



COUNSELING, INFORMED CONSENT, AND DEBRIEFING (CCD) FOR CESAREAN SECTION: HARD TO DEFINE, ACHIEVE, AND MONITOR

Key findings from a mixed methods study in the Democratic Republic of Congo (DRC), India, and Nigeria

This is a joint collaboration between researchers from The London School of Hygiene & Tropical Medicine, EngenderHealth, Kinshasa School of Public Health, Population Council India, and NPHD.

COUNSELING, INFORMED CONSENT, AND DEBRIEFING (CCD) before and after cesarean section comprise important aspects of respectful maternity care. However, prior research indicates significant gaps may exist in these elements of care in many low- and middle-income countries.¹ To better understand attitudes, preferences, and practices related to CCD in the context of both emergency and non-emergency surgical obstetric care, the MOMENTUM Safe Surgery in Family Planning and Obstetrics project* conducted a mixed methods study (including interviews, focus group discussions, observations, and record reviews) in Democratic Republic of Congo (DRC), India, and Nigeria.

Our inquiry was guided by Beauchamp and Childress's Elements of Informed Consent Model²

PRECONDITION: Competence to decide and voluntariness in deciding

INFORMATION: Disclosure of information, recommendations of a plan, and patient understanding of both

CONSENT: Decision in favor of a plan and authorization to conduct that plan

KEY FINDING: HIGHLY VARIABLE CONTENT IN WRITTEN CONSENT FORMS

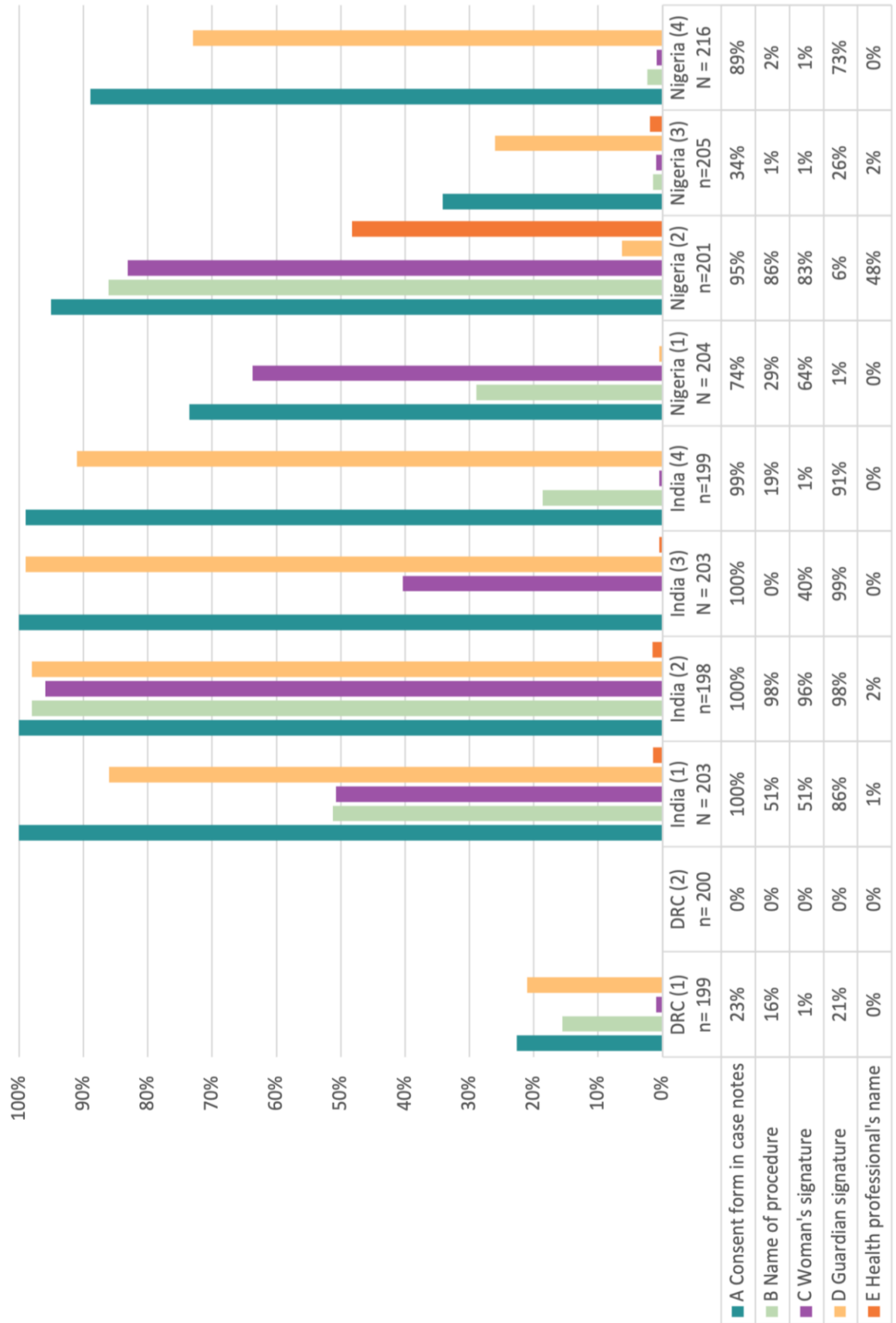
Documentation of consent varied considerably between hospitals and countries, from all medical records containing a form in India to no consent forms in one DRC setting. Even where other information was provided in the consent form, such as the name of the procedure and the doctor's name, a signature of the woman's consent was often missing.

“No, we don't have a written document for this purpose. However, in the event of refusal [of a cesarean section], we make a note of ‘discharge’ in her medical record to document the fact that she (or her guardian/companion) declined the recommended cesarean section”

—Doctor interview, DRC

* <https://usaidmomentum.org/about/projects/safe-surgery-in-family-planning-and-obstetrics/>

Figure 1: Documented consent for cesarean section in women's medical records, % in DRC, India, and Nigeria



The World Health Organization recommends the following measure of quality:

“The proportion of procedures in the health facility that require written consent for which there is an associated record of the woman’s consent.”

*Quality statement 5.1**



Scan to see consent forms.

KEY FINDING: COUNSELING AND INFORMED CONSENT PROCESSES ARE VARIED AND INADEQUATE, AND DEBRIEFING NOT CARRIED OUT

Despite providers having knowledge of what good consent practices entail, this knowledge did not translate into good practice. Even where documented consent existed, observation showed that documentation did not necessarily equate with high-quality informed consent processes. Providers expressed need for training on debriefing.

Key observations included:

- **PROVIDERS DEMONSTRATED KNOWLEDGE AND UNDERSTANDING OF COUNSELING AND CONSENT CONCEPTS.** In interviews, most doctors provided correct explanations of the importance of meaningful counseling, consent, and promoting women’s agency.
- **POST-CESAREAN DEBRIEFING WAS POORLY UNDERSTOOD** and conflated with discharge advice. High quality debriefing should include explanations on the procedure, any complications, and post operative recovery; and be an opportunity for women to ask questions. Examples of inappropriate approaches to disclosing interventions (e.g., hysterectomy) or outcomes such as stillbirth were observed.
- **CONSENT FORMS ARE PERCEIVED AS PROTECTION FROM LITIGATION BY SOME DOCTORS.** Observation frequently showed that, in practice, "informed" consent often involved a focus on signing forms.
- **COMMUNICATION WITH THE PATIENT WAS OVERWHELMINGLY ONE-WAY** (doctor/nurse to patient) and seen as a way to convince women/their companions to accept decisions already made by the doctor.
- **CLIENTS SOUGHT INFORMATION FROM "NON-MEDICAL" STAFF.** Women and their families often turned to non-clinical health facility staff, other women, or members of their community to ask questions about procedures.
- **SOCIOECONOMIC STATUS AFFECTS INFORMED CONSENT.** Observations showed that the quality of informed consent processes was lower for women who were considered to be poor and from rural areas.
- **WOMEN OFTEN DON’T SIGN CONSENT FORMS FOR THEMSELVES.** In all three settings, many health care workers, women, and families felt that women should not, or could not, consent by themselves. In some settings only husbands or male relatives were given information and asked to sign consent forms.
- **TRUE CONCERNS ABOUT CESAREAN SECTIONS WERE NOT ADDRESSED.** Concerns around cesarean section often related to costs, impact on fertility, impact on women’s social standing, fear of surgery, and concern about the recovery period. These issues were rarely addressed or discussed in the informed consent or communication processes.

“If you undergo cesarean section, your husband will look down on you and say you are now very old which is why you could not give birth on your own (...). They say you no longer have the strength for anything again.”

—Woman interview, Nigeria

KEY FINDING: POOR INFORMED CONSENT PROCESSES ARE DOWNSTREAM OF WIDER HEALTH SYSTEM CHALLENGES

PAYMENT FOR CESAREAN SECTION

In Nigeria and DRC, hospitals required a deposit to be paid before treatment. With emergency patients, especially those who had not booked in the facility previously, this could cause substantial delays between the doctor's decision to operate and surgery. If consent forms were produced, it was only after the family had secured funds, paid for surgery packs, and, in some cases, arranged blood tests in nearby clinics. Discussion and decision-making often came in relation to payment for the procedure, rather than in relation to the consent form or an explicit informed consent process.

SHORTAGES OF RESOURCES AND STAFF

All health workers felt overworked, and many felt unsupported by the system in which they were working. System-wide challenges included shortages of staff and drugs, and late payment of salaries.

KEY CONSIDERATIONS MOVING FORWARD

Consent for cesarean section is complex and multi-dimensional, and context matters. Emerging recommendations from this study's findings include:

- Women's and families' need for information and their decision-making are shaped by a wide range of formal and informal interactions, involving diverse actors at various stages of the process. The concerns that women and families have about cesarean section should be taken seriously and be discussed as part of the informed consent process.
- Doctors and other health workers require training and support to communicate better with patients from a range of socio-economic backgrounds, including before and after surgery.
- Financial barriers, power relations, and gender dynamics should be considered when understanding and improving CCD processes and ensuring that all components of an informed consent process are carried out.
- All health workers should be trained to give women the information they need to make decisions and to seek women's consent, unless incapacitated, even if they also wish to consult with family members.
- Information should be made available to community members to inform their decisions around cesarean section. This should address key knowledge gaps including costs, impact on fertility, and process.
- Consent forms and records should be improved as a reminder of key components of the informed consent process but are unlikely to be sufficient as a single intervention to improve quality of CCD.
- Debriefing is misunderstood and underutilized but has potential to center women's experiences of care.

Challenges with the informed consent process provide useful insights as to whether women are receiving quality respectful care. It is unlikely that meaningful CCD can be achieved without health system strengthening, improving women's status / addressing gender inequality, reducing financial barriers for women, and supporting health workers.

REFERENCES

¹ Counselling, Informed Consent and Debriefing for Caesarean Section in Sub-Saharan Africa: A Scoping Review, *International Journal of Gynecology & Obstetrics*, 10.1002/ijgo.15079

² Beauchamp TL, Childress JF. *Principles of biomedical ethics*. Fifth Edition. Oxford University Press. 2001