



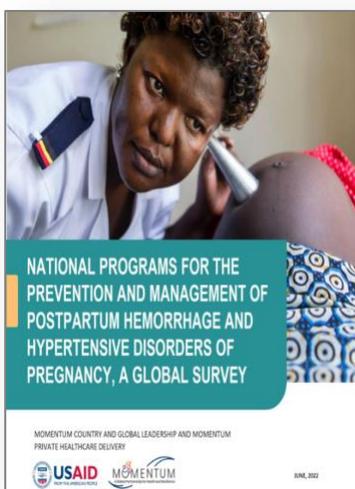
Technical Brief

NATIONAL POLICIES AND PROGRAMS FOR THE PREVENTION AND MANAGEMENT OF POSTPARTUM HEMORRHAGE AND HYPERTENSIVE DISORDERS OF PREGNANCY, A GLOBAL SURVEY

Highlights and Key Messages from the Survey

BACKGROUND

Postpartum hemorrhage (PPH) and hypertensive disorders of pregnancy (HDP) continue to be two of the three leading direct causes of maternal death in low- and middle-income countries.¹ While reducing maternal deaths from preventable causes is a global priority, and many countries are working to reach the global target set by the 2030 Sustainable Development Goal (SDG) 3 of a global maternal mortality ratio less than 70 per 100,000 live births, the World Health Organization (WHO) predicts this goal will not be achieved given the current pace of progress.²



In 2011 and 2012, the U.S. Agency for International Development (USAID), with support of the Maternal and Child Health Integrated Program and partners, conducted a survey of national programs working to reduce maternal mortality from PPH and pre-eclampsia/eclampsia (PE/E). Results from these surveys provided a country- and global-level snapshot of policies, practices, supplies, and activities to guide national and global program managers and policy-makers in setting national priorities and managing their programs. Since 2012, several critical updates have occurred in the global guidance on prevention and management of PPH and HDP. In addition, while there is increased awareness and recognition of the vital role the private sector plays in provision of maternal and newborn health services, little is known about the quality of care provided in the private sector and the extent to which evidence-based policies, quality assured commodities, and clinical best practices are used in this sector.

Thus, in 2022, USAID, with support from MOMENTUM Country and Global Leadership and MOMENTUM Private Healthcare Delivery and their multiple partners, conducted a survey of national programs working to reduce maternal and newborn mortality from PPH and HDP. The MOMENTUM teams jointly led the current survey to: 1) improve the collective understanding of changes made and best practices sustained since the last survey, 10 years ago; 2) understand how countries are implementing new global guidelines; and 3) better understand the private sector's role in national PPH and HDP programs.

From January to May 2022, 31 countries in sub-Saharan Africa, South and Southeast Asia, and Latin America and the Caribbean (LAC) completed a 69-question survey on PPH and HDP practices and policies in the public and private sectors. Convening of key country stakeholders and data collection was led by MOMENTUM Country and Global Leadership and MOMENTUM Private Healthcare Delivery through Jhpiego country offices with the exception of seven countries where the United Nations Population Fund (UNFPA) led the process: Colombia, Dominican Republic, El Salvador, Honduras, Paraguay, Peru, and Uruguay. Using purposive sampling, participating countries identified key informants across the public and private sectors—experts in maternal health policy, education, procurement and distribution logistics, health management information system (HMIS) data collection, and public and private sector programs—to review nationally available data and policy documents and hold technical discussions on the survey questions. Each country group reached consensus and provided a single set of responses for the survey, which were then analyzed. Findings from the 2022 survey generated several compelling insights into the current status of national programs addressing PPH and HDP; these insights have implications for national policies, guidelines, capacity building and training, midwife scope of practice, data tracking on HMIS, programs, and future research.

KEY MESSAGES

- Prioritize integration of the latest global evidence and interventions into national policies and guidelines.
- Amplify socialization and dissemination efforts for the latest global evidence and guidelines through pre-service education and in-service training as well as monitoring and supportive supervision in the facility setting.
- Strengthen professional associations' role in MNH national forums, policy development, dissemination, and use of policies and best practices.
- Strengthen ministry of health oversight across public and private sectors.
- Improve availability of quality assured medications at the point of care through consistent procurement, improved logistic and commodity management, and reliable distribution systems across public and private sectors.
- Expand the midwifery scope of practice in line with global and national recommendations across public and private sectors.
- Create opportunities for public and private sectors to work together in capacity building, commodity supply chain, updating and development of national guidelines, and emergency referral systems between sectors; include the private sector in strategic planning efforts.
- Strengthen existing health information systems and improve reporting between public and private sectors.
- Continue to strengthen data collection on key maternal, newborn indicators to improve PPH and HDP surveillance and monitor equity in access and outcomes for different population groups.
- Examine the acceptability, feasibility, and impact of use for newer PPH prevention interventions such as heat-stable carbetocin and treatment interventions such as tranexamic acid, uterine balloon tamponade, and the non-pneumatic anti-shock garment.

TABLE 1: COUNTRIES INCLUDED IN SURVEY FROM 2011–2022

Year	Region	Countries (new additions in 2022 shown in bold)
2011	Africa	Angola, Democratic Republic of the Congo, Ethiopia, Equatorial Guinea, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, Zanzibar, Zimbabwe
2011	Asia	Afghanistan, Bangladesh, India, Indonesia, Nepal
2011	LAC	Bolivia, Guatemala, Honduras, Nicaragua, Paraguay
2012	Africa	Angola, Democratic Republic of the Congo, Ethiopia, Equatorial Guinea, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zanzibar, Zimbabwe
2012	Asia	Afghanistan, Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Timor-Leste, Yemen
2012	LAC	Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay
2022	Africa	Burkina Faso, Côte d’Ivoire , Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Sierra Leone , South Sudan, Uganda, Zambia
2022	Asia	Bangladesh, Burma (Myanmar) , India, Indonesia, Nepal, Pakistan
2022	LAC	Colombia, Dominican Republic , El Salvador, Guatemala, Honduras, Paraguay, Peru, Uruguay

SUMMARY OF KEY FINDINGS

Quantitative and qualitative results from the survey were organized into seven themes. Key findings from each theme are presented below.

THEMES FOR STRENGTHENING PPH AND HDP PROGRAMS

- Essential drug availability
- National guidelines updated to global management principles
- Quality and procurement policies at the national level
- Midwife scope of practice
- Capacity building and training updated to global best practices
- National reporting on select maternal health indicators
- Bottlenecks and scale-up opportunities

Theme	Current data highlights	Private sector highlights
<p>Essential drug availability</p>	<p>PPH:</p> <ul style="list-style-type: none"> Oxytocin is reported to be in 100% of all country essential medicines lists (EMLs). Countries reported an increase in the inclusion of misoprostol into policies and facility-level availability in the last 10 years with 97% of countries reporting misoprostol on the EML compared to 64% of countries in 2012. Misoprostol was also reported to be more available at public facilities in 2022; 18% of countries reported misoprostol available regularly at public facilities in 2012 compared to 61% of countries 2022. Newer drugs for PPH (heat-stable carbetocin for prevention and tranexamic acid for treatment) are on some EMLs (35% of countries reported heat-stable carbetocin is on their EML and 71% of countries reported tranexamic acid is on the EML). <p>HDP:</p> <ul style="list-style-type: none"> MgSO4 is reported to be on all EMLs but only available regularly at central stores by 68% of countries and district/regional medical stores by 52% of countries. Modest improvement was noted in reported regular availability of MgSO4 at the facility level in the last 10 years; reported as regularly available at public facilities in 2012 by 45% of countries and in 2022 by 58% of countries. All countries report having at least one antihypertensive regularly available at the facility level. 	<p>PPH/HDP:</p> <ul style="list-style-type: none"> In general, essential PPH and HDP drugs are similarly available in the private sector as the public sector though most countries reported the private sector charges a fee for lifesaving medications (94% of countries' reported the private facilities charge a fee for oxytocin and 84% of countries' reported the private facilities charge a fee for MgSO4).

Theme	Current data highlights	Private sector highlights
<p>National policy and guidelines updated to global management principles</p>	<p>PPH/HDP:</p> <ul style="list-style-type: none"> All countries reported having three WHO updates fully integrated into national guidelines. These include: oxytocin as the preferred uterotonic, a safe blood transfusion policy, and the active management of the third stage of labor policy includes immediate use of an uterotonic. Other WHO updates for PPH were reported to be integrated into national guidelines by several countries including: use of uterine balloon tamponade for PPH treatment when immediate access to surgery is ensured (90% of countries), tranexamic acid for PPH treatment (77% of countries), heat-stable carbetocin for PPH prevention (45% of countries), and oxytocin injection in the umbilical cord for retained placenta (13% of countries). Oxytocin injection in the umbilical cord is only recommended under conditions of rigorous research. Select WHO updates for HDP were reported to be integrated into national guidelines by several countries including: calcium supplementation in pregnancy for women (65% of countries), low-dose aspirin for certain women (74% of countries), short- and long-term management of women with HDP after childbirth (84% of countries), and criteria for induction before term in severe PE/E (97% of countries). 	<p>PPH/HDP:</p> <ul style="list-style-type: none"> Most countries report the private sector uses national guidelines; 90% of countries report using the guidelines for PPH and 77% of countries report using the guidelines for HDP; however, the qualitative data highlighted some of the challenges for the private sector, such as difficulty monitoring the private sector’s use of the guidelines, variation in consistency of the guidelines use, and the lack of requirement for use. Further investigation is warranted.

Theme	Current data highlights	Private sector highlights
<p>Quality and procurement policies at the national level</p>	<p>PPH/HDP:</p> <ul style="list-style-type: none"> • Policies were reported to be in place for quality assurance in the procurement and distribution of essential PPH medications ergometrine and oxytocin/misoprostol by 77% and 97% of countries respectively. • Many countries also reported inadequate cold-chain storage of oxytocin or systems to ensure 50% solution of MgSO4. 	<p>PPH/HDP:</p> <ul style="list-style-type: none"> • 77% of countries report a logistics management system exists independent of the national procurement system for the private sector. Differing procurement systems between the public and private sectors may lead to sub-optimal quality assurance of medications and commodities, resulting in procurement of ineffective medicines, differing formulations, or even counterfeit drugs. • The private sector exceeded the public sector in countries reporting quality assurance systems to ensure a controlled cold-chain for oxytocin; 61% of countries and 55% of countries respectively. • The private sector lags behind the public sector for quality assurance systems to ensure a 50% solution of MgSO4; 58% compared to 71%, respectively.
<p>Midwife scope of practice</p>	<p>PPH/HDP:</p> <ul style="list-style-type: none"> • Minimal improvements have occurred in reported midwife scope of practice in the last 10 years for the two essential skills of manual removal of placenta for PPH (76% of countries included this skill in 2011 and 77% of countries in 2022) and diagnosing and giving the loading dose of MgSO4 for severe PE/E (81% of countries included this skill in 2011 and 81% of countries in 2022). • In 2022, some countries report having updated the midwifery scope of practice in the private and public sectors to include global best practice such as uterine balloon tamponade (65% of countries' public sector and 52% of countries' private sector), non-pneumatic anti-shock garment (45% of countries' public sector and 29% of countries' private sector), tranexamic acid (65% of countries' public sector and 61% of countries private sector). • Several countries still have a limited scope of practice for midwives or do not have a formal midwife cadre. 	<p>PPH/HDP:</p> <ul style="list-style-type: none"> • On average, countries report the private sector includes fewer essential skills in midwives' scope of practice compared to public sector midwives' scope of practice.

Theme	Current data highlights	Private sector highlights
<p>Capacity building and training updated to global best practices</p>	<p>PPH/HDP:</p> <ul style="list-style-type: none"> All countries reported 100% of public institutions are using updated global guidelines for quality assured oxytocin as first-line uterotonic, updated active management of the third stage of labor, MgSO4 as first-line anticonvulsant for PE/E in pre- and in-service curricula, and 97% of countries report updated management of severe hypertension in pregnancy in pre-service and 100% in in-service curricula. The pre- and in-service curricula updates most often cited as lacking include prevention measures of calcium supplement in populations with low dietary calcium intake, low-dose aspirin in women at risk of HDP, and PPH interventions including tranexamic acid, non-pneumatic anti-shock garment, and uterine balloon tamponade. 	<p>PPH/HDP:</p> <ul style="list-style-type: none"> Countries reported that private training institutions had similar scores to public institutions for both inclusion of global best practices into pre- and in-service curricula; but, overall, countries reported that fewer global best practices for PPH and HDP, such as preventive measures for PE/E and some of the newer PPH interventions, had been integrated into the private sectors' pre-service and in-service curricula compared to the public sector.
<p>National reporting on select maternal health indicators</p>	<p>PPH/HDP:</p> <ul style="list-style-type: none"> National reporting of key indicators improved with 74% of countries reporting they track use of uterotonic after birth in the HMIS and 87% of countries reporting they track number of women with severe PE/E; as compared with 43% and 51%, respectively, in 2012. 	<p>PPH/HDP:</p> <ul style="list-style-type: none"> Private sector was found less likely to report into the HMIS than public sector, but nearly half of all countries report that data from private sector is recorded in the HMIS for the PPH and HDP indicators.

Theme	Current data highlights	Private sector highlights
Bottlenecks and scale-up opportunities	PPH/HDP: <ul style="list-style-type: none"> • Recurrent bottlenecks to scale-up of PPH and HDP programs include: challenges to drug procurement and distribution, poor quality of drugs at point of delivery, inadequate financing of the health system, insufficient human resources, inadequate capacity of maternal and newborn health skilled workers, insufficient commodities, lack of public-private partnerships, need for improved data collection and data review systems, geographical challenges, and need for improved referral systems. • Scale-up opportunities include: increasing public-private partnerships to better coordinate maternal newborn health care across the broader health system, addressing quality of care gaps in both public and private sectors, and improving health system capacity of resources but also data collection and reporting, regulatory systems, dissemination of guidelines, and accreditation of educational institutions. 	PPH/HDP <ul style="list-style-type: none"> • The majority of countries identified several opportunities for collaboration between the public and private sector, including maternal death audits, regular data review, district work planning, and civil society initiatives.

IMPLEMENTATION CONSIDERATIONS

Prioritize integration into national policies and guidelines of all current global evidence and interventions.

Improving access to current global evidence and interventions should continue to be a global and national priority. Inclusion of the private sector and professional associations in revising and updating policy documents, national guidelines, and standards will provide more comprehensive input for better coordinated care from both public and private sectors.

Amplify the dissemination of current global evidence and guidelines through pre-service education and in-service training. There is an opportunity to improve systems to support strengthened capacity-building programs, such as competency-based education, inclusion of private sector in any in-service updates, coordination of the public and private sector for curricula updates, and adequate supervision at the point of care.

Strengthen professional associations’ role in maternal and newborn health national forums and policy development and ministry of health oversight across sectors. Bringing professional associations into the national discussion of maternal and newborn health and policies will potentiate the dissemination and reach of the global guidelines. Ministry of health oversight across sectors will also improve the dissemination of global guidance and the regulatory framework to support the implementation of the guidance.

Address lifesaving medication availability. Focusing on national-level policy and guidelines to increase central and district/regional medical stores availability, prioritizing WHO pre-qualified manufacturers of medications, improving distribution systems of these essential medications to facilities, and expanding access to a greater number of antihypertensives on the EML could result in more consistent and timely use of lifesaving medications.

Expand the midwife scope of practice. Where midwives practice, it is crucial that their scope and training include management of basic obstetric emergencies to optimize their potential to save lives. Attention to updating the midwife's scope of practice and focusing on competency-based skills training in pre-service and in-service training to International Confederation of Midwives' core competencies is needed to help midwives reach their potential in reducing maternal and neonatal mortality.

Create opportunities for public and private sectors to work together. Opportunities could include: joint training and capacity building; improving commodity and coordinating supply chain; collaborating on monitoring and evaluation and reporting; standardizing guidelines used in both sectors; including private sector representatives on national committees leading national strategic planning on reducing maternal and neonatal mortality; investigating the reasons behind and the impact of the limited scope of practice for private sector midwives compared to public sector midwives; exploring the impact of fees for service on maternal health outcomes in the private sector; and investigating quality of care in the private sector including affordability, inclusion, and removing barriers to access.

Continue to strengthen data collection on key maternal and newborn indicators. Consistent and accurate data collection of key maternal and newborn indicators will increase understanding of the prevalence of PPH and HDP complications of pregnancy and the outcomes associated with them. More robust regulatory and accountability mechanisms are needed.

Address quality of medications at point of care. Improvements are needed in the quality of controlled cold-chain systems for oxytocin and in systems to ensure a 50% solution of MgSO₄. While several countries report having national procurement and distribution policies, it would be valuable to research environmental factors that enable and/or hinder application of those policies from point of manufacture to point of distribution.

Improve the emergency referral system. Identify ways to improve the emergency referral and triage systems within and between the public and private sectors.

Explore the advances in management of PPH. Examine the acceptability, feasibility, and impact of use for the newer PPH interventions such as tranexamic acid, heat-stable carbetocin, uterine balloon tamponade, and the non-pneumatic anti-shock garment.

CALL TO ACTION

Increase Public-Private Partnerships

Since most health systems in low- and middle-income countries are a mix of public and private sectors, and there is limited capacity of governments to steward mixed health systems, the public and private sectors should work together with governments to move national maternal health priorities forward. To do this effectively, public-private partnerships will need to collaborate at all levels of the MNH system to: improve governance; continuously update national policies and guidelines; build stewardship capacity; improve health financing; strengthen data collection and sharing; and ensure regulatory capacity, with quality as a central focus in all aspects of MNH service delivery.

Address Quality-of-Care and Equity Gaps

Mapping public and private sector facilities, assessing existing quality of care for routine and emergency maternal and newborn care, and closing existing quality gaps through a variety of quality improvement approaches tailored to the identified challenges are all crucial to improving private sector engagement for MNH. It is important for countries to understand motivators and incentives for the private sector to be engaged in quality improvement and quality assurance efforts. Once there is more understanding of these motivators, investment will be needed in quality systems and promoting a culture of quality. It is important to better understand, adapt, and navigate complex incentive systems that exist and are different for public sector and private sector institutions.

Improve Health System Capacity

Countries' and implementing partners' focus is needed to address broad health system issues that affect the quality of care at health facilities, including: capacity of human resources; quality, access, and availability of medications and commodities for all women, newborns, and children who need them; emergency referral mechanisms; data collection and reporting; regulatory systems, such as registration and licensing of health workers; accreditation of educational institutions; strengthening of clinical governance; dissemination and regulation of national guidelines and policies; public reporting and benchmarking; and training, supervision, and mentorship of health workers. Attention and investment are needed to address the multi-faceted components to build and maintain health system capacity. There is a need to address widening inequities in health outcomes, which will require strengthened information systems and promoting the better use of disaggregated data (e.g., by age, geographic areas, wealth quintiles, migrant status, ethnicity) and adjust programs accordingly.

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¹ Say L, Chou D, Gemmill A, Tunçalp Ö, Moller A-B, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Global Health*. 2014;2(6):e323–33. [https://doi.org/10.1016/S2214-109X\(14\)70227-X](https://doi.org/10.1016/S2214-109X(14)70227-X)

² United Nations. *The 2030 Agenda and the Sustainable Development Goals*. New York: United Nations, 2015. <https://sdgs.un.org/goals/goal3>