MENA Journal of Case Reports
Doi: 10.64913/mmrmjcr.v1i2.53
Volume No.1, 2026

Original Article

A retrospective analysis of the Vaginal Birth After Cesarean Section rate and indications in the UAE

Siddiqua Banu Sayeeda[1*], Ritu Nambiar[1], Maha Ahmed[2]

[1] Dept. of Obstetrics and Gynecology, Burjeel Medical City, United Arab Emirates.
[2] Shaheed Mohtarma Benazir Bhutto Medical College, Karachi, Pakistan.

*Corresponding Author: omersiddiqua@gmail.com

Received: 21/06/2026 ; Accepted: 07/11/2026 ; Published: 12/11/2026

Abstract

With the increasing incidence of cesarean sections, the importance of VBAC cannot be overstated, as it may reduce repeat cesarean sections. This audit aimed to evaluate the number of patients who underwent trial of labor after cesarean (TOLAC), the percentage who achieved VBAC, and the percentage who underwent emergency cesarean following TOLAC. The audit was carried out at Burjeel Medical City, Abu Dhabi, UAE, on women with a single previous lower-segment cesarean.
We retrospectively collected data from medical records for the period from January to December 2024 for analysis. Women with a single previous lower-segment cesarean and pregnancy of ≥37 weeks' gestation were included in the study. Women with a contraindication to vaginal birth detected in their current pregnancy were not recommended for TOLAC and were included in the ERCS group. We analyzed data descriptively, with 95% CIs calculated using the Wilson score method.
Of 128 eligible women, 56 (43.8%; 95% CI 35.5–52.4%) underwent TOLAC and 72 (56.3%; 95% CI 47.6–64.5%) underwent ERCS. Of those who underwent TOLAC, 43 achieved VBAC (76.8%; 95% CI 64.2–85.9%) and 13 (23.2%; 95% CI 14.1–35.8%) required emergency cesarean delivery. Documented reasons for unsuccessful TOLAC included scar tenderness, labor not progressing, and failed induction of labor.
In this single-center audit, the VBAC success rate was within the range reported in international guidelines and the published literature. These data are purely descriptive, as this study did not include a prediction model for VBAC success or safety outcomes. It seems that VBAC is a viable mode of delivery among properly selected women with a single previous lower segment cesarean.

Keywords: Vaginal birth after cesarean, trial of labor after cesarean, repeat cesarean section, cesarean delivery, obstetric audit, maternal outcomes.

1. Introduction

The cesarean section (CS) procedure prevents maternal and infant deaths when it is medically indicated. The global cesarean rate increased from about 7% in 1990 to 21.1% in 2010–2018, ranging from 5% in sub-Saharan Africa to 42.8% in Latin America and the Caribbean [1]. Current trends suggest that about 28.5% of women will have CSs by 2030 [1]. However, despite being a potentially lifesaving intervention when needed, the continuous increase in both primary and repeat cesareans is now regarded as a public health issue [1, 2].
Repeat cesarean deliveries in women who had a cesarean delivery before constitute one of the factors that contribute to the rising cesarean rate [2]. After one prior cesarean, a woman can choose between two possible scenarios concerning her subsequent delivery: elective repeat cesarean (ERCS) or trial of labor after cesarean (TOLAC). When TOLAC ends successfully, the woman delivers vaginally, having a vaginal birth after cesarean (VBAC) [2, 3]. Recently, there has been growing interest in VBAC because it might help reduce repeat cesarean deliveries while ensuring maternal and fetal safety [3, 4].
A variety of benefits to the mother have been found to be associated with successful VBAC as compared to repeat cesarean delivery. These benefits include lower maternal morbidity, fewer intraoperative complications, lower risk of postpartum

© 2026 Copyright by the Authors.
Licensed as an open access article using a CC BY 4.0 license.

bleeding, shorter hospital stay, faster recovery, and reduced health care costs [3–6]. Successful VBAC will also help reduce cumulative complications due to multiple cesarean deliveries, such as placenta previa, placenta accreta spectrum disorder, pelvic adhesion, bladder injury, bowel injury, hysterectomy, and excessive postpartum bleeding [3, 7]. All of these complications increase with each subsequent cesarean delivery.

A substantial body of literature exists on VBAC success rates. According to a recent meta-analysis, the success rate for spontaneous labor is around 74-75%, and for induced labor is around 60-61% [8]. VBAC success rates in large population-based studies range from 60% to 80%, depending on patient selection criteria [3, 9]. Some factors that increase the chance of VBAC include previous vaginal delivery, spontaneous labor, younger maternal age, low body mass index, favorable cervix, and non-recurrent indication for previous cesarean [3, 4, 9, 10].

However, despite the procedure's benefits, it also carries risks. Complications related to an unsuccessful TOLAC procedure and an emergency cesarean delivery have been shown to be associated with higher morbidity both for the mother and the newborn in comparison with a successful vaginal birth or an elective repeat cesarean delivery. One of the most serious complications that might occur during the TOLAC procedure is uterine rupture; however, it is a rare condition for women who have had one previous cesarean delivery [2, 3, 10].

Several professional societies have supported TOLAC for appropriately selected women. The American College of Obstetricians and Gynecologists (ACOG, 2019), the Royal College of Obstetricians and Gynaecologists (RCOG, 2015), the Society of Obstetricians and Gynaecologists of Canada (SOGC, 2019), and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG, updated 2025) advise that TOLAC should be an option for women with a previous lower-segment cesarean who are suitable candidates [3, 4, 11, 12]. More recently, the International Federation of Gynecology and Obstetrics (FIGO) issued good practice recommendations on VBAC (2025) [13].

Little information exists on VBAC outcomes in the UAE. There was a recent study in the UAE involving a cohort of patients, which found that 83% of those eligible for TOLAC were able to give birth via a vaginal delivery, and it emphasized the role of cultural aspects and patients' preferences in the mode of delivery selected [14]. Another study in a tertiary hospital in the UAE described the characteristics and outcomes of patients with a successful VBAC [15]. Nevertheless, institution-specific data on TOLAC utilization, VBAC success rates, and reasons for unsuccessful TOLAC remain limited.

Clinical audit is an important approach for improving the quality of care provided in health care settings. It allows us to evaluate TOLAC efficiency, causes of failed trial of labor, and counseling for women [3–5, 16]. Audits are important when local information is limited.

In light of limited published data on VBAC in the United Arab Emirates, the current retrospective audit has been performed at Burjeel Medical City, Abu Dhabi, to investigate the incidence of TOLAC, the rate of VBAC success, and the frequency of emergency cesarean delivery among women with one prior lower-segment cesarean delivery who have delivered from January to December 2024, and to make a comparison of these results with published national and international data. Unlike studies reporting only VBAC success, this audit examines outcomes in all eligible women with one prior cesarean delivery to show TOLAC uptake alongside the VBAC success rate.

2. Materials and Methods

2.1. Study Design and Setting

This retrospective observational audit was conducted in the Department of Obstetrics and Gynecology at Burjeel Medical City, Abu Dhabi, UAE. It included all women with a singleton pregnancy at ≥37 weeks' gestation and one previous lower-segment cesarean section who delivered from 1st January to 31st December 2024 without any sampling technique. Women with two or more previous cesarean sections, a classic uterine scar, and multiple pregnancy were not considered in this audit. Women in whom a contraindication to vaginal delivery (like non-cephalic presentation or placenta previa) was found in the current pregnancy were not suitable for TOLAC and were kept in the denominator; these women had ERCS (Figure 1). In total, 128 women fulfilled the criteria for inclusion in this audit. The audit aimed to calculate the proportion of eligible women undergoing TOLAC, achieving VBAC, and having unsuccessful TOLAC.

Women who delivered by ERCS without a trial of labor were included in the denominator for TOLAC uptake but were not included in the calculation of the VBAC success rate.

2.2. Data Collection

Data were collected retrospectively from labor and delivery registers and from the hospital's computerized medical records system. Data on antenatal and intrapartum conditions were collected from patients' medical records, and clinical diagnoses were coded using the ICD-10 coding system. The Principal Investigator collected data retrospectively from the records using an Excel data collection form. The co-investigator verified the collected data against the labor and delivery register.

2.3. Definitions and Outcome Measures

TOLAC was defined as a planned attempt at vaginal birth after a previous cesarean section, regardless of whether assistance was needed at delivery. A woman was considered to have achieved VBAC if she delivered vaginally, including assisted vaginal delivery. Unsuccessful TOLAC was defined as emergency cesarean delivery after an attempted trial of labor. ERCS was

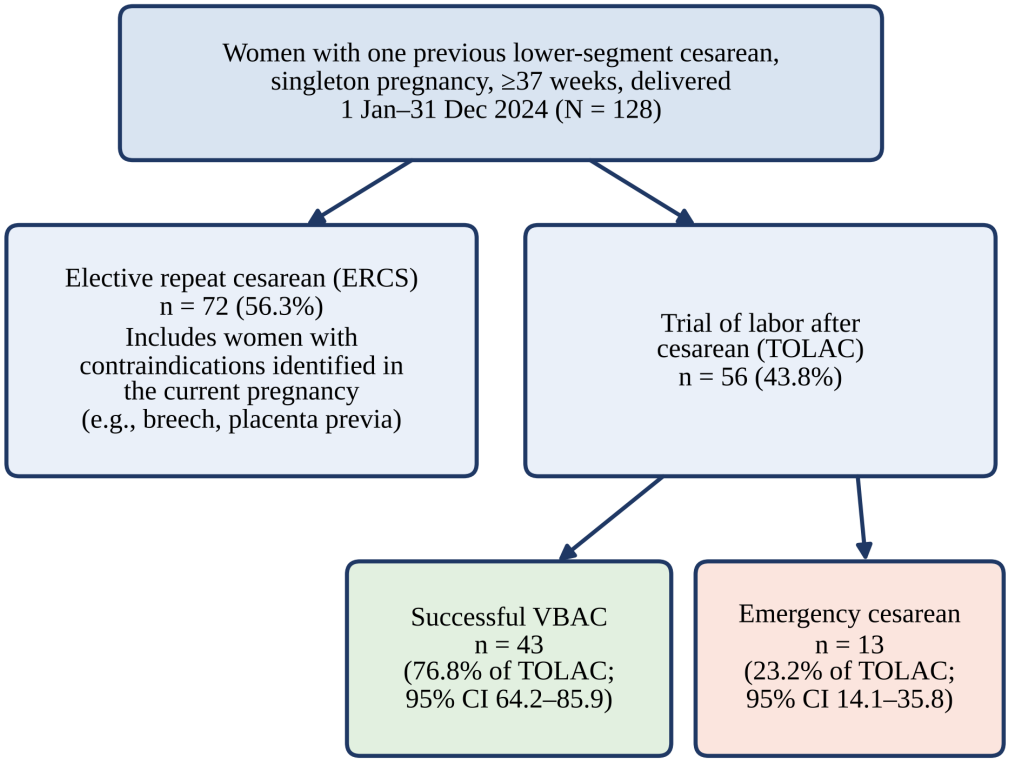


Figure 1: *Flowchart of audit, Burjeel Medical City, 2024 (N = 128).*

defined as a planned cesarean delivery performed without a trial of labor.

We calculated the TOLAC uptake rate as the percentage of all eligible women who underwent TOLAC. The VBAC success rate was calculated as the percentage of women who achieved vaginal delivery among those who underwent TOLAC. Rates are presented as percentages and are compared descriptively with published national and international rates.

2.4. Ethical Considerations

The Research Committee of Burjeel Medical City approved the study (Reference No. BH/REC/119/25). Because of the retrospective design and the use of anonymized medical records, the committee waived the requirement for informed consent. The study strictly maintained patient confidentiality, and all data were anonymized before analysis.

2.5. Statistical Analysis

Data were analyzed descriptively. We presented categorical outcomes (TOLAC uptake, ERCS, VBAC success, and emergency cesarean delivery after unsuccessful TOLAC) as frequencies and percentages. We calculated 95% confidence intervals for proportions using the Wilson score method. We did not perform hypothesis testing, and we present monthly figures descriptively without inferential comparison. We entered and organized data in Microsoft Excel and analyzed them in IBM SPSS Statistics. No missing data were identified for the variables included in the analysis.

3. Results

The 2024 audit included 128 women with one previous cesarean delivery (Figure 1). Of these, 56 (43.8%; 95% CI 35.5–52.4%) underwent TOLAC and 72 (56.3%; 95% CI 47.6–64.5%) underwent ERCS. Table 1 presents the monthly distribution of TOLAC, successful VBAC, and ERCS. Most women who underwent ERCS had other obstetric indications for repeat cesarean section. Some ERCS were performed because of contraindications or other indications identified in the current pregnancy, such as breech presentation, placenta previa, and suspected fetal macrosomia.

Monthly TOLAC uptake and VBAC success varied during the year, but the monthly figures are based on small numbers, and we did not make inferential comparisons. The highest proportion of women undergoing TOLAC was 66.7% in June (8/12), and the lowest was 10.0% in November (1/10). The monthly VBAC success proportion was lowest in May (40.0%; 2/5);

in November, the single TOLAC resulted in VBAC (1/1). We compare the overall VBAC success rate of 76.8% (95% CI 64.2–85.9%) with rates reported in guidelines and published studies in Table 2.

Table 1: Monthly distribution of successful VBAC, TOLAC, and ERCS among women with one previous cesarean delivery in 2024 (N = 128)

Month	Successful VBAC among TOLAC, n (%)	TOLAC, n (%)	ERCS, n (%)
January	4 (80.0)	5 (55.6)	4 (44.4)
February	2 (66.7)	3 (37.5)	5 (62.5)
March	3 (75.0)	4 (44.4)	5 (55.6)
April	3 (75.0)	4 (57.1)	3 (42.9)
May	2 (40.0)	5 (38.5)	8 (61.5)
June	7 (87.5)	8 (66.7)	4 (33.3)
July	7 (87.5)	8 (50.0)	8 (50.0)
August	4 (80.0)	5 (35.7)	9 (64.3)
September	5 (83.3)	6 (40.0)	9 (60.0)
October	4 (80.0)	5 (50.0)	5 (50.0)
November	1 (100.0)	1 (10.0)	9 (90.0)
December	1 (50.0)	2 (40.0)	3 (60.0)
Total	**43 (76.8)**	**56 (43.8)**	**72 (56.3)**

Values are presented as n (%). The percentage of successful VBAC is calculated among women who underwent TOLAC in that month. TOLAC and ERCS percentages are calculated among all eligible women in that month. Monthly numbers are small, so interpret percentages with caution. The Total row gives the percentage of all 128 eligible women (TOLAC and ERCS) and of the 56 women who underwent TOLAC (successful VBAC). VBAC, vaginal birth after cesarean; TOLAC, trial of labor after cesarean; ERCS, elective repeat cesarean section.

Table 2: Reported VBAC success rates in selected guidelines and studies compared with this audit. Rates are those stated in each source; populations and definitions differ.

Source (reference)	Reported VBAC success rate
ACOG Practice Bulletin No. 205, 2019 [3]	60–80%
RCOG Green-top Guideline No. 45, 2015 [4]	72–75%
RANZCOG C-Obs 38, version 4.1, 2025 [12]	Approximately 65–70% across the studies reviewed (range 50–79%)
FIGO good practice recommendations, 2025 [13]	60–80%
UAE cohort study [14]	83% among women eligible for TOLAC
This audit (Burjeel Medical City, 2024)	76.8% (95% CI 64.2–85.9%)

Of the 56 women who underwent TOLAC, 43 achieved VBAC (76.8%; 95% CI 64.2–85.9%), whereas 13 (23.2%; 95% CI 14.1–35.8%) required emergency cesarean delivery. Documented indications for unsuccessful TOLAC included scar tenderness, failure of labor to progress, and failed induction of labor (Table 3).

Table 3: Documented indications for emergency cesarean delivery after unsuccessful TOLAC (n = 13)

Indication for emergency cesarean	n (%)
Scar tenderness	3 (23.1)
Failure of labor to progress	7 (53.8)
Failed induction of labor	1 (7.7)
Other documented indication(s)	2 (15.4)
Total	**13 (100.0)**

4. Discussion

This audit examined TOLAC uptake, VBAC success, and the reasons for unsuccessful TOLAC among women with one previous lower-segment cesarean who delivered at Burjeel Medical City, Abu Dhabi, in 2024. Of 128 eligible women, 56 (43.8%) underwent TOLAC and 72 (56.3%) underwent ERCS. Among the women who underwent TOLAC, 43 (76.8%) achieved VBAC, and 13 (23.2%) required emergency cesarean delivery. The VBAC success rate was comparable to rates reported in international guidance [3, 4, 12, 13]. Because this was a descriptive single-center audit, the findings do not establish the effectiveness or safety of the institution's VBAC practice.

Of the women with a previous cesarean, 43.8% underwent TOLAC. Direct comparison with other centers is limited because eligibility criteria and case mix differ between institutions. TOLAC uptake may be influenced by patient preference, counseling, and clinicians' attitudes toward VBAC, but this audit did not measure these factors. The ERCS group also includes women in whom a contraindication to vaginal birth, such as non-cephalic presentation or placenta previa, was identified in the current pregnancy, which would be expected to increase the ERCS proportion [3, 4, 12].

The VBAC success rate in this audit was 76.8% (95% CI 64.2–85.9%). ACOG reports that 60% to 80% of women who attempt TOLAC achieve vaginal birth, depending on patient selection [3]; RCOG reports a success rate of 72% to 75% [4]; the RANZCOG guideline reports approximately 65% to 70% across the studies it reviewed [12]; and the FIGO recommendations describe success rates of 60% to 80% [13] (Table 3). The rate observed here falls within or slightly above these ranges, although the confidence interval is wide because few women underwent TOLAC. Because success rates depend strongly on patient selection, compare results with other populations with caution. Regionally, a UAE cohort study reported that among the 86% of women eligible for TOLAC, 83% delivered by VBAC [14].

The recent FIGO Good Practice Recommendations describe VBAC as a way to reduce unnecessary repeat cesarean deliveries and emphasize individualized counseling that considers the likelihood of success, future pregnancy plans, and patient preferences. They also emphasize facility readiness and continuous monitoring during labor [13]. The VBAC success rate observed in this audit is consistent with the success rates described in these recommendations.

Our findings are consistent with recent evidence from the UAE. In a cohort study in the UAE, Tariq and Singh observed that among the 86% of women eligible for TOLAC, 83% delivered successfully by VBAC [14]. Another UAE tertiary-care study reported favorable outcomes among women who achieved successful VBAC [15]. The VBAC success rate in our audit (76.8%) is similar to these regional reports, suggesting that VBAC is feasible in the regional healthcare setting for appropriately selected women. However, this audit did not assess maternal or neonatal safety outcomes, so these data cannot support conclusions about safety.

This audit did not evaluate predictors of VBAC success, so the reasons for the observed success rate remain unclear. The literature has proposed patient selection, adherence to institutional protocols, and appropriate intrapartum monitoring as factors that influence VBAC outcomes [13, 17, 18], but these were not assessed here. Published studies have also reported that induction of labor is associated with a lower likelihood of VBAC and a higher rate of emergency cesarean delivery [3, 4, 9, 19]. Failed induction was one documented reason for unsuccessful TOLAC in this audit, but outcomes were not analyzed by labor onset, so we could not test the association.

Among women with unsuccessful TOLAC, the documented indications for emergency cesarean delivery were scar tenderness, failure of labor to progress, and failed induction (Table 2). In the literature, dystocia and non-reassuring findings suggestive of scar complications are among the main reasons for unsuccessful TOLAC [3–5, 10, 20]. Emergency cesarean after TOLAC has been associated with higher maternal and neonatal morbidity than either VBAC or elective repeat cesarean delivery [3–5]. Guidelines therefore recommend that TOLAC be undertaken in facilities where emergency obstetric services are readily available, with close monitoring of the mother and fetus during labor [3, 4, 12]. This audit did not evaluate these safety aspects.

TOLAC uptake and VBAC success varied from month to month, with the highest proportion of TOLAC in June and the lowest in November (Table 1). Because the monthly numbers were small, these differences should not be interpreted as trends or as evidence of seasonal variation. We did not evaluate possible contributors, such as case mix and clinician counseling.

These findings may inform local service planning and counseling. Current guidance emphasizes antenatal counseling, careful assessment of eligibility, and structured labor management [3, 4, 12, 13], and recommends that clinicians provide balanced information on both TOLAC and ERCS so women can make informed decisions [3, 4, 21, 22]. Whether a higher rate of VBAC would reduce overall cesarean rates and cesarean-related morbidity at this institution cannot be determined from these data.

This audit did not evaluate maternal or neonatal safety outcomes such as postpartum hemorrhage, uterine rupture, or NICU admission. The findings therefore reflect TOLAC uptake and VBAC success only and do not provide a safety comparison between TOLAC and ERCS.

A strength of this audit is that it describes practice at a tertiary referral center in the UAE and includes all eligible women who gave birth during the audit period. The results also add to the limited regional literature on TOLAC and VBAC rates.

In this audit, the observed VBAC success rate was comparable with published benchmarks. The literature suggests that appropriate patient selection, counseling, and intrapartum monitoring are important for safe VBAC practice, and measures such as structured counseling, informed consent, clinical audit, and, where appropriate, mechanical cervical ripening with Foley catheters have been discussed as ways to support VBAC [3, 4, 9, 10, 20]. This audit did not assess whether any of these measures influenced outcomes at the study institutions.

5. Limitations and Future Perspectives

Some of the limitations of this study include the following. As an audit study, it is subject to bias arising from information availability and completeness. This study did not consider variables such as maternal age, parity, vaginal delivery prior to the previous C/S, indication for the previous C/S, body mass index, inter-delivery interval, or whether labor was spontaneous or induced. Thus, we could not identify factors predicting TOLAC utilization and success, and we could not compare the two groups (TOLAC and ERCS). Another limitation is the single-center design at a private tertiary care hospital.
The sample size was also small, especially among women who had undergone TOLAC; therefore, confidence intervals were too wide to identify independent predictors of VBAC success, and monthly figures are based on very small numbers. Furthermore, clinicians selected women who had undergone TOLAC as the best candidates for VBAC; therefore, the VBAC success rate refers to these selected women. Finally, the audit focused on delivery outcomes; maternal and neonatal complications were not considered, so it does not compare the safety of TOLAC and ERCS.
Future research should include other centers and larger sample sizes to validate these results. In addition, prospective studies that consider maternal background, obstetric risk factors, patient preference, and maternal and neonatal outcomes will help identify the determinants of VBAC success.

6. Conclusion

In this single-center retrospective audit, the VBAC success rate was comparable to published benchmarks, suggesting that TOLAC can be a feasible option for appropriately selected women in this setting. Because this was a descriptive audit, the findings do not identify predictors of VBAC success or compare maternal and neonatal safety between TOLAC and ERCS. Multicenter studies with larger samples and safety outcomes are needed.

7. Declarations

Ethics Approval and Consent to Participate

The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. The Burjeel Medical City Research Ethics Committee approved the study (Reference No. BH/REC/119/25). Because of the study's retrospective nature and the use of anonymized medical records, the ethics committee waived the requirement for informed consent.

Consent for Publication

Not applicable

Data Availability Statement

The datasets used and/or analyzed during this study are available upon reasonable request from the corresponding author.

Conflicts of Interest

The authors declare no conflicts of interest.

Funding

This research received no funding.

Author Contributions

SBS and RN conceived and designed the study, performed data collection and analysis, interpreted the data and results, and wrote the manuscript. MA reviewed and edited the manuscript. SBS reviewed and edited the final manuscript. The final version of the manuscript has been read and approved by all authors.

Acknowledgments

The authors thank the staff of the Department of Obstetrics and Gynecology and the Medical Records Department at Burjeel Medical City for supporting data collection and record retrieval for this study.

Use of Artificial Intelligence

During manuscript preparation, ChatGPT was used for language editing and improvement of clarity. The authors reviewed and edited all outputs and take full responsibility for the final content.

8. Abbreviations

The following abbreviations are used in this manuscript:

ACOG	American College of Obstetricians and Gynecologists
CS	Cesarean Section
ERCS	Elective Repeat Cesarean Section
ICD-10	International Classification of Diseases, 10th Revision
LSCS	Lower Segment Cesarean Section
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynecologists
RCOG	Royal College of Obstetricians and Gynecologists
SOGC	Society of Obstetricians and Gynecologists of Canada
TOLAC	Trial of Labor After Cesarean
UAE	United Arab Emirates
VBAC	Vaginal Birth After Cesarean
WHO	World Health Organization

References

[1] Betrán, A.P.; Ye, J.; Moller, A.B.; Souza, J.P.; Zhang, J. Trends and projections of caesarean section rates: global and regional estimates. *BMJ Glob Health* **2021**, 6(6), e005671. [CrossRef]

[2] Vogel, J.P.; Betrán, A.P.; Vindevoghel, N.; Souza, J.P.; Torloni, M.R.; Zhang, J.; *et al*. Use of the Robson classification to assess caesarean section trends in 21 countries: A secondary analysis of two WHO multicountry surveys. *Lancet Glob Health* **2015**, 3(5), e260–e270. [CrossRef]

[3] American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 205: Vaginal birth after cesarean delivery. *Obstet Gynecol.* **2019**, 133(2), e110–e127. Available from: https://journals.lww.com/greenjournal/abstract/10.1097/aog.0000000000003078~acog-practice-bulletin-no-205-vaginal-birth-after-cesarean?redirectionsource=fulltextview. Accessed on 9 November 2026.

[4] Royal College of Obstetricians and Gynaecologists. Birth after previous caesarean birth (Green-top Guideline No. 45). London: *RCOG*; **2015**. Available from: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/birth-after-previous-caesarean-birth-green-top-guideline-no-45/. Accessed on 9 November 2026.

[5] Qiu, L.; Zhu, J.; Lu, X. The safety of trial of labor after cesarean section (TOLAC) versus elective repeat cesarean section (ERCS): a systematic review and meta-analysis. *J Matern Fetal Neonatal Med* **2023**, 36(1), 2214831. [CrossRef]

[6] Fobelets, M.; Beeckman, K.; Faron, G.; Daly, D.; Begley, C.; Putman, K. Vaginal birth after caesarean versus elective repeat caesarean delivery after one previous caesarean section: A cost-effectiveness analysis in four European countries. *BMC Pregnancy Childbirth* **2018**, 18(1), 92. [CrossRef]

[7] Silver, R.M.; Landon, M.B.; Rouse, D.J.; Leveno, K.J.; Spong, C.Y.; Thom, E.A.; *et al.* Maternal morbidity associated with multiple repeat cesarean deliveries. *Obstet Gynecol.* **2006**, 107(6), 1226–1232. [CrossRef]

[8] Wingert, A.; Hartling, L.; Sebastianski, M.; Johnson, C.; Featherstone, R.; Vandermeer, B.; *et al.* Clinical interventions that influence vaginal birth after cesarean delivery rates: Systematic review and meta-analysis. *BMC Pregnancy Childbirth* **2019**, 19(1), 529. [CrossRef]

[9] Grobman, W.A. Rates and prediction of successful vaginal birth after cesarean. *Semin Perinatol* **2010**, 34(4), 244–248. [CrossRef]

[10] Landon, M.B.; Hauth, J.C.; Leveno, K.J.; Spong, C.Y.; Leindecker, S.; Varner, M.W.; et al. Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. *N Engl J Med* **2004**, 351(25), 2581–2589. [CrossRef]

[11] Dy, J.; DeMeester, S.; Lipworth, H.; Barrett, J. No. 382-Trial of Labour After Caesarean. *J Obstet Gynaecol Can* **2019**, 41(7), 992–1011. [CrossRef]

[12] Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Birth after caesarean (C-Obs 38), version 4.1. Melbourne: *RANZCOG*; August **2025**. Available from: https://ranzcog.edu.au/wp-content/uploads/Birth-After-Caesarean.pdf. Accessed on 07 October 2026.

[13] Barnea, E.R.; Ramasauskaite, D.; Ubom, A.E.; Di Simone, N.; Mueller, M.; Borovac-Pinheiro, A.; *et al.* FIGO good practice recommendations for vaginal birth after cesarean section. *International Journal of Gynecology & Obstetrics* **2025**, 171(1), 17–31. [CrossRef]

[14] Tariq, S.; Singh, N. Exploring vaginal birth after cesarean: Success rates and cultural decisions in the United Arab Emirates. *Cureus* **2024**, 16(2), e54880. [CrossRef]

[15] Tom, A.M.; Prince, C.M.; Ali, S.S.; Muhammed, S.; Sreejith, A. Patient Characteristics and Obstetric Outcomes of Successful Vaginal Birth after Cesarean Section: A Retrospective Study in a Tertiary Hospital in United Arab Emirates. *Womens Health Rep* **2025**, 6(1). [CrossRef]

[16] Ogrinc, G.; Davies, L.; Goodman, D.; Batalden, P.; Davidoff, F.; Stevens, D. SQUIRE 2.0 (Standards for Quality Improvement Reporting Excellence): Revised publication guidelines from a detailed consensus process. *BMJ Qual Saf* **2016**, 25(12), 986–992. [CrossRef]

[17] Wu, Y.; Kataria, Y.; Wang, Z.; Ming, W.K.; Ellervik, C. Factors associated with successful vaginal birth after a cesarean section: A systematic review and meta-analysis. *BMC Pregnancy Childbirth* **2019**, 19(1), 360. [CrossRef]

[18] Habak, P.J.; Khaparde, G.; Vadakekut, E.S. Vaginal birth after cesarean delivery. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; **2025**. Available from: https://www.ncbi.nlm.nih.gov/books/NBK507844/. Accessed on 09 November 2026.

[19] Germano, C.; Mappa, I.; Cromi, A.; Busato, E.; Incerti, M.; Lojacono, A.; *et al*. Induction of labor in women with previous cesarean section and unfavorable cervix: A retrospective cohort study. *Healthcare (Basel)* **2023**, 11(4), 543. [CrossRef]

[20] Phillips, J.M.; Polyakov, D.; Amdur, R.L.; Ahmadzia, H.K. Trial of labor after cesarean: Maternal and neonatal outcomes from the Consortium on Safe Labor. *J Neonatal Perinatal Med* **2024**, 17(1), 1–5. [CrossRef]

[21] Sandall, J.; Tribe, R.M.; Avery, L.; Mola, G.; Visser, G.H.; Homer, C.S.; *et al*. Short-term and long-term effects of caesarean section on the health of women and children. *Lancet* **2018**, 392(10155), 1349–1357. [CrossRef]

[22] Begley, K.; Daly, D.; Panda, S.; Begley, C. Shared decision-making in maternity care: Acknowledging and overcoming epistemic defeaters. *J Eval Clin Pract* **2019**, 25(6), 1113–1120. [CrossRef]