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Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean

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ABSTRACT

Problem: Clinical practice guidelines indicate that over 80% of women with a previous caesarean should be offered a planned vaginal birth after caesarean (VBAC), however only one third of eligible women choose to plan a VBAC. To support informed choices for birth after caesarean, it is necessary to understand the factors that influence women's decision-making.
Aim: The goal of this study was to explore attitudes towards and experiences with decision-making for mode of delivery after caesarean from the perspectives of Canadian women.
Methods: In-depth, semi-structured interviews were conducted with 23 women eligible for VBAC in three rural and two urban communities in British Columbia, Canada, during summer 2015. Constructivist grounded theory informed iterative data collection and analysis.
Findings: Women's decision-making experiences were a process of "seeking control in the midst of uncertainty." Women formed early preferences for mode of delivery after their primary caesareans and engaged in careful deliberation during their inter-pregnancy interval, consisting of: reflecting on their birth, clarifying their values, becoming informed, considering the feasibility of options, deliberating with the care team, and making an actual choice. Women struggled to make trade-offs between having a healthy baby and social attributes of delivery, such as uninterrupted bonding with their newborn.
Conclusions: Women begin decision-making for birth after caesarean earlier than previously reported and their choices are influenced by personal experience and psychosocial concerns. Future interventions to support choice of mode of delivery should begin early after the primary caesarean, to reflect when women begin to form preferences.
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Statement of Significance

Problem or issue

Only one third of eligible women choose to plan a vaginal birth after caesarean (VBAC).

What is already known

Bonding with one's newborn and psychological health are key factors in women's choices for mode of birth.

What this paper adds

Women formed a preference for mode of birth immediately after the first caesarean. Decision support from clinicians did not address their concerns for newborn bonding or psychological health. Women would benefit from early decision support after the primary caesarean. This support should include discussion of women's values and first caesarean experience.

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1. Introduction

The caesarean section rate has risen steadily worldwide since the 1990s. One key reason for this trend is an increase in repeat caesareans, which account for one-third of all caesareans in most high-income countries.[1] Caesarean sections expose mothers and newborns to excess risk of morbidity and mortality, including uterine rupture, hysterectomy, operative injury, puerperal fever, and newborn respiratory problems.[2,3] Consequently, clinical practice guidelines recommend that eligible women be offered a vaginal birth after caesarean (VBAC).[3–5] In Canada, where this recommendation was first published by the Society of Obstetricians and Gynecologists of Canada (SOGC) in 2005,[3] the repeat caesarean rate has continued to rise, demonstrating a clear gap between best evidence and practice. Canadian caesarean rates are highest in the westernmost province of British Columbia (BC).[6] In 2012–13, 82% of women with a previous caesarean were eligible to attempt a VBAC; however, only 33% of these women attempted a vaginal birth.[7] Among those women who did attempt a VBAC, 71% had a vaginal birth as planned.[7] These rates suggest that the dissemination of best evidence does not guarantee that women will be supported to make informed choices for birth after caesarean.

In response to this evidence-to-practice gap, there has been rapid development of shared decision-making (SDM) interventions to support women making the choice for mode of birth after caesarean.[8] SDM is a model of decision-making in which care providers give information on clinical risks and benefits to the woman, support her to gain clarity about her values, listen to her personal health goals and how these align with standards of care, and engage with the woman to make a shared decision for mode of birth.[9] Women who are informed of the risks of repeat caesareans may be more likely to prefer planned VBAC, which would in turn lead to a decrease in caesarean rates and adverse outcomes.[10] SDM interventions include patient resources (e.g. decision aids, pamphlets, websites, or videos), interactive decision coaching approaches, and skills training for care providers. The study of SDM interventions has been dominated by effectiveness studies focused on the quality of the decision-making *process*.[9] Randomized controlled trials of SDM interventions for birth after caesarean have been associated with a significant increase in women's knowledge of the clinical risks and benefits of mode of birth.[8,9]

However SDM interventions for mode of birth have been difficult to implement in routine practice. In Horey et al.'s meta-analysis of three randomized controlled trials involving SDM support for mode of birth after a caesarean (n = 2270 women; high-income countries), the authors found no difference in the proportion of women who achieved a match between their preferred and actual mode of birth (RR 1.02, 95% CI 0.96–1.07, n = 1921 women), suggesting that contextual factors mediated the effectiveness of the interventions.[8] Previous qualitative studies have observed that women's attitudes towards and experiences with mode of birth vary by health service resources, care provider type, and culture. A systematic review and meta-analysis of 38 international quantitative studies involving 19,403 women found that women in North America express a greater preference for elective repeat caesarean (21.3%; 95% CI 16.4–26.7) in comparison to women from Australia (13.8%; 95% CI 2.0–33.6) and high-income countries in Europe (11.0%; 95% CI 7.6–15.0). Emerging research suggests that clinical relationships and care provider preferences,[11] hospital levels of services,[12] and the availability of in-house anaesthesia[13] also may be associated with variation in caesarean section rates.

In order to implement SDM for birth after caesarean in Canada, it is necessary to develop an understanding of "local evidence" including different stakeholders' attitudes and experiences with birth after caesarean, and the health services and policy context in which decision-making takes place.[14] To that end, the aim of this study was to understand the factors that support or impede SDM for birth after caesarean in British Columbia. This paper presents findings from interviews with women who had a history of caesarean; findings from analysis of interviews with care providers and decision maker stakeholders are presented elsewhere.

2. Participants, ethics, and methods

2.1. Research design

This study employed a qualitative design informed by constructivist grounded theory[15] and was conducted in partnership with knowledge users in the British Columbia Optimal Birth Fraser Health Task Force, a multidisciplinary group of clinicians and health service decision makers mandated to increase women's access to vaginal birth. Knowledge users are individuals who are "likely to be able to use the knowledge generated through research in order to make informed decisions about health policies, programs and/or practices."[16] These partners provided input in developing the study design and interpretation of data to ensure that the study results would be relevant to the needs of knowledge users in the BC health care system, and to increase the likelihood that clinicians and service decision makers would accept and trust the findings. Ethical approval was sought and obtained from the UBC Behavioural Research Ethics Board and the ethics boards of Northern and Fraser Health Authorities. The funding organisations that provided financial support for the study had no role in the collection of data, its analysis and interpretation, or in the right to approve or disapprove publication of the finished manuscript.

2.2. Setting and participants

A purposive sample of communities in British Columbia, Canada, was selected. Each "community" was defined as the population catchment residing within 2 h travel time of a hospital facility with obstetrical services that support planned VBAC.[3] In our choice of communities we sought diversity in annual numbers of births, annual VBAC rate, the type of surgeon who provided local caesarean section (obstetrician, general surgeon, or general practitioner with enhanced surgical skills [GPESS]), and geography (rural, semi-urban, and urban sites). We identified the initial sample of communities and, following feedback from our stakeholder partners, we included an additional criterion: on-call vs. in-house access to obstetric and anaesthesia services for caesarean section.

Participants included English-speaking women of childbearing age (18–45 years old), who had given birth by caesarean, were considering a future pregnancy, were eligible for VBAC birth based on the Canadian clinical practice guidelines,[3] and who resided in one of the purposively sampled communities. Recruitment occurred through three methods: (a) third-party recruitment by maternity clinic staff, public health nurses, and leaders of community-based perinatal health programs; (b) poster advertisement in community settings and antenatal clinics; and (c) "snowball" sampling whereby participants shared the study information with potentially eligible women in their social networks and interested women then contacted the study team by email. Recruitment continued until categories suggested by the data demonstrated "theoretical sufficiency," that is, "when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories."[15, p. 113] All participants who met eligibility criteria and agreed to participate engaged in an interview; none declined to participate.

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2.3. Data collection

Data were collected between April and August 2015. In-depth, open-ended interviews were conducted by a female PhD Candidate experienced in in-depth interviewing and grounded theory methodology (SM). Each was audio-recorded and took place either in the participant's home, place of work, or by phone if the participant could not meet in person during fieldwork visits. The informed consent form, purpose of the study, and study description were provided to participants in advance. At the start of each interview participants were given an opportunity to ask questions about the study process and then signed their consent to participate. Each interview began with the question, "Tell me briefly about your labour and birth experiences." Subsequent probes asked about participant behaviour, experiences, and attitudes towards decision-making for repeat caesarean and VBAC. Only one interview was conducted per participant. Each lasted on average 60–90 min with the longest interview lasting three hours. Memo-writing occurred throughout data collection and analysis to capture thoughts, identify patterns, processes, and assumptions embedded in the data, identify gaps in data collection, crystallize questions and directions to pursue, and serve as a record of the research and the analytic process.

2.4. Data analysis

Data analysis took place from August to December 2015. Audio-recordings were transcribed and a research team member (SM) de-identified the transcripts by censoring personal names and places and assigning a numeric identifier for each participant (participant numbers are in parentheses in Section 3 below). Two research team members (SM, JK) independently read and coded a sample of transcripts. The coding process consisted of: (1) open and in vivo coding to identify properties of emerging concepts, (2) focused coding to identify and organise codes into batches of similar or related phenomena, (3) comparing data to data (i.e. constant comparison), and (4) theoretical coding to sort, synthesise, and organise the data into major conceptual categories. When compared, the two codebooks had conceptual congruency indicating the team members identified similar phenomena in the transcripts. The researchers merged the two codebooks for semantic congruency and coded a further two transcripts to test the merged codebook for fit and relevance. Through the additional coding and discussion, they determined that the merged categories achieved both fit and relevance; the codebook had reflected participants' experiences and made implicit processes and structures visible.[15]

Two team members (SM, EW) then independently coded all transcripts. Coding was facilitated by use of NVivo analysis software (version 11). Throughout the analysis Fraser Health stakeholder and women's health advocate partners were given presentations of emerging findings and asked to give "member-checking" feedback on what the preliminary study findings meant to them in their context and experience. Dissent was noted and unless a factual error needed correcting the findings were unaltered.

2.5. Rigour

Verification strategies were pursued throughout the research process to ensure reliability and validity,[17] including constant comparison, keeping a data trail through memos, and sampling to theoretical sufficiency. During data collection and analysis we sought to be attuned to the participants' comfort level, to relative differences in power and status, and to the effect of gender, race, and age on the interviews. The interviewer had young children of her own and experience as a doula, but no previous personal experience with caesarean birth. These personal childbirth experiences were discussed with participants where relevant to develop trust and rapport.

3. Results

Five hospital sites met the study criteria: three in rural northern BC and two in southwestern BC. Participants included: (a) women who had had a recent primary caesarean (n = 8); (b) women who were pregnant with a second child and planning a birth after caesarean (n = 7); and (c) women who had given birth after caesarean (n = 8), half who had planned a VBAC and half who gave birth by planned elective repeat caesarean. Amongst the 15 women who had had a recent primary caesarean or were pregnant again, their preferences were represented equally: five expressed a preference for planned VBAC, five for planned repeat caesarean, and five were uncertain. Of the eight participants who were considering mode of birth after two caesareans, three preferred VBAC and five preferred repeat caesarean, consistent with their preferences for their first birth after caesarean. One was uncertain. All participants lived with a partner and the majority were born in Canada, had a college diploma or university degree, and were between the ages of 30 and 39. Three women were Canadian Aboriginal, one South Asian, and the remainder were Caucasian. Table 1 provides a description of participant characteristics, while Table 2 outlines each participant's childbirth history.

Analysis of participants' narratives revealed that women's experience of decision-making for birth after caesarean was a process of "seeking control in the midst of uncertainty." Women sought control through their decision-making process, which was organised around six conceptual themes: *reflecting on their birth, clarifying their values, becoming informed, considering the feasibility of options, deliberating with the care team,* and *making an actual choice.* These key themes are illustrated in Fig. 1, which builds on previous theoretical models of shared decision-making developed by Entwistle and Watt[18] and Légaré et al.[19]

Table 1
Demographic characteristics of women.

Characteristic	N (%)
Region	
Rural	16 (69.6)
Urban	7 (30.4)
Ethnicity	
Aboriginal (Canadian)	3 (13.0)
Asian	0 (0.0)
Caucasian	19 (82.6)
South Asian	1 (4.3)
Age	
<20 years	0 (0.0)
20–29 years	5 (21.7)
30–39 years	16 (69.5)
>40 years or more	2 (8.7)
Living with a partner	
Yes	23 (100.0)
No	0 (0.0)
Annual household revenue	
<$35,000	1 (4.3)
$35,000–$70,000	8 (34.8)
>$70,000	14 (60.9)
Highest level of education received	
Graduated high school	1 (4.3)
College or technical/trade	7 (30.4)
University degree	15 (65.2)

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Table 2
Childbirth histories of participants.

Woman	Previous births	Induction	Indication for caesarean	Past birth preference	Current/future birth preference	Primary provider	Region	Mental health[a]
001	1) Planned CS 2) ERCS	–	Breech Maternal request	Vaginal CS	CS	Midwife	Urban	–
002	1) Unplanned CS	Yes	Failure to progress	Vaginal	VBAC	Midwife	Urban	Anxiety
003	1) Unplanned CS 2) Pregnant	No	Failure to progress	Vaginal	Uncertain	Midwife	Urban	Anxiety
005	1) Unplanned CS 2) ERCS 3) Pregnant	Yes	Failed induction Recommended ("small pelvis")	Vaginal CS	CS	Family physician	Urban	–
006	1) Planned CS 2) Pregnant	–	Placenta previa	CS	CS	Family physician	Urban	–
007	1) Unplanned CS 2) Pregnant	No	Dystocia	Vaginal	VBAC	Midwife	Rural	Depression
010	1) Unplanned CS 2) CS during VBAC	No No	Dystocia Fetal distress	Vaginal VBAC	Uncertain	Midwife	Urban	Depression
024	1) Planned CS	No	Breech	CS	CS	Family physician	Rural	–
025	1) Unplanned CS	No	Failure to progress	Vaginal	VBAC	Midwife	Rural	–
028	1) Unplanned CS	No	Dystocia	Vaginal	VBAC	Family physician	Rural	Depression
029	1) Unplanned CS	No	Failure to progress	Vaginal	CS	Midwife	Rural	–
030	1) Unplanned CS	No	Dystocia	Vaginal	Uncertain	Family physician	Rural	–
031	1) Unplanned CS	Yes	Failed induction	Vaginal	CS	Family physician	Rural	–
034	1) Unplanned CS 2) Pregnant	No	Failure to progress	Vaginal	Uncertain	Family physician	Rural	Anxiety
035	1) Unplanned CS 2) VBAC 3) Pregnant	No	Fetal distress	Vaginal VBAC	VBAC	OB	Rural	–
036	1) Unplanned CS 2) Pregnant	No	Failure to progress	Vaginal	VBAC	GPESS	Rural	–
037	1) Unplanned CS	No	Failure to progress	Vaginal	Uncertain	GPESS	Rural	–
039	1) Planned CS 2) Pregnant	–	Breech	CS	Uncertain	OB/GPESS	Rural	–
040	1) Unplanned CS 2) VBAC 3) VBAC	Yes	Failure to progress	Vaginal Home VBAC Home VBAC	Home VBAC	OB/Midwife	Rural	Depression
045	1) Unplanned CS 2) Pregnant	No	Failure to progress/ malposition	Vaginal	VBAC	OB/GPESS	Rural	–
048	1) Unplanned CS 2) ERCS 3) Pregnant	No	Failure to progress Maternal request	Vaginal CS	CS	OB/FP	Rural	Depression
049	1) Unplanned CS 2) VBAC	No	Failure to progress	Vaginal VBAC	VBAC	OB/family physician	Rural	Depression
054	1) Unplanned CS 2) ERCS 3) Pregnant	No	Fetal distress Recommended ("big baby")	Vaginal Uncertain	CS	Midwife	Urban	–

CS: Caesarean.
ERCS: elective repeat caesarean.
GPESS: general practitioner with enhanced surgical skills.
[a] Self-reported postpartum mental health state after primary caesarean.

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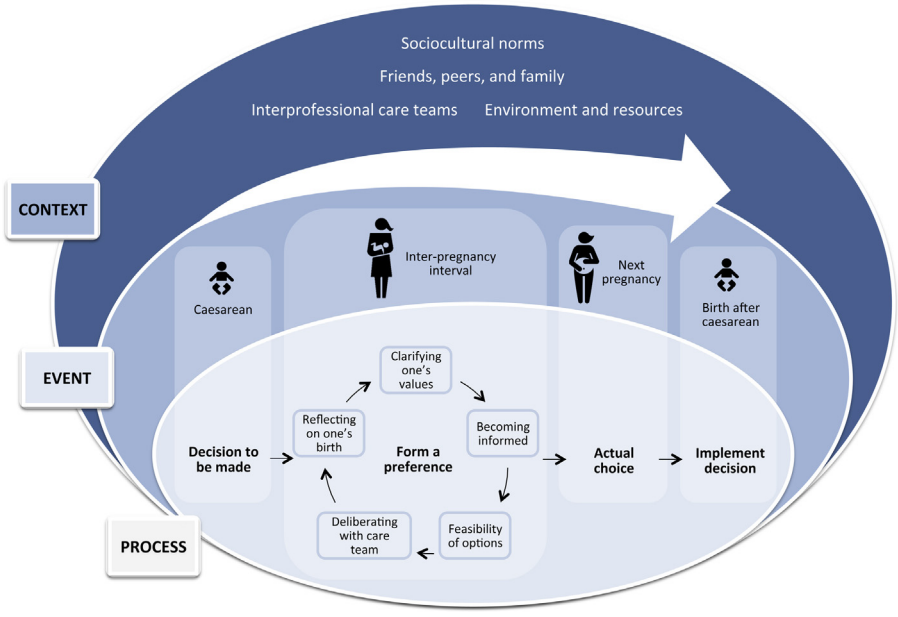

Fig. 1. Women's decision-making process for mode of delivery after caesarean.

3.1. Seeking control in the midst of uncertainty

Women who had an unplanned caesarean during first or second stage labour (n = 19) typically felt "*out of control*" during their birth, due to overwhelming hormones, labour interventions, or unexpected events that precipitated a caesarean. Making the decision for birth after caesarean was a process of seeking and regaining control over their birth experience. For participants whose previous unplanned caesarean had triggered postpartum depression and anxiety, planning their next birth experience was a way to avoid uncertainty: *"I need to plan this so that it helps me keep this [anxiety] in control . . . Going into having a VBAC would be giving up that control that I was working for to keep the postpartum [anxiety] away."* (048) Some participants described seeking control over decision-making authority, which was connected to their sense of self, identity, and autonomy: *"I want to be that active participant. I don't want to be the bystander in my own delivery."* (002) To ensure control as an active participant in decision-making, women communicated their birth preferences clearly to a partner or doula, or sought midwifery care, which they perceived to be more supportive of women's choices.

3.2. Reflecting on the prior birth experience

During their inter-pregnancy intervals, women reflected on the memory of their first births. Many expressed a sense of "*failure*" at not having achieved their desired vaginal birth in spite of their education and planning. In contrast, the four women who had elective caesareans for their first child, for breech presentation (n = 3) and placenta previa (n = 1), characterised their caesarean births as friendly, predictable, and calm. All four women feared the uncertainty of a vaginal birth and consequently leaned towards repeating the caesarean experience.

For all participants the most negative attribute of their caesarean experience was being immediately separated from their newborn for one hour following birth, or longer for women who received general anaesthesia. Women described feeling anxious, abandoned by their nurses, and confused about the location and wellbeing of their child. Many felt that the loss of this first hour with their first baby had far-reaching effects on their ability to breastfeed and bond, as one described: "*I lots of time feel she is not my baby. I love her but I felt like she was a stranger when she came out [Cries] and it took months before I felt like I got to know her*" (028). Nine women described experiencing postpartum depression and/or anxiety and expressed that their mental health issues began with the emotional trauma of being separated from their baby in the immediate postpartum.

3.3. Clarifying values

Throughout her inter-pregnancy interval each woman considered the extent to which the positive and negative characteristics of vaginal and caesarean birth were personally important to her. These included maximizing the baby's health, discovering the baby's sex, experiencing uninterrupted bonding in the immediate postpartum, avoiding emotional trauma, feeling cared for and respected by one's care providers, having a quicker recovery, and maintaining abdominal and perineal muscle strength. Participants recognised that they would have to make "trade offs" and give up something in order to achieve their desired birth experience.

Women emphasised that "*of course*" they wanted a healthy baby above all else, which they felt an elective repeat caesarean would guarantee (although this is not in fact the case). Equally important for many was immediate and uninterrupted bonding: "*The biggest thing is immediate skin to skin in the OR. It's extremely hard to get here . . . I think that would be the number one huge thing for me to try and get that love feeling right after birth*" (007). This participant was willing to accept trade offs, including the increased risk of uterine rupture, in order to maximise her chances of experiencing bonding after a vaginal birth.

Women's access to resources and social support also influenced their values and preferences. Some participants lived far from extended family and had concerns about recovering from caesarean surgery and not being able to lift their toddler for six weeks. While this motivated some to plan a VBAC for a short recovery, others opted for a repeat caesarean to schedule help from

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family and friends. The impact of surgical recovery was information shared by other experienced mothers, not care providers.

3.4. Becoming informed

During women's inter-pregnancy interval and subsequent pregnancy, they began to seek out information to fill in their knowledge gaps. No participant who had an intrapartum caesarean felt she had a full understanding of why it occurred. Participants described multiple opportunities for "de-briefing" their birth experience with their care team in the early postpartum, but most found the lack of information dissatisfying. One participant described an exchange with her obstetrician at her 6-week postoperative check-up:

> "*I asked, 'Was this like a freak thing or was it something wrong with me anatomically, and what are my chances for a VBAC?' He looked at my chart, and he says, 'It says persistent OP [occiput posterior]' . . . It was like, 'that's my birth story that you just summed up in "persistent OP."' I wanted more information than that.*"' (025)

To gain confidence in their preference, participants actively sought statistics on the risks and benefits of attributes of VBAC and repeat caesarean that were important to them. They primarily Googled information and landed at sites including Babycenter, WebMD, Huffington Post, and Motherisk. Women also sought out information in the form of birth stories, which helped them gain certainty with their preference. It was a therapeutic process for the eight women who experienced postpartum depression and anxiety. One took up amateur birth photography to witness natural births, while another became a member of the International Caesarean Awareness Network (ICAN). Many participants felt they would be "judged" for having had a caesarean and were selective in revealing their mode of birth only to women who they expected would empathize with their experience. For most women, the act of engaging in this research interview was part of that therapeutic process.

3.5. Considering the feasibility of options

A number of participants who had unplanned primary caesareans questioned whether their hospital would have the resources to safely support planned VBAC and uninterrupted bonding. Other women gained information on the feasibility of options through the media and friends, as one rural woman who preferred a repeat caesarean described:

> "*I know a friend of mine, when she was considering a VBAC the doctor had told her . . . 'If your uterus ruptured we have two minutes to get you to surgery to stop the bleeding before you bleed out. And we don't keep a surgeon at the hospital 24 hours a day.' . . . That was one of her deciding factors to do a repeat c-section.*" (048)

These access factors motivated some women to travel to seek midwifery care or to have an unattended home birth, which they felt would increase their chances of having the vaginal birth they desired.

3.6. Deliberating with the care team

Although most of the women's decision-making occurred while they were not receiving care from the health system, they did deliberate with care providers immediately before/after their primary caesarean, and during their subsequent pregnancy. Discussions with physicians were brief and remembered as a one-way information provision. Many described feeling rushed and others feared that by asking too many questions they would be perceived as a "*resistant patient*" (049). As a result, few women told their physician about the attributes of mode of birth that were most important to them. Women wished to "*talk about what your priorities are*" (001), and to receive information "*ahead of time*" so that could consider their options and prepare questions before appointments (005). Pamphlets and materials written for the general population were considered "*impersonal*" (025) and not useful for making a decision. Midwifery clients had more opportunities for deliberation, spread out over multiple one hour long appointments.

Women under the care of a midwife or family physician were referred to an obstetrician around the 36th week of their pregnancy for an informed consent consultation. All but one woman had solidified a choice for mode of birth by this time. Rather than assist in their decision, the obstetric consult caused these women to question their choice. The one participant who was undecided felt pressured to make a choice and regretted signing consent for a repeat caesarean without consulting her midwives and husband (054). Another midwifery patient felt the consultant gave a biased and "*scary*" presentation of the risks of her planned VBAC: "*[I felt] irritated. Yeah. I knew that if there was a real risk they would tell me. There was risk in everything, so I felt like it was an unnecessary appointment*" (010).

3.7. Actual choice

Of the 23 participants, only six (26%) were uncertain of their preference for mode of birth after caesarean. Two had recently had an unplanned primary caesarean, three were pregnant after their primary caesarean, and one woman had recently had a planned VBAC that had resulted in an emergency caesarean for fetal distress. They felt that they had time to consider their options and were not ready to make a choice yet. The 17 participants who were certain of their preference found it difficult to make an actual choice because of the difficult trade-offs involved in the decision. For one participant, choosing a repeat caesarean meant giving up the social identity she dreamed of having through a vaginal birth: "*I was making a decision that my children were going to be born by caesarean. It was like the closing of a door to [vaginal birth] . . . So deciding that I was willing to let go of that dream was challenging*" (054).

Women spoke about the difference between their *preference* for mode of birth and their *actual choice*. Many women expressed that they did not begin trying to get pregnant again until they felt confident in their preference for VBAC or repeat caesarean. While some described themselves as "planners" and formed an early confidence in their preference, others took a long time to become confident in making an actual choice for repeat caesarean: "*It wasn't a light decision. This was months in the making. Lots of discussion*" (005). Ultimately, women wanted more support from their care team or partner when making their decision: "*It feels like a lot to kind of be the one making the decision all by yourself*" (001). Many expressed that being an active and "*empowered*" (049) participant in the decision-making process was the key to being satisfied with their birth experience, regardless of their mode of birth or outcome.

4. Discussion

Our findings from this qualitative analysis of women's experiences of choosing mode of birth after caesarean indicate that the decision-making process is complex and challenging. Women "seek control" over their decision-making and birth experience in the midst of uncertain outcomes. Key findings include the insight that participants' decision-making process began during the inter-pregnancy interval when participants'

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contact with the health care system was limited. As well, we observed that participants struggled to make trade-offs between clinical and social outcomes of mode of birth. This reflects findings from previous qualitative studies in Australia,[20] the United Kingdom,[21] and the United States,[22,23] as well as Black et al.'s recent meta-ethnographic synthesis of 20 papers reporting the views of 507 women from four countries.[24] Our analysis adds to this literature an in-depth understanding of women's concerns about health service limitations. For instance, where hospitals did not support uninterrupted bonding post-caesarean, women felt they had to give up that experience in order to maximize well-being for their baby.

Previous studies on women's decision-making for birth after caesarean have focused on interventions *during* pregnancy.[25] Findings from our present study indicate that women would benefit from decision support as early as the immediate postpartum following a primary caesarean. For some participants forming a preference for mode of birth and gaining confidence in that choice was a necessary step before becoming pregnant again. It is important that women have quality evidence about the potential benefits and harms of health care options before considering the attributes that matter most to them, otherwise they may rely on information that is incomplete, inaccurate, biased, or not pertinent to their clinical situation.[26,27]

Our findings also indicate that information on the clinical risks and benefits of mode of birth after caesarean is not sufficient to assist women to make an actual choice. Women desired information about their *primary* caesarean. What were the indications for their first surgery? Would those indications recur in their next labour and birth? Could they have had a vaginal birth if other actions had been taken? In the absence of information from care providers about their first birth, participants relied on personal knowledge from their caesarean experience, and information from peers and the Internet. Previous studies involving postpartum interviews with women who gave birth after caesarean similarly observed that women rely heavily on knowledge from their previous birth experience(s), which were frequently characterised by fears of being physically incapable of having a vaginal birth.[28,29] Additional contextual factors worked synergistically to influence women's preferences and their birth planning. For instance, women who had family in town to provide support during postpartum recovery found it easier to manage the uncertainty of their birth date and the outcome of a planned VBAC.

Some limitations of this study may be noted. The study was set in a single province, British Columbia, which may limit the transferability of findings to jurisdictions with different population demographics and density, and models of maternity health services. Participants were primarily Caucasian and well educated, which was the result of having limited resources for sampling. Similarly, due to funding constraints, all interviews were conducted in English, which limited our ability to investigate cultural differences in women's decision-making. The sampling frame also excluded communities with no local access to caesarean section, because the SOGC clinical practice guidelines do not recommend birth after caesarean in such settings. Future studies may engage community outreach recruitment in order to explore the attitudes and experiences of women from different socio-cultural backgrounds and from communities with no surgical maternity services.

Interviews were conducted at one time point in women's childbearing experience, thus the differences observed between participants' attitudes may have been a reflection of the point in time that each was interviewed during her decision-making process. To minimise the effects of this limitation, we asked participants to reflect on their previous mode of birth decision-making experiences, and to discuss changes in their attitudes and what triggered those changes. We also sampled for women who were at different time points in their decision-making journey.

Finally, we did not observe any differences in decision-making by income level or education, however this may reflect our small, relatively homogenous sample of older, well-educated mothers. Analysis revealed few differences between the experiences and attitudes of women who lived in rural communities, compared to their urban counterparts. Some rural women lived one to two hours from their hospital facility and had traveled to one of the study communities to secure a planned VBAC.

5. Conclusion

This study provides insight into women's attitudes towards and experiences with decision-making for mode of birth after caesarean and illuminates the context of their decision-making process. Our findings suggest that women begin to form preferences for mode of birth after their primary caesarean and they desire more information in the immediate postpartum on the reasons for their caesarean birth. Care providers may use that opportunity to affirm women's eligibility for planned VBAC in future pregnancies. To support the implementation of SDM for birth after caesarean in Canada, discussion of mode of delivery may also include consideration of the social and psychological attributes that are essential to each woman's decision, such as uninterrupted postpartum bonding and mental well-being. The format and dissemination of SDM interventions should be considered in the format that women prefer, which in this study included face-to-face discussion with their care provider, conversation with peers, and the Internet.

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