Misoprostol for Postpartum Hemorrhage: From Evidence to Action  
July 14-15 2011 / New York

Introduction

Family Care International, working in collaboration with Gynuity Health Projects, brought together more than 50 leading advocates, health providers, program managers, and policy makers to discuss and develop advocacy strategies for improving access to misoprostol for prevention and treatment of postpartum hemorrhage (PPH). At the meeting, participants:

1. identified opportunities and challenges for promoting access to misoprostol for PPH
2. reviewed advocacy and policy strategies
3. drafted a set of core advocacy messages
4. provided input on a draft advocacy communications strategy

A key output from the meeting was a set of draft advocacy messages to promote misoprostol’s role in PPH prevention and treatment with a range of audiences at the global, regional, and country levels. These messages will provide a framework for driving policy change and expanding access to misoprostol in the coming years.

Session Summaries

Session 1: Setting the stage: The research and policy framework  
Moderator: Debra Jones, Family Care International  
Presenters: Rasha Dabash, Gynuity Health Projects; Melanie Pena, Gynuity Health Projects

Rasha Dabash, Gynuity Health Projects  
Current evidence on misoprostol’s role in the prevention and treatment of PPH / Presentation slides

Research has provided solid evidence of the use of misoprostol for prevention of PPH in a range of settings: most hospital-based studies found non-significant differences between misoprostol and injectable uterotonic; community-based randomized clinical trials (RCTs) conducted in Guinea-Bissau, The Gambia, India, and Pakistan show a reduction in PPH and other clinical markers, such as hemoglobin change, among women who received misoprostol. The community-based studies illustrate that misoprostol has the potential to address coverage gaps and provides logistical advantages for community settings. To-date, no comparative studies have been conducted on misoprostol vs. oxytocin in primary health centers or home delivery settings.

While until recently there was limited research on misoprostol’s role in PPH treatment, recently published hospital-based RCTs provide evidence that it is an effective first-line treatment for PPH. The clinical evidence to date can be categorized into four models of how misoprostol has been used to treat PPH:

1. First line treatment after prophylactic uterotonic: A double blinded, placebo-controlled RCT compared whether 800mcg sublingual misoprostol is similarly effective as 40 IU intravenous oxytocin for treating PPH. In settings where women were given oxytocin in the third stage of labor, misoprostol was equivalent to IV oxytocin in treating PPH (Blum et al., The Lancet Jan 2010).
2. **First-line treatment after no prophylaxis**: The same trial outlined in model 1 was also conducted in settings where women did not receive prophylactic oxytocin. Both misoprostol and oxytocin were very effective in stopping bleeding in 9 out of 10 women diagnosed with PPH, although oxytocin performed slightly better. The study suggests that in situations where IV oxytocin is not feasible, misoprostol is a good alternative treatment option (Winikoff et al., *The Lancet* Jan 2010).

3. **Adjunct treatment**: Results from four studies (Hofmyer, Zuberi, Walraven, Widmer) showed no benefit of simultaneous administration of IV oxytocin + 600mcg sublingual misoprostol over IV oxytocin alone for PPH treatment.

4. **Last resort**: There are a number of case reports on use of misoprostol as a last ditch effort when all uterotonic treatments have failed. While it is difficult to suggest a research design that would document the benefit of misoprostol in such a scenario, more than likely, the possible benefits of giving misoprostol probably outweigh any limitations given the critical nature of the woman.

Beyond these clinical scenarios we should think about program models which also take into account program- and cost-effectiveness; for example, a new hybrid model of secondary prevention, whereby a safe and effective treatment dose of 800mcg sublingual misoprostol is administered at 350mls of blood loss. This model has several potential advantages, including medicating fewer women, reducing costs and potentially improving acceptability. Gynuity Health Projects will be conducting research to compare primary prevention to this hybrid strategy at the community level in India and Egypt.

**Melanie Peña,** Gynuity Health Projects  
**The policy framework for misoprostol for PPH / Presentation slides**

Misoprostol is used in a variety of clinical settings, often with outdated protocols that are not based on evidence. National clinical guidelines are often slow to reflect the latest research, resulting in challenges in providing the most effective evidence-based health care. International organizations, including the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO), and the International Confederation of Midwives (ICM), have published clinical and policy guidelines related to the use of misoprostol for PPH in different contexts and settings. These guidelines provide guidance for standardizing clinical practice and knowledge.

**WHO**

- **Recommendations on the Prevention of Postpartum Hemorrhage, 2007**: To reduce blood loss after delivery, WHO recommends that active management of the third stage of labor (AMTSL) be offered to all women delivering with a skilled health professional. Misoprostol is recommended only in situations where skilled health workers are not able to provide AMTSL.

- **Guidelines for the Management of PPH and Retained Placenta, 2009**: Misoprostol may be considered as a third line of treatment for the management of PPH, because of its ease of administration and low cost compared with injectable prostaglandins. However, WHO does not recommend the distribution of misoprostol to community-level health workers or women and their families for routine or emergency use. WHO recommends additional research to understand how PPH can be managed effectively at the community level.

**FIGO and ICM**

In 2006, FIGO and ICM stated that misoprostol may be used for prevention, “In situations where no oxytocin is available or birth attendants’ skills are limited,” and acknowledge that misoprostol may be appropriate for treatment “in low resource settings and has been used alone, in combination with...”
oxytocin, and as a last resort for PPH treatment.”

FIGO is in the process of updating its guidelines, which will include a recommendation for the use of misoprostol for preventing and treating PPH in settings where oxytocin is not available. The guidelines are expected to be issued in 2012.

**The Model List of Essential Medicines**

The WHO Model List of Essential Medicines (EML) is an evidence-based resource providing guidance to national leaders and Ministries of Health on the medicines to be prioritized for the health of populations. In March 2011, misoprostol (200mcg tablet) was added to the WHO EML for the prevention of PPH. The Expert Committee for the Selection and Use of Essential Medicines noted that “600 micrograms [misoprostol] given orally is effective and safe for the prevention of PPH in settings where oxytocin, currently the standard of care to prevent PPH, is not available or feasible. Moreover, the Expert Committee moved misoprostol from the complementary to the core list of essential medicines, validating the drug’s important role in women’s health.

While there is consensus that misoprostol is a safe and effective option for PPH, challenges remain in ensuring that clinical guidelines reflect the latest evidence, and ensuring that health providers know of and practice evidence-based regimens. Advocacy and education can play a key role in informing countries of the international guidelines on use of misoprostol for PPH; promoting inclusion of misoprostol in national clinical guidelines; and ensuring that evidence-based regimens are adopted.

**Discussion**

Participants noted that in many countries policies which support the use of misoprostol have been in place for some time, but have not translated into its improved use and availability. In India, for example, there exist policies supportive of misoprostol’s use for PPH, but many midwives and other health providers do not know about its role in preventing or treating postpartum bleeding.

It was noted that there is a time lag between when evidence is available and published and when clinical and other policy guidelines are updated to reflect this new evidence. It was suggested that WHO should be encouraged to revise its guidelines sooner to make it easier to adapt the guidelines for use at the country level. Even with evidence-based guidelines, there is a need to ensure that the scientific research reaches the intended audience, and informs knowledge and practice.

---

Session 2: Surveying the field: Barriers and challenges  
**Presenter:** Francine Coeytaux, Independent Consultant

**Moderator:** Francine Coeytaux, Independent Consultant  
**Panelists:** Lilian Sepulveda, Center for Reproductive Rights; Debbie Armbuster, USAID; Beverly Winikoff, Gynuity Health Projects

Francine Coeytaux, Independent Consultant  
Mapping misoprostol globally and regionally for PPH: Opportunities, challenges, and barriers

Between 2010 and 2011, FCI commissioned a series of mappings at the global and regional levels to:

- identify organizational priorities and challenges related to misoprostol’s role in PPH;
- highlight key barriers, challenges, and strategies; and
- assess opportunities for collaboration, and advocacy and policy change.

Interviews were conducted with partner agencies, organizations, and individuals working on misoprostol for PPH at the global level and at the regional levels, including Latin America & the Caribbean, Eastern Africa, Western Africa, South Asia, and Middle East/North Africa.

Key findings included:

1) A growing number of organizations are working in this area, and most made the case for integrating the use of misoprostol into health services programming worldwide;
2) Respondents believe that misoprostol offers a real opportunity to make a difference in maternal mortality—one that is not dependent on waiting for health systems to be strengthened; and
3) Respondents believe that misoprostol is a life-saver, especially at the community level.

Survey respondents identified the following barriers to increasing access to misoprostol:

- lack of consensus on international clinical guidelines
- the association of misoprostol with abortion
- concerns about safety and side effects
- issues related to labeling and packaging
- provider scope-of-practice issues, including delegation to lower-level providers, and
- controversy over provision at community level, including fear of women’s empowerment.

Panel discussion

Lilian Sepulveda, Center for Reproductive Rights  
Right to use misoprostol, a human rights perspective

The ability to access and use misoprostol for PPH can be framed as a human right, enshrined in international treaties and standards. There are various human rights that frame individuals’ ability to access and use misoprostol:

1) right of women to access reproductive health services
2) right to health (of which sexual and reproductive health is a key element)
3) right to scientific progress and its benefits, and
4) right to nondiscrimination, gender equality and health equity.

Under international human rights law, governments are obligated to protect these rights, and ensure that these are upheld. In addition, governments must take steps to ensure access to high-quality health services, which includes misoprostol. When access to quality health care is denied, individuals’ human rights are violated, and governments can be held accountable for these violations.

Debbie Armbruster, USAID
Potential for the incorrect or mistimed use of misoprostol

All uterotonic drugs can cause uterine contractions in pregnancy and during the postpartum period. The potential for these drugs to cause harm in postpartum is very little; however, in labor, it can be significant. We know that the use of misoprostol to induce labor is common, and that it is an effective treatment option. Current WHO guidelines recommend 25mcg oral misoprostol for labor induction. Providing the right dosage has been challenging as dedicated 25mcg pills are not readily available (and must be cut from 200mcg pills). Incorrect dosages for inducing labor have resulted in serious adverse events, such as ruptured uteruses. The use of misoprostol for labor induction is a source of concern and could negatively impact programs aimed at introducing misoprostol for PPH. Information about correct regimens of misoprostol for use for labor induction will help reduce inappropriate use of the drug. There is an urgent need to disseminate clear and correct information to health providers, and have approved protocols as soon as possible.

Beverly Winikoff, Gynuity Health Projects
Misoprostol’s association with abortion

The idea that “stigma” may derail the expanded use of misoprostol for the prevention and treatment of PPH may be an overblown issue. It could also be an excuse promoted by those who prefer not to use the technology. To understand the arguments put forward, we can begin by listing them:

- **Distribution by lower-level health workers** could be unsafe, because the pills would be used for abortion. But we already have evidence that when women who do not have access to safe abortion services use misoprostol in this way, it is not unsafe, and in fact, saves lives.
- **Women will share the pills with friends and neighbors.** But studies have shown that women take the medication as directed. Indeed, they have only one dose at hand and would not be likely to give away pills that they have been told are important for their own health.
- **Health workers will sell the pills.** But health worker medical supplies are regulated and pills distributed so that no lower-level provider could create commerce with any of the medications.

All indications to the contrary, the drug may actually not be stigmatized: Doctors are enthusiastic providers of misoprostol in their own practices. The reluctance to allow wider use could be a disguise for other motivations such as:

- Fear of change
- Laziness
- Power plays
- Economic interest in holding onto a commodity in demand
- The need to say “something” in order to sound knowledgeable
We also need to look at the opposite side of the coin and ask: why are women’s health advocates so enthusiastic and eager to spread the technology widely without good evidence that large-scale programs are effective? For example, the drug is often called “life-saving” when we have no direct evidence that this is literally the case when used programmatically for PPH. There is better evidence for misoprostol’s role in saving lives as an abortion drug, even when used clandestinely, than for its use in large PPH programs. Conversely, there is stronger evidence of the danger of widespread use by medical doctors to induce labor than its use by women to induce the termination of pregnancy.

Discussion
Participants discussed how the human rights framework can be used by national organizations to advocate with governments for increased access to and availability of misoprostol for PPH. It is important to frame access to misoprostol as a matter of health equity and gender equality.

There was also substantial discussion about whether current evidence support the claim that misoprostol saves lives. It was noted that there is evidence that misoprostol reduces blood loss and the need for additional intervention; there is not sufficient data to determine whether mortality is directly averted due to uterotonic use.

It was noted that research has shown that the potential for women to use misoprostol incorrectly for PPH is minimal: in a study of 20,000 women, there was only one case of incorrect use of the drug, which was a suicide attempt. The greater potential and danger of incorrectly using the drug exists in the hands of doctors, not women.

Session 3: Communities, camps, and clinics: Using misoprostol in a range of settings
Moderator: Jeffrey Smith, Jhpiego
Panelists: Nuriye Hodoglugil, Venture Strategies Innovations; Lisa Thomas, World Health Organization; Godfrey Mbaruku, Ifakara Health Institute

Nuriye Hodoglugil, Venture Strategies Innovations
Community distribution of misoprostol for prevention of PPH

Research indicates that there is strong potential for using misoprostol at the community level, specifically to prevent PPH. There are a number of models for distributing misoprostol at the community level; these include:

1. Misoprostol is distributed to women at facility-based antenatal care visits.
2. Community health workers distribute misoprostol to women at home.
3. Misoprostol is included as part of safe birth kits.
4. Misoprostol is provided through pharmacies and private sector outlets (social marketing).

The cultural context and setting must be considered when choosing the most appropriate distribution model. There are challenges with ensuring that the drug is available to women at the community level, including:

- Lack of clarity of what we mean by community-level.
- Lack of clear guidance and policies for distribution of misoprostol at the community level, including authority of community health workers and health providers to administer
misoprostol.

- Beliefs that promoting community-based distribution of misoprostol deters women from delivering in a health facility. A range of factors influence why women do and do not go to the health care facility to give birth, and we do not know the reasons why women are not delivering in this setting. More evidence is needed to understand if community distribution of misoprostol influences facility-level births.

Lisa Thomas, World Health Organization
Use of misoprostol in relief/humanitarian settings

We cannot address maternal mortality without addressing the relief setting: 42 million people are displaced due to conflict and 2010 was the deadliest year for natural disasters in at least two decades. Data has shown that no crisis-affected, low-income country has reached a single MDG. Misoprostol has tremendous potential for impact in a relief setting where there is little organized or systematic health care infrastructure. Misoprostol is included in inter-agency field guidelines and manuals related to reproductive health for humanitarian contexts.

In crisis settings, misoprostol has recently been included in Inter-Agency Reproductive Health Kit number 8 for treatment of incomplete abortion. Humanitarian agencies are considering using misoprostol for PPH through community-based distribution and other mechanisms. There is, however, a need to systematically evaluate and monitor these interventions to build the evidence base and provide a solid foundation for advocacy.

Godfrey Mbaruku, Ifakara Health Institute, Tanzania
Use of misoprostol in primary and secondary health facilities

In developing countries, there are huge shortages of skilled birth attendants. Nurses and midwives attend most births at primary and secondary health facilities, and are often the only health providers available to manage childbirth-related complications. Since PPH is a sudden and unpredictable life-threatening condition, it makes sense that nurses and midwives should be able to give treatment for these complications. Oxytocin’s logistical challenges, such as the need to be stored in a cool, dark place and the fact that it must be injected, does not make it a suitable treatment for most women.

In Tanzania, misoprostol is used in both primary and secondary health facilities. There exists an acute shortage of skilled health care workers and skilled obstetricians—there is currently one obstetrician/gynecologist per 500,000-2 million patients.

Advocacy must be a concerted effort, which includes health provider associations (e.g., FIGO), ministries of health, politicians, and women’s empowerment and advocacy groups. Dissemination of data must reach all stakeholders who have the potential to advocate for the use of misoprostol. Advocacy efforts can be strengthened if we are able to show the number of potential lives saved, as well as the evidence of the use and effectiveness of the drug. If we want to reach MDG 5, PPH prevention must happen. Misoprostol is safe, effective, cheap, and user-friendly – and we must advocate for its use at the community level.
Discussion
Participants noted that community-level distribution of misoprostol should not be implemented as a vertical program, but integrated with broader efforts to promote quality maternal health care. Community-level distribution strategies must be accompanied by education and messaging related to the importance of accessing maternal health care at health facilities.

Whether we can and should promote community-based distribution is not the only question; we must address both prevention and treatment at all levels of the health care system. In terms of program- and cost-effectiveness, we need to think about whether a prevention-plus-treatment approach vs. a treatment-as-needed approach may be the best use of limited resources.

It was noted that the effect of distributing clean birth kits on delivery at a health facility was also studied. The conclusion reached: a range of factors interplay to influence a woman’s and her family’s decision to give birth at a health facility, and that we simply may not have the answer to this question.

Sessions 4 & 5: Making the case: Developing evidence-based messages (Working groups’ messaging and report back/discussion)
Moderator: Francine Coeytaux, Independent Consultant

During this session, participants divided into three groups to review and develop strategic advocacy messaging related to the following topics:
- Availability of misoprostol
- Safety and efficacy
- Association with abortion

For each of these topics, participants were asked to complete a messaging grid (see Annex 1: Strategic Messaging) and respond to the following questions:
1. Is the current messaging related to your topic consistent with the available scientific evidence?
2. Is the current messaging related to your topic compelling to drive policy change? Why or why not?
3. What alternative messaging can you develop that reflects current evidence and is persuasive?

Discussion
In the report back to the full group, participants shared the strategic messaging developed by the groups (see Annex 1: Strategic Messaging). In the subsequent discussion, participants discussed the need to first identify target audiences, and tailor messages to that particular audience.

Some participants noted that it is important to be upfront about all the indications related to misoprostol’s use, and that strategies for its introduction for PPH are the same for other indications. In Kenya, for example, the strategy that was employed included information on all potential uses of misoprostol, even abortion. Others countered that this may not be possible on a practical level (due to funding constraints), and that this can distract or divert from attention or support for PPH.
Session 6: Driving policy change: Experiences from three countries

Moderator: Andres de Francisco, Partnership for Maternal, Newborn & Child Health

Presenters: Kusum Thapa, Nepal Society of Obstetricians & Gynecologists; Wilfrido Leon, Hospital Gineco Obstetrico Isidro Ayora; Joseph Karanja, University of Nairobi

Kusum Thapa, Nepal Society of Obstetricians & Gynecologists

Nepal: From Pilot program to national strategy / Presentation Slides

In Nepal, the leading cause of maternal death is PPH. Nepal has a low rate of institutional deliveries, and low uterotonic coverage. In addition, there are high levels of provider absenteeism and low staff retention, particularly in remote areas. The government’s strategy for preventing PPH is promoting active management of the third stage of labor, and use of misoprostol at homebirths.

The government piloted a study in one district where misoprostol was distributed by female community health volunteers for use at home births. The results from the study showed that this was a feasible strategy, and that it significantly increased uterotonic coverage, specifically in remote settings. Misuse and inappropriate timing was not found to be a problem. Based on these results, the government recommended scaling-up this strategy to other districts. Partners from the maternal & newborn health community, along with the Nepal Society of Ob/Gyn, played a key role in advocacy.

Community-based distribution of misoprostol for use in childbirth has now been scaled up to 22 districts. Key achievements include:

- Policy approval for national scale up secured in a short period of time;
- Misoprostol is prioritized by government for prevention of PPH at homebirth, along with commitment to institutional deliveries and skilled birth attendance;
- Strong advocacy by professional organizations;
- Scale-up strategy in phases;
- Strong coordination by a range of partners.

While Nepal’s strategy to expand community-based distribution is considered successful, a number of challenges remain, including distributing misoprostol and ensuring its availability in remote areas.

Dr. Wilfrido Leon, Hospital Gineco Obstetrico Isidro Ayora, Ecuador

Inclusion of misoprostol in national EML / Presentation Slides

In 2011, misoprostol was added to Ecuador’s EML. Beginning in 2006, a number of supportive policies were implemented and laid the groundwork for the incorporation of misoprostol in the national EML; these include:

- The national plan (2008) included the reduction of maternal and neonatal deaths
- Development of national norms and protocols for maternal and neonatal health (2008)
- Development of family planning norms and protocols (2010)

For many years, women’s groups, medical associations, and advocates tried unsuccessfully to lobby for its inclusion in the EML. Concerted advocacy by influential individuals and agencies, both from within and outside the ministry of health, led to a decision by the national health council (CONASA) to include misoprostol on the EML.

Misoprostol for PPH: From Evidence to Action
In order to secure widespread acceptance and use of misoprostol for PPH, the following challenges have to be addressed:

- Ensuring availability of uterotonics;
- Progressive incorporation of obstetric norms and protocols;
- Building clinical capacity;
- Resistance to change by health personnel;
- Negative reputation of misoprostol.

Joseph Karanja, University of Nairobi, Kenya

Policy change to register misoprostol for PPH/ Presentation Slides

Misoprostol is available for the treatment and prevention of PPH in Kenya. In 2010, a number of policies in support of misoprostol’s role for PPH were enacted; these include:

- Registration of misoprostol for obstetric gynecological indications;
- Inclusion of misoprostol in the essential medicine list, and national clinical guidelines;
- Development of clinical protocols.

Advocacy activities to achieve these goals employed a multi-pronged strategy:

- Pilot studies on the safety, efficacy, and feasibility of misoprostol’s use for PPH
- Seminars on the correct use of misoprostol
- Media appearances and newspaper articles
- Teaching about correct use of misoprostol in RH to nursing, midwifery, and medical students and residents
- Reviewing the EML and developing clinical guidelines

Initially, a pilot project on community-based distribution of misoprostol was conducted in two districts. The project included awareness-raising campaigns using culturally appropriate posters, pamphlets, and other materials. Results from the program indicated that the distribution of misoprostol tablets to pregnant women at antenatal visits and through community midwives is safe (97% of women used it correctly), feasible (98% of women who attended antenatal care enrolled in the project), and effective (95% of home births were protected with misoprostol).

The project recommended the distribution of misoprostol at antenatal care visits and through community midwives be scaled up throughout Kenya to ensure greater numbers of women are protected from PPH. Training of health care providers to distribute this drug and increased community sensitization about preparing for safe delivery should accompany these efforts.

Discussion

Participants noted that Nepal provides a model which other countries can adapt for their own country contexts; there was a high degree of coordination among the major agencies working on maternal and newborn health and strong advocacy by civil society groups.

There is a need to have robust evaluation schemes which provide evidence of impact, and which provide the basis for driving evidence-based advocacy campaigns.
Participants also discussed how the packaging of misoprostol was handled in each of these countries. In Nepal, different packaging and labeling has been used to differentiate between the many uses of the drug (for medical abortion, for PPH, etc.). This has proved to be a good mechanism for ensuring that the drug is used correctly.

In Ecuador, where the institutional delivery rate is 80%, the most significant barrier to wider use and availability of misoprostol is the resistance from health providers. Inclusion of misoprostol in the EML and in national norms does not mean that it will be widely accepted or used by health providers.

Participants requested whether it would be possible to get data from pilot projects in the various countries, and discussed how this information can be used to inform new program development.

Session 7: Learning from success: Lessons from other advocacy campaigns
Moderator: Nirvana Gonzalez Rosa, Latin American and Caribbean Women’s Health Network
Panelists: Elizabeth Westley, International Consortium for Emergency Contraception; Rebecca Gomperts, Women on Waves; Scott Wittet, PATH

Scott Wittet, PATH
HPV vaccine for cervical cancer / Presentation Slides

We know that 275,000 deaths due to cervical cancer occur annually. Of these deaths, 88% occur in low-resource settings. The HPV vaccine can have a dramatic impact on reducing the rates of cervical cancer globally.

PATH employs four main advocacy strategies to promote greater use and availability of the HPV vaccine; these include:
- Raising awareness (through publications, web-based resources, calls to action)
- Reducing global barriers (the need for scientific evidence, high price of vaccine)
- Support country planning; and
- Promoting comprehensive prevention, including vaccination and screening.

PATH develops and maintains websites such as the RHO cervical cancer library, which offers resources on cervical cancer and cervical cancer prevention programming. PATH also works in close partnership with international health agencies, including WHO, PAHO, FIGO, and the GAVI Alliance, and provides leadership for the Alliance for Cervical Cancer Prevention and the Cervical Cancer Action coalition (CCA). CCA also spearheaded the Global Call to Stop Cervical Cancer, a mechanism to document the growing demand for the HPV vaccine through op-eds, letters, and other statements of support from heads of state and key stakeholders.

At the country level, PATH recently completed a series of HPV vaccine demonstration projects that have generated solid evidence about the most effective strategies for immunizing young adolescent girls in the developing world. Lessons learned focus on planning for screening and vaccination, providing accurate, science-based data and information, and steps for decision-making. Additionally, PATH facilitates linkages between planners and program managers with tools (such as the Cervical Cancer Prevention Action Planner) and technical assistance.
Emergency Contraception
Elizabeth Westerly, International Consortium for Emergency Contraception / Presentation Slides

Emergency contraception (EC) and misoprostol have existed in the global market for a long time. There are a number of lessons from EC that we can apply to misoprostol, and these center principally around the components of access. There are several components of access that we must pay attention to when introducing a new reproductive health technology. They are all very important – lack of attention to any one component can result in women and couples having less access. All these components – and more – need to be in place in order for success. Components of access include product development and production, drug registration, availability, awareness, correct or “actionable” knowledge, and affordable cost.

Additionally, it is important to understand who is gaining access. EC was seen to gain availability in urban middle-to-upper-income women and has not been routinely integrated into contraceptive counseling or HIV counseling. This issue of health equity is of continued concern.

Rebecca Gomperts, Women on Waves
Medical Abortion / Presentation Slides

Women on Waves has developed and implemented a range of strategies to disseminate information and increase women’s access to medical abortion. The channel through which this information is disseminated depends on the political and cultural setting. In Ireland, Poland, Portugal, and Spain, Women on Waves carried out ship campaigns to provide safe abortion services. In other countries, stickers and money stamping have been used to convey information about the use of misoprostol. In Tanzania, Kenya, and Uganda, local women’s organizations are trained through community outreach to provide information about the use of misoprostol for safe abortion and PPH prevention. In Tanzania, the local women’s organization has been able to open their own pharmacy, where they are able to sell and dispense the drug. Women on Waves also utilizes web-based strategies (www.womenonweb.org) to share information and provide support for women.

Safe abortion hotlines were created in Ecuador, Chile, Argentina, Peru, Venezuela, Indonesia, and Pakistan. In Pakistan and Indonesia, the hotline is implemented in conjunction with a community outreach intervention. In Pakistan, youth have been a major advocate for the drug’s acceptance. Our self-censorship is often the major obstacle in providing access to this drug. “If we give women the information, they will be able to overcome the obstacles themselves.”

Discussion
One participant noted that there are lessons from other sectors which can inform our strategies for dealing with the controversial aspects related to misoprostol: “How can we use what has been learned in India regarding myths about vaccines to inform our advocacy regarding misoprostol’s association with abortion?”

Some noted whether the misoprostol community can replicate the strategy for the HPV vaccine and develop a global call for action for misoprostol. Women on Waves suggests that we should bypass the providers: “All we need to do is make sure women know about misoprostol and they can use it by themselves without a doctor or other health professional for a safe abortion or PPH prevention.” Should our strategies solely focus on informing women?
Session 8: Driving policy change: Audiences and messages
Debra Jones, Family Care International
Messages and audiences for advocacy & policy / Presentation Slides

Moving from evidence to action requires a strategic approach, where our message is a structured, powerful, goal-oriented, target-audience-specific statement. Identifying a common goal and objectives will allow us to identify our audiences, and channels of communication, and allow us to create our strategic advocacy campaign. Goals and objectives we identified include:

- Inclusion of misoprostol in national protocols, EMLs, and clinical trainings
- Disseminate information on PPH
- Increase access and availability to where every woman has the ability to get a uterotonic
- Reduce and eliminate maternal mortality through the prevention and treatment of PPH
- Link advocacy efforts for misoprostol to MDG4 & 5 efforts

Understanding our audiences is an integral part in creating our message. It is important that we compile the lessons learned from other projects and programs, and use them to ensure that we achieve our goal. We must use all forms of communications in order to reach our audiences.

Target audiences are important to identify. However, we must be cognizant of the messages we send to each audience and the cultural and political setting in which they reside. Potential audiences identified by participants include: professional associations, training institutions, medical doctors, midwives, health care providers, decision makers’ with the responsibility to update clinical guidelines, consumers, the media, community members (men and women), donors, and pharmaceutical companies.

Once we identify our target audience(s), we must also identify our potential partners in this campaign. Such partners can include:

- Organizations currently working on the Global Strategy for Women and Children’s Health who have $40 billion in committed donor dollars
- The private sector
- Humanitarian and relief organizations – to assess the potential of including misoprostol in relief kits addressing gender-based violence.

In addition to identifying partners, we must also reach out to potential champions and leaders willing to speak out and be the “face” of the campaign. These champions include decision makers, health care providers, educators, and community members, among others.

Next steps include defining our story, building a coalition, and creating a call to action. We must create a story that can be adapted and tailored for each setting. We must also be prepared to respond to ant-choice arguments which view increased access to misoprostol as increasing access to abortion. It is particularly important to be careful in wording our messages, for example: changing the language from “misuse,” which has a negative connotation, to “incorrect” or “mistimed” use of misoprostol.

Participants identified potential top line messages:

- PPH and unsafe abortion account for 40% of maternal mortality. Misoprostol is a tool which can combat 40% of maternal deaths.
- Misoprostol is a safe and effective intervention.
- Focus on the MDGs.
Participants identified opportunities for advocacy and dissemination of messages in 2011 and 2012:

- WHO EML Committee (Oct 2012): supporting documentation must be submitted well before the October deadline
- Country EMLs
- Global Strategy for Women’s and Children’s Health – Country commitments
- Women Deliver 2012 Regional Consultations
- Social Determinants of Health Conference (Brazil, October 2011)
- MCHIP Regional Meeting Asia (March/April 2012)
- ECSA meeting (Tanzania, Oct 2011)
- FLASOG (September 2011)
- ESCAOGS (Maputo, October 2011)
- FIGO World Congress (Rome, Italy, Oct 2012)
### Annex 1: Strategic Messaging

**Group 1: Safety & efficacy**

<table>
<thead>
<tr>
<th>Current Messages</th>
<th>Alternative strategic messages</th>
</tr>
</thead>
</table>
| • Misoprostol is a powerful drug. Its incorrect use can result in uterine rupture.  
  o Yes, this is a message that’s out there. And it is true... But we need to address it, and come up with something more positive. This is very negative and scary.  
• Dosage is an important policy question.  
  o This is accurate, but is not compelling to drive policy change, and it overemphasizes one potential risk without mentioning any of the very real potential benefits.  
  o One way to approach is as pharmacy industry does – start with the benefits, then follow with warnings of potential risks.  
  o Need clarity of use in prevention vs. use in treatment. There are still open questions, especially regarding when can it be used in the continuum.  
  o Shouldn’t isolate miso as if it is aspirin for a headache – it is a tool that can be integrated in broader more complex approaches to PPH.  
  o All drugs are powerful, and all drugs have side effects. So we need to turn this around – powerful and effective, just like other drugs; have risks, just like other drugs. “Use it well, use it right, it does good things.”  
  o Think (re: policy makers): What’s your biggest bang for your buck?  
  o Misoprostol is a life-saving drug.  
  o ‘Lifesaving’ is the conclusion – all of our arguments have to total up to that.  
  o No one hesitates to say that oxytocin saves lives (in context of PPH) – why should we hesitate to say it regarding misoprostol... regardless of lack of direct statistical evidence.  
  o We do not have the evidence to make the statement that it is a life-saving drug. | • Misoprostol improves the health of women in a number of ways... important to learn about proper use  
• Misoprostol is most effective when provided after delivery of the baby (especially for use with service providers)  
• A way of addressing one of the largest killers of women in childbirth.  
• Getting access to misoprostol now will help reduce maternal mortality and achieve MDG5. (Most neglected MDG, lagging behind) – i.e., connect it to the big picture. (For policy audience) (But “not a silver bullet” – part of the arsenal of tools...)  
• At policy level: drug with multiple purposes  
• A woman needs to have a uterotonic [avoid the oxytocin vs. misoprostol debate]  
• Cost-effective: good word with parliamentarians/policy makers  
• “Correctly used, safe and effective” – but only when needed.  
• Misoprostol is a safe, effective, lifesaving intervention.  
• ‘Saves women’s lives’  
• Misoprostol effectively stops post-partum hemorrhage, the leading cause of maternal deaths worldwide.  
• You could save up to 130,000 lives...  
• Misoprostol is as good as oxytocin, so why not make it available to all? |
### Group 2: Availability

<table>
<thead>
<tr>
<th>Current messages</th>
<th>Alternative strategic messages</th>
</tr>
</thead>
</table>
| Misoprostol should be made available only in health facilities where oxytocin cannot be used, because oxytocin is the gold standard for prevention and treatment of PPH. | • Every woman should have the right to access uterotonics drugs wherever she gives birth for the prevention and treatment of PPH  
• Governments, donors, and implementing partners must work together to ensure availability of drugs.  
• Community distribution of misoprostol is an important distribution method and should complement efforts to promote skilled care. |

### Group 3: Association with abortion

<table>
<thead>
<tr>
<th>Current Messages</th>
<th>Alternative strategic messages</th>
</tr>
</thead>
</table>
| Misoprostol will be used for abortion if made widely available for PPH. | • PPH and unsafe abortion are leading causes of maternal mortality. We have a drug that can reduce maternal mortality and help countries reach the MDGs.  
• There is no scientific evidence that any method will increase abortion.  
• To withhold misoprostol, a life-saving drug from women who need it, is a violation of human rights.  
• Misoprostol is a safe, inexpensive, and readily available drug that can be used for several purposes.  
• Women already use many methods to induce abortion of which many are dangerous.  
• By providing misoprostol you uphold a woman’s right to health  
• Misoprostol can cause an abortion, so can a stick. Misoprostol is much safer. |