# Self-Rated Competence of Ugandan Healthcare Workers to Obtain Informed Consent for Autopsy

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*Abstract.* We examined the self-rated competence of Ugandan healthcare workers (HCWs) in obtaining informed consent for autopsies, considering the challenges of low autopsy acceptance rates globally. In September and October 2023, we conducted a nationwide cross-sectional study of HCWs, who provided informed consent to participate and completed an online, self-administered questionnaire. Participants' self-rated competence in obtaining informed consent for autopsy was assessed through Likert scale questions. Knowledge and practices were also assessed. All scores were converted to percentages, with scores ≥80% indicating higher competence. We enrolled 216 HCWs (including 145 [67.1%] doctors), with a mean age of 31.6 ± 7.2 years. Overall, 55.6% ($n = 120$) had ever assisted in obtaining consent for autopsy, 43.6% ($n = 100$) had ever obtained consent for autopsy themselves, and 13.4% ($n = 29$) had ever attended training on obtaining consent for autopsy. The mean competency score was 59.8 ± 17.0% (perfect score, 100%), with 29 (13.4%) participants demonstrating high competence. Healthcare workers with adequate knowledge had higher competence scores (odds ratio [OR]: 15.0, 95% CI: 6.17–36.58, $P < 0.001$). Compared with nurses/midwives, doctors had 73% lower odds of having a high competence score (adjusted OR: 0.27, 95% CI: 0.08–0.94, $P = 0.040$). Fewer than one in five Ugandan HCWs demonstrated high self-rated competence or possessed adequate knowledge regarding informed consent for autopsies, and only a few had received specialized training on how to obtain consent for an autopsy. Therefore, there is a pressing need for enhanced training and increased awareness among Ugandan HCWs in obtaining informed consent for autopsies.

## INTRODUCTION

Postmortem autopsy remains a crucial diagnostic tool and is considered the gold standard for accurately determining the causes of death, thus playing a significant role in providing accurate data on the actual burden of disease and related mortality rates.[1,2] Such information serves as an important basis in the development of informed policies, interventions, and public health strategies regarding disease prevention, control, and eventual eradication within a community.[1,2]

In low- and middle-income countries such as Uganda, the acceptance rate of hospital autopsies (non-medicolegal postmortem examination) remains a critical concern, presenting significant challenges to the precise determination of causes of death.[3] Despite the well-established diagnostic benefits of autopsies in different health conditions, some community members consider this procedure unacceptable, thus leading to high rates of nonacceptance. Although there is limited evidence worldwide, reported autopsy acceptance rates range from 38% to 75%.[4–6] Various reasons for nonacceptance have been documented, including the desire to avoid burial delays, perception of no utility in knowing the cause of death, contentment with the clinical diagnosis, time constraints, fear of disfigurement, and adherence to cultural practices.[4,6,7] Notably, greater knowledge about the process and reasons for autopsy examinations have been shown to increase the likelihood of being willing to provide consent for the procedure.[5] Therefore, such factors can be used to increase autopsy acceptance rates.

The process of obtaining informed consent for autopsy requires healthcare workers (HCWs) to possess not only a comprehensive understanding of the ethical framework governing autopsies but also the skills and ability to effectively communicate with grieving families to secure their consent for autopsy.[8,9] The challenging task of translating complex medical concepts into a simple and easily comprehensible language adds to the complexity of this process. In addition, the influence of sociocultural factors should be taken into consideration during the communication process, as these factors significantly shape the families' decisions regarding autopsies.[5,10] Unfortunately, most HCWs are not adequately trained in the intricacies associated with obtaining consent from grieving families for the autopsy of their loved ones.[11]

Limited data exist regarding the competence of HCWs in obtaining informed consent for autopsy. However, we hypothesized that the prevailing low acceptance rates may be attributed to a perceived low level of competence among HCWs in effectively communicating with patients or their caregivers to consent to autopsies. Therefore, this study aimed to investigate the self-rated competence of Ugandan HCWs in obtaining informed consent for autopsies.

## MATERIALS AND METHODS

**Study design.** In September and October 2023, we conducted a nationwide online cross-sectional study to assess the self-rated competence of HCWs in Uganda regarding the process of obtaining informed consent for autopsies.

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**Participants.** The study participants were HCWs actively involved in clinical care and were likely to be asked to be involved in obtaining patient consent for autopsies. They were from diverse specialties including medical officers, midwives, clinical officers, and nurses across different levels of clinical practice from private to public and lower health facilities to national specialized referral hospitals. All participants were 18 years of age or older, had completed a health-related program, and provided informed consent to participate in the study. We excluded Ugandan HCWs not directly involved in patient care.

**Data collection.** An online, self-administered questionnaire was developed using KoBoToolbox, open-source software developed by the Harvard Humanitarian Initiative with support from United Nations agencies, CISCO, and partners to support data management by researchers and humanitarian organizations (https://www.kobotoolbox.org/). The servers are secure and encrypted with strong safeguards and protection against data loss. The link to the data collection study tool was shared on major platforms for nurses, doctors, and midwives, including hospital pages; medical, midwifery, and nursing school alumni groups; and the Uganda Medical Association WhatsApp groups.

*Data collection tool.* The data collection tool was developed by the authors and reviewed by a panel of experts in medical ethics, autopsy pathology, infectious diseases, and research methodology to ensure content validity. Additional questions were obtained from a literature review.[12] Prior to data collection, a pilot study was conducted to assess the questionnaire's clarity, reliability, and appropriateness among HCWs in a single WhatsApp group who were later excluded from the final enrollment. Questions with Cronbach $\alpha$ scores <0.7 were removed from the questionnaire.

The data collection tool comprised four sections including sociodemographics, self-rated competence, knowledge, and practices regarding obtaining informed consent for autopsy.

The sociodemographic section had seven questions including age, sex, professional designation, place of work, level of hospital, and years of experience in the healthcare field. Self-rated competence was assessed using 10 questions assessing participants' self-perceived competence in obtaining informed consent for autopsies using a Likert scale, ranging from "strongly disagree" to "strongly agree." In addition, participants rated their overall competence on a numerical scale from 0 to 10.

The knowledge and practices sections had 10 questions and 16 questions, respectively. These included questions assessing participants' knowledge of legal and ethical requirements for obtaining consent, their understanding of autopsy procedures, and their communication skills.

## STATISTICAL ANALYSES

Categorical data were presented as frequencies and percentages, and continuous data were summarized as mean and SD or median and interquartile range as appropriate. For self-rated competence questions, a 5-point Likert scale was used. Answers were categorized into five equal range levels through the following equation: length of category = (maximum value − minimum value) divided by number of alternatives (i.e., $[5 - 1] \div 5 = 0.80$) (Table 1).

TABLE 1
Distribution of categories

| Likert Scale | Range |
| --- | --- |
| Strongly agree | 4.21–5.00 |
| Agree | 3.41–4.20 |
| Neutral | 2.61–3.40 |
| Disagree | 1.81–2.60 |
| Strongly disagree | 1.00–1.80 |

Mean scores and SDs were calculated for the self-rated competence and knowledge sections. We converted the mean scores to percentages, and based on the modified Bloom's cutoff point, an HCW who scored ≥80% on the correct knowledge questions section was considered to have "adequate knowledge," whereas HCWs who scored <80% were considered to have "inadequate knowledge." Similarly, HCWs who scored ≥80% on the self-rated competence questions section were considered to have high self-rated competence. We conducted multivariable logistic regression to assess the association between high self-rated competence and selected exposures. Variables with a $P < 0.2$ at bivariable analysis and those known to describe competence from the literature were added to the multivariable model and adjusted for confounding. We also assessed the relationship between competence and knowledge of the participants using Pearson's correlation. Data were analyzed in Stata v. 15.0 (StataCorp LLC, College Station, TX). A $P < 0.05$ was considered statistically significant.

**Ethical approval plan.** The study protocol was approved by the Gulu University Research and Ethics Committee (#GUREC-2023-635). Informed consent was sought from all participants. Ethical regulations outlined in the Declaration of Helsinki were observed throughout the study. Anonymity was guaranteed during data collection to ensure confidentiality and encourage honest responses. No hospital- or participant-identifiable information beyond basic demographics was requested.

## RESULTS

**Participant characteristics.** Of the 216 participants enrolled, most (69.0%; $n = 149$) were 25–34 years old (mean age ± SD: 31.6 ± 7.2 years). More than two-thirds (70.4%; $n = 152$) were men, and slightly more than a half (51.9%, $n = 112$) had attained a bachelor's level of education. More than a third (47.2%; $n = 102$) worked at public hospitals. Less than a quarter (13.4%) had ever attended a training session related to obtaining consent for autopsy (Table 2).

**Self-rated competence and knowledge of HCWs regarding obtaining informed consent for autopsy.** The mean score for the competence questions was 59.8 ± 17.0, and 13.4% ($n = 29$) reported a high self-rated competence score (≥80% overall score for the competence questions). When the participants self-rated their competence on a scale of 0–10, 18.9% ($n = 41$) reported a high competence score (≥80%) in obtaining informed consent for autopsy.

The mean score for the knowledge questions was 40.3 ± 32.8; 18.5% ($n = 40$) had adequate knowledge about obtaining informed consent for autopsy (i.e., had an overall score of ≥80% for the knowledge questions) (Table 3).

**Practices of HCWs regarding obtaining informed consent for autopsy.** Just over half (54.2%; $n = 117$) reported that they rarely or never engaged in open and transparent communications with patients or their family members during the

TABLE 2
Sociodemographic characteristics of the participants

| Characteristic | Frequency (%) |
|---|---|
| Age (in years), mean ± SD | 31.6 ± 7.2 |
| 20–24 | 14 (6.5) |
| 25–34 | 149 (69.0) |
| ≥35 | 53 (24.5) |
| Sex | |
| Male | 152 (70.4) |
| Female | 64 (29.6) |
| Professional designation | |
| Nurse/midwife | 52 (24.1) |
| Clinical officer | 19 (8.8) |
| Medical officer/intern doctor | 93 (43.1) |
| Specialist/senior house officer* | 52 (24.1) |
| Place of work (type of hospital) | |
| Private for profit | 48 (22.2) |
| Public hospital | 102 (47.2) |
| Private not for profit | 56 (25.9) |
| Clinic | 19 (8.8) |
| University teaching hospital | 32 (14.8) |
| Level of hospital | |
| Health center IV | 37 (17.1) |
| General hospital | 58 (26.9) |
| Regional referral | 40 (18.5) |
| National referral | 43 (19.9) |
| Clinic | 24 (11.1) |
| Medical center | 26 (12.0) |
| Other† | 19 (8.8) |
| Work experience (in years) | |
| Median (IQR) | 5 (2–8) years |
| ≤5 | 120 (55.6) |
| 6–10 | 63 (29.2) |
| ≥10 | 33 (15.3) |
| Ever attended a training related to obtaining autopsy consent | |
| Yes | 29 (13.4) |
| No | 187 (86.6) |

IQR = interquartile range.
* Specialties included internal medicine, pediatrics, pathology, surgery, obstetrics and gynecology, emergency medicine, psychiatry, and anesthesia.
† Other levels of hospitals were health center III, and nongovernmental organization.

process of seeking consent for autopsy. Just less than half (43.6%; $n = 100$) had ever obtained consent for autopsy, and 55.6% ($n = 120$) had ever assisted in obtaining consent for autopsy (Table 4).

**Relationship between evaluated competence and knowledge in obtaining informed consent for autopsy.** There was a strong relationship between evaluated competence and knowledge of HCWs regarding obtaining informed consent for autopsy ($r = 0.714$, $P < 0.001$) (Figure 1). There was no statistically significant difference in competence ($P = 0.835$) or knowledge ($P = 0.318$) scores across cadres of HCWs.

**Factors associated with high competence scores.** Healthcare workers with adequate knowledge had higher competence scores (odds ratio [OR]: 15.0, 95% CI: 6.17–36.58, $P < 0.001$). Compared with nurses/midwives, doctors had 73% lower odds of having a high competence score (adjusted OR: 0.27, 95%CI: 0.08–0.94, $P = 0.040$) (Table 5).

## DISCUSSION

In this study, which was designed to assess the self-rated competence of HCWs in Uganda in obtaining informed consent for autopsies, several key findings emerged. We found that only 13.4% of HCWs had high competence. Furthermore, only 18.5% of the participants had adequate knowledge of informed consent processes for autopsy. This suggests that a considerable number of HCWs were not adequately prepared for this important task, potentially affecting the quality and ethical conduct of autopsies. Our findings have implications in designing interventions to improve the practice of obtaining informed consent for autopsies in healthcare settings in Uganda. In Uganda, nurses, midwives, and doctors undergo training in obtaining consent for treatments and procedures, including autopsies, as part of their undergraduate curriculum. After qualifying and obtaining a practicing license, individuals from these professions are considered eligible to obtain consent for hospital autopsies.

Informed consent is a crucial component in medical practice, as it is a fundamental pillar in the ethical principles that guide healthcare.[13] In medical practice, informed consent involves a thorough and systematic process of providing sufficient information about the potential risks, benefits, and alternative options associated with a specific medical

TABLE 3
Self-rated competence of Ugandan healthcare workers regarding obtaining informed consent for autopsy

| Variable | Mean | SD | Description |
|---|---|---|---|
| On a scale of 1–5, how would you rate your confidence in explaining the purpose and procedure of autopsies to patients or their family members? | 3.4 | 1.04 | Neutral |
| How competent do you consider yourself in discussing the potential benefits and risks of autopsies with patients or their family members? | 3.2 | 0.99 | Moderately Competent |
| To what extent do you feel skilled in addressing patients' or family members' concerns and answering their questions related to autopsies? | 3.1 | 0.99 | Moderately Skilled |
| How knowledgeable do you perceive yourself to be about the legal requirements for obtaining patient consent for autopsies? | 2.7 | 1.06 | Moderately Knowledgeable |
| How knowledgeable do you perceive yourself to be about the ethical requirements for obtaining patient consent for autopsies? | 2.9 | 1.04 | Moderately Knowledgeable |
| How confident are you in your ability to obtain informed consent from patients or their family members for autopsies? | 3.2 | 1.03 | Moderately Confident |
| How comfortable are you in dealing with cultural or religious considerations that may influence the autopsy consent process? | 2.9 | 1.06 | Neutral |
| How competent do you feel in accurately and comprehensively documenting consent for autopsies? | 3.0 | 1.13 | Moderately Competent |
| How well do you believe you communicate the potential emotional impact of autopsies on patients or their family members? | 3.1 | 1.05 | Neutral |
| To what extent do you feel prepared to handle questions or concerns related to organ donation in the context of autopsies? | 2.7 | 1.24 | Moderately Prepared |
| How confident are you in your ability to address any potential conflicts or disagreements among family members regarding autopsy consent? | 2.7 | 1.11 | Moderately Confident |
| Cumulative Mean Score | 4.0 | 0.85 | Moderately Competent |

TABLE 4
Practices of healthcare workers regarding obtaining informed consent for autopsy

| Variable | Frequency (%) |
| --- | --- |
| How often do you engage in open and transparent communication with patients or their family members during the autopsy consent process? | |
| Occasionally | 57 (26.4) |
| Rarely or never | 117 (54.2) |
| Most of the time | 28 (13) |
| Always | 14 (6.5) |
| Do you use any specific tools or visual aids to assist in explaining the purpose and procedure of autopsies to patients or their family members? | |
| Yes | 43 (19.9) |
| No | 173 (80.1) |
| Tools or visual aids used to assist in explaining the purpose and procedure of autopsies to patients or their family Members | |
| Brochures or pamphlets | 13 (30.2) |
| Diagrams or illustrations | 29 (67.4) |
| Videos or animations | 8 (18.6) |
| None of the above | 2 (4.7) |
| Other* | 1 (2.3) |
| How do you address potential language barriers when obtaining consent for autopsies? | |
| Use professional interpreters | 69 (31.9) |
| Use translated written materials | 25 (11.6) |
| Seek assistance from bilingual colleagues | 138 (63.9) |
| Other† | 12 (5.6) |
| How do you handle conflicts or disagreements among healthcare professionals involved in the autopsy consent process? | |
| Hold team discussions or meetings to resolve conflicts | 101 (46.8) |
| Seek guidance from a supervisor or senior colleague | 95 (44) |
| Follow institutional protocols or guidelines | 75 (34.7) |
| Have you encountered situations where patients or their family members have refused consent for an autopsy? | |
| Yes | 135 (62.5) |
| No | 81 (37.5) |
| If yes, how do you handle situations where patients or their family members refused consent for an autopsy? | |
| Provide further information and address concerns | 64 (47.4) |
| Respect their decision and explore alternative options, If available | 95 (70.4) |
| Involve a Medical ethics committee or legal advisor | 8 (5.9) |
| Other‡ | 1 (0.7) |
| How do you document and store consent forms and related information in accordance with legal and institutional requirements? | |
| Electronic medical record system | 27 (12.5) |
| Paper-Based Filing System | 148 (68.5) |
| Combination of Electronic and Paper-Based Systems | 48 (22.2) |
| Other§ | 9 (4.2) |
| How frequently do you seek feedback or engage in professional development activities to improve your skills in obtaining consent for autopsies? | |
| Rarely or Never | 135 (62.5) |
| Occasionally | 65 (30.1) |
| Regularly | 16 (7.4) |
| Aware of any institutional protocols or guidelines specifically related to obtaining consent for autopsies | 68 (31.5) |
| Ever obtained consent for an autopsy | 100 (46.3) |
| Ever assisted in obtaining consent for autopsy | 120 (55.6) |
| Ever observed an autopsy procedure | 151 (69.9) |
| Ever assisted in an autopsy procedure | 98 (45.4) |
| Ever performed an autopsy procedure | 21 (22.6) |
| Had exposure to autopsy during training | |
| Many times | 51 (23.6) |
| Sometimes | 65 (30.1) |
| Rarely | 46 (21.3) |
| Never | 54 (25) |
| Had exposure to autopsy during current clinical practice | |
| Many times | 21 (9.7) |
| Sometimes | 38 (17.6) |
| Rarely | 74 (34.3) |
| Never | 83 (38.4) |

* Other included results from mortuary.
† Other included use of a Google translator, other health workers, or patient caretakers who knew the language.
‡ Other included convincing the patient and family.
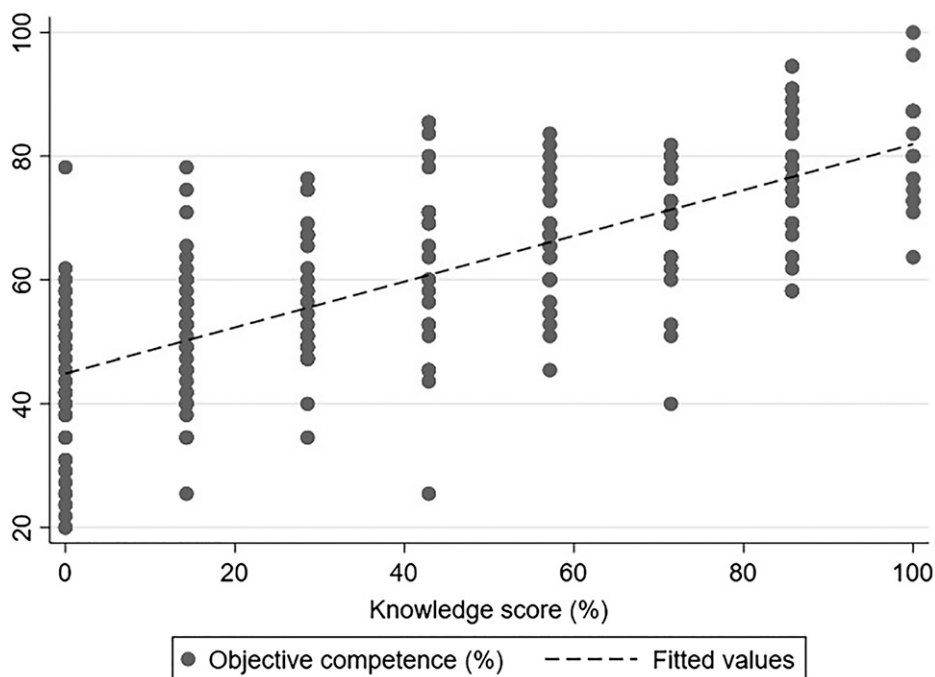§ Other included writing in the patient book.

FIGURE 1. Relationship between evaluated competence and knowledge of healthcare workers regarding obtaining informed consent for autopsy.

procedure or intervention, with the aim of ensuring that the recipient fully comprehends the information provided and allows them to decide what is best.[14] Furthermore, informed consent rests on the fact that the decision-maker should possess the competence to make a clear and voluntary decision regarding the procedure or intervention at hand.[14–16] However, the provision of informed consent among patients and next of kin is hindered by several factors such as emotional stress and anxiety related to illnesses, varying levels of health literacy leading to difficulty in interpreting medical information, and the influence of cultural beliefs and biases.[17–19]

In our study, the mean knowledge score on informed consent for autopsy was as low as 40%, and only about 19% scored ≥80%. The knowledge, skills, and practices of HCWs play a vital role in influencing acceptance and consent for any medical procedure. Our findings are consistent with a study in the Democratic Republic of Congo that found only about 30% of HCWs scored 80% or higher in knowledge related to informed consent, whereas in Ethiopia, about 50% properly practiced informed consent during procedures.[20,21] Similarly, among chief residents in major teaching hospitals in the United States, only 50% reported adequate knowledge and competence in obtaining informed consent for autopsy.[22] These findings highlight both knowledge and skills gaps in obtaining informed consent. Factors such as age, years of experience, adequate content of the consent form, proper training on informed consent, longer time dedicated to the consent process, and possessing adequate knowledge and positive attitudes have been shown to be significantly associated with proper informed consent practice.[20] We did not find any difference in knowledge scores across cadres, with doctors, nurses/midwives, and clinical officers demonstrating similar knowledge on informed consent for autopsy. Given the emotional turmoil and discomfort

among the bereaved family, obtaining informed consent is even more challenging to navigate.

We found that doctors were 73% less likely to have high competence in obtaining consent for autopsies compared with nurses. This observation is not surprising; with the high patient-to-doctor ratio in Uganda, doctors tend to shift many of their responsibilities, including obtaining consent for procedures, to nurses and midwives. Consequently, the lower cadres are actively involved in consenting patients and have gained more practical competence compared with doctors. A study in the United Kingdom revealed that most informed consents for autopsies are obtained by clinicians who are not part of the autopsy team. In that study, more than 65% of the pathologists involved in conducting autopsies reported that they were too busy to obtain informed consent, and more than 85% believed that consent for autopsies should be obtained by the clinical team responsible for the patients during their lifetime, rather than by pathologists.[23]

Furthermore, the relatively low evaluated competence scores compared with global self-assessment scores (13.4% versus 18.9%, respectively) suggest a degree of overestimation of self-awareness among HCWs regarding their competence in this area. Studies have shown that HCWs tend to overestimate their competence in clinical practice.[24] This is consistent with the Dunning-Kruger effect of cognitive bias, in which individuals with limited abilities lack the skills to recognize their own incompetence, resulting in an overestimation of their capabilities.[25]

**Limitations.** Our study is not without limitations. First, the sample size was small, with most of the participants being doctors; thus, it may not be representative of the entire healthcare workforce in Uganda. Moreover, senior HCWs were underrepresented. This could be due to the mode of data collection (i.e., using online platforms), whereby older

TABLE 5
Association between sociodemographic characteristics and self-rated competence of healthcare workers regarding obtaining informed consent for autopsy

| Variable | Competence n (%) | | Crude OR | 95% CI | P-Value | Adjusted OR | 95% CI | P-Value |
|---|---|---|---|---|---|---|---|---|
| | Low n = 187 | High n = 29 | | | | | | |
| Age (in years) | | | | | | | | |
| 20–24 | 11 (5.9) | 3 (10.3) | 1 | – | – | 1 | – | – |
| 25–34 | 130 (69.5) | 19 (65.5) | 0.54 | (0.14–2.10) | 0.37 | 0.91 | (0.13–6.33) | 0.928 |
| ≥35 | 46 (24.6) | 7 (24.1) | 0.56 | (0.12–2.51) | 0.447 | 2 | (0.15–26.07) | 0.597 |
| Sex | | | | | | | | |
| Male | 128 (68.4) | 24 (82.8) | 1 | – | – | 1 | – | – |
| Female | 59 (31.6) | 5 (17.2) | 0.45 | (0.16–1.24) | 0.124 | 0.43 | (0.12–1.52) | 0.191 |
| Highest Level of qualification | | | | | | | | |
| Certificate/diploma | 43 (23) | 7 (24.1) | 1 | – | – | – | – | – |
| Bachelor | 100 (53.5) | 12 (41.4) | 0.74 | (0.27–2.00) | 0.549 | – | – | – |
| Master's and above | 44 (23.5) | 10 (34.5) | 1.4 | (0.49–4.00) | 0.535 | – | – | – |
| Professional designation | | | | | | | | |
| Nurse/midwife | 43 (23.0) | 9 (31.0) | 1 | – | – | 1 | – | – |
| Clinical officer | 15 (8.0) | 4 (13.8) | 1.27 | (0.34–4.75) | 0.718 | 1.07 | (0.20–5.81) | 0.940 |
| Doctor | 129 (69.0) | 16 (55.2) | 0.59 | (0.24–1.44) | 0.247 | 0.27 | (0.08–0.94) | **0.040** |
| Had training on obtaining consent for autopsy | | | | | | | | |
| Yes | 73 (39.0) | 21 (72.4) | 1 | – | – | 1 | – | – |
| No | 114 (70.0) | 8 (27.6) | 0.17 | (0.07–0.43) | <0.001 | 0.66 | (0.19–2.35) | 0.521 |
| Ever obtained consent for an autopsy | | | | | | | | |
| Yes | 79 (42.2) | 21 (72.4) | 0.24 | (0.10–0.58) | 0.001 | 1.19 | (0.33–4.34) | 0.792 |
| No | 108 (57.8) | 8 (27.6) | 1 | – | – | 1 | – | – |
| Ever observed an autopsy procedure | | | | | | | | |
| Yes | 126 (67.4) | 25 (86.2) | 3.03 | (1.01–9.08) | 0.048 | 2.55 | (0.52–12.54) | 0.248 |
| No | 61 (32.6) | 4 (13.8) | 1 | – | – | 1 | – | – |
| Ever assisted in an autopsy procedure | | | | | | | | |
| Yes | 77 (41.2) | 21 (72.4) | 3.75 | (1.58–8.90) | 0.003 | 1.13 | (0.31–4.18) | 0.851 |
| No | 110 (58.8) | 8 (27.6) | 1 | – | – | 1 | – | – |
| Knowledge | | | | | | | | |
| Inadequate | 166 (88.8) | 10 (34.5) | 1 | – | – | 1 | – | – |
| Adequate | 21 (11.23) | 19 (65.5) | 15.02 | (6.17–36.58) | <0.001 | 16.51 | (4.24–64.35) | **<0.001** |
| Work experience (in years); median (IQR): 5 (2–8) | | | | | | | | |
| ≤5 Years | 100 (56.2) | 15 (51.7) | 1 | – | – | 1 | – | – |
| 6–10 Years | 53 (28.3) | 10 (34.5) | 1.32 | (0.56–3.14) | 0.529 | 1.16 | (0.34–3.96) | 0.815 |
| ≥10 Years | 29 (15.5) | 4 (13.8) | 0.97 | (0.30–3.13) | 0.953 | 0.32 | (0.04–2.67) | 0.290 |

IQR = interquartile range; OR = odds ratio.
Bold value represents the statistically significant findings.

people are less engaged and online data collection generally produces low response rates. Furthermore, most of the study participants were drawn from major hospitals where autopsies are done for medical-legal purposes and hence have a relatively higher exposure for obtaining consent for autopsies. However, we derived our study survey from the published literature and validated its reliability to assess competence and knowledge regarding consent for autopsy in this population. This study provides baseline data for training and further research on capacity building in obtaining ethically sound autopsies and potentially improves uptake of diagnostic autopsies for clinical care and research in Uganda. An interventional study investigating the impact of training to improve the competence of HCWs in obtaining consent and its impact on the acceptance of autopsy among patients and their next of kin is recommended.

## CONCLUSION

In this study, we found that only about one in every five Ugandan HCWs had high self-rated competence or possessed adequate knowledge regarding informed consent for autopsies. Therefore, there is a pressing need for enhanced training and increased awareness among Ugandan HCWs in the process of obtaining informed consent for hospital autopsies. It is imperative to prioritize comprehensive training and awareness initiatives aimed at improving competence and knowledge of HCWs in obtaining informed consent for autopsies through standardized education and continuous professional development programs.

from all participants. Ethical regulations outlined in the Declaration of Helsinki were observed throughout the study. Anonymity was guaranteed during data collection to ensure confidentiality and encourage honest responses. No hospital- or participant-identifiable information beyond basic demographics was requested.

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