ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

New WHO Recommendations Help to Focus Implementation[1]

WHO Recommendations for Active Management of the Third Stage of Labour (AMTSL), 2012

The use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour is recommended for all births.

Oxytocin (10 IU, IV/IM) is the recommended uterotonic drug for the prevention of PPH.

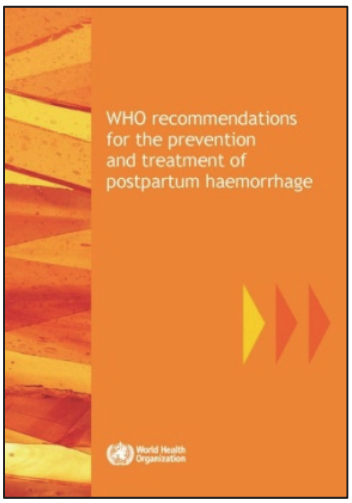
In settings where skilled birth attendants are available, controlled cord traction (CCT) is recommended for vaginal births if the care provider and the parturient woman regard a small reduction in blood loss and a small reduction in the duration of the third stage of labour as important.

In settings where skilled birth attendants are unavailable, CCT is not recommended.

Sustained uterine massage is not recommended as an intervention to prevent PPH in women who have received prophylactic oxytocin.

Postpartum abdominal uterine tonus assessment for early identification of uterine atony is recommended for all women.

CCT is the recommended method for removal of the placenta in caesarean section.



In early 2012, the World Health Organization (WHO) held a technical consultation to review global evidence related to the prevention and management of postpartum haemorrhage (PPH), which is still the most common cause of death for women during pregnancy. Since 2007, WHO recommendations have supported active management of the third stage of labour (AMTSL) as a critical intervention for PPH prevention. AMTSL has become a central component of the PPH reduction strategies of governments around the world. As a result of the 2012 meeting, WHO has issued new recommendations regarding AMTSL, which can be used to strengthen and focus the implementation of this lifesaving intervention.

What Is New and Different about AMTSL in These Recommendations?

AMTSL as a prophylactic intervention is composed of a package of three components or steps: 1) administration of a uterotonic, preferably oxytocin, immediately after birth of the baby; 2) controlled cord traction (CCT) to deliver the placenta; and 3) massage of the uterine fundus after the placenta is delivered. In 2012, the results of a large WHO-directed, multi-centred clinical trial[2] were published and showed that the most important AMTSL component was the ***administration of a uterotonic***.

The WHO trial also demonstrated that the addition of CCT did almost nothing to reduce haemorrhage. The women who received CCT bled 10 mL less (on average) than women who delivered their placenta by their own effort. There was a real difference, however, in terms of the length of the third stage: third stage was an average of six minutes longer among those women who did not receive CCT. The authors acknowledged that this can be an important amount of time, not so much for the woman, but for the management of busy labour and delivery units.

Considering data from this trial and the existing evidence concerning the role of routine uterine massage in the prevention of PPH, the WHO issued new recommendations clarifying that although administration of a uterotonic remains central to the implementation of AMTSL, the performance of CCT and immediate fundal massage are optional components.

[1] World Health Organization. *WHO recommendations for the prevention and treatment of postpartum haemorrhage*. 2012. WHO: Geneva, Switzerland.
[2] Gulmezoglu AM et al. Active management of the third stage of labour with and without controlled cord traction: a randomised, controlled, non-inferiority trial. *Lancet* 2012; March 6, 2012. DOI:10.1016/S0140-6736(12)60206-2.

Frequently Asked Questions about New AMTSL Recommendations

Does this mean that AMTSL is now something different or should be called by a new name?
No, it is not necessary to change the name or thinking about AMTSL, since the main components have not changed and AMTSL is so widely understood and practiced. Such a change might result in confusion that could slow down programme expansion. Instead, as programmes expand and improve the use of AMTSL, they should put greater emphasis on the first component, the administration of a uterotonic.

Should national policies regarding AMTSL now be changed?
National policies should continue to promote AMTSL and ensure that systems are in place to monitor and track its implementation. Policies should support the practice of AMTSL in all maternity facilities of the health system and by all cadres with midwifery skills. Policies should also direct the routine availability of high-quality oxytocin and encourage storage of oxytocin in a cool environment.

Should training materials and pre-service education programmes be amended to reflect the new recommendations?
Training and education programmes should continue to train providers in all the elements of AMTSL, since CCT and fundal massage remain important techniques that providers may need to perform in other situations, for example, in the management of retained placenta or PPH resulting from uterine atony. CCT decreases the time to the delivery of the placenta, and therefore may be important in busy labour wards or for a single provider.

A Refocused Approach to Prevention of PPH Using AMTSL

Uterotonic: Ensure that every woman is offered a uterotonic immediately after the delivery of the baby. Oxytocin is the preferred drug to prevent PPH.

Delayed cord clamping: Delay clamping the cord for at least 1-3 minutes to reduce rates of infant anaemia.

CCT: Perform CCT, if required.

Postpartum vigilance: Immediately assess uterine tone to ensure a contracted uterus; continue to check every 15 minutes for 2 hours. If there is uterine atony, perform fundal massage and monitor more frequently.

Oxytocin quality and supply: Ensure a continuous supply of high-quality oxytocin. Maintain the cool chain for oxytocin, and remember that potency is reduced if oxytocin is exposed to heat for long periods.

What does this mean for non-skilled providers?
Because of the clear evidence that the administration of a uterotonic is the most important component in AMTSL, ministries of health should put in place policies and programmes to ensure that every woman is offered a uterotonic immediately after birth—whether she delivers in a facility with a skilled provider or at home in the presence of a non-skilled provider. This can be done through the promotion of AMTSL in facilities and the development of community-based programmes for the use of misoprostol for women who deliver at home. These kinds of efforts can increase coverage to ensure that close to 100% of pregnant women are protected from life-threatening PPH.

If we have a concern about the quality of oxytocin in our facilities, what should we do?
Oxytocin potency deteriorates when it is exposed to temperatures greater than 30°C for prolonged periods of time. For this reason, oxytocin should be distributed and stored along a "cool chain." Oxytocin can be stored at room temperature in the labour unit for limited periods, as long as health managers routinely check and rotate stock and monitor drug quality.

Implications for Policy, Training and Service Delivery

AMTSL has not changed. Instead, there is now a greater ***emphasis*** on the use of a uterotonic at ***every*** birth.

Although these new WHO recommendations highlight the importance of the administration of a uterotonic in the prevention of PPH, they in fact **do not** suggest that there should be a change in how providers are trained in AMTSL or how AMTSL is implemented in health care facilities that provide delivery services. These recommendations clarify the most important components of AMTSL and suggest that there should be an expanded emphasis on ensuring that every woman, regardless of where she delivers, is offered a high-quality uterotonic at the time of birth. This emphasis can both increase coverage, by expanding the number of women who can be provided a uterotonic and thus be protected from PPH, and increase quality, by allowing programme managers and supervisors to focus on the most effective components in the package of care.

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