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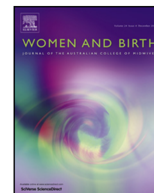

Original Research - Qualitative

A qualitative study showing women's participation and empowerment in instrumental vaginal births

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ABSTRACT

Background: An instrumental birth with a ventouse or forceps is a complicated birth, possibly resulting in fear of childbirth which could influence the entire birth experience negatively. Patients who are actively involved in their care have a stronger sense of satisfaction and a sense of participation can contribute to shorter hospital stays.
Aim: To describe the experience of participation for women involved in an instrumental delivery with ventouse or forceps.
Method: Qualitative semi-structured interviews with 16 women who gave birth aided by a ventouse or forceps. Their answers were analyzed through qualitative content analysis. In addition the women were asked to evaluate their experience during the delivery. Using a numerical scale (NRS) the birth experience was graded by choosing a number between 0 (worst possible experience) and 10 (best conceivable experience).
Findings: Two themes were extracted from the data: *To be part of a team* and *To feel empowered*. Five categories were identified from the women's descriptions of the experience of involvement during the instrumental delivery: *to cooperate*; *to understand*; *to have contact*; *to participate*, *and to not be involved*. Those women who rated their experience as low grade, described a lack of involvement in their childbirth compared to those women who rated their experience as high.
Conclusion: This study shows how cooperation and empowerment of the woman are two key factors in order for the women to have a positive experience of their instrumental vaginal births. The study also shows that empowerment is created when the woman is actively engaged and participates in the birth process which gives her the feeling of being part of the team, creating an environment based on mutual understanding.

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Statement of significance

Problem or issue

To examine how women describe their experience of participation and involvement when giving birth instrumentally.

What is already known

Women who experience that they have participated in their care report a higher degree of satisfaction. Studies have shown that women who give birth aided by a ventouse or forceps run the risk of having a negative birth experience.[5,7,9]

What this paper adds

To be part of "the team" with staff and to feel empowered during childbirth aided by a ventouse or forceps was important for the women's sense of participation.

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1. Introduction

An instrumental birth is an intervention where the woman gives birth aided by a ventouse or forceps. In Sweden, approximately eight percent of all obstetric births are performed with a ventouse or forceps and among primiparous women approximately 15%.[1] An instrumental birth is used to expedite or facilitate the birth of the baby. Indications for usage of forceps or a ventouse include: a danger of fetal hypoxia, poor progress, contraction weakness, or that the woman cannot push properly due to exhaustion or illness.

The intervention with forceps or a ventouse could be an emergency situation when there is little or no time for the woman, her partner or hospital staff to prepare for it.[1] All instrumental interventions involve an increased risk of complications for both the mother and child. The most common complications for the mother are vaginal tearing, sphinkter damage, perineal pain and dysparenuia.[2,3]

For the child there is an increased risk of complications following forceps or a ventouse, such as head lacerations, cephalhematoma, subgaleal hemorrhage and very rarely intracranial hemorrhage.[4]

Earlier studies[5–7] show that an instrumental delivery influences the childbirth experience. Women commonly experience an instrumental birth as more traumatic than a vaginal birth. Severe fear of childbirth is more common in women whose earlier experiences of childbirth ended with a ventouse[5] possibly resulting in the couple not wanting more children.[6] Some fathers can even have a sense of the child having been harmed and therefore might demand to have a Cesaerean section in the future.[8] Women whose birth ends with a ventouse or forceps generally have a worse birth experience compared to those who give birth vaginally spontaneously. Four percent fewer women who have experienced an instrumental birth subsequently birth another baby.[9] An increased fear of childbirth is reported for 27.5% of those who give birth by a ventouse and 24% of them desired a caesarean section in a future pregnancy.[10]

Henderson describe that a patient's sense of having participated involve being part of the decision making process regarding implementation and evaluation of the care given. Patient participation is defined as a dynamic process which evolves over time and is an integral part of the work for the hospital staff.[11] This reciprocal process occurs through partnership, understanding of the patient, and emotional work where partnership is seen as a necessary process as a basis for participation.[12] The patient is participating when there's a dialogue which can evolve over time and phases of illness, care and treatment between the hospital staff and the patient.[13,14] Studies (National Board of Health and Welfare; Kiessling and Kjellgren) have shown that when a patient is involved in her own care, the outcome is better, for example a decrease in relapses and shorter hospital stays [15,16]. It has also been shown that women who have not felt involved in their birthing care are less satisfied.[17] There is a dearth of studies exploring women's experience of participation during childbirth aided by a ventouse or forceps. To gain more knowledge in this field, the purpose of this study was to describe the experience of participation in connection with an instrumental birth.

2. Method

2.1. Study design

An interview based study of 16 women who had experienced an instrumental delivery (ventouse and forceps) was conducted aided by a semi-structured questionnaire. A content analysis was used to analyze the responses. Qualitative methods are used to describe and understand people's experiences in order to gain deeper knowledge.[18]

2.2. Participants and ethics

Women who had given birth with the help of instruments were consecutively asked to participate in the study. The criteria for participants used was an instrumental vaginal birth as well as fluency in the Swedish language. Exclusion criteria was any birth mother whose child was treated at a neonatal ward.

Women were provided oral and written information about the study. All informants were told that participation was voluntary and that the interview transcripts would be treated confidentially. Furthermore, they were informed that they could withdraw from the study at any time without any consequence regarding their care and contact the research team if they needed to talk to someone after the interview. The interviews were conducted during the period 2012-05-11 and 2012-07-09 at a hospital in Stockholm where there were a total of 8832 births that year. A total of 19 women were asked to participate, and of those asked, two declined participation and one woman who initially had agreed to take part changed her mind before the interview. In total 16 women who had given birth aided by ventouse or forceps were interviewed two to five days after giving birth.

The study was approved by the Ethical Committee at the Karolinska Institute, (dnr.2012/399-31/4).

2.3. The interviews

Two midwives conducted the interviews (MS and SZ). The mothers were interviewed in either the postnatal ward, in the hospital room (single room), or in a private room during their follow-up appointment at the hospital. The interview questionnaire focused on the concept of participation. All interviews began with an open ended question in which the woman freely could reflect upon and speak about her childbirth. Thereafter questions were posted regarding the respondents' sense of involvement during childbirth and they were encouraged to describe their experience of participation.

Finally the women were asked to evaluate their birth experience. Using a numerical scale (NRS) the women graded their experience by choosing a number between zero (the worst possible birth experience) and ten (the best conceivable birth experience).

A pilot interview was conducted to test the interview questionnaire which later was included in the data material since it corresponded to the purpose of the study. The interviews were recorded in full and lasted between 24 and 63 min.

2.4. Data analysis

In order to analyze the interviews, qualitative content analysis with an inductive approach was used. The analysis was done according to the model of Granheim and Lundman.[19] In the inductive approach there is no prepared theory or model utilized in the analytical process. The recorded material was listened to in order to obtain a more holistic picture of the whole. Thereafter, the interviews were transcribed verbatim in their entirety. All interviews were read through several times to obtain the whole picture of the material.

Meaningful units, relevant to the study, were identified in the interviews. These units were condensed into codes where the core message was increased to a higher level of abstraction. The codes could initially fit under several subtitles to enable a comparative process with colour categorized codes. Finally, themes were formulated.

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