NCT EVIDENCE BASED BRIEFING
Vaginal Birth After Caesarean (VBAC) - part 3

By Cynthia Clarkson, NCT Co-chair Research Networkers’ Panel, Debbie Chippington Derrick and Gina Lowdon, NCT Caesarean Birth/VBAC Co-ordinators, and Mary Newburn, NCT Head of Policy Research.

Introduction

This is the third of a three part briefing on vaginal birth after caesarean section (VBAC).1,2 The briefing reviews the evidence relating to the options for pregnant women who have already had one or more caesarean births. The benefits and risks of caesarean birth for both mothers and babies have been reviewed separately.3 Part 1 of this briefing included the history of caesarean section (CS) and subsequent modes of birth, the incidence of VBAC, and the conditions that influence VBAC in women planning a vaginal birth after a caesarean. Part 2 compared planned VBAC with planned repeat caesarean. Part 3 addresses the views and experiences of childbearing women who have previously had a caesarean, and concludes with discussion of national guidance for care in pregnancy following a caesarean section for England, Wales and Scotland.4,5

Women's views about birth

Women's views about, and preferences for, birth are affected by many factors. Their ideas about what is important and valuable, their attitudes to risk, their aspirations and fears, and what they have experienced all play a part.

There is limited research information about women's views about birth following a previous caesarean. Women will have come to their caesarean deliveries having had a variety of hopes and expectations for their births and a variety of experiences of pregnancy. Some will have had no experience of labour - and for those that have there will be a huge range of experiences - as well as different reasons for the caesarean surgery being carried out. Some will have been fully involved in the decision-making process, whereas others will have had little explanation and been given few options. Research on the views of women who have had a caesarean in a previous pregnancy rarely relates their views to these very different experiences.

The National Sentinel Caesarean Section Audit included a survey to explore women's preferences for childbirth. Three quarters of first-time mothers expressed a preference for vaginal birth, 3.3% a preference for caesarean section, 10.1% had no preference, and 6.7% felt their preference was dictated by medical indications. The views of women who had already had a baby were rather different and were affected by how the women's previous babies had been born. Of those women who had only given birth vaginally, preference for a vaginal birth increased to 86.1%, preference for a caesarean section remained similar at just 3.2%, and the numbers of those who felt their preference was dictated by medical reasons fell to 5.3%. Among women with a previous caesarean section preference for a vaginal birth dropped to 45%, with 19.9% preferring a repeat caesarean section, and 27.1% feeling that their preference was dictated by medical reasons. Although desire for a caesarean was greater in these women, of those who felt that they had options, more than twice as many expressed a preference for a vaginal birth. Other studies have found that women who have undergone caesarean section have a range of views about subsequent births.6

Women may feel that the reasons for the first caesarean, elective or emergency, are strong enough to reassure them that their caesarean was the best option for them and their baby, so it would be surprising if some of these women did not express a greater preference for a caesarean. Women who have had an emergency caesarean where they perceive there has been a sudden medical emergency putting the life of the mother or baby in immediate danger will value caesareans for saving life. Similarly, women who have had an emergency caesarean for either of the two most common reasons, 'failure to progress' or suspected fetal distress, have often come to the caesarean after what has felt like a long and difficult labour, so again expressing a preference for a caesarean is understandable.7 This is one way for them to take some control and avoid repeating the previous negative experience. Women who have had a previous caesarean are therefore more likely to be accepting of another caesarean for the birth of their next child for a variety of reasons:

- they may feel a caesarean is safer for their baby/themselves
- they believe VBAC is dangerous
- vaginal birth is an unknown experience, whereas a caesarean is not
- they may not know VBAC is an option
- they may believe that they are unlikely to achieve a VBAC
- they are not prepared to put themselves through another traumatic labour.

On the other hand, there are many women who, having had one or more caesareans in previous pregnancies, would very clearly prefer a vaginal birth next time. How their baby is born can be a matter of great personal significance for many women. The negative emotions associated with a caesarean can include grief, a sense of personal failure, anger, a feeling of betrayal or abuse by health care professionals, loss of control and lowered self-esteem.8

There is also a strong feeling among some women that health professionals, researchers and society at large, consider the impact of a caesarean on their lives in the weeks and months after the birth to be of little

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consequence. Recent research suggests that the risks and consequences of caesareans that extend beyond the in-patient period have not been adequately measured, but cannot be ignored. Women having a repeat caesarean go home not only to recover from surgery and look after their baby, but usually also to look after other children. They are often in pain, and may experience a number of additional health problems including anaemia and wound infection, often with little help at home. Once women are discharged from hospital, the midwife and/or GP carry out most post-operative care. As a result, when problems do occur following a caesarean, consultant obstetricians are unlikely to appreciate the practical and emotional impact they can make on women’s lives.

What affects women’s views?

It is usual for women to decide soon after having a baby how they anticipate any subsequent birth, or at any rate, to form a clear expectation early in another pregnancy. Women are sometimes not given the opportunity in the early postnatal period to discuss the reasons for their caesarean with a health professional and are therefore left to form their own conclusions. Often discussion about another birth does not take place until late in a subsequent pregnancy, leaving women little time to prepare. The need for evidence-based information to be given to women following an emergency CS has been highlighted. In a small qualitative study of women who were planning for a caesarean birth following a previous emergency caesarean, York and colleagues reported that women were concerned about safety and tended to be fearful about vaginal birth, which was unfamiliar to them. They preferred the idea of a planned caesarean to the chance of needing an emergency caesarean. However, concerns about their physical ability to give birth vaginally also led to feelings of disappointment and personal failure.

While previous events influence attitudes to repeat caesarean or vaginal birth, the attitudes of fearful women can be changed if they have opportunities to build up their confidence, sufficient time to do so and assurances about how their care will be managed during the forthcoming pregnancy and birth.

For those who are pregnant after previously having had a caesarean, the advice and support they receive is of critical importance. The attitudes and opportunities they encounter are likely to influence their views and their confidence. Yet for many, VBAC is never even actively considered. In a small study in Scotland, 60% of the women having a planned repeat caesarean indicated that they were unaware of any other delivery option. The National Sentinel Caesarean Section Audit Report found that of women who underwent a repeat caesarean only 44% were reported to have been offered a VBAC and the range between hospitals was very wide; from 8% to 90%. Over a quarter of the consultants surveyed said that if a woman had previously had a caesarean because of ‘failure to progress’, they would offer a planned caesarean rather than a planned VBAC; a smaller proportion would also do so if the previous caesarean was for fetal distress (6%) or for breech (5%). Health professionals have personal views and varying tolerance of risk. This affects how they assess each woman’s circumstances and interpret research evidence or written guidelines, as well as the extent to which they offer VBAC and support women who would like to have a vaginal birth.

A woman’s attitude towards a VBAC is partly shaped by her thoughts about whether previous events are likely to be repeated. If she had an emergency caesarean because of slow progress during labour or a diagnosis of fetal distress, she may lack confidence in her ability to give birth and for her baby to be born safely. On the other hand, with the increased knowledge and self-awareness that comes with experience of birth and motherhood, a woman may become pro-active in seeking information and making arrangements to help her achieve a vaginal birth in her next pregnancy.

York and colleagues found that discussions with relatives, friends and others who had had similar experiences played a significant role in how women made sense of their experience and planned for the future. While detailed discussion with health professionals seemed to be a secondary consideration, the women in the study would have welcomed more consistent written information. Others have emphasised the need for more evidence-based information about the risks and benefits of alternative modes of birth.

Barriers to VBAC

For those women who are interested in considering a VBAC or who are offered the opportunity of a VBAC, there can be many barriers to overcome. The terminology used by health professionals is often negative and judgemental: ‘failure to progress’, ‘trial of labour’, ‘trial of scar’. If the lack of enthusiasm from health professionals and the huge amount of confusing and contradictory information on the safety, or otherwise, of VBAC does not dissuade her from trying, the hospital policies governing the way VBAC labour is managed can create new difficulties.

Continuous electronic monitoring is usually recommended for women who have previously had a caesarean and is intended to safeguard the mother and baby against undue risks. However, it may change feelings and behaviour of women and midwives, shifting the focus towards potential pathology rather than facilitating the physiological process. Continuous monitoring can reduce women’s comfort, privacy and mobility, raising anxiety and the chance of an emergency repeat caesarean. Rather than feeling cared for and given maximum support to achieve a straightforward vaginal birth, the woman can feel that she is pitted against the system; challenged to prove herself against all the odds. Precautionary interventions, such as continuous fetal monitoring and intravenous lines set up ‘just in case’, imposed time limits, fasting and the hospital environment may make vaginal birth more difficult for women who have the added psychological disadvantage of having previously had a caesarean. Women may feel that units with immediate access to an operating theatre do not provide an optimal environment for labour. It is important that maternity units address the factors that seem to reduce, or maintain low rates of caesarean, so as to minimise the iatrogenic effects of large institutions and a medicalised environment. A ‘social model of care’
is important to build up women's confidence and provide them with support.\textsuperscript{32}

While some consider that technological facilities and skilled medical care should be readily available in case they are needed, the 'medical model of care' should not dominate the culture of the unit and quality of care provided.\textsuperscript{32,34} Some women who have had a previous caesarean feel that planning for a home birth is preferable for them in order to achieve control of events, an optimal environment and positive support from healthcare professionals during labour.\textsuperscript{35}

Enkin and colleagues concluded that

- A planned vaginal birth after a previous caesarean section should be recommended for women whose first caesarean section was by lower segment transverse incision, and who have no other indication for caesarean section in the present pregnancy.

- The care of a woman in labour after a previous lower segment caesarean section should be little different from that of any woman in labour.

- Hospital facilities need not differ from those that should be available to all women giving birth, irrespective of their previous history.

- The likelihood of vaginal birth is not significantly altered by the indications for the first caesarean section (including 'cephalopelvic disproportion' and 'failure to progress'), nor by a history of more than one previous caesarean section.\textsuperscript{36}

### National guidance for care in pregnancy following a caesarean section

In England and Wales, the National Institute for Health and Clinical Excellence (NICE) has published a guideline with recommendations about pregnancy and childbirth after a caesarean.\textsuperscript{4} NICE concludes that the risks and benefits of vaginal birth after CS compared with repeat CS are uncertain. NICE emphasises the importance of maternal preferences and priorities, and they consequently state that 'pregnant women who have had a previous CS and who want to have a vaginal birth should be supported in this decision'. They recommend that professionals discuss with women during pregnancy the overall risks and benefits of CS, including the risk of uterine rupture and the risk of perinatal mortality and morbidity. Summary details are provided about how women should be informed.

NICE recommends that women 'should be offered' electronic fetal monitoring during labour and care during labour in a unit where there is immediate access to CS and on-site blood transfusion services. However, both these recommendations were only 'good practice points' (GPP), based on the view of the Guideline Development Group, and are not supported by research evidence. In addition, the NICE guideline indicates that induction of labour may be offered, but that women and health professionals should be aware of the increased risk of uterine rupture.

In Scotland, following a national audit of practice, the Expert Advisory Group on Caesarean Section recommended that 'clinicians and women should regard 'trial of labour' as the norm for delivery after a previous caesarean section'.\textsuperscript{5} The report also noted that much of the literature on the risks and benefits of VBAC comes from the US, where established practice strongly favours repeat caesarean. Given this cultural difference, the results cannot be directly referred to the UK context. In the UK there is a positive good track record of less interventionist care; over 60% of 'planned VBACs result in a vaginal birth, regardless of selection criteria'.\textsuperscript{5}

### Conclusion

In conclusion, it is difficult to get clear unbiased answers to the questions women may have about VBAC. All the retrospective cohort studies tend to concentrate on the risks, not the benefits, of planned or achieved VBAC. They focus on short term maternal morbidity, the deaths of babies, and the outcomes when uterine rupture occurs.\textsuperscript{37} Frequently the decision making process fails to take into account the importance of vaginal birth for many women, and the multiple benefits to mother and baby of a straightforward vaginal birth, including advantages in establishing breastfeeding\textsuperscript{38,39} and to later born siblings. Nor does it consider the long-term implications of repeat caesarean including abnormal placentation in subsequent pregnancies, with the risk of placenta praevia and placenta accreta increasing progressively with each successive caesarean.

### Key points

- Following a caesarean delivery, women's views and preferences for another birth vary widely. They are affected by their experiences, fears, understandings about safety issues and the way different options, are presented and discussed with them.

- There are currently many barriers for women when considering their options for a birth after caesarean. Recognising the potential negative effects of additional monitoring and heightened anxiety, particular care should be taken to provide balanced information following a caesarean birth and during subsequent pregnancies. In addition a supportive environment and empowering care are important during labour.

- Further research is needed on women's experiences of VBAC and what women feel is important in helping them to have the kind of birth that is right for them and their baby.

### References

3. National Childbirth Trust. NCT Evidence based
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