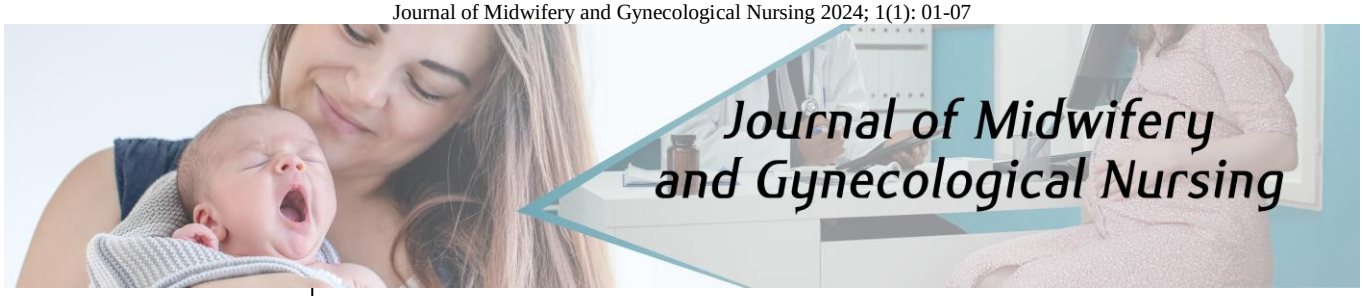

E-ISSN: xxx-xxxx
P-ISSN: xxx-xxxx
www.gynejournal.com
JMGN 2024; 1(1): 01-07
Received: 09-07-2024
Accepted: 12-08-2024

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Role of midwives in promoting vaginal birth after cesarean (VBAC): Outcomes and Challenges

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Abstract
With rising Cesarean Section (CS) rates worldwide, the importance of safe, evidence-based alternatives such as Vaginal Birth After Cesarean (Vbac) has come into sharper focus. Midwives play a central role in promoting and supporting VBAC, offering not only clinical expertise but also emotional reassurance and patient-centered education. This paper explores the role of midwives in advancing VBAC practices, the outcomes associated with midwifery-led care, and the various institutional and cultural challenges that affect implementation. Drawing from recent research, guidelines, and field observations, this paper underscores how empowering midwives can lead to improved maternal outcomes and greater birthing satisfaction.

Keywords: VBAC, greater birthing satisfaction, improved maternal, challenges

Introduction
The global escalation in Cesarean Section (CS) deliveries over recent decades has emerged as a significant public health concern. While cesarean delivery is a critical surgical intervention that has revolutionized obstetric care and saved countless lives in cases of maternal or fetal distress, its overuse-particularly in low-risk pregnancies has led to a cascade of avoidable complications and increased healthcare burdens. According to the World Health Organization (WHO), an optimal cesarean section rate should lie between 10% and 15%, as rates beyond this threshold have not been associated with improved maternal or neonatal outcomes. Despite these recommendations, cesarean birth rates have continued to climb worldwide, with countries such as Brazil, Egypt, Turkey, and parts of South Asia reporting rates exceeding 40-50%.

One of the downstream effects of high CS rates is the increasing population of women who face limited birthing options in subsequent pregnancies. Traditionally, women with a prior cesarean were routinely scheduled for a repeat cesarean delivery, often with minimal discussion about alternatives. However, advancements in obstetric knowledge and clinical evidence now support vaginal birth after cesarean (VBAC) as a safe and beneficial option for many women, particularly those with a single low-transverse uterine scar and no contraindicating risk factors. When carefully managed, VBAC not only minimizes the risks associated with multiple surgical births, such as placenta accreta, bladder injury, and infection, but also facilitates shorter recovery times, lower healthcare costs, and improved maternal satisfaction.

Despite the evidence in favor of VBAC, its implementation remains limited in many healthcare systems due to a variety of clinical, institutional, and societal barriers. A pervasive culture of defensive medicine, fear of litigation, inadequate training in managing VBAC scenarios, and lack of institutional support contribute to the continued preference for elective repeat cesarean deliveries (ERCD). In addition, many women are either unaware of VBAC as a viable option or are discouraged from pursuing it due to perceived risks or lack of adequate support from their healthcare providers.

Amid these challenges, midwives have emerged as pivotal figures in supporting the resurgence of VBAC. Midwifery care, which emphasizes the normalcy of childbirth, informed decision-making, and continuous labor support, is particularly well-suited to facilitate VBAC. Unlike the often fragmented and medicalized approach of conventional obstetric care, midwives adopt a holistic model that places the woman at the center of care.

This philosophy aligns closely with the principles needed to encourage and support VBAC, which requires trust, ongoing communication, risk assessment, and a willingness to allow the natural progression of labor while remaining vigilant for signs of complications.

Midwives bring a unique set of clinical and interpersonal skills to the VBAC context. They are trained to assess eligibility for VBAC by carefully reviewing a woman's obstetric history, including the type of uterine incision, inter-pregnancy interval, and overall health status. During the antenatal period, midwives engage in shared decision-making by providing comprehensive counseling about the risks and benefits of VBAC compared to repeat cesarean delivery. This process not only empowers women but also fosters a sense of autonomy and confidence in their birth choices. During labor, midwives provide hands-on physical and emotional support, utilize non-pharmacologic comfort measures, and monitor fetal and maternal well-being. Their continuous presence throughout labor has been associated with reduced intervention rates and better birth outcomes, making them ideal advocates for VBAC.

Furthermore, midwives often work collaboratively with obstetricians and other healthcare professionals, creating integrated care models that ensure safety while preserving the natural aspects of childbirth. In settings where midwives are allowed to lead VBAC care, studies have reported higher success rates, lower intervention frequencies, and greater maternal satisfaction compared to obstetric-led models. For example, research by Kennedy et al. (2010) [3] found that women receiving midwifery-led care were significantly more likely to feel heard, respected, and supported in their birth plans, including those pursuing VBAC.

Nevertheless, the promotion of VBAC by midwives is not without obstacles. Institutional policies in some hospitals prohibit midwives from managing VBAC cases, even when women are low-risk and appropriately counseled. The lack of VBAC-specific training in many midwifery education programs further complicates the issue, as midwives may feel underprepared to handle the potential complexities associated with uterine rupture or other rare complications. Additionally, in resource-limited settings, the absence of round-the-clock surgical backup makes VBAC logistically difficult, if not unsafe. Cultural attitudes and misinformation about vaginal delivery after cesarean also pose significant barriers, particularly in communities where cesarean birth is perceived as more advanced or risk-free.

In this context, the need to strengthen midwifery-led VBAC care becomes not only a matter of improving maternal outcomes but also a step toward more respectful, patient-centered maternity care systems. This paper explores the multifaceted role of midwives in promoting VBAC, the outcomes of midwifery-led models of care, the challenges faced in their implementation, and the institutional reforms necessary to support their expanded role. By understanding and addressing these dimensions, healthcare systems can unlock the full potential of VBAC and midwifery collaboration to reduce unnecessary cesarean births and improve overall maternal health outcomes.

Why VBAC Matters

Vaginal Birth After Cesarean (VBAC) is a pivotal element of modern obstetric care that offers a safe, cost-effective, and empowering alternative to repeat cesarean delivery. As cesarean rates surge globally, the relevance of VBAC has increased-not only from a clinical standpoint but also from psychosocial, economic, and public health perspectives. Understanding the magnitude of its benefits requires examining clinical data, cost comparisons, maternal preferences, and system-level implications.

Globally, the cesarean delivery rate has nearly doubled over the past two decades. According to a 2019 study published in *The Lancet*, the global cesarean rate rose from 12.1% in 2000 to 21.1% in 2015 and is projected to reach 29% by 2030 if current trends continue. In countries like Brazil, Egypt, Turkey, and Iran, the rates exceed 50%. This dramatic rise is not fully explained by medical necessity, indicating a shift toward over-medicalization of childbirth.

The WHO estimates that cesarean delivery rates above 15% at a population level are not associated with further reductions in maternal or neonatal mortality. Instead, they introduce preventable risks and costs. Thus, VBAC becomes crucial as a strategy to reduce unnecessary surgical interventions.

Table 1: Cesarean Section Rates and VBAC Opportunities by Country

Country	CS Rate (%)	Recommended VBAC Promotion (%)	Health System Concern
Brazil	55.7	High	High elective CS in private sector
Egypt	51.8	High	Institutional preference for CS
India	21.5	Moderate	Uneven distribution across states
Sweden	17.3	Low to Moderate	Strong midwifery integration
USA	32.0	High	High repeat CS rates
WHO Ideal Rate	10-15	High necessity	Benchmark for safe delivery

Source: WHO; Betrán et al., The Lancet, 2016

Clinical Benefits of VBAC

VBAC is associated with lower maternal and neonatal morbidity compared to elective repeat cesarean delivery (ERCD) in appropriately selected cases. The key clinical benefits include:

- Reduced maternal blood loss and risk of hemorrhage
- Lower postoperative infection rates
- Shorter hospital stays and quicker return to normal activity
- Lower incidence of surgical complications such as adhesions and bladder injury
- Preservation of uterine integrity for future pregnancies

The landmark NICHD MFMU Network study by Landon et al. (2004) [1], involving over 45,000 women, found that 74% of women attempting a trial of labor after cesarean (TOLAC) achieved a successful vaginal birth. The risk of uterine rupture was only 0.7%, and maternal and neonatal outcomes were generally favorable.

Table 2: Comparison of Outcomes - VBAC vs. Repeat Cesarean

Outcome Metric	VBAC (%)	Repeat Cesarean (%)	Interpretation
Maternal Infection	1.8	6.4	VBAC lowers infection risk
Uterine Rupture	0.7	0.4 (during ERCD)	Slightly higher, but still rare
Blood Transfusion Requirement	1.1	2.2	VBAC has half the risk
Neonatal Respiratory Distress Syndrome	3.5	6.2	Lower in VBAC due to natural labor onset
Hospital Stay >3 days	9.3	31.4	VBAC shortens recovery
Maternal Satisfaction	High	Moderate	Higher with VBAC

Source: Landon MB et al., 2004; Grobman WA et al., 2007 [1, 5]

VBAC offers substantial psychological and emotional benefits. Women who successfully deliver vaginally after cesarean frequently report a sense of accomplishment, improved self-esteem, and emotional healing from previous birth trauma. A 2010 study by Kennedy et al. [3] Found that over 85% of women who delivered vaginally after cesarean reported high satisfaction, compared to just 60% of those undergoing repeat cesareans. Moreover, offering VBAC increases a woman's sense of autonomy and supports shared decision-making. Women who felt supported in making birth choices were less likely to experience postpartum depression or dissatisfaction with care.

From a cost-effectiveness standpoint, VBAC offers significant savings to healthcare systems. Repeat cesareans typically require longer operating room times, greater use of anesthesia, higher rates of postoperative care, and more prolonged hospital stays. According to the Agency for Healthcare Research and Quality (AHRQ):

- Average cost of a cesarean delivery in the US: $13,590
- Average cost of a successful VBAC: $9,460
- Estimated system savings per 100,000 VBACs annually: Over $400 million USD

The economic benefits are even more pronounced in low- and middle-income countries where surgical resources are limited and where preventing unnecessary procedures can substantially improve resource allocation. VBAC plays a vital role in achieving international goals related to maternal and new-born health. By reducing avoidable surgical interventions, VBAC contributes to the Sustainable Development Goal 3 (SDG 3)-which aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births. As the number of women with previous cesareans increases each year, promoting VBAC becomes a key strategy in reducing cumulative maternal risks in subsequent pregnancies. Moreover, VBAC aligns with the principles of respectful maternity care, as endorsed by the WHO, ensuring that women have access to choices in their childbirth journey, are informed of risks and benefits, and are supported in their preferences without coercion or discrimination. Midwives bring a unique skill set and philosophy to maternity care that emphasizes continuity, trust, and respect. Their ability to build strong relationships with women throughout pregnancy and labor makes them well-suited to support VBAC, which often involves nuanced decision-making and reassurance.

Key aspects of their role include:

- **Personalized Counseling:** Midwives spend time with women, explaining the benefits and risks of VBAC, often correcting misinformation or past trauma related to their previous cesarean. This trust-based relationship often encourages women to consider VBAC more confidently.
- **Risk Assessment and Care Planning:** Midwives are trained to assess medical eligibility for VBAC by reviewing prior cesarean records, checking uterine scar type, and evaluating birth intervals. This helps identify the safest candidates.
- **Labor Support:** During labor, midwives provide hands-on emotional and physical support, use non-pharmacologic comfort techniques, and avoid unnecessary interventions that might increase the risk of surgical birth.
- **Collaboration with Obstetricians:** Midwives work closely with physicians to ensure that timely surgical intervention is available if complications arise, ensuring both safety and autonomy.

The Midwife's Role in VBAC

Midwives play a transformative role in advancing the practice of Vaginal Birth After Cesarean (VBAC), offering a model of care that is inherently aligned with the principles of physiological birth, autonomy, and respect for women's choices. Unlike obstetricians, whose practice is often shaped by institutional protocols and surgical readiness, midwives are trained to view birth as a normal biological process. This philosophy positions them ideally to support women in making informed decisions about attempting a VBAC, especially in settings where cesarean deliveries have become routine rather than exceptional.

Central to midwifery-led VBAC care is the establishment of trust through sustained interaction and continuity of care. Women with a prior cesarean often carry psychological burdens-ranging from feelings of failure to unresolved trauma-stemming from their previous birth experience. Midwives provide space for these emotions to be acknowledged and processed. Through extended antenatal counseling sessions, they offer balanced, evidence-based information on the risks and benefits of VBAC compared to elective repeat cesarean delivery. This not only empowers women but also fosters a sense of control and preparedness that is often absent in more clinical, directive care models.

The clinical responsibilities of midwives in the context of VBAC are extensive and critical. They undertake comprehensive risk assessments to determine whether a woman is a suitable candidate for VBAC, taking into account factors such as the type of uterine scar, the number of prior cesareans, and the time interval between births, fetal presentation, and overall maternal health. This assessment is not merely a checklist but part of a broader conversation in which the woman's preferences, values, and concerns are weighed alongside medical indicators. When candidates are deemed suitable, midwives proceed to collaboratively develop birth plans that reflect safety considerations while honoring the woman's autonomy. During labor, midwives are at the forefront of care, providing both clinical oversight and compassionate presence. Their continuous support

throughout the birthing process has been shown to significantly increase the likelihood of successful VBAC. Techniques such as upright positioning, hydrotherapy, massage, and guided breathing are used to promote natural labor progression. Importantly, midwives are also vigilant for early warning signs of complications such as uterine rupture or abnormal fetal heart patterns. When needed, they coordinate seamlessly with obstetric and surgical teams, ensuring timely interventions without compromising the woman's dignity or agency. The role of midwives does not end with delivery. In the postpartum period, they engage in debriefing sessions with the mother, helping her process the birth experience and understand the clinical outcomes. This emotional closure is particularly valuable for women with a history of traumatic cesarean births. Additionally, midwives provide education on recovery, breastfeeding, and planning for future pregnancies, reinforcing the woman's sense of competence and confidence. Midwifery-led VBAC programs have demonstrated significantly better outcomes in both maternal satisfaction and clinical success. Studies such as the one conducted by Kennedy et al. (2010) [3] report that hospitals with strong midwifery integration see VBAC success rates as high as 72%, compared to 55% in traditional obstetric-led care. These improvements are attributed not only to the technical competence of midwives but to the holistic and woman-centered framework within which they operate. Furthermore, women under midwifery care report feeling more respected, better informed, and more involved in decision-making processes-a stark contrast to experiences of coercion or neglect sometimes reported in high-intervention hospital environments. The effectiveness of midwifery-led VBAC is not limited to outcomes alone. It represents a broader cultural shift toward care models that prioritize empowerment over paternalism and recognize birth not merely as a medical event but as a significant life experience. When midwives are fully supported through institutional policies, collaborative practice frameworks, and ongoing training, their ability to facilitate safe and satisfying VBACs is maximized. In this way, midwives act as both clinicians and catalysts for a more humane, respectful, and effective maternity care system.

Outcomes of Midwifery-Led VBAC

The outcomes associated with midwifery-led Vaginal Birth After Cesarean (VBAC) care underscore the value of re-centering maternity services around physiological processes, personalized support, and evidence-based clinical decision-making. Numerous studies and systematic reviews have consistently demonstrated that when midwives are given the opportunity to lead VBAC care-within a system that includes appropriate screening protocols and emergency backup-success rates increase, intervention rates decline, and maternal satisfaction improves.

A substantial body of research supports the claim that midwife-led VBAC care results in higher rates of successful vaginal births. One of the most cited studies in this regard is the multicenter analysis by Kennedy et al. (2010) [3], which found that VBAC attempts managed primarily by midwives had a success rate of approximately 72%, compared to 55% in obstetrician-led settings. This finding has been echoed across various health systems, including those in the United Kingdom, the Netherlands, Sweden, and parts of the United States, where midwifery models of care are well-integrated. The higher success rates in these models are generally attributed to a combination of continuous labor support, judicious use of interventions, and trust-based patient relationships that encourage physiological progression of labor.

These clinical successes are closely tied to lower rates of common obstetric interventions. In midwifery-led VBACs, rates of labor augmentation with synthetic oxytocin, early epidural administration, and instrumental deliveries are all significantly reduced. These reductions are not only cost-effective but are also clinically beneficial, as they are associated with fewer postpartum complications, lower incidence of perineal trauma, and improved neonatal outcomes. The Cochrane Review by Hodnett et al. (2013) [7] further supports this by showing that continuous support during labor-an essential characteristic of midwifery care-correlates with shorter labors, decreased use of analgesia, and higher rates of spontaneous vaginal birth.

Patient-reported outcomes also reflect the strength of midwifery-led VBAC. Women frequently describe feeling more empowered and satisfied with their birthing experience when supported by midwives. Unlike conventional obstetric models that can feel rushed or impersonal, midwifery-led care is characterized by sustained presence and genuine emotional support. This continuity is especially important for women attempting VBAC, many of whom carry emotional scars from previous cesareans. In interviews and postnatal surveys, women often cite their midwives as the most trusted and reassuring figures during labor. This relational aspect has measurable psychological benefits, including reduced rates of postpartum depression and anxiety, which have lasting implications for maternal-infant bonding and long-term health.

The institutional benefits of successful midwifery-led VBAC are also substantial. Shorter hospital stays, lower surgical supply use, and fewer anesthetic procedures all contribute to decreased operational costs. In national health systems, widespread implementation of midwifery-led VBAC programs could result in millions of dollars in annual savings. These savings are even more impactful in low- and middle-income countries, where healthcare infrastructure is often strained and surgical capacity is limited. By reducing the number of avoidable repeat cesareans, midwifery-led care alleviates surgical burden and frees up critical resources for emergency cases.

While the risk of uterine rupture remains a primary concern in any VBAC scenario, data suggest that midwives, when operating within structured care pathways and collaborating with multidisciplinary teams, manage these risks effectively. The rate of uterine rupture remains low-typically between 0.5% and 0.9%-and is not significantly higher in midwife-led care when strict eligibility criteria and monitoring protocols are followed. In fact, timely identification of rupture symptoms and swift escalation to surgical teams has been documented as highly effective in integrated midwifery models, where communication between care providers is fluid and predefined.

Moreover, midwifery-led VBAC contributes positively to long-term reproductive health. By reducing exposure to multiple abdominal surgeries, women retain a broader range of safe birth options in future pregnancies. This is particularly important given the rising awareness of cumulative cesarean risks, including placenta accreta spectrum disorders, surgical adhesions, and increased maternal mortality with each successive cesarean.

Encouraging VBAC through midwifery not only improves outcomes in the current pregnancy but also lays the foundation for safer, more flexible reproductive planning in the years ahead.

In conclusion, the outcomes of midwifery-led VBAC care are compelling across multiple dimensions-clinical, psychological, economic, and institutional. The evidence is clear: when midwives are trusted to guide eligible women through VBAC, the result is a more humanized, cost-effective, and successful maternity experience. The data speak not only to improved physical outcomes but also to the broader impact on how women perceive and experience birth. As such, investing in midwifery-led VBAC models is not merely a matter of clinical efficiency-it is an investment in respectful, sustainable, and equitable maternity care systems.

Challenges Faced by Midwives in Promoting VBAC

Despite the mounting evidence in favor of midwifery-led Vaginal Birth After Cesarean (VBAC) and the well-documented outcomes associated with such care, midwives across many healthcare systems continue to face substantial challenges in promoting, supporting, and executing VBAC practices. These obstacles are multifaceted, ranging from institutional rigidity and legal constraints to sociocultural beliefs and systemic gaps in training and infrastructure. Collectively, they contribute to a persistent underutilization of VBAC, even in cases where clinical eligibility and patient preference clearly support it. One of the most significant barriers is the existence of restrictive institutional policies that limit or completely prohibit midwives from managing VBAC cases. In many hospitals, particularly in regions where obstetricians hold exclusive decision-making authority, midwives are often excluded from labor management once a woman has a history of cesarean delivery. These restrictions are frequently based on outdated risk assessments or blanket liability concerns rather than individualized risk-benefit analyses. As a result, many women who might otherwise qualify for VBAC under current guidelines are either discouraged or denied the opportunity to attempt it, regardless of their preferences or the clinical appropriateness of a trial of labor after cesarean.

Closely tied to institutional barriers is the pervasive fear of litigation among healthcare providers. The rare but highly publicized risk of uterine rupture during a VBAC attempt has led to an overly cautious legal climate, in which providers, including hospitals, adopt defensive practices to avoid potential lawsuits. Even when national or international guidelines support VBAC for certain patient profiles, hospitals may choose to limit VBAC availability or mandate obstetrician-led oversight, effectively side-lining midwives. This legal overcorrection not only compromises evidence-based care but also erodes professional confidence among midwives, many of whom feel unsupported in offering the full scope of services they are trained to provide. In addition to legal and policy-based constraints, the lack of sufficient infrastructure in certain regions poses a serious logistical challenge to the safe execution of VBAC. Successful and safe VBAC requires 24/7 access to surgical backup, anesthesia services, and neonatal care. In rural or under-resourced areas, such facilities may be absent or unreliable, making VBAC attempts risky from a systems perspective, regardless of the individual woman's eligibility. Midwives working in such contexts often face ethical dilemmas, where they must balance respect for a woman's choice with the practical limitations of their environment. The result is a cautious reluctance to promote VBAC, not out of clinical doubt, but because of systemic shortcomings.

Compounding these issues is the inconsistency in midwifery training related to VBAC. While most midwives receive comprehensive education in normal labor and birth, not all are adequately prepared to manage the specific risks associated with VBAC or to recognize the subtle early signs of complications such as uterine dehiscence or rupture. This lack of uniform training and simulation-based preparedness may lead some midwives to lack the confidence needed to fully advocate for VBAC or to be excluded from hospital credentialing processes. Furthermore, continuing education programs that include VBAC protocols, emergency drills, and interprofessional simulations are not universally available, creating disparities in practice readiness even among highly motivated midwives. Cultural beliefs and societal norms also act as invisible yet powerful constraints on VBAC promotion. In certain regions, cesarean birth is seen not as a surgical necessity but as a symbol of modernity, affluence, or even status. Women may choose elective repeat cesareans because of misinformation, familial pressure, or the desire to avoid labor pain. In such contexts, midwives may encounter resistance not from hospitals or doctors, but from the very women they seek to support. Correcting these misconceptions requires extensive community outreach, culturally sensitive education, and the normalization of vaginal birth as a positive, empowered choice after cesarean. However, such public health interventions are rarely part of structured maternity services, placing an additional burden on midwives to educate while providing care.

Another critical challenge is the fragmentation of care that results when midwives are not integrated into the larger obstetric system. VBAC is safest when conducted in collaborative, team-based settings where midwives, obstetricians, anesthesiologists, and pediatricians operate with mutual respect and shared protocols. Unfortunately, in many hospitals, midwives operate in parallel to, rather than in collaboration with, obstetric services. This disconnect leads to inconsistent messaging, undermines continuity of care, and can create confusion or fear among laboring women. Without systemic collaboration, midwives remain constrained, unable to realize the full potential of their training in VBAC support.

These challenges form a complex web of barriers that cannot be addressed through individual effort alone. Midwives, even the most experienced and dedicated, require institutional, legal, and educational support to promote VBAC effectively. They must be empowered not just through policy permission but through systemic inclusion in care planning, decision-making, and leadership within maternity services. Addressing these issues is not only a matter of clinical reform but also a broader commitment to equity, autonomy, and respect in childbirth.

Recommendations to Enhance VBAC Promotion

Promoting Vaginal Birth After Cesarean (VBAC) as a mainstream, safe, and accessible option within maternity care requires deliberate and comprehensive action across policy, clinical practice, education, and public awareness. Midwives are central to this reform, but without structural support, their role remains underutilized and constrained. To

truly integrate VBAC into routine obstetric care, it is essential to address the systemic, institutional, and cultural factors that currently limit its availability and acceptance.

At the policy level, national guidelines must be updated and implemented in ways that actively support midwifery-led VBAC care. While several professional bodies, including the American College of Obstetricians and Gynecologists (ACOG), the Royal College of Obstetricians and Gynaecologists (RCOG), and the World Health Organization (WHO), have issued statements supporting VBAC under certain clinical conditions, these guidelines often remain aspirational unless translated into hospital protocols and licensing policies. Regulatory frameworks should empower midwives to act as primary care providers for eligible VBAC candidates and ensure they are part of multidisciplinary teams involved in planning and delivering such care. This requires shifting from hierarchical models of obstetric dominance to collaborative, integrated approaches where midwives' roles are institutionalized rather than conditional. Training and capacity building represent another critical area for intervention. Midwifery education programs must include in-depth modules on VBAC, covering risk assessment, emergency recognition, labor management, and interdisciplinary communication. Equally important is the provision of regular, practical simulation exercises that allow midwives to rehearse VBAC scenarios, including rare but high-stakes emergencies such as uterine rupture. Such training not only enhances competence but also builds confidence and professional credibility, particularly in institutions where midwives are expected to justify their scope of practice. Infrastructural readiness is also necessary to expand VBAC safely. This includes ensuring that facilities offering VBAC have 24-hour surgical backup, accessible anesthesia services, and neonatal support. In settings where such backup is not possible-such as rural or resource-limited hospitals-referral networks must be strengthened, and telehealth protocols can be developed to support shared care planning. Rather than restricting VBAC altogether in these areas, systems should be put in place to extend access through creative, context-specific solutions that uphold safety without denying choice. Beyond the clinical setting, raising community awareness is key to countering the stigma and misinformation surrounding VBAC. Many women are unaware that vaginal delivery after a cesarean is even an option, let alone a recommended one for many scenarios. Public health campaigns, educational workshops, and antenatal classes must explicitly address VBAC as a normal, supported birth path. These efforts should include culturally sensitive messaging and be designed to reach not only expectant mothers but also families, community elders, and influencers who often play a role in birthing decisions. Midwives can serve as visible champions in these efforts, helping to reframe VBAC as a healthy, empowered, and achievable outcome. Another area of importance is the institutional culture within healthcare settings. Hospitals that wish to promote VBAC must foster environments that value shared decision-making, respect patient autonomy, and prioritize non-interventionist birth practices where appropriate. Midwives should be actively involved in developing VBAC protocols and participating in outcome audits and quality improvement initiatives. Their presence on clinical guideline committees, ethics boards, and policy review panels can help ensure that VBAC is not just permitted but promoted as part of high-quality maternity care. Investment in research is also necessary to strengthen the case for VBAC and midwifery-led models of care. More longitudinal and context-specific studies are needed to examine the outcomes of VBAC in diverse healthcare systems, particularly in low- and middle-income countries where the infrastructure and training contexts may differ from those in high-income countries. Funding for implementation research can help identify effective strategies for scaling VBAC promotion programs, evaluating both their clinical efficacy and cost-effectiveness. Taken together, these recommendations offer a comprehensive framework for normalizing VBAC within modern maternity care. They affirm the central role of midwives as both practitioners and advocates, while acknowledging the broader systems that must be mobilized to support them. Implementing these changes will not only increase the rates of successful VBAC but also elevate the overall standard of care by reinforcing the principles of respect, autonomy, and evidence-based practice. By creating environments in which midwives can confidently and safely offer VBAC to eligible women, health systems take a definitive step toward reducing unnecessary cesareans, enhancing maternal outcomes, and restoring agency to the childbirth experience.

Conclusion

Vaginal Birth After Cesarean (VBAC) stands as a clinically supported, cost-effective, and woman-centered alternative to the growing normalization of repeat cesarean deliveries. At a time when cesarean rates continue to climb-often without corresponding improvements in maternal or neonatal outcomes-VBAC offers an opportunity to restore balance in maternity care by aligning with physiological norms, preserving maternal autonomy, and enhancing long-term reproductive health. Yet, the true potential of VBAC can only be realized when supported by the right model of care, and that model, as evidenced across numerous healthcare settings worldwide, is most effectively delivered through midwifery-led practice. Midwives bring to VBAC a unique blend of clinical competence, individualized support, and unwavering commitment to respectful, informed childbirth. Their role goes far beyond managing the physical aspects of labor. It encompasses the psychological reassurance of women with prior cesarean experiences, the crafting of birth plans rooted in shared decision-making, and the provision of vigilant, non-invasive support during labor that prioritizes both safety and dignity. The data surrounding midwifery-led VBAC is compelling. Success rates are higher, interventions are fewer, maternal satisfaction is greater, and system costs are lower. These outcomes speak not only to midwives' technical abilities but to the foundational ethos of their practice: that childbirth should be guided, not controlled; supported, not overridden. However, despite the overwhelming evidence and numerous guidelines supporting midwifery involvement in VBAC, a wide array of challenges persists. Institutional policies, legal fears, infrastructural inadequacies, and cultural misconceptions continue to restrict access to VBAC and undermine the role of midwives. These barriers are not simply clinical-they are reflections of broader systemic inertia that resists shifting power, redistributing trust, and reimagining care models that center around the birthing person rather than the procedure. In many settings, midwives remain underutilized not because they are unqualified, but because systems have not

adapted to fully integrate their expertise in settings where VBAC could thrive. Overcoming these challenges requires more than localized efforts. It demands a coordinated response that includes policy reform, standardized training, infrastructure investment, community education, and a cultural reorientation of how we view childbirth after cesarean. Health systems must be willing to invest in collaborative models of care where midwives are not only included but empowered. Hospitals must move beyond defensive medicine and embrace evidence-based practice. Educational institutions must equip midwives with the full scope of knowledge and confidence to manage VBAC cases safely. And perhaps most importantly, women themselves must be equipped with the information, encouragement, and support to make decisions free from fear, coercion, or misinformation. The promotion of midwifery-led VBAC is not a marginal reform-it is a transformative opportunity. It symbolizes a return to trusting the physiology of birth, valuing the experiential knowledge of women, and embracing a healthcare model that recognizes childbirth as both a medical and human event. It is a reminder that progress in maternity care is not measured by the number of surgical interventions available, but by the number of choices respected, the number of outcomes improved, and the number of women who feel empowered by their birth experiences. As we move forward, centering midwives in the conversation around VBAC is not just a strategy for reducing cesarean rates it is a statement of commitment to safe, respectful, and woman-led care.

Conflict of Interest
Not available

Financial Support
Not available

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How to Cite This Article
Parvin N. Role of midwives in promoting vaginal birth after cesarean (VBAC): Outcomes and Challenges. Journal of Midwifery and Gynecological Nursing. 2024;1(1):01-07