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REVIEW ARTICLE

Obstetrics

Counseling, informed consent, and debriefing for cesarean section in sub-Saharan Africa: A scoping review

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Abstract

Background: Counseling as part of the informed consent process is a prerequisite for cesarean section (CS). Postnatal debriefing allows women to explore their CS with their healthcare providers (HCPs).

Objectives: To describe the practices and experiences of counseling and debriefing, the barriers and facilitators to informed consent for CS; and to document the effectiveness of the interventions used to improve informed consent found in the peer-reviewed literature.

Search Strategy: The databases searched were PubMed, EMBASE, PsycINFO, Africa-wide information, African Index Medicus, IMSEAR and LILACS.

Selection Criteria: English-language papers focusing on consent for CS, published between 2011 and 2022, and assessed to be of medium to high quality were included.

Data Collection and Analysis: A narrative synthesis was conducted using Beauchamp and Childress's elements of informed consent as a framework.

Main Results: Among the 21 included studies reporting on consent for CS, 12 papers reported on counseling for CS, while only one reported on debriefing. Barriers were identified at the service, woman, provider, and societal levels. Facilitators all operated at the provider level and interventions operated at the service or provider levels.

Conclusions: There is a paucity of research on informed consent, counseling, and debriefing for CS in sub-Saharan Africa.

KEYWORDS

Africa, cesarean section, communication, counselling, debriefing, informed consent, obstetric surgical procedures

1 | INTRODUCTION

Cesarean section (CS) is the most performed surgical procedure in sub-Saharan Africa.[1] The last few decades have seen a significant rise in the use of CS at a global level, with rapid increases in low- and middle-income countries (LMICs).[2] Sub-Saharan Africa is the region with the lowest CS rate, estimated at 5.0% of all live births in 2018, and rising slowly compared with other regions.[2] Despite this, there is

consistent evidence to support socioeconomic disparities in CS use within countries in the region, with wealthier, urban-dwelling, educated women more likely to receive CS than poorer, rural women with a low level of education.[3] Therefore, it is evident that there is a need to ensure universal access to safe and indicated CS in this region.

Informed consent should be an prerequisite for surgical procedures, including CS.[4,5] Consent represents the practical implementation of respect for autonomy, one of four pillars in the seminal *Principles of Biomedical Ethics* by Beauchamp and Childress.[5] The informed consent process is described with seven elements divided into three domains: preconditions, information, and consent (Table 1).[5]

Cesarean section is classified by urgency into either "planned" procedures performed before labor onset or "emergency", unplanned procedures performed after labor onset.[6,7] The majority of cesareans performed in sub-Saharan Africa were indicated in emergency situations.[8] There are specific challenges to obtaining consent in cases of emergency CS where the required urgency of clinical decisions may leave limited time for counseling.[9] Postnatal debriefing by healthcare providers (HCPs) is important so women can understand the events and details of their CS, with time to ask clarifying questions.[10] The explanation of obstetric procedures is associated with improved satisfaction with the birth experience; and explanation and postnatal debriefing are associated with improved psychological outcomes in postpartum women.[10,11]

Best practices for counseling and informed consent have common themes in guidelines published by government bodies, including the ministries of health in Kenya and South Africa as well as professional organizations, such as the International Federation of Obstetrics and Gynecology (FIGO) (Figure 1).[4,6,12,13] Reflecting the preconditions for informed consent set out in Table 1, FIGO states that, for consent to be valid, the patient should display voluntariness and be involved in the decision-making process to the fullest extent permitted by their capacity.[13] As part of the counseling process, women should be provided with information (Table 1) on what the procedure involves (including purpose, expected duration, and method), indication for CS, benefits and risks to herself and the baby, any treatment alternatives (including associated benefits and risks), potential intraoperative procedures, anesthesia, and postoperative recovery.[4,6,12,13]

Ineffective client–provider communication and even lack of consent for obstetric surgical procedures, including CS, have been identified as issues worldwide.[14] Effective communication and respect and dignity make up two of the eight domains of the Quality of Care Framework

TABLE 1 Beauchamp and Childress's elements of informed consent.[5]

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

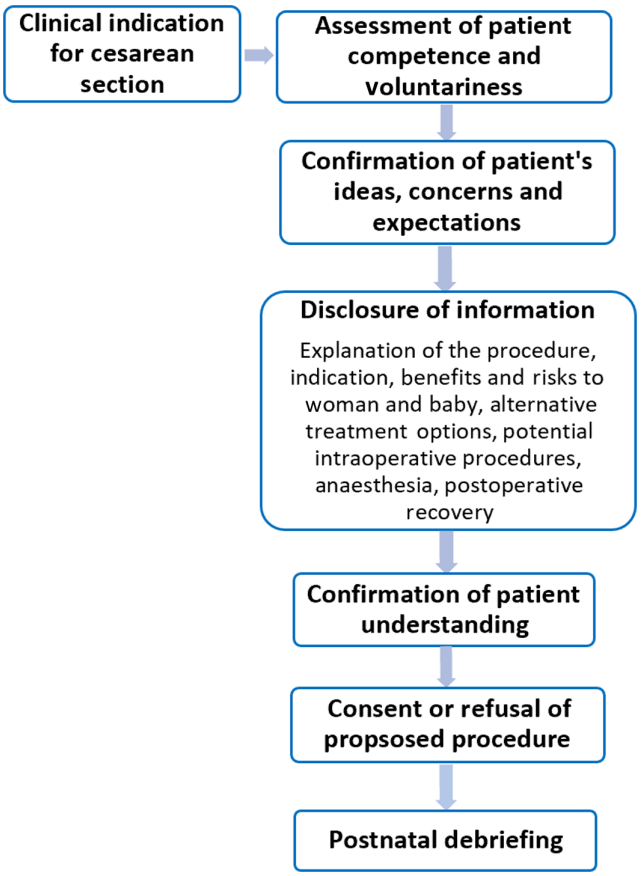

FIGURE 1 Model informed consent process for cesarean section.[4,6,12,13]

for maternal and newborn health proposed by WHO.[15] To improve respectful maternity care for women undergoing CS in sub-Saharan Africa, there is a need to better understand informed consent processes, practices, and experiences, as well as the barriers and facilitators to optimal informed consent. Currently, there are no literature reviews on this topic following a comprehensive search of the literature.

We conducted this scoping review with the aim of mapping the existing literature on counseling, informed consent, and debriefing for CS in sub-Saharan Africa and the barriers and facilitators to these processes. The specific objectives of this scoping review are: to describe the findings on the practices and experiences of counseling for CS and post-cesarean debriefing, and barriers and facilitators to informed consent practices; and to document the effectiveness of the interventions used to improve informed consent for CS. We conducted a scoping review as the range of existing literature on counseling, informed consent, and debriefing for CS in sub-Saharan Africa was unclear. The initial scope of this review included LMICs in Latin America, Asia, and Africa. The three regions have very distinct obstetrics and health system contexts with respect to the relative proportions of cesarean sections that are planned versus emergency; and the role of the private sector in the provision of maternity care. Therefore, the analysis was subsequently designed to be conducted separately for each region. In this paper, we are focusing on the results for the African context.

2 | MATERIALS AND METHODS

This scoping review is based on an externally reviewed protocol. The framework for scoping reviews created by Arksey and O'Malley and the recommendations by Levac et al. on the appropriate use of this framework were used to guide this scoping review.[16,17] The review follows Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) extension for scoping reviews checklist.[18]

2.1 | PICo framework

As several qualitative or mixed method papers were anticipated, the PICo (population, interest, and context) framework for qualitative studies was used to develop a search strategy.[19]

The population (P) were pregnant and postpartum women, women's husbands and family members, and HCPs. Three key areas of interest (I) were counseling, informed consent and debriefing for CS, and the context (Co) we focused on was sub-Saharan Africa.

2.2 | Literature search

Seven bibliographic databases were searched: three covering all regions (PubMed, EMBASE, and PsycINFO) and four regional databases covering the geographical regions of interest to the authors (Africa-Wide Information, African -Index Medicus, LILACS, IMSEAR).

Three broad areas were identified for the search strategy:

1. obstetric surgery;
2. counseling, informed consent and debriefing;
3. geographical location (not necessary for the regional databases).

Medical subject heading (MeSH) terms in PubMed, EMBASE, and Global Index Medicus, and the thesaurus feature in PsycINFO and Africa-Wide Information were used to generate search terms appropriate for each database. Search terms were combined using Boolean operators "OR" and "AND". Quotation marks ("") and truncation (*) were used where relevant. In addition, the reference lists of all included studies were hand-searched to identify relevant studies.

We initially searched six databases in June 2021. An updated database search in July 2022 additionally included African Index Medicus.

2.3 | Selection criteria

English language papers focusing on consent for obstetric surgery published between 2011 and 2022 assessed to be of medium to high quality were included. Literature reviews, commentaries, letters, and opinion pieces with no primary or secondary data were excluded. Studies focusing on consent for research and papers focusing on informal antenatal discussions around CS were excluded.

2.4 | Screening process

We used the systematic review software EPPI Reviewer (version 4.12.2.0) for de-duplication and the two-stage screening process (first titles and abstracts, and second full-text articles) to determine if the articles met the study objectives. Three reviewers were involved in the initial standardization of the papers of interest to this review by triple screening 250 papers with discussion and consensus to reconcile disagreements.

2.5 | Data extraction

Data extracted from studies meeting the inclusion criteria after screening on full text were compiled using a Microsoft Excel spreadsheet.

2.6 | Quality appraisal

The Mixed Method Appraisal Tool (MMAT) was used to assess the risk of bias and quality of the included studies, which consists of five questions for each type of study.[20] The response to each question is either a "yes" or "no", with "yes" scoring 1 and "no" scoring 0. The grading criteria have been summarized in Table 2.

2.7 | Data analysis

A narrative synthesis of the key themes in the literature on counseling, informed consent, and debriefing for CS in sub-Saharan Africa was conducted. Beauchamp and Childress's elements of informed consent were used as a framework to consider the impact of barriers and facilitators identified in this review on the three key domains of informed consent: preconditions, information, and consent.

3 | RESULTS

3.1 | Study selection

We identified 21 studies covering 10 sub-Saharan African countries. The initial 2021 search returned 3829 titles after removing duplicates. The updated 2022 search returned no additional relevant papers. The PRISMA flow chart (Figure 2) summarizes the study selection process.[21] After exclusion of 1 low-quality paper,

TABLE 2 Mixed Method Appraisal Tool (MMAT) scoring criteria.[20]

MMAT score	Quality of study
4–5	High
2–3	Medium
0–1	Low

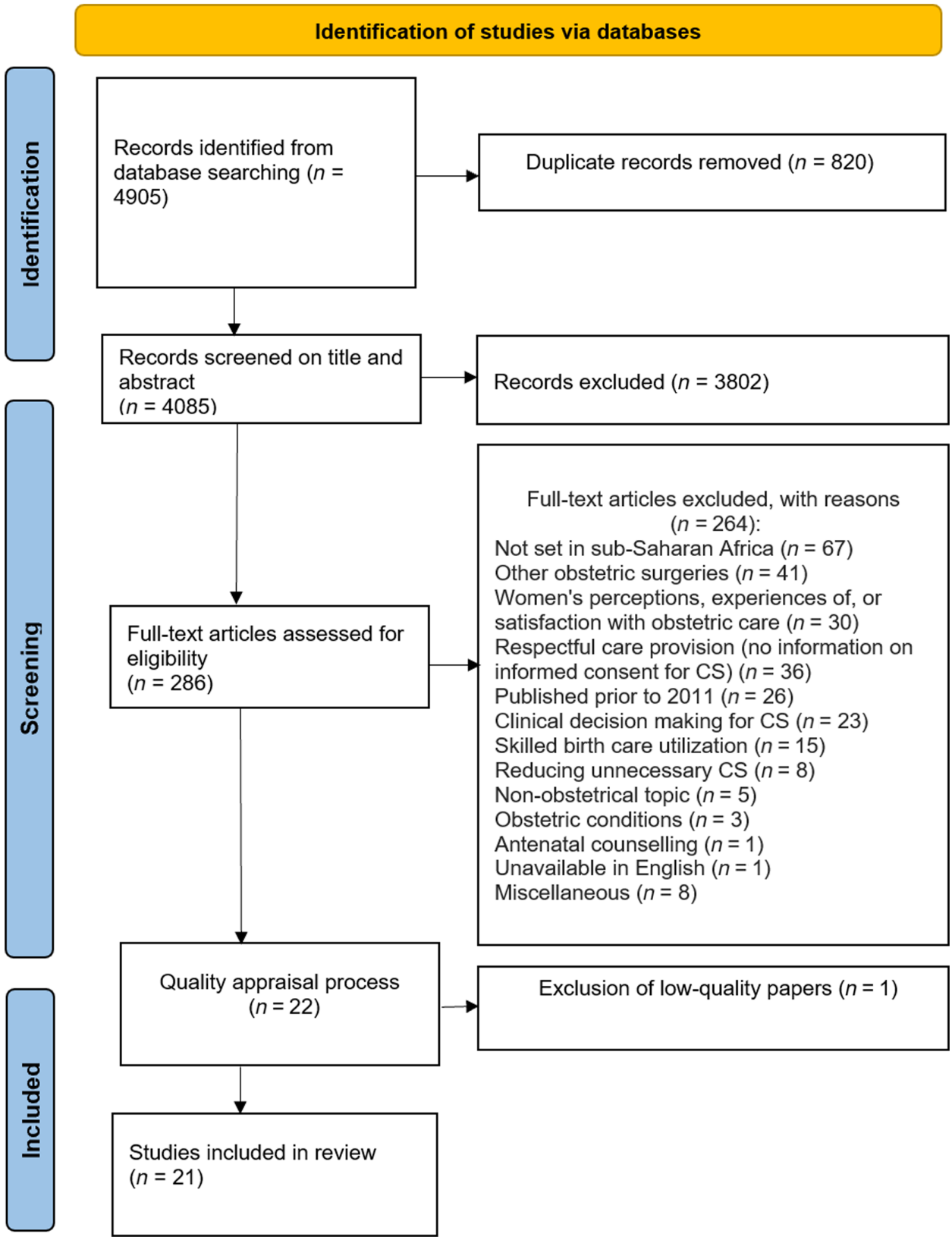

FIGURE 2 PRISMA flow chart summarizing study selection process.

the remaining papers consisted of 2 medium and 19 high-quality papers.

3.2 | Study characteristics

The study characteristics of the included studies have been summarized in Table 3. Data were collected on the authors, date of publication, country, hospital context, type of CS, study design, study population and sample size, and data collection methods.

3.3 | Practices and experiences of counseling and debriefing

The practices and experiences of counseling and debriefing for CS covered in this review are explanations of the procedure, indication, risks, anesthesia, postoperative care, alternative treatments, patient understanding, HCPs answering questions and addressing concerns, non-consented CS, emergency CS, and debriefing. The findings are summarized in Table 4.

3.4 | Barriers to informed consent

Woman-level

Low level of education

A study set in Somalia reported women from rural low-income families with no formal education were more likely to rely on their families to engage in the informed consent process on their behalf compared with educated women.[22] A southern Nigerian study found women without a tertiary education were more likely to hold the belief that men, as heads of families, should make the decision to have a CS on their behalf compared with women with a tertiary education.[23] Malawian and Tanzanian studies found women with low levels of education were uninformed about their rights and, therefore, expected HCPs make decisions on their behalf with little counseling.[24,25]

Labor pain

Labor pain acts as a communication barrier to the counseling process for CS, particularly in cases that necessitate emergency CS because of the negative impact on women's decision-making capacity.[24]

Language barrier

In a rural hospital in Malawi, the majority of HCPs spoke Chichewa, while many of the women belonged to the Yao ethnic group and only spoke Chiyao.[24] In Benin, language differences between HCPs and women made counseling difficult.[26]

Distrust in health care providers

Women delivering in a private facility in South Africa perceived their HCPs as motivated by ease of performing CS and money.[27] A study set in Somalia found the cultural and religious emphasis on the ability of women to bear children meant the community did not trust the indication surgeons gave for CS because of the association of the procedure with hysterectomy, stillbirth, and death.[22]

Young age

A Malawian study found that younger age of the woman was associated with being counseled using fewer components of the informed consent process.[28]

Provider level

Paternalism

In a private facility in South Africa, women felt that they were marginalized in the decision-making process and pressured into accepting CS.[27] A Tanzanian study found doctors felt justified in making decisions on behalf of women with a low level of education.[25]

Fear of blame and litigation

HCPs perceived obstetrics as a specialty at high risk of blame and litigation.[24,25] Therefore, HCPs placed significant emphasis on obtaining written consent to protect themselves in the event that complications arose because it symbolized the transfer of liability from themselves to the women.[24,25] This led to the partial disclosure or downplaying of risks to prevent refusal of the proposed CS.[24] In Somalia, the law dictates that HCPs must obtain consent from the family instead of the woman, and to perform CS without this would put them at risk of litigation or even violence.[22]

Poor knowledge on informed consent

All residents in obstetrics and gynecology taking part in a Nigerian study failed to identify five key components of the informed consent process as identified by the author: capacity, voluntariness, disclosure of information, comprehension of disclosed information, and documentation of the informed consent process and its outcome.[29] Large proportions of residents failed to identify anesthesia and its associated risks (21.5%), benefits of surgery (55.6%), alternative treatment (56.3%), and diagnosis (59.3%) as information that should be disclosed to the patient.[29] Only 37.0% of residents correctly identified that a 17-year-old married girl can consent to her own CS according to Nigerian law.[29] This poor knowledge is reflected by the fact that only 42% of residents ever received a bioethics lecture.[29]

There is evidence to suggest that HCPs are inadequately prepared to counsel women with a low level of education. In Tanzania, HCPs are willing to counsel women, but encounter challenges because of women's low level of education.[25] In Malawi, HCPs perceived these women as lacking the ability to fully engage in the informed consent process.[24] In the same country setting, women's inability to read English or Chichewa was associated with a greater number of components of the informed consent process for CS not being completed.[28]

TABLE 3 Key characteristics of included studies.

Author (date of publication)	Objective(s)	Country	Hospital context	Type of cesarean section	Study design	Study population and sample size	Data collection methods
Afaya et al. (2020)	To explore post-cesarean women's experiences of midwifery care in a public hospital	Ghana	Private, non-profit, Catholic general hospital in Eikwe that serves as a referral center for the Ellembele district	Planned and emergency	Qualitative	*n* = 22 postoperative women	Semi-structured interviews Focus groups
Bakker et al. (2021)	To explore the beliefs and experiences of HCPs on informed consent for CS in Malawi	Malawi	Rural referral mission hospital in southern Malawi providing free-of-charge maternity care	Planned and emergency	Qualitative	*n* = 22 HCPs (clinical officers, nurse-midwives, midwifery students)	Clinical observations Semi-structured interviews Focus group discussion
Hastings-Tolsma et al. (2018)	To explore the experiences of women who delivered via either vaginal birth or CS	South Africa	Both public and private hospitals	Not specified	Qualitative	*n* = 12 postpartum women (three had a CS)	In-depth interviews Field notes
Husby et al. (2019)	To explore the experiences of women who have undergone CS in Sierra Leone	Sierra Leone	Private, non-profit hospital (two women), public district hospital (seven women), public national referral hospital (seven women)	Planned and emergency	Qualitative	*n* = 16 postoperative women	Semi-structured Interviews
Lange et al. (2016)	To conduct an ethnographic study of childbirth in hospitals following the introduction of Benin's CS polic	Benin	Five publicly funded hospitals	Planned and emergency	Qualitative	*n* = 62 postpartum women. Unspecified number of healthcare providers and family	Semi-structured interviews (postpartum women) Participatory observation (HCPs and family)
Litorp et al. (2015)	To explore the perceptions, experiences, and attitudes of CS among women and HCPs	Tanzania	Large, tertiary, referral hospital in Dar es Salaam. Hospital accepts both public and private insurance	Planned and emergency	Qualitative	*n* = 13 postoperative women *n* = 16 HCPs (consultants, specialists, residents, midwives)	In-depth interviews
Richard et al. (2014)	To explore the perceptions of CS among pregnant women and the experiences of CS among postoperative women. To explore the socio-economic implications of CS within the household	Burkina Faso	District hospital with 24 maternity beds in Bogodogo. Emergency obstetric surgery is only possible for 1 day a week	Not specified	Qualitative	*n* = 75 pregnant women *n* = 35 postoperative women	Five focus groups (pregnant women) Individual semi-structured interviews (postoperative women)
Roux et al. (2011)	To explore the experiences and perceptions of South African women who delivered by emergency CS	South Africa	Private hospital	Unplanned CS (defined as woman delivering her baby via CS despite her desire to deliver vaginally)	Qualitative	*n* = 10 postoperative Caucasian women	In-depth interviews

TABLE 3 (Continued)

Author (date of publication)	Objective(s)	Country	Hospital context	Type of cesarean section	Study design	Study population and sample size	Data collection methods
Stal et al. (2015)	To explore the perceptions of the quality of emergency obstetric care received by women who delivered in a rural Tanzanian referral hospital	Tanzania	Rural Tanzanian referral hospital	Not specified	Qualitative	*n* = 19 postpartum women (16 cesareans) *n* = 3 HCPs	Semi-structured interviews Participatory observation
Ezeome et al. (2018)	To assess the perceptions and beliefs of pregnant women towards CS, including their views towards decision-making on the mode of delivery	Nigeria	Tertiary referral hospital in Enugu, Southeast Nigeria	Not specified	Descriptive cross-sectional	*n* = 200 pregnant women	Interviewer-administered questionnaire
Nnaji et al. (2012)	To assess the extent of women's involvement in decision-making for CS	Nigeria	Three tertiary health facilities in Anambra state	Not specified	Descriptive cross-sectional	*n* = 327 postoperative women	Interviewer-administered questionnaire
Ogunbode et al. (2015)	To audit informed consent processes for planned and emergency CS in a Nigerian tertiary care hospital	Nigeria	Tertiary referral hospital in Ibadan, southwest Nigeria	Planned (21%) and emergency CS (79%)	Descriptive cross-sectional	*n* = 150 postoperative women	Interviewer-administered questionnaire
Ohaeri et al. (2019)	To assess women's satisfaction with CS and their involvement in the decision-making process for CS	Nigeria	University of Benin teaching hospital in Benin city	Planned (122) and emergency (93) CS	Descriptive cross-sectional	*n* = 215 postoperative women	Semi-structured questionnaire
Okonta (2015)	To identify gaps in the knowledge relating to the informed consent process of residents in obstetrics and gynecology attending a national conference in Nigeria	Nigeria	N/A	Not specified	Descriptive cross-sectional	*n* = 182 HCPs (residents in obstetrics and gynecology)	Self-administered questionnaire
Anikwe et al. (2019)	To explore the experiences of CS among postoperative women	Nigeria	Referral hospital in Abakaliki, Ebonyi State	Planned (25%) and emergency (75%) CS	Analytical cross-sectional	*n* = 245 postoperative women	Interviewer-administered questionnaire
Enabudoso et al. (2012)	To assess the level of maternal autonomy using maternal preference to sign the consent form for CS To evaluate sociodemographic and obstetric associations with maternal autonomy	Nigeria	Tertiary health facility in Benin city	Planned (27%) and emergency (73%) CS	Analytical cross-sectional	*n* = 197 postoperative women	Interviewer-administered questionnaire
Abdillahi et al. (2017)	To examine maternal near-miss and death after emergency CS in Somaliland. To explore the impact of the legal prerequisite for family consent for CS	Somalia	Main referral hospital in Somaliland located in the capital city, Hargeisa	Emergency CS	Mixed method – prospective cross-sectional study and qualitative study	*n* = 50 postoperative women (women who experienced near-miss or death after emergency cesarean delivery) *n* = 17 HCPs (nurses, midwives, doctors) in direct contact with women in labor	WHO near-miss tool used to collect data on maternal near-miss and maternal death Semi-structured interviews with HCPs covering decision-making for CS

(Continues)

TABLE 3 (Continued)

Author (date of publication)	Objective(s)	Country	Hospital context	Type of cesarean section	Study design	Study population and sample size	Data collection methods
Afulani et al. (2019)	To evaluate the effect of an integrated simulation-based intervention on respectful maternal care provision	Ghana	Implemented in seven facilities in the East Mamprusi District in northern Nigeria: one mission referral hospital, four large health centers and two small community health centers	N/A	Before and after intervention	*n* = 533 (215 pre-intervention, 318 post-intervention)	Interviewer-administered questionnaire
Asefa et al. (2020)	To compare childbearing women's experiences of mistreatment before and after the implementation of a respectful maternity care intervention	Ethiopia	Three public hospitals in the Southern Nations Nationalities and Peoples Region (SNNPR): one primary hospital and two general hospitals	Not specified (pre-intervention 12%, post-intervention 22.6%)	Before and after intervention	*n* = 388 postoperative women (198 pre-intervention, 190 post-intervention)	Interviewer-administered questionnaire
Teshome et al. (2018)	To assess whether a multicomponent intervention is associated with improved surgical informed consent for obstetric and gynecologic surgeries	Ethiopia	Tertiary teaching hospital in Hawassa, in the capital of the Sidama region	N/A	Before and after intervention	*n* = 457 postoperative women (230 pre-intervention, 227 post-intervention)	Interviewer-administered questionnaire
Zethof et al. (2020)	To assess the impact of a multicomponent intervention on postoperative women's recollection of information regarding informed consent for CS in Malawi	Malawi	Rural referral mission hospital in southern Malawi providing free-of-charge maternity care	Pre-intervention group: planned (17.5%) and emergency (82.5%) CS Post-intervention: planned (15%) and emergency (85%)	Before and after intervention	*n* = 160 postoperative women (80 pre-implementation, 80 post-implementation)	Interviewer-administered questionnaire

Abbreviations: CS, cesarean section; HCP, healthcare provider; N/A, not applicable.

TABLE 4 Practices and experiences of counseling and debriefing for cesarean section.

Practices and experiences of counseling and debriefing	Studies contributing to review findings	Summary of findings
Explanation of the procedure	Two studies: Anikwe et al., Zethof et al.	A Nigerian study found that 65.4% of women were satisfied with their HCP's explanation of CS.[39] An intervention study conducted in Malawi found that only 55.0% of women in the pre-intervention group reported HCPs explaining the procedure.[28]
Indication	Six studies: Zethof et al., Ohaeri et al., Anikwe et al., Litorp et al., Richard et al., Stal et al.	Two studies found evidence to support women being informed about the indication for their CS. In Malawi, an intervention study found that pre-intervention 96.3% of women reported being counseled on indication, while in Nigeria, a study found 89.8% of women reported the same.[28,31] Four studies found evidence of women receiving poor or no counseling regarding indication. A Nigerian study found that only 41.6% of women were satisfied with information they received regarding the indication for their CS and, in Tanzania, a study found that postpartum women felt the information they received regarding the indication for their CS was lacking.[25,39] In Burkina Faso, a study found HCP's counseling on indication for CS was too vague and led to significant uncertainty.[42] Midwives participating in a Tanzanian study recognized that most women did not know the indication for their CS.[37]
Risks	Two studies: Ogunbode et al., Zethof et al.	A Nigerian study found that women were receiving insufficient counseling regarding risks.[30] The majority of post-cesarean women reported being counseled on the risk of blood transfusion (86.0%) and hemorrhage (88.7%), while few women 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%), tubal ligation (4.0%), and laceration to the baby (6.0%).[30] In Malawi, an intervention study found only 31.3% of women in the pre-intervention group received any counseling regarding the risks associated with CS.[28]
Anesthesia	One study: Anikwe et al.	A Nigerian study found that only 27.0% of women were satisfied with the counseling they received on anesthesia.[39]
Postoperative care	Three studies: Richard et al., Ogunbode et al., Husby et al.	A study conducted in Burkina Faso found the health and well-being of women recovering from CS was being harmed by HCP's vague counseling on postoperative care.[42] This is illustrated by the case of a woman who was told by HCPs not to soak her wound, who interpreted this as not being allowed to wash.[42] A Nigerian study found very few women reported receiving any postoperative counseling regarding oral intake commencement (25.3%), suture removal (18.7%), ambulation commencement (16.0%), wound dressing removal (15.3%), and bladder catheter removal (13.3%).[30] By contrast, a Sierra Leonean study found women were content with counseling on postoperative care which covered breastfeeding, wound care, caring for their babies, and postoperative analgesia.[33]
Alternative treatment options	One study: Hastings-Tolsma et al.	Postpartum women participating in a South African study recalled how obstetricians failed to explain their options to them and, consequently, they felt pressured into accepting CS over vaginal delivery.[41]
Understanding	Two studies: Nnaji et al., Ohaeri et al.	In Nigeria, a study found that 82.9% of postoperative women felt they understood the doctor's counseling on CS.[58] However, in the same country, another study found only 41.4% of postoperative women felt the counseling process helped them to understand the risk associated with CS.[31]

(Continues)

TABLE 4 (Continued)

Practices and experiences of counseling and debriefing	Studies contributing to review findings	Summary of findings
Healthcare providers answering questions and addressing concerns	Three studies: Anikwe et al., Stal et al., Husby et al.	A Nigerian study found 78% of women felt their doctors listened to their worries, compared with 40% who felt the same about nurses.[39] In Tanzania, post-cesarean women participating in a study reported midwives did not adequately communicate with them and address their concerns.[37] By contrast, women participating in a Sierra Leonean study described how doctors and nurses comforted them and addressed their concerns before the procedure.[33]
Non-consented cesarean section	Two studies: Richard et al., Lange et al.	Women participating in a study conducted in Burkina Faso reported that HCPs did not inform them of the decision to perform CS, and this only became apparent when they were on the operating table.[42] In Benin, a study found that half of the women who had an emergency CS were not informed they would receive a CS.[26]
Emergency cesarean section	One study: Afaya et al.	A Ghanaian study found women who had received an emergency CS were particularly dissatisfied with the information they received during the informed consent process compared with those who had undergone planned CS.[38]
Debriefing	One study: Roux et al.	A South African study found that post-cesarean women felt they needed to speak to their HCPs to discuss the reasons their CS was performed and have their questions answered.[27] Understanding what occurred through the debriefing process helped to improve their acceptance of the procedure and satisfaction with their overall birth experience.[27]

Abbreviations: CS, cesarean section; HCP, healthcare provider.

Service-level

Time constraints

Healthcare practitioners in one study in Malawi agreed that time constraints in cases of obstetric emergency justified forgoing counseling for CS and rescinding the woman's right to refuse the procedure.[24] In these cases, guardians provided written consent on behalf of the women, who were considered to lack capacity, or emergency CS was performed without written consent.[24] Similarly, a study conducted in Benin found that time constraints forced some HCPs to prioritize performing emergency CS over counseling women.[26]

Poorly-designed consent forms

There is evidence of poorly-designed consent forms only available in the hospitals' working language that fail to accommodate women who speak a different language.[24,30]

Societal level

Cultural and gender norms

Cultural and gender norms in sub-Saharan Africa were found to limit women's participation in the informed consent process for CS. In Somalia, there is prerequisite for consent from a male member of the woman's family before HCPs can perform CS, and some Tanzanian tribes possessed a cultural reverence for vaginal delivery, pressuring women to refuse CS.[22,25] A southern Nigerian study found written consent was most commonly provided by husbands (41.4%), followed by women (36.3%) and then relatives (7.0%).[31]

Women are also choosing to have others engage in the informed consent process for CS on their behalf, but these decisions can be influenced by cultural and gender norms. For example, a southeastern Nigerian study found 90% of women believed that men should sign the consent forms for CS, with 80% of these women explaining they held this belief because men, as heads of households, should be making these decisions.[32] The same study found that younger women were more likely than their older counterparts to hold the belief that husbands should decide on delivery mode.[32]

3.5 | Facilitators to informed consent

Provider level

Shared decision-making

There was some evidence of women playing an active role in the decision-making process for CS. In a Sierra Leonean study, these women reported feeling in control and, therefore, calmer.[33] In a South African study, women involved in decision-making felt respected and were accepting of subsequent events.[27]

Verbal explanation

A Malawian study found that HCPs took the time to use simple language to counsel women and ask women to paraphrase to check understanding.[24] This helped overcome barriers to communication posed by

TABLE 5 Interventions to facilitate informed consent for cesarean section.

Author (date of publication)	Intervention	Outcome(s) of interest	Findings of interest
Afulani et al. (2019)	Simulation training for HCPs with facilitated debriefing sessions to improve both clinical skills and respectful maternity care	Communication and autonomy	There were significant ($P<0.001$) increases in the proportion of women reporting HCPs explaining the procedure (20.9%–59.7%), HCPs speaking to them in a language they could understand (81.4%–92.8%), involvement in decision-making (25.1%–59.1%) and feeling they could ask HCPs questions (24.7%–50.3%).
Asefa et al. (2020)	Multi-component intervention: HCP training, wall posters, and post-training supervision	Non-consented care	There was a significant ($P<0.001$) decrease in the proportion of non-consent reported for obstetric surgery (CS or episiotomy), from 65.1% in the pre-intervention group to 38.6% in the post-intervention group.
Teshome et al. (2018)	Multi-component intervention: standardized consent form, wall posters, HCP training, and post-training supportive supervision	Respondents reporting receiving components of surgical informed consent: asked to give consent, provided written consent, indications, potential complications, consequences of refusal of surgery, alternative treatment options, type of anesthesia to be used, presented with anesthesia options, expected duration of the surgery, use of decision-making aids, supportive environment to refuse proposed surgery, adequate time for decision-making, and given an opportunity to ask questions	Significant differences ($P<0.001$) were only observed between the pre-intervention and post-intervention groups with regard to six components of surgical informed consent: type of anesthesia (11.3%–44.3%), alternative treatment options (24.3%–43.2%), potential complications (11.7%–28.2%), consequences of refusal of surgery (48.3%–63.4%), adequate time for decision-making (30.9%–53.1%), and the opportunity to ask questions (61.5%–88.5%).
Zethof et al. (2020)	Multi-component intervention: standardized checklist, wall posters on informed consent guidelines, and HCP communication training	Level of incompleteness defined as the number of informed consent components not discussed as reported by women Recollection of individual components of the informed consent process: indication, explanation of procedure, complications, implications for future pregnancies and written and verbal consent enquiry	Incompleteness scores were 26.0% lower in the post-intervention group compared to the pre-intervention group. The only significant ($P<0.05$) improvement in women's recollection of information between pre-intervention and post-intervention groups was on risks (31.3%–58.8%). There were statistically insignificant increases observed in the proportion of women recollecting receiving an explanation of the procedure (55.0%–68.8%), implications for future pregnancies (53.7%–66.3%), and written and verbal consent enquiry (83.3%–91.3%) between the groups.

Abbreviations: CS, cesarean section; HCP, healthcare provider; SIC, surgical informed consent.

language differences and women's low educational level, as well as the issue of consent forms being unavailable in women's native language.[24]

Good knowledge on informed consent

In Malawi, all HCPs in one study had good knowledge of the concept of informed consent and were able to provide a definition.[24] Some of these HCPs acknowledged that the primary motivation behind gaining written consent should not be to protect themselves from litigation as this undermines the purpose of the informed consent process.[24]

3.6 | Interventions

Interventions (Table 5) identified that facilitate the informed consent process for CS include standardized consent forms, educational wall posters, HCP communication training, post-training supervision, and simulation training.[28,34–36]

4 | DISCUSSION

We identified only a small number of papers in the peer review literature reporting counseling related to consent for CS in sub-Saharan Africa and only one paper mentioning debriefing. We found evidence of suboptimal informed consent processes in the African settings represented in this review. Our review suggests that women are receiving vague, limited, or no information on what the procedure entails, indication for CS, risks, anesthesia, postoperative care, and alternative treatment options.[25,28,30,31,37–41] Additionally, we found some evidence of non-consented CS.[26,42]

TABLE 6 Barriers to Informed Consent for Cesarean Section (CS) Categorized using Beauchamp and Childress's Elements of Informed Consent.

Barriers		
Preconditions	**Information**	**Consent**
	Poorly designed consent forms Language barriers Provider fear of blame and litigation Young age of woman	Distrust of health care providers
Labor pains		
	Time constraints	
Women's low level of education, paternalism, cultural and gender norms, poor provider knowledge of informed consent		

Women's low level of education was the most commonly reported apparent barrier to informed consent identified in the included studies.[22–25] Time constraints and labor pain were reported as barriers to informed consent in the context of emergency CS, as any delay to CS could be life-threatening and women are likely to be in labor.[24,26] This is reflected by the qualitative findings that non-consented emergency CS was common and women who underwent this procedure were more dissatisfied with the counseling they received compared with women who underwent planned CS.[26,38,42]

Some of the barriers identified in this review are corroborated by a systematic review set in Africa published in 2020, which found that paternalism, language barriers, poor provider communication training, lack of consent forms, gender norms, and cultural beliefs are key barriers to surgical informed consent.[43] Finally, there is no consensus on what represents optimal informed consent for CS in the papers represented in this review.

4.1 | Beauchamp and Childress's elements of informed consent

Beauchamp and Childress's elements of informed consent (Table 1), which consists of three key domains (preconditions, information, and consent), will be used to discuss the impact of barriers (Table 6) and facilitators (Table 7) on the informed consent process.

4.2 | Barriers

This review identified that time constraints affected the informed consent process for emergency CS.[24] In these cases, HCPs believed they were justified in foregoing counseling women and obtained consent from husbands and family.[24] A randomized control trial conducted in the United States found that the total time spent counseling patients as part of the informed consent process was the strongest predictor of patient comprehension.[44] Therefore, it can be argued that time constraints act as a barrier to the disclosure of information, women's understanding, and consent, particularly in cases of emergency CS.

TABLE 7 Facilitators to Informed Consent for Cesarean Section (CS) Categorized using Beauchamp and Childress's Elements of Informed Consent.

Facilitators		
Preconditions	**Information**	**Consent**
	Verbal explanation Standardized consent forms	
	Shared decision-making	
Good provider knowledge on informed consent, health care provider training, educational wall posters, supportive supervision of providers		

Language differences between women and their HCPs was a key communication barrier identified in this review.[24,26] It was found that poorly designed consent forms only exacerbated this issue as they were not inclusive of all native languages.[24,30] The purpose of a consent form is to facilitate the informed consent process by ensuring the patient has received full disclosure of information, provided by HCPs in a systematic fashion, with adequate time to ask questions.[45] Therefore, language barriers and poorly designed consent forms act as barriers to the disclosure of information and women's understanding.

This review identified labor pain as a barrier to informed consent because HCPs reported that this affected women's decision-making capacity and their ability to communicate.[24] This is particularly an issue in cases of emergency CS where women may be in debilitating pain.[24,46] Labor pain is consistently ranked highly on pain rating scales compared with other pain experienced during the life course, and impairs the cognitive skills required to make valid informed decisions.[47,48] Therefore, labor pain is a barrier to patient competency, a precondition for informed consent, and the disclosure and understanding of information.

Another barrier to the disclosure of information was HCP fear of blame and litigation.[22,24,25] This finding is consistent with evidence that fear of litigation in obstetrics is prevalent, including in Africa. For example, 27% of Kenyan obstetricians cited this as a reason for the rising trend in the use of CS, and in Tanzania, trainees in obstetrics believed pursuing a CS over vaginal birth protected them from

blame.[49,50] The present review found that this fear led to HCPs foregoing full disclosure of risks to minimize women's anxiety to obtain written consent.

The present review found that women and their families may not always trust the information disclosed by HCPs and their recommendations for CS.[22,27] This differed depending on the country or hospital setting. In low-income Somalia, women delivering in Hargeisa's main referral hospital and their families distrusted the indication given for CS because they associated the procedure with hysterectomies, stillbirth, and even death.[22,51] In a private hospital in an upper middle-income South Africa, women believed their obstetricians made decisions to promote their financial interests and time, which corroborates the extensive literature on the overuse of CS in private settings.[27,51]

The present review found that young age of the woman acts as a barrier to informed consent for CS. Younger women received counseling on fewer components of the informed consent process on CS compared with their older counterparts.[24] Bowser and Hill have previously highlighted issues faced by adolescents and young women seeking obstetric care, including experiences of stigma and discrimination from HCPs.[14] The present review suggests that the young age of the woman undergoing CS acts as a barrier to Beauchamp and Childress's information domain, as there is evidence to suggest that adolescents and young women are receiving inadequate counseling.

This review found that HCPs in obstetrics and gynecology have significant gaps in their knowledge on counseling and informed consent, particularly with regard to young women and women with a low level of education.[24,25,28,29] This is consistent with the evidence that doctors from multiple specialties can have a poor understanding of informed consent in Africa. For example, a Ugandan study found that 34% of surgeons of different specialties did not know the definition of informed consent.[52] Therefore, as it is the HCP's responsibility to conduct the informed consent process, inadequate knowledge of informed consent among HCPs poses a significant barrier to all three domains of the informed consent process, as identified by Beauchamp and Childress.

Women's low level of education as a barrier to the informed consent process was a recurring theme in this review and was also found to be associated with other barriers, including paternalism and cultural and gender norms.[22–25,27,31,32] There is evidence that patients with limited educational attainment may lack the ability to understand the information disclosed to them, particularly on risks.[40] The papers in this review suggest paternalism, cultural and gender norms all undermine women's voluntariness because they facilitate the transfer of women's decision-making power from themselves to their husbands, families, and HCPs.[22,25,27,31,32] Women affected by these barriers were more likely to have a low level of education and therefore, more likely to receive partial disclosure of information from HCPs and to have husbands and family consent on their behalf.[22–25] As a result, women's low level of education, paternalism, and cultural and gender norms are barriers to all three of Beauchamp and Childress's domains of informed consent.

4.3 | Facilitators

A small number of facilitators, including interventions, were identified in this review.[24,27,28,33–36] Consistent with the findings of an existing systematic review, this scoping review found that verbal explanation improves patient understanding of disclosed information.[24,53] Shared decision-making improves knowledge of disclosed information and reduces decisional uncertainty.[27,33,54] As mentioned previously, poorly designed consent forms are also a barrier to the disclosure of information and, therefore, introducing standardized consent forms can facilitate this process.[28,36] This is supported by a previous literature review on interventions to improve informed consent which found that standardized consent forms improved the disclosure of information on benefits, risks, and postoperative care.[55]

Healthcare provider training, including the use of communication training, lectures, simulations, and educational wall posters, aim to improve provider knowledge, itself identified as a facilitator of informed consent in this review.[28,34–36] Again, as mentioned previously, HCP knowledge influences all three domains of the informed consent process. A Cochrane review of interventions to improve informed consent found that well-informed and skilled HCPs were most likely to achieve good, informed consent.[56]

Finally, a 2017 systematic review found that clinical supervision can improve compliance with interventions designed to improve patient health outcomes.[57] Therefore, it can be considered a facilitator to all three of Beauchamp and Childress's domains.

4.4 | Strengths and limitations

This scoping review was based on an externally reviewed protocol and utilized a broad search strategy to conduct an extensive search of the published literature using several databases. Furthermore, quality control during the screening process was achieved by triple screening a sample of papers and discussing any disagreements between the authors.

Key limitations include the exclusion of grey literature and non-English language papers, and only one person conducted the process of extracting and interpreting the data.

5 | CONCLUSIONS

The paucity of papers identified in this review highlights the need for further research covering more countries in this region, specifically on debriefing, which represents a significant gap in the literature. A key finding in this region was the influence of husbands and families in the informed consent process for CS; however, there were no studies in this scoping review with this group as a study population. More research is required on the experiences of informed consent for CS among marginalized groups, including adolescents, disabled women, and women in fragile settings. Additionally, research is

needed into interventions to improve informed consent for CS, including at the woman level and in cases of emergency CS.

Recommendations for policy to improve informed consent for CS were identified. First, there is a need to promote the use of standardized consent forms and processes for CS, HCP training, and supportive supervision for HCPs and job aids, including wall posters. Second, ethics education needs strengthening in medical, nursing, and midwifery curricula, pre-service, in-service, and postgraduate training. Third, antenatal counseling on CS is needed to address women's sociocultural aversion to CS in this region, which could also help to mitigate the impact of time constraints due to emergency CS. Fourth, awareness-raising of CS in the wider community to build trust in the procedure as a life-saving intervention is needed. Fifth, awareness-raising around the negative impact of deeply entrenched paternalism and cultural and gender norms in healthcare is required at the provider level, and in wider society legislation is required to empower women socially and economically. Finally, despite some papers in this review finding that standardized consent forms can facilitate counseling and informed consent for CS, we also found this can be undermined by HCP fear of litigation and it is therefore crucial this is addressed. This issue can also be mitigated by building trust in the procedure through antenatal education and awareness-raising.

AUTHOR CONTRIBUTIONS

Veronique Filippi, Louise-Tina Day, Loveday Penn-Kekana, and Oona Campbell contributed to the protocol development. Sumeya Faysal, Veronique Filippi, and Loveday Penn-Kekana screened the results from the database searches. Sumeya Faysal, Veronique Filippi, Louise-Tina Day, Oona Campbell, Vandana Tripathi, Farhad Khan, Karen Levin, and Renae Stafford contributed to manuscript editing and review. Vandana Tripathi, Farhad Khan, Karen Levin, and Renae Stafford also oversaw the project.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

All relevant data are within the manuscript and its supporting information files.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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