A4

Monitoring and evaluating framework to reduce maternal mortality due to postpartum hemorrhage

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Contents

Assignment

Develop an M&E framework for a 3-year initiative to reduce maternal mortality due to postpartum haemorrhage, through wide training of midwives and upgrade of health facilities in active management of the third stage of labour (AMTSL). (Monitoring and evaluating family planning / reproductive health programmes: an introduction - Alfredo Luis Fort)

Postpartum hemorrhage is the leading cause of maternal mortality worldwide. It can be prevented by providing training to midwives and upgrade of health facilities in active management of the third stage of labor (AMTSL). AMTSL brings about safer and faster delivery of the placenta through administration of oxytocic drugs within the first minute after birth, controlled umbilical cord traction with counter-traction to the uterus, and massage of the uterine fundus through the abdomen[1].

Goal

To reduce maternal mortality due to postpartum haemorrhage within 3 years.

Objectives

Training of midwives and upgrade of health facilities in active management of the third stage of labour (AMTSL).[2]

Description

Number and percent of women in facilities and homes where the woman received AMTSL by SBAs in targeted areas in a specified time period (3years). This includes vaginal deliveries only.[3]

Targeted areas are those where maternal and child health programs are implementing AMTSL interventions – these include public and private health facilities, rural and urban health facilities, as well as home births with SBAs.

AMTSL is defined as the following three key steps:

- Having first palpated the uterus to check there is no other baby, give a uterotonic drug within 1 minute of delivery. Oxytocin is the drug of choice and is given intramuscularly into the thigh.
- Controlled cord traction. Apply pressure on the uterus in an upward direction towards the woman's head while at the same time pulling with a firm, steady tension on the cord in a downward direction.
- Immediately after the delivery of the placenta and membranes, begin to massage the uterus and continue until it is firm.[1]

Training

- Include AMTSL in appropriate pre-service and in-service curricula and trainings.
- Provide support for training (e.g., through audiovisuals, anatomic models, reference materials, job aids, and training supplies).
- Carry out training follow-up, monitoring, and supervision.
- Confirm authorization and legal authority of provider cadres who can deliver AMTSL and related services, including injections. (Consider facility and community level.)
- Integrate AMTSL into comprehensive safe motherhood training programs.[4,5]

Infection prevention

Infection prevention practices should follow five standard principles:

- Every person, client or staff is considered potentially infectious.
- Hand-washing is the single most important practice for preventing cross-contamination.
- Wear gloves before touching anything wet such as broken skin, mucous membranes, blood, or other body fluids, or handling anything soiled.
- Use other protective items including apron or gown if splashes or spills of any body fluids are expected.
- Follow safe work practices and guidelines for care with sharps, cleaning of instruments, and disposal of waste.[1]

Service delivery

- Ensure adequate infrastructure, labor/delivery space, and utilities (e.g., running water, toilets, and electrical power).
- Support training using job aids, supervision, and monitoring.
- Make available logistics system support (e.g., cold or cool chain with light protection for drug commodities and appropriate packaging and dosage for prophylaxis and treatment, including oxytocin and/or ergometrine or syntometrine, on the Essential Drugs List).
- Support cross-cutting issues (e.g. quality improvement, infection prevention, and access to skilled assistance at delivery).
- Provide supplies (e.g. oxytocin, needles, and syringes).[4,5]

Unit of measure

Unit of measure will be number and percentage.

Data collection method

AMTSL data can be collected in two ways:

- When AMTSL is included in the facility records (e.g., delivery register, partograph, patient chart), or where logbooks are used for SBAs for home deliveries (does not include caesarean section or abortion), the data recorded during the specified time period can be collected.
- In cases where AMTSL is not part of routine data collection, the number of women receiving AMTSL is determined by surveys (self-administered or interviewer-administered) as a proxy for what actually happens.

Quality of data

Where data are collected through routine data collection, validation checks should be performed by supervisory visits that include observation of births. In a low-birth rate facility or for home deliveries, this can be accomplished by implementing demonstration of births and inspecting supplies of uterotonic (preferred oxytocin) in the facility or home. In the cases where patients procure their own uterotonic (preferred oxytocin) and there are no births currently happening during the supervisory visit, provision of AMTSL can be determined by surveying staff at the facility or home.

Where there is no routine data collection, supervisory visits should still be performed, observational where possible, and then demonstration in the cases where observation is not possible due to lack of deliveries during the supervisory visit (for facility and home). Supervisory visit frequency will be determined by the ministry of health (national, district in the cases where this is decentralized) when AMTSL is included in routine data collection. For instances where AMTSL is not included in routine data collection, supervisory visits should occur once during the site specified period.

Data source(s)

Timing/Frequency of Data Acquisition: Facility registers, logbooks or surveys (primary) -semi-annually.

Method of calculation

For facility and home births, the percentage is calculated by dividing the number of women who received AMTSL recorded in the past time period where AMTSL is recorded (numerator) by the total number of women with vaginal deliveries recorded in the past time period (denominator). Site specified time period includes during the past zero to twelve months, and can be set at fixed intervals for different locations.

For example, some sites may record data during one month and some during three months.[3]

Data reporting

Facility registers, logbooks, or surveys reported by Ministry of Health semi-annually.

References

1. Bishop RA, Litch JA, Tuggy M. Active Management of the Third Stage of Labor: A Clinical Tutorial. Seattle: PATH; 2008.
2. Fort AL. Monitoring and evaluating family planning / reproductive health programmes: an introduction. Paper presented at: Training Course in Sexual and Reproductive Health Research; 2011 Jul 1; Geneva. Available from: http://www.gfmer.ch/SRH-Course-2011/research-methodology/Monitoring-evaluating-FP-RH-programmes-Fort-2011.htm
3. World Health Organization. Recommendations for the prevention of Postpartum Haemorrhage. Geneva: World Health Organization; 2007.
4. International Confederation of Midwives and International Federation of Gynecology and Obstetrics. 2003. Joint statement: Management of the third stage of labour to prevent postpartum haemorrhage.
5. World Health Organization and World Bank. Managing complications in pregnancy and childbirth. Geneva: World Health Organization and World Bank; 2010.