International Journal of Women's Health

Dovepress
Taylor & Francis Group

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LETTER

Critique on "Investigating the Success Rate of Vaginal Delivery After Cesarean Section and Its Associated Factors in Afghan Women: Insights from a Maternity Hospital in Kabul" [Letter]

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Dear editor

We read with interest the article by Golzareh et al, titled "Investigating the Success Rate of Vaginal Delivery After Cesarean Section and Its Associated Factors in Afghan Women: Insights from a Maternity Hospital in Kabul".[1] While this study provides preliminary insight into VBAC outcomes in an Afghan setting, we believe that several methodological and analytical limitations undermine the reliability and applicability of its conclusions.

Selection Bias and Generalizability

The exclusive inclusion of women deemed eligible for a trial of labor after cesarean (TOLAC) introduces significant selection bias and likely overestimates the VBAC success rate of 79.2%.[1] Excluding higher-risk patients limits external validity and prevents extrapolation to the broader cesarean population. The authors do not justify their eligibility criteria or discuss how these criteria affect outcome interpretation across varied Afghan healthcare settings.

Limited Scope of Study Design

Conducting the study at a single tertiary care hospital in Kabul restricts generalizability. Resource availability and clinical expertise differ substantially between urban and rural facilities in Afghanistan, affecting VBAC outcomes.[2] A multicenter design would better capture regional variability, as demonstrated in Ethiopian comparisons of urban versus rural VBAC success rates.[2]

Insufficient Study Duration

A six-month data collection period is inadequate to account for seasonal variations in obstetric outcomes. Fluctuations in healthcare access, maternal nutrition, and workload can influence delivery rates and complications.[3] Longer observation windows, such as five-year retrospective analyses, reveal significant cyclical patterns that a short-term study could miss.[3]

Incomplete Consideration of Confounding Variables

Key clinical factors—maternal body mass index (BMI), labor induction methods, and provider experience—were omitted from the regression model, risking residual confounding. Meta-analyses identify elevated BMI (adjusted OR ≈ 0.50) and induced labor (OR ≈ 0.58) as independent predictors of VBAC failure.[4] Without controlling for these variables, the reported associations may be misleading.

Received: 30 June 2025
Accepted: 22 July 2025
Published: 25 July 2025

Interpretation and Conclusion Overreach

The authors conclude broadly on the feasibility of VBAC in Afghanistan despite methodological constraints. A retrospective, single-center study with limited covariate control cannot support strong causal or predictive claims.[5] The discussion should temper conclusions and explicitly acknowledge these limitations.[1]

Conclusion

Golzareh et al contribute valuable initial data on VBAC in Afghanistan; however, design, analytical, and interpretive shortcomings impede the study's strength. Future research should employ multi-center, prospective methodologies with longer durations and comprehensive variable inclusion to generate more robust, generalizable findings.

Disclosure

The authors declare no competing interests in this communication.

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https://doi.org/10.2147/IJWH.S550582