AMERICAN COLLEGE of NURSE-MIDWIVES

POSITION STATEMENT

Care of the Pregnant Person with a History of Cesarean Birth

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

- People who have experienced cesarean births have the right to safe and accessible options for subsequent births including vaginal birth after cesarean (VBAC).

- Pregnant people should receive evidence-based information and counseling to guide their decision-making when they consider labor after cesarean versus elective repeat cesarean. Shared decision-making should be based on patient preferences and the potential benefits and risks of VBAC, planned elective repeat cesarean, and cesarean during labor to pregnant people, newborns, and future pregnancies.

- Access and support to choose labor after cesarean is a health equity issue. ACNM condemns the disenfranchisement of persons of color, linguistic minorities and rural people's rights to shared decision-making and access to high quality, person-centered care.

- Certified nurse-midwives (CNMs) and certified midwives (CMs) are qualified to provide perinatal care for people who had a prior cesarean birth. This care includes evidence-based education, shared decision-making, ongoing risk assessment, and establishment of appropriate arrangements for medical consultation and emergency care should they become necessary.

- CNMs and CMs are qualified to provide high-quality postpartum care to people following cesarean birth. Postpartum people should receive information regarding the birth event, reasons for cesarean, any complications, and counseling about future mode of birth, as well as how to optimize success for VBAC if desired.

- Regardless of their geographic location, socioeconomic status, or type of medical care coverage, pregnant people 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 those who are candidates for labor after cesarean.

- Continued research that includes high-quality studies is needed to identify necessary resources, factors, and clinical care associated with VBAC success rates and maternal and newborn health outcomes.

Background

Globally, cesarean birth is more common than in the past and rates continue to rise despite a lack of reported improvements in maternal or neonatal mortality with cesarean rates above 10%-15%.[1] The cesarean birth rate increased in the United States from a low of 4.5% in 1965 to a high of 32.9% in 2009.[2] In 2020, the cesarean birth rate increased from the prior year from 31.7% to 31.8% and from 21.6% to 21.9% for primary cesarean births. The cesarean birth rates increased for each of the three largest self-identified race and Hispanic-origin groups from 2019 to 2020: from 30.7% to 30.8% for non-Hispanic White people; from 31.3% to 31.4% for Hispanic people; and from 35.9% to 36.3% for Non-Hispanic Black people. Black pregnant people continue to have the highest cesarean birth rate.[3]

Healthy People 2030 has recommended a target national rate for cesarean birth in the low-risk nulliparous, term, singleton, and vertex (NTSV) population of 23.6%.[4] The NTSV cesarean birth rate peaked in 2008 at 28.1%, declined to 25.9% in 2020, and is currently still above national targets.[3] Research indicates that between 60%-80% of pregnant people attempting labor after cesarean will have a successful VBAC.[5] Per US birth certificate data, the VBAC rate was up in 2021 to 14.2% compared to 2020 (13.9%), but much lower than reported rates in 1989 of 28.6%, with highest rates among Non-Hispanic White people (14.0%), followed by Non-Hispanic Black people (13.7%) and Hispanic people (13.4%).[2,3]

Current research shows that CNMs and obstetricians have similar rates of planned VBAC success and rates of complication during intrapartum care.[6] ACNM supports the role of CNMs and CMs to provide care to pregnant people during the antepartum, intrapartum, and postpartum period. Midwives should engage with hospital policymakers to support VBAC as a safe and viable option and remove barriers encountered by pregnant people.

Given current rates of cesarean birth, discussion of risks and benefits to VBAC is critical to achieve target rates and to confront rising rates of primary and repeat cesarean birth. The benefits and harms of labor after cesarean compared to elective repeat cesarean were evaluated at a 2010 National Institutes of Health Consensus Conference, concluding that trial of labor is a reasonable option for many pregnant people with one prior low transverse uterine incision.[7] One benefit of VBAC is reducing the likelihood of maternal morbidity associated with multiple cesarean births such as placenta previa and accreta. The risks of maternal morbidity (i.e., blood transfusion, admission to intensive care unit, etc.) and maternal mortality are greater with repeat elective cesarean than VBAC but higher for those who have an unscheduled repeat cesarean during the course of labor after cesarean.[5,8]

Uterine rupture is the primary risk of concern with labor after one or more cesarean births at 0.07% for repeat cesarean and 0.71% for trial of labor after cesarean.[5] Risk of uterine rupture

varies based on several factors, the most significant of which is type of uterine scar. Pregnant people with previous T-shaped, classical or fundal cesareans, or prior uterine rupture are at significantly higher risk for uterine rupture during labor and are therefore not candidates for TOLAC.[5]

After careful review of the overall evidence, the American Collegeof Obstetricians and Gynecologists (ACOG) published an updated practice bulletin to support pregnant people with the following conditions undergoing labor after cesarean[5]: two prior low transverse uterine incisions, previous low vertical incision, gestation beyond 40 weeks, twin gestation appropriate for vaginal birth, obesity, successful external cephalic version, and unknown scar type without clinical suspicion of previous classical uterine incision performed in an extremely preterm birth.[5]

Many pregnant and birthing people express interest and preference for VBAC.[9-11] However, many pregnant people encounter obstacles to access such as finding a provider and location that support VBAC.[12,13] When pregnant people do not have access to safe and supportive hospital-based VBAC, they may opt to choose community birth after cesarean.[14] Recent evidence from Canada and England, which both have integrated maternity care systems, have indicated similar outcomes with home- and hospital-based VBAC, though risks for severe complications exist, and pregnant people should be counseled accordingly.[15,16] ACNM encourages an integrated maternity care system with options for pregnant people who have experienced prior cesarean birth and alignment with ACOG recommendations for hospital-based care for those seeking VBAC with access to emergency services. VBAC services should be available for pregnant people, regardless of their socioeconomic status or insurance type. To promote optimal outcomes, it is essential to have well-established, ongoing communication between midwifery and obstetric providers to facilitate timely consultation, transfer of care, and surgical intervention, if necessary.

It has been found that when providers engage in discussion related to VBAC and when pregnant people receive prenatal midwifery care, they are more likely to elect labor after cesarean.[5,10,17] Engaging in shared decision-making with accurate risk assessment and discussion of benefits and harms is a hallmark of midwifery care and is of utmost importance when caring for pregnant people with a history of cesarean birth. VBAC calculators can be used within shared decision-making conversations to assess predicated success and morbidity, although the use of calculators has also been associated with restricted access to VBAC.[18-20] The Maternal-Fetal Medicine Units Network's VBAC calculator is an example for use in the clincal setting.[5] Additionally, CNMs and CMs support the removal of race/ethnicity from the Society for Maternal and Fetal Medicine's (SMFM) predicted calculation of successful VBAC as race is socially constructed and there are no biological differences between racial groups.[21] Including race/ethnicity in the calculator underestimated VBAC rates of Black and Hispanic pregnant people, which could potentially and unnecessarily discourage minority people from labor after cesarean,[5] and further exacerbate health disparities.[18,22] Recent updates to the SMFM VBAC calculator have removed race and ethnicity and substituted presence or absence of chronic

hypertension requiring treatment, although validation studies remain to be conducted on these updates.[18,19]

Clinical factors associated with VBAC success and failure have been documented. Pregnant people in spontaneous labor with a Bishop score >4 and those who have had a prior vaginal birth are more likely to succeed as compared to people with a Bisoph score <4 or without prior vaginal birth.[5,23] Pregnant people who experienced a cesarean because of an arrest disorder or who require induction or augmentation of labor are at higher risk for unsuccessful VBAC.[5,23] Midwives should engage in personalized risk assessment and shared decision-making, eliciting patient's preferences and values when conducting counseling related to VBAC. Midwives are well positioned to support pregnant people with a prior cesarean birth by promoting physiologic labor and birth.[5,23] Postpartum people should receive follow-up to review the labor and birth events, any complications, and counseling about future mode of birth, including if they are candidates for labor after cesarean or repeat cesarean birth if they desire future pregnancy.[24] Ongoing research is necessary to identify clinical care interventions that may promote successful VBAC.

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Note: Midwifery and midwives as used throughout this document refer to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American Midwifery Certification Board (AMCB).

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