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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

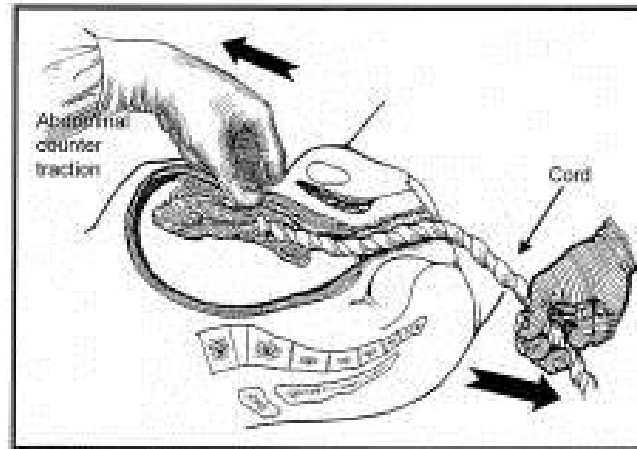


Fig 1 Brandt-Andrews technique of controlled cord traction

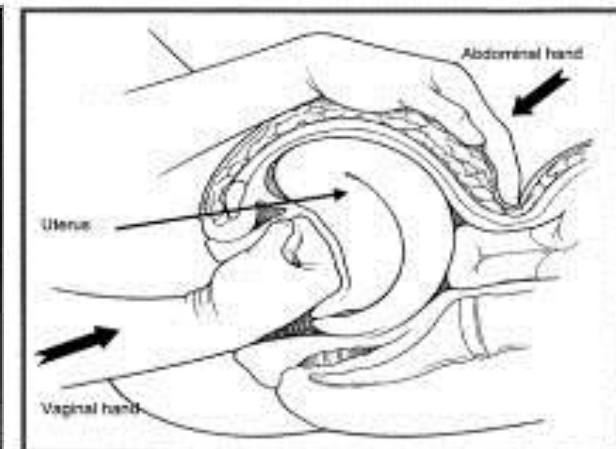


Fig 3 Bimanual internal compression of the uterus

■ Comprehensive EmOC

- Uterine artery ligation
- B-lynch procedure
- Hysterectomy
- Blood transfusion



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The Evidence for the Treatment of PPH

Intervention	Quality of Evidence	Strength of Recommendation
No recommendation for blood loss quantification over clinical estimation	low	strong
Uterotonics: <ul style="list-style-type: none"> ▪oxytocin: 1st line ▪ergometrine: 2nd line ▪prostaglandins: 3rd line 	very low to low	strong
If PPH occurs after AMTSL, oxytocin alone should be used in preference to adjunct misoprostol	moderate to high	strong
Uterine massage*	very low	strong
Bimanual compression*	very low	weak
External aortic compression*	low	weak

The Evidence (*continued*)

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

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*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?