Facility-based active management of the third stage of labour: assessment of quality in six countries in sub-Saharan Africa

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Introduction

Haemorrhage is estimated to cause 27.1% of the 287 000 maternal deaths that occur annually. Postpartum haemorrhage can be prevented by the active management of the third stage of labour – an intervention that can reduce maternal blood loss by up to 66% compared with physiological or expectant management. While the annual numbers of maternal deaths attributable to haemorrhage fell sharply between 1990 and 2013, postpartum haemorrhage continues to be the global leading cause of maternal death. The problem does not appear to be a lack of effective interventions but rather the failure to implement such interventions properly in all settings.

Maternal care has traditionally been tracked by two key indicators: the proportion of births attended by skilled birth attendants and antenatal care coverage. However, these two indicators may not reflect the content or quality of the care available. For example, the presence of skilled birth attendants does not guarantee that appropriate interventions are correctly implemented at appropriate times. A recent assessment identified 18 quality-of-care indicators for evaluating facility infrastructure and supplies needed for active management were audited and relevant guidelines reviewed.

Findings

Most (94%; 2173) of the women observed were given oxytocin (2043) or another uterotonic (130). The frequencies of controlled cord traction and uterine massage and the timing of uterotonic administration showed considerable between-country variation. Of the women given a uterotonic, 1640 (76%) received it within three minutes of the birth. Uterotonics and related supplies were generally available onsite. Although all of the study countries had national policies and/or guidelines that supported the active management of the third stage of labour, the presence of guidelines in facilities varied across countries and only 377 (36%) of 1037 investigated providers had received relevant training in the previous three years.

Conclusion

In the study countries, quality and coverage of the active management of the third stage of labour were high. However, to improve active management, there needs to be more research on optimizing the timing of uterotonic administration. Training on the use of new clinical guidelines and implementation research on the best methods to update such training are also needed.
and coverage of the active management of the third stage of labour in facility-based deliveries in six countries in sub-Saharan Africa. We investigated the separate components of such management – focusing on uterotonic provision to reflect the most recent research and guidelines. The relevant national policies – if any – and the availability of the various commodities needed for such management were also assessed.

**Methods**

**Study design**

With a cross-sectional design, we used direct observation of facility-based labour and delivery to assess quality of care in normal delivery practice and the management of selected complications during active management of the third stage of labour. For each of our six study countries, a routine checklist for the clinical observation of labour and delivery (available from the corresponding author) was adapted from a previous study and partly based on the *Managing complications in pregnancy and childbirth: a guide for midwives and doctors* manual. There were only minor differences between the six checklists: each was piloted during the training of the data collectors. Lessons from the first two countries where the survey was implemented – i.e. Ethiopia and Kenya – helped refine the tools used elsewhere.

In each study facility, we audited the infrastructure and supplies needed and reviewed whether national policies and/or practice guidelines supported the active management of the third stage of labour. Providers were interviewed and tested on their knowledge of maternity care. In five of our study countries, data were collected, using customized forms, on smartphones or tablet computers. In Kenya, however, data were recorded on paper.

Our data collectors were midwives and doctors who were currently in clinical practice. Clinical refresher training was offered before the collectors were trained as observers. The latter training included four days in a classroom followed by one or two days of pretesting the data collection form – in all the study countries except Kenya – on smartphones or tablets. In role-play simulations based on the MamaNatalie and NeoNatalie models (Laerdal, Stavanger, Norway), trainees assumed the roles of observer, client and health-care provider and practised using the checklists for uncomplicated and complicated births. At the end of the training, data collectors also visited a nearby non-study facility to practise using the checklist in the field.

**Study setting**

The data for this study were collected, between 2009 and 2012, in surveys in Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, and the United Republic of Tanzania (Table 2). Each survey, which took two to four weeks to complete, was supported by the United States Agency for International Development via the Maternal and Child Health Integrated Program and facilitated by staff at the programme’s headquarters in Washington, United States of America, the programme’s country office in each study country and the six corresponding ministries of health. At the time of survey implementation, the maternal mortality ratio, in deaths per 100 000 live births, ranged from 440 in Madagascar to 790 in the United Republic of Tanzania. In five of our six study countries, approximately 35–55% of women gave birth in facilities and nearly all pregnant women made at least one visit to an antenatal care clinic. Ethiopia had the lowest percentages of facility-based births (10%) and of pregnant women receiving antenatal care at least once (34%).

**Participants**

Women were approached as they arrived at the labour and delivery ward, received a description of the study by the observer and those that consented to participate were followed. There were up to three women per observer and several observers per facility. If a woman who came in had a complication – such as pre-eclampsia – or if she developed a complication during labour, she would be prioritized for observation.

### Table 1. Components of active management of the third stage of labour in various guidelines

| Source of definition | Administration of uterotonic | Timing of uterotonic administration | Controlled cord traction | Uterine massage | Delayed cord clamping |
|----------------------|-----------------------------|-------------------------------------|--------------------------|----------------|-----------------------|
| FIGO/ICM (2003)      | Recommended                 | Within a minute of the birth        | Recommended              | Recommended    | Not mentioned         |
| WHO (2007, 2009)     | Recommended                 | Soon after birth                    | Recommended              | Recommended    | Recommended           |
| WHO (2012)           | Recommended                 | In third stage of labour            | Optional                 | Optional       | Recommended           |

FIGO: International Federation of Gynaecology and Obstetrics; ICM: International Confederation of Midwives; WHO: World Health Organization.

### Table 2. Survey samples used to study the active management of the third stage of labour in six countries, sub-Saharan Africa, 2009–2012

| Sample                        | Ethiopia | Kenya | Madagascar | Mozambique | Rwanda | United Republic of Tanzania | Total |
|-------------------------------|----------|-------|------------|------------|--------|-----------------------------|-------|
| Facilities visited            | 19       | 409   | 36         | 46         | 72     | 61                          | 643   |
| Facilities with deliveries    | 18       | 170   | 36         | 46         | 64     | 56                          | 390   |
| Hospitals                     | 18       | 150   | 27         | 21         | 42     | 17                          | 275   |
| Health centres and dispensaries | 0     | 20    | 9          | 25         | 22     | 39                          | 115   |
| Deliveries observed           | 192      | 626   | 347        | 525        | 293    | 706                         | 2689  |
| Deliveries with third stage of labour observed | 117 | 564   | 288        | 507        | 225    | 616                         | 2317  |
Overall, 2689 women consented to observation and 2317 of these women were observed during the third stage of labour and therefore included in our final analysis (Table 2). Although 643 health facilities were visited, the number visited in each study country varied widely – from 19 in Ethiopia to 409 in Kenya (Table 2). Only the 390 visited facilities where labour and delivery were observed were included in the final analysis. The other 253 either did not offer labour and delivery services or had no clients during the observation period.

**Study size**

All samples, except that of Tanzania, were believed to be nationally representative of facilities with at least moderately high utilization (Table 3). In Kenya, the survey was implemented within a national Service Provision Assessment run by ICF Macro (Calverton, USA). Ethiopia's sample was limited to hospitals with at least five deliveries per day. In Madagascar, the sample included all facilities with at least five deliveries per day. In Rwanda, a survey was a census of district and referral hospitals and a random selection of district health centres. The two surveys in the United Republic of Tanzania were planned to serve as the baseline and endline of a quality improvement project run by the Maternal and Child Health Integrated Program and only included facilities in project regions.

**Variables**

At the time that our study was conceived in 2008, the International Federation of Gynaecology and Obstetrics/International Confederation of Midwives’ definition of the active management of the third stage of labour was still widely used. This definition includes uterotonic administration within a minute of the birth, controlled cord traction and uterine massage. We collected data on each of these components and also on the components of the relaxed definition that included uterotonic administration within three minutes of the birth. The type of uterotonic administered – if any – was recorded. Variables were created based on “yes” or “no” responses to checklist items. Any “do not know” responses were excluded. Analyses of the timing of uterotonic administration were based on observers’ recordings of the times. If not recorded, the timing of administration was assumed to have been more than three minutes after the birth. Kenyan observers estimated the timing of administration as at delivery of the anterior shoulder, within a minute of the baby’s delivery or after placental delivery.

**Statistical analysis**

The data for each study country were analysed separately. Post-stratification weights were applied to the observations to account for differences between the numbers of observed and expected deliveries at each facility. Weights were based on the relevant national health management information systems or facility registers. For each study country, descriptive statistics were generated separately for each investigated component of the active management of the third stage of labour and for the combination of all such components.

Facilities were assessed for the presence of at least one non-expired dose of oxytocin, ergometrine or misoprostol.

| Country                | Sampling frame | Facility selection | Facility type                                    | Geographical distribution |
|------------------------|----------------|--------------------|-------------------------------------------------|----------------------------|
| Ethiopia               | 2008–2009 AMDD assessment of EmOC | By delivery caseload – all facilities with at least five deliveries per day | Central and specialized, regional, zonal, and district hospitals | Five of the nine regions plus Addis Ababa and Dire Dawa |
| Kenya                  | Ministry of health list of facilities | Selected to be nationally representative | National referral, provincial, district, sub-district, and other hospitals, health centres, clinics, dispensaries and maternities | National |
| Madagascar             | 2009 UNFPA/AMDD assessment of EmOC | By delivery caseload – all MCHIP-supported facilities with at least two deliveries per day | Regional, district, and teaching hospitals and health centres | 17 of the 22 regions |
| Mozambique             | Ministry of health list of facilities | By delivery caseload – all MCHIP-supported facilities with at least two deliveries per day | Central, district, general, provincial, and rural hospitals and rural and urban health centres | National |
| Rwanda                 | Ministry of health list of facilities | By level of facility and location – all district-level and higher hospitals plus one randomly selected health centre per district | District, military, and teaching/referral hospitals and health centres | National |
| United Republic of Tanzania | Facilities that were MAISHA-supported in 2009 | By level of facility and delivery caseload – all MAISHA-supported facilities with at least one delivery per day | Regional hospitals, health centres and dispensaries | 15 of the 30 regions |

AMDD: averting maternal death and disability; EmOC: emergency obstetric and neonatal care; MAISHA: Mothers and Infants, Safe Healthy Alive; MCHIP: Maternal and Child Health Integrated Program; UNFPA: United Nations Population Fund.

a Including three facilities, in three different regions, that did not have at least three deliveries per day.

b Two of the investigated regions had no health centres that had at least one delivery per day. In each of these two regions, the facility with the highest delivery caseload was surveyed.
that was onsite – i.e. in the delivery room or a neighbouring room. Such drugs were recorded as “not present” if the observer did not personally see a dose.

**Ethical considerations**

The study protocol was approved by ethical review boards in each country and by the Johns Hopkins Bloomberg School of Public Health, which ruled that the protocol was exempt from review under the United States Code of Federal Regulations, 45 CFR 46.101(b) (5). Informed consent was obtained from all study participants, including facility directors, health workers and patients.

**Results**

Providers with nurse or midwifery training performed most of the observed deliveries in each study country (Table 4). In the knowledge test, 440 (42%) of the 1037 providers investigated indicated training in delivery care but only 377 (36%) said that they had received training in the active management of the third stage of labour (Table 5).

Data on the availability of a uterotonic in the delivery room were missing for 12 of the 390 facilities included in the final analysis. Of the remaining 378 facilities, 344 (91%) and 329 (87%) had at least one uterotonic and oxytocin available in the delivery room, respectively. Only 41 (75%) of the 55 Tanzanian facilities included in the final analysis had oxytocin available onsite – with more hospitals stocking the drug than health centres (Fig. 1).

The syringes and needles needed to administer oxytocin were available in almost all facilities. Availability of ergometrine and misoprostol varied widely. Of the 378 facilities, 166 (44%) – including only four (22%) of the 18 Ethiopian facilities – displayed clinical guidelines for a normal delivery, that included the provision of active management of the third stage of labour, either on a wall or in another easily visible location.

For routine deliveries, each study country included the active management of the third stage of labour – including all components in the International Federation of Gynaecology and Obstetrics/International Confederation of Midwives definition\(^1\) and oxytocin as the preferred uterotonic – in its service delivery guidelines. In each country’s essential drug list, oxytocin was registered and indicated for use in the active management of the third stage of labour. All of the relevant national policies noted that any provider who was considered to be a skilled birth attendant was eligible to administer uterotonics.

**Individual management components**

In the 2317 deliveries observed, uterotonin administration was nearly universal (Table 6). Oxytocin was the most frequently used uterotonic. Among the study countries, Kenya demonstrated the highest frequency of controlled cord traction and uterine massage. Of the 2173 women given a uterotonic at any time, 1640 (76%) received it within three minutes of the birth. However, in only 1124 (52%) of the 2173 women given a uterotonic was it administered within a minute of the birth.

Fifty of the women observed developed postpartum haemorrhage and all but one of these 50 women had been given oxytocin. The other woman had not received any uterotonic.

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| Table 4. Qualifications of providers observed performing deliveries in six countries, sub-Saharan Africa, 2009–2012 |
|---------------------------------------------------------------|
| **Qualification** | **Ethiopia** | **Kenya** | **Madagascar** | **Mozambique** | **Rwanda** | **United Republic of Tanzania** | **Total** |
|-------------------|--------------|------------|----------------|----------------|-----------|-----------------------------|---------|
| (no. of providers (%)) | (n = 192) | (n = 626) | (n = 347) | (n = 525) | (n = 293) | (n = 706) | (n = 2689) |
| **Physician**\(^a\) | 39 (20) | 6 (1) | 65 (19) | 1 (< 1) | 6 (2) | 13 (2) | 130 (5) |
| **Nurse or midwife**\(^b\) | 137 (71) | 614 (98) | 258 (74) | 433 (82) | 260 (89) | 627 (89) | 2329 (87) |
| **Non-qualified staff**\(^c\) | 0 (0) | 6 (1) | 1 (< 1) | 52 (10) | 2 (1) | 45 (6) | 106 (4) |
| **Student**\(^d\) | 9 (5) | 0 (0) | 21 (6) | 23 (4) | 13 (4) | 11 (2) | 77 (3) |
| **Other or unknown**\(^e\) | 7 (4) | 0 (0) | 2 (1) | 16 (3) | 12 (4) | 10 (1) | 47 (2) |

\(^a\) General practitioners, obstetricians, gynaecologists, other specialists, resident junior doctors and – in the United Republic of Tanzania – assistant medical officers.

\(^b\) Bachelor of science, diploma, registered and enrolled nurses, bachelor of science, diploma, registered and enrolled midwives, nurse/midwives and nursing officers.

\(^c\) Also includes health officers in Ethiopia, paramedics in Madagascar and maternal and child health aides in the United Republic of Tanzania.

\(^d\) Medical attendants, health assistants and traditional birth attendants.

\(^e\) In Mozambique this category included resident junior doctors.

\(^*\) In Kenya this category included students.

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| Table 5. Self-reported training in previous three years of providers who were observed delivering babies in six countries, sub-Saharan Africa, 2009–2012 |
|---------------------------------------------------------------|
| **Focus of training** | **Ethiopia** | **Kenya** | **Madagascar** | **Mozambique** | **Rwanda** | **United Republic of Tanzania** | **Total** |
|-----------------------|--------------|------------|----------------|----------------|-----------|-----------------------------|---------|
| (no. of providers (%)) | (n = 79) | (n = 234) | (n = 138) | (n = 186) | (n = 145) | (n = 255) | (n = 1037) |
| Delivery care | 40 (51) | 82 (35) | 41 (30) | 105 (56) | 63 (43) | 109 (43) | 440 (42) |
| AMTSL | 30 (38) | 72 (31) | 29 (21) | 91 (49) | 58 (40) | 97 (38) | 377 (36) |

AMTSL: active management of the third stage of labour.
Discussion

In all six of our study countries, the quality and coverage of the active management of the third stage of labour were high. The practice of at least one component of such active management was nearly universal. Uterotonic administration was the most frequently observed component and is generally considered to be the most important. However, there was wide variation among the study countries in the use of controlled cord traction, uterine massage and the timing of uterotonic administration.

Encouragingly, skilled birth attendants conducted almost all of the observed deliveries, uterotonics and other related supplies were usually present onsite and all of the study countries had national policies or guidelines for the active management of the third stage of labour. However, the surveys revealed a low frequency of provider training in active management during the previous three years and the frequent unavailability in delivery rooms of relevant guidelines.

In our study, almost as many women received a uterotonic more than one minute after the birth as within a minute of the birth. Confusingly, there are many differing recommendations on when a uterotonic should be administered. A review of active versus expectant management for women in the third stage of labour, found six recommendations, including "at the delivery of the anterior shoulder", "immediately following birth" and "within two minutes of birth". The International Federation of Gynaecology and Obstetrics/International Confederation of Midwives definition recommended "within one minute" – whereas the 2007 and 2009 WHO guidelines recommended "soon after birth of the baby". The most recent – i.e. 2012 – WHO guidelines simply recommended "during the third stage of labour".

The need for further information on the optimal timing of uterotonic administration has been identified in almost all of the relevant WHO guidelines, trial reports and Cochrane reviews since 2007. However, neither in a five-country assessment of the impact of all components of the active management of the third stage of labour nor in an eight-country assessment of such active management with and without controlled cord traction was the timing of uterotonic administration discussed.

Confusion over changing definitions and guidelines is a barrier to optimal implementation of the active management of the third stage of labour. Studies from Colombia, Ghana and the United Republic of Tanzania have concluded that the lack of uniformity in definitions may contribute to the creation of barriers to effective dissemination of knowledge, consistent training, and implementation of clinical guidelines in practice. Many health facilities in low-resource countries are under-staffed so that a single provider may need to manage several deliveries concurrently and may be unable to provide all of the recommended interventions at the recommended times – even when the necessary supplies are available. Given the current focus on uterotonic use, future research and guidelines should define the upper and lower time-limits for uterotonic administration to prevent postpartum haemorrhage.

The presence of confusing guidelines, low provision of training and lack of monitoring of content have previously been identified as barriers to optimal implementation of the active management of the third stage of labour. In 2012, it was observed that the providers of active management need improved educational and training opportunities. A multifactorial intervention – using clinical leaders, clear service delivery guidelines, regular reviews and supportive materials – could improve the implementation of active management. The development of appropriate standards and guidelines and clinical audits could promote a so-called culture of quality throughout a country’s health facilities and systems.

The active management of the third stage of labour in Ethiopia and the United Republic of Tanzania has been assessed in 2005–2006. We also surveyed these two countries in 2010. Comparisons between the data indicate that progress has been made in both countries. However, sampling differences and changing definitions mean that such comparisons have to be handled with care. Since 2005, both countries have developed their first national policies and guidelines for the prevention of postpartum haemorrhage.

Discussion

Fig. 1. Availability of uterotonics in health facilities in six countries, sub-Saharan Africa, 2009–2012

Note: The plotted data only relate to the 378 facilities – 18 in Ethiopia, 170 in Kenya, 34 in Madagascar, 40 in Mozambique, 61 in Rwanda and 55 in the United Republic of Tanzania – in which data on uterotonic availability were collected.
The percentage of observed Tanzanian women who received a uterotonic within one minute of the birth rose from 10% in 2005–2006 to 50% in 2010 and oxytocin represented 31% and 81% of the uterotonic doses observed in 2005–2006 and 2010, respectively. The percentage of observed Ethiopian women who received a uterotonic within one minute of the birth rose from 41% in 2005–2006 to 79% in 2010. Over the same period, the percentage of oxytocin use increased from 68% to 98%.

The use of direct observation – which remains rare in the assessment of obstetric quality of care – may be considered a strength of this study. However, it also allows potential bias. Observers’ judgments – even if standardized through training and assessed using inter-rater reliability measures – may not be correct. Further, the observer’s presence may have stimulated improvements in the performance of the observed provider.\(^5\) The surveys were limited to observing care practices for facility-based deliveries only and do not provide data on home births. In a recent study of uterotonic use after delivery that included both facilities and homes, it was estimated that only 40% of Tanzanian women received a uterotonic\(^6\) – a value much lower than the 99% recorded by us in health facilities. While we used a wide variety of sampling strategies, the surveys were nationally representative and used standardized approaches for the assessment of active management that enabled cross-country comparisons. This study built local capacity to conduct direct observational research and collected baseline data that should be useful in future assessments. Based on these survey tools, a new index has been developed to measure the quality of facility-based labour and delivery care. This should make it quicker and easier to repeat such assessments.\(^6\)

Our analysis focuses primarily on the process component of quality of care – i.e. the actual health care given to patients.\(^6,\!6,\!8\) Although we present some information on the human and material resources,\(^9,\!8\) our study was not designed to assess quality of care based on outcomes.\(^5\) A full evaluation of the quality of the active management of the third stage of labour would require assessment of the inputs, processes, outputs and outcomes.

Although we found evidence of progress being made since 2005, there is still room for improvement. As new evidence becomes available and revisions to global guidelines are developed, national policies and guidelines should also be updated. As an organization responsible for setting global standards in health practice, WHO is in the best position to ensure that new guidelines are introduced in countries. National guidelines, in turn, should stimulate appropriate training and the production of updated standard management guidelines that are readily available at the facility level.\(^9\) National health management information systems should include uterotonic provision to enable

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### Table 6. Implementation of components of the active management of the third stage of labour in six countries, sub-Saharan Africa, 2009–2012

| Component | Ethiopia (n = 117) | Kenya (n = 564) | Madagascar (n = 288) | Mozambique (n = 507) | Rwanda (n = 225) | United Republic of Tanzania (n = 616) | Total (n = 2317) |
|-----------|------------------|----------------|----------------------|----------------------|----------------|--------------------------------------|-----------------|
| Deliveries any uterotonic given DUG (% of deliveries) | 114 (97) | 531 (94) | 243 (84) | 454 (90) | 221 (98) | 610 (99) | 2173 (94) |
| Oxytocin was given (% of DUG) | 112 (98) | 522 (98) | 242 (100) | 453 (100) | 220 (100) | 494 (81) | 2043 (94) |
| Ergometrine was given (% of DUG) | 2 (2) | 4 (1) | 1 (< 1) | 0 (0) | 1 (< 1) | 25 (4) | 33 (2) |
| Syntometrine was given (% of DUG) | 0 (0) | 5 (1) | 0 (0) | 1 (< 1) | 0 (0) | 1 (< 1) | 7 (< 1) |
| Misoprostol was given (% of DUG) | 0 (0) | 0 (0) | 0 (0) | 0 (0) | 0 (0) | 90 (15) | 90 (4) |
| Uterotonic was given < 1 minute after birth (% of DUG) | 90 (79) | 422 (79) | 99 (41) | 156 (34) | 55 (25) | 302 (50) | 1124 (52) |
| Uterotonic was given 1–3 minutes after the birth (% of DUG) | 15 (13) | 0 (0) | 81 (33) | 163 (36) | 88 (40) | 169 (28) | 516 (24) |
| Uterotonic was given > 3 minutes after the birth (% of DUG) | 9 (8) | 109 (21) | 63 (26) | 135 (30) | 78 (35) | 134 (22) | 528 (24) |
| Controlled cord traction was performed (% of deliveries) | 92 (79) | 499 (88) | 171 (59) | 269 (53) | 166 (74) | 464 (75) | 1661 (72) |
| Uterine massage was performed (% of deliveries) | 49 (42) | 496 (88) | 158 (55) | 360 (71) | 107 (48) | 361 (59) | 1531 (66) |
| Any AMTSL component was performed (% of deliveries) | 114 (98) | 562 (100) | 254 (88) | 490 (97) | 224 (100) | 611 (99) | 2255 (97) |
| AMTSL was performed within 1 minute of birth (% of deliveries) | 35 (30) | 352 (62) | 52 (18) | 84 (17) | 21 (9) | 178 (29) | 722 (31) |
| AMTSL was performed within 3 minutes of birth (% of deliveries) | 40 (34) | 352 (62) | 107 (37) | 174 (34) | 62 (28) | 261 (42) | 996 (43) |

AMTSL: active management of the third stage of labour.

\(^a\) Percentages shown represent the values obtained after weighting according to each surveyed facility’s delivery caseload.

\(^b\) In Kenya, uterotonic administrations within 1 and 3 minutes of the birth were not distinguished.

Note: Percentages have been rounded.
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Maláxay

Tập quản lý tích cực của giai đoạn ba trong sản phụ ở các quốc gia châu Phi cận nhiệt đới

Mục tiêu

Tập hợp và phân tích dữ liệu từ 2317 trường hợp được theo dõi từ 390 cơ sở y tế ở 6 quốc gia châu Phi cận nhiệt đới gồm Ethiopia, Kenya, Madagascar, Mozambique, Rwanda và Tanzania, nhằm đánh giá chất lượng của việc quản lý tích cực giai đoạn ba trong sản phụ.

Phương pháp

Trong giai đoạn từ 2009 đến 2012, 2317 trường hợp được theo dõi, bao gồm những phụ nữ đang bị theo dõi trong giai đoạn ba trong sản phụ. Các nhân viên y tế đã ghi nhận thông tin về việc sử dụng thuốc nội tiết hoặc cách thức xử lý khác, và việc kiểm tra cơ sở y tế để đảm bảo việc chuẩn bị của các nhân viên y tế.

Kết quả

Hơn 94% (2173) trường hợp đã được sử dụng thuốc nội tiết, trong đó có 2043 trường hợp được sử dụng thuốc nội tiết một cách không đúng quy định. Việc sử dụng thuốc nội tiết có thể được thực hiện một cách không đúng quy định, dẫn đến tình trạng không an toàn cho mẹ và con.

Thúc đẩy

Việc tập hợp và phân tích dữ liệu này cung cấp cho các nhà quản lý y tế và các cơ sở y tế cơ sở dữ liệu để có thể cải thiện chất lượng của việc quản lý tích cực giai đoạn ba trong sản phụ. Việc này đòi hỏi sự thay đổi cách thức của các nhân viên y tế và việc cung cấp sự hỗ trợ từ các nhà ngành y tế để nâng cao chất lượng của dịch vụ.

Résumé

Prise en charge active du troisième stade du travail dans les établissements médicaux: évaluation de la qualité dans six pays de l’Afrique subsaharienne

Objectif Evaluez la qualité de la prise en charge active du troisième stade du travail dans les établissements médicaux en Éthiopie, au Kenya, à Madagascar, au Mozambique, en République-Unie de Tanzanie et au Rwanda.

Méthodes Entre 2009 et 2012, 2317 femmes hospitalisées dans 390 établissements de santé ont été directement observées, à l’aide d’une analyse transversale, lors du troisième stade du travail. Les observateurs ont constaté l’utilisation de médicaments utérotoniques,
de la traction contrôlée du cordon et de massages utérins. Les infrastructures et le matériel nécessaires à une prise en charge active ont été contrôlés et les directives applicables ont été examinées.

**Résultats** La plupart des femmes observées (94%; 2173) ont été traitées par ocytocine (2043) ou à l’aide d’un autre uterotonic (130). La fréquence de la traction contrôlée du cordon et des massages utérins ainsi que le moment choisi pour administrer l’utérotonique variaient considérablement d’un pays à l’autre. Parmi les femmes traitées à l’aide d’un médicament utérotonique, 1640 (76%) l’ont reçu dans les trois minutes qui suivent la naissance. Les utérotoniques et le matériel associé étaient généralement disponibles sur place. Si tous les pays étudiés disposaient de politiques et/ou de directives nationales soutenant la prise en charge active du troisième stade du travail, la présence de directives dans les établissements variait selon les pays et seuls 377 (36%) des 1037 prestataires sondés avaient bénéficié d’une formation appropriée au cours des trois années précédentes.

**Conclusion** La qualité et le nombre des bénéficiaires de la prise en charge active du troisième stade du travail étaient élevés dans les pays étudiés. Il est cependant nécessaire pour améliorer la prise en charge active de mener davantage de recherches afin d’optimiser le moment d’administration de l’utérotonique. Une formation à l’utilisation de nouvelles directives cliniques et une recherche sur la mise en œuvre des meilleures méthodes pour mettre à jour cette formation sont également nécessaires.

**Resumen**

**Objetivo** Evaluar la calidad de la gestión activa de la tercera etapa del parto en establecimientos sanitarios de países sub-saharianos.

**Métodos** Entre 2009 y 2012, se observaron 2.317 mujeres en 390 establecimientos durante la tercera etapa del parto utilizando un diseño transversal. Los observadores registraron el uso de medicamentos uterotónicos, la tracción controlada del cordón y el masaje uterino. Se realizaron visitas a las instituciones para revisar los materiales, dispositivos y suministros necesarios para la gestión activa y se revisaron las directrices relevantes. Los resultados de las visitas mostraron considerables diferencias entre países. De las mujeres que recibieron un medicamento uterotónico, 1,640 (76%) lo recibieron dentro de los tres minutos posteriores al nacimiento. Los medicamentos uterotónicos y los suministros relacionados estaban generalmente disponibles en el lugar. A pesar de que los países estudiados tenían políticas nacionales y directrices que apoyaban la gestión activa de la tercera etapa del parto, la presencia de dichas directrices en los establecimientos sanitarios variaba dependiendo del país, y solo 377 (36%) de los 1.037 proveedores de establecimientos sanitarios habían recibido una formación relevante durante los tres años previos.

**Conclusión** En los países estudiados, la calidad y cobertura de la gestión activa durante la tercera etapa del parto eran elevadas. Sin embargo, es necesario realizar más investigaciones sobre cómo optimizar el momento de la administración uterotónica de cara a mejorar la gestión activa. También hace falta formación en el uso de las nuevas directrices médicas y investigación sobre la aplicación de los mejores métodos para actualizar dichas formaciones.
