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

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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)

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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.

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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.

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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.

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Misoprostol Use in Two Pilot Districts

District	Number of pregnant women registered	Number of women delivered	Number of women delivered at home	Number of women who took misoprostol
Tangail	22,050*	19,066	16,513	**15,605 (95%)**
Cox's Bazar	25,320	19,188	17,477	**16,689 (95%)**

*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.

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Major Advocacy Milestones

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

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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.

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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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