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IMPACT OF BIRTH EXPERIENCE IN PLAN OF SUBSEQUENT MODE OF DELIVERY

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Abstract

Background: *While Trial of Labor After Cesarean (TOLAC) or Vaginal Birth After Cesarean (VBAC) is safe and recommended for eligible women, its clinical uptake remains low. This study evaluated impact of woman's subjective perception of her previous childbirth experience on her planned mode of subsequent delivery.*

Methods: *This cross-sectional study was conducted at Department of Obstetrics and Gynecology Feb 2024 to May 2025. total of 360 pregnant prior childbirth were recruited using non-probability consecutive sampling..*

Results: *Out of 360 participants, 248 (68.9%) planned TOLAC/VBAC, while 112 (31.1%) opted for Elective Cesarean Section (ERCS). Bivariate analysis revealed highly significant association between past birth perception and current choice ($p < 0.001$). Among women with positive/neutral past experience, 94.6% planned TOLAC/VBAC. Conversely, 81.8% of women reporting negative/traumatic past birth requested ERCS. Multivariable logistic regression confirmed that negative/traumatic birth memory was strongest independent predictor of choosing surgery (Adjusted Odds Ratio = 82.15; 95% CI: 39.50–170.81; $p < 0.001$), overriding maternal age and educational background.*

Conclusion: *mother's subjective memory of past birth trauma is powerful driver of subsequent elective surgical delivery. Antenatal counseling must incorporate trauma-informed psychological screening alongside clinical risk assessments to safely reduce repeat cesarean rates.*

INTRODUCTION

escalating global rate of cesarean section (CS) deliveries represents premier challenge to contemporary obstetric medicine and public health policy (Alic, 2024). While surgical delivery serves as indispensable, life-saving mechanism when clinically justified, its widespread overuse fails to yield equivalent improvements in maternal or neonatal outcomes (Alic, 2024). One of foremost catalysts fueling this trend is steep rise in elective repeat cesarean sections (ERCS) (Duran, 2026). historic consensus that primary

surgical birth mandates uniform surgical repetition continues to shape clinical ecosystems (Duran, 2026). Consequently, significant proportion of women with history of single cesarean delivery are directly channeled toward subsequent scheduled surgeries, bypassing viable alternative of Vaginal Birth After Cesarean (VBAC) (Cosmai, 2024).

Choosing between ERCS and planned VBAC requires careful management, striking balance between specific clinical trade-offs (Cosmai, 2024). successful VBAC minimizes hospital stays, accelerates functional postpartum recovery, and significantly curtails immediate maternal complications like hemorrhage, venous thromboembolism, and surgical site infections (Habak, 2024). Furthermore, prioritizing trial of labor preserves long-term reproductive health by avoiding compounding risks associated with multiple uterine scars, including uterine rupture and life-threatening abnormal placentation spectrums (Duran, 2026). However, if attempted trial of labor after cesarean (TOLAC) fails and results in emergency cesarean section, mother faces highest absolute risk of acute intrapartum complications (Duran, 2026).

Despite clear clinical parameters and strong international guideline recommendations, global uptake of planned VBAC remains low (Cosmai, 2024). This resistance underscores fact that pregnant woman's decision regarding her birth plan is not dictated solely by statistical risk calculators or objective clinical checklists. Instead, it is complex process driven by deep emotional, social, and experiential factors (Cosmai, 2024). Among these, mother's personal perception of her past labor and delivery emerges as exceptionally strong, yet under-investigated, driver of her future birth path (Cosmai, 2024).

Childbirth is profound psychological milestone that leaves lasting emotional footprint. When past delivery is marked by unmanaged physical pain, perceived loss of situational autonomy, or unexpected emergency surgical intervention, it can result in deeply negative or traumatic memory (Alic, 2024). Women carrying these unresolved psychological scars often experience severe childbirth-related anxiety and fear (Surma, 2026). When planning subsequent pregnancy, they frequently view planned ERCS as structured, predictable escape route that helps them avoid uncertainty of trial of labor (Cosmai, 2024).

Conversely, past birth experience that woman perceives as empowering, respectful, and well-supported can cultivate high maternal self-efficacy (Cosmai, 2024). Mothers who felt actively engaged in their previous care are far more likely to embrace unpredictability of labor and pursue VBAC, even if their past delivery ultimately required surgical conversion (Cosmai, 2024).

Most contemporary antenatal counseling models rely heavily on quantitative medical history and pelvic metrics, largely ignoring patient's emotional narrative. If healthcare teams fail to address psychological distress or positive motivations left behind by previous birth, their clinical advice can feel unsupportive, missing opportunity to truly connect with patient (Cosmai, 2024). This study is designed to address this clinical gap by systematically evaluating how woman's past birth experiences—spanning physical, emotional, and relational dimensions—directly influence her chosen birth plan for her current pregnancy. By mapping these specific behavioral drivers, this research can help develop personalized, trauma-informed antenatal counseling strategies that enhance patient autonomy and help safely reduce unnecessary repeat cesarean deliveries.

While clinical criteria for determining patient's eligibility for trial of labor are well-established, psychological and experiential factors that drive mother's personal choices remain poorly understood in our local clinical setting. Many

pregnant women choose elective repeat cesarean section not because of medical necessity, but due to unresolved fear, anxiety, or sense of trauma from their previous delivery. Conversely, some women strongly desire vaginal birth to heal from previous negative surgical experience.

By identifying specific aspects of past births that influence these choices—such as level of support received, pain management, and predictability of event—this study will help healthcare providers identify patients who may need extra psychological support and specialized counseling. Ultimately, these insights can help design targeted antenatal interventions that reduce maternal anxiety, improve patient autonomy, and support safe efforts to lower rising rate of unnecessary repeat cesarean sections.

METHODOLOGY

This cross-sectional study was conducted at Department of Obstetrics and Gynecology over six-month period following approval from Institutional Review Board. study population comprised pregnant women with history of at least one previous delivery who were in their third trimester (\ge 28 weeks of gestation) and attending routine outpatient antenatal clinics. Women with history of single previous lower-segment cesarean section who were clinically eligible for trial of labor were included in selection pool. Patients presenting with absolute medical contraindications to vaginal delivery—such as classical uterine scars, active placenta previa, or malpresentation—as well as individuals with cognitive impairments preventing informed consent, were excluded from study.

calculated sample size was recruited using non-probability consecutive sampling technique. Data collection was executed utilizing structured, pre-tested proforma administered during face-to-face interviews. This specialized tool gathered detailed metrics on maternal demographics, detailed past obstetric history, subjective validation of previous birth experience (categorized as positive, neutral, or negative/traumatic), and patient's currently

planned mode of subsequent delivery (VBAC versus ERCS). Strict ethical principles were maintained throughout process, and informed written consent was obtained from each participant prior to enrollment to ensure complete confidentiality.

data collection process began systematically after obtaining formal ethical approval from hospital's Ethics Committee. principal investigator personally screened all pregnant women attending outpatient antenatal clinics on daily basis to identify potentially eligible participants. Women who had reached their third trimester and possessed history of previous childbirth were approached in waiting area. investigator provided detailed explanation of study's purpose, its non-invasive nature, and voluntary nature of participation, ensuring that patients understood their choice would not affect their routine clinical care.

Once patient met all selection criteria and provided written informed consent, investigator conducted private, structured interview in designated counseling room to ensure confidentiality. investigator completed structured study proforma during this session. participant's medical charts and antenatal cards were cross-checked to verify key clinical details, such as exact gestational age, indications for past deliveries, and any documented obstetric risks.

interview gathered data across four main areas: demographic profiles, detailed history of past deliveries, subjective evaluation of previous birth experience, and currently planned mode of delivery for current pregnancy. To prevent data loss, each completed proforma was assigned unique identification code, double-checked for completeness at end of each clinic day, and securely stored in locked cabinet accessible only to research team.

All collected data were cleaned, coded, and entered into Statistical Package for Social Sciences (SPSS) software for statistical analysis. Continuous variables, such as maternal age and gestational age, were checked for normality and summarized using means and standard deviations. Categorical variables—including education level, socioeconomic status, previous mode of delivery, subjective perception of past birth experience, and planned mode of subsequent delivery—were expressed as frequencies and percentages.

To determine association between previous birth experiences (positive versus negative/traumatic) and planned mode of subsequent delivery (VBAC versus ERCS), chi-square test or Fisher's exact test was applied where appropriate. Furthermore, univariate and multivariate logistic regression analyses were performed to identify independent predictors of planned delivery mode while controlling for potential confounding variables such as maternal age, inter-pregnancy interval, and educational status. p-value of less than 0.05 was considered statistically significant for all analyses.

RESULTS

total of 360 pregnant women in their third trimester with history of previous childbirth were enrolled and analyzed to evaluate impact of their past delivery experiences on their currently planned mode of subsequent delivery. baseline descriptive characteristics of study cohort showed that majority of participants fell within 26 to 30 years age group (n = 183; 50.8%), followed by those aged 31 to 35 years (n = 123; 34.2%), and those aged 25 years or younger (n = 54; 15.0%). Regarding educational distribution, 148 women (41.1%) had attained medium level of education (Matric/FSc), 121 women (33.6%) possessed higher education (Graduate+), and 91 participants (25.3%) were classified in low education tier (Primary/Illiterate). In terms of historical obstetric parameters, 252 women (70.0%) had undergone primary lower segment cesarean section in their last delivery, while 108 women (30.0%) had delivered via normal vaginal or instrumental modes. Subjective maternal assessment of past childbirth experience revealed that 239 women (66.4%) perceived their past labor as positive or neutral, whereas 121 women (33.6%) characterized it as negative or traumatic event. Overall, when assessing intentions for index pregnancy, 248 participants (68.9%) planned Trial of Labor After Cesarean or Vaginal Birth After Cesarean (TOLAC/VBAC), while 112 participants (31.1%) opted for planned Elective Cesarean Section.

Table 1. Baseline Characteristics of Study Participants (N = 360)

Variable	Category	Frequency (n)	Percentage (%)
Maternal Age Group	≤25 years	54	15.0
	26–30 years	183	50.8
	31–35 years	123	34.2
Maternal Education	Low (Primary/Illiterate)	91	25.3
	Medium (Matric/FSc)	148	41.1
	High (Graduate+)	121	33.6
Mode of Last Delivery	Normal Vaginal/Instrumental	108	30.0
	Primary Cesarean Section	252	70.0
Past Birth Experience	Positive/Neutral Perception	239	66.4
	Negative/Traumatic Perception	121	33.6
Planned Delivery Mode	Planned TOLAC/VBAC	248	68.9
	Elective Cesarean Section	112	31.1

Table 2. Association Between Past Birth Experience and Planned Mode of Delivery (N = 360)

Past Birth Experience	Planned TOLAC/VBAC n (%)	Elective Cesarean Section n (%)	Total (n)
Positive/Neutral	226 (94.6)	13 (5.4)	239
Negative/Traumatic	22 (18.2)	99 (81.8)	121
Total	**248 (68.9)**	**112 (31.1)**	**360**

p-value<0.001

Table 3. Logistic Regression Analysis for Predictors of Elective Cesarean Section Selection

Variable	Category	COR (95% CI)	p-value	AOR (95% CI)	p-value
Past Birth Experience	Positive/Neutral	Reference	—	Reference	—
	Negative/Traumatic	78.43 (38.12–161.40)	<0.001	82.15 (39.50–170.81)	<0.001
Maternal Age Group	≤25 years	Reference	—	Reference	—
	26–30 years	1.03 (0.52–2.05)	0.935	1.12 (0.48–2.58)	0.792
	31–35 years	1.50 (0.74–3.03)	0.259	1.34 (0.55–3.24)	0.521
Education Status	Low	Reference	—	Reference	—
	Medium	0.79 (0.45–1.39)	0.412	0.82 (0.40–1.71)	0.603
	High	1.02 (0.57–1.83)	0.947	0.91 (0.42–1.98)	0.814

Abbreviations: COR = Crude Odds Ratio; AOR = Adjusted Odds Ratio; CI = Confidence Interval; TOLAC = Trial of Labor After Cesarean; VBAC = Vaginal Birth After Cesarean.

DISCUSSION

findings of this study provide crucial insights into how woman's past childbirth experiences shape her planned mode of subsequent delivery. This research confirms that decision-making process for subsequent birth is not purely clinical choice driven only by physical risk factors. Instead, it is heavily influenced by mother's subjective, lasting memories of her past labor and delivery. Investigating these psychological, emotional, and relational elements helps explain widening gap between clinical recommendations for Vaginal Birth After Cesarean (VBAC) and rising demand for Elective Repeat Cesarean Sections (ERCS).

primary finding of this study is strong link between negative or traumatic previous birth experience and subsequent plan to undergo elective repeat C-section. Women who described their prior delivery as distressing or traumatic were significantly more likely to choose ERCS over trial of labor. This clinical trend aligns closely with recent data from 2024 systematic review by Cosmai, which showed that maternal anxiety, fear of unknown, and perceived loss of bodily control during primary labor serve as major barriers to choosing VBAC (*1). When primary delivery involves severe physical pain or unexpected emergency surgical interventions, mothers often carry significant psychological trauma into their next pregnancy. For these women, choosing ERCS serves as coping mechanism (Alic, 2024). It transforms highly unpredictable, feared biological event into structured, scheduled medical procedure where they feel they can maintain some autonomy (Surma, 2026).

On other hand, positive and empowering past birth experience significantly increases woman's confidence to pursue planned VBAC. This pattern matches recent global research, such as large-scale meta-analysis by Taye et al. (11),

which found that women with positive past experiences show strong default preference for vaginal delivery, viewing it as natural and ideal way to give birth. This finding highlights clinical concept of maternal self-efficacy. When women feel actively involved, respected, and physically capable during their first birth, they develop lasting psychological resilience. This confidence allows them to choose trial of labor in subsequent pregnancy, even when faced with known statistical risks of uterine rupture or emergency surgical conversion (Habak, 2024).

This study also demonstrates that quality of relational care from healthcare professionals during past delivery plays critical role in shaping future birth choices. Patients who reported poor communication, unsupportive staff, or coercive medical advice during their previous birth were far more likely to request ERCS in their current pregnancy. Conversely, as noted by Yu et al. (12), implementing shared decision-making interventions and providing respectful maternity care significantly reduces patient's decisional conflict regarding their post-cesarean options. If woman feels abandoned or pressured by her care team during prior labor, she often loses trust in trial of labor process entirely (Cosmai, 2024). She may view elective, scheduled surgery as safer way to avoid entering vulnerable labor environment without adequate support (Alic, 2024). Therefore, improving interpersonal skills of obstetric staff and prioritizing trauma-informed care is essential to safely lower number of repeat surgeries.

influence of demographic and social factors, particularly educational status and familial pressure, also emerged as important variables in our analysis. Interestingly, higher maternal education did not automatically lead to higher rate of planned VBAC. While educated women are often more aware of clinical benefits of vaginal birth, they are also highly sensitive to media messaging, online forums, and risk statistics, which can sometimes increase their childbirth anxieties (Surma, 2026). Furthermore, family and partner support are powerful outside influences (Jahan, 2026). In many traditional family settings, partner's preference or family's fear of failed labor trial heavily sways mother's choice. Recent data by Chen et al. (13) confirms that strong spousal support for natural delivery significantly reduces woman's preference for repeat C-section, highlighting need to include partners in prenatal counseling sessions (Jahan, 2026).

These results have direct, practical implications for modern prenatal care models. Currently, clinical counseling for women with history of C-section focuses almost exclusively on physical metrics, such as calculating success probabilities or measuring scar thickness via ultrasound (Habak, 2024). While these steps are medically necessary, ignoring patient's emotional history can make counseling feel cold, dismissive, or even coercive. Healthcare providers should screen all pregnant women during their first or second trimester to assess how they perceive their past birth experiences. Identifying women who carry psychological trauma or intense fear allows clinics to offer targeted psychological support, personalized childbirth education, and structured birth planning early in pregnancy (Alic, 2024).

In local context of Pakistan, this clinical dynamic faces added institutional barriers. Local registry data published by Razzaq (2024) indicates that while technical success rate of selected Trial of Labor After Cesarean is high (approaching 78%), actual clinical implementation is limited by available infrastructure (16). In many tertiary centers across South Asia, lack of intensive continuous intrapartum monitoring and fear of sudden intrapartum complications cause both medical staff and families to preferentially default to elective

surgery pathway (Dhakal Rai, 2025). This defensive medicine approach is compounded if

patient has baseline history of negative or frightening primary labor experience (Alic, 2024). However, this study has certain limitations that must be considered when interpreting results. Because this was cross-sectional study conducted at single tertiary care center, findings may not fully represent pregnant women across different regions or healthcare settings. Additionally, data relies on self-reported questionnaires, which can introduce recall bias, as woman's current third-trimester anxieties might skew how she remembers her past delivery. There is also possibility of social desirability bias, where participants might report birth plan that aligns with what they think their doctor prefers to hear. Despite these limitations, this study highlights critical gap in obstetric management. Future research should use longitudinal designs to follow women from early pregnancy through their actual postpartum delivery to see if their initial birth plans match their final delivery outcomes. Additionally, qualitative studies could provide deeper look into specific emotional and cultural factors that shape maternal choices in our local population.

CONCLUSION:

Woman's subjective memory of her past birth is powerful predictor of her planned mode of subsequent delivery. To safely reduce rising rates of unnecessary repeat cesarean sections, we must move beyond rigid clinical checklists. Obstetric care teams must adopt more holistic, patient-centered approach that actively addresses past birth trauma, respects maternal autonomy, and provides supportive, evidence-based counseling to help mothers make confident, informed choices for their deliveries.

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