ABSTRACT

Background: Evidence-based care is important to ensure the quality of intrapartum care. The Philippines has made efforts to disseminate the evidence-based guidelines, however, there are still big gaps between those guidelines and actual practice. The gap exists in two types of intrapartum care, one is in adequate recommended practices which should be provided to all mothers, and another is in potentially harmful practices which should not be provided or be conducted only when it is needed. To overcome these gaps, it is important to understand which gap is existing and how the practice differs from the recommendation, and the reason to conduct the potentially harmful practices. To know healthcare provider's perception which affects on performing the potentially harmful practices helps further understanding of the situation. The episiotomy and fundal pressure are mainly focused as the potentially harmful practices, since the rapid increase of those practices has been emphasized particular in middle-income countries with increasing of facility-based delivery.

Objectives: This study aimed; to describe the gap between actual intrapartum practice and evidence-based guidelines; to identify the associated factors which affect healthcare provides to perform the episiotomy and fundal pressure; to explore the perception of healthcare providers to the potentially harmful practices.

Methods: A mix-method study with convergent parallel design was conducted from May to June 2018 in a tertiary government hospital in Davao City, the Philippines. This study included direct observation of intrapartum practices during the 2nd and 3rd stages of labour, semi-structured interviews and focus group discussions (FGD) with doctors, midwives and nurses. Parturient

mothers were included regardless of the risk-status from the 2nd stage of labour. Women with intrauterine fetal death at the admission, breech presentation, multiple pregnancy and epidural analgesia were excluded. Emergency caesarean section cases were withdrawn. Observed intrapartum practices were; birth position of woman, episiotomy, fundal Pressure, Valsalva maneuverer, fetal heart rate monitoring, prophylactic use of uterotonics, delayed umbilical cord clamping, controlled cord traction, uterine tones assessment, uterine massage and manual removal of placenta. Information on mother's characteristics, complication, delivery progress and baby were also collected as possible associated factors. The semi-structured interviews were conducted when the healthcare provider did the episiotomy or fundal pressure during observation to confirm the reason of the practice. Three sessions of FGD were conducted with each type of healthcare staff to probe their understanding and experience of the episiotomy and fundal pressure. Descriptive statistics and multivariable analysis were used for quantitative data, categorical strategy was used for qualitative data.

Results: A total of 170 deliveries were included in this study. Half of the women were primiparas, and most of the mothers delivered spontaneously (90.6%). The gaps were revealed in lack of FHR monitoring (57.1%), episiotomy rates for primiparas (92.1%), fundal pressure rates (31.2%) and the use of oxytocin for the augmentation at the 2nd stage of labour (12.1%). Primiparas had 38.8 times higher risk of being performed episiotomy compare to multiparas (95%CI 12.57-119.65). Episiotomy was more likely conducted when the duration of the 2nd stage exceeded 30 minutes, the chance was 4.62 times higher compared with the shorter 2nd stage (95%CI 1.31-16.29). For the fundal pressure, primiparas were more often received fundal pressure than multiparas (OR

2.94, 95%CI 1.32-6.56). It was more likely performed when the 2nd stage exceeded 30 minutes, the chance was 4.14 times higher (95%CI 1.56-11.03). Pregnancy complications showed the protective effect on the episiotomy. Neither fundal height nor FHR monitoring influenced the implementation of episiotomy and fundal pressure. From the interviews and FGDs, it was revealed that the health care providers recognize that primiparas without episiotomy are at risk for severe laceration, fundal pressure is effective to hasten the 2nd stage and healthcare providers feel "long" when the 2nd stage exceeded 30 minutes. Those perceptions were divergent with the evidence behind the guidelines. The risk factor of the 3rd and 4th degree of perineal laceration was also analysed, since it occurred in 17.1% of women in this study. Heavier birth weight more than 3500g (OR8.53 ,95%CI 1.76-41.29), episiotomy (OR 20.69,95%CI 2.34-182.71), fundal pressure applied with instrumental delivery (OR 9.64,95%CI 3.15-29.48) were strongly associated with the occurrence of the severe perineal laceration. This result was coherent with previous studies.

Conclusion: There were some gaps between the evidence-based guidelines and actual practices. Primiparity and the duration of the 2nd stage influenced the healthcare providers decision to perform potentially harmful practices. The perception of those practices was divergent with the evidence, and empirical knowledge more influenced their practice. The potential harmful practices contributed the occurrence of severe lacerations. Established evidence should be interpreted correctly, and the negative effect of potentially harmful practices must be highlighted to improve their dairy practices.