



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



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ARTICLE INFO

Article history:

Received 30 November 2014

Received in revised form 8 October 2015

Accepted 11 October 2015

Available online 23 October 2015

Keywords:

Narrative inquiry labour

Pain

Perception

Experience

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.

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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

emotions during the conversations and my own reflections as a midwife and a woman who has gone through labour.

In all, two major tape-recorded conversations were held with each woman, one during the antenatal period and another within two weeks after delivery. I had the opportunity to spend some time at the labour ward when each woman reported in labour. I explained to the women during the antenatal conversations that my role at the labour ward was strictly observational and was upon their invitation through a phone call. All five women willingly informed me on phone at the onset of labour and invited me to be present. Observations at the labour ward were recorded as field notes and included how the women reacted to labour pain and also observations of how midwives managed the labour pain. The aim of the labour ward observations was to serve as a guide to direct post delivery conversations. The observations also helped me to make meaning of the narrative accounts shared by the women after delivery. Although I had permission from the hospital to be at the labour ward, to ensure that my presence at the labour ward did not influence the work of the midwives, I volunteered on several occasions to assist at labour ward four weeks before any of the women was due for delivery. All five consented both verbally and in writing during the antenatal period to hold conversations with me at their homes after delivery. Further confirmation was sought again few days before the home visit. A conversation guide was used to further inquire into the participant's stories of childbirth. The transcribed conversations and field notes were used to construct narrative accounts for each participant and sent to participants to read and respond to. This was to ensure that the narrative accounts reflected the women's stories as told.

3.1. Data analysis

Data analysis was done concurrently with data collection. The method of data analysis for narrative inquiry as proposed by [Clandinin and Connelly \(2000\)](#) was used. This involves two main steps; the writing of interim research text as the first step and the writing of final research texts as the second step. Field notes were written immediately after each conversation and were reviewed extensively prior to subsequent conversations with the women. The tape-recorded conversations were listened to repeatedly soon after each conversation and were transcribed verbatim. After transcribing the conversations and field notes personally, I constructed interim narrative accounts for each woman. While transcription was initially verbatim, my experiences as a woman who has experienced labour pains and a midwife was documented, bringing forth my own embodied responses to the stories told. The inclusion of my own embodied responses was based on [Clandinin's \(2013\)](#) assertion that in narrative inquiry both researcher and participants are considered as co-composers of narrative accounts. According to [Clandinin \(2013\)](#) it is the unfolding lives of participants, and researchers that matter. As I read the transcribed data I took notice of each dimension in the framework proposed by [Connelly and Clandinin \(2006\)](#). To attend to temporality I began each account by going backward to reflect on women's past perception of labour pain. For the women who had previous labour experience their actual past experiences of labour pain was explored. Each woman's narrative of present perception and experience of labour pain was also noted to ascertain any change in perception or experience. The second dimension, being the personal and social dimension was attended to by writing to reflect the feelings, hopes, desires and reactions of the participant and myself. I also brought to light the role other people such as midwives and significant others played in the entire experience. Whilst attending to time, personal and social dimension I paid attention to the third dimension 'place' by consciously reflecting on the different places where the various experiences took place.

After writing the narrative accounts as interim research text I personally sent each woman's narrative account back to her. The women were given enough time agreed upon with each woman to read and reflect on her narrative account. Although all five women could read and write two requested that I read to them what I had written. After reading the accounts, each woman and I had a discussion and responded to the co-compositions. No major changes were made to the accounts but rather some of them reemphasized what was very important and were happy it had been captured. The final research text was constructed from the validated accounts after which all narrative accounts were read over and over to identify major threads in each story. The stories were read again a couple of times to identify the threads that resonated across stories. These narrative threads across all stories are discussed in the light of other research as findings. All five women were asked to select pseudonyms for the writing of narrative account both interim and final text.

4. Participant's stories

Each of the five women in the study had unique accounts of their labour pain experience yet there were similar threads that resonated in all the stories giving the women a common voice as to how they would want to be assisted to deal with the inevitable pain associated with labour. In this paper I present highlights of accounts of the first three women in the subsequent paragraphs. I will however make reference to the remaining two stories as I discuss the findings of the study.

4.1. Hannah's story

Hannah a 32-year-old poly-technique graduate was carrying her 4th pregnancy when I first met her at the antenatal clinic. During our first conversation Hannah narrated the perception she held about labour pain before her first labour experience. She explained how her knowledge about labour pain at the time of her first delivery was socially constructed from other women's stories of birth rather than from information given by midwives at the antenatal clinic. Hannah said: *"I was told by different people that labour is painful; In fact I heard from different people that labour was a very painful experience but must be endured"*. According to Hannah her first labour pain experience started at home in the night. Gradually the pain began to increase but she had to endure till the morning. She described it saying: *"At home my husband was with me so he would massage the part where I felt the pains. . . he would rub my thigh for a while and then the pain will disappear for some time. When we got to the hospital however there were several patients on admission in the labour ward so there was nobody to spend time with me"*. Hannah had this to say as she described labour pain: *Labour is painful, it is extraordinary, it is really extraordinary, labour pain is extraordinary Labour pain. It is a different kind of pain, it is different from any kind of pain I have experienced. With my first experience I did not have any such thing as pain relief. I wasn't given anything for pain, I had to endure. I would have been happy if my husband had stayed with me to help me cope with the pain.*

Hannah's second labour pain experience was managed differently. She described it by saying: *"The second one was different. It was a very different experience altogether. I thought the first one was painful but when I experienced the second delivery I found it to be even more painful. This time one of the nurses (midwives) tried to help me because she saw that I was suffering due to pain. When I complained of pain in any part of my body she will try to help by holding me and encouraging me to endure and that it will be over soon.* Although Hannah's physiological labour pain was managed better during her second delivery she described another kind of pain as

she narrated her experience; the pain of losing a child during birth. Hannah said *“By the time the baby was coming I was very tired and it was getting to morning. The nurse later told me to pray to seek God’s help. As we (the midwife and Hannah) went on praying, a time came that I could not continue but all I could do was to shout Jesus! Jesus! The midwife told me to call on Him louder because the baby was coming. As I kept on shouting the baby came but the baby was not crying well. The other nurse then came for the baby, they tried giving oxygen but it was too late. I saw that if they had offered any help earlier the baby would have survived. I must say that with the second one I went through real pain. Hannah concluded that: “It is very painful to lose a child at birth, that pain never goes away”.*

Hannah’s experience with labour pain during her third delivery was similar to her first experience. Labour pain was not well managed. Having experienced an uneventful pregnancy and counting on her previous labour experience, Hannah was prepared as a Ghanaian woman to endure childbirth pain for the third time.

When I met Hannah she was preparing for another delivery, the events of the past occasionally crept into her present thoughts, making her fearful of the impending delivery. She decided to deliver at a different hospital. Hannah told me *“My plan is that since I have been told that the midwives at the labour ward in this hospital are fewer than the clients and so they cannot divide themselves among the clients. I know that I may or may not have someone to come to be with me so when I feel the pain I will just go ahead and rub where I feel the pain for relieve. They (midwives) also said that they would have wished that the husbands will come with their wives so I wish my husband could be with me considering how he helped me in my first delivery”.* The knowledge she had received and the plan she had for her fourth delivery made a difference in her labour experience. During our post delivery conversation Hannah stated that: *“While I was there I was experiencing the pains. Each time I felt the pain I would lie on my left hand side and breathe through my mouth till the pain stops... I was fortunate (her face beaming with excitement as she recalls) to have some student midwives around, the student who was with me kept reassuring me that it will be over soon. Even when she (the student) moved away from where I was, I would call her when I felt the pain and she will come. She will either hold my hand or massage where I felt the pain. The midwives had time for me, they came when I called them even in the night.*

The talk that was given during antenatal made me understand some of the things I was experiencing during the latter part of pregnancy. The other places I attended antenatal in the past, talk was also given but not much was said about labour pain in all these places. . . I was fortunate to have a student by me throughout. This really helped me to endure the pain. Concerning the support Hannah noted: *“I really wish my husband were around. He kept calling me on phone to check on me. At a point he heard me crying that I was suffering, so he promised to keep praying for me. But when the midwives heard me telling him that I was suffering they told me they were not going to allow me to use the phone again because I will make my husband worried and disturbed at home”.*

4.2. Edith’s story

Edith was carrying her second pregnancy when we first met at the antenatal clinic during one of her antenatal visits. Her excitement about being part of the study was evident when we met to have our initial conversation in her house, she shared her past experience with enthusiasm and we both looked forward to another new experience. Edith talked about her perception about labour pains and how she built this perception. She recalls many things about labour that were said by people other than nurses and midwives: *“As for me my mother in law told me that labour is so painful so ask God to give you strength to endure. It was the same thing my mother also told me. She said labour is painful so make up*

your mind to endure... others said you will have to endure the pain no matter what, it is part of motherhood. So when you are pregnant you must make up your mind to endure the pain internally”. Edith was of the view that expert opinion on labour pain management was inadequate and called for more education. According to her: *“more should be done; those who are experts who have studied human behaviour and labour, if they speak it will carry more weight than if it is coming from an ordinary person. So they should try and educate us on labour pain. I am told that private hospitals give more special treatment compared to the government hospitals. I do not know if it is because private hospitals charge more. But I think the care you receive reduces the pain because at that moment the woman goes through a lot so if she does not get that little comfort it makes labour more painful. I’ve also heard people comparing service and care at the private hospitals to the government ones”.* Narrating her first experience of labour pain Edith had this to say: *Labour started during the night but because I was told that I have to endure for a long time I did not wake my husband up, I paced up and down in the room but at a point he woke up and saw me sitting on the bed. The pain was becoming unbearable; I felt the pain was too much. I called my childhood friend whose husband was a doctor at the hospital and described what I was going through to him. He said it was possible that it is labour. He asked me to take a few of my things and go to the hospital. To be honest they (midwives) never taught me anything about labour pain. All I know is from other people who had given birth before as well as my mother and mother in-law”.* When I inquired from Edith how her labour pain was managed she had this to say: *“when it becomes painful I will just lie down and hold on to the bed tightly and cry a little till it stops then I will pace up and down for a while. When the pains come back I will go back and hold the bed frame tightly and scream when it becomes unbearable till it stops. I cried sometimes but I was told by the midwives that the pain was normal so I should endure it. It is true you just have to endure it but at a point it becomes so unbearable and difficult that you just have to cry. I can say that the bedstead really suffered because I kept holding it tight whenever the contractions came (both of us laughed at that statement). I will pace up and down when it wears off until the time came to push. So that is how I managed the pain, I used my own strategy to cope.*

Edith narrated her second labour pain experience when I visited her at home one week after delivery. She was very eager to describe what went on during that period with regards to labour pain. She started by telling me what happened when she arrived at the labour ward. Edith said: *“When I arrived she (midwife) took me to the antenatal ward. The pain was so unbearable that I could not be still. The baby’s heart beat was checked by the midwife, I was told everything was alright with the baby so I should take it easy and behave myself because if I don’t and continue to shout I will use up my strength and will not have energy when I need it. I went to lie on the bed and when I had contractions and the pain becomes unbearable I will hold the bed and moan in pain until the pain goes off. After some time I was examined again by the midwife and told that I was 5 cm dilated so I should move to the labour ward. Edith continued her narration about how she had to endure the pain until the baby was born: “I wasn’t given any medication and no one told me what to do to cope... At the labour ward I indeed displayed because the contractions were strong and the pain unbearable and I felt like pushing. I was just moving up and down holding the window, bed, everything I could lay my hands on. There was nothing they could say for me to listen. I told the midwife that this labour is more painful than the first one. Although I had given birth before the pain was so much that at a point I couldn’t resist shouting. I really made noise, I was shouting, was restless, moving about holding onto anything I could get. I would have loved it if my husband was with me but he was not allowed in. Even when he brought me something he was asked to leave it at the nurses’ station and I would get up and go for it. He was not allowed to come in and see me until we were discharged to go home. Though*

I had gone through a lot of pain I was so happy, really happy when the baby came out. They (midwives) have to teach us a lot about how to manage labour pain because most of us are naïve although some of us try to read on our own but expert advice and teaching will help. It should start during the antenatal period so that before you come in labour you will be in tune with what will go on there. In effect there should be more education on labour pain management”.

4.3. Rebecca's story

It was in that room that the pain became severe. All along I thought the pain was severe until then. I started crying (we both laughed). I really cried. The pain was on and off. The sad part was that it took a long time for me to deliver. The midwives were not even ready to come to me, they said my time was not up. I could scream so hard and call them 'aunty nurse the baby is coming' and one will respond that the baby is not coming without coming to see me. From time to time when I scream very hard one of them (midwives) will come and examine me and go without saying anything, I was lying there in pain crying, she (midwife) came and ask me to get up and walk about. I got up and walked about. When the pain became severe I will stop and stand still for a while holding on to the bed and scream. It went on like that for a long time. I kept crying and asking God to deliver me. At a point the pain was overwhelming, I did not know what was wrong with me but when the pain comes I will start running. I run from one end to the other in the ward. The midwives shouted that I should stop but I just couldn't. Something will just move me and I will run back and forth; it was crazy.

It was the morning elderly midwife who kept encouraging me. She will come and hold my hand and tell me it will be alright. She kept encouraging me. From time to time she will come and rub my arms. She said that the baby's head was low so I will deliver within an hour. My eyes were really red, I had cried and cried. I kept crying and calling for my mother so the midwife asked me if my mother will come and deliver for me? (Her mother was not allowed to see her, she was outside the whole period). I actually asked the midwife on 3 occasions during the night if she could give me some medicine to reduce the pain, but she did not mind me. So when I asked again the other one who came to encourage me she said there was no medication but I should try to endure but it shall be well. Rather it was one of the women who sweeps the ward (orderly) who told me to breathe through my mouth. So I did it for a while then when I stop the pain will be so severe that I will start shouting. Also when I move about it made the pains bearable but I couldn't lie at one place. I became discouraged, I wasn't sure I could endure. That was when I started crying for my mother to come. I kept wondering if indeed there was no medication for how labour is. I had no hope anywhere I was so lonely.

5. Analysis and discussion

5.1. Making sense of the stories

As I read through each narrative account I was cognisant of the uniqueness of each story. Reading story after story I became increasingly aware of the resonant threads that run through the experiences. The narrative inquiry approach illuminated the emotional aspect and the experiences of pain during childbirth as shared by the women. The five women shared their personal emotional experience of labour pain. Their fears, uncertainties, joys and desires for education and support from both family and caregivers were also emphasized. It was obvious from their experiences that information about pain relief and the use of both pharmacologic and non-pharmacologic methods of pain relieve were inadequate and or sometimes absent. Hannah said *“With my first experience I did not have any such thing as pain relief. I wasn't given any thing*

for pain, I had to endure”. Similarly Edith said *“I think the care you receive reduces the pain because at that moment the woman goes through a lot so if she does not get that little comfort it makes it painful”* To be honest they (midwives) never taught me anything about labour pain. All I know is from other people who had given birth before as well as my mother and mother in law”. Rebecca also had to endure the pain, she explains that *“I kept crying and calling for my mother so the midwife asked me if my mother will come and deliver for me? She (midwife) told me to exercise patience”* According to Olivia *“Nobody told me anything about how to cope with labour pain, I kept calling on God to deliver me. I called Aunty nurse so is there nothing you can do for me? I am suffering too much, I will die oo. Then the nurse said that nobody dies here”.* Esenam's experience was not different she also had to endure the pain. *I was just screaming in pain. I couldn't bear the pain at all. I felt I was going to die. I had nothing for the pain.*

Five narrative threads were identified in the study: perception of labour pain as severe and yet must be endured; the need for education and use of pain relief during labour; use of religion as a coping strategy; the strong desire for support during labour; and intuitive use of non-pharmacological methods of pain relief. Three of these threads are presented in this paper.

5.2. Labour is painful, I know I have to endure but I need pain relief

Embedded in the women's narrative accounts is the perception that labour pain is a severe form of pain associated with the natural process of birth that must be endured. All five women described labour as a very painful experience. The women held this perception before and after their first encounter with labour. Although during labour and at the height of their pain, the desire for pain relief was expressed, the inherent perception that a woman must be prepared to endure labour pain was not completely erased after birth. Perhaps the reason for this strong perception is the lack of accessible information about pain relief options available for a woman during antenatal. Coupled with this is the inadequate or absence of pain relief options during the labour experience. None of the women were given the option of pain relief before or during labour. Even when some forms of non-pharmacological methods were used they did not know that it was specifically for pain management. In all narrative accounts labour pain was described as severe using various adjectives. [Obuna and Umeora \(2014\)](#) conducted a study in Nigeria and noted that ignorance of available pain relief by women and cultural inclination, accounts for low request of pain relief during labour. They also suggested that the reluctance of attending health personnel to routinely offer pain relief when available account for poor utilization of obstetric analgesia.

Hannah had the highest number of deliveries among all five women. She was also the only one who had gone through the loss of a child at birth and had delivered at three different health facilities. Hannah's perception about labour and labour pain management was that labour is painful and must be endured. She had this perception before she experienced labour for the first time and after her fourth delivery she still held this perception. In her own words she said *“labour is very painful no matter how many times you go through”.* She described the pain with words like *“extraordinary”* and *“cut from a knife”.* Speaking about her second delivery she said *“the second one was a very different experience altogether. When I experienced the second delivery I found it to be more painful. It felt like a knife was being used to cut me”.* Hannah said the pain was different from any other pain she had experienced and as such, pain relief must be seriously considered as an option for women in labour.

The other women in the study shared similar experiences about their perception of labour pain, narrating how they also grew up with the mind that labour is painful and a woman must be pre-

pared to endure. In different ways, they recalled how they had been told to endure the pain because there was no relief: *“labour is so painful so ask God to give you strength to endure”, “I decided to endure the pain and probably cry a little”*. Edith stated: *“I also recall telling the midwife that second delivery is so painful. She replied by saying that you who have delivered before if this is what you are saying then what should a first timer say”*. The option of pain relief was not presented to Edith; it was all about enduring the pain. According to her, the pain was *“unbearable” “strong” “serious”*.

Rebecca had this to say: *“as a woman I had to endure, I didn’t have a choice”*. She described the pain as *“overwhelming”*. Olivia said *“labour is more painful than people even say it is... when I complained the midwife told me I should try and endure”*.

Esenam built her perception about labour right from age eight when she heard her mother shouting in response to labour pain while delivering at home. What she saw and heard the night her mother gave birth at home in the village gave her the impression that labour is a painful experience that could be endured. In her own words she says: *“all I knew was that it will be painful so I have to endure”*. She was not surprised when she was also told by the midwife to endure the pain.

The perception of labour pain as being different and comparable to no other pain as expressed by women in this study echoes what Wong (2009) said about childbirth pain. According to Wong, childbirth pain is one of the most severe types of pain a woman will endure in her lifetime. Similarly Gould (2000) also noted that most women report childbirth as being painful with some of them describing it as intolerable. The idea of childbirth pain being the most severe type of pain, intolerable, overwhelming, incomparable and unbearable as has been described suggests a pain that must be relieved rather than endured or tolerated. It is interesting that I did not come across any literature alluding to the fact that a woman must be prepared to endure labour pain. Although not well documented there is an acceptable notion in Ghana across the various cultural divides that labour is a painful process which women must be prepared to endure. Inability to tolerate pain in general is considered a sign of emotional weakness. It is an unconscious infusion of culture that indirectly becomes a part of the socialization process among many Ghanaians. In as much as I appreciate the cultural implications of endurance of pain as a sign of emotional strength, I am also aware of the agony some women go through and their desire for pain relief. Given the subjective nature of pain, the individual response to pain must be seriously considered. I am also not certain how such perception influences how Ghanaian midwives manage labour pain as they attend to women during birth.

Several decades ago when the concept of pain was not well understood, efforts were made through various means such as exorcisms, use of herbs and performance of rites to treat pain. This was later followed by the use of anaesthesia (Squire, 2000). Pillitteri (2007) argued that the idea of pain-free labour in the 1800s attracted a counter reaction due to the excessive use of sedatives and analgesics. The natural childbirth movement based on non-pharmacologic methods followed this. In as much as some women in Ghana do receive some form of pain relief, my submission is that women everywhere in Ghana must be educated on options of pain relief during labour. I strongly propose a more active use of non-pharmacological methods of pain relief, which has the additional benefit of providing emotional support with no side effect and at minimal financial cost to women in labour. The perception that women must endure labour pain is not supported by research and does not reflect the desires of women. Simkin and Bolding (2004) emphasised that the use of non-pharmacologic approaches aimed at both pain relief and prevention of suffering is consistent with midwifery practice and the choice of many women. Simkin and Bolding (2004) again stated

that suffering is different from pain and is not an outcome that is usually measured after birth. The aim of the midwife should not just be to relieve pain but also to prevent suffering, hence the use of non-pharmacological methods either alone or in combination with medication. This gap needs to be bridged by presenting Ghanaian women with options for pain relief.

5.3. Intuitive use of non-pharmacological methods of pain relief

Pain relief in this study was mainly non-pharmacological. Although women described the use of one non-pharmacological method or the other, they did not identify the coping strategies used as pain relief methods. Some of the actions described by the women such as massage, touch, breathing technique, movement, position change and support are documented non-pharmacological methods. In most cases the women just adopted and used these methods out of their own intuition, or because they had heard other stories from other women at home. These methods were not regarded by the women in this study as methods of pain relief but rather as strategies for coping. As a result none of the five women verbally mentioned the use of pain relief methods, neither were they consistent in the use of these techniques. It is interesting to note that women in this study on their own intuition used most of the non-pharmacological methods identified in literature (Brown et al., 2001; Simkin & O’Hara, 2002).

After delivery the women acknowledged that the methods helped them to cope with pain at all stages of labour. Hannah at several stages of her labour used a combination of methods and reported positive results. According to her *“I got a student who stood by me and kept reassuring me when I had contractions. She kept telling me I would be relieved within some short time... She would also rub my hands and engage me in conversation. She continued rubbing and stroking my body not necessarily where I was feeling the pains. This together with the conversation helped the pain to come down”*. In another account at different stages she described what she did: *“Each time I felt the pain I would lay on my left hand side and breathe through my mouth till the pain stops”* and *“I also observed a picture on the wall... so I kept looking at it... looking at it took my mind off the pain for a moment”*. Edith also described her experience by saying: *“I will just lie down and hold on to the bed tightly and cry a little till it stops then I will pace up and down for a while”* and *“pace up and down when it wears off until the time came to push”*. Rebecca also had this to say: *“At a point the pain was overwhelming, I did not know what was wrong with me but when the pain comes I will start running (laughing). As for running I run from one end to the other in the ward. The midwives shouted that I should stop but I just couldn’t. Also when I move about it made the pains bearable but I couldn’t lie at one place. Esenam: As for them (midwives) they came from time to time to tie my hand (check my blood pressure) but they didn’t do much for me. They just kept telling me to stop crying but I just continued because I was in pain. I never asked for anything to be done or medicine to be given and they also did not offer me any. I did nothing because I was told that, that is how it is. I just kept turning in bed and snapping my fingers when I felt the pain”*.

Olivia’s account also revealed the use of non-pharmacological methods of pain relief: *“I felt relieved when I stood up, the squatting also gave some relieve. As for lying on my left I couldn’t bear it at all but the nurses also kept telling me to lie on my left. They kept telling me to stop making noise else I would not be able to push when the time comes. The nurse said if I really want my baby then I shouldn’t make that kind of noise. I should try and endure. The nurses had a trolley by my bed so I kept hitting the trolley with my hand very hard. When the pain is severe I will get up and hold onto the drip stand by my bed firmly and groan”*. The intuitive use of non-pharmacological pain relief method was identified across all the narrative

accounts. [Abushaikh \(2007\)](#) commented that non-pharmacological methods can reduce the perception of pain and can be applied individually or combined. Non-pharmacological methods can be used by all women and at every stage of the labour process without any adverse effect to mother and baby ([Abushaikh, 2007](#)). The notion that control of labour pain and prevention of suffering is a major concern to both clients and caregivers by [Simkin and Bolding \(2004\)](#) could not be confirmed from the accounts given by participants in the study. This is because the concern by midwives to relieve pain was not reflected in the stories women shared. Additionally the view by [Simkin and Bolding \(2004\)](#) that the use of non-pharmacologic was the choice of many women could not be verified because the women were not presented with pain relief options and hence there was no choice. One major thing lacking was education on pain relief option that will enhance the consistent and confident use of non-pharmacological methods of pain relief. Although there is literature on pain management, from the labour pain experience narrated by these women, there seem to be a gap between research and practice which calls for further inquiry.

5.4. Support women through labour

The importance of support during labour has been documented in several studies. Continuous support has been identified as one important factor for a positive birth experience for women. It is suggested that the benefits of support are greater when the support person is not a member of the hospital staff. As expressed by the women in this study, as much as they would appreciate the support of midwives, they advocated for the support of a family person. These benefits include reduction in the use of analgesia, greater childbirth satisfaction and shortened duration of labour ([Hodnett et al., 2007](#); [Simkin & O'Hara, 2002](#)). [Wong \(2009\)](#) is of the opinion that all women deserve emotional support during labour whether by the partner, a family member, a non-professional or a professional staff member. Hannah's story like all the other women, highlights the benefit of support. In her first delivery she had the advantage of the support of her husband during the period she was home. Despite her wishes, her husband could not continue to be with her from the moment she got to the hospital. The setting of the labour ward did not favour the admission of a support person to be with the women during labour.

Hannah also recognised the lower number midwife to client ratio that contributed to the highly inadequate support she experienced. In another account during her third delivery she acknowledged the support she enjoyed from student nurses on duty and how helpful it was to her. All five women narrated various instances in their experience that they craved emotional support. Because I have personally experienced childbirth, I could relate to the experiences of the participants as each one shared her experience about lack or inadequate support during labour.

The control of labour pain and prevention of suffering are of major concern to both clients and caregivers ([Simkin & Bolding, 2004](#)). Edith's story emphasised the importance of midwives showing support through words of encouragement. She was of the view that although such gestures will not reduce or remove the pain, they contribute to the alleviation of suffering. Edith also advocated for the need to allow other support persons to be with women while in labour. During our post delivery conversation Edith reflected positively about the short visit by her brother-in-law during her first delivery and how it gave her some assurance and comfort to endure. In her plea for support from the midwives Edith made this assertion:

"If I had someone with me it would have helped. As you know when you are going through difficult times alone it is not easy but if there is someone with you, although you will still feel the pain the person's

presence will bring some encouragement". This notwithstanding, Edith acknowledged the challenge on the part of the midwives and said: *"Unfortunately they (midwives) were only two on duty and there were other patients... so you can imagine".*

Spousal support during labour may be determined by cultural as well as environmental factors. For the women in this study their husbands were not allowed in the labour ward because the labour ward setting did not provide much privacy to accommodate a partner. Contrary to what [Mullany \(2006\)](#) noted that husbands in Nepal are not normally accepted within the childbirth environment because of cultural and traditional beliefs. Husbands in this study were not allowed into the labour ward due to environmental factors. [Callister, Khalaf, Semenic, Kartchner, and Vehvilainen-Julkunen \(2003\)](#) also noted that Chinese women had support from a family member but not the father of the baby. On the other hand participants in this study did not have any family member supporting them. This is because it was not the policy of the hospital, and the labour ward setting could not accommodate a spouse or family member as a support person.

Although there is no evidence suggesting that the lack or inadequate support may have adverse effects on birth outcomes, the benefit of support such as reduced duration of labour, reduction of the use of pharmacologic pain relief and the reduction in obstetric interventions is clear ([Hodnett et al., 2007, 2011](#); [Simkin & O'Hara, 2002](#)).

In Ghana the use of non-pharmacological methods of pain relief is not foreign considering the fact that traditional birth attendants (TBA) trained or untrained are the first point of call for most pregnant women living in deprived parts of the country ([Smith et al. 2000](#)). Most of these TBAs are not trained in the use of medications such as pethidine or epidural among others. Although information gathered from people who have had encounters with TBAs indicate that some non-pharmacological methods of pain relief such as continuous support, constant reassurance and touch therapy are used, there is no documented evidence to this effect.

6. Conclusion

Using narrative inquiry methodology, five women in their third trimester of pregnancy were purposefully selected and engaged over a period of time. The cordial and non-judgmental relationships built between these women and I facilitated our conversations where they freely and willingly shared their labour pain experiences. Based on their narrations, I constructed narrative accounts for each participant. These accounts were then placed side by side to identify resonating threads that run across the stories. The threads were then discussed with reference to existing literature and lessons learnt were highlighted.

The findings of this study conclude that some women in Ghana do not receive adequate pain management during labour. Several factors may have contributed to this lapse in maternity care. Among these is the inadequate antenatal education on labour and labour pain management. Coupled with this is the lack of proper assessment of labour pain. The non-pharmacological method of pain relief that seems to be the major method of pain relief is not consistently used to reap the full benefit. Finally the support received from both the caregivers and family members is inadequate due to institutional barriers and possibly the lack of education for health care professionals.

As I return to the narrative accounts of my participants I want to emphasise that the learning brought forth was dependent on my strong relationship with each of them. While I identified narrative threads that resonated across their experiences, I sought to avoid generalisations of perceptions that are commonly accepted about

labour pain. Each woman's experience of childbirth is unique and each one of my participants wanted this to be recognised.

7. Recommendations

Based on the findings of the study I recommend that firstly, education on pain management should be strongly incorporated into antenatal health education by midwives. Secondly, protocol for pain management during labour should be developed by health protocol developers to serve as guidelines for practice. Thirdly, the support system for women in labour should be strengthened. This can be achieved by adopting a hospital policy that allows for a spouse or family member to be present with a woman during labour.

Conflict of Interest

None declared.

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