Çankırı Karatekin University
Graduate School of Health Sciences

Master of Nursing Science Thesis

WOMEN'S KNOWLEDGE ABOUT ELECTIVE CESAREAN SECTION COMPLICATIONS AT MATERNITY AND CHILDREN HOSPITAL IN DIWANIYAH CITY

By

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Advisor

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ÇANKIRI 2023

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The Degree of Master of Nursing Science

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2023

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ETHICS STATEMENT

The thesis entitled “Women's Knowledge About Elective Cesarean Section Complications At Maternity And Children Hospital In Diwaniyah City” which was prepared and presented as a thesis, was written by myself and in accordance with the scientific, academic rules and ethical conduct. The idea/hypothesis of my thesis solely belongs to my supervisor and to me. The research pertaining to the thesis was conducted by myself and therefore, all of the used sentences and interpretations within the work belongs to me.

I declare the aforementioned issues to be correct.

Signature

April 2023

Zinah Mohammed Jahil JAHIL

ABSTRACT

WOMEN'S KNOWLEDGE ABOUT ELECTIVE CESAREAN SECTION COMPLICATIONS AT MATERNITY AND CHILDREN HOSPITAL IN DIWANIYAH CITY

Zinah Mohammed Jahil JAHIL

Master of Science in Nursing

Advisor: Asst. Prof. Dr. Esra ARSLAN GÜRCÜOĞLU

April 2023

Elective caesarean sections are primary caesarean sections that are performed according to the desire of the pregnant woman without a medical justification or reasons for that at the mother's request. The study aimed to assess women's attitude, perception and knowledge about the complications of elective caesarean section.To determine the influence of demographic characteristics on attitude, perception, and knowledge.A descriptive study was conducted in the Maternity and Children Hospital in Al-Diwaniyah city of 285 married women and they were selected using the Yamane's formula for calculating the sample size. Data were analyzed using statistical and inferential procedures. The highest percentage (42.8%) of the participants falls within the age group (25 to 32) years. (73.3%) of the study sample had previously undergone elective caesarean sections, and the reason for choosing a caesarean section was - fear for the fetus, a high percentage (70.2%) of the participants and (57.9%) fear of labor pains. Although the highest percentage (28.1%) of the participants graduated from college, there is a lack of awareness of the complications of ECS the mean score of overall knowledge (1.48) poor knowledge. In this context, education and awareness programs should be intensified about the complications of elective caesarean sections. The study of 285 women showed that there was a statistically significant relationship between knowledge, attitudes, perception and demographic characteristics**.**

2023, 72 pages

Keywords: Elective Cesarean Section, Complications of Cesarean, Knowledge, Assessment

ÖZET

DIWANIYAH ŞEHRI KADIN DOĞUM VE ÇOCUK HASTANESINDE ELEKTIF SEZARYEN KOMPLIKASYONLARI HAKKINDA KADINLARIN BILGISI

Zinah Mohammed Jahil JAHIL

Hemşirelik, Yüksek Lisans

Tez Danışmanı: Dr. Öğr. Üyesi. Esra ARSLAN GÜRCÜOĞLU

Nisan 2023

Elektif sezaryen doğumlar, tıbbi bir gerekçe veya sebep olmaksızın, gebenin isteği üzerine, gebenin isteğine göre gerçekleştirilen primer sezaryenlerdir. Bu çalışmada, kadınların elektif sezaryen komplikasyonları hakkındaki tutum, algı ve bilgilerinin değerlendirilmesi, demografik özelliklerin tutum, algı ve bilgi üzerindeki etkisinin belirlenmesi amaçlanmıştır. Al-Diwaniyah kentindeki Doğum ve Çocuk Hastanesinde 285 evli kadın üzerinde tanımlayıcı bir çalışma yapılmıştır. Örnek büyüklüğünü hesaplamak için Yamane'nin formülü kullanılmıştır. Veriler istatistiksel ve çıkarımsal prosedürler kullanılarak analiz edilmiştir. Katılımcıların çoğunluğu (%42,8) 25-32 yaş grubundadır. Araştırma örnekleminin %73,3'ü daha önce elektif sezaryen geçirmiştir. Katılımcılar sezaryeni seçme nedeni %70,2 oranla fetüs için korku ve %57,9 oranla doğum ağrısından korkma olarak belirtmişlerdir. Katılımcıların en yüksek yüzdesi (%28,1) üniversite mezunu olmasına rağmen, Elektif Sezaryen (ECS'nin) komplikasyonları hakkında daha fazla bilgi sahibi olunması gerekmektedir. Genel bilginin ortalama puanı (1.48) zayıf bilgidir. Bu bağlamda, elektif sezaryen komplikasyonları konusunda eğitim ve bilinçlendirme programları yoğunlaştırılmalıdır. 285 kadın üzerinde yapılan çalışma, bilgi, tutum, algı ve demografik özellikler arasında istatistiksel olarak anlamlı bir ilişki olduğunu göstermiştir.

2023, 72 sayfa

Anahtar Kelimeler: Elektif Sezaryen, Sezaryen Komplikasyonları, Bilgi, Değerlendirme

PREFACE AND ACKNOWLEDGEMENTS

Before all, great thanks to Allah, the Merciful, and the Compassionate. I would like to express my deepest thanks and gratitude to Asst. Prof. Dr. Esra ARSLAN GÜRCÜOĞLU for her guidance, and scientific assistance. I wish to express my sincere thanks to all the distinguished professors and the discussion committee, and special and great thanks to my mother and father for their support and encouragement throughout my study. Finally, special thanks are extended to all the women who participated in this study for their patience and cooperation during their interviews.

Zinah Mohammed Jahil JAHIL

Çankırı-2023

CONTENTS

LIST OF ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
ANOVA	Analysis of variance
CDMR	Cesarean delivery on maternal request
CPD	Cephalopelvic disproportion
CS	Cesarean section
CSMR	Caesarean section on maternal request or demand
CSMR	Cesarean sections on maternal request
CTG	Cardiotocography
CTGs	Cardiotocography section
DVT	Deep Vein Thrombosis
ECS	Elective caesarean section
ERCD	Death elective repeat cesarean birth
GA	Gestational age
ICU	Intencev care unit
MRI	Magnetic Resonance Imaging
NICU	Neonatal intensive care unit
PTSD	Pre-traumatic stress disorder
PTSD	Posttraumatic stress disorder
P-value	Probability value
SD	Standart Deviation
SSC	Skin- to- skin contact
TOLAC	Trail of labor after caesarean
VBAC	Vaginal birth after caesarean
VTE	Venous Thrombosis and Embolism

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1. INTRODUCTION

Babies are delivered via one or more incisions made in the mother's belly and uterus during a caesarean section, which is an operative surgery. When the health or life of the mother or the infant is at danger during a vaginal birth, a CS may be necessary. The only time a Caesarean section should be performed is when it is medically necessary to do so in order to better the result for the mother or child. Some are performed on demand without medical reasons to do so. According to the World Health Organization, only medical need should justify such action (WHO, 2015).Common factors include the suggestion of caesarean section, a prior cesarean birth, cephalopelvic disproportion (When the baby's head cannot pass through the opening of mother's pelvis) and fetal distress (WHO, 2010).The decision to perform a cesarean section is often subjective and up to the discretion of the obstetrician. In most cases, a cesarean section is performed as a main (first) option when labor has stalled. In the clinical scenario of absolute cephalopelvic disproportion (CPD), the fetus is too big in relation to the bony pelvis to permit vaginal birth even under ideal conditions. When a fetus has relative CPD due to malpresentation, its size exceeds the limits of the bony pelvis (brow, compound presentation) (Norwits & Schorge, 2013).In a caesarean section, incisions are made in the mother's abdominal and uterine walls to facilitate the birth of the baby. The cesarean section (CS) is a routine surgical technique in modern obstetrics that may save the lives of both the mother and the baby. The incidence of cesarean sections is rising, despite recommendations from the World Health Organization that it not surpass 15% Short- and long-term hazards to the mother, the baby, and any future pregnancies are increased by cesarean sections. When it comes to precautions, facilities, and planning, an emergency cesarean operation and a planned cesarean section are two completely separate things (Darnal & Dangal, 2020).It is estimated by the American College of Obstetricians and Gynecologists (ACOG) that 2.5% of all births in the United States are caesarean delivery on mother desire (ACOG, 2013).Primary caesarean section conducted at the desire of the pregnant woman without medical justification or obstetric grounds is known as caesarean section on maternal request or demand (CSMR) (Kalish et *al*., 2008).

More and more cesarean sections are being performed in private hospitals without proper medical justification. With the development of advanced anesthetic techniques and the establishment of standard operating procedures, the safety of cesarean sections has increased significantly. Nonetheless, the risks associated with this method of giving birth are higher than those associated with a typical vaginal delivery, including an increased risk of infection, prolonged hospitalization, and even death (Samanta et *al*., 2008). Acceptability of CS has increased throughout time, leading to an increasing CS rate in industrialized countries whereas poor nations struggle with the challenges of a low CS rate despite the clear and present risk to the mother and child (Afaya et *al*., 2018). In fact, prenatal clinics were the primary informational source for 54% of pregnant women, whereas the media was the primary informational source for 22%. Contrary to the findings of a research performed in Cape Coast, where 68% of respondents said that the media was their primary source of knowledge (KojoPrah et *al*., 2017). Compared to normal-weight women, obese women are more likely to undergo a cesarean section and have a lower incidence of vaginal birth following cesarean (Kawakita et *al*., 2016). Patients who are well informed about their diseases are better equipped to take part in shared decision-making, according to the available evidence. Given their lack of birthing knowledge, individuals passively follow their care provider's instructions (Ajeet et *al*., 2011). One of the individual factors of cesarean births is a woman's socioeconomic level. Differences in delivery methods across different socioeconomic groups (typically measured by income, employment, or education) that persist after controlling for medical risk factors (Milcent & Zbiri, 2018). In the industrialized world, the mortality rate from caesarean sections is 13 per 100,000 whereas the death rate from vaginal births is 3.5 per 100,000. Risk to the mother is three times higher than with a vaginal delivery, according to the National Health Service of the United Kingdom. In resource-rich environments, however, the probability of dying from either cause is quite low (Wikipedia, 2010). Adhesion formation, incisional hernias (which may need further surgery to repair), and wound infections are all possible complications after a caesarean section, as they are following any abdominal procedure. Having a caesarean delivery decreases a woman's fertility somewhat compared to having a vaginal birth, but only little (Wikipedia, 2010).

More than a quarter 27.3% of the 107,950 births studied were CS in China, which had the highest rate of operations, nearly half 46.2% of the births in the survey were CS. The nine countries studied were Cambodia, China, India, Japan, Nepal, the Philippines, Sri Lanka, Thailand, and Vietnam. There is a higher risk of mother and newborn mortality, ICU hospitalization, blood transfusion, hysterectomy, and internal iliac artery ligation (to reduce pelvic hemorrhage) with these surgical procedures compared to natural childbirth (WHO, 2010). Cesarean sections have been performed for many reasons, including medical complications and societal and economic ones. The dread of discomfort, vaginal exam, psychological pressure, and ignorance are other reasons. (Leone et *al*, 2008; Jamshidi et *al*., 2005).

1.1 Importance of study

There is little data on the frequency of cesarean delivery at the mother's request or the extent to which this practice contributes to the rising rate of elective cesarean deliveries; however, it is believed that 2.5% of all births in the United States are cesarean delivery at the mother's desire (Birsner & Porter, 2019). Rates of cesarean sections are not a perfect indicator of healthcare quality. Although caesarean sections have been linked to poor maternal health, the incidence of these procedures vary widely depending on factors such as provider and hospital practice and the preexisting health of the patient (Gupta & Kaplan, 2017). Having a CS has, sadly, become a social norm for relieving pain and has had repercussions for public health. Complications such as endomyometritis, hemorrhage, thromboembolism, premature labor and death (in mother), respiratory distress syndrome, resistive pulmonary hypertension, and damages like injury, bruising, or other traumas in newborn occur when CS imposes higher danger to the mother than vaginal birth (Navaee & Abedian, 2015). Efforts have been made to lower CS rates and associated complications via interventions such healthcare professional education and attitude changes (Gunnervik et *al*., 2010). Attempts have been undertaken to lessen the prevalence of CS via a few different methods. As one concrete example, in Iran, where women are educated and encouraged to prepare themselves emotionally and mentally for a natural delivery, the country's CS rate has dropped by 15% (Navaee & Abedian, 2015).

1.1.Statement of the problem

"Women's Knowledge, Attitude and Perception about Elective Cesarean Section Complications at Maternity and children Hospital in Diwaniyah City".

1.2 . Objectives of the study

1. To assess attitude, perception and knowledge of women about elective cesarean section complications.
2. To determine the effect of demographic characteristics on attitude, perception and knowledge.

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2. LITERATURE REVIEW

2.1 Background

Surgically removing a baby from its mother is called a "CS" The mother's abdominal and uterine parts must be cut for this treatment. Despite being dangerous abdominal surgery, cesarean delivery is the most common practice in certain countries, including the United States (Feder, 2014). Cesarean sections were so rare in the 19th century that a doctor had to observe a physical aberration like no cervical opening before contemplating one. The few births attended by doctors, their lack of obstetrics expertise, and the horrific side effects of surgery contributed to this. Only one of the 121 infants born at Philadelphia Lying-In between October 1895 and March 1896 had an abdominal pregnancy that needed surgery (Wolf, 2018). Cesarean sections have caused many catastrophes for mothers and babies. The roots of abdominal opening to remove the fetus are lost in ancient mythology, mythos, and tradition. According to Greek mythology, Asclepius was born from his mother's slit abdomen. After Semele's death, Zeus took Dionysus from her womb and gave him life. Eastern Hindu and Buddhist civilizations also tell of forced births by abdominal cuts. Buddha supposedly glimpsed the light via his mother Maya's cesarean section. This surgery is mentioned in Persian literature. Ferdowsi discusses Rostam's cesarean delivery in Shahnameh (Capogna, 2017). Since 1985, the WHO has said, "There is no logic for any location to have Caesarian Sections (CS) rates higher than 10-15%." CS are now worldwide. According to 2009 and 2010 research, 24.5% and 25.7% of Iraqi women have CS (Nasir & Amir, 2017). Increasing cesarean rates are puzzling. Medical, institutional, legal, psychological, and social factors contribute to the issue. India follows this trend. The rate rose from 2.9% of births in 1992–1993, to 7.1% in 1998–1998, to 10.2% in 2005–2006 in India. The range is wide (2% to 30%) and varies by location, state, and even city neighborhood (Ajeet et *al*., 2011).

Iraq's 24.4% CS rate above the recommended 10%. Between 2008 and 2012, cesarean sections in Iraq grew substantially. Cesarean sections are surprisingly common in private facilities (Shabila, 2017).

The global rate of cesarean section (CS) deliveries is increasing. The Turkish CS rate is the highest in the world, at 53.1%. According to Burdur Provincial Health Directorate figures from 2018 and 2019, normal birth rates are 49.2% and CS rates are 50.8% (Sütlü , 2021). Most obstetricians use their discretion to decide when to do a cesarean section. Most primary (first) cesarean sections are due to labor stagnation. Absolute cephalopelvic disproportion (CPD) occurs when the fetus is too large for delivery from vaginal even under perfect circumstances. Malpresentation causes relative CPD, which surpasses the bony pelvis (brow, compound presentation) (Norwitz & Schorge, 2013).

This technique has reached 30% in several healthcare systems. In 150 years, caesarean section has gone from being a last option that frequently killed the woman to a favoured method of delivering delivery (Baskett et *al*., 2014).

Highlighting the significance of the study based on the research strategy for health from the Iraqi Ministry of Health, increased rates of cesarean section compared to natural vaginal deliveries at health facilities in Iraq are shown in the Table 2.1.

Table 2.1 Rates of caesarean deliveries in the governorate of Iraq government and private hospitals and according to its delivery for the years 2009-2012 (Mohsen & Nasr, 2015).

No	Items	2009				2010				2011				2012			
		Government Hospitals		Private Hospitals		Government Hospitals		Private Hospitals		Government Hospitals		Private Hospitals		Government Hospitals		Private Hospitals	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1-	Baghdad	39800	33.8	44605	73.6	41588	34.8	48758	78.4	51056	36.6	48601	80.6	52975	38.8	46214	96.2
2-	Al Basrah	10722	14.3	2461	40.6	13219	16.5	1837	38.4	14597	18.0	1706	35.8	21716	26.2	1680	35.0
3-	Nainawa	16425	19.2	703	96.7	18023	19.7	866	98.2	20401	21.3	565	99.0	21616	22.3	680	100
4-	Maysan	4104	15.3	0	0	3910	15.7	0	0	3834	15.7	0	0	4040	17.4	0	0
5-	Al Quadisiya	8015	37.2	5660	85.5	7931	34.8	6398	92.8	8823	44.0	5119	92.1	9636	35.8	5028	98.6
6-	Deyala	7649	26.2	2089	97.9	8813	29.1	1766	94.1	10236	31.0	1770	99.9	10630	32.1	1725	100
7-	Al Anbar	8088	25.3	1959	61.1	9417	27.3	3937	74.3	10683	30.9	2408	54.1	11793	33.8	2133	57.5
8-	Babil	14557	28	1542	99.4	11532	28.0	1735	99.9	12991	29.0	1927	91.0	11883	26.9	1696	100
9-	Karbala	6117	22.3	3474	84.3	6789	22.2	4175	87.1	7751	25.7	4239	82.7	7517	24.3	4403	89.4
10-	Kirkuk	5817	22.9	1202	94.9	7040	26.2	1235	95.9	8136	26.9	1086	98.1	9218	28.0	1242	98.4
11-	Wasit	8695	31.8	190	79.9	8748	32.2	50	53.8	11287	35.8	0	0	10807	34.4	0	0
12-	Dhi Qar	7877	24.8	885	100	10318	31,9	1421	99.9	10656	27.2	1626	100	9056	23.3	1902	99.8
13-	Al Munthana	4991	21.2	290	100	5399	22.1	40	100	5866	22.7	0	0	6075	23.4	0	0
14-	Salah Al Deen	3839	20.9	723	97.2	3623	21.1	1333	95.6	5530	27.0	1953	96.7	5686	26.1	2021	88.9
15-	Al Najaf	7520	22.2	3944	83.9	9049	25.4	3607	85.9	10974	28.8	3011	87.7	12435	31.1	2840	91.2
Total without		154216	24.6	69727	74.80	165399	25.9	77158	79.6	192821	27.8	74011	79.7	205283	29.3	17564	77.9

2.2. Cesarean section

During pregnancy or delivery, a cesarean section may save the mother and child. This surgery has grown rapidly and unnecessarily in recent decades, making it one of the most controversial subjects in modern obstetrics (Di Renzo & Malvasi, 2017). It is crucial to anticipate future births due to the increased rate of CS. Past options were recurrent cesareans. Compared to intentional repeat cesarean delivery, vaginal birth after cesarean (VBAC) reduces maternal morbidity and death elective repeat cesarean birth (ERCD). The mother's uterus might explode if the VBAC fails. VBACs need creative thinking. Trail of labor after caesarean (TOLAC) is also impacted by non-medical variables. According to recent studies, many women who have had cesarean sections may try a VBAC (Rezai & Labine, et *al* 2016).

2.3.Classification of cesarean birth

If the obstetrician, midwife, and anesthesiologist use the same categorization system, they can better discuss patient anesthetic options. Whether to use a general or local anesthetic depends on the mother's medical and obstetric history as well as the urgency of the birth (spinal or epidural) (Prasad, 2019). CS are classified differently depending on the source. Cesarean section classifications may be broken down into two broad categories: emergency and elective/scheduled (Torloni et *al*., 2011).

2.3.1. Emergency cesarean sections (during labor)

A cesarean section done for causes developing during labor is known as an emergency cesarean section (Seshadri & Arjun, 2015).

2.3.1.1. A. Maternal indications for emergency caesarean sections (during labor)

1. Prolonged/obstructed labor: Prolonged labor surpasses 24 hours. This may be attributed to a prolonged latent period, more than 20 hours in a primigravida or more than

14 hours in a multipara or delayed or absent cervical dilatation in the active phase of labor and extended fetal descent. Did not match any documents (Toy et *al*., 2016).

2. Cephalopelvic disproportion (CPD): Impedes labor advancement. Malformed or insufficient maternal pelvises may cause CPD. Usually diagnosed after childbirth, it might be suspected before labor (Seshadri & Arjun, 2015).

2.3.1.2. Elective or planned cesarean section

For the mother's or child's health, a doctor may perform a cesarean section during antepartum. This treatment is done on a pregnant woman who has not gone into labor. For a variety of reasons both mother and child, elective cesarean sections may be done (Seshadri & Arjun, 2015).

2.3.1.2. A. Maternal indications for elective cesarean section

1. Previous Cesarean Delivery: Most mothers with a history of caesarean section are warned of the complications and risks of vaginal delivery, including uterine rupture. Multiple cesarean sections cause immediate and delayed maternal and perinatal morbidity (Gayer et *al*., 2014).

2. Placental disorder

A. **Placenta previa:** Women with this issue should be close to a hospital since the bleeding worsens during pregnancy. In such circumstances, a cesarean section is the only choice, and they frequently occur between the 37th and 38th weeks of pregnancy. Partial placenta praevia may cause birth. (Becher & Stokke, 2013).

B. **Abruptio placenta:** Abruptio placenta requires rapid cesarean delivery to prevent maternal shock, clotting issues, and infant mortality (Leifer, 2011)

3. Preeclampsia: Even at term, many obstetricians recommend cesarean delivery for preeclampsia patients, despite the substantial risk of maternal morbidity (Pretscher et *al*., 2020).

4. Maternal HIV: Is a reason to have a C-section and prevent it from spreading to the infant (Seshadri & Arjun, 2015).

5. Maternal herpes: Herpetic vaginal lesions or prodromal symptoms indicative of genital herpes warrant a caesarean section delivery for women who come in labor (Arias et *al*., 2020).

6. An elderly primigravida: Who have conceived after extensive infertility treatment may qualify for an elective cesarean delivery. Her pregnancy may cause fetal macrosomia, hypertension, and diabetes (Seshadri & Arjun, 2015).

7. Pelvic anatomy: The pelvis consists of three bones that come together and create the birth canal. Whether a vaginal delivery is feasible is determined by the inner diameters of the birth canal and how they correspond with the head of the fetus, as illustrated in Figure. 2.1 (Van Blarcom, 2019). The pelvis may not be conducive to a vaginal birth for a number of different reasons:

A.Congenitally: A pelvis more like a man's (android) would make giving birth harder. For a healthy birth, the pubic angle must be broad (Becher & Stokke, 2013).

B. Different conditions: Malformations of the pelvis can be brought on by a variety of factors, such as rickettsia, pelvic fractures, spondilolistesis, and childhood starvation (Arulkumaran et *al*., 2020).

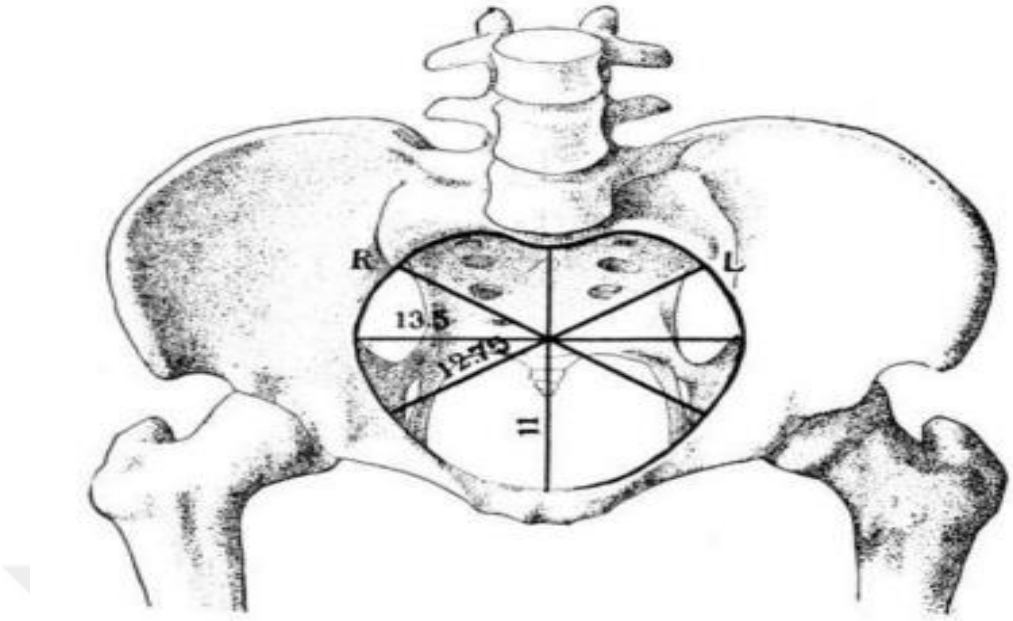

Figure 2.1 Normal Pelvic (Hameed, et al 2021)

8. Cervical cancer

A. **Needing a CS** to avoid the risks of bleeding and infection during a vaginal birth (Seshadri & Arjun, 2015).

B. Fetal indications:

1. **Fetal growth restriction:** Oligohydramnios/abnormal fetal growth Doppler results need a surgical delivery to avert fetal impairment (Seshadri & Arjun, 2015).
2. **Twin pregnancy:** Monoamniotic twins, conjoined twins, triplets, and higher-order multiples need caesarean section. If the first twin is not cephalic, most physicians advocate a caesarean procedure to avoid locked twins and their morbidity and death (Arulkumaran et al., 2020).
3. **Malpresentations of the baby, which include:**

A.Transverse lie (Arias *et al.,* 2020).

B. Breech presentation.

4. **Large babies (Macrosomia):** Macrosomia is a birth weight over the 90th percentile of 4000–4500 g. Fetal macrosomia is more common in women with preexisting diabetes or gestational diabetes whose pancreas secretes more insulin to combat pregnancy-induced insulin resistance. Caesarean delivery, bladder damage, and vaginal tissue trauma are mother birth hazards. Fetal/neonatal concerns include birth injuries such broken clavicle and brachial plexus nerve injury from shoulder dystocia, lower Apgar scores, longer hospitalizations, and probable death (Forbes & Watt, 2021).
5. **A previous adverse perinatal event:** Stillbirth or a difficult vaginal delivery resulting in an asphyxiated newborn may warrant an elective cesarean section (Seshadri & Arjun, 2015).

2.3.1.1. B. Fetal indications for Emergency Cesarean Sections (during labor)

1. Fetal Distress: Fetal distress is vague. In cardiotocography (CTG), it denotes a worrying fetal heart rate rhythm with hypoxia and metabolic acidosis (Capogna, 2017). Pinard horns or CTGs measure heart rate to detect fetal distress. Hospitals utilized CTGs. Birth hypoxia lowers fetal heart rate below 100. 0.5% of newborns have cord prolapse. Vaginal birth must occur within minutes. If not, do an emergency section (Becher & Stokke, 2013).

2. Prolapsed umbilical cord: If the cervix is completely dilated, umbilical cord prolapse demands emergent delivery. Cesarean delivery is typical (Perry et *al*., 2018).

3. Pathological cardiotocography (CTG): Pathological cardiotocography may indicate acute hypoxia or neonatal asphyxia. Fetal acidosis requires a cesarean surgery or vacuum or forceps deliver. (Mylonas & Friese, 2015).

2.3.1.1. Non-Medical indicated (On Maternal Request) cesarean delivery on maternal request (CDMR)

It is a medically unnecessary cesarean section when the pregnant patient requests the procedure even if there is no medical need for it (Nama & Wilcock, 2011).

1. The Reasons for caesarian section on maternal request without clinical indications: Dread of birth, safety concerns, birth history of relatives, fear of pain, and sexual assault were stated by 91 Swedish woman first-time CS requesters (Eide et *al*., 2019). Cesarean section without medical indication is usually caused by:

1.1. Psychological factors (Tokophobia): Pregnancy and childbirth phobia is tokophobia. This phobia causes women to avoid pregnancy and childbirth (Bhatia et *al*., 2012). Despite wanting children, this dread may cause women to forgo pregnancy or choose a Caesarean section to avoid vaginal delivery (Cherry & Gans, 2020).

A.Primary tocophobia factors: A nulliparous who fears childbirth has primary tokophobia. This generally follows peer comments or her mother's poor delivery experience (Lal, 2017).

B. Secondary tocophobia: An unpleasant recollection from a previous birth or outwardly disappointing conditions may cause tokophobia after a great delivery experience (Lal, 2017).

1.2. Desire to have a planned delivery: Emergency cesarean surgery, vacuum extraction, terrible agony, and dread of delivery in future pregnancies are strongly linked (Størksen et *al*., 2012). Many previously delivered women would choose for a CS if they required a subsequent instrumental birth (Avasarala & Mahendran, 2009). Birth preparation, labor and delivery, and posttraumatic stress disorder are all linked in major ways (PTSD) (Nama & Wilcock, 2011).

1.3. Sociocultural factors: There is evidence that social influences cause fear. When pregnant, friends and family affect women. Labor and birth myths may frighten

women. Birth tales from family and friends may affect a pregnant woman's confidence and self-efficacy (Otley, 2011). Media's harmful impact is debated. Most pregnant women and their partners research online. Knowledge sources may be poor or wrong (Hundely et *al*., 2014).

2.4.Types of cesarean section surgery

2.4.1. The low transverse incision

A low transverse incision reduces blood loss, rupture risk, and healing time. If the fetus is big or the incision site has a placenta previa, it may not be possible. As seen in figure, this incision allows future vaginal birth after cesarean VBACs figure 2.2 (Leifer, 2019).

2.4.2. The low vertical incision

A low vertical incision generates minimum blood loss and facilitates birth of a bigger fetus. It is more prone to rupture following a second delivery than the traditional incision, as seen in figure 2.2 (Leifer, 2019).

2.4.3. The classic incision

The traditional incision causes greater blood loss and is more prone to burst with future pregnancy. However, if the baby is in a transverse lying or there is scarring or a placenta previa in the lower anterior uterus (figure), it may be the only option figure 2.2 (Leifer, 2019).

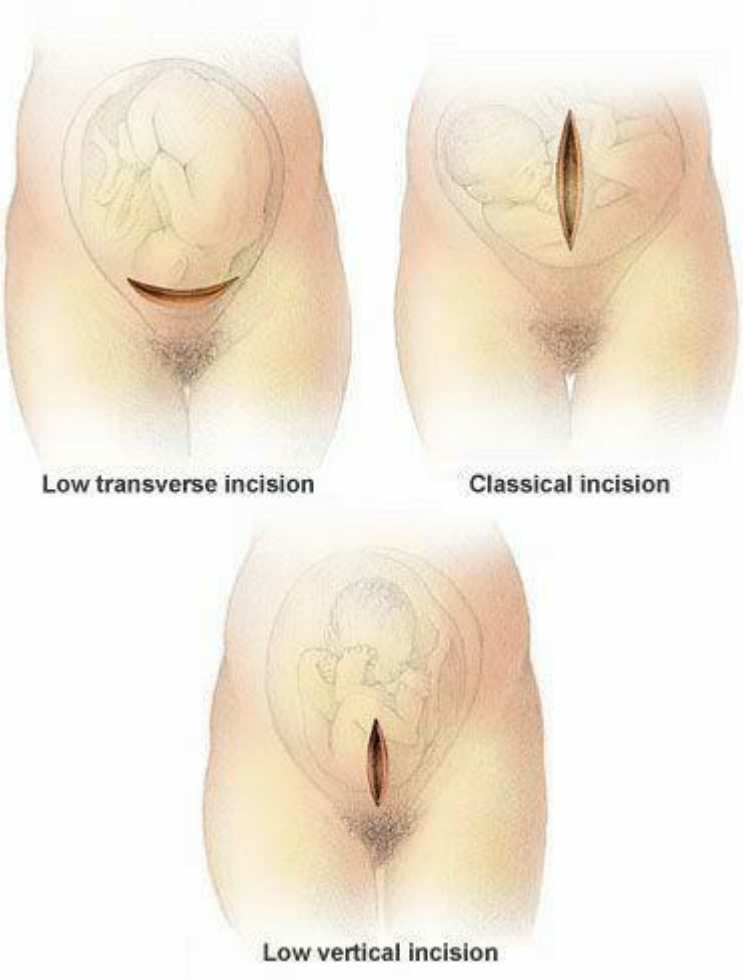

Figure 2.2 Cesarean birth incisions. After a cesarean, the low transverse uterine incision allows vaginal delivery. Sometimes low vertical and traditional incisions are employed. (Mayoclinic, 2022)

2.4.4. Ethical considerations

Obstetricians often perform CS. Patients must provide informed permission before procedures, meaning they must know the pros and risks. Where feasible, women may pick their surgery, incision, and anesthetic (Subrata et *al*., 2013).

Obstetricians follow four medical ethics principles:

1. Autonomy
2. Justice
3. Non-maleficence
4. Beneficence

Autonomy respecting patient values and non-maleficence not harming are the most crucial concepts. Medical professionals have an ethical obligation to society to allocate healthcare resources wisely to operations and therapy that have strong evidence of a net benefit to health, but their fiduciary duty to women is to prioritize her interests above those of others. Justice principles make CSMR decisions challenging (Nama & Wilcock, 2011).

Patient–physician relationships shape medical ethics. An informational or deliberative relationship assumes the patient has the medical knowledge, background, and competence to make a choice and evaluate patient to align medical plan with her values (Nama & Wilcock, 2011). Many international foundations like the International Federation of Gynecology and Obstetrics state that performing cesarean section without medical indication is unethical and dangerous to the mother or baby, but patients' autonomy should be respected and offered cesarean section, which is reasonable but not justified (Nama &Wilcock, 2011).

2.5.Complications of cesarean birth

Chorioamnionitis increases the risk of post-CS complications include endometritis, pelvic abscess, wound infection, thromboembolism, and bacteremia (Martin, 2020). The patient's medical issues and the medical team's expertise affect cesarean delivery morbidity and mortality (Creasy et *al*., 2014).

21.4% of Norwegian women experienced several CS complications. 9–10 cm cervical dilatation surgeries have greater complication rates. General anesthesia, low gestational age, and fetal macrosomia were independent complications risk factors (Becher & Stokke, 2013). These operations may increase the risk of mother mortality, baby death, critical care unit hospitalization, blood transfusion, hysterectomy, or internal iliac artery ligation (to limit pelvic hemorrhage) compared to spontaneous vaginal birth (Koh et *al*, 2020). Cesarean complications include:

2.5.1. Maternal Short-Term Dangers

2.5.1.1.Infection

After cesarean delivery, up to 11% of women have endometritis, wound infection, or urinary tract infection from surgical site infection, which may be underreported since symptoms may present after discharge and be treated outpatient (Carter et *al*., 2017).

2.5.1.2.Hemorrhage

Injuries to the uterus or ovaries (intra-abdominal) or other abdominal (extra-abdominal) arteries or veins are possible causes. It's not uncommon for them to be catastrophic, perhaps fatal situations (Rosa et *al*., 2019).

2.5.1.3.Venous thrombosis and embolism (VTE)

Venous thrombosis and embolism (VTE) occurs throughout pregnancy, delivery, and the postpartum. Both cesarean and vaginal birth mothers die from thromboembolic events (Evangelista et *al*., 2018).

Pregnancy or postpartum pulmonary embolism is uncommon but serious. Half of severe postpartum pulmonary embolisms occurred within 24 hours. CS may cause greater pulmonary embolism than deep venous thrombosis (DVT) than vaginal birth, according to previous evidence (Martillotti et *al*., 2017).

2.5.1.4.Wound disruption

Disruption of the cesarean laparotomy is frequent, and reclose with sutures is best. (Becher & Stokke, 2013).

Dehiscence, when a sutured incision rips apart, may occur. Dehiscence normally happens 5-12 days after suturing, when collagen synthesis is at its height. Approximately half of

dehiscence incidences are connected with wound infection, although they also may be the consequence of sutures tearing due of severe tension. Obesity increases dehiscence risk because adipose tissue is hard to suture (Craft et *al*., 2019).

2.5.1.5.Psychological outcome

According to several research, cesarean-delivery mothers are less satisfied with their birth experience, less likely to breastfeed, and take longer to connect with the infant. Some women sense loss, failure, and fury (Becher & Stokke, 2013).

2.5.1.6.Maternal morbidity

Cesarean section delivery has a 0.1% maternal morbidity rate, which is 2–10 times greater than vaginal birth. Cesarean section increases maternal morbidity (infection, thromboembolism, wound dehiscence) (Norwitz & Schorge, 2013).

2.5.1.7.Breast feeding problems

CS decreased breastfeeding rates, depriving babies of the nutrients in mother breast milk (Moussawi et *al*., 2015).

Studies have revealed that caesarean birth increases the likelihood of not nursing during the first hour and never breastfeeding. Additionally, solely nursed caesarean section babies gained less weight than vaginal birth kids did (Capogna, 2017).

Postpartum separation is frequent. In typical hospital care, newborn newborns are carried wrapped or clad in their mother’s arms, put in open cribs or under radiant heaters. Skin-to- skin contact (SSC) commences ideally at birth and should persist constantly until the conclusion of the first breastfeeding. SSC entails laying the dry, nude infant prone on the mother's bare bosom, frequently wrapped with a warm blanket. According to mammalian neuroscience, personal interaction in this setting triggers neurobehaviors that satisfy

fundamental biological requirements. This "sensitive phase" after birth may program future physiology and behavior (Moore, 2016).

2.5.1.8.Organ damage

Repeated surgery or adhesions might harm the bowel. After lengthy labor when the bladder is shifted caudally, prior caesarean section where scarring obliterates the vesicouterine gap, or vertical extension of the uterine incision, bladder damage is more likely (Kenny & Myers, 2017).

2.5.2. Maternal Long Term Risks

Cesarean deliveries dramatically increase long-term morbidity (Clark and Silver, 2011).

2.5.2.1.Abnormal placentation

Placental implantations and uterine scarring may cause aberrant placentation in future pregnancies. Thus, myomectomy, uterine malformations, multiple gestations, multiparty, advanced maternal age, smoking, and previous placenta previa enhance the incidence of placenta previa (Callahan, 2013).

2.5.2.2.Scar complications

Myometrium thickness at the C-section scar decreases with increasing C-section rate, however there is no standardization for this measurement (Benacerraf et *al*., 2014).

2.5.2.3.Uterine rupture

Rupture of the uterine wall, which includes the serosa layer and improper connection between the uterine cavity and the peritoneal cavity, is the most dangerous complication that may arise after a cesarean section (Rodgers et *al*., 2012)

2.5.2.4.Adhesions

Usually between the uterus and adjacent organs. With more cesareans, adhesions become more severe (Di Renzo et *al*., 2017). After cesarean delivery, morbidly adherent placenta risk increases. Three or more cesarean sections increase the chance of placenta previa and morbidly adherent placenta to 1.8–3.7%. Major obstetric hemorrhage, big blood transfusions, hysterectomy, and critical care unit hospitalization are the most common consequences. Ultrasound, color flow mapping, and MRI improve early prenatal diagnosis (Capogna, 2017).

2.5.2.5.Psychological morbidity

Women who desire Cesarean section or have a significant dread of delivery had poorer sociability scores, more anxiety, and more depressive symptoms. These risk factors for pre-traumatic stress disorder (PTSD) (Nama &Wilcock, 2011).

2.5.2.6.Ectopic pregnancies following caesarean section

2.5% of pregnancies are ectopic. Surgery and infection are known epidemiological risk factors for tubalectopic pregnancy. Current research suggests that 98% of ectopic pregnancies are tubal and caused by a combination of blastocyst retention in the fallopian tube due to poor embryo–tubal transit and tubal environment changes that enable early implantation (Jauniaux & Grobman, 2016).

2.5.3. Risk for baby

The infant is more likely to have difficulties in breastfeeding, respiratory issues at delivery, and neonatal intensive care unit (NICU) hospitalization with less mother-baby interaction (Simkin et *al*., 2010).

A. Surgical incisions that are accidentally cut and need suturing (Goer et *al*., 2007).

B. Being born prematurely (between 34 and 36 weeks of gestation) because of planned operation (Landon et *al*., 2021).

C. Prematurity complications: Respiratory, nutrition, and jaundice issues from premature birth. These issues are more frequent with lower birth weights and earlier gestational ages (Ashford et *al*., 2018).

D. Complications with respiration: Elective CS newborns may be at higher risk of neonatal respiratory morbidity due to gestational age (GA) at delivery. Respiratory morbidity may lead to newborn intensive care unit hospitalization, separation of mother and child (preventing binding and breastfeeding), respiratory assistance, unpleasant treatments, antibiotics, mechanical ventilation, and serious problems (Stordeur et *al*., 2016).

E. Hospital readmission (Engle et *al*., 2008).

2.6.Risk Factors for Avoiding a Caesarean Section

Induction of labor after 41 weeks, use of program during labor, consultant obstetrician who decides on cesarean section and fetal blood collection for irregular heart rate pattern minimize the probability of cesarean section (Capogna, 2017).

2.7.Role of reducing needless cesarean sections

One of the first stages in altering the maternity care culture is educating expectant mothers on how to decrease their likelihood of having a cesarean section (Smith et *al*., 2016). Both the nursing staff and the patient need to be aware of how vital mobility is during labor (Edmonds & Jones, 2013). Early labor support teaching, delaying admission to the labor until active labor, and increasing mother mobility have been demonstrated to reduce the cesarean section rate (Smith et *al*, 2016).

When have access childbirth and relaxation sessions make pregnancy low-risk moms more likely to deliver vaginally (Khunpradit et *al*., 2011).

Fear of delivery is less recognized than other perinatal mental health disorders, prompting requests for more awareness (Gutteridge, 2020). That prenatal education should include delivery dread, caesarean section pros and cons, and education for women with childbirth fear. Given the rising worry about caesarean section morbidities and the evidence of long-term mental and emotional effects of untreated delivery anxiety, women's emotional well-being should be prioritized above birth mode (O'Connell, 2019). Allowing the woman to move freely after admission in active labor (Ondeck, 2014). Midwife, consultant, obstetrician, counselor, and psychiatrist may meet CS-requesting women. (Nama &Wilcock, 2011).

3. MATERIAL METHODS

In this section, we will discuss the methods used in this research and how they contributed to the achievement of the study's aims.

3.1.Design of the Study

In order to find out how much women in the Women's and Children's Hospital in the city of Diwaniyah knew about the risks associated with elective caesarean sections, a descriptive research was carried out.

3.2.Setting of the study

Al-Diwaniyah city was the location of the research. Women were interviewed at the Women's and Children's Hospital in the morning, both in private and public wards, as well as the pre-operative room and a private room. The number of births by caesarean section is approximately 2720 annually in this hospital. Number of patient bad in women's halls annually 2198. All deliveries in the city of Diwaniyah are brought to this hospital, making it the sole facility of its kind in the area.

3.3. Sample of the Study

3.3.1. Inclusion Criteria

A non-probability, non-random sample of 285 pregnant (primary or multiparous) married women (In Iraq, all women were married who undergo for birth) who either wanted to undergo an elective cesarean section or had one in the past without medical necessity was selected.

3.3.2. Exclusion Criteria

1. Women with vaginal delivery.
2. Women who needed medical reasons to have a caesarean section.

3.3.3. Place and sample

A sample was selected from the total study population 1000 During the 3 months prior to the sample collection in the Maternity and Children Hospital in Al-Diwaniyah city, and the sample size was determined as 285 according to the Yamane's formula for calculating the sample size. In addition to Cochran's formula, Yamane (1967) introduced another simple formula for measuring sample size from a population . According to that, for the 95% confidence level and (p = 0.05), the sample size should be:

Where (N) represents the population size of the study group in the Maternity and Children Hospital in Al-Diwaniyah city for the previous three months and (E) is the level of accuracy (Yemen, 1967).

n = N / ((1 + N (e^2)))

Number = 1000

E=0.05

N = 1000 / ((1 + 1000 (0.05) ^2) = 285

∴N = 285

This figure represents a representative sample from the current study of all women participating in the stasis category at the Maternity and Children's Hospital in Al-Diwaniyah City.

3.4. Instrument used for data collection

Reviewing relevant literature and research, as well as drawing on prior experience, a questionnaire was developed and piloted for this investigation (as seen in) (Appendix2). There are three components of the research instrument.

A. **Part I: Socio-Demographic information:** It takes into account the woman's age, her level of education, her occupation, her place of residence, her monthly income (as she sees it), and the size of her family.
B. **Part II: Reproductive Information**: Includes Parity, Gravity, Abortions, Live Births, Infant Deaths, and Previous Gynecological Operations Other Than a Cesarean Section.
C. **Part III:** Awareness of women for the risks associated with elective CS and knowing the source from which she get information about the complications of a caesarean section and the reasons for choosing an elective caesarean section. This section is divided into three sections:

A. First: Five questions assessed the participants' attitudes about the elective CS complications. The section was graded from 5 to 10, with a 2 being the only response that showed a good attitude and the others receiving a 1 point .

B. Second: There were 3 questions in the perceptions portion/part about elective CS complications. The pregnant may choose between "know" and "don't know" for each question. Each answer was given a score between 1 and 2 point, with 1 being the right one. As a result, possible answers for this section's total score were 3–6.

C. Third: There were three sections about knowledge about elective CS complications:

1. Ten questions assessed the participants' knowledge about the short-term elective CS complications. The section was graded from 10 to 20 point, the answer to them was a being the only response 2 that showed (I know) and (I dont know) receiving a 1.

2. Eight questions assessed the participants' knowledge about the long-term elective CS complications. The section was graded from 8 to 16 point, the answer to them was a being the only response 2 that showed (I know) and (I dont know) receiving a 1.

3. Seven questions assessed the participants' knowledge about the newborn complications. The section was graded from 7 to 14 point, the answer to them was a being the only response 2 that showed (I know) and (I dont know) receiving a 1.

The levels of the previous parts were identified through the arithmetic mean, as: (1-1.49 poor, 1.50-2 good)

3.5. Validity of the Questionnaire

An approval was obtained by text message from Al-researcher Redha, 2017 to use it in the study (as seen in) (Appendix1). A team of (ten) specialized experts meets to assess of the tool. Total (five) faculty members from the College of Nursing at the University of Baghdad. Two faculty members from the Institute of Health and Medical Technology in Baghdad and (2) faculty members and an obstetrician-gynecologist from the Maternity Teaching Hospital in the Karbala Health Directorate. (One) Professor of Statistics at the College of Medicine, University of Karbala. These professionals evaluate the design of the questionnaire submitted to them to ensure its completeness, accuracy and ease of reading. An approval was obtained by text message from Al-Baha to use it in the study. Based on the recommendations of the specialists, minor modifications were made to the questionnaire (Redha, & Khairi, 2017).

3.6. Pilot study

A pilot study was conducted on 20 married women were excluded from the original study sample who underwent elective caesarean section on request. It was conducted before the original sample was taken for the study. The study was conducted from October 1 to October 10, 2022.

The purposes of the pilot study are:

1. Determine the obstacles that may hinder the study process.
2. To measure the reliability of the questionnaire.

3. Estimating the average time required for data collection.
4. Obtaining the clarity and adequacy of the content of the questions. (Powlett & Hengler, 1999)

3.7. Reliability of the Questionnaire

The reliability is determined through coefficient alpha (cornbach's alpha) to test the degree of internal consistency and the normal range value is between .00 and +1.00 (Polite & Hungler, 1999), the obtained result is equal to (0.80) which is considered positive and significant

3.8. Results of the Pilot Study

After a test run, all of the survey questions were simple and straightforward. Each woman in the research was interviewed for 15 to 20 minutes.

3.9. Methodology for Collecting Data

Face-to-face interviews were used to collect the necessary information using (forms), because most samples cannot read and write and during these sessions, the researcher discussed the study's goals and significance. Each interview with a woman take between 15 and 20 minutes. The interview sessions spanned three months, from October 16, 2022, to December 16, 2022.

3.10. Ethics committee Arrivals

Prior to collection of the data, formal administrative approvals were obtained to conduct the study from:

A. Approval of Çankırı Karatekin University Council / Nursing Department The approval of the Ethics Committee for Scientific Research of Turkey was obtained (Appendix 3).

B. Iraqi Ministry of Health/Al-Diwaniyah Health Directorate/Training and Human Development Department/Knowledge and Research Administration Division/Research Committee Decision Approval Statement (Appendix 4).

C. Each woman who participated in the study gave her informed verbal agreement. Participation was oral, optional, and anonymous. As anticipated, a separate meeting was organized with the female patients in the wards to explain the research and its goals to them. It was made clear to all the women that their participation is voluntary and that they each have the ability to opt out.

3.11. Limitation of the study

The collection of the data took a long time (3 month) because of the difficulty in finding volunteers. Some pregnants refused to participate in the study.

3.12. Statistical Procedures

The evaluation of data was made with the statistical program called SPSS SPSS (IBM SPSS Statistics 24). The personal characteristics of the participants in the study were examined with descriptive statistics such as mean, standard deviation, number and percentage. Normal distribution fitness of the data was investigated by Kolmogorov-Smirnov and/or Shapiro-Wilk-W tests. Parametric methods were used for the measurement values that conform to the normal distribution. In accordance with parametric methods, the Independent two-sample t-test was used to compare the measurement values of two independent groups, and the ANOVA test method was used to compare the measurement values of three or more independent groups. The significance level was taken as $p<0.05$

In order to analyze the sample and find the effects:

1. Descriptive statistics:

a. Mean of the scores

$$\bar{x} = \frac{1}{n}\left(\sum_{i=1}^{n} x_i\right) = \frac{x_1 + x_2 + \cdots + x_n}{n}$$

b. Percentage

$$\% = \frac{\boldsymbol{Frequency}}{\boldsymbol{Sample\ Size}}\, x100$$

c. "SD" Standard deviation:

$$S.d = \frac{\sum(X - \bar{X})^2}{n - 1}$$

d. We used " Cronbach's alpha" to measure the internal stability of the resolution

$$\alpha = \frac{K}{K-1}\left[1 - \frac{\sum_{i=1}^{K} \sigma_{ii}}{\sum_{i=1}^{K}\sum_{j=1}^{K} \sigma_{ij}}\right]$$

2. To find the effect of demographic characteristics on attitude, perception and knowledge, we used:

a. Independent two-sample t-test

$$t = \frac{\bar{X}_1 - \bar{X}_2}{s_p\sqrt{\frac{2}{n}}}$$

b. Analysis of variance (ANOVA)

Source of variance	Sum of square	d.f	Mean square	F
Between Groups	$SS_B = \sum \frac{(\sum xP1)^2}{n} - \frac{(\sum xP)^2}{n}$	$df_B = K-1$	$\frac{MS\beta}{MS\beta}$	$\frac{MSB}{MSW}$
Within Groups	$SS_W = \sum (\sum xP1)^2 - \frac{(\sum xP)^2}{N}$	$df_w = N-k$	$\frac{SSw}{DFw}$	
Total	$SS_T = \sum (\sum xP1)^2 - \frac{(\sum xP)^2}{N}$	$df_1 = N-1$		

4. RESULTS

This chapter presents the results of the analysis of the data that are in correspondence with the objectives of the study. Those results are organized as follows:

Table 4.1. Distributions of the Study Sample Based on Socio Demographic Factors (n=285)

Variables		**Analysis**	
Age	Mean ± SD	31.31 ± 7.9	
	Group	**Frequency (n)**	**Percent (%)**
	17 to 24	53	18.6
	25 to 32	122	42.8
	33 to 40	67	23.5
	41 to 48	43	15.1
Residence	Urban	205	71.9
	Rural	80	28.1
Educational Level	Not Read or Write	7	2.5
	Primary School	62	21.8
	Secondary School	41	14.4
	Intermediate School	37	13
	Diploma	58	20.4
	Bachelor's	80	28.1
Occupation	House Wife	138	48.4
	Employed	108	37.9
	Student	17	6
	Free Work	22	7.7
Monthly Income	Enough	49	17.2
	Barely Enough	207	72.6
	Not Enough	29	10.2
Family Members	3 to 5	159	55.8
	6 to 8	103	36.1
	9 to 11	23	8.1
	Total	285	100.0

Table 4.1 shows that the majority of participants (42.8%) are between the ages of 25 and 32, with a mean and standard deviation of 31.31±7.9, while the minority (15.1%) are between the ages of 41 and 48. The percentage of participants who live in urban regions is 71.9%, while the percentage of participants who live in rural areas is 28.1%. In terms

of educational attainment, the highest percentage of participants (28.1%) graduated from college, while the lowest percentage (2.5%) cannot read or write. The jobs of the participants show that the majority of them (48.4%) are housewives, while the minority (6%) are students. Monthly Income of Participants: From their perspective reveals that 72.6% of them have barely enough monthly income, while 10.2% believe their monthly income to be insufficient. The highest percentage of participants with family members was 55.8% in groups 3 to 5, while the lowest percentage was 8.1% in groups 9 to 11.

Table 4.2. Reproductive Characteristics of the Study Sample (n =285)

Reproductive Information	Groups		Frequency(n)	Percentage (%)
Gravida	1		38	13.3
	2		71	24.9
	3		64	22.5
	4		42	14.7
	6		55	19.3
	7		15	5.3
Para	1		57	20
	2		81	28.4
	3		54	18.9
	4		53	18.6
	6		32	11.2
	7		8	2.8
Delivery Mode	Pervious Elective Caesarean Section	No	76	26.7
		Yes	209	73.3
	Planned Elective Caesarean Section	No	235	82.5
		Yes	50	17.5
	Normal Delivery	No	283	99.3
		Yes	2	0.7
	Elective Caesarean Section And Normal Delivery	No	207	72.6
		Yes	78	27.4
		Total	285	100
Number of dead birth	Null		211	74
	1		54	18.9
	2		17	6
	3		3	1.1
	1		54	18.9
	2		17	6
	3		3	1.1
Number of living birth	1		141	49.5
	5		50	17.5
	3		89	31.2
	7		5	1.5
	Total		285	100

Table 4.2 indicates the reproductive characteristics of participants, with the large rate of 24.9% having two pregnancy and the lowest percentage of 5.3% having seven pregnancies. In terms of valence, the maximum percentage of participants (28.4%) have two deliveries, while the lowest percentage (2.8% of participants) have seven deliveries. In terms of delivery mode, 73.3% of participants had a previous elective cesarean section, while 0.7% had a normal delivery. In terms of the numbers of death babies, the maximum percentage (74% of participants) have none death babies, while the lowest percentage (1.1% of them) have three. In terms of abortions, 74% of participants have never had any abortion, while the lowest percentage, 1.1%, has had three. In terms of the percentage of participants who have surviving children, the maximum percentage is 49.5% have one children alive, while the lowest percentage is 1.5%, who have a total of seven children alive.

Table 4.3. Overall Assessment of the Attitudes of the Participants about Elective Caesarean Sections Complications

		N	%	Mean± SD	Assessment
Overall assessment	Negative Attitude	107	37.5	1.56±0.203	Positive Attitude
	Positive Attitudes	178	62.5		
	Total	285	100		

n= Frequency, % = Percentage, SD= standard deviation, [mean of scores (M.S) = 2, Negative attitude M.S. = 1-1.49, Positive attitudes M.S. = 1.50-2].

Table 4.3 shows the overall assessment of the attitudes of the participants about elective Cesarean sections complications; 62.5% of the participants had positive attitudes about elective Cesarean sections complications. While 37.5% of the participants had negative attitudes, the mean score of the participants was 1.56, indicating a positive overall assessment.

Table 4.4. Sources of Elective Caesarean Section Complications Knowledge

Sources		Frequency (n)	Percentage (%)
Null	No	186	65.3
	Yes	99	34.7
Doctor	No	152	53.3
	Yes	133	46.7
Media	No	188	66.0
	Yes	97	34.0
Family	No	241	84.6
	Yes	44	15.4
Friends	No	247	86.7
	Yes	38	13.3
	Total	285	100

According to Table 4.4, the majority of participants 46.7% get their information from doctors, whereas the minority 13.3% get it from friends.

Table 4.5. Overall Assessment of the Perception of the Participants about Elective Caesarean Sections Complications

		n	%	Mean± SD	Assessment
Overall assessment	Poor Perception	110	38.6	1.6±0.30	Good Perception
	Good Perception	175	61.4		
	Total	285	100		

n= Frequency, % = Percentage, SD= standard deviation, [mean of scores (M.S) = 2, poor Perception M.S. = 1-1.49, Good Perception M.S. = 1.50-2].

Table 4.5 shows the overall assessment of the perception of the participants about elective Cesarean sections complications; 61.4% of the participants had good perception about elective Cesarean sections complications. While 38.6% of the participants had poor

perception, the mean score of the participants was 1.6, indicating a good overall assessment.

Table 4.6. Causes of Choosing Elective Caesarean Section

		Frequency (n)	Percentage (%)
Fear for fetus	No	85	29.8
	Yes	200	70.2
Fear from labor process	No	213	74.7
	Yes	72	25.3
Fear from labor pain	No	120	42.1
	Yes	165	57.9
Mistreatment	No	242	84.9
	Yes	43	15.1
	Total	285	100.0

Table 4.6 shows the causes of choosing elective caesarean section among the participants. 70.2% of the participants, had chosen a caesarean section due to fear for labor process. While 15.1% of participants had chosen a caesarean section due to concerns about mistreatment.

Table 4.7. Assessment Knowledge of the Participants about Elective Caesarean Sections Complications

Variables		n	%	Mean ±SD	Assessment
Short term complications	Don't Know	113	39.6	1.53±0.215	Good Knowledge
	Know	172	60.4		
Long term complications	Don't Know	144	50.5	1.48±0.233	Poor Knowledge
	Know	141	49.5		
New born complications	Don't Know	183	64.2	1.45±0.264	Poor Knowledge
	Know	102	35.8		
Overall assessment	Don't Know	176	61.8	1.48±0.214	Poor Knowledge
	Know	109	38.2		
	Total	285	100		

n= Frequency, % = Percentage, SD= standard deviation, [mean of scores (M.S) = 2, poor Knowledge M.S. = 1-1.49, Good Knowledge M.S. = 1.50-2].

According to table 4.7 the assessment of the participants' knowledge of elective Cesarean section complications, the knowledge characteristic with the largest means score was 1.53±0.215 relates to seeking information around short-term complications, while that the knowledge characteristic with the shortest mean 1.45±0.264 which is regarded as above the cut off point indicate to new-born complications. Overall Knowledge Assessment: The mean score was 1.48±0.214 , which is considered above the cutoff point, refers to poor knowledge.

Table 4.8. Distribution of the Women's Attitude, Perception and Knowledge Total Scale Based on the Residence (n = 285)

Variables	Residence	n	Mean ±SD	t	p
Attitude	Urban	205	1.59±0.204	4.637	**.000**
	Rural	80	1.47±0.174		
Perception	Urban	205	1.63±0.300	2.383	**.018**
	Rural	80	1.54±0.277		
Knowledge	Urban	205	1.52±0.230	5.091	**.000**
	Rural	80	1.38±.120		

n= number of participants, SD= standard deviation, Non-Significant at P> 0.05; Significant at p<0.05

According to Table 4.8, attitudes, perception and knowledge about elective Cesarean section complications, with residence all have a high statistical significance ($p < 0.05$) .

Table 4.9. Distribution of the Women's Attitude Total Scale Based on the Age, Educational Level, Occupation, and Monthly Income.

Variables	Groups	n	Mean ±SD	F	p
Age	17 to 24	53	1.464±0.178	12.587	**.000**
	25 to 32	122	1.629±0.198		
	33 to 40	67	1.549±0.209		
	41 to 48	43	1.474±0.157		
Educational Level	Not or And Write	7	1.485±0.106	10.994	**.000**
	Primary Schools	62	1.429±0.176		
	secondary Schools	41	1.561±0.196		
	Intermediate Schools	37	1.508±0.197		
	Institute	58	1.600±0.187		
	Bachelor's	80	1.650±0.192		
Occupation	Houses Wife	138	1.489±0.188	17.470	

Variables	Groups	n	Mean ±SD	F	p
	Employ	108	1.659±0.197		**.000**
	Student	17	1.494±0.159		
	Free work	22	1.518±0.1468		
Monthly income	Enough	49	1.604±0.221	4.106	**.017**
	barely enough	207	1.557±0.195		
	Not Enough	29	1.469±0.208		
	Total	285	1.556±0.203		

n= number of participants, SD= standard deviation, Non-Significant at p> 0.05; Significant at p<0.05

According to Table 4.9 attitudes of participants about ECS complications is associated with age of women, educational level, occupation, monthly income and has a high level of statistical significance.

Table 4.10. Distribution of the Women's Perception Total Scale Based on the Age, Educational level, Occupation, and Monthly Income.

Variables	Groups	n	Mean ±SD	F	p
Age	17 to 24	53	1.616±0.309	2.763	**.042**
	25 to 32	122	1.658±0.288		
	33 to 40	67	1.557±0.286		
	41 to 48	43	1.534±0.301		
Educational level	Do not Read or Write	7	1.428±0.370	2.694	**.021**
	Primary Schools	62	1.510±0.287		
	Secondary Schools	41	1.658±0.283		
	Intermediate Schools	37	1.612±0.266		
	Institute	58	1.666±0.292		
	College	80	1.629±0.304		

Variables	Groups	n	Mean ±SD	F	p
Occupation	House Wife	138	1.562±0.287	5.108	**.002**
	Employ	108	1.632±0.305		
	Student	17	1.843±0.239		
	Free work	22	1.590±0.270		
Monthly income	Enough	49	1.578±0.278	2.088	**.126**
	Barely enough	207	1.628±0.294		
	Not Enough	29	1.517±0.328		
	Total	285	1.608±0.296		

n= number of participants, SD= standard deviation, Non-Significant at p> 0.05; Significant at p<0.05

According to Table 4.10 perceptions of participants about ECS complications is associated with age of womens, educational level, and occupation and has a statistical significance, but has no statistical significance with monthly income (p-value < 0.05).

Table 4.11. Distribution of the Women's Knowledge Total Scale Based on the Age, Educational level, Occupation, and Monthly Income

Variables	Groups	n	Mean ±SD	F	p
Age	17 to 24	53	1.432±0.209	8.383	**.000**
	25 to 32	122	1.552±0.236		
	33 to 40	67	1.441±0.171		
	41 to 48	43	1.409±0.155		
Educational level	Not Read or Write	7	1.263±0.094	13.693	**.000**
	Primary School	62	1.363±0.107		
	Secondary School	41	1.443±0.178		
	Intermediate School	37	1.433±0.122		
	Institute	58	1.535±0.188		
	College	80	1.597±0.274		
Occupation	Housewife	138	1.394±0.123	25.982	**.000**
	Employ	108	1.608±0.258		

Variables	Groups	n	Mean ±SD	F	p
	Student	17	1.444±0.223		
	Free work	22	1.445±0.099		
Monthly income	Enough	49	1.519±0.233	1.055	**.349**
	Barely enough	207	1.477±0.207		
	Not Enough	29	1.452±0.232		
	Total	285	1.482±0.214		

n= number of participants, SD= standard deviation, Non-Significant at p> 0.05; Significant at p<0.05**.**

According to Table 4.11, knowledge of participants about ECS complications is associated with women of age, educational mode, and occupation and has a high level of statistical significance, but has no statistical significance with monthly income (p< 0.05).

5. DISCUSSION

This chapter interprets the findings of the study with evidence supports related to the objectives of the study as following:

5.1.Part 1: Reproductive information

Gravida the highest percentage (24.9%) of participants have two pregnancies as shown in the table 4.2. The results agree with Redha et al. (2017) study that the large rate 50% of the participants had 2-3 pregnancies. Most pregnant women in their first pregnancy opted for a caesarean section (Ghasvari et *al*., 2009). Approximately of 156 participants in the study, about 70% in the second pregnancy, prefer elective c-section (Faisal Cury and Paulo, 2006). Para Regarding parity, the highest percentage of 28.4% of the participants had been born twice. These findings are consistent with the findings of Abdelredha and Khairy (2017) for participants having 1 to 2 births, a significant 65% equivalence.The parity results are consistent with the study of Majlesi et al (2020) who had a single birth rate of approximately 71.2%, the highest percentage of the study sample. In terms of mode of delivery, the majority of participants 73.3% had a previous elective cesarean section; the results agree with those of Abdul Redha and Khairi (2017) the large rate 42% of the participants had previous ECS. This result compatible with the study by Ahmed & Al-Tawil (2018) who stated that the large rate 86.6% of the participants have ECS. This result agrees with the study by Gadeer et al. (2020) who supply the large rate 53% of the participants have ECS. This result agrees with the study by Hameed & Ibrahim. (2021) the large rate 59% of the participants in the study had CS. In connection with the death babies, the large rate 74% of the participants not had dead births. This result agrees with the finding in a study held in Iraq by Hameed and Ibrahim (2021) the large rate 74% of the participants had no history of the stillbirth. This result is consistent with the findings of Abdul Redha and Khairi 2017, which indicated that 93% of the participants did not have stillbirths. In terms of abortions the highest percentage of the number of abortion 74% of the participants had no history of miscarriage, This result disagree with Flores et al. (2008) and according to Pang et al. (2007), prior abortion history was regarded as a risk factor when deciding whether to have a CS. This finding is consistent with a research

by Kadhim et al. (2019) which found that 66% of the study group had no prior abortions. This finding is consistent with Khairi (2015) assertion that more than half of the participant's rate 65% did not previously have an abortion. This conclusion is consistent with the findings of a research conducted in Iraq by Hameed and Ibrahim (2021), where the largest percentage (66%) of the participants had never undergone an abortion. In terms of the number of children still alive, 49.5% of participants had at least one kid still alive. This finding is consistent with the research of Hameed & Ibrahim (2021), which found that 25% of the study group had a live one kid. This outcome is consistent with a study conducted in Iraq by (Redha & Khairi, (2017), which found that 62% of the participants had (1-2) live children.The result agree with Sufang (2007) assumption that women who have just one kid choose a cesarean delivery. These findings reflect women's beliefs about the efficiency of cesarean deliveries in assuring infant life and reducing mortality and delivery difficulties.

5.2.Part 2: Women Awareness Regarding Elective Cesarean Section

Table 4.4 demonstrates that a considerable percentage of participants (46.7%) acquire their iniformation from doctors, which contradicts the findings of Abed-Alruda & Khairi study (2017), regarding the source of knowledge, families are the most common source of information for 43% of the research participants. This finding contradicts the findings of Ajeet et al. (2011), who indicated that friends or relatives (54.7%), the media (24.5%), and health staff (20.8%) are the most prevalent sources of knowledge about cesarean delivery difficulties. In terms of the reason for choosing elective cesarean delivery, the biggest number of participants (70.2%) Fear for the fetus and labor pain 57.9% were the reasons for opting for elective caesarean delivery. As demonstrated in Figure (4.6). This conclusion agrees with Khairi (2015), who indicated that fear of losing the baby and labor discomfort were the primary reasons why women chose caesarean delivery.

1-Attitude

Table 4.3 shows the overall assessment of the attitudes of the participants about ECS complications; 62.5% of the participant's attitudes were positive about ECS complications (which means they prefer ECS), the mean score of the participants was (1.56). According to Table 4.8, attitudes, perception and knowledge about ECS complications, with residence all have a high statistical significance ($p< 0.05$). According to Table 4.9, attitude of participants about elective Cesarean delivery complications is associated with age of the participant, level of study, occupation, monthly income and has a high level of statistical significance. The results of Naim et al. (2015) that there is a statistically significant relationship between a pregnant woman's professions, level of education, and the attitude. ($P < 0.05$).

Another study by Pevzner et *al*. (2008) that disagrees with the finding of this study, reported that 93% and 88% considered vaginal delivery safer for both mother and child and 95% of subjects did not. In favor of cesarean section. The study of Varghese et *al*. (2016) disagrees with this finding. Reported that 89% of the women had a positive attitude towards vaginal delivery. A high rate of caesarean sections was observed among women suffering from primary and secondary infertility, as they believed that giving birth by caesarean section gave birth to healthier babies than babies born vaginally.

2-Perception

In Table 4.8 attitudes, perception and knowledge about elective cesarean section complications, with residence all have a high statistical significance ($p < 0.05$). In table 4.5 shown the highest mean of score 1.6, indicating a good overall assessment. 61.4% of the participants had positive attitudes about the complications of elective caesarean section. That mean is that they prefer cesarean delivery, despite its complications. The study Ajeet et *al*. (2011) concluded that 77.2% of women perception that caesarean

section is a risky procedure and therefore prefer vaginal delivery, while 47.3% of women believe that vaginal delivery is more risky than caesarean section and therefore prefer caesarean sectıon . 68.5% is more Positive about prefer caesarean section. In addition, 44% of the women considered a caesarean section more risky than a vaginal delivery.

5.3. Women's Knowledge about Cesarean Section Complications

According to Table 4.8, attitudes, perception and knowledge about ECS complications, with residence all have a high statistical significance ($p < 0.05$).

Table 4.7 shows the overall knowledge assessment are in the poor level 61.8% the mean score 1.48, which is considered above the cutoff point, refers to poor knowledge. This finding is congruent with the outcome by Hameed and Ibrahim (2021), who discovered that the most of overall knowledge statistics (63%) were unsatisfactory Women's knowledge about CS the mean score (from 1.22 to 1.31) were poor significance. These findings too are comparable with the findings of Mungrue et al. (2010), who discovered that the majority of women (46.2%) had very little knowledge to make educated judgments regarding choosing CS as the preferred method of birth. These finding are agree with those of Ghotbi et *al*. (2014) who showed that the knowledge test score was lower. The knowledge questionnaire was presented to women in general, and 333 (55.6%) of the participants received poor scores. These outcome are also agree with those of Ashimi et al. (2013) who show the outcome of testing knowledge was lower 222 participants, (59.1%) had inadequate knowledge. These outcome are agree with those by Ajeet et al. (2011) who found that the majority participants (65.1%) have poor knowledge. Other reaserch show that mothers' awerness of the risks and complication of elective cesarean delivery has not improved, and there is still a negative attitude about cesarean procedures (Naeim et al., 2015). The outcome of Maharlouei et al. (2013) reported shows that there is lack knowledge of women about maternal and fetal complications of cesarean delivery, and mothers with poor knowledge take the higher attitude by choosing cesarean section of childbirth. Lack knowledge and loss of appropriate education around various labor pain are contributing factors for increased elective cesarean delivery (Laluei et *al*., 2009). A pregnant woman's awareness of both the pros and cons of cesarean sections and

natural childbirth are important factors regarding methods of termination of pregnancy, strategies should be put in place in order to enhance maternal information (Ghasvari et *al*., 2015). The role of professional expert is to do prepartum care and take notices and to give appropriate education in order to promote the information of pregnant female. It is recommended the cooperation of mothers, ministries of health, society, especially medical society (Serçekus et *al*., 2009).

5.4. The Correlation between Demographic Data and Women's Knowledge Variables

According to Table 4.11, knowledge of participants about ECS complications is associated with age participants, level of educational, and occupation and has a high level of statistical significance, but has no statistical significance with monthly income (p-value < 0.05).

This result agrees with the outcome by (Redha, B. A. A., & Khairi, D. S. H. (2017) that shows a strong statistical association between knowledge and (age group and level of educational). This result also agrees with the outcome by Hameed & Ibrahim (2021) which demonstrates the correlation between women's awareness of cesarean delivery and demographic traits (age and economic status were significant and Level of education was high-significance). The studies in France, reported that women with a lower level of education are more likely to have a caesarean section more frequently than women with higher education, such as Italian mothers (Milcent & Zbiri, 2018).

6. CONCLUSION

6.1.Conclusion

In the light of the outcomes of the study, the researcher concludes the following points:

1. Conclusions related to the first objective: General knowledge about CS for most of the participants was determined at a poor level.
2. Conclusions related to the second objectives: The results of the study of 285 samples showed that there is a relationship between women's knowledge of the complications of caesarean section and their demographic characteristics (age, occupation, and the level of education are of high importance) and it has statistical significance for the economic status (monthly income).

6.2. Recommendation

1. It is recommended to provide pregnant women with information on delivery options, including their symptoms, traits, and problems, throughout the prenatal period. This will enable women to make an informed decision through primary health care facilities.
2. It is recommended to power ethical principles in clinical practices in obstetric clinics so that the doctor evaluates each case before deciding to perform a caesarean section when the woman requests it.
3. It is recommended to educate women through the media about the complications of cesarean section through training and role-playing to reduce cesarean delivery.
4. It is proposed to held cooperation between the Ministries of Health and Education to spread awareness among female students by providing awareness lectures and video clips related to the complications of elective caesarean section and other activities.

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EXTENDED TURKISH ABSTRACT

Sezaryen doğum, vajinal doğumla karşılaştırıldığında komplikasyonlara neden olabilen önemli cerrahi bir operasyodur. Gebe kadınlar, normal doğum korkusu veya doğumla ilgili daha önce olumsuz bir deneyim yaşama gibi psikolojik nedenlerle ve ayrıca eş, aile, doktor ya da arkadaşların etkisiyle elektif sezaryen doğumu tercih etmektedir. Kadınlar hastanede sezaryen doğumun, vajinal doğumdan daha güvenli ve daha az ağrılı olduğuna inanmaktadır. Sezaryen doğumların büyük bir kısmı herhangi bir tıbbi neden olmaksızın yapılmaktadır. Sadece vajinal doğumun gerçekleşmesi imkansız olduğunda ve acil durumlarda anne ve bebeğin sağlığını korumak için sezaryen doğum yapılması gerekmektedir. Ne yazık ki, sezaryen doğum toplumda acıdan kaçınma kültürü haline gelmiştir. Irak'ta da buna bağlı olarak sezaryen doğum oranları oldukça yüksek görülmektedir. Tanımlayıcı tipteki bu çalışmada, kadınların elektif sezaryen komplikasyonları hakkındaki tutum, algı ve bilgilerinin değerlendirilmesi, demografik özelliklerin tutum, algı ve bilgi üzerindeki etkisinin belirlenmesi amaçlanmıştır.

Al-Diwaniyah kentindeki Doğum ve Çocuk Hastanesi'nde son üç ayda sezaryen doğum yapan kadınlar çalışmanın evrenini oluşturmuştur. Örnek büyüklüğünü hesaplamak için Yamane formülü kullanılmıştır. Yamane (1967), Cochran'ın formülüne ek olarak, bir popülasyondan örneklem büyüklüğünü ölçmek için başka bir formül geliştirmiştir. Buna göre güven düzeyi için %95 ve (p=0,5) belirlenmiş ve 285 kadın çalışmanın örneklemini oluşturmuştur. Çalışmda kullanılan veri toplama araçları, 3 bölümden oluşmaktadır. Birinci bölüm yaş, cinsiyet, meslek, konut, eğitim düzeyi, maddi durum, ailedeki birey sayısını içeren demografik bilgilerden oluşmaktadır. İkinci bölüm obstetrik verileri içeren kürtaj sayısı, canlı çocuk sayısı, ölü çocuk sayısı ve doğum şekli gibi sorulardan oluşmaktadır. Üçüncü bölümde elektif sezaryen konusunda kadınların tutum, algı ve bilgilerini ölçmeye yönelik toplam 25 maddeden oluşan ölçek kullanılmıştır. Veriler, 16 Ekim-16 Aralık 2022 tarihleri arasında araştırmacı tarafından yüz yüze toplanmıştır. Uygulanan veri toplama formları yaklaşık 15-20 dakikada tamamlanmıştır. Araştırmacı,

katılımcılardan veri toplamadan önce, araştırmayı ve amaçlarını sözlü olarak açıklayıp görüşmek için sözlü ve yazılı onam almıştır. Çankırı Karatekin Üniversitesi Etik Kurulu ve araştırmanın yapıldığı hastaneden çalışmanın uygulanabilmesi için yazılı izinler alınmıştır. Verilerin değerlendirilmesi SPSS 23.0 istatistik programı ile yapılmıştır. Çalışmada yer alan katılımcıların kişisel özellikleri ortalama, standart sapma, sayı ve yüzde gibi tanımlayıcı istatistiklerle incelenmiştir. Verilerin normal dağılım uygunlukları Kolmogorov-Smirnov ve/veya Shapiro-Wilk-W testleri ile araştırılmıştır. Normal dağılıma uyan ölçüm değerleri için parametrik yöntemler kullanılmıştır. İki bağımsız grubun ölçüm değerlerinin karşılaştırılmasında bağımsız iki örneklem t-testi, üç ve daha fazla bağımsız grubun ölçüm değerlerinin karşılaştırılmasında ANOVA testi yöntemi kullanılmıştır. .Anlamlılık düzeyi $p<0.05$ olarak alınmıştır.

Araştırma, katılımcıların çoğunluğunun (%42,8) 25-32 yaşları arasında olduğunu ve ortalama yaşın 31,31±7,9 olduğunu göstermiştir. Kentsel bölgelerde yaşayan katılımcıların oranı %71,9'dur. Eğitim durumu açısından, katılımcıların çoğu (%28,1) yüksekokul mezunudur. Katılımcıların çoğunluğunun (%48,4) ev hanımı olduğu ve %72,6'sının yetersiz gelire sahip olduğu görülmektedir. Aile üyeleri 3-5. gruplarda olan katılımcıların en yüksek yüzdesi %55,8 olmuştur. Kadınların %24,9'u iki kez gebelik geçirmiştir. Kadınların çoğunluğunun kısmı (%28,4) iki doğum yaptığı belirlenmiştir. Doğum şekli açısından, katılımcıların %73,3'ünün daha önce elektif sezaryen geçirdiği saptanmıştır.

Kadınların elektif sezaryen komplikasyonlarına yönelik tutumlarının genel olarak değerlendirilmesine bakıldığında, kadınların %62,5'isinin elektif sezaryenı tercih ettikleri görülmüştür. Araştırmaya katılanların çoğunluğu (%46,7) elektif sezaryene yönelik bilgilerini doktorlardan aldığını belirtmiştir. Kadınların elektif sezaryen komplikasyonlarına ilişkin algısının genel olarak değerlendirilmesine bakıldığında, katılımcıların %61,4'ünün elektif sezaryenı iyi bir uygulama olarak gördükleri belirlenmiştir. Kadınların elektif sezaryeni tercih etme sebeplerine bakıldığında, kadınların %70,2'si fetüsün sağlığına ilişkin korku ve %57,9'u doğum ağrısından kaynaklanan korku olarak belirtmiştir. Kadınların % 61,8'nin elektif sezaryen komplikasyonları hakkındaki bilgilerinin zayıf olduğu belirlenmiştir. Kadınların elektif sezaryen doğum komplikasyonlarına ilişkin tutumları ile yaş, eğitim düzeyi, meslek ve

aylık gelir arasında istatistiksel olarak anlamlı düzeyde ilişki olduğu saptanmıştır($p<0,05$). Kadınların elektif sezaryen doğum komplikasyonları hakkındaki algısı ile kadının yaşı, eğitim düzeyi ve mesleği arasında ilişki olduğu belirlenmiştir($p<0,05$). Kadınların elektif sezaryen doğum komplikasyonları hakkındaki bilgisi ile kadınların yaşı, eğitim düzeyi ve mesleği arasında istatistiksel olarak anlamlı ilişki olduğu görülmüştür($p<0,05$)

Sonuç olarak, kadınların çoğunun elektif sezaryen doğum komplikasyonları hakkındaki genel bilgi testinin sonucunun zayıf düzeyde olduğu belirlenmiştir. Kadınlar, doğum öncesi dönem boyunca semptomları, özellikleri ve sorunları da dahil olmak üzere doğum seçenekleri hakkında bilgi verilerek, sezaryen doğumun komplikasyonları konusunda sağlık uzmanları tarafından eğitilmelidir. Kadınların doğum hakkında eğitilmeleri, bilinçli bir karar vermelerini sağlayacaktır. Kadın doğum kliniklerinde klinik uygulamalarda etik ilkelerin güçlendirilmesi önerilmektedir. Sezaryen doğumu azaltmak için medya programları aracılığıyla rol-model eğitim yoluyla, kadınları sezaryen doğum komplikasyonları hakkında bilgilendirmek önerilmektedir.

APPENDICES

APPENDIX 1. Author's consent to use the study tool.

APPENDIX 2. Questionnaire

APPENDIX 3. Approval of Cankiri Karatkin University

APPENDIX 4. Approval of Iraqi Ministry of health.

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