

Journey to Confidence: Women's Experiences of Pain in Labour and Relational Continuity of Care

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Introduction: An evaluation carried out at King's College Hospital Foundation National Health Service Trust in London identified that women who received continuity of carer from the Albany Midwifery Practice were significantly less likely to use pharmacological pain relief when comparisons were made with eight other midwifery group practices and the local maternity service as a whole. This study was designed to explore women's views of this phenomenon.

Methods: We conducted a thematic analysis of semistructured, audiotaped, in-depth interviews with 10 women who reflected on their experiences of preparation and support for pain in labour and midwifery continuity of carer with Albany midwives, using a qualitative descriptive methodological approach.

Results: Women reflected positively on how, throughout pregnancy and labour, their midwives promoted a sense of their ability to cope with the challenge of labour pain. This building of confidence was enabled through a relationship of trust that developed with their midwives and the value of hearing other women's stories during antenatal groups. These experiences enhanced women's ability to overcome fears and self-doubt about coping with pain and led to feelings of pride, elation, and empowerment after birth.

Discussion: Women valued being encouraged and supported to labour without using pharmacological pain relief by midwives with whom they developed a trusting relationship throughout pregnancy. Features of midwifery approaches to pain in labour and relational continuity of care have important implications for promoting normal birth and a positive experience of pregnancy, labour, and birth for women.

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INTRODUCTION

Support from caregivers who have a strong belief in women's ability to give birth without pharmacological pain relief has been identified as an important feature of midwifery practice, especially where a two-way trusting relationship can evolve.^{1–4} When women receive midwife-led continuity of care from a small number of midwives, they are less likely to use pharmacological pain relief in labour, are more likely to have an intervention-free labour and birth, and report an increased sense of control.⁵ This is significant in view of widespread concerns about rising intrapartum intervention rates, including the use of epidural anaesthesia and narcotics, associated with both physical and psychological morbidity.^{6–9}

Studies in a range of high-income countries have revealed that effective forms of pain relief are usually not associated with greater satisfaction with the experience of birth for women who have uncomplicated labours^{10–12} or with women's sense of psychological and physical well-being.^{13,14} Culturally diverse groups of women

have described childbirth as a difficult yet empowering experience, leading to a sense of achievement and feeling of pride in their ability to cope with intense pain.^{15–19} Women have identified that the way in which midwives supported and guided them through their pain, on their own terms, enabled them to feel confident and contributed to them feeling intensely positive about their capabilities and inner strength.^{16,17,20}

Anxiety about labour has been shown to be a predictor of negative consequences, including a lack of satisfaction with the experience of labour and birth and poor emotional well-being in the postnatal period,¹⁰ maximum pain during labour,²¹ and dystocia and emergency caesarean section.²² The number of women who are fearful of labour pain and who expect to have epidural anaesthesia has increased significantly in the last 2 decades,^{10,23} and some form of pharmacologic pain relief in labour has become the norm for women in Western maternity unit culture.^{24,25} This was highlighted in an evaluation at King's College Hospital National Health Service (NHS) Foundation Trust, London, which found that 84% of 3292 women undergoing in-hospital births in 1999 had some form of pharmacologic pain relief in labour.²⁶ However, a notable exception was reported. When compared to eight other midwifery group practices providing midwifery continuity of care at King's and the maternity service as a whole, the Albany Midwifery Practice had

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lower rates of intervention, and significantly lower use of pharmacological pain relief: 69% of women receiving care from Albany midwives did not use any pharmacological pain relief, compared to 18% in the other midwifery group practices and 16% who underwent in-hospital births (Table 1).

As part of the evaluation, a survey of women's experiences of care in the maternity service was undertaken. Women who received care from Albany midwives were more likely to know the midwives caring for them in labour well and to have continuous support in labour from these midwives. When asked if they had received adequate pain relief, significantly more Albany women said that they did not require pain relief (Table 2). The researchers suggested that one possibility for this difference might be the antenatal preparation and development of confidence that results because of the personal relationship that develops between a woman and her midwife during pregnancy. They concluded that the difference in women's opinions warranted further research and that this might make a valuable contribution to maintaining physiological childbirth.²⁶

This article reports on research designed in response to this recommendation. An in-depth exploratory study was undertaken to explore the experiences of a sample of women who received care from Albany midwives—in particular, how this care may have influenced how they approached and experienced pain in labour.

METHODS

Aim of the Research

This research was an extension of a study that took place at King's College London during 2005 and 2006, which aimed to gain an understanding of the processes at work within continuity of carer models that are associated with positive health outcomes. Continuity of carer is defined as each woman having care from the same two midwives through pregnancy, labour, birth, and the first few weeks postpartum. In the initial part of the study, 10 women who had received continuity of carer with Albany midwives consistently described how the trusting relationship they were able to develop with their midwives en-

abled a sense of calm and confidence that impacted positively on their experiences of pregnancy, labour and birth, and breastfeeding.^{27,28} In light of this finding and the previously identified recommendation to explore the Albany Midwifery Practice's low rates of pharmacological analgesia from women's perspectives,²⁶ a decision was made to interview 10 additional women to look more specifically at the perceived influence of the care they received on their experiences of preparation and support for pain in labour. A qualitative descriptive methodological approach was employed, this being the method of choice when straight description of phenomena is desired.²⁹

Setting

The Albany Midwifery Practice is a NHS community midwifery group practice that is based in a leisure centre in one of the most materially and socially deprived areas of London. The practice is composed of six self-employed midwives working under contract from King's College Hospital Foundation NHS Trust as an integrated part of the collaborative maternity services offered through this NHS teaching hospital. The midwives work in a caseload practice model, each midwife taking responsibility for the care of 36 women per year (plus 36 women for whom they provide care as a secondary midwife) from booking in early pregnancy through to 28 days after birth. Between 1999 and 2004, 95% of births at the Albany Midwifery Practice were attended either by a woman's primary or secondary midwife; and 85% of births were attended by her primary midwife.³⁰ Continuity of carer is possible because midwives are on call 24 hours per day, 7 days a week (apart from 3 months of annual leave).

The Albany midwives have been particularly successful in facilitating normal birth and home birth; over a 12-year period, 40% to 50% of women booked with Albany midwives have given birth at home. Women are encouraged to keep an open mind about the place of birth and to make a final decision either to have an in-hospital birth or to stay at home in labour if it is clear that their labour is progressing well without complications. Practice audit data from 1999 to 2004³⁰ show a high spontaneous labour rate of 90%; a relatively low caesarean section rate of 15.5%, of which 4% were elective; and high breastfeeding rates of 95% at birth and 72.5% after 28 days. These positive outcomes are particularly noteworthy, considering the level of social disadvantage of the population served and that local women of all risk levels are able to access the practice.

The Albany midwives have placed continuity of carer at the heart of their philosophy,^{31,32} and they have a track record of achieving high levels of continuity of carer.

Women and their partners are encouraged to attend the antenatal groups facilitated by the midwives where there is

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Table 1. Comparative 1999 Pregnancy and Birth Statistics: Albany Midwifery Practice

Pregnancy and Birth Data	Albany Practice (N = 206 Women and 208 Babies), %	King's Midwifery Practices (N = 1258 Women and 1290 Babies), %	King's College Hospital NHS Trust (N = 4044 Women), ^a %
Ethnicity			
White	42	43	46
Black	45	40	42
Asian and Chinese	9	4	5
Place of birth			
Home (including BBA)	43	11	7
Hospital	57	89	93
Attendance at birth			
Primary midwife	89	64	NA
Other Albany midwife	9	NA	NA
BBA	2	9	NR ^b
Birth outcomes			
Spontaneous vaginal birth	77	67 ^c	63
Caesarean section	18	24	25
Induction of labour ^d	5	10	11
Pain relief			
None	69	18	16 ^d
Use of pool at all	13	0.2	NR ^b
Entonox (nitrous oxide) at all	10	52	61 ^e
Pethidine (meperidine)	1	21	24 ^e
Epidural	17	25	35 ^e

BBA = birth before arrival (unattended home birth—baby born before the arrival of a midwife or doctor; includes planned hospital and planned home births); NA = not applicable; NHS = National Health Service.

Source: Sandall et al.²⁶

^aIncludes 752 women who gave birth at home with community midwives who were not in a group practice.

^bNot reported.

^cThis value is 73% if a group practice for high-risk women is excluded.

^dIncludes all births (spontaneous vaginal births, assisted births, and caesarean sections).

^eOf 3,292 women who had in-hospital births.

a focus on networking, information sharing, and valuing each other's expertise.^{20,31,32} There is no set agenda for these groups, and women can attend from early pregnancy as often as they want. Women and their

partners return to the group with their new babies and talk about their experiences of labour and birth and the early weeks of motherhood, and these stories provide a focus for discussion and learning.

Table 2. Women's Evaluations of Care During Labour

Survey Question (N = No. of Respondents, Varies by Question)	Albany Practice (N = 62) %	Midwifery Practices (N = 68) %	Kings Total (Core Staff, N = 52; Community Midwives, N = 49) %
Place of birth (N = 231)			
King's College Hospital	52	68	73
Home	48	32	27
Continuity of caregiver (N = 219)			
I knew one (or more) of the midwives well	92	52	48
I had not met any of the midwives before	2	25	38
Continuous support in labour (N = 218)			
One midwife with you all the way through your labour?	93	79	76
Women's views of pain relief in labour (N = 209)			
Did you feel you were offered adequate pain relief in labour?			
No pain relief required	49	15	24
Yes	47	79	70
No	4	7	6
Enough information was given in labour about the type of pain relief chosen	86	88	89

Source: Sandall et al.²⁶

Sample

Following institutional review board approval for an extension of the initial study from the local research ethics and research and development committees, time constraints dictated that a process of purposive heterogeneity sampling was the most appropriate method of recruitment. The Albany midwives identified women for whom they had recently provided care; who had experienced a spontaneous vaginal birth; and who represented a cross-section of women in terms of age, socioeconomic background, and ethnicity. The women were given an information sheet by the midwives and gave permission for the researcher to contact them to discuss their potential participation in the research before giving written consent. All the women had been recently discharged from midwifery care at 4 weeks postpartum.

Data Collection

The women participated in audiotaped, face-to-face interviews with one interviewer (N.L.). The interviews were conducted in the women's homes in privacy and lasted approximately 60 minutes. Each semistructured interview began with an invitation for the participant to describe her experiences of care from Albany midwives while reflecting on how the midwives may have influenced how she approached and experienced pain in labour. This invitation was repeated as necessary as the women described their experiences of pregnancy, labour and birth, and new motherhood. There were no other specific interview questions; further questions were reserved for clarification purposes. Each woman chose a pseudonym; whenever the participants mentioned family members or midwives, these names were also substituted with pseudonyms in the transcripts.

Data Analysis

Audiotapes of the interviews were transcribed verbatim and checked for accuracy by the interviewer. The tran-

scripts were then formatted and coded by another researcher (S.B.) who collated the data in a table-formatted document in identified themes. The interviewer also identified themes in a separate process and comparisons were made. Consensus was reached about themes, and minor adjustments were made in the organisation of the data under thematic and sub-thematic headings.

RESULTS

Table 3 identifies the participants by their chosen pseudonym, age, parity, ethnicity, place of birth of their baby, and whether or not they had a supportive partner.

Overview of Findings

Women reflected positively on how, throughout pregnancy and labour, their midwives promoted a sense of their ability to cope with the challenge of labour pain. This building of confidence was enabled through a relationship of trust that developed with their midwives and the value of hearing other women's stories during antenatal groups. These experiences enhanced women's ability to overcome fears and self-doubt about coping with pain and led to feelings of pride, elation, and empowerment after birth. These findings are presented under the major themes that were identified in the analysis.

Building Confidence During Pregnancy

The women in this study described a process of building confidence in their ability to labour and give birth without using pharmacological pain relief that was mediated by a trusting relationship with their midwives. This began at the booking visit, which was held in the women's homes, and usually lasted a couple of hours. Women described the way the midwives engaged with them about their questions and worries, including initiating discussions about pain, in a way that "didn't talk down to you" (Sharon).

The "two-way" relationship of trust that developed during pregnancy was described using phrases like,

Table 3. Characteristics of 10 Women Who Received Midwifery-Led Continuity of Carer With Albany Midwives

Name ^a	Age, y	Parity	Ethnicity ^b	Place of Birth	Supportive Partner
Angela	25	Second baby	Black Caribbean	Hospital (first baby born in hospital)	No
Favour	23	First baby	Black African	Hospital	Yes
Isobel	30	Second baby	White British	Home (first baby born at home with Albany midwives)	Yes
Izabella	31	First baby	Polish	Home	Yes
Jo	34	First baby	White Canadian	Home	Yes
Lily	34	First baby	White British	Home	No
Linda	31	Second baby	Black African	Home (first baby born in hospital)	Yes
Millie	37	Second baby	White British	Home (first baby born in hospital with Albany midwives)	Yes
Sharon	17	Second baby	Mixed race	Hospital (first baby born in hospital)	No
Susan	38	First baby	White British	Home	Yes

^aPseudonym chosen by participant.

^bAs defined by participant.

“feeling really close to them,” “like sisters,” or “friends” who were “just as happy as you are when the baby comes.” Although many of the women described the midwives as their “friends,” there was recognition of the importance of the midwives’ expertise and their professional role of guidance:

“They’re always one step ahead, leading you very, very carefully and gently” (Susan).

It mattered to women that their midwives seemed interested in them and their baby. This contributed to building self-confidence:

“The midwives encouraged me a lot, they talked to me a lot and made me feel that I was OK, and I’m strong, and the baby is a happy baby. Through the pregnancy they made me feel that pregnancy is a good thing and interesting to them, you know? So they made me feel...everything about me is something that I can do” (Favour).

Women linked their growing confidence to the way their midwives shared information and discussed choices with them in a “calm” and “open” way. They described them as “knowledgeable,” “experienced,” and “knowing the evidence”: qualities that helped women prepare for labour and opened up possibilities such as labouring in water and adopting different positions to ease pain. Women described feeling reassured by discussions that centred on the nature of pain in labour and strategies for coping with pain:

“They were explaining it’s not like other pain... they were talking about [how] it’s manageable pain... to be honest, I was so educated I kind of knew what was going to happen, even though I’d never had a baby. So it was really reassuring, really reassuring” (Izabella).

Continuity of Carer: “Knowing Who Would Be There in Labour”

Women used words like “feeling at ease” and “comfort” when describing how important it was to them during pregnancy to know the midwives who would be there during labour and birth:

“You just find instant comfort, and you know that no matter what happens they’ll be there. That was really important. I think that’s the biggest thing: that you’re not going to be stuck with somebody that doesn’t care, or changing people, not tons of different faces. You’ve got the same people all the way through” (Jo).

Building Confidence to Give Birth at Home

Most of the women who gave birth at home would not necessarily have chosen that option, but they explained how

their midwives encouraged a “wait and see” approach: “If your labour is progressing well, we can stay at home. If you need help, we will go to hospital.” The midwives gave the women the opportunity to reconsider the commonly held view that birth in a hospital is always the safest option:

“She never pushed me saying, that is the best, she always gave me the choice, and she said, birth either in the hospital, either in the house, she just let me know that it’s my choice, she just said the advantages of it, and to be honest, after researching it and obviously going to antenatal groups, that convinced me 100% that that’s what I wanted to do” (Izabella).

The option of giving birth at home was possible for women because they trusted the expertise of their midwives. Discussions with their midwives enabled women to face their fears, in some cases enabling significant differences in their thinking about their capabilities and the type of birth they wanted:

“As time went on I became very clear that I didn’t want the elective caesarean and actually I went to the other end of the spectrum...I was very clear that I wanted a home birth, I didn’t want any intervention unless it was absolutely necessary” (Lily).

Learning From Other Women’s Stories in the Antenatal Group

Up to 50% of women who receive care from Albany midwives attend the antenatal groups that the midwives facilitate. All of the women in this study—and several partners—attended these groups, which are also open to women who are not receiving care from Albany midwives. Women can attend as often as they like throughout pregnancy, and the focus is on sharing information and promoting social support. The groups start with a round of introductions, and then women raise the issues that are most important to them. Discussion is focused around the diverse stories told by women returning to the group with their new babies.²⁰ The value of this approach was reiterated frequently:

“The group covers everything—everything from multiple births and caesareans to babies being delivered on their own on the carpet, you name it, you’ve heard about it when you’ve been there a while. There’s a very good feeling there, everyone encourages each other, and everyone’s very open, and you feel free to talk about anything, which is absolutely brilliant” (Isobel).

Some women remembered other women’s birth stories when they were in labour and this gave them a frame of reference that was useful when they were finding it hard to cope with pain:

“Sometimes I thought, ‘Am I going to make it,’ you know? Am I going to make it? How is it going to be? How am I going to cope? But on the other hand, I remember, it’s like flashing back and I remember all the experiences being shared by other women, which makes me feel strong, strong again” (Favour).

The Albany midwives always attend births in pairs. One of the roles of the second midwife is to take photographs of labour and birth if the woman wants photographs to be taken. Many women proudly agree to their photographs being shown by the midwives in the groups, a practice that several women described as transformative:

“Somebody came in [to the antenatal group] with their birth photos, and that changed my whole head space, and kind of how I viewed what was going to be a birthing experience after that. She talked very passionately about her birth, the good bits and the bad bits, and we got to see all the kind of...the head coming out, and blood, but it was so endearing and so truthful that it was obviously very empowering as well. So rather than being shocked and horrified, I felt a bit more prepared for what might be in store” (Isobel).

Support for Coping With Pain During Labour

The level of confidence that had built up during pregnancy affected how women coped with pain during labour. Again, this was expressed in terms of trusting the midwives—in particular, their reassurance:

“I think it depends on knowing the midwives so well because they do make you feel quite at ease, because if you’re scared and you haven’t got anyone reassuring you, you’re just panicking and it hurts a lot more” (Sharon).

Words of encouragement and reassurance from their midwives were an important feature of the memories women had of their labours. Even when labour presented challenges, women referred to the midwives helping them to “stay calm” and believe in their abilities:

“All throughout, she said to me, ‘You’re coping fine Linda.’ I felt assured...that was how she was making me feel calm...” (Linda).

“They kept telling me that although it was painful, the contractions were actually doing something, they were bringing the baby down and they were bringing the baby out, and that’s really helpful...Just people saying things that made you believe you really can do it” (Millie).

“She Believed in Me When I Didn’t Believe in Myself”

Women who gave birth in hospital laughed as they told stories of begging for “pain relief” for a short while during

the transition phase of labour, but being pleased that their midwife had encouraged them to continue without having an epidural:

“I was requesting for caesarean, I was requesting for everything! Because I just wanted to get over with it. I just said I was going to die. At one point I felt like I was going to faint, and stuff like that. I said, ‘Please Sandra, I want pain relief.’ I was actually begging her, ‘Please, please, please.’ I said, ‘I’m going to die! I won’t be able to do this! Do you want to kill me?’ Stuff like that. I said to her as well, why is she doing this to me? I said, ‘What are you doing to me Sandra, don’t you like me or something?’ Just because I wanted her to feel guilty! I went on and on at her! I just kept on going!” (Angela).

Women described their midwives being confident to work with them in this way because they knew them well and had discussed their wishes in-depth during pregnancy.

Pride and Elation After Birth

Such stories of transition were juxtaposed by the same women giving descriptions of elation and pride following the baby’s birth, as described here by the woman who was quoted above:

“As soon as he was born the pain stopped, immediately. I felt strong. I felt like...I’ve done it! I felt great about myself that I didn’t have to go through all that unnecessary drugs” (Angela).

Women consistently linked their pride about coping with pain to feeling strong and confident and to a positive start to new motherhood. This was particularly evident in the stories told by women who had doubted their abilities during labour and had been encouraged by their midwives to continue labouring without pharmacological pain relief:

“So I was brave! I was strong...So I was like, ‘Yes, I have done it! Yes, I can do it!’ I was so happy. I honestly never had this kind of joy since I was born. I don’t know where this joy came from. I don’t know how to describe the endless joy that came in me...I can’t really explain. I’m very pleased, very pleased, that I did it naturally. I feel so proud, full of myself, I’m very proud to have him naturally. I’m very proud even now” (Favour).

IMPLICATIONS FOR PRACTICE

Systems That Promote Relational Continuity of Care

This small study contributes to understandings of why midwifery continuity of carer is associated with reduced

use of epidural anaesthesia in labour and positive experiences for women.^{4,26,33–35} Although on-call arrangements in many midwifery group practices may not allow the same high levels of intrapartum continuity of care offered by the Albany midwives, studies identifying women's experiences of their care consistently provide qualitative evidence to encourage the development of similar midwifery caseload models and approaches to practice.^{4,26–28}

Women described a complex set of interrelated factors that contributed to them building confidence about their ability to cope with pain in labour and to considering giving birth at home. Continuity of carer with two midwives, combined with the midwives' approaches to practice and communication, enabled confidence through a two-way relationship of trust that evolved: women trusted the expertise and advice of their midwives and, equally important, they felt that their midwives trusted them to be able to labour without pharmacological pain relief through drawing on their own resources and strengths. These findings are similar to those of a large-scale, long-term, multiperspective evaluation of caseload midwifery practice in the United Kingdom, which identified the building of confidence, reciprocity, and relationship in the context of "knowing and being known."³⁶ It may be that the reduction of anxiety and reassurance that women describe in this and other studies^{4,28,36} contributes to the building of confidence and the biobehavioural state of calm and connection associated with increased oxytocin, well-being, and uncomplicated birth.^{37,38}

Preparation for Pain in Labour

Women valued learning from other women's stories in the antenatal group and from looking at their photographs of labour. Birth stories can create bonds between women and inspire confidence³⁹; it seems that information is absorbed differently and remembered when it is attached to real people—as opposed to factual information that is given in the abstract.²⁰ There is a paucity of evidence to identify how antenatal preparation can meet the needs of parents.⁴⁰ Further research is required to identify how antenatal groups, such as the ones described by women in this study, and the sharing of photographs, may be important components of midwifery continuity of care in terms of building women's confidence as they approach labour and new motherhood.

Women spoke positively about how the midwives engaged with them during pregnancy about pain. It has been suggested that women are not prepared adequately for the likelihood that they will need some form of pain relief, that labour is often more painful than expected,^{25,41} and that many women who had not wanted it end up having epidural anaesthesia.¹⁰ Recommendations that women should be better informed about the range of pain relief options during pregnancy tend to focus on the provision of evidence-based information about how to re-

lieve pain.^{42,43} The underlying message women receive may suggest that the option of coping with pain is unrealistic and that the most sensible option is for women to place their trust not in themselves, but in the relative certainty of pain relief offered by epidural anaesthesia. The alternative approach is to focus on building women's confidence around coping strategies for working with pain and reducing anxiety as described here.^{44–46}

Support for Coping With Pain in Labour

Over the last decade, the question of whether evidence supports the need to provide midwifery continuity of care with an intrapartum component has been hotly debated.^{47,48} In this study, the value of having a known and trusted midwife in labour was strongly articulated. Importantly, the relationship of trust women had with their midwife meant that she was able to counteract their requests for epidural anaesthesia with encouragement, convincing them that they could cope with the pain—something for which they were grateful in retrospect, expressing feelings of pride and empowerment related to confidence in their abilities. This is a controversial area of practice, raising uneasy questions about the potential for misjudgement on the part of midwives—particularly where they do not know the woman and have not been able to discuss potential reactions to pain in transition—and the need to respond to women's choices, rather than work with them in a dynamic way.⁴⁹ In the United Kingdom, there is a policy imperative for all maternity care providers to "consider how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice."⁴² This is not straightforward when the choice a woman makes to labour without pharmacological pain relief changes when she is in pain. What is clear, both from this study and others, is that the attitudes of caregivers and labour companions or doulas play an important role in how women are supported to cope with pain in labour,^{11,50} particularly when they are doubting their abilities and need encouragement. Complex challenges about the roles and practices of both midwives and doulas in the absence of midwifery continuity of care will no doubt continue to be explored in the interest of encouraging individual women to have a positive experience around pain in uncomplicated labour.

Limitations of the Study

This small, descriptive study contributes to understandings of the role continuity of carer may play in helping women to build their confidence about how they approach pain in labour. Because the other midwifery group practices at King's College also provide continuity of carer, a larger, comparative study, with an observational component, would be needed to identify how the approaches of

midwives, including their communication and the various characteristics of the model they provide, affect the experiences of women in relation to pain in labour.

CONCLUSION

Women valued being encouraged and supported to labour without using pharmacological pain relief by midwives with whom they developed a trusting relationship throughout pregnancy. Features of midwifery approaches to pain in labour and relational continuity of care have important implications for promoting normal birth and a positive experience of pregnancy, labour, and birth for women.

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