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Original Article

Involvement of Women in Cesarean Section Decision and Their Satisfaction

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1- ABSTRACT

Background: Caesarean section (C.S) is a surgical procedure used to prevent or treat life-threatening maternal or fetal complications. C.S as a major abdominal surgery in the world is one of the most frequently performed In Egypt, It accounted for 72% of births in 2021. **Aim**: The study aimed to determine how involved and satisfied women were with their decision to have a cesarean section. **Method:** Mixed research design will be utilized for this study. **Study subjects:** A convenient sample includes 167 postpartum women who attend Dr. Mohamed Abd El Wahab obstetrics & gynecology center at Dekernes City, Dakahlia Governorate. **Tools**: Three tools were used: A structured interview questionnaire, women's opinion regarding involvement in C.S decision, and Maternal Satisfaction with Cesarean Section (MSCS) scale. **Results:** show that the women who decided to be involved in cesarean section had a good level of perception of individualized care and satisfaction with nursing care and 71.5% of the studied women were satisfied with cesarean birth. **Conclusion:** The majority of the studied women involved in cesarean section were satisfied with their decision and less than third of them were unsatisfied. There is a highly significant association between women's involvement in cesarean section decision and their satisfaction. **Recommendation:** Vitality of psychological support of the parturient women with CS, especially postoperative. Health care providers have an essential role in before & post C.S care

Keywords: Cesarean section, Involvement in Decision Making, Satisfaction.

2- Introduction:

Cesarean section (C.S) is the delivery of the fetus, placenta and membranes through an incision made on the mothers abdominal and uterine walls after 38th weeks of gestation, which is a one of the most common major surgical procedures in health care service **(Angolile, Max, Mushemba, & Mashauri, 2023).** CS plays an important and vital role as some of the deliveries are never possible through the vaginal route without threatening the life or health of the mother or baby. Cesarean delivery is increasing all over the world (**Ahmed, Nahar & Masih, 2021).**

The cesarean section (CS) is the most commonly performed surgery in the world. High CS rates are strongly influenced by financial, social and cultural factors. These factors, especially combined with the public perception that a caesarean delivery is now an almost risk-free procedure, may well be contributing to the rise in the number of CS performed **(Parasiliti et al.,2023).**

Improvements in surgical technique and improvements in safety have led mothers to think of caesarean delivery as a viable alternative to vaginal delivery, even in the absence of any maternal or fetal indication. This perspective, however, overlooks the fact that a CS is a surgical procedure with numerous potential complications for both mother and child. Pregnant women requesting a CS in the absence of obstetric indications has become a highly debated issue in academic as well as popular literature (**Masciullo et al., 2020).**

One of the most difficult decisions that pregnant women and the medical team must make is the method of delivery. Owing to the intricate nature of the decision-making process, suitable and efficient tools are required to enhance and streamline decision-making. These resources can improve information, lessen worries, and include expectant mothers in decision-making **(Hadizadeh, Ghoreyshi, Mohammad, & Rahmani, 2021).**

Women's satisfaction with CS can guide service development and delivery and is a critical predictor for preserving and observing the quality of health care. The concept of satisfaction consists of an attitude, a reaction to an event, and a cognitive evaluation of the emotional reaction. It stands for a balance between the expectations and actual nursing care that women perceive. When the woman receives treatment that surpasses her expectations, she feels extremely happy or

satisfied. Women's satisfaction is influenced by a number of elements. A greater proportion of them expressed satisfaction with the overall setting, hygiene, correspondence, medical care, psychological support, continuity of treatment, and participation in decision-making **(Abdelati, Saadoon, & Roshdi, 2019).**

The rate of cesarean sections (CSs) performed globally is 21.1%. An estimated 20 million (C.S) deliveries take place annually. Sub-Saharan Africa has the lowest incidence, which is 5.0%, while Latin America and the Caribbean have the greatest percentage, which is 42.8% in Europe. In Egypt in 2021, 72% of births were cesarean sections. Additionally, according to the WHO 2021, Egypt is one of only five nations where the number of cesarean sections exceeds that of normal births. No justification for any region to have a cesarean section rate higher than 10–15%" is a statement made by the **World Health Organization (WHO) in 1985 (Marco, 2023).**

Caesarean delivery is crucial for preserving the lives of infants and pregnant mothers who pose a significant risk. According to **Deng, Tang, Liu, Gao, and Zhong (2021),** it can cause bowel or bladder damage, amniotic fluid embolism, air embolism, thromboembolic illness, small bowel obstruction, severe acute maternal morbidity (SAMM), postpartum depression, and postpartum death in mothers and infants **(AbdElatay, Hathout, &Gabr, 2021).** Exaggeration of these complications may occur when women are excluded from C.S. decision-making.

The majority of requested cesarean births have been linked to women's views that CS is a "safe" delivery choice; this assumption has been shown to be a significant factor in the increased incidence of C.S., particularly in developing nations. Women's requests for C.S. are influenced by a variety of factors, including their perceived involvement in the decision-making process for CS, their fear of giving birth vaginally, and genital complications and their impact on their sexual relationship after a vaginal birth (**Panda, Begley & Daly, 2020).**

According to earlier research, women who participated in C.S. decision-making expressed a sense of fulfillment of their desires and contentment. According to **Anjum, Husain, and Naseem (2018),** women expressed satisfaction with the information and explanation provided by healthcare practitioners regarding the indication of cesarean section delivery (**Anjum, Husain, Naseem, 2018). (Chen, Hutchinson, Nagle, & Bucknall, 2018).** Because treatment is subjective and complex, it can be difficult to gauge how satisfied women are with the quality of care they receive. Expectations are the main factor influencing it, since they have a big impact on creating a happy birthing experience and increased satisfaction levels **(Sarhan, 2022).**

2.1 Aim of the study

The purpose of the study was to evaluate women's happiness with and involvement in the choice to have a cesarean section.

2.2 Research question

Q1: Did the woman get involved in cesarean section decision?

Q2: What is the level of women's satisfaction regarding involvement in the Cesarean section?

3- Method

3.1 Research design

The research methodology used for this study was mixed (qualitative and quantitative). Quantitative descriptive research examines a condition's prevalence in a given population at a given point in time, without making any assumptions or proposing a reason for the prevalence. In order to determine women's opinions about their engagement in C.S. decisions, a qualitative study will be conducted.

3.2 Setting

The current study was conducted at Dr Mohamed Abd El Wahab obstetrics & gynecology center at Dekernes City, Dakahlia Governorate.

3.3 Subjects

The study subjects included a convenient sample of 167 postpartum women who will attend Dr Mohamed Abd El Wahab obstetrics & gynecology center at Dekernes city, Dakahlia governorate, at the period from May 2022 to November 2022.

3.4 Sample size

Based on data from literature (Anjum et al., 2018), to calculate the sample size with precision/absolute error of 5% and type 1 error of 5%:

Sample size = [(Z1-α/2)2. P (1-P)]/d2Were,

$Z_{1-\alpha/2}$ = is the standard normal variate, at 5% type 1 error ($p<0.05$) it is 1.96.

P = the expected proportion in population based on previous studies.

d = absolute error or precision.

So,

Sample size = $[(1.96)^2(0.925). (1-0.925]/ (0.04)^2 = 166.5$

Based on the above formula, the sample size required for the study is 167.

3.5 Data Collection Tools

Data was collected using three tools:

Tool l: Structured Interview Questionnaire: The questionnaire was developed by the researcher after reviewing the related literature (Wambach et al., 2016) and consisted of two parts:

Part 1: Socio-Demographic Characteristics of the Studied Women: It included the following maternal characteristics: age, educational level, occupation, residence, period of marriage **a**nd income).

Part 2: Obstetric History of the Studied Women: It consisted of gestational age, number of antenatal visits, parity, number of living children, abortion, previous delivery mode, place of previous delivery, previous obstetric complications, and current pregnancy complications).

Tool II: Women's Involvement in CS Decision Questionnaire: The study evaluated women's participation in C.S. decision-making. Probing questions were asked after an open-ended question to find out how women felt about being included in the C.S. decision.

Tool III: Maternal Satisfaction with Cesarean Section (MSCS) Scale

The 42-item, 10-subscale Mother Satisfaction with Cesarean Section (MSCS) measure is taken from (Gungor & Beji, 2012) and includes the following: perception of medical staff, readiness for C-section, consoling, information and decision-making involvement, meeting baby, postpartum care, hospital room, hospital facilities, respect for privacy, and meeting expectations. The overall score is between 42 and 210. For the SMMS-cesarean birth, a cut-off score of 146.5 was determined; scores above this threshold signify higher levels of satisfaction.

3.6 Research Process

I. **The preparatory stage** the head of the Dr. Mohamed Abd El Wahab Obstetrics & Gynecology Center officially granted authorization to perform the current study. A review of the relevant national and international literature was conducted before designing the data gathering tool. Then, prior to gathering the real sample, a pilot study involving 17 women was carried out. From the beginning of February 2022 to the beginning of March 2022, this process took roughly one month.

2. Phase of data collection: The Dr. Mohamed Abd El Wahab Obstetrics & Gynecology Center provided the data. Official approval from the head of the Dr. Mohamed Abd El Wahab Obstetrics & Gynecology Center was obtained in order to conduct the study. The investigator worked in the aforementioned environment three days a week, from 9 a.m. to 2 p.m., until the estimated sample size was reached. The researcher performed in-person interviews with parturient ladies after introducing herself to them. This happened about two hours after the birth, giving the women enough time to recover and respond to the questions.

The women's privacy and confidentiality were protected; the researcher encouraged the women's cooperation by outlining the purpose of the study and getting their approval. The participated women had signed a written informed consent that they approved to participate in the research. Consent encompassed permission to be interviewed, writing their responses, and using a tape recorder. Eligible mothers who accepted to share their information with the researcher, were interviewed personally with the researcher at the postpartum room. After they received their intended care, the researcher introduced the structured interview questionnaire to her and explained the whole content of the questionnaire, which included women's socio-demographic data obstetric history.

After completion of the predesigned questionnaire, recording or documenting the conversation had started, one open-ended question was asked to elicit women's opinions regarding involvement in cesarean section decision. Probing questions were used to explore deeper into experiences, the researcher asked the mother in details about her current experiences.

3.7 Data Analysis

Data analysis was done according to the following:

I- Quantitative data: (obstetric and sociodemographic factors) was collected using the most up-to-date, legitimate, and trustworthy statistical techniques. The statistical software for social sciences (SPSS) for Windows version 26 (SPSS 7 Inc., Chicago, IL, USA) was used to analyze data on a compatible personal computer. As needed, the gathered data was coded, categorized, statistically examined, and shown as necessary using tables, figures, percentages, and numbers. All of the data were categorical, with mean, standard deviation, and person correlation given as numbers and percentages. To compare

categorical groups, the chi square (x2) test was employed. At $p<0.05$, statistical significance was established.

II. Qualitative data: The researcher conducted a literature review for the data analysis of the qualitative study while analyzing the qualitative data **(Amir, Zewawi & Jaroudi, 2017**). The Arabic transcription of the data was followed by an English translation. The data were coded and categorized using Burnard's 14 steps for assessing qualitative interview transcripts **(Burnard, 1991).**

Stage 1: Making Notes

Following each interview, the researcher took notes and recorded every detail pertaining to the woman's experience. Additionally, when the researcher attempted to gather responses that are connected to the same issue together in a category, "memos" were written regarding the methods of categorizing the data. Memos assist the recording of thoughts and theories that the researcher has while working with the data and act as memory aids. These memos enable the researcher to document anything that catches her eye in the early stages of the study of the data.

Stage 2: Reading Transcripts

After completing the interviews, the researcher went through the transcripts and took notes as she went. This stage's goal is to totally immerse oneself in the facts and comprehend the respondent's "life word."

Stage 3: Go back and read again

After reading the transcripts through once more, the primary categories that covered every part of the content—aside from "dross"—were noted down. The term "dross" refers to the unhelpful "fillers" in the interview as well as the topics that are not pertinent to the subject (Field and Morse, 1985). The vast majority of the interview data should be explained by the "headings" or "category system." At this point, categories can be created at any time.

Step 4: Establishing a List of Categories: A survey was conducted and the categories list was categorized under higher-order topics. By combining some of the comparable categories into larger ones, the goal is to decrease the total number of categories. The following five major topics comprised the key categories at this point:

1-Involvement of women in cesarean section.

2-Preoperative care.

3-Operative care.

4-Postoperative care.

5- Psychological support

Stage 5: List of subheadings: After eliminating the titles that were redundant or extremely similar, a new list of subcategories and subheadings was generated. Seventeen sub-themes were derived from the five primary themes.

Stage 6: The categorization method's Validity: The purpose of this step was to protect against researcher bias and guarantee the correctness of the categorization technique. This can be accomplished by asking two coworkers to independently create a new classification scheme while keeping the researcher's list hidden. Subsequently, the three lists of categories are examined and any necessary modifications are made.

Stage 7: Examining the subheading list and the transcript: To determine the extent to which the finalized list of categories adequately captures all parts of the interviews, transcripts and subheadings are reread alongside the list of categories. As needed, adjustments are performed.

Stage 8: The categories list is colored-coded: Every transcript is examined using the list of headings and categories, and then it is "coded" in accordance with the list of headings for each category. Here, colored highlighting pens are utilized to differentiate each transcript segment according to a category and subheading as:

- Involvement of women in cesarean section*: blue*
- Preoperative care: red
- Operative care: green
- Postoperative care: yellow
- Psychological support: orange

Stage 9: Gathering coding information

The transcript is divided into sections that correspond to each code, and all of the items associated with each code are gathered collectively. Here, the context of the coded passages is preserved by using multiple photocopies of the transcripts. Every statement made during an interview has a context. The parts on each side of the coded sections can be cut out together with the coded areas thanks to the numerous copies.

Here, a word of caution needs to be said. Interviews lose their "whole" quality when sections are segmented, making it impossible to understand the context of a specific comment or exchange of

ideas. Because of this, a second "complete" transcript.

Stage 10: Developing Themes and Sub-Themes Sheets: After cutting out the pieces, paste them onto sheets with the proper headings and subheadings.

Stage 11: Verifying the category's suitability: A subset of responders was requested to verify that the categorization system was appropriate. Did this quote from your interview fall within this category, the questioner questioned them? Does this? As needed, adjustments were made. This made it possible to keep an eye on the categorization process's veracity.

Stage 12: Gathering the components: For easy access while compiling the results, every area was filed together. Along with the original cassette recordings, copies of the entire interviews were kept on file for the writing up phase. The researcher should immediately consult the text or the recording if any questions arise when writing up the study.

Stage 13: Composing the report

The writing up procedure starts after all the sections are combined. Beginning with the first section, the researcher chose the different data examples filed under it and provided a commentary that connected the examples. After then, the researcher went on to the following part and so on, until all of the data had been documented. Throughout the entire writing process, the researcher maintained an open mind regarding the necessity of consulting the "complete" transcripts of the interviews and the original audio recordings. It is feasible to adhere more closely to the original contexts and meanings in this way.

Stage 14: Composing a summary of the results: The researcher has to make a decision at this point regarding whether or not to connect the commentary and data examples to the literature. There are two paths one can take. Initially, the researcher can compile the results and demonstrate each area with actual interview transcripts. Next, create a different part where you draw parallels and contrasts between those results and the literature on the subject. Second, the investigator might decide to include citations to the relevant literature in the report of the results. This turns the research "findings" section into a presentation of the findings as well as a comparison of those findings with earlier studies. The second approach was chosen by the researcher since it was more understandable and useful (Burnard, 1994).

Validity of the categorization process

The study tool was reviewed by three women's healthy and midwifery experts. These experts assessed the tool for clarity, relevance and applicability. Changes were considered according to their comments as certain sentences were simplified to be easily understood by the women.

3.9 Ethical Considerations

An ethical approval was obtained from the head of the woman's health and midwifery nursing department followed by approval from the Research Ethics Committee at The Faculty of Nursing, Mansoura University to conduct the study. After describing the study's aim, the director and head of the Obstetrics and Gynecology center gave his official permission to perform the study.

Each parturient woman included in the study gave her informed consent prior to the study, after the nature objective of the study was clarified. The participants were reassured about the anonymity, privacy, safety and Confidentiality of the collected information throughout the whole study. The participants were informed about their rights to refuse participation or Withdraw from the study at any time. Code numbers instead of names of the C.S cases were used for identifications. After finishing data collection all sheets were burned.

4. **Results**

Table (1) showed that 58.7% of studied women aged from 25-35 years old at average mean ±SD 28.4±7.1, 43.7% of them had a university education or higher.82.6% were of the housewives and from rural areas. Also, 47.3% were between 5-10 years of marriage and 82% of them had 4000-8000 pounds.

Table (2) presented that (55.1%) of studied women had gestational age <39 weeks. (56.3%) of them were multi para and (63.5%) attended ≥ 4 antenatal visits. (89.2%) of them had no abortion, no previous and current complications, 64.7% of them had one or two children, (77.7%) had previous vaginal birth and (72.3%) in a non-governmental institution.

Figure (1) illustrated that 35.7 of the studied women had anemia in their current pregnancy

Table (4A) showed that (79%) of studied women were strongly agreed with number of doctors and nurses involved in and prepared for cesarean. (56.3%) of studied women strongly agreed with comforting measures. (49.1%) of

studied women strongly agreed with knowing doctors and nurses responsible for care before cesarean. (74.3%) of studied women were strongly agreed with holding baby and breast feeding earlier.

Table (4B) showed that (62.9%) of studied women strongly agreed with postpartum care for themselves and their baby. (90.4%) of studied women were strongly agreed with comfortable room, facilities and maintaining privacy. (56.9%) of studied women agreed with meeting better care and having beautiful experience.

Figure (2) presented that (83.2%) of the studied women were satisfied regarding perception of health professionals, preparation for cesarean, meeting baby and hospital room.

Figure3.Shows that 71.5% of the studied women were satisfied with cesarean birth.

Table (5) showed that There existed a statistically significant correlation between women's satisfaction and university education or higher, employee, income.

Table (6) Showed that a strong statistically significant relationship existed between women's pleasure and previous cesarean birth and previous delivery in non-governmental institution.

Table 1. Demographic Characteristics of the Studied Women (n=167)

Items	n	%
Age (Years)		
18 – 25	52	31.1
25 – 35	98	58.7
> 35	17	10.2
Mean ±SD	28.4 ±7.1	
Educational level		
Basic Education	34	20.4
Secondary Education	60	35.9
University Education or higher	73	43.7
Occupation		
House wife	120	71.9
Employee	47	28.1
Residence		
Rural	138	82.6
Urban	29	17.4
Period of Marriage (years)		
< 5	62	37.1
5 – 10	79	47.3
> 10	26	15.6
Income		
< 4000	14	8.4
4000 – 8000	137	82.0
> 8000	16	9.6

Table 2. Obstetric Data of the Studied Women. (n=167)

Items	n	%
Gestational age (weeks)		
< 39	92	55.1
39 or More	75	44.9
Antenatal visits		
< 4	61	36.5
4 or More	106	63.5
Parity		
Primiparous	73	43.7
Multiparous	94	56.3
Abortion		
Zero	149	89.2
1	12	7.2
2 and more	6	3.6
Number of living children		
1 – 2	108	64.7
3 – 4	53	31.7
More than 4	6	3.6
Previous mode of delivery (n=94)		
Vaginal	73	77.7
CS	21	22.3
Place of previous delivery (n=94)		
Governmental Institution	26	27.7
Non-governmental Institution	68	72.3
Previous obstetric complications. (n=6)		
Bleeding	4	66.7
Wound infection	2	33.3
Current pregnancy complications. (N=28)		
Pre-eclampsia	2	7.1
Placenta previa	2	7.1
Gestational hypertension	8	28.6
Gestational diabetes	6	21.4
Anemia	10	35.7

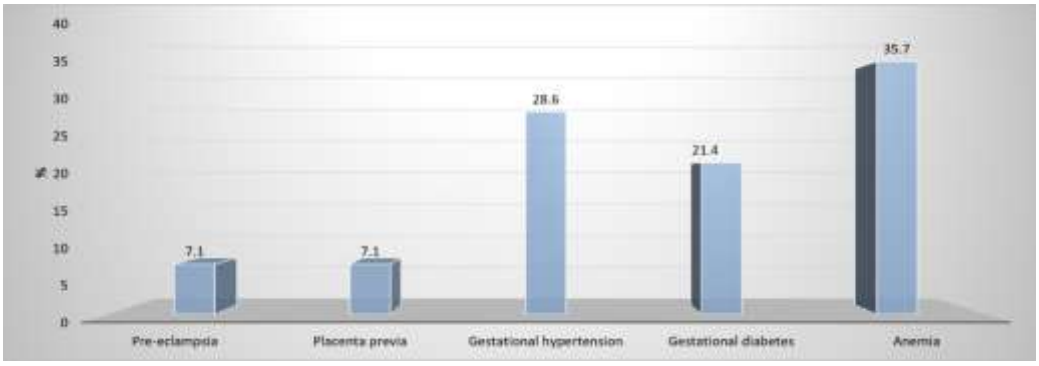

Figure 1. Distribution of Current Pregnancy Complications (n=28).

Part II. Women's opinion regarding involvement in C. S decision. Open questions were asked to the respondents answer as the following

Table 3A: Theme (1) Involvement of Women in Cesarean Section.

1.1	**Agreement of cesarean section.**
1.1.1	"I decided to deliver C.S because I am afraid from vaginal pain". (n=65)
1.1.2	"I considered to deliver C.S because I delivered my previous here by C.S" (n=21)
1.1.3	"My neighbors told me that C.S has a shorter duration than vaginal birth so that, I delivered by this method" (n=39).
1.1. 4	"I heard about patient-controlled analgesia (PCA) and told my obstetrician to receive it after birth". (n=42).
1.2	**Indication of cesarean section**
1.2.1	"My previous delivery was C.S, so my current delivery will be C.S" (n=21).
1.2.2	"It is my desire to deliver C.S as I can't tolerate the pain of vaginal birth" (n=75).
1.2.3	"My obstetrician indicated C.S for me because head of my baby was large" (n= 20).
1.2.4	"I had current obstetric complication such as placenta was lie down (n=2), gestational hypertension (n=8), gestational diabetes (n=6) and anemia (n=10)" (n=26).
1.2.5	"My obstetrician recommended C.S as I had preeclampsia and I afraid of getting fits during normal birth" (n=2).
1.2.6	"My obstetrician decided with me to deliver C.S as I suffer from heart disease" (n=1).
1.2.7	"My obstetrician recommended C.S as amount of fluid decreased around my baby" (n=12).
1.2.8	"My obstetrician examined me and my pelvis is narrow" (n=7).
1.2.9	"I delivered C.S because I have twins" (n=3).
1.1	**Informed consent.**
1.1.1	"My obstetrician told me about the C.S procedure and I signed the consent (n=55).
1.1.2	"Nurse told me about the C.S informed consent and I signed it (n=49).
1.1.3	"No one told me about the informed consent but I knew that my husband signed the consent" (n=30).
1.1. 4	"No one told me about the informed consent but I knew that my brother signed the consent" (n=18).
1.2	"Nurse told me about the C.S details before operation, after that I signed the consent" (n=15).
1.2.1	**Person involved in decision.**
1.2.2	"I decided to deliver C.S alone" (n=64).
1.2.3	"My obstetrician explained to me the indications and I agreed with him" (n=48).
1.2.4	"My husband and me involved in the decision after the obstetrician explain to me the reason" (n=34)
1.2.5	"My mother involved with me in the decision" (n= 11).
1.2.6	"My obstetrician and my husband involved in the decision" (n= 10).

Table 3B. Theme (2) Preoperative Care

2.1	**Preparation of preoperative care:**
2.1.1	"The obstetrician asked me just to do some investigations before cs" (n=152).
2.1.2	"Nurse gave me vit k injection before CS by one day" (n=167).
2.1.3	"The obstetrician ordered me to be fast before operation at least 8 hours" (n=158).
2.1.4	"The obstetrician explained to me risks and benefits of procedure". (n=99)
2.1.5	"Nurse performed skin preparation, asked me to remove all jewelry and checked my nails free from nail polish or any acrylic fingernails as nails used to assess capillary refill". (n=85).
2.1.6	"Nurse helped me to dress in operating room gown and insert cannula for Iv infusion". (n=167).
2.1.7	"Nurse sterilized my abdomen and put sterilized towel around place of incision to reduce spread of bacteria on skin and wound infection after birth" (n=167)
2.1.8	"Nurse installed urinary catheter after I took the anesthesia". (n=167)
2.2	**Duration of the operation.**
2.2.1	"The obstetrician told me that the operation will spend 2 hours" (N=57).
2.2.2	"Nurse told me that the operation will take nearly one hour and 45 minutes" (N=23).
2.2.3	"I asked nurse about the duration of operation and she answered that it will take nearly 2 hours" (n= 66).
2.2.4	"I know that the operation will take about one hour and half as my previous delivery took this time'' (n= 21).
2.3	**Type of anesthesia used.**
2.3.1	"The obstetrician explained to me types of anesthesia and its side effect' (n=167).
2.3.2	"I obstetrician advised me to take spinal anesthesia as it was my desire to be conscious at birth (n=95).
2.3.3	"The obstetrician ordered giving me general anesthesia because of my health status" (n=9).
2.4	**Incision type of operation.**
2.4.1	"The obstetrician told me that the operation incision will be horizontal" (n=129).
2.4.2	"I asked the nurse about the incision of operation and she told me that it will be horizontal" (n=38).
2.4.3	"Obstetrician informed me. Comparing closure with sutures vs closure with staples, suture closure of the cesarean skin incision reduced composite wound problems by 50% (n=145).

Table 3C: Theme (3) Operative Care

3.1	**Type of cesarean section**
3.1.1	"I asked the obstetrician about C.S type and he said there are two types, we used lower segment incision which made cut through the abdomen and lower part of uterus and another type is a classical incision refers to vertical cut on the uterus which only used for extreme emergencies" (n=73).
3.1.2	"The nurse told me that operation will be in the same previous site" (n=21).
3.1.3	Parturient women said that "I know operation will be under umbilical about 5 to 6 inches" (n=30).
3.1.4	"No one told me about the type of C.S" (n=10)
3.1.5	"My previous delivery was vaginal so I hadn't enough information about C.S" (n=33).
3.1.6	"No one told me but I know that most of women delivered by low segment cesarean incision" (n= 99).
3.2	**Wound suturing and welding.**
3.2.1	"I was concentrated with health team and I asked about the types of suture used" (n=77).
3.2.2	"The obstetrician and nurse explained that they use vicryl as it's absorbable" (n=80)
3.2.3	"The obstetrician and nurse involved in wound welding and suturing the edges of wound and told me that stitches will be removed within 5 to 7 days after surgery" (n=17)
3.3	**Skin to skin contact.**
3.3.1	"Nurse helped me to get baby skin to skin contact with me immediately baby delivered" (n=150).
3.3.2	"I kissed my baby after birth and put him on my breast" (n=47).
3.3.3	"I was very happy when I touched my baby in the operative room and hold him over my breast" (n= 88)
3.3.4	"The nurse held the baby and helped him in latching my breast" (n=32)
3.3.5	"The obstetrician and nurse told me about importance of skin to skin contact which strengthen my early bond with my baby and make breastfeeding easier" (n=167)
3.3.6	"I read about importance of skin to skin contact so I asked health care provider to made it" (n=15)

Table 3D. Theme (4) Postoperative Care

4.1	**duration of hospital stay**
4.1.1	"Nurse transferred me to postpartum room to receive care after c.s during the first 2 hours after operation". (n=167).
4.1.2	"My obstetrician told me that I will stay in hospital at least 8-12 hours for close observation". (n= 117)
4.1.3	"My husband asked nurse about the duration that We will stay in hospital after operation and she answered nearly 8 hours" (n=50)
4.1.4	"Nurse put my baby rooming in with me" (n=160)
4.2	**4.2 postoperative care**.
4.2.1	4.2.1 "The obstetrician checked my wound after delivery and instructed me to keep wound clean and dry for faster healing and reducing the risk of infection" (n=158).
4.2.2	"Nurse measured vital signs many times during staying in postoperative room" (n=155).
4.2.3	"Nurse performed and taught me uterine massage to prevent bleeding" (n=147)
4.2.4	"Nurse put elastic stock on my legs to prevent other problems" (n= 145).
4.2.5	"Nurse gave me analgesic IV to relieve postoperative pain (n=150).
4.2.6	"I heard about PCA from my neighbors and I ordered it from my obstetrician" (n=80).
4.2.7	"Obstetrician ordered PCA to me and I accepted it to relieve my pain" (n=45).
4.2.8	"Nurse encouraged me to initiate breast feeding within 2 hours after birth" (n=157).
4.2.9	"The baby's vital signs and any indications of an infection were assessed by the nurse. (n=125)
4.2.10	"The nurse checked my wound dressing, level of ambulation, urine output, indicators of breast engorgement, and amount of blood loss (n=156).
4.2.11	"Nurse gave me RH injection as my blood ABO is (-o) (n=8).
4.2.12	"Nurse put baby under the heater and made immediately baby care" (n=136).
4.2.13	"obstetrician inserted a drainage tube in wound to remove discharges and fluids, Nurse observed any change in color of discharged fluids and empty tube when full with third quadrants amount of discharge, also asked me to keep wound dry and clean" (n=3)
4.2.14	"Nurse encouraged me for walking to improve circulation" (n=150)
4.3	**Postoperative follow up and counselling.**
4.3.1	"Nurse told me breastfeeding is very important to help baby grow healthy and breastfeeding should be every 2 hours" (n=167)
4.3.2	"Nurse asked me to note carefully the first bowel movement after surgery as if no bowel movement has been observed, the physician may order a stool softener". (n=167).
4.3.3	"Nurse advised me to eat a diet high in roughage and drink plenty of fluid to facilitate bowel movement". (n=98)
4.3.4	"Nurse advised me to walk around for helping in recovery. Also stop blood clots and swelling in my leg" (n=135
4.3.5	"The obstetrician asked me for first follow up within 7 days" (n=167).

Table 3E. Theme (5) Psychological Support

5.1	**Supportive persons**
5.1.1	"My husband gave me support and cooperation during the period of childbirth". (n=120).
5.1.2	"My family was the source of support for me during delivery". (n= 145).
5.1.3	"Nurses were supportive with me and answered my all questions". (n=124).
5.1.4	"The obstetrician was helpful and informed me with all steps of procedure" (n=106).
5.1.5	"The obstetrician, nurse and my family were supportive". (n=150).
5.2	**Allowed visitors**
5.2.1	"the hospital system allowed for (2-3) persons to visit me every hour according to visiting hours from 12am – 3pm " (n=75)
5.2.2	"My family were very happy to see my lovely baby" (n=165).
5.2.3	"My family was allowed to see me one by one every half hour and wearied mask" (n=60).
5.2.4	"My husband told my family don't come to hospital and visit me on my house after discharge" (n=25).
5.2.5	"My mother and my husband were only with me in hospital" (n=17).
5.3	**5.3 Discharge plan:**
5.3.1	"The obstetrician made discharge plan for me including medication and follow up schedule" (n= 159).
5.3.2	"The obstetrician advised me to eat healthy food and walk for well recovery" (n=160).
5.3.3	"The obstetrician ordered me to adhere the medication specially antibiotics" (n=156).
5.3.4	"The obstetrician asked me for follow up within every 2 weeks until lochia stopped" (n=167).
5.3.5	"Nurse give me health education about personal hygiene and perineal care" (n=167).
5.3.6	"Nurse advised me about types of lochia and its normal characteristic to seek help if changes occur" (n=89)
5.3.7	"Nurse instructed me about the importance of newborn care and immunization. (n=148).
5.3.8	"Nurse instructed me not to lift any heavy weight" (n=55)
5.3.9	"Nurse instructed me to keep wound clean and dry and look for signs of infection such as redness, pain, swelling of the wound and bad- smelling discharge report this to my obstetrician" (n=160)
5.3.10	"Nurse taught me about counseling for family planning methods" (n=135).
5.3.11	"Nurse instructed me about importance breastfeeding for me to prevent disease and baby to increase immunity" (n=167).

Part III. Maternal Satisfaction with Cesarean Section (MSCS) Scale

Table (4A): Maternal satisfaction with cesarean birth

Items	Strongly disagree		Disagree		Neutral		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%
Perception of Health Professionals										
The number of doctors, midwives and nurses involved in my care was enough during my hospital stay.	0	0.0	0	0.0	4	2.4	31	18.6	132	79.0
The doctors, midwives and nurses involved in my birth treated me/behaved well.	0	0.0	0	0.0	0	0.0	30	18.0	137	82.0
The doctors, midwives and nurses involved in my birth treated my family well	0	0.0	0	0.0	0	0.0	25	15.0	142	85.0
I believe that doctors have done necessary medical interventions during childbirth	0	0.0	2	1.2	4	2.4	29	17.4	132	79.0
I was taken in the operating room for cesarean birth without delay at the scheduled time	4	2.4	0	0.0	0	0.0	40	24.0	123	73.7
Preparation for Cesarean										
Nurses spent enough time to prepare me for cesarean birth	2	1.2	8	4.8	0	0.0	47	28.1	110	65.9
The nurses spent enough time to meet my needs before cesarean birth	2	1.2	4	2.4	4	2.4	53	31.7	104	62.3
Comforting										
Everyone told me just what I should do before cesarean birth.	4	2.4	8	4.8	4	2.4	57	34.1	94	56.3

I'd like to have had more help to reduce my stress before cesarean birth.	21	12.6	64	38.3	8	4.8	52	31.1	22	13.2
My family should have received more attention to reduce their stress before cesarean birth	43	25.7	92	55.1	0	0.0	18	10.8	14	8.4
Information and Involvement in Decision Making										
I knew which doctors and midwives & nurses would be responsible from my care before cesarean birth	6	3.6	16	9.6	2	1.2	61	36.5	82	49.1
I was informed about all necessary procedures before cesarean birth	4	2.4	10	6.0	4	2.4	89	53.3	60	35.9
My partner/family was informed about all necessary procedures before cesarean birth	2	1.2	10	6.0	2	1.2	93	55.7	60	35.9
The doctors and midwives & nurses took into account everything I said before cesarean birth.	2	1.2	7	4.2	2	1.2	92	55.1	64	38.3
Doctors and nurses explained me everything about cesarean birth before operation.	2	1.2	8	4.8	6	3.6	94	56.3	57	34.1
Doctors and nurses explained my partner/family everything about cesarean birth before operation.	2	1.2	10	6.0	8	4.8	92	55.1	55	32.9
My consent was asked before performing the procedures related with my care during birth.	0	0.0	8	4.8	4	2.4	81	48.5	74	44.3
Consent of my partner / family was asked before performing the procedures related with my care during birth when necessary	0	0.0	6	3.6	6	3.6	77	46.1	78	46.7
Meeting Baby`										
After birth, I'd like to hold my baby earlier	4	2.4	2	1.2	0	0.0	37	22.2	124	74.3
After birth, my family would love to be able to see the baby earlier.	2	1.2	0	0.0	0	0.0	41	24.6	124	74.3
After birth, I'd like to breast feed my baby earlier	6	3.6	2	1.2	2	1.2	34	20.4	123	73.7

Table (4B). Maternal satisfaction with cesarean birth

Items	Strongly disagree		Disagree		Neutral		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%
Postpartum Care										
Some more things could have been done to reduce my pain and discomfort after birth	16	9.6	85	50.9	8	4.8	23	13.8	35	21.0
Nurses met my needs adequately during the days after birth.	0	0.0	8	4.8	4	2.4	65	38.9	90	53.9
Nurses spent enough time to give information about my own care after birth.	4	2.4	4	2.4	4	2.4	60	35.9	95	56.9
Nurses spent enough time to give information about the care of my baby.	2	1.2	8	4.8	8	4.8	54	32.3	95	56.9
Nurses spent enough time to help breastfeeding	6	3.6	16	9.6	0	0.0	43	25.7	102	61.1
The information received from different caregivers about self-care and baby care was consistent	2	1.2	12	7.2	6	3.6	42	25.1	105	62.9
Hospital Room										
The room in which I stayed during preparation for cesarean was clean and adequate to meet my needs.	0	0.0	0	0.0	0	0.0	22	13.2	145	86.8
The room in which I stayed after birth was comfortable and adequate to meet my needs	0	0.0	0	0.0	2	1.2	16	9.6	149	89.2
The room in which I stayed after birth was suitable for the visits of my family and friends	0	0.0	0	0.0	0	0.0	16	9.6	151	90.4
Hospital Facilities										
My family had a proper and comfortable place in the hospital to rest and wait during birth.	0	0.0	0	0.0	2	1.2	21	12.6	144	86.2

We could easily find everything we needed in hospital.	0	0.0	6	3.6	0	0.0	22	13.2	139	83.2
The food service was good at hospital	6	3.6	4	2.4	10	6.0	32	19.2	115	68.9
Respect for Privacy										
There were people coming in and out of my room unnecessarily during preparation for cesarean.	0	0.0	2	1.2	4	2.4	18	10.8	143	85.6
There were people coming in and out of my room unnecessarily after birth.	0	0.0	4	2.4	4	2.4	15	9.0	144	86.2
Health-care personnel showed respect to my privacy during their practices.	0	0.0	4	2.4	8	4.8	23	13.8	132	79.0
Special moments I lived with my family before and after cesarean birth were interrupted by medical staff because of routine interventions that could be delayed easily	0	0.0	8	4.8	32	19.2	34	20.4	93	55.7
Meeting Expectations										
I could not get any better care in this hospital.	53	31.7	91	54.5	6	3.6	12	7.2	5	3.0
My birth experience was completely as I had expected and hoped	6	3.6	15	9.0	20	12.0	91	54.5	35	21.0
The cesarean birth took longer than I had expected	46	27.5	89	53.3	4	2.4	14	8.4	14	8.4
I had not expected to have some of the medical interventions used at my birth	17	10.2	104	62.3	21	12.6	20	12.0	5	3.0
This birth was one of the most beautiful experiences in my life	10	6.0	14	8.4	23	13.8	95	56.9	25	15.0

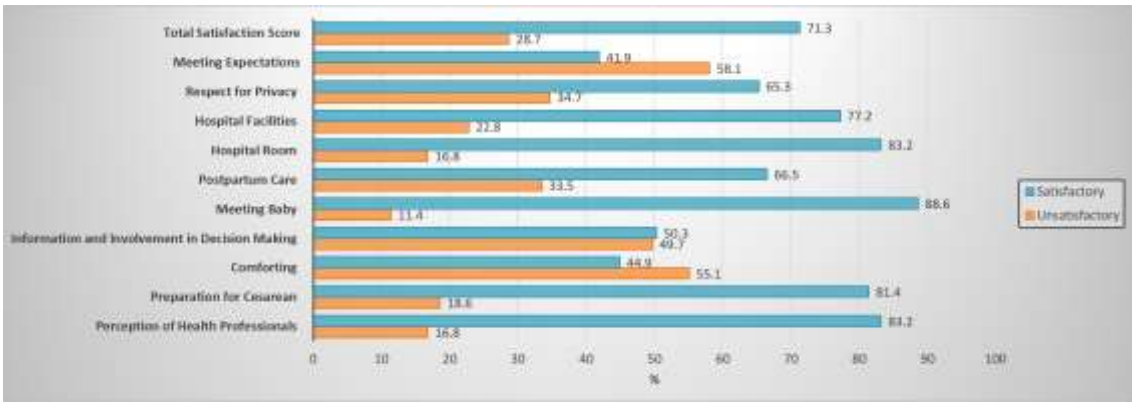

Figure2. Number and Distribution of the Maternal Satisfaction in Cesarean Birth Domains and Score

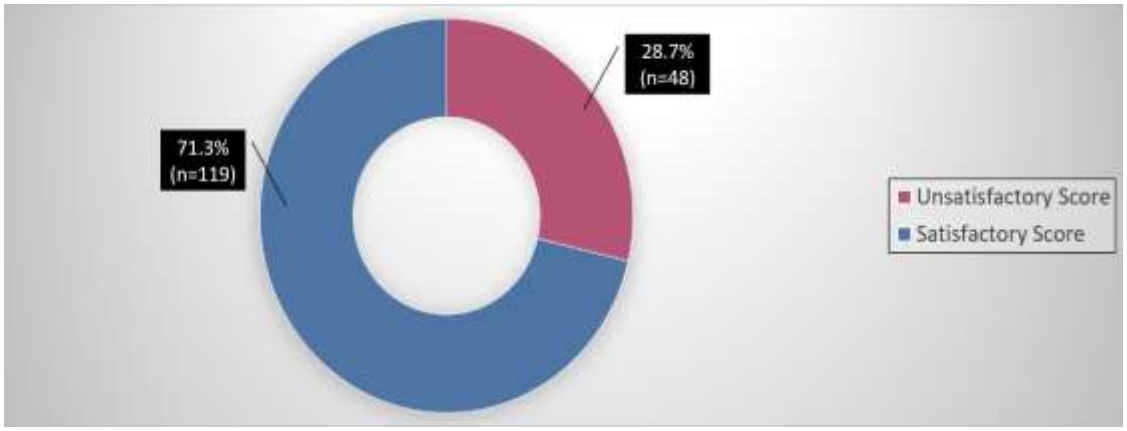

Figure 3. Total Maternal Satisfaction with Cesarean Birth.

Table 5. Association between the demographic characteristics of the women and maternal satisfaction score

items	Unsatisfactory (n=48)		Satisfactory (n=119)		Chi – Square / Fisher's exact test	
	n	%	n	%	X^2	*p*
Age (Years)						
18 – 25	12	25.0	40	33.6		
25 – 35	31	64.6	67	56.3		
> 35	5	10.4	12	10.1	1.218	0.544
Educational level						
Basic Education	32	66.7	2	1.7		
Secondary Education	4	8.3	56	47.1		
University Education or higher	12	25.0	61	51.3	90.622	<0.001**
Occupation						
House wife	24	50.0	96	80.7		
Employee	24	50.0	23	19.3	15.912	<0.001**
Residence						
Rural	41	85.4	97	81.5		
Urban	7	14.6	22	18.5	0.363	0.547
Period of Marriage (years)						
< 5	18	37.5	44	37.0		
5 – 10	17	35.4	62	52.1		
> 10	13	27.1	13	10.9	7.752	0.021*
Income						
< 4000	4	8.3	10	8.4		
4000 – 8000	28	58.3	109	91.6		
> 8000	16	33.3	0	0.0	44.280	<0.001**

Table 6. Association between obstetric data of the women and maternal satisfaction.

Items	**Unsatisfactory (n=48)**		**Satisfactory (n=119)**		**Chi – Square / Fisher's exact test**	
	n	%	n	%	X^2	*p*
Gestational age (weeks)						
< 39	28	58.3	64	53.8		
39 or More	20	41.7	55	46.2	0.286	0.593
Antenatal visits						
< 4	15	31.3	46	38.7		
4 or More	33	68.8	73	61.3	0.809	0.368
Gravidity						
Primigravida	16	33.3	26	21.8		
Multigravida	32	66.7	93	78.2	2.396	0.122
Parity						
Primiparous	24	50.0	49	41.2		
Multiparous	24	50.0	70	58.8	1.082	0.298
Abortion						
Zero	40	83.3	109	91.6		
1	6	12.5	6	5.0		
2 and more	2	4.2	4	3.4	2.971	0.226
Number of living children						
1 – 2	33	68.8	75	63.0		

3 – 4	13	27.1	40	33.6		
More than 4	2	4.2	4	3.4	0.695	0.707
Previous mode of delivery (n=94)	**(n=24)**		**(n=70)**			
Vaginal	7	29.2	66	94.3		
CS	17	70.8	4	5.7	43.683	<0.001**
Place of previous delivery (n=94)	**(n=24)**		**(n=70)**			
Governmental Institution	15	62.5	11	15.7		
Non-governmental Institution	9	37.5	59	84.3	19.552	<0.001**
Previous obstetric complications						
No	44	91.7	117	98.3		
Yes	4	8.3	2	1.7	4.370	0.037*
If yes, what were your complications? (n=6)	**(n=4)**		**(n=2)**			
Bleeding	2	50.0	2	100.0	1.500	0.221
Wound infection	2	50.0	0	0.0	1.500	0.221
Current pregnancy complications						
No	36	75.0	103	86.6		
Yes	12	25.0	16	13.4	3.272	0.070
If yes, what are your current complications? (n=28)						
Pre-eclampsia	2	16.7	0	0.0	2.872	0.090
Placenta previa	2	16.7	0	0.0	2.872	0.090
Gestational hypertension	4	33.3	4	25.0	0.233	0.629
Gestational diabetes	2	16.7	4	25.0	0.283	0.595
Anemia	2	16.7	8	50.0	3.319	0.069

5- Discussion

Cesarean sections are now among the most performed surgeries worldwide, with a rate of 72% in Egypt and 21% globally **(Eman, 2023).** Over the previous three decades, there has been a rise in the utilization of cesarean sections. Nowadays, cesarean sections account for around one-third of births in several affluent nations (**Mahsa, et al., 2024)**. Despite the fact that the World Health Organization (WHO) recommends an acceptable percentage of cesarean sections of no more than 10-15% **(Lemlem, 2024).**

The purpose of the current study was to evaluate women's happiness with and involvement in the choice to have a cesarean section. The current study's findings, which showed that over two thirds of the women surveyed were content with their cesarean section and that roughly a third were not, helped to achieve this goal. Thus, the research questions were addressed by the study's findings.

Regarding women's involvement in C.S. decisions, the current study found a highly significant relationship between their satisfaction and their involvement. This finding was consistent with **Saskia's (2013)** finding that women's satisfaction with childbirth is not directly influenced by the mode of delivery. Effective analgesia, support during labor, and decision-making involvement seem to be the most crucial elements that enhance women's birth experiences.

The results of the current study show that there are a number of reasons why the number of cesarean births on maternal request (CDMR) has increased, but among the primary ones are fear of the pain, bad labor experiences in the past, worries about fetal harm or death from vaginal birth, positive attitudes toward cesareans due to convenience, and quick deliveries without labor pain. This outcome is consistent with the findings of **Felice (2022),** who examined 22 maternal requests for cesarean sections and found that over half of the women in the study made such a request.

The current study makes it clear that obtaining informed permission is essential to providing women-centered care. This result is consistent with research conducted by panel **Karen (2022)** on satisfaction with informed consent following a cesarean section, and by **Faysal et al. (2024)** on counseling, informed consent, and debriefing following a cesarean section in sub-Saharan Africa, which demonstrated that women who had CDs were more satisfied with the consent process than other women. This may be explained by the fact that cesarean sections (CDs) are among

the most common operations performed on women. As such, it is crucial that women undergoing CDs are informed about the indications, technique, risks, complications, and other details of CDs before providing their consent.

Concerning preoperative fasting, the current study revealed that the majority of the ladies were fasting approximately 8 hours prior to the operation. This result is consistent with the findings of **(Sharon, 2023)** who examined cesarean sections and noted that it is customary to request that a patient remain "NPO" after midnight. It is typical to request a six-hour fast from the patient. The latest improved recovery protocols advise against giving the women solid meals until six hours before the planned surgery and to encourage them to drink clear liquids until two hours before.

Additionally, this is in line with the findings of **(panelYeeLing & Sabeetha, 2024),** who investigated the effects of free access to water prior to surgery under spinal anesthesia and found that, in comparison to fasting from midnight onward for planned cesarean delivery, free access to water up until the call to dispatch to the operating room significantly increased maternal satisfaction scores with assigned preoperative oral intake regime.

Regarding the type of incision, the current study found that most of the women under investigation had horizontal incisions. This finding is consistent with research conducted by **Rebecca (2020),** who investigated the relationship between the location of skin incisions made during cesarean delivery and wound complications. She found that vertical incisions during cesarean delivery may be more likely to result in wound complications than transverse incisions. This might be the result of increased awareness of cesarean sections and high levels of education.

According to postoperative care High levels of discomfort during the first 24 hours after a cesarean delivery have recently been observed, according to postoperative treatment. The current study shows that because intravenous patient-controlled analgesia (PCA) relieves post-operative pain, over two thirds of the women evaluated either ordered or preferred to use it following C.S. This result is consistent with **Pauline et al., 2023** report, which stated that PCA has a well-established track record of providing excellent pain relief, and that it is now widely accessible as an acute pain relief treatment after cesarean sections. Using PCA may also provide mothers a greater sense of control over their pain following surgery.

This may be explained as accurate assessment of pain severity of post-cesarean section helps to choose the most appropriate anesthetic approach, drug, and dose. Also, the PCA proved that it’s more effective in pain’s relief after cesarean section and more superior especially for visceral pain, can easily be applied and Complications and side effects was minimal when adjusting the doses, so that women be more satisfied and easily.

In terms of psychological support, the current study demonstrated that most of the women under study had more than one helpful person during childbirth, including their husbands, families, mothers, and medical professionals including obstetricians and nurses. This is in line with the findings of **Julia Leinweber's study from 2023**, "Developing a woman-centered, inclusive definition of positive childbirth experiences," which stated that professional maternity care providers can act as a "safe haven" for the birthing person by offering support during childbirth, which has been repeatedly identified as the most important factor for a positive childbirth experience. It has been discovered that providing women with ongoing support, or simply "being with" them during labor and delivery, improves their experiences.

This can be explained as the satisfaction of women with their childbirth experience was differentiated following to their psychological adjustment after giving delivery. Because of this, women who overcame anxiety following C.S. and received psychological support from family and medical professionals returned to their regular lives more quickly and with more satisfaction.

Measurement of the satisfaction of women is a crucial component of quality assurance programs for nursing. It has been discovered that scales designed to gauge people's experiences with and satisfaction with nursing are valid, dependable, and capable of identifying variations between wards and hospitals **(van, Bitter, Hendriks, Vermeulen, & Oostveen, 2023).**

The experience of labor has been positively impacted by women's decision to choose cesarean delivery over other delivery methods. **Agheera (2018)** conducted a study on women's involvement in decision-making regarding cesarean sections and their postpartum satisfaction, which provided evidence for this claim. This was consistent with the findings of the current study, which demonstrated the strong correlation between women's satisfaction and their involvement in C.S. decisions.

This can be explained by the fact that women who are involved in decision-making receive pertinent information from health care practitioners. This information may include details about the procedure type, indication, options, risks, advantages, complications, alternatives, and outcomes, as well as the freedom to accept or reject the decision. Participation in decision-making increased autonomy, empowerment, and efficacy. Women and healthcare professionals will have better relationships and interactions, which will increase patient happiness and care quality.

Additionally, a study by **Getu, Dadhi, Gesisa, Feyisa, and Yohannes (2023)** found that a caesarean delivery that does not involve women in decision-making undermines trust between women and health care providers. The study looked at women's involvement in decision-making and associated factors among women who underwent a caesarean section. It also violates women's autonomy, which can make them feel powerless. Women could also find it difficult to heal and reach their health objectives.

6- Conclusion

Based on the results of the current study, it is concluded that women's contentment and their engagement in the choice of a cesarean section are closely correlated. A strong statistical correlation was found between women's happiness with their university degree and sufficient income. Furthermore, a strong statistically significant correlation was found between women's satisfaction and prior cesarean delivery, previous delivery in non-governmental institutions. The majority of the studied women involved in cesarean section were satisfied with their decision and less than third of them were unsatisfied.

7- Recommendations

Based on the study findings, the following is recommended:

- Involvement of women in decision making regarding C.S delivery, positively impact their health and strengthen their relationship with the infant.
- Importance of psychological support of the parturient women with C.S especially Pre & postoperative.
- Health care providers have an important role in pre & post C.S care.

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