Iranian women's experiences of the episiotomy consent process: a qualitative study

Abstract

Background **Knowledge of the benefits and complications of interventions related to medical procedures, such as episiotomy, enables women to make informed decisions regarding these interventions. This study investigated women's experiences of the episiotomy consent process in Iran.**

Methods **This qualitative study gathered data from 20 women through in-depth semi-structured interviews. The participants were selected from hospitals, health centers and gynecology clinics in Tehran. Content analysis was used to establish themes from the gathered data.**

Results **The participants' experiences showed that they felt that their needs were not met and that they were excluded from decision making regarding their birth.**

Conclusions **Women were excluded from decision making and their unmet needs presented ethical challenges in the performance of episiotomy procedures. Neglecting women's expectations, inducing absolute trust in obstetricians or midwives and failing to obtain informed consent paved the way for forced episiotomies. Proper education and obtaining informed and voluntary consent may facilitate women's rights being respected.**

Keywords

Decision making | Episiotomy | Experiences | Informed consent

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In 1950, episiotomy was introduced as a surgical technique to reduce the risk of severe perineal tears, shorten the duration of birth and prevent damage to the pelvic floor (He et al, 2020). However, this technique can result in postpartum pain, wound site infection and long-term dyspareunia (Muhleman et al, 2017). The benefits of routine episiotomy have been a subject of controversy (Muhleman et al, 2017), and clinical guidance and professional communities currently recommend episiotomy only when there are clinical indications (American College of Obstetricians and Gynecologists, 2006; Royal College of Obstetricians and Gynecologists, 2015; World Health Organization, 2018a; National Institute for Health and Care Excellence, 2019). Despite these recommendations, the rate of episiotomy in vaginal births remains high in some countries and has been reported in 97% of primiparous women in Iran (Kajoye Shirazie et al, 2009; Cunningham et al, 2010).

The term informed consent has existed since the late 1950s as part of patient rights (Grady, 2015). At present, it has been affirmed as a basic human right of pregnant women during childbirth and postpartum care (Berg et al, 2001; Grady, 2015; Karim et al, 2019). Communication from the obstetrician or midwife about allowing or refusing specific interventions plays a key role in promoting informed decision making between a pregnant mother and the obstetrician or midwife to improve the health of the mother and baby (Stevens, 2009; Karim et al, 2019). Any examination, intervention or treatment without informed consent is considered a form of physical assault, and it is vital to obtain a mother's consent before any examination, birth and postpartum care (Marshall, 2000; Stevens, 2009; Karim et al, 2019).

Although women may grow more knowledgable about episiotomy with an increased number of births, they must still be provided with sufficient information and counselling before the procedure is performed. Not having such information is a major obstacle to obtaining informed consent (Bakai et al, 2011). In 2017, a Cochrane review examining the use of episiotomy reported that studies did not take into account women's

priorities and views about the procedure and the results that were important to them (Jiang et al, 2017). The World Health Organization (2018b) episiotomy policy states that informed consent from women is required to perform the procedure.

Women have previously reported that they had poor knowledge of episiotomy and its consequences and were seldom asked for their consent (Djanogly et al, 2022). Many women's knowledge of episiotomy results from previous birth experience, and so women must be provided with information and counselling before the procedure (Ibrahim et al, 2018). According to the principles of evidence-based care, decision making by service providers about surgical and medical interventions should be shifted toward independent decision making by clients (Diorgu and Steen, 2017).

Childbirth in Iran is medicalised, and pregnancy and childbirth are perceived as a pathological process that requires intensive monitoring and care by physicians (Nourizadeh et al, 2012). This attitude has perpetuated the perception that the mother's role is as a patient and has weakened women's control over their bodies, undermined their confidence in natural childbirth and violated their right to an informed choice (Nourizadeh et al, 2012). As the purpose of medical procedures is to improve the health and wellbeing of the individual, obtaining the patient's consent to such procedures is essential, even when there may be a risk of harm. The patients' consent is an indicator of the effectiveness, efficiency, productivity and quality of health and medical services (Purbakhsh, 2010; Bakai et al, 2012). Improving the quality of women's care is an essential component to improve and promote the health of pregnant women worldwide (Jolivet et al, 2020).

Informing women about episiotomy and their rights is important, as they should be able to freely make informed decisions about any surgical procedures. Thus, the present study investigated women's experiences of the episiotomy consent process in Iran.

Methods

This qualitative study was conducted using content analysis. A total of 20 primiparous or multiparous women who had an episiotomy were purposively selected for their diversity in terms of age, parity, education, occupation, episiotomy history and type of hospital. Sampling was conducted in hospitals, health centers, and women's clinics affiliated with Shahid Beheshti University of Medical Sciences in Tehran, and continued until data saturation was reached.

Data collection

Data were collected through in-depth semi-structured interviews conducted in Persian. By prior arrangement with officials and staff, interviews were conducted in secluded rooms in the health centers or hospitals. All interviews were recorded with the participants' permission and transcribed, and each interview lasted 40–55 minutes. The researcher also collected data through observation, note-taking during the interviews and the use of existing documents, the participants' medical records, which detailed the participants' birth and episiotomy history, and demographic characteristics such as age, education and employment.

The in-depth interviews began with the question 'were you provided with information about episiotomies before the procedure was carried out?' and continued following a semi-structured interview guide. The guide's questions were designed by the research team members using open coding to ensure the questions were valid, and an external observer adept in qualitative research and reproductive health was engaged.

The questions in the interview guide included:

- What were your needs and expectations during the episiotomy? Can you elaborate?
- Had you been informed before an episiotomy?
- Was informed consent taken to perform an episiotomy on you?
- Before performing an episiotomy, was basic information as well as the complications and benefits of an episiotomy explained to you?
- During labor and before the episiotomy, were you given the right to choose whether or not to do it?

The participants' answers guided the progress of the interviews and further questions.

Data analysis

Data were analysed using conventional content analysis according to the stages proposed by Graneheim and Lundman (Graneheim et al, 2017). Data were analysed as they were collected. In stage one, each interview was typed verbatim and entered into MAXQDA10 software for analysis. In the second stage, semantic units were extracted from the interview texts, and the concepts in the text were written as an abstract. In stage three, semantic units were summarised and assigned appropriate codes. Encoding began concurrently with the interviews. In stage four, codes were categorised based on similarities and differences, and subcategories were formed. In stage five, after classifying the categories, themes were extracted from concepts in the text. Following data analysis, the results were then translated into English and reviewed by the research team members to ensure accuracy of the translation.

Data accuracy and rigor

Lincoln and Guba (1985) proposed four criteria for assessing the accuracy and rigor of qualitative

data: credibility, dependability, transferability and confirmability. In the present study, these standards were followed to bolster the accuracy and rigor of the data (Lincoln and Guba, 1985).

Credibility denotes activities that increase the probability of obtaining credible data. The methods used to ensure credibility included prolonged engagement and sustained observation, triangulation (combination), searching for disconfirming evidence, review of interpretations against raw data, member checking and peer checking (Speziale et al, 2011; Holloway, 2016). The data obtained from the interviews, after implementation and coding, were reviewed by the research team. To confirm the coding, at the end of the interview, participants were asked to review the researcher coding and either confirm it was correct or correct it.

Dependability is equivalent to reliability in quantitative studies (Delamont, 2012). In the present study, to ensure the similarity of the questions put to participants, an open coding method was used and an external observer adept in qualitative research and reproductive health was engaged.

Transferability is synonymous with generalisability in quantitative research and refers to the likelihood of the study data producing similar meanings for others in similar situations (Stommel and Wills, 2004; Speziale et al, 2011). In the present study, data transferability, irrespective of the researcher's assumptions (exclusion or reduction), was made possible through rich data explanation and scientific consultation with experts to make the findings transferrable for evaluation and judgment by others.

Confirmability refers to the agreement between several independent individuals regarding the relevance, accuracy and meaning of the data (Polit and Yang, 2015). Confirmability was ensured through sampling with maximum diversity in terms of age, time passed since episiotomy, number of pregnancies, education, occupation and type of hospital, as well as by comparison to the results obtained by others, and details of the qualitative method.

Table 1. Participants' demographic characteristics

Characteristic	Category	Frequency, *n*=20 (%)
Age (years)	Mean ± standard deviation	29.2 ± 5.89
Number of births	Mean ± standard deviation	1.75 ± 1.11
Education	Illiterate	2 (10.0)
	Elementary School	4 (20.0)
	Middle School	1 (5.0)
	Diploma	4 (20.0)
	Associate	2 (10.0)
	Bachelor	5 (25.0)
	Masters	2 (10.0)
Employment status	Housewife	14 (70.0)
	Employed	6 (30.0)
History of episiotomy	First birth	12 (60.0)
	Second or further birth	8 (40.0)
Type of hospital	Public	8 (40.0)
	Private	7 (35.0)
	Educational	5 (25.0)

Ethical considerations

Before data collection, the study was approved by the Shahid Beheshti University of Medical Sciences (approval number: IR. SBMU. PHARMACY. REC. 1400. 210). The importance of informed consent, the study objective and methods, maintenance of data confidentiality and the right to participate in the study or withdraw from it if they chose so were explained to the participants, who provided written consent to participate in the study.

Results

A total of 20 women aged 18–42 years participated and their demographic details are shown in *Table 1*. Data analysis allowed for the extraction of the main study subject: women's perceptions of whether their rights were respected by obstetricians/midwives in the process of performing an episiotomy. The results included one theme, two categories, five subcategories and 14 codes (*Table 2*). Several of the participants submitted to an episiotomy under circumstances where their needs were not met and where they were not included in the decision-making process. These issues formed the basis of women's experiences of the episiotomy consent process.

The theme, 'women's experiences of the episiotomy consent process', consisted of two categories: women's unmet needs and not being included in episiotomy-related decisions. Participants reported that their expectations were ignored during episiotomies and they were subjected to mistreatment by obstetricians or midwives. Furthermore, the participants felt deprived of their right to choose by absolute trust being induced in obstetricians or midwives and a failure to obtain their consent for an episiotomy. Participants reported that they were forced to submit to an episiotomy without adequate information or education.

Women's unmet needs

The category 'women's unmet needs' consisted of two subcategories: 'women's expectations of obstetricians or midwives' and 'dissatisfaction with obstetricians or midwives' actions'.

Table 2. Codes, subcategories, categories and themes

Code	Subcategory	Category	Theme
Expecting painless repair	Women's expectations of obstetricians or midwives	Women's unmet needs	Women's experiences of the episiotomy consent process
Expecting re-anesthetisation because of pain			
Ignoring women's pain during episiotomy and repair	Dissatisfaction with obstetricians' or midwives' actions		
Mistreating women during repair			
Obtaining uninformed consent	Failure to obtain informed consent to episiotomy	Women not being included in decision making	
Failure to obtain written informed consent			
Failure to inform women before performing an episiotomy			
Absolute trust in obstetricians or midwives regarding type of birth	Deprivation of the right to choose		
Absolute trust in obstetricians or midwives regarding episiotomy			
Inducing absolute trust in obstetricians or midwives			
Inadequate knowledge	Mandatory acceptance of episiotomy		
Lack of experience			
Mandatory acceptance of episiotomy			
Condition of the newborn			

Women' expectations of obstetricians or midwives

Some participants experienced 'unbearable' pain and burning sensations during episiotomy repair and expected obstetricians or midwives to respond appropriately. This subcategory included two codes: 'expecting painless repair' and 'expecting re-anesthetisation because of pain'.

Participants did not anticipate pain after labour, expecting a painless and comfortable time following birth.

> ***'I expected not to feel such pain after bearing the pain of childbirth and wanted to be relieved'. P4, episiotomy in first birth***

Some participants expected re-anesthetisation because of the pain they felt:

> ***'I wished that they would anesthetise me again so that I would not feel the pain, but it was so annoying'. P6, episiotomy in first childbirth***

Dissatisfaction with obstetricians' or midwives' actions

This subcategory included two codes: 'ignoring women's pain during episiotomy and repair' and 'mistreating women during repair'.

Some participants informed obstetricians or midwives of the pain or burning sensation they felt during the episiotomy but received improper responses.

> ***'I told them the incision was painful, and they said that it wasn't important and that I should keep calm'. P14, episiotomy in all four births***

> ***'I told them the suturing was painful and I felt burning, and they said it was normal and was the same for everybody'. P12, episiotomy in first birth***

Participants reported inappropriate behaviour from obstetricians or midwives during the repair.

> ***'I told them suturing was painful, and they said that I was talking too much and they could not anesthetise me anymore because they already had and I should bear the pain'. P4, episiotomy in first birth***

Women not included in decision making

Participants reported that they were in a passive state from the time of admission to the completion of birth because they signed an uninformed consent to any intervention during birth, such as an episiotomy or

urinary catheter insertion. Ultimately, they felt forced to submit to an episiotomy, one of the most sensitive and important obstetric surgeries, as a result of a lack of experience and information. This category consisted of three subcategories: 'failure to obtain informed consent', 'deprivation of the right to choose' and 'mandatory acceptance of episiotomy'.

Failure to obtain informed consent

This subcategory included three codes: 'obtaining uninformed consent', 'failure to obtain written informed consent' and 'failure to inform women before performing an episiotomy'.

> ***'Consent? I don't remember such a thing. I don't think they had my consent. I remember whatever I signed or wrote on that day, and there was no such a thing at all'. P1, episiotomy in first birth***

> ***'I did not fill in or sign a consent form'. P3, episiotomy in first birth***

Participants reported that they were not informed before an episiotomy was performed.

> ***'[The midwife] did not tell me during childbirth that she was going to do an incision, just did the incision quickly and took the baby out. I would have been prepared if I had been told beforehand'. P13, episiotomy in first and second birth***

Deprived of the right to choose

This subcategory included three codes: 'absolute trust in obstetricians or midwives regarding type of childbirth', 'absolute trust in obstetricians or midwives regarding episiotomy' and 'inducing absolute trust in obstetricians or midwives'.

Participants reported that they were encouraged to have absolute trust in obstetricians or midwives and taught to do so.

> ***'We were just told in prenatal classes that we should not insist on not having the incision and that we should trust the doctor, otherwise the tearing would be worse'. P9, episiotomy in first birth***

Some participants believed that they were in a special situation because of physical pain and emotional stress during childbirth. They felt forced to forego making decisions and instead trust obstetricians or midwives completely during labour because of their lack of sufficient information or their wish to be relieved of labour pain. Some participants had absolute trust in obstetricians or midwives regarding an episiotomy.

> ***'In the hospital, you trust the people around. You have no access to anywhere, just to that person and accept whatever they say. If the doctor says "caesarean", you accept it, and if he says "normal birth", you accept it'. P11, episiotomy in first birth***

Mandatory acceptance of episiotomy

This subcategory consisted of four codes: 'inadequate knowledge', 'lack of experience', 'mandatory acceptance of episiotomy' and 'condition of the newborn'.

Participants reported that they felt their insufficient information and inexperience were reasons to accept a mandatory episiotomy.

> ***'If I had been informed and known from the outset, I would not have allowed the incision'. P7, episiotomy in first birth***

> ***'This happened because it was my first childbirth and I had no experience'. P7, episiotomy in first birth***

For some, undergoing an episiotomy without prior notice meant that they accepted it without protest.

> ***'I had no problem with the incision because the doctor said that the incision was very small and it would cause no problem'. P1, episiotomy in first birth***

> ***'I am not upset about this incision'. P11, episiotomy in first birth***

In emergencies, participants gave priority to the condition of their newborn over their right to choose, and considered an episiotomy to be necessary to savethe child and ensure its health.

> ***'Giving birth to a healthy baby was important to me, and I did not care about the suture if it helped'. P2, episiotomy in first birth***

Discussion

This study explored women's experiences of the episiotomy consent process in Iran. Women's rights should be respected by healthcare staff while their medical and health needs are addressed. However, studies have shown that globally, a woman's right to informed consent during childbirth is often undermined or ignored (Wolf and Charles, 2018). Accepted reasons to forgo informed consent are life-threatening or emergency situations and the protection of a woman's life (Wolf and Charles, 2018).

Women' unmet needs

The present study's results show that the needs of the participants during an episiotomy had not been met. They

expected obstetricians and midwives to respond to their needs, and this had a significant effect on their satisfaction. Satisfaction is a cognitive and emotional response, during which a service recipient confirms the fulfillment of their needs, and in medical services, both psychosocial and physical needs are important. This means meeting their needs, including by avoiding unnecessary intervention and through proper and principled communication between obstetricians/midwives and women, as well as the active participation of women during childbirth (Hashemi et al, 2017; Arbabi et al, 2020).

Women's expectations of obstetricians and midwives were evident from their experiences. A medical team should be adequately aware of and informed about a service user's needs and how to satisfy them. They should also be sufficiently familiar with the conditions that satisfy these needs and respect women's human rights while meeting these needs (Musaei et al, 2010). A qualitative study of women's experiences following severe perineal trauma showed how women can feel vulnerable and helpless throughout childbirth, suturing and postpartum, and found that these feelings were a direct consequence of obstetricians' or midwives' actions (Priddis et al, 2014). The actions of obstetricians or midwives during labour, childbirth and postpartum directly impact how women process and understand their feelings following severe perineal trauma. Women who experience severe perineal trauma and its complications may compare this permanent change in themselves with other women who have had a vaginal birth with no perineal trauma (Priddis et al, 2014). Midwives and obstetricians should therefore strike a balance between maintaining the medical perspective and responding to women's needs. While care providers may consider their actions and interactions normal, some women consider them injurious. Therefore, care providers need to know how their actions affect women's emotional and mental experience of childbirth in addition to its physical outcome (Nieuwenhuijze et al, 2014; Reed et al, 2017).

Dissatisfaction with obstetricians' and midwives' performance was an important element of women's experiences of episiotomy in a study conducted by Diorgu and Steen (2017), which found that in addition to a failure to obtain informed consent, episiotomies were performed without local anesthesia, a treatment that women regarded as inhumane and harsh. However, health obstetricians and midwives have different views of women's experiences (He et al, 2020). Some believe that episiotomy pain is usually tolerable, both during suturing and the postnatal period. For this reason, obstetricians and midwives have been reported not to check that women are effectively anesthetised during suturing (He et al, 2020). In addition, the expectation of pain tolerance extends to the postnatal period. Woman may request pain relief after birth, but obstetricians or midwives reject the request because the level of pain is thought by them to be tolerable (He et al, 2020).

Key points

- Respecting women's rights when an episiotomy is required, and complying with professional ethics' standards, play an essential role in improving the health of mothers and improving medical services.
- In many cases, these rights are not respected in Iran.
- This matter requires proper planning, promotion of midwives' professional knowledge and ethics and the use of the charter of ethics.
- Obtaining informed consent, informing a woman before performing an episiotomy, ensuring a woman's participation in decision making and giving women the right to choose episiotomy are essential to ensure women's satisfaction with their experiences of an episiotomy.

Intentional or unintentional disrespect and mistreatment on the part of obstetricians and midwives during childbirth adversely affects women's experiences of childbirth and violates their right to dignified and respectful care. It is important to note that care providers' disrespect is not always intentional and can be accompanied by other respectful and compassionate forms of care (Bohren et al, 2015). Nonetheless, women's experiences of disrespect while receiving care should receive attention regardless of intention. Obstetricians or midwives may provide explanations for women's negative experiences, but these explanations should not be used to justify the continued disrespect of women (Diorgu and Steen, 2017).

Women not included in decision making

An important issue for the present study's participants was failure to obtain informed consent. Some specialists believe that episiotomy is a surgical procedure that can be done without a woman's consent, as they feel it is a small operation, with limited and controllable complications (da Costa et al, 2011). Dengo et al (2016) reported that women felt the lack of prior consent was important because, according to the women interviewed, most were not consulted about the procedure beforehand. Moreover, some only realised that they had undergone an episiotomy when the incision was being repaired.

An episiotomy is considered a surgery, but women may not be given the right to decide whether they want to have it. It is therefore an invasive act, both physiologically and psychologically. Women should be informed, and their informed consent should be obtained before the procedure. Furthermore, they should know about the potential risks and benefits without violating their sexual and reproductive rights. Studies have confirmed that women experience negative emotional and psychological consequences of episiotomy, which violate their rights and deprive them of independence and the right to

control their bodies (Mselle et al, 2013; Okafor et al, 2015; Dengo et al, 2016). The violation of rights and lack of autonomy may affect a woman's mental and emotional health, in addition to disrespecting them and depriving them of the right to control their bodies (Ibrahim et al, 2018). Women want to be involved in the process of decision making and the management of childbirth. When these needs are not met, they experience negative emotions such as fear, anger and despair, as well as feelings of powerlessness, vulnerability and the inability to make informed decisions regarding self-care (Elmir et al, 2010; Stankovic, 2017).

The Ministry of Health of Brazil has improved perinatal and childbirth midwifery services and made changes to their maternity healthcare model. These changes focus on humane care that respects the entire physiology of labour and the process of childbirth and regards providing women with information as a way to promote empowerment, share responsibilities and encourage women to be independent (Quitete and Vargens, 2009; Malheiros et al, 2012). The aim of empowering women is to allow them to have a fully dignified, safe and independent experience of pregnancy, childbirth and the postpartum period (Prata et al, 2017). In Iran, the present study results suggest that there is still a long way to go in allowing women's independent decision-making power, as their right to choose and make decisions is currently in the hands of obstetricians and midwives. Women's right to make informed decisions and choices must be upheld and encouraged by obstetricians and midwives (Dengo et al, 2016).

An important issue perceived by the present study's participants was that they were deprived of the right to choose. Women have the right to be informed about the care they receive, and in this way, are empowered to participate in making decisions that affect their lives (de Souza et al, 2011). Diorgu and Steen (2017) investigated Nigerian mothers' perceptions of disrespect during labour and reported that they felt that there was a lack of freedom of choice regarding episiotomy and birth position. Additionally, they showed that midwives and obstetricians dominated the process of childbirth care. Some participants were never consulted about an episiotomy, and, for some, even the birth position was chosen and executed by obstetricians or midwives.

In the present study, the participants reported accepting the decisions made by people they considered to be specialists and believed that their knowledge and expertise gave them the power to dominate and control the childbirth process. Decision making by obstetricians or midwives may be based on the belief that a woman's dissent can be harmful to them and should be considered to be disobedience (Diorgu and Steen, 2017). A qualitative study by Dengo et al (2016) showed that women felt that their body could not endure natural childbirth without an episiotomy and, therefore, that they needed the obstetricians' or midwives' help to widen the birth canal by episiotomy to facilitate the passage of the fetus with less risk. Furthermore, women's lack of information forced them to assume an obedient role and comply with the decisions made by specialists.

Episiotomy is associated with other interventions in childbirth, such as forced supine position during childbirth or instrumental birth (Mselle and Eustace, 2020). These interventions consolidate and reflect obstetricians' and midwives' intervention and control during childbirth, meaning women are deprived of their role and the choice to have a natural childbirth. Women's lack of information about their body and episiotomy leads to significant consequences, particularly regarding specialists' power and control over women's bodies, through the idea that the episiotomy is a necessary procedure to help them in a natural process (de Souza et al, 2011; Dengo et al, 2016). Other studies have shown that because of excessive interventions and over-medicalisation, women do not consider childbirth a physiological process, allowing specialists to have dominance over a mother's body (Wey et al, 2011; Dengo et al, 2016). These results show the need to restore women's independence in the process of childbirth in Iran.

Mandatory acceptance of episiotomy was an important element of participants' responses in the present study. During childbirth or even pregnancy, the participants did not receive information about episiotomy, leading to a lack of knowledge of the procedure. They were subsequently forced to accept an episiotomy and its risks without prior knowledge. Women have been reported to enthusiastically seek information during prenatal care and increase their own knowledge by exchanging information with other women (Malheiros et al, 2012). By obtaining relevant information, women can be empowered to make decisions and have more control over their bodies (Quitete and Vargens, 2009; Malheiros et al, 2012).

The lack of informed consent appears to be widespread and has been reported in other similar studies. Women with episiotomy experience have reported that they did not know this would happen and did not receive any information about it before or during childbirth (Dengo et al, 2016; He et al, 2020). Being informed may strengthen women's autonomy during childbirth, and this is an important challenge in women's health care (Previatti and Souza, 2007). According to international guidelines, the failure to inform women and obtain their consent before an episiotomy is considered unethical care and can be considered physical abuse (Miller and

Lalonde, 2015). Planning for this procedure and other interventions should be part of antenatal education (Amorim and Katz, 2008; Dengo et al, 2016).

Strengths and weaknesses

This qualitative study is the first in Iran to investigate women's experiences of the episiotomy consent process. Its strengths included the diversity of participants (primiparous and multiparous women). Additionally, although there was a potential for recall bias, many participants had no difficulty recalling the event, which shows the profound effect of their experiences.

The study limitations included non-generalisability of the results, although this is often the case in qualitative studies. Some participants lacked knowledge of their rights, which likely affected their ability to recognise relevant incidences and ethical challenges.

Conclusions

Childbirth often involves medical interventions that women must consent to before they are performed or carried out. Women consent both on their own behalf and on behalf of their unborn child. The physical pain, emotional pressure or emergency medical interventions that are often associated with childbirth do not impede women's legal eligibility, and no treatment, even with the best of intentions, should be performed without their consent.

The present study investigated women's experiences of the episiotomy consent process and its results show that there are many challenges that should be considered when providing services. Episiotomy procedures can be ethically and legally challenged by not including women in decision making. Neglecting women's expectations, inducing absolute trust in obstetricians or midwives and the failure to obtain informed consent may pave the way for a forced episiotomy. Proper education and obtaining informed and voluntary consent ensures women's rights are respected when undergoing episiotomy. **BJM**

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