PREVENTING PPH MORTALITY GLOBALLY: HOW ARE WE DOING?

PPH CoP

10 July 2025

Welcome / Bienvenue

Professor Andrew Weeks, MB ChB MD FRCOG

Professor of International Maternal Health
Women's & Children's Health
University of Liverpool

AGENDA

10 July 2025

- Welcome & Introductions
- Presentations with Q&A:
  - **Trends in maternal mortality estimates 2000 to 2023** by Dr Lale Say (WHO)
  - **Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis** by Dr Jenny Cresswell (WHO)
  - **Reducing PPH mortality through a local network of clinicians - the Uganda Maternity and Neonatal System** by Dr Kenneth Mugabe (Uganda)
- Closing

DISCLAIMER

The content you are about to see includes medically appropriate but graphic images. Viewer discretion is advised. The intention is not to offend but to provide information to health practitioners and implementers. Proceed only if you are comfortable with potentially sensitive topics.

Clause de non - responsabilité

Le contenu que vous êtes sur le point de voir comprend des images médicales appropriées mais graphiques. Il est conseillé de faire preuve de discernement. L'intention n'est pas d'offenser mais de fournir des informations aux praticiens de la santé et aux personnes chargées de la mise en œuvre. Ne poursuivez que si vous êtes à l'aise avec des sujets potentiellement sensibles.

Trends in maternal mortality 2000 – 2023

Dr Lale Say, WHO

PPH COP webinar, 10th July 2025

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Trends in maternal mortality estimates 2000 to 2023

Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division

World Health Organization · unicef for every child · UNFPA · WORLD BANK GROUP · United Nations Department of Economic and Social Affairs

Methodology

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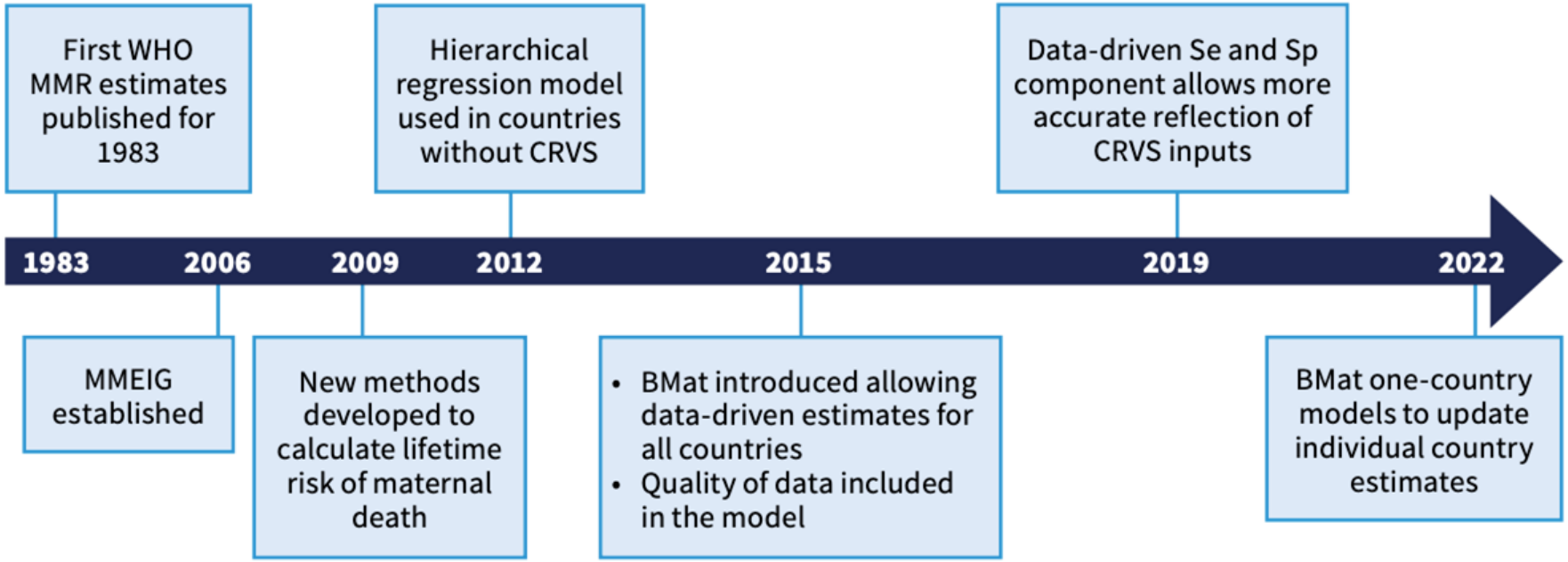
Global maternal mortality estimates – UN Interagency effort

- The United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG)
- Comprised of the **WHO, UNICEF, UNFPA**, the **World Bank Group** and **UN DESA**

Fig. 3.3 Key milestones in the evolution of United Nations and MMEIG methods, 1983 to 2022



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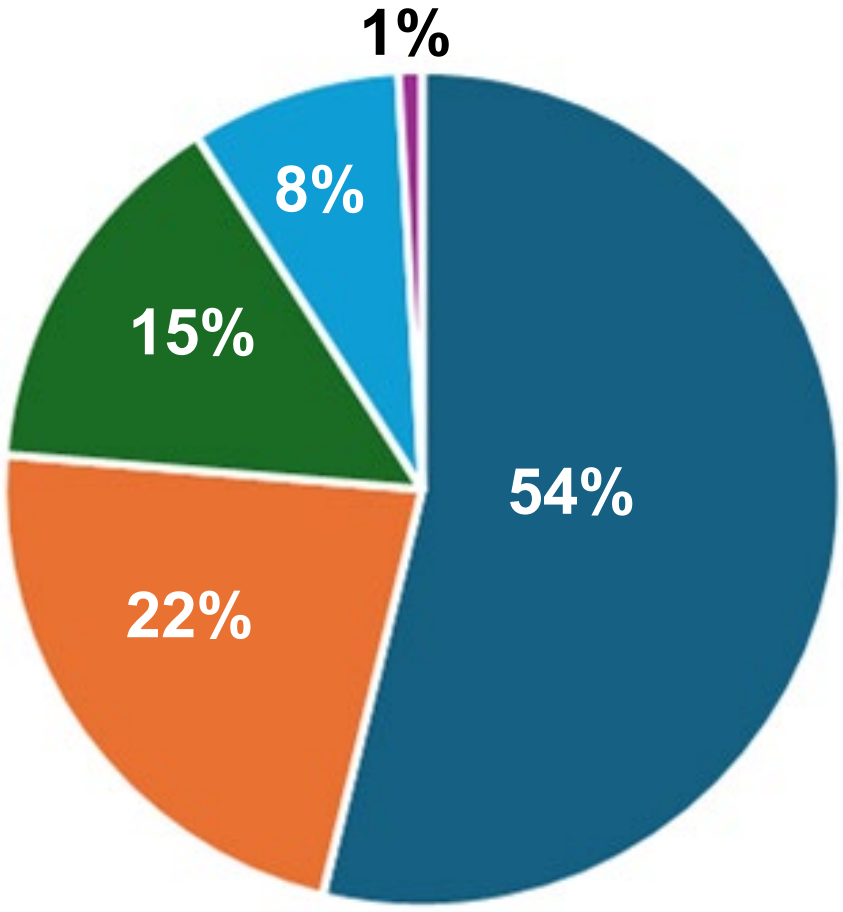
Sources of data used in generating the 2000–2023 estimates

- We included 5727 country-years of data covering the period 1985 to 2023.
- Majority of the maternal mortality data inputs came from Civil Registration and Vital Statistics (54%), followed by Population-based surveys (DHS or MICS) (15%).



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Methods

Data processing and adjustment

- Maternal mortality data is often subject to misclassification and under-reporting
- To account for this, we adjust data for potential missing and misclassified maternal deaths; these adjustments depend on the type of the data source
- Data is also adjusted if it uses the pregnancy related deaths definition, or if it was collected using a sibling survival history .

Modelling approach

- BMis model: For countries that have a CRVS system, we use BMis, The Bayesian Misclassification model to account for errors in reporting of maternal death in the CRVS to obtain the BMis adjustment factors.
- BMat model: For all countries, we use a Bayesian maternal mortality estimation model to estimate the MMR for each country-year of interest.
- The models described above are broken down into global and 1-country implementations.

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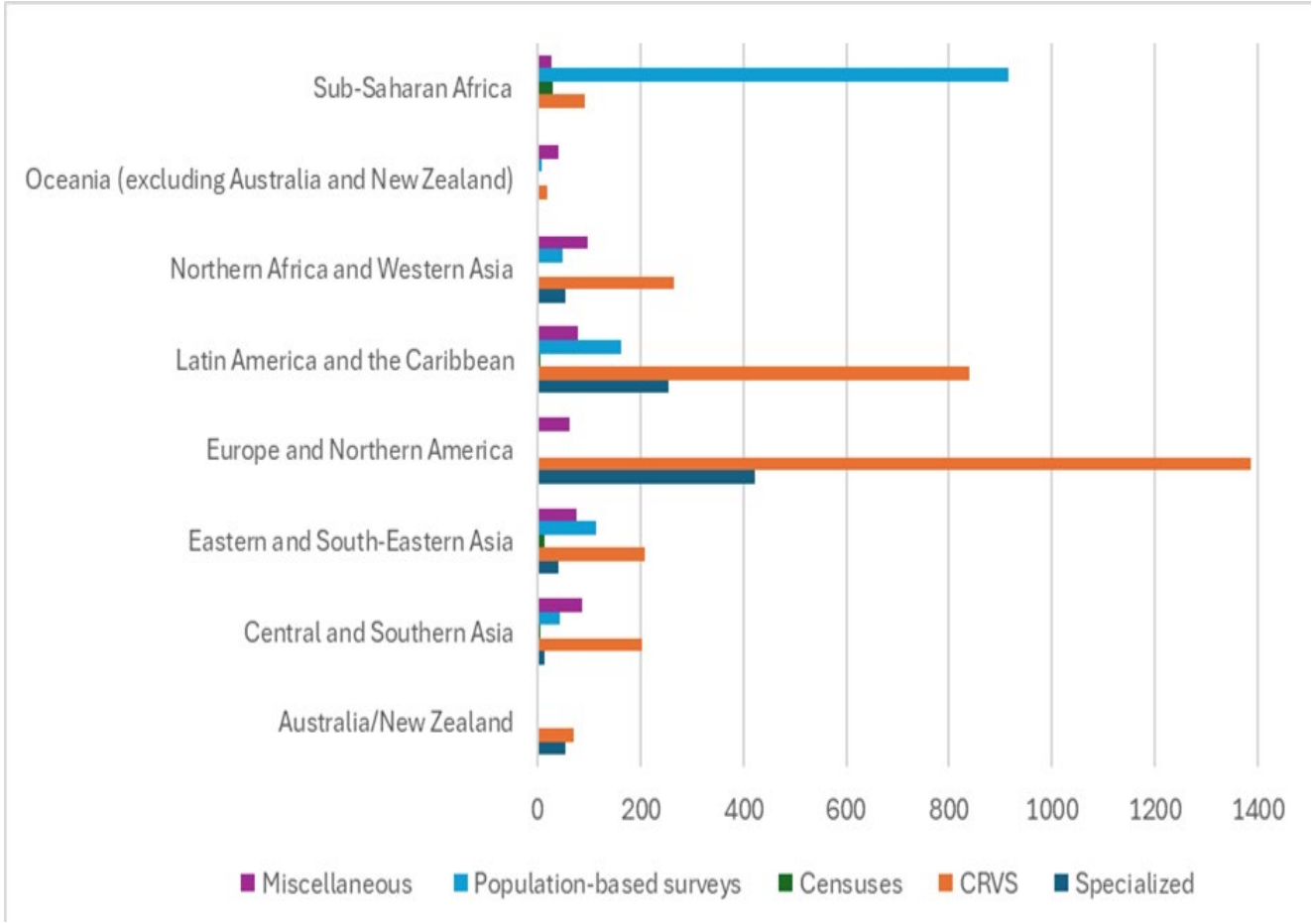
Data inputs by SDG region

- The majority of the country-years comes from Europe and North America region(33%) and Latin America and the Caribbean region (23%).
- CRVS was the most predominant data sources for all regions except for sub-Saharan Africa.
- Population based surveys were the main data sources for sub-Saharan Africa.



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Key findings

Levels and trends in maternal mortality 2000 to 2023

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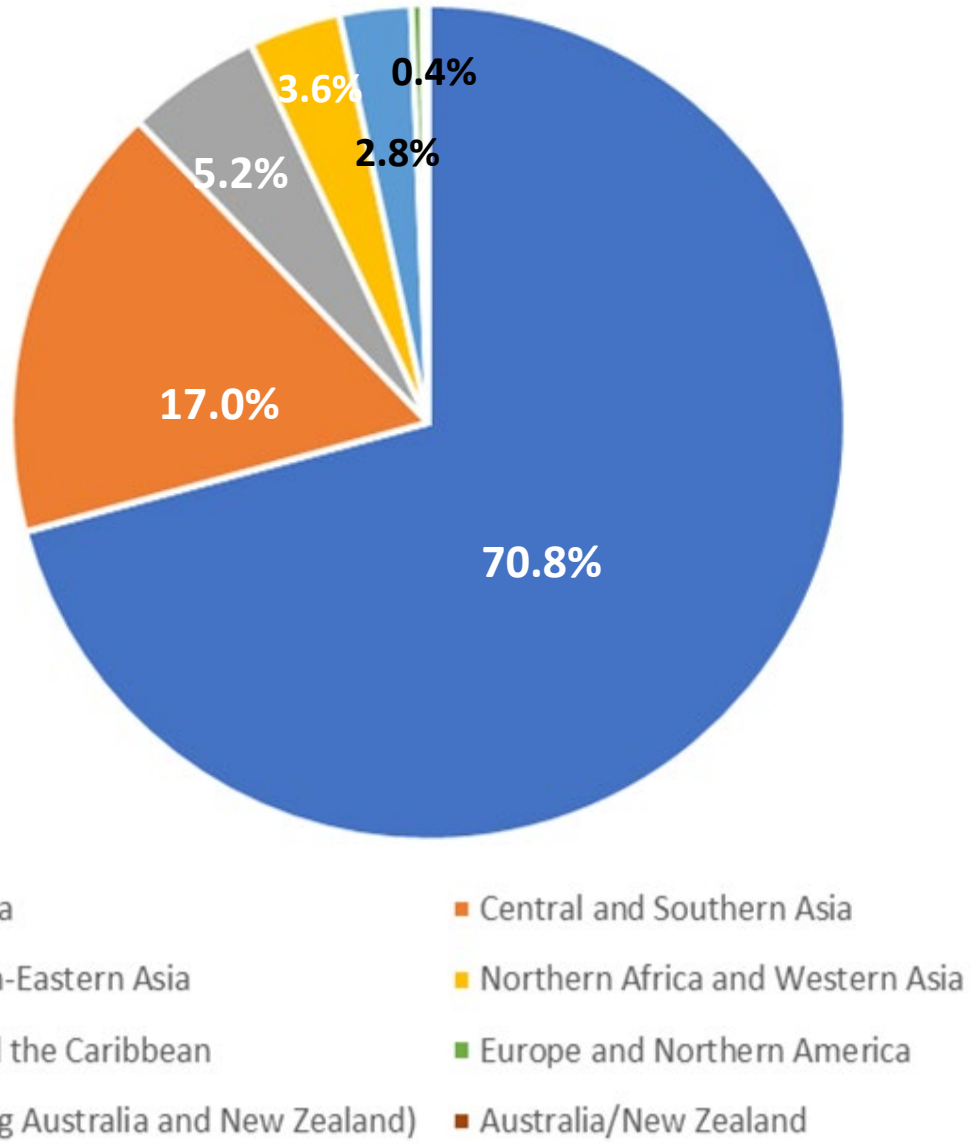
Global MMR in 2023

- Globally, 260000 (UI 230000 to 309000) maternal deaths occurred in 2023
  - MMR of 197 per 100,000 LB (UI 174 to 234)
  - 712 maternal deaths every day, 30 maternal deaths per hour or one maternal death every 2 minutes globally
- Sub-Saharan Africa accounted for 71% of global maternal deaths, followed by Central and Southern Asia which accounted for almost 17%
- The least-developed countries (LDCs) accounted for 43.9% of all maternal deaths in 2023



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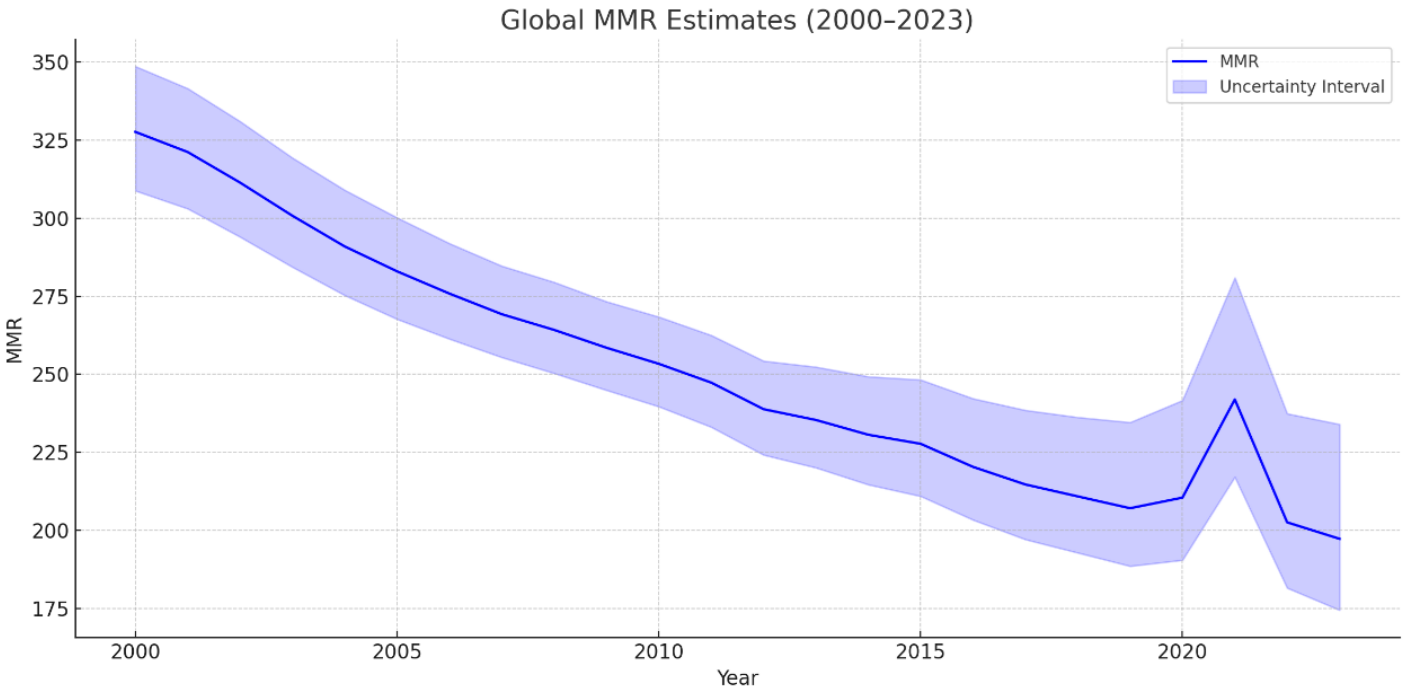
Global trends in MMR



Between 2000 and 2023

- MMR fell by 40% from 328 (UI 308 to 352) to 197 (UI 174 to 234), with 2.2% average ARR

Between 2016 and 2023

- MMR declined from 220 (UI 203 to 242) to 197 (UI 174 to 234), with 1.6% average ARR and 10% decline

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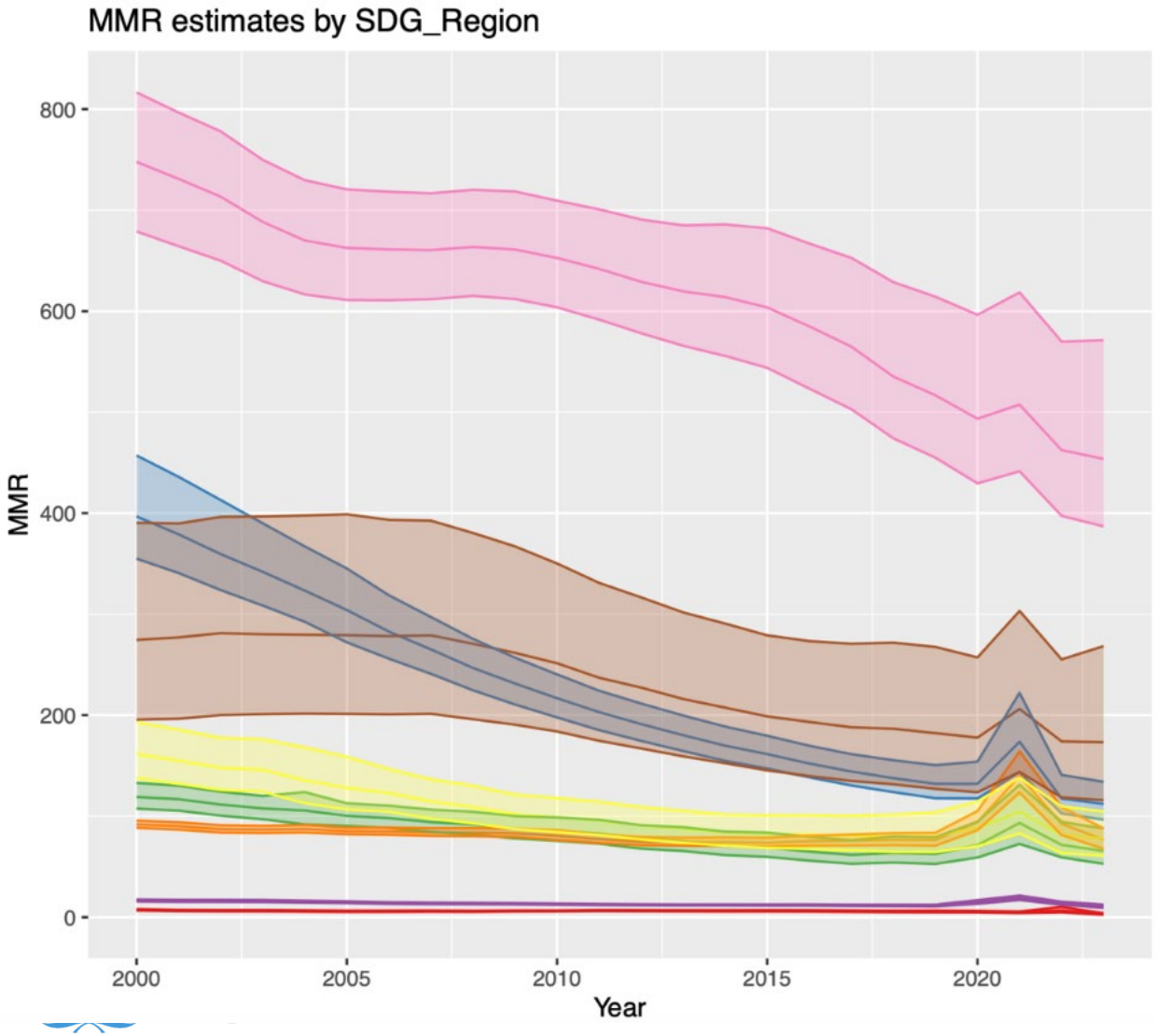
Regional MMR in 2023



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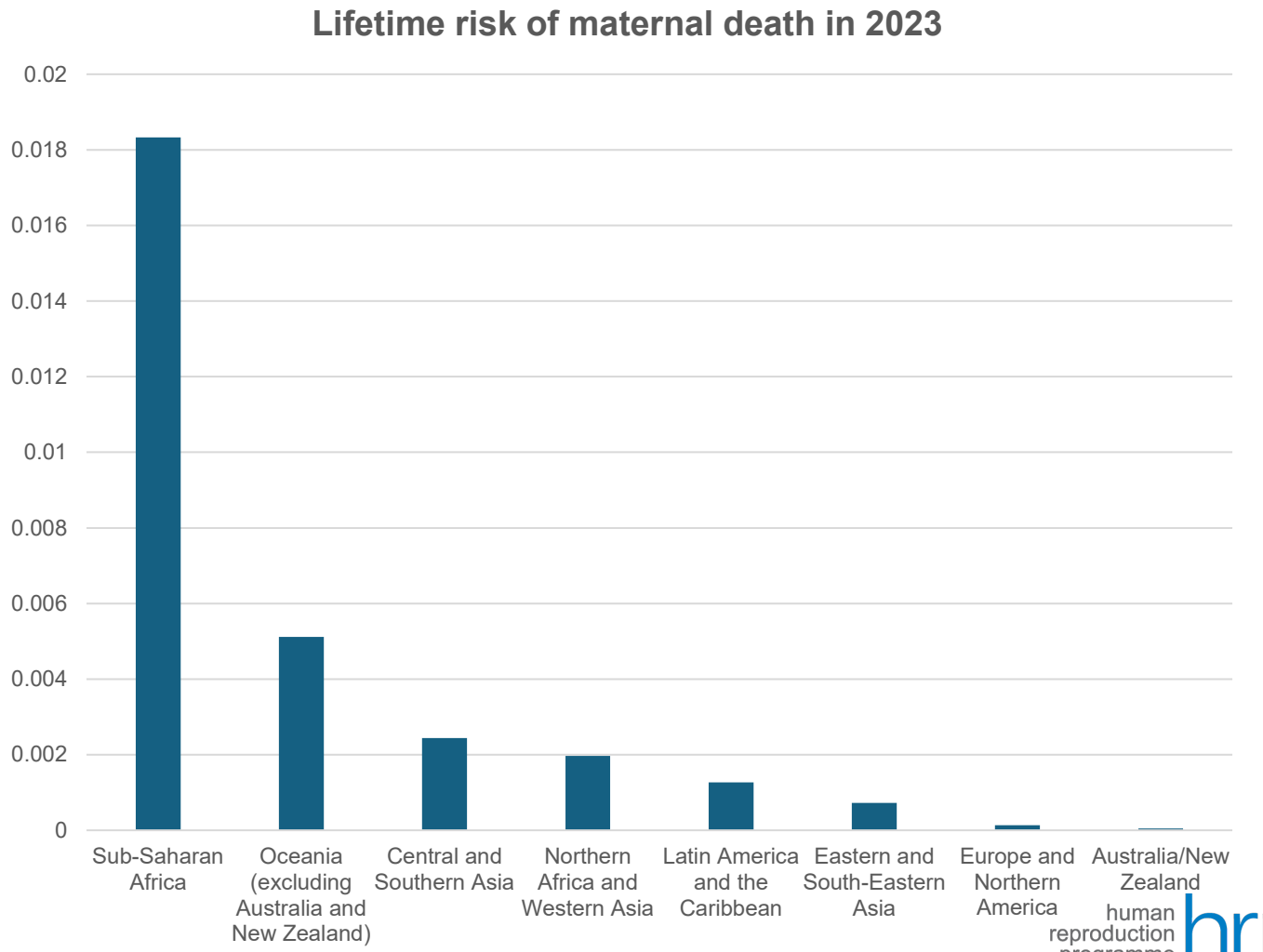
Regional Lifetime risk of maternal death in 2023

- The lifetime risk of dying from a maternal cause was estimated the highest in sub-Saharan Africa, at 1 in 55
- By contrast, in Australia and New Zealand in 2023 it was 1 in 21248– approximately 400 times lower than in sub-Saharan Africa



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Country level MMR in 2023

- No countries were estimated to have had **extremely high** maternal mortality (defined as MMR of over 1000)
- **Nine** countries are estimated to have had **very high** MMR in 2023 (MMR 500-999). Those countries are:

  Nigeria (993), Chad (748), Central African Republic (692), South Sudan (692), Liberia (628), Somalia (563), Afghanistan (521), Benin (518), and Guinea-Bissau (505)
- **14** countries had a **high** MMR (MMR 300-499)
- **43** countries had a **moderate** MMR (100-299)
- **130** countries had a **low** MMR (below 100), of these, **74** had a **very low** MMR (less than 20)

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Maternal deaths per 100 000 live births (MMR), 2023

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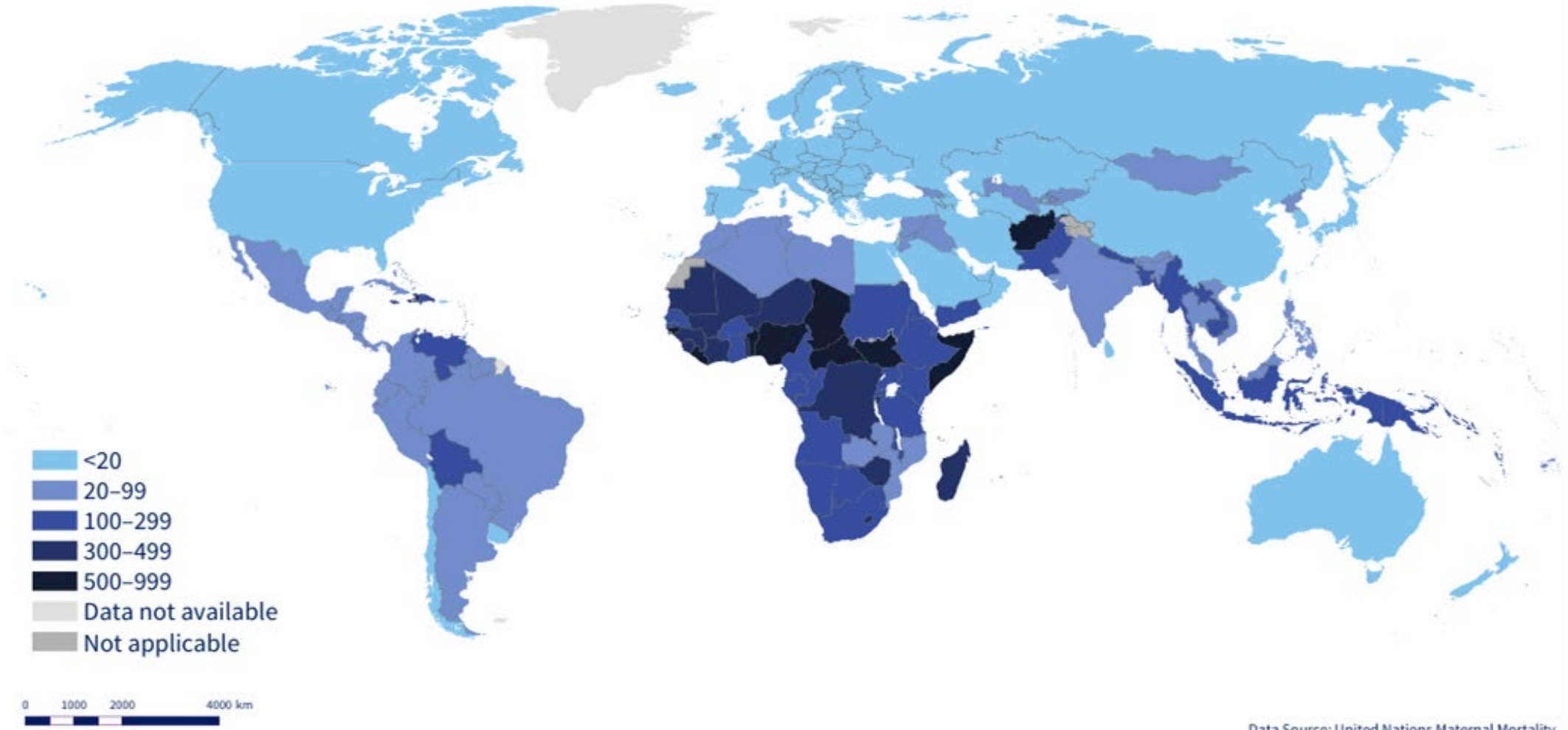

Data Source: United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG)
Map Creation Date: **11 March 2025**
Map Production: WHO GIS Centre for Health, DNA/DDI

COVID-19 pandemic

- In 2021, MMR rose in most regions (except Australia & NZ)
- By 2022, MMR returned to pre-pandemic levels
- MMR spikes in 2021 mirrored excess deaths among women 15–49
- Maternal death share stayed stable during the pandemic

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MMR in Small island developing States (SIDS)

- First time to include SIDS in our estimates
- SIDS = 57 entities with 65M people, facing unique environmental and social challenges
- 2023 MMR: 193 (UI 155 to 253)

MMR in fragile and conflict-affected settings

- 61% of global maternal deaths in 2023 occurred in fragile/conflict settings
- 17 conflict-affected countries: MMR : 504 (UI 413 to 674); 55% of global maternal deaths
- 20 socially fragile countries: MMR : 368 (UI 300 to 473); 7% of deaths
- Strengthening health systems & PHC investment is critical

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Progress towards SDGs

- Current progress is too slow to meet the SDG target (global MMR <70 per 100,000 LB)
  - ➢ At 1.6% ARR (2016–2023), MMR in 2030 would be 177
  - ➢ At 2.5% ARR (2000–2023 rate), MMR would be 169
- Meeting SDG target needs a 14.8% ARR until 2030

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More work to do …

To advance progress, multisectoral/collective action is required to address the causes of maternal mortality

- Most maternal deaths are preventable
- We need to address social determinants of maternal health –ethnicity, age, disability, socioeconomic inequalities
  - ➢ Humanitarian and fragile contexts
- Need for maternal health and survival to remain high on the global health and development agenda
- More work is needed to improve the measurement of maternal mortality

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Global and Regional Causes of Maternal Death 2009–20

Jenny Cresswell

Scientist, Dept of Sexual & Reproductive Health & Research incl HRP, WHO

PPH CoP Webinar, 10 July 2025

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Introduction

- Maternal mortality remains a global health priority.
- SDG 3.1: global MMR <70 per 100 000 live births by 2030.
- Approx 95% of maternal deaths occur in low-income and lower-middle-income countries (LMICs).
- Nearly all maternal deaths are due to preventable causes.
- Accurate information on causes of maternal deaths needed to inform policy & programming.

- First update in a decade to the global causes of maternal mortality; first time maternal suicide & late maternal death included.

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Objectives

- Estimate causes of maternal deaths by region (2009–2020) according to seven groups: abortion, embolism, haemorrhage, hypertensive disorders, pregnancy-related sepsis, other direct causes, and indirect causes.
- Describe data reporting maternal suicides.
- Describe data relating to late maternal deaths.

- Inform policies with up-to-date data.
- Support SDG progress tracking.

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Methods 1/2

- Data sources: CRVS from the WHO Mortality Database; national/subnational reports published by Member State (MMEIG database; search of MOH & NOS websites); journal articles identified via bibliographic databases.
- Multi-strategy systematic review
  - Latin-script: MEDLINE, Embase, Global Index Medicus etc
  - Chinese-script: Wanfang, CNKI
  - Russian-script: eLIBRARY.RU

- Where cause of death described in free text and OB-GYN assigned ICD code to best ability using information available.

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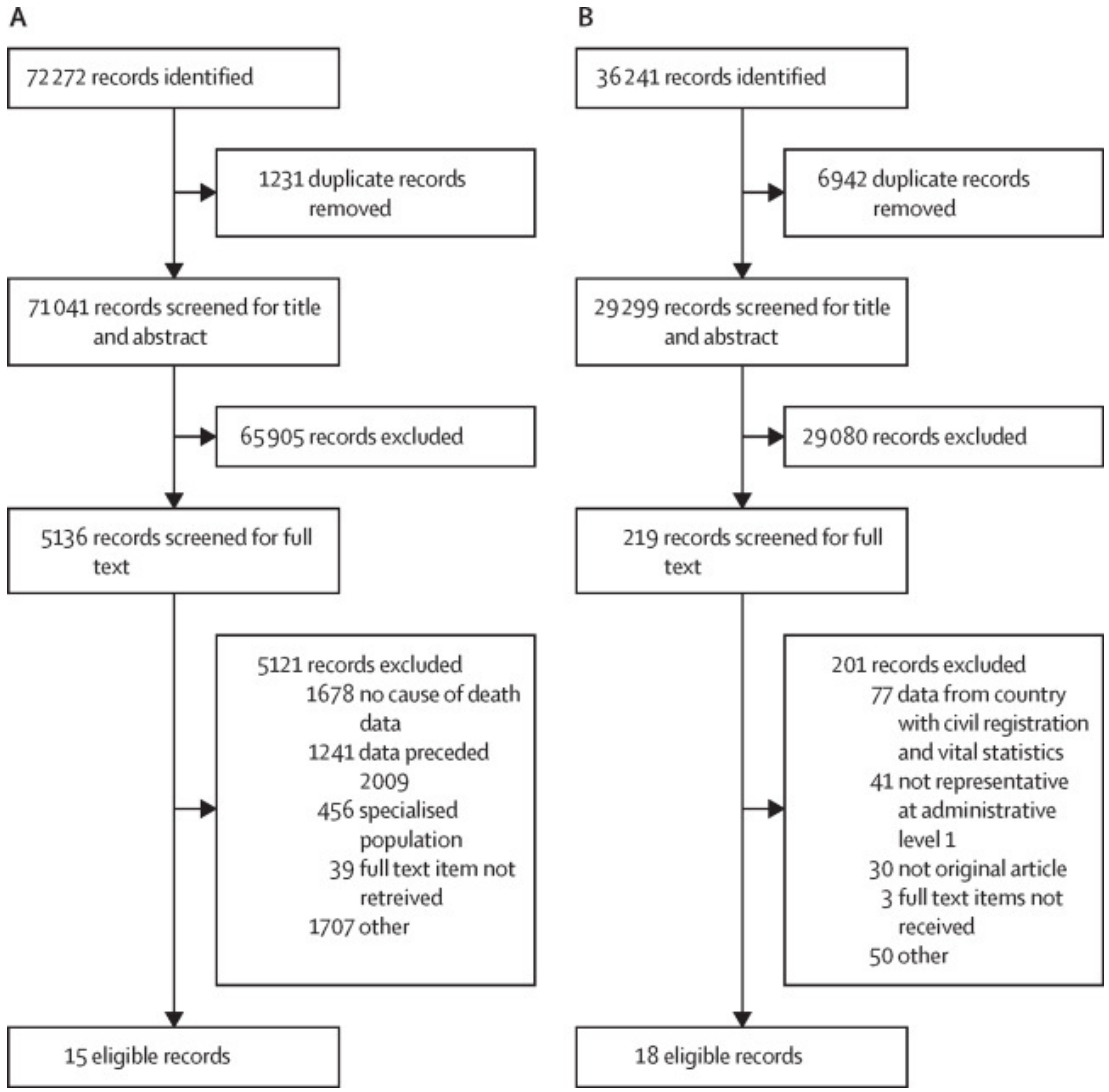
CRVS:
110 countries, covering 908 country-years

MOH & NOS Reports:
28 countries covering 79 country-years

Overall:
- 1+ input for 129 countries
- No input for 56 countries (30%)

Bibliographic databases:



20 countries covering 33 country-years

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Input datasets

- 1+ empirical input for 129 countries.
- No input for 56 countries (30%); 34 of which were in Sub-Saharan Africa.
- The total number of maternal deaths in the final input dataset was 139 381, which represents 3·7% of the 3 813 266 maternal deaths estimated by the MMEIG to have occurred over this period, globally.

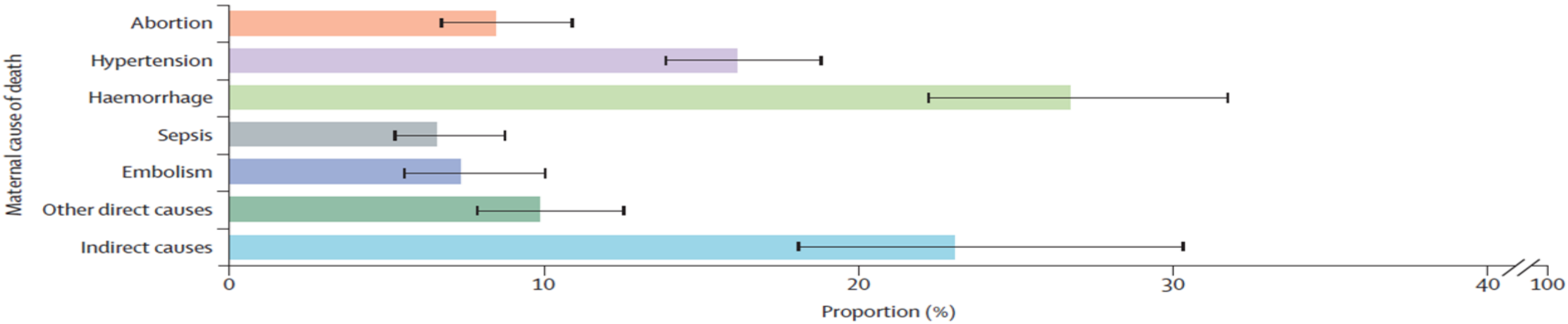
Methods 2/2

- Groupings: ICD-MM framework

- Statistical model: Bayesian hierarchical model
  - Accounts for regional correlations.
  - Assigns varying amounts of uncertainty depending on quality & likely bias in data source.

- Descriptive statistics used to summarise maternal suicides & late maternal deaths as insufficient empirical information identified to justify modelling.

Global causes distribution



(Bars indicate median values with 80% uncertainty intervals)

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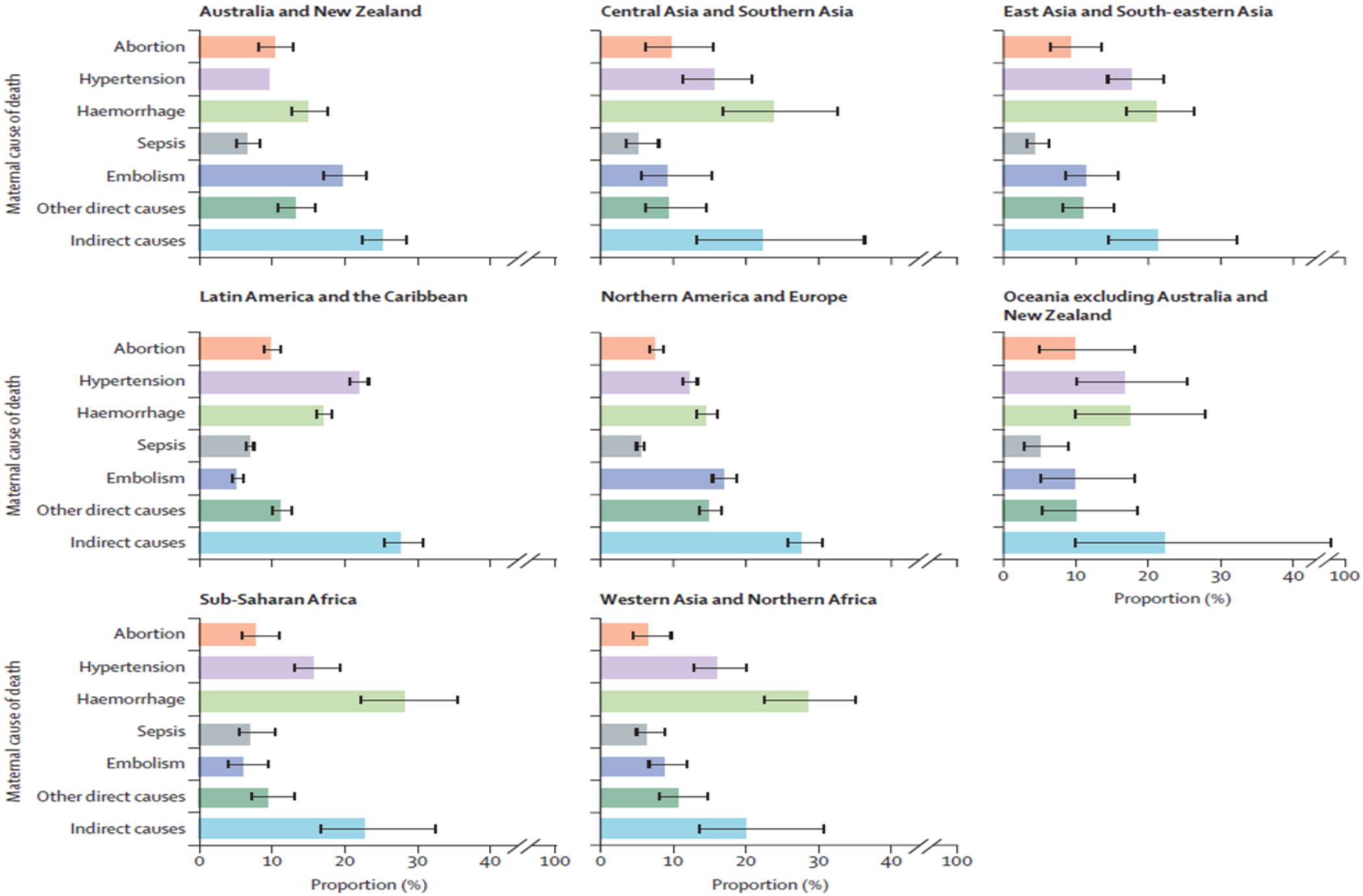
Australia and New Zealand
Central Asia and Southern Asia
East Asia and South-eastern Asia
Latin America and the Caribbean
Northern America and Europe
Oceania excluding Australia and New Zealand
Sub-Saharan Africa
Western Asia and Northern Africa
Maternal cause of death
Abortion
Hypertension
Haemorrhage
Sepsis
Embolism
Other direct causes
Indirect causes
0
10
20
30
40
100
Proportion (%)

Haemorrhage deaths: by time period

	Antepartum		Intrapartum		Postpartum		Total	
	n	% (80% UI)	n	% (80% UI)	n	% (80% UI)	N	% (80% UI)
Haemorrhage								
Global	240 173	6·2 (4·7–8·8)	192 538	5·0 (3·7–7·3)	571 940	14·8 (11·6–18·6)	1 028 470	26·7 (22·2–31·7)
Australia and New Zealand	11	4·3 (3·0–6·0)	8	3·4 (2·1–5·1)	17	7·0 (5·0–9·3)	37	14·9 (12·5–17·7)
Central Asia and Southern Asia	41 414	5·1 (2·9–8·8)	38 851	4·8 (2·7–8·3)	105 482	13·0 (8·0–19·3)	194 770	24·0 (16·8–32·6)
Eastern Asia and South-eastern Asia	13 529	5·0 (3·5–7·4)	8753	3·2 (2·2–5·0)	33 483	12·4 (9·4–16·5)	57 296	21·3 (17·0–26·6)
Latin America and the Caribbean	4203	4·3 (4·0–4·9)	2220	2·3 (2·0–2·7)	9897	10·2 (9·5–11·1)	16 435	17·0 (16·0–18·2)
Northern America and Europe	679	4·1 (3·6–4·9)	551	3·3 (2·8–4·1)	1136	6·9 (5·9–8·1)	2394	14·5 (13·0–16·2)
Oceania*	315	4·3 (1·8–8·8)	184	2·5 (1·0–5·5)	708	9·7 (4·4–17·3)	1287	17·6 (9·9–28·0)
Sub-Saharan Africa	167 286	6·6 (4·6–9·9)	132 220	5·2 (3·6–8·2)	394 825	15·6 (11·2–20·9)	717 502	28·4 (22·2–35·5)
Western Asia and Northern Africa	7860	6·4 (4·3–9·8)	5537	4·5 (3·0–7·2)	20 555	16·7 (12·3–21·9)	35 075	28·5 (22·4–35·2)

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Suicides during pregnancy & postpartum

- Maternal suicide is considered a direct maternal death by WHO.
- Not captured by civil registration or in MMEIG estimates.

- Globally, only 12 countries reported at least one maternal death from suicide. The proportion of maternal deaths due to suicide varied by region, ranging from below 1% in sub-Saharan Africa, to 26% in Australia and New Zealand.

- Robust confidential enquiry systems in the UK and Ireland show that maternal suicide is currently the third largest cause of direct maternal deaths occurring during or within 42 days of pregnancy and the leading cause of direct late maternal deaths.

Late maternal deaths

- 111 countries reported at least one late maternal death between 42 days and 1 year postpartum.
- By SDG region, the average ratio of late maternal to maternal deaths ranged from <0·01 (Oceania) to 0·07 (Western Asia & Northern Africa).
- Only four countries conducted a confidential inquiry that included late maternal deaths (France, Morocco, UK, USA); of these, France, the UK, and the USA all had ratios higher than 0·1. The UK reports a ratio higher than 1, meaning that there were more late deaths than those up to 42 days.
- Common causes of death differ: mental disorders, diseases of the nervous system, cardiomyopathy in the puerperium, other diseases of the circulatory system, and malignant neoplasm.

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Conclusions (1/3)

- **Obstetric haemorrhage** remains the leading cause of maternal death globally, disproportionately affecting women in LMICs. The existence of effective clinical interventions means deaths from haemorrhage are largely preventable.

- Most haemorrhage deaths took place in the postpartum period.

- **Hypertensive disorders** remain the second most common direct obstetric cause of death and were the leading cause of maternal death in Latin America and the Caribbean.

- There has been no substantial change in the proportion of maternal deaths due to **indirect causes** (23%) since the two previous WHO analyses (20% in 2006; 27% in 2014), which remain the second largest cause of maternal death.

Conclusions (2/3)

- **Missing data** and **misclassification** remain a substantial problem for assessing causes of maternal death.
- Likely to be particular issue for certain groups of causes (eg. indirect or late deaths that often take place away from obstetrics ward).
- Strengthen **CRVS**; **triangulate** data sources,
- ICD-11 being rolled out which contains many new tools to facilitate accurate cause of death coding.

Conclusions (3/3)

- With haemorrhage remaining the leading cause of maternal death globally, the **WHO Roadmap for Postpartum Haemorrhage 2023 to 2030** provides key priorities for: **i) research, ii) norms and standards, iii) implementation, and iv) advocacy**. These four strategic areas were identified by key stakeholders to accelerate progress towards reducing deaths from postpartum haemorrhage.
- The dual challenge of direct and indirect obstetric causes highlights the need for a **health systems approach** that integrates obstetric and non-obstetric providers across the continuum of care.
- Further evidence needed on late maternal deaths & maternal suicide.

PPH CoP WEBINAR

10TH JULY 2025.

Reducing PPH Mortality in Eastern Uganda

DR. KENNETH MUGABE MBChB, MMED, FCOG(ECSA)

THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

ELGON LOCAL MATERNITY & NEONATAL SYSTEM

ELMNS

"Every life matters"

Elgon Local Maternity and Neonatal System

Introduction

- Inaugurated December 2022.
- A collaboration and accountability platform.
- Eastern Uganda, with Mbale as principal town (245KM from Kampala)
- Catchment population: 5.5M (2024 national census)
- Fertility rate: Bugisu,4.8 ; Bukedi,6.5 (Uganda, 5.2) UDHS 2022.

Elgon LMNS Roles

Provides regional leadership for maternal and newborn care

Spearheads capacity building of all health workers in the region through trainings, mentorships during support supervision at spoke facilities and placement at the Hub, and dissemination of update national guidelines.

Coordinate all MNH referrals

Track and redistribute medical commodities and essential medicines to facilities that are acutely deficient

Identify non-functional medical equipment and mobilize the regional workshop engineers to repair them.

Lead awareness campaigns to sensitize communities (PPH is part)

Advocacy and collaboration with regional, national and international partners to mobilize resources to improve regional MNH indicators

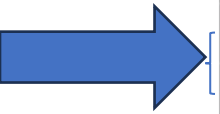
Human resource for Health. Track and advocate for increased critical health workforce for MNH

Research

Causes of death by region

Table 6: Causes of maternal deaths by region FY2022/2023

Elgon



Regions	Haemorrhage	Hypertensive Disorders of Pregnancy	Indirect Causes (Anaemia, Malaria, HIV/AIDS & other infections)	Pregnancy Related Sepsis	Abortion complications	Pre-existing disease	Anaesthetic Complications	Ectopic Pregnancy Complications	Others	Non Obstetric cause	Unknown
Acholi	25.4%	6.0%	11.9%	26.9%	13.4%	7.5%	1.5%	4.5%	1.5%	1.5%	0.0%
Ankole	32.2%	23.0%	6.9%	9.2%	4.6%	1.1%	6.9%	2.3%	2.3%	1.1%	10.3%
Bugisu	33.0%	16.5%	13.8%	11.9%	7.3%	7.3%	1.8%	0.0%	0.9%	3.7%	3.7%
Bukedi	52.3%	13.6%	6.8%	9.1%	0.0%	4.5%	4.5%	2.3%	2.3%	0.0%	4.5%
Bunyoro	44.2%	7.8%	19.5%	15.6%	6.5%	2.6%	1.3%	1.3%	0.0%	0.0%	1.3%
Busoga	45.3%	21.1%	11.6%	5.3%	5.3%	2.1%	2.1%	1.1%	1.1%	1.1%	4.2%
Kampala	37.9%	22.0%	10.7%	8.5%	6.8%	5.1%	2.3%	1.7%	1.7%	0.6%	2.8%
Karamoja	27.3%	9.1%	27.3%	0.0%	0.0%	0.0%	9.1%	9.1%	9.1%	0.0%	9.1%
Kigezi	44.4%	13.9%	8.3%	8.3%	5.6%	8.3%	0.0%	0.0%	2.8%	0.0%	8.3%
Lango	34.0%	4.3%	21.3%	6.4%	4.3%	2.1%	4.3%	4.3%	4.3%	0.0%	14.9%
North Central	57.4%	19.8%	6.9%	4.0%	4.0%	2.0%	0.0%	0.0%	0.0%	0.0%	5.9%
South Central	41.8%	22.4%	6.0%	7.5%	3.0%	1.5%	0.0%	3.0%	1.5%	1.5%	11.9%
Teso	35.0%	13.3%	16.7%	8.3%	3.3%	3.3%	0.0%	5.0%	1.7%	0.0%	13.3%
Tooro	37.3%	7.5%	22.4%	4.5%	11.9%	3.0%	3.0%	1.5%	0.0%	0.0%	9.0%
West Nile	42.4%	10.9%	17.4%	6.5%	2.2%	4.3%	6.5%	1.1%	0.0%	0.0%	8.7%
National	39.9%	15.7%	12.8%	9.1%	5.7%	3.9%	2.6%	1.8%	1.3%	0.8%	6.3%

What were the gaps?

- Low numbers of critical human resource (4 specialists in entire region, no or few doctors at some CEmONC sites)
- Non- functional CEmONC sites
- Poor referral systems
- Frequent stock-out of essential medicines
- Broken down equipment especially in theatres and laboratories
- Low utilization of data generated in health facilities.

- No MPDSR structures and processes in most health facilities.
- No evidence-based practices for lower-cadre health workers
- No identification of high-risk pregnancies in ANC
- Blood distribution (no timely access), some CEmONC sites not pre-qualified for BT
- No regional leadership and accountability platform to coordinate MNH services and strengthen MPDSR processes.

7-point plan

1. Governance, leadership and coordination
2. Strengthened clinical capacity and service delivery
3. Improved emergency response and referral systems
4. Data, surveillance, and accountability
5. Community engagement and demand generation
6. Develop high-risk antenatal clinics
7. Mobile data for referral tracking, reward system and research.

1. Governance, Leadership and Coordination

a) LMNS links policy makers, political district leaders and health workers for annual engagements

b) Resource mobilization

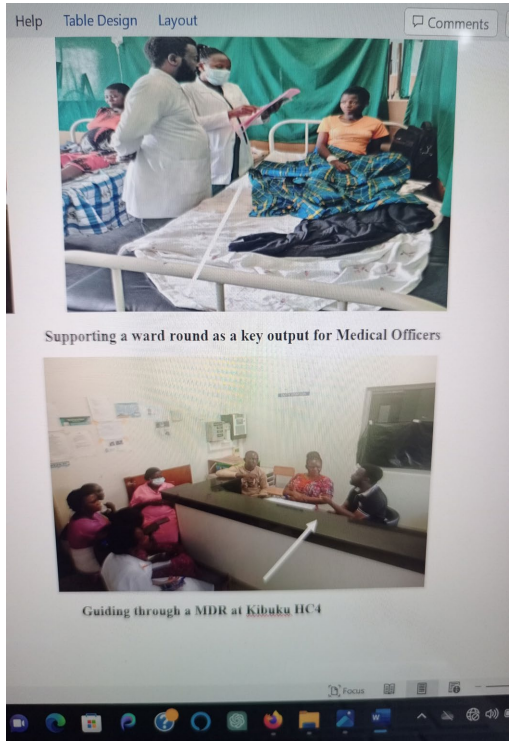
Advocate for dedicated financial support from regional implementing partners to support MNH activities.

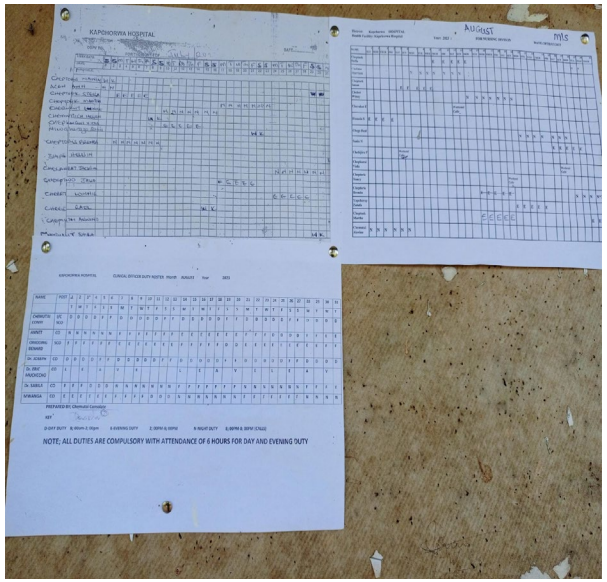
c) Supportive Supervision

Implement regular mentorship and supervision by regional maternal and neonatal health specialists.

Minister of Health and DG interacting with Elgon region political leaders and H/Ws

Elgon LMNS secretariat 2022


Help
Table Design
Layout
Comments
Supporting a ward round as a key output for Medical Officers
Guiding through a MDR at Kibuku HC4


KAPCHORWA HOSPITAL
August
NOTE: ALL DUTIES ARE COMPULSORY WITH ATTENDANCE OF 6 HOURS FOR DAY AND EVENING DUTY


OXYTOCIN CORNER

2. Strengthened Clinical Capacity and Service Delivery.

a) Started **specialized training** for local OBGYNs & anaesthetists

- Increased deployment and equitable distribution of key HR across high-burden districts. Improved staffing from 79% in FY23 to 83% in FY24 (Source: iHRIS).

b) **In-service capacity building**.

- Formed a team of regional E-MOTIVE trainers (4ToTs).
- Monthly virtual and on-site low-dose, high-frequency simulation-based trainings on E-MOTIVE.

c) Availability and use of **essential medicines** like uterotonics.

- Track and ensure continuous availability, safe administration and storage practices of uterotonics (oxytocin, misoprostol) at all delivery sites and if need be, redistribute them.

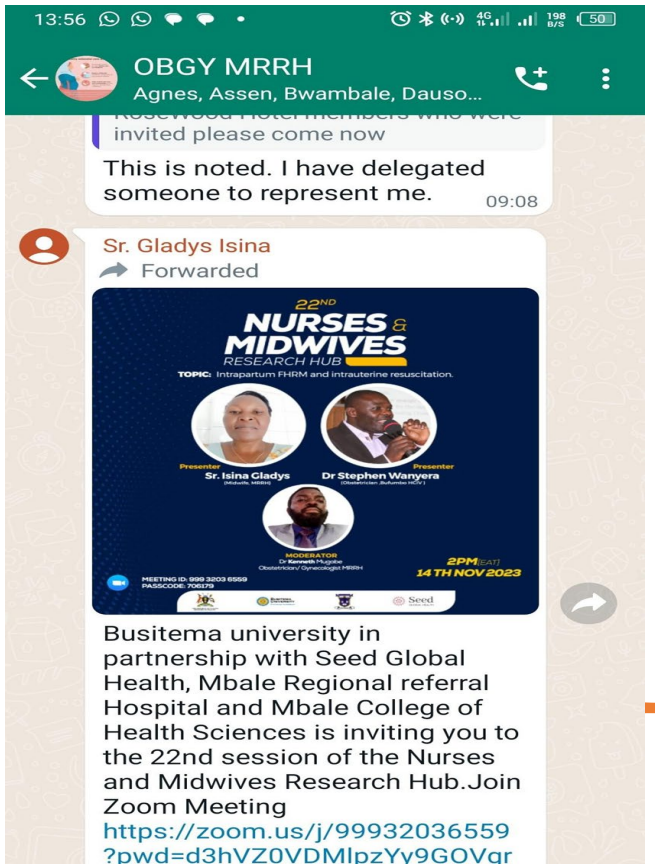
Simulation

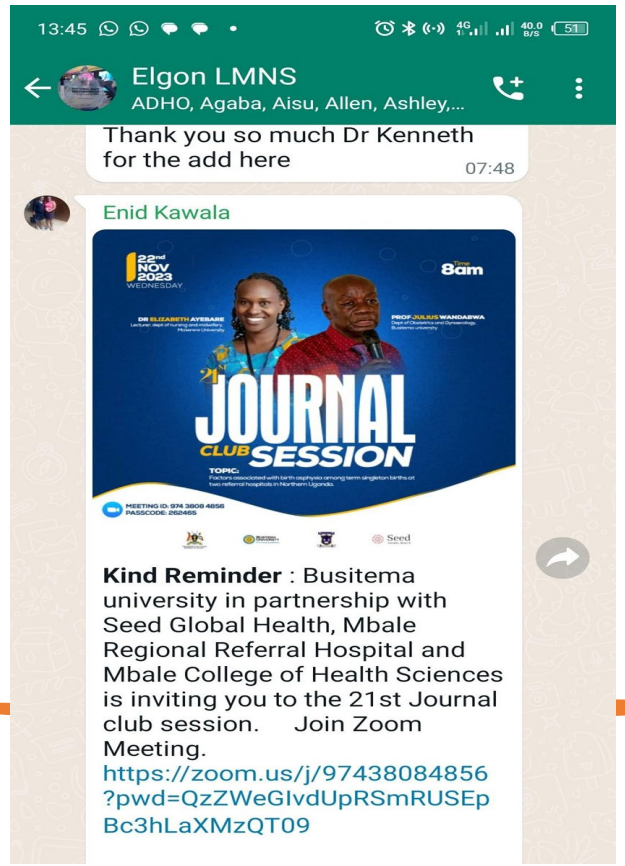
Mentorship drills for doctors, midwives, anaesthetists and students (promoting working as emergency teams)

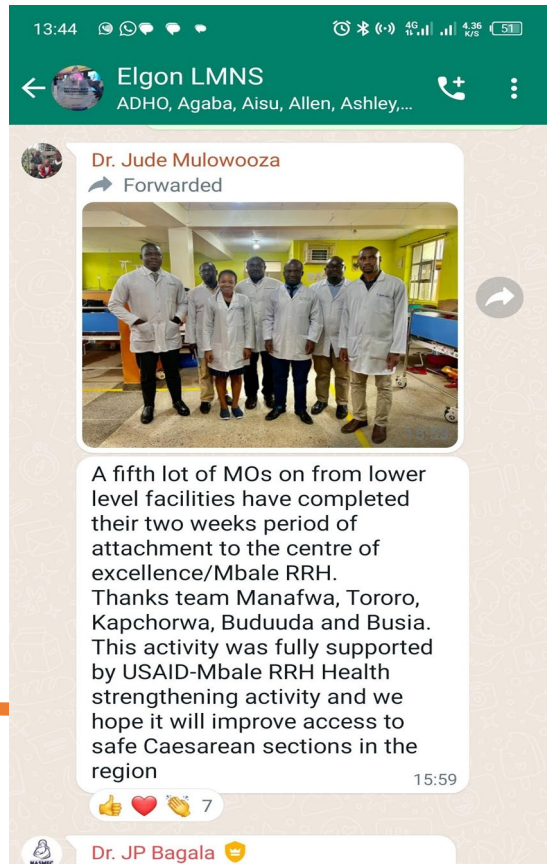
Peer-to-Peer mentorship: midwives mentor themselves

Partners for the LMNS actions

Partnering with training institutions for capacity building through journal clubs and research hubs







3. Improved Emergency Response and Referral Systems

a) 24/7 Emergency Obstetric and Neonatal Care (EmONC)

- Upgraded select facilities to provide CEmONC, including blood transfusion and surgical care (6 were functioning sub-optimally - now all 22 facilities are functional).

b) Referral and Transport Systems

- Improved efficiency of referral and ambulance system for rapid transport of PPH cases. 8 more ambulances allocated to the region

c) Blood Availability

- Strengthened regional blood bank response to timely dispatch of blood (through LMNS platforms).
- Prequalified and prepared all 22 CEmONC facilities to receive and use blood products.
- Direct communication with regional blood bank
- Blood is moved to the patient instead of referring a patient for transfusion.

4. Data, Surveillance, and Accountability

a) Maternal and Perinatal Death Surveillance and Response (MPDSR)

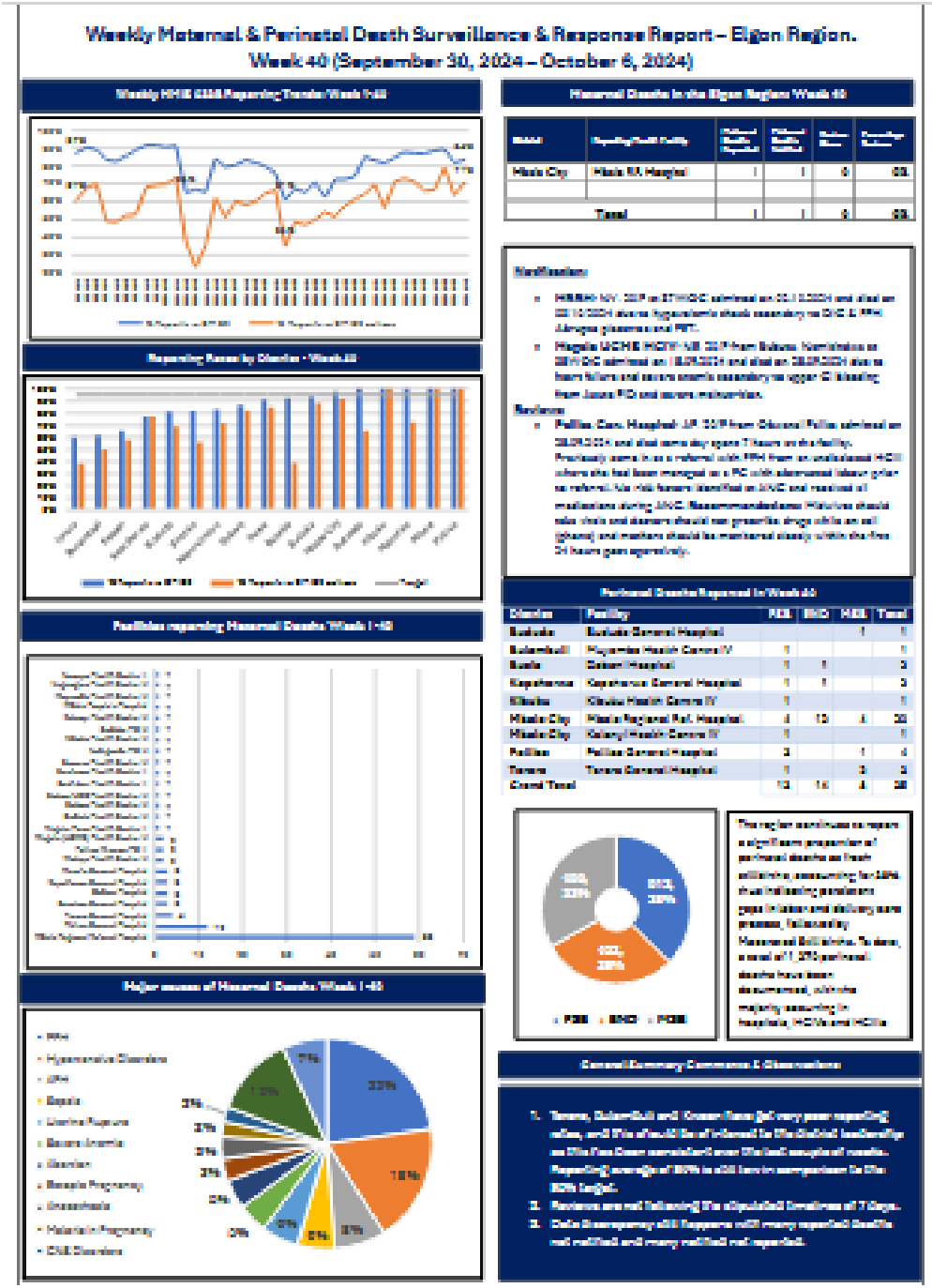
- Established MPDSR committees in all districts and conduct regular review meetings.
- Document and address systemic failures contributing to PPH deaths through weekly LMNS regional meetings.

b) Real-time PPH case monitoring

- Set up a regional data dashboard to monitor PPH cases and outcomes of care.

c) Confidential enquiries and audits.

- We conducted 6 confidential enquiries into maternal deaths to inform policy and practice.

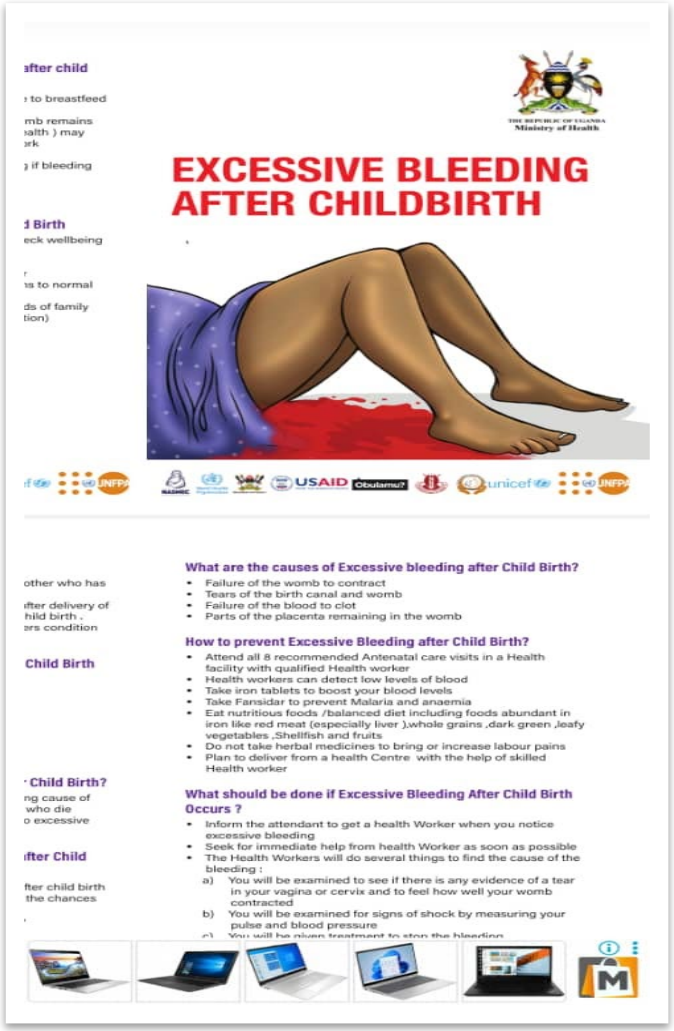


5. Community Engagement and Demand Generation

a) The LMNS runs weekly radio talk shows, annual awareness community walks to educate communities on PPH danger signs and the need for facility-based delivery.

a) Created strategic partnerships with other implementing partners like Seed Global Health, USAID-UHA, Rotary international, Banks to support efforts to create awareness on PPH.

Translated our PPH messages into local languages.



HIGH-RISK PREGNANT WOMEN CLINIC DAYS

1. Busiu HC IV - Clinic Runs on Thursdays
2. Namatala HC IV - every Wednesday
3. Kapchorwa Hospital - every Thursday
4. Kaserem HC IV - every Thursday
5. Masafu Hospital - every Tuesday and Wednesday
6. Busia HC IV - every Wednesday
7. Bufumbo - every Thursday
8. Butebo HC IV - every Wednesday
9. RRH - every Wednesdays
10. Budaka HC IV - every Tuesday
11. Bubulo HC IV - to establish
12. Bugobero HC IV - every Wednesday
13. Bududa Hospital - every Monday Tuesday Wednesday
13. Kaproron HC4 - every Tuesday
15. Buwasa HC IV- Every Thursday and
16. Budadiri HC IV - every Wednesday.
17. Dabani Hospital - every Wednesday
18. Mulanda HC IV every Thursday
19. Nagongera HC IV every Wednesday ... Read more

06:57

6. High-risk pregnancy clinics.

- Opened in all CEmONC sites in Elgon region in 2023.
- High-risk pregnancies especially for conditions like PPH, are identified and linked for better care.
- Run by doctors weekly.

7. Innovation and technology:

Referral tracking, reward system and research.

- Referral Tracking that informs mentorships

Using ODK app on midwives' phones in labour ward.

This links to a google sheet on my laptop

Helps in timely awareness of referrals coming in.

Reward system

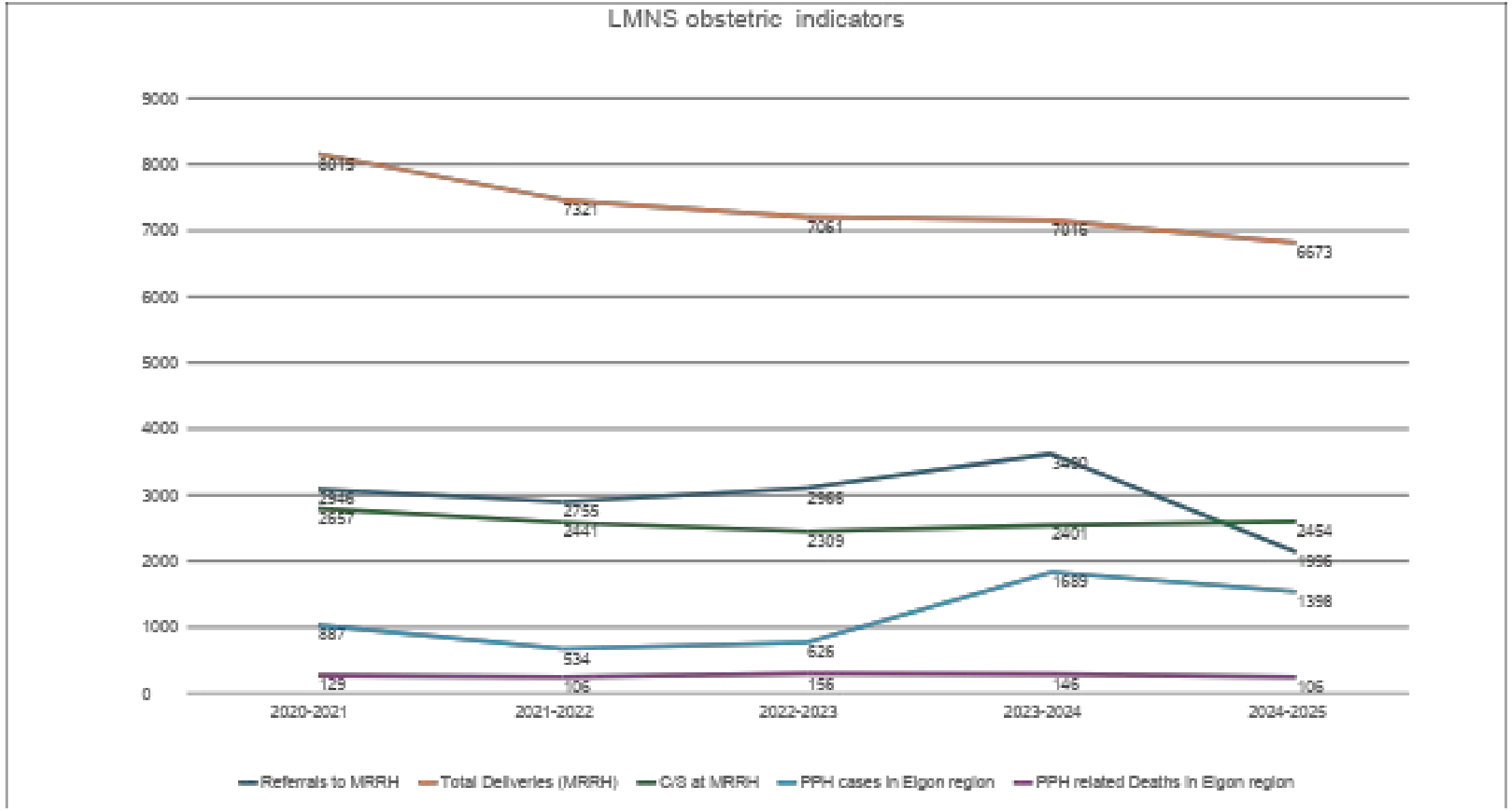
- Started in August 2023
- Done monthly
- A tool that enables objective assessment was developed.
- Displayed on a **WALL OF FAME!**

Has it worked?

Some local regional indicators have improved from 2022:

- ANC attendance has increased from 76% to 94% (18%)
- ANC 4 has increased from 45% to 57% (12%).
- Health facility deliveries at 75%.
- Reduced referrals to MRRH (by 32%), deliveries (by 17%) and C/S rate (by 13%)
- Increased PNC attendance (from 56% to 60%)
- Regional PPH cases identified raised by 37%, but PPH deaths reduced by 34%.

(MOH- Elgon LMNS annual Reports 2022- 2025)


LMNS obstetric indicators
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
8015
7321
7061
7016
6673
2946
2755
2988
3390
1996
2657
2441
2309
2401
2454
887
534
626
1689
1398
129
106
156
145
106
2020-2021
2021-2022
2022-2023
2023-2024
2024-2025
Referrals to MRRH
Total Deliveries (MRRH)
C/S at MRRH
PPH cases in Elgon region
PPH related Deaths in Elgon region

Conclusion

- An integrated regional approach that combines skilled care, emergency preparedness, community mobilization, and system accountability can significantly reduce PPH deaths.

- Strong leadership and sustained investment through a local maternity and newborn system, and finding local solutions for local problems, are critical to achieving lasting impact.

Elgon LMNS wins the 2023 National Prize

THANK YOU.

Questions & answers

Please type your questions into the Q&A box

Questions et réponses

Veuillez poser toutes vos questions dans la boîte de questions et réponses

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