

Knowledge, Attitude And Perception Of Filipino Parturient Women Towards Labor Analgesia*

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ABSTRACT

Background and Objective of the Study

Painful labor produces maternal physiological changes that may affect maternal and fetal wellbeing. Little is known about whether parturients would be amenable to labor analgesia. The objective of this study is to investigate the knowledge, utilization and preferences of methods of pain relief in labor by expectant mothers in order to design a labor analgesia program.

Methodology

This is a cross sectional study wherein 278 parturients were requested to complete a researcher-administered survey following informed consent to assess the knowledge, attitude and perception regarding labor analgesia and to estimate the correlation of awareness and acceptability with demographic variables. Statistical analysis was done using IBM SPSS V17.01 using 5% margin of error and 95% confidence interval. A p-value of <0.05 is considered to be significant to the study.

Results

Most of the patients (n = 199, 71%) were unaware of labor analgesia. When the option of labor analgesia was offered only 36% (106) accepted it. Among them preference of the method of labor analgesia was treating doctor to take the decision regarding the pain alleviation method in 59 (55%), epidural in 29 (27%), 10 (9%) preferred spinal anesthesia. Among 172 (77%) who refused labor analgesia, the most common reason for refusal was it is harmful to the baby (26%) followed by the reason that they want to experience natural child birth (18%).

Conclusion

Knowledge and acceptance of labor analgesia was significantly less in antenatal women, irrespective of age, parity, occupation or religion in our study group. The most significant reason for refusal of labor analgesia was because it is thought to be harmful to the baby. A graduate level of education, an urban background or a previous surgical experience had a positive impact on the knowledge and acceptance of labor analgesia.

INTRODUCTION

Background of the Study

Although a happy and meaningful experience, childbirth is one of the most challenging occurrences encountered by women during their lives. Painful labor produces maternal physiological changes that may affect maternal and fetal wellbeing. The maternal catecholaminergic surge in norepinephrine and epinephrine in response to labor pain increases maternal oxygen consumption, which may lead to incoordinate uterine action, consequently causing decreased placental perfusion. In some cases, increased maternal oxygen consumption may be deleterious to maternal and fetal health. In addition, maternal hyperventilation in response to labor pain causes adverse effects such as reduced fetal oxygen delivery. Besides these acute maternal and fetal hemodynamic and metabolic responses, intense labor pain has been correlated with the development of postpartum posttraumatic stress, postpartum depression, and persistent pain.^[1]

An array of regional nerve blocks, systemic analgesic, and nonpharmacologic techniques

*2nd Place, 2020 Philippine Society of Anesthesiologists Inc. Research Contest Presentation

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are currently used for labor analgesia. Nonpharmacologic methods are commonly used, but the effectiveness of these techniques generally lacks rigorous scientific study. Neuraxial labor analgesia, most commonly epidural or combined spinal-epidural, is the most effective method of pain relief during childbirth, and the only method that provides complete analgesia without compromising the, muscular tone, and pressure sensation. Current techniques commonly combine a low dose of local anesthetic with a lipid soluble opioid. Neuraxial analgesia does not increase the rate of cesarean delivery compared to systemic opioid analgesia; however, dense neuraxial analgesia may increase the risk of instrumental vaginal delivery.^[2]

Giving an epidural analgesia is said to be beneficial by improving patient care outcome and this far outweighs the benefits than the risk. It was stated that epidural analgesia not commonly received by immigrant women in western countries that may be due to racial origin^[3]. Asian women were unlikely to receive epidural analgesia in comparison with non-Hispanic white women in the western countries that may be due patient's preference which has a major role in their decision-making^[4]. In developing and low-income countries, labor pain relief utilizations were low and not routinely practiced^[5-6].

Significance of the Study

In the Philippines, especially in government hospitals, the laboring mother seldom receives interventions to reduce pain.^[7] Epidural labor analgesia is the gold standard and ideal method in providing pain relief during labor and delivery^[5]. Despite its advantages, it is not completely accepted and practiced in many developing countries.

In the Philippines, practice and concepts of obstetric anesthesia are hindered by several beliefs and perceptions. In 2003, approximately 3,150 spontaneous vaginal deliveries were attended in the Charity Service of the Philippine General Hospital, which is a good representative of obstetric cases done in a tertiary hospital in Manila. Out of these vaginal deliveries, only 1,100 mothers (35%) were

given some form of analgesia during labor. In the private admissions, 86% to 90% of patients (n=693) get analgesia in various forms.^[8] In the University of Santo Tomas Hospital, in year 2015, there were 148 private and 40 clinical patients, who were given labor analgesia. Comparatively, in the year 2016, 163 private and 21 clinical patients were given labor analgesia by an anesthesiologist. With this disparity at hand, a questionnaire to assess knowledge, attitude and perception (KAP) on labor analgesia has been made. As more expectant mothers become aware of the possibility of pain-free labor, linked to their rights to improved quality of obstetric care, their expectations for the use of pain relief agents during labor and delivery is bound to increase. The type, safety and effectiveness of pain relief agents would also become important topics for women and their families. However, little information is available on what women know about pain relief agents and even less information is available to women about the choices available to them. This study hopes to raise conversations on the perspectives of expectant mothers on pain relief utilization in labor. It primarily seeks to investigate the knowledge, preferences and utilization and of pain relief agents in a cohort of antenatal women.

Objective of the study

To investigate the knowledge, attitude and perception of parturients towards labor analgesia.

Specific Objectives:

1. To measure the following factors among parturients:
 - a. knowledge of labor analgesia
 - b. attitude towards labor analgesia
 - c. perception towards labor analgesia
2. To compare the measured factors by:
 - a. age
 - b. religion
 - c. educational status
 - d. parity
 - e. income
 - f. occupation
 - g. residence
 - h. previous surgery

Review of Related Literature

Knowledge and Awareness

The patient's knowledge on labor pain is one of the main factors for diagnosing correct pain etiology, in order to have the proper pain management in achieving the best pregnancy outcome ^[11]. In the western countries, minority patients and low literacy contributes to the disparity on knowledge of labor analgesic options ^[12]. This may be due to their socioeconomic status, educational background and said to have a traditional mentality ^[3]. In studies, the knowledge of Asian Women on labor analgesia is low to moderate with only about 47% was exposed to epidural analgesia and 9.5% knows about labor analgesia ^[13-15] (table 1). The source of information is an important factor for their understanding regarding labor analgesia. Most of the source of their information is from friends and relatives and next is from media or readings (table 2). However, some of the participants obtain their information from antenatal clinics or previous experiences. Level of awareness is high and this is attributed to increasing discussion in antenatal health talks. The ambivalence and refusal of the providers are seen in areas with low resource setting ^[6]. The method of giving labor analgesia, about 53.3% knows it was given by epidural and others describe it as lower back injections (table 3). As with their understanding on the effectivity of epidural analgesia for labor about 42.3% believe that it works but the others about 52% seems not (table 4). ^[13-16]

Table 1. General Knowledge on Labor Analgesia

Study ID	Yes	No
Naithani 2011	9.5%	90.5%
To 2007	47%	53%

Table 2. Source of Information on Labor Analgesia

Study ID	media or readings	antenatal clinic	friends or relatives	previous Labor
Mohamed 2013	13%	8%	42%	18%
Naithani 2011	42.11%	-	42.11%	15.79%
To 2007	24%	31%	46%	13%

Table 3. Method of Labor Analgesia

Study ID	Epidural	IM/IV	Lower Back injections	others
Mohamed 2013	53.3%	-	-	46.7%
Naithani 2011	10.52%	15.79%	52.63%	21.05%
To 2007	16%	7%	-	76%

Table 4. Effectivity of Labor Analgesia

Study ID	Yes	No	Others
Mohamed 2013	42.3%	20.7%	37.3%
To 2007	-	52%	48%

Attitude

Attitude is a significant predictor that influences once use of epidural analgesia ^[17]. Asian women, whether in western countries or not, the attitude towards labor analgesia is influenced by woman's upbringing, culture, ethnic group, age and peer pressure. This attitude is also largely influenced by their access to knowledge and availability of labor analgesia ^[5]. With their poor knowledge on epidural analgesia most of them will not take it or undecided ^[13-15]. However other showed an impartial result regarding labor analgesia, about 32 % will accept, 34.9% will not and 33.1% were undecided ^[16-17]. The most reason for this, most pregnant women wanted to experience natural birth about 74.03%, for they believe that birth process for years without the any intervention. The other factors with this attitude are due to the advised of relatives and friends, and partner's preference. The stage of pregnancy the parturient is in affects their decision, for usually parturient attitude in the late part of pregnancy more clearly predicts the events of labor ^[17].

Fears and misconceptions contribute to the portion of patients on availing the labor analgesia. In Manila, Philippines with year 1980's, fear is said to be the most important cause in the slow progression of obstetric anesthesia in general. However, gradually the beneficial effects of epidural analgesia were introduced ^[18].

Perception

In traditional mentality, it states that pain in labor is usually considered a positive feature of labor, the idea of relieving it is opposed, and this said to denote the successful bonding with the baby. However it also stated that better education has better understanding of the birth process and about pain relief in labor. ^[12, 14]

The use of epidural analgesia was associated with significantly less pain as expressed postnatally. There was a better overall experience of labor and majority are satisfied and it stated that it is the most effective and safe option^[13]. Many women were perceptive in accepting the labor analgesia after counseling with health care providers. In the Philippines, it was noted by 2013, about 95% of the live births received antenatal care from a skilled provider. This leads to further discernment among Filipinos.^[19]

Asian Women on Labor Analgesia

In Systematic Review done last 2015, was done to determine the KAP on labor analgesia of Asian Women as there were no studies done in Filipino women. By knowing these parameters, it can help in better care and approach to our parturient patients. The results showed that the knowledge and awareness of Asian women regarding labor or epidural analgesia is relatively low to moderate (9.5 to 47%), with a high GRADE level of evidence. The perception and attitude of Asian women toward using labor or epidural analgesia in the studies is said to be influenced by traditional values and past experiences, and most most of them will not take it and undecided, with a moderate GRADE level of evidence.^[14]

METHODOLOGY

Study Population

The questionnaires were administered to prenatal parturient women in their 2nd and 3rd trimester and those for vaginal delivery after cesarean. The patients that were excluded were those who had previous cesarean section and planned cesarean section for the succeeding pregnancy, multiple gestations, teenage pregnancy, and still birth. The study secured approval from IRB as well as from the Department of Obstetrics and Gynecology in gathering participants at the out-patient clinics during clinic hours from their patients, coming from University of Santo Tomas Hospital Private and Clinical Division.

The KAP Questionnaire

The questionnaire was adapted from the 9-item Knowledge Attitude Perception (KAP) Questionnaire toward labor analgesia developed by Naithani U, et al (2011) for Indian antenatal women. This questionnaire underwent a face validation by the review of 3 experts on the field of labor analgesia in a study by Roldan in 2017.

Questionnaire Translation

The 9-item KAP questions on labor analgesia and demographic characteristics was translated to Filipino from the validated English version by a Filipino teacher, Ms. Zendel Rosario Taruc, PhD. This was then back translated by an English Teacher, Ms. Evalyn Abiog, PhD.

Face Validation

The Filipino version of the KAP questionnaire was reviewed by 3 experts on the field of labor analgesia. The experts certified that the 9-item question can measure the KAP towards labor analgesia of Filipino women.

Reliability Testing

The validated Filipino Translated questionnaire answered by 21 patients, with a power of 91%, showed an overall Cronbach's alpha of 0.6463. This signifies that the questionnaire has an acceptable reliability in assessing the KAP on labor analgesia.

The 9-item KAP labor analgesia questionnaire may be divided into three domains: knowledge, attitude and perception. Questions 1-4 pertains to attitude on labor pain, questions 5-8 pertains to knowledge on labor analgesia, and question number 9 to perception. The domains on knowledge and attitude had an acceptable reliability with Cronbach's alpha of 0.7023 and 0.6655, respectively. The alpha for perception could not be computed since the domain had one question.

Sample size

OpenEpi was used to calculate the minimum sample size of the study. Specifying a design effect of 1, margin of error equal to 5%, proportion equivalent to 50%, and finite population of 1000, the minimum sample size required is 278.

Sampling methodology

The study employed a convenience sampling design to select study participants.

Questionnaire administration

The study was conducted at the University of Santo Tomas Hospital and participants were gathered at the out-patient clinics during clinic hours coming from the Department of Obstetrics and Gynecology.

Parturient women who are lined-up in the Obstetric and Gynecologic Department were requested to complete the researcher-administered survey following informed consent. The participants were approached by an Anesthesiology resident where discussion of the study was made.

Eligible patients were asked to answer the questionnaire after discussing the study, showed their willingness to participate in the study, have read and signed the written informed consent, before or after their prenatal pre-natal visit.

After the parturients have read the survey, a study investigator was always available to assist participants in completing the survey and to clarify any questions that arose. The survey consists of two sections. The first section examines demographics, (age, religion, education level, parity, occupation, residence and previous caesarean delivery). The second section consists of questions, and assesses knowledge and options of labor analgesia, sources of information and perceptions on labor analgesia. Among those with a previous experience of delivery, participants were asked to score their previous pain experience using the

numeric rating score. On average, each survey took about 5-10 minutes. Each question expresses only one idea (i.e., no questions contained "and") and no questions were phrased in a negative form. Answer types included choosing from a menu of choices, yes/no/neutral, or pains scores on a scale of 0 to 10 (not and).

Data analysis

All data gathered were encoded in MS Excel. Each item was presented in frequencies or percentages.

Statistical analysis was done using IBM SPSS V17.01 using 5% margin of error and 95% confidence interval. A p-value of <0.05 is considered to be significant to the study.

ETHICAL CONSIDERATIONS

This study was conducted in accordance with the Declaration of Helsinki and good clinical practice.

REC Approval and Informed Consent

The study commenced upon the approval of the University of Santo Tomas Hospital Research Ethics Committee.

Participants were approached at the University of Santo Tomas Hospital's out-patient clinics. Consent were secured from participants at the Department of Obstetrics and Gynecology outpatient clinics where answering of the questionnaire were done. The participants were approached by an Anesthesiology resident where discussion of the study was made. No subject was able to participate in this study without written documentation of informed consent. The principal investigator informed the participants of their right to refuse to participate or withdraw from the study. The parturient participation in the study is completely voluntary and free from coercion. The principal investigator was the one to administer the questionnaire to the participants. No faculty

member of the Department of Anesthesiology was involved in the recruitment and data collection process.

Data Safety and Confidentiality

To ensure privacy, confidentiality and anonymity, the patient's identifying information, i.e. names, address, hospital number, admission number, email address, as well as names of physicians and other health care providers, were not collected or the study cannot link individual responses with participants' identities. The study did not collect identifying information of research participants unless it is essential to the study protocol. However, the age, gestational age, parity, religion, residence (urban or rural), occupation and education are essential parts of the objectives and therefore were included in data gathering. Instead, each patient were assigned a code (year-month-patient number), example 15-03-01. These assigned codes were encoded in the Excel form which is stored with security codes and password. Information about research projects is separate from information about routine clinical care. Informed consent from the patients were obtained in which prior to taking part in this study; they agreed to take part in answering the survey questionnaire.

Compensation

No compensation was given to the participants.

Benefits

The women in labor may be enlightened on the benefits of having labor analgesia for her and the child by explaining to the mother that labor pain is a stress that has an effect also to the baby by leading to a decrease in placental perfusion, uncoordinated uterine activity, and dysfunctional labor. The labor pain may be controlled with labor analgesia which gives maternal satisfaction and better outcome for the baby. This is consistent with promoting the life and health of the mother and

fetus. The possibility of providing access to counseling for the woman about these issues were part of this discussion. It will be also explained that their participation may help in to further the care of pregnant women with labor analgesia.

Risks and Inconveniences

Pregnant patients are considered part of the scientifically complex research subjects base from the workshop done by NIH Office of Research on Women's Health last 2010. These patients has a combination of physiologic and ethical complexity. The ethical complexity is shown with the considerations in the need to balance the interests of the pregnant woman and the fetus. Pregnant women have the same capacity for autonomous decision making as their nonpregnant counterparts, including decisions regarding whether or not to participate in appropriate research studies. These were maintained and given to the research participants. The wellbeing and care of the woman who is pregnant and of her fetus always takes precedence over research considerations. Research involving the woman may affect the fetus, and research involving the fetus will affect the woman. Maternal and fetal risks are deeply interconnected, and consideration of enrolling pregnant women in research requires balancing the risk of fetal harm with the potential for benefit and the importance of the information to be gained on the health of women and fetuses. The risks and benefits to each were carefully considered in every case, and discussed with the woman. There are no entailed physical, social, legal and economic risks in this study but a minimal psychological risk may be involved due to learning on labor analgesia may affect their perspective.

Discontinuation

Any subject who previously consented may choose to withdraw from participation at any point during the study.

Conflict of Interest

No potential conflicts of interest have been identified. The principal investigators and co-investigators report no disclosures. No external funding has been received for this study. The primary investigator shouldered all expenses incurred.

RESULTS

During the study period, a total of 278 parturients were recruited in this study who attended antenatal clinic at the Out Patient Department of University of Santo Tomas Hospital. The parturients were mostly on the 30-40 age group (45%), with single parity in 96 (35%) and multiple parity in 182 (65%). Most of the patient were Catholic 163 (59%) and employed 142 (57%). Their economic status was above poverty line with income of under 40,000pHp (68%) and they were in the third trimester of pregnancy (49%). The educational status of the study population showed an education up to graduation in 45% (126). [Table 1].

Attribute	Frequency (n) (278)	Percentage (%)
Age group		
<20	27	9.71
20-30	118	42.45
30-40	126	45.32
>40	7	2.52
Religion		
Catholic	163	58.63
Iglesia ni Cristo	26	9.35
Christian	72	25.9
Baptist	17	6.2
Islam	0	0
Jesuit	0	0
Educational Status		
Primary	2	0.72
Secondary	58	20.87
College Undergraduate	92	33.09
College Graduate	126	45.32
Post Graduate	0	0
Civil Status		
Single	3	1.08
Common Law Wife/With Partner	82	29.5
Married	178	64.03
Separated	15	5.39
Annuled/Divorced	0	0
Parity		
Primipara	96	34.53
Multipara	182	65.47

Weeks of Gestation		
20-28 weeks	47	16.91
28-37 weeks	138	49.64
37-42 weeks	91	32.73
greater than 42 weeks	2	0.72
Income		
under 40,000/month	189	67.99
40,000-59,999/month	87	31.29
60,000-99,999/month	2	0.72
100,000-249999/month	0	0
250,000 and over/month	0	0
Occupation		
housewife	97	34.89
employed	142	57.08
self employed	39	14.03
Residence		
rural	110	39.57
urban	168	60.43
Previous Surgery		
None	233	83.8
Yes	45	16.19

Table 1. Demographic and obstetric characteristics of respondents

Women were inquired about the cause and severity of any past experience of severe pain and asked to grade it using 0-10 visual analog scale (VAS), most women graded it at 1-3 (52%); 4-6 (45%) or 7-10 (2%). Ninety-six (34%) of women had no past experience of labor pains while majority of the rest graded previous labor pain as grade 4-6 (41%). Expected labor pain of the present pregnancy was graded by the majority as 4-6 (51%) or 1-3 (47%). If asked about their attitude towards labor pain, 153(55%) expressed confidence. [Table 2].

Past Experience of Severe Pain			Previous Labor Pain Score			Expected Labor Pain			Attitude Towards Labor Pain		
Score	No. of Patients	%	Score	No. of Patients	%	Score	No. of Patients	%		No. of Patients	%
0	0	0	0	96	34.53	0	0	0	Confident	153	55.04
1-3	145	52.16	1-3	57	20.50	1-3	131	47.12	Fear	49	17.63
4-6	126	45.32	4-6	116	41.53	4-6	142	51.08	Anxious	76	27.34
7-10	7	2.52	7-10	9	3.24	7-10	5	1.80			

Table 2: Distribution of cases on the basis of score given to past experience of severe pain, previous labor pain and expected labor pain using VAS

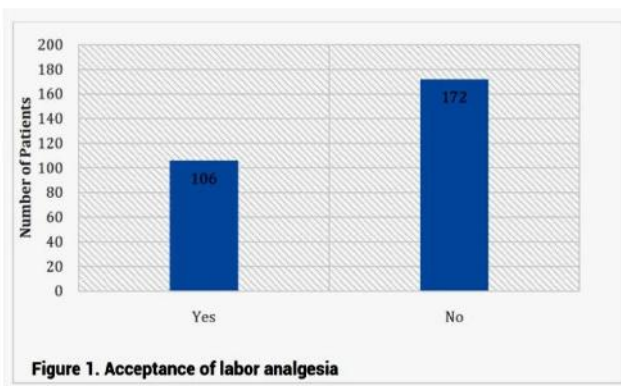
One hundred and ninety-nine (71%) women were unaware about labor analgesia. Among 79 (28%) women who were aware about labor analgesia, forty-four (55%) knew that it was provided by injection in the lower back termed as 'epidural or spinal' and twenty-three (29%) via IV

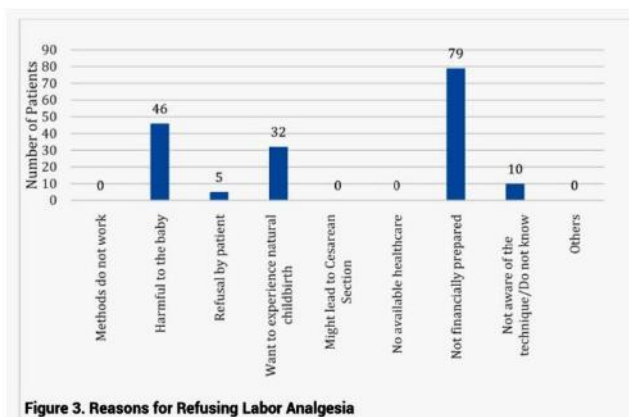
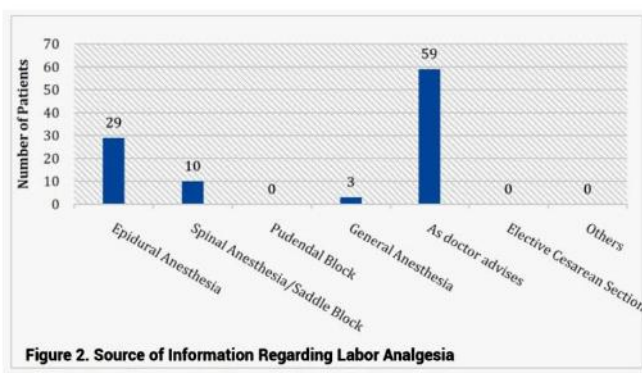
injection. 59% (45 / 79) described the provider of labor analgesia to be an anaesthesiologist and twenty-nine (36%) by any doctor. Majority of the source of information were from friends and relatives (69%). [Table 3]

Table 3. Characterization of respondent's access to information about pain relief in labor

Knowledge of labor analgesia			Methods of Labor Analgesia			Source of Information About Labor Analgesia			Provider of Labor Analgesia		
	n	%		n	%		n	%		n	%
Yes	79	28.42	Acupuncture	0	0	Previous Labor	15	18.99	Operating Surgeon	5	6.33
No	199	71.58	Epidural Analgesia	44	55.7	Friends and Relatives	55	69.62	Nurse/compounder	29	36.71
			Spinal Anesthesia						Any Doctor		
			Deep Breathing Exercises/Lamaze	9	11.39	Media (Audio/Visual)	6	7.59	Anesthesiologists	45	59.96
			IV Injections	23	29.11	Printed Literatures	3	3.8	Do not Know	0	0
			IM Injections	3	3.80	Others	0	0			
			Do not know	0	0						

When the option of pain alleviation during labor was offered, only 36% (106) accepted it. [Figure 1] Among them, preference of the method of labor analgesia was treating doctor to take the decision regarding the pain alleviation method in 59 (55%), epidural in 29 (27%), 10 (9%) preferred spinal anesthesia. Among 172 (77%) who refused labor analgesia, the most common reason for refusal was it is harmful to the baby (26%) followed by the reason that they want to experience natural child birth (18%).





Women with an educational status of a graduate level had a positive impact on the awareness of painless labor ($P = 0.046$). The women who were graduates, urban, or had a previous surgery were found to have a significantly better knowledge regarding spinal and epidural as a method of labor analgesia ($P = 0.046$, $P = 0.046$, $P = 0.024$, respectively) and knowledge that the provider of labor analgesia was called the anaesthesiologist or any doctor. A significant source of information for graduates regarding labor analgesia was friends and relatives.

DISCUSSION

An increasing number of women worldwide are using epidural analgesia as a pain management strategy during labor, but in our study, we found that only 28% of the women were aware of the availability of pain relief during labor; and when the option of painless labor was offered for their current pregnancy only 38% accepted it. The incidence of awareness and acceptance of labor analgesia from

Nigeria (27 and 57.6%, respectively)^[2] and Lagos (38.9 and 65.3%, respectively)^[12] differ from Australia (98 and 80%, respectively).^[3] This discrepancy in the level of awareness and acceptance could be attributed to the fact that child birth is still viewed as a physiological process in most of the developing countries, which is managed with as little interference as possible. Many women still do not know that pain of labor can be relieved.^[13] The experience of pain in labor is unique for each woman^[14] and the attitude toward labor may also be influenced by a woman's upbringing, culture, ethnic group, age and peer pressure.^[1] In some studies the past experience and expected labor pain were graded as high as 8.4 and many women were afraid and scared of labor pain,^[4,13] while in our study the past experience or expected labor pains were graded as low as 4 to 6; and most of the women were confident that they could cope with the labor pains. It has been observed that in developing countries like India and South Africa,^[13] antenatal education may be of even greater importance, as women may be less educated than women from the industrialized world and therefore, have a poorer knowledge of human reproduction. Furthermore, their ability to seek and access information is limited, so women are dependent on the education provided by relatives, friends,^[1,3] and health workers.^[13] They identified tablets and IV / IM injections as methods to provide pain relief in labor, few were aware of epidural or breathing exercise as methods of painless labor.^[1,2,13] Use of intrapartum epidural analgesia is reported to vary considerably with the women's insurance status, race, parity, age and the specialty of the physician managing the labor. Race and lower socioeconomic status were seen as univariate predictors of refusal for epidural analgesia for labor; while full / part time employment, higher income, higher educational level, a prior educational program and knowledge about epidural were documented as univariate predictors of acceptance.^[7,15] The degree of subjective pain, low parity and a high level of education were associated significantly with the acceptance of epidural labor analgesia.^[2,14,16] In our study, except the graduate level of education, none of the demographic variables like age, religion, parity, occupation or background had improved awareness and acceptance of labor analgesia. This

implicates a general, low level of knowledge in all strata of society. Pain in labor is usually considered a positive feature of labor and the idea of relieving it is often opposed in developing countries. This reflects traditional values, according to which pain during labor denotes successful bonding with the baby. A girl child who is sensitized to such values during her growing period learns to accept and endure the pain of childbirth.^[13] The educational level of our study population were mostly graduates and had a significantly better knowledge about labor analgesia ($P = 0.046$). This shows that women with better education can understand the birth process and have the ability to gather information about pain relief in labor and may gradually develop acceptance for it. It has been highlighted that healthcare providers in developing countries are either ignorant or consider educating women on pain relief methods during labor as a low priority issue. This apparent neglect is emphasized further by the observation that even women who had prior antenatal visits with obstetric healthcare providers did not have increased awareness.^[2] In contrast, a recent study in a tertiary obstetric hospital of Australia^[3] revealed that almost all women accessed antenatal information regarding intrapartum pain management, usually from multiple and varied sources. The vast majority of women were well-informed regarding their pain management in labor. They were more concerned with the maternal side effects than the fetal effects when deciding against pain management and this may be due to a greater awareness in their population that fetal side effects of epidural analgesia in general, are small. More women in Australia received information from an anaesthetist / obstetrician, while women in the United Kingdom received it from the media.

It is difficult to change the attitude and perception of the female population toward issues related to childbirth. Educational status does have a positive correlation with the acceptance of the methods for pain relief during childbirth. In the current scenario, even if pain relief during childbirth is offered, the poorly educated women are apprehensive and consequently refuse interventions. This reflects on our healthcare system, which is not geared up to provide sufficient

cognitive and emotional preparation for childbirth. Considering the level of education in our population, dedicated childbirth educators could help in improving obstetric care, help in allowing women to make their own decisions regarding childbirth and also sensitize them to accessing analgesia in labor.

CONCLUSION

The researcher conclude that knowledge and acceptance of labor analgesia was significantly less in antenatal women, irrespective of age, parity, occupation or religion in our study group. The most significant reason for refusal of labor analgesia was because it is thought to be harmful to the baby. A graduate level of education, an urban background or a previous surgical experience had a positive impact on the knowledge and acceptance of labor analgesia.

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