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Management of third stage labour following vaginal birth in Iran: A survey of current policies



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ABSTRACT

Objective: this study was aimed to provide information on policies for the practice of managing the third stage of labour in Iran, including discussion of related systematic evidence.

Design: this survey used a standard questionnaire to obtain information about prevention and early treatment of postpartum haemorrhage from all geographical areas in Iran, in 2010.

Setting: the survey included maternity units from 23 provinces, covering 129 out of a total of 560 maternity units in Iran.

Participants: at least one public hospital, one private hospital and one rural birth facility unit were included from each province. Questionnaires were completed by the unit's senior midwife with support from the unit's lead obstetrician.

Findings: all the units who were approached responded to the study including 69 public hospitals, 32 private hospitals and 28 rural birth facility units. The rate of active management of the third stage of labour was 57 per cent, although answers to individual components of management indicated a higher rate for active interventions than expectant management. Ninety-four per cent of the responding centres indicated oxytocin administration, 71 per cent apply early cord clamping and 65 per cent apply controlled cord traction. A lack of standard definition for postpartum haemorrhage was reported in 18 per cent of units.

Key conclusions: a high rate of active management was reported in Iran with variation in its different components which is in line with the international findings. These policies were mainly congruent with the existing systematic evidence except for timing of cord clamping.

Implications for practice: there is a need for improvement in locally sensitive policy development, continuing education, establishing accurate auditing systems and ensuring access to facilities such as blood banks and products in rural units. Efforts to reduce maternal mortality and morbidity and investigations into their causes should be extended to factors beyond the third stage of labour care clinical components.

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Introduction

Postpartum haemorrhage is a major cause of maternal mortality across the world, mainly in developing countries (World Health Organisation, 2007). Although several other factors contribute to the mothers' safety during birth such as maternal malnutrition and poor health, poverty and available facilities

such as transfer, access to blood transfusion and intensive care, third stage of labour care is considered a crucial step in preventing postpartum haemorrhage related mortality and morbidity (Lalonde et al., 2006).

The two major care approaches for the third stage of labour include active management and expectant management. According to the International Confederation of Midwives and International Federation of Gynecology and Obstetrics (Lalonde et al., 2006), active management should be offered to all women, including administration of uterotonics, (delayed) cord clamping, controlled cord traction and uterine massage (Lalonde et al., 2006). Expectant management is commonly considered as no or

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minimum intervention, allowing the separation of the placenta without using any pharmacological agents. This approach relies on naturally circulating oxytocin at birth, stimulating uterine contraction. Usually no uterotonics, cord clamping or early cord cutting is applied and the placenta is expelled by maternal efforts (Rogers et al., 1998). In some cases they may use nipple stimulation by putting babies to the breast (Bullough et al., 1989) and/or using an upright position aided by the gravity forces in the separation and delivery of the placenta (Thilaganathan et al., 1993). In an explorative study of midwives who used active management in at least 30 per cent of births, the majority of them described the expectant management of the third stage of labour as a 'watchful waiting' with no intervention necessary (Begley et al., 2012). Although there is variation in the details of each approach; the whole package of active management has been shown to be effective in reducing postpartum haemorrhage (Begley et al., 2011).

It is reported that postpartum haemorrhage accounts for 30 per cent of maternal mortality in Iran (Ministry of Health, Reproductive Health, Internal publication, May 2005, Tehran, Iran). According to the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics (Lalonde et al., 2006), with appropriate management of the third stage of labour based on the existing evidence, a considerable number of maternal deaths can be avoided. Exploring baseline information on the existing policies for managing the third stage of labour can be helpful for comparative purposes and for identifying areas in which further improvements need to be made.

This study was designed to provide an overview of current strategies for care in the third stage of labour in Iran and comparing it with the existing systematic evidence in the field.

Methods

This descriptive survey of policies on the third stage of labour care and practice related facilities was conducted in 2010. The data collection tool was a questionnaire adapted from the 'European project on obstetric haemorrhage reduction: attitudes, trial and early warning system (EUPHRATES)' with permission (Winter et al., 2007) and translated into Persian (the official language in Iran). The questionnaire was translated by one of the co-authors and tested by five practitioners to ensure it was understandable prior to administration. The main questions related to cord clamping and cutting, the use and timing of uterotonic drugs; applying controlled cord traction; the length of time before the placenta is considered to be retained and the length of time before placenta is manually removed. The questionnaire asked the respondents about the unit's overall policy and practice on each intervention being used always, sometimes, rarely or never. Questions about the existence of written policies, facilities and level of activities in the preceding year were also included. The questionnaire included two separate sections for the management of the third stage of labour following vaginal birth as well as after caesarean section, the results from the former section is presented in this article.

The project was granted approval by Ahvaz University Ethics Committee which had the role of the Principal Investigator in Iran.

Setting

Iran is a middle income country with considerable improvements in its maternal and child health over the last few decades (Azemikhah et al., 2009; UNICEF, 2010a). Iran has a total population of above 73 million people (World Bank, 2010) with 71 per

cent urbanised, an annual growth rate of 0.7 per cent and total fertility rate of 1.7 (Azemikhah et al., 2009). On average half of women undergo caesarean section in Iran (Ostovar et al., 2012) and in private hospitals the rate of caesarean section is as high as 80–100 per cent in some units (Ahmad-Nia et al., 2009).

More than 97 per cent of delivery care is provided by skilled birth attendants and about 96 per cent of births are 'Institutional deliveries' (UNICEF, 2010a) meaning they take place in maternity units either in public (governmental) hospitals, private hospitals or in rural birth facility units. The main difference between a rural birth facility unit and other maternity units is that they include a midwife (and other skilled health-care workers) but an obstetrician may not be available. In both public and private hospitals' maternity units, midwives are involved in intrapartum care but obstetricians are the lead care providers. Midwives generally provide the care during labour and deliver women but in private hospitals the latter is usually exclusively done by obstetricians (Soltani and Sandall, 2012).

Participants

Out of 31 provinces in Iran (Statistical Centre of Iran, 2006), 23 were included in the study via convenience sampling where attempts were made to include all geographical areas.

There are 560 maternity units in Iran, 129 of which were approached for this survey.

As the postal system is not reliable and not commonly used in Iran, the questionnaires were distributed by research co-ordinators in 23 provinces and the completed questionnaires were collected by the research co-ordinators and handed to the lead research co-ordinator at Ahvaz University for data entry and analysis. It was ensured that at least one public hospital, one private hospital and one rural birth facility unit were represented from each province. The questionnaires were completed by the unit's senior midwife with the support of the lead obstetrician in that unit.

Data were analysed using the Statistical Package for the Social Sciences (SPSS, version 17). The study was funded by the World Health Organisation which had no further role in the conduct of this study. All data were treated confidentially.

Findings

Table 1 shows the range of included provinces in relation to their geographical locations and population density. All geographical areas were represented in the study including all highly populated provinces. A total of 129 maternity units which were approached, took part in the study including 69 public hospitals, 32 private hospitals and 28 rural birth facility units. Due to ethical consideration and to maintain confidentiality the names of provinces rather than cities are provided.

The number of responding units to the question about the number of births during the study year varied, including 138,691 normal vaginal births ($n=112$), 110,520 caesarean births ($n=114$) and 1492 instrumental births ($n=107$).

Participants' responses are presented below, under two main headings of 'Prevention of postpartum haemorrhage' and 'Early treatment of postpartum haemorrhage' after vaginal birth.

Prevention of postpartum haemorrhage

Table 2 summarises responses on strategies for the prevention of postpartum haemorrhage and different components of the third stage of labour care, in different settings. Fifty-seven per cent of respondents stated that they use active management for

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