

**EXPERIENCES OF MIDWIVES ON ACTIVE MANAGEMENT OF THIRD STAGE OF
LABOUR IN DISTRICT HOSPITALS, OMUSATI REGION**

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ABSTRACT

Active Management of Third Stage of Labour can prevent post-partum haemorrhage. According to Prevention of Postpartum Hemorrhage Initiative (POPPHI, 2009), active management of the third stage of labor (AMTSL) can reduce the incidence of postpartum hemorrhage by up to 60%. According to Marshall, Buffington, Beck and Clark (2008), postpartum hemorrhage is one of the leading causes of maternal deaths in many countries, accounting for 60% of maternal deaths. This fact is also true for Namibia where the highest direct cause of maternal deaths for the period April 2010 to March 2012 was linked to bleeding after delivery (MoHSS, 2014).

The purpose of the study was to explore and describe midwives' experiences on AMTSL in Omusati region. The study objectives were to explore midwives' experiences on AMTSL and describe the midwives' experiences on AMTSL.

The study employed a qualitative, explorative, descriptive and contextual design that used focus group discussion and individual interviews to collect data that was analyzed through content analysis. Purposive sampling method was used to select nineteen participants from among 53 midwives distributed across the four district hospitals in Omusati region involved in the study.

The study revealed that there was good awareness and knowledge of AMTSL among midwives in Omusati region, and the study participants expressed positive experience in using AMTSL to manage the third stage of labour as they have noted decreased incidence of post-partum haemorrhage and shortened delivery time in applying the method. However, some midwives in Omusati region lacked proper understanding of AMTSL. Midwives in Omusati region experienced challenges in implementing AMTSL due to insufficiency in staff coverage in labour

wards and oxytocin stored in rooms outside the delivery room. This has often resulted in oxytocin not being administered within the recommended time frame during AMTSL.

Recommendations are made in this study to improve maternal care services by availing updated guidelines, offer refresher courses and supportive supervision. The researcher also recommends improvement in staff coverage in labour wards, keeping a fridge in labour room where oxytocin is stored will prevent some delays in giving oxytocin. Areas for future research including the impact of staff shortage on quality obstetric care in the country have been highlighted.

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DEDICATION

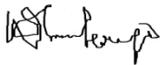
I dedicate this work to all health workers in Omusati region along with my loving family. A special thanks to my parents who have offered me their unconditional love, patience, support and guidance throughout my study.

DECLARATIONS

I, **Wilhelmina T. M. Shikongo**, hereby declare that, Midwives Experience on Active Management of Third Stage of Labor in District hospitals, Omusati region, Namibia, is a true reflection of my own study and has not been submitted for any degree in any other University.

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19. 02 2019

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Wilhelmina T. M. Shikongo

Date

LIST OF ABBREVIATIONS

AMTSL.....ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

ANC.....ANTE NATAL CARE

DIC.....DISSEMINATED INTRAVASCULAR COAGULATION

E/N/M.....ENROLLED NURSE MIDWIFE

EMONC.....EMERGENCY OBSTETRIC AND NEONATAL CARE

FGD.....FOCUS GROUP DISCUSSION

HIV.....HUMAN IMMUNE VIRUS

MOHSS.....MINISTRY OF HEALTH AND SOCIAL SERVICES

PPH.....POSTPARTUM HAEMORRHAGE

R/N.....REGISTERED NURSE

SMO.....SENIOR MEDICAL OFFICER

UNAM.....UNIVERSITY OF NAMIBIA

WHO.....WORLD HEALTH ORGANISATION

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

The study was done to look at the midwives' experiences based on the World Health Organization (WHO) recommended method of managing the third stage of labour referred to as "the Active Management of Third Stage of Labour". The study is based on the experiences of midwives working in Omusati region in Northern Namibia.

Globally, more than 287,000 women die each year because of maternal deaths, and this translates into 786 women dying every day (Ministry of Health and Social Services [MoHSS], 2014). Maternal deaths in Namibia is reported at 116/100 000 according to MoHSS and Namibia Statistics agency (NSA 2013).

In 2012, Namibia reported 63 783 institutional deliveries and 116/100 000 maternal deaths (MoHSS, 2014). According to Marshall, Buffington, Beck and Clark (2008) postpartum hemorrhage is one of the leading causes of maternal deaths in many countries, accounting for 60% of maternal deaths. This fact is also true for Namibia where the highest direct cause of maternal deaths for the period April 2010 to March 2012 is linked to heavy bleeding after delivery (MoHSS, 2014).

Maternal labour is conventionally divided into three stages. The first stage of labour begins with onset of sustained contractions up to full dilatation of the cervix and the second stage commences from full dilatation of the cervix to complete delivery of the fetus. The third stage of labour commences with the completed delivery of the fetus and ends with the completed delivery of the placenta and its attached membranes (Marshall, Buffington, Beck and Clark 2008). During this stage, one of the two methods that can be used to manage the third stage is the passive (physiological) method and the active method. The use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour is recommended by the World Health Organization (WHO) for all births. Oxytocin (10 international units [IU], intravenously or intramuscularly [IV/IM]) is the recommended uterotonic drug for the prevention of postpartum haemorrhage (WHO, 2012). To prevent postpartum haemorrhage, WHO (2012) recommends the use of oxytocin 10 IU intra-muscular injection (IMI) within one minute of the birth of the baby (Marshall et al., 2008).

The WHO (2009) reported that the primary aim of active management of third stage of labour is to reduce postpartum haemorrhage and is regarded as a successful preventive intervention. In Active Management of Third Stage of Labor, (AMTSL) a number of interventions are applied in combination, and comprises of three components: administration of an uterotonic soon after delivery of the baby; controlled cord traction for placental delivery; and uterine massage after delivery of the placenta. It is documented that AMTSL reduces the occurrence of severe postpartum hemorrhage by approximately 60–70% (WHO, 2009).

According to Dippenaar, Da Serra & McCall Sellers (2012) the reasons for undertaking AMTSL is to prevent excessive vaginal bleeding. Namibia adopted the use of AMTSL to manage the third stage and recommend that AMTSL should be used in all health facilities across the country where deliveries undertaken (MoHSS, 2014).

In addition, a survey done in Iran by Afshari, Medforth, Aarabi, Abedi & Soltani (2014) on active management of third stage of labour found that, active management of third stage of labour is most commonly used in delivery units in Iran, but the study did not provide information on the number of maternal mortality and morbidity related to the postpartum haemorrhage reported by the participants due to lack of accurate auditing system. Afshari et al. (2014) further stated that almost one third of maternal mortality in Iran has been attributed to the management of postpartum haemorrhage.

Furthermore, in a study done by Schack, Elyas, Brew & Pettersson (2014) in Accra Ghana, it was found that guidelines for procedures (including AMTSL) recommended both by WHO and by the Ghanaian Ministry of Health, designed to prevent a huge threat to women's health, were not being followed despite regular training sessions. Generally, this means availability of guidelines does not usually mean compliance with the guidelines in practice. A study done in a large public teaching hospital in Egypt reported AMTSL in 15% of all deliveries (Tsu, Tran, Nguyen and Luu, 2006).

Additionally, a study carried out in Nigeria on active management of labour (Oladapo, Fawole, Loto, Adegbola, Akinola, Alao and Adeyemi, 2009) concluded that AMTSL was familiar but

poorly understood among obstetric care providers. Oladapo et al. (2009) further suggested that there is a need for improvement in healthcare quality and practitioners' adherence to recommended guidelines on AMTSL; this urgently requires educational interventions that target those who provide routine care.

Since Namibia recommended the adoption of AMTSL in conducting deliveries, no research or reports have been done on the adoption of the guideline by the midwives in conducting deliveries or their experience in following the guidelines. What is obvious is that many cases of institution-based maternal deaths are still happening in Namibia largely due to post-partum haemorrhage. The researcher noted that there are limited resources or information on experiences of midwives regarding AMTSL. Studying this topic will help to shed light on experiences of midwives in adopting and implementing the practice. It will contribute to literature and help to make recommendations for possible policy and operational interventions to improve the quality of care provided in labour wards.

The researcher therefore aimed to explore and describe the experiences of midwives on Active Management of Third Stage of Labour package in hospitals in Omusati region.

1.2 Background of the study

The third stage of labor starts with the complete birth of the baby and ends with the delivery of the placenta and membranes (Dippenaar et al. 2012). Smith (2015) wrote that the clinician immediately recognizes that from a practical perspective, the risk of complications continues for

some period after delivery of the placenta. For this reason, many authorities have advocated a so-called fourth stage of labor, which begins with the delivery of the placenta and lasts for an arbitrary period afterward. According to Smith (2015) the most commonly chosen duration for fourth stage is 1 hour; however, periods as long as 4 hours have been suggested. The length of the third stage itself is usually 5-15 minutes. The absolute time limit for delivery of the placenta, without evidence of significant bleeding, remains unclear. Periods ranging from 30-60 minutes have been suggested.

When the baby is born, the contractions continue and the uterus becomes smaller. This usually causes the placenta to separate from the uterine wall. Some of the small uterine blood vessels tear as the placenta pulls away, so there is bleeding until the uterus is completely empty and can contract tightly.

In the past, midwives waited for the placenta to separate and encouraged the woman to deliver the placenta by pushing down during the next uterine contraction. Today, to limit blood loss, it is recommended that the placenta is quickly delivered by actively managing the third stage. Dippenaar et al. (2012), describe active management of third stage of labour as a policy whereby prophylactic administration of an uterotonic, as a precautionary measure aimed at reduction in the risk for postpartum haemorrhage, is applied regardless of the assessed obstetric risk status of the woman. The same authors further wrote that an active management policy usually includes the routine administration of an uterotonic agent either, intravenously, intramuscularly or even orally. Prophylactic infusion of large doses of uterotonics diluted in intravenous solutions may be

administered over several hours following the birth; this would be considered to be part of an active management policy.

In clinical studies, it has been found that active management of third stage of labour can prevent postpartum haemorrhage. If the placenta remains in uterus more than thirty minutes there will be more bleeding (Marshall 2008). Marshall further emphasised that active management of third stage of labour lessens the amount of blood loss during the third stage of labour, and it prevents uterine atony up to 60%. In agreement to Marshall, Peate & Hamilton, (2014) stated that uterine atony is reduced by 70% when using active management of third stage of labour. For this reason the WHO (2012) recommends that AMTSL should be used for all vaginal births to deliver the placenta.

Lewis (2015) is of the view that the third stage of labour should be discussed with the woman, and it is important to ensure that the woman understands that it can be achieved naturally without intervention. Dippenaar et al. (2012) added that no matter what an individual midwife's personal practice may be or what the best available research evidence recommends, it is ultimately the woman's decision as to how she would ideally wish her pregnancy and birth plan to be followed. There may be philosophical, religious or cultural beliefs that influence her decision. Lewis (2015) further stressed that the woman needs to understand that this decision is only made at the end of second stage of labour. To be able to do this, midwives should ensure they have skills for both physiological and active management of labour and avoid mixing elements of the two methods because it may have implication on the outcome.

Macdonald & Magill-cuerden (2012) wrote that traditionally the third stage has been regarded as hazardous because of the risk of postpartum haemorrhage. Postpartum haemorrhage is a major cause of maternal death in the world. Macdonald & Magill-cuerden (2012) further state that the benefits of active management cannot be questioned for women at risk of postpartum haemorrhage. However, indiscriminate use of active management of third stage of labour for women at low risk has been challenged.

Jangsten, Hellström & Berg (2010), found out that some midwives preferred individualised management, and questioned the wisdom of ‘blindly’ following prophylactic treatment recommendations. Prevention of Postpartum Haemorrhage Initiative (POPPHI) (2010), wrote that predicting who will have PPH based on risk factors is difficult because two-thirds of women who have PPH have no risk factors. Therefore, all women are considered at risk, and hemorrhage prevention must be incorporated into care provided at every birth.

An alternative to active management of third stage is the expectant management, also known as passive or physiological or natural management. This package is characterized by activity on the part of the woman; the midwife’s role is one of “watchful waiting”. An understanding of the physiology of the third stage of labour is needed to make a successful delivery of placenta and membranes with appropriate rather than indiscriminate use of intervention.

1.2.1 Physiology of the third stage of labour.

Macdonald et al. (2012), indicated that during labour, the uterine muscles contract and retract under the influence of naturally produced oxytocin. These muscles continue to contract and retract during the third stage to expel the placenta and membranes; the control of bleeding is brought about by the same physiological process. Placenta separation begins with the contractions that deliver the baby's trunk and then complete in the next two or three contractions. During this process there is a remarkable reduction in the size of the uterus diminishes the size of placental site. Placental separation is divided into three phases: the latent phase, detachment phase and expulsion phase (Macdonald et al., 2012). These authors described the three phases as follow:

The latent phase is the period of delivery from delivery of the infant to the beginning of placenta separation. During the stage, the placenta-free uterine wall thickens under the influence of intermittent contractions.

Detachment phase is the period of placental separation and detachment from uterine wall; this is brought about by the thickening of uterine wall over the site of placental attachment. The myometrium adjacent to the lower edge of the placenta contracts and thickens. This reduces the placental site surface and further leads to shearing off of the placenta in that area. This continues until the whole placenta is detached and this normally is achieved within three minutes (Macdonald et al., 2012).

Expulsion phase is the period from complete separation of the placenta to vaginal expulsion. During this phase the upper uterine segment contracts strongly forcing the placenta to fold in on

itself and then descend into lower segment and then into the vagina; gravity and sometimes maternal effort brought about by stimulation of the pelvic floor, leads to expulsion of placenta and membranes (Macdonald et al., 2012).

Following the expulsion phase several mechanisms come into play to control the bleeding from the maternal sinuses at the site of placental attachment. The empty uterus contracts causing the uterine wall to come into opposition, the myometrium continues to contract and retract and the interlacing muscle fibres constrict the torn blood vessel, blood clotting is initiated and the uterine cavity quickly becomes covered with a fine protective mesh (Macdonald et al., 2012).

Dippenaar et al. (2012) described the signs and symptoms of third stage of labour as follow: The uterus is tightly contracted and retracted and becomes hard and round (like a cricket ball). The uterus can be palpated abdominally through the maternal anterior abdominal wall, between the rectus abdominis muscles; it also rises in the abdomen because it is trying to push the placenta out. A fresh trickle of blood is noted vaginally, and finally the placenta is expelled from the birth canal with the help of maternal effort. The membranes are detached from the uterine wall merely by the weight of the placenta descending in the birth canal, causing traction on the membranes and thereby stripping them off the deciduas. The average amount of blood loss in a normal third stage of labour is 150 – 250ml (Dippenaar et al., 2012).

The placenta separates in one or two ways; these are the Schultze (shiny) method and the Matthews-Duncan (dirty) method. The manner of placenta separation then prescribes the way in which the placenta will emerge at the birth canal (Dippenaar et al., 2012). According to Dippenaar et al. (2012), when placenta is implanted high-up near or in the uterine fundus, the centre of the placenta separates from the uterine wall first, the blood (retro placenta clots) collects in the centre of the placenta and causes the placenta to invert as it descends in the uterus and birth canal. The shiny fetal surface emerges from the vaginal orifice first with the blood clot contained within the membranes, and little blood is spilt, the membranes are usually intact except for the hole where the baby was born.

The second type, the Matthews-Duncan, applies when the placenta is implanted in the side of the uterine body. During this method the lower edge of the placenta separates from the uterine wall first, causing the bleeding which dislodges the membranes below the bleeding and blood escapes from the uterus into the vagina and eventually out of the vaginal orifice. The separation continues upwards and when it is complete, the lower edge of the placenta slips through the cervical os and emerges from the vaginal orifice first together with a gush of blood, to be followed by the maternal surface of the placenta and torn ragged membranes (Dippenaar et al. 2012).

Any factor that interferes with the physiological process can influence the outcome of the third stage of labour.

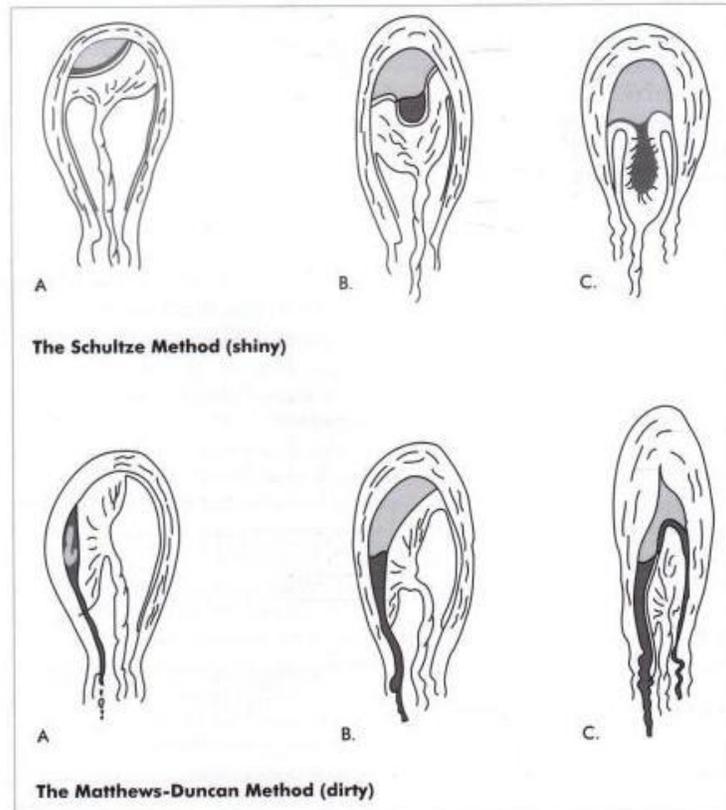


Figure 1.1 Types of placenta separation (Dippenaar, Da Serra & McCall Sellers, 2012)

1.2.2 Factors that may interfere with the physiological process of the third stage of labour.

Macdonald et al. (2012) listed the following factors as factors that interfere with the physiological process of the third stage: previous postpartum haemorrhage, anemia, clotting disorder, and pregnancy induced hypertension, over-distended uterus as in polyhydramnios, multiple pregnancy or fibroid. Other factors include grand multiparity, induction / augmentation of labour, poor uterine action during labour and delivery, long first or second stage, instrumental delivery, oxytocic drugs, dehydration during labour, full bladder at onset of the third stage of labour and, how the third stage of labour is managed.

In addition Dippenaar et. al. (2012) listed two main factors that interfere with normal third stage physiology, coagulation failure and atonic uterus. Coagulation failure is caused by several conditions: disseminated intravascular coagulation (DIC) caused by fibrin degradation product in the blood circulation, and conditions that may predispose to DIC are pre- eclampsia/ eclampsia, exacerbated by placenta abruption or a dead fetus remaining *in utero* for longer than four weeks. In rare instances, blood dyscrasias, an inherited blood disorders such as Von Willebrand's disease (a defect in the factor VIII complex), and platelets dysfunction or other bleeding disorders caused by a deficiency in a blood factor may result in interference with normal third stage physiology. Platelets disorder such thrombocytopenia and rarely leukemia may also be the cause of coagulation failure.

Atonic uterus is caused by the inefficient contraction and retraction of the myometrium. Factors contributing to this are: full bladder which displaces the uterus and therefore prevent efficient contraction and retraction of the uterus; overstretched uterine muscle fibres as a result of large baby, polyhydramnios or multiple pregnancies; tired or debilitated muscle fibres, due to prolonged or obstructed labour. Other contributory factors include anaemia, gross malnutrition, high parity and the administration of anaesthetic agents may result in an inert uterus. Abnormal uterine action may cause bleeding as a result of incoordinated uterine action or constriction ring. Both of these could be caused by mismanagement as a result of mishandling of the uterus or inappropriate use of the oxytocic drugs (Dippenaar et al. 2012).

Placental pathology such as partial placenta accreta, mismanagement of the third stage of labour, abnormal presentation where the placenta may partially separate as it may occur in a breech delivery or after the delivery of the first baby in multiple pregnancies may also cause abnormal uterine action. Retained products of conception, any piece of placenta or membranes retained in uterus could result in inefficient uterine contraction and retraction and cause haemorrhage (Dippenaar et al., 2012).

1.2.3 The physiological process of haemorrhage control in the third stage.

Two physiological processes bring about the haemorrhage control in the third stage of labour (Dippenaar et al., 2012), - the normal coagulation process of the blood and the constricting effect of the uterine muscles. The coagulation process occurs with any wound, from the release of thromboplastins through to the formation of fibrin. The so called 'living ligature' effect of the criss-cross muscle fibres of the myometrium cause the constriction contracting and retracting uterine muscles on the blood vessel that controls blood loss. Failure in either of these physiological processes will result in uncontrolled haemorrhage. This can happen if the uterus is able to contract but there is failure of the coagulation process, as continued bleeding in itself will prevent the uterus from contracting efficiently. Conversely, if the coagulation is normal, but the uterus is atonic, severe haemorrhage can result.

Dippenaar et al. (2012), further wrote that the musculature of the uterus is arranged in such a way that the contracting and retracting of the criss-crossing uterine muscle fibre, after the birth of the baby and separation of the placenta, controls of the bleeding from the exposed blood vessels (no bleeding from placenta site if placenta does not separate). The smooth muscle fibre of the

uterine musculature are arranged in figure eight around the blood vessels as these vessels pass through the uterine wall, therefore contraction of the uterus following the delivery of the baby constricts the vessels that had previously supplied blood to the placenta. The uterus contracts and retracts, and bleeding from the placenta site is controlled. For these reasons, the efficiency of the uterus is directly proportional to the efficient separation of placenta and the efficient control of haemorrhage, if the clotting mechanism is normal (Dippenaar et. al. 2012).

The illustration below shows how the blood vessels contract and relaxed as a result of the constrict effect of the uterine muscle fibers to control the bleeding from the placental site.

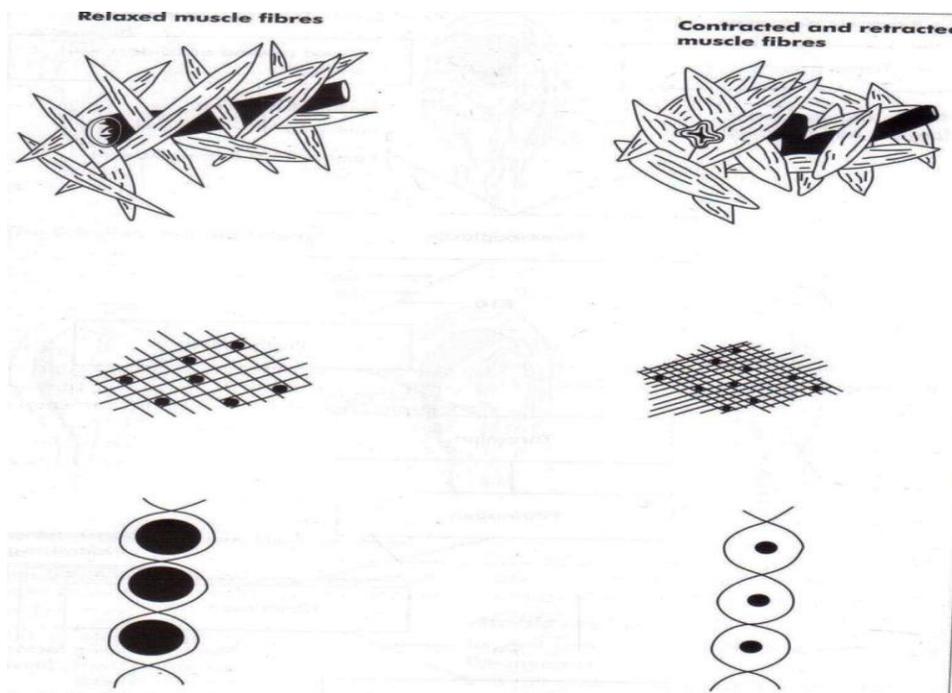


Figure 1.2. The constriction effect of uterine muscles on blood vessels. (Source: Dippenaar, Da Serra & McCall Sellers, 2012).

1.2.4 Experiences of midwives on Active Management of Third Stage of Labour globally.

Several studies have been done to look at midwives' experiences on third stage of labour across the globe. A study done in Sweden by Jangsten et al. (2010), indicated that Swedish midwives are responsible for managing normal childbirth, including the third stage, and doctors are only consulted in case of complications. The study found that most Swedish midwives preferred not to administer prophylactic oxytocin immediately, awaiting the normal physiological process instead. The midwives wished to make their own decisions, stressed the importance of individualised management, and questioned the wisdom of 'blindly' following prophylactic treatment recommendations. This decision happens to contradict the updated WHO (2012) recommendation that imply AMTSL to be offered to all women at birth. The midwives in the Swedish study were found to be very experienced and confident in their management of labour and some worked at university hospitals with a high annual number of births.

Other research findings also appear to contradict the blanket recommendation on administration of an uterotonic to all women in the third stage of labour. In study conducted in New Zealand, Dixon, Tracy, Guilliland, Fletcher, Hendry & Pairman (2013) described the outcomes of care during the third stage of labour when midwives work in a Lead Maternity Carer role providing non-fragmented care across the whole continuum from antenatal, labour and birth to postnatal care. The study indicated that the use of physiological third stage care resulted in lower levels of blood loss, and less need for manual removal of the placenta when preceded by a spontaneous labour and normal birth. The results in this study suggest that physiological third stage care

should be considered and supported for women who are healthy and have had a spontaneous labour and birth regardless of birth place setting. Furthermore Dixon et al, (2013) suggested that further research should determine whether the use of an uterotonic as a treatment in the first instance may be more effective than as a treatment following initial exposure prophylactically. To some extent Dixon et al.(2013) concur with Jangsten et al. (2010), however he specifically pointed out when physiological management is deemed to be used, for example, for women who are healthy and have had a spontaneous labour and birth.

In a study done by Michael (2015) to determine factors affecting the effective management of third stage of labour it was reported that the main causes of deaths are: Complications during third stage of labour, infection, obstructed labor and eclampsia. The most commonly reported complications of labour were: Prolonged/Obstructed labour (0.9%), Hemorrhage (Postpartum, and ante- partum) (0.8%) and Retained placenta (0.8%). Uterine atony was not quantitatively reported. Respondents to interviews have associated it with postpartum hemorrhage and also with aged and multigravida. Most of the reported hemorrhage is the postpartum hemorrhage.

There were also some reported cases of intrapartum hemorrhage. Although most of the personnel interviewed were aware of active management of third stage of labour and its basic components there are some slight variations in the details of implementation of the components. Observation of the implementation of active management also showed that same variations exist among different health workers. The major difference was found in the timing of the administration of uterotonic medication. Another major barrier to the management of active third stage of labour

was found to be lack of available maternal life-saving medicines and supplies like misoprostol and oxytocin. Michael (2015) therefore felt that proper management of third stage of labour will significantly reduce maternal deaths. Also, maternal medicines and supplies in combination with the skilled birth attendance are very important to achieve a comprehensive maternal death reduction program.

Schack, Elyas, Brew & Pettersson (2014) conducted twelve in-depth interviews with labor ward midwives who all had previous training in AMTSL. The interviews took place in 2011 at three hospitals in Accra Metropolis, Ghana. Findings in this study highlight the need for extended educational interventions and recurrent controls of adherence to guidelines. It should be noticed though that this study has clearly identified that training and repeated education sessions alone will not change practice. Identifying and targeting highly influential midwives would probably have a greater effect.

In a country where reduction of maternal mortality is of high importance but where the number of skilled midwives is inadequate, one would also benefit from a randomized control trial on the effectiveness of task shifting regarding AMTSL. Moreover, considering the latest WHO guidelines, research on the benefits of implementing a more practical approach to managing the third stage of labor in resource-poor settings would be of great value. The Ghanaian midwives felt that if uterine massage could be safely eliminated from routine practice and controlled cord traction optional, the situation for the midwives of Ghana would most certainly be considerably relieved.

1.2.5 Current WHO recommendations on Active Management of Third Stage of Labour.

The World Health Organization (WHO) used Cochrane systematic reviews of randomized controlled trials (RCTs) as the primary source of evidence for the recommendations on AMTSL. In 2007 the WHO released a document based on management of third stage related study carried out in different countries. The scientific evidence for the recommendations was synthesized using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology (WHO, 2012).

The WHO made recommendations for treatment of PPH and management of third stage of labour in 2007. These recommendations were then revised based on twenty two up-to-date systematic reviews. The revised and new recommendations were developed and adopted by an international group of experts who participated in the WHO Technical Consultation on the Prevention and Treatment of PPH, held in Montreux, Switzerland, 6–8 March 2012.

According to WHO (2012), most deaths resulting from PPH occur during the first 24 hours after birth; the majority of these could be avoided through the use of prophylactic uterotonics during the third stage of labour and by timely and appropriate management. In light of new available evidence, component of the ‘active management of the third stage of labour’ was examined and relevant recommendations were made that all women giving birth should be offered uterotonics during the third stage of labour for the prevention of PPH; oxytocin (IM/IV, 10 IU) is

recommended as the uterotonic drug of choice. Other injectable uterotonics and misoprostol are recommended as alternatives for the prevention of PPH in settings where oxytocin is unavailable.

The importance of controlled cord traction (CCT) was revisited because of new evidence. This intervention is now regarded as optional in settings where skilled birth attendants are available, and is contraindicated in settings where skilled attendants do not assist with births. Early cord clamping is generally contraindicated. Continuous uterine massage is not recommended as an intervention to prevent PPH in women who have received prophylactic oxytocin, as it may cause maternal discomfort, require a dedicated health professional, and may not lead to a reduction of blood loss.

However, surveillance of uterine tonus through abdominal palpation is recommended in all women for early identification of postpartum uterine atony.

In summary, the Guideline Development Group (GDG) considered the use of uterotonics as the main intervention within the active management of third stage of labour package. In this context, the use of misoprostol for the prevention of PPH by community health care workers and lay health workers is supported in settings where skilled birth attendants are not present. The GDG also issued recommendations for reducing blood loss during the third stage of labour in caesarean sections. Oxytocin is the recommended uterotonic drug for the prevention of PPH in caesarean sections. Cord traction is recommended in preference to manual removal when assisting placental delivery in caesarean sections (WHO, 2012).

1.3 Statement of the problem

In 2012, Namibia reported 25% of direct maternal mortality due to obstetric haemorrhage (MoHSS, 2014). Midwives in Namibia have been trained on Emergency Obstetric and Neonatal Care (EmONC) that included Active Management of Third Stage of Labour but mortality due to haemorrhage is still high. The report on maternal mortality in Namibia indicates that Omusati region is ranked number one on maternal mortality, reporting 78 deaths between 2010 -2012 (MoHSS, 2014), making the region the largest contributor to preventable maternal deaths in Namibia.

Ever since the training on Emergency Obstetric and Neonatal Care (EmONC) in 2012 in Namibia, no supportive supervision has been conducted to explore how the midwives are adapting to the implementation of the guidelines including Active Management of Third Stage of Labour. According to Marshall, Buffington, Beck and Clark (2008) 70% to 90% of immediate postpartum haemorrhage is due to uterine atony (Marshall, et al., 2008). These percentages of postpartum haemorrhage can be reduced by using Active Management of Third Stage of Labour.

To the researcher's knowledge no qualitative study has been conducted in Omusati region and elsewhere in Namibia to determine experiences of midwives on the practice of AMTSL. The researcher therefore became interested in understanding the experience of the midwives regarding AMTSL.

It is against this background that, the researcher explored and described the experiences of midwives (in the four district hospitals in Omusati region) on Active Management Third Stage of Labour.

1.4 Purpose of study

The purpose of the study was to explore and describe the existing midwives' experiences on active management of third stage of labour in Omusati region.

1.5 Objectives of the study

The objectives of the study were to:

Explore the experiences of midwives on Active Management of Third Stage of Labor (AMTSL).

Describe the experiences of midwives on Active Management of Third Stage of Labor (AMTSL).

1.6 Significance of the study

The study is the first of its kind in Omusati region and the findings are expected to contribute to the knowledge in the field of midwifery in Omusati with new insight that might facilitate improved practice of AMTSL. The insight gained from the outcome of this research through exploring the experiences of midwives might be used to formulate strategies in obstetric care and

thereby improve the quality of life for women and children in Omusati region and Namibia in general.

1.7 Definition of concepts

The following terms are defined because they have unique meaning in the study:

Experience - refers to direct observation of or participation in events as a basis of knowledge (Merriam Webster's online dictionary, 2017). In this study the word experience refers to what the midwives experienced or observed when implementing the active management of third stage of labour and to what the midwives think will help the adoption of active management of third stage of labour in labour units to prevent postpartum haemorrhage.

Midwife - a midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the International Council of Midwives' (ICM) Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education. A midwife is one who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery (ICM 2011). In this study, the word midwife will refer to someone who has a basic registration as Registered Midwife (RM), Registered Nurse and Midwife (RNM) or as Enrolled

nurse midwife (EN/M) and employed to work as such in any of the health facilities. The person could have additional qualification in other discipline.

Third stage of labour -refers to the period following the completed delivery of the newborn until the completed delivery of the placenta (Marshall, et al., 2008). In this study the third stage of labour is the key focus because the AMTSL is expected to be performed during this stage.

Active Management of Third Stage of Labour (AMTSL) involves the routine administration of uterotonic agent before the placental delivery, clamping of the cord and delivery of the placenta with the use of controlled cord traction (with counter pressure) (Marshall, et al., 2008). In this study, the researcher will explore and describe the experience of midwives regarding implementation of AMTSL.

Maternal death -As referred to in this study indicates the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental cause (MoHSS, 2014).

Postpartum hemorrhage (PPH) - can refer to two types of postpartum haemorrhage, primary postpartum haemorrhage defined as loss of blood estimated to be >500mls, from the genital tract within 24 hours of delivery, whereas secondary postpartum haemorrhage is defined as abnormal

bleeding from the genital tract, after 24 hours of delivery until six weeks postpartum (Royal College of Obstetricians and Gynaecologists, 2011). In this study the word postpartum haemorrhage will mean the loss of blood after delivery of five hundred or more from genital tract, or any amount of blood loss that result in clinical signs of shock.

Uterotonic agent –An uterotonic, also known as ecbolic, is an agent used to induce contraction or greater tonicity of the uterus. Uterotonics are used both to induce labor, and to reduce postpartum haemorrhage (WHO, 2012). In this study the uterotonic referred to is mainly used to reduce postpartum haemorrhage, for example oxytocin.

1.8 Outline of the report

This report is divided into five chapters:

Chapter 1 - Introduction - gives a general overview of the research including the rationale, aim and objectives of the research as well as definition of the key terms of the research.

Chapter 2- Methodology - presents the approach the researcher adopted in conducting the research including the study design, population and sampling, data collection measure to ensure trustworthiness, handling and analysis of the research results as well as ethical issues in research.

Chapter 3 - Research results - presents the findings of the research.

Chapter 4 - Discussion of results and literature control - discusses the findings of the research

highlighting its significance and compares the findings to what other researchers have reported on the topic.

Chapter 5 - Conclusions, Limitations and Recommendations–Presents a summary and draws

conclusion of the findings of the research in line with the research objectives, highlighting the main limitations of the research and makes recommendations for policy and practice and hints at areas for further research.

1.9 Summary

This chapter introduced the study and looked at the background of the study, the reasons why the study was done is explained in the problem statement, concepts used in the study are defined under the purpose of the study, objectives of the study and the significance of the study were all discussed. The next chapter will look at the method that was employed to explore and describe midwives experience on active management of third stage.

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 Introduction

In this chapter the research methodology that includes the study design, study population, sampling and piloting of the data collection instruments, data collection and data analysis as well as ethical considerations will be described.

2.2 Research design

Research design is the set of logical steps taken by the researcher to answer the research question (Brink, 2010).

The study used a qualitative, explorative, descriptive and contextual design that explored and described the experiences of midwives on the implementation of active management of third stage of labor. The study is described as qualitative because the researcher sought to understand the midwives' experience on AMTSL and did not involve quantifying the magnitude of the issue, explorative because it investigated or examined systematically how the midwives managed third stage of labour actively, investigating their acceptance of the practice, the facilitators and the challenges. The study was descriptive because the researcher described the phenomena as they occur, and contextual because the study outcome depended on the situation in which the information were found.

The study followed the phenomenological approach and examined the midwives' experience through descriptions that are provided by the midwives. The design was chosen to obtain information through semi-structured individual interviews and focus group discussion. Furthermore, the design allowed participants to share their views freely and provided an opportunity to probe further.

2.2.1 Phenomenological approach.

Phenomenological approach describes a lived experience of a phenomenon (Waters, 2017). Phenomenological approach was used because this is a qualitative study and analysis of narrative data methods was used; also essentially, the researcher focused on meaning of the experiences, behaviors and narratives. Focus group discussion and individual interviews were used to collect data without in any way directing or suggesting their description; clarification of details using follow up questions and probing was used. The findings are presented according to the themes of the descriptions of the participants' experience.

2.3 Research setting

The study was conducted in the four districts Hospitals in Omusati region namely; Oshikuku, Okahao, Outapi and Tsandi district Hospitals that are fully funded by the Government of the Republic of Namibia. Omusati region is one of the regions with the highest population in Namibia and has a population of more than 200 000 people (MoHSS, 2012/2013). The region has 4 district hospitals, 6 health centres and 40 Primary Health Care clinics and many outreach points (MoHSS 2017).

The region is predominantly an agricultural region in which mahangu (sorghum) is successfully cultivated as a staple food. A canal, which carries water from the Ruacana River to Oshakati passes through the town of Outapi, the region's capital. Water from this canal is used for irrigation of the large government-run farm at Etunda, where crops such as maize, watermelons, tomatoes, potatoes, and bananas, amongst other fruits and vegetables are grown. Omusati Region borders the Kunene Province of Angola in the north, while domestically Omusati shares borders with Ohangwena region in the northeast, Oshana region in the east and Kunene region in the south-west. Omusati Region has 12 political constituencies: Anamulenge, Elim, Etayi, Ogongo, Okahao, Okalongo, Onesi, Oshikuku, Outapi, Ruacana, Tsandi, as well as Otamanzi. The Namibia Population and Housing Census results show that Omusati region had a population of 243 166 people of which 133 621 are women and 109 545 are men (Namibia Statistics Agency, 2011).

2.4 Target Population

Target population refers to the entire group or object to which the researcher wishes to generalize the findings of a study (Nieswiadomy, 2011). Therefore the target population for this study was all the midwives who are working in maternity wards in the four district hospitals in Omusati region. The four district hospitals in Omusati region where data was collected are: Okahao, Oshikuku, Outapi and Tsandi. There were 53 midwives working in maternity wards in the region at the time of the study. Oshikuku had 18 midwives, Tsandi 10 midwives, Okahao, 9 midwives and Outapi 16 midwives at the time of the interview.

2.5 Sample and sampling

A sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research study (Brink, 2010). In this study a purposive sampling method was utilized to select study participants in all four district hospitals. This was due to the fact that some midwives were occupied and not available during the data collection and the researcher selected those available and willing to participate in the study.

The researcher managed to conduct two focus group discussions, each consisted of six midwives, and seven individual interviews, hence a total of 19 midwives were interviewed as part of the study. Oshikuku and Okahao hospitals had only six participants each who agreed to participate in the study, therefore two group discussions were conducted, one group at each hospital. At Tsandi hospital five participants agreed to take part and therefore five individual interviews were conducted there. At Outapi, the researcher only conducted two individual interviews with two participants that agreed to participate in the research. The researcher did not continue collecting data at other facilities because the interview generated similar results that convinced the researcher that saturation has been achieved.

2.6 Data collection

Data are the pieces of information or facts that are collected in scientific investigation (Nieswiadomy, 2011). In this study the researcher conducted two focus group discussions and seven individual interviews. Individual interviews were conducted due to the fact that the number of participants was not enough to form focus group at Tsandi and Outapi hospitals.

Therefore, the researcher did individual interviews at these facilities. A guide for the focus group discussion and interview was used during data collection. The following main question was used during the interviews and focus group discussion: “**Tell me your experiences regarding the management of Active Management of Third Stage of Labour**”. Subsequently, the researcher followed the interview guide and asked all the questions in the guide; furthermore, probing was utilized based on the participants’ response. The research captured the non-verbal communication, and verbatim note taking was employed. The focus group discussions and the interview were audio-taped and transcribed verbatim after the interviews.

The following section will indicate how the data was collected at each hospital and who participated in the FGD and individual interviews.

2.6.1 Data collection at Tsandi district Hospital.

Five individual interviews were conducted at Tsandi Hospital; this was done into two visits. During the first visit the researcher interviewed three participants, they were the only midwives on duty on the day, and arrangement was then done with the other two midwives who were interviewed in the second visit. There was no focus group discussion done at Tsandi due to the fact that the number of participants to form a focus group was not reached. Three registered nurses and two Enrolled nurse midwives were interviewed.

2.6.2 Data collection at Oshikuku Hospital

The researcher conducted one focus group discussion at Oshikuku Hospital; the focus group consisted of six participants. The group was made up of four registered nurses and two Enrolled nurse midwives. There was no individual interview done at Oshikuku Hospital.

2.6.3 Data collection at Okahao Hospital

The researcher had one focus group discussion at Okahao Hospital; the group consisted of six participants, four registered nurses and two Enrolled nurse midwives. No individual interview was conducted at Okahao Hospital.

2.6.4 Data collection at Outapi Hospital.

Two visits were made by the researcher to Outapi hospital. During the first visit the researcher could not conduct interview, the reason being the unit was extremely busy with many referrals to Intermediate Hospital Oshakati, as result of which only three nurses where available but due to the influx of patients the researcher cancelled the interviews that were booked for that day. The researcher made the second appointment, visited the hospital and secured two individual interviews, one registered nurse and one Enrolled nurse midwife.

2.7 Pilot study

A pilot study involves a miniature, trial version of the planned study. People are selected for the pilot study that have similar characteristic with the sample that will be used for the actual study (Nieswiadomy, 1998). In this study a pilot study was conducted at Okalongo health center in Omusati region to test the instruments, whether they were understood by the participants as well test the procedures that the data collection process will take during actual field work. The piloting included one focus group discussion and two individual interviews. The findings from the pilot study were analyzed to identify interview items that may need to be rephrased to improve understanding by the participants in the main study.

The guide for focus group discussion was used for both individual and focus group discussion. The interview started with the central question “**Tell me your experience regarding the active management of third stage of labour**”? Subsequent questions followed as per focus group discussion and individual interview guides and probing based on participants’ response.

The problems identified during the pilot study were rectified as follow:

- ❖ Participants understood the word experience as the actual doing or implementation rather than what they have experienced regarding the AMTSL method.
- ❖ In focus group discussion, some participants were dominating the discussion.
- ❖ Participants struggled to understand question 7 because that was too long.

The pilot study enabled the researcher to give a thorough explanation of the meaning “experience” prior to the interviews and group discussion during the main data collection. Furthermore, the researcher broke down question 7 into two parts, first the researcher asked about the benefits in using AMTSL and once the participant finish answering then the researcher asked the last portion of the question which was on disadvantages and challenges experienced in using AMTSL.

2.8 Preparation for the research field works

Field work preparation was done before the date of the interviews by making arrangements with the management of health facilities and midwives to secure convenient time and venue for the interviews. At each hospital, the number of midwives available on the date of the interviews was obtained from the nurse managers and unit managers.

Firstly, the researcher scheduled appointments with the Senior Medical Officers (SMOs) and the letter of permission from Omusati region Director of Health and Social Services was presented to the Senior Medical Officer at the respective district. The SMOs granted the researcher permission to collect data from their hospitals and introduced the researcher to the nurse manager who subsequently led the researcher to the unit manager of the labour wards. The researcher briefed the ward in-charge and the staff on duty on the reasons for the visit and scheduled appointment with those who agreed to participate.

2.9 Field notes

Field notes were created by the researcher to remember and record the behaviors, activities, events and other features of the setting being observed, (Cohen & Crabtree, 2006). For this study the researcher set aside time and place for writing field notes. Generally, field notes should be written as soon after observation as possible. All field notes were labeled with date, time, location and details of the participant. The research question and study design provided some theoretical criteria to decide what to record, and when, where and how to record field notes. During the interviews and group discussion the researcher observed the non-verbal communication. Observation is a systematic data collection approach. Researchers use all of their senses to examine people in natural settings or naturally occurring situations, (Cohen & Crabtree, 2006).

In this study the researcher observed and noted both verbal and the non-verbal communication, observation note helped the researcher to understand and infer meaning from what participant

said. It was therefore critically important for the researcher to observe and note how the participants reacted.

2.10 Voice record

Recording research interviews is a great way to capture qualitative data in thesis or dissertation research and ensures descriptive validity. While taking notes and writing down observations is important, it is likely that the researcher will miss out on some details. An audio recording of an interview also allows the researcher to refer back to the interview and take a fresh look at the interview data afterwards, (Isaac, 2017).

In this study, the researcher recorded the focus group discussions and individual interviews using the built-in voice recorder in the mobile phone; the researcher also downloaded the voice recorder onto a tablet computer, this was also used to record the interviews at the same time. Double recoding of the interview was done to ensure that information is not lost in case one device stopped functioning during the interview. The tablet computer and the mobile phone were placed in the centre on the table or the chair provided. This was done to make sure that all participants' voices were captured and audible enough for a smooth transcribing.

Recording the interview assisted the researcher to listen and remember what was said by the participants. The researcher used the recorded audio and compared with the notes taken during

the interview to transcribe the interview. Participants were assured that the reason for recording is for future reference and for the study purposes only to ensure credibility of the research.

2.11 The interpersonal attitudes and skills used during data collection

2.11.1 Interpersonal attitude

The word attitude in this study refers to an orientation on the part of the researcher that was employed during individual interview and focus group discussion to establish rapport and to demonstrate caring and a non-judgemental attitude and also to show understanding of the participants' view while communicating with all participants. In this study the researcher made an introduction that put participants at ease by stating that there is no wrong or right answer and that participants should feel free to share their thoughts and ideas. During the interview and focus group discussion, when the researcher had a different view on what the participant had said, the researcher did not show whether the answer given by client was wrong but rather encouraged the participants to talk by nodding the head and making sound like "aha" to show interest.

2.11.2 Congruence

Congruence means the quality or state of agreeing, coinciding or being congruent (Merriam Webster 2017). In this research the researcher ensured this quality by maintaining consistence during interview and focus group discussion. The researcher maintained consistency during probing. This consistency helped build a relationship of trust which enabled the participants to provide valid information to describe their experience regarding AMSTL. The researcher asked

the central question to start the interview and that enabled the participants to open up and share their experiences regarding active management of third stage of labour.

2.11.3 Acceptance

During focus group discussion and individual interview the researcher maintained that there was no right or wrong answer and all answer are acceptable and did not show directly or indirectly show that the answer was right or wrong or to make any judgments during the discussion. Nevertheless all contributions were welcomed as they added value to the findings.

2.11.4 Minimal verbal response.

The researcher in this study allowed participants to share their experiences with minimal interruption, verbal and non-verbal communication from the researcher was kept to a minimal although non-verbal communication such as tilting the head and nodding were used during probing as a way to enlist more information without interrupting the conversation.

2. 12 Techniques used during data collection

Reflecting feelings

During reflecting feelings the researcher reflects what the participants said in a summary form. This was done gently and in a soft way so that the participant does not get an impression that what she said was right or wrong, but rather putting back what the participant said in a summary

form. This was done to make sure that what the researcher heard is exactly what the participant said.

Paraphrasing

Paraphrasing was employed by the researcher at the end of every session; this was done by repeating participant's statements or message using fewer words.

Focusing

Focusing was ensured by the researcher by redirecting conversation toward the original intention or toward the aim and objective of the interview. This was done by only allowing the participants to talk a little bit outside the topic then the researcher will bring them back.

Timing

Participants were given sufficient opportunity to describe their experience and were not interrupted in any way before finishing what they intended to articulate. This meaning that a reasonable amount of time is allowed to elapse between the time the participants have finished speaking and the researcher makes a reflection. In this way, the participants are given adequate time to hear the reflection.

Silence

Silence is golden, stated Isaac (2017). This method was used by the researcher to allow the participants to think and come out with the right answer. When the researcher needed to ask a question, this was done after the interviewee had finished talking.

Probing

Probing assisted the researcher to gain more information regarding AMSTL from the participants. After the participant answered the question from the guide, the researcher asked additional questions so that the participants clarified their answer. This added value and gave meaning to the findings.

Reflective summary

During reflective summary the researcher summarised the participant idea and confirmed with the participants.

2. 13 Measures to ensure trustworthiness

Shenton (2004) identified Guba's criteria that can be employed to ensure trustworthiness. These criteria are credibility, transferability, dependability and conformability.

2.13.1 Credibility

Credibility is how confident the qualitative researcher is in the truth of the study's findings. This boils down to the question of "How do you know that your findings are true and accurate?"(Olivia, no date).The following provisions may be applied by researchers to promote confidence that they have accurately recorded the phenomena under scrutiny:

Table 2.1 Criteria and application for credibility

Strategy	Criteria	Application
Credibility	The adoption of research methods well established	The research followed a qualitative, exploratory and descriptive methodology which is suitable for the topic.
	The development of an early familiarity with the culture of participating organizations	The researcher is a registered nurse who is working at Oshikuku maternity ward in Omusati region and established contact and familiarity with the SMOs and nurse managers in each of the participating hospital. The researcher is also familiar with the culture of patient care in the health facilities
	Purposive sampling	The researcher used purposive sampling to select midwives to participate in the study.
	Triangulation	Two focus group discussions were conducted by the researcher. Seven individual interviews were also conducted and the findings from both approaches formed the basis of the report.
	Tactics to help ensure honesty in informants	Voluntary participation by participants was emphasized. To create rapport, participant were informed at the beginning that, during the interview there is no right or wrong answer
	Iterative questioning	Probes to elicit detailed data and iterative questioning. Researcher returned to matters previously raised by participants and extracted related data through rephrased questions.
	Frequent debriefing sessions	The researcher maintained contact with her supervisor throughout data collection.
	Peer scrutiny of the research project	The University of Namibia, MoHSS and Omusati regional management team reviewed the proposal. The research supervisor and other experienced researchers also reviewed the proposal
	Member checks	The researcher played the recording to the participants at the end of the session.

2.13.2 Transferability

Transferability is how the qualitative researcher demonstrates that the study's findings are applicable to other contexts. In this case, "other contexts" can mean similar situations, similar populations, and similar phenomena, (Olivia, no date).

2.13.2.1 Application for transferability.

The researcher provided detailed information which allowed transferability of judgement by others.

2.13.3 Dependability

Dependability is the extent that the study could be repeated by other researchers and that the findings would be consistent. In other words, if a person wanted to replicate your study, they should have enough information from your research report to do so and obtain similar findings as your study did (Olivia, no date). To enable the readers understand the methods used and their effectiveness the researcher explained the following criteria of dependability.

Table 2.2 Criteria and application for dependability

Strategy	Criteria	Application
	The research design and its implementation	The researcher conducted individual interview and focus group discussion. Hence, two focus group discussion and seven individual interviews were conducted.
	The operational detail of data gathering	The researcher collected the data through focus group discussion and individual interview, the interview and FGD were audio recorded, transcribed and then analyzed.
	Reflective appraisal of the project	The reflective summaries at the end of the session were employed by the researcher. The audio recorded were played back for the participants by the researcher.

2.13.4 Conformability

Conformability is the degree of neutrality in the research study's findings. In other words, this means that the findings are based on participants' responses and not any potential bias or personal motivations of the researcher. This involves making sure that researcher bias does not skew the interpretation of what the research the said to fit a certain narrative (Olivia, no date). In this study the researcher used collected data by using focus group discussion and individual interviews, in addition the researcher used direct quote to present the data. The research process and the analysis method are well documented and allow for review and critical appraisal by other researchers.

2.14 Data analysis

According to Brink (2010), the data in qualitative research is non-numerical, usually in the form of written words or video tape, audiotape and photographs. Therefore analysis of data in qualitative studies involves examination of words rather than the numbers that are considered in quantitative studies. In this study the data from focus group discussion and individual interviews were transcribed verbatim and content analysis was done according to Tesch (1990). The main steps involved are:

Step 1: The researcher read through all the transcripts carefully over and over to get sense from the recorded interview. Ideas that come to mind were noted

Step 2: The researcher made a random selection and picked one interview, read through the document and made inference based on meaning rather than content; these inferences were written down on the margin of the document.

Step 3: After the researcher had completed reading and coding all interview documents a list of all the topics and similar topics were clustered together. These concepts were rearranged in three different columns.

Step 4: The researcher revisited the data. The concepts were abbreviated into codes and the codes were written next to the appropriate text. The researcher made a trial using this method of data organisation to observe for the new categories.

Step 5: The researcher converted the most descriptive word into categories and grouped similar concept, interrelationships were indicated with line that were drawn to between matching categories.

Step 6: Finally the researcher made abbreviations for each category and arranged these codes in order.

Step 7: After finishing with the coding, the data belonging to each category were in the same place and analysis was performed.

Step 8: The existing data were recorded where the researcher sees it fit. Summary and conclusions was drawn from the coded data and the findings from the research were compiled.

Data from the focus group discussion and individual interview were analyzed separately but followed similar pattern. Areas of concurrence and divergence will be highlighted under the presentation of results in chapter 4.

2.15 Ethical consideration

Permission to conduct the research was sought and obtained from the University of Namibia Research Review Committee and the Research Committee of the Ministry of Health and Social Services as well as from the Director of Health and Social Services for Omusati Region.

The study used three basic ethical principles to guide the researcher. According to Brink (2010), these principles are: respect for person, beneficence and justice. These rights are based on human rights and need to be protected as they touch on right to self-determination, privacy and confidentiality, fair treatment and to being protected from harm and discomfort. These core principles are described below:

2.15.1 Respect for person.

Respect for person maintains that human beings have intrinsic and unconditional moral worth and should always be treated as if there is nothing of greater value than they are. This principle rests on the unique capability of human beings to behave as rational agents, that is, self-aware and capable of objective thought and the ability to reason. The ability to reason is believed to give humanity an intrinsic dignity that must be respected above all other considerations. (Ethics at glance, no date) In this study all the research participants were treated with respect and dignity and they were informed that their participation in the research is voluntary and they could withdraw at any point during the research process without penalty.

The objectives of the research were explained to them and informed consent obtained in writing. There was no physical, emotional, psychological, social, economic, or legal harm involved, no coercion. The participants were not asked for their names instead the participants were coded in order to identify them. Participants confidentiality was ensured by not sharing the information linked to the participant's names with other individuals. The privacy of the participants was ensured by making sure that no one else had access to the collected data except the researcher and her supervisors at UNAM. Participants were made aware that their participation is voluntary and there was no incentive from the researcher. Participants were allowed to ask questions and the researcher's contact details were provided to the participants, when the need to communicate arises.

2.15.2 Beneficence

Beneficence is defined by Beauchamp and Childress (2009). as compassion; taking positive action to help others; desire to do good; core principle of patient advocacy. For this study the research explained to the participants that the outcome of the research will enable the Ministry of Health and Social Services and other stakeholders to design programmes that will ensure smooth implementation of the active management of third stage of labour and this could result in improved efficiency and confidence among the midwives in their line of duty.

2.15.3 Justice

Derived from the work of Butts and Rich (2008), this principle refers to an equal and fair distribution of resources, based on analysis of benefits and burdens of decision. Justice implies that all citizens have an equal right to the goods distributed; regardless of what they have contributed or who they are. In this study although the researcher adopted a purposive sampling approach, all the midwives who were available on duty had an equal chance of participation in the study.

The researcher ensured that the research participants were treated equally, no participants was asked to spend money to come for the interview but rather the interviews were conducted at the participants' duty station and at their convenient time. Also, the outcome of the research will help policy makers in understanding the experiences of midwives on AMTSL and hopefully develop strategies that would make the method the preferred approach in managing labour in all

health facilities in the region and the country in general. The outcome of the research would be shared in a feedback session with the participants and other midwives in the region.

2.16 Summary

The chapter looked at the method that the researcher followed in conducting the research. It described how the research was designed, the tools used to obtain data and how the data was handled and analyzed. Focus group discussion, interviews and field notes were employed to collect data while purposive sampling was utilized to select participants for the study. The ethical aspects that are important in the research were described as well as the way the researcher ensured credibility, transferability, dependability and conformability of the research. The following chapter will present the study findings along the themes and sub-themes that were identified during the analysis of the data.

CHAPTER 3

RESEARCH RESULTS

3.1 Introduction

In this chapter, a detailed description of the results of the study is presented. The results are based on the data collected by means of focus group discussion and individual face to face semi-structured interview using the designed interview guide and further probing. The findings from the focus group discussions and individual interviews are presented according to the themes and sub-themes that emerged during the analysis, taking into account the aim and objectives of the study. Data that were collected are those regarding how the midwives managed the third stage actively, the challenges they faced when managing third stage of labour and their perspectives on ways to strengthen the use of active management of third stage of labour.

3.2 Description of study groups and participants

Data was collected from nineteen midwives. There were two focus group discussions of six participants each. Seven semi-structured individual interviews were conducted where it was difficult to get enough participants to constitute a focus group. Participants included ten registered nurses and nine Enrolled nurse midwives who carry out midwifery duties in the health facilities. The years of experience in maternity varied among participants, from one year to fifteen years of experience and all participants were female. Three participants worked for one year and less, one participant worked for three years and 15 participants worked for four years and above.

3.3 Finding from individual interview and focus group discussion

The researcher conducted seven individual interviews altogether, four at Tsandi district Hospital three at Outapi District Hospital. In the same vein two focus groups discussion were conducted, one at Oshikuku District Hospital and another at Okahao District Hospital, each focus group consisted of six participants. The researcher used a similar tool to collect data during individual interview and focus groups discussion. The theme and sub-theme that emerged during data analysis are presented below, firstly in a table form summarizing theme and sub-theme. The themes and sub-themes are further explained and supported with relevant quotes from the study participants.

Table 3.1 Indicating main themes and sub-themes

	Main theme	Sub-theme
1	3.3 1.Experience's of midwives on application of AMTSL	a) Knowledge of AMTSL b) Preparation for AMTSL c) Application and practice of AMTSL
2	3.3.2 Challenges experienced in implementation and practice of AMTSL	a) Delay in presentation of some clients in labour b) Oxytocin access and administration c) Staffing c) (i)Availability and allocation c) (ii)Skills c) (iii) Training needs
3	3.3.3 Experienced benefits of AMTSL	a) Time required for delivery b) Control of bleeding and post-partum haemorrhage c) Client satisfaction d) Staff satisfaction

3.3 1. MAIN THEME 1: EXPERIENCE'S OF MIDWIVES ON APPLICATION OF ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR.

Sub-theme a): Knowledge of AMTSL

One of the objectives of the research was to explore midwives' experience on active management of third stage of labour. To do this the researcher first asked if the participants have knowledge on what AMTSL is. All participants in the individual interviews and FGDs stated that they had heard of active management of third stage of labour. However, the meaning and application of AMTSL seemed to differ among participants. One of the participant who participated in an individual interview at Tsandi District Hospital, a registered midwife who has worked in labour ward for three years had this to say:

“Just that process of giving oxytocin and using the controlled cord traction method, so you are acting; once you see that there is separation of the placenta and the cord is lengthening, the cord length is increasing”.

Contrary to the above statement, in the focus group discussion at Okahao District Hospital, a registered midwife who has worked in labour ward for four years had this to say:

“Ok, first we give oxytocin 10 iu imi and then, we wait for sign of placenta separation which is blood coming out and the cord is lengthening, becoming long, you see signs of placenta coming out and we do controlled cord traction hold by the with right hand on the lower side abdomen of the woman and then one hand your right hand or left hand will try to pull out the placenta with the cord and then after that after the birth of the placenta what we usually do is we rub the

uterus and then after rubbing the uterus you see that it has become like a ..., is like a cricket ball something hard; then we try to go in and remove the clots if there is any so if we remove we try the two removing the clots and rubbing the uterus but you still see it is bulky is not contracted”

Another participant, an enrolled midwife who has worked for three years in labour ward at Tsandi District Hospital during an individual interview stated thus:

“Active management of third stage of labour is taking measures on preventing the complication which may arise in third stage of labour like PPH where the woman go into PPH will develop shock , will be losing too much blood and getting anaemic that is why the action you have to take so that you can prevent all those”.

Sub-theme b): Preparation for AMTSL

The researcher sought to know from the participants how they prepared for AMTSL. In an individual interview, a registered midwife who has worked for three years in labour ward at Tsandi District Hospital stated that: *“Ja, it has to be in the syringes just ready and put it on the ice pack to maintain cold chain”*(referring to oxytocin). Similarly in a FGD midwives shared their experiences. An enrolled midwife who has worked for three years in labour room at Oshikuku District Hospital during focus group discussion said *“First you have to take the oxytocin from the fridge and put it on the ice pack”.*

Sub-theme c): Application and practice of AMTSL

Some midwives in this study narrated that active management of third stage is applied to all birthing mothers and they do not choose amongst the patient whom to apply AMTSL as shown

by their statements below. In a FGD, an enrolled midwife who has worked for three years in labour ward at Oshikuku District Hospital said, *“In all the woman we just need to use active management”*.

In an individual interview a registered nurse who had worked for one year in labour ward at Tsandi District Hospital stated as follows:

“Ok, management of third stage of labour, first of all you have to rule out the second baby like palpating the mother’s abdomen, after that you give oxytocin 10 ml imi then you deliver the placenta by cord traction and the placenta supposed to be out within 7 to 15 minutes and not more than thirty minutes”.

Some participants on the contrary managed third stage of labour depending on what is available, meaning they do not at all time practice AMTSL. A registered nurse worked for six years in labour ward stated that *“It only depend on what I have at that moment”*.

3.3.2 MAIN THEME 2: CHALLENGES EXPERIENCED ON IMPLEMENTATION AND PRACTICE OF ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR.

Sub-theme a): Delay in presentation of some clients to labour ward

Most midwives experienced certain challenges in implementing AMTSL, as reported in both FGD and individual interviews. What came out loud in both groups is the delay of mothers to present to labour ward. A registered nurse who has worked for one year in labour ward during an individual interview at Tsandi District Hospital had this to say:

“I mean like when they are coming they are usually maybe 9cm or sometimes maybe fully dilated; they don’t come in first stage of labour. they will come already in the second stage. That is what we have really experienced”.

A similar concern was raised by a registered nurse who has worked for one year in labour ward as she narrated thus:

“Some they use to come head on perineum and some they didn’t attend ANC so it will be difficult, you don’t know what situation that woman is in, and whether the position of the baby is fine and because the mother didn’t go for sonar it will be difficult”.

In an individual interview at Tsandi District Hospital an enrolled midwife who has worked for eight years in labour ward stated that, *“the challenges is only the PMTCT women, some come only with one test, they default to come for the second one after three months and they come head on perineum”.*

Sub-theme b): Oxytocin access and administration

Participants in this study stated that oxytocin is stored in the fridge, and the fridge is in a different room, in some cases a distance from labour room. Some stated that the fridge is usually in the treatment room. This has resulted in some cases for oxytocin being given to the birthing mother some minutes after the birth of the baby. In the individual interview a registered nurse who has worked for seven years in labour ward at Outapi District Hospital said, *“We keep in the fridge in our treatment room”.*

A registered midwife who has worked in labour ward for five years had this to say:

“We have a fridge in a different room that is meant for oxytocin”.

Most midwives in this study indicated that they usually administer oxytocin to birthing mothers immediately after the birth of the baby. During the focus group discussion at Oshikuku District Hospital, a registered midwife who has worked for six year in labour ward stated thus:

“We give oxytocin immediately once the baby is out, making sure that there is no second twin, then within one minute we use controlled cord traction and make sure that the placenta is out, once the placenta is out you rub the uterus”.

Sub-theme c): Staffing

Participants were asked the number of midwives per shift and indicated that on average there can be five to six midwives during the morning shift and four midwives on average in the afternoon.

The participants further indicated that they currently work as a team; although there is a delegation of duties and they do help each other. *“We just work as team”*, said a registered midwife who has worked in labour ward for 11 years during the focus group discussion at Okahao District Hospital.

Another participant, an enrolled midwife who has worked in labour ward for one year said this:

“It really affects us because we don’t have a specific person like you are working just in labour room; we don’t have a specific person in baby room and post natal; we just work like that.

Today you are in labour room, tomorrow you are elsewhere. It means we are not really enough to be at the specific station like you are working in labour room”.

In agreement, a registered midwife who has worked for six years in labour ward said, *“Just to add, but there are times you find yourself very, very busy in the labour ward , some staff can be come from post natal to assist , we work as a team”*.

Sub-theme c) (i): Skills

Participants were asked if they have the necessary skills to perform AMTSL. Some participants indicated confidence in using the AMTSL method. During an individual interview at Tsandi District Hospital an enrolled midwife who worked for three years and five months said:

“We use to have in-service training, our staff some of them they use to go for EmONC and when they come back they use to do in-service training for us to upgrade us on new things which we need to use”.

Some however showed uncertainty in their responses like a registered midwife who has worked for six years in labour ward at Outapi simply stated, *“I think we are trained”*. During a FGD at Okahao District Hospital an enrolled midwife who has worked for eleven years in labour ward stated, *“We were trained by those who attended EmONC, they know it.”*

Sub-theme c) (ii): Training needs

The researcher sought to hear from participants whether all midwives are trained on AMTSL. Most midwives indicated that they are trained on how to manage third stage actively during their basic training, but further cited the need for in-service training because guidelines are ever

changing. During a FGD an enrolled midwife who has worked for one year in labour ward at Okahao District Hospital stated clearly like this:

“My suggestion is that, it is needed that all nurses or midwives there is a need for in-services training for all the midwives on how to manage the third stage so they can gain skills and knowledge.”

A registered nurse who has spent one year in labour ward at Tsandi District Hospital, during an individual interview stated that:

“The only suggestion I will suggest is on in-service training since some staff are really, were trained those years and maybe were using passive as you have said, we have to do in-service training just to refresh them up and also train those who were never trained because now the guidelines are changing everything is revised, so I think we should just do in-services training”.

In another individual interview, an enrolled midwife who has worked for three years and five months in labour ward at Tsandi District Hospital stated that, *“all we have to do is just strengthen the in-service training so that we can at least know changes and new things; we can use active method in third stage”.*

3.3.3 MAIN THEME 3: EXPERIENCED BENEFITS OF ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR.

Sub-theme a): Time required for delivery

Participants claimed that when using AMSTL they are likely to save time because they do not have to wait longer for third stage to complete and time that may be spent attending to

complications increase AMTSL method is not used. During the individual interview, an Enrolled nurse midwife who has worked for one year in labour ward stated that. *“This method prevents a lot of complication that may arise as a result of a woman losing a lot of blood, so the benefit then is that the active method is more beneficial to the patient and also to you when it comes to time wise you are also favored by the use of this method”*. During the FGD at Oshikuku District Hospital, a registered midwife who has worked for one year in labour ward stated that, *“I think AMTSL shorten the third stage of labour.”*

Sub-theme b): Control of bleeding and post-partum haemorrhage

Most midwives in the study experienced benefits when using active management of third stage of labour (AMTSL). They stated that the method helps to control bleeding earlier and this prevents post-partum haemorrhage. A registered nurse who has worked for one year in labour ward stated:

“So far, the benefit that we noticed so far is that bleeding is controlled earlier; the mother do not go, most of them do not go into postpartum haemorrhage, because this helps to contract the uterus and expel all the retained product of conception and then we have also noticed that yea, is basically the bleeding that is controlled by active management.”

She further stated that the number of patients going into post-partum haemorrhage is reduced, as she stated that, *“I understand on postpartum haemorrhage is any bleeding that change the wellbeing of the mother so it just means we did not really experience a lot of people going into PPH or their physiology changing due to bleeding, so it has minimized that number”*.

Midwives compared the benefits experienced between the two methods of managing third stage of labour. They stated that unlike the passive method, when using AMTSL the placenta comes out well and complete. This is how a registered nurse who has worked for six years in labour ward stated:

“ Like incase I give the woman the oxytocin the placenta comes out well and complete but with the one not given oxytocin there are always a bit of delay and I am also likely to experience retained membranes as well and also the uterus is also not contracting well”.

Midwives experienced a shorter third stage when using AMTSL method, as a registered nurse who has worked for one year in labour ward said, *“I think it shorten the third stage of labour”.*

An enrolled midwife who has worked for one year in labour ward stated that *“it makes the uterus contract well”* while another participant, a registered nurse who has worked in labour ward for one year said, *“actually the active management helps us to prevent PPH since oxytocin we give helps the uterus to contract and stop the bleeding”.*

Sub-theme c): Client satisfaction

On client satisfaction there was no direct satisfaction that the midwives heard from their clients, but midwives felt their patient were satisfied because they have not noted any patient coming back with complaint or complications. An Enrolled nurse midwife who has worked for one year in labour ward said, *“waiting delivery of placenta you might delay giving oxytocin and then the woman may bleed then she come back with anaemia. I think using active method is much better because you just give within those minute the woman might not bleed.”*

Most midwives however indicated that they have not heard of any report from their patient. One of the participants a registered midwife who has worked for five years in labour ward stated that, *“No report because they consider it is normal”*.

Sub-theme d): Staff satisfaction

It is worthy to note that many of the participants in the individual interview as well as the FGD have spoken highly about the satisfaction they got in using AMTSL. During a focus group discussion an enrolled midwife who has worked for one year in labour ward stated that *“that time it was time consuming because you have to wait for even up to 20 minutes just for the placenta to come out, now after you give oxytocin the placenta can quickly come out”*.

Similarly another participant, a registered midwife from Outapi District Hospital who has worked for seven years in labour ward experienced satisfaction when using AMSTL and stated that *“the advantage of active method is you can give oxytocin, I mean before delivering the placenta, it means after the placenta come out the uterus is already contracted”*.

A registered midwife from Oshikuku District Hospital who has worked for one year in labour ward, during an individual interview stated that *“actually the active management helps us to prevent PPH since oxytocin we give help the uterus to contract and stop the bleeding”*.

Whereas some other participants loved the AMTSL method to manage third stage, some participants expressed some concern regarding the AMTSL method to manage third stage in multipara and elimination of maternal to child transmission (EMTCT) mothers. In the FGD an enrolled midwife who has worked for three years in labour ward said, *“the method actually is*

very good but sometime it is very difficult to manage mothers on HAART and for multipara it is a challenge”.

3 .4 Summary

This chapter presented the combined findings from the individual interview and focused group discussions. The findings reveal that midwives in Omusati region have some knowledge on active management of third stage of labour. There is a high level of awareness of active management of third stage of labour among midwives. This was shown by their responses to the question on knowledge to AMTSL. However a mix up of the criteria in AMTSL and passive management of third stage of labour was evident, as in their response some participants indicated waiting for the gush of blood and lengthening of the cord which does not fall under AMTSL. The participants also indicated that though some have the necessary skill to manage third stage using AMTSL, in service-training is the key point to greater improvement in managing third stage actively in addition to improvement on staff allocation to labour ward. The next chapter will discuss these findings and compare them with the findings from other researchers in the field.

CHAPTER 4

DISCUSSION OF RESULTS AND LITERATURE CONTROL

4.1. Introduction

This chapter presents a discussion of the findings of the research. The results were already presented in Chapter 3. The findings are discussed to highlight the key elements of midwives' experiences on active management of third stage of labour in Omusati region. The findings are further discussed highlighting the implications of the findings and how they compare to the work of other researchers. The discussion is presented in line with the themes and sub-themes generated from the research data as presented in the previous chapter.

4.2.1 MAIN THEME 1. EXPERIENCE'S OF MIDWIVES ON APPLICATION OF AMTSL.

Three sub-themes discussed in this section are, knowledge of AMTSL, preparation for AMTSL and application and practice of AMTSL.

Sub-theme a): Knowledge of Active Management of Third Stage of Labour.

Knowledge is defined by Collin dictionary (2017) as awareness, consciousness, or familiarity gained by experience or learning. In this study majority of the participant understood and could

define active management of third stage of labour. Participants in this study were asked to explain how they managed third stage using active management of third stage of labour (AMTSL). Among the three steps of AMTSL uterine massage was the least step to be followed. Participants felt that active management of third stage of labour is the best method to manage the third stage of labour because it prevents postpartum haemorrhage. Participants in this study further indicated that active management of third stage of labour helps to shorten third stage. This is so because midwives do not have to wait for placenta to be delivered before giving oxytocin. According to the participants, AMTSL helps the uterus to contract faster, therefore, stopping the bleeding on time.

Jangsten, Hellström and Berg (2010) in their study to explore Swedish midwives' experiences of management of third stage of labour found that midwives in the Swedish study were found to be very experienced and confident in their management of labour. In the present study midwives indicated that AMTSL is the best method to manage third stage. Contrary to the finding in this study Jangsten et al (2010), demonstrated that management of the third stage of labour varies greatly and not all midwives were convinced that administration of prophylactic oxytocin in the third stage of labour was always the best alternative for all women who had a normal birth. Their decisions concerning third stage management were based on a combination of previous experience, hospital guidelines, risk assessment and sensitivity to each woman's needs.

Sub-theme b): Preparation for Active Management of Third Stage of Labour.

Preparation is defined by Merriam-Webster dictionary (2018), as the action or process of making something ready for use or service or of getting ready for some occasion, test, or duty. Active

management of the third stage of labor (AMTSL) is a globally recommended three-step method that in clinical trials has been proven effective in prevention of postpartum-haemorrhage. Therefore preparation for AMSTL is very critical. Preparation includes staff, medication to be given, equipment and the environment for delivery.

In this study participants indicated that they give oxytocin to some birthing mother immediately after the birth of the baby. As a result of staff shortage majority of participants in this study highlighted that, in some cases oxytocin is given late and not within the prescribed time of one minute after birth. The findings are similar to what other researchers have reported as indicated below.

In sub-Saharan Africa, Bartlett, Cantor, Lyman, Kaur, Rawlins, Ricca, Tripathi and Rosen (2015) assessed the quality of active management of third stage of labour in Ethiopia, Kenya, Madagascar, Mozambique, Rwanda and the United Republic of Tanzania between 2009 and 2012 among 2317 woman using a cross sectional design and direct observation of the management of the third stage of labour. Observers in this study recorded the use of uterotonic medicines, controlled cord traction and uterine massage.

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 variation between countries. Among the women given an uterotonic, 1640 (76%) received it within three minutes of the birth. Uterotonics and

related supplies were generally available onsite. Although participants in the present research reported that oxytocin was available on site, it was usually not kept in the labour room and might have contributed to the delay in the administration of the injection although the average duration of administration after birth could not be estimated.

Quality and coverage of active management of the third stage of labour is important to ensure the desired reduction in post-partum haemorrhage and maternal mortality is achievable. In this study participants reported that sometime oxytocin is out of stock and midwives have to revert to passive management of third stage of labour as was reported at one study facility.

Bartlett et al. (2015) were however of the opinion that, to improve active management of third stage of labour more researches on optimizing the timing of uterotonic administration is needed. Afshari, Medforth, Aarabi, Abedi and Soltani (2014) conducted a study in Iran aimed to provide information on policies for the practice of managing the third stage of labour. The researchers stated that the rate of active management of the third stage of labour was 57%, although answers to individual components of management indicated a higher rate for active interventions than expectant management. A high rate of active management was reported in Iran with variation in its different components which is in line with the international findings.

In the current study participant also demonstrated similar results, as most respondents indicated that they use active management to deliver the placenta. Similar high awareness and usage of AMTSL was reported from Nigeria. In a study conducted by Oladapo et al. (2009) to assess the provider's knowledge on AMTSL among 361 labour and delivery professionals in public tertiary

obstetric centres in southwest Nigeria, majority (90.6%) of the respondents reported being aware of AMTSL as an obstetric intervention and 49.7% were aware of FIGO/ICM recommendation on AMTSL. The researchers reported that AMTSL was a familiar but poorly understood intervention among obstetric care providers in this region. Improvement in healthcare quality and practitioners' adherence to recommended guidelines on AMTSL urgently requires educational interventions that target those who provide routine delivery care and organisation of the health care delivery system in such a way that enables providers to act on acquired knowledge.

Sub-theme c): Application and practice of Active Management of Third Stage of Labour.

Participants in this study indicated that AMTSL is applied to all birthing mothers, except in situation where oxytocin is not available. It was reported by participants in this study that when oxytocin is not in stock midwives use the passive method to manage third stage. The implications with this practice are that cases of post-partum haemorrhage seem more common with the expectant method of placental delivery than with AMTSL. Participants in this study also highlighted that it is time consuming to wait for placenta to separate when using the passive method, considering the shortage of staff and high flow of patients to labour ward.

Active management is recommended for all women by WHO (2012), the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) (ICM and FIGO, 2006; 2003). Contrary to the above recommendations, NICE (2007) stated that women at low risk of postpartum haemorrhage (PPH) who request physiological management should be supported, while the Royal College of Midwives (2012) and a Cochrane review done by Begley, Gyte, Devane, McGuire & Weeks (2015) pointed out

that women should be given information on the benefits and risks of active and physiological management to support an informed choice.

Sub-theme d): Practices of Active Management of Third Stage of Labour.

The researcher further sought to explore midwives' knowledge on active management of third stage of labour using oxytocin and asked participants how they manage third stage of labour actively. It emerged from the study that midwives in Omusati region are trained on how to manage third stage of labour actively. They are aware of the method of AMTSL and the benefits that it carries and they actually do practice active management of third stage. However, the results from the study shows show that some midwives in Omusati region mixed the two methods of managing third stage, the active and the passive methods. Some midwives answered during the interview that they wait for signs of placenta separation.

According to a Cochrane review by Begley, Gyte, Devane, McGuire and Weeks (2015) and WHO (2012) active management of the third stage involves three components: 1) giving a drug (a uterotonic) to contract the uterus; 2) clamping the cord early (usually before, alongside, or immediately after giving the uterotonic), before cord pulsation stops; 3) traction is applied to the cord with counter-pressure on the uterus to deliver the placenta by controlled cord traction and applying uterine massage. WHO (2012) suggest waiting for two to three minutes before clamping the cord.

Hence waiting for signs of placenta separation, such as lengthening of the cord and gush of blood as stated by participants in this study is not indicated for active management of third stage of labour.

The findings in this study are similar to a study carried out in Nigeria on active management of labour. Oladapo, Fawole, Loto, Adegbola, Akinola, Alao & Adeyemi, (2009) stated that, AMTSL was a familiar but poorly understood intervention among obstetric care providers. They further suggested that there is a need for improvement in healthcare quality and practitioners' adherence to recommended guidelines on AMTSL;

Contrary to the above findings, a retrospective study carried out in New Zealand by Dixon, Tracy, Guilliland, Fletcher, Hendry and Pairman (2010) stated that the use of physiological third stage care resulted in lower levels of blood loss, and less need for manual removal of the placenta when preceded by a spontaneous labour and normal birth. The results suggest that physiological third stage care should be considered and supported for women who are healthy and have had a spontaneous labour and birth regardless of birth place setting. Jangsten, Hellström and Burg (2008), supported the above in their study among the Swedish midwives on their experiences on third stage of labour. They stated that, active management of third stage of labour should not be prescribed for all women especially where midwives are experienced and confident to assess the physiological process and should be limited to women with likely complications based on assessment and following the guidelines.

However, Jangsten et al. (2008), specifically looked at Swedish midwives experience on third stage of labour in general contrary to this study that aim to look at midwives experience

specifically on “active” management of third stage labour. Important to note in the above research finding is that physiological management is recommended in “spontaneous labour”, that is labour that occurred naturally and “normal birth” birth without any intervention; on top of that the midwives experience and confidence in managing third stage is of utmost importance.

Participants in the present study mentioned all the steps for active management of third stage.

In this study only few participants indicated that they carry out uterine massage as part of AMTSL even though they portrayed a high positive attitude towards AMTSL.

In a similar study by Shack, Elyas Brew and Pettersson (2014), in Accra Ghana, it was found that uterine massage was not implemented, even though the general attitude towards AMTSL was positive. Thus, despite regular training sessions, the midwives did not follow the national guidelines. Some contributing factors or challenges to difficulties in providing AMTSL to all women have been pointed out in this study. The most alluded challenge was insufficiency in staff coverage of labour ward. Midwives in this study indicated that there are times they conduct deliveries alone, this has a negative implications on AMTSL method because, as midwives pointed out there are delays in administration of oxytocin drug. The fact that the definition of AMTSL has changed several times since the introduction in 2003 might also be an aggravating factor. Contrary to Shack et al. (2014) view on the definition of AMTSL, WHO (2012) maintained that AMTSL has not changed. Instead, there is now a greater emphasis on the use of an uterotonic at every birth.

4.2.2 MAIN THEME 2: CHALLENGES EXPERIENCED IN IMPLEMENTATION AND PRACTICE OF AMTSL

Three sub-themes emerged and are discussed below:

Sub-theme a): Delay in presentation of some clients in labour

Participants cited that some pregnant women present to labour room unbooked at ante natal, most unbooked pregnant women present to labour unit being fully dilated or with head on perineum. Late presentation to labour wards according to midwives makes it difficult to administer oxytocin timely because midwives have to rush to prepare for the delivery and to collect oxytocin. Most often oxytocin is given but after the prescribed time of one minute. Delay in presentation in labour affects the preparation of the midwives for AMTSL. Where proper preparation has not been made, mistakes may be made during the delivery process.

Sub-theme b): Oxytocin access and administration

Oxytocin was available at most facilities that were visited except at one hospital where oxytocin stock-out was occasionally experienced and the facility used syntometrine to manage third stage during oxytocin stock out.

To maintain cold chain and the efficacy of the medicine, oxytocin is stored in the fridge. In this study midwives expressed concern over the time required to collect oxytocin from the fridge usually in a different room indicating that oxytocin is given few minutes after the delivery of the baby. The findings in this study concur with Hodgins (2014), who mentioned that, challenges remain with distribution, proper storage, and maintaining a regular supply of the medicine. There

are reasons; in particular, to be concerned about *temperature stability* and *storage conditions*, as WHO (2012), stated that oxytocin is affected by temperature above 30°C.

It emerged from this study that all facilities visited had a fridge available for oxytocin storage, however it was a concern that such fridges were kept in rooms outside the delivery room and midwives have to get it from the fridge in preparation for delivery. The challenge lies in the fact that during emergency delivery when a woman presents with head on perineum, oxytocin is given after the prescribed time of one minutes of birth of the baby. Muiruri, Osur and Okello (2016), in their study in Kenya to determine factors influencing utilization of AMTSL concluded that availability of equipment or storage of such equipment in places far from where care is provided is a barrier to provision of nursing care.

Sub-theme c): Staffing

Participants in this study cited that staff shortage in labour room hinders the implementations of AMSTL, they further allude that, in some instances midwives conduct deliveries alone. This practice has a negative impact on AMTSL because the woman in labour may not receive oxytocin within the prescribed time.

Shack et al. (2014), pointed out two factors that are considered to be counteractive to the efforts of implementing AMTSL, these are patient overload in relation to staff coverage and non-conducive physical working conditions. The situation as the present research has revealed in some of the health facilities conforms to this assertion.

Sub-theme c) (i): Availability and allocation

Some contributing factors to difficulties in providing the best possible care have been pointed out in this study; the most cited factor was insufficiency staff coverage in labour ward. The midwives have also identified staff shortage as a possible barrier to their practice of AMTSL.As

a result of staff shortages, guidelines for procedure recommended by WHO and adopted by Namibian Ministry of Health and social Services, designed to prevent a huge threat to women's health, were not followed completely despite regular training sessions.

In a similar study conducted by Shack et al. (2014) in Accra, Ghana, to determine challenges experienced when implementing AMTSL, it was found that uterine massage was not implemented, even though the general attitude towards AMTSL was positive. Thus, despite regular training sessions, the midwives did not follow the national guidelines. Some contributing factors to difficulties in providing AMTSL to all women have been pointed out in this study, the most important being insufficiency in staff coverage.

Midwives in the present study indicated that there are times they conduct deliveries alone; this has a negative implication on AMTSL method because, as midwives pointed out there are delays in administration of oxytocin drug.

Shack et al. (2014), added that what cannot be accomplished in practice obviously deteriorates in importance, (for example lack of timing in administration of oxytocin within the prescribed time of one minute). Thus, inadequate adherence to existing guidelines must be regarded as a potential threat to safe medical processes, a problem seemingly shared by other countries in the region.

Sub-theme c) (ii): Skills

This study outcome revealed that, the general attitude towards AMTSL was positive however, as per participant responses to questions related to AMTSL it is quite evident that some midwives lack the skills to manage third stage actively. Most midwives failed to distinguish between the two methods of managing third stage and some omitting uterine massage as part of the three steps of AMTSL.

Some participants highlighted lack of training to update midwives on changes made in the guideline. In places where in-services training are carried out, adapting new procedures however, most likely depend on the active engagement of the midwife in charge of training. The qualitative findings in this study highlight the need for extended educational interventions and recurrent controls of adherence to guidelines.

Several studies have been done to look at midwives' experiences on third stage of labour across the globe. A study done in Sweden by Jangsten et al. (2010) indicated that Swedish midwives are responsible for managing normal childbirth, including the third stage, and doctors are consulted in case of complications. The study found that most Swedish midwives preferred not to administer prophylactic oxytocin immediately, awaiting the normal physiological process instead. The midwives wished to make their own decisions, stressed the importance of individualised management, and questioned the wisdom of 'blindly' following prophylactic treatment recommendations. This decision happens to contradict WHO (2006) and the updated WHO (2012) recommendation that imply AMTSL to be offered to all woman at birth. The midwives in the Swedish study were found to be very experienced and confident in their

management of labour and some worked at university hospitals with a high annual number of births.

Although some of the participants in the present study have worked for many years in the labour ward, their confidence in making decisions pertaining to managing the third stage of labour expectantly or actively cannot be ascertained, although the recommendation was adopted by the Ministry of Health and Social Services is AMTSL.

Sub-theme c) (iii): Training needs

On the job training programs are important for personnel and are carried out within an institution or agency. It may include orientation programs or formal training workshops. Participants in this study felt that in-service training would strengthen the use of AMSTL. According to American College of Nurse Midwives (ACNM) human resources are at the heart of any health care system with continuing education of the providers being critical to maintaining a competent workforce. Therefore in-service training should be the centerpiece of any organization.

Schack, Elyas, Brew and Pettersson (2014), conducted twelve in-depth interviews with labor ward midwives who all had previous training in AMTSL. The interviews took place in 2011 at three hospitals in Accra Metropolis, Ghana. Findings in this study highlight the need for extended educational interventions and recurrent controls of adherence to guidelines. It should be noticed though that this study has clearly identified that training and repeated education sessions alone will not change practice. Identifying and targeting highly influential midwives would probably have a greater effect.

In a country where reduction of maternal mortality is of high importance, like Namibia, but where the number of skilled midwives is inadequate, one would also benefit from a randomized control trial on the effectiveness of task shifting regarding AMTSL. Moreover, considering the latest WHO guidelines, research on the benefits of implementing a more practical approach to managing the third stage of labor in resource-poor settings would be of great value. The Ghanaian midwives felt that, if uterine massage could be safely eliminated from routine practice and controlled cord traction optional, the situation for the midwives of Ghana would most certainly be considerably relieved.

4.2.3 MAIN THEME 3: EXPERIENCED BENEFITS OF AMTSL.

Sub-theme a): Time required for delivery

In this study the result shows that midwives have positive experience with the AMTSL method. Participants in this study strongly felt that when using AMTSL, time is saved because they do not have to wait for signs of placenta before giving the uterotonic. The added benefit of this method as alluded to by participants is that bleeding is controlled earlier and one does not spend scarce time managing post-partum cases. According to the findings most midwives felt that AMTSL should be the method to be used to every woman who delivers because it helps the birthing mothers and the attending midwives. Many of the respondents felt it was an easier method for management of the third stage of labour.

Marshall, Buffington, Beck and Clark (2008) compared the benefits of AMTSL and Expectant management of third stage of labour (EMTSL) in the areas of when to give the uterotonic, whether to wait or not, for the signs of placenta separation and how the placenta is delivered. Uterotonic is given within 1 minute of the baby's birth (after checking for a second baby) in AMTSL while in EMTSL uterotonic is given after placenta is delivered. Marshall et al. (2008) further stated that, in AMTSL do not wait for signs of placenta separation, instead, palpate the uterus for a contraction, wait for the uterus to contract, then apply controlled cord traction while supporting the uterus with counter traction. During EMTSL one would wait for signs of placenta separation such as, gush of blood, lengthening of cord and the uterus becomes rounder and smaller as the placenta descends and delivered by gravity assisted by maternal effort (Marshall et al. 2008). The waiting part in EMTSL allows the birthing mother to bleed sometimes so much that it results in PPH.

Sub-theme b): Control of bleeding and post-partum haemorrhage

Participants in this study reported that AMTSL has several benefits when used to manage third stage of labour. In their responses midwives in Omusati region indicated that AMTSL prevent postpartum haemorrhage, it makes the uterus contract which help to stop the bleeding and it shorten the third stage of labour.

The study results concur with finding by Journal of Obstetrics and Gynecology Canada (JOGC) (2009), where randomized controlled (RCTs), systematic reviews, and clinical practice guidelines published between 1995 and 2007 were screened for relevance of AMTSL in prevention of postpartum haemorrhage. Similar to this study, JOGC (2009) concluded that, active management of the third stage of labour (AMTSL) reduces the risk of PPH and should be offered and recommended to all women. Oxytocin (10 IU), administered intramuscularly, is the

preferred medication and route for the prevention of PPH in low-risk vaginal deliveries. JOGC (2009) further suggest that care providers should administer this medication after delivery of the anterior shoulder.

Prata, Bell and Weidert (2013) stated that active management of the third stage of labor is considered the “gold standard” strategy for reducing the incidence of PPH. It combines nondrug interventions (controlled cord traction and cord clamping) with the administration of an uterotonic drug, the preferred uterotonic being oxytocin. In agreement, the Perinatal Education Program (2016) highlighted that when active management is used the incidence of postpartum haemorrhage is reduced.

Sub-theme c): Clients satisfaction

Majority of the participants indicated that there were no client reports on the benefits of AMTSL because clients consider it normal. However participants believe that AMTSL have benefited many clients as many clients do not report back to the health facility with any complications.

The researcher searched for studies of client reported benefit and could not secure any; perhaps it is high time to conduct such studies since AMTSL should be understood by midwives as well as the women who is pregnant or in labour.

Equally important for this reason is the fact that a study carried out in Ghana revealed that most midwives rejected guidelines from Obstetricians and Gynaecologists of Canada believing that the

guideline did not take into account women's preferences in the management of this phase of labour.

In fact, the use of uterotonics as a component seems to be the only one with little controversy, thus making it a reason for not fully practicing the intervention (Tan, Klein, Saxell, Shirkoohy & Asrat, 2008). Right after the placenta is delivered, rubbing the uterus is a good way to contract it and stop the bleeding. Many women need their uterus rubbed to help it to contract, then every 15 minutes for 2 hours, then every 30 minutes (Open Learning 2017). For this to happen the midwife will need to show the woman how to rub her own uterus, or a relative may help. The figure below illustrates this.



Figure 4.1 Show the woman how to rub her own uterus. (Source: Open Learning University 2017).

Sub-theme d): Staff satisfaction

The researcher sought to find out from participant whether there are any benefits in using AMTSL. All the participants in the FGD and individual interviews agreed that AMTSL benefitted all parties, the midwives and the birthing mothers. Participants indicated that in this era of shortage of staff there are times the number of birthing mothers are more than the midwives. In such cases, if AMTSL is used it saves time; this enables midwives to attend to the

next patient. The hustles of managing post-partum haemorrhage are reduced because such case rarely occurs when AMTSL is implemented. The cost of blood transfusion and surgical services are reduced when AMTSL is used. Midwives can easily learn AMTSL in a relatively short time. Midwives in this study expressed the need for uniject devices, because to get the syringe and the needle is time consuming especially when the midwife is alone on duty.

Similar concerns were found in a study conducted in Thanh Hoa Province, Vietnam by Tsu, Levin, Tran, Hoang and Huong (2009), in their study to analyze cost-effectiveness of active management of third-stage labour in Vietnam. Tsu et al (2009) stated that using the uniject device instead of ampoules would add only a small incremental cost but would enable midwives in difficult settings to benefit from its greater ease of use. They further stated that governments could not only satisfy the preferences midwives have expressed for the uniject device but also increase the likelihood that AMTSL will be practiced more consistently. AMTSL with uniject devices would also be cost neutral or even slightly cost saving when savings from averted PPH cases are considered.

4.3. Summary

This chapter presented a discussion of the key findings of the research based on the themes and sub-themes that emerged from the research and discussed in relation to available literature on the topic. The research show that the challenges experienced in Omusati region are not in isolation but rather a regional if not global concern. The next chapter will provide conclusion and recommendation on the findings

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATION

5.1 Introduction

The three main themes and sub-themes that emerged during analysis were discussed in the previous chapter according to the midwives experiences on active management of third stage of labour. This chapter focuses on the conclusions, limitations, and recommendations of the study, whereby the study findings will be summarized and, for operation and improvement in obstetric care, recommendations for further research on the topic are made and the main limitations of the study highlighted.

5.2 Conclusions

5.2 1 Conclusion for objective 1: Explore midwives' experiences on active management of third stage of labour

This study revealed that most midwives in Omusati region are trained in AMTSL and they apply AMTSL method to all birthing mothers. Participants in this study expressed their confidences with the method highlighting that AMTSL is the best method to manage third stage of labour. Majority of the participants in the FGD as well the individual interview indicated that Active

Management of Third Stage of Labour shortens third stage of labour, stops the bleeding early and reduces cases of post-partum haemorrhage. As a result of the afore-mentioned factors many maternal deaths related to post-partum haemorrhage have possibly been averted.

It emanated from the interview and FGD that some midwives' practice of AMTSL differ from the recommended guidelines. To the above factor, the participants indicated several factors that hampered their efforts to implement AMTSL accurately. Late arrival (sometimes arriving with head on perineum) of the pregnant mothers to labour wards usually results in late giving of the oxytocin. Staffing constraint was the most cited challenge in full scale adoption of AMTSL in the labour units. Nevertheless, the staffs were generally positive about the implementation of AMTSL as the preferred approach in managing third stage of labour. Staffs in labour units indicated a strong need for refresher training and better reorganization of labour rooms and material support to strengthen adoption of AMTSL in conducting deliveries. Another factor that hinders the adoption of AMTSL is organization of the labour wards with oxytocin often kept in a different room away from the delivery room; this often hampers the effective adherence to guidelines on AMTSL with respect to the timing of the administration of oxytocin.

5.2.2 Conclusion for Objective 2: Describe midwives' experiences on active management of third stage of labour

In general, a positive attitude towards AMTSL was observed among midwives in Omusati region, although the engagement displayed in implementation of the practice differed among the hospitals. The midwives expressed interest in more training in AMTSL.

The participants expressed varying levels of ability to implement AMTSL. This is advised by the fact that oxytocin is sometimes out of stock at some facilities and the midwives have to use what is available such as syntometrine.

In addition to the high patient load, the unpredictable progress of labor made it difficult to plan work, especially when working alone. Midwives described situations where they failed to provide oxytocin within the prescribed time especially when pregnant mothers present late to labour ward. Therefore, the importance of preparation was strongly emphasized by the midwives, particularly regarding the administration of oxytocin, which was due to be given after each delivery. Syringes with oxytocin were consequently prepared in advance to avoid any delay.

The participants reported that training sessions on AMTSL were regularly held at different facilities, available for some but not all midwives. After completing a workshop, the participants were expected to disperse skills and theoretical knowledge to their colleagues in the labor ward, through in-service training sessions.

AMTSL has been fairly applied by midwives in all districts in Omusati region, and many birthing mothers benefited from this practice. Yet, there is still room for better understanding and application.

5.3 Recommendations

In order to achieve the Sustainable Development Goal on reducing maternal mortality, the incidence of PPH must decrease. AMTSL is an important tool in preventing PPH; however, it must be clarified how it should be used in countries with scarce resources. Considering the difficulties in implementing already existing guidelines, modifications of guidelines must be made with careful consideration. In light of the new WHO recommendations on AMTSL, the qualitative findings in this study highlight the need for extended educational interventions and recurrent controls and supervision of adherence to guidelines. It should be noticed though that this study has clearly identified that training and repeated education sessions such in-service training alone will not change practice. Identifying and targeting highly influential midwives would probably have a greater effect. With the above findings and discussion the researcher can confidently state that the objectives set were adequately achieved in the study.

Based on the research findings the researcher makes the following recommendations for management, practice and for further research in relation to the study objectives. The researcher believes that these findings will contribute to the improvement in obstetric services in Omusati region. The recommendations are made for the Ministry of Health and Social Services, the Regional Management Team for Omusati Region and all District Health Management Teams in Omusati region. Other Regional Management Teams and District Health Management Teams that are contextually similar to Omusati region may benefit from these recommendations.

5.3.1 Recommendation for the Ministry of Health and Social Services.

The study revealed that AMTSL is implemented in all the health facilities but there are differences in understanding by the midwives and implementation across the health facilities.

Recommendations is hereby made that the Ministry of Health take the lead to develop guidelines on obstetric care and update Standard Treatment Guidelines to comply with the FIGO/ICM/WHO recommendations for AMTSL regarding the timing of the administration of the uterotonic drug. It may be necessary to add a column to existing labor and delivery logbooks to monitor the use of AMTSL.

There is a need for supportive supervision after training, refresher training and staffing and supplies. Modification of labour rooms to accommodate a small fridge for storage of oxytocin and easy access will ensure timely administering of oxytocin by midwives.

5.3.2 Recommendations for the management team in Omusati region.

The research results indicated that midwives in Omusati region are mixing the criteria for AMTSL with the passive management of third stage of labour.

It is recommended in this study that, the management team at district hospitals liaise with the regional management team to make sure that all midwives who are working in maternity wards

get training and refresher courses in obstetric care to improve knowledge and skills that will help keeping midwives abreast with new developments. Develop a plan to improve the administration of the uterotonic drug within one minute of the delivery of the baby.

The regional management team should organize a refresher training to train all midwives in the districts to practice AMTSL, since this study shows that they are able to comply with AMTSL according to FIGO/ICM/WHO standard. The Ministry should also include AMTSL in supervision as an indicator of quality performance in obstetric care.

It emerged from the study that availability of staff in maternity ward is a limiting factor; the study result also shows that oxytocin is stored in a fridge that is kept in a different room.

The regional and the district management team should ensure adequate coverage of labour units by allocating enough staffs and collaborate with the national level to revise the staff establishment. The labour ward organization should be made more user friendly by availing space for a fridge where oxytocin will be stored, and procurement of oxytocin should be done in relation the facility's demand thus ensuring proper stock management. This can be taken care of by the hospital management team at each facility.

Districts hospitals should work with other stakeholders in the communities to raise awareness on the timely reporting of pregnant women to the hospitals, before or on onset of labour. Also, the establishment of maternity waiting homes near the hospitals where these do not exist to avoid late arrival of women in labour room and proper preparation and implementation of AMTSL should be considered as a priority.

Areas for further research

The following have been identified as areas for further research to provide a better understanding on the topic:

- Effects of staff shortages on the provision of obstetric care in Namibia.
- Qualitative studies to obtain community perceptions on delivery of obstetric care services and reasons for first and second delay in the region.
- Studies that examine effect of traditional practices on implementation of AMTSL.
- The role of task shifting in the practice of AMTSL.

5.4 Limitations of the study.

It was difficult to bring midwives together at the same time to form a group discussion in some of the health facilities. This is because midwives work shift duty, daily activities have to continue while the interview was in progress and also, some midwives work during the night and were not willing to show up for the interview. Some midwives were present but they opted not to participate in the study. The researcher did individual interview at facilities where the number of participants was limited for a focus group discussion.

The study was only done in the district hospitals in Omusati region and did not cover other health facilities (public and private) where deliveries are also conducted.

This study was based on self-report by the midwives and could not be corroborated by any direct observation. It might be possible that some of the issues stated by the midwives may not be a true reflection of their actual practice of AMTSL.

5.5 Summary

Active management of third stage of labour is aimed to reduce postpartum haemorrhage which is the major cause of maternal deaths in Namibia. The WHO has recommended that oxytocin should be given within one minute of birth of the baby as a component of active management of third stage of labour. This has been included in the guidelines on emergency obstetric and newborn care in Namibia for which several health care workers were trained since 2012.

AMTSL is implemented in all the health facilities in Omusati region, but there are differences in understanding by the midwives and implementation across the health facilities. The study further revealed that administering oxytocin after one minute of birth can be related to unpreparedness of the midwives due to late arrival of pregnant women to the labour wards and oxytocin which is stored in rooms far from delivery rooms.

The researcher believes this study might be a reasonable source of information for programme managers, researchers and policymakers. Areas for further research to further deepen knowledge in this key area of maternal and child health has been highlight

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ANNEXURE 1 RESEARCH PERMISSION LETTER FROM UNAM POSTGRADUATE STUDIES

CENTRE FOR POSTGRADUATE STUDIES

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneers Park
☎ +264 61 206 3275/4662; Fax +264 61 206 3290; URL: <http://www.unam.edu.na>



RESEARCH PERMISSION LETTER

Student Name: Wilhelmina Shikongo

Student number: 9962034

Programme: MPH

Approved research title: Experiences of midwives on active management of third stage of labor in district hospitals, Omusati Region

TO WHOM IT MAY CONCERN

I hereby confirm that the above mentioned student is registered at the University of Namibia for the programme indicated. The proposed study met all the requirements as stipulated in the University guidelines and has been approved by the relevant committees.

The proposal adheres to ethical principles as per attached Ethical Clearance Certificate. Permission is hereby granted to carry out the research as described in the approved proposal.

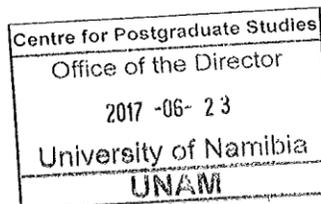
Best Regards

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Name: Dr Marius Hedimbi
Director: Centre for Postgraduate Studies
Tel: +264 61 2063275
E-mail: directorpgs@unam.na

23/06/17

Date



ANNEXURE 2: LETTER TO REQUEST PERMISSION FROM MINISTRY OF HEALTH TO COLLECT DATA

Wilhelmina T. M Shikongo

P.O BOX 4044

Ondangwa

13 January 2017

**To: The Permanent Secretary
Ministry of health and Social Services
Private Bag 13198
Windhoek**

Dear Dr. A. Mwoombola

Subject: Request for permission to undertake a research study

I am Ms. Wilhelmina Shikongo, a registered nurse at ST. Martin Hospital Oshikuku in Omusati region, under the Ministry of Health and Social Services. I am hereby requesting permission to undertake a research study at Oshikuku District Hospital, Outapi District Hospital, Tsandi District Hospital and Okahao District Hospital - Omusati region. I am currently registered with the University of Namibia School Of Public Health as a Master of Public Health student. To undertake t a research study is mandatory to complete this Master Degree.

The title of my research is: **Experiences of midwives on Active Management of Third Stage of Labour in district Hospitals, Omusati region**. I plan to interview midwives in maternity wards in Omusati region because of their experience in the topic. The process will be overseen by my supervisors, Dr. S.A. David and S. W. Kuugongelwa of the University of Namibia. I do pledge to adhere to all ethical principles.

Your usual support will be appreciated.

Yours Faithfull

.....

ANNEXURE 3: LETTER OF PERMISSION TO COLLECT DATA FROM MINISTRY OF HEALTH



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 - 203 2562
Fax: 061 - 222558
E-mail: hngombe@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3

Enquiries: Dr. H. Nangombe

Date: 26 May 2017

Ms. Wilhelmina T.M. Shikongo
University of Namibia
School of Public Health
Namibia

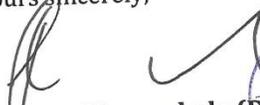
Dear Ms. Shikongo

Re: Experiences of Midwives on active management of third stage of labor in district Hospital, Omusati Region

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for academic purpose;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

- 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
- 3.5 Preliminary findings to be submitted upon completion of the study;
- 3.6 Final report to be submitted upon completion of the study;
- 3.7 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


Andreas Mwoombola (Dr)
Permanent Secretary



ANNEXURE 4: LETTER TO REQUEST PERMISSION TO COLLECT DATA FROM OMUSATI**REGION**

Wilhelmina T. M. Shikongo
P.O BOX 4044
Ondangwa
14 June 2017

**The Director of health
Ministry of Health and Social Services
Omusati region
P/BAG 504: Outapi**

Dear Mr. Amoomo

Subject: Request for permission to undertake a research study in the region.

I am Ms. Wilhelmina Shikongo, a registered nurse at ST. Martin's Hospital Oshikuku in Omusati region, under the Ministry of Health and Social Services. I am hereby requesting permission to undertake a research study at Oshikuku District Hospital, Outapi District Hospital, Tsandi District Hospital and Okahao District Hospital - Omusati region, pilot study will be done at Okalongo Health Centre. I am currently registered with the University of Namibia School Of Public Health as a Master of Public Health student. To undertake t a research study is mandatory to complete this Master Degree.

The title of my research is: **Experiences of midwives on Active Management of Third Stage of Labour in district Hospitals, Omusati region.** I plan to interview midwives in maternity wards in Omusati region because of their experience in the topic. The process will be overseen by my supervisors, Dr. S.A. David and S. W. Kuugongelwa of the University of Namibia. I do pledge to adhere to all ethical principles.

Your usual support will be appreciated.

Yours Faithfully
Wilhelmina Shikongo

.....

**ANNEXURE 5: LETTER OF PERMISSION TO COLLECT DATA FROM OMUSATI
REGION**

9 - 0/0001



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 504
Outapi

DIRECTORATE: OMUSATI REGION

Tel No. 065-251800

Fax No. 065-251071

Enquiries. Mr. A. Amoomo

Date. 15 June 2017

Ms. Wilhelmina T M Shikongo
P. O Box 4044
Ondangwa
Namibia

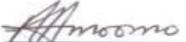
Dear Ms. Shikongo

RE. Request for permission to undertake a research study

1. We acknowledged receipt of your letter dated 14 June 2017 with the above mentioned subject.
2. We are pleased to inform you that your request for a permission to undertake a research study at Oshikuku District Hospital, Outapi District Hospital, Okahao District Hospital and Tsandi District Hospital has been granted.
3. Produce this permission to the Hospital Management before commencing data collection.
4. Submit a copy of your dissertation once publication is finalized.

We wish you all the best in your endeavors.

Sincerely yours.


Alfons Amoomo (Mr.)
Regional Director



"Health for All"

ANNEXURE 6: GUIDE FOR FOCUS GROUP DISCUSSION / INTERVIEW

Research Title: Experience of midwives on active management of third stage of labor in district hospitals, Omusati region, Namibia

Researcher: Wilhelmina. T.M. Shikongo

Student number: 9962034

The Focus groups consist of 6-8 participants per group. The researcher ensured that the participants are comfortably seated in a safe and convenient environment before the discussion commences. The researcher introduced herself to the participants. Participants were informed that participation is voluntary and they are free to withdraw at any point during the interviews. Each participant was assigned a number for use during the focus group discussion to ensure anonymity and confidentiality.

Q1. Tell me your experiences regarding active management of 3rd stage of labour and how you manage the 3rd stage of labour?

Q2. What benefits have you noted in using active management of third stage of labour?

Q3. What challenges have you experienced in using active management of 3rd stage of labour in this facility?

Q4. What differences have you observed when using active management of third stage of labour compared to traditional approach or passive management of 3rd stage of labour?

Q5. What specific suggestions do you have regarding the use of active management of 3rd stage of labour?

Q6. How are the duties allocated in your unit?

Q7. Tell me how you make the selection of women for active management of 3rd stage of labour?

Q8. What are the common challenges with the pregnant women who come to deliver in this health facility?

Q9. Explain how you understand and active management of 3rd stage of labour?

Q10. For interest sake, approximately how many normal deliveries and how many assisted deliveries are attended to in your unit over the last six months?

ANNEXURE 7: PARTICIPANT 'S CONSENT

Title: EXPERIENCE OF MIDWIVES ON ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR IN DISTRICT HOSPITALS, OMUSATI REGION, NAMIBIA.

Informed consent

PART I Information sheet

This consent form is for skilled midwives who are invited to participate in a research.

My name is Wilhelmina Shikongo a student for Master of Public Health at the University of Namibia

The study has three main objectives;

Explore midwives experience on Active Management of Third Stage of Labour.

Describe midwives experience on using Active Management of Third Stage of Labour method.

Identify factors that facilitate and/or hinder the adoption of AMTSL as the preferred approach in labour management among midwives in Omusati region.

This research will involve your participation in a group discussion that will take about one and a half hour, and/or a one hour interview for those who will be selected for the additional interview.

Participation in this research is entirely voluntary. If choose to participate you are free to withdraw your decision will have no bearing on your job or any work related evaluation reports.

There will be no direct benefit to you, but your participation is likely to help us understand how best to provide services during delivery and prevent postpartum haemorrhage and therefore reduce maternal deaths in Omusati region and Namibia in general.

The entire discussion will be tape – recorded, but no-one will be identified by name on the tape. The tape will be kept in a safe lockable place where only the researcher has access to. The information recorded is confidential, and no one else except the researcher, my supervisors and UNAM postgraduate committee will have access to the tapes. The tapes will be destroyed after the research is completed.

The **focus group discussion** will be guided by me and an assistant will help me to take some notes. We can also answer questions about the research that you might have. The discussion will take place at your work place only people who take part in the discussion, and an assistant and myself will be present during this discussion.

For the **additional interviews**, those selected will be interviewed by myself or an assistant working with me on this research.

You do not have to answer any question or take part in the discussion/interview/survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable. We will ask you and others in the group not to talk to people outside the group about what was said in the group.

This research has been approved by the Research Ethics Committee of UNAM and the Ministry of Health and Social Services. If you have any questions, you can ask them now or later. If you wish to ask questions later, contact the researcher at wllmshhikongo8@gmail.com cell phone numbers 0812856757

Part II: Certificate of Consent

I have read the foregoing information, I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Name of Participant _____ Signature of Participant _____

Researcher's signature _____

Date _____

ANNEXURE 8: PARTICIPANTS ATTANDANCE SHEET – INDIVIDUAL INTERVIEW

Attendee Code	Cadre	Years at this facility	Male or female?	Time worked at maternity
1	R/N	1 year	Female	1 year
2	R/N	3year	Female	3 years
3	E/NM	5years	Female	3 years 5 months
4	E/NM	15 years	Female	8 years
5	R/N	7 years	Female	7 years
6	R/N	8 years	Female	6 years
7	EN/M	2years	Female	1 year

ANNEXURE 9: PARTICIPANTS ATTANDANCE SHEET- FOCUS GROUP**DISCUSSION**

Attendee Code	Cadre	Years at this facility	Male or female?	Time worked at maternity
P1	E/NM	3 years	Female	1 year
P2	R/N	5 years	Female	5 years
P3	E/NM	3 years	Female	3 years
P4	R/N	1 year	Female	1 year
P5	R/N	1 year	Female	1 year
P6	R/N	6 years	Female	6 years
P7	R/N	23	Female	18years
P8	R/N	6years	Female	4 years
P9	R/N	9years	Female	7years
P10	E/NM	1 year	Female	8months
P11	E/NM	18years	Female	11 years
P12	E/NM	5 years	Female	5 years

ANNEXURE 10: FOCUS GROUP DISCUSSION TRANSCRIPT

INTERVIEWER = Is the Researcher

P = Participant

INTERVIEWER: For interest sake, approximately how many normal deliveries and how many assisted deliveries are attended to in your unit over the last six months?

P 1: Approximately 65 or 70.

P3: Approximately let say 60 or less for six months that will be 361 normal deliveries.

INTERVIEWER: How many staffs are usually working in the labour ward in each shift and how are the duties allocated?

P1: Six or five for the month but on daily basis you can get three in the morning, three in the afternoon or four three or even three two.

INTERVIEWER: How are the duties allocated in your unit?

P1: We just work as a team.

INTERVIEWER: What are the common challenges you face with the pregnant women who come to deliver in this health facility? Do they usually come early in labour?

P1: Some they come on time, some fully dilated and some they come already deliver.

P3? Some deliver on the way.

INTERVIEWER: How does that affect your work if a patient come already about to deliver does that give you enough time to do all the observation or how , what happen then?

P5E/NM: No sometimes the other one can deliver while we are not finish to complete the file because some they can deliver without take this observation.

P1: Even the fetal heart rate you just start, with head on perineum you can't do observation.

INTERVIEWER: Explain how you understand and active management of 3rd stage of labour?

P2: R/NM: Ok, first we give oxytocin 10 iu imi and the, we wait for sign of placenta separation which is blood coming out and the cord is lengthening becoming long you see signs of placenta coming out and we do controlled cord traction hold by the with right hand on the lower side abdomen of the woman and then one hand your right hand or left hand will try to pull out the placenta with the on the cord and then after that after the birth of the placenta what we usually do is we rub the uterus and then after rubbing the uterus you see that it has become like a is like a cricket ball something hard then we try to go in and remove the clots if there is any so if we remove we try the two removing the clots and rubbing the uterus but you still see it is bulky is not contracted what we do sometimes we add on the unit of oxytocin we add and the to help contracting the uterus and then we try to examine the placenta to see a retaining membrane or something and what is causing the placenta the uterus atony so when the uterus is not contracting most of the time is retaining membranes so we check if there is any retained , if there is any retained we remove and then if there is nothing we try to empty the bladder cause sometimes it can be the bladder is full.

P3: Firstly before we give oxytocin we also we check whether there is a second baby

P5: And also you try to massage the uterus for 15 minutes

INTERVIEWER: Did you mean 15minutes or seconds ?

P2: Is second

INTERVIEWER: I would like to go back to number2 you said you put your hand in the woman's abdomen, what does that hand usually do?

P1: The hand that you are putting in the woman's abdomen you just have to do it like this (showing with left hand how to apply counter pressure) then you push back the uterus

INTERVIEWER: But why?

P2 Sometime the placenta might come out the uterus may follow the placenta when you are pulling out so it help to separate the placenta from the uterus.

INTERVIEWER: So, you actually preventing uterine inversion

P2: inversion yes.

INTERVIEWER: This is what they call now the counter pressure.

INTERVIEWER: Again this is a follow up question, if the uterus is bulky you add more oxytocin how much of oxytocin you have to give and how do you give it, you give it still imi or?

P5: You put normal saline 1L and we add 20 oxytocin in it, then you still massages the uterus.

INTERVIEWER: Please share with me your experience regarding active management of 3rd stage of labour? P5: "Actually the active management helps us to prevent PPH since oxytocin we give help the uterus to contract and stop the bleeding".

P4: "I think it shorten the third stage of labour".

P2: Only when it comes to injection some women don't like to be injected.

INTERVIEWER: Tell me how you make the selection of women for active management of 3rd stage of labour?

P4 E/M: We give it to everyone who came to deliver.

INTERVIEWER: What are the benefits you have noted in using active management of third stage of labour?

P2: It prevent PPH

P1: It makes the uterus contract well.

INTERVIEWER: What are the common challenges with the pregnant women who come to deliver in this health facility?

P2: No challenges

P3: The method actually is very good but sometime it is very difficult to manage mothers on HAART that and multipara it is a challenge

INTERVIEWER: What differences have you observed when using active management of third stage of labour compared to traditional approach or passive management of 3rd stage of labour?

P1: That time it was time consuming because you have to wait for even up to 20 minutes just for the placenta to come out, now after give oxytocin the placenta can come out.

P2; No report because they consider it is normal.

INTERVIEWER: Are all the staffs in your labour ward skilled in using Active Management of Third Stage of Labour? If not, how will this be remedied?

P1: Yes

P4: We were trained by Kuku.

P5: We were trained by those who attended EmONC, they know it.

INTERVIEWER: What specific suggestions do you have regarding the use of active management of 3rd stage of labour?

P1: My suggestion is needed that all nurses or midwives there is a need for in-services training for all the midwives on how to manage the third stage so they can gain skills and knowledge.

P2: I think looking back on what the benefit of it to prevent PPH so I think it is recommendable for us to use the active management of third stage of labour, to manage third stage of labour with active method to prevent most of our women from going into PPH and to reduce maternal death as we have seen that it being caused by excessive bleeding after delivery.

P3: In addition to that we also need to give health education to all expecting mothers to come to the hospital on time to deliver in hospital and not to deliver at home.

Do you have many cases of mothers delivering at home?

P1: They are many.

P4: Some will tell you no transport,, most of them they just give that excuse of no transport.

P2: Other says it is precipitated labour so she start two hours then the baby is out

INTERVIEWER: Do you have the waiting shelter near the hospital?

P3: We have it, is just outside the hospital.

P5: To elderly, some they say they don't have money to pay

INTERVIEWER: How much are they paying?

P2: I asked them they say \$13.00 for three weeks.

INTERVIEWER: Have you experienced maternal death this year?

P2: It is quite rare.

INTERVIEWER: Because you refer the complication?

INTERVIEWER: Concerning the health education was it done, if you have picked up that mothers are coming late, you have picked up that problem what has been done about it to make sure that midwives who working in the clinics or in ante natal, what has been done? What communication has been?

P2: Ok, once we get those BBA and home deliveries, what we do is the nurse at PHC at the clinic will be informed about it because the number is increasing maybe they were two last month and they became five this months, so we have to inform them and then them they have to give health education on that because I was at ANC for two months I have seen that they give health education at ANC.

P4: In addition to deliver in the hospital or home I think it does not that the person is not having information maybe I don't know what is wrong with our people

P2: Ignorance

P4: Ja, ignorance because at ANC one of the topic at the ANC visit is to deliver in the hospital

P3: According to the reason that we are picking from then since we are getting reason from them why did you deliver at home, there is no indication that they are afraid of health worker or coming to the hospital. That was not their reason.

P1: Just to add on that what I have notice our people they like their homes very much it is just difficult, she can say no, I am having a small children they stay alone in the house something like that.

ANNEXURE 11: INDIVIDUAL INTERVIEW TRANSCRIPTS

INTERVIEWER = Is the researcher

P = Participant

Registered Nurse, Tsandi D. Hospital. (1 year of maternity experience)

INTERVIEWER: Tell me your experience regarding the Active Management of Third Stage of Labour.

P1: R/N, So far we have been working I found out that it has been working like using the active method of management of third stage of labour. We really did not have experienced lots of prolonged third stage, so far.

INTERVIEWER: For interest sake, approximately how many normal deliveries and how many assisted deliveries are attended to in your unit over the last six months

P1: Like in Tsandi, there are months that we get a lots of people delivering and there are months that we get like five or so, it depend on the month.

INTERVIEWER: How are the duties allocated in your unit?

P1: Usually we have five to four, five in the morning and four in the afternoon each day and we just work , we delegate ourselves it is like if two are in labour room the other two are working in post rooms, we work together we usually don't let one work alone or you work for the whole day at a certain place if one has conducted a delivery you can be next that is how we work.

INTERVIEWER: What are the common challenges you face with the pregnant women who come to deliver in this health facility? Do they usually come early in labour?

P1: Ok, the main challenge is lack of education, although we really do a lot of health education if so to say, our population is a bit ignorant they come on a later stage and I think they have other things that they believe that if you come in maternity there will be lots of PV (vaginal examination) done and other staff I think they are discussing like that they cause them to come at a later stage

There are challenges also on transport and distance and lots of people staying very far and not everyone can afford to stay at a place where we are, maybe on the food and other staffs so they rather stay home and transport is really a problem . Most of people are staying in the remote area so they can only get transport at times it is not always usually available so they come a bit late.

INTERVIEWER: So when they come late what exactly do you mean?

P1: I mean like when they are coming they a usually maybe 9cm or sometimes maybe fully dilated they don't come in first stage of labour they will come already in the second stage that is what we have really experienced

INTERVIEWER: Has this now have been maybe caused some problems when a patient come already fully dilated, maybe when they come 9cm, have it caused any problem when it come to your service or your care?

P1: Iya, it can a bit in the fact that now you have to do things in rush, sometimes you may not even do all the vital signs because you have to rush to a PV and this person is already fully and you need to fill in that green file sometimes you do delivery first and then you have to come back and fill in the file where you be some of the vital sign will be pending because they suppose to be taken when the baby is still in uterus so you end delivering your baby without even checking the fetal heart rate or the other one is doing fetal heart rate and other staff here you are delivering the place will not be in a normal arrangement and things will be a bit mess up and in a rush.

INTERVIEWER: Please can you explain how you manage the 3rd stage of labour?

P1: Ok, Management of third stage of labour.. first of all you have to rule out the second baby like palpating the mother 's abdomen, after that you give oxytocin 10 ml imi then you deliver the placenta by cord traction and the placenta suppose to be out within 7 to 15 minutes and not more than thirty minutes.

INTERVIEWER: The placenta, you just mentioned that it shouldn't be not more than 15 minute what happen if you are trying to deliver the placenta and then, 15 minutes passed and the placenta haven't come out what actually , what action do you take or what other thing that the midwives do to make the placenta deliver or maybe to help this mother to be save?

P1: Ok, if the third stage get prolonged you have to empty the bladder because it sometimes also hinder with the detachment of the placenta, you have to calm the mother because if the mother is tense again it hinder with the contraction of the uterus, so you have to make sure that the uterus is empty, the mother is relaxed and then you can inform the doctor if then the placenta has not come out.

INTERVIEWER: What is your understanding of active management of third stage of labour?

P1: My understanding is actually the use of oxytocin to deliver the placenta

INTERVIEWER: Tell me how you make the selection of women for active management of 3rd stage of labour?

P 1: No we don't select all patients we manage the third stage using active management.

Interviewer: So that means every mother that deliver in the hospital

INTERVIEWER: What are the benefits you have noted in using active management of third stage of labour?

P1: So far, the benefit that we noticed so far is that bleeding is controlled earlier the mother do not go most of them do not go into postpartum haemorrhage, because this help to contract the uterus and expel all the retained product of conception and then we have also noticed that iyaa is basically the bleeding that is controlled by active management.

INTERVIEWER: When you say is less bleeding how much bleeding are we talking about?

P1: Ok , we cannot really estimate the bleeding like in terms of less because as I understand on postpartum haemorrhage is any bleeding that change the wellbeing of the mother so it just means we did not really experience a lot of people going into PPH or their physiological changing due to bleeding so it has minimized that number.

INTERVIEWER: What challenges have you experienced in using active management of 3rd stage of labour in this facility?

P1: On the disadvantage we did not experience a lot apart from fear of the prick like when you have now to tell the mother I am going to inject you here a lot of mothers really show some expression like fear of injection, apart from that we really did not experienced disadvantages on the management. On the challenge maybe we will emphasis on lack of staffs because sometimes if the women are a lot there are days that you are really busy and you are alone the timing maybe then you may take time go take or withdraw the oxytocin and there is no one to give and then

you give , otherwise we really did not experience stock out or something. Since I came here I really have not see oxytocin out of stock.

INTERVIEWER: Where do you keep you oxytocin?

P1: We have a fridge where we keep oxytocin in there.

INTERVIEWER: You have a fridge where you are a keeping; you have a fridge in the labour room?

P1: No, is in the fridge the room next to labour.

INTERVIEWER: Now when a woman come, let me say this mother come early in labour she came in the first stage not in the second stage so you have enough time to put everything together, how do you, does that also affect you giving oxytocin on time?

P1: Not really, but still it depend because ok when a woman in when you found out the woman is fully you have to now put the oxytocin also there in the on the ice prepared already but it depend now to the giving let me say we are just two conducting the delivery the others are conducting in the other room now your assistant will be receiving the baby and taking care of the baby and you now after ruled out the second baby you have to give it yourself is not like you just say give oxytocin then you continue maybe is just the staff part it did not really affect the whole thing .

INTERVIEWER: That means now because of staffing you end up giving oxytocin later.

P1: A bit later.

INTERVIEWER: Are there times when you have to do the delivery alone?

P1: No not really, we are always two.

INTERVIEWER: Always two, now I would you like to explain more, when you say staffing, I would think that when one is busy doing the delivery so the other nurse should be ..

P1: Receiving the baby obviously.

INTERVIEWER: Ja, when you are receiving the baby right, what is the responsibility of the other midwife? You are two.

P1: That is what I am saying if I am the one conducting the delivery; the responsibility of the next midwife is to receive the baby. Let me say we are done preparing we prepared everything and then in case now the baby now has respiratory problem, this person will not be here she will take the baby to the warmer and resuscitated or something and you are left alone those are the only times where now you extend the time because you are left alone and doing everything, otherwise we did not really have much challenges.

INTERVIEWER: Only when the baby has problems

INTERVIEWER: What report have been reported by your clients that you have used active management of third stage of labour compared with the traditional approach or passive management of 3rd stage of labour?

P1: So far I did not meet such case.

INTERVIEWER: What specific suggestions do you have regarding the use of active management of 3rd stage of labour?

P1: Yes I will recommend that because that is the only way we can shorten the time of delivering or finishing the third stage of labour and this is the only way we can manage or control bleeding and prevent other complications. The only suggestions I will suggest on in-service training since some staff really, where trained those years and maybe where using passive as you have said, we have to do in-service training just to refresh them up and also train those who were never trained because now the guidelines are changing everything is revised, so I think we should just do in-services training.

INTERVIEWER: You said the guidelines are changing, do you have a guideline on how to manage third stage of labour here in your units.

P1: Yebbo

INTERVIEWER: Is this guideline from the ministry of health

P1: I don't know but I have seen it.

INTERVIEWER: Any other suggestion any other questions on what we have discussed here?

P1: Not really.