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What do midwives need to know about approaches of women towards labour pain management? A qualitative interview study into expectations of management of labour pain for pregnant women receiving midwife-led care in the Netherlands

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ABSTRACT

Objective: to investigate factors important to women receiving midwife-led care with regard to their expectations for management of labour pain.
Design: semi-structured ante partum interviews and analyses using constant comparison method.
Participants: fifteen pregnant women between 36 and 40 weeks gestation receiving midwife-led care.
Setting: five midwifery practices across the Netherlands between June 2009 and July 2010.
Main outcome: women's expectations regarding management of labour pain.
Results: we found three major themes to be important in women's expectations for management of labour pain: preparation, support and control and decision-making. In regards to all these themes, three distinct approaches towards women's planning for pain management in labour were identified: the 'pragmatic natural', the 'deliberately uninformed' and the 'planned pain relief' approach.
Conclusion: midwives need to recognise that women take different approaches to pain management in labour in order to adapt care to the individual woman.

Background

Labour pain is a complex, subjective and multidimensional phenomenon with not only sensory components but also an important emotional, motivational and cognitive dimension (Melzack 1999; Lowe, 2002). Labour pain ranks high in order of severity when compared to other experiences of pain in life (Niven, 1992; Lally et al., 2008). Many pregnant women have concerns about the level of pain they will experience and how they can manage this pain during labour (Lally et al., 2008). At the same time, many women have described their childbirth as a difficult but empowering experience and that they were proud especially of their ability to cope with the labour pain (Vries de, 2005; Hayes-Klein, 2012). Management of labour pain encompasses pharmacological, non-pharmacological and other approaches such as the woman's relationship with the health professional (Hutton et al., 2009; Anim-Somuah et al.; 2011; Hodnett et al., 2011; Klomp et al., 2012).

Hodnett (2002) showed in a systematic review of 'Pain and women's satisfaction with the experience of childbirth' that four main factors are associated with childbirth satisfaction: (1) personal expectations, (2) the amount of support from caregivers, (3) the quality of the caregiver–patient relationship, and (4) the involvement in decision-making. These factors appear to be so important that they override the influence of age, socio-economic status, ethnicity, childbirth preparation, the physical birth environment, pain, immobility, medical intervention and continuity of care when women evaluate their childbirth experience. Involvement and participation in the birthing experience was also identified as a significant theme by Fenwick et al. in the study of a self-selected cohort of Western Australian women; these authors concluded that involvement in the birthing process had an important influence on women's childbirth experience (Fenwick et al., 2005).

Use of some form of pharmacological pain relief has become the norm in developed countries with the number of women who

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prefer epidural analgesia as a means of pain relief in labour increasing during the past two decades (Declercq et al., 2007; Van den Bussche et al., 2007).

Dutch maternity care

Although the Netherlands has a tradition of birthing without pharmacological pain management, the number of women using pharmacological pain relief is rising in this country over the past decade as well (PRN, 2008).

The Netherlands has a community-based maternity care system, with approximately 80% of all pregnancies starting in midwife-led care (PRN, 2008). Low-risk women in midwife-led care may choose to give birth at home, in a birth centre or in hospital. If risk factors or complications arise, women are referred to obstetrician-led care. Medical interventions such as pharmacological pain relief, electronic fetal monitoring and augmentation of labour only take place in secondary care.

New guidelines on the use of pharmacological pain relief introduced in the Netherlands state that women's request is a sufficient medical indication for pharmacological pain relief during labour and that epidural analgesia is the method of choice for the elimination of labour pain (CBO, 2008). In addition the guidelines of the Royal Dutch Organisation of Midwives (KNOV) recommend that midwives should make concrete care plans together with pregnant women based on the women's expectations and preferences regarding pain management during labour (Boer and Zeeman, 2008). These guidelines together with the influence of Dutch and international media and friends and family of women have probably had an influence in raising the usage of pharmacological pain management in the Netherlands (Amelink-Verburg et al., 2009). Nevertheless, among developed countries the Netherlands still has a relatively high rate of physiological births not involving the use of pharmacological pain relief. This makes it an ideal time and setting to study women's expectations regarding the management of labour pain. People's expectations of specific items are shaped by knowledge of this item and personal preferences. An investigation of this topic in the Netherlands may generate important insights for countries that are currently encouraging midwife-led care in order to support physiological birth (Walsh and Devane, 2012).

Aim

This study set out to explore pregnant women's expectations of labour pain and labour pain management including preparation of labour pain management; the amount of support from caregivers; the quality of the caregiver–woman relationship; and the involvement in decision-making.

Methods

We conducted semi-structured ante partum interviews with clients from five midwifery practices across the Netherlands between June 2009 and July 2010 for the purposes of this qualitative study. Our study was approved by the Medical Ethical Committee of University Medical Center (VUmc) in Amsterdam.

The practices selected were located in different parts of the country, in both rural and urban areas. We chose these eligibility criteria in view of the explorative nature of the study.

Participants

We included women who spoke Dutch, were between 36 and 40 weeks pregnant, and were receiving midwife-led care at the time of the interview. In the Netherlands, only low-risk pregnant women can receive midwife-led care; this means they must have singleton pregnancies with cephalic presentation, no previous caesarean section and no other delivery risk factors according to the Dutch Obstetric Indication List (VIL, 2003). We chose the lower pregnancy limit of 36 weeks because midwives usually discuss childbirth with their pregnant clients between 32 and 36 weeks of pregnancy. The characteristics of the 15 respondents are presented in Table 1. Apart from Dutch women, we intended to include Turkish, Moroccan and Surinamese women in the study sample because they represent the largest groups of non-Dutch ethnic background in the Netherlands. It has been shown that ethnic background influences health behaviour and engagement with health-care services (Hosper et al. 2008; Dryden et al. 2012). We also intended to include women who varied as regards age, parity, level of education and intended place of birth, because these factors are expected to affect expectations of pain management (Winston and Oths, 2000; Simkhada et al., 2008).

Data collection

In each of the five participating practices, the midwife or her practice assistant asked eligible pregnant women at their antenatal care visit for consent to be approached by the researcher. We continued to look for more participants until data saturation was reached.

All interviews were conducted in Dutch at the women's homes by the main researcher (TK). The interviewer explained to each woman that all information from the interview would be strictly confidential. The women gave informed consent for participation in the study and the interview was taped by a digital voice recorder. The interviewer kept field notes in a logbook, referring to the context of the interview, the circumstances of the interviewee and reflections on her own role as interviewer. The interviewer explained to the women that she was a former practising midwife and that she would like to interview the women in her role as a researcher. The interviewer also explained to the women that there were no good or bad answers and that as researchers we were interested in women's own thoughts, beliefs and opinions (Boeije, 2012).

The interviews were guided by a topic list based on literature on expectations and satisfaction with childbirth generally and with pain management during labour (Fenwick, 2005; Rijnders et al., 2008; Escott et al., 2009; Hodnett et al., 2011). Although the studies of Hodnett et al. and Rijnders et al. are based on actual experience of labour pain management, it was considered that the themes they identified would provide a useful basis for our study because expectations influence experience in birth and labour pain management as in other fields. All questions in the interview were open formulated (Boeije, 2012).

Our semi-structured interviews contained the following topics: expected labour pain during labour and childbirth; expected methods of pain relief, involvement in decision-making about pain management during labour; plans and agreements with caregiver and partner, preparation for management of labour pain and expectations of the role of health professionals and partner in pain management during labour. If necessary, further exploratory questions were asked (see Appendix for topic list).

Data analyses

All interviews were transcribed by the first author (TK) and an assistant. The transcripts were coded and analysed with the aid of the qualitative software programme ATLAS.ti and further analysed by the constant comparison method (Glaser and Straus, 1967, ren.1995). The following baseline information was collected for all study participants: age, level of education, country of birth of the woman and of her parents, parity and intended place of birth. The level of education