MOMENTUM
Safe Surgery in Family Planning and Obstetrics

Research Brief

INFORMED CONSENT FOR CESAREAN SECTION IN SUB-SAHARAN AFRICA

A Scoping Review Brief

BACKGROUND

Safe, appropriate cesarean section (CS) is an important part of essential obstetric care. CS is one of the most commonly performed procedures in the world. Informed consent is a necessary and important precondition for any surgical procedure, CS included. While informed consent should fulfill certain criteria (see text box), it can be challenging to fulfill all these criteria, especially in obstetric emergency situations.

The Respectful Maternity Care Charter notes that "everyone has the right to information, informed consent, and respect for their choices and preferences—including companion of choice during maternity care and refusal of medical procedures."[1] However, poor patient communication and lack of informed consent for obstetric surgical procedures, including CS, are pervasive in low- and middle- income countries, including in those Sub-Saharan Africa (SSA).[1] There is a need to better understand informed consent practices, including the barriers and facilitators to informed consent in the context of CS, in order to ultimately ensure that care during childbirth is delivered in a respectful manner. While emergency situations add complexity, informed consent, along with counseling and debriefing, need to be supported and strengthened across labor and delivery care.

Informed Consent Criteria

- **Preconditions:** Competence to understand and decide; voluntariness in deciding[3]
- **Information:** Disclosure of material information, recommendation of a plan, and patient understanding of both[3]
- **Consent:** Decision in favor of a plan and authorization[3]

Together, **counseling, informed consent, and debriefing (CCD)**, ideally with the patient as well as their partner and family, if appropriate, comprise crucial aspects of respectful maternity care, including during surgical obstetric procedures.

OBJECTIVES

The original scoping review conducted by the London School of Hygiene and Tropical Medicine (LSHTM), on which this brief is based, sought to better understand the existing range of literature on informed consent practices for CS in low- and middle- income countries. The scoping review mapped and synthesized evidence from existing literature on the practices and experiences of counseling, informed consent, and debriefing (CCD)—including barriers, facilitators, and interventions to promote these practices—to highlight key

challenges and any previously successful programmatic interventions to address them. The review also identified research gaps and provides recommendations for future research.

METHODS

The PICO (population, interest, and context) framework for qualitative studies aims to develop research questions (based on the above objectives) and a search strategy.[2] For the scoping review, the population included pregnant women, postpartum women, spouses and family members, and healthcare providers; interest included informed consent, counseling, and debriefing for CS; and context comprised countries at all income levels in SSA. The scoping review relied on the Beauchamp and Childress framework to analyze barriers and facilitators on the main domains of informed consent (preconditions, information, and consent – table 1).[3]

The review used three databases (Embase, PsycINFO, and PubMed), with an initial focus on studies from three geographical regions (Latin America and the Caribbean, Southeast Asia, and SSA) before narrowing the scope to SSA. Final inclusion criteria included intervention, cross-sectional, cohort, and qualitative studies as well as clinical audit reports and published guidelines appraised to be of high- or medium-quality based on the Mixed Method Appraisal Tool (MMAT),[*] published in English (including translations) between 2011 and 2021. Areas of interest reflected those defined above for the PICO framework as well as respectful care literature, including formal counselling and consent inquiry for CS. This review excluded all other reports, such as literature reviews, commentaries, letters, opinion pieces with no primary or secondary data, and studies on consent for research covering other areas of interest (e.g., other obstetric surgeries, consent for research, respectful care literature not referencing consent for surgery, and antenatal counseling and discussions of CS), published prior to 2011, not available in English, and assessed as low-quality per the MMAT criteria.

RESULTS

The initial search yielded 4,609 titles; 3,829 records remained after removal of duplicates. Following title and abstract screening, LSHTM excluded 3,590 additional titles. Of the 239 titles retained, LSHTM eliminated 220 studies after reading the full text, leaving 19 studies. Researchers identified three additional studies from reference lists or prior knowledge. In total, LSHTM appraised 22 studies using the MMAT and further excluded one low-quality study, yielding 21 peer-reviewed studies covering 10 countries in SSA: Nigeria (N=8), Ethiopia (N=2), Ghana (N=2), Malawi (N=2), South Africa (N=2), Benin (N=1), Burkina Faso (N=1), Sierra Leone (N=1), Somalia (N=1), and Tanzania (N=1). Several key themes emerged from the literature, including practices and experiences of informed consent in SSA, barriers, and facilitators.

PRACTICES AND EXPERIENCES

[*] LSHTM used the MMAT tool to assess the quality of the qualitative, quantitative, and mixed-methods studies following a full-text screening and reference list search. Generally, one would report on the quality of the studies narratively. However, for the purpose of the scoping review, LSHTM used five questions for each study before assigning an overall numerical score, with scores of four and five indicating high-quality, scores of two and three indicating medium-quality, and scores of zero and one indicating low-quality.

Practices and experiences encompassed explanation of the procedure,[4,5] indication for CS,[4–8] counseling on risks inherent in the procedure,[4,9] counseling on anesthesia and on postoperative care,[6,8–11] explanation of alternative treatment options,[11] women's understanding of the information disclosed,[6,12] health providers answering questions and responding to concerns,[6,7] non-consented CS,[8,13] and emergency CS.[14] Multiple studies revealed gaps in the provision of information on *indication for CS*.[4-8] One cross-sectional study from Nigeria reported only 41.6% of women were satisfied with the information provided to them about the CS indication.[6] Studies characterizing the *disclosure of risks* were limited. One study in Nigeria observed that the majority of women reported being counseled post-CS on the risk of blood transfusion (86.0%) and hemorrhage (88.7%), while few received counseling on the risk of infection (27.3%), bladder or intestinal injury (17.3%), death (16.0%), repeat CS (14.0%), hysterectomy (11.3%), laceration to the baby (6.0%), or tubal ligation (4.0%).[9]

Counseling on anesthesia[6,15] *and postoperative care* was often insufficient and/or vague.[8-10] For example, one woman interviewed in Burkina Faso interpreted her provider's advice not to soak her wound in water post-CS as not being permitted to bathe.[8-10] Two studies in Nigeria described *women's self-reported understanding of information disclosed during counseling*: 82.9% of women interviewed in the first study during the postoperative period felt that they understood counseling on CS,[12] while only 41.4% of women interviewed during the postoperative period for the second study felt that the process helped them understand CS risks.[5]

There is variability in *terms of providers answering questions and addressing concerns.*[6,7] Most women in one Nigerian study (78%) reported feeling that doctors listened to their concerns, compared to 40% of women reporting that nurses listened.[6] In contrast, women described how doctors and nurses comforted them and addressed their concerns before the procedure in a study in Sierra Leone. This study reported that providers reassured patients that nothing would happen, showed them other patients that survived the surgery, or encouraged spiritual coping. Some reported that staff spoke to them during the operation to maintain contact and repeated their names, or tried to focus their attentions on their newborns as a distraction.[10] In Ghana, those who underwent *emergency CS* expressed dissatisfaction with the information they received during the informed consent process compared to those undergoing elective CS.[14]

BARRIERS AND FACILITATORS

In *Principles of Biomedical Ethics*,[3] Beauchamp and Childress propose seven basic elements of the informed consent process, divided into three domains: preconditions, information, and consent. The LSHTM scoping review used these elements of informed consent (**Table 1**) as a framework for analysis and to inform discussions of barriers and facilitators to informed consent in each study.

TABLE 1. ELEMENTS OF INFORMED CONSENT

Preconditions	Information	Consent
1. Competence to understand and decide 2. Voluntariness in deciding	3. Disclosure of material information 4. Recommendation of a plan 5. Understanding 3 and 4	6. Decision in favor of a plan 7. Authorization of a plan

BARRIERS

The reported barriers to counseling and informed consent for CS identified within the studies appeared at various levels, these included: individual-level barriers,[4,10,13,16–20] provider-level barriers,[7,15–18,20] service-level barriers,[9,13,16] and societal barriers.[5,17,18,21]

At the level of the individual, *low level of education* was a recurring theme related to informed consent in SSA, with providers perceiving women with lower levels of education as lacking the ability to engage in the informed consent process.[16] Women with low levels of education may *exhibit less decision-making autonomy* compared to more educated counterparts, and rely on family members to engage in the process and to make decisions for them;[18] this may be exacerbated by paternalism, cultural, and gender norms.[19] The *inability to read in certain languages* is also associated with components of informed consent not being completed.[4] *Labor pains* are yet another barrier at the individual-level, straining communication between an individual and their provider, detrimentally impacting the capacity for decision-making in that moment, with providers interpreting cries as implied consent for emergency CS.[16] In some settings, individual *distrust of providers* also served as a barrier.

Barriers at the provider level include *paternalism,* where doctors feel justified to make decisions on behalf of women, particularly those with lower levels of educational attainment;[17] *fear of blame and litigation,* given the risks involved in obstetrics,[16–18] (this includes partial disclosure or downplaying of risks to minimize anxiety and prevent refusal of CS);[16] and *providers' own poor or insufficient training on medical ethics and informed consent*.[7,15] [15]

At the service delivery level, reported barriers included *time constraints*, particularly where health providers forwent informed consent in cases of obstetric emergencies.[13,16] *Consent forms* that fail to accommodate patients who speak different languages represented another barrier at the service level.[9,16]

At the societal level, *cultural and gender norms* may limit women's participation in the informed consent process by requiring consent from extended family members before providers can perform emergency CS.[18] Other societal barriers include cultural reverence for vaginal delivery and pressure toward refusing CS,[17] as well as preferences that spouses sign the consent form and make the decision due to their status as head of household.[21]

FACILITATORS

The scoping review also identified provider-level facilitators of informed consent in the reviewed resources. Literature highlighted *shared decision-making,*[10,20] *verbal explanations* (in a language that women understand),[16] *and good health provider knowledge of informed consent*[15,16] as facilitating (good) informed consent practices.[20] Postnatal *debriefing* also presents an opportunity for a woman to obtain more information on events that occurred, complications, postoperative care, and future pregnancy implications, as well as to ask questions to assist in understanding why a provider performed a CS.[22] This is particularly helpful in cases of emergency CS where there are limited opportunities for counseling.[23] In terms of language barriers, some providers attempted to address these by using simple language and by asking women to paraphrase information provided to verify understanding.[16]

The review also included studies outlining specific interventions that helped facilitate informed consent. These were either implemented by the provider or at the service delivery level.[4,26-28] These interventions include standardized checklists, wall posters on informed consent guidelines, provider communication training, post-training supportive supervision, and simulation training to improve the provision of respectful maternity care.[4,26-28]

DISCUSSION

The barriers and facilitators of informed consent for CS span the three domains of informed consent, as developed by Beauchamp and Childress (**Figure 1**).[3]

FIGURE 1. BARRIERS AND FACILITATORS TO INFORMED CONSENT

<table>
<tr><th colspan="3">Barriers</th></tr>
<tr><th>Preconditions</th><th>Information</th><th>Consent</th></tr>
<tr><td></td><td>Poor consent forms
Language barriers
Provider fear of blame and litigation</td><td>Distrust of providers</td></tr>
<tr><td colspan="2">Labor pains</td><td></td></tr>
<tr><td></td><td colspan="2">Time constraints; women’s dependency on others</td></tr>
<tr><td colspan="3">Women’s low level of education; paternalism; cultural and gender norms; poor provider knowledge of informed consent</td></tr>
<tr><th colspan="3">Facilitators</th></tr>
<tr><th>Preconditions</th><th>Information</th><th>Consent</th></tr>
<tr><td></td><td>Debriefing
Shared decision-making
Verbal explanations
Standardized consent forms</td><td></td></tr>
<tr><td colspan="3">Good provider knowledge of informed consent; training; wall posters; supportive supervision of providers</td></tr>
</table>

Each column represents an element of informed consent, as defined by Beauchamp and Childress. The teal color represents barriers and facilitators that span across multiple columns (e.g., preconditions and information).

STRENGTHS, LIMITATIONS, AND RECOMMENDATIONS

LSHTM employed a rigorous search strategy across multiple databases. Limitations of the search included absence of grey literature, as the databases searched did not include an exhaustive list; limiting the search to papers in English; and only one person conducting the process of extracting and interpreting the data. Despite initially identifying numerous articles (N=4,609), the screening and quality appraisal processes ultimately yielded only 21 peer-reviewed studies, indicating that further research on CCD for CS in SSA is needed, and that such research should cover more countries in the region. Within CCD, more research is specifically needed on debriefing, as only one study mentioned debriefing after CS,[20] a significant gap in the literature. More research is similarly needed on interventions to strengthen informed consent, especially at the level of the individual and in cases of obstetric emergency where clinical decisions need to be made quickly, posing challenges to obtaining consent. Despite the influence of spouses and families in the informed consent process for CS, none of articles focused on these groups. Moreover, more research is needed on the experiences of informed consent for CS among marginalized groups, such as those living with HIV and, we would add, adolescents.

The review identified selected recommendations for strengthening counseling and informed consent processes for CS. First, the development, promotion, and use of high-quality standardized materials (such as consent forms for CS and wall posters, including those in local languages) as well as supportive supervision is needed.[4,24–26] Second, medical, nursing, and midwifery school curricula, as well as postgraduate training and in-service training should better incorporate ethics content.[15] Third, antenatal care should include counseling on CS to address women’s sociocultural aversion to CS in some settings; this could potentially help mitigate the impact of time constraints in the event of an emergency CS.[27] Finally, awareness raising of CS in the wider community is needed to build trust in the procedure as a life-saving intervention.[21]

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Acknowledgements

This brief was written by Farhad Khan and Sara Malakoff, using source material from the scoping review, *Informed Consent, Counselling and Debriefing for Caesarean Section in Sub-Saharan Africa: A Scoping Review,* authored by Sumeya Faysal. This brief was edited by Amy Agarwal. We thank Sumeya Faysal, Loveday Penn-Kekana, Renae Stafford, Karen Levin, Vandana Tripathi, and Veronique Filippi for their review. In addition, we thank Robyn Churchill and Rebecca Levine at the United States Agency for International Development for their review. The full report from which this brief was adapted is available upon request to MOMENTUM Safe Surgery in Family Planning and Obstetrics.

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Suggested Citation

USAID MOMENTUM. 2022. *Informed Consent for Caesarean Section in Sub-Saharan Africa: A Scoping Review Brief*. Edited by A. Agarwal. Washington, DC: USAID MOMENTUM Safe Surgery in Family Planning and Obstetrics.

MOMENTUM Safe Surgery in Family Planning and Obstetrics is funded by the U.S. Agency for International Development (USAID) as part of the MOMENTUM suite of awards and implemented by EngenderHealth with partners IntraHealth International, the London School of Hygiene and Tropical Medicine, and Johns Hopkins Center for Communications Programs under USAID cooperative agreement #7200AA20CA00011. For more about MOMENTUM, visit www.usaidmomentum.org. The contents of this report are the sole responsibility of EngenderHealth and do not necessarily reflect the views of USAID or the United States Government.