



REVIEW ARTICLE
DOI:

Volume
1

Issue
1

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Submitted 20 August 2026

Accepted 27 August 2026

Published 01 September
2026

Citation
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Vol 1: Iss 1, 2026.

The article was
originally submitted in
ENGLISH.

Translations into other
languages were
reviewed and validated
by the authors and the
editorial team.

Nevertheless, for the
most accurate
representation of the
subject matter, readers
are encouraged to
consult the article in its
original language.



Rising Cesarean Sections: A Global Trend, Its Drivers, Consequences, and Strategies for Optimizing Use

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Abstract

Cesarean section is essential for preventing maternal and perinatal death in cases where a vaginal birth would be unsafe; nevertheless, its use has increased much more quickly than can be accounted for by changes in obstetric risk alone, and access is still inadequate in many low-resource settings. This situation—characterised by both overuse and underuse—has now become a major global inequity in maternal health.

The aim is to draw together current evidence regarding global and regional trends in caesarean sections, look at both clinical and non-clinical factors that influence the practice, assess the consequences for mothers, newborns, children, the health system, and in terms of equity, and identify strategies that are based on evidence for the purpose of optimizing—rather than merely minimizing—the use of this procedure.

Methods: A structured narrative review was carried out by making use of landmark global analyses, systematic reviews, meta-analyses, international guidelines, and major professional recommendations which were mainly published between 2014 and 2026. Those sources that dealt with epidemiology, determinants, outcomes, classification, audit, intrapartum care, shared decision-making, and policy interventions were given priority. Since this was a narrative synthesis, a pooled effect estimate was not produced.

Results show that the rate of caesarean sections increased from about 7% of all births in 1990 to around 21% in the mid-2010s and is expected to reach 28.5% by 2030, which amounts to approximately 38 million operations each year. The projected rates vary from about 7% in sub-Saharan Africa to over 60% in Eastern Asia. This increase is due to factors such as advances in maternal age and morbidity, previous caesarean delivery, changes in the criteria for intervention, a decline in operative vaginal deliveries, concern about legal action, scheduling incentives, financing through the private sector, maternal preferences influenced by fear and the information available to them, and differences in the quality of labour care. Performing unnecessary surgery puts women at risk of infection, hemorrhage, thromboembolism, complications from anaesthesia, delayed recovery, and a build-up of risks in future pregnancies relating to placenta previa, placenta accreta spectrum, uterine rupture, hysterectomy, and stillbirth. On the other hand, insufficient access to timely caesarean delivery continues to be a major cause of preventable death. Effective optimisation must include the use of the Robson Ten-Group Classification for monitoring, audits and feedback based on indications, evidence-based diagnosis of labour, respectful continuous support, appropriate induction, safe vaginal birth after caesarean, the maintenance of operative vaginal delivery skills, balanced counselling, and reforms to payment and governance.

In conclusion, the right policy objective should not be a fixed numerical limit nor a blanket reduction. Healthcare systems must make sure that every woman who needs it receives a timely caesarean section and at the same time avoid carrying out operations which are unlikely to lead to better outcomes. Success should be measured in terms of equitable access, justifiable indications, patient experience, and risk-adjusted maternal and neonatal outcomes.

Keywords: cesarean section; caesarean delivery; global health; maternal morbidity; neonatal outcomes; Robson classification; health inequity; unnecessary surgery; obstetric care.

Introduction

Caesarean section (CS) represents one of the most important developments in modern obstetrics. When labour is obstructed, there is major placenta previa, in certain cases of abnormal fetal presentation, there is fetal distress, the uterus ruptures, or other emergencies occur, prompt operative delivery can prevent death or serious disability. The public health concern is therefore not the operation itself but rather its unjust and often non-evidence-based application. For some women who need it urgently the procedure is not available or is delayed, while for others the operation is carried out even though their chance of benefiting from it is small.

The rapid rise has been uneven in a geographical sense. Estimates associated with the WHO show an increase from about 7% of births in 1990 to around 21% by 2015, with a projected global rate of 28.5% by 2030—amounting to about 38 million caesarean births each year [1–3]. The national averages mask an even wider variation according to wealth, place of residence, ownership of a health facility, insurance status, and clinical risk. High rates are found among affluent urban populations while there remains an unmet surgical need among rural, poor, displaced, and other marginalized women [2,4].

The review regards the use of cesarean sections as a problem relating to the quality of care and equity rather than as a debate between surgical and vaginal birth. It looks at the reasons for the increasing use of such procedures, the consequences that result from them, and the way in which health systems can tell the difference between appropriate access and unnecessary intervention. Although the term "cesarean" is used in this review, the sources cited might use "caesarean."

Review Approach

This is an organised narrative review; the evidence was obtained from WHO documents and databases, PubMed-indexed reviews, The Lancet series on optimising the use of cesarean sections, Cochrane reviews, FIGO guidelines, and significant population studies. The search terms used were cesarean/caesarean section, global trend, determinants, maternal request, private sector, maternal and neonatal outcomes, long-term outcomes, placenta accreta, Robson classification, audit and feedback, labour support, vaginal birth after cesarean, and the reduction of unnecessary cesareans. A preference was placed on global estimates, systematic reviews, meta-analyses, guidelines, and large cohort studies. The findings were combined in a narrative manner since the variability among populations, definitions, indications, timing, and the way confounders were adjusted means that a single pooled estimate is not suitable for the wide-ranging questions considered in this article.

Epidemiology: From its expansion to global divergence

A global trend analysis that includes more than 95% of all live births estimated that 21.1% of women had cesarean deliveries in 2015; if current trends continue, this figure is expected to reach 28.5% by 2030 [1]. The increase is not just in numbers since each first cesarean adds to the number of women who will have subsequent pregnancies with a uterine scar, thus leading to more repeat operations and making the trend self-sustaining. As a result, a previous cesarean section is both a consequence of present-day practices and a factor that contributes to future rates.

The projected rates for 2030 are very different: they amount to about 63% in Eastern Asia, 54% in Latin America and the Caribbean, 50% in Western Asia, 48% in Northern Africa, 47% in Southern Europe, and 45% in Australia and New Zealand, as compared with around 7% in sub-Saharan Africa [1,3]. The fact that a country has a low rate does not mean that the practice in question is appropriate; it could be due to a lack of surgical facilities, a delay in referring patients, the cost of treatment being unaffordable, or patients being geographically excluded. Likewise, a high national rate does not show that every operation carried out was unnecessary. To interpret the data properly, information is needed regarding the case mix, the indication for the operation, the timing of the operations, and the outcomes.

In different countries the social gradient tends to reverse depending on the main issue involved. In areas with low access, caesarean sections are carried out mainly among wealthier women living in urban areas even though the poorer groups have a greater unmet need in terms of obstetric care. In highly medicalized systems, women who have private insurance and those giving birth in for-profit facilities tend to have considerably higher rates of intervention. The overall global situation is therefore more accurately described as "too little, too late" for some and "too much, too soon" for others [2,4,5].

Pattern	Likely signal	Principal risk	Priority response
Very low population rate	Unmet access, weak referral, cost or geographic barriers	Preventable maternal and perinatal death	Expand safe surgical capacity, transport, blood, anesthesia and referral
High rate concentrated in low-risk groups	Possible overdiagnosis or low intervention threshold	Avoidable surgical morbidity and repeat-CS cascade	Robson audit, second opinion, labour-care reform
High repeat-CS contribution	Large population with previous uterine scar and limited VBAC	Placenta accreta spectrum and cumulative morbidity	Prevent primary CS; offer safe, supported VBAC where appropriate
Large public–private gap	Financial, organizational or scheduling incentives	Inequity and non-clinical variation	Payment reform, transparent reporting and aligned quality standards
Acceptable average with subgroup outliers	National mean masking facility or social inequity	Missed local underuse and overuse	Disaggregate by Robson group, indication, facility and socioeconomic status

Why are Caesarean sections becoming more common?

A woman's age when she becomes a mother, as well as obesity, diabetes, hypertensive disorders, the use of assisted reproductive technology, carrying multiple babies, and having previous surgery on the uterus, can increase the chance of needing an operative delivery. Better fetal monitoring and ultrasound diagnosis have enabled the detection of risks that were not previously known. Yet the changes in demographic and clinical factors cannot entirely explain the extent or the variation between facilities regarding the rate of cesarean sections. Women who are similar to one another often have different modes of delivery according to where and who provides their care, showing the impact of practice culture and system design [2,5].

The choice made during the first birth can have an effect on all subsequent pregnancies. After a cesarean section has taken place, both clinicians and women may prefer a planned repeat operation because of worries regarding uterine rupture, the limited availability of immediate access to emergency operating theatres, or the fact that the institution is unwilling to support a vaginal birth after cesarean (VBAC). While a properly selected trial of labour after cesarean can be a sensible choice in well-resourced settings, access to this option is not even across all areas. Prevention of primary cesarean sections that are not indicated is therefore the most effective long-term strategy.

Older labour curves and rigid expectations of cervical dilation can label physiologic variation as dystocia. WHO guidance emphasizes that the historic 1 cm/hour threshold is not an accurate standalone trigger for intervention and that slower progress alone should not routinely prompt acceleration or operative delivery [12,13]. Early admission before active labour, routine intervention cascades, poorly supported induction, and premature diagnosis of failed induction or arrest may all contribute. Conversely, prolonged delay when maternal or fetal status is deteriorating is unsafe; optimization requires clinical judgement. Caesarean section delivery provides a certain degree of predictability when it comes to staffing and scheduling, especially in situations where the availability of staff during the night and on weekends is low. Under a fee-for-service system, surgery is likely to be reimbursed more than the management of prolonged labour. Concern about the possibility of being sued, the practice of defensive medicine, a lack of supervision by senior doctors, a decreasing confidence in the ability to deliver a baby vaginally, and an inability to tolerate uncertainty may all cause the threshold for intervention to be lowered. Although these factors are seldom explicitly mentioned in the medical record, they help to account for variations that cannot be explained by patient risk [5,6]. In many middle- and high-income countries, higher cesarean section rates have been reported in private facilities on numerous occasions. The fact that a facility is owned does not indicate that the care provided is inappropriate; instead, it is the referral patterns and the characteristics of the patients which are important. Yet when payment incentives, convenience, staffing arrangements, or the way patients are positioned make scheduled surgery more attractive, significant adjusted differences should cause concern. It is essential that reporting be transparent and based on risk adjustment, together with payment neutrality, in order to tell the difference between the complexity of a case and demand induced by the supplier from supplier-induced demand.

Women sometimes ask for a cesarean section due to their fear of labour pain, a previous traumatic birth, concerns about the safety of the fetus, worries regarding their pelvic floor, a wish to have control, cultural beliefs, or because of misinformation. A systematic review has shown that a preference for cesarean section is a minority view in general, although the rate of such preference differs according to the specific context and the woman's previous birth experience [7]. “Maternal request” should not become a shorthand that transfers responsibility from systems to women. Preferences are shaped by counselling, trust, continuity, stories of disrespectful treatment, access to pain relief, and the way in which clinicians present risks. A request should lead to a thorough examination of the woman's underlying concerns, be accompanied by balanced information, involve trauma-informed counselling, and show respect for her informed autonomy—rather than amounting to coercion in either direction [8].

Even though electronic fetal monitoring, ultrasound, and risk prediction can enhance safety, they might lead to false alarms if they are not properly interpreted. The increasing expectation of a perfect outcome results in interventions being carried out even when it is unclear whether there will be any real benefit. The ethical problem here is asymmetric in that the harm avoided by an operation can be seen immediately, while surgical complications in later pregnancies happen years afterwards and are mentally downplayed.

The consequences of increasing the use of caesarean sections

Vaginal delivery without complications is a simpler procedure than a caesarean section, which is a major abdominal operation. Possible complications may involve hemorrhage, the need for a blood transfusion, infection, venous thromboembolism, anesthetic complications, injury to internal organs, problems with the wound, hospital readmission, and a longer recovery period. The absolute risks vary considerably depending on whether the surgery is planned or is emergency surgery and also according to the capabilities of the facility. In places where reliable anesthesia, blood products, infection control measures, or postoperative monitoring are not available, the risks of the operation increase. At the same time, the comparisons are also affected by the reason for the surgery since the women who have an emergency caesarean are often in a sicker condition before the operation takes place. The appropriate question to ask is thus whether the expected benefits outweigh the additional risks in the particular clinical situation.

Early caregiving can be made more difficult by postoperative pain and reduced mobility, and skin-to-skin contact or breastfeeding may be delayed if the care process does not take steps to maintain them. A caesarean section that is emergency-induced or unwanted may be seen as traumatic, particularly in situations where there is poor communication and inadequate consent. However, such outcomes need not occur. The implementation of family-centered caesarean protocols, allowing for immediate contact whenever it is clinically possible, providing adequate pain relief, giving a respectful explanation, and conducting a post-birth debriefing can all contribute to improving the experience.

The biggest impact on population level is the accumulation of risk over a number of pregnancies. Meta-analytic evidence shows that a previous caesarean is associated with placenta previa (odds ratio about 1.74), placenta accreta (odds ratio about 2.95), placental abruption (odds ratio about 1.38), miscarriage (odds ratio about 1.17), and stillbirth (odds ratio about 1.27), although causal conclusions are limited by the observational nature of the studies [9]. The risks relating to the placenta accreta spectrum, hemorrhage, hysterectomy, adhesions, bladder injury, and surgical complexity all increase as the number of previous caesareans goes up. Since fertility is postponed and family size differs, patients' lifelong reproductive intentions should be included in the advice given them—not just regarding the current pregnancy.

Carrying out a scheduled cesarean section before 39 completed weeks without a valid reason increases the occurrence of transient tachypnea and respiratory complications since the hormonal and mechanical changes associated with labour are avoided. Iatrogenic prematurity may happen when the age of the pregnancy is unclear. If a cesarean is required because of fetal distress or obstructed labour, it might instead prevent hypoxic injury or death. It is therefore necessary to differentiate between cesarean sections that are indicated and those that are not and between planned operations and those carried out during labour.

Large observational studies have found associations between having a caesarean section and both asthma and obesity in childhood. A systematic review reported odds ratios of 1.21 for asthma by the age of 12 and 1.59 for obesity by the age of five [9]. Suggested mechanisms involve variations in microbial exposure, perinatal hormones, immune maturation, antibiotic use, and feeding, but it is likely that there remains residual confounding due to maternal obesity, the reason for the caesarean section, genetics, and the environment. The associations should be presented as possible, with small long-term risks rather than as certain outcomes, and must not be used to shame families or to prevent them from having necessary surgery [9,10].

Cesarean delivery requires theatre time, anesthesia, surgical staff, sterilization, postoperative beds, medicines, and management of complications. In resource-constrained systems, avoidable operations can divert capacity from emergency obstetrics and other essential surgery. Yet a narrow cost-reduction agenda is dangerous where access is deficient. Economic evaluation must include the cost of failure to provide Table 2. The benefits, harms, and interpretative cautions. The difficulties associated with a universal "ideal" recovery.

Domain	Potential benefit when indicated	Potential harm or trade-off	Interpretive caution
Maternal survival	Prevents death from obstruction, rupture, hemorrhage or selected comorbidity	Hemorrhage, infection, VTE, anesthesia and organ injury	Emergency indication confounds comparisons
Fetal/neonatal	May prevent hypoxia, trauma or death	Respiratory morbidity with prelabour/early-term birth; iatrogenic prematurity	Risk differs by timing and indication
Future pregnancy	Planned route may avoid scar-labour risk in selected women	Previas, accreta spectrum, rupture, adhesions, hysterectomy	Risk rises with number of prior cesareans

Pelvic floor	Lower observed urinary incontinence and prolapse risk	Surgical and reproductive trade-offs	Vaginal birth is heterogeneous; causality is complex
Childhood	No established long-term advantage without indication	Associations with asthma and obesity	Residual confounding; absolute effects generally modest
Experience	Can provide control or relief from feared labour	Loss of agency or trauma after poorly communicated emergency surgery	Respectful care matters in every mode of birth

Table 2. Benefits, harms, and interpretive cautions

The Problem with a Universal “Ideal Rate”

The figure often quoted, which is between 10 and 15 per cent, was originally established as a benchmark at the level of the population, not as a target for each individual facility. In a later statement the WHO stressed that caesarean sections should be given to women when they need them rather than aiming for a particular rate and that in ecological studies rates above about 10 per cent were not found to lead to any further reductions in maternal and neonatal mortality [11]. Ecological thresholds cannot be used to determine whether or not a particular case is appropriate and tertiary referral hospitals should not be similar to low-risk units.

Crude targets can lead to perverse incentives, for example by having clinicians postpone necessary surgery in order to reach a ceiling, or by organisations appearing successful through the transfer of high-risk women. A well-developed quality framework includes case-mix classification, indications, the timing of decisions, severe maternal outcomes, neonatal outcomes, respectful care and equity. The aim is the optimal use of care—that is, maximising the benefits obtained in a timely manner while at the same time minimising surgery where there is no expected net benefit.

The Robson Ten-Group Classification of Appropriateness

The Robson system divides each woman admitted for childbirth into one of ten mutually exclusive and entirely inclusive groups on the basis of her parity, whether she has had a previous caesarean section, the onset of labour, her gestational age, the position of the fetus, and the number of babies. The World Health Organization recommends it as the global standard for monitoring the use of caesarean sections [11,14,15]. It shows which groups of women contribute most to the overall rate and allows for more meaningful comparisons over time and between different facilities than a simple percentage.

The Robson classification does not in itself establish whether a particular operation was appropriate and contains no information regarding the clinical indication; it must therefore be combined with a review of the indication, outcome data, and a local contextual analysis. Good data quality is a basic requirement: the data on parity, gestation, presentation, the onset of labour, and previous scar status must be complete and consistently defined. A regular multidisciplinary audit should look at the larger patient groups—such as nulliparous term singleton cephalic pregnancies and women with a previous scar—and then pass the results on to the clinical teams.

Strategies to Optimize Use Based on Evidence

It is possible to improve knowledge and deal with fear by using balanced decision aids and childbirth education, particularly if these are provided early on to allow for reflection. Counselling should involve giving absolute rather than just relative risks, it should make the difference between planned, emergency, first and repeat caesarean sections clear, talk about analgesia and labour support, and also consider the future reproductive implications. When a maternal request is made, clinicians should investigate issues relating to pain, trauma, misinformation, pelvic floor concerns and the cultural context while at the same time respecting the patient's right to make an informed choice [8,16].

Continuous companionship, effective communication, privacy, mobility, access to pain relief, and protection from mistreatment are fundamental quality interventions, not merely optional facilities. According to the evidence from systematic reviews, continuous support is linked to a greater chance of a spontaneous vaginal birth and to less frequent use of caesarean sections [17]. The World Health Organization advises having a companion of one's choice and provides for individualized and respectful care during childbirth [12,13]. Women should not be required to accept bad labour conditions in order to avoid surgery.

The protocols must not diagnose active-phase arrest too early and should provide sufficient time for induction if both maternal and fetal conditions remain reassuring. Using standardized criteria, having a senior physician review the case, and ensuring proper documentation before carrying out a non-emergency primary caesarean section can help reduce unnecessary variation. The key point is to allow sufficient time with active monitoring rather than imposing a rigid delay. The tools used in labour care should enable a rise in the level of care when a risk appears and promote patience when progress is slow but safe from a physiological point of view.

Induction must be based on evidence, should be well resourced and include the criteria for cervical ripening and for failed induction. The staff should have the necessary competence in interpreting cardiotocography and must have access to timely advice from senior colleagues in order to avoid making false-positive diagnoses of fetal compromise without failing to recognise genuine deterioration. Simulation, review of cases and the use of consistent terminology all contribute to improving reliability.

In selected women, the safe reduction of caesarean section rates can be achieved by carrying out an external cephalic version for those with a breech presentation, by providing a skilled operative vaginal delivery, by managing twin pregnancies appropriately, and by offering supported vaginal birth after a previous caesarean. However, these methods rely on the competence of the workforce, on informed consent, on having immediate backup support, and on an adequate system of governance. When skills are lost, a self-fulfilling cycle is created in which caesarean section becomes the only available option.

The experts who recommend that caesarean sections should be subject to audit together with timely feedback, and where this is possible, that a second opinion be obtained for certain non-emergency cases [16] believe that audit works best when it is non-punitive, based on sound clinical grounds, carried out repeatedly, and associated with changes that can be put into practice. The dashboards should provide information on both the overall rates and the Robson-specific rates, on both primary and repeat caesareans, on the indications, and on maternal and neonatal outcomes as well as on disparities. Caution should be exercised when publicly reporting the data without making risk adjustments.

Payment should not give a greater reward for a caesarean section than for high-quality care during a vaginal birth. Bundled or diagnosis-related payments, adequate compensation for attendance during labour, and accountability in both the public and private sectors can help to reduce distorted incentives. Since facilities need staff on duty throughout the day, anesthesia, an operating theatre, blood supplies, and the ability to refer patients, a strategy aimed at preventing unnecessary surgery must not compromise access in emergencies. In situations where the rate of caesarean sections is low, investment should aim at expanding capacity rather than restricting it.

It is rare for a single intervention to be able to counter a trend that results from the interaction of clinical, social, and financial factors. In order to be effective, programs must integrate data, have strong leadership, involve patients, provide respectful care, offer training for the workforce, and include policy changes. A local diagnosis should come before any intervention is carried out: for example, the response needed by a hospital which has a high rate of repeat caesareans should be different from that required by one which carries out a large number of caesareans before labour in low-risk first-time mothers, or by one where the low rate of caesareans is due to a lack of anaesthesia.

Level	Core actions	Suggested indicators	Safeguard
Woman/family	Decision aids, birth preparation, trauma-informed counselling, companion of choice	Knowledge, decisional conflict, experience, informed consent	No coercion toward either mode
Clinical team	Evidence-based labour criteria, senior review, fetal-monitoring competency, VBAC/OVD skills	Indication-specific and primary-CS rates; adverse outcomes	Immediate escalation when clinically needed
Facility	Robson dashboard, audit and feedback, second opinion, staffing and theatre readiness	Group-specific rates, decision-to-birth interval, severe morbidity	Risk adjustment and non-punitive learning
Health system	Payment neutrality, referral networks, blood/anesthesia capacity, public-private standards	Equity by wealth/residence; unmet need; catastrophic cost	Do not reduce access in underserved groups
Research/data	Standardized indication and outcome datasets; implementation evaluation	Completeness, comparability, maternal-reported outcomes	Protect privacy; include women's perspectives

Table 3. Multilevel action framework

Special Considerations

When there are no maternal or fetal reasons for a procedure, the counselling should make sure the request is based on full and free consent, investigate any factors that can be changed, and consider both the short-term and long-term consequences. Once a planned caesarean section has been decided after proper counselling, professional advice usually recommends against delivering the baby before 39 weeks in the absence of some other reason and should stress the cumulative risks associated with having multiple future pregnancies [8,18]. Ethical practice must respect autonomy together with the principles of non-maleficence and stewardship, and it is not acceptable either to ignore the patient's fears or to describe the surgery as carrying no risks.

It could be that access is more important than a reduction in the rate. To have the capacity to carry out safe caesarean sections it is necessary to have a working referral and transport system, as well as trained surgical and anaesthetic teams, oxygen, antibiotics, uterotonics, blood, sterilization facilities, the ability to resuscitate newborns and postoperative supervision. Monitoring should cover unmet need, delays, cases of maternal near miss, stillbirths, and affordability. Campaigns for reducing the rate that are introduced from outside can be harmful if they lead to a discouragement of referral or if they bring about the normalization of delays.

The assessment of women who have a uterine scar should be tailored to take into account the previous incision, the reason for the first caesarean section, the number of scars, the factors that occur between pregnancies, the current pregnancy, the woman's preferences, and the capacity of the facility. When making the decision together with the patient, the options of having a planned repeat caesarean and attempting a vaginal birth after a previous caesarean should be compared, including the probability of a successful vaginal delivery and the rare but serious risk of uterine rupture. The safest option will vary according to both the characteristics of the patient and the ability of the system to respond quickly.

Research Priorities

Important gaps remain. First, appropriateness measures should integrate indication, case mix, timing, and outcomes rather than rely on rates alone. Second, more evidence is needed from low-income and humanitarian settings, where both surgical risk and unmet need are greatest. Third, implementation trials should test packages that combine respectful care, decision support, clinical protocols, audit, and financing reform. Fourth, long-term child associations require better control of familial and indication-related confounding. Fifth, women's reported experiences, autonomy, and psychological outcomes should be treated as core endpoints. Finally, datasets should link primary cesarean decisions to outcomes across subsequent pregnancies to reveal lifetime—not merely episode-based—effects.

Implications for Policy and Practice

National strategies should articulate a dual commitment: universal access to timely, safe cesarean delivery when indicated and active prevention of surgery without expected net benefit. Ministries and professional bodies can mandate standardized Robson reporting, establish indication definitions, support confidential review, and align public and private quality requirements. Facilities should identify their dominant contributing groups, select context-specific interventions, and monitor balancing measures such as stillbirth, neonatal encephalopathy, uterine rupture, severe hemorrhage, and maternal experience. A falling cesarean rate accompanied by worse outcomes is not success; neither is a stable outcome profile achieved through escalating surgery without demonstrable benefit.

Conclusion

Rising cesarean use is not a single global epidemic with a single remedy. It is a pattern of profound divergence: inadequate access where operative birth could save lives, excessive intervention where clinical benefit is uncertain, and wide variation shaped by institutions, incentives, professional culture, and women's experiences. Cesarean delivery should remain readily available, technically safe, and respectfully provided. At the same time, every non-emergency decision should be clinically defensible, transparently monitored, and informed by the woman's values and future reproductive plans.

The most credible response moves beyond crude targets. Robson-group analysis, indication audit, contemporary labour care, continuous support, maintained vaginal-birth skills, balanced counselling, equitable financing, and adequate emergency capacity form a coherent optimization strategy. The ethical endpoint is simple to state but demanding to achieve: the right operation, for the right woman, at the right time—and no woman denied lifesaving care because of geography, poverty, or a poorly designed rate target.

Declarations

Ethics approval and consent to participate: Not applicable. This article synthesizes published literature and contains no individual patient data.

Consent for publication: Not applicable.

Funding: The author(s) received no specific funding for this work.

Conflicts of interest: The author(s) declare no conflicts of interest.

Author contributions: To be completed according to the journal's authorship policy.

Data availability: No new dataset was generated or analyzed for this narrative review.

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