

MIDWIVES' EXPERIENCE OF PERINEAL RUPTURE PREVENTION

-A Minor Field Study in Indonesia

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Authors:
Anna-Karin Heikkilä
Hannah Reisinger

Supervisor:
Margareta Westerbotn
Examiner:
Ingela Rådestad

SAMMANFATTNING

Bakgrund

Att drabbas av en perinealbristning vid förlossning kan orsaka ångest och ge konsekvenser som påverkar kvinnors dagliga liv. Över nittio procent av de Indonesiska barnmorskorna saknar fortfarande grundläggande färdigheter och professionell kompetensutveckling inom området tre år efter examen. De främsta riskfaktorerna för att drabbas av en perinealbristning är instrumentell förlossning, att vara förstföderska och barnets födelsevikt. Barnmorskan har stor påverkan för kvinnans risk att drabbas av en perinealbristning. Perinealskydd har en stor betydelse för att minska perinealbristningar.

Syfte

Syftet med studien var att beskriva barnmorskors erfarenhet av perinealbristningar och det förebyggande arbetet i Indonesien.

Metod

Denna studie bygger på en MFS (Minor field study) fältstudie i Indonesien. Den valda metoden var en kvalitativ intervjustudie med ostrukturerade intervjufrågor. Sammanlagt intervjuades femton barnmorskor. Data analyserades med hjälp av en kvalitativ innehållsanalys.

Resultat

Under analysen identifierades tre kategorier; *Det förebyggande arbetet för att skydda perineum, Barnmorskans erfarenhet och kunskap om perinealbristningar* samt *Faktorer som ökar perinealbristningar*. Sex underkategorier identifierades; *Stöd perineum för hand, Långsamt framfödande, Träning ger färdighet, Det barnmorskan kan påverka, De faktorer kvinnan kan påverka* och *Andra faktorer som kan påverka perinealbristningar*.

Slutsats

Den indonesiska barnmorskans perinealskydd för att förhindra bristningar är liknande de perinealskydd barnmorskan är utbildad att tillhandahålla i Sverige. Kunskap och erfarenhet verkar däremot vara begränsad på grund av barnmorskans få assisterade vaginala födslar i Indonesien. Barnmorskorna som intervjuades betonade vikten av utbildning och information i deras arbete att tillhandahålla perinealskydd. De hävdade att om inget perinealskydd används, är det mer sannolikt att kvinnan drabbas av en grad tre eller fyra bristning. Barnmorskorna i Indonesien använder inte varma kompresser och de använder enbart en förlossningsställning, Lithotomy positionen, kvinnan liggandes på rygg. För att ytterligare göra framsteg i det förebyggande arbetet är det nödvändigt med ytterligare kompetensutveckling för de indonesiska barnmorskorna. Detta är en viktig aspekt på grund av de stora antalet indonesiska barnmorskor som inte har tillräckligt med erfarenhet.

Nyckelord

Barnmorskor, perinealbristningar, förebyggande, förlossning, erfarenhet, kunskap

ABSTRACT

Background

The complications of getting affected by perineal ruptures by giving birth can cause anxiety and consequences that affect the daily life of the woman. Over ninety percent of Indonesian midwives had neither acquired any basic skills nor received any further professional development training in this area during the three years following their graduation. The main risk factors for perineal ruptures are instrumentally terminated childbirths, nulliparous and a high birth weight of the baby. The midwife has a major impact on the women's further risk of suffering from a perineal rupture. Perineal protection can play a significant role to reduce perineal ruptures.

Aim

The aim of the study was to describe midwives experience of perineal ruptures preventive work in Indonesia.

Method

This study is based on a MFS in Indonesia. The method chosen was a qualitative interview study with unstructured interview questions. In total, fifteen midwives were interviewed. Data was analyzed using qualitative content analysis.

Findings

During the analysis three categories were identified; The preventive work to protect the perineum, Midwives experience and knowledge of perineal rupture and Factors that increase vaginal ruptures. Six subcategories were identified; Support perineum by hand, To not proceed too fast, Learning by doing, Factors midwife can affect, Factors women can affect and Other factors that may affect.

Conclusion

Indonesian midwife's grip to prevent perineal ruptures are similar to what the authors are educated in Sweden. Knowledge and experience appear to be limited due to the midwife's small number of vaginal births. Midwives emphasized the importance of education and information in their work with perineal protection. They all claimed that if no perineal protection was used, it was more likely for the woman to get a grade three or four rupture. The midwives in Indonesia didn't use warm compresses and did only use one birth position, Lithotomy position, the women laying on her back. To further make a progress in the midwives preventive work against perineal ruptures is to educate and empower Indonesian midwives knowledge. This is an important aspect due to the large number of midwives with poor experiences.

Keywords

Midwives, perineal ruptures, prevention, childbirth, experience, knowledge

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INTRODUCTION

The consequences that result from giving birth affect a huge number of people every year globally. Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth (World Health Organization, 2018). The complications of suffering perineal ruptures can cause anxiety and consequences that affect the daily life of the woman (World Health Organization, 2018). Symptoms like pain, urinary and fecal incontinence, intercourse difficulties and depression can isolate the woman because of fear (Zetterström, 2014).

We are two midwife students from Sweden who have just completed our first internship in obstetrics. By observing childbirths, we recognized the complexity of the issue of perineal ruptures. We are touched by the stories of women who just experienced a birth ending with perineal ruptures and bad experiences. One such example is, having to be separated from her baby due to the need to go to the surgery ward and sew the ruptures. We were therefore interested in getting a deeper understanding of the problem, as we wanted to know more about what we, as future midwives, could do to participate in the fight against perineal ruptures both globally and nationally. We wanted to find out what midwives can do to minimize the perineal ruptures that childbirth may inflict. Therefore, we wanted to gain insight into a developing country's preventive work related to this issue. This study took place in Indonesia in the district of Palu, Central Sulawesi by doing a Minor Field Study. A Minor Field Study is a SIDA-funded program aimed at providing Swedish students with the opportunity to acquire knowledge about developing countries and development issues (SIDA, 2017). Initially, an introduction is given about the country as well as the midwives education in both Indonesia and Sweden, the grading of ruptures and different types of perineal protection to clarify terms for the reader.

BACKGROUND

Indonesia

Indonesia is the largest archipelago state in the world and has a land area of totally 1 904 569 km². The population year 2017 was estimated to 260 580 739 people. The name of the capital is Jakarta, which is located on the island of Java.. The birth rate in Indonesia is 16.2 births per 1000 population. In Sweden the birth rate per 1000 population is 12.1 (Central intelligence agency, 2018).

Palu

Palu is located northeast of Jakarta on the island of Sulawesi in Indonesia. Indonesia is the largest Islamic country in the world, and more than 700 different languages are spoken there. The most common language is Javanese (Globalis, 2013).

Woodward hospital

Woodward hospital is operated by The Salvation Army Health Service in the district of Palu (RS Woodward Palu, 2017). The official opening of the Salvation Army Hospital, then called a Maternity Hospital, with a public polyclinic was 1973. The Maternity Hospital of the Salvation Army was then officially upgraded to a General Hospital in 1986 under the name Woodward Hospital (Rs Woodward palu, 2017). More than fifty percent of all childbirths at the hospital are performed through Cesarean section, according to Reg. nurse Indah Sulistiowati, (7th of April 2018).

Kulawi clinic

The Kulawi Clinic was opened in 1949 when vehicular roads reached interior villages with help of the Netherlands after the Second World War. Kulawi Clinic collaborates with Woodward Hospital by sending their women from the village to the hospital when more advanced care during childbirth is needed (Aragon, 2000).

BPM Sinar Kasih clinic

BPM Sinar Kasih is a private clinic operated by a family, where both mother and daughter are midwives. They have approximately ten deliveries per month, and only normal vaginal childbirths occur at the clinic. In case of emergency, the woman is sent to a hospital depending on which hospital insurance the woman has. The woman stays two to three days after birth at the clinic and has their own family room according to Reg. nurse Indah Sulisiowati, (7th of April 2018). The mean age at first birth of women in Indonesia is 22.8 years, compared to the mean age of Swedish mothers which is 29.1 years (Indexmundi, 2018).

Midwife education and responsibility

Indonesian midwives

To become a midwife in Indonesia you have to complete a three-year post high school diploma programme. Indonesians don't need to have secondary school diplomas to attend midwifery school. This means that most of the students that attend midwifery education are teenagers without any work experience (Hennessy, Hicks & Koesno, 2006). Ten thousand midwives graduate from Indonesia's six hundred midwifery schools every year. The quality of the schools varies widely, with many newly established institutions still having poor educational quality (The World Bank, 2012).

A job description in Indonesia of a midwife doesn't exist (Hennessy et al. 2006). A consequence of not having a job description is underuse of the midwives skills. Absence of a job description makes it difficult to monitor and record individual practice and development needs for midwives (The World Bank, 2012). The 332 midwives who participated in the Study of Hennessy et al. (2006) had neither acquired any basic skills nor received any further professional development training in this area during the three years following their graduation.

Swedish midwives

A prerequisite for admittance to midwifery education in Sweden is being a registered nurse with a nursing identification, which takes three years. Midwifery education is at master level and leads to a new professional registration which gives the right to work as a midwife, which takes another one and a half years. Thus, a total of four and a half years of

studies are necessary to become a midwife in Sweden. Further, admittance to a midwifery program requires a minimum of one year of work experience as a registered nurse. The education in Sweden demands that you have participated in a minimum of fifty deliveries before you graduate, compared to Indonesia where no births are required before the exam (Mittuniversitet, 2018; Hennessy et al. 2006). Midwifery skills are widely applicable in Sweden. There are midwives working in obstetrics, maternity care, postnatal care and gynecology. The midwife's area of responsibility also concerns preventive consulting, prescription rights and contraception (Barnmorskeförbundet, 2018). Three hundred midwives graduate each year from twelve different colleges and universities in Sweden (Statistiska centralbyrån, 2018b; Barnmorskeförbundet, 2018).

The midwife's responsibility in Sweden is based on the National Board of Health (Socialstyrelsen, 2006). In the midwifery program, the competence description should guide the design of the education and in clinical activities in order to form a basis for midwifery skills. The competence description clarifies the midwife's role and required professional skills, thus contributing to providing women with good and safe care. The profession of a midwife places great demands on the ability to work independently, having a scientific approach, having multicultural knowledge and professional responsibility (Socialstyrelsen, 2006).

The midwife's areas of expertise include normal and complicated pregnancies, childbirth and aftercare (Socialstyrelsen, 2006). Other areas of expertise include both instrumental and manual births, and the care of both healthy and sick newborn babies. Midwives must also have the ability to prevent complications and to provide information, advice and support (Socialstyrelsen, 2006).

Perineal rupture

Perineal ruptures are classified by the severity of the affected tissue into first, second, third and fourth degree (Zetterström, 2014). The degree of a perineal rupture depends on the extent to which the surrounding tissues are involved. Grade one is a superficial rupture of the vaginal mucosa and perineum. Grade two is a deep perineal rupture which does not affect the anal sphincter. Grade three is a partial or total rupture through the anal sphincter, whereas grade four is similar to grade three but with an extension through the rectal mucosa (Zetterström, 2014). During a vaginal birth approximately seventy five percent of all women sustain some degree of perineal rupture (Lundquist, Olsson, Nissen, & Norman, 2000). Obstetric anal sphincter injury occurs after two to six percent of all vaginal deliveries in Sweden (Uustal-Fornell, Matthiesen, Sjö Dahl & Berga, 2005). Obstetric anal sphincter injury rates are reported to be higher in Asian women living in Western countries than in those living in Asia. The reasons for the differences is unclear (Bates, Melon, Turner, Chan & Karantanis, 2018).

The main risk factors for perineal ruptures are instrumentally terminated childbirth, nulliparous and high birth weight. In addition lack of communication, if the woman has a short perineum, her age and if fundal pressure is used increase the risk of perineal rupture. Women without known risk factors also suffer from perineal ruptures and it is possible that other factors affect, for example, women's tissues and hereditary factors (Zetterström, 2014).

Injury to the genital tract during vaginal childbirth can lead to adverse health outcomes for the woman (Edqvist, 2016). Examples of symptoms and disorders include severe pain, bleeding, painful intercourse, infections, urinary and anal incontinence and interference with establishment of breastfeeding. Short and long-term health problems from perineal ruptures can significantly affect women's quality of life (Edqvist, 2016). When the perineum is intact women are less likely to experience these kinds of problems (Shorten, Donsante & Shorten, 2002). In developing countries with poor intrapartum care women run an increased risk of suffering health problems after a perineal rupture (Unric, 2016).

Perineal protection

Midwives work actively with preventive measures to prevent perineal ruptures during childbirths (Edqvist, 2016). The midwife has a major impact on the women's further risk of suffering from perineal ruptures. Perineal protection can play a significant role in reducing perineal ruptures (Fahami, Shokoohi & Kianpour, 2012). Midwives can use their hands to protect the perineum, one hand pressed to the perineum and the other hand against the baby's head. This grip is called Ritgen's Maneuver (Bäckenbottenutbildning, 2018a). The Ritgen's maneuver is a method where the midwife uses one hand to identify the baby's chin (Bäckenbottenutbildning, 2018a). The other hand supports the child's head and controls the baby's flexion rotation. A requirement for perineal protection is that the midwife observes when the perineum is high and tensioned before the head intersects (Edqvist, 2016). A whitening perineum can indicate the risk of sustaining a rupture (Edqvist, 2016). In order to avoid perineal ruptures, it is important that the midwife closely monitors the perineum (Nordström & Wiklund, 2014). The midwife uses her hands to achieve a slow progress for the baby to cut through the vulva with the purpose of relieving the woman's tissues and minimizing perineal ruptures (Edqvist, 2016).

To increase tissue elasticity an effective way to reduce damage to the perineum is perineal massage and to use hot compresses (Aasheim, Nilsen, Reinart & Lukasse 2017). It increases the blood flow, elasticity and softness of the tissues (Fahami et al., 2012). The use of warm compresses helps the birth giving woman with a less sense of tingling, burning, pressure and tension in the perineal area. If the tissues are stiff and there is a risk of major tissue damage, a clip in the vulva called episiotomy can widen the delivery of the birth canal to minimize sphincter ruptures (Edqvist, 2016). Episiotomy is mainly done on child indication in Sweden. If the birth is terminated with a vacuum extractor, a doctor or midwife should consider laying an episiotomy as there is evidence that this has a protective effect against sphincter damage of degree three and four (Bäckenbottenutbildning, 2018b).

A slow and controlled birth of the baby is thought to be of importance in order to prevent perineal ruptures (Edqvist, Blix, Hegaard, Olafsdottir, Hildingsson, Ingversen, Mollberg & Lindgren, 2016). During the pushing stage of the birth, communication with the woman is very important (Zetterström, 2014). Encouraging the woman to breathe through the aches and not push actively when the head of the baby cuts through the vulva decreases the risks of perineal ruptures (Edqvist, 2016). In order to help preventing perineal ruptures the midwife has to make sure that the delivery doesn't proceed too fast (Zetterström, 2014). It's important that the pressure against the perineum from the head of the baby doesn't get too high. The midwife can help the woman to have an optimal preventive birth position (Edqvist et al., 2016). Upright birth positions in Western obstetrics are defined as sitting, squatting, sitting on a birth pallet, kneeling and standing. Supine positions are when the woman is lying lateral in a side position, all-fours and semi-recumbent. The Lithotomy

position, where the woman is laid on the back with knees bent, positioned above the hips, and spread apart (Edqvist et al., 2016). Birth positions affect the perineum in different ways and supine positions are associated with perineal injury (Willemijn, Warmink-Perdijk, Koelewijn, Van Diem, Antoine & Lagro-Janssen, 2016). Women who give birth in an upright position such as sitting are more likely to have an intact perineum with no or less injury. Childbirth in the lateral side position is associated with less perineal ruptures compared to childbirth in the Lithotomy position (Meyvis, Van Rompaey, Goormans, Truijen, Lambers, Mestdagh & Mistiaen, 2012).

Problem definition

During a vaginal birth approximately seventy five percent of all women sustain some type of perineal rupture (Lundquist, Olsson, Nissen, & Norman, 2000). Obstetric anal sphincter injury occurs after two to six percent of all vaginal deliveries in Sweden (Uustal-Fornell, Matthiesen, Sjö Dahl & Berga (2005). Obstetric anal sphincter injury rates are reported to be higher in Asian women living in Western countries than in those living in Asia. The reasons for the differences is unclear (Bates et al., 2018). Injury to the genital tract during vaginal childbirth can lead to adverse health outcomes for women. It is part of the midwives responsibility to ensure that women receive safe medical care and a positive experience when giving birth. The midwives' knowledge about how to prevent perineal ruptures is important for minimizing the risk of the women suffering from the ruptures. The authors to the present study wanted to investigate whether midwives in Indonesia provide the same type of perineal protection during vaginal childbirth as the midwives do in Sweden. How do they experience and what is their knowledge about preventive work? What is their experience of perineal rupture in general? What factors do they experience as important to reduce the risk of women suffering from ruptures?

AIM

The aim of the study was to describe midwives experience of perineal ruptures preventive work in Indonesia.

METHOD

Study design

The study design was a qualitative method with unstructured interview questions. It's a flexible method to use where supplementary questions are written down as support during the interviews (Danielson, 2017a). To uncover complex issues involved, a qualitative method provides an emergent design and flexibility (Polit & Beck, 2017). A qualitative method was chosen because it intends to study the person's lived experiences of a phenomenon (Henricson & Billhult, 2017). The authors wanted to gain an understanding of individual personal experiences of perineal rupture prevention. The interview questions include supplementary questions as support for the interviewers (Appendix B). Supplementary questions are important in order to enable the participants to continue answering the question with greater detail or depth than it was originally posed with (Danielson, 2017a). This method provides answers from midwives experiences, perceptions, opinions and knowledge about perineal rupture prevention.

Sample selection

Inclusion criterias

One inclusion criteria was that the midwives were registered and working with childbirths at the maternity ward in the district of Palu. Selected clinics and hospitals were those that the hospital directors decided that the authors had access to visit; Woodward hospital, Kulawi Clinic and the private clinic BPM Sinar Kasih. Another inclusion criterion was that the interviewed midwives had assisted at least one childbirth during their careers.

Participants

The participants in the study were eighteen midwives, all women. Three of the interviews were pilot interviews. The remaining fifteen were used to answer the aim of the study. Their work experience differed from one month and thirty two years. The authors interviewed all available active working midwives at all three clinics. Ten midwives were interviewed at the maternity ward at Woodward hospital. Six midwives from Kulawi Clinic participated and two midwives from BPM Sinar Kasih clinic.

Data collection

Informing directors and midwives

Before arriving in Palu, the director of the hospital was contacted and permission to conduct the interviews was given. An interpreter was assigned. The director of the hospital was contacted through email and received a written summary of the thesis, including the letter of consent and the interview guide (see Appendix A and B).

Letter of consent

To be sure of receiving the participants' full consent, a letter of consent was written that was read out loud before each interview (Appendix A). The authors informed that the interview was being recorded and asked for approval from the participants. The participants gave their full consent verbally through an interpreter before the recording started. The intent was that the participants would receive satisfactory information about the authors, the study, and the aim of the interviews. It's important so that the participants get a deeper understanding of the problem definition (Polit & Beck, 2017).

Interview guide

To get as valuable information as possible, an interview guide was created with several open questions to answer the aim. According to Polit and Beck (2017) the purpose of an interview guide is to make sure that all of the important categories are covered while allowing for the participants to speak freely on each question, sharing their experience with their own words. Interviews were conducted using the guide in Appendix B. When the interview guide was developed, a critical discussion was held between the authors about what kind of information should be valued as relevant to collect.

Pilot interview

According to Polit and Beck (2017) a pilot interview is done in order to be aware of any challenges with the interview guide and the study method and adjust them accordingly. The first three interviews at the first clinic were used as pilot interviews. The questions

were altered and further developed after those interviews. For example, initially the question “*How do you prevent perineal ruptures?*” was asked, which was answered briefly by the participants in the pilot interviews. The authors improved the question after three interviews to become more precise; “*How do you think and experience that you as a midwife can prevent perineal rupture for the woman during vaginal childbirth?*”. The authors also created supplementary questions to ask when participants were given to undeveloped answers. For example; “*What do you do for the woman, what factors help to prevent ruptures?*” and “*Is there anything else that you have learned that can help the woman?*” Supplementary questions were created to get the participants to answer in more detail. The authors also changed the way the interview was held from being in an unsuitable room where people came and went, to a room where the interview could be held without disturbance. None of these three pilot interviews have been included in the findings, because they did not contribute relevant information to the study. According to Trost (2010) it’s inappropriate to include irrelevant information that doesn’t answer the aim.

Data processing

All of the interviews were performed in English. The authors were assigned three different interpreters, one in each clinic. Interpreters translated from Indonesian to English and vice versa because of the language barrier. Before the interview started the interview guide was given to the interpreters. One of the authors read the question out loud and the interpreters translated the question to Indonesian for the participants. All of the participants approved a recorder to be used. The interviews were recorded with two different voice recorders to get a double set, in order to reduce the risk of possible loss of recorded data material. It was also important that both the authors had the opportunity to work on the same interview at the same time. One of the authors asked the questions, while the other wrote down notes of the answers. The authors did this to make sure they understood the participant's response. Laughter, silence and pauses were not transcribed because according to Polit and Beck (2017), they are not relevant if they don't provide any added value to the context. Notes were not made when doubts or other feelings were expressed by the participants. All the interviews were transcribed into English using the recorded material. The fifteen interviews lasted between ten and forty five minutes each. Every interview required being listened through several times during transcription, since it was sometimes hard to hear the exact words. Some words were not translated correctly from Indonesian to English. Words that the authors couldn't understand were looked up using Google Translate (2018). The authors marked what the participants said, and what the authors said, which Danielson (2017a) describes as the most advantageous way to analyze interviews. Irrelevant things, for example if a participant spoke of completely unrelated things, were removed. The transcribed interviews were re-read several times. First separately, then together where the authors marked the text that answered the aim. Markings were compared and discussed between the authors until consensus was reached.

Data analysis

A qualitative content analysis method was used to analyze the data. The authors started to analyze the data when all the interviews with the midwives were done. According to Henricson and Billhult (2017) it is most common for the interviews to be analyzed when the interviews and all data have been collected. The interviews were transcribed separately,

one by one. Transcribing provides a repetition of the interview situation (Danielson, 2017a). After transcribing the meaning units were identified. A meaning unit is a paragraph or a sentence in the transcribed interview that contains a message that the participant wants to convey (Lundman & Hällgren Graneheim, 2012). Meaning units were coded one by one. Identifying and classifying a definition of something is called coding (Polit & Beck, 2017). With the help of an analytical scheme, the authors structured the sentences with associated codes. Several meaning units fit under each code and formed themes which in turn formed subcategories. Subcategories are helpful when hierarchical relationships between the categories are found (Lundman & Hällgren Granheim, 2012).

More codes and subcategories were added when necessary during the work of analysis. During the analysis process, the authors found that some of the units had to be adjusted and some sentences could be moved back and forth between different categories and subcategories. Both of the authors were involved in the development of the analytical scheme. The interviews were read and coded together in accordance to Polit and Beck (2017), who note that it increases the credibility if both authors are active in the coding to ensure accuracy. Three categories and six subcategories were identified in the analysis of the interviews (Table 2.). Examples of meaning units, codes and subcategories divided into the three categories are shown in Table 1.

Table 1. Examples of Meaning units, Codes, Subcategories and Categories

Meaning unit	Code	Subcategory	Category
<i>“Support perineum. Hold the baby's head, one hand on perineum and one hand on the baby's head.”</i>	Support by one hand on perineum	Support perineum by hand	The preventive work to protect the perineum
<i>“It is effective if the midwife uses a strong perineal protection”</i>	Strong perineal protection makes a difference for perineum	Learning by doing	Midwives experience and knowledge of perineal ruptures
<i>“Despite the midwife supporting the perineum, if the mother pushes her bottom up when the pain comes the rupture's degree increases. “</i>	Pelvic floor up	Factors women can affect	Factors that increases vaginal ruptures

Credibility

Reliability and validity are important terms within qualitative research for assessing credibility (Danielson, 2017a). To ensure high credibility the authors discussed the first preliminary interpretation of the data with each other which contributed different perspectives to the analysis process. The content analysis was sent to the supervisor to make sure that it was valuable data according to the aim. As an attempt to establish a high credibility a reliability check was performed. To ensure reliability the authors took all the sorted meaning units and mixed them up. Based on the defined categories both of the authors sorted the meaning units again in different envelopes, without looking at the previously analyzed scheme. The authors then reviewed the envelope contents and compared them to the analysis scheme.. The compliance percentage was calculated by the number of matches and multiplied by a hundred to get the percentage of correctly sorted quotes. The authors discussed the test findings with each other for the quotes that were sorted under the wrong categories. Some meaning units fit better in other categories and some had to be removed from the study since the meaning units didn't answer the aim. Eighty percent of the meaning units were placed correctly, which, according to Danielson (2017a) is a good reliability.

Ethical considerations

During the research, one main ethical aspect was that every interviewed individual participated voluntarily and was free from pressure (Webster, Lewis & Brown, 2014). The information to the participants had to be easily understandable and adequate so that each individual could decide whether they wanted to participate or not. The right to be able to abort their participation was also clearly stated. The authors were considering the risk of participants experiencing discomfort by participating in an interview study on this topic. According to Vetenskapsrådet (2017) research is about reasonably weighing several types of interests against each other. In some situations interests may conflict with each other, for example the authors own interests in obtaining new knowledge in comparison to not causing integrity issues for the participants by asking the questions. The authors took this into account by asking the interview questions in a respectful way. This was done to make sure there were no risks of participants experiencing that the aim of the study violated their integrity (Vetenskapsrådet, 2017).

The authors strived to ensure that the participants understood the meaning of their participation in the study which is in accordance with Vetenskapsrådet (2017.) Confidentiality is a weaker requirement than data treated by anonymity. Information about this study was given verbally to the midwives that participated by an interpreter. It was based on informed consent in order to ensure that the authors did not perform any ethical infringement. Participants were informed that collected data from the interview were being treated confidentially.

Data was kept inaccessible to unauthorized persons on two different password protected computers. No names or social security numbers were written down on the note papers or computers. Each interview was named based on which interview in the scheme it was.

Appendix A and B were preserved safely in a security box during the research period. Unauthorized persons were not able to gain access to them.

According to Vetenskapsrådet (2017) a study must be assessed by a Swedish ethics committee. This research study has undergone an ethical review by an ethical board at Sophiahemmet University before the research study took place (see Appendix D). A local approval was issued by the hospital director about research ethical laws and regulations in force in Indonesia, see Appendix C.

FINDINGS

The findings are based on experience from fifteen Indonesian midwives. The findings of the study will be presented in three main categories and six subcategories (Table 2).

Table 2. Presented categories and subcategories from the analysing process

Category	Subcategory
The preventive work to protect the perineum	Support perineum by hand To not proceed too fast
Midwives experience and knowledge of perineal ruptures	Learning by doing
Factors that increases vaginal ruptures	Factors midwives can affect Factors women can affect Other factors that may affect

The preventive work to protect the perineum

Support perineum by hand

What most midwives said was a matter of priority was to protect perineum with one hand to reduce perineal ruptures. Midwives at all three clinics described that they were supporting the perineum by hand. The most common method was for the midwife to support with one hand on the perineum and the other placed on the baby's head. A minority of the midwives described that they were pressing the other hand above the clitoris when the baby's head cut through the vulva. To receive the head of the baby by pulling the head, the midwives meant that it prevented the baby's chin from tearing the perineum. Most midwives controlled the perineum with their dominant hands while their other hand held the baby's head. The reason for this was that the dominant hand is stronger.

“...support to hold the perineum, one hand hold the perineum, deflexion, one hand on the head, help the baby to flex, rucks the head back and forth... chin can make a rupture...”

Midwives experienced perineal massage as an effective preventive action. This was emphasized particularly at one of the clinics. These midwives described that it's an effective preventive action during labour. One of the midwives at the private clinic said that she had heard of perineal massage as a new method to prevent perineal ruptures, but she had not started using the method in practice.

Another finding in this category was that the midwives at the maternity care at one clinic informed the pregnant women one to two months before estimated date of birth that they should massage their own perineum at home.

“We tell the women to massage the perineum in different positions, the women will not be affected by a perineal rupture if she massage the perineum at home one to two months before estimated date of birth.”

To not proceed too fast

According to the midwives, one important factor for not sustaining a perineal rupture was that the woman had to postpone pushing phase until the cervix was fully retracted, 10 cm. The midwives did vaginal examinations depending on the woman's process in labor, her pain and how she was acting. The midwives explained that in Indonesia they don't use painkillers because it's better for the woman to feel what is happening during labor. It gives the woman control and protects her from ruptures. That was highlighted by all of the midwives at all three clinics.

“They need to feel the pain, it's very important so they can give birth... No painkillers during birth.”

Midwives at two of the three clinics described their experience with decreasing the risk of perineal ruptures. Furthermore, one other preventive intervention that could help against perineal ruptures was mentioned: Control the baby's head so that the pressure against the perineum doesn't get too high. They used episiotomy as a preventive action when the perineum wasn't elastic. Midwives described that episiotomy was a helpful way to help the baby come out faster and to minimize a bigger rupture such as grade three and four.

“When the perineum is not elastic and the mum feel tired, it helps the baby to come out faster with episiotomy and prevents bigger ruptures. “

Midwives experience and knowledge of perineal ruptures

Learning by doing

The midwives' experiences of perineal ruptures varied widely at all three clinics. Some of the midwives had never experienced grade three and four ruptures. Some of the midwives described that if they gave good and strong support to the woman's perineum by hand, the woman didn't suffer from any major ruptures such as grade three and four. Some of the midwives experienced that consulting the doctor was helpful.

“I consult the doctor, based on my experience if you give good support to perineum the woman doesn't risk getting a grade four rupture. “

The majority of all midwives' knowledge about perineal prevention came from the university. Another common knowledge base was from experience from their career. One of the midwives had a PhD in obstetrics and described that her knowledge base was more developed than the other midwives.

“My knowledge is from education and experience. I also attend seminars. We are sharing experience with other colleagues.”

Some of the midwives described that their knowledge was acquired from the doctor who worked at the clinic. This occurred mainly at the hospital clinic. Through all interviews it appeared that the midwives learned by doing. This was said especially at the clinic in the countryside. One of the midwives described that her knowledge came from working alone without a doctor by her side. One midwife claimed that YouTube was a part of her knowledge base.

Factors that increase vaginal ruptures

Factors midwives can affect

In order to answer the important factors that increase the risk of women suffering from ruptures, some of the midwives explained how they observed that wrong support techniques were used when they observed their colleagues. All fifteen midwives emphasized the importance of education and information in their work with perineal protection. They all claimed that if no perineal protection was used, it was more likely for the woman to sustain a grade three or four rupture.

At one clinic the midwives explained that they sometimes are forced to help the woman to get the baby out. They then use fundal pressure by one hand on the stomach and press hard until the baby is born.

“Sometimes in Indonesia they push the stomach, because sometimes the mum don't have the strength because of the pain. Even if the vagina is not fully open they have to push the stomach. This makes a bigger rupture when they have to push the stomach.”

Factors women can affect

Midwives described that there were factors that increased the risk of women suffering from ruptures. One finding at all three clinics by the majority of the midwives were that if the woman pushed her pelvic floor up during labour, she had an increased risk of suffering ruptures. One of the midwives referred to the birth of her own child.

“Sometimes the degree of the rupture is caused by the woman, even if the midwife gives a good support to the perineum, but when the mum push up the bottom when the pain is coming, the rupture gets bigger...Even my mum told me when I was pregnant, don't push up the bottom when you give birth, relax, even though it's painful.”

Another factor of what women can affect which was described by midwives at all three clinics was the lack of communication between the midwife and the woman giving birth.

The communication was described to give the woman guidance about how to push the right way to prevent perineal ruptures. All the midwives claimed that giving birth requires the woman to listen to the midwife.

“ They suffer from less pain and ruptures by listening to the midwife, if the woman push too hard it makes a bigger rupture, and the woman will get more pain from suturing of the rupture...”

“I scare the woman about the ruptures and suturing, it makes her listen better”.

The midwives claimed that women can affect the risk of suffering from rupture by assuming the right birth position. This was a finding from all three clinics. According to the midwives, the right type of birth position was the Lithotomy position.

Other factors that may affect

Midwives described different important factors for the woman to be able to give birth vaginally. One factor that is important is the estimated weight of the baby by using the symfyse fundus (SF) measurement. If the estimated weight is over four kilos, the birth has to be a Caesarian section. If the baby is bigger than the clinical guidelines on SF-measurements, the birth also has to lead to a Caesarian section. If the baby is born in breech, has a large head or has difficulty coming out, the woman is not able to give birth vaginally. Therefore, Caesarean section is the only way to give birth in order to minimize the risk of perineal ruptures according to the participants.

DISCUSSION

Discussion of method

It is the objective of the study that determines what method should be used. It is important that the chosen method is appropriate according to the aim (Henricson & Billhult, 2017). The authors considered that the most appropriate method was chosen because the aim of the study was to highlight the midwife's experiences of perineal ruptures. Therefore, a qualitative interview study was chosen. The unstructured interview questions gave the participants the possibility to describe their experiences, perceptions, opinions and knowledge about perineal rupture prevention. Giving the participants the possibility to explain their own experiences is important when conducting a qualitative interview study (Danielson, 2017a). The authors have speculated if other methods would answered the aim equally accurate and if it would result in similar findings as the chosen interview method. For example a survey questionnaire with a quantitative design which is a useful method for collecting information from many people in a short period of time. A survey questionnaire is suitable when the aim is being measurable (Billhult, 2017). However in this study the authors wanted to investigate the midwives experience, knowledge and opinions. A qualitative interview study suited that better. The authors found that a survey questionnaire wouldn't give the study similar findings. One disadvantage of a survey questionnaire is, that it is easy that the questions reflect the author's way of seeing what is being studied (Billhult, 2017). A possible questionnaire study had become too increasingly influenced by the authors knowledge of the midwives preventive work in Sweden. The qualitative interview resulted in a deeper understanding of the participants preventive actions. The option of doing an observation study was also quickly excluded, as the number of

childbirths were very limited in the three clinics. Polit & Beck (2017) claims that the observation method requires a larger sample sizes. An observation study would neither illuminated the participants experiences, perceptions, opinions and knowledge about the subject in the study's findings. The authors claimed that a deeper understanding of the subject would have been hard to provide with an observation study. It would possibly give a greater amount of data collected. This could further have given a larger measurable quantity wich Polit & Beck (2017) claims is necessary in a study.

Eighteen interviews were performed during the study. Often, things happen during data collection that causes some participants to quit resulting in the entire material having to be renewed (Danielson, 2017a). This was not the case in this study, thanks to the participants knowing about the study in advance, and that they were prepared for the authors' visit which Kvale and Brinkmann (2014) explain is important before an interview study. All midwives completed each interview which affected the findings for the better. With participants cancelling their participations, the findings can decrease (Danielson, 2017a).

One inclusion criteria was that the midwife had assisted at least one childbirth and had provided perineal protection. Many of the participating midwives had lack of experience due to number of assisted childbirths. Therefore, the authors included all registered midwives. If midwives, for example those without a certain experience was excluded, there would have been too few participants in this study. It is important to have enough participants in order not to lose valuable information (Henricson & Billhult (2017). The requirement from the university was a minimum of fifteen participants according to Senior Lecturer Sofia Zwedberg, (15th of January 2018). The number of participants should be between ten and twenty according to Danielson (2017a) to get a good range. The authors were pleased with the number of the midwives in the study. It gave a good and varied finding.

The authors discussed possible risks that could have occurred during data collection before the interviews started. According to Kjellström (2017) one of the most common risks with data collection is that confidential data will be revealed. Therefore the authors have been treating all data based as confidential and a letter of consent was written that was read out loud before each interview to the participants which Kjellström (2017) describes as important. The authors have strived to ensure that any data reported in this study cannot be traced back to any study participant. However the authors have not been able to absolutely guarantee that none will ever see the collected data. On the other hand the authors have chosen to not write down any personal data to minimize the risk like Kjellström (2017) describes. Any names or personal details that could identify the participants were excluded. All processed data was destroyed after transcription. To write all interviews confidentially did not affect the findings in any possible way.

The interview questions were approved by both the director of the hospital and the supervisor of the study. The authors claimed that the asked questions were the most suitable for the aim of the study. According to Henricson (2017) there should be room for highlighting all aspects of the participants' experiences. The questions in the interview guide that the authors found suitable, were the ones that illuminated the study's aim the best. Questions which made the participants respond to out of scope issues were removed. The authors chose to create an interview guide with open questions, before the interviews took place. The questions in the beginning of each interview were the same, but the

supplementary questions could differ depending on what answers were given by the participants. If this had been done with a quantitative method, answers wouldn't have been as explanatory. Therefore, the authors were confident in the choice of a qualitative method.

The included questions are of major importance since they determine the findings. Different formulations may give different answers, which is why the adequacy of the questions should be tested in a pilot interview (Lundman & Hällgren Granheim, 2012). The first three of the total of eighteen interviews had to become pilot interviews because they didn't provide sufficient data. They didn't capture the participants' experiences and perspectives which Trost (2010) describes as important. After the first three interviews the authors realized that they needed to change the questions and added supplementary questions. The role as interviewers was also not clearly stated in the beginning. Since the questions were not asked in a structured manner, they were asked in a way which didn't highlight the aim of the study. The authors initially wanted a better understanding of the way midwives work in Indonesia. Now afterwards in the study process, the authors realized that one trial interview could have been helpful from the beginning to get a deeper understanding of their work. According to Danielson (2017a) a trial interview is needed to test the interview questions according to the aim and design of the study. A trial interview also gives the opportunity to evaluate whether the scheduled time is reasonable and to give the opportunity for the authors to get accustomed to the role as an interviewer (Danielson, 2017a). A trial interview had made the method more effective and the data had been collected faster. It could also have given better quality to the findings according to Danielson (2017a). The authors would have been able to analyze the data even more with both a trial and pilot interviews. The authors claim that even though the role as an interviewer weren't tested in a trial interview, the findings have not been affected. The pilot interviews gave the opportunity to develop the roles as interviewers.

According to Polit and Beck (2017) it's important that the interviews are held in a room where the participants could be interviewed without disturbances. The three first interviews took place in a room that was unsuitable. People came and went throughout the interviews because it was conducted at a midwife expedition. The authors experienced it as a stressful environment and didn't properly hear what the interpreter said. The following fifteen interviews were held in a room in the department with a closed door and only those involved were in the room. It gave the participants a calm environment and they could focus on the questions better. They were not interrupted and the interpreter could be completely focused on the one who spoke. The authors also learned to interview one midwife at a time. Initially, several midwives would listen while the authors interviewed their colleague, as they were curious and thought it was very exciting to be involved. This was also the reason why these three interviews became pilot interviews. The findings were adversely affected by this due to its quantity. If the authors would have included the pilot interviews the study might have received a larger quantity of findings. To select too few participants can give limited findings (Danielson, 2017a).

The authors chose not to bring laughter, silence and breaks into the transcription, because the language barrier made it difficult for the authors to interpret different nuances. For all text analysis, the text is needed to be read and processed (Danielson, 2017a; Trost, 2010). This can be done in different ways with different degrees of interpretation depending on the questions in the interview, but the findings should always show that the aim of the interview study has been achieved (Danielson, 2017a). This decision was made because

the authors did not know what the participants were laughing at, why they were silent for a while and took some breaks when answering. This may have caused some loss of feelings or personal opinions from the participants. On the other hand it had increased the risk of misinterpretation to interpret freely during the transcription without knowing the meaning in the context, like Trost (2010) explains. It was not necessary to include different nuances of participants' responses. The aim of the study was answered without it, so it has not significantly affected the findings as it is not what the aim of the study includes.

When conducting the interviews, tape recorders were used. According to Danielson (2017a) an interview study requires that the data is being transcribed, which is not possible without the interview data being recorded. All of the participants approved the use of recorders. Their permission was granted before the interview started. It was important that the participants were mentally prepared and felt there was a calm environment before they were asked during the interview. The interviews were recorded with two different voice recorders to get a double set. It is useful to test the technical equipment (Danielson, 2017a). During one interview one of the recorders did not start but that did not affect the findings, thanks of the extra recorder been used.

It was required of the authors to have sufficient knowledge in the language to obtain a good understanding during the interview sessions (Trost, 2010). If there was a word or a phrase that the authors did not understand, the authors asked the participant for clarification during the interview session. English is not the authors' native language, which may have affected the study in different ways. When the spoken word was not enough the body language played a major part in the understanding of the respondents answers. For example when the participants wanted to describe a word the interpreter only knew in Indonesian, they showed by hands. If the participants speak a language other than the interviewer, an interpreter may be used during the interview sessions (Polit & Beck, 2017). In this study three different interpreters were used. The interpreters were unfortunately not registered, as there were none in the district where the study took place. The interpreter at the first clinic received a review of the entire interview guide before the interviews started. The purpose was to give the interpreter the ability to translate beforehand difficult words from English to her native language. However the authors experienced that this may have lead to the interpreter using already known words because of her pre-understanding from reading the interview guide thus affecting the participants' answers. For example many midwives answered exactly the same thing when the interpreter asked the question. This may have resulted in less variation of the participants' answers which affects the findings with less answers. The other two interpreters didn't have a pre-understanding that could lead to changes of answers or questions. All of the language was in Indonesian, which may have resulted in translation errors and possible misinterpretations of the content when translating to English. Furthermore this could possibly have lead to misunderstandings of details in the findings and affect the trustworthiness. In order to report a reliable study, it is important that the authors report quality assessment of the findings (Danielson, 2017b). The authors have taken this into account. One ethical dilemma for the interviewers with an interpreter in the field during the interviews is the conflict between the different meaning between the languages (Polit & Beck, 2017). Therefore the authors had to repeat the sentence to make sure that the participants understood the meaning. The authors can not be sure if the interpreters omitted information from the participants which was relevant in the context. However the authors

assumed that they have received everything important, because the answers seemed relevant according to the questions and the findings were complete after the interviews.

The authors have speculated about the fact that this study could have had the opportunity to gain findings from eighteen midwives instead of fifteen if a trial interview was held in the beginning and worked out properly. It could also have increased the credibility of this study. Unfortunately the authors couldn't influence the number of participants, as it was the only possible random sample selection, because of the available midwives at the clinics in this district. However, the goal with qualitative interviews is to achieve something called saturation (Troost, 2010). The authors determined that the interviews achieved saturation based on analysis of those fifteen interviews. When there are no new categories found, when interviewing more participants, the study has achieved saturation (Troost, 2010). The authors didn't always have the best conditions for data collection. Working in the field can be challenging enough, for example the view on punctuality varied greatly. Appointments for some of the interviews turned out to be from three hours to two days later than scheduled, due to the fact that the field study took place in a polychronic culture. In a polychronic culture, time is seen as something less absolute (Stier, 2004). As opposed to in Swedish culture, where punctuality is rather seen as a the standard. The authors needed to adapt to the conditions the hospital director gave them and also the cultural differences during the data collection.

According to the credibility during the authors data analysis and coding process with meaning units, the authors found that many meaning units fitted into several categories and had to be adjusted. Those placed wrong could fit into more than one category. Therefore the definition of the categories were changed and adapted to better distinct names so all meaning units fitted in the adequate category. The authors claim that many of the meaning units didn't answer the aim of the study and thus had to be removed, as they described off topic experiences of the midwives. This can be seen as a limitation in the study. It can further indicate that the questions that were asked included too many answers that did not belong to the subject even though the authors excluded questions earlier in the study process. On the other hand it could also possibly indicate that it was the open questions that made the participants speak freely about the subject which is in order with the chosen interview method. When questions are asked with too many details, it can interrupt the interaction in the interview situation (Danielson, 2017a).

Both of the authors were involved in the development of the analytical scheme. It increases the credibility when both authors are active in the coding to ensure the accuracy (Danielson, 2017a). The authors had the ambition to include a third person to make a reliability check and put the meaning units in the right categories which according to Lundmark and Hällgren Granheim (2012) is useful in order to increase the reliability. The authors could have validated with more people. The authors consider that due to lack of good English skills, a third person from the field working area could find it difficult to place them correctly on the basis of poor English skills. Therefore the authors didn't use a third person because we the authors were in Indonesia. This in turn could risk lowering reliability.

Discussion of findings

In this study, the most prominent finding was that the midwives protected the perineum with both hands in order to reduce perineal ruptures. The most common preventive action was one hand on the baby's head and one hand on the perineum. A minority of the midwives described that they used one hand to press above the clitoris. The preventive action with one hand on the perineum and one hand on the baby's head is entirely in accordance to Edqvist, (2016); Fahami et al. (2012); Bäckebottenutbildning, (2018a) descriptions of preventive actions during the pushing stage of birth. The grip Indonesian midwives describe is in accordance with Ritgen's maneuver (Bäckebottenutbildning, 2018a). This further means that the grip is in line with one of the grips which Swedish midwives use (Bäckebottenutbildning, 2018a). The grip with one hand above the clitoris is not in accordance with the authors knowledge base. On the other hand this can indicate an individual preventive action. As one research article describes it might be suggested that a combination of techniques rather than one single technique can be effective when preventing perineal ruptures (Edqvist et al., 2016). According to Edqvist et al. (2016) midwives' individual performance methods can affect the occurrence of perineal ruptures in a preventive aspect. One research study shows that midwives use different grips depending on the clinical situation and describe that they are using different techniques to reduce ruptures during childbirth (Est, Lau, & Biro, 2014). This can further explain that midwives use individual preventive actions depending on the clinical situation. A Cochrane study describes the difficulties in defining the different techniques for perineal protection. Common for perineal protection is to get a slow and controlled birth of the head (Aasheim et al., 2011).

The findings revealed that some midwives may not always have a hand on the perineum. Even though this didn't appear in the findings, all midwives in the study described that they use some kind of grip when the baby's head is about to be delivered. All kinds of grips could reduce the risk of severe perineal ruptures (Jansova, Kalis, Rusavy, Zemcik, Lobovsky & Laine, 2013). A couple of the midwives claimed that they had the right perineal protection, and therefore never had any perineal ruptures of any degree. That's an interesting way of interpreting the reduced degree of ruptures, or those midwives may simply have had good self confidence.

Another finding in this study was that the midwives experienced massage as an effective preventive action both during labour and one to two months before the estimated date of birth. These findings are in accordance with the Aasheim et al. (2017) and Fahami et al. (2012) research findings. In one Cochrane study there were more women with an intact perineum when perineal massage was performed during labor and a period before the estimated date of birth (Aasheim et al., 2017). Another Cochrane study also shows that providing perineal massage during a period before the estimated time of birth reduces the risk of perineal ruptures that need suturing (Beckman & Stock, 2013). This indicates that Indonesian midwives in this study have talked about preventive actions based on evidence-based knowledge. Furthermore the pregnant women should be aware of the likely benefit of perineal massage and provided with information on how to massage.

According to the findings there is a relationship between the positive effect that massage has to reduce the risk of ruptures and the need of episiotomy like Demirel and Golbasi (2015) describe. Application of perineal massage during active labor decreased the

frequency of episiotomy procedures (Demirel & Golbasi, 2015). Midwives at two of the three clinics the authors visited describe episiotomy as a useful preventive action to decrease the risk of degree three and four ruptures, when the perineum isn't elastic. The midwives also explained that they perform episiotomy in Indonesia to get the baby out faster. According to Bäckebottenutbildning (2018c) episiotomy reduces the risk of fetal asphyxia. On the other hand the midwives didn't talk about episiotomy in relation to fetal asphyxia. It's a risk that this finding may have been unexplained by the midwives. Authors could have questioned whether it was due to fetal asphyxia which further could have explained this finding more clearly.

The findings revealed that achieving a slow controlled birth of the baby to prevent perineal ruptures has been enlightened. Some midwives mentioned it, but it was a minority. A slow controlled birth of the baby is one of the most significant factors in reducing perineal ruptures, according to knowledge based on research (Aasheim et al., 2017; Edqvist et al., 2016). The minority of these midwives talked about slow controlled birth in terms of not pushing too early. They meant that the women had to wait until the uterus was fully retracted. Experienced midwives should be well aware of discouraging the women to push too early since it has detrimental effects on a normal birth outcome (Simpson & James, 2005). This finding can be perceived as confusing according to how to achieve a slow controlled birth of the baby. Other research claims that a slow and controlled birth of the baby is important to prevent perineal ruptures and is related to the position in which the woman gives birth (Edqvist et al., 2016).

In one large study where three thousand women were included, they found that birth position doesn't affect whether the women will sustain perineal ruptures (Edqvist et al., 2016). There is also limited research about the perineal outcome of upright positions (Edqvist et al., 2016). In the findings midwives haven't talked about a slow controlled birth in relation to birth positions. On the other hand the authors may have been too focused on getting answers according to their pre-understanding. It is possible that Indonesian midwives don't experience that upright birth positions affect perineal ruptures since it hasn't been brought up in the findings.

The findings revealed that all three clinics midwives experienced that the woman can affect her risk of suffering from ruptures by assuming the correct birth position, which has been explained as the Lithotomy position. The findings show that all women at the three clinics give birth laying on the bed in the Lithotomy position. None of the participants talked about upright birth positions. This can further indicate that these midwives don't provide it. However research shows that the Lithotomy position is highly associated with perineal ruptures (Edqvist et al., 2016; Willemijn et al., 2016; Meyvis et al., 2012). This is a contradictory finding compared to what other research found prevents perineal ruptures. In Sweden, a recommendation is that the Lithotomy position shouldn't be used routinely in normal uncomplicated childbirths (Bäckebottenutbildning, 2018f). One can speculate why there is such a significant difference on birth positions between Sweden and Indonesia. The findings can further explain that all the midwives are well aware of the fact that it's an increased risk for perineal ruptures when the women's pelvic floor is pushed up from the bed when they are in the Lithotomy position. In the findings they explained that when the women push their pelvic floors up, even if they provide good perineal protection the women sustain larger ruptures. But still they only used the Lithotomy position instead of changing the position. Another analysis of these differences is that they might not have

the best conditions for providing women with another choice of position. The clinics had quite poor birth facilities. They had no beds which could be raised or lowered to ensure that the women can give birth in different positions. They didn't have any stirrups or backrests that could be used to regulate the woman's position.

The findings showed that midwives experienced that they sometimes were forced to help the woman to get the baby out and used fundal pressure. They explain that the fundal pressure was useful when the woman doesn't have the strength to push because of the pain. Fundal pressure increases the risk of severe perineal ruptures and also dyspareunia and urinary incontinence (Moiety & Azzam, 2014; Bäckebottenutbildning, 2018d). The relationship between the Lithotomy position and acute situations due to the findings about use of fundal pressure can be questioned. One might question whether it had been different if the women had had the opportunity to give birth with pain relief. The midwives described in the findings that they were well aware of the fact that fundal pressure increases the risk of perineal ruptures. In the Lithotomy position the women have limited opportunities to control the baby's birth speed (Bäckebottenutbildning, 2018f). It's a helpful position when the baby needs to come out fast. The authors speculated if it is possible that they use the Lithotomy position on the basis of a security aspect or it could be due to poor knowledge about upright birth positions.

The findings showed that the midwives did not talk about perineal rupture prevention based on any general guidelines or memorandums (PM) from the clinic. In Sweden some clinics have recurrent training in perineal protection (Bäckebottenutbildning, 2018e). For example in Norway, the number of degree three and four have fallen sharply, from four and a half percent to about one percent, since an intervention program with education issued by the National Birth Council, has been introduced at most clinics in the country (Hals, Øian, Pirhonen, Gissler, Hjelle, Nilsen, Severinsen, Solsletten, Hartgill, & Pirhonen, 2010). This shows that intervention programs and guidelines can make a difference in reducing the number of perineal ruptures. According to Hennessy et al. (2006) over ninety percent of Indonesian midwives had neither acquired any basic skills nor received any further professional development training in this area during the three years following their graduation. This could obviously affect their updated knowledge of perineal ruptures. This could further be attributed to the fact that Indonesian midwives don't have a job description according to Hennessy et al. (2006) and the consequences of not having a job description leads to underuse of the midwives' skills. Underuse of the midwives' skills could further mean that they don't get the chance to expand their knowledge related to perineal rupture prevention. The findings revealed that the majority of all midwives' knowledge about perineal prevention came from the university. This means that those who worked for many years have not updated their knowledge since they graduated.

The findings showed that a minority of the midwives described that their knowledge came from consulting a doctor. According to Hennessy et al. (2006) that explains the need for a review of midwifery skills and improvements in their education. The majority learned by doing which is interesting as they have so few childbirths and it must take a very long time to acquire good skills. Due to the fact that even a newly-graduated midwife in Indonesia might never have experienced a childbirth, the quality of the midwives' experiences varied greatly. Many midwives did not have much experience even though they had worked for many years. This can affect the quality of the findings. One can speculate about the fact that those who were newly graduated followed and talked about the knowledge they had

just learned, whereas the midwives who had worked for over thirty years answered the questions with more experience but with outdated information. According to Hennessy et al. (2006) it might be expected that having a job description would provide a more informed perception of the nature of the occupational role. The findings in this study underlines the need of new further education in the work with perineal protection which all fifteen midwives emphasized. In order to answer which factors that were central to increasing the risk of women suffering from ruptures, some of the midwives explained how they had observed wrong support techniques being used. According to Aasheim et al. (2017) if certain preventive techniques are proven to cause more harm than good, they should not be provided especially if they cause discomfort to the birthing woman. Midwives need to base their practice on evidence in order to offer the best care possible and to play an active role in the healthcare system like Hennessy et al. (2006) describes.

Another factor in the findings showed and were described by midwives at all three clinics was the lack of communication between the midwife and the woman giving birth. The communication was described to give the woman guidance about how to push the right way to prevent perineal ruptures. All the midwives claimed that giving birth requires that the woman had to listen to the midwife. While the midwife's communication to the woman wasn't a widely discussed topic by midwives in the findings, Swedish guidelines say it's important that the midwife listens to and sees the individual women (Bäckenbottenutbildning, 2018b), but that was not present in the findings from the Indonesian midwives'. The midwives claimed specifically that it was the woman that had to listen to the midwife. Whether this was based on their knowledge from education or if it had to do with cultural aspects is unclear.

In the findings midwives explained factors which either the woman or the midwife could affect in relation to perineal ruptures. It was found being factors which lead to a Caesarian section instead of a vaginal birth. It was explained as factors that would have increased the perineal ruptures if the baby was born vaginally when the baby had an expected birth weight of over four kilos. The risk of perineal rupture might not be present in Indonesia when all women with these factors are automatically given a Caesarean section. Therefore, the authors could speculate about why the Caesarean sections are increasing in Indonesia like Hadiati, Hakimi, Nurdiati & Ota (2014) state in a Cochrane study. This could also explain why the findings showed that some of the midwives never experienced grade three and four ruptures. On the other hand perineal ruptures are also often misclassified by both midwives and obstetrics (Edqvist et al., 2016). It is unclear why Indonesian midwives experience grade three and four ruptures in such a small extent. One can speculate if it's because of the the few births they have per midwife, that the child's size is less than four kilos. It could also be that the midwives are more experienced in providing perineal protection than it seems in the findings. Women that give birth and are being assisted by an unexperienced midwife had a higher rate of perineal ruptures compared with women being assisted by highly experienced midwives (Leytes, Levy, Hiaev, Ginath, Bar & Kovo, 2017). It could also be explained by a possible low incidence of instrumental birth at deliveries which affects larger ruptures such as degree three and four. This has not been present in the findings but requires further research.

Conclusion

The main objective of this study was to gain a deeper understanding of Indonesian midwives' experiences with preventing perineal ruptures. Indonesian midwife's grip to prevent perineal ruptures are similar to what the authors are educated in Sweden. They also have a variety of different types of preventive actions, just like midwives in Sweden provide. Knowledge and experience appear to be limited due to the number of few vaginal births. They have a different view on factors that reduce the risk of perineal ruptures, like the Lithotomy position. Midwives emphasized the importance of education and information in their work with perineal protection. They all claimed that if no perineal protection was used, it was more likely for the woman to get a grade three or four rupture. There are significant differences according to perineal rupture prevention actions between Swedish and Indonesian midwives. The differences are birth positions and the use of warm compresses which are used in Sweden and not used in Indonesia found in this present study. The midwives in Indonesia didn't use warm compresses and did only use one birth position, the women laying on her back. Nevertheless Indonesian midwives have poor opportunities to develop new knowledge due to their poor conditions for practicing and training in their basic skills in the field. To further make a progress in the midwives preventive work against perineal ruptures is to educate and empower Indonesian midwives' knowledge. This is an important aspect due to the large number of midwives with poor experiences.

Further research

The authors suggest that a complementary observation study at the same health centers would be beneficial, to see how they work instead of having it described. Further, the authors suggest that a bigger sample and further data collection in several districts would strengthen the quality of the thesis. The midwives have great significance and impact on women giving birth and receiving perineal ruptures. With an increased understanding of these midwives' experiences, midwives may have more opportunities to offer more specialized care in obstetrics. The skills required to prevent perineal ruptures should characterize every midwife, as a more enlightened midwife can make a difference to the suffering woman.

Clinical relevance

Since perineal ruptures are a very common effect associated with childbirth and these women often need health care, it is certain to meet one of these women during a career as a midwife. This study may raise the awareness of the importance of good perineal protection. In previous research around perineal protection, the focus has mostly been on symptoms, causes and recovery. There are several articles that describe what causes the ruptures, but not how to prevent them. However, the perspective from the midwives and their experiences with perineal ruptures are rarely described, and research does not bring any clear guidelines. Authors claim that there is a need to develop this study by analyzing more midwives' experiences, in order to gain better insight into their work and preventive work. The authors believe there is a need for research on how midwives can prevent perineal ruptures. As students from abroad highlighting this problem area, it may have a small impact for the midwives working to improve the current situation.

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REFERENCES

Aasheim, V., Nilsen, A., Reinar, L & Lukasse, M. (2017). Perineal Techniques During The Second Stage of Labour For Reducing Perineal Trauma. *Cochrane Database of Systematic Reviews*. doi: 10.1002/14651858.CD006672.pub3

Aragon, L.V. (2000). *Fields of the Lord* [ebruary reader version] *animism, Christian minorities, and state development in Indonesia*. Honolulu: University of Hawai'i Press.
Retrieved from:

<https://books.google.co.id/books?id=Rh3z0Lb1xHkC&pg=PA291&lpg=PA291&dq=kula+wi+clinic&source=bl&ots=vVPz0mxCAr&sig=bsexQeuP5ndyHxNp7P50gplqVNw&hl=sv&sa=X&ved=0ahUKEwiWnNu ntfaAhWGqo8KHRACA4AQ6AEIJzAA#v=onepage&q=maternity&f=false>

Barnmorskeförbundet. (2018). *Barnmorskeutbildning*. Retrieved April 17th, 2018 from: från <http://www.barnmorskeforbundet.se/barnmorskan/barnmorskeutbildning/>

Bates, L-J., Melon, J., Turner, R., Symphorosa, S., Chan, S & Karantanis, E. (2018). Prospective comparison of obstetric anal sphincter injury incidence between an Asian and Western hospital. *International urogynecology Journal*. doi:10.1007/s00192-018-3649-8

Beckman, M M., & Stock O M. (2013). Antenatal perineal massage for reducing perineal trauma. *Cochrane Database of Systematic Reviews*. doi: 10.1002/14651858.CD005123.pub3.

Billhult, A. (2017). Enkäter. In Henricson (red.). *Vetenskaplig teori och metod: från idé till examination inom omvårdnad*. (pp. 121-132). (2.edit.) Lund: Studentlitteratur.

Bäckenbottenutbildning. (2018a). *Skydd för perineum*. Retrieved May 12th, 2018 from:<http://backenbottenutbildning.se/index.php/utbildningsmaterial/att-forebygga-bristningar/skydd-for-perineum>

Bäckenbottenutbildning. (2018b). *Skyddande faktorer*. Retrieved May 12th, 2018 from: <http://backenbottenutbildning.se/index.php/utbildningsmaterial/att-forebygga-bristningar/skyddande-faktorer>

Bäckenbottenutbildning. (2018c). *Episiotomi*. Retrieved May 13th, 2018 from: <http://backenbottenutbildning.se/index.php/15-klipp-episiotomi>

Bäckenbottenutbildning. (2018d). *Risikfaktorer för bristning*. Retrieved May 13 th, 2018 from:<http://backenbottenutbildning.se/index.php/utbildningsmaterial/att-forebygga-bristningar/risikfaktorer-for-bristning>

Bäckenbottenutbildning. (2018e). *Rättigheter*. Retrieved May 13th, 2018 from:<http://backenbottenutbildning.se/index.php/metodik/rattigheter>

Bäckenbottenutbildning. (2018f). *Liggande neutrala förlossningsställningar*. Retrieved May 13th, 2018 from: <http://backenbottenutbildning.se/index.php/utbildningsmaterial/forlossningsstallningar/liggande-neutrala-forlossningsstallningar>

Central intelligence agency. (2018). *The world factbook*. Hämtad 18 januari 2018 från <https://www.cia.gov/library/publications/resources/the-world-factbook/geos/id.html>

Danielson, E. (2017a). Kvalitativ forskningsintervju. In Henricson (red.). *Vetenskaplig teori och metod: från idé till examination inom omvårdnad*. (pp. 144-154). (2.edit.) Lund: Studentlitteratur.

Danielson, E. (2017b). Kvalitativ innehållsanalys. In Henricson (red.). *Vetenskaplig teori och metod: från idé till examination inom omvårdnad*. (pp. 285-299). (2.edit.) Lund: Studentlitteratur.

Demirel, G., & Golbasi, Z. (2015). Effect of perineal massage on the rate of episiotomy and perineal tearing. *Int J Gynaecol Obstet*. 131(2), 183-6. doi: 10.1016/j.ijgo.2015.04.048.

Edqvist, M. (2016). Förebygga bristningar under förlossningen. Lindgren, Christensson & Dykes (red.). *Reproduktiv hälsa* (pp. 481-494). Lund: Studentlitteratur.

Edqvist, M., Blix, E., Heegaard, H-K., Olafsdottir, O-A., Hildingsson, I., Ingversen, K., Mollberg, M., & Lindgren, H. (2016). Perineal injuries and birth positions among 2992 women with a low risk pregnancy who opted for a homebirth. *BMC Pregnancy & Childbirth*. 196(16), 1-8. doi: [10.1186/s12884-016-0990-0](https://doi.org/10.1186/s12884-016-0990-0)

Est, C., Lau, R., & Biro, M.A. (2014). Midwives' and doctors' perceptions of their preparation for and practice in managing the perineum in the second stage of labour: A cross-sectional survey. *Midwifery*, 31(1), 122-131. doi: 10.1016/j.midw.2014.07.002.

Fahami, F., Shohooki, Z., & Kianpour, M. (2012). The Effects of Perineal Management Techniques on Labor Complications. *Iranian journal of nursing and midwifery research*. 17 (1), 52-57. Retrieved April 14th, 2018 from: <https://www.ncbi.nlm.nih.gov/pubmed/23493441>

Globalis. (2013). *Indonesien*. Retrieved April 10th from <https://www.globalis.se/Laender/Indonesien>

Google Translate. (2018). *Översätt*. Retrieved April 30th from: <https://translate.google.se/?hl=sv>

Hadiati, D., Hakimi, M., Nurdiati, D., & Ota, E. (2014). Skin preparation for preventing infection following caesarean section. *Cochrane Database of Systematic Reviews*. doi: 10.1002/14651858.CD007462.pub3.

Hals, E., Øian, P., Pirhonen, T., Gissler, M., Hjelle, S., Nilsen, E., Severinsen, A.M., Solsletten C., Hartgill, T., & Pirhonen, J. (2010). A multicenter interventional program to reduce the incidence of anal sphincter tears. *Obstetrics & Gynecology*, 116 (4), 901-908. doi: 10.1097/AOG.0b013e3181eda77a.

Hennessy, D., Hicks, C., & Koesno, H. (2006). The training and development needs of Midwives in Indonesia. *Human Resources for health*, 10(4), 2-12 doi: [10.1186/1478-4491-4-9](https://doi.org/10.1186/1478-4491-4-9)

Henricson, M., & Billhult, I. (2017). Kvalitativ metod. In Henricson (red.). *Vetenskaplig teori och metod: från idé till examination inom omvårdnad*. 2a uppl. (pp. 112-119). Lund: Studentlitteratur.

Indexmundi. (2018). *Sweden Demographics Profile 2018*. Retrieved April 10th, 2018 from:
https://www.indexmundi.com/sweden/demographics_profile.html

Jansova, M., Kalis, V., Rusavy, Z., Zemcik, R., Lobovsky, L., & Laine, K. (2013). Modeling manual perineal protection during vaginal delivery. *International Urogynecology Journal*, 25 (1), 65-71. doi: 10.1007/s00192-013-2164-1.

Karolinska institutet. (n.d). *Svensk Mesh*. Retrieved April 14th, 2018 from:
<https://mesh.kib.ki.se/term/D009765/obesity>

Kjellström, S. (2017). Forskningsetik. In Henricson (red.). *Vetenskaplig teori och metod: från idé till examination inom omvårdnad*. 2a uppl. (pp. 57-79). Lund: Studentlitteratur

Kvale, S. & Brinkmann, S. (2014). *Den kvalitativa forskningsintervjun*. (3. uppl.). Lund: Studentlitteratur

Leytes, M.Y., Levy, S., Hiaev, M., Ginath, Z., Bar, S., Kovo, J. (2017). Does midwife experience affect the rate of severe perineal tears?. *Birth Issues in Perinatal Care*. 44(2), 161-166. doi: <http://dx.doi.org/10.1111/birt.12278>.

Lindholm, E., & Altman, D. (2013). Risk of obstetric anal sphincter lacerations among obese women. *International Journal of Obstetrics and Gynecology*, 120(9), 1110-5. doi: 10.1111/1471-0528.12228

Lundman, B., & Hällgren Graneheim, U. (2012). Kvalitativ innehållsanalys. I M. Granskär & B. Höglund-Nielsen (Eds.), *Tillämpad kvalitativ forskning inom hälso- och sjukvård* (pp. 187-201). Lund: Studentlitteratur.

Lundquist, M., Olsson, A., Nissen, E., & Norman, M. (2000). Is it necessary to suture all lacerations after a vaginal delivery? *Birth*, 27(2), 79-85. doi: 10.1046/j.1523-536x.2000.00079.x

Meyvis, I., Van Rompaey, B., Goormans, K., Truijen, S., Lambers, S., Mestdagh, E., & Mistiaen, W. (2012). *Maternal positions and other variables: effect on perineal outcomes in 557 births*. 39(2), 115-120. doi: 10.1111/j.1523-536X.2012.00529.x.

Mittuniversitet. (2018). *Barnmorskeprogram*. Retrieved May 9th, 2018 from:
<https://www.miun.se/utbildning/program/idrott-halsa-och-varld/barnmorskeprogram/om-programmet/>

Moiety, F. M., & Azzam, A. Z. (2014). Fundal pressure during the second stage of labor in a tertiary obstetric center: a prospective analysis. *J Obstet Gynaecol Res.* 40 (4):946-53. doi: 10.1111/jog.12284.

Nordström, L., & Wiklund, I. (2014). Förlossningens handläggning. In Hagberg., K. Marsal., & M. Westergren (Red.) *Obstetrik* (pp. 107-121). Lund: Studentlitteratur.

Polit, D.F. & Beck, C.T. (2017). *Resource manual for nursing research: generating and assessing evidence for nursing practice.* (10th ed.). Philadelphia: Wolters Kluwer.

RS Woodward Palu. (2017). *Rumah Sakit Woodward Palu.* Retrieved April 26th, 2018 from: <http://www.rswoodwardpalu.com/>

SIDA. (2017). *Sidas stipendier och praktikprogram.* Retrieved April 30th, 2018 from: <https://www.sida.se/Svenska/engagera-dig/sidas-stipendier-och-praktikprogram/>

Simpson, K.R., & James, D.C. (2005). Effects of immediate versus delayed pushing during second-stage of labor on fetal well being: a randomized clinical trial. *Nursing Research*, 54(3), 149-157. Retrieved May 16th, 2018 from: <https://www.ncbi.nlm.nih.gov/pubmed/15897790>

Shorten, A., Donsate, J., & Shorten, B. (2002). Birth Position, Accoucheur, and Perineal Outcomes: Informing Women About Choices for Vaginal Birth. *Birth Issues in Perinatal Care*, 29(1), 18-27. doi:10.1046/j.1523-536X.2002.00151.x

Socialstyrelsen. (2006). *Kompetensbeskrivning för legitimerad barnmorska (2006-105-1).* Stockholm: Socialstyrelsen.

Statistiska centralbyrån. (2018a). *Lönesök hur mycket tjänar en barnmorska.* Retrieved April 22th, 2018 from: <https://www.scb.se/hitta-statistik/sverige-i-siffror/lonesok/Search/?lon=barnmorska>

Stier, J. (2004) *Kulturmöten - en introduktion till interkulturella studier.* Lund: Studentlitteratur.

The World Bank. (2012). *Indonesia: Health Professionals Education Quality Project.* Retrieved April 17th, 2018 from: <http://www.worldbank.org/en/results/2012/04/01/indonesia-health-professional-education-quality-project>

Trost, J. (2010). *Kvalitativa intervjuer.* (4e uppl.). Lund: Studentlitteratur.

Unric. (2016). *Fistula en tragedi som kan förhindras.* Retrieved April 14th, 2018 from: <https://www.unric.org/sv/nyhetsarkiv/27072-fistula--en-tragedi-som-kan-foerhindr>

Uustal-Fornell, E., Matthiesen, L., Sjö Dahl, R., & Berga, G. (2005). Obstetric anal sphincter injury ten years after: subjective and objective long term effects. *BJOG: an*

International Journal of Obstetrics and Gynaecology. Vol. 112, pp. 312 – 316
doi:10.1111/j.1471-0528.2004.00400.x

Vetenskapsrådet. (2017). *God Forskningssed*. Retrieved April 23th, 2018 from:
<https://publikationer.vr.se/produkt/god-forskningssed/>

Zetterström, J. (2014). Perinealbristningar. I H. Hagberg., K. Marsal., & M. Westergren (Red.) *Obstetrik* (pp. 529-540). Lund: Studentlitteratur.

Webster, S., Lewis, J., & Brown, A. (2014). Ethical Considerations in Qualitative Research. K. Metzler (Ed.), *Qualitative Research Practice: A guide for social science students & researchers* (2. edition., pp. 77-110). London: Sage publications.

Willemijn, D.B., Warmink-Perdijk, M.S., Kolewijn, J., de Jonge, A., van Diem, M., Antoine, L.M., Lagro-Janssen, MD. (2016). *Better perineal outcomes sitting birthing position cannot be explained by changing from upright to supine position for performing an episiotomy*. *Midwifery*. Vol. 34, pp. 1-6 doi:10.1016/j.midw.2016.01.010

World Health Organization. (2018). *Maternal mortality*. Retrieved April 25th, 2018 from:
<http://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality>

Appendix A - Letter of consent



To whom it may concern,

We are two midwives students from Sophiahemmet University, Sweden. We are writing our Master Thesis on the subject perineal protection during childbirth, which means that the midwife protects the skin and tissue from tearing. The purpose of this study is to investigate what midwives in Indonesia know about the prevention actions. This method provides answers of the midwives experiences, perceptions, opinions and knowledge.

To get this information we want to ask you, do you allow us to interview you about perineal rupture prevention?

This interview will be strictly confidentially treated.

Thank you for your help!

Yours sincerely,

Anna-Karin Heikkilä and Hannah Reisinger

Appendix B- Interview guide

Form to fill in during the interview

Date and time

Midwife no. _____

Years as a midwife _____

Number of birth _____

Hospital/clinic _____

Interview Questions

1. How do you think and experience that you as a midwife can prevent perineal rupture for the woman during vaginal childbirth?
 - 1.1 What do you do for the woman? What factors help to prevent ruptures?
 - 1.2 Is there anything else that you have learned, that can help the woman?

2. When you do the preventive work against perineal ruptures, how do you think it makes a difference to the woman?
 - 2.1 Do you think the degree of rupture is affected by you as a midwife providing good perineal protection?

3. Where does your knowledge about perineal rupture prevention come from?
 - 3.1 Source of knowledge?



Stockholm 2018-01-15

To Operations Manager of Nursing Academy of the Salvation Army
Mr Robi Sekeon
Obstetric ward, Woodward hospital

Our name are Anna-Karin Heikkilä and Hannah Reisinger and are midwives students at the Sophiahemmet University, semester two. We will write an master thesis of 15 high school credits. The area to be studied concerns perineal rupture prevention. We are therefore very interested in carrying out the work at the obstetric clinic, at Woodward hospital.

If you agree that the study is being performed at the clinic, we are grateful for your signature of this appendix, which is then returned scanned in an email to a_karin@live.se (return email). If you are unsure that the study is being performed out at the obstetric clinic, we are grateful for your report. If you have further questions regarding the survey, please contact us, or our supervisor Margareta Westerbotn, margareta.westerbotn@shh.se.

Sincerely

Anna-Karin Heikkilä

Student signature

Student name clarification

Anna-Karin Heikkilä

Student's telephone number

0046 761 040 057

Students Email Address

a_karin@live.se

Hannah Reisinger

Student signature

Student name clarification

Hannah Reisinger

Student's telephone number

0046 707 209 032

Students Email Address

hannah852@hotmail.com

Summary of the master thesis layout and content

Work title: Perineal trauma prevention in Indonesia

The problem definition is briefly described as: The midwives knowledge about how to prevent perineal ruptures is important to minimize the risk for the women to suffer from perineal ruptures. Research has been conducted into what causes and increases the incidence of perineal ruptures. The information about how midwives take care of women's perineum and prevent the different trauma that can occur is important to increase a global perspective.

The purpose of the work is stated: The purpose is to describe how midwives in Indonesia prevent perineal rupture in women during vaginal delivery.

Specific questions are given: Do the midwives place focus on preventing perineal ruptures at Woodward hospital in Palu, Indonesia?

The work's design and method of data collection is briefly described: We choose to conduct an interview study with a qualitative approach. To interview the midwives in their natural environment, will help us to answer our problem definition.

Duration of work: We will interview 15 midwives.

I hereby agree that Anna-Karin Heikkilä and Hannah Reisinger may perform the "Perineal rupture prevention in Indonesia" study at the clinic during April and May of 2018.

Palu, 10th April 2018

Location Date

Signature, Operations Manager

Dr. Roby - Sekeon, SKM, M. (e), M. IV -
Printed name

Diarienummer 20180212/1400

Etikrådets bedömning om projektet behöver etikprövas

Projektansvarig	Margareta Westerbotn
Titel	PERINEAL TRAUMA PREVENTION IN INDONESIA
Program	Barnmorskeprogrammet
Datum	2018-02-12

*Forskningsetiska rådets anteckningar*Tillståndspliktigt Ja Nej

Kommentarer:

Eftersom detta arbete utförs i sin helhet utanför Sverige så behöver det inte etikprövas i Sverige. Etikrådet vid Sophiahemmet Högskola har granskat projektplan och bedömt att projektet kan genomföras utifrån ett forskningsetiskt perspektiv med villkor att samtliga involverade individer, såväl vårdpersonal som födande kvinnor ger sitt samtycke till att observationsstudien utförs. Ett villkor är också att handledare och studenter tar del av de forskningsetiska lagar och regler som gäller i Indonesien och försäkrar sig om att projektet är godkänt av verksamhetschef eller motsvarande för utförande enligt projektplan.

Vid rapportering av resultat i det färdiga arbetet kan följande mening infogas:

The project plan is approved by the Ethical Review Board at Sophiahemmet University ,
Dnr 20180212/1400

Ledamot av forskningsetiska rådet

Namn Maria Kumlin	Datum 2018-04-11
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