International Journal of Women's Health

Dovepress
Taylor & Francis Group

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COMMENTARY

Women's Right to Surgical Self-Consent: A Legal and Moral Imperative for Somalia

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Abstract: In Somalia, the cultural requirement for male family authorization before surgical procedures even in emergencies remains a silent but deadly barrier to timely care. This practice, particularly in obstetric emergencies such as caesarean section, delays life-saving interventions, heightening risks for mothers and newborns. Evidence from Somaliland shows that nearly half of prolonged caesarean section delays are due to family decision-making for consent, with a measurable increase in severe maternal outcomes. This article is presented as a policy commentary aimed at highlighting the impact of current consent practices on women's health and proposing feasible reforms. Respectfully, this commentary urges lawmakers, healthcare leaders, and community elders to consider a compassionate reform that enshrines a woman's right to make informed decisions about her own health. By aligning policy with both ethical medical practice and Islamic principles of preserving life, Somalia can move toward a safer, more equitable maternal health system. This commentary recommends five key actions: legally affirming women's right to self-consent, enabling emergency presumed consent when delays endanger life, introducing advance antenatal consent to prevent avoidable delays in emergencies, engaging communities to build understanding and acceptance, and strengthening provider training to support respectful and timely decision-making.

Keywords: women's health, health policy, maternal mortality, Somalia, patient autonomy

Maternal health challenges in Somalia are still among the most difficult problems to solve in the world. The maternal mortality ratio of 563 per 100,000 live births.[1] While many factors contribute to this figure limited resources, infrastructure gaps, and the shortage of skilled providers. There is one quiet but significant cause that merits our collective attention, the requirement for male family consent before a woman may undergo surgical care, even when she is competent and in urgent need.

Surgical informed consent is the process through which a patient receives adequate information about a proposed procedure and voluntarily authorizes it.[2] In Somalia, however, married women are often not permitted to provide consent independently, and male relatives most commonly husbands or fathers must authorize surgical interventions on their behalf. This practice creates significant delays in care.

In Somaliland's national referral hospital, 48% of delays exceeding three hours for caesarean section were caused by the need to obtain family consent, most often from male relatives.[3] This delay was associated with a 58% increase in severe maternal outcomes.[3] Financial factors may also prolong decision-making because cesarean section is not universally free, and households may need time to agree on who will cover the cost.

Similar challenges with women's autonomy in surgical consent have been documented in other sub-Saharan African settings, particularly in Nigeria and Ethiopia, where gender norms and family authority structures also limit women's participation in medical decision-making. Studies show that in many Nigerian hospitals, husbands or senior male relatives are often expected to authorize obstetric and surgical procedures, and women may be excluded from discussions about their own care.[4] In Ethiopia, research highlights that social expectations and paternalistic provider attitudes contribute to limited involvement of women in consent processes, especially during emergency obstetric procedures.[5] While these patterns reflect broader regional challenges, the Somali context remains uniquely urgent due to the combination of high maternal mortality, stronger cultural expectations of male-led consent, and legal ambiguity requiring family authorization in emergencies.

Received: 27 August 2025
Accepted: 13 December 2025
Published: 18 December 2025

The practice of requiring male family consent before a woman may undergo surgery is deeply rooted in Somalia's cultural history, where decisions related to health, finances, and family honor have traditionally been made collectively and led by male relatives. These long-standing norms help explain why the practice has persisted, despite its documented risk, many families continue to view consent as a shared household responsibility rather than an individual right. Change has also been slow due to sociocultural expectations around gender roles, limited public awareness of patient autonomy, and the absence of clear legal guidance for clinicians, themes echoed in regional studies on obstetric consent practices.[5] Evidence from other sub-Saharan African countries, including Ethiopia and Nigeria, demonstrates similar where women's involvement in surgical decision-making is constrained by family authority structures and social expectations.[4] However, several countries have begun implementing reforms such as establishing clearer legal frameworks and improving provider communication that show how culturally sensitive policy changes can expand women's autonomy while respecting community values.

Although the strongest available evidence comes from obstetric emergencies such as cesarean delivery, the requirement for male family consent applies across many surgical fields in Somalia. Women frequently lack the authority to provide informed consent for a range of surgical procedures, not only those related to Obstetrics and Gynecology. This pattern is consistent with studies across Sub-Saharan Africa showing systemic barriers to women's participation in surgical decision-making[4] Obstetric cases are emphasized in this commentary because they are the most extensively documented and carry the highest risk of morbidity and mortality in the Somali context.

These norms stem from deep-rooted traditions meant to protect family unity and ensure decisions are made with care. Yet, in the context of emergency medicine, they can inadvertently place women's lives at risk. The WHO Handbook for Guideline Development reminds us that respect for patient autonomy and the urgency of timely surgical intervention are not mutually exclusive they must coexist.[6]

International evidence also shows that delays in accessing emergency obstetric care directly contribute to preventable maternal deaths, as demonstrated in studies from Mozambique.[7] Moreover, Islamic jurisprudence (fiqh) places preservation of life as a supreme principle, offering a compassionate foundation for reform.

Clinicians working in Somalia have described the emotional difficulty of witnessing preventable harm simply because consent could not be obtained in time [3]. These are moments of profound moral distress for providers and heartbreak for families.

A Path Toward Respectful Change

1. Legal Clarification – Clear legal guidance is a necessary first step in protecting women's right to make decisions about their own health. As highlighted in regional reviews, surgical informed consent in sub-Saharan Africa is often shaped by long-standing social norms that limit women's autonomy.[4] In Somaliland, clinicians have noted that the law requires consent from husbands or relatives before performing a cesarean section, even during emergencies a situation that places both women and providers in difficult positions.[5] Explicitly grant competent adult women the right to consent to their own medical and surgical care.
2. Emergency Presumed Consent – In life-threatening situations, delays caused by searching for relatives to authorize surgery can be fatal. WHO guidance emphasizes that clinicians should act promptly to preserve life when waiting for formal consent would result in harm. This principle is especially relevant in emergency obstetric care, where even short delays can worsen outcomes.[5] Empower clinicians to act immediately in life-threatening situations, consistent with WHO recommendations.[6]
3. Community Engagement – Dialogue with religious leaders, elders, and women's groups to foster shared understanding and acceptance. Sustainable change requires more than clinical protocols it depends on community understanding and support. Studies across sub-Saharan Africa, including Somalia, show that cultural expectations, mistrust, and misconceptions about procedures like cesarean section can strongly influence family decision-making.[5] By involving religious leaders, elders, and women's groups in dialogue, it becomes possible to align medical recommendations with cultural values and strengthen community trust in women's right to consent.
4. Provider Training – Equip healthcare workers with the tools to navigate sensitive situations while respecting autonomy.[4,5] Healthcare providers play a central role in ensuring informed consent is meaningful and respectful. However, evidence shows that many providers have limited training in communication and ethical aspects of

consent, particularly in emergency contexts.[4] Strengthening provider training can improve the quality of conversations with patients, reduce misunderstandings, and ultimately support timely and patient-centered decision-making.[5] Investing in such training would directly enhance women's experiences and outcomes.

5. Planning Ahead Through Antenatal ConsentAs a practical short-term step while broader policy reforms are still in progress, antenatal care records could include advance consent from the woman's husband or designated family decision-maker. This would help clinicians act quickly during obstetric emergencies when the woman is unable to provide consent and family members cannot be reached. Although this measure is not a replacement for ensuring women's full legal autonomy, it offers a compassionate and realistic way to reduce preventable delays under the current legal and cultural framework.

Anticipated Challenges and Policy Implications

Implementing reforms to strengthen women's surgical self-consent in Somalia will require addressing several challenges. Cultural resistance remains significant, as many families continue to view male-led consent as customary and protective. Progress is also slowed by the lack of clear national policy, leaving clinicians uncertain in emergency situations. Community education will be essential to correct misconceptions about procedures such as cesarean section. The proposed reforms affect key actors: clinicians would gain clearer guidance, families would adjust to new decision-making roles, and government bodies would take responsibility for establishing and enforcing policy. Recognizing these challenges helps outline practical steps toward a safer and more equitable system for women's surgical care.

Conclusion

The requirement for male consent before urgent surgical intervention is not simply a cultural formality, it is a barrier that costs lives. Several practical steps can help initiate meaningful change. Policymakers can begin by drafting clear national guidelines that affirm women's right to provide their own medical consent, while also outlining emergency pathways such as presumed consent when delays threaten life. Training programs for healthcare providers can strengthen confidence and consistency in navigating sensitive consent situations. In parallel, public education campaigns through antenatal clinics, community centers, and religious institutions can raise awareness about women's rights and the importance of timely decision-making during emergencies.

By enacting compassionate reforms rooted in both ethics and faith, Somalia can save mothers and newborns, uphold women's dignity, and strengthen trust in its healthcare system. The time to act—with empathy and respect—is now.

Acknowledgments

The author would like to express sincere gratitude for encouragement and support for the Center of Research and Development, SIMAD University.

Disclosure

The author declares no conflicts of interest in this work.

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