

Title

An assessment of the knowledge and practice of registered midwives regarding policy guidelines for routine episiotomies at two academic, state tertiary hospitals in the Western Cape.

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Degree

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Episiotomy, policies, guidelines, knowledge, childbirth, perineal trauma, perineal tears.

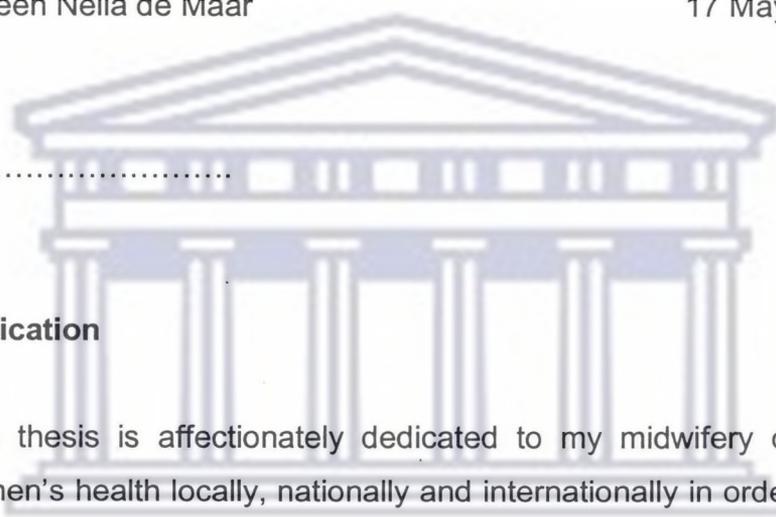
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Declaration

I declare that an assessment of the knowledge and practice of registered midwives regarding episiotomies at two academic state hospitals in the Western Cape is my own work, that it has not been submitted for any degree or examination in any other university, and that the sources I have used or quoted have been acknowledged in the references.

Colleen Nelia de Maar

17 May 2004



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Dedication

This thesis is affectionately dedicated to my midwifery counterparts, and women's health locally, nationally and internationally in order to provide safe, efficient, quality care to mothers and neonates. Being a midwifery tutor has been the highlight of my life.

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Abstract

Title

An assessment of the knowledge and practice of registered midwives regarding policy guidelines for routine episiotomies at two academic, state tertiary hospitals in the Western Cape.

Introduction

An episiotomy is the surgical incision of the perineum. As far as is known, this procedure was done as early as 1741. Sir Fielding Ould, was the first person to describe this procedure in his "Treatise of Midwifery in Three parts", as an aid to assist with difficult deliveries. The implementation of this intervention is a worldwide phenomenon and has been recorded during the 19th century as one of the most common surgical procedures in the clinical practice. The World Health Organisation has taken a clear stand against routine episiotomies and recommend that episiotomy rates should be around 10% and no more than 20%. There are no clear guidelines in the literature available that give true and valid indications for the performance of an episiotomy.

Aim

The aim was to determine whether the two tertiary academic institutions in the Western Cape have policies and guidelines available regarding the performance of episiotomies by registered midwives and to determine the knowledge and practice of registered midwives regarding these policies and guidelines.

Methodology

The researcher made use of a descriptive survey to explore the issue whether guidelines exist regarding episiotomies and whether midwives are aware about these guidelines. Structured questionnaires were used to gain information from the registered midwives. The researcher also made use of documents (birth register) and in-depth interviews (unit managers).

Results

The findings of the study concluded that midwives are aware of the latest evidence that episiotomies are not done routinely even though no evidence of existing policies could be allocated in any of the two wards. The finding further shown that the current guidelines are not based on evidence. Midwives do not directly rely on guidelines in the wards (non available), but an inference is made that the midwives obtain access via secondary sources such as obstetricians. Midwives feels competent to do episiotomies but would like to be updated on knowledge regarding procedures and agree that skills updates are important. They are not aware of how to gain access to evidence based literature such as systematic reviews.

Conclusions

There is an urgent need to inform the regulatory professional body to review their regulations as the current regulation as it stands promotes more harm than good. Similarly is there a need to inform the national, provincial and local government / institutions, that if they publish guidelines they need to ensure that these guidelines are based on the latest evidence where possible. It is further important that policies be available to all members of staff to update them self with current information. In-service updates on evidence and

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practical skill workshops should be implemented to ensure that midwives stay competent in procedures that are not done regularly.



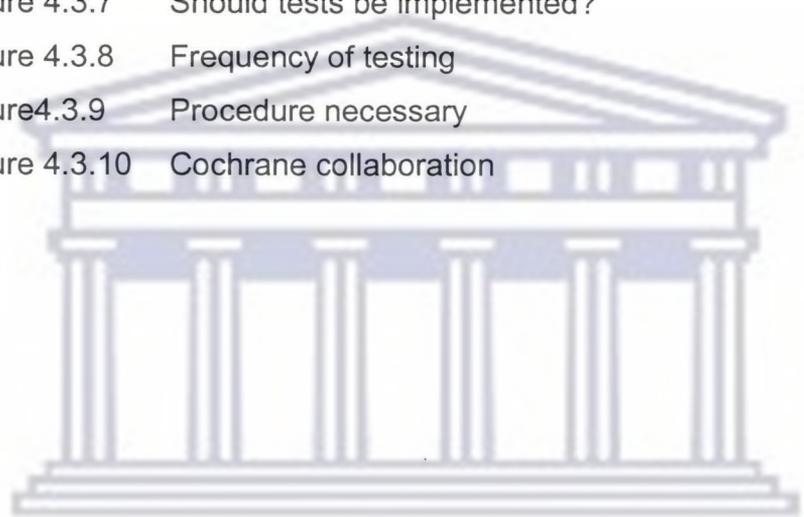
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Chapter one Orientation to the study

1.1 Introduction

The word "episiotomy" derives from the Greek word "episeion", pudenda and tome, which refer to a surgical incision of the pudenda (van Goeverden & Uys, 1996:33). As far as is known does it appear that this procedure was done as early as 1741. Records stated that Sir Fielding Ould, a Dublin midwifery practitioner, was the first person to describe this procedure (Myers-Helfgott & Helfgott, 1999:206).

Most practitioners advocate that the routine use of episiotomies is needed because it prevents injury to the pelvic floor and it reduces perineal trauma, especially. They also believe that it prevents the occurrence of third and fourth degree tears (Lede, Belizan & Carroli, 1996:1399). Little evidence exists to support the original argument that episiotomies limit perineal trauma and most data indicate that episiotomies predispose perineal lacerations. In view of this evidence does the World Health Organisation recommend that episiotomy rates should be around 10% and no more than 20% (Nikodem, 1999:133).

It can be assumed that that policy makers work in good faith when they design policies or guidelines. The problem is that many of these guidelines are not based on good evidence, they are therefore ineffective and they waste valuable resources and may harm the people that they are set up to assist or guide. It is a further concern that policy makers do not know the facts

and need to be educated regarding evidence before they write policy statements (Ament, 1998:41]. South Africa in specific does not have money to waste on any policy regarding treatments or interventions that have been shown to be ineffective. The researcher could not find guidelines in the literature on the true and valid indications for the performance of an episiotomy.

1.2 Research problem

A problem exists in the current clinical midwifery settings in that midwives are unaware of what the content of current policies and guidelines regarding the knowledge and practice of episiotomies are.

1.3 Research purpose

The purpose of this study is to determine the knowledge and practice of registered midwives regarding episiotomy policies and guidelines.

1.4 Aim

The aim is to determine whether the two tertiary academic institutions in the Western Cape have policies and guidelines available regarding the performance of episiotomies by registered midwives and to determine the knowledge and practice of registered midwives regarding these policies and guidelines.

1.5 Research statement

Registered midwives are unaware of the content and availability of policies and guidelines regarding episiotomies.

1.6 Definitions

Episiotomy: "An episiotomy is a surgical incision of the perineum in order to enlarge the introitus" (Nolte, 1998:190). An episiotomy refers to a surgical incision in the perineum to enlarge the vaginal opening making the birth of the fetus easier. It is performed by the caregiver during the second stage of labour and needs repair by suturing.

Perineum: "This is a diamond-shaped space lying beneath the pelvic floor. The area is divided into two triangles, the urogenital triangle anteriorly and an

anal triangle posteriorly. They are divided by a transverse band made up of the perineal muscle and the base of the urogenital diaphragm" (Nolte, 1998:47).

Perineal body: "In women, the perineal body lies between the vagina and rectum and consists of fibrous tissue. It is this part which stretches from the fourchette to the anus" (Nolte, 1998:47).

Perineal tears:

First degree tear - the skin of the perineum is torn, involving the fourchette, the perineal skin and the vaginal mucosal membrane (Nikodem, 1999:156).

Second degree tear - the skin and muscle of the perineum is torn, involving the fourchette, perineal skin, vaginal mucosal membrane, perineal fascia and muscle (bulbo-cavernosus, ischio-cavernosus and transverse perineal muscle) (Nikodem, 1999:156).

Third degree tear - the anal sphincter is torn, the rectum occasionally (Nikodem, 1999:156).

Fourth degree tear - This laceration extends through the anal sphincter, through the rectal mucosa and exposes the lumen of the rectum (Nikodem, 1999:156).

Registered midwife: According to the South African Nursing Council Regulation No. 387 of 15 February 1985 as amended by Regulation 2490 of 26 October 1990, a registered midwife is "A person who is registered as a midwife in terms of the Nursing Act of 1978 (Act No 50 of 1978).

Midwifery regimen: The regulation and implementation of those matters, which through midwifery intervention, have an influence on the course, and management of pregnancy, labour and puerperium, including the provision of care plans, implementation and evaluation.

1.7 Research setting

Permission will be obtained to do research in the labour wards of the obstetric units in two tertiary academic state hospitals in the Western Cape.

1.8 Research design

A descriptive survey will be done using a self-answered structured questionnaire to obtain data from the midwives. The researcher will also make use of documents (birth register) and in-depth interviews (unit managers).

1.9 Population

The study population consists of all registered midwives employed in obstetric units at two academic, tertiary, state hospitals in the Western Cape.

1.10 Sample size

The sample size will consist of a convenience sample that will be made up of all the registered midwives that are working in the units during the time of data collection and that will be willing to participate in the study.

1.11 Procedure for data gathering

The study will be conducted in three distinct phases.

Phase one – Record review of maternity records.

Phase two – Self-administered, structured questionnaires to midwives.

Phase three – In-depth interviews with unit managers.

1.12 Instrument

A retrospective record review of birth registers will be used to collect the data during phase one. A structured, self-administered questionnaire will be used to evaluate the knowledge and practice of registered midwives regarding episiotomies and in-depth interviews will be held with the unit managers.

1.13 Validity

The instrument will be tested for:

Face validity: This procedure is based on subjective views. Thus when one looks at the questionnaire does it “look” as if it focuses on the topic that needs to be evaluated. Content validity will also be assessed: It is important that the content (type of questions) of the instrument is related to the focus of what needs to be measured.

1.14 Reliability

The quality of the research is enhanced by the degree of reliability and validity that the measuring instrument has. Reliability of an instrument refers to the degree of consistency with which it measures the element it is designed to measure. A pilot study will be done on respondents that are not part of the final study to ensure that the instrument is reliable.

1.15 Data analyses

Epi info 2002 will be used to analyze the quantitative data. The findings will be illustrated by means description and the use of bar charts in chapter four. Common themes and written description of findings will be formulated from responses of the open-ended questions and interviews.

1.16 Dissemination of results

Results will be given in chapter four and discussed in chapter five. An article will be written and will be submitted to a peer group reviewed journal such as *Curationis* for publication. Copies of the mini thesis will also be available in the library of the University of the Western Cape. Feedback will also be given to the management and the participants of the two hospitals.

1.17 Ethical considerations

Approval to conduct the study will be requested from the Higher Degree Ethics committee of the Faculty of Community and Health Sciences as well as the Senate of the University of the Western Cape. Further ethical approval to conduct the study will be obtained from the ethical committees of the two hospitals. Consent will also be obtained from the Assistant Director of Nursing and the Heads of Obstetrics of the two hospitals and all the participants.

1.18 Conclusion

Chapter one is the proposal outline of the study. It is essential that the researcher give thought to all the steps in the research process before she starts with the data collection. The proposal serves as a guideline to execute the study and contribute to the validity and reliability of the process.



Chapter two Literature review

2.1 Introduction

A literature review was done to assist the researcher to gain background knowledge pertaining to the field of interest. The review has drawn on international and national literature that covered the topic of episiotomies. A search strategy was followed using databases such as "PubMed" and the "Cochrane Library" to obtain information. Literature pertaining to the research question will be discussed under the following headings:

Historical background

Possible benefits for the routine use of episiotomies

Possible disadvantages for the routine use of episiotomies

Indications and guidelines for the use of episiotomies

Episiotomy techniques and practice

Financial implications associated with episiotomies

Advocacy

2.2 Historical background

The word "episiotomy" derives from the Greek word "episeion", pudenda and tome, which refer to a surgical incision of the pudenda (van Goeverden & Uys, 1996:33). Rightly, an episiotomy is actually the surgical incision of the perineum. In midwifery practice an episiotomy refers "to a surgical incision

through the perineum, to enlarge the vaginal opening..." (Nikodem, 1999:156). The perineum refers to the perineal skin, fourchette, vaginal mucosa, perineal fascia, bulbocavernosus, ischiocavernosus and transverse perineal muscle (Nikodem, 1999:156).

As far as is known does it appear that this procedure was done as early as 1741. Records stated that Sir Fielding Ould, a Dublin midwifery practitioner, was the first person to describe this procedure in his "Treatise of Midwifery in Three parts", as an aid to assist with difficult deliveries (Myers-Helfgott & Helfgott, 1999:206; Harrison, Brennen, North, Reed & Wickham, 1984:1971; Thorp & Bowes, 1989:1027). The origin of the mediolateral episiotomy may stem directly from the oblique incision suggested by Dubois in 1847 (Myers-Helfgott & Helfgott, 1999:306). During 1878, Broomall advocated that the routine use of an episiotomy might prevent perineal injury (Thorp & Bowes, 1989:1027).

The implementation of this intervention is a worldwide phenomenon and has been recorded during the 19th century as one of the most common surgical procedures in the clinical practice. The implementation increased especially after 1920 when De Lee proposed that an episiotomy would preserve the integrity of the pelvic floor (Myers-Helfgott & Helfgott, 1999:306). Elective episiotomies were encouraged prophylactically to decrease maternal and infant morbidity and mortality between 1915 and 1935 (Myers-Helfgott & Helfgott, 1999:306). As medical technology advanced women moved to hospital settings to give birth to their infants and by 1945 more than 70% of

women gave birth in hospital settings and they were thus at a high risk to receive this intervention (Myers-Helfgott & Helfgott, 1999:307).

By 1985, cutting of an episiotomy was the second most common surgical procedure performed in the United States of America (USA) after cutting of the umbilical cord and an incidence of over 80% has been reported (Pritchard 1985 in Maier & Maloni, 1997:155; Harrison et al., 1984:1972, & Althaba, Belizan, Bergel, 2002:945). Bates (2002:1) referred to the decline in the overall incidence of episiotomy rate from 56% to 31% in the USA over the time period of 1979 to 1997, but reported on the disparity of the incidence of episiotomies between black and white women, as well as the higher incidence in private hospitals. During that time period more than 60% of white women compared to 26.6% in non-white women and 65.7% women in private settings versus 35% in government settings had episiotomies. Another study done via an electronic audit of medical databases showed a significant decrease in the rate of episiotomies in the USA from 69.6% in 1983 to 19.4% in 2000 (Goldberg, Holtz, Hislop & Tolosa, 2002:395).

In England, more than 50% of women received episiotomies by the end of 1980. The incidence of episiotomies gradually decreased in England over the years from 50% to 37% in 1985 and even as low as 16% in 1998 (Madumsa-Butshe, Dyllal & Garner, 1998:1). Countries such as Argentina reported episiotomy rates of up to 92% in primiparous women during the time period of 1995-1998 in hospitals (Althabe et.al., 2002:945). They experienced no difference in the incidence between private settings or government settings.

By 1998 the episiotomy rates in some of the academic hospitals in South Africa was still as high as 40% (Nikodem,1999:134). Sweden has been able to reduce the overall incidence of episiotomy from 33.7% in 1989 to 24.5% in nulliparous women. They reported rates as low as one percent in multiparous women and six percent in nulliparous women (Rockner & Fianu-Jonasson 1999:95).

The World Health Organisation has taken a clear stand against routine episiotomies and recommend that episiotomy rates should be around 10% and no more than 20% (Nikodem, 1999:133).

2.3 Possible benefits for the routine use of episiotomies

- **Prevention of tears and perineal complications**

The prevention of severe perineal tears that may lead to third and fourth degree tears is most probably the major justification given by most practitioners for the routine use of episiotomies. Practitioners further believed that these severe laceration lead to urinary and fecal incontinence or ultimately may lead to a cystoceles, prolapse of the uterus or rectoceles (Lede, Belizan & Carroli, 1996:1399). The statement by De Lee, that the enlargement of the introits during childbirth to enable the practitioner to restore the vaginal anatomy and pelvic muscles to the prepartum condition had a major impact on all health professionals (Myers-Helfgott & Helfgott,

1999:306). Most practitioners advocate that the routine use of episiotomies is implemented to prevent injury to the pelvic floor and reduce perineal trauma, especially that it would prevent the occurrence of third and fourth degree tears (Lede et al., 1996:1399; Myers-Helfgott & Helfgott, 1999:308).

- **Shortening of second stage and prevention of fetal injury**

Episiotomies are also commonly done to assist mothers when caregivers perceived that women are suffering from exhaustion and are too tired to push during the second stage of labour. Most obstetricians feel that the routine use of episiotomies to shorten the second stage of labour especially during assisted deliveries is needed to accelerate the safe delivery of an already compromised infant. It is further said to be beneficial to cut an episiotomy to assist during the delivery of an infant who presents with shoulder dystocia.

2.4 Possible disadvantages for the routine use of episiotomies

- **Increase the incidence of severe perineal tears**

Scientific evidence has proved that the major justification for the implementation of the routine use of episiotomies is indeed incorrect and that episiotomies is a major contributing factor to severe trauma such as third and fourth degree tears (Lede et al., 1996:1400; Reynolds, 1995:281). Myers-

Helfgott & Helfgott (1999:308) quoted a study that showed the relationship between episiotomies and third and fourth degree tears. Women who did not have episiotomies had an incidence of 0% - 2.3%, whilst those who had episiotomies had incidence severe tears of between 3%-24%. They further stated that studies have consistently showed that the use of routine episiotomy is indeed associated with the increase incidence of anal and rectal damage. Harrison et al., (1984:1972) also support these findings. They have found that none of the women who were allowed to deliver without an elective episiotomy had any third degree tears, but the incidence of third degree tears in the elective episiotomy group were six percent. In a survey reporting on a large sample size existing of 24 000 women, it became apparent that women who had a midline episiotomy is 50 times more likely to experience a third or fourth degree tear (Maier et al., 1997:157).

Cumulative data meta-analyses done by Thorp & Bowes (1989:1028) showed that 6.5% of women who had a midline episiotomy experienced a third or fourth degree laceration versus 1.4% in those who did not had episiotomies. These conclusions are further supported by Labrecque & Baillargeon (1999: 797), where they stated that a median episiotomy is strongly associated with severe perineal trauma.

The incidence of severe perineal trauma (third and fourth degree tears) have significantly reduced in countries where they have been able to reduce the episiotomy rate (Rockner, 1999:95). A study done in Denmark supported these findings where they have found that midwives who have the lowest

episiotomy rates 22% versus 55% had a lower incidence of anal sphincter trauma 1.2% versus 2% (Hendriksen , Bek, Hedegaard & Secher, 1992:952).

It is further known that the overall risk of spontaneous tears is 3.3 times higher in women who have been exposed to previous perineal trauma such as an episiotomy (Sylvie, Michel, Sylvie, Sylvie & Jean-Jacques, 2001:334). This evidence support the issue that episiotomies should be avoided at all cost as it does more harm than good.

There maybe a small disadvantage in the avoidance of episiotomy as some trials have shown that it may be associated with an increase risk of anterior lacerations such as para-urethral labial and vaginal wall tears but these injuries are not so severe as injuries to the posterior anatomy (Nikodem, 1999: 157).

Jander & Lyrenas (2001:231) did a retrospective survey and identified some risk factors that could possibly increase the risk of third and fourth degree tears. The following factors were associated with a higher incidence of severe perineal trauma; primiparity, squatting on a low birth stool, age >35 years, birth weight > 4000 g, vacuum extraction, median episiotomy, giving birth between 03h00 and 06h00, the use of analgesia and oxytocin. Most of these are obviously not avoidable, but one should take cognizance of them and those that can be avoided such as median episiotomies should be implemented to reduce the incidence of severe lacerations.

Little evidence exists to support the original argument that episiotomies limit perineal trauma and most data indicate that episiotomies predispose perineal lacerations. It is clear from the evidence that episiotomies have no protective effect to prevent third and fourth degree tears that they actually cause the very trauma that they are suppose to prevent.

- **Shortening of second stage and prevention of fetal injury**

Randomised, controlled trials have examined the issue of whether episiotomies do shorten the second stage of labour, especially if fetal distress is present. None of these trails could confirm the claim that episiotomies do shorten the second stage of labour. There were no significant time difference in the second stage of labour between the women who had episiotomies and those who did not (Myers-Helfgott & Helfgott, 1999:3120). Myers-Helfgott & Helfgott (1999:315) stated that; "No scientific claim seems to exist for the beneficial effect of episiotomy in shortening the second stage of labor or preventing fetal distress as measured by Apgar scores, cord blood gases, or admissions to the neonatal intensive care unit."

Case review studies that examined the effect of injury on the infant in cases where shoulder dystocia occurred found no evidence to support the routine cut of an episiotomy to decrease the risk for the infant. In a way it is logical as shoulder dystocia is a problem with the fetal shoulder against the bony pelvis

of the mother and not against the soft tissue of the perineum (Myers-Helfgott & Helfgott, 1999:316).

It is claimed that episiotomies may decrease the risk or injury of intraventricular hemorrhage (IVH), fetal asphyxia and the risk of mental retardation (Myers-Helfgott & Helfgott, 1999:314). Even though this is claimed very few trials have examined the statements. Three small trials examining whether episiotomies indeed do decrease IVH, failed to show any correlation between episiotomies and the decrease occurrence of IVH. In other studies no differences in Apgar scores were detected between women who had episiotomies and those who did not (Myers-Helfgott & Helfgott, 1999:312).

It appears to be an international policy to cut an episiotomy when operative vaginal deliveries are anticipated. Retrospective analyses using large databases have raised the question whether there are any benefits to cut an episiotomy during assisted deliveries as no advantages to neonatal morbidity or mortality were shown in doing so (Myers-Helfgott & Helfgott, 1999:312).

- **Effect on pelvic relaxation**

It is logical that the act of childbirth in itself contributes to pelvic floor injury in several different ways and that the impact of the fetal head during parturition may have an impact on the pelvic nerves (Myers-Helfgott & Helfgott,

1999:312). About one third of women developed urinary stress incontinence due to a weakness caused by the denervation of the pelvic muscles during pregnancy and birth. No studies support the issue that episiotomies prevent pelvic floor damage (Myers-Helfgott & Helfgott, 1999:313).

Episiotomies have been associated with decrease in muscle tone of the pelvic floor. Electromyographic studies confirmed that women who had intact perineums had the strongest pelvic floor muscles and that nearly half of the women who had an episiotomy had subnormal manometric results. Women who had episiotomies or third or fourth degree tears had the weakest pelvic floor muscles and took the longest to recover their muscle function after childbirth (Myers-Helfgott & Helfgott, 1999:314). Yoder (2000:no page) stated that higher rates of anal incontinence is found during the first six months in women who had episiotomies and an increase risk in vaginal prolapse, rectovaginal and anal fistulas has also been described.

- **Bloodloss and death**

There is no doubt that the incision of an episiotomy is a bloody experience regardless of what technique is used. Additional blood loss of up to 600 mls can be attributed to the procedure. Episiotomies contributes a significant risk factor to one of the five major causes of maternal deaths viz postpartum haemorrhage. Avoidance of a simple harmful procedure such as the routine use of episiotomies is a powerful way to decrease postpartum haemorrhage

and indirectly maternal morbidity and mortality (Myers-Helfgott & Helfgott, 1999:318). Perineal trauma (episiotomy) has been associated with maternal death due to haemorrhage (Myers-Helfgott & Helfgott, 1999:302).

- **Edema, pain, scar tissue unsatisfactory healing, infection and dehiscence**

Episiotomies carry the same risks as other surgical procedures, including increased blood loss, poor wound healing and infection. Complications such as pain, edema and the increase risk for infection and possible formation of scar tissue has been mentioned as disadvantages of episiotomies. A retrospective survey have shown that women who had spontaneous tears experience much less pain than those who had episiotomies, 15% compared to women who had episiotomies 37% (Myers-Helfgott & Helfgott, 1999:319).

Harrison et al. (1984:1973) showed in a comparative study that the immediate pain during the first four days post delivery is similar between women who had episiotomies and those who experienced second degree tears that needed suturing. They stated that women who had intact perinea required the least analgesia post delivery and those who had episiotomies or second degree tears needed the same amount of analgesics.

Complications during repairing of episiotomies or perineal lacerations may occur. Occasionally the suturing can be asymmetry or the rectum can be

penetrated leaving an opening for fistula formation and occasionally excessive narrowing of the introitus can occur. The formation of haematomas of the perineum has been reported with the performance of episiotomies. Haematomas can form and become infected, which could lead to rectovaginal fistulas (Myers-Helfgott & Helfgott, 1999:318).

The incidence of infection post episiotomies varies between 0.35% and 10% (Myers-Helfgott & Helfgott, 1999:320). The severity of infection ranges from a simple stitch infection to more serious complications such as perineal abscesses, rectovaginal fistulas, anorectal abscesses, anal sphincter disruption, fecal incontinence and necrotizing fasciitis. The incidence of perineal infections when associated with episiotomy dehiscence varied between 23% to 78% (Myers-Helfgott & Helfgott, 1999:321).

Several trials have addressed the issue of postpartum pain related to episiotomies and compared to tears or intact perineums. The results of most of the studies gave homogenous conclusions that women who has episiotomies suffer more pain in the wound area during the first week and up to six weeks post partum (Myers-Helfgott & Helfgott, 1999:319).

There is no evidence to proof that that a straight surgical incision is easier to repair than a lacerated tear and that the incidence of infection is less (Myers-Helfgott & Helfgott, 1999:312). What is known is that women who had episiotomies had poorer healing than those who experienced spontaneous lacerations (Myers-Helfgott & Helfgott, 1999:312).

From the literature it is clear that most authors refute the concept that the recuperative period after episiotomies are less painful than from a spontaneous tear. This raises awareness for the need to explore the real valid indications to perform an episiotomy and to standardize episiotomy policies, in an attempt to decrease the overall incidence.

- **Overall wellbeing and hospitalization**

The popular press refer to an episiotomy as “the unkindest cut” and sometimes as a form of genital mutilation (Bates, 2002:1). The gender violence and psychological impact of episiotomies are not well described in the literature. These invasive procedures reinforce the inherent incompetence and untrustworthiness of the female body. The destruction and reconstruction of the female genitals allow men to feel in control over the female body. (Nikodem, 1999: 127).

Another complication maybe psychological pain, negative effect on well-being and difficulties to bond with the newborn or to care for the infant Steen, 1998:228; Bruce, 2003:1). It has been reported that 64% of women viewed episiotomies as stressful during the postpartum period (Maier et al., 1997:157). Episiotomies may result in complications, which do increase the length of hospital stay or re-hospitalisation (Nikodem, 1999:128).

- **Dyspareunia**

Long term effects such as dyspareunia have also been associated with the routine use of episiotomies. Women who had intact perinea or who sustained perineal tears resumed intercourse earlier, had less pain on the resumption of intercourse and were sexually more satisfied (Lede et al., 1996:1401; Myers-Helfgott & Helfgott, 1999:313).

Myers-Helfgott & Helfgott, (1999:319) referred to a retrospective survey done by Kitzinger & Walters where they found that 19% of women who had episiotomies experience dyspareunia versus 11% in those who had spontaneous tears. Bex & Hofmeyr (1987:100) followed women up, one to two years post delivery, they found that significantly more women who had episiotomies experienced dyspareunia (40%). None of the women who had tears experienced dyspareunia. In another study quoted in Nikodem (1999:131) 47% of women experienced dyspareunia at three months and the most common reason why women did not resume sexual relations within three months post delivery was perineal pain.

Although it is not feasible to do prospective randomized trials to investigate the effect of episiotomies on dyspareunia it is clear from the retrospective evidence that episiotomies do negatively influence women's sexual functioning. Research debates indicate that women delivered by midwives who avoid episiotomies were more likely to resume intercourse within a month after delivery. The Berkshire trial in the United Kingdom, indicates, that

significantly more women in the restrictive episiotomy policy, than in the liberal policy group, had resumed intercourse one month after childbirth (Lede et al., 1996:1; Maier & Malone, 1997:157).

2.5 Indications and guidelines for the use of episiotomies

It can be assumed that that policy makers work in good faith when they design policies or guidelines. The problem is that many of these guidelines are not based on good evidence, they are therefore ineffective and they waste valuable resources and may harm the people that they are set up to assist or guide. It is a further concern that policy makers do not know the facts and need to be educated regarding evidence before they write policy statements (Ament, 1998:41]. South Africa in specific does not have money to waste on any policy regarding treatments or interventions that have been shown to be ineffective. There are no clear guidelines in the literature available that give true and valid indications for the performance of an episiotomy. It is recommended by the authors of a Cochrane systematic review that trails should be done to answer the questions of what should the indications be for the use of restrictive episiotomies (Thacker, 2000;1615).

The evidence on valid indications for an episiotomy is still a highly debated topic, but it is generally regarded that all midwives and obstetricians should know how to perform an episiotomy. With the movement away from routine episiotomies the question has arises what is the knowledge and practice of

registered midwives regarding episiotomies and what is stated in the guidelines for performing episiotomies. The concern is that staff members may be less knowledgeable regarding the guidelines and may be less experienced in the performance of episiotomies because of the decrease incidence thereof in the some maternity wards. A further concern is that there is no uniformity regarding the indications and the method used to perform episiotomies or to suture or what suturing material to use. These variances in factors maybe because staff is not well acquainted with the guidelines or maybe there are no guidelines in the facilities.

The South African Nursing Council R2488, states, "An episiotomy may be performed by a registered midwife to prevent a severe tear of the perineum or complications relating to the child, provided the head is on the perineum". Guidelines for maternity care in South Africa, a manual for clinic, community health centers and district hospitals stated the following:

"Episiotomy should only be performed for a valid indication:

- Thick or rigid perineum
- Fetal distress in second stage of labour
- Prolonged second stage of labour with the fetal head bulging the perineum
- Maternal conditions where easy and rapid delivery is required, e.g. cardiac disease
- Breech or assisted deliveries
- Previous third degree tear
- Delivery of preterm babies where the perineum is tight"

Lorenz, Mogtara, Garner (1998:83) suggested that the introduction of a labour chart (partogram) maybe a good vehicle to introduce a policy / guideline on avoiding of episiotomies. Sadly, but true, episiotomies are also indicated to give midwifery and medical students the opportunity to practice a procedure (Myers-Helfgott & Helfgott, 1999:308; van Goeverden & Uys, 1996:34; Maduma-Butshe et al., 1998:1179), despite the moral and ethical controversy of learning the healing art by access to human bodies (Hill, 2003:924).

Literature indicates that Klein and others support the use of a "highly selective use of episiotomy for special fetal and maternal conditions" such as fetal distress (Yoder, 2003:no page). Implementation or the actual following of guidelines is a complex process. It is commonly known that most people are resistant to change. Specific steps are essential to ensure that practice will change. Some of these steps involve reflection of current practices, examination of evidence available in the literature, preferable drawn from systematic reviews and then lastly the incorporation of this external knowledge with internal knowledge and skills (Ebrahim & Ogumbanjo, 2003:21).

This literature search has confirmed the statement that there is a lack, nationally and internationally, on effective guidelines regarding episiotomies. This statement is reinforced by Robinson, Norwiz, Cohen & Lieberman. (2000:216), that obstetricians have different views regarding the indications to

perform episiotomies, and that the strongest association for indications lies with provider category rather than on guidelines or indications such as estimated birth weight > 4000g or fetal distress. It is therefore essential to take care that the caregivers attitudes needs to be addressed, because implementation of guidelines will not change care if the attitudes of the caregivers do not change (Robinson et al., 2000: 217).

2.6 Evidence on selective episiotomies versus routine episiotomies

Literature concluded that episiotomies should be restricted Myers-Helfgott & Helfgott, 1999:322). In line with the best available evidence is it very clear that routine episiotomies should no longer be practiced (Maduma-Butshe et al., 1998:1179). Routine episiotomies is an ineffective practice and policy which result in complications, harming people and wasting resources, thus reflecting poor quality of care Myers-Helfgott & Helfgott, 1999:313; Althaba et al.,2002:1; Blevins, 1998:1-3).

2.7 The practise for performing episiotomies

Different techniques can be used to perform and suture episiotomies. The most common techniques that have been described are the "midline" and "mediolateral" techniques. The midline incision is commonly used in the USA, as the belief that it is easier to heal and cause less discomfort for the women.

The mediolateral incision is commonly used in South Africa and the United Kingdom as practitioners believe that it may cause fewer tears into the rectum (Myers-Helfgott & Helfgott, 1999:308). The South African Nursing Council Regulation 2488 No. 4 does not stipulate whether a midwife should perform a midline or a mediolateral episiotomy.

Technique refers to the timing, type and depth of the incision, as well as the suturing materials used for repairing an episiotomy. Van Goeverden & Uys (1996:35) refer to the timing of an episiotomy as "when the presenting part is born immediately afterwards" (crowning).

The incision techniques mostly described are midline and mediolateral techniques.

Examination of standard texts suggested that episiotomies should begin in the midline and subtend an angle of at least 40 degrees, with most of the texts stating an angle of 45 to 60 degrees (Tincello, Williams, Fowler, Adams, Richmond, Alfirevic, 2003:1043).

"A midline episiotomy incises the vaginal mucosa for 2-4 cm, extends downwards through the tendinous point of the perineum, and finishes short of the external anal sphincter muscle. As the cut is through fibrous tissue there is little blood loss, but there is a risk of extending into the rectum" (Jackson, 1994:100).

“A medio-lateral episiotomy cuts through the vaginal mucosa for a short distance, then continues either to the left or the right of the perineum, through the bulbocavernosus, superficial transverse perinei, and in some cases the levatores ani muscles, but avoiding Bartholin’s gland and duct. Care must be taken not to excise the ischioanal fossa, as these can sometimes become infected or be the site of a haematoma” (Jackson, 1994:100).

Steen (1998:228) defines trauma as “the morbid condition of a body produced by a wound or external violence.” A few non-randomised cohort trials have addressed the issue of mediolateral versus midline episiotomies, but currently with the evidence available the outcome of which method is best cannot be answered. Those in favour of the midline episiotomy stated that it improves wound healing and has a lesser effect of pain and sexual dysfunction. Those against a midline episiotomy states that it increase the incidence of third and fourth degree tears (Labrecque et al., 1997:5; Robinson et al., 2000:214). Given the available evidence, the researcher have to support the issue that a median episiotomy given to primiparous women may increase the incidence of third and fourth degree tears and therefore should be avoided (Sylvie et al., 2001:5).

Suturing methods have been researched and evidence of best practice is available. It has been shown that a continuous, two-layer repair (muscle and vaginal mucosa) of an episiotomy and second degree tear appears to reduce pain and dyspareunia with no increase risk of wound breakdown. Thus a

subcutaneous skin suture is used and the skin is not penetrated during suturing (Jackson,1994:100; Nikodem,1999:131).

This view is supported in literature which suggests that continuous sutures is easier to repair, patients walk better soon and have less discomfort The type of suturing material has been research and evidence shown that the best suturing material to use is polyglycolic or polyglactin absorbable synthetic suture material (Jackson,1994:100-104).

2.8 Financial implications associated with episiotomies

Cost savings is an important factor and by lowering the incidence of episiotomy a healthcare setting can reduce their costs of up to 25% (Lede et al., 1996:1400). Literature showed a significant decrease in the use of suturing material ($p < 0.01$) and a saving in midwives time when they implement a restrictive episiotomy policy. Hueston (1996: 1004) indicates in his study that 1.98 million women would receive an episiotomy with childbirth, resulting in 390,000 extra hospital days and a significant rise of \$351 million in annual health care expenditure.

Calculated money saved with a policy of selective episiotomies compared to a policy with routine episiotomies were reported in two Latin American countries: Brazils savings, ranging from 15-30 million US\$, and Venezuela would be between 3,5 and 7 million US\$ (Carroli, Belizan & Stamp, 1999:1).

Developing countries have limited resources; therefore, time and money spent on health should be effective. If not, then we as midwives are responsible for encouraging deprivation and poverty. The development of effective practices and policies to implement controlled, quality maternal and neonatal health care regarding episiotomies must become a priority in obstetrics. Potential monetary savings could be significant when considering the number of women who undergo an episiotomy each year. Nurse advocacy and budgeting cognizance of current innovations and change need to be considered when devising quality assurance programmes in obstetric units. Continuous research to standardize episiotomy policy is the essence for cost-effective nursing care and improvement in incidence rates of episiotomies.

2.9 Advocacy

From the literature it is evident that white, nulliparous women who are on a medical aid, had an epidural during her labour and were delivered by an obstetrician are at highest risk to have an episiotomy (Hueston, 1996:1003). Midwives can reduce the incidence of unneeded unjustified procedure such as an episiotomy by educating women on their right of choices during childbirth and by the implementation of guidelines and policies that restrict the liberal use of episiotomies (Maier et al., 1997: 157). Compared with obstetricians midwives do have a lower incidence of episiotomy rate but in

general midwives or obstetric nurses have very little control over obstetricians decisions to perform an episiotomy, but should use their skills to advocate to the patient her rights to avoid the routine use of episiotomies (Maier et al., 1997:159). The introduction of patient advocacy and direct care of women in labour are good recommendations to be implemented, to prevent perineal trauma and unnecessary episiotomies (Maier et al., 1997:155).

There is concern that women are not informed of their options prior to the procedure (episiotomy) and their consent is not sought, raising ethical questions about the practice of midwives (Blevins, 1998:1-2). Blevins mention the ethical principle "freedom of choice". It is very difficult to make an informed decision while one is in pain about to deliver and consent should be obtained during the ante natal period or first stage of labour. Ethics and law indicate that any restriction to "freedom of choice" denies clients the right to make decisions about their own bodies (Blevins, 1998:1-2). This reflects malpractice. All women should be allowed informed choices. Motivation of self interest in terms of power and authority should be discarded for the interest of the health and safety of mothers and their babies.

Health care demands expertise from midwives to enable them to meet the needs of the community. It is of paramount importance that the clinical nursing specialist in midwifery and neonatology adapts to the changed South African health care policies and technological progress. Midwives must involve themselves in the formulation of directives and contribute by making

recommendations based on research findings for the scope of practice within the South African context.

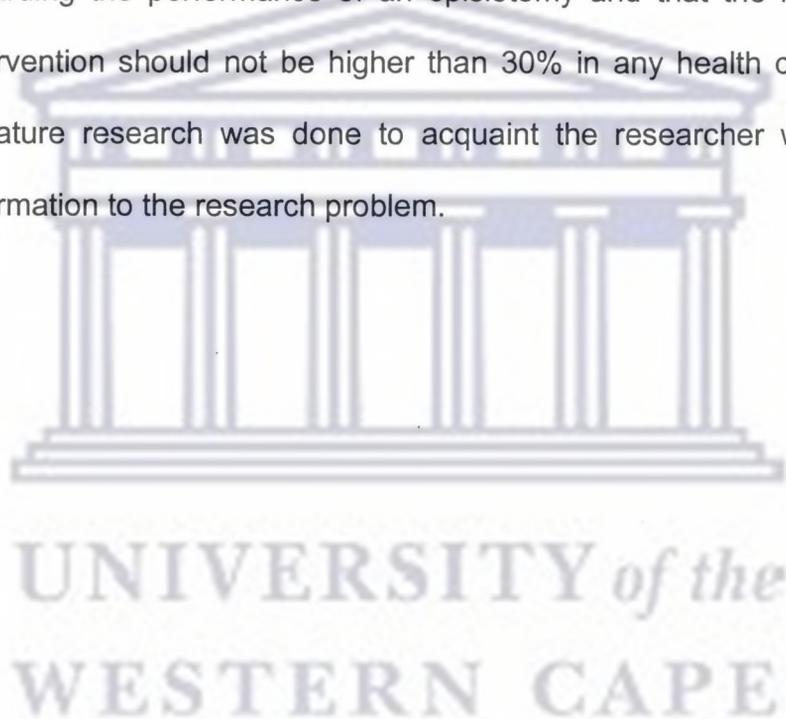
2.10 Conclusion

The conclusion is quite clear in view of the evidence in the literature. There is no evidence to support the routine use of an episiotomy as it has no beneficial effects for women or their infants. On the contrary the routine use of episiotomies may cause harm and do increase the clinical morbidity in post partum women. Restrictive episiotomies may increase the risk of anterior lacerations. This literature search has shown that there is no evidence that episiotomies decrease severe perineal trauma such as third and fourth degree tears neither does it shorten the second stage of labour or prevent fetal injury such as birth asphyxia or low Apgar scores. Indeed there is enough evidence to prove that episiotomies put women at an increased risk of third and fourth degree tears, increase the overall incidence of interventions, has a negative effect on the pelvic floor muscles, causes an increase in the incidence of post partum haemorrhage and may cause death. The morbidity is further increased and women who had episiotomies suffer from edema, pain, infection and sexual dysfunction. It also may have psychological implications and definitely raises the cost of hospital care.

There are not sufficient and clear guidelines based on evidence regarding the indications to perform an episiotomy. Midwives practice a variety of incision

and suturing techniques. There is no conclusive evidence to support the mediolateral episiotomy rather than the midline cut, when an episiotomy is performed. Further evidence show that a two layer continuous, subcuticular (non skin) suturing technique using polyglycolic and polyglactin absorbable synthetic suturing material is the most effective.

In view of this review is it essential that clear guidelines should be drawn up regarding the performance of an episiotomy and that the incidence of this intervention should not be higher than 30% in any health care facility. This literature research was done to acquaint the researcher with background information to the research problem.



Chapter three Research Methodology

3.1 Introduction

Research methodology refers to the method or logical framework that is used in the decision making process during the process of scientific research. A combination of qualitative and quantitative research methods was used during this project to collect the information. A detailed description of the scientific methods and procedures used to carry out this project will be described in chapter three.

3.2 Research problem

The researcher has identified a problem in the clinical settings that registered midwives are unsure of what the indications for episiotomies are. Several guidelines regarding episiotomies exist, but it appears that midwives are unaware what the actual content of current policies and guidelines are regarding the practice of episiotomies.

3.3 Research purpose

The purpose of this study was to determine the knowledge and practice of registered midwives regarding episiotomy policies and guidelines.

3.4 Aim

The aim was to determine whether the two tertiary academic institutions in the Western Cape have policies and guidelines available regarding the performance of episiotomies by registered midwives and to determine the knowledge and practice of registered midwives regarding these policies and guidelines.

3.5 Research statement

Registered midwives are unaware of the content and availability of policies and guidelines regarding episiotomies.

3.6 Definitions

Episiotomy: "An episiotomy is a surgical incision of the perineum in order to enlarge the introitus" (Nolte, 1998:190). An episiotomy refers to a surgical incision in the perineum to enlarge the vaginal opening making the birth of the fetus easier. It is performed by the caregiver during the second stage of labour and needs repair by suturing.

Perineum: "This is a diamond-shaped space lying beneath the pelvic floor. The area is divided into two triangles, the urogenital triangle anteriorly and an

anal triangle posteriorly. They are divided by a transverse band made up of the perineal muscle and the base of the urogenital diaphragm" (Nolte, 1998:47).

Perineal body: "In women, the perineal body lies between the vagina and rectum and consists of fibrous tissue. It is this part which stretches from the fourchette to the anus" (Nolte, 1998:47).

Perineal tears:

First degree tear - the skin of the perineum is torn, involving the fourchette, the perineal skin and the vaginal mucosal membrane (Nikodem, 1999:156).

Second degree tear - the skin and muscle of the perineum is torn, involving the fourchette, perineal skin, vaginal mucosal membrane, perineal fascia and muscle (bulbo-cavernosus, ischio-cavernosus and transverse perineal muscle) (Nikodem, 1999:156).

Third degree tear - the anal sphincter is torn, the rectum occasionally (Nikodem, 1999:156).

Fourth degree tear - This laceration extends through the anal sphincter, through the rectal mucosa and exposes the lumen of the rectum (Nikodem, 1999:156).

Registered midwife: According to the South African Nursing Council Regulation No. 387 of 15 February 1985 as amended by Regulation 2490 of 26 October 1990, a registered midwife is "A person who is registered as a midwife in terms of the Nursing Act of 1978 (Act No 50 of 1978).

Midwifery regimen: The regulation and implementation of those matters, which through midwifery intervention, have an influence on the course, and management of pregnancy, labour and puerperium, including the provision of care plans, implementation and evaluation.

3.7 Research setting

The research took place in the labour wards of the obstetric units in two tertiary, academic, state hospitals in the Western Cape.

3.8 Research design

The research design is the overall plan for obtaining answers to the questions being studied and for handling some of the difficulties encountered during the research process (Polit & Hungler, 1993:38).

The researcher used a survey research design as it was felt that this design would be appropriate to answer the research question. This design involves the participation of subjects and is usually exploratory and descriptive in nature (Mouton, 2003:152). The use of structured questionnaires is recommended for this design and the researcher used a structured questionnaire with close and open-ended questions for the registered

midwives. The researcher also made use of documents (birth register) and in-depth interviews (unit managers).

The limitations of this study are the small number of participants and the low degree of control effect over the generalisability of the findings.

3.9 Population

Population refers to the general population of cases that meets a designated set of criteria. The entire set of individuals or object has some common characteristic (Polit & Hungler, 1993:38,442). The study population was all registered midwives employed in obstetric units at two academic state hospitals in the Western Cape. Both obstetric units at Hospitals A and B had about 20 registered midwives on their shift rosters at the time of the study, making up a total of 40 registered midwives. The eligibility criteria for the study was the qualification as a registered midwife currently working in the obstetric units of Hospital A & B.

3.10 Sample size

The sample size consisted of a convenience sample that was made up of all the registered midwives that were working in the units during the time of data collection and that were willing to participate in the study. Convenient

sampling is a non-probability approach, which has a risk of bias and errors. Convenience sampling entails the use of the most conveniently available people as subjects in a study (Polit & Hungler, 1993:176). This sampling method is based on the judgment of a researcher regarding the characteristics of a representative sample. A sample is chosen on the basis of what the researcher thinks to be an appropriate person. Registered midwives conduct deliveries and episiotomies in the labour wards at the two hospitals and both hospitals were tertiary, state, academic hospitals. The group was thus a homogenous group. When the phenomena under investigation are fairly homogeneous within the population, the risk of bias is decreased (Polit & Hungler, 1993:176-177).

The convenience sample was chosen from the total population. The sample size was made up of the unit managers and registered midwives of the two hospitals and that were willing to participate in the study. At Hospital A the delivery room was staffed with 9-10 registered midwives per week of whom five were allocated to the labour ward per day, and one registered midwife who performs administrative and clinical functions. Two registered midwives alternate administrative and clinical functions at Hospital B, while six to seven of them were allocated to the labour ward per day. The registered midwives allocated to the labour wards at both hospitals work opposite shifts, and those allocated to perform administrative and clinical functions work straight shifts.

3.11 Procedure for data gathering

The study was conducted in three distinct phases.

Phase one – Record review

Maternity records were reviewed at each of the two academic hospitals to determine the total number of deliveries and spontaneous vaginal deliveries. The incidence of perineal trauma such as episiotomies performed has also been noted. The data reviewed was done retrospectively over the same six months period in both hospitals.

Phase two – Self administered, structured questionnaires

The researcher asked permission from the unit manager to distribute the questionnaire to the midwives. The unit manager at each hospital distributed the questionnaires to the midwives in the unit. The completed questionnaires were then collected by the ward secretary or unit manager and kept in a safe place until collected by the researcher.

Phase three – In-depth interviews

In-depth interviews were conducted with one unit manager at each of the obstetric units to gain information about episiotomy policies. Appointments

were made with the managers of the delivery units at both hospitals. The interview was in the form of an informal discussion and the researcher recorded some notes while conversing with the manager. No recorder was used to record the discussion. At the end of the interview the researcher confirmed her notes with the nurse manager to ensure that she interpret the discussion correctly.

The initial interviews were conducted with the unit managers before the questionnaires were distributed. The interviews lasted about 20 -30 minutes. The exit interviews were conducted on the day that the researcher collected the completed questionnaires.

3.12 Instrument

A measuring instrument in the human sciences refers to the data collection instrument (Mouton, 2003:100). A retrospective record review was used to collect the data during phase one. Records provide a readily available and valuable source of information for research. The greatest advantage of a record review is that it is unbiased as data has already been collected, thus researcher bias cannot be introduced. Other advantages of using records are as follows: They often cover a long period of time, they are inexpensive, convenient and time-saving. Some disadvantages of using records include the following: The researcher cannot add to the record if it is incomplete, conditions under which the records were collected are usually unknown, the

records were not collected for this specific study, and the researcher has to rely on integrity that the data was recorded correctly (Treece & Treece, 1982:269).

A structured, self-administered questionnaire was used to evaluate the knowledge and practice of registered midwives regarding episiotomies (Annex 1). The absence of an interviewer minimizes bias in the responses that may reflect the respondent's reaction to the interviewer rather than to the questions themselves (Polit & Hungler, 1993:205). Another advantage is that the respondents are anonymous so they are more likely to comment exactly how they feel and that it can be completed in a short time period. The questionnaire took about 10 minutes to complete. This design allows the researcher to examine the points of view of a number of individuals as they share their opinions about the topic. It was also not necessary for the registered midwives and the unit managers to reach consensus. Response alternatives, ranged from a simple yes or no to rather complex expressions of opinion. Although questionnaires are much less costly and require less time and energy to administer, the researcher does not have the opportunity to interact with the subject (Treece & Treece, 1982:228-229).

Questionnaires were in English, since it was the current used medium of communication in the hospitals. The questionnaire consisted of both open and closed ended questions. The questionnaire consisted of thirteen questions.

Questions focused on the indications and criteria used by registered midwives in deciding whether to perform an episiotomy and to compare their practices with institutional policies and protocol of episiotomies.

3.13 Validity

A questionnaire was used as the measuring instrument to collect data in phase two. When a new designed questionnaire is used it is essential that it be tested for reliability and validity (Treece & Treece, 1982:172). Validity is more important than reliability and if a study is to be meaningful the instrument must be valid (Treece & Treece, 1982:183). Validity refers to the degree to which an instrument measures what it is intended to measure (Polit and Hungler, 1993:244,245,248).

Face validity: This procedure is based on subjective views. Thus when one looks at the questionnaire does it "look" as if it focuses on the topic that needs to be evaluated.

Content validity: It is important that the content (type of questions) of the instrument is related to the focus of what needs to be measured.

The researcher tested the instrument for face validity and content validity by discussing the instrument with tutors at the Western Cape College of Nursing,

one of the supervisors and two obstetricians. The critique that was received was incorporated before the questionnaire was distributed.

The researcher is a lecturer and is competent to conduct interviews. The subjects participating in the project were registered midwives thus all of them had tertiary education and was competent to read, write and understand English. The truth of responses is a key concern when data are obtained through questionnaires and interviews. The researcher attempted to increase the validity of responses by ensuring that respondents were very clear on the nature of the research e.g. why the research was done, what was being studied and how the data would be collected and used.

3.14 Reliability

The quality of the research is enhanced by the degree of reliability and validity that the measuring instrument has. Reliability of an instrument refers to the degree of consistency with which it measures the element it is designed to measure. Thus it refers to how constant an instrument measures the occurrence of interest. It refers to the consistency and dependability of an instrument, or to the accuracy of the data in the sense of their stability or repeatability (Burns & Grove, 1993:778).

Reliability was tested by doing a pilot study three midwives and two obstetricians. These midwives were not working at the study sites. The pilot

was done to serve as a trial run of the instrument to see if it was in further need of revision (Polit & Hungler, 1993:40). The objectives of the pilot study were to determine whether the instrument accurately measure the research question, whether the subjects understand the content items in the instrument and to determine whether the instrument will provide the needed data. Following the pilot study it was felt that some of the original open-ended questions should be to closed-ended questions. These suggestions were incorporated in the final product.

Methods for establishing reliability and validity in qualitative research (in-depth interview) differ from those used in quantitative research. Terms, such as dependability, credibility, trustworthiness and transferability are mentioned in the literature (Polit & Hungler, 1993:253-255). The researcher ensure the above by confirming her notes with the unit managers after she conducted the interviews to make sure that the notes were a true reflection of the discussions.

3.15 Data analyses

Epi info 2002 was used to analyze the quantitative data. The findings are illustrated by means of descriptive paragraphs and bar charts in chapter four. Common themes and written description of findings were formulated from responses of the open-ended questions and interviews. Organization and interpretation of data were done systematically.

3.16 Dissemination of results

Results are given in chapter four and discussed in chapter five. The intend is to write an article for submission to a peer group reviewed journal such as *Curationis* for publication. Copies of the mini thesis will also be available in the library of the University of the Western Cape. Feedback will also be given to the management and the participants of the two hospitals.

3.17 Ethical considerations

The protocol to conduct the study has been approved by the Higher Degree Ethics committee of the Faculty of Community and Health Sciences as well as by the Senate of the University of the Western Cape. Further ethical approval to conduct the study was obtained from the ethical committees of the two hospitals. Consent was also obtained from the Assistant director of Nursing and the Heads of Obstetrics of the two hospitals.

Verbal permission was obtained from all the participants, and they were informed of the aim and process of the study. They were informed that participation in the study was voluntary, and that they could withdraw at any time. They were all assured of confidentiality and anonymity.

3.18 Conclusion

This chapter focused on the methodology of the research. The participants, research designs, data collection and procedures were addressed. The reliability and validity of the data collection instruments were substantiated.



Chapter four Results

4.1 Introduction

The results obtain during the data gathering process will be presented in this chapter. The results will be presented in the three phases. Phase one addresses the results obtained from the birth registers. The results obtained from the self administered structured questionnaires were addressed during phase two and phase three will concentrate on the entry and exit in-depth interviews with the unit managers.

4.2 Phase one - Review of the maternity records

The researcher visited the respective labour wards to obtain information from the maternity registers. It was decided to look at a period of six months (May – October) to obtain an average total. The total deliveries recorded at the two hospitals were 4127. Both these hospitals are tertiary hospitals. The total number of normal vertex deliveries was 2595 / 4127 (62.9%). The caesarian rate was 32.5% (1341/4127), assisted deliveries were 2.71% (111 / 4127) and 80/4127 (1.93%) deliveries were breech or recorded as “other” (Figure 4.1).

The researcher look at the incidence of perineal trauma in all the deliveries as recorded in the maternity registers over the same time period. Information

about perineal trauma was available on 2777 records. The overall incidence of the episiotomy rate was 19.4% (540 / 2777). Second degree tears occurred in about 5.86% (163 / 2777) of women and only 0.54% (15 / 2777) had a third degree tear (Figure 4.2).

Figure 4.1 Deliveries at both hospitals

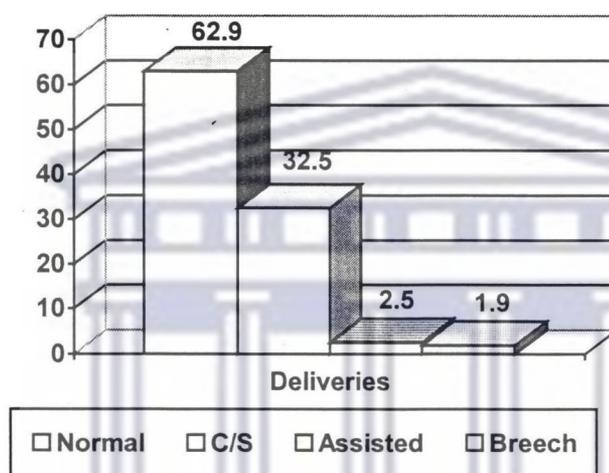
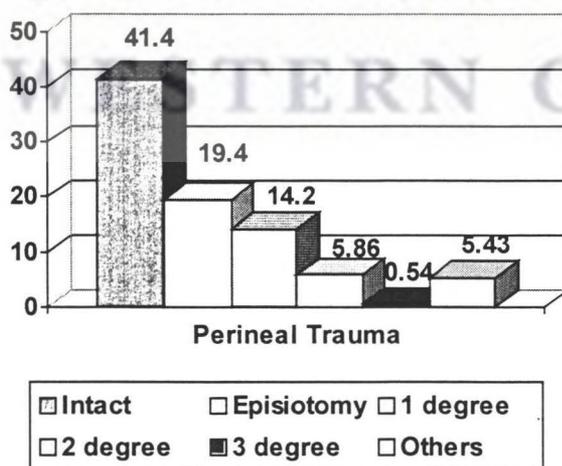


Figure 4.2 Incidence of perineal trauma



4.3 Phase two – Questionnaires with registered midwives

The close ended questions were analysed and frequencies of the respondents answers are given in 4.3.1 and depicted in figures 4.3.1 – 4.3.10. The open ended questions are addressed under 4.3.2.

4.3.1 Phase two – Close ended questions

Nearly two thirds (78.4% 29 / 37) of the respondents felt that it is important to have a policy on episiotomies in a labour ward. Slightly more than half (56.8% 21 / 37) of the midwives stated that they were aware of existing policies in their institutions. The answers of the respondents reflected that 73.3% (22 / 30) of them were knowledgeable about their episiotomy policies. The majority (70.4% 19 / 27) of these midwives stated that they consistently apply the guidelines reflected in these policies when executing episiotomies. Although most (91.4% 32 / 35) of the midwives felt that they are competent with the episiotomy technique, 80% (28 / 35) of them indicated that there is a need to test their competency related to the episiotomy techniques. A similar percentage (80% 28 / 35) stated that competency tests regarding episiotomy techniques should be conducted and half of them (48% 12 / 25) suggested that the evaluation of competency should be done bi-annually. Nearly two thirds (68.5% 24 / 35) of the midwives felt that episiotomies are no longer needed. Knowledge about the Cochrane collaboration was minimal (5.4% 2 / 37) among midwives at these two hospitals (Figure 4.3.1-10).

Figure 4.3.1 Important to have episiotomy policies

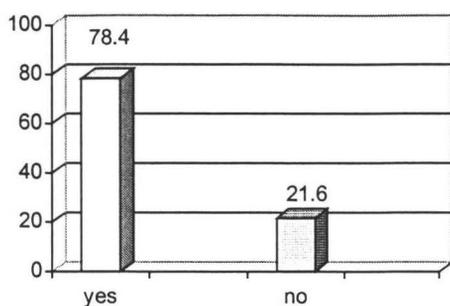


Figure 4.3.2 Existing policies at institution

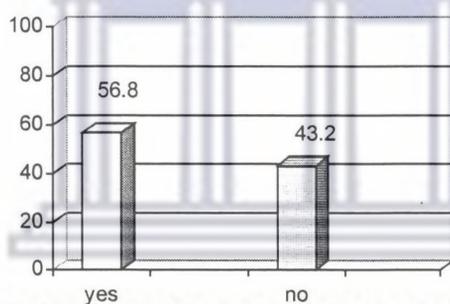


Figure 4.3.3 Knowledgeable about the policy

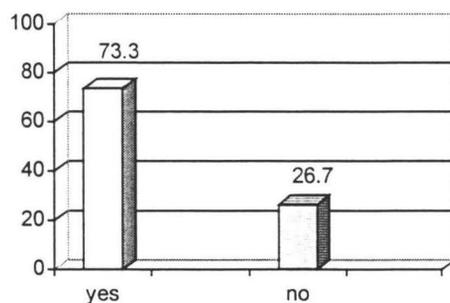


Figure 4.3.4 How do you apply the policy

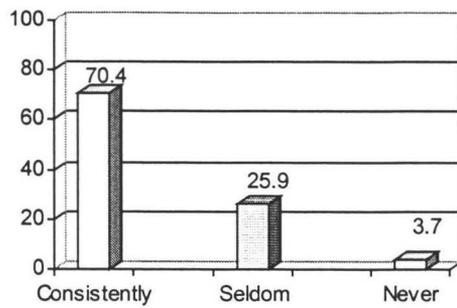


Figure 4.3.5 Competent with technique

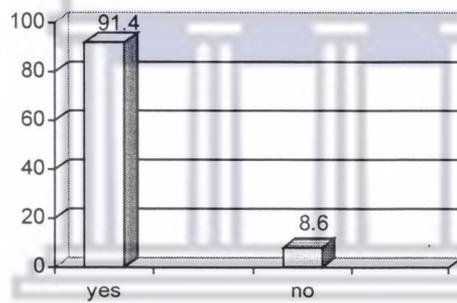


Figure 4.3.6 Need for competency tests

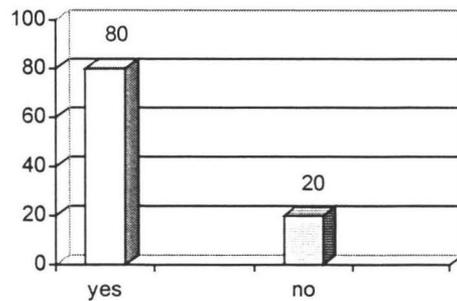


Figure 4.3.7 Should tests be implemented?

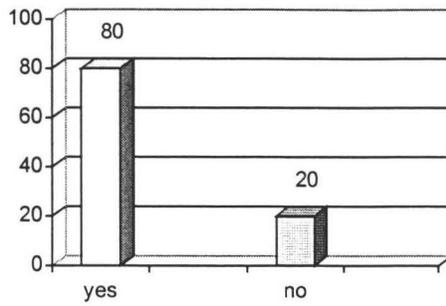


Figure 4.3.8 Frequency of testing

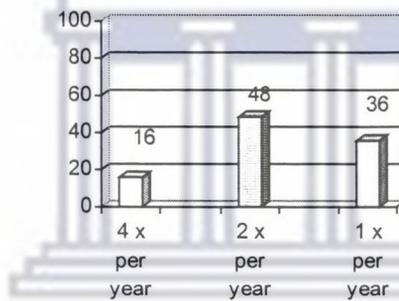


Figure 4.3.9 Procedure necessary

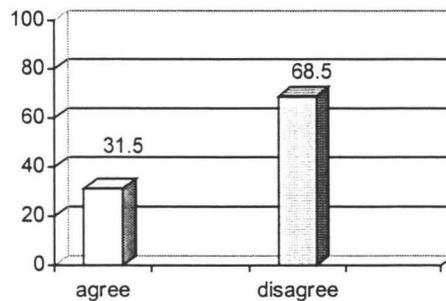
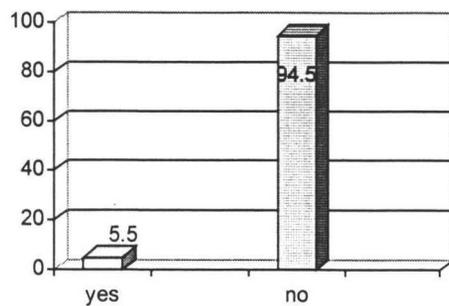


Figure 4.3.10 **Cochrane collaboration**

4.3.2 Phase two – Open ended questions

Very few midwives responded to the open ended questions. Themes were therefore not combined and all the actual responses are given below.

Reasons given of why midwives felt that policies should be seldom or never applied were:

"Policies are not necessary for skilled midwives."

"Policies are not always applied."

"Episiotomies are done unnecessary."

"Episiotomies are time consuming."

"Tears are better."

"To shorten the second stage."

"To prevent third degree tears."

"Fetal distress."

Reason that midwives given why they agree or disagree on the justification of episiotomies were:

“Proper perineal support.”

“Doulas.”

“Prevent third degree tears.”

“Episiotomies are not necessary with a skilled manager.”

“Circumstantial.”

“High turnover rate.”

“Indications.”

4.4. Personal interviews with unit managers at entry level.

4.4.1 Personal interview with the unit manager of hospital A at entry level

The unit manager was on leave during this period, therefore the first interview was done with the second in charge with her verbal permission in her office. According to the acting unit manager at Hospital A, nine to ten registered midwives are on the shift roster. Five registered midwives are functional in the labour ward on a daily basis. These registered midwives are responsible for direct patient care on opposite shifts. The unit manager does the administration and also assist with deliveries when the unit is very busy. These registered midwives were on duty from 07h00 to 19h00 for 3 scattered

days, while the unit manager did administration and clinical midwifery from 07h00 –16h00 from Monday to Friday.

The unit manager reported that they have approximately 10 deliveries per day. On enquiry about a current policy regarding episiotomies, she responded as follows: “At present, we do not have any episiotomy policy in writing. The midwives normally follow the norm to cut an episiotomy when it is necessary.” She further indicated: “It is important to have some guidelines because we get midwifery and medical students. I’ll have to speak to the head nurse about this.”

The researcher obtained permission from the acting unit manager. She explained the aim of the study as well as the procedure that would be followed. The acting manager gave her permission and 30 questionnaires were left with the acting manager to hand out to the midwives. The interview was concluded in about 20 minutes.

4.4.2 Personal interview with the unit manager of hospital B at entry level

A personal interview was scheduled and conducted with one of the unit managers of Hospital B with her verbal permission in her office. The unit manager reported that approximately six to seven registered midwives are on duty from 07h00-19h00 per day, performing direct patient care. The birth rate

at this institution is approximately 350-450 deliveries per month. The unit managers are on duty from 07h00-16h00, one unit manager is responsible for the administration of the unit while the other unit manager does clinical midwifery. These two unit managers also complement each other's duties when necessary.

When the researcher enquired about a copy of their episiotomy policy, the response was; "We do have a written policy on episiotomies for the performance by registered midwives, but quite frankly I do not know where it is. The midwives know what is expected of them. They rather leave a patient to sustain second and third degree tears than performing episiotomies. Episiotomies are performed very seldom in our unit. Our midwives hardly perform episiotomies, since we were informed by the obstetricians that an episiotomy by itself implies second to third degree tears."

The researcher discussed the structured questionnaire with the unit manager. She agreed to distribute the questionnaire and would ask the respondents to complete it. Thirty copies of the structured questionnaires were left with the unit manager for distribution to the midwives. The unit manager made a verbal agreement to leave the completed questionnaires with the ward secretary in a sealed envelope. The interview was concluded in about thirty minutes.

4.4.3 Exit interview with unit manager at hospital A

The researcher return to hospital A to collect the structured questionnaires and to conduct an exit interview with the unit manager. On her arrival in the ward it become known that the main unit manager are has returned from leave. The researcher confirmed her appointment and asked permission to conduct an interview. The initial response of the unit manager was; "Oh... yes, I heard all about it. Apparently the midwife who was in charge at the time reported the matter to the Nursing Service Manager. Approximately one month after you were here, a working group was formed to develop an episiotomy policy for our unit. My only concern is that the labour ward staff were not involved. This policy was implemented only a few weeks ago."

From above remarks it seemed as if this unit manager would have liked the labour ward staff and herself to be involved in the development and decision-making process of labour ward policies.

The researcher asked the unit manager how she feels about the new policy. Her answer was; "The episiotomy policy is basically similar to what we've learnt in our training, nil extra, but it is good and has been accepted". The researcher asked her then about her personal view about the policy on which the unit manager responded; "A policy is a good reference to orientate new personnel. It serves as an update in instances of uncertainty and can be used for student midwives in their training". She also said "restrictive episiotomy policies should be used according to the midwives initiative" and mentioned

other issues such as “re trial of labour, doctors complaints to management e.g. some time ago, an unexpected shoulder dystocia resulted in a patient sustaining severe perineal lacerations and a third degree tear because an episiotomy was not performed. Student midwives must be taught and supervised, and new staff must also be orientated regarding protocols and procedures”.

The unit manager confirmed positively that she belief that is necessary to update the knowledge and skills of registered midwives regarding episiotomies. She then mentioned that midwives sometimes use different techniques in spite of the prescribed medio-lateral episiotomy technique prescribed for midwives. The unit manager expressed further concern about the general overall situation in the labour ward; “Midwives go overseas, and posts are not filled since five months ago. There is an absenteeism rate of approximately one midwife sick or on vacation per day, leaving us with four registered midwives per day and the chief professional nurse for administration and clinical midwifery. Our normal vertex deliveries are now approximately 10 per day plus 3-4 caesarean sections. In reality we need 8-10 midwives per day for tertiary midwifery care. The Nursing Service Manager promised appointment of new personnel due to economic constraints it does not happen immediately though. We need more midwives in our unit, doctors trust midwives to teach medical staff.”

The unit manager then handed over the completed questionnaires from the midwives and the interview ended after about 30 minutes.

4.4.4 Exit interview with unit manager at hospital B

The researcher telephonically confirmed the appointment with the same unit manager that was present at the entry interview. The researcher asked the unit manager if there are any questions she would like to asked her on which the unit manager responded that she had no questions other to “ I thought that you had completed your thesis”. The unit manager further confirmed that there was no change in the number of staff members; “Nothing has changed, I still did not find the written episiotomy policy, and I am going on leave soon.”

When asked about perceptions regarding the application of knowledge and skill of registered midwives in terms of episiotomies, the response was, “New midwives are very liberal with episiotomies during their first month in the labour ward, and need to be orientated and monitored.”

The researcher raised the question of how does the unit manager ensure that they keep the overall episiotomy incidence low? At this stage the unit manager responded that it was difficult due to renovations going on in the labour ward. She further stated that the fourth year medical students and student midwives used to demonstrate episiotomies on cows' perinea while supervised by obstetricians or the clinical unit manager and hopefully this will continuo once the renovations have been completed. She further stated that registered midwives use the medio-lateral episiotomy technique in this unit but that different suturing techniques are used such as continuous suturing technique. It was also mentioned “experience does count.”

The interview lasted about 30 minutes, where after the researcher thanked the unit manager and collected the completed questionnaires from the secretary.

4.5 Conclusions

The results of this survey showed that incidence of episiotomies (19.4%) are within the WHO expectations. It further showed that there is a lack of the availability of a policies or guidelines regarding the practice of episiotomies. This confirms the original research problem that was raised by the researcher: The researcher has identified a problem in the clinical settings that registered midwives are unsure of what the indications for episiotomies are. Several guidelines regarding episiotomies exist but it appears that midwives are unaware what is the content of current policies and guidelines regarding the practice of episiotomies". It further shows that midwives identified a need for yearly competency tests on procedures such as episiotomies. A lack of knowledge regarding evidence base literature such as the availability and access to systematic reviews from the Cochrane collaboration has been identified.

Chapter five Discussion**5.1 Introduction**

This chapter discusses the major research findings in relation to the relevant literature. Limitations of the study will also be acknowledged.

Recommendations for future research and practice will also be mentioned.

5.2 Discussion of results

In line with the best available evidence, the World Health Organization has taken a clear stand that routine episiotomies do more harm than good. They further recommended that no obstetric unit should have episiotomy rates higher than 20%. The two academic hospitals are tertiary hospitals and a high population of the women who deliver there could be classified as high-risk women. The episiotomy rate (19.4%) during the time of the investigation was within the recommend WHO limit even though these are high-risk units.

The Department of Health (DoH) spent millions every year on literature and documentation concerning procedures and policies. The problem is that the DoH hardly ever follows up whether these policies are implemented or whether these policies reach the target that it is intended to reach. The findings of this study confirm the lack of implementation of policies and guidelines. The Department of Health has produced a book "Guidelines for

maternity care in South Africa, a manual for clinic, community health centers and district hospitals". This book has been in circulation since 1998 and 2002. Clear guidelines concerning episiotomies are written in this book. Not one of the unit managers at any stage during their interviews referred to these guidelines and only 56.8% of midwives stated that they were aware of any existing policies regarding episiotomies.

Even though no existing policies could be located in any of the two labour wards the majority of midwives responded that they are knowledgeable about episiotomy policies and that they consistently apply their knowledge to practice. No distinction was made whether the policies they referred to was institutional, provincial or national guidelines or the unwritten policies that underlines the rules and regulations of SANC or whether it was unwritten policies based on information received from the obstetricians.

An important finding was that despite the issue that no policies were visible in the wards the midwives did not practice routine episiotomies. This finding was validated by the low incidence of episiotomies extracted from the records.

Nearly two thirds of the respondents felt that it is important to have a policy on episiotomies in a labour ward and that they would like to have an opportunity to update their practices at least every six months. This need of information was further validated by the lack of knowledge of the Cochrane Collaboration. The South African Cochrane Centre is part of the International Cochrane Collaboration. They are situated in Belville at the Medical Research Centre.

The Cochrane Database of the Systematic Reviews published electronic systematic reviews four times a year. These systematic reviews are subject to extensive peer review, follow a standard format and are regularly updated in response to new information. The database is freely accessible to academic institutions and it appears that the registered midwives at the two academic hospitals are unaware of this.

A further problem that was identified is that the current rules and regulations and guidelines that were found in the literature are not based on evidence. For instance, The South African Nursing Council Regulation No. 2488 of 26 October 1990 No. 7(5) states that "An episiotomy may be performed to prevent a severe tear of the perineum." There is no evidence from the literature to support this regulation. It is evident from the literature in chapter two that an episiotomy do not prevent a severe tear but actually contribute to the increase risk of a third degree tear.

The "Guidelines for maternity care in South Africa, a manual for clinic, community health centers and district hospitals" stated that "Episiotomy should only be performed for a valid indication:

Thick or rigid perineum

Fetal distress in second stage of labour

Prolonged second stage of labour with the fetal head bulging the perineum

Maternal conditions where easy and rapid delivery is required, e.g. cardiac disease

Breech or assisted deliveries

Previous third degree tear

Delivery of preterm babies where the perineum is tight" (National Maternity Guidelines Committee, 2002: 36).

Once again, no evidence could be found in the literature to support any of the above statements.

5.3 Conclusions

The researcher identified a problem in the clinical settings that registered midwives are unsure of what the indications for episiotomies are. The aim was to determine whether the two tertiary academic institutions in the Western Cape have policies and guidelines available regarding the performance of episiotomies by registered midwives and to determine the knowledge and practice of registered midwives regarding these policies and guidelines.

The findings of the study concluded that midwives are aware of the latest evidence that routine episiotomies is not justified even though no evidence of existing policies could be allocated in any of the two wards. The finding further shown that the current guidelines are not based on evidence. Midwives do not directly rely on guidelines in the wards (non available), but an inference is made that the midwives obtain access via secondary sources such as obstetricians. They also are not aware and do not have free access to evidence based literature such as systematic reviews.

5.4 Limitations

It is important to take in cognizance that this is a mini-thesis. The aim is to introduce the researcher to the methodology of research. It is believed that the aim was met despite the limitations of the study.

The first limitation is the lengthy period over which the study was conducted. The data was collected during 2002 and is only now ready for publication. Another problem is that the researcher should have made an attempt to collect the data sheets from the unit managers within a week and not after six months when she did the exit interviews.

The study was done only at the two tertiary hospitals in the Western Cape, thus a small population sample and it does not provide national data. The researcher made use of a self-answered questionnaire and some respondents did not complete all the questions, thus missing data is a limitation.

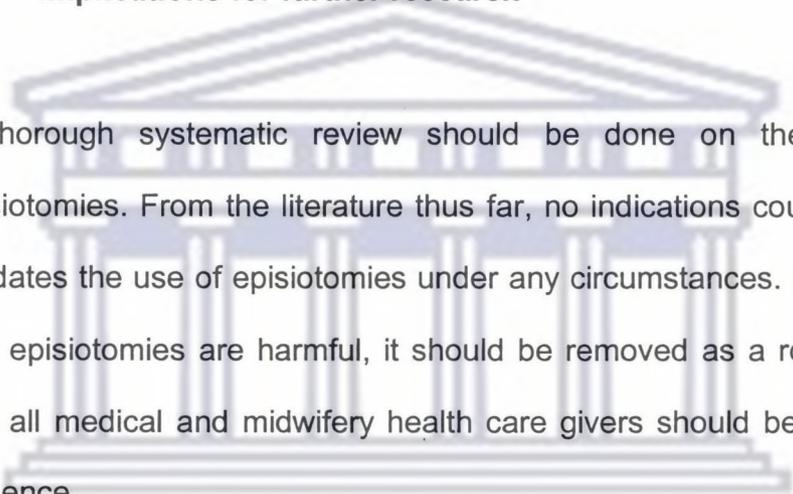
5.5 Recommendations for practice

There is an urgent need to inform SANC to review their regulations as the current regulation as it stands promote more harm than good. Similarly is there a need to inform the DoH and provincial government, that if they publish guidelines they need to ensure that these guidelines are based on the latest

evidence where possible. It is further important that policies be available to all members of staff to update them self with current information. In-service updates on evidence and practical skill workshops should be implemented to ensure that midwives stay competent in procedures that are not done regularly.

5.6 Implications for further research

A thorough systematic review should be done on the indications of episiotomies. From the literature thus far, no indications could be found that validates the use of episiotomies under any circumstances. If evidence show that episiotomies are harmful, it should be removed as a routine procedure and all medical and midwifery health care givers should be updated on the evidence.

The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment.

UNIVERSITY *of the*
WESTERN CAPE

ANNEXURE A

QUESTIONNAIRE

TITLE

THE ASSESSMENT OF KNOWLEDGE AND SKILLS OF REGISTERED MIDWIVES IN RELATION TO EPISIOTOMY POLICIES.

INSTRUCTION:

Please answer the following questions by ticking in the appropriate box. All your answers will be treated in the strictest confidence. Thank you for assisting.

- 1. Is it important to you to have episiotomy policies? YES NO
- 2. Are there existing policies regarding episiotomy at your institution? YES NO
- 3. If yes, indicate whether you are knowledgeable about it. YES NO
- 4. How do you apply these policies? CONSISTENTLY SELDOM NEVER
- 5. State at least two reasons if you choice IS SELDOM/NEVER.

.....
.....
.....

- 6. Do you know what the Cochrane Collaboration is? YES NO
- 7. Episiotomies should be performed? CONSISTENTLY SELDOM NEVER

8. Motivate your answer.
.....
.....
.....

- 9. Which method to you use when cutting an episiotomy? Medio-lateral Median
- 10. Should competency tests regarding this technique be conducted? YES NO
- 11. If yes, indicate how often you would like a competency test 6 MONTHLY
QUARTERLY
YEARLY

12. If no, please motivate your answer.
.....
.....
.....

13. Make at least two recommendations to improve quality care regarding episiotomies.
.....
.....
.....

11 Rose Court
West Street
Grassy Park
7945
15 October 2001

RE: CONSENT FOR QUESTIONNAIRE

Dear Respondent

I am conducting a mini-thesis regarding episiotomies performed by registered midwives at the two tertiary hospital (Tygerberg and Grootte Schuur) in the Western Cape.

The research will focus on:

- development of episiotomy policies for registered midwives in labour wards
- knowledge and practice of registered midwives regarding their institutional policies
- a comparison of the available episiotomy policies and practices of registered midwives at Tygerberg and Grootte Schuur Hospitals
- making recommendations to improve quality care in midwifery

Participation in the study's voluntary for all registered midwives currently employed in the labour wards at Grootte Schuur and Tygerberg Hospitals. Confidentiality, anonymity and confidentiality of respondents and patients' identities will be assured. The contribution of all participants will be appreciated and not use to jeopardize their employment in any way. Each individual respondent can be assured of the right to withdraw from the study without a penalty.

I am extremely grateful for your participation in this research, and will be pleased to share the results of the study with you when it is completed.

Completion of the questionnaire will take approximately 20 minutes of your time.

I thank you.



MRS C.N. DE MAAR

UNIVERSITY OF CAPE TOWN



Research Ethics Committee
Faculty of Health Science
Anzio Road, Observatory, 7925
Queries : Xolile Fula
Tel : (021) 406-6492 Fax: 406-6390
E-mail : Xfula@curie.uct.ac.za

24 July 2001

REF REC: 067/2001

Ms. CN. De Maar
Western Cape College of Nursing
Private Bag
Surwell, 7762

Dear Ms. De Maar

AN ASSESSMENT OF THE KNOWLEDGE AND PRACTICE OF REGISTERED MIDWIVES REGARDING EPISIOTOMIES AT TWO TERTIARY HOSPITALS (TYGERBERG AND GROOTE SCHUUR) IN THE WESTERN CAPE

Thank you for your letter to the Research Ethics Committee dated 18th July 2001.

It is a pleasure to inform you that your study has been formally approved on the 23 July 2001.

Please quote the above REC reference number in all correspondence

Yours sincerely

A handwritten signature in cursive script, appearing to read 'C Swanepoel'.

PROFESSOR CR SWANEPOEL
CHAIRPERSON

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