



## EXPERIENCES OF WOMEN DURING THE PROLONGED LATENT PHASE OF LABOR IN A SOUTH-SOUTH TEACHING HOSPITAL, PORT HARCOURT, NIGERIA

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**ABSTRACT:** *Background & aim: The latent phase of labour lacks uniformity in its definition and is complex to understand. This phase is often overlooked and does not get the attention it requires despite the advances in maternity care because it is difficult to differentiate it from false labour. The onset of labour is subjective and there is need for collaborative effort to diagnose the prolonged latent phase of labour. The overall aim of this study was to explore the experiences of women during the prolonged latent phase of labour. Methods: A phenomenological qualitative design was used, in-depth interviews (IDIs) and Key informant interviews (KIIs) were conducted and in addition a self-administered questionnaire which contained the consent form and socio-demographic data was administered for both interviews. Five primiparous and multiparous women and three midwives were interviewed. The interviews were tape recorded in addition to note taking and observation of the respondents. Data was analyzed thematically. Results: 4 themes (labour onset and duration, labour experience, coping strategies, care and outcome) were identified from the study. Conclusion: The prolonged latent phase of labour is related to caesarean section and neonatal admission in Sick Baby Unit (SCBU), although the experience is not palatable, having a positive birth experience depends on the type of intrapartum care given by the caregivers during the prolonged latent phase of labour.*

**KEYWORDS:** Prolonged Latent Phase, Primiparous, Multiparous, Thematic, Intrapartum

## INTRODUCTION

The first stage of labour according to the World Health Organization is the time from the commencement of contractions to full dilatation of the cervix, the stage is sub-divided into the latent phase and the active phase of labour and currently, there is little concession to the limits of the latent period of labour. Consequently, it is suggested that mother's ought to be educated that a standard length regarding the latent first stage has not been built up and can shift broadly from one individual to another (WHO, 2011, 2018)

The latent phase is considered to be the time between the onset of contractions to cervical dilatation of 3-4cm during which time the cervix becomes completely effaced, contractions occur more often, becomes stronger, and becomes more regular (Holmes & Baker, 2006,



Gbaboro *et al*, 2006) were very specific in their meaning of the early labour which incorporates uterine contractions every 10 minutes or longer with the cervical dilatation < 3cm with little or no effacement (Incerti *et al*, 2011). said the stage differs from one individual to another and from labour to labour, it is once in a while portrayed as the “early” or “passive” first stage, may take a few days or be as short as a few hours and that the phase is often overlooked and does not get the attention it requires despite the advances in maternity care. There is a lack of consensus in the available literature regarding the duration of the latent phase of labour, and it has been described to range between 2-20 hours depending on parity (Blix *et al*, 2008, Abalos *et al*, 2018) According to Gabba, Steven, Niebyl, Jennifer & Simpson (2007), the prolonged latent phase of labour is defined as when the latent phase of labour lasts longer than 20 hours for a nulliparous woman and 14 hours for multiparous woman before entering into the active first phase of labour.

The latent phase of labor is complex, not completely understood and lacks uniformity in its definition and this makes its diagnosis problematic (Rhoades & Cahill, 2017). It is often difficult to differentiate the latent phase from false labour therefore, the usefulness of recording the latent phase of labour in the partograph was questioned. It was then removed from the WHO partograph that was modified in year 2000 and is currently in use (Mathew *et al*, 2007, Engida *et al*, 2013). The determination of the onset of labour and its experience is too subjective and there are limited studies on the prolonged latent phase of labour but women are being sent home at times in early labour with the claim that their labour has not been established and they are unable to discern which stage or phase they are in. Some of them stay longer at home even with obvious signs of labour because of their previous experience of neglect in early labour or being sent back and they end up having some complications therefore, a more collaborative approach is required for the diagnosis of the prolonged latent phase of labour because the recognition and management of this phase may reduce the risk of obstetric interventions and caesarean section (Greulich & Tartant, 2007, Karn, 2007).

## METHODOLOGY

### Study Setting

This study was conducted at the University of Port Harcourt Teaching Hospital, Rivers State. The study was carried out in the post natal ward of the hospital which is a sub-unit in the obstetric and gynaecology unit. The post-natal ward is for mothers who have just delivered till discharge and an average of 110 women are admitted monthly.

### Study Population

The study population comprised of both primiparous and multiparous women who had experienced the prolonged latent phase of labour.

### Inclusion Criteria

1. Post natal women who gave birth at term and had prolonged latent phase of labour.
2. Women who gave birth 0 – 6weeks ago.
3. Midwives working in the labour ward.



### **Exclusion Criteria**

1. Women who were induced before labour started.
2. Mothers whose baby presented other than cephalic.
3. Mothers who had stillbirth.
4. Midwives who had spent less than 5 years in the labour ward.

### **Study Design**

A Phenomenological qualitative design was used for the study. This design aided in providing in-depth understanding of the women's experiences of the prolonged latent phase of labour.

### **Sample Size Determination**

For phenomenological studies, 3-10 participants are recommended (Creswell, 2014). However, data collection ends when data saturation is reached and for this study data saturation was reached with the fifth respondent as no further information was added.

Midwives were also interviewed as key informants to buttress the type of care given to the women during the prolonged latent phase of labour and data saturation was reached with the third participant. Therefore, 8 respondents participated in the study altogether.

### **Sampling Method**

Purposive sampling was used for the study. Women who had experienced the prolonged latent phase of labour and met the eligibility criteria were specifically identified and selected through their folders at the post-natal ward.

Purposive sampling method was also used for the midwives i.e those that were met on duty and that also met the eligibility criteria were interviewed.

### **Study Instrument**

Three instruments were used in this study i.e the questionnaire and the interview guides.

The first instrument was a self-administered questionnaire which consisted of two sections namely the consent and the socio-demographic data sections.

The second instrument was the interview guide for the In-depth interview (IDI). It contained open-ended questions on perception of the prolonged latent phase of labour, duration, symptoms, care/management and support, the coping strategies employed during the prolonged latent phase of labour and finally, the outcome of labour.

The Key informant interview guide (KII) for the midwives was the third instrument. It helped to address what happened to women during the prolonged latent phase of labour and the pharmacological and non-pharmacological interventions available for them.

### **Data Collection Process**

The participants were selected at the post-natal ward of the University of Port Harcourt Teaching Hospital. Consent was taken and appointments for the interviews were made based



on the respondent's convenience, the venue and time was also agreed on. Interviews were audio recorded in order to ensure that all the information the respondents (both the IDI and KII) had said were all captured for analysis, notes were also taken by a research assistant to allow the researcher to concentrate on the interview and allow a flow of conversation with little or no interruptions from the interviewee and to also observe the participants reactions and body language. Each interview lasted for about twenty minutes. Each interview was transcribed verbatim from the tape recorder which enabled familiarity with the contents of each interview.

### **Duration**

### **Data Analysis**

The thematic method of analysis was used where themes were generated to capture important information about their experiences. The broad themes were narrowed down for further analysis - using color coding through each transcript. The analysis followed the six phases described by Braun & Clarke (2006). Phase 1 – Familiarity with the data, Phase 2- generating initial codes, Phase 3 – searching for themes, Phase 4 – reviewing themes, Phase 5 – defining and naming themes, Phase 6 – providing the report. Generalization of the phenomenon was made after data analysis.

### **Ethical Approval/ Consideration (for both IDI and KII)**

#### **Ethical Clearance:**

The ethical approval was gotten from the research ethics committee of the University of Port Harcourt and the University of Port Harcourt Teaching Hospital.

#### **Permissions & Consent:**

Appropriate permission was taken from the matron in charge of the maternity unit as well as the Nurses on duty. Wilful consent was sought for from the respondents. Information letter/Consent Form was given to the participants (mothers and the midwives) to fill.

#### **Confidentiality:**

- i. The participants were assured of confidentiality of the information given.
- ii. Their names were not used and was not required during the interview.
- iii. The interview was kept strictly confidential and was available only to those involved in the study, i.e. researcher, research supervisors.
- iv. The recorded interview and the notes taken was kept secured and will be discarded when no longer needed.

#### **Privacy Risks:**

A quiet place was provided at the side of the ward for the interview by the duty nurses to prevent interference/ distractions during the interview and to provide privacy of information. The procedure was a non-invasive one as such there was no risk. None of the participants had recall of a traumatic labour experience and so none required referral to a psychologist for expert care.



## RESULT AND ANALYSIS

**Table 1: Socio-Demographic Characteristic of Respondents (IDI)**

Variable	Total (n=5)
<b>Marital Status</b>	
Married	5
<b>Level of education</b>	
secondary	1
tertiary	4
<b>Number of times pregnant</b>	
1	2
2	1
3	2
<b>Number of children alive</b>	
1	2
2	3

For the IDI, all five of the respondents were married, four had tertiary education, two were primipara, two got pregnant for the third time and three gave birth the second time.

**Table 2: Socio-Demographic Characteristic of Respondents (KII)**

Variable	Total (n=3)
<b>Marital Status</b>	
Married	3
<b>Work experience (years)</b>	
5	2
10	1
<b>Designation</b>	
Principal nursing officer	2
Senior nursing officer	1

From the KII data, all three of the midwives were married, they were all experienced and had spent 5-10years in the maternity unit.

The data analysis revealed four main themes. These were made up of a number of sub themes.

**Table 3: Themes and Sub-Themes**

THEME	SUB THEMES
1. Labour onset and duration	A- Description of the onset of labour B- Fear of prolonged hospital stay C- Hours of labour before active phase began
2. Labour experience	A- Education/knowledge about condition B- Symptoms C- Care givers attitude



3. Coping strategies	A- Exercise and activities B- Lack of knowledge of non-pharmacological techniques to be used in labour
4. Care and outcome	A- Obstetrician and Midwifery care B- Support system C- Outcome of labour

## Results

### A. Description of the Onset of Labour

All five of the multiparous and primiparous women were able to recognize the onset of labour. They were able to describe the onset of their labour through the symptoms they had and the signs seen. Therefore, all the women were definite in their recall of how labour started.

*A respondent said "at first the labour began on Sunday afternoon... ..didn't observe the time, ... .She said I will see something like catarrh, at that point I had pains around my waist and tummy, the pain was now severe, so when that pain started, I knew it was labour..... I went to ease myself and I saw something like catarrh". (Participant 1)*

*Another said "on the 18<sup>th</sup> Tuesday was when I got show in the morning like around 7am, followed by mild contraction." (Participant 3)*

*On Thursday 26<sup>th</sup> March I didn't even know that it was labour at first. It started around 9am so I could not sleep I was having this kind of pain and the pain will come very little time it will stop, it will come, it will stop". (Participant 2)*

*"I was having contraction before I saw show, it was like 7pm, show 8pm". (Participant 5)*

### B. Fear of Prolonged Hospital Stay

Four of the five women had confidence staying at home and delayed in coming to the hospital because they didn't want a long hospitalization.

*A participant reported "I got show on Tuesday, on Wednesday I went to the hospital. I had confidence to stay at home because of my past experience, I'm no longer a learner." (Participant 3)*

*Another said "I did not come to hospital early so I won't stay long... my own was that I did not want to get there and stay long, but at the end I stayed longer". (Participant 1)*

*Another said "I didn't want to stay long in the hospital, I went to the hospital in the evening...I prefer staying at home than to stay in the hospital and the people at home will be anxious and expecting". (Participant 5)*

### C. Hours of Labour Before Active Phase Began

Based on the women's report and the findings from their folders, their latent phase was 18 hours and above which is an indication that the phase was prolonged.





From the record in her folder, it took the 1<sup>st</sup> participant more than 24 hours. She said *"the labour began on Sunday, it was not too severe but as at Monday, it became very severe. I endured the pain till Monday evening that I went to the hospital. I was in agonizing pain all through that Monday till Tuesday morning.... the dilatation was crawling from 2cm to 4cm Tuesday morning"*. (Participant 1)

With the records from the folder of the 3<sup>rd</sup> respondent, she was diagnosed of prolonged latent phase of labour after 48 hours of labour onset and was taken to the theater for emergency caesarean section. According to her *"I got show on Tuesday around 7am, on Wednesday I was taken to the hospital, Thursday I was taken to the theater. What the doctor said was that my cervix was not opening at all."* (Participant 3)

Another said *"I woke up at around 3am and saw water just little...but in the evening I went to the hospital...at that time I was feeling pains around my waist very mild....in the evening of the second day that should be Friday....the pain has intensified at intervals....water was still coming out...the midwife checked my vaginal it was 1cm dilated. That same night it was about 3cm before I was taken to the theatre"*. (Participant 4)

## **Labour experience**

### **A. Education/Knowledge about Condition**

According to the women's self-report, all 5 of the women were not taught about the latent phase during antenatal / clinic (ANC) classes, they were not also educated about the phase or what they were going to go through during labour. But according to the midwives, they are taught at ANC and also educated while on admission.

All the women interviewed did not really have a clear-cut understanding of the care that was given to them. When asked if they were educated about the phase and that it could be prolonged, their responses were:

*"There was nothing like that, each time I was checked it's madam you have not started. It was not mentioned during the ANC"*. (Participant 3)

Another said *"they did not mention it during ANC but a midwife I met in the first health center I registered said early labour can be fast and it can be prolonged depending on individuals"*. (Participant 1)

Another said *"they did not educate me."* (Participant 2)

### **B. Symptoms**

#### **i. Pain/ Irregular Contraction**

Three of the women experienced some degree of pain as a starting point. The nature of all the women's pain was similar and indescribable, the intensity also increased with time. All the respondents had irregular/ weak / mild contractions initially and same increased with time.

A participant said *"I was having this kind of pain that was off and on. When I got to the labour room the pain was serious, it will come, and it will go. I wasn't comfortable around my waist.... Contraction was not regular; it was weak not strong"*. (Participant 2)



Another said *“the contraction was mild initially, then with time the contraction increased or started fully at 11pm the following day and it did not stop from that 11pm till the next day I was taken to theater. When the contraction was much, I was not resting..... Pain started from the stomach turns round, don’t know how to describe it, it doesn’t have description”*. (Participant 3)

Another said *“...at that time I was feeling pains around my waist and it was very mild...contraction wasn’t that strong, I knew it wasn’t enough to bring the baby out, I knew it has not gotten to the peak”*. (Participant 4)

Another said *“when I got to the hospital, contraction stopped that 1am. Then started again 1pm till I delivered”*. (Participant 5)

## ii. Show

Four of the five women had shown at the onset of labour or shortly after. *“I saw a discharge like catarrh, it was much”*. (Participant 2)

Another said *“the first sign I got was show”*. (Participant 3)

Another said *“I went to ease myself and I saw something like catarrh”* (Participant 1)

Another said *“I saw show an hour after contraction started.”* (Participant 5)

## iii. Other Symptoms

From the study, four of the women had water break, all five had backache, insomnia and loss of appetite, one had restlessness, stomach cramp and one vomited during the phase.

A participant said *“I wasn’t comfortable around my waist, I felt like urinating and defeacating but I couldn’t, I saw a little water 9am that Thursday. I did not sleep; I was having backache and stomach cramp. I did not feel like eating”*. (Participant 2)

Another said *“...My water was leaking already when I got to the hospital.... I didn’t eat, there was no appetite”*. (Participant 3)

Another person’s account was *“.... the pressure was much, it was serious...I did not sleep, I didn’t close my eye. When I requested for food I could not eat, then later in the process of the labour, the little I could eat I vomited it”*. (Participant 1)

## C. Care Givers Attitude

All the women were pleased with the attitude of the caregivers towards them despite the slow progression of their labour.

A participant said *“they were always checking on me as in after sometime..., when they discovered there wasn’t any reasonable progress, their attention was now on me and they became very serious.”* (Participant 1)

Another said *“they were really caring, they tried... I did not feel neglected.”* (Participant 2)





Another said *“yes they were supportive, they checked me, they encouraged me, and tried to calm me down...they were friendly and encouraging.”* (Participant 4)

## **Coping Strategies**

### **A. Exercise and Activities**

The women engaged in different activities at home and in the hospital, three washed, three cooked, two cleaned their houses, two engaged in exercise such as walking around (although their movement was restricted in the labour room due to ruptured membrane), one engaged in breathing exercises and all the five women rested i.e. lying down.

A participant said *“I was just resting, lying down and resting, there was no one to rub my back now, I was just wallowing in pain, did breathe in and breathe out exercise.”* (Participant 3)

Another said *“nobody to help me, actually I really washed, I washed a lot, after washing I just lie down. In the hospital, I was walking up and down, if I walk awhile, I will lie down, I wasn't comfortable lying down.”* (Participant 2)

Another said *“even with the pain, I managed to cook vegetable soup, I cleaned my house, I still cleaned the toilet. In the hospital, I did not sit down, I was just calling on my God. I walked and lay down..... they will always ask me why are you coming down, I will say I want to go and ease myself even when I don't feel like”.* (Participant 1)

Another said *“what really helped me was that I was just lying down on the bed to ease the pain, I think that was the best position for me.”* (Participant 5)

### **B. Lack of Knowledge of Non-Pharmacological Techniques to be Used in Labour**

All the women seemed not to have the knowledge of the use of diversional therapy (e.g. watching of TV), relaxation techniques, changing of position, warm bath, playing of games, watching of films, and rehydration by drinking of water etc. as a form of management of labour. They just concentrated on their pain in the hospital. Three of the five women drank water, two had warm baths. Also, support persons were not allowed into the maternity unit hence, they were not able to provide non-pharmacological care such as rubbing of the abdomen, rubbing of the lower back, provision of psychological care etc. was impaired.

A participant said *“I did not watch T.V, T.V was not my problem, I ate, drank water and after eating I went to take my bath”* (Participant 5)

Another said *“early morning around 5am, they said I should take my bath...I said bathing is not my problem...if I had known, I would have taken my bath. I did not watch T.V.”* (Participant 1).

Another said *“I just rested, I didn't watch T.V, and I was just wallowing in pain”.* (Participant 3).



## Care and Outcome

### A. Obstetrician and Midwifery Care

The women did not really have a clear-cut understanding of the care that was given to them. None of the women were given pain relief as well, all the women except one had CS done.

A respondent said *“they did not give me pain relief, they did not give me drip...when they looked into my file, they said I have to do CS so I was there till around 6am on Saturday when they took me to theatre”*. (Participant 2)

Another said *“they were always checking on me and when I ask what am I still waiting for? They will tell me it’s not yet time, they did not give me any pain relief, they gave me drip after the pain started so serious on Tuesday, they didn’t tell me what it was for... they decided to rush me to theatre”*. (Participant 1)

Another said *“they wanted to give me pentazocine in the previous hospital before I was referred here...I told them I don’t need it....I was taken to the theater on Thursday.”* (Participant 3)

### B. Non-pharmacological interventions

According to the three midwives, the non-pharmacological care they give includes diversional therapy, reassurance, encouraging them to move around (those that have not ruptured their membrane), showing them other mothers that have progressed, educating them, encouraging liberal fluid intake and light diet if they have appetite, providing a comfortable environment etc.

A midwife said *“we allow them to move around, we also encourage them to take liberal fluid intake, we also educate them to allay anxiety, and they watch TV. We also show them other mothers who have progressed in labour to encourage them. We do educate those who have ruptured their membrane on the reason to stay in bed to prevent cord prolapse”*. (KII 2)

Another said *“words of assurance, sending them back home is still non-pharmacological, encourage them that it’s not yet time, her mind will be at rest that you’ve checked her baby that everything you did (Vaginal Examination, vital signs, Fetal Heart Rate) is ok. In the hospital, we tell them what they will be expecting, monitor contraction to know if weak, moderate or very strong, make the environment comfortable for them, they watch TV, fan is on, mosquito net is there so no mosquito bite, and they have freedom of movement. A patient that has ruptured her membrane will not move around to prevent cord prolapse, patient with pregnancy induced hypertension, pre-eclampsia will not move around, they will be monitored on the bed even if they want to ease themselves, we give bedpan, if she doesn’t have poor appetite, we can give light food.”* (KII 1).

### C. Pharmacological or Medical Intervention

The pharmacological interventions mentioned by the 3 midwives were: cervical ripening with mistoprostol, amniotomy from 3cm depending on the descent, pain relief such as paracetamol and pentazocine (with promethazine for those that react to pentazocine), rehydration, caesarean section, augmentation with oxytocin if there is no obstruction.



*“Ripening of cervix with misoprostol, amniotomy from 3cm depending on the descent. When there are abnormal signs like tachycardia, signs of pre-eclampsia, they take them to theatre. When the latent phase is prolonged and there is no obstruction, they augment with oxytocin, pain relief if need be”. (KII 1)*

*Another said “Induction if the labour is not well established and for primipara, if OS is closed, FHR is ok, they use mistoprostol 25mcg vaginally to induce that is cervical ripening and from 3cm, they can augment with oxytocin drip. Sometimes, they do rupture of membrane from 3cm, when they rupture, it gives good contraction. We do give paracetamol and pentazocine if FHR is ok, some react to it so we give promethazine, we rehydrate with 0.9% normal saline”. (KII 2)*

#### **D. Support System**

There's no provision for the spouses and relatives in the labour ward. They are always outside and can only communicate with the women on phone if need be. Their husbands, in-laws and other relatives understood with them, were running around, taking care of the house and praying for them.

*A participant said “my family were supportive....my mother was there for me, my sister very supportive in terms of care and money...they cannot come and see me but they were very supportive in prayer”. (Participant 1)*

*Another said “they did not allow them to enter, my in laws understood my condition, my husband was running around”. (Participant 2)*

*Another said “it was only my husband I was communicating with at that time, he wasn't worried, as he knew I was going to make it. My sister was helping with my daughter at home.” (Participant 5)*

#### **E. Outcome of Labour**

One of the women had the active phase prolonged, one developed high blood pressure, all five except one ended up having a Caesarean section, two had complications such as sepsis and wound breakdown, and one had intestinal obstruction. Three of the five women had their babies admitted at the SCBU due to respiratory distress, one out of the three babies also had hypoglycaemia and other complications.

*A respondent said “it managed to get to 6cm that was where it ended on Tuesday before they took me to the theater in the afternoon. Immediately they brought the baby out, they said the baby was breathing too fast, later it became slow, they had to take her to SCBU and I couldn't see her until I was fit to leave my bed. The baby too suffered if not for that prolonged labour, the baby would have been fine.”(Participant 1)*

*Another said “the baby went to SCBU, I don't even know the reason and I refused to ask....maybe the baby began to be weak. Immediately they lose the wire, the wound did not close so they had to start dressing again.”(Participant 2)*

*Another said “by the time I got to the theatre, my amniotic fluid was smelling, I'm still treating wound sepsis and I had acute intestinal blockage. The baby “at first they said his sugar level was low, the next thing I heard was that he has respiratory distress.” (Participant 3)*



Another said “*in the evening of the second day, virginal examination was 3cm, the baby was in distress and my blood pressure high, they had to do CS. The baby came out fine*”. (Participant 4).

## DISCUSSION

### Women's Perception of the prolonged latent phase of labour

The primipara women had the confidence to stay at home and coped well due to what they've heard from others that they can be sent back home if they go early. Due to their previous experiences, the multiparas stayed back to prevent being sent back home and for fear of prolonged stay in the hospital. Also, majority of the women had tertiary education and their exposure/ knowledge gave them the confidence that things were under control. This is in contrast with the study of Carlsson *et al.*, 2009 & 2012) which reported that some women lacked the confidence to stay at home, and felt a certain amount of security from being in the hospital environment i.e. some women felt very secure in hospital with midwifery and medical staff because of the fear of the unknown and anxiety related to the phase of labour.

When the phase became prolonged without any reasonable progress, most of the women were bothered, worried and anxious. This is corroborated by previous studies (Eric *et al*, 2010, Laura *et al*, 2014) according to them, when the women's experiences of their contractions are not consistent with the cervical dilation, it also leads to abnormal and indifferent feelings. In addition, women recognized the onset of labour with its signs and symptoms which included pain, they saw their pain as indescribable and according to Laura *et al*.2014) women's descriptions of their pain experiences depends on their states of mind that is, if the mind remains focused, open and accepts the inner experience, including pain, then there's more positive reporting of the labour experience. On the other hand, if the mind is distracted and the thought processes sees pain as catastrophic, then there's self-judgment and a negative evaluation of pain. Women's evaluations of their pain can also be influenced by their personal beliefs, desires, and their social environment.

Although, the women had negative feelings about the phase being prolonged, all of them perceived a high quality of care given by the caregivers which resulted in a more positive birth experience. This is contrary to the findings in Angerby's study (Angerby, 2018) where a greater percentage were less content with the birth experience, and had more negative feelings during labor and birth, they perceived the quality of care as poor, and had a more negative birth experience regardless of parity, her study also revealed that a prolonged latent phase was related negatively to the quality of intrapartum care, birth experience, and feelings for women giving birth.

This study equally found out that the women were not dependent on the caregivers and support persons as they were left alone with other women in labour although the phase was not conducive, they saw it as what they had to pass through to have a child and they believed that they were in capable hands to care for them contrary to the study by Nystedt, Högberg & Lundman (2006) that highlighted exhaustion, dependence on caregivers assistance and support, understanding prolonged labour experiences as being suddenly taking ill or finding oneself in a life-threatening condition dependence on others(e.g spouse, family, friends) and an overwhelming fear of losing oneself and the baby.



## **Duration and Symptoms of the Prolonged Latent Phase of Labour**

### **1. Duration**

From the study, the duration of the prolonged latent phase was from 18 to over 48 hours. This is in line with the findings of Gross *et al*, (2003) who reported that some women recorded their onset of labor over a relative short period of time while for others, it may last several hours or even days before the baby was born. The duration of the prolonged latent phase was >18 h in the study of Angeby *et al*.(2008).

### **2. Symptoms**

All the women interviewed experienced some degree of pain and irregular contraction, the nature of their pain/contraction was similar and indescribable, the intensity also increased with time for most of them. Their contraction was not commensurate with their cervical dilation. Four of the women had shown and their water broke (spontaneous rupture of membrane) at the onset of labour as well.

Some other signs and symptoms experienced by the women included: poor cervical dilatation (all five) backache (all), Insomnia (all), stomach cramp (one), loss of appetite (all), anxiety (one) and vomiting (one), high blood pressure (one). The above findings are in line with the findings of Gross *et al*. (2003, & 2006) where they reported that 66.5% had spontaneous rupture of membranes either before or after their onset of labour, 60% reported pains as a sign of labour i.e. recurrent mild to moderate painful uterine contraction/ non-current mild to moderate painful uterine contraction. Other symptoms include restlessness, anxiety, emotional distress, contractions not commensurate with cervical dilatation, cervical dilatation less than 4cm for days after the onset of labour and insomnia. This is also supported by Karn (2007) who reported irregular pain, loss of water from the birth canal, stomach upset, and sleep disturbance as the symptoms in her study.

## **Health Interventions and Care During the Prolonged Latent Phase of Labour**

### **1. Care givers care**

The women interviewed were pleased with the attitude of the caregivers towards them during the prolonged latent phase of labour, they saw them as caring, supportive. This agrees with WHO (2011 & 2018) that a woman presenting at a labour ward shall be admitted and supported appropriately even if she is in the latent phase of labour. Also, the women wished to be properly carried along in their management. This is in agreement with Angerby's report (2018) that women valued a welcoming manner and wanted to take an active part in making decisions about their further care. This study also shows that the women did not really have a clear cut understanding of the care that was given to them and according to their self-report, the women were not taught about the latent phase of labour during ANC classes, they were not also educated about the phase or what they would go through during labour. But according to the midwives, they are taught at the ANC and also educated while on admission. The women's self-report is in contrast with the WHO's stand that says "it is recommended that women should be informed that a standard duration of the latent first stage has not been established and can vary widely from one woman to another.





Moreover, the opinion of the midwives in this study is that it is better for mothers to stay at home in the latent phase of labour especially the primigravida to prevent anxiety and prolonged/ undue hospitalization as long as it is not contraindicated. It was also revealed that it is the O&G management's practice to send women back home in early labour when it is not contraindicated (i.e FHR is okay, no rupture of membrane, no Cephalopelvic disproportion, no high blood pressure etc.). This is in agreement with Karn's study (2007) that maternity services worldwide do not place any emphasis on the need to manage the latent phase of labour and encourages women and their birthing partners to stay home for as long as they can cope without the aid of professional support or stronger pain relief. Also, in the study by Eri *et al* (2011) the main objective from the midwives' point of view was to keep the women at home for as long as possible 'for their own good' to avoid exposure to medicalization.

## 2. Non-Pharmacological Intervention

The non-pharmacological care identified in this study includes sending them back home till labour is fully established especially the primigravidas (and if not contraindicated), rest, diversional therapy, reassurance, encouraging them to move around (those that have not ruptured their membrane), showing them other mothers that have progressed, educating them, encouraging liberal fluid intake and light diet if they have appetite and making the environment (ward) comfortable for them.

This is in agreement with the study of the American College of Obstetricians and Gynecologists (2012) and Lorna (2011). They both agreed that non – pharmacological measures should be the first line of action and they include : rest, rest & more rest, encouraging eating of well-nourished diet, keeping well hydrated and drinking of energy drinks, having warm baths, being in a quiet environment (in normal situation, the best place to be for the woman is in her own home/environment rather than in the labour ward), aromatherapy ( this helps to manage pain, improve sleep quality, reduce stress, agitation and anxiety), listening and questioning, hypnobirthing, using relaxation technique, education (keeping her informed by explaining what her body was doing and why), necessary and adequate support and advice, position changes( laying on the other side, standing, walking). Although, aromatherapy and hypnobirthing have not been widely practiced in the hospitals in Nigeria.

## 3. Pharmacological or Medical Interventions

The pharmacological interventions identified in this study were: cervical ripening with mistoprostol, amniotomy from 3cm depending on the descent, pain relief such as pentazocine with promethazine (for those that react to pentazocine) and paracetamol (although all the women were not given any pain relief), rehydration with 0.9% normal saline, augmentation with oxytocin if there is no obstruction and caesarean section. The above interventions agrees with that of the American College of Obstetricians and Gynecologists, and Lorna which includes augmentation of labour if the non-pharmacological measures does not provide relief, analgesics or sedatives when there's no contraindication to relieve the patients' discomfort, allow for rest while monitoring for labor progression (this is called therapeutic rest). According to them augmentation with amniotomy or either of the two will help to achieve the active phase as most women with a prolonged latent phase of labor will enter the active phase with expectant management which is reasonable for women at 4-6 cm dilation with reassuring maternal and fetal status however, they feel a prolonged latent phase is not a criteria for caesarean section.





The study also agrees with that of Karn (2007) whose statistics showed 28.5% had pethidine, 37.5% had caesarean section done, 81.2% had their labour augmented, amniotomy 25%, oxytocin 18.7%, amniotomy + oxytocin 37.5%. Also, Janssen and Weissinger (2014) reviewed women who perceived their labour to be more than 24 hours at the time of hospital admission which was associated with caesarean section and other obstetrical interventions and outcomes.

In this study, all the women except one had cesarean section done in the long run. This supports the study by Angeby (2018) on the “prolonged latent phase of labour: prevalence, labour outcomes, quality of care, women’s experiences and preferences, and psychometric properties in Sweden” in which a prolonged latent phase (>18 hours) was associated with more obstetrical interventions. This study therefore supported her conclusion that a prolonged latent phase of labor can be regarded as a risk factor for more obstetrical interventions.

#### **4. Support**

The importance of the support system during labour especially when it is being prolonged cannot be over emphasised. In this study, the spouses and relatives were supportive and caring both at home and in the hospital. Their husbands, in-laws and other relatives understood with them and were running around, taking care of the house and praying for them. This supports WHO (2011, 2018) that says some women want lots of affection and love to be listened to while others will want to be given some space but they all must be given adequate encouragement and reassurance, this will make them feel more relaxed and will help them cope better. The support system encourages women to move around and be active, provide massage, mediate between the women and the caregivers, advocates for their preferences. They also help women to build their confidence and feel in control through reassurance and these will lead to a positive birth experience.

But unfortunately, majority of the hospitals in Nigeria do not have provision for the spouses and relatives in the labour ward. Patients are left with other patients in labour and the midwives hence, relatives/ partners are always outside and can only communicate with the women on phone if need be. This is in contrast to the study by Karn (2007) which shows that their partners/husbands had a significant role to play in the latent phase labor, her study revealed that 61% of partners/husbands, 19.3% of family members, family of 0.85% were present at birth and 1.4% had no one to stay with them.

#### **Coping Mechanisms of Women During the Prolonged Latent Phase of Labour**

From the study, the women engaged in activities at home (such as washing, cooking, cleaning of the house) and exercises such as walking around (although the movement of some of them was restricted in the labour room due to ruptured membrane), breathing exercises and rest i.e. lying down, cold bath etc. This is in support of Karn’s study (2007) which showed that there were many coping aids employed by women in the early stages at home, and women utilized many methods of distracting themselves from the discomfort and pain of early labor contractions which include walking 64.7%, shower 34.5%, resting in bed 34.5%, breathing exercises/yoga 28%, bath 24.2%, paracetamol 17%, birthing ball 16.2%, massages 14% and TENS 14%. Others include music 1.7%, cold drink 0.085%, aromatherapy, T.V, leaning over against someone, hot tea, food/glucose drink, relaxing/relaxation etc. Her study concluded that women may share similar views but their experiences and approaches are different whether



they are primiparous or multiparous which shows the uniqueness surrounding early labor and birth.

### Outcome

In this study, the outcome of the prolonged latent phase of labour included caesarean section for all the women except one, complications of cesarean section such as intestinal obstruction in one, sepsis and wound breakdown in two, one also had the amniotic fluid infected, three of the babies had low to moderate apgar score with respiratory distress and were admitted into SCBU, one of the babies had hypoglycaemia, one of the respondents also had the active phase prolonged and one had raised blood pressure. This corroborates the report of Angerby (2018) in which women with prolonged latent phase are more likely to have the active phase of labour prolonged, emergency caesarean sections regardless of parity, and an apgar score less than seven at five minutes.

### CONCLUSION

In this study, the women diagnosed their labour based on the symptoms they experienced while the midwives diagnosed true labour in line with their hospital's management's criteria. Majority of the women experienced pain, show, irregular/ weak contractions as an indication that labour had commenced. To prevent being sent back home and prolonged hospitalization, majority of the women did not go to the hospital early even when they had ruptured their membrane (which is a risk of introducing infection to the baby and the uterus) and employed various means of coping methods. It was discovered that the prolonged latent phase of labour is a risk for obstetric interventions such as caesarean section as all except one of the women interviewed had CS done, SCBU admission for babies and complications from caesarean section. Also, having a prolonged latent phase of labour in previous pregnancy does not automatically guarantee a repeat in subsequent pregnancies. Furthermore, the women viewed the prolonged latent phase of labour as unpleasant but had a positive birth experiences through the appreciable care given by the care givers.

### Conflicts of Interest

Authors declared no conflicts of interest.

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