EAST AFRICA

Regional Perspectives on Challenges and Opportunities:

Background

Postpartum hemorrhage (PPH) remains a major cause of maternal mortality, accounting for nearly one quarter of deaths worldwide.[1] Between 1997 and 2007, one third (34%) of maternal deaths occurring in Sub-Saharan Africa were due to PPH.[2]

Most cases of PPH can be effectively prevented or treated with known clinical interventions and technologies. Oxytocin is the most widely used drug for prevention and treatment of PPH. Misoprostol, an oral tablet originally developed to treat gastric ulcers, is also effective in preventing and treating PPH. It is particularly useful in settings with limited refrigeration, and where skilled health professionals and oxytocin, the current standard of care, are not available or accessible.

Family Care International (FCI) is working with Gynuity Health Projects and partners to promote better understanding, use, and acceptance of misoprostol for PPH prevention and treatment at the global, regional, and country levels. An important step in this process is to identify the challenges, barriers, and opportunities to more widely introduce misoprostol for this indication. FCI commissioned global and regional mapping surveys to identify:

- Key advocacy goals, messages, and strategies used by organizations working on misoprostol for PPH
- Advocacy and policy priorities and challenges
- Opportunities for collaboration, advocacy, and policy change at the global, regional, and country levels

This report summarizes the findings of the East Africa regional survey conducted between February and March 2011. Ten organizations working at the regional level described their work on

misoprostol, shared their motivations for involvement in misoprostol work, discussed prevailing barriers to increasing access to and availability of misoprostol for PPH, and identified strategies for addressing them.

Key reasons for investing in misoprostol for PPH

Interviewees underscored the potential of misoprostol to prevent PPH, particularly among women who deliver at home, as the primary reason for investing in this intervention. Most of the interviewees are involved in various activities related to misoprostol, including research, advocacy, training, and policy making, with various organizations taking different approaches. For example, one organization advocates for skilled birth attendance and identifies misoprostol for PPH as a "stop-gap" measure for those unable to access skilled birth attendance in time. Another organization focuses on misoprostol for PPH because many countries in sub-Saharan Africa are using misoprostol and there is a need to generate evidence on its safety and efficacy for PPH.

[1] http://www.who.int/selection_medicines/committees/expert/18/applications/Misoprostol_application.pdf
[2] Countdown to 2015: Maternal, Newborn & Child survival, Decade Report (2000-2010)

Perceived barriers to expanding use of misoprostol for PPH

Interviewees identified a range of barriers to expanding use of misoprostol for its PPH indication; these are highlighted below in order of importance, followed by quotations from interviewees. (Note: these are the respondents' perceptions and may not be supported by the available evidence.)

Association of misoprostol with abortion: All the respondents indicated that misoprostol's indication for abortion makes policy makers apprehensive that it will be used for this purpose if made widely available for PPH.

"Changing the mindset of the population to see misoprostol differently is a challenge. The same dosage is used for preventing PPH as far as procuring abortion, and our population is highly conservative."

Lack of clear guidance on the use of misoprostol for the prevention of PPH: According to the World Health Organization (WHO) guidelines on the prevention and management of PPH, misoprostol is recommended in settings where no skilled health worker or oxytocin is available. Interviewees indicated that WHO guidelines are not clear enough for policy makers to make decisions on its use for PPH.

"Policy makers feel there is insufficient evidence on dosing levels and side effects for the use of misoprostol for PPH."

[3] "Clarifying WHO position on misoprostol use in the community to reduce maternal death." World Health Organization Department of Reproductive Health and Research. Geneva. 2010. http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.11_eng.pdf

Controversy over the cadre of staff to administer misoprostol: There is lack of consensus as to which cadre of health workers can safely and effectively administer misoprostol for PPH. The WHO and most East African governments contend that it should be administered only by skilled birth attendants.

"Administration of misoprostol and deliveries should not be done by traditional birth attendants. In remote areas, community midwives who are trained can safely administer misoprostol for PPH."

However, others interviewed asserted that trained community health workers (CHWs) can administer misoprostol to women.

"If CHWs can give injectable Depo-Provera, they can also administer misoprostol with some training. The cadre of health worker and their level of training have nothing to do with it."

Concern that distribution of misoprostol in communities will increase home births: Some respondents believe that distribution of misoprostol at the community level will deter women from delivering in a health facility.

Weak accountability mechanisms in East African health systems: Most interviewees noted that it might be difficult to closely monitor misoprostol distribution by CHWs at the community level.

"CHWs are not in formal health employment, nor subject to disciplinary regulations of the formal health sector. Use of misoprostol outside of this sector provides opportunities for potential abuse."

Insufficient evidence on the safety of misoprostol for PPH: Half of the respondents believe that there is insufficient data to convince policy makers to scale up the use of misoprostol for PPH, and that more evidence is needed on side effects and proper dosage.

"We need better research in quantifying the parameters involved in PPH, such as amount of bleeding. The current measurements for bleeding are very subjective."

Other respondents indicated that the current evidence is sufficient to support misoprostol's safety and efficacy in preventing and treating PPH.

"There is sufficient data for misoprostol to enter communities as a uterotonic. What is needed is operational research to test the feasibility and effectiveness of training providers at the community level."

Strategies for action

Respondents provided a range of strategies for addressing the prevailing barriers to wider acceptance and use of misoprostol for PPH. These included the following:

- Conduct operations research to provide evidence on the feasibility of introducing misoprostol within the health system and at the community level
- Provide updated and clear guidelines on misoprostol's use for PPH, specifically addressing its use at the community level, and specifying the cadre of provider who can administer the medication
- Use evidence-based information, advocacy, and training to address the prevailing misconceptions and beliefs surrounding its use

Conclusion: Opportunities in the region

As the findings from this survey indicated, a conservative policy and social environment make it challenging to widely introduce misoprostol for its PPH indication. Most countries in East Africa have restrictive laws against abortion, and intense social stigma increases the difficulty of convincing policy makers that misoprostol will not be used for indications other than PPH.

However, there do exist opportunities for addressing these barriers through research, policy/advocacy, and in program implementation:

- Operational research in sub-Saharan Africa can demonstrate the safety, effectiveness, and impact of misoprostol once it is scaled up and distributed by lower-cadre staff.
- Community-level distribution of misoprostol can be used as an opportunity to share health messages on skilled birth attendance and birth preparedness to pregnant women.

Resources produced by participating organizations

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Prata N, Mbaruku G, Grossman A, Holston M, Hsieh K. Community availability of misoprostol: is it safe? *African Journal of Reproductive Health*. 2009; 13 (2):117-28.

Grossman A, Graves A, Rwamushaija E, Park C. Misoprostol for safe motherhood: one tablet, two life saving indications. *African Journal of Midwifery and Women's Health*. 2010;4(3):121-5.

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Prata N, Mbaruku G, Campbell M, Potts M, Vahidnia F. Controlling postpartum hemorrhage after home births in Tanzania. *International Journal of Gynecology and Obstetrics*. 2005;90 (1):51–5.

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WHO. Clarifying WHO position on misoprostol use in the community to reduce maternal death. Geneva: Department of Reproductive Health and Research; 2010.

WHO, UNICEF. Countdown to 2015 decade report (2000-2010): taking stock of maternal, newborn and child survival. Washington DC: WHO Press; 2010.

Organizations surveyed

DKT International (Ethiopia)
East Central and Southern Africa College of Nursing
East Central and Southern Africa Health Community
East Central and Southern Africa Obstetrics and Gynecology Society
Jhpiego Ethiopia
Jhpiego Kenya
Regional Center for Quality of Health Care (Kampala, Uganda)
USAID/East Africa
Venture Strategies Innovations (Kenya)
WHO, Regional Office for Africa

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