

Midwives' perspectives regarding episiotomy practice in Kurdistan region/Iraq

Received: 2/1/2015

Accepted: 7/6/2015

Safiya Sabri Piro*

Hamdia Mirkhan Ahmed**

Abstract

Background and objective: Local professional norms, experiences in tainting, and individual provider preference may lead to wide practice variation in rate and practice of episiotomy by midwives. The aim of this study was to find out the midwives' perspectives regarding practicing of episiotomy in three main cities of Kurdistan region/Iraq.

Methods: A cross-sectional, descriptive study was conducted on 53 midwives working in delivery room in three maternity teaching hospitals in the three biggest cities of Kurdistan Region of Iraq. A questionnaire was constructed for the purpose of the study and data were collected by interview with midwives. F test and Chi-square test were used for analyzing the data.

Results: The majority (88.7%) of midwives thought that the rate of episiotomy were high in their hospitals that were attributed to five factors; maternal (77.35%), fetal (39.62%), midwives (37.73%), obstetricians (30.18%) and hospital policy and health system (20.75%). The opinion of midwives regarding how to decrease the rate of episiotomy included improving midwifery care during delivery (77.35%), reforming health system (60.37%), reforming hospital policy (50.94%) and improving maternal care during pregnancy (26.41%).

Conclusion: Taking into consideration the midwives' perspectives and views regarding episiotomy and providing training courses may help in decreasing the rate of episiotomy and its practice in correct way in Kurdistan's maternity hospitals.

Keywords: Episiotomy, Midwives, Kurdistan, Iraq.

Introduction

An episiotomy is a surgical incision made into the perineum, which if required should only be performed immediately prior to birth to enlarge the vaginal outlet and to assist the birth of the baby.¹ The reason for using episiotomy depends on the need to minimize the risks of severe spontaneous maternal trauma and fetal comprise.² Performing episiotomy has undergone a number of revisions starting from 1920s when routine episiotomy was advocated to the 1980s when restrictive use of episiotomy became the recommended practice.³ There is no evidence to support the use of routine episiotomy in any circumstance, not even when there has been a previous third-degree tear.¹

The World Health Organization also supports the restricted use of episiotomy (less than 20%) as there is no evidence that routine episiotomy decreases perineal damage.⁴ Australian research has shown a high prevalence of maternal health problems up to six months after birth, with one or more health problems reported by 94% of women. Painful perineum (21%) and sexual problems (26.3%) were two of the most commonly cited. These problems were especially relevant to primiparous women and to women who had an episiotomy and/or instrumental birth.⁵ Episiotomy rates widely vary between countries, institutions, and individuals because of differences in attitudes and training.⁶ Wide practice variation in rate

*School of nursing, faculty of medical sciences, University of Duhok, Duhok, Iraq.

**Department of maternity nursing, college of nursing, Hawler Medical University, Erbil, Iraq.

and practice of episiotomy suggest that episiotomy use is heavily driven by local professional norms, experiences in tainting, and individual provider preference rather than variation in the physiology of vaginal birth.⁷ It is in the scope of practice of a midwife to infiltrate the perineum and perform an episiotomy. The use of episiotomy should, however, be restricted to expediting the birth only when the presenting part is fully distending the birth only when there is evidence of a non-assuring fetal heart rate pattern.¹ Although there is no formal statistics regarding rate of episiotomy in Iraq, the Kurdistan's midwives are performing episiotomy without restrictions. Midwives are responsible for performing episiotomy but they are not allowed to suture it. Knowing the perspective and thoughts of midwives are necessary to improving a program and changing health and hospital policy for restriction of performing episiotomy. The aim of this study was to find out (1) some aspects of practicing episiotomy by midwives in three main cities of Kurdistan region/Iraq, (2) the midwives' perspectives regarding rate of episiotomy, (3) the opinion of midwives toward accepting the responsibility of suturing of episiotomy.

Methods

This cross-sectional, descriptive study was conducted between July 1st, 2013 and July 10th, 2014 in the three governorates of Erbil, Duhok and Suleimanya of Kurdistan Region of Iraq. The study was conducted in the three biggest maternity teaching hospitals in the main cities of each governorate. All midwives (n=53) working in delivery rooms were included as study sample. The purposive sampling method was used. Midwives who had less than one year experience of working in delivery room were excluded from the study (12 midwives). The study was approved by the Ethical Committees of the College of Nursing of Hawler Medical University and the Directorate of Health of

each governorate. Midwives had nursing or midwifery qualification as described in the Table 1. There is no difference between job description of midwives with nursing and midwifery qualifications. Therefore, this study refers to all participants as "midwives". The purpose of the study was explained to each midwife during personal interview, and an informed verbal consent was obtained. Data were collected through interview with midwives. A questionnaire was constructed for the purpose of the study by researcher that included the following variables: Demographic characteristics of the study sample and questions regarding their practice and their perspective regarding rate of performing episiotomy. Open ended questions were used to find out the perspectives of midwives regarding reasons of episiotomy. The researcher categorized the reasons into five factors; maternal factors (high number of mothers, primipara, previous perineal repair, obesity, uncooperative and exhaustion mothers), fetal factors (high number of big baby and tired baby and meconium), midwives factors (few numbers of midwives, fear from complications and punishment in case of problem), obstetricians factors (early admission, decreasing number of operation, high use of pitocin, order for all primipara by obstetricians) and hospital policy and health system factor (no prenatal education, routine care). Data were analyzed using the statistical package for the social science (version 18). Analysis of variance (ANOVA) was used to compare means of three groups. Chi-square test of association was used to compare proportions. Fisher's exact test was used when more than 20% of the cells of the table have expected count less than 5. A *P* value of ≤ 0.05 was considered as statistically significant and ≤ 0.01 as highly significant. Questions regarding opinion of midwives regarding episiotomy were analyzed qualitatively.

Results

The number of midwives participated in the study from the three cities was as following: Erbil 17, Duhok 18 and Sulemanya 18. There was statistically significant difference regarding demographic characteristics of midwives in terms of age, years of experience in delivery room, specialty and

level of education in nursing/midwifery and shift of working; the mean age and years of experience in delivery room of midwives in Sulemanya was lower than in Erbil and Duhok. The majority of midwives in Sulemanya and Duhok were midwives and were graduated from secondary or institute of midwifery (Table 1).

Table 1: Frequency distribution of demographic characteristics of the study sample in three cities

Variables	Erbil No. (%)	Duhok No. (%)	Sulemanya No. (%)	P value
Age (Mean ± standard deviation)	40±9.478	39.33± 3.835	34.17±5.448	0.022
Years of experience in delivery room (Mean ± standard deviation)	11.24±10.214	21.22±4.609	8.39±6.801	<0.001
Specialty				
Nurse-midwife	8(47)	1(5.5)	1(5.5)	0.002*
Midwife	9(53)	17(94.5)	17(94.5)	
Level of education				
primary school of nursing	2(11.7)	12(66.7)	2(11.1)	<0.001*
secondary school of nursing/ midwifery	11(64.7)	5(27.7)	7(38.9)	
nursing/midwifery institute	1(5.9)	1(5.6)	7(38.9)	
college of nursing/midwifery	3(17.7)	0(0)	2(11.1)	
Shift of working				
morning	7(41.1)	3(16.7)	1(5.5)	0.010
evening & night	2(11.8)	0(0)	0(0)	
all shift	8(47)	15(83.3)	17(94.5)	

* Fisher-exact test was applied.

There was highly significant difference between midwives' practice of three cities regarding informing mother prior to performing episiotomy and giving instructions to mother after episiotomy. Almost all midwives try to avoid episiotomy and majority of them did not accept mother's request about avoiding performing

episiotomy. There was no significant difference between midwives in three cities. The highest proportion (54.54%) of answers of midwives regarding reasons of refusing the request of mother for performing episiotomy was as follows "the mothers don't know the complications and we know they need it" (Table 2).

Table 2: Practice of midwives regarding episiotomy.

Practice	Erbil No. (%)	Duhok No. (%)	Sulemanya No. (%)	P value
Try to avoid episiotomy				
- yes	15(88.2)	14(77.3)	16(88.2)	0.706*
- no,	2(11.8)	4(22.2)	2(11.1)	
Give instructions to mother with episiotomy				
- yes	0(0)	18(100)	17(94.4)	<0.001
- no	17(100)	0(0)	1(5.6)	
Inform mother to perform episiotomy				
- yes	14(82.4)	13(72.2)	5(27.8)	<0.001*
- no	2(11.8)	2(11.1)	13(72.2)	
- sometimes	1(5.8)	3(16.7)	0(0)	
Accept mother's request regarding refuse performing episiotomy				
- yes	4(23.5)	4(22.2)	1(5.6)	0.284*
- no	13(76.5)	13(72.2)	17(94.4)	
- sometimes	0(0)	1(5.6)	0(0)	
	No. (%)			
If no why?				
- I am responsible for complications not mother	16(36.36)			
- Mother don't know the complications and I know she need it	24(54.54)			
- In case of induction of labor episiotomy must be done (obstetricians say)	1(2.27)			
- No answer	1(2.27)			

* Fisher-exact test was applied.

The majority (88.7%) of the study sample thought that episiotomy rate was high in their hospitals. The answers of midwives regarding reasons of high rate of episiotomy were related to five factors; maternal (77.35%), fetal (39.62%), midwives (37.73%), obstetricians (30.18%) and hospital policy and health system (20.75%). The opinion of midwives regarding how to decrease the rate of episiotomy included improving midwifery care during delivery (77.35%), reforming health system (60.37%), reforming hospital policy (50.94%) and improving maternal

care during pregnancy (26.41%). In answer of this question "do you want to accept the responsibility of suturing episiotomy if hospital policy allows you?", most of midwives (64.2%) answered "yes" and the more frequent reasons for positive answer were "this is midwife decision (my cutting) and midwife is more expert than obstetricians" (Table 3). Only nine of midwives had training course regarding episiotomy. In addition they mentioned that "there is no clear hospital policy and specific guideline regarding restrictive episiotomy practice."

Table 3: Midwives' perspective regarding high rate of episiotomy.

Questions	Yes* No(%)	No No(%)
High rate of episiotomy in hospital?	47(88.7)	6(11.3)
If yes, mention the reasons		
A- Maternal factors	41(87.23)	-
B- Fetal factors	21(44.68)	-
C- Midwives factors	20(42.55)	-
D- Obstetricians factors	16(34.04)	-
E- Hospital policy and health system	11(23.40)	-
F- I don't know	1(2.12)	-
Ways of decreasing the rate of episiotomy		
A- improving midwifery care during delivery	41(87.23)	-
B- Reforming health system	32(68.08)	-
C- Reforming hospital policy	27(57.44)	-
D- Improving maternal care during pregnancy	14(29.78)	-
E- I don't know	2(4.25)	-
Accepting to take responsibility of suturing of episiotomy if health policy assigned you.	34(64.2)	19(53.5)
If yes why?		
- this is midwife decision (my cutting)	4 (8.51)	-
- midwife is more expert than obstetricians	13 (27.65)	-
- Discharge mother sooner	8 (50)	-
- obstetricians are not available all time	3 (8.82)	-
- we do every things just no suturing	1 (2.94)	-
If no why?		
- this is not midwife responsibility	6 (17.64)	-
- midwives have no enough time	3 (8.82)	-
- high responsibility	4 (8.51)	-
- lack of training on suturing	1 (2.94)	-
- procedure is associated with complications	4 (8.51)	-

* Multiple answers by the same midwife for the same question were recorded.

Discussion

As there is no evidence to support the routine episiotomy and WHO recommendations for restricted use of it,⁴ knowing the midwives' practice and their opinion regarding performing episiotomy is one of the main areas in delivery care. The aims of the present study were to understand the pattern of practicing episiotomy by midwives and the reasons of high rate of episiotomy from their perspective, in addition to find out the opinion of midwives toward accepting the responsibility of suturing of episiotomy. The results of the present study indicated that the majority of midwives are trying to avoid episiotomy, almost all of midwives in Duhok and Sulaymaniyah cities are giving instructions to mother after discharge from delivery room, more than half of them inform the mother before performing episiotomy. The majority of midwives are refusing to accept the mother request for avoiding episiotomy because of responsibility and fear from complications of not performing episiotomy. Results of a study done by Rashid and Ali on 75 midwives, who were working at the delivery room in six hospitals in Baghdad city/Iraq, indicated that 68 of them never inform the mother before performing the episiotomy.⁸ Most midwives try to avoid episiotomies because they feel that the recovery is longer and more uncomfortable than with a non surgical delivery or even with repair of a tear. They pointed out that tears are usually much smaller than an episiotomy incision and rarely go through muscle.⁹ Midwives must get the verbal consent from the woman prior to performing the episiotomy.¹ Midwives' reasons for performing episiotomies were attributed to midwifery training, fear of doing harm and perceived clinician expectation, and were not consistent with current international practice guidelines. Reasons for avoiding episiotomies were associated with patient-centeredness and job satisfaction. Midwives agreed on the need to reduce episiotomy rates.¹⁰ In a study done by

Tackla et al on all midwives working in Pumwani Maternity Hospital, they found lack of specific guidelines on specific procedures, personal attitude and inadequate administration support for evidence-based episiotomy practice.¹¹ An understanding of factors underlying this decision-making process will inform future strategies to change practice using motivational and other learning theories, hence aligning episiotomy practice in delivery units to current accepted practice guidelines.¹² No appropriate episiotomy practice by Kurdistan Midwives may be due to this fact that each maternity teaching hospital in three cities of Kurdistan provides care for more than one million populations. The crowded delivery rooms with few numbers of midwives and beds may be the cause for labor and delivery care in low quality and standards. In a study conducted by Goldberg et al to determine the effect of large body of literature strongly advocating the selective use of episiotomy, they concluded that there was a statistically significant reduction in the overall episiotomy rate between 1983 and 2000. They discussed that this change in practice pattern may largely be due to impact of a growing body of literature against routine episiotomy, including that derived from randomized controlled trials. Additionally, improved patient education and participation in decision making and changes in use of forceps and vacuum assistance probably play a role in reducing the overall number of episiotomies. No specific policy or educational initiative regarding episiotomy was implemented during the study period.⁶ The majority of midwives in the present study viewed episiotomy as a highly practiced procedure in delivery rooms. They mentioned many factors which play a role in the present high rate of episiotomy as maternal factors (high number of mothers, primipara, AP repair, obesity, uncooperative and exhausted mothers), fetal factors (high number of big baby and tired baby and meconium), midwives

factors (few numbers of midwives, fear from complications and punishment in case of problem), obstetricians factors (early admission, decreasing no of operation, high use of pitocin, order for all primipara by obstetricians) and hospital policy and health system factor (no prenatal education, routine care). The results of the present study are supported by the results of Wu et al on 77 midwives in Singapore, in which maternal factors, neonatal factors and midwives factors were associated with increased risk of episiotomy.^{13,14} Some delivery practices, such as 'hand on' compared with 'hands poised' for perineal guarding have been shown to be associated with higher rates of episiotomy,¹⁵ and provider experience, beliefs and training are other potential factors that may influence episiotomy rates.¹⁶ Improving midwifery care during delivery (giving enough time to the mother, encourage mother to be cooperate, no supine position and premium support during delivery, increase movement of the mother), reforming health system and health policy (increase number of midwives, decrease number of mothers admitted, no early admission, no giving early piton, supporting midwives, encourage for home delivery) and improving maternal care during pregnancy (prenatal education and exercise, normal baby size) were midwives' opinion for decreasing the rate of episiotomy. Results of a study done by Henriksen et al on 30 midwives to evaluate the use of feedback by graphical profiles of rates of episiotomy and the impact on clinical practice and perineal state after spontaneous vaginal deliveries assisted by midwives with different attitudes towards episiotomy, showed that the overall rate of episiotomy decreased by about 7% from 37.1%. They concluded that changes in the use of episiotomy induced by awareness of clinical practice among midwives seem to increase the incidence of parturient with intact perineum without a concomitant rise in tears of the anal sphincter.¹¹ Robinson

et al found that the strongest factor associated with episiotomy at delivery was category of obstetric provider, in which midwives performed episiotomies at lower rate (21.4%) than faculty (33.3%).¹² In the present study only nine midwives had updating training course on episiotomy. No hospital policy or guidelines are present for restrictive episiotomy and its practice. Most of midwives have low level of education in midwifery. All of these may play role in their view and attitude regarding rate of episiotomy and ways of decreasing it. The majority of the midwives in the present study mentioned that if the health policy assigned them to take responsibility of suturing the episiotomy, they will accept it. Taking the responsibility of suturing the episiotomy by midwives may encourage them to practice it according to evidence and improve their practice and perspective regarding decreasing the rate of episiotomy. According to the International Confederation of Midwives, suturing episiotomy is included in essential competency of midwives.¹⁷ The limitations of the present study were using individual interviews instead of focus groups to identifying their perspectives and studying few aspects of midwives' practice regarding episiotomy.

Conclusion

Taking into consideration of midwives perspectives and views regarding episiotomy and providing training courses and guidelines for practicing it as well as sharing their experience between them by group discussions may help to decreasing the rate of episiotomy and its practice in correct way in Kurdistan maternity hospitals. Further studies are needed on quality of episiotomy procedure and complications.

Conflicts of interest

The authors report no conflicts of interest.

References

1. Pairman S, Tracy S, Thorogood C, Pincombe J. *Midwifery: preparation for practice*. 2nd ed. Sydney: Elsevir; 2010. 551
2. Fraser D, Cooper M. *Myles Textbook for Midwives*. 15th ed Churchill Livingstone. Edinburgh; 2009. 523
3. Thacker B, Banta H. Benefits and risk of episiotomy: An interpretative review of the English literature (1860-1980). *Obstet Gynacol* 1983; 38:322-8.
4. Fernandes S, Benjamin E, Edwards G. Using evidence to reduce the rate of episiotomy in a Dubai hospital. *Evidence Based Midwifery* 2009; 7 (2):60-3.
5. Brown S, Lumley J. Maternal health after childbirth: results of an Australian population survey. *BJOG* 1998; 105:156-61.
6. Goldberg J, Holtz D, Hyslop T, Tolosa J. Has the use of routine episiotomy decreased? Examination of episiotomy rates from 1983 to 2000. *The American College of Obstetricians and Gynecologists* 2002; 99(3):395-400.
7. Viswanathan M, Hartmann K, Palmieri R, Lux L, Swinson T, Lohr K, et al. The use of episiotomy in obstetrical care: A systematic review. *AHRQ Evidence Report Summaries*; 2005.
8. Rashid A, Ali R. Assessment of nurse-midwives' knowledge and practices toward second stage of labor. *Iraqi Sci J Nursing* 2010; 23:15-26.
9. Samuels M, Samuels N. *The new pregnancy*. USA: Mike samules and Nancy Samuels; 1996.
- 10- Teckla N, Omoni G, Mwaura J, Omuga B. Evaluation of evidence-based episiotomy practice by midwives. *AJM* 2010; 4(2):80-7.
11. Henriksen TB, Bek KM, Hedegaard M, Secher NJ. Methods and consequences of changes in use of episiotomy. *BMJ* 1994; 309:1255-8.
12. Robinson J, Norwitz E, Cohen A, Lieberman E. Predictors of episiotomy use at first spontaneous vaginal delivery. *Obstet & Gynecol* 2000; 96 (2):214-8.
13. Wu L, Lie D, Malhotra R, Allen J, Tay J, Tan T, et al. Risk factors and midwife-reported reasons for episiotomy in women undergoing normal vaginal delivery. *Arch Gynecol Obstet* 2013a; 288:1249-56.
14. Wu L, Lie D, Malhotra R, Allen J, Tay J, Tan T, et al. What factors influence midwives' decision to perform or avoid episiotomies? A focus group study. *Midwifery* 2013b; 29:943-9.
15. Rochez R, Waterfield M, Freeman R. Hands on or hands off the perineum: a survey of care of the perineum in labor (HOOPS). *International Urogynecology Journal* 2011; 22: 1279-85
16. Hartmann K, Viswanathan M, Palmieri R, Gartlehner G, Thorp J, Lohr K. Outcomes of routine episiotomy: a systematic review. *J Am Med Assoc* 2005; 293:2141-8.
17. Fullerton J, Severino R, Brogan K, Thompson J. The International Confederation of Midwives' study of essential competencies of midwifery practice. *Midwifery* 2003; 19(3):174-90.