การดูแลอย่างต่อเนื่องในระยะคลอดโดยสามี เน้นการใช้เทคนิคการนวดบรรเทาปวด

Continuous Labour Support by the Husband or Partner, focusing on Massage Techniques for Pain Relief

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บทคัดย่อ

การคลอดเป็นเหตุการณ์ที่ยิ่งใหญ่ในชีวิตของสตรีที่ต้องเผชิญกับการเจ็บครรภ์คลอด ในโรงพยาบาลรัฐบาลส่วนใหญ่ในประเทศไทย ไม่อนุญาตให้สมาชิกในครอบครัวหรือสามีเข้ามาดูแลหญิงคลอดในระยะคลอด การดูแลอย่างต่อเนื่องในระยะคลอดมีบทบาทสำคัญต่อประสบการณ์การคลอดและผลลัพธ์ของการคลอด หลักฐานเชิงประจักษ์แสดงถึงประโยชน์ของการดูแลอย่างต่อเนื่องในระหว่างการคลอด ทั้งในด้านการบรรเทาปวด ลดระยะเวลารอคลอด การใช้ยาบรรเทาปวดและอัตราการผ่าตัดคลอด และส่งเสริมความพึงพอใจของหญิงคลอด โดยเฉพาะเมื่อได้รับการดูแลจากครอบครัวหรือสามี การขาดแคลนพยาบาลที่ดูแลในระยะคลอดอาจส่งผลให้การใช้ยาบรรเทาปวดมากขึ้น การจัดการความปวดโดยไม่ใช้ยา เช่น เทคนิคการนวด เป็นวิธีที่ง่ายต่อการฝึกและมีประสิทธิภาพในการบรรเทาปวดในระยะคลอด ดังนั้น การผสมผสานการดูแลอย่างต่อเนื่องในระยะคลอดโดยสามีที่ได้รับการฝึกการดูแลหญิงคลอดโดยมุ่งเน้นเทคนิคการนวดบรรเทาปวด จะช่วยยกระดับคุณภาพการดูแลและผลลัพธ์ของมารดาและทารกได้ บทความนี้มีวัตถุประสงค์ในการอธิบายประโยชน์ของการดูแลอย่างต่อเนื่องโดยสามีในระหว่างการคลอด มุ่งเน้นการใช้เทคนิคการนวดบรรเทาปวด รวมถึงการเสนอแผนการเปลี่ยนแปลงอย่างเป็นรูปธรรม เพื่อนำไปสู่การปฏิบัติในสถานบริการของโรงพยาบาลรัฐในประเทศไทย

คำสำคัญ: การดูแลอย่างต่อเนื่องในระยะคลอด, การดูแลโดยสามี, เทคนิคการนวดบรรเทาปวด

Abstract

Childbirth is a major event of a women's life in which they have to deal with labour pain inside unfamiliar environment and people. Women giving birth in most public hospitals in Thailand are not allowed to have family members or husbands attending during labour, leaving women facing the scary and uncomfortable situation by themselves. Continuous labour support has played a pivotal role in determining positive or negative childbirth experiences and outcomes. Ample evidence has shown the advantages of continuous labour support on labour pain, duration of labour, analgesic use, cesarean section rate, and women's satisfaction, especially when support is provided by family members or husbands. Although

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conventional labour cares are provided by midwives, a shortage of midwives has led to a dissatisfaction and negative experiences amongst women giving birth. Labour pain management seems to use more pharmacological methods leading to unfavorable side effects on mothers and newborns. Non-pharmacological pain management such a massage technique which is uncomplicated for training, has been underpinned by extensive evidence demonstrating the effectiveness on labour pain relief. Therefore, the combination of continuous labour support by husbands, who are trained to support labouring women focusing on massage techniques, would optimize the quality of maternity care and maternal and neonatal outcomes. This article aims to describe the benefits of continuous labour support by husbands or partners during childbirth, focusing on massage techniques with the realistic plan for a proposed change strategy to apply and embed the practice within maternity settings of public hospitals in Thailand.

Keywords: continuous labour support, husband or partner support, massage techniques for pain relief

Childbirth is an important and intimidating event for women due to the physiological and psychological changes, labour pain and unfamiliar healthcare environments. Women perceive that giving birth is a risky situation for them and their babies.[1] The experiences during childbirth will be remembered for the rest of a women's life and might provide long term effects, positively or negatively, on their life, well-being, and health.[2] A positive experience can empower the transition to motherhood.[2], On the other hand, a negative one causes health impacts such as postpartum depression[3], and fear of giving birth[4]. The quality of labour support from the people close beside the women, especially family members, throughout the labour and delivery is pivotal for labouring women and their families.[5] Additionally, labour pain also is an important factor influencing a women's experiences during labour. Women who deal with the labour pain effectively could have a more natural birth process and less uncomplicated treatments or intensive interventions for pain relief.[6] This article aims to describe the benefits of continuous labour support by husbands or partners during childbirth, focusing on massage techniques with a proposed change strategy to apply and embed the practice at maternity settings in public hospitals in Thailand. Moreover, the roles of midwives as change agents or team members will be emphasized, which could optimize the quality of maternity care and maternal and neonatal outcomes in Thailand.

Continuous labour support

Continuous labour support has become exception rather than routine since most women across the world give birth in the hospital rather than home, leading to the concern of the dehumanization of women's childbirth experiences.[7] The continuous support includes emotional support such as continuous presence, reassurance and praise, information support regarding progression of labour, advising on the pain relief techniques during labour, comfort methods (such as touching, massage, warm baths or showers, promoting mobility, and ensuring adequate fluid intake and output), and speaking up on behalf of the women.[7,8]

The World Health Organization proposed that continuous labour support facilitates better childbirth consequences.[8] Additionally, the beneficial outcomes of continuous labour support have been widely reported, which include shorter duration of labour, increase spontaneous vaginal delivery, reduce intrapartum analgesia, and higher childbirth

satisfaction.[7] Moreover, a systematical review added that continuous support during labour decreases caesarean birth, instrumental vaginal birth, and negative feelings about childbirth experiences.[10] On the other hand, lack of continuous support during childbirth has potentially resulted in the experience of labour and birth being dehumanised.[8] Additionally, the labour support can benefit in the neonatal outcomes, including having fewer 5-munite Apgar scores less than, reducing the admission to the neonatal intensive care unit, discharging within 48 hours, demonstrating more mother-newborn attachment and bonding, and increasing the initial breastfeeding rate and duration.[8]

Supporters during labour and delivery

Normally labour support in hospitals is provided by midwives or trained doulas (a female non-medical childbirth assistant) that were trained to provide physical, emotional, and information labour support.[9] However, husbands, female relatives, or friends have increasingly provided labour support. Hodnett et al. pointed out that labouring women receive greater benefits of continuous labour support when the companion was not the hospital staff.[10] The randomised control trial in Thailand showed that labouring women receiving support by close female relative during labour was significantly related to a shorter duration of labour and are more satisfied with childbirth experiences, compared to those were not supported.

Dr.Robert Bradley, an obstetrician/ gynecologist, introduced that laboring women would have a supportive coach/husband in the natural childbirth process.[11] Therefore, husbands or family members tend to optimise continuous labour support. Male involvement is related to the improvement of maternity care services in developing countries.[12] Although a recent survey of women's childbirth experiences in the United States has shown that 82% of pregnant women have a husband or partner present during labour[13], male involvement during childbirth remains low in low to middle income countries.[14]

Husband continuous support during labour

There still a lack of studies on the attitudes of Thai women towards husband or partner support during labour. A study showed that Thai women prefer family members presence during labour for tackling inadequate intrapartum care from healthcare providers.[15] A study of family member participation during labour, in which the supporters almost always were husbands, found the benefits of reducing labor pain, duration of labour, and increased satisfaction in the pregnant mother.[16] Moreover, a study on husbands providing continuous support during labour in Nepal suggested that continuous support from husbands during labour has directly influenced the perceived postnatal support, with an effect on decreasing anxiety and depression among new mothers.[17]

There is also no evidence about the cost-effectiveness in low-middle income settings, including Thailand.[8] Nevertheless, evidence in high income settings has shown that this intervention could provide significant cost savings in terms of decreasing caesarean section by 25%, instrumental vaginal birth by 10%, and the use of pain relief by 10%. In addition, it might establish itself as a low-cost intervention, if the companions are family members,[8] which could enhance the probability of such projects.

Non-pharmacological pain relief during labour focusing on massage techniques

Women's preferences for the choices of labour pain relief methods depend on their expectations, complexity of labour, and severity of labour pain.18 Non-pharmacological approaches are found as an effective and safe labour pain

management in low-risk pregnant women, which are recommended to be used according to women's values and preferences.[19]

Massage therapy as a technique to stimulate peripheral sensory reception, according to "Gate Control Theory"[20], is one of the non-pharmacological therapies which are recommended for pain relief during childbirth.[21] Several randomized controlled trials (RCTs) demonstrated the effectiveness of massage to relieve severe labour pain, fewer analgesic medication use, shorten duration of labour, and enhance childbirth experiences.[22] RCTs on effects of massage on pain and anxiety during labour suggested that massage is a cost-effective care, reducing pain and anxiety during labour[23], despite not changing its characteristics and location.[23]

Combination led optimistic cares during labour: The change proposed

Pregnant women giving birth in most public hospitals in Thailand have been prohibited relatives attending during labour and delivery.[15] Therefore, labouring women have to encounter labour pain without any family members present, which leads to increased maternal fear and anxiety, resulting in exacerbating labour pain. In many maternity care settings, intensive interventions have been used increasingly during childbirth. Pharmacological methods, such as epidural analgesia, have been offered and given routinely and tend to increase risks of potential side effects occurring.[24] The lack of healthcare providers and inadequate support appear to impact on the severity of labour pain and satisfaction of childbirth.

A strategy of maternity care in Thailand points out that continuous labour support should be implemented as complementary care, combined with enhanced family centered-care.[15] To optimize maternal-neonatal care, continuous labour support should be combined with a non-pharmacological pain relief, such a massage technique, that is easy to train husbands or partners to provide during labour. Partners providing effective massage during labour might surpass the advantages for optimizing birth.

This strategy aims to reduce analgesic medication, epidural analgesia, cesarean section, derive great gratification of women, emphasize family's roles, and decrease the maternity care cost of the healthcare organization. Moreover, this will also resolve dissatisfaction in pregnant women caused by insufficient intrapartum care because of a heavy workload and time availability to provide supportive care during labour.

Considering feasibility and viability of continuous labour support by husbands

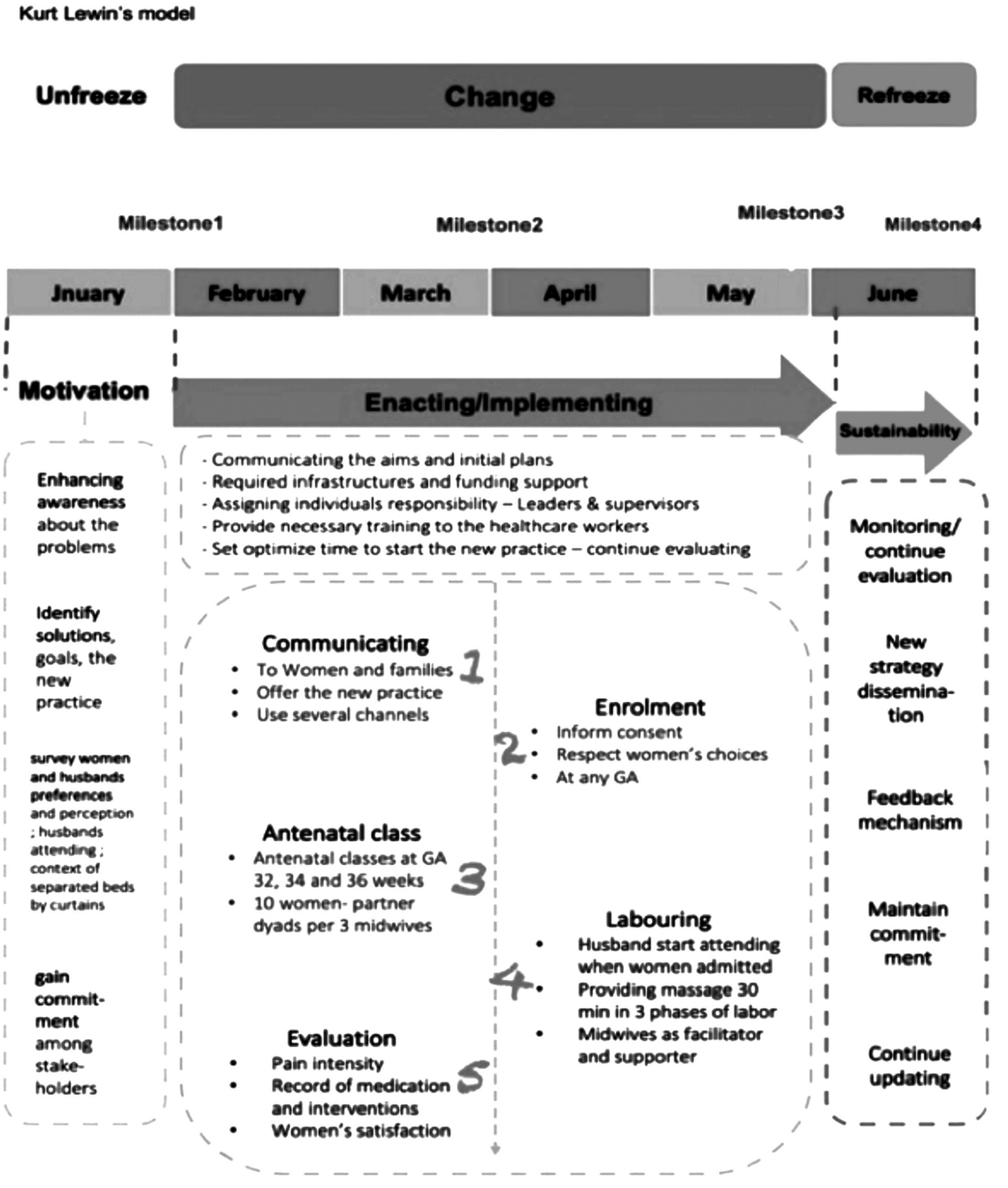
There is extensive evidence demonstrating the benefits of continuous labour support in high income and low-middle income settings, which support the value of this practice.[8] However, the implementation seems to be constrained by substantial barriers. The major obstacle impeding feasibility and viability of this strategy in the public hospital settings in Thailand, tends to be the structure of labour wards; separated beds by curtains. Similarly, the WHO highlighted that privacy considerations due to space is the significant barrier to partner attendance during labour.8 To tackle this difficulty, the target hospital might need to re-organize ward space to utilize available private rooms, combined with investigating preferences of couples and feelings about partner presence and curtain divided beds in the initial phase, and consideration about infrastructure and funding support in subsequent phases.

Further apprehension seems to be the women and partner attitudes towards company during labour in Thailand. Chunuan suggested that the companionship of partners seems unfeasible in

Thailand due to the unbearable and unskillful feelings of Thai men dealing with the physical and psychological needs of women during labour.[15] However, these ambiguous aspects need to be explored whilst simultaneously providing the required skills to partners throughout this change project. Although childbirth preparation classes have been delivered in many public hospitals, husbands or partners still require assistance from healthcare professionals during the labour.

How to implement the change in the target setting

The change process to achieve the project's goals have to be announced to healthcare workers at implementation. The change process uses the linear change model proposed by Kurt Lewin.[25] The process is divided into three phases: motivation, enacting, and sustainability. These three phases will be employed within six months.



Unfreeze: motivation phase

Motivation phase (Unfreeze) aims to raise the awareness about current practice concerns. For instance, high use of medication, invasive intervention and low satisfaction about childbirth experiences. Women and husband preferences through to husband attendance during labour should be explored whilst the goals and plans have to be introduced to the stakeholders. The project's leader is the key person to operate this initial step and provide the required information. The period covers the first month of the process, with evaluation at the first milestone (figure 1).

The major challenge of organizational development is leading change in a health care setting in which leaders encounter several barriers whilst encouraging new implementation of projects.[26] Continuous labour support by husbands or partners is recognized as large-scale change, involving many stakeholders including hospital director, policy makers, doctors, midwives, and other staff. Therefore, to apply the practice as routine it requires pursuing key strategies, embracing commitment among stakeholders, effective communication, a clear change process, a realistic activity plan, and continuous evaluation.

Gaining commitment is an important strategy proposed on large-scale change in healthcare organizations.[25] The commitment to a new approach should be gained amongst all stakeholders involved, internal and external of the hospital. The project leader has to foster awareness of the current practices, particularly increasing analgesic and intensive interventions uses during labour, the restriction on family members attendance, and the disrespecting of the women and their families' preferences. Meanwhile, the potential solutions to tackle these problems are required to be indicated and pitched to the stakeholders for gaining strong commitments to set up continuous labour support by husbands at the target setting.

Change: Enacting/Implementing phase

After gaining commitment and project approval, communication is a key issue of change implementation, working as an important tool for announcing, explaining, and preparing people.[25] The project should be communicated to all stakeholders effectively. First, the new policy and facilities provided to support this change are announced. Second, the rationale, purposes and plan of the project underpinned by the evidence-based practices, are communicated to healthcare workers and medical/nursing students. Ultimately, midwives and staff offer the new practice to women and their families. An effective method could be verbal introduction followed by issuing of a leaflet with more detail of additional care.

The enacting/implementing phase (Change) intends to prepare the required infrastructure, funding support, and documentation. In the settings where the labour wards have a limitation to allocate the private areas for labouring women and partners, there is a need to plan for the organizing or renovating of the wards if the funding support is available. However, if the survey of women and partners' opinions on continuous labour support separated beds by curtains show an agreement to proceed with this project without a reorganisation of the ward, the husbands attending during childbirth might be allowed to be present in the setting with an application of the privacy rule.

Communicating with women and their families about the new service, particularly the criteria of eligible women who are in low-risk pregnancy categories, avoid interruption between this practice and other critical cares if needed. Project enrolment can be conducted through several

channels, such as healthcare staff advice or information leaflet, followed by the enrolment that will be available at antenatal care unit. Childbirth preparation classes are held for the women who are in third trimester of pregnancy, gestational age 32 weeks onward. Midwives will provide the required knowledge and train the needed skills, focusing on massage technique for pain relief to the dyads. Class material focuses on massage therapy. Five steps of the activity plan (Figure 1) will be implemented in the target setting, and the practice will be monitored and evaluated continuously to gather all results including feedback from stakeholders through the enacting phase.

During the labouring period, husbands or partners will start attending their wives when they are admitted to the labour ward. The dyads will be allocated to the private birthing area and provide the trained massage techniques during the class. However individual pain relief preferences should be respected. Midwives will undertake the role as facilitator and supporter when partners need assistance. The massages used are based on several trails examining effects of massage provided by attendants. This technique will provide firm and rhythmic massage to shoulders and back, including abdominal effleurage and sacral pressure, for 30 min in three phases: latent phase (3-4 cm cervical dilatation), active phase (5-7 cm cervical dilatation), transition phase (8-10 cm cervical dilatation).[22]

Refreeze: Sustainability phase

Sustainability phase (Refreeze) focuses on continued evaluation against the objectives for this practice and gradual improvement by using feedback mechanisms, leading to yield the practice's sustainability. Sharing the new practice based-outcomes is essential to establish broad generalization into different settings. Meanwhile, new evidence based-practices need to be updated for the project's development.

Evaluation will be the labour pain measured after 30 min of massage at each phase, using the numeric rating scale (NRS-11),[26,27,28] which is normally used in the target setting. Satisfaction will be evaluated at 24 hours post-birth, using the 'women's views of birth labour' satisfaction questionnaire (WOMBLSQ4) including the aspect of partner support. The hospital's records of analgesic medication use, epidural analgesia, and modes of delivery are assessed concurrently throughout labour, linking to the cost of maternity care. Moreover, the outcomes and feedbacks are reported to the stakeholders at milestone points (Figure 1) for maintaining the commitment of this change.

This change strategy would be a good guide for implementing continuous work support by husbands or partners in public hospitals in Thailand. It was suggested that the phases of freezing, changing, and refreezing must be in order during implementation. Change is difficult, but to be successful, Midwives play an important role in leading the team to achieve the goals, especially leadership skills. Therefore, midwives should be trained in the following essential leadership skills;

- Emotional intelligence to improve integration and productivity.

- Communication and listening to improve interpersonal relationships and communicate important information and common goals.

- Team collaboration and engagement, impacting network building.

- Monitoring and feedback to improve performance and capacity.

- Empowerment, motivation and recognition should be embedded in the leader to drive individuals and the team forward.

In addition, midwives should be aware of

the issues and highlight the reasons why this needs to change and what we need to archive. Knowledge of continuous labour support and non-pharmacological pain management is also needed, which midwives can teach husbands or partners in a preparation course and help with husband labour support.

In conclusion, the continuous labour support by husbands tends to gain enormous advantages for maternal-neonatal healthcare based on extensive evidence. The change strategies are proposed to operate the implementation, comprising of gaining strong commitment amongst stakeholders, effective communication, comprehensive change process, practicable activities plan, and constant evaluation. Although there are some barriers that impede change implementation, the well-planed arrangement for infrastructure, funding, and healthcare professions, will lead to the success of change management. In addition, midwives play a main role in successful change, whether as leaders or as part of the team. This practice seems to optimize childbirth outcomes in terms of reducing analgesic medication use and invasive interventions that lead to the cost-effectiveness of intervention, enhancing the maternal satisfaction and promoting family-centered care.

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