Abstract

Background: Postpartum haemorrhage is the main cause of maternal mortality in rural areas of low-income countries.

Aims: This study investigated the causes of maternal death from postpartum haemorrhage in rural areas of Sistan and Baluchestan, and determined the effect of three interventions on midwives’ management of haemorrhage.
Methods: Maternal deaths in women with postpartum haemorrhage between 9 April 2012 and 9 April 2013 were reviewed to determine what contributed to the death. Following the review, prostaglandin was permitted for use in rural maternity units. A flowchart on managing haemorrhagic shock and a training workshop on management of postpartum haemorrhage were also developed for midwives working in rural areas. After the interventions, all cases of postpartum haemorrhage (n = 81) that occurred during 23 September 2014–23 February 2015 in rural maternity facilities were reviewed based on 19 indicators. A control group (n = 81) was selected from women with postpartum haemorrhage who had been admitted to the same maternity units before the interventions.

Results: After the training interventions, more midwives used more than one method to estimate blood loss and higher doses of oxytocin to control haemorrhage. They showed improvements in the use of intravenous fluid therapy, pulse and blood pressure checks, external uterine massage, and uterotonic drugs. Following training, more women were admitted to hospital in a stable condition and recovered and were discharged (P = 0.002), and fewer had surgical interventions (P = 0.007).

Conclusion: Midwives' management of postpartum haemorrhage improved after the interventions. Training programmes should be based on study of the local situation to identify shortcomings. Regular monitoring of outcomes is needed to detect and resolve failures.

Keywords: Postpartum haemorrhage, maternal death, midwifery, training, Islamic Republic of Iran

Citation: Moudi Z; Tabatabaei SM; Sargazi-Moakhar Z; Mollashahi SS; Zaboli M. Empowering midwives to manage postpartum haemorrhage in rural areas of Islamic Republic of Iran: lessons learnt from cases of maternal death. East Mediterr Health J. 2019;25(x):xxx–xxx. https://doi.org/10.26719/emhj.19.008

Received: 12/03/18; accepted: 09/08/18

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Introduction

In 2015, about 303,000 women worldwide died of pregnancy- and childbirth-related complications. About 99% of these deaths occurred in low-income settings (1), mostly in the remote and rural areas (2).

Severe antepartum, intrapartum and postpartum bleeding is still the leading cause of maternal death (1,3). This complication can kill a healthy woman within 2 hours (4). It is estimated that more than 25% of all maternal deaths and almost half of postpartum deaths are related to postpartum haemorrhage (5). The rate of postpartum haemorrhage has been reported to have increased in some high-income countries mainly because of atonic postpartum haemorrhage (6).

Primary postpartum haemorrhage is defined as vaginal bleeding of more than 500 mL after childbirth (7). More than 75% of deaths attributed to postpartum haemorrhage could be prevented. In developing countries, postpartum haemorrhage mortality is high (5,8). Previous studies have shown that treatment is most effective if started promptly (9). In 80% of cases of postpartum haemorrhage, women receive substandard care (10), underestimation of blood loss, delayed diagnosis and management of haemorrhage, treatment failures (11), lack of easy-to-use local protocols (active management of the third stage of labour), lack of adequate education and training, and poor communication. In addition, organizational deficiencies, such as staff shortages, insufficient team work and coordination, and long distance between health care facilities and hospitals play an important role in the occurrence of adverse maternal complications and death in low- and middle-income countries (3,6,12).

Sistan and Baluchestan Province is the largest province in the Islamic Republic of Iran, with a population of 2.5 million. Villages are scattered over large areas and the province is affected by floods during periods of heavy rain. These problems make it difficult for nomadic people and villagers to easily access health services.

Zahedan and Iranshahr universities of medical science are in charge of health services in the province. The population covered by Zahedan University of Medical Sciences is about 1,620,518 people. The university provides free health services through a broad network; this network has a referral system comprising health centres in the periphery going through to secondary and tertiary hospitals in the nearest urban areas and Zahedan, the provincial capital (13).
In rural areas, each village has a rural health centre, which has a doctor and 10 health workers who provide care and manage complex health problems. Some rural health centre have a maternity facility with trained midwives (14). These facilities provide delivery and maternal health care services for people living in the catchment areas of the health centre, including the main village where the health houses are located and satellite villages that are covered by the health houses. The health house is the first contact between families and the health system in the Islamic Republic of Iran. It is staffed by a trained health care provider called behvarz. Behvarz are multipurpose health care workers who provide primary health care services to people living in rural areas (13,15). According to the World Health Organization (WHO), Sistan and Baluchestan Province has shortages of health care providers (e.g. doctors and midwives(16)), and high employee turnover forces health care mangers to recruit staff from among inexperienced graduates.

The province has the highest total fertility rate (3.7 children per woman) in the country. Moreover, according to unpublished data (Vice-Chancellery for Health, Zahedan University of Medical Sciences, 2016), while the population covered by Zahedan University of Medical Sciences was about 2% of the total population of the Islamic Republic of Iran, 10.8% of maternal deaths in the country occurred in Sistan and Baluchestan. Previous studies have shown that postpartum haemorrhage was the leading cause of maternal morbidity and mortality in underprivileged provinces such as Sistan and Baluchestan (17).

Following such reports of maternal death associated with postpartum haemorrhage in rural delivery facilities in Sistan and Baluchestan, interventions were designed on the directive of the Deputy of Health of Zahedan University of Medical Sciences to improve the management of postpartum haemorrhage in the province.

The aim of our study was to investigate the effect of implementing a set of measures interventions (use of misoprostol, flowchart and a training workshop) on the performance of midwives in managing postpartum haemorrhage in rural areas of Sistan and Baluchestan Province.

**Methods**

A quasi-experimental (before and after) design was used to demonstrate the performance of midwives in managing postpartum haemorrhage before and after implementing the interventions. Women in the sample investigated before the intervention were different from those after the training intervention (18). The intervention phase of the study was designed in three stages.
Investigating the reasons for maternal death from postpartum haemorrhage

First, the medical records of all cases of postpartum haemorrhage that occurred in the areas covered by Zahedan University of Medical Sciences between 9 April 2012 and 9 April 2013 were reviewed by a panel of experts (including maternal health experts, midwives, physicians, and a reproductive health researcher) to investigate the cause of maternal death from postpartum haemorrhage.

The main problems in managing postpartum haemorrhage identified by the panel were: 1) management of the third stage of labour (e.g. lack of proper and timely use of oxytocic drugs), 2) delayed diagnosis of postpartum haemorrhage and underestimation of blood loss, 3) mismanagement of postpartum haemorrhage, 4) delay in deciding to refer the woman with postpartum haemorrhage to hospital, 5) inappropriate prescription of medications by general practitioners or midwives (including vitamin K or atropine and adrenaline for the management of bleeding or resuscitation), 6) insufficient administration of uterotonic drugs (e.g. oxytocin), 7) lack of familiarity with the signs and symptoms of shock, 8) inappropriate management of shock (e.g. insufficient fluid replacement), and 9) long distance between rural maternity units and the nearest hospital (average: 81.5 km, range: 35–200 km).

Designing a set of measures

Three measures were taken: 1) obtaining permission from the Ministry of Health and Medical Education to purchase and use prostaglandin (misoprostol) in rural areas, 2) developing a flowchart for the diagnosis and treatment of haemorrhagic shock in rural areas, and 3) training midwives working in rural areas.

Permission to use prostaglandin (misoprostol)

Because of the long distance between the maternity units and the nearest hospitals, administration of long-acting uterotonic drugs (misoprostol) would help manage postpartum haemorrhage. Therefore, permission for the use of this medicine, and the related guidelines on it, was obtained from the Iranian Ministry of Health and Medical Education. As a result, rural maternity facilities were supplied for the first time with pulse oximetry and misoprostol for the management of postpartum haemorrhage cases.

Development of the training programme

A training programme was developed based on the problems and malpractices that were identified on a review of cases of maternal death. In addition, a flowchart was developed using WHO guidelines, and guidelines on the diagnosis and treatment of postpartum haemorrhage.
and haemorrhagic shock were also devised (19–23). The draft obstetric haemorrhage flowchart was sent to a panel of experts including obstetricians, anaesthetists, physicians, midwives and public health authorities, and modifications were made based on their feedback and comments. The final draft of the flowchart was approved by the Department of Family Health, Population and School Health, and the Iranian Ministry of Health and Medical Education. The flowchart was designed for use as a wall chart to provide practical guidance for midwives on the diagnosis and management of haemorrhagic shock.

**Training general practitioners and midwives**

A team of experts (including maternal health experts, an obstetrician, an anaesthetist and a reproductive health researcher with a midwifery background) were the workshop facilitators and instructors. All midwives working in rural maternity facilities (n = 46) participated in a two-day training on how to manage the third stage of labour, and diagnosis and management of postpartum haemorrhage and shock using the WHO guidelines. The workshops were held in January and February 2014.

A total of 20–25 midwives and nine general practitioners participated in each training workshop. Midwives were divided into four groups and in each group, two to three general practitioners who worked in rural health centres were also included. Before starting the first day of the training workshop, each group was asked to write the step-by-step procedure for managing the third and fourth stages of labour. They were also encouraged and given some time during the workshop to share their real-life experiences. At the end of the first day of the workshop, the participants were asked to identify the differences between their actual practice at work and the instructions they were given in the workshop that were based on the standard protocols. They were encouraged to critically reflect on and challenge their own practices at work.

On the second day of training (management of postpartum haemorrhage and shock at maternity facilities and during referral to hospital), a summary of cases of four maternal deaths was given to the participants and they were asked to identify the key factors that led to the woman’s death based on a three-delay model (delay in seeking care, delay in getting to a health facility, and delay in provision of adequate care) (24). At the end of each session, the participants’ questions were answered and they were given training files.

**Evaluating changes after the training intervention**

Of 28 rural maternity facilities, those with more than 10 childbirths per month were selected (n = 20).
Six months after the training intervention, detailed information on the management of postpartum haemorrhage was collected from the records of all 81 cases of postpartum haemorrhage that occurred between 23 September 2014 and 23 February 2015 in rural maternity facilities. For each case of postpartum haemorrhage, the case of a woman who had had postpartum haemorrhage and had been admitted to the same maternity unit before the training intervention was selected as a control.

Data were collected through review of medical records by maternal health experts, who were trained to complete the case report form. Cases with postpartum haemorrhage were identified by the midwife in charge of the labour ward.

**Data collection instrument**

Data were collected using a 19-item case report form. A set of performance indicators for different aspects of management of postpartum haemorrhage in primary care settings was developed by the researchers. It included methods used to estimate blood loss; administering uterotonic medicines and intravenous fluid replacement therapy before hospital referral; timely hospital referral; administering uterotonic medicines and non-pharmaceutical measures such as uterine massage during referral; women’s condition at admission and outcome. After the draft case report form was developed, it was sent to five experts on the management of postpartum haemorrhage and training steps. They were asked to provide their comments (e.g. deletion of irrelevant items and addition of missing items) to ensure that the form included all relevant items. Then, the case report form was pilot-tested by 10 midwives in the field after which the final form was sent again to the above-mentioned panel of experts for their final approval. The different aspects of postpartum haemorrhage management (before and during hospital referral) were compared between the pre-intervention and post-intervention groups. The data collected in the approved case report form included the following: cause of haemorrhage; diagnosis method; treating doctor informed when haemorrhage was diagnosed; length of time for doctor to reach the woman’s bedside; uterotonic drugs given (type and amount); intravenous fluids given after diagnosis and up to hospital referral (type and amount); use of a pulse oximetry device; number of peripheral veins used for cannulation; intravenous catheter sizes and colours used for first and second intravenous lines; veins used for peripheral intravenous cannulation; Foley catheter inserted; length of time between haemorrhage diagnosis and calling for an ambulance; length of time between calling for an ambulance and arrival at hospital; measurement of vital signs and prevention of haemorrhage during patient transfer to the hospital; amount and type of intravenous fluids administered between haemorrhage diagnosis and arrival at hospital; patient’s general condition at hospital admission; care and outcome after hospital admission.

**Statistical analysis**

SPSS, version 20, was used for statistical analyses. To compare categorical and binary data before and after the training intervention, data were analysed using the chi-squared test and
Fisher exact test for $2 \times 3$, $2 \times 4$ and $2 \times 5$ tables with cells with expected values less than 5. Two-tailed tests were used. A P-value less than 0.05 was considered statistically significant.

**Ethical considerations**

Our study aimed to assess the effect of the use of WHO guidelines and common clinical management procedures for postpartum haemorrhage in Sistan and Baluchestan province. In the management of postpartum haemorrhage, nothing was done to the women beyond what the WHO guidelines and clinical management procedures recommended. In addition, we ensured that the results of the analysis did not identify subjects in order to preserve confidentiality and anonymity. Therefore, according to previous studies, for studies on quality control or medical audits, ethical review was not necessary, and use of personal medical records without involving the patients concerned is acceptable (25).

**Results**

Forty-seven midwives participated in the study, 53% of whom had an associate degree (awarded by universities following a two-year degree programme) and the remainder had a bachelor degree; most (53%) had graduated from government universities and 46.8% from Azad University (private university). The majority of the midwives (79%) had more than four years of work experience, 17% had 2–4 years and 4% had less than two years of work experience.

In terms of the performance of the midwives before and after the training intervention, a significantly greater proportion of the midwives in the post-intervention group used more than one method to estimate the extent of haemorrhage other than observation (such as the weight and the number of blood-soaked sheets, changes in blood pressure and pulse, deteriorating general condition, and primary signs of shock) (Table 1).

The trainings resulted in a higher doses of oxytocin being given to control haemorrhage and also misoprostol being given (Table 2). Misoprostol was mainly used in rural areas (14 cases) where the driving time to the nearest hospital was about two hours. After implementing the haemorrhage management training intervention, significant improvements were seen in IV fluid therapy measures taken before referral of pregnant women to hospital (Table 3).

After the training intervention, the midwives' management of haemorrhage during the referral of
pregnant women on their way to hospital in the ambulance significantly improved in terms of the number of peripheral IV lines inserted, the volume of IV fluid given, regular pulse and blood pressure checks, external uterine massage, and administration of uterotonic drugs \( (\text{Table 4}) \). After the training, a significantly greater proportion of women with haemorrhaging were admitted to hospitals in a stable condition.

In comparison with women in the pre-intervention group, those in the post-intervention group were significantly more likely to recover and be discharged (56% versus 44%) \( (P = 0.002) \) and less likely to have surgical interventions (17% versus 83%) \( (P = 0.0007) \) \( (\text{Table 4}) \). Fewer were also admitted to the intensive care unit (44% versus 56%) but the difference was not statically significant. One woman died in the post-intervention group while there were no cases of maternal mortality in the pre-intervention group.

**Discussion**

Our study showed that following the interventions – use of misoprostol, flowchart and training – midwives’ management of postpartum haemorrhage improved significantly in most areas.

In line with our results, Esscher (2014) noted that analysis of the etiology of death could clarify why the incidence of maternal death was higher in some groups (26). WHO reported that many countries have made progress in managing births in health facilities, but this often does not lead to a reduction in maternal mortality. This is due to the quality of care provided in health facilities (27). In fact, to ensure quality of care for maternal health requires evidence-based and systematic approaches to identify effective strategies and interventions and develop monitoring indicators at the facility level (28). In addition, it is important to find strategies and interventions that take account of the regional context and resources and that can be implemented within the existing health care systems (29).

Provision of good quality care in health care facilities, especially in remote areas, can be achieved through competent midwives and health care providers (27,29,30). In line with our study, Evans (2014) showed that one-day simulation training in postpartum haemorrhage prevention and management could boost the knowledge and confidence of midwives (31). In addition, our study showed that training on the prevention (active management of third stage of labour) (20), detection (blood loss) and management of postpartum haemorrhage (on-site and during referral), and the use of simple measures, such as emptying the bladder, uterine massage, intramuscular and intravenous administration of injectable uterotonic drugs (e.g. oxytocin) and misoprostol can improve maternal outcomes and be lifesaving in remote areas (12,32).
One woman died in the post-intervention group (she was in shock on admission to hospital), while there were no cases of maternal mortality in the pre-intervention group. Training together with regular audits, monitoring of local outcomes, and feedback can help ensure adherence to the regulations and standards of care, thereby reducing the prevalence of postpartum haemorrhage and maternal mortality (6,33,34).

Our study had a number of limitations. First, the sample size was fairly small which could decrease statistical power. Second, we examined the simultaneous implementation of three interventions (use of prostaglandin, a flowchart and a training workshop). Therefore, it was not possible to separate the effect of each intervention on the improvement of the health outcomes following postpartum haemorrhage. Nevertheless, we believe that these limitations do not undermine the value of the study because the interventions clearly led to improvement in the management of postpartum haemorrhage by midwives in a low-resource district.

Based on the present findings, training midwives who provide childbirth services to mothers can improve the health outcomes of mothers following postpartum haemorrhage in rural areas. Training programmes should be based on the study of maternal death records and review of maternal medical records. Finally, regular monitoring of outcomes is needed after the interventions to detect and promptly resolve any failures that may occur.

Acknowledgements

We thank the midwives who participated in the training course, the staff for contributing to data collection, and Zahedan University of Medical Sciences for logistics support.

Funding: None.

Competing interests: None declared.

References


Thursday 4th of April 2019 04:42:01 AM