Misoprostol *for*
POSTPARTUM
HEMORRHAGE

LATIN AMERICA AND THE CARIBBEAN

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] Evidence indicates that PPH causes an estimated 21% of all maternal deaths in Latin America and the Caribbean (LAC).[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 LAC regional survey, conducted between December 2010 and February 2011. Thirteen organizations working at the regional level described their activities, 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

There was general agreement among participants that the main reason for investing in misoprostol for its PPH indications is to reduce maternal mortality. Most interviewees specifically mentioned the substantial proportion of maternal deaths in LAC that occur among women who do not have access to quality obstetric care (e.g., skilled attendance and emergency obstetric care).

Perceived barriers and strategies for action

Participants identified a range of barriers, and specific strategies for addressing them, in increasing access to and use of misoprostol for PPH in LAC. Reported barriers are listed below, followed by a quote from an interviewee.

Association with abortion: Strong abortion stigma, driven by Catholic influence, affects misoprostol availability. The fear of its use for abortion plays a role in drug distribution, and sales and availability of misoprostol are often limited to hospitals and large maternity clinics.

[1] http://www.who.int/selection_medicines/committees/expert/18/applications/Misoprostol_application.pdf
[2] Khan KS, Wojdyla D, Say L, Gülmezoglu AM, Van Look PFA. WHO analysis of causes of maternal death: a systematic review. *The Lancet*. 2006;367(9516):1066-1074.

Ministries of Health (MOH) limit misoprostol to referral hospitals, fearing that it will be used as an abortifacient if made available at primary health posts. Participants also noted that government decision makers fear that misoprostol will be used for abortion in high-risk situations, such as in a late-stage pregnancy. Many health providers do not use it in order to avoid stigma from colleagues.

Strategy proposed by respondents:

- Offer values-clarification workshops that allow health providers to reflect on their own values and to consider modifying their health practice to include misoprostol for PPH.

Low acceptance among health providers: Lack of experience with its use, and fear of being singled out by other providers for using a drug associated with abortion were given as possible explanations for low acceptance of misoprostol among health providers. One respondent explained that misoprostol use for prevention of PPH was difficult to advocate at hospitals because many physicians believe that all the resources (human and material) necessary for treatment are readily available, therefore making misoprostol irrelevant.

"The Church's weight is strong and there are only a few providers that argue misoprostol use for PPH is solely a medical topic and not one of religious or personal preference."

"Misoprostol is not used because of fear due to lack of experience with its use, fear to be singled out by other providers, fear because it's a drug that has to do with abortion."

Strategies proposed by respondents:

- Identify influential health professionals who shape providers' curricula and training, such as university professors, to advocate for misoprostol for PPH.
- Work with universities to include misoprostol for PPH in curricula for physicians, nurses, and other mid-level health providers.
- Form a group of technical experts to convey evidence-based, consistent, and simple messages on the use of misoprostol for PPH.

Policy and legal issues: In many countries, misoprostol is not included in national strategies and guidelines, essential drug lists, and clinical norms. Furthermore, there are also legal restrictions on the level of health provider who can prescribe the medication. For example, physicians have sole legal authority to administer misoprostol, even though a great proportion of deliveries are attended by nurses or midwives.

- Identify influential spokespersons who can lead national discussions and dialogues, and advocate for misoprostol's acceptance and approval for PPH.

- Strengthen ob-gyn knowledge and support their role as advocates in fora where drug-related policies are decided.
- Strengthen civil society role in promoting government accountability mechanisms (i.e civil society can ensure that supportive policies are implemented with the needed budgetary commitments).

"There are countries within the region that have very restrictive laws regarding abortion and this directly affects availability of misoprostol, regardless of its use."

Strategies proposed by respondents:

- Provide government decision makers with evidence-based data on the role of misoprostol in prevention and treatment of PPH, using consistent messages in the region and within countries.
- Open dialogues with decision makers (legislators, MOH officials) to allow for discussion and reflection on controversial issues.

Product characteristics: A range of product-specific issues were raised by respondents; they include problems with labeling, quality concerns, and the high cost of the drug.

Strategies proposed by respondents:

- Package misoprostol specifically as a "postpartum" pill; the branding would include tablets in a different color and clear labeling for PPH use.
- Promote registration of misoprostol at the country level as a potential strategy to lower cost.

Interest group influence: Physicians and pharmaceutical companies were identified as groups whose interests represent barriers to increasing misoprostol use for PPH. Physicians in some settings are opposed to building capacity of mid- or low-level health providers for fear that their own workloads, and thus incomes, will decrease. Further, pharmaceutical companies are not interested in marketing the drug because of low profitability.

Strategies proposed by respondents:

- Involve women and women's groups in promoting advocacy around misoprostal's use for PPH. This could be a women-owned intervention, particularly in countries that have strong women's groups and networks.

Low regional priority: A number of factors make the use of misoprostol for PPH a low priority for the LAC region, including:

- A high physician-to-population ratio in the region makes use of the drug a "harder sell," considering that the main advantage of misoprostol is its use in remote settings with limited access to skilled health providers.
- A number of countries, such as Argentina, Uruguay, Chile, and Colombia, have high percentages of institutional deliveries, with oxytocin routinely available in health facilities.

Strategy proposed by respondents:

- Focus advocacy in countries with high maternal mortality and limited access to health facilities or skilled health providers.

Availability of evidence: Most respondents indicated that research on misoprostol was sufficient. Some felt that additional research was necessary.

Strategies proposed by respondents:

- Conduct research in LAC region on cost-effectiveness and its use in community settings
- Compile successful experiences and lessons from the LAC region for advocacy with key decision makers.

Use by traditional birth attendants (TBAs): Many respondents felt that TBAs should be able to administer misoprostol at home births. Some expressed concern as to whether they would be able to correctly use it. It was noted that training and investment in TBA-driven initiatives has not resulted in maternal mortality reduction.

"The problem is that the scientific evidence has not reached the Ministries of Health.

There is no evidence on costs and cost effectiveness.

More research is needed on community use of misoprostol."

Conclusion: Opportunities in the region

Respondents identified concrete opportunities for advocacy to increase understanding and use of misoprostol for its PPH indication. These include:

- Strong networks of physicians' and women's groups
- Long history of inter-agency collaboration on health
- Successful experiences of introducing the drug in countries including Chile and Argentina

Interviewees expressed interest in scaling up efforts to promote misoprostol use for PPH. This would depend on the availability of funds, the possibility of inter-agency collaboration, and the generation of additional evidence.

Misoprostol for PPH resources produced by participating organizations

Fescina RH, De Mucio B, Díaz Rossello JL, Martínez G, Serruya S. Sexual and reproductive health: Guides for the PHC Focused Continuum of Care of Women and Newborns, 2010, Second edition, Montevideo, Uruguay (CLAP/SMR publication 1573). Available at: http://www.scribd.com/doc/35919139/Atencion-de-La-Madre-y-Recien-Nacido

CLACAI, Ipas. Misoprostol and Medical Abortion in Latin America and the Caribbean, 2010. Available at: http://www.ipas.org/□/media/Files/Ipas%20Publications/MISOLAC2E10.ashx

Pathfinder International, Peru. Training Module: "Atención integral de la hemorragia intra y postparto y el uso de los trajes anti shock no pneumaticos." First ed. November 2009.

Ministry of Health and UNFPA, Colombia. Flow diagrams for the management of severe maternal morbidity. PowerPoint.

Organizations surveyed

Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX)

Federación Latinoamericana de Sociedades de Obstetricia y Ginecología (FLASOG)

Latin American Center for Perinatology, Women and Reproductive Health, Pan American Health Organization, Regional Office / WHO

Centro Rosarino Estudios Perinatales (CREP)

FIGO

Hebron Pharmaceutics

Pathfinder International

Society of Obstetricians and Gynecologists of Canada

UNFPA, Latin America and the Caribbean Regional Office

UNICEF, Latin America and the Caribbean Regional Office

United States Agency for International Development (USAID)

For further information about this initiative, please contact:

FAMILY CARE INTERNATIONAL

588 Broadway, Suite 503
New York, NY 10012 USA
pphproject@familycareintl.org

www.familycareintl.org

Gynuity HEALTH PROJECTS

15 East 26th St, Suite 801
New York, NY 10010 USA
pubinfo@gynuity.org

www.gynuity.org

Photo credits: Joey O'Loughlin