New guidelines for the prevention, diagnosis, and treatment of postpartum haemorrhage: ending the geography of risk

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On Oct 5, 2025—the inaugural World Postpartum Haemorrhage Day—WHO, the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives launch consolidated guidelines for the prevention, detection, and treatment of postpartum haemorrhage.[1] The symbolism of launching these guidelines at the FIGO President's Session in Cape Town, South Africa, matters but the substance matters more: these guidelines represent a single, unifying standard designed to reduce the equity gap that has long determined who suffers haemorrhage after birth, who is recognised, who is treated, and who survives. The new, consolidated guidelines have been built to work where postpartum haemorrhage burden is highest—where resources are most constrained—and they are designed to be implementable at pace. What is new is clear: a pragmatic prevention hierarchy, pathways for community administration, objective quantification of blood loss with earlier action thresholds, and a standardised first-response treatment bundle.[1]

The consolidation of guidelines is not just tidy editing: it is, above all, an equity intervention. Fragmented recommendations have led to uneven practice and delayed uptake. By aligning the prevention–detection–treatment continuum with enablers (eg, supportive infrastructure), and by also stating what not to do when skills or supplies are scarce, the guidelines make the correct care easier to deliver everywhere. The guidelines recognise where women give birth, who is present, and what commodities are reliably available, and they reduce ambiguity that so often paralyses action in the first minutes of a dire emergency.

A number of important shifts stand out. First, the prevention package moves from best available to available best. Oxytocin 10 IU given intramuscularly or intravenously remains the first-line treatment where quality-assured supply and a reliable cold chain exist; heat-stable carbetocin (100 µg given intramuscularly or intravenously) is preferred where the cold chain is unreliable. Oral misoprostol (400–600 µg) is the alternative only in cases where injections and a reliable cold chain are not feasible. That pragmatic hierarchy reduces vulnerability to stock-outs and power cuts, which remain a daily reality in many settings with a high burden of postpartum haemorrhage. It also allows national programmes to choose confidently between good options rather than be immobilised by an ideal they cannot reliably deliver.

Second, the guidelines meet women where they are. In settings with high rates of community birth or where skilled birth attendants are scarce, the guidelines endorse administration of misoprostol by trained community or lay health workers. Where skilled personnel are absent, antenatal distribution for self-administration is considered an option, provided that there is appropriate counselling, monitoring, and evaluation. Thus, these guidelines reposition postpartum haemorrhage prevention as something that can be delivered safely and effectively beyond a labour ward.[2]

Third, the detection of postpartum haemorrhage, which is a major roadblock to effective management, shifts decisively from eyeballing to objective measurement. Routine quantification of blood loss using calibrated drapes at vaginal birth, paired with early and clear thresholds for action, is normalised. The first 2 h postpartum receive heightened attention in the new guidelines. Importantly, a measured blood loss of 300 mL or more alongside any abnormal vital signs, such as tachycardia or hypotension, are treated as a signal to intervene, not to watch and wait until the conventional threshold of 500 mL is met. Normalising accurate and objective quantification (eg, using calibrated drapes) with earlier action thresholds serves as an intervention in its own right, reducing missed diagnoses and triggering timely treatment. This revision of the diagnostic criteria is a major change: it reduces diagnostic bias—particularly in crowded labour wards—and overcomes the limitations of visual estimation, which often underdiagnoses haemorrhage. This new threshold will provide a common language for teams to act rapidly and decisively.[3]

As soon as the diagnosis is made, treatment is protocolised as a first-response bundle designed to

Panel: **Next steps to effectively prevent, diagnose, and treat postpartum haemorrhage**

- Governments and ministries of health rapidly adopt and adapt these guidelines nationally, with explicit equity targets for the lowest-performing regions and facilities
- Governments and ministries of health secure quality-assured commodities:
  - Prevention (eg, oxytocin as first line, heat-stable carbetocin where cold chain is unreliable, and misoprostol where injections or cold chain are not feasible)
  - Diagnosis (eg, calibrated drape or weighing scale; blood pressure measurement devices; and a method for pulse counting, whether an oximeter where possible, or a timer)
  - Treatment (eg, oxytocin as first line, ergometrine or ergometrine-containing combinations where not contraindicated as second line, misoprostol where injections or cold chain are not feasible; tranexamic acid; intravenous crystalloid such as 0·9% sodium chloride [normal saline]; and a functional blood transfusion system)
  - Supportive care (eg, oral and intravenous iron)
- Health regulators enable task-sharing and responsible self-care (eg, license community and lay administration of misoprostol where births occur outside facilities, with monitoring and evaluation; and ensure that midwives' regulatory scope of practice permits them to administer the necessary drugs)
- Health facility managers institutionalise training and simulation and drills; embed job aids; and track a small set of ward-level indicators regularly
- Health facility managers undertake death and near-miss reviews regularly; generate simple, publicly accessible dashboards; and ensure resources are linked to improvements in process and outcome

work across settings. The MOTIVE bundle (uterine massage, oxytocic drugs, tranexamic acid, intravenous fluids, examination, and escalation) is administered as a package and without delay.[5] The time-critical benefit of tranexamic acid within 3 h of postpartum haemorrhage diagnosis is unambiguous because the evidence of diminishing effect with delay is clear.[4] Such evidence-based treatment bundles reduce unwarranted variation and protect against omission of any of these crucial interventions. They make doing the right thing timely and easy, particularly where staffing is low and turnover is high.

The importance of good antenatal and postnatal care in mitigating risk factors for bleeding is at the core of these guidelines. They address anaemia as both a driver of risk and a determinant of recovery. The guidelines recommend daily oral iron and folate in pregnancy, support alternate dosing where side-effects reduce adherence, and prioritise intravenous iron when rapid correction is necessary or oral therapy fails, provided systems are in place to recognise and manage rare cases of anaphylaxis. Postpartum, there are context-specific recommendations for oral iron, or intravenous iron where speed or intolerance demands it. In regions where anaemia is endemic, these are lifesaving equity levers when implemented into routine care.

Importantly, the guidelines avoid harm by discouraging ineffective or unsafe practices, such as routine or liberal episiotomy at spontaneous vaginal birth, sustained uterine massage for haemorrhage prevention after prophylactic oxytocin, early cord clamping (<1 min) without neonatal indication, and controlled cord traction if a skilled attendant is unavailable. Where controlled cord traction is recommended for use (by skilled attendants following a vaginal birth or during a caesarean section), its benefits are balanced with prerequisites.

Escalation of care is framed to match resources without resignation to constraints. For refractory bleeding, the guidelines embrace temporising strategies that are feasible in most settings, such as bimanual uterine compression, external aortic compression, and the use of non-pneumatic anti-shock garments, while placing conditionality around uterine balloon tamponade based on the uncertainty of underpinning evidence. Uterine balloon tamponade is appropriate for bleeding due to uterine atony only in cases where first-response bundles are reliably implemented, other causes of bleeding have been reasonably excluded, trained personnel are available, maternal status can be monitored, and immediate recourse to surgery and access to blood products is possible. That conditionality protects women from a false sense of security and protects health systems from investing in technologies without the support they require. Uterine artery embolisation is recommended where resources allow, but safe surgical interventions must be available as a last resort in all settings.

Guidelines by themselves do not save lives; people and systems do. These guidelines tie clinical action to a moment: World Postpartum Haemorrhage Day on Oct 5 will exist to keep this agenda publicly visible and annually accountable. The day responds to, and operationalises, the Roadmap to Combat Postpartum Haemorrhage (2023–2030) and mobilises health ministries, professional societies, research institutions, industry and innovators, funders, civil society, and women's groups to address shared priorities.[6] World Postpartum Haemorrhage Day will create annual touchpoints to track progress and correct the course, as an advocacy infrastructure designed to serve the clinical one.[7] The next steps are not a mystery: we must adopt and adapt fast (panel).

Postpartum haemorrhage is about time—to recognise, to act, and to escalate. The consolidated guidelines save time where this saves lives. The equity test now is whether health-care systems can move fast enough to implement these guidelines. Women die when they do not.

SA reports honorary and unpaid advisory or board positions at the South Asian Federation of Obstetrics and Gynaecology (Maternal and Perinatal Health Committee), the Society of Obstetrics and Gynaecology of Pakistan (Academic Board and Executive Committee member), and the Association for Mothers and Newborns (Vice President). All other authors declare no competing interests.

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See **Online** for appendix

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