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A narrative inquiry into women's perception and experience of labour pain: A study in the western region of ghana

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ABSTRACT

There is a general notion among Ghanaian women that the labour is a painful process that must be endured. Regardless of this notion, labour pain experience overwhelms most women. The aim of this study was to inquire into women's perceptions and experience of labour pain and how women cope with pain. Using the narrative inquiry methodology, five low risk pregnant Ghanaian women; two nulliparous and three multiparas were purposefully selected. Tape-recorded conversations, writing of field notes and journals were used as the main source of data collection before delivery and within one week after delivery. The women's perception of pain before and after delivery was used to construct narrative accounts from which the findings of the study were generated. To ensure credibility of each narrative account, the interim narrative accounts constructed by the researcher were sent to the women to read and respond to. The findings revealed that before the labour experience, women perceived labour as a painful experience expected to be endured. Antenatal education on labour pain management was inadequate. Additionally use of pain relief methods was lacking although women expressed need for pain relief. Furthermore the findings revealed inadequate physical and emotional support for women in labour to help cope with labour pain. In conclusion the researcher recommends that midwives in consultation with clients adopt a more active method of assessing labour pain. Also antenatal education on pain relief options must be provided. A more conscious effort to provide support for women in labour should be promoted.

1. Introduction

Childbirth, since the beginning of time, has always been associated with pain. The desire for pain relief in labour has been in existence in most societies for a long time. Historically, various measures were taken to relieve childbirth pain. Ancient civilizations of Babylon, Egypt, China and Palestine used various exorcisms to combat pain (Squire, 2000). Records of pain and its treatment reveal the use of herbs, drinking of wine, use of pressure, heat, water and sun (Squire, 2000). Historically, pain has been related to evil, magic, witchcraft and demons. As such pain relief in general was the responsibility of sorcerers, shamans, priests and priestesses who used herbs, rites and ceremonies as their protocol (Radford & Radford, 2004; Squire, 2000).

From the beginning of the 20th century there has been a wide range of pharmacological and non-pharmacological methods to help reduce the pain associated with childbirth. These include pharmacological methods such as epidural anaesthesia, the use of pethidine, nitrous oxide, meperidine (Demerol) and paracervical block (Leeman, Fontaine, King, Klein, & Ratcliff, 2003). There are also several non-pharmacological methods such as, lower back massage, breathing techniques, partner or doula support which have no adverse effects on either mother or baby (Brown, Douglas, & Flood, 2001). The non-pharmacological approach to pain management includes a wide variety of techniques that addresses not only the physical sensations of pain, but also attempt to prevent suffering by enhancing the psycho-emotional and spiritual components of care. In this approach, pain is perceived as a side effect of a normal process (labour) and the primary goal is not to make the pain disappear but to help the woman cope with the pain better. Instead, a woman is educated and assisted by her caregivers, childbirth educators, and support person to take an active role in decision-making regarding pain relief (Lowe, 2006).

1.1. The need to manage labour pain

As Leeman et al. (2003) stated most women report that labour is painful, but most physicians have little understanding of the nature of labour pain. According to Leeman et al. (2003) many physicians believe that the main determinant of childbirth

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satisfaction is major physiological pain relief. Invariably pharmacological pain relief is resorted to as the best method. Perhaps how labour pain is managed may change if women described their perceptions of pain before labour and their actual experience of pain. The subjective characteristics of pain, as well as the various factors that influence the perception of pain shifts responsibility to the caregiver to ensure that the labouring woman is the center of every decision about pain management in labour. In other words the midwife's actions should be influenced by the woman's preference of pain management options available to her. Furthermore the fact that both pharmacological as well as non-pharmacological methods of pain relief can be used to manage labour pain is evident in literature. These options when presented to women during the antenatal period can help them make informed choices about how to manage pain when in labour. The role of personal support is highly recommended since it takes care of both the physical and psychological needs of woman during labour (Hodnett, Gates, Hofmeyer, Sakala, & Weston, 2011). In as much as several aspects of support and pain management in general have been researched, there is a lack of evidence in the utilization of these findings in Ghana. D'Ambruoso, Abbey, and Hussein (2005) also noted that health professionals' attitude towards patients is a critical element of care. D'Ambruoso et al. (2005) argued that staff attitude, cost of perceived quality of care and proximity of service, influence women's expectation and hence their patronage of services. Thus if cost of pain management is bearable and midwives have a positive attitude towards assessment and management of labour pain it will influence women's decision to seek professional care when in labour. Women's experiences with childbirth pain and its implications for practice in the Ghanaian context are missing from the literature hence the need for this study.

There is no significant data that links labour pain management to maternal mortality. However, there is evidence indicating that the support women receive during childbirth reduces the number of required interventions, the use of pharmacologic pain relief, and shorten duration of labour (Hodnett, Gates, Hofmeyer, & Sakala, 2007; Simkin & O'Hara, 2002). Similarly, Wong (2009) commented on the direct and indirect effects of labour pain on both mother and fetus. Wong noted that severe labour pain can stimulate behaviours such as anxiety and apprehension thereby negatively affecting the woman's psychological experience of childbirth. Wong (2009) concluded that effective pain management could mitigate these effects. If every birth is to be attended by a skilled provider, then efforts should be made to ensure women have a satisfactory childbirth experience. Since pain is inevitable in labour, its effective management is key to a positive birth experience. This narrative inquiry will contribute to the body of knowledge with regards to labour pain and highlight areas of pain management that needs to be strengthened.

2. Methodology

Narrative inquiry is one of the multiple methodologies under the umbrella of qualitative research and appropriate for the study of human experiences. The theoretical basis for this research stems from Connelly and Clandinin (2006) who argue for the development and use of narrative inquiry as a methodology. According to Clandinin and Connelly (2000) narrative inquiry is a process of gathering information for the purpose of research through storytelling as the researcher explores experience. Narrative inquiry comes from a view that human experience is conveyed by human beings who as storytelling organisms, individually and collectively lead storied lives.

> "People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry; the study of experiences as story, is first and foremost a way of thinking about experience"
>
> (Connelly & Clandinin, 2006).

The three dimensional framework for understanding stories proposed by Connelly and Clandinin (2006) was used in this research. The framework is made up of temporality (past, present and future), personal/social interaction (feelings, hopes, desires, aesthetic reactions and moral disposition of the inquirer and participant as well as relationship between participant and inquirer), and the third dimension being place (Connelly & Clandinin 2006). Place is described by Connelly and Clandinin (2006) as "the specific concrete physical and topological boundaries of place or sequence of places where the inquiry and event took place". Ultimately narrative inquiry is the expression of lived and told stories of experience which involves the telling, retelling, living and reliving of a person's experience in relation to place, time and social context (Clandinin & Connelly, 2000).

The three dimensional framework direct the researcher's attention while conducting a narrative inquiry. Temporality was captured when women's perception about childbirth pain in the past, during antenatal period, and their experience of labour pain were explored. The women had the opportunity to reflect on how their experiences would impact their future experience of childbirth. The second dimension in the framework was explored by having conversations with the women about their hopes, desires, feelings, interaction with caregivers or support persons and other individual factors such as religious beliefs that impacted their experiences of labour pain. The third dimension of place was also explored to narrate how the different physical places such as the antenatal clinic where education on labour pain management is given as well as the home environment, and the first and second stage rooms in the labour ward influenced the labour pain. Additionally the interactions between these three narrative components of the framework were explored.

Five low risk pregnant women in their 3rd trimester were purposively selected for participation in the study. The inclusion criteria for the study was: pregnant women with 36 weeks gestation and above who had made at least two antenatal care visits and plan to deliver at the hospital were data was collected. To avoid the problem of language barrier, participants had to be Ghanaians who spoke English, Akan or both. To address the issue of ethics, ethical clearance was obtained from the institutional review board of the Noguchi Memorial Institute for Medical Research at the University of Ghana and also clearance from the health facility where data was collected. A written consent form was signed by each of the five women after it had been explained to them in detail. As part of ensuring trustworthiness of the study, a hard copy of the constructed interim narrative accounts was given to each participant to read and respond to. This was to ensure the credibility of the final narrative accounts as a true reflection of the experiences of the women in the study.

3. Data collection: being in the field

Arrangement for one-on-one conversations was made with each woman who was willing to be part of the study at a time and place agreed upon by each woman. During the initial interaction with each woman an informed consent was obtained. Data collection was through tape-recorded conversations, writing of field notes and journals in which I recorded observations such as