Changing Maternal Health Policy and Programs in Bangladesh: Misoprostol for Prevention of Postpartum Hemorrhage

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Mayer Hashi project
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Background

- The maternal mortality rate in Bangladesh decreased from 322 deaths per 100,000 live births in 2001 to 194 per 100,000 in 2010.
- Postpartum hemorrhage (PPH) is still the leading cause of maternal death (31% in 2010).
- Facility deliveries increased from 15% in 2001 to 29% in 2011.
- The government emphasizes the use of community skilled birth attendants for home births and the development of a midwifery cadre to increase skilled attendance at facilities.
- EngenderHealth, through the USAID-funded Mayer Hashi project, supports the Ministry of Health & Family Welfare in preventing PPH through a two-pronged approach:
  - Active management of the third stage of labor at the facility level in 21 low-performing districts
  - Community-based distribution and use of misoprostol

(Ref: BMMS 2001 and 2010, BDHS 2011)
History

- Misoprostol was first discussed in Bangladesh in a 2006 national meeting on evidence-based best practices for reducing maternal mortality.

- Given the high rate of home delivery in Bangladesh, maternal health experts believed misoprostol could help reduce maternal mortality due to PPH.

- A PPH Prevention Task Force was formed, with EngenderHealth as the Secretariat.

- The PPH Prevention Task Force developed a step-wise plan for introducing misoprostol that included a two-phase pilot in two districts.
Advocacy Process: Introduction of Misoprostol

- Reviewed international literature/studies on misoprostol for PPH prevention and discussed these in the PPH Prevention Task Force.
- Developed and implemented a two-phase misoprostol pilot to assess fieldworkers’ ability to safely distribute misoprostol.
- Ensured registration of misoprostol for PPH prevention indication working with pharmaceutical companies and Directorate of Drug Administration.
- Evaluated the pilot program and shared findings with stakeholders.
- Shared information regularly among organizations involved in misoprostol piloting and research programs and the Government.
- Involved and motivated policymakers through frequent meetings and joint field visits.
- Shared project findings and international studies with policymakers through regular meetings.
Advocacy Process (2)

- Conducted advocacy training for Task Force members.
- Developed national scale-up plan with PPH Prevention Task Force, several partners, under Government leadership.
- Planned phased scale-up with continuous meetings and consultations to advance policy and program issues.
# Misoprostol Use in Two Pilot Districts

<table>
<thead>
<tr>
<th>District</th>
<th>Number of pregnant women registered</th>
<th>Number of women delivered</th>
<th>Number of women delivered at home</th>
<th>Number of women who took misoprostol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangail</td>
<td>22,050*</td>
<td>19,066</td>
<td>16,513</td>
<td>15,605 (95%)</td>
</tr>
<tr>
<td>Cox’s Bazar</td>
<td>25,320</td>
<td>19,188</td>
<td>17,477</td>
<td>16,689 (95%)</td>
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*In both districts, 70% of pregnant women were registered by the fieldworkers.

Good results from the pilot districts played an important role in the advocacy process.
## Major Advocacy Milestones

<table>
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<tr>
<th>Date</th>
<th>Milestone</th>
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<tr>
<td>October 2006</td>
<td>National PPH Prevention Task Force is established.</td>
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<tr>
<td>May 2008</td>
<td>The Directorate General of Drug Administration approves misoprostol for prevention of PPH and includes it in the updated essential drug list.</td>
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<tr>
<td>August 2008</td>
<td>The pilot testing of community-based distribution of misoprostol by GOB and NGO fieldworkers is approved.</td>
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<tr>
<td>March 2010</td>
<td>The misoprostol dose for preventing PPH—400 mcg—is agreed upon and approved for national use.</td>
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<tr>
<td>May 2010</td>
<td>The National Technical Committee of the DGFP approves distribution of misoprostol through DGFP field structures.</td>
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<td>September 2010</td>
<td>The national scale-up plan is approved.</td>
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<td>July 2011</td>
<td>Community-based distribution of misoprostol is included in the Health Population Nutrition Sector Development Program and the Operational Plans of the DGFP and DGHS.</td>
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<tr>
<td>2011/2012</td>
<td>Misoprostol is included in the DGFP and DGHS management information system.</td>
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Lessons Learned

- Advocacy and sensitization is a continuous and long process.
- It is important for advocates to be flexible and adapt their strategy according to need along the way.
- A combination of advocacy and pilot program implementation is vital to advancing a new issue effectively.
- Formation of a task force under the leadership of the government with all key groups represented, including professional bodies, is of key importance.
- Involving the government every step of the way is crucial to creating ownership.
- Advocacy by the appropriate professional body is essential.
- Policies can be changed if a consistent advocacy process is followed and if the right people are sensitized and convinced that the issue is a national priority.
Next Steps

- Phased scale-up of misoprostol program was started in four districts; two more districts have just been added.
- The focus for advocacy is now on advancing the scale-up. This includes, for example, ensuring government purchases of misoprostol.
- Other advocacy topics include establishing a solid supervision and monitoring and evaluation system, ongoing on-the-job training, and a behavior change communication program.
- Training of trainers for remaining districts will take place over the next six months.
- The PPH Prevention Task Force will remain active, to discuss PPH prevention issues, including misoprostol.
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