



SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF GHANA

WORLD POSTPARTUM HAEMORRHAGE DAY · 5 OCTOBER

Postpartum Haemorrhage: The Facts

An advocacy fact sheet for discussion with international, regional and national partners. Global, African and Ghanaian evidence on the leading preventable cause of maternal death.

45,000

women die from PPH worldwide each year

70%

of global maternal deaths occur in Africa

8

women die every day in Ghana from delivery-related complications

Why 5 October

World PPH Day was declared by FIGO, the International Confederation of Midwives and partners, and first observed on 5 October 2025 at the FIGO World Congress in Cape Town. It arose from the WHO Roadmap to Combat Postpartum Haemorrhage 2023–2030, which called for unifying advocacy to keep PPH at the top of the global health agenda.

The inaugural day also marked the launch of the WHO, FIGO and ICM Consolidated Guidelines for the Prevention, Diagnosis and Treatment of Postpartum Haemorrhage — the first time these three bodies have produced a single unified framework on the subject.

From 2025 onward the day is marked annually, each year with a priority theme. It is a moment for collective action, advocacy and accountability, and a reminder that PPH is not only a clinical emergency but a question of equity.

1. What postpartum haemorrhage is

Postpartum haemorrhage is excessive bleeding after childbirth. It is the most dangerous complication of childbirth because of the speed at which it escalates: a woman can bleed from stable to critical in under an hour.

The definition changed in 2025 — and the change matters

The consolidated guidelines now define clinically significant PPH as blood loss of 300 mL or more accompanied by signs of low blood volume, such as low blood pressure or a rapid pulse, OR blood loss of 500 mL, whichever comes first.

The older 500 mL threshold meant that a woman who was already shocked at 350 mL did not formally have

PPH. The new definition recognises that a smaller loss in an anaemic woman — common across much of Ghana — is just as dangerous. It shifts the whole system towards earlier detection, which is where the lives are saved.

Why women die of it

- It is fast. Most deaths occur within hours of birth, often before a woman can reach a facility able to transfuse.
- It is usually not detected early enough. Blood loss judged by eye is systematically underestimated, and the error grows as the loss grows.
- The first response is often incomplete. Uterotonics are given, but the bladder, genital tract tears and retained tissue go unchecked, and escalation comes late.
- Blood is frequently unavailable. Where it is available, it may arrive too late.
- Anaemia multiplies the risk. A woman who starts labour anaemic has far less reserve, and anaemia in pregnancy is common in this setting.

2. The global picture

Fact	Figure
Maternal deaths worldwide, 2023	Approximately 260,000
Of those, deaths attributable to PPH	Nearly 45,000 — close to one in six maternal deaths
Women affected by PPH each year	Millions
Rank among causes of maternal death	Leading cause of maternal mortality worldwide
WHO Roadmap to Combat PPH	Launched October 2023, running to 2030, across research, norms, implementation and advocacy
Consolidated WHO / FIGO / ICM guidelines	Launched 5 October 2025; 51 recommendations covering prevention, diagnosis, treatment, supportive care and health system interventions — 20 new or updated and 31 integrated from existing guidance
Preventability	PPH is both preventable and treatable with timely, evidence-based interventions that already exist

The geography of risk

High-income countries have seen dramatic declines in deaths from PPH. Women in sub-Saharan Africa and South Asia continue to die at disproportionately high rates — despite the availability of effective preventive, diagnostic and treatment measures.

In fragile and conflict-affected settings the risk is highest of all, because skilled birth attendance, life-saving commodities and emergency obstetric care are often simply inaccessible.

This is the central advocacy point for World PPH Day. The science is settled. What differs between a woman who lives and a woman who dies is not knowledge but where she gives birth.

3. The African picture

Fact	Figure
Share of global maternal deaths occurring in Africa	Around 70%
Where PPH deaths concentrate	The majority of maternal deaths from PPH occur in the WHO African Region
Newborn deaths	Deaths in the first month of life are the single biggest driver of mortality in sub-Saharan Africa

Donor financing trend	Donor aid for maternal, newborn and child health in ten sub-Saharan African countries fell by 49% in 2025
Domestic share of health spending	Of every US\$10 spent on health in those countries, just US\$2.10 came from domestic government resources
Projection if the gap is not filled	Over one million additional maternal deaths by 2040
Fact	Figure
SDG 3.1 target	Fewer than 70 maternal deaths per 100,000 live births by 2030

3.1 The evidence that changed regional practice

The E-MOTIVE trial, conducted across 78 secondary-level hospitals and 210,132 women in Kenya, Nigeria, South Africa and Tanzania, tested early detection of PPH using a calibrated blood-collection drape followed by a treatment bundle delivered within 15 minutes of diagnosis.

A 60% reduction, using a plastic drape and a trolley

The trial found a 60% relative reduction in the composite outcome of severe PPH (blood loss of 1000 mL or more), laparotomy for bleeding, or maternal death from bleeding.

The intervention was not a new drug. It was objective measurement of blood loss instead of guessing, and a bundle — uterine Massage, Oxytocics, Tranexamic acid, Intravenous fluids, genital tract Examination and Escalation — delivered together and fast.

The process evaluation found it acceptable and feasible in African secondary-level hospitals. The one condition for success was blunt: access to the necessary supplies and medicines. Where the drugs are not on the shelf, the bundle cannot be delivered.

4. The Ghanaian picture

310

maternal deaths per 100,000 live births (GMHS 2017)

819

maternal deaths recorded in 2024

28–35%

of maternal deaths due to haemorrhage

4.1 Mortality

Indicator	Figure	Source
Maternal mortality ratio	310 per 100,000 live births for the seven years preceding the survey	Ghana Maternal Health Survey 2017, the most recent
Institutional maternal mortality	Rose from 100.22 per 100,000 in 2023 to 101.68 in 2024 — stalled progress	GHS Annual Report 2024
Maternal deaths recorded	875 in 2018; 838 in 2019; 819 in 2024; 504 between January and June 2025	GHS
Daily toll	Eight women die every day from delivery-related complications	Reported at the GHS 2024 Annual Report launch
Highest-burden region	Ashanti records the highest maternal mortality	Parliamentary record
Tertiary referral load	A maternal mortality ratio of 801 per 100,000 at Korle Bu Teaching Hospital over 2021–2023	Published 2025
Distance from target	Maternal mortality remains about three times the SDG target	GHS 2024 Annual Report launch

4.2 How much of it is haemorrhage

National sources differ, because they measure different populations by different methods. All of them place haemorrhage among the top two causes.

Source	Haemorrhage	Hypertensive disorders
Ghana Maternal Health Survey 2017 — direct maternal deaths	29.7%	14.3%
Ghana Statistical Service 2024 brief — audited maternal deaths	28.4%	40.7%
Central Region DHIMS2 surveillance, 2020–2024	34.6%	26.0%
Western Region institutional death audit	31.3%	35.8%

National review of PPH practice, 2014	24% of maternal deaths attributed to PPH alone	—
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Two observations for discussion. First, hypertensive disease is overtaking haemorrhage as the leading cause in several Ghanaian datasets, so a PPH campaign should be framed as part of obstetric emergency readiness rather than as a single-cause appeal. Second, haemorrhage, hypertensive disease and sepsis together account for roughly three quarters of institutional maternal deaths — which means a concentrated investment in three conditions could move the national figure.

4.3 The system around the woman

- **Skilled delivery coverage is falling** — from 60.62% in 2023 to 55.26% in 2024. Active management of the third stage of labour, the single most effective preventive measure against PPH, cannot be delivered to a woman nobody is attending.
- **The underlying drivers are structural** — inequities in primary healthcare access, gaps in quality of care, inadequate data systems, and insufficient workforce capacity at community and primary level.
- **Deaths occur inside facilities** — in Central Region surveillance, 99% of maternal deaths occurred in healthcare institutions. The problem is no longer principally that women fail to arrive; it is what happens after they do.
- **A new commodity is coming** — heat-stable carbetocin, at around GH¢9.00 per dose, is being made available. It does not require a cold chain, which is its decisive advantage in facilities where oxytocin storage cannot be guaranteed.
- **Ghana is an adopter, not a trial site** — the E-MOTIVE trial did not include Ghana. What exists here is implementation, led by partners including CHAI, Jhpiego and International Health Partners. The case to be made nationally is for scale-up of proven care, not for further proof.

The number Ghana does not have

There is no national figure for the incidence of postpartum haemorrhage in Ghana. DHIMS2 records maternal deaths and audits; it does not record haemorrhage events. We can say how many women die of PPH. We cannot say how many women have a PPH and survive, nor what proportion of those who bleed go on to die.

Without that denominator, case fatality cannot be calculated, and the effect of any intervention cannot be demonstrated. Data quality compounds the gap: one regional audit found that records in DHIMS2 matched the audit reports actually held at the Regional Health Directorate in only 9 of 22 districts.

Establishing national PPH incidence and case fatality is a concrete, fundable ask — and a measurable commitment that a government or partner can make on World PPH Day.

5. What works — and already exists

Nothing in this list is experimental. Each is recommended, available, and inexpensive relative to the cost of a maternal death.

Intervention	What it does
Active management of the third stage of labour	A uterotonic within one minute of birth, controlled cord traction and uterine massage — the foundation of prevention at every birth

Objective measurement of blood loss	A calibrated drape instead of visual estimation. Visual estimation systematically underestimates loss, and the error grows as the bleeding worsens
The treatment bundle, delivered together and fast	Uterine massage, oxytocics, tranexamic acid, intravenous fluids, genital tract examination and escalation — within 15 minutes of diagnosis, not sequentially over an hour
Tranexamic acid, given early	Benefit falls as time from onset increases, so it belongs at the start of the response rather than at the end
Heat-stable carbetocin	A uterotonic that does not require refrigeration — decisive where cold chain is unreliable
Anaemia prevention and treatment in pregnancy	A woman who begins labour anaemic has far less reserve when she bleeds
Blood availability and functioning transfusion services	The single commonest reason a treatable haemorrhage becomes a death
Regular simulation drills	Teams fail on sequence and speed, not on knowledge. Drills fix sequence and speed
Referral with pre-alert and a standard handover	So that the receiving team is assembled before the woman arrives, not after
Maternal death and near-miss review, without blame	The mechanism by which each death changes the next case rather than being filed

6. What we are asking for

Tiered by audience, so that each conversation on 5 October ends with a specific and achievable request.

To international partners and funders

- Protect maternal and newborn health financing. A 49% fall in donor aid in a single year, against a projected one million additional maternal deaths by 2040, is the most consequential number in this fact sheet.
- Fund implementation, not further proof. The evidence for early detection and the treatment bundle is settled; what is unfunded is getting it into every delivery room.
- Fund commodities and the training to use them together. Equipment delivered without competence sits unused, and this has been documented repeatedly in Ghanaian facilities.
- Support blood service strengthening, which no clinical bundle can substitute for.

To regional bodies and professional colleges

- Harmonise around the consolidated WHO, FIGO and ICM guidelines, so that a provider trained in one country is trained to the same standard in the next.
- Expand simulation-based training, mentorship and continuing professional development in emergency obstetric care across the region.
- Share implementation learning between adopter countries, so that each does not rediscover the same barriers.

- Advocate jointly for domestic financing, given the contraction in external support.

To national government and the Ministry of Health

- Adopt the consolidated guidelines into national protocols, including the revised PPH definition, and resource the cascade so that current versions reach the bedside.
- Reverse the decline in skilled delivery coverage. This is the prevention measure with the widest reach and it is moving in the wrong direction.
- Guarantee uninterrupted supply of uterotonics, tranexamic acid and calibrated drapes to every facility conducting deliveries, and complete the introduction of heat-stable carbetocin.
- Establish national PPH incidence and case-fatality reporting, so that progress can be measured rather than asserted.
- Strengthen the National Blood Service and facility-level transfusion readiness.
- Invest in the midwifery workforce at community and primary level, which is where the coverage gap sits.
- Resource maternal and perinatal death surveillance and response, and protect its no-blame character.

To facilities, clinicians and midwives

- Give a uterotonic within one minute of every birth, without exception.
- Measure blood loss objectively. Stop estimating by eye.
- Deliver the bundle together and within fifteen minutes of diagnosis, with named roles assigned before the emergency.
- Drill it monthly, and time the drill.
- Review every death and every near miss, and let the findings change next month's training.

7. Key messages and talking points

7.1 For speeches and media

- "Bleeding after childbirth kills around 45,000 women every year, and almost every one of those deaths could be prevented with care that already exists."
- "The science is settled. What decides whether a woman lives is not what we know — it is where she gives birth."
- "In Ghana, eight women die every day from complications of childbirth. Haemorrhage is among the two leading causes."
- "A plastic drape that measures blood loss, and a bundle of treatments given within fifteen minutes, cut severe outcomes by sixty per cent in African hospitals. This is not a new drug. It is doing known things, quickly and in the right order."
- "We are not asking for new science. We are asking for oxytocin on the shelf, blood in the fridge, a midwife at the bedside, and a team that has practised."
- "Donor funding for maternal health fell by half in a single year. If that gap is not filled, the projection is more than a million additional maternal deaths by 2040."

7.2 For community and public audiences, in plain language

- Bleeding heavily after birth is an emergency. It can become dangerous within minutes.
- Give birth where there is a trained midwife or doctor and where help is available if something goes wrong.

- Attend antenatal care, and take the medicines for anaemia. A woman with strong blood survives bleeding far better.
- Know the danger signs: soaking more than one cloth quickly, dizziness, fainting, a racing heart, feeling cold or confused.
- Plan before labour: where she will give birth, how she will travel, who will decide, who will donate blood if needed.
- Donate blood. Blood donation saves mothers.

7.3 Suggested commitments to seek on the day

An awareness day without a commitment is a press release. These are small enough to be agreed in a single conversation.

Audience	A commitment they could make today
Ministry of Health	A date for adopting the consolidated guidelines into national protocols
Ghana Health Service	National PPH incidence and case-fatality reporting added to routine data collection
Regional directorates	Calibrated drapes and the PPH bundle available in every delivery facility in the region
Funders and partners	A costed commitment to commodity security for uterotonics and tranexamic acid
Teaching and regional hospitals	Monthly PPH simulation drills, timed and documented, in every maternity unit
Audience	A commitment they could make today
National Blood Service	A target for blood availability in facilities conducting deliveries
Media	Sustained coverage beyond the day itself, following the national figures annually
The public	A blood donation drive tied to the date each year

8. Sources

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