Exploring the Perceptions and Preparedness for Episiotomy Amongpost Partum Mothers in Northern Ghana: A Qualitative Study

Timothy Gazari (tgazari@uds.edu.gh)
University for Development Studies
Gideon Awenabisa Atanuriba
Central Hospital, Tamale, N/R
Paulina Gariba Anagbe
Seventh Day Adventist Hospital, Tamale

Research Article

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Abstract

Background

Episiotomy is a surgical incision made on the perineum of a woman to increase the vulval diameter during child birth at the second stage of labour. It is practiced all over the world and said to be the most common obstetric surgical procedure globally. Prevention of extensive blood loss, prolapse of genital organs and shortening of the second stage of labor are reasons for its practice. However, the experiences of women who undergo this phenomenon remain largely unexplored.

Methods

an institutional based descriptive qualitative design was employed in this study and a semi structured interview guide was used for data collection. Purposive sampling was used to recruit the participants for the study. Recorded in-depth interviews were conducted and data were analysed using thematic analysis.

Results

Episiotomy was perceived as useful procedure that facilitates birthing by cutting. It was also opined by participants that the procedure spoils the vaginal orifice and those who undergo the procedure were not “women enough”. Participants also felt there was generally poor preparation prior to undergoing the procedure and no opportunity offered to accept or decline the procedure.

Conclusion

Postpartum mothers had fair knowledge but were not adequately prepared for the procedure. Their perception was just about the procedure helping them to deliver their children and did not know of other benefits and effects. They as well did not go through proper consent process. The study recommends structured education on episiotomy during antenatal and the practice of restrictive episiotomy over routine episiotomies.

Background

Episiotomy is a surgical incision made on the perineum of a woman to increase the vulval diameter during child birth at the second stage of labour (1). It is practiced all over the world and said to be the most common obstetric surgical procedure globally (2, 3). Episiotomy emerged in the 18th century, practiced in the 19th century with increased acceptance and performance in the 20th century (60% of deliveries) since obstetrician De Lee opined prevention of extensive blood loss, prolapse of genital organs and shortening of the second stage of labor as reasons for its practice (4–6).

Globally, depending on which part of the world a woman delivers, about 10–95% of them will have an episiotomy (6). Episiotomy is a standard obstetric procedure that is routinely performed across the world. For instance in France 71.3% for primiparous women and 36.3% for multiparous women, in Latin America between 1995–1998 (92.5%), in the year 2000 in Canada (28.3%) and US (32.7%) while in Taiwan at 2002,100% was reordered among primiparous women (7). Current evidence shows high performance of episiotomies in Sub Sahara Africa than developed countries in Europe(8). For instance, an epidemiological study in Burkina Faso showed 22% (9), and in neighboring Nigeria 62.1% (1). The episiotomy rates at a tertiary facility in Ghana were 17.4% for all the parturients and 31.4% for the nulliparas in a previous study (10).

According to a qualitative study conducted in China, women had minimal knowledge of the procedure prior to childbearing and were not well taken through the consent process (11). (11) concluded by alluding to the fact that women receive little information in advance about episiotomy as many knows little about the procedure until active labour. However, the procedure has a wide range of physical and psychological consequences. Causing long- term anxiety about the damage done to them as women.

In a Brazilian study, episiotomy was viewed as something that aids birth depending on the size of the baby and ensures the mother does not remain open, while others believed it was unnecessary(12). A study on knowledge and perceptions on episiotomy among pregnant women in Ibadan Nigeria revealed that 65.5% have ever heard of episiotomy and 31.2% have personal experience of having undergone the procedure (13). The WHO reports that, “women felt they were poorly informed about the reasons for performing an episiotomy and were rarely asked for their permission” (14). According to (5) to decide whether or not to cut a woman, professionals must rely on their best clinical judgment and professional ethics. The incision must be very necessary. Despite the fact that this is a little incision, it is still considered a surgical procedure with risks and advantages. Clinicians and future mothers must know when, how, and why to undertake this surgery. The latter awareness is important.

The WHO recommends selective/restrictive episiotomy over routine/liberal episiotomy(14) following this some major health facilities in Ghana have a selective episiotomy policy in place in which episiotomy is performed for specific indications such as delay in second stage, shoulder dystocia, fetal distress, and vacuum deliveries (10). An anecdotal report from the maternity unit of Seventh Day Adventist Hospital in Tamale reveals that out of 1,960 deliveries, 25% (492) were via episiotomy. Even though there exist a downward trend of episiotomy rates in the developed world, that of sub-Saharan Africa continue to be relatively high(10) yet little is known about the perceptions and preparedness of post-partum women who are the subjects of this phenomenon.

Methods

Study setting and site

The study setting was the Tamale Metropolis in the northern region of Ghana. This metropolis is the fastest growing in West Africa sub region with a huge business opportunities that draws people from

even neighboring countries (15, 16).

Tamale Seventh Day Adventist Hospital was the site where participants were recruited for the study. The hospital is a Christian Health Association-Ghana (CHAG) facility providing inpatient and Out Patient Care (OPD) services to population in and around the metropolis.

Study design

The study employed an institutional based descriptive qualitative design. This design allows for the description of a phenomena without laying much emphasis on the interpretation made with them(16,17).

Study Population, sampling technique and sample size

Population refers to the aggregate of people or cases for which a researcher is interested in to collect data or information to answer research questions (17). The population for this study was all post-partum women who have undergone episiotomy seeking for health care at the Post-Natal Clinic (PNC) of SDA Hospital-Tamale.

The study employed a purposive sampling technique to recruit the participants. According to (18) this approach of sampling refers to an instance whereby the researcher have good knowledge about the population therefore handpicks members of the population by personal judgment. Many qualitative researchers sample size is determined by data needs using data saturation(18,19). The sample size was determined by data saturation which is when ideas, themes, categories or information becomes repetitive and redundant. As such no new information is obtained with further data collection or interviews(16). Saturation was achieved at the eighth participant.

Data collection tool and procedure

The study used a self-developed semi-structured interview guide for gathering of the data. This guide was created using the study's objectives as well as empirical research findings from previous studies on the experiences of women who have undergone episiotomy.

After proper entry into the study site, participants for this study were approached at the Post-Natal Clinic of the hospital from 8th February to 29th April, 2021. The researchers approached the clients at the unit before or after their consultations to introduce the study to them using the Participant Information Leaflet for recruitment purposes. Also, nurses and midwives at the unit were used as Contact Persons to get to post-partum mothers who meet the eligibility criteria. Those who willingly consent were allowed to choose the time, date and place of convenience (within the hospital or home) for their interviews. Face to face individual in-depth interviews were conducted with only the researchers present which is lasted 45-60 minutes. These interviews were audio recorded.

During the data collection period each of the researchers took Field Notes and have a well written Daily Reflective Journals kept. The inferences from these notes were in-cooperated in the data analysis.

Participants were given a nose mask each before and two after the interviews.

Data management and analysis

Thematic analysis was employed to identify patterns within the qualitative data that are important or interesting to interpret and make sense of it (20-22). The interviews were transcribed verbatim immediately after audio recording and was familiarized with by via reading and re-reading.

This study adapted the six step of Lichtman, (2006) as cited in (22) as follows; (1) creating initial codes, (2) revising these codes, (3) establishing initial list of central ideas or categories, (4) reorganizing the initial list to fit into actual meanings, (5) initial codes are collapsed and categories/subcategories reorganized and finally (6) moving categories into themes or concepts. To make the analysis sound and reflecting the actual opinions of the participants prior to analysis biases and prior knowledge of the phenomena was bracketed. A final validation step of member checking was executed by sending some the final transcripts and finding to participants for confirmation. Discrepancies were then be checked and amended appropriately (24).

Trustworthiness

Lincoln and Guba concepts of credibility, transferability, dependability and confirmability that parallels the conventional quantitative assessment criteria of validity and reliability(25) were adhered to as measures of ensuring the trustworthiness of the study (22). The credibility of the current study was ensured by using iterative questioning and probes, peer debriefing and member checking. Keeping coherent and consistent information and a thick description of the protocols for the conduct of the study and the study setting were measures deployed to achieve dependability and transferability. Confirmability pontificate objectivity or neutrality of the data. To this end, each researcher kept a Reflective Journal which was used to enhance objectivity. While an audit trail was done with the research protocols.

Ethical considerations

The study protocol received research ethics committee approval from the Ethics Review Board of the Kwame Nkrumah University of Science and Technology (KNUST) School of Medical Sciences, Ghana (ref: CHRPE/AP/131/21) after the topic and proposal was approved by the researcher's supervisors. Written permission was obtained from the management of the hospital. The study adhered to the ethical principles for the conduct of research among human subjects, thus consent, fairness, justice and respect for human rights. Anonymity was ensured by assigning pseudonyms (P1 to P12) to each participant during recruitment. The pseudonyms were used when quoting verbatim expressions of the participants in the findings of the study. For confidentially and data preservation, the transcripts were saved in a passworded personal computer and encrypted.

Results

Table 1: Demographic characteristics of study participants

Number	Pseudo-name	Age	Marital status	Level of education	Parity	Number of episiotomies	Time after episiotomy
1	Ajara	23	Married	Tertiary	G1P1A	1	4 weeks
2	Mariam	30	Married	None	G1P1A	1	7 days
3	Abena	27	Married	Tertiary	G1P1A	1	
4	Sahada	25	Married	SHS	G1P1A	1	
5	Adwoa	38	Married	Basic	G2P2A	2	3 Days
6	Memuna	34	Married	Tertiary	G2P2A	2	
7	Hawa	28	Married	SHS	G1P1A	1	Six weeks
8.	Ishah	27	Married	Tertiary	G1P1A	1	[1]

The demographic characteristics in table 1 show that all the participants were married and were between the ages of 23-38 with an average age 21 years. Only one participant did not have any form of education with many (5 out of 7) having secondary education and above. Majority (5 out of 7) were primids. While two had previously undergone the procedure, the rest has just undergone this procedure for which they described as painful.

Table 2: Summary of **Themes and Sub-themes**

Theme number	Theme	Sub-themes
	Fair perceptions of episiotomy	1. Procedure that allows the baby come out by cutting.
		2. Episiotomy is useful
		3. “it spoils the place/vagina” and Not a woman enough
	Poor preparation before episiotomy	1. Inadequate counselling
		2. No opportunity to accept or reject procedure

Theme 1: Fair Perceptions of Episiotomy

As shown in table 2, Fair Perceptions of Episiotomy was the first theme which explains women understanding, usefulness and misconceptions of episiotomy. The participants showed fair understanding of the procedure especially on why the procedure was done on them. They all agreed that

it was useful procedure but shared misconceptions about the undergoing the procedure. This theme is explained in the following subthemes

Sub theme 1: Procedure that facilitates child birth.

They narrated episiotomy was a painful procedure that facilitate the process of child birth when the vagina is tight or the child head is too big hence can't deliver unless they are cut. Their understanding of episiotomy is emphasized by the following;

"*A cut that is done by the midwife on a woman in labour when the head of the baby is big or when the vagina of the mother is too small for the baby head this is done to help deliver the baby faster"* (Abena, 27 years, GIP1A)

"*cutting to help the baby come out because your baby head is too big so they have to do that so that they can deliver your baby and you the mother will be free" (Memuna, 34 years, G2P2A)*

"a painful but helpful procedure that the nurses do, to a woman to help her deliver her baby" (Mariam, 30 years, GIP1A)

Sub theme 2: Episiotomy is Useful

Participants intimated the procedure to be useful even though painful. They mentioned the ability to have their babies born healthy as an excitement despite the abrupt and painful nature of being given a cut.

"*it's helpful because if you are in labour for a long time and you are not able to push the baby out you may lose your life or your baby and also if not because of the procedure I don't think I will be alive today*" (Sahada, 25 years, GIP1A).

"*immediately they gave me the cut I was able to push my baby out so it is helpful*" (Abena, 27 years, GIP1A).

"The way it's helpful is that, the baby will come out successful but the pain and the cut is very painful" (Hawa, 28years, G1P1A).

Sub theme 3: "It spoils the Place (**Vagina**)**" and Not a Woman Enough**

An overwhelming misconception and believes of women were about their vaginas becoming wider/spoil and being regarded as not being a woman enough. Participants opined that women who undergo this procedure have their vaginas becoming wider/spoil.

"*Your husband is likely to go out, he said you have spoiled the place, the place has spoiled so he can't go inside again*" (Hawa, 28years, G1P1A).

Abena (27 years, GIP1A) lamented

"My friends told me that when you undergo the procedure your under(vagina) becomes open and your husband will not enjoy you again, so the moment the midwife told me I became scared because I was always praying against being cut, I wanted to keep my private parts tight even after delivery for my husband".

While another woman, Memuna (34 years, G2P2A) illuminate how long lasting the effects to be leading to broken homes

"it brings about broken homes, fights in marriage it can even let the man go out and be chasing other women. if the place is not sowed(sutured) well, it makes the place widen. The man might not enjoy you unless an understanding man but if he is not the understanding type, he will not say anything he will just keep quiet by the time you know he is chasing women outside".

Another, cultural misrepresentation of the procedure bordered on the questioning of the womanhood of the participants. As those who underwent this procedure were deemed as not being women enough.

"*if you are a woman, you should give birth without a cut or any problem*" (Hawa, 28years, G1P1A).

"*when a woman is not able to push the child out on her own or by herself then they believe you are not a strong woman but when you are able to go through the pain and push out the child safely and alive then you are a real woman"* (Sahada, 25 years, GIP1A).

and by extension Sahada says women who are able to deliver at home are real strong women "*who deliver at home all by herself".*

Theme 2: Poor Preparation before Episiotomy

This is second major theme as seen in table 2. This theme discusses the standard procedure to be undertaking prior to invasive procedures in health care systems. It delves into the psychological preparation of women before and after they were cut for their babies to be born. Emphasis is laid on prior to the procedure and whether or not the women were given the opportunity to accept or reject the procedure.

Analysis of information revealed little or no psychological preparation/counselling before this life saving procedure was done. Most often they were told after the procedure and even when it was done before the procedure it was just to inform them but not to allow them make self-determination of their willingness to undertake the cut. It must be emphasized at the time when women were told of the procedure was at critical moments of the second stage of labour as such full disclosure including short to long term side effects were not possible to be done. This theme is discussed under; inadequate counselling and no opportunity to accept or reject the procedure.

Sub theme 1: Inadequate Counselling

Many the women were not given any counseling at all and not told they were going to be cut. This is what some the women said;

"……so, she(midwife) told me that they wanted to help me by cutting me. At first, I said no. Then they asked me if I wanted to get cuts all over my vagina? but if they cut me, it will just be one place and they will sow(suture) it nicely for me. So, I agreed and they cut me. However, I wasn't prepared, but at the stage they told me all that matters for me was for my baby to come out alive and healthy so whatever they were to do to me for my baby to out was ok" (Adwoa, 38 years, G2P2A)

Mariam (30 years, G1P1A) even though not counselled prior to the episiotomy, wasn't concerned after all. She expressed

"No please I wasn't counselled. But what preparation is there to make, as a woman you should be ready for anything or any complications during labour but to me this cutting is not even a complication"

While Memuna (34years, G2P2A) who was told only after the procedure said

"No. I wasn't told; it was after the procedure they told me that my baby head was big so they had to cut me to make room for the baby to come out. And according to them, they did not know it will happen like that"

Sub theme 2: No Opportunity to Accept or Reject Procedure

The women were not even given the opportunity to accept or reject.

Sahada (25 years, G1P1A) lamented

"I was informed by the midwives that they were going to cut me. However, it appears they inform me but not asking for my opinion, because I don't remember saying yes or no to them to cut me"

"I was not counselled and not given the opportunity to agree or disagree for the procedure" (Memuna, 34 years, G2P2A).

While others who were not told were of the view that they would have agreed if they were told after all.

"*they did not give me the opportunity to accept or not but even if they did give me such an opportunity I will still accept to be cut"* (Mariam, 30 years, G1P1A).

"They didn't give me the opportunity to accept or decline from the procedure. They just did it and that was not the best because I wanted to search my mind before but all I feel was a sharp pain and that was it they have cut me" (Abena, 27 years, GIP1A).

Discussion

In this study majority (6 out of 8) the participants were primids with an average age of 21 years. This findings goes to confirm several studies that has associated the high performance of this procedure among primids in Saudi Arabia and Palestine respectively (26, 27). This similarity shows how vulnerable first-time mothers are to this procedure due to lack of experience and ability to push for labour to advance well without assistance. In the study in Palestine for example they indicated the reason for procedure was for protection of perineum (59.5%) and fetal distress (6.9%). The findings also become similar in aspect of being conducted in a predominantly Muslim community. The association of this painful procedure to prim parity has serious implication on positive birthing experiences and may deter some women from having facility delivery which is already a problem in the northern part of Ghana. It is important therefore for practitioners to consider restrictive performance of the procedure as recommended by WHO.

Post-partum mothers perceived the procedure as one that a cut is made to allow the child come out easily. There was unanimous admonition that the procedure was useful, however there were misconceptions of those women who undergo this procedure were not women enough. While others posit that the procedure “spoiled or widened” their vaginas. Mothers, most of whom are first time, had just a fair understanding or knowledge of the procedure due to non-education about the procedure during ANC and/ or few hours before active labour. Just an understanding of it being a procedure that allows the baby come out by cutting is not enough and require structured education of the mutual benefits of the procedure to the baby and mother. Their description of the procedure as being useful is an indication of wanting to have a healthy child without problems. This finding is consistent with (26) in Saudi Arabia among 626 women where just 40% were able to describe the episiotomy correctly even though about 60% of the participants has heard of the procedure before. Evidence of parity and previous history of episiotomy as factors associated with awareness to the procedure sprouts serious gaps in educating potential mothers of the procedure and no opportunity to demystify womanhood association with the procedure. To be able to maximize the benefits of the procedure health care professionals and systems/facilities need to incooperate the topic in women teachings at ANC.

On usefulness of the procedure this study contradict a study conducted by (24) among first timers mothers experiencing episiotomy in Saudi Arabia. Where only one participant out of five downplayed the usefulness of the procedure as she felt the procedure wasn’t necessary. In as much as these evidence shows discontent of mothers about the procedure due to poor knowledge, pain and lack of consent before the procedure. A sample size of five with just a participant disbelieving the usefulness of the procedure may not show any significance compared to our current study of about eight participants. It is our considered opinion the procedure is useful especially if practitioners use restrictive approach instead of routine. As routine episiotomies have been discredited by WHO and many obstetric and gynecological associations and experts. Further studies on perception of the usefulness of the procedure among mothers is crucial to ensure the plight of mothers are well incooperated in episiotomy practice and attitudes among care providers

Also, the findings concur with a study conducted among Chinese women(11) where there existed poor knowledge about the procedure before childbirth. Women could not explain the procedure, its benefits and

consequences. It further explores the need to inform women about the procedure before active labour. Even though some were told of the procedure during active stage of labour there were others who were only told just after the procedure and childbirth. These have lasting impression about confidence in vaginal deliveries in their subsequent pregnancies.

In this study there was poor preparation of mothers before the procedure. It was characterized by poor counseling and education of the women prior to the performance of the cut. As such many mothers did not have the opportunity to accept or reject. This becomes problematic because the women were informed about the procedure when there was active labour and were not given to opportunity to make informed decision. They had to accept for the procedure to be done on them because there was no time for them to even consult their partners or caregivers. This is inconsistent with standard practice of invasive procedures where just oral consent alone is not enough but structured procedure of full disclosure and self-determination. In Nigeria Ibadan (13) just 19% of mothers who delivered via this procedure were willing to have undergone the procedure while more than half (56.6%) were unwilling to recommend the procedure for their friends and relatives. This study shows the unwillingness of women to undergo the procedure and even recommend for others and was seen in this current study. This unwillingness is associated with poor understanding of the procedure, the abrupt nature the consent was obtained by midwives/ health care professional during labour. Which does not allow mothers to make informed decisions. As such makes mothers associate the procedure with bad experiences. Another study in Nigeria (26) reports a mother expressing her discontent with the procedure because she only noticed the sutured perineal incisions after birth. As such clearly showed she never consented to the procedure.

However, this current study contrast (29) in Brazil among 577 women who delivered by vagina where 40.97% were not aware of being given an episiotomy cut. This goes to affirm non consent by many mothers during childbearing for medical and surgical procedures such as cesarean section, labour induction and vagina examination we presuppose. This study even though contrast our findings because all mothers were told of the procedure during active labour or right after the cut to deliver, it's absolutely against good practices which requires self determination after full disclosure. These gaps in practice and attitudes need to be taken seriously to reduce acts that are tantamount to abusive and disrespected care. As practices such as this violate women rights and autonomy during child bearing.

According to (28) in Brazil for instance among obstetricians knowledge was adequate in 44.5% of the cases, attitude 10.9%, and practice, in 26.8% of the cases. An adequate knowledge than adequate attitude or practice, indicates even though improved knowledge is crucial but insufficient to change the outlook of episiotomies in Brazil. This study draws from the evidence because the approach to the practice of the procedure at the hospital has lasting implications on respectful maternity care. It is therefore important for an improved education of the care providers in the practice and attitudes towards women in regards to performance of the procedure. Poor attitudes and practices of the procedure may span out legal charges, especially with routine episiotomies as against restrictive (31).

Conclusions

Majority of mothers who underwent the procedure are primids and of an average age of 21 years.

Mothers perceived the procedure as one that aid child birthing and those who underwent the procedure as not being women enough.

Mothers were not physically or psychologically prepared enough for the procedure. Counselling on the procedure occurred during active labour where it was short lived and fragmented just to inform them and were not given opportunity to accept or reject the procedure as they were in a stage where refusal was highly impossible. The study suggests systematic episiotomy teaching throughout pregnancy and the use of restrictive episiotomies rather than routine episiotomies.

Declarations

Ethical approval and consent to participants: The study protocol received research ethics committee approval from the Ethics Review Board of the Kwame Nkrumah University of Science and Technology (KNUST) School of Medical Sciences, Ghana (ref: CHRPE/AP/131/21). Written permission was obtained from the hospital authorities before conducting the study. Participants' privacy, confidentiality, anonymity, and voluntary participation were ensured throughout the research process. Written informed consent was obtained from all participants and their legal guardians included in the study. All methods were carried out in accordance with relevant guidelines and regulations and the declaration of Helsinki.

Consent for publication: Not applicable

Data availability: the data supporting for the study is available upon written request to the first author.

Conflict of interest: None declared

Authors' contributions

Conceptualization: Timothy Gazari, Paulina Gariba Anagbe

Data curation: Timothy Gazari Paulina Gariba Anagbe

Formal analysis: Timothy Gazari,

Interviews: Atanuriba Gideon Awenabisa, Paulina Gariba Anagbe

Methodology: Timothy Gazari, Atanuriba Gideon Awenabisa

Project administration: all authors

Resources: Timothy Gazari, Paulina Gariba Anagbe

Supervision: Timothy Gazari

Writing original draft: Timothy Gazari

Writing, review and editing: all authors

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