



Identifying barriers to
the use of active
management of the
third stage of labor
(AMTSL) by
providers: a set of
tools

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Prevention of Postpartum
Hemorrhage Initiative

I. Why promote active management of the third stage of labor (AMTSL)?

At least one quarter of all maternal deaths worldwide are due to postpartum hemorrhage (PPH). It is estimated that as many as 14 million women experience postpartum hemorrhage every year and that almost 130,000 of these women die as a result.¹ Most of these deaths occur within 24 hours of delivery.²

PPH is unpredictable, with two-thirds of PPH occurring in women with no identifiable risk factors. Without proper management, PPH can rapidly progress to cause life-threatening blood loss, often within several hours. Because of this unpredictability and rapid progression, reducing the incidence of PPH, and improving PPH outcome when it does occur, remains a challenge.

A simple and practical intervention to reduce the incidence of PPH has been identified, globally endorsed, and widely promoted for more than a decade as part of programs to reduce maternal mortality. Routine practice of AMTSL has been shown to dramatically reduce hemorrhage by up to 60 percent.^{3,4} AMTSL also reduces the need for more complex medical interventions to stop bleeding and reduces the need for blood transfusion. This is of particular benefit in settings where provision of such maternal health services is still problematic.

AMTSL speeds the delivery of the placenta and averts uterine atony to reduce PPH. AMTSL is:

- Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, **before the placenta is delivered.**
- Controlled umbilical cord traction (CCT).
- Uterine massage after the delivery of the placenta and every 15 minutes for two hours.

AMTSL is recommended for:

- Every woman.
- Every birth.
- Every skilled provider.

AMTSL is a standard component of obstetric training of most physicians, midwives, and other skilled birth attendants, especially those trained in Anglophone countries. Yet, in actual practice, many skilled providers, even those working in settings where a large percentage of births are facility-based and maternal mortality from hemorrhage is high, do not routinely practice this simple life-saving intervention.

II. What we already know: brief review of AMTSL quantitative research

Documentation of the widespread underutilization of AMTSL, particularly in developing countries, is increasing. Direct observation of providers in many settings has shown an unexpected level of third stage mismanagement. In one large study conducted at 15 university-based referral obstetric centers, only 25 percent of observed deliveries included correct practice of AMTSL. Quantitative studies conducted recently in Tanzania, Ethiopia^{5,6}, and Egypt⁷ also demonstrated substantial gaps in routine, universal use of AMTSL in these diverse settings. For example, appropriate AMTSL was used in 29 percent of observed births in Ethiopia, 15 percent in Egypt, and 7 percent in Tanzania.

The methods used in the quantitative studies in Tanzania, Ethiopia, and Egypt—structured interviews, document review, and direct observation of births—provided detailed baseline data on several key determinants influencing use of AMTSL by skilled attendants. These factors (represented schematically in Figure 1) include current AMTSL national policy, clinical guidelines and protocols, provider training at national and facility level, logistics, and actual practice of each specific component of AMTSL among facility-based skilled attendants. Community perceptions of PPH were also explored in the studies, recognizing the documented need for programs to address both the “demand” and “supply” side of the AMTSL equation.⁸

Some of the main findings of the quantitative AMTSL studies are listed by category in Table 1. Once documented, gaps can be addressed by such interventions as support to AMTSL advocacy and policy, updating AMTSL training, and strengthening systems for supply and logistics of uterotonic drugs.

Figure 1. Determinants of the routine use of AMTSL.

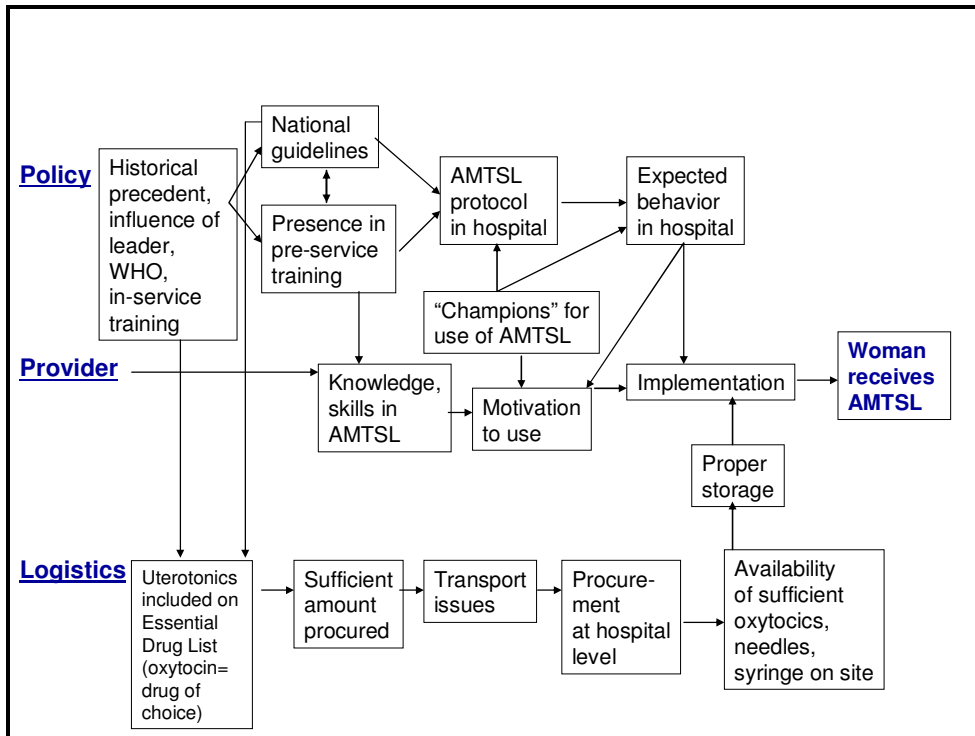


Table 1: AMTSL findings from quantitative studies Tanzania, Ethiopia, and Egypt: Identifying barriers to the use of AMTSL by providers: a set of tools.

Policy/protocols/guidelines	Supply/logistics	Provider training	Conditions of service	Performance of specific elements of AMTSL
<p>Written protocols are in place for emergency deliveries but not normal birth.</p> <p>National policy for AMTSL is missing—PPH not included in treatment guidelines.</p> <p>Ergometrine versus oxytocin specified by national protocol.</p> <p>Outdated protocols and training stated that uterotonics should not be used prior to delivery of placenta.</p> <p>Storage temperature for uterotonic drugs is incorrect in national protocol.</p>	<p>Stock of uterotonics is usually adequate.</p> <p>Some total stockouts are due to delay in ordering or consumption exceeding expectation (E).</p>	<p>Original training is outdated.</p> <p>Pre-service or in-service training did contain AMTSL.</p> <p>Providers’ poor understanding of steps/components of AMTSL.</p> <p>Lack of knowledge of effectiveness of AMTSL in reducing PPH.</p> <p>Ten percent knew all three components of AMTSL despite 93 percent claimed AMTSL training.</p>	<p>High caseload is main obstacle.</p> <p>Poor workload distribution, no assistant for provider.</p> <p>AMTSL is not recorded in delivery books.</p> <p>AMTSL is not included in supervisory mechanisms.</p> <p>No audits of PPH, no consequences of lack of AMTSL use.</p>	<p>Regional variations in components of AMTSL used.</p> <p>Low volume facilities had a lower percent use of AMTSL.</p> <p>AMTSL use varied by time of birth (less AMTSL during night shifts).</p> <p>AMTSL use varied by maternal parity, age.</p> <p>Risk approach or “targeting” used to guide use of uterotonics.</p> <p>Delay in oxytocin administration (three minutes versus one minute—if three minutes instead of one minute for oxytocin allowed, increases from 29 percent to 40 percent AMTSL used in Ethiopia.</p> <p>Uterotonics given after delivery of placenta (fear of inadvertently causing placental retention if given before placenta delivered).</p>

<p>National guidelines are not distributed to regions, districts.</p>				<p>Provider preference for certain elements of AMTSL over other elements.</p> <p>“Mixed” management of third stage (some elements of active and some elements of passive mixed together in a single delivery).</p> <p>Cord traction/early cord clamping not done despite administration of uterotonic drug.</p> <p>Cord traction applied prior to administration of uterotonic.</p> <p>Harmful practices practiced: fundal pressure or message prior to delivery of placenta, cord traction without uterine support.</p>
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III. Promoting improved AMTSL practices: what we still need to learn

Results of the quantitative AMTSL research provides essential information required to address country-specific gaps in AMTSL policy, protocol, training, logistics, and conditions of service at facilities providing obstetric care. Addressing those gaps is the first step in **creating an enabling environment in which improved AMTSL practices can take place**. These enabling factors are also called behavioral antecedents, conditions that must be in place before individual providers or obstetric teams can perform the recommended actions.

But the research showed that non-use of AMTSL in the facilities observed could not be attributed to deficits in the enabling environment alone. Some providers routinely performed AMTSL despite the lack of an enabling environment, and other providers did not use AMTSL even when all conditions for its use were favorable. Knowledge and skills are essential to perform AMTSL. However, **skilled attendants must also be motivated to routinely and correctly provide AMTSL as part of their obstetric practice**.

Several AMTSL research reports suggested that the levels of non-use of AMTSL documented should be a powerful incentive to further examine barriers to scaling up improved AMTSL practices (Egypt). Qualitative research can complement the quantitative research findings and provide a deeper understanding of the “provider factors” that influence use or non-use of AMTSL by skilled attendants.

A set of simple qualitative research tools has been developed to help program planners better understand the attitudinal factors, barriers, and resistances to improved practice of AMTSL among both individual providers and obstetric teams. The tools also elicit information **from a provider perspective** on motivational factors and incentives to AMTSL use, and suggestions on how to effectively inform skilled attendants about the importance of AMTSL. Incorporating this type of input from skilled attendants and others who may influence use or non-use of AMTSL into interventions can result in more rapid and effective AMTSL scale up.

IV. Strategic plan: what we need to do next

Improving provider AMTSL practice includes two distinct elements: 1) assuring that AMTSL is performed correctly (timely initiation of all three components of care), 2) universal application of AMTSL (every woman, every birth, every provider), and 3) recording on the woman’s chart and in the delivery log that AMTSL was provided. The steps in developing a set of country-specific interventions to improve provider performance of both elements of AMTSL are listed in Figure 2. These activities should take place in countries where interventions are already underway to improve the enabling environment for AMTSL.

Figure 2: Ten steps to improve provider AMTSL practices.

1. Review existing regional and country-specific AMTSL literature and identify information gaps.
2. Conduct country-specific AMTSL situation analysis (quantitative) to document baseline AMTSL practice.
3. Conduct AMTSL qualitative research.
 - a. In-depth interviews/focus group discussions
 - b. Trials of improved practices (TIPS)
4. Analyze qualitative research results to identify actual AMTSL behaviors in country-specific setting and underlying AMTSL barriers, resistances, and motivators.
5. Based on research, develop **locally feasible** set of AMTSL emphasis behaviors—compare “ideal” AMTSL behaviors (global recommendations) with what providers say they can/will do.
6. Develop research-based, country-specific, AMTSL-improved practice goals, objectives, and targets—negotiated behavior change.
7. Develop locally-appropriate strategy to improve AMTSL practice, including national, facility-level, and community-based interventions.
8. Develop and pretest prototype messages, materials, and tools to support activities to promote AMTSL.
9. Work with local commercial marketing group/artist/graphic designer/broadcast team to develop AMTSL promotional materials.
10. Finalize AMTSL materials and launch campaign; evaluate.

The qualitative research plan and research tools for use with AMTSL providers are generic, designed to be adapted by local researchers to local circumstances. The toolkit includes well known methodologies such as **focus group discussions and in-depth interviews**. In addition, another method can provide information to help improve AMTSL practices—TIPS.

TIPS tests the feasibility of research-based “ideal AMTSL practices” in the reality of a provider’s daily practice environment. TIPS provide an opportunity for skilled attendants to try the recommended AMTSL practices in their actual work setting. Based on

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experiences from the trials, program planners can “fine-tune” recommended behaviors and strategies that may have been developed based on initial research findings.⁹ They can also identify ways to better assist or support the provider to practice AMTSL correctly.

V. Examples of possible country-level interventions to promote improved AMTSL practice

Once the qualitative research analysis and research-based strategy formulation have been completed, detailed information will be available to guide the development of appropriate interventions to promote improved AMTSL practice. A package of interventions would include activities at the national and facility level.

Some ideas for possible activities include:

Provider interventions: facility-level performance improvement

- AMTSL checklist (program planners).
- Skilled attendant AMTSL self-assessment (individual).
- Facility AMTSL self-assessment (obstetric team).
- “Academic detailing” (behavior change intervention).
- Developing mechanisms to improve provider motivation/incentives (behavior change intervention).

National-level AMTSL promotional campaign: marketing AMTSL

- Radio spots.
- Print media/materials.
- Identifying/promoting AMTSL facilities: “signage.”

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Additional Reference

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Appendix 1: Generic qualitative research plan: improving active management of the third stage of labor (AMTSL) practices among skilled attendants

The qualitative research plan is designed to be conducted among skilled birth attendants working at regional- or district-level facilities. Permission to conduct interviews and trials of improved practices (TIPS) must be obtained well in advance of initiating research activities.

This qualitative research is designed to be rapid, action-oriented research, to quickly address gaps from the quantitative research, and to guide the development of a package of interventions and activities to promote increased use of realistic improved AMTSL practices.

Between five and ten facilities should be selected. Since the information collected will guide development of a national campaign to promote improved AMTSL practices, the facilities selected for interviews should be geographically representative—one located near to the capital city, a few located farther away, and one or two facilities very distant.

Five to ten skilled attendants can participate at each facility, depending on time and resources available. Respondents should be representative of the cadre of personnel performing deliveries in the country-specific setting; usually, this will be predominantly midwives or general practitioners. Skilled attendants who perform home deliveries in addition to facility-based births may also be included. If possible, at least five skilled attendants per site should be enrolled for TIPS that take place separately from the in-depth interviews.

The minimum research plan would select five facilities, and at each of these five facilities there would be in-depth interviews (25 total), one focus group (five total), and five AMTSL TIPS (25 total) to be conducted. This is adequate to formulate recommendations for improved AMTSL behaviors.

The maximum research plan would select ten facilities, each of which would include five in-depth interviews (50 total), one focus group (ten total) and five AMTSL TIPS (50) to be conducted.

Type of respondent	Location/facility (near/far/very far)	Focus groups	In-depth interviews	TIPS
Skilled birth attendants: <ul style="list-style-type: none"> • Midwives • Auxiliary midwives • Others (doctors) 	Five to ten	One per facility	Five per facility	Five per facility

Appendix 2: In-depth interview with skilled attendant: improving active management of the third stage of labor (AMTSL) practices

INTERVIEWER: _____ DATE OF INTERVIEW: _____

Skilled provider “ideal” AMTSL behaviors:

The skilled birth attendant will:

- 1. Be able to correctly define AMTSL and understand the relationship between AMTSL and postpartum hemorrhage (PPH).**
- 2. Perform AMTSL correctly as part of routine obstetric practice:**
 - Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, **before the placenta is delivered.**
 - Controlled umbilical cord traction (CCT) (with counter traction).
 - Uterine massage after the delivery of the placenta and every 15 minutes for two hours.
- 3. Provide AMTSL to every woman, at every vaginal birth, by every provider.**
- 4. Promote use of AMTSL to colleagues and clients.**

Research objectives:

Overall research objective:

To identify and explore underlying factors influencing the use or non-use of AMTSL among skilled birth attendants.

Specific research objectives:

1. To document skilled provider definition of, perception of the need for, and effectiveness of AMTSL.
2. To determine the preferred method of third stage management and reasons for preference.
3. To document barriers and resistances to the routine use of AMTSL as part of daily obstetric practice among skilled birth attendants.
4. To explore skilled provider’s perspective on acceptability and feasibility of AMTSL and universal application of AMTSL.
5. To identify motivating factors to AMTSL use.
6. To identify health system factors influencing use of AMTSL from provider perspective.
7. To identify client factors influencing use of AMTSL from provider perspective.
8. To document the nature and extent of social networks among skilled providers and how these networks might best be used to rapidly spread information about AMTSL to peers and community at large.
9. To elicit skilled attendants’ ideas on types of interventions that might be successful as part of a national/local campaign to promote AMTSL use.

Introduction

Good morning, my name is _____. Thank you for taking time out of your busy day to talk with me.

We are talking with skilled birth attendants (midwives, physicians, or nurses) to find out how they feel about some specific practices during delivery. We hope to use this information to develop a program to help reduce postpartum hemorrhage (PPH). We will only use the information you give us for that purpose, to help develop programs. Your answers are confidential and you do not have to give your name if you do not want to, so please speak freely. The interview will take about 45 minutes of your time.

I am going to ask you some basic identification information first.

Respondent ID:	
Name: (optional)	Age: (optional)
Type of skilled provider/job title:	Doctor Midwife Nurse Auxiliary Nurse Other
Name/type of health facility:	Regional hospital District hospital Health center Other
Average number of deliveries per month at facility:	Average number of deliveries per month this provider:
Hours worked (day shift/night shift/other):	Approximate date last training/refresher in normal deliveries:
Number of years in practice:	

Part 1: Questions per topic area

Notes for the interviewer

Key ideas to explore:

- Skilled provider's definition of, perception of the need for, and effectiveness of AMTSL.
- Preferred method of third stage management and reasons for preference.

First, I would like to ask a few questions about the training you have received in management of third stage labor.

1. What type of training have you had in managing third stage of labor? When?
2. Does your daily practice differ from your training? How? Why?

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3. There are several ways that skilled attendants can manage the third stage of labor. Can you tell me some of those ways?
 - a. Have you heard about AMTSL?

After spontaneous response, probe if necessary:

AMTSL, expectant/physiologic management, “mixed management,” other AMTSL.

4. 4. You told me that you have/have not heard of AMTSL. Let me ask you again to be sure, how would you define AMTSL?

After the provider gives her/his definition, explain that the definition we are using here for AMTSL is:

- Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, **before the placenta is delivered.**
- CCT with counter traction.
- Uterine massage every 15 minutes for two hours.

5. What do you think about this type of management of third stage? Do you think AMTSL is effective to reduce PPH? Why/why not?
6. Is it a necessary part of a safe delivery? Why/why not?
7. About how often do women you deliver experience PPH? What about your colleagues, how often do you think their patients experience PPH?
8. Can you tell me which women/births should get AMTSL? Why/why not?
9. Is there a way that most of your colleagues prefer to manage third stage of labor?
10. Is that the way that you yourself prefer to manage third stage? Why/why not?

I would now like to talk a bit about the conditions on the ward when you are performing deliveries.

11. Are there other staff working with you to help? What kind of staff usually?
12. Do they help directly with the women you are delivering, or help with other births that are taking place during your shift?

Notes for the interviewer

Key ideas to explore:

- Skilled provider’s perspective on acceptability and feasibility of AMTSL and universal application of AMTSL.
- Barriers and resistances to the routine use of AMTSL as part of daily obstetric practice

among skilled birth attendants.

- Health system factors influencing use of AMTSL from provider's perspective.
- Client factors influencing use of AMTSL from provider's perspective.

13. Do you think most of the skilled attendants you work with would be willing to practice AMTSL if they are not already? Why/why not?

14. And yourself, would you be willing to practice AMTSL? Why/why not?

15. What things make it difficult for you and **your colleagues** to practice AMTSL regularly as part of daily obstetric practice?

After receiving answers, PROBE as needed:

Policy/guidelines.

Training/experience.

Expectations of hospital staff.

Work conditions.

16. What things make it difficult for you yourself to practice AMTSL regularly? Same as what you told us about colleagues?

17. What things would make it easier for you and your colleagues to use AMTSL?

18. You told me what would make it easier for your colleagues to practice AMTSL more. Is it the same for you? Why/why not?

We talked about conditions of service at the facility where you work and how those conditions affect your ability to perform AMTSL regularly. I would like to ask you a few more things about your workplace.

19. Is there a specific place on a woman's delivery record, or the hospital delivery book, where a skilled provider can record whether or not AMTSL was performed? What do you think about having a specific place to record this information?

20. Where would be a good place to record this AMTSL information?

21. What supplies do you need for AMTSL? Are they regularly available? Why/why not (barriers)?

PROBE:

Oxytocin/ergometrine/syntocin/syntometrine/misoprostol/other.

Needles, syringes.

Others.

Barriers to obtaining these supplies.

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22. Is there regular supervision of you and your colleagues? By whom? How often? Does the supervision include anything about AMTSL? Are there other mechanisms to monitor providers use or non-use of AMTSL?

PROBE:

Audits of AMTSL practices/quality assurance mechanisms.

Audits of maternal deaths.

Other.

23. How soon after delivery are women without recognized complications usually discharged? How do you or your colleagues know if a woman you delivered experiences PPH or dies from PPH after she leaves the facility?

24. Or, if you deliver her at home, how do you know of PPH occurring in that woman or death from PPH?

25. Any consequences for AMTSL use or non-use?

PROBE:

Recognition from peers/superiors.

Performance-based bonuses.

26. To review, if you could name one thing, what makes it hard for you to perform AMTSL? If you had to pick one thing, what might make it easier for you to perform AMTSL?

27. If skilled providers had a poster in the labor ward, or some other way to remind them during their shift to use AMTSL, would that help? Why/why not?

28. What would be an effective way to remind providers to use AMTSL every birth?

Notes for the interviewer

Key ideas to explore:

- Motivating factors to AMTSL use

I mentioned that we are trying to develop programs to help reduce PPH.

29. What do you think might be some good ways programs could motivate yourself and your colleagues to practice AMTSL more regularly as part of your daily practice? Why?

TEA BREAK

Part 2: Concept testing

Notes for the interviewer

Key concept to explore:

- Skilled provider's perspective on acceptability and feasibility of each specific component of AMTSL and universal application of AMTSL.

We talked a lot about AMTSL already, but let's go back and really talk in detail. AMTSL has three parts. I am going to ask you specifically about each separate part of AMTSL.

Review three components of AMTSL:

- Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, **before the placenta is delivered.**
- Controlled cord traction (CCT) with counter traction.
- Uterine massage after delivery of the placenta and every 15 minutes for two hours.

For administering a uterotonic drug:

The recommended practice is prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, **before the placenta is delivered.**

30. What is your opinion on giving oxytocin/ergometrine/syntocinon as soon as possible after the baby is born, before the placenta is delivered? Why/why not?
31. Do you usually give oxytocin/ergometrine/syntocinon as part of AMTSL? On which women? Why/why not?
32. How do you select which uterotonic drug to use?
Oxytocin, ergometrine, syntocinon, other
33. What might be a more realistic recommendation? Why?

For CCT:

The recommended practice for CCT is supporting the uterus with upward motion while gently applying traction to the cord.

34. What is your opinion on doing CCT as part of AMTSL? Why/why not? (If needed, remind them that according to our definition of AMTSL, CCT is performed with the first contraction after oxytocin is given.)
35. What might be a more realistic recommendation? Why?

For uterine massage:

The recommended practice for uterine massage is to massage the uterus gently after the delivery of the placenta and every 15 minutes for two hours.

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36. What is your opinion of uterine massage every 15 minutes for two hours as part of AMTSL? What are the constraints to this?

37. What might be a more realistic recommendation? Why?

38. Some providers use one or two parts of AMTSL but not all three. Any idea why this might be?

There is a slogan used about AMTSL: “Every woman, every birth, every skilled provider”.

39. What do you think of that? Agree or disagree? Why?

40. Is it possible—AMTSL at every birth by every provider? Why/why not?

Notes for the interviewer

Key ideas to explore:

- Social networks of skilled providers.
- Skilled attendants’ ideas on types of interventions that might be successful as part of a national/local campaign to promote AMTSL use.

What you have already told me has been so helpful. The last few questions I would like to ask you are a bit different. Instead of asking clinical questions about your practice and the practice of your colleagues, I would like us to talk a bit about something else that will help us develop PPH programs.

41. What might be some good ways to convince your colleagues and all skilled attendants that it is a good idea to adopt AMTSL as part of routine obstetric practice?

42. If we wanted to get the information about AMTSL out to other skilled providers, do you have any ideas what would be a good way to get the word out? Why would that be effective?

43. Are there professional groups you meet with such as professional organizations? What about social groups (such as women’s groups)?

44. What could be the role of the media in creating awareness and advocating for AMTSL? Would radio, television, and print media like billboards, posters, and newspaper articles be effective? Why/why not?

45. Is there a person or persons that are very respected by skilled providers, a person who might most effectively convince midwives and others to use AMTSL? Who and why?

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46. Are there professional journals or other publications frequently read by midwives and others that could be used to promote AMTSL?
47. What could be the role of communities in promoting AMTSL? Do you think it would be a good idea to promote AMTSL to communities and families? Why/why not? (Probe about barriers at the community level.)
48. If yes, how would you suggest promoting AMTSL to communities and families?
49. Is there anything that you would like to ask me before we end the discussion?

Thank you. Good bye.

Appendix 3: Improving active management of the third stage of labor (AMTSL) practices focus group discussion (FGD) guide for skilled providers

INTERVIEWER: _____ DATE OF INTERVIEW: _____

FGD #:	Type of facility: regional hospital district hospital health center other
Number of participants:	Average number of deliveries per month at facility:
Location/facility:	Average number of deliveries per month per provider:
Type of skilled providers participating:	Number of years in practice:
Midwife/auxiliary midwife/doctor/other (specify)	Approximate date of last training/refresher in normal deliveries:

Skilled provider “ideal” AMTSL behaviors:
<p>The skilled birth attendant will:</p> <ol style="list-style-type: none"> 1. Be able to correctly define AMTSL and understand the relationship between AMTSL and postpartum hemorrhage (PPH). 2. Perform AMTSL correctly as part of routine obstetric practice: <ul style="list-style-type: none"> • Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, before the placenta is delivered. • Controlled cord traction (CCT) with counter traction to the uterus. • Uterine massage after delivery of the placenta and every 15 minutes for two hours. 3. Provide AMTSL to every woman, every birth, every provider. 4. Promote use of AMTSL to colleagues and clients.

Research objectives:
<p>Overall research objective: To identify and explore underlying factors influencing the use or non-use of AMTSL among skilled birth attendants.</p> <p>Specific research objectives:</p> <ol style="list-style-type: none"> 1. To document skilled provider’s definition of, perception of the need for, and effectiveness of AMTSL. 2. To determine the preferred method of third stage management and reasons for

- preference.
3. To document barriers and resistances to the routine use of AMTSL as part of daily obstetric practice among skilled birth attendants.
 4. To explore skilled provider’s perspective on acceptability and feasibility of AMTSL and universal application of AMTSL.
 5. To identify motivating factors to AMTSL use.
 6. To identify health system factors influencing use of AMTSL from provider’s perspective.
 7. To identify client factors influencing use of AMTSL from provider perspective.
 8. To document the nature and extent of social networks among skilled providers and how these networks might best be used to rapidly spread information about AMTSL to peers and community at large.
 9. To elicit skilled attendants’ ideas on types of interventions that might be successful as part of a national/local campaign to promote AMTSL use.

Introduction

Good morning, my name is _____. Thank you for taking time out of your busy day to talk with me.

We are talking with skilled birth attendants (midwives, physicians, and nurses) to find out how they feel about some specific practices during delivery. We hope to use this information to develop a program to help reduce postpartum hemorrhage. We will only use the information you give us for that purpose, to help develop programs. Your answers are confidential and you do not have to give your name if you do not want to, so please speak freely.

Part I

Basic line of questioning.	Probes: after spontaneous response, probe if necessary.
Document skilled provider’s definition of, perception of the need for, and effectiveness of AMTSL.	<p>AMTSL, expectant/physiologic management, “mixed management”, other.</p> <p>What do you think about this type of management of third stage labor? Do you think AMTSL is effective to reduce PPH? Why/why not? Is it a necessary part of a safe delivery? Why/why not?</p> <p>PROBE: Reduces PPH by up to 60 percent, reduces blood loss, shortens third stage of labor, reduces need for surgery and blood transfusion.</p>
Determine the preferred method of third stage management and reasons for	Which women/births should get AMTSL? Why/why not?

<p>preference.</p>	<p>Is there a way that you and/or most of your colleagues prefer to manage third stage of labor?</p>
<p>Document barriers and resistances to the routine use of AMTSL as part of daily obstetric practice among skilled birth attendants.</p>	<p>What things make it difficult for you or your colleagues to practice AMTSL regularly as part of daily obstetric practice?</p> <ul style="list-style-type: none"> • Policy/guidelines. • Training/experience. • Drugs and supplies are available. • Expectations of hospital staff. • Work conditions on the ward when you are performing deliveries. <p>Are there other staff working with you to help? What kind of staff is usually available? Do they directly help you with the women you are delivering, or help with other births?</p>
<p>Identify motivating factors to AMTSL use.</p>	<p>What do you think might be some good ways programs could motivate you and your colleagues to practice AMTSL more regularly as part of your daily practice? Why?</p> <ul style="list-style-type: none"> • Recognition from peers. • Performance-based bonuses, other. <p>What might be some good ways to convince your colleagues and all skilled attendants that it is a good idea to adopt AMTSL as part of routine obstetric practice?</p>
<p>Identify other health system factors influencing use of AMTSL from provider's perspective.</p>	<p>Supplies—uterotonic drugs/needles and syringes Supervision Record keeping Expectations of other staff</p>
<p>Identify client factors influencing use of AMTSL from provider's perspective.</p>	<p>Client expectations Financial considerations Other</p>
<p>Document the nature and extent of social networks among skilled providers and how these networks might best be used to rapidly spread information about AMTSL to peers and community at large.</p>	<p>Any ideas on what would be a good way to get the word out? Why would that be effective?</p> <p>What professional groups you meet with (such as professional organizations)? Personal women's social groups?</p>

	<p>Media? Would radio, television, print media (billboards, posters, newspaper articles) be effective? Why/why not?</p>
<p>Elicit skilled attendants' ideas on types of interventions that might be successful as part of a national/local campaign to promote AMTSL use.</p>	<p>Is there a person, or persons, that is very respected by skilled providers, a person who might be an effective motivator for AMTSL use, to convince others to use it?</p> <p>Are there professional journals that could be used to promote AMTSL?</p> <p>What about communities? Do you think it would be a good idea to promote AMTSL to communities and families? Why/why not? How?</p> <p>If they knew they could get an injection (and CCT and massage) to reduce bleeding, would more women come to facilities for delivery?</p>

Part II. Concept Testing

<p>Skilled provider's perspective on acceptability and feasibility of AMTSL and universal application of AMTSL.</p>	<p>I am going to ask you specifically about each separate part of AMTSL.</p> <p>Review three components of AMTSL:</p> <ul style="list-style-type: none"> • Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, before the placenta is delivered. • CCT with counter traction to the uterus. • Uterine massage after the delivery of the placenta and every 15 minutes for two hours. <p>For administering a uterotonic drug: The recommended practice is prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, before the placenta is delivered.</p> <p>What is your opinion on giving a uterotonic as soon as possible after the baby is born, before the placenta is delivered? Why/why</p>
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	<p>not?</p> <p>Do you usually do this part of AMTSL? On which women? Why/why not? How do you select which uterotonic drug to use (oxytocin, ergometrine, syntocinon, other)?</p> <p>What might be more realistic recommendation? Why?</p> <p>For CCT: The recommended practice for CCT is supporting the uterus with upward motion while gently applying traction to the cord.</p> <p>What is your opinion on doing CCT as part of AMTSL? (If needed, remind that CCT is defined here as occurring with the first contraction after giving uterotonic drug.)</p> <p>What might be a more realistic recommendation? Why?</p> <p>For uterine massage: The recommended practice for uterine massage is to massage the uterus gently every 15 minutes for two hours.</p> <p>What is your opinion on doing uterine massage after delivery of the placenta and every 15 minutes for two hours as part of AMTSL? Why/why not?</p> <p>What might be more realistic recommendation? Why?</p> <p>Some providers use one or two parts of AMTSL but not all three. Any idea why this might be?</p>
<p>Acceptability and feasibility of universal application of improved AMTSL practice to all women.</p>	<p>There is a slogan used about AMTSL: “For every woman, at every birth, by every skilled provider”.</p> <p>What do you think of that? Agree or disagree? Why?</p>

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	Is it possible—AMTSL every birth by every provider? Why/why not?
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Is there anything that you would like to ask me before we end the discussion?

Thank you. Good bye.

Appendix 4: Trials of Improved Practices (TIPS) Skilled Birth Attendants

Active management of the third stage of labor (AMTSL) TIPS research objectives:

Research objectives:

- To test the acceptability and feasibility of improved AMTSL practices among skilled birth attendants.
- To negotiate feasible, realistic improved AMTSL practices with skilled providers who have tested the recommended AMTSL practices as part of their daily obstetric practice.

TIPS tests the feasibility of research-based “ideal AMTSL practices” in the reality of a provider’s daily practice environment. TIPS provides an opportunity for skilled attendants to try the recommended AMTSL practices in their actual work setting. The five steps in AMTSL TIPS are listed below under “follow-up visit.”

AMTSL TIPS should be conducted among skilled birth attendants who perform deliveries frequently. The TIPS can take place over a two-week period, or longer if resources allow. Shorter duration of trials may result in higher levels of participation and recording by participants, who are skilled attendants busy with routine duties.

Improved AMTSL practice includes two distinct elements: 1) assuring that AMTSL is performed correctly (timely initiation of all three components of care) and 2) universal application of AMTSL (every woman, every birth, every provider). The AMTSL TIPS research will investigate the acceptability, feasibility, and adherence to both components.

AMTSL speeds the delivery of the placenta and averts uterine atony to reduce PPH.

AMTSL is:

- Prophylactic administration of oxytocin (or other uterotonic) within one minute, immediately after delivery of the baby, **before the placenta is delivered.**
- Controlled cord traction (CCT) with counter traction to the uterus.
- Uterine massage after the delivery of the placenta and every 15 minutes for two hours.

AMTSL is recommended for:

- Every woman.
- Every birth.
- Every skilled provider.

INTERVIEWER: _____ DATE OF INTERVIEW: _____

First visit: Introduction

Good morning, my name is _____. Thank you for taking time out of your busy schedule to participate in the trials of improved AMTSL practices (also called TIPS).

We are asking skilled birth attendants to tell us their current practices during third stage of labor, and then to try the recommended AMTSL practices for two weeks. We hope to use this information to develop recommended AMTSL practices that are realistic for your work setting, as part of a national program to help reduce postpartum hemorrhage. We will only use the information you give us for that purpose, to help develop realistic AMTSL recommendations and programs. Your answers are confidential and you do not have to give your name if you do not want to, so please speak freely.

I am going to ask you some basic identification information first.

Respondent ID:	
Name: (optional)	Age: (optional)
Type of skilled provider/job title:	Doctor Midwife Nurse Auxiliary Nurse Other
Name/type of health facility:	Regional hospital District hospital Health center Other
Average number of deliveries per month at facility:	Public or private sector
Hours worked (day shift/night shift/other):	Average number of deliveries per month this provider:
Number of years in practice:	Approximate date last training/refresher in normal deliveries:

Let me explain how this will work:

- Explain TIPS process, objective, and schedule.
- Review current skilled attendant AMTSL practices/recommended practices.
- Review recording forms.

Follow-up visit:

Thank you for participating in the AMTSL TIPS trials for the past two weeks. Let's review what happened as you were trying the improved practices. Can I see your record book?

- Determine compliance with improved AMTSL practices, why/why not, how modified/why, positive/negative reactions.
- Document motivations and constraints.

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- Determine if tried improved practices/was successful/will continue.
- Negotiate “feasible” AMTSL practices based on participant’s experience.

Steps in TIPS:

1. Recruit participants/obtain consent.
2. Conduct **INITIAL** visits:
 - Explain TIPS process, objectives.
 - Review current skilled attendant AMTSL practices/recommended practices.
 - Review recording forms.
3. Conduct the **FOLLOW-UP** visits:
 - Determine compliance with improved AMTSL practices, why/why not, how modified/why, positive/negative reactions.
 - Document motivations and constraints.
 - Determine if tried improved practices/was successful/will continue.
 - Negotiate “feasible” AMTSL practices based on participant’s experience.
4. Analyze the overall AMTSL TIPS results.
5. Develop recommendations for programming, recommendations for further research (“checking research”).

Appendix 5: Improving active management of the third stage of labor (AMTSL) Practices Strategy Development Worksheet

Target Group: Skilled Birth Attendants

Recommended AMTSL practices	Actual AMTSL practices	Improved practices required	Barriers/resistances	Motivating factors	Conditions of acceptability	Communication BCC interventions	Training	Service conditions/system improvements	Policy/standards and protocol changes