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Original Research Article

Attitude and knowledge of Latvian women towards episiotomy

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ABSTRACT

Background: Although episiotomy is one of the most common surgical procedures, there is still not a lot of research on patients' experience, knowledge and attitudes.
Methods: A structured questionnaire was developed and carried out online to evaluate the knowledge and attitudes toward episiotomy among pregnant women and women who had given birth in the previous three years.
Results: In this study, 1394 respondents were included. 72.6% of respondents knew what episiotomy was and why the procedure was performed, and 50.9% of those women acknowledged that before labour they did not receive an adequate amount of information. There is a correlation between the knowledge of episiotomies and refusal of the procedure (Spearman's r=-0.133, p≤0.001). In case of insufficient information, women were more likely to refuse the procedure. 36.2% of women who experienced episiotomy were informed about the procedure and gave their consent to it and 51.9% did not, the rest could not give a concrete answer.
Conclusions: Women are not provided with sufficient information about episiotomies during pregnancy. In the majority of cases, patient involvement in the decision-making is not observed. Women must be provided with choices and obtaining their consent should be an integral part of the procedure.

Keywords: Episiotomy, Perineal lacerations, Childbirth, Qualitative research

INTRODUCTION

Episiotomy is the surgical enlargement of the vaginal outlet by an incision of the perineum during labour to ease the delivery of the foetus. This procedure is done with scissors or a scalpel and requires repair by suturing.[1] Indications for performing episiotomy during vaginal delivery without additional conditions are signs of foetal distress, insufficient progress of delivery and threatened third- or fourth-degree lacerations.[2]

It is more and more advised to restrict the routine use of unnecessary episiotomy since the procedure has the potential for short- and long-term complications.[3] The most-reported complications of episiotomy include infection, pain and dyspareunia.[4]

The WHO in 1996 recommended an episiotomy rate of approximately 10% in vaginal deliveries.[2] Some sources state that the overall rate of episiotomy, which is less than 10%, is quite rare. Sweden (6.60% in 2010), Iceland (7.20% in 2010), and Denmark (4.90% in 2010) are the countries representing a small overall episiotomy rate.[5] The rates in Latvia were: 10.64% per 1000 live births in 2021.[6]

In 2018, the WHO stated that routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth. There cannot be determined a precise rate of episiotomies, however, this procedure has its role in obstetric emergencies (the indications listed before).[7]

Surgical interventions such as episiotomy can be a cause of great anxiety; therefore, it is essential that women receive relevant information on the episiotomy-its indication. And they must know that it is performed by skilled healthcare providers that are attentive to their needs.[7]

Aim of the study

The purpose of our study was to determine the level of knowledge and understanding of Latvian women about episiotomy, as well as to assess the experiences of women who had episiotomies.

METHODS

A mixed method study was carried out from November 2021 to May 2022.

A literature review was conducted to understand the current situation on episiotomy in the medical literature. This was performed by using PubMed and Medline databases and searching for "episiotomy" and a variety of search terms, f.e., "indication," "prevention," "complication," "incidence" and "patient knowledge".

A questionnaire assessing demographics, existing knowledge on episiotomy and perineal lacerations and attitude towards episiotomy was developed. Specific questions were asked to the individuals that stated they had experienced episiotomy: administration of pain relief, giving consent to the procedure and consequences. To most questions it was possible to answer with the following options: "strongly agree", "more agree", "neither agree nor disagree", "more disagree" and "strongly disagree". In the description of answers, "agree" included both "more agree" and "strongly agree"; "disagree" includes both "more disagree" and "strongly disagree". We also included open-ended questions so that women could provide discretionary input.

The questionnaire was distributed online via social media tools (such as Facebook and Instagram) in February 2022. Online distribution was suitable in Latvia because of the high internet user percentage. According to the International Telecommunication Union data, the percentage of individuals using the internet in Latvia in 2020 was 88.9%.[8] Inclusion criteria for the survey were women aged 18 years or older who were currently residing in Latvia and were pregnant or that had been in labour in the previous three years. The form was available in the Latvian and Russian languages to ensure that most citizens of Latvia answered it in their native and comfortable language. The authors organised the translation of the questionnaire from Latvian to Russian and pilot testing. Women were reassured that their responses were anonymous. Women were asked to consent to be included in the research and fill in the form for the first time. To achieve the aim of the study, the responses were pooled to conduct a sub-analysis on the following groups of individuals: pregnant women vs. women post-delivery primiparas vs multiparas. Participants of the survey were representative of the target population.

The statistical analyses were performed using the IBM SPSS Statistics 27. A p value of less than 0.05 was considered statistically significant. Descriptive statistics were generated, parametric tests and correlation analyses were conducted to find the association among variables. Bivariate correlations were conducted to explore the relationships between variables. The Spearman correlation measures the strength and direction of association between two variables, and it is a non-parametric statistic. In this study, Spearman's correlation was used between knowledge of episiotomies and refusal of the procedure, between age and better knowledge of preventing perineal lacerations. The correlation was also used to measure strength between education and better knowledge of preventing perineal laceration, as well as, between satisfaction with the healthcare provider's attitude and receiving information and giving consent before episiotomy was performed.

RESULTS

In February of 2022, 1528 respondents filled the questionnaire. Following the inclusion criteria, 1394 women were included in the study. These respondents had given birth in the time from 2019 or were pregnant at the time of the conducted survey. Demographics are shown in Table 1.

The included subjects were in the age range from 18 to 46 with a mean age of 30.8±4.9 years. 330/1394 (23.7%) were pregnant and the remaining 1064/1394 (76.3%) had given birth in the previous 3 years.

Knowledge of episiotomies

Of included respondents, 1012/1394 (72.6%) agreed with the statement, that they knew what episiotomy was and why the procedure was performed, 515/1012 (50.9%) of those women acknowledged that before labour they did not receive an adequate amount of information. Only 311/1394 (22.3%) agreed that they had received sufficient information on episiotomies (its procedure, postpartum period, wound care).

More than a half of women, 847/1394 (60.8%) disagreed with receiving sufficient information about episiotomy (its procedure, postpartum period, wound care). Of these respondents, 336/847 (39.7%) were primiparous and 298/847 (35.2%) were multiparous women. 236/1394 (16.9%) neither agreed nor disagreed with this statement (Table 2).

Women who answered with agreement 311/1394 (22.3%) were asked to provide where they received the information. They were able to give multiple answers. The most common sources of information were 87/311

(28.0%) obstetrician-gynaecologists, 88/311 (28.3%) midwives, 87/311 (28.0%) antenatal classes, and 173/311 (55.6%) themselves searching for information in various resources. 33/311 (10.6%) answered others with the most common answers: being healthcare workers themselves and getting information from a doula. The results are shown in Figure 1.

Table 1: Summary demographic characteristics of women.

Demographics	Number of respondents	Sample distribution
Language of the form		
Latvian	1266	90.8
Russian	128	9.2
Age (years)		
18-20	21	1.5
21-25	197	14.1
26-30	495	35.5
31-35	461	33.1
36-40	193	13.8
41-46	27	1.9
Received education		
Higher education	1032	74
Secondary general education	158	11.3
Secondary professional education	182	13.1
Primary education	21	1.5
Incomplete primary education	1	0.1
Times of previous labour		
None	330	23.7
1	583	41.8
2	356	25.5
3	96	6.9
4	24	1.7
≥5	5	0.4
Place of residence		
In the capital (Rīga)	599	43
In one of the largest cities (Daugavpils, Liepāja, Jelgava, Jūrmala, Ventspils, Rēzekne, Jēkabpils or Valmiera)	289	20.7
In another city	332	23.8
In the countryside (in the parish center, homestead, etc.)	174	12.5

Women's perspective on episiotomies

Of the respondents, 609/1394 (43.7%) admitted to being afraid of episiotomy being performed during labour and similarly, 650/1394 (46.6%) confessed that the perineal lacerations alarmed them. It is worth mentioning that 886/1394 (63.6%) of women were worried about childbirth.

Spearman's rho identified a negative correlation r=-0.133, p≤0.001 between knowledge of episiotomies and refusal of the procedure. The less information respondents had of episiotomies, the more likely they would not consent to the operation.

It can also be noted that acceptance of episiotomy in different situations varies: at 1063/1394 (76.2%) if the midwife deems it necessary; 1144/1394 (82.1%) if the doctor deems it necessary and 1308/1394 (93.8%) if there are signs of foetal distress.

A weak Spearman's correlation r=0.048, p=0.072 was found between age and better knowledge of preventing perineal lacerations and a weak correlation r=0.095, p≤0.001 between education and better knowledge of preventing perineal lacerations, and that suggests that age and education is not a significant factor in better knowledge.

Main questions addressing episiotomies were compared between sub-populations (Table 3).

A slight increase in knowledge on episiotomies is visible in multiparous women with an agreement of 357/481 (74.2%) in comparison with women that are nulliparous 228/330 (69.1%). It can also be noted that among pregnant women 19/330 (5.7%) would refuse episiotomy under any circumstances, among primiparous 35/583 (6%) and 40/481 (8.3%) among multiparous women. Significant differences between the sub-populations were not identified.

Episiotomy experience

Of the respondents, 663/1394 (47.6%) experienced episiotomy and 731/1394 (52.4%) did not experience episiotomy during labour. The respondents that revealed having episiotomy were led to a separate questionnaire section asking more detailed information about their experience (Table 4).

Of 663 women that experienced episiotomy, 142/663 (21.4%) respondents agreed on receiving sufficient information about episiotomy (its procedure, postpartum period, wound care), 121/663 (18.3%) neither agreed nor disagreed, and 400/663 (60.0%) disagreed on receiving the information before labour.

240/663 (36.2%) of women who experienced episiotomy were informed about the procedure and consented, and 344/663 (51.9%) disagreed with the statement.

A positive correlation was found between satisfaction with the healthcare provider's attitude and receiving

information and giving consent before episiotomy was performed (Spearman's rho r=0.468, p≤0.001). This correlation implies that the better respondents were informed about the performed procedure the more satisfied they were with the provider. The authors identified that 174/663 (26.2%) strongly disagreed with the statement that they received sufficient analgesia before the procedure.

Table 2: Attitudes of participants towards different aspects of episiotomies.

Attitudes of participants towards different aspects of episiotomies	Strongly disagree, out of 1394	More disagree, out of 1394	Neither agree nor disagree, out of 1394	More agree, out of 1394	Strongly agree, out of 1394
	N (%)	N (%)	N (%)	N (%)	N (%)
I am aware of what an episiotomy is (how and why it is performed)	107 (7.7)	102 (7.3)	173 (12.4)	386 (27.7)	626 (44.9)
Before giving birth, I got sufficient information about episiotomy: its procedure, postpartum period, wound care, etc.	542 (38.9)	305 (21.9)	236 (16.9)	190 (13.6)	121 (8.7)
Before giving birth, I received enough information on how to avoid perineal lacerations	475 (34.1)	259 (18.6)	261 (18.7)	221 (15.9)	178 (12.8)
I would prefer a cesarean over an episiotomy	705 (50.6)	182 (13.1)	307 (22.0)	81 (5.8)	119 (8.5)
I would prefer a natural tear in labour rather than an episiotomy	192 (13.8)	154 (11.0)	436 (31.3)	218 (15.6)	394 (28.3)
I would agree to an episiotomy if the midwife deemed it appropriate during labour	36 (2.6)	81 (5.8)	214 (15.4)	377 (27.0)	686 (49.2)
I would agree to an episiotomy if the doctor deemed it appropriate during labour	34 (2.4)	51 (3.7)	165 (11.8)	359 (25.8)	785 (56.3)
I would agree to an episiotomy if the doctor or midwife thought that baby wasn't getting enough oxygen and wanted to speed up the delivery	20 (1.4)	18 (1.3)	48 (3.4)	202 (14.5)	1106 (79.3)
I would agree to an episiotomy in the event of operative vaginal delivery, to help prevent severe lacerations	55 (3.9)	45 (3.2)	146 (10.5)	283 (20.3)	865 (62.1)
I would never agree to an episiotomy	825 (59.2)	227 (16.3)	248 (17.8)	59 (4.2)	35 (2.5)
I am/was worried about giving birth	96 (6.9)	152 (10.9)	260 (18.7)	341 (24.5)	545 (39.1)
I am/was afraid of vaginal delivery	420 (30.1)	248 (17.8)	219 (15.7)	230 (16.5)	277 (19.9)
I am/was afraid of the possibility of needing a caesarean	280 (20.1)	215 (15.4)	219 (15.7)	281 (20.2)	399 (28.6)
I am/was afraid that the perineal muscles might tear during childbirth.	223 (16.0)	229 (16.4)	292 (20.9)	292 (20.9)	358 (25.7)
I am/was afraid of the possibility of needing an episiotomy	282 (20.2)	228 (16.4)	275 (19.7)	243 (17.4)	366 (26.3)

Table 3: Diversity of opinions based on parity.

Diversity of opinions based on parity	Pregnant		Primiparous		Multiparous	
	Agreed	Disagreed	Agreed	Disagreed	Agreed	Disagreed
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
I am aware of what an episiotomy is (how and why it is performed)	228/330 (69.1%)	55/330 (16.7%)	427/583 (73.3%)	79/583 (13.5%)	357/481 (74.2%)	75/481 (15.6%)
Before giving birth, I got sufficient information about episiotomy: its procedure, postpartum period, wound care, etc.	64/330 (19.4%)	213/330 (64.6%)	143/583 (24.6%)	336/583 (57.6%)	104/481 (21.6%)	298/481 (62%)
Before giving birth, I received enough information on how to avoid perineal lacerations	76/330 (23%)	182/330 (55.1%)	186/583 (31.9%)	302/583 (51.8%)	137/481 (28.5%)	250/481 (52%)

Continued.

Diversity of opinions based on parity	Pregnant		Primiparous		Multiparous	
	Agreed	Disagreed	Agreed	Disagreed	Agreed	Disagreed
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
I would never agree to an episiotomy	19/330 (5.7%)	250/330 (75.8%)	35/583 (6%)	463/583 (79.4%)	40/481 (8.3%)	339/481 (70.5%)

Table 4: Experience of respondents that have undergone episiotomy.

Experience of respondents that have undergone episiotomy	Strongly disagree, out of 663	More disagree, out of 663	Neither agree nor disagree, out of 663	More agree, out of 663	Strongly agree, out of 663
	N (%)	N (%)	N (%)	N (%)	N (%)
Before giving birth, I got sufficient information about episiotomy: its procedure, postpartum period, wound care, etc.	236 (35.6)	164 (24.7)	121 (18.3)	84 (12.7)	58 (8.7)
Before performing an episiotomy, I was informed about the manipulation and gave my permission to do it	279 (42.1)	65 (9.8)	79 (11.9)	82 (12.4)	158 (23.8)
Sufficient analgesia was provided before the procedure	174 (26.2)	53 (8.0)	82 (12.4)	99 (14.9)	255 (38.5)
I was satisfied with the approach and attitude towards me as a patient	74 (11.2)	61 (9.2)	101 (15.2)	157 (23.7)	270 (40.7)
An episiotomy was a necessary manipulation in my case	21 (3.3)	37 (5.8)	107 (16.7)	161 (25.2)	314 (49.1)

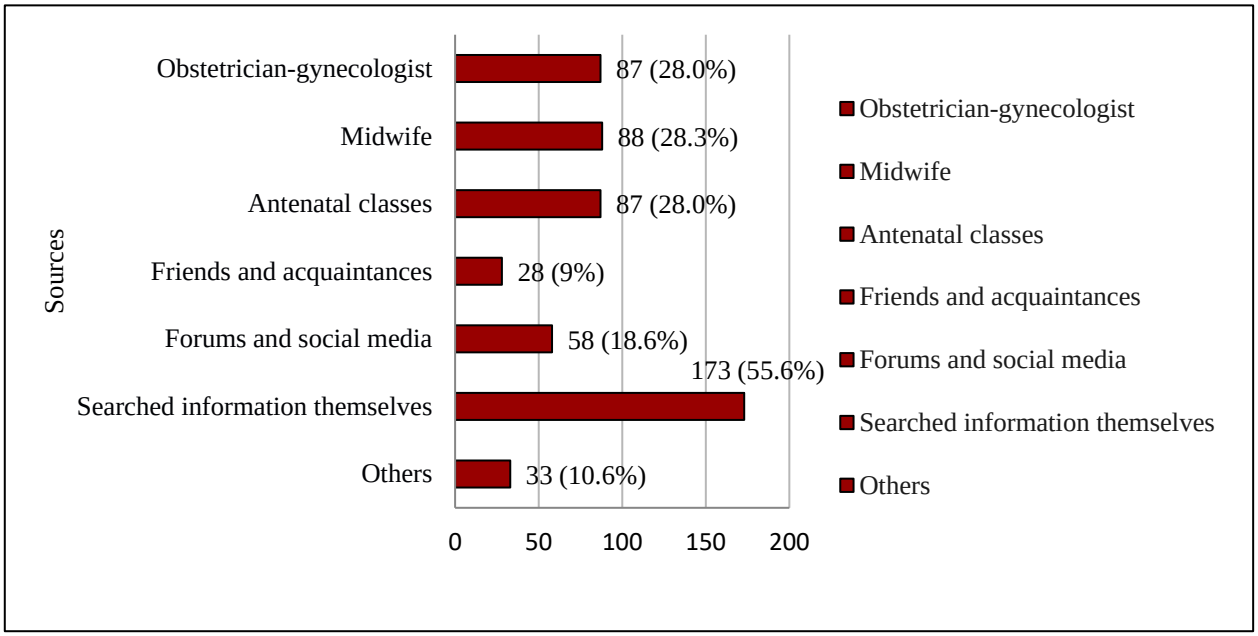

Figure 1: Information sources.

DISCUSSION

The WHO has stated that it is necessary for women to have a positive childbirth experience that fulfils their expectations, including a psychologically safe environment, and to have a sense of control in decision making. It is also recommended, in settings with well-established midwifery programmes, to provide continuity of care, in which a known midwife supports a woman throughout the antenatal, intrapartum, and postnatal period.[7] In Latvian settings, such continued care from midwives in the active labour phase might not be always possible to ensure, since the number of active midwives

per 100 000 inhabitants is 19.63, which is almost twice as lower than WHO European region with 44.58.[9] Lack of human resources can lead to divided attention among patients and less investment in patients as individuals. A model with uninterrupted midwife care during labour would ensures that women would be more pleased with their care, labour, themselves and the baby.[10]

The data showed that a large proportion of women were informed about episiotomies, however, the information was not acquired from medical staff. The authors believed that episiotomies should be a more common part of the conversation between pregnant women and their healthcare providers to achieve better knowledge and therefore higher prophylaxis of perineal lacerations. It was also worth mentioning that the physician had to use the most effective communication methods to deliver the information corresponding to each patient.[11] It had been confirmed that prophylaxis done by women and healthcare providers during labour can decrease the need for episiotomies.[12]

Another aspect of the need to receive sufficient knowledge about episiotomy can be identified when looking at the positive correlation between satisfaction with the healthcare provider's attitude and receiving information along with giving consent before episiotomy was performed. This correlation showed that patients who received information and provided consent to the procedure were more satisfied with their specialists and healthcare. Other publications suggested that effort had to be put into boosting a positive perception of the healthcare experience.[13] As seen from this correlation, providing adequate information would contribute to treating the patient as an individual, not just as a condition.

There had been dated issues with requiring documented consent and lacking a discussion about the procedure, its risks and outcomes.[14,15] In one study it was estimated that 40.79% of women were not aware of undergoing the procedure.[16] A similar situation was detected during this study, where the majority of women were not informed about the procedure before it was made and did not provide their consent to it. The decision of performing the procedure was made mostly by their health care provider, a similar situation is also observed in other studies.[17] Episiotomy being one of the most frequent surgical interventions, still is overlooked and does not fulfil the steps and measures as any other surgical manipulation.[18] As seen in our study, women should be informed about the procedure, its risks and possible outcomes, and have the option to make an informed decision.

Childbirth and procedures related to episiotomy is a cause of fear and anxiety. In our study, 63.6% of respondents admitted to being worried about childbirth and 43.7% admitted their worries about episiotomy being performed. Some publications demonstrated a significant decrease in fear after obtaining comprehensive information on the subject of childbirth, episiotomy.[19] One of the main milestones of patient-oriented care should involve emotional support and alleviation of fear and anxiety, therefore the authors believe that is still a concern that has to be addressed among women and physicians.[20]

It had been noted that women would be more accepting of episiotomy in cases where it would benefit child health. In one study 95% of women would agree to episiotomy to hasten the delivery in the event of foetal distress, similar results were found in our study, where 93.8% of respondents would agree to episiotomy in case of distress.[19]

The authors identified that 26.2% strongly disagreed with the statement that they received sufficient analgesia before the procedure. Adequate local anaesthesia should be administered before episiotomy.[7]

Strengths

During our study, we managed to sample a significant number of women and the response rate to the survey was commendable. The questionnaire was made in two languages to make it more convenient for women to complete since the most commonly spoken languages are Latvian 62.1% (official language) and Russian 37.2%.[21] This research highlighted the need for better communication among pregnant women and healthcare providers.

Limitations

Some women did not fill in all the questions or did not completely understand some of them. Survey being in two languages was one of the strengths, but we still had to admit that we got a significantly smaller response from Russian-speaking women; however, this could also be explained that many Russian-speaking women might have chosen to fill in the questionnaire in Latvian. For future studies, we would suggest reaching out to more women and considering adding English as another language. In further research, we would advise interviewing women to attain a better understanding of their experiences and to clarify their answers.

CONCLUSION

Although the rates of episiotomy use are decreasing and setting a new trend to selective/restrictive use rather than routine, it remains one of the most frequently used surgical procedures. There is not enough information about episiotomies provided to women during pregnancy. Antenatal education about episiotomies is crucial to women, it reduces anxiety, and increases satisfaction and acceptance of the procedure. Patient involvement in the decision-making is not observed in the majority of cases, providing women with choices and obtaining consent should be an integral part of the procedure.

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