Experience of the informed consent during elective caesarian delivery at Selected Public Hospital in Addis Ababa Ethiopia, 2025. A descriptive qualitative study.

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Abstract

Background: Informed consent is a fundamental ethical and legal principle that ensures patients can make informed decisions about their healthcare. It requires healthcare providers to clearly communicate the risks, benefits, complications, and alternatives of medical procedures, enabling voluntary and informed patient approval.

Objective: To explore the experience of informed consent during elective cesarean delivery from the perspectives of healthcare providers and postpartum women in selected public hospitals in Addis Ababa, from February to March 2025.

Methods: A descriptive qualitative study was conducted at Tikur Anbessa Specialized Teaching Hospital, St. Paul Hospital, and Ras Desta Demtow Memorial Hospital. Purposive sampling was used to select 12 healthcare providers and 15 postpartum women. Data were collected through in-depth interviews. Coding was carried out using both inductive and deductive approaches. Thematic analysis was used to identify patterns, supported by ATLAS.ti 9 for data organization.

Results: The study revealed gaps in informed consent practices for elective cesarean delivery. From healthcare providers' perspectives, three main themes emerged: experience of informed consent, challenges in obtaining consent, and suggestions for improvement. From postpartum women's perspectives, themes included their experience of informed consent, communication with providers, and perception of autonomy and decision-making. While providers claimed to inform patients, they often did not fully explain the consent form. Most women reported receiving limited information focused mainly on the indication for surgery.

Conclusion: The informed consent process for elective cesarean delivery was improperly practiced. Improving provider communication, enhancing training, digitalizing the consent process, redesign consent form and empowering women about their rights are essential to achieving ethical, patient-centered care.

Keywords: Informed consent, Cesarean section, Patient experience, Healthcare provider.

Introduction

Informed consent is the process where healthcare providers clearly explain the possible risks, benefits, complications, and other options for a medical procedure. This helps patients make voluntary and informed decisions about their care(1). It is based on the patient's legal right to make their own healthcare choices and the healthcare provider's ethical duty to support those decisions(2)(3) Informed consent is an important part of medical practice around the world and supports patient independence and respect (2)(4).

It is more than just a legal formality. Informed consent is a two-way process that helps build a good relationship between patients and healthcare providers. This cooperation improves the quality of care, increases trust, helps achieve better results, and makes patients more satisfied with the services they receive(2)(5)(6). This is especially important in areas like obstetrics and gynecology, where shared decision-making is often needed(7) (5).

The Federation of International Gynecology and Obstetrics (FIGO) recommend that women should receive clear and relevant information about their health condition. This includes the proposed procedure, its benefits, possible risks, alternative options, and details about anesthesia and its risks. This helps women make decisions that match their needs and preferences (8). In surgical situations, especially those involving anesthesia, providers must give full information to support shared decisions(9)(10).

Informed consent also protects patients legally by making sure no procedure is done without their permission. At the same time, it promotes important values like autonomy, self-determination, and respect for the patient's body and rights(4)(11). When surgical informed consent is done properly, even complex procedures are more likely to be accepted by patients who understand the risks. This builds patient trust, improves satisfaction, reduces legal problems, and helps healthcare services work more effectively(12)(6).

In sub-Saharan Africa, informed consent practice is shaped by cultural beliefs, limited resources, and low awareness (13). In Ethiopia, Addis Ababa, study show that many women undergoing cesarean deliveries are not fully informed about the procedure, risks, or alternatives, and decisions are often made without their active

participation(14). Healthcare providers face many challenges, including fear of blame, lack of time, inadequate training, heavy workloads, and the use of complex language (15) (16) (17). As a result, informed consent is often reduced to a formality rather than a meaningful process.

Although most women are asked to sign consent forms, many do not receive enough information to make informed choices. Studies showed that more than half of women missed key elements of surgical informed consent, and some were asked to sign forms just before surgery, even while on the operating table(18)(19). Limited time, stressful environments, and lack of privacy discourage women from asking questions or refusing procedures(20). Women are often unaware of their right to decline or discuss other options, and explanations about anesthesia, side effects, or complications are frequently missing (21)(22)(23)(24) In many cases, decision-making power is shifted to husbands, families, or providers due to cultural and gender norms (25)(26).

Healthcare providers also report problems such as poor understanding of consent practices, inadequate consent forms, low patient awareness, and a weak legal framework (27) (28) (29). To avoid refusals, some providers only partially disclose information (15). System-wide issues like poor infrastructure, language barriers, and limited training further weaken the consent process(26) (30). Involving women in decisions improves satisfaction and trust in care, while exclusion leads to fear, confusion, and dissatisfaction (31) (32) (33). Despite surgical informed consent is vital for ethical and patient-centered care (34) its application is often incomplete. In Ethiopia while nearly all women are asked for consent, many receive limited information, and the process mainly protects providers rather than empowering patients (14) (18). Most previous studies focus on checklists rather than women's personal experiences or the views of the providers obtaining consent (14) (18). This leaves a gap in understanding how to improve informed consent in maternal care.

This study aims to fill that gap by examining the real life experiences of postpartum women and healthcare providers, from antenatal care to cesarean delivery.

Methods and Materials

Study was conducted in three selected public hospitals: Tikur Anbessa Specialized

Teaching Hospital (TASH), St. Paul's Hospital Millennium Medical College (SPHMMC), and Ras Desta Demtow Memorial Hospital from February to March 2025.

Study Design

A descriptive qualitative research design was employed to explore the experiences of informed consent during cesarean delivery from the perspectives of healthcare providers and postpartum women.

Postpartum Women: Women who had undergone elective cesarean delivery and had completed their immediate postoperative care but had not yet been discharged from the hospital

Healthcare Providers: Gynecologic residents are primarily responsible for obtaining informed consent from patients undergoing cesarean delivery. In all study settings, information during antenatal follow-up is typically provided by physicians. Therefore, gynecologic residents were purposively selected for this study, as they are most involved in the consent process for elective cesarean deliveries.

Sampling Methods

Both group of participants who met the inclusion criteria were selected using a purposive sampling method.

Sample Size:

All eligible participants during the study period were included until data saturation was achieved. 12 healthcare providers and 15 postpartum women were included.

Data Collection Method

Face-to-face in-depth interviews were conducted with postpartum women and healthcare providers using a semi-structured interview guide developed based on prior studies on informed consent practices. On average, each interview lasted 30 minutes and was conducted in a comfortable setting within the hospital to ensure confidentiality and participant comfort.

The guide was initially prepared in English and then translated into Amharic and Afaan Oromo to accommodate participants who spoke different languages. It was pre-tested at Gandhi Memorial Hospital with two post-cesarean women and two healthcare providers prior to formal data collection. Daily verbatim transcription of the recorded

audio and field notes was conducted in Amharic and Afaan Oromo, followed by translation into English.

Trustworthiness of the Study:

Considerable time was spent with participants to build trust and gain deeper insights. Data triangulation was ensured by incorporating multiple perspectives from both women and healthcare providers. Language triangulation enhanced accuracy through bilingual data collection. A detailed description of the study setting, population, and context was provided to support transferability. An audit trail was maintained to document each step of the research process, including coding and theme development. Researcher biases and preconceptions were bracketed during data collection and analysis to ensure that the findings reflected the participants' experiences.

Data Analysis

A thematic analysis approach was used to analyze the data. After completing data collection, the interviews were transcribed and reviewed multiple times for familiarity by reading both the transcripts and field notes. Key phrases and concepts were identified and coded using both inductive and deductive methods. Similar codes were grouped into categories, which were then clustered to form overarching themes. These themes were reviewed and refined to ensure they accurately reflected the dataset. ATLAS.ti 9 software was used to manage and organize the data systematically.

Ethical Considerations

The purpose of the study was explained to participants, and informed consent was obtained. The collected data were kept confidential and used solely for research purposes. Ethical clearance was obtained from the Ethical Review Committee of Addis Ababa University, School of Nursing and Midwifery. This clearance was then submitted to the study hospitals Tikur Anbessa Specialized Hospital, St. Paul's Millennium Medical College and to the Addis Ababa Health Bureau for Ras Desta Damtew Memorial Hospital. The Ethical Review Committees of all institutions reviewed the submissions and provided feedback. The comments were addressed, and final ethical approval was granted to collect data from all three hospitals

Result

A total of 27 participants were included in the study: 12 healthcare providers and 15 women. Among the 12 healthcare providers, 5 were male and 7 were female. Two had less than one year of experience, while the rest had one year or more. All healthcare providers were gynecologic residents. None of the healthcare professionals had received training related to informed consent. The women's ages ranged from 23 to 40 years. All women were multiparous except for one participant. Regarding education, one woman had no formal education, four had completed secondary school, four had a diploma, four had a bachelor's degree, and two had a master's degree. Among the 15 Women, eight were employed and seven were unemployed.

The findings of the study are presented and classified into two sections: the first present's results from the healthcare providers' perspective, and the second from the postpartum women's perspective. Each section includes three main themes, with each theme further divided into subthemes or categories.

Healthcare providers' perspective.

The healthcare providers' perspective describes their experiences and views on the informed consent process during elective cesarean delivery. It has three main themes:

Table 1 Presentation of emerged themes and subthemes about healthcare providers' perspectives on the informed consent.

S.No.	Themes	Subthemes
1	Experience of informed consent	Time of information delivery and sign consent Content of information Communication and understanding Patient autonomy and perception Legal and ethical awareness among providers
2	Challenges related informed consent	Time and workload Patient condition System and consent form
3	Suggestions for improvement	Suggestion about system problem Form design

Theme 1: Experience of the Informed Consent Process

This theme includes five subthemes: Time of information delivery and signing consent, Content of information, Communication and understanding, Patient autonomy and perception, Legal and ethical awareness of providers.

Subtheme 1.1: Timing of Information Delivery and Consent Signing

Healthcare providers reported that since the operation is planned, general information about the mode of delivery and the indication for cesarean section is typically discussed during antenatal care. However, specific information related to informed consent is often provided much later, at the

time of signing the consent form. The timing of consent signing varied across hospitals: it could be the day before surgery, just before surgery, on the operating table, or during preparation for the operation.

The following statement from a participant illustrates the timing of information delivery:

"Information for informed consent is usually given just before the patient enters surgery. However, the indication for surgery, mode of delivery, and birth preparedness are discussed during antenatal care." (Health Care Provider participant 1)

In one setting participant report women were admitted the night before surgery and had adequate time to receive detailed information.

"They sign the informed consent the day before surgery. We give them time to decide; we tell them all the information." (HCP4)

However, in two other settings, consent was often signed on the day of surgery sometimes during preparation or even on the operating table.

"they sign the consent just before surgery."(HCP 8)
"Consent is obtained on the operating table, and in many cases, it is not attached to the document because the document is stored online in the system." (HCP7)

Subtheme 1.2: Content of Information

Providers reported that they inform patients before obtaining consent, but they do not cover all the information included in the consent form. Most healthcare providers reported giving case-based information rather than a full explanation of information to every patient.

"We do not tell mothers in detail about complications of surgery... We only tell them the reason for surgery. Maybe if the mother has a high risk of complications and we fear something may happen, we inform her, but we do not inform all mothers in detail." (HCP2)

Regarding anesthesia the participant report complications of anesthesia were told to patient.

"Complications of both full and half anesthesia are explained, and patients usually accept the professional's decision." (HCP1)

Subtheme 1.3: Communication and Understanding

This subtheme describes how providers approach patients, focusing on the methods they use to communicate and assess patient understanding. Participant reported making efforts to communicate in languages patients understand and to check their comprehension. The following statement was taken from a participant

"We inform patients using a language they understand, sometimes involving a translator. We allow them to ask questions to check their understanding." (HCP1)

Not all providers consistently checked patients' understanding some report.

"I provide full information, but I do not always check the patient's understanding." (HCP8)

Subtheme 1.4: Patient Autonomy and Perception

Participants recognized informed consent as a patient's right and acknowledged the patient's right to refuse surgery without coercion. The following statements were received from participants:

"Informed consent is the patient's right... Patients have the right to refuse. We do not force them." (HCP2)

Some providers admitted to encouraging patients to accept their recommendations.

"We don't present the surgery as optional; we counsel and encourage the patient to proceed for their benefit." (HCP8)

Subtheme 1.5: Legal and Ethical Awareness among Providers

Providers reported that informed consent serves as protection against medico-legal issues, acts as an agreement between patients and providers, fosters cooperation,

and gives providers confidence in delivering care. The following statements were received from participants

"Informed consent benefits the patient by preparing her mentally and emotionally to accept possible outcomes, and it benefits us by giving us confidence and protecting us from medico-legal issues." (HCP5)

Theme 2: Challenges Related to Informed Consent

This theme describes the challenges providers face related to informed consent. It has three subthemes: Time and workload, patient condition, and system and consent form.

Subtheme 2.1: Time and Workload

This subtheme describes the time and workload challenges providers face during antenatal care and the consent-signing process. Participants reported that time constraints and heavy workloads are significant barriers to providing effective and comprehensive informed consent.

"There is not enough time to counsel patients... The number of patients and healthcare providers is not comparable, and this creates a challenge. " (HCP8)

Subtheme 2.2: Patient Condition

This subtheme highlights challenges related to the patient's condition that providers face during the consent process. Issues such as limited patient understanding and a lack of awareness about their rights and responsibilities were noted as major obstacles to obtaining informed consent.

"*Sometimes, after hearing that surgery is needed, mothers discontinue ANC follow-up, and we don't know where they go. If we try to call, they don't answer. This shows the misunderstanding they have about surgery. Some mothers do not ask questions or understand even after counseling." (HCP3)*

"In the community, many patients do not understand their rights and obligations." (HCP7)

Subtheme 2.3: System and Consent Form

This subtheme addresses system-related problems experienced by participants during the consent process. These include issues such as incomplete components of the consent form, excessive form length, lack of training, and the absence of separate consent forms for anesthesia and surgery. The following statements were received from participants:

"*Our informed consent form is long, and its length has one disadvantage: sometimes patients discontinue reading after starting because it is too long.*" (HCP5)

Training gaps were also highlighted.

"*Many senior and resident doctors from obstetrics and gynecology are going to court because of incomplete documentation. We are now more alert after hearing of colleagues facing legal issues due to incomplete informed consent documentation, but it is not good to act only after a problem arises. Healthcare professionals should receive training before starting work.*" (HCP2)

Theme 3: Suggestions for Improvement

This theme presents the suggestions provided by participants for improving the informed consent process based on their experiences. It includes two subthemes: Suggestions about system problems and Suggestions regarding the consent form.

Subtheme 3.1: Suggestion about system problems

This subtheme highlights providers' suggestions for addressing system-related problems. Recommendations include early admission of patients, creating awareness about informed consent, preparing consent forms in multiple languages, ensuring institutional support to protect healthcare providers in cases of legal liability, and providing proper training on the informed consent process

Most participant suggest the prepartion of informed consent by deffirent language.

"*It would be good to prepare consent forms in different languages so that patients can read and understand in their own language rather than relying on translation.*"(HCPP7)

Others called for institutional support.

"*There should be a strong, well-established organization to defend healthcare professionals. Currently, if a doctor faces legal issues, they have to hire their own lawyer individually, which is not good. There should be an official organization under the Ministry of Health*." (HCP2)

Participants recommended training on informed consent practices.

"*As I mentioned, we work based on experience. It would be good if we received training on informed consent standards because this is our daily work.*" (HCP4)

Subtheme 3.2: Form Design

This subtheme presents participants' suggestions regarding the content and structure of the consent form. They recommended including all essential components in the form and separating the consent forms for anesthesia and surgery to enhance clarity and understanding.

"*The informed consent form should be revised to include complications. If patients know and sign, it reduces the doctor's legal liability*." (HCP2)

It would be better to have separate informed consent forms for surgery and anesthesia." (HCP1)

Postpartum Women's Perspective

The postpartum women's perspective provides insight into their experiences and feelings regarding the informed consent it has three major themes:

Table 2 Presentation of emerged themes and subthemes about postpartum women's perspectives on the informed consent.

S.No.	Themes	Subthemes
1	Experience of informed consent.	Timing and process of consent
		Content and adequacy of consent
		Anesthesia related information
2	Communication and interaction with health care providers.	Providers behavior and engagement
		Patient communication comfort
3	Perception of autonomy in decision making	Involvement in decision making
		Emotional response to process

Theme 1: Experience of Informed Consent

This theme describes women's experiences related to the timing of receiving information, signing consent, and the conditions under which consent was signed. It also addresses the content of information women received during antenatal care and at the time of signing consent. It encompasses three subthemes:

Subtheme 1.1: Timing and Process of Consent

Most women in the study reported signing consent forms in rushed conditions, often during preparation for surgery, after changing into surgical attire, or even on the operating table. The timing of consent signing varied between hospitals.

A few women reported being admitted the day before surgery and were allowed sufficient time before signing the consent form.

"I had heard that I would need an operation when I came here at seven months. They gave me time to read and think before the surgery, and I signed it the night before the surgery." (Patient participant 3)

However, many women indicated they were not given adequate time to consider their decision before signing, with some stating they signed the forms promptly to avoid wasting time.

"At that time, they said 'enter and change your clothes,' and after changing clothes, they brought the paper to sign. You cannot refuse to sign or ask to read; you are between life and death how can you say, 'let me read it'?" (PP1)

"I was already on the operation bed and felt tension at that time, so I didn't think about asking to read it or asking them to read it for me." (PP8)

Subtheme 1.2: Content of Information

This subtheme indicates the content and adequacy of information women received from antenatal care to the signing of consent. Most women reported they were only told that they would undergo an operation and knew only the reason for the surgery.

Most women stated they received limited or no detailed information about the surgery:

"On follow-up, they didn't tell me anything about the operation. They

didn't tell me details about the operation, but they told me I would have an operation." (PP1)

"I didn't hear any other information except the reason for the operation." (PP5)

A few women reported they received some information, such as the possibility of blood transfusion, bleeding, and the duration of the surgery

"One doctor informed me about the complications of surgery, like bleeding." (PP3)

Subtheme 1.3: Anesthesia related information.

The women reported that they were not informed about the benefits and complications of anesthesia.

"They didn't tell me the benefits and complications of anesthesia." (PP6)

Theme 2: Communication and Interaction with Healthcare Providers

This theme describes women's experiences of communication and interaction with healthcare providers, focusing on how providers approach women from the women's perspective. It includes two subthemes: provider behavior and engagement, and patients' communication comfort and involvement

Subtheme 2.1: Provider Behavior and Engagement

This subtheme examines how healthcare providers introduce themselves to women and how women are invited to ask questions. Women in the study reported that the surgeons did not introduce themselves. Some women recognized the surgeon's face, while others did not even know whether the surgeon was male or female because they wore masks. Some reported being unable to identify the surgeon due to the presence of many providers and not knowing who performed the surgery. The following statements were received from providers

"The surgeon didn't introduce himself to me. I think the surgeon was male. There were females; I think they were nurses. I didn't see because there was a blanket covering me." (PP11)

"I didn't know who gave me the anesthesia or who the surgeon was because they wore masks and didn't introduce themselves." (PP15)

Some women also noted they were not invited to ask questions:

"They didn't give me a chance to ask questions. I didn't ask questions." (PP9)

Subtheme 2.2: Patient's Communication Comfort and Involvement

Some participants expressed a preference not to receive detailed information about potential complications, fearing that such information might increase their anxiety and lead them to refuse the surgery. They preferred to rely on healthcare providers to make the best decision on their behalf, rather than being presented with all possible complications, which could lead to a dilemma.

Additionally, some women reported refraining from asking questions due to fears of being rebuked by providers, a lack of confidence, or unawareness of their right to inquire. Generally, there was a tendency to accept providers' decisions without question. Some participants believed that healthcare professionals intentionally withheld information to avoid potential refusal of the procedure.

Some participants preferred not to hear detailed information:

"As a professional, it is better if they counsel you and choose the better option for you rather than telling you all the side effects, which could lead to tension. You can then decide without dilemma." (PP4)

Others believed information was intentionally withheld to avoid fear or refusal:

"I thought that if they informed me about everything, I might be frightened or might not come, and that could affect my life. For this reason, I thought they didn't tell us everything." (PP14)

Some participants feared asking questions due to lack of awareness or confidence:

"We don't have experience asking questions like 'why' and 'how' when something is given to us; we just say 'okay, okay.' I think it is because of our knowledge level and low education." (PP12)

Theme 3: Perception of Autonomy in Decision-Making

This theme explores women's experiences of autonomy in decision-making during cesarean deliveries, focusing on whether their choices were respected and their emotional responses during the consent

process. It encompasses two subthemes: involvement in decision-making and emotional responses to the consent process.

Subtheme 3.1: Involvement in Decision-Making

Despite receiving limited information, most women in the study trusted healthcare providers and accepted their decisions. They believed that providers possessed greater knowledge and would not intentionally cause harm. Additionally, the women reported that they were not coerced into accepting the decisions made.

Some women recognized their right to refuse but still deferred to the professionals:

"I know I have the right to refuse, but I also know that refusing would put me at risk because I don't know better, but they are professionals." (PP14)

Many participants expressed trust in healthcare providers and accepted their decisions:

"I didn't ask what they were giving me; I left everything to them, trusting that they knew better than me. I trust healthcare providers and believe they take their responsibility seriously before God." (PP2)

Some women affirmed that their decision was respected:

"No one forced me to have the operation, either from healthcare providers or family. I decided by myself." (PP7)

Subtheme 3.2: Emotional Response to the Process

This subtheme explores women's emotional responses to the consent process, focusing on whether they experienced tension or felt comfortable.

Women described emotional reactions such as fear and shock:

"I was shocked when I heard I would need an operation because they had initially told me I could try labor." (PP15)

Discussion

This study described the experience of informed consent during elective cesarean delivery from the perspectives of both healthcare providers and post caesarian section women. Participants from both groups acknowledged that, even though the operation was planned, informed consent was not appropriately practiced, and they mentioned different reasons for this.

Healthcare providers in the study understood informed consent as a patient's right and a collaboration between women and providers. This understanding aligns with study conducted in Malawi on health care providers perspective (15). However, providers acknowledged they did not give detailed information, focusing mainly on the reason for surgery and delivering case-based information. This practice falls short of FIGO's recommendation that women should receive adequate information about the proposed treatment (8). This finding is consistent with another study conducted in different region of Ethiopia, which found that the application of informed consent standards for cesarean sections is inconsistent, with many women receiving insufficient information (14)(18)(35).

All women in the study were informed about the possibility of having surgery during antenatal care, which contrasts with another study where less than half a percent of participants reported being told they might need surgery in the future during their antenatal visit (14). This difference may be due to our study focusing only on elective surgeries.

Women reported receiving limited or superficial information some were only told the reason for the surgery, while others felt they were not informed about potential risks, complications, or alternatives. Most women reported receiving no specific information about the type, risks, or benefits of anesthesia. This contrasts with ACOG's definition of informed consent as a process that involves clear communication of risks, benefits, complications, and alternatives, enabling patients to make informed and voluntary healthcare decisions (5).

Providers demonstrated an awareness of the legal importance of informed consent, particularly as a form of protection against medico-legal liability. This awareness aligns with existing literature indicating that fear of litigation motivates documentation practices (18). However, focusing on legal protection rather than patient empowerment risks shifting the purpose of informed consent from a patient-centered process to a defensive medical practice (36).

Some healthcare providers reported giving information without verifying women understands, and women also noted that their comprehension was not checked. This finding contradicts FIGO's recommendation that providers should confirm patients' understanding by asking them to summarize the information and addressing any

misunderstandings through clarification and repetition (8).

Women in the study acknowledged that healthcare providers knew better and wanted them to choose what was best. This finding aligns with another study in which providers perceived that women lacked understanding of the information provided and expected healthcare workers to make decisions for them(15). Even with the insufficient information delivered, women trusted healthcare providers and accepted their decisions.

On the other hand, providers justified giving limited information due to fear of patient refusal. This finding is consistent with a study in Malawi, where providers stated they hid information for fear of refusal. However, this approach undermines patient autonomy and violates the ethical standards of patient-centered care (16).

Some women in the study did not want to hear detailed information about surgical complications, fearing it would increase anxiety and lead to refusal. Others preferred that providers make the decisions to avoid being placed in a dilemma. No previous study has reported this specific finding from the women's perspective, likely due to the limited number of qualitative studies exploring women's experiences in detail. However, this result aligns with healthcare provider perspectives in other studies(15).

Women reported that consent was often obtained in a rushed manner, typically during moments of high stress such as in the operating room or immediately before surgery, without adequate time for reflection. Several women mentioned they were asked to sign documents without prior explanation or the opportunity to read the content. This is similar to other studies where patients often report having inadequate time to make informed decisions, with discussions taking place just minutes before surgeries, leaving them feeling vulnerable and less inclined to ask questions (36)(14)(35). Such practices stand in contrast to FIGO's recommendations, which emphasize that informed consent should not be a one-time event conducted immediately before a procedure. Except in emergencies, the process should involve multiple discussions over time, allowing patients the opportunity to thoroughly reflect on the information provided and engage in meaningful dialogue before deciding (8).

Participants in this study reported key barriers to effective informed consent,

including a lack of training and heavy workloads among healthcare providers. These challenges are consistent with findings from a study conducted in Italy, where healthcare providers similarly faced inadequate training and excessive workloads, which hindered the consent process(37). In addition, healthcare providers in this study highlighted language barriers and patients' level of understanding, insufficient time, poorly designed consent forms, limited patient awareness, and fear of patient refusal. This aligns with findings from Malawi and Ethiopia (15)(29).

Women in the current study also expressed a lack of confidence in asking questions and a tendency to simply agree with what they were told, which they attributed to limited knowledge. This is supported by a systematic review from Africa by Faysil, which found that low educational attainment, paternalistic healthcare attitudes, and restrictive cultural and gender norms often limit women's autonomy in healthcare decision-making(26). These similarities may be linked to broader socioeconomic factors that influence women's access to education, information, and empowered participation in their own care.

Limitations of the Study

As a qualitative finding may not be generalizable. Additionally, the study relied on participants' self-reported experiences, which may be subject to recall bias or social desirability bias.

Strength of study

The study's inclusion of both postpartum women and healthcare providers provided a balanced view of the informed consent process. Conducting research across teaching and primary hospitals added contextual diversity. Using both Amharic and Afaan Oromo in interviews ensured inclusiveness, and enhancing the quality and credibility of the data.

Conclusion

Although the procedures were elective, the informed consent process was often inadequately implemented and treated as a formality rather than a meaningful, patient-centered interaction. While healthcare providers understood informed consent as an ethical and legal duty, in practice, they mostly shared only the reason for surgery with limited discussion of risks, benefits, anesthesia options, or alternatives. Women similarly reported that consent was rushed, often occurring right before surgery, with little chance to read documents, ask

questions, or make informed choices. Most women only knew the reason for surgery, and few received information about possible complications. Providers also cited barriers such as time pressure, lack of training, high patient loads, systemic challenges, and poorly designed consent forms.

Recommendations

Based on the study findings, it is recommended that hospital administrators and policymakers provide training for healthcare providers, digitalize the consent process, and redesign consent forms to be clearer and more comprehensive. Empowering women about their rights and using separate consent forms for surgery and anesthesia are also essential to ensure truly informed and patient-centered decision-making.

List of Abbreviation and Acronym

ANC - Antenatal care

ACOG - America college of Gynecology and Obstetrics

C/S- Cesarean Section

FIGO- International Federation of Gynecology and Obstetrics

HCP- Health Care Provider.

PP - Patient participant

SIC- Surgical Informed Consent

SPHMMC - St. Paul Hospital Millennium Medical College

TASH - Tikur Anbesa Specialized Teaching Hospital

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