



Women's perceptions of induction of labour outcomes: Results of an online-survey in Germany[☆]

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ABSTRACT

Objective: induction of labour (IOL) is a common procedure in high income countries. It may be conducted for medical as well as non-medical reasons. Women's views on induction of labour have not extensively been evaluated as yet. Also, women's preferences for certain methods of induction including alternative and complementary methods need further exploration in order to meet their expectations and needs.

Design and setting: we published a short online questionnaire on women's views and experiences with IOL.

Measurements and findings: we asked for indication and gestational age at induction; method of induction, duration of labour and mode of birth. We also asked for the extent of desired, and experienced support and participation in decision-making. Within four weeks of being online, 698 women answered the questionnaire. Most frequent reasons for induction were postmaturity (51.7%), doctor's recommendation (31.6%) and medical complications (25.6%). Most women were induced with misoprostol or dinoprostone, but nearly half of the respondents were also offered, or asked for, complementary and alternative methods (CAM). 50% or more women would have preferred more information on alternatives to IOL, methods of IOL, side effects of the drugs, information on alternatives (59.2%) and on the medication (55.3%). Many would have wished for more support (49.9%) with decision-making (55.2%), and more time (54.1%).

Key conclusion: women's expectations and needs regarding IOL are widely unmet in current clinical practice.

Implications for practice: there is a need for evidence-based information and decisional support for pregnant women who need to decide how to proceed once term is reached.

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Introduction

Induction of labour is a common procedure in high income countries. It may be conducted for medical as well as non-medical reasons. Potential advantages and disadvantages, indications, risks, and methods are still researched and discussed. Induction from 37

weeks onwards is likely to decrease stillbirths in high risk pregnancies (Hedegaard et al., 2015). Mishanina et al. (2014) found a reduced risk of fetal death in their subgroup metaanalysis regarding induction compared with expectant management (RR 0.50, 95% CI 0.25–0.99; I²=0%). This result is available for 60 trials and does not provide information on gestational age (Mishanina et al., 2014).

There are different means for induction of labour. Mechanical methods comprise stretching of the cervix via insertion of luminaria or balloons as well as digital manipulation ("sweeping") through the cervical os, and amniotomy (Bricker and Luckas, 2000; Boulvain et al., 2005; Jozwiak et al., 2012). Complementary methods include homoeopathy, acupuncture, hypnosis and others (Smith, 2003; Smith et al., 2013; Weston and Grabowska, 2013; Nishi et al., 2014). Medical induction of labour is a well-researched area. Many agents

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have been tested in trials, with oxytocin, dinoprostone and misoprostol being the most common medication. A recent Cochrane review concluding that oral misoprostol – although not licensed in many countries – may be a reasonable choice due to its low price, uncomplicated storage and simple handling properties, although it seems to have similar risk and effectiveness profiles as the other medications (Alfirevic et al., 2014). Still, there are reports of adverse events like uterine rupture following misoprostol induction in scarred and non-scarred uteri (Thomas et al., 2003; Ezegwui, 2006; Mazzone and Woolever, 2006; Wacker et al., 2011; Veena et al., 2012; Rydahl and Clausen, 2014). It is difficult to estimate risks of (misoprostol) induction, although it is an off-label medication in most countries, and adverse events are not systematically reported (Rydahl and Clausen, 2014).

As it is generally considered safe for both mother and child once term is reached, it may even be applied for on maternal request. However, there is an ongoing debate on – possibly underestimated – adverse effects of induction. These can be sentinel events like uterine hyperstimulation leading to uterine rupture, haemorrhage, amniotic fluid embolism, fetal distress including hypoxia and even death of mother and child (Wagner, 2005; Khabbaz et al., 2009; Dowswell et al., 2010; Alfirevic et al., 2011; Wacker et al., 2011; Abenhaim et al., 2013). High rates of premature births have also been found to correlate with non-medically indicated inductions (Chang et al., 2013). Other considerations relate to negative birth experiences for women and their partners, particularly to both frustrating failures of induction as well as extremely fast and painful labours (Shetty et al., 2005; Heimstad et al., 2007; Gatward et al., 2010).

Women's views on induction of labour have not extensively been evaluated as yet. It is known that women want to participate in decision-making (Emslie et al., 1999; Taylor and Armour, 2000). Heimstad et al. randomized 508 women at 41 weeks into an induction and an expectant group with serial monitoring. 74% of women who had an induction versus 38% of women in the expectant group would opt for the same treatment in another pregnancy (Heimstad et al., 2007). Gatward and colleagues interviewed 23 women at term who were either induced or had a spontaneous onset of labour. They found that women were more satisfied with their birth experience when labour had started on its own. Women found it difficult to make choices between their own preferences and the perceived implications for their unborn. Most indicated a need for more honest information on what to expect (Gatward et al., 2010). Shetty et al. conducted a survey on 450 women in each-an induction and expectant group-of healthy term women. Women in the induction group were less satisfied and had a higher caesarean section rate than the control group. All had wanted more information prior to induction (Shetty et al., 2005). Maternal satisfaction is not routinely reported with induction of labour (Vogel et al., 2013). Observational data suggest that women with induced labour compared to those with spontaneous onset of labour were generally less satisfied with aspects of their care and significantly less likely to have a normal birth (Henderson and Redshaw, 2013). This may be related to staff shortages, neglect, pain and anxiety in relation to getting the induction started and once it was underway. Prior to induction women refer to the safety of infant, women's trust in their clinician, relief of discomfort and/or anxiety, diminish potential or actual risk, and lack of informed decision making as the most important topics with respect to induction (Moore et al., 2014). Having had the experience of IOL, the most frequently named topics were lack of informed decision making, induction as part of a checklist, women's trust in their clinician, happy with induction, and opportunities to improve the experience (Moore et al., 2014). In a randomized controlled trial Nasser compared oral versus vaginal application of misoprostol. Women experienced vaginal

examination more painful in the vaginal group (19.7% versus 36.1%, RR 0.5, 95% CI 0.3–0.9). Overall, women's experience was better with the sublingual application (RR 2.0, 95% CI 1.2–3.3) (Nassar et al., 2007). Also, women's experiences with balloon dilatation were encouraging (Kehl et al., 2013). “Failed” induction (induction not progressing to contractions/dilatation) was experienced as wasted effort and pain, a feeling of having been let down, and disappointment (Henderson and Redshaw, 2013). In a regional study from Sweden the authors found that women who had an induction of labour had a less satisfactory birth experience than women who went into spontaneous labour; most of those inductions had been performed for medical reasons (Hildingsson et al., 2011).

The rate of labour induction in Germany was 21.74% ($n=150,099$) in 2014 (AQUA-Institut, 2015). Most women were induced by medical methods (98.48%, $n=147,822$) (AQUA-Institut, 2015). The medication is not specified in routine perinatal data documentation, but a recent publication suggests that approximately half of those inductions are initiated with misoprostol (orally), whereas the other labours are induced with dinoprostone (vaginally) (Voigt et al., 2015). Most frequent indications were rupture of membranes (24.0%) and post-term pregnancy (31.9%), followed by pre-eclampsia (4.9%), placental dysfunction (6.8%) and fetal demise (0.7%) (AQUA-Institut, 2015), whereas fetal mortality is generally low, particularly at and beyond term (Schwarz et al., 2015). 144,807 women had their labours induced, most of them (98.6%) by medication. There is no data available on whether or not induction of labour in term pregnancies has successfully progressed to a vaginal birth. In 2014, the caesarean section rate in singleton pregnancies ($n=677,204$) was 31.17% ($n=211,062$). The decision to perform a caesarean section after the onset of labour was made in 15.62% ($n=105,794$) of all singleton deliveries. Delay in first stage was documented in 21.88% ($n=23,153$) as the reason for the caesarean, but routinely collected data do not allow to link these to a failed induction. Women's views on induction of labour, their preferences regarding various methods, their information needs and their experiences with induction have not extensively been established.

This study aims to explore women's views on, and experiences with induction of labour. As it is pregnant women (not caregivers) who experience labour and birth as one major life event, it is of great importance to include their views in decision-making about any intervention. Women's views and preferences should be in the focus of women-centred, evidence-based care. In particular, we surveyed (1) reasons for IOL (2) women's need for support in decision-making (3) their self-assessment of length of labour from induction until birth (4) and their perspective on future childbirth. We also assessed women's satisfaction with their experience by enquiring their willingness to recommend the procedure to family and friends (Hays et al., 1999; De Silva, 2014). Finally, we wanted to find out whether there are correlations between women's experiences, method of induction, and mode of birth.

Methods

We issued an online questionnaire with ten questions. Ethical approval was obtained by Hannover Medical School (No. 2645-2015). Women were asked in a structured paragraph of the survey about the reason for and method of IOL (in particular misoprostol), gestational age when IOL was initiated, duration of IOL, support with decision-making, and mode of birth. The question on method of IOL could be answered with more than one option. Support was categorized as information needs (alternatives to IOL, medication effects), support with decision-making and participation, time for decision-making. Any of these questions left space for a

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