NATIONAL PROGRAMS FOR THE PREVENTION AND MANAGEMENT OF POSTPARTUM HEMORRHAGE AND HYPERTENSIVE DISORDERS OF PREGNANCY

A Global Survey

MOMENTUM Country and Global Leadership

USAID FROM THE AMERICAN PEOPLE

MOMENTUM A Global Partnership for Health and Resilience

OCTOBER, 2022

MOMENTUM works alongside governments, local, and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

This report was produced by Jhpiego and PSI under the MOMENTUM suite of awards, funded by the U.S. Agency for International Development (USAID). MOMENTUM is made possible by the generous support of the American people through Cooperative Agreement(s) 7200AA20CA00002 and 7200AA20CA00007. For more information about MOMENTUM, visit www.usaidmomentum.org. The contents of this report are the sole responsibility of Jhpiego and PSI and do not necessarily reflect the views of USAID or the United States Government.

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Suggested Citation

Noriega A, Sharma G, Gomez P, Somji A, Blockett A, Stalls S. 2022. *National Programs for the Prevention and Management of Postpartum Hemorrhage and Hypertensive Disorders of Pregnancy, A Global Survey*. Washington, DC: USAID MOMENTUM.

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ACKNOWLEDGEMENTS

We are deeply grateful to our partners and colleagues around the globe who are working to improve the lives of women and children every day. Multiple partners, including representatives from governments, Ministries of Health, UN agencies, education boards and universities, professional associations, private sector partners from nongovernmental organizations, for-profit and faith-based organizations, and health workers, have generously shared their time and expertise in this survey.

We would like to give special thanks to the United States Agency for International Development (USAID), MOMENTUM Country and Global Leadership, MOMENTUM Private Health Care Delivery, and Jhpiego country offices in Bangladesh, Burma (Myanmar), Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Guatemala, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Sierra Leone, South Sudan, Uganda, and Zambia. We would also like to give special thanks to the United Nations Population Fund (UNFPA) Latin America and Caribbean Regional Office (LACRO) for leading the work in Colombia, Dominican Republic, El Salvador, Honduras, Paraguay, Peru, and Uruguay, as well as for their collaboration with Jhpiego in Guatemala.

We also thank our colleagues from USAID—Debbie Armbruster, Emma Clark, Robyn Churchill, Deborah Horowitz, Becca Levine, Lory Meoli, Malia Boggs, Richard Chiou, Clancy Broxton, Intissar Sarker, and Susan Ross—who contributed broadly to this report with thoughtful guidance throughout the duration of the activity and review of both the survey instrument and the report.

MOMENTUM would like to acknowledge the significant contributions of partners from the UNFPA, USAID-supported programs including the Postpartum Hemorrhage Community of Practice, implementing partners, Population Services International, the Jhpiego Maternal and Newborn Health Team, and USAID MOMENTUM country programs from our partner countries mentioned above. Lastly, we also acknowledge the many contributions in all aspects of survey development, country coordination, and drafting of this report from Katie Bartels, Leah Elliott, Ana Petricel, and Mathea Pielemeier.

ABBREVIATIONS AND ACRONYMS

AMTSL	Active Management of the Third Stage of Labor
BEmONC	Basic Emergency Obstetric and Newborn Care
DRC	Democratic Republic of the Congo
EML	Essential Medicines List
FBO	Faith-based Organization
HDP	Hypertensive Disorders of Pregnancy
HMIS	Health Management Information System
HSC	Heat-Stable Carbetocin
IRB	Institutional Review Board
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MgSO4	Magnesium Sulfate
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MRP	Manual Removal of the Placenta
NASG	Non-Pneumatic Anti-Shock Garment
NGO	Nongovernmental Organization
PE/E	Pre-Eclampsia/Eclampsia
PPH	Postpartum Hemorrhage
SDG	Sustainable Development Goal
TXA	Tranexamic Acid
UBT	Uterine Balloon Tamponade
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

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 death from preventable causes is a global priority, and many countries are striving to reach the global target set by the 2030 Sustainable Development Goal 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]

The U.S. Agency for International Development (USAID), with support from MOMENTUM Country and Global Leadership and MOMENTUM Private Healthcare Delivery and through their multiple partners, has prioritized supporting national programs aimed at reducing preventable maternal deaths, stillbirths, and neonatal deaths on a global scale. In 2011 and 2012, 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 of 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 evidence-based 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 played by the private sector 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, commodities, and practices are used in this sector. Thus, the MOMENTUM teams jointly led a survey in 2022 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 the 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 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 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 concluded with a single set of responses for the survey, which was 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.

ESSENTIAL DRUG AVAILABILITY

Most countries report the majority of essential medications for PPH and HDP are on their essential medicine list (EML), indicating an enabling policy environment. All countries report oxytocin and magnesium sulfate are on their EML. Misoprostol is reported to be on the EML in 97% of countries. More recent PPH medications, such as heat-stable carbetocin for prevention and tranexamic acid for treatment, are starting to be included in EMLs; their inclusion is reported at 35% and 71% of countries respectively. All countries report at least one WHO-recommended antihypertensive is on their EML. The four antihypertensives recommended by the WHO are reportedly included in the EML in the majority of countries: hydralazine (77% of countries), labetalol (71% of

countries), methyldopa (81% of countries), and nifedipine (97% of countries). While the policy environment for essential PPH and HDP medications exists in most countries, there were lower rates of available medications reported at the health facility level compared to the district/regional and central medical stores. Focus on national-level policy and guidelines to address improving district/regional and central medical store availability of these essential medications; access and utilization at the facility level; and expanding antihypertensives included on the EML could result in more consistent and timely use of lifesaving medications.

NATIONAL POLICY AND GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES

Many countries have made progress towards updating national guidelines for prevention and treatment of PPH and HDP to current global management principles. Newer but highly effective medications for PPH, including heat-stable carbetocin for prevention and tranexamic acid for treatment, are already integrated into some countries' national guidelines. Ensuring safety with the introductions and roll-out of new medicines should be a global and national priority. While more than half of countries reported that all WHO recommendations (with the exception of umbilical vein injection of oxytocin for treatment of retained placenta that is only recommended under conditions of rigorous research) were included in the national guidelines, clearly there is still work to be done to integrate all WHO updates for PPH and HDP into national guidelines for all countries across public and private sectors. In addition, a compelling improvement has occurred globally over the past 10 years in use of misoprostol—a useful medication to prevent and treat PPH that is effective, inexpensive, has a long shelf-life, and can be used by lay health workers in community settings[3]—likely as a result of a favorable policy environment. In 2012, misoprostol was reported as rarely available at most facilities, with few countries having misoprostol in their EML or national guidelines; in 2022, it was reported to be on 97% of EMLs and estimated as regularly available (i.e., greater than 80% of the time) at public facilities in nearly 61% of countries surveyed.

MEDICATION QUALITY AND PROCUREMENT POLICIES AT A NATIONAL LEVEL

The quantitative and qualitative survey results identified a need and interest in addressing quality of medications at point of delivery. Improvements are needed in the quality of a controlled cold-chain for oxytocin and the systems required to ensure adequate storage and availability of a 50% solution of magnesium sulfate in both the public and private sectors. Additionally, most countries (approximately 75%) reported independent procurement processes for medications and commodities used in the private sector. Countries reported that the private sector sources medicines and commodities primarily from local wholesalers (97% of countries for both PPH and HDP), ministries of health (16% of countries for PPH and 13% for HDP), and donors (32% of countries for PPH and 23% for HDP). Given the wide range of procurement sources for the private sector, governments will need creative ways to address this complex challenge to ensure that quality-assured medications and commodities are being provided. The use of appropriate and standardized procurement processes, strong regulatory frameworks, appropriate labelling, and investment in cold-chain resources for both private and public sectors has potential to improve overall quality of medications and commodities used in a country. While several countries reported having national procurement and distribution policies, it would be valuable to conduct implementation research to understand factors that enable and/or hinder application of those policies from point of manufacture to point of distribution.

MIDWIFE SCOPE OF PRACTICE

The midwife's scope of practice for providing basic emergency obstetric skills is still limited in some countries. It is critical that where midwives practice, they be empowered and educated to manage basic obstetric emergencies as recommended in the 2019 International Confederation of Midwives' *Essential Competencies for Basic Midwifery Practice* and also as listed among essential interventions by the WHO.[4, 5] This survey revealed there has been minimal to no change in advancing midwives' scope of practice compared to the 2011 and 2012 multi-country survey data. Task-sharing, updating policies to expand midwifery scope of practice, and use of competency-based training in pre-service education and in-service training are reinforced in qualitative responses as key for national program scale-up.

CAPACITY BUILDING AND TRAINING IN GLOBAL BEST PRACTICES

As the policy environment for implementing updated PPH and HDP global guidance improves, a programmatic opportunity exists to support dissemination and widespread utilization of these guidelines through capacity building in pre-service education and in-service training. For clinical education, out of the 10 updated global guidance components for PPH and HDP assessed in the survey, all countries reported public sector institutions have integrated three updates into pre-service curricula and in-service training: 1) magnesium sulfate is first-line anticonvulsant for PE/E; 2) quality-assured oxytocin is first-line uterotonic for PPH; and 3) use of updated active management of third stage of labor. While no global guidance components were reported by 100% of countries for private institutions, 97% of countries estimated that the 10 updated global guidance components for PPH and HDP assessed in the survey were integrated into pre-service curricula in private institutions and at least 84% of countries estimated that they were integrated into in-service training in private institutions. The least integrated global guideline for public and private institutions is umbilical vein injection of oxytocin for treatment of retained placenta (that is only recommended under conditions of rigorous research) and use of the non-pneumatic anti-shock garment for PPH treatment. Digital learning and blended hybrid learning methodologies that have shown promise during the COVID-19 pandemic could improve access to and quality of capacity building in PPH and HDP programs. Renewed emphasis on updating pre-and in-service curricula while ensuring best practices in clinical education, such as use of simulation and appropriate use of simulation aids, may help enable providers to be competent and confident to implement the latest standards of care for PPH and HDP. In addition, fostering public-private sector collaboration is highlighted by several countries as key to successful implementation of guidelines through dissemination of global updates, joint public-private sector in-service capacity building, and curricula review.

NATIONAL REPORTING ON SELECT MATERNAL AND NEWBORN HEALTH INDICATORS

While there has been improvement in national reporting on key indicators for maternal and newborn health (MNH), reporting on coverage is currently not comprehensive. In this survey, 74% of countries report including in their HMIS an indicator to measure use of a uterotonic and 87% of countries report including in their HMIS an indicator to measure the number of women with severe PE/E. In comparison, in 2012, just 43% of countries had reported a PPH coverage indicator (active management of third stage of labor) and 51% reported an HDP prevalence indicator (number of women with severe PE/E) in the HMIS. Continuing to strengthen data collection on key MNH indicators will serve to more accurately capture PPH and HDP complications of pregnancy and the outcomes associated with them.

BOTTLENECKS AND SCALE-UP OPPORTUNITIES

Survey data showed recurrent bottlenecks to scale-up of PPH and HDP programs included challenges to drug procurement and distribution, poor quality of drugs and inadequate supply at point of delivery, sub-optimal financing of the health system, insufficient human resources, inadequate capacity of MNH skilled workers, inadequate commodities, lack of public-private partnerships, need for improved data collection and data review systems, geographical challenges, and need for improved referral systems. Two recurring areas of focus emerged in the analysis as key responses to reducing barriers to broad application of global guidelines: 1) public-private sector collaboration; and 2) quality assurance of commodities and quality-improvement approaches in clinical practices.

The findings from this survey provide a broad overview of several national-level components that are key to successful PPH and HDP reduction programs. Data can be viewed for individual countries in most of the graphics in the report and in the country-specific profiles in the appendix. Changes in clinical practice can also be reviewed through the survey findings that show trends across all countries surveyed. While national programs and policy-makers aiming to reduce preventable maternal deaths from PPH and HDP are the primary target audience of this report, professional associations, education councils, private sector stakeholders, and global MNH organizations may also find the information useful for strategic planning and consideration of future research.

INTRODUCTION

Reducing maternal deaths from preventable causes has been a global priority for decades. The current global target set by the 2030 Sustainable Development Goal (SDG) 3 is a global maternal mortality ratio (MMR) of less than 70 per 100,000 live births.[6] Based on the current pace of progress, the World Health Organization (WHO) estimates that this target will not be reached. While progress has been made—the global MMR decreased from 342 per 100,000 live births in 2000 to 211 per 100,000 live births in 2017—it is not evenly distributed and some countries still have a persistently high MMR (MMR > 500) or an extremely high MMR (MMR > 1,000). A disproportionate burden of maternal death persists in sub-Saharan Africa and South and Southeast Asia, accounting for 86% of estimated maternal deaths in 2017.[7]

Reducing the MMR is a complex endeavor requiring multi-faceted strategies across different levels of the health system and beyond. Important external factors such as humanitarian crises, shocks, and climate change—as well as contextual factors such as quality of care, access to family planning, and competency-based education for health workers—are some of the many issues that may influence mortality reduction. The United States Agency for International Development (USAID), with the support of MOMENTUM Country and Global Leadership and MOMENTUM Private Healthcare Delivery and their multiple partners, has prioritized supporting national programs to reduce preventable maternal deaths, stillbirths, and neonatal deaths on a global scale. In 2011 and 2012, USAID—with the support of the Maternal and Child Health Integrated Program—conducted a survey of national programs working on reducing maternal mortality from postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E). Results of these surveys provided country and global-level snapshots of policies, practices, supplies, and activities to guide national and global program managers and policy-makers in setting national priorities and managing their programs.[8, 9]

Since 2012, several critical changes have occurred in the global guidance on preventing and managing PPH and hypertensive disorders of pregnancy (HDP). In addition, while there is increasing awareness and recognition of the vital role played by the private sector in providing maternal and newborn health (MNH) services worldwide, little is known about the quality of care provided in the private sector and the extent to which evidence-based policies, commodities, and practices are used in the private sector. Therefore, in 2022 MOMENTUM led a 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 the new global guidelines; and 3) bring greater awareness of the private sector's role in national programs addressing PPH and HDP.

The 2022 survey is an opportunity to explore more deeply the contextual environment affecting national programs and their implementation of PPH and HDP reduction programs. It is also uniquely able to describe changes, progress, and challenges to scale-up of PPH and HDP programs over the last decade, given that 23 of the 31 countries surveyed in 2011 and 2012 are represented in the 2022 survey. In sharing the survey results in this report, it is hoped that countries will use this information to make further progress in reducing PPH and HDP complications, improving MMR, and helping their countries—and the world—to accelerate progress towards the SDG 3 target.

METHODS

From January to May 2022, 31 countries in sub-Saharan Africa, South and Southeast Asia, and Latin America and the Caribbean (LAC) completed a global survey focused on PPH practices and policies in the public and private sector. Sub-Saharan African countries included: Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo (DRC), Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Sierra Leone, South Sudan, Uganda, and Zambia. South and Southeast Asian countries included: Bangladesh, Burma

(Myanmar), India, Indonesia, Nepal, and Pakistan. LAC countries included: Colombia, Dominican Republic, El Salvador, Guatemala, Honduras, Paraguay, Peru, and Uruguay. Convening of key country stakeholders and data collection was led by MOMENTUM through Jhpiego country offices with the exception of Colombia, Dominican Republic, El Salvador, Honduras, Paraguay, Peru, and Uruguay, where it was led by the United Nations Population Fund (UNFPA). See Table 1 for a list of countries for 2011, 2012, and 2022 surveys.

SURVEY INSTRUMENTS

The survey tool was comprised of quantitative and qualitative questions and included questions retained from the 2011 and 2012 iterations of the survey for temporal comparison.

Some questions were modified to improve clarity and include private sector comparisons. Questions were added to assess: 1) integration of updated WHO guidelines into national policy, national guidelines, curricula, and logistics; 2) the private sector's role in all programmatic areas; and 3) professional association involvement in policy development. The survey tool was validated through a robust and iterative process that involved expert reviewers from the Postpartum Hemorrhage Community of Practice, USAID, Population Services International, and the Jhpiego Maternal Newborn Health team. Ultimately, of the 46 questions on the 2012 survey, 16 questions were retained, 19 questions modified, and 11 removed. The qualitative questions expanded on the quantitative questions to add depth and clarity to the responses.

2022 Survey Core Components

1. Policy
2. Capacity building
3. Logistics
4. National reporting of select maternal health indicators
5. Programming
6. Bottlenecks and scale-up opportunities

The 69 questions in the 2022 survey addressed six core components: policy, capacity building, logistics, national reporting of select MNH indicators, programming, and bottlenecks and scale-up opportunities. See Appendix C for the 2022 survey tool.

The survey and informed consent were translated into French, Spanish, and Portuguese and programmed into Survey Monkey, an online survey platform. A hard copy of the survey was made available to countries that preferred to complete it offline.

DATA COLLECTION PROCEDURES

Data collection occurred between January and May 2022 and was coordinated by the MOMENTUM teams in Washington, D.C. In total, 35 countries were invited to participate, of which 31 countries ultimately participated (see Table 1). Of these, 28 were identified as MOMENTUM priority countries. Seven countries in the LAC region (Colombia, Dominican Republic, El Salvador, Honduras, Paraguay, Peru, and Uruguay) were selected to participate by UNFPA, which led data collection in those countries. MOMENTUM Country and Global Leadership led data collection in the remaining 24 countries. In each country, an in-country focal person to lead the data collection was identified by the Ministry of Health (MOH), the MOMENTUM team, UNFPA, professional associations, or partner organizations. The contact list of focal persons from the 2011 and 2012 surveys was referenced, though nearly all countries reported new focal persons. All communication, including email and phone calls with the focal person, were conducted in their preferred language (English, French, Portuguese, or Spanish).

Using purposive sampling, the focal person for each country collaborated with local partners and key stakeholders to consult with or establish a national consultative group that had representation from expert

stakeholders—suggested stakeholders included the MOH; universities/education councils; professional associations and councils for midwifery, nursing, and obstetrics-gynecology; formal private sector stakeholders from nongovernmental organizations (NGOs); faith-based organizations (FBOs); and UN agencies—to respond to the survey. Overall, the number of key informants ranged from one to 50, with an average of 10–20 key informants per country. Three countries included only one key informant: Ethiopia, Mozambique, and Zambia and only one country, Côte d'Ivoire, included more than 20 key informants. Several attempts were made by the coordinating team in Washington, D.C., to communicate and support those countries with one key informant to ensure wider representation of key informants; however, ultimately no further key informants were included.

Country teams took an average of three weeks to respond. The national consultative group could respond to the survey virtually or in-person, but input from and discussions with multiple key informants were required; each country ultimately submitted one consolidated response. Key informants verified responses with nationally relevant documents such as policies, essential medicines lists (EMLs), national guidelines, curricula, and clinical standards. Any clarifications required to complete the survey were handled between the coordinating team in Washington, D.C., and a country's focal person.

Due to travel and meeting restrictions during the COVID-19 pandemic, countries gathered data in three different ways:

- Countries sent the survey to key informants to fill out or review before the consultative meeting, then met virtually or in-person to discuss questions at the consultative meeting where there were discrepant views.
- Countries conducted the survey with key informants individually, both in-person and virtually, then gathered in a small consultative group to review responses and formulate one survey response.
- Countries reviewed, discussed, and responded to the survey in its entirety at an in-person or virtual consultative meeting.

DATA ANALYSIS

Surveys were programmed in English, French, Portuguese, and Spanish into Survey Monkey, and responses were translated back to English. The coordinating team in Washington, D.C., checked country surveys for completeness and clarity and contacted the country focal person for any clarifications or missing data. The coordinating team analyzed quantitative responses across the public and private sectors and across time, comparing to 2011 and 2012 data for select countries. Quantitative data was then transferred into Microsoft Excel for further analysis. Graphics were designed using Microsoft Power BI. Composite scores were developed for all quantitative indicators except "bottlenecks and scale-up opportunities," which was all qualitative data. The composite score was calculated by highlighting key components of each theme, giving a score of 1 for a "yes" or equivalent response per indicator, and totaling the scores. No efforts were made to weight certain questions over others. Qualitative responses were coded and analyzed using pre-defined themes: 1) essential drug availability; 2) national guidelines updated to global management principles; 3) quality and procurement policies at the national level; 4) midwife scope of practice; 5) capacity building and training updated to global best practices; 6) national reporting on select maternal health indicators; and 7) bottlenecks and scale-up opportunities. Illustrative quotes were integrated into the quantitative data where applicable.

ETHICAL APPROVAL

The survey protocol, informed consent, and survey tool were reviewed by the John Hopkins University Institutional Review Board (IRB) and granted a "Not Research/Public Health Practice" determination for implementation. One country (South Sudan) required local IRB approval to implement the survey, and support from MOMENTUM headquarters was given to gain IRB approval there. All study participants within countries completed and signed informed consent forms. Given that the survey occurred during the COVID-19 pandemic, careful instruction was given to all participating countries to follow national, institutional, and local COVID-19 protocols. The MOMENTUM teams reviewed the institutional COVID-19 protocols prior to survey implementation.

FINDINGS

OVERVIEW

Findings from 31 countries in sub-Saharan Africa, South and Southeast Asia, and LAC were included in the survey (see Table 1 for list of countries surveyed). Twenty-one of the 31 countries that participated in the 2011 survey and 22 of the 37 countries that participated in the 2012 survey were included in the 2022 survey. In addition, eight countries were added in 2022: Burkina Faso, Burma (Myanmar), Colombia, Côte d'Ivoire, Dominican Republic, Peru, Sierra Leone, and Uruguay. In total, 23 countries that participated in 2022 had also participated in 2011 and/or 2012. The countries in bold font in the table below represent additional countries included in the 2022 survey.

TABLE 1: COUNTRIES INCLUDED IN SURVEY FROM 2011–2022

Year	Region	Countries (new additions shown in bold)
2011	Africa	Angola, Democratic Republic of the Congo (DRC), Ethiopia, Equatorial Guinea, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, Zanzibar, Zimbabwe
2011	S/SE Asia	Afghanistan, Bangladesh, India, Indonesia, Nepal
2011	LAC	Bolivia, Guatemala, Honduras, Nicaragua, Paraguay
2012	Africa	Angola, DRC, Equatorial Guinea, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zanzibar, Zimbabwe
2012	S/SE 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,** DRC, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, **Sierra Leone**, South Sudan, Uganda, Zambia
2022	S/SE Asia	Bangladesh, **Burma (Myanmar),** India, Indonesia, Nepal, Pakistan
2022	LAC	**Colombia**, **Dominican Republic**, El Salvador, Guatemala, Honduras, Paraguay**, Peru, Uruguay**

Of the 35 countries invited to participate in the survey, four did not complete the survey (Burundi, Niger, Rwanda, and Tanzania). Multiple attempts were made to support and communicate with these countries. MOMENTUM Country and Global Leadership and MOMENTUM Private Healthcare Delivery will continue to work with these countries and others to share the survey findings.

The 2022 survey builds upon findings from the previous rounds (2011 and 2012) and explores key themes pertinent to national PPH and HDP prevention and management programs through both a public sector and private sector perspective. Comparison of these key themes across 11 years offers a unique opportunity to understand trends in progress and identify areas for further focus with special attention towards private and public sector coordination in national reduction strategies for management of PPH and HDP.

The findings presented in this section are organized by key themes. These key themes are: 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 MNH indicators, and bottleneck and scale-up opportunities. Each theme is then explored for a total composite score, 2022 data highlights, temporal data comparisons, and private sector highlights where relevant. Both quantitative and qualitative data are presented in the findings by theme.

Themes for Strengthening PPH and HDP Programs:

1. Essential drug availability
2. National guidelines updated to global management principles
3. Quality and procurement policies at the national level
4. Midwife scope of practice
5. Capacity building and training updated to global best practices
6. National reporting on select maternal and newborn health indicators
7. Bottleneck and scale-up opportunities

THEME 1: ESSENTIAL DRUG AVAILABILITY

OVERVIEW OF PPH DRUG AVAILABILITY

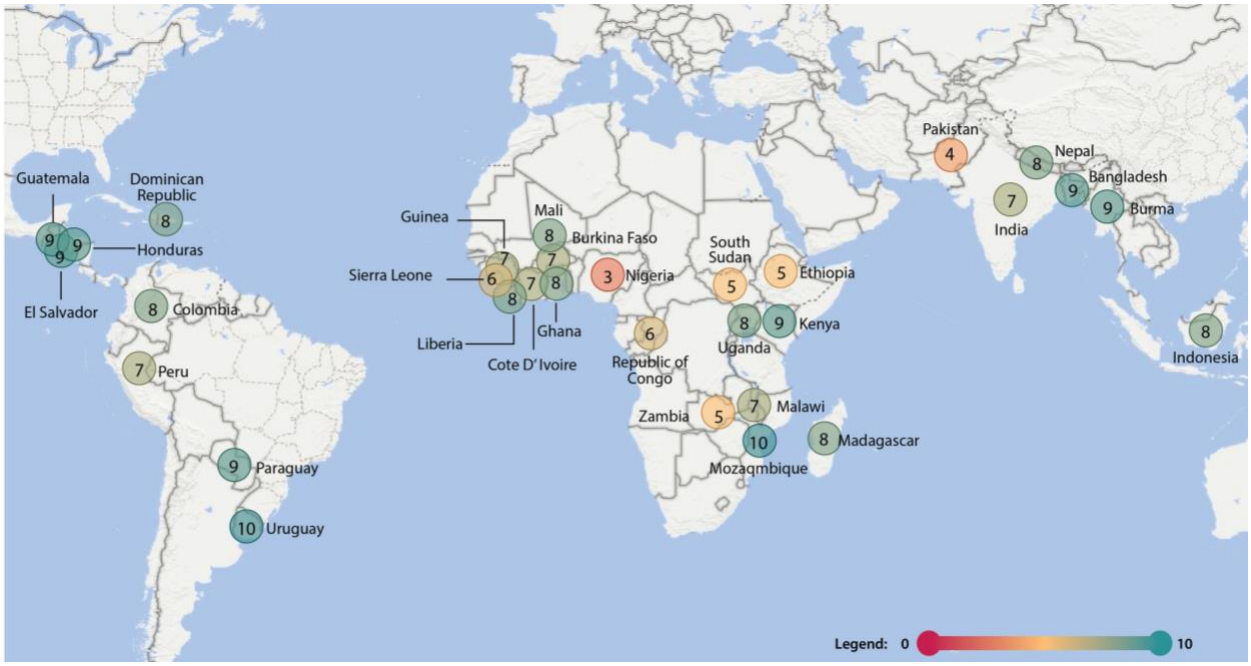
Drug availability considers three key components: availability of essential drugs on the EML, availability at district/regional and central medical stores, and availability at facilities providing maternity care. Across the countries surveyed, 58% scored eight or higher out of the maximum of 10 for their composite score of drug availability for uterotonics. Policies requiring availability and utilization of essential PPH drugs on the EML are generally reported. The 2022 data revealed that 100% of countries reported having oxytocin and 97% of countries reported having misoprostol on their EMLs for prevention and treatment of PPH—indicating an enabling policy environment.

Stock-outs of oxytocin at the central level were estimated as rare (i.e., once a year or less) by approximately 94% of countries. Seventy-seven percent of countries estimated that oxytocin was regularly available (i.e., at least 80% of the time) at public facilities and 84% of countries estimated regular availability of oxytocin at private facilities. Sixty-one percent of countries estimated misoprostol was regularly available in public

facilities and 58% of countries estimated it was regularly available in private health facilities. Countries also estimated that most private facilities charge for oxytocin (with roughly 6% making it available at no cost) as compared to public facilities where oxytocin was estimated to be given at no cost in 77% of countries (see Figure 1). Of note, data from this survey was derived from country working groups' best estimates and no country-specific health facility assessments or surveys were conducted.

Newer medications recommended by the WHO for PPH, namely, heat-stable carbetocin (HSC) for PPH prevention and tranexamic acid (TXA) for PPH treatment, have been added to some countries' EMLs; 35% of countries reported HSC was on their EML and 71% of countries reported TXA was on their EML.

FIGURE 1: OVERVIEW OF DRUG AVAILABILITY FOR PPH, 2022



Note: The composite score for PPH drug availability is calculated based on 10 key indicators that cover inclusion of essential drugs in the EML (oxytocin, misoprostol), their availability in public and private sectors, whether they are given free of charge, and whether there have been stock-outs at central or regional levels. A higher score indicates better performance than a lower score. See Appendix B for the breakdown of composite score by country.

CURRENT AND TEMPORAL DATA HIGHLIGHTS

OXYTOCIN

For many years, oxytocin has been the gold-standard medication for PPH prevention and treatment recommended by WHO; all countries in 2011 and through 2022 reported oxytocin on their EMLs. In comparing country estimates of oxytocin availability between 2011, 2012, and 2022, it is clear there have been improvements in three areas that were assessed: 1) oxytocin was estimated to be more regularly available (i.e., at least 80% of the time) at public facilities in 77% of countries in 2022 compared to 50% of the countries in 2012 ("regularly available" was not defined in the 2012 survey); 2) oxytocin was estimated to be provided free of charge at public facilities in 77% of countries in 2022 compared to 73% in 2012; and 3) 94% of countries estimated that stock-outs of oxytocin were rare (i.e., once a year or less) at the central level in 2022 compared to 29% of countries in 2011 and 55% of countries in 2012 (see Table 2).

TABLE 2: OXYTOCIN AVAILABILITY, 2011–2022

● - Yes, x - No

Answers left blank were either not answered or country was not part of survey at the time to provide an answer.

Oxytocin on the EML for prevention and treatment of PPH 2011-2022	2011	2012	2022
Bangladesh	●	●	●
Burkina Faso			●
Burma			●
Colombia			●
Côte D'Ivoire			●
Dominican Republic			●
DRC	●	●	●
El Salvador		●	●
Ethiopia	●	●	●
Ghana	●	●	●
Guatemala	●	●	●
Guinea	●	●	●
Honduras	●	●	●
India	●	●	●
Indonesia	●	●	●
Kenya	●	●	●
Liberia	●	●	●
Madagascar	●	●	●
Malawi	●	●	●
Mali	●	●	●
Mozambique	●	●	●
Nepal	●	●	●
Nigeria	●	●	●
Pakistan		●	●
Paraguay	●	●	●
Peru			●
Sierra Leone			●
South Sudan	●	●	●
Uganda	●	●	●
Uruguay			●
Zambia	●		●
Total	**21/21**	**22/22**	**31/31**

Oxytocin regularly available at facilities 2012-2022	2012	2022
Bangladesh	x	●
Burkina Faso		●
Burma		●
Colombia		●
Côte D'Ivoire		●
Dominican Republic		●
DRC	x	x
El Salvador	●	●
Ethiopia	●	●
Ghana	●	●
Guatemala	●	●
Guinea	x	●
Honduras	●	●
India	●	●
Indonesia	●	●
Kenya	●	●
Liberia	x	●
Madagascar	x	●
Malawi	x	x
Mali	●	●
Mozambique	●	●
Nepal	x	●
Nigeria	x	x
Pakistan	x	x
Paraguay	●	●
Peru		●
Sierra Leone		x
South Sudan	x	x
Uganda	x	●
Uruguay		●
Zambia		x
Total	**11/22**	**24/31**

2012: Regularly available not defined
2022: Regularly available is defined as >80% of the time

Oxytocin free of charge at public facilities 2012-2022	2012	2022
Bangladesh	●	●
Burkina Faso		●
Burma		●
Colombia		x
Côte D'Ivoire		●
Dominican Republic		●
DRC	x	x
El Salvador	●	●
Ethiopia	●	●
Ghana	●	x
Guatemala	●	●
Guinea	●	●
Honduras	x	●
India	●	●
Indonesia	●	●
Kenya	x	●
Liberia	●	●
Madagascar	●	x
Malawi	●	●
Mali	x	x
Mozambique	●	●
Nepal	●	●
Nigeria	x	x
Pakistan	●	x
Paraguay	●	●
Peru		●
Sierra Leone		●
South Sudan	x	●
Uganda	●	●
Uruguay		●
Zambia		●
Total	**16/22**	**24/31**

Stockouts of oxytocin at central level are rare 2011-2022	2011	2012	2022
Bangladesh	x	x	●
Burkina Faso			●
Burma			●
Colombia			●
Côte D'Ivoire			●
Dominican Republic			●
DRC		x	●
El Salvador		●	●
Ethiopia	x	●	x
Ghana	●	●	●
Guatemala	x	●	●
Guinea	x	x	●
Honduras	●	x	●
India	x	●	●
Indonesia	●	●	●
Kenya	●	●	●
Liberia		x	●
Madagascar	●	●	●
Malawi	x	x	●
Mali	x	x	●
Mozambique	x	●	●
Nepal	x	●	●
Nigeria	x	x	x
Pakistan		x	●
Paraguay	●	●	●
Peru			●
Sierra Leone			●
South Sudan	x	x	●
Uganda		●	●
Uruguay			●
Zambia	x		●
Total	**6/21**	**12/22**	**29/31**

2011: Rare not defined
2012, 2022: Rare is defined as once a year or less

MISOPROSTOL

Misoprostol has been recommended by the WHO for PPH prevention and treatment since 2012,[10] and 2022 data indicates it has been widely accepted and integrated into the EMLs for 97% of countries, compared to 64% of countries surveyed in 2012. In addition, misoprostol availability has increased significantly from 2012, when 18% of countries estimated misoprostol being regularly available ("regularly available" not defined in the 2012 survey) at public maternity centers; in 2022, 61% of countries estimated it was regularly available (i.e., at least 80% of the time) at public maternity centers. In 2012, a lack of government support for misoprostol was identified in the qualitative data as a barrier to more widespread inclusion of misoprostol in national policies and more availability of misoprostol at facilities. While improving misoprostol availability at maternity facilities was still needed in 2022, the impact of national-level policy changes to include misoprostol in PPH prevention and treatment has likely had a direct impact on availability of misoprostol at the facility level (see Table 3).

Illustrative quotes highlighting challenges to misoprostol availability from three countries:

> *"Misoprostol is available in all hospitals but not at the first level of care, according to national guidelines."*
>
> **– Quote from the LAC region**

> *"In public health facilities, some misoprostol is available in part because patients and their families buy it outside of the facility."*
>
> **– Quote from the Africa region**

> *"Data from private facilities on misoprostol is that it is not readily available."*
>
> **– Quote from the South/Southeast Asia region**

In 2012, WHO recommended that misoprostol be available for PPH prevention for women giving birth at home without a skilled MNH provider. For countries with a high rate of births outside facilities, misoprostol availability for community or home births has the potential to significantly reduce PPH. Thus, the 2011 and 2012 surveys inquired if the WHO recommendation was being piloted and/or scaled up. In 2012, 41% of countries reported piloting misoprostol for home birth and 18% reported scaling up misoprostol for home birth. Qualitative data from 2012 identified lack of government support for misoprostol use in home births was the primary driver for the limited progress in use of misoprostol at home birth. Seven of the 28 countries

that provided qualitative responses in 2012 reported that their governments did not support misoprostol for use at home births.

While the 2022 survey did not ask about piloting or scaling up misoprostol for home birth, it did query if misoprostol for home birth was national policy—32% of countries responded positively to a policy for misoprostol usage outside of facilities (see Table 4).

TABLE 3: MISOPROSTOL AVAILABILITY, 2011–2022

● - Yes, x - No

Answers left blank were either not answered or country was not part of survey at the time to provide an answer.

	Misoprostol on EML for prevention and treatment of PPH 2011-2022			Misoprostol regularly available at public facilities 2012-2022	
	2011	2012	2022	2012	2022
Bangladesh	●	●	●	●	●
Burkina Faso			●		x
Burma			●		●
Colombia			●		●
Côte D'Ivoire			●		x
Dominican Republic			●		x
DRC	●	x	●	x	●
El Salvador		●	●	●	●
Ethiopia	●	●	●	x	x
Ghana	●	●	●	●	●
Guatemala	x	x	●	x	●
Guinea	x	x	●	x	x
Honduras	●	●	●	x	●
India	●	●	●	●	●
Indonesia	x	x	x	x	●
Kenya	●	●	●	x	●
Liberia	x	●	●	x	●
Madagascar	x	x	●	x	●
Malawi	●	●	●	x	x
Mali	●	●	●	x	●
Mozambique	x	x	●	x	●
Nepal	●	●	●	x	●
Nigeria	●	●	●	x	x
Pakistan		x	●	x	x
Paraguay	●	x	●	x	●
Peru			●		x
Sierra Leone			●		x
South Sudan	x	●	●	x	x
Uganda	●	●	●	x	●
Uruguay			●		●
Zambia	x		●		x
Total	**13/21**	**14/22**	**30/31**	**4/22**	**19/31**

2012: Regularly available not defined
2022: Regularly available is defined as >80% of the time

TABLE 4: MISOPROSTOL FOR PPH PREVENTION AT HOME BIRTH, 2011–2022

● - Yes, x - No

Answers left blank were either not answered or country was not part of survey at the time to provide an answer.

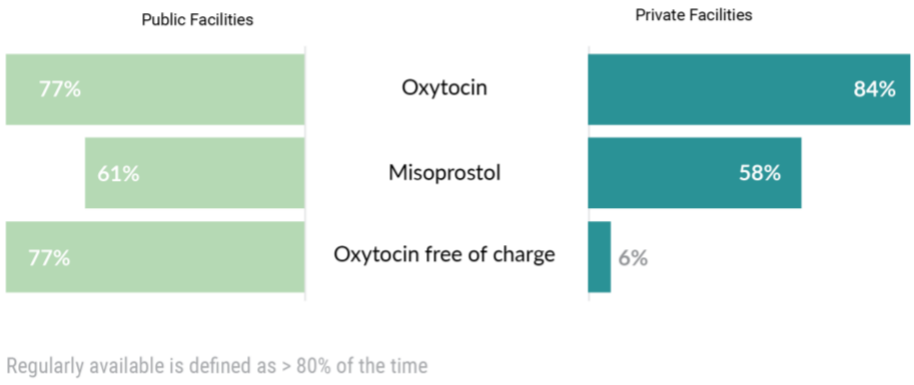
	Misoprostol for home birth is piloted 2011-2012		Misoprostol for home birth scaling up 2011-2012		Misoprostol for home birth is national policy 2022
	2011	2012	2011	2012	2022
Bangladesh	●	●	x	●	x
Burkina Faso					●
Burma					●
Colombia					x
Côte D'Ivoire					●
DRC	x	x	x	x	x
Dominican Republic					x
El Salvador		x		x	x
Ethiopia	x	●	●	●	x
Ghana	●	●	x	x	x
Guatemala	x	x	x	x	●
Guinea	x	x	x	x	●
Honduras	x	x	x	x	x
India	●	x	●	x	●
Indonesia	●	x	x	x	x
Kenya	●	●	x	x	x
Liberia	x	x	x	x	x
Madagascar	x	x	x	x	●
Malawi	x	x	x	x	x
Mali	x	x	x	x	x
Mozambique	●	●	x	x	x
Nepal	●	●	●	●	●
Nigeria	●	●	●	●	●
Pakistan		●		x	●
Paraguay	x	x	x	x	x
Peru					x
Sierra Leone					x
South Sudan	x	x	x	x	x
Uganda	x	●	x	x	x
Uruguay					x
Zambia	●		●		x
Total	**9/21**	**9/22**	**5/21**	**4/22**	**10/31**

PUBLIC AND PRIVATE SECTOR HIGHLIGHTS

Countries estimate both public and private sectors had regular availability (i.e., at least 80% of the time) of oxytocin in the 2022 survey; namely, 77% of countries estimated regular availability in public facilities and 84% of countries reported regular availability in private facilities. Roughly 61% of countries estimated that misoprostol was regularly available (i.e., at least 80% of the time) in public facilities, and 58% of countries estimated it was regularly available in private facilities.

Although oxytocin and misoprostol availability at both public and private facilities could still be improved, the surveys showed there was considerable improvement in estimated public facility availability since 2012, when only four of 22 countries estimated misoprostol being regularly available at public facilities, as compared to 16 of the same 22 countries estimating misoprostol as regularly available at public facilities in 2022. Oxytocin was estimated as regularly available in 11 of 22 countries in 2012 and in 24 of 31 countries in 2022 (see Tables 2 and 3). Regular availability was not defined in the 2012 survey, but it was defined in 2022 to be at least 80% of the time. The most significant discrepancy between the public and private sectors was the cost of oxytocin; 77% of countries estimated that there is no cost at public facilities but only 6% of countries estimated no cost at private facilities. The impact of charging a fee for oxytocin at private facilities is unclear and was not assessed in this survey. However, future research could examine whether charging a fee for oxytocin has any impact on treatment delays and/or whether some women do not have access to oxytocin for prevention of PPH due to cost-related barriers (see Figure 2).

FIGURE 2: REGULAR AVAILABILITY OF MEDICATIONS FOR PPH IN THE PUBLIC AND PRIVATE SECTOR, 2022



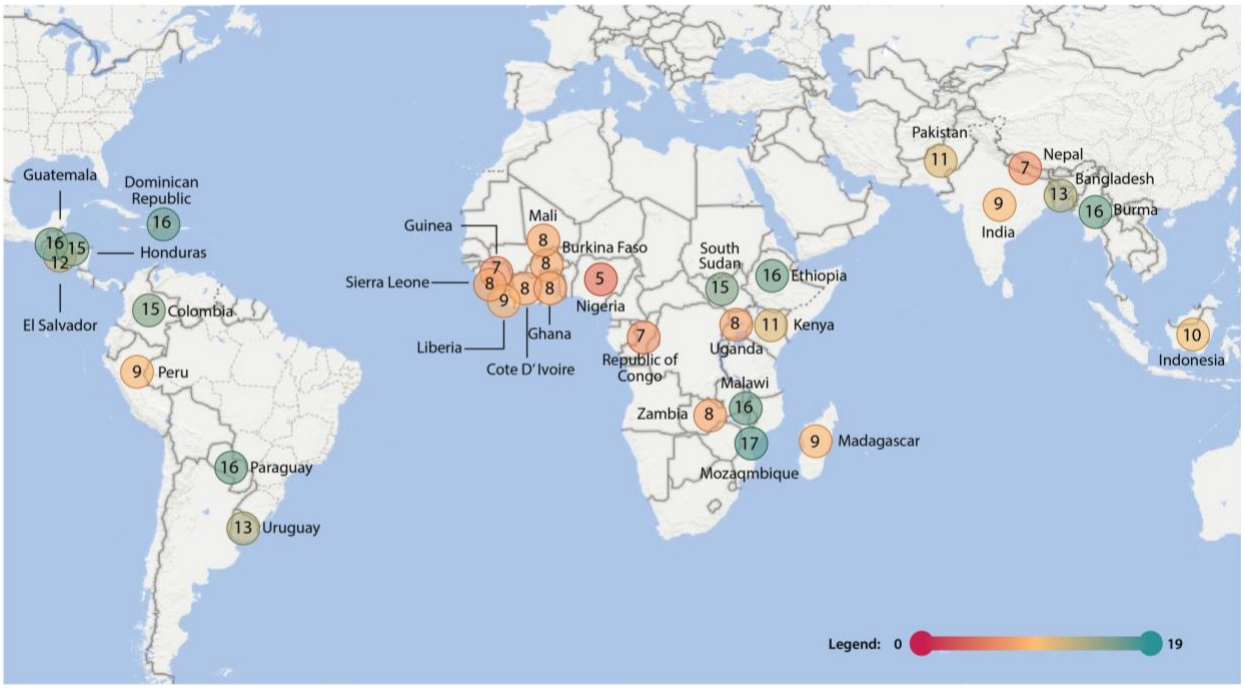
OVERVIEW OF HDP DRUG AVAILABILITY

The composite scoring for drug availability looks at three key components for essential drugs: 1) inclusion on the EML; 2) availability at the district/regional and central medical stores; and 3) availability at facilities providing maternity care. The composite score varied widely across countries for HDP drug availability primarily because of the scoring criteria used, which gave equal weight to all possible antihypertensives recommended by the WHO. However, since one antihypertensive medication is not recommended over another, a lower score does not necessarily mean poor availability of all HDP drugs. Instead, a lower score correlates with less availability of one of the four antihypertensive drugs on the EML or less frequent availability of drugs in public or private sector health facilities since each drug was given a score of "1" if available. Nonetheless, the overall regular availability of antihypertension and anticonvulsant medications could be improved in all the countries surveyed.

All countries reported at least one WHO-recommended antihypertensive drug being on their EML, and all countries reported magnesium sulfate (MgSO4) on their EML. The increasing number of policies for HDP drug availability supports a favorable policy environment for scale-up of the global guidelines.

Since antihypertensive drug availability was not included in the 2011 or 2012 surveys, only 2022 data is available. MgSO4 stock-outs were estimated as rare (i.e., once a year or less) at the central level by 68% of countries, but district/regional-level stock-outs were estimated to be more common, with only 52% of countries estimating stock-outs to be rare. Availability of drugs at the facility level was estimated as relatively similar between public and private facilities. The four different antihypertensive drugs were reportedly available to varying degrees at public and private health facilities. Countries estimated nifedipine was the most regularly available (i.e., at least 80% of the time) in 65% of countries' public facilities and 52% of countries' private facilities. Methyldopa was estimated as regularly available in 61% of countries' public and 52% of countries' private facilities. The estimated least regularly available drugs are hydralazine and labetalol, with 32% of countries' public facilities and 35% of countries' private facilities estimating that they are regularly available. Exploring drug availability and barriers to increased availability is warranted given the lower estimated rates of essential HDP drugs in stores and facilities (see Figure 3).

FIGURE 3: OVERVIEW OF DRUG AVAILABILITY FOR HDP, 2022



Note: The composite score for HDP drug availability is based on 19 indicators that cover four antihypertensive drugs (labetalol, hydralazine, methyldopa, and nifedipine) and anticonvulsant drug (MgSO4) on the EML, regular availability of these drugs in public and private facilities, whether they are provided at no cost in public and private sectors, and whether stock-outs occur at central and regional levels. A higher score indicates better performance than a lower score. See Appendix B for the breakdown of composite score by country.

CURRENT AND TEMPORAL DATA HIGHLIGHTS

MAGNESIUM SULFATE

Regular availability of MgSO4 at public facilities has shown small improvements over the past 10 years, with regular availability of MgSO4 at public facilities estimated by 48% of countries in 2011 ("regularly" was not defined in the 2011 survey), 45% of countries in 2012 ("regularly" was not defined in the 2012 survey), and 58% of countries in 2022 ("regularly" defined as greater than 80% of the time). The overall estimated rates of regularly available MgSO4 remain lower than the 100% recommended by global guidelines.

TABLE 5: MAGNESIUM SULFATE DRUG AVAILABILITY, 2011–2022

• - Yes, x - No

Answers left blank were either not answered or country was not part of survey at the time to provide an answer.

	MgSO4 on EML for severe PE/E 2011-2022			MgSO4 regularly available at public facilities 2011-2022		
	2011	2012	2022	2011	2012	2022
Bangladesh	•	•	•	x	x	•
Burkina Faso			•			x
Burma			•			•
Colombia			•			•
Côte D'Ivoire			•			x
Dominican Republic			•			•
DRC	•	•	•	x	x	x
El Salvador		•	•		•	•
Ethiopia	•	•	•	x	x	•
Ghana	•	•	•	•	x	x
Guatemala	•	•	•	•	•	•
Guinea	•	•	•	x	x	x
Honduras	•	•	•	•	•	•
India	•	•	•	x	•	•
Indonesia	•	•	•	x	•	•
Kenya	•	•	•	•	•	•
Liberia	•	•	•	•	x	•
Madagascar	•	•	•	x	x	x
Malawi	•	•	•	x	x	•
Mali	•	•	•	•	x	•
Mozambique	•	•	•	•	•	•
Nepal	•	•	•	x	•	x
Nigeria	•	•	•	x	x	x
Pakistan		•	•		x	x
Paraguay	•	•	•	•	•	•
Peru			•			x
Sierra Leone			•			x
South Sudan	•	•	•	x	x	•
Uganda	•	•	•	•	•	x
Uruguay			•			•
Zambia	•		•	•		x
Total	**21/21**	**22/22**	**31/31**	**10/21**	**10/22**	**18/31**

2011, 2012: Regular availability not defined
2022: Regular availability is defined as >80% of time

There does seem to be a possible discrepancy between medical store availability of MgSO4 at the central and district level and facility level. Data from countries surveyed in 2022 estimate MgSO4 was regularly available (i.e., greater than 80% of the time) at the central level in 68% of countries, but only 52% of countries estimate MgSO4 was regularly available at the district/regional levels, and 58% of countries estimate MgSO4 was regularly available at the facility level (see Table 5). From the qualitative data, more than half of countries identified a recurring issue of inadequate commodities as a top bottleneck to PPH and HDP programs.

Possible causes for the lower-than-optimal regular availability of MgSO4 at facilities could include poor forecasting by facilities, cost, and inconsistent availability at the district and/or central stores.

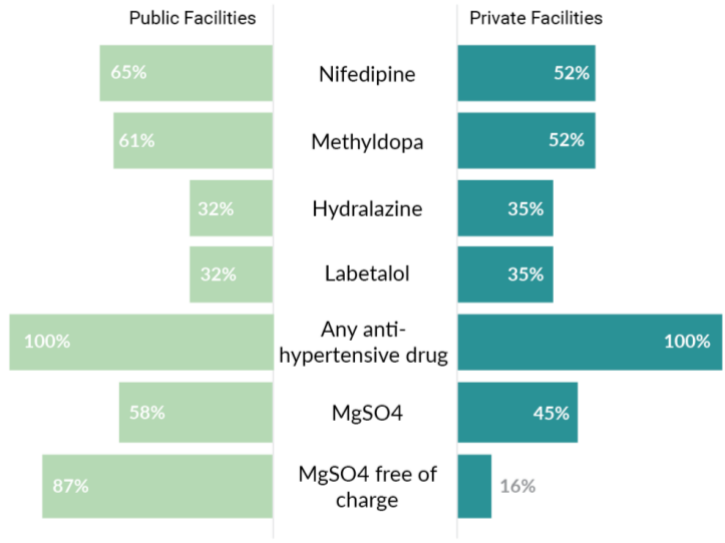
Illustrative quotes from two countries regarding concern for availability of HDP commodities:

> *"Stock out of HDP commodities due to low budgetary allocation."*
>
> **– Quote from the Africa region**

> *"Unavailability of medicines, weakness in logistics programming mechanisms, and poor budget allocation at the local level."*
>
> **– Quote from the LAC region**

PRIVATE AND PUBLIC SECTOR HIGHLIGHTS

FIGURE 4: REGULAR AVAILABILITY OF MEDICATIONS FOR HDP IN THE PUBLIC AND PRIVATE SECTOR, 2022



Regularly available is defined as > 80% of the time

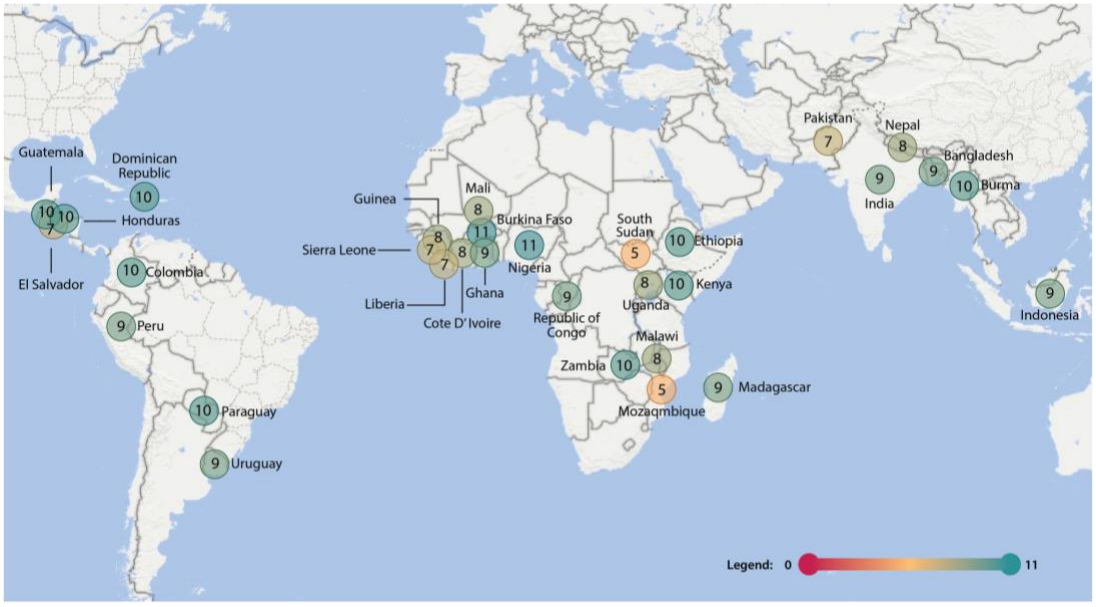
Each country reported at least one WHO-recommended antihypertensive was on their EML and regularly available (i.e., greater than 80% of the time) at public and private facilities. The antihypertensive drugs that countries more often estimated to be regularly available at facilities were nifedipine (by 65% of countries for public facilities and 52% of countries for private facilities) and methyldopa (by 61% of countries for public facilities and 52% of countries for private facilities). The drugs that were less often identified as regularly available at facilities were hydralazine (estimated to be regularly available by 32% of countries' public facilities and 35% of countries' private facilities) and labetalol (estimated to be regularly available by 32% of countries' public facilities and 35% of countries' private facilities). In addition, MgSO4, the first-line anticonvulsant recommended for all women with severe PE/E, was estimated by countries to be only available regularly by 58% of countries in the public sector and 45% of countries in the private facilities. This lifesaving medication should always be available since it must be administered on an emergency basis upon diagnosis. The survey findings show that there has been little progress in the estimated regular availability of MgSO4 at the public facility level in the last decade, 45% in 2012 compared to 58% in 2022("regular availability" not defined in the 2012 survey and defined as more than 80% of the time in the 2022 survey). In the 2022 survey, more than half of countries name inconsistent availability of MgSO4 as a bottleneck to HDP programs in the qualitative data. However, given the quantitative nature of most survey questions, the survey does not explore why availability has not improved (see Figure 4).

THEME 2: NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES

OVERVIEW OF NATIONAL GUIDELINES

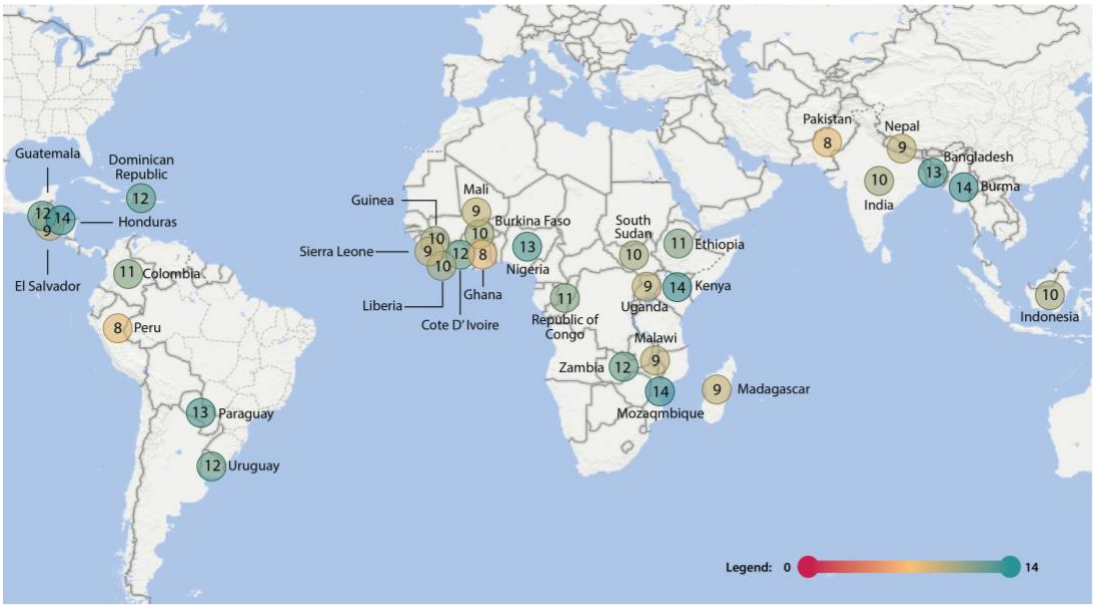
Survey questions related to PPH and HDP sought to assess the inclusion of current WHO guidance for drugs and practice guidelines into reported national guidelines. Across the 23 PPH and HDP recommendations included in the survey, some were reported to be integrated into national guidelines by all countries and other recommendations were only integrated into guidelines by 13% of countries. Countries scoring lower in composite scores for PPH were more likely to not have some of the newer PPH guidelines integrated into national guidelines (e.g., use of TXA and non-pneumatic anti-shock garment [NASG]) and/or the private sector was reported as not using national guidelines for PPH more than the public sector. Countries with lower HDP composite scores were more likely to have fewer antihypertensive medication options in their guidelines and the private sector was more frequently reported as not using national guidelines for HDP (see Figures 5 and 6).

FIGURE 5: OVERVIEW OF UPDATED NATIONAL GUIDELINES FOR PPH, 2022



Note: The composite score for PPH national guidelines is calculated based on inclusion of 11 key indicators in the national guidelines: oxytocin as preferred uterotonic; PPH treatments of TXA; uterine balloon tamponade (UBT), NASG, blood transfusion services, and active management of third stage of labor (AMTSL) are updated; use of ergometrine/methylergometrine, oxytocin-ergometrine, and/or misoprostol; and whether the private sector uses national guidelines. A higher score indicates more global management principles are integrated into the national guidelines. See Appendix B for the breakdown of composite score by country.

FIGURE 6: OVERVIEW OF UPDATED NATIONAL GUIDELINES FOR HDP, 2022



Note: The composite score for HDP national guidelines is calculated based on inclusion of 14 key indicators in the national guidelines covering four antihypertensive drugs (beta blocker [labetalol], hydralazine, methyldopa, and nifedipine) for non-severe and severe hypertension; first-line anticonvulsant drug (MgSO4); recommendations for induction versus expectant management in severe PE/E; short-and long-term management for women with HDP; prevention strategies of low-dose aspirin and calcium supplementation during pregnancy for certain women; and whether the private sector uses national guidelines. A higher score indicates more global management principles are integrated into the national guidelines. See Appendix B for the breakdown of composite score by country.

CURRENT AND TEMPORAL DATA HIGHLIGHTS

All countries have integrated three of the seven WHO recommendations for PPH (from WHO recommendations published in 2018 and 2020)[11, 12, 13, 14] into their national guidelines with: 1) oxytocin as the preferred uterotonic; 2) a policy for safe blood transfusion; and 3) the AMTSL policy updated to include immediate use of an uterotonic. Use of UBT for PPH treatment was reported by 90% of countries to be in the national guidelines and TXA for PPH treatment was in 77% of countries' national guidelines. In addition, qualitative data supports interest in scaling up UBT as a PPH treatment strategy since many countries already have some experience in using UBT. Results from ongoing trials examining UBT use in low-resource settings will be useful, particularly in settings where immediate access to surgery can be ensured as per existing WHO recommendations. HSC, a newer drug recommended for prevention of PPH by the WHO, was reported to be in 45% of countries' national policies and guidelines. Oxytocin injection in the umbilical vein for retained placenta is a newer intervention as well and was just starting to be integrated into national guidelines as reported by 13% of countries. Contextually, this is appropriate since WHO has only recommended this intervention in the setting of rigorous research. Further investigation into the research of this intervention and its use in resource-constrained settings is important before widespread dissemination of the intervention (see Figure 7).

Illustrative quotes from three countries highlighting the interest in introduction and scale-up of WHO PPH recommendations:

"Scale up UBT [is] cost effective, easy to use and assemble, have available balloon tamponade at all levels [of the health care system]."

– Quote from the South/Southeast Asia region

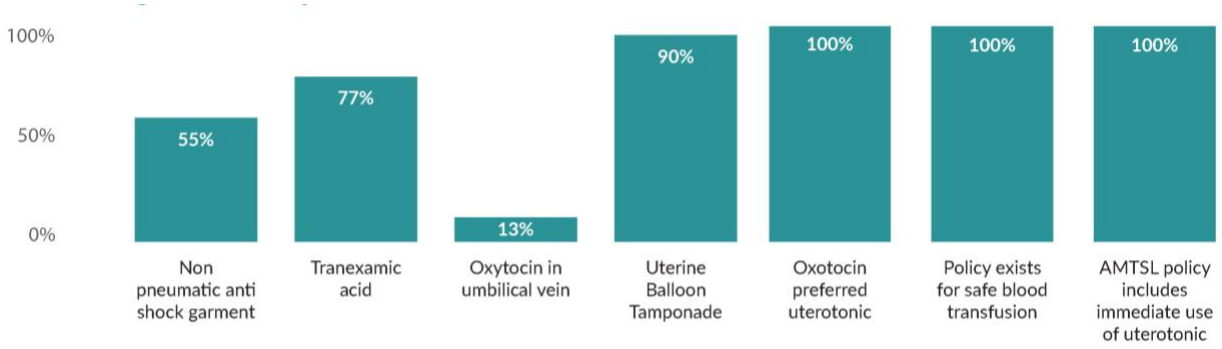
"Introducing TXA into the essential medication list will permit the updating of documents like the norms and protocols, training curricula, etc."

– Quote from the Africa region

"Introduce new technology [for prevention and treatment of PPH] (e.g., introduction of carbetocin, balloon tamponade, anti-shock garment and link up the private and public sectors in trainings/capacity building)."

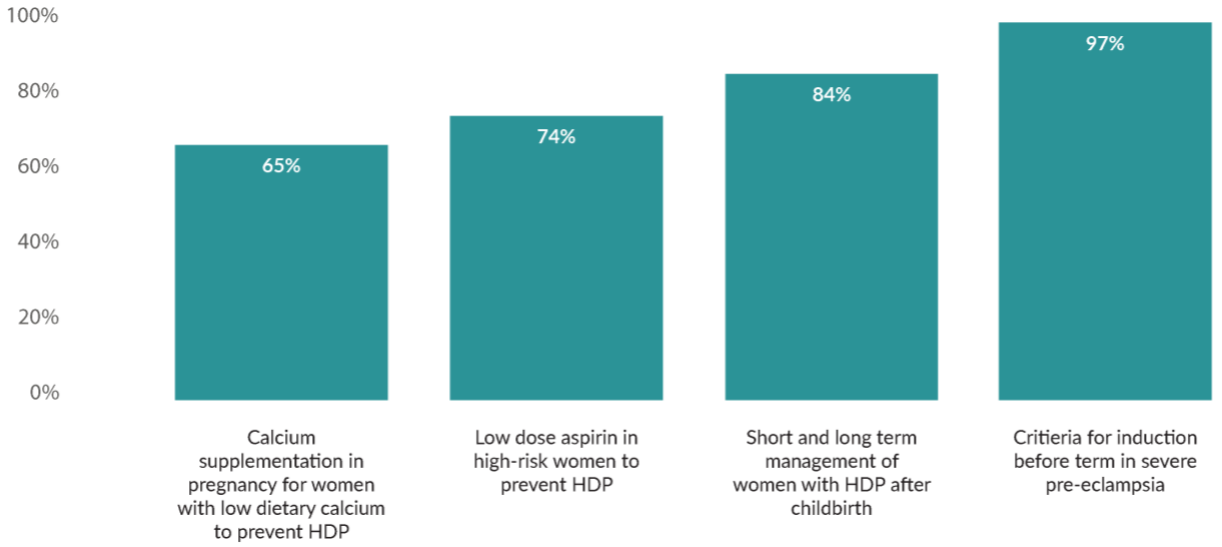
– Quote from the Africa region

FIGURE 7: PROPORTION OF COUNTRIES WITH THE NEW WHO GUIDANCE REFLECTED IN PPH NATIONAL GUIDELINES, 2022



National guidelines are reported to be updated to include criteria for induction of labor before term in women with severe PE/E in 97% of countries. More than half of countries reported national guidelines were updated to include the current WHO recommendations for short-and long-term management of women with HDP, preventive measures of giving low-dose aspirin during pregnancy for women with HDP risk factors, and calcium supplementation during pregnancy for women with low dietary calcium. The least frequent recommendation found to be included in guidelines was calcium supplementation, which was recommended by the WHO in 2018 (see Figure 8).[15]

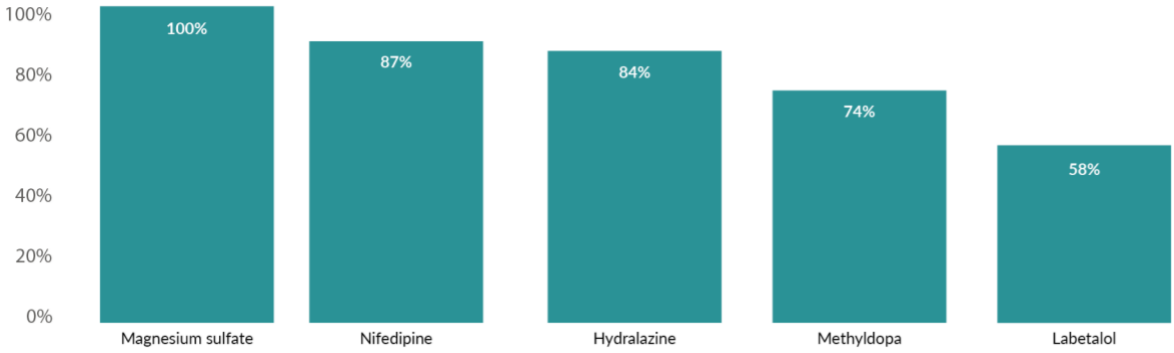
FIGURE 8: PROPORTION OF COUNTRIES WITH THE NEW WHO GUIDANCE REFLECTED IN HDP NATIONAL GUIDELINES, 2022



All countries reported MgSO4 was in the national guidelines as an anticonvulsant for severe PE/E, which is consistent with the 2011 and 2012 findings. This indicates a continued global commitment to the use of MgSO4 with HDP. Compared to the 2012 survey, a decline was noted in diazepam as a first-line anticonvulsant in national guidelines. For example, diazepam was reported as a first-line anticonvulsant by 68% of countries in 2012; it declined to 32% in the 2022 survey. This is possibly due to increased awareness of the superior efficacy of MgSO4 for the prevention of eclampsia compared to other anticonvulsants. All countries reported that at

least one antihypertensive drug was in the national guidelines for severe PE/E, with most countries averaging at least two of the medications in the national guidelines (see Figure 9).

FIGURE 9: PROPORTION OF COUNTRIES WITH THE NEW WHO GUIDANCE ON HDP DRUGS REFLECTED IN NATIONAL GUIDELINES, 2022



WHO recommends four antihypertensives (labetalol, hydralazine, methyldopa, and nifedipine) to treat severe PE/E. All countries reported that at least one of the recommended antihypertensive drugs was in their national guidelines in 2022. More countries reported to have included labetalol and methyldopa in their national guidelines since 2011. In 2011, 29% of countries reported labetalol in their national guidelines compared to 41% in 2012 and 58% in 2022. In 2011, 57% of countries reported methyldopa in their national guidelines, compared to 64% in 2012 and 74% in 2022. Given the primarily quantitative nature of this portion of the survey, the reason for increased inclusion of labetalol and methyldopa in the national guidelines was not captured (see Table 6).

TABLE 6: HDP DRUGS IN NATIONAL GUIDELINES, 2011–2022

● - Yes, x - No

Answers left blank were either not answered or country was not part of survey at the time to provide an answer.

	Labetalol			Hydralazine			Methyldopa			Nifedipine			Magnesium Sulfate		
	2011	2012	2022	2011	2012	2022	2011	2012	2022	2011	2012	2022	2011	2012	2022
Bangladesh	x	●	●	x	●	●	●	●	●	●	●	●	●	●	●
Burkina Faso			x			●			●			●			●
Burma			●			●			●			●			●
Colombia			●			●			x			●			●
Côte D'Ivoire			x			●			x			●			●
Dominican Republic			●			●			●			●			●
DRC	●	x	●	●	●	●	x	●	●	●	x	●	●	●	●
El Salvador		x	x		●	●		●	x		●	x		●	●
Ethiopia	x	x	x	●	●	●	●	●	x	●	●	x	●	●	●
Ghana	x	x	●	●	●	●	x	●	x	●	●	●	●	●	●
Guatemala	x	x	●	●	●	●	●	●	●	●	●	●	●	●	●
Guinea	x	●	x	●	●	●	x	x	●	●	●	●	●	●	●
Honduras	●	●	●	●	●	●	x	x	●	●	●	●	●	●	●
India	x	x	●	●	●	●	x	x	●	●	●	●	●	●	●
Indonesia	●	x	x	●	x	x	●	●	●	●	●	●	●	●	●
Kenya	x	●	●	●	●	●	●	x	●	●	●	●	●	●	●
Liberia	●	●	x	●	●	●	●	●	●	●	●	●	●	●	●
Madagascar	x	x	●	●	●	x	x	●	x	●	●	x	●	●	●
Malawi	x	x	●	●	●	●	x	x	●	●	x	●	●	●	●
Mali	x	x	x	x	●	x	●	●	●	●	●	●	●	●	●
Mozambique	x	x	●	●	●	●	x	●	●	●	●	●	●	●	●
Nepal	x	x	x	●	x	●	●	x	●	●	●	●	●	●	●
Nigeria	●	●	●	●	●	●	●	x	●	x	●	●	●	●	●
Pakistan		●	x		●	●		x	x		●	●		●	●
Paraguay	x	●	●	x	●	●	●	●	●	x	●	●	●	●	●
Peru			x	●	●	x			●			●			●
Sierra Leone			●			●			●			x			●
South Sudan	x	x	x	●	●	●	●	●	●	●	x	●	●	●	●
Uganda	x	●	x	●	●	●	x		x	x	●	●	●	●	●
Uruguay			●			x		●	●			●			●
Zambia	●		●	●		●	●		●	●		●	●		●
Total	**6/21**	**9/22**	**18/31**	**19/21**	**20/22**	**26/31**	**12/21**	**14/22**	**23/31**	**18/21**	**19/22**	**27/31**	**21/21**	**22/22**	**31/31**

PRIVATE AND PUBLIC SECTOR HIGHLIGHTS

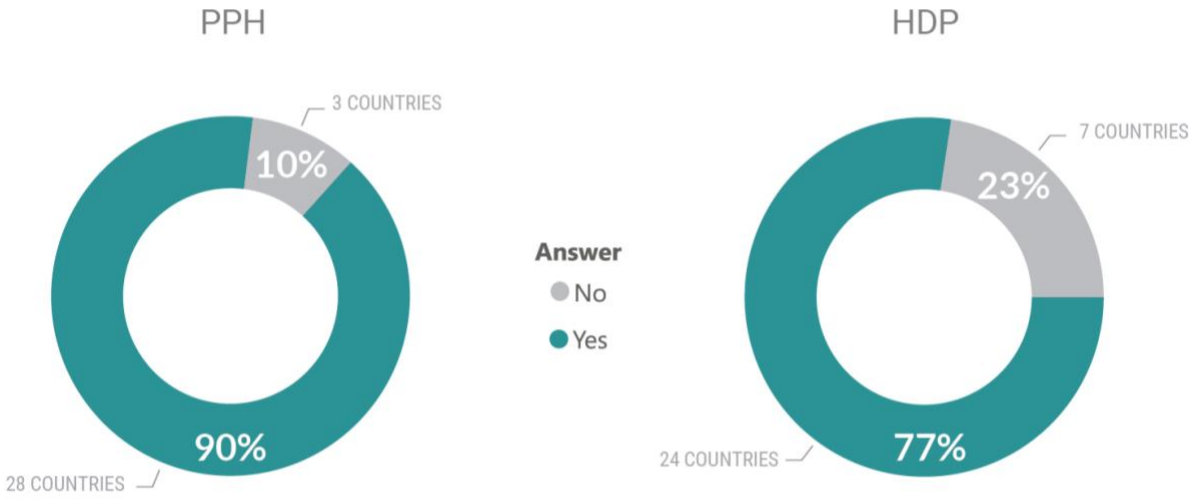
A majority of countries report that the private sector follows the national guidelines, with 90% of countries estimating private sector use of national guidelines for PPH and 77% of countries for HDP. Notable in the qualitative data from 2022, half of countries identified improving use of national guidelines in the private and public sector as an opportunity for public-private sector collaboration. Recurring themes in the qualitative data include difficulty monitoring the private sector's use of national guidelines and that national guideline use in the private sector can vary widely. The use by both sectors of the same national guidelines strongly benefits national programs aiming to reduce PPH and HDP; however, further investigation into verifying this data is needed (see Figure 10).

Illustrative quotes from two countries regarding private sector use of national guidelines:

> *"The private sector has different levels of care, does not always comply with national protocols, the health personnel do not always have the training or level of experience [needed] in complying with national protocols, and clinics do not always have the needed protocols."*
>
> **– Quote from the LAC region**

> *"There are private hospitals that have [national] protocols, but their application is not mandatory."*
>
> **– Quote from the LAC region**

FIGURE 10: NATIONAL GUIDELINES FOLLOWED IN THE PRIVATE SECTOR, 2022



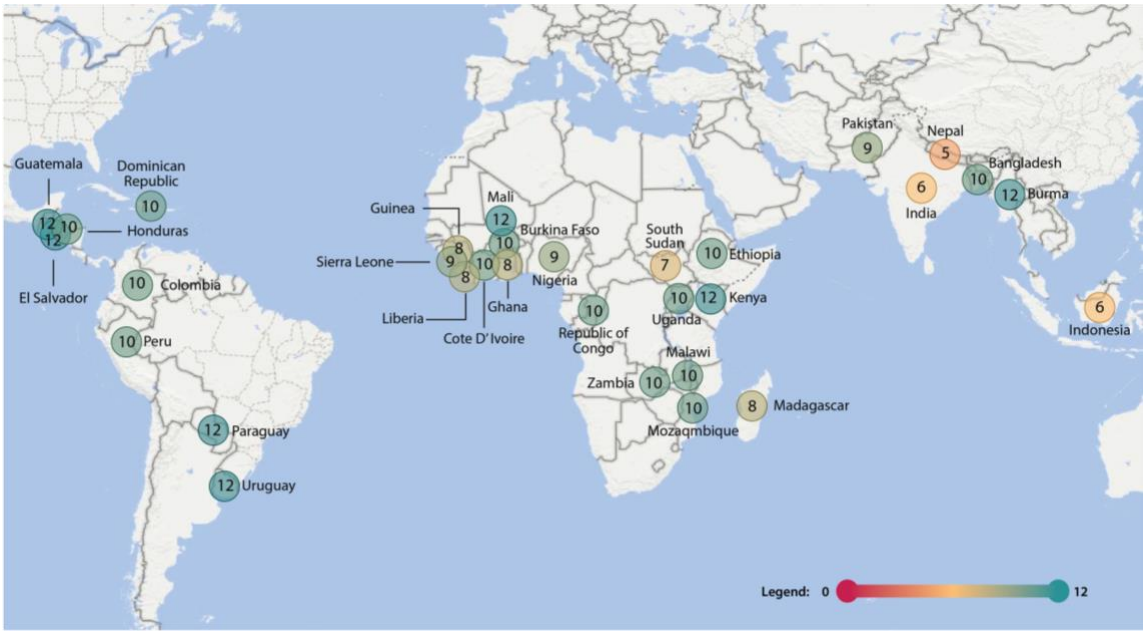
THEME 3: MEDICATION QUALITY AND PROCUREMENT POLICIES AT THE NATIONAL LEVEL

OVERVIEW OF MEDICATION QUALITY AND PROCUREMENT POLICIES

Quality and procurement policies at the national level look at policies for three PPH medications (oxytocin, misoprostol, and ergometrine) and systems to ensure an effective cold-chain for oxytocin and availability of a 50% solution of MgSO4. Since this theme is new in 2022, there is no comparison data from prior years. While

most countries reported procurement and distribution policies for oxytocin, misoprostol, and ergometrine, only 55% and 61% of countries reported public facilities and private facilities, respectively, have systems in place to ensure a controlled cold-chain for oxytocin. In addition, 71% and 58% of countries estimate public facilities and private facilities, respectively, have a system to ensure a 50% solution of MgSO4. The variation in composite scores reflects the low reporting of systems to ensure quality of drugs and the variance between the public and private sectors (see Figure 11).

FIGURE 11: OVERVIEW OF MEDICATION QUALITY AND PROCUREMENT POLICIES FOR PPH AND HDP, 2022



Note: The composite score for medication quality and procurement policies comprised 12 indicators including: whether national procurement and distribution policies exist for oxytocin, misoprostol, and ergometrine; whether systems exist to manage a controlled cold-chain for oxytocin and to ensure a 50% solution of MgSO4 in public and private facilities; and whether logistics systems exist to procure and distribute essential PPH and HDP drugs in the private sector. A higher score indicates policies exist for procurement and distribution and systems are in place for quality assurance of medications in the public and private sector. See Appendix B for the breakdown of composite score by country.

CURRENT AND TEMPORAL DATA HIGHLIGHTS

Nearly all countries reported having relevant national procurement (97% of countries) and national distribution, storage, and transportation (94% of countries) policies that assure quality products according to WHO qualifications or the relevant national authority for misoprostol and oxytocin. A total of 77% of countries report national procurement policies and national distribution, storage, and transportation policies for ergometrine (see Figure 12). Having an enabling policy environment to ensure quality of medications is key to supporting facilities to provide quality medications at the point of delivery to women. Ensuring quality medications at point of delivery warrants further inquiry. Understanding the challenges of tracking data on essential medication use and implementing quality assurance mechanisms to ensure adherence to clinical protocols may be important considerations to improve quality of medications at point of care. Some countries identified ensuring quality of oxytocin as a bottleneck for PPH programs in the qualitative data, as noted in the illustrative quotes below.

Illustrative quotes from two countries on concern for quality of medications at point of delivery:

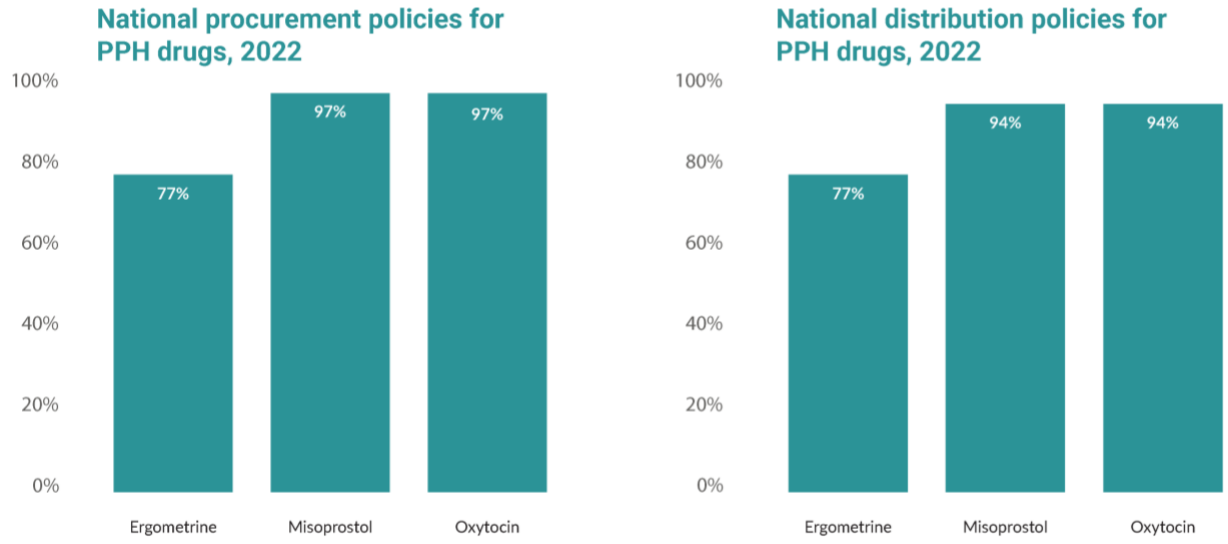
"They [oxytocin and misoprostol] are included in the national EML. There are two conditions to consider: the brand and quality, conservation and storage. The standards allow the acquisition of quality products; however, sometimes the lowest cost prevails for the acquisition processes."

– Quote from the LAC region

"Potency of oxytocin especially in public facilities is likely to be interrupted due to lack of knowledge on how to monitor temperature and challenges with availability of a working refrigerator with on and off electricity power."

– Quote from the Africa region

FIGURE 12: PROPORTION OF COUNTRIES REPORTING PROCUREMENT AND DISTRIBUTION POLICIES FOR UTEROTONICS, 2022



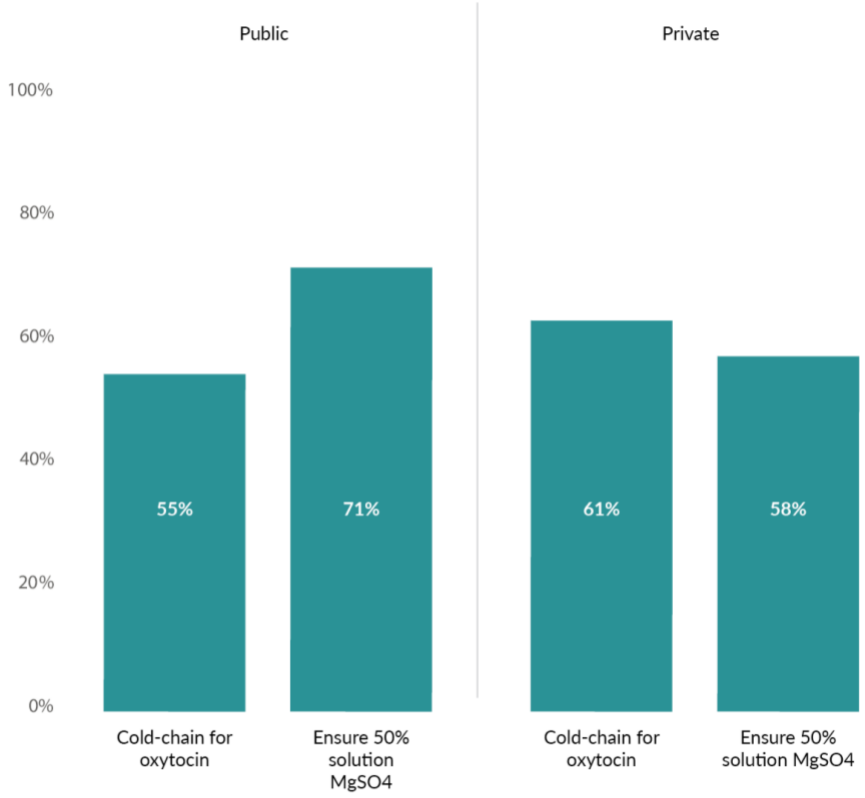
PRIVATE AND PUBLIC SECTOR HIGHLIGHTS

Approximately 77% of countries surveyed report a logistics management system independent of the national procurement system for the private sector to procure essential PPH and HDP medications. Ninety-seven percent of countries report PPH and HDP commodities are sourced from local wholesalers, with some medications procured free from the government (approximately 16% of countries for PPH and 13% for HDP) and donors (approximately 32% of countries for PPH and 23% for HDP). Having different procurement systems for the public and private sector could contribute to sub-optimal quality assurance of medications and commodities.

Ensuring an adequate cold-chain storage for oxytocin—from the point of manufacture to the point of delivery to a woman at the time of childbirth—is key to appropriate and timely management of PPH. Unfortunately, only 55% of countries report public facilities and 61% of countries report private facilities maintain a

controlled cold-chain for oxytocin. For oxytocin to remain effective, a controlled cold-chain is critical and tailoring the procurement and distribution procedures to assure an optimal cold-chain is vital. In addition, ensuring a 50% solution of MgSO4 is key to having the therapeutic anticonvulsant effect while mitigating magnesium toxicity; 71% of countries estimated public facilities and 58% estimated private facilities have a system in place to ensure a correct solution of MgSO4 available to maternity facilities. These findings indicate the need to address quality assurance of medications along the whole procurement and distribution pathway to point of delivery (see Figure 13).

FIGURE 13: PROPORTION OF COUNTRIES ESTIMATING QUALITY ASSURANCE SYSTEMS FOR DRUGS IN THE PUBLIC AND PRIVATE SECTORS, 2022

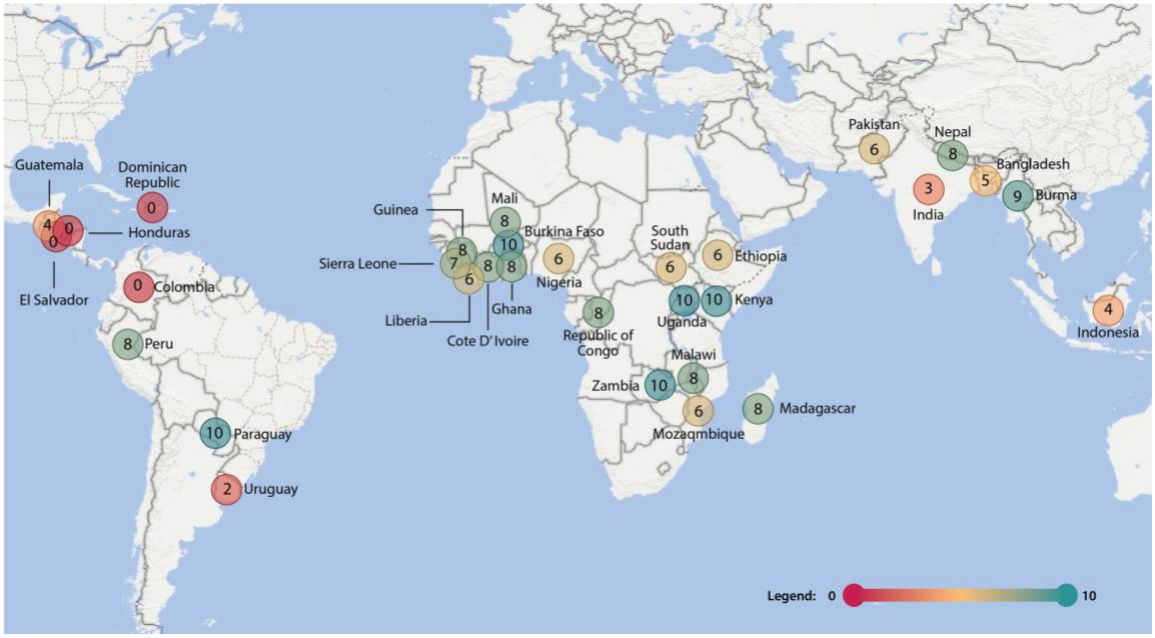


THEME 4: MIDWIFE SCOPE OF PRACTICE

OVERVIEW OF MIDWIFE SCOPE OF PRACTICE

This theme examines the scope of practice of formally trained midwives. There are significant regional differences noted as some LAC countries report they do not have a formally trained midwife cadre, although both Guatemala and the Dominican Republic report a midwife cadre is in development in their countries. This theme looks at the integration of a few key global updates for PPH management into the scope of practice of midwives, including use of TXA, use of UBT, application/removal of a NASG, manual removal of placenta (MRP), and the authority to diagnose severe PE/E and give the first loading dose of MgSO4. A wide range of composite scores is noted in the scope of midwifery practice. Lower composite scores are noted for countries without a formally trained midwife cadre; countries report that the private sector in general has significantly fewer PPH interventions included in midwives' scope of practice. Further research is needed to understand why private sector midwives might have a reduced scope compared to public sector midwives (see Figure 14).

FIGURE 14: OVERVIEW OF MIDWIFE SCOPE OF PRACTICE FOR PPH AND HDP, 2022



Note: Composite score for midwife scope of practice consists of 10 indicators, including performing essential PPH interventions, such as giving TXA, using UBT, applying and removing NASG, and MRP—in the public and private sectors; performing essential PE/E interventions, such as diagnosing severe PE/E and giving the initial dose of MgSO4—in the public and private sectors. A higher score indicates a broader midwife scope of practice across the public and private sectors. See Appendix B for the breakdown of composite score by country.

CURRENT AND TEMPORAL DATA HIGHLIGHTS

There is global support for midwives' scope of practice to include providing services needed to reduce the main causes of maternal mortality, as described in the essential competencies for midwifery practice by the International Confederation of Midwives.[16] This survey compared two components of essential competencies for midwives from 2011 to 2022, including MRP for PPH, and diagnosing severe PE/E, and giving the first loading dose of MgSO4.

The scope of practice for midwives that includes MRP, diagnosing severe PE/E, and giving MgSO4 did not change significantly from 2011 and 2012. In 2011, 76% of countries reported midwives' scope included MRP; in 2012, this number was 64%, and in 2022, this number was 77%. Diagnosing severe PE/E and giving the first loading dose of MgSO4 was reported as part of their scope by 86% of countries in 2011, by 77% in 2012, and by 81% in 2022 (see Table 7). It is unclear as to why the scope of midwives' practice has not improved more over the last decade. The modest improvement from 2011 to 2022 could be attributed to the changes in countries included in the survey between years and that the 2022 survey includes more countries that do not have a formally trained midwife cadre. Continuing to advocate for midwives to be educated with the skills needed, and authorized, to practice their full scope is important in implementing national-level strategies to reduce maternal mortality from PPH and HDP.

Regional differences between Asia, Africa, and LAC are most pronounced in comparing the midwife scope of practice with 2011, 2012, and 2022 data, with Asia and Africa having the least restrictive scopes of practice and LAC with the most restrictive scope for midwives (see Table 7).

TABLE 7: MIDWIFE SCOPE OF PRACTICE, 2011–2022

● - Yes, x - No

Answers left blank were either not answered or country was not part of survey at the time to provide an answer.

	Public sector midwives' scope includes manual removal of placenta 2011-2022			Public sector midwives' scope includes diagnosing PE/E and giving initial dose MgSO4 2011-2022		
	2011	2012	2022	2011	2012	2022
Bangladesh	x	x	●	●	●	●
Burkina Faso			●			●
Burma			●			●
Colombia			x			x
Côte D'Ivoire			●			●
Dominican Republic			x			x
DRC	●	●	●	x	●	●
El Salvador		x	x	x	●	x
Ethiopia	x	●	●	x	●	●
Ghana	●	●	●	●	●	●
Guatemala	●	x	●	x	x	●
Guinea	●	●	●	●	●	●
Honduras	●	x	x	●	x	x
India	x	x	x	●	●	●
Indonesia	●	x	x	●	●	x
Kenya	●	●	●	●	●	●
Liberia	●	●	●	●	●	●
Madagascar	●	●	●	●	●	●
Malawi	●	●	●	●	●	●
Mali	●	●	●	●	x	●
Mozambique	●	●	●	●	●	●
Nepal	x	●	●	●	●	●
Nigeria	●	●	●	●	●	●
Pakistan		x	●		x	x
Paraguay	●	●	●	●	●	●
Peru			●			●
Sierra Leone			●			●
South Sudan	x	x	●	●	x	●
Uganda	●	●	●	●	●	●
Uruguay			x			●
Zambia	●		●	●		●
Total	**16/21**	**14/22**	**24/31**	**18/21**	**17/22**	**25/31**

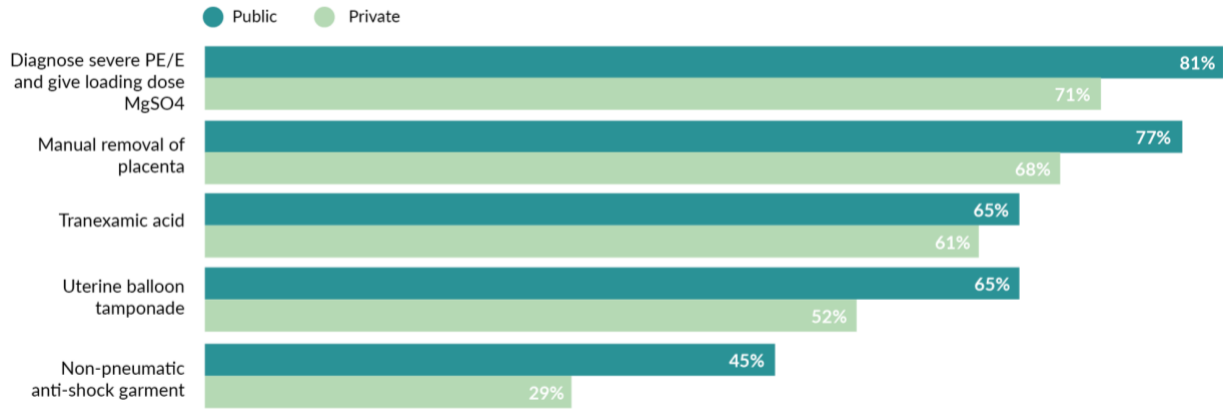
PUBLIC AND PRIVATE SECTOR HIGHLIGHTS

The scope of practice for midwives in the public and private sector is variable, with private sector midwives' scope more restrictive than the public sector. For many countries, both public and private sector midwives' scope were reported to include diagnosing severe PE/E, giving the first loading dose of MgSO4 (included in public sector midwives' scope by 81% of countries and included in private sector midwives' scope by 71% of countries), and MRP (77% of countries report MRP in public sector midwives' scope and 68% report MRP is in private sector midwives' scope). The more recent global guidelines for PPH treatments, such as the use of TXA, UBT, and the NASG, were reported to be included in the scope of practice for midwives in a number of countries. Across the countries surveyed, 65% of countries report TXA was included in a public sector midwife's scope, 65% included UBT, and 45% included NASG. In the private sector, these numbers were lower with 61% of countries reporting TXA in private sector midwives' scope, 52% included UBT, and 29% included NASG (see Figure 15). The reasons for the differences in midwives' scope between public and private sector remains unclear. Qualitative data does reflect a possible gap in training.

Illustrative quote highlighting possible difference in public and private sector midwife scope of practice from one country:

> *"Uterine balloon tamponade and applying the anti-shock garment are part of competencies of midwives but are not routinely practiced in private sector facilities because of lack of training."*
>
> **– Quote from the Africa region**

FIGURE 15: MIDWIFE SCOPE OF PRACTICE IN PUBLIC AND PRIVATE SECTORS 2022



THEME 5: CAPACITY BUILDING AND TRAINING IN GLOBAL BEST PRACTICES

OVERVIEW OF CAPACITY BUILDING

Capacity building and training in global best practices look at whether curricula are updated to current WHO recommendations on PPH and HDP for pre-service education and in-service training in both public and private institutions. Countries' composite scores ranged from 18–40, with lower scores attributed to fewer updates in the curricula, especially in the private sector (see Figure 16).

Overall, several global best practices, as noted below, were reported as integrated into pre-service education and in-service training in many countries in both public and private institutions. For instance, at least 97% of countries reported best practices integrated into public institutions' pre- and in-service curricula included: quality-assured oxytocin as first-line uterotonic, updated AMTSL, and MgSO4 as first-line anticonvulsant for severe PE/E and management of severe hypertension in pregnancy. The same updates were reported by at least 94% of countries for private institutions' pre-service curricula and by at least 84% of countries for private institutions' in-service curricula. The global best practice least likely to be in pre- and in-service curricula was umbilical vein injection of oxytocin for management of retained placenta as a PPH treatment, which is only recommended under conditions of rigorous research (see Figures 17 and 18).

Countries reported that private institutions had similar scoring patterns as public institutions in pre- and in-service curricula, but countries overall reported that fewer global best practices for PPH and HDP are integrated into the private sectors' pre-service curricula and in-service curricula compared to the public sector. Further examination of training curricula of public and private sector institutions is needed to assess and identify specific gaps. Renewed emphasis on updating pre-service and in-service curricula with evaluation of training and education may help to assure that students acquire the knowledge and skills they need. A recurring theme in the qualitative data is the need for improvements in pre-service education and in-service training. In fact, 87% of countries surveyed identified improvements in pre-service education and in-service training as opportunities for public and private institutions to work together, and 100% of countries named the need for capacity building of health workers as a bottleneck to both PPH and HDP national programs.

Illustrative examples from two countries on strengthening capacity building:

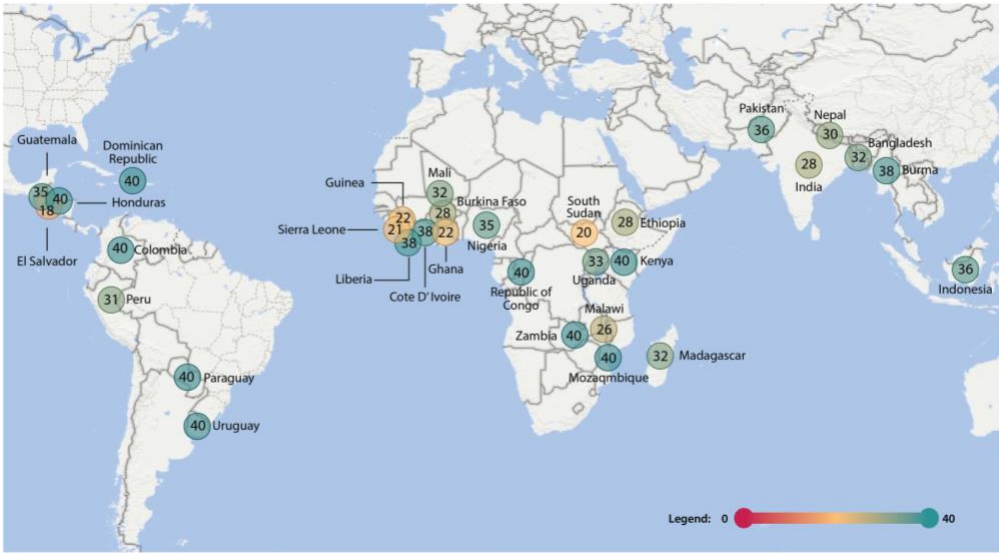
"Improve teaching in pre-service education, find opportunities to mentor providers, reinforce quality improvement in both public and private sectors, actively disseminate up-to-date national directives in both public and private sectors."

– Quote from the Africa region

"Introduction of new technology [for prevention and treatment of PPH] (e.g., introduction of carbetocin, balloon tamponade, anti-shock garment) by linking up the private and public sectors in trainings and capacity building."

– Quote from the Africa region

FIGURE 16: OVERVIEW OF CAPACITY BUILDING FOR PPH AND HDP, 2022



Note: Composite score for capacity building and training in global best practices for PPH and HDP includes 40 indicators: pre-service and in-service curricula in public and private institutions updated to include oxytocin as the preferred uterotonic; UBT, TXA, and NASG for PPH treatments; updated AMTSL; and practice guidance for non-severe hypertension, severe hypertension, anticonvulsant, prevention of PE/E with low-dose aspirin, and calcium supplementation during pregnancy for at-risk groups. A higher score indicates more global best practices are integrated into the pre- and in-service curricula. See Appendix B for the breakdown of composite score by country.

CURRENT DATA HIGHLIGHTS/PUBLIC AND PRIVATE SECTOR HIGHLIGHTS

Both pre-service and in-service curricula follow similar patterns in the data, with public institutions reported to have slightly higher rates of curricula updates than private institutions. All countries estimated that 100% of public institutions were using updated global guidelines for quality-assured oxytocin as first-line uterotonic, AMTSL, and MgSO4 as first-line anticonvulsant for PE/E and management of severe hypertension in pregnancy. The least common update reported to be integrated into pre-service and in-service curricula for public and private institutions is umbilical vein injection of oxytocin for treatment of retained placenta, which is only recommended in settings of rigorous research per WHO and is understandably not as readily included in the updates. Improvement is needed in updating public and private institutions' curricula to include preventive guidance for HDP with low-dose aspirin for women at high-risk for HDP and calcium supplementation in populations with low dietary calcium intake.[17, 18] In addition, improvement is needed in updating curricula on appropriate use of NASG and TXA for treatment of PPH in both public and private training institutions. Sixty-eight percent of countries reported that private training institutions included in-service training for UBT to treat PPH versus 87% of countries that reported public sector's inclusion of UBT in in-service training. Interestingly, several countries reported public and private institutions were more aligned on this component in pre-service education, with 81% of countries' public institutions and 77% of countries' private institutions including UBT in curricula (see Figures 17 and 18).

FIGURE 17: PROPORTION OF COUNTRIES REPORTING PRE-SERVICE CURRICULA UPDATED TO GLOBAL PRINCIPLES, 2022

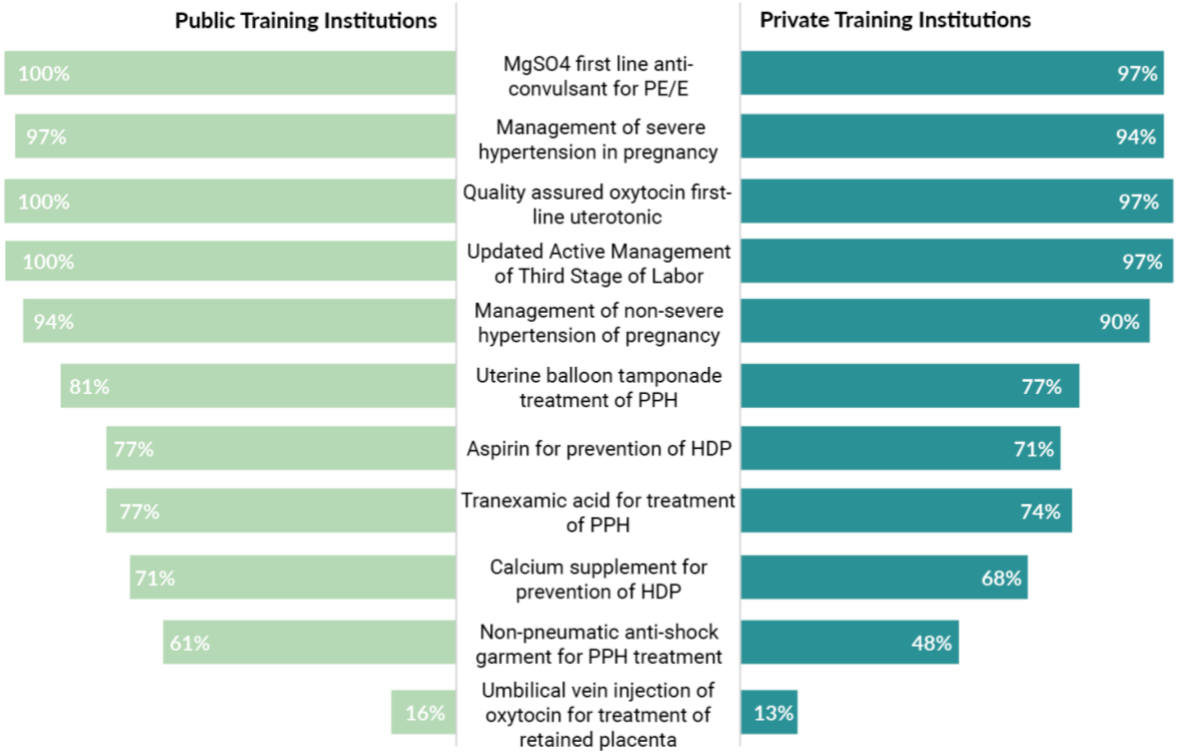
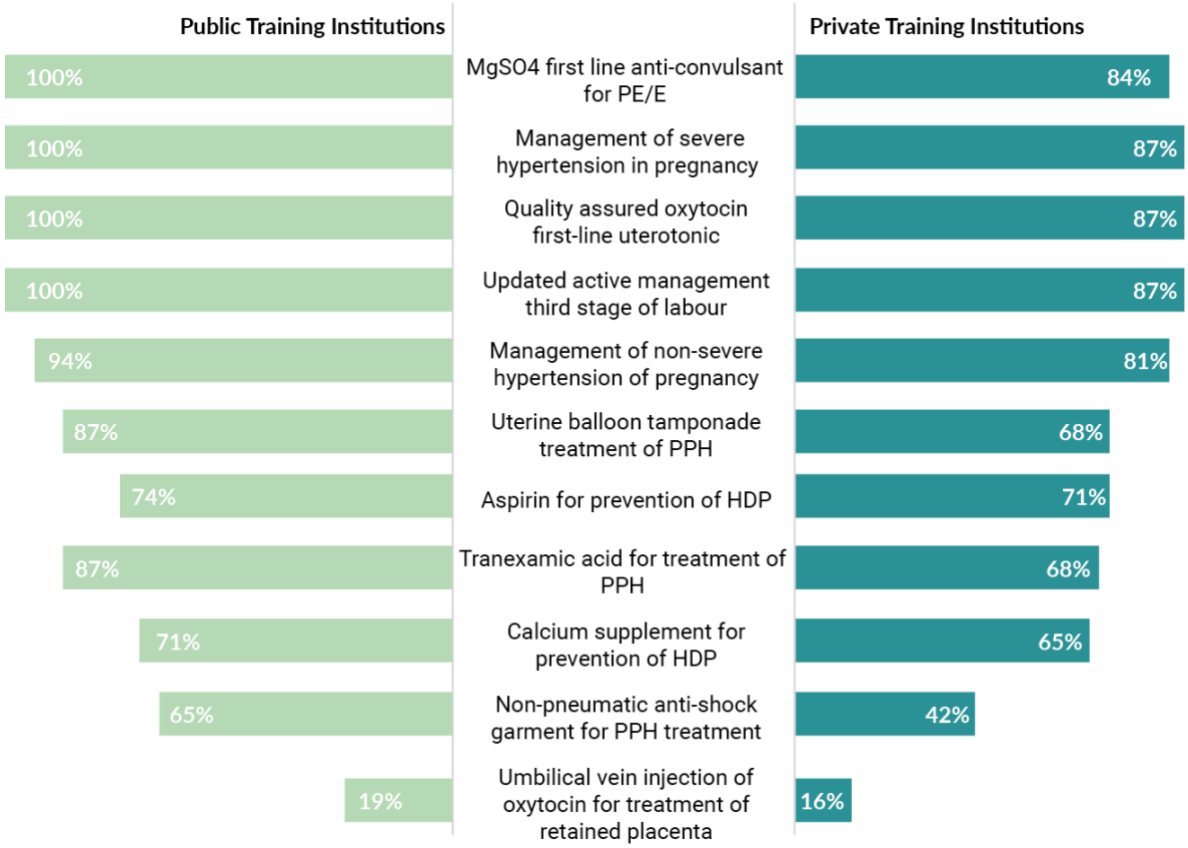


FIGURE 18: PROPORTION OF COUNTRIES REPORTING IN-SERVICE CURRICULA UPDATED TO GLOBAL PRINCIPLES, 2022



THEME 6: NATIONAL REPORTING ON SELECT MNH INDICATORS

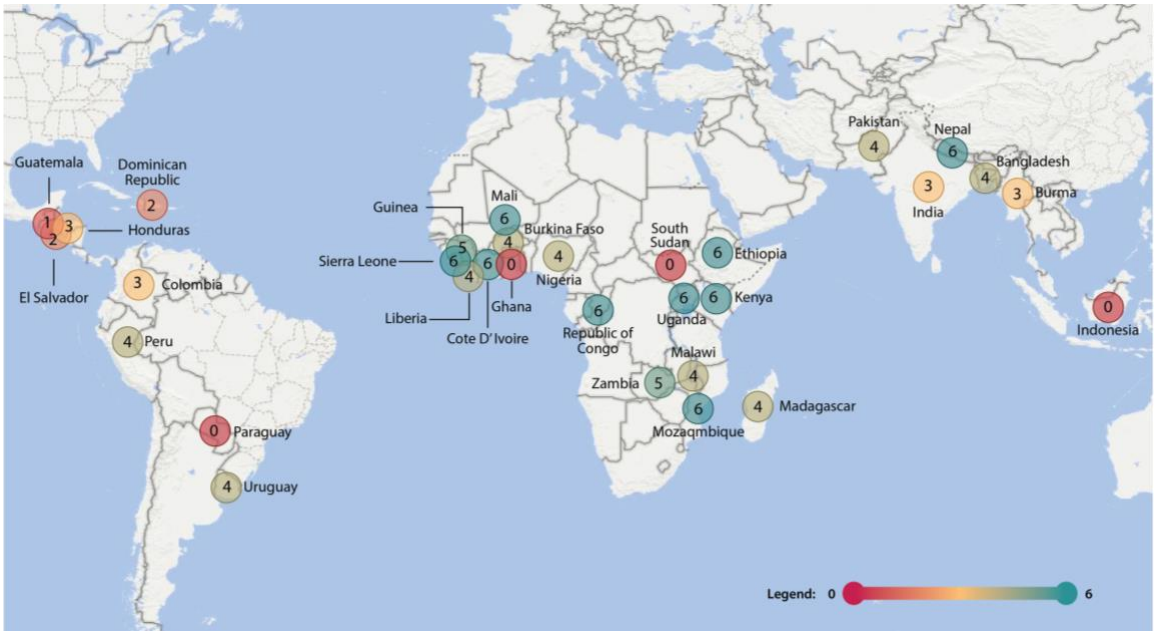
OVERVIEW OF NATIONAL REPORTING

The theme for national reporting on select MNH indicators notes whether an indicator for PPH and HDP is included in the health management information system (HMIS), whether the private sector reports on a PPH and HDP indicator in the HMIS, and whether national accountability measures exist to link reporting of the national HMIS indicator to implementation of the policy and guidelines for PPH and HDP management at the facility level. Composite scores ranged from 0–6 across countries. The region with the highest composite score for reporting on MNH indicators is Africa. Lower composite scores corresponded with less reporting from the private sector and less reported national accountability mechanisms linking HMIS reporting to policies at the facility level (see Figure 19).

The 2022 survey inquired about two indicators, one for PPH (i.e., use of a uterotonic immediately after birth for PPH prevention) and one for HDP (i.e., the number of women with severe PE/E). Seventy-four percent of countries reported including an indicator to measure use of a uterotonic immediately after birth for PPH prevention in their HMIS and 87% of countries reported including an indicator to measure the number of women with severe PE/E. Additional verification of HMIS data was not conducted. Private sector figures were lower for the same indicators, with 45% of countries estimating the private sector reports on the PPH indicator in the HMIS and 52% of countries estimating that the private sector reports on the HDP indicator in the HMIS. More than half of countries estimated a national-level accountability mechanism linking reporting

of an HMIS indicator to implementation of the national policy and guidelines at facility level for both PPH (65% of countries) and HDP (55% of countries). Improving all sector reporting in the HMIS, especially from the private sector, as well as improving accountability mechanisms for HMIS reporting, will enhance the quality and accuracy of data captured at facility level to better inform national programs. In addition, using an indicator that reflects treatment and management for PE/E could be more instructive than an indicator reflecting diagnosis alone.

FIGURE 19: OVERVIEW OF NATIONAL REPORTING FOR PPH AND HDP, 2022



Note: Composite scores for national reporting on select MNH indicators encompasses six components: tracking whether a uterotonic is given; number of women with severe PE/E in the HMIS; whether private sector reports those same indicators (uterotonic given and number of women with severe PE/E) in the HMIS; and whether national accountability mechanisms exist to link HMIS reporting to policies at facility level. A higher score indicates the PPH and HDP indicators are in the HMIS, the private sector reports in the HMIS, and there are national accountability mechanisms. See Appendix B for the breakdown of composite score by country.

CURRENT DATA HIGHLIGHTS/PRIVATE AND PUBLIC SECTOR HIGHLIGHTS

National reporting of indicators for PPH and HDP in the HMIS has improved over the last 10 years; in 2022, 74% of countries reported that they tracked use of a uterotonic after birth and 87% tracked the number of women with severe PE/E in the HMIS—as compared with 43% and 51%, respectively, in 2012. The private sector is reported to provide less data entry into the HMIS than the public sector, but nearly half of all countries reported that data from the private sector is reported in the HMIS for the PPH and HDP indicator (see Figure 20). More than half of countries reported data collection and monitoring and evaluation (M&E) as bottlenecks in the 2022 qualitative data, as noted in the illustrative quotes below.

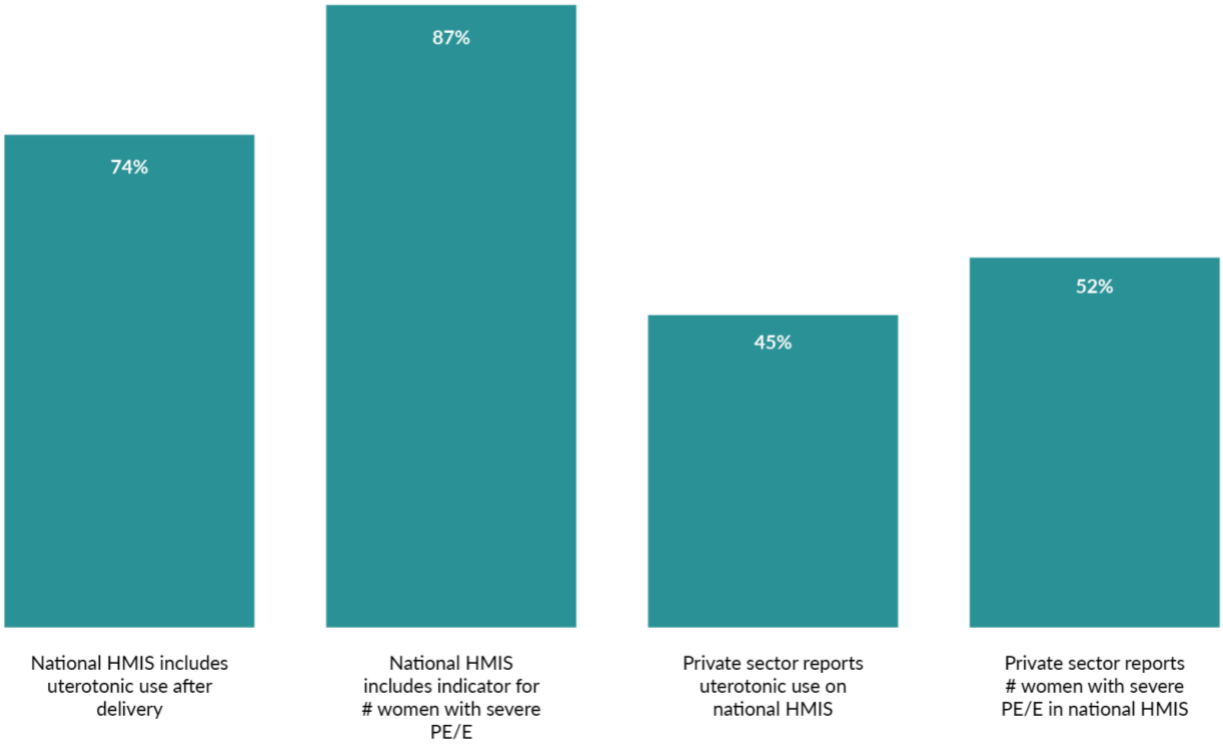
Illustrative examples from three countries regarding concern for data collection and M&E in PPH and HDP national programs:

> *"Need to strengthen monitoring, which is linked to insufficient financing."*
>
> **– Quote from the LAC region**

> *"Regular mentoring and supervision should be improved."*
>
> **– Quote from the Africa region**

> *"Scale-up private sector reporting to HMIS."*
>
> **– Quote from the Africa region**

FIGURE 20: PROPORTION OF COUNTRIES REPORTING PPH AND HDP INDICATORS IN HMIS FOR PUBLIC AND PRIVATE SECTOR, 2022



THEME 7: BOTTLENECKS AND SCALE-UP OPPORTUNITIES

Responses to qualitative questions on opportunities and challenges for scale-up raise recurrent bottlenecks such as: 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 MNH skilled workers, inadequate commodities, lack of public-private partnerships, need for improved data collection and data review systems, geographical challenges, and need for improved referral systems. Two recurring areas of focus emerged in the analysis: 1) public and private sector collaboration; and 2) quality assurance of commodities and quality-improvement approaches in clinical practices.

PUBLIC AND PRIVATE SECTOR COLLABORATION

Public and private sector collaboration is a recurring theme throughout all sections of the survey and across all countries surveyed. Four key considerations emerged regarding bottlenecks, and potential scale-up, of public and private sector collaboration. These include: 1) improving systems to ensure public and private sector use of the same treatment guidelines; 2) improving referral systems within and between public and private sectors; 3) building capacity and training providers in the public and private sectors; and 4) strengthening M&E systems within both sectors.

A need to **improve systems** to ensure that the public and private sectors adhere to national guidelines is reflected in the qualitative data for nearly all countries. While some countries reported both sectors used the national guidelines, several countries reported that the extent to which the private sector adheres to the national guidelines is not well known. For countries citing that the private sector was not using the national guidelines, reasons included: use of the national guidelines in the private sector was not mandatory, no regulation of the private sector to confirm use, lack of access of the private sector to in-service training that promotes use of the national guidelines, and lack of awareness by the private sector of the national guidelines.

Countries that reported both sectors were using national guidelines offer insight into how to scale-up use of guidelines, namely by having professional associations disseminate them to both sectors and ensuring MOH oversight of both public and private sector sensitization and implementation of guidelines.

Illustrative quotes from two countries where private and public sector use the national guidelines:

"The standard [of the national guidelines] is from the professional organization, and applied to both [public and private] sectors."

– Quote from the South/ Southeast Asia region

"The Ministry of Health and Social Welfare provides training in national regulations to the private sector. Adherence to the national guidelines issued by the MOH is mandatory."

– Quote from the LAC region

The importance of **improving the referral system** within and between public and private sectors is reflected in several countries' qualitative data; one-third of countries identified referral systems as a bottleneck to their PPH and HDP programs. The consequence of inadequate referral systems most mentioned is delay in appropriate and timely care. Further investigation is needed into where these bottlenecks occur, such as between primary and secondary levels of care or referrals between the private to public facilities. Notable examples in the qualitative data include insufficient recognition of risk during antenatal care, transport logistics such as poor roads, not enough functional ambulances, and weak referral networks. Suggestions for scale-up of referral systems noted in the data include building an affordable and sustainable referral system and creating frameworks to promote collaboration between the public and private sectors.

Illustrative quotes from three countries on opportunities for improving referral systems:

"[There is] a weak referral system, there needs to be an affordable and sustainable referral system."

– Quote from the Africa region

"There is a Public-Private Partnership for Health framework that promotes collaboration between the private and public sectors."

– Quote from the Africa region

"Create a care network for referral."

– Quote from the Africa region

Capacity building and training on the PPH and HDP updated global guidelines is identified as a potential opportunity for public and private sector collaboration by most countries in the qualitative data. Common themes for scale-up of capacity building and training on the updated PPH and HDP global guidelines across several countries include: providing in-service training to both public- and private-sector providers simultaneously, involving the private sector in curricula updates and policy/guidelines updates, and coordinating and supervising dissemination of global updates to reach both public and private sectors. Multi-faceted approaches to strengthening capacity building were described by two countries below.

Illustrative quotes from two countries on enhancing capacity building and training:

"Introduction of evidence-based practices in medical colleges, which would enhance quality of services of graduates, more skills-based management, mentoring and coaching, and [introducing] innovations and expansion of innovations (NASG, condom tamponade) manufacturing through private sector."

– Quote from the South/ Southeast Asia region

"Disseminate updated policies to all [public and private] sector, orientation of staff in in-service, pre- service and tutors on updated guidelines, review curriculum with the regulatory body of nursing and midwifery. To consider extending service level agreement facilities on maternity services, especially to do with PPH management and prevention."

– Quote from the LAC region

The need to **strengthen M&E systems** was mentioned as a bottleneck by some countries surveyed. The qualitative data indicates the bottleneck was influenced by a lack of accountability in data reporting, slow updating processes for regulatory frameworks, and insufficient financing for M&E systems. Regular data review and maternal death audits are identified by nearly all countries as opportunities for public and private sector collaboration. Building on interest for public and private sector collaboration in these areas is an opportunity that could impact national M&E systems broadly. Improvements to M&E systems suggested in the data include systems of accountability at all levels of the health system, supervision for all sectors, and policies that prioritize regulatory frameworks for MNH programs.

Illustrative quotes from three countries regarding improvements for M&E systems:

"[Need] accountability, monitoring, evaluation and supervision by the MOH to providers of maternal and neonatal services [public and private sectors]."

– Quote from the LAC region

"Increase supervision on authorization of private centers in obstetrics and neonatal care."

– Quote from the LAC region

"There is a Healthy Motherhood law that regulates priority actions for the prevention of a maternal death; a legal framework for the health system as a regulatory mechanism."

– Quote from the LAC region

QUALITY ASSURANCE/IMPROVEMENT IN COMMODITIES AND PRACTICES

The second area of focus noted in the survey's qualitative data was quality assurance of commodities and quality-improvement processes through enhanced use of data for decision-making to improve clinical practices. This requires adoption of approaches using a broad combination of tools, techniques, and processes reflective of qualitative and quantitative pathways that will enable health workers to take the right decisions based on their individual contexts. These approaches can range from adaptive management techniques, such as after-action reviews, pause and reflect, and facility-based quality-improvement teams that focus on data management and utilization.

The three key considerations that emerged under this area were: 1) improving quality of care available at facilities; 2) assuring quality control of medications; and 3) strengthening the policy environment that enables quality assurance/improvement of commodities and practices.

Improving the quality of care available at health facilities is a recurring issue noted in the qualitative bottleneck data, specifically regarding adequately trained MNH skilled personnel and facilities having sufficient commodities and supplies to perform timely PPH and HDP interventions. Capacity of MNH skilled personnel is cited as a bottleneck by 71% of countries surveyed. Contributing factors to this barrier described

by some countries were a lack of supervision after training, need for competency-based training in pre- and in-service education, and delays in disseminating global updates into practice. Insufficient commodities and supplies to perform adequate PPH and HDP interventions at the point of delivery was cited by 58% of countries as a bottleneck for PPH and HDP national programs. Examples of inadequate commodities include a lack of blood and blood products and unreliable availability of essential medications. Concepts to consider for scale-up reflected in the qualitative data include: quality-improvement-focused coaching, mentorship, and training; improved service models at health facilities; skills-based training; and tele-communication networks between facilities.

Illustrative quotes from four countries on considerations for scaling up quality of care available at facilities:

"Scale-up ongoing QI [quality improvement] coaching, mentorship, supervision, and training."

– Quote from the Africa region

"Reinforce the capacity of training, supervisory personnel, equipment, and organization of services at the health facilities."

– Quote from the LAC region

"Education program standardization with on-site simulation and creation of tele-assistance networks between hospitals."

– Quote from the LAC region

"Address stock-outs of HDP commodities [due to low budgetary allocation]."

– Quote from the Africa region

Quality control of medications was reflected in the qualitative data as an improvement gap for some countries. Thirteen percent of countries reported this as a bottleneck for PPH and HDP national programs; the countries commented that, for quality control of medications, the need to manage oxytocin with a coldchain system and the lack of availability of 50% solution of MgSO4 impacts service delivery.

Scale-up considerations generated in the data mentioned increasing budget allocation for medications such as MgSO4, improving the cold-chain of oxytocin, and introducing HSC into national policy as an additional effective prevention tool for PPH where cold-chain of oxytocin cannot be guaranteed.

Illustrative quotes from three countries on considerations for scaling-up quality control of medications:

"Collaborate with the national vaccine program for joint utilization of refrigerators. Furnish solar fridges to health facilities to maintain the oxytocin cold-chain and use cold boxes to store oxytocin in the delivery room."

– Quote from the Africa region

"Increase the budget allocation for supplies for maternal and newborn health and make MgSO4 freely available at all facilities."

– Quote from the Africa region

"[Due to] the challenge of storing oxytocin in health facilities and the non-availability of TXA, introduce heat-stable carbetocin into the national policy for PPH [prevention]."

– Quote from the Africa region

The policy environment's impact on enabling quality assurance measures in commodities and quality-improvement processes in clinical practices was mentioned by 38% of countries surveyed. Some of the countries elaborated on the following barriers related to this issue: a lack of national strategy; a lack of policy for essential medicines; a need to align national policies with national guidelines; and a need to reinforce use of guidelines at the point of care.

Illustrative quotes from three countries for potential improvements to policy enabling quality assurance measures:

"[Provide] clarity on management protocols irrespective of existing service delivery guidelines."

– Quote from the South/Southeast Asia region

"Revisit the policy of free maternity care in the framework of implementation of health insurance."

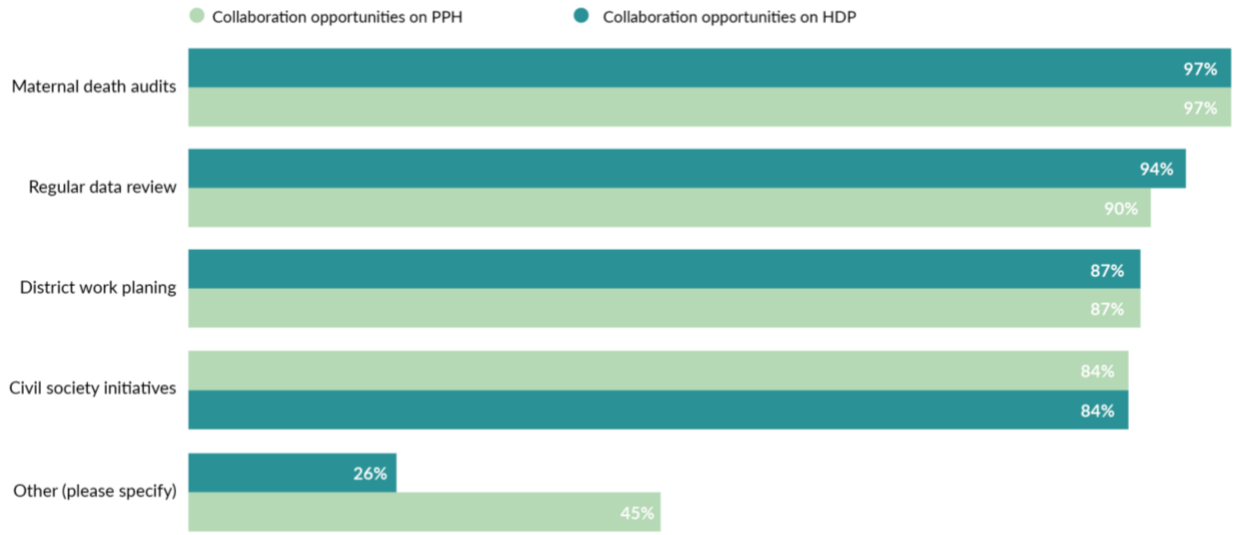
– Quote from the Africa region

"Involve decision-makers in following up on the strategies for the prevention of HDP."

– Quote from the LAC region

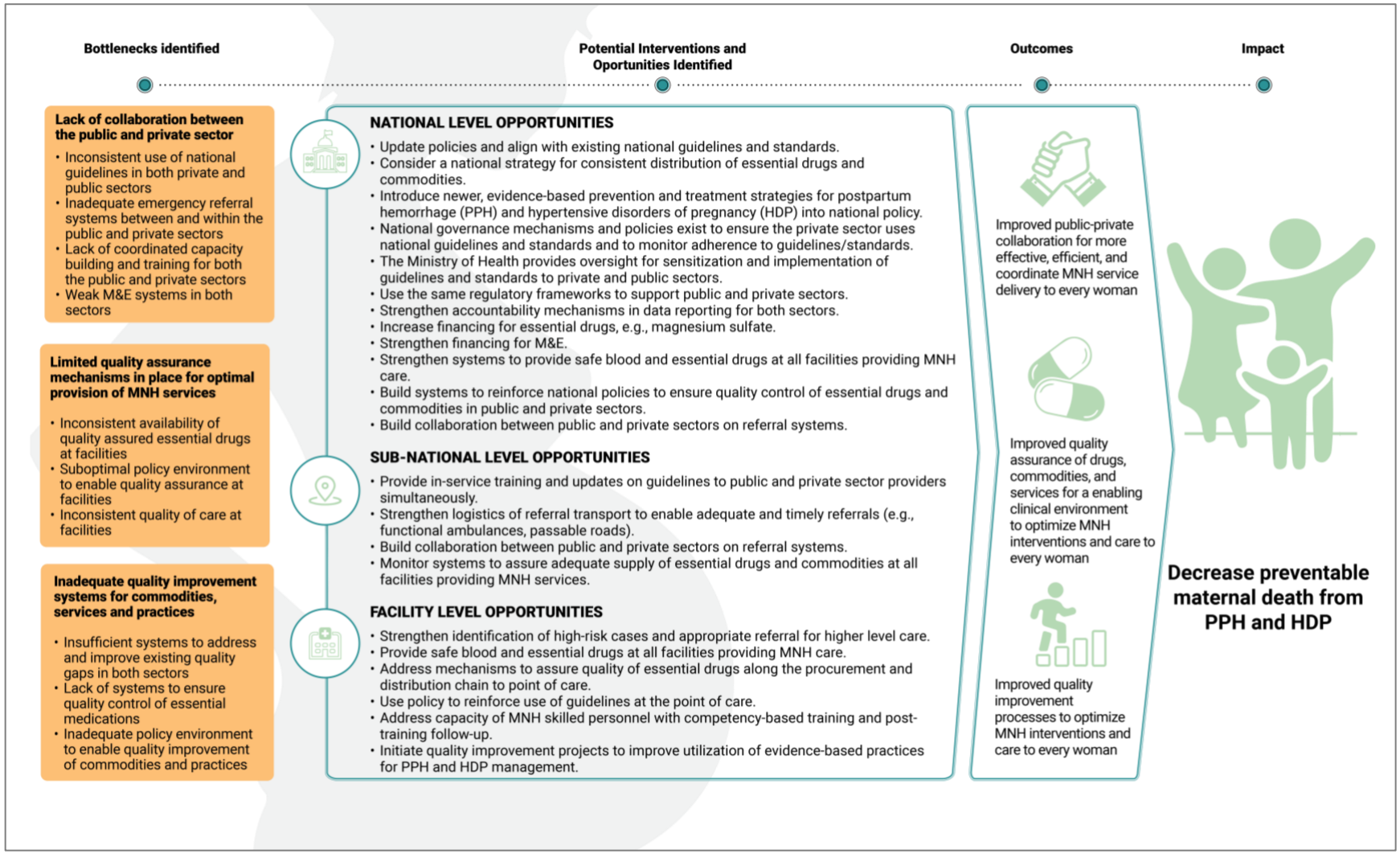
Most countries identified several potential opportunities for the public and private sectors to collaborate, as shown in Figure 21. Most countries (97%) mentioned opportunities to collaborate on maternal death audits. Regular data review, district work planning, and civil society initiatives were also reported as potential opportunities by most of the surveyed countries. Frequently mentioned in the "Other" category included: strengthening referral systems; including private sector in in-service training; and alliance building with professional associations (see Figure 21).

FIGURE 21: PROPORTION OF COUNTRIES IDENTIFYING OPPORTUNITIES FOR PUBLIC AND PRIVATE SECTOR COLLABORATION, 2022



The primary bottlenecks identified in the survey and the national, subnational, and facility-level scale-up opportunities are summarized below in Figure 22.

FIGURE 22: SUMMARY OF BOTTLENECKS AND SCALE-UP OPPORTUNITIES IDENTIFIED FROM THE GLOBAL PPH AND HDP SURVEY



DISCUSSION

Findings from the 2022 multi-country survey generated several compelling insights into the current status of national programs addressing PPH and HDP that have implications for national policy, guidelines, capacity building, midwifery scope of practice, data tracking, programs, and future research.

Continuing to support and advocate for national policies and guidelines reflective of global evidence and guidance is a cornerstone of reaching the SDG 3 goal. Integration of the PPH and HDP global guidance issued within the past 10 years was reported to be reflected in policy documents concerning EMLs, national clinical guidelines, and pre- and in-service curricula to strengthen capacity of providers to respond to these obstetrical complications. In 2022, two of the essential drugs for PPH and HDP—oxytocin and MgSO4—are reported to be in all countries' EMLs and national guidelines. However, variation does exist; some PPH and HDP updates were reported in national guidelines and pre- and in-service curricula for only half of all countries and other updates were reported by nearly all countries.

Integration of global best practices into national guidelines and curricula varied significantly, possibly due to some recommendations requiring more complex systems to support implementing an intervention and less time and opportunity for recent guidance to be integrated. Some recommendations—such as misoprostol for PPH prevention and treatment—have been integrated more fully than others, namely TXA and NASG for PPH treatment and low-dose aspirin and calcium supplementation in high-risk women for HDP prevention. Other recommendations that impact how an intervention should be used create more challenging implementation scenarios, such as UBT for PPH treatment, which is recommended only when access to surgical intervention and blood services are available.

Another highlight from the 2022 data was the substantial shift in several countries' national policies around misoprostol for PPH prevention and treatment. With this shift in policy, misoprostol has been included in national guidelines and pre- and in-service curricula in all regions evaluated and was reported to be more available at the point of care. Misoprostol is a useful medication to prevent and treat PPH that is effective, inexpensive, has a long shelf-life, and can be used by lay health workers in community settings.[19] In the multi-country analysis of PPH and PE/E from 2012, misoprostol was reported by only 18% of countries as regularly available ("regularly available" was not defined in the 2012 survey) at facilities offering maternity services and very few countries reported having misoprostol in their EML or national guidelines. Misoprostol availability at the facility level has greatly improved since 2012, with the medication being reported as regularly available (i.e., greater than 80% of the time) in approximately 60% of countries' public facilities and private facilities. The increase in misoprostol's availability at facilities expands the toolkit for MNH skilled health personnel in managing PPH.

Despite the fact that HDP continues to be a leading cause of maternal death, the survey documented limited change over the past 10 years in drug availability of first-line anticonvulsant medication at the facility level, with MgSO4 estimated by 58% of countries as regularly available (i.e., greater than 80% of the time) in public facilities and by 45% of countries for private facilities. Qualitative data reinforced the importance of addressing adequate drug availability, competence of MNH skilled personnel, and HDP data collection and management through the HMIS in the public and private sectors. The policy environment exists to enable and initiate programmatic implementation; the data from this survey can serve as a catalyst for moving policy into action with known, highly effective interventions and guidelines that will optimize women's childbirth outcomes.

The midwife's scope of practice for providing basic emergency obstetric skills (BEmONC) is still limited in some countries. It is critical that where midwives practice, they be empowered and educated to manage

basic obstetric emergencies as recommended in the 2019 International Confederation of Midwives *Essential Competencies for Basic Midwifery Practice* and as listed among essential interventions by WHO.[20, 21] Two BEmONC skills included in the 2011, 2012, and 2022 surveys were: 1) MRP, and 2) recognizing severe PE/E and giving the first loading dose of MgSO4. Comparing 2011/2012 and 2022 data, there was minimal to no change in expanding midwives' scope of practice. In 2022, 77% of countries reported that public sector midwives' scope included MRP, and 81% reported public sector midwives' scope included recognizing severe PE/E and giving the loading dose of MgSO4. In 2022, task-sharing, updating of policies to expand midwifery scope of practice, and use of competency-based training in pre- and in-service education were reinforced in qualitative responses as key components for national program scale-up.

As the policy framework in countries is strengthened for implementing the updated PPH and HDP global guidance, continued attention to appropriate dissemination of these guidelines will be useful. Dissemination activities will need to include careful orientation, training, and capacity building of health workers in pre-service education and in-service training; appropriate monitoring and supportive supervision in the facility setting is also required. Quantitative and qualitative data supports the need to include the private sector in any in-service updates and coordinate the public and private sectors for all curricula updates.

There has been improvement in national reporting on key indicators for MNH, even though those indicators were still not found in all countries surveyed. Seventy-four percent of countries reported inclusion of an indicator measuring use of an uterotonic immediately after delivery and 87% of countries reported including an indicator to measure the number of women with severe PE/E in the HMIS in 2022, compared to 43% and 51% respectively in 2012. Despite the higher percentages of countries reporting on these two indicators, qualitative data revealed regulating the quality of data collection and M&E as significant challenges for more than half of countries surveyed. In addition, using an indicator that measures treatment and management for PE/E could be more instructive than an indicator reflecting diagnosis and/or prevalence alone.

In addition to exploring policies, commodities, and practices to improve management and prevention of PPH and HDP, the 2022 survey broadens the scope of understanding of the context in which health care delivery occurs by looking at both the private and public sectors. While historical data from the private sector are limited and there was more variation in clinical practices in the private sector than the public sector, the private sector is rapidly becoming a significant provider of maternity services in many countries. A recent analysis of 70 low- and middle-income countries revealed that the private sector provides over one-third of maternal health services, accounts for a 44% mean market share among users of antenatal care, and a 40% mean market share for delivery care.[22] Several countries in the 2022 survey identified building and strengthening public-private partnerships as a priority, noting opportunities include collaborating on maternal perinatal death surveillance and response, regular data review, district work planning, and civil society initiatives. Optimizing engagement with the private sector will be key to coordinated efforts and effective strategies to reach SDG 3.

LIMITATIONS

The survey was formulated to be as objective as possible within the available timeframe, human resources, and funding. Efforts were made to limit subjectivity in the survey tool and to provide clear and consistent instructions to national partners implementing the survey; however, the findings should be interpreted in the context of certain limitations.

While most of the 2022 survey questions asked for objective, quantitative responses, it is possible that not all key informants had the same level of access to the most accurate and current national documents to verify responses. In addition, the qualitative responses have the potential to be subjective as they reflect the

opinions of respondents and, while they provide vital information to contextualize and triangulate the quantitative data, they may not reflect the majority opinion of all expert groups in a given country and should not be generalized.

Attention was given to limiting subjectivity in the survey implementation; however, there are a few points of potential bias. First, the national consultative committee that was formed in each country to respond to the survey varied in the number of individuals and the individuals' expertise. The number of key informants in each country varied from one to 50, with the majority of countries averaging 10 to 20 key informants. While selection criteria recommended representation from the MOH, education councils, professional societies, NGOs, FBOs, and forprofit organizations, each country selected their key informants based on their individual context. This could lead to variations between countries' survey input sources using the sampling framework. Second, countries were asked to verify their responses with national documents such as policies, EMLs, and national guidelines and curricula; however, it was not confirmed by the coordinating team whether or not a country carried out this verification procedure and it is likely that countries estimated numbers. Third, the survey was implemented during the COVID-19 pandemic, which required flexibility in data collection to accommodate local protocols for mitigation of COVID-19, such as allowing the national consultative meeting to occur virtually or in-person, and allowing individuals to respond to the survey independently followed by a small consultative group discussing and collating the responses. This variation in data collection approaches could cause some countries to respond differently. As an example, a country that held in-depth group discussion versus a more limited discussion based on individual responses could well yield more detailed data.

Since the survey was conducted in three different regions of the world, there were potential impacts of language on the survey findings. For instance, different countries use the term "midwife" to mean different types of health care workers, ranging from traditional birth attendant, traditional midwives, and formally educated and trained midwives. In the LAC region, some countries do not have midwives as defined by this survey to be educated and trained midwives. Care was taken to define any terms that could cause confusion within the survey; however, some questions in the survey are not relevant to countries that do not have a formal midwife cadre. In addition, the survey was translated into three languages: French, Portuguese, and Spanish. While experienced translators were used in all communications, it is possible some nuances were lost in translation between English and the other languages.

RECOMMENDATIONS AND CALL TO ACTION

Numerous recommendations emerged from the 2022 multi-country analysis of national programs for the prevention and management of PPH and HDP.

Prioritize integration into national policies and guidelines of all current global evidence and interventions. Broadening 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 in-service education updates using the national guidelines will provide more comprehensive input for better coordination and care from both public and private sectors—a finding that is reinforced in the quantitative and qualitative data. Since current and updated policies and guidelines are critical to enabling appropriate service delivery at the facility level, continued country leadership in updating all policies and guidelines to global best practices is vital.

Amplify the dissemination of the current global evidence and guidelines through pre-service education and in-service training. There is an opportunity to improve systems to support and strengthen 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 MNH national forums, policy development, and MOH oversight across sectors. Bringing professional associations into the national discussion of MNH and policies will potentiate the dissemination and reach of the global guidelines. MOH 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 and quality. Focusing on national-level policy and guidelines to increase central and district/regional medical store 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 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 focus 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 chains; collaboration on M&E and reporting; standardization of guidelines used in both sectors; including private sector representatives on national committees leading national strategic planning on reducing maternal and neonatal mortality; and in developing and disclosing regulatory frameworks.

Continue to strengthen data collection on key MNH indicators. Consistent and accurate data collection of key MNH indicators will serve to more accurately portray the prevalence of PPH and HDP complications of pregnancy and the outcomes associated with them. More robust regulatory and accountability mechanisms are needed.

This survey also highlighted the need for the following recommended areas of research:

- **Quality of medications at point of delivery**. Improvements are needed in the quality of controlled cold-chain systems for oxytocin and 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.
- **Private sector**. Opportunities for research identified in the qualitative and quantitative data include: involving private sector providers in in-service training and updates, standardizing use of national guidelines in the private sector, developing systems for the private sector to procure quality-assured medications and commodities through the same channels as the public sector, improving data reporting between the two sectors, integrating private sector data within national HMIS systems, investigating the impact of a 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 investigate quality of care in the private sector, including removing barriers to access, affordability, and inclusion.
- **Improve the emergency referral system**. Identify ways to improve the emergency referral and triage system within and between the public and private sectors.
- **Advances in management of PPH**. An additional research opportunity identified from this survey is examining the acceptability, feasibility, and impact of use of newer PPH interventions for the prevention of PPH, such as HSC and treatment of PPH such as TXA, UBT, and the NASG.

Because of the thorough and valuable input from participating countries in this survey, the findings reflect an increased understanding of PPH and HDP policies, commodities, and practices that have evolved in the past decade. While we have made considerable advances in reducing maternal morbidity and mortality, we also know that the SDG targets will not be met without redoubling efforts. Given that PPH and HDP remain the major causes of maternal mortality, our hope is that this data will provide a variety of recommendations that will create a clear pathway to a world where no woman dies needlessly from complications of pregnancy and birth.

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 MNH 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

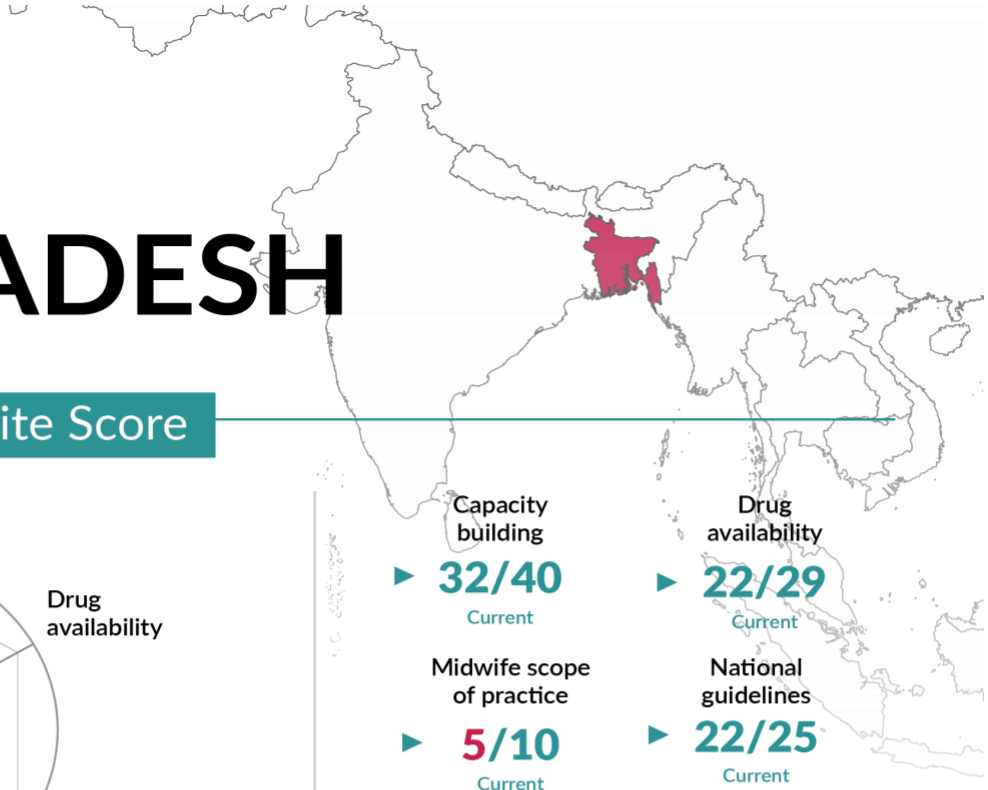
Mapping public and private sector facilities, assessing existing quality of care for routine and emergency maternal and newborn care, and closing existing quality gaps through a variety of quality-improvement approaches tailored to identified challenges are all crucial to improving private sector engagement 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

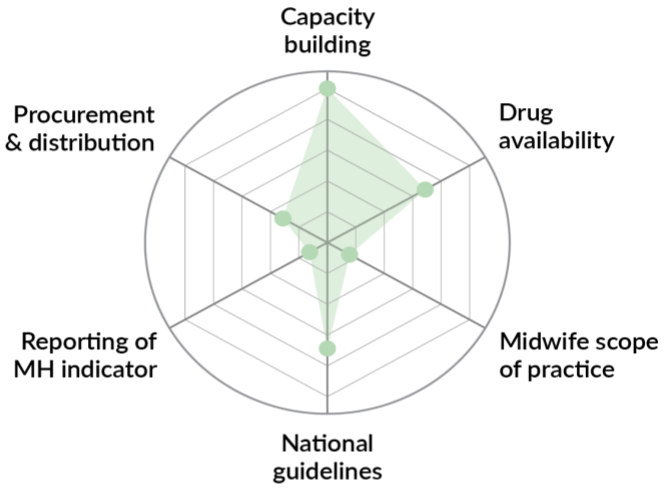
Countries' and implementing partners' focus is needed to address broad health system issues that affect the quality of care at health facilities, including: capacity of human resources; quality, access, and availability of medications and commodities for all women, newborns, and children who need them; 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. This 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.

APPENDIX A – COUNTRY PROFILES

Country Profile:
BANGLADESH



Current Composite Score



Capacity building
▶ 32/40
Current

Drug availability
▶ 22/29
Current

Midwife scope of practice
▶ 5/10
Current

National guidelines
▶ 22/25
Current

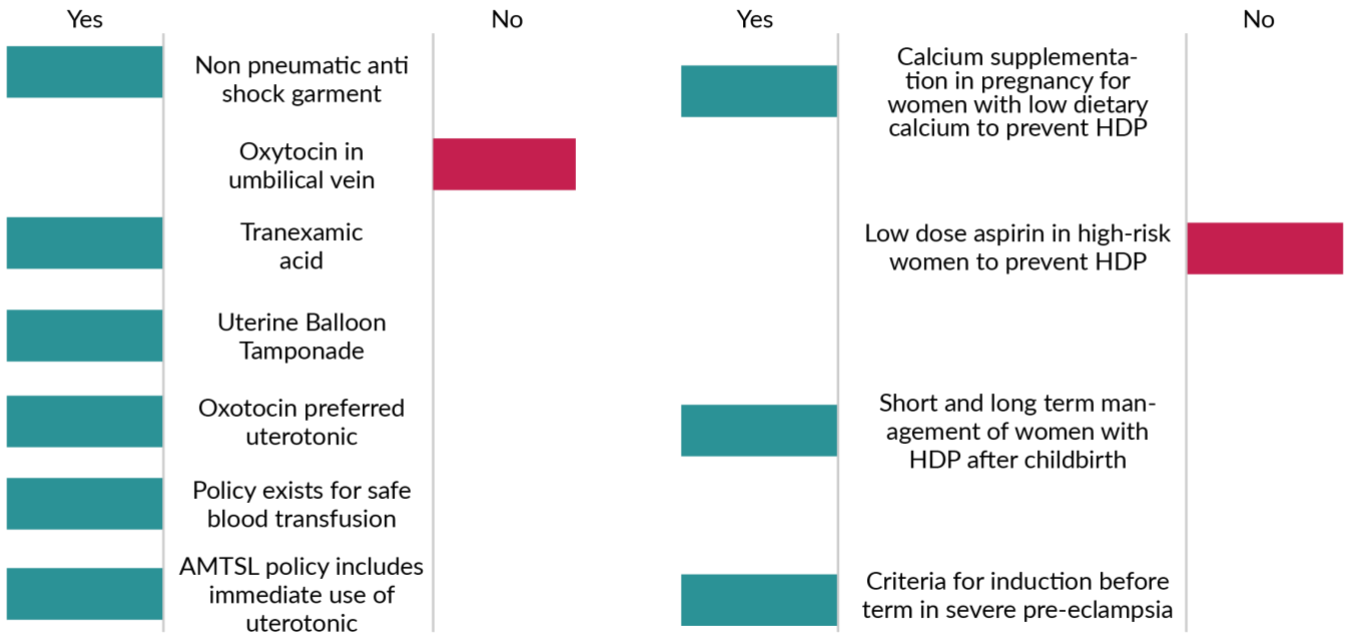
Reporting of MH indicator
▶ 4/6
Current

Procurement & distribution
▶ 10/12
Current

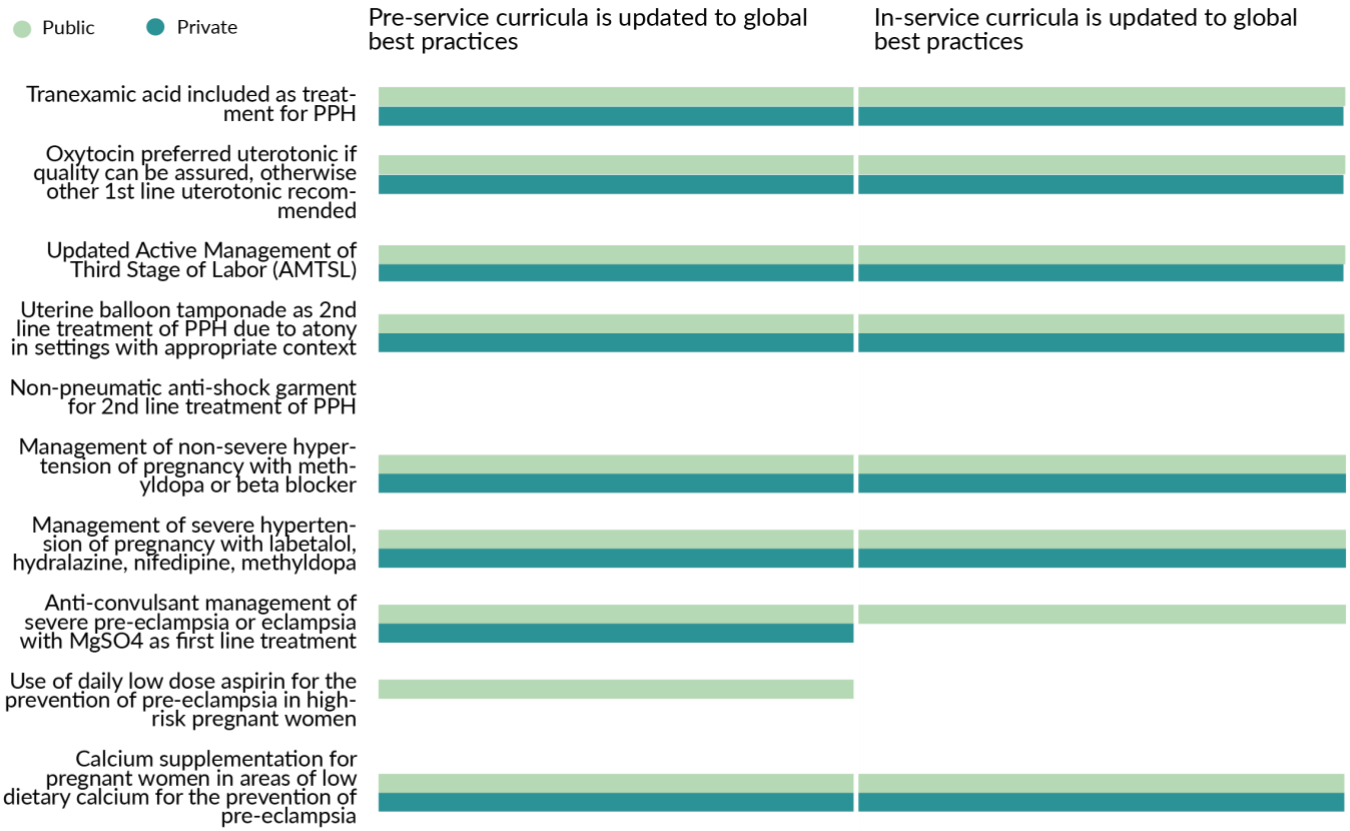
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☑	☑	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

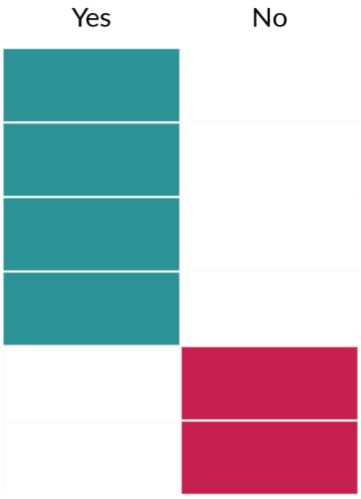


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Bangladesh

PRIVATE SECTOR HIGHLIGHTS



- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

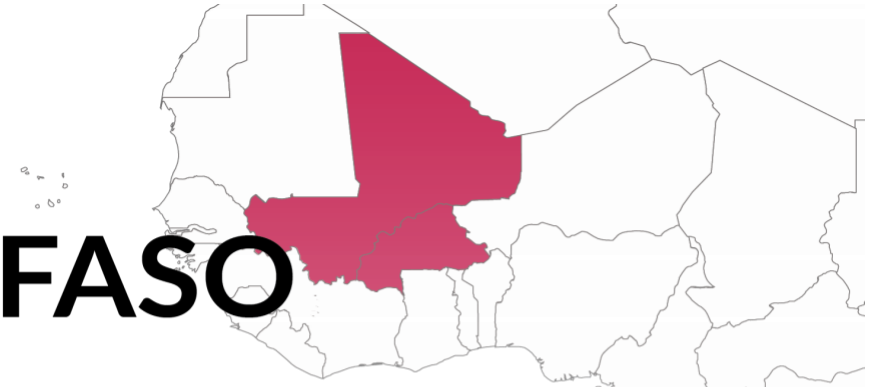
Opportunities for PPH

- "Policy and protocols are prepared but not implementing well, especially quality assurance."
- "Need to trained to trainers and service providers."
- "Need to made available at service and logistics."
- "More frequently need to upscale, facility delivery more in private sectors need to increase."

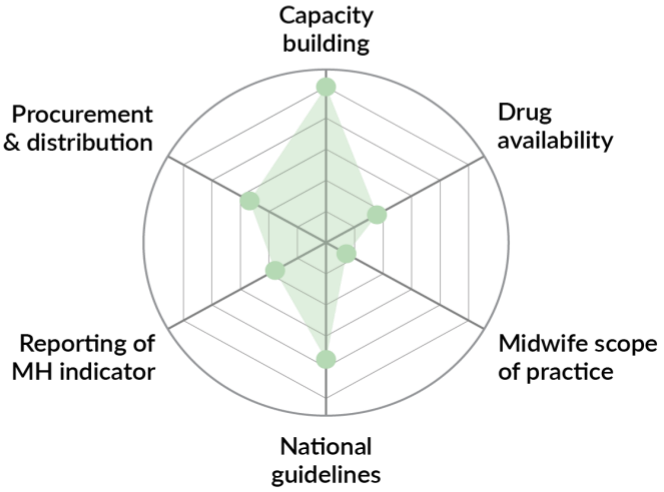
Opportunities for HDP

- "There need to involve the private sectors."
- "To create more awareness in district hospital and upazila level, there need to involve more providers."
- "To increase the confident level of doctors, Midwives and Nurses, there need all the service providers capacity building through training. and incorporate those training in national policy."

Country Profile:
BURKINA FASO



Current Composite Score



Capacity building
▶ 28/40
Current

Drug availability
▶ 15/29
Current

Midwife scope of practice
▶ 10/10
Current

National guidelines
▶ 21/25
Current

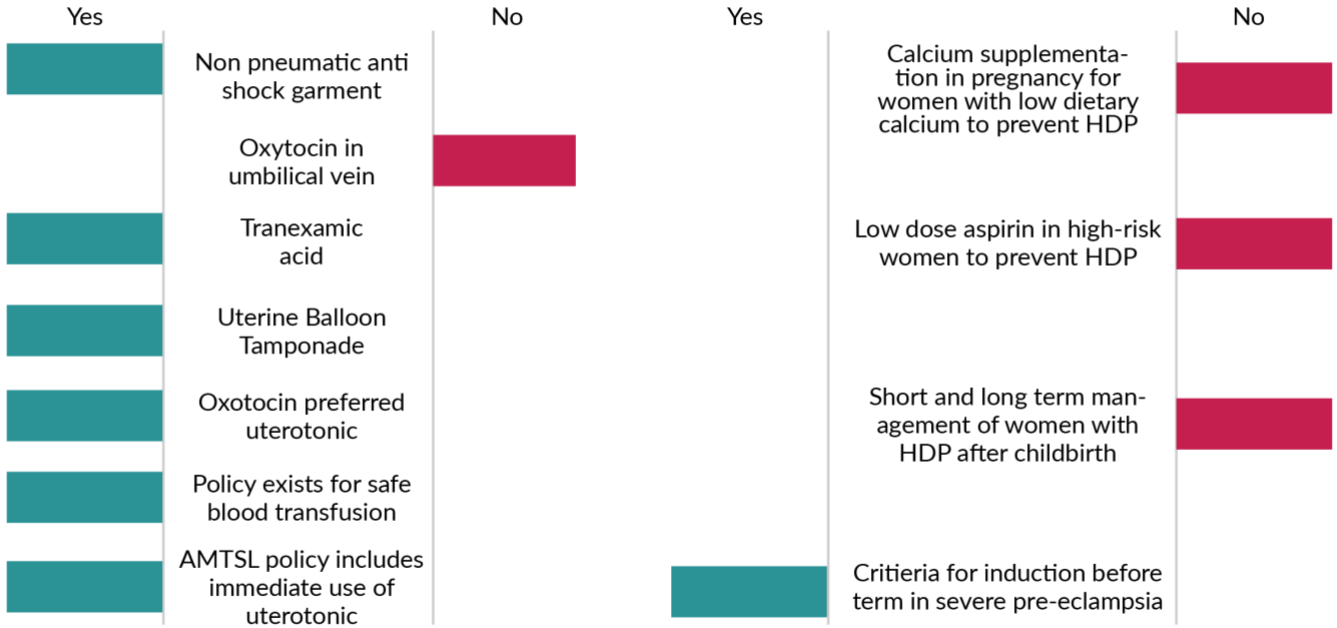
Reporting of MH indicator
▶ 4/6
Current

Procurement & distribution
▶ 10/12
Current

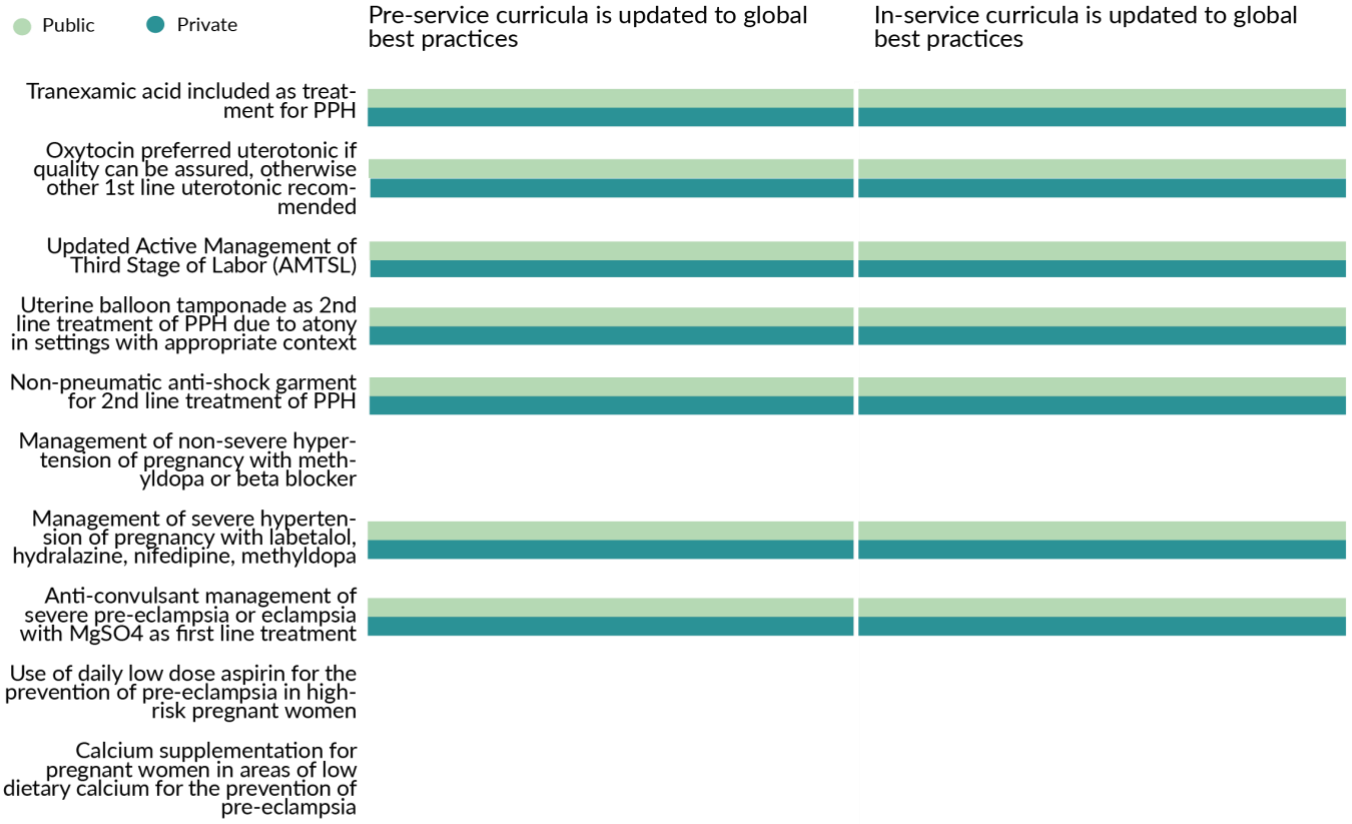
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☒	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☒	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Burkina Faso

PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

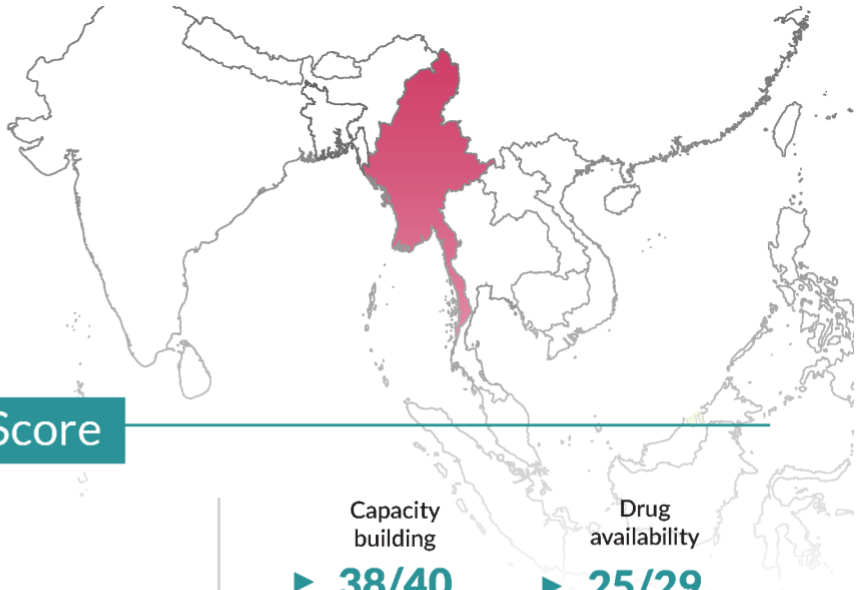
Opportunities for PPH

- "Improve teaching in pre-service education."
- "Find opportunities to mentor providers."
- "Reinforce quality improvement in both public and private sectors."
- "Active dissemination of up-to-date national directives in both public and private sectors."

Opportunities for HDP

- "Improve teaching in pre-service education."
- "Find opportunities to mentor providers."
- "Reinforce quality improvement in both public and private sectors."
- "Active dissemination of up-to-date national directives in both public and private sectors."

Country Profile: BURMA



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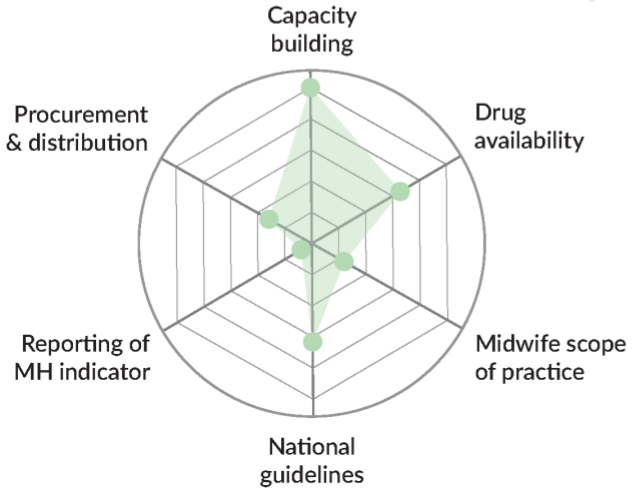


Capacity building	38/40 Current
Drug availability	25/29 Current
Midwife scope of practice	9/10 Current
National guidelines	24/25 Current
Reporting of MH indicator	3/6 Current
Procurement & distribution	12/12 Current

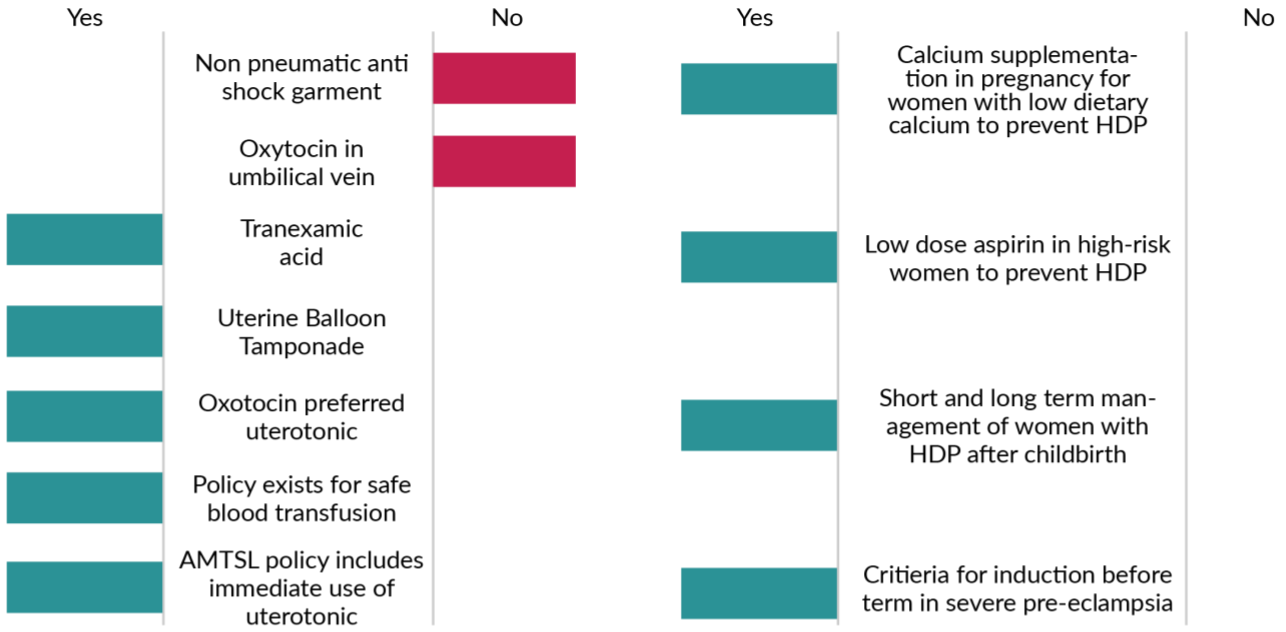
Numbers reflected in red are scores <75%

DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

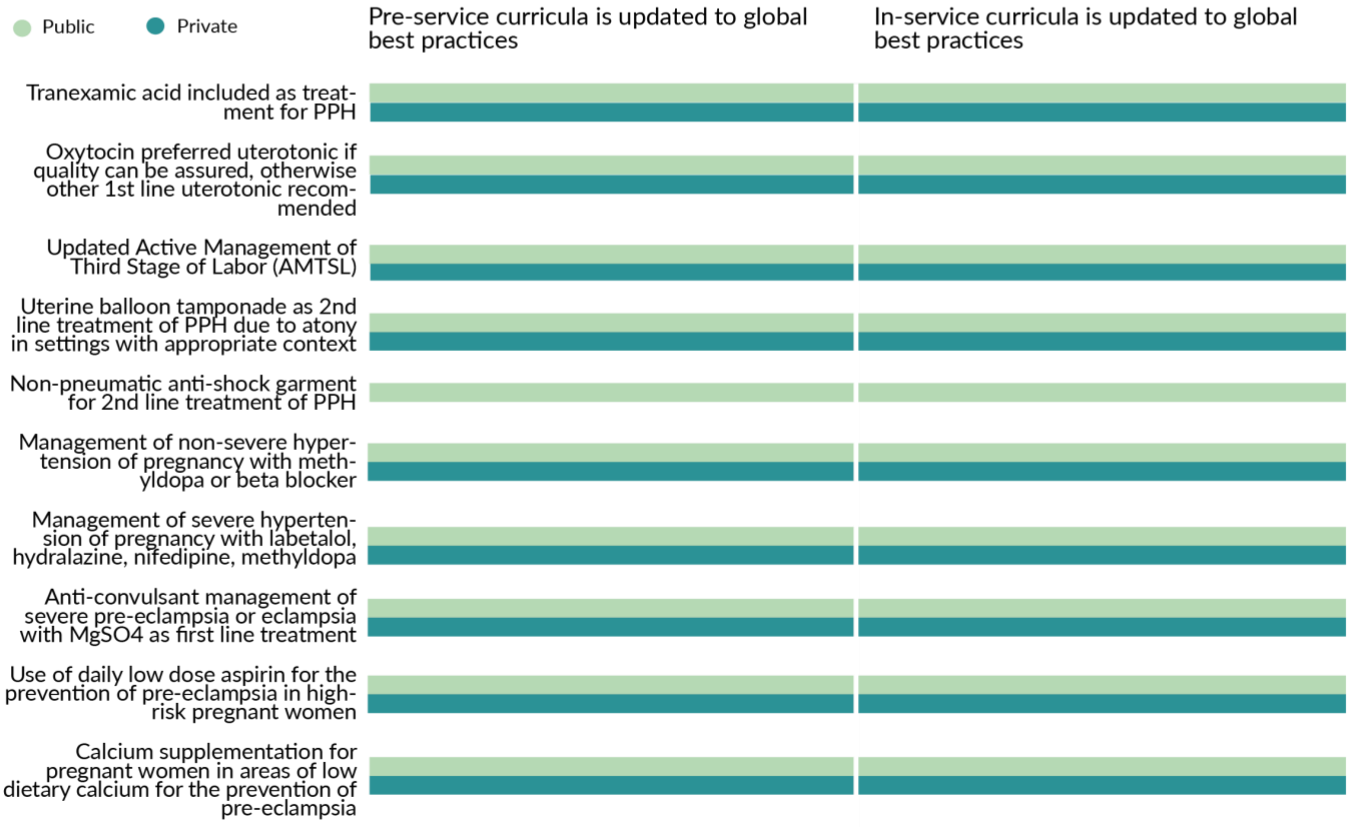
	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☑	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☑	☑

Regularly available is >80% of the time

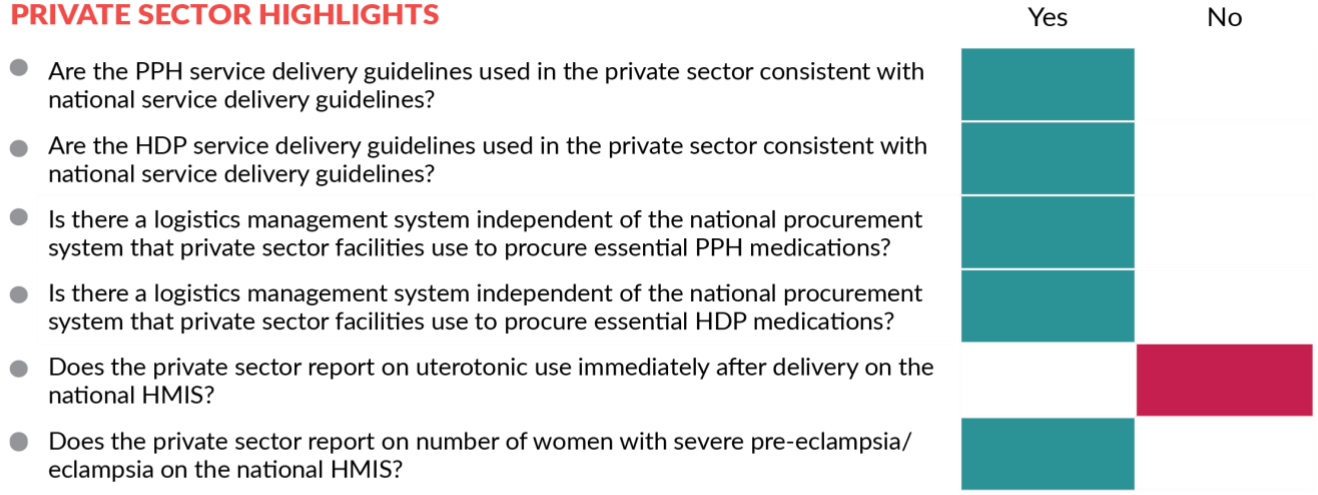
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

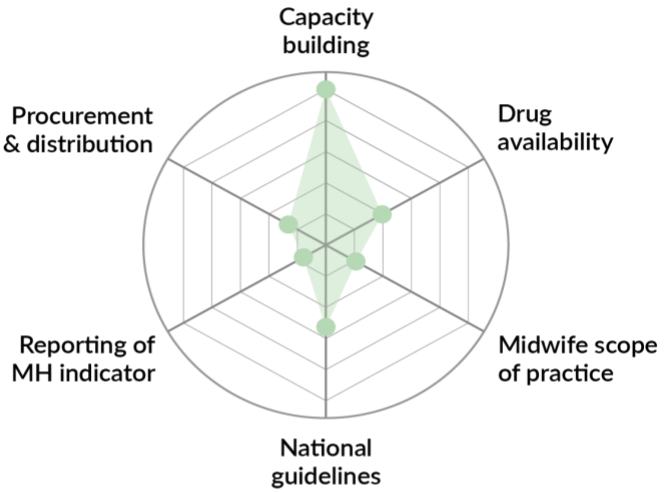
- "Expansion of regulatory mechanisms to ensure national guidelines are followed in all health sectors - public, private, NGO, and Ethnic Health Organization (EHO)."
- "It would be good chance basic health staff (public or private) can get updated trainings and adequate facilities for prevention and management of PPH."
- "Engage with private hospitals and explore potentials for delivering PPH services by active payment mechanism and capacity building training."
- "Basic Emergency Obstetric Care/Comprehensive Emergency Obstetric Care."

Opportunities for HDP

- "Training of health workforce to monitor closely women with pre-eclampsia and eclampsia according to national guidelines."
- "Data collection and data for decision making/Regular audit."
- "Updated training."
- "Adequate facilities."
- "Capacity building training to private providers and commodity support according to guidelines."
- "Development of Nurse Midwife led Centers for maternal and newborn care; Non profit organization of volunteers and close maternal and fetal surveillance."

Country Profile:
COTE D'IVOIRE

Current Composite Score



Capacity building
▶ 38/40
Current

Drug availability
▶ 15/29
Current

Midwife scope of practice
▶ 8/10
Current

National guidelines
▶ 22/25
Current

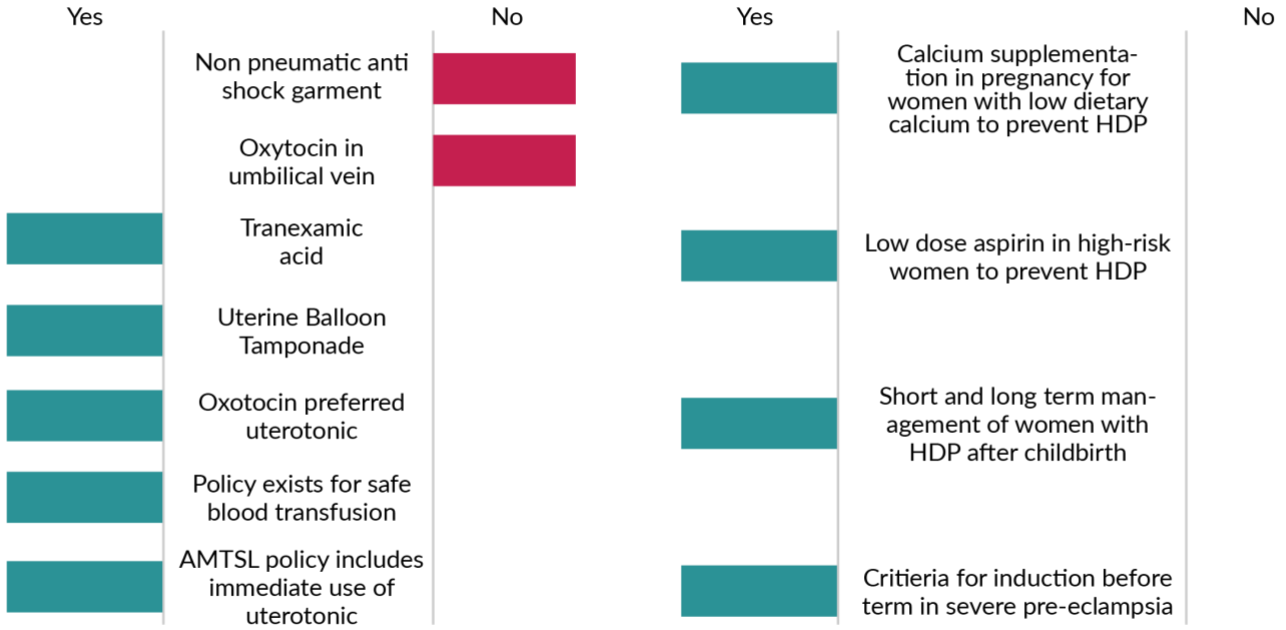
Reporting of MH indicator
▶ 6/6
Current

Procurement & distribution
▶ 10/12
Current

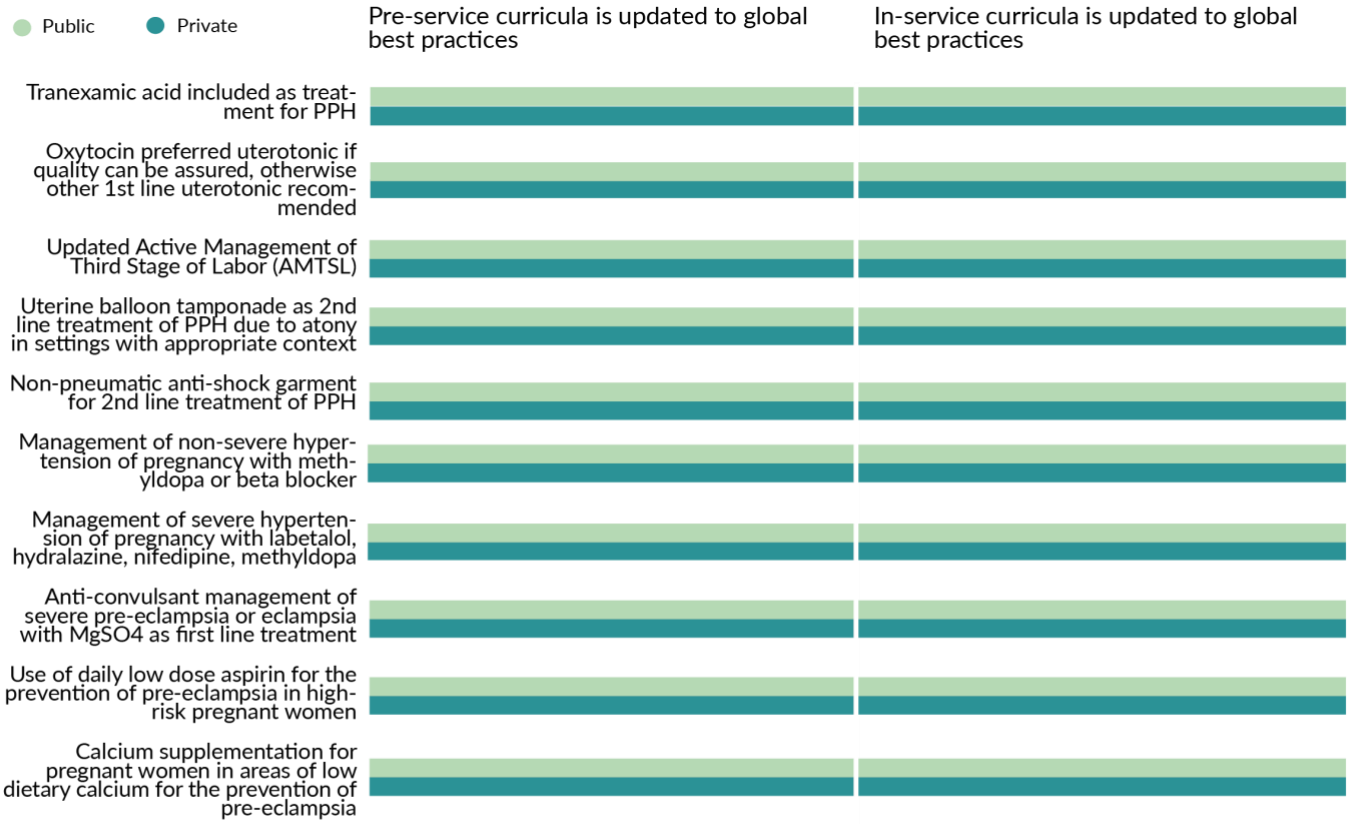
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☒	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☒	☒

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Cote D'Ivoire

PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

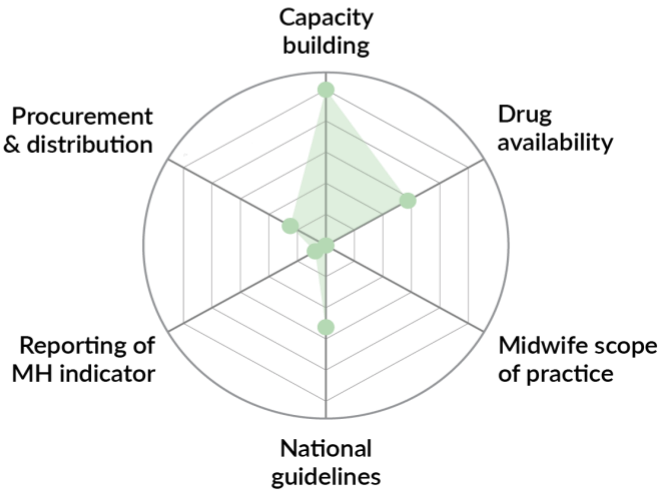
- "Strengthen public-private partnership, disseminate and orient on updated and approved policy documents, standards and guidelines with scaling up of community-based interventions focused on client needs and satisfaction."
- "Initiate regular evaluations with updates on high impact interventions done by health providers."
- "Ensure and maintain availability of strategic pharmaceutical inputs and drugs for the management of PPH and HDP."

Opportunities for HDP

- "Strengthen public-private partnership, disseminate and orient on updated and approved policy documents, standards and guidelines with scaling up of community-based interventions focused on client needs and satisfaction."
- "Initiate regular evaluation with update on high impact interventions done by health providers."
- "Ensure and maintain availability of strategic pharmaceutical inputs and drugs in the management of PPH and HDP."

Country Profile: COLOMBIA

Current Composite Score



Capacity building
40/40
Current

Drug availability
23/29
Current

Midwife scope of practice
0/10
Current

National guidelines
21/25
Current

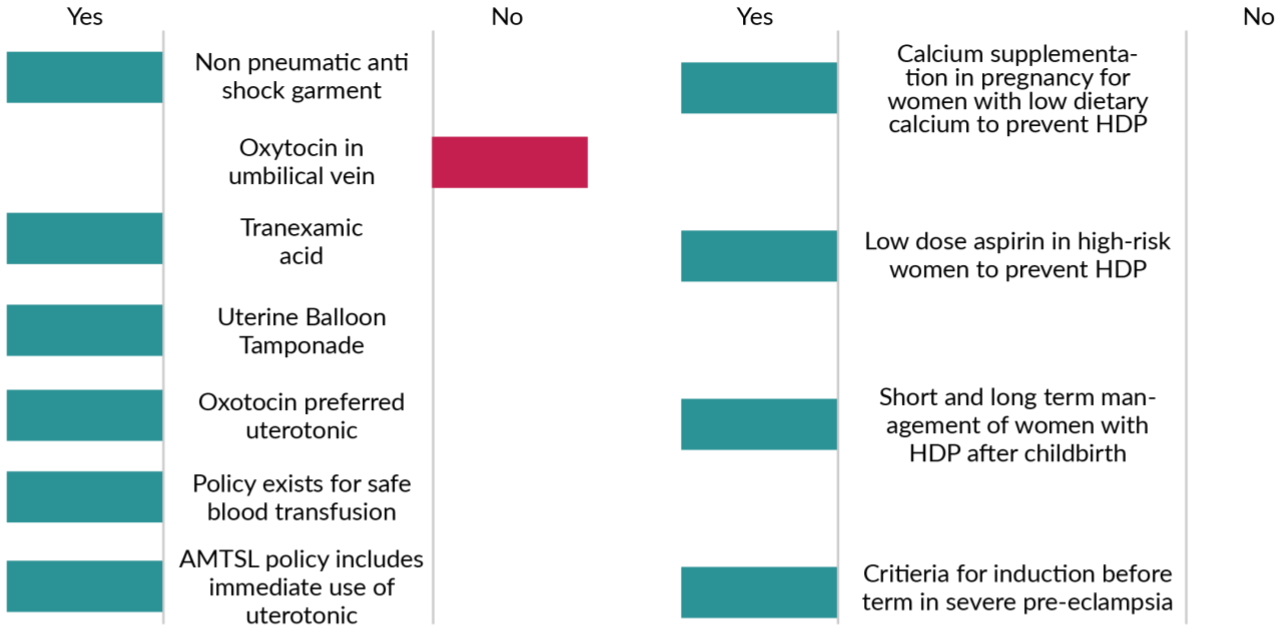
Reporting of MH indicator
3/6
Current

Procurement & distribution
10/12
Current

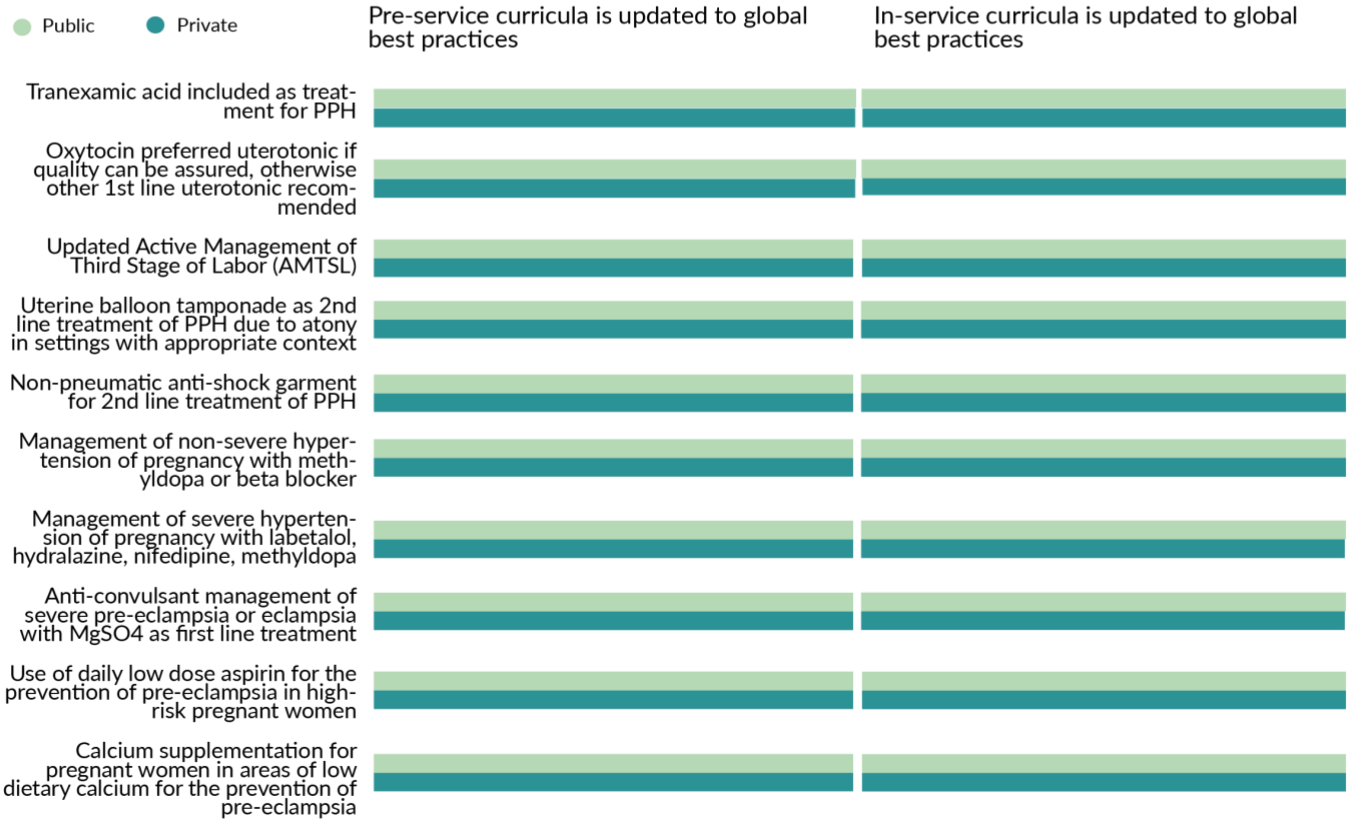
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☑	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

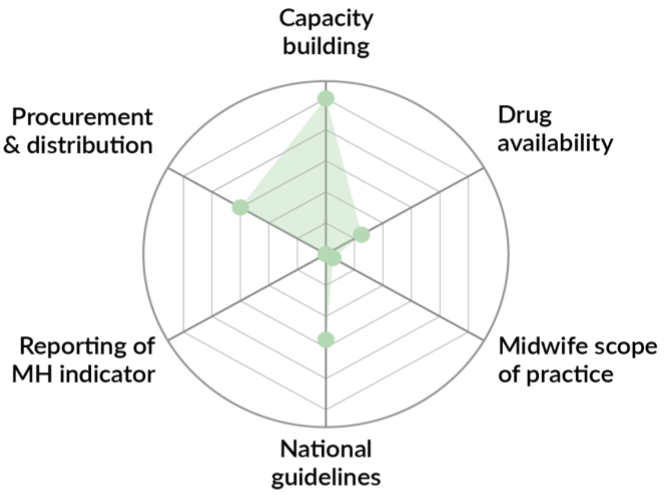
- "Educational program standardized by institutions, with on-site simulation and creation of tele-assistance networks between hospitals. Strengthen human talent skills, especially 1st level of care, in addition to providing support in supply management issues."

Opportunities for HDP

- "Educational program standardized by institutions, with on-site simulation and creation of tele-assistance networks between hospitals."

Country Profile:
DOMINICAN REPUBLIC

Current Composite Score

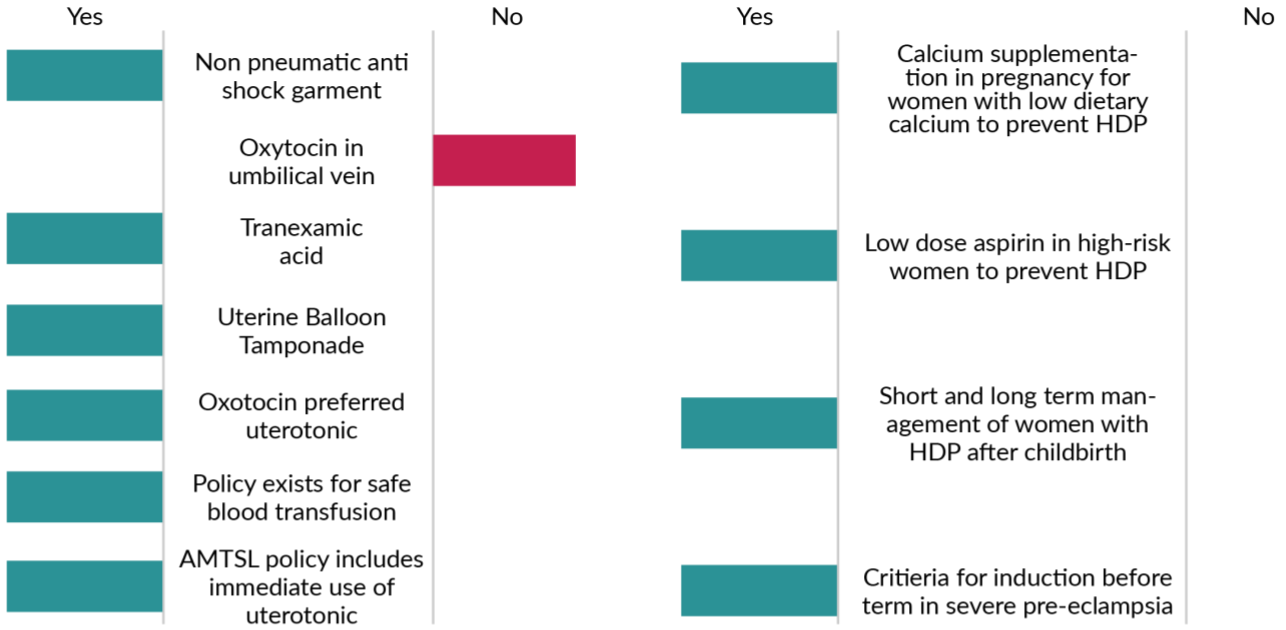


Capacity building ▸ 40/40 Current	Drug availability ▸ 24/29 Current
Midwife scope of practice ▸ 0/10 Current	National guidelines ▸ 22/25 Current
Reporting of MH indicator ▸ 2/6 Current	Procurement & distribution ▸ 10/12 Current

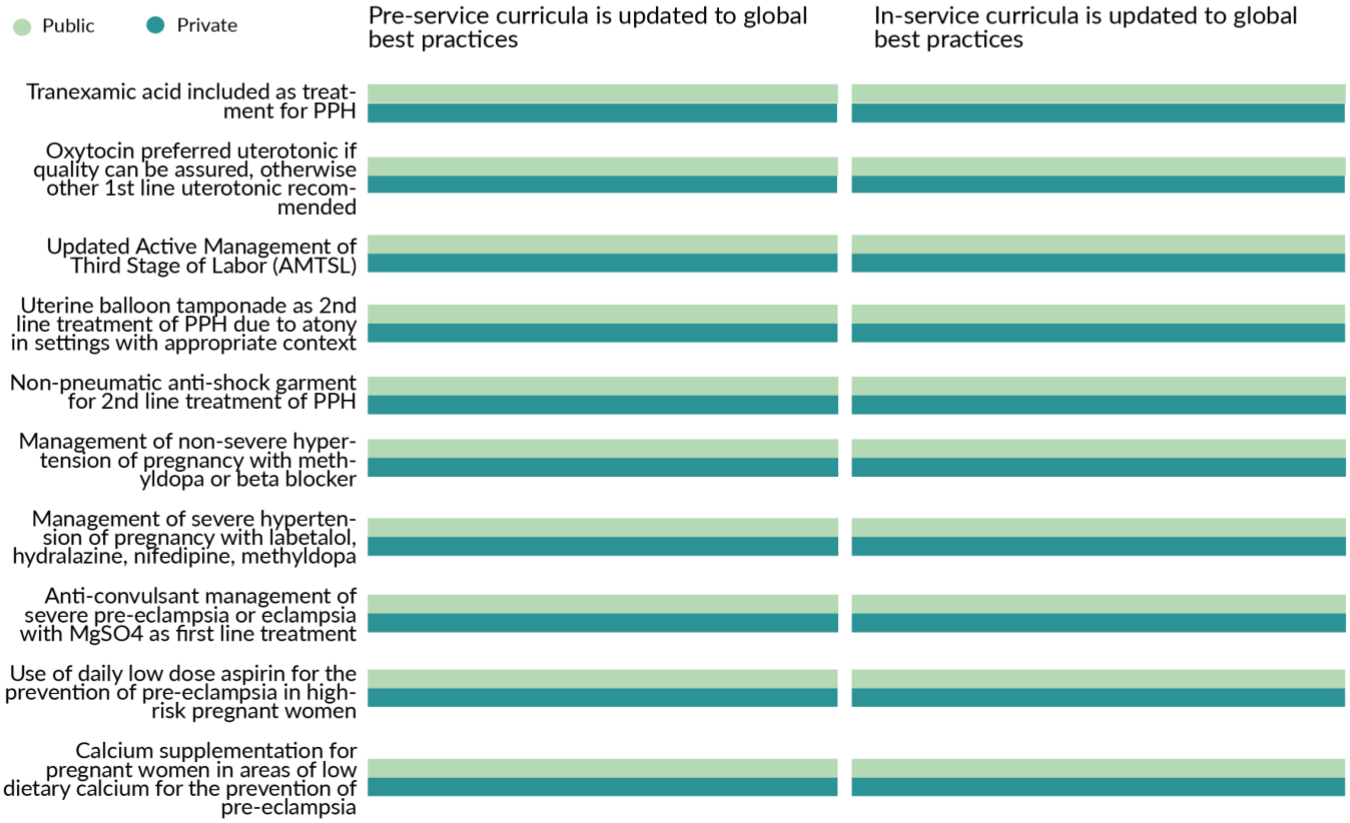
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☒	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS

- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

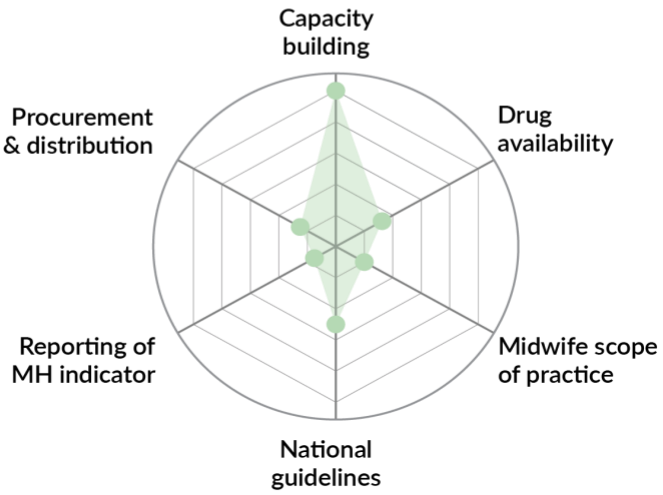
- "Maintain the alliance between the National Health Service and the Ministry of Public Health to continue promoting actions to improve the quality of obstetric and neonatal care."
- "Strengthen public-private alliances."
- "Strengthen the monitoring system for adherence to protocols and plans for improvement."
- "Strengthening the problem-solving capacities of health facilities (staff) that provide care for pregnancy, childbirth and the puerperium."
- "Regular training for health providers on PPH."
- "Follow-up on the authorization of private centers in obstetric and neonatal care."

Opportunities for HDP

- "Strengthening the capacities (skills) of health providers."
- "Prevention programs on the identification of warning signs at the community level."
- "Strengthen post obstetric event contraception."

Country Profile: DEMOCRATIC REPUBLIC OF THE CONGO

Current Composite Score

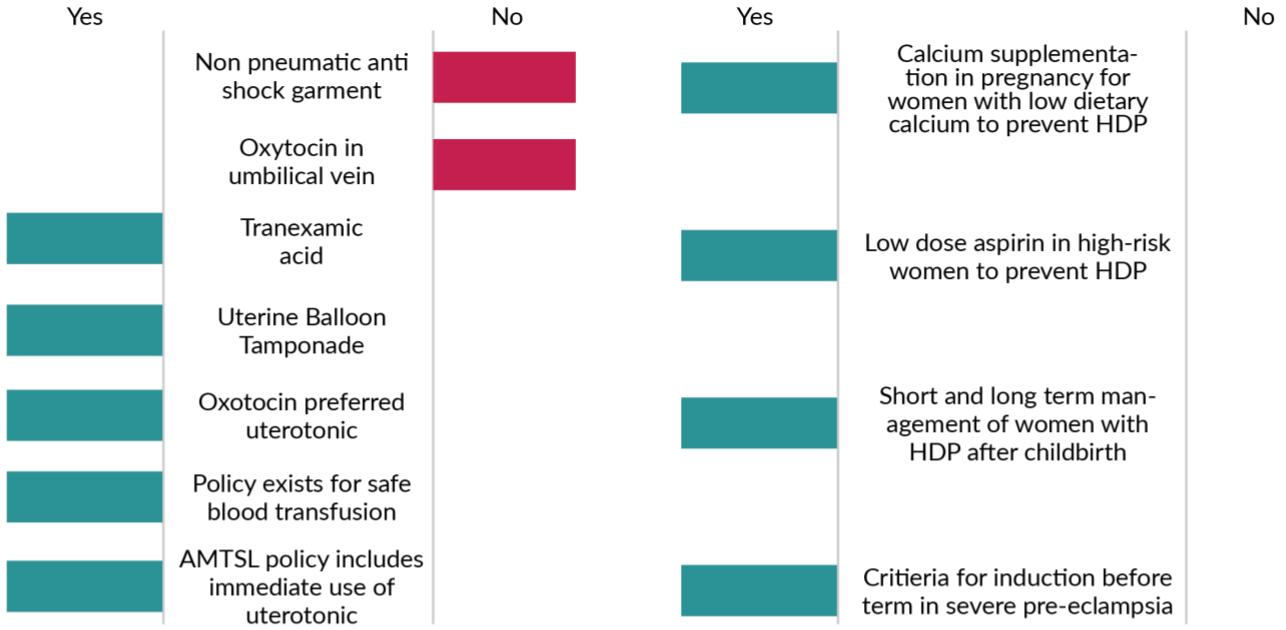


Capacity building ▶ 40/40 Current	Drug availability ▶ 13/29 Current
Midwife scope of practice ▶ 8/10 Current	National guidelines ▶ 20/25 Current
Reporting of MH indicator ▶ 6/6 Current	Procurement & distribution ▶ 10/12 Current

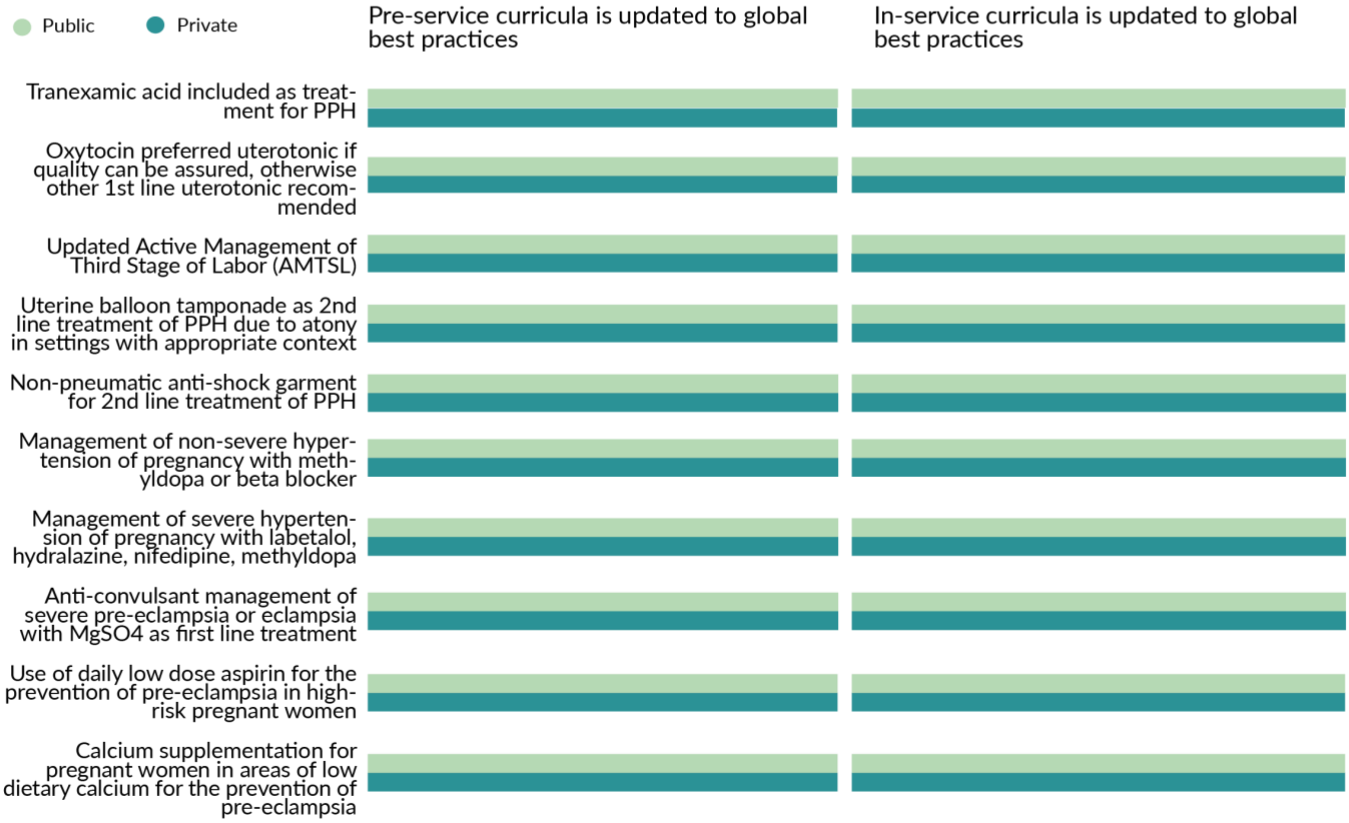
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	✓	✗	✓	✗	✓	✓
Oxytocin	✓	✓	✓	✗	✗	✓
Magnesium Sulfate	✓	✓	✓	✗	✗	✓

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

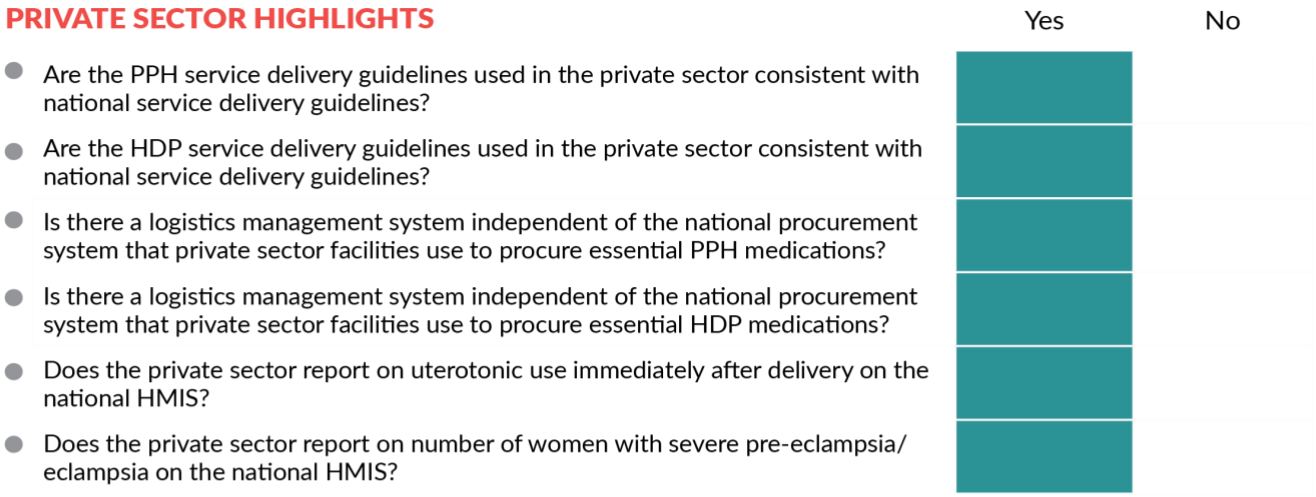


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Democratic Republic of the Congo

PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

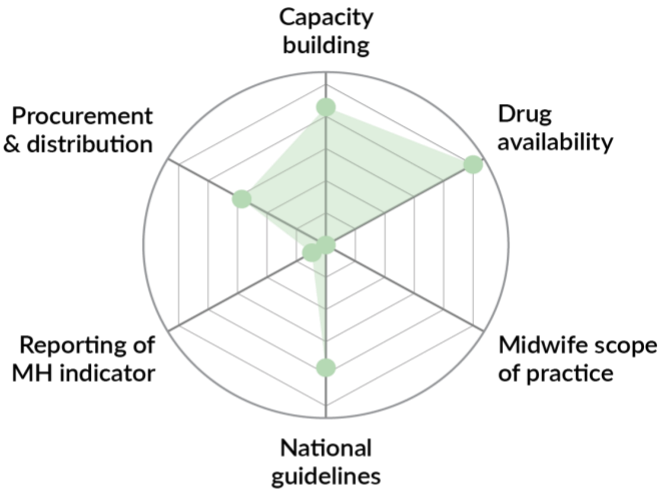
- "The involvement of professional societies: Congolese Society of Obstetricians and Gynecologists and Congolese Society of Midwives in MNH+N and FP/ASRH."
- "The private sector must be integrated into pre-service and continuing education: revision of curricula in medical and midwifery schools, continuing education of obstetrical nurses, emergency obstetric and neonatal care training with various partners (Canadian Society of Obstetricians and Gynecologists, Jhpiego, etc.), clinical mentoring."
- "Supply of inputs and drugs within the framework of Universal Health Coverage (UHC)."
- "Revisiting national norms and policies; collaboration on approaches to fight against PPH; collaboration with organizations that work for women."

Opportunities for HDP

- "The involvement of professional societies: Congolese Society of Obstetricians and Gynecologists and Congolese Society of Midwives in MNH+N and FP/ASRH."
- "The private sector must be integrated into pre-service and continuing education: revision of curricula in medical and midwifery schools, continuing education of obstetrical nurses, emergency obstetric and neonatal care training with various partners (Canadian Society of Obstetricians and Gynecologists, Jhpiego, etc.), clinical mentoring."
- "Supply of inputs and drugs within the framework of Universal Health Coverage (UHC)."
- "Revisiting national norms and policies; collaboration on approaches to fight against PPH; collaboration with organizations that work for women."

Country Profile: EL SALVADOR

Current Composite Score

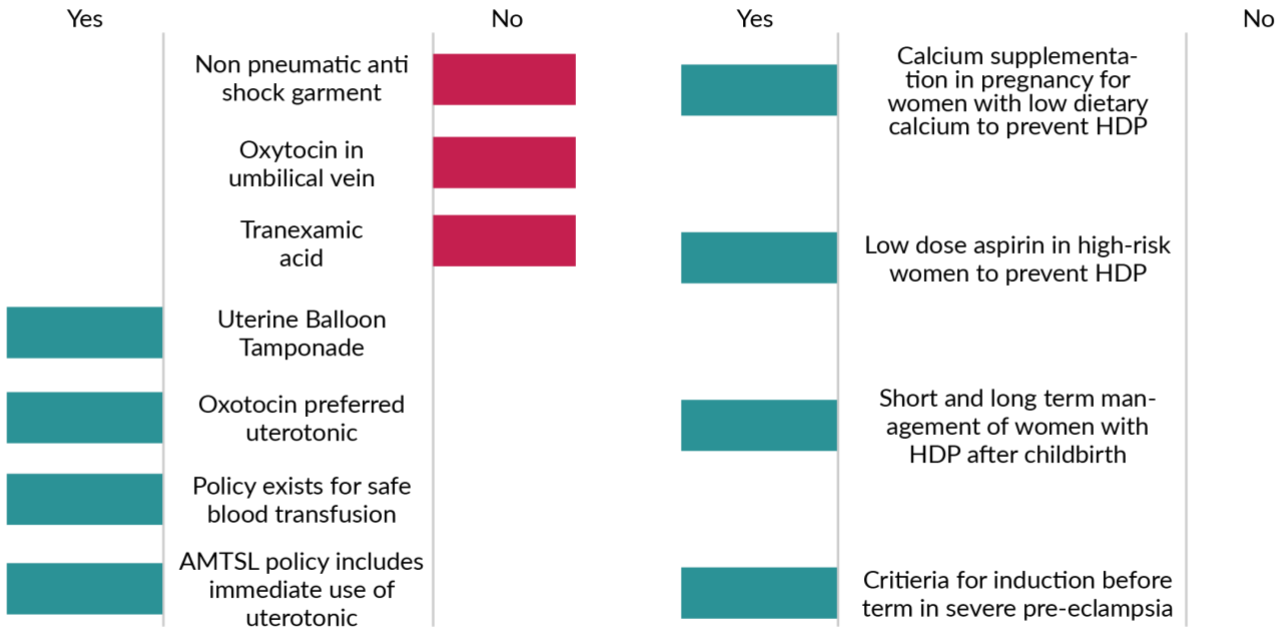


Capacity building ▶ 18/40 Current	Drug availability ▶ 21/29 Current
Midwife scope of practice ▶ 0/10 Current	National guidelines ▶ 16/25 Current
Reporting of MH indicator ▶ 2/6 Current	Procurement & distribution ▶ 12/12 Current

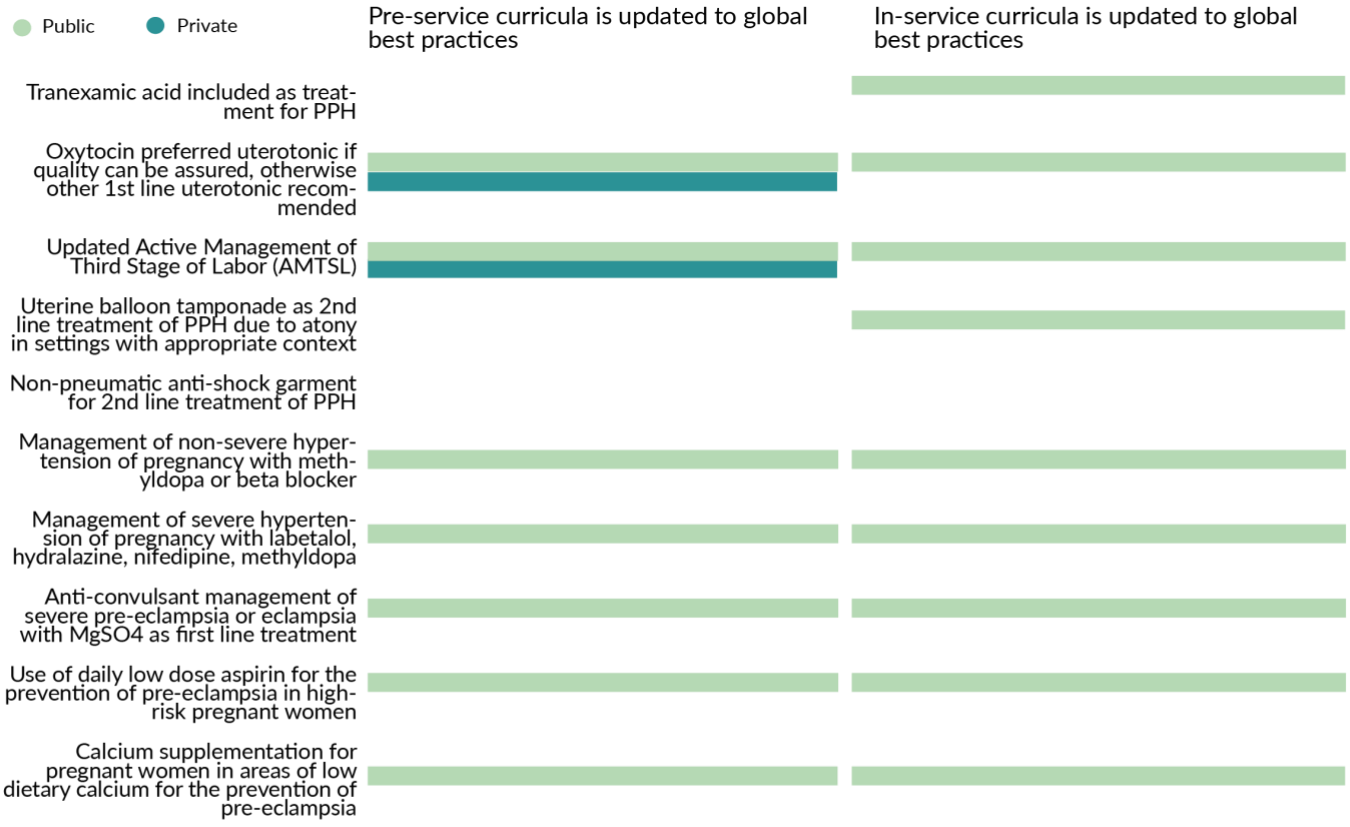
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	☑	☑	☑	☑	☑
Oxytocin	N/A	☑	☑	☑	☑	☑
Magnesium Sulfate	N/A	☑	☑	☑	☑	☑

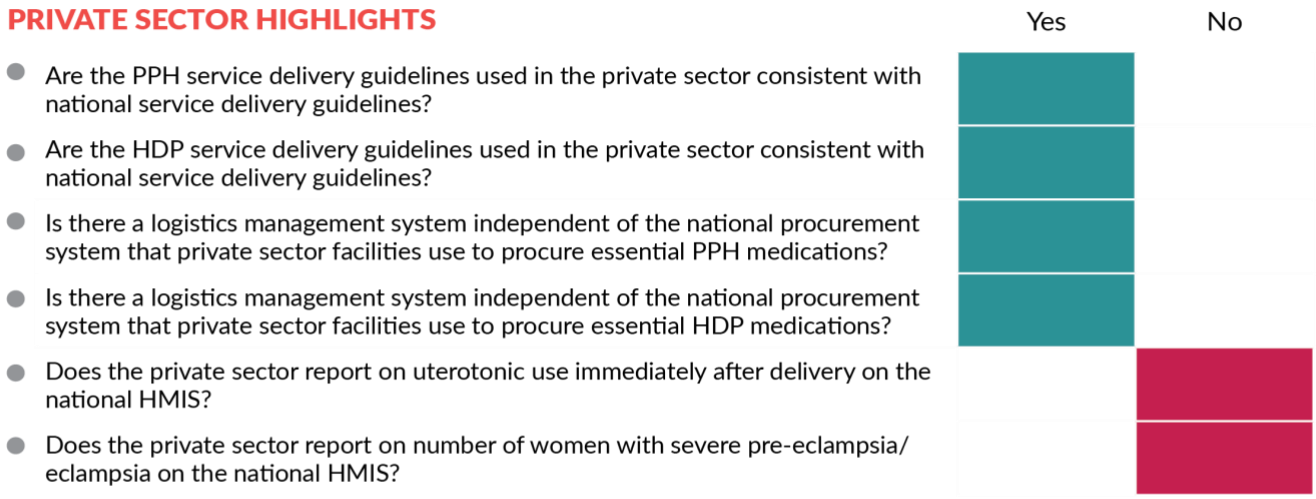
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

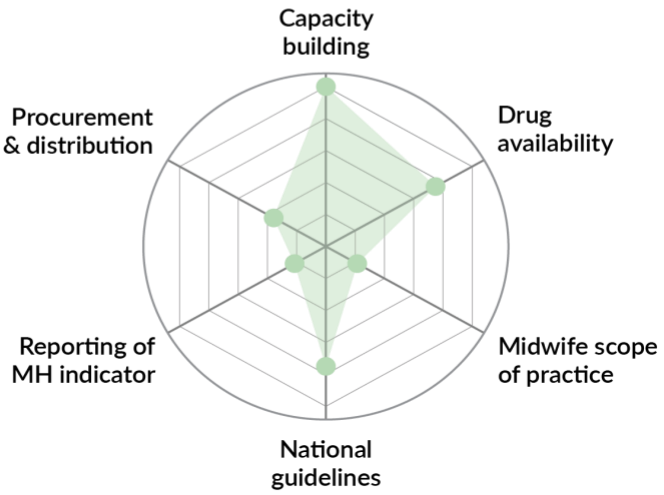
- "Incorporation of the private sector in the processes of development and disclosure of regulatory frameworks."
- "Integrate information from the public and private system into a single data collection system."

Opportunities for HDP

- "Incorporation of the private sector and universities in the updating of protocols. Creation of simulation centers in the main maternity hospitals."

Country Profile: ETHIOPIA

Current Composite Score

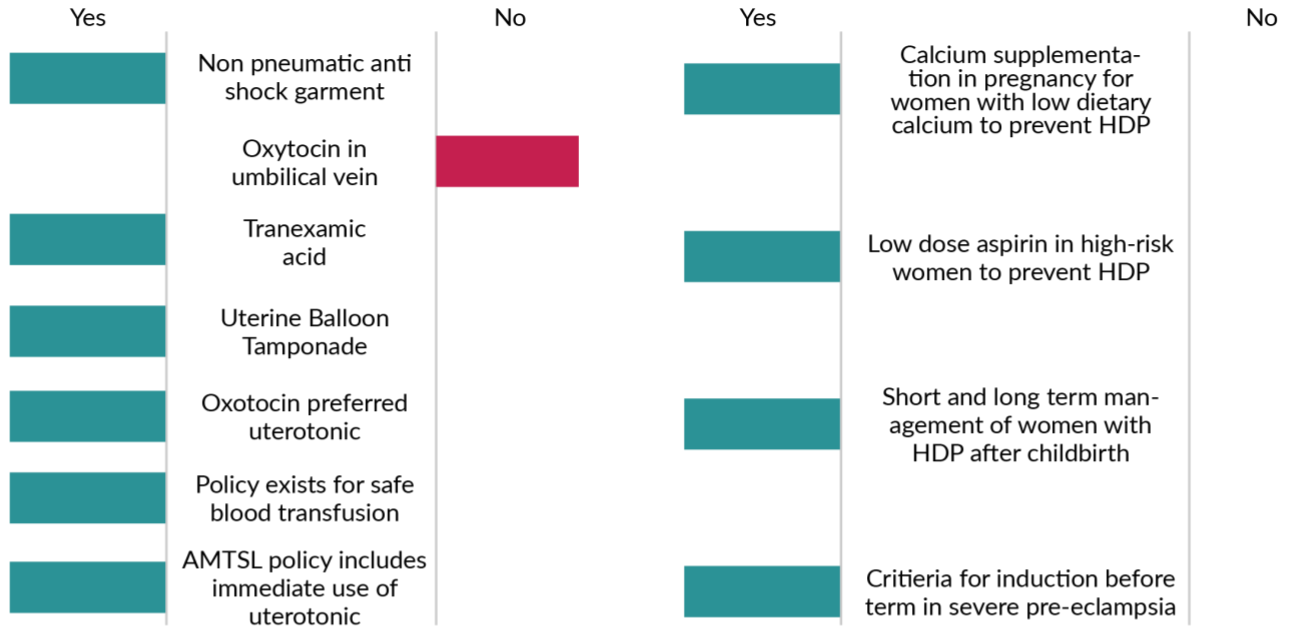


Capacity building ▸ 28/40 Current	Drug availability ▸ 21/29 Current
Midwife scope of practice ▸ 6/10 Current	National guidelines ▸ 21/25 Current
Reporting of MH indicator ▸ 6/6 Current	Procurement & distribution ▸ 10/12 Current

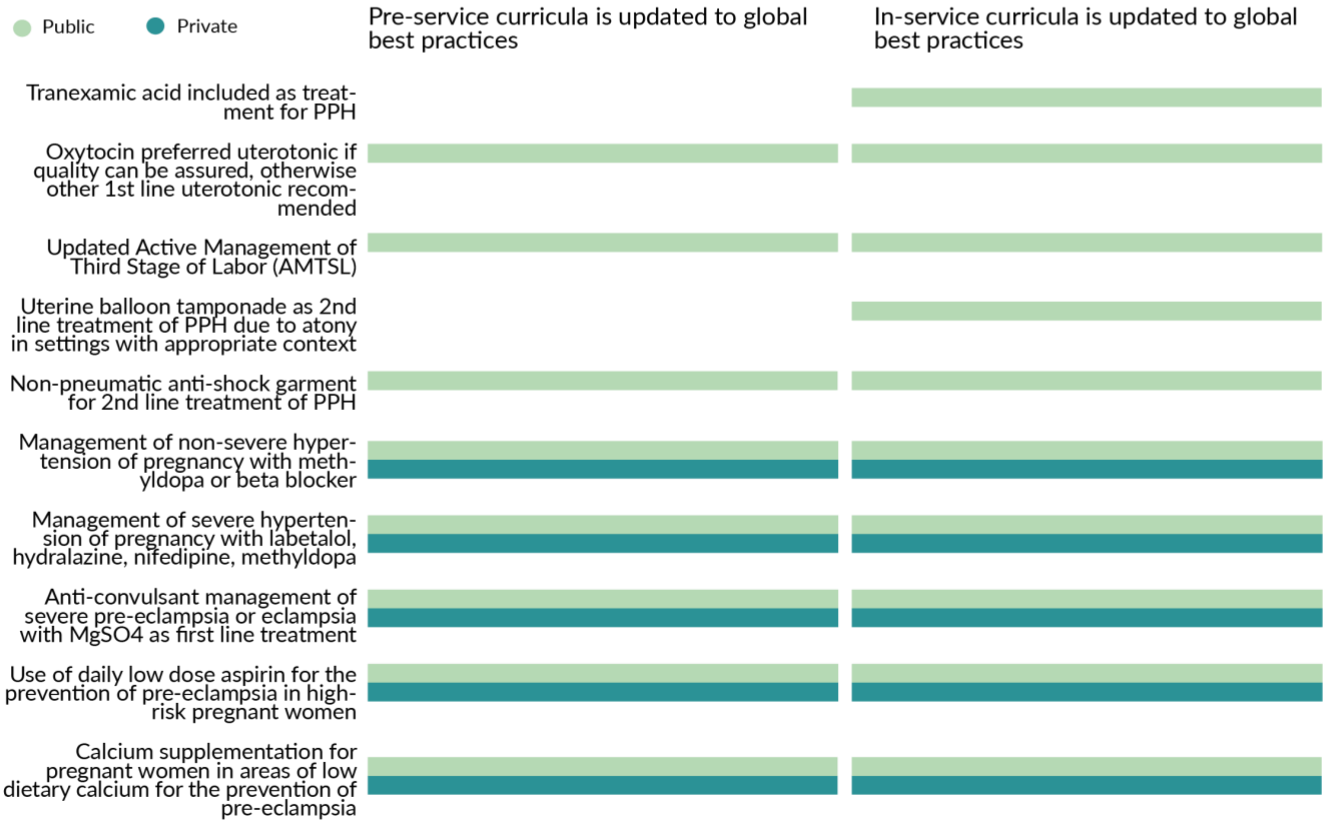
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☒	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

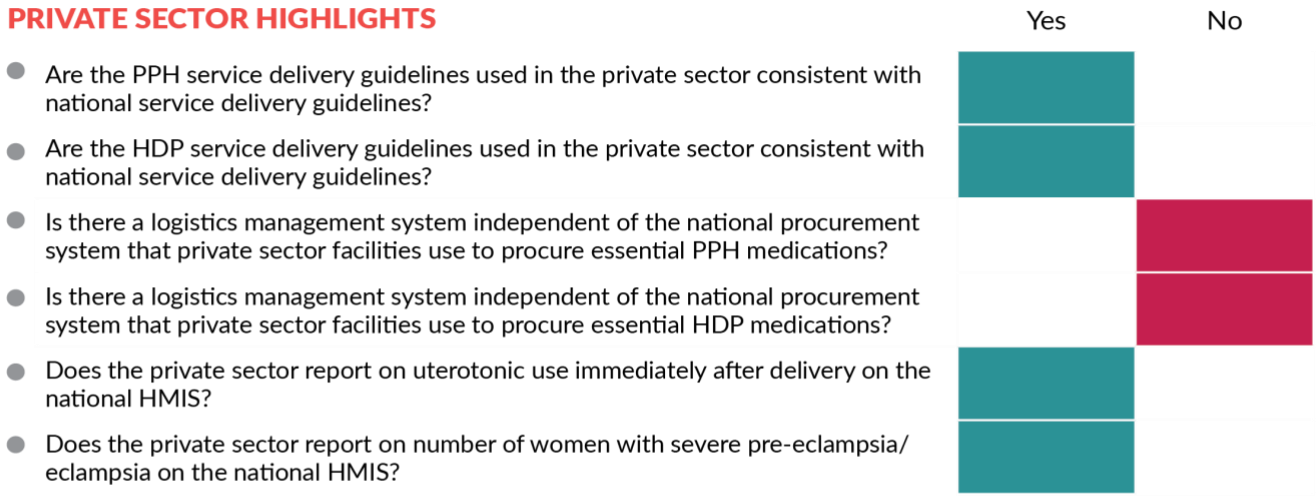


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Ethiopia

PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

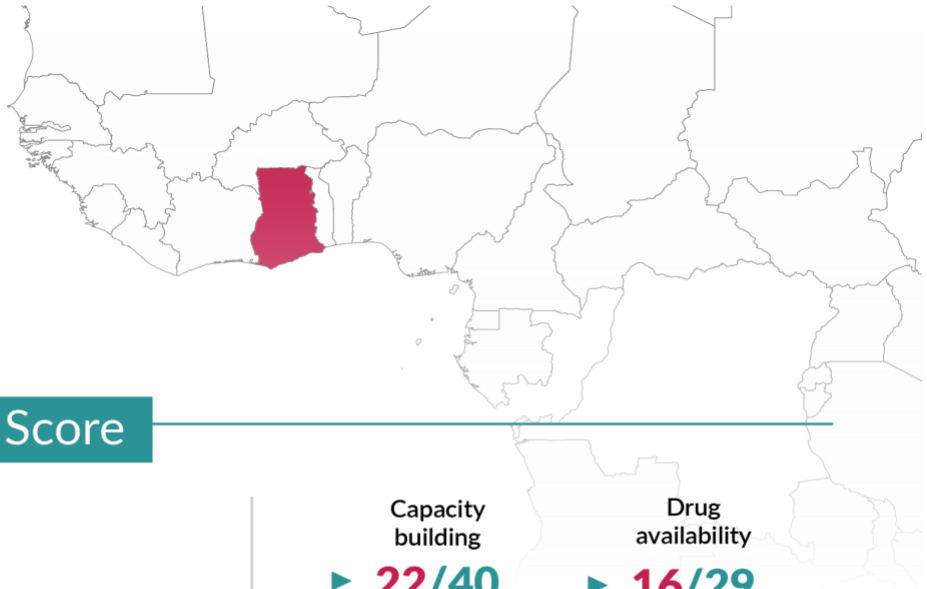
Opportunities for PPH

- "The MOH transformational plan, strategic directions, guidelines, and protocols support any program introduction, expansion, or scaleup."

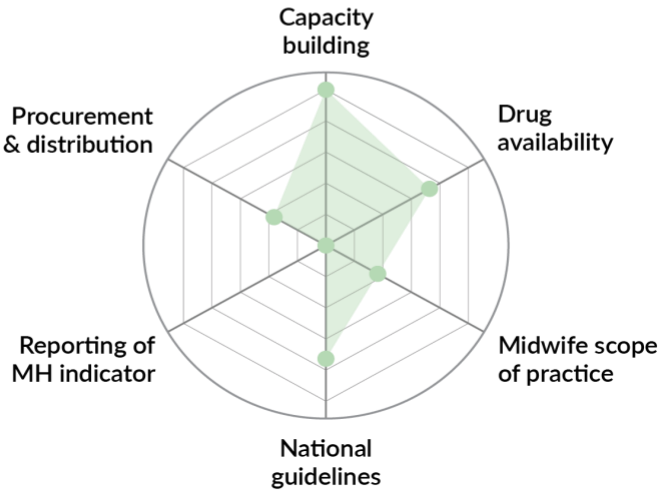
Opportunities for HDP

- "The MOH transformational plan, strategic directions, guidelines, and protocols support any program introduction, expansion, or scaleup."

Country Profile: GHANA



Current Composite Score

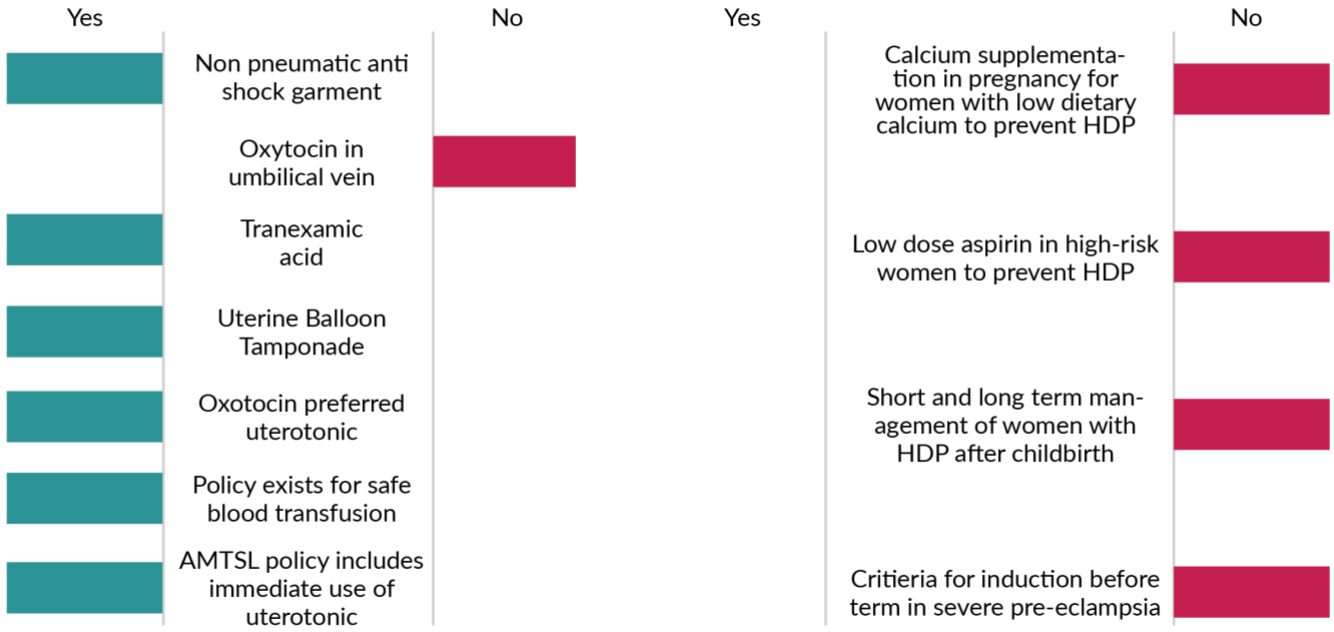


Capacity building ▶ 22/40 Current	Drug availability ▶ 16/29 Current
Midwife scope of practice ▶ 8/10 Current	National guidelines ▶ 16/25 Current
Reporting of MH indicator ▶ 0/6 Current	Procurement & distribution ▶ 8/12 Current

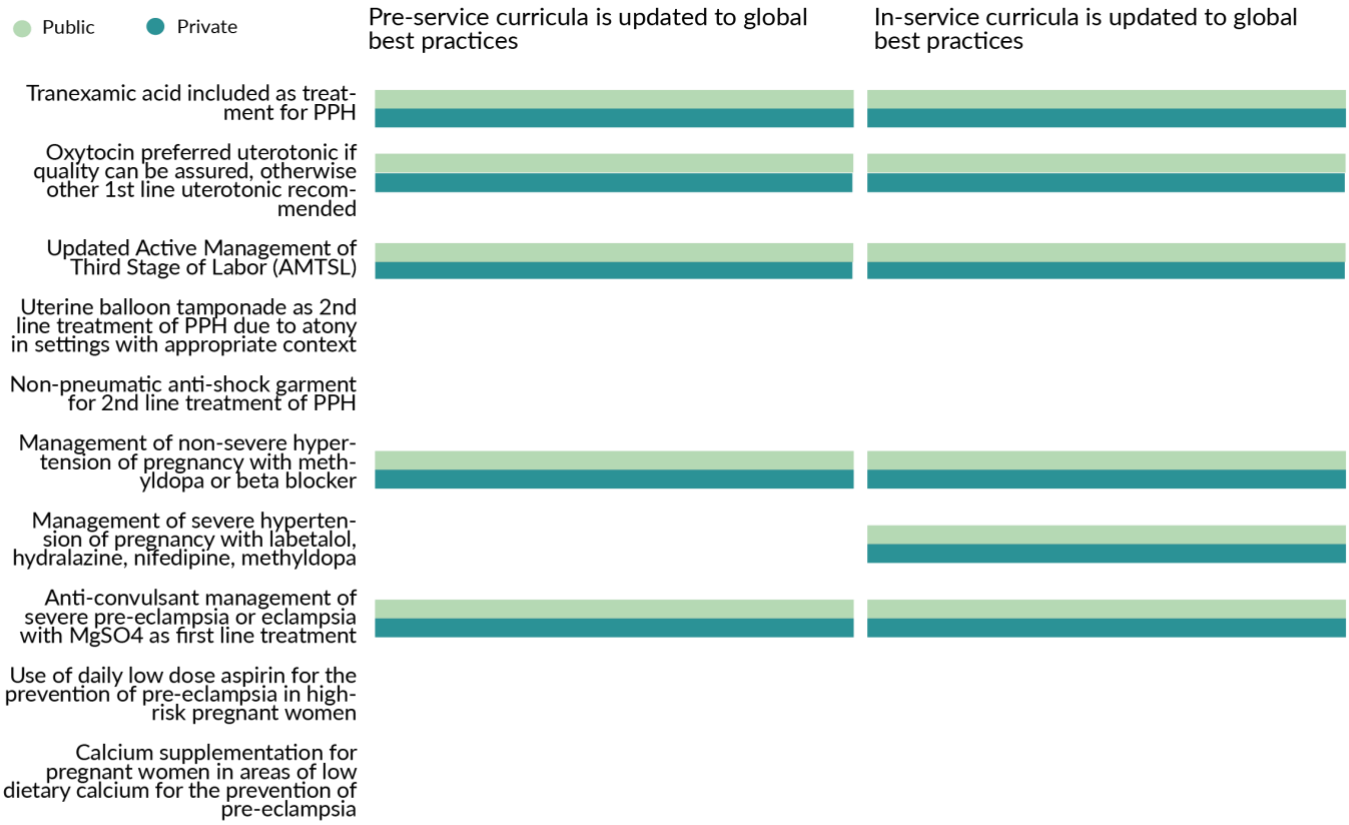
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☑	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☑	☑

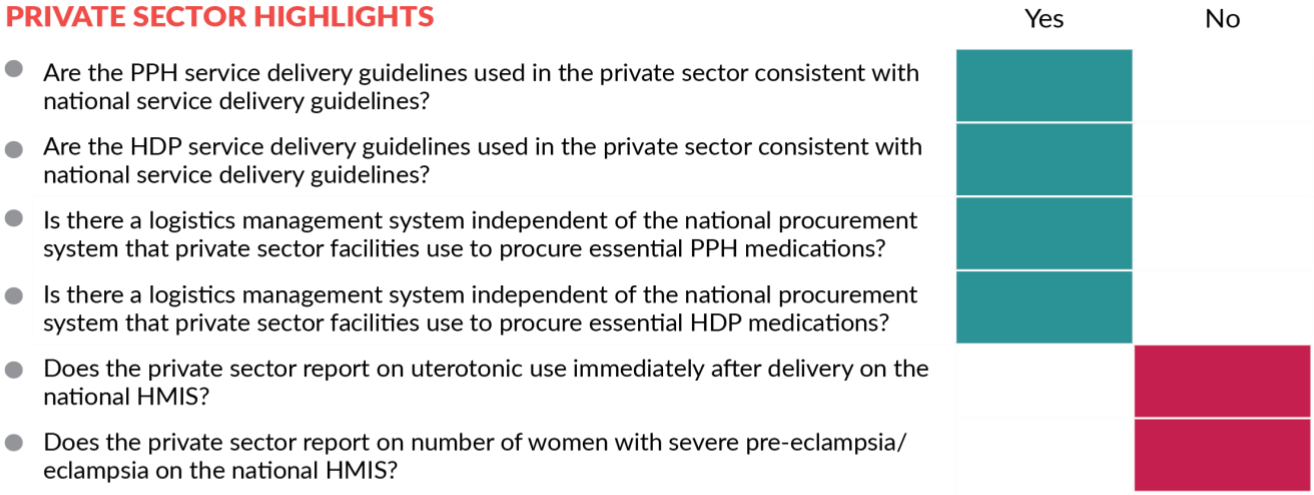
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

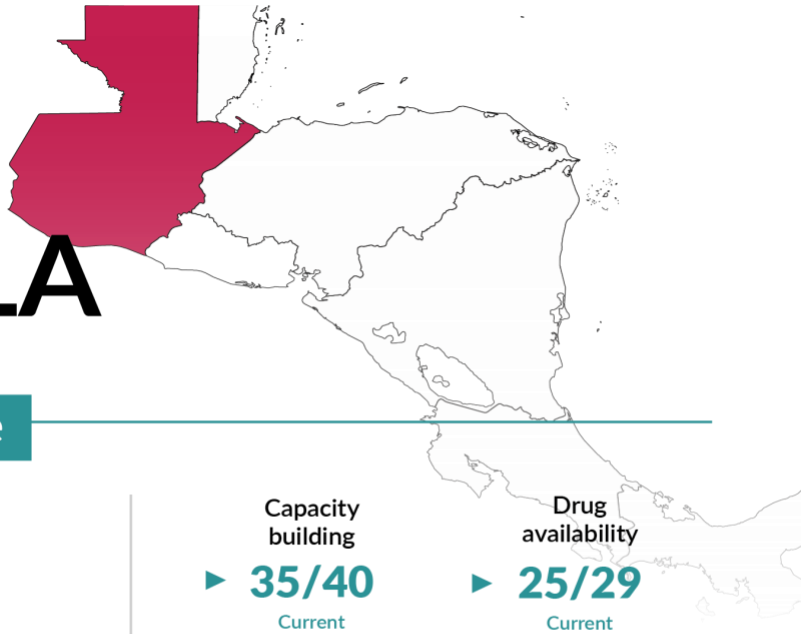
Opportunities for PPH

- "Introduction of new technology e.g baloon tamponade, anti-shock garment, introduction of carbetocin."
- "Linking up the private and public sectors in trainings/capacity building."

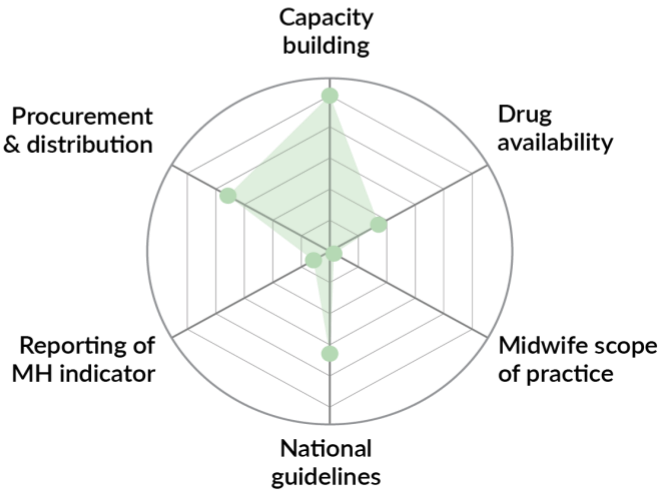
Opportunities for HDP

- "Introduction of HDP into national data collection."
- "Systems for procurement and distribution of magnesium sulfate."
- "Training on site for both public and private sectors."
- "Networking and linkage to appropriate referral systems for HDP."

Country Profile: GUATEMALA



Current Composite Score



Capacity building
35/40
Current

Drug availability
25/29
Current

Midwife scope of practice
4/10
Current

National guidelines
23/25
Current

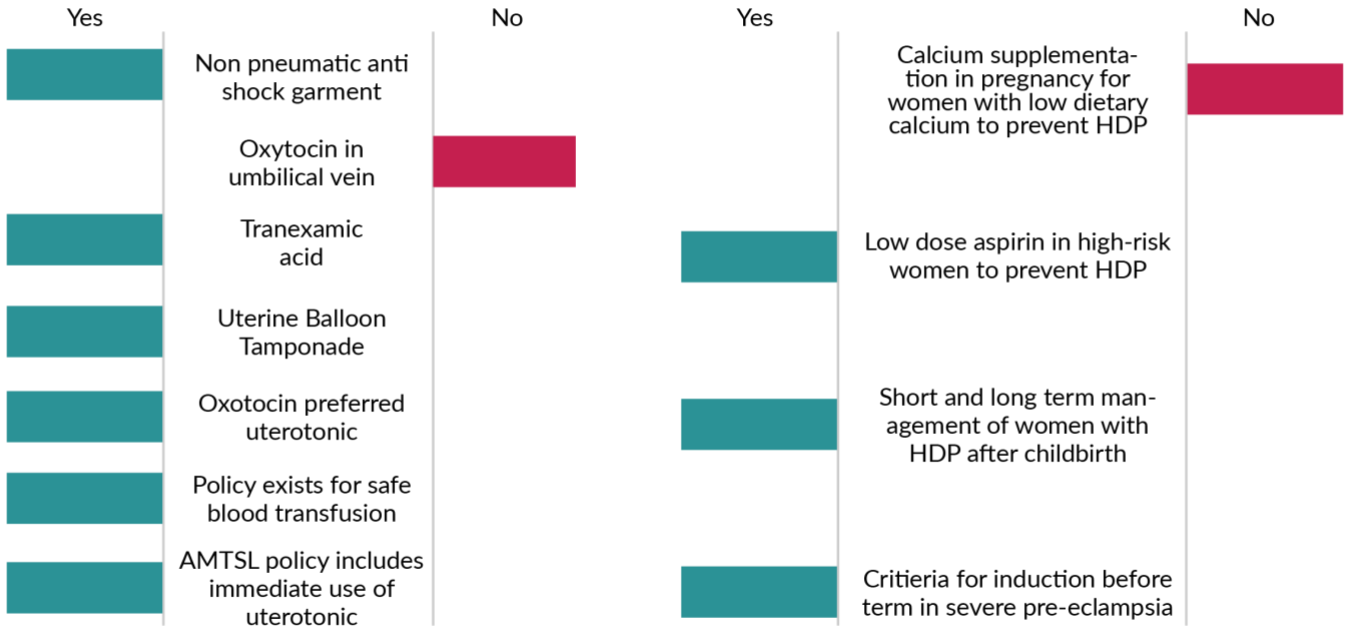
Reporting of MH indicator
1/6
Current

Procurement & distribution
12/12
Current

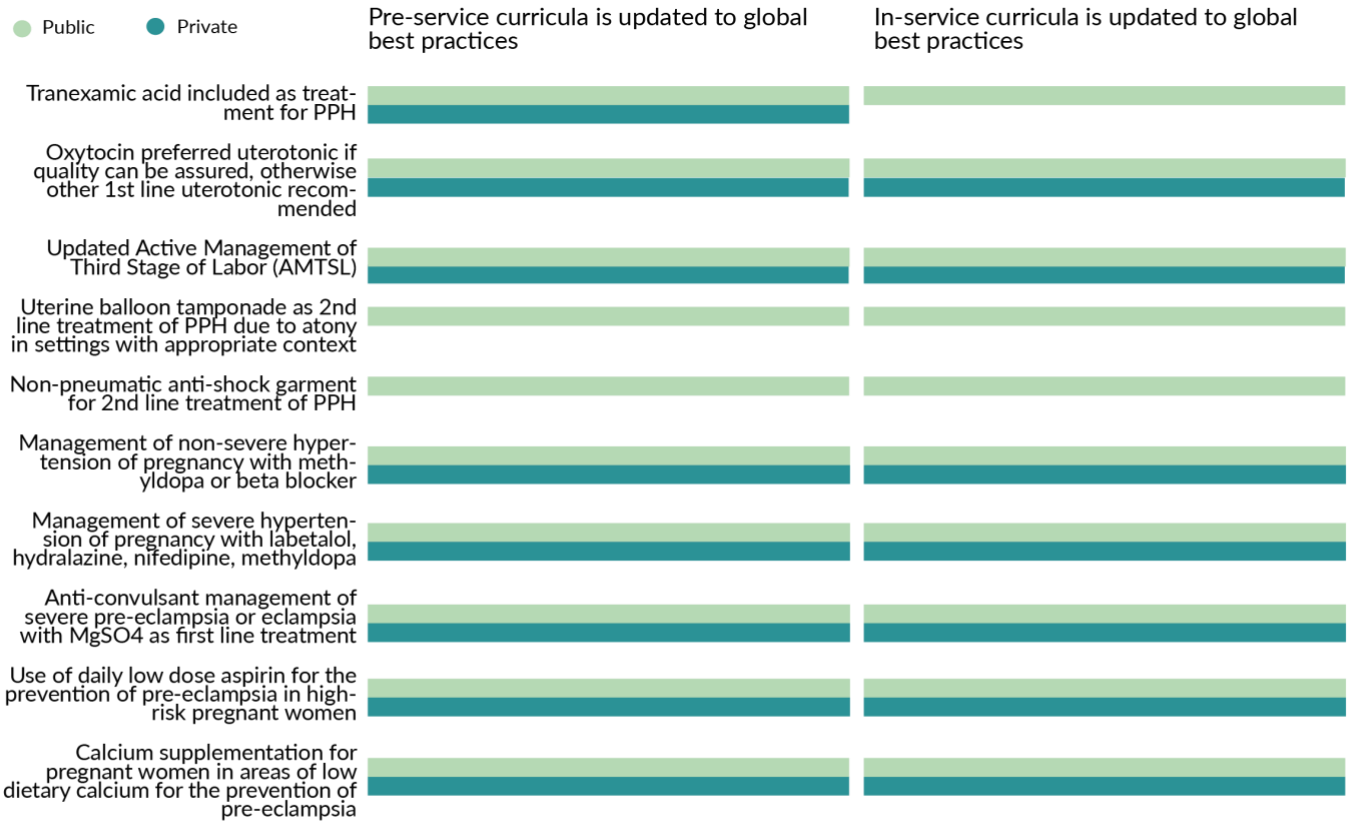
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☒	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

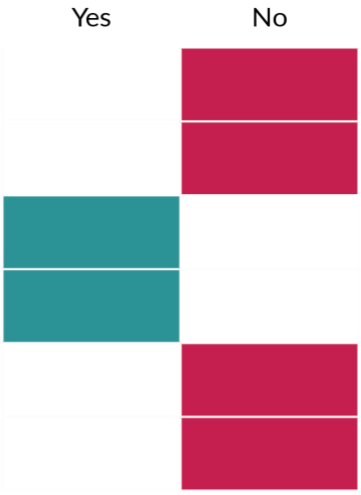


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Guatemala

PRIVATE SECTOR HIGHLIGHTS



- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

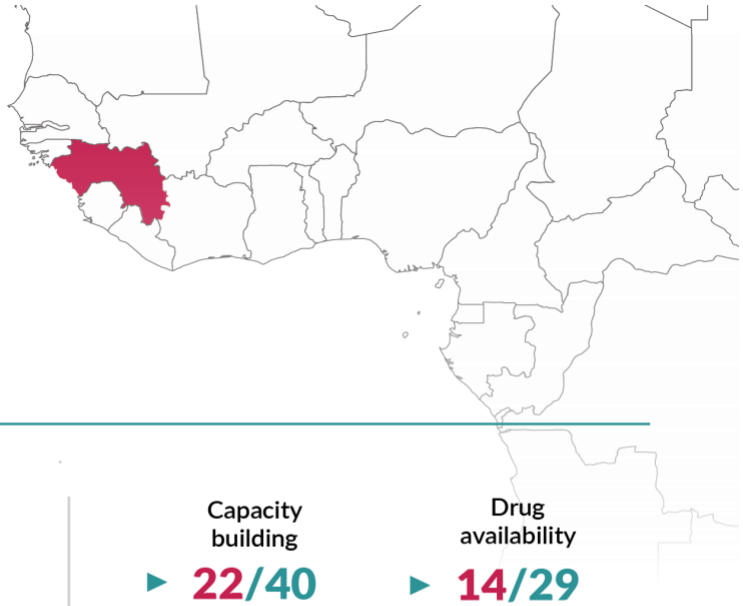
Opportunities for PPH

- "Logistics in the public sector."
- "There is a Healthy Motherhood law that regulates the priority of actions for the prevention of maternal death."
- "Legal framework of the health system as a regulatory entity."
- "Training of midwives of the university technical level."
- "Private universities with EPS (Supervised Professional Exercise) that rotate in the healthcare system."

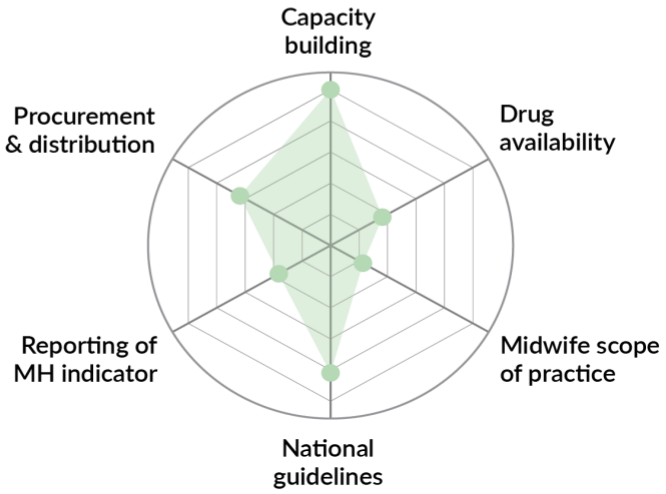
Opportunities for HDP

- "Logistics in the public sector."
- "Healthy motherhood law."
- "Legal framework for the reduction of maternal death."
- "Training of midwives of the university technical level in the health system."
- "Participation of the Universities in the training of professionals."
- "Learn from COVID-19 to accelerate public-private coordination, with guidelines."

Country Profile: GUINEA



Current Composite Score



Capacity building
22/40
Current

Drug availability
14/29
Current

Midwife scope of practice
8/10
Current

National guidelines
18/25
Current

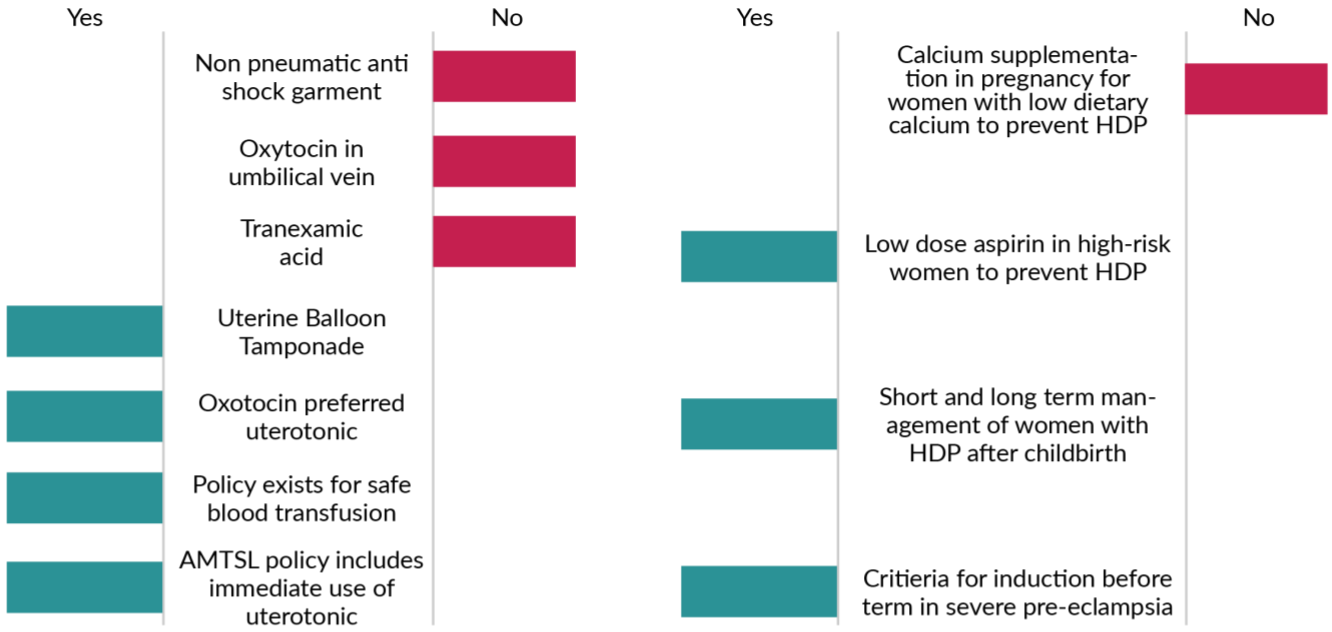
Reporting of MH indicator
5/6
Current

Procurement & distribution
8/12
Current

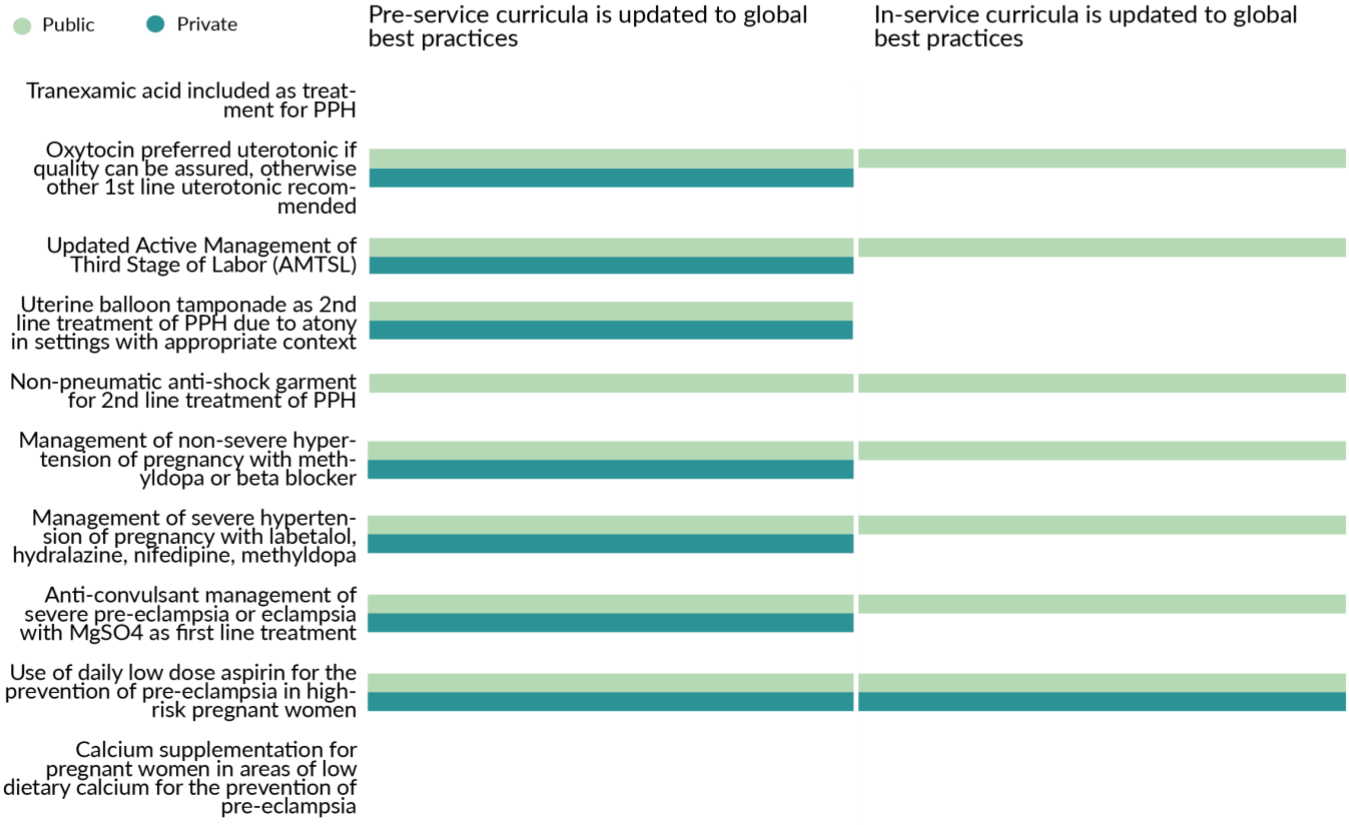
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☒	☑	☒	☒	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☒	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

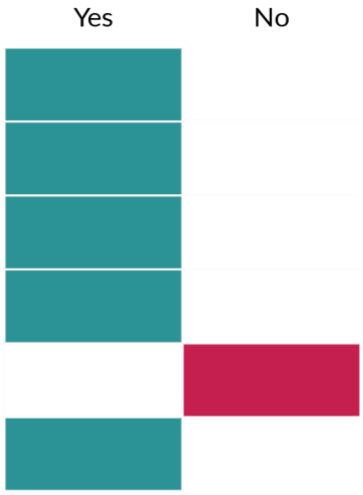


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Guinea

PRIVATE SECTOR HIGHLIGHTS



- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

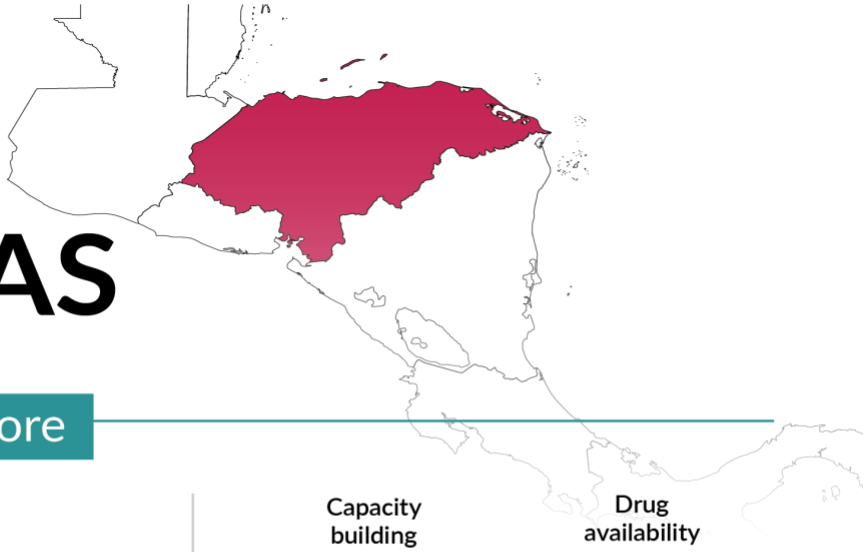
- "The introduction of TXA into the essential medications list will permit the updating of documents like the norms and protocols, training curricula, etc."
- "The introduction at scale of the anti-shock garment as second-line treatment of PPH in pre-service and in-service education and as care in health facilities."
- "The introduction into the reproductive health norms and procedures and implementation at scale of umbilical vein injection of oxytocin for treatment of retained placenta, and into pre-service and in-service education and as care in health facilities."
- "Disseminating Information about utilisation of misoprostol at health facility and community levels for PPH."
- "The existence of a national family health and nutrition directorate for regular updating of norms and for efforts to go to scale."
- "The presence of technical and financial partners to accompany the MOH across reproductive health programs."

Opportunities for HDP

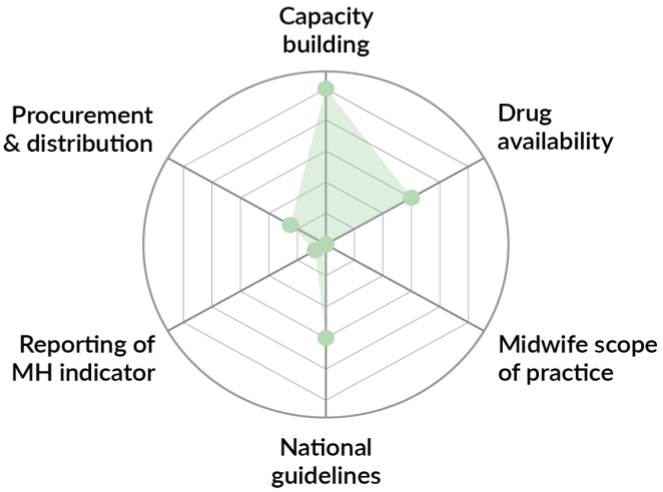
- "Speed up the integration of the private sector into the national health information system: information, communication, training, equipping, supervision."
- "The integration of the private sector in training sessions on HDP via BEmONC and CEmONC."
- "The recent existence of a national directorate of public and private hospitals will permit the effective participation of the private sector at all levels."
- "The existence of a national family health and nutrition directorate to regularly update normative documents and for efforts to go to scale."
- "The presence of technical and financial partners to accompany the MOH across reproductive health programs."

Country Profile: Guinea

Country Profile:
HONDURAS



Current Composite Score



Capacity building
▶ 40/40
Current

Drug availability
▶ 24/29
Current

Midwife scope of practice
▶ 0/10
Current

National guidelines
▶ 24/25
Current

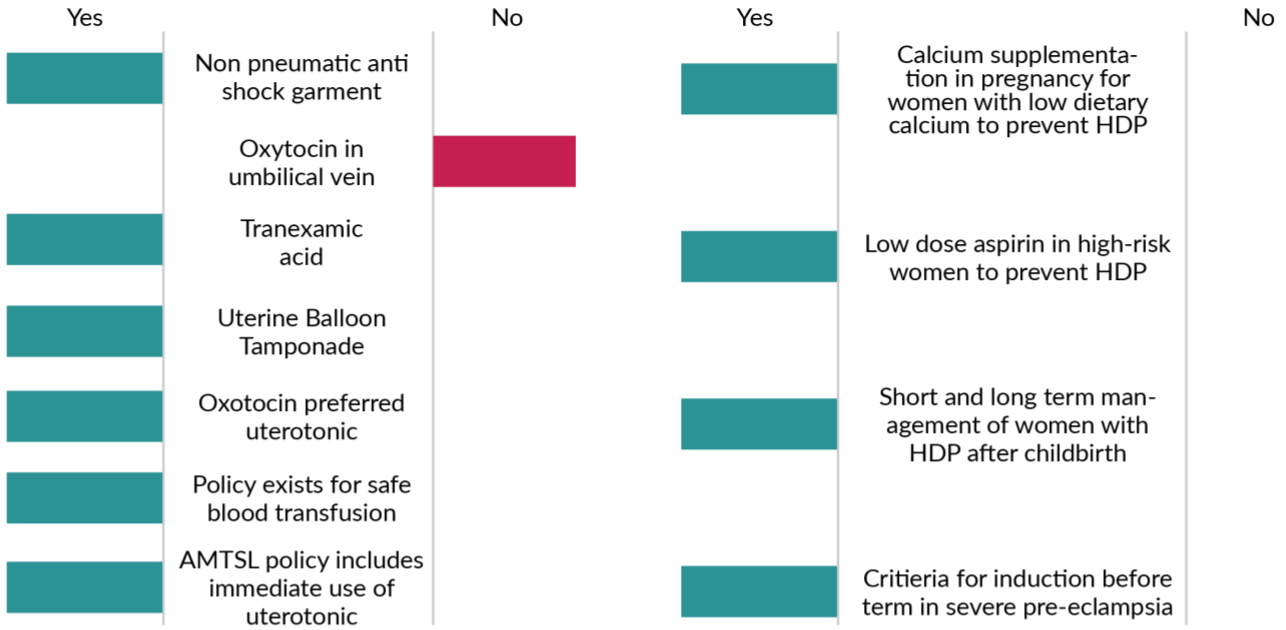
Reporting of MH indicator
▶ 3/6
Current

Procurement & distribution
▶ 10/12
Current

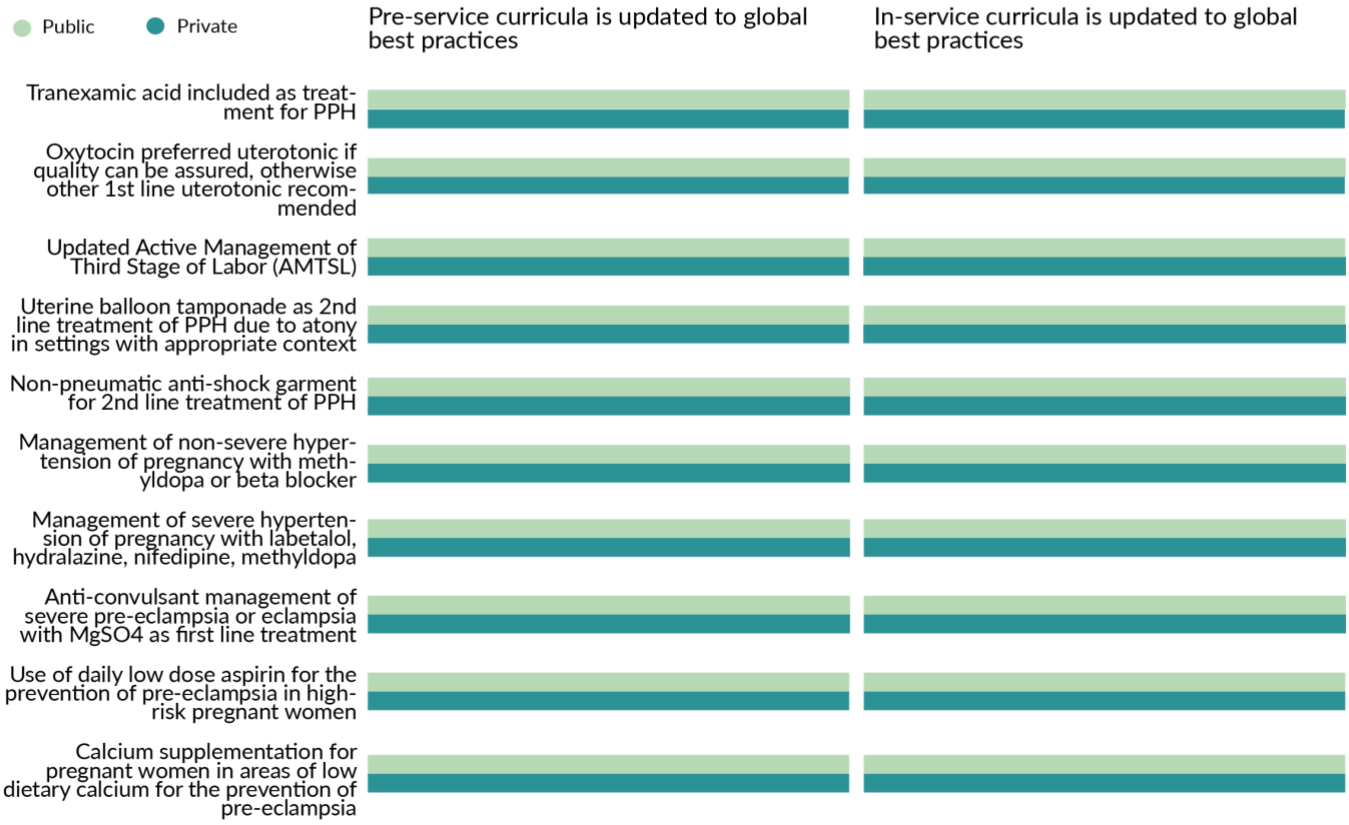
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

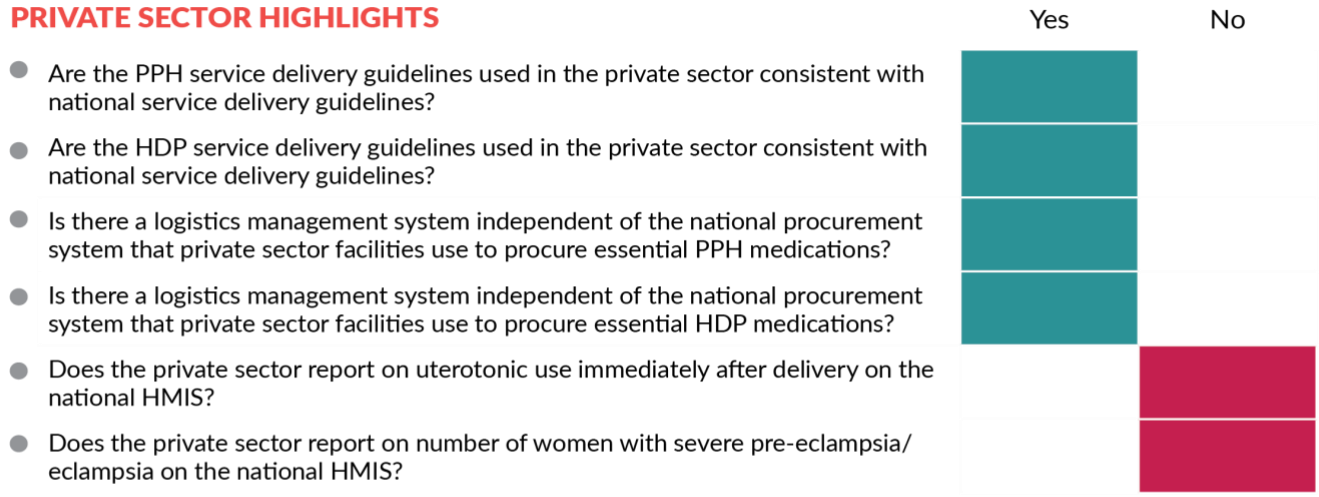
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

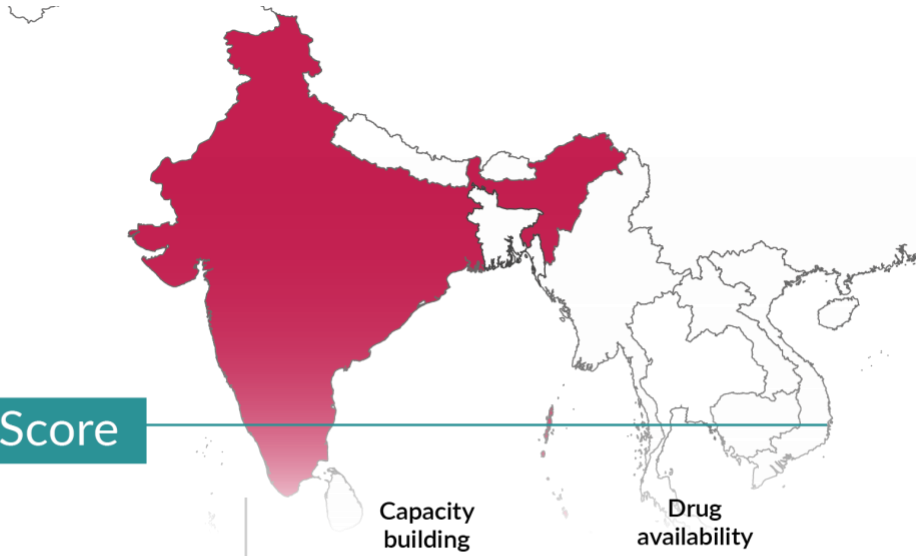
Opportunities for PPH

- "Continuous updates in maternal and neonatal health servers in the public and private sectors."
- "Standardization of PPH management protocols in the public and private sectors."
- "Exchange of experiences."

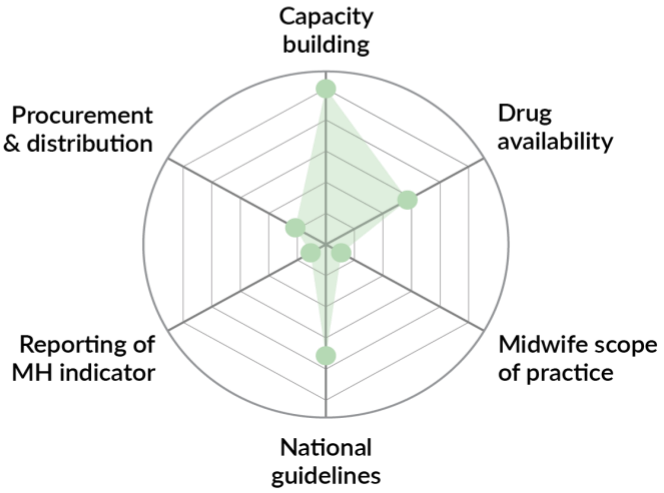
Opportunities for HDP

- "Updating of the standard, follow-up, monitoring, evaluation and accountability."
- "Standardization of protocols at the public and private level."
- "Expansion of opportunities for agreements with academic institutions."

Country Profile: INDIA



Current Composite Score



Capacity building
28/40
Current

Drug availability
16/29
Current

Midwife scope of practice
3/10
Current

National guidelines
20/25
Current

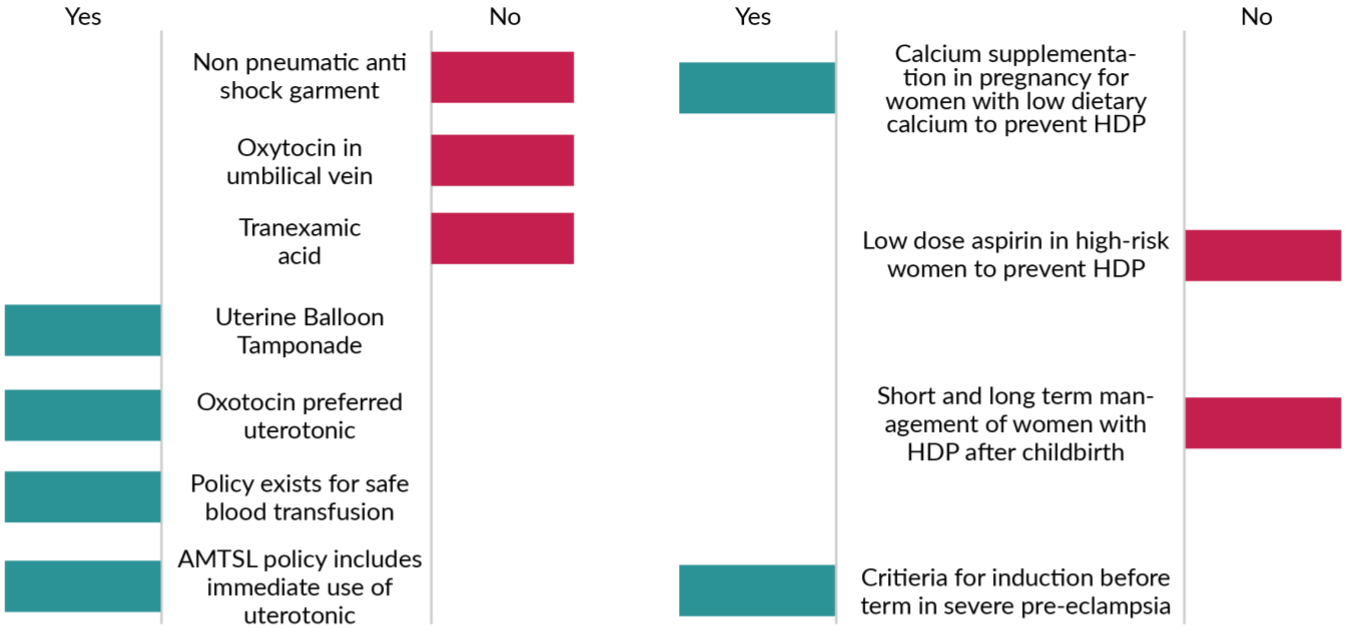
Reporting of MH indicator
3/6
Current

Procurement & distribution
6/12
Current

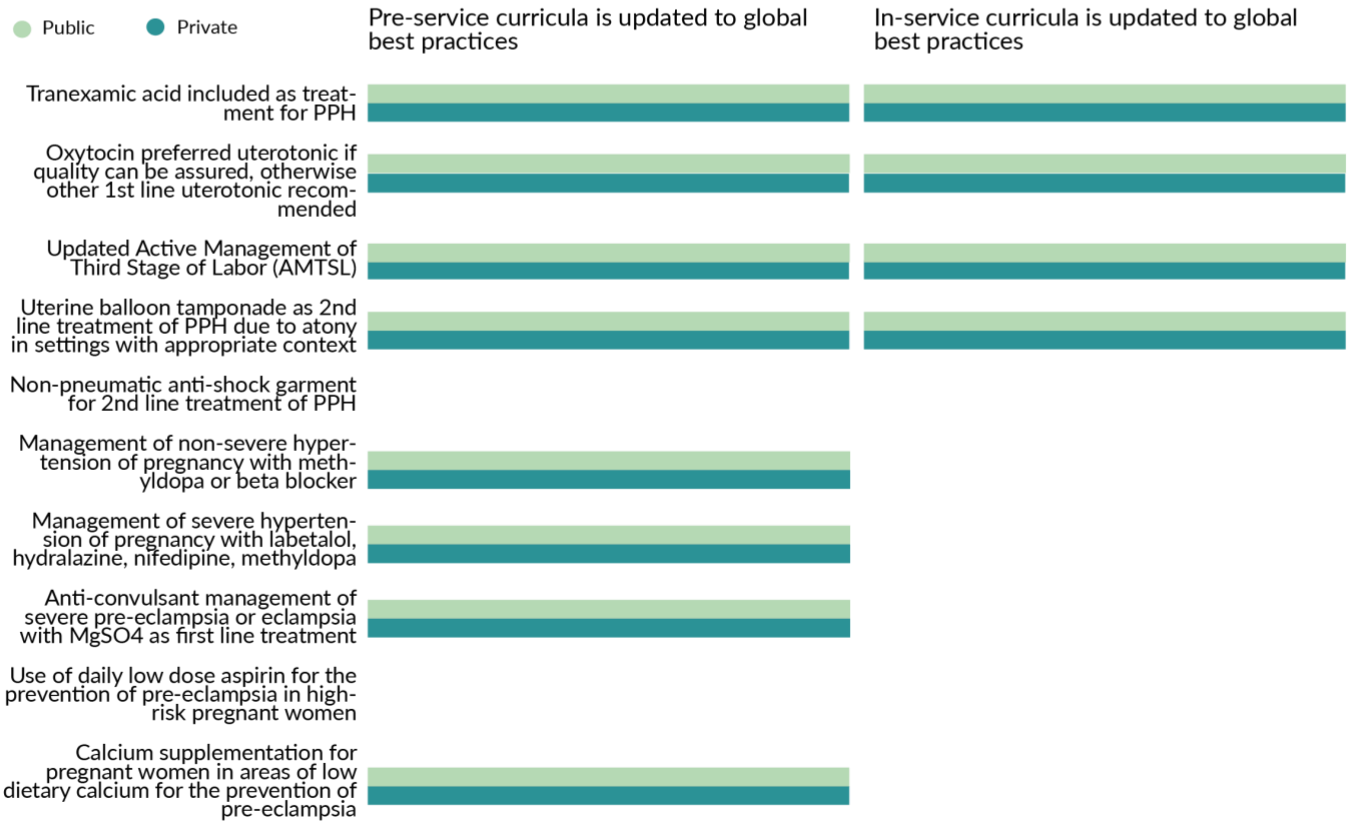
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☑	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

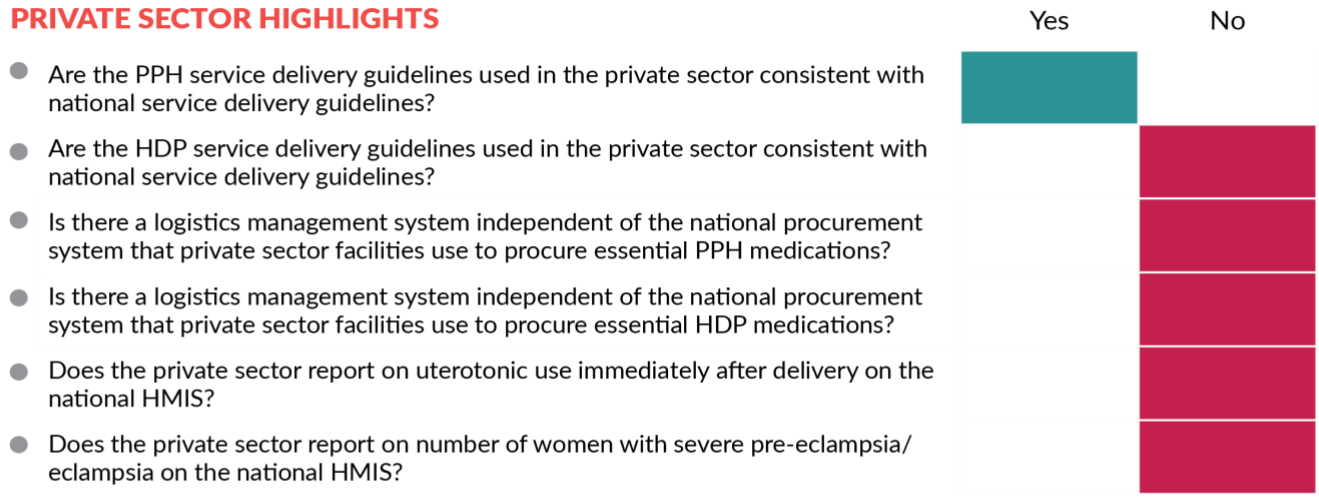


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: India

PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

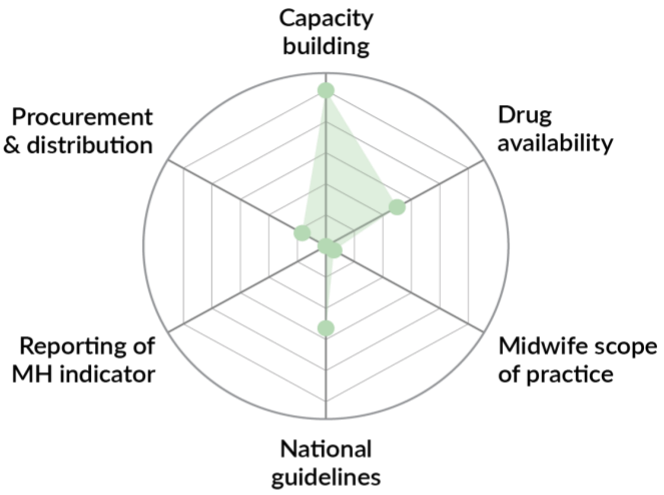
- "Use of heat stable carbetocin (HSC)."
- "Cost-effective, easy to use, assemble UBT."
- "NASG."
- "PPH Bundle approach."

Opportunities for HDP

- "Early diagnosis by simple measure even at community level."
- "Aspirin prophylaxis."
- "Total district approach."
- "Use of technology."
- "Public private collaboration."
- "Uniform Capacity building opportunities."

Country Profile:
INDONESIA

Current Composite Score

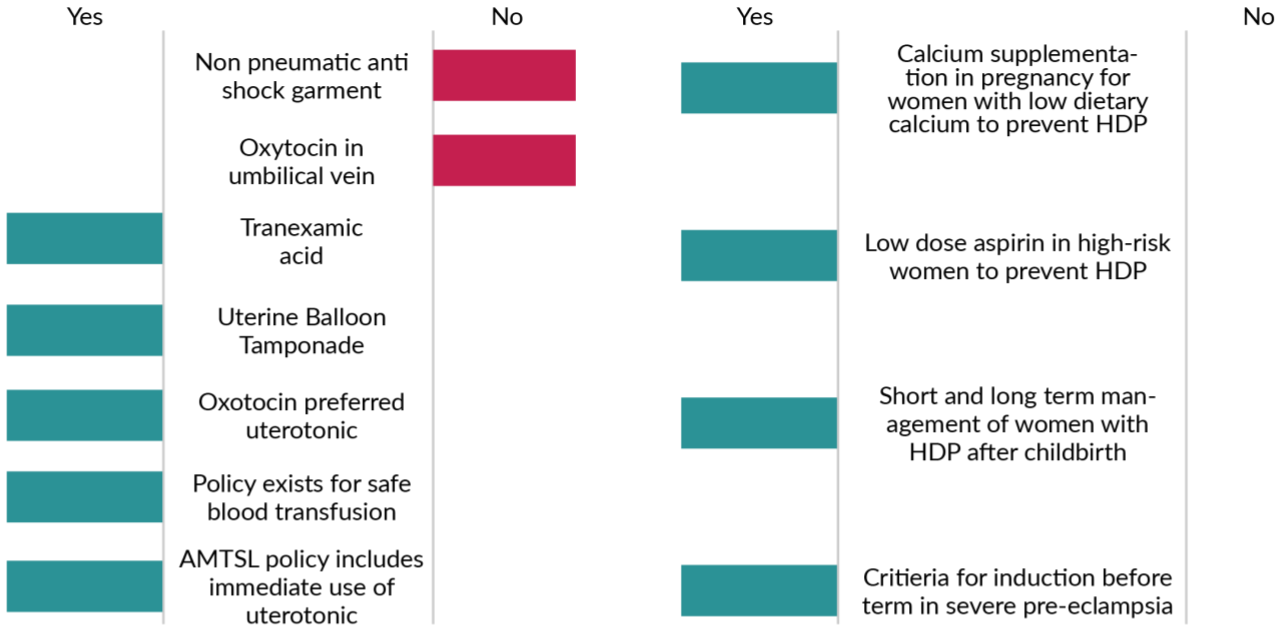


Capacity building ▶ 36/40 Current	Drug availability ▶ 18/29 Current
Midwife scope of practice ▶ 4/10 Current	National guidelines ▶ 19/25 Current
Reporting of MH indicator ▶ 0/6 Current	Procurement & distribution ▶ 6/12 Current

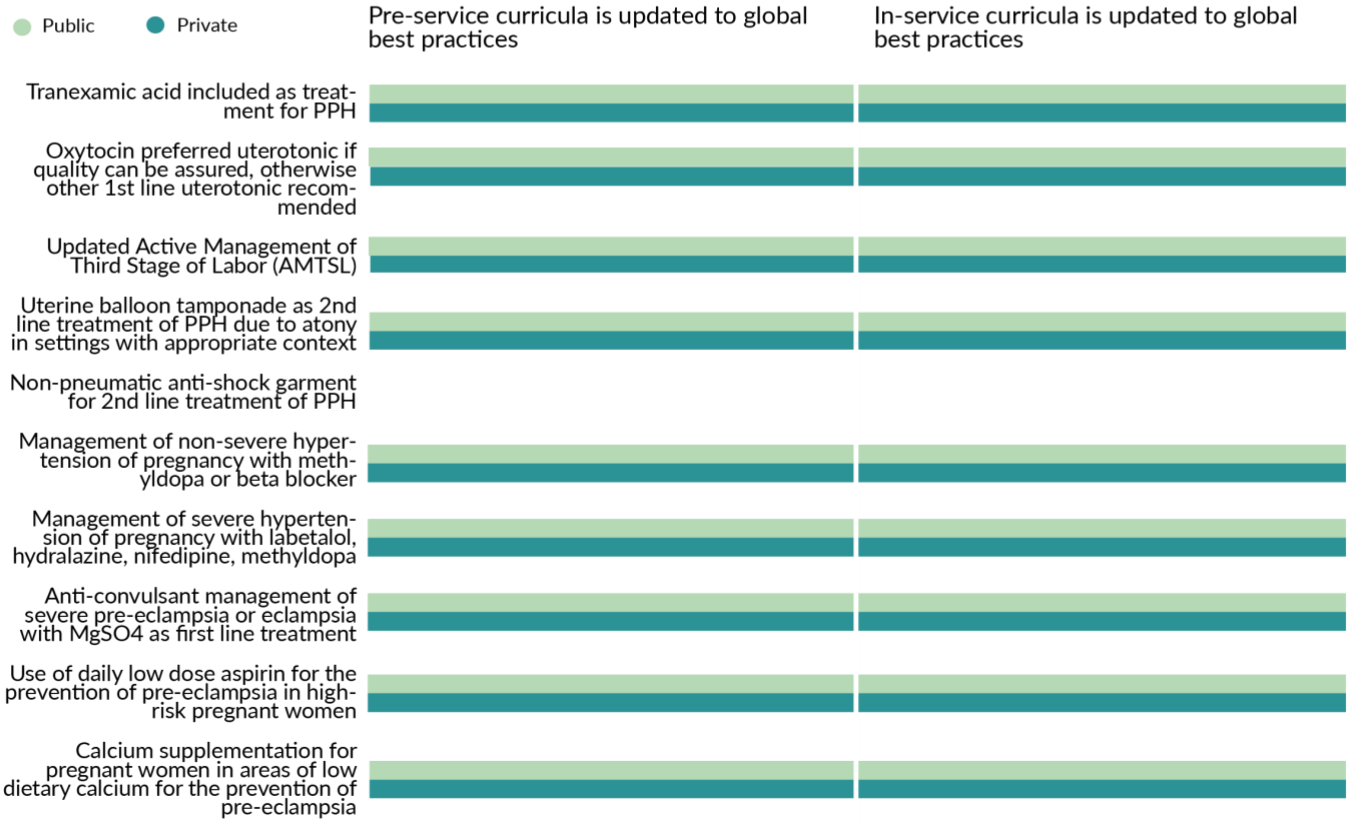
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☒	☒	☒	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

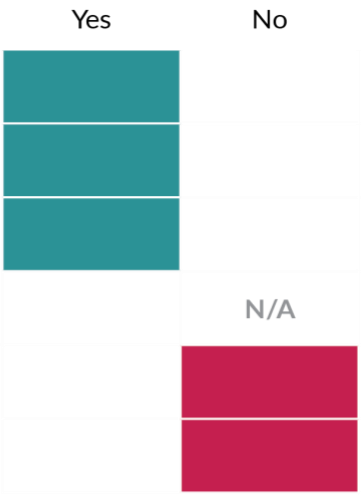
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

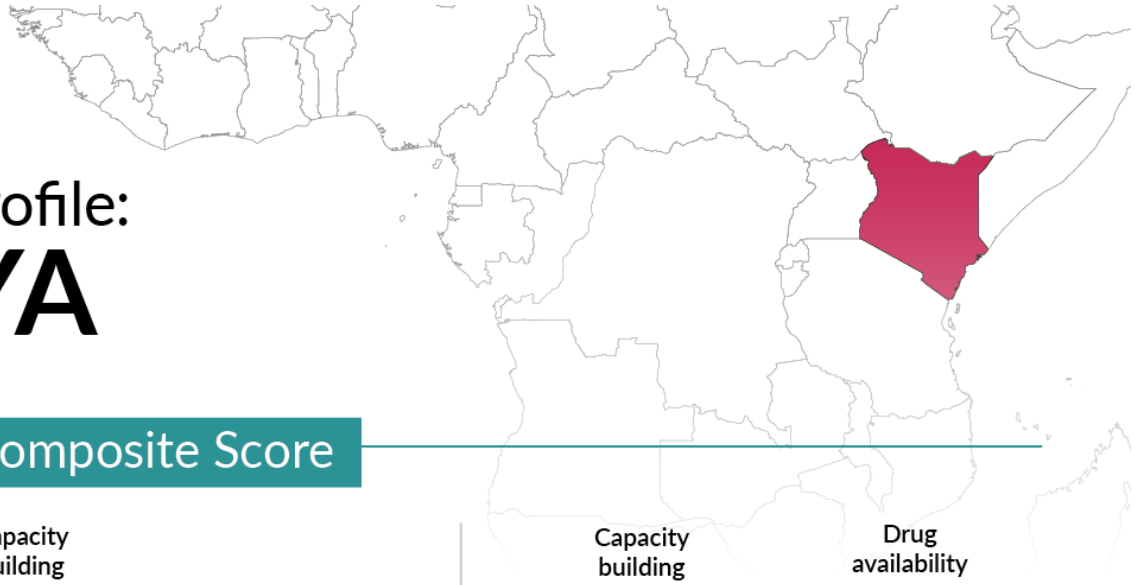
POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

- "Hospital mentoring, webinar, training."

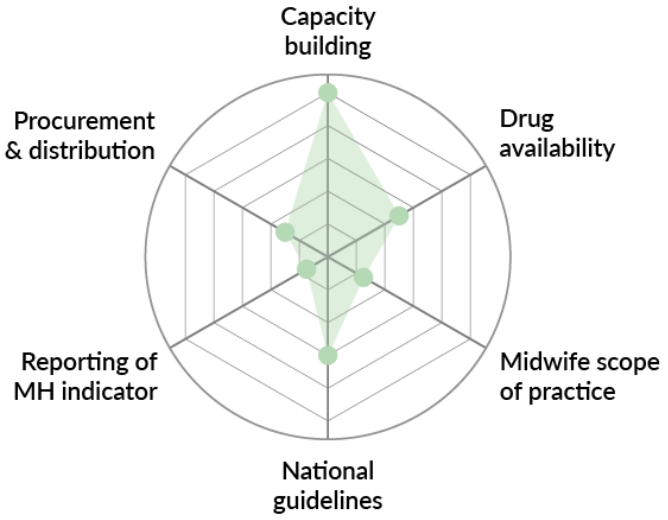
Opportunities for HDP

- "Virtual webinars."



Country Profile:
KENYA

Current Composite Score



Capacity building
▶ 40/40
Current

Drug availability
▶ 20/29
Current

Midwife scope of practice
▶ 10/10
Current

National guidelines
▶ 24/25
Current

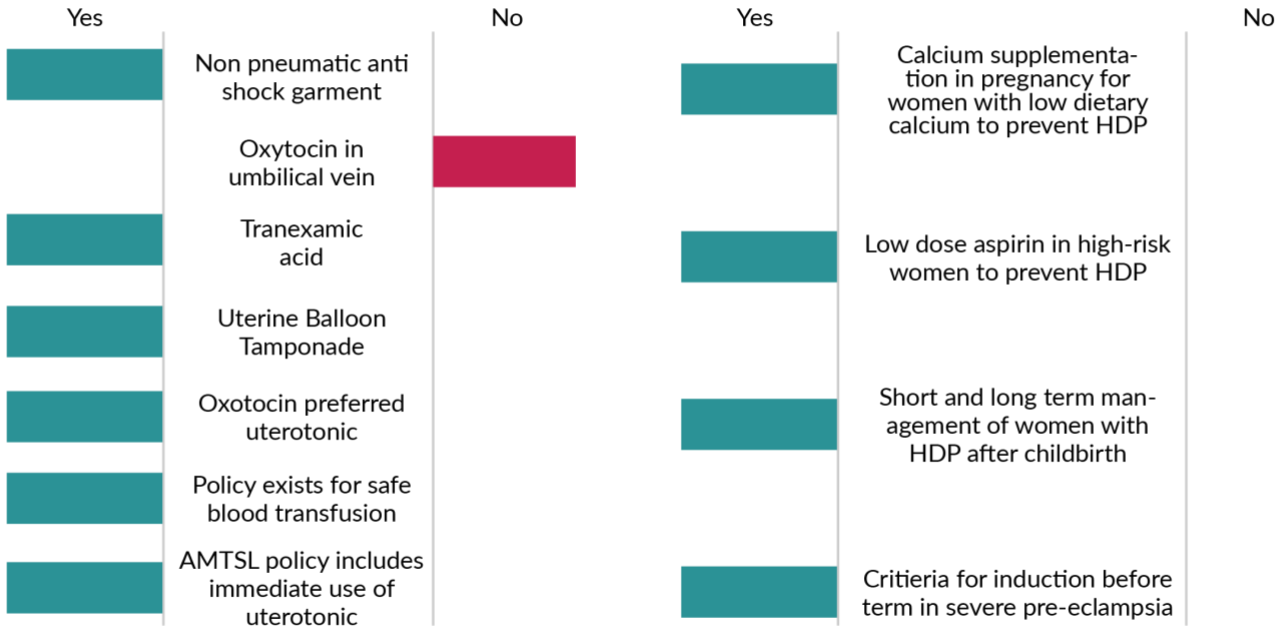
Reporting of MH indicator
▶ 6/6
Current

Procurement & distribution
▶ 12/12
Current

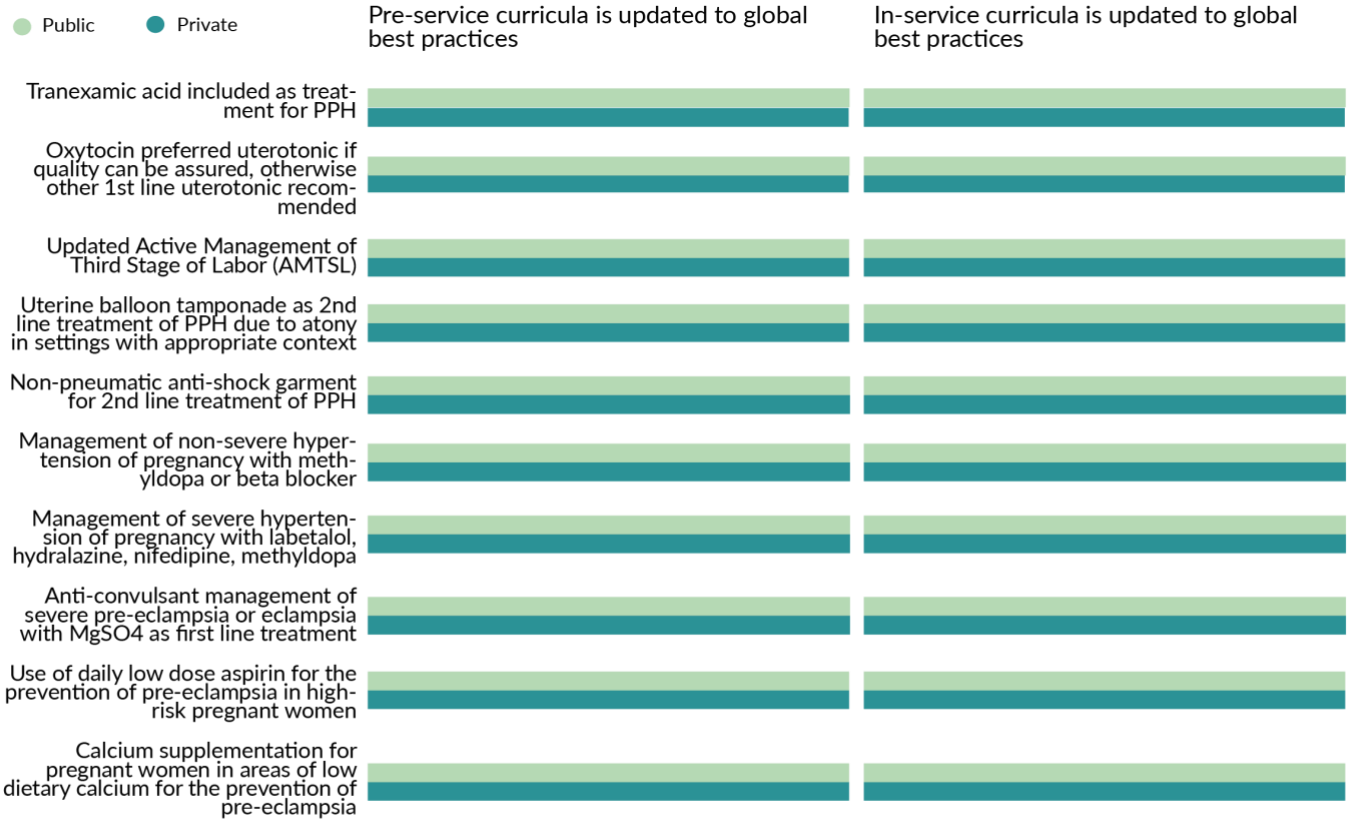
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Kenya

PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

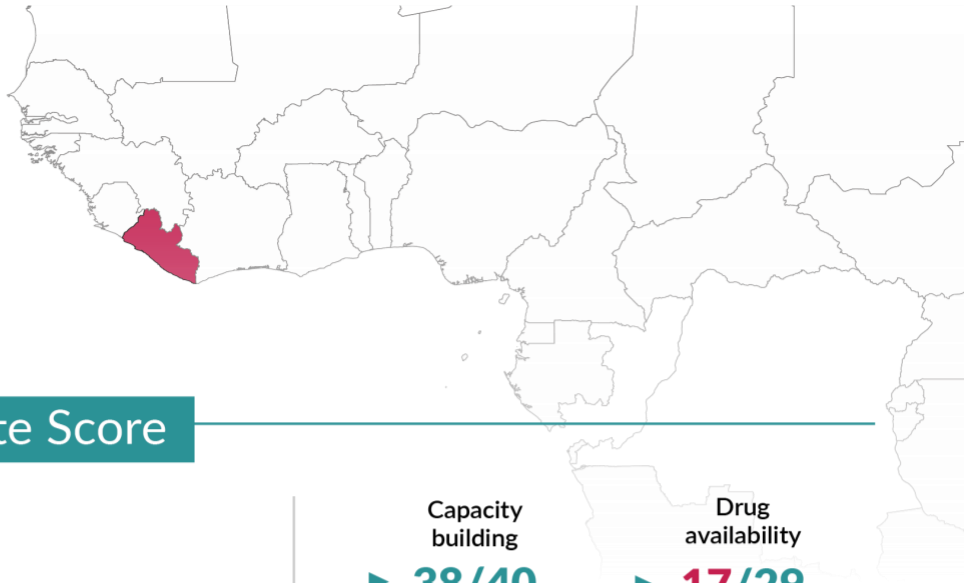
Opportunities for PPH

- "There is private public partnership/ collaboration in place, strengthen pubic private partnership in commodity supply chain, monitoring evaluation and reporting."

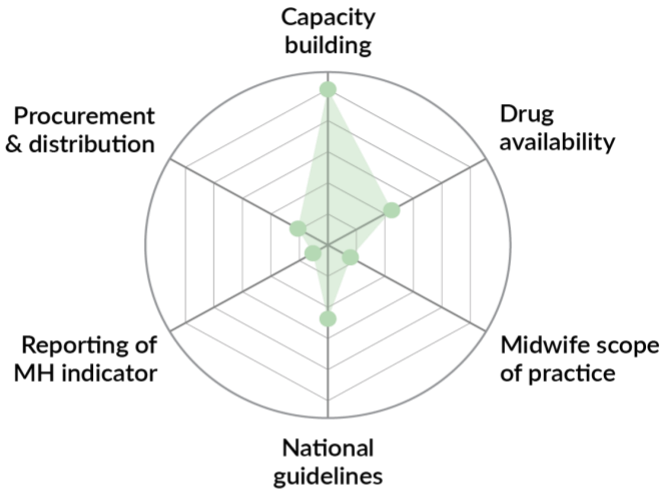
Opportunities for HDP

- "Capacity building of health care providers on HDP, Addressing stock out of HDP commodities"

Country Profile: LIBERIA



Current Composite Score



Capacity building
38/40
Current

Drug availability
17/29
Current

Midwife scope of practice
6/10
Current

National guidelines
18/25
Current

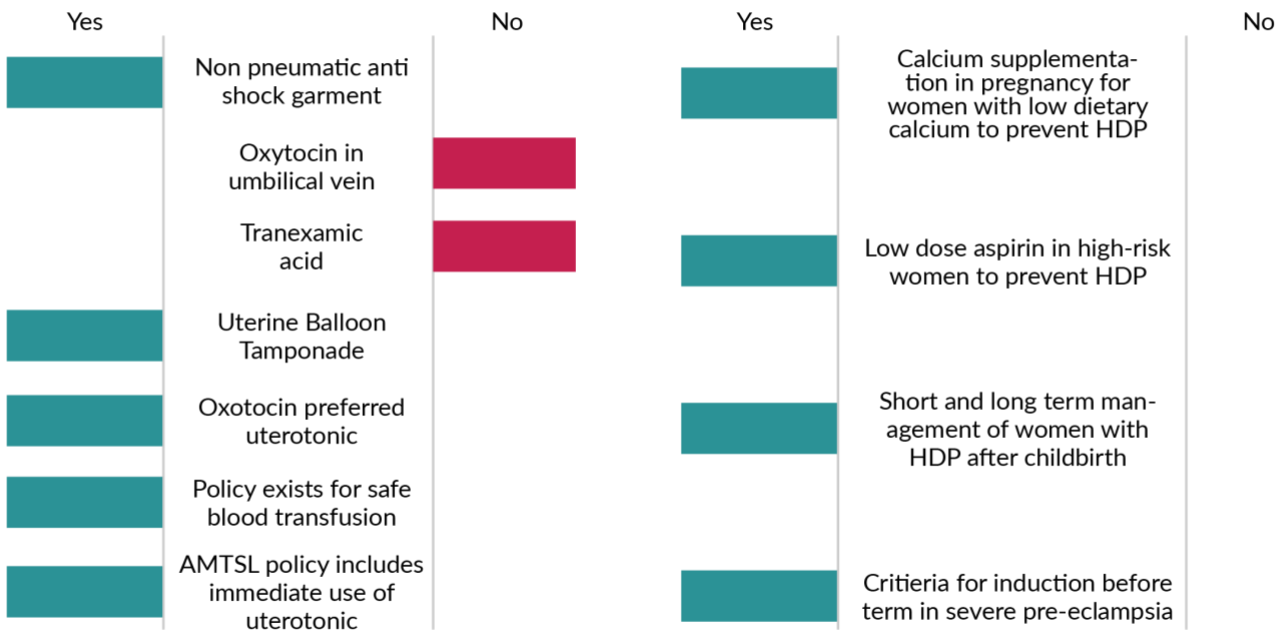
Reporting of MH indicator
4/6
Current

Procurement & distribution
8/12
Current

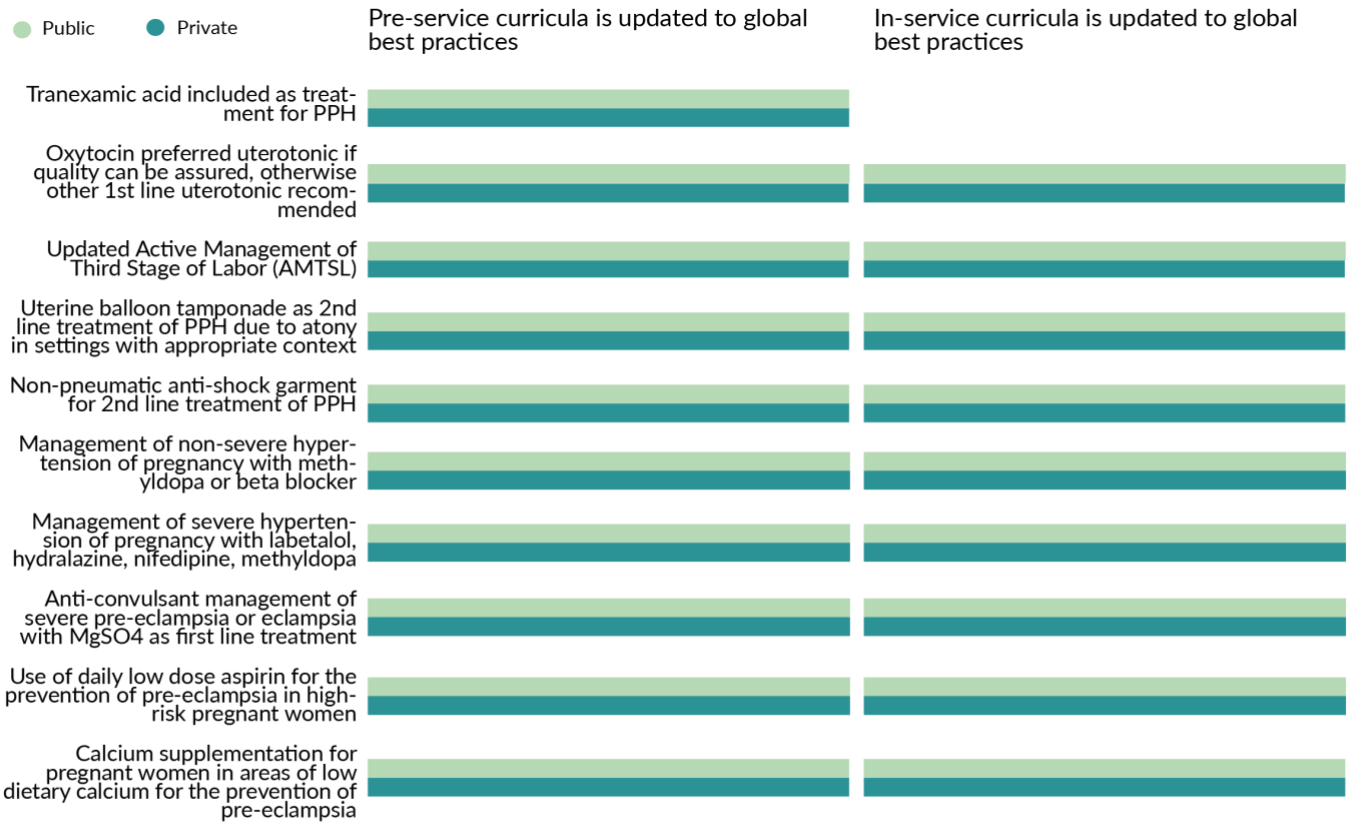
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☑	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Liberia

PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?		
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?		
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?		
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?		
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?		
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?		

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

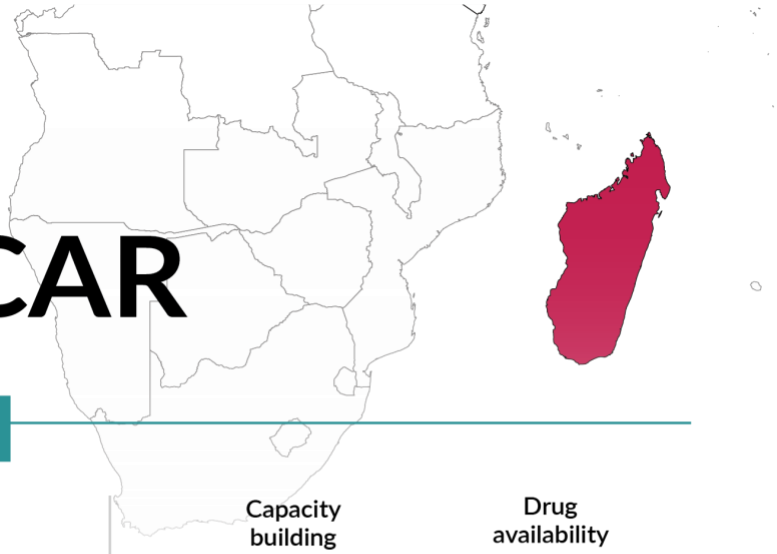
Opportunities for PPH

- "Healthcare federation of Liberia, a consortium supported by USAID assists government in relation to expansion of maternal health programs."
- "Private sector eagerness to support public sector in improving maternal health services including addressing PPH."
- "Capacity building of healthworkers, capacity building especially in supplies and logistics or commodity management."

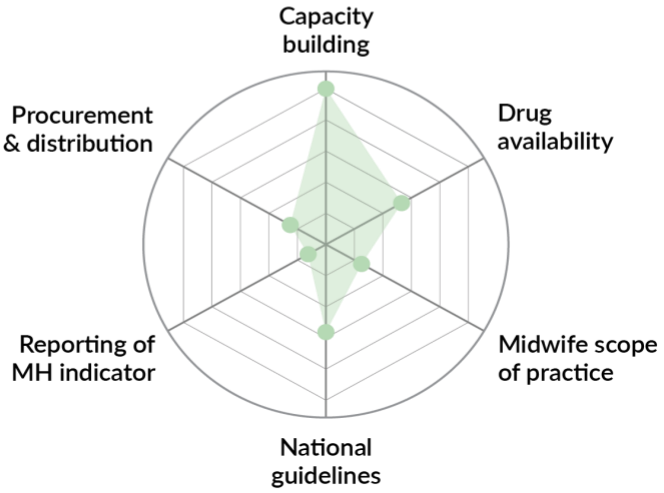
Opportunities for HDP

- "Healthcare federation of Liberia, a consortium supported by USAID assists government in relation to expansion of maternal health programs."
- "Private sector eagerness to support public sector in improving maternal health services including addressing HDP."
- "Capacity building of healthworkers on management of HDP, capacity building especially in supplies and logistics or commodity management to address HDP."

Country Profile:
MADAGASCAR



Current Composite Score

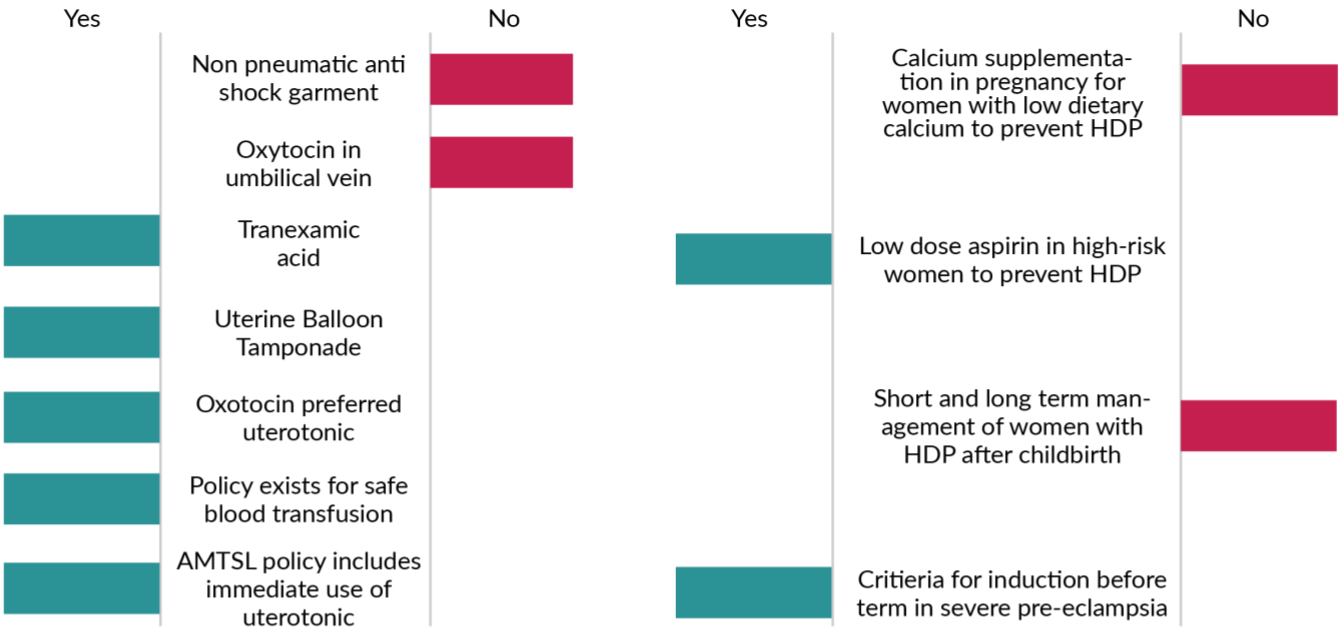


Capacity building ▶ 32/40 Current	Drug availability ▶ 17/29 Current
Midwife scope of practice ▶ 8/10 Current	National guidelines ▶ 18/25 Current
Reporting of MH indicator ▶ 4/6 Current	Procurement & distribution ▶ 8/12 Current

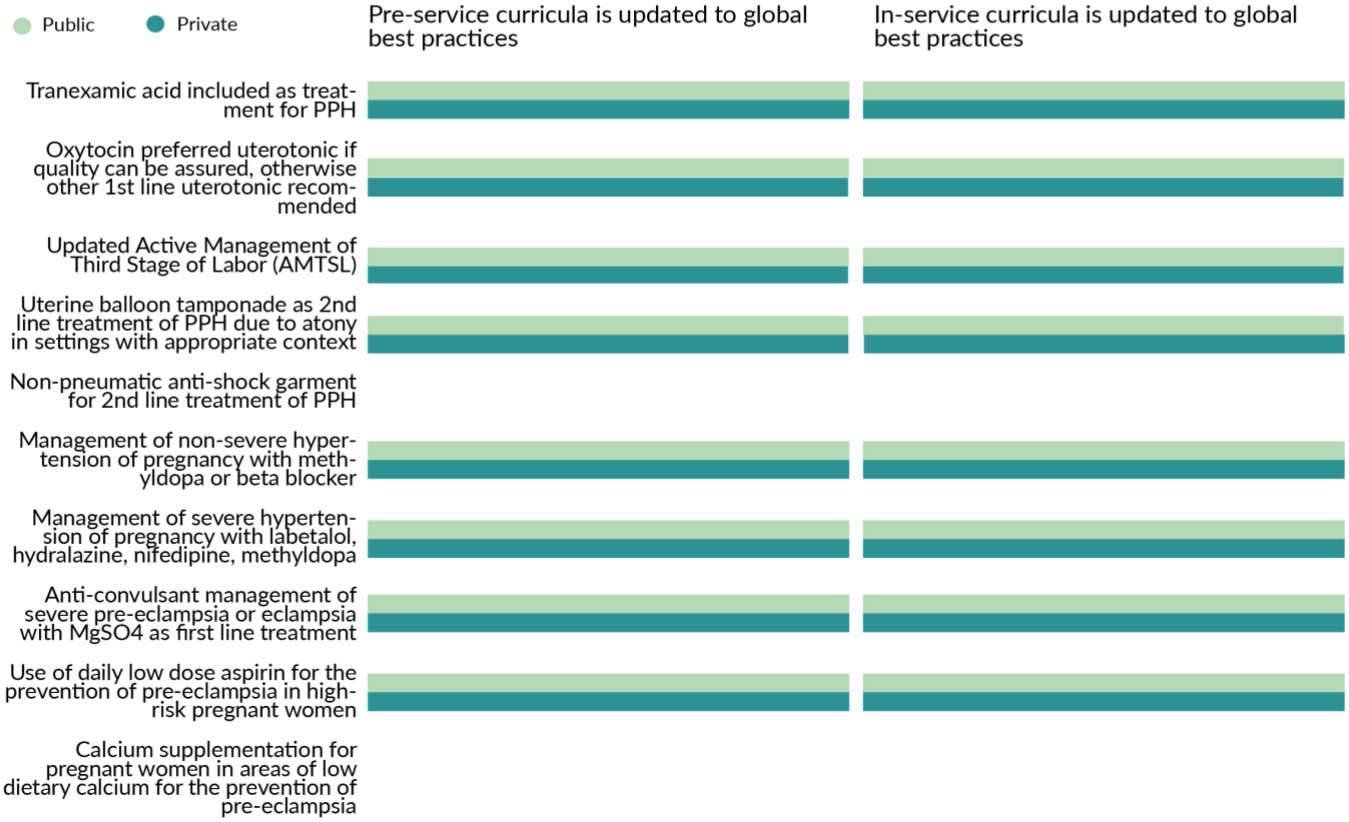
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☒	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☒	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

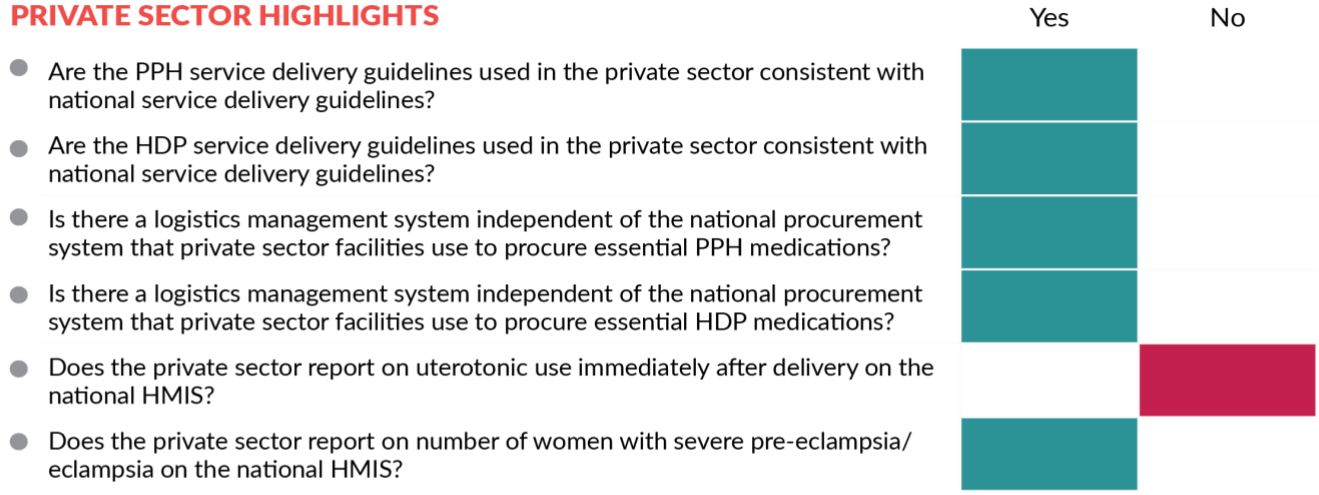


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Madagascar

PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

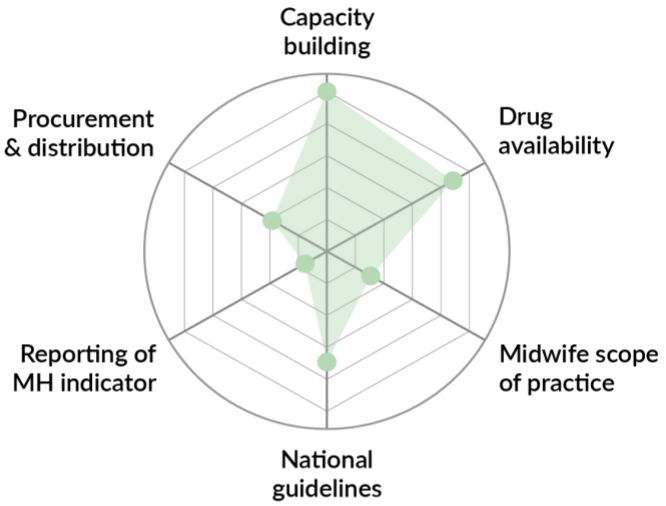
- "Updating of the pre-service education program."
- "Provide the same continuing education programs to public and private sector providers."
- "Update on policies and protocols related to PPH."
- "Integrating products into the national essential medicines list."
- "Formulation and integration of a key indicator into the GIS/monthly activity register."
- "Information and communication technology: Partograph, virtual mentoring for treatment of PPH."
- "Establishing a charter between providers and clients (provider rights, client rights)."

Opportunities for HDP

- "Updating pre-service education programs."
- "Provide the same continuing education trainings to public and private sector providers."
- "Updating of policies and protocols re treatment of HDP."
- "Integration of products in the EML and national distribution chain."
- "Establishing a charter between providers and clients (provider rights, client rights)."
- "Provision of materials: blood pressure machines."
- "Availability of urine test strips, protein tests in facilities."

Country Profile:
MALAWI

Current Composite Score

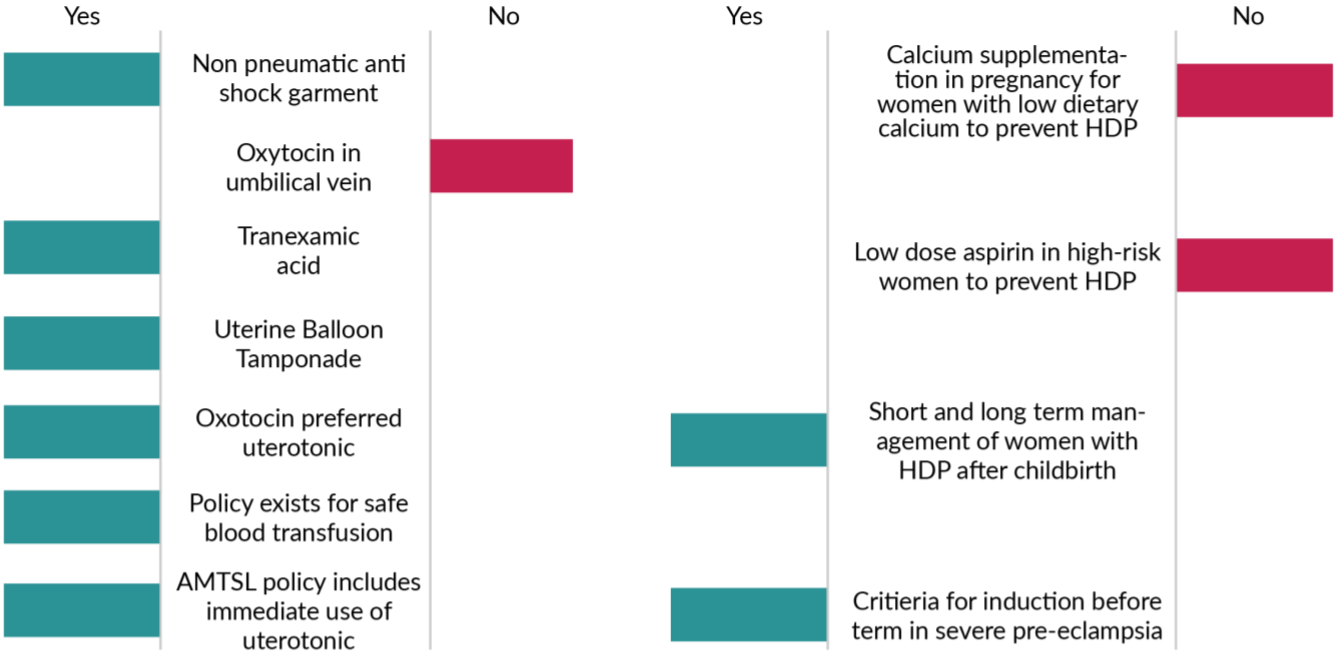


Capacity building ▶ 26/40 Current	Drug availability ▶ 23/29 Current		
Midwife scope of practice ▶ 8/10 Current	National guidelines ▶ 18/25 Current		
Reporting of MH indicator ▶ 4/6 Current	Procurement & distribution ▶ 10/12 Current		

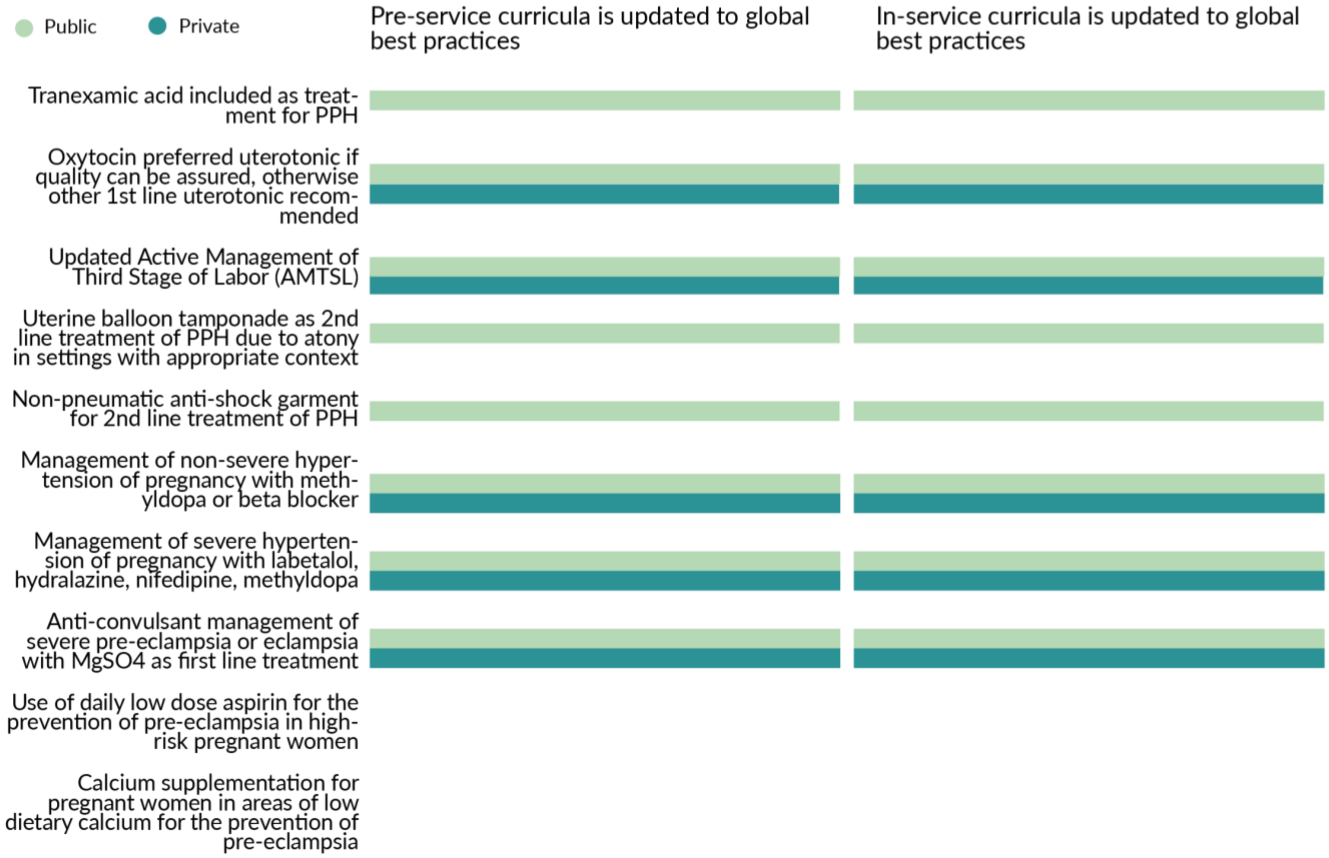
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☒	☑
Oxytocin	☑	☑	☑	☒	☒	☑
Magnesium Sulfate	☑	☑	☑	☒	☒	☑

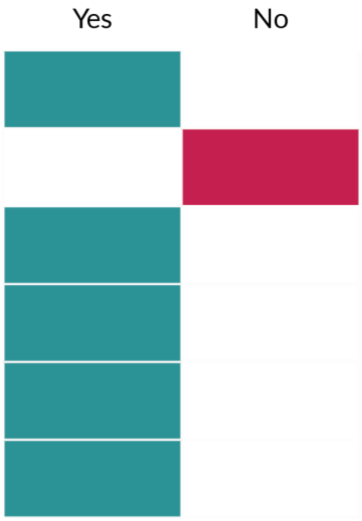
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



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- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

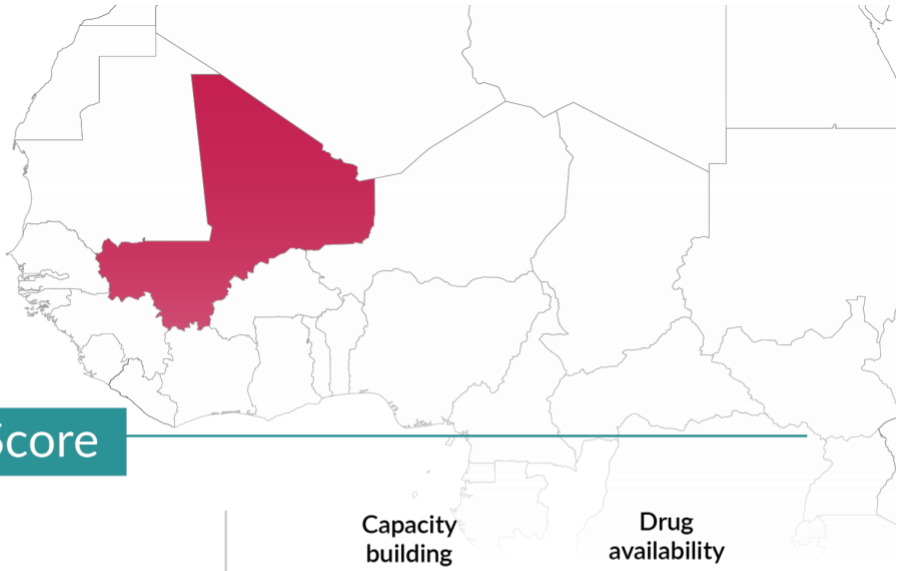
Opportunities for PPH

- "Dissemination of updated policies to all sectors."
- "Orientation of staff in the in-service, pre-service and tutors on updated guidelines."
- "Review of curriculum with the regulatory body of nursing and midwifery."
- "To consider extending Service Level agreement facilities on maternity services especially to do with PPH management and prevention."

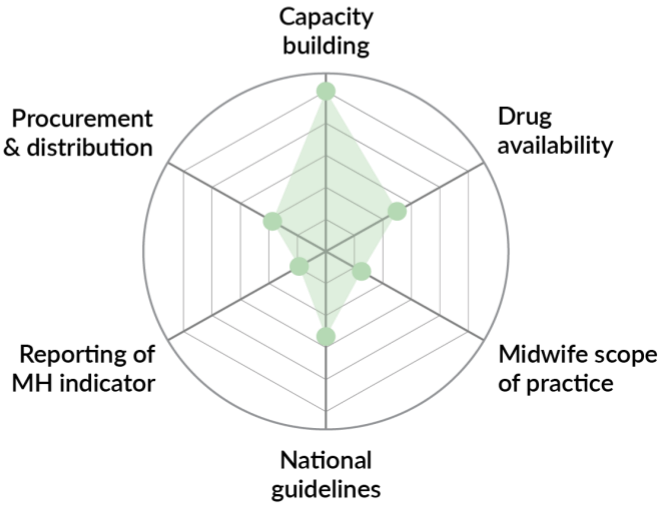
Opportunities for HDP

- "Rolling out of policy dissemination on updates to all relevant sectors both private and public."
- "Orientation of staff in the preservice (tutors) and in service trainings."
- "Review of curriculum with the regulatory body to include latest information on management of HDP."
- "To consider extension of Service level agreement areas with faith based Institutions on management". of HDP so that the services are accessible to a lot of women."

Country Profile: MALI



Current Composite Score

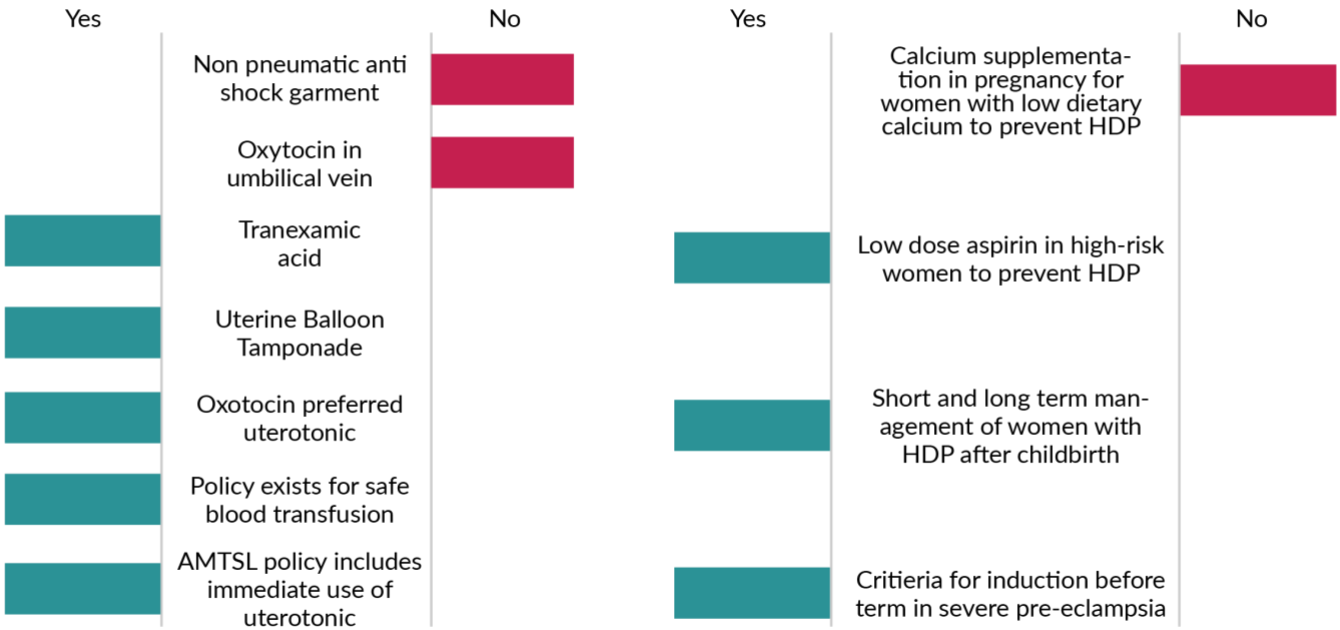


Capacity building	32/40 Current
Drug availability	16/29 Current
Midwife scope of practice	8/10 Current
National guidelines	17/25 Current
Reporting of MH indicator	6/6 Current
Procurement & distribution	12/12 Current

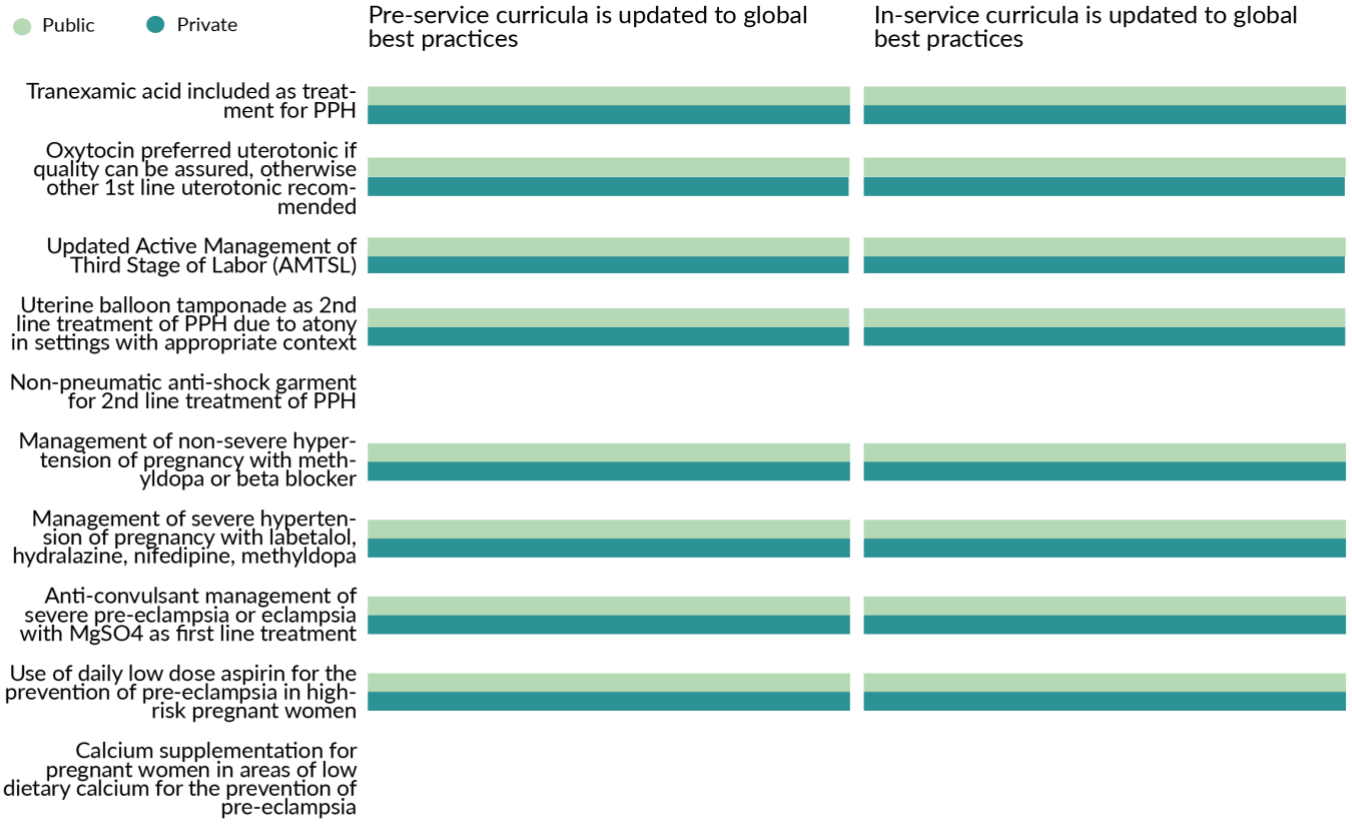
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☑	☒
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

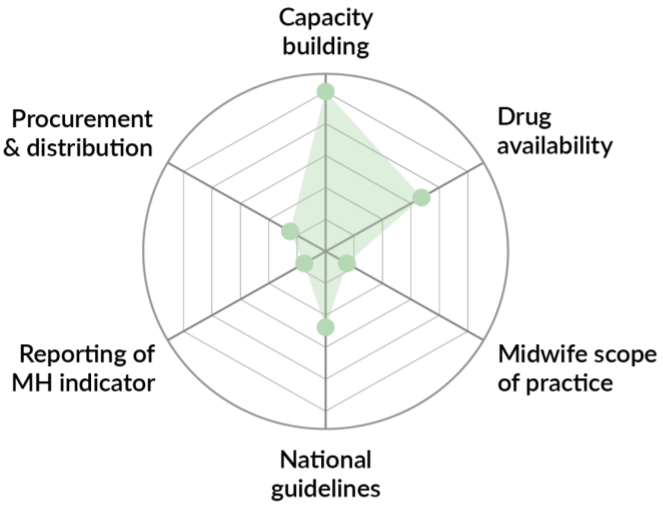
- "Availability of TXA at all levels."
- "Provider training on PPH treatment: balloon tamponade, anti-shock garment, introduction of umbilical vein injection of oxytocin."
- "Taking into account use of heat stable carbetocin in the national PPH treatment guidelines (sic)."

Opportunities for HDP

- "Mass distribution of calcium."
- "Invigoration of public-private dialogue."

Country Profile:
MOZAMBIQUE

Current Composite Score



Capacity building
▶ 40/40
Current

Drug availability
▶ 27/29
Current

Midwife scope of practice
▶ 6/10
Current

National guidelines
▶ 19/25
Current

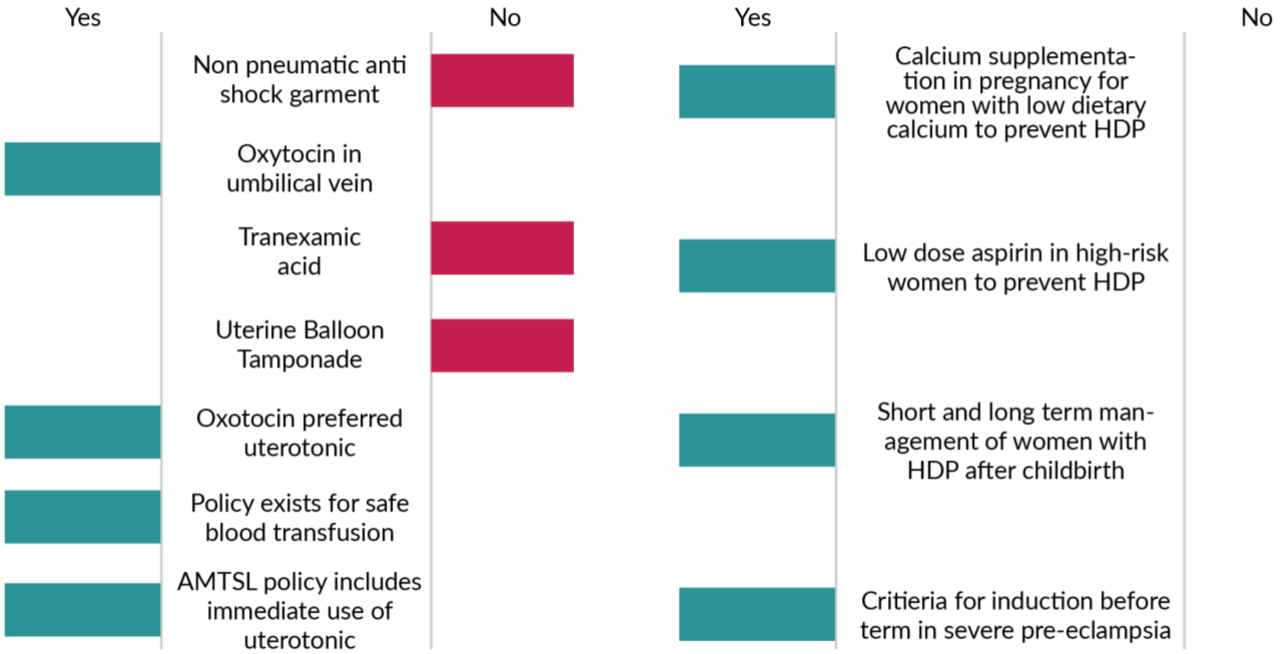
Reporting of MH indicator
▶ 5/6
Current

Procurement & distribution
▶ 10/12
Current

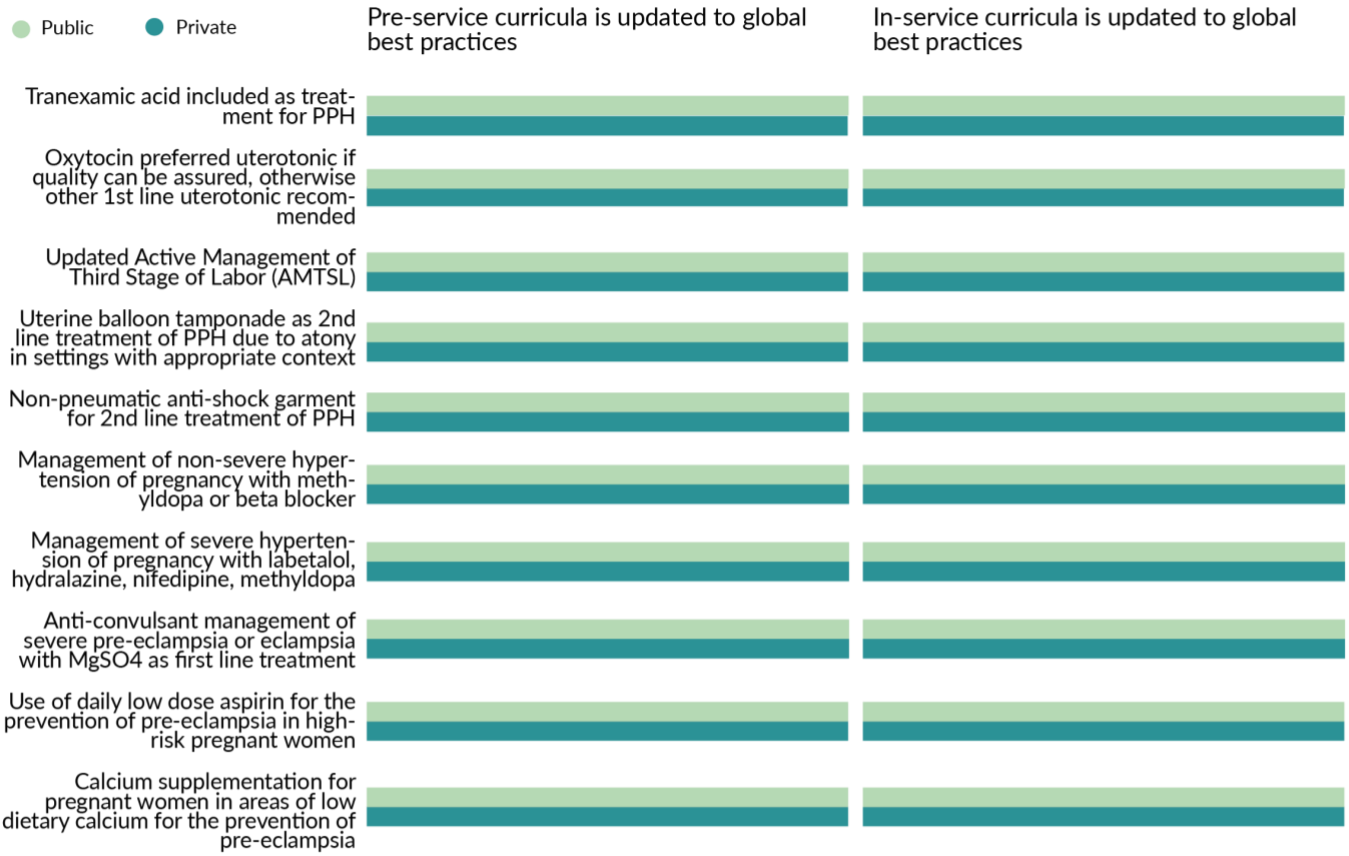
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☒	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

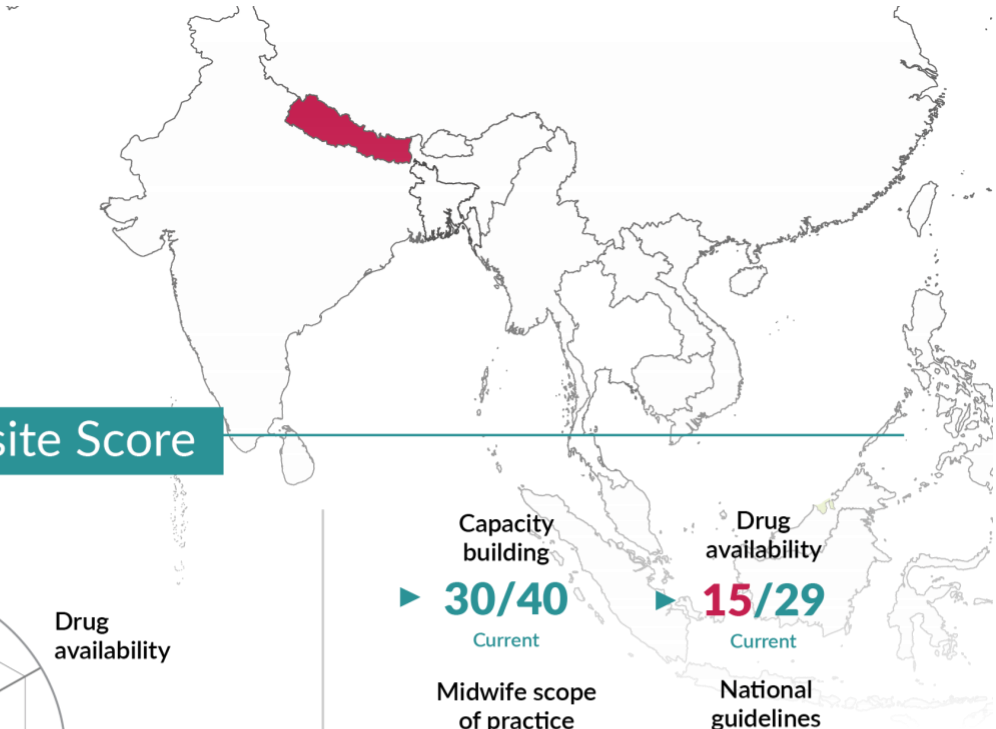
Opportunities for PPH

- "I Think this is in all country."

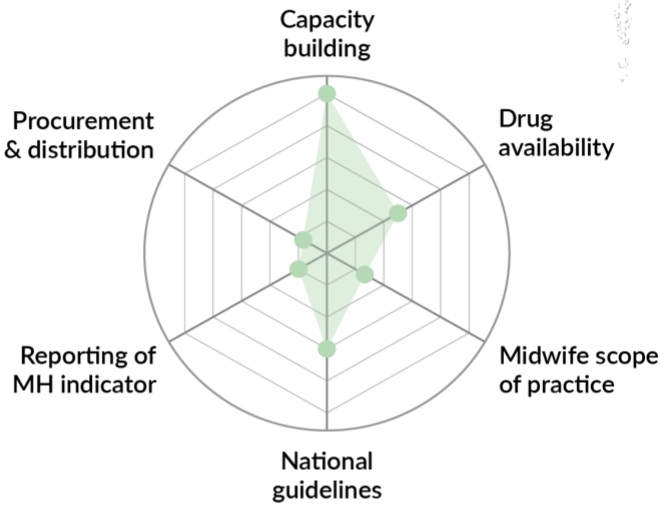
Opportunities for HDP

- "There is in all HFs."

Country Profile: NEPAL



Current Composite Score



Capacity building
30/40
Current

Drug availability
15/29
Current

Midwife scope of practice
8/10
Current

National guidelines
18/25
Current

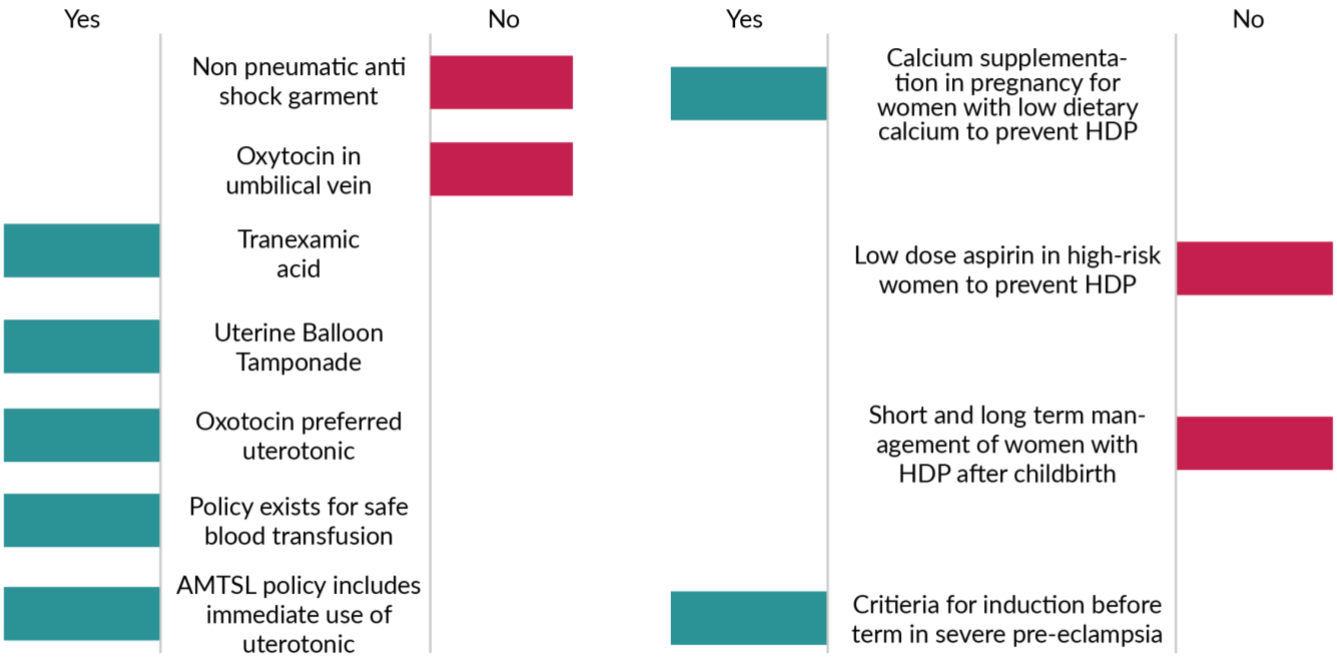
Reporting of MH indicator
6/6
Current

Procurement & distribution
5/12
Current

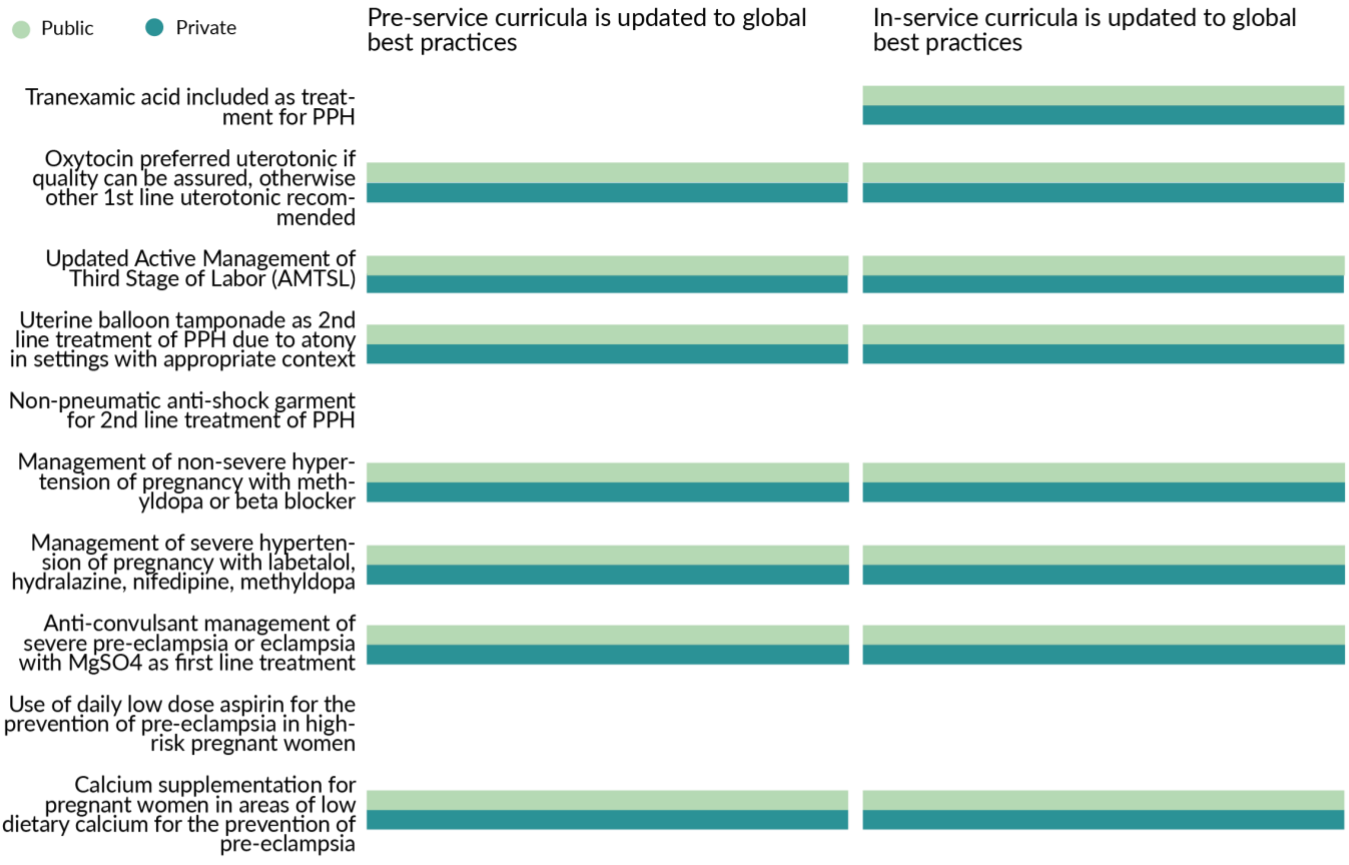
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☒	☑

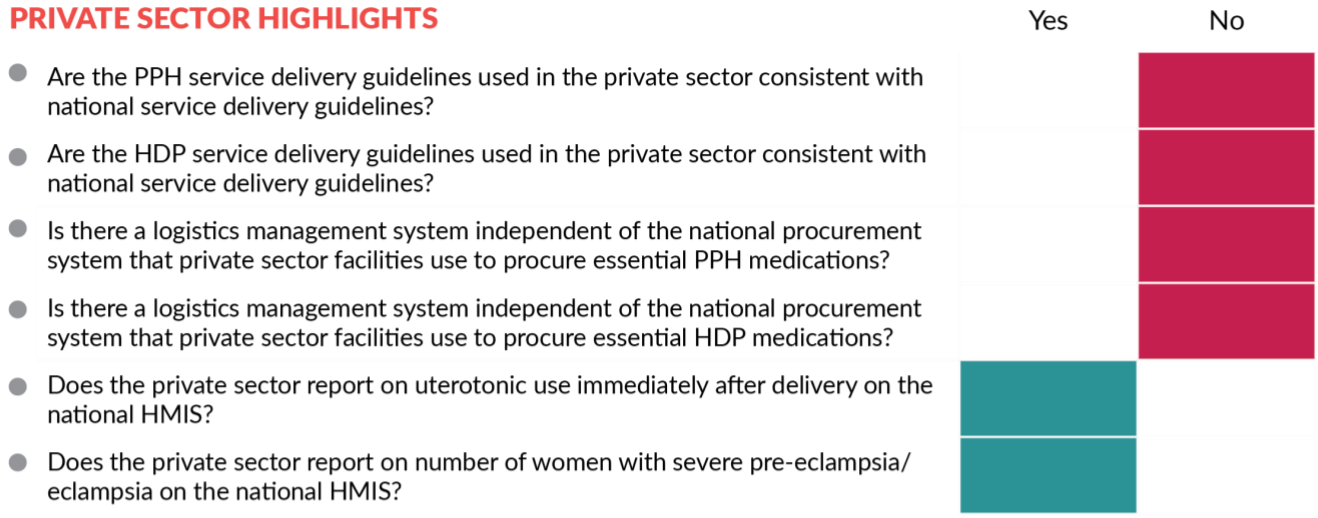
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

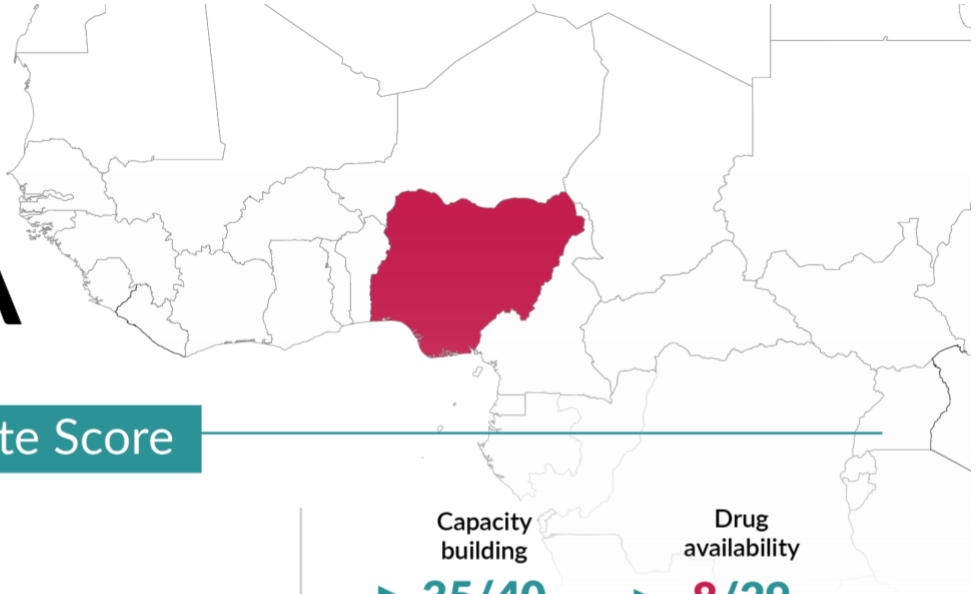
Opportunities for PPH

- "Introduction of evidence-based practices in medical colleges which would enhance quality of services of graduates."
- "Updating existing in-service curriculum to incorporate updated evidence-based practices."
- "An integrated approach to ongoing programs on maternal health and family planning."
- "Orientation on PPH bundle approach for management at all levels of health facilities."
- "Availability of tranexamic acid."
- "More skill-based management, mentoring and coaching on PPH management."
- "Implementation of Safe motherhood roadmap, introduction of midwifery courses, development of Nepal health sector strategy 2022-2030."
- "Innovations and expansion of innovation (NASG, Condom tamponade) manufacturing through private sector."

Opportunities for HDP

- "Updating in-service and pre-service curriculum."
- "Ensuring availability of commodities and drugs."
- "Scaling up calcium supplementation similar to Iron supplementation."
- "Early identification in ANC, if ANC is done by qualified health professional."
- "Targeted IEC/BCC activities are required and could be integrated with existing Birth Preparedness Package (BPP)."
- "Engagement of the private sector."
- "More country-based research for the programme to be introduced."

Country Profile: NIGERIA



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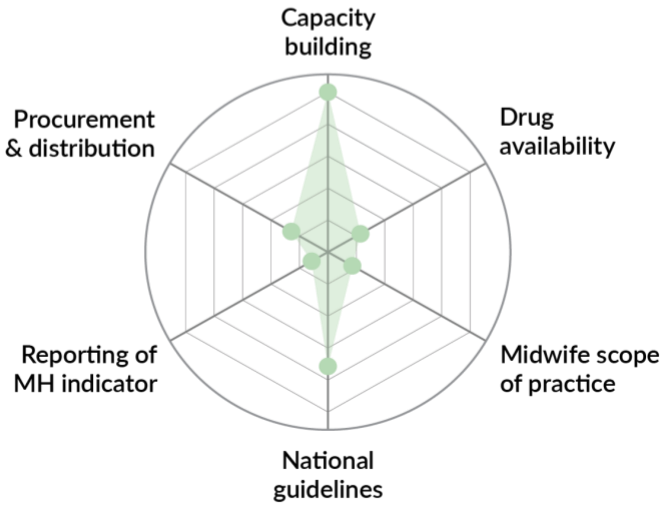


Capacity building
35/40
Current

Drug availability
8/29
Current

Midwife scope of practice
6/10
Current

National guidelines
25/25
Current

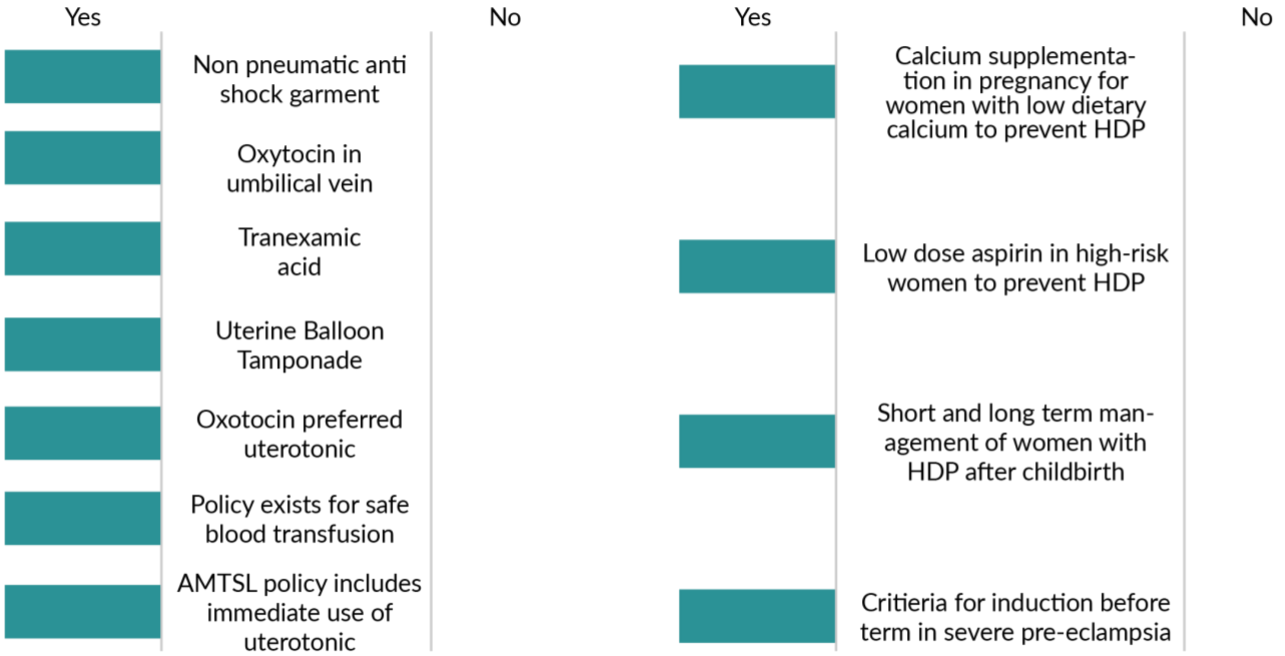
Reporting of MH indicator
4/6
Current

Procurement & distribution
9/12
Current

DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☒	☑
Oxytocin	☑	☑	☑	☒	☒	☑
Magnesium Sulfate	☑	☑	☑	☒	☒	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



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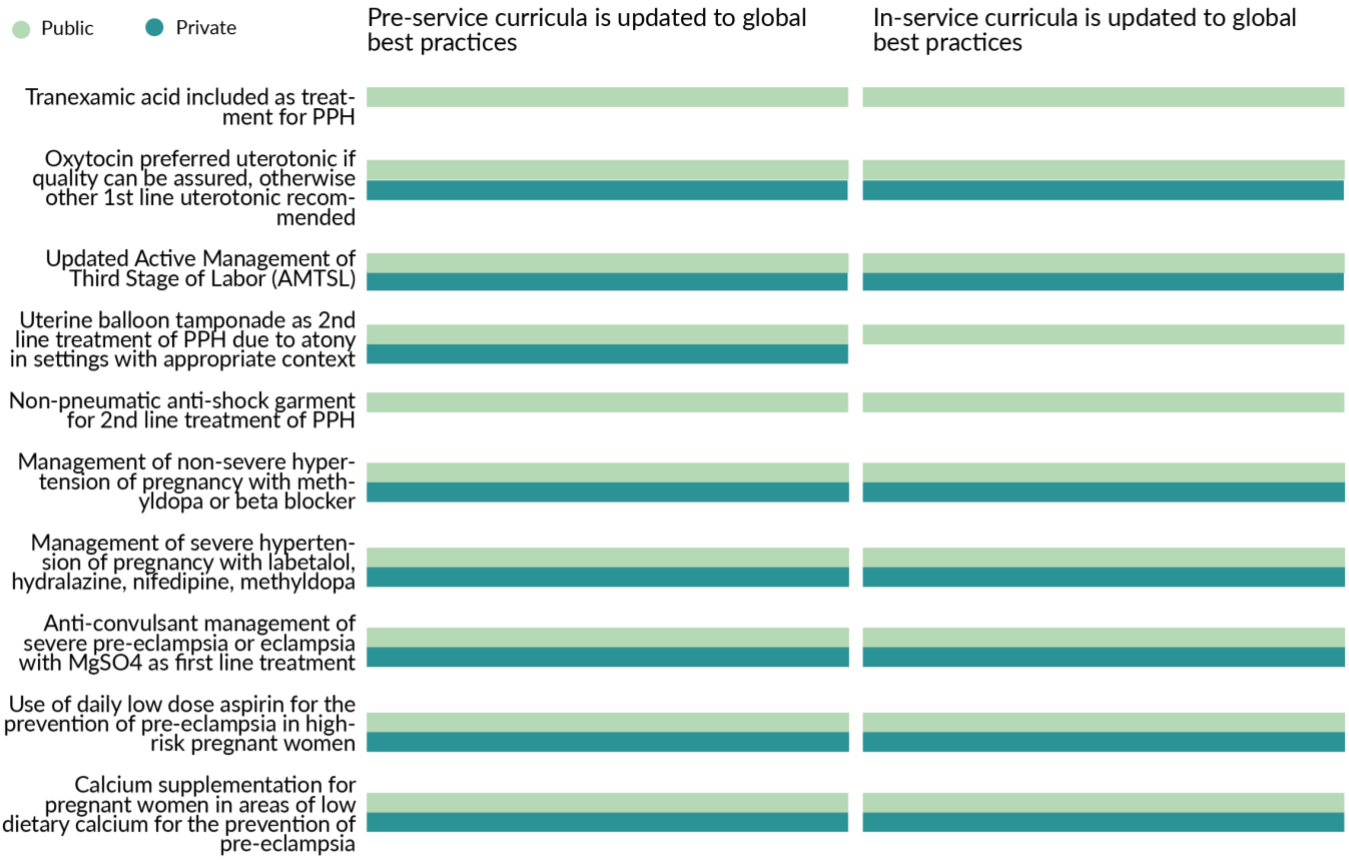
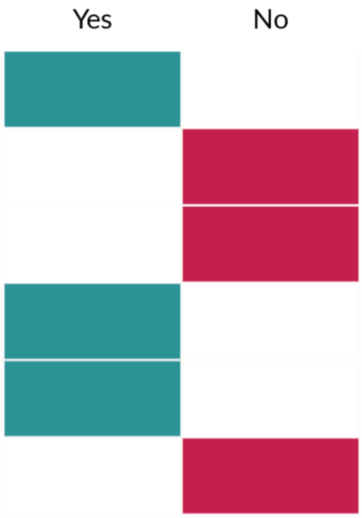


PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

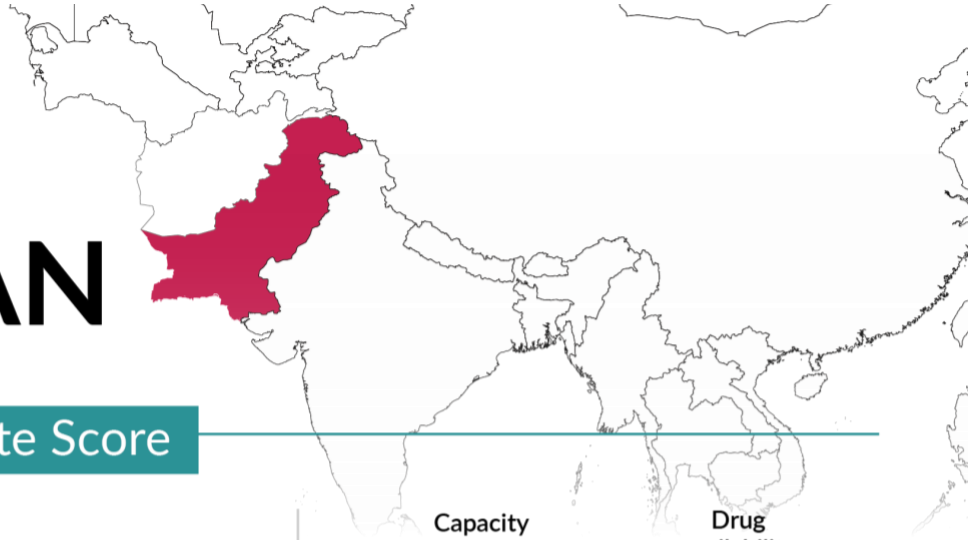
Opportunities for PPH

- "Leveraging on the Quality Improvement and MPDSR (Maternal and Perinatal Death Surveillance and Response) meetings at the LGA (Local Government Area) and state level."
- Data quality assessment and improvement "meetings, BHCPF (Basic Healthcare Provision Fund) and DRF (Drug Revolving Fund)."
- "Involvement of Public and Private sectors in health sector reformations."
- "In service training both private and public."
- "Task shifting and task sharing method due to shortage of workers."
- "Logistics and commodity management, newborn care and maternal and private sector involvement."

Opportunities for HDP

- "Expand the scope of coverage."
- "In service training both private and public."
- "Task shifting and task sharing method due to shortage of workers."
- "Capacity building."
- "SSV (Supportive Supervision Visits) and mentorship."
- "In-service training."
- "Quality of care and emergency response for maternal, newborn and child."

Country Profile: PAKISTAN



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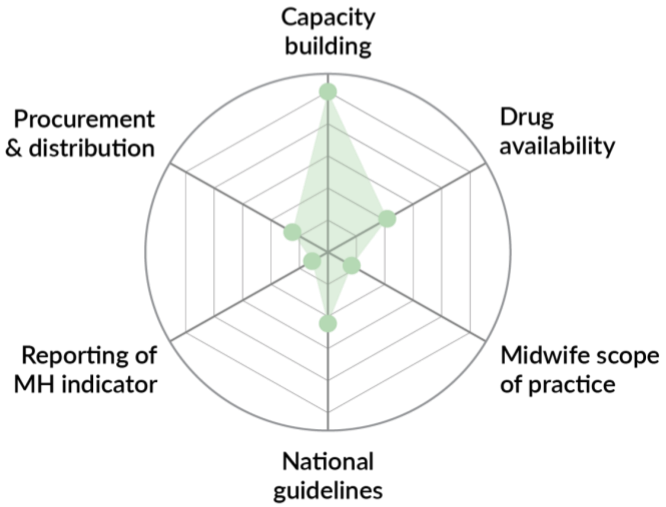


Capacity building
36/40
Current

Drug availability
15/29
Current

Midwife scope of practice
6/10
Current

National guidelines
16/25
Current

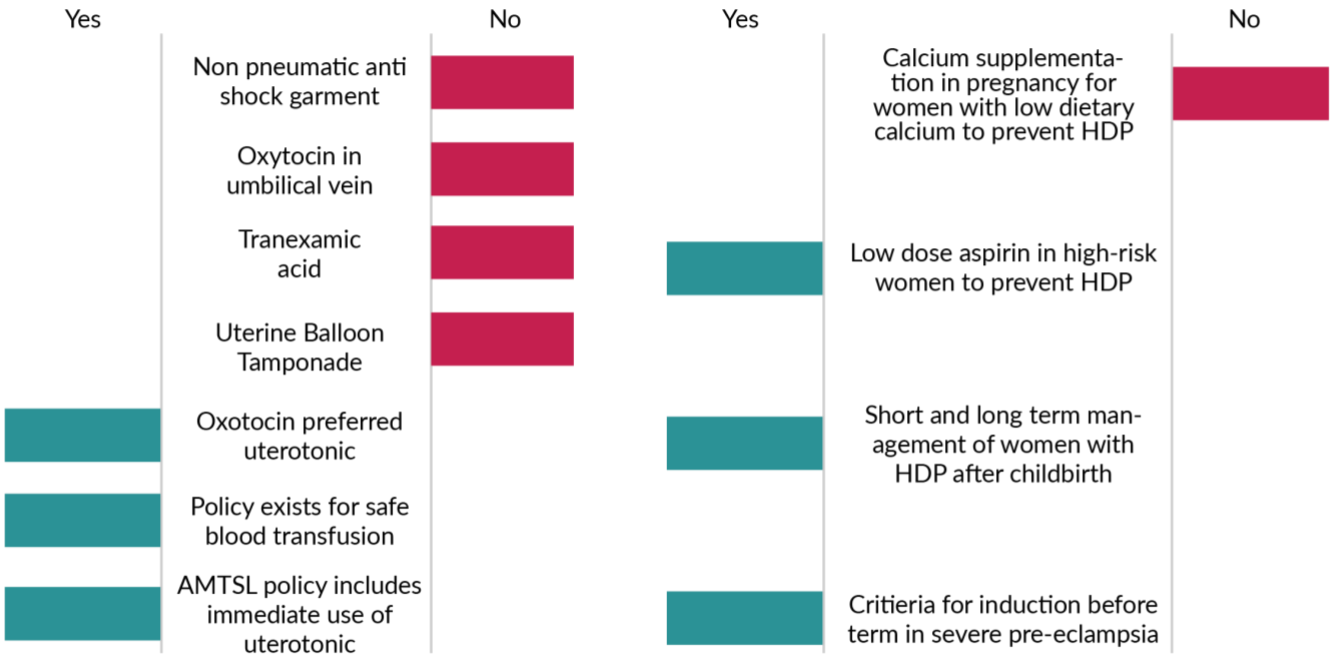
Reporting of MH indicator
4/6
Current

Procurement & distribution
9/12
Current

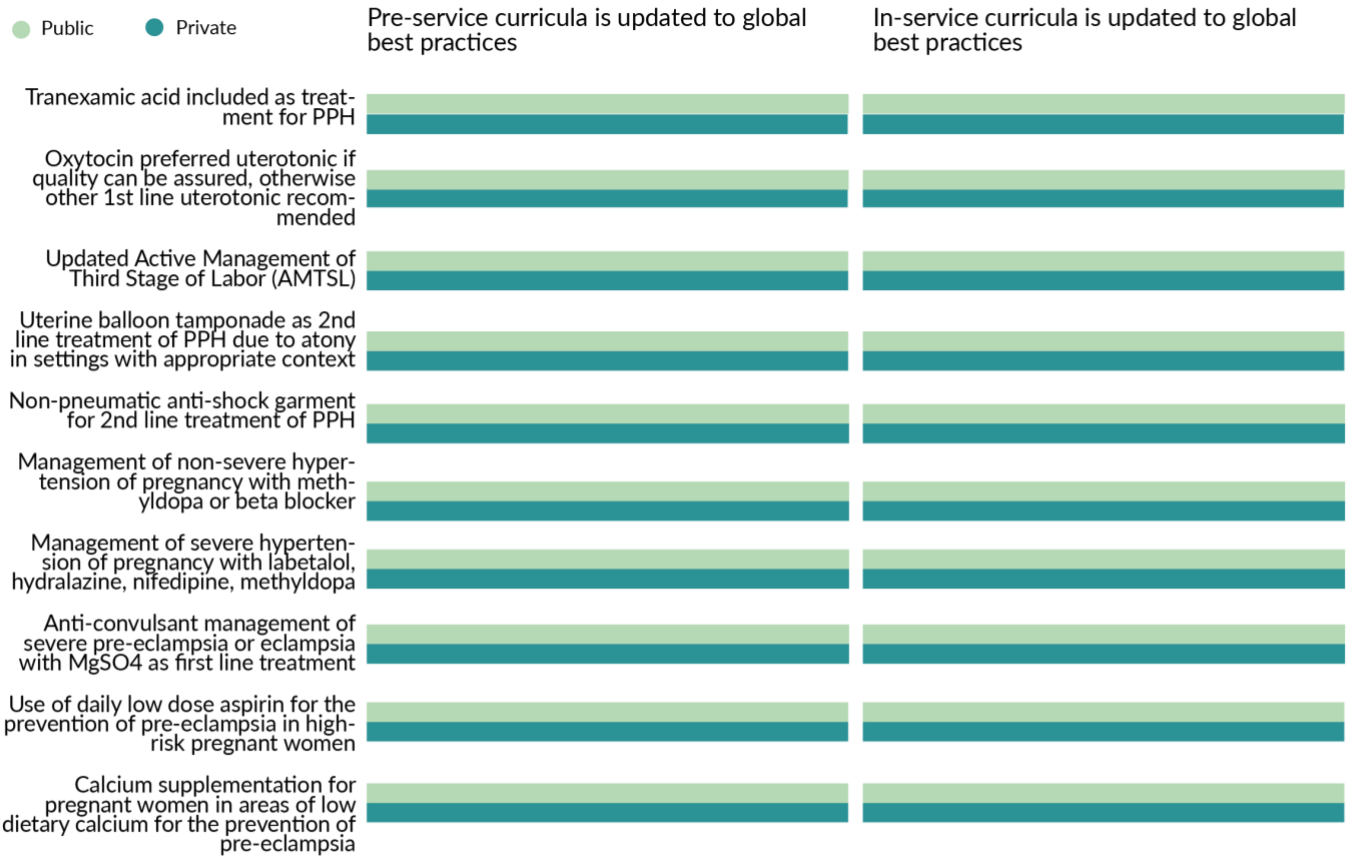
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	☒	☑	☒	☒	☑
Oxytocin	N/A	☑	☑	☒	☒	☑
Magnesium Sulfate	N/A	☑	☑	☒	☒	☑

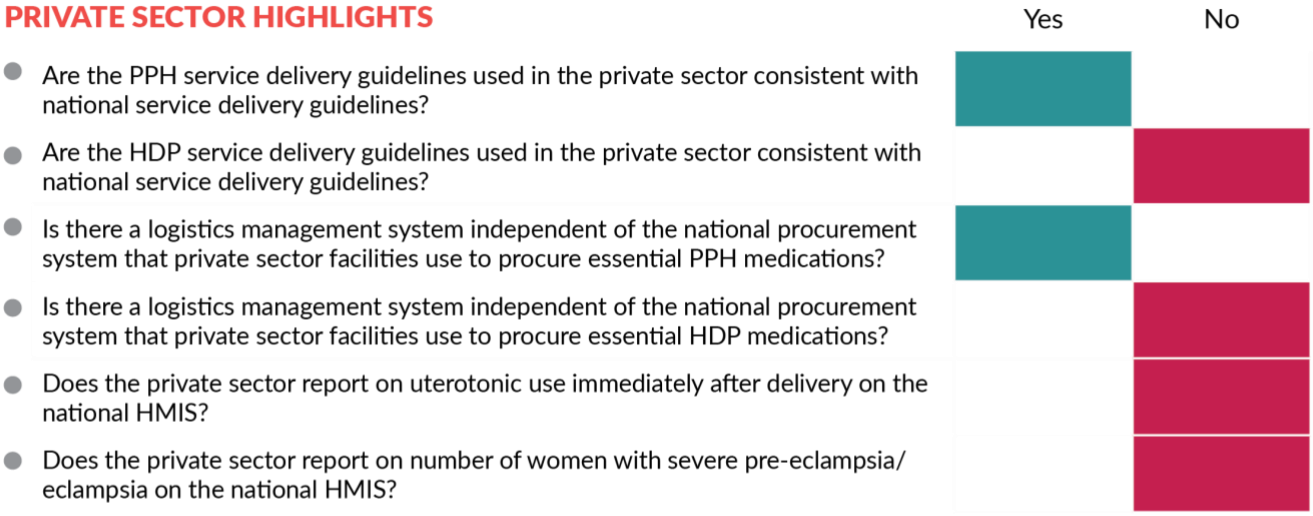
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

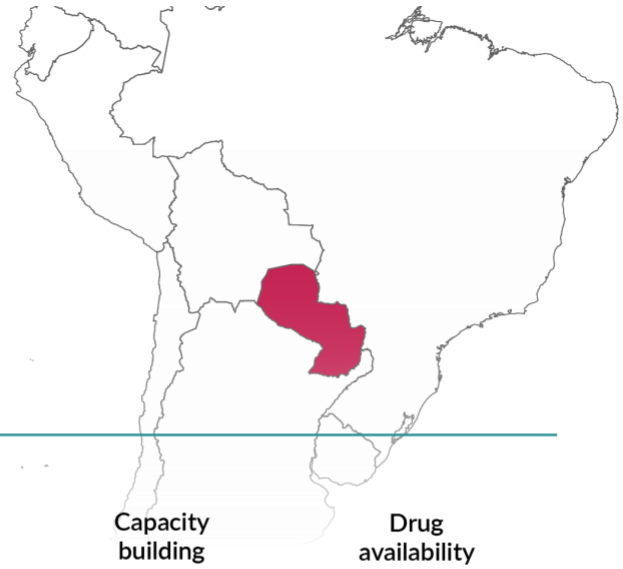
Opportunities for PPH

- "Improved human resource, capacity building/strengthening of logistic system. Through Health Care Commissions (HCCs) by enforcement of PPH guidelines."

Opportunities for HDP

- "Procurement, training and compliance to be ensured."

Country Profile:
PARAGUAY



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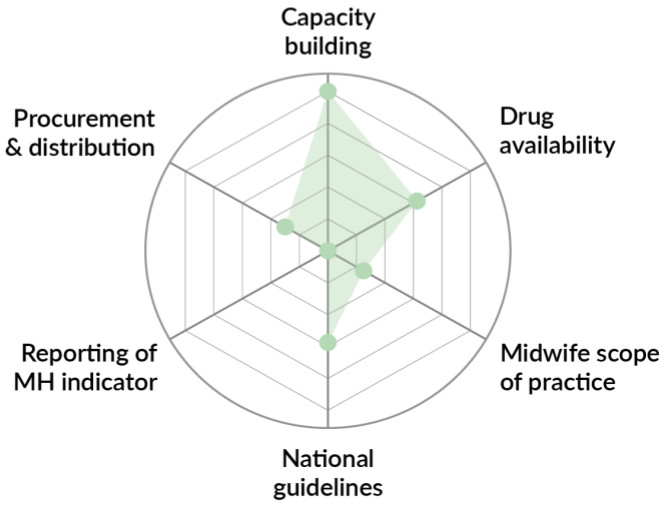


Capacity building
▶ 40/40
Current

Drug availability
▶ 25/29
Current

Midwife scope of practice
▶ 10/10
Current

National guidelines
▶ 23/25
Current

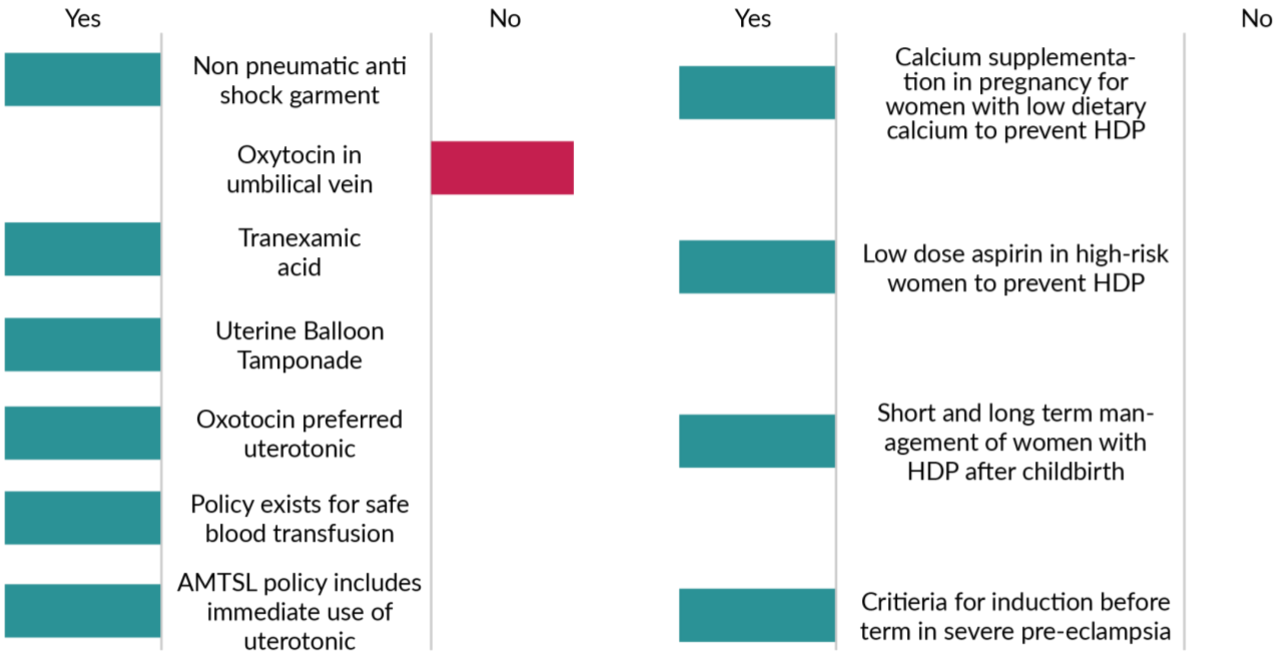
Reporting of MH indicator
▶ 0/6
Current

Procurement & distribution
▶ 12/12
Current

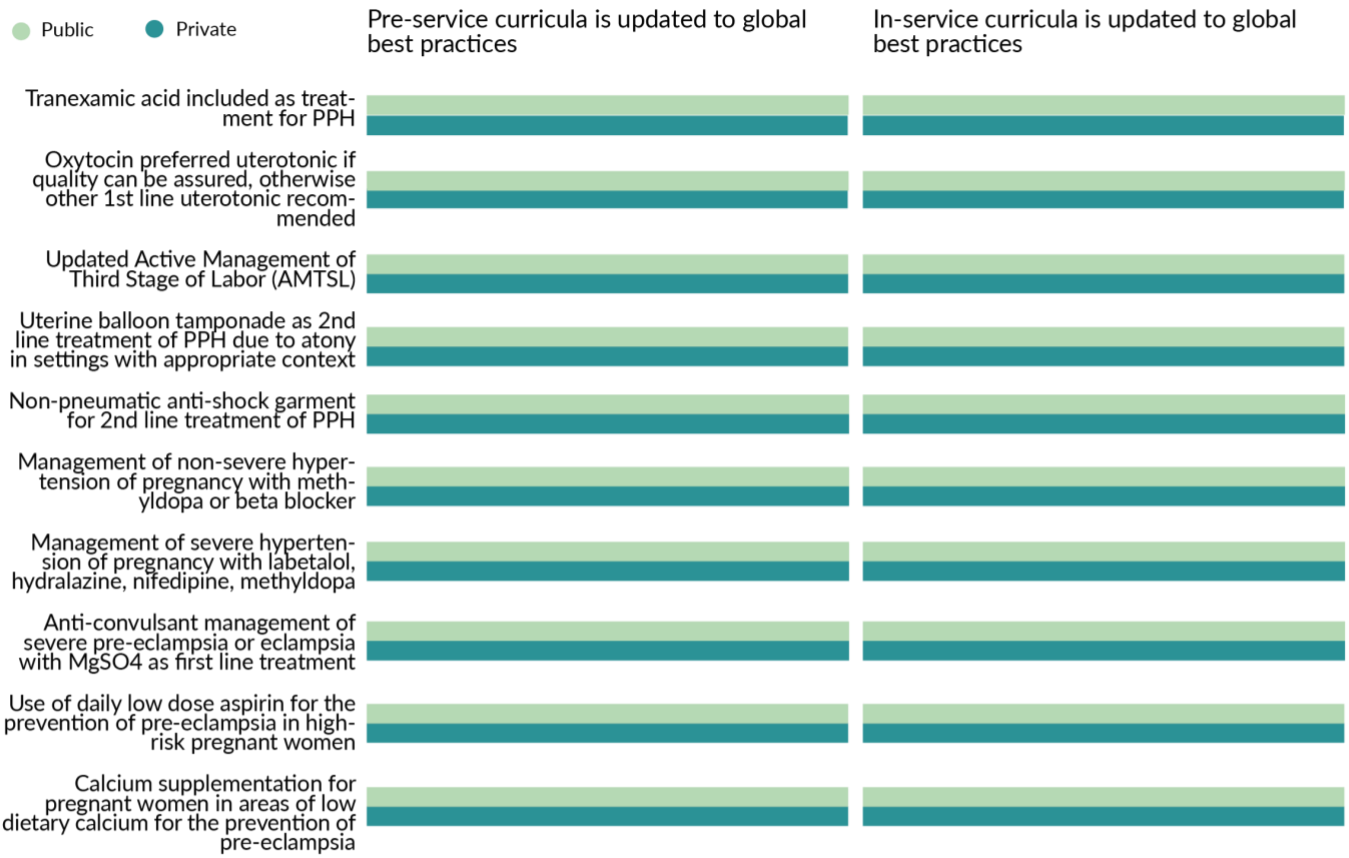
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☒	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☑	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☑	☑

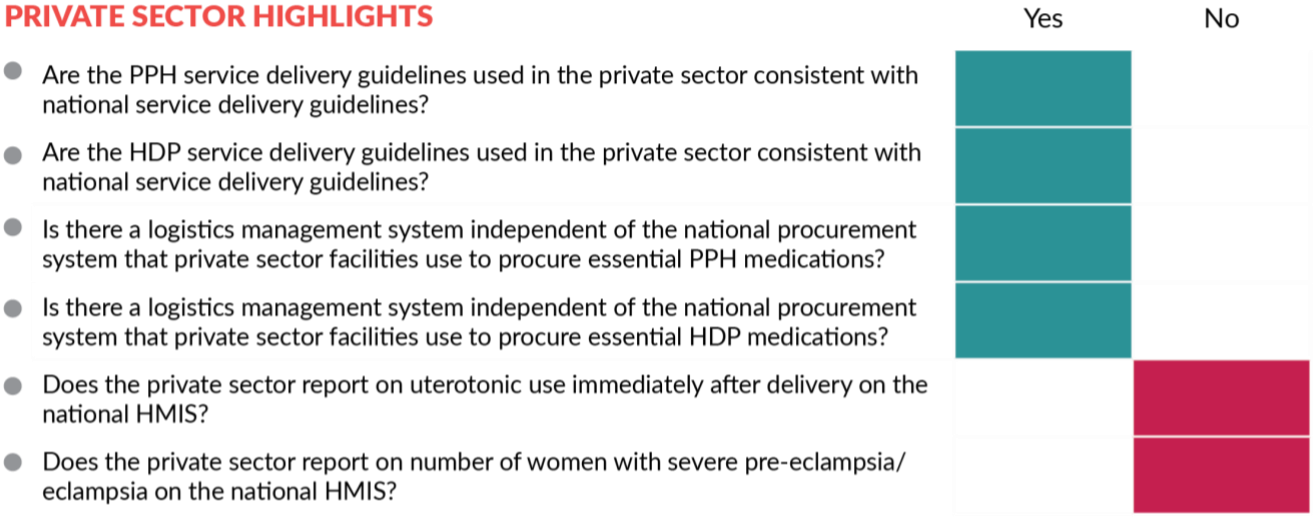
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

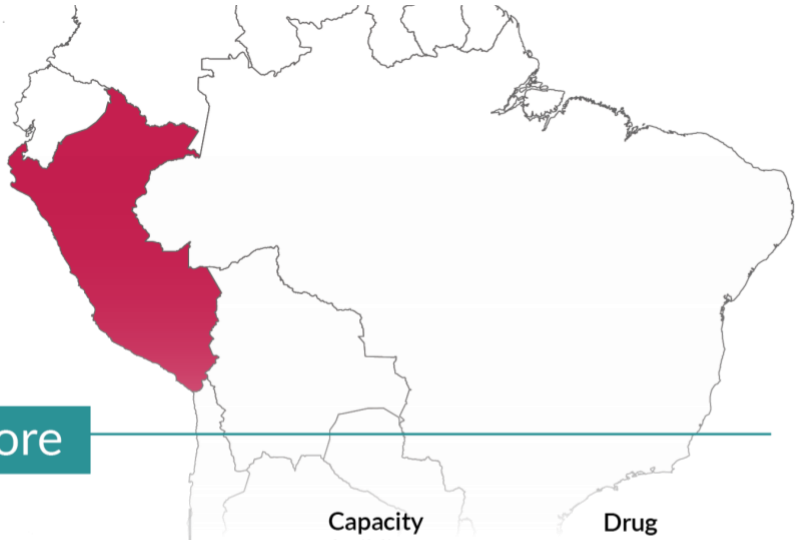
Opportunities for PPH

- "For some years now, the private sector and training schools have been requesting training in national regulations to the MOH, the Paraguayan Association of Obstetricians (AOP its acronym in Spanish), and to the Federation of Gynecology and Obstetrics. In addition, spaces are provided in scientific congresses to socialize these regulations. National instructors from the AOP, the Federation of OB/GYN and the MOH."
- "AOP and MOH agreement."
- Agreement with the Hospital de Clínicas and MOH for a low and medium simulation training room."

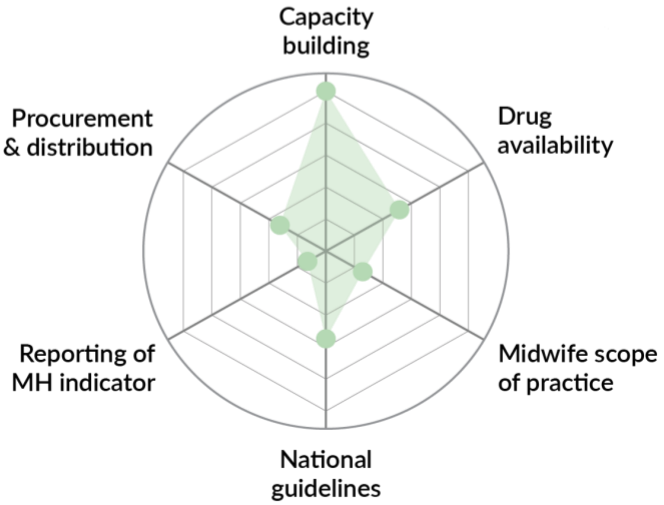
Opportunities for HDP

- "Alliances, contracts and agreements between the MOH, the AOP, the Federation of OB/GYN, and with the Rassmus Foundation."
- "National SRH Plan."
- "National Plan for accelerated reduction of the MMMF/N (morbidity and mortality materna, fetal and neonatal)."
- "Mobilization for the reduction of maternal and neonatal mortality."

Country Profile: PERU



Current Composite Score



Capacity building
▶ 31/40
Current

Drug availability
▶ 16/29
Current

Midwife scope of practice
▶ 8/10
Current

National guidelines
▶ 17/25
Current

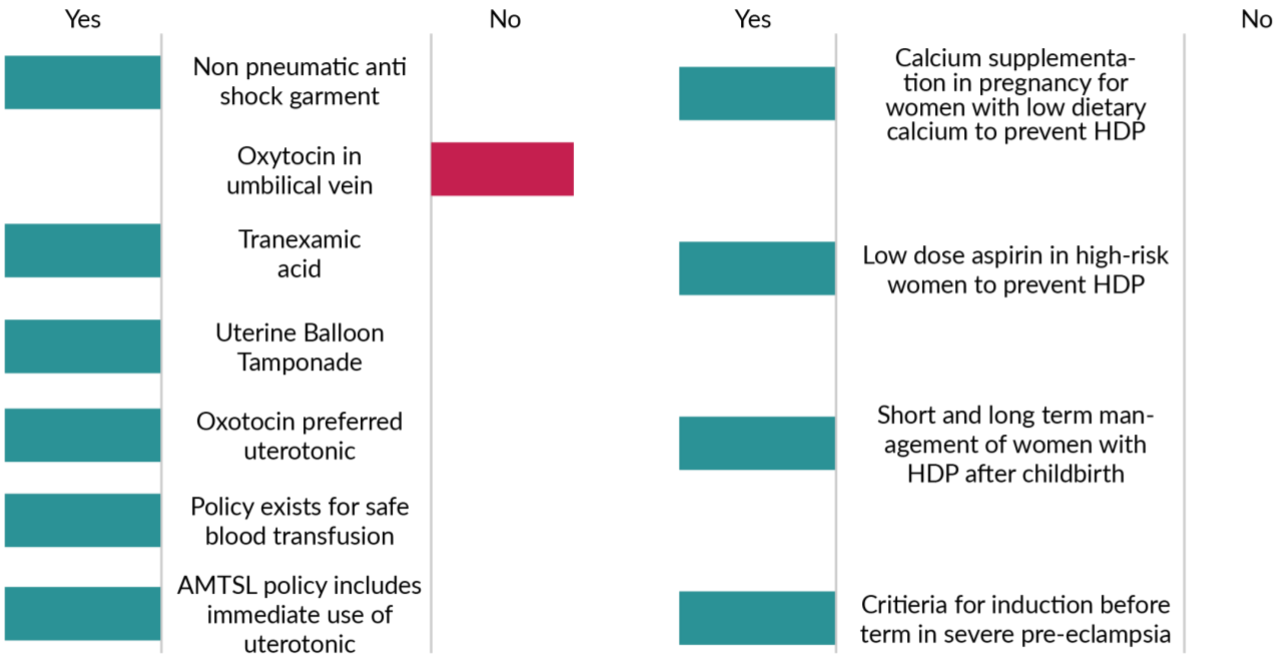
Reporting of MH indicator
▶ 4/6
Current

Procurement & distribution
▶ 10/12
Current

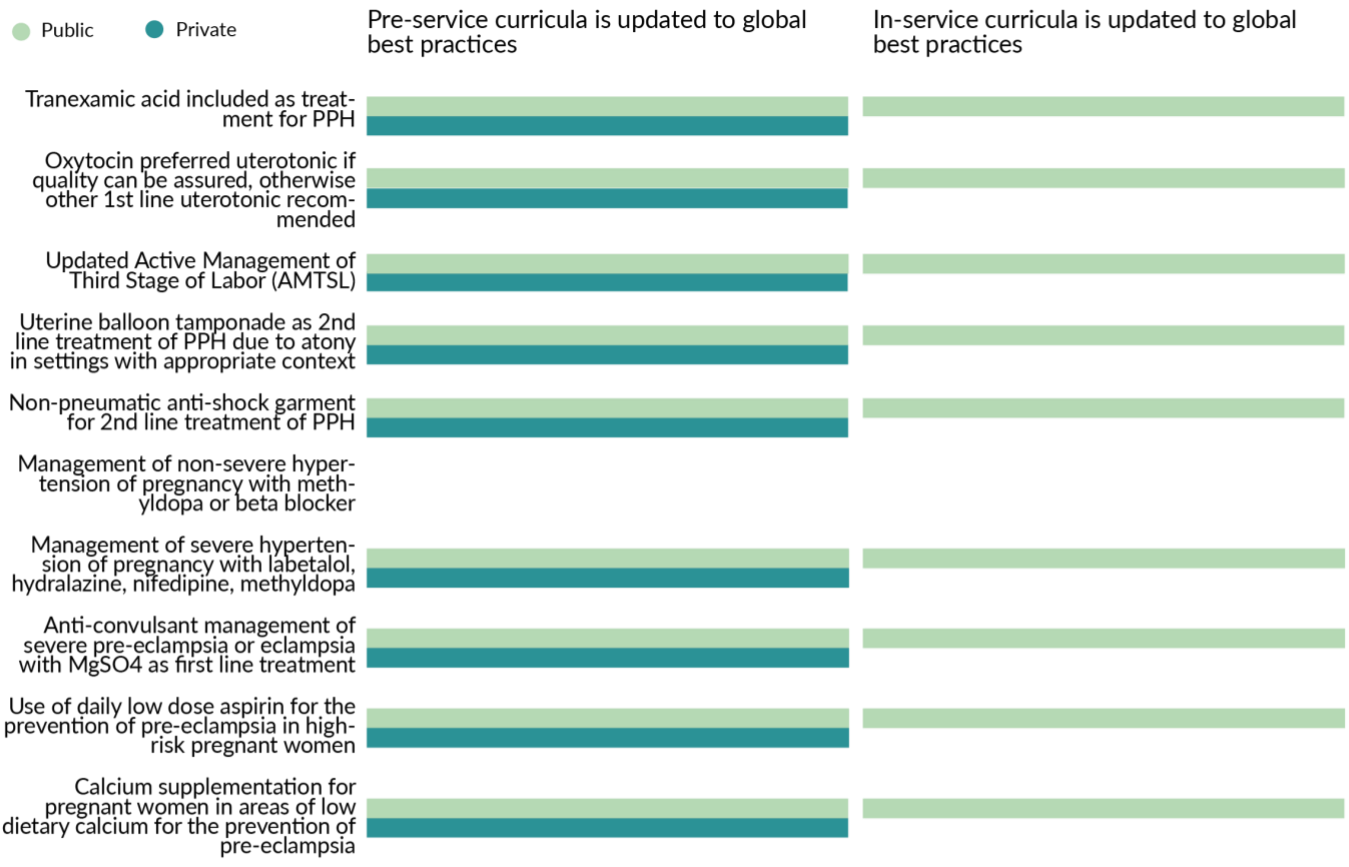
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☒	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☒	☑

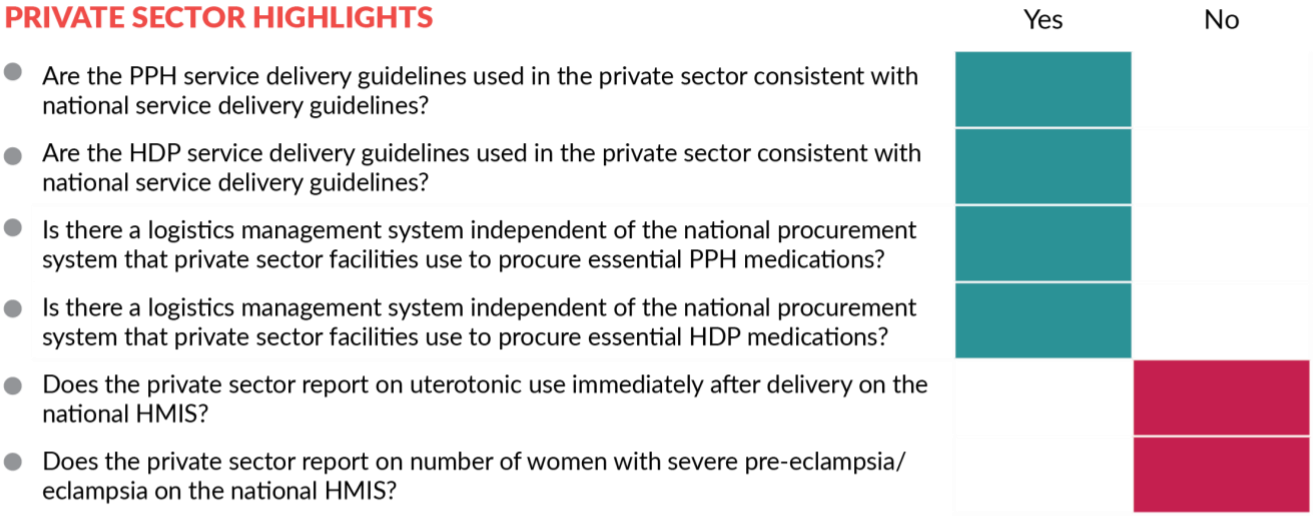
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



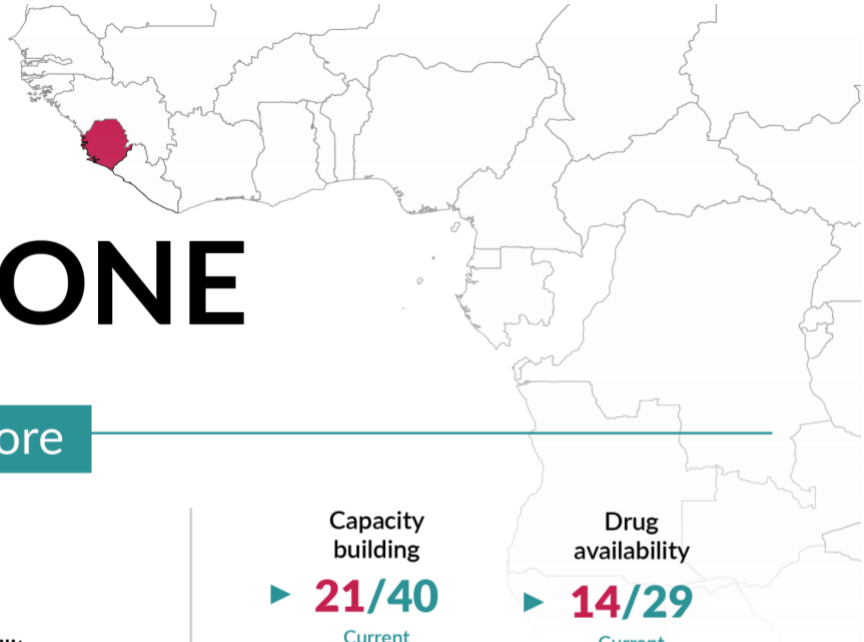
POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

- "The creation of the Integrated Health Networks promoted by MOH, also the training of new health professionals, the updating of the National Plan for Reduction of Maternal Death, the expansion of telemedicine and remote care."

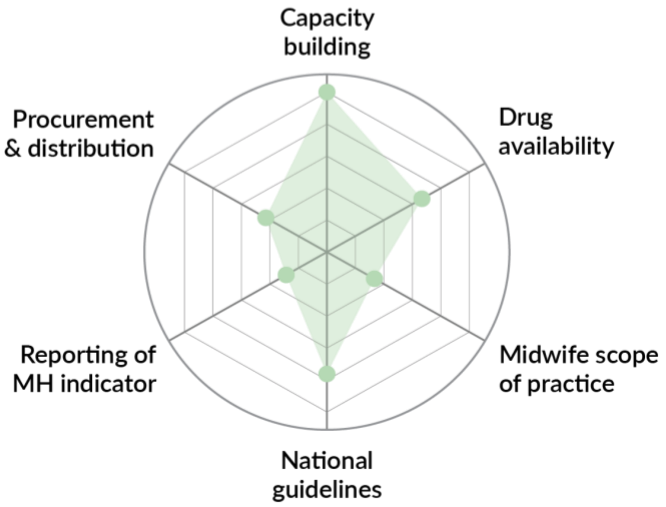
Opportunities for HDP

- "The Integrated Networks of Health Services, the training of new professionals, and training by telemedicine and remote routes, strategies to increase demand, with intercultural relevance and social communication strategies, expansion of the road network, improve pre-conception control, prenatal (hourglass, in the first and last trimester, inversion of the pyramid)."



Country Profile:
SIERRA LEONE

Current Composite Score

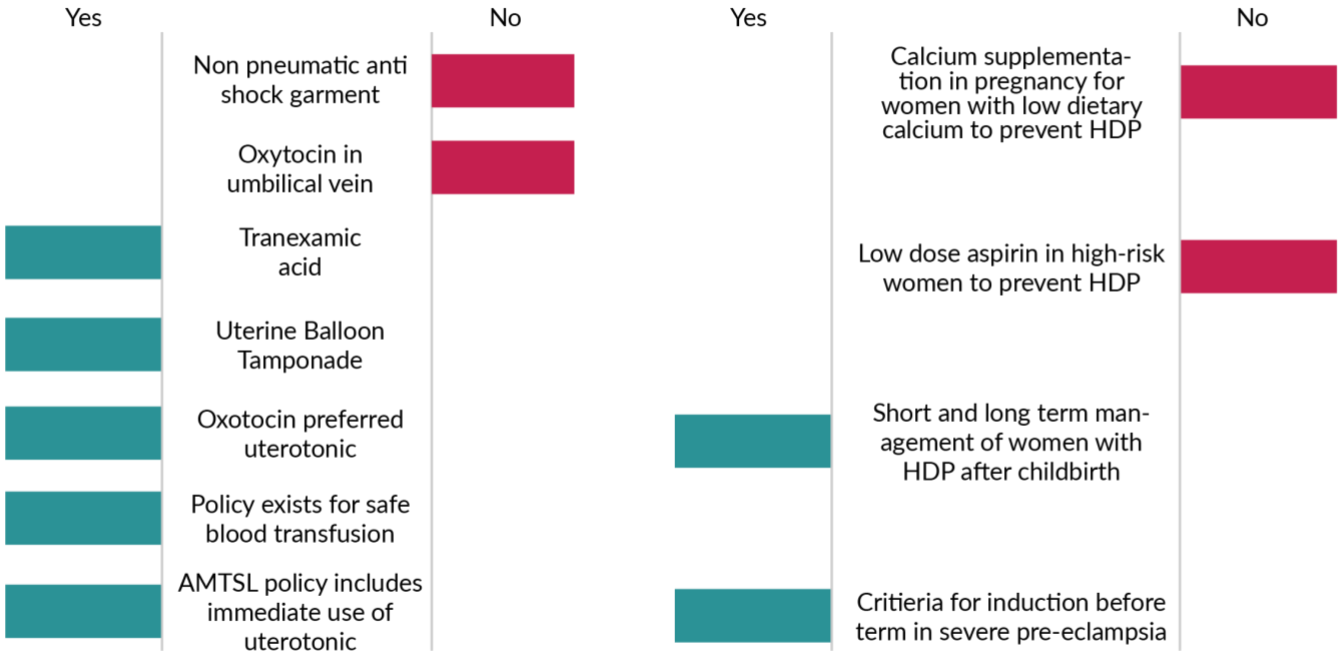


Capacity building ▶ 21/40 Current	Drug availability ▶ 14/29 Current
Midwife scope of practice ▶ 7/10 Current	National guidelines ▶ 16/25 Current
Reporting of MH indicator ▶ 6/6 Current	Procurement & distribution ▶ 9/12 Current

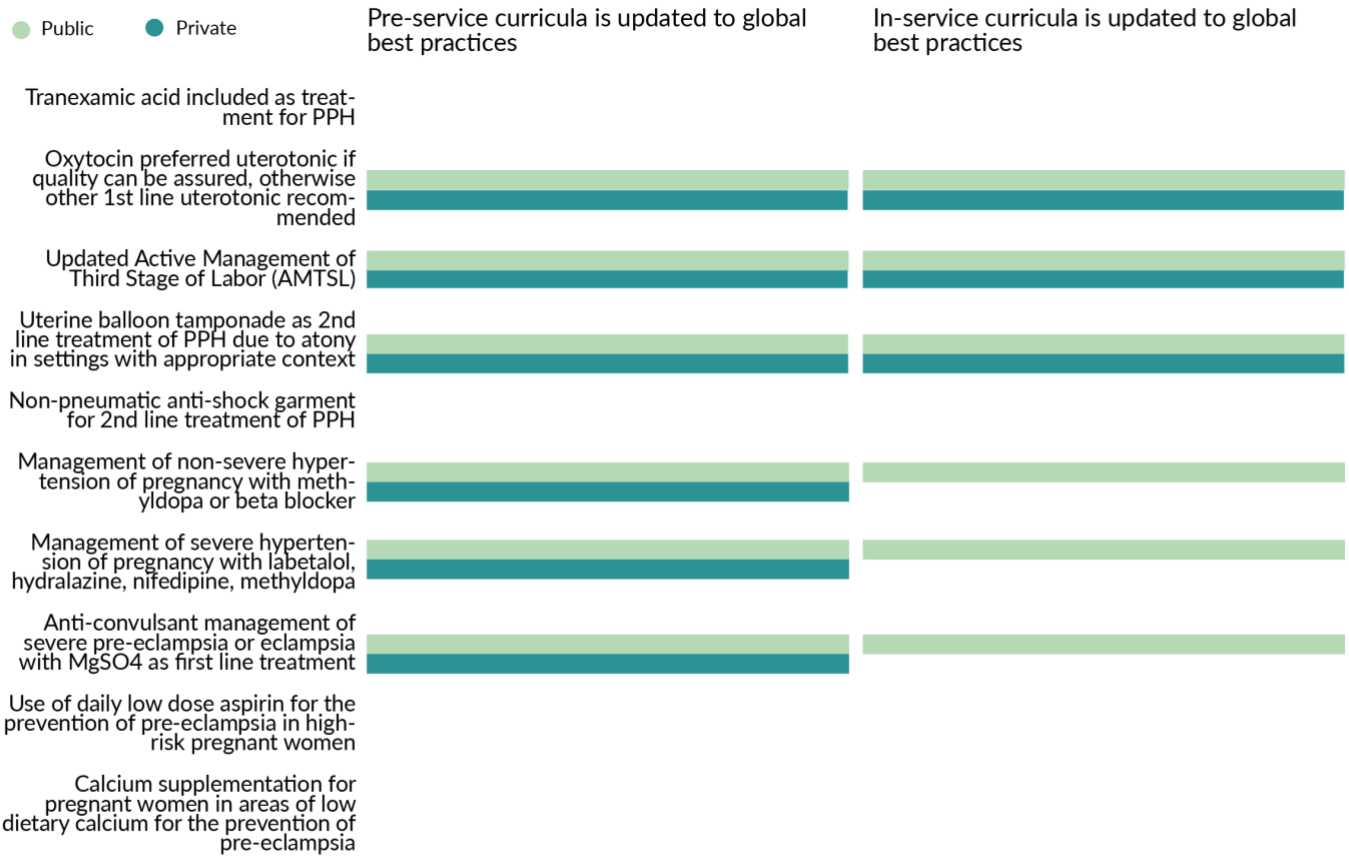
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☒	☑
Oxytocin	N/A	N/A	☑	N/A	☒	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☒	☑

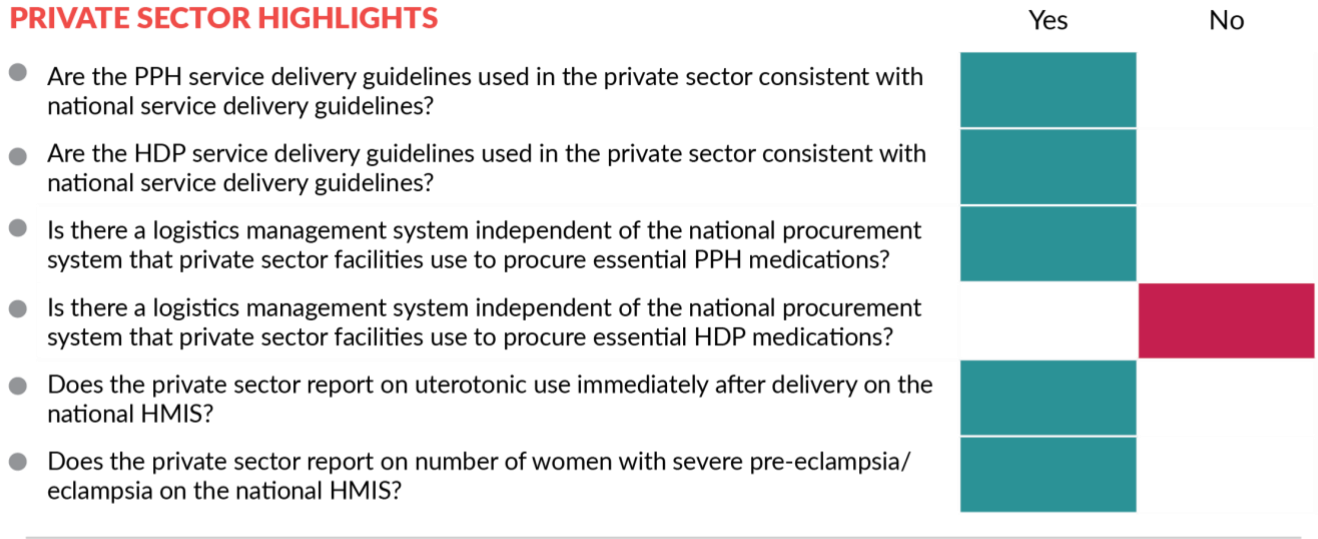
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

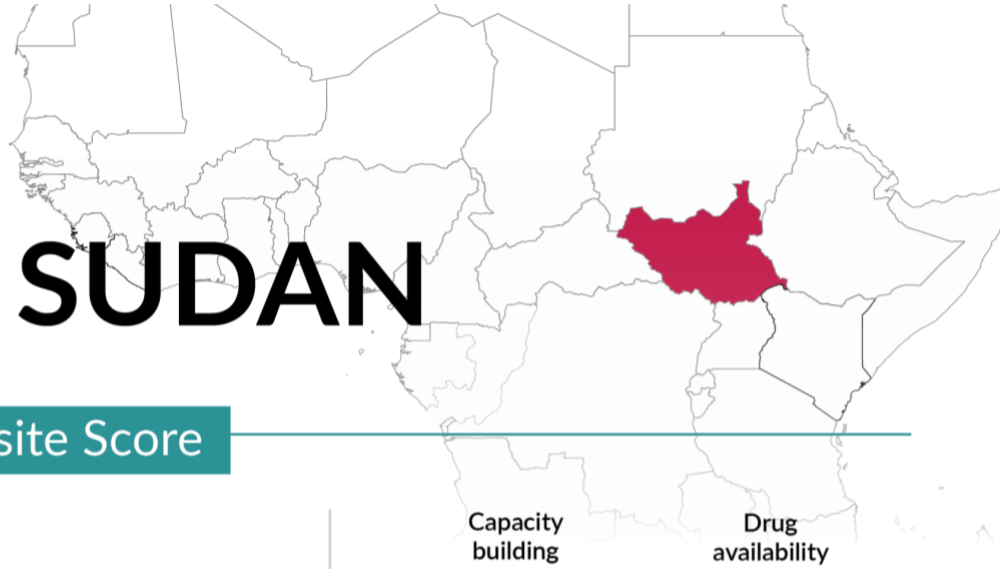
Opportunities for PPH

- "Alignment of partner plans to National priority."
- "More partners interested in MNH and specifically for PPH Management."
- "Institutionalization of MDSR, Quality Improvements approaches in RMNCH."
- "Scale-up engagement of the private sector in PPH programming."
- "Scale-up private sector reporting to HMIS."

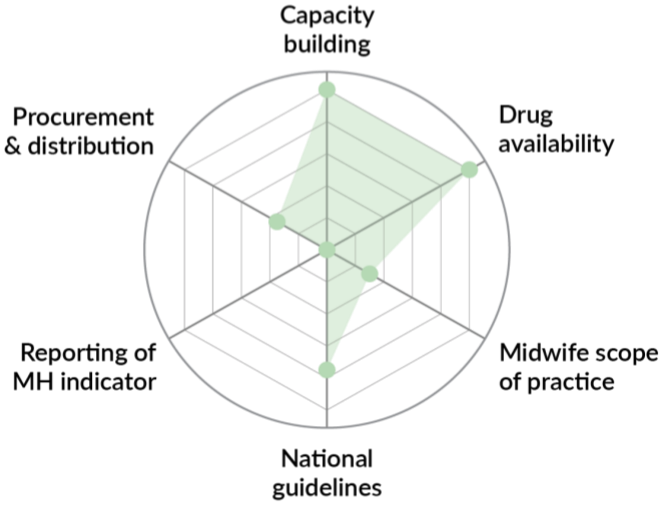
Opportunities for HDP

- "Quality of Care and Improvement initiative (respectful maternity care, patient satisfaction surveys, patient centered care)."
- "Institutionalization of Maternal Death Surveillance and Review, verbal autopsy at community level."
- "Availability of dedicated and salaried Quality of Care and Patient Safety Officer."
- "National Framework on Mentorship."
- "Community Health Workers involvement in PPH and HDP programs."

Country Profile: SOUTH SUDAN



Current Composite Score



Capacity building
▶ 20/40
Current

Drug availability
▶ 20/29
Current

Midwife scope of practice
▶ 6/10
Current

National guidelines
▶ 15/25
Current

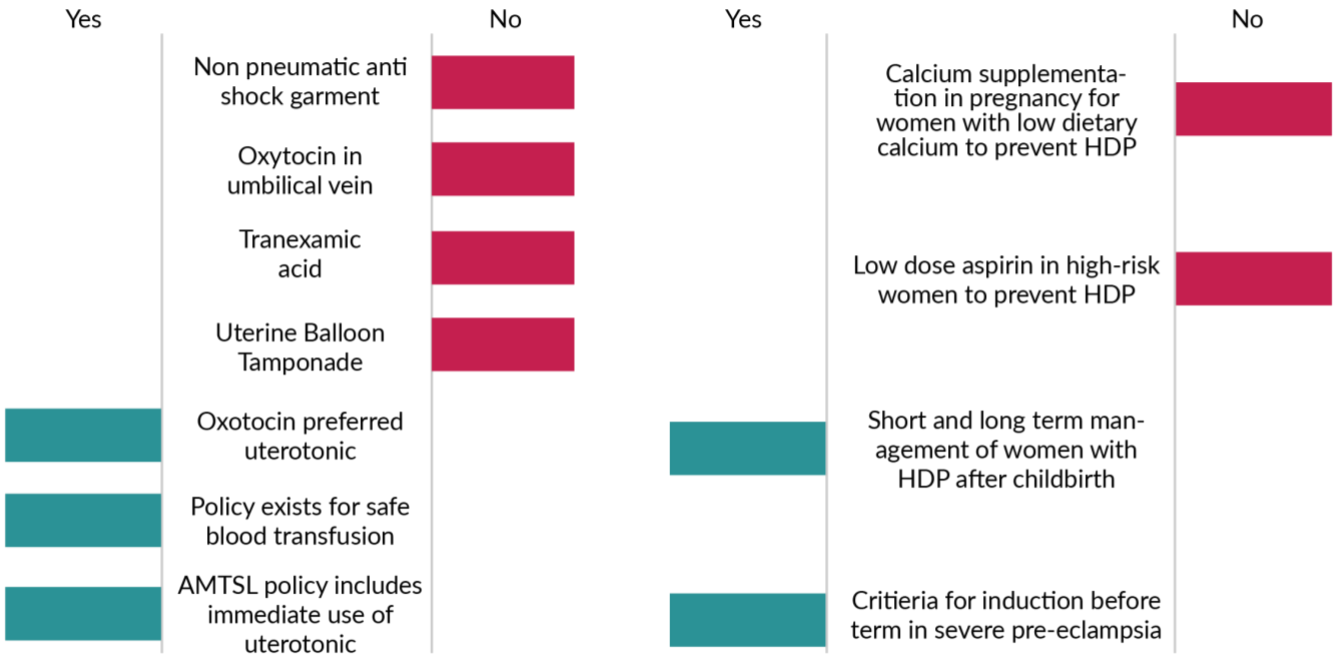
Reporting of MH indicator
▶ 0/6
Current

Procurement & distribution
▶ 7/12
Current

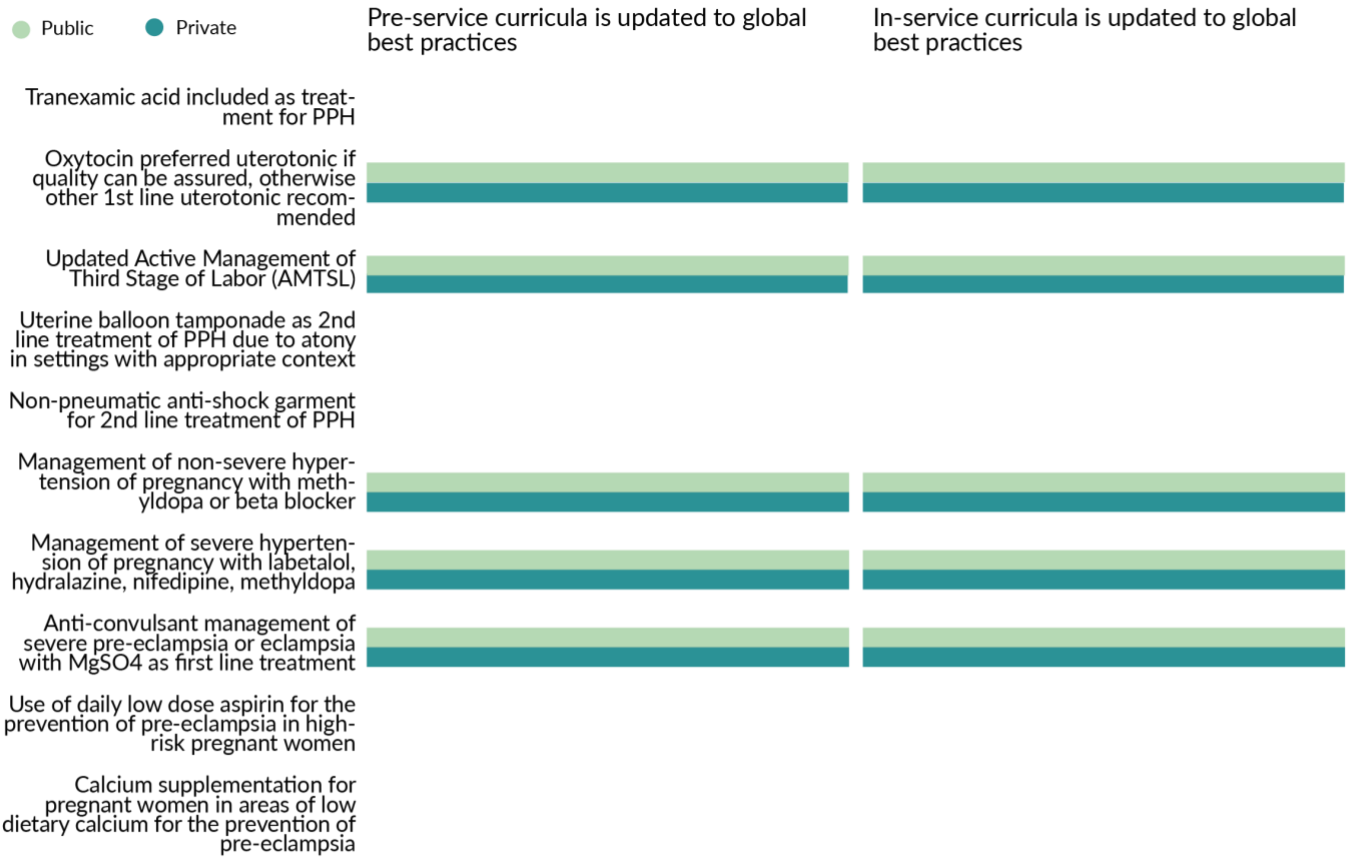
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	☑	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☒	☑	☑

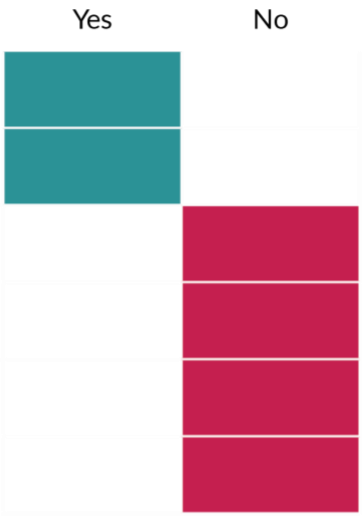
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

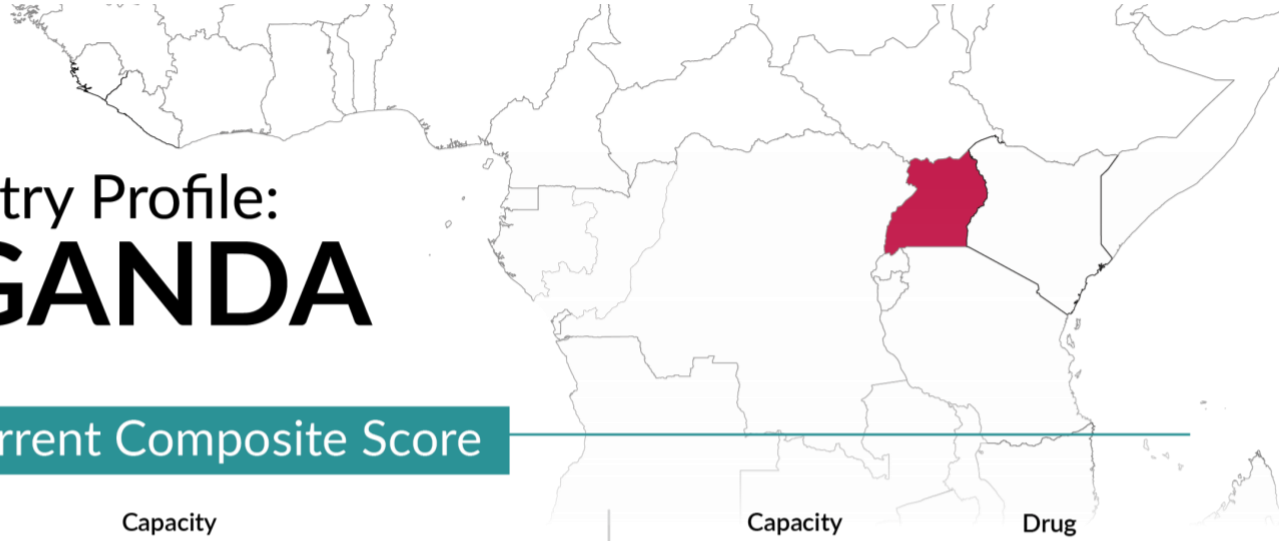
POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

- "Collaboration on Development of policies."
- "Scale-up of trainings for HCW."

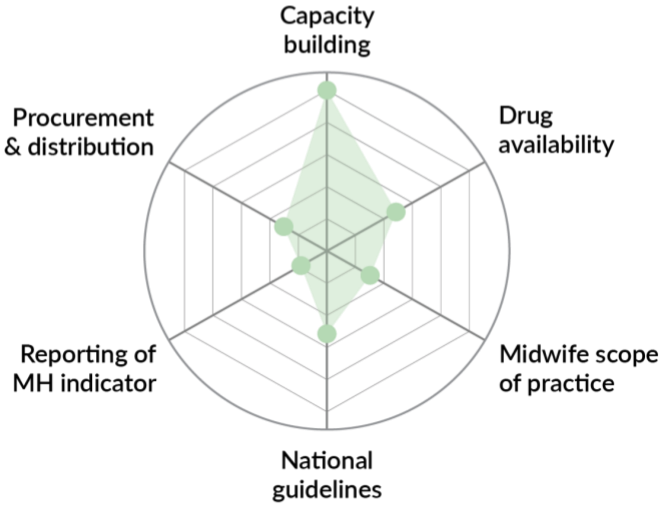
Opportunities for HDP

- "Inadequate human resource for health, inadequate capacity of human resources for health."
- "Scale-up of trainings, capacity building of health care workers."



Country Profile: UGANDA

Current Composite Score



Capacity building
33/40
Current

Drug availability
16/29
Current

Midwife scope of practice
10/10
Current

National guidelines
17/25
Current

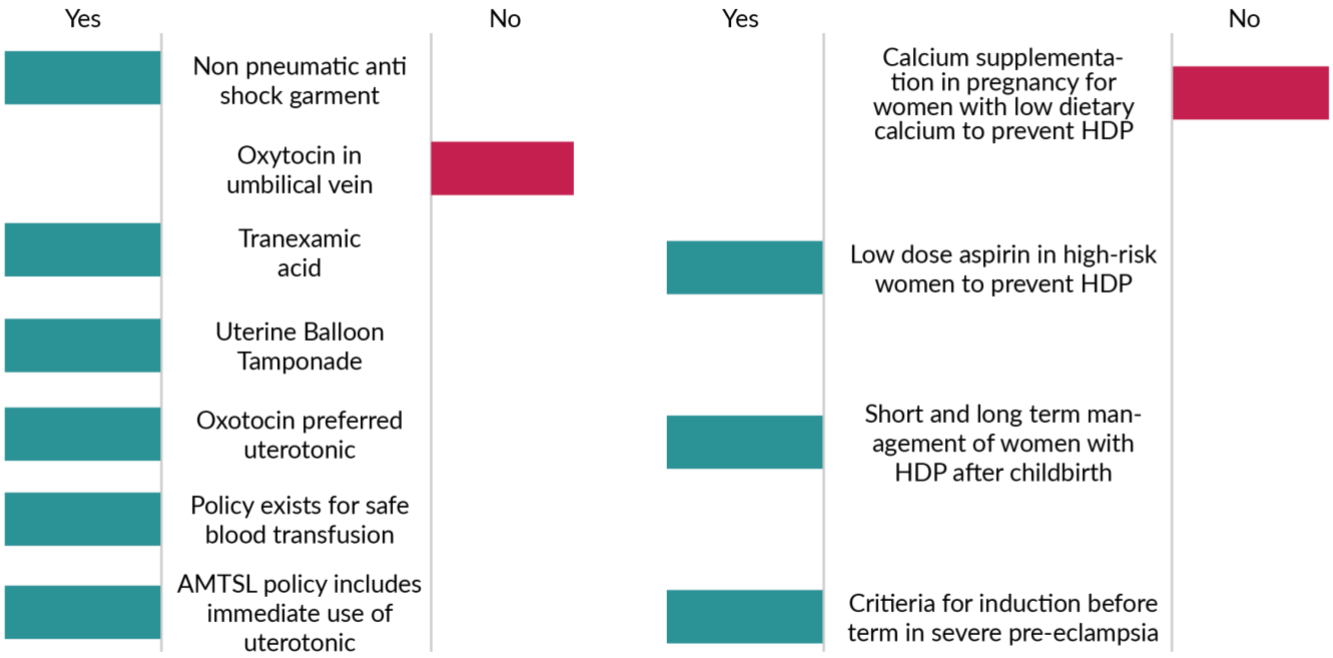
Reporting of MH indicator
6/6
Current

Procurement & distribution
10/12
Current

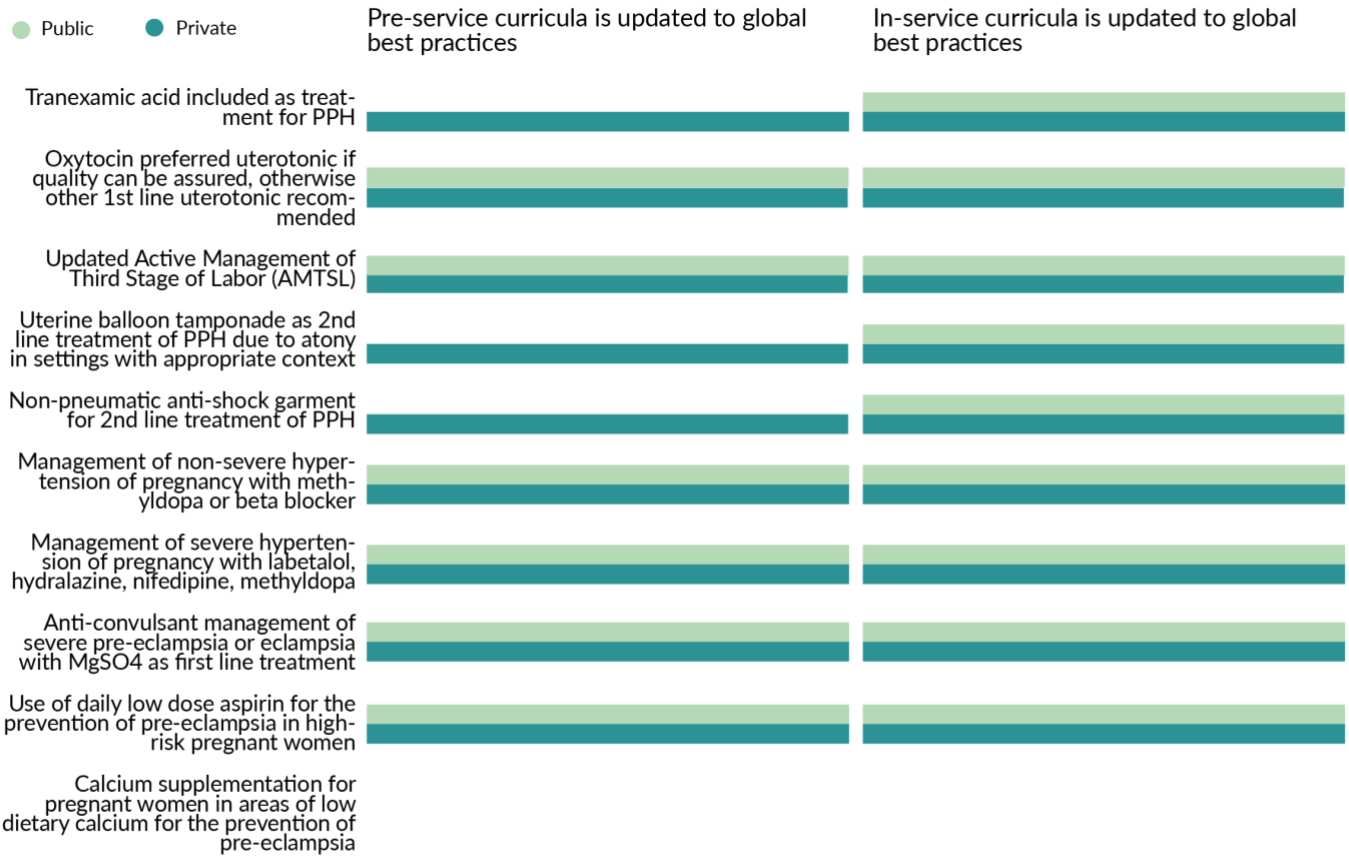
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☑	☑	☑	☒	☑	☑
Oxytocin	☑	☑	☑	☒	☑	☑
Magnesium Sulfate	☑	☑	☑	☑	☒	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS

	Yes	No
Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?	■	
Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?	■	
Does the private sector report on uterotonic use immediately after delivery on the national HMIS?	■	
Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?	■	

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

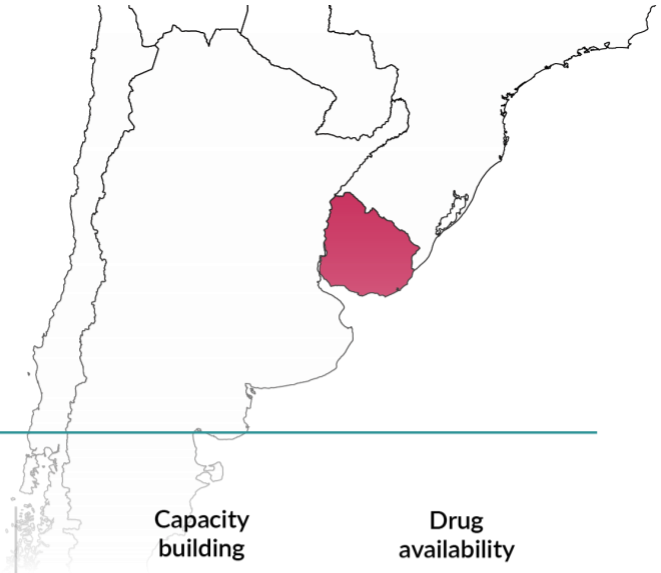
Opportunities for PPH

- "There is a Public Private Partnerships for Health (PPPH) framework that promotes collaboration between the private and public sectors. Other opportunities are planning meetings, program review, training activities and conferences/webinars."

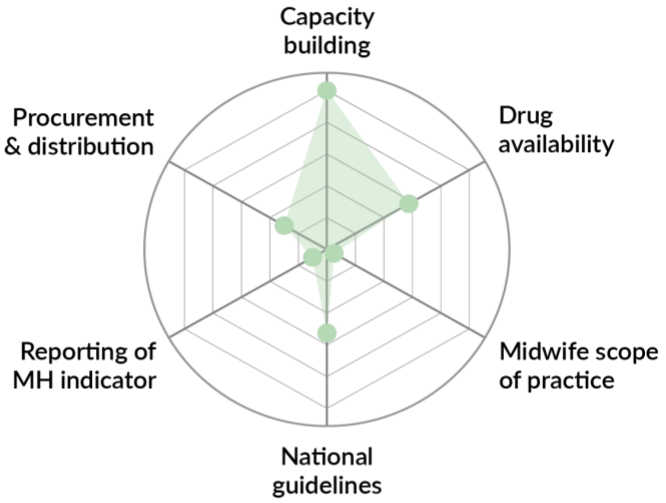
Opportunities for HDP

- "Central, regional and district level planning meetings/workshops."
- "In-service training, Monitoring and Evaluation."

Country Profile:
URUGUAY



Current Composite Score



Capacity building
▶ 40/40
Current

Drug availability
▶ 23/29
Current

Midwife scope of practice
▶ 2/10
Current

National guidelines
▶ 21/25
Current

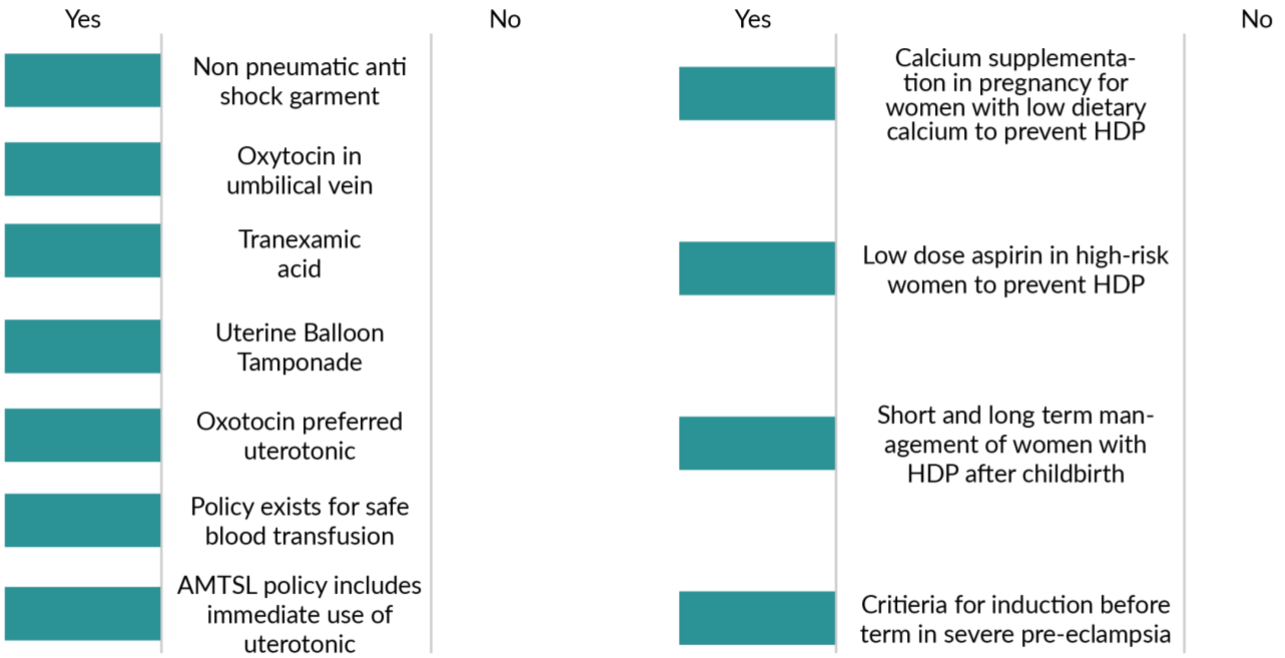
Reporting of MH indicator
▶ 4/6
Current

Procurement & distribution
▶ 12/12
Current

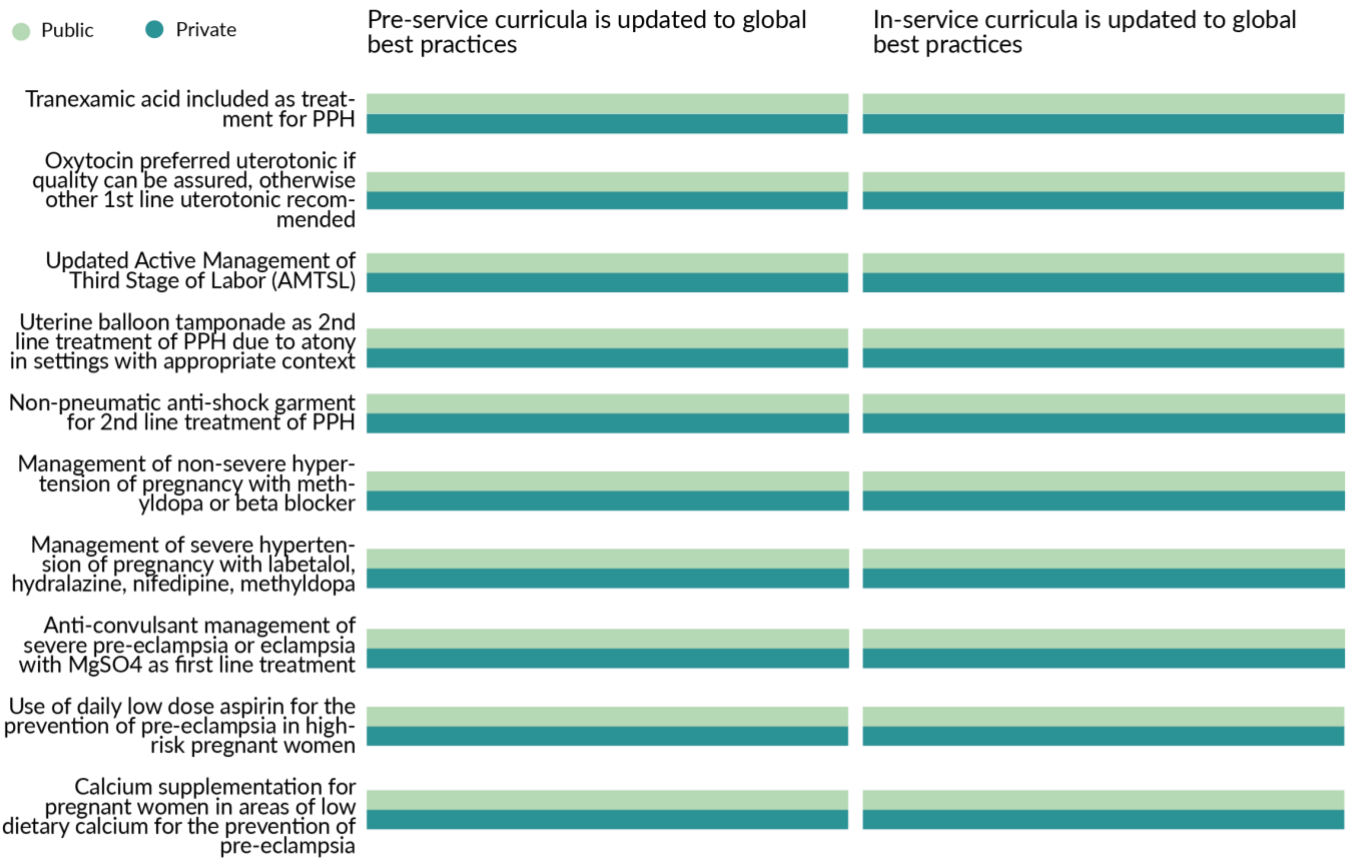
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	N/A	N/A	☑	N/A	☑	☑
Oxytocin	N/A	N/A	☑	N/A	☑	☑
Magnesium Sulfate	N/A	N/A	☑	N/A	☑	☑

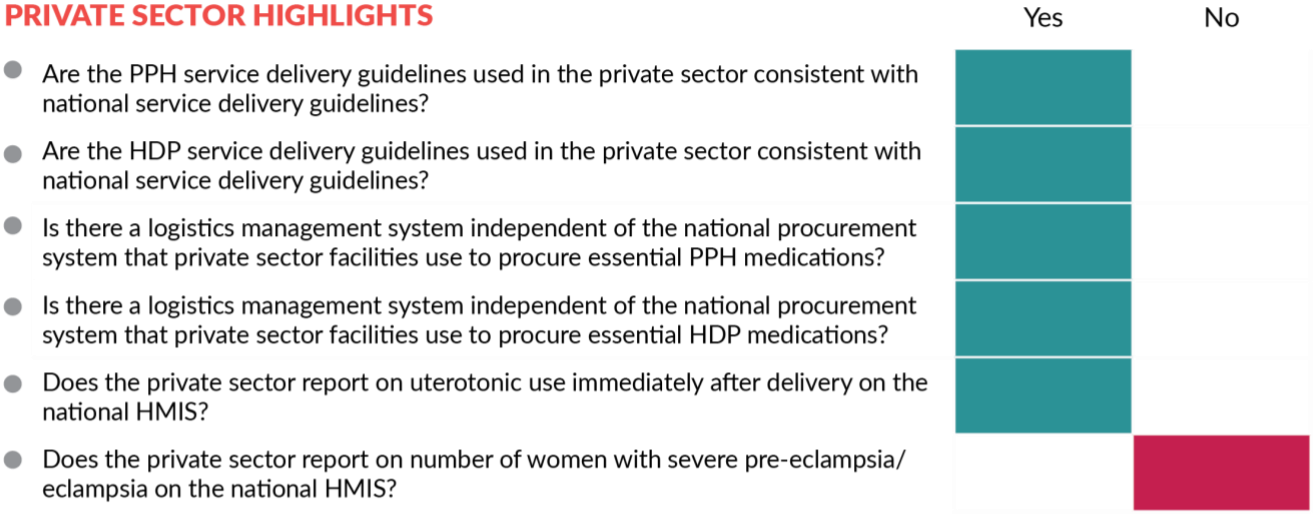
NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



PRIVATE SECTOR HIGHLIGHTS



POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

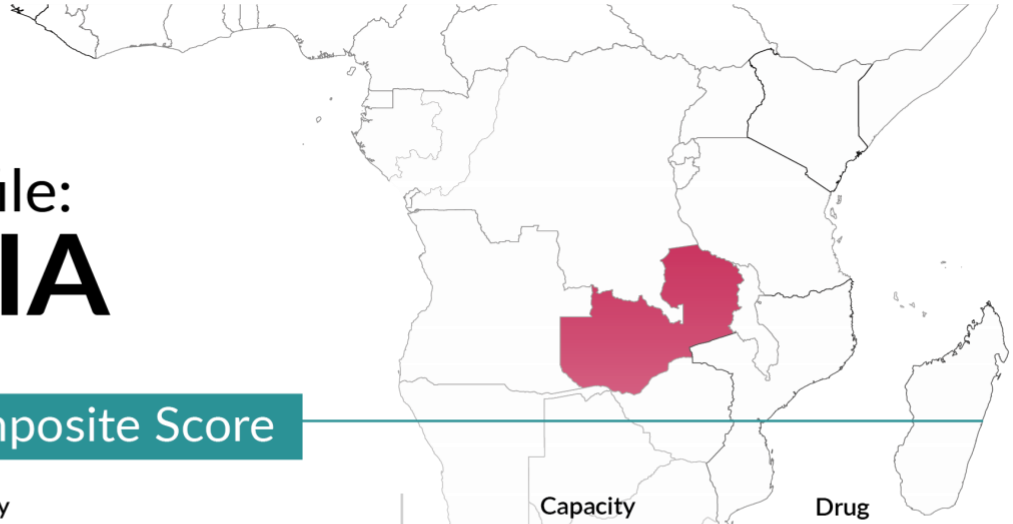
Opportunities for PPH

- "Have available protocols, training plans, and supplies are always available. Conduct in-service training in Emergency Obestetric Care. It would be good if it were mandatory throughout the System."

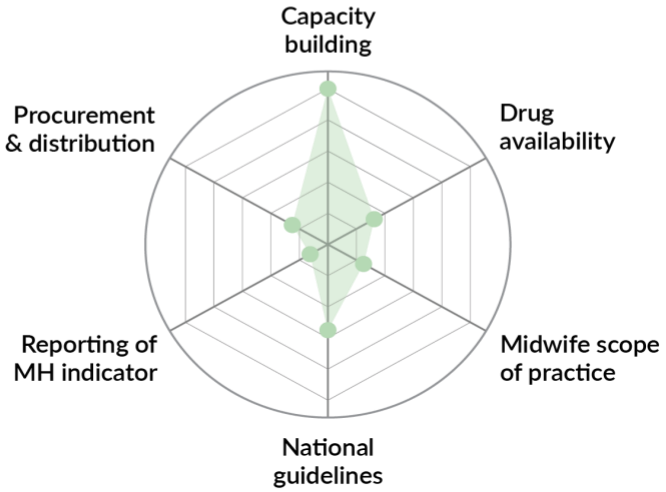
Opportunities for HDP

- "To have the protocols and training and the necessary supplies available. In service training in emergency obstetrics. It would be best if it was mandatory (training) for both private and public."

Country Profile: ZAMBIA



Current Composite Score

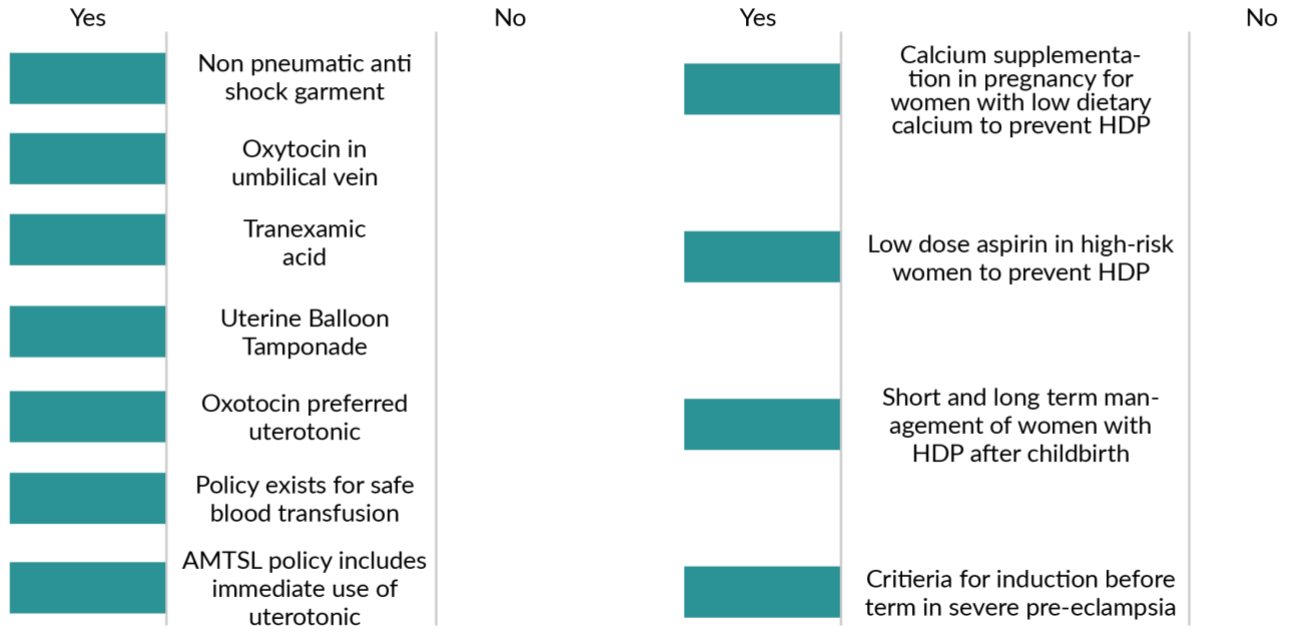


Capacity building	40/40 Current
Drug availability	13/29 Current
Midwife scope of practice	10/10 Current
National guidelines	22/25 Current
Reporting of MH indicator	5/6 Current
Procurement & distribution	10/12 Current

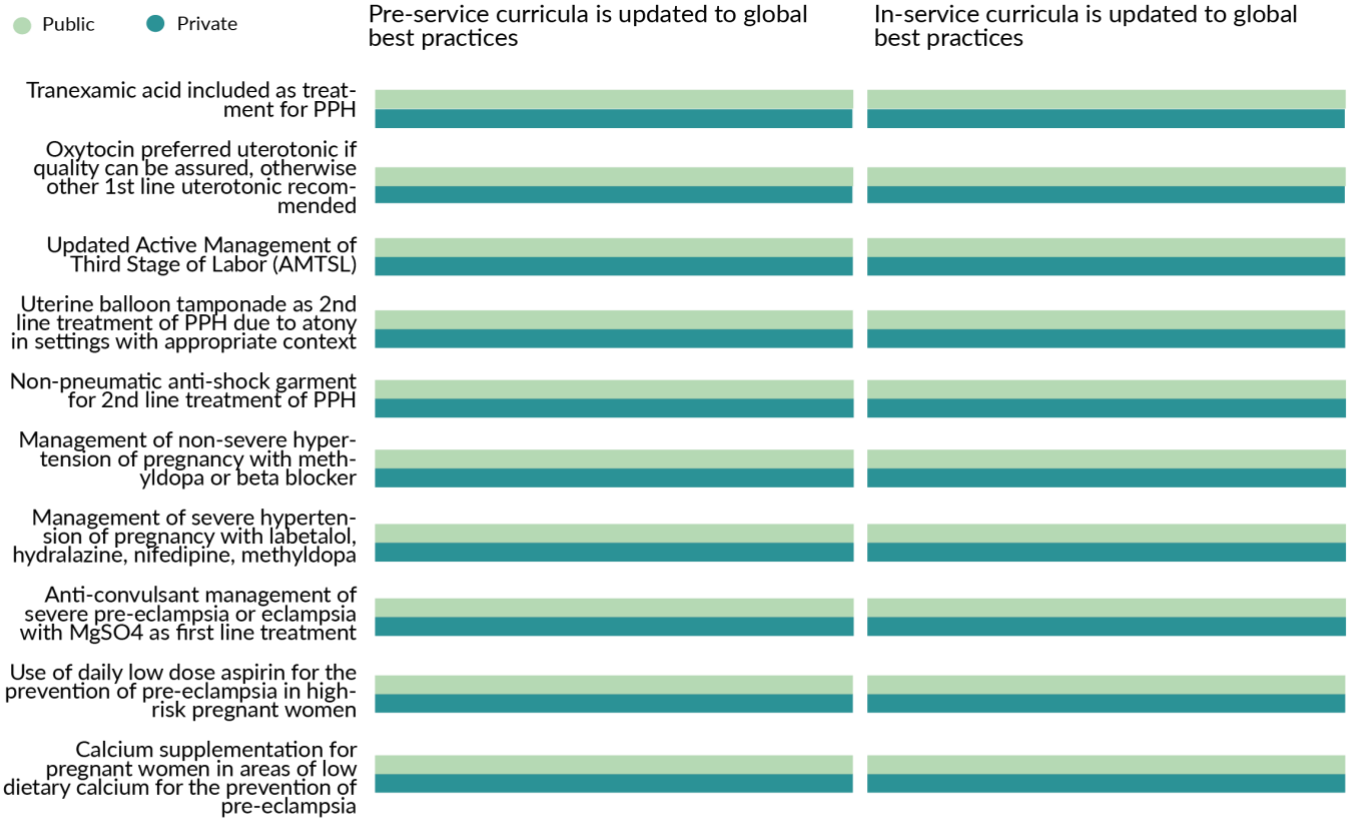
DRUG AVAILABILITY FOR SELECT FIRST-LINE PPH AND HDP MEDICATIONS

	Drug on EML 2011-2022			Drug regularly available at public facilities 2012-2022		Drug in national guidelines 2022
	2011	2012	2022	2012	2022	2022
Misoprostol	☒	N/A	☑	N/A	☒	☑
Oxytocin	☑	N/A	☑	N/A	☒	☑
Magnesium Sulfate	☑	N/A	☑	N/A	☒	☑

NATIONAL GUIDELINES UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP

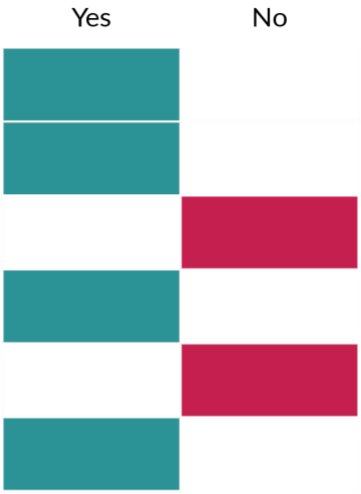


CURRICULA UPDATED TO GLOBAL MANAGEMENT PRINCIPLES FOR PPH AND HDP



Country Profile: Zambia

PRIVATE SECTOR HIGHLIGHTS



- Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential PPH medications?
- Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential HDP medications?
- Does the private sector report on uterotonic use immediately after delivery on the national HMIS?
- Does the private sector report on number of women with severe pre-eclampsia/ eclampsia on the national HMIS?

POTENTIAL OPPORTUNITIES FOR PROGRAM INTRODUCTION, EXPANSION OR SCALE-UP IN THE PUBLIC AND PRIVATE SECTORS

Opportunities for PPH

- "Hemorrhage is the major contributor to maternal deaths in Zambia. All efforts to prevent these maternal deaths due to PPH will impact positively in the lives of Zambian People."

Opportunities for HDP

- "Capacity building (Training; Mentorship). Health systems strengthening; Community engagement."

APPENDIX B – COMPOSITE SCORING BY THEME AND COUNTRY

Composite Scores for PPH Drug Availability 2022

	Oxytocin on EML	Misoprostol on EML	Oxytocin stock-outs rare at central level	Oxytocin stock-outs rare at district/ regional level	Misoprostol regularly available at public facilities	Misoprostol regularly available at private facilities	Oxytocin regularly available at public facilities	Oxytocin regularly available at private facilities	Oxytocin free at public facilities	Oxytocin free at private facilities
Bangladesh	1	1	1	1	1	1	1	1	1	0
Burkina Faso	1	1	1	1	0	0	1	1	1	0
Burma	1	1	1	1	1	1	1	1	1	0
Colombia	1	1	1	1	1	1	1	1	0	0
Côte D'Ivoire	1	1	1	1	0	0	1	1	1	0
Dominican Republic	1	1	1	1	0	1	1	1	1	0
El Salvador	1	1	1	1	1	1	1	1	1	0
Ethiopia	1	1	0	0	0	0	1	1	1	0
Ghana	1	1	1	1	1	1	1	1	0	0
Guatemala	1	1	1	1	1	1	1	1	1	0
Guinea	1	1	1	1	0	0	1	1	1	0
Honduras	1	1	1	1	1	1	1	1	1	0
India	1	1	1	1	1	0	1	0	1	0
Indonesia	1	0	1	1	1	1	1	1	1	0
Kenya	1	1	1	1	1	1	1	1	1	0
Liberia	1	1	1	0	1	1	1	1	1	0
Madagascar	1	1	1	1	1	1	1	1	0	0
Malawi	1	1	1	1	0	1	0	1	1	0
Mali	1	1	1	1	1	1	1	1	0	0
Mozambique	1	1	1	1	1	1	1	1	1	1
Nepal	1	1	1	1	1	0	1	1	1	0
Nigeria	1	1	0	0	0	0	0	1	0	0
Pakistan	1	1	1	1	0	0	0	0	0	0
Paraguay	1	1	1	1	1	1	1	1	1	0
Peru	1	1	1	1	0	0	1	1	1	0
Republic of the Congo	1	1	1	1	1	1	0	0	0	0
Sierra Leone	1	1	1	1	0	0	0	1	1	0
South Sudan	1	1	1	1	0	0	0	0	1	0
Uganda	1	1	1	1	1	0	1	1	1	0
Uruguay	1	1	1	1	1	1	1	1	1	1
Zambia	1	1	1	1	0	0	0	0	1	0

Composite Scores for HDP Drug Availability 2022

	Labetalol on EML for severe PE/E	Hydralazine on EML for severe PE/E	Methyldopa on EML for severe PE/E	Nifedipine on EML for severe PE/E	MgSO4 on EML for severe PE/E	MgSO4 free at public facilities	MgSO4 free at private facilities	MgSO4 regularly available at public facilities	MgSO4 regularly available at private facilities
Bangladesh	1	1	0	1	1	1	0	1	1
Burkina Faso	1	1	1	1	1	1	0	0	0
Burma	1	1	1	1	1	1	0	1	1
Colombia	1	0	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	1	0	0	0
Dominican Republic	1	1	1	1	1	1	0	1	1
El Salvador	0	1	1	0	1	1	0	1	1
Ethiopia	1	1	1	1	1	1	0	1	1
Ghana	1	1	0	1	1	1	1	0	0
Guatemala	1	1	1	1	1	1	0	1	1
Guinea	1	1	1	1	1	1	0	0	0
Honduras	0	1	1	1	1	1	0	1	1
India	1	1	1	1	1	1	0	1	0
Indonesia	0	0	1	1	1	1	0	1	1
Kenya	1	1	1	1	1	1	0	1	0
Liberia	0	1	0	1	1	1	0	1	1
Madagascar	0	1	1	1	1	0	0	0	0
Malawi	1	1	1	1	1	1	0	1	1
Mali	0	0	1	1	1	0	0	1	0
Mozambique	1	1	1	1	1	1	1	1	1
Nepal	0	0	0	1	1	1	0	0	0
Nigeria	1	1	1	1	1	0	0	0	0
Pakistan	1	1	1	1	1	1	1	0	0
Paraguay	1	0	1	1	1	1	0	1	1
Peru	1	0	1	1	1	1	0	0	0
Republic of the Congo	1	1	1	1	1	0	0	0	0
Sierra Leone	1	1	1	1	1	1	0	0	0
South Sudan	0	1	1	1	1	1	0	1	0
Uganda	0	1	0	1	1	1	0	0	0
Uruguay	1	0	0	1	1	1	1	1	1
Zambia	1	1	1	1	1	1	0	0	0

Composite Scores for HDP Drug Availability 2022 continued

	Stock-outs of MgSO4 rare at central level	Stock-outs of MgSO4 rare at district/regional level	Labetalol regularly available at public facilities	Hydralazine regularly available at public facilities	Methyldopa regularly available at public facilities	Nifedipine regularly available at public facilities	Labetalol regularly available at private facilities	Hydralazine regularly available at private facilities	Methyldopa regularly available at private facilities	Nifedpine reguarly available at private facilities
Bangladesh	0	0	1	0	1	1	1	0	1	1
Burkina Faso	0	0	0	0	0	0	0	0	1	1
Burma	1	1	0	0	1	1	1	1	1	1
Colombia	1	1	1	0	0	1	1	0	1	1
Côte D'Ivoire	1	1	0	0	0	0	0	0	0	0
Dominican Republic	1	1	0	1	1	1	0	1	1	1
El Salvador	1	1	0	1	1	0	0	1	1	0
Ethiopia	0	0	1	1	1	1	1	1	1	1
Ghana	0	0	0	0	1	0	0	0	1	0
Guatemala	1	0	0	1	1	1	1	1	1	1
Guinea	1	0	0	0	0	0	0	0	0	0
Honduras	1	0	0	1	1	1	1	1	1	1
India	0	0	1	0	0	1	0	0	0	0
Indonesia	0	0	0	0	1	1	0	0	1	1
Kenya	0	0	1	1	1	1	0	0	0	0
Liberia	1	0	0	0	1	1	0	0	0	0
Madagascar	1	0	1	1	1	1	0	0	0	0
Malawi	1	1	0	1	1	1	0	1	1	1
Mali	1	1	0	0	1	1	0	0	0	0
Mozambique	1	1	1	1	0	1	1	1	0	1
Nepal	1	1	0	0	0	1	0	0	0	1
Nigeria	0	0	0	0	0	0	0	0	0	0
Pakistan	0	0	0	0	0	0	1	1	1	1
Paraguay	1	1	1	0	1	1	1	1	1	1
Peru	1	1	0	0	1	1	0	0	0	0
Republic of the Congo	0	0	0	0	1	0	0	0	1	0
Sierra Leone	1	1	0	0	0	0	0	0	0	0
South Sudan	1	1	0	1	1	1	1	1	1	1
Uganda	1	1	1	0	1	0	0	0	0	0
Uruguay	1	1	1	0	0	1	1	0	0	1
Zambia	1	1	0	0	0	0	0	0	0	0

Composite Scores for National Guidelines for PPH Updated to Global Management Principles 2022

	National guidelines include TXA for treatment of PPH	National guidelines include UBT for treatment of PPH	National guidelines include NASG for treatment of PP	Private sector uses PPH national guidelines	National guidelines include oxytocin as preferred uterotonic	National policy includes giving misoprostol to women delivering at home or without a skilled birth attendant for PPH prevention	National policy includes updated AMTSL	National policy for blood transfusion services	National guidelines include ergometrine/ methylergometrine if oxytocin quality not guaranteed	National guidelines include oxytocin-ergometrine if oxytocin quality not guaranteed	National guidelines include misoprostol if oxytocin quality not guaranteed
Bangladesh	1	1	1	1	1	0	1	1	1	0	1
Burkina Faso	1	1	1	1	1	1	1	1	1	1	1
Burma	1	1	0	1	1	1	1	1	1	1	1
Colombia	1	1	1	1	1	0	1	1	1	1	1
Côte D'Ivoire	1	1	0	1	1	1	1	1	0	0	1
Dominican Republic	1	1	1	1	1	0	1	1	1	1	1
El Salvador	0	1	0	1	1	0	1	1	1	0	1
Ethiopia	1	1	1	1	1	0	1	1	1	1	1
Ghana	1	1	1	1	1	0	1	1	1	0	1
Guatemala	1	1	1	0	1	1	1	1	1	1	1
Guinea	0	1	0	1	1	1	1	1	1	0	1
Honduras	1	1	1	1	1	0	1	1	1	1	1
India	0	1	0	1	1	1	1	1	1	1	1
Indonesia	1	1	0	1	1	0	1	1	1	1	1
Kenya	1	1	1	1	1	0	1	1	1	1	1
Liberia	0	1	1	0	1	0	1	1	1	0	1
Madagascar	1	1	0	1	1	1	1	1	1	0	1
Malawi	1	1	1	1	1	0	1	1	0	0	1
Mali	1	1	0	1	1	0	1	1	1	1	0
Mozambique	0	0	0	1	1	0	1	1	0	0	1
Nepal	1	1	0	0	1	1	1	1	1	0	1
Nigeria	1	1	1	1	1	1	1	1	1	1	1
Pakistan	0	0	0	1	1	1	1	1	0	1	1
Paraguay	1	1	1	1	1	0	1	1	1	1	1
Peru	1	1	1	1	1	0	1	1	1	0	1
Republic of the Congo	1	1	0	1	1	0	1	1	1	1	1
Sierra Leone	1	1	0	1	1	0	1	1	0	0	1
South Sudan	0	0	0	1	1	0	1	1	0	0	1
Uganda	1	1	1	1	1	0	1	1	0	0	1
Uruguay	1	1	1	1	1	0	1	1	1	0	1
Zambia	1	1	1	1	1	0	1	1	1	1	1

Composite Scores for National Guidelines for HDP Updated to Global Management Principles 2022

	National guidelines include beta-blocker for non-severe hypertension	National guidelines include hydralazine for non-severe hypertension	National guidelines include methyldopa for non-severe hypertension	National guidelines include nifedipine for non-severe hypertension	National guidelines include hydralazine as first line anti-hypertensive in severe pre-eclampsia/ eclampsia	National guidelines include labetalol as first-line anti-hypertensive in severe pre-eclampsia/ eclampsia	National guidelines include methyldopa as first-line anti-hypertensive in severe pre-eclampsia/ eclampsia	National guidelines include nifedipine as first-line anti-hypertensive in severe pre-eclampsia/ eclampsia	National guidelines include recommendation on induction of labor for severe pre-eclampsia/ eclampsia before term	Private sector uses national HDP guidelines	National guidelines include Calcium supplementation in pregnancy for at risk women	National guidelines include management of women with HDP after giving birth	National guidelines include aspirin during pregnancy for at risk women	National guidelines include MgSO4 is first-line anti-convulsant in severe PE/E
Bangladesh	1	1	1	1	1	1	1	1	1	1	1	1	0	1
Burkina Faso	1	1	1	1	1	0	1	1	1	1	0	0	0	1
Burma	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Colombia	0	0	1	1	1	1	0	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	0	0	1	1	1	1	1	1	1
Dominican Republic	0	0	1	1	1	1	1	1	1	1	1	1	1	1
El Salvador	0	0	1	1	1	0	0	0	1	1	1	1	1	1
Ethiopia	1	1	1	1	1	0	0	0	1	1	1	1	1	1
Ghana	1	0	1	1	1	1	0	1	0	1	0	0	0	1
Guatemala	1	1	1	1	1	1	1	1	1	0	0	1	1	1
Guinea	0	0	1	1	1	0	1	1	1	1	0	1	1	1
Honduras	1	1	1	1	1	1	1	1	1	1	1	1	1	1
India	1	0	1	1	1	1	1	1	1	0	1	0	0	1
Indonesia	0	0	1	1	0	0	1	1	1	1	1	1	1	1
Kenya	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Liberia	0	0	1	1	1	0	1	1	1	0	1	1	1	1
Madagascar	1	1	1	1	0	1	0	0	1	1	0	0	1	1
Malawi	0	0	1	1	1	1	1	1	1	0	0	1	0	1
Mali	0	0	1	1	0	0	1	1	1	1	0	1	1	1
Mozambique	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Nepal	0	1	1	1	1	0	1	1	1	0	1	0	0	1
Nigeria	1	1	1	1	1	1	1	1	1	0	1	1	1	1
Pakistan	1	0	1	0	1	0	0	1	1	0	0	1	1	1
Paraguay	1	0	1	1	1	1	1	1	1	1	1	1	1	1
Peru	0	0	0	0	0	0	1	1	1	1	1	1	1	1
Republic of the Congo	0	0	1	0	1	1	1	1	1	1	1	1	1	1
Sierra Leone	1	0	1	0	1	1	1	0	1	1	0	1	0	1
South Sudan	1	0	1	1	1	0	1	1	1	1	0	1	0	1
Uganda	1	0	1	0	1	0	0	1	1	1	0	1	1	1
Uruguay	1	0	1	1	0	1	1	1	1	1	1	1	1	1
Zambia	1	0	1	0	1	1	1	1	1	1	1	1	1	1

Composite Scores for Quality and Procurement Policies at the National Level 2022

	System to ensure 50% solution of MgSO4 in public sector	System to ensure 50% solution of MgSO4 in private sector	Logistics management system for private sector for PPH	Logistics management system for private sector for HDP	Public facilities have controlled cold-chain for oxytocin	Private facilities have controlled cold-chain for oxytocin	National procurement policy for oxytocin	National procurement policy for misoprostol	National procurement policy for ergometrine	Distribution, storage, transport policy that meets international norms for oxytocin	Distribution, storage, transport policy that meets international norms for misoprostol	Distribution, storage, transport policy that meets international norms for ergometrine
Bangladesh	1	1	1	1	1	0	1	1	0	1	1	1
Burkina Faso	1	1	1	1	0	0	1	1	1	1	1	1
Burma	1	1	1	1	1	1	1	1	1	1	1	1
Colombia	0	0	1	1	1	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	1	1	1	0	1	1	0
Dominican Republic	1	1	1	1	0	0	1	1	1	1	1	1
El Salvador	1	1	1	1	1	1	1	1	1	1	1	1
Ethiopia	1	1	0	0	1	1	1	1	1	1	1	1
Ghana	0	0	1	1	0	0	1	1	1	1	1	1
Guatemala	1	1	1	1	1	1	1	1	1	1	1	1
Guinea	0	0	1	1	0	0	1	1	1	1	1	1
Honduras	0	0	1	1	1	1	1	1	1	1	1	1
India	1	1	0	0	1	1	0	0	0	1	1	0
Indonesia	0	0	1	1	1	0	1	1	1	0	0	0
Kenya	1	1	1	1	1	1	1	1	1	1	1	1
Liberia	1	1	0	0	0	0	1	1	1	1	1	1
Madagascar	0	0	1	1	0	0	1	1	1	1	1	1
Malawi	1	1	1	1	1	1	0	1	1	1	1	0
Mali	1	1	1	1	1	1	1	1	1	1	1	1
Mozambique	1	1	1	1	1	1	1	1	0	1	1	0
Nepal	1	1	0	0	0	0	1	1	1	0	0	0
Nigeria	0	0	0	1	1	1	1	1	1	1	1	1
Pakistan	1	1	1	0	1	1	1	1	0	1	1	0
Paraguay	1	1	1	1	1	1	1	1	1	1	1	1
Peru	0	0	1	1	1	1	1	1	1	1	1	1
Republic of the Congo	1	1	1	1	0	0	1	1	1	1	1	1
Sierra Leone	1	1	1	0	0	0	1	1	1	1	1	1
South Sudan	0	0	0	0	1	1	1	1	0	1	1	1
Uganda	1	1	1	1	0	0	1	1	1	1	1	1
Uruguay	1	1	1	1	1	1	1	1	1	1	1	1
Zambia	1	1	1	1	0	0	1	1	1	1	1	1

Composite Scores for Midwife Scope of Practice 2022

	Public sector midwife scope includes diagnosing severe PE/E and giving initial loading dose of MgSO4	Private sector midwife scope includes diagnosing severe PE/E and giving initial loading dose of MgSO4	Performing manual removal of placenta - Public Sector Midwives	Performing manual removal of placenta - Private Sector Midwives	Applying/removing non-pneumatic anti-shock garment - Public Sector Midwives	Applying/removing non-pneumatic anti-shock garment - Private Sector Midwives	Giving tranexamic acid - Public Sector Midwives	Giving tranexamic acid - Private Sector Midwives	Management of uterine balloon tamponade - Public Sector Midwives	Management of uterine balloon tamponade - Private Sector Midwives
Bangladesh	1	1	1	1	0	0	1	0	0	0
Burkina Faso	1	1	1	1	1	1	1	1	1	1
Burma	1	0	1	1	1	1	1	1	1	1
Colombia	0	0	0	0	0	0	0	0	0	0
Côte D'Ivoire	1	1	1	1	0	0	1	1	1	1
Dominican Republic	0	0	0	0	0	0	0	0	0	0
El Salvador	NA	NA	0	0	0	0	0	0	0	0
Ethiopia	1	1	1	1	1	0	1	0	0	0
Ghana	1	1	1	1	0	0	1	1	1	1
Guatemala	1	0	1	0	1	0	0	0	1	0
Guinea	1	1	1	1	0	0	1	1	1	1
Honduras	0	0	0	0	0	0	0	0	0	0
India	1	NA	0	0	1	0	0	0	1	0
Indonesia	1	1	0	0	0	0	0	0	1	1
Kenya	1	1	1	1	1	1	1	1	1	1
Liberia	1	1	1	1	1	0	0	0	1	0
Madagascar	1	1	1	1	0	0	1	1	1	1
Malawi	1	1	1	1	1	0	1	1	1	0
Mali	1	1	1	1	0	0	1	1	1	1
Mozambique	1	1	1	1	0	0	1	1	0	0
Nepal	1	1	1	1	0	0	1	1	1	1
Nigeria	1	1	1	0	1	0	1	0	1	0
Pakistan	0	0	1	1	1	1	1	1	0	0
Paraguay	1	1	1	1	1	1	1	1	1	1
Peru	1	1	1	1	1	1	1	1	0	0
Republic of the Congo	1	1	1	1	0	0	1	1	1	1
Sierra Leone	1	1	1	1	0	0	0	1	1	1
South Sudan	1	1	1	0	0	1	0	1	0	1
Uganda	1	1	1	1	1	1	1	1	1	1
Uruguay	1	1	0	0	0	0	0	0	0	0
Zambia	1	1	1	1	1	1	1	1	1	1

Composite Scores for Pre-service Capacity Building and Training in Global Best Practices 2022

	Anti-convulsant management of severe pre-eclampsia or eclampsia with magnesium sulfate as first line treatment - Public Sector Training Institutions	Anti-convulsant management of severe pre-eclampsia or eclampsia with magnesium sulfate as first line treatment - Private Sector Training Institutions	Calcium supplementation for pregnant women in areas of low dietary calcium for the prevention of pre-eclampsia - Public Sector Training Institutions	Calcium supplementation for pregnant women in areas of low dietary calcium for the prevention of pre-eclampsia - Private Sector Training Institutions	Management of non-severe hypertension of pregnancy with methyldopa or beta blocker - Public Sector Training Institutions	Management of non-severe hypertension of pregnancy with methyldopa or beta blocker - Private Sector Training Institutions	Management of severe hypertension of pregnancy with labetalol, hydralazine, nifedipine, or methyldopa - Public Sector Training Institutions	Management of severe hypertension of pregnancy with labetalol, hydralazine, nifedipine, or methyldopa - Private Sector Training Institutions	Oxytocin preferred uterotonic if quality can be assured, otherwise other 1st line uterotonic recommended - Public Training Institutions	Oxytocin preferred uterotonic if quality can be assured, otherwise other 1st line uterotonic recommended - Private Training Institutions
Bangladesh	1	1	1	1	1	1	1	1	1	1
Burkina Faso	1	1	0	0	0	0	1	1	1	1
Burma	1	1	1	1	1	1	1	1	1	1
Colombia	1	1	1	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	1	1	1	1	1
Dominican Republic	1	1	1	1	1	1	1	1	1	1
El Salvador	1	0	1	0	1	0	1	0	1	1
Ethiopia	1	1	1	1	1	1	1	1	1	0
Ghana	1	1	0	0	1	1	0	0	1	1
Guatemala	1	1	1	1	1	1	1	1	1	1
Guinea	1	1	0	0	1	1	1	1	1	1
Honduras	1	1	1	1	1	1	1	1	1	1
India	1	1	1	1	1	1	1	1	1	1
Indonesia	1	1	1	1	1	1	1	1	1	1
Kenya	1	1	1	1	1	1	1	1	1	1
Liberia	1	1	1	1	1	1	1	1	1	1
Madagascar	1	1	0	0	1	1	1	1	1	1
Malawi	1	1	0	0	1	1	1	1	1	1
Mali	1	1	0	0	1	1	1	1	1	1
Mozambique	1	1	1	1	1	1	1	1	1	1
Nepal	1	1	1	1	1	1	1	1	1	1
Nigeria	1	1	1	1	1	1	1	1	1	1
Pakistan	1	1	1	1	1	1	1	1	1	1
Paraguay	1	1	1	1	1	1	1	1	1	1
Peru	1	1	1	1	0	0	1	1	1	1
Republic of the Congo	1	1	1	1	1	1	1	1	1	1
Sierra Leone	1	1	0	0	1	1	1	1	1	1
South Sudan	1	1	0	0	1	1	1	1	1	1
Uganda	1	1	0	0	1	1	1	1	1	1
Uruguay	1	1	1	1	1	1	1	1	1	1
Zambia	1	1	1	1	1	1	1	1	1	1

Composite Scores for Pre-Service Capacity Building and Training in Global Best Practices 2022 continued

	Tranexamic acid included as treatment for PPH - Public Training Institutions	Tranexamic acid included as treatment for PPH - Private Training Institutions	Updated Active Management of Third Stage of Labor (AMTSL) - Public Training Institutions	Updated Active Management of Third Stage of Labor (AMTSL) - Private Training Institutions	Uterine balloon tamponade as 2nd line treatment of PPH due to atony in settings with appropriate context - Public Training Institutions	Uterine balloon tamponade as 2nd line treatment of PPH due to atony in settings with appropriate context - Private Training Institutions	Non-pneumatic anti-shock garment for 2nd line treatment of PPH - Public Training Institutions	Non-pneumatic anti-shock garment for 2nd line treatment of PPH - Private Training Institutions	Use of daily low dose aspirin for the prevention of pre-eclampsia in high-risk pregnant women - Public Sector Training Institutions	Use of daily low dose aspirin for the prevention of pre-eclampsia in high-risk pregnant women - Private Sector Training Institutions
Bangladesh	1	1	1	1	1	1	0	0	1	0
Burkina Faso	1	1	1	1	1	1	1	1	0	0
Burma	1	1	1	1	1	1	1	0	1	1
Colombia	1	1	1	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	1	1	1	1	1
Dominican Republic	1	1	1	1	1	1	1	1	1	1
El Salvador	0	0	1	1	0	0	0	0	1	0
Ethiopia	0	0	1	0	0	0	1	0	1	1
Ghana	1	1	1	1	0	0	0	0	0	0
Guatemala	1	1	1	1	1	0	1	0	1	1
Guinea	0	0	1	1	1	1	0	0	1	1
Honduras	1	1	1	1	1	1	1	1	1	1
India	1	1	1	1	1	1	0	0	0	0
Indonesia	1	1	1	1	1	1	0	0	1	1
Kenya	1	1	1	1	1	1	1	1	1	1
Liberia	1	1	1	1	1	1	1	1	1	1
Madagascar	1	1	1	1	1	1	0	0	1	1
Malawi	1	0	1	1	1	0	1	0	0	0
Mali	1	1	1	1	1	1	0	0	1	1
Mozambique	1	1	1	1	1	1	1	1	1	1
Nepal	0	0	1	1	1	1	0	0	0	0
Nigeria	1	0	1	1	1	1	1	0	1	1
Pakistan	1	1	1	1	0	0	1	1	1	1
Paraguay	1	1	1	1	1	1	1	1	1	1
Peru	1	1	1	1	1	1	1	1	1	1
Republic of the Congo	1	1	1	1	1	1	1	1	1	1
Sierra Leone	0	0	1	1	1	1	0	0	0	0
South Sudan	0	0	1	1	0	0	0	0	0	0
Uganda	0	1	1	1	0	1	0	1	1	1
Uruguay	1	1	1	1	1	1	1	1	1	1
Zambia	1	1	1	1	1	1	1	1	1	1

Composite Scores for In-Service Capacity Building and Training in Global Best Practices 2022

	Anti-convulsant management of severe pre-eclampsia or eclampsia with magnesium sulfate as first line treatment - Private Sector Training Institutions	Anti-convulsant management of severe pre-eclampsia or eclampsia with magnesium sulfate as first line treatment - Public Sector Training Institutions	Calcium supplementation for pregnant women in areas of low dietary calcium for the prevention of pre-eclampsia - Private Sector Training Institutions	Calcium supplementation for pregnant women in areas of low dietary calcium for the prevention of pre-eclampsia - Public Sector Training Institutions	Management of non-severe hypertension of pregnancy with methyldopa or beta blocker - Private Sector Training Institutions	Management of non-severe hypertension of pregnancy with methyldopa or beta blocker - Public Sector Training Institutions	Management of severe hypertension of pregnancy with labetalol, hydralazine, nifedipine, or methyldopa - Private Sector Training Institutions	Management of severe hypertension of pregnancy with labetalol, hydralazine, nifedipine, or methyldopa - Public Sector Training Institutions	Oxytocin preferred uterotonic if quality can be assured, otherwise other 1st line uterotonic recommended - Private Training Institutions	Oxytocin preferred uterotonic if quality can be assured, otherwise other 1st line uterotonic recommended - Public Training Institutions
Bangladesh	0	1	1	1	1	1	1	1	1	1
Burkina Faso	1	1	0	0	0	0	1	1	1	1
Burma	1	1	1	1	1	1	1	1	1	1
Colombia	1	1	1	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	1	1	1	1	1
Dominican Republic	1	1	1	1	1	1	1	1	1	1
El Salvador	0	1	0	1	0	1	0	1	0	1
Ethiopia	1	1	1	1	1	1	1	1	0	1
Ghana	1	1	0	0	1	1	1	1	1	1
Guatemala	1	1	1	1	1	1	1	1	1	1
Guinea	0	1	0	0	0	1	0	1	0	1
Honduras	1	1	1	1	1	1	1	1	1	1
India	0	1	0	1	0	1	0	1	1	1
Indonesia	1	1	1	1	1	1	1	1	1	1
Kenya	1	1	1	1	1	1	1	1	1	1
Liberia	1	1	1	1	1	1	1	1	1	1
Madagascar	1	1	0	0	1	1	1	1	1	1
Malawi	1	1	0	0	1	1	1	1	1	1
Mali	1	1	0	0	1	1	1	1	1	1
Mozambique	1	1	1	1	1	1	1	1	1	1
Nepal	1	1	1	1	1	1	1	1	1	1
Nigeria	1	1	1	1	1	1	1	1	1	1
Pakistan	1	1	1	1	1	1	1	1	1	1
Paraguay	1	1	1	1	1	1	1	1	1	1
Peru	1	1	1	1	0	0	1	1	0	1
Republic of the Congo	1	1	1	1	1	1	1	1	1	1
Sierra Leone	0	1	0	0	0	1	0	1	1	1
South Sudan	1	1	0	0	1	1	1	1	1	1
Uganda	1	1	0	0	1	1	1	1	1	1
Uruguay	1	1	1	1	1	1	1	1	1	1
Zambia	1	1	1	1	1	1	1	1	1	1

Composite Scores for In-Service Capacity Building and Training in Global Best Practices 2022 continued

	Tranexamic acid included as treatment for PPH - Private Training Institutions	Tranexamic acid included as treatment for PPH - Public Training Institutions	Updated Active Management of Third Stage of Labor (AMTSL) - Private Training Institutions	Updated Active Management of Third Stage of Labor (AMTSL) - Public Training Institutions	Uterine balloon tamponade as 2nd line treatment of PPH due to atony in settings with appropriate context - Private Training Institutions	Uterine balloon tamponade as 2nd line treatment of PPH due to atony in settings with appropriate context - Public Training Institutions	Non-pneumatic anti-shock garment for 2nd line treatment of PPH - Private Training Institutions	Non-pneumatic anti-shock garment for 2nd line treatment of PPH - Public Training Institutions	Use of daily low dose aspirin for the prevention of pre-eclampsia in high-risk pregnant women - Private Sector Training Institutions	Use of daily low dose aspirin for the prevention of pre-eclampsia in high-risk pregnant women - Public Sector Training Institutions
Bangladesh	1	1	1	1	1	1	0	0	0	0
Burkina Faso	1	1	1	1	1	1	1	1	0	0
Burma	1	1	1	1	1	1	0	1	1	1
Colombia	1	1	1	1	1	1	1	1	1	1
Côte D'Ivoire	1	1	1	1	1	1	0	0	1	1
Dominican Republic	1	1	1	1	1	1	1	1	1	1
El Salvador	0	1	0	1	0	1	0	0	0	1
Ethiopia	0	1	0	1	0	1	0	1	1	1
Ghana	1	1	1	1	0	0	0	0	0	0
Guatemala	0	1	1	1	0	1	0	1	1	1
Guinea	0	0	0	1	0	0	0	1	1	1
Honduras	1	1	1	1	1	1	1	1	1	1
India	1	1	1	1	1	1	0	0	0	0
Indonesia	1	1	1	1	1	1	0	0	1	1
Kenya	1	1	1	1	1	1	1	1	1	1
Liberia	0	0	1	1	1	1	1	1	1	1
Madagascar	1	1	1	1	1	1	0	0	1	1
Malawi	0	1	1	1	0	1	0	1	0	0
Mali	1	1	1	1	1	1	0	0	1	1
Mozambique	1	1	1	1	1	1	1	1	1	1
Nepal	1	1	1	1	1	1	0	0	0	0
Nigeria	0	1	1	1	0	1	0	1	1	1
Pakistan	1	1	1	1	0	0	1	1	1	1
Paraguay	1	1	1	1	1	1	1	1	1	1
Peru	0	1	0	1	0	1	0	1	1	1
Republic of the Congo	1	1	1	1	1	1	1	1	1	1
Sierra Leone	0	0	1	1	1	1	0	0	0	0
South Sudan	0	0	1	1	0	0	0	0	0	0
Uganda	1	1	1	1	1	1	1	1	1	1
Uruguay	1	1	1	1	1	1	1	1	1	1
Zambia	1	1	1	1	1	1	1	1	1	1

Composite Scores for National Reporting on Select MNH Indicators 2022

	National level accountability mechanisms linking reporting of HDP indicator in HMIS to policies at facilites	National level accountability mechanisms linking reporting of PPH indicator in HMIS to policies at facilites	Indicator for # women with severe PE/E in HMIS	Indicator for giving uterotonic immediately after delivery in HMIS	Private sector reports on # women with severe PE/E in HMIS	Private sector reports on uterotonic use immediately after delivery on the national HMIS
Bangladesh	1	1	1	1	0	0
Burkina Faso	0	0	1	1	1	1
Burma	0	0	1	1	1	0
Colombia	0	0	1	0	1	1
Côte D'Ivoire	1	1	1	1	1	1
Dominican Republic	0	1	1	0	0	0
El Salvador	0	0	1	1	0	0
Ethiopia	1	1	1	1	1	1
Ghana	0	0	0	0	0	0
Guatemala	0	0	1	0	0	0
Guinea	1	1	1	1	1	0
Honduras	1	0	1	1	0	0
India	0	1	1	1	0	0
Indonesia	0	0	0	0	0	0
Kenya	1	1	1	1	1	1
Liberia	1	1	1	1	0	0
Madagascar	1	1	1	0	1	0
Malawi	0	0	1	1	1	1
Mali	1	1	1	1	1	1
Mozambique	1	1	1	1	1	1
Nepal	1	1	1	1	1	1
Nigeria	0	1	1	1	0	1
Pakistan	1	1	1	1	0	0
Paraguay	0	0	0	0	0	0
Peru	1	1	1	1	0	0
Republic of the Congo	1	1	1	1	1	1
Sierra Leone	1	1	1	1	1	1
South Sudan	0	0	0	0	0	0
Uganda	1	1	1	1	1	1
Uruguay	0	1	1	1	0	1
Zambia	1	1	1	1	1	0

APPENDIX C – SURVEY TOOL

Thank you for participating in the multi-country analysis on postpartum hemorrhage and hypertensive disorders of pregnancy policies, practices and commodities in the public and private sectors.

- This survey reflects the most current updates and guidelines on PPH and HDP of the World Health Organization;
- In this survey "private sector" refers to all facilities or institutions that are beyond the purview of national governments that includes for-profit, not-for-profit, faith-based and other charitable institutions;
- Each key informant will need to read and sign the informed consent;
- It is possible to change responses until the survey deadline of 31 March 2022;
- Please refer to national policies, service delivery guidelines, and other national documents to verify responses;
- If you have any technical difficulties, please contact Mathea Pielemeier via email at Mathea.Pielemeier@jhpiego.org.

THANK YOU FOR YOUR IMPORTANT CONTRIBUTIONS TO BETTER UNDERSTAND CURRENT PROGRESS IN POSTPARTUM HEMORRHAGE AND HYPERTENSIVE DISORDERS OF PREGNANCY.

SECTION I: POSTPARTUM HEMORRHAGE (PPH)

POLICY

1. Are either of the following medications on the National Essential Medicine List (EML) for **prevention and treatment** of PPH?

	Yes	No
Oxytocin	☐	☐
Mistoprostol	☐	☐

2. Is tranexamic acid on the EML for **treatment** of PPH?

   ☐ Yes ☐ No

3. Is heat-stable carbetocin on the EML for the **prevention** of PPH?

   ☐ Yes ☐ No

4. Are the PPH service delivery guidelines used in the private sector consistent with national service delivery guidelines?

   ☐ Yes ☐ No

   Please list any additional comments here: _____

5. Do the national service delivery guidelines include **oxytocin** as preferred uterotonic?

☐ Yes ☐ No

6. Are national service delivery guidelines updated to include the following PPH treatments? Select all that apply:

	Yes	No
Tranexamic acid	☐	☐
Uterine balloon tamponade	☐	☐
Non-pneumatic anti-shock garment	☐	☐
Umbilical vein injection of oxytocin retained placenta	☐	☐

7. Is it national policy to offer women delivering at home or without a skilled birth attendant, **misoprostol** to be taken after birth for PPH prevention?

☐ Yes ☐ No

8. Are there relevant national procurement policies for the medications listed below that assure quality products (WHO qualified or by relevant national authority) as they are procured? Select all that apply:

	Yes	No
Oxytocin	☐	☐
Mistoprostol	☐	☐
Ergometrine	☐	☐

Please list any additional comments here: _____

9. Are there policies in place for the below medications' distribution, storage, and transport (from port to facility) that meet international norms? Select all that apply

	Yes	No
Oxytocin	☐	☐
Mistoprostol	☐	☐
Ergometrine	☐	☐

Please list any additional comments here: _____

10. What medications are approved through national policy and service delivery guidelines for PPH prevention if quality of oxytocin cannot be guaranteed? Select all that apply

☐ Heat-stable carbetocin

☐ Ergometrine/methylergometrine

☐ Oxytocin-ergometrine

☐ Misoprostol

11. Is there a national policy for safe blood transfusion services?

☐ Yes ☐ No

12. Is national policy for Active Management of the Third Stage of Labor updated to include immediate use of a uterotonic?

☐ Yes ☐ No

13. Do midwives' scope of practice include (select all that apply):

	Public sector midwives	Private sector midwives
Giving tranexamic acid	☐	☐
Management of uterine balloon tamponade	☐	☐
Performing umbilical vein injection	☐	☐
Applying/removing nonpneumatic anti-shock garment	☐	☐
Performing manual removal of placenta	☐	☐

Please list any additional comments here: _____

14. Are any of the professional societies listed below involved in development and updating of national level PPH documents (e.g., national policies, service delivery guidelines, pre-service and in-service curricula, and/or quality assurance and quality improvement)?

	Yes	No
Midwifery	☐	☐
Nursing	☐	☐
Obstetrics/gynaecology	☐	☐

Other (please specify) : _____

CAPACITY BUILDING

15. Are **pre-service** curricula for training institutions updated for all skilled maternal newborn health (MNH) personnel to include (select all that apply)

	Public training institutions	Private training institutions
Oxytocin preferred uterotonic if quality can be assured, otherwise other 1st line uterotonic recommended	☐	☐
Tranexamic acid included as treatment for PPH	☐	☐
Uterine balloon tamponade as 2nd line treatment of PPH due to atony in settings with appropriate context	☐	☐
Non-pneumatic anti-shock garment for 2nd line treatment of PPH	☐	☐
Umbilical vein injection of oxytocin for treatment of retained placenta	☐	☐

Please list any additional comments here: _____

16. Are **in-service** curricula for training institutions updated for all skilled maternal newborn health (MNH) personnel to include (select all that apply):

	Public training institutions	Private training institutions
Oxytocin preferred uterotonic if quality can be assured, otherwise other 1st line uterotonic recommended	☐	☐
Tranexamic acid included as treatment for PPH	☐	☐
Uterine balloon tamponade as 2nd line treatment of PPH due to atony in settings with appropriate context	☐	☐
Non-pneumatic anti-shock garment for 2nd line treatment of PPH	☐	☐
Umbilical vein injection of oxytocin for treatment of retained placenta	☐	☐

Please list any additional comments here: _____

17. Which private sector providers are included in public sector in-service training on PPH? Select all that apply:

☐ From non-governmental organizations From faith-based organizations

☐ From for-profit organizations

☐ Don't know

☐ Other (please specify): _____

LOGISTICS

18. Is **oxytocin** regularly available at facilities that offer maternity services?

	Regularly (>80% of time)	More than half the time (50-80% of time)	Less than half the time (<50% of time)	Procured externally by patient/family	Never
Public facilities	☐	☐	☐	☐	☐
Private facilities	☐	☐	☐	☐	☐

Please list any additional comments here: _____

19. Is **tranexamic acid** regularly available at facilities that offer maternity services?

	Regularly (>80% of time)	More than half the time (50-80% of time)	Less than half the time (<50% of time)	Procured externally by patient/family	Never
Public facilities	☐	☐	☐	☐	☐
Private facilities	☐	☐	☐	☐	☐

Please list any additional comments here: _____

20. Is **misoprostol** regularly available at facilities that offer maternity services?

	Regularly (>80% of time)	More than half the time (50-80% of time)	Less than half the time (<50% of time)	Procured externally by patient/family	Never
Public facilities	☐	☐	☐	☐	☐
Private facilities	☐	☐	☐	☐	☐

Please list any additional comments here: _____

21. Do **health** facilities that offer maternity services have a controlled cold-chain (refrigeration at the correct temperature) for oxytocin prior to use?

	Yes	Sometimes	No
Public facilities	☐	☐	☐
Private facilities	☐	☐	☐

22. Is **oxytocin** free of charge to patients at facilities that offer maternity services?

	Yes	Sometimes	No
Public facilities	☐	☐	☐
Private facilities	☐	☐	☐

23. How frequently do stock-outs of **oxytocin** occur?

	Frequently (once in every 2 months)	Sometimes (every 3-6 months)	Rarely (once a year)
At the central level	☐	☐	☐
At the district/regional level	☐	☐	☐

Please list any additional comments here: _____

24. Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential medications?

☐ Yes ☐ No

25. From where does the private sector source PPH commodities? Select all that apply:

☐ Received free from the government central medical store

☐ Received free from donors

☐ Procured from local wholesaler/retailers

☐ Other (please specify): _____

26. How does the private sector receive and distribute PPH commodities? Select all that apply:

☐ Government deliveries

☐ Private sector goes to source to collect

☐ Private sector has wholesaler/ other distributor delivery

☐ Other (please specify): _____

NATIONAL REPORTING OF MH INDICATOR

27. Is an indicator of giving a uterotonic immediately after delivery included in the national Health Management Information System (HMIS)?

☐ Yes ☐ No

28. Does the private sector report on uterotonic use immediately after delivery on the national HMIS?

☐ Yes ☐ No

If no, why not?: _____

29. Are there national level accountability mechanisms that link reporting of the national HMIS indicator to implementation of the policy and guidelines for PPH prevention and treatment at the facility level?

☐ Yes ☐ No

If no, why not?: _____

PROGRAMMING

30. Which activities in PPH prevention and management are being supported by the Ministry of Health (MOH), World Health Organization (WHO), UNICEF, UNFPA, and/or other multilateral implementing partners? Select all that apply:

☐ Health system governance (health service financing, eliminating policy barriers)

☐ National policy (essential medicine list, national policies and service delivery guidelines consistent with current WHO standards)

☐ Drugs and equipment (logistics, procurement, quality assurance)

☐ Service delivery capacity at sites (reliable infrastructure, personnel and systems to deliver services)

☐ Health worker pre-service and in-service training (competency based, curricula consistent with WHO)

☐ Partnership development (private/public sector, professional associations, local government, non-governmental organizations, MOH collaboration)

☐ Community awareness of maternal newborn health issues (civil society, women's group advocacy for early recognition of problems and referral)

☐ Health technology and information systems (improved devices, procedures, systems of data management)

☐ Other (please specify): _____

31. Which activities in PPH prevention and management are being undertaken by the private sector? Select all that apply:

- ☐ Health system governance (health service financing, eliminating policy barriers)
- ☐ National policy (essential medicine list, national policies and service delivery guidelines consistent with current WHO standards)
- ☐ Drugs and equipment (logistics, procurement, quality assurance)
- ☐ Service delivery capacity at sites (reliable infrastructure, personnel and systems to deliver services)
- ☐ Health worker pre-service and in-service training (competency based, curricula consistent with WHO)
- ☐ Partnership development (private/public sector, professional associations, local government, non-governmental organizations, MOH collaboration)
- ☐ Community awareness of maternal newborn health issues (civil society, women's group advocacy for early recognition of problems and referral)
- ☐ Health technology and information systems (improved devices, procedures, systems of data management)
- ☐ Other (please specify): _____

32. What percent of districts are covered by current national PPH programs? (Provide your best possible estimate)

- ☐ 90-100%
- ☐ 80-90%
- ☐ 70-80%
- ☐ 60-70%
- ☐ 50-60%
- ☐ Less than 50%

OPPORTUNITIES FOR EXPANSION AND SCALE-UP

33. Please describe any potential opportunities that you see for program introduction, expansion or scale-up in the private and public sectors.

_____

_____

_____

_____

34. What opportunities are there for the public and private sector to collaborate on PPH prevention and management? Select all that apply:

- ☐ District work planning Regular data review
- ☐ Maternal death audits
- ☐ Civil society initiatives to reduce PPH
- ☐ Other (please specify): _____

35. What are the three most significant bottlenecks to scaling up PPH reduction programs in your country? Briefly describe what is being done or could be done to address the bottlenecks.

1) _____

2) _____

3) _____

SECTION II: HYPERTENSIVE DISORDERS OF PREGNANCY (HDP) POLICY

36. What drugs are approved through national policy/ service delivery guidelines for administration as first-line anti-hypertensives in **non-severe hypertension of pregnancy**? Select all that apply:

- ☐ Beta blocker, e.g. labetolol
- ☐ Hydralazine
- ☐ Methyldopa
- ☐ Nifedipine
- ☐ Other (please specify): _____

37. What drugs are approved through national policy/ service delivery guidelines for administration as first-line anti-hypertensives in **severe pre-eclampsia or eclampsia**? Select all that apply:

- ☐ Labetolol
- ☐ Hydralazine
- ☐ Methyldopa
- ☐ Nifedipine
- ☐ Other (please specify): _____

38. What drugs are listed on the National Essential Medicines List (EML), as antihypertensives in management of **severe pre-eclampsia or eclampsia**? Select all that apply:

- ☐ Labetolol
- ☐ Hydralazine
- ☐ Methyldopa
- ☐ Nifedipine
- ☐ Other (please specify): _____

39. What drugs are approved through national policy/service delivery guidelines as first-line anticonvulsants for **severe pre-eclampsia or eclampsia**? Select all that apply:

- ☐ Magnesium sulfate
- ☐ Diazepam
- ☐ Other (please specify): _____

40. Is magnesium sulfate on the National Emergency Medicine List for **severe pre-eclampsia and eclampsia**?

- ☐ Pre-eclampsia
- ☐ Eclampsia

41. Do the national policy/service delivery guidelines include recommendations on induction of labor versus expectant management of women with **severe preeclampsia** before term?

☐ Yes ☐ No

42. Do the national policy/service delivery guidelines include recommendations on induction of labor versus expectant management of women with **mild preeclampsia** before term?

☐ Yes ☐ No

43. Do the national policy/service delivery guidelines include recommendations for short- and long-term management of women who have had HDP after giving birth?

☐ Yes ☐ No

44. Do the national policy/ service delivery guidelines include **low dose acetylsalicylic acid** for the prevention of pre-eclampsia in high-risk women?

☐ Yes ☐ No

45. Do the national policy/ service delivery guidelines include **calcium supplementation** in pregnancy for women living in areas of low dietary calcium?

☐ Yes ☐ No

46. Are the HDP service delivery guidelines used in the private sector consistent with national service delivery guidelines?

☐ Yes ☐ No

47. Are midwives authorized to diagnose severe pre-eclampsia/ eclampsia and administer initial (loading) dose of magnesium sulfate at the lowest level facility that they work at within the health system?

	Yes	**No**
Midwives in the public sector	☐	☐
Midwives in the private sector	☐	☐

48. Are any of the professional societies listed below involved in development and updating of national level HDP documents (e.g. national policies, service delivery guidelines, preservice and in-service curricula, and/or quality assurance and quality improvement)?

	Yes	**No**
Midwifery	☐	☐
Nursing	☐	☐
Obstetrics/gynaecology	☐	☐

CAPACITY BUILDING

49. Are **pre-service** curricula for training institutions updated for all skilled maternal newborn health (MNH) personnel to include (select all that apply):

	Public training institutions	Private training institutions
Management of non-severe hypertension of pregnancy with methyldopa or beta blocker	☐	☐
Management of severe hypertension of pregnancy with labetalol, hydralazine, nifedipine, methyldopa	☐	☐
Anti-convulsant management of severe pre-eclampsia or eclampsia with MgSO4 as first line treatment	☐	☐
Use of daily low dose aspirin for the prevention of pre-eclampsia in high-risk pregnant women	☐	☐
Calcium supplementation for pregnant women in areas of low dietary calcium for the prevention of pre-eclampsia	☐	☐

Please list any additional comments here: _____

50. Are **in-service** curricula for training institutions updated for all skilled maternal newborn health (MNH) personnel to include (select all that apply):

	Public training institutions	Private training institutions
Management of non-severe hypertension of pregnancy with methyldopa or beta blocker	☐	☐
Management of severe hypertension of pregnancy with labetalol, hydralazine, nifedipine, methyldopa	☐	☐
Anti-convulsant management of severe pre-eclampsia or eclampsia with MgSO4 as first line treatment	☐	☐
Use of daily low dose aspirin for the prevention of pre-eclampsia in high-risk pregnant women	☐	☐
Calcium supplementation for pregnant women in areas of low dietary calcium for the prevention of pre-eclampsia	☐	☐

Please list any additional comments here: _____

51. Which private sector providers are included in public sector in-service training on HDP? Select all that apply:

☐ From non-governmental organizations From faith-based organizations

☐ From for-profit organizations

☐ Don't know

☐ Other (please specify):_____

LOGISTICS

52. Is **magnesium sulfate** available at facilities that offer maternity services?

	Regularly (>80% of time)	More than half the time (50-80% of time)	Less than half the time (<50% of time)	Procured externally by patient/family	Never
Public facilities	☐	☐	☐	☐	☐
Private facilities	☐	☐	☐	☐	☐

Please list any additional comments here: _____

53. Are the below medications available at public facilities that offer maternity services?

	Regularly (>80% of time)	More than half the time (50-80% of time)	Less than half the time (<50% of time)	Procured externally by patient/family	Never
Labetolol	☐	☐	☐	☐	☐
Hydralazine	☐	☐	☐	☐	☐
Nifedipine	☐	☐	☐	☐	☐
Methyldopa	☐	☐	☐	☐	☐

Please list any additional comments here: _____

54. Are the below medications available at **private** facilities that offer maternity services?

	Regularly (>80% of time)	More than half the time (50-80% of time)	Less than half the time (<50% of time)	Procured externally by patient/family	Never
Labetolol	☐	☐	☐	☐	☐
Hydralazine	☐	☐	☐	☐	☐
Nifedipine	☐	☐	☐	☐	☐
Methyldopa	☐	☐	☐	☐	☐

Please list any additional comments here: _____

55. Is **magnesium** sulfate free of charge to patients at facilities that offer maternity services?

	Yes	No
Public facilities	☐	☐
Private facilities	☐	☐

56. How frequently do stock-outs of **magnesium sulfate** occur?

	Frequently (once in every 2 months)	**Sometimes (every 3-6 months)**	**Rarely (once a year)**
At the central level	☐	☐	☐
At the district/regional level	☐	☐	☐

57. Is there a system in place to ensure a **50% solution of magnesium sulfate** is available in country?

	Yes	**No**
Public facilities	☐	☐
Private facilities	☐	☐

58. Is there a logistics management system independent of the national procurement system that private sector facilities use to procure essential medications?

☐ Yes ☐ No

59. From where does the private sector source HDP commodities? Select all the apply: Received free from the government central medical store

☐ Government deliveries

☐ Private sector goes to source to collect

☐ Other (please specify): _____

60. How does the private sector receive and distribute HDP commodities? Select all that apply:

☐ Received free from donors

☐ Received free from donors

☐ Private sector has wholesaler/ other distributor delivery

☐ Other (please specify): _____

NATIONAL REPORTING OF MH INDICATOR

61. Is an indicator for the number of women with severe pre-eclampsia/eclampsia included in the national Health Management Information Systems (HMIS)?

☐ Yes ☐ No

62. Does the private sector report on number of women with **severe pre-eclampsia/ eclampsia** on the national HMIS?

☐ Yes ☐ No

If no, why not?: _____

63. Are there national level accountability mechanisms that link reporting of the national HMIS indicator to implementation of the policy and guidelines for HDP prevention and treatment at the facility level?

☐ Yes ☐ No

If yes, please describe: _____

PROGRAMMING

64. Which activities in HDP prevention and management are being supported by the Ministry of Health (MOH), World Health Organization (WHO), UNICEF, UNFPA, and/or other multilateral implementing partners? Select all that apply:

☐ Health system governance (health service financing, eliminating policy barriers)

☐ National policy (essential medicine list, national policies and service delivery guidelines consistent with current WHO standards)

☐ Drugs and equipment (logistics, procurement, quality assurance)

☐ Service delivery capacity at sites (reliable infrastructure, personnel and systems to deliver services)

☐ Drugs and equipment (logistics, procurement, quality assurance)

☐ Health worker pre-service and in-service training (competency based, curricula consistent with WHO)

☐ Partnership development (private/public sector, professional associations, local government, non-governmental organizations, MOH collaboration)

☐ Community awareness of maternal newborn health issues (civil society, women's group advocacy for early recognition of problems and referral)

☐ Health technology and information systems (improved devices, procedures, systems of data management)

☐ Other (please specify): _____

65. Which activities in HDP prevention and management programming are being undertaken by the private sector? Select all that apply:

- ☐ Health system governance (health service financing, eliminating policy barriers)
- ☐ National policy (essential medicine list, national policies and service delivery guidelines consistent with current WHO standards)
- ☐ Drugs and equipment (logistics, procurement, quality assurance)
- ☐ Service delivery capacity at sites (reliable infrastructure, personnel and systems to deliver services)
- ☐ Drugs and equipment (logistics, procurement, quality assurance)
- ☐ Health worker pre-service and in-service training (competency based, curricula consistent with WHO)
- ☐ Partnership development (private/public sector, professional associations, local government, non-governmental organizations, MOH collaboration)
- ☐ Community awareness of maternal newborn health issues (civil society, women's group advocacy for early recognition of problems and referral)
- ☐ Health technology and information systems (improved devices, procedures, systems of data management)
- ☐ Other (please specify): _____

66. What percent of districts are covered by current HDP programs? (Provide your best possible estimate)

- ☐ 90-100%
- ☐ 80-90%
- ☐ 70-80%
- ☐ 60-70%
- ☐ 50-60%
- ☐ Less than 50%

OPPORTUNITIES FOR EXPANSION AND SCALE-UP

67. Please describe any potential opportunities that you see for program introduction, expansion or scale up in the public and private sectors.

_____

_____

_____

_____

68. What opportunities are there for the public and private sector to collaborate on HDP? Select all that apply:

- ☐ District work planning
- ☐ Regular data review
- ☐ Maternal death audits
- ☐ Civil society initiatives to reduce PPH
- ☐ Other (please specify): _____

69. What are the three most significant bottlenecks to scaling up HDP management programs in your country? Briefly describe what is being done or could be done to address the bottlenecks.

_____

_____

_____

DEMOGRAPHICS

70. Which country do you represent?

_____

71. What was the approximate number of respondents to the survey?

_____

72. What groups were represented by your key informants? Select all that apply:

- ☐ Ministry of health
- ☐ Obstetrics-gynaecology professional association
- ☐ Nursing professional association
- ☐ Midwifery professional association
- ☐ Obstetrics-gynaecology education council
- ☐ Nursing education council
- ☐ Midwifery education council
- ☐ Non-governmental organizations
- ☐ Faith-based organizations
- ☐ For-profit organizations
- ☐ Other (please specify): _____

73. In responding to questions in this survey about the private sector, how did you determine your response? Select all that apply:

- ☐ Key private sector stakeholders were involved in consultation
- ☐ Associated with data captured in a national database
- ☐ An educated estimate
- ☐ No available data
- ☐ Other (please specify): _____

74. Is there any additional information you would like us to know?

_____

_____

_____

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