IMPACT OF MIDWIVES PRACTICES INITIATION ON POSTPARTUM HAEMORRHAGE REDUCTION IN PUBLIC HOSPITALS IN GAZA STRIP, PALESTINE

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PERPUSTAKAAN TUNKU TUN AMINAH

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Dedicated to:

To my beloved parents, who without their enthusiasm and encouragement, I would never step in this way

and

To my kind, mindful understanding husband "Dr. Saleh" and my children Sara, Yousef and Yamen, who supported me on each step of the way.

My love for you all remains forever…

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ABSTRACT

The primary Postpartum Haemorrhage (PPH) has occupied the highest factor leading to maternal mortality. PPH is the bleeding from the genital tract of 500 ml or more in the first 24 hours following the delivery of the baby. As compared to the developed countries, maternal mortality in Palestine has been found to be high with the 36.5 death per 100000 births. Poor health care leads to acute and chronic clinical and psychological morbidity. Therefore, there is growing agreement among public health professionals that midwifery has an important contribution to provide a safe delivery and excellent mother and new-born infant care. Applying certain practices in the scope of midwife can lead to a PPH reduction. Consequently, the objectives of this study are to examine the relationship between Breast Feeding (BF), Skin to Skin Contact (SSC) and Active Management of the Third Stage of Labour (AMTSL) on PPH reduction at Gaza strip, Palestine and to examine the impact of these practices (BF, SSC and AMTSL) on the PPH reduction at Gaza strip, Palestine. The population of this study are the midwives working in the labour room at public hospitals in Gaza, Palestine. Quantitative approach has been applied for this study and questionnaire was distributed in the public hospitals of Gaza for the data collection purpose. The response rate was of 82%. SPSS 22 is used as the research instrument to perform the analysis and to study the relationships among the variables. The results of the study demonstrated that the midwife practice initiation (BF, SSC and AMTSL) have significant impact on the PPH reduction. The study contributes in the research field by providing a significant relationship between the practices in the scope of midwife and PPH rate reduction. Contribution of the findings are discussed and recommendations for future research are presented.

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ABSTRAK

Pendarahan selepas bersalin (PPH) adalah penumbang tertinggi kematian ibu. PPH adalah pendarahan dari saluran genital 500 ml atau lebih dalam tempoh 24 jam selepas kelahiran bayi. Berbanding dengan negara-negara maju, kematian ibu di Palestin didapati tinggi dengan kematian sebanyak 36.5 juta setiap 100,000 kelahiran. Penjagaan kesihatan yang lemah membawa kepada klinikal kronik dan akut dan penyakit psikologi. Oleh itu, ahli profesional kesihatan awam bersetuju bahawa perbidanan mempunyai sumbangan yang penting kepada kelahiran yang selamat bagi ibu dan penjagaan bayi yang baru dilahirkan. Mempraktikkan amalan tertentu dalam skop perbidanan boleh membawa kepada pengurangan PPH. Oleh yang demikian, objektif kajian ini adalah untuk mengkaji hubungan antara penyusuan susu ibu (BF), sentuhan kulit ke kulit (SSC) dan pengurusan aktif peringkat ketiga bersalin (AMTSL) terhadap pengurangan PPH di Gaza, Palestin dan untuk mengkaji kesan amalan ini (BF, SSC dan AMTSL) ke atas pengurangan PPH di Gaza, Palestin. Populasi kajian ini adalah bidan yang bekerja di bilik bersalin di hospital-hospital awam di Gaza, Palestin. Pendekatan kuantitatif telah digunakan untuk kajian ini dan soal selidik diedarkan di hospital awam Gaza bagi tujuan pengumpulan data. Kadar respons ialah 82%. SPSS 22 telah digunakan sebagai instrumen kajian untuk menjalankan analisis dan mengkaji hubungan antara pembolehubah. Keputusan kajian menunjukkan bahawa amalan perbidanan (BF, SSC dan AMTSL) mempunyai kesan yang signifikan terhadap pengurangan PPH. Kajian ini menyumbang dalam bidang penyelidikan dengan mengenalpasti hubungan yang signifikan antara amalan dalam skop perbidanan dan pengurangan kadar PPH. Sumbangan daripada penemuan ini telah dibincangkan dan cadangan untuk penyelidikan masa depan telah dibentangkan.

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LIST OF ABBREVIATIONS

MMR - Mortality Rate Ratio

PPH - Post-partum Haemorrhage

HIV - Human Immunodeficiency Virus

AIDS - Acquired Immune Deficiency Syndrome

SBA - Skilled Birth Attendants

WHO - World Health Organization

UNICEF - United Nations Children's Emergency Fund

MDG - Millennium Development Goals

ANC - Antenatal Care

CS - Caesarean section

ICM - International Confederation of Midwives

DCC - Delayed Cord Clamping

ECC - Early Cord Clamping

CCT - Controlled Cord Traction

BF - Breastfeeding

SSC - Skin to Skin Contact

AMTSL - Active Management of the Third Stage of Labour

UNFPA - United Nations and Population Fund

mL - Millilitre

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CHAPTER 1

INTRODUCTION

1.1 Research Background

Increasing interest in the quality of healthcare has led to the focus of the maternal mortality and morbidity rate reduction. Generally, efforts to improve health care lead to decrease maternal mortality rate. Maternal mortality is defined as the death of either a pregnant woman or death of a woman within 42 days of delivery, miscarriage, termination or ectopic pregnancy providing the death is associated with pregnancy or its treatment (Alkema et al., 2016).

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Maternal mortality is an important indicator of a woman's health both in developing countries and developed countries (Knight et al., 2015). Maternal mortality is influenced by the woman's social and economic status and by her nutritional status in childhood and adulthood. Maternal mortality is also an indicator of the woman's access to Antenatal Care (ANC) and delivery services, and of the quality of these systems (Nair et al., 2015). Maternal mortality is also an extensive problem, but its causes and prevalence are not accurately clear and well recognized directly after the birth, collection of routine and complete information about causes of maternal death has not been possible because of inadequacies of data collection and absence of vital registration systems in most countries (Say et al., 2014).

Every year, an estimated 289 000 mothers died during pregnancy and childbirth, across the globe and many more suffer from disabilities (Say et al., 2014).

These disabilities can be one or more of infertility, impaired mobility, fistula, chronic pain, and damage to the reproductive system (Chou et al., 2016). Children who survive after their mother's death are ten times more likely to die within two years than those whose both parents survive (Ith, 2013). Other research studies has highlighted the problem of maternal mortality and stated that approximately ten million children under five years of age die, two million of them in the first day of life (J. Campbell, Fauveau, ten Hoope-Bender, Matthews, & McManus, 2011) and another two million before the end of their first month (Lawn, Cousens, Zupan, & Team, 2005). According to World Health Organization statistics, 25% of maternal deaths in developing countries are caused by PPH (Ngwenya, 2016).

In developing countries, maternal health conditions are the leading cause of maternal mortality and disability among women of reproductive age (Filippi et al., 2006). Previous studies show that 15% of all pregnant women develop life-threatening complications and 80% of women's deaths result from direct obstetric complications (Hailu & Berhe, 2014) (Graham, Bell, & Bullough, 2001). These complications include hypertensive disorders, prolonged obstructed labour, abortion-related complications, haemorrhage (bleeding), and infection (de Bernis, Sherratt, AbouZahr, & Van Lerberghe, 2003; Ronsmans, Graham, & group, 2006).

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Postpartum period or postnatal period is recognized as the time beginning immediately after the birth of a child and extending for about six weeks (Ross, McLean, & Psych, 2006). In this period, primary Post-partum Haemorrhage (PPH) is estimated to be responsible of nearly 25% of all maternal deaths globally. In addition to that, other causes which are indirect causes like malaria, HIV/AIDS and anaemia account for about 20% of maternal deaths (AbouZahr, 2003) (Khan, Wojdyla, Say, Gülmezoglu, & Van Look, 2006) (Van Lerberghe, Manuel, Matthews, & Cathy, 2005).

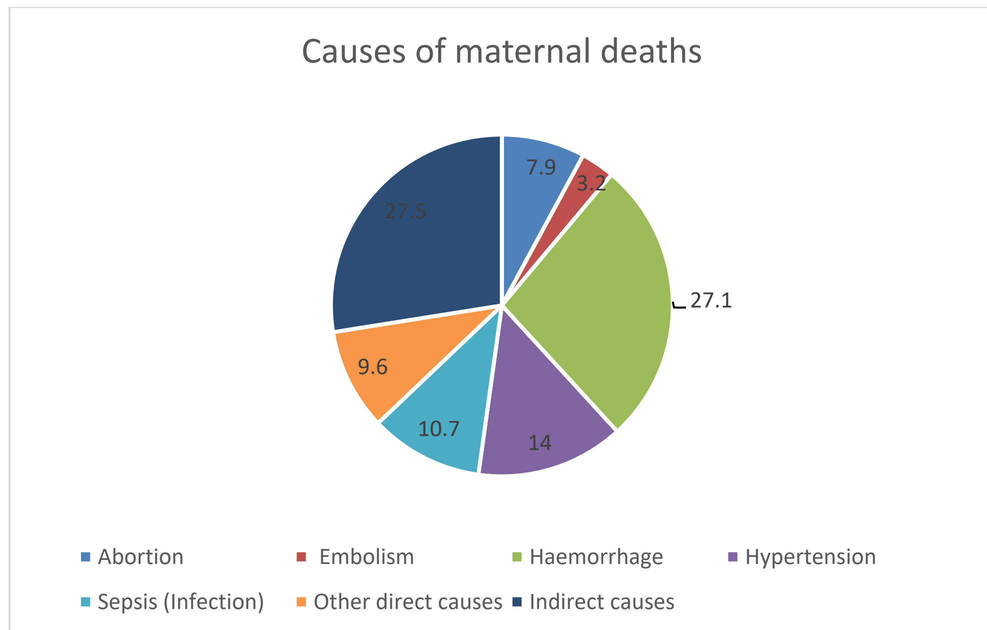

Figure 1.1 Global causes of maternal death: WHO systematic analysis

The maternal deaths are not equally distributed globally (Ronsmans et al., 2006). The highest obstetric risk is in sub-Saharan Africa (Ronsmans et al., 2006). The maternal mortality ratio is much greater in certain areas of the region more than others in East and South-East Asia (Sauvarin, 2006). In the poorest countries, the risk of a woman dying due to pregnancy or childbirth is approximated to be one case in each six cases, while in north Europe it is approximated to be one case for each 30,000 cases (Ronsmans et al., 2006).

Based on the Palestinian ministry of health report published in 2009 (Abdo et al., 2012) estimates of maternal mortality in the Palestinian territories vary widely in the absence of a well-structured national monitoring system. In a report published by World Health Organization (WHO) in 2009, maternal mortality in the Palestinian territories for 2008 was estimated at 46 per 100,000 live births. These estimates rank the Palestinian territories in the 83rd place among the world countries in terms of Maternal Mortality Rate (MMR) and in the 12th place among Arab countries, trailing behind al Gulf countries, Jordan, Tunisia, Libya and Egypt. Based on WHO estimates, maternal mortality has been reduced from 92 in 1990 to 46 in 2008, reflecting a 3.8% decline per year. This is higher than the average worldwide

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reduction of 1.3% and lower than the target reduction according to Millennium Development Goals (MDG) 5 (5.5%) (Abdo et al., 2012).

In particular, the socioeconomic condition in the Gaza Strip hereafter noted as ‘Gaza’ has deteriorated dramatically following imposition of a blockade by the Israeli government in 2007 (UNRWA, 2013). The medical causes of maternal deaths are similar throughout the world (AbouZahr, 2003). Underlying the medical causes is a range of socio-economic and cultural factors that interact and exacerbate each other. These include women’s status and position within their culture and communities. Socio-economic and cultural realities, including illiteracy, poverty, women’s unequal access to maternity services, and their lack of decision-making power in families and societies contribute to maternal disability or death (Koblinsky et al., 2006). Poorer mothers, or those who are disadvantaged, are more likely to die in childbirth than are more rich mothers. The poor are not only those with the lowest incomes, but those who are the most denied of health care, education and other aspects of physical and social well-being (United-Nations, 2008). Childbirth can be particularly dangerous when it occurs too early in a woman’s life, when pregnancies follow each other too closely because of a lack of access to contraception, when a woman is malnourished during pregnancy, or suffers from the low social, economic, and legal status of women or there is inadequate access to emergency obstetric and new-born care (Starrs, 2006). These factors are often crucial in causing death or illness to the mother (WHO, 2002).

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Although the degree and type of risk related to pregnancy, birth, postpartum, and the early weeks of life differ between countries, the need to implement an effective, sustainable, and affordable improvements in the quality of healthcare is common to all (Renfrew et al., 2014). Therefore, new knowledge is needed to eliminate avoidable maternal and new-born mortality and morbidity.

Midwifery has an important contribution to provide high-quality maternal and new-born infant care (Renfrew et al., 2014). Despite the high quality and widespread availability of infant intensive care technology all over the world, the infant mortality rate in Palestine remains higher than that of many developed

nations. In 2010, the Occupied Palestinian Territory is allocated in the highest countries under-5 (under age 5) - a critical indicator of the well-being of children- mortality per 1000 of the mortality rate where it has the rank of 91 with the value of 22 death / 1000 live births (UNICEF, 2012). In 2013, with the same indicator, Palestine is ranked in the highest under-5 rank with a 22 death / 1000 live births and a rank of 89 (UNICEF, 2014) which means it is still of the highest countries with the mortality rate. Currently, 79 countries have an under-five mortality rate above 25 (WHO, 2015c).

Primary Postpartum Haemorrhage (PPH) is one of the top five causes of maternal mortality in both developed and developing countrie (Mousa & Alfirevic, 2003). PPH is the leading cause of maternal mortality worldwide (Carroli, Cuesta, Abalos, & Gulmezoglu, 2008). The high mortality rate is due to uncontrolled blood loss, and rapid onset of PPH (Abedi, Jahanfar, Namvar, & Lee, 2016). PPH is also associated with long-term morbidity due to anaemia, blood transfusion, renal failure, coagulation deficiencies and hysterectomy.

Ninety-nine percent of all maternal deaths occur in the developing countries, and PPH makes a major contribution to these deaths (Chua, Arulkumaran, Lim, Selamat, & Ratnam, 1994). Despite data showing that oxytocic drugs used routinely reduce the risk of PPH by 40%, or that PPH can be prevented in one of every 22 women given an oxytocic (Devikarani & Harsoor, 2010), oxytocic drugs are not available for routine use in the third-stage of labour in many parts of most developing countries.

1.2 Research Problem

Postpartum hemorrhage (PPH) is the first cause of maternal death worldwide, it is responsible for an estimated 127,000 deaths annually (Saccone, Caissutti, Ciardulli, & Berghella, 2018). It can be one of the life threating problems (Simonazzi, Saccone, & Berghella, 2016) (Xodo et al., 2016). PPH, if uncontrolled or untreated, can quickly lead to shock and death (McCormick, Sanghvi, Kinzie, &

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McIntosh, 2002). Moreover, every year there are an estimated 139 million births (DeSA, 2013) among the world. Within these births, an estimated 289 000 women die annually during pregnancy, childbirth, or soon after (Say et al., 2014). Unfortunate poor healthcare does not just result in mortality; it leads to acute and chronic clinical and psychological morbidity for the women who survive (Koblinsky, Chowdhury, Moran, & Ronsmans, 2012). Poor quality care is not just about the lack of services, there is a global concern about the overuse of interventions that were designed to manage complications (Renfrew et al., 2014).

Most pregnancy-related complications are unpredictable, but almost all can be treated and prevented if all pregnancies are planned, all pregnant women are assisted by a professional midwife throughout their pregnancy and particularly during birth and the early post-partum period (O. M. Campbell, Graham, & group, 2006). There is growing consensus and agreement among public health professionals that midwifery care has an essential contribution to provide maternal and new-born services with high-quality (WHO, 2005). The introduction of skilled midwife working effectively with medical and public health colleagues, has been associated both with a rapid and sustained decrease in PPH. Delivering high quality maternity care is the responsibility of every midwife. Midwives are all needed to be activists determined to take both small and big steps to directly or indirectly improve the health care.

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Based on the United Nations Children's Emergency Fund (UNICEF), Palestinian territories is allocated among the highest mortality rate in the world over statistics (UNICEF, 2017). In Palestine, maternal mortality ratios for 2000 and 2001 were 29.2 and 36.5 per 100,000 live births, respectively. PPH is the second highest factor leading to death (Al-Adili, Johansson, & Bergström, 2006) which is considered high in compare to developed countries.

Prevention of PPH focuses on medical and pharmacological methods. Other non-pharmacological interventions to prevent PPH have been sparsely reported in medical literature, but skin-to-skin contact (SSC) between mother and newborn and breastfeeding (BF) immediately or shortly after birth, Active Management of the

Third Stage of Labour (AMTSL) have been identified as possible psychophysiological interventions to reduce PPH (Almutairi, 2017). Inadequate research has been carried out to study and identify the relationship between BF, SSC and AMTSL on PPH reduction in Gaza strip. Less previous study exists confirming the relationship between breastfeeding, skin to skin contact and active management of the third stage of labour together on PPH reduction in Gaza strip in isolated studies. In this research study, these three practices are combined to study the simultaneous impact of these three practices combination on the of PPH reduction in Gaza Strip, Palestine.

1.3 Research Questions

i. What is the relationship between breastfeeding and postpartum haemorrhage reduction at Gaza strip, Palestine?
ii. What is the relationship between skin to skin contact and postpartum haemorrhage reduction at Gaza strip, Palestine?
iii. What is the relationship between active management of the third stage of labour and postpartum haemorrhage reduction at Gaza strip, Palestine?
iv. What is impact of breastfeeding, skin to skin contact and active management of the third stage of labour on the postpartum haemorrhage reduction at Gaza strip, Palestine?

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1.4 Research Objectives

The aim of this research is to examine the role of trained, motivated and educated midwife for the postpartum haemorrhage reduction. It anticipates addressing the following objectives:

i. To examine the relationship between breastfeeding and postpartum haemorrhage reduction at Gaza strip, Palestine.
ii. To examine the relationship between skin to skin contact and postpartum haemorrhage reduction at Gaza strip, Palestine.

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