

Qualitative views on episiotomy amongst accouchers and pregnant women in a tertiary hospital in Southern Nigeria

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Abstract

Background: In 2018, the World Health Organization recommended the restrictive use of episiotomy by midwives and obstetricians on pregnant women undergoing vaginal birth. Unfortunately, the use of episiotomy is still fairly common in Africa.

Aim: We examined the qualitative views on episiotomy amongst accouchers and pregnant women at the Rivers State University Teaching Hospital in southern Nigeria.

Methods: A cross-sectional design was employed. Census sampling was used to enrol 19 accouchers (house officer doctors = 7 and nurse-midwives = 12) and 43 third-trimester pregnant women. Narrative data were collected through focused group discussion using an interview guide and a digital audio recorder. Collected data were transcribed and subjected to coding, content and thematic analysis to enable categorisation of themes.

Results: Respondents were 22–46 years old. The accouchers mentioned several indications for episiotomy which were not consistent with current evidence in literature. In contrast to pregnant women's views, the accouchers reported that episiotomy is a clinician's choice, so pre-informing the pregnant woman about it is optional. Pregnant women were of the view that they should be more involved by being the ones to decide whether they want to receive episiotomy or not. Even when the accouchers viewed episiotomy as having some clinical uses, the pregnant women suggested that episiotomy should be banned.

Conclusion: The views of the accouchers and pregnant women were not totally aligned with each other. More sensitisation of accouchers and pregnant women is required to ensure re-alignment of views based on available evidence.

Keywords: Birth, episiotomy, hospital, Nigeria, parity

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INTRODUCTION

Episiotomy grew into a routine practice by midwives and obstetricians to pregnant women experiencing childbirth within the 20th century.^{1,2} It involves a deliberate surgical cut

into the perineum of a pregnant woman with an intention to facilitate vaginal birth.^{3,4} It became a routine due to the historical belief that it made the birth canal wider, and prevented tear of the perineum.^{5,6} Consequently, up to 92% of childbearing women had episiotomies performed on

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them across countries.^{7,8} In view of this, several meticulously designed research studies began investigating the clinical value of episiotomy.⁹⁻¹¹ Its usefulness hence became an issue of debate following mounting empirical evidence in the wake of the 21st century.^{12,13} Several randomised studies demonstrated that episiotomy was associated with an increased risk of anal sphincter injuries.¹³ Published evidence made the World Health Organization recommend an episiotomy rate of 10%, if episiotomy is not avoidable.¹⁴ In addition, the International Federation of Gynaecology and Obstetrics opined that in view of available evidence, restrictive use of episiotomy is supported, especially in situations where there is a threat for perineal laceration, when it has already begun and when there is an urgency to deliver the fetus.¹⁵ In line with the fore mentioned, episiotomy practice has since declined in Europe, however, this decline is yet to be observed in Africa and East Asia.^{8,16,17}

The use of episiotomy in the absence of indication is a fairly common practice in Africa.^{9,16} This may have been driven by the existing knowledge asymmetry between accouchers and pregnant women.¹³ Some accouchers do not explain the episiotomy procedure or involve the pregnant woman in episiotomy-related decisions.¹⁸ Not understanding the implications and empirical evidence relating to episiotomy makes the pregnant women more vulnerable to receiving episiotomy and clinician's quick to performing episiotomy. Furthermore, childbearing women who had experienced episiotomy may as well have their opinions about it.¹⁰ Previous studies reveal that the rationale for performing routine episiotomy on childbearing women is influenced by views and attitudes of accouchers.¹⁸ Based on this premise, the qualitative examination of the degree of alignment in views between accouchers and pregnant women about episiotomy is justified. This study, therefore, assessed the views on episiotomy amongst accouchers and pregnant women in a tertiary hospital in south-southern Nigeria using a qualitative approach.

METHODS

This cross-sectional facility-based study was carried out between January and June 2020 at Rivers State University Teaching Hospital in southern Nigeria. A qualitative approach was utilised to facilitate a more in-depth meaning of responses from the study respondents. The study population comprised 19 accouchers (house officer doctors = 7 and nurse-midwives = 12) that are practising in the labour ward of the hospital and 43 registered third-trimester pregnant women attending antenatal clinic in the facility. Census sampling technique was used to enrol all members of the population into the study.

A two-part interview guide and a digital audio recorder were used for focused group discussions (FGDs) and data collection. Part 1 involved interview items for the accouchers such as: When is episiotomy warranted? What assessments do you do before performing episiotomy procedure? Who makes the choice for episiotomy? How do you involve the pregnant woman in episiotomy-related decisions? Is there any institution-based guideline or policy regarding episiotomy in your facility? Part 2 involved interview items for the pregnant women such as: When is episiotomy warranted? Were you involved in the decision process regarding episiotomy which you received in the past? What is your feeling towards episiotomy?

Narrative data were collected through FGD sessions. Each FGD composed 8–9 respondents and lasted an average of 30 minutes. Collected data were transcribed, coded and analysed using content and thematic analysis methods with the aid of Nvivo Qualitative Analysis Software (Nvivo QDA version 11, QSR International Inc., Boston, Massachusetts, USA). The analysis identified six themes relevant to the aim of this study. The accouchers were coded skilled birth attendants (SBAs) 1–19, while pregnant women were coded pregnant women (PWs) 1–43 for reasons of anonymity.

Ethical approval to carry out this study was obtained from the University of Port Harcourt Research Ethics Committee (Protocol ID: G2018/PUT/MAS/MMW/FT/034). Permission was obtained from the hospital management and heads of selected units before data collection. Written informed consent was obtained from each individual who took part in the study after assuring them of the confidentiality of any given information. All collected data were protected and utilised for the approved academic purpose. Anonymity of the respondents and hospital facility were maintained throughout the period of this study.

RESULTS

Table 1 summarises the background characteristics of the study participants (accouchers and pregnant women), and it showed that the accouchers had a mean age of 36.8 (6.4) years. Nine (47.4%) of them were aged between 36 and 44 years, and 13 (68.4%) were females. Nine (47.4%) of them were midwives with diploma level education and a mean of 7.0 (2.9) years clinical practice experience. The mean years of labour ward experience was 5.3 (2.4) years. In addition, all the antenatal women were married, and had a mean age of 33.3 (5.9) years. Twenty-six (60.5%) of them

Table 1: Background characteristics of study participants

Variable	n (%)	Mean (SD)
Accouchers (n=19)		
Age (years)		
18-26	1 (5.3)	
27-35	7 (36.8)	
36-44	9 (47.4)	
45-53	2 (10.5)	
Mean		36.8 (6.4)
Gender		
Male	6 (31.6)	
Female	13 (68.4)	
Highest educational qualification		
Nursing Diploma (RM)	9 (47.4)	
Nursing Bachelors (BSN, RM)	2 (10.5)	
Nursing Masters (MSN, RM)	1 (5.2)	
Medicine Bachelors (MBBS)	7 (36.8)	
Years of clinical experience (years)		
1-5	7 (36.8)	
5-10	9 (47.4)	
10-15	3 (15.8)	
Mean		7.0 (2.9)
Years of labour ward experience (years)		
1-5	13 (68.4)	
5-10	5 (26.3)	
10-15	1 (5.3)	
Mean		5.3 (2.4)
Pregnant women (n=43)		
Age (years)		
21-32	17 (39.5)	
33-44	26 (60.5)	
Mean		33.3 (5.9)
Marital status		
Married	43 (100)	
Previous experience with episiotomy		
Previously had episiotomy	37 (86.1)	
Have never had episiotomy	6 (13.9)	

SD: Standard deviation

were aged between 33 and 44 years, and had experienced episiotomy in previous vaginal births (n = 37, 86.1%).

With respect to responses of the accouchers, the identified themes were as follows: when episiotomy is warranted, assessments done before episiotomy, the choice of episiotomy, maternal involvement in episiotomy decisions and availability of institution-based policy on episiotomy.

a. When episiotomy is warranted

The accouchers linked the indications for episiotomy to a situation where the birth canal is small for the passage of the foetus:

Episiotomy becomes vital when the foetus is macrosomic (big), or too large to pass through the unattended vaginal introitus (opening) (SBA 5).

They related the need for episiotomy to when the foetus has presented abnormally hence requiring a wider vaginal canal to be born.

It is a problem when the foetus presents with the face or the shoulder. In order to be able to manipulate the foetus in such a way as to ensure delivery, an episiotomy is given (SBA 8).

The need for episiotomy was aligned to the presence of crowning with suspected foetal distress.

Until the head of the foetus has distended the perineum, episiotomy is not given (SBA 11). But if there was prolonged second stage (of labour), as soon as the foetal head is seen very close to the perineum then episiotomy can be given (SBA 2).

b. Assessments done before episiotomy

The accouchers hinted some clinical assessments that they perform to identify need for episiotomy.

I would check for slow progress of the birth process, after descent of the head and crowing (SBA 1). My opinion is that assessment for need of episiotomy begins prior to first stage of labour, at this time I perform a cephalopelvic fit test [...]. It can give an idea whether episiotomy will be needed or not (SBA 9). Even before the second stage of labour, an assessment of size of the foetal head using the thumb and forefinger is important (SBA 4).

c. The choice of episiotomy

The accouchers perceived that the choice of episiotomy lies majorly with the caregiver.

The caregiver is a trained person. If in line with the caregiver's expertise, one feels that episiotomy is essential in one situation or the other, I feel the caregiver should go ahead with it (SBA 6). The pregnant mother is not seeing her perineum; it is the caregiver who sees the perineum [...] so can decide on the need for episiotomy (SBA 3).

d. Maternal involvement in episiotomy decisions

The accouchers agreed that informed consent should be obtained, but that it is not feasible to do so many times.

It is ideal to obtain informed consent before giving episiotomy, but I must say that at the heat of the moment, it is often not possible to wait for a response from the pregnant woman before giving the episiotomy (SBA 5).

e. Availability of institutional policy on episiotomy

The accouchers testified that the practice of episiotomy is not regulated by institutional policy at the present time.

At the moment, this facility does not have a policy on episiotomy. We use guidelines of external bodies like WHO (World Health Organization) and other international obstetrics organisations. So whether to use or not use episiotomy is left to the intuition of the caregiver (SBA 8).

With respect to responses of the pregnant women, the following themes were identified: when episiotomy is warranted, the choice of episiotomy, maternal involvement in episiotomy decisions and feelings towards episiotomy.

a. When episiotomy is warranted

The pregnant women associated the requirement for episiotomy to foetal size.

If the baby (foetus) is large, the vagina will be slashed to bring it out before it dies (PW 13).

They believed that episiotomy makes the birth canal larger or wider.

The cut into the vagina is to make the passage roomy so as to allow baby to pass easily (PW 7).

The pregnant women hinted that if the baby is of normal characteristics, then the need for episiotomy is not justified.

If all necessary tests and scan (ultrasound) is done, and it is confirmed that the baby is normal, then episiotomy cannot be used [...] (PW 41).

b. The choice of episiotomy

The pregnant women felt that episiotomy should be a decision between the pregnant woman and the clinician.

In the birth of my second child, episiotomy was given without my knowledge. I did not feel that was good, especially when I began having some serious pain when I sit. In the birth of my first child, I had no episiotomy and I was fine afterwards. So, pregnant women should be the ones to make the choice because the body is the woman's (PW 28).

c. Maternal involvement in episiotomy decisions

The pregnant women reported that accouchers do not involve them in episiotomy-related decisions.

I think midwives and doctors know when there is need for episiotomy, no doubt, but at least they should tell the pregnant woman who pays for the services they are rendering and wait for her to decide whether or not to have it [...] (PW 17).

d. Feelings towards episiotomy

The pregnant women expressed gross dislike for episiotomy.

I don't like the whole idea of episiotomy. Personally, I think episiotomy should be banned [...] (PW 12). Going by the nature of discomfort that women have after episiotomy, I do not think it should be used on any woman who is having vaginal birth, no matter what (PW 3).

DISCUSSION

In this study, the accouchers reported that episiotomy was required when the foetus is larger than the vaginal passage in the presence of foetal distress. This finding supported a study which found that tight perineal tissue and shoulder dystocia were mentioned as indications for episiotomy by midwives and obstetricians in Oman.¹⁷ On the contrary, the indications offered by the accouchers did not agree with a study which noted that episiotomy increased the risk of perineal damage.⁴

This study found that the accouchers will assess the degree of stretch of the perineum before performing episiotomy. This finding was in line with conventional practice as it corroborates a study which confirmed that the obstetrical

caregivers check for descent of the foetal head and crowning before episiotomy.⁵ More so, this finding was not aligned with a study which concluded that no obstetrical condition is enough indication for episiotomy.¹⁵

This study found that the accouchers asserted that accouchers have every right to decide and perform episiotomy as they see fit. This opinion was in contrast to the view of the pregnant women who felt that a pregnant woman should retain the choice to demand episiotomy or not. This conflict of views may result in disagreements in practice and violation of women's right to choice of treatment. This finding supported a study which found that pregnant women were not often empowered by accouchers to make decisions about episiotomy.¹⁹

This study found that the accouchers were of the idea that informed consent should be obtained before episiotomy procedure, but do not often do so due to time constraints. Furthermore, the pregnant women reported that they should be pre-informed and allowed to make a decision before episiotomy is done. This finding corroborates two studies which noted that during the fast-paced activities of the labour ward, there was often no time for the accouchers to offer adequate information on episiotomy to pregnant women.^{6,18}

This study found that the accouchers had limited availability of facility-based policy on episiotomy. This finding might produce the confused practice of episiotomy. This finding aligned with two other studies that found that a number of obstetrical caregivers have limited access to institutional guidelines on episiotomy in Africa and Asia.^{2,5} This finding would imply a need for hospital facilities to urgently develop facility-based policies regarding episiotomy practice.

This study found that pregnant women had negative feelings towards episiotomy and some of them feel that episiotomy should be banned. This finding supported a Nigerian study which found that about six in ten pregnant women will advise their relatives against episiotomy.²⁰ This finding would imply that pregnant women would not demand episiotomy. More so, this finding was in contrast with another Nigerian study which found that nine in ten pregnant women were willing to deliver in a secondary health facility whether or not they will be given episiotomy.²¹

The major strength of this study is the in-depth responses of accouchers and pregnant women regarding episiotomy. On the other hand, one limitation was that this study was

conducted in one hospital facility, therefore, the results may not generalise outside the study population.

CONCLUSION

The views of the accouchers were not based on current empirical evidence and literature, and were not well aligned with those of pregnant women regarding episiotomy. The pregnant women had negative feelings about episiotomy and suggested that it should be banned.

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Conflicts of interest

There are no conflicts of interest.

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