HIGH-LEVEL POLICY BRIEF

Accelerating access to essential postpartum haemorrhage interventions

Closing the policy, regulatory, financing and access gaps that keep proven PPH tools out of reach across Africa

Haemorrhage, excessive bleeding before, during or after childbirth, is the leading cause of maternal mortality in sub-Saharan Africa, responsible for nearly one-third of all maternal deaths. Despite significant progress in preventing maternal mortality since 2000, the current rate of reduction is insufficient to meet the Sustainable Development Goal of fewer than 70 deaths per 100,000 live births by 2030 (SDG 3.1). Africa accounts for the heaviest burden of maternal deaths globally, with an estimated 182,000 mothers dying in 2023. A constraint on progress is the lack of sustainable financing for reproductive health services and quality-assured maternal health commodities. Data indicate that no low- or lower-middle-income country in East and Southern Africa is meeting the Guttmacher-Lancet Commission's estimated Africa regional per capita cost ($17.93) for fully meeting needs for contraception, abortion, and maternal and newborn care at WHO-recommended standards. Indeed, the median for lower- and lower-middle-income countries was less than $1 in 2019.

Progress in reducing maternal mortality has stalled since 2015, with current trends projecting an average Maternal Mortality Ratio (MMR) of 350 deaths per 100,000 live births by 2030 in Africa. Much of the progress came from increasing care coverage; such as antenatal care visits, and childbirth with a skilled attendant. However, increased coverage of services alone is not sufficient to accelerate reductions in maternal mortality. Even when service access is high, limited access to essential commodities will result in poor health outcomes. The global response must evolve to be more focused on improving quality of care; including the right package of services, using the right health products.

The life-saving potential of proven products and interventions to prevent and manage postpartum haemorrhage (PPH) remains unrealized due to systemic policy, regulatory, capacity and access gaps across the continent. The new WHO/FIGO/ICM Consolidated Guidelines for the prevention, diagnosis and treatment of PPH (2025) offer an evidence-based pathway for PPH prevention, detection and management. The Guidelines’ 51 revalidated, updated and new recommendations highlight the urgent need for earlier detection and faster intervention - steps that could save the lives of tens of thousands of women in the Southern African Development Community (SADC) Region each year. However, these recommendations require consistent availability and use of a range of quality products that remain largely inaccessible across the SADC Region.

> To accelerate progress, the global PPH community - including SADC Member States - must move from fragmented, slow adoption to an **integrated, 'end-to-end' implementation model** that prioritises access to recommended health tools and interventions - linking policy, procurement, financing, and pre- and in-service training.

1 out of 3

maternal deaths in sub-Saharan Africa are caused by haemorrhage

182,000

maternal deaths in 2023

350

deaths per 100,000 live births projected by 2030 in Africa

The table below highlights some of the key interventions and products that could help drive down the PPH burden in the SADC Region, and the access gaps that partners and working together to overcome.

Key intervention	Clinical rationale	Current adoption gap in Africa
Uterotonic use for PPH prevention: oxytocin, HSC and misoprostol	The use of a quality-assured uterotonic is recommended for the prevention of PPH during the third stage of labor for all births: - Oxytocin is uterotonic that is recommended for prevention and management of PPH. Oxytocin requires cold-chain storage. - Heat-stable carbetocin (HSC) is recommended for prevention and it is as effective as oxytocin, but does not require cold-chain storage. - Misoprostol is recommended in settings where women give birth outside a health facility and in the absence of skilled health personnel.	Oxytocin is widely used but faces serious quality issues due to non-compliant manufacturing, non-quality-assured procurement, and inappropriate transport/ storage conditions. HSC uptake is slow. Recommended by WHO since 2018, it was only included in the national policies and guidelines of 7 SADC countries by the end of 2025. Procurement is largely donor-dependent. Currently, HSC is available at access price for public sector health facilities by the manufacturer. Misoprostol is unevenly used across Africa. It also faces quality issues due to inappropriate storage conditions (it is affected by moisture).
Objective assessment of blood loss and provision of a PPH treatment bundle: E-MOTIVE approach, including TXA	- To improve Early detection and prompt treatment of PPH, routine objective measurement of blood loss is recommended for all women post-delivery. Replacing subjective visual estimation with objective measurement using devices like calibrated drapes is essential for early, accurate diagnosis. - A standardized treatment bundle is recommended for PPH management (first-line treatment). The care bundle includes immediate uterine massage, administration of oxytocics, tranexamic acid (TXA), IV fluids, genital tract examination, and escalation of care if needed. Prompt provision of this full package of care reduces death due to bleeding when given early (as soon as PPH has been detected).	Objective measurement: lack of universal availability and use of calibrated drapes or other measurements for all births. E-MOTIVE approach: recommended by WHO since 2023, it is being rolled out slowly in many SADC countries. TXA is included or being included in most national EMLs, but gaps persist in its routine national forecasting and in the allocation of domestic funding for its procurement.
Stabilizing women, buying time for referral and treating PPH: UBTs and NASGs	Temporizing measures (bimanual compression, aortic compression, Non-pneumatic Anti-Shock Garment (NASG) and uterine balloon tamponade (UBT)) help stabilize women, control bleeding and buy time for definitive interventions—especially when PPH due to uterine atony does not respond to first-line treatment and while awaiting surgery, blood transfusion, or referral. The use of UBT and NASG is encouraged where referral delays are common, but only in facilities that reliably implement first-line PPH care, have trained providers and have assured access to surgical care and blood products if UBT is used.	UBT and NASG are not yet widely used across the SADC Region, although their use is growing. Countries leading adoption include South Africa for UBT, and Zambia for NASG. There are good examples of scale-up, but much more room remains for expansion in additional contexts.

Main Barriers to the Implementation of Recommended Interventions:

1

Slow and fragmented policy translation

Lack of formal, coordinated mechanisms to promptly integrate new WHO guidance into National Guidelines, Essential Medicines Lists (EML), and training curricula.

2

Regulatory delays and market barriers

Slow national regulatory approval processes and lack of a central "anchor organization" to steer innovations through the value chain.

3

Supply chain and financing constraints

Uneven access to quality-assured commodities due to procurement delays, stockouts, limited domestic funding, restrictive financial rules (e.g., pre-payment barriers), and public procurement systems that tend to prioritize cost-based tendering over quality-assured supplier selection.

4

Health workforce readiness

Inadequate skills and confidence among frontline workers due to limited competency-based training, on-site mentoring, and restrictive midwifery scopes of practice.

Policy recommendations

To realize the life-saving potential of PPH interventions, SADC Member States must adopt a coordinated, multi-sectoral approach across four priority areas.

National Policy and Governance

Make adoption deliberate rather than incidental; connecting each new guideline to the orders and training that bring it into practice, with one body owning the process.

Implement an "end-to-end" adoption mode
Establish clear, coordinated policy implementation pathways that mandate a link between national guideline updates, procurement orders, and facility-level training.

Designate a national "anchor organization"
Mandate a lead body (e.g., a technical agency or dedicated Ministry department) to steward all PPH innovations through every stage of the value chain, from policy approval to routine supply and use.

Mandate routine protocol updates
Institutionalize periodic, mandatory updates of national clinical guidelines and Essential Medicines Lists (e.g., annual/biannual cycles) to maintain immediate alignment with global evidence.

Regulation, Financing, Procurement, and Supply Chain

Speed products to market and protect the funding that keeps them in stock, so commodities are reliably available rather than donor-dependent or vulnerable to stockouts.

Accelerate regulatory approvals
Utilize fast-track pathways and actively participate in regional harmonization initiatives (like the African Medicines Regulatory Harmonisation Program) and bilateral/multilateral agreements to speed up national approval for the full range of WHO-recommended PPH commodities.

Secure domestic financing for "game-changers”

A. Dedicate specific, protected budget envelopes for the routine procurement of quality-assured uterotonics and new and lesser-used medicines (HSC, TXA) and devices (drapes, UBTs, NASGs), making use of regional pooled procurement initiatives such as SADC Pooled Procurement Services.
B. Leverage innovative financing mechanisms such as UNFPA Supplies compact and ensure smooth transition from donor-dependent pilot projects.

Strengthen supply planning and procurement
Integrate PPH commodities into routine, national quantification and annual supply plans. Introduce procurement flexibilities (e.g., framework contracts) to ensure timely availability and prevent stockouts.

Clinical Practice and Quality of Care

Put the right products in every delivery room and support providers to use them consistently across the full prevention–diagnosis–treatment pathway.

Ensure the full range of WHO-recommended PPH commodities is available

C. **Prevention:** guarantee access to quality-assured oxytocin, HSC, and misoprostol (for home births, when a skilled birth attendant is unavailable).
D. **Diagnosis:** Equip all delivery facilities with calibrated drapes for objective blood loss measurement and ensure routine use.
E. **Treatment:** ensure immediate availability of TXA, uterotonics, IV fluids, and access to temporizing devices like the NASG and UBT. Develop emergency response trays/trolleys and institute clinical drills to practice prompt coordinated responses.

Decentralize adoption with technical support
Create national support mechanisms (digital job aids, clinical Apps, helpdesks) to support rapid, decentralized adoption and uniform application of guidelines at the district and facility level. Ensure regular case reviews for all cases with PPH or other obstetric emergencies.

Health Workforce and Facility Systems

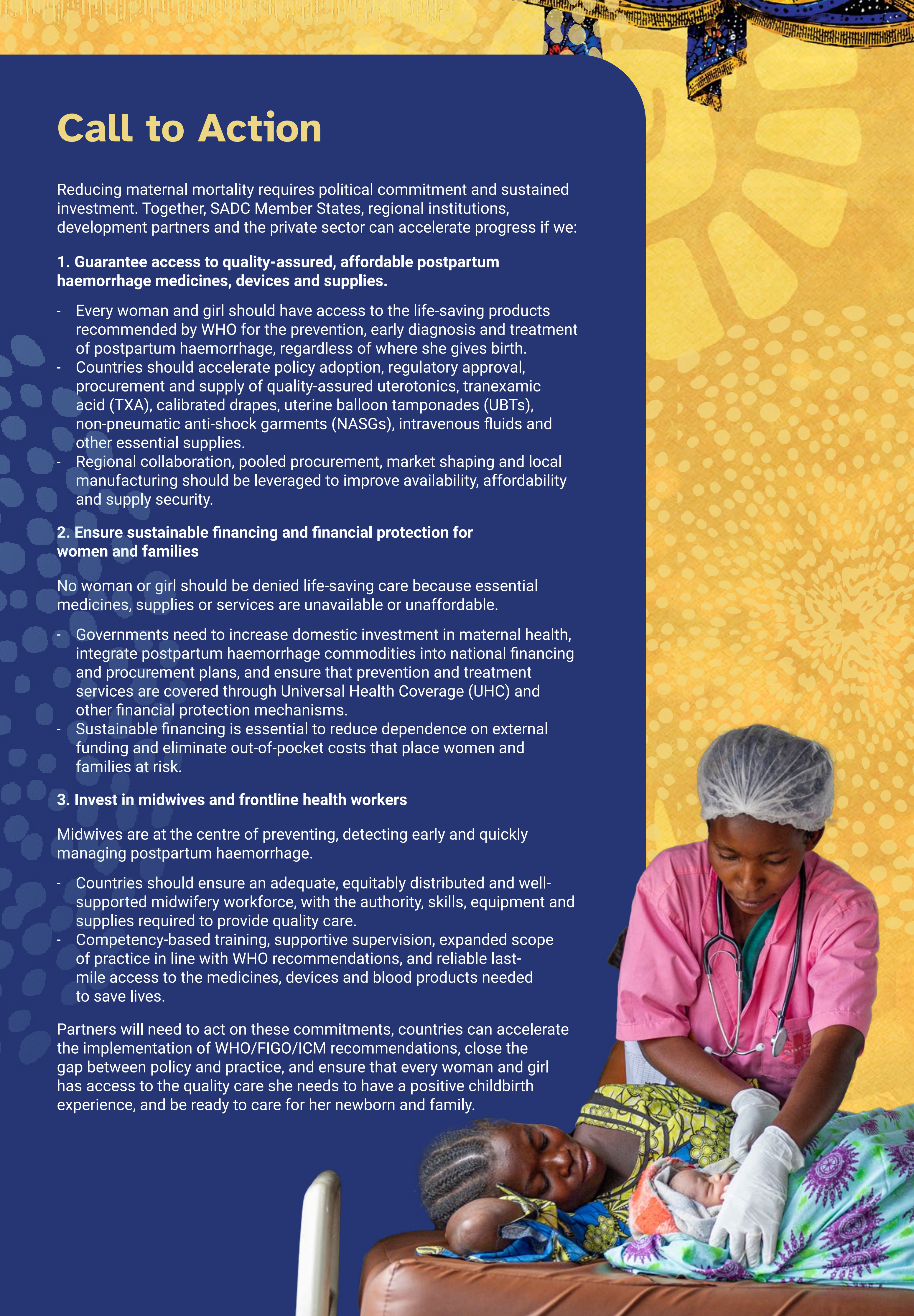
Empower midwives to act, build their skills through hands-on training, and sustain the staff, facilities and blood supplies that emergency obstetric care depends on.

Expand and harmonize midwives' scope of practice
Urgently revise task-sharing/task-shifting policies to officially enable midwives to administer all life-saving PPH interventions in line with the new WHO/FIGO/ICM guidelines.

Scale up competency-based training
Roll out mandatory, multi-disciplinary, simulation-based training (e.g., Bleeding After Birth training course) and on-site mentoring focusing on the E-MOTIVE care bundle for all maternal health staff.

Strengthen accountability
Conduct regular maternal death and near-miss reviews and publicly link findings to tangible improvements in resources, training, and practice.

Invest more in Health workers and healthcare facilities
Training, deploying, and retaining skilled birth attendants requires substantial long-term capital investment. Due to low public health budgeting, health workers are frequently underpaid, leading to heavy migration to urban areas or wealthier countries. This leaves rural facilities highly understaffed and unable to offer emergency obstetric care. Many SADC countries lack the sustainable public financing required to establish, regulate, and maintain comprehensive national blood transfusion services. This leads to chronic, severe blood shortages and inadequate regional storage hubs.



Call to Action

Reducing maternal mortality requires political commitment and sustained investment. Together, SADC Member States, regional institutions, development partners and the private sector can accelerate progress if we:

1. Guarantee access to quality-assured, affordable postpartum haemorrhage medicines, devices and supplies.

- Every woman and girl should have access to the life-saving products recommended by WHO for the prevention, early diagnosis and treatment of postpartum haemorrhage, regardless of where she gives birth.
- Countries should accelerate policy adoption, regulatory approval, procurement and supply of quality-assured uterotonics, tranexamic acid (TXA), calibrated drapes, uterine balloon tamponades (UBTs), non-pneumatic anti-shock garments (NASGs), intravenous fluids and other essential supplies.
- Regional collaboration, pooled procurement, market shaping and local manufacturing should be leveraged to improve availability, affordability and supply security.

2. Ensure sustainable financing and financial protection for women and families

No woman or girl should be denied life-saving care because essential medicines, supplies or services are unavailable or unaffordable.

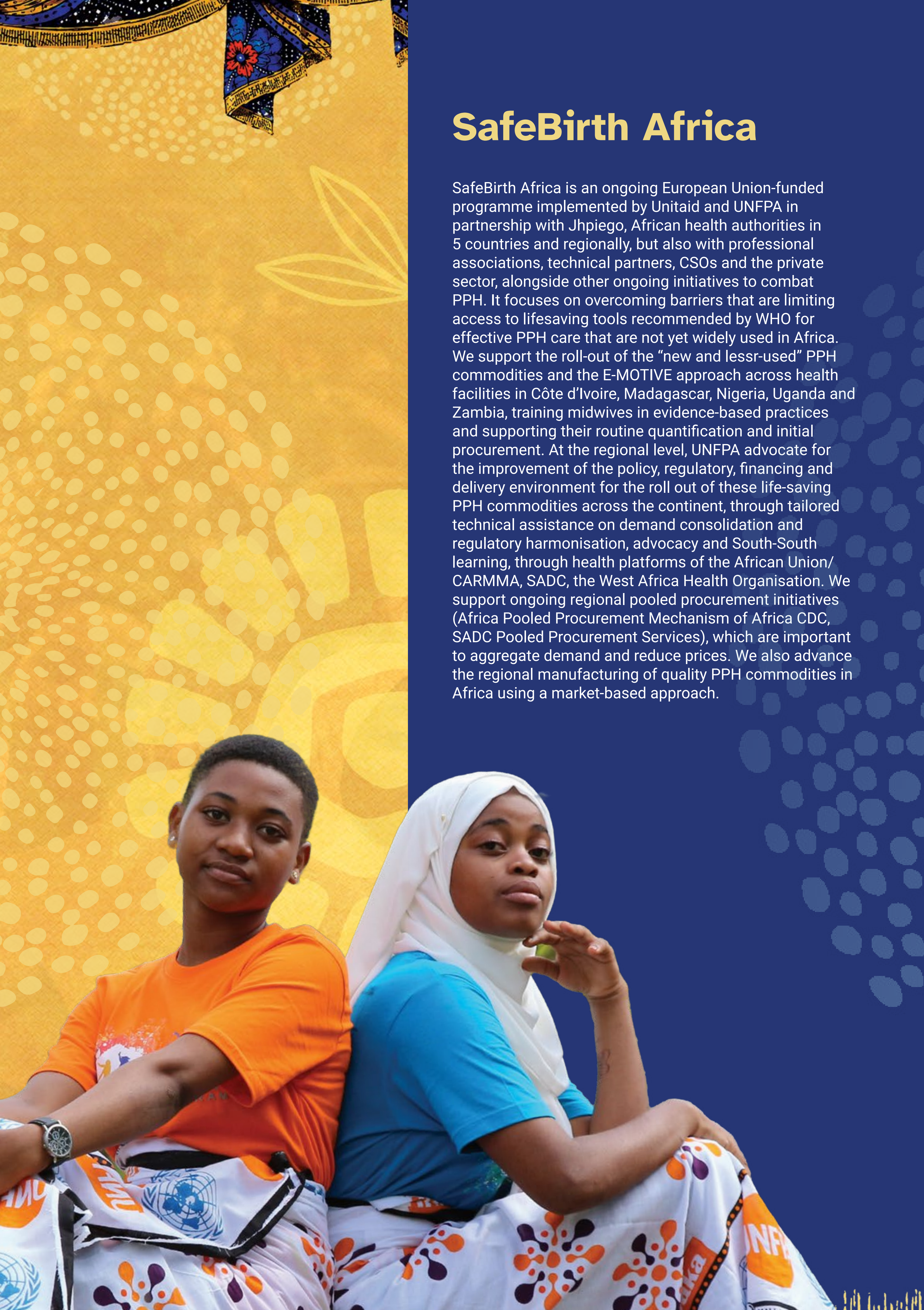
- Governments need to increase domestic investment in maternal health, integrate postpartum haemorrhage commodities into national financing and procurement plans, and ensure that prevention and treatment services are covered through Universal Health Coverage (UHC) and other financial protection mechanisms.
- Sustainable financing is essential to reduce dependence on external funding and eliminate out-of-pocket costs that place women and families at risk.

3. Invest in midwives and frontline health workers

Midwives are at the centre of preventing, detecting early and quickly managing postpartum haemorrhage.

- Countries should ensure an adequate, equitably distributed and well-supported midwifery workforce, with the authority, skills, equipment and supplies required to provide quality care.
- Competency-based training, supportive supervision, expanded scope of practice in line with WHO recommendations, and reliable last-mile access to the medicines, devices and blood products needed to save lives.

Partners will need to act on these commitments, countries can accelerate the implementation of WHO/FIGO/ICM recommendations, close the gap between policy and practice, and ensure that every woman and girl has access to the quality care she needs to have a positive childbirth experience, and be ready to care for her newborn and family.



SafeBirth Africa

SafeBirth Africa is an ongoing European Union-funded programme implemented by Unitaid and UNFPA in partnership with Jhpiego, African health authorities in 5 countries and regionally, but also with professional associations, technical partners, CSOs and the private sector, alongside other ongoing initiatives to combat PPH. It focuses on overcoming barriers that are limiting access to lifesaving tools recommended by WHO for effective PPH care that are not yet widely used in Africa. We support the roll-out of the “new and lessr-used” PPH commodities and the E-MOTIVE approach across health facilities in Côte d’Ivoire, Madagascar, Nigeria, Uganda and Zambia, training midwives in evidence-based practices and supporting their routine quantification and initial procurement. At the regional level, UNFPA advocate for the improvement of the policy, regulatory, financing and delivery environment for the roll out of these life-saving PPH commodities across the continent, through tailored technical assistance on demand consolidation and regulatory harmonisation, advocacy and South-South learning, through health platforms of the African Union/ CARMMA, SADC, the West Africa Health Organisation. We support ongoing regional pooled procurement initiatives (Africa Pooled Procurement Mechanism of Africa CDC, SADC Pooled Procurement Services), which are important to aggregate demand and reduce prices. We also advance the regional manufacturing of quality PPH commodities in Africa using a market-based approach.

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