Examples of successful advocacy on misoprostol for postpartum hemorrhage

CASE STUDY 1:
INCLUSION OF MISOPROSTOL ON ESSENTIAL MEDICINES LIST FOR PPH IN KENYA

In 2016, the Kenya Essential Medicines List (KEML) included misoprostol for the first time in the oxytocic’s section, indicating its use for the prevention and treatment of postpartum hemorrhage (PPH). The inclusion resulted from various factors including 1) strong collaboration among key stakeholders who formed a taskforce to lead the advocacy campaign 2) The development of a targeted advocacy strategy detailing appropriate messages for different target audiences 3) Regular follow-up with the primary decision-makers and 4) the use of strong evidence. Timing was also very important. Following the World Health Organization’s (WHO) release of its updated Model List of Essential Medicines in 2015, the government of Kenya began updating its own EML, which was an opportune time to influence the inclusion of misoprostol for PPH on the KEML.

While the inclusion of misoprostol in the KEML is an important step, continued advocacy is needed to ensure that high-quality misoprostol is available to women when needed and that it is administered correctly. Support needs to be provided to the national procurement authorities to acquire the right dosage and formulation, ensure that the government has adequate funds allocated to stocking misoprostol in public health centers, and update standard treatment guidelines and pre- and in-service health training curricula.

Click here for a blog on the advocacy success.

CASE STUDY 2:
GOVERNMENT ENDORSEMENT OF NATIONAL POLICY FOR COMMUNITY-BASED DISTRIBUTION OF MISOPROSTOL IN MADAGASCAR

In 2014, Madagascar took significant steps to formalize a national policy for community-based distribution of misoprostol. In September 2014 the government endorsed the intervention through the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Action Plan. This action plan includes a roadmap focused on the introduction and scale up of use of misoprostol for the prevention of PPH and chlorhexidine for the prevention of newborn infection. This was followed by the release of a “ministerial note” from the Minister of Health, which authorizes community-based distribution of misoprostol for prevention of PPH when oxytocin is not available. A national Technical Working Group (TWG) was set up and played an instrumental role in the development and adoption of the roadmap, and in facilitating initial implementation of misoprostol pilot studies in country. The TWG included representatives from various MOH departments, United Nations agencies such as WHO and UNFPA, donors including USAID, and project staff from international nongovernmental organizations (NGOs). Concerns that misoprostol can be used for abortion led to initial resistance from influential stakeholders and was a barrier to the process. This concern was addressed through targeted advocacy by members of the TWG, who used international and local evidence to champion the need for a community-based solution to PPH. Additionally, the TWG developed specific guidelines for implementation to help prevent misuse of misoprostol at the community-level and reduce concerns of critics for example the guidelines dictate that Community Health Volunteers (CHVs) were to wait until the 36th week of pregnancy to distribute the drug and document the woman’s name in their register as the recipient of three misoprostol tablets. Coupling misoprostol with the non-controversial chlorhexidine for prevention of newborn infection in a community-based intervention package helped to destigmatize misoprostol. The TWG continues to advocate for the scale-up of misoprostol as the MOH develops a national introduction and implementation plan.

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CASE STUDY 3:
CHANGES IN POLICIES, PROTOCOLS, AND REGULATORY ENVIRONMENTS FOR MISOPROSTOL AT THE PROVINCIAL LEVEL IN PAKISTAN

Between 2012–2014 Mercy Corps (an international NGO) initiated an advocacy program with the aim of reducing the high rates of maternal mortality in two provinces of Pakistan. At the time of the campaign misoprostol was widely available but not used for PPH management. The initiative led to inclusion of misoprostol into the province-specific essential drugs list, development and endorsement of clinical protocols for misoprostol by provincial health departments and the inclusion of misoprostol into pre-service training curriculum for several health cadres.

The key elements of the advocacy focused on 1) a consolidation of the evidence— bringing together available global, regional and local evidence on use of misoprostol 2) Presentation of the evidence— multi-stakeholder process involving community, local NGOs, district representatives. The feedback from these groups was shared with the provincial level Technical Working Groups (TWG) who reviewed the evidence and provided recommendations to the Provincial Steering Committees (PSCs) on the specific policies necessary to endorse and 3) consensus building.

The changes resulted from a consultative and evidence-based process involving many stakeholders which put the government at the center of the initiative. Additionally champions were identified within the provincial health departments to further the cause. Relationship building and follow up with stakeholders was essential. The initiative was targeted and had specific goals. Further the devolved structure of Pakistan meant that changes could be made at the provincial level without the need to involve the federal government. The use of multi-stakeholder forums helped to secure an enabling environment for the policy changes to take root. Stakeholders targeted included: policymakers at the provincial level such as women parliamentarians, the Minister for Health, the Health Secretary, the Director General for Health Services, and provincial Program Managers for the Provincial Program for Family Planning and Primary Health Care and the Provincial Program for Maternal, Newborn and Child Health (MNCH), representatives of the Society of Obstetricians and Gynaecologists of Pakistan, the Pakistan Nursing Council, the Pakistan Medical Association, and the Pakistan Paediatric Association; policy implementers at the district level such as Executive District Officer (Health), District Coordinators for Lady Health Workers (LHWs) and MNCH programs, public and private healthcare providers, owners of private pharmacies/drug stores, and opinion leaders including civil society and community-based organizations, journalists, religious leaders, tribal chiefs, LHWs and other community health workers such as traditional birth attendants, and women of reproductive age.

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