POSITION STATEMENT

Vaginal Birth After Cesarean

It is the position of the American College of Nurse-Midwives (ACNM) that

- Women who have experienced cesarean births have the right to safe and accessible options for subsequent births.
- Women should receive evidence-based information to guide their decision making when they consider labor after cesarean versus elective repeat cesarean. Informed consent/informed refusal should be based on knowledge of the potential benefits and harms to women and newborns of vaginal birth after cesarean (VBAC), elective repeat cesarean, and cesarean performed during labor when VBAC was planned.
- Certified nurse-midwives and certified midwives are qualified to provide antepartum and intrapartum care for women who are candidates for VBAC. This care includes evidence-based education, informed consent, ongoing risk assessment, and establishment of appropriate arrangements for medical consultation and emergency care should they become necessary.
- Regardless of their geographic location, socio-economic status, or type of medical care coverage, women should have access to qualified maternity care providers and birth settings that offer VBAC and possess the capability to respond in a timely manner should complications occur. Professional liability carriers and institutional decision makers should not prohibit maternity care providers or facilities from providing care to women who are candidates for labor after cesarean.
- Continued research that includes high quality studies is needed to identify necessary resources and factors associated with VBAC success rates and maternal and newborn health outcomes.

Background

The overall cesarean birth rate increased in the United States from a low of 4.5% in 1965 to a high of 32.9% in 2009.[1] Since then, the rate declined slightly to 32.0% in 2015.[2] The cesarean birth rate for primiparous, low-risk women (singleton, > 37 weeks gestation, vertex presentation) peaked in 2008 at 28.1%[3] but has since declined to 25.8% in 2015.[2]

Per U.S. birth certificate data, the VBAC rate in 2015 was 11.9% compared to 28.6% in 1989.[2] The success rate for women who attempted labor after cesarean was 70% in 2015,[3] which is consistent with previously reported rates.[1,4,5] Women with prior cesareans and prior vaginal births have higher VBAC success rates (83%-94%).[5] The success of VBAC varies by age, setting, provider types, parity, and obstetric history.[3,4,5]

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The benefits and harms of labor after cesarean compared to elective repeat cesarean were evaluated at a 2010 National Institutes of Health (NIH) Consensus Conference,[4] in an evidence report,[5] and in a systematic review.[6] While the NIH consensus panel concluded that trial of labor is a reasonable option for many pregnant women with one prior low transverse uterine incision, trial of labor and elective repeat cesarean have important risks and benefits that differ for each woman and her fetus. Rupture of the uterus is the primary risk of concern for women who labor after one or more cesarean births. The incidence of uterine rupture in these women is 4.7/1000 whereas the incidence is 0.3/1000 in women who undergo elective repeat cesarean.[5,] Risk of uterine rupture varies based on several factors, the most significant of which is type of uterine scar. Women with previous T-shaped cesareans or fundal surgeries are at significantly higher risk for uterine rupture during labor and are therefore not candidates for labor after cesarean.[7] The risks of maternal morbidity (blood transfusion, admission to intensive care unit) and maternal mortality are greater with repeat elective cesarean than VBAC, and VBAC reduces the likelihood of maternal morbidity associated with multiple cesarean births.[8,9]

As the rate of VBAC in the hospital setting has decreased, the rate in out of hospital settings has increased.[3] Evidence indicates a slightly increased risk of newborn complications associated labor after cesarean in the homebirth setting, and women should be counseled accordingly.[10] Women who are candidates for labor after cesarean should be encouraged to consider VBAC, and VBAC services should be available for women in all geographic areas, regardless of their socioeconomic status or insurance type. Key recommendations regarding this option include shared decision making, informed consent/refusal, continuous risk assessment, heightened surveillance of fetal heart rate patterns according to established criteria, and optimization of factors associated with VBAC success.[11] Well-established, ongoing communication between midwifery and obstetric providers to facilitate timely consultation, transfer of care, and surgical intervention if necessary is an essential component to promote optimal outcomes for mothers and their newborns.

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Note. Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse Midwives Certification Council, Inc. (ACC).

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