WOMEN'S SATISFACTION WITH SHARED DECISION-MAKING PROCESS OF CAESARIAN SECTIONS AND ASSOCIATED FACTORS AMONG POST CS DELIVERY WOMEN ATTENDING ST JOSEPH HOSPITAL IN KILIMANJARO, TANZANIA.

Secilia A. Kimaro, (BScN)

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Department of Community Nursing

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By

Secilia A. Kimaro

A Dissertation Submitted in (Partial) Fulfilment of the Requirements for Master of Midwifery and Women's Health at

Muhimbili University of Health and Allied Sciences.

October, 2024

CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled **"*Women's Satisfaction with shared decision-making-process of caesarean sections and associated factors among women attending St Joseph Hospital, Kilimanjaro, Tanzania*"** in (partial) fulfilment for the requirement for Masters of Science in Midwifery and Women's Health of Muhimbili University of Health and Allied Science**.**

_____

Dr. Joel A. Seme PhD

(Supervisor)

_____

Date

_____

Mr Baraka M. Morris

(Co-Supervisor)

_____

Date

DECLARATION

I, Secilia A. Kimaro, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature ……..Date…….

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DEDICATION

This work is dedicated to my beloved husband Dr Elisante Muna who has been a source of inspiration and gave me strength when I thought of giving up, and who continually provided moral, spiritual, and financial support.

ABSTRACT

Background: Caesarean section (CS) rates are rising globally, including in Tanzania, where shared decision-making (SDM) is crucial for patient-cantered care. However, the satisfaction of women with the SDM process during CS and the influencing factors are underexplored in Tanzania. St. Joseph Hospital in Kilimanjaro, serving a diverse population, provides an ideal setting to investigate these issues. Factors such as education, socio-economic status, communication quality, cultural beliefs, and family involvement significantly impact satisfaction. This study aims to evaluate post-CS delivery women's satisfaction with the SDM process at St. Joseph Hospital and identify associated factors. This study aimed to determine the post CS delivery women's satisfaction with SDM process and associated factors among women attending St. Joseph Hospital, Kilimanjaro, Tanzania.

Methodology: A cross-sectional study was conducted at St. Joseph Hospital targeting women aged 18 and above who had undergone a caesarean section. A total of 319 Participants were selected using simple random sampling, and data were collected through Interviewer administered Questionnaire. The primary outcome measured was patient satisfaction with shared decision-making during caesarean delivery. Data analysis was performed using SPSS version 25. A multivariable logistic regression analysis was performed to determine significant predictors of satisfaction at a p-value <0.05.

Results: The mean participant age was 30±16.3 years. The majority resided in town 191(59.9%), were married 250(78.4%), had secondary or higher education 220(69.0%), and were employed 258(80.9%). Most participants were multiparous 230(72.1%), initiated ANC in the 2nd and 3rd trimester 264(82.8%), and underwent emergency CS 185(58.0%). The informed consent was most commonly provided by general practitioners (GPs) 103(54.2%).

The proportion of participants who were satisfied with shared decision regarding CS was 222(69.6%). Patients with a history of cesarean section (CS) were less satisfied (61.6%) compared to those without (78.1%), and elective CS patients reported higher satisfaction (77.4%) than emergency CS patients (64.0%). Satisfaction was highest among patients who received consent from specialists (94.7%), and those with adequate knowledge (73.0%) and good provider-to-patient communication (71.7%) were more satisfied. In

multivariable logistic regression, individuals with no history of cesarean section (CS) had an adjusted odd ratio (aOR) of 2.797 (95% CI [1.511, 5.178], p = 0.001). Those who underwent elective CS had an aOR of 2.367 (95% CI [1.293, 4.332], p = 0.005). Informed consent provided by a specialist was associated with a notably higher aOR of 9.468 (95% CI [2.617, 34.258], p = 0.001). Adequate knowledge among patients was linked to an aOR of 4.135 (95% CI [1.512, 11.312], p = 0.006), while good communication showed an aOR of 4.461 (95% CI [1.474, 13.503], p = 0.008).

Conclusion: This study highlights the importance of patient involvement in the decision-making process for CS, emphasizing that it leads to higher satisfaction, particularly for those new to CS or undergoing elective procedures. The research suggests that active patient participation and thorough information provision may help address the rising CS rates by empowering patients and improving their satisfaction with the healthcare services provided.

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LIST OF ABBREVIATION

ANC	Antenatal Care
AOR	Adjusted odds ratio
CI	Confidence interval
COR	Crude odd ratio
CS	Caesarean section/ delivery
IRB	Institutional review board
MUHAS	Muhimbili University of Health and Allied Sciences
PNC	Post Natal Care
SDM	Shared decision-making;
SPSS	Statistical Package for Social Sciences
WHO	World Health Organization.
RCHC	Reproductive and child health clinic.
CTC	Care and Treatment Clinic

OPERATION TERMS

A caesarean section is a surgical delivery method in which a baby is born through an incision made in the mother's abdomen and uterus.

Caesarean section rates - The Total number of Caesarean deliveries over the number of births in percentage.

C-section satisfaction refers to the contentment mothers feel after delivery. Factors like pain management and communication with healthcare providers affect it. High satisfaction leads to smoother recovery and a positive outlook on future pregnancies**.**

Post-delivery care is the physical and emotional support given to a woman after childbirth to ensure her well-being and recovery. It includes monitoring vital signs, pain management, breastfeeding support, emotional care, and guidance on new-born care.

Postnatal refers to the period following childbirth.

Satisfaction with shared decision making refers to the extent to which patients feel involved and empowered in the decision-making process.

Shared decision-making is a collaborative process between healthcare providers and patients, in which both parties work together to make healthcare decisions based on the patient's preferences, values, and clinical evidence**.**

Surgical informed consent is when a patient agrees to a procedure after understanding its details, risks, benefits, and alternatives and signing a consent form.

The patient-to-doctor relationship is the patient's perception of the doctor's care, attitude, and behaviour towards the patient.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

A Caesarean section (CS) is a surgical procedure to deliver a baby through abdominal and uterine incisions (1). It can be elective (planned) or emergency (unplanned due to complications) (2,3). Globally, the rate of CS has been increasing, with significant variations across regions (4). The World Health Organization (WHO) projects that by 2030, nearly 29% of all births globally may be by caesarean section. In Tanzania, the CS rate is approximately 6%, which is lower than the global average of 21.1% (5). However, in urban areas like Kilimanjaro, the rates are higher due to better access to healthcare facilities.

Shared decision-making (SDM) is a collaborative process that involves patients and healthcare providers working together to make healthcare decisions. SDM ensures that patients are well-informed about their options and that their preferences and values are considered in the decision-making process. In the context of CS, SDM can lead to better patient outcomes by ensuring that women understand the reasons for the procedure and feel involved in the decision. This can reduce anxiety, improve satisfaction, and enhance trust in healthcare providers. However, implementing SDM in Tanzania faces challenges such as limited resources, cultural barriers, and varying levels of health literacy (6,7).

Several factors influence women's satisfaction with CS, including the quality of communication with healthcare providers, the level of involvement in decision-making, and the perceived necessity of the procedure (8–12). Previous studies have shown that women who are actively involved in the decision-making process tend to have higher satisfaction levels (8–12). Satisfaction with CS is crucial as it impacts both maternal and neonatal outcomes. Positive experiences can lead to better mental health and quicker recovery for mothers, while negative experiences can result in trauma and reluctance to seek future medical care.

Various demographic, socio-economic, and clinical factors can influence satisfaction with the SDM process. These include age, education level, socio-economic status, previous childbirth experiences, and the presence of medical complications (13,14). Cultural and societal attitudes towards CS and SDM also play a significant role in shaping women's experiences

and satisfaction (13,14). In Tanzania, traditional beliefs and practices may affect women's perceptions of CS and their willingness to participate in SDM. Understanding these factors is essential for improving patient-centered care.

This study aimed to fill the gap in existing research on women's satisfaction with the SDM process for CS in Tanzania. By identifying the factors associated with satisfaction, the study provided valuable insights for healthcare providers and policymakers. The findings had significant implications for healthcare policy and practice in Tanzania, particularly in improving the quality of care and patient satisfaction at St. Joseph Hospital.

1.2 Problem statement

Caesarean section (CS) is a controversial clinical procedure that has been overused and underused globally, despite its potential benefits in improving maternal and new-born outcomes. After being used in clinical settings, it significantly enhanced the outcomes for mothers and new-borns (15). According to recent reports, the standard optimal rate for caesarean sections has been exceed in many different nations around the globe (12,16,17). Fernando et al discussed the high caesarean section rate in private hospitals, nearly twice the caesarean rate of public hospitals. Research shows only 6-12% of women wish to deliver by caesarean section, but 34% of healthy nulliparous women at public hospitals and 45% at private hospitals end up delivering via caesarean (18). This indicates that health system factors and care processes move patients toward caesarean delivery more than individual preferences.

Research in Tanzania indicates that many clinicians believe it is safer to withhold information from less-educated women and that many women do not agree that clinicians must secure permission before procedures (19). The absence of regulatory frameworks and mechanisms for redress may contribute to a "normalization" of care provided without satisfactory consent. Professional standards and job aids are required to ensure informed consent in caesarean section counselling processes. Research in developed countries shows that most women who undergo caesarean sections are satisfied with their involvement in the decision-making process (20,21). However, there is limited information on women's satisfaction with shared decision during informed consent for caesarean section (CS) in developing countries

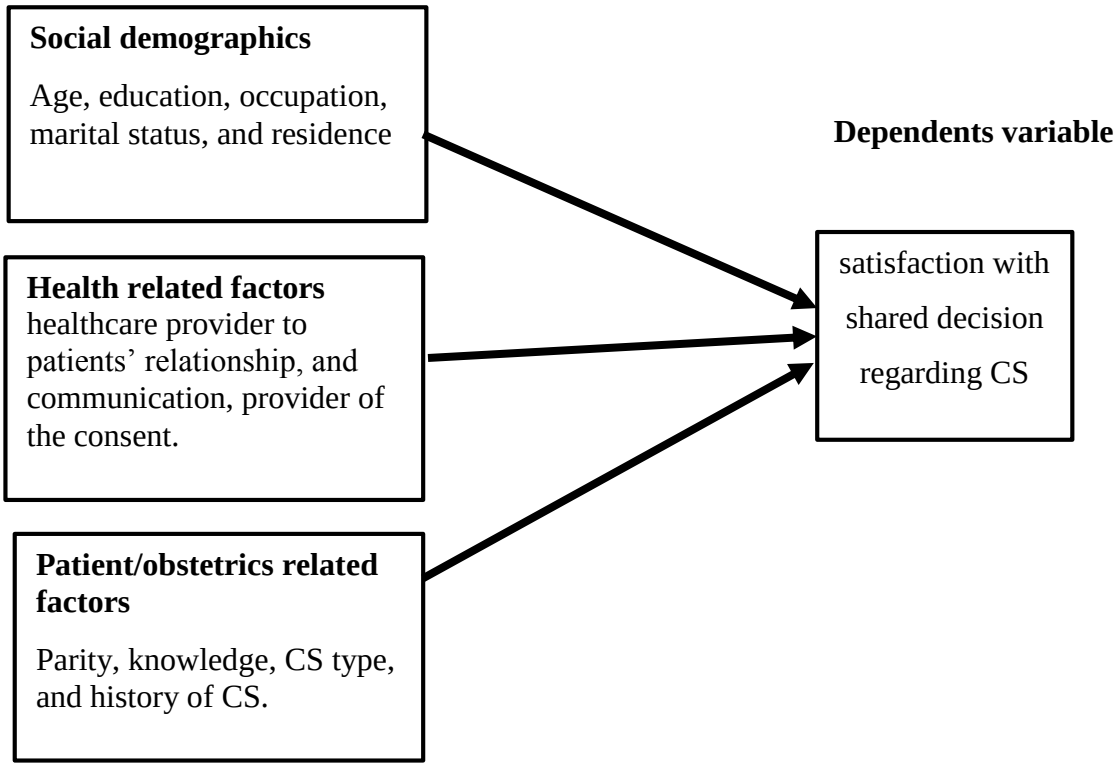
While it is known that all women undergoing CS at St Joseph hospital are given the informed consent which enhances the shared decision, it is unknown whether women are satisfied with the process. Studying the maternal satisfaction with shared decision and associated factors will provide baseline data for situational analysis grounding implementation studies. Therefore, this study aimed to determine the level of satisfaction with shared decision and associated factors among women who underwent CS at St Joseph hospital.

1.3 Conceptual framework

The conceptual framework (developed from the literature review) used in the study shows the relationship between satisfaction with shared decisions as the dependent variable and health concepts that have been shown to theoretically and empirically influence satisfaction with shared decisions.

Effective communication between healthcare providers and patients is critical to achieving high levels of patient satisfaction. In Tanzania, healthcare providers must use clear and straightforward language appropriate for the patient's literacy level and provide information and explanations about medical procedures in the patient's mother tongue (22). In Ethiopia and Southern Africa, women's satisfaction during childbirth is improved when they are provided with adequate information about care and are actively involved in decision-making (23). Patients' socioeconomic status can also affect their communication with medical professionals, as those from lower classes tend to receive less information (24). Building trust and respect between healthcare providers and patients through effective communication is essential for achieving high levels of patient satisfaction (25). Additionally, women's satisfaction with shared decision-making during caesarean sections is associated with their knowledge level, and maternal request for a caesarean can affect post-operative care and pain management satisfaction (26,27).

Independents variables



***Source*: Developed from the literature review.**

Figure 1: Conceptual Framework

1.4 Significance of the study

The current study seeks to assess the degree of satisfaction among women regarding the collaborative decision-making process concerning caesarean sections. The findings will add to the scant body of knowledge currently available on maternal satisfaction with perioperative care in Tanzania and lay the groundwork for further research by healthcare professionals. The findings will assist in improving quality of the maternal health services Tanzania.

1.5 Research Question

1.5.1 Broad research question

To what extent are women satisfied with shared decision-making regarding c/section at St Joseph hospital in Kilimanjaro, Tanzania?

1.5.2 Specific Research Questions

1. What is the proportion of women satisfied with shared decision-making regarding CS at St Joseph hospital in Kilimanjaro, Tanzania?
2. What are the factors associated with satisfaction with shared decision-making regarding CS at St Joseph hospital in Kilimanjaro, Tanzania?

1.6 Objective

1.6.1 Broad objective

To assess the extent of women satisfaction with shared decision-making regarding CS at St Joseph hospital in Kilimanjaro, Tanzania.

1.6.2 Specific Research Objectives

1. To determine the proportion of women satisfied with shared decision-making process regarding CS at St. Joseph hospital in Kilimanjaro, Tanzania.
2. To identify factors associated with women’s satisfaction with shared decision-making process regarding CS at St Joseph hospital in Kilimanjaro, Tanzania.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Overview

Shared decision-making (SDM) in the context of caesarean sections (CS) has gained significant attention globally as a means to enhance patient-centered care. Studies have shown that SDM can lead to improved patient satisfaction, reduced anxiety, and better overall outcomes. In high-income countries, the implementation of SDM has been associated with a decrease in unnecessary CS procedures and an increase in patient satisfaction (28). For instance, research in the United States and Europe indicates that when women are actively involved in the decision-making process, they are more likely to feel empowered and satisfied with their childbirth experience. However, despite these benefits, the adoption of SDM in CS remains inconsistent, with barriers such as time constraints, lack of training, and cultural differences impacting its widespread implementation. In some studies, up to 50% of women reported being involved in SDM regarding their mode of delivery (28).

Regionally, in sub-Saharan Africa, the practice of SDM in CS is still emerging. In Tanzania, the rate of CS has been increasing, yet the integration of SDM into clinical practice faces several challenges (29). Studies conducted in Dar es Salaam have highlighted that only 38% of women are involved in the decision-making process regarding their mode of delivery (29). Factors such as low levels of education, limited awareness of patient rights, and cultural norms that prioritize medical authority over patient autonomy contribute to this gap (29). Efforts to promote SDM in Tanzania include training healthcare providers, raising awareness among patients, and addressing systemic barriers to ensure that women can actively participate in decisions about their childbirth options (29). These initiatives are crucial for improving maternal satisfaction and outcomes in the region.

2.2 Maternal satisfaction with shared decision-making regarding CS

Caesarean sections are a standard surgical procedure for women during childbirth. However, studies have shown that the satisfaction level of women with the shared decision-making process before the procedure varies greatly. In Petra Kolip and Roland Buchter conducted a study that revealed 62.3% of women who underwent Caesarean sections felt satisfied with the preoperative shared decision-making process and would choose the same decision again

under similar circumstances (11). A 2019 facility-based cross-sectional study conducted by Binyam Demisse Sisay in southwest Ethiopia showed that only 41.8% of women were satisfied with the shared decision-making process when undergoing a Caesarean section(21). This study highlights the importance of adequate information provision, with 45.7% of the participants reporting being adequately informed about the Caesarean section, which was essential to their decision(21). A cross-sectional study conducted by Tsegaw Biyazin Tesfa in the Oromia region of Ethiopia found that 57% of women were dissatisfied with the informed consent provision before the surgical procedure (30). The study further revealed a significant disappointment in the consent component: the information provision about the risk of postoperative pain treatment options. Lastly, a cross-sectional study conducted in Edo State, Nigeria, by Ohaeri, Aideloje, and Agorye Ingwu found that the satisfaction level of women with the Caesarean section decision-making procedure varied. While 67.4% of women were delighted, 24.7% were satisfied, and 7.9% were poorly satisfied(31).

It is essential to ensure that women are adequately informed about the procedure and the risks involved. Moreover, healthcare providers should involve women in decision-making to ensure their satisfaction and comfort. However, there is scarcity of published data about maternal satisfaction for shared decision among women who have had CS.

2.3 Factors associated with satisfaction with shared decision regarding CS

2.3.1 Social-demographic characteristics

Numerous studies have been conducted in Ethiopia and Southern Africa to analyse the factors influencing maternal satisfaction during childbirth. Binyam Demisse Sisay's study in southwest Ethiopia found that urban residency was strongly associated with higher satisfaction rates among women who underwent caesarean sections (30). Similarly, a recent study conducted in the Oromia region of West Ethiopia in 2020 reported that participants from urban settings were more likely to be satisfied than their rural counterparts (21). Ozkan SA's study delved into the factors affecting maternal satisfaction during normal and caesarean births and identified that higher education levels of spouses, women's employment, and non-use of enemas during birth increased maternal satisfaction among women who had caesarean births (32). Conversely, a systematic review conducted by Hodnett across Southern Africa highlighted that women's active involvement in decision-making and having a say in decisions about their care were critical determinants of childbirth satisfaction (33).

Dissatisfaction was associated with a lack of participation in decision-making and inadequate information and education about the care.

2.3.2 Health related factors

In the context of postoperative maternal satisfaction with preoperative shared decision-making regarding caesarean section (C-section), health-related factors that may influence satisfaction include physical recovery from the surgery, pain management, and the overall health and well-being of the mother and baby (23,34). However, the preoperative shared decision-making process can also significantly impact overall satisfaction.

Shared decision-making involves a collaborative process between the healthcare provider and the patient, where they work together to make decisions about the patient's care based on their values and preferences (35). In the case of a C-section, shared decision-making might involve discussing the risks and benefits of the procedure, as well as alternative options, such as vaginal birth, with the patient and allowing them to make an informed decision based on their circumstances and preferences (32,36).

Research has shown that when patients feel involved in the decision-making process, they are more likely to be satisfied with their care and have better outcomes(30,37). Therefore, ensuring that patients are well-informed and involved in the decision-making process regarding their C-section can be essential in promoting overall satisfaction and well-being.

2.3.3 Patient-related factors

The results of a study conducted in Edo State, Nigeria, by Ohaeri, Aideloje, and Agorye Ingwu suggest that women's satisfaction with shared decision-making procedures during their involvement in caesarean sections is closely linked to their level of knowledge (31). Another study from Jimma Medical Center in Ethiopia found that participants with no referral history from other health settings were more likely to be satisfied with the provision of informed consent during obstetric and gynaecologic surgeries (30). Similarly, Amir HE, Zewawi NE, and Jaroudi DA's study reported that maternal request for a caesarean section was significantly associated with post-operative care and pain management satisfaction (38).

2.3.4 Service-related factors

Effective communication between healthcare providers and patients ensures informed decision-making and patient satisfaction (39). In Tanzania, healthcare providers are required

to communicate health information in a language that patients can understand, taking into account their literacy level (40). Informed consent is mandatory for all medical interventions except in limited circumstances. Studies have shown that when patients have access to medical information in their mother tongue, they are more likely to make informed decisions, participate in the process, and feel respected (11,37,41–43).

A study conducted in 2020 at Jimma Medical Centre in Ethiopia analysed the satisfaction of women who underwent obstetric and gynaecologic surgery with their informed consent (30). The study found that women who received informed consent in their mother tongue were twice more likely to be satisfied with the informed consent than those who did not. Additionally, explaining the procedure in the mother tongue increased the likelihood of satisfaction by 2.4 times. Another survey study conducted in Switzerland showed that language played a significant role in shared decision satisfaction, particularly for Turkish and Serbo-Croat speakers (37). Poorly written operation descriptions led to dissatisfaction with shared decisions while explaining the procedure in the mother tongue improved satisfaction.

A study conducted in 2019 by Binyam Demisse Sisay in southwest Ethiopia aimed to assess maternal satisfaction with shared decision-making among women undergoing caesarean sections (44). The study found that spending more time with care providers led to a higher rate of satisfaction among patients. Similarly, a 2020 study conducted at Jimma Medical Center in Ethiopia found that patients who received information about surgical informed consent for more than 10 minutes were more likely to be satisfied with the provision of informed consent than those who received the information for less than 5 minutes (30). In Sweden, a study also found that little involvement in decision-making, lack of encouragement, and insufficient time for personal questions increased dissatisfaction with childbirth (45).

A cross-sectional study by Ozkan SA. Analysed maternal satisfaction in normal and caesarean births using cut-off points. The study found that women who had a normal birth were more satisfied if they had planned the pregnancy, had five or more antenatal controls, did not receive enemas during birth, and managed pain control with pharmacological methods (32).

2.4 Summary of the literature

Studies on maternal satisfaction with shared decision-making (SDM) regarding caesarean sections (CS) reveal significant variability in satisfaction levels. For instance, Petra Kolip and Roland Buchter found that 62.3% of women were satisfied with the SDM process before their CS, while a study by Binyam Demisse Sisay in southwest Ethiopia reported only 41.8% satisfaction. Additionally, 45.7% of participants in Sisay's study felt adequately informed about the procedure, highlighting the importance of information provision. In contrast, Tsegaw Biyazin Tesfa's study in the Oromia region of Ethiopia showed 57% dissatisfaction with informed consent, particularly regarding postoperative pain management options. In Edo State, Nigeria, Ohaeri, Aideloje, and Agorye Ingwu found varying satisfaction levels, with 67.4% of women being delighted, 24.7% satisfied, and 7.9% poorly satisfied. Factors influencing satisfaction include urban residency, higher education levels, and active involvement in decision-making. Despite these findings, there is a scarcity of published data on maternal satisfaction with SDM among women who have had CS, particularly in Tanzania, indicating a need for further research to understand and improve SDM practices and associated factors in this context.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

This study utilized a quantitative cross-sectional design to determine the proportion of women who satisfied the shared decision-making process during C-section and identify associated factors.

3.2 Study site

The study was conducted at St. Joseph Hospital, Kilimanjaro, Tanzania. St. Joseph Hospital is a private institution founded by a Catholic church owned by Sisters of Our Lady Kilimanjaro (15). It is located in Soweto ward, Moshi, Kilimanjaro Region. The Hospital was founded back in 2001 and has undergone a steady expansion ever since. With over eleven departments, it caters to a wide range of medical needs, including Outpatient and Inpatient care, Orthopaedic, Dialysis, General Surgery, Gynaecology, Dental, Physiotherapy, CTC, RCH, ENT, Hypertension clinic, and Diabetic clinic (15). The average number of women giving birth per month at St Joseph is 250, of which over 100 are delivering through CS (15).

St. Joseph Hospital in Moshi, Kilimanjaro Region, was an ideal site for research on satisfaction with shared decision regarding with CS birth. The hospital has many referrals from surrounding healthcare centres, a significant volume of monthly deliveries, and a strong track record in maternal and child health. Also, the hospital's various medical departments, including Obstetrics and Gynaecology, cater to the medical needs of pregnant women and new mothers. Furthermore, the hospital is easily accessible by public transport, making it convenient for potential participants.

3.3 Study population

The study focused on women who underwent C-sections in the postnatal ward, postnatal clinic and RCH at St Joseph Hospital.

3.3.1 Inclusion Criteria

The study recruited over-18-year-old women who were on postnatal clinics, wards and those attending RCH four months’ post CS.

3.3.2 Exclusion Criteria

Women who met the inclusion criteria but were critically ill at the time of data collection were excluded from the study.

3.4 Sample size estimation

As shown below, the formula for estimating a single proportion is used to calculate the internally valid sample

size to estimate satisfaction of shared decisions in this study.

$$n = \frac{Z^2 * P * (1-P)}{\varepsilon^2}$$

n = Estimated sample size

Z = it is the Z-score of a critical level, taken at 95% =1.96

P = 24.7%The existing magnitude of satisfaction with the shared decision, reported by a previous study in Nigeria (31).

ε = critical value of Z statistic taken at 5%.

$$n = \frac{1.96^2 * 0.247 * (1 - 0.247)}{0.05^2}$$

Therefore, the projected sample size will be = 286

Adjusting for non-response by adding 10% of the sample, the projected sample size was 315 Post CS women.

3.5 Sampling technique

In the study, participants were chosen using a simple random sampling method from the outpatient postnatal, RCH, and postnatal wards. The selection process employed a lottery system where pieces of paper marked with "yes" or "no" were mixed in a box. Women visiting the clinic for Cesarean section follow-up were invited to draw a paper at random. The drawn paper, once unfolded, indicated whether they were selected for the study. Those who drew a "yes" were asked for their consent to participate. This procedure was repeated until the desired number of participants was attained.

3.6 Variables

3.6.1 Dependent Variable

The participant's satisfaction with the shared decision on the caesarean section were the dependent variable. A questionnaire of six statements was used to determine the satisfaction

levels of participants with the caesarean section shared decision. The questionnaire had five-point Likert scale responses ranging from 1 to 5. A score of 1 stood for "completely dissatisfied", while five represented "completely satisfied". The descriptive analysis of individual items was conducted. The maximum expected score was 30, while the minimum was 6. For the purpose of conducted logistic regression, a linear score was converted into a binary scale for the purpose of conducting logistic regression. The participants who scored 50 and above were considered satisfied otherwise dissatisfied. This grouping were adopted from a study previously conducted in Ethiopia (21).

3.6.2 Independent Variables

Variable	**Measure**	**Level**
Age	Continuous	mean/standard deviation
Marital status	Nominal	Married/ vs unmarried
Residence	Nominal	Urban/Rural
Occupation	Nominal	Employed vs Unemployed
Educational status	Ordinal	Informal/ primary vs secondary/college/diploma/higher education
Knowledge	Ordinal	Adequate/Inadequate
Parity	Nominal	Null parous vs Multiparous
ANC debut	Continuous	Median/range(Minimum-Maximum) At median (<12 weeks vs 12+weeks)
History of previous CS	Nominal	Yes/No
Type of CS	Nominal	Emergency vs Elective
Health care provider who requested consent	Nominal	Ob-gyn specialist/General practitioner/resident Midwives/Nurses
Had adequate time to decide	Nominal	Yes/No
Information for informed consent	Nominal	Yes/No
Patient-to-doctor relationship	Ordinal	Good/Not good

The patient-doctor relationship was evaluated using a questionnaire with nine yes/no items. A good relationship was defined as patients answering "yes" to at least seven items (19).

Knowledge was assessed with a questionnaire with eight questions, participants who scored right to at least four items, were considered as “adequate knowledge” otherwise, inadequate.

3.7 Data collection tool

The questionnaire was the data collection tool used in this study. This questionnaire was developed by the principal researcher following rigorous literature review and conceptualization of the topic. This questionnaire was closed ended composed of different constructed and different scales adopted from different sources. The first section consisted of social demographic characteristics of the participant. The second section had seven obstetric related. The third part consisted of eight services related items. The fourth section consisted of six-patient’s satisfaction assessing items, which were adopted from a previously conducted study in Ethiopia. The firth part consisted of nine items related to patient-provider’s relationships, which were adopted from study previously conducted in diverse background (7). The last part consisted ten-knowledge assessment questionnaire which were adopted from a previously conducted study in Nigeria(31).

3.7.1 Reliability and validity of the tool

Following a thorough literature review, the principal investigator composed a questionnaire for the study. The questionnaire underwent a rigorous evaluation process by a team of experts, including the supervisor, co-supervisor, two Obstetrics and Gynaecology specialists, and a member of the Institute of Review Board committee. They ensured the questionnaire's conceptual and item equivalence, accuracy, clarity, and effectiveness in conveying the intended message. Once the English version was finalized, it was translated into Swahili and evaluated again. The questionnaire was then pilot-tested on 5% of the anticipated sample size. The content of the questionnaire was improved through rewording for clarity, and easy comprehensions. Rewording of the terms such as informed consent, autonomy, contentment and equity. Also, phrases such as adequacy of consultation times and involvement in decision making were rewritten in long forms for easy comprehensions. The questionnaire was then analysed using SPSS software to test its reliability, with a Cronbach alpha value of 0.69 considered to be reliable. Items with low reliability were removed from the final version.

3.8 Data collection procedure

Data was collected at St. Joseph Hospital in Moshi, Kilimanjaro, among women who gave birth through CS. The data collection process started in May 2024 after obtaining ethical clearance from the MUHAS IRB and permission from St. Joseph administrative management.

Research assistants, nurses at St. Joseph Hospital were responsible for data collection. randomly select at postnatal ward and clinic and RCH. Data collection was done from Monday to Friday between May and June 2024.

The research assistant-initiated dialogue and provided detailed information about the purpose of the study and their potential participation. After reviewing medical records for eligibility criteria, eligible participants were requested to participate by signing the consent form.

The research assistant conducted a one-on-one interview in one of the consultation rooms for those at the postnatal clinics. For those in the postnatal ward, data was collected near their beds. The research assistant read the questions to the participants and jotted down their responses. After data collection, the research assistant thanked the participants for their participation.

All the filled-out questionnaires were handed to the principal investigator, who checked them for completeness and kept them in a drawer accessible only to PI.

3.9 Data processing and analysis

The data for the study was collected and entered and analysed using SPSS version 28. Before the analysis, the data was screened for accuracy, including checking for missing, forgotten, and double entries and correcting syntax errors and wrong entries manually.

The study results were summarized using descriptive analysis. For categorical variables, proportion and frequency were used, while central tendencies were used for continuous variables based on the data distribution. The summarized data was presented in tables, figures, and text.

A chi-square bivariate analysis test was conducted for detection of significance group differences. The statistical group differences of ≤ 0.25 were included in the multivariable logistic regression for independent association with satisfaction with shared decision making

process. The statistically significantly associated variables with satisfaction of shared decision making were considered at p value ≤ 0.05.

3.10 Ethical consideration

The study acquired ethical clearance from MUHAS IRB and a permission letter from the St Joseph Hospital administration. The participants were given information about the study's aim and risks; potential participants were given written consent, supplemented verbally. The interview was conducted in a private room, and participant names were coded to ensure privacy.

3.11 Dissemination of the study findings

This is academic research to partially fulfil the requirement for the degree award of Master of Science in midwifery and women's Health at the Muhimbili University of Health and Allied Sciences (MUHAS). MUHAS will be provided with hard copies and electronic copies for reference. The findings will be submitted to St Joseph so that study recommendations-based findings can be implemented. The study will be presented in seminars, conferences, and hospital symposiums. The results will also be published in international journals.

CHAPTE FOUR

4.0 RESULTS

This study recruited 319 women who underwent CS at St. Joseph Hospital, Moshi.

4.1 Characteristics of the study participants.

The mean age was 30 years and standard deviation was 16.3. Table 1, shows the characteristics and experiences among 319 participants who underwent CS. The majority resided in town 191(59.9%), were married 250(78.4%), had secondary or higher education 220(69.0%), and were employed 258(80.9%). Most participants were multiparous 230(72.1%), initiated ANC in the 2^{nd} and 3^{rd} trimester 264(82.8%), and underwent emergency CS 185(58.0%). The informed consent was most commonly provided by general practitioners (GPs) 103(54.2%).

Table 1: Social demographics and obstetric information of the study participants (N=319)

Variables	N(%)
Age group	
18-24	73 (22.9)
25-34	197 (61.8)
35+	49 (15.4)
Residence	
Town	191 (59.9)
Rural	128 (40.1)
Marital Status	
Married	250 (78.4)
Unmarried	69 (21.6)
Education Level	
Primary/Lower	99 (31.0)
Secondary/Higher	220 (69.0)
Occupation	
Employed	258 (80.9)
Unemployed	61 (19.1)
Parity	
Prim	89 (27.9)
Multi	230 (72.1)
ANC 1st contact	
1st trimester	55 (17.2)
2nd trimesters	264 (82.8)
History of CS	
Yes	164 (51.4)
No	155 (48.6)
Current CS	
Emergence	186 (58.3)
Elective	133 (41.7)
Informed Consent Provider	
Specialist	57 (17.9)
GP	140 (43.9)
Midwife	122 (38.2)
Knowledge	
Inadequate	26 (8.2)
Adequate	293 (91.8)
PPC quality	
Good	297 (93.1)
Not good	22 (6.9)

PPC→ Patient-provider communication quality

4.2 Women's satisfaction with shared decision-making regarding CS

The overall median score of the study participant's satisfaction with shared decision was 57.5, with minimum and maximum of 0 and 100 respectively in a standard linear scale. The proportion of participants who were satisfied with shared decision regarding CS was 222(69.6%).

Table 2 shows satisfaction across five domains: 59.5% felt adequately informed about the caesarean section, 57.4% believed the decision was best for them, 54.9% found the decision consistent with their values, 53.6% expected to carry out the decision successfully, and 54.9% felt autonomous in making the decision.

Table 2: Distribution of the satisfaction domains (N=319)

ITEM	Complete Dissatisfied	Dissatisfied	Neutral	Satisfied	Complete Satisfied
Satisfaction with Information	92 (28.8%)	9 (2.8%)	28 (8.8%)	100 (31.3%)	90 (28.2%)
Personal Decision Satisfaction	88 (27.6%)	18 (5.6%)	30 (9.4%)	104 (32.6%)	79 (24.8%)
Consistency with Values	97 (30.4%)	8 (2.5%)	39 (12.2%)	110 (34.5%)	65 (20.4%)
Expectation to Carry Out Decision	86 (27.0%)	17 (5.3%)	45 (14.1%)	103 (32.3%)	68 (21.3%)
Autonomy	106 (33.2%)	19 (6.0%)	22 (6.9%)	96 (30.1%)	76 (23.8%)

Figure 2, the overall Satisfaction. Despite the positive responses in other areas, when it comes to overall satisfaction with the decision, a significant 36.4% were completely dissatisfied.

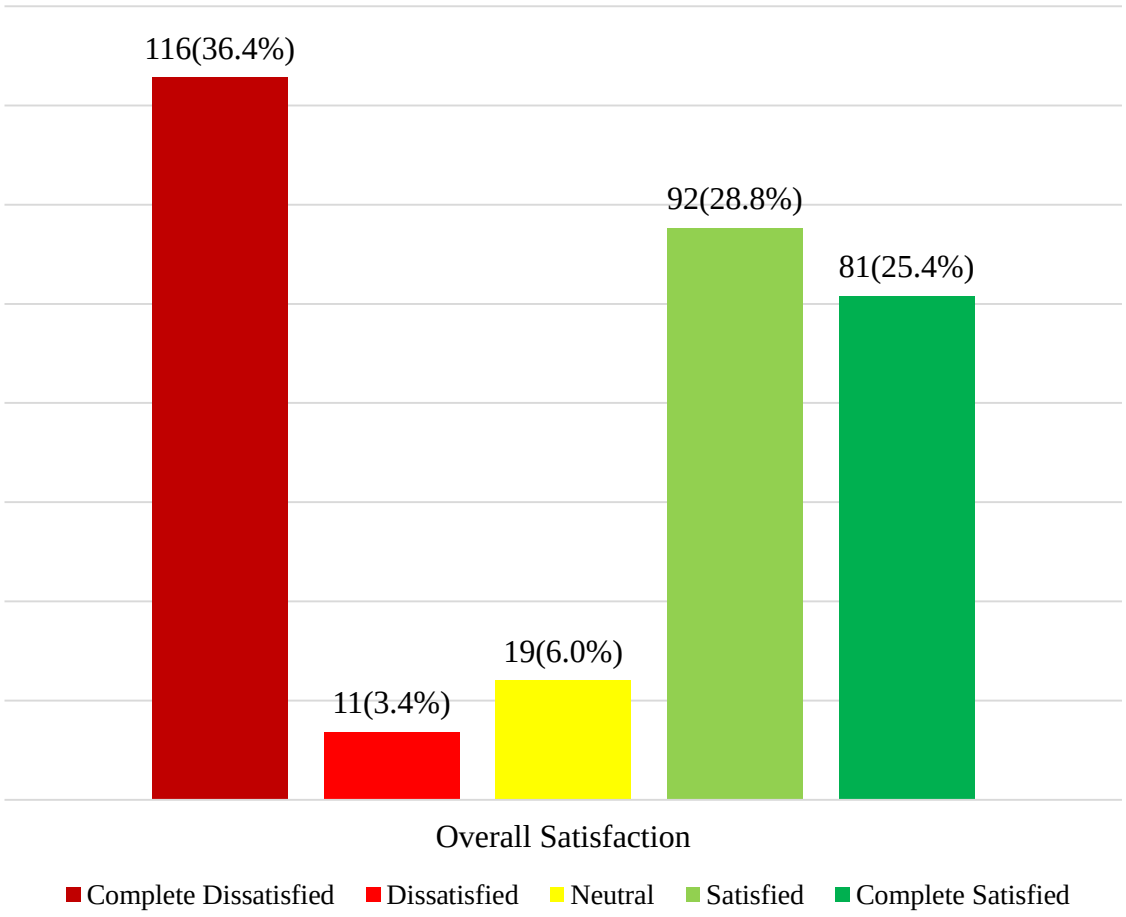


Figure 2: Overall satisfaction of women who underwent CS regarding the shared decision post CS delivery.

4.3 Factors associated with women's satisfaction with shared decisions regarding CS birth

4.3.1 Bivariate analysis of the factors associated with women's satisfaction with shared decision regarding CS birth.

The analysis revealed several significant differences in satisfaction levels among various groups. The significant difference was observed in satisfaction based on the history of cesarean section (CS), with those having a history of CS being less satisfied (61.6%) compared to those without (78.1%), $\chi 2(1, N=319) = 10.45$, $p=.001$. Similarly, the type of current CS also showed a significant difference, with elective CS patients reporting higher satisfaction (77.4%) compared to emergency CS patients (64.0%), $\chi 2(1, N=319) = 6.63$, $p=.01$. The consent provider was another significant factor, where patients who received

consent from specialists reported the highest satisfaction (94.7%), followed by those who received consent from midwives (66.4%) and general practitioners (GPs) (62.1%), $\chi 2(2, N=319) = 18.52$, p=.001. Knowledge levels also significantly impacted satisfaction, with those having adequate knowledge being more satisfied (73.0%) compared to those with inadequate knowledge (30.8%), $\chi 2(1, N=319) = 24.89$, p=.001. The quality of provide-to-patient communication (PPC) was significantly associated with satisfaction, where good PPC resulted in higher satisfaction (71.7%) compared to not good PPC (40.9%), $\chi 2(1, N=319) = 9.88$, p=.002.

Table 3: Bivariate analysis of the factors associated with women's satisfaction with shared decision regarding CS birth (N=319)

Variables	Satisfied [N(%)]	Dissatisfied [n +**(%)]	p value
Age group			0.119*
18-24	56(76.7)	17(23.3)	
25-34	137(69.5)	60(30.5)	
35+	29(59.2)	20(40.8)	
Residence			0.141*
Town	127(66.5)	64(33.5)	
Rural	95(74.2)	33(25.8)	
Marital Status			0.235*
Married	178(71.2)	72(28.8)	
Unmarried	44(63.8)	25(36.2)	
Education level			0.772
Primary/Lower	70(70.7)	29(29.3)	
Secondary/Higher	152(69.1)	68(30.9)	
Occupation			0.865
Employed	179(69.4)	79(30.6)	
Unemployed	43(70.5)	18(29.5)	
Parity			0.169*
Prim	67(75.3)	22(24.7)	
Multi	155(67.4)	75(32.6)	
ANC start			0.929
1st trimester	38(69.1)	17(30.9)	
2nd trimester	184(69.7)	80(30.3)	
History of CS			0.001*
Yes	101(61.6)	63(38.4)	
No	121(78.1)	34(21.9)	
Current CS			0.01*
Emergence	119(64.0)	67(36.0)	
Elective	103(77.4)	30(22.6)	
Consent provider			0.001*
Specialist	54(94.7)	3(5.3)	
GP	87(62.1)	53(37.9)	

Midwife	81(66.4)	41(33.6)	
Knowledge			0.001*
Inadequate	8(30.8)	18(69.2)	
Adequate	214(73.0)	79(27.0)	
PPC quality			0.002*
Good	213(71.7)	84(28.3)	
Not good	9(40.9)	13(59.1)	

*PPC→ Patient-provider communication quality. *statistically significantly different, p≤0.25*

4.3.2 Multivariable logistic regression analysis of the factors associated with women's satisfaction with shared decision regarding CS birth.

A multivariable logistic regression analysis was conducted to examine the factors associated with women's satisfaction with shared decision-making in caesarean sections. Table 4, the analysis included variables such as age, residence, marital Status, parity, history of caesarean section (CS), type of current CS, informed consent provider, knowledge, and patient-provider communication.

The results indicated that women with no history of CS were significantly more likely to report satisfaction compared to those with a history of CS, with an adjusted odd ratio (aOR) of 2.797 (95% CI [1.511, 5.178], p = 0.001). This means that women with no history of CS were approximately 2.8 times more likely to be satisfied. Additionally, women who underwent elective CS were more likely to be satisfied compared to those who had emergency CS, with an aOR of 2.367 (95% CI [1.293, 4.332], p = 0.005). This indicates that women who had elective CS were about 2.4 times more likely to report satisfaction. Women who received informed consent from a specialist were significantly more satisfied compared to those who received it from a midwife, with an aOR of 9.468 (95% CI [2.617, 34.258], p = 0.001). This suggests that women were nearly 9.5 times more likely to be satisfied when informed consent was provided by a specialist. Women with adequate knowledge were significantly more likely to be satisfied compared to those with inadequate knowledge, with an aOR of 4.135 (95% CI [1.512, 11.312], p = 0.006). This means that women with adequate knowledge were about 4.1 times more likely to be satisfied. Patient-provider communication quality was significantly associated with satisfaction. Women who reported good communication were significantly more satisfied compared to those who reported poor communication, with an aOR of 4.461 (95% CI [1.474, 13.503], p = 0.008). This indicates that women who experienced good communication were approximately 4.5 times more likely to be satisfied.

Table 4: Factors associated with women's satisfaction with shared decisions regarding CS delivery (N=319)

Variables	aOR	CI	p-value
Age group			
18-24	Ref		
25-34	0.603	0.263 —1.381	0.232
35+	0.4	0.14 —1.143	0.087
Residence			
Town	Ref		
Rural	1.631	0.93 —2.859	0.088
Marital Status			
Married	.778	.432—1.400	0.402
Unmarried	Ref		
Parity			
Prim	0.872	0.416 —1.83	0.717
Multi	Ref		
History of CS			
Yes	Ref		
No	2.797	1.511 —5.178	0.001
Current CS			
Emergence	Ref		
Elective	2.367	1.293 —4.332	0.005
Informed Consent Provider			
Specialist	9.468	2.617 —34.258	0.001
GP	0.781	0.444 —1.373	0.391
Midwife	Ref		
Knowledge			
Inadequate	Ref		
Adequate	4.135	1.512 —11.312	0.006
PPC quality			
Good	4.461	1.474 —13.503	0.008
Not good	Ref		

PPC→ Patient-provider communication quality

CHAPTER FIVE

5.0 DISCUSION

5.1 Discussion

This study found that the proportion of women satisfied with shared decision regarding CS was 69.9%. Patient satisfaction in CS decision-making was higher among those with no prior CS, elective CS cases, and when managed by obstetrics-gynaecology specialists. Adequate patient knowledge and effective provider communication were also found as a key to higher satisfaction levels.

The satisfaction proportions observed in the study reflects participant approval of the shared decision-making process during Caesarean section deliveries. This result is encouraging as it suggests a majority of women felt involved in the decision-making process of their delivery method. The clinical context here emphasizes the importance of patient autonomy and involvement in healthcare decisions, which has been shown to improve patient satisfaction and outcomes (46). This finding aligns with other studies indicating that shared decision-making contributes to higher satisfaction rates in obstetric care (10). This underscores the necessity for healthcare systems to discern the multifaceted reasons behind the rise in CS rates, ensuring that each procedure is justified, aligning with the best interests of both mother and child, and is a collaborative decision with the patient.

Patients without a history of CS were more satisfied with shared decision-making compared to those with a history of CS. This could be interpreted as a novelty effect, where patients experiencing CS for the first time may feel more positive about being involved in the decision due to the lack of prior experience. This contrasts with findings (47,48), who reported no significant difference in satisfaction between first-time and repeat CS patients. The implication for clinical practice is that providers should be aware of the potential for differing satisfaction levels based on patient history and tailor their communication accordingly.

Elective CS was associated with higher satisfaction regarding shared decision-making than emergency CS. This could be due to the more planned and less stressful nature of elective CS, allowing for better patient-provider communication and decision-making. This is supported by others (49,50), which found that elective surgeries often result in higher patient

satisfaction due to the perceived control over the situation. Clinically, this suggests the need for improved communication strategies during emergency situations to enhance patient satisfaction.

Women who were given consent with specialist were associated with significantly higher odds of patient satisfaction compared to those given consent by midwives. This may reflect the specialist's higher level of training and expertise in managing CS deliveries, which can instil greater confidence and satisfaction in patients. This finding is consistent with literature suggesting that specialist care can lead to improved satisfaction in surgical outcomes (51). The implication is that while midwives play a crucial role in obstetric care, there may be a need for specialist involvement in certain cases to optimize patient satisfaction.

The strength of this study lies in its robust examination of patient satisfaction with the shared decision-making process in caesarean section delivery. By capturing a significant percentage of participant contentment, it highlights the positive correlation between patient involvement and satisfaction. Furthermore, the study's alignment with previous research reinforces the reliability of its findings, contributing valuable insights to the ongoing discourse on patient-centred care in obstetrics.

The study's cross-sectional design among postnatal women has a limited understanding of the temporal relationship between childbirth experiences and satisfaction outcomes. However, a researcher incorporated simple random sampling to enhance the representativeness of the study population. Also, the researcher applied a logistic regression analysis in establishing the association between satisfaction with shared decisions and factors associated with it.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The findings of this study suggest that patient involvement in the decision-making process is crucial for satisfaction, especially for those without prior CS experience and those undergoing elective procedures. The role of obstetrics-gynaecology specialists appears to be significant in patients' satisfaction, indicating that specialist care can positively impact the informed consent process. To address the rise in CS rates, it is essential to ensure that patients are genuinely involved in shared decision-making and that they are provided with comprehensive information to make informed choices. This approach could potentially mitigate the trend of increasing CS rates by empowering patients and enhancing their satisfaction with the care received.

6.2 Recommendations

Based on the result of this study, the following recommendations can be made to enhance patient satisfaction with shared decision-making during caesarean section delivery.

i. Implement comprehensive educational programs for expectant mothers on the risks and benefits of CS, ensuring they have adequate knowledge to participate in informed consent.
ii. Develop protocols that prioritize patient-provider communication, especially for those undergoing elective CS, to improve satisfaction with shared decision-making.
iii. Encourage the involvement of Obs-gyn specialists in the decision-making process, as their expertise is associated with higher patient satisfaction.
iv. For patients without a history of CS, create tailored decision-making support tools that reflect their higher satisfaction rates and address their specific needs and concerns.

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8.0 APPENDICES

8.1 Appendix I: Consent form English version

TITLE OF THE STUDY: SATISFACTION WITH SHARED DECISION-MAKING REGARDING C/SECTION AND ASSOCIATED FACTORS AMONG WOMEN ATTENDING ST JOSEPH HOSPITAL IN KILIMANJARO, TANZANIA.

Introduction: My name is Secilia August Kimaro, a post graduate student in the department of community health school of nursing.

Purpose of study: This study aims at assessing the women satisfaction with shared decision and associated factors among mothers who gave birth through C-section at St Joseph Hospital.

Participant's role: Upon signing of informed consent, your role is to respond to questions asked by principal investigator guided by questionnaire. The inclusion is by your own choice after having understood the purpose and all clarification of questions by principal investigator. However, you are at liberty to withdraw from the study at any point without consequences.

Risks and benefits: No risks involved when participating in the study. The results of this study may aid in choice of appropriate management in future.

Cost: No cost will be incurred by the participants.

Compensation: No compensation to participants.

Confidentiality: No name or identifying information of the participants will be captured currently or in future. All responses will be stored under lock and key by principal investigator.

Contacts: Any participant has a right to contact principal investigator (phone number: 0753326152), supervisor and director of research and publications before, during and after the research to ask any questions. I hereby request you sign the attached consent form.

Consent Declaration

I……, been above 18 years old and having been informed about the study I hereby voluntarily consent to participate in the study. The purpose of the study has been explained to me by principal investigator and all questions fully answered to my satisfaction. The benefits and risks of the study have been explained to me and am free to withdraw from the study at any point and will not hinder me from getting treatment at the hospital. I hereby give my consent to be interviewed and information from my file can be used also as having the purpose of this study.

Signature……Date……

Researcher's statement

I……. confirm that I have explained to the participant the purpose and the nature of the study.

Signature……

Date……

Tel: ……...

8.2 Kiambatanisho II: Fomu ya rithaa ya kiswahili

Kichwa cha utafiti: Kuridhika Kwa Mama Pamoja Na Sababu Zinazoambatana Nazo Kwa Kufanya Maamuzi Ya Pamoja Miongoni Mwa Wanawake Wajifungua kwa njia ya upasuaji liopitia Sehemu ya upasuaji Katika Hospitali Ya St Joseph Kilimanjaro, Tanzania.

Utangulizi: Mimi Secilia August Kimaro mwanafunzi katika Chuo kikuu cha Sayansi na Tiba Shirikishi Muhimbili. Nasoma shahada ya uzamili wa afya ya wanawake katika Uuguzi.: Utafiti huu unalenga kutathmini kuridhishwa kwa wanawake na uamuzi wa pamoja na mambo yanayohusiana miongoni mwa akina mama waliojifungua kwa upasuaji katika Hospitali ya St Joseph.

Jukumu la mshiriki: Baada ya kusainiwa kwa idhini ya ufahamu, jukumu lako ni kujibu maswali yaliyoulizwa na mpelelezi mkuu kwa kuongozwa na dodoso. Ujumuishaji ni kwa chaguo lako mwenyewe baada ya kuelewa madhumuni na ufafanuzi wote wa maswali na mpelelezi mkuu. Walakini, uko huru kujiondoa. kutoka kwa utafiti wakati wowote bila matokeo.

Hatari na faida: Hakuna hatari zinazohusika wakati wa kushiriki katika utafiti. Matokeo ya utafiti huu yanaweza kusaidia katika uchaguzi wa usimamizi unaofaa katika siku zijazo.

Gharama: Hakuna gharama itakayotozwa na washiriki.

Fidia: Hakuna fidia kwa washiriki.

Usiri: Hakuna jina au taarifa ya utambulisho ya washiriki itakayonaswa kwa sasa au siku zijazo. Majibu yote yatahifadhiwa kabati litakalofungwa kwa kufuli na ufunguo na mpelelezi mkuu.

Anwani: Mshiriki yeyote ana haki ya kuwasiliana na mpelelezi mkuu (namba: 07538326152), msimamizi na mkurugenzi wa utafiti na machapisho kabla, wakati na baada ya utafiti ili kuuliza maswali yoyote.

TAMKO LA RIDHAA

Mimi……, nimekuwa na umri wa zaidi ya miaka 18 na baada ya kuarifiwa kuhusu utafiti nakubali kwa hiari yangu kushiriki katika utafiti. Nimefafanuliwa na mchunguzi mkuu na maswali yote yamejibiwa kwa kuridhika kwangu.Faida na hatari za utafiti zimefafanuliwa na niko huru kujiondoa katika

utafiti wakati wowote na haitanizuia kupata. kwa matibabu hospitalini.Kwa hivyo ninatoa idhini yangu ya kuhojiwa na taarifa kutoka kwenye faili yangu inaweza kutumika pia kama yenye madhumuni ya utafiti huu.

Sahihi……

Kauli ya mtafiti

Mimi

……

……

…….

Sahihi…….

Tarehe……

Simu: ……

8.3 Appendix III: Questionnaire English version

Socio-demographic characteristics

1. Age_____
2. Place of residence_____
    a) Town
    b) Rural
3. Marital status_____
    a) Married
    b) Single
    c) Cohabiting
    d) Divorced
4. Educational Status_____
    a) Informal education
    b) Primary education
    c) Secondary education
    d) Diploma/certificate education
    e) College diploma
    f) Higher Education
5. Occupation_____
        a) Employed
        b) self employed
        c) Dependent

Obstetrics characteristics

6. Parity____
7. Started ANC follow-up at ___ week.
8. Do you have a history of previous caesarean? ___Yes/No
9. Type of current caesarean section___
    a) Emergency
    b) Medical
    c) Maternal request.

Service-related factors

10. Was the informed consent process conducted in easy language/Mather language?
    (a) Yes
    (b) No
11. Did you feel you had adequate information about a caesarean section?
    (a) Yes
    (b) No
12. Health care provider who provided informed consent
    (a) Ob-gyn specialist
    (b) General practitioner/resident
    (c) Midwives/Nurses
13. Did you feel that you had an adequate time to decide to have CS?
    (a) Yes
    (b) No

Patient satisfaction with operative Care

Instruction: You will read seven statements that a person can recall about his/her PCP. Please choose the appropriateness of each statement for your PCP by marking one number per statement. The meaning of the numbers is as follows:

1= completely dissatisfied, 2 = Dissatisfied, 3= Neutral, 4 = Satisfied, 5 = completely satisfied.

Question items	1	2	3	4	5
1. I am satisfied that I was adequately informed about the caesarean section important to my decision.					
2. The decision I made was the best decision possible for me personally					
3. I am satisfied that my decision was consistent with my values					
4. I expect to successfully carry out (or continue to carry out) the decision I made					
5. I am satisfied that this was my decision to make					
6. I am satisfied with my decision					

The patient-provider communication relationship questionnaire.

Description: You are presented with nine statements regarding your healthcare provider during the CS procedure. Please indicate which information you believe you should receive from your healthcare provider beforehand. Simply check the box that corresponds to your choice.

ITEM	Yes	No
1. My PCP (Primary Care Provider) helps me		
2. My PCP has enough time for me		
3. I trust my PCP		
4. My PCP understands me		
5. My PCP is dedicated to help me		
6. My PCP and I agree on the nature of my medical symptom		
7. I can talk to my PCP		
8. I feel content with my PCP's treatment		
9. I find my PCP easily accessible		

Knowledge questions

Description: You will read ten information that a person should have been given by the health care provider during the delivery operation. Please select yes if you were notified or no if you were not notified regarding your delivery operation:

ITEM	Ye(1)	No(2)
1. The information on indication of operation		
2. The alternative of operation		
3. The chance to express opinions		
4. The chance to ask questions		
5. The amount of information about operation		
6. The information was easy to understand		
7. The awareness on benefit of operation		
8. The awareness on risk of operation		
9. Involvement of in the discussion about operation		
10. Involvement in the decision making on operation		

8.4 Appendix IV: Dodoso

Tabia za kijamii na idadi ya watu

1. Umri_____

2. Mahali pa kuishi_____

    a) mji

    b) Vijijini

3. Hali ya ndoa_____

    a) Kuolewa

    b) Mmoja

    c) Kuishi pamoja

    d) Walioachika

4. Hali ya Elimu_____

    a) Elimu isiyo rasmi

    b) Elimu ya msingi

    c) Elimu ya sekondari

    d) Elimu ya Diploma/cheti

    e) Diploma ya chuo

    f) Elimu ya Juu

5. Kazi_____

Tabia za uzazi

6. Usawa____

7. Ulianza kuhudhuria clinic ya ujauzito mimba ikiwa na muda gani?___

8. Je, una historia ya upasuaji wa awali? ___Ndio/Hapana

9. Aina ya upasuaji wa sasa

    a) Dharura

    b) Matibabu

    c) Ombi la mjazito.

Mambo yanayohusiana na huduma

10. Je, idhini ilichukuliwa kwa lugha rahisi/lugha unayoielewa
    (a) Ndiyo
    (b) Hapana

11. Je, ulihisi ulikuwa na taarifa za kutosha kuhusu kujifungua kwa njia ya upasuaji?
    (a) Ndiyo
    (b) Hapana

12. Ithini ya hiyo iliyoombwa na
    (a) Mtaalamu wa Ob-gyn
    (b) Daktari mkuu/mkazi
    (c) Wakunga/Wauguzi

13. Je, ulihisi kuwa ulikuwa na muda wa kutosha wa kuamua kuwa na CS?
    (a) Ndiyo
    (b) Hapana

Maswali kuhusu kuridhika kwa mama anaejifungua kwa njia ya upasuaji kuhusishwa katika maamuzi au la.

Maelezo: Utasoma taarifa saba ambazo mtu anaweza kukumbuka kuhusu mtoa huduma wake wakati wakujifungua kwa njia ya operesheni. Tafadhali chagua namba ya chaguo linalokufaa kwa kila Taarifa hapo chini kuhusu mtoa huduma wako wakati wakujifungua kwa njia ya operesheni. Kila Taarifa inaendana na Nambari tano za machaguo zenye maana elezwa hapa chini.

1= sijaridhika kabisa, 2 = Sijaridhika, 3= Sina upande wowote, 4 = nimeridhika, 5 = nimeridhika kabisa.

SWALI	1	2	3	4	5
1. Nimeridhika kwamba nilifahamishwa vya kutosha kuhusu sehemu ya upasuaji muhimu wa maamuzi wangu.					
2. Uamuzi niliofanya ulikuwa uamuzi bora zaidi kwangu binafsi					
3. Nimeridhika kwamba uamuzi wangu ulilingana na maadili yangu					
4. Natarajia kutekeleza kwa ufanisi (au kuendelea kutekeleza) uamuzi niliofanya					
5. Nimeridhika kwamba huu ulikuwa uamuzi wangu wa kufanya					
6. Nimeridhika na uamuzi wangu					

Mtazamo wa mshiriki kuhusiana na mawasiliano ya mgonjwa na mtoaji huduma za afya.

Maelezo: Utasoma taarifa tisa ambazo mtu anaweza kutoa kuhusu mto huduma wa afya wake wakati wa operesheni ya kujifungua. Tafadhali chagua Taarifa unayofikiri inafaa kupokea kutoka kwa mtoa huduma wako wa afya kabla ya zoezi la operesheni ya kujifungu. Weka alama kwenye kisanduku inayaoendana na chaguo lako.

Swali	Ndio	Hapan
1. Muhudumu wangu hunisaidia		
2. Muhudumu wangu ana muda wa kunitosha		
3. Ninamwamini PCP wangu		
4. Muhudumu wangu ananielewa		
5. Muhudumu wangu amejitolea kunisaidia		
6. Muhudumu wangu na mimi tunakubaliana juu ya asili ya dalili yangu ya matibabu		
7. Ninaweza kuzungumza na PCP wangu		
8. Ninahisi kuridhika na matibabu ya Muhudumu wangu		
9. Ninampata Muhudumu wangu anapatikana kwa urahisi		

Maswali ya maarifa

Maelezo: Utasoma taarifa kumi ambazo mtu alipaswa kupewa na mto huduma wa afya wakati wa opereshini ya kujifungua. Tafadhali chagua ndio kama ulipewa Taarifa au la kama hukupewa Taarifa kuhusiana na opereshini yako ya kujifungua

Swali	Ndion(1)	Hapana(2)
1. Habari juu ya dalili ya operesheni		
2. Njia mbadala ya operesheni		
3. Nafasi ya kutoa maoni		
4. Nafasi ya kuuliza maswali		
5. Kiasi cha habari kuhusu operesheni		
6. Habari ilikuwa rahisi kuelewa		
7. Uelewa juu ya faida ya operesheni		
8. Uelewa juu ya hatari ya operesheni		
9. Kushiriki katika majadiliano juu ya uendeshaji		
10. Kushiriki katika kufanya maamuzi juu ya operesheni		

8.5 Appendix V: Ethical Clearances

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATIONS

Ref. No.DA.282/298/01.C/2202 Date: 29/04/2024

MUHAS-REC-04-2024-2202
SECILIA AUGUST KIMARO
SHOOL OF NURSING
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: WOMEN'S SATISFACTION WITH SHARED DECISION-MAKINGIN PROCESS OF CAESARIAN SECTIONS AND ASSOCIATED FACTORS AMONG WOMEN ATTENDING ST JOSEPHHOSPITAL IN KILIMANJARO, TANZANIA.

Reference is made to the above heading,

I am pleased to inform you that the Chairperson has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 29/04/2024
EXPIRATION DATE OF APPROVAL: 29/04/2025

STUDY DESCRIPTION:
Purpose:
The purpose of this observational cross sectional study is to assess women's satisfaction with shared decision-making process regarding c/section and associated factors among women attending St Joseph hospital in Kilimanjaro, Tanzania

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided: https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2015453.pdf and in the MUHAS archives.

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain Data Transfer Agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain Material Transfer Agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country.
8. Apply for and obtain permission to publish the results from National Institute for Medical Research. The application should be before submitting to a publisher and not concurrently through the email publications@nimr.or.tz.
9. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No. 23 of 1979, PART III section 10 (2)
10. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
11. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://drp.muhas.ac.tz/.

Muhimbili University of Health and Allied Sciences
DIRECTOR
Research, Publications & Innovations
Box 65001

Dr. Nahya Salim Masoud,
Chairperson, MUHAS Research and Ethics Committee

8.6 Appendix VI: Introduction Letter

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.431/2022/2024

07TH May, 2024

Medical Officer Incharge
St Joseph Hospital (COH)
P.O.Box 330
MOSHI.

Re: INTRODUCTION LETTER OF SECILIA AUGUST KIMARO

The bearer of this letter is Secilia August Kimaro (HD/MUH/T.431/2022/2024), a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing MSc. Midwifery and Womens Health.

As part of her studies she intends to do a study titled: **"Women's Satisfactions With Shared Decision-Making in Process Of Caesarian Sections And Associated Factors Among Women Attending St Joseph Hospital In Kilimanjaro, Tanzania.**The research has been approved by the Chairman of University Senate.

Kindly provide her the necessary assistance to facilitate the conduct of her research.

We thank you for your cooperation.

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c. Secilia August Kimaro

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam: Tel. G/Line: +255-22-2150302/6; Ext. 1015; Direct Line:+255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz;Web:https://www.muhas.ac.tz

8.7 Appendix VI: Introduction letter

8.8 Appendix VII: Permission Letter



CONGREGATION OF THE SISTERS OF OUR LADY OF KILIMANJARO

ST JOSEPH COUNCIL DESIGNATED HOSPITAL

P.O Box 330 Soweto - Moshi Tel +255 (27) 2753843, +155762367977

Email: info@stjosephhospitalmoshi or tz

"HUDUMA BORA KWA AFYA BORA

Ref:stj/pm/001

DIRECTOR OF POST GRADUATE STUDIES
MUHIMBILI UNIVERSITY OF HEALTHY AND ALLIED SCIENCE
P.O. Box 65001
Dar Es Salaam
7th May 2024

RE: INTRODUCTION LETTER FOR SECILIA AUGUST KIMARO

The above name subject has been granted permission to conduct data collection for her stu... titled **"Women Satisfactions With shared Decision Making in Process of Caesarean Sections and Associated Factors Among Attending St Joseph Hospital in Kilimanjaro, Tanzania"**.
We wish her all the best in her studies.

Sincerely Yours

DIOCESE OF MOSHI
SRS. OF OUR LADY OF KK
ST. JOSEPH HOSPITAL
Box 330 - MOSHI

Philipo G. Moshi, Md, Mmed
Deputy Medical Officer Incharge