

Research Article**Caesarean Section Audit Using the Robson Ten-Group Classification System:
A Retrospective Study****Dr Sushma Rachel S¹, Dr Rashmi M B²**

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Abstract**Background**

Caesarean section (CS) is an important intervention when medically indicated, but rising CS rates have raised concerns about the appropriate use of operative delivery. The Robson Ten-Group Classification System (TGCS) is a standardised classification system for auditing CS based on routinely recorded obstetric characteristics.

Aim: The aim of this study was to assess the CS rate in a unit in the Department of Obstetrics and Gynaecology (OBG) and to determine the Robson groups that contribute most significantly to the CS rate.

Methods:

We conducted a retrospective hospital-based observational study among women delivering in a unit of Obstetrics and Gynaecology at Raichur Institute of Medical Sciences and Teaching Hospital, Raichur, Karnataka between January and June 2026. Delivery records were reviewed for demographic, obstetric, fetal/neonatal, and cesarean-related variables. Cesarean deliveries were classified according to the Robson TGCS.

Descriptive analysis was performed for overall CS rate, contribution of each Robson group to overall CS, major indications for CS, primary versus repeat CS and TOLAC outcomes.

Results

During the study period a total of 744 deliveries were noted of which 363 were CS and 381 were vaginal deliveries with an overall CS rate of 48.7%. Women aged between 21 and 34 years were 70.5% of cesarean deliveries, 49.3% were primigravida and 50.7% were multigravida. Primary CS accounted for 221 (60.88%) cases and repeat CS for 142 (39.11%). Group 5 had the highest number of CS contributing to the total CS number (97; 26.70%) followed by Group 1 (87; 23.96%), Group 10 (74; 20.38%), and Group 2 (37; 10.19%). All four groups together accounted for 81.23% of all cesarean deliveries. Main indications were cephalopelvic disproportion (55; 15.15%), prior one CS with refusal for TOLAC (52; 14.32%), fetal distress (40; 11.01%) and prior one CS with CPD (38; 10.46%). Six women had TOLAC, four had VBAC and two had failed TOLAC.

Conclusion

Our unit CS rate was 48.7% with major contributors being Groups 5, 1, 10 and 2. CS audit was important for prior cesarean related indications and primary CS indications. Regular Robson-based monitoring, standardised assessment of labor and fetal indications, and appropriate counselling regarding TOLAC may help identify opportunities to optimise CS utilisation while maintaining maternal and neonatal safety.

Keywords: Cesarean section; Robson classification; Ten-Group Classification System; obstetric audit; primary cesarean section; repeat cesarean section; TOLAC; VBAC.

Introduction

Cesarean section is a potentially life-saving intervention if performed for appropriate maternal or fetal indications. The rate of cesarean delivery has increased substantially worldwide, however, with considerable variation between countries, regions and healthcare facilities. Global estimates indicate that about 21.1% of births were by CS in 2018 and that further increases are expected in the next decade. [1] Nationally in India, the CS rate increased from 17.2% during 2015–2016 to 21.5% during 2019–2021, but large disparities exist at state and healthcare-sector levels. [2,3]

However, high CS rate at an individual hospital can not only be interpreted by comparison with the reference rate at the population level. Institutional CS rates are significantly affected by the case mix, referral pattern, maternal and fetal risk profile and the availability of specialist services. Furthermore, an overall CS rate does not indicate which obstetric populations contribute the most to operative deliveries. Thus, classification of women by standardised obstetric characteristics and study of specific groups contributing to CS are necessary for meaningful quality improvement. [4]

The Robson Ten-Group Classification System proposed a standardised framework for assessing,

monitoring and comparing CS rates. Women were classified into 10 mutually exclusive groups based on parity, previous CS, onset of labor, gestational age, fetal presentation and number of fetuses. [4,5] The Robson classification is recommended by the World Health Organization (WHO) as an international standard for institutional CS auditing. It allows for identification of groups that contribute most to CS and comparison across time and between healthcare facilities.

Internationally, research has shown that there is a lot of variation in the groups responsible for CS. In a secondary analysis of WHO multicountry data from 21 countries, CS rates increased in several Robson groups, and women with a previous CS became an increasingly important contributor to overall CS rates.[6] Similar results were found in studies carried out in tertiary hospitals, where Groups 1, 2, 5 and 10 were identified as the main contributors, but their relative importance varied according to institutional characteristics and case mix. [7,8]

The objective of the present study was to audit the cesarean deliveries in a unit of department of OBG at a tertiary care teaching hospital by using the Robson TGCS. The primary aim was to find out our unit's CS rate and the major Robson groups contributing to cesarean delivery. Secondary objectives were to describe maternal and obstetric characteristics, to identify major indications for CS, to compare primary and repeat CS, to describe fetal/neonatal outcomes and to assess outcomes among women undergoing TOLAC.

Materials and Methods

Study Design and Setting

This was a retrospective hospital-based observational study conducted in our unit (out of four units) in the Department of Obstetrics and Gynecology of Raichur Institute of Medical Sciences and Teaching Hospital, Raichur, Karnataka. The study included deliveries that occurred in our unit between January 1 and June

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30, 2026. The study period included 744 deliveries in our unit. Of these, 381 were vaginal deliveries and 363 were cesarean deliveries.

Study Population

All deliveries recorded during the study period were considered for calculation of unit CS rate. Women who underwent CS constituted the principal population for the analysis of maternal characteristics, cesarean indications and distribution across the reported Robson groups.

Data Collection

Relevant information was obtained from hospital delivery records. Variables available for analysis included maternal age, parity, primary or repeat CS, gestational age, onset of labor, fetal presentation, singleton or multiple pregnancy, Rh status, fetal status at birth, APGAR score, birth weight, NICU admission, indication for CS, Robson group and TOLAC outcome.

The source dataset recorded 78 women aged <20 years, 256 aged 21–34 years and 29 aged >35 years. Primigravida women accounted for 179 cases and multigravida women for 184 cases.

Robson Ten-Group Classification
Cesarean deliveries were categorised into the 10 Robson groups according to parity, previous uterine scar, onset of labor, gestational age, fetal presentation and number of fetuses. The classification is consistent with the WHO framework. [4,5]

Robson group	Definition
Group 1	Nulliparous, singleton, cephalic, ≥ 37 weeks, spontaneous labor
Group 2	Nulliparous, singleton, cephalic, ≥ 37 weeks, induced labor or prelabor CS
Group 3	Multiparous, without previous CS, singleton, cephalic, ≥ 37 weeks, spontaneous labor
Group 4	Multiparous, without previous CS, singleton, cephalic, ≥ 37 weeks, induced labor or prelabor CS
Group 5	Multiparous, previous CS, singleton, cephalic, ≥ 37 weeks
Group 6	Nulliparous, singleton breech
Group 7	Multiparous, singleton breech
Group 8	Multiple pregnancy
Group 9	Singleton transverse or oblique lie
Group 10	Singleton cephalic pregnancy <37 weeks

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The WHO implementation manual emphasises that the Robson system is intended to classify the entire obstetric population rather than only women undergoing CS.[4] In the present dataset, the available Robson table contains the number of CS in each group and their contribution to total CS and total deliveries; group-specific denominators for all deliveries were not available in the supplied dataset.

Outcomes

The primary outcome was the overall institutional CS rate.

Secondary outcomes included:

1. Contribution of each Robson group to total CS.
2. Maternal and obstetric characteristics of women undergoing CS.
3. Primary versus repeat CS.
4. Indications for CS.
5. Fetal and neonatal outcomes.
6. TOLAC/VBAC outcomes.

Statistical Analysis

Categorical variables were summarised using frequencies and percentages. The overall CS rate was calculated as:

Overall CS rate = total cesarean deliveries / total deliveries × 100.

For Robson groups, the contribution to total CS was calculated as:

Contribution to total CS = CS in individual Robson group / total CS × 100.

The contribution of each group to the total delivery population was calculated using the total number of deliveries as the denominator.

Results

Overall Delivery Profile

A total of **744 deliveries** occurred during the six-month study period in our unit. There were 381 vaginal deliveries and 363 cesarean deliveries, corresponding to an overall CS rate of **48.7%**. The monthly number of deliveries ranged from 102 in February to 145 in May. The highest number of cesarean deliveries was recorded in May (71), while the lowest was recorded in March (53).

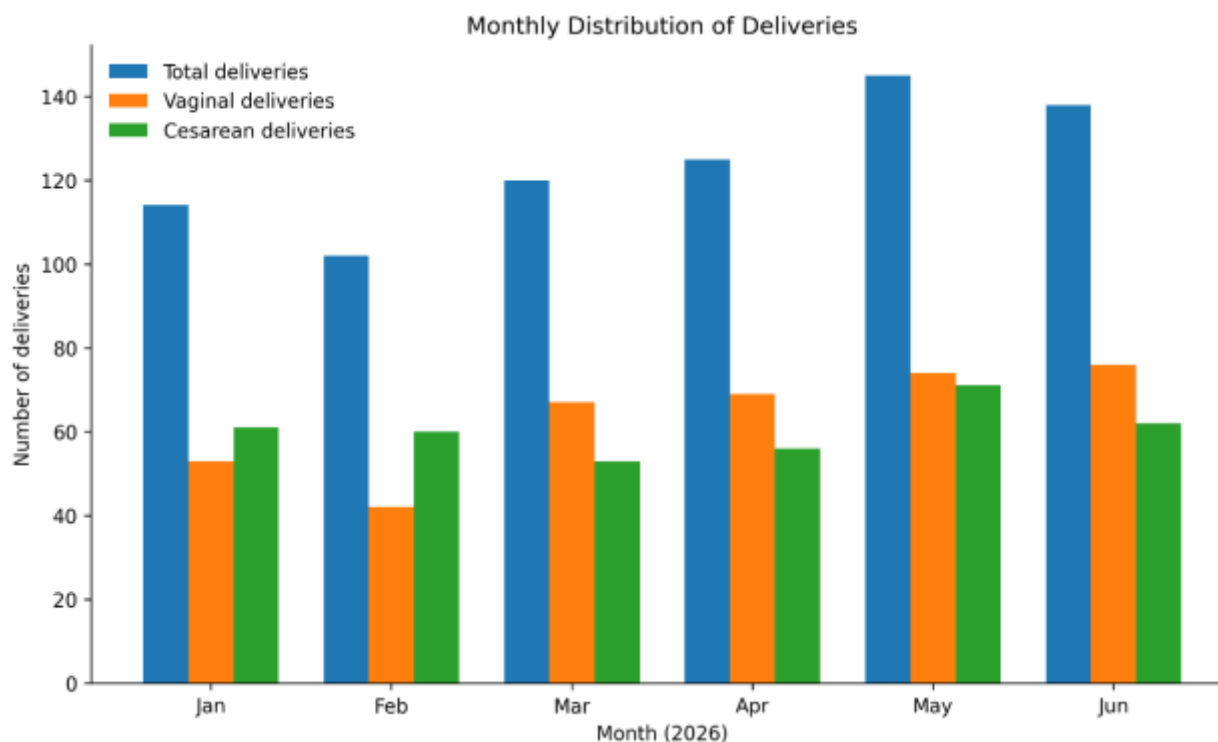
Table 1. Monthly distribution of deliveries

Month	Total deliveries, n	Vaginal deliveries, n	CS, n	CS rate within month
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January 2026	114	53	61	53.5%
February 2026	102	42	60	58.8%
March 2026	120	67	53	44.2%
April 2026	125	69	56	44.8%
May 2026	145	74	71	49.0%
June 2026	138	76	62	44.9%
Total	744	381	363	48.8%*

*The study reports an overall CS rate of 48.7%; 363/744 calculates to approximately 48.8% because of rounding.



Maternal and Obstetric Characteristics

The majority of women undergoing CS were aged 21–34 years (256; 70.5%). Women younger than 20 years accounted for 21.48%, while those aged >35 years accounted for 7.98%.

Primigravidae and multigravidae women represented 49.3% and 50.68%, respectively. Primary CS accounted for 60.88% of procedures, whereas repeat CS accounted for 39.11%.

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Most cesarean deliveries occurred at term gestation. A total of 239 women (65.8%) delivered at 37–40 weeks, while 74 (20.38%) were <37 weeks and 50 (13.77%) were >40 weeks.

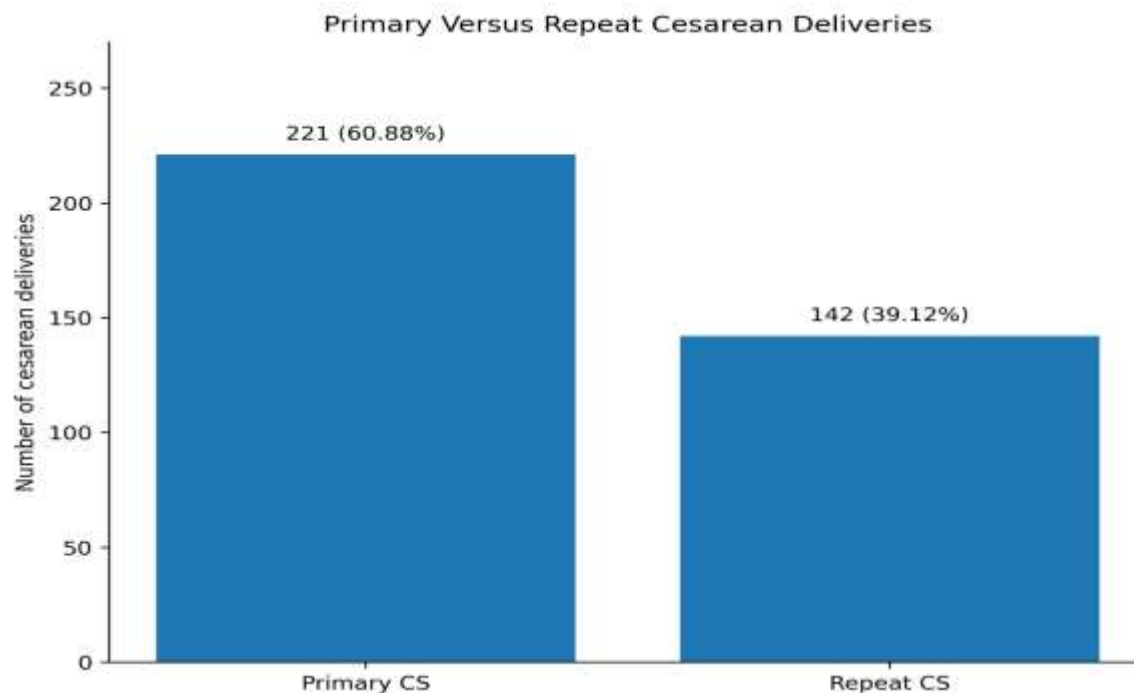
Spontaneous onset of labor was recorded in 258 cases (71.07%), induction in 48 (13.22%), and prelabor CS in 57 (15.7%). Cephalic presentation predominated (346; 95.31%), and singleton pregnancies accounted for 358 cases (98.62%). There were 5 multiple pregnancies reported in our study.

Table 2. Maternal and obstetric characteristics of women undergoing CS

Variable	n	%
Age		
<20 years	78	21.48
21–34 years	256	70.50
>35 years	29	7.98
Parity		
Primigravida	179	49.30
Multigravida	184	50.68
Type of CS		
Primary CS	221	60.88
Repeat CS	142	39.11
Gestational age		
<37 weeks	74	20.38
37–40 weeks	239	65.80
>40 weeks	50	13.77
Onset of labor		

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Spontaneous	258	71.07
Induced	48	13.22
Prelabor CS	57	15.70
Presentation		
Cephalic	346	95.31
Breech	14	3.80
Transverse/oblique/brow/fac e	3	0.82
Pregnancy type		
Singleton	358	98.62
Multiple	5	1.37
Rh-negative pregnancy	17	4.68



Fetal and Neonatal Outcomes

There were 362 reported live births and eight reported intrauterine deaths. APGAR scores were documented as <7 in 39 cases (10.74%) and >7 in 323 cases (88.98%). Most reported birth weights were between 2.5 and 3.9 kg (286; 78.78%). NICU admission was recorded in 17 cases (4.68%).

Table 3. Reported fetal and neonatal outcomes

Variable	n	%
Live birth	362	99.72
Intrauterine death	8	2.20
Stillbirth	0	0
APGAR <7	39	10.74
APGAR >7	323	88.98
Birth weight <1.5 kg	21	5.78
Birth weight 1.5–2.4 kg	63	17.35

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Birth weight 2.5–3.9 kg	286	78.78
Birth weight >4 kg	0	0
NICU admission	17	4.68

Distribution of Cesarean Deliveries According to Robson Classification

Group 5 was the largest contributor to CS, accounting for 97 cases (26.70% of all CS). Group 1 contributed 87 cases (23.96%), Group 10 contributed 74 (20.38%), and Group 2 contributed 37 (10.19%).

The remaining groups contributed smaller proportions of the total CS burden. Groups 3, 4, 6, 7, 8 and 9 together accounted for 68 cases, or approximately 18.7% of all CS.

The four largest contributing groups—Groups 5, 1, 10 and 2—accounted for **295 of 363 cesarean deliveries (81.23%)**.

Table 4. Distribution of cesarean deliveries according to Robson TGCS

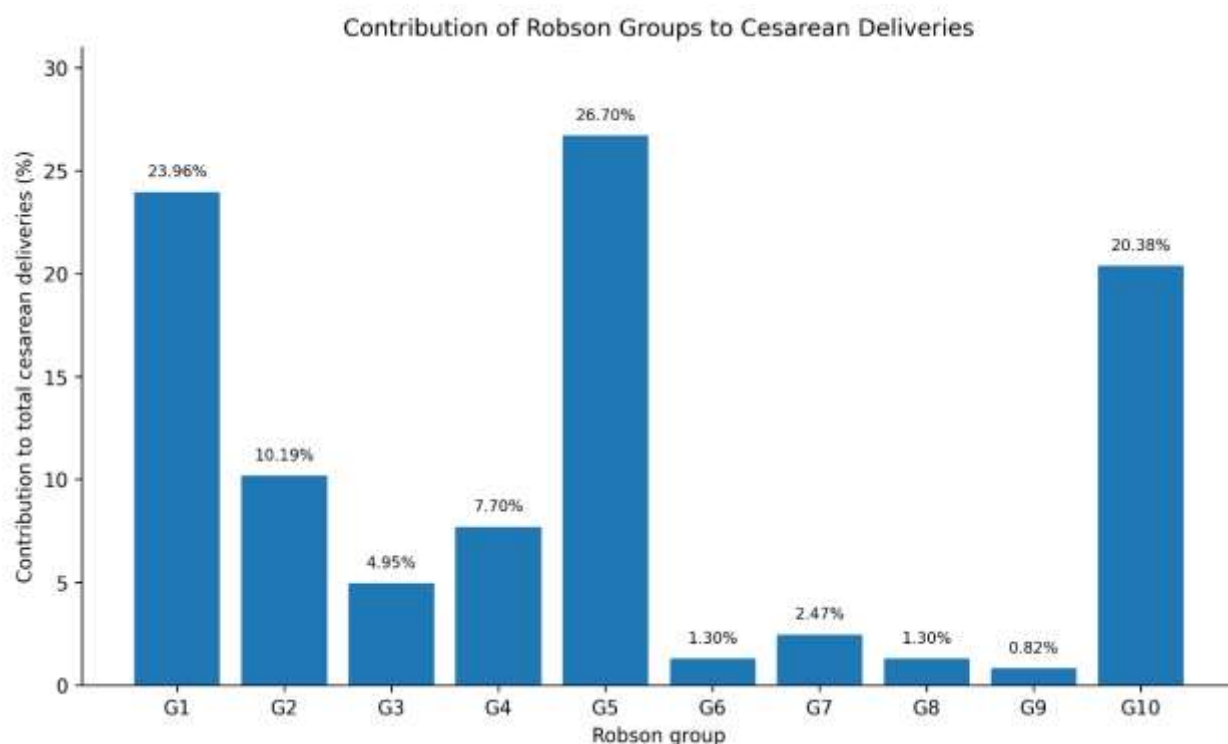
Robson group	CS, n	Contribution to total CS, %	Contribution to total deliveries, %
Group 1	87	23.96	11.69
Group 2	37	10.19	4.97
Group 3	18	4.95	2.41
Group 4	28	7.70	3.76
Group 5	97	26.70	13.03
Group 6	5	1.30	0.67
Group 7	9	2.47	1.20
Group 8	5	1.30	0.67
Group 9	3	0.82	0.40

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Group 10	74	20.38	9.94
Total CS	363	100	—
Total deliveries	744	—	100
Overall CS rate	48.7	—	—

CS, cesarean section; TGCS, Ten-Group Classification System.

Figure 3



Indications for Cesarean Section

The most frequent indication for CS was CPD (55; 15.15%), followed by previous one LSCS with refusal for TOLAC (52; 14.32%), fetal distress (40; 11.01%), and previous one LSCS with CPD (38; 10.46%). Other important indications included previous two LSCS (26; 7.16%), scar tenderness (25; 6.88%), severe preeclampsia/eclampsia with poor Bishop's score (22; 6.06%), and failed induction (21; 5.78%).

Table 5. Indications for cesarean section

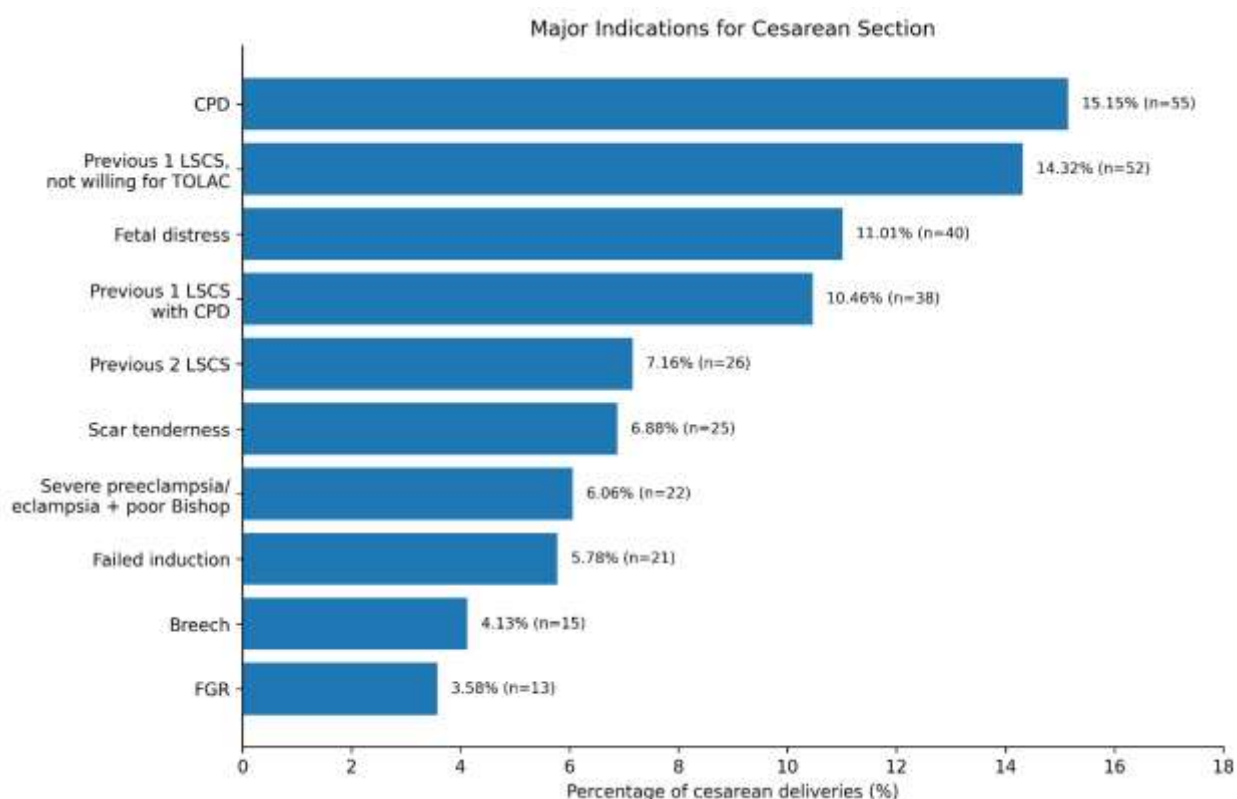
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Indication	n	%
CPD	55	15.15
Previous 1 LSCS not willing for TOLAC	52	14.32
Fetal distress	40	11.01
Previous 1 LSCS with CPD	38	10.46
Previous 2 LSCS	26	7.16
Previous 1 LSCS scar tenderness	25	6.88
Severe preeclampsia/eclampsia with poor Bishop score	22	6.06
Failed induction	21	5.78
Breech	15	4.13
Fetal growth restriction (FGR)	13	3.58
Abruptio placenta	8	2.20
Placenta previa	6	1.65
Arrest of labor	6	1.65
Severe oligohydramnios	5	1.37
Multiple pregnancy with malpresentation	5	1.37
Post-dated pregnancy with oligohydramnios	4	1.10
Obstructed labor	3	0.82
Contracted pelvis	2	0.55

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Polyhydramnios	2	0.55
Previous 3 LSCS	1	0.27
Rupture uterus	1	0.27

CPD, cephalopelvic disproportion; FGR, fetal growth restriction; LSCS, lower-segment cesarean section; TOLAC, trial of labor after cesarean.



TOLAC and VBAC Outcomes

Six women with previous cesarean delivery were reported as willing and eligible for TOLAC. Four achieved successful VBAC, while two underwent repeat CS following failed TOLAC.

Table 6. TOLAC outcomes

Outcome	n
Women willing and allowed for TOLAC	6

Successful VBAC	4
Failed TOLAC	2

The observed successful VBAC proportion among these six women was 66.7%; however, the sample was too small to provide a reliable estimate of the unit's VBAC success.

Discussion

In our retrospective audit, the overall CS rate in our unit was 48.7% during the 6-month study period. The principal finding was that four Robson groups (Groups 5, 1, 10 and 2) comprised more than four-fifths of all cesarean deliveries. The largest contributor was Group 5, followed by Group 1, Group 10 and Group 2. This distribution shows that previous cesarean delivery and primary cesarean populations contributed a substantial part to the institutional operative delivery burden.

The observed unit's CS rate is substantially higher than the national Indian CS rate of 21.5% reported in NFHS-5. [2,3] This difference should not be interpreted as an indication of inappropriate CS solely on the numerical comparison. The comparison of CS rate in different units was not interpreted. Population level estimates and hospital-based rates are measuring different things, and tertiary hospitals may be treating a higher proportion of complicated and referred pregnancies. CS rates much higher than population rates have also been reported in studies of Robson classification in tertiary hospitals. For example, Abubeker et al. reported a CS rate of 34.7% in a tertiary hospital in Addis Ababa, whereas Abdo et al. reported a rate of 32.8% in a referral hospital in southern Ethiopia. [7,8]

The value of the Robson system is not to establish a universally desirable CS rate for all hospitals but to identify the obstetric populations contributing to the local rate. WHO recommends this classification specifically so that it can identify the groups contributing most to CS, to facilitate comparisons and to assess the impact of interventions. [4,5]

Group 5 as the Major Contributor in the present study, Group 5 (women with a previous cesarean scar and a singleton cephalic pregnancy at term) was the largest contributor with 97 cases (26.70% of all CS). This finding is clinically important because the growth of the population with previous CS can create a self-perpetuating increase in repeat cesarean delivery.

Several institutional studies have emphasised the significance of Group 5. In the Cureus study, which is used as the reference format for the present study, Group 5 contributed the most to all CS with 34.97%. [9] In the WHO multicountry analysis, women with prior CS were also identified as an increasingly important determinant of CS rates in several settings. [6]

Previous indications of CS-related effects were strong in the present study. Unwillingness for TOLAC was the indication for CS in 52 women (14.32%). Thirty-eight (10.46%) women had previous CS with CPD, 25 (6.88%) had scar tenderness and 26 (7.16%) had two previous CS.

The results show that management of the previous-scar population is an important part of future institutional audit.

TOLAC should not be viewed as a “one-size-fits-all” strategy to reduce CS; it should be utilized on a case-by-case basis with appropriate resources. ACOG guidance emphasises individualised assessment, discussion of risks and benefits, and shared decision making when considering TOLAC versus elective repeat CS. [10,11]

Contribution of Group 1

Group 1 was the second largest contributor with 87 CS deliveries (23.96%). Group 1 includes nulliparous women with singleton cephalic term pregnancies in spontaneous labor. The investigation of the specific clinical indications for operative delivery is needed to understand a significant contribution of CS in what is usually considered a relatively low-risk obstetric population.

In the present study, CPD and fetal distress were among the top indications overall. However, the data presented do not show a cross-tabulation of individual indications vs Robson Groups 1–10. Hence, the present study cannot specify precisely which indications contributed to the Group 1 contribution.

Future audits should cross tabulate indication by Robson group particularly Groups 1 & 2 as interventions to reduce primary CS in these populations may reduce the number of women entering Group 5 in future pregnancies.

Contribution of Group 10 Group 10 accounted for 74 CS deliveries (20.38%). This group includes singleton cephalic pregnancies delivered before 37 weeks including women with previous CS. This relatively large contribution by this group likely reflects the presence of preterm pregnancies requiring operative delivery for maternal or fetal indications.

Group 10 has also been reported with high contribution in other tertiary care studies. Group 10 was the main source of CS in the study of Abubeker et al., accounting for 19.1% of the CS.

[7] The between-institution variation demonstrates that referral characteristics, obstetric case mix and local clinical practice have an impact on the contribution of groups.

The present study does not include detailed indications for each Group 10 case, therefore it is not possible to ascertain how many procedures were performed for fetal, maternal, placental or other indications. Such information will be useful in future audits.

Group 2 Contribution

There were 37 cesarean deliveries (10.19%) in Group 2. Group 2 includes nulliparous women with singleton cephalic term pregnancies undergoing CS or induction prior to labor. This group is especially relevant to institutional quality improvement because it includes both induced labor and prelabor cesarean delivery.

Indication of failed induction was reported in 21 (5.78%) cases. Appropriate patient selection, standardised induction protocols and consistent criteria for diagnosis of failed induction may therefore be relevant components of future audit. WHO recommends that strategies to reduce unnecessary CS include the use of evidence-based clinical guidelines, regular audits of CS and timely feedback to healthcare professionals. [12]

Repeat versus primary cesarean section

Primary CS accounted for 60.88% of all cesarean deliveries, and repeat CS accounted for 39.11%. That said, this finding suggests that repeat CS reduction measures alone would not capture the bulk of procedures in this study.

The performance of a primary cesarean delivery is especially important because it alters the obstetric profile of future pregnancies by creating a uterine scar and increasing the likelihood of another operative delivery. Proper management of indications for cesarean in the first birth, especially in nulliparous women, could thus have implications beyond the index pregnancy.

The main indications for primary CS populations in this study were CPD, fetal distress and failed induction. These indicators need to be interpreted

carefully in the clinical context, as diagnostic labels alone do not determine appropriateness for CS. Future institutional audits should therefore review the clinical documentation supporting each indication and, where appropriate, whether evidence-based criteria were met.

Indications for Cesarean Section CPD was the commonest indication in 55 cases (15.15%). Fetal distress (40; 11.01%) formed the third commonest indication. Other significant indications were CS-related factors, severe hypertensive disease, failed induction and breech presentation.

Particular caution is required in the interpretation of indications such as CPD, fetal distress and arrest disorders. Labor management, fetal surveillance practices, timing of intervention and clinician thresholds can influence these diagnoses. Therefore, an audit should differentiate between absolutely unavoidable indications and possibly modifiable intrapartum indications rather than assuming that all procedures under a specific diagnostic category were inappropriate.

The leading indications for primary CS in the Cureus reference study were fetal distress, failed induction and arrest of labor and they suggested the need for regular review of indications and standardised protocols. [9]

TOLAC/ VBAC

Six women were documented as willing and allowed to have TOLAC. Four had VBAC and two failed TOLAC. While the observed proportion of success was 66.7%, the very small denominator limits meaningful estimates of unit's VBAC success.

Although the number of TOLAC cases is low, it still deserves attention as the largest Robson group in this study was Group 5. ACOG recommends individualised counselling and shared decision-making regarding TOLAC including assessment of likelihood of successful VBAC and individual maternal and fetal risks. [10,11]

The aim of a TOLAC program should not be to reduce the CS rates per se. Rather women who are eligible should be counselled and provided access to safe, adequately monitored labor when TOLAC is elected and clinically appropriate.

Implications for Practice

1. CS audits based on Robson should be performed on regular basis, so that changes in the distribution of groups can be tracked over time.
2. Primary CS should be reviewed in a structured way, especially in Groups 1 and 2.
3. Evidence such as CPD, fetal distress and failed induction should be supported by standardised clinical criteria and documentation.
4. Women with a previous CS should be counselled individually about TOLAC and repeat CS options when clinically appropriate.
5. Finally use of Robson classification should be used in conjunction with indication-based audit and not as a substitute for clinical review. WHO recommends regular auditing and feedback as part of a package of interventions to optimise CS utilisation. [12]

Study Strengths

The main strength of this study is the use of the Robson TGCS to organise an unit's CS audit. The study also offers a current six-month snapshot of CS use, reports detailed indication data, differentiates primary from repeat CS, and reports TOLAC outcomes.

The study provides a useful institutional benchmark against which later audits can be measured.

Limitations

The study has several limitations.

First, it was retrospective and therefore dependent on the accuracy and completeness of existing hospital records. Second, it was a single unit at a teaching institution study done over a 6-month period, limiting generalisability to other units as well as hospitals and populations. Comparative audits and analyses with other units of the department in the hospital would give better interpretations.

Third, the available Robson data provide the number and contribution of CS within each group, but not complete group-specific denominators for all deliveries. Thus, the study made available did not allow calculation of CS rates by group. This is an important distinction, as an ideal full Robson audit should include the size of each group, the CS rate within each group, the contribution to overall CS and the contribution to the overall obstetric population. [4]

Fourth, available data do not allow for a cross-tabulation of CS indications by Robson group. So the study identifies the main drivers of the total CS burden, but cannot identify which specific indications drove each Robson group.

Fifth, VBAC success was difficult to interpret because the TOLAC sample was small.

Conclusion

This retrospective institutional audit demonstrated a 48.7% cesarean section rate among 744 deliveries during January–June 2026 in one unit of the department of OBG. The main contributors were Robson Groups 5, 1, 10 and 2, which together accounted for 81.23% of all cesarean deliveries. Group 5 had the greatest contribution emphasising the significance of previous cesarean delivery and management of the uterine-scar population. Repeat CS was less common than primary CS with CPD, prior CS-related indications and fetal distress being the most common indications reported.

These findings support ongoing institutional surveillance with the Robson classification, indication-based review of primary CS, standardised labor and induction practices, and appropriate counseling concerning TOLAC. Robson-based audits can provide a practical framework for identifying institution-specific targets for quality improvement while retaining access to medically necessary cesarean delivery.

Conflict of Interest

None.

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