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Japanese women's experiences of pharmacological pain relief in New Zealand

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ABSTRACT

Background: In Japan, most women manage labour pain without pharmacological interventions. However, New Zealand statistics show a high percentage of epidural use amongst Asian women. Entonox (a gas mixture of nitrous oxide and oxygen) and pethidine are also available to women in New Zealand. This article investigates how Japanese women in New Zealand respond to the use of pharmacological pain relief in labour.

Questions: The study was guided by two research questions: (1) How do Japanese women experience and manage labour pain in New Zealand? (2) How do they feel about the use of pharmacological pain relief?

Methods: Thirteen Japanese women who had given birth in New Zealand were interviewed individually or in a focus group. The conversations were analysed using thematic analysis.

Findings: Although in Japan very few women use pain relief, nine women received epidural and/or Entonox out of 11 women who experienced labour pain. The contrast between their Japanese cultural expectations and their birth experiences caused some of the women subsequent personal conflict.

Conclusion: Japanese women's cultural perspectives and passive attitudes were demonstrated to influence the decision-making process concerning pain relief. It was concluded that understanding Japanese cultural worldviews and approaches to the role of pain in labour would help maternity providers in their provision of appropriate care for Japanese women.

1. Introduction

While pharmacological methods are not commonly offered for managing labour pain in Japan, pain relief methods such as epidurals, Entonox (a gas mixture of nitrous oxide and oxygen) and pethidine are widely used in New Zealand. In terms of ethnic groups, New Zealand statistics show Asian women have the highest percentage of epidural use (36.4%) compared to European (33.0%), Pacific peoples (18.4%), and Māori (14.8%).[1] There are no national statistics regarding ethnic groups for other pharmacological pain relief methods.

The reason for this ethnic difference is unclear. The concept of cultural safety is well developed and integrated in the New Zealand healthcare setting due to the specific historical context as a bicultural nation. Accordingly, the knowledge of Māori, Pacific Islanders and European health and birth practices is well addressed.[2–4] However, Rasanathan, Ameratunga, and Tse[5] point out that Asian health still remains outside the frame of reference for the majority of health professionals, despite nearly 10% of the population identifying as being of Asian descent in New Zealand.[6] Also, the term "Asian" is too broad to grasp the diversity of women from this region of the world because Asians originate from approximately fifty nations.[7] Japanese women comprise one of the groups within this rich social and cultural mix. The New Zealand population of Japanese increased more than three times in the decade 1991–2001 (from 2970 to 10,002 residents).[8] This number reached 13,569 in 2010,[9] with women constituting two thirds of the population.[10] Despite this trend, Japanese birth experiences in New Zealand have not been specifically documented until now.

The contrast between the Japanese system and tradition and the high percentage of epidural use among Asians in New Zealand invites the following questions; "How do Japanese women experience and manage their labour pain in New Zealand?" and "How do they feel about the use of pharmacological pain relief methods?" This article addresses these issues by exploring Japanese women's birth experience in one region in New Zealand with particular reference to their experiences of managing labour pain and responses to offers of pharmacological pain relief.

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2. Literature review

Japan is unique in that it has a very small proportion of women who have any pharmacological pain relief, compared to other developed nations. According to recent statistics,[11] the epidural rate for childbirth is 2.6% in Japan compared to 28% in New Zealand.[1] While Entonox and pethidine are also widely utilised by women in New Zealand,[12] their administration is also very rare in Japan.[13]

Okutomi and Minagawa[14] found that only a quarter of the Japanese women had heard about epidural use for labour and birth, and only 16.5% of the women knew what it was. In contrast, the large majority of the women in the study knew about breathing methods (93%) and water birth (82%). Amano[15] also maintains that epidurals have never been able to attract the attention of Japanese who have a different cultural and social background from that of Western countries. For reference, the low rate of epidural use does not result in a high rate of Caesarean section in Japan. The rate of Caesarean section in Japan is 18.4% compared to New Zealand's rate of 23.7%.[1,16]

The exact percentage of epidural use by women from each country including Japan is unclear in the New Zealand statistics. However, the ratio of Asians' epidural use in New Zealand is 36.4%, which is high compared to both the Japanese context and other Asian countries' birth context.[17] For some, this high epidural use may be perceived as good service. Nelson[18] suggests that the lower use of epidurals among Māori women is the result of unequal service levels and less choice for them. Even if this difference among ethnicities is a consequence of unequal care as Nelson maintains, it still does not account for the high percentage of epidural use by Asians in New Zealand. Regardless of the impartiality or partiality of the care, it is obvious that Asian women have an increased chance of having epidural pain relief in New Zealand. Japanese women, therefore, would also have a higher chance of having an epidural in New Zealand than in Japan.

Furthermore, Illich[19] claims that experiencing pain is an important part of traditional cultures, and that each culture has a unique way to express pain as a meaningful thing. If culture and society play an important role in women's response to labour pain, there is the high possibility that women who are isolated and far from their mothers, close friends, and their traditional community are less likely to receive culturally appropriate information about labour pain and coping methods. As immigrants, Japanese women in New Zealand may also accept the care offered in New Zealand rather than follow their own tradition regarding pain relief measures.

3. Participants and methods

3.1. Participants

Thirteen Japanese women who had given birth in New Zealand within the previous three years agreed to participate in the study. The recruitment was undertaken using a snowball technique among members of a Japanese community based in Dunedin, New Zealand. Information pamphlets about the study had been distributed. Those who were interested in participating in the research read the information letter and signed the consent form.

3.2. Methods

A qualitative research approach was chosen to give voice to the women's understanding of their experience, and two methods of data collection were used. First, nine individual interviews were undertaken to seek participants' perspectives through their own personal narratives. Building on the interview findings, the issues raised were discussed in detail with four other participants in a subsequent focus group.

The data was analysed using a thematic analysis process outlined by Braun and Clarke.[20] This is a fundamental method of simply organising and describing the data, which allows the researcher to stay close to the women's voices. The transcriptions of the data were read and re-read to generate initial codes, and the codes were categorised to develop themes.

Ethical approval for the study was obtained from the Otago Polytechnic Research Ethics Committee (ETHICS 470). This process included consultation with the Kaitohutohu with regard to how the study might apply or impact for Māori.

4. Findings

4.1. Demographics

The demographic profiles of the women were similar. Their ages ranged from 32 to 42-years old. Level of education ranged from high school to university study, with eight of the women having studied at universities in New Zealand. The women had lived in New Zealand for between two and 19 years with an average of 10 years, and had considerable work experience in New Zealand. Eight of the women had one child and five women had between two and four children. All the children were born in New Zealand.

In New Zealand the care is provided and managed throughout childbirth by a Lead Maternity Carer (LMC) who can be a Midwife, General Practitioner, or Obstetrician. The LMC system provides continuous complete maternity care throughout pregnancy and childbirth for each individual woman.[21] In 2010, 78.2% of women chose midwives as their LMC.[22] In this study, 11 of the 13 women chose a midwife as their LMC and two chose an obstetrician.

For their most recent birth, all the women in this study chose a hospital as the place to have their babies. Ten women gave birth vaginally and the other three women had unplanned Caesarean births. Interventions experienced by the women included induction of labour, vacuum extractions and forceps delivery. One woman received no medical intervention during her birth.

4.2. Findings

Among the 13 participants in this study, two had a Caesarean section before labour started. Among the other 11 women, nine had used either or both Entonox and epidurals (Entonox and epidural: 5, Entonox only: 3, epidural only: 1) to relieve their labour pain. Three themes emerged from their experiences. They were (1) intention to/not to use pharmacological pain relief, (2) passive attitudes, and (3) conflicts over using pharmacological pain relief.

4.2.1. Intention to/not to use pharmacological pain relief

Two women did not use any pharmacological pain relief. Their intention to have a normal birth was signalled by their choice of midwife and the preparation of a birth plan. Both gave birth in hospital, but chose midwives who were experienced in home births as they wished to have natural labour and births. The experiences of these two women agree with Leap's hypothesis[23] that homebirth midwives are more likely to support working with pain rather than trying to remove the pain. As one woman commented:

> I told my midwife that I would never use the epidural. At the birth, nothing crossed my mind. It was too late to use anything... My body pushed and pushed with no space to think of such a thing. (#1)