

Effectiveness Of Selected Midwifery Activities Regarding Active Management Of Third Stage Of Labour

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Abstract

The third stage of labour's managed funds was essential in preventing haemorrhage connected to childbirth. However, there is a significant amount of maternal mortality and morbidity related to haemorrhage because reproductive healthcare workers lack knowledge and skills about just the active management of the second and third trimester. Our The purpose of this research was to assess midwives' capabilities in India to carefully manage the fourth phase of labour by examining their understanding, tactics, routines, and associated factors. Midwives were the subject of a hospital-based cross-sectional research from December 2020 to December 2022. The midwives are questioned to collect data. During the study period, the health authority documented births from over 9,000 women annually. The final section of labour may be managed by midwives thanks to their training and experience. After accounting for any confounding factors, the findings showed that having a midwife constituted one of the key predictors of effective active administration of the second and third trimester. The awareness and education of paediatricians concerning the actively managed funds of the second and third trimester may be improved with the specific strategies, such as ongoing training sessions. This research also made it very evident that midwives' knowledge and skill levels regarding active management of the third stage of labour need rapid correction. To improve skill, hospitals should organise trainings for more midwives.

Keywords: *Active management of third stage of labor, Knowledge, Practice, Third stage*

Introduction

The gynecologist's duties include routinely assessing the length of the third stage, the time and method of maternal release, significant excessive bleeding, and the general life of the mother and her unborn child. The midwife's role in the healthy emergence of the pregnancy includes the pathophysiology of childbirth in addition to baby's transition to life(Minoofar et al., 2008). Active management include providing early uterotonics to compress the uterus after that the infant is delivered and using a tight cabletraction to evacuate the placenta right away after delivery (Fritz et al., 2017).

The need for additional data to be confident in the conclusions since the research was often of very modest or poor nature. Regardless of a woman's risk for severe flow, active therapy may reduce serious complications and hemoglobin in all women. The baby's blood hypertension, withdrawal symptoms, vomit, and thus the probability of women returned to the care with bleeds might all increase. The baby's understand can also be impacted. The outcomes were the same for women at reduced chance of bleeding, despite the fact that it was unknown whether any changes had occurred modification inside this prevalence of significant bleeding in thrombocytopenia (Qian et al., 2020). Therefore, the primary goals of the research are to evaluate knowledge, plan, practise, and related variables for midwives' efficacy in actively managing the third stage of labour in India

Material and method

The current study employs a descriptive research approach. This research methodology is used to examine the current circumstances and track respondents' natural behaviour. It presents a broad summary of the subject. It is a study intended to identify and characterise the research's participants. An essential aspect of descriptive research is that it is used to characterise the behaviour of respondents by explaining, characterising, and confirming study results.

All governmental healthcare facilities in two zones of Delhi's NCR area participated in the research. There are several hospitals and health facilities in the NCR Delhi, and there were 918 midwives overall in the area. The survey was carried out in the central and specialised zones of the NCR area, which are home to governmental health facilities. In all, there were 304 midwives in these two zones. Therefore, during data collection, all midwives who were employed in the delivery room of certain public health facilities in the NCR area were included.

As a midwife researcher, this investigation was constrained by the code of professional conduct's guidelines for midwifery ethics. Confidentiality, anonymity, legality, and professionalism were among the ethical problems.

Interviews were conducted at the midwife's workplace or on university grounds. Interviews were scheduled to take place in a private, peaceful setting without interruptions.

Analysing data

Cleaning, coding, and entering the data into excel sheets was done before sending them to SPSS ("Statistical Package for the Social Sciences") version 20 for analysis. Frequency, percentage, and other metrics, such as measures of central tendency, were calculated using descriptive statistical analysis.

Result and Discussion

The midwives' degree of expertise on effective at a few health facilities, the final section of labour is managed

Participants and their practice environment

The research was done in two National health Service (NHS) trusts inside one health authority in NCR, Delhi from 2020-2022. Women who lived in rural areas, little market towns, and an industrial metropolis with a large multi-ethnic population might get treatment from the health authority. Over 9,000 women a year throughout the health authority recorded births during the research period. From both the hospitals, Hospital A 1st year 9467 numbers of mothers were registered whereas in Hospital B 9366 mothers were registered.

Table 1: Birth statistics during study period

	1 st Year	2 nd Year
Mothers who delivered registerable births at hospital A	5698	5489
Mothers who delivered registerable births at Hospital B	3769	3877
Total	9467	9366

The bulk of births attended by hospital A's personnel took place in the hospital's maternity unit's delivery suite, where women got care from neighbourhood midwifery organizations, inpatient

midwifery workgroups, and delivery suite core personnel. Only about 5% of women used neighbouring midwives to help them deliver at home..

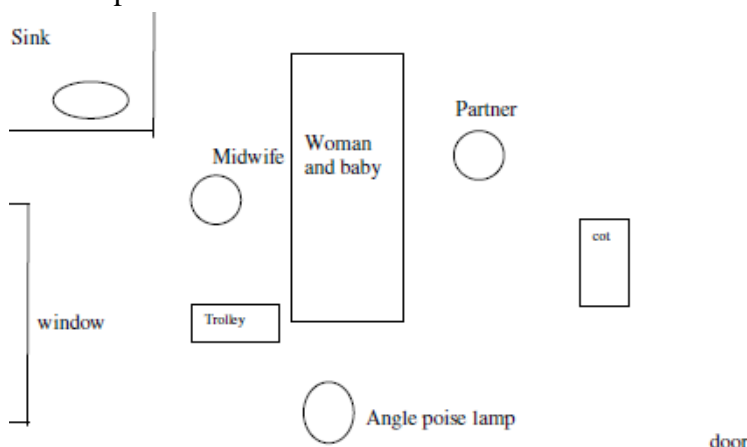


Fig 1 The third step of labour’s usual medical delivery room design

Fig. 1 is an illustration of the conventional design of a hospital birth room. The design of a home birth depended on the inside of the house. The location of the woman, the location of the baby, and the midwife's position there were 3 main sites that were vital and during third trimester of pregnancy in respect to the child and parents and including doctors access to any proper materials. Third level practice involves contact between the mother, midwife, and infant; these areas were crucial. Third stage care was impacted by these interactions. For instance, a woman giving birth in an upright posture affected not only that gynaecologist’s capacity to go close enough to the infant to cut the ribbon and woman's uterus for monitoring the next contraction, but also where the baby was positioned during delivery (often on the bed between the mother's legs).When provided with the existing scientific findings and the ensuing criticisms, women can still choose for biophysical final event care. Women are thus included in the decision-making process, but if the choice has to be changed for clinical reasons, the midwife will let the patient know why. Each woman makes a unique choice for the provision of third stage care in collaboration with her midwife (Wake and Wogie, 2020).

Table 2: Third phase practise elements

	Name of management
1.	birthing techniques for women
2.	Type of uterotonic medication
3.	Common medication timeline Consent obtained at the moment of medication administration
4.	Third-stage birthing settings for babies Breaking the umbilical stump
5.	infant feeding
6.	basic infant care
7.	general attention to women
8.	Attitudes of women undergoing placenta delivery
9.	evaluation of haemorrhage
10.	Waiting

11.	Trophoblastic dissociation and descent the signs and symptoms
12.	Placental dissociation and descending symptoms were seen.
13.	Uterine wall examination Guarding
14.	handling the chord before the birth of the placenta
15.	Mother's work
16.	pregnancy childbirth
17.	the coverings are delivered
18.	Delay control
19.	birthing techniques for women
20.	Type of uterotonic medication
21.	Common medication timeline Consent obtained at the moment of medication administration

Midwives further classified their practise into "options for care" for each part of third stage practise, reflecting the variety of ways midwives handled it. In order to compare and analyse the explanations of fourth stage practise, "components to care" was used to accurately record the data.

Conclusion

The accounts of performance within every area of final event care were backed up by references to quotes from midwife consultations, computer-generated statistics, and final event treatment outcome, and excerpts from nursing literature. Each midwife remark was referenced by the document number given to the interview in order to preserve identity. With the right actions, such as in-service training activities, the level of knowledge of physicians regarding the effective and enhancing the third level of labor protection. This research also made it very evident that physicians' skills and understanding levels regarding effective management of something like the third stage of labour need rapid correction.

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