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Opinions of Obstetricians and Midwives for Vaginal Birth after Cesarean Section: A Qualitative Study in Türkiye

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Abstract

BACKGROUND/AIMS: The most effective strategy to stop the increasing worldwide popularity of cesarean delivery and to break the logic of "once a cesarean, always a cesarean" is "vaginal birth after cesarean (VBAC)". Health professionals are highly influential in women's birth preferences. Therefore, there is an urgent need to focus on the views of midwives and obstetricians about VBAC section. The aim of this study was to investigate the opinions of obstetricians and midwives about VBAC.

MATERIALS AND METHODS: This study adopted two qualitative research approaches, phenomenology and case study. A total of 26 healthcare professionals, including 12 obstetricians and 14 midwives, were interviewed in this study. One-to-one in-depth phone interviews were held with the midwives and obstetricians and these interviews were audio-recorded. The obtained data were written out completely and analyzed thematically. This study aligns with the Consolidated Criteria for Reporting Qualitative Research checklist.

RESULTS: Three main themes and nine sub-themes were obtained in this research. The main themes described are "Healthcare Professional Factors", "Healthcare System Factors", and "Clinical/Pregnant Woman Factors".

CONCLUSION: As a result of the interviews, in addition to the lack of information about VBAC delivery, various factors which prevent this application from being widespread were determined. Accordingly, with these ideas in mind, there is a need to organize training programs in order to improve healthcare professionals' knowledge and skills about VBAC section. It is recommended to provide the necessary legal regulations and raise awareness on vaginal births after cesarean deliveries.

Keywords: Vaginal birth after cesarean section, obstetrician, midwife, qualitative study

INTRODUCTION

Cesarean section (CS) rates are increasing all around the world. Upon examining CS statistics among the countries of the Organization for Economic Cooperation and Development (OECD), Türkiye ranked first with a CS rate of 54% in 2019. According to the data, Korea has a CS rate of 45%, Poland 38%, Italy 33%, and the USA 32%.[1] The fact that the rate in our country, Türkiye, is 54% in the international records is remarkable in illustrating the subject's importance. In its statement on cesarean delivery rates, the World Health Organization declared that the safe range of cesarean delivery rates of the International Health Community was between 10% and 15% and that exceeding this range was not effective in reducing maternal and neonatal mortality rates.[2] Elective repeat cesarean deliveries (ERCD) are profoundly influential regarding the increase in CS rates.[3] The rates of repeated cesarean deliveries among the OECD countries are between 45.5% and 93.5%.[4] The most effective strategy to stop the increasing worldwide popularity of cesarean deliveries and to break the logic "once a cesarean, always a cesarean" is vaginal birth after cesarean (VBAC).[5-7] The effectiveness of this strategy on reducing the number of cesarean deliveries was

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proven in the previous century with Trials of Labor after Cesarean (TOLAC). VBAC is an invaluable approach for women having been found eligible for TOLAC to experience vaginal birth.[7,8] Finland, Sweden and the Netherlands are developed countries with high VBAC rates ranging from 45% to 55%.[9] In a study conducted with health professionals in these countries, it was stated that it is important to decide on the choice of mode of delivery together with the woman, to support the woman, for midwives and obstetricians to act together, and to adopt a common approach for VBAC.[9] With this in mind, it has been reported in many studies in the literature that health professionals are influential on women's birth preferences.[10-12] For this reason, it is necessary to know the opinions of obstetricians and midwives on this subject.

It was highlighted in a systematic review and meta-synthesis study that the factors affecting the delivery preferences of healthcare professionals should be investigated.[13] Also, the urgency to conduct studies examining the qualitative aspects of the interaction between healthcare professionals and pregnant women, as well as the effects of such interaction on the decision-making process has been reported on in the literature.[14] It was emphasized in another meta-synthesis study that studies on this subject should be conducted in different countries for the promotion of VBAC.[15] The aim of this study was to review midwives' and obstetricians' opinions regarding VBAC.

Research Question

What are the views of obstetricians and midwives on VBAC?

MATERIALS AND METHODS

Study Design

This study was a descriptive qualitative study conducted in order to evaluate the opinions of obstetricians and midwives on VBAC. This study adopted two qualitative research approaches, phenomenology and case study. Qualitative research, which is of the phenomenological type, aims to make general inferences on the experiences of more than one person. Phenomenology, a type of qualitative research, is also a 20th century philosophy defined by the German mathematician and author Edmunnd Husserl. The philosophy of phenomenology, which is frequently preferred in nursing and health sciences, emphasizes the transfer of experience and experiences to daily life. Case studies, on the other hand, are the collection of data under certain themes as a result of obtaining data about a situation in limited times and places in various ways and examining these data in-depth.[16] Case studies, which are a preferred approach in the field of some health sciences such as psychology and medicine, aim to reveal the results of an event.[17] Our research was planned in line with the qualitative research paradigm based on a 32-item Consolidated Criteria for Reporting Qualitative Research, a guide for qualitative studies.

Participants

The research sample consisted of obstetricians and midwives who actively worked in obstetrics services in state hospitals, maternity hospitals, university hospitals, or private hospitals in Türkiye and who were within the sample chosen through a snowball sampling method. A total of 26 healthcare professionals, including 12 obstetricians and 14 midwives, were interviewed in this study.

The study population consisted of obstetricians and midwives working in active obstetric services in state hospitals, obstetrics and gynecology hospitals, university hospitals or private hospitals in Türkiye. According to the 2020 Turkish Statistical Institute, a total of 59,040 midwives and 171,259 physicians were working in Ministry of Health, university or private hospitals.[18] According to 2018 data from the Ministry of Health, General Directorate of Health Services, Department of Manpower, 5,608 of the physicians working were gynecologists or obstetricians.[19] In this study, the purposeful sampling method, which is one of the most widely used non-probability sampling strategies, was applied.[17] The research sample consisted of obstetricians and midwives working in any of the above-mentioned health institutions. By using the "theoretical sampling" approach to determine the sample size, the data collection process was completed at the stage when the concepts and processes which could be the answer to the research question started to repeat (saturation point). Considering similar studies, it was predicted that this number would be at least 12-15 for each group (obstetricians and midwives) and this number was reached in the study as expected.[12]

Data Collection

The data were collected through in-depth, one-to-one interviews with healthcare professionals using a semi-structured interview form developed by the researchers and evaluated by an expert committee (obstetrician lecturer, midwife lecturer).

The questionnaires to introduce the participants were prepared separately for obstetricians and midwives. The introductory questionnaire includes nine questions for obstetricians and seven questions for midwives.

In this study, a semi-structured interview form was used to collect qualitative data. In order to obtain the opinions of obstetricians and midwives on VBAC, the form consists of open-ended questions and includes a total of four questions with two sub-items each.

The questions in the semi-structured questionnaire were prepared in line with the opinions and suggestions of the obstetrician and midwife faculty members in a meeting held with the expert committee. The data were collected by phone calls made via WhatsApp. The researcher conducted all interviews from home due to coronavirus disease-2019. Appointments were made with obstetricians and midwives working at the clinic. Appointment days and times varied according to the availability of the health professionals.

After receiving permission for recording, the interviews were audio-recorded. The research data were collected using an introductory questionnaire prepared separately for obstetricians and midwives and a semi-structured interview form prepared for both groups. The introductory questionnaire form had nine questions for obstetricians and seven questions for midwives. There were a total of four questions with two sub-items in the form consisting of open-ended questions in order to get the opinions of obstetricians and midwives about VBAC. The interviews lasted 15-20 minutes due to the workload of the obstetricians and midwives working at clinics during the pandemic. Data were collected between January and July, 2021.

Ethical Procedures

This research was approved by the Ege University Scientific Research and Publication Ethics Committee (approval number: 09/05-676, date: 15.10.2020). An informed consent form was read to the healthcare professionals at the start of their interview. Their consent was obtained

at the beginning of the audio interview by asking them to declare to "have read, understood, and accepted the informed consent form." The midwives are referred to as "MW 1, MW 2 etc.", and the obstetricians are referred to as "OBS 1, OBS 2 etc.". During the collection of the data, the rules in the Helsinki Declaration were followed.

Statistical Analysis

Initially, one-to-one, in-depth interviews were conducted with the obstetricians and the midwives. The interviews were recorded as audio recordings. The raw transcripts of the recordings were transcribed into the Microsoft Word program. The accuracy of the data in the Microsoft Word document was checked by repeatedly listening to the recordings. A categorization matrix was created in line with the purpose of this study. The data were presented for an expert opinion. All data were examined in terms of content in accordance with the categories, and it was re-evaluated as to whether the data conformed to the categorization and then it was coded. The data were collected under the themes determined by the program MAXQDA 2020, and an evaluation was accordingly made between the coded data and the researcher's notes in accordance with an expert opinion. Following these stages, the data were visualized.[20]

Rigor

This research had limitations related to validity and reliability, which is a concern in all qualitative research.

For validity, these limitations were tried to be overcome by defining the characteristics of the research sample, environment and processes in detail at a level which could be compared with other samples, obtaining as much unbiased and in-depth information from the participants as possible, and obtaining confirmation of the information provided.

For reliability, the individuals who were data sources in this study were clearly identified, the interviews were audio recorded, and detailed information on data collection and analysis methods was provided in the research report.[17]

RESULTS

As for the socio-demographics of the participants, a total 26 healthcare professionals from 12 different provinces, including 14 midwives and 12 obstetricians participated in this study. The age range of the participants varied between 23 and 47 years. The midwives had different work experiences ranging from 1 to 29 years, while the obstetricians had expertise from 2 to 7 years. Of the midwives and obstetricians who agreed to participate in this study, 13 were actively working in public hospitals, 6 in maternity hospitals, 2 in private hospitals, and 5 in university hospitals with 19 of them having VBAC experience. The socio-demographic characteristics of the interviewed midwives and obstetricians are shown in Table 1.

The findings are presented in three main categories: "Healthcare Professional Factors", "Healthcare System Factors", and "Clinical/ Pregnant Woman Factors" (Figure 1).

Main Theme 1: Healthcare Professional Factors

The theme of Healthcare Professional Factors was divided into three sub-themes: "Status of Recommending VBAC", "Unplanned" and "Impact on Opinion after VBAC Experience".

Sub-Theme 1: Status of Recommending VBAC

Healthcare professionals who declared that they did not recommend VBAC explained their reasons for not recommending it. Healthcare professionals usually stated that they did not recommend VBAC due to possible complications, inadequate equipment in their hospital, the presence of past surgical operations, the fear of childbirth in women, the lack of enough studies on VBAC and inter-pregnancy intervals of less than twelve months.

"Honestly, I do not recommend it because of the possible complications" [MW12].

"I do not recommend it because the hospital has limited equipment. There is no blood bank in the hospital. There is no on-call anesthesia team or obstetrician in the hospital. That is why I do not recommend it" [OBS3].

"I do not recommend it as there are too few studies on this subject" [MW8].

"I do not recommend it if inter-pregnancy has an interval of less than two years" [MW5].

Other health professionals explained why they recommend VBAC. Healthcare professionals declared that they could recommend VBAC to appropriate pregnant women after evaluating the women in terms of factors such as the inter-pregnancy interval, vaginal examination findings, and chronic diseases. In addition, they also talked about the advantages of vaginal delivery.

"The women I recommend VBAC to are those with a cesarean delivery history with an interval of at least two years, having no problem relating to the mother or her pelvic structure. If I do not see any problems relating to this delivery, then I have them opt for VBAC" [OBS9].

"If there are four to five years between inter-pregnancy, I recommend VBAC" [OBS6].

"I recommend VBAC. Because vaginal birth has certain advantages for both the mother and her baby. It enhances the bond between the mother and her baby. It has both medical and psychological benefits. Also, it avoids cesarean delivery-related traumas" [MW4].

Sub-Theme 2: Unplanned

Healthcare professionals stated that their VBAC experiences were mostly unplanned, and they had to use the vaginal birth method as the dilatation and effacement processes had been completed:

"Generally, VBAC is unplanned. The pregnant woman comes with a cervix dilation of eight to nine centimeters and childbirth occurs" [MW6].

Sub-Theme 3: Impact on Opinion after VBAC Experience

The midwives' opinions were positively affected after VBAC experiences, while obstetricians who are against VBAC, on the other hand, stated why they were still against VBAC.

"Women who prefer a caesarean section in their first birth do not need to have a caesarean section again. All women have a chance of vaginal delivery" [MW6].

Table 1. Socio-demographic characteristics of the participants

Participants	Hospital	Gender	Age	City	Work experience (years)	VBAC experience
Midwife 1	Maternity hospital	Female	29	Ankara	8	Yes
Midwife 2	Maternity hospital	Female	35	Ankara	12	No
Midwife 3	Maternity hospital	Female	46	Ankara	28	Yes
Midwife 4	State hospital	Female	23	Ankara	1	No
Midwife 5	Maternity hospital	Female	42	Ankara	17	No
Midwife 6	Maternity hospital	Female	38	Ankara	19	No
Midwife 7	State hospital	Female	47	Bursa	29	No
Midwife 8	Maternity hospital	Female	28	İzmir	6	No
Midwife 9	University hospital	Female	24	Kocaeli	2	Yes
Midwife 10	University hospital	Female	38	İzmir	15	No
Midwife 11	State hospital	Female	43	Balıkesir	9	Yes
Midwife 12	State hospital	Female	30	Manisa	8	Yes
Midwife 13	State hospital	Female	26	Manisa	4	Yes
Midwife 14	State hospital	Female	30	Manisa	12	Yes
Obstetrician 1	State hospital	Female	34	İzmir	6	Yes
Obstetrician 2	State hospital	Female	32	Edirne	2	Yes
Obstetrician 3	State hospital	Female	31	Gümüşhane	5	Yes
Obstetrician 4	Private hospital	Female	31	İstanbul	2	Yes
Obstetrician 5	University hospital	Female	33	İzmir	2	Yes
Obstetrician 6	State hospital	Female	36	Eskişehir	7	Yes
Obstetrician 7	State hospital	Female	34	İstanbul	6	Yes
Obstetrician 8	University hospital	Female	35	Diyarbakır	3	Yes
Obstetrician 9	Private hospital	Male	36	İstanbul	4	Yes
Obstetrician 10	State hospital	Male	30	İzmir	2	Yes
Obstetrician 11	State hospital	Male	36	Sivas	3	Yes
Obstetrician 12	University hospital	Female	37	İzmir	7	Yes

VBAC: Vaginal birth after cesarean.

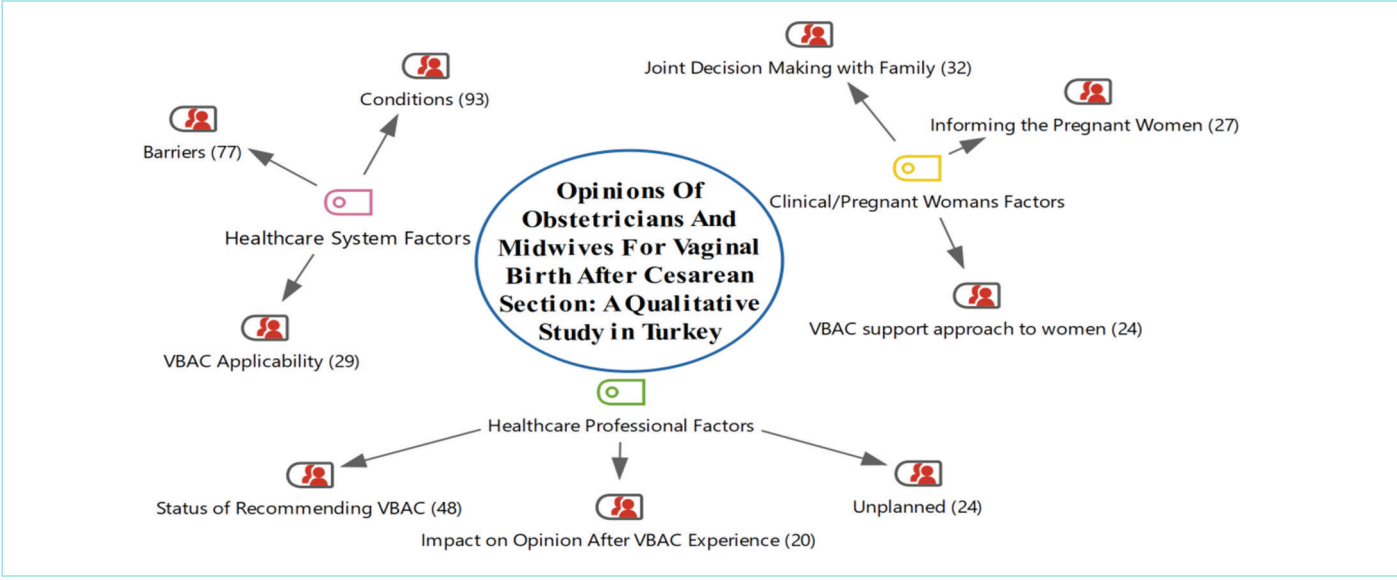

Figure 1. Codes of themes of the opinions of obstetricians and midwives for vaginal delivery after cesarean section.
VBAC: Vaginal birth after cesarean.

"It did not change my opinion. We can see how thin the lower segment got because of the previous cesarean deliveries. I believe it has a high probability of a uterine rupture caused by contractions. The VBAC experience did not give me much except anxiety" [OBS2].

Main Theme 2: Healthcare System Factors

The theme of Healthcare System Factors was divided into three sub-themes: "Conditions", "Barrier" and "VBAC Applicability".

Sub-Theme 1: Conditions

Health professionals stated that women should be informed in detail about VBAC, the pregnant woman should be followed up regularly before delivery, and the reason for the previous caesarean section should be known. They stated that it would be an advantage if the woman had a history of vaginal delivery. Health professionals have stated that VBAC can be done in fully equipped centers. They also have talked about the importance of having the experience of performing VBAC.

"The family should be well informed. It should not be the 'It is so popular to have a vaginal birth' kind of awareness. They should know all the risks" [OBS1].

"The pregnant women must not have any cesarean indications under any circumstances. The reason for the previous cesarean should be well investigated" [MW10].

"The fact that the patient had a previous vaginal birth may be seen as a simple factor since it will facilitate the labor progression" [OBS3].

"There should be a neonatal intensive care unit at the hospital where we can immediately supply the necessary blood products which should be provided" [MW9].

"There should be an on-call anesthesia expert and obstetrician in the hospital. We should be able to process the pregnant woman to a cesarean within minutes" [OBS1].

"VBAC may be recommended by physicians as the experience and expertise develop in Türkiye" [OBS11].

Sub-Theme 2: Barriers

The healthcare professionals stated some barriers to VBAC. These factors include malpractice lawsuits filed against them in cases of any complications, CS indications, insufficient experience, workload, lack of time, the status of women in society, pregnant women lacking information about VBAC, and the fear of vaginal delivery. The healthcare professionals participating in this study specified that the most common barrier to VBAC was the risk of uterine rupture. Midwives have criticized the fact that obstetricians always prefer ERCD.

"The experts have hesitations because of malpractice suits. A legal regulation should be made about this" [OBS5].

"We do not have enough experience" [OBS6].

"It is a little about the status of women in society. The people here avoid taking women to hospital by valuing them, and therefore the pregnancies cannot be followed up. That is why we know the problems we will encounter" [MW9].

"I think the patients are not adequately informed about this. This inevitably causes an increase in cesarean rates" [MW12].

"The pregnant women do not want vaginal birth because of the fear of normal birth and their anxiety about it" [OBS11].

"Even a small membrane bleeds in cases of ruptures. Both baby and mother may be dead within minutes or even seconds. I think both are equally very valuable. VBAC is like a gamble" [OBS1].

"We act according to the obstetrician's decision. The obstetrician's choice of birth is important" [MW7].

Sub-Theme 3: VBAC Applicability

The obstetricians and midwives had a disagreement on VBAC applicability in our country. They predominantly declared that the VBAC applicability was low in the current healthcare system.

"I do not find public hospitals appropriate at all. Because only one physician is on call. It can be very difficult to even keep up with normal patients. Much closer follow-up and more experienced midwives are required for VBAC" [OBS7].

"It can be applied if desired. Why not? The delivery room is a place open to development" [MW14].

"I think it may be applied in the current healthcare system. Most public hospitals have these opportunities. My current hospital also has these opportunities" [OBS2].

Main Theme 3: Clinical/Pregnant Woman Factors

The theme of Clinical/Pregnant Woman Factors was divided into three sub-themes: "Joint Decision Making", "Informing the Pregnant Women", "VBAC approach to women".

Sub-Theme 1: Joint Decision Making with the Family

The healthcare professionals, in general, specified the requirement for a joint decision with the woman and her family on the delivery preference:

"A joint decision should be made by clearly talking about all of the risks. It should not be a unilateral decision" [MW8].

"I want every woman to be sure of her birth choice. It's not good to force people to do things" [OBS1].

Sub-Theme 2: Informing the Pregnant Women

The healthcare professionals who encountered women with previous cesareans and their families said they only provided information if the women asked about VBAC.

"I explain if the pregnant woman asks. However, I do not suggest VBAC" [OBS4].

"If the conditions are OK, every time, I ask if they are considering VBAC" [OBS9].

Sub-Theme 3: VBAC Support Approach to Women

Some of the midwives and obstetricians participating in this study declared that they support VBAC. Some, on the other hand, have

stated that they do not support VBAC and will refer pregnant women to another medical institution.

"If there are no complications and most importantly, if the woman wants it, I support VBAC. Of course, by informing about the benefits and risks" [MW4].

"I support VBAC and explain all of the risks completely to the pregnant women. I have not experienced anything negative yet" [OBS9].

"I inform the pregnant women of the possible risks. I explain that I do not recommend VBAC. If the woman wants VBAC, I suggest that the pregnant woman talks to another doctor who will undertake this risk" [OBS2].

DISCUSSION

Most of the obstetricians and midwives participating in this study stated that they had VBAC experience. However, health professionals stated that they did not plan VBAC and that they had to have vaginal delivery to women who had previously had a CS. However, it has been reported that women who want VBAC in the Netherlands are followed up by their obstetrician throughout their pregnancy and care services are provided by midwives, obstetricians and assistant doctors in the hospital.[9] In Sweden, it is known that VBAC is recommended for pregnant women who have had a previous CS and have no complications.[9]

The reason why the results of this study are different from the literature can be said to be because of the higher rates of VBAC in other countries, where health professionals have experienced VBAC many times and as a result of gaining experience, they prefer VBAC in a planned manner without hesitation.

Those midwives who had previously experienced VBAC who participated in this study were positively affected. However, obstetricians stated that VBAC did not add anything to them other than causing anxiety. After the VBAC experience in the literature, the opinions of the obstetricians were divided into two. While one of the obstetricians with VBAC experience stated that they chose ERCD to avoid negative results, another obstetrician shared his sadness that he could not perform VBAC because his patient wanted a CS and he lost his patient due to a cesarean complication.[12] Looking at the results, it can be seen that midwives are more in favor of vaginal delivery compared to obstetricians. The reason why obstetricians prefer CS is that they think that the negativities which may occur at the time of birth will put them in a difficult situation. In this situation, it is thought that VBAC rates can be increased significantly with the support of obstetricians.

The obstetricians and midwives participating in this study stated that women should be given detailed information about complications. Similarly, in a study conducted in Ireland, Italy and Germany, health professionals were of the opinion that VBAC should be offered to women as a birth choice and it emphasized the importance of informing the woman about VBAC in detail and impartially while discussing the possible risks.[12,21] It is extremely important that the woman and her family be made aware of VBAC, which is one of their birth preferences, and that they decide on their own will. Obtaining the consent of the woman is also extremely valuable for the obstetrician and midwife in order to perform their profession without fear.

The obstetricians and midwives mentioned that the conditions in the hospital should be improved in order to perform VBACs. Panda et al.[13] mentioned that TOLAC is not preferred due to insufficient hospital conditions. In addition, similar to the results of this study, it is considered important for health professionals to experience VBAC in the literature.[21] Therefore, it is thought that it is extremely important for midwives, who follow pregnant women in the prenatal period and provide one-on-one counseling, to receive the necessary training and gain experience in order to offer VBAC as a birth preference to pregnant women.

Similar to the results of this study, health professionals consider the risk of uterine rupture as the biggest barrier to VBAC.[12] According to this result, this barrier can be removed with the development of tools which can predict the risk of uterine rupture and the development of scales which can evaluate the suitability of women for VBAC.

The obstetricians and midwives participating in this study stated that they were disturbed by malpractice lawsuits and that they could not take any risks in order to avoid being exposed to such lawsuits. In the study of Firoozi et al.[22], it was stated that health professionals moved away from VBAC because they did not want to take legal responsibility.[22] In line with the results of the studies, it can be seen that obstetricians and midwives want to feel safe in cases of any problems during VBAC. In this situation, it is extremely important to develop health policies to support health professionals and to support them in their implementation of VBAC.

In this study, the obstetricians and midwives stated that they did not have enough time to inform the pregnant woman because the hospitals were very busy. Similarly, in a study conducted in Australia, health professionals stated that the current system is not suitable for VBAC and they did not have enough time to inform the patients about the harms and risks.[10] There is a need to increase the number of health professionals and well-equipped health institutions in order to provide quality health services to every pregnant woman and also to provide the necessary training.

While studies conducted at the international level do not mention the woman's right to speak and their status in society as a possible barrier to VBAC, attention should be drawn to women's rights to speak in society in Türkiye. Midwives criticize the value given to women by their spouses/mothers-in-law and also the public attributed the inability of women to be followed up regularly to the pressure exerted on these women and stated this as being a barrier to VBAC. In another study conducted in Türkiye, it was also mentioned that the family and relatives of the woman were influential in the decision of birth preference.[23] Therefore, it is thought that it is important to follow up and inform the woman with her family throughout the pregnancy period in terms of making a joint decision in the birth preference.

CONCLUSION

There is a need to organize training programs in order to improve healthcare professionals' knowledge and skills regarding VBAC. The provision of delivery preferences to women and the development of policies regarding joint decision-making by healthcare professionals and pregnant women on the mode of delivery can increase the rates of VBAC. There is a need to improve hospital conditions so that emergency intervention can be provided in unplanned situations during labor,

and there is a need to strengthen healthcare professionals, and to implement laws and regulations supportive of VBAC. VBAC must be offered to pregnant women by healthcare professionals as a delivery choice. Healthcare professionals should support the participation of all pregnant women in this training. It is recommended to increase qualitative and quantitative research on the subject, and conduct evidence-based research.

MAIN POINTS

- The lack of knowledge about vaginal birth after cesarean section and other various factors such as malpractice prevented the application from being widespread.
- Obstetricians have concerns about vaginal birth after cesarean delivery.
- Midwives believe that vaginal birth after caesarean section is a chance for women who have already had a caesarean section.
- Conditions in hospitals should be improved so that vaginal delivery is preferred after cesarean section.
- Health policies that support obstetricians and midwives are needed.

ETHICS

Ethics Committee Approval: This research was approved by the Ege University Scientific Research and Publication Ethics Committee (approval number: 09/05-676, date: 15.10.2020).

Informed Consent: An informed consent form was read to the healthcare professionals at the start of their interview.

Authorship Contributions

Surgical and Medical Practices: N.Ü.B., E.Ç.T., Concept: N.Ü.B., E.Ç.T., Design: N.Ü.B., E.Ç.T., Data Collection and/or Processing: N.Ü.B., Analysis and/or Interpretation: N.Ü.B., E.Ç.T., Literature Search: N.Ü.B., E.Ç.T., Writing: N.Ü.B.

DISCLOSURES

Conflict of Interest: No conflict of interest was declared by the authors.

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REFERENCES

1. Statista. Cesarean sectionrates in OECD countries in 2019. (2019). https://www.statista.com/statistics/283123/cesarean-sections-in-oecd-countries/
2. WHO. WHO statement on caesarean section rates. World Health Organization, 2015.
3. Roberts CL, Algert CS, Ford JB, Todd AL, Morris JM. Pathways to a rising caesarean section rate: a population-based cohort study. BMJ Open. 2012; 2(5): e001725.
4. Macfarlane AJ, Blondel B, Mohangoo AD, Cuttini M, Nijhuis J, Novak Z, et al. Wide differences in mode of delivery within Europe: risk-stratified analyses of aggregated routine data from the Euro-Peristat study. BJOG. 2016; 123(4): 559-68.
5. Gözükara F, Eroğlu K. A Way to Prevent the Increase in Cesarean Birth: Vaginal Birth After Cesarean Instead of "Once a Cesarean Always a Cesarean" Approach and the Roles of Nurse. Hacettepe University Faculty of Health Sciences Nursing Journal. 2018; 18(2): 89-100.
6. Kaimal AJ, Grobman WA, Bryant AS, Norrell L, Bermingham Y, Altshuler A, et al. Women's Preferences Regarding the Processes and Outcomes of Trial of Labor After Cesarean and Elective Repeat Cesarean Delivery. J Womens Health (Larchmt). 2019; 28(8): 1143-52.
7. ACOG, XVII. ACOG practice bulletin no. 205: vaginal birth after cesarean delivery. Obstet Gynecol. 2019; 133(2): 110-27.
8. Bonzon M, Gross MM, Karch A, Grylka-Baeschlin S. Deciding on the mode of birth after a previous caesarean section - An online survey investigating women's preferences in Western Switzerland. Midwifery. 2017; 50: 219-27.
9. Lundgren I, van Limbeek E, Vehvilainen-Julkunen K, Nilsson C. Clinicians' views of factors of importance for improving the rate of VBAC (vaginal birth after caesarean section): a qualitative study from countries with high VBAC rates. BMC Pregnancy Childbirth. 2015; 15(1): 196.
10. Foureur M, Turkmani S, Clack DC, Davis DL, Mollart L, Leiser B, et al. Caring for women wanting a vaginal birth after previous caesarean section: A qualitative study of the experiences of midwives and obstetricians. Women Birth. 2017; 30(1): 3-8.
11. Karabulutlu Ö. Identifying The Women`s Choice of Delivery Methods of and The Factors That Affect Them. Florence Nightingale J Nurs. 2012; 20(3): 210-8.
12. Kurtz Landy C, Sword W, Kathnelson JC, McDonald S, Biringer A, Heaman M, et al. Factors obstetricians, family physicians and midwives consider when counselling women about a trial of labour after caesarean and planned repeat caesarean: a qualitative descriptive study. BMC Pregnancy Childbirth. 2020; 20(1): 367.
13. Panda S, Begley C, Daly D. Clinicians' views of factors influencing decision-making for caesarean section: A systematic review and metasynthesis of qualitative, quantitative and mixed methods studies. PLoS One. 2018; 13(7): e0200941.
14. Goodall KE, McVittie C, Magill M. Birth choice following primary Caesarean section: mothers' perceptions of the influence of health professionals on decision-making. Journal of Reproductive Infant Psychology. 2009; 27(1): 4-14.
15. Lundgren I, Begley C, Gross MM, Bondas T. 'Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section). BMC Pregnancy Childbirth. 2012; 12: 85.
16. Subaşı M, Okumuş K. Case Study as a Research Method. Current Perspectives in Social Sciences. 2017; 21(2): 419-26.
17. Yildirim A, Simsek H. Qualitative Research Methods in Social Sciences. 1999.
18. Institute, T. S. (2023). Türkiye in Statistics 2022.
19. Taner MZ. Human Resources in the Specialty of Obstetrics and Gynecology. https://www.sdplatform.com/Dergi/1157/Kadin-dogum-uzmanlik-dalinda-insan-kaynaklari.aspx
20. Yakut Çayır M, Sarıtaş MT. Computer Assisted Qualitative Data Analysis: A Descriptive Content Analysis (2011-2016). Necatibey Faculty of Education Electronic Journal of Science. 2017; 11(2): 518-44.
21. Lundgren I, Healy P, Carroll M, Begley C, Matterne A, Gross MM, Grylka-Baeschlin S, Nicoletti J, Morano S, Nilsson C, Lalor J. Clinicians' views of factors of importance for improving the rate of VBAC (vaginal birth after caesarean section): a study from countries with low VBAC rates. BMC Pregnancy Childbirth. 2016; 16(1): 350.
22. Firoozi M, Tara F, Ahanchian MR, Latifnejad Roudsari R. Health Care System Barriers to Vaginal Birth after Cesarean Section: A Qualitative Study. Iran J Nurs Midwifery Res. 2020; 25(3): 202-11.
23. Kisa S, Kisa A, Younis MZ. Opinions and attitudes of obstetricians and midwives in Turkey towards caesarean section and vaginal birth following a previous caesarean section. J Int Med Res. 2017; 45(6): 1739-49.