, the subthemes identified in the analysis explicate how women explored options for birth and how they came to decide on choosing a HBAC. Once the decision was made, women discussed how they planned for their HBAC and the importance of the relationship with their private midwife. Women enthusiastically described the positive effect the HBAC had on them. The comparisons between models of care in the hospital and at home were also discussed, as are the reactions to what they would do if a HBAC was no longer an option. Throughout the chapter, the
responses from private midwives in the focus group are presented to add depth to the findings.

**Table 5-1: 'How it's never happening again' subthemes and concepts**

<table>
<thead>
<tr>
<th>How it's never happening again</th>
<th>Concept</th>
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<tr>
<td>Subtheme</td>
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<td>Knowledge is power</td>
<td>Not having the right knowledge at the time</td>
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<td>Putting risk in perspective</td>
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<td>Weighing it all up</td>
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<td>Believing it is a safe option</td>
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<td>Avoiding judgment through selective telling</td>
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<td>Gathering support</td>
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<td>Respect and partnership</td>
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<td>Learning to have faith in my body</td>
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<td></td>
<td>Dealing with the what ifs</td>
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<td>I felt like superwoman</td>
<td>I knew I could do it</td>
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<td></td>
<td>Benefits of being at home</td>
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<td></td>
<td>Confident as a mother</td>
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<td></td>
<td>The personal becomes political (becoming a homebirth advocate)</td>
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<td>There is just no comparison</td>
<td>Restricted by policy</td>
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<td>I need a third view</td>
<td>Under the radar</td>
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5.2 Knowledge is power

The women in this study took steps to ensure they were knowledgeable about the factors that increase the risk for uterine rupture, stating that intervention in the hospital environment has a direct relationship to increased uterine rupture risk. Some women identified that the risk of giving birth in hospital included being pressured to have a repeat caesarean or being subject to the cascade of intervention, including early induction. Other women discussed the risk of rupture being the same regardless of location, home or hospital but that the chance of a successful VBAC is higher at home.

So then I started to research all these studies on VBAC ... and a lot of it kept leading to homebirths. I started reading some studies ... and home birthing stood out to me as it was a 97% success rate, so I thought if I ever want to birth my child, I think that’s where I want to be. (Josephine)

The new knowledge the women gained in their search for information and understanding helped them develop confidence in their decision to have a HBAC. Some women spent from a few weeks to a few years reading and learning about VBAC.

I think it was just that I’d armed myself with so much knowledge. (Anne)
Women dealt with their fears of uterine rupture by becoming knowledgeable on the statistical risk of that occurring but also by discussing with their care providers physical signs of uterine rupture and how to identify them. Having an understanding of the risk of rupture allowed women to feel confident in their pursuit of a HBAC.

*I like facts, I like research and I like going back to original statistics … the risk of a scar rupture is so low … I think 0.3 is the magic number and I can choose to take that risk but also knowing that when you look into it that you do generally get warning signs if something is going to happen, there is pain, things happen before you get to that point anyway.* (Susan)

The women in this study did not rely solely on published research for their information gathering but also accessed online information including social media and videos of homebirth and water births. Some women found alternative parent education programs helpful.

During the focus group with the PPMs, the subject of women being informed and how to discuss VBAC with them was explored. Midwives stated that women were already informed about HBAC before they engaged the midwife’s services.
We are working with the most informed women there are out there, even just the idea that they are choosing a homebirth to begin with, they have done their research. (PM focus group)

5.2.1 Not having the right knowledge at the time

This concept describes how women reflect on the knowledge they had at the beginning of their giving birth journey compared to the knowledge they have after their HBAC. Some women identified that they had very little knowledge and had done little research, whereas other women felt they had some knowledge but it was insufficient to prevent the caesarean.

I hadn’t done any of the research that I have now done into all the benefits of natural birth but no-one had told me that. (Amy)

Some women reflected on the sources of their knowledge during their first pregnancy and found they were not adequately informed or prepared, including after attending antenatal classes presented by the hospital.

They pass that off to an antenatal class up at the hospital which is not a great place to get your information from ... from what I remember it was just a menu of what drug options are available to you and a time line that fits along with the drug menu. (Jodie)
Following the previous caesarean experience and their journey into motherhood, the women were able to identify the areas that they now felt they were more knowledgeable about. The women described the lack of information given by health professionals during their first pregnancy as a disappointment.

> Since then I’ve learnt that there are lots of things you can ask for, you can ask for the baby to be brought straight to your chest, you can start breastfeeding straight away, you can have your baby in recovery with you, and I felt really, I guess I felt really ripped off that no one told me that, that they just assumed they could go on about their job that was such a way that was easiest for them but not necessarily best for us. (Louise)

Whilst the women identified that the lack of knowledge and increased vulnerability was to be expected due to a lack of experience in giving birth, they also believed health professionals compounded this situation by their lack of willingness to provide full information to women.

5.2.2 Putting risk in perspective

The women in this study were found to be informed and knowledgeable about the risks involved in having a HBAC and this information was derived from current research and statistical information around VBAC.
As much as people perceive home birth as this big, risky thing, I’m not one to take unnecessary risks. (Anne)

The women were able to personalise the risks and consider what was going to be most relevant to them.

It was just having to overcome the fears of, like, rupture. Because that’s always the big thing in hospital, uterine rupture. Oh my gosh, rupture, rupture, rupture! That was a big thing. Once I researched that and got the facts, I went, “Geez, I’ve got more chance of haemorrhaging than rupturing.”... That’s when I kind of went, “No, I can do it. Of course I can do it.” (Leslie)

Women discussed the importance of knowledge and also the importance of informed decision-making around birth and how they were intricately related to their sense of control.

I think the decisions to research and understand risk and act in what you see as your best interest in understanding them, I don’t think we do that enough in most things and this is something that is the most important thing that you will ever do and so that taking that control, understanding
the risks, making those decisions I think is really important and I think it is a shame that it doesn’t happen more. (Susan)

During the focus group, midwives were asked whether they thought the women understood the risks associated with HBAC.

A lot of them have done their research; they say I have a 15-20% chance of having a VBAC in the system versus 80-90% chance if I have a VBAC at home. (PM focus group)

5.2.3 Weighing it all up

Women in this study explored not only the risk of uterine rupture but also the risk of repeat caesarean on their body and their baby. The women mentioned that the risks for repeat caesarean included abnormalities in the location of the placenta, postpartum haemorrhage, wound infection and scar adhesions, as well as neonatal risks such as respiratory distress. This information came from health professionals, personal contacts and research.

And I said to him [obstetrician], “But what about the risks of repeat caesarean?” … This is when he said, you know, “You’ve got placenta abruption, placenta previa, you’ve got haemorrhage, you’ve got this, you’ve got that and he went on and on and on. (Anne)
Women also reported they did not consider only the importance of a live baby and live mother, but that avoiding a traumatic birth was also important to them. The women weighed up the risks of surviving a traumatic birth at the hospital, to the risk of complications occurring during a HBAC.

*Just going to the hospital didn’t mean that we were both going to come out alive, and it certainly didn’t mean that we weren’t going to come out traumatised, and just being alive wasn’t enough. And I was pretty confident that we weren’t going to die at home, but ... to me just being alive isn’t enough ... there’s more to it than that risk. (Mary)*

During the focus group, the midwives were prompted to consider if they thought women who chose HBAC saw risk differently; they responded with:

*“Emotional” (PM focus group)*

*“And the risk of losing control, having the control taken away from them in the hospital” (PM focus group)*

This concept reflects the view that women not only focused on the risk of uterine rupture but also on the risks of repeat caesarean as well as the risk of having a traumatic birth experience. The PPMs identified the importance of losing control for women alongside the emotional issues that can occur from a
VBAC in hospital. For women, weighing up the risks and putting the risks in perspective influenced their journey towards considering a HBAC.

5.2.4 Believing it to be a safe option

Before committing to a HBAC, women evaluated all of the information they had found, and some spoke with private midwives; subsequently, they decided to have a HBAC. Some women found that the knowledge and expertise of private midwives reassured them about the safety of their decision to have a VBAC.

_We realised that it's supported by intelligent and well-researched people ... we suddenly realised that ... it was a safe option. It seemed to be that the only way we were going to be able to do it was to come home. Simple as that._ (Anne)

For some women, the period of reflection since their previous birth, along with their new knowledge, that helped them decide on a HBAC.

_What I took away more than anything else from that experience [the previous VBAC in hospital] was "why was I there?", there was no need for, the only thing that I needed was the syntocinon shot when I started to bleed and a private midwife carries that and I think that was the light bulb experience._ (Susan)
5.3 Avoiding judgment through selective telling

Once the decision to have a homebirth was made, women faced the hurdle of telling family and friends about their choice. Homebirth is not a mainstream option in Australia so women anticipated the reactions could potentially be negative and damaging. Given this context, some women indicated that avoiding telling people was their preferred option. Some avoided associating with those they knew would be against it and others chose to wait until the baby was born before disclosing their HBAC choice.

When we announced the birth, we sent everyone a text message that said you know, was born via a planned homebirth into water at home then we got all these messages back saying "What do you mean she was born at home?", "What do you mean it was planned?" "You were having hospital visits two months ago." And we dealt with it then ... if it didn’t work out, I didn’t want to have to tell everyone why it didn’t work out. (Louise)

Some women found they had a positive reaction from family or friends and that this was often related to whether there was a previous positive experience of homebirth or natural birth within the family context.
My husband’s grandmother absolutely commended me, she home birthed all her ... she was very positive towards it, and ‘cos she was when she started talking about it, a lot of the family started coming around. (Josephine)

The women did not expect positive reactions from the hospital staff and therefore some women decided to avoid telling the hospital about their decision to homebirth.

I didn’t tell the hospital I was doing a homebirth, I just stayed under the radar. (Amy)

Those who did inform the hospital often received an adverse reaction.

I had mentioned to the hospital about ... home birth. I just said to them I was looking at options and ... I missed an appointment ... they rang me two days later and ... gave me a lecture ... the midwife who was in charge of the high risk team ... rang me and gave me a lecture about how dangerous home birth would be. (Leslie)

5.3.1 Supportive health professionals
Throughout the women's pregnancy journeys, they sometimes found supportive health professionals. Positive reactions came from their GP, a midwife or obstetricians. When the reaction to homebirth was not negative, the women felt respected. Women also found that health professionals who were honest and upfront in their information sharing and advice were beneficial, especially if they subsequently supported the woman, regardless of her decision.

He (obstetrician) was very good. He explained, you know, the risks and the pros and the cons. He suggested different tools, perhaps I could use Calmbirth and a doula, those sorts of things. He provided me with more information as well, and then I kind of went away and started researching more. He did say to me though that he had had a couple of ladies try a VBAC after 4C (four previous caesareans) ... he’d never had anyone be successful. So he was upfront about it. (Leslie)

Health professionals who had contact with homebirth previously tended to have a more positive reaction to a woman disclosing her choice to have a HBAC.

My GP had a homebirth ... when I fell pregnant with my second one her first comment to me ... was "don't you let those doctors near it" [laughs], she’s pretty cool. She asked me would I come and check in with her and I think it was just as much to know what was going on and she gave me her number
so that if during the birth if I wanted somebody there I could call her, so she is pretty cool. (Susan)

5.4 Gathering support

As part of the women’s HBAC journey, many described four key areas of support: their partner, a doula (or close female friend/relative), a VBAC support group and their private midwife. The first three of these areas of support will be explored next.

5.4.1 Getting your partner on board

All of the women in the study had male partners and enlisting their partner into the decision to homebirth was identified as an important factor. Women described a range of strategies they used to approach HBAC with their partners and the different issues that arose in these discussions.

Partners were occasionally aware of the woman’s wishes to have a HBAC prior to the pregnancy, which then allowed for early questioning and exploring of issues.
The first time I sort of mentioned it was before I was pregnant and he sort of said what about this, what about that, what if something went wrong, but that was all in one conversation and at the end he said well, it’s your body, I trust you will make the right decision, so he was okay, he said he wanted to check everything off so I did that with him so he felt better about it. (Jodie)

Discussing the research evidence related to VBAC and HBAC was identified as a beneficial way for the partner to understand the basis of the decision. Sometimes this was the woman presenting the facts to her partner and sometimes the midwife showed the evidence to the partners.

I decided I was going to homebirth and my husband was a little bit “oh, I’m not sure” so I told him all the statistics and showed him everything that I had read and the research that it’s actually safer and these are qualified midwives and I would like to do this process and so he backed me, he said that’s fine, if you would like to go down that path I’ll back you. (Josephine)

Occasionally the decision to homebirth arose from the partner's wishes and their beliefs and fears around hospitals. Deciding to hire a private midwife brought financial costs and was sometimes identified as a difficulty between couples. Some couples found the midwife was able to assist with flexible payment plans.
It took a little while to convince my husband, because of the money side of things, it was so late in the game to go crap, we need four thousand dollars, but the midwife that we had, she, she was happy to take a deposit and let us pay it off when we could. (Louise)

One woman in the study identified that her partner raised concerns regarding her ability to manage the labour at home, based on her previous experiences in the hospital.

But he ... I think the fact that I’d had the caesareans ... and, I mean he’d been with me through all the labours and he knows ... you know, how difficult the posterior labours and that were, he ... felt that I wouldn’t be able to manage at home. Which was his main concern, I think. More so that with anything going wrong, he just thought that I wouldn’t manage ...

(Leslie)

The midwives in the focus group were able to identify the importance of women having a supportive partner.

I find most of their partners are [supportive] because they’ve seen it, “I saw what she went through last time, so whatever she wants!” I think for all women, even if giving birth in hospital, supportive partners are important,
because if the person that you live with that loves you is telling you that you can’t do it then how are you going to believe it yourself? (PPM focus group)

5.4.2 Investing in birth support

Some women also sought out additional support during labour by engaging a doula (an individual with training to assist women with natural birth). Reasons given for hiring a doula included the continuity of care that results from the relationship as well as having someone with a strong belief in normal birth regardless of the location. Some women found that when the hospital became inflexible and risk averse towards VBAC, the doula offered suggestions about alternative birth options, occasionally being the one to put the woman in contact with a private midwife.

*I originally had planned to hire a doula ... because, I was told I couldn’t have a home birth through the hospital, I couldn’t have a water birth through the hospital, basically because I was considered high risk, and it was the doula who I contacted that put me in touch with the midwife.*

*(Carol)*

As the birth location changed from hospital to home, the doulas originally hired for hospital births then had a role to play in the homebirth.
I did hire a doula, which was the best thing I have ever done, she was brilliant, and I still think if it wasn’t for her I would not have got either my VBAC or my home birth ... because she’s just fabulous. (Leslie)

5.4.3 Engaging with VBAC support groups

Support groups were accessed at various times during the women’s journey to a HBAC. Most women joined support groups when planning a HBAC but in some instances a support group was accessed prior to pregnancy. Joining the group prior to pregnancy allowed for exploration of ideas and becoming educated on choices available.

I joined a caesarean support group CARES SA, and I went there when my baby was like eight weeks old, and I first heard the term VBAC and I was like, astounded. I did heaps of reading, heaps of talking ... I was going to the CARES meeting every month, and hearing people’s birth stories every month. (Mary)

Going to a homebirth specific support group allowed for a regular opportunity to have support from other home birth women. Women said that through a process of becoming immersed in the community and hearing alternative birth
stories, it allowed for a normalising of homebirth. The support groups also provided an opportunity for women to meet midwives who supported HBAC.

*I remember saying at that meeting, in front of everyone, that homebirth scared me, and I, I didn’t think I’d be comfortable giving birth at home because I wanted to be somewhere where I’d feel safe and I thought how funny it was that in such a short period of time, the place where I felt safe had so drastically changed. (Louise)*

Women who did not have access to face-to-face support groups had the opportunity to join support groups via social media websites.

*On the Facebook sites there were other women who had had VBACs and HBACs, you know, who ... give you support, and encouragement. (Carol)*

PPMs recognised that women accessed support groups and acknowledged they are a good source of support and information.

*They have also often found their support through various support groups, you know like Facebook VBAC support groups and that sort of thing, they have often already searched out that sort of stuff and yes, as I said, been very informed. (PM focus group)*
5.5 Respect and partnership

The following subtheme and concepts focus on the woman and her relationship with her private midwife. Women identified the differences between models of care experienced previously and the care provided to them from a private midwife.

Within this theme, the women acknowledged how important support and friendship, continuity of carer and an unobtrusive presence during birth were for them. Alongside the individualised care also came the feeling of safety, as is described below.

_The independent midwives were all about safety but I come first. There’s, there’s no guidelines, there’s no procedures, it’s kind of like tailor made care … even though it was still safety focused, it wasn’t safety slash liability focused ... it was about me so that was a big difference._ (Anne)

The women in this study found their private midwife supported their decision making in a way that did not make the women feel uncomfortable or belittled. This encouraged the women to explore further information and increased their confidence.
My confidence grew tenfold, because I wasn’t being treated like a time bomb, I was being treated like a woman doing the thing that women are made to do. (Anne)

Instead of being given prescriptive advice and selective information, the women found that the private midwife expected the woman to find her own information and draw her own conclusions. The woman established that the midwife was an expert in her field.

If I had any decisions to make she brought me books so that I could then make my own decisions and she was there to support that ... not being told that she is the expert but even though she is. (Jodie)

Women identified that their private midwife gave them more time. They stated the appointments were often much longer than other models of care, from one and a half hours to three hours at a time. During these long appointments, the midwife would discuss the pregnancy but also family relations.

She comes and visits me and we spend an hour and a half talking, not just about the pregnancy but how babies effect the whole family, about my other siblings [women’s other children], about my husband, my other support, it’s just nurturing and what I think birthing your baby should be. (Josephine)
Women highlighted the emotional support provided by the private midwife as an important part of midwifery care. This holistic care included preparation of the giving birth space, identifying fears and concerns and discussions on who will be present for the birth. During the focus group the midwives were asked if they did anything differently when caring for women planning to HBAC. Debriefing was found to be the most prevalent difference.

_I think debriefing their first birth, with the women that I’ve worked with and really going back in and clearing any old stuff from their last birth and knowing that this birth is a new experience, I think it’s really important._

_(PPM focus group)_

A couple of midwives gave further information on what they described as their debriefing process and discussed how they use the women’s previous hospital notes to educate, inform and make alternate plans for the birth to come. Alongside ‘debriefing’, the midwives identified that they gave the women time and encouragement as well as believing in the woman’s ability to give birth.

The equal partnership between the midwife and the woman, compared to the traditional health professional ‘expert and novice’ approach is discussed below. Presenting the importance of the woman’s own knowledge of her body alongside the midwife’s knowledge led towards a respectful partnership.
It’s respect and partnership, you’re not some superior person that has this knowledge that the woman doesn’t have, she equally has knowledge of herself and her body and you’re there just to provide information and talk that through with her, it’s an equal partner and just in the fact that you respect her and her choices, she wants to choose your care and she wants to birth at home and she is fully informed then we have the skills to support that. (PPM focus group)

5.5.1 Seeing just one person

A major difference with private midwifery was with the continuity of care the women experienced. This was noted to be different compared to a hospital antenatal clinic.

If you were lucky you got the same person two or three times in a row but you had to be lucky for that to happen and then you turn up to the hospital and it’s complete potluck if you know any of them. (Susan)

Some women described that antenatal care was not commenced until the second trimester in the hospital system with the expectation that the woman’s GP would see her in the first trimester. The following example shows how the
availability of the private midwife during her first trimester helped this woman when she was feeling 'fragile' and how this was important for her.

I knew that ... continuity of care in the early weeks, when I was ... a bit, you know, I thought I had it all together and then I got pregnant and I was a bit fragile about it, you know, when you're first pregnant and it's like a reality now, I needed the same ... carer the whole way through. (Mary)

The private midwife was identified as a professional who is able to help the woman navigate through the system of VBAC.

Having a VBAC, I really needed continuity of care, so I engaged a private midwife at 10 weeks because I knew it was just going to be an uphill battle. (Natalie)

5.5.2 She would sit back and observe

The care the private midwife gave to the woman during labour and birth is focused on in this concept. Some women found their midwife displayed a silent yet observant demeanour, calmly reassuring the woman whilst monitoring the baby.
My midwife, 9 times out of 10 I would not have even remembered she was there, she would just sit back, and observe, you know? (Carol)

During the stresses of labour, the private midwife is described as remaining calm and supportive as well as flexible and respectful, waiting for the woman to be ready to interact with her and doing that in whatever location and position the woman was in at the time.

When I was labouring and I could not possibly get out of the hallway, we stayed in the hallway, and when she wanted to have a look she asked me, and she said, “You tell me a good time.” And it was between contractions and she got down, and she manoeuvred around me, in the hallway, in the dark, with a torch, to have a look. (Mary)

Rather than following routine policies regarding examinations, the private midwife was able to offer an individual approach, with some women not wishing for internal examinations and others finding reassurance in them.

Even with things like a vaginal exam. I asked for them, because my midwife wouldn’t routinely do them, you know? But that was something I wanted so that I knew … I need to know that I’m progressing and I’m getting somewhere. But I asked for it, she was perfectly happy to do it. (Lesley)
The private midwives in the focus group discussed the care they provided for women having a HBAC at home. They described being more watchful of the women’s behaviour and vigilant for abnormalities but this was balanced with the notion of the woman not being aware this was happening.

*I think from a clinical point of view I am more heightened than with everybody else, then I am just watching for more things, but I’m not letting her know that, it’s just what we do I guess, it’s so individual.* (PPM focus group)

In the focus group, the private midwives also identified that they were able to support women during early labour, being aware this is a normal occurrence but one where the women need extra support.

### 5.6 Preparing for birth

The women in the study prepared for giving birth in a variety of ways. Some discussed the practical preparation they did in their home for the birth; others discussed the physical and mental preparation. Women spent time preparing their labour and giving birth space by decorating the area and getting the pool
prepared, making the area ‘her’ space where she would feel comfortable and safe to labour and birth.

*In preparation we got everything ready about a month before, we put plastic down in the lounge, put curtains up, blew the pool up, it was the middle of winter so we got it all nice and warm and stuff like that.* (Amy)

5.6.1 Training for the marathon of birth

A few women in the study described how they prepared both physically and mentally for their HBAC by using relaxation techniques and yoga.

*I did a hypno-birthing course, which was really good, that helped with my breathing and just getting into the zone. I did some yoga. In bed I would practice the breathing and listen to, you get a CD with the hypno-birthing book, listening to positive affirmations and things.* (Carol)

Some women found that the desire to achieve a HBAC and prevent being high risk directed them to seek alternative therapies and manage their diet and treatments.
I saw a naturopath and started ... training, ... I got an exercise bike and I was on the bike for 30 minutes a day and I didn’t eat what the diabetes clinic told me to eat, I ate more of a naturopathic diet, I took apple cider vinegar, I stopped eating grains, ... I got my calories from protein and stuff, I took a naturopathic diabetes tablet with chromium and cinnamon ... I cut out sugar, obviously, and started cooking with alternatives and I only put on 5 kilos in my pregnancy. (Natalie)

5.6.2 Learning to have faith in my body

The foundation of the preparation was the belief that the woman had an intrinsic ability to give birth. Some women expressed how they found this source of giving birth knowledge from their own family history, or from other women’s stories.

On the day of my labour I just said, “You know what, I’m just going to step into my genetic history here and just birth like the women in my family.”

(Natalie)

Women who had a previous vaginal birth said their confidence and knowledge came from understanding how their own bodies had laboured and birthed before.
I know my body; I’ve had … well now I’ve had nine babies. All of my labours have been very similar, you know the babies all arrive roughly the same time. I know what’s going to happen, and they just didn’t believe me, I’m naturally a confident person, and I knew that I could do it. Especially after having my VBAC in the hospital I thought, God, if I could do it at hospital, I can do it at home. (Leslie)

Women described that learning and understanding about the giving birth process gave them confidence in their ability to give birth; other women found they relied on trusting their instincts.

One of the private midwives identified how important she felt it was to trust the women’s own instincts. She provided an example of the time when she transferred a woman from a planned homebirth to a hospital birth, based on the woman’s own instincts.

I guess, I do this anyway, but I had one woman who was having her first vaginal birth after caesarean, … she came to me … and said “It just feels really different, it doesn’t feel right, I want to go to hospital” and I said OK, I didn’t actually, I probably did get up and do some observations, but I just thought, nope, that woman knows something’s not right. (PPM focus group)
5.6.3 Dealing with the what ifs

The majority of the women had thought about and mentioned the plans they had if the need to transfer arose. Some women identified the distance of their home from the hospital as a benefit, with travel time ranging from 30 to 5 minutes.

And I think, for us it also felt safe because even though we weren't fans of the hospital, it is only a couple of kilometres away. And we went, “You know what, if it took an hour from when my second caesarean section was deemed emergency to when he was born ... and the hospital's five minutes away ... we're going to get within that timeframe anyway. (Anne)

Some women also mentioned that they made sure adequate insurance was in place to cover any ambulance transfer.

We took out accidents cover just in case we wanted to transfer, so we weren't denying the fact that there were, that that could be a possibility, you know, we talked about that, we prepared for that. (Louise)

5.7 “I felt like superwoman”
During the semi-structured interviews, women, “How did you feel after your VBAC at home?” The women unanimously described feelings of empowerment and joy. Some stated they were amazed or proud they had not required any analgesia or had any complications requiring a transfer to hospital.

*I felt like superwoman, it was wonderful, it was wonderful, there wasn’t a moment when I was in labour that I was wondering about pain medication or transferring to the hospital or, it was just, I dunno, I just did it, I just did whatever I needed to do. (Louise)*

Even when there had been complications and a transfer to hospital, the women still expressed feelings of euphoria and accomplishment. For some, the HBAC brought healing after a previous traumatic birth experience. The positive feelings remained with the women after their HBAC experience, often for years after the event.

*It stayed as one of the best moments of my life, still, and that was, you know, four, four and a half years ago, you … I would not ever … forget, I don’t think, how … elated I was, to have, to have actually done it. (Mary)*

The private midwives in the focus group also acknowledged the positive feelings expressed by women who achieved a HBAC.
It sets you up, you’re on top of the world, I’ve done this, I can do anything now. (PPM focus group)

I’ve just done several … where they’re “I did it, I did it, Oh my God I did it!” just those words over and over as they look at their baby, they just did it, it’s amazing! (PPM focus group)

5.7.1 I knew I could do it

For many of the women, the HBAC allowed for a feeling of completeness and belonging.

You know, it just … it makes me feel so happy, and you know, complete, and, you know, I, I got to enter into this … you know, not, not club but I feel like, you know, this is what I was meant to do, as a woman. (Natalie)

Some women were surprised by the ease of labour and giving birth at home and some also felt a sense of pride and achievement. Part of the excitement and accomplishment that women felt, involved wanting to announce the birth to the people who had been negative about their decision to have a HBAC.
I kind of felt like ... you know, like up yours to everyone who told me that I was silly for doing it, or that I was putting myself in danger or my baby in danger, I felt like saying, you know, “Look, I did it, and we’re both alive.”
(Carol)

5.7.2 Benefits of being at home

Women described the added and unexpected benefits associated with remaining at home. Recovering from a vaginal birth was substantially easier compared to a caesarean birth. One aspect mentioned was the ability to mobilise and go ‘out and about’ so soon after the birth.

We were out and about on day two ... to be able to have my own food, in my own place and physically I was absolutely fine ... I was tired but physically I was so good, that for me is a lot of it, that I felt so much better. (Susan)

Other women found they were able to achieve better relaxation by being at home. Having the ability to choose to stay at home and focusing on bonding with the baby was also identified.

Then with her I was like, no I’m not doing it that way, that doesn’t work, I’m not leaving the flat for two weeks, I’m not crossing that line into the kitchen and I’m just going to enjoy my bubble because normal life will
come back soon enough and I’m just going to bond with my baby and that was amazing doing that, just snuggling there in bed, just letting her sleep in my arms all the time, that was a beautiful time. (Jeanne)

Some women explained how they felt they had achieved more privacy in their own home and explained how they had fewer unwelcome visitors.

When you’re at the hospital, you’re public property, anyone can come and see you, because the visiting hours say when they can come and see you. But when you’re at home, people are much less likely to wanna encroach on that personal space. (Louise)

5.7.3 Confident as a mother

Many of the women in this study sought a HBAC because of previous birth trauma and the resultant feelings. After the HBAC, some women found that the way they interacted with their baby and their feelings around motherhood had changed. Some women found they had a deeper bonding experience at home with their baby and that by feeling better after the HBAC, they felt better as a mother. They also experienced an increase in their confidence as a mother.

After birthing Jack who was my birth at home, I was confident as a mother, I was never confident as a mother with Faith. (Josephine)
The women in the study were able to articulate how having a HBAC had a positive influence on motherhood; how making their own decisions and seeing what their body was able to achieve contributed towards becoming a good mother.

*There is a lot of stuff in the media now about the decision to have a homebirth is a selfish decision, these things matter, it’s this belief that the mental health of the mother doesn’t matter and this other insidious message that as long as you have a healthy baby, nothing else matters … it makes me so cross … but the women I’ve talked to about homebirths say it’s not about that, it’s about decision making and risk assessment and knowing what you’re capable of, and all of those things that actually make you a good mother, it’s not a selfish matter. (Susan)*

5.7.4 The personal becomes political (becoming a homebirth advocate)

Women described the positive effects of a HBAC on their attitude towards their own bodies and their confidence as mothers. This produced a roll-over affect because the women felt they had a responsibility to share their experiences and wisdom with other pregnant women, to make sure other women did not experience the trauma they did, and for them to know a way to avoid repeat
Some women highlighted the need for education for women on the use of interventions and prevention of the first caesarean.

So ... you know, it just ... definitely home birth, absolutely. I'm a big home birth advocate now. And like I said, I will encourage my daughters to home birth because it ... I just think it's the best thing for them. And imagine if you do that first time, you know? If you don't have to go through the hospital system and you don't have to deal with the interventions and the unnecessary caesareans and the ... everything. Just to be able to have a home birth first up, and realise how wonderful it is. That would be amazing! (Leslie)

Many women in the study had used their HBAC experience as a springboard for training or planning to become a doula, to assist other women to have the opportunity to explore their choices.

Absolutely, I plan to be a doula myself when she is a few years older. (Amy)

The women were aware of the issues surrounding private midwifery practice and legislation, with some believing government should not be involved.
The risk of your child dying in a myriad of other circumstances are far more likely than when you are giving birth to it, so I really don’t see why birth should be the point where governments intervene and say you can’t do what you want to do. Nobody checks when I come home that I have my child in a safe sleeping environment. Or like I said, the car seat is safe, so why do they feel the need to enforce safety and if you are going to [go] by statistics, then really, that’s my viewpoint on it! (Jodie)

Medicare rebates for eligible midwives was mentioned and was seen as a positive reform for women. It was also identified that some midwives attending women having a HBAC had been reported to AHPRA and some women felt they could not share their HBAC story due to a risk to their midwife.

5.8  There is just no comparison

The majority of the women interviewed made direct comparisons between care providers from their previous pregnancy and birth and the care provided by their private midwife. Negative aspects of understaffing and fragmented care contribute to the impersonal nature of mainstream services, compared to a midwife who interacted with the whole family. The women were able to
articulate the relationship between intrinsic hospital practices and the perceived lack of respect and empathy from the hospital staff.

Prenatally, the time, it’s just huge, when you walk into the hospital and you get five minutes, you get “wee into this jar, stand on this scale, let me measure you, is there anything you need to know” and it is factory like, so the time and the relationship stuff is vastly different. I was actually talking to a woman at work today who’s 18 weeks/19 weeks pregnant and talking about her first visits experience with the midwives at the hospital and she actually was quite distressed by it, the midwife at the hospital didn’t even introduce herself before even asking the ‘have you been sexually abused’ questions and they didn’t even know this woman’s name and was being asked have you ever been sexually assaulted and that comes from the queue system, sitting in a room and it’s next, next and I think individuals should do it better but it’s a systematic problem. (Susan)

Women felt their PPM worked for them, in contrast to hospital midwives being employed by the health service. This resulted in the feeling that the hospital policies and procedures were of greater importance than individualised care.

My first birth, the midwives were working for the midwifery program in the hospital, and in my second and definitely my third, my midwife was working for me. (Mary)
In comparison, private obstetricians or public health service care providers did not always recognise the importance of woman-centred care and focused instead on the aesthetic benefits of their service.

_We went to a private hospital and we asked our obstetrician when we went back this time, what we can expect from the private hospital and he started talking about the size of the rooms and the television._ (Jodie)

Women were able to identify the differences between the care they received from their private midwife compared to the care they received from the hospital in relation to decision making and sense of control. Women reported that the private midwife encouraged them to do their own research and make their own decisions.

_With the homebirh, my midwife didn’t make any decisions for me, she just said okay these are the options, read up on it and tell me what you decide, where with the hospital they make the decisions to see what fits in with you, with them and it’s up to you to put up a fight if you want something different to that rather than making those choices from the outset._ (Jeanne)

5.8.1 Restricted by policy
Some participants recognised the constraints that hospital policies and procedures placed on midwives working within mainstream maternity care. They believed that midwives emphasised adherence to policies rather than providing individualised woman-centred care.

*I found the midwives to be really lovely, I did find that unfortunately they repeated hospital policy to me more than I needed to hear.* (Louise)

Even when the relationship between the woman and a hospital midwife working in a continuity of care model was good, some women noticed that the hospital policies influenced the care given.

*The caseload midwife, she believed in birth, that was a plus, but she was restricted by hospital policy, so her beliefs didn’t matter because she had a job to do and first and foremost was that hospital.* (Anne)

The women were able to acknowledge that their wish for a VBAC excluded them from publicly-funded homebirth models. They were also able to identify the problems other women may experience when policies were rigidly applied depending on the model of care, for example, assessing Group B Streptococcus status. Women identified the issue of hospital midwives being restrained by work time limits, whereas PPMs were not, for long labours.
You don’t get it in hospital, there, there’s no way you can get one on one midwife, you know, stay with you for 15 hours ... encouraging you to do what needs to be done. (Leslie)

In the focus group, PPMs indicated they were able to provide women with all the information needed to come to a decision that was informed and she was comfortable with.

I think they know that from us they are going to get informed consent, true informed consent, not informed coercion, and the right of refusal. (PPM focus group)

5.9 I need a third view

The women in the study were asked what they would do if legislation restricted a midwife from attending a woman planning a HBAC. All of the women stated they would wish to have another HBAC. Women were aware that in the context of new legislation restricting midwifery practice, some midwives may practice as an unregistered midwife. The women had varying views on that, some were quite accepting of the need to use an unregistered midwife and some highlighted that it puts the midwife at risk. Many of the women saw the logical
progression from a HBAC with a midwife to having a freebirth and most women thought that would happen with more frequency if restrictions were put on this option of a HBAC. Women raised concerns about freebirth. Some women said the need for midwifery care and/or transfer to hospital for complications during their homebirth made them scared to freebirth. Only a few women confidently stated they would choose to freebirth.

I would weigh up all the risks and if the pregnancy was straightforward and I’ve already had two VBACS, so yes, a very strong possibility that I would go ahead and do it at home. (Jeanne)

The majority of women were aware of the issues but were undecided on what they would do and hoped they would not be put into the position to have to decide.

The women who were sure they would not freebirth indicated their decision was based on their preference to have a trained healthcare professional who was able to monitor the baby and be aware of and treat any complications that may arise. Some women reflected on the complications they experienced during their HBAC.
I’ve attended freebirth and that’s been a different kind of experience, it’s not actually something I would do for myself, for my security, in just how I feel about it, I need a third view that’s not me and my partner. (Susan)

These women discussed how they would instead reluctantly choose to attend a hospital for their birth. The women stated they would approach the hospital differently this time, with increased confidence to question and advocate for themselves.

So in my case I would probably have to reluctantly go back to a hospital. But in saying that, it would ... it would be on my terms. I would know what I could decline and what I couldn’t. (Leslie)

5.9.1 Under the radar

Private midwives were asked what they would do if legislation meant they were not allowed to support women having a HBAC. Only one midwife stated she would not maintain her registration, although this would not be her preferred course of action. Becoming an unregistered midwife was not seen as a viable option for some of the midwives and this was attributed to the importance of their business and how they would feel being unregistered when practising.
No, I don't think I would, I don't think I would be serving the women, I would be freaking out every time I attended a birth. I can understand why some people would do it, absolutely, but I don’t think it’s for me … I think the adrenaline of transferring, and resussing babies, it’s not worth that. (PPM focus group)

Rather than become unregistered, the midwives gave alternative suggestions such as leaving the profession or encouraging the women to take the decision to HBAC to court as a fundamental human right to choose. Others felt they would encourage women to rally against prohibitive legislation. Another area discussed was the need for more research around the safety of HBAC.

Research, education, the research issue is surely, I haven’t found much, there isn’t much research … Not on the safety of VBAC at home, we need that evidence to support our practice. (PPM focus group)

5.10Conclusion

This chapter has explored the steps the women went through and the knowledge they gained in planning their HBAC. The findings demonstrate how women gathered support for their HBAC decision and how important positive support was. The relationship with their PPM was explored, with the central
feature being a respectful partnership. The practical preparations for a homebirth were identified. The joyful and healing emotions and benefits of achieving a HBAC often led women into new roles related to birth such as becoming a doula or being involved in birth activism. The perspectives and experiences of the PPMs obtained in the focus group are also reflected in many of the subthemes. At the end of this chapter, perspectives were presented of women and PPMs about legislation that would preclude HBAC.
6 DISCUSSION

6.1 Introduction

This study has explored the reasons why women choose to have a HBAC and their experiences of HBAC. Twelve women took part in in-depth interviews and eight PPMs participated in a focus group. The overarching theme that emerged from the data was ‘It’s never happening again’ and the themes ‘Why it’s never happening again’ and ‘How it’s never happening again’ captured women’s words and experiences. In this chapter, some of the key issues from the study will be explored in relation to the current literature and examined through a feminist lens.

From the overarching theme of ‘It’s never happening again’ emerged the strong drive women had to not repeat the negative experiences from their previous birth/s. The caesarean experience is revisited by the women in the theme ‘Why
it's never happening again’ with women describing episodes of bullying, intimidation and unwanted interventions. Within this theme, the women approach the hospital for a VBAC and describe further episodes of bullying and intimidating behaviour. In the theme ‘How it’s never happening again’ women identify how they became knowledgeable and sought support, including employing a PPM, on their journey to achieve a HBAC.

This discussion chapter explores the key findings in relation to relevant contemporary literature and debates. The following issues are discussed: the immediate and subsequent impact of a negative birth experience, described by some women as a traumatic birth and the potential that for some, this will result in trauma symptoms and for some a diagnosis of PTSD; the consequences of a health system that treats women with disrespect and for some this is experienced as abuse; the overmedicalisation of pregnancy and birth and the importance of support for decision-making and choices in relation to birth.

Finally, this chapter addresses the current climate of HBAC in response to the views of women and PPMs in the focus groups around the choices they would make if HBAC were no longer a supported option.

6.2 Birth Trauma

Women in this study described, often in detail, that their previous birth experience was traumatic and this was the fundamental reason they sought an
alternative option such as HBAC; they did not want to repeat that experience. This is highlighted by the overarching theme, 'It's never happening again'. In the literature, terms such as birth trauma, Post-Traumatic Stress Disorder (PTSD) and acute stress disorder are used, and at times they are used interchangeably (Ayers, McKenzie-McHarg, & Slade, 2015; Hackett, 2014; Quinn, Spiby, & Slade, 2015). A description of birth trauma can be found in the difference between women who adjust well to motherhood following a perceived difficult birth experience and those whose difficult birth experience has a psychological and emotional impact on their postnatal period (Hackett, 2014). Both PTSD and acute stress disorder are defined in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) with acute stress disorder developing shortly after giving birth and lasting up to one month and PTSD being on-going and lasting more than one month (Ayers, McKenzie-McHarg, et al., 2015; Creedy, 2000; Hackett, 2014; Kendall-Tacket, 2014; Quinn et al., 2015).

The classification for PTSD includes being exposed to or threatened with death, serious injury or sexual violence; having intrusive symptoms such as nightmares or flashbacks, avoidance symptoms, negative alterations in cognitions and mood, such as self-blame or detachment, changes in arousal or reactivity, such as sleep disturbances and hypervigilance (Ayers, McKenzie-McHarg, et al., 2015). These need to have lasted for more than one month since the event (Hackett, 2014; Kendall-Tacket, 2014). It has been suggested around 3.1% of all postnatal women and 15.7% of women with a psychiatric history, including postnatal depression and/or women who had complications during
pregnancy or intrapartum, will be diagnosed with PTSD; however, many may not seek, or avoid diagnosis or treatment, or may be misdiagnosed (Grekin & O’Hara, 2014; McKenzie-McHarg et al., 2015). Worldwide, 3.1% of postnatal women are diagnosed with PTSD which equates to around 4.3 million women every year (Ayers, McKenzie-McHarg, et al., 2015).

Women in this study described many of the characteristics of PTSD in the themes ‘Treated like a piece of meat’ and ‘Traumatised by it for years’. One woman noted sleep disturbances and other avoidance symptoms when she could not share her birth story in a parenting group, and a few women described how they blamed themselves for a while after their traumatic birth experience. Four of the women in this study identified how their feelings lasted longer than one month, with descriptions of still being teary at six weeks with the child and family health nurse, or at four weeks not being able to sleep due to flashbacks, and another not being able to talk about giving birth, three to four months later. These women were referred to counselling services, although none stated they had been formally diagnosed with PTSD.

This study supports previous studies of women’s experience of caesarean, particularly in relation to birth trauma (Beck, 2011; J. Fenwick, Gamble, J., Mawson, J., 2003; Thomson, 2010). Feelings that seem to be attributed to a traumatic birth, regardless of mode of birth, include feeling vulnerable, frightened, out of control, ignored and abandoned, anxious, guilty and self-blaming (Bruijn, 2008; R. Elmir, Schmied, V., Wilkes, L., Jackson, D, 2010; Fenech
A greater number of breastfeeding difficulties have been reported after a traumatic birth (Coates, Ayers, & de Visser, 2014; Iles & Pote, 2015; Kendall-Tacket, 2014) as well as flashbacks of the birth during breastfeeding (Beck, 2011). One woman in this study found breastfeeding to be difficult and aligned this with her lack of confidence due to her traumatic birth experience and another woman focused on the importance of successfully breastfeeding, ‘So that I could be something … decent for my baby’ (Mary). The literature demonstrates both the negative and positive effects of breastfeeding following a traumatic birth, from feeling violated to having flashbacks or experiencing healing from gaining increased confidence and feeling connected to their baby (Coates et al., 2014; Kendall-Tacket, 2014). The positive effects could be related to women attempting to overcome their traumatic experience by focusing on the current and future experience, as has been found with research into the effects of having a positive birth following a traumatic birth and also in part due to the hormonal benefits breastfeeding can give some women (Thomson, 2010).

It is suggested that the first anniversary of a traumatic birth can be a time of distress for women as they remember their traumatic feelings (Beck, 2011). The effects of remembering a traumatic birth can impact on lifelong self-esteem and willingness to seek healthcare (Forssen, 2012; Thomson, 2010). For some women, a previous traumatic birth can be the reason to request a repeat caesarean (Tully & Ball, 2013). The effects of PTSD and birth trauma can have a
detrimental effect on maternal-infant relationship bonding and attachment, relationships with partners, with avoidance of intimacy and sex, and on future reproductive choices (R. Elmir, Schmied, V., Wilkes, L., Jackson, D, 2010; Iles & Pote, 2015; McKenzie-McHarg et al., 2015).

Little research has been conducted on the prevention, screening or treatment of PTSD and ASD following traumatic birth. Known effective treatments for PTSD in other contexts include cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR), and debriefing (Kendall-Tacket, 2014; McKenzie-McHarg et al., 2015). In this study, Natalie stated that “I never failed the Edinburgh scale, but I used to get quite close to it.” (Natalie), She identified it was a traumatic birth and she was symptomatic six weeks postnatal; therefore, although screened for postnatal depression, potentially she was not screened for PTSD. Screening for PTSD following childbirth is not routine, nor well researched’ many symptoms, but not all, overlap with the more commonly screened and diagnosed condition of postnatal depression (McKenzie-McHarg et al., 2015). Different screening tools are available and used in research such as the Post-traumatic Diagnostic Scale and the Mini-International Neuropsychiatric Interview–Post-Traumatic Stress Disorder (MINI-PTSD) (Ayers, Wright, & Ford, 2015; Foa, 1997; Gamble, 2005). In a study by Gamble et al (2005), the MINI-PTSD tool was used with women four-six weeks postnatally and it was found that women with a history of an emergency caesarean or instrumental birth had higher rates of PTSD (72% and 79%) compared to women who had a vaginal birth or elective caesarean (16% and
A lack of health professional skills in identifying women at risk of PTSD, skills in screening those with symptoms, in diagnosis and identifying pathways of referral for treatment of PTSD, may be contributing to the low numbers of women diagnosed and assisted (Kendall-Tacket, 2014; McKenzie-McHarg et al., 2015).

6.3 Disrespect and abuse during pregnancy and childbirth

The attitude of, and treatment by, health care providers towards women can be a contributing factor towards having a traumatic birth experience (Beck, 2006; Coates et al., 2014). This became evident in this study when women described experiencing disrespect and abuse during a previous caesarean birth and again when approaching hospitals for a VBAC during their second pregnancy.

The Lancet midwifery series published in 2014 found the two major areas of dissatisfaction in maternity care are disrespectful care and the medicalisation of birth and that these can contribute to negative health outcomes for women and babies (Renfrew et al., 2014). It was identified that women want to be given information and education that is relevant to them and to have care that is provided by respectful health care providers, that is free from cruelty and abuse (McKinnon, Prosser, & Miller, 2014; Renfrew et al., 2014). This is supported by research on women’s experiences of traumatic birth where uncaring attitudes of
health professionals were found to be an important influence (Beck, 2011; Symon, 2009). Recent World Health Organisation guidelines (World Health Organization, 2014) highlight that women commonly experience verbal abuse, coercive medical procedures and a lack of informed consent during pregnancy and giving birth. This abuse is said to be evident across both resource rich, low and middle income countries and is insidious in nature (Freedman & Kruk, 2014). The White Ribbon Alliance states that disrespect and abuse in maternity care is a violation of human rights and has formulated seven universal rights for respectful maternity care (Windau-Melmer, 2013). Most relevant to this thesis are that every woman has the right to “information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care” and “be treated with dignity and respect” (Windau-Melmer, 2013, pp. 77,78).

Research undertaken with pregnant women with complex health needs, such as women with a high BMI (Nyman, Prebensen, & Flensner, 2010) and new mothers on a methadone program (Harvey, 2012), have also found incidences of verbal abuse, hurtful comments and perceived judgments, suggesting disrespectful care may be felt most acutely by women who are marginalised or experiencing difficult situations. Women who choose to have freebirths and homebirths, where risk factors are present, also experienced high levels of disrespectful care (M. K. Jackson, 2014). Women in this study described disrespect and abuse, seen in the themes ‘I was traumatised by it for years’ and ‘A piece of meat on a cold slab’. Examples included being given medication
without consent, being prevented from using birth equipment or not being provided adequate birth equipment such as a mat on the floor, to being lied to regarding the cervical dilatation progression prior to caesarean.

Freedman and Kruk suggest disrespect from healthcare providers is the result of a health system at crisis point, identifying that accountability and quality are the two crisis areas (Freedman & Kruk, 2014). Good quality maternity care requires good quality relationships between health care providers and each other, and with women and their families (Downe, Finlayson, & Fleming, 2010; Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008; Shamian, 2014). Fundamental to good quality care is a service that does not fail its employees due to unattainable targets and unacceptable pressures on overworked staff. Low staff moral due to lack of staffing, lack of resources or mismanagement, can negatively impact the quality of care being provided.

It is also recognised that the behaviours and activities in a health system are representative of the society it is serving (Freedman & Kruk, 2014). Feminist authors have identified that the abuse and exploitation of women emerges from a patriarchal structured society where women are under-represented in areas of power, policy and decision making (Lee & Kirkman, 2008; Letherby, 2003). Midwives say maternity care provided in a medically-dominated hospital environment places women at the bottom of the hierarchy (Lee & Kirkman, 2008). Midwifery literature supports the feminist viewpoint that this medicalisation and patriarchy is damaging to women. Midwives working within
hospital institutions often find it is more acceptable and easier to conform to the expected medical model than to work against it; in turn, they expect and encourage women to conform and capitulate (Keating & Fleming, 2009; O’Connell & Downe, 2009). Women who do not wish to conform and instead question their position within this hierarchy are targeted and labelled as ‘difficult’ (M. Stewart, 2004a).

In this study the majority of women did not plan, at the beginning of pregnancy, to have a HBAC and instead approached hospitals for a VBAC. The findings demonstrated that women were subjected to disrespectful and hurtful attitudes from hospital staff when requesting a VBAC. This is reflected in the subtheme of ‘The inflexible system’ and it’s concepts such as ‘Realising the system is inflexible’ and ‘Bullied again, hospital as trauma’. Women received threats that included being reported to child welfare services to being asked ‘Do you want to have a dead baby?’ Some threats came when women were attempting to negotiate the interventions they did not wish to have during labour and giving birth, such as continuous monitoring or having an intravenous catheter.

The negative attitudes from the hospital staff led women to seek alternative options and led them towards, and ultimately to achieve, a HBAC. The women in this study were able to use the resources available to them to discover an alternative option to giving birth in hospital and, for the majority, the capacity to employ a PPM. Women in this study have a privileged status in western society due to their ethnicity, class and educational level. Deciding to avoid
giving birth in hospital facilities due to previous disrespectful treatment is evident in low and middle income countries where women prefer to give birth at home with a traditional birth attendant who is respectful of culture and personal preferences (Bohren et al., 2015). As has been explored in this thesis, their option was not the popular mainstream choice. For many women the option of accessing a PPM is either unknown, too fearful or beyond their reach due to financial constraints. Third wave feminists have criticised the utopian ideal of giving birth at home as favouring women of class and resources (Beckett, 2005). Beckett (2005) highlights that some women will not be able to access homebirth as an option as they do not have safe home birth conditions; for example, households with family violence, crowded housing and poor living conditions, or women without the resources to access private midwifery care (Beckett, 2005). Women in this study had the ability and resources to give birth safely in a homebirth environment.

Disrespect and abuse in maternity care can come in different guises ranging from women experiencing physical and verbal abuse to the withholding of appropriate care (Windau-Melmer, 2013). In developed countries, as was found in this study, some women are choosing to avoid bullying behaviour by giving birth at home. Women planning a VBAC are seen as high risk due to the, albeit small, risk of having a uterine rupture (Symon, 2009). Studies exploring women’s reasons for giving birth at home when there are risk factors present (including HBAC) found that the women had previously experienced disrespectful care and were choosing to birth outside the hospital system to
avoid a repeat of this experience (Jackson, 2014; Symon, 2009). Women who are unable to access private midwifery care or choose not to have a midwife in attendance may decide to freebirth (H. G. Dahlen, Jackson, & Stevens, 2011; M. Jackson et al., 2012).

6.4 Avoiding over-medicalisation of birth

This study used a feminist framework to underpin the analysis and interpretation of women’s experiences of having a HBAC. As discussed in the methodology chapter, the over-medicalisation of childbirth became a focus of feminists who raised concerns about the rise in medical interventions and the role played by obstetric hegemony. Conceptual frameworks explaining this issue include Jordan’s work on authoritative knowledge (Jordan, 1997) and the work of Davis Floyd on technocratic birth (R. Davis-Floyd, Sargent, C., 1997). The natural birth movement gained momentum in the 1970s and 1980s with increasing recognition of the value of midwifery care, giving birth at home and breastfeeding, as ways for women to regain control over their giving birth decisions and as a form of resistance to the dominance of the patriarchal obstetric system (Beckett, 2005; Behruzi, 2013; Simkin, 1996).

Women in this study identified the over-medicalisation of childbirth as a major factor that led to their previous caesarean. In the subtheme ‘A piece of meat on a cold slab’, women described inductions, sedatives, IV therapy, CTGs and
epidurals and believed these events contributed to their negative birth experience. The extent of over-medicalisation can be seen in research undertaken in other countries apart from Australia. The US Listening to Mothers-2 survey of 1573 women published in 2007 found most of the participants experienced at least one of the following interventions: CTG, vaginal examinations, IV therapy, urinary catheters and epidural/spinal analgesia; only 2% of women experienced a combination of spontaneous onset of labour, upright birthing positions and skin to skin with the baby (Declercq, Sakala, Corry, & Applebaum, 2007; Sakala & Corry, 2007). Sakala and Corry (2007) stated:

The typical childbirth experience has been transformed into a morass of wires, tubes, machines, and medications that leave healthy women immobilized, vulnerable to high rates of surgery, and burdened with health concerns while caring for their newborns (p. 185).

The implications of over-medicalisation of childbirth include increased financial demands on healthcare and increased morbidity and mortality for women and babies (Conrad, Mackie, & Mehrotra, 2010; Renfrew et al., 2014; World Health Organization, 2015). In 2005 it is estimated unnecessary medical intervention in normal pregnancy and birth cost over $18 billion annually in the USA, making it the highest-costing medicalised condition, higher than the entire body image alteration and obesity industry which cost more than $13 billion (Conrad et al., 2010). The over-medicalisation of normal pregnancy and birth has huge ramifications for low and middle-income countries which model their health
care systems on developed countries. Increased caesarean rates in low resource countries leads to higher rates of complications, permanent disability or death because major operations are unable to be performed safely nor complications dealt with properly (World Health Organization, 2015). As has been discussed in the introduction and literature review chapters, the risks involved in repeat operative deliveries for subsequent pregnancies include: an increase in operative trauma, placenta praevia and accreta, surgical injury, adhesions, postpartum haemorrhage, endometritis and hysterectomy (Crowther, 2012; Gilbert, 2012; Landon, 2004; Nigam & Anand, 2015; Silver, 2006).

A positive effect of reducing overmedicalisation, decreasing caesarean rates, and focusing on treating women with respect and individualised care, would be less women having a caesarean section for their first birth. In addition there would be a corresponding reduction in the number of women who experience birth as a traumatic even and therefore less women having to make the decision whether to plan a VBAC or a repeat caesarean. Greater access to midwifery continuity of care programs may well be a step in the right direction for to ensure women have more spontaneous births, less interventions and a higher rate of satisfaction with their care (Sandall, 2015).

Women in this study expressed the clear intention of avoiding unnecessary intervention, reported in the theme, ‘Why it’s never happening again’. This led women to choose to have their babies at home after a previous caesarean section. Qualitative research shows women want more control over their environment and to avoid birth interventions and that these are important factors in their choice of birth location (Boucher, Bennett, McFarlin, & Freeze,
Alternatively, women choosing to give birth in the hospital focus more on fear that something may go wrong and on the need for emergency caesareans (Coxon et al., 2014).

Under the subtheme ‘Knowledge is power,’ women in this study discussed the comparison between this birth and their previous experience and how they used published research and other women’s stories when deciding to plan for a HBAC. One of the major factors was to avoid medicalised birth. This is also supported in research as a reason for women, more generally, choosing to birth at home (Boucher et al., 2009; M. Jackson et al., 2012). A study undertaken in the USA found that 24% of 160 women who chose to give birth at home stated the reason was to avoid unnecessary interventions including, specifically, continuous fetal monitoring and analgesia such as epidurals (Boucher et al., 2009). Jackson et al. (2012) found that women associated an increased risk of complications with unnecessary interventions and this was amongst the reasons to choose to birth at home.

There is evidence women who actively avoid interventions and over-medicalisation of their births are subsequently stigmatised by health care professionals and family and friends for going against the socially-expected norms (Ashley, 2012; M. K. Jackson, 2014; Murray-Davis, McDonald, Rietsma, Coubrough, & Hutton, 2014). This was emerged in the subtheme ‘The inflexible system’ in this study. Here women expressed their wish to negotiate
interventions with health care providers but they experienced resistance and bullying behaviour, as discussed earlier in this chapter.

6.5 Seeking and Gathering Support

One of the key findings from this study was the sources of support for women planning a HBAC. Support came from family and friends, groups of women with similar experiences and from PPMs. Finding support for a HBAC was an important aspect in preparing for a HBAC. The subtheme ‘Gathering support’ demonstrates how, for many of the women, it was important to have the support of their partner, hire a doula (for some) and find a like-minded group of women, such as a support group, either online and/or face-to-face.

Many of the women found that family and friends had negative attitudes towards their decision to have a HBAC, which led to many engaging in ‘Avoiding judgment through selective telling’, whereas other women had surprisingly positive reactions to their decision. Catling-Paull and colleagues (2011) found selective disclosure was also important for women who chose to give birth at home through a publicly-funded homebirth program. Others found this also applied for women planning homebirth or freebirth in the context of risk factors (M. K. Jackson, 2014). The wider societal discourse about homebirth being dangerous and risky is accentuated by the medicalised view of birth portrayed in the media (Nall, 2013). The dangers of homebirth are often misinterpreted.
and over-inflated in the mainstream media, with a focus on the patriarchal viewpoint that the safety of the newborn is of higher importance and significance than the potential damage to the mother caused by over-medicalisation of pregnancy and birth (Nall, 2013; Sweet, 2010).

To counterbalance the negative opinions on HBAC, many of the women sought out other women with similar experiences and ethos, as demonstrated in the subtheme ‘Engaging with VBAC support groups’, either online or face-to-face. The women described the support and encouragement they found from the groups. Online support groups, social media and blogging are increasingly popular forums for women; they are readily accessible and offer commonality with other women and a degree of anonymity (Bainbridge, 2002; Betts, Dahlen, & Smith, 2014; H. Dahlen, Homer,C., 2011; Konhelm-Kalkstein, 2015; Stadman Tucker, 2009).

Feminist discourse is changing to include the advent of a ‘fourth wave’ of feminism (Baumgardner, 2011; Cochrane, 2013; Fortini, 2008; Munro, 2013; Philipson, 2013; Phillips & Cree, 2014). This new wave emerged, together with the rise of social media, as a medium for large numbers of women to rally through online media (Baumgardner, 2011). The tools are blogs, Twitter and Facebook, as well as websites and online magazines where feminists can simply ‘like’, retweet, comment or sign online petitions, while carrying on with their daily activities; alternatively, they can choose to be further involved with marches and demonstrations (Baumgardner, 2011; Cochrane, 2013; Phillips & Cree, 2014).
Support groups during pregnancy have been found to have many benefits including gaining knowledge and as a way to form new friendships (Doran & Hornibrook, 2013; Neves, Salim, Soares, & Gualda, 2013; Rotundo, 2011; D. Smith, Taylor, & Lavender, 2014). Other benefits include decreasing the severity of depression amongst women with antenatal depression (Field, Diego, Delgado, & Medina, 2013), reducing preterm births and increasing breastfeeding rates in teenagers (Rotundo, 2011) and increasing the uptake in regular exercise and healthy eating in women with a high BMI (D. Smith et al., 2014). Other research suggests support groups can play an important role in the reduction of PTSD-avoidant behaviours by providing a sense of safety through interpersonal relationships (Charuvastra & Cloitre, 2008).

### 6.6 Support from their midwife

The women in this study disclosed that the relationships they formed with their private midwife were based on respect and trust. They felt well informed and completely involved with the decision-making process and this was reflected in the subtheme ‘All about safety but I came first’. The importance of this respectful relationship is supported by work on ‘redemptive births’ where women reflected on their positive birth experience following a negative birth experience (Thomson, 2010) and with women who have had previous birth trauma (Beck, 2011). Women choosing to have a homebirth through a publicly-funded homebirth program also reported that a midwife’s positive approach
and respectful attitude contributed to the confidence they had in their midwives and the beneficial relationship that was developed (Catling-Paull et al., 2011).

Women having their first births at home or in hospital also reported that support from midwives was related to the trusting relationship, the time invested in this relationship and the information and communication given by the midwife (H. G. Dahlen, Barclay, & Homer, 2010). The benefit for women of having positive relationships with midwives during their pregnancy is reported as an overall better birth experience (Campling, 2015; Davison, Hauck, Bayes, Kuliukas, & Wood, 2015). Women in this study were able to compare this model of care to the previous types of care they had experienced in ‘There is just no comparison’ and ‘Restricted by policy’ and found continuity of care and support had major benefits for their care. Research continues to demonstrate that women prefer continuity of care and this model of care has positive effects on normal birth rates, intervention rates and cost (McLachlan et al., 2008; Renfrew et al., 2014; Sandall, 2013; Thomson, 2010; S. K. Tracy et al., 2011; S.K. Tracy et al., 2013).

In this study women also identified the difference between having a midwife who was independent of the system and employed by the woman, compared to a midwife who was governed by hospital policy. The PPMs were reported as being more supportive and understanding of the woman’s wishes and more likely to encourage the woman to make informed decisions, compared to hospital-based midwives and obstetricians. The differences in the balance of power between women and midwives, where women have a financial
contractual agreement with their midwife, are explored in a thesis by Garratt (2014). The process of auditioning and hiring a private midwife in a partnership, places the balance of power in the woman’s favour, which can be positive for the women’s sense of control and autonomy in the birth process, but can also expose the midwife’s vulnerability in the relationship (Garratt, 2014).

The vulnerabilities experienced by PPMs include lack of insurance, fears of litigation, unrealistic expectations from women with complex needs and maintaining a balance between supporting women against the need to give expert recommendations on practice (Garratt, 2014). In the focus group, midwives discussed how a PPM would react if HBAC was no longer a supported option. The PPMs highlighted the need for group actions such as lobbying and rallying as an important response, rather than providing unregulated midwifery care and thereby risking deregistration and lack of income.

The benefits for midwives of practising independently from the hospital system were seen to be the deep relationship and connection that can be established between the midwife and the woman. The relationship is described as a partnership based on trust and respect where the midwife provides support and information to enable the woman to explore her options and be supported regardless of her decisions (Ashley, 2012; Garratt, 2014; Hunter et al., 2008; Kontoyannis, 2008; Plessis, 2005). Garratt (2014) found the strength of the antenatal relationship facilitated a deeper knowing of the woman in labour, by recognising what is normal for the woman; as well, being in-tune with the woman led to enhanced midwifery care. This contrasts to low quality and
disrespectful care contributing to poor health outcomes for both mother and baby in fragmented care models (Renfrew et al., 2014).

Aspects of midwifery care that contributed to this beneficial relationship included the amount of time spent with each woman during antenatal appointments. This was identified by the PPMs in this study in the subtheme ‘Respect and partnership’ and was also found in Garratt’s (2014) study. Compared to 15-minute appointments in hospitals, independent midwives reflected on their flexible, self-managed work arrangements which allowed for appointments at weekends or evenings, usually between 1-3 hours in length, with the majority of that time spent listening and talking (Garratt, 2014; Plessis, 2005). Part of the relationship between the midwife and the woman is the development of a friendship, which allows for reciprocity and storytelling on the part of the midwife (Garratt, 2014; Hunter et al., 2008). Midwives described a ‘finite friendship’ where the woman learnt aspects about the midwife that may be seen as superficial but helped the woman to trust and relate to the midwife. For example, as also reported by Garratt (2014), names of the midwife’s family, birth stories and snippets about the family were shared to facilitate closeness and equality. Both the women and the PPMs in this study discussed the benefits of the length of the appointments and the friendship that developed during the pregnancy.

Many of the attributes of private midwifery and the relationships with women align with feminist principles. The midwives in Garratt’s (2014) study described
a feeling of a ‘sisterhood’ as independent midwives, which aligns with the second wave feminist mantra of ‘sisterhood and solidarity’, as well as partnerships based on equality, respect and trust which represent major tenets of feminism (M. Stewart, 2004b). The use of reciprocity in the midwife-woman relationship is just as important in feminist research because it allows for building rapport between the researcher and participants (Alasuutari, 2008; Hunter et al., 2008; Webb, 1993).

Taking a feminist perspective, it could be suggested that midwives working outside of the hospital system are able to work free from the constraints of institutional systems and inflexible policies and are able to be autonomous in their work (Yuill, 2012). Midwives working within the patriarchal and hierarchal medicalised institutions find that it is difficult to act in an autonomous way and to advocate for the woman (Lee & Kirkman, 2008). As others have stated, they are ‘with institution rather than with woman’ (Brodie, 2002).

A New Zealand study explored data from midwives who were able to attend to women both in the home and in hospital and compared outcomes for primiparous women (S. Miller, Skinner, J, 2012). It was found that when midwives attended to women at home, they gave more evidence-based care, such as water immersion, minimal vaginal examinations and upright position for birth, compared to when they attended women in the hospital environment.
(S. Miller, Skinner, J, 2012). This confirms the assertion that environment can shape practice (Murray-Davis et al., 2014; Vedam et al., 2012).

Midwives working outside of the system resist the recognised authoritative knowledge of obstetrics (R. Davis-Floyd, Davis, E., 1997). The result of this socially ‘deviant’ behaviour can be the vexatious reporting of midwives to governing bodies and restrictive practice for PPMs, a realistic and on-going fear for PPMs in Australia (H. G. Dahlen & Caplice, 2014; Newnham, 2014; Rigg, Schmied, Peters, & Dahlen, 2015). Private midwifery practice has other challenges alongside vexatious reporting. PPMs provide an on-call service for clients and many PPMs who have limited or no other access to colleagues to share this service, experience disruption of the work-life divide and require an understanding and supportive family (Sjöblom, Lundgren, Idvall, & Lindgren, 2015). Income is generated from private clients and, in some areas, the interest in homebirth may be limited, requiring the midwife to supplement income with other paid work (Johnston, 2001). PPMs have their practice and decisions scrutinised closely if they are caring for a woman at home and, for whatever reason, have to transfer to the hospital (Johnston, 2001; Sjöblom et al., 2015). PPMs also have difficulties accessing on-going professional development compared to hospital midwives. Even with the above negative issues associated with private practice, homebirth midwives in Nordic countries stated that the positive experiences outweigh the negatives (Sjöblom et al., 2015). Consideration of what would happen if HBAC was no longer an available option for women will now be discussed.
6.7 The current climate and future of HBAC

As discussed in the introductory chapter, there are many challenges and changes for PPMs and homebirth consumers in Australia today. The women in this study were acutely aware of these issues and their concerns were voiced in the theme ‘I need a third view’. The decisions varied about where the women would give birth, if a midwife-assisted homebirth was not available, with some women identifying freebirth as an option and others expressing discomfort with this notion.

Little is written about women’s experience of freebirth. In response to the Maternity Services Review (2009) in Australia, submissions from some women said freebirth was their only choice due to a lack of midwifery services because of location, cost or the fear of repeating a previous traumatic experience (H. G. Dahlen, 2012). Avoiding a previous traumatic experience was also found to be a reason for freebirth for women having a high-risk homebirth (M. K. Jackson, 2014). As with the women in this study, research supports the argument that some women choose their birth location based on their desire for normality, and as a result of finding themselves excluded from low risk models such as birth centres, due to evolving risk factors (Freeze, 2008; M. K. Jackson, 2014; Newnham, 2014; Rigg et al., 2015).
The PPMs in the focus group expressed a view that given the choice between either practising without midwifery registration or no longer continuing to support HBAC, the majority would reluctantly not be able to assist women to achieve a HBAC but would actively campaign for this not to be the case.

6.8 Conclusion

This chapter has discussed the major findings of the study in relation to current research. Previous traumatic birth experiences have been identified as a major reason for women seeking alternatives rather than risking over-medicalisation and further complications in subsequent births. Inflexible institutional policies and procedures, and practitioners who enforce them, deter women from giving birth in hospital. Women choosing to give birth at home seek support from women with similar experiences and beliefs, from face-to-face groups and the online medium. Many women planning to give birth at home employ a PPM. PPMs provide a different and more positive style of support compared to what women receive in standard maternity care. Current issues around insurance and legislation can potentially prevent PPMs from attending women planning a HBAC, leading to decreased choice in childbirth and increased rates of freebirth. In the final chapter of this thesis, a summary of the study will be provided, along with the potential implications and the limitations of this research.
7 CONCLUSION

7.1 Introduction

Debate continues in the current literature on the safety of VBAC and is even more intense in relation to HBAC. However, little research is available on the reasons women choose HBAC. During the interviews undertaken for this study, women reflected on their decision to have a HBAC and related this to their experience of a previous caesarean section. Most women in this study described their previous experience as traumatic. When women became pregnant and approached the hospital for a VBAC, many found little or no support for their choice and they were subjected to restrictive hospital practices and negative reactions from health practitioners. Women found the health care professionals they encountered were not prepared to negotiate the need for interventions such as continuous CTG monitoring or IV cannulas. This led women to seek alternative options and to consider a HBAC.
Three key strategies were identified that assisted women in this study to achieve a HBAC. These were becoming knowledgeable about VBAC, finding support and employing a private midwife (for the majority of participants). Women in this study described their HBAC as both empowering and healing. In this concluding chapter, a summary of the main findings from this study are provided and the implications and limitations of this study explored. The chapter concludes with suggestions for future research.

7.2 Rationale for the study

This study grew from the consideration of questions such as ‘why are VBAC rates at home higher than in hospital?’ and ‘how are the experiences of women having a HBAC different to women having a VBAC?’ A qualitative approach allowed for a focus on the individual experiences of women who chose to have a HBAC. The primary interest in HBAC came from my personal journey from a planned homebirth to hospital transfer and VBAC. This narrative was shared in a reflexive account in chapter three. When exploring the research around HBAC and VBAC it became evident there was a lack of research around the experiences of women who had a HBAC. This study was an opportunity to fill this gap and, as well, it was important to provide a forum where women’s voices could be heard. In the literature review chapter, the discrepancy between VBAC rates at home and in the hospital environment was explored (Beckmann et al., 2014). Subsequently, this study reveals what factors can drive women to choose a HBAC.
7.3 The value of feminist methodology

An aim of feminist research is to capture women’s experiences and highlight gender differences and inequalities through the acknowledgment and validation of women’s individual stories (Yuill, 2012). A feminist methodology was used for this study to examine and critique current organisation of maternity care and the dominance of patriarchal medical authority that influences women’s experiences of exploring and choosing to have a HBAC.

As identified in the previous chapter, feminist authors have criticised the option of homebirth with a PPM as only benefiting women with access to resources. Throughout women’s history and across the world today, homebirth occurs in a myriad of different homes with women of different ethnicity and wealth, planned or not planned, chosen or due to no other choice' with a midwife or without (Boucher et al., 2009; Garces et al., 2012; M. K. Jackson, 2014). Aligning with third wave feminist views of inclusivity, homebirth should be included as a valid birth choice for women and set within a framework of midwifery support and access to tertiary referral services (Shamian, 2014). Where access to hospitals is difficult due to distance or availability, more locally based midwives and birth options are required. When women are not supported in their choices at hospital, access to PPMs should be valued, encouraged and available. Feminist
research focusing on these inequalities allows for a deeper and greater understanding on the institutional and societal influences.

It was clear these women experienced a loss of control over their birth experience and this was primarily shaped by medical discourses of birth as risky and high rates of intervention. The domination of the institutional controlled obstetric-led care also played a role. Using a feminist lens provided insight into the actions that women in this study took in relation to choosing a HBAC. The women articulated benefits they experienced from choosing a PPM who ‘walked alongside’ them on their pregnancy journey, offering support and partnership (Menke, Fenwick, Gamble, Brittain, & Creedy, 2014). This demonstrates the value of the feminist principles of equality and respecting a woman's authoritative knowledge of her body.

7.4 It's never happening again

The results of this study identified an overarching theme of ‘it's never happening again’. Women resolved not to repeat their previous birth experiences. This overarching theme was divided into ‘why it's never happening again’ (chapter 4) and ‘how it's never happening again’ (chapter 5). ‘Why it’s never happening again’ explored the experiences and feelings that women had from their operative births and any subsequent births in the hospital system.
'How it’s never happening again’ identified the factors that contributed to the success of the HBAC, such as knowledge attainment and support from significant others including their PPM. Throughout both chapters, the thoughts and opinions of the PPMs in the focus group were interwoven with the women’s words to add greater depth to the work.

7.5 Implications of the study

Although this is a small study, of 12 women, it does contribute to the body of knowledge about homebirth, exploring the reasons for, and experiences of, women choosing to give birth at home following a caesarean section. The inclusion of this study in undergraduate and postgraduate midwifery teaching would highlight the systemic influences that often result in traumatic birth experiences and how empowered, well-resourced women explore alternative birth options. Continuing professional development is also required for obstetric and midwifery professionals to understand the impact of a previous traumatic birth and the effect of institutional bullying on women’s postnatal mental health, specifically to PTSD identification and treatment.

Within this study it has become evident that women may experience birth trauma from operative birth and subsequently can be re-traumatised by health care providers when approaching the hospital for a VBAC. PPMs play a vital role in supporting women and offering a partnership where women feel valued, respected and encouraged to become experts regarding their own body. PPMs...
require the support and legislative protection to continue to provide midwifery care for women wishing to have a HBAC. Many women do not have access to a PPM due to availability and cost. Mainstream maternity services need to increase access by women planning to have a VBAC to models of care that provide continuity of care.

Advocacy for women wishing to have a HBAC and/or a VBAC is required when local and national policies on maternity care are being written to ensure the consumer's voice is heard. Policies regarding VBAC need to be reviewed to allow for the acceptance of women who wish to avoid interventions they regard as harmful.

This study also identified that women may choose a HBAC after attempting to negotiate care within a hospital. With this knowledge, hospital based practitioners may be able to gain understanding and compassion for women choosing to have a VBAC in hospital, which may lead to increased satisfaction and better experience for women. Specifically, women wished to avoid unnecessary interventions and restrictive obstetric practices such as CTG monitoring/IV cannulation and induction or augmentation. Processes need to be put in place so hospital staff can feel supported and not fear disciplinary action when approached by women wishing to make choices outside of policies and protocols. With this added support, a more flexible interpretation of polices and protocols that allows for compromise and agreement can be found. In effect, working alongside women rather than turning them away.
7.6 Limitations

The limitations of this study include the small sample size and that it consists of a self-selected cohort of women from one country. The women in the cohort were educated and articulate and had the resources to access alternative options and private midwifery care. Therefore, the experiences of these women may not reflect those of women in other countries, women without resources, or women who choose to have a VBAC in hospital. Further research is required to shed additional light on this. The results from the PPM focus group were also from one small group and therefore generalisations to other PPMs cannot be made. As has been discussed in the section on reflexivity, as the author, I had an insider status both as a mother who had a VBAC and as a PPM and this could be identified as a limitation in relation to bias.

7.7 Recommendations for future research

This study has alluded to some of the factors that could contribute to the increasing numbers of women choosing to have a VBAC at home in Australia; however, further research with larger cohorts is necessary to gain a more detailed understanding of the extent of this decision. Research is required to explore the safety and outcomes of women having a HBAC to provide a stronger evidence base to influence recommendations for practice. This study has highlighted the dislike women have regarding inflexible hospital policies around
VBAC, such as continuous monitoring and precautionary intravenous access. Research into the safety and outcomes of women having a HBAC or a VBAC in birth centres and hospitals without the use of interventions such as continuous CTG monitoring and IV therapy is an important avenue to explore.

Further research is required into how midwifery services can be more flexible and responsive to the needs of individual women, to prevent women feeling they have no option apart from a homebirth. Fundamentally, hospital maternity services need to improve VBAC rates. Research is required into how to improve and identify the systems with a negative impact on VBAC rates. In this study, the statements from hospital-based health care providers reflected the dominant biomedical discourse surrounding birth and VBAC. This viewpoint often had a negative impact on women and requires further investigation. Exploration into the language used by health professionals when interacting with women planning a VBAC throughout the antenatal period and towards term may highlight the context of these decisions and the positive and negative attitudes directed towards women. Observing and recording health care professional discourse and behaviours during labour and birth discussion with women opting for a VBAC may also provide insight into the challenges women may experience.

7.8 Conclusion
This thesis explored the reasons for, and experiences of, women having a HBAC and found women’s previous caesareans left them feeling dissatisfied and disempowered, causing them to resolve that ‘it’s never happening again’. Once pregnant and ‘armed’ with knowledge about natural birth and VBAC, the women approached hospital services with wishes for a VBAC without over-medicalisation. However, when it became evident hospital policy was non-negotiable, the women found another option in homebirth. Women found support in other women and many employed a PPM who offered encouragement and individualised midwifery care. The women who achieved a HBAC described the experience as both healing and empowering. Women and PPMs were knowledgeable about current homebirth and private midwifery issues in Australia and vowed to fight to ensure HBAC remains a supported and valid option for women in Australia.
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9 APPENDICES
Appendix 1 – Flyer for women

Vaginal Birth after Cesarean

Research Study

Have you had a VBAC at home?
I am looking for women to interview who are willing to share their story around VBAC at home.

Share your story!

For more information and to express your interest please contact Hazel Keedle on 0408661503 or hazelkeedle@gmail.com
Appendix 2 - Participant Information Sheet

School of Nursing and Midwifery
University of Western Sydney
Hazel Keedle
hazelkeedle@gmail.com
0408661503

Women's reasons for and experiences of choosing a homebirth following a caesarean section

Participant Information Form

Thank you for your interest in my Masters research project. This project commenced in 2011 and is expected to be completed by 2015. Please find below detailed information about the research that is to be undertaken and what is hoped will be discovered.

What is this research about?

A Masters Research degree is a University degree, which is done independently by a student researcher. The researcher develops a research question and then sets about to answer it. It is expected that the research project will contribute positively to a pool of knowledge and have a benefit to society. Hazel Keedle will be undertaking a Masters and seeking to answer the question "what are Women's reasons for and experiences of choosing a homebirth following a caesarean section?".

Who is conducting this study?

I (Hazel Keedle) am the primary researcher for this research and will be working under the supervision of Associate Professors Hannah Dahlen, Virginia Schmeid and Dr Elaine Burns of the School of Nursing and Midwifery at the University of Western Sydney. I currently work as a Privately Practicing Midwife and as a Caseload midwife in Orange, NSW.

Who is funding this study?

This study is yet to attract internal or external funding and there are no funding bodies that have an interest in the outcome of this research project.

Who can participate in this research?

It is anticipated that participants are women and fit into the following criteria:

- Have had a homebirth following a previous caesarean section
- Are planning to have a homebirth following a previous caesarean section

What does participation in this research involve?
Participation in this project is voluntary and participants are welcome to decline or withdraw participation at anytime without ramification. In order to answer the research question it is intended that women who choose to participate will be asked to have a one to one interview with Hazel Keedle to discuss why they are choosing or have chosen to have a vaginal birth after caesarean (VBAC) at home. It is anticipated that the interview will be conducted in an informal manner and will be digitally recorded to make collecting information more efficient. Participants have the freedom to elect the location of the interview and can choose to conduct it in their home. As the research project develops Hazel may contact you for a second interview and to ask further question about your experience. Participants will also be asked to fill out a short demographic form which will help Hazel describe the general characteristics of the participants who chose to take part in this research. Participants may also be asked if they know anyone else who may be interested in taking part in this research.

How much time will the study take?

It is anticipated that the interview will be about an hour.

Will the information I give be confidential?

Yes, everything you disclose to Hazel about your personal information and birthing choices will be confidential and at no time in the research process or at the time the findings are published will you be identified as having taken part in this research. The only people who will be aware of your participation are Hazel Keedle and her Supervisors Hannah Dahlen, Virginia Schmeid and Elaine Burns who will have access to the information you provide for this project. All documents, recordings and information gathered throughout this research project will be stored in a locked filing
Appendix 3 - Midwife flyer

Vaginal Birth after Caesarean

Research Study

Do you support women to have VBAC at home?

Please come along to a focus group with privately practicing midwives who support women that choose to VBAC at home.

Friday 16th August, 10am

For more information and to attend please contact Hazel Keedle on 0408661503 or 17340162@student.uws.edu.au
Appendix 4 – Participant Consent Form

School of Nursing and Midwifery
University of Western Sydney
Hazel Keedle
hazelkeedle@gmail.com
0408661503

Women’s reasons for and experiences of choosing a homebirth following a caesarean section

Participant Consent Form

I, ___________________________________________ (name) Of

___________________________________________ (Address)

Have read and understood the information for participants on the above named research study and have discussed the study with Hazel Keedle (the principle researcher)

I have been made aware of the procedures involved in the study, including any known advantages of disadvantages to participating in this study.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research is strictly confidential.

I understand that interactions with the researcher will be recorded.

I agree to being contacted in the event that the researcher requests additional information.

I understand that the information I provide for this research project will become part of publications including but not limited to journal submissions, Masters thesis, books and conference presentations.

Name: ___________________________________________

Signature: ___________________________ Date: _______________

Contact phone number ______________________ Email: ______________________
Appendix 5 – Midwife Information Sheet

Participant Information Sheet (General)

An information sheet, which is tailored in format and language appropriate for the category of participant - adult, child, young adult, should be developed.

**Note:** If not all of the text in the row is visible please 'click your cursor' anywhere on the page to expand the row. To view guidance on what is required in each section 'hover your cursor' over the bold text. Further Instructions are on the last page of this form.

**Project Title:**  Womens' reasons for, and experiences of, choosing a homebirth following a caesarean section

**Who is carrying out the study?**
Hazel Keedle Masters of Nursing (Honours) candidate  
Associate Professor Hannah Dahlan  
Professor Virginia Schmied  
Dr Elaine Burns

The research will form the basis of the degree of Masters of Nursing (Honours) at the University of Western Sydney under the supervision of Associate Professor Hannah Dahlan, Professor Virginia Schmied and Dr Elaine Burns

**What is the study about?**
To explore the reasons for and experiences of women who chose to have a homebirth following a caesarean section by interviewing women who have had this experience. It is hoped that the information will deepen our understanding about the choices women make and the experiences involved from the women's viewpoint. This information may then assist other women and their health care providers in the issues surrounding the choice to have a vaginal birth after caesarean (VBAC).

**What does the study involve?**
Midwife Participant Information  
An audio recorded focus group for privately practising midwives in Sydney, NSW. The researchers will organise a focus group and will offer questions regarding women having a VBAC at home. This will lead to discussions which will be recorded digitally. The discussions will be transcribed and be used for the study.

**How much time will the study take?**
It is anticipated that the focus study will take 1-2 hours.

**Will the study benefit me?**
There will be no direct benefit to participants. It is hoped that the information provided will increase knowledge and understanding about the reasons women choose to VBAC at home. It is hoped that the focus group will deepen the understanding about women's choices and decision making from the midwife's perspective.
Will the study involve any discomfort for me?
Confidentiality will be maintained and the participants’ identities will be anonymised in the study. If you experience any discomfort you will be encouraged to access counselling services through Sydney Women’s Counselling Centre on 02 9718 1955 or Lifeline on 131 114.

How is this study being paid for?
There is funds available for the study from University of Western Sydney.

Will anyone else know the results? How will the results be disseminated?
All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Can I withdraw from the study?
Participation is entirely voluntary; you are not obliged to be involved and - if you do participate - you can withdraw at any time without giving any reason and without any consequences.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the chief investigator’s contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?
When you have read this information, Hazel Keedle will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Hazel Keedle on 0408 661 503 or email 17340162@student.uws.edu.au.

What if I have a complaint?
This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is [enter approval number].

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you may be asked to sign the Participant Consent Form.

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Appendix 6 – Midwife Consent Form

Participant Consent Form

This is a project specific consent form. It restricts the use of the data collected to the named project by the named investigators.

**Note:** If not all of the text in the row is visible please 'click your cursor' anywhere on the page to expand the row. To view guidance on what is required in each section 'hover your cursor' over the bold text.

**Project Title:** Women’s reasons for, and experiences of, choosing a homebirth following a caesarean section

**MIDWIFE CONSENT FORM**

I, ________________________, consent to participate in the research project titled Women’s reasons for, and experiences of, choosing a homebirth following a caesarean section.

I acknowledge that:

I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to the focus group and audio recording.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

Signed:

Name:

Date:

**Return Address:**

Dr Hannah Dahlen  
Associate Professor of Midwifery  
College of Health and Science  
School of Nursing and Midwifery  
University of Western Sydney  
PO Box 1132 Penrith BC NSW 2751.

This study has been approved by the University of Western Sydney Human Research Ethics Committee.

The Approval number is:  

228
Appendix 7 – Ethics Approval Letter

UWS HUMAN RESEARCH ETHICS COMMITTEE

8 October 2012

Associate Professor Hannah Dahlen,
School of Nursing and Midwifery

Dear Hannah,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H9853 “Women’s reasons for, and experiences of, choosing a homebirth following a caesarean section”, until 1 January 2015 with the provision of a progress report annually and a final report on completion.

Please quote the project number and title as indicated above on all correspondence related to this project.

This protocol covers the following researchers:
Hannah Dahlen, Virginia Schmied, Elaine Burns, Hazel Keedle.

Yours sincerely

Dr Anne Abraham
Chair, UWS Human Research Ethics Committee