Monitoring and Evaluation of PPH Prevention, Detection and Treatment at Health Facilities



Recommended Indicators and Practical Tips

The WHO publication of Consolidated guidelines for the prevention, diagnosis and treatment of postpartum haemorrhage (2025) is a major milestone in advancing the Roadmap to combat postpartum haemorrhage between 2023 and 2030. Experience shows that translating new health guidelines into action requires consideration of all health systems building blocks – including strengthening routine health information systems and equipping clinical teams to routinely track and measure implementation processes and outcomes. Initially, this helps health workers and decision-makers assess the fidelity of implementation, track quality of care and see the impact of new interventions on people's lives, and over time it provides critical information on progress and impact.

To support countries in adopting the consolidated guidelines, WHO and partners have created a toolkit of resources, including an implementation guide with step-by-step instructions for developing a monitoring and evaluation plan emphasizing the importance of having clearly defined, measurable PPH indicators that can be routinely captured and analyzed through national health information management systems (HMIS) and periodic health facility assessments. It provides stakeholders with guidance on how to (1) select specific, measurable PPH indicators to monitor recommended intervention inputs, processes, outputs, and outcomes, (2) identify updates needed to integrate PPH indicators into national data infrastructure, (3) set targets for selected indicators, and (4) visualize and use data to make decisions.

The Unitaid-funded Accelerating Measurable Progress and Leveraging Investments for Postpartum Hemorrhage Impact (AMPLI-PPHI) project, led by Jhpiego in partnership with PATH and the International Federation of Gynaecology and Obstetrics (FIGO), worked in close partnership with governments from the Democratic Republic of Congo, Guinea, India, Kenya, Nigeria and Zambia. From 2022 – 2026, with complementary funding from the European Union's Safe Birth Africa Initiative (a joint Unitaid-UNFPA venture and a Global Gateway Flagship Project) and the Gates Foundation, the project catalyzed adoption and scale-up of newly recommended PPH products: heat-stable carbetocin (HSC) for PPH prevention, calibrated drapes for PPH detection, tranexamic acid (TXA) as part of the MOTIVE bundle to treat PPH and misoprostol for PPH prevention in home births. Working alongside key stakeholders to create an enabling environment for implementation beyond initial project sites, AMPLI-PPHI teams have tested new metrics and supported integration of new indicators and tools in national data systems.

> This AMPLI-PPHI technical brief presents recommendations for **PPH indicators** to prioritize, and **practical tips for integrating new PPH indicators in routine health information systems**, based on evidence and learning generated through implementation support and monitoring at primary, secondary, and tertiary facilities across six distinct country health systems. Indicator recommendations are aligned with and complementary to global guidance and accompanied by real-world examples of decisions and trade-offs to consider.

Recommended Output and Outcome Indicators

Intervention/ Topic	Indicator	Definition (N = Numerator, D = Denominator)	Data Source	Guidance for integration into routine data systems
PPH Prevention	Proportion of women who received a quality-assured uterotonic drug for PPH prevention within one minute after the birth of the baby or babies ***Rationale:*** *Assesses whether women receive timely*, appropriate, evidence-based PPH prevention with quality-assured medicines.*	**N:** Number of women giving birth in a facility who received a quality-assured uterotonic drug for PPH prevention within the immediate postpartum period (i.e., within 1 minute after birth of the baby or babies), in line with active management of the third stage of labor. Assumes all products available in the government facilities are approved by the relevant national regulatory authorities and thus quality-assured. **D:** Total number of women who gave birth (live births and stillbirths) in a facility. *Disaggregated by the type of uterotonic administered (oxytocin, heat-stable carbetocin (HSC), misoprostol)*	Maternity / Labor & Delivery registers	Add a field in registers, reporting forms, and electronic systems to capture the uterotonic used. Under that field, include uterotonic codes as subcategories: oxytocin, HSC, Misoprostol, None ***Variation from WHO implementation guidance:*** *includes disaggregation by uterotonic type to inform quantification, procurement planning, and learning on drug-specific outcomes.*
PPH Detection	Proportion of women giving birth whose postpartum blood loss was objectively quantified and documented ***Rationale:*** *Ensures early and accurate detection of PPH and documents whether blood loss is objectively measured, informing quality of care and response.*	**N:** Number of women giving birth whose postpartum blood loss was objectively quantified (rather than visual estimation) using a standardized measurement device (e.g., calibrated drape, MaternaWell tray, or other device) and the value documented in clinical records including maternity registers. **D:** Total number of women who gave birth (live births and stillbirths) in a facility. *Disaggregated by:*	Maternity / Labor & Delivery registers	Add columns adjacent to blood loss field in the registers, reporting forms and electronic systems to capture measurement method: Objective measurement (Y/N) If Yes, select device used: Drape, MaternaWell tray, Other device. This enables clear distinction between objective measurements and visual estimates of blood loss. ***Variation from WHO implementation guidance:*** *includes disaggregation by mode of delivery and by measurement device to strengthen*

Intervention/ Topic	Indicator	Definition (N = Numerator, D = Denominator)	Data Source	Guidance for integration into routine data systems
		Delivery type (Vaginal, Cesarean) *Measurement device (calibrated drape, MaternaWell tray, or other device)*		*interpretation of objectively measured postpartum blood loss and support assessment of measurement practices*
PPH Incidence	Proportion of all women who gave birth in the health facility who had PPH ***Rationale:*** *Measures the burden of PPH in facilities, highlighting quality-of-care gaps and informing targeted actions to reduce preventable maternal mortality.*	**N:** Number of women diagnosed with PPH in a facility (i.e. ≥500mL blood loss, or ≥300mL blood loss and any abnormal hemodynamic sign (pulse >100 bpm, shock index >1, systolic blood pressure <100 mmHg, or diastolic blood pressure <60 mmHg) within the first 24 hours after birth)) **D:** Total number of women who gave birth (live births and stillbirths) in a facility	Maternity / Labor & Delivery registers	Explicitly capture PPH cases in registers, reporting forms, and electronic systems. ***Variation from WHO implementation guidance:*** *None*
PPH Incidence (Severe)	Proportion of all women who gave birth in the health facility who had severe PPH ***Rationale:*** *Identifies the severity of PPH to enable timely, appropriate interventions and improve care to prevent maternal deaths.*	**N:** Number of women diagnosed with severe PPH in a facility (i.e. ≥1,000mL blood loss) **D:** Total number of women who gave birth (live births and stillbirths) in a facility	Maternity / Labor & Delivery registers	Capture blood loss volume and severe PPH in the registers, reporting forms and electronic systems. ***Variation from WHO implementation guidance:*** *None*
PPH Treatment	Proportion of women with PPH who received the first-response treatment bundle within 15 minutes of PPH diagnosis (including at least one uterotonic drug and tranexamic acid).	**N:** Number of women diagnosed with PPH who received a first-response treatment bundle (including at least a treatment uterotonic and tranexamic acid) within 15 minutes of diagnosis, in accordance with WHO-recommended emergency management of PPH	Maternity / Labor & Delivery registers	Add treatment codes beneath the PPH treatment indicator field in the registers, reporting forms and electronic systems to indicate which drugs were given for treatment: Uterotonic (Oxytocin/ Misoprostol/ Ergometrine) and TXA ***Variation from WHO implementation guidance:*** *None*

Intervention/ Topic	Indicator	Definition (N = Numerator, D = Denominator)	Data Source	Guidance for integration into routine data systems
	Rationale: *Measures the administration of the treatment bundle and how quickly* women with PPH receive life-saving treatment, reflecting the timeliness of emergency response and quality of care in preventing severe complications and maternal deaths.*	**D:** Total number of women diagnosed with PPH in the facility		
PPH Case Fatality	Proportion of all women diagnosed with PPH who died before discharge ***Rationale:*** *Identifies PPH-related maternal deaths, ensuring accurate documentation and tracking of facility-level outcomes.*	**N:** Number of women diagnosed with PPH who died before discharge from the facility **D:** Total number of women diagnosed with PPH in the facility	Maternity / Labor & Delivery registers	Add fields in registers, reporting forms, and electronic data systems to record final maternal status of PPH cases before discharge (Alive / Died). ***Variation from WHO implementation guidance:*** *Revised indicator specifies deaths occurring before discharge to better reflect in-facility PPH case fatality and quality of PPH management.*

Practical Tips

01 Apply Standard Assumptions When Timing of Interventions is not Captured

*Although some indicators specify the timing of uterotonic or TXA administration, timing data are not routinely captured in routine HMIS registers. Timing of clinical events and interventions is more commonly documented in the partograph, Labor Care Guide, patient case notes and electronic medical records, making routine assessment of timeliness challenging. Assessing timeliness of intervention should therefore rely on complementary methods such as direct observation during supervision and targeted medical record reviews. Where feasible, programs should strengthen documentation—such as by updating registers to include time fields and through supportive supervision or periodic audits—to validate adherence to recommended timing and improve confidence in indicator interpretation.

02 Strengthen Point-of-Care Documentation

- Ensure birth attendants record all PPH-related interventions immediately to reduce omissions.
- Hand-draw additional columns in registers for key PPH indicators not captured in national HMIS tools during transition to formal integration.
- Advocate for updating facility data collection tools (e.g., registers, reporting forms) to clearly capture:
  - Preventive interventions (e.g., uterotonics/HSC)
  - PPH and severe PPH classification
  - Treatments (e.g., uterotonic, TXA, other E-MOTIVE components)

03 Link and Use Commodity Data to Interpret PPH Indicators

- Regularly triangulate PPH intervention data with commodity availability and use (e.g., uterotonics for prevention, calibrated drapes, uterotonics for treatment, TXA) to identify gaps between reported cases and treatments provided.
- Maintain up-to-date stock records and conduct routine reviews to ensure data reflects actual service delivery. Use this combined analysis to quickly detect inconsistencies (such as high PPH cases with low TXA use), prevent stock-outs, and improve both the accuracy and interpretation of PPH indicators.

04 Conduct Routine Data Verification

- Establish strong communication between maternity units, pharmacy and records departments.
- Perform regular cross-checks before monthly reporting between:
  - Labor and maternity registers
  - Stock/commodity records
  - Patient case notes (spot checks)
  - Monthly summary forms (primary source documents for HMIS data reporting)
- Use these checks to identify and correct discrepancies early. Verify that aggregated HMIS reports fully reflect facility-level records to minimize data loss during roll-up.

05 Use Data Visualization for Decision-Making

- Implement a simple maternity ward dashboard updated monthly to track the full PPH prevention, detection and treatment continuum: uterotonic coverage for PPH prevention (by uterotonic type); recorded blood loss; PPH cases and severity; treatments administered; maternal outcomes (including deaths).
- Use dashboards for routine review meetings and performance monitoring.