

**Summer Training at
District Health Society, Himatnagar,
NHM Gujarat
(April 1–May 31, 2014)**

**Active Management of Third Stage of Labour in Sabarkantha District,
Gujarat**

By

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**Under the guidance of
Dr. Shilpi Mishra Sharma**

**MBA- Hospital & Health Management (MBA-HM)
2013-2015**



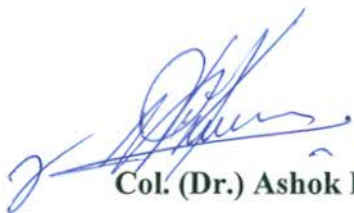
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CERTIFICATE

This is to certify that **Dr. Nareshkumar Prajapati**, student of Post Graduate Programme in Health Management, Institute of Health Management Research, Jaipur, batch 2013 – 15. He has done his summer training for the period of **April 1st to May 31st, 2014 under District Health Society Himatnagar, Sabarkantha, NHM Gujarat** under my guidance. During this period he has completed his study as a part of partial fulfillment of the course requirements, recommended for the Post Graduate Diploma in Health and Hospital with specialization in Health Management. Topic of study given by NHM Government of Gujarat during his summer training was “**Active Management of Third stage of Labor**”. All the data related to the study is the Primary data. His approach to the projects has been sincere, scientific and analytical.

I wish him all the best for his future endeavor.



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CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Dr. Nareshkumar Prajapati, student of Post Graduate Programme in Health Management, Institute of Health Management Research, Jaipur, batch 2013 – 15. He has done his summer training for the period of April 1st to May 31st, 2014 under District Health Society Himatnagar, Sabarkantha. During this period he has completed his study as a part of his curriculum activity given by NHM Government of Gujarat during his summer training on the topic of Active Management of Third stage of Labor. He was also involved in various activities to get understanding of Health System. He was quite active to take the participation in different kinds of meeting at district level.

I wish him all the best for his future endeavor.

Date- 31/05/2014

મુખ્ય જિલ્લા આરોગ્ય અધિકારી
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To Whomsoever It May Concern

This is to certify that **Dr. Nareshkumar Prajapati**, a student PGDHM(Post Graduate Diploma in Health Management), from Institute of Health Management Research, Jaipur has done his summer training at Sabarakantha Districts in NHM Gujarat on the topic of "Active Management of Third Stage of Labor" from April 1 to May 31, 2014.

We wish him all success in his future endeavor.

Place: Gandhinagar

**Member Secretary (SHS) &
Additional Director (P.H.)
Gandhinagar**

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Dr.Nareshkumar Prajapati

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ACRONYMS

AMTSL	Active Management of the Third stage of Labor
BEOC	Basic Essential Obstetrics Care
CCT	Controlled Cord Traction
EmONC	Emergency Obstetric and Neonatal Care
FIGO	Federation International of Gynecology and Obstetrics
ICM	International Confederation of Midwives
IM	Intramuscular
IMR	Infant Mortality Rate
IU	International Unit
IV	Intravenous
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
POPPHI	Prevention of Postpartum Hemorrhage Initiatives
PPH	Postpartum Hemorrhage
SBA	Skilled Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

DEFINITIONS

Maternal Mortality Ratio (MMR): The maternal mortality ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

Skilled Birth Attendant (SBA): SBA refers exclusively to people with midwifery skills (for example midwives, doctors and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications.

Postpartum Hemorrhage (PPH): PPH is generally defined as blood loss from the birth canal greater than or equal to 500 ml after birth, while severe PPH is blood loss greater than or equal to 1000 ml.

Third Stage of labour (TSL): Third stage of Labour is the period during which the uterine muscles contract and the placenta gradually separates from the uterine wall. It can be carried out either passively or actively.

Active management of the third stage of labor (AMTSL): AMTSL is an evidence-based, low cost intervention used to prevent postpartum hemorrhage that can help to prevent primary PPH.

MDG-5: The fifth Millennium Development Goal adopted by world leaders at the Millennium Summit at the United Nations in the year 2000, the goal is to improve maternal health in which

Target 5A: Reduce by three quarters, between 1990 and 2015

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

Functional Delivery Point (FDP): According to Government of India Benchmarks for each level of facility are fixed which is, for District Hospital (DH) more than 50 deliveries per month, for Sub district hospital (SDH) and FRU CHC more than 20 deliveries per month, for Non FRU CHC, 24*7 PHC and Non 24*7 PHC more than 10 deliveries per month and for Sub centre (SC) more than 3 deliveries per month. When these public facilities fulfilled above criteria, are known as functional delivery point.

*“Women are not dying because of a disease we cannot treat.
They are dying because societies have yet to make the decision that
their lives are worth saving.” Mamoud Fathalla,
President of the International Federation of Gynecology and Obstetrics
(FIGO), World Congress, Copenhagen 1997
Maternal and Newborn Health Toolkit*

1. INTRODUCTION

1.1. Sabarkantha

1.1.1. Geography

Sabarkantha is a district in Northeast of Gujarat state of India spread across an area of 7390 km². The administrative headquarters of the district is Himmatnagar. It is bounded by Rajasthan state to the northeast, Banaskantha and Mehsana districts to the west, Gandhinagar and Kheda districts to the south and Panchmahal District to the east. It comprises of 14 talukas out of which 9 are non-tribal talukas, namely Himatnagar, Prantij, Bayad, Idar, Vadali, Talod, Modasa, Malpur and Dhansura and 5 are tribal talukas, namely Bhiloda, Vijaynagar, Khedbrahma, Poshina and Meghraj. Himatnagar, Prantij, Modasa, Talod are the major industrial locations in Sabarkantha mainly for agriculture, ceramics, chemicals and milk processing.

1.1.2. District Profile

Sabarkantha has a total population of 24, 27,346 as per Census 2011 (ST- 20.2%, SC- 8.3%) with a population growth of 16.56%. Rural population consists of 85% of total population. Out of total, around 21% people lie under BPL category. It has a Total Sex Ratio of 947 females per 1000 males and Child Sex Ratio of 879 females per 1000 males. The literacy rate for the district is 66.6% (Source: Census, 2011). There are a total of 1372 villages out of which 1365 are revenue villages.

Healthcare is provided by 1 District Hospital, 2 Sub-District Hospitals, 19 Community Health Centres, 68 Primary Health Centres and 413 Sub Health Centres. There are a total of 3264 Anganwadi centres (3062 in rural areas and 202 in urban areas). Out of 69 PHCs, there are 17 24*7 PHCs (28 Tribal and 40 non-Tribal).

However, there were 992 Infant Deaths reported in 2012-13 and 1170 Infant deaths (2013-14), giving Infant Mortality Rate of 21.29 per 1000 live births (2013-14). District data shows that in 2012-13 Maternal deaths were 24 and maternal deaths in 2013-14 were 45.

1.2. Active Management of Third Stage of Labour

Active management of the third stage of labor (AMTSL) is a feasible and inexpensive intervention that can help to prevent primary PPH and save millions of women's lives.

The AMTSL involves three main components:

- First is, the use of uterotonic agents within one minute following the birth of the baby. Oxytocics (such as oxytocin and ergometrine) and prostaglandins or its analogue such as misoprostol have strong uterotonic properties and have long been used to treat uterine atony and reduce the amount of blood lost during childbirth and placental delivery. The use of these uterotonic drugs immediately after the delivery of the newborn is one of the most important interventions used to prevent PPH (POPPHI, 2010).
- Second is delivery of placenta with Controlled Cord Traction (CCT) which involves the traction on the cord during a contraction combined with counter-traction upward on the uterus with the provider's hand placed immediately above the symphysis pubis. CCT facilitates expulsion of the placenta once it has been separated from the uterine wall.
- The third component is the massage of the uterus after delivery of the placenta, which is an action used after the delivery of the placenta in which the provider or the woman places one hand on the fundus of the uterus through the woman's abdomen to rub or knead the uterus until it is firm. (ICM/FIGO, 2003). Studies show that there is considerable evidence that early cord clamping does not benefit mothers or babies and may even be harmful.

It is recommended in the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs/ LVHs/ SNs, that oxytocin should be the first drug of choice for AMTSL before misoprostol and ergometrine, and these drugs should be available in all health facilities from National and Referral Hospitals to dispensaries where deliveries take place. Therefore the main purpose of this

study was to assess the current knowledge and practice of skilled birth attendants in AMTSL in Sabarkantha District, Gujarat State.

2. LITERATURE REVIEW

Each year in India, roughly 28 million women experience pregnancy and 26 million have a live birth. Of these, an estimated 67,000 maternal deaths and one million newborn deaths occur each year. In addition, millions more women and newborns suffer pregnancy and birth related ill-health. Thus, pregnancy-related mortality and morbidity continues to have a huge impact on the lives of women and their newborns.

The maternal mortality ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

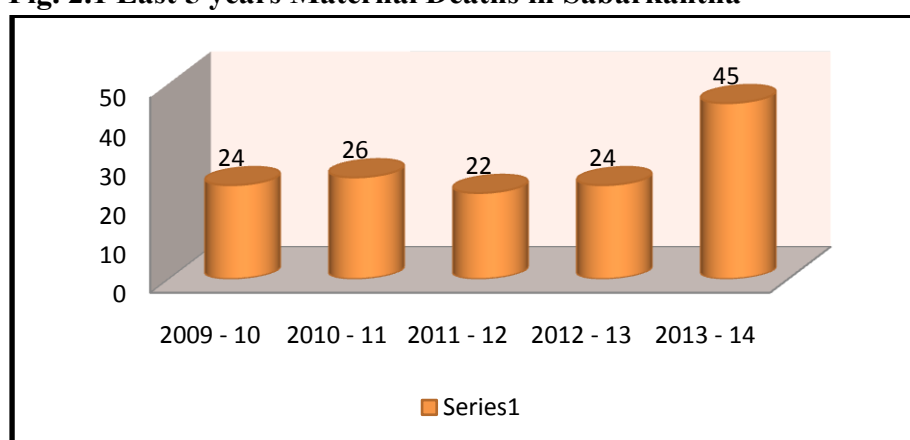
Maternal Mortality Ratio (MMR) in India has shown an appreciable decline from 398/100,000 live births in the year 1997-98 to 301/100,000 live births in the year 2001-03 to 254/100,000 live births in the year 2004-06 as per the latest RGI-SRS survey report, released in April 2009. However, to accelerate the pace of decline of MMR in order to achieve the NRHM and MDG Goal of less than 100 per 100,000 live births, there is a need to give impetus to implementation of the technical strategies and interventions for maternal health. Levels of maternal mortality vary greatly across the regions, due to variation in underlying access to emergency obstetric care, antenatal care, anemia rates among women, education levels of women, and other factors. The Maternal Mortality Ratio of India has declined from 212 in 2007-2009 to 178 in 2010-2012.

Maternal Deaths in Sabarkantha

Table 2.1 Last 5 years Maternal Deaths

Sr. No	Total Population	Year	No of Maternal Death
1	2275008	2009 – 10	24
2	2275008	2010 – 11	26
3	2427346	2011 – 12	22
4	2427346	2012 – 13	24
5	2428589	2013 – 14	45

Fig. 2.1 Last 5 years Maternal Deaths in Sabarkantha



The above data shows that in year 2013 – 14 numbers of maternal deaths were 45, which is more than 24 maternal deaths of previous year 2012 – 13. These increased numbers of maternal deaths in year 2013 – 14 were because of significant improvement in reporting system of district.

Causes of maternal deaths may be direct or indirect. The focus till now has largely been on addressing the direct causes of maternal deaths. However, indirect causes also need to be addressed to further reduce MMR and achieve the Millennium Development Goal (MDGs). The indirect causes also include the socio-economic determinants of health which are referred to as the three known delays:

- 1) Delay in making a decision on the need for medical care;
- 2) Delay in reaching the appropriate facility in time; and
- 3) Delay in initiating the correct treatment at the health facility.

The first two 'delays' relate directly to the issue of access to care, encompassing factors in the family and the community, including transportation. The third 'delay' relates to factors in the health facility, including quality of care. Unless the three delays are addressed, mortality and morbidity cannot be reduced. In practice, it is crucial to address the third delay first, as it would be useless to facilitate access to a health facility if quality health care services are not available at the health facility. Socio-economic status of women and families, community awareness, birth preparedness, complication readiness, and good referral linkages are linked to the first and second delays. The third delay can be addressed only through the availability of good quality basic and emergency obstetric and neonatal services.

In December 2000, 149 Heads of State or Government and 189 Member States jointly endorsed the Millennium Declaration which committed signatories to achieving, by 2015, ambitious goals in poverty reduction, alleviation of hunger, control of disease, achievement of universal education and reversing environmental degradation. These goals are known collectively as the Millennium Development Goals (MDGs). The MDGs will serve as the framework for reporting on progress in development for the next 15 years, with achievements measured in terms of a 1990 baseline and a 2015 target. This framework aims to bring all development partners together around a common, unified agenda that is focused on poverty alleviation. The reduction of maternal mortality is one of the key goals of the Millennium Declaration.

In the MDG framework, two indicators are proposed for monitoring progress towards the maternal health goal namely, the maternal mortality ratio and the proportion of deliveries with a skilled health care provider. The need for access to skilled health care for pregnancy, birth and the postnatal period has been central to WHO's Making Pregnancy Safer initiative. However, In the Making Pregnancy Safer initiative, together with the experiences of partners working in safe motherhood, have shown that countries have yet to integrate increasing access to skilled care for pregnant women into their national health and development plans. Concerns have been expressed that the strategies required are complex and too difficult to implement because of human resource constraints.

There is now a global consensus on what must be done to eliminate the menace of maternal deaths once and for all. Already in 1999, a joint WHO/UNFPA/UNICEF/World Bank statement¹ called on countries to “ensure that all women and newborns have skilled care during pregnancy, childbirth and the immediate postnatal period”. Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/ his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care. Since skilled care as defined above can be provided by a range of health professionals, whose titles may vary according to specific country contexts, it has been agreed to refer to this health care provider as the “skilled attendant” or “skilled birth attendant”, so as to avoid confusion. Thus:

The term ‘skilled attendant’ refers exclusively to people with midwifery skills (for example midwives, doctors and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage* or refer obstetric complications.

*Manage was added in 2000 by the Inter-Agency Group for Safe Motherhood in recognition that some skilled attendants will also have competencies to manage complications.

Source: A Joint WHO/UNFPA/UNICEF/World Bank Statement on Reduction of Maternal Mortality, 1999.

Also, the concept of the skilled attendant is not always well understood. Even when it is understood, there are operational difficulties in identifying precisely what skilled attendants should do, how they should be trained and deployed, and what it will cost.

3. RATIONAL/ NEED OF STUDY

In childbearing, women need a continuum of care to ensure the best possible health outcome for them and their newborns. The skilled attendant is at the centre of the continuum of care. She/he will also need strong working links with health care providers at the secondary and tertiary levels of the health system. However, without a skilled attendant to provide a continuum of care from the community to the highest level of referral for those who require this, maternal and newborn health cannot be assured.

Postpartum Hemorrhage (PPH) is the leading cause of maternal deaths. It occurs in over 10% of all births and is associated with a case fatality rate of 1% while 25% of all maternal deaths are caused by severe hemorrhage (WHO 2005). Without proper management, PPH can rapidly progress to life-threatening blood loss, often within several hours.

PPH is generally defined as blood loss greater than or equal to 500 ml within 24 hours after birth, while severe condition is blood loss greater than or equal to 1000 ml within 24 hours. Most cases of morbidity and mortality due to PPH occur in the first 24 hours following delivery and these are regarded as primary whereas any abnormal or excessive bleeding from the birth canal occurring between 24 hours and 12 weeks postnatal is regarded as secondary PPH. It may result from failure of the uterus to contract adequately (atony), genital tract trauma (i.e. vaginal or cervical lacerations), uterine rupture, retained placental tissue, or maternal bleeding disorders. Uterine atony is the most common cause and consequently the leading cause of maternal mortality worldwide (ICM, 2003). Twenty five percent of all maternal deaths are caused by severe hemorrhage (WHO, 2005).

- * Almost all of these deaths (99%) occur in the ~~de~~developing" world.
- * Ten million women are lost in every generation.
- * Four million newborn babies die every year, also from causes that are mainly preventable and typically linked to the mother's health.

At the community level, the skilled attendant will often be the only qualified and accredited health care worker with exclusive responsibility for the care of women during pregnancy,

childbirth and the immediate postnatal period. Certainly, others — ranging from traditional birth attendants (TBAs), to nurses— will contribute to the care of women and newborns. Well intended efforts to reduce maternal and newborn mortality and morbidity have been under way for more than a decade.

Active management of the third stage of labor (AMTSL) is a feasible and inexpensive intervention that can help save thousands of women's lives with the help of SBA's. The inclusion of AMTSL in the WHO evidence-based manual Managing complications in Pregnancy and Childbirth also attests to the international acceptance of this practice as the standard of care.

The World Health Organization (WHO) Making Pregnancy Safer Technical Update on prevention of PPH by AMTSL recommends that –AMTSL should be practiced by all skilled attendants at every birth to prevent postpartum hemorrhage.”

Causes of Maternal Deaths in Sabarkantha

Table 3.1 Causes of Maternal deaths in S.K in 2013-2014

Causes	No. of Deaths	% of Causes
PPH	15	33.33
Septicemia	10	22.2
Koch's	7	15.6%
DIC	4	8.9
Cardiac	3	6.7
Pulmonary Embolism	2	4.44
Others	4	8.9
Total	45	100.00

Sources: District Maternal Health Report

Above data shows that the most of maternal death in Sabarkantha occurred because of PPH, out of 45 total numbers of deaths 15 deaths were occurred because of Post Partum Hemorrhage and it was almost 33% and the second most common cause of maternal death was septicemia which was 22%.due to that 10 deaths of maternal death were occurred.

4. RESEARCH QUESTION

What is the current level of knowledge and practice among skilled birth attendants for AMTSL in Sabarkantha district of Gujarat?

5. OBJECTIVES

- To assess the knowledge of skill birth attendants for active management of third stage of labour.
- To assess the practice of SBAs for AMTSL.

6. METHODOLOGY

6.1. Study Design

The study is of descriptive in nature type. There is a quantitative approach in this study.

6.2. Target Population

All skilled birth attendants, working in Functional delivery Points (FDPs), in Sabarkantha district, Gujarat.

6.3. Sampling

In this study Purposive sampling was used. So, In Sabarkantha district there are 26 FDPs. This study includes 13 Functional delivery Points (FDPs) according to convenience.

6.4. Sample Size

35 skilled birth attendants from 13 Functional delivery points (FDPs) were selected and interviewed.

6.5. Data Collection Approach

All data was collected by using questionnaire which had major two parts (AMTSL knowledge, standard steps of practice of AMTSL) containing close ended structured questions to interview participating skilled birth attendants. Practice of AMTSL was done through observation as well as self administered checklist on vaginal deliveries by using a standard tool developed on the basis of Ministry of Health and family Welfare of India.

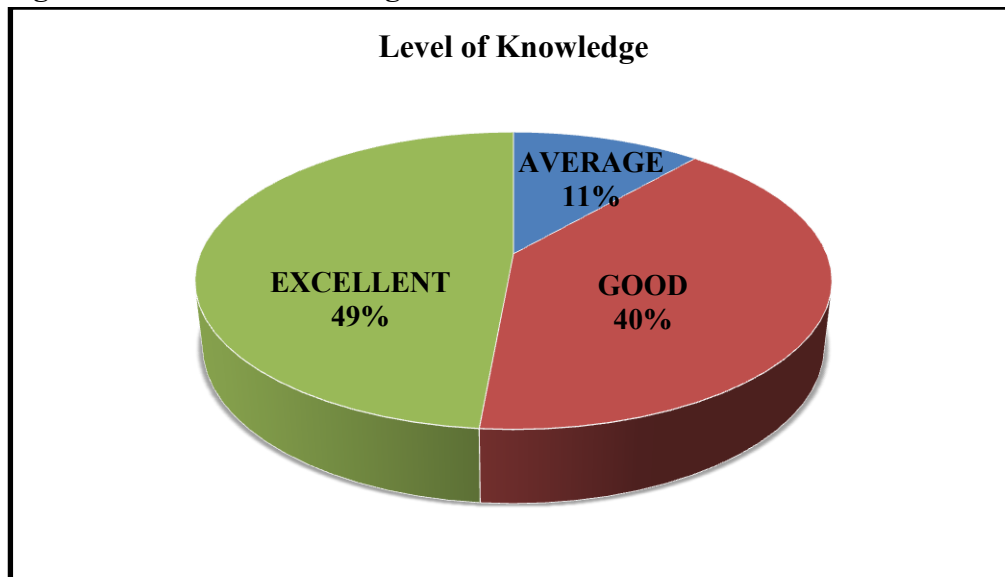
7. DATA ANALYSIS

Each correct response of specific knowledge question on AMTSL or observational skill weighed 1 mark out of 100% score while each incorrectly and not done procedure were given a weight of zero mark. Data was coded, entered and finally analyzed in the computer with the help of Microsoft excel.

Table 8.1 Categorization of Level of knowledge of SBAs'

Categorization According to Response	Total No of Respondent (N=35)	Percentage
AVERAGE (Response up to 10 answer correctly)	4	11.4%
GOOD (Response up to 12 answer correctly)	14	40.0%
EXCELLENT (Response Up to 15 answer correctly)	17	48.6%

Figure 8.1 Level of knowledge of SBAs' for AMTSL

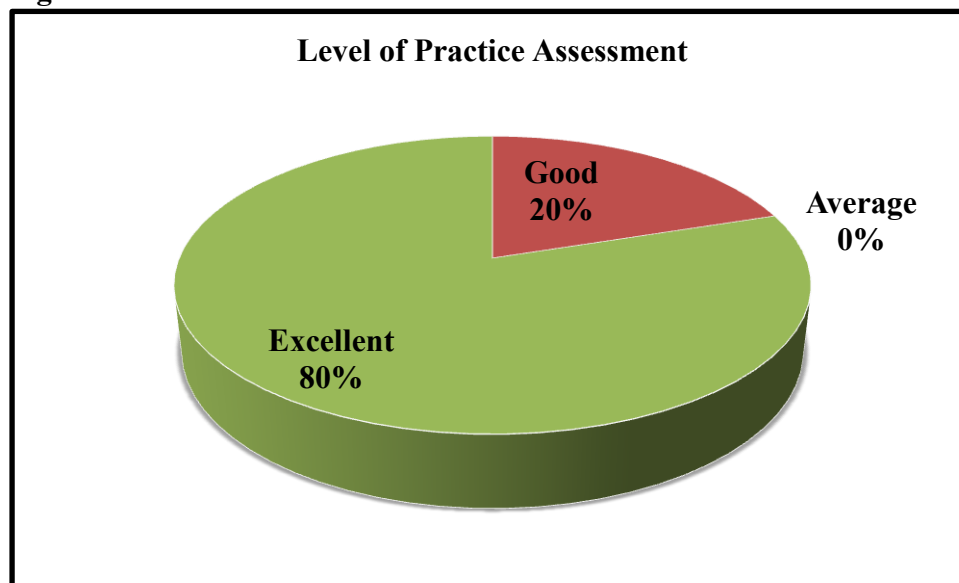


There are 49% skilled birth attendants who have excellent knowledge of AMTSL. 40% SBAs have good knowledge of AMTSL and 11% have average knowledge related with active management of third stage of labour. Result of the study shows each respondent gave more than 8 correct answers.

Table 8.2 Categorization of practice of SBAs

Categorization According to response	Total No of Respondents (N=35)	Percentage
Average (>14 correct response)	0	00%
Good (up to 16 correct response)	7	20%
Excellent (Up to 18 correct response)	28	80%

Figure 8.2 Level of Practice Assessment



As the above figure shows that 80% skilled birth attendants were excellently practicing AMTSL according to standard steps of active management of third stage of labour and 20% doing good practice of AMTSL. During the practice assessment it was found that number of skilled birth attendants who are practicing AMTSL poorly and averagely were zero.

8. ETHICAL CONSIDERATION

Informed consent was sought from participants before they participate in the study, and was allowed to opt out if they wished to. Confidentiality was assured by using participant identification numbers instead of their actual names.

9. CONCLUSION

I would like to conclude that in Sabarkantha district when Knowledge of skilled birth attendant was assessed it shows that for each question all SBAs gave more than 60% correct answers and there are 49% respondent who have excellent knowledge of AMTSL, 40% have good knowledge and 11% have average knowledge of AMTSL.

In practice assessment, 80% skilled birth attendants doing AMTSL practice excellently and remaining 20% are doing good practice of AMTSL. Percentage of skilled birth attendants who were practicing AMTSL averagely were zero.

Some of SBAs' while filling practice assessment checklist, it was observed that, though they know that about the 3rd step of AMTSL i.e. fundal massage should be done every fifteen minutes interval for first two hrs still they are not practicing it properly.

Finding of the study shows that maximum skilled birth attendants knows about the first line of uterotonic drug with its rout & dose of that drug, about CCT and fundal massage after control cord traction

10. REFERENCES

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APPENDICES

Appendix A: Participant's Consent Form

As part of my research study, I am undertaking a research project on Active Management of Third Stage of Labour in Sabarkantha District of Gujarat.

The project examines about the knowledge of skilled birth attendants and how they are practicing active management of third stage of labour.

I would like to request you to fill this questionnaire and give your answer during interview. This will take approximately 30 minutes.

Your participation is completely voluntary and there will be no negative consequences to you for not participating. Your privacy will not be hampered due to this study.

During the interview, you will have the opportunity to stop the interview at any time.

Your completion and return of the survey is taken as an indication of your consent to participate.

Thank you for considering participating in this study.

Sign of Respondent

Date:

Appendix B: Knowledge Questionnaire

GENERAL INFORMATION	
Section A	
1) Name of Organization/ Work Place:	
2) Designation:	
3) Year of Experience	
4) Date:	

KNOWLEDGE ASSESSMENT THROUGH MULTIPLE CHOICE QUESTIONS	
Section B	
Read each question carefully before choosing a response. Give the best response for question. જવાબ પસંદ કરતા પહેલા દરેક પ્રશ્ન કાળજીપૂર્વક વાંચો. પ્રશ્ન માટે શ્રેષ્ઠ જવાબ આપો.	
1) AMTSL (Active Management of Third Stage of Labour) should be practice a. Only on women who have a history of PPH b. Only on the primipara c. Only on the multipara d. On all women giving birth vaginally 1) AMTSL ના સક્રિય મેનેજમેન્ટ ની પ્રેક્ટિસ કરવી જોઈએ એ. માત્ર પીપીએચ ઇતિહાસ ધરાવે છે તેજ સ્ત્રીઓ પર બી. માત્ર primipara પર સી. માત્ર multipara પર ડી. બધા સ્ત્રીઓ જે vaginally જન્મ આપે	
2) What should a skilled birth attendant rule out before administering a uterotonic drug? a. Pulsation of the umbilical cord. b. Uterine contractedness. c. The presence of another baby. d. Signs of placenta separation (e.g., lengthening of the cord). 1) એક કુશળ જન્મ પરિચરે uterotonic દવાઓ આપતા પહેલા શું તપાસ કરવી જોઈએ એ. Umbilical Cord ના ધબકારા બી. ગર્ભાશય નું contractedness. સી. બીજા બાળક ની હાજરી. ડી. Placenta અલગ થવાના (દા.ત. Cord ની લંબાઈ) ચિન્હો.	

2) The first line uterotonic recommended for AMTSL is a. Ergometrine b. Oxytocin c. Misoprostal d. Other (Please specify)..... 2) AMTSL માટે ભલામણ કરેલી પ્રથમ લાઇનની uterotonic દવા છે એ. અરુગોમેટરીન Ergometrine બી. ઓક્સીટોસિન સી. મિસોપ્રોસ્ટાલ Misoprostal ડી. અન્ય (ઉલ્લેખ કરો)	
3) The recommended dose of that drug (selected in Question 3) during AMTSL is a. 5 IU b. 10 IU c. 600 mcg d. Other (please specify) 3) AMTSL દરમિયાન (પ્રશ્ન 3 માં પસંદ કરેલી) દવા ની યોગ્ય માત્રા છે એ. 5 IU બી. 10 IU સી. 600 mcg ડી. અન્ય (સ્પષ્ટ કરો)	
4) The recommended route to give that drug (selected in Question 3) during AMTSL is a. Oral b. Intramuscular (IM) c. Intravenous (IV) d. Other (Please specify) 4) AMTSL દરમિયાન (પ્રશ્ન 3 માં)પસંદ કરેલી દવા નો યોગ્ય માર્ગ છે એ. ઓરલ (મોઢે થી) બી. ઇન્ટ્રામસ્ક્યુલર (IM) સી. અંતઃનળીય (IV) ડી. અન્ય (ઉલ્લેખ કરો)	
5) The three main sequential components of AMTSL are a. Uterotonic drug administration, immediate uterine massage after delivery of the placenta and CCT (Control Cord Traction) b. Immediate uterine massage after delivery of the placenta, CCT and Uterotonic drug administration c. Uterotonic drug administration, CCT and immediate uterine massage after delivery of the placenta.	

d. Other (Please specify) 6) AMTSL ના ત્રણ મુખ્ય ક્રમાંકિત ઘટકો છે એ. Uterotonic દવા આપવી, Placenta ની ડિલિવરી પછી તરત જ ગર્ભાશયનું મસાજ અને CCT (Control Cord Traction) બી. Placenta ની ડિલિવરી પછી તરત જ ગર્ભાશયનું મસાજ, CCT અને . Uterotonic દવા આપવી સી. . Uterotonic દવા આપવી, CCT અને Placenta ની ડિલિવરી પછી તરત જ ગર્ભાશયનું મસાજ. ડી. અન્ય (ઉલ્લેખ કરો)	
6) The following is (are) believed to be harmful practice (s) when performing AMTSL. a. Massaging uterus before delivering the placenta b. Applying Controlled Cord traction (CCT) without fundal support c. Both d. Other (Please specify) 7) નીચેનાં અભ્યાસ (ઓ) માંથી AMTSL કરી રહ્યા હોય ત્યારે હાનિકારક અભ્યાસ (ઓ) માનવામાં આવે છે છે. એ. Placenta ની delivery કરાવ્યા પહેલાં ગર્ભાશય ની માલિશ કરવી બી. Fundal આધાર વિના કંટ્રોલ કોર્ડ ટ્રેક્શન (CCT) કરવું સી. બંને (એ & બી) ડી. અન્ય (ઉલ્લેખ કરો)	
7) What should be the duration of AMTSL? a. 1minute if relaxed within 3 minutes b. 5 minutes c. 5-10 minutes d. Other (Please specify) 8) કેટલા સમય માં AMTSL પૂર્ણ થયેલું હોવું જોઈએ? એ. 1minute જો 3 મિનિટ ની અંદર હળવું થઈ ગયું હોય બી. 5 મિનિટ સી. 5-10 મિનિટ ડી. અન્ય (ઉલ્લેખ કરો)	
8) Active management decreases: a. The incidence of PPH (Post Partum Hemorrhage). b. The length of the third stage of labor. c. The percentage of third stages of labor lasting longer than 30 minutes. d. All of the responses are correct.	

9) સક્રિય મેનેજમેન્ટ ઘટાડે છે: એ. પીપીએચ (પોસ્ટ પાર્ટમ હેમરેજ) ની ઘટનાઓ. બી. Labour નાં ત્રીજા તબક્કાનો સમયગાળો. સી. Labour નાં ત્રીજા તબક્કાની ટકાવારી જે 30 મિનિટ કરતાં વધારે લાંબી ચાલે. ડી. જવાબો તમામ યોગ્ય છે	
9) In the first two hours post delivery uterine massage to a woman should be done in an interval of; a. 15 minutes b. 30 minutes c. 45 minutes d. 60 minutes e. Other (Please specify) 10) એક મહિલા ને delivery થયા પછી ના પ્રથમ બે કલાકની અંદર ગર્ભાશય મસાજ અંતરાલે થવું જોઈએ; એ. 15 મિનિટ બી. 30 મિનિટ સી. 45 મિનિટ ડી. 60 મિનિટ ઈ. અન્ય (ઉલ્લેખ કરો)	
10) If the placenta does not descend after two attempts of CCT (Control Cord Traction): a. Consider placenta accreta and prepare the patient for a surgical intervention. b. Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well-contracted again. c. Administer a second injection of oxytocin 10 IU IM. d. Administer a different uterotonic because the first uterotonic was not effective. 11) જો placenta CCT (કંટ્રોલકોર્ડ ટ્રેક્શન)નાં બે પ્રયાસો પછી પણ નીચે ઊતરતું ન હોય તો: એ. Placenta accreta નો વિચાર કરો અને સર્જીકલ હસ્તક્ષેપ માટે દર્દી ને તૈયાર કરો. બી. Cord ને ખેંચવાનું ચાલુ ન રાખો; Cord ને ધીમેથી પકડો અને ગર્ભાશય ફરીથી સારી રીતે સંકોચન થાય ત્યાં સુધી રાહ જુઓ. સી. 10 IU IM ઓક્સીટોસિન ઇન્જેક્શન બીજી વખત આપો	

ડી. પ્રથમ uterotonic અસરકારક ન હતી તેથી અલગ uterotonic દવા આપવી	
12) If an atonic uterus does not contract after fundal massage, the next step is to a. Give additional uterotonic drugs b. Perform bimanual compression of the uterus c. Start an IV infusion d. Explore the uterus for remaining placental fragments 12) એક શક્તિવિહીન ગર્ભાશય fundal મસાજપછી પણ contract નથાય તો, આગળના પગલાં છે એ. વધારાની uterotonic દવાઓ આપો બી. ગર્ભાશયનું bimanual સંકોચન કરો સી. આઈ વી ઈનફ્યુઝન શરૂ કરો ડી. ગર્ભમાં બાકીનાં ટુકડાઓ માટે ગર્ભાશય ને એક્સપ્લોર કરો	
13) Screening for, preventing, and treating anemia during pregnancy can: a. Prevent PPH. b. Reduce the risk of dying from PPH. c. Make AMTSL less risky. d. All of the above. 13) ગર્ભાવસ્થા દરમિયાન એનિમિયાની ની સારવાર અને અટકાવવા નાં સ્ક્રીનીંગ થી: એ. પીપીએચથી બચાવે છે. બી. પીપીએચ થી મરવાનું જોખમ ઘટાડે છે. સી. AMTSL ને ઓછી જોખમી બનાવે છે. ડી. જવાબો તમામ યોગ્ય છે	

14) The dose and route for the initial management of PPH before refer the women to the FRU (First refferal unite) 5 IU Intramuscular (IM) stat 5 IU in 500ml Ringer Lactate Intravenously (IV) 20 IU Intramuscular (IM) stat 20 IU 500 ml Ringer Lactate Intravenously (IV) 14) સ્ત્રીઓને FRU (પ્રથમ રેફરલ યૂનીટ) પર રેફર કરતા પહેલા પીપીએચનાં પ્રારંભિક સંચાલન/ સારવાર માટે Inj ઓક્સીટોસિન ની માત્રા અને માર્ગ છે એ. 5 IU ઇન્ટ્રામસ્ક્યુલર (IM) સ્ટેટ બી. 5 IU (IV) 500ml રિંગર Lactate માં ઇટ્રાવિનસલી (IV) સી. 20 IU ઇન્ટ્રામસ્ક્યુલર (IM) સ્ટેટ ડી. 20 IU 500 રિંગર Lactate માં ઇટ્રાવિનસલી (IV)	
15) What are the dose and route of Magnesium Sulphate injection for the intial management of eclampsia? 5 ml (2.5gm) deep intramuscularly (IM) in each buttock 10 ml (5gm) deep intramuscularly (IM) in each buttock 15 ml (7.5gm) deep intramuscularly (IM) in each buttock 20 ml (10gm) deep intramuscularly (IM) in each buttock 15) Eclampsia ના પ્રારંભિક સંચાલન/ સારવાર માટે મેગ્નેશિયમ સલ્ફેટ ઇન્જેક્શન ની માત્રા અને માર્ગ શું છે? એ. 5 ml (2.5gm) દરેક નિતંબ માં ઊંડા intramuscularly (IM) બી. 10 ml (5gm) દરેક નિતંબ ઊંડા intramuscularly (IM) સી. 15 ml (7.5gm) દરેક નિતંબ માં ઊંડા intramuscularly (IM) ડી. 20 ml (10gm) દરેક નિતંબ માં ઊંડા intramuscularly (IM)	

Appendix C: Practice Assessment

Procedure: Active Management of Third Stage of Labour	Done	Not Done
1) After delivering the first baby palpates the abdomen and rules out presence of another fetus before continuing.		
2) Administers 10 units of IM oxytocin. If oxytocin is not available, administers 0.5 mg of Ergometrine (NOT in preeclamptic/ eclamptic women) or Prostaglandins. Indicate whether this is		
3) (a). Done within 1 minute? Or		
(b) Done within 3 minutes? Or		
(c) Done for more than 3 minutes?		
4) Clamps cord close to perineum		
5) Uses sponge/artery holding forceps in clamping the cord		
6) Places the other hand just above the woman's pubic bone to stabilize uterus for CCT		
7) Waits for a strong uterine contraction (2 – 3 minutes)		
8) Does wait for a gush of blood		
9) During the contraction, applies controlled traction (CCT) to the cord so as to avoid uterine inversion:		
10) Pulls the cord gently, firmly, and uniformly downward to deliver the placenta		
11) Supporting the placenta with both hands.		
12) Extracts the membranes gently with lateral movements.		
13) Immediately massages the uterine fundus.		
14) Ensures that the uterus does not relax after stopping uterine massage		
15) Checks to see if the tissues are complete.		
16) Checks to see if the placenta is whole and intact.		
17) Examines the woman for cervical or vaginal tears, or episiotomy to be repaired.		
18) Reports that she will assess uterine contraction, every 15 minutes in the first hour, then twice hourly in the next hour.		