Implementing Evidence-Based PPH Prevention and Management

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Introduction

- Existence of PPH prevention and treatment solutions

- However, every year 14,000 women died from PPH

- Main reason: Lack of implementation of these solutions
Clinical Interventions

- **Basic EmOC**
  - Management of shock
  - Uterotonics
  - Bimanual compression
  - Suturing of lacerations
  - Aortic compression
  - Manual removal of placenta

- **Comprehensive EmOC**
  - Uterine artery ligation
  - B-lynch procedure
  - Hysterectomy
  - Blood transfusion
## The Evidence for the Treatment of PPH

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Quality of Evidence</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No recommendation for blood loss quantification over clinical estimation</td>
<td>low</td>
<td>strong</td>
</tr>
<tr>
<td><strong>Uterotonics:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- oxytocin: 1\textsuperscript{st} line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- ergometrine: 2\textsuperscript{nd} line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- prostaglandins: 3\textsuperscript{rd} line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>very low to low</td>
<td>strong</td>
<td></td>
</tr>
<tr>
<td>If PPH occurs after AMTSL, oxytocin alone should be used in preference to adjunct misoprostol</td>
<td>moderate to high</td>
<td>strong</td>
</tr>
<tr>
<td>Uterine massage*</td>
<td>very low</td>
<td>strong</td>
</tr>
<tr>
<td>Bimanual compression*</td>
<td>very low</td>
<td>weak</td>
</tr>
<tr>
<td>External aortic compression*</td>
<td>low</td>
<td>weak</td>
</tr>
</tbody>
</table>

The Evidence *(continued)*

<table>
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<tr>
<th>Intervention</th>
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<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine balloon or condom tamponade if uterotonics not available or failed*</td>
<td>low</td>
<td>weak</td>
</tr>
<tr>
<td>Non-pneumatic anti-shock garments</td>
<td>no recommendation</td>
<td>no recommendation</td>
</tr>
<tr>
<td>If failure of other measures and resources available, uterine artery embolization may be used*</td>
<td>low</td>
<td>weak</td>
</tr>
<tr>
<td>Isotonic crystalloids should be used in preference to colloids for resuscitation of women with PPH</td>
<td>low</td>
<td>strong</td>
</tr>
</tbody>
</table>

*PPH due to atony*
Program Approaches

- HBLSS
- Basic EmOC
- Comprehensive EmOC
- QI approaches
- Safe transfer and referral approaches
- Blood and blood substitutes
PPH National Action Plan

1. Policy Level

2. Community Level

3. Facility Level

4. Monitoring and Evaluation
Policy Level

1. Recognition of community-based PPH prevention and treatment strategies
2. Reproductive health commodity security including oxytocic drugs policy
3. Blood distribution decentralization at district hospital level
4. Partnership between MOH and health professional associations (ob/gyns, midwives, public health professionals, anesthesiologists)
Community

- BCC activities
- Community case prevention and management of PPH
- Sustainable emergency obstetric referral system by the community and for the community
Facility Level

- Provider training (in-service and pre-service++)
- Use of evidence-based guidelines for PPH prevention and management depending on the type of facility
- Regular facility readiness assessment for obstetric complication including PPH
- Regular supervision +++
Monitoring and Evaluation

1. Policy Level

2. Community Level

3. Facility Level
Conclusion

- The cause of death is not PPH but delay in treating PPH
- Continuum of actions from the policy level to the community = Key to reducing maternal deaths from PPH
- PPH-related death elimination campaign?