



EPISIOTOMY PRACTICE AND ITS INDICATIONS FROM 2009-2018 IN TWO SELECTED HOSPITALS IN YENAGOA, BAYELSA STATE

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ABSTRACT: *Background: Episiotomy is a deliberate surgical incision to the perineum of woman in labour during vaginal delivery at the second stage of labour to facilitate the passage of the fetus. The procedure is performed with episiotomy scissors when the perineum is thin and out stretched, during a uterine contraction prior to crowning. Aims: To determine the practice of episiotomy and its indicators in two selected hospitals, Federal Medical Centre Yenagoa and Niger Delta University Teaching Hospital Okolobiri, Bayelsa State. A null hypothesis was put forward: There is no significant relationship between duration of second stage labour and indication/practice and between parity and practice of episiotomy in the hospitals. Relevant literatures were reviewed. Methods: Descriptive study, purposive sampling technique was used in which all mothers who were delivered via episiotomy at the two selected hospitals from 2009-2018. Checklist was used for data collection; case files of all deliveries were retrieved. Results: Percentages, tables and figures were used. 914 (100%) engaged in selective episiotomy practice in both hospitals, with 36.8 (40.3%) indicating episiotomy as primigravida permeating disrespectful maternity care. The null hypothesis was tested using Chi-square (X^2) statistical tool at 0.05 level of significance and at a degree of freedom of 4. Statistical illustration of relationship between indication and practice of episiotomy: The Chi-square table on this is $X^2 = 36.453$ at a P value of 0.021 which is less than 0.05 and as such null hypothesis accepted. On the other hand, relationship between duration of second state of labour and practice of episiotomy shows that the duration of second stage of labour influences the practice of episiotomy from Chi-square table value which is $X^2 = 20.361$ at a P value of 0.042 which is less than 0.05 thus null hypothesis was rejected and the alternate hypothesis accepted. Conclusion: Policy makers should define the goal and objective, train and retrain professionals on the practice of episiotomy procedure. Midwives and obstetricians should encourage perineal massage from 3rd stage of labour to prevent perianal tear.*

KEYWORDS: Episiotomy, Practice, Indications, Hospitals, Woman Labour, Nigeria



INTRODUCTION

Background of the Study

Episiotomy is the second most frequently performed obstetric operation and was first introduced across Europe in 1742, as widening of the vaginal opening was believed to accelerate labour, protect the fetal head and prevent severe obstetrical anal sphincter injuries (Kaled, Katariina, Erik, Mohammed, Hadil, Manuela, Ase & Sahar, 2018). It is routinely practiced in many countries despite the fact that many studies have reported the side effects of episiotomy including inadequate prevention of obstetric anal sphincter injuries (OASIS), and increased risk of OASIS (Thomas, Emilie Jonathan, Denis, Catherine & Paul, 2019).

It is a deliberate surgical incision to the perineum of woman in labour during vaginal delivery at the second stage of labour to facilitate the passage of the fetus. The procedure is performed with episiotomy scissors when the perineum is thin and out stretched, during a uterine contraction prior to crowning. (Kalis, Rusavy Prka, 2017)

According to Izuka, Dim, Chigbu, and Obiora-Izuka, (2014) episiotomy has become one of the most commonly performed surgical procedures in the world, yet it was introduced without strong scientific proof of its effectiveness. Therefore, despite many years of its practice, the operation has remained controversial (Izuka, et al., 2014).

The practice of episiotomy changes between nations (Clesse, Lighezzolo and Lavergne, 2018). One European examination announced episiotomy performance from 3.7% in Denmark to 75% in Cyprus (Blondel, Alexander and Bjarnadóttir, 2016). In Arab nations, the practice of episiotomy are still high: 41.4% in Jordan, 52.2% in Saudi Arabia, 62% in Lebanon and 64% in United Arab Emirates (Hussein, Dahlen and Duff, 2016). In Nigeria, a report from Zaria, indicated an episiotomy practice of 35.6% after every single vaginal delivery and 88.5% in primigravidae; while in Enugu, the practice was 40.4% for women all things considered and 76.2% in primigravidae. Another interesting report from Calabar, Nigeria demonstrated a relatively low episiotomy practice of 20.1% among all women that had a vaginal delivery; there was no definition into equality gatherings (Inyang-Etoh and Umoiyoho, 2012).

There are different opinions about the applicability of episiotomy including preventing severe perineal laceration during childbirth, especially in the primigravidae. However, the maternal benefits of episiotomy include the reduction in the likelihood of third degree perineal tears, preservation of muscle relaxation of the pelvic floor and perineum leading to improved sexual function, and reduced risk of fecal and urinary incontinence, as well as ease of repair and better healing than laceration because it is a straight and clean incision (Izuka et al, 2014). In the newborn, episiotomy is said to lessen delayed second stage brought about by inflexible perineum, prompting fetal asphyxia, cranial injury, cerebral drain and mental impediment; it might likewise decrease the chance of fetal shoulder dystocia. On the other hand, the conceivable antagonistic impacts of episiotomy incorporate the iatrogenic cutting of the anal sphincter or rectum particularly in midline episiotomies or unavoidable extension of the incision, the unsuitable anatomic outcomes, for example, skin labels, asymmetry or unnecessary narrowing of the introitus, vaginal prolapse, recto-vaginal fistula and fistula-in-ano, expanded blood loss and hematoma, pain and edema in the episiotomy area, contamination and dehiscence, and sexual brokenness (Izuka et al, 2014).



Indications for episiotomy vary between countries and are influenced by the opinion of the clinician in charge of the delivery. Primiparity, instrumental delivery, fetal malpresentation, fetal distress, large fetal size, breech delivery, shoulder dystocia and rigid perineum are the most common indications reported for episiotomy (Svetkov, Stoikov & Lukanovich, 2010). The American College of Obstetricians and Gynecologists (ACOG) depicted shortening of the second stage of labour and high danger of OASIS as the most continuous signs for episiotomy. The ACOG, the Royal College of Obstetricians and Gynecologists (RCOG), and the National Institute for Health and Care Excellence (NICE) propose utilizing episiotomy on clinical trials only (Kaled et al, 2018). However, episiotomy is routinely practiced across Nigerian hospitals particularly for the primigravidae. Consequently, it may prevent pregnant women from accessing quality intrapartum and increase barriers for professional care. Therefore, it becomes expedient to describe the evolution of episiotomy practice and its indicators from 2009 to 2018 Bayelsa State Nigeria.

Statement of Problem

Universally, approximately 140 million births occur every year. The majority of these are vaginal births among pregnant women with no identified risk factors for complications, either for themselves or their babies, at the onset of labour (WHO, 2018). However, in conditions where complications arise during labour, the risk of serious morbidity and death increases for both the mother and baby. Over a third of maternal deaths and a substantial proportion of pregnancy-related life-threatening conditions are attributed to complications that arise during labour childbirth or the immediate postpartum period. Similarly, approximately half of all stillbirths and a quarter of neonatal deaths result from complications during labour and childbirth (WHO, 2017). Therefore, improving the quality of care around the time of birth has been identified as the most impactful strategy for reducing stillbirths, maternal and newborn deaths.

World Health Organization (2019) recommended to all birth professional on the need to promote respectful physiological birth process free from routine episiotomy in all birth centres for women seeking intrapartum care. However, despite this recommendation, there is an increase in the practice of episiotomy in health care facilities in low- and middle-income countries (LMICs) like Nigeria and the indications for the procedure are based largely on clinical opinion and anecdote. Furthermore, few research studies have been carried out episiotomy and no study has been carried out specifically in Bayelsa State, Nigeria, on episiotomy practices and its indicators. In view of the above, the researcher intends to retrospectively assess the episiotomy practices and its indicators from 2009 to 2018 in two selected hospitals in Yenagoa, Bayelsa State.

Study Justification

The researcher was privileged to work in both private and public health care facilities designed to render obstetric services to expectant women. She had witnessed various indications for given episiotomy to women during delivery as a student and as a registered nurse-midwife in Bayelsa State. Most of these women who had episiotomy were primip who do not have any clinical indication for episiotomy but rather given based on routine hospital policy. The uncritical liberal practice that was borne out of hospital policy was opposed by most women; hence the women were unwilling to use these hospitals for delivery, contributing to increase barriers for professional care. The researcher viewed some of the reasons for giving episiotomy



by the health professionals in the health care facilities as mere assumptions since they were not supported empirically. Since that time, she had been going about with unanswered questions relating to the episiotomy practices in the hospitals. In order to find answers to those questions, she sought to carry out a study describing the evolution of episiotomy practice and its indicators from 2009 to 2018 in Bayelsa State, where she resides.

In addition, there is no verifiable data on this in Bayelsa State Nigeria. Thus, this study will provide vital information on episiotomy practices and its indicators in Bayelsa State.; and as such enable policymakers, midwives and hospital managements to reach informed decisions regarding indications for and technique of episiotomy in other to provide quality nursing care during childbirth.

Scope of Study

This study is delineated to the records of women who had episiotomy and its indicators from 2009 to 2018 in two selected hospitals in Bayelsa State.

Objective of the Study

General Objective: The general objective of this study is to determine the practice and indicators of episiotomy from 2009 to 2018 in two selected hospitals in Bayelsa.

The Specific Objectives are to:

- Determine the practice of episiotomy in two selected hospitals in Bayelsa State
- Identify common the indicators for episiotomy in two selected hospitals in Bayelsa State
- Determine episiotomy practice for each year in two selected hospitals in Bayelsa State
- Determine the parity of women that received episiotomy in the selected hospitals

Research Question

- What are the practices of episiotomy in two selected hospitals in Bayelsa State?
- What are the indicators for episiotomy in two selected hospitals in Bayelsa State?
- What is the episiotomy practice for each year in two selected hospitals in Bayelsa State?
- What are the parities of women that received episiotomy in the two selected hospitals?

Research Hypothesis

1. There is no significant relationship between duration of second stage labour and indication/practice of episiotomy in two selected hospitals in Bayelsa State
2. There is no significant relationship between parity and practice of episiotomy in two selected hospitals in Bayelsa State.



Significance of the Study

This study will engender information on the practice of episiotomy and its indications in the two selected hospital in Bayelsa. An assessment of these indicators will help midwives and other health professionals to plan ahead during labour in order to avoid or minimize giving episiotomy.

The results of this study will be of nonpareil use to policy makers and the administrators of Bayelsa State Hospitals Management Board as they reflect the situation on ground regarding episiotomy practices and its indicators from 2009 to 2018 in two selected hospitals in the State. The hospital management will use the study results to enhance respectful maternity care policy documents as stated by the World Health Organization (2019). Other stakeholders, especially the midwives and obstetricians will use the results to educate women on the importance of physiologic birth process free from episiotomy in hospitals. In this way, proper administrative measures will be put in place with a view of ensuring compliance with policies, laws and education regarding episiotomy practice and its indicators including complications, and prevention. Such measures are necessary in improving and encouraging the utilization of WHO care guideline for the reduction of episiotomy practice in hospitals among midwives and obstetricians. It will also help midwives to provide quality nursing care during labour, delivery, and puerperium

Finally, the study's findings will provide baseline evidence for related studies in the area and also provide basis for further research work

Operational Definitions

Practice: The type of episiotomy given to mothers in the selected hospital

Episiotomy: Mechanically making a deliberate incision on the vaginal wall of mothers in the selected hospitals to allow the baby easy passage

Indicators: Factors responsible for episiotomy in the two hospitals

Women: Mothers that delivered via episiotomy in the two selected hospitals.

RESEARCH METHODOLOGY

Study Area

This study was conducted in two health care facilities in Bayelsa State, Nigeria. The hospitals include Federal Medical Centre, Yenagoa and Niger Delta University Teaching Hospital Okolobiri. These hospitals are both tertiary hospitals and are located at strategic locations which are very accessible to the population. They both act as referral center from general and cottage hospitals as well as private and primary health care facilities within and outside Yenagoa Local Government Area. They provide preventive, diagnostic and curative health care including research and are run by all cadre of medical professionals including nurses, midwives, and trainees.

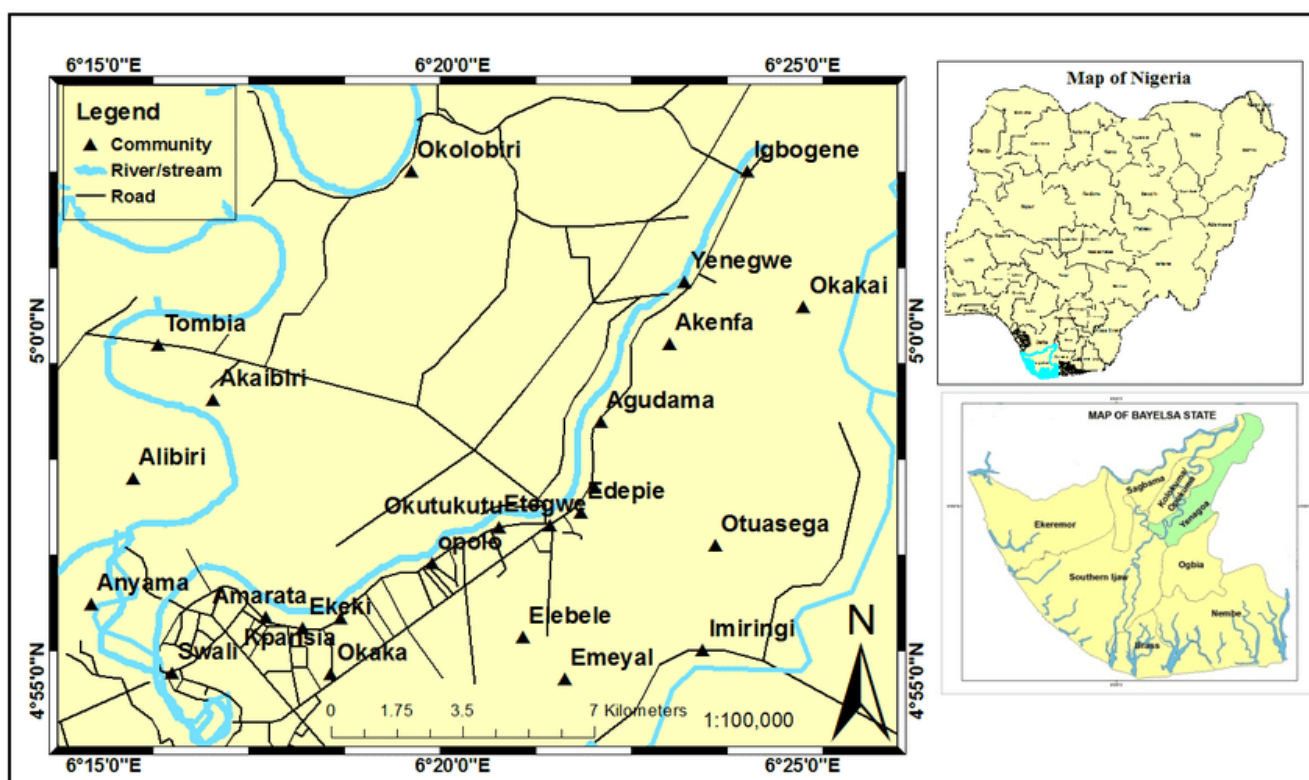


Figure 2.2: Map of Yenagoa Showing Study Communities

Source: www.researchgate.net/figure/Map-of-Yenagoa-showing-study-communities

Federal Medical Centre

Federal Medical Centre is a tertiary health institution which was established on the 19th April, 1959 as general hospital and was officially made Federal Medical Centre in September, 1999. It is located in Ovom Community in Yenagoa Local Government Area, Bayelsa State. It is accessible through a road named after it “Hospital Road” off Melford Okilo road, by water it is via the Bebelibiri River (Hospital waterside) which leads to the facility. It is bound on the West by a river, in the East by a Creek Motel, in the North by Ministry of Education and in the South by Ministry of Works. It is surrounded by about 19km fence and has two (2) entrance gates. The facility has staff strength of 554 nurses and other medical professionals. It is made up of 27 wards and 15 units. The facility also serves as referral centre to the neighbouring communities and most pregnant women from Yenagoa and its neighboring villages visit this hospital for antenatal and delivery. Therefore, the setting is suitable for this type of study.

Niger Delta University Teaching Hospital, Okolobiri

Niger Delta University Teaching Hospital, Okolobiri was established in 1982 as a cottage hospital located at Okolobiri. Okolobiri is a community in Gbarain-Ekpetiama in Yenagoa Local Government Area of Bayelsa State. The cottage hospital was built by the then Old Rivers State Government of Chief Melford Okilo’s Administration. The conception and implementation of the cottage hospital brought the opportunity to the people in that locality to



access medical care. It remained a cottage hospital until the creation of Bayelsa State in 1996 by General Sani Abacha's led Administration. As a State, it became imperative to upgrade the cottage hospital into a General Hospital as part of the states' developmental agenda.

The upgrading was implemented by the military administrator, Group Captain Phillip Ayeni in 1996. With the establishment of the Niger Delta University and the College of Health Sciences in Bayelsa State, there was the urgent need to train medical students, house officers, nurses and students from other paramedical disciplines. It is in this light that the Niger Delta University Teaching Hospital was established in October 2007 by upgrading the General Hospital to the status of a Teaching Hospital. The hospital has a staff strength of about 544 nurses and other medical and non-medical professions. It comprises several units such as antenatal, surgical, medical, maternity, orthopedic, public health, mental health and pediatric unit.

Research Design

Research design may be defined as the overall plan for addressing a research question, which includes specifications for enhancing the study's integrity by Polit and Beck, (2017). A descriptive research design was used for this study. It was designed to retrospectively determine the episiotomy practices and its indicators in two selected hospitals in Bayelsa State.

Study Population

This comprises the entire group of persons or objects that the researcher is interested in studying (Polit & Beck, 2012). For this study, the target population was all mothers who delivered via episiotomy between 2009 and 2018 in the two hospitals.

Inclusion Criteria: Any mother that delivered via episiotomy within the stipulated period whose records has up to six items in the demographic and obstetric data and clinical profile will be eligible.

Exclusion Criteria: Any mother who delivered via episiotomy within the stipulated period but has up to six items missing from both the demographic and social will not be used.

Sample and sampling technique

A purposive sampling technique was adopted in which all mothers who were delivered via episiotomy at the two selected hospitals from 2009 to 2018 and satisfy the inclusion criteria were used.

Study Instrument

The instrument for data collection was checklist developed by the researcher after extensive review of literature and hospital records. The checklist consists of four sections Section A was designed to collect the demographic data of the mothers. Section B was designed to collect the obstetric data of the mother, section C was designed to assess the practice of episiotomy in the two selected hospitals and finally, section D was designed to determine indicators for episiotomy in the two selected hospitals.



Validity of Instrument

The instrument was given to my project supervisors and other consultant in obstetrics/neonatology for content validity and the instrument was modified according to their recommendations.

Reliability of Instrument

The reliability of the measuring instrument was ascertained using a test-retest method with a sample of 20 case file drawn from cases Diète Koki Memorial Hospital Yenagoa, within 5 years. The instrument was repeated after two weeks using the same instrument. The results were analyzed using Pearson Product Moment Analysis to determine the reliability coefficient which was found to be 0.78.

Methods of Data Collection

Polit and Hungler (2011) define data as information obtained in a course of a study. Data collection is a process of gathering data necessary to address a research problem. Data collection is aimed at understanding not only human actions and experiences, but also making explicit the underlying intentions and meanings from the data which is in words, gestures, symbols and artefacts. The directors of medical records of both hospitals were presented with the approval letter and agreement was reached on the time, duration, venue and other logistics for sorting out the files and completing the checklists. Case files of all the deliveries between 2009 and 2018 were reviewed. Data collection was done over 8 weeks, working 5 days per week from 8am to 2pm.

Method of data analysis

The data collected were imputed into the computer using Statistical Package for Social Sciences (SPSS) version 23 and results was presented using descriptive statistics in form of table, percentage, pie chart and bar chart and inferential statistics in form of chi-square was used to test the hypotheses generated.

Ethical Consideration

All related ethical issues were addressed during the conduct of this study. Ethical clearance was obtained from the department which was used to obtain approval from each hospital. During the conduct of the research, the following ethical principles regarding each participant were respected:

Confidentiality and Anonymity: The information obtained from the records was treated confidentially and patients' anonymity was maintained. Thus, participants' names were not required. The identities of participants were not disclosed during report writing and article publication. Participants were protected through the principle of anonymity. All records obtained were used purely for research purposes.

Beneficence: The findings of this study were informed policies and programmes that focused on improving the health of women. The results of this research will help hospitals management and stake-holders in the health care industry especially those in charge of obstetric care. It also creates a strategy to reduce the practice of episiotomy through education program to the women



and obstetric care managers including mothers on the need for compliance in perinatal preparation and early booking for supervision to reduce episiotomy.

Non-maleficence: This study did not employ any invasive procedure. Each participant was protected from physical harm and superfluous psychological trauma or embarrassment since hospital records was used. Question items in the questionnaires were structured in such a way that protects the culture of the participants.

RESULTS AND DISCUSSION

A total of 1688 women had episiotomies from 2009-2018 in both hospitals, however, only 914 (54.1%) case files were retrieved and the remaining 774(45.9%) were damaged by rain as a result of poor storage facilities. All 914 case files were analyzed using Statistical Package for the Social Sciences (SPSS) version 23. Details of the results obtained are presented in tables and charts which are shown below and testing of hypotheses generated

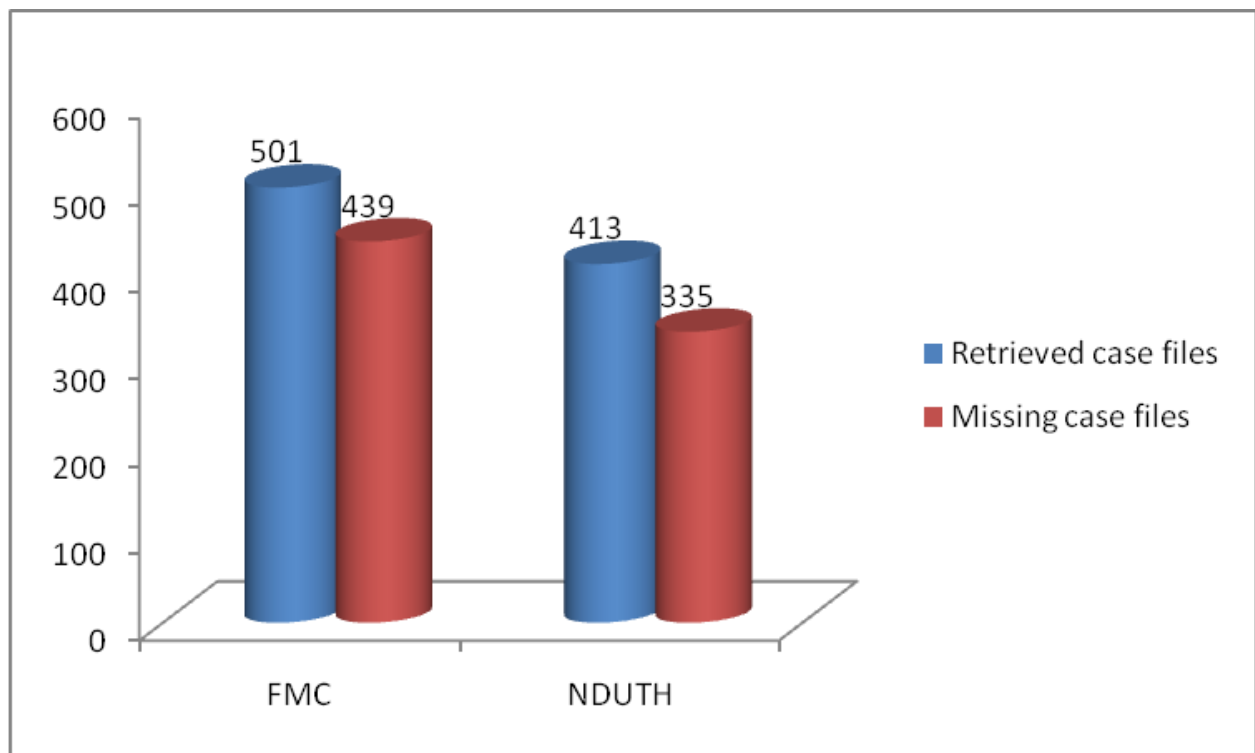


Figure 4.1 shows that 501(29.7%) of the case files of women who had episiotomies between 2009-2018 were retrieved from Federal Medical Centre (FMC) while 439(26.0%) of the case files were missing. 413(24.5%) of the case files were retrieved from Niger Delta University Teaching Hospital (NDUTH) while 335(19.9%) of the case files were missing.

**Table 4.1: Socio- Demographic Characteristics of Respondents (n=914)**

Variable	Responses	Frequency	Percentage
Age X=35.45 SD=8.949	20-30	204	22.3
	31-40	654	71.6
	41-50	56	6.1
Ethnicity	Ijaw	602	65.9
	Hausa	51	5.6
	Igbo	88	9.6
	Yoruba	109	11.9
	Others	64	7.0
Level of education	No formal education	28	3.1
	Primary	120	13.1
	Secondary	537	58.8
	Tertiary	229	25.0
Occupation	Schooling	113	12.4
	Civil Servant	520	56.9
	Trader	103	11.3
	Artisan	58	6.3
	Others	120	13.1

Table 4.1 shows that majority of the respondents 654 (71.6%) were between 31-40 years, 204 (22.3%) were between 20-30 years, while 56 (6.1%) were between 41-50 years. Majority of the respondents 704 (77.0%) were married, 208 (22.8%) were single while 2 (0.2%) were divorced. Most of the respondents 602 (65.9%) were from Ijaw, 109 (11.9%) were from Yoruba, 88 (9.6%) were Igbo, 51 (5.6%) were Hausa while the remaining 64 (7.0%) of the respondents were from other ethnicity. More than half of the respondents 537 (58.8%) had attained secondary level of education, 229 (25.0%) of the respondents had attained tertiary level of education, 120 (13.1%) of the respondents had attained primary level of education while 28 (3.1%) of the respondents had no formal education. 520 (56.9%) of the respondents were civil servants, 113 (12.4%) were students, 103 (11.3%) were traders 58 (6.3%) were artisans while the remaining 120 (13.1%) of the respondents had other occupations.

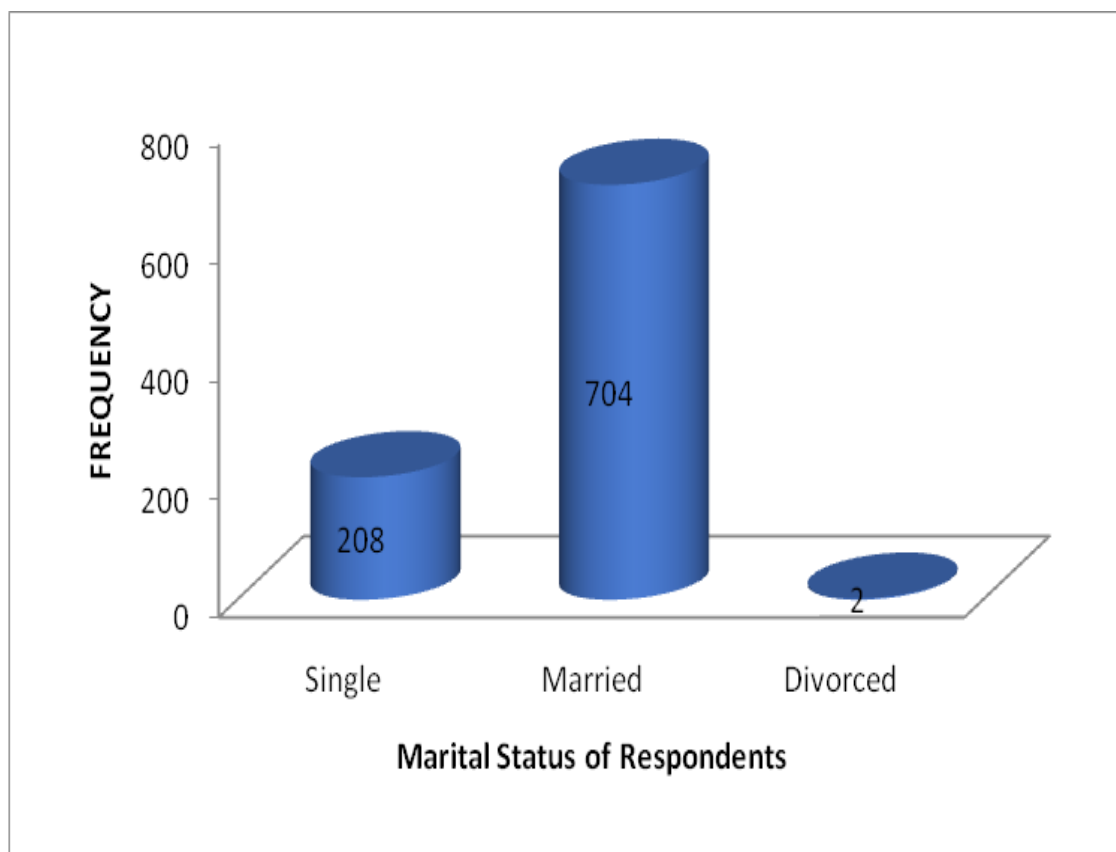


Figure 4.2 shows that majority of the respondents 704 (77.0%) were married, 208 (22.8%) of the respondents were single while 2 (0.2%) were divorced.

Table 4.2: Obstetric (parity...) Characteristics of Respondents (n=914)

Variable	Responses	Frequency	Percentage
Parity	1-2	522	57.1
	3-4	304	33.3
	Above 4	88	9.6
Gestational Age at delivery	Preterm	234	25.6
	Term	655	71.7
	Post term	25	2.7
Duration of second stage labour	Normal	308	33.7
	Prolong	606	66.3
Baby birth weight	Low birth	201	22.0
	Normal	640	70.0
	Macrosomia	73	8.0



Table 4.2 shows that More than half of the respondents 522 (57.1%) had a parity of 1-2, 304 (33.3%) of the respondents had a parity of 3-4 while 88 (9.6%) of the respondents had a parity of above 4. Majority of the respondents 655 (71.7%) gestational age at delivery was at term, 234 (25.6%) had a preterm delivery while 25 (2.7%) had a post term delivery. Most of the respondents 606 (66.3%) had a prolonged duration of second stage of labour while 308 (33.7%) of the respondents had a normal duration of second stage of labour. Majority of the respondents 640 (70.0%) had normal birth weight babies, 201 (22.0%) had low birth weight babies while 73 (8.0%) of the respondents had a macrosomic babies.

Table 4.3: Practices of Episiotomy in the Selected Hospitals (n=914)

Variable	Responses	Frequency	Percentage
Type of episiotomy practice	Routine	0	0.0
	Selective	914	100.0
Type of episiotomy given	Midline (median)	0	0.0
	Medio-lateral	914	100.0
Who performed the episiotomy	Midwife Specialist	708	77.5
	Obstetrician	206	22.5
consent form signed or requested before episiotomy	Yes	0	0.0
	No	914	100.0

Table 4.3 shows that all the respondents 914 (100%) engaged in selective type of episiotomy practice. All the respondents 914 (100.0%) were given medio-lateral type of episiotomy. Majority of the respondents 708 (77.5%) had episiotomy done by a midwife specialist while 206 (22.6%) of the respondents had episiotomy done by an obstetrician. All the respondents 914 (100%) stated that there was no consent form signed or requested before episiotomy.

Table 4.4: Indicators for Episiotomy in Selected Hospital between 2009- 2018

Indicators	Frequency	Percentage
Prolonged second stage	254	27.8
Instrumental delivery (forceps or vacuum extraction).	86	9.4
Rigid perineum	58	6.3
Breech delivery	10	1.1
Maternal exhaustion/ distress	14	1.5
Preterm delivery	54	5.9
Primigravid	368	40.3
Uncooperative delivering mother	70	7.7

Table 4.4 shows the indications for episiotomy in order of magnitude with primigravid constituting 368 (40.3%), prolonged second stage 254 (27.8%), instrumental delivery 86 (9.4%), uncooperative delivering mother 70 (7.7%), rigid perineum 58 (6.3%), preterm delivery 54 (5.9%), maternal exhaustion/distress 14 (1.5%) while breech delivery constitute 10 (1.1%) .



Table 4.5: Total Number of Annual Delivery, Spontaneous Vaginal Delivery and Episiotomy from 2009- 2018 in Selected Hospitals

Year	FMC			NDUTH		
	No of delivery	No of SVD	No of episiotomy	No of delivery	No of SVD	No of episiotomy
2009	524	420	90	721	501	80
2010	628	415	100	759	592	121
2011	721	352	179	688	488	92
2012	445	401	116	559	359	83
2013	1508	1066	166	584	351	101
2014	1132	733	77	441	257	66
2015	1355	920	79	497	307	74
2016	1200	801	67	365	224	50
2017	6201	809	40	399	255	42
2018	558	312	26	423	256	39
TOTAL	14,272	6,229	940	5,436	3490	748

Table 4.5 shows that in the year 2009, FMC had 524 deliveries, 420 spontaneous vaginal deliveries (SVD) and 90 episiotomies while NDUTH had 721 deliveries, 501 were SVDs and 80 episiotomies. In the year 2010, FMC had 628 deliveries, 415 SVD and 100 episiotomies while NDUTH had 759 deliveries, 592 SVDs and 121 episiotomies. In the year 2011, FMC had 721 deliveries, 352 SVDs and 179 episiotomies while NDUTH had 688 deliveries, 488 SVDs and 92 episiotomies. In the year 2012, FMC had 445 deliveries, 401 SVDs and 116 episiotomies while NDUTH had 559 deliveries, 359 SVDs and 83 episiotomies. In the year 2013, FMC had 1508 deliveries, 1066 SVDs and 166 episiotomies while NDUTH had 584 deliveries, 351 SVDs and 101 episiotomies. In the year 2014, FMC had 1132 deliveries, 733 SVDs and 77 episiotomies while NDUTH had 441 deliveries, 257 SVDs and 66 episiotomies. In the year 2015 FMC had 1355 deliveries, 920 SVDs and 70 episiotomies while NDUTH had 497 deliveries, 307 SVDs and 74 episiotomies. In the year 2016, FMC had 1200 deliveries, 801 SVDs and 67 episiotomies while NDUTH had 365 deliveries, 224 SVDs and 50 episiotomies. In the year 2017, FMC had 6201 deliveries, 809 SVDs and 40 episiotomies while NDUTH had 399 deliveries, 255 SVDs and 42 episiotomies. In the year 2018, FMC had 558 deliveries, 312 SVDs and 26 episiotomies while NDUTH had 423 deliveries, 256 SVDs and 39 episiotomies.

**Table 4.6: Rate of Episiotomy from 2009- 2018 in Selected Hospitals**

Year	FMC		NDUTH	
	Frequency	Percentage	Frequency	Percentage
2009	90	9.6	80	10.7
2010	100	10.6	121	16.2
2011	179	19.0	92	12.3
2012	116	12.3	83	11.1
2013	166	17.7	101	13.5
2014	77	8.2	66	8.8
2015	79	8.4	74	9.9
2016	67	7.1	50	6.7
2017	40	4.3	42	5.6
2018	26	2.8	39	5.2
TOTAL	940	100	748	100

Table 4.6 shows that, in the year 2009, 90 (9.6%) of the respondents from FMC had episiotomy while 80 (10.7%) of the respondents from NDUTH had episiotomy. In the year 2010, 100 (10.6%) of the respondents from FMC had episiotomy while 121 (16.2%) of the respondents from NDUTH had episiotomy. In the year 2011, 179 (19.0%) of the respondents from FMC had episiotomy while 92 (12.3%) of the respondents from NDUTH had episiotomy. In the year 2012, 116 (12.3%) of the respondents from FMC had episiotomy while 83 (11.1%) of the respondents from NDUTH had episiotomy. In the year 2013, 166 (17.7%) of the respondents from FMC had episiotomy while 101 (13.5%) of the respondents from NDUTH had episiotomy. In the year 2014, 77 (8.2%) of the respondents from FMC had episiotomy while 66 (8.8%) of the respondents from NDUTH had episiotomy. In the year 2015, 79 (8.4%) of the respondents from FMC had episiotomy while 74 (9.9%) of the respondents from NDUTH had episiotomy. In the year 2016, 67 (7.1%) of the respondents from FMC had episiotomy while 50 (6.7%) of the respondents from NDUTH had episiotomy. In the year 2017, 40 (4.3%) of the respondents from FMC had episiotomy while 42 (5.6%) of the respondents from NDUTH had episiotomy. In the year 2018, 26 (2.8%) of the respondents from FMC had episiotomy while 39 (5.2%) of the respondents from NDUTH had episiotomy.



Test of Formulated Hypotheses

Formulated hypotheses were tested during the course of the study and the results obtained were presented in tables below.

The research hypotheses were:

Hypothesis 1

Null hypothesis 1 (H₀): There is no significant relationship between the parity and practice of episiotomy in two selected hospitals in Bayelsa State calculated P value (0.05) is greater than level of significance.

Alternate hypothesis 1 (H₁): There is significant relationship between the parity and practice of episiotomy in two selected hospitals in Bayelsa State if P value is less than 0.05.

Table 4.7: Statistical Illustration of Relationship Between Parity and Practice of Episiotomy in two Selected Hospitals in Bayelsa State (n=914)

Variable	Responses	Practice of episiotomy			Chi-Square X ²	df	P-Value
		Routine (n=0)	Selective (n=914)	Total			
parity	1-2	0	522	522	36.453 ^a	2	0.021 Significant H ₀ rejected
	3-4	0	304	304			
	Above 4	0	88	88			
	Total	0	914	914			

Table 4.7 shows a significant association between parity of respondents and episiotomy practice with P-value=0.021 < 0.05. Since the P-value is lesser than the significance value (0.05), the null hypothesis was rejected and the alternate hypothesis accepted. This implies that parity influences the practice of episiotomy.

Hypothesis 2

Null hypothesis 2 (H₀): There is no significant relationship between duration of second stage labour and practice of episiotomy in two selected hospitals in Bayelsa State

Alternate hypothesis 2 (H₁): There is significant relationship between duration of second stage labour and practice of episiotomy in two selected hospitals in Bayelsa State



Table 4.8: Statistical illustration of relationship between duration of second stage labour and practice of episiotomy in two selected hospitals in Bayelsa State. (n=914)

Variable	Responses	Practice of episiotomy			Chi-Square X ²	df	P-Value	
		Routine (n=0)	Selective (n=914)	Total				
Duration of second stage labour	Normal	95	308	308	20.361 ^a	1	0.042	Significant H ₀ rejected
	Prolong	134	606	606				
	Total	247	46	293				

Table 4.8 shows a significant association between duration of second stage labour and practice of episiotomy in two selected hospitals with P-value=0.042 < 0.05. Since the P-value is lesser than the significance value (0.05), the null hypothesis was rejected and the alternate hypothesis accepted. This implies that duration of second stage labour influences the practice of episiotomy.

DISCUSSION OF RESULTS

Research Question One: Practices of Episiotomy in the Selected Hospitals (n=914)

Episiotomy practice varies globally, in most countries the procedure recommended as restrictive or routine which varies from region to region. This is seen among United State of America and England in 1995 to 2003, involving more of the nulliparous and multiparous women undergoing vagina delivery, it not amazing to discover that the same is practice among midwives and obstetricians who are professionals in the care of pregnant women undergoing vagina delivery in Nigeria specifically in Federal Medical Centre Yenagoa and Niger Delta University Teaching Hospital Okolobiri Yenagoa.

Results from the table 4.3, 914 (100%) engaged in selective type of episiotomy practice, also; 914 (100.0%) respondents' practice medio-lateral type of episiotomy.

In view that, 708 (77.5%) majority of the episiotomies were done by midwives, while 206 (22.6%) of the respondents had episiotomy done by an obstetrician. From that same table, 914 (100%) respondents stated that there was no consent form signed or requested before episiotomy.

This is supported by Izuka, dim, Chigbu and Obiora-Izuka (2014) who opined that surgical procedure is practiced globally, and with strong scientific proof of its effectiveness hence it has remained controversial. Conversely, Carroli & Mignini, 2009 suggested that episiotomy should be restrictive since women suffer post-operative trauma such as dyspareunia, urinary incontinence.



Research Question Two: Indicators for Episiotomy in two Selected Hospital between 2009-2018.

The primary indication for any episiotomy should be if the fetus is compromised in the second stage of labour and birth needs to be facilitated quickly in rare cases a rigid perineum that is unquestionably obstructing the process of delivery. Evidence shown on table 4:4 that 368(40.3%), constitute the extent with primigravida, while prolonged second state amounted to 86(9.4%) instrumental delivery, on a common ground that uncooperative delivery of mother necessitated the practice up to 70 (7.7%), rigid perineum 58 (6.3%) maternal exhaustion, distress 14 (1.5%).

This is in line with Medecine (2019) that episiotomy should be indicated following prolonged delivery in a compromised fetal state, when completion of the birth process is been obstructed by the perineum, shoulder dystocia, maternal exhaustion, preterm delivery and primigravida.

Research Question Three: Rate of Episiotomy from 2009-2018 in two Selected Hospitals.

Evidence against routine episiotomy policy was aggregated which leads to several publications comprising of routine and restrictive practice of the procedure. WHO, 1996 in its guideline, chose to denounce the reliability of the systematic use of the episiotomy by proposing an indication restively its use to less than 10% of deliveries which disappears as the years goes by.

The analyzed data in table 4.6 shows that, in the year 2011, 179 (19.0%) there was significant increase from FMC had episiotomy while 92 (12.3%) from NDUTH had episiotomy. In the year while in 2013, 166 (17.7%) of the respondents from FMC had episiotomy while 101 (13.5%) of the respondents from NDUTH had episiotomy. There was drastic reduction in the year 2018, 26 (2.8%) of the respondents from FMC had episiotomy while 39 (5.2%) of the respondents from NDUTH had episiotomy.

The study is in view of (Klein, 1995, 2010; Clesse et al 2018) that all these scientific publications made it possible to sanitize professionals to consider routine episiotomy as obsolete. The researcher considered China, India, Philippines or Tanzania including Nigeria with evidence of having close range such as 16.5% which is same in Nigeria as evident in the year 2010 in the two selected hospitals in Bayelsa State (Clesse et al, 2018).

CONCLUSION

Globally, more women are choosing to deliver by choice than ever before. This challenges the notion that delivering a baby is a natural process that should be facilitated but not interfered if it is unnecessary. On one side of the debate are those that suggest that respecting the woman's choice of mode of delivery is in itself a good and desirable clinical practice as it respects the woman's rights to free choice (autonomy) while the other camp suggests it is a futile, frivolous, and disrespectful and unnecessary practice that exposes the health of the woman and her baby to unwanted potential harm and therefore against the principle of non-maleficence. While the preference of routine episiotomy is experience in both the developing and developed world and opposition and support are exhibited in almost all societies, the ethical and social analysis taking into account issues like distributive justice and national health resources, the local safety



surrounding episiotomy practice and indicators (reasons) why midwives/obstetricians choose to carry out the procedure may differ from society to society. While the ethical principle of beneficence, autonomy, justice, and maleficence are argued to be universal, the applicability ought to take into consideration the particularities or specifics of a community.

It can be argued that the lack of knowledge and adequate health care resources (man-power and equipment) in the developing world which makes the women not to receive basic training on perineal preparation/massage including understanding the key role of the passenger and favourable passage for episiotomy free vaginal delivery, the questionable safety issues surrounding the procedure would favour that, episiotomy should be on demand only on a severe case. Where episiotomy may demand to be in the best interest of the women and her baby, it is suggestive that such a procedure be considered still.

For most of the developing world, access to life saving emergency still practitioners are not readily available to care conduct skillful vaginal deliveries to save the women and those of their babies. The potential harms in many cases, much higher than experienced in some developing nations tip the equation in favour of physiologic birth where there are no clinical indications for episiotomy.

It should be explored what women actually need to understand in order for them to make informed decisions about the mode of delivery and the need for perineal preparation that will preserve their own health and that of the babies. Health practitioners need to understand that a request/practice of episiotomy may make a cry for help in several areas of a woman's life. It is also important for national associations of obstetricians and midwives to debate and formulate guidelines on how to handle complex ethical dilemmas as patients' chosen episiotomy. (Lavender, Kingdom, Hart, Gobbay, Neilson & Gyte, 2005)

RECOMMENDATIONS

Based on the finding the following recommendation were put further: policy makers should define the goal and objective, train and retrain professionals on the practice of episiotomy practice to avoid routine practice of the procedure. Midwives and obstetricians should encourage perineal massage from 3rd stage of labour to prevent tear and routine episiotomy procedure.

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