Misoprostol for Postpartum Hemorrhage: Advocacy, Approval, Access

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Healthy lives. Measurable results.
Misoprostol for Postpartum Hemorrhage: Advocacy, Approval, Access

Amy Boldosser-Boesch, Family Care International
Webinar, May 8th 2013
Why Misoprostol for PPH?

- PPH is leading cause of maternal death
- Conventional uterotonics for PPH prevention and treatment are largely unavailable or not feasible
- Misoprostol is safe and effective: easier to use, available, low cost, require few skills
Advocacy: Definition

Advocacy = Change

- National and political commitments
- Policy & budget implementation (policy match national commitments; policy adequately funded and implemented)
- Knowledge and awareness among communities, women and families
- Public perceptions and attitudes
Advocacy for Misoprostol for PPH
Why needed?

- Lack of national commitment and leadership

- Supportive policies (EML, STGs) not in place, not evidence based

- Supportive policies not translated into improved availability of misoprostol in health system

- Prevailing misconceptions/resistance among policy makers & health providers
Strategy Linked to Outcomes

**Advocacy Strategy**
- Enlist champions and advocates
- Develop messaging on lives saved
- Disseminate evidence-based information
- Monitor budgetary commitments, forecasting and supply

**Outcome**
- Supportive policies in place
- Misconceptions addressed, change in attitudes
- Improved implementation of policies
- Reliable supply and distribution of drug
Introducing misoprostol for postpartum hemorrhage in Tanzania

From Policy to Practice

Nuriye Nalan Sahin-Hodoglugil, MD, MA, DrPH
Associate Medical Director
Misoprostol in Tanzania (2005)

- Lack of local evidence of feasibility and efficacy
- Emerging guidance on standardized regimes for use
- A controversial product in a country with a restrictive abortion law
- Use in PPH not legitimimized in policies
  - Off-label use, no dedicated registered product
  - Not on national EML or WHO EML for PPH
Strategies for action

- Identify credible product champions
- Actively engage professional medical associations, the MOHSW and other stakeholders
- Conduct operations research to generate local evidence
  - Demonstrate feasibility of community level use for PPH prevention via ANC distribution
  - Focus on PPH prevention, not treatment at the community level
Strategies for action, continued…

- Develop clear policies and guidance for use, defining where and by whom.
- Use evidenced-based information to guide training and advocacy efforts.
- Shift the dialogue from an “abortion drug” to “an essential medicine”.
- Register a dedicated product with the national drug authority.
  - Permit the importation, distribution and sale for PPH indication in the public & private sectors.
Key policy and program milestones

- Misoprostol Registered for PPH (2007)
- Standard Treatment Guidelines/EML (2007)
- Guidelines for Use of Uterotonics in AMTSL (2008)
- Emergency Obstetric Care (EmOC) Job Aids (2008)
- VSI, IHI, Bixby Operations Research (OR) on misoprostol distribution through ANC visits (2009-2010)
- Misoprostol registration amended to include treatment of incomplete abortion and miscarriage (Jan 2011)
- Presentation of OR Results to MOHSW (Feb 2011)
- Regional Experts’ Summit, Dar es Salaam (July 2012)
As of 2012, few providers trained on misoprostol

Knowledge of and exposure to policy

53% report knowledge that misoprostol for PPH prevention is included in the Tanzania standard treatment guidelines.

48% of facilities have a copy of the EmOC Job Aids.

41% of facilities have a copy of the Guidelines for Use of Uterotonics in Active Management of the Third Stage of Labour.

Strategies for success

• Keep MOHSW actively engaged and informed
• Foster strong partnerships and lead from behind
• Leverage regional differences (e.g., Zanzibar)
• Convene national & regional thought leaders to share best practices, foster collaboration, incite friendly competition & establish a network
Priority areas for action

1. Disseminate national standard treatment guidelines and the EML policies widely

2. Expand trainings and generate demand for misoprostol among health providers and pharmacists
Asante! Thank you!

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May 8, 2013
INTRODUCING MISOPROSTOL FOR PPH: THE UGANDA EXPERIENCE

Dr. Moses Muwonge

8th May, 2013

Advocacy, Approval, Access Webinar
### Uganda: Status of Maternal Health

<table>
<thead>
<tr>
<th>Year</th>
<th>2000-2001</th>
<th>2006</th>
<th>2011</th>
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<tr>
<td>Maternal Mortality Ratio</td>
<td>524</td>
<td>418</td>
<td>438</td>
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Approximately 25% of deaths are due to Postpartum Hemorrhage (PPH)

Source: Uganda DHS

- Registered only for treatment of peptic ulcers

- Policies: Clinical Guidelines specified treatment for peptic ulcer disease

- No guidelines and plans for use of misoprostol

- No quantification and procurement

- Misoprostol restricted for use at referral/specialist levels of health system
Introduction of Misoprostol in Uganda: Advocacy strategies

- Need for compelling data for registration
- Need for political support for change of government policy on misoprostol
- Need for a change agent within the Ministry of Health
- Financial support
Political Support

- Partners in Population and Development (PPD ARO) played a critical role to soften the political ground (Dr. Jotham Musinguzi)

- The Minister of Health was briefed about importance of misoprostol and his support proved critical
Internal Support within MOH

The Assistant Commissioner RH was very supportive:

- Actively advised advocates how to navigate the delicate issue of misoprostol
- Navigated critical issue of abortion vs. use for PPH (abortion is illegal in Uganda)
- Mobilized key stakeholders within the MCH cluster
- Garnered support for funds to procure misoprostol
Technical Support

- VSI provided critical information for registration (experience with Tanzania, Nigeria, Nepal)

- PACE Uganda (Affiliate of PSI) provided a launch pad for coordination of registration, development of guidelines and pilot project

- Establishment of a steering committee

- Association of Uganda Obstetrician and Gynecologists developed guidelines
Enabling factors

- VSI had successfully registered use of misoprostol for PPH in Nigeria, Tanzania and Nepal
- Support from the Association of Uganda Obstetricians and Gynecologists
- Financial support through VSI to procure first consignment of misoprostol
- Use of media and support of more than 700 community members in the 10 pilot districts
Outcomes

- June 2008: misoprostol tablets registered in Uganda for legal importation, distribution, marketing for PPH

- December 2008: change of policy, clinical guidelines developed

- June 2009: launch of misoprostol program in public sector in 10 districts

- For the first time, government procured misoprostol for the public sector (FY 2009/10)

- Misoprostol included on the distribution list (National Medical Stores List)

- January 2013: Misoprostol included on the Essential Medicines and Health Supplies list, Uganda Clinical Guidelines
Challenges

- Need for policy change to scale up to community level
- Need to deepen demand creation (social marketing for misoprostol to rural clinics)
- Build capacity of health workers
- Align national guidelines with WHO guidelines whereby first line is oxytocin, second line is ergometrin and then misoprostol
Lessons learned

Introduction of any under utilized method in public sector requires:

- political will
- technical expertise
- change agents within the public sector
Thank You!
Increasing Access to Misoprostol in Somaliland

Manuela Tolmino, Health Services Technical Advisor, PSI Somaliland
Status of Maternal Health in Somaliland

- MMR: 1,044 /100,000 live births
- PPH: one of the leading causes of maternal death
- Health system challenges: lack of proper cold chain in low resourced Health Facilities (HFs)
Introducing Misoprostol in Somaliland Health Facilities

- **Program goal**: contribute to the reduction in maternal morbidity and mortality related to PPH in Somaliland

- **Process**
  - **2007-2008**: Meetings held with MOH, partners, international organizations and health institutions
  - **2009**: MOH approval
  - **2009-2013**: Phased implementation plan for distribution in Health Facilities

- **Funded by**: Governments of UK and Netherlands
Project Implementation Plan

- **Initial phase (2009):** Training health workers on AMTSL
  - 690 health providers trained

- **Pilot Phase (2010):** One maternity hospital in Hargeisa
  - Joint monitoring and supervision with MOH every two weeks
  - Monitoring stock by hand count
  - Approval from MOH DG of every stock released

- **Expansion Phase (2011-2012/2013):** All HFs with delivery services and qualified health providers (60 HFs).
  - Quarterly monitoring and supervision
Behavior Change Communication

- BCC on safe motherhood and health facility delivery through interpersonal communication sessions
- Branded communication targeting health providers
Key Achievements

- **13,102 women** have taken misoprostol for prevention or treatment of PPH (between April 2010 to March 2013)
- **1,139 health providers** trained on AMTSL through health institutions and universities (between 2009-2013)
Challenges and Barriers for Program Implementation

- Misoprostol not included in the National Essential Medicine List (EML) 2006 and Standard Treatment Guidelines (STG) 2007
- Initial resistance from health authorities: negative perception of misoprostol
- Refusal by MOH to distribute misoprostol at community level
- Difficult to build health providers’ capacity (time and resources)
Lessons for Successful Program Implementation

- From initial pilot to wider distribution: ability of PSI to roll out and monitor misoprostol use for PPH
- Support from Venture Strategies during the preparatory work
- Support of prominent personality/champion
- Strong focus on AMTSL training
- Involvement of MOH during all phases of implementation plan
Advocacy: What is still needed?

National Essential Medicine List and Standard Treatment Guidelines under revision but resistance still exists for inclusion of misoprostol for PPH

UNHCR, M. Deghati, August 2009
What can be done?

- Continue to share evidence on PPH as major cause of maternal death, and use of misoprostol as effective alternative in low-resources setting
- Document and share PSI’s program and achievements
- Use evidence-based advocacy at the Somalia Health Sector Coordination and national level
- Engage medical associations and INGOs to exert pressure on policy makers
- Increase exposure of MOH and medical associations to other similar contexts (i.e. study tours)
Thank you!
THANK YOU!

Sign up here: http://knowledge-gateway.org/misoprostol/

For more information on misoprostol for PPH, relevant journal articles, news stories, project updates, and upcoming events.