Maduka NR. Babcock Univ. Med. J.2025 8(1):15-23
https://doi.org/10.38029/babcockuniv.med.j..v8i1.631
eISSN: 2756-4657

RESEARCH ARTICLE OPEN ACCESS

Experiences and Acceptability of Episiotomy Among Parous Women in a Secondary Health Facility in South-South Nigeria

Experiences and Acceptability of Episiotomy

Maduka NR[1]ID

[1]*Department of Obstetrics and Gynaecology, Central Hospital, Agbor, Delta State Nigeria*

Submitted: 17t October 2024
Accepted: 3rd February 2025
Published: 30th Juner 2025
ID: Orcid ID

Abstract
Objective: Episiotomy, a surgical incision made in the perineum during childbirth, has been widely used in obstetric practice to facilitate delivery and prevent severe perineal tears. However, its routine use has been a subject of considerable debate, particularly concerning its necessity, efficacy, and acceptability among women. This study was therefore designed to assess the experiences and acceptability of episiotomy among parous women receiving care in a secondary Health facility in South-South Nigeria.
Method: This was a cross-sectional study among all consenting women attending the postnatal clinic between 1st July 2023 to 30th June 2024 who had an episiotomy during delivery. A self-administered questionnaire was used for data collection from 302 respondents selected using a purposive sampling technique. Data were entered into SPSS version 25 and analysed using descriptive and inferential statistics at a 5% level of significance.
Results: The episiotomy acceptance rate was 17.6%, with occupation and educational level as the only significant factors influencing acceptance ($p< 0.05$). Half of the participants were not informed before the episiotomy was given, and 25.2% were unaware of the reason for the procedure. Anaesthesia was not administered to 59.6% of the participants before the procedure, and 39.1% had their stitches done without anaesthesia. Most participants (57.6%) felt that they could have given birth without the need for an episiotomy. Severe pain (10.3%) and wound breakdown (6.3%) were the most commonly reported complications.
Conclusion: The study highlights the need for improved communication, informed consent, and pain management during episiotomy.

Keywords: Episiotomy, Health facilities, Nigeria, Women's Health

Plain English Summary

Episiotomy is cut on the vagina during vaginal delivery to increase its diameter to aid the delivery of the baby. It is a very common practice, especially for women delivering for the first time. Many authorities like the World Health Organisation have queried its routine use and advocated that it should be restrictive rather than routine. Many women also go through the procedure without giving consent and most of the time, no pain relief is given. This study was conducted to find out the experiences of women who have delivered before with episiotomy and to find out if they would accept the procedure again. The finding showed that 17.6% say they will accept it again. Half of the women did not give consent for the procedure and many did not know the reason why it was given. More than half of the participants felt the procedure was not

Correspondence:
Dr Maduka, Roy N
Department of Obstetrics and Gynaecology, Central Hospital, Agbor,
Delta State Nigeria.
+2348037264634, roymaduka@yahoo.com

necessary. The recommendation is that health workers should get informed consent for episiotomy, communicate better with the patient and ensure adequate pain relief.

Background

Episiotomy is a common procedure in obstetric care, with its use influenced by various factors over the years, reflecting the dynamic nature of obstetric practice. Episiotomy refers to a surgical incision on the perineum during the second stage of labour to enlarge the diameter of the vulval outlet to facilitate passage of the foetal head and prevent an uncontrolled tear of the perineal tissue (1, 2, 3). The early practitioners, such as Sir Fielding Ould, initially advocated for episiotomy specifically in cases where the perineum was tight, particularly when labour was prolonged, aiming to facilitate a safer and more efficient delivery process (4). Despite the perceived advantages, the procedure can result in complications like pain in the immediate postpartum period, the wound can become infected, and the scar can cause long-term dyspareunia. Over the years, the practice of episiotomy has gone through several reviews starting from the 1920s when routine episiotomy was advocated to the 1980s when restrictive use of episiotomy became the recommended practice (1). In recent times, the advantages of routine episiotomy have been widely debated (5). Research findings indicate that routine episiotomies often do not provide many benefits but may increase the risk of complications (6). Women who undergo the procedure may experience increased postpartum pain, a higher risk of infection, prolonged healing, and dyspareunia, with the potential for more severe tearing involving the anal sphincter muscles (2, 7). WHO expressed a lack of evidence to perform routine or liberal use of episiotomy for women undergoing spontaneous vaginal birth and recommended restrictive episiotomy (8). Cochrane reviews, show a lack of evidence supporting routine episiotomy, suggesting that selective use leads to better outcomes for mothers without increasing risks for the baby (6). The shift in obstetrics toward individualized, patient-centred care emphasizes respecting women's preferences and providing interventions based on evidence and necessity, rather than routine protocols. This information, promoting a restrictive approach to episiotomy, is easily accessible to educated women, and it is therefore expected that education level will be inversely related to episiotomy acceptance.

The World Health Organization (WHO) guidelines advise against routine episiotomy, recommending its use in no more than 10% of spontaneous vaginal births (8). The prevalence of episiotomy varies widely worldwide with figures as low as 1% reported in Sweden and 80% in Argentina (9). Enaruna et al reported a prevalence of 36.6% at the University of Benin Teaching Hospital Benin (10), while incidences of 45%, (3), 54.9% (11), and 35.6% (12) in Enugu, Lagos and Zaria, Nigeria respectively have been reported.

Since episiotomy is a surgical intervention, informed consent is essential before performing it on a woman in labour. However, in reality, women are often not fully informed about the specific risks and benefits of the procedure, and written consent is rarely obtained, falling short of the standard practice for all other surgical procedures (3).

Guidelines for episiotomy have primarily been established from a medical perspective, prioritizing healthcare providers' decisions over women's autonomy and preferences (13). A 2017 Cochrane review highlighted those studies neglected to consider women's views and priorities when evaluating episiotomy (6). Furthermore, the WHO has noted that women often report inadequate information and lack of consent before episiotomy, underscoring the need for improved consent practices especially as it concerns episiotomy procedure (14). Episiotomy without full patient consent is a disturbing example of abusive maternity care, eroding women's confidence in healthcare systems and jeopardizing efforts to increase facility-based deliveries, a critical strategy for reducing maternal deaths (15, 16).

Currently, there is mounting evidence that suggests that most women prefer to avoid the procedure. Oluwasola et al (17) in Ibadan Nigeria reported that 73.9% of participants in their study stated that they would not accept episiotomy even when indicated. The fear of having episiotomy has been documented as one of the reasons why some women elected to have Caesarean section (18). A common misconception exists that episiotomy can be performed without pain or anaesthesia, particularly if done during the height of a uterine contraction when the perineum is most stretched. However, this notion has been debunked, as women typically experience significant pain during the procedure, which can be effectively alleviated by the use of local anaesthetics (19). In the study by Abubakar et al (1) in Kano, 7.1% of the participants stated that no analgesia was given to them during the episiotomy procedure and 30.4% were left beyond one hour before their episiotomy was repaired.

WHO has recently acknowledged the importance of prioritizing a positive childbirth experience shifting the focus towards women-centred care and outcomes (8). In this context, understanding women's experiences and perspectives on episiotomy is crucial for informed decision-making and possible acceptance of the procedure when indicated.

Episiotomy is a common obstetric intervention worldwide, including in Nigeria, where it is often performed without adequate informed consent or consideration of women's preferences (20, 21). Despite its prevalence, there is a paucity of research on the experiences and acceptance of episiotomy among women who have had the procedure in their previous delivery in South-South Nigeria.

This research seeks to investigate the perspectives and possible influencers of the acceptance of episiotomy among previously delivered women regarding the procedure in a secondary health facility in South-South Nigeria. This is in a bid to generate valuable knowledge that will inform healthcare providers, policymakers, and researchers, ultimately leading to enhanced maternal healthcare and better outcomes for women in the region.

Materials and Methods:

Study design

This cross-sectional study was conducted at the postnatal clinic of Central Hospital Agbor, Delta State Nigeria between 1st July 2023 to 30th June 2024.

Study setting

The Hospital was established in the year 1906. It is a 250-bed hospital located in the South-South region of Nigeria. It provides general medical care and specialist services to indigenes of Delta State and neighbouring parts of Edo State. The Obstetrics and Gynaecology department has two consultants who are both fellows of the National Postgraduate Medical College of Nigeria and the West African College of Surgeons. The hospital attracts a monthly antenatal booking of over two hundred women, and the delivery rate is about 1100/year, with an average of 200 women attending post-natal clinics monthly. Agbor is a kingdom in Delta State, Nigeria, having a boundary with neighbouring Edo State. The people of Agbor town are Ika and they speak the Ika dialect of the Igbo language. In November 2007, the Delta State Government introduced a free maternal health program which covers the cost of antenatal care, delivery including CS, postpartum, and postnatal care up to 6 weeks after delivery/birth, as well as surgical management of ruptured ectopic pregnancy and blood transfusion. This program has been sustained to date by successive governments.

Study Population

All consenting women attending postnatal clinics who delivered with episiotomy within the study period were recruited and interviewed. For each participant, informed verbal consent was obtained following a detailed explanation of what the study entails and the possible benefits in future Obstetric care.

Inclusion and Exclusion criteria

All women who delivered with episiotomy and attended the postnatal clinic during the study period were eligible to participate after providing informed consent. Postnatal women beyond six weeks were excluded to reduce recall bias.

Sample size Calculation

The study sample size of 302 was derived based on the formula: $N= Z^2pq/e^2$, where N=minimum required sample size, Z=standard variate (1.96), P=estimated acceptance of episiotomy of 22.2% from the study by Odo et al, (22) q=(1-p), e^2 =acceptable error at 0.05. $N= (1.96)^2 (0.22) (0.78)/ (0.05)^2$=264. The minimum sample size was further increased to 290 assuming a 10% attrition rate. To increase the external validity, 302 patients presenting within the study period and consented were recruited. The socio-demographic characteristics, experience regarding previous episiotomy, complications experienced, and their acceptance of episiotomy in the future if indicated were documented.

Sampling technique

Purposive sampling technique involving all women who had episiotomy within the study period.

Data collection

It was conducted using a self-administered questionnaire. The questionnaires were initially pretested among 20 newly delivered women and found to be appropriate before they were administered. The questionnaires were self-administered, however, for non-literate participants a trained clinic staff assisted in filing out the question by ticking the corresponding answer on the questionnaire that the respondents answered. This method helped to ensure correct answers were entered and it also helped to reduce attrition rate.

Data analysis
The data generated were analyzed using the IBM Statistical Package for Social Science (SPSS) version 25. Variables were presented with descriptive statistics using frequencies, percentages, and means (standard deviation) and presented as tables. Inferential statistics was done using the Chi-square test or Fischer exact test where appropriate for categorical variables with the level of significance at p values <0.05.

Results
Of 330 patients approached to join the study, only 315 returned the questionnaires for analysis. Of the 315 returned questionnaires, 302 had complete information and these were included for analysis.
The mean age of participants was 28.4 ±5.18years. The maximum and minimum ages were 18 and 42 years while the modal age was 30 years with the age group 21-25, 26-30 and 31-35 contributing 27.8%, 35.1% and 19.9% respectively. Multiparous women were in the majority (53.6%) while primiparity and grand-multiparity recorded 43.0% and 3.3 % respectively. As expected, participants were predominantly Christian contributing 97.4% while the Muslims were only 2.0%. All participants had attained a formal education with secondary and tertiary levels contributing 66.2% and 31.8% respectively. Owners of medium and small-scale businesses were in the majority (62.3%). Home managers, civil servants, professionals and artisans were 13.9%, 8.6%,7.9% and 7.3% respectively. The majority (78.1%) of the participants have undergone the episiotomy procedure once while 21.9% have received episiotomy more than once. (Table 1).

Table 1: Sociodemographic characteristics of participants

Variable	Frequency	Percentage (%)
Age		
≤20	22	7.3
21-25	84	27.3
26-30	106	35.1
31-35	60	19.9
≥36	30	9.9
Parity		
1	130	43
2 to 4	162	53.6
>4	10	3.3
Religion		
Christians	294	97.4
Muslims	6	2
Traditional	2	0.7
Ethnicity		
Ika	168	55.6
Ibos	82	27.2
Yoruba	8	2.6
Hausa	2	0.7
Others	42	13.9
Education		
Primary	6	2
Secondary	200	66.2
Tertiary	96	31.8
Occupation		
Civil Servants	26	8.6
Traders	188	62.3
Home managers	42	13.9
Professionals	24	7.9
Artisans	22	7.3

Number Episiotomy		
Once	236	78.1
>once	66	21.9

Of the 302 participants, 53 (17.6%) indicated they would agree to undergo an episiotomy again, if necessary, whereas 249 (82.4%) would choose to avoid the procedure.

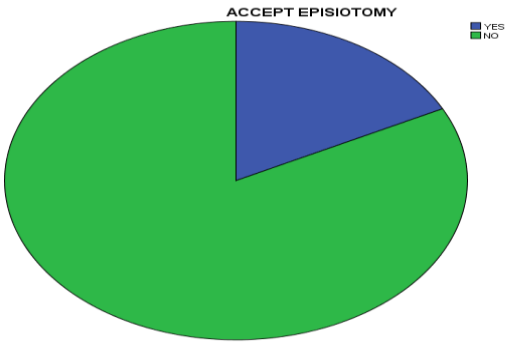

Figure 1: Acceptance of Episiotomy

Educational status and occupation of participants were the factors significantly associated with acceptance or rejection of episiotomy. Women with a primary level of education were significantly more likely to accept episiotomy when offered the procedure compared to women with secondary and tertiary levels of education. Civil servants were more likely to accept episiotomy procedures when compared to small and medium-scale business owners, home managers and professionals. (Table 2).

Table 2: Association between Acceptability of Episiotomy and Sociodemographic Characteristics

Variable	Accept	Will not accept	p-value
Age			
≤20	2	20	
21 to 25	12	72	
26 to 30	20	86	0.46
31 to 35	14	46	
≥36	4	26	
Parity			
1	25	104	
2 to 4	26	136	0.23
>4	0	10	
Religion			
Christianity	52	242	
Islam	0	6	0.425
Traditional	0	2	
Ethnicity			
Ika	30	138	
Igbo	16	66	
Yoruba	0	8	0.612
Hausa	0	2	
Others	6	36	
Education			
Primary	60	6	
Secondary	20	180	<0.001

Tertiary	32	64	
Occupation			
Civil servant	14	12	
Traders	22	166	
Home managers	4	38	<0.001
Professionals	8	16	
Artisans	4	18	

The majority of the episiotomies were performed by midwives/nurses (71.5%) while Doctors performed only 26.5%. Half of the participants said they were not informed before the episiotomy was administered and a quarter of the participants reported not being aware of while the episiotomy was given. Anaesthesia was not given in 59.6% of the participants before administering the episiotomy while 39.1 % had their episiotomy sutured without anaesthesia given. Episiotomy was complicated in 19.9% of the participants. More than half (57.6%) of the participants believed they could have delivered without the procedure. (Table 3)

Table 3: Experience of respondents from previous episiotomy procedure

Experiences	Yes (%)	No (%)
Were you informed before the episiotomy was given?	152 (50.3)	150 (49.7)
Do you know why they gave you episiotomy?	226 (74.8	76 (25.2
Anaesthesia before the episiotomy was given?	122 (40.4)	180 (59.6)
Did they teach you how to care for the episiotomy?	232 (76.8)	70 (23.2)
Did they give you anaesthesia during the suturing?	184 (60.9)	118 (39.1)
Take home antibiotics and analgesics?	238 (78.8)	64 (21.2)
Did you have any complications?	60 (19.9)	242 (80.1)
Could you have delivered without the episiotomy?	128 (42.4	174 (57.6)

The commonest complications recorded were severe pain 10.3 %, episiotomy breakdown 6.3% and perineal bleeding 1.4%. (Table 4).

Table 4: Complications reported following episiotomy

Complication	No	Percentage (%%)
Severe pain	31	10.3
Wound break down	19	6.3
Perineal Bleeding	4	1.4
Unable to urinate	2	0.7
Difficulty sitting down	2	0.7
Perineal damage	2	0.7

Discussion

In this study, the acceptance rate of episiotomy was 22.2%, the same as documented by Odo et al (22) in Enugu Nigeria who recorded an acceptance rate of episiotomy of 22.2% among participants who were aware of the procedure of episiotomy in their study. The finding also aligned closely with Oluwasola et al (17) finding in Ibadan, Nigeria, which reported an acceptance rate of 19.7% when the procedure was indicated. Education level and occupation were significant sociodemographic factors influencing episiotomy acceptance. Women with higher education levels tended to be more averse to episiotomy. This may be attributed to their ease of access to available information favouring restrictive episiotomy.

Half of the participants said they were not informed before the episiotomy procedure was performed on them. This finding is slightly lower than the findings by Abubakar et al (1) and Inyang-Etoh et al (2) which reported 66.1% and 61.5% respectively of unconsented episiotomy procedures. Studies have

also reported that most women are given an episiotomy without prior information or counselling, and the wound might even heal without their awareness of its presence (2, 23). The low unconsented episiotomy rate in this study may be related to the strong patient-centred care and regular training of ANC nurses in the centre. There is a firm policy stating that providing patients with free antenatal care and delivery should not justify their mistreatment during childbirth, including performing procedures like episiotomy without their consent. Also, antenatal classes are routinely conducted before each antenatal care visit to educate patients about the antenatal period, labour, and postpartum periods and their expectations. These efforts may have played a role in the low incidence of unconsented episiotomies observed in this study.

A quarter of the participants said they were not aware of the reasons why episiotomy was administered while 57.6% believed they could have delivered without the episiotomy highlighting the extent of dissatisfaction among participants. Studies have consistently shown that women's experiences during labour, childbirth, and early postpartum periods greatly impact their satisfaction with care (24,25). Negative experiences can deter women from seeking future maternity care, especially in low-income and middle-income countries highlighting the importance of quality care (26, 27).

Local anaesthesia was not administered before episiotomy was given in 59.6% of the participant and 39.1% had their episiotomy sutured without anaesthesia. Inyang-Etoh et al (2) reported 45.8% had episiotomies given without anaesthesia in their series. A common misconception suggests that episiotomy can be performed without pain during peak uterine contraction. However, guidelines recommend confirming adequate anaesthesia before episiotomy and administering local anaesthetics if needed to minimize discomfort (6). Providing sufficient pain relief before and during the stitching of an episiotomy can significantly lessen the pain and discomfort linked to the procedure. This, in turn, may lead to greater acceptance when an episiotomy is necessary, ultimately enhancing maternal healthcare services.

A total of 21.2% of patients did not receive take-home antibiotics, and 23.2% of participants were not instructed on episiotomy care. The complication rate reported stood at 19.9%. Given the conditions in the labour wards of many hospitals, it is crucial to administer antibiotics and provide counselling on post-episiotomy care to lower the likelihood of postoperative complications.

The majority (71.5%) of the episiotomies were given by midwives while Doctors administered only 26.5%. This is consistent with practice in our labour wards where Doctors are only called in to conduct more difficult deliveries.

The complication rate reported was 19.9% which was slightly lower than the 23.2% reported by Abubaker et al (1). The commonest complications reported were severe pain 10.3%, wound breakdown 6.3%, and perineal bleeding 1.4%. Inadequate suturing skills, the use of chromic suture material, tension on the suture lines, and early complications such as hematoma formation and clinical infections are among the factors reported to contribute to episiotomy breakdown (28). Many of the episiotomies were sutured by house officers and medical officers who may not have acquired the requisite technique for episiotomy repair.

Study strengths and limitations

The study focused on parous women who have experienced childbirth and episiotomy, it therefore enhanced the reliability of insights into episiotomy since these women have direct personal experiences. The study only included women who had given birth within the preceding six weeks to minimize recall bias. However, eliminating recall bias may not be feasible given the study's dependence on the patients' accounts. The participants received care from various healthcare professionals, meaning that the impact of the healthcare providers' skills and ranks was not considered. Additionally, the study did not address long-term complications of episiotomy.

Conclusion

This study explored the acceptability and experiences of parous women regarding episiotomy in a secondary health facility in South-South Nigeria. The findings reveal that despite the benefits of episiotomy, its acceptance and experiences vary among parous women. It highlights the need for improved communication, informed consent, and adequate pain management during episiotomy procedures. Episiotomy, like any other surgical procedure, requires that informed consent should be taken before administering it. However, considering the stress and pains of labour, it may be extremely difficult to obtain informed consent for episiotomy, especially at the second stage of labour when the procedure is given. An individualized approach where the antenatal period is used to exchange information and explore values and preferences concerning the relevant procedures in labour like episiotomy

may be a valid alternative to ameliorate unconsented procedures in labour. Detailed information regarding procedures like episiotomy can be explained to patients during the antenatal classes. It is anticipated that this approach will keep the patients informed to accept or reject the procedure when indicated and reduce the high rate of unconsented episiotomies. By addressing the concerns and experiences of parous women regarding episiotomy, healthcare providers and policymakers can work towards improving maternal healthcare outcomes, enhancing patient satisfaction, and promoting a positive childbirth experience.

The study, however, did not address among other things, the long-term complications associated with episiotomy. Future research should consider these factors to provide a more comprehensive understanding of women's experiences and the possible influencers of acceptance of episiotomy procedures when indicated**.**

List of abbreviations:
WHO: World Health Organization

Declarations

Ethical approval and consent to participate
The study protocol was approved by the Ethical Committee of the hospital with ethical no E/Com.AMZ/02/23. Recruitment of study participants was voluntary based on verbal briefing in English, pidgin English or the local languages as appropriate. The study was executed following the guidelines of the Declaration of Helsinki, 2013. For each participant, an informed verbal consent was obtained following detail explanation of what the study entails and the possible benefits in future Obstetric care. The wish of those who opted were respected.

Consent for publication
All the authors gave consent for the publication of the work under the Creative Commons Attribution-Non-Commercial 4.0 license.

Availability of data and materials
The data and materials associated with this research will be made available by the corresponding author upon reasonable request.

Competing interests
The authors declare that they have no competing interests.

Funding
Nil.

Author contributions
MNR was responsible for all aspects of the work and approved the submitted final version.

Acknowledgement
The author wishes to appreciate the medical officers and nurses in the postnatal clinic and the labour for their assistance in data collection. Special thanks to the women who participated in the study. Thanks to Miss Annabel, Nwaneka and Somtochukwu for assisting in entering the data into SPSS.

References:

1. Abubakar MY, Suleiman MM. Perception of episiotomy among pregnant women in Kano, North-Western Nigeria. Niger J Basic Clin Sci 2015; 12:25-9. https://doi.org/10.4103/0331-8540.156676
2. Inyang-Etoh EC, Umoiyoho AJ. The practice of episiotomy in a university teaching hospital in Nigeria: How satisfactory? Int J Med Biomed Res 2012; 1:68-72. https://doi.org/10.14194/ijmbr.1111
3. Chigbu B, Onwere S, Aluka C, Kamanu C, Adibe E. Factors influencing the use of episiotomy during vaginal delivery in Southeastern Nigeria. East Afr Med J 2008; 85:240-3. https://doi.org/10.4314/eamj.v85i5.9618
4. Longo LD. Classic pages in obstetrics and gynecology. A treatise of midwifery. In three parts by Sir Fielding Ould, Dublin, O. Nelson & C. Connor, 1742. Am J Obstet Gynecol 1976; 124:656. https://doi.org/10.1016/0002-9378(76)90070-3
5. Muhleman AM, Aly I, Walters A, Topale N, Tubbs SR, Loukas M. To cut or not to cut, that is the question: a review of the anatomy, the technique, risks, and benefits of an episiotomy. Clin Anat 2017; 30:362–72. https://doi.org/10.1002/ca.22836
6. Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. Cochrane Database Syst Rev. 2017 Feb 8;2(2):CD000081. https://doi.org/10.1002/14651858.CD000081.pub3
7. 22 Bekele H, Tamiru D, Debella A, Getachew A, Yohannes E, Lami M et al. Magnitude of episiotomy practice and associated factors among women who gave birth at Hiwot Fana Specialized University Hospital, Eastern Ethiopia. Front. Glob. Women's Health, 2022 (3) https://doi.org/10.3389/fgwh.2022.911449

8. WHO. Intrapartum Care for a Positive Childbirth Experience. WHO. Geneva. 2018; 150-5
9. World Health Organization Reproductive Health Library; 2003. Accessed from: http://apps.who.int/rhl/pregnancy_childbirth/childbirth/2nd_stage/jlcom/en/index .html on 20th February 2018.
10. Enaruna NO, Ilevbare FO. Current trends in the utility of episiotomy in a University Hospital, Benin City, Nigeria. Ibom Med J 2018; 2:77-85. https://doi.org/10.61386/imj.v11i2.365
11. Ola ER, Bello O, Abudu OO, Anorlu RI. Episiotomies in Nigeria- should their use be restricted? Niger Postgrad Med J 2002; 9:13-6. https://doi.org/10.4103/1117-1936.171017
12. Sule ST, Shittu SO. Puerperal complications of episiotomies at Ahmadu Bello University Teaching Hospital, Zaria, Nigeria. East Afr Med J 2003; 80:351-6. https://doi.org/10.4314/eamj.v80i7.8717
13. He S, Jiang H, Qian X, Garner P. Women's experience of episiotomy: a qualitative study from China. BMJ Open. 2020 Jul 19;10(7): e033354. https://doi.org/10.1136/bmjopen-2019-033354
14. World Health Organization. WHO recommendation on episiotomy policy. The WHO Reproductive Health Library; Geneva: World Health Organization; 2018.
15. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, et al. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy Childbirth. 2015;15(1):306. https://doi.org/10.1186/s12884-015-0728-4
16. Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gülmezoglu AM. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reprod Health. 2014;11(1):71.
17. Oluwasola TAO, Folasade A. Knowledge and Perception of Pregnant Women to Episiotomy in Ibadan doi: 10.4103/2278-960X.194508
18. Maduka NR, Enaruna NO. Preferred Mode of Delivery and its Determinants Among Nulliparous Women Attending Antenatal Clinic in A Secondary Health Facility in South-South Nigeria. Ibom Med J. 2024;17(3):500-506
19. Senanayake H, Adikaram R, Alwis T, Ahmad M, Gunathilaka BB. Perception of pain during episiotomy in a tertiary care centre in Sri Lanka. Ceylon Med J 2011; 56:41-2. https://doi.org/10.4038/cmj.v56i1.2895
20. Ladi-Lawal AO, Olaniyan OA. Episiotomy in Nigeria: A review of the literature. Afr J Reprod Health. 2015;19(2):13-22.
21. Uneke CJ, Ajaegbu E O. Informed consent and obstetric practice in Nigeria: A review of the literature. Journal of Medical Ethics and Legal Studies. 2014; 2(1):1-9.
22. Odo CC, Okwelogu IS, Eleje GU, Ogbonnaya NP. Comparative analysis of knowledge, attitude and acceptance of episiotomy among first-time and multiparous parturients in Enugu, Nigeria. Am J Clin Exp Obstet Gynecol 2021;7(1):1-11
23. Lívia A, Sousa R, Maria A, Pereira M, Claudia M, Hipólito V, et al. Meanings assigned by puerperal women to episiotomy. Int Arch Med 2016; 9:1-7
24. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLoS Med. 2015 Jun 30;12(6): e1001847; discussion e1001847. https://doi.org/10.1371/journal.pmed.1001847
25. Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gülmezoglu AM. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reprod Health. 2014 Sep 19;11(1):71. https://doi.org/10.1186/1742-4755-11-71
26. Sika AG, Beke A, Abekah-Nkrumah G. Predictors of satisfaction with childbirth services in public hospitals in Ghana. Int J Health Care Qual Assur 2011; 24(3):223–37. https://doi.org/10.1108/09526861111116660
27. Mekonnen ME, Yalew WA, Anteneh ZA. Women's satisfaction with childbirth care in Felege Hiwot Referral Hospital, Bahir Dar City, Northwest Ethiopia, 2014: cross-sectional study. *BMC Res Notes* 2015; 8:528. https://doi.org/10.1186/s13104-015-1494-0
28. Puissegur A, Accoceberry M, Rouzaire M, Pereira B, Herault M, Bruhat C, et al. Risk Factors for Perineal Wound Breakdown in Early Postpartum: A Retrospective Case-Control Study. J Clin Med. 2023;12(8):3036. https://doi.org/10.3390/jcm12083036