WOLKITE UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCE

DEPARTMENT OF MIDWIFERY

MAGINTUDE OF EPISIOTOMY PRACTICE AMONG MOTHERS WHO GAVE BIRTH AT WORABE COMPREHENCIVE SPECIALIZED HOSPITAL, WORABE TOWN , SOUTHWEST, ETHIOPIA, 2022.

BY	ID NO
1. AMANUEL PETROS	129/11
2. MASTEWAL MULAT	189/11
3. MISGANAWU WORKE	195/11

Advisors

1. YIBELITAL MESFIN. (BSc; MSc)
2. MESFIN DIFER. (BSc; MSc)

A REASERCH THESIS TO BE SUBMITTED TO WOLKITE UNIVERSITY COLLEGE OF MEDICEINE AND HEALTH SCIENCES DEPARTEMENT OF MIDWIFERY IN PARTIAL FULLFILMENT OF THE BACHELOR OF SCIENCE DEGREE IN MIDWIFERY

WOLKITE UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCE

DEPARTMENT OF MIDWIFERY

MAGINTUDE OF EPISIOTOMY PRACTICE AMONG MOTHERS WHO GAVE BIRTH AT WORABE COMPREHENCIVE SPECIALIZED HOSPITAL, WORABE TOWN , SILTE ZONE **2022.**

Advisors

1. YIBELITAL MESFIN (BSc; MSc)
2. MESFIN DIFER (BSc; MSc)

JUNE, 2022,

WOLIKTE, ETHIOPIA

Acknowledgments

First of all, we would like praise the almighty God for giving us strength during the overall process of our work! We gratefully thank to Wolikte University faculty of medicine and health science department of midwifery for giving this chance.

Secondly, we would like to express we deep gratitude to we research advisors, Mr. Yibeltal Mesfin (BSc; MSc) and Mr. Mesfin Difer (BSc; MSc) for their encouragement and great support in providing Constructive comment, guidance and suggestion for the development of this research.

TABLE Contents

Acknowledgments III
TABLE Contents IV
Table1 VI
Table2 Distributions of Obstetric factors for episiotomy practice VI
LIST OF FIGUR VII
ACRONYMS AND ABBREVATIONS VIII
ABSTRACT IX
INTRODUCTION IX
OBJECTIVES IX
METHODS IX
RESULTS IX
CONCLUSION IX
1. INTRODUCTION ..... - 1 -
1.1 1.1.1 BACKGROUND INFORMATION ..... - 1 -
1.2 STATEMENT OF THE PROBLEM ..... - 1 -
1.3 SIGNIFICANCE OF THE STUDY ..... - 2 -
2. LITERATURE REVIEW ..... - 4 -
2.1 Epidemiology of episiotomy practice ..... - 4 -
3. OBJECTIVES ..... - 5 -
3.1 GENERAL OBJECTIVE ..... - 5 -
3.2 SPECIFIC OBJECTIVES ..... - 5 -
4. METHODS AND MATERIALS ..... - 6 -
4.1 THE STUDY AREA AND PERIOD ..... - 6 -
4.2 STUDY DESIGN ..... - 6 -
4.3 POPULATION ..... - 6 -
4.3.1 SOURCE POPULATION ..... - 6 -
4.3.2 STUDY POPULATION ..... - 6 -
4.4 INCLUSION AND EXCLUSION CRITERIA ..... - 6 -
4.4.1 INCLUSION CRITERIA ..... - 6 -
4.4.2 EXCLUSION CRITERIA ..... - 6 -
4.5 SAMPLE SIZE AND SAMPLING TECHNIQUES ..... - 6 -

4.5.1 SAMPLE SIZE ..... - 6 -
4.5.1 SAMPLING TECHNIQUE ..... - 7 -
4.6 VARIABLE ..... - 7 -
4.6.1 DEPENDENT VARIABLE ..... - 7 -
4.6.2 INDEPENDENT VARIABLE ..... - 7 -
4.7 DATA COLLECTION INTRUMENT AND METHODS ..... - 8 -
4.6.3 DATA COLLECTION INSTRUMENT ..... - 8 -
4.6.4 DATA COLLECTION METHOD ..... - 8 -
4.7 OPERATIONAL DEFINITION AND DEFINITION OF TERMS ..... - 8 -
4.8 DATA ANALYSIS ..... - 8 -
4.9 DATA QUALITY CONTROLS ..... - 9 -
4.10 ETHICAL CLEARANCE ..... - 9 -
5. RESULTS ..... - 10 -
Obstetric factors for episiotomy practice ..... - 11 -
6. DISCUSSION ..... - 14 -
7. CONCLUSION AND RECOMMENDATION ..... - 15 -
7.1 CONCLUSION ..... - 15 -
7.2 Recommendation ..... - 15 -
7.3 LIMITATION AND STRENGTH OF THE STUDY ..... - 15 -
7.3.1 STRENGTH OF THE STUDY ..... - 15 -
7.3.2 LIMITATION OF THE STUDY ..... - 15 -
REFERENCE ..... - 16 -
ANNEXES ..... - 21 -
Annex 1 Questionnaire ..... - 21 -
INTRODUCTIONSS OF THE QUESSIONNERS ..... - 21 -
Dear participants, ... - 21 -
Annex –II: Questionnaire ..... - 22 -

List of table

Table1 Distributions of socio-demographic characteristics ……..13

Table2 Distributions of Obstetric factors for episiotomy practice……14

TABLE3 characteristics of episiotomy practices ……15

LIST OF FIGUR

Figure 1 magnitude of episiotomy practices at Worabe comprehensive specialized hospital **march 1 to April 20.**

ACRONYMS AND ABBREVATIONS

ANC-Antenatal Care

APGAR-Activity, Pulse rate, Grains, Appearance, Respiratory rate

BSC-Bachelor of Science

CI -Confidence Interval

EP:-Episiotomy Practices

GA-Gestational Age

Kg -Kilogram

MD -Medical doctor

MDG-Millennium development goal

MM -maternal mortality

NRFHBP- Non reassuring fetal heart beat pattern

SVD-Spontaneous Vaginal Delivery

WHO-World Health Organization

WCSH:-Worabe comprehensive specialized hospital

ABSTRACT

INTRODUCTION Episiotomy is the surgical enlargement of the vaginal orifice by an incision of the perineum during the second stage of labor or just before delivery of the baby. During the 1970s, it was common to perform an episiotomy for almost all women having their first delivery, apparently for prevention of severe perineum tears and easier subsequent repair.

World Health Organization recommends an episiotomy rate of about 10% or less.

However, the finding from studies conducted in different parts of Ethiopia revealed that the magnitude of episiotomy practice range above 30%.

OBJECTIVES-To assess the magnitude of episiotomy practice among women who give birth at Worabe comprehensive specialized hospital, Worabe town, Silte Zone, Ethiopia from March 1 to april 20, 2022

METHODS an institution-based cross-sectional study was conducted at government health facilities of Worabe town from March 1 up to April 20 2022. A total of 367 mothers who give birth was selected using systematic sampling technique. Data was collected using a structured and pretested questionnaire, entered and analyzed by Statistical Package for Social Sciences version-20. Descriptive statistics was done. Finally, result was presented in texts, tables, and bar charts.

RESULTS-During study period there were a total of 367 pregnant mothers attend to labor ward and respondent rate was 99.73%. Out of this 116(31.6%) (27-36.8) had episiotomy while 251(68.4%) were not. The prevalence was higher.

CONCLUSION

During the study period, the prevalence of episiotomy performed was high when compared with World health organization recommendations. Therefore, effort should be made to prevent routine epiostomy practice through creating awareness, adjusting the national guideline and monitoring the facticity of the health care facilities to exciting the protocol.

1. INTRODUCTION

1.1 1.1.1 BACKGROUND INFORMATION

Episiotomy is defined as surgically performed, perineum enlargement, with incision during the second stage of labor, with a scissor or a scalpel blade and requiring suture for its correction.

Episiotomy is one of the most commonly performed surgical procedures worldwide, performed in 30–63% of all deliveries and, in some regions, in up to 93% of nulliparous women (1).

There are different types of episiotomy median (or midline) episiotomy, Medio lateral, J incision, Others usually modifications of the median episiotomy, such as the addition of bilateral transverse cuts to the apex to create an inverted "T"(2) A modification of median episiotomy is performed by adding two transverse incisions in opposite directions just above the expected location of the anal sphincter (3), Medio lateral is the most frequently used type of episiotomy in Europe (4). The exact definition is often unclear, J- shaped episiotomy commences with a midline incision and is then curved laterally to avoid the anus, and anterior episiotomy or deinfibulation (the procedure of opening the scar associated with some degrees of female genital mutilation) is usually performed during delivery on women who have had female infibulation performed previously (4)

Regularly performance of episiotomy was recommended in the past with the aim of preventing damages to the pelvic floor, because this was believed to reduce the incidence of genital dystopias, in addition to protecting the anterior perineum and shortening the expulsion period (5). Benefits for the fetus were also reported, such as reducing cephalic pole compression in the delivery channel, which could bring about cerebral damages, mainly in premature and macrocosmic fetuses.(5)

1.2 STATEMENT OF THE PROBLEM

Episiotomy practice has high burdens on mothers which can increase the extension of perineal lacerations and increase the risk of infection for women, hemorrhage, pelvic floor dysfunction, dyspareunia, rectovaginal fistulas, hematomas, among others. Such complications have negative impacts on the parturient’s quality of life and the maternal-fetal relationship, in addition to being related to higher expenses in the health system, which increases the length of hospital stay.

Worldwide according to research conducted in one European, episiotomy rates ranged from 3.7% in Denmark to 75% in Cyprus (2). Similar study in India and China shown that the magnitude of episiotomy continues to be high which range from 60% to 80% (4). And also United States episiotomy was routinely performed on nearly all primipara until the end of and declined to 39% (3).

In developing countries including Asian ones like India, the prevalence of episiotomy was 90% (5). The rate of episiotomy in developed countries is on the decline, but in developing country remains the same.

In Africa it ranges from 63.3% in the South Africa to 100% in the Guatemala for nulliparous women and other evidence in Rwanda has been reported for nulliparous 80.1% and 19.9% for multiparous women (7). The same study conduct In Nigeria, a report from zaria showed an episiotomy rate of 35.6% following all vaginal deliveries and 88.5% in primigravidae; while in Enugu the rate was 40.4% for women of all parities and 76.2% in primigravidae (8).

When we comes to the Ethiopian context the prevalence of episiotomy practice was reported as 68.0% in Arbaminch, Northest Ethiopia (9).

Different researches had tried to identify factors associated to episiotomy practice. Among them study conducted in Arbaminch general hospital south Ethiopia showed that the association of EP with history of previous breech delivery, had female genital mutilation, had given birth for the first time, and a previous history of chronic illness. And also similar study conducted in Axum Town, Tigray Region, North Ethiopia investigated that face presentation, Null parity, Birth attendant and 1st minute Apgar score were significantly associated with practices of episiotomy (9).

Although overwhelming studies have been conducted in different areas of Ethiopia, there is still a gap on assessment of EP and its associated factors particularly in Silte zone, Southern Ethiopia. Therefore this study is aimed to assess the magnitude of EP among pregnant giving birth at obstetric and gynecologic center of Worabe comprehensive specialized hospital. .

1.3 SIGNIFICANCE OF THE STUDY

This study was asses magnitude of episiotomy practice among women and used as base for further study on similar topics at different set ups. The results from the study was help to make

aware the magnitude of the problem to those health professionals who give delivery care services guide including about the episiotomy practice, prevalence of episiotomy, types of episiotomy. Completeness instruments during the procedure, proper procedure according to the protocol for episiotomy repair would be improved; it was encouraged on Prevention of perineal tear and post episiotomy complication. It was also use for policy makers and health planners. The findings was also provide up-to date information for academicians and could be used as a basis for further research in issues concerning episiotomy practice.

2. LITERATURE REVIEW

Episiotomy is a term defined as surgical enlargement of the vaginal orifice during the last part of the second stage of labor or childbirth by an incision to the perineum (36). There are different types of the episiotomy including (Median, Modified median, Lateral, Radical lateral, anterior episiotomy, 'J'-shaped episiotomy and Medio lateral episiotomy). But the major types of episiotomy (median and Medio lateral) are usually described in standard obstetric and midwifery texts (36).

2.1 Epidemiology of episiotomy practice

Worldwide according to research conducted in one European, episiotomy rates ranged from 3.7% in Denmark to 75% in Cyprus (37). Similar study in India and China shown that the magnitude of episiotomy continues to be high which range from 60% to 80% (39). And also United States episiotomy was routinely performed on nearly all primipara until the end of and declined to 39% (38).

In developing countries including Asian ones like India, the prevalence of episiotomy was 90% (40). The rate of episiotomy in developed countries is on the decline, but in developing country remains the same.

In Africa it ranges from 63.3% in the South Africa to 100% in the Guatemala for nulliparous women and other evidence in Rwanda has been reported for nulliparous 80.1% and 19.9% for multiparous women (42). The same study conduct In Nigeria, a report from Zaria showed an episiotomy rate of 35.6% following all vaginal deliveries and 88.5% in primigravidae; while in Enugu the rate was 40.4% for women of all parities and 76.2% in primigravidae (43).

When we comes to the Ethiopian context the prevalence of episiotomy practice was reported as 68.0% in Arbaminch, Northeast Ethiopia (44). Study conducted in south eastern Nigeria Episiotomy was 43% performed in women who had vaginal birth.(b. chigbu, s. onwere, c. aluka, c. kamanu and e. adibe, factors influencing the use of episiotomy during, may (2008)

3. OBJECTIVES

3.1 GENERAL OBJECTIVE

To assess magnitude of episiotomy practice among women who give vaginal birth at worabe comprehensive specialized hospital, Worabe town, southwest, Ethiopia from march 1 to April 20/ 2022

3.2 SPECIFIC OBJECTIVES

To determine the magnitude of episiotomy practice at worabe comprehensive specialized hospital, worabe town.

4. METHODS AND MATERIALS

4.1 THE STUDY AREA AND PERIOD

The study was conducted in worabe comprehensive specialized hospital. It is found in Worabe town silte zone, SNNP, Ethiopia. The town is located in southern part of Ethiopia at 172 kms from Addis Abeba, and 202kms from Hawassa. The hospital offers a full range of obstetric, gynecologic and focused antenatal care services, and has a high volume of maternity patients Worabe comprehensive specialized hospital in worabe town which serves for a total of 2.5millions populations. The average delivery service in a month 339.The Hospital has labor and delivery room which give services for pregnant mothers. The room operates with multidisciplinary staffs (Gynecologist, midwives and clinical nurse) through all the days of weeks.

4.2 STUDY DESIGN

Institutional based cross sectional study design was employed.

4.3 POPULATION

4.3.1 SOURCE POPULATION

The source population was all pregnant women who come for delivery at worabe comprehensive specialized hospital.

4.3.2 STUDY POPULATION

The study populations was all pregnant women who attending vaginal delivery at worabe Comprehensive specialized hospital.

4.4 INCLUSION AND EXCLUSION CRITERIA

4.4.1 INCLUSION CRITERIA

The study populations was all pregnant women who attending vaginal delivery at worabe comprehensive specialized hospital during the study period

4.4.2 EXCLUSION CRITERIA

Women who was seriously ill and unable to give response

4.5 SAMPLE SIZE AND SAMPLING TECHNIQUES

4.5.1 SAMPLE SIZE

Sample size was determined using the formula for a single population proportion for cross sectional study with the following formula. By using population proportion 68.0% in the

arebaminch study (8), confidence interval 95%, margin of error 5% and population is normally distributed Z value is 1.96.

$$n = \frac{(Z_{\alpha/2})^2 p(1-P)}{d^2} = \frac{(1.96)^2 * 0.68(1-0.68)}{(0.05)^2} = 334$$

Where n=minimum sample size needed

p=proportion (68.0%)

Z=significance level at confidence interval of 95%

d=margin of error (0.05)

Z α/2=value of standard normal distribution corresponding to significant level of alpha (α) 0.05 which is 1. 96.

By considering the nonresponse rate of 10%, to the calculated sample size, the total Mothers who giving birth was targeted for the study. 33.4+334=367.4 approximately 367 maximum sample size.

4.5.1 SAMPLING TECHNIQUE

In this study the sample was select by using systematic sampling technique from mother who was attend vaginal delivery during the study period.

4.6 VARIABLE

4.6.1 DEPENDENT VARIABLE

Episiotomy practice

4.6.2 INDEPENDENT VARIABLE

Obstetric VARIABLE

Gravidity/ Parity

Demographic VARIABLE

Age

ANC follow up

History of prolonged labor

Presence of meconium

FGM

Fetal presentations

Mode of delivery

Privies history of episiotomy

Fetal weight Educational status

- Gestational age

-Attendant professionals

Marital status

Place of residence.

Prolonged labour

Family income

4.7 DATA COLLECTION INTRUMENT AND METHODS

4.6.3 DATA COLLECTION INSTRUMENT

Data was collected using structured questionnaire and checklist, which have socio-demographic variables, practice of episiotomy. The questionnaire was prepare in English; during collection of data questioner translate in to the Amharic language. The instrument was adapted from different literatures developed for similar purpose by different authors and tools designed by various researches and from checklist prepared for during the procedure.

4.6.4 DATA COLLECTION METHOD

Data was collect using client interview by structural questionnaire and observing the procedure by filling the prepared checklist. Health professions who are performing the procedure are not aware of the study because to prevent social destructibility and the checklist was fulfilled by the students who are on practice.

4.7 OPERATIONAL DEFINITION AND DEFINITION OF TERMS

Episiotomy practice: an incision into the tissues surrounding the opening of the vagina (perineum) during a difficult birth at the stage when the infant's head have partly emerged through the opening of the birth passage and with proper procedure and repair.

4.8 DATA ANALYSIS

The data was collect and check for completeness and enter into the computer and analyze using spss version 20 software. Analysis was done by the investigator using the same computer package.

Frequency, proportion, means and SD was use. Descriptive statistical was done. Finally, result was present in texts, tables and bar.

4.9 DATA QUALITY CONTROLS

A questioner was collect and check for its clarity, understandability, completeness and consistency conduct in Worabe hospital which are worabe town on 10% before the time of data collection. Data collectors (group members) write card number on the data formant during extraction the data collection so that any Identification errors were traced back using the card numbers. Any error, ambiguity incompleteness encountered were address before starting next day activity. Data quality was ensured during collection coding, entry and analysis.

4.10 ETHICAL CLEARANCE

Letter of ethical clearance was obtain from wolkite University. Letter of permission was obtained from worabe comprehensive specialized hospital administration office, Obstetrics and Gynecology department and lobar ward Verbal consent was take from study participant before they give birth, anonymity and confidential of responses was kept.

5. RESULTS

Social-demographic characteristics of the respondents.

During the study period, there were a total of 367 pregnant mothers attend to the labor ward with response rate 99.73% of worabe comprehensive specialized hospital from March 1 to April 20/2022 .Out of this, 116 (31.6%)(27-36.8) were episiotomy procedure performed while 251 (68.4%) were not performed. Of which the procedure done 76(65.5%) were urban resident and (34.5%) were rural resident. All the respondents for whom episiotomy procedure done 116(100%) and not were married.

Concerning age group of respondents, almost half present of respondents found in age group of 20-34, which accounts 200(54.5%). Concerning Ethnicity, 356(97%) and 11(3%), and were silte, and others respectively. With regard to educational status of the respondents, 90(24.5%) secondary, 94(25.6%) primary, 146(39.8%) illiterate and 37(10.1%) certificate and above.

Table1: Distributions of socio-demographic characteristics of respondents who under gone episiotomy at Worabe comprehensive specialized hospital**.**

Variable	Categories	Frequency	Percentage
Resident respondent	**Urban**	**211**	***57.5***
	Rural	**156**	**42.5**
Occupation	**Housewife**	**276**	**75.2**
	Daily laborers	**24**	**6.5**
	Merchant	**29**	**7.9**
	Government employee	**38**	**10.4**
Age	**16-19**	**107**	**29.2**
	20-34	**200**	**54.5**
	35-49	**60**	**16.3**
Marital status	**Married**	**367**	**100**
Religion	**Muslim**	**318**	**86.6**
	Orthodox	**24**	**6.6**
	Protestant	**25**	**6.8**
Educational status	**Primary**	**94**	**25.6**
	Secondary	**90**	**24.5**
	Higher	**37**	**10.1**
	Illiterate	**146**	**39.8**
Ethnicity	**Silte**	***356***	***97***
	Others	***11***	***3***
Income category	**1500-4500**	**272**	**74.1**
	4600-6000	**57**	**15.5**
	6100-8500	**38**	**10.4**

Obstetric factors for episiotomy practice

All most all study participants had normal body weight 345(94%).regarding ANC follow up study participants had completed less two follow up 318(86.6).(see table below)

TABLE2 Distributions of Obstetric factors characteristics of respondents who under gone episiotomy at Worabe comprehensive specialized hospital **march 1 to April 20/ 2022**

Variable	Categories	Frequency	Percentage
Gravidity	**Prem**	**67**	***18.3***
	Mulity	**215**	**58.6**
	Grand mulity	**85**	**23.2**
ANC follow up	**Less than 2**	**318**	**86.6**
	Above 2	**49**	**13.4**
Presence of meconium	**Yes**	**32**	**8.7**
	No	**335**	**91.3**
FGM	**Yes**	**1**	**0.3**
	No	**366**	**99.7**
Fetal presentation	**Vertex**	**366**	**99.7**
	Breech	**1**	**0.3**
Mode of delivery	**SVD**	***339***	***92.4***
	Vacuum	***28***	***7.6***
Fetal weight	**Lbw**	**20**	**5.4**
	Nbw	**345**	**94**
	Macrosum	**2**	**0.5**
Total	**367**		**100**

MAGINTUDE OF EPISIOTOMY PRECTISIS

Of all study participants, 116(31.6%) (27-36.8) of the study participants had performed episiotomy practice level (figure 1)

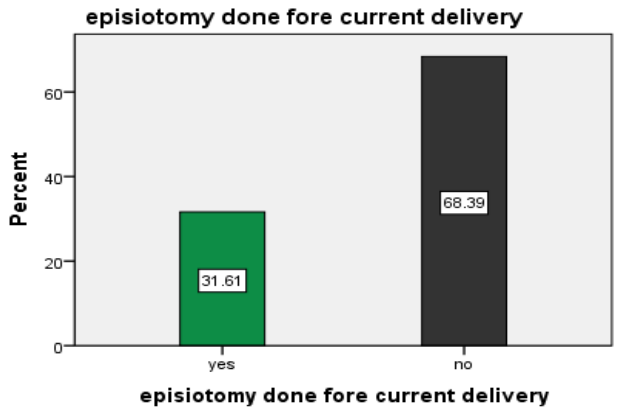


Figure 1 magnitude of episiotomy practices at Worabe comprehensive specialized hospital **march 1 to April 20; 2022**

Practice of episiotomy among study partcipanties

Episiotomy was more practice for urban population than rural resident. Moreover, EP was practice on the respondent's age between 20-34.

The study again showed EP was practice on primary and secondary school completed women

TABLE3 characteristics of episiotomy practices

Characteristics		**Episiotomy**			
		Yes	%	No	%
Residence of respondents	Urban	76	20.7	135	36.9
	Rural	40	10.9	116	31.6
Age	19 and below	44	12	63	17.2
	20-34	70	19.1	130	35.4
	35 and above	2	0.5	58	15.8
Education					
	Illiterate	25	6.8	121	32.9
	Primary	37	10.1	57	15.5
	Secondary	42	11.4	48	13.1
	Higher education and above	12	3.2	25	6.8
Ethnicity	Silte	112	30.5	244	64.5
	Others	4	1.1	7	1.9

6. DISCUSSION

The primary objective of this study was to assess the magnitude of Episiotomy practice among pregnant mothers who gave birth at worabe compressive specialized hospitals with 99.73% response rate. In current study, there were a total of 367 pregnant mothers gave birth at worabe compressive specialized hospitals. The descriptive analysis of this study showed that 116(31.6%) of pregnant mothers who gave birth at worabe compressive specialized hospital were episiotomy procedure performed while 251(68.4%) were not performed. Of which the procedure done 76(65.5%) were urban resident and 34.5% were rural resident. All the respondents from whom episiotomy procedure done 116(100%) were married.

Episiotomy practice was high in this study when compared to other studies conducted in different areas. The prevalence of the episiotomy done in U.S Hospital linked Nevada Birth Registry and Nevada Impatient Hospital discharges (24.8%), at Brazil (29.1%), at South Albert (13%). However, possible reason may be due to no capacity building for health workers on skill training, education on indication and status of the labor), health institutions(expansion) were also found to be important and low when compared with research done at Canada(58.4%) and South Eastern Nigeria,(45%)(16, 22, 29).

The weight of the neonates categorized were 2500g to 3999g, which accounts 345(94.0%), 20(5.4%) were 1500g to 2499g and greater than 4000g were 2(0.5%). the most neonates weight was found between 2500g to 3999g. This was consistent with study done at south Alberta (3500g to 4200g) which more fetal weighing for fear of perineal laceration (22). 28(7.6%) were to assist instrumental delivery of vacuum, which was consistent with research done at Rotunda Hospital, Ireland (which was to assist instrumental delivery followed by Non reassurance fetal heart) (27, 28).

318(86.6%) had ANC follow up and 282(76.8%) of them were Primigravida and 85(23.2%) were multigravida. When compared with research done at south Eastern Nigeria, it has similar finding (90% of primi underwent episiotomy procedure) (29).

7. CONCLUSION AND RECOMMENDATION

7.1 CONCLUSION

During the study period, the prevalence of episiotomy performed was high when compared with world health organization recommendations.

7.2 Recommendation

This study indicated that, skill training for the service provider of found to be critical for quality episiotomy service.

Therefore the hospital should provide skill training and avail guidelines for health workers, which enable them to practice appropriate time of episiotomy.

7.3 LIMITATION AND STRENGTH OF THE STUDY

7.3.1 STRENGTH OF THE STUDY

The study employed both quantitative and qualitative (observational) approach.

The utilization of appropriate statistical methods to minimize biases was made and the data was analyzed using appropriate statistical test.

7.3.2 LIMITATION OF THE STUDY

The study did not include critically ill delivering mothers whom were episiotomy procedure done so that the study may not represent all episiotomies done.

No study was done in this hospital in the same field of study so far and this study tried to assess prevalence and practice of episiotomy which could be extrapolated to other health institutes

REFERENCE

1Althabe F, Belizan JM, Bergel E, Episiotomy rates in primiparous women in Latin America; Hospital based descriptive study. BJM 2002; 324; 945-6.

1. DE Frances CJ, Hall MJ, Podgornik MN. 2003 National Hospital Discharge survey. Advance data; No. 359, Hyattsville (MD) ; National centre for Health statistics; 2005. Available at ; http;//www.cdc. Gov/ncgs/data/ad/ad 359. Pdf. Retrieved December 29, 2005 (level II-3)

2. Martin JA. Hamilton BE. Sutton PD, Ventura SJ, Menacker F, Munson ML, Births; final data for 2003, Natl vital stat Rep 2005; 54(2); 1-116, (level II-3).

3. Gilstrap LC, Oh W; Guidelines for perinatal care, 5th edition, Washington, DC, American Acadamy of paediatrics, 2002.

4. FEBRASGO, Manual the orientation ; association episiotomy and vaginal delivery, 2002; 4;48-9

5. Carroli G, Mignini L, Episiotomy for vaginal birth. Cochrane Database systematic review 2009, issue 3, Art N0; CD000081

6. Hagos CH, Foreman KJ, Naghavi M, AhnSy, Wang M, Lopez AD , lozno R. Murray CJL, Maternal mortality for 181 countries, 1980-2008; a systematic analysis of progress towards millennium development Goal 5.Lacent April 12, 2010 D0I; 10.1016/50140-673(10) 60518-1.

7. United Nations population Fund, " The state of the World's Midwifery'' Accessed in August 2011 http;//www.unfpa.org/sowmy/report/home.html.

8. Cunningham FG,Mc Donald Pc, Gant NF ,et al,Fetal Growth Retardation. In ;Cunningham FG, Williams JW, eds, Williams obstetrics 20thed, Stanford .conn;Appleton and lange ;1999;839-50

9. World Health Organization 1993, converge of maternity care , Maternal health and safe motherhood program 3;3

10. Per Gorar; Jenz-Jorgen –platz- Christenson, Boinge B. and Gerald W, J1999, Advantage or disadvantage of Episiotomy compared with spontaneous perineal laceration, obstetric and Gynecologic survey 31 (27-28

11. World Health Organization 1997, Routine Episiotomy , safe motherhood 18 (2) ;7

12. Leeman L, Fulhlove AM, Borders N, Manocchio R, Albers LL, Rogers RG, Postpartum perineal pain in a low episiotomy setting ; association with severity of genital trauma, labor care , and birth variables. Birth 2009; 36;283-8.

14. LARRYC. GILSTRAP III, MD, F. GARY CUNNGHAM, MD, J. PETER VANDORSTEN, MD, chapter 5; Operative Obstetrics second Edition , 2002.63-88.

15. Fenner DE, Genberg B, Fecal and Urinary incontinence after vaginal delivery with anal sphincter disruption in an obstetrics unit in the United states. Am J obstetGynecol, 2003; 189(6); 1543-1550.

16. Gulzar H. shah . M. stat. M.S.S PhD, etc; Episiotomy and Obstetric trauma in Neveda ; Evidence from Linked Hospital Discharge and birth Date ; Journal of the Neveda public health Association ,vol. 4 .Issue 1. Shah et al . 2005.

17. FrankmanEa, Wang L, Bunker CH, et al, Episiotomy in the United states; has anything changed ? AmJObstetGynecol 2009, 200; 573.E1-573-e7.

18. Nancy L.S. Howden, MD, Anne M.Laleber. MD, etc ; Episiotomy use among Residents and fsculty compared with private practitioners. American College of obstetrics and gynaecologist vol. 103,No, 2, January 2004.

19. JAMES RUDERMAN, MD, CCFP, JUNEC. CARROLL. MD. CCFP etc ; Episiotomy differences in practice between family physicians and obstetricians. Canadian family physician vol. 38; November 1998.

20. CynthiacoelhomedeirosDecarvaiho, Alex sandro Rolland souza, Prevalence and factors associated with practice of episiotomy at a maternity school in recife, Pernambuco, Brazil , Rev Assoc. Med Bras 2010, 56(3); 333-9.

21. Journal of clinical Nursing , 21, 2209-2218,DOI;10.1111/j. 1365-2702.2012.04133.x Flora MB da silva, PhD, Nurse midwife, National council for scientific and Technological development 2012, Brazil; Risk factors for birth related perineal trauma; a cross sectional study in birth center.

22. Andrea Hargrove MD, Kristy penner MD ‘’Family physician and obstetrician episiotomy rates in low risk obstetries in southern Alberta 2011, 57;450-6.

23. Maureen Macleod, Deidre J, Murphy; Operative vaginal delivery and the use of episiotomy –A survey of practice in the United kingdom and Ireland European Journal of obstetrics and Gynecology and reproductive Biology 2006.

24. Iran J Nurs midwifery Res.2011 summary 16(3); 197-201 ; Difference in episiotomy technique between midwives and midwifes and medical students ; AghdasKanini M.sc and TalaatKhadjyzadeh M.sc ; Iran J Nurs midwifery Res . 2011 summery; 16(3); 197-201.

25.FereshtehJahdi, Department of midwifery, Episiotomy Discomfort reliefs using cold Gelpads in primiparas Iranian Women (A comparative study), research journal of medical science 5(3). 150-154, 2011.

26. B. W. C. Sathiyasekaran, Gopalpalani, etc population based study of episiotomy Sri Ramachandra Journal of medicine nov 2007.

27. Allison shorten and Brett shorten; Women's choice? The impact of private health insurance on episiotomy rates in Australian hospitals; midwifery 2000; 16, 204-212.

28. Ratchadawansooklim, JadsadaThnkhamrop, etc; The outcomes of midline versus mediolateral episiotomy; Department of obstetrics and Gynecology, facult of medicine; KhonKaem University, KhonKaen, Thailand. 2007.

29. RF HARRISON, M BRENNAN, etc; Is routine episiotomy necessary; Department of obstetrics and Gynecologist, Trinity college unit at the Rotunda Hospital, Dublin 1 , Ireland. British medical journal volume 688;30 June ,2006.

30. B. Chigbu, S. onwere, C. Aluka, C. Kamanu and E. ADIBE factors influencing the use of episiotomy during vaginal delivery in south Eastern Nigeria, East African medical Journal vol.85 No 5 may 2008.

31. NazimahIdris; Routine versus selective mediolateral episiotomy for the prevention of third or fourth degree lacerations in nulliparous women; Department of obstetrics and Gynecology, Malaysia.

32.Maria .W. ; A two years retrospective review of episiotomy at Jimma Teaching Hospital, South western Ethiopia, Department of obstetrics and Gynecology , facult of Medicine, Addis Ababa University. P.O .Box 9086 . Addis Ababa, Ethiopia.

33. Federal Democratic Republic of Ethiopia Population census commotion, Summary and Statistical Report of the 2007 Population and Housing Census Result

34. Aguiar BM, Silva TPR, Pereira SL, Sousa AMM, Guerra RB, Souza KV, et al. Factors associated with the performance of episiotomy. Rev Bras Enferm. 2020;73(Suppl 4):e20190899. doi: http://dx.doi.org/10.1590/0034-7167-2019-0899

35. Worku SA, Mitku YM, Getahun SA (2019) Episiotomy Practice and its Associated Factor among Women Who Gave Birth at Public Health Institutions of Akaki Kality in Addis Ababa, Ethiopia. Clinics Mother Child Health 16: 317. doi:10.4172/2090-7214.100031

36. Carroli G, Mignini L. Episiotomy for vaginal birth. Cochrane Database Syst Rev. 2009

37. Blondel B, Alexander S, Bjarnadóttir RI. Variations in rates of severe perineal tears and episiotomies in 20 European countries: a study based on routine national data in Euro-Peristat project. Acta Obstet Gynecol Scand. 2016;95(7):746–754. doi:10.1111/aogs.12894

38. Dotun Ogunyemi JM, Mohsen B. Demographic variation and clinical association of episiotomy and sever perineal laceration in vaginal delivery. JNMA. 2006;98(11):1874. 27. Mbukani R, Kakoma JB. Is nulliparity a risk factor for poor obstetrical and neonatal outcomes in rwandan district hospitals ? A prospective observational study at muhima district hospital. Rwanda Med J. 2012;69(1):50–53

39 .S. Singh, T. Thakur, N. Chandhiok, and B. S. Dhillon, "Pattern of episiotomy use & its immediate complications among vaginal deliveries in 18 tertiary care hospitals in India," The Indian Journal of Medical Research, vol. 143, no. 4, pp. 474– 480, 2016.

40. Kropp N, Hartwell T, Althabe F. Episiotomy rates from eleven developing countries. Int J Gynaecol Obstet 2005;91(2):157-159. doi:10.1016/j.ijgo.2005.07.013.

41. 6. Shojae KK, Dawati A, Zayeri F. Frequency and side effect of episiotomy in primiparous women: a three-month longitudinal survey. Qom Univ Med Sci J. 2009;3(2):47-50. 7. Ekwempu CC. Maternal injuries. In: Agboola A, ed. Textbook of Obstetrics and Gynaecology for Medical Students. Ibadan: Heinemann Educational Book Plc; 2006:477- 80.

42. Graham ID, Carroli G, Davies C, Medves JM. Episiotomy rates around the world: An update. Birth 2005;32:219-23

43. Onah HE, Akani CI. Rates and predictors of episiotomy in Nigerian women. Trop J Obstet Gynaecol 2004;21:44-5.

44. W. Marai, "A two years retrospective review of episiotomy at Jimma teaching hospital, southwestern Ethiopia," *Ethiopian Medical Journal*, vol. 40, no. 2, pp. 141–148, 2002.

ANNEXES

Annex 1 Questionnaire

INTRODUCTIONSS OF THE QUESSIONNERS

Dear participants,

We are working as data collectors for the research conducted by, midwifery BSc student of at wolkite University, so we are here today to collect information on magnitude of episiotomy practice and associated factors by interviewing clients using structured questionnaire and checklist for observational study with all third trimester pregnant women who episiotomy procedure was performed in Worabe comprehensive specialized hospital all the information you provide will help the hospital and the staff to improve the services. Your name will not be recorded in any part of the questionnaire in order to ensure confidentiality of the information you provide. The study doesn't have any harm to the study mothers and to their newborn, since it will use the routine procedures carried out usually in attending deliveries in labor ward and there will not be any interventions which harm the mother as well as the neonate.

We will appreciate if you volunteer to participate in this study. Would you please avail them some time and take part in this exercise?

Mothers have right not to be included on the study if they are not comfortable or voluntary. If they agree informed consent was taken by the data collector.

Benefits

Your participation in this research may not directly provide you a certain benefit as an individual. But it helps us in assessing the prevalence and determinant of episiotomyand to design better intervention to reduce unnecessary episiotomy.

Risks and Side effects

There are no side effects and known risks related with this kind of research so far. The only discomfort could be from sharing us few minutes (about 20 minutes) for interview.

No □ If No, please thank and stop interviewing. Yes .if yes, pleases thanks and continues.

Annex –II: Questionnaire

Date……

Participant identification number ……...

Section- I- Socio-demographic variables

1) Place of residence.1. urban 2.rural

2) Age in complete years. ;_____

3) Marital status.1.married 2.Divorced 3.Single 4.Widowed

4) Occupational status.1.Housewife 2. Government Employer 3.Daily laborer 4.Merhant

5) Educational status. 1. Illiterate 2.Primary 3.Secondary 4. Certificate and Above

6) Respondents religion. 1. Muslim 2. Protestant 3.Orthodox 4.Others specify_____

7) Ethnicity, 1. Silte 2. Amhara 3. Oromo 4. Others specify_____

8) Family's income per month? _____Ethiopian birr.

9) ANC Follow up 1.Yes 2.No

10) Gravidity 1.primi 2. multi 3. Grand muti

11) parity 1. zero 2.two 3. Two—four 4. Above five

12) Presence of medical disease 1).Hypertension 2). Gestational diabetes 3). Other (specify)

13) Gestational age in weeks. 1. <37 2.37-42 3.>42 4). Unknown

14). Absence of previous vaginal delivery 1).yes 2). No

15) Informed consent1. Yes 2.No

16) Maternal weight by kg…….

17) Maternal height by centimeter …….

Section-III- labor characteristics variables

No	Questions	Response	Code
16	Duration of labor complete in Hour	----------	
17	Use of oxytocin	1. Yes 2. No	
18	Use of misoprostol	1. Yes 2. No	
19	Use of analgesia	1. Yes 2. No	
20	Is the health professional get permission to perform episiotomy	1. Yes 2. No	
21	Period of fetal expulsion complete in hour	----------	
22	Condition of fetal heart rate during 2nd stage	1. Normal (120-160) 2. Bradycardia(<100) 3. Tachycardia (>180)	
23	Fetal presentation	1. Vertex 2. Breech 3. Other(specify)	
24	Mode of delivery	1. NVD 2. Vaccum 3. Forceps	
25	Presence of me conium	1. Yes 2. No	
26	Time of delivery	1. Day 2. Night	
27	Indication for episiotomy	1. prolonged labor 2. NRFHR	

		3. APH 4. Breech 5. Fetal prematurity	
28	Attendant	1. Midwifery 2. Obstetrician 3. Nurse 4. Ho	

Section –IV perinatal and maternal outcome variables

No	Question	Response	Code
29	APGAR score (1^{st} &5^{th} minute)	1. Very low (0-3)2. Low (4-6) 3. Normal (>7)	
30	Birth weight (kg)	1. Low birth weight (<2.5 kg) 2. Normal birth weight (2.5 - 3.9 kg) 3. Macrosomia (>4kg)	
31	Perinatal laceration	1. Yes 2. No	
32	Perineal tear	1. No 2. Grade –I 3. Grade-II 4. Grade-III 5. Grade-IV	
33	Type of episiotomy	1. Medial 2. Medio lateral	
		3. Other(specify)	

34	Counseled for perineal care	1. Yes 2. No	
35	Previous hx of cesareans section	1. Yes 2. No If you have yes; how many time? Specify……	
36	Previous hx of episiotomy	1. Yes 2. No If you have yes; how many time? Specify……..	
37	History of female genital mutilation	1.yes 2. no	
38	previous breech delivery	1.yes	
39	Episiotomy done fore current delivery	1 yes 2 no	

T H A N K YOU

Name of the data collector_____

Signature_____

ASSURANCE OF PRINCIPAL INVESTIGATORY

The undersigned agree to accept responsibility for the scientific ethical and technical conduct of the research pepper and for provision of required progress report as preterm condition of the faculty of midwifery in effect at the time of grant forwarded as the result of this applications.

Name of investigation

1. **AMANUEEL PETEROS**
2. **MASTEWAL MULAT**
3. **MISGANAW WORKIE**

Date June 2022 **signature----------**

ADVISORS

1. **YIBELITAL MESIFINE**
2. **MESIFINE DIFER**

Date June 2022 **signature ----------**