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Health Policies for Vaginal Birth After Cesarean (VBAC): Current Status and Future Perspectives

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Abstract

Vaginal Birth After Cesarean (VBAC) is a delivery method that enables women with a history of cesarean section to opt for vaginal delivery in subsequent pregnancies. The World Health Organization (WHO) and various health authorities support VBAC as a strategic approach to reduce unnecessary cesarean rates. Recognized as a safe delivery option for women with prior cesarean births, VBAC is promoted in many countries due to its positive impact on maternal health. However, the feasibility and widespread adoption of VBAC depend on various factors, including health policies, clinical protocols, healthcare professionals' attitudes, and public awareness.This study is a narrative review that examines current policies and perspectives related to Vaginal Birth After Cesarean (VBAC). The aim of the study is to investigate existing health policies that promote VBAC, evaluate international practices, and propose applicable strategies for the Turkish healthcare system. Furthermore, the study analyzes the effects of VBAC on maternal and neonatal health, highlighting the importance of evidence-based policies. In conclusion, for VBAC to become a safe and widely accepted birth option, comprehensive reforms are needed, including the development of clinical protocols, training programs for healthcare professionals, patient education initiatives, financial incentives, and the establishment of VBAC-supportive hospitals. The effective implementation, societal adoption, and continuous evaluation of these reforms are essential for the long-term promotion of VBAC, improvement of maternal and neonatal health outcomes, and the sustainability of healthcare systems.

Keywords: Vaginal birth after cesarean (VBAC), Health policies, Childbirth management, Maternal health.

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Sezaryen Sonrası Vajinal Doğum (VBAC) İçin Sağlık Politikaları: Mevcut Durum ve Gelecek Perspektifleri

Öz

Sezaryen Sonrası Vajinal Doğum (SSVD), daha önce sezaryenle doğum yapmış kadınların sonraki gebeliklerinde vajinal doğumu tercih etmelerine olanak tanıyan bir doğum yöntemidir. Dünya Sağlık Örgütü (DSÖ) ve çeşitli sağlık otoriteleri, gereksiz sezaryen oranlarını azaltmak amacıyla SSVD'yi bir strateji olarak desteklemektedir. SSVD, sezaryen doğum öyküsü olan kadınlar için güvenli bir doğum yöntemi olarak kabul edilmekte ve anne sağlığı üzerindeki olumlu etkileri nedeniyle birçok ülkede teşvik edilmektedir. Ancak, SSVD'nin uygulanabilirliği ve yaygın şekilde benimsenmesi; sağlık politikaları, klinik protokoller, sağlık çalışanlarının tutumları ve toplumsal farkındalık gibi çeşitli faktörlere bağlıdır. Bu çalışma, Sezaryen Sonrası Vajinal Doğum (SSVD) ile ilgili mevcut politikaları ve bakış açılarını inceleyen bir derleme çalışmasıdır. Çalışmanın amacı, SSVD'yi teşvik eden mevcut sağlık politikalarını incelemek, uluslararası uygulamaları değerlendirmek ve Türk sağlık sistemi için uygulanabilir stratejiler önermektir. Ayrıca, SSVD'nin anne ve yenidoğan sağlığı üzerindeki etkileri analiz edilerek, kanıta dayalı politikaların önemi vurgulanmaktadır. Sonuç olarak, SSVD'nin güvenli ve yaygın olarak kabul gören bir doğum seçeneği haline gelmesi için; klinik protokoller, sağlık profesyonellerine yönelik eğitimler, hasta bilgilendirme programları, finansal teşvikler ve SSVD dostu hastanelerin oluşturulmasını içeren kapsamlı reformlara ihtiyaç vardır. Bu reformların başarılı şekilde uygulanması, toplumsal düzeyde benimsenmesi ve sürekli olarak değerlendirilmesi; uzun vadede SSVD'nin yaygınlaşmasını sağlayacak, anne ve yenidoğan sağlığını iyileştirecek ve sağlık sistemlerinin sürdürülebilirliğine katkı sunacaktır.

Anahtar Kelimeler: Sezaryen sonrası vajinal doğum (SSVD), Sağlık politikaları, Doğum yönetimi, Anne sağlığı.

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Extended Abstract

The increasing global trend in cesarean section (CS) rates, particularly among women with prior cesarean deliveries, presents significant challenges to public health and health system sustainability. Vaginal Birth After Cesarean (VBAC) is widely supported by the WHO and various national health authorities as an evidence-based strategy to reduce the rising incidence of unnecessary repeat cesareans. Cesarean births, while lifesaving in specific medical scenarios, have been associated with greater maternal morbidity, longer recovery times, increased risks in future pregnancies, and higher healthcare costs. Despite its documented advantages, VBAC remains underutilized in many healthcare systems. The lack of accessible information, combined with deeply rooted cultural perceptions and institutional hesitancy, hinders its adoption. This study investigates how health policy frameworks shape the implementation of VBAC and explores tailored strategies that could increase its uptake in Türkiye, a country grappling with one of the highest CS rates among OECD nations.

To effectively promote VBAC, national health systems must implement multidimensional reforms targeting clinical, institutional, legal, and social barriers. Clinical recommendations include development and enforcement of evidence-based VBAC protocols, enhanced midwifery-led care, and integration of predictive tools like the DEVI-CS model to support individualized decision-making. Training programs should be made mandatory for obstetric care providers, emphasizing emergency management skills and up-to-date knowledge of VBAC eligibility and monitoring. Institutional commitment, supported by regulatory oversight, is essential for ensuring that hospitals maintain the infrastructure and personnel required to offer VBAC safely and consistently. Legal reforms should provide protection for clinicians who adhere to VBAC protocols, thus alleviating fear of litigation. Furthermore, health systems should adopt financial incentive models that reward successful VBAC practices, especially in public hospitals. Public awareness campaigns must also be prioritized, using both traditional media and digital platforms to communicate the safety and benefits of VBAC to prospective mothers and their families.

In conclusion, VBAC represents a strategic opportunity to reduce unnecessary cesarean deliveries, improve maternal health outcomes, and ensure more sustainable healthcare spending. In Türkiye, the success of national VBAC protocols depends on the alignment of institutional practices, clinical training, and community engagement. With the right policy framework, VBAC can be repositioned as a standard and empowering birthing option within modern maternity care.

The global rise in cesarean section (CS) deliveries, especially among women with a history of prior CS, has become a major public health concern. While CS can be life-saving when medically indicated, its increasing overuse without strict clinical justification has been associated with higher maternal morbidity,

delayed postpartum recovery, reduced fertility in subsequent pregnancies, prolonged hospital stays, and greater financial burdens on healthcare systems. One promising solution to reduce unnecessary repeat CS is Vaginal Birth After Cesarean (VBAC), a practice that allows women with one or more previous cesarean births to attempt a vaginal delivery under appropriate clinical supervision. VBAC is recognized by the WHO and many national health agencies as a safe and effective method for eligible women to give birth vaginally after a previous cesarean.

WHO advocates for reducing unnecessary cesarean procedures and endorses Vaginal Birth After Cesarean (VBAC) as a safe and effective alternative for eligible women. VBAC, when performed under proper clinical conditions, reduces the likelihood of surgical complications, enhances postpartum recovery, and preserves future reproductive autonomy. From a global health policy perspective, promoting VBAC aligns with Sustainable Development Goal 3, which emphasizes reducing maternal mortality and ensuring universal access to reproductive healthcare. Countries aiming to meet these targets must consider not only clinical safety but also patient autonomy, cost-effectiveness, and equity in access to childbirth options. VBAC enables women to reclaim decision-making power in their birthing process while reducing overmedicalization.

Türkiye, as an upper-middle-income country with a mixed public-private healthcare system, presents both challenges and opportunities in VBAC implementation. Türkiye classified by the World Bank as an upper-middle-income country with a GNI per capita of USD 11,820 in 2023 (World Bank, 2024), and characterized by a mixed public-private healthcare system, presents both challenges and opportunities in VBAC implementation. While public hospitals generally follow Ministry of Health protocols, private institutions may prioritize profitability, often favoring elective cesareans. Bridging this policy-practice divide requires coordinated governance, better data tracking on VBAC outcomes, and alignment of provider incentives with public health goals.

In addition to national-level efforts, local health authorities and civil society organizations can play a pivotal role in normalizing VBAC through community-based education programs. Empowering midwives and nurses, who often serve as primary points of contact during pregnancy, is crucial for disseminating accurate information and fostering trust. Research also suggests that storytelling, peer support groups, and positive VBAC narratives can counter fear-based messaging around vaginal birth.

Keywords: Vaginal birth after cesarean (VBAC), Health policies, Childbirth management, Maternal health.

Introduction

The global rise in cesarean section (CS) rates over the past few decades has prompted increasing concern among health professionals, policymakers, and researchers. While cesarean delivery can be life-saving when medically indicated, its overuse is associated with increased maternal and neonatal risks, higher healthcare costs, and long-term reproductive consequences. One critical strategy to mitigate the rising CS trend is the promotion of Vaginal Birth After Cesarean (VBAC), a clinically safe and cost-effective option for many women with a previous cesarean delivery. Despite its benefits and endorsement by various professional organizations, VBAC remains underutilized in many countries due to a complex interplay of medical, legal, institutional, and cultural barriers. Countries with high CS rates, such as Türkiye, face unique challenges in integrating VBAC into routine obstetric care.

This study aims to examine the existing health policies that promote VBAC and to propose applicable strategies for the Turkish healthcare system based on international practices. Furthermore, it will evaluate the effects of VBAC on maternal and neonatal health, highlighting the necessity of evidence-based health policies. The study will also analyze the barriers to VBAC implementation and emphasize the importance of training programs, awareness campaigns, and structural reforms in healthcare services. Ultimately, the findings aim to contribute to the development of health policies that reduce cesarean section rates and encourage normal childbirth.

Current Health Policies Regarding Vaginal Birth Policies

Cesarean delivery rates have been increasing globally, particularly in developed countries. Since 1990, cesarean section rates have increased across all regions. The most substantial rises have been observed in Eastern Asia (44.9%), Western Asia (34.7%), and Northern Africa (31.5%). According to current projections, by 2030, approximately 28.5% of all births worldwide are expected to be delivered by cesarean section (Betran et al., 2021). Notably, Türkiye already exceeds this projection by a significant margin, with 57.55% of all births occurring via cesarean section between 2018 and 2023 (Ulgu et al., 2023). This exceptionally

high rate raises concerns not only about maternal and neonatal health risks but also about the increasing economic burden on the national healthcare system.

The reasons behind women's preference for cesarean delivery are rooted in both medical and non-medical factors. Medical factors include complications arising during pregnancy, labor, and childbirth, while non-medical factors often involve fear of labor pain or the desire to schedule a specific delivery date (Landon, 2024). For women who have undergone a cesarean section in their first birth, two primary options are generally available for subsequent deliveries: repeat cesarean section (RCS) or vaginal birth after cesarean (VBAC). Women with a history of cesarean delivery often opt for another cesarean in later pregnancies, contributing to a cumulative increase in cesarean rates (Willy et al., 2025). However, although the proportion remains relatively low, a significant number of women with uncomplicated pregnancy and delivery histories are suitable candidates for attempting VBAC (No, 2015).

Elective cesareans performed without medical indication, solely based on maternal request, are frequently cited as contributing factors to rising cesarean rates, accounting for 2.6% to 26.8% of all cesareans (Jacquemyn et al., 2003). An Australian study found that the primary reason for elective cesareans was women's reluctance to attempt planned VBAC or breech vaginal birth (Quinlivan et al., 1999). In Sweden, the rate of non-medically indicated cesareans tripled between 1997 and 2006, with the most common reasons being previous cesarean (28%) and fear of childbirth (13%) (Karlström et al., 2010). In a study conducted in the United States, the most commonly reported reason for preferring vaginal birth was the desire to experience a vaginal delivery, whereas the most frequently cited reason for choosing cesarean birth was a previous cesarean delivery (Attanasio et al., 2019). Both primary and repeat cesareans are strongly associated with maternal request, childbirth fear, and negative birth experiences (Størksen et al., 2013).

The rising global cesarean section rates pose risks to both maternal and neonatal health by increasing the likelihood of complications during childbirth. Moreover, compared to vaginal delivery, cesarean sections impose an additional burden on a country's healthcare economy. The WHO

recommends reducing unnecessary cesarean sections and encourages the adoption of evidence-based strategies for birth management (Özkaya, 2009).

Current Health Policies Regarding Vaginal Birth After Cesarean (VBAC)

VBAC is an obstetric approach that allows women who have previously delivered via cesarean section to give birth vaginally in subsequent pregnancies (Bashir et al., 2018). VBAC is recommended as an alternative to repeat cesarean, particularly for women at low risk of complications (Lin et al., 2019). The success rate of VBAC varies depending on maternal characteristics, obstetric history, and the onset of labor. Research has shown that the overall success rate of VBAC ranges between 60% and 90% (Stamilio & Shanks, 2008). This rate is notably higher among women who have previously had a successful VBAC. Furthermore, women who experience a successful VBAC are more likely to choose VBAC again in subsequent pregnancies. Major advantages of VBAC include faster postpartum recovery, reduced risk of infection, and positive effects on fertility. In addition to its positive impact on maternal health, VBAC helps prevent unnecessary cesarean deliveries and supports the sustainability of healthcare systems (Sri & Xiang, 2016).

Despite these advantages, the widespread implementation of VBAC faces several challenges. The most significant of these challenges is uterine rupture and the potential need for emergency cesarean. For this reason, women who are candidates for VBAC should be carefully evaluated (Wu et al., 2019). Many pregnant women cited concerns for their child's safety, as well as family or partner pressure as reasons for rejecting VBAC (Aloufi et al., 2025). A study conducted in Türkiye compared cases of vaginal birth after cesarean (VBAC) with those of repeat cesarean sections. The findings suggest that VBAC may be a safe option for the infant; however, potential risks of uterine complications for the mother should be carefully considered. This consideration is seen as a significant factor influencing maternal birth preferences (Göynümer et al., 2006). The lack of standardized clinical protocols, insufficient knowledge among healthcare providers, legal and ethical concerns, limited public awareness, and restrictive institutional birth policies hinder the applicability of VBAC

(Özkaya, 2009). In countries like Türkiye, where cesarean rates are high, it becomes essential to evaluate alternative approaches to childbirth management. Therefore, developing policy recommendations that support the integration of VBAC into the national healthcare system is of critical importance (Topaktaş & Beylik, 2024).

Studies show that women actively seek balanced information about VBAC and expect a more supportive approach from healthcare providers (Lundgren, 2012). However, VBAC-related websites often lack comprehensive, evidence-based content, instead reflecting commercial or promotional objectives (Bantan & Abanhaim, 2015). When informational support is insufficient, some women seek alternative sources such as online forums to meet their information needs. The global decline in VBAC rates and increase in cesarean rates underscores the importance of better addressing women's information needs and decision-making processes. Nevertheless, there is still a lack of research exploring women's perspectives on how to improve VBAC rates in countries with low adoption (Nilsson et al., 2017).

In 1999, the American College of Obstetricians and Gynecologists (ACOG) issued a policy requiring that surgical intervention capabilities be "immediately available" for women attempting a trial of labor after cesarean (TOLAC). This policy led many hospitals to discontinue their VBAC services, and as a result, the VBAC rate dropped from 28% in 1996 to below 8% by 2010 (Signore & Spong, 2010). Roberts et al. (2007) examined how ACOG's policy affected hospitals' willingness to offer VBAC and its impact on women's birthing options. Among the 230 hospitals performing cesarean deliveries, 222 were assessed, and 30.6% (68 hospitals) had discontinued VBAC services following the 1999 guideline. This policy significantly limited access to VBAC. Smaller and more remote hospitals were particularly affected, often ceasing to offer VBAC due to the requirement of having surgical and anesthesia teams on standby at all times. Factors such as hospital size, birth volume, and proximity to other maternity centers increased the likelihood of maintaining VBAC services. As a result of these policy changes, women with a history of cesarean delivery experienced restricted birth options, contributing to rising cesarean rates.

In 2005, the effectiveness of health policies based on the Self-Management Program (SMP) in reducing cesarean rates was evaluated in Taiwan. While such policies can lead to short-term increases in VBAC rates, additional strategies are necessary to ensure long-term sustainability. It was emphasized that raising awareness among both women and healthcare professionals is essential for the effectiveness of VBAC-promoting policies (Liu et al., 2013). Similarly, a study conducted in Florida revealed that the VBAC rate had fallen below 1%, primarily due to concerns regarding medical liability (malpractice) and restrictive healthcare policies (Cox, 2011). Firoozi et al. (2020) aimed to explore the reasons for low VBAC rates in Iran from a healthcare systems perspective. Cesarean section rates in Iran were reported to be high, with repeat cesareans being commonly practiced. However, this situation poses risks to both maternal and neonatal health and contradicts the country's fertility policies. Although VBAC is proposed as an alternative to repeat cesareans, systemic barriers within the healthcare infrastructure limit its implementation. Lundgren et al (2012) found that women often experience uncertainty when making decisions about childbirth and face challenges in accessing reliable information. The study also highlighted that the attitudes of healthcare providers play a significant role in the decision-making process. In countries like Türkiye, where cesarean section rates are high, it is critical to educate healthcare professionals and provide women with comprehensive information to support VBAC decision-making and adoption.

Health Policy Recommendations for VBAC

According to global data from 2018, the overall cesarean section rate was reported as 21.1%. This rate varies across regions, with Europe at 25.7%, Asia at 23.1%, Latin America and the Caribbean at 42.8%, and Africa at 9.2% (Betran et al., 2021). VBAC rates vary significantly across countries, ranging from 9.6% to 52.2% (Tilden et al., 2017). In the United States, the VBAC rate is 32%, while in Australia and the United Kingdom, it is 32% and 26%, respectively (Schemann et al., 2015). Among European Union countries, VBAC rates are higher in Finland, the Netherlands, and Sweden (45–55%) and lower in Germany, Ireland, and Italy (29–36%). In Türkiye, the VBAC rate was reported to be 16% in 1999, 17.8% in 2000, 23.5% in 2001, and 27.1% in 2002 (Gözükara & Eroğlu, 2011). Despite these

differences, the overall success rate of VBAC ranges from 70% to 87% (Gross, 2015). It is also important to highlight the variation in cesarean section rates between public and private hospitals, as private institutions often report significantly higher cesarean rates. Addressing this imbalance may require policy interventions, including reducing financial incentives or limiting reimbursement for hospitals with particularly high cesarean rates, to encourage adherence to evidence-based childbirth practices. Meta-syntheses of studies conducted in the United Kingdom, the United States, and Australia reveal that women often experience uncertainty and anxiety when deciding on VBAC, and that experienced clinicians frequently do not support the practice. Many women feel isolated in their expectations of vaginal birth and lack adequate support in decision-making (Lundgren et al., 2012), which may partly explain the generally low VBAC rates in these countries.

VBAC has the potential to reduce cesarean rates, improve maternal health, and ease the burden on healthcare systems (Bashir et al., 2018). Despite its benefits, there are medical, institutional, cultural, and financial barriers that hinder the widespread adoption of VBAC. To address these challenges, comprehensive and multidimensional health policies that actively promote VBAC are essential.

Establishing Clinical Protocols and Guidelines for VBAC

To ensure the safe implementation of VBAC, specific clinical criteria must be established. Therefore, VBAC should be conducted in hospitals with advanced emergency intervention capabilities and supported by clearly defined clinical protocols and guidelines. The first of these protocols requires that the previous cesarean section must have involved a low transverse uterine incision. The current pregnancy should be a singleton with a cephalic presentation, and there must be no history of uterine rupture or severe complications in the previous delivery (Trojano et al., 2021). Furthermore, women eligible for VBAC should undergo continuous fetal monitoring throughout labor (Wu et al., 2019).

A VBAC intervention package implemented in hospitals, comprising three key components: provider training, structured discussions, and patient education tools, has contributed to a 6% reduction in cesarean section

rates (Miazgaet al., 2025). Additionally, the newly developed DEVI-CS prediction model, based on easily accessible clinical variables, has demonstrated the ability to estimate the likelihood of a successful vaginal birth attempt in women with a history of cesarean delivery. This model can assist in postpartum planning and facilitate shared decision-making between patients and healthcare providers. Decision curve analysis of the model has shown net clinical benefits across thresholds ranging from 5% to 90% (Pegu et al., 2025).

In Türkiye, the Ministry of Health published the VBAC Clinical Protocol on November 18, 2024. This protocol was developed to enhance the safety of VBAC practices and to ensure that healthcare professionals follow current knowledge and clinical practice standards throughout the process. It aims to promote the adoption of a standardized national approach to VBAC and to provide practical benefits in clinical settings. While the protocol represents a positive step toward prioritizing the safety and standardization of VBAC, its practical applicability appears limited. It presents significant shortcomings, particularly in its lack of detailed consideration for patient rights and ethical principles, as well as in the absence of clearly defined monitoring and accountability mechanisms necessary for effective implementation.

Developing Training Programs for Healthcare Professionals on VBAC

Training healthcare professionals plays a pivotal role in the promotion and safe implementation of VBAC. Obstetricians, midwives, and nurses should receive regular training in VBAC management, risk assessment, and emergency response (Brill & Windrim, 2003). Enhancing their competence in identifying suitable candidates and managing the labor process is essential. Midwives should receive specialized training to support the VBAC process and recognize emergency situations during labor (Tariq & Singh, 2024). Educating nursing staff on normal birth and VBAC has been associated with reduced cesarean rates and increased VBAC rates (Lyndon et al., 2025).

Koken et al. (2007) observed that healthcare professionals preferred cesarean delivery at a higher rate than the general population and were more likely to choose this mode of delivery for their own births. This

finding suggests that the rising cesarean rates in Türkiye are supported by both the healthcare system and individual preferences. In the study conducted by Arikan (2011), it was found that 61.8% of actively practicing obstetricians in Türkiye preferred cesarean delivery for themselves or their partners. In more recent times, however, this perception appears to have shifted. A study conducted at Ankara City Hospital among obstetricians and gynecology residents revealed notable findings regarding their attitudes toward VBAC. When asked whether they would recommend VBAC to pregnant women, 44.2% were undecided, 42.4% would not recommend it, and only 13.4% stated that they would. Among those who were undecided about or opposed to recommending VBAC, 82.48% cited medicolegal concerns as the primary reason for their stance (Desdiciogleet al., 2021). It is crucial to promote accurate guidance so that VBAC is accepted as a normal birth option and to reduce the stress healthcare providers experience due to perceived risks. In particular, legal reforms are needed to mitigate medicolegal concerns.

Research has shown that hospitals with high rates of operative vaginal deliveries tend to have lower cesarean rates (Willy et al., 2025). The reliability of operative interventions in the context of VBAC should be further studied and considered as a complementary topic in training programs.

Enhancing VBAC Awareness and Strengthening Patient Counseling Services

Educational efforts targeting pregnant women are vital for improving VBAC success rates. During pregnancy, women should be provided with detailed information about the benefits, risks, and key success factors of VBAC (Stamilio & Shanks, 2008).

Studies have indicated that while internet use can positively influence health literacy and promote healthy behaviors, it also carries the risk of exposure to inaccurate, incomplete, or misleading information. The majority of VBAC-related websites reviewed in the literature were found to have similar content, which often reflects the site's primary purpose (e.g., informational, commercial, or promotional) and the cesarean rates in the respective country (Wagner et al., 2022).

A study conducted in Thailand demonstrated the effectiveness of a web-based decision support system for VBAC using an AI-driven innovative approach (Yang et al., 2024). Similarly, another study reported that interactive and secure websites contributed positively to VBAC success rates (Shorten et al., 2019). In a study from Saudi Arabia, 45.6% of participants reported being familiar with the term VBAC, while 67.5% lacked sufficient knowledge about it. Many participants cited concerns for their child's safety as a reason for refusing VBAC and accepting a recommended cesarean, while others pointed to family or spousal pressure (Aloufi et al., 2025).

In their study, Turan and Say (2003) highlighted the positive impact of antenatal education on promoting general birth awareness and encouraging vaginal birth. Similarly, in a randomized controlled trial conducted by Çankaya and Şimşek (2020), antenatal education provided to pregnant women resulted in improved psychological well-being and a higher rate of vaginal deliveries. However, to date, no specific study has been identified in Türkiye focusing exclusively on VBAC-specific education programs. Therefore, it is recommended that pregnant women receive targeted education on VBAC. Written materials and decision support tools comparing different birth options should be provided to VBAC candidates. Health ministries and hospitals should launch informational campaigns through social media, public service announcements, and brochures to emphasize the safety and benefits of VBAC (Lin et al., 2019). These initiatives should be expanded to target not only women but also family members who may influence the decision-making process.

Developing Financial and Institutional Policies to Promote VBAC

To reduce cesarean rates, financial incentives and institutional reforms should be implemented within healthcare systems. Healthcare institutions that successfully perform VBAC should receive additional funding from governmental or insurance bodies (Sri & Xiang, 2016). Regulatory measures can be applied to hospitals with excessively high rates of unnecessary cesareans. Insurance coverage for VBAC candidates should be expanded to include reduced birth costs and VBAC counseling services (Wu et al., 2019). Financial incentive schemes can be developed to

increase VBAC rates and encourage more women to choose vaginal birth. These policies would not only promote a shift toward natural childbirth but also reduce unnecessary healthcare expenditures. Implementing such measures in Türkiye could help foster more informed birth choices and improve maternal health outcomes.

Expanding the VBAC-Friendly Hospital Model

Creating suitable birth environments is essential to encourage VBAC. Specialized maternity centers should be established with capabilities such as epidural anesthesia, emergency cesarean readiness, and the presence of expert medical teams (Upendram & Al-Rubaish, 2009). Obstetricians, midwives, and anesthesiologists should collaborate as a multidisciplinary team to effectively manage VBAC cases.

Research conducted in different countries has shown that women exposed to excessive medical interventions during labor report significantly lower satisfaction and increased likelihood of trauma (Adler et al., 2020). Therefore, minimizing unnecessary medical interventions during VBAC not only supports a positive birth experience but also contributes to maternal psychological well-being. Moreover, reducing overall cesarean section rates may, in turn, decrease the future demand for VBAC attempts. Approaches that prioritize minimal intervention and support women's active participation in the birthing process have the potential to reduce perceptions of traumatic birth and enhance satisfaction levels. Postpartum services should also be provided to support both physical and psychological recovery.

Studies have shown that women prefer approaches that allow labor to begin spontaneously and avoid unnecessary interventions. Findings suggest that women desire more time and space to experience birth naturally. Thus, adopting a more cautious and supportive approach that allows women to progress through labor at their own pace is essential (Ormsby et al., 2025). VBAC clinics should be integrated into maternity hospitals to provide individualized counseling and support. Diversifying the range of services offered and ensuring priority access to VBAC-friendly facilities would enhance both the quality and accessibility of maternal healthcare services.

Conclusion

VBAC is a significant birthing option for both maternal health and sustainability of healthcare system. Promoting VBAC offers various benefits, including reducing unnecessary cesareans, facilitating faster postpartum recovery, lowering the risk of complications and infections, and enhancing the cost-effectiveness of healthcare services (Bashir et al., 2018).

This study proposes multidimensional health policy strategies to promote VBAC, including the development of clinical protocols, training for healthcare providers, patient education programs, financial incentives, and the establishment of VBAC-friendly hospitals. The effectiveness of these protocols should be monitored and shared with the public to ensure transparency and continuous improvement. Identifying appropriate candidates, carefully managing the labor process, and providing adequate emergency infrastructure are essential for increasing VBAC success rates (Lin et al., 2019). Predictive models that estimate the likelihood of VBAC after a previous cesarean based on clinical variables should be utilized and further developed (Pegu et al., 2025).

Raising awareness among healthcare professionals about the benefits of VBAC, expanding VBAC-supportive birth practices, and shaping health policies accordingly can contribute to promoting natural birth and reducing cesarean rates (Stamilio & Shanks, 2008). In conclusion, a comprehensive health policy supporting VBAC can empower women to make informed birth choices, improve maternal and neonatal health outcomes, and enhance the efficiency of healthcare systems. Therefore, implementation, acceptance, and continuous evaluation of such reforms are crucial for the long-term success of VBAC initiatives (Wu et al., 2019).

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Veri Erişilebilirliği Beyanı: Bu makale, daha önce yayımlanmış literatürün incelenmesine dayanmaktadır ve özgün veri üretimini içermemektedir. İncelenen kaynaklara ilişkin ek materyal veya bilgiler, makul bir talep üzerine sorumlu yazardan temin edilebilir.

Teşekkür: Yazarlar teşekkür beyan etmemiştir.

Yazar Katkıları: Bilgen Şimşek; Fikir, Tasarım, Denetleme, Kaynaklar, Veri Toplama ve/veya İşleme, Analiz ve/veya Yorumlama, Literatür Taraması, Eleştirel İnceleme. **Dilek Kolca;** Fikir, Tasarım, Denetleme, Materyaller, Veri Toplama ve/veya İşleme, Analiz ve/veya Yorumlama, Literatür Taraması, Yazma, Eleştirel İnceleme. **Mustafa Mete;** Kaynaklar, Materyaller, Yazma.

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