

## Women's Experiences with Birth after Cesarean in Kentucky: Findings from a Statewide Survey

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### Overview

This report summarizes selected findings related to women's experiences of birth after cesarean in Kentucky. Our research team conducted an online survey to understand the experiences of women in Kentucky who have given birth after a previous cesarean delivery. The survey asked questions related to a woman's first cesarean birth and their subsequent pregnancy and birth. Researchers from the University of Louisville School of Public Health and Information Sciences, Yale University, and Florida State University collaborated on the survey design, which was open for responses from May to October 2024.

### Background

In Kentucky, 88.1% of women with a previous cesarean delivery have a subsequent repeat cesarean.<sup>1</sup> While vaginal birth after cesarean (VBAC) is an evidence-supported, cost-effective mode of birth for many women with a history of cesarean, and one that many women desire, the VBAC rate in the United States remains low.<sup>2</sup> Recognizing the low rate of VBAC, Healthy People 2020 set a goal of increasing the rate to 18.3% of women with a previous cesarean by 2020.<sup>3</sup> In 2024, the national VBAC rate was 15.1%.<sup>4</sup> While this represents a modest increase from previous years (2018: 13.3%, 2019: 13.8%, 2020: 13.9%), the current rate falls short of the Healthy People 2020 goal. Though more progress is needed to increase the national VBAC rate, Healthy People 2030 does not include a VBAC-related goal.<sup>5</sup>

Despite professional organizations' recommendations to provide the option to labor after cesarean for appropriate candidates, and an average trial of labor after cesarean (TOLAC) success rate of 74.7% (2020), deciding how to give birth in subsequent pregnancies can be a complex decision.<sup>6,7</sup> There are multiple barriers to accessing VBAC, including institutional and provider factors (e.g. hospital bans on TOLAC or provider preferences for repeat cesarean), and individual-level factors (e.g. childcare or work-related responsibilities).<sup>7,8</sup> A significant obstacle to VBAC is finding a supportive provider, as a provider's preference for mode of birth affects women's choices about their own birth after cesarean.<sup>9</sup> When women are able to find a supportive provider and have a planned VBAC, they report greater autonomy in decision making and more respectful care than those who do not plan a VBAC.<sup>9</sup> Women who have a history of cesarean, particularly unplanned cesarean, report high rates of birth-related trauma and low satisfaction with their birth experience.<sup>10</sup> Patient-centered approaches to maternity care during pregnancy that allow women with a history of cesarean to discuss their concerns and choices about desired mode of birth (repeat cesarean or VBAC) has long-lasting impacts on their relationship with the healthcare system, mother-infant bonding, and health behaviors including breastfeeding.<sup>11</sup> Patient experiences of care influence the narrative of their birth experience even more than their final mode of birth after cesarean. For instance, women who desired a VBAC but ultimately had a repeat cesarean reported having a positive birth experience when they felt respected and heard by their healthcare providers.<sup>11</sup>

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## Methodology

Given the high number of women in Kentucky who have experienced a pregnancy and birth following a prior cesarean, we sought to understand what birth after cesarean looks like in the Commonwealth. We conducted an online survey with the support of the Kentucky Cabinet for Health and Family Services through a State-University Partnership. The survey was distributed statewide to women who had a previous cesarean birth and at least one subsequent birth. We inquired about the experiences of women who were able to complete an English-language survey and lived in Kentucky at the time of their subsequent birth. We used flyers, personal and professional networks, and partnered with community-based organizations and coalitions across the state to recruit participants. The survey included multiple choice questions and gave participants an opportunity to provide open-ended comments. Many of the questions on the survey were used directly or modeled after existing surveys including the *Listening to Mothers in California* survey.<sup>12</sup> We used a validated scale in the survey, the Mother's Autonomy in Decision Making (MADM) Scale, to measure experiences of maternity care during both primary cesarean and subsequent pregnancies. The survey took an average of 11 minutes to complete. Participants did not receive an incentive for completing the survey.

In addition to responses to multiple choice survey questions, we received many memorable and moving quotes and stories from women who completed the survey, generating a rich dataset that cannot be described in a single report. In this research brief we focus on describing participants' experiences during their pregnancy and birth after cesarean.

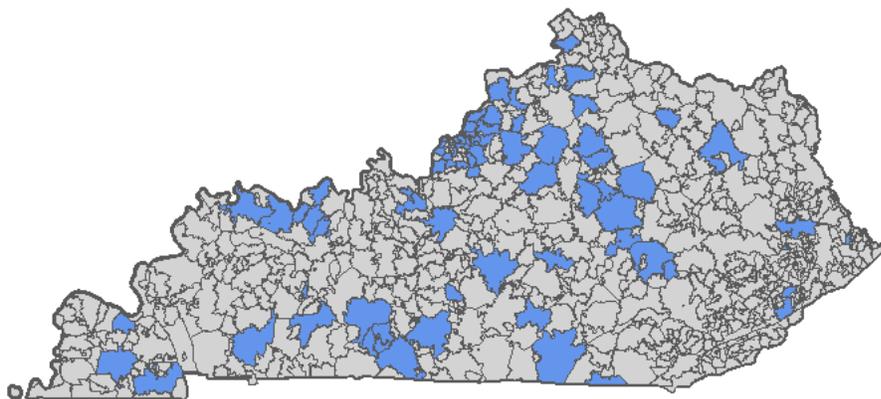
This survey was conducted concurrently with our survey of Kentucky birth providers about their perspectives and practices related to VBAC. The findings from that survey can be found [here](#).

## Overview of the Survey Participants

We received fully completed surveys from 182 of the 245 women who provided consent and started the survey, for a completion rate of 74%. Below, we provide a summary of participant demographics. Additional demographics and tables can be found [here](#).

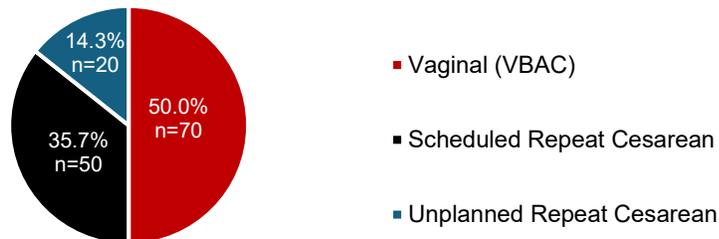
Participants across the state responded to the survey, with more robust participation from residents of Central Kentucky relative to Western and Eastern Kentucky (Figure 1). Participants reported giving birth after cesarean at 21 hospitals in the state, with Norton Women's and Children's Hospital (n=36), Baptist Health Louisville (n=13), University of Louisville Hospital (n=11), and University of Kentucky Albert Chandler Medical Center (n=8) most represented.

**Figure 1. Distribution of Responses by Participant Residence Zip Code at the Time of the Survey**



Most participants (35.1%) were between the ages of 35-39 (mean age: 38.3), White (97.8%), married (98.5%), had a college degree or higher (75.4%), and used commercial insurance to pay for their birth after cesarean (68.2%). Nearly all women had prenatal care for their pregnancy after cesarean (98%) and the average week of gestation of their first prenatal care visit was 8.3. Almost a quarter (23.6%) of participants had a doula present for their birth after cesarean, primarily paid for out-of-pocket (84.9%).

**Figure 2. Participant Mode of Birth after Cesarean**



Most participants had a VBAC (50%), followed by scheduled repeat cesarean (35.7%), and unplanned repeat cesarean (14.3%) (Figure 2).

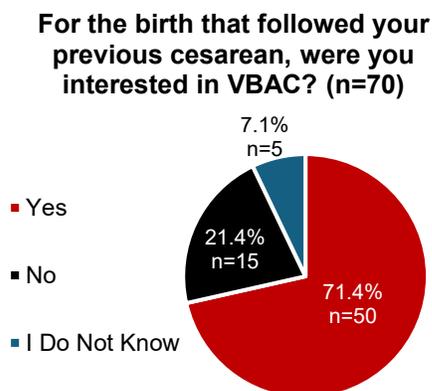
## Key Findings

In this section, we report selected findings related to women's experiences of birth after cesarean delivery. Results highlighted in this section are based on participant responses to the Mother's Autonomy in Decision Making Scale (MADM), a validated scale to assess women's autonomy and role in decision making during maternity care for their birth after cesarean. This scale represents a measure of shared-decision making and measures women's ability to lead decision-making during maternity care.<sup>13</sup> We also provide illustrative quotes from participants' open-ended responses.

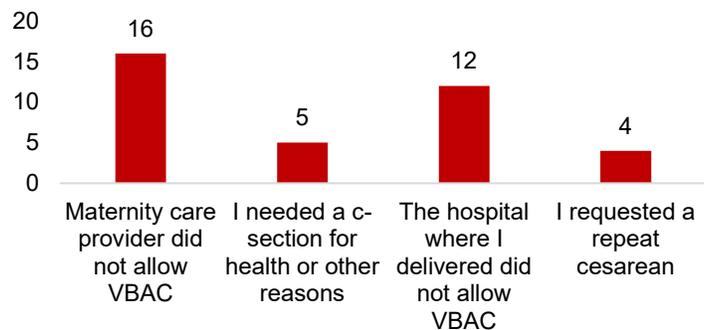
### Finding 1: The patient-provider relationship strongly influences a patient's ultimate mode of birth after cesarean.

We asked women who had a repeat planned or unplanned cesarean delivery (n=70), "For the birth that followed your first cesarean delivery, were you interested in trying to have a VBAC?" Most participants (71.4%) indicated that they were interested in VBAC (Figure 3). Most women (88.9%) who were interested in VBAC reported speaking with their provider about their interest.

**Figure 3. Interest in VBAC**



**Figure 4. Reason for Not Ultimately Planning or Attempting a VBAC**



\*Participants could select more than one option. Numbers represent frequencies.

**The most commonly cited reason for desiring but not planning or attempting a VBAC was that the participant's maternity care provider did not allow VBAC (34.0%).**

Some participants shared their experiences with providers who were not supportive of their desired VBAC:

*"I deeply regret going to an OB for my TOLAC. I wanted a VBAC and it turns out my OB was very against that. She had me sign a waiver before birth but then came into my hospital room and recorded me with her phone waiving responsibility and made me feel terrible about my choice, while I was having contractions."*

*"I was shamed for asking for a VBAC by my OB-GYN. I was told it would be selfish and I would risk dying and leaving my children behind."*

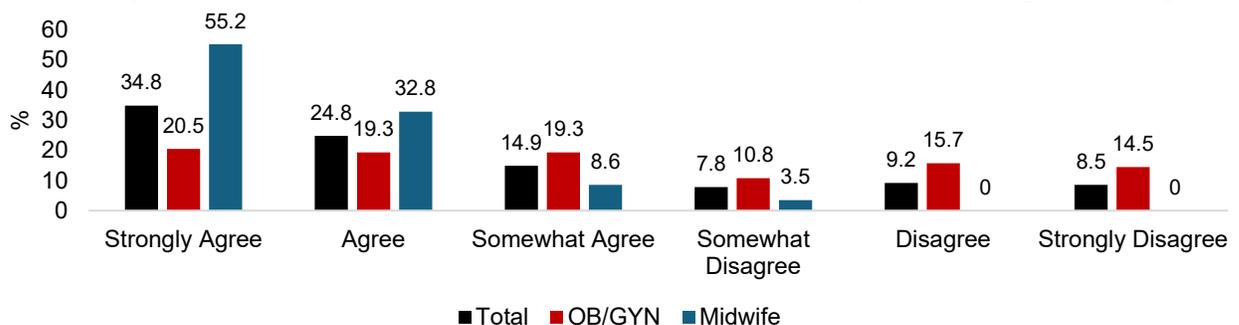
*"I went against medical advice and pushed for a VBAC even though they just wanted to schedule another c-section. I did not want that. My health records showed I was a good candidate for VBAC considering my c-section was not a result of medical emergency but doctor's choice."*

One participant shared that, while her primary OB-GYN was not supportive of VBAC, she went into labor before her scheduled cesarean and the provider on call facilitated a desired VBAC, demonstrating the importance of provider practices and perspectives as a facilitator/barrier to mode of birth after cesarean:

*"My OB told me I would have to schedule a C-section for my second delivery so I did. But I prayed that I could have a vaginal delivery and my water broke in the early morning on the day of my scheduled C-section. The doctor who was on call was the doctor in the practice that had just received an award for the most VBACs in the state! She delivered my first VBAC."*

When patients are provided with information about their options for birth after cesarean, including both the advantages and disadvantages, they feel more empowered in their decision-making.<sup>14,15</sup> Overall, 59.6% of participants strongly agreed or agreed that their provider informed them of different options for their maternity care. Participants who saw a midwife for their care, compared to those who saw an OB-GYN, were more likely to strongly agree or agree that their provider informed them of their options for maternity care (88% vs. 39.8%, respectively). Conversely, 30.2% of participants who saw an OB-GYN for their maternity care either disagreed or strongly disagreed with the statement that their provider informed them of their options (Figure 5).

**Figure 5. "My doctor or midwife told me that there are different options for my maternity care."**



Many participants reported being unaware of their options for birth after cesarean, primarily not knowing that VBAC was an option for them. Providers played an important role in educating patients about their options for mode of birth after cesarean or, alternatively, in not providing information that could have helped inform their decision-making. Participants shared:

*“I was never told I could have tried for a VBAC. It was assumed from the beginning that I would have another cesarean.”*

*“I wish I would have had more information from my provider or known what to ask regarding the possibility of a VBAC.”*

*“I was nervous I'd be told no [if I asked for a VBAC]. My provider never brought it up so I thought I shouldn't either.”*

*“I did not know about providers outside of the care I received from my doctor. If I would have known a VBAC existed, I would have tried. I would have left my provider to do so. I would have found a provider experienced in breech birth and VBACs.”*

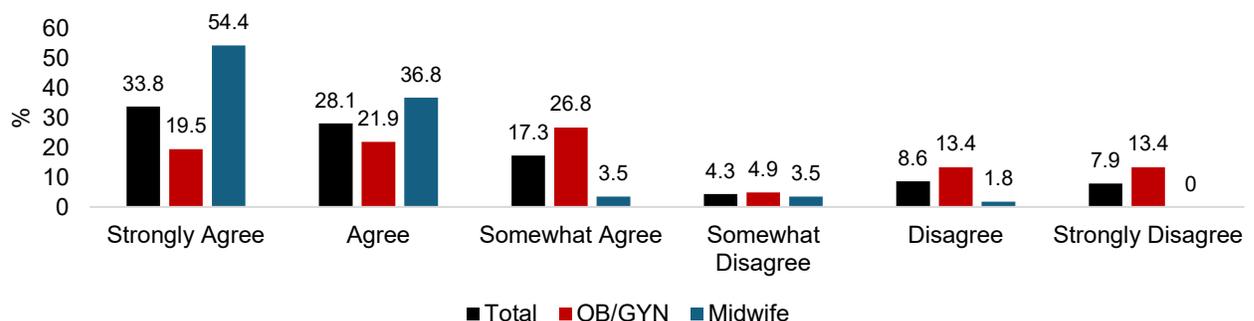
Participants reported positive experiences with providers who offered information about their birth options and provided support for informed decision-making. Participants shared:

*“I had always thought if you had a c-section you couldn't have a vaginal birth after; however, my OB explained that I could.”*

*“My doctor for this pregnancy never felt rushed and always brought up topics to discuss. She gave me the risks and benefits of many different aspects of my care so that I could make informed decisions. She was supportive of every choice that I made.”*

Overall, 79.2% of participants strongly agreed, agreed, or somewhat agreed that their maternity care provider explained the advantages/disadvantages of their maternity care options. Participants who saw midwives for their maternity care were more likely than those who saw OB-GYNs to strongly agree or agree with the statement (Figure 6).

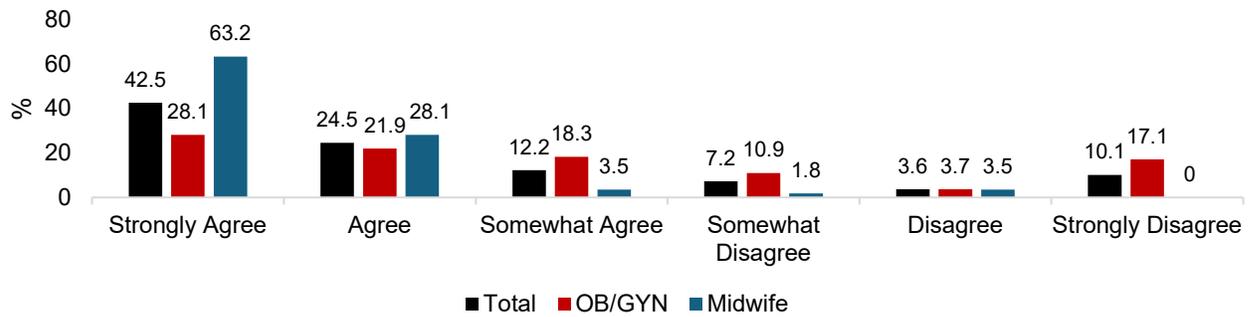
**Figure 6. “My doctor or midwife explained the advantages/disadvantages of the maternity care options.”**



**Finding 2: Systemic and structural barriers limited the ability of participants to choose the best options for care for their birth after cesarean.**

While the majority of participants strongly agreed (63.2%) or agreed (28.1%) that they were able to choose what they considered to be their best care options, several participants disagreed (20.9%) (Figure 7).

**Figure 7. “I was able to choose what I considered to be the best care options.”**



In the open-ended comments, participants shared their experience with structural and systemic barriers to their desired options, including a planned VBAC. Hospital policies banning TOLAC were a frequently cited barrier:

*“I requested TOLAC and was denied due to ‘policy.’ I felt I was not taken seriously and was forced to have a repeat CS [cesarean] against my wishes.”*

*“Hospital policies for VBAC seemed to be non-negotiable even though policy is not synonymous with law.”*

*“At 41 weeks gestation, an OB I had never seen removed the CNM [Certified Nurse Midwife] from my care and told me I could not have a VBAC and c-section was my only option in their hospital. It was devastating and I ended up in a hospital I had never been to having a c-section with a doctor I didn’t know.”*

Multi-provider practices, and differing views among providers in the practice, were also experienced as a barrier to a desired VBAC.

*“I was told throughout my entire prenatal care that I was a great VBAC candidate. Then when I went into labor the on-call doctor was not comfortable with a VBAC at all so we ended up having another c-section. I felt like the on-call doctor fear-mongered me into a c-section.”*

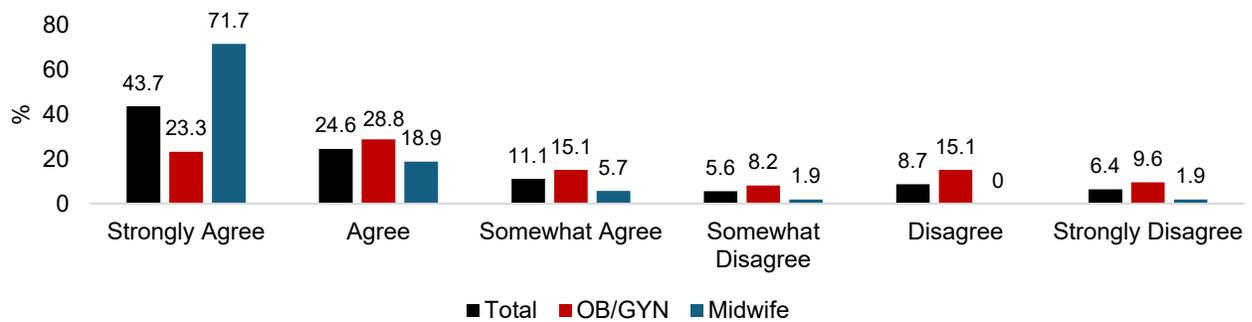
*“My OB-GYN told me I could attempt a VBAC if I wanted, but only if I went into labor naturally. They also said they would not allow me to go past 40 weeks. I did not go into labor naturally before week 39, and had a scheduled c-section a couple days before 40w. I had to schedule it a couple days before 40w in order to get the care provider I wanted from the multi-provider practice.”*

### Finding 3: Participants who had midwifery care reported overwhelmingly positive experiences with maternity care for their birth after cesarean.

Midwives were frequently mentioned by participants as supportive birth providers, especially regarding VBAC. This finding aligns with existing evidence reporting that birth in midwifery-led settings, compared to obstetric settings, is associated with increased rates of VBAC.<sup>16</sup> Participants who saw a midwife for their maternity care were more likely to strongly agree or agree that they were able to choose the best care options compared with those who saw an OB-GYN (91.3% vs. 50%, respectively) (Figure 7).

Further, while 68.3% of participants strongly agreed or agreed that their provider respected their choices, those with midwifery care were much more likely than those with OB-GYN care to agree. Among those with midwifery care, 90.6% strongly agreed or agreed that their provider respected their choices compared to 52.1% of those with an OB-GYN provider (Figure 8).

Figure 8. “My doctor or midwife respected my choices.”



Participants shared their experiences with midwifery care for their birth after cesarean:

*“I saw the same group of midwives with my VBAC pregnancy because I trusted them deeply. I felt confident that all my other options were exhausted before c-section in my first pregnancy and it was the right choice for a healthy delivery. They gave me incredible informed consent discussions and fully respected my choices. My VBAC with them was one of the most beautiful experiences of my life.”*

*“I sought out a home birth midwife because no doctors were interested in entertaining a VBAC for me, despite me meeting all criteria. My home VBAC was AMAZING. It was such a respectful, wonderful experience and I went on to have two more births at home with that midwife because of the extreme difference in care and experience.”*

*“My maternity care for my second birth was night and day from my first. Thanks to my midwife, I was able to have a successful unmedicated VBAC home water birth. I’ll forever be grateful to her!”*

*“I was very empowered, never had to deal with the VBAC success calculator, my midwives were team VBAC from the beginning and I loved the support.”*

## Conclusion

Increasing access to midwifery-led care, options for birth settings, and patient-centered care using shared-decision making approaches can increase access to VBAC and expand patient options for birth after cesarean. Additionally, these approaches can facilitate improved satisfaction with the birth experience, an often overlooked but important measure of care quality. Increasing access to VBAC

will decrease the long and short term complications associated with surgical cesarean birth and will contribute towards the improvement of Kentucky's VBAC rate. Finally, we acknowledge the limitations of these results, including the lack of sociodemographic diversity which we intend to address in future research. We thank all the women who shared their experiences for this study.

## For More Information

For more information about this study, please contact the study lead, Melissa Eggen, PhD, MPH at: Email: [melissa.eggen@louisville.edu](mailto:melissa.eggen@louisville.edu)  
Phone: 502-852-6662

This survey was done in conjunction with a survey of maternity care providers about their perspectives of VBAC. That report can be found [here](#).

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