

Robson Classification as a tool for monitoring and intervening in institutional cesarean section rates

Cesarean section is an intervention that, when well indicated, reduces maternal and neonatal morbidity and mortality. However, the number of cesarean sections has been increasing worldwide, without any concomitant improvement in maternal or perinatal outcomes.^{1,2} Currently, cesarean section is the most commonly performed surgery in the world and Brazil ranks second in the global ranking.¹ This excess of births by surgery is recognized as a global public health problem and identified as an epidemic, since the evidence associates it with short and long term complications for the binomial.^{2,3}

Estimates made by the World Health Organization (WHO) in 2021 project even higher numbers of cesarean sections by 2030.¹ Although the magnitude of cesarean section rates is a concern in most countries, there are others with a shortage of resources and consequently, complications due to its unavailability. These disparities are also projected to continue, despite the increase in this global surgical practice, which makes the problem even more complex, since complications and financial burdens from underuse and for the abusive use, coexist.⁴ Therefore, optimizing the use of cesarean sections requires global attention.

There are a number of interventions proposed to reduce cesarean section rates, but none of them alone is enough to solve the problem and many have not been tested in randomized clinical trials.⁴ Rather than a simplistic alternative, reducing the practice requires improving the quality of care and ongoing health education, with plural interventions that can modify the health system, medical conduct, or be directed at the demands of women or the economical system. The presence of a companion, continuous individual support during labor, induction of labor, external cephalic version and planned pelvic delivery are some of the possible clinical interventions to reduce cesarean sections in scenarios of unnecessary surgery.⁴

Among the non-clinical strategies for reducing rates is the adoption of continuous and systematic monitoring.^{5,6} In October 2014, the WHO proposed the Robson Classification system as a global standard for assessing, monitoring and comparing cesarean section rates within health facilities over time and between facilities.⁷ Standardizing the way cesarean section rates are classified, facilitates audits, making it possible to analyze and compare them in different settings. Due to its applicability, it makes it possible to compare countries with different socioeconomic realities, as well as analyzing temporal trends.⁷

The categories in Robson classification are fully inclusive and mutually exclusive, allowing all women admitted for termination of pregnancy to be allocated to a single group. The ten groups in the classification take into account six basic obstetric variables: parity, presence or absence of a previous cesarean section, the way labor began, the number of fetuses, fetal presentation and gestational age, which are routinely used in the management of women admitted for termination of pregnancy. For this reason, the classification is considered simple, robust, reproducible, clinically relevant and prospective, allowing analysis of the cesarean rate within and between groups of women.^{7,5}

This tool makes it possible to understand the specific contribution of each group to the overall cesarean section rate and local obstetric practices, enabling comparisons between different hospitals serving the same clientele profile. It is also used to evaluate the effectiveness of interventions proposed to reduce cesarean sections and to assess the quality of data in medical records. Therefore, it is essential to implement the monitoring of cesarean section rates using the Robson Classification in a systematic and universal way, with the aim of drawing up policies to reduce cesarean sections that are appropriate for each location and maternity hospital.^{7,5} It is necessary to delve into the problem to understand what allows such alarming rates and to assume that we are going against the grain of scientific evidence, since the best evidence does not support these figures.⁸




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