

## KNOWLEDGE AND PRACTICES OF ACTIVE MANAGEMENT OF THIRD STAGE LABOUR AMONG BIRTH ATTENDANTS IN OGBOMOSO AREA OYO STATE, NIGERIA

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### ABSTRACT

Maternal morbidity and mortality remain a huge public health problem in developing countries for decades, despite different strategies and intervention aimed at reducing it, the rate and prevalence remains high. Post-partum haemorrhage (PPH) being the leading cause can be prevented if every third stage labour is actively managed. This study assessed knowledge and utilization of active management of third stage labour (AMTSL) by birth attendants in Ogbomoso as well as the factors influencing the practice. Descriptive research design was used. 300 skilled birth attendants from primary, secondary and tertiary health institutions in Ogbomoso, Oyo-State participated in the study. The instrument for data collection was a self-developed structured questionnaire, designed to assess knowledge, utilization and factors affecting the practice of active management of third stage labour. The result showed that many participants had good knowledge (62.3%) while (37.7%) participants demonstrated poor knowledge. Level of practice of active management of third stage Labour was graded into low and high: 42.7% were adjudged high while 57.3% were low. The hindering factors observed were inadequate manpower (60.7%), shortage of oxytocin (47%) while 44.7% perceived the procedure to be time consuming. Also, there is a significance relationship between knowledge and practice of Active management of third stage Labour. Frequent monitoring and supervision of birth attendants to assess their practices will be beneficial to ensure safety of lives and improved quality of care is recommended.

### Introduction

Postpartum haemorrhage (PPH) is the leading cause of maternal death worldwide, with an estimated mortality rate of 140,000 per year accounting for approximately one maternal death every 4 minutes (Oladapo et al, 2009). The prevalence of PPH has been estimated to be 5.77% of all delivery and responsible for 27% of all maternal deaths worldwide (WHO, 2006). Severe bleeding in the postpartum period is the single most important cause of maternal deaths worldwide and more than half of all maternal deaths occur within 24 hours of delivery, most commonly from excessive blood loss (Winter et al, 2007). Post-partum haemorrhage (PPH) is the single largest cause of maternal death particularly in developing countries (WHO, 2012). In African the situation is worse as 33.9% of maternal deaths are due to PPH (Uganda Survey, 2007). Maternal mortality ratio of 814 per 100,000 live births and some 55,000 maternal deaths has been reported in Nigeria annually, presently its 2% of the world's population, but accounts for 10% of the world's maternal deaths and ranks second globally in the number of maternal deaths (WHO, 2006). Susheela 2007 reported that a clinical guideline for the prevention of post-partum haemorrhage widely recommend provision of a package of interventions known collectively as active management of the third stage of labour (AMTSL), also discovered that PPH has been shown to be effectively prevented by the use of active management of the third stage of labour (AMTSL) (WHO, 2006). WHO making

pregnancy safe technical update (2006) also revealed that AMTSL is intended to reduce post-partum blood loss through expediting placental delivery and preventing uterine atony. Active management of the third stage of labour (AMTSL) is a feasible and inexpensive intervention that can help to save millions of women's lives especially in poor resource settings (WHO, 2006).

Active management of the third stage of labour (AMTSL) is a combination of action performed during the third stage of labour to prevent post-partum haemorrhage (PPH), the components of AMTSL are administration of a uterotonic drug within one minute after the baby is born, controlled cord traction (CCT) and uterine massage immediately after delivery of the placenta (Uganda Survey, 2007) (Tsu VD. et al, 2006). Based on an extensive review of the literature, the joint statements by the international confederation of midwives/International federation of obstetrics and gynaecologists (ICM/FIGO) recommends that active management of third-stage of labour be offered to all women, because the presence of risk factors cannot be used to predict postpartum haemorrhage, the quantity of blood loss, and use of blood transfusions (Tan WM. et al, 2008). The prevention of postpartum haemorrhage initiative (2013) reported that postpartum haemorrhage (PPH) is commonly defined as blood loss > 500ml in the first 24 hours after delivery and severe PPH is loss of 1000ml or more (Downey C, Bewley S, 2010).

The use of active management of the third stage of labour (AMTSL), has been associated with nearly 60% reduction in PPH occurrence and that universal use of AMTSL will prevent 27% of deaths from PPH (Stanton C. et al, 2009). A retrospective study from Geneva compared active versus expectant management in a rural setting showed that PPH occurred less often in the actively managed group compared with the expectant management group (WHO, 2012). Fawole and his colleague (2014) found that even though several studies have shown that AMTSL is an effective evidence-based intervention for the prevention of uterine atony and PPH, the knowledge, correct and timely practice in Nigeria are still very low (Oladapo OT. et al, 2009). A study done in Uganda elucidated some factors as being responsible for low utilization of AMTSL during delivery including inconsistent guidelines on AMTSL, lack of adequate staff and inability of the old midwives to adapt to the new guidelines (Soltani 2008, Leedy & Ormrod 2005). It was discovered that some of the difficulties in implementing AMTSL are insufficiency in staff coverage leading to task shifting and the frequent change in the definition of AMTSL since its introduction in 2003 (POPPHI, 2012). Lack of training was a barrier to the implementation of AMTSL (POPPHI, 2007). This study is proposing to assess the knowledge and practices on active management of third stage of labour among birth attendants in Ogbomoso Oyo State Nigeria.

### Statement of The Problem

Approximately 14 million women suffered from postpartum haemorrhage worldwide resulting into 287,000 women dying while pregnant or giving birth (Qureshi & Luban 2011). WHO reported that postpartum haemorrhage (PPH) is the leading cause of maternal mortality worldwide with a prevalence rate of approximately 6% (Sheldon et al, 2012). Africa has the highest prevalence rate of about 10.5%. In Africa and Asia, where most maternal deaths occur, PPH accounts for more than 30% of all maternal deaths. PPH is the leading cause of maternal death in low-income countries and is the primary cause of approximately one-quarter of global maternal deaths (Prendivile et al, 2001). The most common cause of PPH is uterine atony, a condition in which the uterus failed to contract after delivery of the foetus and/or placenta (Uganda Survey, 2007). Among PPH survivors, an estimated 12% will suffer from the consequences of severe anaemia.

Annually, an estimated 52,900 Nigeria women die from pregnancy related complications (Piper 2010). A woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13, compared with 1 in 35 in Ghana and 1 in 2800 in develop countries (Myles & Margaret 2003). Various studies had consistently demonstrated poor knowledge, practice and various challenges serving as a barrier for the effective use of AMTSL by the skilled birth attendants which is proven effective strategy to prevent PPH the main cause of maternal death (Brewerton & Miilward 2001). In a study carried out in Tanzania, on the knowledge of AMTSL only 9% made correct statements regarding all the component as in the definition of AMTSL, these included uterotonic drug administration within 1 minute following the delivery of the foetus, controlled cord traction and uterine massage every 15minutes up to two hours after delivery (Piper 2010). In general, 91% of health care providers made no correct statements regarding the definition of AMTSL with 36% and 46% of the healthcare providers mentioning one and two components of AMTSL, respectively (Bukley 2009, Cafrol et al, 2008). Also, study carried out in Uganda shows that the practices of the birth attendants were very poor as evidenced by only 28% using only one component of AMTSL during delivery of their clients (Dawason et al, 2012, Leedy & Ormrod 2005). About 28% of the delivery was without the use of controlled cord traction while 8% never used any uterotonics to conduct third stage of labour all these demonstrated very poor practices of birth attendants as regards AMTSL (Decastra & Gomes 2013). About 31% of all deliveries had oxytocin given with no restrictions on timing in AMTSL according to ICM/FIGO definition (Ogunjinmi et al, 2012). In a study carried out in Uganda, the use of AMTSL according to the ICM/FIGO definition was observed in 5.4% of deliveries, if the definition of AMTSL is relaxed to allow for administration of the uterotonic drug within three minutes of delivery of the foetus, the proportion receiving AMTSL increases to 7.3% (Downey & Bewley 2010). In another study in Uganda only one third (33.3%) of the health facilities visited had the national clinical guidelines with 35% of the facilities having no stock of oxytocin which is the drug of choice in the ICM/FIGO guideline (Downey & Bewley 2010, Fawcus 2007). Despite the fact that the key component of AMTSL which are prophylactic administration of oxytocin 10 IU

within 1 minute following the birth of the baby, delivery of placenta with controlled cord traction (CCT), uterine massage after delivery of the placenta every 15 minutes for two hours were not difficult to carry out, the practice is not satisfactory (Fawole et al, 2013). With various review of evidences from AMTSL studies, it was concluded that AMTSL should be provided for all women delivering in all health facility because of its ability to prevent postpartum haemorrhage. All these evidences show that there is still poor knowledge, practices and challenges towards the use of this AMTSL (Fawcus 2007, Figueras et al, 2008).

### Justification for The Study

Postpartum haemorrhage is still ranked among the top three major causes of maternal death globally. WHO suggests that 25% of maternal deaths are due to postpartum haemorrhage (PPH) (Figueras et al, 2008). Maternal mortality rates have declined dramatically in the developed world, yet PPH remains a leading cause of maternal mortality in Nigeria (Fawole et al, 2013). WHO recommendations have supported active management of the third stage of labour (AMTSL) as a critical lifesaving intervention for postpartum haemorrhage (PPH) prevention, and AMTSL has become a central component of PPH reduction strategies of government around the world (Figueras et al, 2008). Despite the fact that the key components of AMTSL which are prophylactic administration of Oxytocin 10 I.U within 1minute following the birth of the baby, delivery of placental with controlled cord traction (CCT) and uterine massage after delivery of placenta every 15minutes for two hours were not difficult to carry out, the practice is not satisfactory with various review of evidence from AMTSL studies (Soltani 2008, POPPHI, 2012). Implementation guidelines for Nigeria 2011 concluded that AMTSL should be provided for all women delivering per vagina in all health facility because of its ability to prevent postpartum haemorrhage (Hammah et al, 2013). Third stage of labour is the stage in which normal case can within a minute become abnormal and successful delivery can turn swiftly to disaster (Brewerton & Miilward, 2001).

PPH may cause anaemia, weakness and fatigue, prolonged hospitalization, establishment of breastfeeding may be affected, blood transfusion as a result of anaemia carries risk of transfusion reaction and sepsis and any exploration or instrumentation of the uterus increases the risk of sepsis (Brewerton & Miilward 2001, Bukley 2009). Expectant or

physiological management of third stage of labour is not the right intervention for the prevention of PPH because in the event of expectant management, routine administration of the uterotonic drug is withheld, the umbilical cord is left unclamped until pulsation has ceased or the mother requests it to be clamped or both and the placenta is expelled by the use of gravity and maternal effort. With this approach, therapeutic uterotonic administration would only be administered to stop bleeding once it has occurred or to maintain the uterus in a contracted state when there are indications that excessive bleeding is likely to occur (Brewerton Miilward 2001, Schack et al, 2014).

### General Objective

This study assess the knowledge and practices on active management of third stage of labour among birth attendants in Ogbomoso Oyo State Nigeria.

### General Objective

1. To identify the level of knowledge of active management of third stage of labour among birth attendants in Ogbomoso?
2. To determine the practice of active management of third stage of labour among birth attendants in Ogbomoso?
3. To assess the barriers to the practice of active management of third stage of labour among birth attendants in Ogbomoso?
4. To determine the relationship between the knowledge and practice of active management of third stage of labour among birth attendants in Ogbomoso?

### Research Questions

1. What is the level of knowledge of active management of third stage of labour among birth attendants in Ogbomoso?
2. What is the practice of active management of third stage of labour among birth attendants in Ogbomoso?
3. What are the barriers to the practice of active management of third stage of labour among birth attendants in Ogbomoso?
4. What is the relationship between the knowledge and practice of active management of third stage of labour among birth attendants in Ogbomoso?

### Hypothesis

1. There is no significant association between socio-demographic characteristics of the birth attendants and the practice on active management of the third stage of labour.
2. There is no significant association between the knowledge of birth attendants and the

practice on active management of the third stage of labour.

### Materials and Method

Descriptive cross-sectional research design was adopted to assess level of knowledge and practice of active management of third stage labour among birth attendants in Ogbomosho area. The study area is Ogbomosho. Ogbomosho is the zonal headquarters of the five local government areas namely Ogbomosho North, Ogbomosho South, Ogo - Oluwa, Orire and Surulere local government areas of Oyo state. It is located on latitude  $4^{\circ} 15^{\text{E}}$  and longitude  $8^{\circ} 08^{\text{N}}$  about 40 Kilometres south up Ilorin, Kwara state capital. Ogbomosho metropolis is made up of two local government Areas namely Ogbomosho North local Government with its headquarters at Kinnira, Ogbomosho and Ogbomosho south local government with its headquarters at Arowomole, Ogbomosho.

The people of Ogbomosho are predominantly Yoruba with Hausa, Igbo, Fulani, Ghanaians and other tribes cohabiting together. Inhabitants of Ogbomosho practice Christianity, Islam and Traditional religious. The compactions of inhabitants of Ogbomosho include Christianity, Islam and Traditional religion. The occupations of inhabitants of Ogbomosho include civil servant, Traders, Farmers and commercial drivers<sup>12</sup>. The health institutions in Ogbomosho offering maternal and child care include two tertiary institutions which are Ladoke Akintola University Teaching Hospital and Bowel Teaching Hospital, a secondary health institution which is State Hospital Ogbomosho, numerous primary health care facilities and private hospitals.<sup>20</sup> This study was conducted in Ladoke Akintola University Teaching Hospital, Bowel Teaching Hospital Ogbomosho, State Hospital, Primary health centres and private health facilities all within Ogbomosho area.

The estimated population of the birth attendants in Ogbomosho area is 900, and they work at tertiary, secondary, primary and private health facilities. The birth attendants working at the labour wards who are directly involved in delivery taking and the skilled birth attendants in the labour wards who are willing to participate in the study were included in this study. Birth attendants that are not working in the labour wards of the hospitals, birth attendants that are not directly involved in taking deliveries and unskilled birth attendants in Ogbomosho area were excluded from this study.

The sample size was determined using Fischer formula, using the formula the minimum sample size is 300 birth attendants. The first subject was chosen by Simple random sampling and subsequent subjects by systematic random sampling. A structured interviewer administered questionnaire was used as an instrument to obtain information from the respondents.

The questionnaire consisted of 30 items. The questionnaires were divided into four sections: social demographic characteristics, knowledge of AMTSL, practice of AMTSL and barriers to the use of AMTSL. Confidentiality of the respondents were assured. All the ethics guiding biomedical research and freedom to decline participation were observed. Validity of the instrument was established. The research instrument was pretested among 30 birth attendants in Oyo town, about 50 kilometres from Ogbomosho. This was to ensure validity and reliability of the instrument it also gave an idea of the level of difficulty and complexity which could affect the administration of the instrument. The pretested instrument (questionnaires) was analysed and necessary modification were made and yielded a coefficient of 0.87.

### Results

As presented in Table 1, many respondents (52.3%) were within the age of 31-40 years and 79.7% were females. More than half (52.3%) were Christians. Most of them (56%) had 6-10 years of practice and 41.3% were working in Primary Health Care Centres. Also, 37.7% (113) of the respondents were Registered Midwives, 21.3% (64) were Registered Nurses, 20.7% (62) were CHEW, 14.3% (43) were CHO while the remaining 6% (18) were Medical Doctors.

**Table 1: Demographic Characteristics of the Respondents**

VARIABLE		N	%
Age Group	20-29	39	13.0
	30-39	157	52.3
	41-50	93	31.0
	51-60	11	3.7
Sex	Male	61	20.3
	Female	239	79.7
Religion	Christianity	157	52.3
	Islam	143	47.7
	Traditional	0	0
Year of practice	1-4	70	23.3
	5-9	168	56.0
	10-14	57	19.0
	>16 years	5	1.7
Categories of hospital setting	Tertiary	64	21.4
	Secondary	112	37.3
	Primary	124	41.3

As presented in table 2, all the respondents are aware that all women giving birth should be given uterotonics, 93.7% of the respondents also agreed that control cord traction should only be performed by skilled birth attendants while only 59.7% of the respondents knew the components of Active management of third stage of Labour. Overall, 187 (62.3%) of the respondents demonstrated good knowledge of Active management of third stage of Labour while 113 (37.7%) had poor knowledge.

As presented in Table 3, 36% of the respondents often give oxytocin on the delivery of the anterior shoulder, 34% often delivered placenta by CCT while 44.7% often examine the placenta after delivery. Overall, 42.7% had high level of practice while 57.3% had low level of practice of active management of third stage of Labour. Similarly, Table 4 shows that, the hindering factors observed were inadequate manpower (60.7%), shortage of oxytocin (47%) while 44.7% perceived the procedure to be time consuming.

**Table 2: Knowledge of Active Management of Third Stage Labour**

Variable	Correct response (%)	Incorrect response (%)
All women giving birth should be given uterotonics	300 (100)	0 (0)
Route of administration Uterotonics should be	172 (57.3)	128 (42.7)
CCT should be performed by skilled birth attendants	281 (93.7)	19 (6.3)
Uterine massage should be done	168 (56)	132 (44)
AMTSL can successfully reduce the rate of PPH	186 (62)	114 (38)
The cord should be clamped at	189 (63)	111 (37)
Method of Placental delivery	167 (55.7)	133 (44.3)
Components of AMTSL include	179 (59.7)	121 (40.3)
AMTSL is used for both vaginal delivery and caesarean section	207 (69)	93 (31)
Uterotonics should be administered	212 (70.7)	88 (29.3)

**Table 5: Relationship Between Age and Practice of Active Management of Third Stage Labour**

Age	High practice (128)	Low practice (172)	X <sup>2</sup>	df	P-value	Remarks
21-30	13(10.2)	26(66.7)	1.88	3	0.598	Not significant

**Table 3: Practice of Active Management of Third Stage of Labour Among the Respondents**

Variable	Often (%)	Rarely (%)	Never (%)
Oxytocin is given on the delivery of the anterior shoulder	108 (36)	111 (37)	81 (27)
Oxytocin is given after the delivery of the baby	78 (26)	162 (54)	60 (20)
The cord is clamped and cut immediately	136 (45.3)	109 (36.3)	55 (18.4)
Breast feeding of the baby commences immediately after delivery	117 (39)	88 (29.3)	95 (31.7)
Placental can separate and deliver spontaneously	97 (32.3)	156 (52)	47 (15.7)
Placental is delivered by CCT	102 (34.0)	117 (39.0)	81 (27.0)
Examination of placental after delivery	134 (44.7)	97 (32.3)	69 (23.0)
Uterus is emptied immediately after delivery by massaging	101 (33.7)	187 (62.3)	12 (4.0)

As presented in Table 4, the hindering factors observed were inadequate manpower (60.7%), shortage of oxytocin (47%) while 44.7% perceived the procedure to be time consuming.

**Table 4: Barriers to The Practice of Active Management of Third Stage of Labour**

Barriers	Yes (%)	No (%)
Inadequate manpower	182 (60.7)	118 (39.3)
Shortage of oxytocin	141 (47.0)	159 (53.0)
Non-compliance of patient during the procedure	121 (40.3)	179 (59.7)
AMTSL is time consuming	134 (44.7)	166 (55.3)
Hospital policy	119 (39.7)	181 (60.3)
Inadequate skill about AMTSL	102 (34.0)	198 (66.0)

Table 5 shows that X<sup>2</sup>=1.88, df=3, P-value=0.598, since the calculated p-value is greater than 0.05, the null hypothesis is accepted, hence there is no significant relationship between the age of the respondents and their level of practice of AMTSL.

31-40	70(44.6)	87(55.4)
41-50	41(44.1)	52(55.9)
51-60	4(36.4)	7(63.6)

Table 6 shows that X<sup>2</sup>=0.89, df=1, P-value=0.441, since the calculated p-value is

greater than 0.05, the null hypothesis is accepted, hence there is no significant relationship between the gender of the

respondents and their level of practice of Active management of third stage of Labour.

**Table 6: Relationship Between Gender and Practice of Active Management of Third Stage Labour**

Gender	High practice (128)	Low practice (172)	X <sup>2</sup>	Df	P-value	Remark
Male	25(41.0)	36(59.0)	0.89	1	0.441	Not sig
Female	103(43.1)	136(56.9)				

Table 7 shows that X<sup>2</sup> = 2.21, df =1, P-value=0.362, since the calculated p-value is greater than 0.05, the null hypothesis is accepted, hence there is no significant

relationship between the religion of the respondents and their level of practice of Active management of third stage of Labour.

**Table 7: Relationship Between Religion and Practice of Active Management of Third Stage Labour**

Religion	High practice (128)	Low practice (172)	X <sup>2</sup>	df	P-value	Remark
Christianity	69(43.9)	88(56.1)	2.21	1	0.362	Not sig
Islam	59(41.3)	84(58.7)				

Table 8 shows that X<sup>2</sup>=4.88, df=3, P-value=0.015, since the calculated p-value is lesser than 0.05, the null hypothesis is rejected, hence there is significant relationship between

the year of practice of the respondents and their level of practice of Active management of third stage of Labour.

**Table 8: Relationship Between Years of Practice and Level of Practice of Active Management of Third Stage Labour**

Years of practice	High practice (128)	Low practice (172)	X <sup>2</sup>	df	P-value	Remark
1-5	32(45.7)	38(54.3)	4.88	3	0.015	Sig
6-10	69(41.1)	99(58.9)				
11-15	25(43.9)	32(56.1)				
>16	2(40.0)	3(60.0)				

Table 9 shows that X<sup>2</sup>=6.95, df=4, P-value=0.0138, since the calculated p-value is less than 0.05, the null hypothesis is rejected, hence there is significant relationship between

the occupation of the respondents and their level of practice of Active management of third stage of Labour.

**Table 9: Relationship Between the Occupation of the Respondents and Practice of Active Management of Third Stage of Labour**

Occupation	High practice (128)	Low practice (172)	X <sup>2</sup>	Df	P-value	Remark
Medical Doctor	15(83.3)	3(16.7)	6.95	4	0.0138	Not sig
RN	24(37.5)	40(62.5)				
RM	49(43.4)	64(56.6)				
CHO	15(34.8)	28(65.1)				
CHEW	25(40.3)	37(59.7)				

Table 10 shows that X<sup>2</sup>=5.25, df=3, P-value=0.027, since the calculated p-value is lesser than 0.05, the null hypothesis is rejected, hence there is significant relationship between

the place of work of the respondents and their level of practice of Active management of third stage of Labour.

**Table 10: Relationship Between the Place of Work of the Respondents and Their Level of Practice of Active Management of Third Stage of Labour**

Categories of hospital	High practice (128)	Low practice (172)	X <sup>2</sup>	Df	P-value	Remark
Tertiary	26(40.6)	38(59.4)	5.25	3	0.027	Sig
Secondary	47(42.0)	65(58.0)				
Primary	55(44.4)	69(55.6)				

Table 11 shows that there is a significance relationship between knowledge and practice of

Active management of third stage of Labour ( $X^2=2.26$ ,  $df=1$  and  $P\text{-value}=0.042$ )

**Table 11: Relationship Between Knowledge and Practice of Active Management of Third Stage of Labour**

Knowledge	Practice		$X^2$	Df	P-value	Remark
	High level	Low level				
Good	98(52.4)	89(47.6)	2.26	1	0.042	Sig
Poor	30(26.5)	83(73.5)				

### Discussion

This section contains the discussion, conclusion and recommendations of the study based on the findings already detailed in chapter four. The major findings from the study were discussed with respect to the specific objectives, research questions and hypothesis set for the study in relation to findings from previous related studies. The discussion was done under research questions for better understanding. It also provides recommendations based on the study conclusions.

Majority of the respondents (62.3%) had high knowledge of AMTSL while 37.7% had poor knowledge, this finding was supported by the study conducted in five selected countries Benin, Ecuador, Jamaica, Nicaragua and Rwanda among skilled birth attendants (i.e. Midwives, Nurses and Doctors) revealed high level of knowledge of AMTSL (Artymuk et al, 2013). Also, a study conducted in 2012 on survey of prophylactic use of uterotonics in the third stage of labour in the Netherlands with the objective of investigating current knowledge about AMTSL in midwifery practices and obstetric departments in the Netherlands found out that 87.5% (N=528) agreed that administering prophylactic uterotonics was a component of AMTSL, 96.1% of midwives and 98.8% of Obstetricians.

Contrary to the findings of this study is the findings of the study carried out in Tanzania on the knowledge of (AMTSL) Active management of third stage of labour where only 9% made correct statements regarding all the components as in the definition of (AMTSL) Active management of third stage of labour, these included uterotonic drug administration within 1 minute following the delivery of the foetus, controlled cord traction and uterine massage every 15 minutes up to two hours after delivery of the placental (Bukley 2009).

The finding on the level of practice of AMTSL revealed that 42.7% had high level of practice while 57.3% had low level of practice of

AMTSL. This shows that a wide gap exists between current evidence-based standards and current levels of provider competence. Same was also observed in Benin; Ecuador, Jamaica and Rwanda by Sultani (2008). Also, study carried out in Uganda shows that the practices of the midwives were very poor as evidenced by only 28% using only one component of AMTSL during delivery of their clients<sup>19</sup>. About 27% of the delivery was without the use of control cord traction while 8% never used any uterotonics to conduct third stage of labour, all these demonstrated very poor practices of birth attendants as regards AMTSL (Bukley 2009).

In a study carried out in Uganda, the use of AMTSL according to the ICM/FIGO definition was observed in 5.4% of deliveries, if the definition of AMTSL is relaxed to allow for administration of uterotonic drug within three minutes of delivery of the foetus, the proportion receiving AMTSL increases to 7.3% (Downey & Bewley 2010). This study also revealed that 36% of the respondents often give oxytocin on the delivery of the anterior shoulder, 34% often delivered placenta by CCT while 44.7% often examine the placenta after delivery. This is not in line with the findings of the study carried out in Iran where 94% of the responding centres indicated oxytocin administration, 71% applies early cord clamping and 65% apply controlled cord traction (WHO 2006).

This study revealed that year of practice of respondents and categories of hospital setting are significant. This is in line with the findings of the study carried out in Dublin which revealed that the type of hospital (whether tertiary, secondary or primary health care facility) where birth attendants' practice has been found to have influence on the practice of AMTSL (Begley & Gyte 2002). Also year of experience has been associated with a reduction in practice (probably as a result of lack of knowledge) of the older birth attendants delegating bulk of the duties to the younger birth attendants (Begley et al, 2009).

The hindering factors observed were inadequate manpower (60.7%), shortage of oxytocin (47%) while 44.7% perceived the procedure to be time consuming. This is in line with the findings of the study conducted in Uganda which revealed the factors responsible for low utilization of AMTSL as inconsistent guidelines on AMTSL, lack of adequate staff and inability of the old birth attendants to adapt to the new guidelines (Soltani 2008). It was also discovered that some of the difficulties in implementing AMTSL are insufficiency in staff coverage leading to task shifting and the frequent change in the definition of AMTSL since its introduction in 2003 (POPPHI 2012). Lack of training was a barrier to the implementation of AMTSL (POPPHI, 2007). Sultani (2008) suggested that absolute staffing level was crucial for achievement of good outcome, the experience and proper deployment of available birth attendants were equally necessary.

In views of the findings of this study, it implies that the skills and practice of birth attendants are not congruent with their knowledge of AMTSL. This gap can be bridged by reorienting the birth attendants on the importance of quality practice and instituting standards to measure the performances of the birth attendants providing the care. With the right attitude, knowledge, proper education and practice, the lives of women would be in safer hands. The need for continuous training and retraining of birth attendants are vital to improving the standard of practice. World Health Organization recommends that maternity care providers should receive fresher training or updates in knowledge every 3-5 years. This is to buttress the need for in-service training. The need for improvement in the quality of midwifery care cannot be over emphasized, hence the need to embrace avenues that could improve staffing pattern. Implementing staffing ratio will however, provide great opportunity for improving patients care.

### Conclusion and Recommendations

In conclusion, the respondents have good knowledge of active management of third stage of labour, but the practice is highly deficient for reasons attributable to systemic failure though not devoid of personal lapses.

As professionals, persistent request for resources that will contribute to high

productivity and demonstration of competence is expected. Where this is not forthcoming, the profession and society must be informed; otherwise, it will lead to querying the competence of such professional group. Sustained government and political will in the areas of health resource allocation will help birth attendants' practice what they know effectively thus reducing maternal mortality resulting from post-partum haemorrhage.

It was recommended that, Government should create policy support for the routine use of active management of third stage of labour as one of the most effective interventions to prevent postpartum haemorrhage; constant supply of drugs and consumables that are needed by birth attendant to assist labouring women throughout the period of labour (e.g Oxytocin). Birth attendants should be encouraged to attend workshops and seminar on AMTSL to help improve their service delivery.

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