



ORIGINAL RESEARCH – QUALITATIVE

The barriers and facilitators to evidence-based episiotomy practice in Jordan



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ABSTRACT

Aim: This paper examines the barriers to evidence-based episiotomy practice in Jordan and identifies strategies that may be effective in introducing evidence-based practice.

Background: Episiotomy is routinely undertaken during birth in many parts of the world, including in the Middle East with little scientific evidence of benefit. There is a paucity of research examining the underlying drivers for episiotomy rates, and why they are higher in some countries.

Method: This study, conducted in Jordan, used a quality improvement approach and comprised three phases. In phase one, a retrospective file review of 300 births was conducted. In phase two, 15 face-to-face interviews were conducted with 10 midwives and five key stakeholders (managers and doctors). A feedback and discussion session using the audit and review model was conducted in phase three with 23 health professionals to identify strategies to reduce the episiotomy rate.

Results: The episiotomy rate was 41.4% overall (91% of primiparous women and 24% of multiparous women). Six major themes emerged from the thematic analysis of data: 'Policy: written but invisible and unwritten and assumed'; 'the safest way'; 'doctors set the rules'; 'midwives swimming with the tide'; 'uncooperative and uninformed women' and 'the way forward'.

Conclusions: Non-evidence based episiotomy practices are widely used during birth in this Jordanian hospital and numerous barriers to change exist. Medical professionals dictate childbirth practice and midwives fear recrimination if they go against the 'unwritten policy'. Strategies to change practice include development of evidence-based information for women, education of midwives and doctors, and policy review.

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Summary of relevance

Problem

High episiotomy rates in Jordan.

What is already known

Episiotomy is routinely performed on primiparous women in Middle-eastern countries. The World Health Organization recommends the restrictive use of episiotomy with a rate of 10–20% considered acceptable. Various strategies have been implemented to change and reduce the incidence of episiotomy

including, Continuous Quality Improvement (CQI) processes to effect practice change.

What this paper adds

This paper highlights the significant barriers to implementing evidence-based episiotomy practice in Jordan. Currently policy is based on personal opinion and preference of medical professionals; midwives are expected to follow an unwritten policy that dictates that all primiparous women require an episiotomy and midwives believe that if they do not follow doctors' orders they will be punished. It is also evident that women are viewed in a disparaging way as uncooperative and uninformed. In this cultural context it will be difficult to achieve evidence-based episiotomy practice however a number of strategies may pave the way for change.

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1. Introduction

Historically, episiotomy has been performed to prevent severe perineal trauma and to facilitate an easier/faster birth of the baby.^{1–3} For the past two decades however, clinicians and researchers have raised questions about the possible harm of episiotomies, such as immediate and prolonged perineal pain, extension to third and fourth degree tears, excessive blood loss, wound infections, long term dyspareunia, and faecal and urinary incontinence.^{4–6} A Cochrane review published in 2009 found restrictive episiotomy was associated with a number of benefits including less posterior perineal trauma, less suturing and fewer complications and no difference in pain measures or severe perineal trauma.⁵ The only harm reported was an increased risk of anterior perineal trauma with restrictive episiotomy.⁴ While the performance of episiotomy may be justified for specific maternal and foetal indications it appears that this surgical procedure continues to be undertaken too frequently in the developed and now in the developing world. In some parts of the world such as the Middle East, the rate of episiotomy is often over 50%⁷ and in some Eastern European countries, rates as high as 99% have been reported.⁸ In contrast, the Netherlands has an episiotomy rate of 8%; the United Kingdom, 14%, and a similar rate in Australia.⁹

The World Health Organization recommends the restrictive use of episiotomy with a rate of 10–20% considered acceptable.¹⁰ Various strategies have been implemented to change and reduce the incidence of episiotomy including, Continuous Quality Improvement (CQI) processes to effect practice change.¹¹ Fernandes et al.⁷ conducted an educational programme for all of the health professionals (midwives, nurses and doctors) in the labour room in a hospital in Dubai. They asked all midwives to record the reason for performing episiotomies, and this was followed by interviews with midwives about use and indications for episiotomy. They reported a decline in episiotomy rates from 64% to 52% in 2007 with a further decrease to 22.4% in 2008.⁷ These and other researchers indicate that a focused practice change programme that includes an educational component with the opportunity for interaction, discussion and sharing of ideas can be effective in changing practice.^{7,12,13}

However, few studies have reported the change process particularly examining how barriers were overcome to change episiotomy practice. The study reported in this paper aimed to address this gap by examining the barriers to evidence-based episiotomy practice in Jordan. Particular focus was placed on investigating the perceptions and beliefs of midwives, physicians and managers around episiotomy use and to explore effective strategies to introduce evidence-based episiotomy practice in Jordan.

2. Methods

2.1. Study design

A quality improvement approach was selected as the most appropriate methodology with which to determine current episiotomy practices at the study site, and to identify and plan appropriate strategies for change.¹⁴ The focus of this study was on the *PLAN* component of the quality improvement cycle. *PLAN* incorporates components such as identifying the current practice related to episiotomy practices, and developing strategies for changing these practices. Data were collected in three phases; in phase one, a retrospective file review of 300 births was conducted using an audit and review model. In phase two, face-to-face, in-depth semi-structured interviews were conducted with staff in the maternity unit. A feedback and discussion session using a review model was conducted in phase three.

Ethics approval for the study was obtained from the University of Western Sydney (now Western Sydney University) ethics committee number H9695 in June 2012. Formal written approval was also obtained from the Jordanian Ministry of Health.

2.2. Study setting

The study was conducted in one of the major maternity hospitals (Princess Badeea Hospital) in Irbid in the northern part of Jordan. In Jordan, as in many Middle Eastern countries, midwives provide maternity care for pregnant women with uncomplicated pregnancies and births but in most maternity units, midwives' practice is directed by obstetricians.¹⁵

2.3. Study participants and recruitment

In phase one, 300 birth records were randomly selected and reviewed. This sample size was determined because it represents around 10% of births in the hospital in one year. Both multiparous and primiparous women were included in this review. Birth records of women were included irrespective of whether women had a vaginal birth or instrumental birth. The files of women who had a caesarean section were excluded from the review.

In phase two of the study, both purposive¹⁶ and self-selecting convenience samples were used to obtain the participants. A flyer was placed in the maternity unit to inform health professionals about the study and to invite them to participate. In total, 15 health professionals participated in phase two: 10 midwives and five key stakeholders that included physicians and managers. Participants were aged between 24 and 43 years. Participating midwives ranged in experience from eight months to 22 years. Two of the registered midwives had completed a Bachelor Degree in Midwifery at university, while eight midwives had completed a two or three year Diploma in Midwifery in a nursing college. Two out of the five key stakeholders were resident doctors in the maternity unit, with the remainder (three) being senior managers.

Similar recruitment processes were used to invite staff to participate in the feedback and discussion session. A sample of 23 participants including 13 midwives, eight registered nurses and two assistants in nursing attended the feedback and discussion session. Only three of the 10 midwives who participated in the interviews in phase two also participated in the feedback and discussion session in phase three. These three midwives and the additional 20 staff who participated in this session in phase three were all provided full information about this part of the study and signed written consent forms prior to the start of the workshop. These participants were aged between 27 and 47 years. Their professional experience ranged from two to 24 years.

2.4. Data collection

In phase one, a retrospective file review of 300 births from the six-month period February 2012 to July 2012 was conducted in August 2012. The data were entered directly into an Excel database.

Data in phase two were collected by face-to-face semi-structured interviews with the consenting health professionals. Open-ended questions and prompts (see [Table 1](#)) were used to ensure that the participants would talk both broadly and more specifically about their practice. In addition, a brief structured questionnaire was used to collect information about the participants' socio-demographic details (e.g. age, sex, date of birth, occupation, education level, date and place of interview). The interviews were conducted in a private room in the maternity unit or in the clinical education centre during October and November

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