

ROBSON'S TEN GROUP CLASSIFICATION SYSTEM FOR DECREASING CESAREAN SECTION RATES IN 2ND MATERNITY HOSPITAL IN SAMARKAND

Abduganieva Hilola Abduhafiz kizi

Samarkand Medical University

Department of Obstetrics and Gynecology, FPDO

Samarkand, Uzbekistan.

Agababyan L.R

PhD Associate Professor

Abstract: *This article discusses Robson's ten-group classification system for reducing cesarean rates and its use in the Samarkand maternity hospital.*

Key words: *Cesarean section, fetus, baby, child, obstetrician, delivery, surgeon, medical staff.*

Often, doctors prefer to perform the sensitive part in a nursing home if the life of the little one or the future mother is threatened. The main indications for emergency surgery are: placental abruption, severe fetal hypoxia, insufficiency of the cervix. With the help of cardiotocography (sensors that record the baby's heartbeat), doctors monitor the well-being of the baby during birth. If something goes wrong, they immediately intervene. Don't worry: Doctors are just as interested in having a natural baby as you are.

Therefore, the decision on the operation may be the only other way. In which cases do women have a cesarean and how is the operation performed?

Every pregnant woman gets new, not like the previous one. Childbirth, in turn, is also different. If the first baby was born with the help of surgeons and a gynecologist, it does not mean that everything will happen according to this scenario. What if there will be a second caesarean section? What is important for a woman to know herself? Can I avoid surgery? Today's article will answer these and other questions. How will you know if your body is recovering after the procedure, whether it is possible or not, what term is planned for the third pregnancy, the second caesarean section, of course, and whether it is definitely due to spontaneous labor or not.

Reducing caesarean section rates is a multifaceted challenge that requires an integrated approach involving various stakeholders, including health care providers, policymakers, and expectant mothers. Some strategies to help lower cesarean rates include:

1. Promote awareness: Educating expectant mothers about the benefits and risks of different delivery methods, including vaginal delivery and caesarean section, can help them make informed decisions. This can be done through prenatal classes, information materials, and conversations with health care providers.

2. Support for vaginal birth after caesarean section (VBAC): Encourage and support women who have had a previous caesarean section to consider VBAC if it is safe and appropriate for the situation. A VBAC can be a suitable option for many women and can help prevent unnecessary repeat cesarean births.

3. Implementation of evidence-based guidelines: Health care providers should use evidence-based guidelines for labor management, including measures such as induction of labor and continuous fetal monitoring. This can help prevent unnecessary C-sections and encourage vaginal delivery.

4. Foster shared decision-making: Encourage shared decision-making between health care providers and mothers-to-be, where both parties discuss the risks, benefits, and individual circumstances before choosing a birthing method. and reviews. This approach allows women to actively participate in the decision-making process.

5. Improve access to obstetric care: Expanding access to obstetric care can provide women with additional options for low-risk pregnancies and promote a personalized and holistic approach to birth.

6. Consider systemic factors: Assess and address any systemic factors that contribute to high cesarean rates, such as financial incentives, medico-legal issues, and organizational culture. These factors may influence the decision-making process and contribute to the overuse of cesarean sections.

It is important to note that reducing cesarean rates must prioritize the health and safety of mother and baby. Each birth should be evaluated individually and cesarean should be performed when medically necessary or at the request of the mother.

Robson's ten-group classification system is a method used in obstetrics to classify and analyze cesarean rates within a health care facility or population. This helps identify the main causes of cesarean delivery and allows comparisons between different groups.

The classification system divides all pregnant women into ten mutually exclusive groups based on specific obstetric characteristics. These characteristics include factors such as previous caesarean section, gestational age, fetal presentation, and number of fetuses. Each woman is assigned to only one group based on the most suitable character.

The main purpose of Robson's classification system is to provide a standardized way to analyze and compare cesarean rates in different populations or health care settings. By grouping women, it allows for a more accurate assessment of C-section rates and helps identify areas where interventions or improvements are needed to reduce unnecessary C-sections.

It should be noted that the classification system itself does not directly reduce cesarean rates. Instead, it serves as a tool to identify areas for potential intervention and improvement in midwifery care. A practical reduction in cesarean rates requires the implementation of appropriate strategies and practices based on the results of the analysis and use of the classification system.

Robson's ten-group classification system is a method used to analyze and compare cesarean rates in different maternity hospitals. It divides women into ten groups based on various factors such as parity, previous caesarean section, gestational age and fetal presentation. By analyzing cesarean rates within each group, hospitals can identify areas for improvement and implement strategies to reduce unnecessary C-sections. It seems that the 2nd maternity hospital in Samarkand used this classification system to optimize C-section rates.

REFERENCES:

1. Afanaseva M.Kh., Bolotskikh V.M., Kuzminykh T.U. Osobennosti provedeniya rodovozbuzhdeniya u patsientok s prejdrevremennym izlitiem okoloplodnykh vod na fone otsutstviya biologicheskoy gotovnosti k rodam pri donoshennom sroke // Journal of obstetrics and gynecology. - 2016. - No. 1. - S. 4-8.

2. Burkitova A.M., Prokhorova V.S., Bolotskikh V.M. Aktualnye diagnosticheskie i klinicheskie problemy.Pri perenoshennoy beremennosti v vremennom obusherstve.Sankt-Peterburg; Journal of obstetrics and gynecology. - 2017. - Т. 66. - No. 2. - S. 93-103

3. Буйнова О.Е. Параметры сердечно-дыхательного синхронизма при пролонгированной беременности / О.Е. Буйнова, Г.А. Пенжоян, Ю.М. Перов // Кубанский научный медицинский вестник - 2008. - №6 (105). -С.6-9.

4. Елевсинова Ж.К., Бекмамбетова К., Ергешбаева А., и др. Переношенная беременность в современном акушерстве // Вестник КАЗНМУ. - 2013. -№ 2. - С. 37-43