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A study to determine the factors affecting the effective management of third stage of labour in some selected health facilities in Adamawa State Nigeria

Article Review by Ukwo Joy Michael
Master of Public Health, Texila American University
Email: - michael.ukwojoy@yahoo.com

Introduction

Most maternal deaths are avoidable through the use of known interventions. However, those interventions are often inaccessible to many of those in need. As with most African communities, Hemorrhage (of which postpartum hemorrhage is most common) is the leading cause of maternal mortality in Adamawa State. Postpartum hemorrhage is mainly caused by complications arising during the third stage of labor. Effective management of the third stage of labor has the potential of significantly reducing maternal mortality. The process, component and the effects of services offered in the management of third stage of labour in Adamawa state has been under-investigated. Understanding the process and effects of management of third stage of labour and factors associated with poor outcomes is key to designing effective policies and programme to reduce maternal deaths and improve maternal health status[i]. The aim of this research is therefore to fill the gap in present understanding of factors associated with maternal deaths that occur as a result of the management of the third stage of labour in Adamawa State in order to make evidence-based recommendation for improved programmatic intervention.

Methodology

The study design involved cross-sectional as well as retrospective methods which permitted analysis at different levels. Cross sectional approach was used to highlight descriptively the trends of the variables under study while case-control design was used to probe for hypothesized associations. A multistage cluster sampling method was used. Two Local Government Areas were purposively selected from each of the three senatorial zones of the state. Each senatorial zone represents the social, cultural and economic units in the State and samples drawn from them are generalizable across the State.[1] All the tertiary and secondary public health facilities in the LGAs were included in the sample. A list of all public and private health facilities in each Local Government Area (LGA) was obtained from the Health Management Information System (HMIS) unit of the Ministry of Health. From the list of each LGA, two public primary health facilities comprising of one urban and one rural primary health facilities with highest delivery rates were selected. Similarly, two private health facilities comprising of one private for-profit and one private not-for-profit health facilities with high delivery rates were selected. In each health facility, the personnel in –charge of deliveries were identified and interviewed. All delivery records for the period of one year (July, 2013 to June, 2014) were obtained from selected primary health care facilities and same were obtained for the period of six months (January to June, 2014 from the secondary health care facilities) In- depth interviews were administered to health personnel in-charge of deliveries in each of the selected health facilities. Delivery process was observed by some trained observers in some selected health facilities

Result:

Finding from the research shows there are a high numbers of deliveries in the 29 health facilities visits with a total of 10278 deliveries recorded within 6months with a maternal death of 21 with a ratio of 204 per 100,000 live births. Poor reporting and detail documentation of maternal death was observation in the register domicile at the health facilities which makes it difficult to conduct surveillance and response of

maternal death. Interview with in charge of health facilities indicate that Over 90% maternal death occur in secondary and tertiary health facilities. Although the immediate cause of deaths were not explicitly recorded the delivery registers, other records and responses during interviews showed 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 antepartum) (0.8%) and Retained placenta (0.8%). Uterine antony 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.

Management of third stage of labour

All the health personnel interviewed were aware of active management of third stage of labour and its basic components. However, 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 is in the timing of the administration of uterotonic medications. While the standard practice is to administer uterotonic medication immediately after the delivery of the anterior shoulder, some health personnel do administer the medication just after engagement of the baby and before even the delivery of the head begins. However, the skilled personnel are not always available in all the health facilities. Another major barrier to the management of active 3rd of the labour is lake of available maternal lifesaving medicine and supplies like mistropotol and oxytocin.

Conclusion

Proper management of 3rd stage of labour in secondary and tertiary health facilities will significantly reduce maternal death. Also maternal medicine and supplies in combination with the skill birth attendance is very key to achieve a comprehensive maternal death reduction programs. In line global best practice detail report and recording keeping will aid good maternal death surveillance and response.

Reference

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